



# Out of Hours Palliative Care Advice: who's calling and what do they need to know?

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## Introduction:

Provision of palliative care outside of 'Working Hours' remains both a priority and a challenge.

End of life and death has become progressively more institutionalised in the first world.

In Ireland in 2010 in-patient care, accounted for place of death for 74% of deaths in that year. <sup>1</sup>

## Aims and Objectives:

This study examines out of hours calls by health care professionals to a hospice.

## Method:

- A retrospective review of 32 months of records of out of hours calls from December 2014 to September 2017.
- Only calls related to patients who had not, or were not subsequently referred to the hospice service were included.
- Call data included information on the caller, patient, problem and documented advice given. Calls were recorded in an ISBAR format.
- The resulting database was analysed for trends and common call themes.

## Results:

A total of 235 calls were included.

194 calls (84%) were from Non Consultant Hospital Doctors and 41 calls (16%) were from nurses working within the acute hospitals.

231 of patients were in acute hospitals at the time of calling. The patient profile was female (49%) and male (51%) and malignant 131 (56%), non-malignant 101 (44%) conditions. Lung (21%), colorectal (13%) and haematological malignancy (8%) were the most common specific malignant diagnoses. Pneumonia and sepsis in the setting of multi-morbidity (23%) was the most common non-malignant diagnosis, followed by heart failure and stroke.

Female	49%
Male	51%

Malignant	56%
Non-malignant	44%

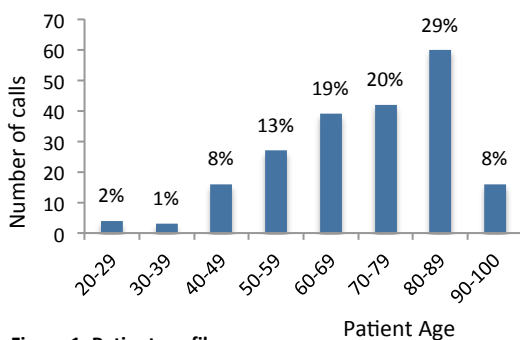


Figure 1. Patient profile

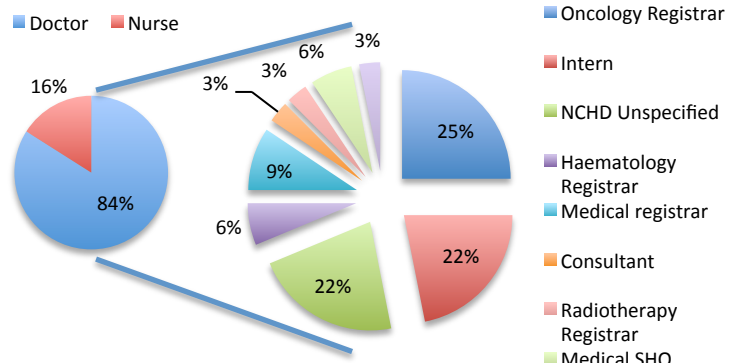


Figure 2 . Profile of callers to hospice

Problem	no. of calls	%
Advice re CSCI titration	71	24%
End of life Care	56	19%
Agitation	44	15%
Pain Control	31	10%
Secretions	27	9%
Opioid toxicity	22	7%
Dyspnea	14	5%
Advice re anticipatory meds	12	4%
Nausea & vomiting	10	3%
Seizures	8	3%

Table 1 . Symptoms by frequency

Commonest reason for calls was for advice regarding symptom management in the form of continuous subcutaneous syringe driver titration in line with breakthroughs, end of life care in particular management of terminal delirium and secretions, followed by pain management, management of opioid toxicity, dyspnoea and advice regarding anticipatory medications.

**Conclusion:** The above highlights a limited number of recurrent issues requiring specialist palliative care advice. We believe that the above data could be used to provide targeted education intervention to health professionals to support generalist palliative care provision in acute hospital setting.

## References:

1. Murray, E. & Series, I. H. F. P. Access to Specialist Palliative Care Services and Place of Death in Ireland. 10 (2013).
2. Ridley, J. Z. & Gallagher, R. Palliative Care Telephone Consultation: Who Calls and What do they Need to Know? *J. Palliat. Med.* (2008). doi:10.1089/jpm.2008.0002



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