International Collaborative for Best Care for the Dying Person

Tenth International Research Conference on Best Care for the Dying Person

Liverpool, UK – 20th November 2025

CONFERENCE GUIDE

University of Liverpool

Association for Palliative Medicine Of Great Britain and Ireland

NHS Liverpool University Hospitals NHS Foundation Trust

Contents

WELCOME TO LIVERPOOL

20th November 2025

Dear Colleague,

On behalf of the University of Liverpool and the International Collaborative for Best Care for the Dying Person, it gives me great pleasure to welcome you to Liverpool for this conference on Best Care for the Dying Person.

The programme for the event aims to provide an overview of innovative developments relating to end-of-life care, and offers an opportunity to share research, educational initiatives and best practice at both national and international levels.

I very much hope that you enjoy the conference and that you find it beneficial in your current and future practice. If you require any assistance during the day, please don't hesitate to approach a member of the team.

Kind regards,

J. E. Ellershaw

Professor John Ellershaw MA FRCP

Professor of Palliative Medicine

Head of the Palliative Care Unit, University of Liverpool

Chair of the International Collaborative for Best Care for the Dying Person

PROGRAMME

MORNING PROGRAMME	
08:45	**Registration and coffee**
SESSION 1 – Chaired by Professor Carl Johan Fürst Lund University, Sweden	
09:30	**Opening Address** ***Professor John Ellershaw***
09:35	**Welcome** ***David Melia,*** *Group Chief Nursing Officer, University Hospitals of Liverpool Group* ***Professor Peter McCormick,*** *Associate Pro-Vice Chancellor for Postgraduate Affairs and International Partnerships, University of Liverpool*
09:40	**The International Collaborative for Best Care for the Dying Person: Successes over the past ten years and ambitions for the future** ***Professor John Ellershaw*** *Professor of Palliative Medicine, University of Liverpool, and Chair of the International Collaborative for Best Care for the Dying Person*
10:00	**The International EU Horizon 2020 iLIVE Project: key research findings and implications for palliative care practice** ***Professor Agnes Van Der Heide*** *Professor of Decision-Making and End of Life Care, Department of Public Health, Erasmus University Medical Centre, Netherlands*
10:20	**The National Audit of Care at the End of Life (NACEL): What have we learned and how can we drive forward improvement in care for the dying?** ***Dr Mary Miller*** *Consultant in Palliative Medicine, Oxford University Hospitals, UK and NACEL Clinical Lead*
10:40	**Panel Discussion**
11:00	**Coffee and Poster Viewing**
SESSION 2 – Chaired by Professor Carl Johan Fürst Lund University, Sweden	
11:20	**What has the palliative care community learned from the implementation of Physician Assisted Suicide in the State of Victoria, Australia?** ***Associate Professor Mark Boughey*** *Consultant in Palliative Medicine, St Vincent's Hospital Melbourne, Australia*
11:40	**Is it possible to develop European-wide standards for palliative care education? The EU COST Action CODE-YAA Project** ***Dr Stephen Mason*** *Senior Lecturer, University of Liverpool, UK*
12:00	**Digital Legacy in Palliative Care Research: Challenges and Opportunities** ***Dr Amara Nwosu*** *Senior Clinical Lecturer, Lancaster University, UK*
12:20	**Panel Discussion**
12:30	**Lunch and Guided Poster Viewing (13:00-13:30)**

<table>
<tr><th colspan="3">AFTERNOON PROGRAMME</th></tr>
<tr><th colspan="3">SESSION 3 – PARALLEL SESSION A
In-person delegates may choose any one of the following 50-minute sessions:</th></tr>
<tr><th>Time</th><th>Session</th><th>Location</th></tr>
<tr><td rowspan="4">13:30</td><td>1. Oral presentations from submitted abstracts
<i>Led by Dr Vilma Tripodoro, Pallium LatinoAmerica, Argentina, and Dr Susie Wilkinson, University of Liverpool, UK</i></td><td>Main Hall
<i>13th Floor</i></td></tr>
<tr><td>2. Driving Quality Improvement through NACEL
<i>Led by Dr Mary Miller & Dr Julie Bellieu</i></td><td>Space 7
<i>12th Floor</i></td></tr>
<tr><td>3. Ethical Issues in Care for the Dying
<i>Led by Associate Professor Mark Boughey & Dr Teodora Manea</i></td><td>Space 8
<i>12th Floor</i></td></tr>
<tr><td>4. Education in Palliative Care
<i>Led by Dr Stephen Mason & Catarina Simões RN</i></td><td>Space 9
<i>12th Floor</i></td></tr>
<tr><td>14:20</td><td colspan="2">Five minute break to change sessions</td></tr>
<tr><th colspan="3">SESSION 4 – PARALLEL SESSION B
In-person delegates may choose any one of the following 50-minute sessions:</th></tr>
<tr><th>Time</th><th>Session</th><th>Location</th></tr>
<tr><td rowspan="4">14:25</td><td>5. Oral presentations from submitted abstracts
<i>Led by Dr Marisa Martin Rosello, Fundacion Cudeca, Spain, and Grethe Skorpen Iversen RN, Haukeland University Hospital, Norway</i></td><td>Main Hall
<i>13th Floor</i></td></tr>
<tr><td>6. Driving Quality Improvement through NACEL
<i>Led by Dr Mary Miller & Dr Julie Bellieu</i></td><td>Space 7
<i>12th Floor</i></td></tr>
<tr><td>7. Ethical Issues
<i>Led by Associate Professor Mark Boughey & Dr Teodora Manea</i></td><td>Space 8
<i>12th Floor</i></td></tr>
<tr><td>8. Education in Palliative Care
<i>Led by Dr Stephen Mason & Catarina Simões RN</i></td><td>Space 9
<i>12th Floor</i></td></tr>
<tr><td>15:15</td><td colspan="2">Tea and Poster Viewing</td></tr>
<tr><th colspan="3">SESSION 5 – Chaired by Professor John Ellershaw</th></tr>
<tr><td>15:35</td><td colspan="2"><i>Global Challenges in Care for the Dying – the Lancet Commission Report</i>
<i>Roger Phillips</i><i>, BBC Broadcaster, in conversation with </i><i>Dr Libby Sallnow, Associate Professor, University College London and first author of the Lancet Commission on the Value of Death: bringing death back into life (2022).</i></td></tr>
<tr><td>16:15</td><td colspan="2">Prizes for oral and poster presentations
<i>Professor John Ellershaw</i></td></tr>
<tr><td>16:20</td><td colspan="2">Looking to the future
<i>Professor John Ellershaw</i></td></tr>
<tr><td>16:30</td><td colspan="2">Close</td></tr>
</table>

PLENARY PRESENTATIONS

The International Collaborative for Best Care for the Dying Person: Successes over the past ten years and ambitions for the future

Professor John Ellershaw

University of Liverpool

Professor John Ellershaw MA FRCP is Professor of Palliative Medicine at the University of Liverpool, where he has led the development of palliative care research and education since 2004. As Head of the University's Palliative Care Unit (PCU), he supervises a multi-professional team engaged in the delivery of research on four core themes: Best Care for the Dying Person; Clinical Pharmacy & Pharmacology; Education Research & Development; and Supportive & Palliative Care. He also plays a major role in undergraduate and postgraduate education in relation to both palliative care and communication skills. At the University Hospitals of Liverpool Group, Professor Ellershaw is a consultant in palliative medicine and leads the research and development portfolio in palliative care across the Royal Liverpool University Hospital and Aintree University Hospital. Professor Ellershaw is the founding chair of the International Collaborative for Best Care for the Dying Person, a group of leading thinkers, practitioners, and researchers from 77 counties united by the common goal of improving care for dying people and their families across the globe.

The International EU Horizon 2020 iLIVE Project: key research findings and implications for palliative care practice

Professor Agnes van der Heide

Erasmus University Medical Centre, Rotterdam, NL

Professor Agnes van der Heide, MD, PhD, is a researcher working at the department of Public Health at Erasmus MC, University Medical Center Rotterdam, in the Netherlands. Her research focuses on clinical, epidemiological and ethical aspects of palliative and end-of-life care. She has a special interest in end-of-life decision making. She has been the PI of several large international research projects. Currently, she coordinates the iLIVE project, an EU funded study on cross-cultural experiences of end-of-life care.

The National Audit of Care at the End of Life (NACEL): What have we learned and how can we drive forward improvement in care for the dying?

Dr Mary Miller

Oxford University Hospitals, UK and NACEL Clinical Lead, UK

Dr Mary Miller is Consultant in Palliative Medicine at Oxford University Hospitals NHS Foundation Trust, Honorary Senior Clinical Lecturer in Palliative Medicine at the University of Oxford, Director OxCERPC (Oxford Centre for education and research in palliative care) and National Clinical Lead NACEL (National audit of care at the end of life). She qualified from University College Cork in 1988 and trained and worked in palliative medicine in Ireland, Sweden and the UK. She has been a consultant in palliative medicine in Oxford since 1998. Dr Miller has a strong interest in education; completing a Diploma in Learning and Teaching at Oxford University (2005), was Training Programme Director and Regional Specialty Advisor (2002 – 2008) and leads the Oxford Advanced Courses in Pain and Symptom Management (2005 - present). She is an elected member of the Education Committee of the Association of Palliative Medicine and joint lead of the postgraduate education special interest forum. Dr Miller is the Clinical Lead for the National Audit of Care at the End of Life (2023 onward). The audit focuses on deaths in hospitals (acute, community and mental health) in England, Wales and Jersey. Mary is interested in trends over time and presents widely to disseminate information about care at the end of life.

What has the palliative care community learned from the implementation of Physician Assisted Suicide in the State of Victoria, Australia?

Associate Professor Mark Boughey

St Vincent's Hospital Melbourne, Australia

Associate Professor Mark Boughey is the Director of Palliative Care at St Vincent's Hospital Melbourne, Victoria, Australia, with appointments at the University of Melbourne and the Centre for Palliative Care. With over 35 years of experience in palliative care clinical practice and programme and service development and improvement, he has held leadership positions within State, National, and International programmes. He has led local and national bodies involved in education and training. He is a past president of the Royal Australian College of Physicians Chapter of Palliative Medicine, chairs both the Renal Supportive Care Pathway Working Group and the Victorian Aboriginal Palliative Care Collaborative and has mentored emerging palliative medicine leaders in less developed countries through the International Palliative Medicine Leadership Development Initiative. He is currently on the Executive Committee of the International Collaborative for Best Care for the Dying Person.

Is it possible to develop European-wide standards for palliative care education? The EU COST Action CODE-YAA Project

Dr Stephen Mason

University of Liverpool, UK

Dr. Stephen Mason PhD, PGCHE, BA(Hons), FHEA is a palliative care researcher, educator, and academic leader at the University of Liverpool, where he serves as Senior Lecturer and Research & Development Lead in the Palliative Care Unit. He directs the MSc in Palliative and End-of-Life Care programme and champions interdisciplinary research collaboration to advance palliative care education and practice. As the lead author of the European Association for Palliative Care (EAPC) Core Curricula for Undergraduate Medical Education, he has helped shape international standards in palliative medicine training. He also contributes as a Work Package Lead in the EU COST Action CODE (YAA) network, driving innovation in palliative and end-of-life care educational research across Europe.

Digital Legacy in Palliative Care Research: Challenges and Opportunities

Dr Amara Nwosu

Lancaster University, UK

Dr Amara Nwosu is a Senior Clinical Lecturer and Physician in Palliative Care at Lancaster University and Liverpool University Hospitals NHS Foundation Trust. Amara's research interest involves evaluation of novel digital health approaches and their potential role in palliative care. Dr Nwosu is a Churchill Fellow, and he has completed research attachments in the USA and the Netherlands, to research how artificial technology and design can improve palliative care.

Global Challenges in care for the dying: The Lancet Commission Report on the Value of Death

A conversation between Roger Phillips and Dr Libby Sallnow

Roger Phillips

BBC Broadcaster, UK

Roger Phillips is a renowned broadcaster who presented a daily phone-in programme on BBC Radio Merseyside until his retirement in 2021. His abilities have been recognized on many occasions as the winner of countless awards, including "Sony Speech and Talk Broadcaster of the Year". He has been honoured by the University of Liverpool with an honorary Doctorate of Laws, and Liverpool John Moores University with an honorary Fellowship. He is Visiting Professor in Broadcast Journalism at Liverpool Hope University.

Dr Libby Sallnow

Marie Curie Palliative Care Research Department at University College London, UK

Dr Libby Sallnow is an Associate Professor and Head of Department of the Marie Curie Palliative Care Research Department at University College London. She works as a palliative medicine physician the community setting for the NHS in London, is a guest professor at the End-of-Life Care Research Group at the Vrije Universiteit in Belgium and an honorary consultant at the WHO Collaborating Centre for Country Capacity Building in Palliative Care in Kerala, India. She has helped lead and develop the fields of new public health approaches to end-of-life care, compassionate communities and social approaches to death, dying and loss over the past two decades in the UK and internationally. She is Co-Editor-in-Chief of the journal Palliative Care and Social Practice and the first author of the Lancet Commission on the Value of Death: bringing death back into life.

ORAL PRESENTATIONS FROM SUBMITTED ABSTRACTS

Programme

SESSION 1	
13:30	**Serious Illness Conversations as a transformative event: Results from a UK qualitative study** *Dr Tamsin McGlinchey, University of Liverpool, UK*
13:40	**Better care during the last days of life after implementation of the Swedish Palliative Care Guide (S-PCG) - a nationwide register-based study** *Sofia Persson, Palliativt utvecklingscentrun, Sweden*
13:50	**Understanding the Work-related Experiences of People Bereaved During the Covid-19 Pandemic: A Thematic Analysis** *Alice Woolman, Cardiff University School of Medicine, UK*
14:00	**Proteomic changes in urinary extracellular vesicles involving water homeostasis and hormonal stress signaling before death in cancer patients** *Professor Lia Van Zuylen, Amsterdam University Medical Centre, Netherlands*
14:10	**Appropriate palliative sedation in care for the dying at home: exploring future scenarios** *Dr Arianne Stoppelenburg, Erasmus University Medical Centre, Netherlands*
14:20	**Break**
SESSION 2	
14:25	**Transforming end-of-life care: Impact of palliative education on nursing practice** *Nicola Mendick, University of Liverpool, UK*
14:35	**An ethnography of health-care assistants, porters and domestics in the social organisation of end-of-life care.** *Anne-Marie Raftery, University of Salford & The Christie NHS Foundation Trust, UK*
14:45	**The Impact of Disease Stage Awareness on Meaning in Life and Hopelessness Among Cancer Patients** *Yeva Ghukasyan, National Center of Oncology named after V. A. Fanarjyan, Armenia*
14:55	**Equitable Bereavement Care for All Ethnicities: Key learning from a comprehensive national qualitative study** *Dr Catriona Mayland, University of Sheffield, UK*
15:05	**From Concept to Clarity - A qualitative study of the Death Literacy Index adaptation for the Estonian context** *Dr Piret Paal, Institute of Palliative Care, Paracelsus Medical University, Austria*
15:15	**Tea**

LC2540 Serious Illness Conversations as a transformative event: Results from a UK qualitative study

Author(s):	Tamsin McGlinchey[1], Stephen Mason[1], Jude Robinson [2], John Ellershaw[1] *[1] [1] University of Liverpool, UK; [2] University of Glasgow*
Background:	Although death is an inevitable part of life, it is often treated as if it is not, precluding important conversations about future care planning and end of life care between patients and clinicians. The Serious Illness (SI) Care Programme is a 'systems-wide' intervention to improve communication, care planning and quality of life for patients with serious illness.
Aim(s):	Highlight the transformative impact of Serious Illness Conversations, using data from a qualitative study of patient and clinician experiences of SI Conversations in one UK hospital.
Methods:	A phenomenological approach was taken, using one-to-one narrative style interviews with patients (cancer and renal failure) and clinicians, with experience of the SI conversation, analysed using Reflexive Thematic Analysis.

Results:	Two interrelated themes are presented: Despite the emotional load, SI conversations were transformative events, supporting patients to re-frame their expectations for care and restore a hope for their future despite a limited prognosis. It was a reflective experience that did not exacerbate patients' concerns but focussed discussion on them so that tangible 'action' could be taken. However; Systemic barriers and organisational culture inhibited integration into clinical practice due to inflexible clinic structures, and an underlying reticence from clinicians to initiate the conversation for fear of 'getting it wrong'.
Conclusions:	Findings highlight the positive impact of these conversations on patients, and challenge prevailing assumptions that clinical discussions about death and dying are inherently negative. Promoting and improving the way that patients and clinicians engage in such conversations should be a key imperative for care providing organisations.

LC2557 Better care during the last days of life after implementation of the Swedish Palliative Care Guide (S-PCG) – a nationwide register-based study

Author(s):	Sofia Persson, Christel Hedman, Anette Duarte, Carl Johan Fürst, Maria EC. Schelin
Background:	The Swedish Palliative Care Guide (S-PCG) is a comprehensive decision support document aimed at enhancing person-centered palliative care throughout the entire palliative trajectory. Currently, S-PCG is implemented in approximately 600 primary and specialized palliative care units in Sweden, but its effects have not been scientifically evaluated
Aim(s):	To investigate whether use of S-PCG increase quality of care during the last week in life.
Methods:	This study included all registered deaths (n=397,761) from 5,524 care units between 2016 and 2022. Deaths were categorized into four groups: pre-S-PCG, 0–2 years before implementation (n=12,956, 3.3%); implementation period, 0–1 year after implementation (n=5,984, 1.5%); established use, more than 1 year after implementation (n=15,718, 4%); and units not using S-PCG (n=363,103, 91.2%). The primary analysis compared pre-S-PCG versus established S-PCG, with non-use as a control group.
Results:	Eleven outcome measures related to communication, symptom relief, and presence at dying were evaluated. Nine of eleven outcomes showed statistically significant improvement during established use compared to the pre-implementation period. The largest changes were seen in end-of-life conversations with patients (77.5% vs. 86.8%) and relief of confusion (30.5% vs. 38.4%). When analyzed separately, primary palliative care showed significant improvement in 9 of 11 outcomes, whereas specialized palliative care showed significant improvement in 3 of 11 outcomes.
Conclusions:	Implementation of S-PCG, a documentation support adapted for all diagnoses in complex end-of-life care, increases the quality of care, particularly in primary palliative care.

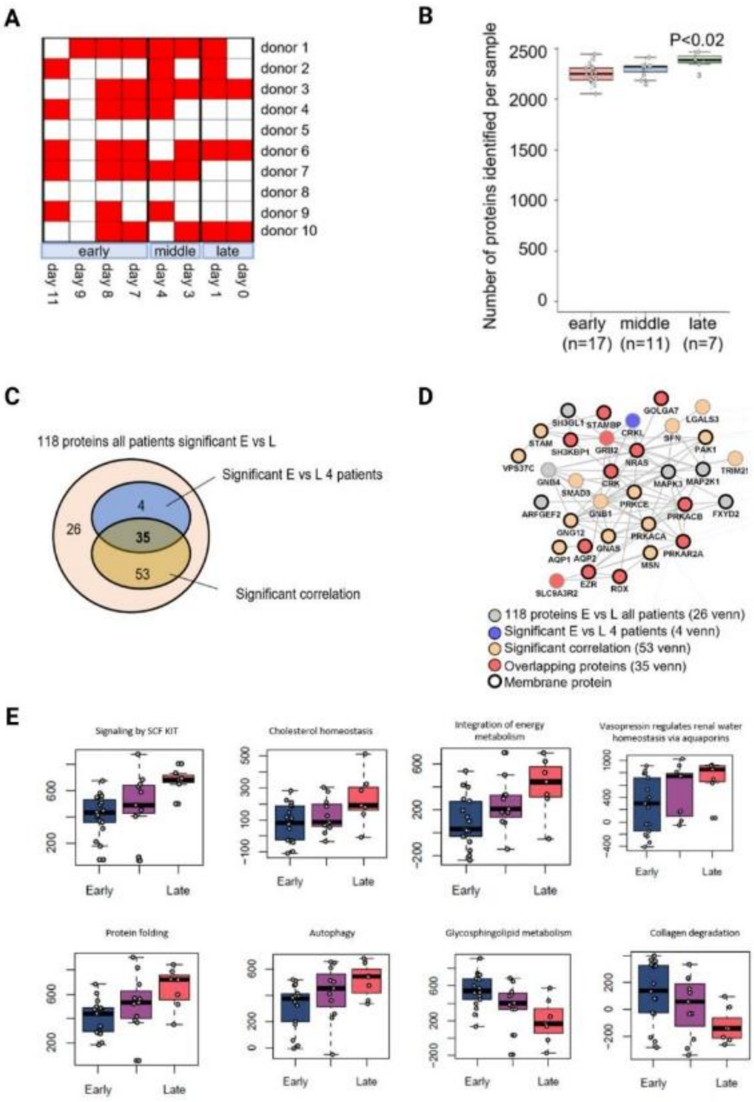
LC2519 Understanding the Work-related Experiences of People Bereaved During the Covid-19 Pandemic: A Thematic Analysis

Author(s):	Alice Woolman, Emily Harrop, Sylvia Goss, Mirella Longo
Background:	Bereavement is experienced by a significant proportion of the working population annually with many implications for working life. Despite reports of the varied impacts of grief on the

	workplace, minimal qualitative evidence exists exploring this relationship. The Covid-19 pandemic provided a unique setting in which to highlight the suitability of bereavement-related support provision in workplaces, alongside its distinct consequences.
Aim(s):	To explore the relationship between grief and workplace environments, policies and practices including the unique challenges of navigating these features during the Covid-19 pandemic.
Methods:	Secondary analysis of free-text comments on work and employment-related bereavement experiences, captured within a longitudinal survey of people bereaved in the UK between March 2020 and January 2021, with data collected at baseline (n=711), c. 8 (n=383), 13 (n=295), and 25 (n=185) months post-bereavement. Qualitative data were analysed through an inductive, thematic approach.
Results:	Four main themes and ten subthemes highlighted the benefits and value of supportive workplaces through the key roles of both employers and colleagues, alongside the implications of inadequate support and bereavement policy on grieving. Specific pandemic-related challenges were also reported, alongside barriers to taking sufficient leave from work and transitioning back to work and for some, prolonged employment change or deciding to leave work following their bereavement.
Conclusions:	The workplace can play a vital role in individuals' experiences of bereavement and in turn, bereavement can have significant and lasting effects on working life. There is a need for supportive and compassionate workplace provision that recognises the varied impacts of bereavement and adequately meets employees' needs.

LC2525 Proteomic changes in urinary extracellular vesicles involving water homeostasis and hormonal stress signaling before death in cancer patients

Author(s):	Juan J. Fierro1*, Zita Kruize1*, Bregje A. A. Huisman2,3, Margriet A. M. Wieles-Griffioen2,3, Connie R. Jimenez4, Sander R. Piersma4, Thang V. Pham4, Irene V. Bijnsdorp4,5,, Lia van Zuylen1† 1 Amsterdam UMC, Vrije Universiteit Amsterdam, Department of Medical Oncology, Cancer Center Amsterdam, Amsterdam, Netherlands 2 Amsterdam UMC, Vrije Universiteit Amsterdam, Department of Anesthesiology, Amsterdam, The Netherlands 3 Hospice Kuria, Amsterdam, The Netherlands 4 Amsterdam UMC, Vrije Universiteit Amsterdam, Department of Medical Oncology, Cancer Center Amsterdam, OncoProteomics Laboratory, Amsterdam, The Netherlands 5 Amsterdam UMC, Vrije Universiteit Amsterdam, Department of Urology, Cancer Center Amsterdam, Amsterdam, The Netherlands * These authors contributed equally to this work and share first authorship. †Correspondence author
Background:	Recognizing the dying phase in cancer patients is crucial for tailoring end-of-life care, but no reliable markers exist to identify this stage. Extracellular vesicles (EVs) from biofluids reflect their tissue of origin and may serve as biomarkers by indicating physiological changes that occur as death approaches.
Aim(s):	This study explores the urinary EV proteome in the final days of life as a step toward predicting the dying phase.

Methods:	Urine was collected twice a week from cancer patients with a life expectancy shorter than three months admitted to hospice care. Longitudinal sample collection from 11 to 0 days before death took place and samples were grouped as early (7-11 days), middle (3-4 days) and late (0-1 day) based on days before death. EVs were isolated using the ME-kit and proteomes profiled (n=8 patients, 35 samples) by LC-MS/MS based proteomics. Statistical analyses were performed using Limma and differential proteins were annotated for biological processes using Gene Ontology and String-network.
Results:	In total 2805 urinary EVs proteins were identified. Protein abundance increased at the late stage (Fig 1. B), with 118 proteins significantly increased compared to the early samples. Of these, 35 proteins were found to be significant upregulated across four patients with a complete time-point profile (Fig 1. C). Upregulated proteins were highly connected and mainly involved in water homeostasis and stress-hormonal signaling (Fig 1. D). Furthermore, protein time-dependent changes were observed between early and late time-points (Figure 1. E). 
Conclusions:	Urinary EVs proteome changes shortly before death. Whether these changes are exclusively related to death and can act as predictors of the dying process requires further exploration.

LC2534 Appropriate palliative sedation in care for the dying at home: exploring future scenarios

Author(s):	Arianne Stoppelenburg1, Agnes van der Heide[1], Marieke Sonneveld[2], Hans van Delden[3], Judith Rietjens[1,2] 1 Department of Public Health, Erasmus MC, Rotterdam, the Netherlands 2 Faculty of Industrial Design Engineering, Delft University, Erasmus MC, Delft, the Netherlands 3 Department of Bioethics & Health Humanities, University Medical Center of Utrecht University, the Netherlands
Background:	Continuous palliative sedation (CPS) is considered a last resort option to relieve refractory suffering at the end of life. In 2021, CPS was provided to 25% of all people dying while being attended at home by a general practitioner in the Netherlands. This is a substantial increase compared to 2015 (21%) and 2010 (12%).
Aim(s):	To gain insight into possible future scenarios for the use of CPS.
Methods:	We developed two potential and challenging future scenarios for the use of CPS, building on the Dunne & Raby speculative design method. During a 1,5 hour workshop at the Dutch National Palliative Care Conference in 2024, participants were presented with the scenarios. Mentimeter was used to identify perceived characteristics of 'good' sedation.
Results:	In the 'Do-It-Yourself' scenario, CPS is administered by family members, using online guidance, without the involvement of professional healthcare providers. In the 'Dying Without Suffering hotel' scenario, CPS as well as bereavement support are strictly protocolled to enhance efficiency. These scenarios were discussed in round table groups, with in total 115 participants (mainly palliative care professionals). They discussed what emotions or thoughts the scenarios evoked, which elements they found (un)desirable and why. Suggested characteristics of 'good' sedation were: proper information and communication, tranquility, alleviating suffering, guidance, proportionality and managing expectations.
Conclusions:	The increasing use of CPS calls for a societal and ethical debate on its future. Our approach can serve as an example of how to reflect on the future of palliative sedation and palliative care in general.

LC2551 Transforming end-of-life care: Impact of palliative education on nursing practice

Author(s):	Nicola Mendick, Tamsin McGlinchey, John Ellershaw, Stephen Mason,
Background:	With approximately one-third of acute hospital patients in their last year of life, optimal end-of-life care remains a critical challenge. National reports highlight persistent gaps in care quality, particularly in emergency and acute settings. The LUHFT Chief Nurse Scholarship enabled nurses to undertake a Postgraduate Certificate in Palliative and End-of-Life Care, aiming to bridge the theory-practice divide and improve patient outcomes.
Aim(s):	This preliminary analysis evaluated the programme's impact on nursing practice, focusing on how education transformed clinical approaches to palliative care within Liverpool University Hospitals NHS Foundation Trust (LUHFT).
Methods:	A thematic analysis of reflective assignments from two student cohorts (2023–2025) identified key practice changes. Data were structured around seven emergent themes, with illustrative

	quotes highlighting the transformative learning process.
Results:	Participants demonstrated significant shifts in practice: (1) holistic pain assessment using the "total pain" model, (2) evidence-based decision-making (e.g., reducing non-beneficial interventions), (3) advanced communication (SPIKES framework), and (4) enhanced interprofessional collaboration. Nurses reported greater confidence in advocating for patient-centred care and navigating systemic barriers.
Conclusions:	The programme successfully fostered reflective, evidence-based palliative care, equipping nurses to deliver compassionate, individualised end-of-life care. These findings support scaling such educational interventions to address national care gaps while enhancing professional resilience. Future research will expand with the inclusion of focus group data to strengthen the recommendations.

LC2513 An ethnography of health-care assistants, porters and domestics in the social organisation of end-of-life care

Author(s):	Dr Anne-Marie Raftery (Lead Nurse, Palliative Care Nurse, The Christie NHS Foundation Trust).
Background:	The research revealed aspects of end-of-life care undertaken by health care assistants, porters and domestics that are not usually seen or talked about. These rich set of ideas helps revive ethnography - not only within an organisation, but palliative care more broadly whilst raising the profile of this important work.
Aim(s):	Ethnography is an attempt to tell a holistic, well-studied story about a culture or subculture using a different lens. This contextually based research renders explicit their role and experience in the social organisation of end-of-life care.
Methods:	This ethnographic study, with full ethical and Trust approval used a qualitative, naturalistic approach, the primary data gathering method being participant observation, shadowing and following their everyday routines. Data gathered from observations was deepened further through semi-structured interviews of 15 staff across the three staff groups.
Results:	The research revealed indigenous ways in which ancillary staff provide care for patients at end-of-life. Capturing *'in the moment'* actual interactions of everyday lives and practices within busy clinical environments - accessing subcultures, *'hanging out'* in spaces and corridors occupied by support staff. These essential components offer different dimensions which speaks to what is permissible in an inclusive culture where all roles are valued and considered, regardless of hierarchy.
Conclusions:	The study revealed the often unrecognised or invisible skills of health care support staff - exploring beyond what is seen, felt, or recognised as 'care' in care work. As end-of-life care is 'everyone's business', striving for an inclusive, compassionate workforce must include how support staff are affected and supported.

LC2546 The Impact of Disease Stage Awareness on Meaning in Life and Hopelessness Among Cancer Patients

Author(s):	Yeva Ghukasyan
Background:	In recent decades, the role of patients' awareness of their diagnosis and disease stage has been a growing focus in psycho-oncological research.
Aim(s):	This study aims to explore how awareness of disease stage influences levels of hopelessness,

	meaning in life, and attachment styles among palliative patients.
Methods:	Eighty patients aged 30–80 receiving palliative care at the V. A. Fanarjyan National Center of Oncology were enrolled. Participants were divided into two groups: those aware of their disease stage (Group A, n = 45) and those unaware (Group NA, n = 35). Data were collected using the Beck Hopelessness Scale (BHS), the Meaning in Life Questionnaire (MLQ), and the Adult Attachment Scale (AAS).
Results:	Hopelessness was negatively correlated with attachment-related closeness in both groups (Group A: r = -0.287; Group NA: r = -0.416, $p < 0.05$). In Group A, hopelessness also showed a positive correlation with anxious attachment (r = 0.274). No significant associations were found between hopelessness and meaning in life dimensions in Group A. However, in Group NA, moderate negative correlations emerged between hopelessness and both presence of meaning (r = -0.528) and search for meaning (r = -0.458).
Conclusions:	This study provides important insights, highlighting disease stage awareness as a mediating factor in the relationships among hopelessness, meaning in life, and attachment to close others, paritcullary a secure attachment style and strong social support can significantly reduce hopelessness, even in the palliative phase.

LC2524 Equitable Bereavement Care for All Ethnicities: Key learning from a comprehensive national qualitative study

Author(s):	Catriona R Mayland, Emily Fisher, Adejoke Oluyase, Nikel Hector-Jack, Toslima Khatun, Rukia Saleem, Naureen Khan, Shirin Shahid, Riffat Mahmood, Gurpreet Grewal-Santini, Monika Afolabi, Candice Wang, Sarah Ng, Katherine Bristowe, Emily Harrop, Zoebia Islam, Jonathan Koffman, Gurch Randhawa, Lucy E Selman, Sabina Bajwah.
Background:	Those from ethnically diverse groups experience worse health outcomes due to long-standing inequities. This extends to outcomes related to grief as bereavement support services reach fewer than 1:20 people from ethnically diverse communities.
Aim(s):	To share insights from the ‘Equitable Bereavement Care for All Ethnicities’ study, the largest, most comprehensive, ethnically diverse, qualitative research study in UK healthcare to date.
Methods:	We adopted core principles of respect, trust and equity of access, to inform our study, with cultural safety at the core. Community Research Link Workers (representatives from community organisations) were trained and mentored to support recruitment, data collection and analysis. Participants were purposively sampled by sex, ethnicity, type of death, and relationship to the decedent. Focus groups and individual interviews were conducted with participants in their preferred language. Data were analysed using framework analysis.
Results:	Eight focus groups and 34 individual interviews were conducted with 120 participants (age 21-80, male=54). Representation included a wide range of ethnically diverse communities (e.g., Bangladeshi, Indian, Chinese, Pakistani, Black African, Black Caribbean, Arab, White Irish, Polish). Four main themes were identified describing participants’ bereavement experiences: 1. Racism, 2. Cultural influence and expectations, 3. Duality of support from faith and religious networks and the immediate, wider community, and 4. Unique challenges and coping mechanisms. Actionable insights for practice and policy are being developed to inform bereavement service provision.
Conclusions:	Findings identify key transformative insights essential for modelling equitable bereavement services as well as innovative ways to improve inclusive methodology and enable meaningful co-design partnerships.

LC2516 From Concept to Clarity - A qualitative study of the Death Literacy Index adaptation for the Estonian context

Author(s):	Piret Upser, Elo-Hanna Seljamaa, Madis Arukask, Ain Riistan, Piret Paal
Background:	This study presents a thematic content analysis of expert focus groups and cognitive interviews conducted during the cultural and linguistic adaptation of the Death Literacy Index (DLI) into Estonian.
Aim(s):	The primary objective was to ensure semantic clarity, emotional appropriateness, and cultural relevance in the formulation of survey questions addressing sensitive end-of-life topics.
Methods:	The initial phase employed iterative focus group discussions with interdisciplinary experts in medical anthropology, theology, folklore, linguistics, and palliative care (n=5). In the second phase, preliminary testing was conducted through cognitive interviews (n=9) using the think-aloud method. People with different demographic backgrounds completed the questionnaire while verbalizing their interpretation and reasoning.
Results:	Analysis of these discussions highlighted key areas of conceptual and lexical debate. For instance, distinctions between *suutlikkus* (capability) and *valmisolek* (readiness), as well as emotional nuances in terms like *lein* (grief), were central to achieving linguistic precision. Similarly, culturally sensitive terminology for care settings and roles, such as *palliatiivne ravi* (palliative care) versus *hooldusravi* (nursing care), and *surija* (the dying person) versus *inimene elu lõpus* (person at the end of life) were closely examined. Minor lexical decisions significantly influenced the perceived meaning and emotional impact of survey items. For example, *juurdepääs* (access) was preferred over *saadavus* (availability) to emphasize the possibility of engaging with services, while *elukoha lähedal* (near one's residence) was deemed more precise than *kodus* (at home). The cognitive interviews uncovered recurring difficulties, including ambiguity around the reference point of certain questions (e.g., whether they referred to a specific individual) and a lack of relevant personal experience (e.g., whether they could lift or bathe someone if they had never done so). Respondents expressed the need for an additional response option such as "not applicable." A central lexical issue emerged regarding the term *kogukond* (community), which was interpreted inconsistently across participants as either a place-based or relationship-based concept. To resolve this, the questionnaire was revised to include the clarification: *suhtlus- ja tutvusringkond* (circle of friends or acquaintances). All nine participants failed to identify the meaning of palliative care.
Conclusions:	The findings underscore the critical role of context-sensitive language in the development of culturally valid end-of-life research instruments. This study offers a practical and transferable methodological framework for future cross-cultural adaptations of the DLI and similar tools as well impulses for linguistics, in particular lexical debates.

POSTER PRESENTATIONS

OPTIONAL GUIDED POSTER VIEWING SESSION (PRINTED POSTERS ONLY)

13:00-13:30, Exhibition Space

Green	Best Care for the Dying Person Led by Professor Agnes van der Heide	Poster Author
LC2514	Nursing decisions at the bedside: Best care for the comatose dying person, a qualitative study	Tricia O'Connor
LC2528	The behaviour of Quality Indicators over time: can we infer a standard?	Mary Miller
LC2537	Referrals to Palliative Care – best care for the patient or the organisation?	Carl Johan Fürst
LC2549	Foundation doctors' experiences of death and dying: A scoping review	Cora Marks

Blue	End of Life Care in the Emergency Department Led by Associate Professor Mark Boughey	Poster Author
LC2510	Tissue Donation Referrals in the Emergency Department	Karl Cook
LC2522	A systematic review exploring the optimal pre-bereavement support	Paula McCarthy
LC2531	End of life care in the Emergency Department: a quality improvement project to address an uncomfortable reality	James Purcell
LC2536	Creating an alert system to enhance care of patients in the Emergency Department	Virginia Marsh-Bowen

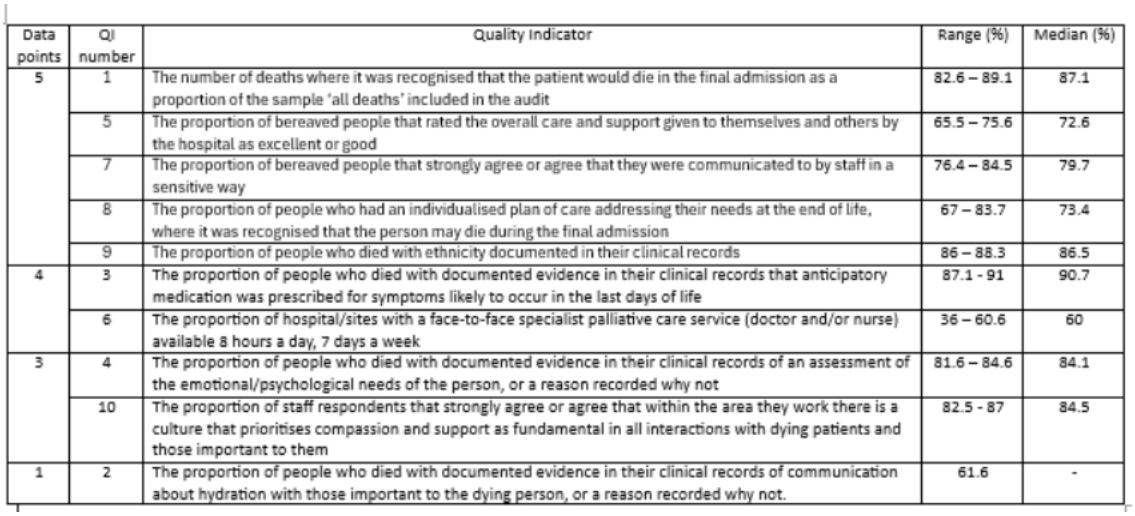
Orange	Digital Innovations for Care of the Dying Led by Dr Marisa Martin Rosello	Poster Author
LC2505	Digital legacy in planning for end-of-life: A scoping review	Sarah Stanley
LC2533	Advancing Usability in Digital Care Plan for End-of-Life Patients: Ongoing Development of the Cui-DAR-CUDECA App	Alejandro Moya-Fernandez
LC2543	Evaluating the effectiveness of a digital e-PROM follow-up pilot in palliative care: a retrospective service evaluation study	Rakshanda Raj
LC2561	Accuracy and reliability of the staff proxy-completed Integrated Palliative care Outcome Scale (IPOS): A Scoping Review	Liz Edwards

Red	Psychosocial and Holistic Care Led by Grethe Skorpen Iversen RN	Poster Author
LC2511	Family-centred cancer care: End of life education for health and social care professionals	Jeffrey Hanna
LC2512	Self-directed ending of life through voluntarily stopping eating and drinking	Arianne Stoppelenburg
LC1518	Beyond Pain: Exploring emotional and physical suffering in Argentine palliative care patients	Vilma Tripodoro
LC2541	Easing Family Distress: An integrated literature review of approaches to managing death rattle	Ellie Shingles

BEST CARE FOR THE DYING PERSON

LC2514 Nursing decisions at the bedside: Best care for the comatose dying person, a qualitative study	
Author(s):	Tricia O'Connor RN MN, Assoc Prof Aileen Collier RN PhD, Prof Karen Strickland RN PhD , Prof Catherine Paterson RN PhD
Background:	Dying patients often become comatose in the final days and hours of life. Once comatose these patients rely entirely on others to identify and meet their care needs. Gaining insight into how specialist palliative care nurses make decisions around care needs of these vulnerable comatose patients may help guide care of dying patients in other contexts.
Aim(s):	To understand how specialist palliative care nurses make decisions regarding the assessment and care of comatose dying patients.
Methods:	An interpretivist-constructivist paradigm informed the design of this qualitative semi-structured interview study of 21 specialist palliative care nurses. The study took place in a metropolitan city in Australia. Data were analysed through the theoretical lens of the Person-centred Nursing Model of the Cognitive Continuum Theory using Braun and Clarke's Reflexive Thematic Analysis.
Results:	Nurses discussed their thoughts on clinical assessment, moral and ethical conflicts, and communication when making decisions around care provision for this vulnerable population. The resultant themes included: The moral dilemma of others distress – physical versus existential; The jigsaw of nurse assessment; and Navigating the tensions between family advocacy and clinical judgment.
Conclusions:	When vulnerable dying patients are no longer able to express their needs, the decision-making capacity of the nurse is paramount to tailor care to their specific holistic care needs. The clinical skills of nurses intersect deeply with compassion and relational engagement. Findings offer insightful perspectives into best nursing care of the comatose dying person.

LC2528 The behaviour of Quality Indicators over time: Can we infer a standard?	
Author(s):	Mary Miller, Heather Murray, Joylin Brockett
Background:	Ten key quality indicators were selected to support quality improvement in care at the end of life. NACEL aims to track indicator performance over time (2018,19, 21, 22, 24).
Aim(s):	To understand the indicator performance over time.
Methods:	Results by year, where available, were mapped to the quality indicators. Changes to the question were noted.
Results:	Table 1:



Data points	QI number	Quality Indicator	Range (%)	Median (%)
5	1	The number of deaths where it was recognised that the patient would die in the final admission as a proportion of the sample 'all deaths' included in the audit	82.6 – 89.1	87.1
	5	The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good	65.5 – 75.6	72.6
	7	The proportion of bereaved people that strongly agree or agree that they were communicated to by staff in a sensitive way	76.4 – 84.5	79.7
	8	The proportion of people who had an individualised plan of care addressing their needs at the end of life, where it was recognised that the person may die during the final admission	67 – 83.7	73.4
	9	The proportion of people who died with ethnicity documented in their clinical records	86 – 88.3	86.5
4	3	The proportion of people who died with documented evidence in their clinical records that anticipatory medication was prescribed for symptoms likely to occur in the last days of life	87.1 - 91	90.7
	6	The proportion of hospital/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week	36 – 60.6	60
3	4	The proportion of people who died with documented evidence in their clinical records of an assessment of the emotional/psychological needs of the person, or a reason recorded why not	81.6 – 84.6	84.1
	10	The proportion of staff respondents that strongly agree or agree that within the area they work there is a culture that prioritises compassion and support as fundamental in all interactions with dying patients and those important to them	82.5 - 87	84.5
1	2	The proportion of people who died with documented evidence in their clinical records of communication about hydration with those important to the dying person, or a reason recorded why not.	61.6	-

Conclusions:	Six quality indicators are at or above 80%. This is the standard of care.

LC2537 Referrals to palliative care – best care for the patient or the organisation?

Author(s):	Carl Johan Fürst, Ursula Scheibling, Petra Tegman
Background:	Palliative care relies on timely and appropriate referrals to ensure patients receive the right level of care. Yet, mismanaged referrals can cause unnecessary suffering and frustration for both patients and healthcare providers.
Aim(s):	This study examined how specialized palliative care units (PCUs) in Sweden handle referrals, focusing on the referral reception process.
Methods:	Members of the Swedish Society for Palliative Medicine were sent a web-based survey featuring a fictional patient case.
Results:	Seventy-four professionals responded, representing their units in various regions and care settings. Findings revealed that while many PCUs have formal referral guidelines, some lack clear assignment descriptions or use outdated criteria, resulting in inconsistent referral practices. The scope of specialized PC varies widely across units; some take on broader medical responsibilities driven by political decisions, creating ethical and logistical challenges. Referral assessments are commonly conducted by physicians or teams, often requiring direct patient contact. Referrals may be rejected if specialized care needs are unclear, though some units provide consultative support.
Conclusions:	Regional differences exist in referral handling, including the level of patient contact before decision-making and the influence of administrative or financial factors. Inconsistent criteria, particularly regarding eligibility and care needs, lead to varying interpretations within the same unit. Terms like "palliative stage" and "complex needs" are vague, contributing to confusion about patient selection and the role of specialized palliative care, which is often viewed as limited to end-of-life care despite evidence supporting earlier intervention. The study highlights the need for continuous internal review of referrals and outcomes to improve quality and reduce inequality in specialized PC across Sweden.

LC2549 Foundation Doctors' Experiences of Death and Dying: A Scoping Review

Author(s):	Dr Cora Marks, Dr Joseph Marks (Joint first authors)
Background:	Foundation doctors are a significant proportion of the resident doctor workforce, especially out of normal working hours. They are frequently involved in medical emergencies and regularly provide care for patients at the end of life. This is often their first professional role, and the intense workload, long hours and limited clinical experiences places them at high risk of stress and moral injury. Despite this, there is limited understanding of how foundation doctors experience caring for those who are dying, the challenges faced, and the impact this has on their wellbeing and future professional development.
Aim(s):	This scoping review aims to outline the existing literature on foundation doctors' experiences of death and dying, demonstrate key themes and highlight knowledge gaps to inform future research.
Methods:	A scoping review was conducted following Arksey and O'Malley's framework. Relevant databases were searched for studies exploring foundation or equivalent resident doctors' experiences of giving end of life care. Relevant articles were screened and thematically analysed.
Results:	Foundation doctors felt underprepared to manage those who were dying and struggled to communicate with families. Barriers to good care included emotional distress, perceived lack of formal training in palliative care, inadequate supervision, and feeling isolated, particularly overnight. Positive experiences included supported learning opportunities and increased confidence managing common symptoms.
Conclusions:	This review highlights the importance of robust research into the best way to train foundation doctors to support those at the end of life. Addressing this may improve both the care provided to patients and families and the wellbeing of resident doctors.

END OF LIFE CARE IN THE EMERGENCY DEPARTMENT

LC2510 Tissue Donation Referrals in the Emergency Department

Author(s):	Karl Cook
Background:	Tissue donation can support the grieving process for families following sudden death and improve outcomes for transplant recipients. Despite an established "care after death" pathway, no patients dying in the Emergency Department (ED) were being referred for tissue donation, contrary to trust policy.
Aim(s):	To increase tissue donation referrals for ED deaths to 50% by March 2025.
Methods:	A quality improvement project was launched to address this gap. Initial barriers included lack of staff awareness and a complex referral process across two electronic systems (PENs and ADT Dashboard). Interventions included targeted education, dissemination of referral guides, and introduction of aide memoire cards in key clinical areas. Three Plan-Do-Study-Act (PDSA) cycles were completed, with retrospective reviews of ED deaths to assess referral compliance.
Results:	Referral rates increased from 0% to over 50% by December 2024, achieving the project goal ahead of schedule. Staff engagement and accessible prompts were key drivers of success. However, referral consistency declined during periods of project lead absence, highlighting a need for sustained oversight. Further work is ongoing to establish a feedback loop with the

	National Blood and Tissue Service to improve understanding of referral outcomes.
Conclusions:	Simple, targeted interventions can significantly improve tissue donation referral rates in the ED. Embedding sustainable practices and feedback mechanisms will be essential to maintain progress and support bereaved families.

LC2522 A systematic review exploring the optimal pre-bereavement support

Author(s):	Paula McCarthy
Background:	Caregivers of terminally ill individuals often experience psychological distress well before the death of their loved one. Pre-bereavement support has been identified as a critical component in easing the transition into bereavement and promoting caregiver well-being. However, there remains limited consensus on what constitutes optimal pre-bereavement support.
Aim(s):	To examine and synthesise existing evidence on effective pre-bereavement support strategies for caregivers, identifying key components, delivery methods, outcomes, and contextual factors influencing their success.
Methods:	A comprehensive search of electronic databases including Liverpool John Moore's University's 'Discover', CINAHL, and MEDLINE was conducted, covering studies published between (2017-2025). Inclusion criteria encompassed peer-reviewed studies focusing on pre-bereavement interventions.
Results:	7 studies (published 2017–2023); conducted in 6 countries (Canada, Australia, Switzerland, USA, Germany, Ireland/Australia). Key findings: • **Informal support** (family/friends) are often preferred over professional support • **Professional support** often rated poorly, especially relating to post-bereavement care • **Practical support** (e.g., funeral help) frequently lacking • **Variation** in time frames, recruitment, and methods when providing bereavement support • **Better support** linked to improved mental health
Conclusions:	The review highlighted the critical importance of pre-bereavement support in reducing caregiver distress and improving end-of-life outcomes. While many caregivers benefit from palliative services, a lack of consistent follow-up, limited tailoring, and systemic barriers leave significant gaps in bereavement support.

LC2531 End of life care in the Emergency Department: a quality improvement project to address an uncomfortable reality

Author(s):	James Purcell, Kate Gleeson, Tom Steele
Background:	Due to long lengths of emergency department (ED) stay we see increasing "expected" deaths in this setting. Previous audit data has shown areas for improvement in measures of end-of-life

	care compared with benchmarks across other areas of the hospital.
Aim(s):	To implement a quality improvement approach to improve key measures of quality of end-of-life care for patients who die expectedly in the Royal Liverpool Hospital Emergency Department.
Methods:	This QI project is using iterative Plan-Do-Study-Act (PDSA) cycles to address key measures for improvement identified from baseline audit data. These were prescription of anticipatory symptom control medication, evidence of holistic assessment and personalised plan of care for the dying person usage. Deaths in the emergency department, excluding those who arrived in cardiac arrest or had a sudden unexpected deterioration in department are reviewed, and data collected and analysed using Microsoft Excel. Results inform ongoing targeted interventions to improve these measures of quality of care.
Results:	This project is ongoing and results will be presented. Initial interventions include implementation and dissemination of a prescribing protocol for anticipatory symptom control medications, update of emergency department resources related to end-of-life care and education of emergency department staff.
Conclusions:	Providing care of the dying is now common in emergency departments in the NHS. This quality improvement project aims to drive this to be the best it can be in challenging circumstances.

LC2536 Creating an Alert System to enhance care of patients in the Emergency Department

Author(s):	Virginia Marsh Bowen
Background:	Dying patients known to Primary Care Specialist Palliative Care were spending an inappropriate amount of time in the Emergency Department on admission before being referred to Specialist Palliative Care. This led to increased length of stay, increasing risk of the patient dying in a place not of their choice.
Aim(s):	To identify these patients in order that they could be seen quicker to improve outcomes, manage symptoms more effectively and arrange rapid discharges. To ensure those patients who are imminently dying within the Emergency department are supported.
Methods:	Liaison with technology team to establish if an 'alert' could be added to our hospital patient record alerting the Specialist Palliative Care team in real time that a palliative patient had presented to the Emergency Department. Governance with Primary Care services approved. Alerts subsequently added to patient records.
Results:	It was identified following a period of audit that having the alert system in place allowed us to see, assess and treat patients within 3 hours of presenting to the Emergency Department. Volume of patients seen within the Emergency Department increased significantly.
Conclusions:	Allocating an alert to the Hospital medical record of patients known to Primary Care Specialist Palliative Care Services has improved the quality of care given to those patients within the Emergency Department. Symptoms have been assessed and managed by a Specialist in palliative care alongside the medical team. Treatment plans agreed and urgent discharges arranged. The has saved hospital admissions, improved patient outcomes and supported patients to die in their place of choice.

DIGITAL INNOVATIONS FOR CARE OF THE DYING

LC2505 Digital legacy in planning for the end-of-life: A scoping review

Author(s):	Sarah Stanley, Karen Higginbotham, Caroline Mogan, Julie-Ann Hayes, Cristina Vasilica, Mari Lloyd Williams
Background:	The need for palliative care is increasing and it is essential to consider emerging technologies that have the potential to enhance care for palliative patients and their carers. The creation of online content, and digital media stored on devices, is often described as a digital legacy. There is limited knowledge about how digital legacy is included in planning for the end of life.
Aim(s):	To conduct a scoping review of the literature to describe healthcare professionals, patients receiving palliative care, caregivers, and bereaved people's experience of including digital legacy in planning for the end-of-life.
Methods:	A scoping review of the literature was carried out. The question was formulated using the population, exposure, outcome (PEO) format as follows: '*What is known from the existing literature about healthcare professionals, patients receiving palliative care, caregivers, and bereaved people's experience of including digital legacy in planning for the end-of-life?*'
Results:	506 records were screened, 10 were included in the review. A number of examples of the use of digital legacy were identified. Themes identified from the literature include digital legacy showing the authentic person, digital legacy evoking emotion, digital legacy to maintain a connection and preparing digital legacy.
Conclusions:	People receiving palliative care use digital legacy as a way to make memories and capture the essence of their character, often finding time for reflection and creating a sense of empowerment. A person's digital legacy could be discussed with healthcare professionals, and others who are important, to support in planning for the end-of-life.

LC2533 Advancing Usability in Digital Care Plan for End-of-Life Patients: Ongoing Development of the Cui-DAR-CUDECA App

Author(s):	Alejandro Moya-Fernández, Mª Jesús de la Ossa-Sendra, José Miguel Morales-Asencio, María Luisa Martín-Roselló, Pilar Barnestein-Fonseca
Background:	Cui-DAR care plan is a culturally adapted version of the International Collaborative's 10/40 model, developed to standardize and improve end-of-life care. In response to growing interest in digital health tools, the Cui-DAR-CUDECA App is being designed to facilitate care planning through mobile technology. The current phase focuses on evaluating usability to ensure it meets the needs of healthcare professionals in clinical settings.
Aim(s):	To assess and refine the Cui-DAR-CUDECA App through usability tests among healthcare professionals, with the objective of improving its clarity, navigability, and integration into end-of-life care workflows.
Methods:	Usability testing has begun with a purposive sample of healthcare professionals from the CUDECA Foundation. Participants are providing structured feedback through the System Usability Scale (SUS), the MAUQ questionnaire, and regular focus groups. Feedback is guiding iterative modifications to the app's interface, including content layout, terminology, and

	logical flow. A UI/UX design expert has joined the project to enhance visual structure, user guidance, and clinical relevance.
Results:	Initial feedback from participants indicates usability issues related to terminology, screen hierarchy, and task navigation. Modifications have been introduced progressively, focusing on simplifying data entry and clarifying information structure. Early qualitative data from group discussions suggest improved engagement and perceived utility after changes.
Conclusions:	The ongoing usability phase is yielding actionable insights that are driving a more intuitive and efficient design of the Cui-DAR-CUDECA App. Collaboration with a UI/UX specialist is strengthening its potential as a digital decision-support tool for end-of-life care. Further refinement and testing will support its viability for broader clinical implementation.

LC2543 Evaluating the effectiveness of a digital e-PROM Follow-Up Pilot in Palliative Care: a retrospective service evaluation study.

Author(s):	Dr. Rakshanda Raj (MSc Palliative and End of Life Care Student, University of Liverpool), Dr. Dan Monnery (Consultant in Palliative Medicine, The Clatterbridge Cancer Centre NHS Foundation Trust)
Background:	Palliative care patients often face complex symptoms. Routine in-person follow-up can be burdensome and may not reflect patient preferences. To address this, a digital follow-up pilot using electronic Patient Reported Outcome Measures (ePROMs) was introduced to enable remote symptom monitoring and personalised intervention.
Aim(s):	To evaluate the effectiveness of a digital e-PROM follow-up model using patient and service outcomes.
Methods:	This retrospective service evaluation compared two cohorts: patients enrolled in the digital e-PROM pilot and a historical control group who received in-person follow-up. Data extracted from electronic health records included demographics, Integrated Palliative care Outcome Scale (IPOS) scores, clinic attendance, and secondary care use. Comparative statistical analyses were performed.
Results:	295/680 (43%) eligible patients agreed to participate in the 12-month pilot. No significant demographic differences were observed between the e-PROM and standard follow-up groups. 916 remote IPOS scores were completed, of which 314 did not require a clinical appointment, resulting in clinical efficiency. Compared to controls, e-PROM participants had a relative reduction of 0.2 appointments per patient per year. There was no difference in secondary care use resulting from fewer appointments (0.86 appointments per patient/year compared with 0.9 for controls, p=0.52).
Conclusions:	Digital e-PROM follow-up in palliative care is a feasible and potentially effective alternative to standard follow-up. It may reduce clinical burden while maintaining patient-centred outcomes. Further exploration is needed to guide sustainable implementation.

LC2561 Accuracy and Reliability of the staff proxy-completed Integrated Palliative care Outcome Scale (IPOS): A Scoping review

Author(s):	Liz Edwards
Background:	The Integrated Palliative Care Outcome Scale (IPOS) is a validated tool used in palliative care to assess the symptom burden of patients with advanced illness, allowing for tailored care.

	Ideally, patients self-complete the IPOS, but as their condition worsens, they may be unable to do so. In such cases, it can be completed by family caregivers or healthcare staff proxies. However, the accuracy and reliability of proxy-completed IPOS are debated.
Aim(s):	This scoping review investigated the accuracy and reliability of staff proxy-completed IPOS in adult palliative care. It examined existing literature, methods comparing patient and staff IPOS scores, and factors affecting their agreement.
Methods:	This study followed the latest Joanna Briggs Institute guidelines for scoping reviews and the PRISMA-ScR framework. A three-step search strategy identified relevant studies from various databases. Inclusion criteria were studies comparing patient and staff IPOS scores, involving patients aged 18 or over with advanced illness and no cognitive impairment, and staff of any role providing care.
Results:	Six studies met the inclusion criteria, all using similar methods to compare IPOS scores. Agreement levels varied significantly across IPOS items, with the highest agreement for physical symptoms. Most studies found the staff proxy-completed IPOS reliable and valid, though confidence levels ranged from acceptable to good. Factors influencing agreement included patient and staff characteristics, illness phase, symptom fluctuation, and staff-patient interaction time.
Conclusions:	The review highlighted a lack of sufficient research on the agreement between patient and staff IPOS scores.

PSYCHOSOCIAL AND HOLISTIC CARE

LC2511 Family-centred cancer care: End of life education for health and social care professionals

Author(s):	Dr Jeffrey R Hanna and Prof Cherith J Semple on behalf of the Family-Centred Cancer Care Team
Background:	Consistently, healthcare professionals highlight a lack of knowledge, skill and training to support adults who are dying and have significant caregiving responsibilities for children (<18).
Aim(s):	To deliver and evaluate an educational intervention to equip healthcare professionals on how best to support families when an adult with significant caregiving responsibilities is dying.
Methods:	An evidence-based and theory-driven face-to-face educational intervention has been developed and delivered to over 2000 professionals. The intervention was evaluated using three levels of Kirkpatrick's Model of Evaluation. Pre-test, post-test surveys were completed immediately before-and-after the intervention with 239 professionals using a validated self-efficacy scale and single-item questions evaluating perceived usefulness and relevance (levels one/two). Qualitative interviews were conducted with fourteen professionals up to 19-months post-intervention to explore if, and how the intervention impacted professionals' practice (level three).
Results:	Quantitative findings demonstrated a statistically significant improvement in self-efficacy post-educational intervention ($p < 0.001$). Qualitative data highlighted professionals gained new approaches to progress end-of-life conversations with adults, despite some familial resistance to sharing the reality of the situation with children. Positive intervention content shaping clinical practice included a bereaved parent's lived experience and a communication framework.

	Some professionals considered a booster session and opportunities to practice conversations necessary to further consolidate learning into practice.
Conclusions:	Evidence and theory-driven education can positively impact professionals' provision of family-centred care. Recently, this face-to-face educational intervention has been adapted and evaluated to a standalone, self-directed, 40-minute eLearning intervention. Alongside the promotion of this sustainable and equitable education, advanced communication skills programmes should incorporate adult-child end-of-life conversations.

LC2512 Self-directed ending of life through voluntarily stopping eating and drinking

Author(s):	Arianne Stoppelenburg[1], Fenne Bosma[1], Suzanne van de Vathorst[2], Agnes van der Heide[1] [1] Department of Public Health, Programme Healthcare Quality & Sustainability, Erasmus MC, Rotterdam, Netherlands, [2] Department of Public Health, Programme Medical Ethics, Philosophy and History of Medicine, Erasmus MC, Rotterdam, the Netherlands
Background:	Some people choose to end their own lives without the help of a physician. One way of such self-directed termination of life is voluntarily stopping eating and drinking (VSED).
Aim(s):	To gain insight in the decision-making process leading up to the choice of VSED, in who is involved in the process, how the implementation proceeds and how the quality of dying is perceived.
Methods:	We conducted a qualitative interview study among confidants of someone who died by VSED. The confidants were purposively selected after completing an online questionnaire. Interviews were conducted by 3 researchers using a topic list. Interviews were recorded with an audio recorder and transcribed verbatim. Data was analysed thematically using NVivo.
Results:	We conducted 16 interviews. Reasons for choosing a self-directed death, in addition to psychological or physical suffering, were: a rejected euthanasia request and not wanting to burden another person with the termination of life. The decision was usually made independently, and then communicated to loved ones. In some cases. VSED was suggested as an option by a health care provider. Experiences with the trajectory of VSED and the quality of dying varied. Some confidents reported that the process took longer than expected and that VSED had resulted in an undignified death.
Conclusions:	Experiences with VSED vary. VSED may not lead to the desired course of death in all cases. Health care professionals should be cautious about suggesting that VSED is an option.

LC2518 Beyond Pain: Exploring emotional and physical suffering in Argentine palliative care patients

Author(s):	Vilma A. Tripodoro, Silvina Montilla, Juan Pablo Pereyra, Clément Meier, Susana Handelsman, Verónica Veloso, Mariana Delfino, Silvio Pederiva, Ida Korfage, Agnes van der Heide, on behalf of iLIVE Consortium (EU Horizon 2020 ID: 825731)
Background:	Physical and emotional distress are prevalent among patients in palliative care and are associated with diminished quality of life. Understanding the relationship between physical and emotional distress and individual symptoms is crucial for optimising symptom management. In Latin America, including Argentina, limited evidence exists about this subject near the end of life.
Aim(s):	To examine the associations between 12 common symptoms and physical and emotional distress among patients receiving PC in Argentina, and how these associations evolve over

	time.
Methods:	Data were collected from patients in their last phase of life enrolled in the iLIVE Project in Argentina (2020–2023) at baseline (n = 171) and follow-up (n = 85). Ordinary least squares regression models were used to assess the partial associations between physical and emotional distress and 12 individual symptoms (e.g., pain, shortness of breath, tiredness), controlling for covariates such as age, gender, living situation, education level, main diagnosis, mobility, and self-care.
Results:	Pain showed a significant positive association with physical distress at both baseline ($\beta = 0.14$, $p < 0.001$) and follow-up ($\beta = 0.12$, $p < 0.001$). Tiredness, drowsiness, and sleep problems were also significantly associated with physical distress, particularly at baseline. Emotional distress was strongly linked with anxiety (baseline: $\beta = 0.11$, $p < 0.001$; follow-up: $\beta = 0.09$, $p < 0.05$) and depression (baseline: $\beta = 0.13$, $p < 0.001$; follow-up: $\beta = 0.14$, $p < 0.001$). These associations varied over time, with some symptoms (e.g., drowsiness, constipation) gaining prominence in follow-up assessments.
Conclusions:	This study confirms the multidimensional nature of suffering and highlights the evolving relationship between symptoms and distress near the end of life. Findings support the need for dynamic, culturally sensitive, and interdisciplinary approaches to symptom management and expanding access to PC in Argentina through public policies and system-level investments.

LC2541 Easing Family Distress: An Integrated Literature Review of approaches to Managing Death Rattle

Author(s):	Ellie Shingles
Background:	Respiratory secretions of “Death rattle” are caused by a buildup of airway secretions and are a common symptom in dying patients. Although there is no evidence to suggest that secretions cause discomfort for the individual, the sound can be distressing for relatives to witness. Despite its prevalence, research lacks clarity on how this can affect grief and bereavement process for families.
Aim(s):	To critique current literature and explore the impact of “death rattle” on families supporting dying patients.
Methods:	An integrated literature review was conducted using Scopus, MEDLINE, PsycINFO and CINAHL databases. Searches were focussed using developed inclusion and exclusion criteria. Articles identified for inclusion were screened using the CASP Critical Appraisal Tools, and Thematic Analysis was used to generate themes and synthesise findings.
Results:	Six articles met all inclusion criteria and were included for analysis. Three themes were developed. 1. **Communication and education**: Ensuring that relatives do not misinterpret the sounds and that the correct support is given. 2. **General management**: Medically and holistically managing symptoms. Ensuring that emotion validation is provided to the relatives to aid the burden of grief. 3. **Family-centered care**: The demand to treat the symptom emanates from the relatives’ concerns and the staff’s attempts to ease relative distress, and relatives must be involved in the care plan.
Conclusions:	Providing compassionate communication to relatives can help relieves their feelings of anxiety and distress in relation to the presence of “death rattle”. To support the bereavement process, healthcare professionals should ensure that relatives receive

	reassurance, education, and psychological support.

e-POSTER PRESENTATIONS

LC2502 Journal clubs in palliative care: evaluation of a Toolkit to implement a hospice journal club

Author(s):	Sarah Stanley, Catherine Eddy, Paula Brown, Kate Davison, Tom Steele, Amara Callistus Nwosu
Background:	Journal clubs support staff development and can improve clinical practice; however, several challenges prevent hospice implementation. To address these challenges, we developed a Toolkit to facilitate the implementation of research-focused journal club in a hospice.
Aim(s):	1) The use a Toolkit to implement a palliative care journal club a hospice. 2) To observe the educational impacts resulting from the journal club.
Methods:	A Toolkit was used to implement the journal club in a hospice over 6 months. After the pilot, participants completed a feedback questionnaire. Qualitative interviews were conducted with senior management to determine their views and opinions of the journal club implementation.
Results:	Six journal club sessions were conducted, with a mean attendance of 12 people per session. Forty-two people attended the journal clubs, representing all areas of hospice care. Twenty-one (50%) participants completed the questionnaire and four staff were interviewed. Feedback was positive with all respondents (n=21, 100%) stating the journal club was useful. Nine (42.7%) respondents had presented at the journal club, and all enjoyed the experience (n=9/9, 100%). Most respondents wanted to present at future journal clubs (n=13, 61.9%). Staff described positive outcomes (including quality improvement, staff development and research), attributable to the journal club. Opportunities to improve the Toolkit for wider implementation were recorded.
Conclusions:	The Toolkit resulted in the implementation of a journal club in a hospice, leading to positive outcomes for staff and service users. Therefore, the journal Toolkit can potentially improve clinical and research outcomes, at no cost, in other hospices.

LC2503 Dexamethasone advice by Hospital Specialist Palliative Care team: review of current practice

Author(s):	Samantha Green (Trainee Advanced Clinical Practitioner), Dr Sarika Hanchanale (Consultant in palliative care)
Background:	Dexamethasone is frequently utilised in palliative care for symptom management due to its anti-inflammatory properties and insignificant mineralocorticoid effect. Despite these advantages, dexamethasone has potential adverse effects: gastritis, hyperglycaemia, increased susceptibility to infections etc. Therefore, it is important that patients are given information and steps are taken to monitor the side effects. This quality improvement project aims to evaluate the current practice of a Hospital Specialist Palliative Care Team (HSPCT) in the recommendation of dexamethasone for symptom control.
Aim(s):	To review the current practice of Hospital Palliative Care Team when recommending Dexamethasone (steroids) for symptom management.
Methods:	A retrospective review of medical records was conducted, involving a random selection of case notes from October 2023 to June 2024. Data from 29 case notes collected and analysed

	in Excel sheet.
Results:	The findings identified several areas of good practice; documentation of rationale for initiating Dexamethasone in 97% of cases, appropriate starting doses were prescribed for all patients. A gradual dose reduction and scheduled review were recommended for 66% of patients. However, several areas for improvement were identified: discussions regarding the potential side effects of dexamethasone were documented in only 14.28% of cases. Guidance on the use of proton pump inhibitors (PPI) was provided in 45% of cases, and advice on blood sugar monitoring was given in only 17%. Only five patients were discharged on dexamethasone and all with appropriate dosing recommendations and follow-up advice.
Conclusions:	Improvement is needed in areas like advising on PPI and blood glucose monitoring. Guidance including steroid management in dying patients will be written. Team education will be provided and audit will be repeated in one year.

LC2504 Improving the experience of dying patients, and families, with End of Life Care Healthcare Assistants

Author(s):	Elizabeth Zabrocki, Anne Cockburn
Background:	Dedicated End of Life Care Healthcare Assistants (HCAs) were made substantive in the Newcastle palliative care service in 2019 on the back of a pilot. There role is invaluable to the Trust and their remit continues to evolve in response to feedback.
Aim(s):	The aim of dedicated HCAs is to provide 1:1 holistic care to dying patients in hospital, and those important to them, to address the unmet need on busy hospital wards.
Methods:	HCAs are supported palliative specialists to proactively identify patients through an alert system linked to electronic prescribing. The proportion of patients we support this way with a non-cancer diagnosis is much higher than those referred into the service, addressing inequity through a proactive model. The HCAs have been instrumental supporting our charitable fund enabling us to provide ‘the little things that make a big difference’ to families. The role modelling the HCAs provide real-time has evolved into a training package for all new and current HCAs in our Trust.
Results:	Our reach to all dying patients across the Trust proactively is achievable with the inclusion of HCAs in the multidisciplinary team. Patient/family/staff experience is improved by HCAs. The evolution of the non-clinical roles the HCAs have in managing our charitable fund and education are invaluable to the delivery of the Trust Strategy.
Conclusions:	The HCA role has addressed the unmet needs after exploring various models. Patients can receive timely personal care, families are supported, concerns are escalated promptly and Trustwide ambitions to improve care of dying patients are being enacted.

LC2506 Single Registered Practitioner for Syringe Drivers in The Community

Author(s):	Jessica Thompson & Charlotte Botes
Background:	Community Nurses expressed concerns about increasing workloads, particularly related to syringe driver management. Protocol was for two staff to attend a syringe driver visit. With a growing aging population and a rise in community deaths on the Wirral, a need for more efficient practices emerged. Feedback from staff highlighted the potential for improvement in how syringe drivers are managed.

Aim(s):	To provide community nurses with the autonomy to attend syringe driver visits as a single registered practitioner. The aim was for 25% of syringe driver visits to be completed by a single practitioner by May 2025.
Methods:	A proof-of-concept project was trialled in one Community Nursing team. Criteria was clarified and expanded to define when a syringe driver could be safely set up or re-primed by a single registered practitioner. Pre-implementation surveys and training were conducted. The Plan-Do-Study-Act (PDSA) cycle guided the project. Daily surveys were completed for each syringe driver visit, and data on incidents, complaints, and feedback were monitored.
Results:	All teams reported improvements. Comparing the first and last weeks of the trial showed increased efficiency and positive feedback. Time was saved, capacity was released, and the risk of second checker bias was eliminated. On average, 59.6% of syringe drivers were completed by a single practitioner by the end of the six-week proof of concept.
Conclusions:	The single practitioner model for syringe drivers is safe, effective, and has been successfully rolled out across all teams, improving capacity and staff satisfaction.

LC2507 Evaluating the impact of a Collaborative Young Adult Palliative & End of Life Care Service (using case studies and stakeholder feedback)

Author(s):	Louise Smith
Background:	Young adults (YA) are a unique cohort of people[1]. Therefore, have a unique set of needs when approaching EOL[1] that are not met fully by either Paediatric or Adult Palliative Care Teams alone[1]. We developed a dedicated YA Palliative & EOLC service for YA's aged 16-25, that works across paediatric and adult settings[1], incorporating the skills of the wider collaborative team[1,2].
Aim(s):	To evaluate the impact of the collaborative service, on the YA's who access it, together with their families. To assess any value to adult stakeholders we have collaborated with, and gauge the overall impact of the service.
Methods:	We collated comments from texts received from YA's during their illness, and gathered feedback from families and professionals, received via our 'young person death review' (YDPR) process. Case studies will be utilised to add context to the feedback[3].
Results:	The feedback shows evidence of effective, supportive relationships built between the team and the YA's and their families … 'thank you so much, you're the best!' 'We were so lucky to have you guys looking after us…we couldn't have got through it without you'). YPDR feedback demonstrated the value felt by professionals we collaborated with… 'You have no idea, your service is fundamental to my TYA's'… 'it's reminded me of why we do what we do, especially in difficult times.
Conclusions:	Both paediatric and adult teams are very skilled in EOLC, but don't look after huge numbers of YA's, so difficult to grow confidence and experience with this cohort[1,4]. By having a dedicated young adult team collaborating with existing teams, we can provide added layers of care to ensure YA's with advanced, progressive or incurable illness, can live as well as possible until they die[5].

LC2508 Delivering Excellence in End-of-Life Care in the Emergency Department: A Nursing Perspective

Author(s):	Karl Cook
Background:	Emergency departments (EDs) are increasingly places where people approach and experience the end of life. The unpredictability of acute care, rising multimorbidity, and the under-resourcing of community palliative services mean more patients present to EDs in the final stages of illness. Nurses are often the first to recognise dying and initiate essential care, despite the ED's high-pressure, intervention-focused environment.
Aim(s):	To explore how excellence in end-of-life (EoL) care can be delivered by emergency nurses in UK EDs, with a focus on advance care planning (ACP), preferred place of death, family and bereavement support, and staff wellbeing.
Methods:	This narrative review and discussion synthesises national policy, nursing literature, and evidence-based interventions relevant to EoL care in emergency settings. It considers system barriers, cultural shifts, clinical innovations, and the expanding role of emergency nurses.
Results:	EDs can provide high-quality, goal-aligned care at the end of life when supported by access to ACP documentation, integrated records, education, and interprofessional collaboration. Nurses play a critical role in recognising dying, facilitating rapid discharge, managing symptoms, and supporting families. However, emotional burden and organisational pressures contribute to moral distress. Sustained improvements require systemic change.
Conclusions:	Emergency nurses are key to delivering excellent EoL care. They must be supported through training, system design, and organisational culture that values palliative approaches. With adequate support and leadership, EDs can offer compassionate, person-centred care even in the most acute settings.

LC2509 Discharge Letter Audit: Communicating Key Information to GPs for Palliative Care Patients on Discharge from Hospital

Author(s):	Dr Poppy Pawlik
Background:	High quality discharge letters improve patient care by facilitating effective communication between secondary and primary care. When discharging a patient with specialist palliative care needs it is important to include specific information – including documentation of resus status and details of any advanced care planning.
Aim(s):	• To identify whether patients have key information recorded on discharge letters as per the set standards • To compare current performance with previous audit cycle
Methods:	Data was collected retrospectively from electronic discharge letters and notes from specialist palliative care inpatient unit over a period of six months (Oct 2024-March 2024). Data was collected and analysed using Excel sheet.
Results:	Data comprises 28 patients with majority with malignant diagnosis (68%). 100% had discharge letters sent on the day of discharge and had follow-up documented in this and previous audit. GSF register was requested in only 46% of patients (57% previous audit). ACP was recorded in 14% (16% previous audit). Improvement was seen in resus status documentation (96%) compared to previous audit (73%).
Conclusions:	Overall the picture on the reaudit cycle is mixed. Further improvement is needed in requesting

	GSF registration for our patients. Education will be provided to all new doctors. Poster providing guidance of completion of letter created and displayed on the unit.

LC2515 Driving Quality Improvement through the National Audit of Care at the End of Life (NACEL).

Author(s):	Jessica Moss
Background:	NACEL evaluates the quality and outcomes of care experienced by the dying person and those important to them during the last admission before death in hospital in England, Wales and Jersey. The audit draws on NICE Guidelines and Quality Standards (NG31, QS13 and QS144) and One Chance to Get It Right (2014). A redesign of the audit commenced in 2023 with a focus on driving quality improvement.The main QI offer for 2024 has been via webinars, “drop in sessions” and dedicated pages on the website. In 2024, 99% of all qualifying organisations participated in NACEL.
Aim(s):	Assess engagement of NACEL participants with the NACEL QI offer Evaluate QI support that has been delivered Identify successes and opportunities for further development
Methods:	Count organisational representation at QI webinars and ‘drop in sessions’ Evaluate QI webinars via survey feedback from participants Review google analytics for QI section on NACEL website
Results:	75% of participating organisations attended at least one QI webinar and/or a drop in session. All QI webinars scored over 4/5 stars Positive trend for hits on QI pages of website
Conclusions:	One year after the re-design of NACEL, there is much to be celebrated with regard to engagement with driving quality improvement from the audit data. 75% of organisations are engaging with the QI offer. A scoping exercise and targeted approach to the 25% who are not engaging could provide useful insight and inform a differing approach to the current QI offer.

LC2517 Bridging Science and Practice: Science Communication in the CODE-YAA@PC-EDU Project

Author(s):	Cornelia Brandstötter-Gugg, Piret Paal, Tania Ximena Pastrana, Minna Hökkä & Sofiya Shunkina
Background:	In response to an age-related increase in deaths from chronic diseases and the urge for integration and improvement of education in palliative care, an EU-funded COST Action (CA22127) called “COllaboratively DEveloped culturallY Appropriate and inclusive Assessment tool for Palliative Care EDUcation” (CODE-YAA@PC-EDU) was initiated.
Aim(s):	The project aims to develop an evidence-based, culturally and ethically appropriate self-assessment tool (CODE-YAA) to measure, explore and promote access to palliative care education across the Pan-European region. Science communication is one integral aspect of the project. The goal is to involve stakeholders, healthcare professionals and the public to promote political uptake of scientific knowledge.
Methods:	Strategies used in the CODE-YAA@PC-EDU project blur the distinction between research and public engagement, and present science communication as a participatory research method itself.

Results:	The project has implemented a comprehensive science communication strategy including regular webinars, summer schools and participation in international conferences. The project's science communication team ensures dissemination of knowledge via social media, a website and newsletter. Collaboration with international and national associations for palliative care and the inclusion of experts from various countries enhance visibility and stakeholder involvement. The newly appointed ethics and gender equity officers support responsible and inclusive research practices.
Conclusions:	Science communication plays a central role in bridging the gap between science and practice. The project is aware of the importance of science communication and aims to increase the visibility of palliative care education in both public and political areas. This will reduce inequalities in access to palliative care through the improvement of palliative care training.

LC2520 Making research routine: a clinician developed process for identification of patients for recruitment to research studies

Author(s):	Tom Steele, Helen Hughes, Grace Ting
Background:	Recruiting patients close to the end of their life to research studies is vital in building an evidence base for the best care for dying people. Evidence suggests palliative care patients want to be involved in research, yet barriers remain in the identification and approach of those eligible.
Aim(s):	Develop a structured approach to embed identification of patients for recruitment to research into routine clinical practice.
Methods:	In preparation for two research studies, clinical team members from palliative care services at Liverpool University Hospitals - a hospital advisory service and a hospital based inpatient unit- developed processes to identify and approach eligible patients. Support was provided through a RESPACC learning set. A new standard operating procedure (SOP) was created in keeping with hospital specifications.
Results:	Processes were refined and optimised during the study periods and applied to a third setting (hospice inpatient unit). Both studies successfully recruited their target sample size from all parts of the service. Key components of the final SOP include involvement of researchers in multidisciplinary team meetings, delineated roles and responsibilities, core information required from researchers and specific processes for patient identification from each service. Close communication between researchers and link clinicians within services and visibility of researchers to clinical teams was crucial in the success of these studies.
Conclusions:	This iteratively developed process will facilitate efficient recruitment to future palliative care research studies. Clinical teams leading this work, within a RESPACC process, has offered secondary benefits in promoting a research culture.

LC2521 Impact of integrated, multiprofessional palliative care models on reducing avoidable hospital admissions: a systematic review

Author(s):	Amy Reed
Background:	Every five minutes, someone dies without receiving the necessary care and support (Marie

	Curie, 2023). This systematic review examines the impact of integrated, multi-professional palliative care models on reducing avoidable hospital admissions. With rising demand for person-centred care in chronic and life-limiting illnesses, the review assesses whether collaborative approaches improve quality of life while minimising hospital use.
Aim(s):	To explore how integrated, multi-professional palliative care models reduce avoidable hospital admissions by examining their effectiveness, cross-sector collaboration, system impact, and implementation challenges.
Methods:	A structured search using the PICO framework was conducted across MEDLINE and CINAHL (March-April 2025). The strategy combined free-text keywords and controlled vocabulary, focusing on studies published post-2019. Inclusion criteria targeted adults receiving palliative or supportive care within integrated models. Five studies, three qualitative and two quantitative, met the criteria and were critically appraised using recognised tools.
Results:	Thematic synthesis identified three key themes: interprofessional collaboration, barriers to integration, and impact on admissions. Three studies showed a direct or theorised reduction in hospital use through integrated care, with all highlighting improved coordination and continuity. Variation in study quality and context limited generalisability but emphasised the relevance of integrated models across healthcare settings.
Conclusions:	Integrated, multi-professional palliative care shows potential to reduce avoidable hospitalisations and enhance patient outcomes. However, the current evidence base is limited. Further high-quality, outcome-driven research is needed to assess key components of integration, particularly in non-cancer populations and varied care environments. Future studies should also explore the leadership role of Advanced Clinical Practitioners in driving integration and coordinating care.

LC2523 Ensuring Quality of End-of-life Care in Iceland: on the way to build a Registry

Author(s):	Antoine Elyn, Margrét Guðnadóttir, Svandís Íris Hálfdánardóttir, Adeline Tracz, Sigríður Zoéga, Arna Dögg Einarsdóttir, Valgerður Sigurðardóttir, John Ellershaw, Thor Aspelund, Maria Schelin
Background:	Recording data to promote quality improvement of end-of-life care is challenging. For that purpose, this pioneering project is to establish the Icelandic Palliative and End-of-Life Care Registry (IPEC-R), through three distinct steps.
Aim(s):	(1) Assess automatized capturability of end-of-life care outcomes from health records, to build the End-Of-Life Icelandic Database (EOLID). (2) Translate and validate in Icelandic (ELQ-ICE) the Swedish Healthcare Professionals' Questionnaire. (3) Evaluate the feasibility and impact of implementing IPEC-R.
Methods:	Settings: Home, Hospital and Nursing Homes. Population: Preselected Healthcare Units. (1) Qualitative focus-groups and retrospective pilot testing using a 2023-2024 death sample. (2) Translation following EORTC Guidelines and psychometric validation. (3) Repeated transversal analyses with qualitative interviews.
Results:	Health and administrative databases are useful to capture end-of-life care outcomes. Given cultural specificity, the validation of culturally sensitive measurement tools is essential to accurately assess what matters most at the end-of-life. Using the same questionnaire as in the Swedish Palliative Care Registry will be useful to compare practices and to enhance international end-of-life research. We emphasize that implementing IPEC-R is feasible, and that its use may leads to measurable improvements in the quality of end-of-life care.

Conclusions: IPEC-R will enable systematic benchmarking across care settings, support policy-making, and foster equity in end-of-life care. It will provide a robust infrastructure for research and international collaboration, positioning Iceland at the forefront of innovation in palliative and end-of-life care quality assessment.

LC2527 Providing care at the end of life: How do community hospitals compare to acute hospitals?

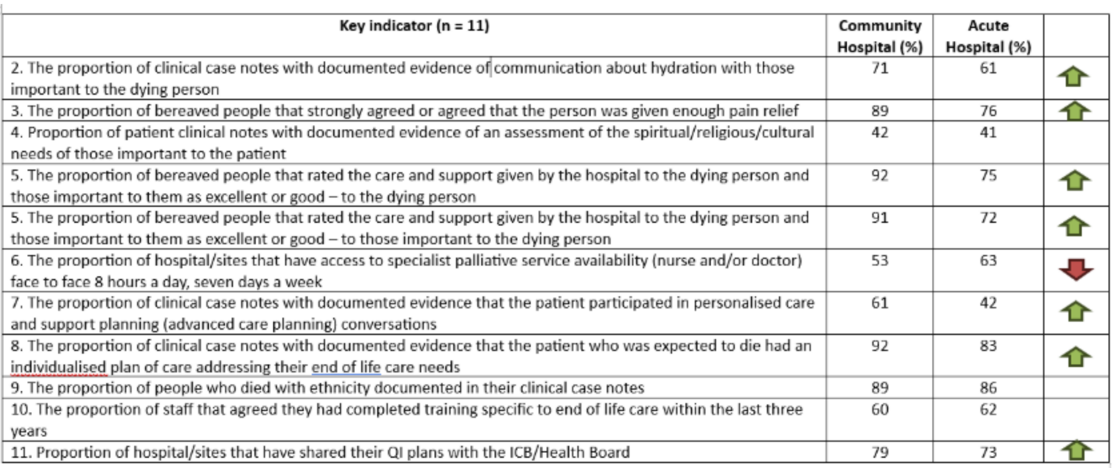
Author(s): Mary Miller, Heather Murray, Joylin Brockett.

Background: Deaths in hospital in England, Wales and Jersey may take place in community or acute hospitals. In 2024, community hospitals made up 23% of submissions (56/242).

Aim(s): To understand if there is a difference in care provided in acute and community hospitals.

Methods: Data was analysed by death in community or acute hospital.

Results: Table 1:



Key indicator (n = 11)	Community Hospital (%)	Acute Hospital (%)	
2. The proportion of clinical case notes with documented evidence of communication about hydration with those important to the dying person	71	61	⇧
3. The proportion of bereaved people that strongly agreed or agreed that the person was given enough pain relief	89	76	⇧
4. Proportion of patient clinical notes with documented evidence of an assessment of the spiritual/religious/cultural needs of those important to the patient	42	41	
5. The proportion of bereaved people that rated the care and support given by the hospital to the dying person and those important to them as excellent or good – to the dying person	92	75	⇧
5. The proportion of bereaved people that rated the care and support given by the hospital to the dying person and those important to them as excellent or good – to those important to the dying person	91	72	⇧
6. The proportion of hospital/sites that have access to specialist palliative service availability (nurse and/or doctor) face to face 8 hours a day, seven days a week	53	63	⇩
7. The proportion of clinical case notes with documented evidence that the patient participated in personalised care and support planning (advanced care planning) conversations	61	42	⇧
8. The proportion of clinical case notes with documented evidence that the patient who was expected to die had an individualised plan of care addressing their end of life care needs	92	83	⇧
9. The proportion of people who died with ethnicity documented in their clinical case notes	89	86	
10. The proportion of staff that agreed they had completed training specific to end of life care within the last three years	60	62	
11. Proportion of hospital/sites that have shared their QI plans with the ICB/Health Board	79	73	⇧

Conclusions: Care of the dying and support of those important to the patient is better in community hospitals.

LC2529 Beyond the Pandemic: End-of-Life Care Lessons from Latin America to Inform Future Health Emergencies

Author(s): Vilma A. Tripodoro[1,2], Pedro Pérez-Cruz[3], Marina Khoury[4], Martha Ximena León[5], José Mario López Saca[6], Michelle Uchida[7], Verónica Veloso[4], Ángela Acero[5], Sebastián Soto-Guerrero[3], Marco Rodríguez6, on behalf of the CO-LIVE Latin America research group.

[1] RED-InPal Pallium Latinoamérica, Buenos Aires, Argentina.

[2] ATLANTES, Global Observatory of Palliative Care, Institute of Culture and Society, University of Navarra, Spain

[3] Pontificia Universidad Católica de Chile, Santiago de Chile, Chile

[4] Instituto de Investigaciones Médicas Alfredo Lanari, Universidad de Buenos Aires, Argentina

[5] Universidad de La Sabana, Bogotá, Colombia

[6] Hospice La Cima, El Salvador

[7] Barretos Cancer Hospital, Brazil

Background: The COVID-19 pandemic exposed major weaknesses in end-of-life care (EOLC), especially in Latin America, where fragmented health systems and inequities worsened suffering.

Aim(s): To explore bereaved relatives' perceptions of EOLC during the pandemic across five Latin American countries; identify predictors of perceived care adequacy; and assess alignment

	with the Core Outcome Set (COS) for best care for the dying person.
Methods:	A cross-sectional online survey using an adapted iCODE (Care Of the Dying Evaluation) questionnaire was conducted in Argentina, Brazil, Chile, Colombia, and El Salvador (2021–2023). The primary outcome—perceived "adequate care" in the last 48 hours of life—was derived from two iCODE items. Logistic regression identified associated factors.
Results:	Among 1,125 respondents, only 51% perceived care as adequate. This varied significantly by country, from 45% in Argentina and Colombia to 81% in El Salvador ($p < 0.001$). Independent predictors of perceived care adequacy included personal care support ($p < 0.001$), emotional support ($p < 0.001$), trust in professionals ($p < 0.001$), symptom relief ($p \leq 0.001$), effective communication ($p = 0.012$), and family involvement in decision-making ($p = 0.045$). COVID-19-related restrictions were negatively associated with care perception. Mapping findings to the COS revealed consistent gaps in spiritual support, shared decision-making, and communication.
Conclusions:	Relational, emotional, and physical aspects of care strongly influenced families' perceptions of EOLC during the pandemic. The COS offers a practical framework to identify and address care gaps. Its adoption could promote holistic, culturally sensitive, and resilient palliative care systems in Latin America, essential for future health emergencies.

LC2530 Influencing Best Practice for Palliative and End of Life Patients in a Large Acute Hospital Trust

Author(s):	Tina Willis[1], Kieran Foulkes[1] [1]Liverpool University Hospitals NHS Foundation Trust, Liverpool, UK
Background:	Quality Improvement (QI) in the NHS involves understanding how services are currently delivered, identifying areas for improvement, implementing changes and measuring the impact of change (The Health Foundation, 2021). A structured approach is essential to enhance Palliative and End of Life Care within an Acute hospital setting.
Aim(s):	To develop a Palliative, End of Life and Bereavement (PEOLB) Strategy which embodies evidence based practice and nationwide standards, alongside internationally agreed principles to improve the experience of patient's and those important to them.
Methods:	A working group produced a comprehensive strategy which incorporates six workstreams, each containing a series of objectives: Patient and Family Experience, Service Integration, Workforce Training and Development, Transitions of Care, Research and Development, End of Life Outcomes. Our vision: 'A person-centred approach to delivering integrated, responsive, palliative, end of life and bereavement services across all settings.'
Results:	Strategy endorsed by the Chief Nurse. A multi-faceted approach designed to demonstrate outcomes, including robust thematic analysis of data, improving knowledge through education and digital platforms, engagement events, staff and service user feedback, development of specialist services, collaboration with research partners and international colleagues, benchmarking through participation in the National Audit of Care at the End of Life.
Conclusions:	Quality improvement is directly attributable to the commitments set out in the PEOLB Strategy. A systematic approach is crucial to sustaining a culture of continuous development, empowering staff to make a difference to those we have the privilege to care for. Regular monitoring, communication and vigorous action plans amplify the measures required to drive progress.

LC2532 Myofascial pain syndrome in cancer patients: a narrative review of current practice

Author(s):	Katie Richardson, Dan Monnery, Alexandra McDougall, Matthew Greig, Seamus Coyle
Background:	Myofascial pain syndrome (MPS) is a musculoskeletal disorder characterised by the presence of myofascial trigger points and associated regional pain. Despite its clinical relevance, MPS remains under-researched within the oncological field, where pain is both prevalent and multifactorial in origin.
Aim(s):	This narrative review aims to evaluate current evidence regarding the prevalence and management of MPS in cancer patients, with an emphasis on diagnostic challenges, therapeutic approaches, and identification of gaps within the literature.
Methods:	A narrative search was conducted across Embase, Medline and Emcare, using keywords related to MPS and cancer. From 87 studies initially identified, 21 met inclusion criteria following screening and full-text review. An additional 5 studies were sourced through manual citation review, resulting in a total of 26 studies included.
Results:	Prevalence estimates of MPS in cancer patients varied widely, reflecting heterogeneity in diagnostic criteria and studied populations. Research primarily involved individuals with incurable cancer, head and neck cancer, and breast cancer survivors. Trigger point injections, particularly with lidocaine, demonstrated short-term analgesic benefits, with cumulative efficacy observed following repeated administrations. Manual therapy interventions showed variable yet promising outcomes, although short follow-up durations limited interpretability. Pharmacological treatments remain under-investigated, with existing evidence limited to isolated case reports.
Conclusions:	MPS is a prevalent yet frequently overlooked source of pain in cancer patients. The absence of standardised criteria contributes to diagnostic inconsistency and limits comparability across studies. Future research should prioritise diagnostic standardisation and clinical trials to inform individualised, evidence-based management strategies for MPS in oncological populations.

LC2535 Caring for the Carers

Author(s):	Virginia Marsh Bowen
Background:	It was identified from feedback that Carers who choose to stay with their loved one during the dying phase have no access to facilities that would make their stay more comfortable.
Aim(s):	To establish provision to make carer's stay more comfortable whilst they sit at the bedside of their dying loved one.
Methods:	Following feedback received, a focus group was convened and ideas submitted as to how we could support the carers of our dying patients.
Results:	It was identified that having access to simple toiletries, and somewhere comfortable to sleep were some of the main requirements for our carer group
Conclusions:	Funding identified and recliner chair beds purchased for relatives of those dying in the hospital. Comfort bags created including toiletries, car park pass and two knitted hearts (one for patient and one for relative) to keep.

LC2538 Grieving process of the family caregiver of an adult chronic patient during the dying process

Author(s):	Catarina Simões, Margarida Vieira, Paula Sapeta
Background:	The grieving process of the family caregiver of an adult chronic patient begins before the death and is influenced by personal and contextual factors, as well as emerging conditions within the interaction continuum. Access to information that facilitates awareness of the inevitability and imminence of death is crucial in this process.
Aim(s):	Identify the factors that affect the grieving process of family caregivers during the final hours and days of a patient's life.
Methods:	A qualitative methodology was used, more specifically Grounded Theory according to Strauss and Corbin, using a theoretical sample based on interviews and recording observations during the interviews.
Results:	Inevitably, actions involving family and economic reorganization occur during the adaptive process. However, personal and contextual influencing conditions emerge within the continuum of interaction. These include the characteristics of the dying process, task overload, the complexity of care and the presence and availability of a formal carer. In the interaction continuum, information is structuring. The use of a care model that brings together best practices in the last hours and days of life can be an excellent response in the management of modifiable influencing conditions.
Conclusions:	The grieving process of the family caregiver of an adult chronic patient begins before the death and is influenced by modifiable and non-modifiable factors, with the intervention of the health care professional being among the first throughout the process.

LC2539 Healthcare Professionals' Experiences of Compassionate Extubation in Paediatric Palliative Care: A Systematic Review of Qualitative Research

Author(s):	Milly Queiroz de Araujo University of Liverpool, Liverpool, United Kingdom Isabella Krauser Hospital das Clinicas, Universidade de São Paulo (USP), São Paulo, Brazil Stephen Mason University of Liverpool, Liverpool, United Kingdom Janet Oakes-Sutherland Claire's House Children's Hospice and University of Liverpool, Liverpool, United Kingdom
Background:	Compassionate extubation—the planned withdrawal of mechanical ventilation at the end of life—is a sensitive and complex component of paediatric palliative care (PPC). While clinical and ethical guidance exists, there remains limited understanding of the lived experiences of healthcare professionals involved in this process. Emotional, ethical, and logistical challenges are often underexplored in the literature, despite their significant impact on team wellbeing and care delivery.
Aim(s):	This systematic review aims to synthesise qualitative evidence on how healthcare professionals experience compassionate extubation in PPC settings, to inform future training, emotional

	support, and policy development.
Methods:	The review will follow PRISMA guidelines and apply a thematic synthesis approach. A comprehensive search will be conducted across PubMed, Scopus, CINAHL, PsycINFO, Google Scholar, and Web of Science, in addition to grey literature and citation tracking. Eligible studies will include qualitative or mixed-methods designs reporting on the perspectives or experiences of healthcare professionals involved in compassionate extubation in paediatric contexts. Quality assessment will be conducted using the CASP qualitative checklist.
Results:	The review will identify recurring emotional, ethical, and practical themes, highlighting barriers and facilitators to compassionate practice in various care settings.
Conclusions:	By consolidating current qualitative evidence, this review will provide in-depth insight into the realities of compassionate extubation in PPC and support the development of training, policy, and emotionally sustainable models of end-of-life care for children and their families.

LC2542 Evidence-informed learnings from an Australian study to inform the 10/40 model: The comatose dying person

Author(s):	Tricia O’Connor RN MN, Assoc Prof Aileen Collier RN PhD, Prof Karen Strickland RN PhD, Prof Catherine Paterson RN PhD
Background:	The 10/40 model provides a framework for improving the quality of care for dying individuals; however, the dying is not a homogeneous group. Some individuals become comatose before death and are no longer able to make decisions nor articulate their needs. The 10/40 model requires further evidence-informed insights to address the unique needs of this cohort to ensure a comfortable, dignified death.
Aim(s):	To further inform the 10/40 model by highlighting the ‘comatose dying person’.
Methods:	A suite of research was undertaken; two systematic reviews, two retrospective cohort studies and one qualitative study, to understand the holistic care needs of the comatose dying. Synthesised data could inform further development of the 10/40 model to include care for this cohort.
Results:	Findings were published separately. This presentation draws together evidence from these studies to provide new evidence-informed insights of the comatose dying person’s specific needs. In a cohort of 2,438, approximately 50% of dying individuals were comatose for 2.1 days on average before death. Findings reveal they have awareness yet lack a voice leaving them vulnerable to having unmet needs. Palliative specific assessment scores can aid recognition of imminent death to enable earlier communication and shared decision-making. Nurses play a critical role in assessment, interpreting needs, and decision-making. Education and awareness are fundamental. Family are key participants as the individual’s voice and witness.
Conclusions:	Specific needs of the comatose dying person and their family in the last days and hours of life are highlighted to further inform the 10/40 model and enable high quality care.

LC2544 The Role of Family in End-of-Life Decisions of Older Adults with Advanced Kidney Disease: A Scoping Review

Author(s):	▪ Andy Sim Gim Hong, University of Liverpool, Liverpool, UK; Singapore General Hospital, Singapore ▪ Stephen Mason, University of Liverpool, Liverpool, UK ▪ Chao Fang, University of Liverpool, Liverpool, UK ▪ Lalit Kumar Radha Krishna, National Cancer Centre Singapore, Singapore ▪ Marjorie Foo Wai Yin, Singapore General Hospital, Singapore ▪ Amy Chow Yin Man, University of Hong Kong, Hong Kong
Background:	Shared decision-making (SDM) is heralded as the preferred approached to help patients with advanced kidney disease to make informed treatment decisions along their illness trajectory. This is especially important for older patients as they often have significant comorbidities and higher incidents of mortality while on dialysis. Although the role of the family in SDM is recognised by numerous professional bodies, they are briefly discussed or mentioned in existing literature.
Aim(s):	The main objective of this scoping review is to survey available empirical evidence on the role of the family in end-of-life (EoL) decision-making of older adults with advanced kidney disease.
Methods:	This review is informed by JBI methodology and the Preferred Reporting Items for Systematic Reviews and Meta Analyses extension for Scoping Review (PRISMA-ScR) guidelines. MEDLINE (Ovid), Scopus, and CINAHL Ultimate, PsycINFO and PubMed were searched for full-text studies in English. Two reviewers will independently screen and select records for data extraction. A data extraction tool created based on the Three-Talk Model of SDM will be used to categorise the data extracted from the included studies. Thematic analysis will be conducted.
Results:	A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis was conducted and no current or underway systematic reviews or scoping reviews on the topic were identified. Findings from the review will be shared at the conference.
Conclusions:	A narrative summary will describe the findings in relation to the review's objectives and questions. It will also highlight current research gaps to inform future studies.

LC2545 Supporting the Supporters: Psychological Self-Regulation Practices and Staff Wellbeing in a Palliative Care Clinic

Author(s):	Sofya Sahakyan – Clinical Psychologist, National Oncology Centre named after V.A.Fanarjyan, Yerevan, Armenia
Background:	Palliative care staff frequently face high emotional demands that can lead to burnout, reduced communication quality, and compassion fatigue. Supporting the psychological wellbeing of caregivers is essential for ensuring dignified care for dying patients. In our clinic,

	we introduced a structured, long-term psychological support initiative for nurses and care assistants.
Aim(s):	To explore how daily psychological self-regulation practices influence emotional wellbeing and interpersonal dynamics among palliative care staff, and to assess potential links between burnout symptoms and personality traits.
Methods:	Over the course of 18 months, small-group self-regulation sessions (2–6 participants per session) were conducted nearly every working day. Techniques included breathing exercises, guided relaxation, meditation, art therapy, and selected cognitive strategies. In 2025, we initiated an exploratory study using the MMPI personality inventory and burnout screening tools to assess correlations. Data analysis is currently in progress.
Results:	While formal statistical results are pending, initial clinical observations suggest improved team communication, reduced emotional tension, and increased empathy in staff–patient interactions. Participants reported feeling more supported and emotionally stable after regular engagement in self-regulation practices. Staff also became more attentive to patients' emotional states and began more frequently referring them to psychological support when needed.
Conclusions:	Preliminary insights highlight the value of integrating daily psychological support for palliative care staff. Structured self-regulation practices appear to foster emotional resilience and enhance the caregiving environment. Further research will refine understanding of individual personality patterns in relation to burnout and inform future team-based interventions.

LC2547 Updating to version 2.0. 'The Last Days of Life'- a framework for an individualized end of life care plan

Author(s):	Grethe Skorpen Iversen[1] and Katrin Ruth Sigurdardottir[1,2] [1]Regional Centre of Excellence for Palliative Care, Western Norway, Haukeland University Hospital, Bergen, [2]Palliative Care Centre, Department of Pain and Palliative Care, Haukeland University Hospital, Bergen, Norway
Background:	'The Last Days of Life', is a care plan for dying patient and their families, when death is imminent. Since 2015, it has been used across various settings in Norway, including nursing homes, community homecare, hospitals and palliative care wards. The Regional Centre of Excellence for Palliative Care oversees the nationwide implementation of this plan. In alignment with the 10/40 Model of care for the dying, it has been approved for congruence by the International Collaborative for Best Care for the Dying Person.
Aim(s):	To update 'The Last Days of Life' document in accordance with recommendations from the Norwegian Directorate of Health and feedback from user sites.
Methods:	The document update was carried out within a local workgroup and the nationwide reference group for 'The Last Days of Life'. This was followed by 'Think-aloud' interview with a strategic group of user sites, before pilot testing across all types of user sites.
Results:	The five participants in the 'Think-aloud' group and the five pilot sites were asked to assess the clarity and comprehensibility of the changes. Feedback on the wording and format was predominantly positive and considered an improvement. Following the deaths of 38 patients, feedback was collected from both experienced (n=31) and less experienced staff (n=7) via

	survey. The document was found to be easy to understand (n=32), clear and unambiguous (n=11) and unclear (n=1).
Conclusions:	Version 2.0 document was well-received, with positive feedback from both the 'Thinkaloud' group and pilot sites. The majority found the document clear, easy to understand, and unambiguous, indicating successful improvement in clarity for diverse user sites.

LC2548 Validation of the Spanish Subjective End-of-Life Health Literacy Scale through Community-Based Workshops in Argentina

Author(s):	Vilma A. Tripodoro, Verónica Inés Veloso, María Bélen Carballo, Clément Meier, María Coller, Ana Dominguez Mon, Natalia Luxardo, Stella Di Gennaro, Sandra Castro, Maria Verdugo on behalf of the PCA-Argentina Group
Background:	Health literacy is critical in shaping individuals' ability to make informed end-of-life decisions. However, culturally adapted tools to measure end-of-life-specific health literacy are lacking in Spanish-speaking populations. In addition, Latin America faces unique social and cultural challenges around death and dying, underscoring the need for validated instruments that reflect local realities.
Aim(s):	To culturally adapt and validate the Spanish version of the Subjective End-of-Life Health Literacy Scale (S-EOL-HLS) through community-based workshops in Argentina.
Methods:	The scale was translated using a forward–backwards method and initially tested in five community workshops across urban and rural regions in Argentina (n = 70). Face validity was then assessed by a panel of eleven experts. Based on this feedback, seven additional workshops were conducted to refine and confirm the adapted version, along with cognitive interviews involving five adults and ten participants who completed the test-retest. Participants completed the scale and a brief sociodemographic questionnaire. Psychometric analyses included exploratory factor analysis (EFA) on the first set of workshops and confirmatory factor analysis (CFA) on the Please refer to the abstract submission guidance overleaf before completing the proforma.second set (n = 127), as well as internal consistency (Cronbach's alpha) and construct validity testing.
Results:	Preliminary findings suggest that the Spanish S-EOL-HLS demonstrates acceptable internal consistency and a coherent factor structure. Feedback from participants and expert reviewers led to culturally sensitive adaptations that improved clarity and relevance. Initial tests of construct validity show patterns consistent with theoretical expectations.
Conclusions:	The Spanish S-EOL-HLS seems to be a culturally valid tool for assessing end-of-life health literacy in Argentina. It offers a promising resource for research, community engagement, and improving end-of-life communication and planning in Spanishspeaking populations.

LC2550 From OPCARE9 to the iLIVE Volunteer Study: A story of International Collaboration and Research

Author(s):	Tamsin McGlinchey, Stephen Mason, Ruthmarijke Smeding, John Ellershaw

Background:	Across Europe hospital palliative and end-of-life-care volunteer services (EOLC-VS) are relatively uncommon, particularly for patients in the last weeks of life. The iLIVE Volunteer Study will evaluate the use of hospital EOLC-VS's across 5 countries.
Aim(s):	Describe the development of the iLIVE Volunteer Study, through a rigorous process of international collaboration and research generated from two innovative projects.
Methods:	1. 2008 – 2011: OPCARE9 Work Package 5: Voluntary Service Funded by the EU FP7 Coordination & Support Action grant, OPCARE9 systematically investigated current practice and evaluated the evidence base for Volunteering in EOLC across different healthcare environments and diverse cultures. Two specific methods were used: • Systematic Review of the literature • Delphi study on the role of volunteers 2. 2012 – 2014: Development of a hospital EOLC-VS in one UK hospital Funded by the Dimbleby Marie Curie Research Fund, a hospital EOLC-VS was developed and implemented. A qualitative interview study explored perceptions of the service with: • Relatives/friends • Healthcare professionals • volunteers
Results:	Findings and recommendations from OPCARE9 supported the development and implementation of a UK hospital EOLC-VS. The subsequent qualitative evaluation led to further improvements to the UK service, and a recommendation to explore the transferability of hospital EOLC-VS's across other cultures and contexts. The international Collaborative for Best Care for the Dying Person, formed following OPCARE9, undertook the iLIVE Volunteer Study, one of 8 work packages from the Horizon 2020 iLIVE Project. The iLIVE Volunteer Study developed a European Core Curriculum for hospital end-of-life care volunteer services, which supported the development of services across five countries.
Conclusions:	Knowledge and understanding from OPCARE9 and the UK EOLC-VS paved the way for the development of the iLIVE Volunteer Study, facilitating the development of hospital EOLC-VC's across 5 countries.

LC2552 Psychological Distress in Patients With Stage 4 Cancer Receiving Palliative Chemotherapy: A Comparative Study	
Author(s):	Merine Babayan
Background:	Psychological distress is common among patients receiving palliative chemotherapy but often remains under recognised in routine care. Identifying the specific concerns underlying distress in advanced-stage cancer is crucial for effective psychosocial support.
Aim(s):	To assess distress levels and associated psychosocial concerns in patients with stage 4 cancer undergoing palliative chemotherapy, compared to patients with stage 3 disease, using the

	NCCN Distress Thermometer and Problem List.
Methods:	A cross-sectional study was conducted with 140 adult patients (aged 35–75) at the National Center of Oncology after V. A. Fanarjian. The Armenian version of the NCCN Distress Thermometer and Problem List was administered. Patients were stratified by cancer stage (stage 4: n=70; stage 3: n=70). Descriptive statistics and thematic analysis were used.
Results:	Clinically significant distress (DT ≥4) was reported by 67% of patients with stage 4 cancer, compared to 44% in the stage 3 group. Fatigue was the most common physical concern across both groups. Stage 4 patients reported greater issues with pain, loss of abilities, sadness, anger, and feelings of worthlessness. Spiritual concerns—such as fear of death, thoughts about the afterlife, and a loss of meaning—were more prominent in the stage 4 group.
Conclusions:	Patients with stage 4 cancer receiving palliative chemotherapy experience high levels of psychological and spiritual distress. Routine screening with tools like the NCCN Distress Thermometer can guide timely, person centred psychosocial interventions in palliative care settings.

LC2553 Exploring the Use of Virtual Reality in a Hospice: A Multi-Methods Study

Author(s):	Katie Flanagan, Marie Curie Palliative Care Research Department, University College London, London, UK Victoria Vickerstaff, Centre for Evaluation and Methods, Wolfson Institute of Population Health, Queen Mary University of London, London, UK Briony Hudson, Policy and Research, Marie Curie, London, UK Libby Sallnow, Marie Curie Palliative Care Research Department, University College London, London, UK Nicola White, Marie Curie Palliative Care Research Department, University College London, London, UK
Background:	Virtual reality (VR) is increasingly used in healthcare, with evidence suggesting benefits for people with incurable illnesses, including reduced pain and anxiety. However, existing studies are limited by small sample sizes and inconsistent designs. Further research is needed to understand if VR could be integrated into routine hospice care.
Aim(s):	To explore whether VR could be adapted to a hospice setting, and whether it reduces common symptoms patients experience at the end of life.
Methods:	This multi-methods study includes three phases: 1. A national survey (N=89) explored current VR use in UK hospices. 2. Interviews with hospice patients and staff (N=10) are underway to understand attitudes towards VR. 3. A six-month single-arm pre-post intervention study in a UK hospice will measure and evaluate the frequency of VR use in a real-world setting, symptom relief and the feasibility of implementation.

Results:	The survey revealed that 56% hospices did not own a VR headset. Barriers to adoption included a lack of funds (40%) and insufficient resources for implementation (28%). VR was used to address symptoms like boredom (80%), anxiety (73%) and depression (47%). Interviews suggest that VR is valued for enabling patients to engage in meaningful activities they can no longer do physically. However, staff had concerns about sustainability.
Conclusions:	Virtual Reality is seen largely seen in a positive light by hospice staff and patients, but concerns remain about how it would be used over the long term. Preliminary results for Phase 3 will be presented at the conference.

LC2554 Clinical and Ethical Challenges Balancing End-of-Life Preferences and Caregiver Capacity: Case in Advanced Palliative Care

Author(s):	Patricia Coelho, Conceição Reisinho, Paulo Marques, Maria José Lumini, Catarina Simões
Background:	Patients receiving palliative care frequently express a strong wish to remain and die at home. However, these preferences may conflict with the emotional resilience and practical capacity of caregivers, creating complex clinical challenges that demand specialised intervention.
Aim(s):	To analyse how deliberative decision-making combined with psychosocial support can reconcile patient autonomy and caregiver limitations in the context of end-of-life care.
Methods:	Qualitative case study: examined the trajectory of a 38-year-old woman with advanced glioblastoma admitted to a Palliative Care Unit, presenting with fluctuating levels of consciousness and progressive neurological decline. Her husband remained constantly by her side, committed to fulfilling her wish to return home, yet simultaneously exhibiting profound fear and exhaustion. He frequently requested invasive interventions, such as airway suctioning, despite the preservation of protective reflexes, reflecting significant emotional distress. The multidisciplinary team provided psychosocial support, clarified the therapeutic intentions, and aligned care delivery with the patient's preferences and the caregiver's actual capacity.
Results:	The husband's ambivalence, caught between love, duty, and a sense of incapacity, highlighted anticipatory grief and substantial caregiver burden. Values clarification and deliberative dialogue enabled the care plan to evolve, maintaining in-patient care until clinical stability allowed reconsideration of home discharge with continued support, ensuring symptom control and safety for both patient and caregiver
Conclusions:	This case underscores the importance of early recognition of caregiver burden, the integration of psychosocial support, and advance care planning grounded in ethical deliberation. Balancing respect for patient autonomy with the caregiver's realistic capacity is essential to achieving dignified, person-centred care transitions and minimising avoidable suffering at the end of life.

LC2555 Integrating Deliberative Ethics into Nursing Education: A Project for End-of-Life Care

Author(s):	Patricia Coelho, Catarina Simões, Rui Nunes
Background:	End-of-life care often involves complex clinical and ethical decisions where patient preferences, family expectations, and healthcare realities must be carefully weighed. Teaching future health professionals to navigate these scenarios through deliberative models can promote more balanced and ethically acceptable care planning
Aim(s):	To analyse an educational strategy using deliberative decision-making to enhance nursing students' competencies in managing end-of-life situations that require aligning patient autonomy, family dynamics, and clinical feasibility.
Methods:	This project outlines the design of an educational intervention aimed at nursing students to enhance their competencies in deliberative decision-making for end-oflife care. The project involves developing structured case-based scenarios reflecting ethically complex end-of-life situations, guided by Diego Gracia's deliberative model. Planned activities include small group discussions, identification of patient values and clinical priorities, formulation of proportionate care plans, and facilitated debriefings to consolidate ethical reasoning and communication skills. Evaluation will consider students' reflective outputs and perceived confidence in handling ethically challenging cases.
Results:	It is anticipated that this educational project will strengthen nursing students' ability to identify ethical conflicts, articulate patient-centred preferences, and propose care plans that balance patient wishes with family and clinical considerations. The project also expects to enhance students' confidence in addressing ethica complexity and in applying deliberative dialogue to reach proportionate and ethically acceptable decisions in palliative care settings.
Conclusions:	Integrating deliberative decision-making frameworks into nursing education holds significant potential to strengthen future practitioners' capacity to navigate ethically complex end-of-life decisions. This pedagogical approach is expected to foster reflective, patient-centred care planning that balances respect for autonomy with realistic clinical and family considerations, , promoting ethically sound care that is congruent with best practice at the end of life.

LC2556 Integrating Suicide Prevention Pathways into Palliative Care: A Phased Collaborative Model

Author(s):	Louisa Wainwright
Background:	Suicide risk is significantly elevated among individuals with palliative diagnoses, particularly those with ischaemic heart disease, chronic obstructive pulmonary disease and low survival rate cancers. Despite this, structured mental health provision remains largely absent from UK palliative care services. Clinicians report limited confidence, unclear protocols and fragmented referral pathways.
Aim(s):	To design, implement and evaluate a collaborative care model that integrates suicide prevention strategies into routine palliative practice within an NHS hospital setting.
Methods:	The projects takes a six stage approach, beginning with baseline surveys and reflective journals to assess staff knowledge and confidence. Reciprocal participation in multidisciplinary meetings will identify integration opportunities. A join assessment period follows, allowing real time collaboration. Data collection includes repeated surveys, staff reflections, two structured focus groups to co-design practical tools (e.g referral pathways, patient and staff resources).

Results:	Anticipated outcomes include improved staff confidence in addressing suicidality, earlier mental health referrals, enhanced patient experience , and clearer collaborative working protocols. Mixed-methods evaluation will explore qualitative learning and potential cost-effectiveness.
Conclusions:	This project addresses an urgent service gap by embedding mental health expertise into palliative care settings. Through reflection, shared learning and practical tools, the model supports the delivery of safer, compassionate care for these individuals who are experiencing severe psychological distress. It also provides a replicable, evidence informed framework for any other NHS trusts seeking to implement parity of esteem between physical and mental health.

LC2558 Improving End-of-Life Care in Emergency Departments: A Quality Improvement Audit of Palliative Care Integration

Author(s):	Rebekah Lawrence Supervisors: Dr Vicky Price, Dr Steven Mason
Background:	Emergency Departments frequently serve as the first point of contact for patients with advanced life-limiting illnesses during their final months of life. While EDs are optimally designed for acute resuscitation and life-saving interventions, this paradigm often conflicts with palliative care principles focused on comfort, symptom control, and quality of life. Current evidence suggests that around 30% of palliative patients receive non-beneficial interventions in hospitals, potentially compromising patient dignity and increasing healthcare costs without improving outcomes.
Aim(s):	This retrospective clinical audit evaluates adherence to established palliative care standards in two emergency departments in the North-West of England. We examine whether treatment decisions for patients known to specialist palliative services align with documented care preferences and national guidelines (NICE NG31, RCEM 2023).
Methods:	Using a structured proforma, we will analyse 60 cases (from January-June 2025) assessing: 1) documentation of advance care plans, 2) clarity of care plans/ goals, 3) involvement of palliative teams, and 4) concordance between interventions and patient wishes. Secondary outcomes include inappropriate intervention rates.
Results:	Findings will be benchmarked against Royal College of Emergency Medicine quality indicators and the Ambitions for Palliative Care framework. *The audit employs a Plan-Do-Study-Act methodology to identify both systemic barriers and exemplary practices*. Results will inform targeted interventions including staff education programs, clinical decision support tools, and streamlined palliative referral pathways. Dissemination will occur through peer-reviewed publication, national conference presentations, and local policy briefings to drive measurable improvements in end-of-life care delivery
Conclusions:	Audit is ongoing but will be published at conference.

LC2559 Bringing Care Home: Is a ‘Hospice at Home Service’ Cost-Effective?

Author(s):	Mrs Lonan Challis, Prof John Ellershaw, Prof Dyfrig Hughes, Dr Stephen Mason
Background:	The increased intensity of care at the end of life leads to rising healthcare costs. Palliative care, which aims to improve quality of life (QoL) for those with life-limiting illnesses, is considered a cost-effective approach. However, studies investigating the cost-effectiveness of home-based palliative care are limited and rarely adopt a societal perspective, which includes the contributions of informal carers and third-sector organisations.
Aim(s):	To evaluate the cost-effectiveness of a hospice at home (HaH) service compared to the absence of this service for patients with end-stage chronic obstructive pulmonary disease (COPD) and their carers using a Markov model.
Methods:	A Markov model will simulate four care settings for 6,687 COPD patients in their final year: home, hospice, residential/nursing home, and hospital. Two scenarios will be compared: (1) usual care without Hospital at Home (HaH), and (2) usual care with HaH. The model will run over 365 cycles using data from clinical sources, literature, national statistics, and expert opinion. A societal perspective will be adopted. Cost-effectiveness metrics (ICERs, net benefit) and sensitivity analyses will be calculated.
Results:	A scoping review identified six themes of how carers are affected by home-based palliative care: sense of security, team involvement, normality, caregiving confidence, QoL, and satisfaction. These outcomes could be positive and negative and were influenced by the carer-healthcare professional relationship. These findings will inform the model's carer-related outcomes.
Conclusions:	The development of the Markov model is ongoing, with analysis to be presented at the Tenth Annual International Conference on Best Care for the Dying Person in November.

LC2560 Retrospective Analysis of Palliative Care educational achievements following Hospital merger

Author(s):	Kirsten Morris, Alison Hassall, Palliative Care Quality and Strategy Team, Dr S. Hanchanale & Dr K. Marley
Background:	The merger of three acute hospital Trusts occurred at the height of the COVID-19 pandemic, creating significant disruption to routine clinical practice and education. As the pandemic eased, clinical education across the newly unified Trust was re-established in accordance with national policy and professional guidelines. Strategy Implementation: From 2022 to 2025, the Trust implemented a comprehensive Palliative, End of Life Care and Bereavement Strategy, aiming to standardize and enhance care delivery across all sites. A key component of this strategy was the development of a Trust-wide workforce training and education program.
Aim(s):	This retrospective analysis evaluates the progress and achievements in workforce education related to palliative and end-of-life care following the Trust merger and during the post-pandemic recovery phase.
Methods:	Educational registers for each training programme were collected for the 2023–2024 and 2024–2025 financial years. Pre- and post-course feedback was obtained from delegates at every session, alongside facilitator feedback, which was also systematically gathered. Attendance

	figures and qualitative and quantitative feedback from both years were comprehensively reviewed to evaluate the reach, quality, and impact of all education programmes delivered.
Results:	From the results, we were able to identify key gaps in palliative and end of life care education across the workforce. In response, the team adapted existing content and developed several new training programmes to address identified needs. These included the 'Mayfly' programme, Intermediate Communication Skills training, and a One-Day Introduction to Palliative and End of Life Care, tailored separately for registered and non-registered staff. Additionally, a 'Palliative and End of Life Care Champions' programme was established to embed learning and support practice change at a local level.
Conclusions:	Education to date has proven successful, with measurable improvements in engagement and confidence across staff groups. Looking ahead, data from the 2025–2026 period will be critical in shaping the next phase of development and in identifying ongoing knowledge gaps in palliative and end of life care at all levels of the workforce. Strengthening in-depth understanding in this area will remain essential for all Trust staff committed to delivering the highest standards of compassionate, person-centred care to patients and their loved ones.

OUR SPONSOR

Ethypharm

Ethypharm is an independent pharmaceutical company with a global reach, specialising in pain and substance dependence therapies. Expanding its CNS product portfolio, Ethypharm aims to better serve patients and healthcare providers. Its wide range of injectable products addresses critical care needs in emergency and intensive care units. Additionally, Ethypharm develop complex generics that optimise healthcare costs.

For more information on Ethypharm contact us at 01277 266600 or email us at info@ethypharm..com