St Luke's
Hospice Plymouth

REFERRAL CRITERIA AND GUIDANCE FOR REFERRAL TO COMMUNITY SPECIALIST PALLIATIVE CARE SERVICES

Introduction

Specialist Palliative Care is the active, total care of patients with progressive, advanced disease that is no longer amenable to curative treatment. Management of pain and other symptoms and provision of psychological, social and spiritual support to patients and their families is paramount. The service is delivered by a specialist, multi disciplinary team for those patients who have unresolved problems that cannot be dealt with by other generalist services.

The St Luke's Community Team consists of specialist nurses, occupational therapists, occupational therapy support worker, social worker and social care support workers. We also have specialist palliative care doctors available.

Criteria for referral to the St Luke's Community Team -

- The patient has progressive disease i.e. cancer or other life threatening illness e.g. End stage heart failure/neurological condition.
- Lives within the area covered by the service and/or registered with a GP within the area covered by the service

AND

Has one or more of the following:-

- Pain related to progressive disease uncontrolled by simple analgesia &/or first line strong opioid &/or first line adjuvant.
- Other physical symptom(s) uncontrolled by first line drug treatment.
- Support required by other key healthcare professionals with decisions around whether treatments, e.g. including artificial nutrition and hydration should be withdrawn or withheld.
- Dying complicated by complex care needs, psychological, social or spiritual distress in patient or family for which specialist palliative care support or advice would be helpful.
- The patient's distress impacts severely on their ability to carry out usual daily routines and is not transitory and is not an acute reaction to bad news.
- Complex presentations relating to reduced function and independence.

Urgency of Referrals

The Specialist Palliative Care Team is not responsible for providing an emergency response (although within our working hours we may sometimes be able to respond rapidly). This is the responsibility of the primary or secondary healthcare teams involved.

Criteria for urgent referral (assessment by phone or visit within 2 working days (Mon-Fri)

Patient has a rapidly deteriorating/changing condition with complex symptom control/management problems that have not responded to current interventions.

ALL OTHER REFERRALS WILL BE CONTACTED WITHIN 7 WORKING DAYS

Outcome of Referrals

Intervention by the team will be at one of four levels:

Level 1 – Advice and Information is offered to professional colleagues directly by the team. The team will make no contact with patient.

Level 2 – The team will make an advisory visit. Such visits will be single, unless otherwise requested by the referrer, and further contact will be made by the professional referrer only. This may include sign posting to other services.

Level 3 – The team makes short-term interventions with the patient or family when specific problems need several visits. The intention is then to withdraw and make Open Access. Re-activation on to caseload may be made as necessary.

Level 4 – The team makes multiple interventions. There are ongoing problems requiring continuing, regular assessment.

Open Access

This means that a patient will not be routinely contacted by the Community Specialist Palliative Care Team. The patient, family or a healthcare professional, can re-activate the referral if the situation changes and the referral criteria, as above, are met.

The decision to make a patient open access will be discussed with the patient and GP and referrer (if different). A letter confirming the conversation and all contact information they require will be sent to the patient. This will be copied to the GP and referrer (if different).

Patients will become Open Access when intervention has been as listed in outcome of referral Level 1-3 or if Level 4 involvement and:

- There has been resolution of multiple, complex or refractory physical symptoms.
- There is no longer a need for Specialist Palliative Care follow up and /or the patients on-going needs are more appropriately met by other health and social care agencies.
- The patient's difficult social, psychological or spiritual issues have been addressed.
- The family and carer needs requiring Specialist Support have been addressed.
- The patient chooses not to accept Specialist Palliative Care input.

Who can refer?

New referrals are accepted from General Practitioners, Consultants, Clinical Nurse Specialists, Community Nurses and other clinical staff

New referrals are not routinely accepted from patients or families directly – they will be advised to contact their GP or other healthcare professional involved.

Referral process

The referrer to complete the St Luke's Specialist Palliative Care Community Service Referral Form. This is available on the hospice website or paper copies are available from the Community Team and can be faxed to the Community Team Administration office on 01752 788055.

Referrers can also contact the Community Administration Team on 01752 964200 Monday to Friday 9am to 5pm who will complete the form over the phone.

Weekends/bank holidays - New referrals can be taken but visits will not take place over a weekend/BH.

Patients should be informed and permission given for a referral to our services or if patient is not able to discuss then relevant carer aware of the referral. Referrals will not be accepted without this.

The team may come back to the referrer for more information or approach other HCP's involved if the information provided at referral does not clearly indicate reasons/need for Specialist Palliative Care involvement.

For patients who have a learning disability, (as well as a progressive disease), referrals earlier in the patient pathway will be accepted, in order for Specialist Palliative Care team members to participate in advance health care planning meetings, as appropriate.

Specialist Palliative Care is needed when there are problems requiring more intensive or more expert input. It is hard to define precise distinctions however between those who do and those who do not need Specialist Palliative Care. For this reason informal contact (by phone) for advice on appropriateness of a referral is encouraged.