Hosbis y Cymoedd HOSPICE OF THE VALLEYS

# Hospice of the Valleys

# Referral Criteria and Process

## 1. Introduction:

Hospice of the Valleys is a Community Specialist Palliative Care Service based in Blaenau Gwent providing support, advice, care and comfort to patients and carers who are experiencing a progressive, life-threatening illness, compromised quality of life, loss and grief.

### 1.1. Philosophy of Care

Hospice of the Valleys believes:

In the affirmation of life and that everyone is unique, with individual cultural, spiritual, social beliefs and economic backgrounds and values.

In the value of respect, choice, empowerment, holistic care and compassion, in the care for the whole person to meet all needs – physical, psychological, spiritual emotional and social.

In the freedom and profound dignity of every man and woman.

That our patients should preside over their own care, and that we must respect their own priorities and serve their needs, enabling people to manage their illness with dignity and independence.

In the relief of physical, mental social and spiritual suffering using all the skills, techniques, kindness and wisdom available to us."

### 1.2 Service Aims:

The overall aim of the service is to enable patients to be cared for in their own home if this is their choice and offer support to enable patients to die in their preferred place of care, by:

- providing a service that addresses individual patient need
- providing advice when required regarding pain control and symptom management
- providing physical, psychological, social and spiritual support
- being a resource for other health care professionals and generalist palliative care providers
- contributing to Palliative Care Education Programmes
- providing support for carers in bereavement; in general this would be on a short-term basis with appropriate sign-posting for those who need ongoing support

## 2. Policy Purpose:

The aim if this policy is to ensure:

i. a consistent approach of access to the service
ii. there is equity of access to the service
iii. to ensure that staff working at Hospice of the Valleys have the appropriate information to assist with the process involved in the admission of patients to the service

## 3. Responsibility

**Hospice of the Valleys Board of Trustees** holds ultimate accountability for ensuring appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent.

**The Chief Executive Officer** retains overall responsibility for appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent.

**The Clinical Services Director (CSD)** is jointly responsible with the Palliative Care Consultant for the development of evidence-based guidelines and policies to support appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent; in addition the CSD is responsible for ensuring that the referral policy is effectively implemented at an operational level and that all referrals are considered in accordance with the referral policy and guidelines.

**The Palliative Care Consultant** is jointly responsible with the Clinical Services Director for the development of evidence-based guidelines and policies to support appropriate and equitable access to the service for patients and their families/carers within Blaenau Gwent; in addition the Palliative Care Consultant is responsible for ensuring that the operational implementation of the referral policy and guidelines is supported by an appropriate clinical decision making process.

**The Clinical Team** is responsible for accepting/not accepting referrals in accordance with the referral policy and guidelines

**The Administrative Staff** are responsible for ensuring that referral information is collected in accordance with the referral policy and guidelines and that the required referral data is completed.

## 4. Related Policies:

- Access To Health Records
- Complaints
- Data Protection
- Disclosure Of Information
- Confidentiality
- Discharge
- Information Governance
- Lone Worker

## 5. Definitions

### 5.1 Supportive Care

The National Council for Hospice and Specialist Care Services (NCHSPCS) suggest the following as a working definition:

“helps the patient and their family cope with cancer and treatment of it – from diagnosis, through to cure, continuing illness or death into bereavement. It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease. It is given equal priority alongside diagnosis and treatment”

(NICE: Improving Supportive and Palliative Care for Adults with Cancer, 2004, p18)

### 5.2 Palliative Care

"the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments."

(NICE: Improving Supportive and Palliative Care for Adults with Cancer, 2004, p20)

### 5.3 Specialist Palliative Care:

Offers specialist expertise to support the active care of patients with progressive advanced disease of limited prognosis including interventions to:

- respond to unresolved symptoms and complex psychosocial issues
- respond to complex end-of-life issues
- respond to complex bereavement issues
- provide support and advice to their families, friends and carers
- provide support and advice to non-specialist health care staff

### 5.4 Urgent Referral:

Patients require specialist intervention within 24 – 48hours

### 5.5 Routine referral:

Patients require specialist intervention within 2 – 7 days

## 6. Eligibility Criteria

a) Referrals are accepted on the basis of need, not diagnosis or prognosis

b) The patient will be 18years or older

c) The patient will have a progressive, life-limiting illness requiring complex symptom management

d) Complex problems are defined as those which are severe and intractable and have persisted after competent palliative care by generalists – The Gold Standards Framework, Prognostic Indicator Guidance (2008) is attached at Appendix 1 for reference.

e) Complex problems can arise from multiple domains of need: physical symptoms, psychological symptoms or spiritual/emotional distress

f) Patients who have social needs or whose families show exceptional emotional distress may be referred provided that they also have complex problems in one of the above domains

g) Health Care Professionals caring for the patient/carer who require specialist advice and support

h) Prior to referral competent patients must consent. Referral must be judged to be in the best interests of patients who are not competent.

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i) The patient's General Practitioner must be informed of the referral; the Primary care Team remain as the core service provider for patient care.

### 6.1 When not to refer:

- when patients are not in agreement with the referral or have not been informed of the referral
- when symptoms are well controlled
- when physical, psychological and spiritual needs are being met by present services and support networks
- when a discharge is well supported by others and meets current needs
- when patient needs are mainly social or financial, without a specialist palliative care need and alternative care is the responsibility of the statutory services

## 7. Standards

### 7.1 Routine referrals

Providing all relevant clinical information and data has been provided or is accessible, routine referrals will be contacted within 2 days of receipt of referral and (with the patient's agreement) a home visit arranged within 7 days for initial assessment

### 7.2 Urgent referrals

Providing all relevant clinical information and data has been provided or is accessible urgent referrals will be contacted within 24 hours and seen within 48hours.

## 8. Referral Process

- Any Health or Social Care Professional (with the patients consent) can refer patients
- Patients may self-refer to the service but must be made aware that their General Practitioner will be informed of the referral
- Non-professionals may refer to the service providing the patient is aware of, and consents to, the referral; the patient's general practitioner will be informed of the referral
- Decisions about appropriate intervention are based on comprehensive and detailed information about the patient and this must be provided at the time of referral either:
    - By fax or in writing on the Hospice of the Valleys referral form – a copy of the referral form is attached at Appendix 2.
    - By telephone providing:

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- sufficient information is supplied to enable the person taking the call to fully complete the Hospice of the Valleys referral form
- a completed referral form is provided by the referring agent within 24 hours of the telephone call

- By Aneurin Bevin health Board Unified Assessment Documentation: Referral /Transfer Information for Complex Needs

- Known risks must be highlighted at referral and the service informed of risk mitigating strategies already in place

- Referrals will be triaged at the daily team meeting (Monday – Friday 9.10am) and once a patient has been accepted, a key worker will be assigned based on where the patient lives

- Following initial assessment all new patients will be discussed at the weekly multi-disciplinary team meeting held on Monday mornings and prioritisation of service provision will be made on the basis of clinical need using the RAG system – a copy of the "RAG" system is included at Appendix 3

## 9. Discharge Policy

The length of time a patient stays with the service will vary according to the patient and carer's needs. Patients may be discharged from the service if:

- Following initial assessment they do not meet the criteria
- The patient refuses the service at the initial assessment or any time thereafter
- the patients condition becomes stable, or patient issues are improved or resolved
- the needs of the patient are more appropriately met by other services

All patient discharges will be in accordance with the discharge policy and process