St Andrew’s Hospice

Adult Services Referral Criteria

The following is intended to provide guidance to health professionals to enable appropriate patient referral to St Andrew’s Hospice Adult Services. The criteria varies depending on which element of the service is required by the patient. It is, of course, not comprehensive, and the clinical team are happy to advise further in uncertain situations.

The services are available to people who have life limiting, malignant and/or non-malignant disease. Most patients will have advanced progressive disease and the focus of treatment will have changed from curative to palliative. Please refer to *Appendix 1 – Specific Disease Related Indicators (adapted from the GSF Prognostic Indicators 2008).* The exception to this is referral to the Wellbeing Service.

St Andrew’s Hospice provides interventions at different levels, according to the needs of the individual patient:

- Symptom Control of difficult to manage symptoms
- Psychological and/or Spiritual Support
- Palliative Rehabilitation
- Care of the Dying Patient
- Respite Care both - planned and emergency.

The hospice is unable to accept patients for indefinite care and this should be made clear to the patient and family when referral for admission is being discussed. Most patients will be admitted for a period of assessment; length of stay will be dependent on complexity of need and with the exception of patients who are admitted for end-of-life care, discharge planning commences on admission.

St Andrew’s Hospice acknowledges the importance of advance care planning, recognising that patient have preferences regarding their preferred place of care/death. We are required to prioritise access to all our services according to the complexity of need and therefore, unfortunately, we may not be able to fulfil all requests in as timely a manner as requested.

How to Refer for Inpatient Care

The Referral Indicator Tool (Appendix 2) will assist in establishing the level of need the patient has for admission and can be used to identify a timescale enabling the health professional making the referral to have a target date.

Referrals can be made either by contacting the hospice directly on 01472 571245/571282 or completing the referral form which can be found on our website at http://www.standrewshospice.com

The use of the referral form is to ensure that St Andrew’s staff have the relevant information upon which to base assessment of a patient’s need for Specialist Palliative

Care, and to prioritise accordingly. It is important that as much information is given as possible, as incomplete forms may result in a delay to the referral being processed.

Referrals can be made at any time and will be accepted from all health professionals, patient, relatives and carers with the patient's knowledge and consent.

Referrals for admission are reviewed daily. It may be decided that a face-to-face assessment might be appropriate prior to admission and a member of the Clinical Team will contact the patient directly with the exception of direct GP, Macmillan or Haven team referrals.

Acceptance for admission is dependent on priority and bed availability. This will be communicated directly to the referrer who will be asked to arrange transfer to the hospice. The patients will be admitted under the care of the hospice medical team unless the patients GP wishes to retain the care.

An agreed plan of care will be made in consultation with the patient and their carers/ family. The outcome of the assessment, the plan of care and the review process will be discussed with the referrer and other professionals involved.

Where patients are placed on a waiting list for admission, and urgent care/support is required from the Hospice, for example symptom management advice or psychological support, a discussion will be held with the referrer to assess the level of need and to agree the interventions. There will be regular contact with the referrer and liaison with the partnership team, during this period patients remain on the waiting list, to provide support.

To ensure the patient receives seamless care, where conversations have taken place between the patient and health care professionals regarding resuscitation, preferred priorities of care, preferred place of death and My Future Care Plan. This information and relevant documentation should be available to the hospice team and wider partnership

Currently the ability to admit patients out of hours (4pm – 8am) is limited. To request an admission out of hours the referrer must contact the nurse in charge who will liaise with the on-call doctor.

The hospice will endeavour to signpost the referrer to other services in the community able to support the patient, or if appropriate refer to other services until admission can be arranged e.g. Macmillan Specialist Palliative Care Team, District Nurses and the Haven Team.

Exemptions to this include:

- Competent patients who decline referral
- Patients with diagnosed primary Lymphoedema
- Patients wanting respite following surgery
- Conditions are stable and their needs are mainly social in nature
- Current clinical problems are not related to their life-limiting illness
- Immediate care needs would be best met in the acute setting – e.g. neutropenic sepsis.

Patients who lack capacity

If a patient lacks the capacity to make a decision about admission to the Hospice and there is no relevant Lasting Power of Attorney or Court Appointed Deputy, the decision to admit must be made in their best interests in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice. This may necessitate a Best Interests meeting and may require the involvement of an Independent Mental Capacity Advocate (IMCA). Please attach copies of your assessment of capacity and best interests' documentation including any IMCA report to the referral for admission.

Appendix 1 – Specific Disease Related Indicators

More details of Indicators – the intuitive surprise question , general and specific clinical

Step 1 The Surprise Question

For patients with advanced disease of progressive life limiting conditions - Would you be surprised if the patient were to die in the next few months, weeks, days?

- The answer to this question should be an intuitive one, pulling together a range of clinical, co-morbidity, social and other factors that give a whole picture of deterioration. If you would not be surprised, then what measures might be taken to improve the patient's quality of life now and in preparation for possible further decline?

Step 2 General Indicators

Are there general indicators of decline and increasing needs?

- Decreasing activity – functional performance status declining (e.g. Barthel score) limited self-care, in bed or chair 50% of day) and increasing dependence in most activities of daily living
- Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
- General physical decline and increasing need for support
- Advanced disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Choice of no further active treatment
- Progressive weight loss (>10%) in past six months
- Repeated unplanned/crisis admissions
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumen <25g/l
- Considered eligible for DS1500 payment

Functional Assessments

Barthel Index describes basic Activities of Daily Living (ADL) as 'core' to the functional assessment. E.g. feeding, bathing, grooming, dressing, continence, toileting, transfers, mobility, coping with stairs etc .

PULSE 'screening' assessment - P (physical condition); U (upper limb function);
L (lower limb function); S (sensory);
E (environment).

Karnofksy Performance Status Score
0-100 ADL scale .

WHO/ECOG Performance Status
0-5 scale of activity.

Step 3 Specific Clinical Indicators - flexible criteria with some overlaps, especially with Those with frailty and other co-morbidities.

a) Cancer – rapid or predictable decline

Cancer

- Metastatic cancer
- More exact predictors for cancer patients are available e.g. PiPS (UK validated Prognosis in Palliative care Study). PPI, PPS etc. 'Prognosis tools can help but should not be applied blindly'
- 'The single most important predictive factor in cancer is performance status and functional ability' - if patients are spending more than 50% of their time in bed/lying down, prognosis is estimated to be about 3 months or less.

b) Organ Failure – erratic decline

Chronic Obstructive Pulmonary Disease (COPD)

At least two of the indicators below:

- Disease assessed to be severe (e.g. FEV1 <30% predicted)
- Recurrent hospital admissions (at least 3 in last 12 months due to COPD)
- Fulfils long term oxygen therapy criteria
- MRC grade 4/5 – shortness of breath after 100 metres on the level o confined to house
- Signs and symptoms of right heart failure
- Combination of other factors – i.e. anorexia, previous ITU/NIV resistan organisms
- More than 6 weeks of systemic steroids for COPD in preceding 6 months.

Heart Disease

At least two of the indicators below:

- CHF NYHA Stage 3 or 4 - shortness o breath at rest on minimal exertion
- Patient thought to be in the last year o life by the care team - The 'surprise question'
- Repeated hospital admissions with heart failure symptoms
- Difficult physical or psychologica symptoms despite optimal tolerated therapy.

Renal Disease

Stage 4 or 5 Chronic Kidney Disease (CKD) whose condition is deteriorating with at least 2 of the indicators below:

- Patient for whom the surprise question is applicable
- Patients choosing the 'no dialysis' option, discontinuing dialysis or not opting for dialysis if their transplant has failed
- Patients with difficult physical symptoms or psychological symptoms despite optimal tolerated renal replacement therapy
- Symptomatic Renal Failure – nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload.

General Neurological Diseases

- Progressive deterioration in physical and/ or cognitive function despite optimal therapy
- Symptoms which are complex and too difficult to control
- Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure
- Speech problems: increasing difficulty in communications and progressive dysphasia. Plus the following:

Motor Neurone Disease

- Marked rapid decline in physical status
- First episode of aspirational pneumonia
- Increased cognitive difficulties
- Weight Loss
- Significant complex symptoms and medical complications
- Low vital capacity (below 70% of predicted using standard spirometry)
- Dyskinesia, mobility problems and falls
- Communication difficulties.

Parkinson's Disease

- Drug treatment less effective or increasingly complex regime of drug treatments
- Reduced independence, needs ADL help
- The condition is less well controlled with increasing "off" periods
- Dyskinesias, mobility problems and falls
- Psychiatric signs (depression, anxiety, hallucinations, psychosis)
- Similar pattern to frailty- see below.

Multiple Sclerosis

- Significant complex symptoms and medical complications
- Dysphagia + poor nutritional status
- Communication difficulties e.g. Dysarthria + fatigue
- Cognitive impairment notably the onset of dementia.

c) Frailty / Dementia – gradual decline

Frailty

Individuals who present with Multiple co morbidities with significant impairment in day to day living and:

- Deteriorating functional score e.g. performance status – Barthel/ECOG/Karnofksy
- Combination of at least three of the following symptoms:
  - weakness
  - slow walking speed
  - significant weight loss
  - exhaustion
  - low physical activity
  - depression.

Stroke

- Persistent vegetative or minimal conscious state or dense paralysis
- Medical complications
- Lack of improvement within 3 months of onset
- Cognitive impairment / Post-stroke dementia.

Dementia

There are many underlying conditions which may lead to degrees of dementia and these should be taken into account. Triggers to consider that indicate that someone is entering a later stage are:

- Unable to walk without assistance and
- Urinary and faecal incontinence, and
- No consistently meaningful conversation and
- Unable to do Activities of Daily Living (ADL)
- Barthel score <3.

Plus any of the following:

- Weight loss
- Urinary tract Infection
- Severe pressures sores – stage three or four
- Recurrent fever
- Reduced oral intake
- Aspiration pneumonia.

It is vital that discussions with individuals living with dementia are started at an early to ensure that whilst they have mental capacity they can discuss how they would like the later stages managed.

Appendix 2	St Andrew's Hospice Adult Services In-Patient Unit Referral Indicator Tool		
Reason for Referral	**Indicators**	**Prompt**	**Response Time**
Pain & Symptom Management	• Unresolved, unpredictable and rapidly changing pain and symptoms that cannot be managed in the community or hospital environment by the Primary Health Care Team or community Macmillan team • Unstable condition with sudden exacerbation/ deterioration that requires 24/7 specialist assessment	Physical symptoms such as intractable vomiting, nausea, breathlessness, agitation or untreatable obstruction Spiritual distress and/or psychological disturbances, severe anxiety or depression Uncontrolled pain Complex medication review and monitoring	**Urgent:** Whenever possible, admission to happen within 24 hours by 4pm on weekdays and in consultation with doctor at weekends Prioritised by need and subject to bed availability
Care in Dying	• Dying patient with palliative care needs • Any patient who has indicated preferred place of care/ death to be the Hospice	Deterioration in condition on a daily basis When it is clear the patient is dying and thought to be within the last few days of life Patient may be on the End-of-Life Care Pathway/ Respect Document	**Urgent:** Whenever possible, admission to happen within 24 hours by 4pm on weekdays and in consultation with doctor at weekends

			Prioritised by need and subject to bed availability
Respite	• Temporary physical, emotional or social care of a person in order to provide relief from caring to the primary care provider or to support palliative rehabilitation	Patients requiring palliative care respite Pre-planned goals to be agreed with the patient and/ or family	**Routine:** Pre booked dates by arrangement with patient, family/carer
Emergency Respite	• Respite as above, where there are critical circumstances to respond immediately where other social care provision is unable to support the patient in their current environment and transfer to residential or nursing home care is deemed inappropriate to meet needs		**Urgent:** Whenever possible, admission to happen within 24 hours by 4pm on weekdays and in consultation with doctor at weekends Prioritised by need and subject to bed availability