Referral guide and criteria for East Cheshire Hospice

Updated April 2021

Introduction

Palliative Care is the active total care of patients and their families who have progressive, life limiting and incurable disease, such as metastatic cancer, organ failure (end stage cardiac, renal, respiratory, liver disease) or progressive neurological conditions. It may be part of the overall approach to care, working alongside other specialist services, or it may be the primary approach to care in the later stages of the disease.

The aim of palliative care is to maintain and improve quality of life for patients and their families where possible. This includes providing relief from pain and other distressing symptoms, providing support to help people live as actively as possible until death and to help families cope during a patient's illness and in their own bereavement.

The palliative care needs of many patients can be met by primary care and/or hospital services. Specialist palliative and hospice care is appropriate for patients and carers with more complex needs encompassing physical, psychological, spiritual and social needs, who require additional support.

East Cheshire Hospice services are delivered by a specialist multi-disciplinary team, including nurses, doctors, physiotherapists, occupational therapists, lymphoedema specialist nurse, pharmacists, social care assessor, chaplain, dementia specialist nurse, complementary therapists and psychological support staff.

Capacity & consent

Referral to East Cheshire Hospice should be with the patient's informed consent. If there is a reason to doubt the individual's capacity to consent to

referral and admission, the referrer should complete a Mental Capacity assessment and make a "best interests" decision (Mental Capacity Act 2005) if appropriate. This should be discussed with the patient's legally appointed representative, if appointed, and/or the patient's family/carers.

Population covered

- Patients registered with GPs in Eastern Cheshire (all services)
- Patients registered with GPs in the High Peak area (inpatient unit)
- Requests for Patients from outside of these areas will be considered on an *individual* basis

Timing of referral

A referral may be appropriately made at any point in the patient pathway if the patient has palliative care needs that cannot be met by other generalist services.

Key triggers to a referral include:

- The time of diagnosis
- During or on completion of cancer or other disease specific treatments
- Disease progression
- Disease recurrence or relapse
- Recognition of the last 12 months of life
- Recognition of the last days/weeks of life

General referral criteria

East Cheshire Hospice provides Specialist Palliative care for adults aged 18 and over who have a progressive life limiting illness and complex needs who require assessment and management by the multi-professional team. The hospice also

provides support for their families and carers.

Referrals should be based on the individual's needs rather than diagnosis – the hospice provides care for patients with malignant and non-malignant disease.

East Cheshire Hospice Inpatient Care

Referrals are accepted for patients who have an advanced, progressive, life-limiting illness with palliative care needs who may benefit from the support of the multi-disciplinary hospice team, because management is proving difficult in other settings.

The patient:

- Requires specialist assessment due to complex medical or nursing needs, specifically symptom management
- Requires a period of optimisation following an acute illness/episode or following palliative interventions e.g. radiotherapy
- Requires complex psychological and/or spiritual support
- Has complex needs in last days of life
- Has expressed their preferred place of death as East Cheshire Hospice, without complex needs**
- Has complex social care needs and is requiring crisis intervention

***the Hospice prioritises requests for admission according to the complexity of need and may therefore not be able to admit all requests for end of life care if complexity is low.*

It is recognised that some individuals may not fit the criteria above – these patients may be referred but should be discussed directly with the inpatient team as to the appropriateness of the referral.

The inpatient unit is **unable** to provide care for patients where:

- they are acutely unwell and their care needs would be best met in the acute hospital e.g. neutropenic sepsis
- their condition is stable with mainly social care needs
- their current clinical symptoms/problems are unrelated to their life-limiting illness

Please note: East Cheshire Hospice <u>does not provide long term care</u>. Please make sure that during the referral process the patient is made aware of this prior to admission. Most patients will be admitted for a period of assessment. Length of stay will depend on the clinical needs of the individual patient.

Referral to the Hospice does not preclude involvement of specialist healthcare teams – continued participation and collaborative care is welcomed, particularly in complex conditions. It is recognised that certain interventional treatments cannot be given on site, and transfer to the hospital may be necessary if such treatments are needed.

Referral procedure to the Inpatient Unit

Referrals are accepted from GP's, Hospital teams, District nurses and the Specialist Palliative Care (SPC) Team. If the clinical situation is not clear, the hospice may request an assessment by either a medical practitioner or the SPC team.

Most admissions can be planned in advance. Planned admissions occur within normal working hours, Monday to Friday. The acceptance of admission will depend on clinical need, bed availability, medical and nursing cover.

How to refer

Referral forms can be found on EMIS (Add document letter 'East Cheshire Specialist Palliative Care Referral form' and tick relevant service) OR via East Cheshire Hospice website (www.eastcheshirehospice.org.uk/professionals/how-to-refer/). The purpose of the referral form is to ensure we have the relevant demographic details to gain access to the patient's EMIS medical records and clinical information to facilitate triage and to prioritise admissions.

Up to date information regarding the patient's clinical condition must be documented on EMIS (or accompany the patient if not using EMIS records and/or no shared care agreement in place or the patient does not consent to sharing their clinical records).

There should be direct contact with the hospice clinical team if any of the following apply:

- Oxygen requirements above 35%
- Total Parenteral Nutrition or PEG/RIG feeds
- Healthcare acquired infection
- Spinal line e.g. epidural, intrathecal
- Tracheostomy and/or assisted ventilation
- Chest drain
- Complex mental health history
- Confusion and is ambulant

Monday to Friday:

- Referrals are reviewed by the senior clinical team daily, Monday to Friday.
- Routine referrals received out of hours (evening, weekend & bank holidays) are reviewed the next working day

- Routine requests for admissions will be prioritised by need and a bed offered within 1-3 working days if possible, subject to bed availability and staffing.
- Urgent referral requests received during the day will be discussed by the clinical team on duty who will advise of the earliest opportunity to admit. This is to enable the referrer to make other arrangements if the admission cannot be facilitated immediately. We aim to admit urgent referrals within 24 hours where possible.
- ‘On hold’ referrals can be made for end of life care. Should the referral be activated, additional information may be required. Please note that these are reviewed on a regular basis and removed from the waiting list after 12 weeks if the referral has not been activated.

Out of hours:

- The ability to admit patients outside of normal working hours is limited but out of hours admissions will be considered in urgent cases
- To request an admission out of hours the referrer must contact the nurse in charge who will liaise with the on-call doctor to determine the appropriateness of the request. The acceptance of admission will depend on clinical need, bed availability, medical and nursing cover.
- If accepted for out of hours admission, a bed will be offered within 24 hours

The hospice will signpost the referrer to other services available e.g. Hospice @Home, to support the patient until admission, should this be required. Advice on further management whilst awaiting admission may be sought from the Specialist Palliative Care Team and/or East Cheshire Hospice 24/7 Advice Line.

Transfer of patients to the Hospice Inpatient Unit

Planned admissions will normally occur between 9am-3pm, Monday to Friday, excluding bank holidays. Wherever possible, the hospice will endeavour to give 24 hours notice of bed availability.

- The referring health care team is responsible for ensuring that the patient is fit for transfer to the Hospice
- The referring team are responsible for arranging suitable transport
- The referring team must also inform the patient and carers of the admission arrangements
- If a decision that resuscitation should not be attempted in the case of cardio- respiratory arrest (uDNACPR) has been made, the ambulance team must be informed and the uDNACPR document ('lilac form') sent with the patient
- Patients transferred from Macclesfield District General Hospital should be accompanied by the hospital case notes including the current medication chart; or from other units with legible photocopied notes and transfer documentation.
- Patients admitted from the community should be accompanied by relevant copies of community, medical and/or nursing documentation unless this information is accessible on EMIS.
- All current medication must be brought in with the patient, unless instructed otherwise by the hospice clinical team.

Discharge from the inpatient unit

Discharge planning is conducted in collaboration with relevant professionals, the patients and carers. It will commence shortly after admission, with the exception of those admitted for end of life care, and will be arranged when:

- The patient no longer requires hospice inpatient care as their needs can be met

by other hospice services or by their healthcare teams in the community and/or care home.

- The patient's preference is to be cared for at home, even if their specialist palliative care needs have not been met. Every effort will be made to facilitate a supported and timely discharge in accordance with the patient's wishes.

Should the patient no longer need hospice inpatient palliative care, they may be discharged to the ongoing care of community or hospital services, regardless of the stage of their disease.

Planned Respite

We are able to offer a planned short-term, temporary care to people with progressive, life-limiting illnesses who wish to give their unpaid carers or families a rest from caring. We can provide an opportunity for a planned respite stay of 1 week, with a maximum of 2 weeks respite per year.

Respite criteria:

The following conditions should apply to fulfil the respite criteria:

- The person must have a diagnosis of a progressive life-limiting illness, aged 18 or over, with palliative care needs
- They must be registered with a GP in Eastern Cheshire
- They must be being cared for by family or friends at home (this can be in addition to a funded care package)
- Those living alone may be considered, depending on their situation
- The person referred must be in a stable condition prior to admission so that their planned discharge date is upheld (N.B. If

the person's condition is unstable, requiring an in-patient stay for symptom control or end of life care, the person must be referred to the IPU via a healthcare professional)

- The person must be able to make own travel arrangements to and from the hospice, either through their GP, specialist nurse, district nurse or arrangements made themselves
- Both the person and the carer must agree the need for respite
- The patient must be willing to undertake a Covid-19 test prior to (or in some limited circumstances on arrival at) East Cheshire Hospice.

Referrals can be made by the person requiring respite, carers or healthcare professionals. Respite stays are booked through the hospice Advanced Nurse Practitioners.

Patients not usually eligible for respite care at the hospice:

- Patients who already have a placement in long term care, or who are awaiting a long-term placement.
- Those requiring specialist dementia care.
- Patients requiring 1 to 1 care at all times.
- Patients who have had a positive Covid-19 swab or new onset symptoms following a positive test, in the fourteen days prior to their respite admission. (Cases will be assessed individually as symptoms may be present for longer than the recommended isolation period.)
- Patients that are medically unstable.

Referral procedure:

- Referrals may be made by GP's, specialist nurses, district nurses or initiated by the person requiring respite and family members. The person's GP will always be informed that the patient has been referred for a respite stay.

- If there is any doubt as to the suitability for planned hospice respite, the person's specialist nurse (or other appropriate healthcare professional) will be asked to review the person before the referral is accepted.
- Referral is by completion of an East Cheshire Hospice referral form – the referral information and the person's EMIS medical records will be reviewed by the hospice clinical team prior to a respite stay being offered. If the person's GP does not use EMIS then additional up to date written information on the person's medical condition may be requested.
- The hospice Advanced Nurse Practitioner will liaise with the referrer and book the respite week up to 3 months in advance of the admission date.
- The person will receive confirmation of their admission and discharge dates following acceptance of referral and will be contacted again via telephone approximately 1 week prior to admission date to check that their circumstances have not changed. If there is any change in circumstance that might affect the respite dates, this should be discussed with the hospice clinical team prior to admission.
- A person can receive up to 2 booked respite weeks in any one year, but each respite stay will require a new referral form with up to date information – East Cheshire Hospice does not offer 'rolling respite' admissions.
- If a respite week is cancelled/unfilled, a respite stay may be offered to the next person on the waiting list.
- Referrals must be made via the NHS email account eccg.echospicerespite@nhs.net

Admission process:

- Respite admissions will take place Thursday to Thursday.
- Admission take place between 1-3pm. Discharge will be planned for 11am on the pre-arranged discharge date.
- The person should be accompanied by relevant copies of community, medical and/or nursing documentation unless this information is accessible on EMIS.
- All current medication & wound dressings, if required, must be brought in with the person, unless instructed otherwise by the hospice clinical team. A hospice prescription chart will be completed on admission.
- The person will be issued with an identification wristband.
- A bed will be allocated depending on bed availability and clinical need – a side room cannot be guaranteed.
- Respite admissions are nurse-led - the hospice Advanced Nurse Practitioner will undertake an assessment of the person on the day of admission and will review the person periodically during their respite stay as and when required
- If the person becomes medically unstable during their respite stay a discussion will occur between them and the hospice medical team to determine the best course of action – that may be to transfer to one of the hospice's in-patient beds (depending on availability) or to transfer to acute hospital, whichever is more appropriate.

During the respite stay:

On admission, each person, where appropriate, will have a comprehensive assessment to establish their goals and priorities and to create a personalised programme of support to reflect these. This may include:

- Working with the physiotherapist to maximise function & adopt self-management techniques
- Promoting and maintaining independence, enabling/supporting the person where possible, to maintain their normal routines
- Advance care planning
- Review of medical, nursing and medication needs
- Review of practical needs to make sure all relevant benefits, care and assistance are being accessed at home
- The aim is to empower the person through setting and achieving their own goals – preparing them to proactively manage their health on returning home
- For other people who are less independent, a respite stay will give them the opportunity to have a break from the routine at home and allow their carer some time out to maintain their own health and continue in their caring role once the respite stay is finished

Discharge process:

- Discharge will take place by 11am on the planned discharge date
- If there are no changes to the medication during admission, the person should have enough supply of their usual medication to be able to continue this on discharge. The hospice will not routinely order medications to take home.
- If the person being admitted for respite is known to be requiring additional care, or an alternative place of care on discharge, this must be arranged by the person's community team in advance of respite admission to the hospice so that discharge can take place as planned.
- On discharge a letter will be sent to the person's GP to inform them of their respite stay and to update them of any changes during admission.

Referral procedure to the Sunflower Wellbeing Centre & Outpatient Services

Day therapy provides an opportunity for specialist palliative care assessment and review of patients' needs. This enables the provision of physical, psychological, social and spiritual interventions within the context of a supportive day care or outpatient setting.

Referral Criteria

- Has a diagnosis of progressive life-limiting illness or is a carer for a person with life-limiting illness
- Complex palliative care needs that cannot be met by current health/social care professionals
- Well enough to attend the Sunflower Centre
- Can be transported to the Day Hospice safely via family & friends, specialist taxi/ well enough to get into a car unaided when supported by volunteer drivers/ ambulance transport if accepted by ambulance service
- The patient wishes to attend

Referrals are accepted for:

- General Wellbeing programme
- Fatigue, Anxiety & Breathlessness (FAB) programme
- Living Well
- Motor Neurone Disease Support programme
- Dementia Carers Wellbeing programme
- Dementia Community Companions

To assist with:

- Symptom control

- Complex psychological and/or social needs
- Optimisation following palliative interventions or acute episode following disease progression
- Difficulty coping with a potentially life limiting illness

Referrals may also be made for outpatient appointments for the following:

- Lymphoedema Nurse
- Physiotherapy
- Art Therapy – Psychotherapeutic
- Complementary Therapies
- Blood transfusion
- Admiral Nurse

Day Services

- The patient and their carer will be invited to attend for an initial assessment, at the Sunflower Centre, whereby they will have the opportunity to discuss their concerns and have their needs identified.
- Following on from this assessment we will work with the patient to develop a personal care plan, referring on to appropriate services within the hospice. This will be subject to ongoing review by appropriate members of the team.
- Placements are offered for up to 12 weeks, if the referral is for general wellbeing/optimisation and each person is reviewed during this period. If the person's condition is stable, we will then plan for discharge.
- FAB and Dementia Carers programmes are for a fixed 8 week session
- Living Well sessions are for a 15 week attendance
- There are a wide range of services available within the Sunflower Centre. People may be referred in for a variety of half day or full day programmes.
- The team will liaise with other health and social care professionals as appropriate in the hospice, community or hospital.

Referral Procedure

- Referrals may be made by General Practitioners or Specialist Nurses. They may also be initiated by the patient, family members or other professionals, (e.g. District Nurses, Hospital Medical teams, Social Care teams). Living Well sessions and Dementia services are self-referable. However, the General Practitioner will always be informed that the patient has been referred and is accessing our day hospice services, with the exception of Dementia programme referrals.
- Referral is by completion of an appropriate East Cheshire Hospice referral form. These can be found on the East Cheshire Hospice website.

Discharge will be arranged when:

- The specialist palliative care needs of the patient have been met
- A structured programme has been completed over a set number of weeks
- The patient's needs may be met by their primary or social care professionals, or both
- Outstanding needs do not fall within the Day Hospice criteria
- The patient is not well enough to attend
- The patient no longer wishes to attend

Lymphoedema Clinic

Aim of treatment

- To reduce and/or manage the patient's lymphoedema by providing high quality clinical care, following national guidelines
- To educate and support patients and/or carers to enable them to manage the condition themselves
- To manage associated symptoms of lymphoedema, such as discomfort, cellulitis, or reduced limb function

- To liaise with appropriate health care professionals and other agencies to facilitate on-going support for patients

Referral Criteria

- Lymphoedema secondary to cancer or its treatment
- Lymphoedema secondary to other progressive life limiting illness that fulfils criteria for referral to the Sunflower Centre or Inpatient Unit

Referral Procedure

- Referrals may be made by health care professionals involved with the patient's care, with the agreement of the patient and General Practitioner or Hospital Consultant
- Referral is by completion of a Hospice referral form, which should be signed by a doctor

Note: if the patient has active disease, we may require further information from the patient's doctors, to eliminate contra-indications to treatment

Discharge will be arranged:

- If there is no possibility of making an impact on the patient's needs
- If the patient declines further treatment or repeatedly misses appointments
- If the lymphoedema resolves spontaneously (rare)

Physiotherapy

Referral Criteria

Diagnosis of progressive life-limiting disease with symptoms or issues requiring assessment and/or treatment by a specialist physiotherapist.

For example:

- Weakness, fatigue
- Neurological deficit
- Difficulty with the activities of general living, mobility, moving and handling issues.
- Access issues at home (via referral to community colleagues)
- Breathlessness management
- Pain
- Restrictive scar tissue following surgery
- Symptoms that may be treated by acupuncture, such as pain, hot flushes

Referral procedure

- Referrals may be made by Health Care Professional involved with the patient's care, with the consent of the patient and the General Practitioner or Hospital Consultant
- Referral is by completion of an East Cheshire Hospice referral form

Discharge

- When no further intervention is required the patient will be discharged into the care of community services regardless of the stage of disease.
- Patients may be re-referred following discharge should the service be required
- If the patient declines further treatment

Art Psychotherapy

Referral criteria

Diagnosis of life limiting illness, or carer of someone with a life limiting illness, and have difficulty addressing issues relating to this.

Referral procedure

Referrals may be made by Health Care Professional involved with the patient's care, with the consent of the patient and the General Practitioner or Hospital Consultant

Referral is by completion of an East Cheshire Hospice referral form

Discharge

Discharge is agreed between the therapist and the patient/carer when:

- They are assessed as to being/feeling psychologically stable
- They are planning to access other psychological therapies
- The referral is to offer support for a specified difficulty and that difficulty is either resolved or has become more manageable for the patient
- The patient declines further therapy

Patients may be re-referred following discharge should the service be required

Complementary Therapies

Referral criteria

Diagnosis of life limiting illness, or carer of someone with a life limiting illness, who wish to reduce the symptoms of illness and medical interventions, or assist in maintaining their psychological well being

Referral procedure

Referrals may be made by Health Care Professional involved with the patient's care, with the consent of the patient and the General Practitioner or Hospital Consultant

Referral is by completion of an East Cheshire Hospice referral form

Discharge

Following either a one-off session, or series of four sessions, an assessment / review will be completed.

Blood transfusion

Referral Criteria

Diagnosis of a life-limiting illness with symptomatic anaemia (working guidance of Hb 80g/l).

For transfusion as a day case

The patient is able to:

- Walk and be able to attend to own hygiene needs, with at least minimal assistance
- Able to sit in a chair for the day – attending for the blood transfusion as a day case may take up to 9 hours, and we do not always have a bed available
- Able to attend the Hospice on two separate occasions – for blood sampling and then for transfusion.
- Able to arrange your own transport to and from the Hospice (note transport arranged by GP would not be suitable due to time constraints).
- Supervised for 24 hours following the transfusion in case of illness. If lives alone, would need to organise someone to stay on return home.

The patient has:

- No history of a blood transfusion reaction if has had transfusion in the past.
- Had recent blood tests – though these may need repeating during the visit for blood sample to ensure we have accurate and up to date information about overall condition

Medical history, social and transport circumstances will be considered when deciding if suitable for transfusion at the Hospice, and whether it can be carried out on a Day Case basis. It may be necessary to consider admission to the in-patient unit for an overnight stay.

Discharge

The patient will be discharged back to community professionals on completion of treatment.

Admiral Nurse Outpatient Clinic

Referral criteria

- Person is an active carer for a person living with dementia at home
- Person is currently open to East Cheshire Hospice or previously known to us
- Person is experiencing complex needs relating to their caring role of the person living with dementia that cannot be met by existing services
- Person is able to get themselves to the outpatient's clinic

Referral procedure

- Carer can self-refer or a professional can refer on their behalf with consent
- Referrals can be made by phone to the Admiral Nurse as the person will already be known to us.

Discharge

- The carer is discharged when the current complexity has been resolved as much as is possible
- If the carer declines further input

- The carer can self-refer back at any time if they still meet the criteria

Dementia Carer Wellbeing

This programme is designed to support people who are caring for a person with dementia in their own home.

Referral criteria

To access the service, the individual must be:

- Caring for a person with dementia who lives at home
- Registered with an East Cheshire GP
- If the person living with dementia is attending, with the carer, they must be fully independent
- Able to get themselves to East Cheshire Hospice

Referral procedure

Referrals may be made by Health Care Professional involved with the patient's care, with the consent of the patient, or the carer can self-refer.
Referral is by completion of the dementia referral form available on our website

Referral remit

The programme is an 8 week structured course offered to the carer, where they learn a new topic each week. The person living with dementia can attend our day care unit, if appropriate, so the carer can attend the education element. They will be cared for by an allocated 'Dementia Buddy' during their attendance. This will allow the carer to make full use of support offered, which includes group sessions for information, advice, guidance and peer support. The aim is to provide a safe and relaxed environment in which to share problems or experiences with others in similar situations and enable the development of coping strategies.

The group sessions are facilitated by our Admiral Nurse with different guest professional speakers' across various weeks. Carers are also offered the opportunity to see the Admiral Nurse 1:1 during the course.

Discharge

On completion of the 8 week programme