CA1 Admission Policy

1. Introduction

Saint Michael's seeks to provide high quality support to patients in all of its services, but in doing so must ensure that its resources are used appropriately. To try to achieve this each of the admitting services has procedures and criteria which will be applied to all patients referred to the Hospice.

2. In Patient Unit

2.1Criteria for referrals

Patients are admitted to Saint Michael's Hospice for terminal care, symptom control, assessment and respite care.

All admissions to Saint Michael's Inpatient Unit will be agreed by the Doctor in Charge of admissions and Nurse in Charge of Inpatient Unit. If required, advice should be sought from the Medical Director and Director of Clinical Services or in their absence Head of Outpatient Unit or Head of Inpatient Unit.

2.2 Referral process

All patients must be referred for admission by their consultant or GP or a member of their treating team, with negotiation by all parties. Referrals can be made on the designated form, by letter or by telephone are always followed up with a written referral. All patients must be referred for admission with the agreement of their GP or Consultant. The timing of the admission should be made with the agreement of the hospice staff together with the referrer.

Patients referred from Harrogate and District Foundation Trust are assessed by a member of the hospital and specialist palliative care team if available and transferred to Saint Michael's Hospice as appropriate. The hospital notes should accompany the patient together with relevant nursing and medical documentation.

If clarification of patient need or suitability for hospice care is required, then an assessment visit may be made by a member of the multi-disciplinary team or Macmillan Team and then discussed with staff members in charge.

2.3 Out of hours referrals and admissions

Admission requests will be made by the patient's GP or designated out of hours doctor.

The senior nurse on duty receiving the referral will establish if the admission is appropriate, e.g. that the need is not for acute hospital admission and intervention. If it is clear that the admission is not appropriate the senior nurse may advise the referrer without discussing it with the on call doctor. However if in any doubt the on-call doctor should be contacted to discuss the referral.

The senior nurse should discuss with the on call doctor all other referral requests received out of hours. Where the transfer is requested by a Hospital this will not usually be accepted out hours since the patient is already in a safe, caring environment. If the referral is accepted the GP or doctor making the referral will then contact the patient and arrange any necessary transport.

2.4 Waiting List Guidelines

As In-Patient Unit occupancy rises it is likely that there will be periods of time when there is a waiting list for in-patient admissions. It should be noted that as much information needs to be obtained as possible from the referring source and it may be necessary to supplement this with a Hospice domiciliary assessment in unusual cases.

MDT Meeting - Monday Mornings

Non-urgent referrals or referrals which have been deferred from the weekend may be discussed at the Monday MDT meeting. Appropriate information will be obtained and an admission decision will be made. During the rest of the week non-urgent referrals may be discussed at the morning ward meeting by the Senior Nurse on duty and the Duty Doctor.

Urgent Referrals

Referrals for immediate consideration are discussed by the Senior Nurse on duty and the Duty Doctor. It may be necessary to discuss these also with the Medical Director, Consultant or Director of Clinical Services.

Prioritising Patients

The suggested hierarchy for prioritising of admissions is a follows:

1. Community admissions for acute symptom control and terminal care.
2. Hospital and Nursing Home transfers for symptom control.
3. Hospital transfers for terminal care.
4. Urgent respite admissions (outside the usual respite bed booking).
5. Hospital transfers for rehabilitation or assessment.
6. The patient's already resident in another Hospice (where transfer is considered for geographical convenience).

General Points.

1. It is important to liaise with referrer with outcome of admission request and also to document plans to ensure that the follow up information is up to date and accurate to support decision making.
2. Using the appropriate referral forms for all patients will ensure clarity of information and aid good communication to other team members.
3. It should be remembered that the above guidance is flexible and individual circumstances must be taken into account at all times.
4. All referrals must be filed in the Referral file has a separate section for those on waiting list.

3. Day Therapy Unit

The patient has an active progressive terminal disease with specialist palliative care needs which can be met through Day Therapy Unit attendance.

The patient must be over the age of 18 years and live within the hospice catchment area.

3.1 Referral Process

Any health care professional can make a referral to the Day Therapy. However, referrals are progressed only with the agreement of the patient's general practitioner. Referrals will be activated and if there is any doubt about suitability for hospice care a home visit will be arranged or discussed at the Monday MDT.

On receipt of a referral the Head of Day Therapy Unit will make a decision on whether to accept the referral. However more complex cases may be taken to the Multi-Disciplinary Team Meeting.

Patients who have access Day Therapy previously can be re-referred and duly considered

3.2 Assessment

In-patients will be assessed on unit prior to discharge if it is thought that attendance at Day Therapy would be appropriate. The patient will be given a day and date to attend Day Therapy prior to discharge.

All patients accepted to Day Therapy are offered a programme of care for 10 weeks. This will usually be followed by discharge, but the multi-disciplinary team will review and plan ongoing care. Assessments are made at regular intervals.

Patients will be notified of their review day. Where appropriate it may be helpful to invite relatives to this.

3.3 Day Therapy Attendance

Attendances are normally weekly on the day allocated.

Further days may be offered following ongoing assessment. This may be for a limited time as circumstances warrant

4. Respite

4.1 Admission criteria for respite bed.

Patients are admitted to the Respite bed who are over18 and have a progressive incurable disease for which any treatment is palliative in nature which includes patients with cancer and non cancer diagnoses. The patient and family should normally be aware of the diagnosis.

The patients' physical and psychological symptoms should be stable. If there are symptom control issues, deterioration or problems with care at home they will not be considered for admission for respite but may fulfil criteria for admission to other IPU beds. Respite admission will not be available to patients currently in hospital.

4.2 Period of respite admission

Beds will be booked for 6 nights or in exceptional circumstances 13 nights. Admission will be on Tuesday between 10.30 and 11.00 and discharge will be on Monday between10.30 and 11.00.

Beds can be booked for a maximum of 4 weeks per year with a minimum of 3 months between bookings. This will be at the discretion of the respite bed co-ordinator.

4.3 Preparation for admission

The G.P's surgery should organise ambulance for admission and discharge if required

It is the patient or carers' responsibility to stop and recommence any outside care agencies that are involved.

Patients should bring in all their own medication for their stay and ensure they have enough for at least a week's supply on discharge. Patients should also bring in their own mobility aids, or other specialist equipment e.g. nebulisers, oxygen concentrators.

5. Lymphoedema

Every referral received will be assessed but may be discharged following assessment if a treatment plan is not applicable

Referrals are processed within 72 hours and given a classification on arrival:

- A1 Cancer diagnosis must be seen within 2 weeks of receipt of referral
- A2 Non cancer diagnosis. Primary lymphoedema seen in 3-6 weeks.

Following assessment each patient will have a plan of treatment.

Approved by: Senior Clinical team
Issued: May 2010
Next Review Date: May 2012