CP2 Referral and Admission Policy for All Saint Michael's End of Life Care and Palliative Services

Policy	Referral and Admission Policy for All Saint Michael's Services	**No.**	CP2
Scrutiny group	Board of Trustees	**Trustee approved**	
Last reviewed	March 2018	**Next review**	March 2020
Author (s)	Medical Director/ Head of IPU	**External input**	

1. Introduction

Saint Michael's seeks to provide high quality support to patients in all of its services. In doing so we have a responsibility to 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

2.1 Criteria for referrals

Patients are admitted to Saint Michael's Hospice for terminal care, symptom control, assessment and crisis care. Patients will be considered for admission to the in-patient unit who have a progressive terminal condition with specialist palliative care needs or are in the last days of life. Patients must be over the age of 18 and live in the Saint Michael's catchment area; although discretion can be applied by the Medical Director or Head of the In Patient Unit. (Please see appendix map for the boundaries of the district). Patients from out of area will be considered under the following circumstances: majority of treatment has been provided by HDFT or Saint Michael's is the patient or families preferred place of care or death or patient has SPC needs whilst away from home.
Either the patient or their nominated advocate if lacking capacity must consent to referral and admission to the hospice.
Referrals will be considered for patients from any place of care.

2.2 Referral process

All admissions to Saint Michael's Inpatient Unit will be agreed by the on duty hospice Doctor and the Nurse in Charge of In-patient Unit. If required, advice should be sought from a consultant or the Head/Deputy Head of the In-patient unit.

All patients must be referred for admission by the Specialist Palliative Care Team, their GP or a member of their treating team/consultant who is in liaison with their specialist palliative care team.

Referrals must be made on the designated paper form, completed either by the referrer or the recipient. Contact by letter or by telephone must always result in a written referral. However, admission can be arranged prior to receiving the necessary paperwork so as not to cause unnecessary delay. All patients must be referred for admission with the agreement of their GP or Consultant. The timing of the admission should be agreed between the hospice, patient and referrer.

Admissions can be planned for all hours of all days including weekends. Any number of admissions can be taken in the same day as driven by patient needs with additional medical, nursing and other staff provided as appropriate. The ultimate decision for this rests with the Head of Inpatient Services.

It is important to liaise with the referrer regarding the outcome of the admission request. Any discussions regarding the referral should be clearly documented on the referral paperwork, to support decision making.

Patients referred from hospital should be assessed by a member of their specialist palliative care team. In some circumstances where the case of need is clear and this would cause unnecessary delay in admission this requirement can be waived by the hospice doctor.

If clarification of patient need or suitability for hospice care is required, then an assessment visit may be made by a member of the hospice inpatient multi-disciplinary team or Saint Michael's Hospice Outreach Team and then discussed with appropriate staff members.

2.3 Out of hour referrals and admissions

Admission requests may be made by out of hour's senior health care professionals after escalation to a level of seniority or request for further assessment required to inform the decision to admit in a timely manner by the hospice doctor.

Initially the nurse in charge on the in-patient unit receiving the referral will establish if the admission is appropriate in the same way that a referral would be assessed during normal working hours.

The nurse in charge on the in-patient unit should then discuss with the on call hospice doctor this request. Where the transfer is requested from a Hospital this will usually be accepted out of hours and it should not be delayed on the assumption that the patient is in a safe place. If the referral is accepted the doctor making the referral will then contact the patient.

2.4 Waiting List Guidelines

To prioritise admissions 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.

Waiting lists and prioritisation of admissions will be reviewed every morning by the hospice doctor on duty and the nurse in charge of the in-patient unit.

The safety and well-being of the patient is the overarching consideration in prioritising admission regardless of their place of care.

3. Day Therapy Unit

3.1 Criteria for referrals

The patient can be referred if they have a progressive terminal condition 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 Harrogate District, although discretion can be applied by the Day Therapy Sister.

The patient must be able to exit and enter their property safely either independently or with the help of family as Saint Michael's employees and volunteers have a responsibility to assist patients to the door only.

3.2 Referral Process

Referrals to DTU can be made from the following health care professionals:

- GP
- Consultant
- Specialist Palliative Care Team
- Disease specific CNS
- Community Matron
- Internally via Inpatient Unit/MDT member

Referrals are progressed following discussion at community MDT meeting, unless urgent in which case can be accepted at the discretion of the Day Therapy Sister. If there is any doubt about suitability for hospice day therapy further assessment will be arranged. All accepted referrals for DTU will be contacted by phone the week of MDT discussion and a start date given. This is then followed by written acceptance letter to the patient, a copy is also sent to patient's GP and the referrer e.g. Heart failure nurse.

Contact by letter or by telephone to request admission to DTU services must always result in a written referral.

Patients referred from the Inpatient Unit will be visited by a member of the DTU team prior to their discharge day.

4. Lymphoedema

Patients should be over 18 and be diagnosed with a progressive terminal condition and live within the Saint Michael's catchment area, although some discretion can be applied by the lymphoedema team. A paper referral form should always be used. However, in order to prevent any delay, referrals can be accepted following discussion with the referrer as long as a paper referral is also completed.

Referrals may be progressed only with agreement of the patient's GP or consultant, following consideration by the lymphoedema team.

Referrals can be made by:

- GPs
- Community or practise nurses
- Consultants
- Specialist palliative care team
- Disease specific CNS
- Allied health professionals
- Saint Michael's MDT

5. Saint Michael's Volunteer Visitors

5.1 Criteria for referrals

Patients must be aged 18 or over, diagnosed with an progressive terminal disease, and living within our catchment area. All referrals for this service will be agreed by the Saint Michael's Volunteer Visitor Team.

5.2 Referral process

All patients can be referred by any Healthcare professional, or they can self-refer by obtaining this form on the Hospice Web site. A Team member will make an assessment visit if appropriate to clarify suitability.

7. Neurological Conditions Community CNS

The community neurological conditions nurse specialist provides supports and advice to individuals, their families and significant others living with terminal progressive, advanced neurological conditions such as:

- Huntingdon's Disease
- Motor Neurone Disease, from diagnosis onwards
- Multi Systems Atrophy
- Multiple Sclerosis
- Parkinson's Disease
- Progressive Supranuclear Palsy

7.1 Aim of Service

The service provides a specialist level of care and support; working in collaboration with other health and social care services, with the aim to ensure patients and their carers:

- To be and feel supported
- To have an advocate
- Have their complex needs and symptoms addressed
- Be able to express their wishes and choice's
- Have opportunities to explore and establish advance care plans and advanced decisions to refuse treatment.

7. 2 Criteria for referral:

- Progressive terminal neurological condition*
- First aspiration pneumonia
- Rapid decline in condition
- Complex symptoms
- Complex care needs
- Future care planning and/or mental capacity concerns with regard to health care issues

Special criteria:

- People with Motor Neurone Disease will be seen from diagnosis onwards.
- All other neurological conditions must be in the advanced progressive palliative stage.

7.3 Support provided

- Visit patient were they are – majority of contact is in patients' own homes
- Complex symptom management and advice to patients and other professionals
- Collaborative working with relevant health and social services.
- Link into all other saint Michael's services including Day Therapy, Patient Support Team, Inpatient Unit and Specialist nurses.
- Support, communicate and advocate Advance care wishes and decisions, DNACPR and Best Interest Decisions with wider health and social care teams.
- To prevent inappropriate hospital admissions and support choice in place of care and death
- Carer support

7.4 Who can refer?

Referrals can be taken from any health care professional. The patient and/or their carers can also self-refer via telephone.

7.5 How to refer?

By contacting Saint Michael's specialist nurse team via consultation letter or completing Saint Michael's referral form.

8. Saint Michaels @Home Service

8.1 Criteria for referral

Patients should be age 18 or over and have been assessed by a healthcare professional to be eligible to receive Fast Track Funding via the CCG. All referrals to this service will be agreed by the @Home Service Lead or the @Home Service Co-ordinator or the @Home Service Administrator,.

8.2 Referral Process.

Referrals will be made via Continuing Healthcare (CHC). CHC will telephone Saint Michaels with referral information. The Community Services Team will then look at the capacity of the team and accept or decline the referral based upon this documenting the reason for the decision

Please note this process may change when the final document/service specification has been received and agreed with the CCG.