ST JOHNS HOSPICE **DAY SERVICES CENTRE**

CRITERIA FOR REFERRAL TO THE HIV PROGRAM

1. Primary diagnosis of HIV or Aids; client is aware that they will be attending a centre (Mondays and/or Wednesdays) where the assumption will be made they are HIV+; there may be flexibility around days to attend if the client does not wish to be so clearly identified with an HIV+ population (the centre also has a non-HIV - primarily cancer diagnosis program Tuesdays & Fridays).

2. Identified areas of need and concern (not ALL criteria need apply):

- Need to access complementary therapies; aid to pain management and mobility, countering depression or anxiety, lessening effects of peripheral neuropathy etc.

- Need for increased social interaction; client is socially isolated, has minimal personal supports, has experienced significant loss / multiple losses.

- Lack of or disengagement from a professional support network; (re)connecting and maintaining access to medical, clinical and psychological resources in the community.

- Need for monitoring in relation to:
  - medications; regime, maintenance, compliance
  - treatment processes; symptoms, concerns
  - changes in routine or structure (appetite, sleep etc)
  - mood & behaviour (mental health issues; led by relevant external services)
  - intake & abstinence (drug & alcohol; led by relevant external services)
  - follow-through on appointments etc.

- Need to increase or establish routine and structure; focusing on encouraging an ongoing commitment to accessing individual sessions and group activities.

- Support for specific shorter-term aims (leading to longer-term goals); preparing for access to college & further education, looking at returning to work, resourcing volunteering opportunities; helping bidding for housing; applications for funds and benefits etc.

- Encouraging positive change; (re)building a sense of well-being, personal and social structure and wellness routines.

PLEASE NOTE: if a client does not have a GP on admission to DSC they will be informed it is a requirement of continuing access to services; staff at the centre can enable them to register with a GP; the GP is identified as their primary care provider and a community resource for overall medical care and referral on to other community resources and services.

A Community Nurse Specialist at the centre will conduct clinical assessments on admission and ongoing reviews. They will also assess medical concerns when they arise and manage the situation in the centre, refer on to relevant multi disciplinary staff on site or contact the appropriate external professionals or services. This triage process will allow for the client to be referred quickly on to community resources or escorted/ transported to an acute care facility.

Centre services are client-led; business meetings are held every quarter to discuss concerns, issues and ongoing developments.