East Cheshire Hospice

Referral Criteria and Guide

For

East Cheshire Hospice

Services

Referral Criteria and Guide

Introduction

East Cheshire Hospice provides Specialist Palliative care for people with progressive life limiting illness and support for their families and carers, given by a multiprofessional team.

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

Contents

General Criteria for Referral for Services

All of the below

- Progressive disease which cannot be cured, or the patient has refused treatment if competent to do so
- Complex problems including symptom control, psychological, social or spiritual issues important to the patient
- The problems identified are best dealt with by the Hospice In-patient or Day Care Unit
- The patient agrees to referral to the Hospice if competent to choose
- The patient is registered with a family practice within Eastern Cheshire locality or High Peak and Dales PCT
- Aged 18 years or over.

However, it is recognized that there are "grey areas" where individuals have needs but do not fit all the criteria above.

Such patients may be referred and discussed *individually* with the team as to appropriateness of referral.

For example:

- A patient with progressive disease with a longer prognosis than one year but who has complex needs
- Someone needing extra support around the time of diagnosis of incurable but treatable disease.

Note: that referral to the Hospice service does not preclude involvement of Specialist Teams – continued participation and collaborative care is welcomed, particularly in complex conditions. It is recognized that certain interventional treatments cannot be given on site, and transfer to the hospital may be necessary if such treatments are needed.

Inpatient Care

Referral Criteria

- Diagnosis of progressive life-threatening illness
- Complex palliative care needs
- Cannot be met by current health/social care professionals

See appendix 1 for suggested referral criteria for particular types of illness

Note: the Hospice does not provide long term care.

Referrals are accepted for:

- Symptom control
- Complex psychological and/or social needs
- Rehabilitation following palliative interventions (e.g. surgery, radiotherapy, chemotherapy)
- End of life care

In addition, a single bed is provided for planned respite for those with advanced neurological disease. There is a waiting list for this service.

Referral Procedure

Planned admissions normally occur between 0900 and 1300h, Monday to Friday. Later admission (before 1700h) can be arranged on some days only by prior arrangement.

Referrals should be made by a doctor from the Primary Health Care team or Hospital Medical Team, or by the Clinical Nurse Specialist with the agreement of the GP or Consultant.

The East Cheshire Hospice Referral Form should be completed and posted or faxed.

Admissions are prioritized according to need. Further information may be required to help this, depending on what information has been supplied on the referral form.

Deferred referrals may be made for patients who are likely to need admission in the future. If admission is later requested, a written update should be sent to the hospice.

Details of patients on the deferred waiting list will be reviewed at intervals, and updated information may be requested. If no admission is requested within 6 months of the referral, the details will be removed from the list.

Out of Hours Admissions may be requested for emergencies. The referring team must contact the senior nurse on duty by telephone. The decision as to whether to admit or not is made by agreement between the Senior Nurse and Doctor on call. Up to date written information must accompany the patient and a completed referral form should be faxed to the hospice at the time referral is accepted. The patient's current medication should be brought in.

Transfer of Patients to the Hospice

1. The referring health care team is responsible for ensuring that the patient is fit for transfer to the Hospice
2. The referring team must arrange suitable transport
3. The team must also inform the patient and carers of the admission arrangements
4. If a decision that resuscitation should not be attempted in the case of cardio-respiratory arrest ("DNAR"), the ambulance team must be informed and the DNAR document sent with the patient
5. Patients transferred from Macclesfield District General Hospital should be accompanied by the hospital case notes including the current medication chart; or from other units, by legible photocopied notes and transfer documentation.
6. Patients admitted from the community should be accompanied by relevant copies of community, medical and/or nursing documentation
7. All current medication should be brought in with the patient

Discharge will be arranged when:

- The specialist palliative care needs of the patient have been met
- The patient's needs can be met by their primary or social care professionals, or both, or care home staff if living or moving there.
- It is requested by the patient. Every effort will be made to facilitate a supported and timely discharge in accordance with the patient's wishes

Discharge planning is conducted in collaboration with relevant professionals, the patient and carers.

Hospice Day Care – Dorothy Pearson Unit

Referral Criteria

- Diagnosis of progressive life-threatening illness
- Complex palliative care needs that cannot be met by current health/ social care professionals
- Well enough to attend Day Care
- Can be transported to the Day Care Unit safely
    - Volunteer drivers may transport patients well enough to get into a car unaided
    - Others may be accepted if ambulance transport can be arranged or private transport arranged (friends, family, specialist taxi)
- The patient wishes to attend

***Referrals are accepted for*:**

- Symptom control
- Complex psychological and/or social needs
- Rehabilitation following palliative interventions (such as surgery, radiotherapy, chemotherapy)
- Difficulty coping with a potentially life threatening illness

Referrals may also be made for single therapies rather than the full Day Hospice:

- Physiotherapy
- Occupational therapy
- Art Therapy – psychotherapeutic
- Complementary Therapy
- Breathlessness Clinics
- Fatigue Clinics

Day Care Service

- The patient may be assessed by a member of the Day Care team prior to being accepted, usually at home, to ensure that placement will be beneficial and acceptable
- Placements are offered for up to 12 weeks at a time
- There is access to appropriate members of the multiprofessional team, coordinated by the nursing staff
- An assessment of needs and plan of care are made at the first attendance. This will be subject to ongoing review by appropriate members of the team
- 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 with the GP's agreement
- They may also be initiated by the patient, family members or other professionals, (e.g. District Nurses, Hospital Medical teams, Social Care teams). However, the actual referral should be sent by the GP or Specialist Nurse as above
- Referral is by completion of an East Cheshire Hospice referral form

Discharge will be arranged when

- The specialist palliative care needs of the patient have been met
- The patient's needs may be met by their primary or social care professionals, or both
- Outstanding needs do not fall within the Day Care Unit criteria
- The patient is not well enough to attend
- The patient no longer wishes to attend

Note: the Specialist Palliative Medicine Outpatient Clinic is held weekly on Monday mornings in the Cancer Resource Centre at Macclesfield District General Hospital.

Referrals should be sent directly to the Macmillan Consultant – Doctor Rimmer – at Macclesfield DGH, Victoria Road, Macclesfield, SK10 3BL.

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 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 Hospice Day Care or In-patient 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)

Lymphoedema is an incurable but generally manageable condition. Most patients will need indefinite intervention. After initial assessment and stabilization of the condition, many patients will be placed on a 6 monthly review, including provision of new garments. Those requiring regular intensive treatment will need more regular follow up. A few patients do not require hosiery but will still be monitored.

Physiotherapy and Occupational Therapy Team

Referral Criteria

- Diagnosis of progressive life-threatening illness requiring assessment and/or treatment by a specialist physiotherapist or occupational therapist. For example:
    - Weakness, fatigue
    - Neurological deficit
    - Difficulty with the activities of general living, mobility
    - Breathlessness
    - Pain
    - Restrictive scar tissue following surgery
    - Symptoms that may be treated by acupuncture, such as pain, hot flushes

Access

- The service offers domiciliary therapy as well as hospice based therapy

Referral procedure

- Referrals may be made by Health Care Professional involved with the patient's care, with the knowledge 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 planned
    - Patients may be temporarily discharged, with the option of contacting the team again if problems recur or new ones arise
- If the patient declines treatment

Appendix 1

Indicators that referral to the Hospice may be appropriate:

General *At least one of:*	•Progressive deterioration in physical ability •Dependence in 3 or more activities of daily living •Multiple co-morbidities •Symptoms cannot be alleviated by treating underlying disease •Signs of malnutrition due to illness – cachexia; albumin<25g/l •Severe progression of illness over recent months

Disease Specific Indicators	
Cancer	•Incurable metastatic disease or inoperable disease and •Complex symptomatic, psychological and/or social problems
Cardiac Disease: *At least one of* ***and***	•Advanced heart failure (New York Heart Association Grade 3/4 see below) •Three or more hospital admissions in last 12 months with symptoms of heart failure •Physical or psychological symptoms despite optimal tolerated therapy •Symptomatic arrhythmias resistant to treatment the patient does not want cardiopulmonary resuscitation in the event of an arrest
Pulmonary Disease *At least one of*	•Shortness of breath at rest or minimal exertion (MRC grade 4 or 5 – see below) •Documented progressive disease •Symptomatic right heart failure
Renal Disease: *Unable/ unwilling to undergo dialysis or transplant & at least one of:*	•Patient wishes to stop dialysis •Signs of renal failure (nausea, pruritus, restlessness, altered consciousness) •Intractable fluid overload •Rapid deterioration anticipated by renal team
Neurological Disease *Significant progressive decline in function*	•Unable to walk •Dependent on assistance with activities of daily living •Barely intelligible speech; difficulty in communication •Cachexia •Difficulty eating and drinking and declines feeding tube •Significant dyspnoea and/or requires oxygen at rest and declines assisted ventilation
Liver Disease	•Ascites despite maximum diuretics; spontaneous peritonitis •Jaundice •Hepatorenal syndrome; PTT > 5seconds above control •Encephalopathy •Recurrent variceal bleeding
Other situations include:	•Multiple co-morbidities with no primary diagnosis •Patient medically unfit for surgery for life-threatening disease •Failure to respond to Intensive Care, death therefore inevitable

Scales and Scores Referred to in Guidance

WHO Performance Scale

0: Able to carry out all normal activity without restriction.
1: Restricted in physically strenuous activity, but ambulatory and able to carry out light work.
2: Ambulatory and capable of all self-care, but unable to carry out work; up and about more than 50% of waking hours.
3: Capable only of limited self-care; confined to bed more than 50% of waking hours.
4: Completely disabled; cannot carry out any self-care; totally confined to bed or chair.

Karnofsky Performance Scale

100	Normal, no complaints, no evidence of disease
90	Able to carry on normal activity: minor symptoms of disease
80	Normal activity with effort: some symptoms of disease
70	Cares for self: unable to carry on normal activity or active work
60	Requires occasional assistance but is able to care for needs
50	Requires considerable assistance and frequent medical care
40	Disabled: requires special care and assistance
30	Severely disabled: hospitalization is indicated, death not imminent
20	Very sick, hospitalization necessary: active treatment necessary
10	Moribund, fatal processes progressing rapidly

The New York Heart Association (NYHA) Functional Classification

- Class I (Mild): No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnoea (shortness of breath).
- Class II (Mild): Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnoea.
- Class III (Moderate): Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnoea.
- Class IV (Severe): Unable to carry out any physical activity without discom fort. Symptoms of cardiac insufficiency at rest. If any physical activity is under taken, discomfort is increased.

Medical Research Council (MRC) dyspnoea scale

(Bestall, J et al (1999) Thorax; 54:581-586)

- Grade 1 - ' I only get breathless with strenuous exercise'
- Grade 2 - ' I get short of breath when hurrying on the level or up a slight hill'
- Grade 3 - I walk slower then people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level'
- Grade 4 - ' I stop for breath after walking 100yds or after a few minutes on the level'
- Grade 5 - ' I am too breathless to leave the house'

References:

- Suggested Prognostic Indicators of Advanced Disease. Keri Thomas, Jill Main, Amanda Free. From Gold Standards Framework website. *http://www.goldstandardsframework.nhs.uk/content/non_cancer/suggested_prognostic_indicators_of_advanced_disease.pdf* (accessed 28/9/6)

- End-Stage Disease Indicators. Community Hospices, Maryland. *http://www.communityhospices.org/_assets/TWH_indicator_crds6.pdf#search=%22end-stage%20disease%20indicators%20maryland%22* (accessed 28/9/6)

Appendix 2 - Contact Details

East Cheshire Hospice

- Millbank Drive, Macclesfield, SK10 3DR
- Telephone: (01625) 610364
- Fax: (01625) 665697
- Referrals to: Inpatient Unit, Dorothy Pearson (Day) Unit on Hospice Referral Form to above address – *fax if urgent and confirm receipt by telephone*
- If further forms needed, please contact Hospice directly and a form may be faxed

24 hour Advice Line at East Cheshire Hospice:

- (01625) 666999

Specialist Palliative Care Team (SPCT) - available during Office Hours

Specialist Palliative Care Nurses
Macmillan Consultant in Palliative Medicine
Via Macmillan Secretary at:

- Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL
- Telephone: (01625) 663177
- Fax: (01625) 661378

Macmillan Lung Cancer Nurses

- Ward 3/4 Corridor, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL
- Telephone: (01625) 661997
- Fax: (01625) 663240

Macmillan Pharmacist

- Pharmacy Department, Macclesfield District General Hospital
- Telephone: (01625) 661183
- Fax (pharmacy department): (01625) 661065

East Cheshire Crossroads Macmillan Palliative Care Service
Offers practical support for carers where and when needed, usually in the home
Contact: Anthea Frank, East Cheshire Crossroads (9-5 Mon-Thu; 9-4:30 Fri)

- Sunderland House, Sunderland Street, Macclesfield SK11 6JF
- Tel: 01625 511044
- Fax: 01625 511099
- Email: afrank@eastcheshirecrossroads.org.uk
- help@eastcheshirecrossroads.org.uk

East Cheshire Hospice thanks St Ann's Hospice (Heald Green and Little Hulton) for permission to use their Referral Criteria document as a template for our own.