ST JOHNS HOSPICE **DAY SERVICES CENTRE**

CRITERIA FOR REFERRAL TO THE CANCER CARE (NON-HIV) PROGRAM

1. Primary diagnosis of cancer, motor neurone disease, multiple sclerosis, cardiac and renal failure; client is aware that they will be attending a centre (Tuesdays and/or Fridays) where the assumption will be made they have a life-threatening or terminal illness; there may be flexibility around days to attend if the client does not wish to be so clearly identified with their diagnosis and the people attending (the centre also has a program for people diagnosed with HIV on Mondays and Wednesdays).

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, aiding appetite 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 access to individual sessions and group activities.

- Support for specific shorter-term aims; referring to care services; 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 promoting wellness routines and positive relationships with community resources.

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 triage nurse at the centre will assess medical concerns when they arise and will manage the situation on site, refer on to members of the multi-disciplinary team, or refer to external professionals, services and organisations. This triage process will allow for the client to be referred quickly on to an appropriate resource, and transport to acute care facilities is available.

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