REFERRAL AND DISCHARGE PROTOCOL FOR HOSPITAL SPECIALIST PALLIATIVE CARE TEAM

July 2015

1. Referrals

Urgent referrals will be seen within 48 hours from receipt of referral (as per National Cancer Standards). Where possible, urgent referrals (see below), should be seen within 24 hours of receipt of referral during normal working hours.
Non-urgent referrals should be seen within seven days as per National Cancer Standards.

Where possible CANisc notes should be printed on each patient, the team co-ordinator will make up a set of notes including CANisc where this is deemed necessary

Referrers will be asked to leave details of the patient and the level of urgency on the answer-phone, if urgent review required the answerphone message will ask the referrer to page a team member

When recording in a patient's notes we should record the date that the referral was received by the team.

All referrals should be discussed at the palliative care MDM at the next meeting following their assessment. The outcome and action of this meeting will be recorded in the palliative care case notes. There will be an annual audit of the MDM in line with the National Cancer Standards.

1.2 Referrals from Community Palliative Care Team:

Where referrals have been received from the community palliative care, a team member will discuss with the primary medical team involved with that patient and inform them that the patient is known to the team and we will be following them up whilst they are an inpatient to ensure continuity of care and to enable us to communicate with the community team when there are changes.

1.3 Urgent Referrals Definition:

Those patients with

Unrelieved symptom problems:
Palliative care emergencies: hypercalcaemia, spinal cord compression, SVCO, haemoptysis, haematemesis, terminal agitation, massive terminal haemorrhage
Death rattle
Difficult or intractable Pain,
Difficult or intractable dyspnoea
Difficult or intractable Nausea and Vomiting
Confusion and agitation

Urgent psycho/social problems:
Patients distressed related to diagnosis /prognosis
Family distress related to diagnosis /prognosis
Patient and family distress related to communication issues
Patients and families who wish to make a complaint regarding palliative care

1.4 Late or Delayed Referrals

Those patients who are due to be discharged the same day as the referral is received should be seen face to face by the HPCT and an assessment made prior to discharge. Where this can't be done then this should be communicated to the community palliative care team on the day of discharge.

1.5 Weekend Referrals

At the weekend there will be two CNS on to cover all the hospital sites in UHB.
Patients that are category RED and unstable will be reviewed at the weekend face to face if necessary.
New referrals that have unstable symptoms will be accepted at weekends for assessment. Non-urgent referrals will be assessed during normal working hours.
The CNS can be contacted on a long-range pager. Out of hours advice will be provided by the Marie Curie centre.

1.6 All Referrals

Where possible the CNS's will attend a patient's case meeting where this has been arranged prior to discharge. Where circumstances prevent the CNS from attending then a summary of our intervention should be communicated to the case manager and it should be documented in the HPCT notes.

All referrals cancer and non-cancer referrals will be accepted once there is clear agreement from the medical team involved.

All referrals that have face to face contact with the HPC team will be recorded on CANisc.

All advice calls should be recorded on the one- off advice sheets

1.7 Categorisation of referrals

New referrals should be categorised to improve allocation and monitoring of workload on both sites and to allow for auditing of the dependency needs of patients referred to the team.
Referrals should be categorised as red, amber or green when the referral is received and updated on a daily basis.
Patients in all categories will be discussed at the weekly HPCT MDM

RED

Red referrals will include those who have high surveillance and support needs that need re-assessment on a daily basis:

Symptom needs

These symptoms will require at least daily surveillance and intervention
Unstable or unpredictable symptoms
All those with intractable and complex pain
Complicated or intractable nausea and vomiting
Agitated confusion
Patients on the ICP for the last days of life
Rapid and complex discharges, especially for those patients choosing to die at home.

Emotional needs

High level of emotional support is needed on a daily basis and may include the following:
Newly diagnosed with life threatening illness or reoccurrence of disease
Progression of symptoms
Complex family issues
Imminent death / end of life issues

Family support needs

High levels of support are needed on at least a daily basis either face to face or by telephone:
Where there is a high level of distress for family members
Where there is collusion related to diagnosis of a patient
Where there is conflict about the direction of patient care
Where there have been complaints about the SPCT intervention
Complex or traumatic deaths requiring follow-up and action

Ethical decision-making needs

Where complex decisions need to be made and may include the following:
Continuation of hydration and feeds
Issues related to capacity and decision making
Support for professionals in making ethical decisions related to patient care
Support and advice for diagnosing dying

AMBER

Amber referrals will include those who have moderate surveillance and support needs that will need re-assessment every 2 - 3 days

Symptom needs

These patients will have symptoms needs that need surveillance and intervention every 2 – 3 days
Where patients are showing signs of pain stabilisation
Using less prn medications

Where patients are showing signs of stabilisation of nausea and vomiting, confusion and agitation are resolving

Emotional needs
Where patients are showing signs of adjustment to diagnosis and prognosis
Where patients are expressing normal signs of adjustment in line with their disease progression

Family needs
Where families are showing signs of adjusting to the patient's diagnosis and prognosis
Where families are expressing normal levels of anxiety and distress in line with the patient's disease progression
Follow-up check on death and recording of adverse events needing action
Where families are requiring support and information related to future care and support of the patient

GREEN
These patients will have symptoms needs that need surveillance and intervention on a weekly basis or less.
The patient and family will need to be made aware that they will be seen regularly. The family should be given contact details for the palliative care team.

Symptom needs
These patients may have had symptom problems which through intervention are now stable or have resolved.
They may have advanced disease and be at risk of sudden changes in condition which will require further specialist assessment.
They may need specialist surveillance if in generalist ward environment where changes in symptoms may go un-noticed.

Emotional needs
These patients may require sporadic support and counselling whilst living with and adjusting to a life-threatening illness

Family needs
These families may require intervention from time to time for support and reassurance
Follow-up check of staff/family following death
Community referred patients
These patients may be known to the community and will have been admitted for a problem unrelated to their life-threatening illness. They will need to be kept under surveillance whilst they remain an inpatient.

2. DISCHARGING OF PATIENTS FROM PALLIATIVE CARE TEAM

Patients that are assessed as not having specialist palliative care needs may need to be discharged from the caseload.

Decisions about discharging patients will be made as part of the multidisciplinary weekly meeting.

GUIDE:
Patients with extensive malignant disease should not be discharged due to the likelihood of sudden or rapid changes in condition

Patients whose condition has been unstable within the last month as a result of their end of life diagnosis should not be discharged.

If patients are known to the community palliative care team – they should not be discharged from our caseload.

Patients who are assessed as being asymptomatic – should not be discharged on this basis alone. There may be other specialist palliative care needs by the patient or family.

If the patient refuses input from the team, this should be documented and the medical team should be informed.

2.1 Patients that may need to be discharged may fall into 2 categories

Non-cancer patients

Some of these patients may have needed to be seen as a one off referral for symptom control and therefore it may be appropriate to discharge.
If a patient's condition improves and their prognosis changes it may be appropriate to discharge from caseload e.g. Heart failure patients, patients who resume dialysis

2.2 Cancer patients

Those patients for example from haematology who may have required one-off advice from Palliative Care Team may be appropriate to discharge from the caseload.