Referral Handbook

HALTON HAVEN Hospice *for a special kind of caring*

Halton Haven Hospice
Barnfield Avenue, Murdishaw
Runcorn, Cheshire
WA7 6EP

Tel: 01928-712728
Fax: 01928 – 701201
Email: referrals@haltonhaven.co.uk

www.haltonhavenhospice.co.uk

Registered Charity No. 702654

Contents

Introduction

Halton Haven Hospice is a provider of Specialist Palliative Care for adults over the age of 18, in the community of Halton, who have a life limiting illness with needs, encompassing physical, psychological, social and spiritual needs, and who require specialist assessment and management.

There are times when generalist services may need support to manage the needs of the patient. The Hospice aims to provide a service which can fulfil that role.

The Hospice Inpatient Unit is for Patients with problems who cannot be managed effectively by healthcare professionals in other settings and who would benefit from the support of the specialist palliative care team.

The Day Hospice at Halton Haven provides an opportunity for specialist assessment and review of patients' needs enabling the provision of physical, psychological, social and spiritual interventions within the context of clinical settings.

The Hospice's services are delivered by a specialist multi-disciplinary team, which possesses a wide range of expertise. The team includes:

- Consultants in Palliative Medicine, (Supportive Care UK SCUK)
- Doctors and Nurses with palliative care experience,
- Advanced Nurse Practitioner ANP
- Palliative Care Clinical Nurses,
- Physiotherapist,
- Pharmacist,
- Chaplaincy Support,
- Psychological Support,
- Family Support Unit
- Bereavement Support,
- Complementary Therapy,
- Access to Occupational Therapists, Dietitians and Social Workers.

There is also close liaison and collaboration with hospital and primary health care colleagues and other community health and social care services.

It must be noted at the outset that Halton Haven Hospice is **unable** to provide services for Patients whose:

- Conditions are stable and their needs are mainly social in nature
- Current clinical problems are not related to their life-limiting illness
- Immediate care needs would be best met in the acute setting – e.g. neutropenic sepsis

Patients who are referred and admitted for respite care will not be seen by a Medical Officer/ANP during their stay; they will however receive all nursing care.

Further clarification as to whether a Patient will meet the Hospice's referral/admission criteria can be gained by contacting the Hospice and speaking to Medical Team/ Senior Nursing Staff. If necessary

Nursing Staff may refer callers to either the Hospice Medical Team or the Hospice Registered Manager.

When referring a Patient to the Hospice it is important that you provide us with as much information as possible to facilitate appropriate decision making in respect to safe admissions.

To avoid delays in decision making and admissions please complete all sections of the Referral Form (See Page 11) before sending it to the Hospice. Where a Referral Form is not fully completed it will likely be returned to the sender to complete the missing information.

Inpatient Unit

Inpatient Unit Referral Criteria

Referrals to the Inpatient Unit can be accepted for Patients with a diagnosis of an advanced, progressive, life-limiting illness, who have Specialist Palliative Care needs.

Referral can be made to the Hospice for one or more of the following reasons where they cannot be managed in other settings:

- Symptom control relating to their current disease progression.
- psychological and/or spiritual need
- Social/crisis intervention /Respite care
- Rehabilitation needs following hospital discharge/treatment
- End of life care

Some Patients may require specialist care because of their immediate and difficult situations. In such situations it may be that assessment via Day Hospice Services, rather than the Inpatient Unit would be more beneficial and prevent the need for an Inpatient admission. This will be assessed by the Hospice on receipt of a fully completed referral form and the referrer advised accordingly.

Please make clear in the referral details of all interventions that have so far been tried but have failed to resolve the situation for the patient. This will allow the Hospice to assess what can be offered to the patient through an Inpatient admission. A lack of such information will result in the Hospice contacting you to ask for this.

Please note that the Hospice is **unable** to care for Patients on the Inpatient Unit for an indefinite period of time and **this should be made clear to the Patient and their family by the referrer when Hospice admission is initially being discussed with them.**

Most Patients will be admitted to the Inpatient Unit for a period of assessment, with the length of stay being dependent on the Patient's needs. With the exception of Patients who are admitted for care in the last days of life, **discharge planning will be commenced on the day of admission.**

If it is clear from your own assessment of the Patient's condition that they will require medium to long-term care, we ask that you commence an NHS Continuing Healthcare Application prior to admission to the Hospice in order to facilitate timely, effective and supportive discharge from the Hospice. Where this has been appropriate please provide evidence of the application along with your referral.

Prior to referral, there is a requirement that the Patient is assessed by either a medical practitioner or member of a specialist team, to identify the specific Palliative Care needs of the Patient. Where assessment is made by a member of the specialist team they must confirm that the Patient's medical lead/GP/Hospital Consultant/Community Consultant has consented and agreed to the referral and that the Patient and their family are in agreement with the referral being made.

Further discussion prior to admission will be conducted with the senior clinician and team at the Hospice and the Patient's medical lead/GP/Hospital Consultant/Community Consultant at the daily MDT /Huddle meetings to agree the patient meets the referral criteria.

The Hospice acknowledges the advantages of advance care planning and recognises that Patients may have preferences with regard to their preferred place of care. However, the Hospice is required to prioritise access to all our services according to the complexity of need and, therefore, we will not always be able to accommodate all requests in respect to Preferred Place of Care and/or Preferred Place of Death.

How to Refer to the Hospice Inpatient Unit

The purpose of the Hospice referral form titled: "Warrington and Halton: Referral for Specialist Palliative Care Services" (See Referral Form Page 11) is to ensure that we have the relevant information upon which to base our assessment of a Patient's need for Specialist Palliative Care and to prioritise accordingly. There should be direct discussion with the Hospice team, facilitating further information sharing and to help with preparations for safe admissions, if any of the following apply (Please note that this is not an exhaustive list and the Hospice may contact you for further information about other things);

- Oxygen requirements
- A requirement for blood products or intravenous medication
- Total Parenteral Nutrition
- Peg feeds
- A healthcare acquired infection e.g. C.difficile
- A spinal epidural line
- Confusion and is ambulant
- History of Mental Ill Health

- Tracheostomy
- Chest drains (Rocket drains)

The referral form (See Referral Form Page 11) must be fully completed by the referrer. Incomplete forms may result in delayed admissions as the Hospice seeks any incomplete information. The referral form may be submitted either by email, post or fax. Postal and email addresses and the Fax number can be found on the front page of this Handbook.

Referrals for admission are reviewed on a daily basis. Patients will be accepted for admission to the Hospice dependent on needs meeting referral criteria, bed availability and patient safety. Decisions on referrals will be communicated to the referring team by the Senior Nurse on Duty on the Hospice Inpatient Unit.

Where appropriate the Hospice will endeavour to signpost the referrer to other services able to support the patient until admission can be arranged. Symptom control advice is available from the Hospice Nursing and Medical staff. The 24hr Advice Line is also available if required (24 Hr Advice Line Number: 0844 225 0677).

Referrals for Information Only

Patients referred to the Hospice who may require admission in the future will be placed on the 'for information only list'. If such a Patient subsequently requires admission, dependent on the time lapse since the original referral, updated information about the Patient's current condition and a new Referral Form will be requested in order to assess their current need for specialist Inpatient care.

Referring a Patient "for information only" can facilitate a more timely admission decision if an out of hours request should become appropriate.

Information only referrals will remain in our database for six months from the date of receipt. Following this period referral details will be deleted and any subsequent need for Hospice Services for that Patient will require a new referral with contemporaneous information.

Patients without Capacity

If a Patient lacks the capacity to make a decision about admission to the Hospice and there is no relevant Lasting Power of Attorney or Court Appointed Deputy, the decision to admit must be made in their best interests in accordance with the Mental Capacity Act 2005 and the accompanying Code of Practice. This may necessitate a Best Interests meeting and may require the involvement of an Independent Mental Capacity Advocate (IMCA). Where appropriate please attach copies of your assessment of capacity and best interest documentation, including any IMCA report, to the referral for admission. Please also ensure that you make the Hospice aware of any implications in relation to Deprivation of Liberty Safeguards.

Inpatient Unit Referral Response

Referrals received at the Hospice will be triaged at the earliest opportunity. Requests for admission will be prioritised by clinical need. Referrers will be contacted within 24 hours from receipt of the referral by the Hospice and advised of the bed status at the Hospice at that current time. Contact will be maintained with referrers until an Inpatient Unit bed becomes available and appropriate admissions can take place.

Referrals for urgent admission will be discussed by the Hospice Team and the referrer contacted as soon as possible. The referrer will be informed of whether it is possible to admit the Patient that day. Where admission that day is not possible the referrer will be informed of the current bed status at the Hospice and given advice on the earliest possible opportunity to admit. This will enable the referrer to make other arrangements, where necessary, if the Hospice cannot admit the Patient immediately.

Please note that the Hospice's ability to admit Patients out of hours is limited. Requests for an urgent, out of hours, admission will be handled by Senior Nursing Staff, who will liaise with the On-call medical team/or Hospice Registered Manager to determine the appropriateness of the request. The acceptance of admission out of hours will depend on clinical need, bed availability and medical/nursing cover. The referrer will be contacted with a response to a request for an urgent, out of hours admission as soon as possible by the Senior Nurse and/or On Duty Doctor.

Transfer of Patients to the Hospice Inpatient Unit

Planned admissions will normally occur between 9am - 3pm Monday to Friday (excluding bank holidays). Wherever possible, the Hospice will endeavour to give 24 hours' notice of bed availability.

It is the responsibility of the Patient's current health care team to:

- Ensure the Patient is fit to travel to the Hospice. It may not be appropriate to transfer a Patient who is actively dying
- Inform the Patient/Carer of the admission arrangements
- Arrange suitable transport
- Ensure that the Patient and their family (except where the Patient is actively dying) understand that admission is not for an indefinite period of time, that the length of stay will be determined by the Patient's needs and that discharge planning will commence upon admission.

Patients being transferred to the Hospice should be accompanied by a copy of their hospital/community notes, any NHS Continuing Healthcare documentation and a list of current medications.

Transfer documentation must always accompany the Patient.

Patients transferred from home should be accompanied by a carer wherever possible and all current medications should be brought with the Patient.

Discharge from the Hospice Inpatient Unit

With the exception of Patients who are admitted for care in the last days of life, discharge planning will be commenced by the Hospice on admission.

Any issues which impact on timely discharge will be identified through the admission assessment process and action will be taken to address these issues. Completion of NHS Continuing Health Care Assessments by the referring team, prior to admission, will lend timely support to this process.

Discharge will be arranged for when:

- The Patient no longer requires specialist Inpatient care and their needs can be met by the Community Specialist Palliative Care Teams, perhaps in conjunction with Day Hospice admission where appropriate.
- The specialist needs of the Patient have been met and any remaining needs can be met by the primary/social care team.
- The Patient's preference is to be cared for at home, even if their Specialist Palliative Care Inpatient needs have not been met.

It is the responsibility of Social Services and Community Healthcare Providers to meet the assessed social and healthcare needs of Patients who meet Hospice discharge criteria. This may be through provision of a package of care within the Patient's own home or, in the event of ongoing nursing care needs where the Patient is unable to return home, a care home placement.

The Hospice Family Support Team will be able to offer information, advice and support to the Patient and their family during the discharge process and the Hospice will work with other services to expedite discharge planning.

In the event of a Patient meeting Hospice discharge criteria but having ongoing nursing care needs, where the Patient is unable to return home, the Hospice Family Support Team will provide information, advice and support to the Patient and their family to enable them to make alternative care arrangements e.g. in a Residential / Nursing Home.

Day Hospice

Day Hospice Referral Criteria

Referral to Day Hospice can be made by the Patient's General Practitioner (GP), District Nurse, Hospital team or specialist team within the community.

Patients may also self-refer but this must be done in consultation with their GP.

A referral can be made to Halton Haven Day Hospice for one or more of the following reasons:

- Symptom control i.e. Breathlessness/anxiety management
- Psychological, spiritual and social need
- Rehabilitation assessment following radiotherapy, chemotherapy, surgery and palliative care interventions.

To ensure that, as far as is reasonably practicable, services are delivered in an equitable manner to those who can benefit from them most, the following referral criteria will apply:

- The Patient must be aged eighteen or over
- The Patient Has been diagnosed with a life limiting illness
- The Patient is aware of the referral, they wish to attend Day Hospice and are currently well enough to attend
- The Patient has a discharge date from hospital or they are currently being cared for at home
- The Patient has complex needs that require specialist support and palliative care

The Day Hospice Service provides:

- Access to the Specialist Palliative Care Multi - disciplinary Team.
- A management plan, which is discussed and agreed with the Patient. The management plan will be subject to ongoing review by the Multi - disciplinary Team.
- Liaison with other health and social care professionals (hospital/community)

It is envisaged that a Day Hospice admission would be for a period of twelve weeks. However, Patients will be reassessed at twelve weeks to determine if a longer admission would be appropriate.

How to Refer to Day Hospice

Referrals can be made by Consultants, General Practitioners (GP), District Nurses and hospital medical teams or by specialist teams in either the community or hospital.

Referrals may also be initiated by the Patient, but this must be done in consultation with their GP.

Referral should be done using the referral form titled: "Warrington and Halton: Referral for Specialist Palliative Care Services" (See Referral Form Page 11). The referral form must be fully completed by the referrer – incomplete forms may result in delayed admissions as the Hospice seeks any incomplete information (i.e. Referral Form may be returned to the referrer for completion).

Where referrals are made by health care professionals other than the medical lead (GP/hospital consultant), they must also confirm that the medical lead has been informed of the referral.

Referrers must confirm that the Patient has agreed to the referral to Day Hospice.

The referral form may be submitted either by post, email or fax. Postal and email addresses and the Fax number can be found on the front page of this Handbook.

Day Hospice Referral Response

The Hospice will aim to make verbal contact with the referrer within 3 working days of receipt of the referral form to discuss Day Hospice admission.

Where there are available Day Hospice places the Hospice will aim to contact Patients by telephone, also within 3 working days, to arrange an assessment. The Hospice will schedule the Patient's assessment to occur as soon as possible after that contact.

In the event that Day Hospice is at full capacity at the time of the referral, the Hospice will write to the Patient within 3 working days (copied to the referrer) explaining this. The Hospice will then maintain contact with the Patient and referrer and will arrange for an initial assessment to take place when a Day Hospice place becomes available.

The Patient's GP will be notified within 10 working days of the first attendance of the Patient's Day Hospice admission.

For Patients who do not meet the referral criteria, the Hospice will aim to contact the referrer verbally, within 3 working days of receipt of the referral form, to inform them of this and discuss the reasons. The discussion will be confirmed in writing.

It is the referrer's responsibility to inform the Patient where a referral has been found to be inappropriate at the current time.

Discharge from Day Hospice

Day Hospice admissions are most usually for a period of twelve weeks. However, Patients will be reassessed at twelve weeks to determine if a longer admission would be appropriate.

Discharge criteria may include:

- Individual Patient needs have been met.
- A Patient's needs can be met by their primary and/or social care providers.
- The Patient's outstanding needs do not fall within the referral criteria for Day Hospice.
- The Patient is no longer well enough to keep attending Day Hospice.

Discharge from Day Hospice will be confirmed in writing to the Patient's GP Practice to ensure continuity of care.

Following discharge a Patient may be re-referred to Day Hospice for a further, future admission should there be a change in condition and they develop needs that meet Day Hospice referral criteria.

Referral Form

PLEASE USE BLOCK CAPITALS AND BLACK INK – THANK YOU

<table>
<tr><th colspan="5">WARRINGTON AND HALTON: REFERRAL FOR SPECIALIST PALLIATIVE CARE SERVICES</th></tr>
<tr><td colspan="2">Patient Details</td><td colspan="3" rowspan="2">Relevant Treatments:</td></tr>
<tr><td colspan="2">NHS No:</td></tr>
<tr><td>Title:</td><td>Gender: M / F</td><td colspan="3" rowspan="5"></td></tr>
<tr><td colspan="2">Forename:</td></tr>
<tr><td colspan="2">Surname:</td></tr>
<tr><td>Age:</td><td>DOB:</td></tr>
<tr><td colspan="2">Address:</td></tr>
<tr><td>Post Code:</td><td>Tel:</td><td colspan="3" rowspan="3">Any Known Allergies:</td></tr>
<tr><td>Ethnicity:</td><td>Religion:</td></tr>
<tr><td>Marital Status:</td><td>Smoker? Y / N</td></tr>
<tr><td colspan="2">History of Illness</td><td>ICD in situ:
Y / N</td><td>Deactivated:
Y / N</td><td>Pacemaker in situ:
Y / N</td></tr>
<tr><td colspan="2" rowspan="2">Diagnosis incl. known metastases:</td><td colspan="3">Next of Kin Details</td></tr>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="2" rowspan="2">Patient aware of diagnosis? Y / N</td><td colspan="3">Relationship to patient:</td></tr>
<tr><td colspan="3" rowspan="2">Address:</td></tr>
<tr><td colspan="2">Date of diagnosis:</td></tr>
<tr><td colspan="2" rowspan="2">Other medical conditions:</td><td colspan="2">Post Code:</td><td>Tel:</td></tr>
<tr><td colspan="3">Is the patient living alone? Y / N</td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="3">Where is the patient presently?</td></tr>
<tr><td colspan="3">Involved Professional Details</td></tr>
<tr><td colspan="2">Current Medication (incl. dose and frequency)</td><td colspan="3">GP Name:</td></tr>
<tr><td colspan="2" rowspan="6"></td><td colspan="3">GP Surgery:</td></tr>
<tr><td colspan="2">GP Tel:</td><td>GP Fax:</td></tr>
<tr><td colspan="3">District Nurse:</td></tr>
<tr><td colspan="2">DN Tel:</td><td>DN Fax:</td></tr>
<tr><td colspan="3">Community Specialist Nurse:</td></tr>
</table>

	SN Tel:	SN Fax:
	Hospital Consultant:	
	Hospital Consultant:	
	Hospital Specialist Nurse:	
	Referral Information	
	Is GP aware of referral?	Y / N
	Is Patient aware of referral?	Y / N
	Date last seen by referrer:	

Patient Name:	**NHS No:**

Reason for referral: Please complete with **all** relevant details as incomplete forms will result in processing delay that will impact on patient care.

Current Problems:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Expectations / Aims of Specialist Palliative Care Involvement:

.....

.....

.....

.....

.....

.....

.....

.....

.....

PLEASE INDICATE SERVICE REQUIRED WITH ✓ AND FAX/EMAIL TO APPROPRIATE NUMBER (below)

Hospital Outpatient Clinic (Halton) ATTACH LETTER:	☐	**01925 662347**
Hospital Outpatient Clinic (Warrington) ATTACH LETTER:	☐	**01925 662347**
St Rocco's Hospice Outpatient Clinic:	☐	**01925 630690**
Halton Outpatient Clinic:	☐	**bchft.haltonspct@nhs.net**
Warrington Community Palliative Care team:	☐	**01925 579202**
Halton Community Palliative Care Team:	☐	**bchft.haltonspct@nhs.net**
Warrington & Halton Hospitals Palliative Care Team:	☐	**01925 662347**
St Rocco's Hospice: - **Inpatient**	☐	**01925 630690**
- **Day Therapy Services**	☐	
- **Family Support Team**	☐	

Halton Haven Hospice:	- **Inpatient** ☐	**haltonhavenhospice.inpatients@nhs.net**	
	- **Day Therapy Services** ☐		
	- **Family Support Team** ☐		
For Information Only (to a team above):	☐	**Choose from above**	

Referrer Details		
Printed Name:	Designation:	
Phone Number:	Signature:	Date: