North Devon Hospice

REFERRAL AND TRANSFER PACK

There will be times when a patient in hospital would benefit from a referral to the hospice for on-going care. This might be identified at an out-patient appointment or prior to discharge after an inpatient stay. Hospice input might be required on discharge home, after transfer to another residential setting such as a care home, or because it is agreed the patients' needs will best be met by transfer to our inpatient unit.

To help you assess the need for referral to any of the hospice service and to support a safe and seamless transfer to the inpatient unit, we have put together this quick and easy to read Transfer Pack that will guide you through our referral criteria, information requirements and clinical decision-making process.

OUR SERVICES

North Devon Hospice provides palliative care to people who are eligible for our care services. We operate as one hospice team, providing the following care:

- Specialist symptom control management
- Rehabilitative Palliative Care
- Emotional and spiritual support related to the advanced progressive disease.
- Referral onto other services e.g. financial support
- Education and information for patients and their families, as well as other professionals involved in their care.
- Advance care planning
- Advice and information
- Rapid intervention at home for those in the last weeks of life
- Personal care in the last days of life

Our care services provide this specialist advice and support to patients, and their family/carers, to promote comfort, quality of life, and peaceful death. This support is provided by a multidisciplinary team in the following services:

- **Supportive Care Services**: incorporating counselling, complementary therapy and bereavement support at the hospice in Deer Park and at The Long House in Holsworthy.
- **Community Palliative Care Service:** Incorporating the Clinical Nurse Specialist team and Hospice to Home team, providing care in the person's usual place of residence.
- **Inpatient Service** in our bedded unit at Deer Park

Access to these services is based on assessment of needs to ensure the right care is offered to the right patient, family member or carer at the right time.

- **Healthcare Professional Helpline** – available for Healthcare Professionals only. This telephone line gives direct access to the inpatient unit. During weekday office hours we can connect you straight to our Specialty Doctors. Out of Hours the phone is managed by our inpatient unit team who can advise and will contact our on-call Specialty Doctor where appropriate.

If you think your patient may need referral or transfer to the hospice, this pack will help you prepare all the information you will need to make a referral to our services.

Referral Flowchart

Step 1 –

DOES THE PATIENT MEET OUR CRITERIA

North Devon Hospice Eligibility Criteria

Our eligibility criteria for access to our services is as follows:

- Over 18 years of age (16 years and above by exception)
- Advanced and progressive life limiting illness.
- Responsible Medical Practitioner is in agreement with the referral (i.e. GP, hospital consultant)
- Where possible, the person being referred has given consent for referral (Where the patient does not have the capacity to accept referral to the hospice, the main carer should be aware and accepting of the referral.)

Step 2 - WHAT IS THE REASON FOR REFERRAL

- ✓ the patient has distressing physical, emotional, social or spiritual problems?
- ✓ the patient is at the end of their life, with complex needs?
- ✓ the hospice is their preferred place of care or place of death?

If you have answered yes to **any** of the above needs:

Step 3 - MAKE A REFERRAL

Clinical Nurse Specialists or Supportive Care Services – compete our referral form which can be found here:

https://www.northdevonhospice.org.uk/health-professionals/our-services-and-making-a-referral/

and email to ndh.referrals@nhs.net or ring us to complete the form over the phone (01271 344248 – ask for Duty CNS)

Hospice to Home – ring us on 01271 347 246

Inpatient Services – call our Healthcare Professional Helpline **01271 347214** to initiate referral. Use the Inpatient Services checklist (see below) to guide you through the referral process.

(If you're not sure – give us a ring, we're happy to discuss any potential referrals)

Referral to our Clinical Nurse Specialist team and Supportive Care Service

If your patient is going home or to another residential home setting such as a care home, they may be eligible for ongoing support from our Community Clinical Nurse Specialist Team and our Supportive Care Team.

Please complete the referral form which you can find here: https://www.northdevonhospice.org.uk/health-professionals/our-services-and-making-a-referral

Make sure you include as much detail as possible about the reason for referral. Include any relevant clinic letters or discharge summaries as this will help us identify the right help to best support the patient and their family's needs.

You can email the referral to us at: ndh.referrals@nhs.net or ring us to complete the form over the phone (01271 344248 – ask for Duty CNS)

Referral to our Hospice to Home Service

If you feel your patient needs care at home on discharge from hospital, you can refer to our Hospice at Home Service.

Our Hospice to Home services (H2H) are delivered by a team of Registered Nurses and Senior Healthcare Assistants trained in delivering end of life care and enhanced communication skills.

This team can respond quickly when appropriate, and their visits will usually be in the usual place of care and will fall into the following categories:

- Rapid response care
- Discharge support care
- Admission bridge care
- Discharge bridge care
- Interim care
- Routine care
- RN Support visit

To make a referral or to discuss the ways in which Hospice to Home might be able to help, ring us on 01271 347 246

Referral for Inpatient Admission

Each weekday morning, we hold our Capacity Meeting. This is a multidisciplinary meeting that allows the hospice team to come together to discuss:

- New referrals (since the last meeting) to our services including patients in hospital and in the community.
- Any calls since the last meeting from patients / families or healthcare professionals including any follow-up actions to be taken by our team.
- The current Hospice to Home caseload including capacity to accept new patients.

- Our awareness list:
    - patients who are in the community and are unstable and may need more frequent discussion / intervention.
    - patients for whom a request for admission to the bedded unit has been made.

When a request is made for admission to our bedded unit, the team members present at each Capacity Meeting will consider requests in the context of the following 4 categories:

1. **Accepted for admission today.**
   We have all the information we need and have made the decision to prioritise admission for today. Our team will be in touch for a final Doctor to Doctor and Nursing handover (see below)
2. **Accepted pending further information.**
   We don't yet have enough information about the patient's need and current status to be able to make a clinical decision to admit. Our team will be in touch to gain further information that will help with the decision to admit and when this might happen. Depending on those further conversations the patient may or may not be accepted for admission. Where admission is agreed, we may occasionally be able to admit the patient later the same day. If we are unable to admit that day, the patient will be discussed at the next scheduled Capacity Meeting
3. **Accepted in principle but the acuity of the current caseload means transfer today is not possible.**
   We have all the information we need and have made the decision to admit but because of the acuity of our existing patient caseload when balanced with the needs of the new patient, we are unable to admit today.
4. **Accepted in principle but we have no available bed.**
   We have all the information we need and have made the decision to admit but all 7 of our beds are currently occupied.

If you contact us during the day to discuss a transfer, we may be able to arrange transfer immediately if we have all the information we need and have capacity to admit. If we are unable to admit straightaway, we will discuss the patient at the next scheduled Capacity meeting.

We use a system called SafeCare which includes the following patient descriptors adapted from the Phase of Illness outcome measure. These descriptors, along with a selection of additional tasks, build a shift demand which we then measure against our available staff for each shift. The outcome is a utilisation score which we use to help guide and support our discussions about admissions.

When the utilisation score is high, we have to consider the safety of further admissions especially if we are not able to draw in additional staff to increase the staff : patient ratio. On occasion therefore we may not be able to admit a patient until the acuity score changes.

SafeCare Descriptors

Level of Care	Acuity Guidance
1	*Admission / Discharge / Death* *Removed as a separate level as these activities can be added to any patient level as a task with associated multipliers*
2	STABLE • Patient problems and symptoms are adequately controlled by established plan of care • Further interventions to maintain symptom control and quality of life have been planned • Family/carer situation is relatively stable and no new issues are apparent
3	DYING Death is likely within days • Unconscious • Semi-conscious • Immobile • No diet or fluid intake • Altered breathing pattern and secretions • Family aware of impending death and are requiring minimal emotional support
4	DETERIORATING The care plan is addressing anticipated needs but requires periodic review because: • Patient's overall functional status is declining ie. change in mobility or consciousness is beginning to fluctuate, sleeping more • Patient experiences a gradual worsening of existing problem ie. reduced diet and fluids considering dex • Patient experiences a new but anticipated problem ie. difficulty in swallowing, new medication to control new symptom ie. oral thrush • Family/carers experience gradual worsening distress that impacts on the patient care
5	UNSTABLE An urgent change in the plan of care or emergency treatment is required because: • Patient experiences a new problem that was not anticipated in the existing plan of care • Patient experiences a rapid increase in the severity of a current problem ie requiring stat doses, escalation of drugs • Family/carers circumstances change suddenly impacting on patient care
6	REQUIRES 1:1 CARE Patients requiring 1:1 care

As soon as you think a patient needs to be considered for transfer to our inpatient unit, we recommend you start completing the Transfer Checklist. This will support you with the referral process and enable you to keep a record of where the referral process has progressed to, allowing the process to be expedited by multiple staff over several shifts if necessary.

It is important that you complete the checklist actions prior to transfer. This will ensure we have all the information we need to be able to make a decision about your patient. If you have any concerns, queries or actions that cannot be completed, speak to the Hospice Team using the contact numbers above.

Sample Checklist

Task	Details
Before the hospice has agreed to accept the patient for admission	
Discuss care options with the key staff involved in the patients care at the hospital	- Consider discharge plans and options – home, care home, hospice - Think about where the patient is in their journey, what is their prognosis – days, days to short weeks; weeks to short months etc - Have the team used any prognostic indicators or patient outcome measures to assess level of need e.g. GSF or OACC
Discuss transfer with the patient and family	- Does the patient have an ACP - Does the patient have a TEP form - Have they expressed a preference about their preferred place or care and preferred place of death - What issues, problems, symptoms has the patient identified that the hospice might be able to help with?
Once the team has decided to request admission	
Make a referral to the Hospice	- Call our Healthcare professional advice line **01271 347214** to request referral to our Inpatient Unit. Information our doctor will need: • Medical history • Specific information regarding recent falls/confusion • Oxygen requirements • Infection status - any potential infectious conditions (check if any pre-admission infection screening required) - This discussion will either lead to a decision to admit today OR place the patient on our Awareness List for discussion at the next scheduled Capacity Meeting (see above)
Nursing Team to start nursing handover and discharge paperwork	- Use our Nursing handover Guide below to help you gather all the information we will need for transfer - If you want to discuss the patient, please feel free to call our nurses on 01271 347214 - If things change with the patient's condition, remember to update your information prior to handover
Start the process of arranging TTAs	- The patient may need to bring some TTAs with them on transfer, check with Hospice nurse/doctor prior to requesting from pharmacy so as not to delay transfer (NB: most syringe driver and 'anticipatory' medications are standard hospice stock and will not be required). - As TTAs may take a while to arrange it might be worth considering commencing your paperwork after your initial referral discussion if admission is being considered.
Inform Family	- Advise the patient and family that you have requested admission. - It may be helpful to explain that our team discuss requests each day but that sometimes we can't always admit immediately.

	- Reassure them that we will keep you informed so you can update them about plans.
Once admission is accepted (see categories above). The next bullet points relate to category 1 only	
Our team will contact you to confirm arrangements and take a final handover - see Nursing Handover guide below	
Arrange transport	- The patient should be transferred as soon as possible, ideally to reach hospice by early afternoon. - If the patient has not departed the ward by 2pm then the discharge co-ordinator should liaise with the Hospice team.
Finalise your request for limited TTAs	- TTA section of discharge summary should still be completed by ward team, and reviewed by ward pharmacist, even if no medications need to be sent.
Complete discharge summary	- Before discharge, a copy of the discharge summary should be completed as per usual discharge process
Package and send any paper-based notes	- Any relevant physical documentation should be sent with the patient (The hospice team have read-only access to EPIC).
FOR TRANSFERS DIRECT FROM THE EMERGENCY DEPARTMENT	
Contact our Team	If the patient has arrived in ED but you feel transfer to the hospice is clinically indicated, please contact our team as soon as possible to discuss the possibility of transfer** We can consider admission if we have capacity as long as: • The patient / family has consented to transfer. • All reversible causes have been considered and managed or • It has been discussed and agreed with the patient that further acute treatment is not clinical indicated. • You are able to provide a clinical background to the case. This is especially important if the patient is not already known to the hospice. We are unlikely to be able to agree to immediate transfer if the patient arrives in ED after 3pm but after discussion we may be able to agree to transfer the following morning.

** Occasionally a Paramedic team may contact the hospice direct from a patient's home. If possible, we may be able to:

- offer advice that allows the patient to remain at home without further intervention.
- Mobilise our Hospice to Home service to respond rapidly to provide care, allowing the paramedic to leave and the patient to remain at home.
- Admit the patient direct to the inpatient unit.

As with any referral, we will only be able to admit the patient direct from home if we have enough information to make a decision to admit, have ruled out any reversible causes that need addressing in an acute setting and have capacity to admit.

The checklist can be found here:

https://www.northdevonhospice.org.uk/health-professionals/our-services-and-making-a-referral/

Nursing Handover Guide

We recommend you start collating a nursing handover as soon as the patient is referred for transfer as we will use some of this information to make the final decision regarding transfer. Once we have agreed to transfer the patient our team will be in touch to get an update on the patient to ensure a seamless transfer for the patient and to allow us to continue to deliver high quality and safe care.

This guide outlines the areas of care that are important for us to understand. You do need to complete a form, but when you discuss the patient over the telephone, it will help if you are able to share information about each aspect of the patient's condition and care.

Aspect of Care	Sort of information that's helpful	Why we need this
Symptoms	What are the symptoms that have been unstable over the last few days	To enable us to get on top of any symptoms quickly once the patient has arrived
Allergies	Allergies to medication & food	To enable us to have a drug chart ready as soon as possible and to provide food and drink quickly once they arrive
Mobility	How many staff to mobilise, equipment or aids required	To make sure we have the appropriate staff level, equipment and aids ready
Personal Hygiene and dressing	Support required to wash and dress; staff support and equipment	To make sure we have the appropriate staff level, equipment and aids ready
Falls risk.	Have they had any recent falls, how many and when	To make decisions about which room to allocate the patient, some of our rooms are more visible to the clinical office than others
Agitation / confusion	Has there been any confusion or agitation over the last few days, how has this been managed	To make sure we have the appropriate staffing level to meet patient needs
Mental Capacity Assessment	Does the patient have capacity to make decisions around their care and treatment? Do they require any help with decision making, and who from? Has a mental capacity assessment been completed, or any details of any best interest decisions already made.	To help promote patient choice and plan care in the least restrictive way if the patient lacks capacity. Identifies who we need to involve in clerking on arrival and decisions in care planning
Skin Integrity	Skin integrity at point of transfer Pressure prevention care already in place/ needed. Any pressure ulcers, category and treatment plan	It's a registration requirement that we track all pressure ulcers and demonstrate that all preventative care have been put in place – even if they have come to us from somewhere else

	Any wounds and treatment plan If they have any dressings - date dressing changes due and when last completed	Removing some dressing too soon can be detrimental to skin healing – having a change date means we are continuing with your planned care
Eating & Drinking	Are there any swallowing issues? Do they have a IDDSI level, or any special requirements	Helps us make sure we are safe in what food and drink we are providing
Elimination	Date bowels last opened Constipation/diarrhoea intervention details and date Catheter details, date of insertion and rationale for insertion Continence issues	To appropriately assessment bowel function, ensure patient comfort as soon as they arrive and to continue with your plan of care
Infection	Infection status at time of transfer Results of any pre-admission infection screening required	To enable to us to anticipate infection prevention & control measures that may be required
Medication	All current medications including syringe driver medications. Syringe driver due time on day of transfer. Confirm any TTAs being sent with the patient.	We have a small stock of drugs – we need to check we have the necessary drugs in stock. We can anticipate the change of syringe driver so the patient isn't left without vital medication. If we need you to order any TTAS, this should have been agreed at the point of referral
Family /friends, social situation:	Who has been visiting, who does the patient consider their most important contact, has anyone been particularly involved, or needed emotional support?	So that our teams can be ready to emotionally support the family as soon as they get here, involving our Supportive Care Services if needed
Safeguarding	Are there any safeguarding issues identified and what is the plan	So we can ensure the safety of the patient, our other patients and our staff
Advance Care Plan	Do they have a fully completed TEP form? Is there a stated preferred place of death? Is there a Lasting Power of Attorney?	So we can sure we are acting appropriately, within the law and in accordance with the patient's wishes
Transport	Type of transport planned. Time of collection from ward Send any notes with patient	To ensure our staff are ready to welcome the patient onto the unit and assist the patient with any transfer mobility needs as required

Although we have read access to EPIC we are not able to see all modules and therefore rely on a comprehensive handover to ensure safe transfer and a positive patient experience.

Useful resources

Hospice website – www.northdevonhospice.org.uk

Referral section of hospice website - https://www.northdevonhospice.org.uk/health-professionals/our-services-and-making-a-referral/

Hospice referral email – ndh.referrals@nhs.net

Hospice main telephone number – 01271 344248

Hospice Healthcare professional Helpline – 01271 347214

Hospice to Home direct telephone – 01271 347246