HammondCare Health Specialist Community Palliative Care Service Admission Criteria

Policy
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Next Review Date: 2025
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Portfolio Responsible: HammondCare Health
Version: 3.0

1. Purpose

To outline the admission criteria, scope of practice and referral process for the specialist community palliative care service (CPCS).

2. Scope

Health care professionals, patients and their family/carer requiring referral to the specialist community palliative care service within Northern Sydney Local Health Districts (NSLHD).

3. Background

The World Health Organization (WHO) defines palliative care as: 'An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'.

In alignment with the WHO definition, Palliative Care Australia (PCA) defines palliative care in the contemporary Australian context as: 'Person and family-centered care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life'.

4. Policy

4.1 Criteria for admission

- The patient's primary residence is in the geographical area of Northern Sydney Local Health District; **and**
- The patient is over the age of 18*; **and**
- The patient has a progressive life limiting or life-threatening illness (malignant and/or non-malignant); **and**
- The patient and/or substitute decision maker consents to referral to the service; **and**

One or more of the additional criteria below:

- The patient has complex symptoms that require specialist assessment and management.
- The patient and/or family/carer has complex emotional, psychosocial or spiritual needs related to the life-limiting diagnosis, impacting their care in the community, which require specialist multidisciplinary team (MDT) assessment and management.
- The primary care team and/or patient and care givers would benefit from support when undertaking complex future care planning.
- It would not be unexpected if the patient died in the next 12 months and the primary care team requires additional support and /or advice.

Palliative Care may be provided in collaboration following consultation with the Paediatric Palliative Care Service for patients under the age of 18.

4.2 Out of Scope of Service

Voluntary Assisted Dying (VAD):
HammondCare will not facilitate or participate in the process of VAD. We recognise that VAD is a process, not a specific act, and that we may be caring for patients at any time in this process and we will continue to provide care to these patients and their families/carers. We have put in place careful protocols and processes in relation to requests for VAD, and our team are trained in how to respond and will always do so with empathy and respect.

Alternative Service Providers:
Patients who are referred with needs that are more appropriately managed by alternative providers, such as disease specific supportive care models and/or aged care services, may fall outside the scope of our service ***(unless the patient is thought to be in the final 3 months of life)***. If the team receives a referral such as this, they will endeavour to direct and support the person to access the most appropriate support.

4.3 Referral Process

Referrals can be received from:

- General Practitioners (GPs)
- Acute and Sub-Acute Care Hospitals
- Residential Aged Care Facilities (RACFs)
- Community Health Services

- Nurse Practitioners
- Self-referral

***Specialist Palliative & Supportive Care Service Referral Form North* must be fully completed by referring clinician and faxed or emailed to service.**

Incomplete referrals will be returned to the referrer and may result in delay to commencement of service, and is required to include (where applicable):

- Copies of recent relevant specialist letters
- Copy of recent relevant diagnostics (e.g. scans and pathology results)
- Private Hospital Discharge Summaries
- GP Health summary
- Advance Care Plan
- Advance Care Directive
- Enduring Guardianship documentation
- Current medication list

*If the referral is **URGENT please call the Specialist Community Palliative Care Service on 1800 427 255** to provide a verbal telephone handover to the team.*

4.4 Triage

Urgency of care need is prioritised through equitable, efficient and transparent triage processes for patients referred to the CPCS.

- New referrals will be allocated to a primary specialist palliative care nurse.
- Initial phone contact will utilise Triage Tool RUN-PC to assess specialist palliative care need and guide how urgently the patient needs to be reviewed.
- Patients will be allocated at triage to either clinic or home assessment by the allocated nurse, nurse practitioner or medical staff according to need.

Note - contact with patient and/or family/carer will be attempted up to 3 times before the referrer is notified of the inability to contact the patient/family.

4.5 Admission Process

Following admission to service *(admission criteria met):*

- Primary nurse refers patients and/or their caregivers to the multidisciplinary team members as appropriate.
- Patients and/or caregivers are given and information pack.
- After Hours phone number is given to the patients and/or caregivers.

4.6 Medical Governance

The GP remains the principal medical care provider.

4.7 Shared Care

HammondCare works collaboratively with Northern Sydney Home Nursing Service to meet patient and caregiver needs in their preferred location.

Other shared care models exist with, but are not limited to the following teams:

- Sydney Children's Hospitals Network
- Specialist Chronic Disease teams *(Heart Failure, Renal Supportive Care, Liver Supportive Care)*

Shared care will be dependent on the patient/carers' needs at any given time within the disease trajectory. This seamless service is achieved by effective handovers and transfers between services with the client receiving the appropriate care at the appropriate time without duplicating services.

4.8 Settings of Care

- Personal residences, owned of rented.
- Residential aged care facilities, retirement villages and other communal living arrangements.
- Mobile homes, caravans, cars and other locations as appropriate for people who are experiencing homelessness.
- Group homes and other specialist accommodations for people with disability or mental illness.

4.9 Key Performance Indicators

- Palliative Care Outcomes Collaboration (PCOC) Data

5. Related Documents

- *Palliative Care Australia, Palliative Care Service Development Guidelines, January 2018*
- *NSW End of Life and Palliative Care Framework, 2019-24*
- *National Palliative Care Standards, 5th Edition 2018*
- *Run PC-Triage Tool*

5.1 HCH Policies

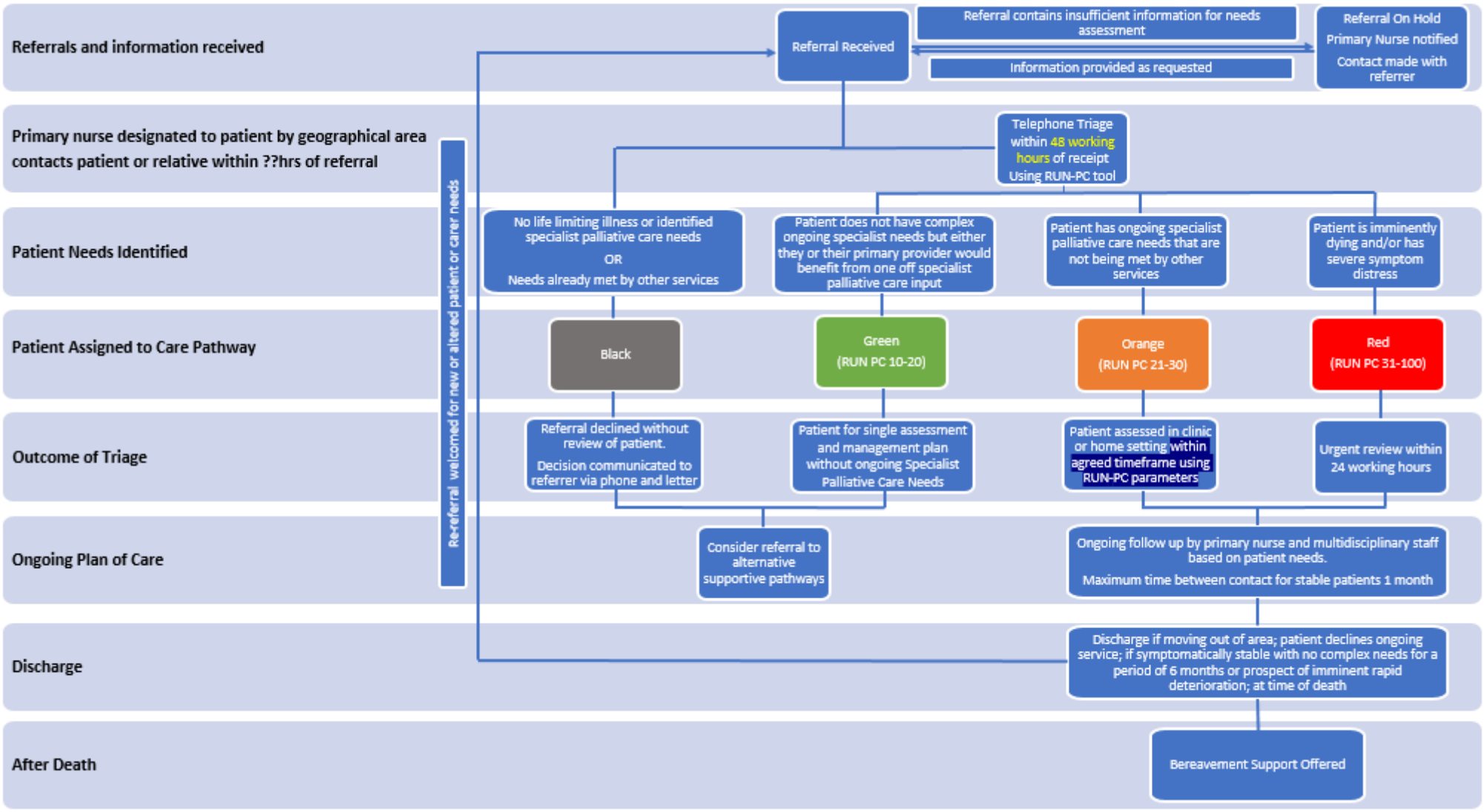
- *HCH Greenwich and Neringah Palliative Care Unit Admission Criteria*
- *HCH Safe Communication in the Community Palliative Care*
- *HCH Comprehensive Care Planning in the Community Palliative Care 2021*
- *HCH Community Discharge from Community Palliative Care 2022*

6. Consultation Groups

- HCH Community Palliative Care Staff
- Service Manager, Community Palliative Care
- Director of Nursing/Operations Manager, North
- Director of Palliative Care
- General Manager, Health and Palliative Care

7. Next Review

- 02/06/2025


Referrals and information received
Primary nurse designated to patient by geographical area contacts patient or relative within ??hrs of referral
Patient Needs Identified
Patient Assigned to Care Pathway
Outcome of Triage
Ongoing Plan of Care
Discharge
After Death
Re-referral welcomed for new or altered patient or carer needs
Referral Received
Referral contains insufficient information for needs assessment
Information provided as requested
Referral On Hold
Primary Nurse notified
Contact made with referrer
Telephone Triage within 48 working hours of receipt Using RUN-PC tool
No life limiting illness or identified specialist palliative care needs
OR
Needs already met by other services
Patient does not have complex ongoing specialist needs but either they or their primary provider would benefit from one off specialist palliative care input
Patient has ongoing specialist palliative care needs that are not being met by other services
Patient is imminently dying and/or has severe symptom distress
Black
Green
(RUN PC 10-20)
Orange
(RUN PC 21-30)
Red
(RUN PC 31-100)
Referral declined without review of patient.
Decision communicated to referrer via phone and letter
Patient for single assessment and management plan without ongoing Specialist Palliative Care Needs
Patient assessed in clinic or home setting within agreed timeframe using RUN-PC parameters
Urgent review within 24 working hours
Consider referral to alternative supportive pathways
Ongoing follow up by primary nurse and multidisciplinary staff based on patient needs.
Maximum time between contact for stable patients 1 month
Discharge if moving out of area; patient declines ongoing service; if symptomatically stable with no complex needs for a period of 6 months or prospect of imminent rapid deterioration; at time of death
Bereavement Support Offered