REFERRAL TO AND DISCHARGE FROM HOSPICE ISLE OF MAN

This policy applies to:

Clinical Staff	✓	**Non-Clinical Staff**	✓	**Volunteers**	✓	**Flexi-Bank Staff**	✓

Policy Title	Referral to and Discharge from Hospice Isle of Man
Originator	Clinical Director
Adapted from	Policy and Operational Procedure on Referrals to Hospice Care (IOM) (Clinical Core Standards Group, 2002)
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Who is Responsible for Review	Director of People & Care Services
Policy Ratified By	Operational Delivery Group
Related Policies/SOPs/Risk Assessments.	
Superceded documents	
Registration and Inspection (R&I) Standards	**Core standards for Independent Hospitals: 1, 2, 11** **Minimum Standards for Hospices: 1, 2, 3, 4, 5, 9, 10**

Where do I find this policy

Our People Policies		Clinical	✓
Keeping You Safe		Safeguarding	
How We Do Business		Operational	
Information Management & Security			

PURPOSE OF THIS POLICY

The purpose of this policy is to:

- Identify those patients for whom referral to Hospice IOM services would be appropriate
- Identify the principles of the referral process through which patients gain access to services provided by Hospice IOM

POLICY

This policy applies to all clinical staff employed by Hospice IOM and all adult patients referred to Hospice IOM. Referral to the children's service has different eligibility criteria and pathways (See Rebecca House Operational Policy).

PROCEDURE

1. Eligibility

For access to services the patient should fulfil the three criteria below:

1.1 **The patient has active and progressive disease.** Patients should have active and progressive disease where our focus of care is palliation of symptoms and quality of life.

This can be a malignancy (cancer) or a non-malignant condition such as heart failure, respiratory failure, renal failure or a progressive neurological condition.

1.2 **The patient has specialist palliative care needs.** Primary health care teams and hospital ward teams will continue to provide the bulk of general palliative care needed by most patients. Palliative care is a whole-person patient centred approach focusing on quality of life, respect for patient autonomy and choice, and encompasses both the patient and their family. The palliative care requirements of some patients will exceed the resources of the primary care teams and referral to specialist palliative care services provided by Hospice Isle of Man will be necessary to address issues which might be:

1.2.1 Physical – uncontrolled physical symptoms.
1.2.2 Psychological – uncontrolled anxiety or depression or other cognitive and behavioural issues.
1.2.3 Social – complex issues involving children, family, and carers, or complex issues relating to physical and human environment.
1.2.4 Spiritual – unresolved issues around self-worth, loss of meaning and hope, requests for euthanasia, or unresolved religious and cultural issues.

These issues should be identified by the referrer on the referral form.

The needs of the patient can be met by services provided by Hospice IOM and that Hospice IOM is the most appropriate agency to provide these services.

1.3 Referrals can be made by General Practitioners, Hospital Consultants, Clinical Nurse Specialists (including those working for the Older Person's Assessment Service), Long Term Conditions coordinators and Senior Allied Health Professionals.

1.4 In each case it is expected that the patient will have seen a specialist in the disease area for which they are referred. i.e. a respiratory physician in the case of respiratory failure or a cardiologist in the case of heart failure. A system of "shared care" will be in place so that their specialist teams (medical and clinical nurse specialist) remain involved even after referral and are available for advice.

2. Referral Procedure

2.1 An electronic Hospice referral form is to be fully completed for each referral, usually by the referrer. Forms which omit key points will be returned to the referrer.

2.2 Once a patient has been referred to Hospice IOM, and the referral has been accepted, a Hospice key worker will be identified. Following this any of the other services we offer can be provided for the patient without further recourse to the referring source. If there are doubts as to eligibility for Hospice services then the referral will be assessed by the Lead Clinician before committing services.

Patients in the Community

- This includes patients living at home, in nursing homes or residential homes.
- The GP has primary medical responsibility for these patients. In most cases the referral will come directly from the GP but in other cases our input will depend on achieving approval from the patient's GP for the intervention suggested.

In Patients in Hospital

- The Hospital Consultant has medical responsibility for patients under their care in the hospital.
- These patients can only be referred with the approval of the Consultant.

3. Initial Assessment

3.1 The Hospice Clinical Team will respond rapidly to requests for involvement with the speed of that response being determined by the clinical situation.

3.2 Patients will be assessed holistically either as an outpatient, in hospital or at their residence.

3.3 As part of the initial assessment the multidisciplinary team will assess the personal and cultural needs of the patient and carer.

4. Discharges

Criteria for Discharge – Regular caseload review will identify situations where discharging the patient from Hospice services may be appropriate. Discharge from Hospice IOM services may be considered in the following situations:

4.1 Where identified goals have been achieved, or problems resolved to an acceptable level for the patient.

4.2 Where a patient is no longer assessed as being likely to be in the last year of life.

4.3 Where the patient is declining further input at the present time.

4.4 Where another service is considered to be more appropriate to address the identified needs.

Discharge Procedure

4.5 Patients for whom discharge is being considered should have their details added to the agenda of the next multidisciplinary team meeting.

4.6 If the patient requires a home assessment this should be planned and completed in advance of the patient going home. Any equipment that is required at home should also be planned and in the home before the patient is discharged.

4.7 Arrangements for discharge, if possible, should be made with the agreement of the patient, involving carers where appropriate.

4.8 The member of the Hospice clinical staff making the discharge should inform the GP and other professionals involved with care of the discharge plan.

4.9 If the patient is being discharged to a care or residential home or going home with a care package, a Covid test should be carried out prior to discharge and recorded in the patient's medical records

4.10 The patient's details will then be removed from the Current Patient List.