

# Referral and Discharge Guidelines for Specialist Palliative Care (Hospital Based Services)

## What is Palliative Care?

Palliative care is provided by **all** health professionals, to be available wherever the patient is (be that in a community setting or an acute hospital) and delivered in a timely way throughout the course of a life limiting illness. A *Specialist* Palliative Care assessment should be available on the basis of **assessed need** rather than simply diagnosis or prognosis. Specialist Palliative Care is provided through accredited services by practitioners that work exclusively in the field of palliative care. It builds on the palliative care provided by generalists and/or the “primary clinical team” and reflects a higher level of expertise in complex symptom management, psychosocial support, grief and bereavement. Palliative care is best delivered through an integrated approach and recognises the roles and responsibilities of both palliative care generalists **and** specialists.<sup>1</sup>

## Referral to Specialist Palliative Care

A referral to **Specialist Palliative Care (SPC)** is appropriate for the direct management/support/advice of patients and families/whanau in situations where there are **complex** palliative care needs.

A referral to Specialist Palliative Care for “**complex need**” emphasizes that this is a level of need that **exceeds the resources of the generalist team and may be in any of the domains of care – physical, psychological, spiritual, social or intellectual.**

## A referral to SPC is appropriate when

- The patient has unrelieved physical symptoms relating to their illness
- The patient and/or family/whanau has unresolved psychological, social, spiritual or religious concerns
- The patient and/or family/whanau need additional support, reassurance or assistance during a period of crisis
- The patient has complex or distressing emotional or behavioral difficulties related to the illness.
- The patient has complex social issues involving children, family or carers (this may include the physical and/or human environment, finances, communication, learning disabilities etc).
- The patient has issues around self worth, loss of meaning and hope (may include requests for euthanasia, as well as other ethical dilemmas)
- The patient has symptoms that are difficult to manage in the context of advancing organ failure and/or medication delivery problems
- It is anticipated that the patient will have complex needs within the community setting on discharge from hospital that require SPC expertise around discharge planning

It should be noted that many patients may still be receiving active treatment for their underlying disease process; the Palliative Care Team will work alongside the referring team to ensure that both symptomatic management and support is maximized. On occasions a member of the SPC may be asked to assist with psychological/ emotional support for the primary clinical team (such as de-briefing) and this would be done on an as-needed basis.

<sup>1</sup>. New Zealand Palliative Care: A Working Definition (26.2.07)

## **Discharge from Specialist Palliative Care**

- The patient's needs (or those of the family/whanau) are adequately palliated and input from specialist services is no longer required. This includes those occasions where it is felt that the patient's needs would be best met by another service, OR
- The patient declines further treatment/ support, OR
- It is mutually agreed that further input would be of no benefit to the patient, OR
- The patient is deceased (unless the SPC team has a designated bereavement service)

A patient can be discharged from the SPC team if/when the patient's and/or family/whanau's needs have been met such that the primary clinical team can continue management.

Re-referrals to the SPC team can be made as often as needed.