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**Ashgate Hospice Palliative Care Specialist Nurse Team Referral Criteria**

**Please note the primary care team will remain the key workers for the patient. Once patient needs are assessed as stable (low complexity) by the Palliative Care Specialist Nurse team they will be discharged to their primary care team and/or signposted to another hospice service for ongoing support and management.**

1. Patients who are 18 and over and registered with a GP from NHS Derby and Derbyshire CCG (North Localities).
2. Have an active progressive advanced disease with a limited prognosis and the focus of care is palliative, rather than curative intent.
3. The patient has consented to:

a) The referral

b) Sharing clinical records/information

NB If the patient does not have capacity to consent then the referral must indicate that a decision has been made in the patients’ best interest according to the Mental Capacity Act. Please indicate who is acting as the patients advocate/main carer.

1. External referrals will only be accepted from Healthcare professionals.
2. The urgency of triage and response will be decided by Community Palliative Care Services based on the information provided. The referrer is required to complete the referral form fully. Any missing information on the referral form may lead to the referral being declined and delays in patient care.

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| Response 7 days 9-5 | Unstable | Deteriorating | Stable |
| High Complexity | Medium Complexity | Low complexity |
| 0-2 days | 3-10 days | 10-21 days |

1. Referrals will be accepted to the **Palliative Care Specialist Nurse Team** for the following:

**Complex symptoms**:

* Complex symptoms not responsive to first line treatment
* Complex opioid and adjuvant regimes
* Titration of medication in context of complex co-morbidities

**Complex Palliative Care Emergencies - where the focus of care is EOL and the treatment plan is not for escalation but to manage at home:**

* Acutely deteriorating patients
* Complex ethical decision making around such issues as sedation and assisted hydration and nutrition
* Seizure management
* Bowel obstruction
* Abdominal ascites
* Sepsis
* Spinal cord compression
* Airway obstruction
* Acute kidney injury not for dialysis
* Complications of diabetes treatment at EOL

**Complex home situations and advance care planning:**

* Complex care management and family needs requiring MDT approach
* Complex social issues, including risk from family or friends
* Complex palliative care needs impacting on psycho-social wellbeing
* Complex advance care planning such as ADRT, best interest, DOLs, and ReSPECT which require Palliative Care Specialist nurse input to facilitate ethical decision-making.