# Referral Criteria for St Leonards Hospice@Home Team

The following information provides guidance on which patients are likely to benefit from a referral to St Leonards Hospice@Home (H@H) team, and which patients are likely to be unsuitable. Informal discussion is encouraged to discuss uncertain situations and to agree appropriateness of these referrals before they are made.

- Referrals to the Hospice@Home service can be made through Single Point of Co-ordination (SPOC) via direct telephone contact (01904 777770).
- All referrals will be triaged by the Nurse in Charge, using a bespoke triage tool which is based on a validated suite of outcome measures.
- Depending on the urgency score and current caseload demands, an approximate time frame of response will be given to the referrer and contact will be made with the patient/family.
- All referrals, assessment and contacts will be clearly documented on SystmOne (S1), utilising the tasking function to communicate effectively between the necessary community services involved with the patient.
- Any healthcare professional involved in the patient care can refer to H@H. Any enquiries from patients/families regarding referrals will be directed back to their key worker.

**Referral Criteria**

All the below:

- Patients must be 18 years of age or above and have a life limiting condition.
- All referrals must be Fast Track funding eligible.
- Patients must consent to a referral being made to the Hospice@Home service or a Best Interests decision made on their behalf.
- Patients must be registered and assigned to the District Nursing service.
- The service is available to patients in their own home, inclusive of care homes and residential homes.
- All referrals must have an Australian Karnofsky Performance Score (AKPS) of 60% or below with a need for hands on personal care.

**Discharge from Hospice@Home team:**

Examples of reasons for discharge are detailed below:

- If the patient has a stable phase of illness or a prognosis longer than weeks and their needs can be met by an alternative service i.e, fast track care package.
- Its recognized prognosis is complex, so the use of a standardized discharge framework tool is used to guide decision making in uncertain situations.
- Patient condition or Karnofsky improves while in a stable phase of illness.
- Patient dies.
- Patient moves out of area.
- Patient declines service.
- Patient is referred to another team or agency.
- Unable to maintain a safe working environment for the H@H team.
- Patient admitted to Hospital/hospice/care home.

If discharge is appropriate, this will be discussed with the patient and family.

The patient's key worker/referrer will also be notified of the discharge from the H@H service.