# Specialist Palliative Care Services in Cornwall

## Referral Guidelines

Referrals will be accepted from any Health Care Professional provided the Patient, Carer and General Practitioner / Consultant are aware and in agreement with the referral to the service. It is important that the Patient / Carer are aware of the services that are available to them.

Referrals will be accepted for any patient over the age of 18 with cancer or any life limiting chronic progressive disease experiencing complex problems that are not responding to routine treatment and therapeutic intervention.

Referral can be made according to the following criteria:

- Those with severe, intractable complex symptoms that have persisted after palliative care by generalist.
- Those and their carers having difficulties in adjusting/coping with their disease, psychologically, spiritually or emotionally.
- Where information and explanation is required relating to the illness, treatment, care options and allied support services.
- Those experiencing difficulties in bereavement, who would benefit from specialist support / further psychological intervention.
- To assess the need for further specialist unit services or inpatient care.
- Health Care professionals who require specialist advice and support with case management.

Patients referred to the service should be identified on the Gold Standard Register or similar within their General Practice if their prognosis is a year or less.

## Discharge Guidelines

All patients and carers known to the service will be made aware that they may be discharged from under the teams care, but that they may also be re-referred again by any health care professional, themselves or carers, according to the above guidance, if their needs or circumstances change at any stage in the future. The needs of the patient will be reassessed in line with the guidelines above, and admission to hospice inpatient care will be determined according to clinical need.

**Reasons for discharge:**

- Patient / family more able to cope emotionally or receiving appropriate on-going support.
- Acute needs stabilized, care to be continued by the Primary Health Care Team or Acute Trust or other provider.
- Patient / family perceive they do not require intervention / support at the current time.
- The Specialist Palliative Care team agree that the service is not appropriate to meet the patient's needs (Referral to another service).
- Patient / carer moved out of the area
- The generalist clinicians feel confident to deliver care without specialist intervention.