

### **Introduction**

“Late referral, crisis referral, and in some instances non-referral of patients with a life-limiting illness to SPCS can significantly impact the quality of life of patients and their caregivers. Uncertainty regarding when to refer and the reasons to refer are also common amongst the general health professional community.” (Giris et al, 2006).

There is a need to identify the patients who will benefit most from specialist palliative care (SPC), identify patients who will benefit from additional support but who don't required SPC, ensure referral to SPC is offered in a timely manner. Patients with non-malignant as well as malignant disease progression should be assessed and their needs take into consideration. This will facilitate equity of access, taking into account that there are finite Palliative Care Service resources.

### **Triggers to consider Assessment and possibly referral to SPCS (refer to the LM Quick Reference Guide)**

- when a patient with a terminal illness, or significant others associated with the patient, have identified needs that are not being adequately addressed by current services
- for patients who present with metastatic malignancies, recurrent or locally extensive disease, deterioration of non-malignant conditions
- in need of complex and rapidly changeable symptom management
- where there is relapse, resistant or refractory disease

### **Assessment prior to referral**

Aim of any assessment is to assist primary care services (GPs, community nurses, allied health professionals, etc) whose primary work is not in palliative care, to objectively determine whether current services and support are adequately meeting the needs of individual patients and their families.

Use of the Needs Assessment Tool: Progressive Disease (NAT:PD) or similar tool (Giris et al, 2006), provides a means to determine if:

- there are unmet complex needs that cannot be managed by current care providers,
- there are unmet needs that could be managed by new care providers
- there are unmet needs that could be managed by increasing support by existing care providers
- there are no unmet needs and current care provision is adequate

Access to the Needs Assessment Tool: Progressive Disease (NAT:PD) and the accompanying Guidelines are available online at <http://www.newcastle.edu.au/research-centre/cherp/professional-resources/>

### **If not referred – what??**

If referral to SPCS is not appropriate, information can still be given to the patient and family about the SPCS for future reference (e.g. “What is Palliative Care?” brochure from PCV <http://pallcare.org.au>; local Palliative Care service brochure).

The assessment may indicate the need to refer for additional support from primary care services, or may indicate benefit of reassessment at various points throughout the patient's illness as their condition changes. It may also identify areas of strength and resilience of the patient and carer.

### **Criteria for Referral (demonstrated need for SPCS)**

Local SPCS may have specific criteria for admission that you may need to be aware of. Patients referred to the Specialist Palliative Care Service will have an advanced, progressive disease, where the focus of care has changed from curative to palliative and the prognosis is limited. Some patients who have complex specialist needs will benefit from being referred at an earlier stage, from diagnosis onwards. The referrer must include information to confirm that their assessment has indicated a demonstrated need for SPCS involvement e.g. copy of assessment forwarded with referral; indicate in text “identified significant carer difficulty in providing physical care”.

Common criteria will include:

- referral from any member of the care team, or the patient/family themselves
- awareness and consent of the patient for the referral to be forwarded
- complex physical symptom management (pain, nausea, dyspnoea, fatigue etc)
- complex psychosocial and spiritual needs of the patient and/or family or carer
- terminal care and support if the patient wishes to remain at home

### **Determine Urgency**

All referrals should indicate the urgency (low, routine, urgent) and those identified as “Urgent” should include information indicating reason that urgent assessment is required. This allows the SPCS to prioritise their assessment and interventions. Urgency should be triggered when:

- there are physical or psychological symptoms causing distress that are not responding to current management or interventions
- the patient’s condition is deteriorating rapidly.

### **Communication between SPCS and Primary Care Services**

As with any complex service provision there is a need for communication and coordination to prevent duplication of services, and to ensure all needs are met. There are many ways for communication to occur, on an informal basis, or formally arranged. These may include:

- support plan that includes all services and support of family & friends
- regular meetings or phone contact between service providers
- electronic communications when changes in need identified
- Case Conferencing (all services plus patient and family)

With either formal or informal communications, there should be triggers to identify when additional information sharing is required (e.g. when condition has changed significantly, when current support is no longer required).

### **Discharge from SPCS**

As needs change over time, there will be a proportion of patients who have required support from the SPCS who no longer require this level of support. This will mean that patients will be reassessed and discharged if their condition stabilises, and adequate support can be provided by other services. This may be when:

- Investigations reveal less advanced disease than previously thought
- There has been a positive response to treatment (patient now in remission)
- Disease evident is only slowly progressive (condition is stable over a period of time)
- Symptoms have improved and manageable without continued SPCS intervention
- Assessment by the SPCS has identified that needs are more appropriately met by other service providers
- the patient is competent to make decisions and requests no further input from the SPCS
- the patient or carer is reluctant to allow effective SPCS input

### **References**

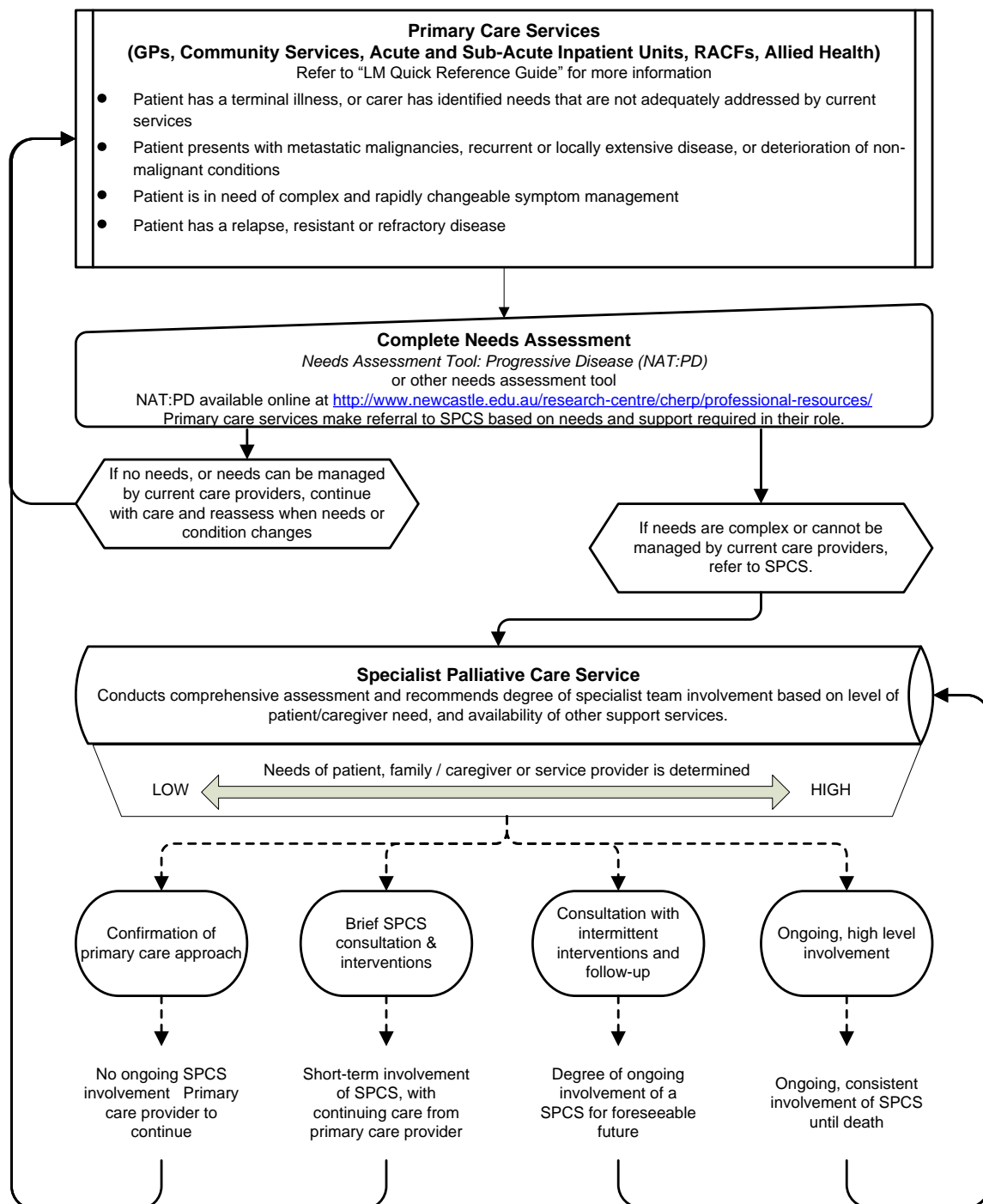
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Adaption of "Figure 1- Model for needs-based assessment and triage to appropriate level of palliative care service involvement" from Giris et al, 2006)