



St Benedict's  
HOSPICE

# **ST BENEDICT'S HOSPICE**

Specialist Palliative Care Team

Palliative Care Service Profile  
& Referral Pathways



**SUNDERLAND TEACHING PRIMARY CARE TRUST**  
**ST BENEDICT'S HOSPICE PALLIATIVE CARE SERVICE**

Palliative care aims to provide relief from suffering and improve the quality of life for both patients and their families. It takes a holistic approach, acknowledging that suffering is more than physical distress, and recognising that the patient requires a combination of physical, psychological, social and spiritual care.

Palliative care is delivered by two distinct categories of health and social care professionals;

1. The patient and families usual carers i.e. district nurse, GP.  
This level of care can be described as general palliative care. It is a vital and integral part of everyday clinical practice
2. Professional carers who specialise in Palliative Care.  
Specialist palliative care services are provided for patients and their families where there is a moderate to high complexity of need. The services provided at St Benedict's Hospice fall into this category.

The palliative care team provide a service to the population of Sunderland and some bordering localities.

Patients may be referred to the service with a malignant disease or with progressive illness where the prognosis is limited and the focus of care is on the quality of life.

Referral will be with the full knowledge and agreement of the patient, doctor, and nurse in charge of the team undertaking the patients care and management.

Palliative Care Services include:

- 1 St Benedict's Hospice inpatient unit
- 2 St Benedict's Hospice day care services
- 3 24 Hour Advice Line
- 4 Specialist Nursing Service
- 5 Lymphoedema Service
- 6 Outpatient Clinics (Consultant)
- 7 Domiciliary Visits (Consultant)
- 8 Out of Hours Palliative Care Nursing Service

## ST BENEDICT'S HOSPICE INPATIENT UNIT

St Benedict's Hospice has up to 12 inpatient beds offering Specialist Palliative Care.

We aim to provide an environment where the principles of holistic care can be applied, with equal emphasis on physical, psycho/social and spiritual needs. This care is available for both patients and their carers.

The inpatient unit is a specialist unit, providing active treatment for the management of pain and other symptoms as well as respite and terminal care. We aim to discharge our patients back into the community where appropriate. We are unable to provide continuing long term inpatient care.

The hospice does not normally admit after 5 pm or at weekends as there are no medical personnel on site at these times.

### **Referrals may be made by:-**

- Hospital Consultant,
- Specialist Palliative Care Nurses and Cancer Site Specific Nurse (Sunderland Royal Hospital).
- General Practitioner/District Nurse with GP consent
- Out of Hours Palliative Care Team
- Named nurse from acute services with the consent of the consultant in charge of the care

Referrals may be made in writing or by telephone to the Hospice Team

Tel: 0191 5699195. Faxes are acceptable using the designated form to 0191 5699649/ 49649.

### **Referral Criteria for Inpatient Care**

Patients who are referred for inpatient care will have any of the following care needs

- Physical i.e. symptom relief, specialist nursing care, terminal care
- Psychosocial i.e. opportunity to explore and deal with problems and fears; practical help with social/financial problems
- Planned Respite Care in Chronic Progressive Disease i.e. Patients with chronic progressive disease e.g. Multiple Sclerosis, Motor Neurone

Disease, who would benefit from respite care in the Hospice inpatient area are offered:-

1. An admission for up to 2 weeks' duration
2. Up to 4 admissions a year

3. No more than 1 patient requiring respite care can be admitted at one time
4. Notice of admission is required - preferably at least one month and will be arranged at the convenience of the family and the hospice team.

- Urgent Respite for family/carer relief

The provision of non specialist palliative care in these circumstances is available at a local nursing home. This service should be explored as a first option, if this is unavailable then St Benedict's can admit.

In order to enable families/carers to continue care of their family member/relative at home the hospice inpatient area can offer an admission of up to 2 weeks duration (should a bed be available).

This admission would be on the understanding that support (including District Nursing and Social Services support) will recommence on discharge from the hospice.

- Clinical Procedures

The following clinical procedures may be carried out as part of specialist palliative care management plan (i.e. not long-term and not for diagnostic purposes):-

- Blood Transfusion
- Abdominal Paracentesis
- Pleural Tap
- Treatment of Hypercalcaemia
- IV Bisphosphonates (for bone pain)

### **Waiting list policy/ allocation of beds**

All referrals to this service are discussed in a multidisciplinary meeting at 9am daily Monday – Friday and priority determined. If beds are available patients will be admitted as soon as transport can be arranged.

If a bed is not available then a waiting list operates and allocation of beds are determined on priority of clinical need.

Referrals made after the daily meeting, if considered a priority, can be admitted the same day if a bed is available.

### **Arranging admission**

Once the referrer has been made aware that a bed is available, it is the responsibility of the GP/ referring ward to book the ambulance.

Routine admission should be arranged for arrival at St Benedict's Hospice ideally between 10-11 am

**ST BENEDICT'S HOSPICE**  
Specialist Palliative Care In Patient Referral

<p><b>REFERRAL:</b></p> <p>Date and time:</p> <p>Taken by:</p>	<p>Referred from: <i>(name and address of referrer)</i></p>  <p><i>(note any other key professionals)</i></p>
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<b>PATIENT DETAILS:</b>		
Surname:	First name:	Title:
Home address:		Sex: Male / Female
		Marital status:
Telephone:		Date of birth:
Current location (if different):		NHS no:
		Unit no:

<b>CLINICAL DETAILS:</b> <i>(including diagnosis, reason for referral and urgency of referral)</i>
<i>(Continue overleaf if necessary with further information or follow-up messages)</i>

<b>CATEGORY OF REFERRAL:</b> <i>(tick one)</i>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient (symptom control)	Inpatient (respite)	Domiciliary	Outpatient	Ward visit
.....REFER TO WARD WAITING LIST.....		.....REFER TO CONSULTANT SECRETARY.....		

<b>ACTION:</b>	
Date put on IP waiting list:	Date for domiciliary visit:
Date for admission:	Date for outpatient clinic:
Date removed from waiting list: <i>(note reasons overleaf)</i>	Date for ward visit:

Further information:

**Further details for HISS system**

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Next of Kin:

Address:

Tel No:

G.P.

Address:

**PLEASE FAX THIS REFERRAL TO: 0191 5699649**

## **ST BENEDICT'S HOSPICE DAY CARE SERVICES**

St Benedict's Hospice has facilities to provide up to 12 places daily Monday - Friday (excluding Bank Holidays) The unit has nursing, medical, PAM and volunteer staff.

The purpose of day care is to focus upon the individual's quality of life through the provision of a wide range of supporting services. Our aim is to maximise and promote independence to enable the patient to remain at home. Patients referred to the service will have an identified need for one or more of the following:

- Psychosocial support e.g. those having difficulty in dealing with the knowledge of diagnosis/prognosis, those with housing, personal, family issues
- Those who need social contact with people in a similar situation-social respite
- Family respite
- On-going supportive care for patients discharged home from the inpatient unit
- Active rehabilitation
- Medical Review
- Supportive interventions i.e. blood transfusions, zoledronic acid etc
- Complementary therapies
- Diversional therapies

### **Referrals may be made by:-**

- Hospital Consultant
- Specialist Palliative Care Nurse Team
- Cancer Site Specific Nurses (Sunderland Royal Hospital) following assessment of the patient and with the agreement of Consultant)
- General Practitioner/District Nurse
- Hospice Team
- Named Nurse Acute Services

Referrals may be made by telephone to the nursing staff in Day Care on tel. 0191 5410031

### **Criteria for Day Care**

Patients referred for day care must meet the following criteria:

- Be diagnosed with a progressive disease which cannot be cured
- Be well enough to travel from home to day care unit in a taxi provided. (NB the taxi drivers are only able to perform limited moving and handling).
- Be aware of diagnosis and referral

## ST BENEDICT'S HOSPICE - 24 HOUR ADVICE LINE

The purpose of the 24 hour advice line is to provide specialist advice to any health care professionals, patients and carers requiring help and information regarding palliative care issues

**TEL: 0191 5699195**

### **Contacting the advice line**

- Contact the above telephone number and provide the hospice nurse with background information i.e. patient's details/problems and telephone contact number.
- The nurse will then contact the Doctor on call and agree action plan.
- You will then be called back by a member of the Palliative Care Team as soon as possible with this information.
- A record will be kept of the enquiry and be the subject of team discussion, in order to provide educational and administrative/service information.

## **ST BENEDICT'S HOSPICE MACMILLAN SPECIALIST PALLIATIVE CARE NURSING TEAM**

The specialist palliative care nurses work to improve the quality of life of people with cancer and other progressive diseases. The role of the team is to provide specialist advice and support to patients, carers, and healthcare professionals across primary and secondary care when the patient's symptoms and carers issues become more complex.

The specialist palliative care nursing team are part of a wider service within Sunderland Teaching Primary Care Trust. They are based at St Benedict's Hospice and within Sunderland Royal Hospital.

The service is available from Monday to Friday 8.30 am to 5.00 pm. The teams are not available on Bank Holidays. Any advice outside of these hours can be accessed via St Benedict's Hospice on tel. 5699195 or internal ext. 49195.

The community team comprises of five nurses who are geographically linked to GP practices across the city. They can be contacted on ext 48304, 49748 or 49986. The team are also contactable via bleep or mobile phone via switchboard.

There are 2 specialist nurses available at Sunderland Royal Hospital contactable on ext 47337 or via bleep 52437 or 52388.

Either team can involve palliative care medical staff for advice or hands-on care at home or in SRH.

Changes in a patient's treatment, be it at the suggestion of the Dr or the nurse, will only be made in consultation with the referring GP/consultant.

### **Referrals can be made by;**

- GP
- District nurse
- Hospital Consultant
- Named nurse
- Specialist nurse
- Any member of the specialist palliative care team

Referrals should be made by faxing the designated referral form or SAP1a and 1b (ensuring that any additional information is included) to

**0191 5699253 for community referrals**

**47399 for hospital referrals**

Please note referral forms do not need to be completed when advice only is required.

Once a referral has been received the team will aim to respond / make contact within one working day.

**Referral criteria:**

- The patient should be aged 16 years and above
- The patient should be aware of the referral and consent to such
- The patient must be aware of their diagnosis
- There should be permission of the consultant/GP

The team recognise that the service they provide is complementary to the care you provide to your patient and families and therefore our aims are to

1. Receive referrals for patients with specialist palliative care needs when symptoms become a problem to manage e.g.
  - Uncontrolled pain
  - Nausea and vomiting
  - Constipation
  - Unacceptable side effects of drugs etc
  - Psychological support
  - End of life care

The specialist nurse will visit the patient, make an assessment, and offer advice regarding an appropriate plan of care and review as necessary.

2. Offer advice either by telephone or face to face when a referral or patient assessment is not required e.g. advice on drug conversion, alternative drugs to manage symptoms etc.
3. Through effective training and education equip those caring for people with palliative care needs with the necessary knowledge skill and competence to provide a high quality service.
4. Will initiate and advise on referral to other supporting palliative care services e.g. hospice inpatient unit, day care, medical palliative care review.
5. Work collaboratively with multi professional teams to ensure practice is efficient, effective and evidence based.
6. To ensure adequate and appropriate information is available for service users.

**SPECIALIST PALLIATIVE CARE NURSING SERVICE**

**REFERRAL FORM**

CONSULTANT / GP MUST BE AWARE OF REFERRAL,  
PLEASE CONFIRM:

YES  NO

**THIS REFERRAL IS ASSUMED TO ENTITLE ANY MEMBER OF THE  
PALLIATIVE CARE TEAM TO SEE PATIENT**

**HOSPITAL - FAX THIS REFERRAL ON: 47399**

**COMMUNITY - FAX THIS REFERRAL ON : 0191 5699253/ internal 49253**

Patient's consent to Palliative Care Team involvement:

YES  NO

Referral date ..... Referred by .....

Designation ..... Tel No .....

**PATIENT DETAILS**

Name: ..... D.O.B. ....

Unit No: ..... NHS No .....

Address .....

Post Code ..... Tel No .....

Ethnic origin ..... Interpreter required: YES  NO

If Yes specify .....

Patient's carer / Next of kin .....

Relationship .....

Address ..... Tel No .....

General Practitioner ..... Tel No .....

Consultant ..... Hospital .....

Consultant ..... Hospital .....

**Services involved with the patient:**

District Nurse ..... Social Services .....

Other .....

***Please turn over and complete the other side***

**Medical Information:**



Lymphoedema is a chronic condition which causes swelling of limbs i.e. is primarily caused by damage to or immaturity of the lymph vessels.

The lymphoedema clinic is a nurse led service located within Monkwearmouth hospital providing support, advice and treatment to patients suffering from primary or secondary lymphoedema. It recommended that patients have an initial medical screening to rule out other possible causes of oedema before referral to the lymphoedema clinic. While medical assessment cannot be undertaken, medical advice from hospice staff is available and treatment changes implemented, but only in consultation with the referring Dr.

### **Referral to the clinic**

Referrals must be made in writing and can be sent or faxed to 0191 5699253

Referrals can be received from:

- GPs
- Hospital Consultants
- Hospice Team/specialist palliative care nurses with consultant consent

### **Criteria for referral to include any one of the following**

Swelling of a limb which:

- has been present for 3 months or more in a patient who has had treatment for malignancy i.e. node dissection, radiotherapy
- does not reduce with rest or diuretic therapy and is firm and non pitting in nature
- has been present since birth/childhood
- following investigation rules out venous/arterial compromise and demonstrates lymphatic compromise

**Or** Swelling of face, trunk or genitalia

### **What NOT to refer**

There is very little we can do to improve in the following conditions other than skin care which is best managed in the community.

- Dependency oedema
- Venous oedema

Where the patient experiences the following the cause is likely to be something other than lymphoedema

- Rapid onset of swelling
- Hot limb
- Soft and pitting
- Ulcerated

### **Waiting list**

We aim to see all patients with secondary lymphoedema referred for an initial assessment within 4 weeks of receiving the request, 16 weeks for primary lymphoedema. Once the referral letter has been received, the date will be recorded. Patients will be selected to attend the clinic in data order unless it is considered a clinical priority. Palliative patients will be seen within 7 days.

The lymphoedema receptionist will contact the patient by telephone in order to let the patient know we have received the referral and give appropriate information of waiting time for assessment.

### **Communication**

Patients will receive information leaflets and will be provided with relevant educational material to assist them with their daily management programmes. Contact name and telephone numbers in case of queries/concerns will be provided.

A letter will be sent to the referrer following the initial assessment visit informing them of the care provided, planned and advice given. Updates of care will be sent as appropriate.

### **Assessment visit**

A comprehensive assessment will be carried out for every patient by the Lymphoedema Nurse Specialist and if necessary by a member of the hospice medical team.

### **Home visits**

This will only take place with the consent of the GP, District Nurse and patient and only in instances when it is in the patient's best interest to be seen at home e.g. palliation, immobile, unable to travel.

### **Treatment plans available**

Maintenance Therapy The aim of maintenance is to provide long term control of a non complicated oedema based upon the principles of the 4 cornerstones of care (skincare, massage, exercise and containment)

Decongestive Lymphoedema Therapy This form of treatment package is offered to patients who have more complex oedemas, problems such as lymphorrhea volumes of above 40%, misshapen limbs. This involves a course of daily treatment which may include multi layer bandaging and manual lymph drainage.

Palliation This form of treatment package is appropriate for patients who are in the terminal phase of life where reduction of the limb may not be possible. The aim is to provide comfort and symptomatic relief.

Where possible the management of lymphoedema will be continued in primary care once the patient is on an established treatment pathway.

## **ST BENEDICT'S HOSPICE- CONSULTANT OUTPATIENT CLINICS**

An out-patient clinic is held each week at Monkwearmouth Hospital The clinic is led by a Consultant in Palliative Medicine and supported by a Palliative Care Specialist Nurse.

Referrals may be made to the clinics by:-

- General Practitioners
- Hospital Consultants
- Specialist Palliative Care Nurse Team

Out-patient clinic appointments may be made by referral letter or fax to St Benedict's Hospice on

**0191 5699253**

## **ST BENEDICTS HOSPICE DOMICILIARY VISITS**

On request from a General Practitioner, a home visit may be made by a Consultant in Palliative Medicine or another member of the medical team to a patient who, for some reason, finds it difficult to attend one of the out-patient clinics. Requests for a home visit should be made by the General Practitioner to medical staff at St Benedict's Hospice. If at all possible, domiciliary visits will be made within 2 working days.

## ST BENEDICT'S HOSPICE

### OVERNIGHT PALLIATIVE CARE NURSING SERVICE

The aim of the overnight palliative care nursing service is to enable patients to be cared for in their own homes by responding to and managing pain and other symptoms. They provide advice and support to the patient, carer and other professionals.

The out of hours Palliative care team are based at St Benedict's Hospice and are available from 10.30pm - 8am. Two Registered nurses will be on duty every night.

#### **Referrals can be made by**

- GP
- Primecare
- District nurse/ 24/7 team
- Patient
- Carer
- Marie Curie service
- A&E department at Sunderland Royal Hospital.
- Any member of the specialist palliative care team

Visits can be planned or in response to an urgent/crisis request

Referral to the service can be made by contacting the team via Sunderland Royal Hospital switchboard on 0191 5656256 bleep 52434 or mobile telephone: 07798 925128. Any information for the team should be faxed to 0191 5699649 / 49649

#### **Referral criteria**

- The service is available to all patients within Sunderland, aged 16 years and over, with advanced progressive disease.
- The service is not intended to be a substitute for a medical opinion when required or a domiciliary sitting service.
- Where possible there should be proactive management from district nursing and GPs to enable effective symptom management e.g. by ensuring prescription charts contain specific instruction PRN, increases in dose in response to specific symptoms and where appropriate sufficient supply of drugs.
- The district nursing team caring for patients whose GP wishes to look after their own patients out of hours should inform the overnight team of how to contact the GP.
- Those GP's who use the Primecare for out of hours provision should also leave specific instruction for managing their patient in the event that further drug treatment/dose adjustment is required.