PCNS Team Referral Criteria

The Palliative Care Nurse Specialist (PCNS) service is a specialist level palliative care (SLPC) service. The focus of SLPC is to improve quality of life for people with progressive life-limiting illness and meeting unresolved needs that cannot be met by their core care team. These needs may be physical, psychological, social and/or religious or spiritual. Examples include complex symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions.

Taking this into account, the Katharine House PCNS service will accept referrals for patients with **progressive life limiting diseases (from which they are not expected to recover)**

AND

Has one or more of the following:

- Pain - uncontrolled by simple analgesia or first line strong opioid and/or first line adjuvant
- Other physical symptom(s) uncontrolled by first line drug treatment
- Support with complex advance care planning
- Psychological distress beyond a normal reaction to bad news
- Dying - complicated by complex care needs, psychological, social or spiritual distress in patient or family

Prioritisation of Referrals

The community PCNS Team cannot provide an emergency response; where this is required the referrer is advised to call 999.

The Katharine House Advice Line will triage and prioritise referrals daily, 7 days per week, allocating a response time of 24 hours, 72 hours (3 working days) or 10 working days as appropriate. Advice and intervention may be given during the triage process.

Please bear in mind we can only make a decision based on the information supplied to us.

Outcome of Referrals

Intervention by the team will be at one of four levels:

- **Level 1 –** Advice and Information is offered to professional colleagues directly by the
- team. The team will make no contact with patient.
- **Level 2 –** The team will undertake a specialist assessment and provide advice to professionals and / or patient / carers accordingly. Such visits will be single consultations and may include sign posting to other services for ongoing support.
- **Level 3** – The PCNS team devises a short-term package of interventions with the patient or family when specific problems or needs require several visits. The intention is then to withdraw and make Open Access. Re-activation on to caseload may be made as necessary.
- **Level 4** – The PCNS team makes multiple interventions. On-going or complex problems requiring regular specialist assessment, care planning, / intervention delivery, have been identified.

Once discharged, patients may be re-referred as their needs change, without the need for another referral form.

In all cases, we would assume that the patient has been referred to community nursing services to ensure access to 24 hour support and general palliative nursing care.