Eligibility Criteria for Access to Specialist Palliative Care Services

All people with palliative care needs should have access to an appropriate level of care, regardless of their prognosis, diagnosis or where they are located.

1. Eligibility criteria for access to the Specialist Palliative Care (SPC) Services provided by Hospice Marlborough

People who:

1. Have a progressive, life-limiting condition
   AND
2. Have current or anticipated complexities relating to symptom control, end of life care planning or other physical, psychosocial or spiritual needs that cannot be met by primary palliative care provider(s)
   AND
3. Agree (or an advocate agrees if not person not competent to do so) to the referral to SPC
   AND
4. Currently reside in the catchment area
   AND
5. Are registered with a local primary health care provider

It is recognised that there are "grey areas" and individual referrals may be discussed with the Palliative Care Consultancy team as to assess their appropriateness.

The SPC Team are always available to advise and support other health professionals in their delivery of palliative care, regardless of whether the patient is on the Hospice service.

Please phone us - (03) 5789492

Information is also available on the **Health Pathways website**. http://nm.healthpathways.org.nz/
Also see attached disease specific clinical indicators.

2. Less Appropriate Referrals

Specialist Palliative Care is largely inappropriate for:

1. Patients with chronic stable disease or disability with a life expectancy of several years.
2. Patients with chronic pain problems not associated with progressive life-limiting disease.
3. Competent patients who decline referral.
4. Those patients whose problems are principally psychological and need specialist psychiatric referral, whether or not they have declined such help.

3. Criteria for Specialist Respite Care in the Inpatient Unit at Hospice Marlborough

Specialist respite care may be offered under the following circumstances:

1. If the patient has **complex** needs that the family or caregiver would benefit from a respite break.
2. These care needs are such that they cannot be managed elsewhere, as in an Aged Care facility or supervised facility
3. Patients must be receiving the full Hospice Service.
4. Patients must have carers that require respite.
5. Emergency or planned respite [up to **three days** prior to requiring the respite] is available.
6. Specialist respite care is available for a maximum of five days and not more than once a month.

Further information:
Assessment for respite care and other in-home care is available through the **Needs Assessment Service**. Please phone [0800 244 300].

Disease Specific Clinical Indicators to Guide Referral to Specialist Palliative Care

There are a number of disease specific clinical indicators that may aid in guiding appropriate referral particularly of non-cancer patients.

A. CANCER - RAPID OR PREDICTABLE DECLINE

- Metastatic cancer
- More exact predictors for cancer patients are available e.g. PiPS (UK validated Prognosis in Palliative care Study). PPI, AKPS etc. Prognosis tools can help but should not be applied blindly
- The single most important predictive factor in cancer is performance status and functional ability - if patients are spending more than 50% of their time in bed/lying down, prognosis is estimated to be approximately 3 months or less

B. ORGAN FAILURE - ERRATIC PATIENT DECLINE

<u>Cardiac Disease/Heart Failure</u>

All of below:

- Advanced heart failure - NYHA stage 3 or 4, shortness of breath at rest or on minimal exertion (see appendix 1).
- Recent review by cardiology team to ensure receiving maximum tolerated therapy.
- Patient thought to be in the last year of life by the care team - The 'surprise question'.

Other prognostic factors suggesting limited life expectancy include:

- Poor renal function
- Low sodium
- Refractory hypotension necessitating withdrawal of medical therapy
- Cardiac cachexia

- Diuretic resistance
- Repeated hospital admissions with heart failure symptoms.
- Difficult physical or psychological symptoms despite optimal tolerated therapy.
- Patient has had life-saving therapy and/or an internal cardiac defibrillator deactivated
- Complex advanced care planning or conflicting goals of care

The Hospice service will liaise with the cardiology team where appropriate to maximize symptom management. Admission to service may be short term e.g. 6 weeks and then reviewed.

Pulmonary Disease

All of below:

- Short of breath at rest (MRC grade 4/5 – see appendix 1)
- Severe airflow obstruction – FEV<30% predicted
- Frequent hospital admissions for exacerbations in the last 12 months
- Patient no longer wishes hospital admission for treatment with IV antibiotics/ventilator support for infective exacerbations

Other prognostic factors suggesting limited life expectancy:

- Housebound by disability
- BMI<20 and weight loss
- Receiving long term O2 therapy
- Resistant organisms
- Symptomatic right heart failure/cor pulmonale

Renal Disease

Stage 5 renal failure or Stage 4 chronic kidney disease (see appendix) whose condition is deteriorating **with at least 2 of the indicators below**:

- Patients for whom the surprise question is applicable
- Not able or willing to undergo transplant or dialysis or withdrawing from dialysis
- Complex discussions around dialysis withdrawal
- Patients with difficult physical or psychological symptoms despite optimal tolerated renal replacement therapy
- Patients with symptomatic renal failure (e.g. nausea, pruritus, restlessness and encephalopathy, reduced functional status, intractable fluid overload

Liver Disease

At least one of the following:

- Ascites despite maximum tolerated diuretics: spontaneous peritonitis
- Jaundice
- Hepatorenal syndrome
- Encephalopathy
- Recurrent variceal bleeding if further intervention is inappropriate

AND

- Liver transplant is not indicated

General Neurological Disease

- Significant progressive decline in overall function despite optimal therapy

AND at least one of the following:

- Complex discussion around goals of care
- Communication difficulties and progressive dysphasia
- Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure

Motor Neurone Disease

- Significant complex symptoms and medical complications
- Marked rapid decline in physical status
- Increased cognitive difficulties
- Weight loss
- Low vital capacity <70% of predicted
- Dyskinesia, mobility problems, falls

Parkinson's Disease

- Drug treatment less effective or increasingly complex regime of drug treatments
- Reduced independence, needs ADL help
- The condition is less well controlled with increasing "off" periods
- Dyskinesias, mobility problems and falls
- Psychiatric signs (depression, anxiety, hallucinations, psychosis)
- Similar pattern to frailty- see below

Multiple Sclerosis

- Significant complex symptoms and medical complications
- Dysphagia + poor nutritional status
- Communication difficulties e.g. dysarthria + fatigue
- Cognitive impairment notably the onset of dementia

Cerebral Vascular Accident

- Persistent vegetative or minimal conscious state or dense paralysis
- Medical complications
- Lack of improvement within 3 months of onset
- Cognitive impairment / Post-stroke dementia

Dementia

- Inability to dress and/or walk without assistance and
- Urinary and faecal incontinence and
- No consistent meaningful verbal communication
- Barthel score <3

AND at least one of:

- Difficulty swallowing/eating; weight loss (>10% loss over 6 months)
- Recurrent urinary and/or respiratory infections
- Multiple stage III or IV decubitus ulcers

- Symptoms causing distress

Frailty

Individuals who present with multiple co-morbidities with significant impairment in day to day living and:

- Deteriorating functional score e.g. performance status
- Combination of at least three of the following symptoms:
- weakness
- slow walking speed
- significant weight loss
- exhaustion
- low physical activity
- depression

Other Situations Include:

- Multiple co- morbidities with no primary diagnosis
- Patient medically unfit for surgery for life-threatening disease
- Failure to respond to Intensive Care and death therefore inevitable

References

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www.goldstandardsframework.org.uk

Appendix 1

The New York Heart Association Functional Classification	
Class 1 (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or dyspnoea.
Class 11 (mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical exertion results in fatigue, palpitation or dyspnoea.
Class 111 (moderate)	Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes fatigue. Palpitation or dyspnoea
Class 1V (Severe)	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. Physical activity increases symptoms experienced.

Medical Research Council Dyspnoea Scale	
Grade 1	'I only get breathless with strenuous exercise'
Grade 2	'I only get short of breath when hurrying on the level or up a slight hill'
Grade 3	'I walk slower than people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level'
Grade 4	'I stop for breath after walking 100meters or so or after a few minutes on the level'
Grade 5	'I am too breathless to leave the house'

Stages of Chronic Kidney Disease		
Stage	**eGFR**	**Description**
1	90+	Normal kidney function but urine findings or structural abnormalities or genetic trait point to kidney disease
2	60-89	Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease
3A 3B	45-59 30-44	Moderately reduced kidney function
4	15-29	Severely reduced kidney function
5	<15/on dialysis	Very severe, or end stage kidney failure

W.H.O. Performance Status Clarification	
0	Able to carry out all normal activity without restriction
Grade 1	Restricted in physical strenuous activity, but ambulatory and able to carry out light work
Grade 2	Ambulatory and capable of self-care but unable to carry out work; up and about for more than 50% of waking hours
Grade 3	Capable only of limited self-care; confined to bed more than 50% of waking hours
Grade 4	Completely disabled; cannot carry out any self-care; totally confined to bed or chair

Australia-Modified Karnofsky Performance Scale (AKPS)	Score %
Normal; no complaints; no evidence of disease	100
Able to carry on normal activity; minor sign of symptoms of disease	90
Normal activity with effort; some signs or symptoms of disease	80
Cares for self; unable to carry on normal activity or to do active work	70
Able to care for most needs; but requires occasional assistance	60
Considerable assistance and frequent medical care required	50
In bed more than 50% of the time	40
Almost completely bedfast	30
Totally bedfast and requiring extensive nursing care by professionals and/or family	20
Comatose or barely rousable	10
Dead	0