NHS
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Nursing and Residential Home Triage (NaRT) Tool

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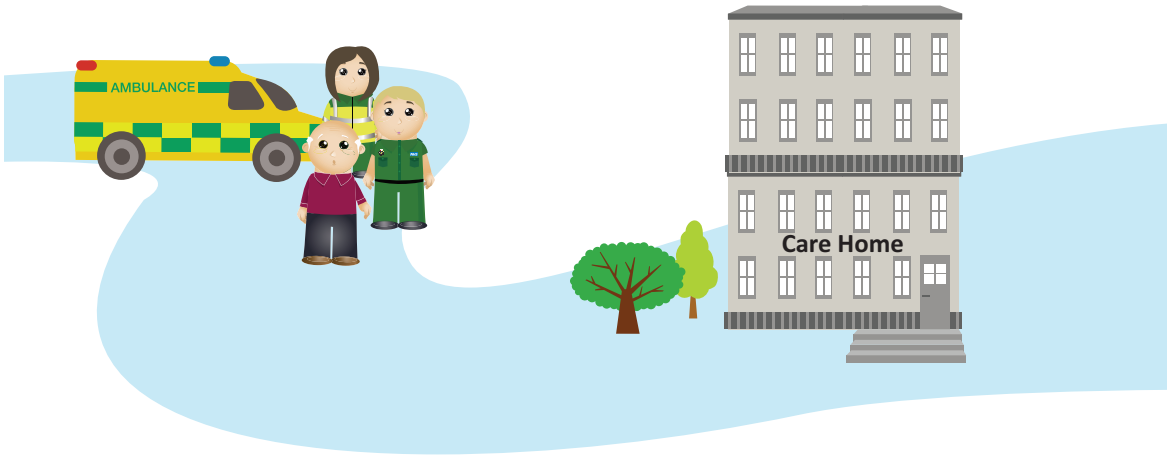

The challenge

Supporting high intensity 999 users to provide improved patient care

One in seven people aged 85 years of age and above, reside in a nursing home or residential care home. Unfortunately, evidence suggests that many are not receiving the best and most appropriate care for their ongoing needs. There can be a lack of understanding around assessment and management resulting in unplanned and unnecessary admissions to hospital.

More appropriate care can often be provided within the patients normal surroundings and by health professionals known to them. Throughout England, there are currently six Enhanced Health in Care Homes (EHCH) vanguards working to improve the quality of life, healthcare and care planning for people living in care homes, nursing homes and residential care homes.

The barriers to more effective care planning and management of residents include the following:

* Lack of integrated care planning that focuses on prevention and pro-active care
* Variable access for care home residents to NHS services locally
* Lack of continuity of care due to high turnover of care home staff
* Lack of initiatives supporting preventative care, within the care home environment across health and social care providers
* Recruitment and retention (including training) within the care sector
* Nursing and Residential Home staff can sometimes struggle to access GP services

NATIONAL PICTURE

* More than half a million people aged 65 and over were admitted as an emergency to hospital with potentially avoidable conditions. Average length of admission for over 65yrs = 11.9 days.
* Among people living in care homes, emergency hospital admissions for avoidable conditions were 30% higher.
* People with a variety of conditions, are admitted to hospital often when it is not in their best interests.
* People who have dementia continue to have poorer outcomes in hospital compared with those without dementia, with a 33% higher mortality rate.

Avoiding inappropriate conveyance for the frail or elderly

Enabling patients to experience improved outcomes

It is widely acknowledged the admittance to hospital for frail and older adult patients can cause additional healthcare issues to arise i.e. increased BP at rest, loss of muscle mass, UT infections etc. Bed rest, or acute inactivity associated with hospitalisa on or disease state, poses a potent threat to muscle tissue and functional capacity.

In older adults, physical inactivity during hospitaliza on is almost an accepted part of the inpatient experience, yet clearly contributes to a host of negative outcomes, including a reduction in the ability to perform activities of daily living, increased incidence of readmission and institutionalisation.

While reduced or limited physical inac vity may be indicated in many patient populations, the practice of subjec ng pa ents to con nuous bed rest without a clear medical indication is a regrettable default position. Conveyance to hospital for the frail or older adult is not always the most appropriate course of action and can cause significant distress to the patient and their loved ones. In many cases, patients with pre-existing co-morbidities can be managed by community based specialist teams rather than acute hospital admission.

By providing a system of partnership working and informa on sharing with key stakeholders, such as Care Homes, Nursing Homes and Residential Care Homes, the Nursing and Residential Triage (NaRT) Tool aims to:

* Reduce the number of high intensity users being admitted to inpatient care
* Support Nursing and Residential Home staff to make the correct decision if calling for clinical assistance
* Increase the numbers of patients accessing care away from emergency departments
* Enhance quality of care for patients with non time-critical presentations
* Reduce the amount of inappropriate 999 calls; whilst supporting appropriate utilisation of emergency services.

Designed for the experts in older adult care

The Nursing and Residential Home Triage Tool (NaRT) is based on the Manchester Triage Group's Manchester Triage System (MTS). MTS is an internationally used system for triaging patients, based on patient presentation NOT diagnosis; the system is reductive to ensure the safety of patients and is reliable and consistent. Developed by two Paramedics in collaboration with Manchester Triage Group and Advanced Life Support Group, the NaRT:

* Is person-centred in its approach to the provision of care within a Care Home, Nursing Home or Residential Home setting.
* Is an example of multi-disciplinary team working between NHS and social care sector
* Is a checklist of presenting symptoms, developed to assist in the assessment of residents by care home staff to support access to the most appropriate healthcare provision
* Enables staff on scene to make an informed decision as to the timeframe required for a clinical assessment to take place and supports improved quality of care and outcomes
* Supports experts in older adult care; Care Home, Nursing Home and Residential Care home staff, who know their clients best and have an informed knowledge of their care needs
* Enables the development and implementation of shared care aims for the benefit of the individual
* Is supported by an e-learning package, with additional training available from ALSG
* Is not a replacement for the use of rou ne GP appointments for residents

END OF LIFE AND CARE PLANS

NB: Should the patient have an End of Life or Care Plan in place, relevant documentation should be consulted prior to calling 999, even in the presence of a red discriminator.

End of life and Community Care Pathways should take precedence over the Triage Tool outcome as long as they are signed and within date.

Preventing deconditioning

Prolonged hospital stays can lead to substantial loss of muscle strength **and physical ability.**

Older people who are admitted to hospital are at more risk of:

Reduced bone mass and muscle strength, approx. 2-5% per day

Reduced mobility

Confusion due to changes in normal routine and environment

Collectively this is known as deconditioning which results in:

* increased confusion or disorientation
* potential risk of falls due to muscle weakness
* loss of appetite and poor digestion
* Increase risk of swallowing issues, leading to pneumonia
* incontinence and constipation.

According to recent statistics, the average length of stay in hospital following admission is 11.9 days. 10 days in hospital equates to 10 years of ageing, for an older person.

Appropriate alternatives to taking an older person to hospital should always be considered in line with the patients immediate and ongoing care needs.

PILOT PHASE

During the pilot phase of the NaRT, the triage tool was proven to reduce inappropriate conveyance of patients and potential admission to hospital by over 50%, with no adverse incidents reported.

For more informa on on the pilot phase and associated statistics, please contact the Urgent Care Development Team by emailing urgentcare.development@nwas.nhs.uk

Nursing and Residential Triage

Date:_____ Time:_____ Completed by:_____

Patient Name:_____ DOB:_____ NHS No (if known):_____

Name of GP Practice or referral pathway:_____

Injury

Does the patient have an EoL or CCP in place? ☐

- Airway Compromise ☐
- Shortness of breath ☐
- Shock ☐
- Stroke symptoms ☐
- FAS Test positive ☐
- Chest pain ☐
- Currently fitting ☐
- Major haemorrhage ☐
- Vascular compromise ☐
- Significant mechanism of injury ☐
- Altered conscious level ☐
- Chemical injury to the eye ☐
- Open fracture ☐
- Severe pain ☐

- Minor Haemorrhage ☐
- Smoke exposure ☐
- Direct trauma to the back or neck ☐
- Deformity ☐
- Unable to use limb ☐
- Has been unconscious ☐
- Recent head injury ☐
- Dizziness prior to a fall ☐
- Facial swelling ☐
- Worrying wound ☐
- Moderate pain ☐

Refer to End of Life or Community Care Pathway prior to calling 999, ensuring it is signed and in date. If in any doubt - call 999

999 Emergency Vehicle Response

Ambulance to be requested via 999 immediately*

*You will still be required to provide all details to the 999 call taker who will prioritise the call based on the information provided

999 ☐ Other ☐

Further Clinical Assessment required

Contact Urgent or Primary Care for clinical assessment

999 ☐ 111 ☐

Single Point of Access ☐ Urgent/ Primary Care ☐

Illness

Does the patient have an EoL or CCP in place? ☐

- Airway compromise ☐
- Shortness of breath ☐
- Shock ☐
- FAS Test positive ☐
- Stroke symptoms ☐
- Chest pain ☐
- Hypoglycaemia ☐
- Currently fitting ☐
- New abnormal pulse ☐
- Altered conscious level ☐
- Oedema to the face and/or tongue ☐
- Vomiting blood ☐
- Passing fresh or altered blood PR ☐
- Signs of meningism ☐
- Non blanching rash ☐
- Abdominal pain and back pain ☐
- Very hot ☐
- Severe pain ☐

- Headache ☐
- Unable to use limb ☐
- New Confusion ☐
- Hot ☐
- Hyperglycaemia ☐
- Dizziness prior to a fall ☐
- Has been unconscious ☐
- Recent head injury ☐
- Persistent vomiting ☐
- Widespread rash or blistering ☐
- Moderate pain ☐

Injury ☐ Contact patients own GP, local AVS scheme, District Nurse if available or Local Primary Care Team Illness ☐

If the patient has fallen and none of the above discriminators are present, assist patient from the floor using correct lifting aids and manual handling techniques or contact local falls/lifting service for assistance.

Patient outcome: ED ☐ GP ☐ District Nurse ☐ SPA/Telehealth ☐ Advice only following further clinical assessment ☐ Other ☐

Audit Correct chart ☐ Correct discriminator ☐ Correct outcome ☐

Manchester Triage System

Nursing and Residential Home Triage Tool
S. Allmark/ M.Wenman V2 Draft

Discriminator Dictionary

Abdominal pain and back pain - pain in the abdomen that radiates to the back or pain from the back radiating to the abdomen
Airway compromise - An airway may be compromised either because it cannot be kept open or because the airway protective reflexes (that stop inhalation) have been lost. Failure to keep the airway open will manifest itself as snoring or bubbling sounds during breathing.
Altered conscious level - Not fully alert; either responding to voice or pain only or unresponsive.
Chemical Injury to the eye - Any substance splashed or placed into the eye within the last 12 hours that caused stinging, burning or reduced vision should be assumed to have caused a chemical injury.
Chest pain - Any pain or discomfort around the chest, may also present as neck, jaw or arm pain.
Currently fitting - Patients who are having a grand mal convulsion and patients currently experiencing partial fits fulfil this criterion.
Deformity - This will always be subjective. Abnormal angulation or rotation is implied.
Direct trauma to the back or neck - This may be top to bottom (loading) for instance when people fall and land on their feet, bending (forward, backwards or to the side) or twisting or distracting such as in hanging.
Dizziness prior to a fall - if the patient reported feeling dizzy or unwell prior to a fall they may have in fact collapsed rather than falling.
Facial swelling - Localised swelling to the face.
FAS Test positive - Facial drooping, any new weakness to limbs or changes in speech.
Has been unconscious - A reliable witness who can state the patient was unconscious or if the patient is unable to remember the incident they are assumed to have been unconscious.
Headache - Any pain around the head that is not related to a particular anatomical structure. Facial pain Is not included.
Hot - If the skin feels hot the patient is said to be hot. A temperature of over 38.5˚C is said to be hot.
Hyperglycaemia - Glucose greater than 17mmol/l.
Hypoglycaemia - Glucose less than 3mmol/l.
Major haemorrhage - A haemorrhage that Is not rapidly controlled by the application of sustained direct pressure and in which blood continues to flow heavily or soak through large dressings quickly.
Minor haemorrhage - A haemorrhage that Is not rapidly controlled by the application of sustained direct pressure and in which blood continues to flow slightly or ooze.
Moderate pain - Pain that is bearable but intense.
New abnormal pulse - Heart rate of over 100 beats/min or less than 60 beats/min in adults or an irregular rhythm.
new confusion - PAtients with new onset confusion.
Non blanching rash - A rash that does not disappear when pressure is applied (tumbler test).
Oedema to the face and/or tongue - Generalised swelling around the face usually involving the lips or swelling of the tongue of any degree.
Open fracture - All wounds in the vicinity of a fracture should be regarded with suspicion. If the wound appears to be over a fracture site and looks to be deep enough for the bone to have reached the skin, then the fracture should be assumed to be open.
Passing fresh or altered blood PR - In active massive GI bleeding, dark red blood will be passed PR. As GI transit time increases thes becomes darker, eventually becoming melaena.
Persistent Vomiting - Vomiting that is continuous.
Recent head injury - A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient but if the patient has been unconscious this should be sought from a reliable witness.
Severe pain - Pain that is unbearable; often described as the worst ever.
Shock - Patient may have signs of sweating, pallor, increased heart rate, hypotension and reduced conscious level.
Shortness of breath - Shortness of breath that comes on suddenly, or a sudden worsening of chronic shortness of breath.
Significant mechanism of injury -has the patient fallen from any height or down stairs? Consider location of injury and frailty of the patient.
Signs of meningism - Classically a stiff neck together with headache and photophobia.
Smoke Exposure - Smoke inhalation should be assumed if the patient has been confined in a smoke filled space. Physical signs such as oral or nasal soot are less reliable but significant if present.
Special risk of infection - a patient with an illness or on treatment which lowers the immune system for example on chemotherapy.
Stroke symptoms - any new weakness to limbs, facial drooping or changes in speech.
Unable to use limb - This could be due to pain, injury or neurological deficit.
Vascular compromise - There will be a combination of pallor, coldness, altered sensation and pain to the injured limb.
Very Hot - Temperature of 41 or above.
Vomiting or passing blood - May be fresh (bright or dark red) or coffee ground in appearance.
Widespread rash or blistering - Any rash or blistering eruption covering more than 10% of the body surface area.
Worrying Wound - A wound that may require cleaning or closure; contaminated wounds; wounds involving glass; puncture wounds especially from animal or human bites (consider wounds to the hand caused by a persons teeth following a punch injury), as these may require antibiotics; any wound over a possible fracture site which may indicate an open fracture.

For further information on the NaRT, please contact:

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