Name of care home:

.....

Resident's name:

.....

Date of birth:

.....

Assessed by:

.....

Assessment date:

.....

Job role:

.....

Safety of Medicines in Care Homes

Symptom assessment tool

Acknowledgements

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Aims

The Symptom Assessment Tool has been developed to assist with identifying and monitoring residents who's health needs are deteriorating.

It is a traffic light system that should help to quickly rate the symptoms and provide practical guidance on the next steps.

The Symptom Assessment Tool does not cover every eventuality and needs to be used alongside the usual decision making by senior staff in the care home

- to help identify a deteriorating resident
- to guide the use of homely remedies
- to provide practical guidance on when to call for medical advice and with what degree of urgency
- to guide care staff, in the absence of nursing staff, in assessing symptoms
- Monitor the introduction of a new medicine and its impact including any adverse side effects

The tool is based on identifying a **CHANGE** in a resident and asking the following questions:

- Is the resident telling you that he/she feels less well or unwell?
- What have I noticed that has changed about this resident?
- Is this new or has it happened before?
- Has this change been gradual (over days to weeks), or sudden (over hours)?
- How long has it lasted for?
- Is it getting worse, staying the same, or coming and going?
- What exactly is the resident, relative or carer worried about?

SYMPTOM ASSESSMENT TOOL

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Conscious level	No change	Gradually	Suddenly
Usual level of consciousness			
Has become more drowsy but rousable			
Has become unrousable (try gentle shaking, talking to resident, pressure on ear lobe to rouse)			

Breathing	No change	Gradually	Suddenly
Usual breathing pattern			
More breathless than usual but able to eat/talk			
Very breathless or gasping			

Temperature	No change	Gradually	Suddenly
Normal temperature			
Temp 37.5-38 (feels hot to touch)			
Temp >38 (very hot, flushed, sweating, rigors - shaking with high temp)			

Pain*	No change	Gradually	Suddenly
No pain or no change in usual pain			
New pain or increased pain not resolving with homely remedy or usual pain relief			
Severe pain (especially chest pain, headache, abdominal pain)			

*Use resident assessment of pain 0-10 (0=no pain, 10=worst pain imaginable) or pain assessment scale is available for those with dementia.

Cough	No change	Gradually	Suddenly
No cough or cold			
Cough and cold, coughed up small amount blood, chesty cough with or without small amount green phlegm			
Severe chesty cough, large amounts yellow/ green phlegm production, wheezy so unable to eat or talk, coughed up large amount blood			

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Facial and body colour	No change	Gradually	Suddenly
No change to colour			
Colour has changed to yellow (look at whites of eyes)			
Looks grey or extremely pale and sweaty or clammy, not resolving after lying on bed for 15mins (may be due to low blood pressure)			

Skin	No change	Gradually	Suddenly
No change in condition of skin			
Pressure sore, ulcer, broken skin, itch, rash, enlarging/changing lesion			
Painful blistering, severe itching or extensive rash, burn			

Lumps	No change	Gradually	Suddenly
No lumps			
Skin lumps, non-tender, normal overlying skin			
New lump breast or scrotum, swellings neck, tender skin lumps			

Swelling limbs	No change	Gradually	Suddenly
No change leg swelling			
Increasing swelling both legs			
Acutely swollen single leg or arm, hot and red or cold and white			

Vision	No change	Gradually	Suddenly
No change to sight			
Itchy eye(s), discharge, mild redness			
Painful red eye, acute visual loss			

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Stroke	No change	Gradually	Suddenly
No signs stroke			
Leaning to one side, using one side less			
Droop to side face and/or loss of use arm, leg, speech or swallow			

Collapse	No change	Gradually	Suddenly
No history collapse			
Generalised weakness, no loss consciousness, resolved within 30mins on bed (lie resident down as cause may be low blood pressure)			
Marked weakness, +/- brief loss consciousness, unresolved by 30mins on bed (check and record pulse and blood pressure if possible)			

Fits/seizures	No change	Gradually	Suddenly
No fits			
Short self-limiting fit in resident with known history fits (be aware of usual pattern of fits)			
First fit in resident not known to have fits or prolonged fit, more than 15mins, in resident known to have fits 20 (low blood sugar in diabetic or low blood pressure may lead to fit)			

Diabetes	No change	Gradually	Suddenly
Stable diabetic control			
Rising blood sugar levels, if able to check, within 4-20 range (NB blood sugars tend to rise if patient has an infection). Increasing thirst.			
Recorded Hi or Low blood sugars on testing (off the scale) in diabetic on tablets or insulin. If no blood sugar level available, diabetic who is suddenly drowsy, sweaty, pale. Diabetic who is very thirsty, drowsy, breathing faster and breath may smell of acetone (like pear drops).			

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Mobility	No change	Gradually	Suddenly
Usual level mobility			
Needing assistance but still able to mobilise			
'Off legs'/unable to mobilise			

Falls	No change	Gradually	Suddenly
No falls			
Fall but no apparent injury (if fall and knocked out - risk of significant head injury even if apparently OK) or recurrent falls			
Fall plus possible fracture/significant injury (if unable to weight bear after fall consider hip or pelvic fracture)			

Eating/vomiting	No change	Gradually	Suddenly
No change to eating pattern			
Reduced appetite, indigestion, occasional vomiting, new food refusal, small coffee ground vomit (may be minor blood loss from stomach)			
Persistent vomiting, severe indigestion, large or persistent coffee ground vomiting, large amount blood in vomit			

Weight	No change	Gradually	Suddenly
No change			
Weight loss (1-2kg in past month)			
Significant weight loss (more than 2kg in past month)			

Swallowing	No change	Gradually	Suddenly
No difficulty swallowing			
Some difficulty swallowing			
Marked difficulty swallowing, choking			

Abdominal swelling	No change	Gradually	Suddenly
No swelling abdomen			
Marked difficulty swallowing, choking			

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Vaginal bleeding	No change	Gradually	Suddenly
No bleeding			
Small bleed/spotting from vagina			
Large blood loss from vagina			

Bowels		Gradually	Suddenly
No change to usual bowel pattern			
Small amount of blood on pad or paper on wiping bottom, loose stools less than twice in a month or bowels open less frequently, single bout of diarrhoea for less than 24 hours			
Recurring diarrhoea more than 24 hrs, severe bleeding from back passage, malena (stool black and tarry-indicates major bleeding higher up), rectal prolapse (bowel hanging out of anus), bowels not open for seven days			

Passing urine		Gradually	Suddenly
No change to usual pattern			
New onset frequent passing urine or new onset incontinence, pain on passing urine. If dipstix available dip urine and record result. (++ leucocytes, nitrites, protein or blood may suggest infection)			
Unable to pass urine, visible blood in urine			

Sleep pattern		Gradually	Suddenly
No change usual pattern			
Difficulty getting off, broken sleep pattern			
No sleep, very disturbed nights, new wandering			

Behaviour	No change	Gradually	Suddenly
Usual pattern of behaviour			
Moderate change in behaviour - more restless, agitated, aggressive or withdrawn			
Marked change – severe agitation, restlessness, aggression			

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Confusion	No change	Gradually	Suddenly
No change to usual level confusion			
Mild confusion of new onset			
Acute confusion/hallucinations (infection can cause confusion)			

Memory	No change	Gradually	Suddenly
No change in memory			
Some short term memory loss			
Significant change in memory/recognition known people			

Mood*	No change	Gradually	Suddenly
No change in usual mood			
Low in mood, sad, occasionally tearful			
Distressed, tearful or very withdrawn			

*Depression is common in older people in care homes and can be treated. There are tools to available to monitor depression.

Notes from actions taken.

Instructions for use

Ring the relevant boxes and refer to page 10 for actions needed.
Go straight to the instructions on action to be taken if you ring any red score.

Consider homely remedies.
If persists >48 hrs, review at regular GP visit or request GP visit within next few days.

If homely remedies are recommended, the homely remedies policy will indicate if medication is available to ease minor symptoms and if it can be taken. Continue to monitor and if there has been no improvement after 48 hours with or without homely remedies than request GP advice.

Request GP or OOH advice/visit that day or next day.

If you have ringed any yellow boxes this may indicates a problem that will need reporting to and advice from the GP within 24 hours but does not usually require an urgent visit. This supports staff in decision making out of hours and confirms when it is reasonable to wait until the next day to request a GP visit. Remember, if you are uncertain about the seriousness of a symptom, err on the side of caution and phone for medical advice.

Request urgent visit from GP/OOH.

In the care home setting, there is usually time to take stock of the situation causing concern, make sure the resident is safe, check advance care plans and resuscitation status for the resident and discuss with colleagues in the team whilst phoning for medical advice and an urgent visit.

There may be circumstances that will require an urgent call to the paramedics/ambulance service. The senior person on duty should be involved in this decision; it is also likely that medical care will still need to be provided.

Increasingly dialling 999 leads to an emergency hospital admission; this may not always be in the best interests of the resident. Discussions should take place with the GP, OOH service and/or the district nursing service to establish if medical care for the resident and support for staff can be provided in the care home setting. Responsibility for making that decision should rest with the GP or OOH service.

Urgent advice/ visit request

If you are going to phone for advice or an urgent visit from a GP or out of hours (OOH) you will need to have the following information to hand.

Situation

Identify yourself and your role, the care home (nursing or residential), the name, date of birth and age of the resident and the problem. Avoid using words such as ‘collapse’ or ‘breathless’ and give a more detailed description of the cause of concern using the answers to the questions listed under aims at the top of page 3.

Background

Describe the resident’s background including information on:

1. Known medical problems (dementia, diabetes, heart disease etc).
2. Medication that the resident is taking.
3. The resident’s wishes, if known or recorded on an advande care plan especially with regard to an advised admission to hospital, as many residents and relatives would prefer to stay in the familiar surroundings of the care home.
4. In the event that an emergency hospital admission is being considered for this resident, provide the views of the resident’s GP, if known or recorded on a medical advance care plan, including decisions made using the Gold Standards Framework.
5. In an emergency situation it is helpful for all concerned to be aware if the resident’s GP has signed a Do Not Attempt Resuscitation or Allow a Natural Death order for that resident (although DNAR is not about providing the appropriate treatment).

Assessment

What do you think might be wrong and what you are worried about.

Recommendation

What do you want to happen now? over the phone or a doctors visit.

Notes

Allergies