**Therapy Triage Criteria V.8**

Intended for guidance only and to be used in conjunction with clinical consideration for each individual situation

**Urgent Response (Consider if 2hr)**

* High risk of admission to hospital due to acute deterioration in health and/or function.
* Urgent assessment/equipment provision where a full therapy assessment is required to stabilise unsafe situation or a deteriorating condition e.g. palliative/ EOL/fast tracked patient, acute increased risk of falls, unable to transfer
* North Somerset only - Acute exacerbation of a respiratory condition requiring urgent chest Physiotherapy to improve Oxygen saturations and facilitate secretion clearance. Reduced saturations compared to patient’s baseline and unable to cough/expectorate.

**Urgent Response <48 Hours**

* Risk of carer breakdown due to acute deterioration in health impacting on function of the patient, increasing risk of admission
* Manual handling difficulties, due to acute deterioration in health impacting on function that present to an immediate risk to harm or admission
* Referrals from the REACT service/ED department to prevent hospital admission. Any identified care needs should be referred by ED/REACT to social care. (NB Triaging clinicians, in discussion with therapists from urgent response is required or re-prioritised accordingly).

**Assessment within 7 days**

* Acute deterioration in function and/or independence related to a recent episode of ill health where there is no risk of hospital admission identified
* Health condition leading to functional deterioration in the last 6 weeks that has potential rehab window to improve with timely therapy intervention e.g. T&O recent fracture with change in weight bearing status or orthopaedic protocol that needs mobilising, reduction in mobility and no equipment or recent input at risk of falls
* North Somerset only - Chest Physio Only (Exacerbation of Respiratory condition within the last 6 weeks).

**Exclusion Criteria or Signposting Alternatives**

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|  | **Alternative option to consider** |
| * Not registered with a BNSSG G.P
 | Referral to services covered by the patients GP surgeryIf the patient lives within BNSSG then advise they consider a change of GP surgery |
| * Under 18s
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| * Exclusively for outdoor mobility – North Somerset/Bristol
* Exception - South Glos do accept outdoor mobility assessment for those who have a health need impacting on their functional ability
 | Voluntary sector or family support? Needs to be specific and not just asking for walking aids |
| * Previous physio/OT input in the last 6 months for the same condition where there has been no change in health and social status
 | Consider discussion with referrer/take discussion to GP MDT. |
| * Any referrals where needs would better be met in MSK outpatients
 | Advise referrer to re-refer to MSK |
| * Referrals related to a specific condition where appropriate treatment can be accessed through a specialist service e.g. Chronic Fatigue/ME, Chronic Pain where there are existing specialist resource/pathways to manage
 | Advise referrer to re-refer to appropriate service |
| * Wheelchair prescription only
 | G.P. refer to Enablement Centre if meets NHS criteria. If not advise private purchase/voluntary organisations |
| * Major adaptations requiring Disabled Facilities Grant
 | refer to Care Direct BCC/Care Connect NSC/ SG SC |
| * Manual Handling review of equipment in place with no acute deterioration or identified health need
 | refer to NH/RH Manual handling team if in a care homeIf they are at home refer to social care |
| * Referrals for ***standard*** slings in a nursing home.
* For residential homes: Where there is an acute deterioration in health that impacts on function we will assess to try and prevent acute admission OR the need to move to a nursing home.
 | Nursing home responsibilityLong term need requires a referral to social care |
| * Seating assessments in care homes are only completed if funding is already agreed –Bristol
* Seating assessment only accepted if there is a postural need alongside a health need (Bristol/south glos)
 | **Redirect referrals to social care if there is no health need alongside the need for 24hr postural management**  |
| * Bathing assessment with no medical/health needs
 | Care Direct BCC/ Care Connect NSC/ SG SC |
| * Review of manual handling equipment where there is no rehab or deteriorating health need.
 | Social care ref for SGSC |
| * Referrals exclusively for Orthotics/splinting
 | G.P. to refer directly to orthotics |
| * Patients open to AWP who require therapy.
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| * Referrals that do not have a specific therapeutic goal
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| * Health conditions that have chronically deteriorated where there is no change to function/risk at home.
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| * Workplace assessments for those who have no other therapy needs
 | * consider referral to voluntary sector or employer to address through occupational health
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**Points for consideration**

* For North Somerset - If a thorough telephone assessment for standalone equipment has been completed then consider RSW to issue equipment. Ensure all other risks/investigations completed by registered therapist during triage. Delegate equipment assessments to APs where appropriate.
* If triaging therapist delegates tasks to an unregistered staff member, ensure they are is up to date with their equipment demonstration and fitting competencies required to carry out the delegated task.
* Is patient aware of the referral and do they know why they have been referred?
* Has referrer gained consent to refer to planned therapy service and identified a goal?
* Lives alone, main carer of another/has dependents, cognition (i.e dementia), safeguarding concerns? Carer break-down – These people need to be referred to social care
* Able to manage basic ADL’s and transfers in order to be safe. E.g. – able to access food/medications, transferring and mobilising in a safe way.
* Review EMIS. Can the needs be met by other HCPs that are going in, such as DNs. Have they already had input, consider benefit of therapist visit and what we are likely to be able to change/improve on?
* New/frequent/increased falls? At risk of fall and injury if not seen. Acutely unwell? How many falls in last 6 months – any loss of consciousness that needs to be addressed/flagged via alternative pathway (GP or Rapid Assessment Clinic for Older People (RACOP)), Falls nurse).
* Manual handling – is care agency involved, can need be met via in-house manual handling advisor, would referral be more appropriate of for Social services OTs?
* Slide sheets/pressure cushions etc – can we give advice to DNs already going in rather than visiting in addition.
* What is the risk if no urgent visit? Can patient be made safe in interim?
* Palliative care patients: Things to insider when deciding how urgent the referral is could include: 1) is this linked to an acute episode of ill health/recent hospital admission. 2) are they fast tracked, 3) are the community nurses involved for palliative care, 4) are they known to the hospice, 5) Level of GP involvement in past month.
* Trauma/Orthopaedic patients – recent elective surgery such as hip and knee replacement OR complex fracture that has a therapy need essential for recovery
* Falls - significant change in falls risk where therapy intervention would reduce further risk and prevent hospital admission. Exclude patients where the primary reason for the fall was substance misuse.