Family Nursing & Home Care

Management and Recognition of the Deteriorating Patient

NEWS2 (National Early Warning Scores) and Recognition of Sepsis

September 2020

Document Profile

Document Registration	Added following ratification
Type	Policy
Title	Management and Recognition of the Deteriorating Patient NEWS2 (National Early Warning Scores) and Recognition of Sepsis
Author	Operational Lead Rapid Response and Reablement
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Description	A policy for the recognition and management of the deteriorating patient. It introduces use of NEWS2 and covers the recognition of sepsis.
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Version control / changes made

Date	Version	Summary of changes made	Author
09/07/20	1		

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1 INTRODUCTION

1.1 Rationale

This policy establishes the minimum standard of type and frequency of clinical observations to be taken on adults both in clinical settings as well as in other community settings, including patient's homes or place of residence for patients within Family Nursing & Home Care by:

- staff identifying deteriorating patients early by observation
- undertaking the use of the National Early Warning Score – NEWS2 (RCP 2017) scoring to highlight change in a patient's condition
- advising staff when and who to inform of deterioration

To standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients.

To reinforce the communication standard of when to call for help. Situation, Background, Assessment and Recommendation (SBAR).

NEWS2 is an aid to clinical decision making – it is not a barrier or alternative to skilled clinical judgement.

1.2 Scope

This policy applies to all adult patients over 18 years of age under the care of the following Adult Community Teams:

- Rapid Response and Reablement Team
- District Nursing Teams

NEWS2 should not be used in children (age <16 years) or in women who are pregnant because the physiological response to acute illness can be modified in children and by pregnancy. Appropriate tools are available in these cohorts of patients including the Paediatric early warning score (PEWS) and the Maternity Early Warning Score) MEWS. NEWS2 may be unreliable in patients with spinal cord injury (especially tetraplegia or high-level paraplegia), owing to functional disturbances of the autonomic nervous system. Use with caution.

1.3 Role and Responsibilities

Chief Executive Officer – has overall responsibility for ensuring there are effective arrangements in place so that staff are appropriately trained and competent to effectively fulfill their role within the organisation and to maintain the safety of patients.

Director of Governance and Care – will ensure systems are in place to update this policy in line with evidence based practice. Monitor, report and investigate incidences reported on Assures related to NEWS2.

Policy Clinical Lead (Author) – The Policy Lead will oversee the implementation and promotion of the policy across the organisation. They will be responsible for monitoring and reviewing the policy as necessary.

Education and Development – is responsible for ensuring that education governance arrangements are in place to ensure the effectiveness of the delivery of NEWS2 across the Organisation and those models of teaching, learning and assessment are fit for purpose.

Operational Leads - are responsible for ensuring that high standards are maintained within their areas of responsibility and the standards set out in this policy are adhered to.

Team Leaders – It is the responsibility of each team leader to ensure staff attend all relevant statutory and mandatory training; and to monitor attendance on a routine basis. They must ensure all appropriate equipment is available and in good working order and ensure staff are appropriately trained, up dated and competent in the process within this policy.

Employee – it is the responsibility of each staff member to ensure they attend all relevant mandatory training and other training if relevant for their role and keep themselves up to date. Staff must be competent in the management and recognition of the deteriorating patient, NEWS2 and recognition of sepsis.

2. POLICY

All patients should have a baseline set of Clinical Observations recorded prior to their nursing/therapy intervention (if possible) and this should be obtained from the point of referral, the patient's normal observations can then be used for comparison, especially if they suffer from chronic illness.

All patients initially assessed and/or admitted onto a case load must have the six physiological parameters recorded and converted into a score for each parameter and then added up to a total score as a baseline on initial assessment.

All patients should have an agreed frequency of observations documented (with rationale provided) in their clinical records. Practitioners need to adhere to the Standard of Frequency of Observations Guidance (Appendix 3) as a guide to how often observations need recording following initial assessment.

However, clinical judgement remains paramount when deciding frequency of observations.

For patients who are receiving End of Life Care or have palliative care needs, it may not be appropriate to continue routine recording of clinical observations. Such decisions should always be jointly discussed and agreed with the patient/family/clinical team/MDT etc. and clearly recorded as agreed within their clinical records.

All patients should have a NEWS2 Score attributed to every set of Clinical Observations.

Identify patients likely to have sepsis and/or who are at immediate risk of serious clinical deterioration and require urgent clinical intervention. A NEWS2 score of 5 or more is a key threshold for an urgent clinical alert and response.

Ensure the recording of the use of oxygen and the NEWS2 scoring of recommended oxygen saturations in patients with hypercapnic respiratory failure (most often due to COPD).

Include new confusion as part of the AVPU scoring scale (which becomes ACVPU).

Recognise the importance of new-onset confusion, disorientation, delirium or any reduction in the Glasgow Coma Scale (GCS) score as a sign of potential serious clinical deterioration.

Provide resources to support staff and training.

2.1 Training and Support

All identified clinical staff recording data or responding to the NEWS2 will be trained in its use and undertake the web based educational tool.

All identified staff will have mandatory training in the recognition and management of the deteriorating patient as part of Induction.

The staff with appropriate skills and competencies to respond to patients with high NEWS2 should be identified.

Additional support will be available by the Organisation's Education and Development Team.

3. PROCEDURE

NEWS2 score should be determined from seven parameters (six physiological, plus a weighting score for supplemental oxygen). Six physiological parameters routinely recorded:

- Respiration rate (RR);
- Oxygen saturation (SpO2);
- Systolic Blood Pressure (BP);
- Heart Rate (HR);
- Level of consciousness and new confusion ('C'), ACVPU, C represents new confusion;
- Temperature (T)

A weighting score of 2 to be added for any patient requiring supplemental oxygen (oxygen delivery by mask or nasal cannula) to maintain their prescribed saturation range.

A score is allocated to each parameter as they are measured, the score is then aggregated.

3.1 Respiration Rate

Respiratory rate is the most sensitive indicator of deteriorating physiology and must be recorded in all patients.

A respiratory rate of < 12 or > 20 should initiate an alert.

Depth, symmetry and pattern of respiration should also be noted and recorded if abnormal.

3.2 Oxygen Saturation

Oxygen saturation (SpO2) should be recorded on all patients. Unless normal for patient, saturation < 90% with or without supplemental oxygen needs to be addressed. Escalation and actions will be based on specific patient presentation.

The concentration of supplemental oxygen should also be recorded and the oxygen delivery device noted. If the patient is receiving supplemental oxygen therapy and has an oxygen saturation reading < 90% (unless normal for patient), the device, flow and equipment should all be checked to ensure optimum oxygenation. Check oxygen cylinder/concentrator capacity, if in use, and ensure there is an adequate supply.

Oxygen saturations will not be accurate in patients with poor circulation/hypo perfusion conditions. A capillary refill time (CRT) test and mottled knee sign can give further information on the patient's perfusion and may initiate an alert. This will need to be discussed with the GP/Doctor and/or Senior Nurse on duty.

In addition false nails and/or nail varnish can invalidate the SpO2 measurement.

3.3 Blood Pressure

Although an elevated blood pressure (hypertension) is an important risk factor for

cardiovascular disease, it is a low or falling systolic blood pressure (hypotension) that is most significant in the context of assessing acute-illness severity. Hypotension may indicate:

- circulatory compromise due to sepsis or volume depletion
- cardiac failure or cardiac rhythm disturbance
- central nervous system depression
- hypoadrenalism and/or the effect of blood pressure-lowering medications

It is important to note that some people have a naturally low systolic blood pressure (<100 mmHg) and this might be suspected if the patient is well and all other physiological parameters are normal, or confirmed by reference to previous records of blood pressure.

Hypertension is given less weighting in the context of acute-illness assessment. Severe hypertension, e.g. systolic blood pressure ≥200 mmHg, may occur as a consequence of pain or distress, but it is important to consider whether the acute illness may also be a consequence of, or exacerbated by, severe hypertension and to take appropriate clinical action. Diastolic blood pressure does not form part of the scoring system for acute-illness severity because it does not add value in this context. However, diastolic blood pressure should be routinely recorded as it may be severely elevated and require treatment in some acute settings, i.e. accelerated hypertension.
Please note:

- a SBP < 90mmHg may be a sign of severe sepsis fluid loss or cardiac shock and requires further assessment of the patient
- falling blood pressure should be regarded as a late sign of deterioration
- in cases of very low blood pressure, the use of electronic BP measuring devices may not be accurate and a manual sphygmomanometer should be used
- Manual sphygmomanometers must be available to all areas and staff should be trained and competent to use them
- all patients with a diagnosis of Atrial Fibrillation should always have a manual BP taken

3.4 Heart Rate/Pulse

The measurement of heart rate is an important indicator of a patient's clinical condition. Tachycardia may be indicative of circulatory compromise due to sepsis or volume depletion, cardiac failure, pyrexia, or pain and general distress. It may also be due to cardiac arrhythmia, metabolic disturbance, e.g. hyperthyroidism, or drug intoxication, e.g. sympathomimetic or anticholinergic drugs.

Bradycardia is also an important physiological indicator. A low heart rate may be normal with physical conditioning or as a consequence of medication, e.g. with beta blockers. However, it may also be an important indicator of hypothermia, CNS depression, hypothyroidism or heart block.

The pulse is a reflection of the heart rate and is frequently measured via the saturation probe on the pulse oximeter or via the automated blood pressure machine. This poses three issues:

- the pulse might not reflect the true heart rate
- pulse properties cannot be determined, i.e. volume and regularity;
- practitioners may not develop expertise in assessing pulse properties;

Please note:

- a manual pulse should be taken at first assessment to assess the pulse properties (rate/rhythm/strength)
- a pulse rate of >90 b/min or < 50 b/min should initiate an alert and a manual pulse should be checked if the heart rate has been read from an automated machine. The rate and regularity should be checked and recorded
- any patient who is identified as having a new irregular pulse noted, or any other concerns with their pulse should be discussed with the doctor/GP and consideration given to a 12 lead ECG being required; if available monitor using the Kardia and if indicated liaise with Cardiac specialist nurses as per agreement.
- patients receiving beta blocker medication will not be able to increase their heart rate to compensate for hypo perfusion conditions, and therefore other abnormal signs (high respiratory rate and low urinary output) will have extra significance

3.5 Level of Consciousness and New Confusion ('C'), ACVPU, C represents New Confusion

A change in the level of consciousness is an important indicator of acute-illness severity. New onset confusion is a sign of potentially serious clinical deterioration in patients and especially those with confirmed or suspected sepsis. The NEWS Review Group (RCP 2017) recommended including 'new confusion' as part of the assessment of consciousness, hence the term ACVPU rather than AVPU to reflect this change. New confusion scores 3 on the NEWS2 chart, indicating a code red (for a single score of 3), i.e. that the patient requires urgent assessment.

3.6 Updated ACVPU assessment

Alert: a fully awake patient. Such patients will have spontaneous opening of the eyes, will respond to voice and will have motor function. Previously, a patient could be considered alert even if disorientated or confused. This is no longer considered appropriate because **acute** alteration in mentation or **new** confusion now scores higher

(3 NEWS points) on the NEWS2 chart, as this can be indicative of serious risk of clinical deterioration, especially in patients with sepsis;

New confusion: a patient may be alert but confused or disorientated. It is not always possible to determine whether the confusion is '**new**' when a patient presents acutely ill. Such a presentation should always be considered to be '**new'** until confirmed to be otherwise. New-onset or worsening confusion, delirium or any other altered mentation should always prompt concern about potentially serious underlying causes and warrants urgent clinical evaluation.

Voice: the patient makes some kind of response when you talk to them, which could be in any of the three component measures of eyes, voice or motor – e.g. patient's eyes open on being asked 'Are you okay?'. The response could be as little as a grunt, moan, or slight movement of a limb when prompted by voice;

Pain: the patient makes a response to a pain stimulus. A patient who is not alert and who has not responded to voice (hence having the test performed on them) is likely to exhibit only withdrawal from pain, or even involuntary flexion or extension of the limbs from the pain stimulus. The person undertaking the assessment should always exercise care and be suitably trained when using a pain stimulus as a method of assessing levels of consciousness;

Unresponsive: this is also commonly referred to as 'unconscious'. This outcome is recorded if the patient does not give any eye, voice or motor response to voice or pain.

Please note:

- conscious level should be initially assessed on all patients using the ACVPU scale;
- deterioration in conscious level can be caused by many factors, and a more comprehensive physical assessment should be undertaken by a competent practitioner;
- new confusion or a change in conscious level is a significant indicator of deteriorating physiology and should be recorded as 3 on the NEWS2 score;
- a response only to pain or unresponsive, correlates to a GCS of < 8 and should be treated as a medical emergency;
- any deterioration in conscious level should be followed by a more in depth assessment of GCS by a competent practitioner
- patients having unexpected seizures are at significant risk and should have a senior medical review (however, in palliative care patients with known brain tumours/metastases – seizures can be a common side effect and can be managed appropriately in primary care after patient has been medically assessed and a clinical management plan commenced)

3.7 Temperature

Temperature is one of the 'vital signs' and should be regularly measured. It is especially important if the patient has any type of likely or confirmed infection and especially in neutropenia patients, and for detecting sepsis.

Temperature, both pyrexia and hypothermia are included in the NEWS2, reflecting the fact that the extremes of temperature are sensitive markers of acute-illness severity, sepsis and physiological disturbance. Low temperature is as significant as high

temperature. The Surviving Sepsis campaign defines one of the parameters for sepsis, as having a core temperature of >38˚ C or < 36˚ C (Ref: www.survivingsepsis.org) Hypothermia is defined as a core temperature < 35˚ C which can become fatal at < 32˚C. Hypothermic patients should be warmed slowly using blankets.

3.8 NEWS2 Observation Chart

The NEWS2 Observation Chart (RCP 2017) and associated documents will be used as standard in the organization. This replaces all other NEWS1/MEWS/TPR charts and these include:

- escalation pathways
- Sepsis pathway
- SBAR

The recording of physiological parameters has been recorded to align to the Resuscitation Council (UK) ABCDE sequence. The ranges for the boundaries of each parameter score are shown on the chart.

All documented observations MUST be in black ink, preferably with a biro pen or documented on the appropriate electronic patient record.

There is a dedicated section (SpO2 Scale 2) for use in patients with hypercapnic respiratory failure (usually due to COPD) who have a clinically recommended oxygen saturation of 88-92%.

The importance of considering serious sepsis in patients with known or suspected infection, or at risk of infection, is emphasised. A NEWS2 score of 5 or more (or 3 in any single parameter) is the key trigger threshold for urgent clinical review and action. **'Think is this Sepsis?'**

3.9 SpO2 Scoring Scale 2

For patients with prescribed oxygen saturation requirements 88-92% (e.g. in patients with hypercapnic respiratory failure).

This should only be used in patients **confirmed** to have hypercapnic respiratory failure on blood gas analysis on either:

- a prior or their current hospital admission and requiring supplementary oxygen
- following the results of an oxygen assessment via a Respiratory Specialist

The decision to use the SpO2 Scoring Scale 2 should be made by a competent clinical decision maker and should be recorded in the patient's clinical notes. In all other circumstances the NEWS SpO2 Scoring Scale 1 should be used.

For avoidance of doubt, the SpO2 Scoring Scale not being used, should be clearly crossed out on the chart.

3.10 Supplemental Oxygen Delivery

When supplemental oxygen is being used to maintain the desired oxygen saturation, the rate of oxygen delivery (L/min) and the delivery system/device should be documented on the NEWS2 chart using the BTS oxygen delivery system/device codes.

Codes for recording oxygen delivery:

Codes for recording oxygen delivery:	
A	(breathing air)
N	(nasal cannula)
SM	(simple mask)
V	(venture mask and percentage) e.g. V24, V28, V35, V40, V80
NIV	(patient in NIV system)
RM	(reservoir mask)
TM	(tracheostomy mask)
CP	(CPAP mask)
H	(humidified oxygen and percentage) e.g. H28, H35, H40, H60
OTH	(other, specifiy……)

3.11 ACVPU

Patients with acute illness may develop an acutely altered mental state manifesting as:

- new confusion or a Glasgow Coma Scale (GSC) <15 - this is an important sign of acute clinical deterioration requiring urgent clinical assessment
- acutely altered mentation may occur as a consequence of sepsis, hypoxia, hypotension or metabolic disturbances, either alone or in combination
- new confusion, delirium or acutely altered mentation scores a single 3 that requires the patient to have an urgent assessment

3.12 Recognising Sepsis

Sepsis is defined as a 'rare but serious reaction to infection in which the immune system response becomes overactive and starts to cause damage to the body itself' (NICE 2016).

Sepsis is a main cause of death and disability in the UK, with almost 60,000 (29%) patients dying and the majority of survivors suffering significant complications.

The subgroup of patients who are more likely to be at risk of sepsis:

- patients who have recently had surgery or those with burns, blisters or cuts to the skin;
- patients who are immunocompromised, including those receiving cancer chemotherapy, immunosuppressive biologics and long-term steroids
- patients post-splenectomy;
- patients with indwelling catheters or cannulas

A NEWS2 score of 5 or more in a patient with signs and symptoms of infection, or clinical deterioration in a patient at high risk of infection, should always prompt the question '**IS THIS SEPSIS?**', complete the appropriate Pre-Hospital Sepsis Screening Tool and Action Plan and trigger an immediate escalation in care.

NB – The NICE Sepsis Guideline CG51 states to not use a person's temperature as the sole predictor of Sepsis.

3.13 Clinical Response

The clinical response to NEWS2 has four key components:

- the urgency of the response;

- the seniority and clinical competencies of clinical staff to attend to the patient;
- the frequency of ongoing clinical monitoring;
- the setting in which the ongoing clinical care should be delivered

NB – CLINICAL CONCERN ABOUT A PATIENT'S CONDITION SHOULD ALWAYS OVERIDE THE NEWS2 IF THE HEALTHCARE PROFESSIONAL CONSIDERS IT NECESSARY TO ESCALATE CARE

An alert should cause the practitioner to stop and think about the implications for the patient. An alert should prompt one or more of the following depending on the severity of the patient's condition:

- extra vigilance (additional observation parameters being measured);
- further assessment and intervention by a competent practitioner;
- re-assessment of all physiological observations in line with NEWS2 guidelines and clinical judgement of registered nurse;
- discussion with the Senior Nurse/ACP/Team Leader/General Practitioner (GP) or Out of Hours GP Service, Medical / Surgical physician.
- 999 Call

3.14 Assessing the Patient

Staff should ensure the patient is able to understand the information given to them and are able to give their informed consent. This may necessitate the use of a professional interpreter and the translation of written information. A capacity assessment should be considered for those patients where there is reason to doubt capacity. Reference should be made to the Organisational Consent Policy.

It is the responsibility of the practitioner undertaking the clinical observations to ensure that the equipment is correctly functioning and has been calibrated subject to Family Nursing & Home Care guidance. Please note that extreme environmental conditions (e.g. hot and cold weather) can affect the accuracy of the readings/correct functioning of the equipment. These factors must be considered when measuring clinical observations and clinical judgement always be applied. In the event of any equipment failure resulting in a missing parameter, the NEWS2 Score cannot be accurately calculated. However, clinical judgement can still apply in the overall assessment of the patient.

Vital signs and NEWS2 scoring will give an indication of the patient's condition. If the patient is deteriorating, a more comprehensive assessment is warranted.

The ABCDE model of assessment is recommended as it gives a rapid, initial assessment of the patient's condition:

- A = Airway
- B = Breathing
- C = Circulation
- D = Disability
- E = Exposure.

Help must be sought as soon as possible if any practitioner feels unable to adequately deal with the situation, or feels that the patient could deteriorate further.

3.15 Seeking Help

Any concerns about the patient must be relayed to the Senior Nurse on duty and/or Doctor/GP responsible for the care of the patient, and recorded in the patients' records.

The following procedure is a guide to calling for help.

Before calling a Doctor/GP/Senior Nurse, make sure you have all the information you need to hand.

Use the SBAR system to communicate:

- **S**ituation – State your name, position and where you are located. State the patients name, age and diagnosis, state why you are calling – the current problem, giving the patient's physiological observation and your assessment findings;
- **B**ackground – State any relevant events leading up to this event, providing further details of the patient (diagnosis, resuscitation category, team responsible for care and reasons for concern)
- **A**ssessment – State what you have assessed the situation to be, for example, 'I believe the patient has developed pneumonia'. Utilise ABCDE to facilitate a structure Assessment handover outlining initial ABCDE along with actions taken and outcomes;
- **R**ecommendation – Be clear about what you are expecting the Doctor/GP or Senior Nurse to do – for example, attend immediately, attend within one hour. Do not hesitate to call 999 if the patient is rapidly deteriorating or you have any major concerns.

All staff within the Organisation **must** be aware of how to summon assistance and call for an emergency ambulance when required to do so.

3.16 Immediate Measures

Simple early measures can often prevent further deterioration of the patient and avoid the need to admit to secondary care.

Interventions will depend on the patients' vital signs and initial assessment but include some of the following:

- appropriate positioning of the patient
- checking that the optimum amount of oxygen is being delivered if appropriate
- checking that vital medications have been given
- giving appropriate medications
- checking that infusions are running up to date

*If you are in any doubt about what to do, or your competency to do it .....**call for help.***

3.17 Documentation

If paper notes are used, all entries on the charts are to be made in black biro (ink).

Temperature, pulse, respiration measurements are shown as black dots. A connecting line must be drawn between each value to help show the trends

Oxygen saturation - the actual percentage must be written e.g. 95%.

ACPVU - the initial for the level of consciousness level e.g. ACVPU.

Blood pressure values are marked with arrow heads, a dashed line is drawn between the arrow head.

Values should be recorded on the chart where they reach a value that would generate a score.

All entries MUST be initialed.

3.18 Mental Health and Learning Disability Patients

All patients admitted by Family Nursing & Home Care must have the six physiological parameters recorded and converted into a score for each parameter and then added up to a total score as a baseline on **admission.**

Patients who refuse or it is unsafe to complete physical observations due to their clinical presentation should have **Respiratory Rate** and **ACVPU** recorded on the NEWS chart and a **Visual A-E Assessment** should be undertaken and recorded on appropriate chart. If the patient scores in any of the ORANGE zones an immediate review **MUST** be undertaken by a Registered Nurse and, Doctor/GP or Senior Nurse **MUST** be contacted. NEWS2 must be completed as soon as possible.

Refusals of blood pressure, pulse, temperature, oxygen saturation should be documented on the NEWS2 chart as '**R**'.

In a patient with a NEWS2 score of 5 or more and has a known infection, signs and symptoms of infection, or at risk of infection think 'Could this be sepsis?' complete the Pre-hospital Sepsis Screening Tool and Action Plan, and escalate care immediately.

The parameters for escalating BP have changed, escalation of BP now triggers when the systolic is >220, therefore it is recommended to follow NICE CG127 Hypertension in adults: diagnosis and management for treatment and diagnosis; as whilst the presentation may not be immediate or acute there still could be potentially dangerous underlying conditions that requires treatment.

4. CONSULTATION PROCESS

Name	Title	Date
Tia Hall	Operational Lead	19/6/2020
Michelle Cumming	Operational Lead	19/6/2020
Elspeth Snowie	Clinical effectiveness	19/6/2020
Adult services	Team Leaders	19/6/2020
Judy Foglia	Governance and Quality Lead	19/6/2020
Anne McConomy	Education and PDN	19/6/2020
Justine Bell	Education	19/6/2020
Kirsty Ross	Specialist ED Registrar	19/6/2020

5. IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Policy to be placed on the Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification

6. MONITORING COMPLIANCE

Compliance with NEWS2 will be monitored via a sample audit. Evidence of non-compliance or poor standards should be referred to the operational lead, team leaders and Education department in order for development plans to be devised and additional training requirements assessed.

7. EQUALITY IMPACT STATEMENT

A statement to show that the document does not discriminate against disadvantaged or vulnerable people

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively
- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity

- ✓ Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times.

See appendix 1 for the completed Equality Impact Screening Tool.

8. GLOSSARY OF TERMS

ABCDE	Airway, Breathing, Circulation, Disability, Exposure
ACPVU	**A**lert, new **C**onfusion, responds to **V**oice, responds to **P**ain, **U**nresponsive. An assessment tool for conscious level
BP	Blood Pressure
COPD	Chronic Obstructive Pulmonary Disease
CRT	Capillary Refill Time
HR	Heart Rate
Hypercapnic Respiratory Failure	An elevated level of carbon dioxide level in the blood
RR	Respiratory Rate
Sepsis	'A life threatening organ dysfunction caused by a deregulated host response to infection'
SBP	Systolic Blood Pressure
SpO2	Peripheral Capillary Oxygen Saturation
T	Temperature

9. REFERENCES

British Thoracic Society (2017) Emergency Oxygen Guideline Group. BTS guideline for oxygen use in adults in healthcare and emergency settings. Thorax, Volume 72 Supplement 1, Page i41.

National Institute for Health and Care Excellence (2016) Hypertension in adults: diagnosis and management. NICE clinical guideline 127. London: NICE

National Institute for Health and Care Excellence (2016) Sepsis: recognition, diagnosis and early management. NICE guideline 51. London: NICE

Royal College of Physicians (2017) National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. RCP, London

10. APPENDICES

Appendix 1 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document: MANAGEMENT AND RECOGNITION OF THE DETERIORATING PATIENT, NEWS2 (NATIONAL EARLY WARNING SCORES) AND RECOGNITION OF SEPSIS			
Date of Assessment	9/9/20	Responsible Department	RRRT
Name of person completing assessment	C Stewart	Job Title	Operational Lead

Does the policy/function affect one group less or more favourably than another on the basis of :		
	Yes/No	**Comments**
• Age	Yes	Not suitable for under 18
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	No	
• Ethnic Origin (including hard to reach groups)	No	
• Gender reassignment	No	
• Pregnancy or Maternity	Yes	Use in caution in pregnancy
• Race	No	
• Sex	No	
• Religion and Belief	No	
• Sexual Orientation	No	
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions** **(what needs to be done to minimise / remove the impact)**	**Responsible Officer**
NEWS2 not suitable for under 18 and pregnancy		Alternative early warning scores in place	HC

Monitoring of Actions
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level

Appendix 2 – NEWS2 Documents for Mental Health / Learning Disability

Patient ID ……..

Name……..

DOB……

URN…….

Department……..

- Observation Chart NEWS2
- Visual A –E Chart
- NEWS2 Scoring aide
- Pre Hospital Sepsis Screen
- Glasgow Coma Scale (GCS)

NEWS2 KEY (0 1 2 3)	NAME:	D.O.B.	URN:	ADMISSION DATE:

	DATE														
	TIME														
A+B Respirations Breaths/min	≥25	3	3	3	3	3	3	3	3	3	3	3	3	3	
	21-24	2	2	2	2	2	2	2	2	2	2	2	2	2	
	18-20														
	15-17														
	12-14														
	9-11	1	1	1	1	1	1	1	1	1	1	1	1	1	
	≤8	3	3	3	3	3	3	3	3	3	3	3	3	3	
A+B SpO_2 Scale 1	≥96														
	94-95	1	1	1	1	1	1	1	1	1	1	1	1	1	
	92-93	2	2	2	2	2	2	2	2	2	2	2	2	2	
	≤91	3	3	3	3	3	3	3	3	3	3	3	3	3	
SpO_2 Scale 2† Oxygen Saturation (%) Use Scale 2 if target range is 88-92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3	3	3	3	3	3	3	3	3	3	3	3	3	
	95-96 on O_2	2	2	2	2	2	2	2	2	2	2	2	2	2	
	93-94 on O_2	1	1	1	1	1	1	1	1	1	1	1	1	1	
	≥93 on air														
	88-92														
	86-87	1	1	1	1	1	1	1	1	1	1	1	1	1	
	84-85	2	2	2	2	2	2	2	2	2	2	2	2	2	
	≤83	3	3	3	3	3	3	3	3	3	3	3	3	3	
Air or oxygen? Refer to front page for codes	A=Air														
	O_2 L/min	2	2	2	2	2	2	2	2	2	2	2	2	2	
	Device														
C Blood Pressure mmHg Score uses systolic BP only	≥220	3	3	3	3	3	3	3	3	3	3	3	3	3	
	201-219														
	181-200														
	161-180														
	141-160														
	121-140														
	111-120														
	101-110	1	1	1	1	1	1	1	1	1	1	1	1	1	
	91-100	2	2	2	2	2	2	2	2	2	2	2	2	2	
	81-90	3	3	3	3	3	3		3	3	3	3	3	3	
	71-80	3	3	3	3	3	3		3	3	3	3	3	3	
	61-70	3	3	3	3	3	3	3	3	3	3	3	3	3	
	51-60	3	3	3	3	3	3		3	3	3	3	3	3	
	≤50	3	3	3	3	3	3		3	3	3	3	3	3	
C Pulse Beats/min	≥131	3	3	3	3	3	3	3	3	3	3	3	3	3	
	121-130	2	2	2	2	2	2	2	2	2	2	2	2	2	
	111-120	2	2	2	2	2	2		2	2	2	2	2	2	
	101-110	1	1	1	1	1	1	1	1	1	1	1	1	1	
	91-100	1	1	1	1	1	1		1	1	1	1	1	1	
	81-90														
	71-80														
	61-70														
	51-60														
	41-50	1	1	1	1	1	1	1	1	1	1	1	1	1	
	31-40	3	3	3	3	3	3	3	3	3	3	3	3	3	
	≤30	3	3	3	3	3	3		3	3	3	3	3	3	
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert														
	Confusion	3	3	3	3	3	3		3	3	3	3	3	3	
	V	3	3	3	3	3	3	3	3	3	3	3	3	3	
	P	3	3	3	3	3	3		3	3	3	3	3	3	
	U	3	3	3	3	3	3		3	3	3	3	3	3	
Blood Sugar															
E Temperature °C	≥39.1°	2	2	2	2	2	2		2	2	2	2	2	2	
	38.1-39.0°	1	1	1	1	1	1	1	1	1	1	1	1	1	
	37.1-38.0°														
	36.1-37.0°														
	35.1-36.0°	1	1	1	1	1	1	1	1	1	1	1	1	1	
	≤35.0°	3	3	3	3	3	3	3	3	3	3	3	3	3	
TOTAL NEWS2 SCORE															
Monitoring Frequency															
Escalation Plan [**Y, N, N/A**]															
Initials															
Additional Parameters	Nausea Score														
	Pain Score														
	Urine output														

Visual A–E Assessment

Only to be used if patient refuses or it is unsafe to complete physical observations (NEWS2)

Family Nursing & Home Care

Assess patients A-E and tick the most appropriate statement
If ANY orange statements are ticked an immediate review by a registered nurse in charge must be completed and medical staff contacted
Complete NEWS2 as soon as possible

Name: _____ **DOB:** ___/___/_____ **ID No:** _____

		Date											
		Time											
Why are you unable to do physical observations (NEWS2)? Refused (R) Unsafe (U) **If patient is in seclusion, time physical obs in line with Seclusion Policy*													
A	• Talking (not just moans and groans) within patient's normal parameters • Breathing is quiet and regular												
	• Breathing is noisy – irregular, fast • Increased breathlessness or airway obstruction causing reduced ability to talk/communicate normally												
B	• Respiratory rate is between 12 – 20 per minute (PLEASE RECORD RESPIRATORY RATE ON NEWS2 OBSERVATION CHART) • It requires no extra effort and does not appear difficult												
	• Respiratory rate is below 12 per minute or above 20 per minute (PLEASE RECORD RESPIRATORY RATE) • Breathing appears to be difficult and/or noisy												
C	• Normal level of mobility for patient • Orientated to time, person and place • Normal skin tone for that patient												
	• Reduced level of mobility which is normal for that patient • Mottled or cyanosed skin • Blue grey tinge to lips • Appears sweaty and clammy												
D	• Alert, responsive and active • Spontaneous speech												
	• Unexpectedly sleepy/drowsy • Change in responsiveness • Unexpected or new confusion, coherence and/or disorientation												
E	• Patient's condition appears stable • No known underlying physical health conditions, interventions or substance misuse												
	• Rash, wounds, actively bleeding • Staff or patient expressing concerns • New pain/discomfort												
Observations completed by:													

Acknowledgement to Leeds and York Partnership NHS Foundation Trust for kind permission to reproduce

TO BE SCANNED INTO ELECTRONIC PATIENT RECORD

Amended version March 2018

The NEWS2 scoring system

Physiolgical parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤ 8		9 – 11	12 – 20		21 – 24	≥ 25
SpO_2 Scale 1 (%)	≤ 91	92 – 93	94 – 95	≥ 96			
SpO_2 Scale 2 (%)	≤ 83	84 – 85	86 – 87	88-92 ≥ 93 on air	93 – 94 on oxygen	95 – 96 on oxygen	≥ 97 on oxygen
Air or Oxygen		Oxygen		Air			
Systolic Blood Pressure (mmHg)	≤ 90	91 – 100	101 – 110	111 – 219			≥ 220
Pulse (per minute)	≤ 40		41 – 50	51 – 90	91 – 110	111 – 130	≥ 131
Consciousness				Alert			CVPU
Temperature (°C)	≤ 35.0		35.1 – 36.0	36.1 – 38.0	38.1 – 39.0	≥ 39.1	

CLINICAL RESPONSE AND ESCALATION PROCESS

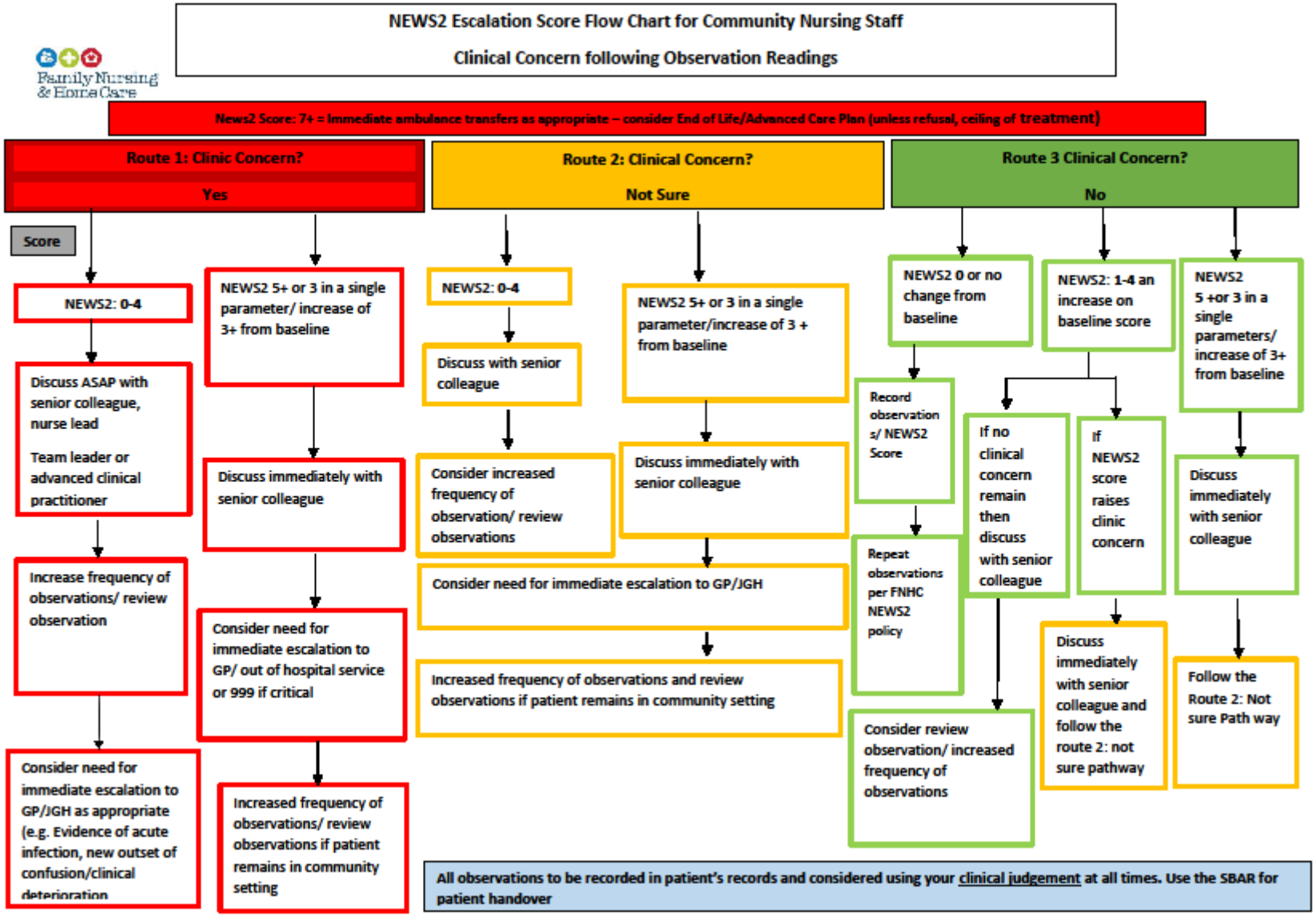
Staff should always use their clinical judgement and seek advice if there are any concerns about the patient, regardless of the calculated score. If NEWS2 is 5 or more (with a known infection, signs and symptoms of infection or at risk of infection) THINK "IS THIS SEPSIS?" and complete the pre-hospital sepsis screening tool.

No risk		
0	As per standard for recording clinical observations guidelines	• Continue routine NEWS monitoring (see standard for recording clinical observations / frequency guidance as per appendix 3 of FNHC National Early Warning Score (NEWS2) policy
Low risk		
Total 1-4	Repeat observations as per clinical judgement from senior	• Inform senior colleague / registered nurse who must assess the patient • Registered nurse decides if increased frequency of monitoring and / or escalation required • If escalation is not required clearly document rationale and ensure safety netting recorded
Low-medium risk		
3 in one single parameter	Repeat observations as per clinical judgement from senior colleague	• Health professional to immediately inform senior colleague / senior nurse / medical team caring for patient who will need to review and decide whether escalation of care is required
Medium risk		**WITHIN 30 MINUTES**
Total 5 or more urgent response threshold	Repeat observations as per clinical judgement from senior colleague	• Increase monitoring as per senior nurse instructions • Inform senior trained nurse who must assess patient & decide if review by GP/ACP is required • Determine management plan in line with scope of practice/national guidelines and/or local policies and procedures • Arrange transfer to acute hospital if appropriate and patient consents
High		**WITHIN 15 MINUTES**
Total 7 or more emergency response threshold	Continuous monitoring required	• Immediately repeat observations and NEWS2 score • Immediately inform senior nurse on duty who must determine management plan in line with scope of practice/national guidelines and/or local policies and procedures and inform GP / Consultant • Arrange transfer to acute hospital if appropriate and patient consents

Blood Pressure Pathway

Normal	90/60 mmHg - 140-90 mmHg	Offer diet and exercise advice as normal brief intervention
Stage one hypertension	Over 140/90 mmHg and below 160/100 mmHg	Offer diet and exercise advice and refer to medical team
Stage two hypertension	Over 160/100 mmHg and below 180/100 mmHg	Offer diet and exercise advice and refer to medical team
Severe hypertension	Systolic 180 mmHg or higher and Diastolic 110 mmHg or above	Requires IMMEDIATE medical assessment

Ref - NICE CG127: Hypertension in adults: diagnosis and management.


NEWS2 Escalation Score Flow Chart for Community Nursing Staff
Clinical Concern following Observation Readings
Family Nursing & Home Care
News2 Score: 7+ = Immediate ambulance transfers as appropriate – consider End of Life/Advanced Care Plan (unless refusal, ceiling of treatment)
Route 1: Clinic Concern?
Yes
Route 2: Clinical Concern?
Not Sure
Route 3 Clinical Concern?
No
Score
NEWS2: 0-4
Discuss ASAP with senior colleague, nurse lead
Team leader or advanced clinical practitioner
Increase frequency of observations/ review observation
Consider need for immediate escalation to GP/JGH as appropriate (e.g. Evidence of acute infection, new outset of confusion/clinical deterioration
NEWS2 5+ or 3 in a single parameter/ increase of 3+ from baseline
Discuss immediately with senior colleague
Consider need for immediate escalation to GP/ out of hospital service or 999 if critical
Increased frequency of observations/ review observations if patient remains in community setting
NEWS2: 0-4
Discuss with senior colleague
Consider increased frequency of observation/ review observations
NEWS2 5+ or 3 in a single parameter/increase of 3 + from baseline
Discuss immediately with senior colleague
Consider need for immediate escalation to GP/JGH
Increased frequency of observations and review observations if patient remains in community setting
NEWS2 0 or no change from baseline
Record observations/ NEWS2 Score
Repeat observations per FNHC NEWS2 policy
Consider review observation/ increased frequency of observations
NEWS2: 1-4 an increase on baseline score
If no clinical concern remain then discuss with senior colleague
If NEWS2 score raises clinic concern
Discuss immediately with senior colleague and follow the route 2: not sure pathway
NEWS2 5 +or 3 in a single parameters/ increase of 3+ from baseline
Discuss immediately with senior colleague
Follow the Route 2: Not sure Path way
All observations to be recorded in patient's records and considered using your clinical judgement at all times. Use the SBAR for patient handover

Pre-hospital Sepsis Screening Tool and Action Plan

To be applied to all non-pregnant adults with fever (or recent fever) symptoms/ infection. Staff should always use their clinical judgement; if they have concerns about a patient seek advice.

Family Nursing & Home Care

	Tick
1. Is the NEWS 5 or above?	☐
AND/OR does the patient look very sick?	☐

N → Low risk of sepsis. **If concerned consider other diagnosis, transfer as required.** Use standard protocols. If not for transfer recommend contact medical staff if concerned, or 999 if patient deteriorates rapidly.

Y

2 .Is the history suggestive of infection?	Tick
Yes, but source not obvious	☐
Pneumonia/likely chest source	☐
Urinary tract infection	☐
Abdominal pain or distension	☐
Cellulitis/septic arthritis/infected wound	☐
Device related infection	☐
Meningitis	☐
Other (specify):	☐

N → Give safety netting advice: call 999 if patient deteriorates quickly

Y

3. Is ONE Red Flag present?	Tick
Responds only to voice or pain/unresponsive	☐
Systolic BP ≤ 90 mmHg (or drop > 40 from normal)	☐
Heart rate > 131 per minute	☐
Respiratory rate ≥ 25 per minute	☐
Needs oxygen to keep SpO_2 ≥ 91%	☐
Non-blanching rash, mottled/ashen/cyanotic	☐
Not passed urine in the last 18 hours	☐
Urine output less than 0.5 ml/kg/hr	☐
Lactate ≥ 2mmol/l	☐
Recent chemotherapy/immunotherapy	☐

N → **4. If ONE of Amber Flags present?**

- Relatives concerned about mental status
- Acute deterioration in functional ability
- Immunosuppressed
- Trauma/surgery/procedure in last six weeks
- Respiratory rate 21 – 24 OR breathing hard
- Systolic BP 91 – 100 mmHg
- Heart rate 91 – 130 OR new arrhythmia
- Not passed urine during last 12 to 18 hours
- Temperature < 36°C
- Clinical signs of wound, device or skin infection

If immunosuppressed and under 18 treat as Red Flag Sepsis

Y → **Sepsis likely**

Transfer to designated destination
Communicate likelihood of sepsis at handover

Y

Red Flag sepsis

This is time-critical, immediate action is required!

Resuscitation:
Oxygen – aim to maintain saturation range 94-98% inc. COPD/Hyper-capnia disease
Record lactacte (if available)
250ml boluses of Sodium Chloride: max 250mls if normotensive, max 2000ml if hypotensive/lactate > 2mmol/l

Communication:
Pre-alert receiving hospital: 'Patient has Red Flag Sepsis'
Divert to A&E
Handover presence of Red Flag Sepsis
(*If patient is currently receiving chemotherapy/ immunotherapy inform Clatterbridge triage line)

Acknowledgment in line with RCP (2017) NEWS2 and British Thoracic Society Emergency Oxygen Guideline Development Group (2017) BTS Guideline for oxygen use in adults in healthcare and emergency settings. *Thorax*, Volume 72 Supplement 1, Page i41. Amended Pre-hospital Sepsis Screening and Action Tool: The Sepsis UK Trust (April 2018)

Glasgow Coma Scale (GCS)

MUST BE COMPLETED TOGETHER WITH A FULL SET OF NEWS2 OBSERVATIONS

Frequency of observations: _____

Date:														
Time:														
Eyes open	Spontaneously	4												
	To speech	3												
	To pain	2												
	Unresponsive	1												
Verbal response	Orientated	5												
	Confused	4												
	Inappropriate words	3												
	Incomprehensible sounds	2												
	None	1												
Motor response	Obeys commands	6												
	Localises to pain	5												
	Withdraws from pain	4												
	Abnormal flexion	3												
	Extension to pain	2												
	None	1												
Total score														

Neurological observations:

Pupils size (mm) 1 2 3 4 5 6 7 8	**Key:** Normal (+) Sluggish (S) None (N)	Right	Size (mm)									
			Reaction									
		Left	Size (mm)									
			Reaction									
	Limb movements Record: Right (R) Left (L) Separately if there is a difference	Arms	Normal power									
			Mild weakness									
			Severe weakness									
			Flexion									
			Extension									
			No response									
		Legs	Normal power									
			Mild weakness									
			Severe weakness									
			Flexion									
			Extension									
			No response									
Do you need to escalate?		YES/NO										
		Initials:										

Appendix 3 Community Nursing Documents

FAMILY NURSING & HOME CARE NEWS 2 OBSERVATIONS CHART

Family Nursing & Home Care

Patient Name: _____

NHS No: _____

Date of Birth: ___/___/___

Baseline Observations Date: ___/___/___

Respiration rate	Oxygen saturation	Any supplemental oxygen	Temperature	Systolic blood pressure	Heart rate	Level of conciousness

Source: _____

Primary care records: ☐

Discharge records: ☐

Other (please state): _____

Please complete Patient Observations scoring in BLACK INK

v1. November 2018

National Early Warning Score (NEWS2)
Observation Chart

Instructions for use - **Medical Staff**	Instructions for use - **Nursing Staff**
• The NEWS2 score (0,1,2,3) and Clinical Response Triggers (Low, Medium and High) are **not** to be adjusted • Alterations to physiological parameters, including the use of SpO_2 Scale 2 for hypercapnic respiratory failure (COPD), **must** be agreed by a GP, ACP or above • All changes **must** be documented, signed and dated with a review period specified (see table below) • All changes must be communicated to the clinical and nursing team	• Observations to be recorded by placing a '●' in the appropriate box • Written figures entered into a box **must** be accompanied by a dot to document the observation • The SpO_2 scale **NOT** being used should be clearly crossed out • Complete NEWS2 Activation template onto EMIS if escalation is required

PHYSIOLOGICAL PARAMETER	3	2	1	0	1	2	3
Respirations rate (per minute)	≤8		9 - 11	12 - 20		21 - 24	≥25
SpO_2 Scale 1 (%)	≤91	92 - 93	94 - 95	≥96			
SpO_2 Scale 2 (%)	≤83	84 - 85	86 - 87	88 - 92 ≥93 on air	93 - 94 on oxygen	95 - 96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91 - 100	101 - 110	111 - 219		Pat	≥220
Pulse (per minute)	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Consciousness				Alert			Confusion, V, P, or U
Temperature (^{0}C)	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	

Codes for recording air or oxygen delivery

A (breathing air) **RM** (reservoir mask) **V** (Venturi mask and percentage) e.g. V24, V28, V35, V40, V80

N (nasal cannula) **TM** (tracheostomy mask) **H** (humidified oxygen and percentage) e.g. H28, H35, H40, H60

SM (simple mask) **CP** (CPAP mask) **NIV** (patient on NIV system) **OTH** (other, please specify)

Alterations to NEWS2 Scoring (use SpO_2 Scale 2 for COPD)
- review date must be documented

Alteration		Parameter	Details of Alteration and Instructions	Review		Dr's Grade	Dr's Signature
Date	Time			Date	Time		

Low risk = A **Urine output 50mls / hr**	**Medium Risk = B** **Urine output 25-50mls / hr** **Inform co-ordinator**	**Fluid Balance Chart**	**High risk = C** **<25mls / hr** **Liaise with Senior Nurse / GP**

NEWS2 KEY (0 1 2 3)	NAME:	D.O.B.	URN:	ADMISSION DATE:

	DATE														
	TIME														
A+B Respirations Breaths/min	≥25	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	21-24	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	18-20														
	15-17														
	12-14														
	9-11	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	≤8	3	3	3	3	3	3	3	3	3	3	3	3	3	3
A+B SpO_2 Scale 1	≥96														
	94-95	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	92-93	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	≤91	3	3	3	3	3	3	3	3	3	3	3	3	3	3
SpO_2 Scale 2† Oxygen Saturation (%) Use Scale 2 if target range is 88-92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	95-96 on O_2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	93-94 on O_2	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	≥93 on air														
	88-92														
	86-87	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	84-85	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	≤83	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Air or oxygen? Refer to front page for codes	A=Air														
	O_2 L/min	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Device														
C Blood Pressure mmHg Score uses systolic BP only	≥220	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	201-219														
	181-200														
	161-180														
	141-160														
	121-140														
	111-120														
	101-110	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	91-100	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	81-90	3	3	3	3	3	3		3	3	3	3	3	3	3
	71-80	3	3	3	3	3	3		3	3	3	3	3	3	3
	61-70	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	51-60	3	3	3	3	3	3		3	3	3	3	3	3	3
	≤50	3	3	3	3	3	3		3	3	3	3	3	3	3
C Pulse Beats/min	≥131	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	121-130	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	111-120	2	2	2	2	2	2		2	2	2	2	2	2	2
	101-110	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	91-100	1	1	1	1	1	1		1	1	1	1	1	1	1
	81-90														
	71-80														
	61-70														
	51-60														
	41-50	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	31-40	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	≤30	3	3	3	3	3	3		3	3	3	3	3	3	3
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert														
	Confusion	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	V	3	3	3	3	3	3		3	3	3	3	3	3	3
	P	3	3	3	3	3	3		3	3	3	3	3	3	3
	U	3	3	3	3	3	3		3	3	3	3	3	3	3
	Blood Sugar														
E Temperature °C	≥39.1º	2	2	2	2	2	2		2	2	2	2	2	2	2
	38.1-39.0º	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	37.1-38.0º														
	36.1-37.0º														
	35.1-36.0º	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	≤35.0º	3	3	3	3	3	3	3	3	3	3	3	3	3	3
TOTAL NEWS2 SCORE															

	Monitoring Frequency														
	Escalation Plan [Y, N, N/A]														
	Initials														
Additional Parameters	Nausea Score														
	Pain Score														
	Urine output														

NEWS2 KEY	NAME:	D.O.B.	URN:	ADMISSION DATE:
0 1 2 3				

	DATE													
	TIME													
A+B Respirations Breaths/min	≥25	3	3	3	3	3	3	3	3	3	3	3	3	3
	21-24	2	2	2	2	2	2	2	2	2	2	2	2	2
	18-20													
	15-17													
	12-14													
	9-11	1	1	1	1	1	1	1	1	1	1	1	1	1
	≤8	3	3	3	3	3	3	3	3	3	3	3	3	3
A+B SpO_2 Scale 1	≥96													
	94-95	1	1	1	1	1	1	1	1	1	1	1	1	1
	92-93	2	2	2	2	2	2	2	2	2	2	2	2	2
	≤91	3	3	3	3	3	3	3	3	3	3	3	3	3
SpO_2 Scale 2† Oxygen Saturation (%) Use Scale 2 if target range is 88-92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3	3	3	3	3	3	3	3	3	3	3	3	3
	95-96 on O_2	2	2	2	2	2	2	2	2	2	2	2	2	2
	93-94 on O_2	1	1	1	1	1	1	1	1	1	1	1	1	1
	≥93 on air													
	88-92													
	86-87	1	1	1	1	1	1	1	1	1	1	1	1	1
	84-85	2	2	2	2	2	2	2	2	2	2	2	2	2
	≤83	3	3	3	3	3	3	3	3	3	3	3	3	3
Air or oxygen? Refer to front page for codes	A=Air													
	O_2 L/min	2	2	2	2	2	2	2	2	2	2	2	2	2
	Device													
C Blood Pressure mmHg Score uses systolic BP only	≥220	3	3	3	3	3	3	3	3	3	3	3	3	3
	201-219													
	181-200													
	161-180													
	141-160													
	121-140													
	111-120													
	101-110	1	1	1	1	1	1	1	1	1	1	1	1	1
	91-100	2	2	2	2	2	2	2	2	2	2	2	2	2
	81-90	3	3	3	3	3	3		3	3	3	3	3	3
	71-80	3	3	3	3	3	3		3	3	3	3	3	3
	61-70	3	3	3	3	3	3	3	3	3	3	3	3	3
	51-60	3	3	3	3	3	3		3	3	3	3	3	3
	≤50	3	3	3	3	3	3		3	3	3	3	3	3
C Pulse Beats/min	≥131	3	3	3	3	3	3	3	3	3	3	3	3	3
	121-130	2	2	2	2	2	2	2	2	2	2	2	2	2
	111-120	2	2	2	2	2	2		2	2	2	2	2	2
	101-110	1	1	1	1	1	1	1	1	1	1	1	1	1
	91-100	1	1	1	1	1	1		1	1	1	1	1	1
	81-90													
	71-80													
	61-70													
	51-60													
	41-50	1	1	1	1	1	1	1	1	1	1	1	1	1
	31-40	3	3	3	3	3	3	3	3	3	3	3	3	3
	≤30	3	3	3	3	3	3		3	3	3	3	3	3
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert													
	Confusion	3	3	3	3	3	3		3	3	3	3	3	3
	V	3	3	3	3	3	3	3	3	3	3	3	3	3
	P	3	3	3	3	3	3		3	3	3	3	3	3
	U	3	3	3	3	3	3		3	3	3	3	3	3
	Blood Sugar													
E Temperature °C	≥39.1º	2	2	2	2	2	2		2	2	2	2	2	2
	38.1-39.0º	1	1	1	1	1	1	1	1	1	1	1	1	1
	37.1-38.0º													
	36.1-37.0º													
	35.1-36.0º	1	1	1	1	1	1	1	1	1	1	1	1	1
	≤35.0º	3	3	3	3	3	3	3	3	3	3	3	3	3
TOTAL NEWS2 SCORE														
	Monitoring Frequency													
	Escalation Plan [Y, N, N/A]													
	Initials													
Additional Parameters	Nausea Score													
	Pain Score													
	Urine output													

NEWS2 scores should be considered using **your clinical judgement** at all times

NEWS2 Score	Frequency	Clinical response to NEWS2 Triggers These clinical responses should always take into account what the normal baseline NEWS2 score/clinical observations are for the patient
No Risk		
0	As per standard for recording clinical observations / frequency guidelines	• Continue routine NEWS monitoring (see standard for recording clinical observations / frequency guidance as per appendix 3 of FNHC National Early Warning Score (NEWS2) policy
Low risk		
Total 1-4	Repeat observations as per clinical judgement from senior colleague / registered nurse	• Inform senior colleague / registered nurse who must assess the patient • Registered nurse decides whether increased frequency of monitoring and / or escalation required • If escalation is not required clearly document rationale and ensure safety netting recorded in patient record
Low-medium risk		
3 in one single parameter	Repeat observations as per clinical judgement from senior colleague / registered nurse	• Health professional to immediately inform senior colleague / senior nurse / medical team caring for patient who will need to review and decide whether escalation of care is required
Medium risk		
Total 5 or more urgent response threshold	Repeat observations as per clinical judgement from senior colleague / registered nurse	**WITHIN 30 MINUTES** • Increase monitoring as per senior nurse instructions • Inform senior trained nurse who must assess patient & decide if review by GP/ACP is required • Determine management plan in line with scope of practice/national guidelines and/or local policies and procedures • Arrange transfer to acute hospital if appropriate and patient consents
High		
Total 7 or more emergency response threshold	Continuous monitoring required	**WITHIN 15 MINUTES** • Immediately repeat observations and NEWS2 score • Immediately inform senior nurse on duty who must determine management plan in line with scope of practice/national guidelines and/or local policies and procedures and inform GP / Consultant • Arrange transfer to acute hospital if appropriate and patient consents

Patient should have a specific management plan which describes usual parameters and has been implemented by the senior nurse/ACP/GP/Doctor

SBAR Communication Checklist (**S**ituation, **B**ackground, **A**ssessment and **R**ecommendation) Follow this SBAR checklist when consulting with a senior colleague or escalating a patient, make sure you have all the details to hand and convey all the SBAR points under each heading:	
S	**Situation:** • I am (name), working at (X) and on the advice of my Senior Colleague (Name X & Tittle X) • I am calling about (patient X) • I am calling because I am concerned that…(e.g. BP is low/high, pulse is XX, temperature • is XX, Early Warning Score is XX)
B	**Background:** • Patient (X) is new on my caseload (XX date) with… • They have had (X/procedure/investigation) • Patient (X)'s condition has changed within the last (XX mins) • Their last set of observations were (XX)
A	**Situation:** • I think the problem is (XX) • And I have… (e.g. given O^2/analgesia/stopped the infusion) OR • I am not sure what the problem is but patient (X) is deteriorating OR • I don't know what's wrong but I am really worried
R	**Recommendation:** • Health Professional to immediately inform senior colleague/registered nurse/medical team caring for patient, who will review and decide whether escalation of care is necessary
Ask receiver to repeat key information to ensure understanding	

National Early Warning Score (NEWS2) Activation Sticker

Team:	**Date:**	**Time:**
Please Complete or Affix Addressograph	**TOTAL NEWS2 SCORE:**	
Surname: Forename: URN: D.O.B:	*Please tick affected parameters:* ◯ Respirations ◯ SpO2 ◯ Blood Pressure ◯ Pulse ◯ ACVPU ◯ Temperature	
Name of doctor informed: Grade of doctor informed:	Time doctor informed: Time doctor arrived:	
Name of nurse (PRINT):	Nurse signature:	

NEWS2 SCORE 5 OR MORE or 3 IN ONE PARAMETER
An agreed medical treatment plan must be documented in the patient's notes
and consider a ceiling of treatment if appropriate

COULD IT BE SEPSIS?

Appendix 4 – Standard of Frequency for Recording Clinical Observations Guidance as per NEWS2

Patient Cohort/Condition	Frequency
On admission to Caseload	ALL Patients to have completion of baseline observations on initial assessment
Referral to GP	Record observations - before contacting GP for a review or if patient is requiring an admission hospital (planned or emergency admission) **To be documented in letter to GP or transfer letter to JGH**
Patients with wounds: • If any new wound identified Patient or carers reports patient feeling unwell at time of visit or within last 24 hours • If a wound has clinical signs of infection and/or a decision has been made to commence an antimicrobial dressing to reduce bacterial load • When taking a wound swab* • Deteriorating wound /not healing	Frequency – observations to be recorded at each visit * Note it is the service who has taken the swab who is accountable for following this up
Patients with other conditions who:- • Present as unwell following holistic assessment • If any concerns re a patient being unwell or carers reports feeling patient feeling unwell at time of visit or within last 24 hours	Record observations at each visit until condition stable
Patients on Intravenous (IV) infusions/transfusions/flushes, any IV access device	Record observations at ***each*** visit
Patients on daily visits for other care interventions with stable condition (administration of medication etc.)	Record observations when updating care plans/nursing summary and as clinically indicated. **Minimum of 6 monthly**
Patient on monthly, 2 monthly, 3 monthly visits (B12 etc.) with stable condition	Record observations when updating care plans/nursing summary and as clinically indicated. **Minimum of 6 monthly**
Patients who are immunosuppressed at each intervention	Record observations as per hospital Care Plan Management Advice unless clinically indicated during visit under any of the above guidance
Patients with urinary catheters	Record observations at each intervention, when updating catheter bundle & as clinically indicated. Minimum 3 monthly Intermittent catheter patient – **as clinically indicated/minimum 3 monthly**
End of life patients	Record observations as clinically indicated in relation to patient, family & multi-disciplinary care planning using Advanced/Anticipatory/ End of Life Care Planning discussions/Gold Standard Framework (GSF) meetings etc. to aid decision making. Decision making must take into account whether there are there are potentially reversible causes for clinical deterioration

The NEWS2 Observation Chart