****

**NEWS2 (National Early Warning Scores), Recognition of Sepsis and the Deteriorating Adult Patient**

**Policy and Procedures**

**June 2025**

**Document Profile**

|  |  |
| --- | --- |
| **Type**  | Policy |
| **Title** | NEWS2 (National Early Warning Scores), Recognition of Sepsis and the Deteriorating Adult Patient |
| **Author** | Hannah Lowe – Trainee Advanced Clinical Practitioner |
| **Category** | Clinical |
| **Date approved by Organisational Governance Approval Group** | 04/06/2025 |
| **Date approved by Chief Executive Officer** | 10/06/2025 |
| **Review date** | 3 years from approval |
| **Document Status** | This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. |

**Version Control/Changes Made**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Version** | **Summary of changes** | **Author** |
| July 20 | 1 | New policy document | Clare Stewart (Operational Lead RRRT) |
| June 2025 | 2 | Complete review of policy. Transferred onto new policy template. References updated. Appendices removed as no longer required:* NEWS2 Documents for Mental Health / Learning Disability (Appendix 2)
* Community Nursing Documents (Appendix 3)
* The NEWS2 Observation Chart Example of Document (Appendix 5)

Wording made more succinct with minor updates from relevant guidelines. | Hannah Lowe (Trainee Advanced Practitioner) |

**CONTENTS**

[1 INTRODUCTION 1](#_Toc200525017)

[1.1 Rationale 1](#_Toc200525018)

[1.2 Scope 1](#_Toc200525019)

[1.3 Role and Responsibilities 1](#_Toc200525020)

[2 POLICY 2](#_Toc200525021)

[2.1 Training and Support 3](#_Toc200525022)

[3 PROCEDURE 3](#_Toc200525023)

[3.1 Respiration Rate 4](#_Toc200525024)

[3.2 Oxygen Saturation 4](#_Toc200525025)

[3.3 Blood Pressure 4](#_Toc200525026)

[3.4 Pulse rate 5](#_Toc200525027)

[3.5 Confusion, mental state and cognition 5](#_Toc200525028)

[3.6 ACVPU assessment 6](#_Toc200525029)

[3.7 Temperature 6](#_Toc200525030)

[3.8 NEWS2 Observation Chart 6](#_Toc200525031)

[3.9 SpO2 Scoring Scale 2 6](#_Toc200525032)

[3.10 Supplemental Oxygen Delivery 7](#_Toc200525033)

[3.11 Recognising Sepsis 7](#_Toc200525034)

[3.12 Clinical Response 8](#_Toc200525035)

[3.13 Assessing the Patient 8](#_Toc200525036)

[3.14 Seeking Help 9](#_Toc200525037)

[3.15 Immediate Measures 10](#_Toc200525038)

[3.16 Paper documentation of NEWS2 10](#_Toc200525039)

[3.17 Patients with Mental Health conditions and Learning Disability 11](#_Toc200525040)

[4 MONITORING COMPLIANCE 11](#_Toc200525041)

[5 CONSULTATION PROCESS 12](#_Toc200525042)

[6 EQUALITY IMPACT STATEMENT 12](#_Toc200525043)

[6.1 EQUALITY IMPACT SCREENING TOOL 14](#_Toc200525044)

[7 IMPLEMENTATION PLAN 15](#_Toc200525045)

[8 GLOSSARY OF TERMS 15](#_Toc200525046)

[9 REFERENCES 16](#_Toc200525047)

[10 APPENDICES 17](#_Toc200525048)

[10.1 National Early Warning Score Chart (NEWS2) Observation Chart 17](#_Toc200525049)

[10.2 Appendix 2 SBAR Communication Checklist 20](#_Toc200525050)

[10.3 Appendix 3 Standard of Frequency for Recording Clinical Observations Guidance as per NEWS2 21](#_Toc200525051)

[10.4 Appendix 4 NEWS2 Escalation Score Flow Chart for Community Nursing Staff Clinical Concern following Observation Reading 22](#_Toc200525052)

# INTRODUCTION

## Rationale

This policy is essential for promoting the early identification and effective management of deteriorating patients across both clinical and community settings. It ensures a consistent approach to recognising and responding to changes in a patient's condition by outlining the following key principles:

**Early Identification:** All staff are responsible for monitoring patients and recognising early signs of deterioration.

**Use of NEWS2:** The National Early Warning Score 2 (NEWS2) is a standardised tool used to detect physiological changes that may indicate clinical deterioration.

**Effective Communication:** The policy provides guidance on when and how to escalate concerns, including identifying the appropriate person to notify.

**Consistency and Standardisation:** It establishes a uniform process for recording, scoring, and responding to physiological observations in acutely unwell patients.

**Structured Communication:** The use of the SBAR (Situation, Background, Assessment, Recommendation) framework is reinforced to support clear and effective communication.

**Clinical Judgement:** NEWS2 is intended to support—not replace—skilled clinical assessment and professional judgement.

## Scope

This policy applies to all adult patients aged 18 years and over who are under the care of Adult Services

The National Early Warning Score 2 (NEWS2) is not suitable for use in the following groups:

**Children under 16 years of age** – due to differing physiological responses to acute illness. The Paediatric Early Warning Score (PEWS) should be used instead.

**Pregnant women** – as pregnancy alters normal physiological parameters. The Maternity Early Warning Score (MEWS) is more appropriate.

**Patients with spinal cord injury, particularly those with tetraplegia or high-level paraplegia** – due to altered autonomic nervous system function, NEWS2 may be unreliable and should be used with caution.

## Role and Responsibilities

**Chief Executive Officer**

The Chief Executive Officer (CEO) holds overall responsibility for ensuring effective systems are in place so that staff are appropriately trained and competent to fulfil their roles and to maintain patient safety.

**Director of Governance and Care**

The Director of Governance and Care is responsible for ensuring this policy is regularly reviewed and updated in line with evidence-based practice. They will also oversee the monitoring, reporting, and investigation of incidents related to NEWS2 that are reported via Assure.

**Head of Education and Development**

The Head of Education and Development is responsible for ensuring that appropriate education governance arrangements are in place to support the effective delivery of NEWS2. They must also ensure that teaching, learning, and assessment models are appropriate and fit for purpose.

**Operational Leads**

Operational Leads are responsible for ensuring high standards are maintained within their areas and that all staff adhere to the requirements of this policy.

**Team Leaders**

Team Leaders must ensure that all staff attend relevant statutory and mandatory training, and that training attendance is routinely monitored. They are also responsible for ensuring that all necessary equipment is available, functional, and that staff are trained, updated, and competent in the processes outlined in this policy.

**Employees**

All employees are responsible for attending relevant mandatory training, and any additional training required for their specific role. They must ensure their knowledge and skills remain up to date and be competent in the recognition and management of deteriorating patients, including the use of NEWS2 and recognition of sepsis.

# POLICY

Patients who are newly assessed or admitted to a caseload must have all six physiological parameters recorded. Each parameter should be scored using the NEWS2 system, and a total score calculated and documented as a baseline at the time of initial assessment.

Following this, the frequency of ongoing observations must be clearly documented in the patient’s clinical records, with a rationale for the chosen interval. Practitioners must refer to the Standard of Frequency of Observations Guidance ([Appendix 3](#_Appendix_3_Standard)) to determine appropriate observation intervals, while recognising that clinical judgement remains essential in each case.

For patients receiving palliative or end-of-life care, routine recording of clinical observations may not be appropriate. Any decision to reduce or discontinue observation frequency must be discussed and agreed upon with the patient (where possible), their family or carers, and the wider clinical or multidisciplinary team (MDT). This decision must be clearly documented in the clinical records.

A NEWS2 score must be assigned to every set of clinical observations recorded. The tool should be used to:

* Identify patients at risk of sepsis or serious clinical deterioration requiring urgent intervention. A NEWS2 score of 5 or more is a critical threshold for escalation.
* Record the use of oxygen therapy and ensure accurate scoring of oxygen saturation targets in patients with hypercapnic respiratory failure (commonly due to COPD).
* Recognise new confusion as part of the ACVPU scale (alert, confusion, voice, pain, and unresponsive scale) (Royal College of Physicians, 2017) and consider it an early indicator of deterioration

In addition to NEWS 2, screening for delirium using the 4AT tool (MacLullich, 2025) may be appropriate in some cases. Also be alert to any reduction in the Glasgow Coma Scale (GCS) (Royal College of Physicians and Surgeons of Glasgow, (no date)), which may signify a serious underlying issue.

Appropriate resources, training, and support will be provided to ensure all staff are confident and competent in applying NEWS2 and recognising deteriorating patients.

## Training and Support

All identified clinical staff responsible for recording observations or responding to NEWS2 must be trained in its use. This includes completion of a recognised web-based educational tool.

Mandatory training on the recognition and management of the deteriorating patient will be provided to all relevant staff during their induction. This training is also required on an annual basis and will be delivered via the Virtual College platform.

Additional learning resources are available through the following:

* [The UK Sepsis Trust](https://sepsistrust.org/)
* [Clinicalskills.net](https://www.clinicalskills.net/)

# 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)
* Pulse rate
* 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.

## 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.

## Oxygen Saturation

**SpO2 Recording**: Record oxygen saturation for all patients. Address SpO2 < 90% unless normal for the patient.

**Supplemental Oxygen**: Record concentration and delivery device. Check device, flow, and equipment if SpO2 < 90% with supplemental oxygen. Ensure adequate oxygen supply.

**Accuracy Issues**: SpO2 may be inaccurate in poor circulation/hypoperfusion. Use capillary refill time (CRT) for additional perfusion info. Discuss with senior staff or GP/Doctor.

**Interference**: False nails and nail varnish can invalidate SpO2 measurements.

## Blood Pressure

**Hypotension (low/falling systolic BP)** is critical in assessing acute illness severity and may indicate:

* Circulatory compromise (sepsis, volume depletion)
* Cardiac failure or rhythm disturbance
* Central nervous system depression
* Hypoadrenalism or BP-lowering medications

**Naturally low systolic BP (<100 mmHg)** may be normal if the patient is well and other parameters are normal.

**Severe hypertension (≥200 mmHg)** may result from pain/distress but can also exacerbate acute illness. Diastolic BP is not used in acute-illness scoring but should be recorded for potential treatment needs.

**Important Notes:**

* Systolic blood pressure< 90 mmHg may indicate severe sepsis, fluid loss, or cardiac shock.
* Falling BP is a late sign of deterioration.
* Use manual sphygmomanometers for very low BP; electronic devices may be inaccurate.
* Manual BP should be taken for patients with Atrial Fibrillation.
* Escalation triggers for BP are now >220 mmHg; follow NICE NG136 guidelines for treatment and diagnosis.

## Pulse rate

Pulse Rate Measurement in Clinical Assessment:

* **Tachycardia** (high pulse rate) may indicate circulatory compromise, cardiac failure, pyrexia, pain, distress, arrhythmia, metabolic disturbances, or drug intoxication.
* **Bradycardia** (low pulse rate) may be normal due to physical conditioning or medication but can indicate hypothermia, CNS depression, hypothyroidism, or heart block.

Pulse Measurement Issues:

* Automated devices may not reflect true rate or pulse properties (volume, regularity).
* Manual pulse should be taken at first assessment to check rate, rhythm, and strength.

Important Notes:

* Pulse rate >90 b/min or <50 b/min should trigger an alert and manual check.
* Older adults may not show increased pulse rate in response to infection but may develop new arrhythmias.
* New irregular pulse or concerns should be discussed with senior clinical staff and may require a 12-lead ECG.
* Patients on beta blockers cannot increase heart rate to compensate for hypoperfusion; other signs (high respiratory rate, low urinary output) are significant.

## Confusion, mental state and cognition

**New confusion** is a critical sign of acute illness, especially in sepsis, scoring 3 on the NEWS2 chart (code red) and requiring urgent assessment.

**Acutely altered mental state** includes:

* New confusion or Glasgow Coma Scale <15, indicating clinical deterioration.
* Causes: sepsis, hypoxia, hypotension, metabolic disturbances.

## ACVPU assessment

**ACVPU Scale and NEWS2 Chart for Assessing Consciousness:**

* **A**lert: Eyes open, responds to voice, has motor function. New confusion scores higher on NEWS2 (3 points) due to risk of clinical deterioration.
* **V**oice: Responds to voice with eyes, voice, or motor (e.g., grunt, moan, slight movement).
* **P**ain: Responds to pain stimulus (withdrawal, flexion, extension). Use with care.
* **U**nresponsive: No response to voice or pain (unconscious).

Key Points:

* Assess all patients initially with ACVPU.
* New confusion/change in consciousness is a serious indicator (score 3 on NEWS2).
* Subtle cognitive changes need history from patient/carer.
* In learning disability/dementia, changes may show as behaviour/irritability.
* Response only to pain/unresponsive correlates to GCS < 8 (medical emergency).
* Unexpected seizures need senior medical review

## Temperature

Monitoring temperature is crucial, especially for patients with infections or neutropenia, as it can indicate sepsis. The **NEWS2** system includes temperature because extremes can signal severe illness. The **Surviving Sepsis Campaign** defines sepsis with a core temperature of **>38˚C** or **<36˚C**. Hypothermia is **<35˚C** and can be fatal below **32˚C**. Note that some patients, like those with cancer, spinal cord injuries, or older adults, may not show a raised temperature even if infected.

## NEWS2 Observation Chart

The recording of physiological parameters follows the Resuscitation Council (UK) ABCDE sequence, ensuring consistency and accuracy. Observations must be documented in black ink or electronically.

For patients with hypercapnic respiratory failure (often due to COPD), the SpO2 Scale 2 section is used, targeting oxygen saturation levels of 88-92%.

A NEWS2 score of 5 or more, or 3 in any single parameter, triggers urgent clinical review and action, emphasising the importance of considering sepsis in at-risk patients.

## SpO2 Scoring Scale 2

**Oxygen Saturation Targets**: Aim for 88-92% in patients with hypercapnic respiratory failure.

**Use of SpO2 Scoring Scale 2**:

* Confirmed hypercapnic respiratory failure on blood gas analysis.
* Requires supplementary oxygen during current or prior hospital admission.
* Based on an oxygen assessment by a Respiratory Specialist.

**Clinical Decision**: Must be made by a competent clinical decision maker and recorded in the patient's notes. Use NEWS SpO2 Scoring Scale 1 in all other cases.

**Documentation**: Clearly cross out the unused SpO2 scoring scale on the chart.

**Measurement Challenges**:

* Difficulty measuring in suspected sepsis due to poor circulation.
* Overestimation in people with dark skin.

## 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 British Thoracic Society 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, specify………) |

## Recognising Sepsis

Sepsis is indeed a critical condition that claims many lives. According to the UK Sepsis Trust, (2024) sepsis causes more deaths annually than lung cancer, and more than bowel, breast, and prostate cancer combined.

Individuals at higher risk of sepsis include:

* Patients who have recently undergone surgery
* Those with impaired immune function, such as individuals with diabetes or those who have had a splenectomy
* Patients with compromised skin integrity
* Immunocompromised individuals, including those receiving cancer chemotherapy, immunosuppressive biologics, and long-term steroids
* Older adults and those with frailty
* Patients with indwelling catheters or lines

A National Early Warning Score (NEWS2) of 5 or more in a patient showing signs and symptoms of infection, or clinical deterioration in a high-risk patient, should prompt the question, "Is this sepsis?" This should lead to the completion of the appropriate Pre-Hospital Sepsis Screening Tool, Action Plan and trigger an immediate escalation in care. It's important not to rely solely on a person's temperature as a predictor of sepsis.

## Clinical Response

The four key components to Clinical Response to NEWS2 are:

* **Urgency**: Determine response speed.
* **Seniority and Competency**: Ensure appropriate clinical staff attend.
* **Monitoring Frequency**: Decide how often to monitor.
* **Care Setting**: Determine the appropriate setting for delivery of care

Notes:

* Consider any advance care plan or directive
* Clinical judgement and concern override NEWS2 if necessary. See escalation flow chart in appendices.

Alert Actions:

* Increase vigilance with additional observations.
* Further assessment and intervention by a competent practitioner.
* Re-assess all observations per NEWS2 and clinical judgement.
* Discuss with Senior Nurse/Advanced Clinical Practitioner/Team Leader/GP or Out of Hours GP Service, Medical/Surgical physician.
* Call 999 if needed

## Assessing the Patient

**Patient Understanding and Consent:**

* Ensure patients understand information and can give informed consent.
* Use interpreters and translate information if needed.
* Consider capacity assessment if there's doubt about the patient's capacity.
* Refer to the Organisational Consent Policy.

**Equipment and Environmental Factors:**

* Ensure equipment is functioning and calibrated.
* Consider environmental conditions affecting readings.
* Apply clinical judgement if equipment fails and NEWS2 can't be calculated.

**Vital Signs and NEWS2:**

* Use vital signs and NEWS2 to assess the patient's condition.
* A comprehensive assessment is indicated if the patient is deteriorating.

**ABCDE Model for Rapid Assessment**:

**A** = Airway

**B** = Breathing

**C** = Circulation

**D** = Disability

**E** = Exposure

## Seeking Help

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.

Any concerns about the patient must be escalated to the senior practitioner 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 communicating your concerns. Please see Appendix 2.

**SBAR**

**Situation**

* State your name, role and location
* State the patients name and age
* Briefly describe the current problem, giving the patient’s physiological observation and your assessment findings

**Background**

* State any relevant events leading up to this event
* Provide relevant medical history/ recent diagnosis/ medications and allergies/ resuscitation status

**Assessment**

* Your assessment and clinical findings
* State what you have assessed the situation to be, for example the possible diagnosis.

**Recommendation**

* Suggest immediate actions or interventions
* Be clear about what you are expecting from the person you are speaking with– 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.

## 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 may 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 time

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

## Paper documentation of NEWS2

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 arrowhead.

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

All entries MUST be initialed.

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

## Patients with Mental Health conditions and Learning Disability

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 the following undertaken and recorded:

* Respiratory Rate
* ACVPU recorded
* Visual A-E Assessment

If the patient scores in any of the ORANGE zones an immediate review MUST be undertaken by a registered practitioner (e.g. Advanced Clinical Practitioner/ registered Nurse) or Doctor/ GP. NEWS2 must be completed as soon as possible.

# 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 for development plans to be devised and additional training requirements assessed.

# CONSULTATION PROCESS

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Date** |
| Tia Hall | Operational Lead – Adult Services | 16/4/25 |
| Claire White | Director of Governance & Care | 16/4/25 |
| Elspeth Snowie | Head of Quality & Safety | 16/4/25 |
| Rachel Foster | Quality & Performance Development Nurse | 16/4/25 |
| Louise Dryden | Team Leader Rapid Response and Reablement Team | 16/4/25 |
| Kathryn Kelly | Advanced Clinical Practitioner | 16/4/25 |
| Justine Le Bon Bell | Head of Education and Development | 16/4/25 |
| Claire Baker | Deputy Sister | 16/4/25 |
| Joanna Champion | Team Lead | 16/4/25 |
| Kirby Lyons | Deputy Sister | 16/4/25 |
| Angela Mwanga | Deputy Sister | 16/4/25 |
| Michelle Margetts | Team Lead | 16/4/25 |
| Angela Stewart  | Sister | 16/4/25 |
| Anne Hughes | Deputy Sister | 16/4/25 |

# EQUALITY IMPACT STATEMENT

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 below for the Equality Impact Assessment for this policy.

## EQUALITY IMPACT SCREENING TOOL

|  |
| --- |
| **Stage 1 - Screening**  |
| Title of Procedural Document: Management and recognition of the deteriorating patient. NEWS2 and recognition of sepsis.  |
| Date of Assessment | 10/4/25 | Responsible Department | RRRT |
| Completed by | Hannah Lowe | Job Title | Trainee Advanced Clinical Practitioner |
| **Does the policy/function affect one group less or more favourably than another on the basis of**: |
|  | **Yes/No** | **Comments** |
| Age | No | Not appropriate for use in 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 | Not appropriate for use 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 Equality Impact Assessment is complete. If YES, a full impact assessment is required: go on to stage 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 use in pregnancy or under 16 years of age. |  | Alternative/ suitable policy  |  |
| **Monitoring of Actions** |
| The monitoring of actions to mitigate any impact will be undertaken at the appropriate level |

# IMPLEMENTATION PLAN

|  |  |  |
| --- | --- | --- |
| **Action** | **Responsible Person** | **Planned timeline** |
| Policy to be uploaded to the Procedural Document Library | Education and Development Administrator | Within 2 weeks following ratification |
| Email to all staff  | Education and Development Administrator | Within 2 weeks following ratification |
| Upload policy (+/- assessment tool) to Virtual College and allocate to relevant staff | Education and Development Department | Within 2 weeks following ratification |
| Relevant staff to sign (via Virtual College) that they have read and understood policy. | All staff notified via Virtual College. | Within 2 months of notification |

# GLOSSARY OF TERMS

|  |  |
| --- | --- |
| **ABCDE**  | **A**irway, **B**reathing, **C**irculation, **D**isability, **E**xposure  |
| **ACPVU**  | **A**lert, new **C**onfusion, responds to **V**oice, responds to **P**ain, **U**nresponsive. An assessment tool for conscious level  |
| **BP**  | **B**lood **P**ressure  |
| **COPD**  | **C**hronic **O**bstructive **P**ulmonary **D**isease  |
| **CRT**  | **C**apillary **R**efill **T**ime  |
| **PR**  | **P**ulse **Rate**  |
| **Hypercapnic Respiratory Failure**  | An elevated level of carbon dioxide level in the blood |
| **RR**  | **R**espiratory **R**ate  |
| **Sepsis**  | ‘A life threatening organ dysfunction caused by a deregulated host response to infection’  |
| **SBP**  | **S**ystolic **B**lood **P**ressure  |
| **SpO2**  | Peripheral Capillary Oxygen Saturation  |
| **T**  | **T**emperature |

# 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. (Accessed April 2025)

MacLullich. A (2025) 4AT Rapid Clinical Test for Delirium. [4AT - Rapid Clinical Test for Delirium Detection](https://www.the4at.com/) (Accessed June 2025)

National Institute for Health and Care Excellence (2023) Hypertension in adults: diagnosis and management. NICE clinical guideline NG136. London: NICE. (Accessed March 2025)

National Institute for Health and Care Excellence (2024) Suspected Sepsis: recognition, diagnosis and early management. NICE guideline NG51. London: NICE. (Accessed April 2025)

Royal College of Physicians (2017) National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. RCP, London (Accessed May 2025)

Royal College of Physicians and Surgeons of Glasgow (no date) Glasgow Coma Scale. [Glasgow Coma Scale](https://www.glasgowcomascale.org/) (Accessed June 2025)

The UK Sepsis Trust (2024) The Sepsis Manual 7th edition. [Sepsis-Manual-7th-Edition-2024-V1.0.pdf](https://sepsistrust.org/wp-content/uploads/2024/07/Sepsis-Manual-7th-Edition-2024-V1.0.pdf) (Accessed May 2025)

# APPENDICES

## National Early Warning Score Chart (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 SpO2 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 SpO2 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**  |
| SpO2 Scale 1 (%)  | **≤91**  | **92 - 93**  | **94 - 95**  | **≥96**  |   |   |   |
| SpO2 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 (⁰C)  | **≤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 SpO2 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** Straight Arrow Connector 22, ShapeStraight Arrow Connector 7, Shape**Balance** **Chart**    | **High risk = C** **<25mls / hr** **Liaise with Senior Nurse / GP**  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NEWS2 KEY**  | **NAME:**  | **D.O.B.**  | **EMIS:**  | **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****SpO2 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  |
| **SpO2 Scale 2† Oxygen Saturation (%)**  Isosceles Triangle 6, Shape | ≥97 on O2  | 3  | 3  | 3  | 3  | 3  | 3  | 3 | 3  | 3  | 3  | 3  | 3  | 3  |
| 95-96 on O2  | 2  | 2  | 2  | 2  | 2  | 2  | 2 | 2  | 2  | 2  | 2  | 2  | 2  |
| 93-94 on O2  | 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  |   |   |   |   |   |   |  |   |   |   |   |   |   |
| O2 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  | 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  |
| 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  | 3  |
| V  | 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** **⁰C**  | ≥39.1⁰  | 2  | 2  | 2  | 2  | 2  | 2  |  | 2  | 2  | 2  | 2  | 2  | 2  |
| 38.1-39.0⁰  | 1  | 1  | 1  | 1  | 1  | 1  | 1 | 1  | 1  | 1  | 1  | 1  | 1  |
| 37.1-38.0⁰  |   |   |   |   |   |   |  |   |   |   |   |   |   |
| 36.1-37.0⁰  |   |   |   |   |   |   |  |   |   |   |   |   |   |
| 35.1-36.0⁰  | 1  | 1  | 1  | 1  | 1  | 1  | 1 | 1  | 1  | 1  | 1  | 1  | 1  |
| ≤35.0⁰  | 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  |   |   |   |   |   |   |  |   |   |   |   |   |   |

Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure

†ONLY use Scale 2 under the direction of a qualified clinician

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

## Appendix 2 SBAR Communication Checklist



## Appendix 3 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   when wound care is to be undertaken OR if the patient condition indicates, for example the patient presents unwell.         \* 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 consider whether there are there are potentially reversible causes for clinical deterioration    |

## Appendix 4 NEWS2 Escalation Score Flow Chart for Community Nursing Staff Clinical Concern following Observation Reading