Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Physiological observations & prevention of deterioration in the acutely ill adult

This APD supersedes: PAT/T 33 V4 - Physiological Observations: Policy for Adult In-Patients in Acute Hospitals

Major changes have been made throughout and it is recommended that you read this document in full.

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	August 2023	Major changes have been made throughout and it is recommended that you read this document in full.	Lee Cutler & Belinda Scarrott
Version 4	September 2019	Change to NEWS2 (national early warning score v2) including new IPOC & Reference to Nervecentre observations. Link to Sepsis care pathway. Training for prevention of deterioration.	Lee Cutler
Version 3	27 March 2014	Major changes have been made throughout and it is recommended that you read this document in full.	Lee Cutler
Version 2	January 2011	Major changes have been made throughout and it is recommended that you read this document in full.	Lee Cutler

Contents

1. INTRODUCTION

Recording physiological observations, **recognising** deterioration using the National Early Warning Score V2 (NEWS2) and **responding** by assessing and treating are the key elements in the care of acutely ill patients (RCP, 2017; NICE, 2007a; NPSA 2007a; 2007b).

2. PURPOSE

- To articulate the standards expected of clinical staff within the Trust.

3. DUTIES AND RESPONSIBILITIES

3.1 Clinical staff must:

Ensure that they are **competent** and undertake the role expected of them in relation to physiological monitoring and deterioration. All members of the clinical team are expected to act in a way that ensures patients are monitored appropriately, that deterioration is recognised and that timely escalation takes place. Within Nervecentre eObservations, users MUST login and select the group of patients they are responsible for and set as 'My patients'. Accurate and contemporaneous record keeping is of key clinical, professional and medico-legal importance. Nervecentre will date and time stamp every action by users automatically. If actions are taken outside the Nervecentre pathway / system they must be documented in the clinical record.

The key roles with the clinical team are those of: recorder, recogniser and responder as described here:

Recording physiological observations is the responsibility of the Registrant who may delegate and provide supervision to health care assistants (HCA), assistant practitioners, associate practitioners and pre-registration students appropriate to role. Physiological observations must be undertaken following approved training and competencey assessment using devices in accordance with local care pathways for specific patient groups/conditions. All registrants must maintain competence in the manual recording of blood pressure to be able to supervise and assess students.

Recognition of deterioration or of physiological abnormalities causing concern using the NEWS2 system is the responsibility of the Registered Nurse. The Nurse must escalate to a responder (Doctor or ACP [advanced clinical practitioner] and CCOT [critical care outreach team]) according to the expected clinical response pathway. The Nervecentre eObservations system will prompt users and suggest actions in response to abnormal physiology. In some situations it will be more appropriate NOT to escalate an elevated NEWS2 to a doctor/ACP in order to reduce excessive notifications and tasks sent to doctors / ACPs. This is often the case when a patient repeatedly has an elevated NEWS2. But specifically when: 1. The patient is improving; 2. The medical team are present; 3. A plan is in place for the elevated score.

Response to deterioration or physiological abnormalities causing concern by the doctor / ACP or critical care outreach team must take place according to the expected clinical response pathway (Nervecentre eObs system). This requires the responder to accept the task assigned to them, complete the task and then close the task.

Clinical staff must **maintain contemporaneous records** pertaining to observations and escalation. In situations where there is chronic abnormal physiology or expected ongoing 'triggering' of NEWS2 – staff recognising these triggers (Registered Nurses) should collaborate with Doctors*, ACPs* and CCOT* to agree and document an appropriate modified monitoring and escalation plan. Observation and escalation models in Nervecentre include:

- **Adult NEWS2** (Auto adjusts frequency and suggests escalation according to national Policy
- **Adult NEWS2 Sats' Scale 2** (As above - for patients who have target Sats' of 88-92%)
- **Adult Deviation from NEWS2** (12 hourly obs regardless of Score and only escalates to Nurse in Charge)
- **Adult End of Life Care** (No set obs frequency and no escalations, ONLY for EoL patients)

*Doctors, ACPs and CCOT are authorised to change observation models in Nervecentre.

3.2 The ward / department manager of the clinical area must:

Ensure that all staff are competent to undertake their role in relation to physiological observations, escalation and record keeping and have read this policy.

Ensure staff can access suitable, functioning equipment for physiological monitoring and that this is used in accordance with local care pathways for specific patient groups/conditions.

In collaboration with the matron and other relevant professionals, must investigate all clinical incidents in relation to deterioration, physiological observations, and escalation and undertake service improvement to prevent their future occurrence.

3.3 The Consultant Medical Practitioner, or Specialist Registrar in their absence, must:

Ensure that any deviation from this policy is documented in the clinical notes (e.g. if the NEWS2 is not appropriate because of expected ongoing physiological abnormalities and/or chronic disease). This must include a plan for physiological monitoring, acceptable parameters and criteria for requesting medical review.

4. Standard Operating Procedure for eObs in Nervecentre

4.1 Nervecentre eObservations is the standard system used for adult inpatients to ensure a high standard of monitoring, detection of deterioration and clinical response. Users of MUST comply with the following procedure:

1. All users must log in using their hand-hand device and remain logged in for their shift (excluding rest/meal breaks). Select the work location and shift times.

2. From the Menu (≡ Top left of screen), select 'Patients'; select the list which includes the patients the user is responsible for. The user will then be prompted to 'CANCEL', 'VIEW ONLY' or 'SET MY LIST'. The user must select 'SET MY LIST' or will not receive notifications about patients which will compromise patient safety.

3. Health Care Assistants recording observations requiring escalation (elevated NEWS2) will be prompted for the Registered Nurse to approve these.

4. Registered Nurses approving observations recorded by a HCA, with elevated NEWS2, MUST use clinical judgement about whether escalation to Doctor/ACP/CCOT is required. Nervecentre will default to 'Escalate'. Not all elevated NEWS2 will require escalation. Over-escalation and repeated escalation will place unmanageable demands on Doctors/ACPs and expose them to excess alerting 'noise' from the system. The following can be selected as reasons for not escalating: 1. The patient is improving; 2. The medical team are present; 3. A plan is in place for the elevated score.

5. If escalation is approved but a Nervecentre sends a message to the Nurse that no Doctor/ACP was found – this means no Doctor/ACP is logged in for that patient. The Nurse MUST record this in the clinical record and contact a responsible Doctor/ACP by another method (e.g. Face-to-face, Bleep/Pager, Mobile phone, Switchboard). The Nurse must escalate through the medical hierarchy until an appropriate clinical response is achieved. All actions around unsuccessful escalation must be contemporaneously recorded in the clinical record.

6. Tasks generated by Nervecentre must be accepted by the user, or rejected (e.g. because the user is unable to undertake the task as busy with another patient). Doctors/ACPs receiving escalation tasks requiring patient review must accept and complete the task in the task list within Nervecentre. This will act as a clinical and medico-legal record of the clinician's actions. Failure to do this may misrepresent the clinician's actions when later investigated or reviewed for clinical or medico-legal reasons.

7. Inability of the user to comply with the above should be escalated to the appropriate person. For technical Nervecentre issues – contact IT. For competence / training issues – contact line manager. For Clinical issues – contact line manager.

8. In the event of failure of Nervecentre all users MUST revert to recording observations on paper charts (See Appendices 1, 2 & 3) and follow the IT SOP for Nervecentre system failure.

5. OBSERVATIONS, EARLY WARNING SCORE AND ESCALATION

5.1 **'Routine monitoring'** includes the following parameters in Nervecentre:

- **Respiratory Rate** (Breaths per minute)
- **Oxygen Saturation** (Percent - %)
- **Inspired Oxygen** (Delivery device & flow / % - depending on device)
- **Blood pressure** (Millimeters of Mercury – mmHg)
- **Pulse (Heart rate)** (Beats per minute. Counted manually by finger palpation over 1 Min)
- **ACVPU** (**A**lert; **C**onfused; responds to **V**oice, **P**ain, **U**nresposive)
- **Temperature**(Degrees Centigrade – ^{o}C)
- **Urine output since last charted / Fluid balance** (mls - Patients with urinary catheters, IV fluids, sepsis)
- **Pain score** (on movement / coughing: 1 – 10)
- **Sedation** (Alert, Mild(occasionally drowsy), Moderate(Frequently drowsy), Severe(Somnolent), Sleeping)
- **Nausea** (No, Nausea only, Nausea and retching, Vomiting)
- **Skin Perfusion** (Normal, Non-blanching, Mottled, Ashen, Cyanotic)

(RCP, 2017, NICE, 2007a, Nervecentre)

5.2 **Minimum standard:** all adult in-patients in acute beds within the Trust, must have at least 'routine monitoring' recorded on initial assessment and then a decision should be made by a Doctor / ACP / CCOT, ideally a Consultant or Registrar, about the most clinically appropriate model in Nervecentre for ongoing monitoring and escalation.

5.3 **The purpose of the NEWS2** is to initiate **escalation** leading to medical review of a patient with abnormal physiology. At every review medical staff must consider whether the **Adult NEWS2** model in Nervecentre is the most clinically appropriate model (see 3.1)

5.4 **Escalation** must take place following the recording of an elevated NEWS2 to ensure patients receive appropriate medical care and do not deteriorate untreated. It is the responsibility of all clinical staff to ensure appropriate escalation takes place.

5.5 **Informed verbal consent** must be obtained from the patient to undertake observations. When a patient refuses, staff must give clear explanations of the importance of observations and why they are necessary. Always document refused consent and refer to Trust Mental Capacity Act policy (PAT/PA 19). Repeat attempts to undertake observations at frequencies stipulated in this policy. Refusal MUST not result in cessation of monitoring / attempts to monitor. Every attempt and refusal MUST be documented.

5.6 **Sepsis screening** is integral to observations. The NEWS2 system is a key trigger for sepsis screening and initial sepsis management. Within Nervecentre automatic prompts for sepsis screening are in-built. A sepsis screening 'assessment' and decision-making tool exists within Nervecentre.

6. MONITORING IN SPECIFIC CLINICAL SITUATIONS

Situation	Minimum observations frequency	Additional parameters to monitor
Irregular pulse	As per Nervecentre model	Blood pressure must be recorded manually – by anaeroid sphygmomanometer
Patients receiving oxygen	As per Nervecentre model	Delivery device & flow rate (BTS, 2008)
Unplanned admission	As per Nervecentre model	
Hydration by intravenous infusion	As per Nervecentre model	Fluid intake & output in mls ideally at the same frequency as physiological observations
Urinary catheter	As per Nervecentre model	Fluid intake & output in mls at the same frequency as physiological observations
Transfer between in-patient areas	As per Nervecentre model	
Surgery, general or spinal anaesthesia	Hourly for 4 hours, then if stable within normal parameters 4 hourly for 24 hours	
Discharge from critical care	As per Nervecentre model	
Non-invasive ventilation (NIV) (Also referred to as Biphasic positive airway pressure (BIPAP))	After commencement: Every 15 minutes for the first hour; then hourly until arterial pH normalises; then at least 4 hourly.	Inspired Oxygen concentration (Percent - % if monitored by Oxygen analyser or Litres per minute if Oxygen is entrained and percentage not measurable). IPAP (inspiratory positive airway pressure) in cmH_2O.EPAP (expiratory positive airway pressure) in cmH_2O (BTS, 2002)
Continuous positive airway pressure (CPAP) or Airvo (nasal high flow)	After commencement: Every 15 minutes for the first hour; then hourly for 4 hours; then at least 4 hourly.	CPAP (continuous positive airway pressure) in cmH_2O. (BTS, 2002)
Underwater seal chest drain insertion	Hourly for 4 hours after insertion, then 4 hourly until removed	Additional parameters as per Trust Chest drain observations chart (WPR 25721).
Tracheostomy	4 hourly until 24 hours after decannulation	See also tracheostomy IPOC & Policy PAT/T 20
Patients in acute pain - score 6 or more	4 hourly	Pain score 30 minutes after analgesia administration
Commencing opiate analgesia or dose or route change	4 hourly for 12 hours then as per Nervecentre model	Nausea score
PCA (patient controlled analgesia)	Hourly for 4 hours; As per Nervecentre model	Nausea score & Volumes used & remaining in syringe (in mls) (See Policy PAT/MM7)
Epidural analgesia	½ hourly for first 2 hours after return to ward. Then hourly for 10 hours. Then As per Nervecentre model	Nausea score, sensory & motor block levels
Acute head/brain injury (including in-patient falls if head injury cannot be excluded (unwitnessed falls)	Immediately then; ½ hourly until GCS = 15; then ½ hourly for 2 hours; then hourly for 4 hours; then 2 hourly thereafter	Neurological observations as per Trust neurological observations chart (NICE, 2007b)
Pregnancy & up to 42 days post partum	As per NEWS2 IPOC/eObs until Drs order otherwise (see Appendix 5)	MOEWS (modified obstetric early warning score) (See Appendix 5)

7. LEARNING & SUPPORT

Learning activity / Staff - roles	Newly registered nurses / AHPs who act in the role of **recorder and recogniser**	Newly appointed nurses or AHPs who act in the role of **recorder and recogniser**	Unregistered staff who act as **recorders** of observations (e.g. HCA)	Doctors, senior and specialist nurses and advanced clinical practitioners who act in the role of **responder**
Attend the preceptorship session on vital Signs training	√	X	X	X
Undertake competence-based learning (face-to-face or elearning) on the Nervecentre eObs application and have an awareness of how to use the NEWS2 IPOC in the event of eObs system failure.	√	√	√	√
Receive training and be assessed as competent to perform physiological observations	X	X	√	X

The eLearning and competency framework for eObs is available on the Hive: https://extranet.dbth.nhs.uk/dbth-digital-transformation/eobservations/

Education and training on the deteriorating patient is essential for all clinical staff caring for acutely ill in-patients. This is delivered appropriate to role detailed in the learning pathway (overleaf).

The critical care outreach team, and the policy author can be consulted and will advise on any issues relating to this policy, deterioration and escalation.

Learning pathway to support clinical staff with deteriorating adult in-patients

Career / Professional Level	Outcome	Indicative content / focus of learning	Learning Methods / Opportunities
Unregistered staff in the role of recorder. (Health care support worker, Assistant practitioner, Associate Nurse)	Acts primarily as **recorder.** Records and interprets physiological observations within the context of the NEWS2 (National Early Warning Score) system. Communicates with Registered staff when there is a NEWS trigger or clinical concern	Measuring and recording observations NEWS2 Fluid balance Sepsis screening Teamwork & Non-technical skills Structured communication & escalation	Vital signs & NEWS training Clinical simulation Personal and directed study Work-based learning / supervised clinical practice
Pre-registration Nursing and Medical staff	Can act as **recorder.** Primarily in learning role with a focus on progression to **recogniser.** Monitoring the patients' condition; interpreting observations and adjusting the frequency of observations and level of monitoring. Communicates with registered staff when there is an NEWS trigger or clinical concern	Measuring and recording observations NEWS2 Fluid balance Sepsis screening Teamwork & Non-technical skills Structured communication & escalation	Pre-registration curriculum Personal and directed study / supervised clinical practice
Registered Nurses and allied health professionals in preceptorship period	Can act as **recorder.** Acts primarily as **recogniser.** Monitoring the patients' condition; interpreting observations and adjusting the frequency of observations and level of monitoring. **Recognises** patient deterioration identified by the NEWS or other clinical indicators. Refers to more senior, skilled or specialist clinical professionals.	ABCDE assessment of the acutely ill patient Teamwork & Non-technical skills Structured communication & escalation Sepsis recognition & management AKI	Preceptorship programme RAMSI course Skills and drills Intermediate Life Support (ILS) course Clinical simulation Personal and directed study Work-based learning / supervised clinical practice
Registered Nurses who take charge of wards / clinical areas **Foundation 1 Doctors**	Can act as **recorder**. Acts frequently as **recogniser.** Primarily in learning capacity with a focus on progression to Primary **responder** who will interpret NEWS and other clinical indicators. Initiates an investigation and clinical management plan. Revises monitoring plan to evaluate treatment. Seeks specialist / expert advice.	ABCDE Teamwork & Non-technical skills Structured communication & escalation Sepsis recognition & management AKI Other common causes of acute deterioration Management of acute deterioration	Skills and drills RAMSI course Intermediate Life Support (ILS) course (NIC) Clinical simulation Foundation 1 teaching programme Personal and directed study Work-based learning Advanced Life Support (ALS) course (F1) Work-based learning / supervised clinical practice
Registered Nurses acting as 'Primary Responders' (e.g. Advanced Clinical Practitioners, Nurse Specialists, Critical Care Outreach nurses) **Foundation 2 Doctors**	Can act as **recorder**. Can act as **recogniser**. Acts primarily as a **responder**. Interprets NEWS and other clinical indicators. Initiates an investigation and clinical management plan. Revises monitoring plan to evaluate treatment. Seeks specialist / expert advice.	ABCDE Teamwork & Non-technical skills Structured communication & escalation Sepsis recognition & management AKI Other common causes of acute deterioration Management of acute deterioration	Advanced Life Support (ALS) course Academic / Career Specialist Training Programmes Foundation 2 Competencies / training programme Clinical simulation Personal and directed study Work-based learning / supervised clinical practice

8. COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Compliance with on-time observations	Matrons and Ward manager	Monthly	DERICK reports Clinical Governance
Doctors/ACPs logged in for the ward and accepting escalation tasks	Ward manager / Nurse-in-charge	Daily	Nervecentre individual patient window; in 'Staff' window
'Unallocated' escalation tasks (where no Doctor/ACP has been found or has accepted the task to review the patient)	Ward manager / Nurse-in-charge	Daily	Nervecentre individual patient window; in 'Tasks' window or Liveflow individual ward overview.
Compliance with NEWS2 observations and escalation when a patient has suffered a cardiac arrest	Resuscitation services / Consultants responsible for patient. The Medical examiners team review all deaths from cardiac arrests.	Quarterly Every Cardiac Arrest	Reported via Datix The resuscitation service report is annual and reported to the Patient Safety Committee.
Compliance with NEWS2 observations and escalation when a patient has suffered a deterioration incident reported in Datix	Ward managers and Matrons	On individual incident basis	Local clinical governance group
Complaints – via the complaints procedure	Ward managers and Matrons	On individual complaint basis	Local clinical governance group

9. DEFINITIONS

Escalation: The timely, multidisciplinary review and treatment of a patient who is deteriorating. The urgency of the review and treatment, and the seniority of the staff involved, must escalate stepwise as the patient becomes more severely ill and unstable.

10. EQUALITY IMPACT ASSESSMENT

This procedural document has been assessed for equality and diversity as described in CORP/EMP 27 (Equality Analysis Policy) and the Equality Diversity and Inclusion Policy CORP/EMP 59 v 1.

11. ASSOCIATED TRUST PROCEDURAL DOCUMENTS CITED

Early Recognition of the severely ill Antenatal/ Postnatal Woman Using the Modified Obstetric Early Warning Score (MSG 166)

Guidelines for the insertion and management of chest drains (PAT/T 29)

Mental Capacity Act 2005 Policy and Guidance (PAT/PA 19)

Non-obstetric emergency care for pregnant and postpartum women (PAT/T 37)

Policy for the Management of Intravenous Patient Controlled Analgesia (IV- PCA) (PAT/MM7)

Patient falls prevention and management policy (PAT PS 11)

Tracheostomy Adult Care Policy (PAT/T 20)

12. REFERENCES

British Thoracic Society Standards of Care Committee (2002) Non-invasive ventilation in acute respiratory failure. *Thorax* 57: 192-211.

British Thoracic Society (2008) Guideline for emergency Oxygen use in adult patients. British Thoracic Society, London.

National Institute for Health and Clinical Excellence (2007a) *Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. Clinical Guideline 50.* National Institute for Health and Clinical Excellence, London.

National Institute for Health and Clinical Excellence (2007b) *Head injury: Triage, assessment, investigation and early management of head injury in infants, children and adults. Clinical Guideline 56*. NICE, London.

National Patient Safety Agency (2007a) *The fifth report from the Patient Safety Observatory: Safer Care for the acutely ill patient: learning from serious incidents*. *PSO/05*. The National Patient Safety Agency, London.

National Patient Safety Agency (2007b) *Recognising and responding appropriately to early signs of deterioration in hospitalised patients*. The National Patient Safety Agency, London.

National Patient Safety Agency (2011) *Essential care after an inpatient fall.* Rapid Response Report. NPSA/2011/RRR001.

Royal College of Physicians (2017) National Early Warning Score (NEWS) 2. Royal College of Physicians, London.

APPENDIX 1 – NEWS trigger categories & Clinical Response (NEWS IPOC page 1)

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NEWS IPOC

AFFIX LABEL HERE IF AVAILABLE

NHS Number: .....
District Number: .....
Surname: .....
Forename(s): .....
Address: .....
.....
D.o.B.: .....

NEWS	Observations	Clinical Response
0	**Minimum 12 hourly***	Continue NEWS monitoring with every set of observations ***Minimum 4 hourly observations if:** admission to hospital / transfer from critical care in last 24 hrs, acute brain injury, NIV, CPAP, Airvo, O_2 therapy, chest drain, tracheostomy, epidural, PCA, opiates commenced, or dose or route change.
LOW **Total 1-4**	**4 hourly** Must score 0 for at least 12 hours before reducing frequency to 12 hourly	**HCA:** Refer to Registered Nurse using SBAR & document referral **RN:** Face-to-face assessment of the patient – then decide if increased frequency of observations and/or review by Dr / ACP is required. Acute rise in NEWS, clinical concern or new sepsis should all be reviewed by Dr / ACP. If in doubt whether to escalate repeat observations within 1 hour & review. Communicate using SBAR & record actions & decisions. **Dr / ACP if attending:** ABCDE assessment & investigations, formulate & document management & monitoring plan. Consider modifying observations & escalation for NEWS score in this category (below). **THINK SEPSIS: If NEWS ≥3 & immunocompromised** (neutropaenia, post chemotherapy) screen for sepsis & document risk level as per sepsis screening & action tool in this IPOC. If Moderate or High risk – proceed to complete the sepsis IPOC and start Sepsis6.
	Modified observations & escalation instructions (eg target limits - please Date, Time & Sign) SpO_2 ☐ **Scale 2** (88-92%)	
MEDIUM **Total 5-6 or 3 in one parameter**	**Hourly** or as documented monitoring plan by Dr / ACP	**HCA:** Refer to Registered Nurse & Nurse in charge using SBAR & document referral **RN:** Urgent face-to-face assessment of the patient. Contact ward doctor / ACP for urgent review within 30 minutes. Consider escalation to Critical Care Outreach if advice needed / patient is not improving. Recheck NEWS hourly until NEWS <5 & the patient is stable for at least 2 hours **Dr / ACP:** ABCDE assessment & investigations, formulate & document management & monitoring plan. Refer to Critical Care Outreach if advice needed / no improvement. If the patient does not improve within 60 minutes call for senior review. **Senior Medical Review:** Assess patient and implement appropriate management plan. Establish criteria for further review / senior review Review DNACPR status, treatment & escalation plan. Consider modifying observations & escalation for NEWS score in this category (below). **THINK SEPSIS: If NEWS ≥5 & could be due to infection** screen for sepsis & document risk level as per sepsis screening & action tool in this IPOC. If Moderate or High risk – proceed to complete the sepsis IPOC and start Sepsis6.
	Modified observations & escalation instructions (eg target limits - please Date, Time & Sign)	
HIGH **Total 7 or more**	**Every 30 minutes** or as documented monitoring plan by Dr / ACP	**HCA:** Urgently refer to Registered Nurse & Nurse in charge of ward/department using SBAR & document referral. **RN:** Immediate face-to-face assessment of the patient. Escalate to senior doctor immediately. Inform Critical Care Outreach if advice needed / patient is not improving. **Dr /ACP & Senior Medical Review:** Immediate assessment and management. Senior Dr to assess response. Senior Dr to review DNACPR status, treatment & escalation plan. Refer Critical Care Consultant / Outreach / if advice needed / no improvement (SpR/ middle grade out of hours) or if admission to critical care is deemed necessary. Consider modifying observations & escalation for NEWS score in this category (below). **THINK SEPSIS: If NEWS ≥5 & could be due to infection** screen for sepsis & document risk level as per sepsis screening & action tool in this IPOC. If Moderate or High risk – proceed to complete the sepsis IPOC and start Sepsis6.
	Modified observations & escalation instructions (eg target limits - please Date, Time & Sign)	

We Care

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Sept 2018
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APPENDIX 2 – NEWS observation chart (pages 2&3 of NEWS IPOC)

NEWS key 0 1 2 3		Full name / Date of birth / Date of admission																
	Date																	Date
	Time																	Time
A+B Respirations Breaths/min	≥25								3									≥25
	21-24								2									21-24
	18-20																	18-20
	15-17																	15-17
	12-14																	12-14
	9-11								1									9-11
	≤8								3									≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96																	≥96
	94-95								1									94-95
	92-93								2									92-93
	≤91								3									≤91
SpO_2 Scale 2* Oxygen saturation (%) Use scale 2 if target range is 88-92% eg in hypercapnic respiratory failure. * Use scale 2 ONLY under the direction of a qualified clinician.	≥97 on O_2								3									≥97 on O_2
	95-96 on O_2								2									95-96 on O_2
	93-94 on O_2								1									93-94 on O_2
	≥93 on air																	≥93 on air
	88-92																	88-92
	86-87								1									86-87
	84-85								2									84-85
	≤83%								3									≤83%
Oxygen and device	O_2 L/%								2									O_2 L/%
	Device																	Device
C Blood pressure mmHg Score uses systolic BP only	≥220								3									≥220
	201-219																	201-219
	181-200																	181-200
	161-180																	161-180
	141-160																	141-160
	121-140																	121-140
	111-120																	111-120
	101-110								1									101-110
	91-100								2									91-100
	81-90								3									81-90
	71-80								3									71-80
	61-70								3									61-70
	51-60								3									51-60
	≤50								3									≤50
C Pulse Beats/min	≥131								3									≥131
	121-130								2									121-130
	111-120								2									111-120
	101-110								1									101-110
	91-100								1									91-100
	81-90																	81-90
	71-80																	71-80
	61-70																	61-70
	51-60																	51-60
	41-50								1									41-50
	31-40								3									31-40
	≤30								3									≤30
D Consciousness	Alert																	Alert
	Confusion								3									Confusion
	V/P/U								3									V/P/U
E Temperature °C	≥39.1°								2									≥39.1°
	38.1-39.0°								1									38.1-39.0°
	37.1-38.0°																	37.1-38.0°
	36.1-37.0°																	36.1-37.0°
	35.1-36.0°								1									35.1-36.0°
	≤35.0°								3									≤35.0°
TOTAL NEW SCORE																		**TOTAL**
Additional Parameters	Pain score on movement (0-3)																	Pain score
	Nausea Score																	Nausea Score
Monitoring frequency																		Monitoring
Escalation of Care Y/N																		Escalation
Initials																		**Initials**

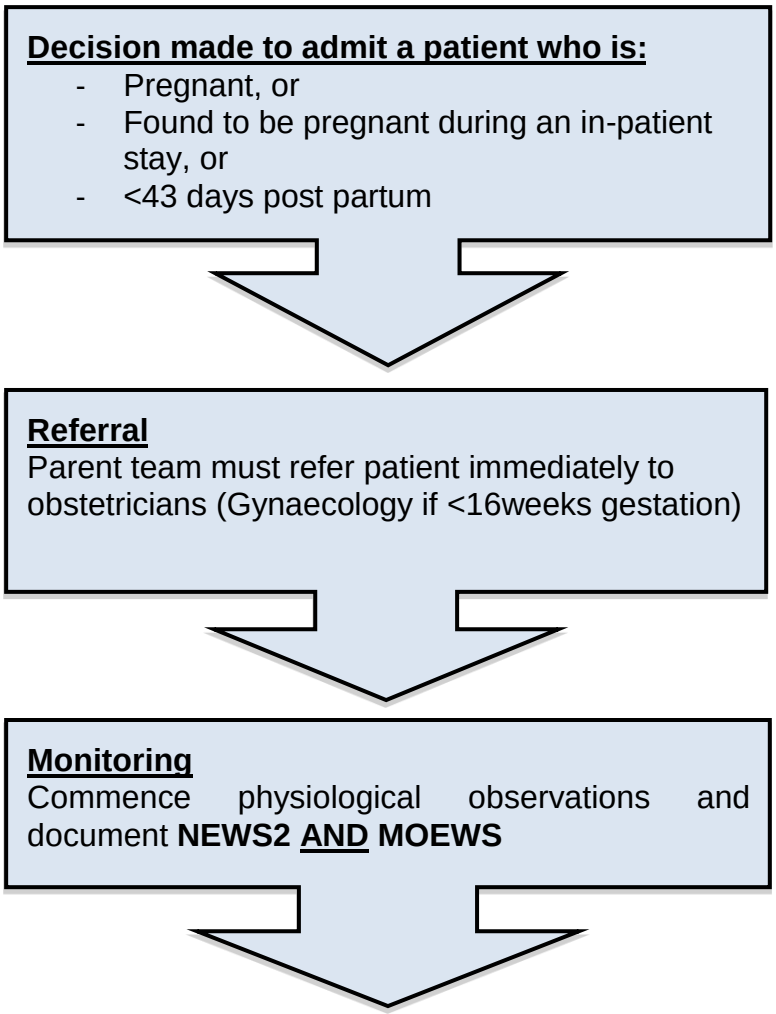
O_2 device key: N = Nasal cannulae, M = Mask, B = BiPAP(NIV), C = CPAP, AV = Airvo, A = Air

APPENDIX 3 – Recording escalation (NEWS IPOC – page 4)

Time and Date	Details of Escalation	Name & Signature

If necessary continue notes in patient records.

APPENDIX 4– Monitoring pregnant in-patients in non-obstetric areas



Deterioration

If the patient triggers NEWS2, follow the NEWS2 model for observations frequency and medical review.

If the patient triggers the MOEWS notify Obstetrics (Gynaecology if <16 weeks gestation) using SBAR and request immediate review

The parent team must collaborate with the Obstetricians / Gynaecologists & agree whether MOEWS is required and document a plan for monitoring and escalation. Until a plan is documented both parent team and Obstetricians / Gynaecologists must be contacted by nursing staff if deterioration / triggering of NEWS2 or MOEWS occurs.

APPENDIX 5– EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Policy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Physiological observations & prevention of deterioration in the acutely ill adult (Pat/T 33 V5)	CSS - Critical Care	Lee Cutler	Existing	14/8/2023

1. **Who is responsible for this policy?** Cross divisions
2. **Describe the purpose of the policy** To ensure appropriate monitoring of patients, detection and response to deterioration
3. **Are there any associated objectives?** Compliance with NICE & RCP guidance
4. **What factors contribute or detract from achieving intended outcomes?** Involves all divisions
5. **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** No
   - **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –
6. **Is there any scope for new measures which would promote equality?** No
7. **Are any of the following groups adversely affected by the policy?** No

Protected Characteristics	Affected?	Impact
a. Age	No	
b. Disability	No	
c. Gender	No	
d. Gender Reassignment	No	
e. Marriage/Civil Partnership	No	
f. Maternity/Pregnancy	No	
g. Race	No	
h. Religion/Belief	No	
i. Sexual Orientation	No	

8. **Provide the Equality Rating of the service / function /policy / project / strategy – tick (☒) outcome box**

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

Date for next review: August 2026

Checked by: **Marie Hardacre** **Date:** 06/09/2024