NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

# Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above)

## Ref CLIN-0099-v1

**Status: Approved**
**Document type: Procedure**

## Contents

# 1 Purpose

Following this procedure will help the Trust to:-

- Standardise practice for all clinical staff in the early recognition and response in the deteriorating patient.
- Facilitate early detection by using the National Early Warning Score (NEWS) tool for the appropriate and timely management of clinical deterioration.
- Reduce clinical risks associated with inappropriately managed clinical conditions.

# 2 Related documents

This procedure describes what you need to do to implement the Physical Health Assessment and Ongoing Monitoring section of the Physical Health and Wellbeing Policy.

The Physical Health and Wellbeing Policy defines standards which you must read, understand and be trained in before carrying out the procedure described in this document.

This procedure also refers to:-

COPD Guideline

Cardiovascular risks (Hypertension and High Cholesterol) Guideline

Rapid Tranquillisation (RT) Policy
Physical Health and Wellbeing Policy
Physiological Assessment Procedure
Diabetes Management Guidelines
Guidelines for Blood Glucose Monitoring
Resuscitation Policy
Mental Capacity Act 2005 Policy
Policy for Consent to Examination or Treatment
Administration of oxygen in an emergency situation for adults and children

# 3 Who this procedure applies to

This clinical procedure applies to all clinical staff employed by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) working within inpatient settings including the care delivered to adults.

## 3.1 Roles and Responsibilities

| Role | Responsibility |
|---|---|
| Executive Director Nursing & Governance | Responsible for the development, review and monitoring of this procedure and practice standards in physical healthcare and for the provision of appropriate training and education to support the delivery of physical healthcare. |
| Medical Staff (including Physical Healthcare Practitioners where available) | Reviewing National Early Warning Score charts on a regular basis.<br>Discuss frequency of recording and requirements to re-set individual patient triggers as part of treatment / care formulation and Multi-Disciplinary Team (MDT) report outs.<br>Responding to any staff concerns and to see the patient:-<br>If the score remains 1-4 after 4 hours<br>Immediately if score 5 and above<br>On call medical staff if not on site must respond promptly and consider advising staff to call emergency services if appropriate<br>Attend relevant training to this procedure. |
| Ward Managers / Clinical Leads | Ensuring that staff have appropriate training and that the National Early Warning Score process is adhered to and that the National Early Warning Score is discussed regularly at report outs/ward rounds.<br>Attend relevant training to this procedure. |
| Registered Nurses and Healthcare Assistants | Ensure the appropriate completion of the National Early Warning Score as per this procedure.<br>Follow the procedure for escalating high scores using the agreed communication tool.<br>Attend relevant training to this procedure.<br>Health Care Assistants should report any escalation to a Registered Nurse but do have authority to call for medical assistance or emergency services if they have sufficient concern about any patient. |

# 4 Procedure

## 4.1 Introduction

The Trust is committed to improving the physical health of its patients and reducing incidents of harm. This clinical procedure will outline how staff can promote the early detection, prevention and management of physical health deterioration.

Physical health deterioration can occur at any stage of a patient's pathway. Within a mental health and learning disability Trust there are certain periods when our patients may be more vulnerable such as:

- during the onset of infection or illness
- during procedures such as dental interventions
- administration of rapid tranquilisation
- during changes of medication
- after a fall
- during a period of deterioration of their mental health
- during an exacerbation of a physical long term condition e.g. Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Cardio Vascular Disease (CVD)

The NEWS should not be used in children (aged <16 years) or in women who are pregnant, because the physiological response to acute illness can be modified in children and by pregnancy. The NEWS may be unreliable in patients with spinal cord injury owing to functional disturbances – use with caution.

Patients who physically deteriorate present with abnormalities that are detectable by simple measurement of physiological observations. Vigilant clinical staff who are trained to recognise and respond to these signs, can prevent further deterioration (Royal College of Physicians 2012).

## 4.2 Background to the Development of the National Early Warning Score

In 2012 the Royal College of Physicians in partnership with the Royal College of Nursing, standardised the assessment and scoring of six simple physiological observations to be used in all NHS Trusts. This standardised approach was created to enable a process of recording, scoring, recognising and responding to changes and/or deterioration in patients with acute illness.

The effectiveness of embedding a National Early Warning Score system is based on two assumptions:-

1. Registered Nurses and Healthcare Assistants have the knowledge and skills to regularly record physiological observations using an agreed NEWS observation chart.
2. If a patient deteriorates, the Registered Nurse or the HCA must escalate physical health care concerns appropriately according to the National Early Warning Score system.

Benefits of using a National Early Warning Scoring system:-

- Improves the quality of patient observation and monitoring
- Improves communication within the MDT
- Allows for timely discussions to support clinical judgement
- Aids securing appropriate assistance for poorly patients
- Gives a good indication of physiological trends
- Provides a sensitive indicator of abnormal physiology
- Ensures that staff in TEWV are using the same tool as Acute Trusts

## 4.3 What is the National Early Warning Score

The National Early Warning Score is based on a simple scoring system in which a score is allocated to six physiological observations (see below). Each individual observation generates a score. When all six scores are added together, this provides the overall NEWS which is set to trigger when a patient is acutely unwell or has abnormal physiology.

| **Physiological observation** | **How to measure** | **How to record** (use black ink) |
|---|---|---|
| Respiration Rate | Count respirations for 1 minute. Try not to let patient know you are counting as this may affect rate. | Enter rate in numbers. |
| Oxygen Saturations (Sats /$SpO_2$) | Using pulse oximeter. | Enter percentage<br><br>Enter tick for patient on $O_2$ |
| Temperature | Using digital equipment: tympanic thermometer or non-contact infrared digital thermometer. | Enter actual figures |
| Systolic Blood Pressure (BP) | Using digital or manual equipment (the NEWS is calculated using the systolic reading- the top number). | Enter actual figures |
| Heart Rate (Pulse) | Heart rate and rhythm is recorded manually by counting the beats felt at the wrist for one minute. Although a digital BP and Sats monitor will record a heart rate, manual recording is the preferred standard. | Enter actual figures.<br>Indicate regular rate (r) and irregular with (i) |
| Level of Consciousness<br>(ACVPU = Alert, New Confusion, Voice, Pain, Unresponsive) | The patient is alert.<br>The patient displays new confusion or agitation.<br>**V**- The patient responds to verbal stimulation.<br>**P**- The patient responds to painful stimulation (squeeze part of the trapezius muscle in the patient's shoulder).<br>**U**- The patient is completely unresponsive. | Tick appropriate box |

## 4.4 Recording the National Early Warning Score

### 4.4.1 Documentation

To facilitate standardisation of recording, a colour coded NEWS chart must be completed.

TEWV Foundation Trust has developed a NEWS chart which includes the required track and trigger response.

New Early Warning Score Chart (Adults) Cardea LP155743 (Appendix 1)

All entries on the NEWS chart must be dated and the time recorded in the 24 hour format.

### 4.4.2 Frequency of Monitoring

As a standard the Trust have agreed the following principles when deciding the frequency of recording NEWS, however each patient should be assessed on an individual basis.

**Regular Monitoring**

The NEWS **must** be completed for all patients on admission to Inpatient Units including Respite Units and ECT Ward / Suite in order to establish a baseline.
All patients will have NEWS recorded twice daily until reviewed by the MDT with the exception of MHSOP/Adult inpatients who require a minimum of at least daily NEWS recording for the duration of their inpatient stay.
The MDT and / or Physical Healthcare Practitioner will agree frequency of monitoring which will form part of an individual intervention plan.

Increase the frequency of monitoring when a patient displays any change in physical or mental health giving cause for concern.

Increase the frequency of monitoring in accordance with the table on the back of the NEWS chart.

Patients who have a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) still require recording of NEWS monitoring unless deemed end of life or palliative care.

Patients cared for within an Eating Disorder Service will require more intensive monitoring and staff within the service will need to ensure that they follow their service specific policies and guidelines.

National Early Warning Scores and intervention plans must be discussed as part of an MDT review/report out and the medical team and/or Physical Healthcare Practitioner should be informed.

For patients confirmed to have hypercapnic respiratory failure prior to or during their current hospital admission, and are requiring supplemental oxygen, a prescribed oxygen saturation target range of 88-92% is recommended. In such circumstances the dedicated SpO2 scoring scale (Scale 2) on the NEWS chart should be used to record and score the oxygen saturation for the NEWS.

The decision to use 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 regular NEWS SpO2 (Scale 1) should be used.

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

**Rapid Tranquilisation**

Following administration of rapid tranquilisation, patients **must** have their physical health and level of consciousness monitored.

Monitoring physiological observations should continue even if the patient is asleep post rapid tranquilisation.

Physiological observations should be monitored every 10 minutes for 1 hour and then every hour for three hours.

If all NEWS cannot be recorded in full, or if observations are refused, monitor breathing as a minimum, observe for pallor, cyanosis, shiver and increased confusion.

### 4.4.3 Additional Considerations when Monitoring and Interpreting NEWS

Always consider the patient's normal baseline observations and the views of the clinical team to assist your clinical judgement.
Remember the NEWS is only one way of detecting early deterioration in a patient's physical health. There are other scoring systems such as the Glasgow Coma Scale (GCS) – Appendix 2.
NEWS should be calculated even if all six physiological observations cannot be measured as individual scores can also be an early warning sign of deterioration.
Patients may refuse to have their physiological observations measured for a variety of reasons. This should be recorded on the NEWS chart and further monitoring attempts must be recorded in Physical Health case-note on PARIS.
It is important to clearly document and report a recorded high blood pressure to a member of the medical team for further review (over 140/90 although this may not trigger a score on the NEWS chart). Medical staff and/or Physical Health Care Practitioner to follow cardiovascular risks (Hypertension and High Cholesterol) Guideline for treatment advice.
When undertaking a lying and standing blood pressure, both recordings should be recorded on the chart but only calculate the full NEWS for the lying blood pressure.

Consider Sepsis (infection) as a cause for deterioration. Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis affects all age groups and can present in any clinical area therefore staff vigilance is critical.

Signs of Sepsis include:

**S**lurred speech
**E**xtreme muscle pain
**P**assing no urine
**S**evere breathlessness
**I** "feel I might die"
**S**kin mottled or discoloured

Assess temperature, heart rate, respiratory rate, blood pressure, level of consciousness and oxygen saturation in young people and adults with suspected sepsis and complete the NEWS.

If NEWS is 5 or above THINK SEPSIS and escalate accordingly.

Examine people with suspected sepsis for mottled or ashen appearance, cyanosis of the skin, lips or tongue, non-blanching rash of the skin, any breach of skin integrity (for example, cuts, burns or skin infections) or other rash indicating potential infection (NICE 2016 Sepsis: recognition, diagnosis and early management)

## 4.5 Interpretation and Response to NEWS

### 4.5.1 Interpretation of NEWS

Once the physiological observations have been recorded and documented on the appropriate NEWS chart, an individual score for each of the six physiological observations is generated which when added together will provide the overall National Early Warning Score. The NEWS system categorises and colour codes the scores as either:-

| | |
|---|---|
| Low score (Yellow) | Colours represent severity of decline in physical health and should determine urgency of clinical response. |
| Medium score (Orange) | |
| High score (Red) | |

A table representing the NEWS scoring system can be found on the back page of each of the appropriate NEWS chart. If there is any doubt about the score seek additional guidance from a medical or nursing colleague.

A single score of 3 on one of the six physiological observations **must** trigger urgent medical attention.

Patients receiving supplementary oxygen at the time of monitoring should have 2 added to the overall National Early Warning Score.

Oxygen can be applied in an emergency situation if oxygen sats are 93% or less. This should be administered using a non-rebreathe mask (with reservoir at 15 litres per minute).

In an emergency situation oxygen may be administered under the Protocol For Administration of Oxygen in an Emergency Situation by any member of staff who has undertaken First Response Training. The Ambulance Service must be called when a patient requires emergency oxygen.

If a patient displays new confusion, which includes disorientation, agitation, delirium, or any new alteration to mental state at the time of monitoring, a 3 should be added to the overall National Early Warning Score.

### 4.5.2 Response to NEWS Total

A National Early Warning Score total may hit an agreed threshold and trigger a response. There are agreed clinical responses for overall scores (see back of NEWS chart). Should the score trigger a response and if you are concerned, there are 3 additional considerations that can be made and should be documented on Paris (see below):

| Additional Considerations if NEWS Triggers |
|---|
| Pain assessment (ask the patient) |
| BM (blood glucose) |
| Passed urine (ask the patient) |

Document response on the NEWS chart (escalation plan) and record the score and actions in the Physical Health case-note on PARIS.

### 4.5.3 Principles for Using Situation, Background, Assessment, Recommendation and Decision (SBARD) Tool within NEWS Procedure

When communicating concerns with another member of staff, the SBARD tool should be used as Trust standard and documented in the Physical Health Case-note on PARIS.

The SBARD tool is based on the following principles:

This is a nationally recognised tool for rapid, effective communication during urgent situations.
The tool has been incorporated on to the back page of each of the NEWS charts.
Inadequate verbal or written communication is recognised as being the most common root cause of serious clinical errors. Therefore including a recognised communication tool within a NEWS chart is critical.
Using the SBARD tool can help prevent breakdowns in verbal and written communication by building a common language platform for communicating critical events, thereby reducing barriers to communication between healthcare professionals.

## 4.6 Recognise and Respond to the Deteriorating Patient: Quick Reference Guide

The standards for recognising and responding to the deteriorating patient have been incorporated into a visual quick reference guide to be displayed within inpatient areas (clinic room). This can also be used as a tool when supporting staff with implementing the procedure (Appendix 3).

# 5 Definitions

| Term | Definition |
|---|---|
| Ambulatory | Capable of walking and not bedridden. |

| | |
|---|---|
| Cardio Vascular Disease (CVD) | CVD is a general term that describes a disease of the heart or blood vessels. Blood flow to the heart, brain or body can be reduced as the result of a blood clot (thrombosis), or by a build-up of fatty deposits inside an artery that cause the artery to harden and narrow (atherosclerosis). There are four main types of CVD: coronary heart disease, stroke, peripheral arterial disease and aortic disease. |
| Chronic Obstructive Pulmonary Disease (COPD) | COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema. People with COPD have difficulty breathing, primarily due to the narrowing of their airways. |
| Diabetes | Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes – type 1 diabetes and type 2 diabetes. |
| National Early Warning Score (NEWS) | The National Early Warning Score is based on a simple scoring system in which a score is allocated to six physiological observations. Each individual observation generates a score. When all six scores are added together, this provides the overall National Early Warning Score which is set to trigger when a patient is acutely unwell or has abnormal physiology. |
| Glasgow Coma Scale (GCS) | The Glasgow Coma Scale or GCS is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. |
| Neuroleptic Naive | A person who has never taken antipsychotic medication before. |
| Parenteral Administration | Taken into the body or administered in a manner other than through the digestive tract, as by intravenous or intramuscular injection. |
| Physiological Observation | Physiological observations are essential requirements for patient assessment and the recognition of clinical deterioration. |
| Sepsis | Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis can lead to septic shock, multiple organ failure and death especially if not recognised early and treated promptly. |
| Situation, Background, Assessment, Recommendation and Decision (SBARD) communication tool | Nationally recognised tool for rapid, effective communication during urgent situations. |

# 6 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line

| |
|---|
| management briefing. |
| • Staff will comply with Trust training relating to this procedure. |

## 6.1 Training Needs Analysis

| Staff/Professional Group | Type of Training | Duration | Frequency of Training |
|---|---|---|---|
| All staff who do NEWS recording | On line ESR training | 15 mins | One off and as required for personal refresh |

# 7 How the Implementation of this Policy will be monitored

| Auditable Standard/Key Performance Indicators | | Frequency/Method/Person Responsible | Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). |
|---|---|---|---|
| 1 | NEWS Datix review group | Monthly/meeting/ Lesley Chapman & Karen Blakemore | Report will be send to all QUAGs every 6 months and reported 6 monthly to Physical Health & Wellbeing Group |

## 7.1 How this procedure will be audited

Service specific and Trust wide audits will be carried out to assess compliance with this procedure. This will form part of the Trust annual clinical audit programme.

Service specific audits must be yearly and comprise of assessment of compliance with the procedure and also staff competency in taking, recording and interpreting readings.

# 8 References

National Institute for Health and Care Excellence (2007) Acutely ill patients in hospital. Recognition and response to acute illness in adults in hospital. London: NICE.

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

Jackson, L. et al. (2007) *Blood pressure centiles for Great Britain*. National Centre for Biotechnology information.

Patient Safety First (2008) The 'How to Guide' for Reducing Harm from Deterioration.

Royal College of Physicians (2012) National Early Warning Score (NEWS). Standardising the assessment of acute-illness severity in the NHS. Report of a Working Party.

Royal College of Physicians (2017) National Early Warning Score (NEWS) 2. Standardising the assessment of acute-illness severity in the NHS. Updated Report of a Working Party: Executive Summary and Recommendations.

Teasdale G, Jennett B: Assessment of coma and impaired consciousness: A practical scale. **Lancet 304**:81–84, 1974

The Royal Marsden Manual of Clinical Nursing Procedures Ninth Edition (Online) Available from: http://www.rmmonline.co.uk/
(Accessed 19th June 2015).

# 9 Document control

| | | |
|---|---|---|
| Date of approval: | 28 January 2019 | |
| Next review date: | 27 July 2022 | |
| This document replaces: | CLIN-0076-v3 EWS procedure | |
| Lead: | Name | Title |
| | Lesley Chapman | Associate Nurse Consultant |
| Members of working party: | Name | Title |
| | Corrie Byron<br>Linda Johnstone<br>Kizzie Hodgson | Physical Nurse Practitioner<br>Lead Nurse Medicines Management<br>Physical Nurse Practitioner |
| This document has been agreed and accepted by: (Director) | Name | Title |
| | Elizabeth Moody | Director of Nursing and Governance |
| This document was approved by: | Name of committee/group | Date |
| | Physical Health and Wellbeing Group | 28 January 2019 |
| An equality analysis was completed on this document on: | 17 December 2018 | |

**Change record**

| Version | Date | Amendment details | Status |
|---|---|---|---|
| 1 | 28 Jan 2019 | Changed procedure to fit with NEWS 2 guidance in order to comply with Royal College of Physicians (2017) National Early Warning Score (NEWS) 2. Standardising the assessment of acute-illness severity in the NHS. Updated Report of a Working Party: Executive Summary and Recommendations. | Published |
| 1 | 30 Mar 2021 | Review date extended to 27 July 2022 | Published |
| | | | |

## 9.1 Appendix 1 – National Early Warning Score Chart (Adults)

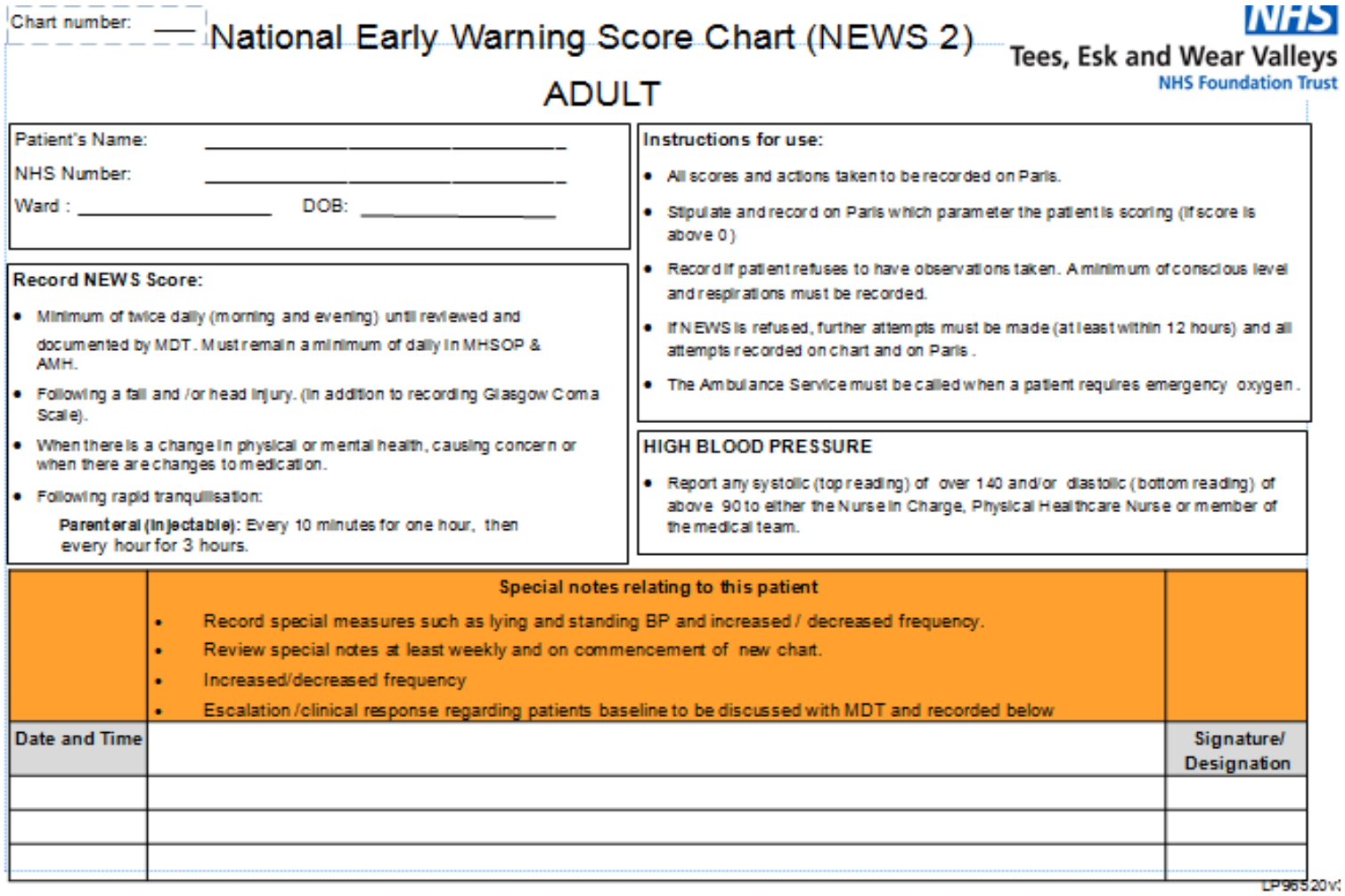

Chart number: ____

# National Early Warning Score Chart (NEWS 2)

## ADULT

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Patient's Name: _____

NHS Number: _____

Ward : _____ DOB: _____

**Record NEWS Score:**

- Minimum of twice daily (morning and evening) until reviewed and documented by MDT. Must remain a minimum of daily in MHSOP & AMH.
- Following a fall and /or head injury. (In addition to recording Glasgow Coma Scale).
- When there is a change in physical or mental health, causing concern or when there are changes to medication.
- Following rapid tranquillisation:

  **Parenteral (injectable):** Every 10 minutes for one hour, then every hour for 3 hours.

**Instructions for use:**

- All scores and actions taken to be recorded on Paris.
- Stipulate and record on Paris which parameter the patient is scoring (if score is above 0)
- Record if patient refuses to have observations taken. A minimum of conscious level and respirations must be recorded.
- If NEWS is refused, further attempts must be made (at least within 12 hours) and all attempts recorded on chart and on Paris.
- The Ambulance Service must be called when a patient requires emergency oxygen.

**HIGH BLOOD PRESSURE**

- Report any systolic (top reading) of over 140 and/or diastolic (bottom reading) of above 90 to either the Nurse in Charge, Physical Healthcare Nurse or member of the medical team.

| | Special notes relating to this patient<br>• Record special measures such as lying and standing BP and increased / decreased frequency.<br>• Review special notes at least weekly and on commencement of new chart.<br>• Increased/decreased frequency<br>• Escalation /clinical response regarding patients baseline to be discussed with MDT and recorded below | |
|---|---|---|
| **Date and Time** | | **Signature/ Designation** |
| | | |
| | | |
| | | |

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| NEWS Score | Clinical Response |
|---|---|
| Total 1-4<br>LOW | Inform registered nurse, who must assess the patient.<br>Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required.<br>Commence a minimum of 4 hourly observations.<br>Document actions on PARIS. |
| 3 in single Parameter<br>RED SCORE | Registered nurse to immediately inform medical team caring for the patient. Medical team to provide advice/plan regarding escalation of care.<br>Commence observations a minimum of hourly.<br>Document actions on PARIS. |
| Total 5–6<br>MEDIUM | Registered nurse to immediately inform medical team caring for the patient. Medical team to provide advice/plan regarding escalation of care.<br>Commence observations a minimum of hourly.<br>Consider calling 9/999 if patient unwell and clinically unstable.<br>Document actions on PARIS and complete Datix |
| Total 7 or more<br>HIGH | Registered nurse to immediately inform medical team caring for the patient. Medical team to provide advice/plan regarding escalation of care.<br>Commence continuous monitoring with NEWS a minimum of every 15 minutes.<br>Consider calling 9/999 if patient unwell and clinically unstable.<br>Constant supervision of the patient.<br>Document actions on PARIS & complete Datix |

| | |
|---|---|
| **Consider sepsis as a cause for deterioration?**<br>**If yes to 3 questions below think sepsis ?** | **Additional considerations if NEWS triggers** |
| Is NEWS 3 or above? | Pain assessment (ask the patient) |
| Does patient have signs of infection? | BM (Blood Glucose) |
| Is the patient known to be susceptible to infections ? | Passed urine (ask the patient) |

| | |
|---|---|
| **A** | The patient is alert. |
| **C** | The patient displays new or increased confusion, new disorientation or new agitation. |
| **V** | The patient responds to verbal stimulation only. |
| **P** | The patient responds to painful stimulation only. |
| **U** | The patient is completely unresponsive. |

**Some patients may have impaired level of consciousness as a consequence of sedation. This must be taken into consideration when acting upon high scores.**

**SBARD: Communication tool for the deteriorating patient**

**S — SITUATION**
1. State your name and unit and check you are talking to the correct person.
2. I am calling about *patient name and location.*
3. The reason I am calling is_____

**B — BACKGROUND**
1. Age.
2. Admitting diagnosis and date of admission.
3. Brief relevant past medical history, relevant drug history and allergies and relevant investigations.
4. The patient's resuscitation status.

**A — ASSESSMENT**
1. Latest physiological observation including NEWS.
2. Explain what you think is the problem.

**R — RECOMMENDATION**
1. Explain what you expect from the referral, including how urgent.
2. Explain what your plan is if you have one.
3. Ask for suggested interim management, including change of treatment, change of frequency of observations and any tests needed.

**(Document any verbal orders and instructions given on PARIS)**

**D — DECISION**
1. Explain rationale for decision.

| NEWS key 0 1 2 3 | FULL NAME | | DATE OF ADMISSION |
|---|---|---|---|
| | DATE OF BIRTH | | |

| | | | | |
|---|---|---|---|---|
| | DATE / TIME | | | DATE / 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 †ONLY use Scale 2 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% |
| **Air or oxygen?** | A=Air | | | A=Air |
| | $O_2$ L/min | 2 | | $O_2$ L/min |
| | 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 | | | 71–80 |
| | 61–70 | | | 61–70 |
| | 51–60 | | | 51–60 |
| | ≤50 | | | ≤50 |
| **C Pulse** Beats/min | ≥131 | 3 | | ≥131 |
| | 121–130 | 2 | | 121–130 |
| | 111–120 | | | 111–120 |
| | 101–110 | 1 | | 101–110 |
| | 91–100 | | | 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 | | | ≤30 |
| **D Consciousness** Score for NEW onset of confusion (no score if chronic) | Alert | | | Alert |
| | Confusion | 3 | | Confusion |
| | V | | | V |
| | P | | | P |
| | U | | | 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° |
| **NEWS TOTAL** | | | | **TOTAL** |
| Monitoring frequency | | | | Monitoring |
| Escalation of care Y/N | | | | Escalation |
| Initials | | | | Initials |

## 9.2 Appendix 2 – Glasgow Coma Scale Chart

Name NHS number

| | Date | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Time | | | | | | | | | | | | | | |
| Eyes open | Spontaneously | 4 | | | | | | | | | | | | | |
| | To voice | 3 | | | | | | | | | | | | | |
| | To pain | 2 | | | | | | | | | | | | | |
| | None | 1 | | | | | | | | | | | | | |
| Best verbal Response | Alert and orientated | 5 | | | | | | | | | | | | | |
| | Confused yet coherent speech | 4 | | | | | | | | | | | | | |
| | Utters inappropriate words or sentences | 3 | | | | | | | | | | | | | |
| | Incomprehensible sounds | 2 | | | | | | | | | | | | | |
| | None | 1 | | | | | | | | | | | | | |
| Best motor response | Obeys commands | 6 | | | | | | | | | | | | | |
| | Localises pain | 5 | | | | | | | | | | | | | |
| | Normal flexion to pain | 4 | | | | | | | | | | | | | |
| | Abnormal flexor | 3 | | | | | | | | | | | | | |
| | Extensor response | 2 | | | | | | | | | | | | | |
| | None | 1 | | | | | | | | | | | | | |
| Total score | | | | | | | | | | | | | | | |
| Initials | | | | | | | | | | | | | | | |

**If patient has fallen and no head injury suspected then follow post falls proforma section 3 and record GCS every 4 hours for 12 hours**

**Any suspicion of head injury or actual head injury follow post falls proforma section 6 and record GCS:-**
**Score 15** - (or usual baseline score) record GCS every 30mins for 2 hours, hourly for 4 hours then 4hourly for further 12 hours
**Score 14 – (or a drop of 1 from baseline score**) request immediate medical attention, GCS every 30mins for 2 hours then hourly for 4 hours, then 4hourly for further 12 hours as a minimum, or longer if instructed by medical staff. If GCS does not return to baseline in 2 hours ask for further medical review and may need increase frequency of recordings
**Score 13 or less (or a drop of 2 from baseline in cognitive impairment)** - call 999 and continue GCS until ambulance arrives
**If in doubt call 999**
*NB Patients with dementia may have a usual baseline GCS of lower than 15. It is important to take this into consideration when deciding on response.*

*LChapmanMHSOP2012*

**Glasgow Coma Scale – completion guide**

**Eye response**

Spontaneously- patient has eyes open and looking about as normal
Eyes will be closed or unfocused but open and focus when you speak to them
Eyes will be closed but will open if you use painful stimuli such as shoulder squeeze
Eyes will not open even when using painful stimuli

**Verbal response**

5. Patient is alert and orientated (e.g. orientated to time and place)
4. Patient is disorientated or confused yet the speech is coherent
Patient is answering with one word answers or sentences that are inappropriate
Patient is making incomprehensible sounds like moaning, screaming, groaning
Patient is making no sounds at all.

**Motor response**

Patient is able to obey commands. They are able to move arms and legs when you ask them to. They can grip your hands etc
Localises pain. If you touch the patient or apply painful stimuli the patient is able to touch your hand and push it away.
Normal flexion to pain. This is when the patient may pull their arm away from the painful stimuli or turn away from you.
3 Abnormal flexion. Arms are usually flexed at elbow and hands turned outwards. Flexion is bringing fists up to the chest or in to body.
Abnormal extension. This is where limbs are straight and rigid. Elbows straight. Head may be back and body rigid also.
1. There is no response at all.

**Remember**

You need to know what your patients normal GCS is.
Patients with dementia may already score low.
It is good practice to assess GCS on admission and write this on front of EWS chart.
It is good practice to get your GCS checked with another member of staff especially when recording baseline and after a head injury
GCS may be altered when delirium or during deterioration of mental health so regular reviews of this are suggested.
Start GCS recording from 1/2hrly if the patient has attended A&E.
Use clinical judgement. It may be necessary to complete more often.
If GCS is due when patient is asleep, they must be woken to do the observations.

## 9.3 Appendix 3 - Equality Analysis Screening Form

**Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page**

| | | | | | | |
|---|---|---|---|---|---|---|
| Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc. | Nursing and Governance/Physical Healthcare | | | | | |
| Name of responsible person and job title | Lesley Chapman, Associate Nurse Consultant | | | | | |
| Name of working party, to include any other individuals, agencies or groups involved in this analysis | Corrie Byron, Kizzie Hodgson, Linda Johnstone | | | | | |
| Policy (document/service) name | CLIN-0099-v1 Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above) | | | | | |
| Is the area being assessed a… | Policy/Strategy | | Service/Business plan | | Project | |
| | Procedure/Guidance | | | √ | Code of practice | |
| | Other – Please state | | | | | |
| Geographical area covered | Trust wide | | | | | |
| Aims and objectives | To standardise practice for all clinical staff in the early recognition and response in the deteriorating patient.<br>To facilitate early detection by using the National Early Warning Score (NEWS) tool for the appropriate and timely management of clinical deterioration.<br>To reduce clinical risks associated with inappropriately managed clinical conditions. | | | | | |
| Start date of Equality Analysis Screening<br>(This is the date you are asked to write or review the document/service etc.) | 27 June 18 | | | | | |
| End date of Equality Analysis Screening<br>(This is when you have completed the equality analysis and it is ready to go to EMT to be approved) | 17 December 18 | | | | | |

**You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3046**

| Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit? | | | | | |
|---|---|---|---|---|---|
| The procedure benefits Service Users by ensuring that a standardised process is undertaken by clinical staff in order to facilitate early detection and timely management of clinical deterioration by using the National Early Warning Score (NEWS) tool. | | | | | |
| Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below? | | | | | |
| **Race** (including Gypsy and Traveller) | No | **Disability** (includes physical, learning, mental health, sensory and medical disabilities) | No | **Sex** (Men, women and gender neutral etc.) | No |
| **Gender reassignment** (Transgender and gender identity) | No | **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) | No | **Age** (includes, young people, older people – people of all ages) | No |
| **Religion or Belief** (includes faith groups, atheism and philosophical belief's) | No | **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) | No | **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) | No |
| **Yes** – Please describe anticipated negative impact/s<br>**No** – Please describe any positive impacts/s | | | | | |

| | | | | |
|---|---|---|---|---|
| Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.?<br>**If 'No', why not?** | **Yes** | √ | **No** | |

| | | |
|---|---|---|
| **Sources of Information may include:**<br>Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc.<br>Investigation findings<br>Trust Strategic Direction<br>Data collection/analysis<br>National Guidance/Reports | | Staff grievances<br>Media<br>Community Consultation/Consultation Groups<br>Internal Consultation<br>Research<br>Other (Please state below) |

Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

**Yes** – Please describe the engagement and involvement that has taken place

**No** – Please describe future plans that you may have to engage and involve people from different groups

Given that this procedure has been produced in accordance with The Royal College of Physicians (RCP) updated National Early Warning Score (NEWS) which was initially produced in 2012, there has been no consultation with service users/stakeholders in terms of the updated review of this actual document/procedure. However, NEWS2 has now received formal endorsement from NHS England (NHSE) and NHS Improvement (NHSI) to become the early warning system for identifying acutely ill patients, including those with sepsis, in hospitals in England (RCP, 2017).

The said procedure is therefore a standardised approach that enables clinical staff working within TEWV NHS Foundation Trust to adhere national, recommended guidance.

| | | | | | |
|---|---|---|---|---|---|
| As part of this equality analysis have any training needs/service needs been identified? | | | | | |
| **Yes** | Please describe the identified training needs/service needs below | | | | |
| A training need has been identified for; | | | | | |
| Trust staff | Yes | Service users | No | Contractors or other outside agencies | No |
| **Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so** | | | | | |
| The completed EA has been signed off by:<br>You the Policy owner/manager:<br>Type name: Lesley Chapman | | | | | Date:4.6.19 |
| Your reporting (line) manager:<br>Type name: Karen Blakemore | | | | | Date: 4.6.19 |
| If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046 | | | | | |