Physiological Observation Policy and National Early Warning Score (NEWS2)

RECOGNITION AND RESPONSE TO THE DETERIORATING ADULT PATIENT

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Target Audience – All clinical staff who have direct patient contact

What NEWS2 means for your patient: your guide to NEWS2 for normally well patients

Concern about a patient should lead to escalation, regardless of the score.

Think sepsis! In a patient with a NEWS2 score of 5 or more and a known infection, signs and symptoms of infection, or at risk of infection, think ‘Could this be sepsis?’ and escalate care immediately.

The patient’s vital signs are indicating they may not be physiologically at full health and there is a risk they could deteriorate. Consider whether acute referral is required or whether the patient can be safely monitored at home.

* or a score of 3 in any individual parameter

The patient needs an urgent medical review in an acute care setting. The RCP recommends hourly observations by an acute clinician: consider whether escalation for critical care is required.

The patient needs an emergency medical review in an acute care setting. The RCP recommends continuous monitoring by an acute critical care team.

In an acute setting this should prompt escalation to a critical care outreach team and probable transfer to a high dependency setting.

Is referral appropriate?
NEWS2 is not to be applied to patients under the age of 16 or pregnant women. Escalation must be appropriate to a patient’s care plan – consider end of life care.
Oxygen saturation scale2 should only be used for for patients with hypercapnic (often termed type 2) respiratory failure (usually due to COPD) who have clinically recommended oxygen saturation of 88–92%. If scale-2 has been used this should be clearly and explicitly documented on the patient clinical record.
Key Points

- This policy provides clear guidance to clinical staff in the recognition, response and escalation of a deteriorating patient.
- This policy applies to all clinical staff required to undertake physiological observations and non-contact observations as part of their role.
- This policy is applicable to all adult patients, except obstetric patients. It also excludes children under 16.
- The National Early Warning Score (NEWS2, Appendix A) enables early identification and prioritisation of patients at risk of deterioration and is the national standard.
- Early recognition and escalation of deterioration reduces the risk of further deterioration and cardiac arrest.
- The non-contact observation tool should be used to assess for deterioration when physiological observations are not possible.
- All clinical staff must be aware of the appropriate escalation process for their service, and use the SBARD tool to communicate when requesting support (Appendix B)

2.0 INTRODUCTION

2.1 Recognition of patients who are deteriorating is extremely important, so that appropriate treatment can be given as soon as possible to improve patient outcomes, and reduce harm to patients. This in turn reduces the risk of cardiac arrest and death. More recently there has been work to improve the recognition of sepsis, in order to ensure early intervention with the sepsis 6, which has been proven to save lives. In the community setting, treatment of deterioration may not always be possible due to the nature of the services, however it is vital that clinical staff know how to recognise and escalate deterioration, so that the patient can get the treatment they need in a timely way. Therefore the focus of this policy is on recognition and escalation of deterioration.

2.2 The NEWS2 scoring system can improve the quality of patient observation and provides a sensitive indicator of abnormal physiology. It enables a standardised approach for the recognition and management of the deteriorating adult patient across all healthcare settings. However, there are times when physiological observations cannot be taken, so the non contact observation tool should be used in this situation, if appropriate. In order to help improve communication related to patient deterioration, the SBARD communication tool is recommended when calling for help.

2.3 In addition, the Somerset Treatment Escalation Plan (STEP) has been developed to help make decisions about resuscitation status and appropriate escalation. Any assessment and treatment of the deteriorating patient should take into account the patient’s STEP. Please see the Somerset Treatment Escalation Plan Policy for more information.

2.4 This policy covers adult patients and children of 16 and over (except obstetrics patients).
3.0 DEFINITIONS

3.1 **ACVPU score**: The ACVPU score is a rapid method of assessing the patient’s level of consciousness. The acronym describes the possible levels of consciousness of a patient A= alert C= new confusion V= responds to voice only P= responds to pain only U= unconscious. If it is unknown that the confusion is new or not, it must be assumed to be new confusion.

3.2 **ABCDE**: airway, breathing, circulation, disability and exposure

3.3 **ACP**: advanced clinical practitioner

3.4 **Glasgow Coma score (GCS)**: a common scoring system used to describe the level of consciousness in a patient following a traumatic head injury

3.5 **Hypercapnic Respiratory Failure** indicates high level of carbon dioxide in the blood caused by a chronic respiratory condition.

3.6 **NEWS2** is the National Early Warning Score. This is a physiological observation scoring system that detects deterioration in adults, triggering review, treatment and escalation of care where appropriate. It is a nationally recommended tool.

3.7 **SBARD**: Situation, Background, Assessment, Recommendation and Decision is an easy to remember mnemonic for a communication tool that can be used to formalise conservations in a structured manner. This can aid clarity in an emergency situation. This can be used in multiple situations such as when requesting advice or support about patient management from a senior clinician or General Practitioner (GP) (See appendix C)

4.0 ROLES and RESPONSIBILITIES

4.1 **Chief Executive**

The Chief Executive is responsible for the statutory duty of clinical governance within the Trust and takes overall responsibility for this policy

4.2 **The Trust Board**

The Trust board have overall responsibility for ensuring that the Trust delivers high quality services that are efficient and effective. The Trust board oversee the running of the trust, make the decisions that shape future direction, monitor performance and ensure accountability.

4.3 **The Director of Patient Care (Community)**

Is responsible for ensuring that staff uphold the principles of delivering safe care to patients and take personal accountability for care provision and omissions: their role is to ensure that appropriate procedures are developed, implemented and maintained.

4.4 **The Deteriorating Patient Lead**

Has responsibility for oversight of the recognition and escalation of patients who are acutely unwell or at risk of physical deterioration, including sepsis. They are responsible for leading reviews of deterioration patients and feeding back learning and good practice to the clinical teams. They identify themes and trends to share with the relevant directorate leads.
4.5 Medical Emergencies Group
Have oversight of the governance arrangements relating to care of the deteriorating patient and monitor the themes and trends, in conjunction with cardiac arrests. They provide assurance to the Integrated Quality Assurance Board relating to adherence and compliance to the policy annually and by exception if required.

4.6 The Clinical Practice Team
Will ensure systems are in place to support training provision for physiological observations, NEWS2, non-contact observations and recognising and escalating patient deterioration. They will also assist in investigation of deteriorating patients via the incident reporting system, provide feedback and identify training/learning points.

4.7 Department and Service Managers
Are responsible for
- Ensuring that the requirements of this policy and procedures are effectively managed within their clinical areas and that staff are familiar with and implement those requirements
- All clinical staff have attended appropriate training for their role
- Ensuring monitoring equipment is in good working order and available to use
- Services have clinical procedures for the safe management of clinical interventions that are known to potentially put patients at risk of deterioration.
- Ensuring there is a clear escalation process in place, and that all staff are aware of this.

4.8 All clinical staff including students, bank and agency staff
Are responsible for
- Complying with the standards within this policy
- Using the NEWS2 or non-contact observations as relevant to their service
- Knowing the escalation process for their service
5.0 RECOGNITION AND ESCALATION OF DETERIORATION

NEWS2

5.1 In services where physiological observations are taken routinely as part of the care delivered e.g. inpatient services, community nursing, the NEWS2 scoring system must be used each time a set of physiological observations are taken.

5.1.1 The frequency of physiological observations and any escalation must be determined by the NEWS2 score. Please refer to Appendix A for more information on the clinical response to NEWS2. Exceptions to this must be agreed by a doctor or Advanced Clinical Practitioner, and documented clearly in the patient record.

5.1.2 NEWS2 is a tool and is an aid to clinical judgment. A review should be sought for any patient causing concern even if they do not have a raised NEWS2 score.

5.1.3 When using NEWS2, Scale 2 must only be used for patients with documented chronic hypercapnic respiratory failure. This can only be diagnosed on blood gas analysis, which is undertaken in an acute setting. For many patients with chronic respiratory failure, their type of respiratory failure may have been determined on a previous acute admission, and if so should be in their health record. If this information is not known on admission, NEWS2 SpO2 scale 1 should be used, and the patient escalated accordingly. It may be necessary to seek information from the patient’s respiratory team in order to clarify. The decision to use scale2 should be clearly recorded and if transferred, clearly communicated in any handover.

5.1.4 Where a NEWS2 score is 3 in one parameter, or 5 or more, sepsis should be considered, and if appropriate the sepsis screening and action pathway completed. A NEWS2 score of this level indicates the patient is severely ill with likely organ dysfunction and requires urgent assessment by a senior clinical decision maker, who can start appropriate treatment. In many community settings, and out of hours, this will require a call to 999 for an ambulance. Please see the Alliance Sepsis Policy for more information.
5.2 The NEWS2 Score and Related risk of Deterioration

<table>
<thead>
<tr>
<th>NEWS Score</th>
<th>Clinical Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>LOW</td>
</tr>
<tr>
<td>Aggregate 1-3</td>
<td>LOW</td>
</tr>
<tr>
<td>RED SCORE* (Individual Score of 3)</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>Aggregate 5-6</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>Aggregate 7 or more</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Physiological parameter</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiration rate (per minute)</td>
<td>≤8</td>
<td>9-11</td>
<td>12-20</td>
<td>21-24</td>
<td>≥25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpO₂ Scale 1(%)</td>
<td>≤91</td>
<td>92-93</td>
<td>94-95</td>
<td>≥96</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpO₂ Scale 2(%)</td>
<td>≤83</td>
<td>84-85</td>
<td>86-87</td>
<td>88-92</td>
<td>≥93 on oxygen</td>
<td>93-94 on oxygen</td>
<td>95-96 on oxygen</td>
</tr>
<tr>
<td>Air or oxygen?</td>
<td>Oxygen</td>
<td>Air</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>≤90</td>
<td>91-100</td>
<td>101-110</td>
<td>111-219</td>
<td>≥220</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse (per minute)</td>
<td>≤40</td>
<td>41-50</td>
<td>51-90</td>
<td>91-110</td>
<td>111-130</td>
<td>≥131</td>
<td></td>
</tr>
<tr>
<td>Consciousness</td>
<td>Alert</td>
<td>CVPU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature ('C)</td>
<td>≤35.0</td>
<td>35.1-36.0</td>
<td>36.1-38.0</td>
<td>38.1-39.0</td>
<td>≥39.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.3 Exceptions to NEWS2

5.3.1 Patients who have chronic illness, may have a deranged physiology, and a normal HIGH NEWS2. Changes in physiological markers may be significant, but at an elevated level. See section 5.1 for when to use scale 2 for patients with documented hypercapnic respiratory failure.

5.3.2 For patients on the end of life care pathway, physiological observations may not be appropriate. Decision-making must take into account whether there are potentially reversible causes for clinical deterioration.

5.3.3 NEWS2 may be unreliable in patients with spinal cord injury (especially tetraplegia or high level paraplegia) owing to functional disturbances of the autonomic nervous system, so should be used with caution.

5.3.4 Any exceptions to following the NEWS2 guidance must be agreed by a doctor or ACP, communicated with the multidisciplinary team and documented clearly in the patient record.

5.4 Physiological Observations


5.4.1 Respiratory Rate
Respiratory rate is the most sensitive indicator of deteriorating physiology and must be recorded numerically in all patients in the patients' record.

A respiratory rate of less than 12 and greater than 20 should initiate an alert.

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

5.4.2 Saturations and oxygen delivery
The oxygen delivery device must be recorded on the patient record.

Codes for recording oxygen delivery using NEWS2
- A (breathing air)
- N (nasal cannula)
- SM (simple mask)
- RM (reservoir mask)
- V (Venturi mask) e.g. V24, V28, V35, V40, V60
- NIV (patient on non-invasive ventilation)
- CP (CPAP mask)
- OTH (other specify…)
- TM (tracheostomy mask)
- H (if humidified oxygen with percentage) eg H28
If oxygen is administered this will add 2 points onto the patient’s NEWS2 score. The oxygen saturations should be recorded as a number percentage on the patient record using scale 1. See section 5.1 on when to use scale 2 on NEWS2.

If oxygen is administered as part of routine care, this should be prescribed. In an emergency it can be given without a prescription. Nail varnish and false nails may invalidate the oxygen saturation level so must be removed before reading result.

The Sa02 probe should only be used for the area it is designed for i.e. finger or ear. They are not interchangeable.

5.4.3 Heart Rate and Blood Pressure
The radial heart rate must be measured manually and recorded numerically. The systolic blood pressure (SBP) component of blood pressure is used to calculate NEWS2. If the blood pressure cannot be recorded by machine, a manual sphygmomanometer reading should be taken. If this is not recordable this should be escalated by a 999 urgent ambulance response, if a doctor or advanced practitioner is not immediately available.

Patients with a diagnosis of Atrial Fibrillation must have a manual blood pressure taken.

Falling blood pressure SBP of 90mmHg or less may be a sign of severe sepsis, fluid loss or cardiac shock and will trigger a NEWS2 score of 3 in one parameter.

Although a patient with a low blood pressure may appear ‘asymptomatic’, this needs to be escalated quickly as it is a system of organ dysfunction and can cause acute kidney injury. The exception to this is where acceptable parameters for SBP have been agreed.

5.4.4 Neurological Assessment
A patient’s neurological condition is an important marker of deterioration.

Any reduction in conscious level is significant and can be an early indication of deterioration and may require urgent transfer and escalation to secondary care.

The ACVPU assessment is an essential element of the NEWS2 see below for more information:

<table>
<thead>
<tr>
<th>ACVPU Scale</th>
<th>A</th>
<th>C</th>
<th>V</th>
<th>P</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
<td>Awake</td>
<td>Confused</td>
<td>Lethargy</td>
<td>Stupor</td>
<td>Coma</td>
</tr>
</tbody>
</table>
New confusion, delirium or acutely altered mental state scores 3 on the NEWS2 score, and indicates a red alert (for a single score of 3), requiring urgent assessment and possible transfer to secondary care.

If it is unclear, if the patient’s confusion is new or their normal state, the confusion should be assumed to be new until otherwise confirmed. If a patient is known to be confused at their baseline cognitive state then they should be scored (A) Alert.

If a patient is unresponsive or only responds to pain this should be treated as a medical emergency. It is recommended that the Glasgow Coma Scale (GCS) is used to assess the patient at this point if staff have the skills to do so. This should be assessed regularly while waiting for help.

Patients having seizures are at significant risk and should have a medical/advanced practitioner review, if available or be escalated to 999. Exceptions to this are patients with known seizure risk, who have a treatment plan in place to manage this. Escalation should take place if the seizure is ongoing, despite treatment.

5.4.5 Temperature
Temperature must be scored numerically.

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

5.4.6 Other Observations
Fluid balance and urine output are not included in the NEWS2 score but it is essential that these are considered with every set of observations. Similarly the pain score and blood glucose may need to be assessed, and recorded in the patient’s record.

5.5 Non-contact Observations
There are times when it is not possible to undertake physiological observations. For example if a patient refuses, or their behaviour makes it challenging, or staff do not do this as part of their role. The non-contact tool provides a structured assessment using the ABCDE approach, to help staff identify 'red flags' which should be escalated.

This tool can be used as a one-off assessment or as part of the ongoing planned care for an individual patient, depending on the clinical setting. A clear plan for assessment using this tool should be put in place for patients in this situation.

The non-contact observation tool should only be used when physiological observations are not possible.

The findings of any assessment using the non-contact observation tool, and actions taken must be documented in the patient record. The paper tool should be uploaded to the patient’s record.
Please see the SOP for Non-contact Observations for more information.

5.6 When a Patient Deteriorates
Simple early measures may prevent further deterioration of the patient and avoid the need to admit to secondary care. Interventions such as appropriate positioning of the patient, giving oxygen (if available) to maintain SpO2 above 94%, or giving appropriate medication.

If the patient has symptoms of chest pain or a tachycardia, an electrocardiograph (ECG) should be recorded if the equipment and skills are available.

5.7 Seeking Help/ Escalation
All clinical staff must be aware of the correct escalation process for their service.

The patient Treatment Escalation Plan should clearly show the level of escalation that is appropriate to the patient. However, discussion with the patient and the family (if possible) should take place about the reason for escalation and to gain consent. Please refer to the Somerset Treatment Escalation Plan Policy for more information.

If the patient requires escalation to a senior clinical decision maker the SBARD system (Appendix B) should be used to communicate the reason for escalation. Please see appendix C for more information.

Escalation must take into account the patients NEWS2 score, symptoms and individual circumstances. The senior clinician must use their clinical judgement to make a decision about the appropriate escalation route. In sudden acute deterioration out of hours, it may be more appropriate to call 999 than to escalate to the Out of Hours medical service.

The frequency of the physiological observations must be done according to the NEWS2 clinical response (appendix A) and this should continue whilst waiting for help. If the patient is transferred to secondary care the historical observations should be readily accessible for the admitting hospital/ team.

More detailed guidance and additional notes for deteriorating patients in specialised areas can be found in Appendix C. This includes MIU, Community services and Mental Health inpatient units plus medical emergencies within the community.
6.0 TRAINING/COMPETENCE REQUIREMENTS

6.1 All clinical staff (including bank and agency staff) must have training and competence in the skills needed for their role.

All training related to this policy is available from the Learning and Development intranet page through the Learning Zone.

<table>
<thead>
<tr>
<th>Training</th>
<th>How delivered</th>
<th>Who for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological Observations (includes NEWS2, sepsis awareness) and SBARD</td>
<td>Face to face – 3 hours</td>
<td>Health care support workers, registered staff needing update</td>
</tr>
<tr>
<td>NEW2</td>
<td>Elearning – 1 hour</td>
<td>All staff who take physiological observations</td>
</tr>
<tr>
<td>Deteriorating patient workshop</td>
<td>Face to face – 7 hours</td>
<td>Registered staff - inpatient areas, community nursing</td>
</tr>
<tr>
<td>Non –contact observations</td>
<td>Elearning - 1 hour</td>
<td>All clinical staff</td>
</tr>
<tr>
<td>Taking an electrocardiograph (ECG)</td>
<td>Face to face – 3 hours</td>
<td>Clinical staff- inpatient areas, community nursing, wellbeing clinics</td>
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</tbody>
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7.0 MONITORING

<table>
<thead>
<tr>
<th>Element of policy for monitoring</th>
<th>Section</th>
<th>Monitoring method - Information source (e.g. audit)/ Measure / performance standard</th>
<th>Item Lead</th>
<th>Monitoring frequency / reporting frequency and route</th>
<th>Arrangements for responding to shortcomings and tracking delivery of planned actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and escalation of deteriorating patients</td>
<td></td>
<td>Periodic and systematic audit of deteriorating patients focussed on use of NEWS2, TEPs, recognition and escalation of deterioration Datix of incidents.</td>
<td>Deteriorating Patient lead</td>
<td>Continuous</td>
<td>Action plans will be monitored by the local directorate governance group and the Medical Emergency Group. Risks will be considered for inclusion in appropriate risk register. Local service review and targeted training</td>
</tr>
<tr>
<td>Use of NEWS2</td>
<td></td>
<td>Formal Audit</td>
<td>Deteriorating Patient Lead</td>
<td>Bi annually</td>
<td>Action plans will be monitored by the local directorate governance group and the Medical Emergency Group. Risks will be considered for inclusion in appropriate risk register</td>
</tr>
</tbody>
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8.0 REFERENCES


Other applicable Trust guidance/policy documents that should be read in conjunction with this policy:
- Sepsis Policy
- Somerset Treatment Escalation Plan
- Resuscitation Policy
- Medical Emergencies Policy
- Mental Capacity (Using the Mental Capacity Act) Policy
- SOP for Non-contact Observations
## 9.0 DOCUMENT CONTROL

<table>
<thead>
<tr>
<th>Document Author</th>
<th>Jenny Hillier – Deteriorating Patient Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Owner</td>
<td>Liz Berry, Clinical Skills Lead</td>
</tr>
<tr>
<td>This Version</td>
<td>1</td>
</tr>
<tr>
<td>Replaces</td>
<td>Physiological Observations of Adult Patients in the Community Setting Policy; Physiological Observations Policy for Inpatients and Minor Injury Units (including Wessex House)</td>
</tr>
<tr>
<td>Approval Date</td>
<td>September 2019 (virtual)</td>
</tr>
</tbody>
</table>
| Ratification Date | November 2019  
|                   | December 2019 | Where | Sompar PRG |
| Date of issue   | January 2020 | Review date | January 2023 |
| Applies to      | All clinical staff; All adult patients and children of 16 and over. | Exclusions | Children under 16; Obstetric patients |
## Clinical Response to Deteriorating Patient

<table>
<thead>
<tr>
<th>NEWS2 SCORE</th>
<th>FREQUENCY OF MONITORING</th>
<th>CLINICAL RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Minimum 12 hourly</td>
<td>Continue routine NEWS2 monitoring</td>
</tr>
<tr>
<td>Total score 1-4</td>
<td>Minimum 4-6 hourly</td>
<td>Healthcare Support Worker must inform registered nurse who must visit/assess the same day. Registered nurse must decide if increased frequency of monitoring and/or escalation of care is required and recorded in patients notes (Revisit later in the day of contact out of hour’s service to follow-up. Consider referral to ACP/GP</td>
</tr>
<tr>
<td>3 in single parameter</td>
<td>Minimum 1 hourly</td>
<td>Registered nurse to review and decide whether escalation of care is necessary</td>
</tr>
</tbody>
</table>
| **Patient SICK**
Total score 5-6 (or 3 in single parameter) | Minimum 15 minute monitoring **Consider sepsis** – use Sepsis screening and action pathway to assess if appropriate | **Mon to Fri, 9 to 5**
- Registered nurse to inform ACP/ward Dr /GP.
- Dr/ACP/GP to complete urgent assessment of acutely ill patient
- Consider escalation of care to an acute setting

**OOH or no Dr/ACP/GP available**
- Consider 999 ambulance if OOH GP not available for consultation within 20 minutes or clinical concern for patients physiological well-being |
| **ACT NOW!**
Total score 7 or more | Continuous monitoring of vital signs Urgently contact wider community team to request support. | Call 999 for immediate transfer to secondary care |
**APPENDIX B SBARD TOOL**

**SITUATION**
Describe the current situation clearly e.g. I am ..... state profession......from...Calling about ..... patient (Name DOB). I am calling because I am concerned that (e.g. sepsis, fall, chest pain) relay observations with NEWS score and current condition

**BACKGROUND**
Briefly state the relevant medical history and reason for admission
Relevant Past medical history
Current medications
Last medical review
Their usual condition and previous NEWS scores

**ASSESSMENT**
Summarise the facts and give your best assessment on what is happening
Patient’s current condition
Patients NEWS score and which parameters are raised

**RECOMMENDATION**
What action are you asking for?
What do you want to happen next?
I want you to see the patient in the next XX hours

**DECISION**
What have you agreed?
We have agreed that you will visit in the next XX hours and in the mean time I will continue with regular observations and escalate if the patient’s condition deteriorates further

Notes (incl. date & time)
APPENDIX C When a Patient Deteriorates in their Home (Community Services and Mental Health)

There may be occasions during clinical practice where a member of staff will encounter a patient whilst on a home visit who is experiencing a medical emergency or who needs an urgent assessment of their physical health that requires assistance from the emergency services.

When this occurs it is clearly important that emergency service are called as soon as possible and that the member of staff is able to remain with the patient until such time as the paramedic arrives. However, it is recognised that there can sometimes be delays in the paramedic crew arriving which may place additional demands or pressure on staff particularly if they have other clinical or personal commitments. Under these circumstances the following guidance should be followed which should ensure that the patient experiencing a medical emergency continues to receive appropriate support.

- In all circumstances professionally registered staff should act in accordance with their professional code of conduct which places a clear responsibility on staff to always act in the best interests of their patients, recognise and work within the limits of their competence and for registered nurses to always offer help if an emergency arises in the practice setting or anywhere else, whilst accepting the limits of their knowledge and competence.

- Unregistered staff visiting patients at home should always act within their sphere of competence and seek advice and support at the earliest opportunity from emergency services and other professionally qualified clinicians within their team.

- Where a member of staff encounters a patient on a home visit that is experiencing a medical emergency or who requires an urgent medical assessment then the member of staff must remain with the patient until such time as the paramedic crew arrives, whilst taking account of their own safety and the safety of others.

- Where it is not possible to call emergency services from the home setting due to the lack of an available landline or poor mobile reception then alternative arrangements will need to take place. This should include:

  a. Talking to anyone else in the home setting to see if they can leave the home setting to call an ambulance. Under these circumstances the person leaving the home must be given a clear handover and instructions as to what is required e.g. call 999, ask for an ambulance and state the medical emergency/situation.

  b. Where there is no one else in the home or it is not appropriate for someone else to leave the home to call an ambulance then it may be necessary for the member of staff to temporarily leave the home setting in order to obtain a mobile reception or find an alternative landline, however the staff member must always return after making the call.

  c. For reasons of lone working staff are discouraged from entering another personal dwelling to make this call and should seek to make the call from a landline in a public area e.g. a shop.

- There may be occasions when there will be a substantial delay in the paramedic crew arriving which may have an impact on the staff members other clinical or personal commitments. Under these circumstances the staff member will need to assess the situation and take advice from a senior clinician/line/duty or on call
manager to determine the best course of action. Under no circumstances should the staff member permanently leave the patient without first seeking advice and approval from a manager.

- In line with Trust values staff should always seek a collaborative approach to managing these situations which will often involve working together and seeking support from other leaders and clinical services in order to allow the member of staff to remain with the patient or swap with another member of staff until such time as emergency services arrive.

- As with all clinical interventions there should be an accurate record of the events detailed within the electronic patient records.

- Where there is a substantial delay in the paramedic crew arriving and as a result this compromises the patients care and delays treatment then an incident form should be completed.

MIU and the Deteriorating Patient

Triage- All patients requiring observations should have a full set of observations performed and a NEWS2 score and recorded in the patient’s record. The challenge for MIU is an accurate assessment of clinical risk to guide a decision over whether to escalate care or to watch and treat.

The patient’s frequency of observations should be dictated by the NEWS2 guidance and acted on appropriately. Clinical judgement and concern should also trigger a response and recognition of patient’s deterioration

**NEWS2 score of ≥3** should trigger clinical review and potentially possible transfer to secondary care.

If patients need to be transferred and escalated to secondary care, the SBARD tool (Appendix B) should be used.

Community Nursing Services

All patients must be initially assessed when admitted onto the caseload, and should have baseline physiological observations taken and a NEWS2 score prior to their nursing intervention. This should be recorded in the patient’s records. The patient’s usual observations can then be used in comparison, especially if they have chronic illness.

The patient’s frequency of observations should be triggered by their NEWS2 guidance (appendix A) and escalated accordingly. Clinical judgement and concern should be used when assessing patients. Safety netting for patients will be based on their personalised care plan and clinical assessment.

Any **NEWS2 score of more than 3** (where this isn’t usual for the patient) should initiate an urgent clinical review and escalation, as possible admission to secondary care may be necessary. The staff will escalate to the GP or 999 according to their clinical assessment and arrange repeat visits based on their assessment.

All clinical interventions must be documented clearly in the patient’s record.
Mental Health Inpatient Units

All patients admitted to an inpatient ward must have physiological observations taken, and a NEWS2 score recorded as a baseline within 4 hours of admission. Patients who refuse or it is unsafe to complete physiological observations due to their clinical presentation, should have respiratory rate and ACPUVA recorded, plus non-contact observations.

Any refusals of any physiological observations should be recorded in the patient record.

The frequency of observations should be dictated by the NEWS2 guidance and acted on appropriately. Any NEWS2 score of more than 3 (where this isn’t documented as usual/acceptable for the patient) should initiate an urgent clinical review and escalation, as possible admission to secondary care may be indicated.

All patients should have an agreed frequency of observations recorded with rationale provided in their clinical record. As a minimum the same observations must be recorded weekly, but where clinically indicated they should be done more frequently, following the NEWS2 guidance.