Guideline for the Completion and Escalation of National Early Warning Scoring (NEWS2) Monitoring System in Adult Patients

University Hospitals of Leicester NHS
NHS Trust

Trust ref: B25/2011

1. Key Words

- NEWS2
- Electronic Observations
- SBARD

2. Introduction and who guideline applies to:

The National Early Warning Score (NEWS2) is a simple, easy to use tool which is used for scoring the physiological measurements recorded from the patient.

NEWS2 assists in identifying acutely ill patients in hospital and those at risk of deterioration. It allows for:

- Treatment to be instigated to prevent further deterioration
- Ongoing assessment of effectiveness of treatment
- Assessment and movement to a higher level of care if appropriate
- Facilitate decision making regarding appropriate ceiling of treatment

If deteriorating patients are identified early enough, simple interventions may prevent further deterioration and imminent collapse.

This guidance applies to all staff in UHL who complete an NEWS2 or have responsibility for acting on and escalating the results of an NEWS2 including (not a definitive list) Medical staff, Registered Nurses, Nursing Associates and HealthCare Assistants.

NEWS2 is used on **all** adult patients within UHL excluding obstetrics (please refer to the MEOWS Policy, Trust ref C16/2018) and those on the Amber Care bundle. All patients discharged from Critical Care areas to ward areas will have NEWS2 observations recorded on Nervecentre prior to leaving.

3. Guideline Standards and Procedures

NEWS2 is a nationally recognised track and trigger system. It consists of a number of routine physiological parameters recorded within the ward environment. These parameters are allocated a score: 0-3 as they depart from normal, the greater the deviation the greater score each parameter receives.

These scores are added together to give a total NEWS2, when this reaches the allocated trigger score the Nervecentre system activates a referral algorithm requiring direct action by the user.

Once clinical staff have been contacted it is their responsibility to clinically assess the patient and decide if medical intervention is required as follows:

a. First line medical intervention and establishment of a review period to assess effectiveness of treatment plan. Establishment of additional calling parameters may be required.
b. First line medical intervention and urgent senior involvement.
c. No treatment indicated at present. New calling or trigger parameters must be established with nursing staff to facilitate on-going monitoring.

The idea is that small changes in these parameters will be seen earlier using NEWS2, than waiting for obvious changes in individual parameters, such as a marked drop in systolic blood pressure.

4. NEWS2 Physiological Parameters

All adult patients within acute hospital settings should have:

- Physical observations recorded at the time of their admission or initial assessment
- Physical observations should be recorded and acted upon by staff who have been trained to undertake these observations and understand their clinical relevance

As a minimum, the following physiological observations should be recorded at the initial assessment and as part of routine monitoring:

- Heart rate
- Respiratory rate
- Blood pressure
- Level of consciousness or new confusion
- Oxygen saturations
- Temperature

5. Identifying patients whose clinical condition is deteriorating or is at risk of deterioration.

NerveCentre should be used to monitor all adult patients in the acute hospital setting.

Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.

The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the eObservations User Guide

6. NEWS2 Intervention Pathways

The NEWS2 total score corresponds with an intervention pathway which lists a set of actions and / or medical and nursing interventions that are required to stabilise the patient's condition and prevent further deterioration

The escalation referral pathway for NEWS2 is demonstrated in colour coded boxes down the left hand side of page 1 (see sample chart in appendix 1)

The action to be taken list is found in the corresponding white boxes on the right.

6.1 NEWS2 Intervention Pathways Out of Hours

NEWS2 continue to be escalated as above.

Ward staff need to bleep the **Out of Hours Response Team (OoHRT)** for any deteriorating patient that they are concerned about (see appendix 1)

The recording and escalation of observations process is outlined in the eObservations User Guide

All referrals should be made using the SBARD referral tool:

Situation
Background
Assessment
Recommendation
Decision

(See sample chart in appendix two)

7. Senior Decision Maker.

This is the Consultant responsible for the patient or the most senior Doctor on duty that can make a formal decision regarding the ongoing treatment of the patient.

8. Referring Patients to the wider Multi-Disciplinary Team - SBARD

When referring a patient to other members of the multidisciplinary team it is important to use a structured communication technique. This allows staff to convey a large amount of information in a uniform, succinct and brief manner. Using a structure is essential as individuals have a variety of communication styles.

SBARD is a tool which enables the referrer to provide this information and stands for Situation, Background, Assessment, Recommendations and Decision.

It is essential that the referrer has the information to hand before making the phone call.

9. Education and Training

Training is provided locally on induction to the organisation through;

- Ongoing clinical support
- NEWS2 e- learning package on HELM.
- The Deteriorating patient for Registered Nurses face to face training
- Deteriorating Patient – Recognition face to face training

10. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Completion of NEWS2	Nursing Quality Metrics	Matrons	Monthly	Metrics reported to Heads of Nursing. Action plans discussed with Ward Sisters to improve compliance

11. Supporting References

NEWS2 (2017) The National Early warning Score: Royal College of Physicians, London

12. Key Words

NEWS2

Electronic Observations

SBARD

13. Equality Impact Statement

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead **Carrie Hayhurst (DART Matron)**	**Executive Lead** **Mr Andrew Furlong – Medical Director**
Details of Changes made during review: 2. Updated MEOWS policy reference- C16/2018 NEWS2 obs recorded on Nervecentre, not paper chart 3. Track and trigger system description added. Nervecentre system "Clinical staff instead of "Medical" staff 5.Addition of hyperlink for eObs user guide 6.1. Addition of OOH escalation process. Addition of eobs user guide. SBARD instead of SBAR. Addition of hyperlink for eObs user guide 8. Changed "Doctors" to "Multi-Disciplinary members" and removed profession, culture and gender as it is not relevant 9. Added in the Deteriorating Patient for Registered Nurses face to face training and Deteriorating Patient – Recognition face to face training Appendix Two updated to SBARD Appendix One wording updated to include response times 13. Added in Equality Impact Statement.	

Appendix One

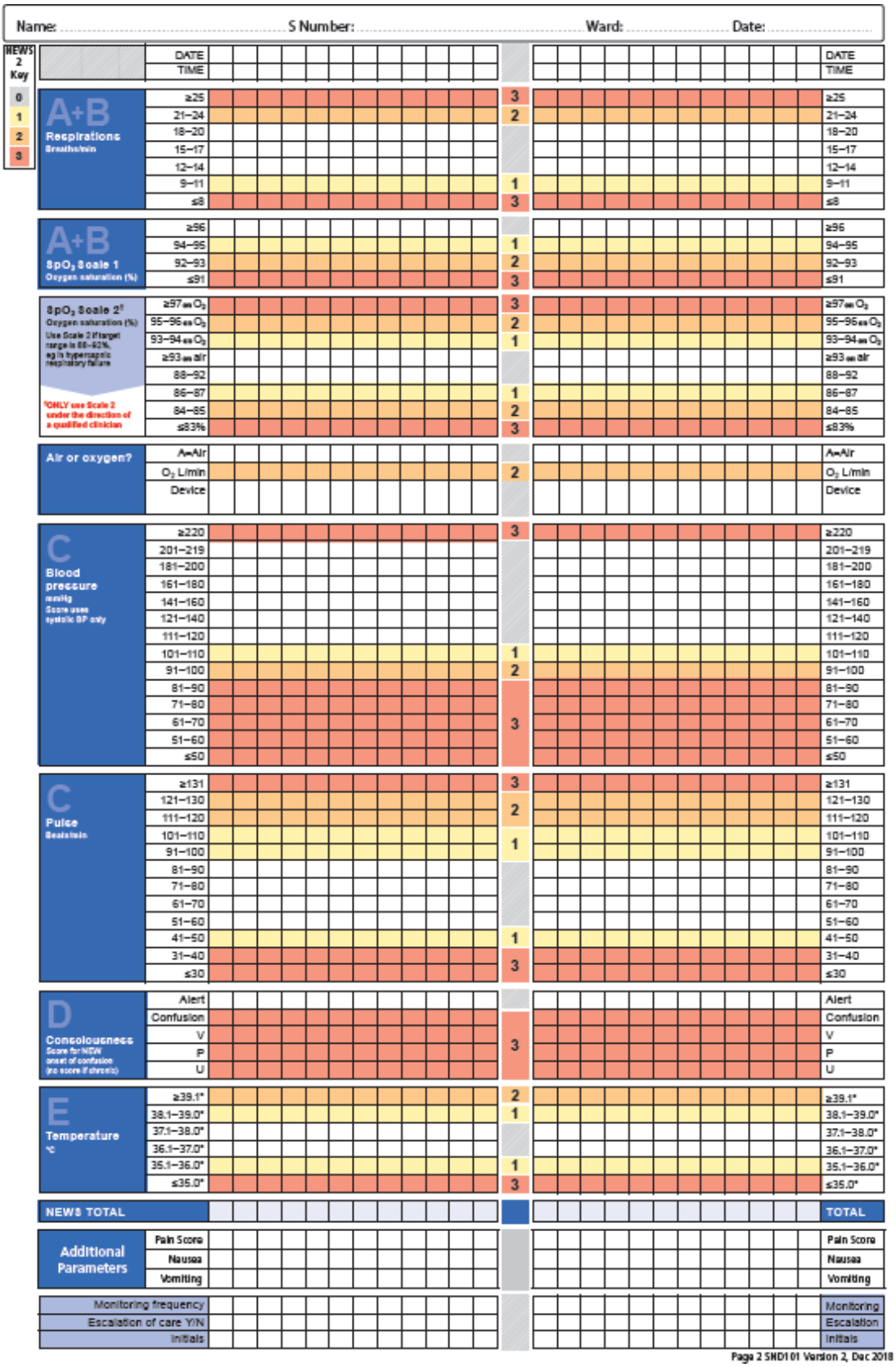
Frequency of Observations

The frequency of observations will depend on the patient's condition but should be at least 12 hourly.

The following sets of parameters are a minimum standard only. The team is responsible for assessing each patient and deciding on the frequency of observations required. Some patients who do not trigger NEWS 2 may/shall require up to one hourly observations.

Clinical Response to NEWS 2 trigger thresholds

NEWS 2 score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS 2 monitoring
Total 1-4	Minimum 4-6 hourly	• Inform registered nurse who must assess the patient • Registered nurse decides whether to increase frequency of monitoring and/or escalation of care is required • **Ward based response**
3 in 1 single parameter	Minimum 1 hourly	• Registered nurses inform the medical team caring for the patient, who will review and decide whether escalation of care is necessary. • Think could this be Sepsis • **Urgent ward based response**
Total 5 or more Urgent Response Threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient, if out of hours Bleep the Out of Hours Response Team (OOHRT). *The Out of Hours Response team operates 4:30pm till 8am weekdays at LRI &GH, LGH 8pm to 8am. Friday 4:30pm (8pm LGH) through to Monday 8am.* • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients. • Provide clinical care in an environment with monitoring facilities. • Think could this be Sepsis. • **Assessment is expected within 60 minutes**
Total 7 or more **Emergency Response Threshold**	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level. If out of hours bleep OOHRT. • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills. Bleep The Deteriorating Adult Response Team (DART). *DART operate 24/7 at all three sites.* • Consider transfer of care to a level 2 or 3 clinical care facility, i.e. higher-dependency unit or ICU. • Clinical care in an environment with monitoring facilities. • **Assessment is expected within 30 minutes**


Name:
S Number:
Ward:
Date:
NEWS 2 Key
0
1
2
3
DATE
TIME
A+B
Respirations
Breaths/min
≥25
21–24
18–20
15–17
12–14
9–11
≤8
A+B
SpO2 Scale 1
Oxygen saturation (%)
≥96
94–95
92–93
≤91
SpO2 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% O2
95–96% O2
93–94% O2
≥93% air
88–92
86–87
84–85
≤83%
Air or oxygen?
A=Air
O2 L/min
Device
C
Blood pressure
mmHg
Score uses systolic BP only
≥220
201–219
181–200
161–180
141–160
121–140
111–120
101–110
91–100
81–90
71–80
61–70
51–60
≤50
C
Pulse
Beats/min
≥131
121–130
111–120
101–110
91–100
81–90
71–80
61–70
51–60
41–50
31–40
≤30
D
Consciousness
Score for NEW onset of confusion (no score if chronic)
Alert
Confusion
V
P
U
E
Temperature
°C
≥39.1°
38.1–39.0°
37.1–38.0°
36.1–37.0°
35.1–36.0°
≤35.0°
NEWS TOTAL
TOTAL
Additional Parameters
Pain Score
Nausea
Vomiting
Monitoring frequency
Escalation of care Y/N
Initials
Monitoring
Escalation
Initials
National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017
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Name: ..... S Number: ..... Ward: ..... Date: .....

Ward Round Review Senior Decision Maker only: (Tick) ☐	Previous INPUT:	Previous 24 hours BALANCE:	Previous OUTPUT:	Patients Weight:

Time	INPUT							OUTPUT							BALANCE
	Oral Intake (mls)	Fluids IV or SC/ Blood	Bolus Drugs	Drug Infusions	PCA/ Epidural	NG/TPN/ PEG/Inj (mls)	Running Total in	Urine	Drains	Drains		Vomit/ NGT	Bowels/ Stoma	Running Total Out	
01.00															
02.00															
03.00															
04.00															
05.00															
06.00															
07.00															
08.00															
09.00															
10.00															
11.00															
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15.00															
16.00															
17.00															
18.00															
19.00															
20.00															
21.00															
22.00															
23.00															
24.00															
Totals															

Total INTAKE= mls	OUTPUT= mls

Urinalysis Date:	pH:	Protein:	Blood:	Leucocytes:	Glucose:	Ketones:	Nitrates:

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Appendix Two

How to Have an SBARD Conversation

Step One.
Situation

Hello I am (name), (X) nurse on ward (X) I am calling about (patient X) I am calling because I am concerned that... (e.g. BP is low/high, pulse is XX, temperature is XX, NEWS2 is .....

The SBARD tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

Quality, Service Improvement and Redesign Tools: SBARD communication tool – Situation, Background, Assessment, Recommendation Decision: **NHS England and NHS Improvement**

Step Two.
Background

Patient (X) was admitted on (XX date) with... (e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is... (e.g. alert/drowsy/confused, pain free)

Step Three.
Assessment:

I think the problem is (XXX)
And I have...
(e.g. given O2 /analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried

Step Four.
Recommendations:

I need you to...
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time?
(e.g. stop the fluid/repeat the obs)

Step 5
Decision

Ask receiver to repeat key information to ensure understanding and confirm the Decision