

Name: \_\_\_\_\_  
NHS no: \_\_\_\_\_ DOB: \_\_\_\_\_ Ward: \_\_\_\_\_

NEWS Key				Date										Date							
0	1	2	3	Time										Time							
<b>A + B</b> Respirations Breaths/min				>25										>25							
				21-24												21-24					
				18-20													18-20				
				15-17													15-17				
				12-14													12-14				
				9-11													9-11				
<b>A + B</b> SpO <sub>2</sub> Scale 1 Breaths/min				<8										<8							
				>96												>96					
				94-95													94-95				
				92-93													92-93				
<b>SpO<sub>2</sub>Scale 2*</b> Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in hypercapnic respiratory failure <b>*ONLY use scale 2 under the direction of a qualified</b>				<91										<91							
				>97 on O <sub>2</sub>												>97 on O <sub>2</sub>					
				95-96 on O <sub>2</sub>													95-96 on O <sub>2</sub>				
				93-94 on O <sub>2</sub>													93-94 on O <sub>2</sub>				
				>93 on air													>93 on air				
				88-92													88-92				
<b>Air or oxygen</b>				86-87											86-87						
				84-85													84-85				
				<83%													<83%				
				A=Air													A=Air				
<b>C</b> Blood pressure Score uses systolic BP only				O <sub>2</sub> L/min											O <sub>2</sub> L/min						
				Device													Device				
				>220													>220				
				201-219														201-219			
				181-200														181-200			
				161-140														161-140			
				141-160														141-160			
				121-140														121-140			
				111-120														111-120			
				101-110														101-110			
				91-100														91-100			
				81-90														81-90			
<b>C</b> Pulse Beats/min				71-80												71-80					
				61-70													61-70				
				51-60													51-60				
				41-50													41-50				
				31-40													31-40				
				>30													>30				
				<b>D</b> Consciousness Score for NEW onset of confusion (no score if chronic)				Alert											Alert		
								Confusion													Confusion
								V													V
								P													P
<b>E</b> Temperature °C				U											U						
				>39.1°													>39.1°				
				38.1-39.0°														38.1-39.0°			
				37.1-38.0°														37.1-38.0°			
				36.1-37.0°														36.1-37.0°			
<b>NEWS TOTAL</b>				35.1-36.0°										35.1-36.0°							
				<35.0°										<35.0°							
<b>Initials</b>														<b>Total</b>							

Always take into account the patient's baseline parameters. An EWS should not replace sound clinical judgement.

A sick patient may not trigger the EWS, likewise a patient who triggers the EWS may not be acutely unwell, hence the importance of a baseline observations and a **normal parameter exception care plan**.

### Modifications For Abnormal Physiology (see care plan)

To be completed by clinicians who medically assess and instruct medical treatment e.g. Medics, CCP's and Nurse Consultants.

News	Observations	Clinical Response
1-4	1-4 hourly (dependant on score)	Refer to registered nurse using SBAR <b>RN</b> – face to face assessment of the patient, NEWS of 1 – 2, increase observations to a minimum of 4 hourly and consider review by Medic if concerned. NEWS 2 of 3 – 4, increase observations to minimum of hourly and contact Medic for advice. <b>Any acute rise or clinical concern such as sepsis should be reviewed by medic. If in doubt escalate to acute hospital.</b> <b>Medic</b> – ABCDE assessment and formulate a management plan. Consider escalation to acute hospital.
5-6	Minimum hourly	Refer to registered nurse using SBAR <b>RN</b> – urgent face to face assessment of the patient. <b>Any acute rise or clinical concern such as sepsis should be reviewed by medic. Urgent review by Medic within 30 minutes. If no assessment by Medic within 30 minutes escalate to acute hospital via ambulance.</b> <b>Medic</b> – ABCDE assessment and formulate a management plan. Consider urgent escalation to acute hospital via ambulance.
7 or more		Urgently refer to registered nurse using SBAR <b>RN</b> – immediate face to face assessment of the patient. Immediate face to face assessment by Medic if available or ambulance. Immediate escalation to acute hospital via ambulance.

#### **RAPID TRANQ**

Any medication given at the point of violence or aggression  
**EWS must be taken** – minimum of CNS rating + **Resps**  
 EVERY 15 mins for 1<sup>st</sup> hour  
 EVERY 30 mins for next 3 hours.

#### **ALWAYS CALCULATE EWS**

Each observation has its own score.  
 If you are unable to take a certain observation for whatever reason, always calculate the score of those observations available.

#### **RESTRAINT**

**EWS must be taken**  
During restraint  
 EVERY 5 mins  
After release  
 EVERY 15 mins for 1<sup>st</sup> hour  
 EVERY 30 mins for next 3 hours

**IF NO OTHER OBSERVATIONS CAN BE TAKEN ALWAYS RECORD CNS (ACVPU) AND RESP RATE AND CALCULATE EWS**

#### **A – Airway Can the patient talk?**

Are there any unusual sounds? Signs of airway obstruction

#### **B – Breathing Is the patient breathing?**

Take respiratory rate; look at pattern and depth of respirations.  
 Take O2 saturations, are they on oxygen, are they sitting upright, can you hear unusual sounds, can they finish a sentence?

#### **C – Circulation Does the patient have a pulse?**

What is the heart rate? Is it regular? What colour are the patient's hands/digits, how does the skin feel, what is the capillary refill time? Take blood pressure, what is the urine output? Is there any bleeding?

#### **D – Disability Is the patient alert and oriented?**

Assess AVPU. Are the pupils equal and reacting? What is the BM? Are they in pain?

#### **E – Exposure Have you missed anything, look top to toe**

Take temperature. Do they have a rash, cool peripheries, swollen legs etc?

**S** – Situation – what is happening now?

**B** – Background – what has happened before (relevant)?

**A** – Assessment – what have you done?

**R** – Response – what do you need now?

## EARLY WARNING SCORE

The New Early Warning Score (NEWS 2) is an escalation tool used to alert clinical staff to the need to contact a doctor or emergency services for patients who give cause for concern because of sudden or deteriorating illness. Within Mental Health and Learning Disabilities in-patient areas, it is also to be used for patients being observed during or after a period of restraint or rapid tranquillisation.

### HOW TO USE THE CHART

Record your observation on the Observation (TPR) chart as normal. Now look up your findings scoring grid and take the score for that column from the top of the column. For example: Your patient is alert, flushed and slightly distressed, has a respiratory rate of **22 breaths per minute**, a pulse rate of **108 beats per minute**, systolic blood pressure is **90 mmHg** and his temperature is **38.2 deg C**.

- Alert scores 0
- Respiratory rate scores 1
- Pulse scores 1
- Blood Pressure scores 1
- Temperature scores 1
- **Total score is 4**

Looking at the second part of the chart a score of 4 is greater than 3 but less than 6, so the Nurse should call the doctor immediately and increase the frequency of observations to every 30 minutes.

Refusal: a patient has the right to refuse physical contact with staff; this may be due to agitation, Confusion, fear or lack of understanding. However, physical observations can always be carried Out without contact and the minimum of this is central nervous system (CNS – AVPU) and Respiratory rate. These physical observations should be recorded on the physical observation chart.

Refusal of any other physical observation for example blood pressure should be recorded in the Nursing notes with an explanation as to why the patient has refused and a plan for repeating required Observations and how this may be undertaken should also be documented. The word refused

MUST NOT be recorded on the physical observation chart, as the rational for refusal cannot be documented fully in the small space available.

Baseline: on admission the patient's physical observations must be taken, these will become the Patient's initial baseline. If the patient's physical presentation changes at any time during their stay Their baseline observation should be reviewed and if needed a new baseline should be recorded.

If this becomes necessary a new sheet should be started and the word NEW should be recorded Underneath BASELINE. This will communicate changes to the baseline to all staff. If a patient Is admitted with a known physical health condition and therefore the baseline scores and triggers on The NEWS 2 a normal parameter exception care plan should be devised with the admitting doctor. This should state the exceptions for this particular patient and give instructions as to when the Patient should be escalated.

The NEWS 2 only uses the Systolic blood pressure measurement within its escalation calculations (both the systolic and diastolic measurement should always be recorded on the physical observation Chart) as the score is used to note early deterioration in patients to

enable a response before a Critical illness where ever possible. In these situations the systolic measurement is the Measurement that tells us the most about the patient, and the one that will change early enough for a response to be effective. The diastolic measurement is important for day to day health, and should still be noted and acted upon when a patient is unwell; however tends to be slower to change in critical illness and therefore no use from an EARLY warning point of view.

### Clinical Judgement

The NEWS 2 score and track and trigger flow is only a guide, if the Registered Nurse becomes concerned

With other aspects of the patient's condition then further action may well be necessary.

### Example One:

If the patient's baseline scores a 3, we take their physical observations and their NEWS 2 is now a 4, we need to take into account the reasons behind the initial 3 on admission and any normal parameter.

Exceptions and care plans.

A NEWS 2 of 3 in any one category needs attention in its own right.

Patient complains of feeling unwell, we take his physical observations.

CNS=A	-NEWS 2 0	-BASELINE = 0
Resps = 22	-NEWS 2 1	-BASELINE = 1
Blood pressure = 98/60	-NEWS 2 1	-BASELINE = 1
Pulse = 112	-NEWS 2 2	-BASELINE = 1 (baseline pulse=109)
Sats = 100%	-NEWS 2 0	-BASELINE = 0
Temp = 37%	-NEWS 2 0	-BASELINE = 0
<b>Overall EWS</b>	<b>4</b>	<b>3</b>

### Example Two:

A patient presents as flushed, sweaty skin and in obvious discomfort. He does not allow any physical contact; therefore we can only gain a CNS and respiratory rate reading;

CNS=A	-NEWS 2 = 0	-BASELINE = 0
Resps = 29	-NEWS 2 = 1	-BASELINE = 0
<b>Overall EWS</b>	<b>1</b>	<b>0</b>

Just looking at the flow chart and EWS of 1 would state to increase the observations and consider speaking to a doctor. However, for this patient the increased respiratory rate added to Flushing, sweating and pain should lead to a nurse making the decision to speak to a doctor.

### Example three:

Patient complains of being unwell. We take her physical observations.

CNS=A	-NEWS 2 0	-BASELINE = 0
Resps = 16	-NEWS 2 0	-BASELINE = 0
Blood Pressure = 180/96	-NEWS 2 0	-BASELINE = 2 (baseline 222/110)
Pulse = 90	-NEWS 2 0	-BASELINE = 2 (baseline 115)
Sats = 100%	-NEWS 2 0	-BASELINE = 0
Temp = 37%	-NEWS 2 0	-BASELINE = 0
<b>Overall EWS</b>	<b>0</b>	<b>4</b>

In this scenario, although the NEWS 2 is a 0 this is a considerable change from the patient's Baseline. A negative change in baseline, although the flow chart would not show concern is Equally concerning as a positive change in baseline. Therefore this patient needs to be seen By a doctor.

Decisions are made after physical observations are taken and EWS calculated. Each physical Observation has its own EWS, and if staff are unable to take a full set of physical observations (for any reason – see above) an EWS score must still be calculated no matter how many physical

Observations have been taken i.e. at the bare minimum we would expect to see CNS and respiratory Rate recorded. We should still see an EWS calculated score, or lying and standing BP. We should still see the EWS calculated for each recording, this can act as a prompt for action to be taken, particularly if the staff are not prompted by the readings alone (a safety net).

KEY – a key has been introduced to the chart, this will help staff to see the “bigger picture”. You will be able to look back at the last like for like incident and compare, which in turn will aid any decisions that need to be made.

- R = restraint
- T = rapid tranquilisation
- U = unwell
- M = monitoring
- B = baseline

How to calculate an New Early Warning Score (NEWS 2) and what action is to be taken

SCORE	0	1	2	3
Pulse	51 – 100	41 – 50 or 101 - 110	111 - 129	< 40 or > 130
Systolic BP	101 – 200	81 - 100	71 – 80 or 201 - 220	< 70 or > 221
Resp rate	9–20	21-30	31-34	< 8 or > 35
Temp	36.1 – 37.9	35.1 – 36 or 38 – 38.5	34 – 35 or 38.6 – 39.9	< 33.9 or > 40
CNS AVPU	ALERT	VOICE	PAIN	UNCONSCIOUS
O2 Saturation	100% - 95%	94% - 90%	89% - 86%	< 85%
SCORE	0		2	3

### ESCALATION PROCEDURE

NEWS 2 greater than 0	Inform registered nurse, suggest repeat observations and note in file. Use clinical judgement to decide if further action is required.
NEWS 2 1-2	Increase frequency of observations to at least 4 hourly, consider informing Doctor if concerned.
NEWS 2 3 in any one category	Contact doctor for advice, increase frequency of observations to at least hourly. Use clinical judgment as patient may be very poorly.
NEWS 2 3-5	Contact doctor and request urgent visit, or if a possible delay of more than 1 hour call an ambulance (or emergency team) unless other advice.
NEWS 2 5 or over	Call doctor for immediate visit, or if a possible delay of more than 30 minutes call an ambulance (or emergency team), unless other advice given by the doctor. Increase observations to at least every 15 minutes.