1. 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:

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

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

1.2 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 Health Care Assistants.

1.3 NEWS2 is used on **all** adult patients within UHL excluding obstetrics (please refer to the MEOWS Policy, Trust ref B20/2008) and those on the Amber Care bundle. All patients discharged from Critical Care areas to ward areas will have an NEWS2 observation chart started prior to leaving.

2. Guideline Standards and Procedures

NEWS2 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 system activates a referral algorithm requiring direct action by the user.

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

1. First line medical intervention and establishment of a review period to assess effectiveness of treatment plan. Establishment of additional calling parameters may be required.
2. First line medical intervention and urgent senior involvement.
3. 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.

3. NEWS2 Physiological Parameters

All Adult patients within acute hospital settings, should have:

- physiological observations recorded at the time of their admission or initial assessment

- Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures 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
- systolic blood pressure
- level of consciousness or new confusion
- oxygen saturation
- temperature.

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

- Nerve centre 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 nerve centre.

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.

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 per appendix 1)

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

All referrals should be made using the SBAR referral tool. S= Situation, B= Background, A= Assessment, R- Recommendation (see sample chart in appendix 1)

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.

Referring Patients to Doctors - SBARD

When referring a patient to Doctors or 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 varying by profession, culture and gender.

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

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

3. Education and Training

Training is provided locally on induction to the organisation, through ongoing clinical support and NEWS2 e-learning package on HELM.

4. 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

5. Supporting References

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

6. Key Words

NEWS2

Electronic Observations

SBAR

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) **Mrs Clair Sandy (Senior DART Nurse)**	**Executive Lead** **Mr Andrew Furlong – Medical Director**
Details of Changes made during review: Section 4: Addition of OOH escalation process. Addition of eobs user guide	

Appendix 1

ADULT OBSERVATION CHART / NEWS 2

NHS
University Hospitals of Leicester
NHS Trust

Full Name: ..... S Number: .....

Date: ..... Ward: .....

ADMITTING WARD: ..... Date: .....

Moved to: ..... Date: .....

Moved to: ..... Date: .....

Moved to: ..... Date: .....

For Senior Decision Maker

NEWS 2 score for escalation: ..... (If different from normal)

Print name: .....

Date: .....

Signature:

Frequency of observations

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

The following set of parameters are a minimum standard only. It is the responsibility of the team to assess each individual patient and make a decision about the frequency of observations required.

Some patients who do not trigger on NEWS 2 may/ shall require up to one hourly observations.

Clinical response to the NEWS 2 trigger thresholds

NEW 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 increased frequency of monitoring and / or escalation of care is required
3 in 1 single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary • Think Could This Be Sepsis
Total 5 or more Urgent Response Threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient and bleep OOHRT • 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
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 registrar level and bleep OOHRT • Emergency assessment by a team with critical care competencies, including practitioner(s) with advance airway management skills. Bleep CCOT • 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

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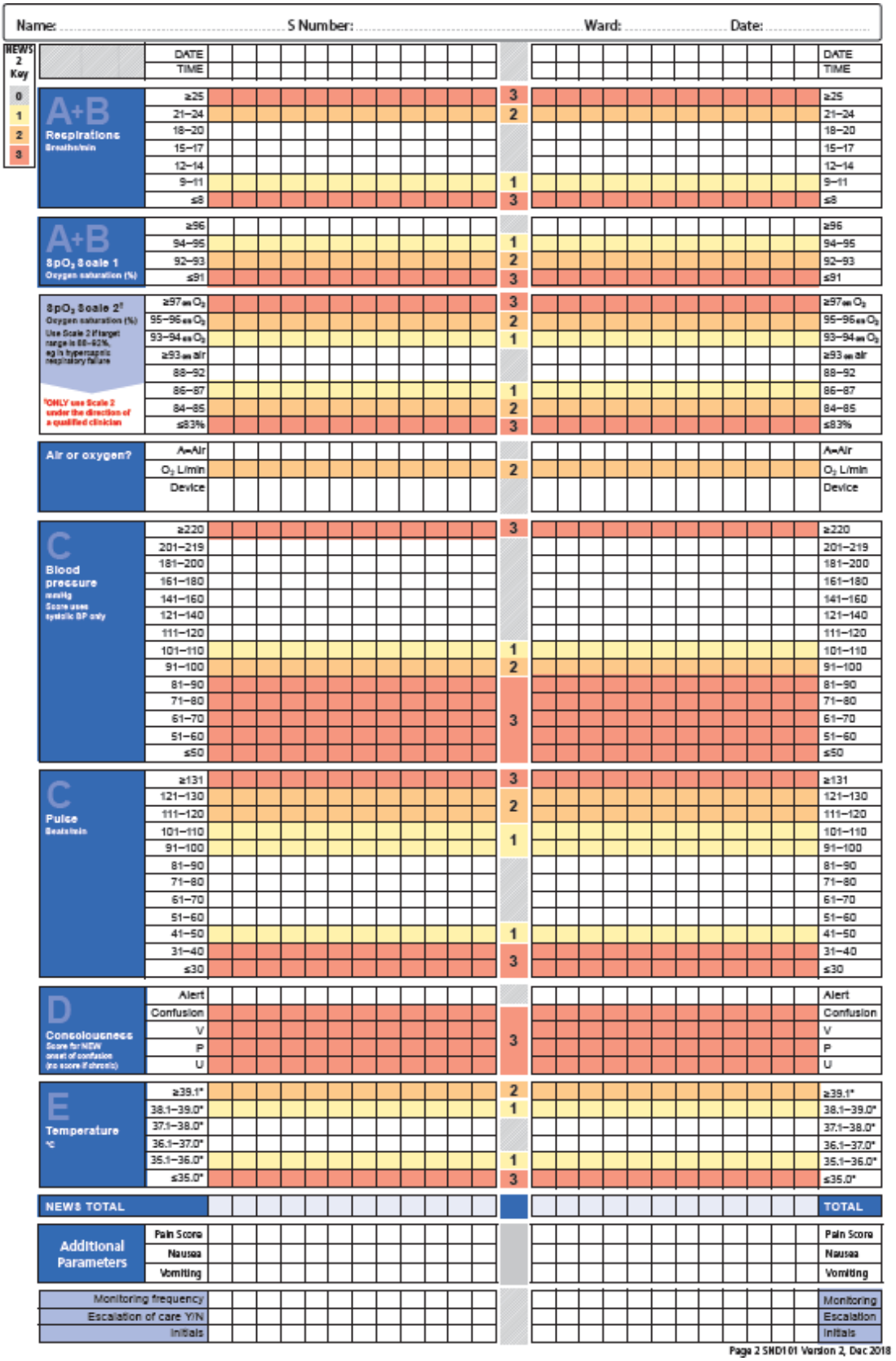
Name:
S Number:
Ward:
Date:
NEWS 2 Key
0
1
2
3
DATE
TIME
A+B
Respirations
Breaths/min
≥25
21–24
18–20
15–17
12–14
9–11
≤8
A+B
SpO2 Scale 1
Oxygen saturation (%)
≥96
94–95
92–93
≤91
SpO2 Scale 2*
Oxygen saturation (%)
Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure
*ONLY use Scale 2 under the direction of a qualified clinician
≥97% on O2
95–96% on O2
93–94% on O2
≥93% on air
88–92
86–87
84–85
≤83%
Air or oxygen?
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
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National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

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															
12.00															
13.00															
14.00															
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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Name: S Number: Ward: Date:

S Situation	I am calling about: ..... Patient's name, and S number Ward location and site I am worried about: ..... NEWS 2 Score: .....
B Background	Reason for admission Patient's medical history Escalation status What has changed since admission
A Assessment	What I think the problem is: ..... A - E Assessment Clinical Observations in detail NEWS 2 Fluid Balance Mobility PAIN SCORE
R Recommendation	What would you like me to do now? ..... ECG, Bloods etc. Who would you like me to contact? ..... When are you coming to review the patient? .....

Complete an AKI Alert Sticker for all patients with any stage of AKI identified on iLab or ICE or who have a urine output <0.5mls/kg/hr for >6hrs. This aids early identification of the cause of AKI and leads to prompt management.

AKI Care Bundle

- EWS Observations
- Assess Fluid Status & monitor Fluid Balance
- Perform Urinalysis
- Consider Renal Ultrasound
- Nephrotoxic Medication Review
- Monitor Bloods
- Timely Referral to Nephrology

Summary of Interventions Name: Hosp. No. Ward: Site:

Date: Time: Total NEWS 2:
Summary:
Signature: Print Name:

Date: Time: Total NEWS 2:
Summary:
Signature: Print Name:

Date: Time: Total NEWS 2:
Summary:
Signature: Print Name:

Date: Time: Total NEWS 2:
Summary:
Signature: Print Name:

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