



Public – To be published on the Trust external website

Title: 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)

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Status: Approved

Document type: Procedure

Contents

1	Introduction	3
1.1	Background to the Development of the National Early Warning Score	3
1.2	Our Journey To Change (OJTC)	4
2	Purpose	4
3	Who this procedure applies to	5
3.1	Roles and Responsibilities	5
4	Related documents	6
5	What is the National Early Warning Score	7
6	Recording the National Early Warning Score	8
6.1	Documentation.....	8
6.2	Frequency of Monitoring	8
6.3	Additional Considerations when Monitoring and Interpreting NEWS	9
7	Interpretation and Response to NEWS	11
7.1	Interpretation of NEWS	11
7.2	Response to NEWS Total	12
7.3	Principles for Using Situation, Background, Assessment, Recommendation and Decision (SBARD) Tool within NEWS Procedure	12
8	Definitions	13
9	How this procedure will be implemented	14
9.1	Implementation action plan	14
9.2	Training needs analysis	14
10	How the implementation of this procedure will be monitored	15
11	References	15
12	Document control (internal)	Error! Bookmark not defined.
13	Document control (external)	16
	Appendix 1 - Equality Impact Assessment Screening Form.....	18
	Appendix 2 – Approval checklist.....	21
	Appendix 3 – National Early Warning Score Chart (Adults)	23
	Appendix 4 – Glasgow Coma Scale Chart.....	27

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 people 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).

1.1 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

1.2 Our Journey To Change (OJTC)

This procedure supports [Our Journey To Change \(OJTC\)](#) as set out in the [Physical Health and Wellbeing policy](#).

2 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.

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
Chief Nurse	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 and Physicians Associates where available)	<p>Reviewing National Early Warning Score charts on a regular basis.</p> <p>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.</p> <p>Responding to any staff concerns and to see the patient: -</p> <ul style="list-style-type: none"> • If the score remains 1-4 after 4 hours • Immediately if score 5 and above or 3 in a single parameter • On call medical staff if not on site must respond promptly and consider advising staff to call emergency services if appropriate • 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.

	Attend relevant training to this procedure.
Registered Nurses, Nursing Associates and Healthcare Assistants	Ensure the appropriate completion of the National Early Warning Score as per this procedure. Follow the procedure for escalating high scores using the agreed communication tool. Attend relevant training to this procedure. 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 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](#)
- [Diabetes Management Guidelines](#)
- [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](#)

5 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 /SpO₂)	Using pulse oximeter.	Enter percentage. 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. Indicate regular rate (r) and irregular with (i)
Level of Consciousness (ACVPU = Alert, New Confusion, Voice, Pain, Unresponsive)	A- The patient is alert. C- The patient displays new confusion or agitation. V- The patient responds to verbal stimulation. P- The patient responds to painful stimulation (squeeze part of the trapezius muscle in the patient's shoulder). U- The patient is completely unresponsive.	Tick appropriate box

6 Recording the National Early Warning Score

6.1 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 ordering number: [LP155743 \(Appendix 3\)](#)

All entries on the NEWS chart must be dated and the time recorded in the 24-hour format. All entries must also be recorded on CITO under the physical health NEWS tab.

6.2 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 (within 4 hours) 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) or ReSPECT form still require recording of NEWS monitoring unless an MDT decision has been made and documented for example if a patient is approaching end of life.

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 must be made by a competent clinician and should be recorded in the patient's electronic care record and the front of the NEWS chart.

In all other circumstances, the regular NEWS SpO2 (Scale 1) should be used.

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, shivering and increased confusion.

6.3 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 4](#). 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 a progress note on CITO.

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). When undertaking a lying and standing blood pressure, all 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**xtrême 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 2024 Suspected sepsis: recognition, diagnosis and early management](#))

[Sepsis screening tool available on the intranet:](#)

7 Interpretation and Response to NEWS

7.1 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:-

Score of 0 (White)	Colours represent severity of decline in physical health and should determine urgency of clinical response.
Low score (Yellow)	
Medium score (Orange)	
High score (Red)	

A table representing the NEWS scoring system can be found on the back of the 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 Oxygen administration in an emergency](#) by any member of staff who has undertaken life support Training. Staff must not adjust the amount of oxygen being delivered without medical guidance or prescription.

7.2 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 CITO (see below):

Additional Considerations if NEWS Triggers
Pain assessment (ask the patient)
BM (blood glucose)
Passed urine (ask the patient)
Delirium screening tools (4AT, PINCHME)

Document response on the NEWS chart (escalation plan) and record the score and actions in a progress note on CITO.

7.3 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 a progress note on CITO.

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.

8 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.

9 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.

9.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
n/a	n/a	n/a	n/a	n/a

9.2 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

10 How the implementation of this procedure will be monitored

Number	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	Monthly Modern Matron Quality Assurance audit	Monthly/ Audit/ Local Modern Matron	Service Improvement and Development Group (SIDG)
2	Yearly NEWS audit trust wide	Yearly/ Audit/ Local areas	Physical Health Group

11 References

British Geriatrics Society (2020) End of life care in frailty: Delirium. London: BGS.

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 (2023) Delirium: prevention, diagnosis and management in hospital and long-term care. London: NICE.

National Institute for Health and Care Excellence (2024) Suspected sepsis: recognition, diagnosis and early management. 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.

Resuscitation Council UK (2024) ReSPECT for healthcare professionals. Accessed at: [ReSPECT for healthcare professionals | Resuscitation Council UK](#) Accessed on: 20/09/2024.

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 (1974) Assessment of coma and impaired consciousness: A practical scale. Lancet 304:81–84.

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

12 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	03 December 2025
Next review date	03 December 2028
This document replaces	CLIN-0099-v1 National Early Warning Score (NEWS) Procedure (Age 16 and above)
This document was approved by	Fundamental Standards of Holistic Care Clinical Assurance Group
This document was approved	03 December 2025
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	14 October 2024 and 03 July 2025 (Chart)
Document type	Public
FOI Clause (Private documents only)	n/a

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.	Withdrawn
1	30 Mar 2021	Review date extended to 27 July 2022	Withdrawn
2	03 Dec 2025	Full Review review with minor clarifications to wording and references updated.	Approved

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The [Equality Impact Assessment Policy](#) and [Equality Impact Assessment Guidance](#) can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance/Physical Healthcare
Title	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)
Type	Procedure/guidance
Geographical area covered	Trust wide
Aims and objectives	<p>To standardise practice for all clinical staff in the early recognition and response in the deteriorating patient.</p> <p>To facilitate early detection by using the National Early Warning Score (NEWS) tool for the appropriate and timely management of clinical deterioration.</p> <p>To reduce clinical risks associated with inappropriately managed clinical conditions.</p>
Start date of Equality Analysis Screening	21 August 24
End date of Equality Analysis Screening	14 October 24 (also 03 July 2025 for chart)

Section 2	Impacts
Who does the Policy, Procedure, 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.

<p>Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?</p>	<ul style="list-style-type: none"> • Race (including Gypsy and Traveller) NO • Disability (includes physical, learning, mental health, sensory and medical disabilities) NO • Sex (Men and women) NO • Gender reassignment (Transgender and gender identity) NO • Sexual Orientation (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) NO • Age (includes, young people, older people – people of all ages) NO • Religion or Belief (includes faith groups, atheism and philosophical beliefs) NO • Pregnancy and Maternity (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) NO • Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners) NO • Armed Forces (includes serving armed forces personnel, reservists, veterans and their families) NO • Human Rights Implications NO (Human Rights - easy read)
<p>Describe any negative impacts / Human Rights Implications</p>	<p>Nil</p>
<p>Describe any positive impacts / Human Rights Implications</p>	<p>Nil</p>

Section 3	Research and involvement
<p>What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)</p>	<p>Best Practice NICE guidelines</p>
<p>Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?</p>	<p>No</p>
<p>If you answered Yes above, describe the engagement and involvement that has taken place</p>	<p>N/A</p>
<p>If you answered No above, describe future plans that you may have to engage and involve people from different groups</p>	<p>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).</p> <p>The said procedure is therefore a standardised approach that enables clinical staff working within TEWV NHS Foundation Trust to adhere national, recommended guidance.</p>

Section 4	Training needs
<p>As part of this equality impact assessment have any training needs/service needs been identified?</p>	<p>Yes</p>
<p>Describe any training needs for Trust staff</p>	<p>Online ESR NEWS training</p>
<p>Describe any training needs for patients</p>	<p>No</p>
<p>Describe any training needs for contractors or other outside agencies</p>	<p>No</p>

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	No	Minor changes at this version only
Have any related documents or documents that are impacted by this change been identified and updated?	n/a	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	

Are supporting documents referenced?	Yes	
6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	No harm
Does the document identify whether it is private or public?	Yes	public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	

Appendix 3 – National Early Warning Score Chart (Adults)

Please see over page for image of the chart

Staff may use the [intranet link to the NEWS 2 aged 16 and above chart](#)

NEWS Score	Clinical Response
3 in single parameter RED SCORE	<ul style="list-style-type: none"> Registered nurse to immediately inform medical team and request patient review. Medical team to undertake urgent review. Commence minimum of hourly NEWS and continue until patient is seen by the medical team. Document in Electronic Care Record (ECR).
Total score 1- 4	<ul style="list-style-type: none"> Registered nurse MUST assess the patient and decide if patient needs a review by medical team. Commence a minimum of 4 hourly NEWS and continue until reviewed by medical team. Check blood sugar if patient is diabetic and action as per Trust protocol. Document in ECR.
5 and 6	<ul style="list-style-type: none"> Get red emergency bag. Registered nurse to repeat NEWS immediately. If medical team are not on the unit call (9)999 immediately. Commence continuous supervision and record NEWS every 30 minutes as a minimum. Consider application of oxygen as per Trust protocol. Check blood sugar and then check ketones if diabetic and blood sugar is over 11mmol/L. Action as per Trust protocol. Assess for pain and consider analgesia. Document in ECR.
7 and over	<ul style="list-style-type: none"> Get red emergency bag. Registered nurse to repeat NEWS immediately. If medical team are not on the unit call (9)999 immediately. Commence continuous supervision and record NEWS every 15 minutes as a minimum. Consider application of oxygen as per Trust protocol. Check blood sugar and then check ketones if diabetic and blood sugar is over 11mmol/L. Action as per Trust protocol. Assess for pain and consider analgesia. Document in ECR.

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

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

SBARD: Communication tool for the deteriorating patient	
Situation	State your name, designation and unit. I am calling about – <i>patient name</i> . I am calling because.... I am concerned because....
Background	Age, admitting diagnosis and date of admission. Brief past medical and drug history including allergies. What has happened? Over what <u>time period</u> ?
Assessment	Latest physiological observations including NEWS. Explain what action you have already taken. What do you think is happening?
Recommendation	Explain what you expect from your referral. Explain what your next steps are if you know. Ask if there is anything that you can do until they review.
Decision	Explain rationale for decision made and document all the above in the ECR.
Consider sepsis as a cause for deterioration:	
<ul style="list-style-type: none"> Is the patient at increased risk of infection? Confusion or delirium High or low body temperature Dizziness due to low blood pressure Tachycardia (fast heartbeat) Skin rash or mottled skin Breathlessness / fast respiration rate Slurred speech Diarrhoea and vomiting 	

DO NOT PUNCH HOLES IN CHART

Chart number: _____

**National Early Warning Score Chart (NEWS 2)
ADULT**

Patient's Name: _____
 NHS Number: _____
 Ward: _____ Date of birth: _____

Recording NEWS Scores:

- NEWS must be recorded on admission to ALL inpatient units.
- NEWS is to be recorded twice daily (morning and evening) until reviewed and documented by MDT. Must remain a minimum of daily in MHSOP & AMH.
- Frequency of recording in forensic, learning disability and long-stay units can be decided by the MDT.
- NEWS must be attempted following a fall and /or head injury (in addition to recording Glasgow Coma Scale and considering head injury protocol).
- When there is a change in the physical or mental health of a patient which is causing concern.
- During Clozapine initiation and titration. Hourly for 6 hours after first dose then at least daily (ideally 2-6 hours after dose)
- 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 are to be recorded in the electronic care record (ECR).
- Stipulate and record in ECR which parameter the patient is scoring in if score is above 0.
- Record if a patient refuses to have observations taken. A minimum of conscious level and respirations must be recorded if a patient refuses.
- If NEWS is refused, further attempts must be made (at least within 12 hours) and all attempts are to be recorded on the chart and in the ECR. If there is a clear rationale for not making further attempts, this must be made clear in ECR.

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 a member of the medical team.

Emergency oxygen

The ambulance service must be called if patient requires emergency oxygen (unless prescribed and clear plans are in place). Follow Trust protocol for 'oxygen administration in an emergency'.

Special notes relating to this patient / patient specific parameters

- Record special instructions such as lying and standing BP and increased / decreased frequency.
- Review special notes at least once weekly and on the commencement of a new chart.
- Escalation /clinical response regarding a patient's baseline to be discussed with MDT and recorded below.

Date/Time	Signature / Designation

Appendix 4 – 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.