1 Introduction

Clinical deterioration can occur at any stage of a patient’s illness; however, there will be certain periods when a patient is more vulnerable to deterioration e.g. the onset of illness, during surgical or medical interventions and during recovery from critical illness. This deterioration is often preceded by or associated with physiological deterioration.

Timely interpretation and escalation of recognised deterioration is of crucial importance in minimising the likelihood of serious adverse events including cardiac arrest and death. Early detection of this physiological deterioration offers the best opportunity to intervene and prevent serious adverse events from further deterioration including cardiac arrest and death. Adult patients at risk of such deteriorations should therefore be identified via basic observations and related early warning scores. All adult patients should have their observations monitored so any deterioration can be detected. This has to trigger a review that will start the process of investigating the cause of the deterioration and instigating the appropriate management as early as possible.

2 Scope

The scope of this policy applies to adult inpatients in the acute setting. It excludes paediatric, critical care areas and maternity patients who, due to their specialist requirements are managed within their own speciality and follow their own observation and escalation policies.

This policy applies to all health care practitioners who measure, record and respond to patients’ physiological observations in the course of their work.

For the purpose of this policy, health care practitioner refers to nurses, midwives, students, doctors, allied health professionals, health care assistants and any staff who use the NEWS charts.

3 Aims

This policy sets out the standards, based on best available evidence, on the care of adult inpatients within the acute hospital setting. This relates to the measurement and recording of physiological observations and the use of a ‘track and trigger’ system to
ensure early recognition of deteriorating patients and subsequent timely and appropriate treatment by competent staff.

The policy enables the Trust to adhere to the NCEPOD 2012 recommendation for optimising early warning scoring systems, the NICE 2007 Guideline 50 on “Acutely Ill Patients in Hospital” and more recently the Royal College of Physicians National Early Warning Score 2012. All three recognise that patients in the acute setting can rapidly deteriorate and the widespread use of track and trigger systems identifies the early signs and symptoms of a deteriorating patient.

This Policy is to be read and used in conjunction with the Resuscitation Policy.

The track and trigger tool of choice which has been agreed across the Trust is the National Early Warning Score (NEWS). This is available on all wards and departments.

4 Duties (Roles and responsibilities)

Trust Board
Supports the EWS Steering Group to ensure the policy is fully embedded to reduce the risk of patient deterioration throughout the Trust.

Chief Executive
Has responsibility for ensuring the Trust has robust policies relating to clinical observations and patient deterioration prevention.

Directorate Managers and Clinical Directors
Have the responsibility to ensure the clinical areas in their directorate implement and comply with the policy. Specifically they are responsible to ensure all staff in their directorate have undertaken their NEWS mandatory training.

EWS Steering Group
Have overall responsibility for overseeing the implementation and monitoring of the policy.

Matrons and Senior Leaders
Have responsibility for implementing this policy within their clinical areas and ensuring staff understand their accountability and responsibility in relation to complying with this policy. Responsible to ensure each ward has an up to date NEWS responders escalation response that is visible at all nursing stations.

CGARD
Have responsibility for monitoring the use of NEWS charts and compliance with the track and trigger algorithm via audit and review.
All staff
Have responsibility for practicing in accordance with the clinical guidance set out in this policy.

5 Definitions

NCEPOD – National Confidential Enquiry into Patient Outcome and Death. These are enquiries which seek to improve health and healthcare by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings.

NICE – The National Institute for Health and Clinical Excellence provides guidance, sets quality standards and manages a national database to improve people’s health and prevent and treat ill health. It makes recommendations to the NHS on new and existing medicines, treatments and procedures, and on treating and caring for people with specific diseases and conditions.

NEWS – National Early Warning Score is a simple physiological scoring system that can be calculated at the patient’s bedside, using agreed parameters which are measured in unwell patients. It is a tool which alerts health care practitioners to abnormal physiological parameters and triggers an escalation of care and review of the unwell patient. It is only applicable to adult inpatients.

NEWS responder - An individual trained in the assessment and initial management of the deteriorating patient.

SBAR -Situation, Background, Assessment, Recommendation, an effective framework for optimising communication between members of the health care team regarding a patient’s condition

TRACK and TRIGGER – Each physiological parameters is allocated a score reflecting the magnitude of disturbance to each of them. The scores are then added up and a total NEWS Score is given. An increased score suggests a deteriorating patient or a patient at risk of deterioration. The greater the score the greater the risk of adverse events.

6 Process Guidelines for the Use of NEWS Charts

The purpose of the NEWS chart is to record and track clinical observations of patients in order to highlight and identify signs of deterioration before they develop adverse events. They will then be given the appropriate treatment at the appropriate time.

The clinical observations for the immediate post operative patient being nursed in the Recovery area will be documented on the anaesthetic sheet. When a patient is assessed as being fit for discharge to the ward, the last set of observations should be scored and handed over to ward staff. Ward medical staff are required to transcribe the $O_2$ prescription.
When patients are discharged from the Critical Care Department, a minimum of the last two sets of observations will be transferred onto the NEWS chart for continuation by ward staff.

Patients transferring from one clinical area to another should continue on the same NEWS chart so the changes in observations can be tracked; unless the change necessitates the use of a spinal or neurological chart as part of their care plan.

6.1 End of Life Care

Patients who are on an End of Life Care Pathway may have the decision taken for them to be removed from the scoring and triggering process of the NEWS, as physiological deterioration is part of the dying process. This will be documented by clinicians in the medical notes and on the NEWS Observation Chart.

6.2 Types of NEWS Charts

There are three types of charts available which are an acute adult inpatient chart, a neurological (neuro) chart and a spinal chart.

Observation and escalation process are the same for all charts, the neurological charts use GCS rather than AVPU.

Patients who have undergone a specific procedure may be following patient pathways where observation timings post procedure are stipulated. These patients will continue on this pathway and be recorded on the NEWS Observation Chart. A NEW Score will be completed each time a set of observations are completed and the patient escalated as appropriate. The NEW score indicates the minimum observation frequency. Patients should be observed at the highest frequency if the patient pathway and the NEW score make different recommendations.

6.3 Observations

- Physiological observations recorded at the time of their admission or initial assessment.
- Variances will be clearly documented on the NEWS Chart
- A clear written monitoring plan that specifies any changes in variances that might be appropriate. This needs to take into account the patients diagnosis, presence of co-morbidities and agreed treatment plan which will be documented in the patient’s medical records.
- Patients will have their observations and a NEW score recorded prior to transfer from one clinical area to another and clearly recorded on the NEWS chart. Once the patient has arrived on the new ward the observations will be recorded again on the NEWS chart.
• As a minimum, the following physiological observations will be recorded at the initial assessment and as part of routine monitoring unless otherwise indicated in the patient record:
  o respiratory rate
  o oxygen saturations
  o Amount of inspired oxygen
  o temperature
  o blood pressure (If a patient requires a lying and standing blood pressure to be completed each time observations are taken, the NEWS will be calculated on the lying blood pressure)
  o heart rate
  o level of consciousness (AVPU score)
• When appropriate the patients’ pain score will also be recorded on the NEWS chart using the Numeric Rating Scale. This will be part of the clinical assessment and on-going monitoring.
• Physiological observations will be taken at a minimum of 12 hourly unless the patient’s NEW score or patient pathway require more regular observations.
• The frequency of monitoring will increase if abnormal physiology is detected, as outlined in the clinical response to the NEW score.
• In specific clinical circumstances, additional monitoring and investigations should be considered as part of the overall patient treatment plan and evaluation of care.

All health care practitioners will utilise the SBAR (Situation, Background, Assessment, and Recommendation) communication tool to facilitate concise and effective dialogue concerning a deteriorating patient. It is not appropriate to just communicate the NEW score it carries little or no meaning by itself, the actual physiological derangements need to be communicated in the context of the patient.

6.4 Variances

Variance can be temporary or permanent (e.g. fast AF in cardiology, could have a temporary variance placed and this must be reviewed in 24 hours, end stage COPD target saturation level below usual variance a permanent variance can be used here ; once sanctioned by medical staff, nursing staff can transcribe permanent variance only).

It must be documented on the chart whether it is a permanent or temporary variance.

Note: variance must be agreed by registrar grade or above but can be documented by any member of the team trained in using the charts, it must be documented who has sanctioned the variance.
6.5 Urine Output

Urine output is not one of the minimum set of observations used in the NEW score. However it is a very useful clinical indicator for patient deterioration. If a patient is on a fluid balance or urine output has been specifically requested to be monitored then it is observed, documented and scored.

If urine output drops to below 30 mls per hour on average for the last period of observation then they will trigger a review by adding 3 points. This would be less than 120 mls in 4 hours, less than 360 mls in 12 hours.

6.6 Escalation Procedure

Trigger thresholds are nationally set and clear on the NEWS chart. A graded response strategy for patients identified as being at risk of clinical deterioration is an integral part of the NEWS chart.

When a patient’s NEW score requires a response that triggers an escalation of care, any actions taken will be clearly documented contemporaneously within the nursing care records and on the front of the NEWS chart.

Whilst the NEWS system facilitates the assessment, early recognition and response to the deteriorating patient it will not deter health care practitioners from exercising their clinical judgement and therefore escalate appropriately. There is a section of the NEWS chart that allows staff to document nursing concern and this is then calculated as part of the NEW score after agreement by the nurse in charge that the concern is valid.

If there is no response from the responder within the response time the call must be escalated.

Each ward will agree their NEWS responders and this will be displayed at all nursing stations.

Patient is negligible risk, score 0 (Colour: white)
- 12 hourly observations
- Continue routine NEWS monitoring with every set of observations

Patient is low risk, score 1-4 (Colour: green)
- 4 hourly observations
- Inform registered nurse who must assess the patient
- Registered nurse to decide if increased frequency of monitoring and/or escalation of care is required by adding nursing concern.

Patient is medium risk, score 5-6, or individual parameter scoring 3 (Colour: orange)
- 1 hourly observations
• NEWS responder: FY 1 and FY 2, designated member of the nursing staff e.g. nurse practitioner
• Response time 30 minutes

Patient is high risk, score 7 or more, or 3 in two parameters (Colour: red)
• Continuous monitoring, as a minimum leave the oxygen saturations probe attached
• Senior NEWS responder: specialty trainee or consultant from base specialty
• Critical Care Outreach Team (in addition to the above)
• Response time ten minutes (Response can be to attend, verbal advice given, variance given, or removal from the NEWS process in End Of Life care. It is recognised that it may not be appropriate or necessary to attend in person within the response time. Some patients will need to be seen in this time frame and the responder may need to delegate or escalate the response if they are not able to do so themselves.)
• If staff require immediate help for a critically ill patient they should call 2222 and ask for the cardiac arrest team to attend the clinical setting

6.7 Standards for Record Keeping

Physiological observations should be recorded at initial assessment and as part of routine monitoring. Senior clinicians may alter/ remove parameters in specific circumstances e.g. the patient with chronic kidney disease that is also anuric or the patient with chronic respiratory disease who has a consistently raised but stable respiratory rate.

7 Education and Training

An education strategy has been written and agreed by the Trust EWS Steering Group. It includes the introduction of NEWS training session. The NEWS Training Programme will be delivered in the following two ways:
  1. Breeze- online access
  2. Lecture theatre/classroom- taught
All relevant staff from adult inpatient wards must either attend the lecture theatre session or undertake the e-learning programme. This excludes paediatric, obstetric, community, outpatient, nurse specialists, research and palliative care staff (unless they use NEWS charts). This is a one off mandatory requirement for all new staff commencing employment in the Trust.

Training will be supported in the ward areas by: Outreach nurses, Directorate Clinical Educators and NEWS cascade trainers.

The NEWS training will be delivered by: Critical Care Outreach staff (Consultants and nurses), Critical Care Consultants, Directorate Cascade Trainers and Clinical Educators.
The Trust Training and Education Department support the administration of the training including the record of attendance and compliance monitoring.

8  **Equality and Diversity**

The Trust is committed to ensuring that, as far as reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

9  **Monitoring Compliance with the policy**

<table>
<thead>
<tr>
<th>Standard / Process / Issue</th>
<th>Monitoring and Audit Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure NEWS charts are completed correctly</td>
<td>Audit of NEWS charts</td>
<td>CGARD</td>
<td>EWS Steering Group</td>
<td>Quarterly</td>
</tr>
<tr>
<td>To ensure appropriate action has been undertaken in the event of a trigger occurring</td>
<td>Review of medical case notes</td>
<td>CGARD</td>
<td>EWS Steering Group</td>
<td>Quarterly</td>
</tr>
<tr>
<td>To provide an update report</td>
<td>Report on process and activity</td>
<td>CGARD</td>
<td>Clinical Risk Group</td>
<td>Six monthly</td>
</tr>
</tbody>
</table>

10  **Consultation and Review**

This policy has been reviewed by the EWS Steering Group in consultation with other interested stakeholders.

11  **References**

- Royal College of Physicians (2012) National Early Warning Score (NEWS) Standardising the assessment of acute-illness severity in the NHS
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. Assessment Date: 19/09/14

2. Name of policy / strategy / service:
   NEWS Policy

3. Name and designation of Author:
   Elaine Coghill Quality and Effectiveness Lead

4. Names & designations of those involved in the impact analysis screening process:
   Dr Alistair Gascoigne CD Patient Safety and Quality, Dr Phil Laws Consultant Anaesthetist, Dr Joe Cosgrove, Consultant Anaesthetist

5. Is this a: Policy √ Strategy [ ] Service [ ]
   Is this: New √ Revised [ ]
   Who is affected Employees √ Service Users √ Wider Community [ ]

6. What are the main aims, objectives of the policy, strategy, or service and the intended outcomes? (These can be cut and pasted from your policy)
   This policy sets out the standards, based on best available evidence, on the care of adult inpatients within the acute hospital setting. This relates to the measurement and recording of physiological observations and the use of a ‘track and trigger’ system to ensure early recognition of deteriorating patients and subsequent timely and appropriate treatment by competent staff. The policy enables the Trust to adhere to the NCEPOD 2012 recommendation for optimising early warning scoring systems, the NICE 2007 Guideline 50 on “Acutely Ill Patients in Hospital” and more recently the Royal College of Physicians National Early Warning Score 2012. All three recognise that patients in the acute setting can rapidly deteriorate and the widespread use of track and trigger systems identifies the early signs and symptoms of a deteriorating patient.

7. Does this policy, strategy, or service have any equality implications? Yes [ ] No √
8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnic origin (including gypsies and travellers)</td>
<td>This policy relates to all adult inpatients no matter what race/ethnicity</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Sex (male/female)</td>
<td>This policy relates to all adult inpatients no matter what sex</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>This policy relates to all adult patients and is not dependent on their religion or belief</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>This policy relates to all adult inpatients no matter what their sexual orientation is</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Age</td>
<td>This policy relates to all adult inpatients</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>This policy relates to all adult inpatients</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>This policy does not discriminate with patients that have had gender re-assignment</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>This policy relates to all adult inpatients</td>
<td>No</td>
<td>n/a</td>
</tr>
<tr>
<td>Maternity/Pregnancy</td>
<td>This policy relates to all adult inpatients</td>
<td>No</td>
<td>n/a</td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No
10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes ☐ No ☑

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Name: Elaine Coghill

Date of completion: 29/09/14

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)