Addressograph

Name: ....

DOB: ....

CHI: ....

NEWS of 5 or more?

Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of .... or individual parameter of ....
is acceptable for this patient because ....

....

Please escalate if ....

....

Print .... Sign .... Designation ....
Date .... Time .... *(only valid if signed and dated)*

***Regardless of NEWS always Escalate if concerned about a patient's condition.**
Escalate immediately if clinical observations cannot be obtained

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 **Urgent response threshold**	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more **Emergency response threshold**	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

Code	Description	Code	Description
A	breathing air	**RM**	reservoir mask
N	nasal cannula (document in litres)	**TM**	tracheostomy mask
SM	simple mask	**CP**	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	**H**	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	**OTH**	Other specify

Date / Time	
Circulation	
Sensation	
Movement	

NEWS Key: 0 | 1 | 2 | 3

Parameter	Range	Score	Range
	Date:		Date
	Time:		Time
A+B Respirations, Breaths/min	≥25	3	≥25
	21-24	2	21-24
	18-20		18-20
	15-17		15-17
	12-14		12-14
	9-11	1	9-11
	≤8	3	≤8
A+B SpO_2 Scale 1, Oxygen saturation (%), Use Scale 1 if target range is 94-98%	≥96		≥96
	94-95	1	94-95
	92-93	2	92-93
	≤91	3	≤91
SpO_2 Scale 2*, Oxygen saturation (%), Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	≥97 on O_2	3	≥97 on O_2
	95-96 on O_2	2	95-96 on O_2
	93-94 on O_2	1	93-94 on O_2
	≥93 on air		≥93 on air
* ONLY use Scale 2 under the direction of a qualified clinician	88-92		88-92
	86-87	1	86-87
Tick box if using SpO_2 Scale 2	84-85	2	84-85
Sign:	≤83	3	≤83
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air		A = Air
	O^2 L/min or %	2	O^2 L/min or %
	Device		Device
C Blood Pressure mmHg, Score uses Systolic BP only. If manual BP mark as M	≥220	3	≥220
	201-219		201-219
	181-200		181-200
	161-180		161-180
	141-160		141-160
	121-140		121-140
	111-120		111-120
	101-110	1	101-110
	91-100	2	91-100
	81-90	3	81-90
	71-80	3	71-80
	61-70	3	61-70
	51-60	3	51-60
	≤50	3	≤50
C Pulse Beats/min. Manual pulse	≥131	3	≥131
	121-130	2	121-130
	111-120	2	111-120
	101-110	1	101-110
	91-100	1	91-100
	81-90		81-90
	71-80		71-80
	61-70		61-70
	51-60		51-60
	41-50	1	41-50
	31-40	3	31-40
	≤30	3	≤30
D Consciousness, Score for new onset of confusion (no score if chronic)	Alert		Alert
	New Confusion	3	New Confusion
	V	3	V
	P	3	P
	U	3	U
E Temperature ^0C	≥39.1^0	2	≥39.1^0
	38.1-39.0^0	1	38.1-39.0^0
	37.1-38.0^0		37.1-38.0^0
	36.1-37.0^0		36.1-37.0^0
	35.1-36.0^0	1	35.1-36.0^0
	≤35.0^0	3	≤35.0^0
NEWS TOTAL			**Total**
	Monitoring frequency		Monitoring
	Escalation of care Y/N		Escalation
	Initials		Initials
	Urine output recorded Y/N		Urine output
	Blood Glucose level or N/A		Blood Glucose
	Pain score (0-10)		Pain
	Nausea score (0-3)		Nausea
	Motor Block score (0-4) or N/A		Motor Block

National Early Warning Score 2 (NEWS2) Chart

NHS Lothian

Addressograph

Name: .....

DOB: .....

CHI: .....

Date chart commenced: .....

This is chart number ..... of this admission

Conscious Level Chart to be completed when clinically indicated

		Date																														
		Time																														
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4																													Eyes closed by swelling = C
		To speech	3																													
		To pain	2																													
		None	1																													
	Best Verbal Response	Orientated	5																													Endotracheal tube or tracheostomy = T
		Confused	4																													
		Inappropriate words	3																													
		Incomprehensible sounds	2																													
		None	1																													
	Best Motor Response	Obey commands	6																													Always record the best arm response
		Localise to pain	5																													
		Flexion to pain	4																													
		Abnormal flexion	3																													
		Extension to pain	2																													
		None	1																													
	Total GCS Score																															
	Right Pupil	Size																														+ reacts - no reaction c. eye closed
		Reaction																														
	Left Pupil	Size																														
		Reaction																														
LIMB MOVEMENT	ARMS	Normal power																														Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																														
		Severe weakness																														
		Extension																														
		No response																														
	LEGS	Normal power																														
		Mild weakness																														
		Severe weakness																														
		Extension																														
		No response																														
		Initials																														

Pupil Scale mm 1 • 2 • 3 ● 4 ● 5 ● 6 ● 7 ● 8 ●

REMEMBER
- **Record all observations** on NEWS2 chart
- **Document concerns/decisions in clinical notes**
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	• obtain IV access • obtain blood samples • prepare fluid challenge • initiate fluid balance chart • call 2222 if no circulation • consider initiating major haemorrhage protocol • monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	• control bleeding • treat any underlying conditions identified • reassess • maintain patient's dignity • evaluate actions

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical Staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Acute Pain Team Out of Hours: on-call Anaesthetist	Mon-Fri: bleep Palliative Care Team Out of Hours: via Switchboard

Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees** **3 - Minimal movement**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

Ref: MPS NHS Lothian 2018 Printed January 2019 V1.1 Review December 2021 LOT 1651