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

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
	O² L/min or %	2	O² L/min or %
	Device		Device
C Blood Pressure mmHg Score uses Systolic BP only	≥220	3	≥220
	201-219		201-219
	181-200		181-200
	161-180		161-180
	141-160		141-160
	121-140		121-140
If manual BP mark as M	111-120		111-120
	101-110	1	101-110
	91-100	2	91-100
	81-90	3	81-90
	71-80		71-80
	61-70		61-70
	51-60		51-60
	≤50		≤50
C Pulse Beats/min	≥131	3	≥131
	121-130	2	121-130
	111-120		111-120
	101-110	1	101-110
Manual pulse	91-100		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		≤30
D Consciousness Score for new onset of confusion (no score if chronic)	Alert		Alert
	New Confusion	3	New Confusion
	V		V
	P		P
	U		U
E Temperature ⁰C	≥39.1⁰	2	≥39.1⁰
	38.1-39.0⁰	1	38.1-39.0⁰
	37.1-38.0⁰		37.1-38.0⁰
	36.1-37.0⁰		36.1-37.0⁰
	35.1-36.0⁰	1	35.1-36.0⁰
	≤35.0⁰	3	≤35.0⁰
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