## **INPATIENT**

## National Early Warning Score (NEWS2) Chart



NEWS key 0 1 2 3		FULL	NAME						NH	NHS NUMBER									
		DATE OF BIRTH								DATE OF ADMISSION									
	DATE TIME																		DATE TIME
A+B Respirations Breaths/min	≥25									3									≥25
	21–24									2									21–24
	18–20																		18–20
	15–17																		15–17
	12–14								8	4									12–14
	9–11 ≤8									3									9 <b>–</b> 11 ≤8
A+B	≥96 94–95								2	1									≥96 94–95
SpO₂ Scale 1	92–93									2									92–93
Oxygen saturation (%)	≤91									3									≤91
	≥97 on O <sub>2</sub>									3									≥97 on O <sub>2</sub>
SpO <sub>2</sub> Scale 2 <sup>†</sup> Oxygen saturation (%)	95–96 on O <sub>2</sub>									2									95–96 on O <sub>2</sub>
Use Scale 2 if target range is 88–92%,	93–94 on O <sub>2</sub>									1									93-94 on O2
eg in hypercapnic	≥93 on air								1										≥93 on air
respiratory failure	88–92																		88–92
	86–87									1									86–87
ONLY use Scale 2 under the direction of	84–85									2									84–85
a qualified clinician	≤83%									3									≤83%
Air or oxygen?	A=Air																		A=Air
- in or oxygen:	O <sub>2</sub> L/min									2									O <sub>2</sub> L/min
	Device																		Device
	≥220									3									≥220
C	201–219																		201–219
Blood	181–200																		181–200
oressure	161–180																		161–180
mmHg Score uses	141–160																		141–160
systolic BP only	121–140																		121–140
	111–120 101–110								2	1									111–120 101–110
	91–100									2									91–100
	81–90																		81–90
	71–80																		71–80
	61–70									3									61–70
	51–60																		51–60
	≤50																		≤50
	≥131									3									≥131
$\mathbf{C}$	121–130																		121–130
Pulse	111–120									2									111–120
Beats/min	101–110									1									101–110
	91–100																		91–100
	81–90																		81–90
	71–80																		71–80 61–70
	61–70 51–60										$\vdash$								51–60
	41–50								2	1									41–50
	31–40																		31–40
	≤30									3									≤30
	Alert																		Alert
D	Confusion																		Confusion
Consciousness	V																		V
Consciousness Score for NEW	P									3									Р
onset of confusion no score if chronic)	U																		U
	≥39.1°									2									>30.1°
F	≥39.1 38.1–39.0°									1									≥39.1° 38.1–39.0°
Temperature °c	37.1–38.0°								3										37.1–38.0°
	36.1–37.0°																		36.1–37.0°
	35.1–36.0°									1									35.1–36.0°
	≤35.0°									3									≤35.0°
NEWS TOTAL																			TOTAL
	g frequency																		Monitoring
Escalation	of care Y/N																		Escalation
	Initials	1 I	1 1	i	1	1 1		1	1 2	///////		- I	1	- I	1	- i - I	1	1	Initials

1. Are you worried your patient is sick?  e.g.  High or low temperature  Sudden deterioration	Tick	Low risk of sepsis. Consider other diagnoses. Consider removing cannula/ catheter Use clinical judgement and/or standard protocols
Unusually drowsy, confused or delirious		
NEWS >3		Give safety netting advice to carers: call 999 if patient deteriorates rapidly, or call 111/ arrange to see GP
↓Ŷ		if condition fails to improve or gradually worsens. Signpost to available resources as appropriate.
2. Are there signs/ symptoms of infection	1?	A N
Yes, but source not obvious		A le cou ONE Amber Flor procent?
Pneumonia/ likely chest source		4. Is any ONE Amber Flag present?
Urinary Tract Infection		Relatives worried about mental state/ behaviour
Abdominal pain or distension		Acute deterioration in functional ability
Cellulitis/ septic arthritis/ infected wound		Immunosuppressed (without recent chemotherapy)
Device-related infection		Trauma, surgery or procedure in last 6 weeks
Meningitis		Respiratory rate 21-24 OR dyspnoeic
Other (specify):		Systolic B.P 91-100 mmHg
↓Y		Heart rate 91-130 OR new dysrhythmia
Perform a full set of observations	ightharpoonup	Not passed urine in last 12-18 hours
		Tympanic temperature ≤36°C
2 lo ONE Ded Flog present?		Clinical signs of wound, device or skin infection
3. Is ONE Red Flag present?	Tick	If under 17 & immunity impaired treat
New deterioration in GCS/ AVPU or acute confusion		as Red Flag Sepsis
Systolic B.P ≤90 mmHg (or ≥40 mmHg below normal)	H	<b>↓</b> Y
Heart rate ≥130 per minute	FILE	At risk of sepsis
Respiratory rate ≥25 per minute	H	1. Same day assessment by GP/ Community Matron
Needs oxygen to keep SpO <sub>2</sub> 92% (88% in COPD)		Is urgent referral to hospital required?     Agree and document ongoing management plan
Non-blanching rash or mottled/ ashen/ cyanotic	H	(including observations frequency, planned second
Not passed urine in last 18 hours	H H	review as agreed with GP / Community Matron)  4. Monitor urine output
Urine output less than 0.5 ml/kg/hr if catheterised	H H	Consider life threatening sepsis mimics e.g. Stroke
Recent chemotherapy (within last 6 weeks)	H H	
V		
Dad Flam Canaial		
Red Flag Sepsis! This is a time critical c	ondition, imm	
1. If appropriate* dial 999, arrange blue light transfer		4. Consider IV fluids
2. If available give O <sub>2</sub> to keep saturations >94% (88-92%	% in COPD)	5. Inform Next of Kin 6. Ensure ambulance crew pre-alert 'Red Flag Sensis'
<ol> <li>Cannulate if skills &amp; competencies allow</li> <li>"Consider individual's advanced plan, if not for transfer consider appropriate li</li> </ol>	mits of care	6. Ensure ambulance crew pre-alert 'Red Flag Sepsis'
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News	Monitoring Frequency	Clinical response						
0	Routine monitor	Continue routine NEWS2 monitoring with every set of observations.						
Total Score 1-4 Parameter	Minimum 4-6 hourly	<b>LOW NEWS2</b> score (1-4), patient to be assessed by a registered nurse or medical staff, who should decide whether a change to frequency of clinical monitoring or an escalation of clinical care is required and documented.						
A single RED score	Escalate immediately	A single <b>RED</b> score must prompt an urgent review by a clinician with competencies in the assessment of acute illness to determine the cause, decide on the frequency of monitoring, or transfer to an acute hospital – Seek senior nursing and or medical advice immediately.						
SICK Total 5-6	Increased frequency to a minimum of one hourly.  Consider Sepsis red flags	<b>Medium NEWS2</b> score (5-6) – 'think sepsis', the patient must be urgently reviewed by a clinician with competencies in the assessment of acute illness. Unless a ward based doctor is available immediately, the patient should be transferred to an acute hospital for an urgent clinical review ( <u>unless</u> the patient has a longstanding long term condition) where higher NEWS2 maybe usual for the patient, or the patient is palliative or at end of life.						
ACT NOW! NEWS 7 or more	Continuous monitoring of vital signs	<b>High NEWS2 score (7 or more)</b> should prompt an emergency assessment by staff within critical care competencies, a patient must be transferred via 999 to an acute hospital, <b>unless</b> as above.						

## For patient triggering NEWS2 score of 5 or more, or 3 in one parameter, please document action taken in the patient record using the SBARD tool below.

## Codes for recording oxygen delivery • Give your name and designation, state where you are calling from **Situation** Describe who you are calling about Describe the reason for your concern A = airGive the date and reason for the admission **B**ackground Describe the patient's diagnosis, mental health act status, relevant treatments, treatment plans and co-morbidities N = nasal cannula Describe the patient's usual presentation SM = simple mask • Have all the information to hand, describe the findings of your assessment of the patient V = venture mask and % (e.g. V24) Physical observations to include temperature, pulse, respirations, blood pressure, level of consciousness and oxygen saturation levels **Assessment** NIV = non-invasive ventilation Describe what you think the problem is, or state you are not sure what is wrong but that you are concerned RM = reservoir mask State what you would like to happen TM = tracheostomy mask Recommendation Determine timeframes State what you will do in the meantime, for example - increase observation levels CP = CPAP mask Summarise and record what has been agreed - checking understanding of both yourself and the person you contacted. Agree call back if needed H = humidified oxygen and % (e.g. H28) Decision OTH = other (please specify) Record name and contact details of person contacted Record date and time of contact