OBSERVATIONS AND ESCALATION POLICY FOR ADULT PATIENTS

POLICY

Reference	CPG-TW-Obs&Esc
Approving Body	Documentation Group
Date Approved	8th June 2023
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**

YES	**NO**	**N/A**
X		

Issue Date	15th June 2023
Version	9.0
Summary of Changes from Previous Version	• Update process for 3000 bleep (no longer in use) • CCOT is now a 24/7 service • Auditing application changed from Perfect Wart to AMaT.
Supersedes	v8.0, CPG-TW-CGTRUS002, issued 6th May 2020 to Review Date June 2023 (ext[1])
Document Category	• Clinical
Consultation Undertaken	• CCOT • Hospital out of Hours • Nervecentre • Ward Leaders and Matrons • Resus • Sepsis Nurse Specialist • NEWS2 Policy Group • Deteriorating Patient Group
Date of Completion of Equality Impact Assessment	28th April 2023
Date of Environmental Impact Assessment (if applicable)	28th April 2023
Legal and/or Accreditation Implications	Not Applicable
Target Audience	This policy covers all staff groups who are involved in caring for adult patients receiving care within the Trust (e.g. Registered Nurses and Students, Doctors, Physiotherapists, Pharmacists, Health Care Support Workers, Operating Department Practitioners).
Review Date	June 2024
Sponsor (Position)	Chief Nurse
Author (Position & Name)	• Corporate Head of Nursing – Yvonne Simpson • Practice Development Matron – Jackie Simpson
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Nursing – Corporate Team
Position of Person able to provide Further Guidance/Information	Corporate Nursing Team

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
• None	N/A
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

1.1 This policy is underpinned by the principle that recognises the importance of ensuring all adult patients' vital signs are accurately and promptly recorded by appropriately trained staff. Where patients' observations are outside of normal parameters or where there are signs of physiological deterioration, staff will take appropriate action to monitor the patient more closely and seek advice and support from other members of the Multidisciplinary Team. This aims to reverse or prevent further deterioration and avoidable harm to the patient. This policy is based on guidance from the National Institute for Health and Care Excellence (NICE, 2007) Guideline number 50 *Acutely Ill Patients in Hospital. Recognition of and response to acute illness in adults in hospital,* in conjunction with the Royal College of Physicians (2017). *National Early Warning Score Second Edition (NEWS2) Standardising the assessments of acute illness severity in the NHS.*

1.2 This policy aims to support the appropriate measuring, recording and escalation of patient's physiological observations in accordance with the National Early Warning Score Second Edition (NEWS2). It aims to depict the roles and responsibilities of different staff members in regards to escalating and responding to the deteriorating patient.

1.3 This policy is issued and maintained by the Chief Nurse (the sponsor) on behalf of the Trust, at the issue date defined on the front sheet, which supersedes and replaces all previous versions.

2.0 POLICY STATEMENT

2.1 **Subject matter:** This policy is limited to Sherwood Forest Hospital Foundation Trust (SFHFT) and covers:

- The roles and responsibilities of different staff groups.
- The monitoring and recording of patient vital signs.
- NEWS2 scoring, escalation and the associated graded response (see Appendix 1a, Appendix 1b, Appendix 2, Appendix 3 and Appendix 4).

2.2 **Staff:** This policy covers all staff groups who are involved in caring for adult patients (e.g. Registered Nurses, Doctors, Physiotherapists, Pharmacists, Health Care Support Worker, Operating Department Practitioners, Student Nurses and Nursing Associates).

2.3 **Exclusions:** The following areas are exempt:

- Paediatric patients in designated paediatric areas - refer to PEWS Escalation.
- Maternity patients - refer to the Maternity Early Warning Scoring (MEWS) Guideline.
- Patients who are on an end of life care plan and no longer require vital signs to be monitored - refer to Last Days of Life for Adults Policy.

3.0 DEFINITIONS/ ABBREVIATIONS:

ABCDE Approach	This is the systematic approach for assessing all patients: **A**irway **B**reathing **C**irculation **D**isability **E**xposure Visit the Resuscitation Councils website for further information.
ACVPU	This tool is used to rapidly assess the level of consciousness where the patient is identified as A – **A**lert C – New onset **C**onfusion or delirium V – responding to **V**erbal stimuli only P – responding to **P**ainful stimuli only or U – **U**nresponsive Any person scoring C, V, P or U will require further, in-depth assessment using the Glasgow Coma Scale (GCS). These parameters all score 3 on NEWS2 (Refer to the Acute Confusion/ Delirium in Adults (including Rapid Tranquilisation) - Guideline for Detection and Management for further information on confusion/ delirium).
ART	The **A**cute **R**esponse **T**eam is a team of acute care professionals including the on call Medical Registrar, Anaesthetic Registrar and CCOT/HOOHP. The ART is available 24 hours a day ONLY at the Kings Mill site to respond to acute deteriorations in a patient's clinical condition.
CCOT	The **C**ritical **C**are **O**utreach **T**eam is a team of experienced senior nurses with a comprehensive range of critical care skills and Advance Life Support training. They provide support to the deteriorating patient within the Kings Mill site only. The CCOT team are on site 24hr a day 7 days a week.
Ceiling Of Treatment	Ceiling of treatment is an individualised patient plan that defines the limits of treatment the patient will receive in the event of deterioration. This should be formally documented in the medical notes/ ReSPECT form by a registrar or above.
Continuous patient observation monitoring	At SFHFT continuous observation monitoring is defined as completing a full set of patient observations and assessment every 30 minutes as a minimum.

CRDM	Chronic Respiratory Disease Model – This is a model within Nervecentre to reduce false alerts for those patients with chronic respiratory diseases including Chronic Obstructive Pulmonary Disease (COPD).
De-toggling	Describes the process of being able to de-escalate a patient's observations on Nervecentre following an appropriate Management Plan documented in the medical notes, e.g. by 'de-toggling' CCOT, a patient will not be escalated to CCOT for a review.
DNACPR	**D**o **N**ot **A**ttempt **C**ardio-**P**ulmonary **R**esuscitation is a decision that is made and formally recorded in conjunction with the patient, to recommend that cardiopulmonary resuscitation (CPR) is not attempted should the patient suffer a cardiac arrest or die. (Refer to the Trust's Cardiopulmonary Resuscitation (CPR) Policy (for Adult, Maternity and Paediatric Patients) for further information).
End of Life Model	A model that can be set on Nervecentre that dictates no observation frequency and has no automatic escalations.
GCS	The **G**lasgow **C**oma **S**core is used to assess a patient's neurological status and is a more in-depth tool than the ACVPU. GCS should be used in all patients who score C, V, P or U on the ACVPU (unless the altered level of consciousness is expected e.g. due to the effects of sedative medication in theatre recovery). The GCS is recorded on Nervecentre.
NA	**N**ursing **A**ssociate – This role is designed to bridge the gap between HCSW's and Registered Nurses. They are registered practitioners with identified roles and responsibilities.
New onset Confusion or delirium	A patient may be alert but confused or disorientated. It is not always possible to determine whether the confusion is 'new when a patient presents acutely ill. Such a presentation should always be considered to be 'new' until confirmed otherwise. New-onset or worsening confusion, delirium or any other altered mentation should always prompt concern about potentially serious underlying causes and warrants urgent clinical evaluation.
HCSW	**H**ealth **C**are **S**upport **W**orker's support the multidisciplinary team in the delivery of high quality care. They address the care needs of individual patients under the direction and supervision of the Registered Nurse.
HOOH/ HOOHP	**H**ospital **O**ut **o**f **H**ours (HOOH) provides effective and safe clinical care outside of normal working hours (17:00-08:00) Monday – Friday and 24 hours Saturday, Sunday and Bank Holidays. HOOH is co-ordinated by the **H**ospital **O**ut **o**f **H**ours **P**ractitioner (HOOHP). The HOOHP is a Registered Nurse with a comprehensive range of expanded roles who acts as a senior nurse clinician with the specific role of providing centralised coordination across the hospital while also supporting clinical teams.

Management Plan	A Management Plan can dictate a patient's individual care needs outside of NEWS2 guidance, including exceptions to physiological parameters, observation frequency and escalation pathway. This must be clearly documented in the medical notes with a clear rationale and a date to be reviewed by a Doctor following consultation with a Speciality Registrar.
Mandatory Vital Signs	The mandatory vital signs include: • Respiration Rate (RR) • Oxygen (O2) Saturations (Sp02) • Inspired O2 • Blood Pressure (BP) • Heart Rate (HR) • Urine • ACVPU • Temperature • Pain • Bowels Where appropriate the following should also be recorded/ instigated: - Oxygen delivery device (refer to Oxygen Policy - Prescription, Administration and Monitoring of Oxygen Therapy in Adults). - Fluid balance monitoring - Blood glucose levels
Nervecentre	The Trust's electronic observation recording system.
NEWS2	National Early Warning Score second edition.
NIC	**N**urse **I**n **C**harge.
Parameters	This is the term used across the Trust to describe the setting of exceptions to individual patient observation parameters outside of NEWS2 guidance. These parameters must be clearly documented within the medical notes in the form of a Management Plan.
Clinical Team	The Clinical Team is defined as the Multidisciplinary team (MDT) who are responsible for a patient's medical needs whilst the patient is in hospital.
Urgent response	An urgent response requires the appropriate clinician to review a patient's escalation within 30minutes.
RN	A **R**egistered **N**urse who is registered with the Nursing & Midwifery Council.
ReSPECT	**R**ecommended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment. (For further information visit the ReSPECT Policy)
SBAR	Is a tool to help facilitate, prompt and aid appropriate communication: **S**ituation **B**ackground **A**ctions **R**ecommendations (See Appendix 7)

Speciality Registrar	A rotational speciality training post. In some areas, suitably qualified clinical fellows or Trust grade doctors may replace this role.
SP02	Peripheral Capillary Oxygen Saturation.
Tag	A 'Tag' is a way of highlighting key pieces of information within Nervecentre including Learning Disability, Dementia, Diabetes, ReSPECT, DNACPR and Falls. Setting a Tag will cause a colourful box with the appropriate information to be displayed on the patient's main demographic screen.
Vocera	Vocera is a real-time hands-free voice communication system.
Ward Based Care	Ward based care is the ceiling of treatment for patients where the decision has been documented within the medical notes by a registrar or above that if the patient's condition deteriorates they are not for escalation to Critical Care. The patient's medical needs instead will be maintained at ward level where interventions such as IV fluids, antibiotics, high flow oxygen or none invasive ventilation may commence.
Ward Doctor	Responsible doctor on a designated ward during the working day.

4.0 ROLES AND RESPONSIBILITIES

4.1 All staff under the scope of this policy and prior to implementing care are responsible for:

4.1.1 Ensuring that the correct lawful consent has been gained and documented in accordance with the Trusts Policy for Consent to Examination, Treatment and Care.

4.1.2 Ensuring a two-stage test is undertaken on any patient where capacity is in doubt. If the patient is found to lack capacity, then a 'Best Interest Checklist' must be completed and the Trusts Mental Capacity Act (MCA) Policy followed.

4.1.3 Ensuring they are confident/ competent in the use of Nervecentre and have accessed the appropriate training or user guide.

4.1.4 Ensuring that the patient's identification data is accurate including Name/ DOB/NHS number/D Number/Location and responsible Consultant) in line with the Policy and Procedure for the Positive Identification of Patients.

4.1.5 Ensuring that they are aware of what to do in the event of Nervecentre downtime (see Nervecentre Business Continuity Plans on the Trust Intranet Page for further information).

4.2 The Registered Nurse is responsible for:

4.2.1 Ensuring that mandatory vital signs are recorded accurately on Nervecentre or in line with the area, i.e. ED, ICU and Recovery record on paper documentation.

4.2.2 If the recording of observations is not possible (for example the patient is off the ward/patient refusal) the Registered Nurse is responsible for recording why the observations have not been performed on Nervecentre or in the Nursing Evaluation.

4.2.3 Ensuring that observations are completed in a timely manner.

4.2.4 Ensuring that Nervecentre electronic handover is completed and up to date including any associate 'Tags' (e.g. ReSPECT and DNACPR). This helps responders to effectively triage deteriorating patients.

4.2.5 Ensuring that observations are recorded and escalated in line with either; this policy, an individual Management Plan within the medical notes or clinical judgement (see Appendix 1a, Appendix 1b, Appendix 2, Appendix 3 and Appendix 4 for specific escalation flow charts).

4.2.6 The Registered Nurse can delegate the recording of observations to a suitably trained and competent Nursing Associate/ Student Nurse or HCSW. However, the Registered Nurse remains responsible for ensuring that observations are recorded accurately and where required are escalated or de-toggled according to the patient's individual Management Plan. If the NEWS2 score is found to be elevated (3 in 1 parameter or an aggregated score of 5,6,7 or above) the Registered Nurse must personally review the patient.

4.2.7 If a patient's clinical condition warrants an urgent medical review and either the appropriate staff are not present on the ward or no clear Management Plan is in place, the Registered Nurse should immediately call the ART on ext. 2222. An ART call should be made for a patient where the NEWS2 score has increased to a 7 or more or if there are significant clinical concerns.

4.2.8 All staff should use this policy and Nervecentre in conjunction with their clinical judgement. If at any point you are concerned, have a question or need further support contact CCOT, HOOHP or a doctor directly via switch or Vocera.

4.3 The HCSW/Student Nurse/ Nursing Associate is responsible for:

4.3.1 Ensuring that they are competent/ confident in the undertaking and recording of observations and that they have completed all the associate competency packages.

4.3.2 Immediately informing the Registered Nurse if a patient has a raised NEWS2 score (3 in 1 parameter or an aggregated score of 5,6,7 or above) or if they or a relative are concerned about a patient.

4.3.3 Ensuring that observations are completed in a timely manner.

4.4 The Clinical Team is responsible for:

4.4.1 The overall management of the patient during working hours. Where relevant and appropriate, they are ultimately responsible for seeking a review by other specialists.

4.4.2 Clearly documenting and conveying the patient's on-going Management Plan to the ward staff. When documenting a Management Plan the following should be considered: triggers for escalation, observation frequency, ceiling of treatment, ReSPECT and resuscitation status.

4.4.3 In line with this policy, the expectation is that where the doctor reviewing the patient has concerns or is unable to resuscitate and stabilise the patient they seek urgent help from a senior colleague.

4.4.4 When an urgent senior review is required (due to clinical concerns or a new NEWS2 of 7 or above) and the senior clinician is not immediately available then an ART call would be appropriate (See ART section 4.8). Any patient who is seen by the ART must be reviewed by the Parent Team within 24hrs of the ART call.

4.4.5 In order for a rapid response to deteriorating patients, any patient outlying in a different speciality should be reviewed by the most immediately accessible doctor to prevent a delay in patient care.

4.4.6 If a patient has exceptions to NEWS2 parameters that should be followed, these should be clearly documented in the medical notes in the form of a Management Plan following consultation with the Speciality Registrar. Management Plans must state the specific individual patient parameters that the nurses should follow and who the Nurse should involve in the patient's escalation pathway.

4.5 On Call Teams are responsible for:

4.5.1 Out of hours the care of the patient reverts to the On Call Speciality Team. The On Call Teams assume the responsibilities as described above for the Parent Team.

4.5.2 Ensuring that they make themselves available to the HOOHP, log into Nervecentre and respond appropriately (be aware that this may include seeing patients within a different speciality depending on work load).

4.5.3 If the clinician is likely to be unavailable to HOOH due to other commitments (e.g. emergency theatre) then they should ensure the HOOHP is made aware (via Vocera) prior to commencing this commitment.

4.5.4 For additional support (between 08:00-23:30) contact CCOT.

4.6 The Critical Care Outreach Team (CCOT) is responsible for:

4.6.1 Providing specialist advice, support and treatment to the deteriorating patient (within the King's Mill site only) 24hrs a day seven days a week, including weekends and bank holidays.

4.6.2 Any patient that deteriorates and has a NEWS2 of 5 or 6 should be escalated to CCOT via Nervecentre. If a patient has a NEWS2 of 7 or above they should be escalated to CCOT directly (via Vocera or bleep.888) and via the Nervecentre device (see Appendix 1a and Appendix 1b).Using clinical judgement if any concerns contact CCOT directly.

4.6.3 CCOT can be contacted at any time during their working hours for advice or support regardless of the patients NEWS2 score.

4.6.4 Any phone calls to CCOT must follow a structured SBAR referral (see appendix 7). Dependent on the clinical situation CCOT will then; provide phone advice, undertake a clinical review or suggest an ART call.

4.6.5 When performing a clinical review on a deteriorating patient CCOT will:

- Perform a thorough review of the patient's history.
- Perform a thorough physical examination using an ABCDE or system based approach.
- Document the examination, outcome and advice within the medical notes.
- Where appropriate, recommend that a doctor reviews the patient's observation parameters, frequency of observations, ceiling of treatment, ReSPECT and resuscitation status in the form of a clearly documented Management Plan within the medical notes.

4.7 Hospital Out of Hours Practitioner (HOOHP) is responsible for:

4.7.1 The triaging and prioritisation of all requests for assistance, treatment or care raised by ward areas on the HOOH electronic system (17:00-08:00, Monday to Friday and 24 hours Saturday, Sunday and Bank Holidays) and the delegation of these tasks to the most appropriate team member via Nervecentre.

4.7.2 Any patient that deteriorates and has a NEWS2 of 5 or 6 should be escalated to HOOHP via Nervecentre. If a patient has a NEWS2 of 7 or above they should be escalated to HOOHP directly (via Vocera or bleep.620) and via the Nervecentre device (see Appendix 1a and Appendix 1b).

4.7.3 Any phone calls to the HOOHP must follow a structured SBAR referral (see appendix 7). Dependent on the clinical situation HOOHP will then; provide phone advice, undertake a clinical review or suggest an ART call.

4.7.4 Attending all ART calls.

4.7.5 Mentoring, supporting and educating nursing staff and junior doctors.

4.7.6 The HOOHP will be the designated Advanced Life Support (ALS) qualified senior nurse on the Resuscitation Team.

4.7.7 The HOOHP can be contacted at any time during their working hours for advice or support regardless of the patients NEWS2 score.

4.7.8 See the Hospital Out of Hours Policy for further information.

4.8 The Acute Response Team (ART) is responsible for:

4.8.1 Reviewing the patient's clinical condition and documenting a clear Management Plan in the medical notes. This may include, but not exclusively, a set of clearly documented clinical interventions and on-going Management Plans, review of treatment of care and resuscitation status.

4.8.2 During the daytime (08:00-17:00) any patient who deteriorates requiring an ART call must be reviewed/ stabilised and then discussed with the responsible Medical Team and Parent Consultant. The ART must discuss the patient with the relevant Speciality Registrar who should contact the on call Consultant as required. All patients requiring an ART call must be reviewed by the Parent Team within 24hrs.

4.8.3 Where the Parent Consultant or Speciality Registrar or above is available or already reviewing the patient or if a Management Plan is in place within the medical notes then an ART call is not mandated.

4.8.4 The responsibility for the on-going medical management of the patient lies with the Parent Team once initial stabilisation has been achieved.

4.9 The Cardiac Arrest Team is responsible for:

4.9.1 Reviewing and assessing the patient's clinical condition following the Advanced Life Support (ALS) algorithm and providing a clear Management Plan that must be documented within the medical notes. This may include, but not exclusively, a set of clearly documented clinical interventions and on-going treatment plans, review of ceilings of treatment, ReSPECT and resuscitation status.

4.9.2 During the daytime (08:00-17:00) any patient who deteriorates requiring a cardiac arrest call must be reviewed/ stabilised and then discussed with the responsible Medical Team and discussed with the Parent Consultant. Out of hours the Cardiac Arrest Team must discuss the patient with the relevant Speciality Registrar who should contact the on call consultant as required.

4.9.3 The responsibility for the on-going medical management of the patient lies with the Parent Team once initial stabilisation has been achieved.

5.0 APPROVAL

Following appropriate consultation this policy has been approved by the Trust's Documentation Group.

6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

6.1 Observations

6.1.1 The National Early Warning Score (NEWS2) is the physiological track and trigger score currently in use to identify deterioration in adult patients across the Trust.

6.1.2 On arrival to the Trust, all patients must have their vital signs performed and a NEWS2 score calculated and recorded.

6.2 Frequency of Observations

6.2.1 For the first 24 hours of admission patients must have a minimum of 4 hourly observations. Following that, if the NEWS2 score is 0, the minimum frequency of observations is 12 hourly at the Kings Mill Site and a minimum of once every 24 hours at Newark and Mansfield. If the NEWS2 score is elevated, then the observation frequency must be increased accordingly. See Appendix 1a, Appendix 1b, Appendix 2, Appendix 3 and Appendix 4 for further guidance on the frequency of observations when the NEWS2 score is above 0. For areas utilising Nervecentre the observation frequency will automatically be dictated in accordance with the appendix flow charts.

6.2.2 It is important to note that the patient's specific condition, intervention and care needs may dictate the frequency of observations outside of this policies guidance. Therefore it is essential that local/ specific policies, procedures and care plans are utilised in conjunction with this policy. This includes (but not exclusively):

- Acute Pancreatitis in Adult Inpatients - initial management Guidelines
- Head Injury Policy
- Post-operative Observations (see appendix 6 of this policy).
- Patient Controlled Epidural Analgesia (PCEA) in Adults and the associated care plan.
- Policy for Fentanyl Patient Controlled Analgesia - Adult Patients and the associated care plan
- Policy for Morphine Intravenous Patient Controlled Analgesia - Adult Patients and the associated care plan
- Day Case Unit Specific Nursing Care Pathways (Available on the Royal Marsden, click here)

6.2.3 To ensure patient safety when commencing or titrating medication, it is important to consult the BNF and the UCL Injectable Guidelines ('blue book') as these may dictate the frequency of observations or the monitoring equipment required (e.g. Cardiac Monitoring) outside of this policies guidance.

6.2.4 If staff have clinical concerns, irrespective of the NEWS2 score the frequency of observations should be increased as appropriate to the clinical concern. The increased frequency should be either manually set on Nervecentre or documented on the front of the paper observation chart by the Registered Nurse.

6.2.5 If the patient's Management Plan within the medical notes dictates the frequency of observations to be outside of NEWS2 and Nervecentre guidance (less frequently), observations on Nervecentre should be 'skipped' in accordance with the Management Plan and the option 'Agreed plan documented in notes' selected. If paper charts are in place, the frequency should be stated on the front of the observation chart and the reasoning explained within the nursing evaluation. The Registered Nurse is encouraged to use their professional judgement and perform more regular observations if they feel the patient's condition warrants.

6.2.6 If a patient is recovering from an acute deterioration, be aware that they are more susceptible to further deterioration. A high level of vigilance is encouraged to monitor the patient and it may be appropriate to continue more frequent observation outside of NEWS2/ Nervecentre guidance.

6.2.7 Only patients who are expected to die and where routine observations (set out in NEWS2) are not required as part of their care should be excluded from having observations recorded. As part of dying, it is not unreasonable for staff to perform an observation if it helps with symptom control and the patient's management, e.g. a temperature may be taken so an anti-pyretic can be administered to maintain comfort or oxygen saturation may be taken to guide staff. This is in line with the Trusts Last Days of Life for Adults Policy. You should consider if the patient is suitable for the end of life model on Nervecentre (see 6.9 for further information on End of Life).

6.2.8 Patients with a DNACPR but still for active treatment must still have their observations performed and be escalated as per this policy.

6.2.9 Patients who are receiving restrictive interventions and/or manual restraint e.g. mittens, must have their mandatory vital signs monitored before, during and after restraint in line with the Trust's Policy for The Use of Restrictive Practice for Adult Patients.

6.2.10 Patients who have been deemed to have capacity may in rare circumstances refuse for observations to be undertaken. In this circumstance, ensure the patient understands the importance and rationale for undertaking physiological observations. If the patient has capacity and still refuses, inform the Nurse in Charge and ensure that you clearly document the refusal on Nervecentre and/or in the nursing evaluation pages. If the patient does not have capacity, Mental Capacity Act (MCA) Policy.

6.3 Management Plan (Parameters/ Exceptions):

6.3.1 In some patients with multiple medical conditions and/ or chronic conditions the standard observation parameters may vary outside of NEWS2 guidance.

6.3.2 Any exceptions to individual patient parameters must be documented in the medical notes in the form of a Management Plan. This must be documented by a doctor following the consultation of a Speciality Registrar or above and verbally communicated to the Registered Nurse caring for the patient. A clear rationale and a date to be reviewed/ reconsidered must also be specified.

6.3.3 The newly defined observation parameters dictated within the Management Plan can be accepted as within normal range for the patient and therefore be considered to score a 0 for that parameter. If observations deteriorate outside of the specified ranges within the Management Plan then the score should reflect the standard NEWS2 guidance and be escalated in accordance with this policy. For example, if a Management Plan stated that a BP of 91-98 systolic was acceptable for the patient, the BP would score 0 and not require escalating. If the BP then dropped to 90/60, the usual NEWS2 score of 3 would apply as the BP is no longer within the parameters specified within the Management Plan and the patient should be escalated in line with this policy.

6.3.4 In order to follow the specified Management Plan within the medical notes, observations on Nervecentre may need to be de-toggled (see section 6.4 for further information) or skipped to ensure the correct escalation pathway and frequency of observations are followed.

6.3.5 Any patients with specific parameters should be highlighted during the ward handover processes and as part of Board Rounds.

6.4 De-escalation within Nervecentre:

6.4.1 In order to follow a specific Management Plan that has been documented in the medical notes, patient's observations can be de-toggled and therefore de-escalated when clinically indicated (see section 6.3 for further information on Management Plans).

6.4.2 The De-escalation of observations in accordance with the patients Management Plan within Nervecentre is completed by de-toggling a specific responder within the escalations page of Nervecentre (the page after inputting observations). The process of de-toggling prevents unnecessary automatic escalations to responders. See the Nervecentre De-escalating Observations user guide for further support. (See EOLC/Palliative care 6.10)

6.4.3 Only a Registered Nurse is able to de-toggle within Nervecentre. If a HCSW/ Student Nurse/ Nursing Associate is seeking authorisation for observations the Registered Nurse must de-toggle the observations if required before submitting the patient's observations.

6.5 **Sp02 Scale 2**

6.5.1 The Sp02 Scale 2 within the NEWS2 has been introduced to improve the ability to identify sick patients, and to reduce false alerts for those patients with chronic respiratory diseases including Chronic Obstructive Pulmonary Disease (COPD), who may normally have lower oxygen saturations. There is good evidence that those with COPD are at risk of oxygen toxicity, and that controlled oxygen (to target saturations of 88-92%) is associated with less morbidity and mortality in exacerbations than high flow oxygen without target saturations.

6.5.2 For those patients with or at risk of Hypercapnic Respiratory Failure, an appropriate clinician should decide if target saturations of 88-92% are appropriate. If appropriate, this target should be clearly documented within the patient's medical notes with an accompanying explanation of the reasoning for utilising this model. The patient can then be placed on the Chronic Respiratory Disease Model (CRDM) within Nervecentre.

6.5.3 The decision to use the CRDM within Nervecentre must be made by a competent clinical decision maker who is either a Registrar or above. A HOOHP or CCOT member can place the patient on the Nervecentre CRDM if a decision to use this model is clearly documented in the medical notes.

6.5.4 Staff should be aware that the NEWS 2 SpO2 Scale 2 (%) changes the associated scoring for the patient's oxygen saturations e.g. Sp02 of 88-92% will not trigger. See appendix 5 for further information regarding the associated scoring for Sp02 scale 2.

6.5.5 If the patient is not at risk of Hypercapnic Respiratory Failure the regular NEWS SpO2 scale 1 should be utilised.

6.6 **Urine output**

6.6.1 Urine output is not included in the NEWS2 score but is a mandatory observation.

6.6.2 Patients with a NEWS2 of 5 or higher must have a strict fluid balance maintained including all input and output. Catheterisation should be based on an individual assessment of the patient's condition and needs.

6.6.3 Any urine output less than 0.5ml/kg/hr for longer than 2 hours (if catheterised) or within 6 hours (if not catheterised) must be escalated to the ward doctor/ CCOT or HOOH unless a clear Management Plan is in place to address this. This may be a sign of significant underlying illness e.g. sepsis.

6.7 NEWS2 scores and actions

6.7.1 See flowcharts Appendix 1a / Appendix 1b – King's Mill Hospital, Appendix 2 – Mansfield Community Hospital, Appendix 3 – Newark Hospital, Appendix 4 – Emergency Department to understand the required actions based on the NEWS2 score.

6.7.2 This policy describes the immediate actions associated with an acute deterioration in a patient's clinical condition.

6.7.3 When a clinical review occurs, due to physiological deterioration, this should include:

- A thorough review of the history and physical examination using an ABCDE approach or system based approach.
- Formulation of a clear medical plan with appropriate investigations and interventions.
- Review of ceilings of treatment, ReSPECT and resuscitation status.
- Evidence of discussion/ involvement of senior colleagues where review occurs by junior staff.
- Clearly documented and communicated Management Plans for ward staff to follow in case of further deterioration or failure to respond to intervention.

6.8 Absence of response to an escalation

6.8.1 In the absence of a response (review or telephone advice as appropriate) from the Medical Team/ HOOH or CCOT within 30mins of the initial escalation then the relevant individuals should be re-contacted by the ward nurse via bleep or Vocera for CCOT (888)/ HOOH(620), Switch for Doctor) and the patient should be escalated to a more senior doctor. If a patient's NEWS2 score has deteriorated further since the initial escalation, then the next level of escalation should be based on the new NEWS2 score.

6.8.2 If there is no response from a responder and you are immediately concerned then immediately call the ART on ext.2222.

6.8.3 Any failure to respond to an escalation should be documented in the nursing evaluation and a Datix completed using one of the following categories deemed most appropriate:

1. Delay due to abnormal observations not escalated.
2. Failure to recognise deteriorating patient.
3. Actions—observations not acted upon.
4. Failure to record observations.
5. Failure to respond.

6.9 Critical Care Referral

6.9.1 Where indicated and appropriate a direct referral to the Critical Care Medical Team (bleep 269) should be made by the attending team.

6.9.2 An ART call or a review by a CCOT member does not automatically mean the patient has been referred to the Critical Care Medical Team. It is the responsibility of the Parent Team to directly refer the patient to the Critical Care Medical Team.

6.10 End of Life/Palliative Care

6.10.1 For many patients the intended purpose of this policy is to ensure there is adequate monitoring and escalation to provide active treatment/ care, but for other patients further treatment and care may be ineffective and often there has been a decision to offer best supportive and palliative care. (See de-escalation 6.4)

6.10.2 Where best supportive and palliative care is being offered, the monitoring of patients must change and be individualised to meet the patient's specific palliative needs and their priorities of care.

6.10.3 For patients in the last days of life, medical and nursing observations may not be required. This is supported by the Trusts clinical guidance referred to as the Red Bundle (see Last Days of Life for Adults Policy).

6.10.4 Where appropriate, a ReSPECT form should be completed and a ReSPECT Tag added to Nervecentre. Follow the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy for further information.

6.11 Escalation of an unwell/ deteriorating member of the public or patient within Out-patient Settings

6.11.1 If you are immediately concerned about an individual or the individual is unresponsive dial 2222 for support. If an individual is found outside of the hospital buildings, summon help locally; send someone inside to dial 2222, consider dialling 999 if ambulance support is required for transfer. When calling 2222, a request for an ART call or cardiac arrest needs to be specified to the operator.

6.11.2 Click here to see the Location of Resuscitation Trollies and the Areas they Serve.

6.11.3 For the KTC, Clinic areas, Plaster Room and Main Entrance follow the KTC Medical assistance Protocol If the individual is not within any of those areas follow the Medical Emergency Site Protocol.

6.11.4 If an individual attends an outpatient's appointment and is found to be unwell but assessed to not be in immediate danger, the patient should have a full set of observations documented on a paper observation chart. The patient should then be transferred to the Emergency Department with a staff member for further assessment and treatment.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 Compliance with this policy across the Trust will be monitored by the Critical Care Outreach Team, led by the Matron for Critical Care on a monthly basis via the Trust's electronic observation monitoring system (Nervecentre) and monthly via the Trust's nursing metrics audit. This data will be reviewed in respect of acuity and dependency scores (Association of UK University hospitals acuity and dependency audit/ Safer Nursing Care Tool) and CCOT daily activity.

7.2 Additional on-going monitoring in areas where poor compliance is identified will be developed with individual ward teams with support from the Head of Nursing and Matron for the respective area.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc.) and by who)**
Observations	Ward leaders and Matrons	AMAT	Monthly	Ward Assurance Meeting
Observations and escalations	Critical Care Matron & CCOT	Descriptive stats from CCOT & Nervecentre data	Monthly	Deteriorating Patient Group

8.0 TRAINING AND IMPLEMENTATION

The contents of this policy will be integrated into training programmes already provided across the Trust. Training includes:

- Acute Illness Management (AIMS) multidisciplinary course (monitored by the Resuscitation Team).
- Mandatory Trust training – Core Skills for Health Care Support Workers and Essential Skills for Registered Nurse/Registered Midwife/ Registered Mental Health Nurse (monitored by Training and Development Department and Ward and Department Leaders).
- Trust Induction training for all staff (monitored by Training and Development Department).
- Trust pain management study days (monitored by Pain Team).
- Nervecentre training - Provided at Trust Induction, by accessing Intranet User guides or by contacting Nervecentre directly via switch/ Vocera.

9.0 IMPACT ASSESSMENTS

9.1 This document has been subject to an Equality Impact Assessment, see completed form at Appendix 8.

9.2 This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 9.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

This policy has been developed with reference to the following guidance:

- British Medical Journal (BMJ, 2018). **Comparison of Early Warning Scores in patients with COPD Exacerbation:** DECAF and NEWS Score. Available at: https://thorax.bmj.com/content/74/10/941 [Accessed 10th March 2020].
- British Medical Journal (BMJ, 2010). **Effects of High Flow Oxygen on Mortality in Chronic Restrictive Pulmonary Disease patients in pre-hospital settings**. Available at: https://www.bmj.com/content/341/bmj.c5462 [Accessed 10th March 2020].
- Department of Health (DH, 2009). **Competences for recognising and responding to the acutely ill patient in hospital.** Gateway reference 11275.
- National Institute for Health and Care Excellence (NICE, 2007). **Acutely Ill Patients in Hospital. Recognition of and response to acute illness in adults in hospital. Clinical Guideline No 50.** Available at https://www.nice.org.uk/guidance/cg50 [last accessed 29 Aug 2019].
- National Institute for Health and Care Excellence (NICE, 2019). **Acute Kidney Injury: Prevention, Detection and management.** Available at https://www.nice.org.uk/guidance/ng148/chapter/Recommendations [Last accessed 4 March 2020].

- NHS Improvements (2018). **SBAR Communication Tool – Situation, Background, Assessment, Recommendation**. Available at https://improvement.nhs.uk/resources/sbar-communication-tool/ [Last accessed 29 Aug 2019].
- Resuscitation Council (2018). **The ABCDE Approach, Underlying Principles**. Available at https://www.resus.org.uk/resuscitation-guidelines/abcde-approach/ [last accessed 29 Aug 2019].
- Royal College of Physicians (RCP, 2017). **National Early Warning Score Second Edition (NEWS2)**. *Standardising the assessment of acute-illness severity in the NHS.* Available at https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2 [Last accessed 29 Aug 2019].

Related SFHFT Documents:

- Acute Confusion/ Delirium in Adults (including Rapid Tranquilisation) - Guideline for Detection and Management.
- Acute Kidney Injury (AKI) Guidelines for Adults: Early Identification and Management
- Acute Pancreatitis in Adult Inpatients - initial management Guidelines
- Cardiopulmonary Resuscitation (CPR) Policy (for Adult, Maternity and Paediatric Patients)
- Conscious Sedation Guideline (Adult Patients)
- Consent to Examination, Treatment and Care Policy
- Deprivation of Liberty Safeguarding Policy
- Head Injury Policy
- Hospital Out of Hours Policy
- Last Days of Life for Adult Policy
- Maternity Early Warning Scoring (MEWS) Guideline
- Mental Capacity Act (MCA) Policy
- Nervecentre Business Continuity Plans
- Nursing Care Pathway for Patients Undergoing General Surgery Procedures
- Oxygen Policy - Prescription, Administration and Monitoring of Oxygen Therapy in Adults
- Patient Controlled Epidural Analgesia (PCEA) in Adults (non-obstetric) Policy
- PCA Policy – Administration of Morphine, Fentanyl or Oxycodone via an Intravenous (IV) Patient Controlled Analgesia (PCA) System in Adults Policy
- Positive Identification of Patients Policy
- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy
- Restraint and Restrictive Practices for Adult Patients Policy
- SEPSIS Guideline - Recognition, Diagnosis and Early Management

11.0 KEYWORDS

Track and Trigger Score; Vital Signs; NEWS; NEWS2; National Early Warning Score; Ward Based Care; post-operative patient monitoring; Observation; Escalations; Deterioration.

12.0 APPENDICES

Appendix 1a Escalation of Observations Flowchart for Adult In-Patients – for King's Mill Site ONLY ***09:00-17:00.***
Appendix 1b Escalation of Observations Flowchart for Adult In-Patients – for King's Mill Site ONLY ***17:00-09:00.***
Appendix 2 Escalation of Observations Flowchart – for Mansfield Site ONLY.
Appendix 3 Escalation of Observations Flowchart – for Newark Site ONLY.
Appendix 4 Escalation of Observation Flowchart – For The Emergency Department ONLY.
Appendix 5 NEWS2 Score.
Appendix 6 Post-Operative Patient Monitoring for Adult Surgical In-Patients.
Appendix 7 SBAR Communication Tool.
Appendix 8 Equality Impact Assessment Form.
Appendix 9 Environmental Impact Assessment Form

Appendix 1a

09.00–17.00 Mon–Fri
Excluding bank holidays

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Escalation of Observation Flowcharts – For King's Mill Site ONLY

High Risk

NEWS2: 7 or above
Or significant clinical concerns

Is this patient for Ward based care?

Yes

Emergency Action!
- Registered Nurse to review patient and medical notes.

If appropriate:
- Escalate to NIC via Nervecentre.
- Escalate to Ward Doctor via Nervecentre.

For immediate review ART call 2222

No

Emergency Action!
- Escalate to NIC via Nervecentre.
- Immediately inform Speciality Reg via Nervecentre.
- Immediately bleep CCOT on 888.

For immediate review ART call 2222

Outcome:
- Response time - immediate.
- Clearly document management plan, ceiling of care and review patients resuscitation status.
- Where appropriate failure to respond to treatment within 2 hrs after treatment commenced demands urgent discussion with responsible consultant and where appropriate referral to Critical Care (bleep 269).

Observation Frequency:
Minimum 30 minutes
Commence urine output monitoring

Medium Risk

NEWS2: 5 or 6

Is this patient for Ward based care?

Yes

Urgent Action!
- Registered Nurse to review patient and medical notes.

If appropriate:
- Escalate to NIC via Nervecentre.
- Escalate toWard Doctor via Nervecentre.

No

Urgent Action!
- Registered Nurse to review patient and medical notes.
- Escalate to NIC via Nervecentre.
- Escalate toWard Doctor via Nervecentre.
- Escalate toCCOT via Nervecentre.

Outcome:
- Response time 30 minutes.
- Review/ discussion must be documented in medical notes.
- Failure of NEWS2 to improve after 2 hours since treatment commenced must be escalated to Speciality Registrar or above and CCOT.
- Speciality Registrar or above is responsible for ensuring patient is discussed with the relevant consultant and where appropriate Critical Care Doctors (Bleep 269).

Observation Frequency:
Minimum 1 hourly
Commence urine output monitoring

Low-Medium Risk

NEWS2:
Single parameter of 3

Urgent Action!
- Registered Nurse to review patient and medical notes.
- Escalate to NIC via Nervecentre.
- Escalate to Ward Doctor via Nervecentre.

Outcome:
- Response time 30 minutes.
- Review by Ward Doctor who will further escalate if concerned and documented in medical notes.
- Re-escalate if patient not reviewed in 30minutes.

Observation Frequency:
Minimum 1 Hourly
Commence urine output monitoring

Low Risk

NEWS2: 0-4

If no clinical concerns continue routine observations
OR
If clinically concerned escalate to NIC/ Ward Doctor via Nervecentre

Outcome if action required:
- Review by Ward Doctor if required and clear management plan documented in medical notes.
- Re-escalate If patient not reviewed by Ward Doctor within 1 hour.

Observation Frequency:
0 Score = Minimum 12 hourly
1-2 Score = Minimum 6 hourly
3-4 Score = Minimum 4 hourly
First 24 hours of admission = 4 hourly

If urine output less than 0.5ml/kg/hr for more than 6 hours (or 2hrs if catheterised) escalate to doctor/CCOT or HOOH

Appendix 1b

17.00–09.00 Mon–Fri
Including weekends and bank holidays

* 08:00-09:00 bleep SHO3 via switch

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Escalation of Observation Flowcharts – For King's Mill Site ONLY

High Risk

NEWS2: 7 or above
Or significant clinical concerns

Is this patient for Ward based care?

Yes

Emergency Action!
- Registered Nurse to review patient and management plan

If appropriate:
- Registered Nurse to review patient and medical notes
- Escalate to NIC via Nervecentre
- Immediately inform HOOH/ on call Registrar*

For immediate review ART call 2222

No

Emergency Action!
- Registered Nurse to review patient and management plan

If appropriate:
- NIC via Nervecentre
- Immediately inform HOOH/on call Registrar*
- Escalate via Nervecentre 24/7

For immediate review ART call 2222

Outcome:
- Response time - immediate
- Clearly document management plan, ceiling of care and review patients resuscitation status
- Where appropriate failure to respond to treatment within 2 hrs after treatment commenced demands urgent discussion with responsible consultant and where appropriate referral to Critical Care (bleep 269)

Observation Frequency:
Minimum 30 minutes
Commence urine output monitoring

Medium Risk

NEWS2: 5 or 6

Is this patient for Ward based care?

Yes

Urgent Action!
- Registered Nurse to review patient and management plan

If appropriate:
- Escalate to NIC via Nervecentre
- Escalate to HOOH/SHO*

No

Urgent Action!
- Registered Nurse to review patient and management plan

If appropriate:
- Escalate to NIC via Nervecentre
- Escalate to HOOH/SHO*
- Escalate via Nervecentre 24/7

Outcome:
- Response time 30 minutes
- If no response and immediately concerned call ART on ext.2222
- Review/ discussion must be documented in medical notes
- Failure of NEWS2 to improve after 2 hours since treatment commenced must be escalated to Speciality Registrar or above and CCOT
- Speciality Registrar or above is responsible for ensuring patient is discussed with the relevant consultant and where appropriate Critical Care Doctors (Bleep 269)

Observation Frequency:
Minimum 1 hourly
Commence urine output monitoring

Low-Medium Risk

NEWS2:
Single parameter of 3

Urgent Action!
- Registered Nurse to review patient and management plan

If appropriate:
- Escalate to NIC via Nervecentre
- Escalate to HOOH/ SHO*

Outcome:
- Response time 30 minutes
- Review by Ward Doctor who will further escalate if concerned and documented in medical notes
- Re-escalate if patient not reviewed in 30minutes

Observation Frequency:
Minimum 1 Hourly
Commence urine output monitoring

Low Risk

NEWS2: 0-4

If no clinical concerns continue routine observations
OR
If clinically concerned escalate to NIC and HOOH/SHO*as appropriate

Outcome if action required:
- Reviewed by Ward Doctor and clear management plan documented in medical notes
- Re-escalate If patient not reviewed by Ward Doctor within 1 hour

Observation Frequency:
0 Score = Minimum 12 hourly
1-2 Score = Minimum 6 hourly
3-4 Score = Minimum 4 hourly
First 24 hours of admission = 4 hourly

If urine output less than 0.5ml/kg/hr for more than 6 hours (or 2hrs if catheterised) escalate to doctor/CCOT or HOOH

Appendix 2

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Escalation of Observation Flowcharts – For Mansfield Site ONLY

High Risk

NEWS2: 7 or above
Or significant clinical concerns

Emergency Action!
- Registered Nurse to urgently review patient
- Escalate to NIC via Nervecentre
- 08:00-17:00 (Mon-Fri) immediately phone the ward Doctor
- Out of hours including weekends and bank holidays immediately phone out of hours GP
- Contact Buddy Ward

Call 9(999) for ambulance transfer to KMH

Outcome:
- Response time within 30 minutes
- Transfer to KMH where appropriate

Observation Frequency:
Minimum 30 minutes
Commence urine output monitoring

Medium Risk

NEWS2: 5 or 6

Urgent Action!
- Registered Nurse to urgently review patient
- Escalate to NIC via Nervecentre
- 08:00-17:00 (Mon-Fri) inform the ward Doctor via Nervecentre
- Out of hours including weekends and bank holidays phone out of hours GP

(9)999 ambulance call if appropriate for urgent transfer to KMH

Outcome:
- Response time 30 minutes
- Review/ discussion must be documented in medical notes
- Transfer to KMH if appropriate

Observation Frequency:
Minimum 1 hourly
Commence urine output monitoring

Low-Medium Risk

NEWS2:
Single parameter of 3

Urgent Action!
- Registered Nurse to review patient
- Escalate to NIC via Nervecentre
- 08:00-17:00 (Mon-Fri) inform the wards Doctor via Nervecentre
- Out of hours including weekends and bank holidays phone out of hours GP

Outcome:
- Response time 30 minutes
- Review by Doctor/ACP who will further escalate if concerned and document in medical notes
- Re-escalate if patient not reviewed in 30minutes

Observation Frequency:
Minimum 1 Hourly
Commence urine output monitoring

Low Risk

NEWS2: 0-4

Is Action required?
Score 0 – Continue with routine observations
Score 1-4 – Registered nurse to review patient and consider if increased frequency of monitoring and/ or escalation of patient required

Outcome if action required:
- 08.00-17.00 (Mon-Fri) Phone ward Doctor
- Out of hours including weekends and bank holidays phone out of hours GP

Observation Frequency:
0 Score = Minimum 24 hourly
1-2 Score = Minimum 6 hourly
3-4 Score = Minimum 4 hourly

00 21/1808

Appendix 3

Sherwood Forest Hospitals
NHS Foundation Trust

Escalation of Observation Flowcharts – For Newark Site ONLY

High Risk

NEWS2: 7 or above
Or significant clinical concerns

Emergency Action!
- Registered Nurse to urgently review patient
- Escalate to NIC via Nervecentre
- 08:00-19:00 (Mon-Fri) immediately bleep ward doctor
- Out of hours including weekends and bank holidays immediately call UCC doctor

Call 9(999) for EMAS ambulance transfer to KMH.
If EMAS can't respond call Ambicorp (01623 880988) for an urgent transfer

Cardiac Arrest: Call 2222

Outcome:
- Response time within 30 minutes
- Transfer to KMH where appropriate

Observation Frequency:
Minimum 30 minutes
Commence urine output monitoring

Medium Risk

NEWS2: 5 or 6

Urgent Action!
- Registered Nurse to urgently review patient
- Escalate to NIC via Nervecentre
- 08:00-19:00 (Mon-Fri) inform ward doctor through Nervecentre
- Out of hours including weekends and bank holidays call UCC doctor
- Consider early transfer to KMH site through discussion with intensivist on ICU (Contactable through switchboard)

Outcome:
- Response time 30 minutes
- Review/ discussion must be documented in medical notes
- Transfer to KMH if appropriate

Observation Frequency:
Minimum 1 hourly
Commence urine output monitoring

Low-Medium Risk

NEWS2:
Single parameter of 3

Urgent Action!
- Registered Nurse to review patient
- Escalate to NIC via Nervecentre
- 08:00-19:00 (Mon-Fri) inform ward doctor via Nervecentre
- Out of hours including weekends and bank holidays call UCC doctor

Outcome:
- Response time 30 minutes
- Reviewed by Doctor and clear management plan documented in medical notes
- Re-escalate if not reviewed/ discussed in 30 minutes

Observation Frequency:
Minimum 1 Hourly
Commence urine output monitoring

Low Risk

NEWS2: 0-4

Is Action required?
Score 0 – Continue with routine observations
Score 1-4 – Registered nurse to review patient and consider if increased frequency of monitoring and/ or escalation of patient required

Outcome if action required:
- 08:00-19:00 (Mon-Fri) inform ward doctor
- Out of hours including weekends and bank holidays call UCC doctor

Observation Frequency:
0 Score = Minimum 24 hourly
1-2 Score = Minimum 6 hourly
3-4 Score = Minimum 4 hourly

Appendix 4

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Escalation of Observation Flowcharts – For The Emergency Department ONLY

High Risk

NEWS2: 7 or above
Or significant clinical concerns

Emergency Action!
- Registered Nurse to review patient and medical notes
- Escalate to NIC
- Escalate to responsible clinician, consultant in charge or middle grade or above in charge overnight

Transfer to Resus

Outcome:
- Response time within 30 minutes
- Discussion with consultant/ middle grade or above
- Clearly document management plan, ceiling of care and review patients resuscitation status
- Consider referral to speciality registrar and on call ED anaesthetist at earliest opportunity

Observation Frequency:
Minimum 30 minutes
Commence urine output monitoring

Medium Risk

NEWS2: 5 or 6

Urgent Action!
- Registered Nurse to review patient and medical notes
- Escalate to NIC
- Escalate to responsible clinician, consultant in charge or middle grade or above in charge overnight

Consider transferring patient to Resus

Outcome:
- Response time 30 minutes
- Review/ discussion must be documented
- Failure of NEWS2 score to improve after treatment commenced must be escalated to consultant in charge/ middle grade or above in charge if they are not the responsible clinician
- Consider presenting problem; increased frequency of observations may be required due to trauma, interventions or rapidly changing conditions

Observation Frequency:
Minimum 30 minutes
Commence urine output monitoring

Low-Medium Risk

NEWS2:
Single parameter of 3

Urgent Action!
- Registered Nurse to review medical plan
- Escalate to NIC
- Escalate to responsible ED clinician

Outcome:
- Response time 30 minutes
- Review by Doctor/ACP who will further escalate if concerned and document in medical notes
- Re-escalate if patient not reviewed in 30minutes

Observation Frequency:
Minimum 1 Hourly
Commence urine output monitoring

Low Risk

NEWS2: 0-4

If no clinical concerns continue routine observations
OR
If clinically concerned escalate to:
- Registered nurse who will review patient and medical plan
- NIC
- Responsible clinician, consultant in charge or middle grade or above in charge overnight

Outcome if action required:
- Reviewed by Doctor/ACP if required and clear management plan documented in medical notes
- Re-escalate If patient not reviewed within 1 hour
- Consider presenting condition as more frequent observations may be required

Observation Frequency:
0 Score = Observations to be repeated prior to discharge/ transfer to ward or if any change in condition
1-4 Score = Observations to be repeated **within the first 2hrs of arrival and before** discharge/ transfer to ward or if change in condition

00 21/1808

Appendix 5

NEWS2 Score:

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≤96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≤93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Appendix 6

Post-operative patient monitoring for Adult Surgical In-Patients:

This post-operative patient monitoring procedure directs the measurement of patient vital signs for the first six hours on return to the ward after surgery. All other areas including Day Case and Endoscopy should follow Day Case Surgical Pathways. For General Surgery patients please also refer to: Nursing Care Pathway for Patients Undergoing General Surgery Procedures.

1. Immediately on return to the ward: Complete a full set of mandatory vital signs:

- Respiratory rate (RR)
- Oxygen saturations (SpO2)
- Inspired O2
- Blood pressure (BP)
- Heart rate (HR)
- Urine output
- Level of Consciousness using ACVPU
- Temperature (T)
- Pain score
- Bowels

Compare this initial set of vital signs with those performed pre-operations and in recovery and check for improvement or deterioration.

Repeat these initial observations **every 30 minutes for 2 hours** and escalate any concerns according to the Observations and Escalation Policy.

In addition to vital signs, **carry out surgery-specific observations** including:

- Wound site
- Wound drainage and record on fluid balance chart
- Urine output and record on fluid balance chart
- IV fluid administration
- Blood glucose levels
- Nausea

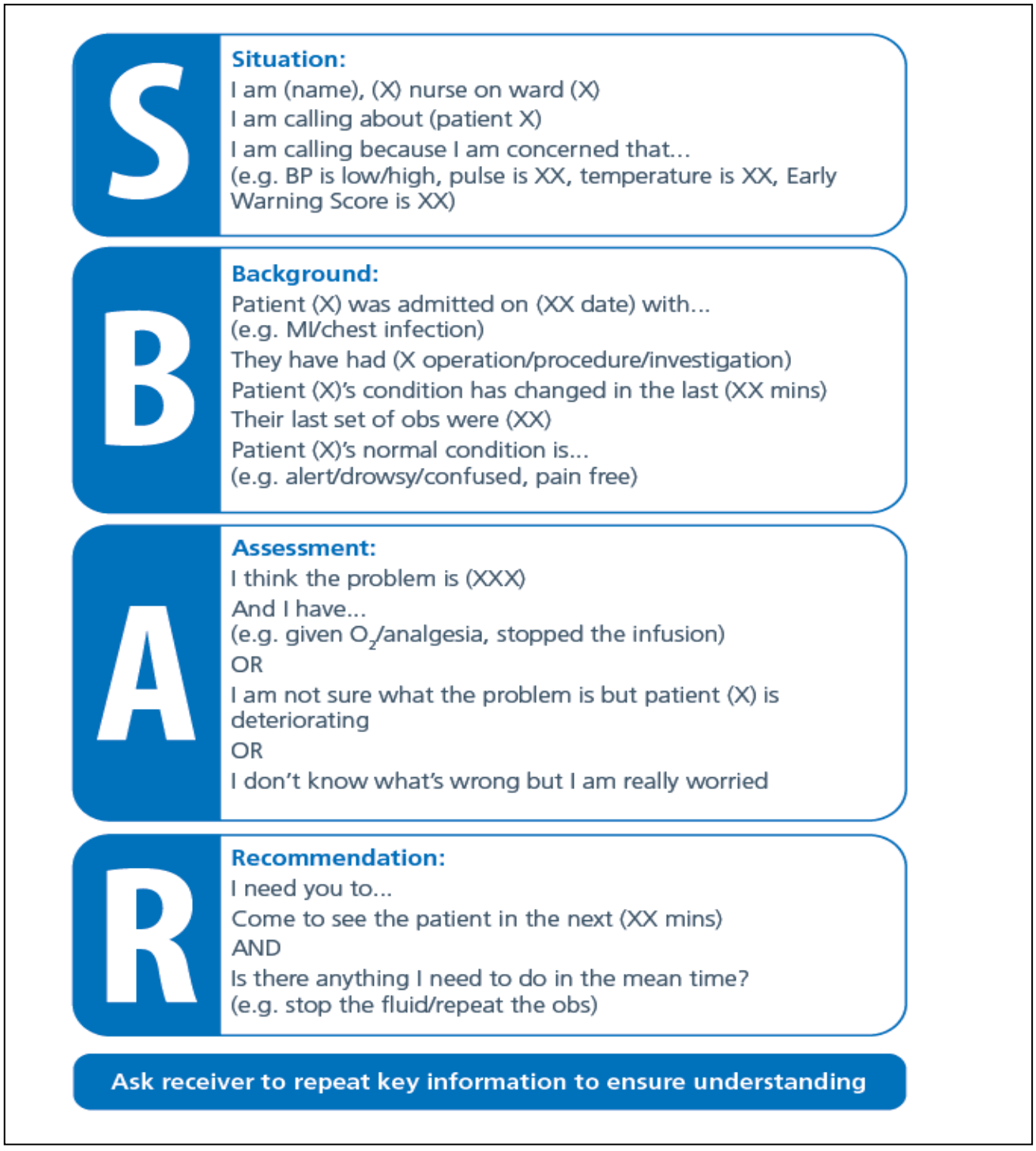
2. After 2 hours of 30 minute observations* (if the cumulative NEWS2 is ≤4and there is no single parameter score of 3) reduce the frequency of observations to **hourly.**
Escalate according to the Observations and Escalation Policy.
*Day surgery patients may have observations discontinued sooner if all discharge criteria have been achieved – refer to Day Surgery guidance.

3. After 4 hours of hourly observations (if the cumulative NEWS2 is ≤4 and there is no single parameter score of 3) reduce observations further to be in line with the Observations and Escalation Policy. From this point onwards the frequency of observations is guided by the NEWS2 score.

Please note: The NEWS2 score is only one indicator of the patient's physiological status. Please make a comprehensive assessment of the patient throughout their recovery period and, if in doubt, escalate any patient you are worried about.

Appendix 7

SBAR Communication Tool:



APPENDIX 8 – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Observations and Escalation Policy for Adult Patients			
New or existing service/policy/procedure: Existing			
Date of Assessment: 28th April 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	Clear guidelines in terms of implementing the policy	None
Gender	None	Clear guidelines in terms of implementing the policy	None
Age	Paediatric and neonatal Patients are excluded from this policy.	See PEWS Escalation.	None
Religion	None	Clear guidelines in terms of implementing the policy	None
Disability	None	Clear guidelines in terms of implementing the policy	None
Sexuality	None	Clear guidelines in terms of implementing the policy	None
Pregnancy and Maternity	Maternity patients are excluded from this policy.	See Maternity Early Warning Scoring (MEWS) Guideline.	None
Gender Reassignment	None	Clear guidelines in terms of implementing the policy	None
Marriage and Civil Partnership	None	Clear guidelines in terms of implementing the policy	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Clear guidelines in terms of implementing the policy	None

What consultation with protected characteristic groups including patient groups have you carried out? • End user staff groups, Nursing and Midwifery Board, Specialist Teams and Deteriorating Patient Group.
What data or information did you use in support of this EqIA? • Reviewed in line with national guidance
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • No
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: **Low Level of Impact** For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment Alison Davidson
Signature: **A.Davidson**
Date: 28th April 2023

APPENDIX 9 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No No No	NA
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No No	NA
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No No No	NA
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No No No	NA
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	NA
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	NA