

OBSERVATIONS AND ESCALATION POLICY FOR ADULT IN-PATIENTS AREAS

		POLICY	
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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, Clinical 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: Airway Breathing Circulation Disability Exposure Visit the Resuscitation Council's website for further information.
ACVPU	This tool is used to rapidly assess the level of consciousness where the patient is identified as A – Alert C – New onset Confusion or delirium V – responding to Verbal stimuli only P – responding to Painful stimuli only or U – Unresponsive 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 Tranquillisation) - Guideline for Detection and Management for further information on confusion/ delirium).
ART	The Acute Response Team 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 Critical Care Outreach Team 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 (DNAR – this may also appear as)	Do Not Attempt Cardio-Pulmonary Resuscitation 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).
Last Days 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 cale 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	Nursing Associate – This role is designed to bridge the gap between CSW'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.
CSW	Clinical Support Worker'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	Hospital Out of Hours (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 Hospital Out of Hours Practitioner (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/ Individualised 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 (SpO2) • 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	Nurse In Charge.
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 Registered Nurse who is registered with the Nursing & Midwifery Council.
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment. (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.
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 (up to 15L/min) oxygen therapy via non-re-breathe mask .
Resident 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. , ACCU 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 line with escalation frequency within Nervecentre.
- 4.2.4 Ensuring that Nervecentre electronic handover is completed and up dated 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 Individualised Management Plan within the medical notes or clinical judgement rationale of which must be documented within the medical notes (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 CSW. However, the Registered Nurse remains accountable for ensuring that observations are recorded accurately and where required are escalated or de-toggled according to the patient's Individualised Management Plan. If the NEWS2 is found to be elevated (3 in 1 parameter or an aggregated score of 5 and above) the Registered Nurse must review . The physical and clinical condition of the patient and document in the medical and nursing notes. NEWS2 above 5 must be completed by the Registered Nurse, until the condition and observations return below NEWS2 5.
- 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 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 (out of hours) or a doctor directly (in hours) via switchboard.

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 (3 in 1 parameter or an aggregated score greater than 5) or if they or a relative are concerned about a patient.

4.3.3 Observations should be completed in line with escalation frequency.

4.4 The Clinical Team is responsible for:

4.4.1 The overall management of the patient during working hours (Monday to Friday, 8am – 5pm). Where indicated by NEWS2 or Individualised Management Plan, 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 an Individualised Management Plan the following should be made explicit: 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 Senior Responsible Clinical team following the Ward Board Round 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 must ensure the HOOHP is made aware (the HOOHP's mobile -07917407232 or bleep 620) prior to commencing this commitment.
- 4.5.4 For additional support () contact CCOT 24/7.

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

- 4.6.1 Providing specialist advice and support to the clinical MDT (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 (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 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.
- 4.6.4 When performing a clinical review on a 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.
- 4.6.5 Hyperlink for the ACCU admitting policy

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 above should be escalated to HOOHP via Nervecentre, if there is no management plan, or any deviation from the management plan. If a patient has a NEWS2 of 7 or above they should be escalated to HOOHP directly (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 can be contacted at any time during their working hours for advice or support regardless of the patients NEWS2 .
- 4.7.7 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 or the Speciality team during the weekend or Bank Holiday.
- 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/Speciality 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 according to the Advanced Life Support (ALS) guidelines..
- 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 CLEAR Group and Clinical Reference 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 used to monitor all 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 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 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 Hospitals. If the NEWS2 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 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 \(Available on the Royal Marsden, click here\)](#)
- Tracheostomy / Laryngectomy ('neck breathers') – Care of Adult Patients Policy

- 6.2.3 To ensure patient safety when commencing or titrating medication, it is important to consult the BNF and the NHS Injectable Medicine Guide (Medusa)) as these may dictate the frequency of observations or the monitoring equipment required (e.g. Cardiac Monitoring) outside of this policies guidance. Any deviation of the guidelines/ polices will be documented and should be made within the patient's notes.
- 6.2.4 If staff have clinical concerns, irrespective of the NEWS2 the frequency of observations should be increased as appropriate to the clinical concern. The increased frequency should be either manually set on Nervecentre, and documented in the patient's notes.
- 6.2.5 If the patient's Management Plan within the medical notes dictates the frequency of observations to be outside of policy (less frequently), observations on Nervecentre should be 'skipped' in accordance with the Management Plan and the option 'Agreed plan documented in notes' selected. 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 expected 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 Trust's [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 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](#).
- 6.2.9 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 patient's notes. If the patient does not have capacity, [Mental Capacity Act \(MCA\) Policy](#).

6.3 Management Plan (Parameters/ Exceptions):

- 6.3.1 Any exceptions to individual patient parameters must be documented in the patient's 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.
- 6.3.2 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 Individualised 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 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.
- 6.3.3 In order to follow the specified Management Plan within the patient's 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.

- 6.3.4 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 CSW/ 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 SpO2 Scale 2

- 6.5.1 The SpO2 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. SpO2 of 88-92% will not trigger. See [appendix 5](#) for further information regarding the associated scoring for SpO2 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 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

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 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 Trolleys 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; ART call; alert; acute response team;

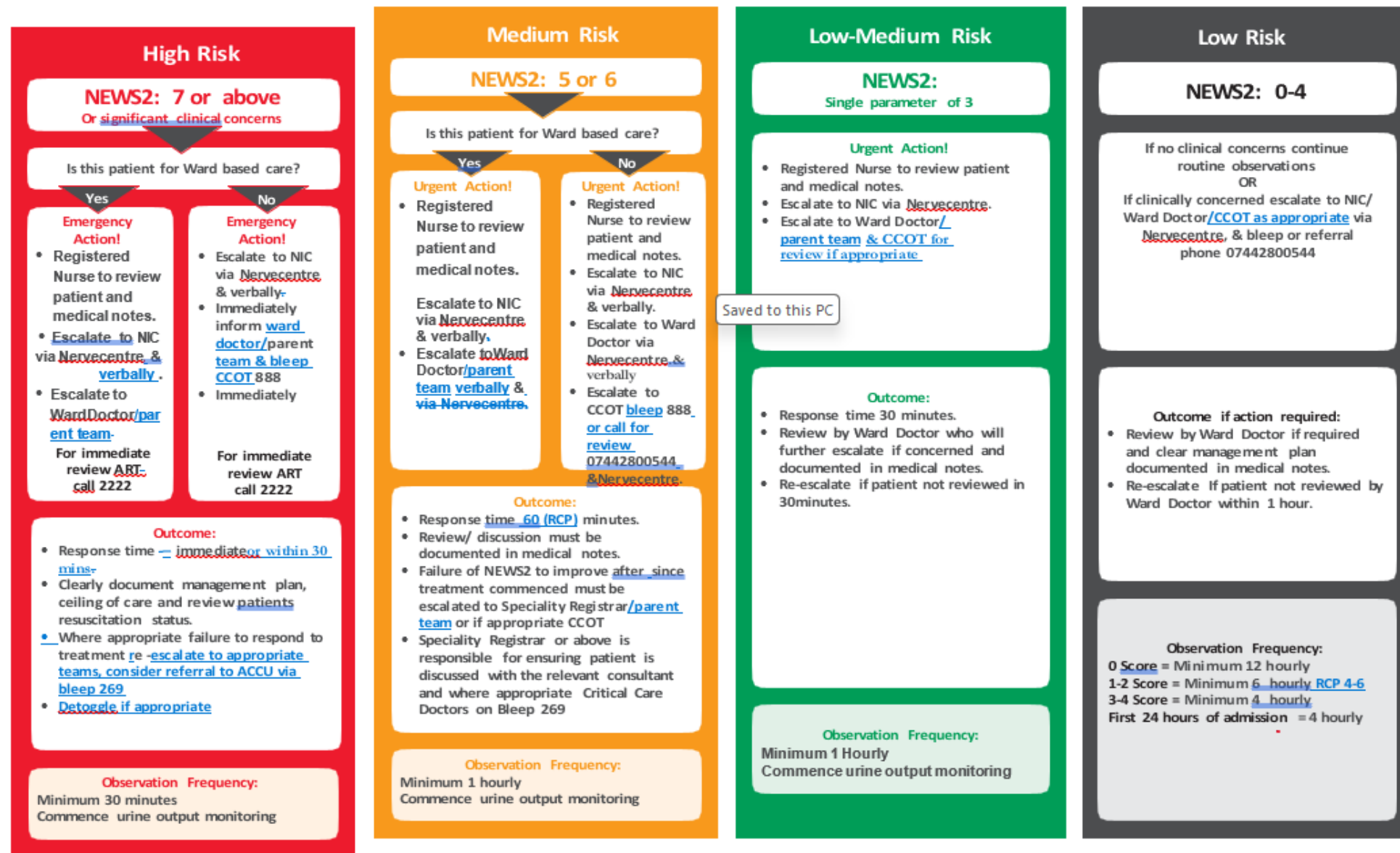
12.0 APPENDICES

- [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

Escalation of Observation Flowcharts – For The Emergency Department ONLY

0001/1000

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



Escalation of Observation Flowcharts – For Mansfield Site ONLY



Escalation of Observation Flowcharts – For Newark Site ONLY



Appendix 5

NEWS2 Score:

Physiological parameter	3	2	1	Score 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 ≤ 4 and 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 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:

S	Situation: I am (name), (X) nurse on ward (X) I am calling about (patient X) I am calling because I am concerned that... (e.g. BP is low/high, pulse is XX, temperature is XX, Early Warning Score is XX)
B	Background: Patient (X) was admitted on (XX date) with... (e.g. MI/chest infection) They have had (X operation/procedure/investigation) Patient (X)'s condition has changed in the last (XX mins) Their last set of obs were (XX) Patient (X)'s normal condition is... (e.g. alert/drowsy/confused, pain free)
A	Assessment: I think the problem is (XXX) And I have... (e.g. given O ₂ /analgesia, stopped the infusion) OR I am not sure what the problem is but patient (X) is deteriorating OR I don't know what's wrong but I am really worried
R	Recommendation: I need you to... Come to see the patient in the next (XX mins) AND Is there anything I need to do in the mean time? (e.g. stop the fluid/repeat the obs)
Ask receiver to repeat key information to ensure understanding	

APPENDIX 8 – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) form

EIA form stage 1:

NAME of EIA Assessor: Yvonne Simpson		Date of EIA completion: 24 November 2025
Department: Corporate		Division: Trust-wide
Name of service/policy/procedure being reviewed or created:		Observations and Escalation Policy for Adult Patients
Name of person responsible for service/policy/procedure:		Yvonne Simpson – Corporate Director of Nursing
Brief summary of policy, procedure of service being assessed: The policy provides guidance on the recording of observations, escalations of observations and the roles and responsibilities within the teams.		
Please state who this policy will affect: Patients, staff,		
Protected characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.
Race & Ethnicity	No	This policy is for all adult inpatients
Sex	No	As above
Age	No	As above
Religion & Belief	No	As above
Disability	No	As above
Sexuality	No	As above
Pregnancy & Maternity	Yes	There is a link within the policy to direct the reader to the policy relating to Maternity

		Escalations as this is different due to the parameters .				
Gender reassignment	No	This policy is for all adult inpatients				
Marriage & Civil Partnership	No	As above				
Socio-Economic factors	No	As above				
What consultation with protected characteristic groups including patient groups have you carried out? There was a discussion with the Women & Children division on whether there would be a benefit on keeping all observation and escalation policies together, but following discussion at CIEAR group it was felt that this would not be appropriate.						
As far as you are aware are there any Human Rights issues to be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? None						
On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality? (delete as appropriate)						
Positive			Negative			
High	Medium	Low	Nil	Low	Medium	High
If you identified positive impact, please outline the details here:						

EIA Form stage 2:

If you have answered 'yes' to any of the above in stage 1, please complete Stage 2 of the EIA

Protected Characteristic	Please explain, using examples of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.	Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.
Race and Ethnicity		
Gender		
Age		
Religion		
Disability		
Sexuality		
Pregnancy and Maternity		
Gender Reassignment		
Marriage and Civil Partnership		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)		

Signature: Yvonne Simpson – Corporate Director of Nursing
Date: 18/8/2025

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