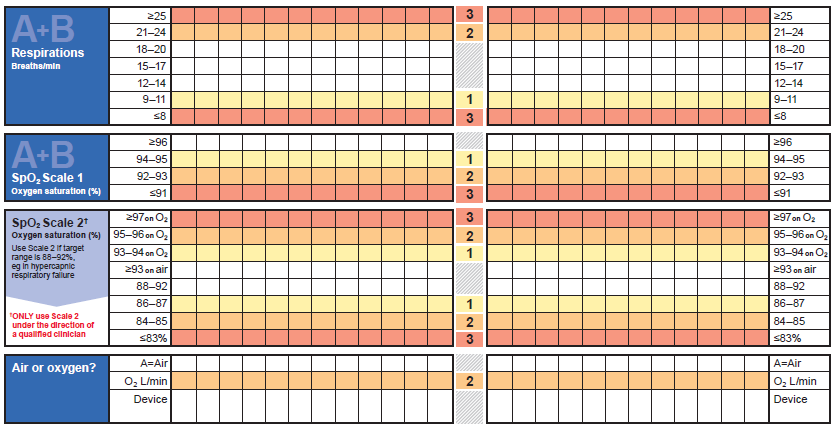
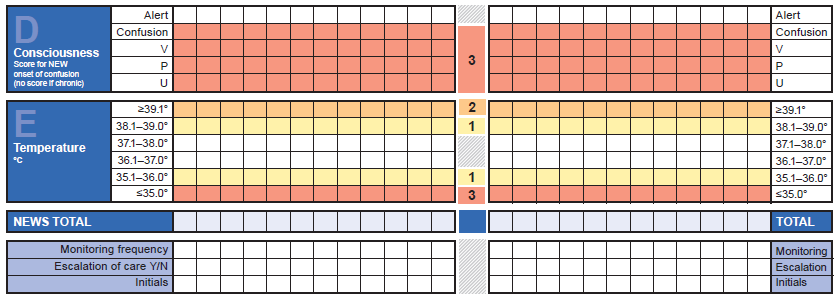
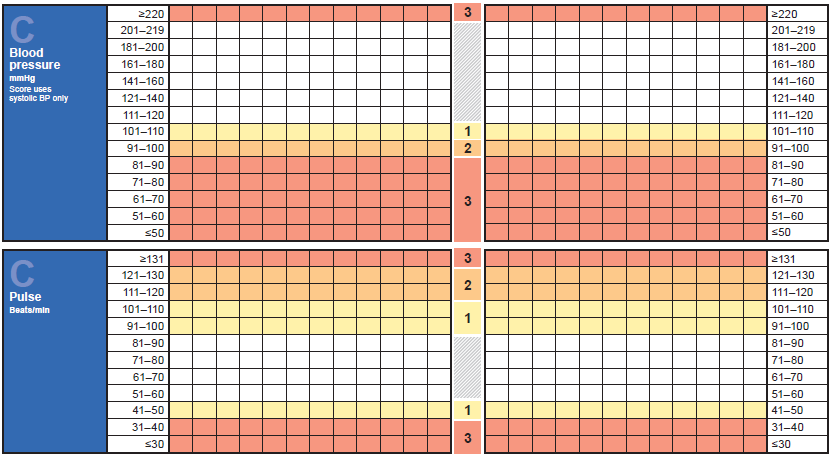
**NEWS2 RT Protocol- Physical Health Observations**

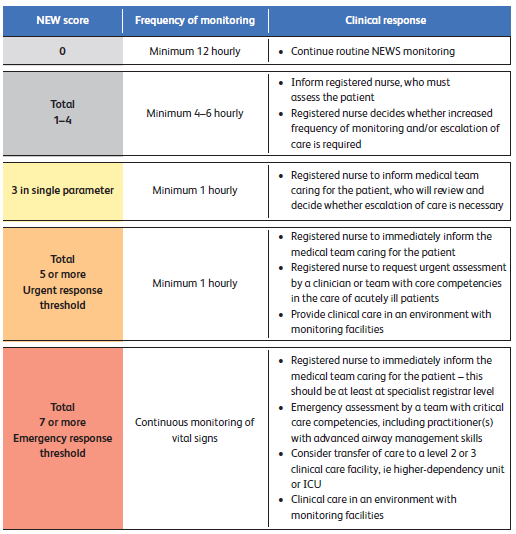


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| --- |
| **Frequency: EVERY 15 MINUTES, FOR AT LEAST ONE HOUR.** Further monitoring beyond 1 hour should be considered if deemed clinically appropriate (scoring is **above 3** for single parameter or **total above 4**). |
| **If you are unable to carry out Physical Health observations, or the patient refuses you must complete Non-Contact Observations of respiratory rate and level of consciousness using AVPU and record these on this chart.** |









n their clinical judgement.

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| --- | --- | --- | --- |
| **NEWS** | **Frequency of Monitoring** | **Clinical Response** | **Variants - Patient Specific** |
| **0** | Routine monitoring of physical observations | * Continue routine NEWS monitoring with every set of physical health observations | Please specify frequency of monitoring physical observations: |
| **Total score 1 - 4 (if 3 in one parameter, see below)** | Twice daily physical observations & discuss with Medical Team | * Inform Registered Nurse who must assess the patient; * Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required; * Discuss with Medical Team / Out Of Hours *(guidance required)* |  |
| **SICK!**  **Total NEWS 5-6 or 3 in one parameter *Consider sepsis red flag signs*** | Increase frequency of physical observations to a minimum of 1 hourly & discuss urgently with the Medical Team. .............................................................  **SEPSIS RED FLAG SIGNS**  **S**lurred speech  **E**xtreme shivering/muscle pain  **P**assing no urine (in a day)  **S**evere breathlessness  **I** feel like I might die  **S**kin mottled/discoloured | * Registered Nurse to urgently inform the Medical Team caring for the patient. * Urgent assessment by Medical Team (give handover using the **\*SBARD tool**) * Assess if transfer of the patient is required * Consider 999 call for ambulance assistance if doctor is unable to assess within 20 minutes / or if concerns remain over the patient’s Physical Wellbeing. * **• CONSIDER SEPSIS SCREENING TOOL** |  |
| **ACT NOW!**  **Total NEWS 7 or more** | Continuous monitoring of patient’s Physical Observations & Initiate an emergency call | * Registered Nurse to **immediately** inform the Medical Team caring for the patient – again out of hours; * 999 call for emergency ambulance assistance to transfer patient to the nearest District General Hospital * Contact patient’s Consultant / nominated Deputy * **CONSIDER SEPSIS SCREENING TOOL** |  |

**Escalation Protocol SBARD**

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| --- | --- | --- |
| **S**  **Situation** | Your name / designation / ward The patient’s name is .. I am concerned because … The NEWS score trigger is. | |
| **B**  **Background** | Treatment Date  Brief history Admission Date MHA Status Medication / therapy | |
| **A**  **Assessment** | A  Airway | Is the patient talking? Any airway noises; e.g. gurgling/stridor |
| B  Breathing | Respiratory Rate (RR)? Any respiratory noises e.g. wheeze? Is breathing laboured? Oxygen saturation levels (SpO2)? |
| C  Circulation | Heart Rate (HR)? Capillary Refill Time (CRT)? Blood Pressure (BP)?  Temperature? |
|  | D  Disability | Level of consciousness (AVPU)? Blood sugar levels? Pupil reactions? |
| E  Exposure | Exposure & environment Bleeding / rashes, etc.? Any other abnormal signs? |
|  |  |
| **R**  **Recommend** | I would like you to do /What would you like me to do? | |
| **D**  **Decision**  **\*Use SBARD Tool (above) to notify Medical Team** | Record what has been agreed on the patient’s notes. | |