Reference Number: 502 **Version Number:** 1	**Date of Next Review:** 7 March 2026 **Previous Trust/LHB Reference Number: N/A**

Deteriorating Patient Policy

Policy Statement

The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating patients so that immediate and appropriate review can be obtained. This policy is therefore aimed at all clinical staff employed within Cardiff and Vale UHB, who are specifically involved in the delivery of care to adult patients cared for in an emergency and ward environment within the UHW and UHL (including MHSOP, Hafan Y Coed and Llanfair Unit).

Policy Commitment

The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating Adult patients so that immediate and appropriate review can be obtained**.**

Supporting Procedures and Written Control Documents

This Policy and the Resuscitation Procedure describe the following with regard to Adult Deteriorating Patients.

Other supporting documents are:

Current NEWS charts (for Adult Patients)

-

Scope

This policy applies to all of our staff in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment has been completed. A Health Impact Assessment (HIA) has not been completed.

Health Impact Assessment	A Health Impact Assessment (HIA) has been completed
Policy Approved by	RADAR – Recognition of Acute Deterioration and Resuscitation Committee and Clinical Effectiveness Committee. Quality Safety and Experience Committee on 7th March 2023
Group with authority to approve procedures written to explain how	

this policy will be implemented	
Accountable Executive or Clinical Board Director	

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	07th March 2023	01.12.2023	
2			

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Executive Summary

Physiological observations are fundamental to the identification of a patient's health status. They provide a baseline that facilitates the early identification of clinical deterioration through which it is possible to improve patient mortality outcomes (National Patient Safety Agency, 2007). Within all healthcare environments the monitoring, measurement, interpretation, and prompt response to physiological observations is one of the core roles undertaken by appropriately educated nurses, healthcare assistants and medical staff: this is relevant in all acute hospital settings (UHW, UHL including Mental Health Services for Older People (MHSOP), Hafan y Coed and Llanfair Unit). However, evidence suggests that the recognition of the deteriorating patient may be delayed if observations are not recorded and if abnormal observations are not acted upon and communicated effectively (National Patient Safety Agency, 2007, National Institute of Clinical Excellence, 2007, and Institute for Health Improvement, 2010).

Guideline 50: Acutely Ill Patients in Hospital (NICE, 2007), advocates the use of a "track and trigger" system. Such systems use an aggregated weighted scoring system for each of the core physiological elements of patient observation i.e. blood pressure, pulse, temperature, respiration, oxygen saturations etc. The culminating total of the sub scores provides an indication of the patients overall clinical health status at that time, and therefore acts as a trigger for taking appropriate intervention.

The National Early Warning Score (NEWS) "track and trigger" system was developed as part of the National 1000 Lives+ patient safety initiative and replaces all previous versions found in Cardiff and Vale University Health Board (UHB)

The overriding ethos of NEWS is to provide a simple physiological scoring system that can easily be calculated at the patient's bedside. The system uses parameters which are measured routinely for all adult inpatients and can be used quickly to identify patients who are clinically deteriorating and require urgent intervention. The graded scoring system (Appendices1,2,3 and 4- NEWS Flowchart) informs of the actions that must be taken in accordance with the score as indicated, such as timeframes for review by the Patient at Risk Team / or doctors. However, it should be noted that due to the complexity of clinical assessment and appropriate treatment according to

individual patient need, this policy and its supporting documentation is unable to provided explicit guidance in terms of the specific clinical intervention that should be taken. It does however; provide explicit guidance on accessing prompt and appropriate clinical assessment, through the implementation of a JUMP CALL pathway (Appendix 5) which empowers junior staff to escalate non-compliance when clinicians who are part of the escalation process fail to attend patient's needs.

This pivotal role of the multidisciplinary team in recording, monitoring and responding to changes in the deteriorating patient's physiological observations has been acknowledged in a number of key evidence-based publications published within the last few years. The culminating 1000 lives campaign document "Rapid Response to Illness" (IHI, 2010), combines recommendations from "NICE 50: Acutely Ill Patients in Hospital (2007)", and "Competencies for Recognising and Responding to Acutely Ill Patients in Hospital (Department of Health 2009)" thereby providing a framework for patient safety and quality that ensure patients are appropriately reviewed by appropriately trained and competent staff within a safe and appropriate time frame, which as such forms the basis of this policy.

Scope of Policy

This policy does not apply to the monitoring of children or obstetric patients. However, the policy acknowledges that occasionally young adults aged between 16 – 18 are placed in acute environments, only in such cases would this policy apply. This policy also does not apply patients within General Intensive Care, Cardiac Intensive Care, Maternity Services, Coronary Care Unit and Theatres; although a NEWS score should be undertaken prior to step down to a ward level bed. Due to the diversity of disease and the complexity of clinical assessment it is beyond the scope of this policy to provide an exhaustive reference source on the clinical management of patients. The scope of this policy is specifically to facilitate the prompt identification of clinically deteriorating patients so that immediate and appropriate review can be obtained.

This policy is therefore aimed at all doctors, registered nurses, healthcare assistants and Allied Healthcare Professionals employed within Cardiff and Vale UHB, who are specifically involved in the delivery of care to adult patients cared for in an emergency and ward environment within the UHW and UHL (including MHSOP, Hafan Y Coed and Llanfair Unit).

Essential Implementation Criteria

The policy specifically provides a framework through which clinicians are informed of their responsibilities in relation to: -

- The minimum standards for monitoring patient's physiological observations.
- Recording and communicating the results of the monitoring of such physiological observations
- Recording and communicating the results of the monitoring of such physiological observations
- The minimum actions and referral route that must be taken in accordance with the NEWS scoring system
- The maximum timeframe within which escalation and review of deteriorating patients must occur

Aims

The policy aims to ensure that all patients cared for within the aforementioned environments receive the appropriate level of physiological observation and subsequent care. This should be aligned with the Treatment Escalation Plan (TEP) which MUST be completed for EVERY patient on admission. The TEP identifies, for all adult patients the level of care for the individual in the event of their deterioration. Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) decisions should also be clearly documented and communicated as per the All Wales policy.

Policy Statement

These Core Standards are applicable for all patients admitted into acute inpatient and emergency settings at UHW and UHL and Mental Health patients in MHSOP wards, Hafan y Coed and Llanfair Unit, and to all Health Board staff who are caring for them: -

If a patient refuses treatment, and / or the taking of physiological observations, then the risks of non-compliance must be explained to the patient.(See also the paragraph on Mental Capacity Act 2005 below). It is essential to be sure that the patient understands the risks and this should be documented and reported to both the nurse-in-charge and the doctor. If language poses a barrier to communication then the nurse/ doctor or allied healthcare professional (as appropriate) must ensure that interpretation/translation services are offered to the patient and/ or relative and provided as required. Reasonable adjustment will be made for disabled patients/carers to ensure equality of communication and policy implementation.

Exploration of underlying causation, and escalation, should be taken if a patient who refuses physiological and / or neurological observations has:-

- received a head injury prior to, or during their period of hospital admission, or
- previously complied with treatment and the taking of such observations
- started acting out of character

Where there is reason to doubt a patient's mental capacity to make a decision about having or not physiological/neurological observation, the Mental Capacity Act 2005 must be followed – see the UHB's Consent Policy to Examination or Treatment Policy for further details.

Minimum Standards for Monitoring Patients Physiological Observations

- A complete set of observations i.e. temperature, heart rate (pulse), blood pressure, respiration rate, pulse oximetry, and level of consciousness and pain assessment, will be undertaken within 1 hour of admission. Some patients may require lying and standing blood pressures. It is also a mandatory requirement to perform and record a one-off blood sugar at the point of admission for ALL patients. This will provide a baseline from which to prescribe nursing and medical interventions. However, it is recognised that more frequent monitoring of blood sugars will be required for those patients who are diabetic, or who are giving cause for concern.
- A complete set of observations (excluding blood sugars in non-diabetic patients) should also be recorded at the point of ward to ward transfers.
- Ward transfers should be clearly indicated on the NEWS observation charts and recorded within the documentation records.
- Glasgow Coma Score must be recorded dependent upon the individual presentation/clinical need. All patients who have sustained unwitnessed falls/ known head injuries either prior to admission, or during their period of hospital admission, must have the Glasgow Coma Score recorded in compliance with NICE 176: Head Injury: assessment and early management (2017). The Cardiff and Vale UHB Head Injury Pathway should also be followed.
- The NEWS protocol is clearly documented on the rear of the NEWS chart and must be complied with at all times.
- There is a NEWS Standard Operating Procedure (Appendix 6) that outlines the process of undertaking NEWS scores, frequency of scoring and escalation of care.
- All observations of pulse must include the palpation and recording of a radial pulse as a minimum standard in order to detect any irregularities such as fibrillation, doubling of beats etc which would not routinely be detected by mechanical devices.
- Respirations must be observed for one full minute. If the patient is in receipt of oxygen therapy the percentage of oxygen being administered must also be checked at source and documented on the observation chart.
- Monitoring equipment must be kept in good working order with regular planned

servicing and calibration in accordance with manufacturer's recommendations. Equipment must be available in a variety of sizes e.g. large blood pressure cuffs, in order to support accurate monitoring of patient's physiological observations.

- That appropriate infection control measures are taken to prevent/minimise the risk of cross infection.

Recording and Communicating the Results of the Monitoring of Physiological Observations

- Only documentation that has been supported by both the Executive Medical Director and the Executive Director of Nursing, and validated by the appropriate levels of consultation and ratification can be used within the Health Board. Amendments and modifications to the documentation must only be made with prior approval of both the Executive Medical Director and the Executive Director of Nursing Director.
- All patient documentation will evidence the following standards within the patient record: -
    - the exact time and date of the observations will be recorded on the NEWS chart
    - the NEWS score must be calculated correctly
    - the frequency of the observations will be notated on the NEWS chart based upon the patient's NEWS Score and the NEWS protocol described on the rear of the NEWS chart.
    - a record of the actions taken e.g. outreach referral, commencement or discontinuation of treatment regimes will be recorded in the patient's documentation. This should be documented on the SBARD document. A copy of which should be inserted into the patient's notes, and a second copy forwarded to the Resuscitation Service for audit purposes.
    - all entries on the observation chart will be signed
    - if observations are undertaken by unregistered staff then these must be counter-signed by a member of registered staff
    - All information will be recorded on authorised Health Board documentation
    - The observational results of all patients causing concern/ triggering on NEWS will be communicated to the nurse in charge of the patient or the Team Leader for onward escalation
    - All patients causing concern / triggering on NEWS will be

highlighted at the ward handover/ safety briefing.

- SBARD(Situation,Background, Assessment, Recommendation, Decisions) will be the format of choice for communicating information during the referral and escalation process.

- The Nurse in Charge must give consideration to contact the next of kin, or nominated family member/advocate if :-
  - the patient's condition gives significant cause for concern
  - the patient requires transfer to a higher level of care e.g. HDU, Theatre, ITU, specialist regional services e.g. Morriston
  - the deterioration is associated with a witnessed or unwitnessed fall.
  - The patient's death is considered imminent

- All communications with the patient's next of kin must be documented in the patients' health records noting: -
  - the date and time of the communication
  - mode of communication e.g telephone, face to face meeting
  - to whom the call was made
  - the detail of the conversation (using the SBAR format)
  - the outcome of the communication e.g. family travelling in to be with patient/ see doctors etc.
  - the name and designation of the staff member contacting the family

- On transfer to another ward or hospital, or discharge all documents pertaining to the patient i.e. medical / nursing records, prescription charts, observation/ NEWS charts, fluid and diet charts etc. must be filed securely within the patient's health records.

Minimum Actions and Referral Route that Must be Taken in Accordance with the NEWS Score

- Any patient who has either a perceived deterioration or who trigger the NEWS score will be referred for immediate review by an appropriately qualified healthcare professional as per NEWS flowchart (Appendix 1,2,3 and 4) i.e.:-
    - The NEWS score is 0 – 2 but the patient is showing cause for concern
    - The NEWS score is 3 – 6
    - The NEWS score is 6 – 8
    - The NEWS score is 9 or above
    - There is any concern about a patient who would not ordinarily trigger a response according to the NEWS protocols
- In order to document the requirement for escalation of care an SBARD form should be completed. A copy is placed in the patient notes and a copy returned to the Resuscitation Service for audit purposes.
- When a patient is causing concern, the appropriate clinician will be alerted immediately and attend the patient within the given timeframe as per NEWS flowchart. The name of the person who is being requested to attend, and the exact time that the request was made will be recorded within the patient record and dated and signed by the person making the referral
- Upon review, the clinician reviewing the patient, should sign the SBARD form to indicate that the patient has been reviewed and indicate the time of the review. The yellow copy should be sent to: The Resuscitation Service, Upper Ground Floor, Jubilee Courtyard, UHW, for audit purposes. The white copy should be filed in the patient's notes
- Any deviation/non-compliance with the time frames stipulated in the NEWS flowchart must result in a DATIX incident form being completed and the JUMP CALL (Appendix 5) pathway being immediately initiated.
- To ensure ongoing patient safety the clinician reviewing the patient will make an accurate and sufficiently detailed record within the patient notes that will include the following:-
    - Exact date and time that the patient was reviewed by the reviewing clinician.

- Signed and printed signatures including bleep numbers for all clinicians involved in the review. An accurate assessment of the patients presenting clinical condition, including differential diagnosis, and measurements as appropriate e.g.location of any lesions, dimensions etc.
- A sufficiently clear and detailed treatment/ action plan to facilitate the safe implementation of care / treatment interventions. Using upper and lower parameters of measurement, or clinical indicators for further escalation or clinical review e.g. the thresholds for systolic and diastolic blood pressure readings etc.
- The time of the next planned review (pending that there is no further deterioration or increase in the NEWS score within the interim).

- On transfer to another ward or hospital, or discharge all documents pertaining to the patient i.e. medical / nursing records, prescription charts, observation/ NEWS charts, fluid and diet charts etc must be filed securely within the patients health records.

Maximum Timeframe within which Escalation and Review of Deteriorating Patients Must Occur

Clinicians MUST respond and attend the patient within the timeframe as indicated within the NEWS flowchart.

- When a patient has been referred to a Clinician it is their responsibility to ensure that the patient is attended to within the required timeframe.
- If a Clinician is requested to attend but unable to do so they must immediately inform the referrer (usually the nurse in charge of the ward) who will then :-
  - document the reason for non-attendance within the patients case notes
  - escalate the referral to another appropriate Clinician. The handover should emphasise that the patent needs to be attended to and reviewed within the original timeframe as specified within the NEWS flowchart

Responsibilities

Individuals Undertaking, Monitoring and Recording the Observations of the Patient (including healthcare support workers and allied healthcare professionals**)**

It is the responsibility of the individual undertaking, monitoring and recording the observations of the patient to ensure that they make the Nurse in Charge of the shift aware of any limitations in his/her practice that would prevent them from safely discharging their duty of care to the patient e.g. unfamiliarity with equipment to be used, lack of training in taking observations, unfamiliar with documentation being used etc. Whilst of relevance to all healthcare staff in terms of accountability for commissions and omission in their practice this is of particular relevance to Registered Nurses and Doctors in terms of remaining accountable under their professional codes of conduct (NMC 2018 & GMC 2013).

ALL STAFF undertaking, monitoring and recording patient observations must ensure:-

- They have undertaken appropriate training and education to ensure that they are competent and capable of performing this role (including use of associated equipment).
- They understand the process for determining and recording the NEWS score and are compliant with the Core Standards as outlined in this policy: -
    - the exact time and date of the observations are recorded on the observation chart
    - that the NEWS score is calculated correctly
    - that a record of the actions taken is recorded.
    - that all entries on the observation chart are signed and countersigned
    - that the required frequency of observations is documented as a result of the NEWS score.
    - that the information is recorded on authorised Health Board documentation

That they immediately communicate to the Nurse in Charge (via the Team Leader if appropriate) for onward escalation any perceived deterioration in the patient, or NEWS score which indicates a deterioration, i.e:-

- The NEWS score is 0 – 2 but the patient is showing cause for concern
- The NEWS score is 3 – 6
- The NEWS score is 6 – 8
- The NEWS score is 9 or above
- There is any concern about a patient who would not ordinarily trigger a response according to the NEWS protocols

Registered Nurses / Doctors /Allied Healthcare Professional delegating the recording and monitoring of observations

Delegation of the task of taking patient observations must be according to the standards set out in the Nursing and Midwifery Council Code for Profession Practice ("The Code"), Health Care and Professions Council Standards of Conduct, Performance and Ethics (SCPE), or General Medical Council's Good Medical Practice. The Registered Nurse, Doctor or Allied Healthcare Professional delegating the recording and monitoring of observations to ensure:-

- That the person(s) to whom the task of recording and monitoring the observations has been delegated, is able to carry out the instructions to the required standards
- To ensure that junior staff/ team members are supported in performing the tasks required of them, and that they are able to do so within their individual level of competency and capability
- The confirmation and outcome
- That the observations are satisfactory and to ensure that the NEWS score is acted upon appropriately
- That subsequent actions are documented incorporating the standards of this policy.

- Where there is a delay in the attendance of the clinician, that the JUMP CALL pathway is initiated immediately and recorded appropriately within the patients nursing/medical record

Clinicians who are Instructed/Requested to Respond to a Deteriorating Patient / NEWS Score

It is the responsibility of the individual who is being requested to respond to a deteriorating patient / NEWS score to ensure that they make known to the Nurse in Charge of the shift and their line manager any limitations in his /her practice that would prevent them from safely discharging their duty of care to the patient. Whilst of relevance to all healthcare staff in terms of accountability for acts and omissions in their practice this is of particular relevance to Registered Nurses and Doctors in terms of remaining accountable under their professional codes of conduct (NMC 2018 & GMC 2013).

ALL STAFF responding to a deteriorating patient/ NEWS score must ensure:-

- They have undertaken appropriate training and education to ensure that they are competent and capable of performing this role (including use of associated equipment).
- They understand the process for by which the NEWS score has been determined and that they are compliant with the Core Standards as outlined in this policy.
- That they respond within the timeframe as indicated within the NEWS flowchart, and that timings are accurately documented in the patient's notes to reflect response times.
- When unable to attend due to competing pressures the Clinician must escalate this to another appropriate Clinician, emphasising the need to attend within the original timeframe as specified within the NEWS flowchart.
- The Clinician who is unable to attend must immediately inform the referrer (usually the nurse in charge of the ward) who will then document the reason for non-attendance within the patient's case notes.

- When responding to instructions/ requests to attend a deteriorating patient/ NEWS score then the actions taken and the actions prescribed must be both verbally communicated to the Registered Nurse caring for the patient and clearly recorded within the patients records as per Core Standards of this policy

Consultants/ Clinical Directors with Overall Clinical Responsibility for the Patient

The Consultant/Clinical Director with the overall clinical responsibility for the patient is accountable for the acts and omissions of care afforded to the patient over the period of admission. It is therefore the Consultants / Clinical Directors responsibility to ensure:-

- That doctors in training are knowledgeable and competent in the interpretation of physiological observations.
- That doctors in training are supervised to ensure that all patients have a documented plan for physiological monitoring that include the following:-
    - Exact date and time that the patient was reviewed by the reviewing clinical professional
    - Signed and printed signatures including bleep numbers for doctors and advanced nurse practitioners/ members of the PART Team
    - An accurate assessment of the patients presenting clinical condition, including differential diagnosis, and measurements as appropriate e.g. location of any lesions, dimensions etc
    - A sufficiently clear and detailed treatment/ action plan to facilitate the safe implementation of care/treatment interventions. Using upper and lower parameters of measurement, or clinical indicators for further escalation or clinical review e.g. the thresholds for systolic and diastolic blood pressure readings etc
    - The time of the next planned review (pending that there is no further deterioration or increase in the NEWS score within the interim)
    - That all members of the Consultants / Clinical Directors team understand their individual responsibilities in terms of responding to an instruction/ request to attend to a deteriorating patient / NEWS score within the given timeframe as specified within the NEWS flowchart and JUMPCALL pathways.

- Failure to comply with the NEWS flowchart and JUMPCALL pathway must result in a DATIX and appropriate actions initiated.

Ward/Departmental Managers and Senior Nurse Responsibilities

- It is the responsibility of Ward/Departmental Managers and Senior Nurses to ensure that within their areas of managerial accountability that:-
- Appropriate and Health Board compliant documentation is available for use by staff.
- A NEWS champion be appointed for each clinical area
- The required level of daily and bi monthly audit as outlined in this policy is undertaken and reported as part of the Quality Dashboard.
- An equipment inventory is maintained which details the asset number, dates of planned maintenance etc. as detailed within the Medical Equipment Management Policy (2015, UHB 082). Staff working within their area of managerial accountability are aware that they are responsible for ensuring :-
    - the prompt removal of defective equipment from respective clinical areas and ensuring that prompt arrangements are made for its repair or condemning as appropriate.
    - DATIX incident reports are initiated where defective equipment has impacted on patient care
    - That any deviation/non-compliance with the time frames stipulated in the NEWS flowchart must result in a DATIX incident form being completed and the JUMPCALL pathway being immediately initiated.
    - All members of the nursing team understand their individual responsibilities in terms of implementing the requirements of this policy.
    - Failure to comply with the NEWS flowchart and JUMPCALL pathway must result in a DATIX and appropriate actions documented and initiated.

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Patient Safety & Quality Leads (Nursing/Medical)

It is the responsibility of the Patient Safety & Quality Leads (Nursing/Medical), to ensure that systems and processes are in place to ensure that :-

- Members of the Nursing and Medical Teams are aware of their responsibilities as outlined in this policy
- Resources and deficits in service provision are managed and escalated appropriately in order to ensure the safe and effective delivery of care within the Clinical Boards and are included within the Risk Register as appropriate
- Incidents arising from a failure to appropriately implement this policy, the NEWS flowchart and JUMPCALL pathway are escalated to the Patient Quality and Safety Team, and Executive Medical Director/ Executive Director of Nursing for information and support as appropriate.
- Incidents arising from a failure to appropriately implement this policy, the NEWS flowchart or JUMP CALL pathway are investigated appropriately so that lessons can be learnt feedback and shared across the Health Board and wider health community as appropriate.
- Professionally accountable individuals who fail to implement the requirements of this policy, the NEWS flowchart and JUMP CALL pathway are investigated under the disciplinary rules if considered appropriate by the Executive Professional Lead and/or the educational supervisor.

Executive Medical Director and Executive Director of Nursing

It is the responsibility of the Executive Medical Director and Executive Director of Nursing to ensure that: -

- Services provided within the Health Board and its composite areas are fit for purpose, providing safe and effective care which is patient centered and evidence based
- Processes and systems are in place to ensure that documentation associated with the implementation of this policy i.e. Observation charts, NEWS score charts, NEWS flowchart and JUMPCALL pathway are those approved by the Health Board.
- The Patient Safety team will oversee the investigation of Serious Incidents i.e. Red Concerns that arise from a failure to implement this policy, NEWS flowchart and JUMPCALL pathway, and to support the implementation of arising recommendations.

Training

- The induction programme for all clinical staff (nurses, doctors and health care support workers) will include awareness raising to this policy, the NEWS flowchart and JUMPCALL pathway.
- Training of staff takes account of the need to comply with all legislation regarding all minority groups.
- All staff using equipment must be trained and instructed in its use, demonstrating their competency and capability to use the equipment for its intended purpose.
- NEWS champions will receive specific training from the Resuscitation Service in order to perform audits and ensure compliance of NEWS protocols

- During the induction period of all new staff, mentors must ensure that all newly registered nurses and health care assistants are competent undertaking the basic physiological observations outlined in the Core Standards of this policy using both electronic and manual means of observation where appropriate e.g. electronic devices which read the pulse and digital palpation of the radial pulse.
- Newly registered staff must be assessed by their preceptor.
- Deficiency in competency and capability in registered staff and health care assistants must be dealt with by the ward / departmental manager.
- Student Nurse and Medical Students undertaking observations must be assessed by their mentor using the appropriate university competency document. Deficiencies must be fed back to the university link tutor and recorded in the practice book.
- A Database for all training undertaken regarding equipment for observations must be maintained by the Ward/ Departmental Manager.
- Any revisions to the policy or adaption of the NEWS flowchart, JUMPCALL pathway must be communicated to all doctors, registered nursing staff and health care assistants. Monitoring and Effectiveness

Audit

The ward /departmental manager or NEWS champion will undertake NEWS audits using the associated audit tool via Tendable at the required frequency.The results of audits will be forwarded to the Resuscitation Service for collation of data regarding NEWS compliance.

The Resuscitation Service has overall responsibility for the auditing of all 2222 calls, including those generated by deteriorating patients.

The Resuscitation Service also conduct audits of standards on NEWS charts to ensure that NEWS protocols are followed.

Results of audits will be fed back to Clinical Boards via the Patient Safety and Quality Frameworks of the Health Board. The Resuscitation Committee (RADAR) will oversee implementation of the policy and associated audits.

References

Cardiff and Vale University Health Board, Medical Equipment Management Policy 2015, Ref UHB 082

http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/18%20%283b

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Appendices

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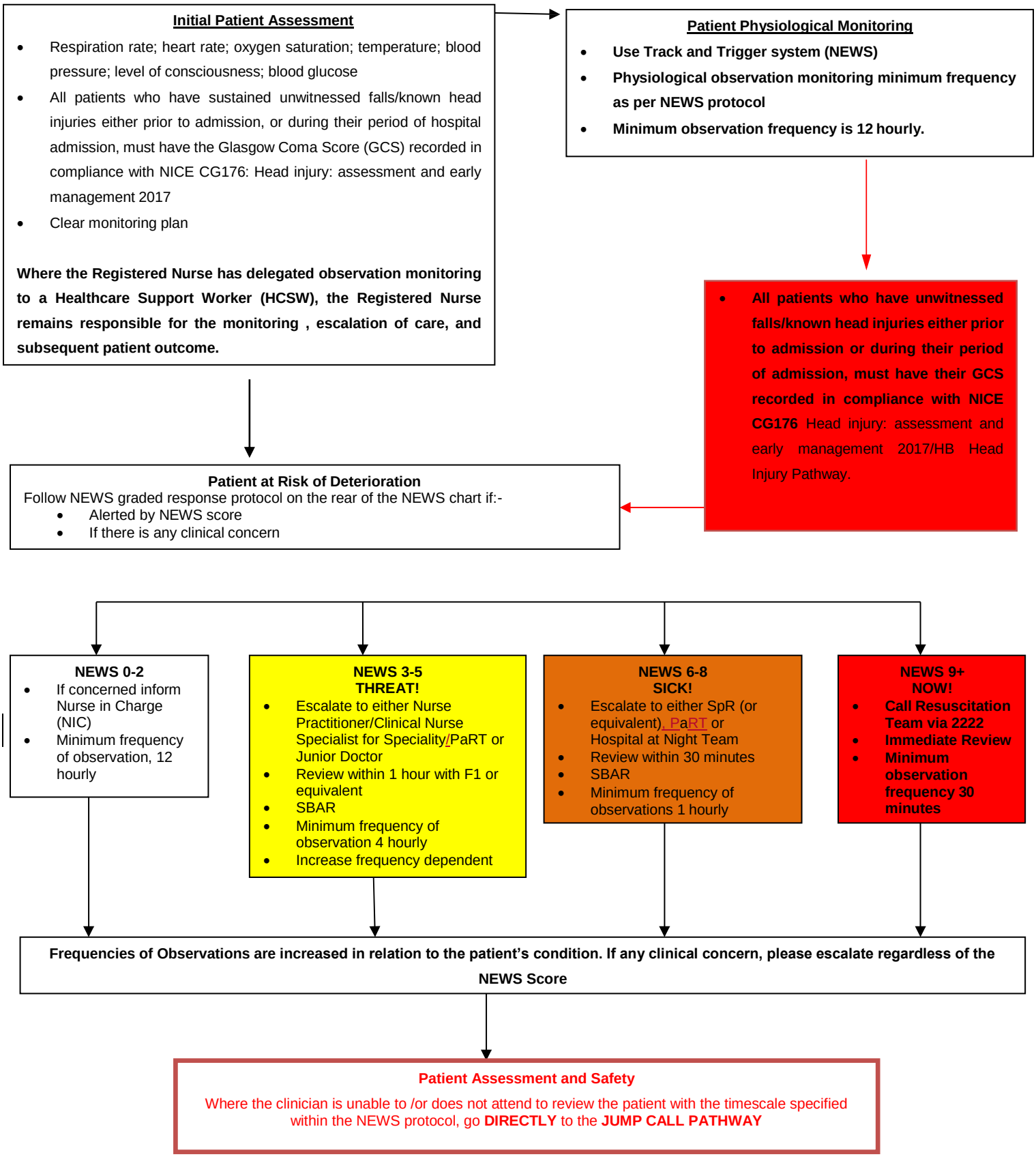
Appendix 1 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Acute Hospital (UHW/UHL)



Appendix 2 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Acute Mental Health

Initial Patient Assessment

- Respiration rate; heart rate; oxygen saturation; temperature; blood pressure; level of consciousness; blood glucose
- All patients who have sustained unwitnessed falls/known head injuries either prior to admission, or during their period of hospital admission, must have the Glasgow Coma Score (GCS) recorded in compliance with NICE CG176: Head injury: assessment and early management 2017
- Clear monitoring plan

Where the Registered Nurse has delegated observation monitoring to a Healthcare Support Worker (HCSW), the Registered Nurse remains responsible for the monitoring , escalation of care, and subsequent patient outcome.

Patient Physiological Monitoring

- **Use Track and Trigger system (NEWS)**
- **Physiological observation monitoring minimum frequency as per NEWS protocol**
- **Minimum observation frequency is 12 hourly.**

- **All patients who have unwitnessed falls/known head injuries either prior to admission or during their period of admission, must have their GCS recorded in compliance with NICE CG176** Head injury: assessment and early management 2017/Head Injury Pathway.

Patient at Risk of Deterioration

Follow NEWS graded response protocol on the rear of the NEWS chart if:-

- Alerted by NEWS score
- If there is any clinical concern

NEWS 0-2

- If concerned inform Nurse in Charge (NIC)
- Minimum frequency of observation, 12 hourly

NEWS 3-5
THREAT!

- Inform Nurse in Charge
- Immediately inform designated nurse/doctor and PaRT (0700-1900)
- Minimum frequency of observations 4 hourly
- Increase frequency dependent on patient response
- SBAR

NEWS 6-8
SICK!

- **Inform Nurse in Charge, then immediately inform most senior designated nurse and doctor and PaRT (0700 – 1900)**
- **Minimum frequency of observation 1 hourly**
- **SBAR**

NEWS 9+
NOW!

- **Inform Nurse in Charge**
- **Call Resuscitation Team via 2222**
- **Immediate Review**
- **Minimum observation frequency 30 minutes**
- **SBAR**

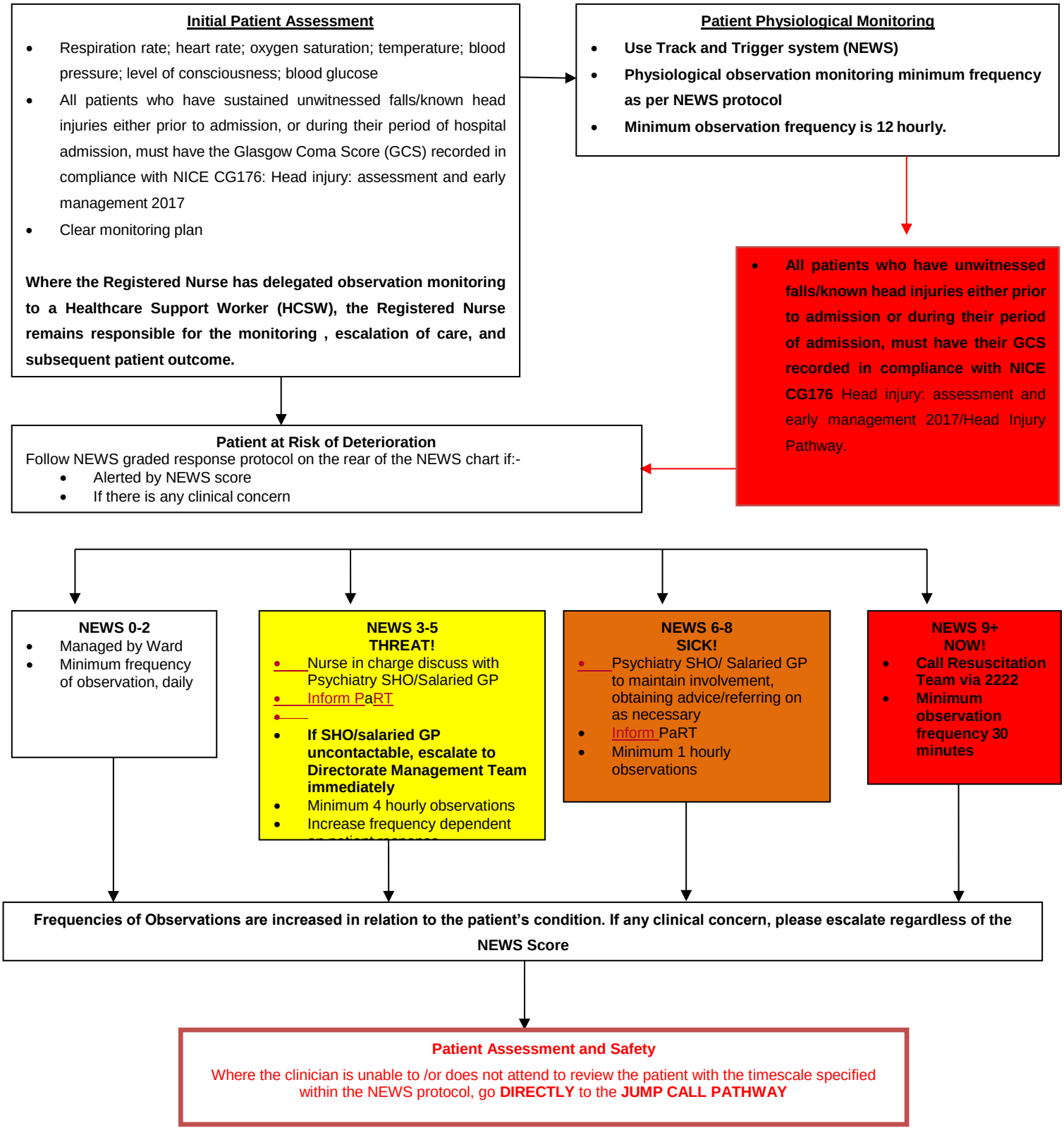
Frequencies of Observations are increased in relation to the patient's condition. If any clinical concern, please escalate regardless of the NEWS Score

Patient Assessment and Safety

Where the clinician is unable to /or does not attend to review the patient with the timescale specified within the NEWS protocol, go **DIRECTLY** to the **JUMP CALL PATHWAY**

Appendix 3 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Mental Health Services for Older People (MHSOP)

In Hours (9am-5pm Monday to Friday)



Appendix 4 – NEWS Flowchart for the Recognition of and Response to Acute Illness in Adults in Mental Health Services for Older People (MHSOP)

Out of Hours (5pm-9am/Weekends/Bank Holidays

Initial Patient Assessment

- Respiration rate; heart rate; oxygen saturation; temperature; blood pressure; level of consciousness; blood glucose
- All patients who have sustained unwitnessed falls/known head injuries either prior to admission, or during their period of hospital admission, must have the Glasgow Coma Score (GCS) recorded in compliance with NICE CG176: Head injury: assessment and early management 2017
- Clear monitoring plan

Where the Registered Nurse has delegated observation monitoring to a Healthcare Support Worker (HCSW), the Registered Nurse remains responsible for the monitoring , escalation of care, and subsequent patient outcome.

Patient Physiological Monitoring

- **Use Track and Trigger system (NEWS)**
- **Physiological observation monitoring minimum frequency as per NEWS protocol**
- **Minimum observation frequency is 12 hourly.**

- **All patients who have unwitnessed falls/known head injuries either prior to admission or during their period of admission, must have their GCS recorded in compliance with NICE CG176** Head injury: assessment and early management 2017/HB Head Injury Pathway.

Patient at Risk of Deterioration

Follow NEWS graded response protocol on the rear of the NEWS chart if:-

- Alerted by NEWS score
- If there is any clinical concern

NEWS 0-2

- Managed by Ward
- Minimum frequency of observation, daily

NEWS 3-5
THREAT!

- Days:discuss with shift coordinator who will call Out of Hours – OOH GP
- Inform PaRT (0700 – 1900)
- Nights: Discuss with Mental Health Night site Manager who will call OOH GP
- Minimum 4 hourly observations
- Increase frequency dependent on patient response

NEWS 6-8
SICK!

- Ward to contact Med Reg for advice (make sure shift coordinator/ Mental Health Night Site Manager are aware)
- Inform PaRT (0700 – 1900)
- Minimum 1 hourly observations

NEWS 9+
NOW!

- **Call Resuscitation Team via 2222**
- **Minimum observation frequency 30 minutes**

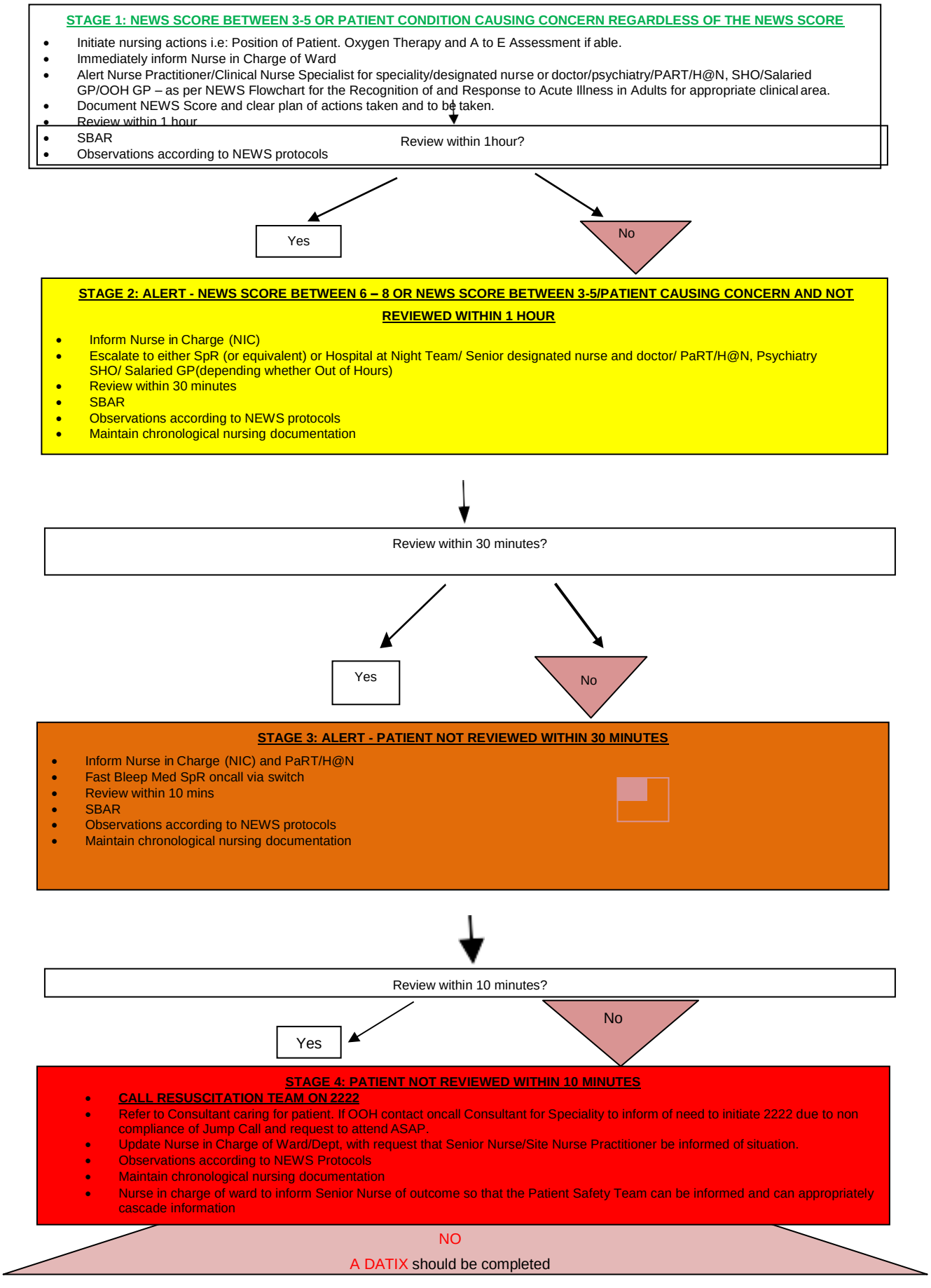
Frequencies of Observations are increased in relation to the patient's condition. If any clinical concern, please escalate regardless of the NEWS Score

Patient Assessment and Safety

Where the clinician is unable to /or does not attend to review the patient with the timescale specified within the NEWS protocol, go **DIRECTLY** to the **JUMP CALL PATHWAY**

Routine Clerking to be done by Psychiatry SHO

Appendix 5 – Jump Call Pathway for Recognition to Acute Illness in Adults in All Settings (Acute, Adult Acute Mental Health, MHSOP)



Appendix 6 – NEWS Standard Operating Procedure (SOP)

Introduction

Published literature from NICE and NPSA highlights that a significant risk to patient safety exists from the lack of recognition and treatment of acutely ill adults in Hospital resulting in a significant increase in potentially avoidable deaths.

NICE 50 guidelines cover the care of all acutely ill adult patients in hospital, including patients in emergency departments. It addresses three key areas:

1. Identification of patients who are either at risk of clinical deterioration or whose clinical condition is deteriorating. This includes assessment of: scoring tools that record physiological parameters and neurological state; the level of monitoring needed; and the recording and interpretation of the data obtained.
2. Response strategies, including the timing of response and patient management, and the communication of monitoring results to relevant healthcare professionals, including the interface between critical care and acute specialities.
3. Discharge of patients from critical care areas back to ward-based care. This includes monitoring requirements on the ward and the timing of transfers.

Organisations will only respond effectively when medical, surgical and critical care areas collaborate in improving systems of care.

An effective system must -

- Operate hospital-wide
- Work 24 hours a day
- Facilitate rapid treatment
- Facilitate escalation of care
- Feedback to referring teams on process and outcome

Roles and Responsibilities

It is recognised that NEWS observations will be undertaken by a variety of staff. However, if NEWS observations are undertaken by Health Care Support

Workers (HCSW, Theatre Assistants (TA) etc. The HCSW or TA etc must sign to indicate that they have taken the patient's observations and a Registered Health Care Worker must countersign the NEWS score in order to acknowledge that a patient's NEWS score has been assessed. Delegation of the task of taking patient observations must be according to the standards set out in the Nursing and Midwifery Council Code for Profession Practice ("The Code"), Health Care and Professions Council Standards of Conduct, Performance and Ethics (SCPE), or General Medical Council's Good Medical Practice.

Documentation

NEWS charts form an essential element of a patient's care and as such all parameters on the chart should be completed. The parameters included in the NEWS chart are Respiration Rate, Oxygen Saturations (SpO2), Inspired Oxygen, Temperature, Blood Pressure, Heart Rate and Neuro (CAVPU). Each parameter on the NEWS chart is of equal importance when determining a NEWS Score. Any parameter that is omitted will result in inaccuracy in calculating a score. This may result in a lack of escalation of care resulting in patient deterioration. Each observation should be inserted into the correct box on the chart i.e White, Yellow, Amber or Red depending upon the score. A numerical value should be inserted into boxes so that observations are recorded accurately. The Date and Time of Observations should be clearly documented on every entry of the chart. The NEWS chart only forms part of the mechanism for patient monitoring and other methods can be employed e.g. hourly urine output, biochemical analysis (e.g lactate, blood glucose, base deficit, arterial pH) and pain assessment (NICE 2016).

Frequency of observations

NICE (2016) Clinical Guideline 50 states –

"Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.

- Physiological observations should be monitored at a minimum of every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
- The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy."

Therefore, within Cardiff and Vale UHB Acute Hospitals, (University Hospital of Wales, University Hospital Llandough) physiological observations should be undertaken at a minimum of every 12 hours. Depending upon the clinical area, the frequency of observations may be increased e.g. minimum 4 hourly, minimum 6 hourly. But the frequency of observations may not be reduced. The Frequency of Observations should be documented on the NEWS Chart.

The reverse of the NEWS chart denotes minimum monitoring frequencies and how this relates to the patient's NEWS score. An increasing NEWS score will inevitably result in increasing the frequency of the patient's observations. Again, this is a minimum requirement – the frequency may be increased to greater than the protocol but never decreased.

- The frequency of observations should be documented in the appropriate space on the NEWS chart every time the observations are undertaken.
- The NEWS Score and Frequency of Observations should be noted on the Patient Status At a Glance board (PSAG) if used on the ward, or clearly communicated with those caring for patients.

Acceptable Parameters

There are four parameters on the NEWS chart that can be adjusted by Medical Staff to allow for the patient's normal physiology. These are Respiratory Rate, O2 Saturations, Blood Pressure and Heart Rate. No other parameters may be adjusted. These parameters are only to be adjusted to reflect a patient's normal ranges when they are not acutely unwell. In the case of O2 Saturations it is recommended that 94–98% is applicable for most acutely ill patients or 88–92% for patient-specific target range for those at risk of hypercapnic respiratory failure (O'Driscoll et al, 2017). This should be documented in the O2 saturations section of NEWS chart.

Some patients may always require oxygen therapy even when they are not acutely unwell. The parameter for inspired oxygen may not be changed even in these patients, as requirement for supplementary oxygen is not considered to be physiologically normally in any patient group. In the case of Inspired Oxygen, trend of oxygen demand should be monitored closely and any increase in oxygen demand should result in an escalation of patient care.

Changes in acceptable parameters should not be made solely in order to prevent a patient from increasing their NEWS score. The changed parameters should reflect the normal physiology for the patient when they are not acutely unwell.

Changes in acceptable parameters should be signed for in the appropriate area of the NEWS chart.

Escalation of Care

Nice (2016) Clinical Guideline 50 recommends a Graded Response Strategy. This graded response is described on the rear of the NEWS chart. The response taken will depend upon the NEWS score calculated.

- A NEWS score of greater than 9 means that a patient requires a response “Now”. This requires a minimum of half hourly observations. This frequency can be increased dependent upon patient response. The Resuscitation Team must be called via telephone using 2222. If the Resuscitation Team is not called via 2222, then the rationale must be clearly documented within the patient’s medical notes. In the vast majority of cases, 2222 must be called. The patient must be reviewed immediately.

If there is any concern with a patient’s condition, then their care can be escalated regardless of the NEWS score. In theory, this could result in a patient scoring 0 on NEWS, and their condition resulting in a 2222 call.

Sepsis

On the rear of the NEWS chart there is a Red Flag Sepsis Screening/Awareness section. If patient scores 3 or above, has suspicion of infection, plus any ONE of the Red Flags, the Sepsis 6 pathway should be initiated. Further information regarding Sepsis can be obtained from the Sepsis Lead for Cardiff and Vale UHB.

Areas that do not use NEWS

Within Cardiff and Vale UHB there are several Clinical Areas that do not use NEWS due to their clinical speciality and the limitations that NEWS presents in those clinical areas. These include (but not limited to) the Intensive Care Unit, Cardiac Intensive Care Unit and Coronary Care Unit. These units do not use NEWS routinely as part of their monitoring of patients, but should include

a NEWS score when a patient is “stepped down” to ward level care, so that a NEWS baseline can be scored.

There is no NEWS scoring in the Children’s Hospital for Wales at the time of writing.

All areas not mentioned above must use NEWS and must complete NEWS on the approved documentation. No area may discontinue using NEWS without prior authorisation from the RADAR Committee.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

DNACPR orders may be present for some patients. The overriding principles of this policy are:

1. To ensure an individual’s life is respected and valued.
2. To ensure early senior clinical involvement and accountability in the decision making process.
3. To make clear that a DNACPR decision must not prejudice any other aspect of care.” (NHS Wales 2016)”

These orders only refer to cardiopulmonary resuscitation, and do not refer as to whether a patient requires NEWS scoring. As stated previously, these patients should have a minimum of 12 hourly monitoring (depending upon the NEWS score) and escalation of the care of these patients should be in accordance with the rear of the NEWS chart.

If NEWS scoring and the escalation of care is no longer appropriate for a patient (e.g those patients who are in the terminal phase of their illness), this should be clearly documented in the notes. It is not appropriate for patients to have observations taken but NEWS scoring discontinued, as nurses responsible for the care of these patients will have no parameters in place in

which to escalate their care. It is also not appropriate to continue active treatment on a patient and discontinue NEWS scoring.

If a patient is in the terminal phase of their illness they may have Care Decisions in Last Days of Life - Symptom Early Warning Scores (SEWS) (NHS 2015) implemented.

References

NHS Wales (2021) All Wales Care Decisions for the Last Days of Life

NHS Wales (2020) "Sharing and Involving" A Clinical Policy For Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults In Wales

NICE (2016). Acutely ill adults in hospital: recognising and responding to deterioration | Guidance and guidelines | NICE. [online] Available at: https://www.nice.org.uk/guidance/cg50/chapter/1-Guidance#graded-response-strategy [Accessed 7 Jul. 2017].

O'Driscoll BR,Howard LS, Earis J, Mak V (2017) BTS guideline for oxygen use in adults in healthcare and emergency settings Thorax 2017;72:i1–i90.