Neurological Observation Chart

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board

Section	Subsection	Item
		Date
		Time
COMA SCALE	EYES OPEN	4 SPONTANEOUSLY
		3 TO SPEECH
		2 TO PAIN
		1 NONE
	BEST VERBAL RESPONSE	5 ORIENTATED
		4 CONFUSED
		3 INAPPROPRIATE WORDS
		2 INCOMPREHENSIBLE SOUNDS
		1 NONE
	BEST MOTOR RESPONSE	6 OBEY COMMANDS
		5 LOCALISE TO PAIN
		4 WITHDRAWS TO PAIN
		3 FLEXION TO PAIN
		2 EXTENSION TO PAIN
		1 NONE
		COMA SCALE SCORE
LIMB MOVEMENTS	ARMS	NORMAL POWER
		MILD WEAKNESS
		SEVERE WEAKNESS
		FLEXION
		EXTENSION
		NONE
	LEGS	NORMAL POWER
		MILD WEAKNESS
		SEVERE WEAKNESS
		FLEXION
		EXTENSION
		NONE
PUPILS	R	C = CLOSED SIZE
		REACTION
	L	C = CLOSED SIZE
		REACTION
Pain / Sedation		3
Pain as X		2
Sedation as O		1
		0
		Nausea Y = Yes / N = No
		Mean Arterial Pressure (MAP)
		Central Venous Pressure (CVP)
		Intracranial Pressure (ICP)
✓when checked		Wound
		Drain
		Arterial line
Angio/ embolism ✓when checked		Stab site
		Pedal pulse
		Colour
		Movement
		Sensation
		Registered nurse initials

Pupil Scale (mm): 10mm, 9mm, 8mm, 7mm, 6mm, 5mm, 4mm, 3mm, 2mm, 1mm

✓ Reacts
Sluggish
— None

If limb power differs indicate
R = Right
L = Left

NEWS CHART

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Addressograph

Ward / Dept

Score	1	2	3
	(yellow)	(orange)	(red)

Parameter	Range
Date	
Time of Observation	
Frequency of Observations	
Respiratory Rate Accept < ……… / >……… Signed:	≥25
	21-24
	12-20
	9-11
	≤8
O2 Saturations Accept < ……… / >……… Signed:	≥96%
	94-95
	92-93
	≤91
Inspired Oxygen	
Temperature	≥39.1
	38.1-39
	36.1-38
	35.1-36
	≤35
Blood Pressure Note record both systolic and diastolic pressures but use systolic only to score **Note:** In atrial fibrillation measure the BP manually Accept systolic BP of ………. For this patient Signed:	≥220
	210-219
	200-209
	190-199
	180-189
	170-179
	160-169
	150-159
	140-149
	130-139
	120-129
	111-119
	101-110
	91-100
	80-90
	70-79
	60-69
	50-59
	40-49
Heart Rate Accept Heart rate of ……..bpm for as normal for this patient Signed:	≥131
	121-130
	111-120
	101-110
	91-100
	81-90
	71-80
	61-70
	51-60
	41-50
	≤40
Neuro	Alert
	Voice
	Pain
	Unresponsive

Consider Glasgow Coma Score if any Neurological concerns

NEWS total score	
OBS Performed by Initials	
Qualified Nurse Initials	

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NEWS CHART

	Physiological Parameters	3	2	1	0	1	2	3
A	Respiratory Rate (bpm)	≤ 8		9-11	12-20		21-24	≥ 25
B	O2 Saturations (%)	≤ 91	92-93	94-95	≥ 96			
	Any supplemental Oxygen		YES		NONE			
C	Systolic BP (mmHg)	≤ 90	91-100	101-110	111-219			≥ 220
	Pulse (BPM)	≤ 40		41-50	51-90	91-110	111-130	≥ 131
D	AVPU score				ALERT			VPU
E	Temperature (°C)	≤ 35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥ 39.1	

Concern about a patient should lead to escalation, regardless of the score.

NEWS	MINIMUM MONITORING	ALERT	REVIEW
Score 0-2	12 Hourly	If concerned inform Nurse in Charge (NIC)	
Score 3-5 **3 = THREAT!**	4 Hourly Increase frequency dependant on patient response	Inform Nurse in Charge, then immediately inform designated nurse/doctor	Review in 1 hour. SBAR
Score 6-8 **6 = SICK!**	1 Hourly	Inform Nurse in Charge, then immediately inform most senior designated nurse and doctor	Review within 30 minutes. SBAR
Score 9+ **9= NOW!**	30 mins	Inform Nurse in Charge, then Call Resuscitation Team via 2222	Immediate SBAR

The Nurse in Charge of each shift must ensure that the designated nurse/doctor names and bleep numbers are updated and clearly displayed on a Patient Status at a Glance Board (PSAG).

Frequency of Observations are increased in relation to the patients condition.
If there is any concern, please escalate regardless of the NEWS score.

SEPSIS SCREENING / AWARENESS

Suspect sepsis if 2 of the following criteria are present - go to sepsis tool

- ☐ Temperature <36°C or >38.3°c
- ☐ Pulse >90bpm
- ☐ WCC>12 or $<4\times10^9$/1
- ☐ Respiratory rate >20/min
- ☐ Acutely altered mental status
- ☐ Hyperglycaemia in the absence of diabetes

START SEPSIS CARE / MONITORING PATHWAY	CONTINUE MONITORING OBSERVATIONS & NEWS REGULARLY AS PLANNED

Neurological observations

Frequency: Refer to individual care plan **and** discuss with medical team **daily** or **each time the patient is reviewed.**

Patient changes requiring review

Any of the following examples of neurological deterioration should prompt urgent review by the supervising doctor:

- Development of agitation or abnormal behaviour.
- A sustained (that is, for at least 30 minutes) drop of 1 point Glasgow Coma Scale (greater weight should be given to a drop of 1 point in the motor response score).
- Any drop of 2 or more points of the Glasgow Coma Scale.
- Development of severe headache or persistent vomiting.
- New or evolving neurological signs or symptoms such as:
  - Pupil inequality / speed of reaction
  - Asymmetry of limb or facial movement
  - Seizures

Special instructions regarding neurological observations

Signed: *Date:*

Pain assessment / observations

Frequency:
- Any patient receiving new IM / SC / Oral opiates must have **BP, P, Resps, Sedation score** and **Pain score** before each administration and 2 hourly thereafter.
- **PCA** – Obs as above, 2 hourly for 48 hours then 4 hourly thereafter if observations within acceptable parameters.
- Sedation score must be recorded if the patients GCS is not being recorded.
- Pain must be assessed and recorded each time the observations are recorded (even if patients are not on opiates).

Pain assessment score

Ask the patient: "Which words best describe the pain you have when you move?"

No pain	0
Mild pain	1
Moderate pain	2
Severe pain	3

Sedation score

If the patient is on opiates but is not having their GCS recorded, a sedation score must be recorded. Look at the patient and decide which of the following apply

Awake	0
Dozing intermittently	1
Mostly sleeping	2
Difficult to waken	3
Normal sleep record as	S

If the patient has a PCA / received opiates and resps <8/min +/- sedation score 2 or more:
- Contact acute pain team or obstetric anaesthetist.
- Administer 15L O2 via reservoir mask.
- Dilute 1ml Naloxone (400mcg) with 3ml Normal Saline (=total 4ml).
- Give 0.5ml (50mcg) increments until patient's resps > 12 and sedation score 0-1.