NEWS Key 0 1 2 3

Parameter	Chronic Hypoxia	Range	Score	Range	Chronic Hypoxia
		Date:		Date	
		Time:		Time	
Respiratory Rate		≥25	3	≥25	
		21-24	2	21-24	
		12-20		12-20	
		9-11	1	9-11	
		≤8	3	≤8	
Sp02	Chronic Hypoxia	Default		Default	Chronic Hypoxia
	≥88	≥96		≥96	≥88
Medical Signature required to use scale for patients with Chronic Hypoxia		94-95	1	94-95	
	86-87	92-93	2	92-93	86-87
	≤85	≤91	3	≤91	≤85
Sign:		Unrecordable	3	Unrecordable	
Inspired 02		% or litres	2	% or litres	
Temperature			2		
		≥39⁰	1	≥39⁰	
		38⁰		38⁰	
		37⁰		37⁰	
		36⁰	1	36⁰	
		≤35⁰	3	≤35⁰	
NEWS SCORE uses Systolic BP			3		
		230	3	230	
		220		220	
		210		210	
		200		200	
		190		190	
		180		180	
		170		170	
		160		160	
		150		150	
If manual BP mark as M		140		140	
		130		130	
		120		120	
		110	1	110	
		100	2	100	
		90	3	90	
		80	3	80	
		70	3	70	
		60	3	60	
		50	3	50	
		Unrecordable	3	Unrecordable	
Heart Rate			3		
		>140	3	>140	
		130	2	130	
		120	2	120	
		110	1	110	
		100	1	100	
		90		90	
		80		80	
		70		70	
		60		60	
		50	1	50	
		40	3	40	
		30	3	30	
		Regular Y/N		Regular Y/N	
Conscious Level		Alert		Alert	
		V / P / U	3	V / P / U	
		New Confusion	3	New Confusion	
Total NEWS score				**Total NEWS score**	
Urine output recorded Y/N				Urine output recorded	
Blood Glucose				Blood Glucose	
Frequency of Observations				Frequency of Obs.	
Structured Response Tool Y/N				SRT Y/N	
Escalation Y/N				Escalation Y/N	
Pain score (0-10)				Pain score (0-10)	
Nausea score (0-3)				Nausea score (0-3)	
Motor Block score (0-4)				Motor Block score (0-4)	
Circulation				Circulation	
Sensation				Sensation	
Movement				Movement	
Initials				Initials	

Patient Name: CHI:

Special Instructions - to be completed by Medical Team

A total NEWS score of .... or individual parameter of ....
is acceptable for this patient because ....

Please escalate if ....

Print .... Sign .... Designation ....
Date .... Time .... *(only valid if signed and dated)*

***Regardless of NEWS always escalate if concerned about a patient's condition**

NEWS Score	Frequency of Observations	Clinical Response
Total 0*	**Minimum 12 hourly / 4 hourly in admission areas**	• Continue routine NEWS monitoring with every set of observations.
Total 1 - 4*	**Minimum 4 hourly** Consider Structured Response Tool Consider Fluid Balance Chart	• Inform registered nurse • Registered nurse assessment using ABCDE • Review frequency of observations • Inform Nurse in Charge • **If ongoing concern, escalate to Medical Team**
Total 5 - 6* or 3 in one parameter	**Increase frequency to a minimum of 1 hourly** Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse assessment • Inform Nurse in Charge • Escalate to Medical Team as per local escalation • Urgent medical assessment • Management plan to be discussed with Senior Trainee or above • Consider level of monitoring required in relation to clinical care
Total 7* or more	**Continuous monitoring of vital signs** Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse to assess immediately • Inform Nurse in Charge • Request immediate assessment by Senior Trainee or above • Case to be discussed with supervising Consultant • If appropriate contact Critical Care for review

NEWS ≥4 Think Sepsis

Are any 2 or more SIRS criteria present?

RECOGNISE

Temperature	<36⁰c or >38⁰c
Pulse	>90 beats/min
White Cell Count	<4 or >12
Respiratory Rate	> 20 bpm
Mental State	New confusion
Blood Sugar	>7.7mmol/L in non-diabetic

and clinical suspicion of infection = SEPSIS

Apply Sepsis 6 within 1 hour

RESUSCITATE

1. Give oxygen to target saturation >94% (NB COPD 88%-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output & start fluid chart

National Early Warning Score (NEWS) Chart

NHS Lothian

Addressograph

Name:

DOB:

CHI:

Consultant: Date chart commenced:

This is chart number this admission

Weight: Actual kgs Estimated kgs

ASU: Ward:

Conscious Level Chart to be completed when clinically indicated

		Date	
		Time	
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4
		To speech	3
		To pain	2
		None	1
	Best Verbal Response	Orientated	5
		Confused	4
		Inappropriate words	3
		Incomprehensible sounds	2
		None	1
	Best Motor Response	Obey commands	6
		Localise to pain	5
		Flexion to pain	4
		Abnormal flexion	3
		Extension to pain	2
		None	1
		Total GCS Score	
Right Pupil		Size	
		Reaction	
Left Pupil		Size	
		Reaction	
LIMB MOVEMENT	ARMS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
	LEGS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
		Initials	

Endotracheal tube or tracheostomy = T

Always record the best arm response

+ reacts
- no reaction
c. eye closed

Record right (R) and left (L) separately if there is a difference between the two sides

Pupil Scale mm 1 2 3 4 5 6 7 8

REMEMBER
- **Record all observations** on NEWS chart
- **Document any** deterioration in the notes - remember the Structured Response Tool
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • Patent • At Risk • Obstructed	→ Suction if indicated → Head tilt, chin lift/jaw thrust → Airway Adjuncts → Administer Oxygen → Call 2222 if at risk
BREATHING	• Respiratory rate • SpO2 • Accessory muscle use • Noises +/- percussion, palpation & auscultation • Position / posture	→ Administer prescribed Oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → Monitor SpO2 / ABGs → Consider chest x-ray → Treat underlying cause → Call 2222 if not breathing
CIRCULATION	• Pulse • Blood Pressure • Capillary refill time • Core temperature / colour • Urine output • Consider 4 body cavities for fluid & blood loss (4 + on the floor) • Monitor drain losses	→ Obtain IV access → Obtain blood samples → Prepare fluid challenge → Initiate Fluid Balance Chart → Call 2222 if no circulation → Consider initiating Major Haemorrhage Protocol → Monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • Blood Glucose • Drugs	→ Re-assess GCS → Check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol → Check Drug Chart → Remember accurate documentation
EXPOSURE	• Top to toe examination • Look for evidence of blood loss / rashes / drains / wounds etc	→ Control bleeding → Treat any underlying conditions identified → Reassess → Maintain patient's dignity → Evaluate actions

Pain Assessment and Management Guidelines

Cancer-related pain: Always score worst pain in the last 24 hours or since last assessment: refer to Palliative Care Guidelines

Acute Pain: Score current pain on movement, e.g. deep breathing: refer to Acute Pain Guidelines

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical staff / Senior Nurse / Nurse Practitioner

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For further advice contact:

ACUTE	PALLIATIVE
Mon-Fri: Bleep Acute Pain Team Out of Hours: On-call Anaesthetist	Mon-Fri: Bleep Palliative Care Team Out of Hours: Via Switchboard

Pain Score	Nausea Score 0-3	Epidural Motor Block Score please do not √ motor block column
0 None Continue to assess pain at least daily	**0 - No Nausea**	0 - **Full Power**
1-3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4-5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6-10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or On-Call Anaesthetist if out of hours

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