National Early Warning Score Adult Patient Observation Chart

(Please use IMEWS observation chart for pregnant women and women in the six week post delivery period)

Patient Name:

Date of Birth:

Healthcare Record No:

Addessograph

Document Number during this Admission

National Early Warning Score Key (ViEWS)

SCORE	3	2	1	0	1	2	3
Respiratory Rate (bpm)	≤ 8		9 - 11	12 - 20		21 - 24	≥ 25
SpO_2 (%)	≤ 91	92 - 93	94 - 95	≥ 96			
Inspired O_2 (FiO_2)				Air			Any O_2
Systolic BP (mmHg)	≤ 90	91 - 100	101 - 110	111 - 249	≥ 250		
Heart Rate (BPM)		≤ 40	41 - 50	51 - 90	91 - 110	111 - 130	≥ 131
AVPU/CNS Response				Alert (A)			Voice (V), Pain (P), Unresponsive (U)
Temp (°C)	≤ 35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥ 39.1	

Note: where systolic blood pressure is ≥ 200mmHg, request immediate medical review.
In COPD patients SpO_2 range 88-92% is common. Request immediate medical review if SpO_2 equal or less than 85%.

Escalation Protocol Flow Chart

Total Score	Minimum Observation Frequency	ALERT	RESPONSE
1	12 Hourly	Nurse in charge	Nurse in charge to review if new score 1
2	6 Hourly	Nurse in charge	Nurse in charge to review
3	4 Hourly	Nurse in charge & Team/On-call Intern	1. Intern to review within 1 hour
4-6 * Use the Sepsis screening pathway if the NEWS is 4 (5 on supplementing O_2) or infection is suspected.	1 Hourly	Nurse in charge & Team/On-call Intern/SHO	1. Intern/SHO to review within 1/2 hour 2. If no response to treatment within 1 hour contact Registrar 3. Consider continuous patient monitoring 4. Consider transfer to higher level of care
≥ 7	½ Hourly	Nurse in charge & Team/On-Call Registrar Inform Team/On-Call Consultant	1. Registrar to review immediately 2. Continuous patient monitoring recommended 3. Plan to transfer to higher level of care
Note: Single Score triggers			
Score of 2 HR ≤ 40 (Bradycardia)	½ Hourly	Nurse in charge & Team/On-call Intern/SHO	1. Intern/SHO to review immediately
*Score of 3 in any single parameter	½ Hourly or as indicated by patient's condition	Nurse in charge & Team/On-call Intern/SHO	1. Intern/SHO to review immediately 2. If no response to treatment or still concerned contact Registrar

*In certain circumstances a score of 3 in a single parameter may not require ½ hourly observations i.e. some patients on O_2.

- When communicating patients score inform relevant personnel if patient is charted for supplemental oxygen e.g. post-op.
- Document all communication and management plans at each escalation point in medical and nursing notes.
- Escalation protocol may be stepped down as appropriate and documented in management plan.

IMPORTANT:
1. If the response is not carried out as above the CNM/ Nurse in Charge must contact Registrar or Consultant.
2. If you are concerned about a patient, escalate care at any stage regardless of the score.
3. Inform medical staff if the score includes the fact that the patient is on Oxygen.

Sepsis Screening Pathway

Are any 2 or more modified Systemic Inammatory Response Syndrome (SIRS) criteria present

- Respiratory rate > 20 (bpm)
- Temperature <36 or >38.3 (oC)
- Heart rate > 90 (bpm)
- WCC < 4 or > 12 x 109/L
- Acutely altered mental status
- Bedside glucose >7.7mmol/L (in the absence of diabetes mellitus)

+ INFECTION SUSPECTED

Note: Some groups of patients, such as older people, may not meet the modified SIRS criteria, even though infection is suspected. Where this occurs check for signs of organ dysfunction and raised biomarkers such as C-reactive protein (CRP)

DIAGNOSED SEPSIS

Intervention within one hour
COMPLETE SEPSIS SIX

TAKE 3
1. Appropriate cultures*
2. FBC and lactate
3. Hourly urine output chart

GIVE 3
4. Maintain O_2 (94-98%)
5. Give IV fluid bolus
6. IV antibiotics

*eg. blood, wounds, invasive line sites, sputum, urine, etc.

Sepsis Pathway Modification
Not all patients meeting modied SIRS criteria have sepsis,OR there may be additional problems requiring dierent management (current Congestive Cardiac Failure (CCF), Diabetic Ketoacidosis (DKA), Myocardial Infarction (MI), Gastro-Instinal (GI) Bleed etc) OR patient may be receiving chemotherapyOR be palliated.

Early Warning Score

0	1	2	3

Early Warning Scoring System

NAME:

HEALTHCARE RECORD No.:

DATE OF BIRTH: Addressograph

ADDRESS:

Consultant:	YEAR:________	WARD:

ABCDE Assessment

AB

RESPIRATORY DISTRESS

Consider:
- Airway
- Hypoxia
- Acidosis

Intervention:
- Immediate medical review
- ABCDE assessment
- Give Oxygen to target: 90% in COPD patients, 96% or more in all other patients
- Request CXR & ABG
- Airway Obstruction: activate Emergency Response System
- Respiratory Acidosis: Consider early non-invasive ventilation

TACHYCARDIA

Consider:
- Loss of conciousness
- Myocardial ischaemia on ECG
- Heart failure.

Intervention:
- Immediate medical review
- Consider activating ERS
- ACLS Algorithm as appropriate

BRADYCARDIA

Consider:
- Electrolyte Disturbance
- Drug Side-effect
- Complete Heart Block

Intervention:
- Immediate medical review
- 12-lead ECG
- Telemetry
- Heart Rate ≤ 40: consider activating ERS
- Document irregular Heart Rate

		DATE
		TIME
Respiration	3	25 Above
	2	21-24
	0	12-20
	1	9-11
	3	8 Below
		Respiration Score
Peripheral Oxygen Saturations (SpO_2)%	0	96 Above
	1	94-95
	2	92-93
	3	0-91
		SpO_2 Score
Any Oxygen scores 3 otherwise score 0	0	Room Air
	3	Any O_2
		O_2 Score
Heart Rate (Beats Per Minute)	3	Above 180
	3	161-170
	3	151-160
	3	141-150
	3	131-140
	2	121-130
	2	111-120
	1	101-110
	1	91-100
	0	81-90
	0	71-80
	0	61-70
	0	51-60
	1	41-50
	2	40 Below
		Heart Rate Score

Urine Output: If there are concerns about urine output (<0.5 ml/kg/hr), contact Doctor for review

C

HYPERTENSION

Consider:
- Pain
- Hypercapnia

Intervention:
- Immediate medical review
- 12-lead ECG

HYPOTENSION

Consider:
- Bleeding
- Myocardial Infarction
- Sepsis

Intervention:
- Immediate medical review
- Check BP manually
- 12-lead ECG
- If no heart failure, stat IV fluids - 500ml
- If no improvement after 20ml/kg: immediate review by doctor
- Systolic BP ≤ 90: refer to escalation protocol

D

NEUROLOGICAL DETERIORATION

Consider:
- Hypoglycaemia
- Acute brain injury
- Pupil response

Intervention:
- Immediate medical review
- Capillary glucose
- Sudden fall in level of consciousness: refer to escalation protocol

E

PYREXIA OR HYPOTHERMIA

Consider:
Sepsis

Intervention:
- Inititiate Sepsis Pathway

MR651B

Parameter	Score	Range
Blood Pressure (mmHg) (Score systolic only)	1	250 Above
	0	231-249
	0	221-230
	0	211-220
	0	201-210
	0	191-200
	0	181-190
	0	171-180
	0	161-170
	0	151-160
	0	141-150
	0	131-140
	0	121-130
	0	111-120
	1	101-110
	2	91-100
	3	81-90
	3	71-80
	3	61-70
	3	51-60
	3	41-50
	3	31-40
		BP Score
AVPU Response	0	Alert (A)
	3	V/P/U
		AVPU Score
Temperature (ºC)	2	39.1
	1	38.5
	1	38.1
	0	37.5
	0	37.0
	0	36.5
	0	36.0
	1	35.5
	1	35.0
	3	34.5
		Temp Score
TOTAL EWS SCORE		
		Blood Glucose
		Bowel Movement
		Pain Score 0-10
		Weight in Kgs
		Escalation Protocol Activated Y/N na
		Initials
		NMBI Pin