National Early Warning Score Adult Patient Observation Chart

National Early Warning Score Key (VIEWs)

<table>
<thead>
<tr>
<th>SCORE</th>
<th>Respiratory Rate (bpm)</th>
<th>SpO2 (%)</th>
<th>Inspired O2 (FiO2)</th>
<th>Systolic BP (mmHg)</th>
<th>Heart Rate (BPM)</th>
<th>AVPU/CNS Response</th>
<th>Temp (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>≤ 8</td>
<td>≤ 91</td>
<td>Air</td>
<td>≤ 90</td>
<td>≤ 40</td>
<td>Alert (A)</td>
<td>≤ 35.0</td>
</tr>
<tr>
<td>2</td>
<td>9 - 11</td>
<td>92 - 93</td>
<td>Any O2</td>
<td>91 - 100</td>
<td>41 - 50</td>
<td>Voice (V), Pain (P), Unresponsive (U)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>12 - 20</td>
<td>94 - 95</td>
<td></td>
<td>101 - 110</td>
<td>51 - 90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>21 - 24</td>
<td>≥ 96</td>
<td></td>
<td>111 - 240</td>
<td>91 - 110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>≥ 25</td>
<td></td>
<td></td>
<td></td>
<td>111 - 130</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: where systolic blood pressure is > 200mmHg, request immediate medical review.
In COPD patients SpO2 range 88-92% is common. Request immediate medical review if SpO2 equal or less than 85%.

Escalation Protocol Flow Chart

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Minimum Observation Frequency</th>
<th>ALERT</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12 Hourly</td>
<td>Nurse in charge</td>
<td>Nurse in charge to review if new score</td>
</tr>
<tr>
<td>2</td>
<td>6 Hourly</td>
<td>Nurse in charge</td>
<td>Nurse in charge to review</td>
</tr>
<tr>
<td>3</td>
<td>4 Hourly</td>
<td>Nurse in charge &amp; Team/On-call Intern</td>
<td>1. Intern to review within 1 hour</td>
</tr>
<tr>
<td>4-6</td>
<td>1 Hourly</td>
<td>Nurse in charge &amp; Team/On-call Intern/SHO</td>
<td>1. Intern/SHO to review within 1/2 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. If no response to treatment within 1 hour contact Registrar</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Consider continuous patient monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Consider transfer to higher level of care</td>
</tr>
<tr>
<td>≥ 7</td>
<td>½ Hourly</td>
<td>Nurse in charge &amp; Team/On-Call Registrar Inform Team/On-Call Consultant</td>
<td>1. Registrar to review immediately</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Continuous patient monitoring recommended</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Plan to transfer to higher level of care</td>
</tr>
</tbody>
</table>

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

Note: In certain circumstances a score of 3 in a single parameter may not require ½ hourly observations i.e. some patients on O2.
- 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 CMN 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.

Patient Name:
Date of Birth:
Healthcare Record No:

Sepsis Screening Pathway

Are any 2 or more modified Systemic Inflammatory Response Syndrome (SIRS) criteria present
- Respiratory rate > 20 (bpm)
- Temperature <36 or >38.3 (°C)
- 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
1. Appropriate cultures*
2. FBC and lactate
3. Hourly urine output chart
4. Maintain O2 (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 modified SIRS criteria have sepsis OR there may be additional problems requiring different management (recent Congestive Cardiac Failure (CCF), Diabetic Ketoacidosis (DKA), Myocardial Infarction (MI), Gastro-intestinal (GI) bleed etc) OR patient may be receiving chemotherapy OR be palliated.
Early Warning Score

Early Warning Scoring System

Consultant: YEAR: WARD:

NAME: HEALTHCARE RECORD No.: DATE OF BIRTH: ADDRESS:

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiration</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>21-24</td>
</tr>
<tr>
<td>0</td>
<td>12-20</td>
</tr>
<tr>
<td>1</td>
<td>9-11</td>
</tr>
<tr>
<td>3</td>
<td>8 Below</td>
</tr>
</tbody>
</table>

Respiration Score

| Peripheral Oxygen Saturations (SpO2)% | 0 | 96 Above |
| 1 | 94-95 |
| 2 | 92-93 |
| 3 | 0-91 |

SpO2 Score

| Any Oxygen score | 0 | Room Air |
| 3 otherwise score | 3 | Any O2 |

O2 Score

| Heart Rate (Beats Per Minute) | 3 | Above 180 |
| 3 | 161-170 |
| 3 | 151-160 |
| 3 | 141-150 |
| 3 | 131-140 |

Heart Rate Score

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

ABCDE Assessment

AB

RESPIRATORY DISTRESS

Consider:
- Airway
- Hypoxia
- Acidosis

Intervention:
- Immediate medical review
- ABCDE assessment
- Give Oxygen to target: 90% in COPD patients, 86% 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 consciousness
- 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

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

### 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

### Pyrexia or Hypothermia

**Consider:**
- Sepsis

**Intervention:**
- Initiate Sepsis Pathway

---

### Blood Pressure (mmHg)

<table>
<thead>
<tr>
<th>Score systolic only</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP Score</td>
<td>31-40</td>
<td>41-50</td>
<td>51-60</td>
<td>61-70</td>
<td>71-80</td>
<td>81-90</td>
<td>101-110</td>
</tr>
</tbody>
</table>

### AVPU Response

<table>
<thead>
<tr>
<th>AVPU Score</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP Score</td>
<td>31-40</td>
<td>41-50</td>
<td>51-60</td>
<td>61-70</td>
<td>71-80</td>
<td>81-90</td>
<td>101-110</td>
</tr>
</tbody>
</table>

### Temperature (°C)

<table>
<thead>
<tr>
<th>Score</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp Score</td>
<td>34.5</td>
<td>35.0</td>
<td>35.5</td>
<td>36.0</td>
<td>36.5</td>
<td>37.0</td>
<td>37.5</td>
</tr>
</tbody>
</table>

### Total EWS Score

<table>
<thead>
<tr>
<th>Blood Glucose</th>
<th>Bowel Movement</th>
<th>Pain Score 0-10</th>
<th>Weight in Kgs</th>
<th>Escalation Protocol Activated Y/N na</th>
<th>Initials</th>
<th>NMBI Pin</th>
</tr>
</thead>
</table>