Leicestershire Partnership NHS Trust

Deteriorating Patient Policy

The aim of this policy is to set out best practice principles in the assessment, identification, and immediate intervention of a deteriorating patient.

Key Words:	Deteriorating, Resuscitation, Clinical observation, NEWS2, PEWS, MARSI	
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Type of Policy	**Clinical**	

Contents

1.0 Quick Look Summary

- The aim of this policy is to provide guidance in the assessment, identification, and immediate intervention of a deteriorating patient.
- Patient deterioration is defined as a person moving from their normal clinical state to a worse clinical state
- This policy focuses on **physical health deterioration**.
- Physiological observations, early warning scoring and appropriate escalation are fundamental in detecting and preventing deterioration.
- The following scoring tools have been chosen for use in our trust:
  - **NEWS2**
  - **PEWS** - a paediatric early warning scoring system (under 18s)
  - **MARSI-MEWS** Management of Really Sick Patients with Anorexia Nervosa
  - **Non- Contact Observations -** can be utilised for patients who present with challenging behaviour to enable sequential monitoring.
- All child and adult in-patients should have their clinical observations recorded at least every 12 hours (routine monitoring).
- Deviation from routine monitoring for all patients within in-patient areas requires a senior clinical staff or MDT decision and the rationale must be detailed in the clinical notes by a senior clinician.
- 'Soft signs' of deterioration: such as new confusion or agitation; change in behaviour; reduced urine output; drowsiness; generally feeling or looking unwell; reduced mobility; and refusing food or fluid may indicate risk of deterioration. This is particularly important for patients who have difficulties with communication i.e., patients with dementia and learning disabilities.
- There are some patients who may not require physiological early warning score monitoring these may include:
  - patients with whom an end-of-life care plan has been developed and agreed specifying a ceiling of treatment.
  - Patients who are at end of their life (last days of life) where a ReSPECT form has been discussed agreed with the patient and completed.
  - Patients receiving non – clinical care from an LPT service may not routinely have physiological health observations carried out.
- To improve communication between clinical staff it is recommended the person calling for advice uses a structured communication tool. SBAR (**S**ituation-**B**ackground-**A**ssessment- **R**ecommendation) is the recommended Trust tool.
- In deterioration of all patients with known or suspected infection full assessments MUST be undertaken with the view to EXCLUDE THE POSSIBILITY of sepsis.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

1.1 Version Control and Summary of Changes

Version number	Date	Comments
1	15.4.2024	New policy

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Director	Medical Director & Director of Nursing, AHPs & Quality
Author(s)	Resuscitation Officer Deputy Director of Nursing and Quality Chair Deteriorating Patient & Resuscitation Group
Implementation Lead	Deteriorating Patient & Resuscitation group & clinical leads
Core policy reviewer group	Deteriorating Patient & Resuscitation group
Wider consultation	Patient Safety Improvement Group

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Patient Safety Improvement Group Quality Forum	Quality & Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.5 Definitions that apply to this Policy

ACVPU	**Alert, new Confusion, Pain, Verbal, Unresponsive** A change in the level of consciousness is a potential important indicator of acute illness severity. NEWS2 has added new confusion into CNS (Central Nervous System) assessment to enable clinical staff to record CNS changes accurately.
CA	**Cardiac Arrest** The sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, apnoea, or agonal respiration with a lack of any signs of life. In simple terms, cardiac arrest is the point of death.
CPR	Cardiopulmonary Resuscitation
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation** Refers to not making efforts to restart breathing and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions/treatment/care such as analgesia, fluid replacement, feeding, antibiotics and essential care.
Deteriorating Patient	The term 'deterioration' can be defined as when a person moves from their normal clinical state to a worse clinical state
Medical Emergency	An injury or illness that is acute and poses an immediate risk to an individual's life or health. These emergencies may require assistance from another person who should be suitably qualified to do so.
EWS **NEWS2**	**Early Warning Score** **National Early Warning Score 2** A multiple parameter or aggregate weighted scoring system, which defines the parameters to be measured and frequency of observations, with cut-off points that should trigger a response. Parameters for adults should include heart rate, respiratory rate, systolic blood pressure, level of consciousness, oxygen saturation, temperature.
Sepsis	Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs (Sepsis Trust, 2023)
S.E.P.S.I.S	An acronym that asks the user to assess for possible non-contact physical health symptoms of sepsis. Person could have any of these symptoms: S = Slurred speech or confusion E = Extreme shivering or muscle pain P = Passing no urine (in a day), S = Severe breathlessness I = It feels like they are "going to die" S = Skin mottled or discoloured

Sepsis Screening Tool	The Sepsis Screening and Action Tool must be completed and followed for adult patients who have signs of deterioration such as a NEWS2 score of 5 or more, and/or soft signs of deterioration indicative of infection, the relevant service specific Sepsis Screening and Action Tool must be completed and followed.
Monitoring plan	A patient plan that details monitoring & frequency of additional observations required outside of the physiological Early Warning Score system that should be recorded in the patient notes.
SystmOne	Patient electronic record.
Brigid	Brigid is an application for clinicians using systmOne linked to the Early Warning Score system.
Observation Chart	A paper copy of patients' clinical observations.
SBAR	A communication tool used by clinical staff to structure communication when handing over information to a clinical colleague about a deteriorating patient. The SBAR communication tool is **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation.
Vital Signs/ Physiological observations	Measures of parameters taken by clinical staff to assess a patient's fundamental physiological function, such as pulse, temperature, systolic blood pressure, respiratory rate, ACVPU (the level to which the patient responds) and oxygen saturation, plus the patient's inspired oxygen requirements.
ABCDE:	**A**irway, **B**reathing, **C**irculation, **D**isability and **E**xposure - structured approach to physical assessment.
Aspiration:	When a foreign object is inhaled into the airways.
CBG	**Capillary Blood Glucose** Capillary Blood Glucose level is the amount of glucose in the blood
Delirium	Acute or new onset confusion, or suddenly more confused than their normal.
ReSPECT	ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment.
LPT	Leicestershire Partnership NHS Trust.

2.0. Purpose and Introduction

The aim of this policy is to is to provide direction and guidance for the co-ordinated approach to identifying any physiological changes in patients and the subsequent actions that aim to prevent further deterioration and those who are at risk of physiological deterioration or acutely ill are identified and responded to effectively.

In LPT patient deterioration is defined as a person moving from their normal clinical state to a worse clinical state. This policy focuses on physical health deterioration.

3.0 Policy requirements

This policy provides guidance for the variety and complexity of adult and paediatric multi – speciality Trust service response to deterioration. This policy reflects National Institute for Care Excellence (NICE) guidance CG50 (1) and NPSA Guidance (2) relating to all aspects of the treatment and care of adults who are acutely ill or at risk of physiological deterioration.

This policy has also been developed to describe the process for managing and mitigating risks relating to all aspects of the treatment and care of adults and children who are acutely ill or at risk of physical deterioration, including sepsis.

4.0 Duties within the Organisation

Policy, Guideline or Procedure / Protocol Author

Senior Resuscitation Officer

Lead Director

Chief Executive, Medical and Nursing & AHP Directors are responsible for ensuring the safe and effective delivery of services; this includes securing and directing resources to support the implementation of this policy.

Directors, Heads of Service

Directors, Heads of Service are responsible for ensuring the safe and effective delivery of services they manage; this includes securing and directing resources to support the implementation and monitoring of this policy.

Ensuring that all staff are aware of their responsibility to adhere to the policy.

Ensure appropriate resources are in place to facilitate adherence to the policy.

Senior Managers, Matrons and Team Leads

Senior Managers, Matrons and Ward Managers/ Team Leaders will ensure that all staff carry out patient observations using the appropriate scoring EWS and SBAR tools, and that adequate staff training is undertaken within their area including compliance with resuscitation and sepsis training.

Ensuring the clinical staff, they are responsible for are aware of and apply this policy into clinical practice.

Staff

All staff members must ensure that they understand the relevant EWS and SBAR and the implications of their use and are up to date with their mandatory resuscitation and early warning scoring and sepsis training specific to their roles and skill set.

All staff must ensure that they follow the EWS guidance, triggers, escalate and action and are responsible for documenting this in the patient's record.

Responsibility of Clinical Staff

Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

If the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

4.1 Physiological observations

Physiological observations, early warning scoring and appropriate escalation are fundamental in detecting and preventing deterioration.

4.2 Physiological Scoring Tools

NEWS (National Early Warning Score) was created by the Royal College of Physicians of London to standardise physiological observational scoring across the NHS, to aid patients at risk of deteriorating and monitor patient improvement or continued deterioration.

NEWS2 allocates a score to the physiological observations undertaken when a patient is being cared for. Six simple parameters form the basis of the scoring system:

- respiratory rate
- oxygen saturations
- temperature
- systolic blood pressure
- pulse rate
- level of consciousness

A score is allocated to each parameter depending on how extreme the parameter varies from the normal. An additional score is added for people requiring oxygen. The total score is then graded into low, medium, and high scores to guide the required action for the responding professional. The aim is to ensure a structured and timely escalation of patients' clinical concern to senior nursing or medical staff.

There are 2 oxygen saturation scales to take account of patients with Type 1 and Type 2 respiratory failure. Allocation of the appropriate scale must be allocated by the most senior member of staff reviewing the patient at time of admission/assessment.

4.3 Identification of patients at risk of deterioration

Physiological observations, and early warning scoring are fundamental in detecting deterioration.

The following scoring tools have been chosen for use in our trust:

- **NEWS2** National Early Warning Score- NHS England and NHS Improvement approved tool as the recommended early warning scoring in adults **(Appendix 1)**
- **PEWS** - a paediatric early warning scoring system (under 18s) **(Appendix 2)**
- **MARSI-MEWS** ((Royal College of Psychiatrists improving care , 2022) -MARSIPAN-guidance-based Modified Early Warning System [EWS; MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa] (MARSIPAN, 2014) a scoring system used specifically with patients with eating disorders used in conjunction with MEED (medical emergencies in eating disorders) (Royal College of Psychiatrists improving care , 2022) **(Appendix 3)**
- **Non- Contact Observations -** can be utilised for patients who present with challenging behaviour to enable sequential monitoring. **(Appendix 4)**

Each warning score details which observations should be recorded, parameters and escalation guidance.

4.3.1 Measurement of clinical/physiological observations

In-patient setting

All children, young people and adults admitted into physical and mental health in-patient services will have their clinical/physiological observations undertaken on their initial assessment and recorded in their records with an agreed acceptable scoring range for them e.g., if a respiratory patient they are likely to trigger respiratory score, a patient with an arrythmia such as long-standing AF will trigger NEWS in their baseline state.

All child and adult in-patients should have their clinical observations recorded at least every 12 hours (routine monitoring), all parameters included in the NEWS.

Deviation from routine monitoring for all patients within in-patient areas requires a senior clinical staff or MDT decision and the rationale must be detailed in the clinical notes by a senior clinician.

Community and outpatient settings

There are a diverse range of services provided by staff working in LPT where it is not routine to carry out clinical/physiological observations as part of care and treatment during a community visit at home, during an outpatient visit or a group activity. If staff have a concern regarding a patient's physical deterioration, they should safety net and refer on to either the GP, 111 or 999 as appropriate. Staff should report this to their line manager or on-call manager for support.

The following community services detailed below undertake clinical/physiological observations as part of routine care and treatment:

CHS

- Community nursing and therapy services at first visit/contact to establish a patient baseline, included in wound assessment monitoring and if there are signs of clinical deterioration, both services have a community NEWS2 escalation protocol (Appendix 5)
- Long term condition services, pulmonary rehabilitation and heart failure teams
- Virtual ward service
- Community Integrated Neurological and Stroke Service

DMH

- Assertive Outreach – supporting metabolic monitoring for those patients unable to attend a clinic or GP practice
- Mental Health facilitators supporting people with serious mental illness (SMI) at home who require physiological observations
- Community Mental Health teams have access to clinical/physiological equipment if required to support someone at home to have their clinical observations taken but not for routine monitoring

FYPC/LDA

- DIANA service – Respiratory physiotherapists

All settings

Where traditional physical assessments cannot be undertaken, an assessment using non-contact observations must be completed along with documentation as to why the physiological measurements were inappropriate.

Observations must be repeated if the health care clinician attending is concerned regarding patient deterioration and escalated as per the applicable early warning scoring pathway.
In community settings, physiological observations will be undertaken as identified by the local service and in line with roles and responsibilities.

These systems are an aid to clinical assessment not a substitute for competent clinical judgement. Concern about a patient's clinical condition should always override. It must be emphasised physiological Early warning score systems may not trigger a score in some patients who are or are becoming acutely unwell.

Early warning score prompts if the clinical professional considers it necessary **to increase** the frequency of monitoring and escalate care. Patients who have evidence of infection including tissue injuries should be considered particularly vulnerable to sudden deterioration.

'Soft signs' of deterioration: such as new confusion or agitation; change in behaviour; reduced urine output; drowsiness; generally feeling or looking unwell; reduced mobility; and refusing food or fluid may indicate risk of deterioration. This is particularly important for patients who have difficulties with communication i.e., patients with dementia and learning disabilities. Clinical staff should observe for soft signs and escalate patients who are causing concern even if the physiological Early warning score is low.

When an increased frequency of observations for a prescribed period is required, for example post fall, or the immediate post op/procedure period, the patient should remain on the physiological Early warning score monitoring and the additional observations entered as required.

4.3.2 Patients who may not require physiological observations.

There are some patients who may not require physiological early warning score monitoring these may include:

- patients with whom an end-of-life care plan has been developed and agreed specifying a ceiling of treatment.
- Patients who are at end of their life (last days of life) where a ReSPECT form has been discussed agreed with the patient and completed.
- Patients receiving non – clinical care from an LPT service may not routinely have physiological health observations carried out.
- Patients whom the senior clinician in charge of the patient's care makes the assessment that EWS monitoring is no longer needed, with the decision and rationale clearly documented on the patients' records.

If there is any doubt as to whether observations should be carried out the clinician should carry out observations document and escalate as necessary.

For the above patients a review of their observational requirements if any should be made on an individual basis and documented in the patient record including the rationale for the decision, minimum frequency if any, a review of the patient's ReSPECT form and DNACPR status if applicable. The decision must be reviewed regularly. If there is a doubt physical health observation should be carried out and acted upon accordingly.

4.4 Non- Contact Observations

On occasion, undertaking traditional sequential physiological observations via standard tools e.g., NEWS2 is either clinically inappropriate or may cause additional distress to the patient. In this event non-contact observations can be used to assess and escalate abnormal or concerning physical health symptoms.

The tool is not intended to determine the severity or acuity of any potential patient deterioration, but to identify any concerns that need further investigation by an appropriate clinician.

The decision to use non-contact observations should be based on the individual circumstances of the patient and documented in the patient record citing the reasons why physiological observations could not be taken using the service designated tool. If the service only uses non-contact observations this is not necessary.

Non- contact observations should be recorded utilising the appropriate paper chart or electronic system **(Appendix 5)**. Documentation should include date, time, findings of the assessment, and escalation if required including actions taken.

If paper charts are used, observations should be signed by the staff member undertaking the assessment. If non- contact observations are undertaken by a non-registered professional the outcome should be reported to the relevant registered professional. Any concern in relation to the outcome of non-contact observations should be escalated via the service specific escalation process using SBAR for clinical review.

The continued use of non-contact observations should be reviewed daily and/or following deterioration by the most senior clinician present.

4.5 Response and Escalation

The physiological Early warning score system identifies a graded response to abnormal physiological observations and can guide clinicians to consider additional interventions or senior review.

Using the graded response as a framework guides the clinician to consider additional interventional management and senior review for advice or physical attendance within a specified timeframe, facilitating patients who are acutely ill or at risk of physical deterioration to receive prompt care and decisions in a timely manner.

During normal working hours this will be a senior nurse, doctor, or advanced nurse practitioner (ANP), out of hours response will be provided by DHU Health Care or on-call medical staff dependent on service specification.

The responder is responsible for informing colleagues if they are unable to attend within the requested time frame to enable an alternative clinician to be contacted or course of action to be undertaken.

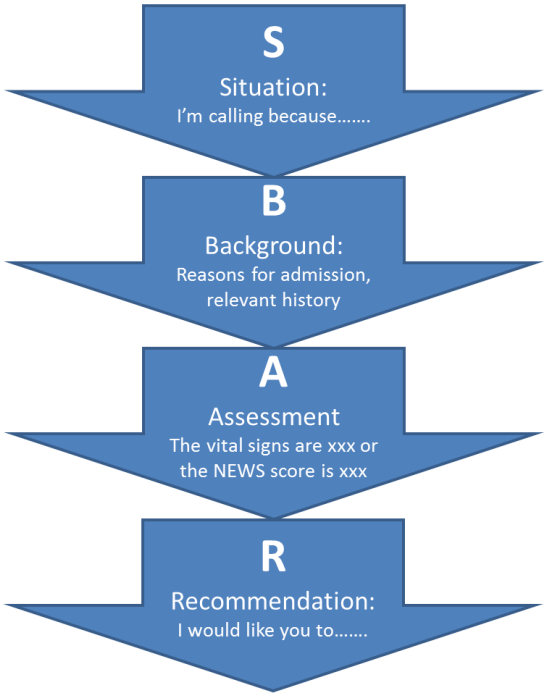
Following escalation, the clinician with the patient is responsible for ensuring ongoing patient monitoring and repeating escalation or calling an alternative responder as necessary.

The person recording the vital signs and triggering an escalation response must document their actions in the patients' records using SBAR (template or handwritten format) if no clinician on site.

The person responding must document their actions and management plan in the patient's care record. The trust has aligned escalation actions across all trust services with a NEWS/PEWS/MARSI score of >3 requiring a formal review by a registered nurse or medical colleague.

4.6 Communicating (escalating) Deterioration.

To improve communication between clinical staff it is recommended the person calling for advice uses a structured communication tool. SBAR (**S**ituation-**B**ackground-**A**ssessment- **R**ecommendation) is the recommended Trust tool. This is easy to remember in an emergency and ensures essential information is communicated enabling an appropriate timely response.



Clinical staff must confirm the contact details for the Next of Kin (NOK) are accurately recorded in the nursing & medical notes. Communication with the patient and their next of kin/main carer should always be clear, sensitive, and honest. Where a patient deteriorates and suffers a medical emergency, and the patient is transferred to an acute hospital the family of the patient should be contacted and informed of the change of condition as soon as possible.

Clinical staff can develop their communication skills in preparation for difficult conversations through learning & development opportunities through the Trust's uLearn system.

4.7 Assessing the adult patient with significant deterioration.

Assessing the adult patient with significant deterioration vital signs and the EWS score will give an indication of the patients' condition. If the patient is deteriorating, a more comprehensive assessment is warranted to fully understand any life-threatening presentations.

The ABCDE model of assessment is recommended as it gives a rapid, initial assessment of the patients' condition. Concern about a patient's clinical condition should always override the EWS if the attending healthcare professional considers it necessary to escalate care.

Sepsis should be considered in any patient with a known infection, signs or symptoms of infection, or in patients at high risk of infection, and a EWS score of 5 or more, or 3 in one parameter – 'think sepsis'.

Patients with suspected infection and a EWS score of 5 or more, or 3 in one parameter may require urgent assessment and intervention by a clinical team competent in the management of sepsis and urgent transfer to an acute hospital.

4.8 Suspect Sepsis

In deterioration of all patients with known or suspected infection full assessments MUST be undertaken with the view to EXCLUDE THE POSSIBILITY of sepsis.

Even where no current signs or symptoms are presently evident clear advice should be given regarding any signs of deterioration. This 'safety netting' process should be fully recorded detailing the information given to the patient if deterioration occurs or concern increases.

BE SUSPICIOUS, a significant number of patients with early stages of sepsis may 'look well', not all will show 'classic sepsis' symptoms and can present with high or low temperatures.

Sepsis screening using the Sepsis Trust tools should be performed. Trust tools/pathways used:

- In-patient sepsis screening tool and flowchart
- Community & outpatient sepsis recognition flowchart **(Appendix 6)**

4.9 Patient transfer to an acute hospital

If transfer to an acute care provider is required, the member of staff responsible for escalating the patient's deterioration must ensure observations are undertaken and recorded in line with the relevant scoring system and/or additional service specific monitoring whilst awaiting conveyance.

4.9.1

When calling 9-999 for an ambulance to attend in an emergency, the request is for further emergency medical support as the patient is not in a place where they can receive appropriate emergency care. This is not intended to be a transfer to Emergency Departments unless it is a planned transfer to access specific investigations (radiology etc).

5.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
Section 4	EWS compliance audits To include a review of deviation from routine monitoring and documentation of the decision	AMAT	DPRG	Quarterly

6.0 References and Bibliography

National INsitute of Health and Clincial Excellence. (2007, july 27). *National Insitute Clinical excellence.* Retrieved from https://www.nice.org.uk/guidance/cg50

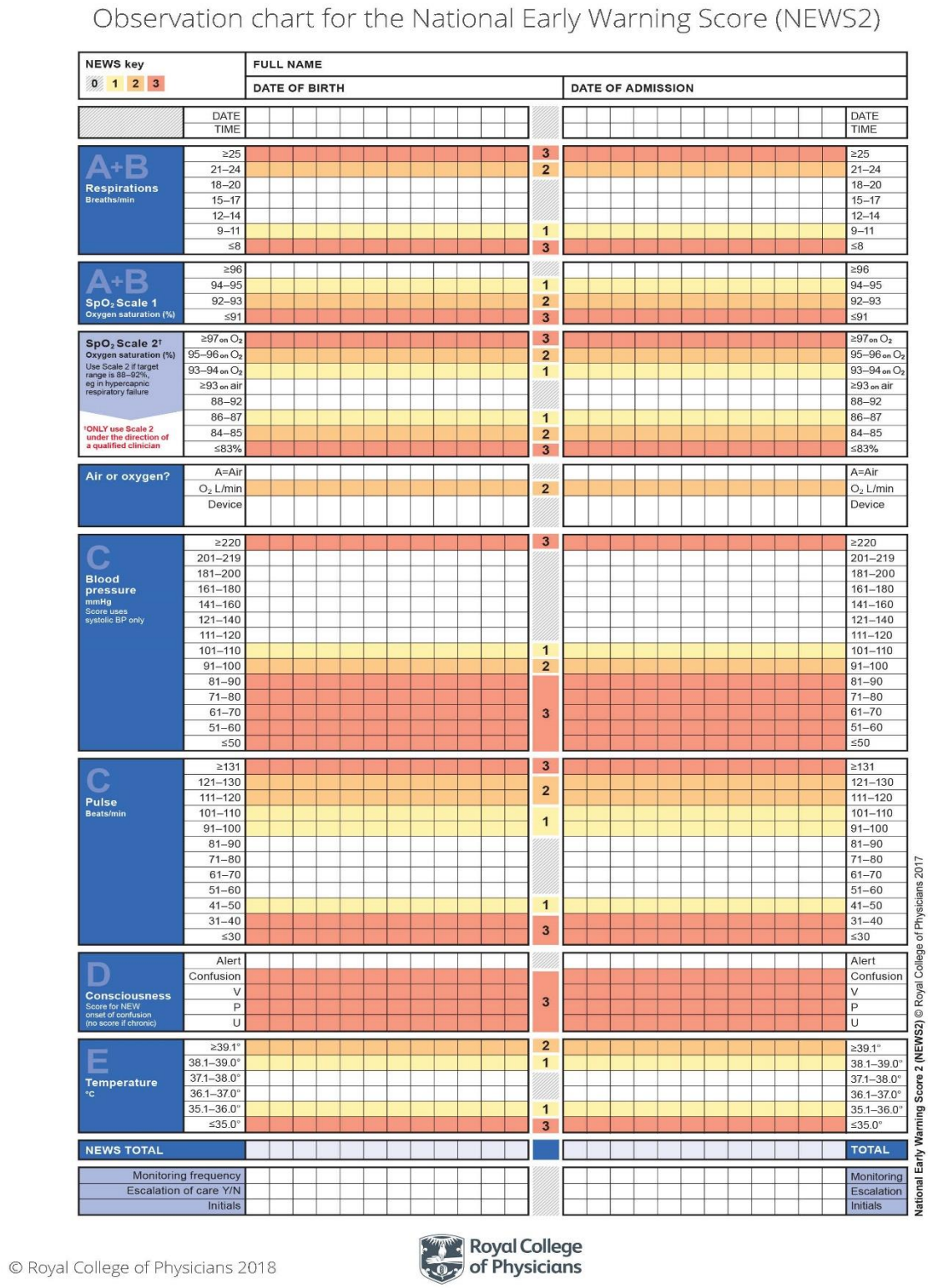
National Institue for Health and Clinical Excellence . (2017, September 13). *National Institue for health and Clinical Excellence.* Retrieved from Nice.org.uk: https://www.nice.org.uk/guidance/ng51

Nursing Midwifery Council . (2022, May 19). *Standards for competence for registered nurses .* Retrieved from www.nmc.org.uk: https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf

Royal College of Psychiatrists improving care . (2022, May). Retrieved from Medical emergencies in eating disorders (MEED): https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

Sepsis Trust. (2023, July 10). *About Sepsis* . Retrieved from The Sepsis Trust : https://sepsistrust.org/about/about-sepsis/

Appendix 1



Observation chart for the National Early Warning Score (NEWS2)

NEWS key 0 1 2 3		FULL NAME / DATE OF BIRTH		DATE OF ADMISSION	
	DATE / TIME				DATE / TIME
A+B Respirations Breaths/min	≥25		3		≥25
	21–24		2		21–24
	18–20				18–20
	15–17				15–17
	12–14				12–14
	9–11		1		9–11
	≤8		3		≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96				≥96
	94–95		1		94–95
	92–93		2		92–93
	≤91		3		≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2		3		≥97 on O_2
	95–96 on O_2		2		95–96 on O_2
	93–94 on O_2		1		93–94 on O_2
	≥93 on air				≥93 on air
	88–92				88–92
	86–87		1		86–87
	84–85		2		84–85
	≤83%		3		≤83%
Air or oxygen?	A=Air				A=Air
	O_2 L/min		2		O_2 L/min
	Device				Device
C Blood pressure mmHg Score uses systolic BP only	≥220		3		≥220
	201–219				201–219
	181–200				181–200
	161–180				161–180
	141–160				141–160
	121–140				121–140
	111–120				111–120
	101–110		1		101–110
	91–100		2		91–100
	81–90		3		81–90
	71–80				71–80
	61–70				61–70
	51–60				51–60
	≤50				≤50
C Pulse Beats/min	≥131		3		≥131
	121–130		2		121–130
	111–120				111–120
	101–110		1		101–110
	91–100				91–100
	81–90				81–90
	71–80				71–80
	61–70				61–70
	51–60				51–60
	41–50		1		41–50
	31–40		3		31–40
	≤30				≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert				Alert
	Confusion		3		Confusion
	V				V
	P				P
	U				U
E Temperature °C	≥39.1°		2		≥39.1°
	38.1–39.0°		1		38.1–39.0°
	37.1–38.0°				37.1–38.0°
	36.1–37.0°				36.1–37.0°
	35.1–36.0°		1		35.1–36.0°
	≤35.0°		3		≤35.0°
NEWS TOTAL					TOTAL
Monitoring frequency					Monitoring
Escalation of care Y/N					Escalation
Initials					Initials

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

Royal College of Physicians

Appendix 2 PEWS tool

PEWS Observation Chart (Over 12) adapted for LPT use

Leicestershire Partnership NHS Trust

Name:	Room:	Obs Freq:

										Score
Date										
Time										
Respiratory rate	≥ 40									4
	30-39									2
	25-29									1
	15-29									0
	10-14									2
	≤10									4
SpO_2	≤91									4
	92-94									1
	≥95									0
Oxygen	≥ 5l/min									4
	≥ 50%									4
	<5l / <50%									2
	50%									2
	Room air									0
Work of breathing	Apneoa									4
	Severe									4
	Moderate									2
	Mild									1
	Normal									0
Heart Rate (BPM) (sitting)	≥ 130									4
	120-130									2
	100-119									1
	70-99									0
	60-69									1
	50-59									2
	≤49									4
Systolic Blood pressure	≥ 140									4
	130-139									2
	120-129									1
	100-119									0
	90-99									1
	80-89									2
	≤50									4
CRT	≥ 3sec									2
	≤ 2sec									0
Temperature (°c)	≥ 39									4
	38									2
	37									1
	36									0
	35									2
	≤ 34									4
ACPVU	A									0
	CVPU									3
Total score										
BM (mmols)										
Observations completed by										

LPT Resus Team Feb 2022

PEWS escalation Score	Frequency of monitoring	Clinical Response
0	Routine monitoring (as per local minimal intervals) Once in a 24 hour period	• Continue routine PEWS\NEWS 2 scoring with every set of physical health observations.
Total 1-4 (if 3 in one parameter see below)	Routine monitoring (as per local minimal intervals) 4-6 hourly	• Inform Registered Nurse who must assess the patient • Registered Nurse to decide frequency of observations and document on PEWS chart • Registered Nurse to assess if review by Doctor or Senior Nurse or escalation of clinical care is required. For areas where medics on site the Registered Nurse should consult with a medic • Ensure patients raised PEWS (outside of usual exception & variance) is discussed at next medical and nursing handover
Total score 5 or 6 or 3 in one parameter	Increase frequency of physical health observations to at least 1 hourly **REMEMBER:** **SEPSIS FLAG SIGNS** **S**lurred speech **E**xtreme shivering / muscle pain **P**assing no urine in 12 hours **S**evere breathlessness **I** feel like I might die **S**kin mottled / discoloured	• Registered Nurse to assess patient, escalate (using SBAR handover tool) to Doctor and request urgent review within 20 minutes • If the Doctor is unable to asses in 20 minutes and concern remains or patient deteriorates further, contact (9)999 for ambulance assistance • Ensure patients raised PEWS (outside of usual exception & variance) is discussed at next medical and nursing handover
Total score 7 or more	Continuous monitoring of physical health observations	• A (9)999 call for ambulance assistance should be made • Registered Nurse to assess patient, escalate using SBAR handover tool to Senior Doctor and request immediate review • Emergency assessment by patients Consultant, on-call Senior Doctor or G.P • Ensure patients raised PEWS (outside of usual exception & variance) is discussed at next medical and nursing handover. • Where possible a Registered Nurse to stay with the patient

Where PEWS is used in areas where a Registered Nurse is not part of the staffing, another appropriately trained professional must initiate the response.

If a decision is made not to follow the clinical response guidance above, this MUST be documented in the patient records for the rationale for the decision.

Nothing in this scheme should prevent a Practitioner making an appropriate response based on their clinical judgement

LPT Resus Team Feb 2022

Appendix 3

MARSI MEWS - adapted for LPT use

Leicestershire Partnership NHS Trust

Name:	Room:	Obs Freq:

Date																		Score
Time																		
Respiratory rate	≥ 25																	3
	21-24																	2
	12-20																	0
	9-11																	2
	≤ 8																	3
SpO_2 scale 1	≥96																	0
	94-95																	1
	92-93																	2
	≤91																	3
SpO_2 scale 2 Use scale 2 if target range is 88-92% eg. In hypercapnic respiratory failure	≥97 on o2																	3
	95-96 on o2																	2
	93-94 on o2																	1
	≥93 in air																	0
	88-92																	0
	86-87																	1
	84-85																	2
	≤83																	3
Air or O_2	Air																	0
	Oxygen																	2
		Sit	Sta	Sit	Sta	Sit	Sta	Sit	Sta	Sit	Sta	Sit	Sta	Sit	Sta	Sit	Sta	
Sitting\standing BP	≥ 160																	3
	150-159																	2
	140-149																	1
	90-139																	0
	80-89																	2
	≤ 79																	3
Postural systolic difference	10-19																	1
	20-29																	2
	≥ 30																	3
Heart Rate (BPM) (sitting)	≥ 110																	3
	100-109																	2
	90-99																	1
	50-89																	0
	40-49																	1
	≤ 39																	3
Temperature (°c)	≥ 39																	3
	38																	2
	37																	1
	36																	0
	35																	2
	≤ 34																	3
ACPVU	A																	0
	CVPU																	3
Total score																		
If BM less than 4 see instructions on reverse of sheet																		
BM (mmols)																		
Observations completed by																		

LPT Resus Team Feb 2022

MARSI MEWS - Modified Early Warning System - Version 2

Leicestershire Partnership NHS Trust

Score	Frequency of monitoring	Clinical Response
0	Routine monitoring (as per local minimal intervals) Once in a 24 hour period	• Continue routine MARSI MEWS scoring with every set of physical health observations
Total 1-4 (if 3 in one parameter see below)	Routine monitoring (as per local minimal intervals) 4-6 hourly	• Inform Registered Nurse who must assess the patient • Registered Nurse to decide frequency of observations and document on MARSI MEWS chart • Registered Nurse to assess if review by Doctor or Senior Nurse or escalation of clinical care is required. For areas where medics on site the Registered Nurse should consult with a medic • Ensure patients raised MARSI MEWS (outside of usual exception & variance) is discussed at next medical and nursing handover
Total score 5 or 6 or 3 in one parameter	Increase frequency of physical health observations to at least 1 hourly **REMEMBER:** **SEPSIS FLAG SIGNS** **S**lurred speech **E**xtreme shivering / muscle pain **P**assing no urine in 12 hours **S**evere breathlessness **I** feel like I might die **S**kin mottled / discoloured	• Registered Nurse to assess patient, escalate (using SBAR handover tool) to Doctor and request urgent review within 20 minutes • If the Doctor is unable to asses in 20 minutes and concern remains or patient deteriorates further, contact (9)999 or 2222 for ambulance assistance • Ensure patients raised MARSI MEWS (outside of usual exception & variance) is discussed at next medical and nursing handover
Total score 7 or more	Continuous monitoring of physical health observations	• A (9)999 or 2222 call for ambulance assistance should be made • Registered Nurse to assess patient, escalate using SBAR handover tool to Senior Doctor and request immediate review • Emergency assessment by patients Consultant, on-call Senior Doctor or G.P • Ensure patients raised MARSI MEWS (outside of usual exception & variance) is discussed at next medical and nursing handover. • Where possible a Registered Nurse to stay with the patient
Where MARSI MEWS is used in areas where a Registered Nurse is not part of the staffing, another appropriately trained professional must initiate the response. If a decision is made not to follow the clinical response guidance above, this MUST be documented in the patient records for the rationale for the decision. **Nothing in this scheme should prevent a Practitioner making an appropriate response based on their clinical judgement**		

Plan for low blood sugar	
4 or above	• Continue routine monitoring
3 to 3.9	• Offer 150mls of Milk or Fruit Juice • Repeat BMs in 30 minutes
2 to 2.9	• Inform Duty Doctor, • Offer 150mls of Milk or Fruit Juice then • Repeat BMs every 15 minutes until above 4
Less than 2	• Emergency bleep duty Doctor and assess ACVPU • Administer oral glucogel, then 150mls of milk or fruit juice • If drowsy or unresponsive prepare equipment for IV access, administer 1mg IM Glucagon • Repeat BMs every 15 minutes until above 4

LPT Resus Team Feb 2022

Appendix 4

NON-CONTACT PHYSICAL HEALTH OBSERVATIONS TOOL

Leicestershire Partnership NHS
NHS Trust

IF A RED BOX STATEMENT IS TRUE: IMMEDIATELY ESCALATE. DO NOT LEAVE THE PATIENT.
DEPENDING ON OUTCOME: CONTACT NURSE-IN-CHARGE OR MEDICAL TEAM USING SBAR OR EMERGENCY AMBULANCE BY DIALLING (9)999 or 2222 FOR IN-PATIENT SETTINGS.
Remember to consider the patient's baseline. Observations taken should be indicative of variances from this baseline

Document assessment on reverse of this form and also in patients EPR notes (upload completed forms to EPR)

Airway clear? If awake, can the patient communicate in the way they normally do (no unusual sounds)	**AIRWAY**	• Airway obstructed? Silence? Coughing? Stridor? *(Suggestive of possible swelling)* Gurgling? Wheezing? Snoring? *(Consider: opening airway, back blows, abdominal thrusts, oral suction)* • Is airway unsafe? (Especially if asleep or resting) Are they at risk of vomiting? *(Consider: moving onto their side and carry out constant observations to prevent choking / aspiration)*
Breathing is quiet and regular? • Breathing 12 - 20 respirations per min? • Breathing causes no extra effort or difficulty? • No abnormal breath sounds?	**BREATHING**	• Noisy? Irregular? Shallow? Rapid? Malodourous/unpleasant odour (E.g. pear drops)? • Difficulty breathing, even with open airway? Is breathing fast, deep or laboured? • Rate: more than 20 breaths per min? Or less than 12 breaths per min? *(Consider: COPD, asthma, heart failure, chest infection? Acute illness? Recent rapid tranquilisation? Or restraint? Need for emergency oxygen? Assisted ventilations with bag & valve mask?)*
Warm, comfortable presentation? • Well perfused skin? • "Normal" complexion for them? • Pink mucous membranes inside the mouth? (If easily visible) • If asleep, monitor movement	• Does patient appear agitated?	**CIRCULATION**
Alert? • Responsive to voice? • No other physical health concerns? • (If patient is unresponsive, then please check if responsive to painful stimuli)		**DISABILITY**
Active, steady gait, resting / sleeping • Eating and Drinking? • How has patient appeared over the last 24 hours? Do they appear 'normal' for them? • Any family/carer concerns?		**EXPOSURE**

- Obvious trauma? Bleeding? Physiological shock? Dehydrated / Malnourished?
- Skin: Flushed? Clammy? Sweating? Cold? Pale? Swollen? Ashen (grey)? Mottled (purplish discoloration)? Swollen? Cyanosed (blue tinge, or discoloration of lips, nail beds, tip of nose or ear lobes)? Blue grey tinge to mucous membranes inside the mouth (Dark skin best seen in inner eye lids and lips)? Pallor: white/light coloured skin = skin takes on white hue, especially on face, inside of lips, eyelids & nail beds? Brown skin = yellow/red. Black skin = ashen grey.

- ACVPU assessment = Unresponsive? Only responds to verbal or physical stimulus?
- Orientation - New or unexplained: Confusion? Disorientation? Sleepy? Drowsy? Fitting? *(Consider: overdose, epilepsy & blood glucose level)*
- Temperature: If able to touch - is skin Hot? Cold? Clammy?
- Other physical health concern requiring additional interventions / monitoring e.g. Asthma? Diabetes? Epilepsy? Intoxication? Drug / Medication side effects?

- Change in ability to mobilise? Inability to stand unaided?
- Muscle rigidity? Change in their ability to mobilise? (E.g. weakness in any limbs?)
- Not eating & drinking? Signs of dehydration? (Dry cracked lips? Not passing urine?)
- Increased: thirst (polydipsia)? And urination (polyuria)?

- Signs of Physical Injury / bleeding / bruising / rash / self-harm? Does patient seem in any pain?
- Signs of Infection – Think: Could this Be Sepsis? (Check Sepsis Screening Tool)
- Patient, Carer, Health / Social / Professional concerns? (Use clinical judgement)

Patient Name: DOB: NHS No.:			If ANY "**RED**" statements are triggered overleaf, tick relevant A, B, C, D or E box below Note your concerns to red trigger in larger box provided (Include escalations, support, monitoring & outcomes)						Name, Signature & Role
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									
Date:		All green statements? (circle if true)	A	B	C	D	E		
Time:									

Important Notes: NEWS2 (National Early Warning Score 2) is always preferred, in conjunction with an ABCDE assessment. The decision to use this Non-Contact Physical Health Guidance & Assessment Framework tool is the decision of the practitioner who has had the relevant training, on a case by case basis and should be determined each time physical health observations are required. This tool aids assessment, but practitioners should always act on their best professional clinical judgement too. Circumstances why non-contact PHO rather than full NEWS2 should be summarised in the patient's electronic record

Differentiating between unconsciousness and sleep: Being asleep is not the same as being unconscious. If someone is asleep we would expect them to occasionally change position while sleeping and for them to have a "normal" complexion for them. If you are at all concerned that the patient is not sleeping, and may be unconscious escalate / evoke full ACVPU assessment of consciousness immediately. **Acknowledgements go to the Somerset and Taunton NHS Trust, from whom this tool has been adapted.**

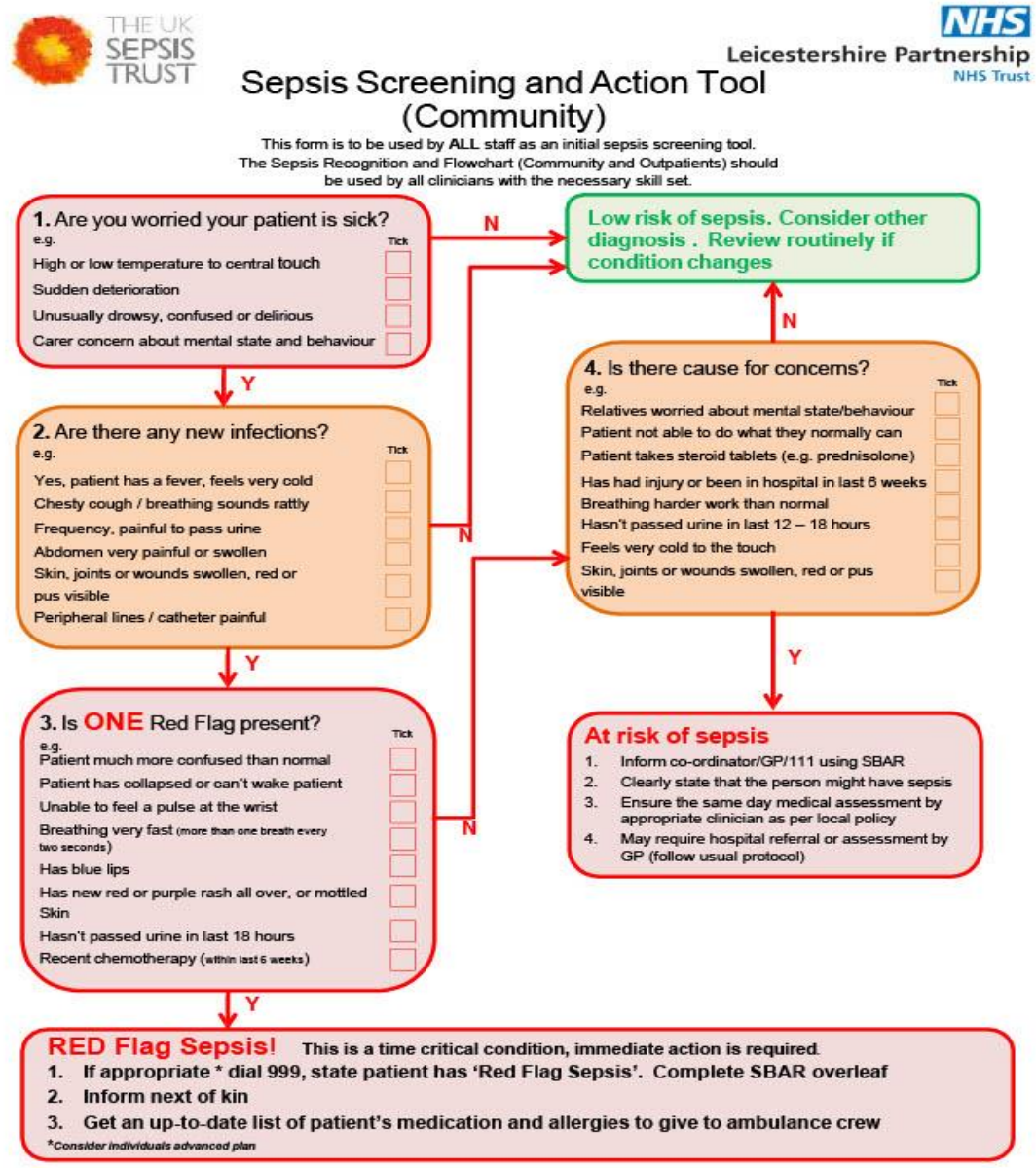
Appendix 5 CHS trigger and escalation guidance

Community Guidance Trigger Thresholds NEWS2

Patients name: Date of Birth: Baseline NEWS score:

NEWS 2 Score	Frequency of Monitoring	Clinical Response
0	Frequency of NEWS2 monitoring to be determined on an individualised basis	• No action required during this visit • For future visits where vital signs are required always calculate a NEWS2 score
1-4	Patient needs to have a specific personalised management plan drawn up which includes • baseline NEWS2 score • acceptable parameters for each vital sign • set frequency of monitoring	**If NEWS2 is outside of patients acceptable parameters:** • Discuss with coordinator on duty (B6/7) to decide if escalation to GP/ANP is required • Repeat observations and review by RN within 4 hours if it is decided that the patient does not require further escalation.
URGENT RESPONSE THRESHOLD Total score **5** or more **OR** **3** in one parameter **SEPSIS FLAG SIGNS** **S**lurred speech **E**xtreme shivering / muscle pain **P**assing no urine in 12 hours **S**evere breathlessness **I** feel like I might die **S**kin mottled / discoloured	Repeat observations every 15 mins until emergency services arrive Check Respect form and DNAR status	**If NEWS2 is outside of patients acceptable parameters:** • **Call ambulance (999)** • Stay with patient until emergency services arrive • Complete Sepsis flowchart **If the ceiling of care is to remain at home**: • Inform the coordinator on duty (B6/7) If a reversible condition is identified consider urgent 999 transfer to hospital • Inform GP & arrange urgent review by GP/ANP to update management plan
EMERGENCY THRESHOLD RESPONSE Total score 7 or more **SEPSIS FLAG SIGNS** **S**lurred speech **E**xtreme shivering / muscle pain **P**assing no urine in 12 hours **S**evere breathlessness **I** feel like I might die **S**kin mottled / discoloured	Repeat observations every 15 mins until emergency services arrive Check Respect form and DNAR status	**If NEWS2 is outside of acceptable parameters:** • **Call ambulance (999)** • Stay with patient until emergency services arrive • Complete Sepsis flowchart **If the ceiling of care is to remain at home**: • Inform the coordinator on duty (B6/7) If a reversible condition is identified consider urgent 999 transfer to hospital • Inform GP & arrange urgent review by GP/ANP to update management plan

Appendix 6 SEPSIS screening and action tool



THE UK SEPSIS TRUST

NHS
Leicestershire Partnership
NHS Trust

Time of call to 9999:	
Call reference number:	
Time crew arrived:	
Location patient transferred to:	

Brief Outline of Patients History

S

Situation:

I am (name), a nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned about XX
(e.g. BP is low/high, pulse is XX, temperature is XX.
Early Warning Score is XX)

B

Background:

Patient (X) was admitted on (XX date) with (e.g. MI/Chest infection)
They have had (X operation / procedure / investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of Obs. Were (XX)
Patient (X)'s normal condition is ....
(e.g. alert / drowsy / confused / pain free)

A

Assessment:

I think the problem is (XXX)
And I have ..... (e.g. given O2 / analgesia / stopped the infusion
OR
I am not sure what the problem is but Patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried

R

Recommendation:

I need you to ....
Come and see the patient in the next (XX) mins
AND
Is there anything I need to do in the meantime? (e.g. stop the fluid / repeat the Obs.)

Ask receiver to repeat key information to ensure understanding

The SBAR Tool originated from the US Navy and was adapted for use in healthcare by Dr. M Leonard and colleagues from Kaiser Permanente, Colorado, USA

Brief Outline of Patients Current Condition

Print name:	Title:	Date:	Time

NB: Paper copies of this document may not be most recent version.
The definitive version will be held on Leicester Partnership Trust eSource
Leicester Partnership Sepsis Pathway adopted from Sepsis UK Trust www.sepsisuk.org

Community
LPT108C Feb 2018

Appendix 7 Training Requirements

Training Needs Analysis

Training topic:	Non-contact observations training National Early Warning Score 2 training Sepsis in Children Sepsis in Adults
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) x Role specific ☐ Personal development
Directorate to which the training is applicable:	x Mental Health x Community Health Services ☐ Enabling Services x Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	All clinical staff – Non-contact observations and SEPSIS Registered Nurses, HCSWs and medics – NEWS2
Regularity of Update requirement:	Non-contact – 2 yearly NEWS2 – 2 yearly SEPSIS – One off
Who is responsible for delivery of this training?	SME: Senior resuscitation officer
Have resources been identified?	eLearning modules
Has a training plan been agreed?	
Where will completion of this training be recorded?	x ULearn ☐ Other (please specify)
How is this training going to be monitored?	Compliance reporting – Directorates and DPRG

Appendix 8 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	x
Respond to different needs of different sectors of the population	x
Work continuously to improve quality services and to minimise errors	x
Support and value its staff	x
Work together with others to ensure a seamless service for patients	x
Help keep people healthy and work to reduce health inequalities	x
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	x

Appendix 9 Due Regard Screening Template

Section 1	
Name of activity/proposal	Deteriorating Patient Policy
Date Screening commenced	15.04.2024
Directorate / Service carrying out the assessment	Enabling
Name and role of person undertaking this Due Regard (Equality Analysis)	Emma Wallis Deputy Director of Nursing and Quality
Give an overview of the aims, objectives and purpose of the proposal:	
The aim of this policy is to provide staff with best practice principles in the assessment, identification, and immediate intervention of a deteriorating patient. The scope of deterioration is physical deterioration	
OBJECTIVES: To improve patient outcomes by ensuring early identification, clinical assessment and intervention for patients with physical health deterioration.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	Positive impact – Use of different age related early warning score tools
Disability	Positive impact – Use of non-contact observations for patients with learning disabilities and communication difficulties
Gender reassignment	No impact
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	No impact
Race	No impact
Religion and Belief	No impact
Sex	No impact
Sexual Orientation	No impact
Other equality groups?	None identified

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	**No**
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This is a low risk policy that takes into consideration a number of protected characteristics including age and disability and has bespoke tools to support clinicians in practice.			
Signed by reviewer/assessor	E Wallis	Date	15.04.24
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Emma Wallis	Date	15.04.24

Appendix 10 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Deteriorating Patient Policy	
Completed by:	Emma Wallis	
Job title	Deputy Director of Nursing & Quality	**Date** 15.4.24

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	N	Clinical observations already taken and in the EPR
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	N	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	N	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**N**	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	N	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	N	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	N	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**N**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Sarah Ratcliffe**
Date of approval	**30.4.24**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust