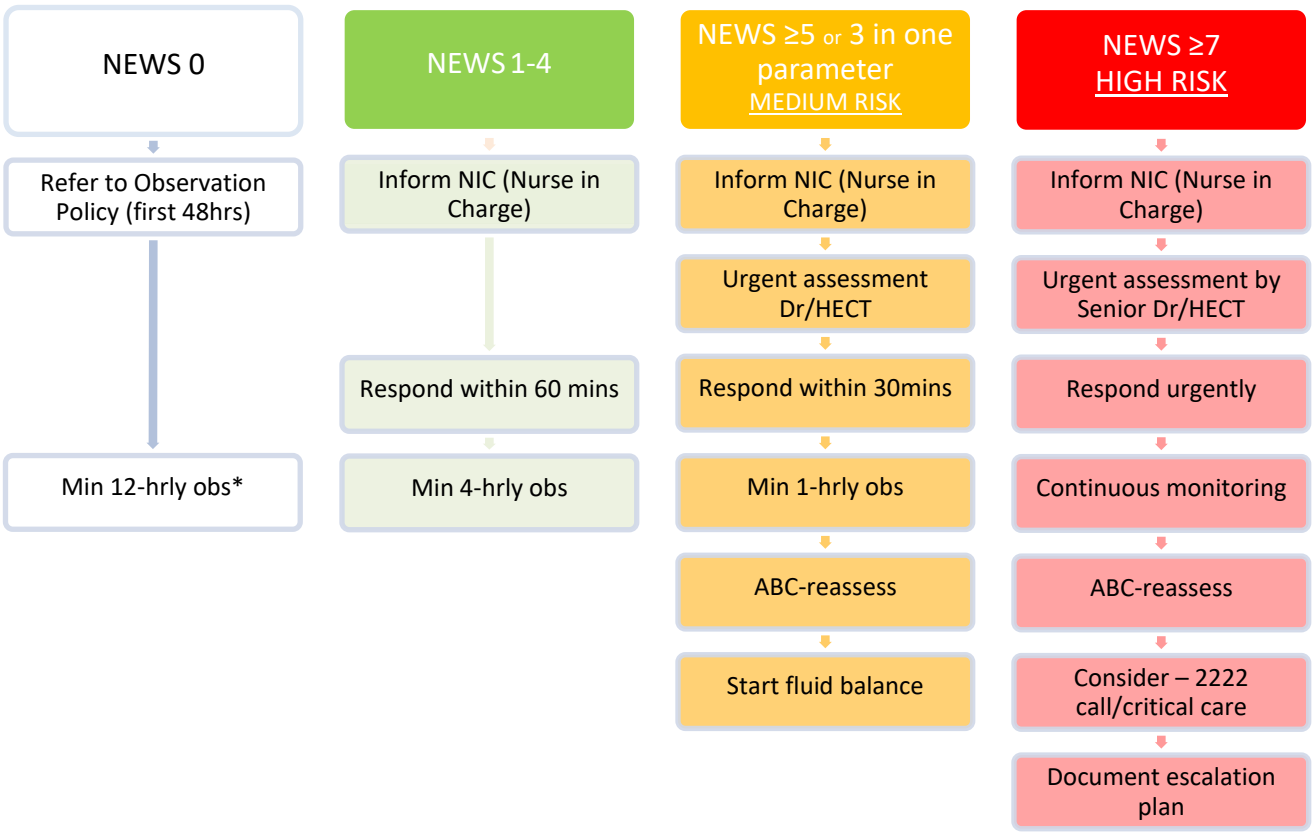
NHS LANARKSHIRE CLINICAL OBSERVATION GUIDANCE (ACUTE CARE)

TARGET AUDIENCE	Acute setting
PATIENT GROUP	All patients > 16 years in the acute setting

Clinical Guidelines Summary



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1. Introduction

Scottish Intercollegiate Guidelines Network (SIGN) guidelines 167 (2023) identifies that patient outcomes can be significantly affected by the processes in place to identify, monitor, respond to and escalate the care of the deteriorating patient. Effective systems should be developed and adapted to the needs of the local patient population, the skills and training of clinical staff and institutional capability.

Nurses and doctors have a vital role in the early identification of patients at risk of deterioration through the monitoring of patient observations and assessment. The importance of accurate and timely observations is clearly documented and seen as essential practice for the recognition and response to acute patient deterioration in hospital (SIGN guidelines 167, 2023).

The Royal College of Physicians (RCP) (2017) and SIGN guidelines 167 (2023) also recommend setting a standard for the frequency of clinical observations and an assessment of competency for the recording of clinical observations as well as assessment and treatment of patients within acute hospitals. This observation guidance sets the standard for the accurate monitoring of observations, utilising research and best practice and refers to the National Institute for Health Care and Excellence (NICE) competency document and SIGN guideline 167 to ensure that the national standard is met and maintained.

National Early Warning Score (NEWS) is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients which then can be used to determine appropriate actions and escalation.

NHSL had previously adopted an adapted version of NEWS 2. However, following the publication of SIGN guidelines 167 (2023) and introduction of Patientrack, NHSL will fully implement NEWS 2 across the acute division.

This guidance covers all of NHSL adult in-patient areas, including theatre areas and all day case areas for adult patients.

2. Purpose

- This guidance is aimed at all clinical staff working within adult in patient areas in NHSL. It sets a clear framework for recording and monitoring of patients observations and associated escalation of concern,
- Outpatient areas are not included within this guidance; however, the lead clinician and lead nurse of the outpatient clinics will determine the frequency and observations required following a risk assessment of patients.
- This guidance applies to patients over sixteen years of age in the acute setting (experienced clinicians should exercise clinical judgment when carrying out vital signs on teenagers whose height and weight may mean their physiology and anatomical development is that of an adult). Staff should seek advice if concerned.
- This guidance does not address maternity patients in NHSL.

3. Minimum Observation Set

- A full set of observations must be taken. This should include Respiratory Rate, Pulse Rate, Blood Pressure, Temperature, Neurological Status, (Alert, Conscious, Voice, Pain, Unresponsive (ACVPU)) and Oxygen Saturation and Oxygen administration.
- If an observation is not recordable or undetectable the observations must be escalated to the nurse in charge and if appropriate the medical team to assess the patient immediately.
- A full set of observations, must be undertaken on admission to all clinical areas. Thereafter the frequency of subsequent observations will depend on the specialty and clinical condition of the patient and NEWS 2 score.
- When patients are transferred from one ward/ department to another, a full set of observations should be completed by the receiving practitioner within 30 minutes of arrival within the new clinical area with the exceptions as below
- All patients should have their observations recorded unless a decision has been made at Band 5 and above to stop observations. Deviation from this observational frequency should be recorded in the notes and appropriate flag added to Patientrack.
- For patients on a documented up to date end of life pathway there is no requirement to record vital signs or complete NEWS 2 scoring. This should be identified on Patientrack to prevent inappropriate prompts to staff to repeat observations. In addition, a Treatment Escalation Plan (TEP) should be put in place. A TEP defines which interventions might benefit an individual if they deteriorate further during an episode of acute care and supports healthcare staff to apply the principles of realistic medicine as identified in Chief Medical Officers Annual Report 2022-2023 (Scottish Government 2023).
- If a Do Not attempt Cardiopulmonary Resuscitation (DNACPR) record is in place

a TEP should also be completed.

4. Clinical Competency

Patient observations should be measured by an appropriately trained and competent member of staff. On induction to NHSL Acute Division all Health Care Support Worker (HCSW) nurses (including bank staff) should be competency assessed before undertaking and recording vital signs.

Clinical Support Workers (CSW) must complete the vital signs course and complete appropriate HCSW standards prior to recording vital signs. Competency assessment should include the manual recording of respirations, pulse and Blood Pressure.

5. The Frequency of Observations

Frequency of observations will depend on the NEWS 2 score as per the NEWS 2 flow chart (see appendix). Clinical judgement can also be used to increase the frequency of clinical observations when staff express "Cause for Concern". This "Cause for Concern" can also be used by any member of staff to escalate patients for review to the Hospital Emergency Care Team (HECT) nursing staff or medical staff at any time.

Oxygen saturation monitoring "trigger setting"

Patients with **known** hypercapnia (high carbon dioxide level), respiratory failure due to Chronic Obstructive Pulmonary Disease (COPD), should have a target saturation of peripheral Oxygen (Sp02) of 88 – 92%. Furthermore, the sensitivity of NEWS 2 may be adversely affected by the chronic physiology of COPD patients with hypercapnia and SpO2 values can be reset by competent clinicians. The SpO2 target for this patient group should be set by a "**Competent clinician band 5 or above"**. Senior clinical leads on site are required to define what a "Competent clinician," is on a local basis. This information should be conveyed to clinicians, wards and departments and reviewed on a regular basis.

Detecting delirium

The includes any patient who has a new-onset confusion, disorientation and/or agitation, where previously their mental state was normal – this may be subtle. The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation. This would score 3 or 4 on the Glasgow Coma Score (GCS) rather than the normal 5 for verbal response), and scores 3 on the NEWS 2 system. The new- onset of confusion was added to the NEWS 2 in order to improve the detection of delirium which carries significant morbidity and mortality and is often a common sign in clinical deterioration, for example in sepsis. It is recommended that

if it is unclear whether a patient's confusion is new or their normal state, the confusion should be assumed to be new until confirmed to be otherwise to minimize risk of delay in recognition of deterioration.

A simple yes / no prompt should be recorded. If the response is 'yes' a 4 Abbreviated Test (4AT) (Royal College of Physicians 2020) must be completed. Staff should escalate this to nurse in charge, medical staff or HECT as directed on the NEWS 2 chart.

Treatment Escalation Plan (TEP) & Realistic Medicine

All patients at risk of clinical deterioration should have a Treatment Escalation Plan (TEP) documented that is completed with input from the patient and their family. Documented plans should be accessible to all care providers. The TEP should include a decision on cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Cardiopulmonary resuscitation status should not be the sole focus of the TEP. TEP's define which interventions might benefit an individual when they present to acute care or if they deteriorate further during an episode of acute care. The TEP may be informed by a patient's Future Care planning discussion but also address the fact that the patient has presented to acute care services, and therefore by definition their clinical status is in flux. The interventions addressed by a TEP should include levels of invasive care to be considered. This may include consideration of advanced therapy in critical care such as invasive ventilation or renal replacement therapy (SIGN guidelines 167, 2023).

6. Escalation

A structured handover process is recommended by SIGN guidelines 167 (2023), in NHSL this should take the form of a Situation Background Assessment Recommendation (SBAR).

Staff are asked to record escalation of high NEWS 2 scores and seek help by escalating as per NEWS 2 guidance. The following section describes the frequency of observations for specific NEWS 2 scores.

NEWS score	Actions
0	1. Refer Observation Policy first 48 hours of admission. 2. Minimum 12 hourly observations unless stopped by Senior decision maker to increase or stop observations altogether. This should be documented in medical and nursing notes.
1-4	1. Inform nurse in charge 2. Respond within 60 minutes. 3. Airway – breathing - circulation (ABC) 4. Minimum 4-hourly observations.
≥5 *or* >3 in one parameter *or* cause for concern	1. Inform Nurse in charge. 2. Medium risk 3. Urgent assessment by Doctor/HECT. 4. Respond within 30 minutes. 5. ABC – reassess 6. Start fluid balance 7. Minimum hourly observations
≥7	If a patient has a NEWS of 7 or above there is a significant cause for concern 1. Immediate observations and an Airway – breathing – circulation – disability – exposure (ABCDE) assessment should be taken by the nurse responder (Nurse in charge) as part of their acute illness assessment. 2. Inform Nurse in charge. 3. High Risk 4. Urgent assessment by senior doctor/HECT. 5. ABC – reassess 6. Continuous monitoring 7. Consider • 2222 call • Critical care

	8. Document escalation plan – frequency of observations must be clearly documented in clinical notes and rationale.

All observations should be recorded on Patientrack or on NHSL NEWS chart (if system failure occurs with Patientrack), or agreed local documentation that has been reviewed by the documentation group (and others including Critical Care Delivery Group (CCDG) as appropriate) for use. All observations should then be initialed if paper copy is utilised. All written chart entries should be clear, legible, written in black pen and the time and date of the observations clearly documented. The practice of recording clinical observations on paper charts should **only** be undertaken in areas that have not implemented Patientrack or in periods of Information Technology (IT) / system failure. The use of paper copies should be documented in patients notes.

Reliability with observational frequency NEWS 2 should be used as a clinical quality indicator for wards and departments as part of the clinical quality dashboard. The reliability of observations should be fed back to the ward staff on a regular basis with designated support for improvement in place.

7. Patientrack

SIGN guidelines 167 (2023) recommends the observations should be transcribed electronically, charted and displayed electronically and be underpinned by effective IT systems, protocols and support to ensure ease of use. NHSL has adopted the use of Patientrack in all acute inpatient areas. NHSL will ensure appropriate paper-based charts are available as a safeguard in the event of IT/System failure. All clinical staff expected to record or review clinical observations should be trained in the use of Patientrack as part of their induction to NHSL.

8. Medical Devices Used to Record Patient Observations

To ensure that observations taken and recorded are as accurate as possible, it is important to remember that equipment can fail and provide false readings if the user is unfamiliar with all of the above. Manual assessment skills including look, listen and feel, and ABCDE are vital for the clinical evaluation of the deteriorating patient. These skills are taught on NHSL clinical courses i.e. CRASH and Acute Assessment of the Critically Unwell Adult Treatment and Escalation (AACUTE). Nursing staff should review the patient using these clinical skills and question and check any spurious observations.

This guidance is neither extensive nor exhaustive and must be used with

clinical judgment and clinical experience in order to detect patient deterioration timely and ascertain support and assistance in order to maintain patient safety. Please summon immediate help when dealing with patients causing concern.

References/Evidence

- Scottish Government (2023) The Chief Medical Officers annual reports 2022-2023. Chief Medical Officer for Scotland - Annual Report 2022–2023 (www.gov.scot) accessed 22nd July 2023

- Health Improvement Scotland (2016) Think Delirium - Improving the Care of Older People Delirium Toolkit. www.healthcareimprovementscotland.org/his/idoc accessed 22 July 2023

- Royal College of Physicians (2017) National Early Warning Score (NEWS 2). National Early Warning Score (NEWS) 2 | RCP London accessed 22nd July 2023

- Royal College of Physicians (2020) National Early Warning Score (NEWS) 2 - Standardising the assessment of acute-illness severity in the NHS Additional implementation guidance Update: March 2020. NEWS2: Additional implementation guidance | RCP London accessed 22nd July 2023

- SIGN (2023) SIGN 167: Care of deteriorating patients. SIGN 167 Care of deteriorating patients accessed 22nd July 2023

Appendices

1. Governance information for Guidance document

Lead Author(s):	Chief Nurse University Hospital Hairmyres/Wishaw/Monklands
Endorsing Body:	NHS Lanarkshire Resuscitation Committee
Version Number:	10
Approval date	February 2024
Review Date:	01/10/2027
Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
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Consultation Process / Stakeholders:	• Resuscitation Committee • Nursing Midwifery Allied Health Professionals (NMAHP) Documentation Group
Distribution:	• Guidelines NHSL Public Facing web page • All wards within NHSL • Management and clinical teams • All educational events

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version**
24/02/2015	M Carberry	Edited and updated	3
22/05/2017	M Carberry	Edited and updated	4
12/12/2017	M Carberry	Title change from policy to guidance	5
26/08/2020	M Carberry	Review date extended due to COVID/Patientrack	6
13/07/2021	M Carberry	Patientrack update with NEWS2	7
22/07/2023	D Watson / L Axford	Edited and updated. Adoption of NEWS2	8
10/10/2023	P Brankin / N Littlejohn	Edited and updated	9
31/01/2023	L Axford	Edited and updated	10
05/07/2024	L Weir	Edited and updated	11
08/11/2024	L Axford	Contents moved to new template	12

2. NEWS 2 flow chart example

(on hold)
NMAHP.OBNEWS.24