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<td>2.4</td>
<td>Apr 2013</td>
<td>Revision</td>
<td>Amendments by Corporate Governance, formatting for document map navigation, automatic table of contents, headers and footers. Title amended to be more concise. Harmonised policy as a result of the merging of Northern Devon Healthcare NHS Trust and NHS Devon community services. Converted to new NHSLA two-part template as a result of recommendations from NHSLA inspection on 27th March 2012.</td>
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<td>2.5</td>
<td>Jul 2013</td>
<td>Revision</td>
<td>Consulted with Medical Director and amendments as suggested. Changes to GP responsibilities.</td>
</tr>
<tr>
<td>3.0</td>
<td>Sep 2013</td>
<td>Final</td>
<td>Approved at Patient Safety Operational Group on 5th September 2013 following consultation.</td>
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<tr>
<td>3.1</td>
<td>Mar 2015</td>
<td>Revision</td>
<td>Amendments to reflect the recommendations from the CQC in the Chief Inspector of Hospitals Inspection Report.</td>
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<td>3.2</td>
<td>Apr 2015</td>
<td>Revision</td>
<td>Amendment from DNAR to DNACPR</td>
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<tr>
<td>3.3</td>
<td>Dec 2016</td>
<td>Revision</td>
<td>Changes to include paediatric patients and update roles of some teams</td>
</tr>
</tbody>
</table>

**Main Contact**
Outreach & Resuscitation Service Manager
Level 5
North Devon District Hospital
Raleigh Park
Barnstaple
Devon EX31 4JB

**Lead Director**
Director of Medicine

**Tel: Direct Dial** – 01271 322331

**Superseded Documents**
Patients at Risk of Deterioration Policy v3.2

**Issue Date**
January 2017

**Review Date**
January 2020

**Review Cycle**
Three years

**Consulted with the following stakeholders:** (list all)
- All members of the Prevention and Resuscitation Group

**Approval and Review Process**
- Par Group
Patients at Risk of Deterioration Policy
FINAL 11.01.17

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<td>Resuscitation, Corporate Nursing</td>
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1. Introduction

1.1. This document sets out Northern Devon Healthcare NHS Trust’s system for the management of patients at risk (PaR) of deterioration. It provides a robust framework to ensure a consistent approach across the whole organisation, and supports our statutory duties as set out in the NHS Constitution.

1.2. This is a document that all clinical staff will work to.
2. Purpose

2.1. The purpose of this document is to ensure that staff identify and respond to seriously ill patients and those at risk of deterioration, early. This has been shown to significantly reduce morbidity and mortality. This is in line with the NICE guidance of recognising seriously ill patients. Acutely Ill Patients in Hospital: Recognising of and response to acute illness in adults in hospital (National Institute for Health and Clinical Excellence 2007). NHS Improvement Patient Safety Alert: NHS/PSA/RE/2016/005. It is also in line with the NCEPOD ‘time to intervene’ report of 2012.

2.2. Implementation of this policy will ensure that:

- Patients remain safe.
- Minimising risk to patients and the organisation.
- This will ensure all patients have standardised care depending on their observations recorded.

2.3. Line managers are responsible for ensuring this policy is implemented across their area of work.

2.4. The policy applies to all clinical staff who care for adult and paediatric inpatients, within Northern Devon Healthcare NHS Trust and those working within the Trust, who are from other trusts, including locum and temporary staff. Patients in active labour, on ICU, on Paediatric HDU or in Recovery are excluded.

3. Definitions

Patients at Risk of deterioration (PaR)

3.1. Those patients that trigger on an Early Warning System or whose condition causes concern to medical or nursing or midwifery staff.

Outreach & Resuscitation Officer

3.2. A qualified individual, who is responsible for providing staff with education on the Early Warning Score and other signs of deterioration, as well as the appropriate response

Adult Cardiac Arrest Team

3.3. A team of qualified individuals which responds to all adult medical emergencies when summoned via the bleep system, the team consists of Medical F1, Medical F2, Anaesthetic Junior, Outreach & Resuscitation Officer / Senior on-call Nurse and a porter.
**Paediatric Arrest Team**

3.4. A team of qualified individuals which responds to all paediatric emergencies when summoned via the bleep system, the team consists of Paediatric register, Neonatal SHO, Anaesthetic Junior, Outreach & Resuscitation Officer/Senior on-call Nurse and a porter.

**Hospital at Night (H@N)**

3.5. The Hospital at Night (H@N) concept is a way to achieve effective clinical care by having one or more multi-professional teams, who between them have the full range of skills and competencies to meet patients’ immediate needs. It allows comprehensive and timely handover between teams of any patients deemed to be at an increased clinical risk, ensuring that they are appropriately reviewed during the night time period.

**Treatment Escalation Plan (TEP)**

3.6. This is a written and signed order of treatment limitations. This is a Devon Wide document that can be used by GP’s and Consultants in charge of the patient’s care. It has a section on the resuscitation status of the individual. The TEP is part of the Resuscitation Policy.

**Paediatric Treatment Escalation Plan (TEP)**

3.7. This is a written and signed order of treatment limitations. It has a section on the resuscitation status of the individual.

**Medical F1 / F2 / ST1 or ST2**

3.8. This refers to the junior medical staff grades.

**Patient Safety Operational Group**

3.9. A multi-disciplinary team that provides oversight and direction for the Trust and its staff.

**Early Warning Score (EWS)**

3.10. A track and trigger system derived from the patient observation chart, which is then used to recognise patients at risk of a cardio-pulmonary arrest. There are Modified Early Obstetric Warning Score (MEOWS), the Paediatric Early Warning Score (PEWS) and the Newborn Early Warning Score (NEWS).
Situation, Background, Assessment and Recommendation (SBAR) Communication Tool

3.11. Situation, Background, Assessment and Recommendation (SBAR) is an easy to remember mechanism that staff can use to frame conversations, especially critical ones, requiring a clinician’s immediate attention and action. It enables staff to clarify what and how information should be communicated between members of the team.

3.12. The tool consists of standardised prompt questions within 4 sections, to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition. The tool helps staff anticipate the information needed by colleagues and encourages assessment skills. Using SBAR prompts staff to formulate information with the right level of detail.

4. Responsibilities

Role of the Prevention and Resuscitation Group

4.1. The Prevention and Resuscitation Group is responsible for:

- Overseeing policy and guideline development and reviewing on a regular basis.
- Receiving reports on training uptakes.
- Reviewing aggregated data on audit activity.
- Identifying organisation-wide and corporate risks.
- Monitoring compliance with National Standards.
- Implementing any audits that the group deem necessary and presenting the data to the group.
- Reviewing and monitoring incident trends relating to the work of the group.
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation.

Role of the Workforce Development Department

4.2. The Workforce Development Department are responsible for:

- Holding central records for all training.
- Ensuring that quarterly reports are sent to the appropriate managers with a copy being sent to the Outreach & Resuscitation Manager.
- Ensuring that managers are informed of any staff who fail to attend training, without prior notification.

Role of the Outreach & Resuscitation Team

4.3. The Resuscitation Team are responsible for:
• Ensuring sufficient availability of training to help staff recognise patients at risk of deterioration and deliver these programs.
• Ensuring that on outreach shifts time is given to work with staff on a 1:1 basis looking at a deteriorating patient.
• Auditing the observation charts and ensuring the results are sent to line managers, the Patient Safety Operational Group, via the Quality Improvement team and the Prevention and Resuscitation Group.
• Ensuring that the workforce Development Department receive copies of the attendance records of all training sessions.

Role of Line Managers

4.4. All Line Managers are responsible for:

• Ensuring that staff are aware of this policy.
• Ensuring that staff are permitted to attend training that will help them to recognise patients at risk of deterioration.
• Ensuring that the observation chart is being used correctly and consistently and that an Early Warning Score or Modified Early Obstetric Warning Score is being recorded each time a set of observations is performed.
• Ensuring that the frequency of observations being recorded is in accordance with this policy.
• Ensuring that equipment needed to monitor patients is available for staff to use and that staff are adequately trained in its use.
• Ensuring that when requested monthly audits on compliance is available to the Quality Improvement Team.
• Ensuring that locum and temporary staff are aware of this policy and are aware of how to record observations and Early Warning Scores.

Role of all Medical Staff within Northern Devon Healthcare Trust

4.5. All medical staff are responsible for:

• Attending a ward / department as quickly as possible, if called to see a critically ill patient, certainly within one hour and initiating treatment in accordance with the patients’ clinical condition. However, if concerned about the patients’ clinical condition, they must seek more senior help as quickly as possible.
• Ensuring that the patient is assessed and a treatment plan implemented. This will be communicated to the nurse / Midwife in charge of the patient and documented in the patient’s notes.
• Documenting clearly in the notes the treatment plan and criteria for review of the patient.
• Ensuring that all F1 / F2 doctors discuss all adult patients with an Early Warning Scores of 6 or more with the specialist trainee or consultant as soon as practicable but certainly within 12 hours.
• Ensuring that all junior doctors discuss all paediatric patients with an Early Warning score of 10 or more with a more senior doctor as soon as practicable but certainly within 12 hours.
- Ensuring that if following treatment the patient fails to improve, a more senior doctor is informed and requested to visit as soon as possible to review the patient, medical plan and consideration is given to if the patient needs transfer to either an acute site or another speciality.
- Ensuring that where maternity patients fail to respond to treatment, consideration is given to involving other healthcare professionals from other specialities.
- Ensuring that where a maternity patient is scoring 2 reds consideration is given to contacting a Critical Care Consultant. This will be done by a Consultant Obstetrician normally.
- Giving guidance to the ward staff on the criteria for contacting medical staff, again if necessary, including who to call and the contact details.
- Ensuring that where it is deemed appropriate for patients at risk of deterioration to have a discussion about their treatment limits and their resuscitation status this is done as per the Resuscitation Policy. This will then be documented using the TEP or the Paediatric TEP form.
- Being aware that a decision not to resuscitate does not imply that the patient is not for active treatment and in these cases the medical staff will ensure that a treatment plan is in place.
- Ensuring that they comply with Trust mandatory training requirements by booking the appropriate Resuscitation / Life Support course. Bookings must be made via the STAR system from the Workforce Development Department. It is also their responsibility to advise the Workforce Development Team at the earliest opportunity if they are unable to attend.
- Incident reporting any adverse incidents that occur in connection with a critically ill patient in accordance with the trust Incident Reporting Policy. on a Trust Incident Reporting Form.
- Complying with this policy.

**Role of GP’s (Devon Doctors providing cover to the Community Hospital Wards OOH’s)**

- All GP’s providing cover to the community hospitals:
- Attending a ward / department as quickly as possible, if called to see a critically ill patient, certainly within one hour and initiating treatment in accordance with the patients’ clinical condition.
- Ensuring that the patient is assessed and a treatment plan implemented. This will be communicated to the nurse in charge of the patient and documented in the patient’s notes.
- Documenting clearly in the notes the treatment plan and criteria for review of the patient.
- Ensuring that if following treatment the patient fails to improve; consideration is given to whether the patient needs transfer to an acute site.
- Giving guidance to the ward staff on the criteria for contacting medical staff, again if necessary, including who to call and the contact details.
• Ensuring that where it is deemed appropriate for patients at risk of deterioration to have a discussion about their treatment limits and their resuscitation status this is done as per the Resuscitation Policy. This will then be documented using the TEP form.
• Being aware that a decision not to resuscitate does not imply that the patient is not for active treatment and in these cases the medical staff will ensure that a treatment plan is in place.
• Incident reporting any adverse incidents that occur in connection with a critically ill patient in accordance with the trust Incident Reporting Policy.
• Complying with this policy.

Role of the Role of All Clinical Nursing Staff / Midwifery Staff

4.6. All clinical nursing staff are responsible for:

4.7. Monitoring the condition of all patients using the observation chart at intervals in line with Appendix A for the acute hospital and Appendix B for community hospitals and Appendix C for maternity patients. Appendix D for paediatric patients

4.8. If the nurse in the acute or community is concerned about an adult patient or the patient triggers with an Early Warning Scores score of 6 or more, then the on call doctor or GP should be contacted, the Situation, Background, Assessment and Recommendation (SBAR) tool should be used for communication with the doctor.

4.9. If the paediatric nurse in the acute is concerned about a patient or the patient triggers with an Early Warning Scores score of 10 or more, then the on call doctor should be contacted, the Situation, Background, Assessment and Recommendation (SBAR) tool should be used for communication with the doctor.

4.10. For maternity patients, if the midwife is concerned or the patient has one red or two yellow triggers then there should be an urgent doctor review. Staff should use the SBAR tool as above for all communication.

4.11. Ensuring the nurse / midwife in charge of the ward is kept informed of the condition of these patients. The nurse in charge will also be responsible for determining the monitoring requirements, including the frequency of the observations as per the guidance in Appendix A, Appendix B or Appendix C, Appendix D (whichever is applicable). However, if the nurse/ midwife in charge considers it necessary to record observations at different intervals than those documented, the nurse looking after the patient should be informed and the rationale should be recorded in the healthcare records.

4.12. For all patients who score higher than or equal to a medium risk, a fluid balance chart will be commenced and 4 hourly balances recorded. Guidance on when and how to record this can be found in Appendix D.
4.13. Activating a cardiac arrest call (using the arrest number of 2222) if they feel that the patient is at risk of imminent cardio-respiratory arrest. If the patient is in a community hospital, 999 should be called for an emergency response. It may be necessary to dial 9 before the 999 to obtain an outside line.

4.14. In the Acute Trust, contacting a more senior doctor, including the consultant, directly if the nurse in charge is concerned about the care the patient is receiving. This must be via bleep 500 at night.

4.15. In the community nurses can contact the GP or Devon Docs if they are concerned. If they continue to have concerns then they must contact the on call manager / matron for advice.

4.16. Ensuring that all patients scoring 6 or more are assessed at the beginning and end of the shifts by the registered nurse / Midwife for that patient. This assessment and findings will be documented in the patient’s notes.

4.17. For paediatric patients scoring a PEWS of 10 or more they should be assessed at the beginning and end of the shift by the registered nurse. This assessment and findings will be documented in the patient’s notes.

4.18. Incident reporting any adverse incidents that occur in connection with a critically ill patient in accordance with the Trust Incident Management Policy.

4.19. Ensuring that they comply with Trust mandatory training requirements by booking the appropriate Resuscitation / Life Support course. Bookings must be made via the STAR system from the Workforce Development Department. It is also their responsibility to advise the Workforce Development Team at the earliest opportunity if they are unable to attend.

4.20. Complying with this policy.

5. Patients at Risk of Deterioration Policy

5.1. Patients at Risk of Deterioration Policy

5.2. This is the standardised Trust-wide approach for the monitoring of in-patients.

5.3. All in-patients, including patients in the Emergency department for whom a decision to admit has been made, will have their vital signs recorded immediately and then monitored as per policy. From this monitoring an Early Warning Score will be recorded.

5.4. Vital signs monitoring will be documented on the patient’s Trust Observation Chart. (Please note that photocopied charts are not acceptable).

5.5. Frequency of vital sign monitoring will be determined from Appendix A for the acute site and Appendix B for the community sites and Appendix C for maternity patients. Appendix D for paediatric patients if the frequency is recorded outside of that specified in this policy, then the rationale should be recorded in the patient’s clinical notes.
5.6. Patients within Intensive Care, Recovery and in Active Labour receive closer monitoring, and do not require an Early Warning Score or MEOWS to be recorded until they are ready for transfer to a ward area. They should have at least one set of recorded vital signs and Early Warning Score completed prior to transfer. This does not preclude staff from doing an Early Warning Score at any time.

5.7. Paediatric patients on Paediatric HDU do not need to have a PEWS performed until ready for transfer to the ward area.

5.8. Patients on Intensive Care or in the middle of a surgical operation, who deteriorate will be reviewed by the Intensive Care doctor and if appropriate escalated to the Consultant Anaesthetist / Intensive Care Consultant for appropriate treatment.

5.9. Vital signs for patients in Intensive Care or Surgery will be recorded on the Intensive Care Chart or the Anaesthetic Chart respectively. No EWS needs to be recorded at this time.

5.10. If a patient is on the Integrated Care Pathway, they can be excluded from having their vital signs monitored.

5.11. Where a patient refuses to have vital sign monitoring and will not consent to this, a record will be kept in the patient’s clinical notes to this effect. It may still be possible to monitor their respiratory rate and record it. If the patient lacks capacity to understand the risks and consequences of refusal then the Mental Capacity Act should be followed and a best interest decision made (in complex situations this is likely to be in the form of a multi-agency meeting). Please refer to the Mental Capacity Act Policy which contains further guidance on assessing and recording mental capacity and best interest decisions.

5.12. Adult: Any non-registered member of staff (for instance, healthcare assistants) who completes vital sign recording must report any vital signs outside of the acceptable range. Therefore any adult patient who scores above 2 must be discussed with the nurse in charge of the ward / area. This will apply even when a patient has chronic ill health which is likely to trigger higher than normal Early Warning Scores.

5.13. Paediatric: Any non-registered member of staff (for instance, healthcare assistants) who completes vital sign recording must report any vital signs outside of the acceptable range. Therefore any Paediatric patient who scores above 5 must be discussed with the nurse in charge of the ward / area. This will apply even when a patient has chronic ill health which is likely to trigger higher than normal Early Warning Scores.
5.14. Maternity: Any non-registered member of staff in Maternity who completes vital sign recording must report any vital signs outside of the acceptable range. Therefore, any patient who scores on yellow trigger must be discussed with the Registered Midwife. This will apply even when a patient has chronic ill health which is likely to trigger higher than normal Modified Obstetric Early Warning Scores.

5.15. Any patient, who has an Early Warning Score of 6 or more, should have a clearly documented treatment plan / medical plan in place. This will be communicated by the clinician / GP, to the nurse in charge of the patient.

5.16. In the Acute hospital all junior doctors who treat patients scoring 6 or more on the Early Warning Score shall discuss with the consultant as soon as practicable and certainly within 12 hours.

5.17. In the Acute hospital all junior doctors who treat paediatric patients scoring 10 or more on the Paediatric Early Warning Score shall discuss with the consultant as soon as practicable and certainly within 12 hours.

5.18. If the patient fails to improve or stays the same following treatment, a more senior doctor will be informed and requested to visit as soon as possible to review the management plan.

5.19. It will be the responsibility of the doctors to give guidance to the ward staff on the criteria for contacting medical staff again if necessary, including who to call and the contact details.

5.20. The Awake-Verbalising-Responding to Painful Stimulus-Unresponsive (AVPU) is the routine way in which neurology is assessed for the Early Warning Score. Where a more detailed neurological assessment is required a supplementary Glasgow coma Score should be used, however the total Early Warning Score should still be documented.

5.21. Compliance with the frequency of observations will be audited.

6. Training Requirements

6.1. All staff who are required to undertake Level 2 or Level 3 Resuscitation training will also receive training on the recognition of deteriorating patient. It is provided within the body of the resuscitation training. This training will be identified through the Trust’s training matrix available via the intranet site under ‘What training do I need?’

7. References

- NHSLA Risk Management Standards
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Time to Intervene? (2012)
- Patient Safety First. ‘How to Reduce Harm from Deterioration’. Patient Safety First website page. Available at: www.patientsafetyfirst.nhs.uk
- Resources to support safer care of the deteriorating patient (adults and children) NHS/PSA/RE/2016/005

8. **Associated Documentation**

- Consent Policy
- Resuscitation Policy
- Incident Management Policy
## Appendix A: Early Warning Score for Acute Hospital – Minimal Standard of Frequency

This is applicable to all adult patients, excluding those in Active Labour, ICU or Recovery.

<table>
<thead>
<tr>
<th>Score Group</th>
<th>Frequency</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable 0 – 2</td>
<td>Low Score Group</td>
<td>Normal Observations minimal 12 hourly:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• respiratory rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• pulse rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• blood pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• oxygen saturation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• temperature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• AVPU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urine output</td>
</tr>
<tr>
<td>Low Risk 3 – 5</td>
<td>Potential for</td>
<td>Inform Nurse in Charge</td>
</tr>
<tr>
<td></td>
<td>Deterioration</td>
<td>Observations at least 4 hourly (more frequent could be required)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Record all of the above</td>
</tr>
<tr>
<td>Medium Risk 6 or nurse</td>
<td>Deteriorating Patient</td>
<td>Observations at least 2 hourly (more frequent could be required)</td>
</tr>
<tr>
<td>concern</td>
<td></td>
<td>• Record all of the above but include Urine Output</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent Doctor review within one hour who must define medical plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If unable to improve vital signs in one hour or serious concern call the SpR or Consultant. Consider a call to the outreach team on bleep 007</td>
</tr>
<tr>
<td>High Risk 7 plus</td>
<td>Critically Ill Patient</td>
<td>Observations at least hourly (more frequent could be required)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Record all of the above but include Fluid Balance with Urine Output</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent Dr review within 30 minutes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A Medical Plan must be defined in conjunction with a Senior Doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If unable to improve vital signs in one hour or serious concern call the SPR or Consultant. Ensure the outreach team are aware.</td>
</tr>
<tr>
<td>Patient Imminent chance of Cardio-Respiratory Arrest</td>
<td>Call the Arrest Team on 2222</td>
<td></td>
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<tr>
<td></td>
<td>If patient has a DNACPR order then consider call to family and on call doctor</td>
<td></td>
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## Appendix B: Early Warning Score for Community Hospitals – Minimal Standard of Frequency

This is applicable to all adult patients, excluding those on the Integrated Care Pathway or Liverpool Care Pathway.

<table>
<thead>
<tr>
<th>Stable 0 – 2</th>
<th>Normal Observations minimal 12 hourly:</th>
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</thead>
</table>
| Low Score Group | • respiratory rate  
• pulse rate  
• blood pressure  
• oxygen saturation  
• temperature  
• AVPU  
• Urine |

<table>
<thead>
<tr>
<th>Low Risk 3 – 5</th>
<th>Potential for Deterioration</th>
</tr>
</thead>
</table>
| Low Risk 3 – 5 | Inform Nurse in Charge  
Observations at least 4 hourly (more frequent could be required)  
• Record all of the above |

<table>
<thead>
<tr>
<th>Medium Risk 6 or nurse concern</th>
<th>Deteriorating Patient</th>
</tr>
</thead>
</table>
| Observations at least 2 hourly (more frequent could be required)  
• Record all of the above but include Urine Output  
Urgent Doctor review who will define medical plan  
If unable to improve vital signs in one hour or serious concern call the GP or 999 |

<table>
<thead>
<tr>
<th>High Risk 7 plus</th>
<th>Critically Ill Patient</th>
</tr>
</thead>
</table>
| Observations at least hourly (more frequent could be required)  
• Record all of the above but include Fluid Balance with Urine Output  
Urgent Dr review within 30 minutes. A Medical Plan will be defined.  
If unable to improve vital signs in one hour or serious concern call the GP or 999 |

<table>
<thead>
<tr>
<th>Patient Imminent chance of Cardio-Respiratory Arrest</th>
<th>Call the Paramedics on 999 or 112</th>
</tr>
</thead>
<tbody>
<tr>
<td>If patient has a DNACPR order then consider call to family and on call doctor</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix C: Early Warning Score for Maternity – Minimal Standard of Frequency

This is applicable to all adult inpatients on Maternity wards, excluding those in Active Labour

<table>
<thead>
<tr>
<th>Stable No Triggers</th>
<th>Low Score Group</th>
<th>Normal Observations minimal 12 hourly:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• respiratory rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• pulse rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• blood pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• oxygen saturation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• temperature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• AVPU</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk 1 Yellow Trigger</th>
<th>Potential for Deterioration</th>
<th>Inform Midwife in Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Observations at least 4 hourly (more frequent could be required)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Record all of the above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium Risk 1 Red or 2 Yellow Triggers or nurse concern</th>
<th>Deteriorating Patient</th>
<th>Observations at least 2 hourly (more frequent could be required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Record all of the above but include Urine Output</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent Doctor review within one hour who must define medical plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If unable to improve vital signs in one hour or serious concern call the SpR or Consultant. Consider a call to the Outreach team on 007</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>High Risk 2 or more Red Triggers</th>
<th>Critically Ill Patient</th>
<th>Observations at least hourly (more frequent could be required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Record all of the above but include Fluid Balance with Urine Output</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent Dr review within 30 minutes. A Medical Plan must be defined in conjunction with a Senior Doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If unable to improve vital signs in one hour or serious concern call the SpR or Consultant. Consider a call to the Outreach team on 007</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Imminent chance of Cardio-Respiratory Arrest</th>
<th>Call the Arrest Team on 2222</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You will also need the Obstetric Emergency Team</td>
</tr>
</tbody>
</table>
## Appendix D: Early Warning Score for Paediatrics – Minimal Standard of Frequency

This is applicable to all paediatric inpatients, excluding those in High Dependency

<table>
<thead>
<tr>
<th>Score Group</th>
<th>Observations and Actions</th>
</tr>
</thead>
</table>
| **Stable 0-4**| Normal Observations minimal 12 hourly:  
- respiratory rate  
- pulse rate  
- blood pressure  
- Capillary Refill  
- oxygen saturation  
- temperature  
- AVPU  
Inform Nurse in Charge  
Observations at least 4 hourly (more frequent could be required)  
- Record all of the above  
- If no improvement within 4 hours inform medical team |
| **Low Risk 5-9** | Potential for Deterioration  
Inform Nurse in Charge  
Observations at least 4 hourly (more frequent could be required)  
- Record all of the above  
- If no improvement within 4 hours inform medical team |
| **Medium Risk 10-12 or nurse concern** | Deteriorating Patient  
Observations at least 2 hourly (more frequent could be required)  
- Record all of the above but include Urine Output  
Urgent Doctor review within one hour who must define medical plan  
If unable to improve vital signs in one hour or serious concern call the SpR or Consultant. Ensure that the HDU nurse is informed. Inform outreach team on 007 |
| **High Risk 13+** | Critically Ill Patient  
Observations at least hourly (more frequent could be required)  
- Record all of the above but include Fluid Balance with Urine Output  
Urgent Dr review within 30 minutes. A Medical Plan must be defined in conjunction with a Senior Doctor  
If unable to improve vital signs in one hour or serious concern call the SPR or Consultant. Ensure HDU nurse is informed. Inform outreach team on 007 |
| **Patient Imminent chance of Cardio-Respiratory Arrest or PEWS >20** | Call the Paediatric Arrest Team on 2222 |
Appendix E: Fluid Balance Charting Standard and Completion Notes v2.3 July 2012

**APPROVED ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asp</td>
<td>Aspirate</td>
</tr>
<tr>
<td>C/F</td>
<td>Carried forward</td>
</tr>
<tr>
<td>Ent</td>
<td>Enteral</td>
</tr>
<tr>
<td>FFP</td>
<td>Fresh frozen plasma</td>
</tr>
<tr>
<td>IV A/B</td>
<td>Intravenous antibiotic</td>
</tr>
<tr>
<td>KCL</td>
<td>Potassium</td>
</tr>
<tr>
<td>MLs</td>
<td>Millilitres</td>
</tr>
<tr>
<td>NBM</td>
<td>Nil by mouth</td>
</tr>
<tr>
<td>NG</td>
<td>Nasogastric</td>
</tr>
<tr>
<td>PV</td>
<td>Per vagina</td>
</tr>
<tr>
<td>PR</td>
<td>Per rectum</td>
</tr>
<tr>
<td>S/C</td>
<td>Subcutaneous</td>
</tr>
<tr>
<td>TWOC</td>
<td>Trial without catheter</td>
</tr>
<tr>
<td>U&amp;E</td>
<td>Urea and electrolyte level</td>
</tr>
<tr>
<td>U/O</td>
<td>Urinary output</td>
</tr>
</tbody>
</table>

**AVOID**

- Wet ++ / Out to toilet / Incontinent

**INFORM MEDICAL STAFF**

- If the hourly urine output measurement drops below 0.5ml/kg/hr for more than 2 hrs, i.e. 70kg = 35ml/hr, 80kg = 40ml/hr

- Fluid Balance must be checked at least 12 hourly by the Registered Nurse in charge of the patient and an entry made in the patient’s case notes at least daily.
- Use the abbreviations listed above.
- All measurements of intake and output are charted immediately to ensure that charts are accurate and up-to-date.
- Weigh items such as incontinence pads and wound dressings. The difference between dry and wet weight in grams approximately corresponds to millilitres of urine or drainage.

**Input**

- Record the type and volume of fluids presented in the appropriate column.
- Specify the fluids given in either the ‘oral’ or ‘other’ column.
- Record bolus doses of iv medications, iv flushes and all iv infusions.
- Number the iv infusion bags when iv fluids presented to correspond with the volume administered.

**Output**

- Record all fluid output in the ‘output’ section.
- Specify the output in the ‘other’ columns.
- If no drainage has occurred, write nil drained or nil aspirated for nasogastric tubes.
- Document residual volume of urine post catheterisation.