Document Control

Title			
Patients at Risk of Deterioration Policy			
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Directorate Corporate Nursing		**Department** Outreach and Resuscitation	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
2.4	Apr 2013	Revision	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.
2.5	Jul 2013	Revision	Consulted with Medical Director and amendments as suggested. Changes to GP responsibilities.
3.0	Sep 2013	Final	Approved at Patient Safety Operational Group on 5th September 2013 following consultation.
3.1	Mar 2015	Revision	Amendments to reflect the recommendations from the CQC in the Chief Inspector of Hospitals Inspection Report.
3.2	Apr 2015	Revision	Amendment from DNAR to DNACPR
3.3	Dec 2016	Revision	Changes to include paediatric patients and update roles of some teams
3.4	January 2019	Revision	To update policy to introduce NEWS2 and to review any additional changes
4.0	March 2019	Final	Approved at Prevention and Resuscitation Group on 20th March following consultation
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Superseded Documents Patients at Risk of Deterioration Policy 3.0			
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Consulted with the following stakeholders: (list all) • Clinical Audit lead? • Head of Learning & Development? • Equality & Diversity Lead? • Health & Safety Advisor? • All members of the Prevention and Resuscitation Group	
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CONTENTS

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

3.1. Patients at Risk of deterioration (PaR)

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

3.2. Outreach & Resuscitation Officer

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

3.3. Adult Cardiac Arrest Team

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.

3.4. Paediatric Arrest Team

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

3.5. Hospital at Night (H@N)

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.

3.6. Treatment Escalation Plan (TEP)

This is a written and signed order of treatment limitations. This is a Devon Wide document that can be used by GP's Nurses 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.

3.7. Paediatric Treatment Escalation Plan (TEP)

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

3.8. Medical F1 / F2 / ST1 or ST2

This refers to the junior medical staff grades.

3.9. Patient Safety Operational Group

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

3.10. Early Warning Score (EWS)

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 the National Adult Early Warning Score (NEWS2) Modified Early Obstetric Warning Score (MEOWS), the Paediatric Early Warning Score (PEWS) and the Newborn Early Warning Score (NEWS)

3.11. Situation, Background, Assessment and Recommendation (SBAR) Communication Tool

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.

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

4.1. Role of the Prevention and Resuscitation Group

- 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.

4.2. Role of the Workforce Development Department

- 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.

4.3. Role of the Outreach & Resuscitation Team

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, and the Prevention and Resuscitation Group. This will then report to the Patient Safety Operational group
- Ensuring that the workforce Development Department receive copies of the attendance records of all training sessions.

4.4. Role of Line Managers

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.

4.5. Role of all Medical Staff within Northern Devon Healthcare Trust

All medical staff are responsible for:

- Attending a ward / department as quickly as possible, if called to see a critically ill patient, 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 F2 doctors discuss all adult patients with an Early Warning Scores of 7 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 only be done by a Consultant Obstetrician.
- 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.

4.6. Role of GP's (Devon Doctors providing cover to the Community Hospital Wards and Day Treatment Centres 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, 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.

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

All clinical nursing staff are responsible for:

- Monitoring the condition of all patients using the observation chart at intervals in line with Appendix A for the acute hospital inpatients over 16 and Appendix B for community hospitals, Appendix C for maternity patients, Appendix D for paediatric patients and Appendix E for community staff attending patients in their own home

- 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 5 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.

- If the paediatric nurse in the acute is concerned about a patient or the patient triggers with an Early Warning 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.

- 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.

- 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, Appendix E (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.

- 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 F.

- 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 or their own home, 999 should be called for an emergency response. It may be necessary to dial 9 before the 999 to obtain an outside line.

- 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.

- In the community staffcan 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.

- Ensuring that all patients scoring 7 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.

- 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

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

- 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.

- Community staff would be expected as a minimum requirement to obtain a set of physiological observations at the commencement of an episode of care (admission to caseload). This might be to ascertain a baseline for the patient or to dictate on-going monitoring if required. If it was to ascertain a baseline then a subsequent set of observations would be expected to be captured at the end of an episode of care (discharge). Community staff would be expected to obtain physiological observations if the patient's needs were exacerbating, deteriorating or if there was an additional health need to assess whereby a clinical rationale was required.

- Complying with this policy.

5. Patients at Risk of Deterioration Policy

- Patients at Risk of Deterioration Policy
- This is the standardised Trust-wide approach for the monitoring of in-patients.
- 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.
- All patients within the ED or MIU will have an initial set of observations recorded on the CAS card
- Vital signs monitoring will be documented on the patient's Trust Observation Chart. (Please note that photocopied charts are not acceptable).
- Frequency of vital sign monitoring will be determined from Appendix A for the acute site on all patients over 16 and Appendix B for the community sites, Appendix C for maternity patients. Appendix D for paediatric patients and Appendix E for patients in their own home. If the frequency is recorded outside of that specified in this policy, then the rationale should be recorded in the patient's clinical notes.
- 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.
- Paediatric patients on Paediatric HDU do not need to have a PEWS performed until ready for transfer to the ward area.
- 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.
- 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.
- If the patient is at ceiling of care on the wards, then observations need not be performed so frequently. This will not prevent the nurses performing observations if they are concerned. Doctors should write a clear management plan that stipulates when they feel further escalation should occur.
- If a patient is on the priorities of care documentation they should be excluded from having their vital signs monitored.

- 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.

- Adult (over 16). 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 or equal to 1 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.

- 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.

- 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.

- Any patient, who has an Early Warning Score of 5 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.

- In the Acute hospital all junior doctors who treat patients scoring 7 or more on the Early Warning Score shall discuss with the consultant as soon as practicable and certainly within 12 hours.

- 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.

- 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.

- 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.

- 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.

- 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). (2007). Emergency admissions: A journey in the right direction. London: NCEPOD. Available at: http://www.ncepod.org.uk/
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Time to Intervene? (2012)
- National Institute for Health and Clinical Excellence (NICE). (2007). CG50. Acutely Ill Patients in Hospital. London: NICE. Available at: https://www.nice.org.uk/
- National Patient Safety Agency (NPSA). (2004). Patient Safety Alert 2004/02. Establishing a Standard Crash Call Telephone Number in Hospitals. NPSA. Available at: http://www.npsa.nhs.uk/
- National Patient Safety Agency (NPSA). (2007). Recognising and responding appropriately to early signs of deterioration in hospitalised patients. London: NPSA. Available at: http://www.npsa.nhs.uk/
- Patient Safety First. 'How to Reduce Harm from Deterioration'. Patient Safety First website page. Available at: www.patientsafetyfirst.nhs.uk
- Department of Health. (2009). Competencies for Recognising and responding to acutely ill patients in hospital. London DH. Available at www.dh.gov.uk
- 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).
- Resources to support safer care of the deteriorating patient (adults and children) NHS/PSA/RE/2016/005
- Royal College of Physicians. National Early Warning Score (NEWS) 2

8. Associated Documentation

- Consent Policy
- Resuscitation Policy
- Incident Management Policy

9. Appendix A: Early Warning Score for Acute Hospital – Minimal Standard of Frequency

This is applicable to all adult patients (over 16), excluding those in Active Labour, ICU or Recovery.

At all times consider conversations and use of a Treatment Escalation Plan		
Stable 0	Low Score Group	Normal Observations minimal 12 hourly: Respirations; Pulse; BP; Oxygen Sats; Temperature; AVPU
Low Risk 1-4	Potential for Deterioration	Inform Nurse in Charge who must assess patient and decide on monitoring plan or if escalation required Observations at least 4 hourly (more frequent could be required)
3 in a single parameter	Potential for Deterioration	Inform Nurse in Charge who must assess patient and decide on monitoring plan or if escalation required Observations at least 4 hourly (more frequent could be required)
Medium Risk 5- 6 or nurse concern	Deteriorating Patient	Observations at least 2 hourly (more frequent could be required) • Ensure urine output is monitored and recorded Urgent Doctor to review who must define medical plan. Consider bleep to outreach team on 007. If unable to improve vital signs in one hour or serious concern call a more senior doctor.
High Risk 7 plus	Critically Ill Patient	Observations at least hourly (more frequent could be required) Urgent Dr (at least F2 or more senior) to review. A Medical Plan must be defined. Following initial review to be discussed with senior colleague at earliest opportunity. If unable to improve in one hour or serious concern call a more senior doctor / Consultant Consider bleep to outreach team on 007.
Patient at Ceiling of Care	On Ward Based Care	4-8 hourly observations with a defined medical plan
Patient Imminent chance of Cardio-Respiratory Arrest	**Call the Arrest Team on 2222** **If patient has a DNAR order then consider call to family and on call doctor**	

10. Appendix B: Early Warning Score for Community Hospital – Minimal Standard of Frequency

This is applicable to all adult patients (over 16), excluding those on the Priorities of Care documentation

At all times consider conversations and use of a Treatment Escalation Plan		
Stable 0	Low Score Group	Normal Observations minimal 12 hourly: Respirations; Pulse; BP; Oxygen Sats; Temperature; AVPU
Low Risk 1-4	Potential for Deterioration	Inform Nurse in Charge who must assess patient and decide on monitoring plan or if escalation required Observations at least 4 hourly (more frequent could be required)
3 in a single parameter	Potential for Deterioration	Inform Nurse in Charge who must assess patient and decide on monitoring plan or if escalation required Observations at least 4 hourly (more frequent could be required)
Medium Risk 5- 6 or nurse concern	Deteriorating Patient	Observations at least 2 hourly (more frequent could be required) • Ensure urine output is monitored and recorded Urgent Doctor to review who must define medical plan. If unable to improve vital signs in one hour or serious concern call the GP or 999
High Risk 7 plus	Critically Ill Patient	Observations at least hourly (more frequent could be required) Urgent Dr to review . A Medical Plan must be defined May need to consider transfer to acute hospital by 999
Patient at Ceiling of Care	On Ward Based Care	4-8 hourly observations with a defined medical plan
Patient Imminent chance of Cardio-Respiratory Arrest	**Call the Paramedics on 999** **If patient has a DNACPR order then consider call to family and on call doctor**	

11. Appendix C: Early Warning Score for Maternity – Minimal Standard of Frequency

This is applicable to all adult patients on maternity wards, excluding those in active labour

At all times consider conversations and use of a Treatment Escalation Plan		
Stable 0 No Triggers	Low Score Group	Normal Observations minimal 12 hourly: Respirations; Pulse; BP; Oxygen Sats; Temperature; AVPU
Low Risk 1 Yellow Trigger	Potential for Deterioration	Inform Midwife in Charge who must assess patient and decide on monitoring plan or if escalation required Observations at least 4 hourly (more frequent could be required)
Medium Risk 1 Red or 2 Yellow Triggers or nurse concern	Deteriorating Patient	Observations at least 2 hourly (more frequent could be required) • Ensure urine output is monitored and recorded Urgent Doctor F2 or higher to review who must define medical plan . 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
High Risk 2 or more Red Triggers	Critically Ill Patient	Observations at least hourly (more frequent could be required) Urgent Dr to review . A Medical Plan must be defined with completion of Critical ill sticker . If unable to improve vital signs in one hour consider escalation to Consultant Anaesthetist Consider a call to the Outreach team on 007
Patient Imminent chance of Cardio-Respiratory Arrest	**Call the arrest team on 2222** **You will also need to activate the Obstetric Emergency Team**	

12. Appendix D: Early Warning Score for Paediatrics – Minimal Standard of Frequency

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

Stable 0-4	Low Score Group	Normal Observations minimal 12 hourly: • respiratory rate • pulse rate • blood pressure • Capillary Refill • oxygen saturation • temperature • AVPU
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**	

13. Appendix E: Early Warning Score for Community – Minimal Standard

This is applicable to all adult patients in their own homes, excluding those on Priorities Of Care documentation.

<table>
<tr><td colspan="3">At all times consider the use of a Treatment Escalation Plan</td></tr>
<tr><td>Stable 0
Low Score Group</td><td>Repeat observations as per care plan</td><td>Normal Observations:
respiratory rate
pulse rate
blood pressure
oxygen saturation
temperature
AVPU
Ask patient about urine output</td></tr>
<tr><td>Low Risk 1 - 4
Potential for Deterioration</td><td>Repeat observations as per care plan</td><td>Healthcare Professional, in discussion with other professionals involved in patient care, to decide if increasing monitoring or escalation needed.
Observations to include all of above</td></tr>
<tr><td>Scoring 3 in a single parameter</td><td>Repeat observations as per care plan</td><td>Healthcare Professional, in discussion with other professionals involved in patient care, to decide if increasing monitoring or escalation needed.
Observations to include all of above</td></tr>
<tr><td>Medium Risk 5 - 6 or
Healthcare Professional concern
Deteriorating Patient</td><td>Repeat observations as per care plan</td><td>Urgently inform a senior clinical decision maker (GP/Nurse Specialist Community/Community Matron/Devon Doctor)
Increase monitoring and if unable to decrease score may need to consider a referral to secondary care.</td></tr>
<tr><td>High Risk 7 plus
Critically Ill Patient</td><td>More frequent observations to be implemented</td><td>Urgent referral to GP or Out of hours Devon Doctor may be indicated. Decision to be made by most senior clinician on duty.
May need to consider calling the Paramedics on 999 or 112 if unable to decrease score. May need to consider staying with patient.</td></tr>
<tr><td>Patient Imminent chance of Cardio-Respiratory Arrest</td><td colspan="2">Call the Paramedics on 999 or 112
unless patient has a DNACPR order then consider call to family and on call doctor</td></tr>
</table>