Recognising Deterioration in Resident Policy

Template

This policy template was created by the St Monica Trust and reviewed by the West of England and West Midland Academic Health Science Networks (WEAHSN and WMAHSN).

The St Monica Trust is a Bristol-based charity with a reputation for providing high quality accommodation and innovative care for older people and is dedicated to providing the best experience of ageing.

Template

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1. INTRODUCTION

This policy provides clear guidance to all staff in the recognition, response and escalation of a deteriorating resident.

This policy applies to all staff required to undertake physiological observations and those who do not take observations as part of their role.

The RESTORE2 tool (see section 3: definitions) - which contains the National Early Warning Score (NEWS2) - enables early identification and prioritisation of residents at risk of deterioration and is a national standard. (See appendix 1 for the RESTORE2 tool).

Early recognition and escalation of deterioration reduces the risk of further deterioration and promotes a timely response to ensure appropriate treatment and/or intervention. This will enable delivery of Right Care at the Right time in the Right place and by the Right Person.

RESTORE2 mini tool should be used to assess for deterioration when the staff member has concerns about the resident and measuring physiological observations is not possible. (See appendix 2 for the RESTORE2 mini tool).

All Care and Nursing staff must be aware of the appropriate escalation process for their service, and use the SBARD tool - see section 3: definitions - to communicate when requesting support.

In addition, the Treatment Escalation Plan (TEP) has been developed to help make decisions about resuscitation status and appropriate escalation. Any assessment and treatment of the deteriorating resident should take into account the resident's TEP/ ReSPECT form.

2. PURPOSE

The purpose of this document is to ensure that staff identify and respond to residents who may be showing early signs of physical deterioration as well as at risk of deterioration. Early recognition and response has been shown to significantly reduce morbidity and mortality.

This policy is to present an early detection physiological assessment using RESTORE2 mini and progressing to the full process RESTORE2 which includes the National Early Warning Score (NEWS2) for the purpose of recognition, escalation and most appropriate response to the deteriorating resident.

A TEP and personalised recommendation (eg ReSPECT) for resident's medical care will be taken into consideration when implementing RESTORE2. It is used in an emergency situation as a reference and communicates the level of intervention or de-escalation in the resident's clinical management.

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3. DEFINITIONS

ABCDE: airway, breathing, circulation, disability and exposure.

ACP: Advanced Clinical Practitioner.

ACVPU score: The ACVPU score is a rapid method of assessing the resident's level of consciousness. The acronym describes the possible levels of consciousness of a patient. A = alert, C = new confusion, V = responds to voice only, P = responds to pain only, and U = unconscious. Confusion must be assumed to be new if it is unknown or for someone with longstanding confusion the condition is worsening.

Carer: In this policy we use the term 'carer' or 'carers' to refer to any member of staff in a residential or nursing home engaged in caring for a resident. This includes individuals with or without a professional registration.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions are included within the TEP (eg ReSPECT) documents that state that a resident should NOT receive cardiopulmonary resuscitation (which can involve chest compressions and shock therapy in an attempt to restart someone's heart).

End of Life care: RESTORE2 can be helpful in identifying when a resident is approaching the end of their life. This can used to have informative conversations with the resident and help to inform their relatives and GP in regard to their wishes. The RESTORE2 tool should be discontinued once the person has an end of life (final days of life) plan.

National Early Warning Signs (NEWS2): This is a physiological observation scoring system that detects deterioration in adults, triggering review, treatment and escalation of care where appropriate. It is a nationally recommended tool widely used in healthcare settings around the UK and forms a 'common language'.

RESTORE2: Recognise **E**arly **S**oft-signs, **T**ake **O**bservations, **R**espond, **E**scalate.
A physical deterioration and escalation tool designed especially for care/nursing and residential homes. The tool is also appropriate for use in the domiciliary care sector including use by family carers. RESTORE2 supports all carers and nurses to recognise when a resident may be deteriorating or at risk of physical deterioration. This will enable colleagues to act appropriately when the resident shows early signs of deterioration and act in accordance with the resident's care plan and Treatment Escalation Plan.

SBARD: Situation, **B**ackground, **A**ssessment, **R**ecommendation and **D**ecision is an easy to remember mnemonic for a communication tool that can be used to formalise conversations in a structured manner. This can aid clarity in an emergency. This can be used in multiple situations such as when requesting advice or support about a

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resident's care management from a senior clinician, paramedic or General Practitioner. The use of the SBARD acronym as headings is a widely recognised communication tool across the acute and community healthcare sectors to communicate details of soft signs and NEWS2, and sharing escalation concerns in a standard way, using a common language. This helps all healthcare workers recognise and respond appropriately to the information given.

Treatment Escalation Plan (TEP):
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT):
A Treatment Escalation Plan (TEP), eg ReSPECT, is a personalised recommendation for someone's medical care, which sets out how health conditions should be managed in the future if a resident deteriorates. A TEP may be informed by an advance care plan, which documents the resident's wider wishes and preferences or an Advance Decision to Refuse Treatment (ADRT), which outlines a person's refusal of a specific treatment.

Vital Signs: Also known as observations, are the measurements of essential body functions such as breathing rate (respiratory rate), oxygen saturations, heart rate (pulse rate), blood pressure, level of alertness and temperature.

4. ROLES AND RESPONSIBILITIES

4.1 *For example,* Director of Care

Has overall responsibility for ensuring processes are in place to provide residents with appropriate care. Ensures there are appropriate quality assurance mechanisms in place in relation to the guidance in this policy. Will provide an overview and coherent understanding of areas of good practice and areas in need of improvement.

4.2 *For example,* Clinical Audit Lead / End of Life Care Lead

Provides clinical and cultural leadership which recognises the care of a person when they are showing any signs of deterioration.

4.3 GP with Care Services Team

Responsible for receiving the RESTORE2 information and documentation and make clinical decisions regarding right care, right time, right place.

4.4 Care Service Managers

Have overall responsibility to ensure that staff are skilled to undertake recognition of the resident who is showing any signs of deterioration. To ensure care is provided effectively, compassionately and to a high standard within their service. They will ensure all staff receive appropriate training to support them in their practice. They will make available the relevant documentation and information leaflets to support recognition of deterioration in the resident. They will identify the education and training needs of their staff to support their provision of care and ensure access to such education and training. They will

determine and communicate the escalation processes for their service, and ensure this is included in local induction for all new staff.

4.5 All Care Staff

All care and nursing staff, including students, bank and agency staff are responsible for:

- Complying with the standards within this policy.
- Using the mini RESTORE2 and full RESTORE2 as relevant to their service.
- Knowing the escalation process for their service.

5. RESTORE2

RESTORE2 has five key components that support carers to recognise deterioration, assess the risk and act on findings (see appendix 1 for RESTORE2 tool):

1. The soft signs of deterioration, which support carers to identify potentially unwell residents.
2. A 'what's normal for this resident' reference box so people understand when a resident's condition has changed and what plans have been put in place to manage this.
3. This includes their normal NEWS2 National Early Warning Score physical observation chart that provides a standardised assessment of risk and sickness.
4. An escalation pathway to ensure the carer 'gets the right help'.
5. A structured communication tool to help the carer 'get their message across'.

6. RESTORE2 MINI SOFT SIGNS

6.1 Knowing the resident

When the resident moves into the care home:

- It is good practice to take a complete set of vital signs (baseline observation) so that the carers know what is normal for them.
- Where possible, the resident will help the carer to support them to live well. The carer needs to know from the resident or family what they would like to happen if they deteriorate or become unwell. Introduce Advance Care Planning discussions.
- Identify if they have a Treatment Escalation Plan, ReSPECT or Do Not Attempt Cardiopulmonary Resuscitation order in place (if not, why not).
- Take time to learn about the resident's usual behaviours so the carers will know if the resident starts doing things that are not normal for them.
- The carer needs to understand the resident's medical history, including the medicines they take regularly.

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Soft signs are the early indicators that someone might be becoming unwell. Soft signs can be related to many things including the resident's:

- physical presentation,
- mental state, or
- behaviour and ability.

Soft signs are particularly useful for residents who have difficulty communicating or understanding information due to dementia or learning difficulties. Taking physiological observations is not a component of RESTORE2 mini, however, soft signs will lead into using the National Early Warning Score (NEWS) system as part of RESTORE2 (full) when escalating your concerns to a healthcare professional or senior colleague.

6.2 When observations are not possible: RESTORE2 mini

There are times when it is not possible to undertake physiological observations. For example, if a resident refuses, or their behaviour makes it challenging, or the carer does not do this as part of their role. The RESTORE2 mini tool provides a structured assessment to help staff identify soft signs ('red flags') which should be escalated and observations can be added where possible.

This tool can be used as a one-off assessment or as part of the ongoing planned care for an individual resident.

The findings of any assessment using the non-contact observation tool RESTORE2 mini, and actions taken must be documented in the resident's record.

7. MEDICAL EMERGENCIES

There are occasions when the early signs of deterioration may indicate a medical emergency. In these cases, it is not appropriate to delay contacting the emergency services.

Contact 999.

It may be appropriate to continue to monitor your resident's vital signs once you have contacted the emergency services. Such situations include:

- Chest pain or a suspected heart attack (not all six signs need to be present for a resident to be having a heart attack).
- Where the individual is displaying signs consistent with having a stroke. F.A.S.T. (Facial drooping, Arm weakness, Speech difficulties and Time to call 999).
- Prolonged seizure where the patient does not have a care plan in place to manage it or their breathing is compromised, or as indicated to do so in their care plan.

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- Where the resident is suspected to have a sustained a significant injury, eg a fracture or head injury.

8. RECOGNITION AND ESCALATION OF DETERIORATION RESTORE2

The need for physiological observations and any escalation of this must be determined by the Senior Care Worker and /or Registered Nurse on duty. The frequency will also be determined by the NEWS2 score of the resident. Exceptions to this must be agreed by a GP or advanced clinical practitioner, and documented clearly in the resident's record.

NEWS2 is a tool and is an aid to clinical judgment. A review should be sought for any resident causing concern even if they do not have a raised NEWS2 score.

There are two scales for blood oxygen levels: Scale1 and Scale 2 respectively. Within the care home environment, **NEWS2 SpO2 Scale 1** is used for all residents, including people with respiratory conditions such as Chronic Obstructive Pulmonary Disease unless you have been specifically instructed otherwise by a lung doctor or nurse.

NEWS2 SpO2 Scale 2: There are a group of people who live with a lower level of oxygen in their blood. These are people with certain lung conditions and a usual oxygen saturation range for them is 88-92%. If this is the case, it should be clearly written in their notes by their lung doctor or nurse, and you should use **Scale 2** to record their oxygen saturations. Otherwise, assume that they need oxygen levels of 96-98%.

Where a complete NEWS2 score is 3 in one parameter, or 5 or more, sepsis should be considered, and if appropriate a sepsis screening and sepsis action pathway completed (refer to *[local infection prevention and control policy/procedures]*). A NEWS2 score of this level indicates the resident is severely ill with likely organ dysfunction and requires urgent assessment by a registered nurse who can start appropriate treatment. In the care home and community service setting, this will require a call to **999** for an ambulance. If a resident's wishes are to be cared for at the care home rather than the hospital, contacting their GP may be more appropriate in this instance.

NEWS2 scores should be considered using your clinical judgement at all times. Residents who have chronic illness may have a deranged physiology, and a normally high NEWS2 score. Changes in physiological markers may be significant. For such residents it is recommended a personalised escalation plan is undertaken with their GP and documented in the ReSPECT / TEP forms.

For residents on the end of life care pathway, physiological observations may not be appropriate. Decision-making must take into account whether there are potentially reversible causes for clinical deterioration. The decision to cease recording observations should be documented on the electronic care plan.

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Any exceptions to following the NEWS2 escalation guidance must be agreed by a doctor or advanced care practitioner, communicated with the multidisciplinary team and documented clearly in the electronic care plan.

9. PHYSIOLOGICAL OBSERVATIONS

Please see the Royal Marsden Manual of Clinical Nursing Procedures, Tenth Edition for the correct procedure for undertaking physiological observations.
[This is possible with an account with the Royal Marsden]

9.1 Respiratory rate

Respiratory rate is the most sensitive indicator of deteriorating physiology and must be recorded numerically in the resident's record.

A respiratory rate of less than 12 and greater than 20 should initiate an alert.

Depth, symmetry and pattern of respiration should be noted and recorded if abnormal.

If oxygen is prescribed and given, the delivery device must be recorded on the resident's care plan record.

Codes for recording oxygen delivery using NEWS2:

- A (breathing air)
- N (nasal cannula)
- SM (simple mask)

If oxygen is administered this will add 2 points onto the resident's NEWS2 score. The oxygen saturations should be recorded as a number percentage on the resident's record using scale 1.

If oxygen is administered as part of routine care, this should be prescribed. Nail varnish and false nails may invalidate the oxygen saturation level so must be removed before reading result.

The Sp02 probe should only be used for the area it is designed for, ie finger or ear. They are not interchangeable.

9.2 Heart rate and blood pressure

The radial heart rate (pulse) must be measured and recorded numerically.

The systolic blood pressure (SBP) component of blood pressure is used to calculate NEWS2 score. If the blood pressure cannot be recorded by machine, a manual sphygmometer reading should be taken.

Residents with a diagnosis of Atrial Fibrillation must have a manual blood pressure taken.

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Falling blood pressure Systolic Blood Pressure of 90mmHg or less may be a sign of severe sepsis, fluid loss or cardiac shock and will trigger a NEWS2 score of 3 in one parameter.

Although a resident with a low blood pressure may appear ‘asymptomatic’, this needs to be escalated quickly as it is a symptom of organ dysfunction and can cause acute kidney injury. The exception to this is where acceptable parameters for SBP have been agreed.

10. NEUROLOGICAL ASSESSMENT

A resident’s neurological condition is an important marker of deterioration.

Any reduction in conscious level is significant. This can be an early indication of deterioration and may require urgent transfer and escalation to secondary care.

The ACVPU assessment is an essential element of the NEWS2.

ACVPU scale:

A **A**lert
C New **c**onfusion
V Responds to **v**oice
P Responds to **p**ain
U **U**nresponsive

10.1 Confusion/ Delirium

New confusion, delirium or acutely altered mental state scores 3 on the NEWS2 score, and indicates a red alert (for a single score of 3), requiring urgent assessment and possible transfer to hospital.

If it is unclear, if the resident’s confusion is new or their normal state, the confusion should be assumed new until otherwise confirmed. However, if a resident is known to be confused at their baseline cognitive state, then they should be scored (A) Alert.

Residents having seizures are at significant risk and should have a medical/advanced practitioner review if available or be escalated to 999. Exceptions to this are residents with known seizure risk, who have a treatment plan in place to manage this. Escalation should take place if the seizure is ongoing, despite treatment.

11. TEMPERATURE

Temperature must be scored numerically.

Both pyrexia (raised temperature) and hypothermia (low temperature) are included in the NEWS2 reflecting the fact that extremes of temperature are sensitive markers of

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acute illness severity, sepsis and physiological disturbance. Low temperatures are as significant as high temperature.

12. OTHER OBSERVATIONS

Fluid balance and urine output are not included in the NEWS2 score but it is essential that the need for these be considered with every set of observations. Similarly, the pain score and blood glucose may need to be assessed and recorded in the resident's record.

13. WHEN A RESIDENT DETERIORATES

Simple early measures may prevent further deterioration of the resident and avoid the need to admit to secondary care. Interventions such as appropriate positioning of the resident, giving oxygen (if available and prescribed) to maintain SpO2 above 94%, or giving appropriate medication.

14. SEEKING HELP/ ESCALATION

All carers must be aware of the correct escalation process for their service which may have been developed using the RESTORE2 NEWS2 Escalation Guide.

The resident's Treatment Escalation Plan should clearly show the level of escalation that is appropriate to their wishes. However, discussion with the resident and the family (if possible) should take place about the reason for escalation and to gain consent.

If the resident requires escalation to the registered nurse on duty, the resident's GP or the emergency services, the SBARD communication system should be used to communicate the reason for escalation (see appendix 1: RESTORE2, and use the SBARD part of the tool).

Escalation using SBARD must take into account what is normal for the resident. It should identify the subtle changes or concern if physiological observation is not possible and escalated to the most senior clinician on duty. The resident's NEWS2 score, symptoms and individual circumstances should be recorded and shared using SBARD. The senior clinician must use their clinical judgement to make a decision about the appropriate escalation route. In sudden acute deterioration out of hours, it may be more appropriate to call 999 than to escalate to the Out of Hours medical service.

The frequency of the physiological observations must be according to the NEWS2 clinical response and this should continue whilst waiting for help. If transferring the resident to secondary care, the historical observations should be readily accessible to the admitting hospital or team.

Clear records of escalation of care must be made, along with the responses received, using the electronic multidisciplinary team form and care plans progress notes,

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documenting appropriate advice sought from the registered nurse on duty and if the response gives further cause for concern.

15. TRAINING/COMPETENCE REQUIREMENTS

All care staff (including bank and agency staff) must have training and competence in the skills needed for their role implementing the RESTORE2 mini and full RESTORE2 tools for those who take observations.

[WEAHSN online learning package is available to support this].

16. MONITORING THE EFFECTIVENESS OF THIS POLICY

The effectiveness of this policy will be monitored via a number of channels:

- *[For example, local monitoring tools]*
- Review of acute hospital admissions as a regular feature of Local Enhanced Scheme meetings with GPs.
- Periodic and systematic audit of deteriorating residents focused on use of NEWS2, TEPs, recognition and escalation of deterioration.
- Local service review and targeted training.
- Formal monthly audit of RESTORE2 mini, RESTORE2 full and NEWS2 in care homes with nursing, which includes residential units' care.

17. RESOURCES

- RESTORE2™: https://www.weahsn.net/our-work/transforming-services-and-systems/keeping-people-safe-during-and-after-covid-19/care-homes-during-covid-19/training-resources-for-care-homes/
- Resources to support the adoption of the National Early Warning Score: https://improvement.nhs.uk/documents/3657/Resources_to_support_the_adoption_of_NEWSFINAL.PDF
- NHS Improvement (2018) Patient Safety Alert: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2). Available from: https://www.england.nhs.uk/publication/patient-safety-alert-safe-adoption-of-news2/
- NHS Improvement (2018) Patient Safety Alert: Risk of harm from inappropriate placement of pulse oximeter probes. Available from: https://www.england.nhs.uk/publication/patient-safety-alert-risk-of-harm-from-inappropriate-placement-of-pulse-oximeter-probes/
- Resources for pulse oximetry training: https://elearning.rcgp.org.uk/course/view.php?id=383

  https://www.youtube.com/watch?v=QabKghrtXps

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18. REFERENCES

- Royal College of Physicians. National Early Warning Score (NEWS2): Standardising the assessment of acute-illness severity in the NHS. London, RCP, 2017
- National Institute for Health and Care Excellence. Sepsis: Recognition, Diagnosis and Early Management. NICE guidelines 51. London, NICE, 2016
- Royal Marsden Manual of Clinical Nursing Procedures (2015), 9th edition, The Royal Marsden Foundation Trust, Wiley, Blackwell

19. APPENDICES

- Appendix 1: RESTORE2
- Appendix 2: RESTORE2 mini

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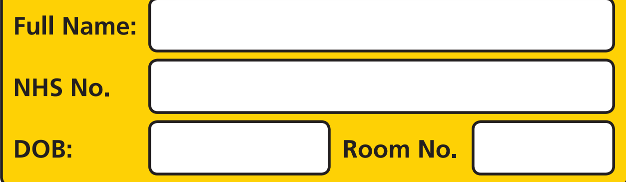
Recognise Early Soft Signs, Take Observations, Respond, Escalate

Adult Physiological Observation & Escalation Chart



Full Name:

NHS No.

DOB: Room No.

Does Your Resident Have Soft Signs of Possible Deterioration

Worse than normal lethargy or withdrawal or anxiety/agitation/ apprehension or not themselves

NEW ONSET OF:

Stroke (facial / arm weakness, speech problems)

Central Chest Pain / Heart Attack / Cardiac arrest

CALL 999 IMMEDIATELY

Worsening shortness of breath (can't talk in sentences), chestiness or fast breathing

Increasing (or new onset) confusion or less alert than normal

New or increasing oxygen requirement

Shivery, fever or feels very hot, cold or clammy

Off food, reduced appetite, reduced fluid intake

New offensive/ smelly urine or can't pee/reduced pee/reduced catheter output

Diarrhoea, vomiting or dehydration (dry lips, mouth, sunken eyes, decreased skin tone)

Cold hands/feet or worsening skin colour or puffiness, mottling or rash

Any concern from the resident, family or carers that the person is not as well as normal

Observations significantly different from normal, including blood sugars

Resident specific soft-signs

e.g. changes to sleep patterns, not interested in usual/specific activities

Increased or new onset pain

Can't walk or 'off legs', less mobile/ co ordinated

If you answer YES to any of these triggers, your resident is at risk of deterioration

RECOGNISE SOFT SIGNS OF POSSIBLE DETERIORATION → TAKE COMPLETE SET OF OBSERVATIONS AND CALCULATE NEWS → ESCALATE USING ESCALATION TOOL AND SBARD COMMUNICATION

Full Name: NHS No.

How to use RESTORE2

RESTORE2 which includes the National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment. If you are concerned about the resident or if one observation has changed significantly ALWAYS ACT ON YOUR CONCERNS AND SEEK ADVICE from a competent clinical decision maker e.g. GP, Registered Nurse or AHP.

- This chart uses aggregated (total) NEWS - it is important that you understand the residents normal NEWS (the score when they are stable and as well as usual) to support appropriate escalation. You should try and establish what is normal for residents on admission with a member of the multi-disciplinary team (e.g. General Practitioner, frailty practitioner).
- **Only a Medical Professional can authorise use of the hypercapnic respiratory failure scale for residents who normally have low oxygen levels as part of a diagnosed condition (e.g. COPD)**
- Use this chart for all your routine observations as per your local policy. If your resident shows ANY of the soft signs of deterioration, record their observations and NEWS immediately on the chart and follow the escalation tool as appropriate, using SBARD to communicate
- There may be a need to re-consider what is normal for the resident following any sustained improvement in their condition or non-acute deterioration.

What's normal for this resident

Print name: Date: Signature:

What is the resident normally like? What observations and NEWS are reasonable and safe for them? When would their GP want you to call them? What escalation has been agreed with the resident (or their advocate)?

End of Life (EOL) or Agreed Limit of Treatment

- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed limit of treatment (e.g. not for hospital admission, not for resuscitation or not for intravenous antibiotics) to identify recoverable deterioration amenable to treatment. It is also useful for anticipating end of life to inform conversations with residents and their relatives - once the resident is on an EOL care pathway, RESTORE2 should be discontinued.

NEWS2 Escalation (get the right help early)

NEWS2	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 6 hourly**
2	Immediate senior staff review, if no improvement in NEWS (or the same) **within 2 hours**, seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 2 hourly**
3-4 / Single Observation 3	Repeat observations within **30 minutes**. If **observations = NEWS +3 or more**, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	**At least every 30 minutes**
5-6	Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	**Every 15 minutes**
7+	Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

Admission to hospital should be in line with any appropriate, agreed and documented plan of care.

Full Name: ____________________ **NHS No.** ____________________

Take observation + calculate NEWS

Parameter														Score
	Date													
	Time													
A+B Respirations Breaths/min	≥25													3
	21-24													2
	18-20													
	15-17													
	12-14													
	9-11													1
	≤8													3
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96													
	94-95													1
	92-93													2
	≤91													3
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure. †ONLY use Scale2 under the direction of a qualified clinician	≥97 on O_2													3
	95-96 on O_2													2
	93-94 on O_2													1
	≥93 on air													
	88-92													
	86-87													1
	84-85													2
	≤83%													3
Air or Oxygen?	A = Air													
	O_2 L/min													2
C Blood pressure mmHg Score uses systolic BP only	≥220													3
	201-219													
	181-200													
	161-180													
	141-160													
	121-140													
	111-120													
	101-110													1
	91-100													2
	81-90													3
	71-80													
	61-70													
	51-60													
	≤50													
C Pulse Beats/min	≥131													3
	121-130													2
	111-120													
	101-110													1
	91-100													
	81-90													
	71-80													
	61-70													
	51-60													
	41-50													1
	31-40													3
	≤30													
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert													
	Confusion													3
	V													
	P													
	U													
E Temperature °C	≥39.1													2
	38.1-39.0°													1
	37.1-38.0°													
	36.1-37.0°													
	35.1-36.0°													1
	≤35.0°													3
NEWS TOTAL														
	Next observation due (Mins/Hrs)													
	Escalation of care Y/N													
	Initials													

Authorising clinician

Signature & Date

ACVPU KEY

A **Alert** awake & responding, eyes open

C **Confusion** New onset of confusion (Do not score if chronic)

V **Verbal** moves eyes / limbs or makes sounds to voice

P **Pain** responds only to painful stimuli

U **Unresponsive** unconscious

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

Full Name: ________________ **NHS No.** ________________

Date
Time

A+B Respirations
Breaths/min

Score	Range
3	≥25
2	21-24
	18-20
	15-17
	12-14
1	9-11
3	≤8

A+B SpO_2 Scale 1
Oxygen saturation (%)

Score	Range
	≥96
1	94-95
2	92-93
3	≤91

SpO_2 Scale 2†
Oxygen saturation (%)

Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure

†ONLY use Scale2 under the direction of a qualified clinician

Score	Range
3	≥97 on O_2
2	95-96 on O_2
1	93-94 on O_2
	≥93 on air
	88-92
1	86-87
2	84-85
3	≤83%

Air or Oxygen?

Score	Range
	A = Air
2	O_2 L/min

C Blood pressure mmHg
Score uses systolic BP only

Score	Range
3	≥220
	201-219
	181-200
	161-180
	141-160
	121-140
	111-120
1	101-110
2	91-100
3	81-90
	71-80
	61-70
	51-60
	≤50

C Pulse
Beats/min

Score	Range
3	≥131
2	121-130
	111-120
1	101-110
	91-100
	81-90
	71-80
	61-70
	51-60
1	41-50
3	31-40
	≤30

D Consciousness
Score for NEW onset of confusion (no score if chronic)

Score	Range
	Alert
3	Confusion
	V
	P
	U

E Temperature
°C

Score	Range
2	≥39.1
1	38.1-39.0°
	37.1-38.0°
	36.1-37.0°
1	35.1-36.0°
3	≤35.0°

NEWS TOTAL
Next observation due (Mins/Hrs)
Escalation of care Y/N
Initials

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SBARD Escalation Tool and Action Tracker

(get your message across)

REMEMBER TO SAY: The residents TOTAL NEWS SCORE is...

Name:

NHS No.

		Notes — Date, Time, Who
S	**Situation** **(briefly describe the current situation and give a clear, concise overview of relevant issues)** (Provide address, direct line contact number) I am… from… (say if you are a registered professional) I am calling about resident… (Name, DOB) **The residents TOTAL NEWS SCORE is...** **Their normal NEWS/condition is…** I am calling because I am concerned that… (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)	
B	**Background** **(briefly state the relevant history and what got you to this point)** Resident XX has the following medical conditions… The resident does/does not have a care plan or DNACPR form / agreed care plan with a limit on treatment/hospital admission They have had… (GP review/investigation/medication e.g. antibiotics recently) Resident XX's condition has changed in the last XX hours The last set of observations was… Their normal condition is… The resident is on the following medications…	
A	**Assessment** **(summarise the facts and give your best assessment on what is happening)** I think the problem is XX And I have… (e.g. given pain relief, medication, sat the patient up etc.) **OR** I am not sure what the problem is but the resident is deteriorating **OR** I don't know what's wrong but I am really worried	

		Actions I have been asked to take (initial & time when actions completed)	Initials
R – D	**Recommendation** **(what actions are you asking for? What do you want to happen next?)** I need you to… Come and see the resident in the next XX hours **AND** Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services) **Decision** **(what have you agreed)** We have agreed you will visit/call in the next XX hours, and in the meantime I will do XX If there is no improvement within XX, I will take XX action.		

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The SBARD technique provides an easy-to-remember standardised framework for critical conversations, including what key information will be communicated about a resident's condition and what immediate attention and action is required. Record all your actions and conversations.

Name: ____________________ **NHS No.** ____________________

Notes — Date, Time, Who	Notes — Date, Time, Who	
		S
		B
		A

Actions I have been asked to take (initial & time when actions completed)	Initials	Actions I have been asked to take (initial & time when actions completed)	Initials	
				R -- D

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Get your message across

Resident/ patient name: | NHS No. | D.O.B.

Raise the Alert within your home e.g. to a senior carer, registered nurse or manager. If possible, **record the observations** using a **NEWS2** based system. **Report your concerns** to a health care professional e.g. Nurse/GP/ GP HUB/111/999 **using the SBARD Structured Communication Tool.**

S — **Situation** e.g. what's happened? How are they? NEWS2 score if available

B — **Background** e.g. what is their normal, how have they changed?

A — **Assessment** e.g. what have you observed / done?

R — **Recommendation** 'I need you to...'

D — **Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)

Key prompts / decisions

Name of person completing: | Signature:

Today's date:

Don't ignore your 'gut feeling' about what you know and see.
Give any immediate care to keep the person safe and comfortable.

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

Does your resident show any of the following **'soft signs'** of deterioration?

- Increasing **breathlessness** or **chestiness**
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel **hot or cold** to touch
- Reduced mobility – **'off legs'** / less co-ordinated
- New or increased confusion/ agitation / anxiety / pain
- Changes to usual level of **alertness / consciousness / sleeping** more or less
- **'Can't pee'** or **'no pee'**, change in pee appearance
- **Diarrhoea, vomiting, dehydration**

Any **concerns** from the resident / family or carers that the person is not as well as normal.

If YES to one or more of these triggers – take action!

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