**Name of Policy:** Use of Early Warning Score System in Adult Patients

**Effective From:** 06/07/2012

<table>
<thead>
<tr>
<th>Date Ratified</th>
<th>04/05/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified</td>
<td>Resuscitation &amp; Deterioration Patient Committee</td>
</tr>
<tr>
<td>Review Date</td>
<td>01/05/2014</td>
</tr>
<tr>
<td>Sponsor</td>
<td>Director of Nursing &amp; Midwifery</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>03/05/2015</td>
</tr>
<tr>
<td>Withdrawn Date</td>
<td></td>
</tr>
</tbody>
</table>

This policy supersedes all previous issues.
## Version Control

<table>
<thead>
<tr>
<th>Version</th>
<th>Release</th>
<th>Author / Reviewer</th>
<th>Ratified By / Authorised By</th>
<th>Date</th>
<th>Changes (Please identify page no.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>March 2009</td>
<td>A Lowery</td>
<td>SafeCare Council</td>
<td>March 2009</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>February 2010</td>
<td>A Lowery</td>
<td>Head of SafeCare</td>
<td>Jan 2010</td>
<td></td>
</tr>
<tr>
<td>2.0</td>
<td>06/07/2012</td>
<td>Mike Bunn / Julie Jones</td>
<td>Resuscitation and Deteriorating Patient Committee</td>
<td>May 2012</td>
<td></td>
</tr>
</tbody>
</table>
## Contents

1.0  Introduction ........................................................................................................ 4  
2.0  Policy Scope ...................................................................................................... 4  
3.0  Aim of Policy ...................................................................................................... 4  
4.0  Duties - Roles and Responsibilities .................................................................... 4  
5.0  Definitions .......................................................................................................... 5  
6.0  Process Guidelines for the Use of EWS Charts ................................................. 6  
7.0  Training .............................................................................................................. 8  
8.0  Equality and Diversity ......................................................................................... 8  
9.0  Process for monitoring compliance with this policy ......................................... 8  
10.0  Consultation and Review ................................................................................... 9  
11.0  Policy Implementation ....................................................................................... 9  
12.0  References ........................................................................................................ 9  
13.0  Associated Documentation .............................................................................. 10  

Appendix 1.  Resuscitation and Deteriorating Patient Committee  
Terms of Reference .................................................................................................. 11
1.0 Introduction

Clinical deterioration can occur at any stage of a patient’s illness, although there will be certain periods during which a patient is more vulnerable, such as at the onset of illness, during surgical or medical interventions and during recovery from critical illness. Patients on general adult wards and emergency departments who are at risk of deteriorating may be identified before a serious adverse event by changes in physiological observations recorded by healthcare staff. The interpretation of these changes, and timely institution of appropriate clinical management once physiological deterioration is identified, is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

2.0 Policy Scope

The scope of this policy applies to adults patients in the acute setting. It excludes paediatric and maternity patients who, due to the specialist areas are managed within their own speciality.

This policy applies to all health care practitioners who are required to measure, record and act on the findings of patient physiological observations in the course of their work.

For the purpose of this policy health care practitioner refers to nurses, midwives, and doctors, allied health professional and health care assistants.

3.0 Aim of Policy

This policy sets out the standards, based on best available evidence, on the care of adult patients within the acute hospital setting, related to the measurement and recording of physiological observations and the use of a ‘track and trigger’ system to ensure patients who are deteriorating are recognised and treated in an appropriate and timely manner.

The Policy enables the Trust to adhere to the NCEPOD 2005 recommendation of optimising early warning scoring systems and NICE 2007 guideline 50 on “Acutely Ill Patients in Hospital” both of which recognise that patients in the acute setting can rapidly deteriorate and the widespread use of track and trigger systems is to be encouraged to recognise the early signs and symptoms of a deteriorating patient.

This Policy is to be read and used in conjunction with RM 27a the “Resuscitation Policy” and OP 24 the “Critical Care Outreach Team Policy”

The track and trigger tool of choice which has been agreed across the Trust is the Early Warning Score (EWS) chart. This is available on all wards and departments.

4.0 Duties - Roles and Responsibilities

4.1 Chief Executive. Has responsibility for ensuring the Trust has robust and effective Policies relating to clinical observations and patient deterioration prevention.
4.2 **Trust Board.** Supports the Resuscitation and Deteriorating Patient Committee to ensure the policy is fully implemented to reduce the risk of patient deterioration throughout the Trust.

4.3 **Resuscitation and Deteriorating Patient Committee** Responsible for overseeing, approving and monitoring the policies, procedures, equipment and standards relating to Resuscitation, Deteriorating Patient Prevention and Do Not Attempt Resuscitation throughout the Trust (See Appendix 1 for the full scope of the committee).

4.4 **Matrons** are responsible for:
- Supporting ward and departmental managers in the implementation of this policy.
- Monitoring the implementation and compliance with this policy.
- Ensuring staff access training commensurate with their role and responsibilities.
- Over viewing monitoring of the use of EWS charts and compliance with the track and trigger algorithm via audit and review within departments.

4.5 **Ward/ Departmental Managers** are responsible for:
- Implementing this policy within their clinical area.
- Ensuring staff understand their accountability and responsibility in relation to complying with this policy.
- Monitoring the use of EWS charts and compliance with the track and trigger algorithm via audit and review.

4.6 **Health Care Practitioners** are responsible for practicing in accordance with the clinical guidance set out in this policy.

5.0 **Definitions**

**NCEPOD** – National Confidential Enquiry into Patient Outcome and Death. These are enquiries which seek to improve health and healthcare by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings.

**NICE** – The National Institute for Health and Clinical Excellence provides guidance, sets quality standards and manages a national database to improve people’s health and prevent and treat ill health. It makes recommendations to the NHS on new and existing medicines, treatments and procedures, and on treating and caring for people with specific diseases and conditions.

**EWS** – Early Warning Score - The Early Warning Score is a simple physiological scoring system that can be calculated at the patient's bedside, using parameters which are measured in the majority of unwell patients. It is a tool to alert nurses to abnormal physiological parameters in order to trigger urgent medical review of the unwell patient.
SBAR A framework for communication between members of the health care team about a patient's condition

6.0 Process Guidelines for the Use of EWS Charts

6.1 The purpose of the EWS chart is to track clinical observations of patients in order to highlight signs of deterioration before patients become seriously ill. They will then be given the appropriate treatment at the appropriate time.

6.2 EWS charts are to be used on all patients being nursed in an acute bed. This includes beds in the Jubilee Wing. In the case of postoperative patients being cared for in the recovery area, the anaesthetic chart will continue to be the document utilised for recording observations until the patient is fit for transfer to the ward. At this point the last 2 sets of observations will be entered onto to a EWS chart for continuation by ward staff.

6.3 All patients should have:

- physiological observations recorded at the time of their admission or initial assessment
- a clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the:
  - patients diagnosis
  - presence of co-morbidities
  - agreed treatment plan.

Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance.

6.4 As a minimum, the following physiological observations should be recorded at the initial assessment and as part of routine monitoring unless otherwise indicated in the patient record:

- heart rate
- respiratory rate
- systolic blood pressure
- level of consciousness (AVPU score)
- oxygen saturation
- temperature
- Urine output

6.5 The EWS chart should be used to monitor all adult patients in acute hospital settings including the Jubilee wing. This includes patients undergoing all invasive procedures including radiological procedures and endoscopy. The EWS chart should accompany the patient to the department where the procedure is being carried out for continued use / monitoring of the patient.
6.6 Physiological observations must be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient. The frequency of observations should be prescribed and reviewed on a daily basis by the nurse in charge of the patient area and the EWS chart signed accordingly by the nurse making this decision.

6.7 The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy.

6.8 In specific clinical circumstances, additional monitoring and investigations should be considered as part of the overall patient care evaluation.

6.9 Staff caring for patients and hence using the EWS chart should have competencies in monitoring, measurement, interpretation and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them.

6.10 The response strategy for patients identified as being at risk of clinical deterioration should be triggered by either physiological track and trigger score or clinical concern.

6.11 Trigger thresholds are locally set and clear on the EWS chart. The threshold should be reviewed regularly to optimise sensitivity and specificity.

6.12 A graded response strategy for patients identified as being at risk of clinical deterioration is an integral part of the EWS chart.

6.13 When a patient EWS score requires action to be taken the score and actions taken should be documented contemporaneously within the nursing care records.

6.14 Whilst the EWS system facilitates the assessment, early recognition and response to the deteriorating patient it should not deter clinicians from exercising their clinical judgement.

6.15 When communicating about a deteriorating patient, all healthcare practitioners should utilise the SBAR (Situation, Background, Assessment, Recommendation) method of communication to facilitate concise and effective dialogue.

6.16 The EWS chart and its efficacy in relation to track and trigger processes should be reviewed on an annual basis to ensure the tools are fit for purpose and meet local needs.

6.17 EWS compliance should be audited on a regular basis, at times agreed locally, and the results of these published along with areas of concern and action to address these.
7.0 Training

All new clinical staff employed within the Trust will be familiarised with the EWS chart and policy on induction training.

Ward managers ensure staff have the knowledge, skills and competence commensurate with their role and responsibilities to assess the acutely ill patient within their clinical area and incorporate EWS training into continued professional development through the CONTACT appraisal process and staff performance review.

Supplementary training is carried out for Health providers as part of wider training programmes such as Health Care Assistant study days, ALERT course, ILS course, ALS courses.

8.0 Equality & Diversity

The Trust is committed to ensuring that, as far as reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

9.0 Process for monitoring compliance with this policy

This policy will be reviewed on a two yearly basis and amended in light of any national guidance. The policy will be managed through the Resuscitation and Deteriorating Patient Committee.

The Resuscitation and Deteriorating Patient Committee will be responsible for assessing compliance with the policy through an annual audit. The annual report will be presented to the Resuscitation and Deteriorating Patient Committee who will report to the Mortality Steering Group who will escalate as necessary to the Patient Quality Risk and Safety Committee.

All audits will follow the guidance and undergo registration with the Safe Care Department. Specific Audits are named below:

<table>
<thead>
<tr>
<th>Standard / process /issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring and compliance of Early Warning Scores</td>
<td>Audit accuracy of every in-patient EWS over 24 hour period</td>
</tr>
<tr>
<td>NHSLA criterion 4.8</td>
<td>Resuscitation / Patient Deterioration committee representatives</td>
</tr>
<tr>
<td></td>
<td>Resuscitation &amp; Patient Deterioration Committee</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
</tr>
</tbody>
</table>

10.0 Consultation and Review

This policy has been reviewed by the Resuscitation and Patient Deterioration Committee in consultation with other interested stakeholders.
11 Policy Implementation

The policy has been implemented following the OP27 policy for the development, management and authorisation of policies will be made available to staff via the Trust intranet and circulated by the Trust Secretary.

12 References


13 Associated Documentation

OP27 Policy for the Development, management and authorisation of policies
RM 27a the “Resuscitation Policy”
OP24 the “Critical Care Outreach Team Policy”
Appendix 1. Resuscitation and Deteriorating Patient Committee Terms of Reference.

Resuscitation and Deteriorating Patient Committee

TERMS OF REFERENCE

1. Constitution & Purpose

The purpose of the Resuscitation and Deteriorating Patient Committee is to implement the Trust Safe Care Strategy / Agenda with particular reference to the recognition and management of the acutely ill adult, and appropriate management of the unexpected deteriorating patient.

Key areas covered will include:

- Preventing / reducing avoidable harm
- Reducing Avoidable Mortality

2. Membership & Quorum

The membership of the committee shall comprise of Medical Consultant Lead, Head of SafeCare, Head of Corporate Risk, clinical representation from each Division, SafeCare Clinical Lead Project Nurse, Resuscitation Officer and representation from senior members of CCOT.

In addition to the core membership, the committee may co-opt additional members as appropriate to enable it to undertake its role.

The Lead Consultant and Head of SafeCare shall jointly assume the role of chair.

To be quorate there should be a minimum of 6 attendees.

3. Meetings

The group will meet on a bi-monthly basis, although additional meetings may be convened as necessary in order to deal with urgent business. The joint chairs will assume responsibility for these decisions.

There is an expectation that members will attend a minimum of 80% of meetings.

Feedback from the Group meetings will be provided to the Nursing and Midwifery Professional Forum by the identified Lead Matron.

4. Key Responsibilities

The key responsibilities of the working group are set out below:
• To oversee the on-going development and implementation of NICE guidance relating to management of the acutely ill adult, by providing a forum for discussion, approval and dissemination of information.

• To ensure the development of a high calibre workforce which has the skills, capacity and flexibility to manage the complex and challenging needs of the acutely ill adult through the provision of education and training.

• Act as the approving body for development and review of all aspects of practice relating to management of the acutely ill adult, care standards, clinical cardiac arrest team provision; including the availability of emergency resuscitation equipment and drugs, implementation of Do Not Resuscitate policy, as well as other relevant documents.

• Co-ordinate work-streams relating to the management the deteriorating patient, the acutely ill adult, and cardiac arrest team provision; agreeing priorities and ensuring efficient and effective use of resources, working where relevant with other services to make best use of Trustwide expertise.

• Working in partnership with external agencies / service providers to maintain a consistent and co-ordinated approach to the appropriate management of the acutely ill adult.

• Review and develop both local and national policies relevant to the care and management of the acutely ill adult, Cardiac arrest team provision and education (RM27a) and Do Not Resuscitate orders (RM27b).

• Review and monitor standards of performance against key local and national objectives and guidance through regular internal, regional and national audit.

**5 Communication and reporting relationships (Appendix1)**

The group will report to SafeCare Council on an annual basis via a formal report. Any areas of concerns or areas of risk identified by the group will be escalated to SafeCare Council at the next scheduled meeting.

**6 Sub-Committees & Review**

The forum will have the authority to set up and disband sub-committees and working groups in order to effectively discharge its function.

The committee will keep under review the number of sub-committees reporting to it and, where possible, ensure that these are time limited working groups with clear terms of reference.

**7. Review**

Terms of Reference will be reviewed annually