Healthcare Support Worker Education and Competency Programme:

National Early Warning Score

Contents

Introduction

Welcome to the NHS Greater Glasgow and Clyde (NHSGGC) Adult Health Care Support Worker (HCSW) National Early Warning Score (NEWS) education and competency programme. You have been nominated to attend this programme by your Senior Charge Nurse (SCN)/Team Leader and have completed corporate induction and the HCSW Code of Conduct.

This programme has three stages:

Before the study day	**At** the study day	**After** the study day
• Please work through this workbook and complete the activities. • This will provide the foundation information for the practical workshop.	• Build on your learning from reading and completing the activities in this workbook. • **Take part** in the practical sessions on measuring and recording pulse, temperature, respiratory rate, blood pressure and ACVPU on the NEWS chart.	• Undertake supervised practice to achieve competency, with the support of preceptor who will sign your competency booklet (this will be provided on the study day). • Achieve final sign off from SCN / Team Lead / Educator.

As there will be a practical element to the workshop, please bring with you:

- Uniform or wear comfortable clothing
- Watch/timer
- Pen
- This workbook
- A willingness to learn

This workbook is to help you prepare and learn about key aspects of NEWS monitoring of adult patients. As you work through this workbook, you will notice there are links to websites (usually in a different colour of text and underlined), please click on these links or use a mobile phone camera to scan and open the QR code to access these resources.

Considerations		
Accountability	It is important to always work within your HCSW Code of Conduct (NES, 2020). Please ensure you have re-read the code, prior to the study day.	Date read……
Consent	Patients should be aware of the procedure you are planning to undertake and give consent for this. This should be from the patient. More information on consent can be found in the 'Consent Policy on Healthcare Assessment, Care & Treatment (NHS GGC, 2021). Please ensure the patient is correctly identified. This can include verbal communication, a check of the name band or patient notes.	Date read……
Adults with Incapacity (AWI)	The Adults with Incapacity Act (AWI) (2000) protects and supports those who lack the capacity to make decisions. The Act allows a person to receive treatment, however, there are safeguards and exceptions. When an AWI section 47 is in place all staff must follow the principles of the Act.	Date read……
Patient Preparation	Ensure your patient is comfortable and safe before, during and after the clinical procedure whilst providing emotional and physical support throughout.	

Equipment	All equipment should be cleaned before and after using it, according to local policy. Choosing the appropriate equipment, correct sized BP cuff, undertake pre-checks on device of choice and ensure it is clean, intact and within service date.	Date read……
Infection Prevention and Control	Before touching your patient, please ensure hand hygiene is carried out as instructed below and appropriate personal protective equipment (PPE) is used as per local infection control policy. Hand Hygiene - NHSGGC	Date read……

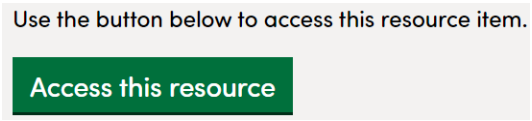
National Early Warning Score (EWS)

Vital signs and observations are essential to assessing a patient's clinical condition. Regular recording and assessment of observations are used to detect signs of serious illness or deterioration and provide the necessary information on how a patient's illness is responding to treatment. Vital signs include:

- Respiratory rate
- Oxygen saturations
- Blood pressure
- Heart rate (pulse)
- ACVPU (level of consciousness)
- Temperature

NEWS (National Early Warning Score) was introduced to improve communication of the deteriorating patient across the UK. The Royal College of Physicians (2012 and 2017) recommended the using the same early warning scoring system across the whole of the UK. This criteria is used in NHSGGC in our NEWs chart. By using NEWS, we can recognise sick patients early and manage any deterioration.

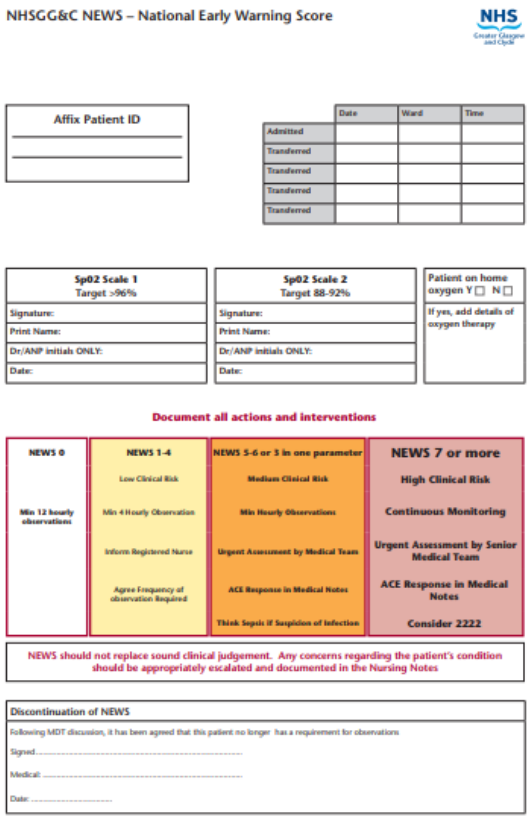
Further information can be found in NHSGGC NEWs Guideline. Once you access the webpage click on this box:



or scan the QR code:

Example of NEWS chart

Front page – In hospital chart



NHSGG&C NEWS – National Early Warning Score

Affix Patient ID

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 hourly observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes

Discontinuation of NEWS

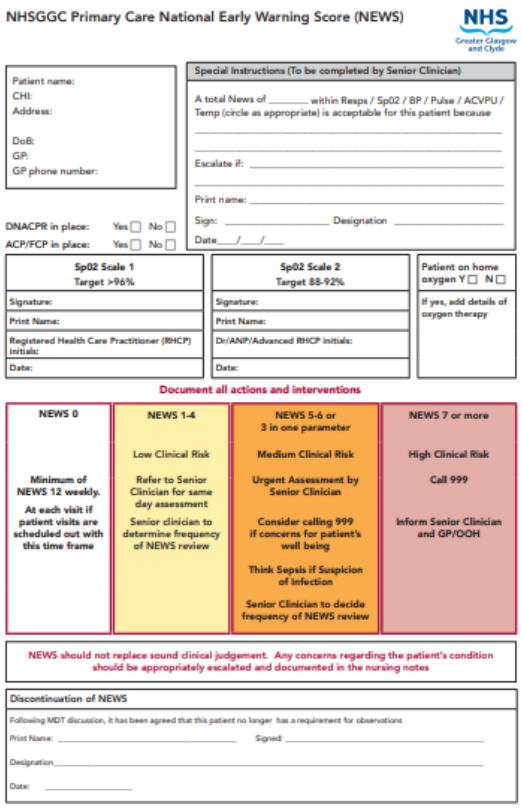
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed:

Medical:

Date:

Front page – Primary Care chart



NHSGGC Primary Care National Early Warning Score (NEWS)

Patient name:
CHI:
Address:

DoB:
GP:
GP phone number:

Special Instructions (To be completed by Senior Clinician)

A total News of _____ within Resps / Sp02 / BP / Pulse / ACVPU / Temp (circle as appropriate) is acceptable for this patient because

Escalate if:

Print name:

Sign: _____ Designation _____

Date___/___/___

DNACPR in place: Yes☐ No☐

ACP/FCP in place: Yes☐ No☐

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Registered Health Care Practitioner (RHCP) initials:	Dr/ANP/Advanced RHCP initials:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Minimum of NEWS 12 weekly. At each visit if patient visits are scheduled out with this time frame	Low Clinical Risk Refer to Senior Clinician for same day assessment Senior clinician to determine frequency of NEWS review	Medium Clinical Risk Urgent Assessment by Senior Clinician Consider calling 999 if concerns for patient's well being Think Sepsis if Suspicion of Infection Senior Clinician to decide frequency of NEWS review	High Clinical Risk Call 999 Inform Senior Clinician and GP/OOH

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

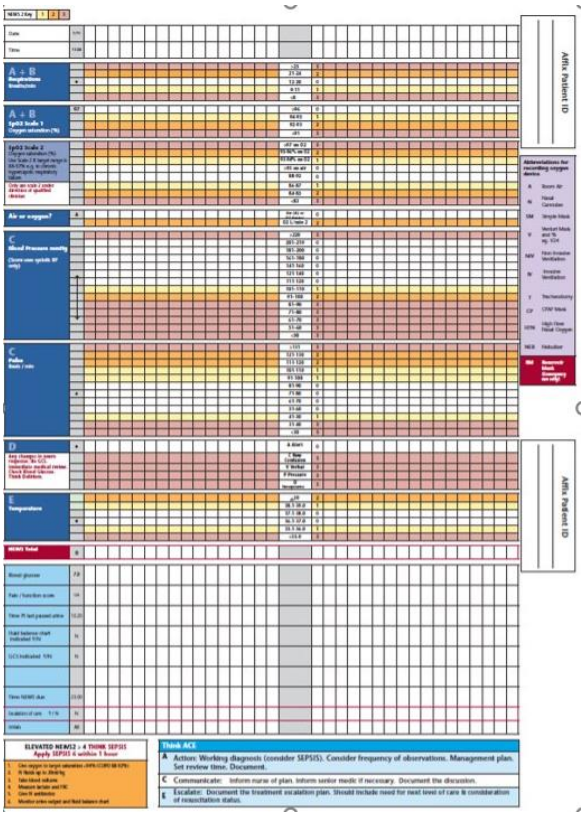
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Print Name: _____ Signed: _____

Designation _____

Date: _____

Inside pages

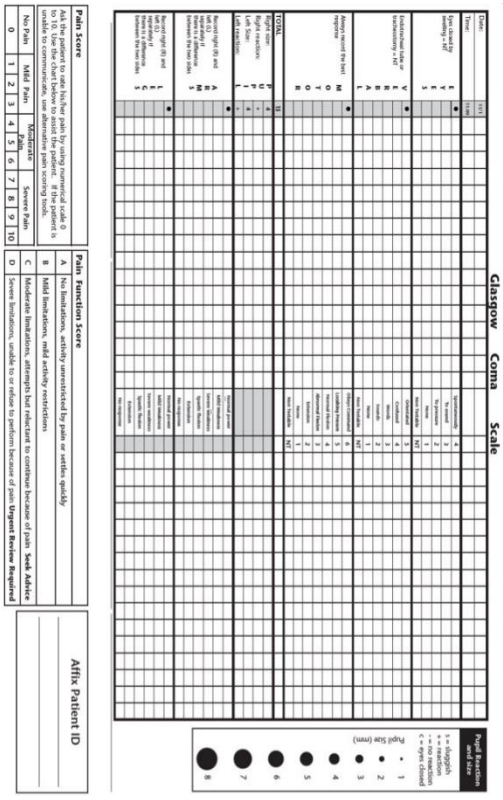


Affix Patient ID

Abbreviations for recording oxygen device

Think ACE

Back page



Pain Score

Pain Function Score

Affix Patient ID

Glasgow Coma Scale

Pupil Reaction and Size

Respiratory Rate

Breathing is the process of air moving in and out of the lungs supplying essential oxygen to the body's organs and tissues.

We can successfully assess a patient's breathing by watching their chest movement, assessing breathing effort, listening for any abnormal breathing sounds and counting the breath rate (speed of breathing over one minute).

Activity: Watch the video:

How do lungs work?

Date watched……

When counting a respiratory rate, both the inspiration (breathing in) and expiration (breathing out) are included as 1 breath and should be counted for **60 seconds** in total and no less. Normal respiration should look effortless, there should be no audible sounds and the chest should move equally (both sides of chest rise and fall at the same time) and at an even rate.

The picture below shows how we accurately document and plot our findings in the NEWS chart. We **must** accurately score the respiratory rate, highlighting any cause for concern by reporting and escalating appropriately, to the correct person.

Activity: What do you think would change your respiratory rate?

……

……

Oxygen Saturations

Oxygen is carried around the body in haemoglobin which is found in red blood cells. A pulse oximeter is a method to measure the level of haemoglobin and is a way of measuring the amount of oxygen in the blood. This is known as oxygen saturations or Sp02.

There are different probes available. These are detachable probes and display a red sensor light when connected correctly.

There are different specific probes for measuring oxygen saturations (shown below). The one shown for use on fingers should **not** be used on ears.

Activity: Watch the video:

How to measure someone's oxygen levels

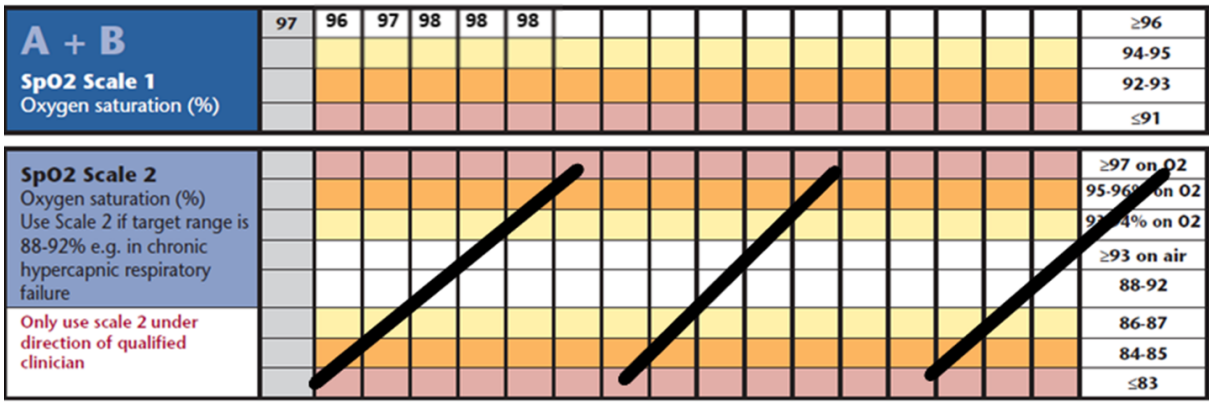
Date watched……..

Finger probe

Ear probe

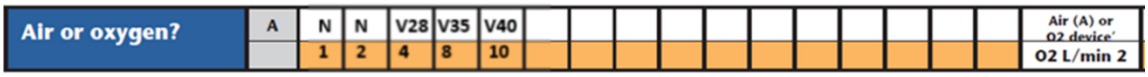
Oxygen saturation levels should ideally be 94% -100% in adults. This is measured on Scale 1. There are a range of conditions that may have differing ranges of acceptable parameters for clinical reasons for example; 88 – 92%. This is measured using Scale 2. The front page of the NEWS chart where a medical professional or Advanced Nurse Practitioner (ANP) should have completed the Sp02 scale to be used. Only one scale should be used, and the scale not being used should be clearly scored out.

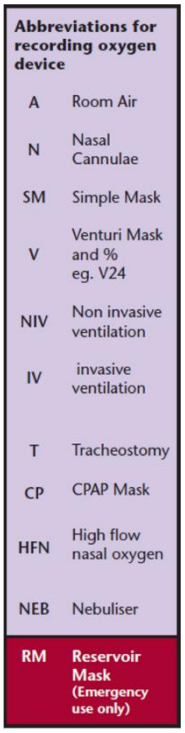
Accurately document and plot findings in the NEWS chart as per picture below:



Air or Oxygen

In the air or oxygen section, it needs to be documented if the patient is breathing room air or receiving oxygen therapy. If receiving oxygen, how many litres and the device being used to administer the oxygen is also documented.





Activity: Think of patients who you have looked after, what has caused oxygen (Sp02) levels to drop?

……

……

Activity: How did your patient look?

……..

Pulse

Activity: Watch the video

How your heart works

Date watched……..

A pulse (also known as your heart rate) is the number of times your heart beats in one minute. We all have different pulse rates and this can change over time. The normal range in an adult is 60 – 100 beats per minute (bpm).

While measuring the pulse rate, you also assess how regular the pulse is and the strength which can be weak (thready) or strong (bounding).

Where on the body can we feel a pulse?

By placing index and middle fingertips together as shown below, we can feel the pulse pushing through the arteries. Please remember **not** to use your thumb to assess a pulse. You have a pulse in your thumb that means it is likely you will feel your own pulse instead of your patient's.

Electronic devices such as a pulse oximeter, described in the oxygen saturation section of this pack, also measure a pulse rate. However, measuring a pulse is not just about the number of beats, but also about the strength, regular/irregular which can **only** be felt manually. Therefore, it is important that if using a pulse oximeter, you must feel a manual pulse.

Activity: During a normal day, what do you think makes your pulse rate increase?

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Activity: During a normal day, what do you think makes your pulse rate slow down?

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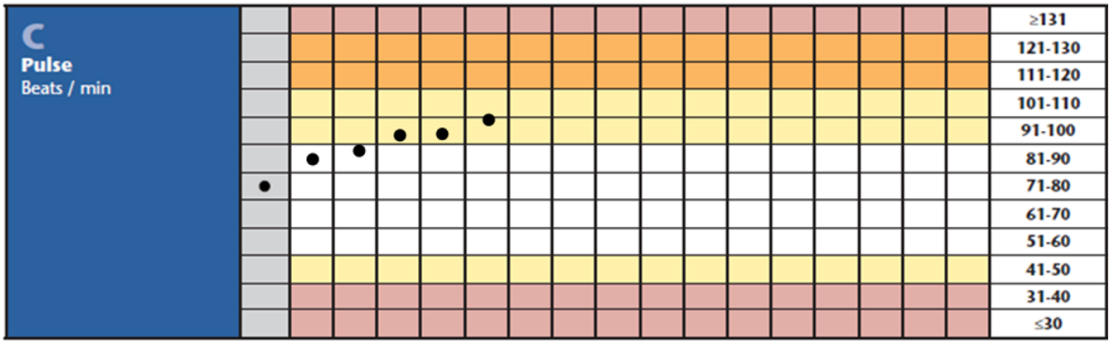
Once a pulse rate has been recorded, document appropriately in the NEWS chart.



Blood Pressure

Activity: Watch the video

How blood pressure works

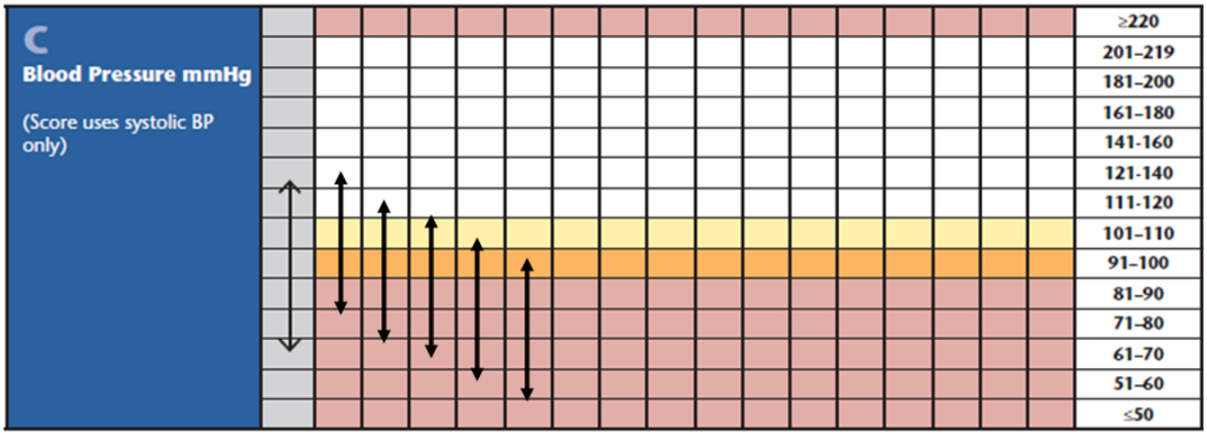
Date watched……

Blood pressure is the pressure that the blood exerts against the inner walls of the blood vessels, and it is the force that keeps the blood circulating continuously, even between heartbeats.

Many factors can affect the accuracy of the blood pressure recorded, including efficiency and accuracy of equipment, use of correct technique and other variables including temperature, exercise, obesity and movement.

We are using a non-invasive method of measuring blood pressure. Most commonly available look similar to these:

The electronic monitor will display two numbers. The highest number is known as the systolic blood pressure, and is the pressure against the artery wall when the heart is contracting and pumping blood around the body. The lower number displayed on the monitor is known as the diastolic blood pressure, and is the pressure against the artery wall when the heart is relaxing and refilling. Blood pressure is measured in mmHg. When documenting a blood pressure in patient notes, you will see this as Systolic/Diastolic. From the picture of the monitor above, this would documented as 125/82mmHg. Once the reading has been identified, it must be charted in the NEWS chart accordingly. Both the systolic and diastolic need to be recorded, but it is only the **systolic** that gets scored on the NEWS chart.



Activity: During a normal day, what do you think makes your blood pressure increase?

……

……

Activity: During a normal day, what do you think makes your blood pressure lower?

……

……

Conscious Level

A rapid assessment of a patient's conscious level can be determined by the ACVPU score. This is a simple acronym for the grading:

A = Alert

C = New confusion, or worsening confusion

V = Verbal response

P = Pressure response

U = Unresponsive

Activity: watch the video

ACVPU

Date watched.....

A = Alert: If a patient is alert or asleep and woken easily, simply plot this on the NEWS chart and score appropriately.

C = New or worsening confusion: if a patient is alert but confused or disorientated. It is a not always possible to determine if the confusion is new. It should be considered new until it can be confirmed as being previously present. New onset or worsening confusion should always cause concern as may have serious underlying causes and will need an urgent review and further clinical assessment.

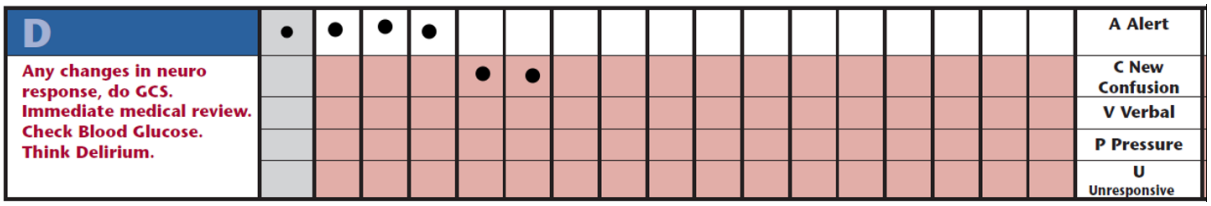
V = Verbal: If the patient is difficult to rouse from sleep or is drowsy and only responds to you speaking to them, this should be documented as a verbal response and escalated immediately to the nurse in charge of the patient for further assessment and escalation if required.

P = Pressure: If the patient does not respond to you speaking to them (verbal response), please seek immediate help for further intervention by medical and nursing staff if you are having difficulty rousing the patient. The next step would be to apply a pressure stimulus by a trapezius squeeze for a **max 10secs** and assess the response.

Trapezius squeeze

U = Unresponsive: the patient is unable to respond to any of the above steps. Please seek immediate help for further intervention by medical and nursing staff.

The outcome of the ACVPU assessment should be plotted accordingly.



Activity: What do you think can affect your conscious level?

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……

Temperature

Measuring the temperature of our patients is important to provide vital information about environmental factors or their infection status.

Normal temperature ranges for healthy adults 36° to 37° although safe ranges on the NEWS is between 36° and 38°. Any temperature above 38° (known as pyrexia) and temperatures between 35° and 36° (known as hypothermia), and below 35° is severe hypothermia.

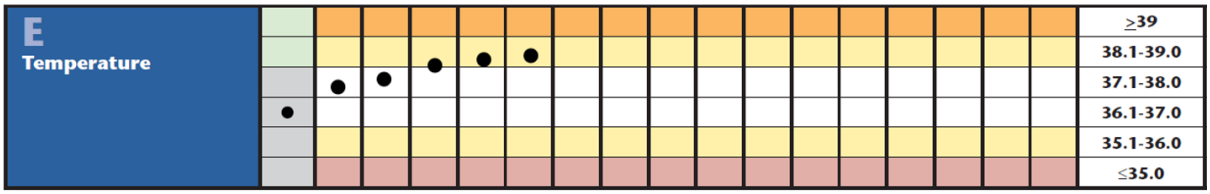
In adults we check temperature using a probe in the ear. This measures heat from the ear drum (tympanic temperature).

Activity: Watch the video

Regulating body temperature

Date watched:……

The temperature should be plotted accordingly:



Activity: What do you think affects your temperature?

……

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Glossary of terms

Term		Meaning	
Hypo	Hypothermia Hypoglycaemia Hypotension Hypoxia	**Low**	Low body temperature Low blood sugar Low blood pressure Low blood oxygen
Hyper	Hypertension Hyperglycaemia	**High**	High blood pressure High blood sugar
Tachy	Tachycardia Tachypnoea	**Fast**	Fast heart rate/pulse Fast breathing rate
Brady	Bradycardia Bradypnoea	**Slow**	Slow heart rate/pulse Slow breathing rate
	Cardiac Arrest		Sudden, unexplained heart stop
A	Apnoea Apyrexia	**Absent**	No breathing No high body temperature / Normal temperature
	Pyrexia		High body temperature

Study Day Programme

Band 3 HCSWs NEWS Study Day Programme	
Morning	• Introductions, aims and ground rules • Professional responsibilities, governance and NEWS clinical guideline • Physiological parameters theory, demonstration, assessment practice and documenting on NEWS • Communication skills and escalation using SBAR theory and demonstration
Afternoon	• Simulated Scenarios (Clinical Skills Lab – Level 1) • Competency booklet explanation and study day evaluation

Tea/coffee/lunch breaks will be included in this programme at appropriate times.

Write down anything you are still not sure about to make sure we answer this at the practical workshop.

Things I'm still not sure about…

……

……

……

……

……

……

……

Well done on completing your pre-course reading. We are looking forward to seeing you at the practical workshop!