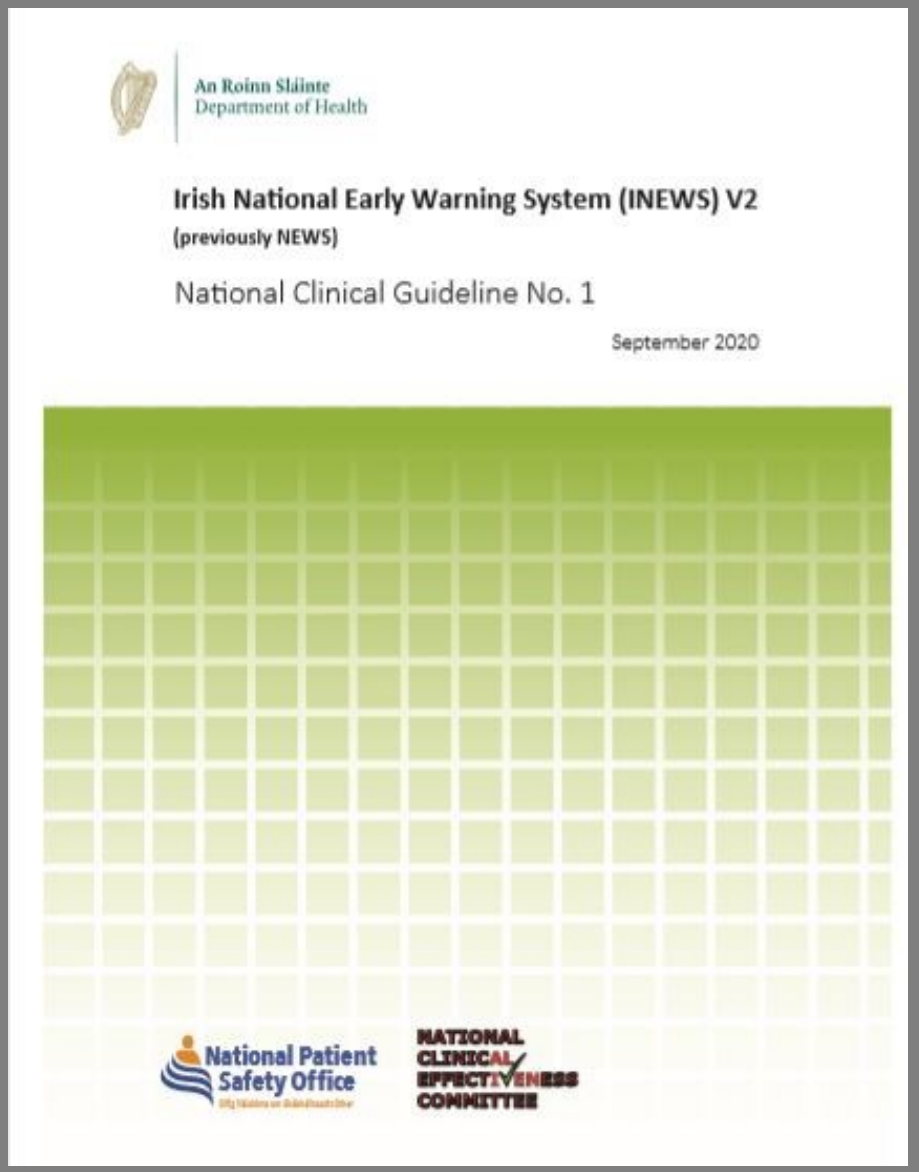
NCEC National Clinical Guideline No. 1. INEWS V2 *(September 2020) – Changes and updates*

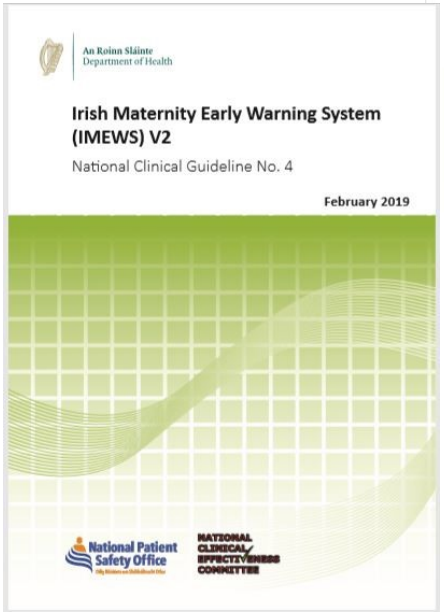
Deteriorating Patient Improvement Programme

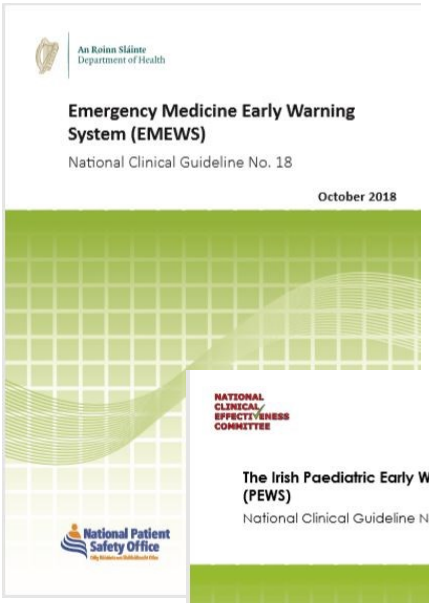
Clinical Design & Innovation

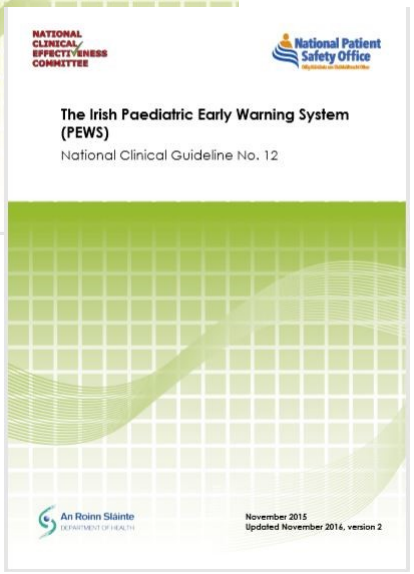
Person-centred, co-ordinated care



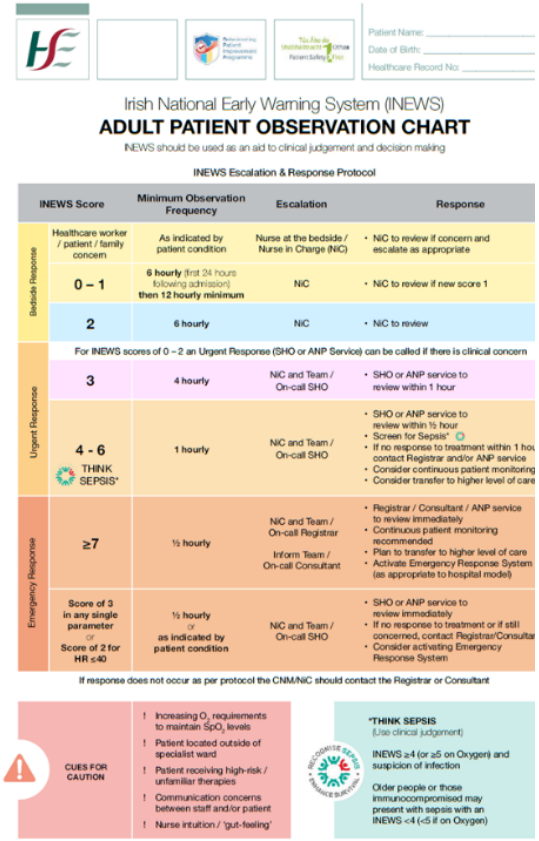
Irish Early Warning Systems







What is INEWS?



Irish National Early Warning System (INEWS)

ADULT PATIENT OBSERVATION CHART

INEWS should be used as an aid to clinical judgement and decision making

Patient Name:
Date of Birth:
Healthcare Record No:

INEWS Escalation & Response Protocol

	INEWS Score	Minimum Observation Frequency	Escalation	Response
Bedside Response	Healthcare worker / patient / family concern	As indicated by patient condition	Nurse at the bedside / Nurse in Charge (NIC)	• NIC to review if concern and escalate as appropriate
	0 – 1	6 hourly (first 24 hours following admission) then 12 hourly minimum	NIC	• NIC to review if new score 1
	2	6 hourly	NIC	• NIC to review
	For INEWS scores of 0 – 2 an Urgent Response (SHO or ANP Service) can be called if there is clinical concern			
Urgent Response	3	4 hourly	NIC and Team / On-call SHO	• SHO or ANP service to review within 1 hour
	4 - 6 THINK SEPSIS*	1 hourly	NIC and Team / On-call SHO	• SHO or ANP service to review within ½ hour • Screen for Sepsis* • If no response to treatment within 1 hou contact Registrar and/or ANP service • Consider continuous patient monitoring • Consider transfer to higher level of care
Emergency Response	≥7	½ hourly	NIC and Team / On-call Registrar Inform Team / On-call Consultant	• Registrar / Consultant / ANP service to review immediately • Continuous patient monitoring recommended • Plan to transfer to higher level of care • Activate Emergency Response System (as appropriate to hospital model)
	Score of 3 in any single parameter or Score of 2 for HR ≤40	½ hourly or as indicated by patient condition	NIC and Team / On-call SHO	• SHO or ANP service to review immediately • If no response to treatment or if still concerned, contact Registrar/Consultar • Consider activating Emergency Response System

If response does not occur as per protocol the CNM/NIC should contact the Registrar or Consultant

CUES FOR CAUTION

- ! Increasing O_2 requirements to maintain SpO_2 levels
- ! Patient located outside of specialist ward
- ! Patient receiving high-risk / unfamiliar therapies
- ! Communication concerns between staff and/or patient
- ! Nurse intuition / 'gut-feeling'

***THINK SEPSIS**
(Use clinical judgement)

INEWS ≥4 (or ≥5 on Oxygen) and suspicion of infection

Older people or those immunocompromised may present with sepsis with an INEWS <4 (<5 if on Oxygen)

An Roinn Sláinte
Department of Health

Irish National Early Warning System (INEWS) V2
(previously NEWS)

National Clinical Guideline No. 1

September 2020

National Patient Safety Office

NATIONAL CLINICAL EFFECTIVENESS COMMITTEE

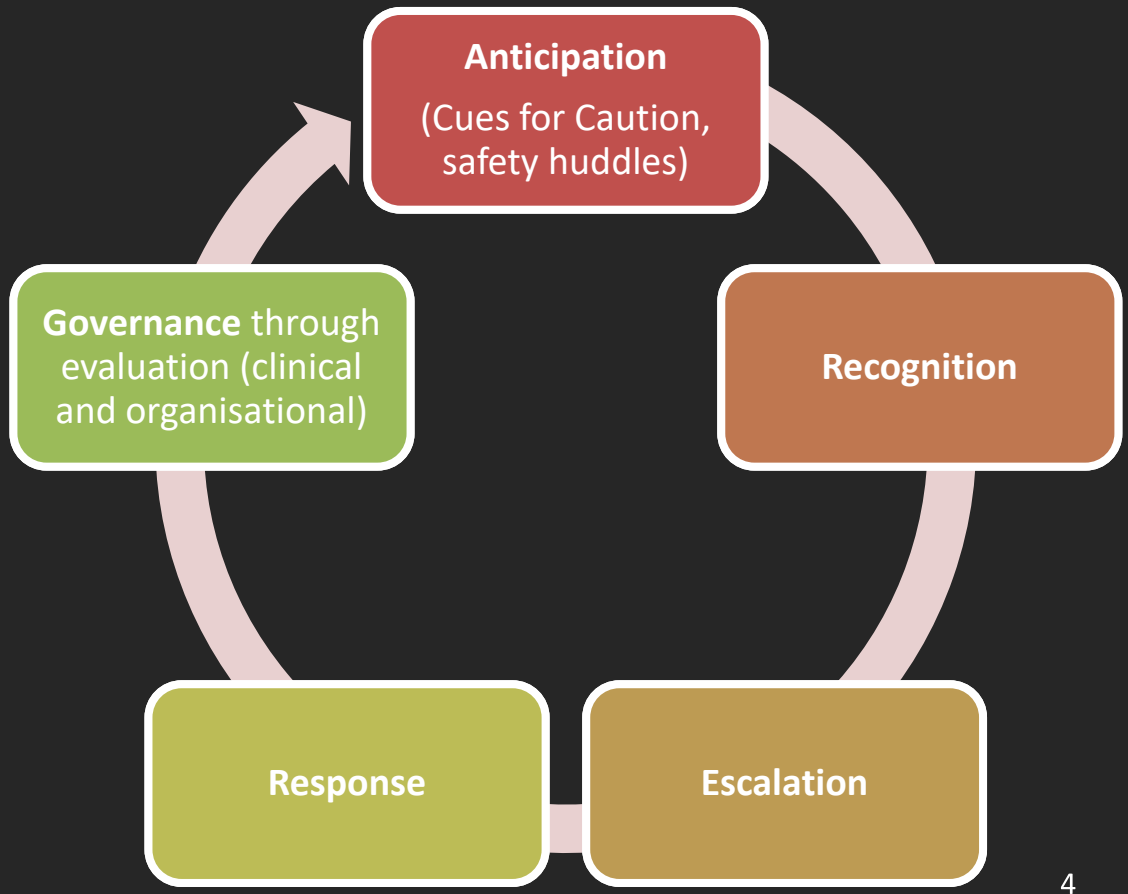
INEWS is an early warning system to assist staff to recognise and respond to clinical deterioration.

Early recognition of deterioration can prevent:

- Unanticipated cardiac arrest
- Unplanned ICU admission/readmission
- Delayed care resulting in prolonged length of stay, patient or family distress, or more complex interventions
- Requirement for more complex interventions

INEWS V2

- INEWS education is **mandatory** for all relevant HCPs.
- HCPs should be familiar with their hospitals INEWS Escalation and Response Protocol.
- INEWS education is to be included in most clinical undergraduate programmes.



INEWS IS OF BENEFIT IN CLINICAL PRACTICE FOR THE FOLLOWING REASONS:

INEWS provides a single **standardised** early warning system for the early detection of acute deterioration in the non-pregnant adult (≥16 years) patient

It provides a **common language** to aid communication between health care providers

It provides an **adjunct to clinical judgement** in the anticipation, recognition, escalation and response to clinical deterioration

It provides a **standardised score** to determine illness severity to support clinical decision making and an appropriate clinical response

It **supports an anticipatory care** approach to the management of the acutely unwell patient

It can help to **improve** the timely recognition and response to deteriorating patients

What's new in INEWS V2?

NEWS to INEWS

System versus Score

Emphasis on clinical judgement

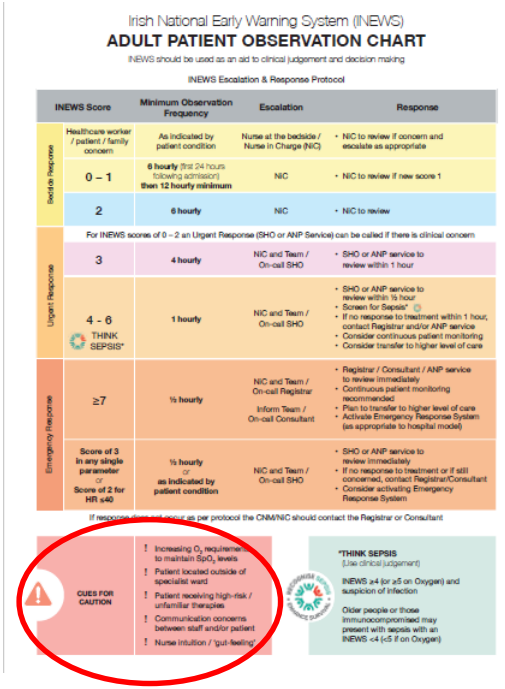
Recognition of healthcare worker, patient and family concern as a key indicator of deterioration

Increased emphasis on changes in respiratory rate as a key early indicator of deterioration

What's new in INEWS V2?

Deteriorating Patient Improvement Programme

'Cues for Caution'
as prompts for staff to consider when monitoring patients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CUES FOR CAUTION

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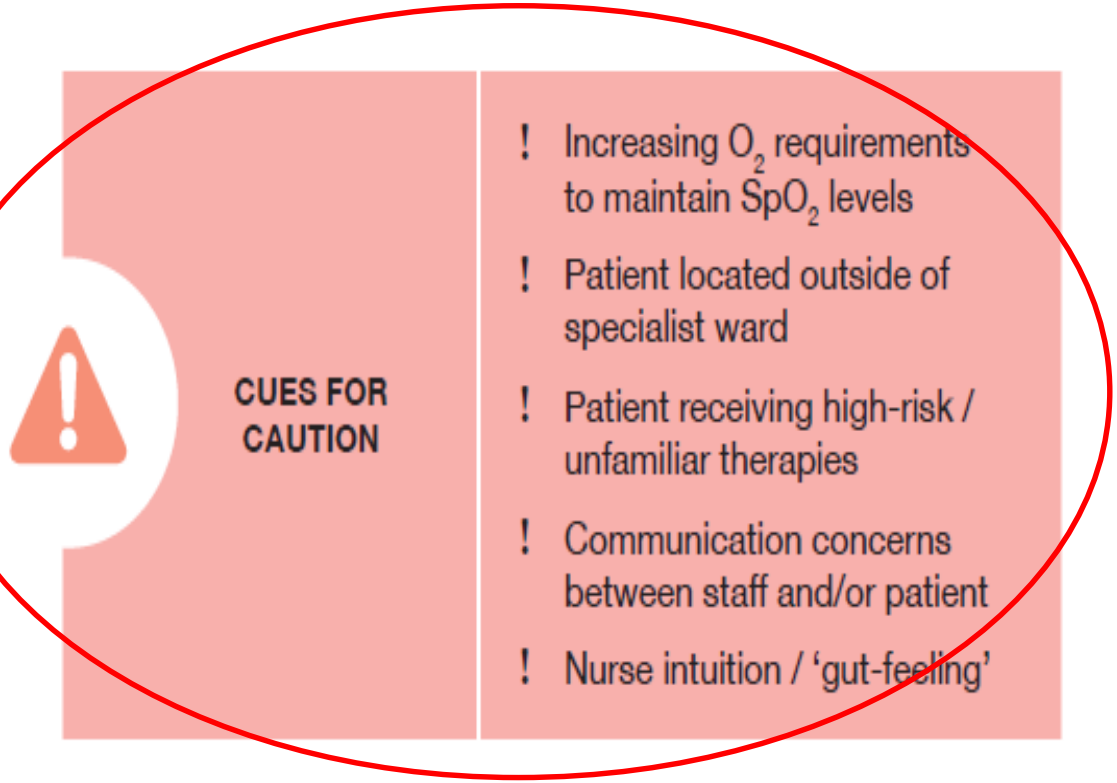


What's new in INEWS V2?

'New confusion' a key early sign of deterioration…AVPU becomes A**C**VPU where '**C**' = 'new confusion/altered mental status/delirium'

Adjustments of INEWS parameters or score not permitted

Option for a short period of escalation deferral by an RGN

Minimum 6 hourly observations x 24 hours following admission

Modified Escalation and Response Protocol (Consultant or Registrar)

Anticipate

The use of **clinical judgement** combined with **situation awareness** using

- ‘cues for caution’,
- staff, patient and/or family concern

&

- safety huddles

to anticipate and manage the potential for deterioration in hospitalised patients.

SAFETY HUDDLES AND/OR SAFETY PAUSES

Deteriorating Patient Improvement Programme

Safety huddles/pauses using trend data and INEWS score to determine next steps of treatment/care

Using clinical judgement identify patients who may deteriorate and communicate this information to all staff

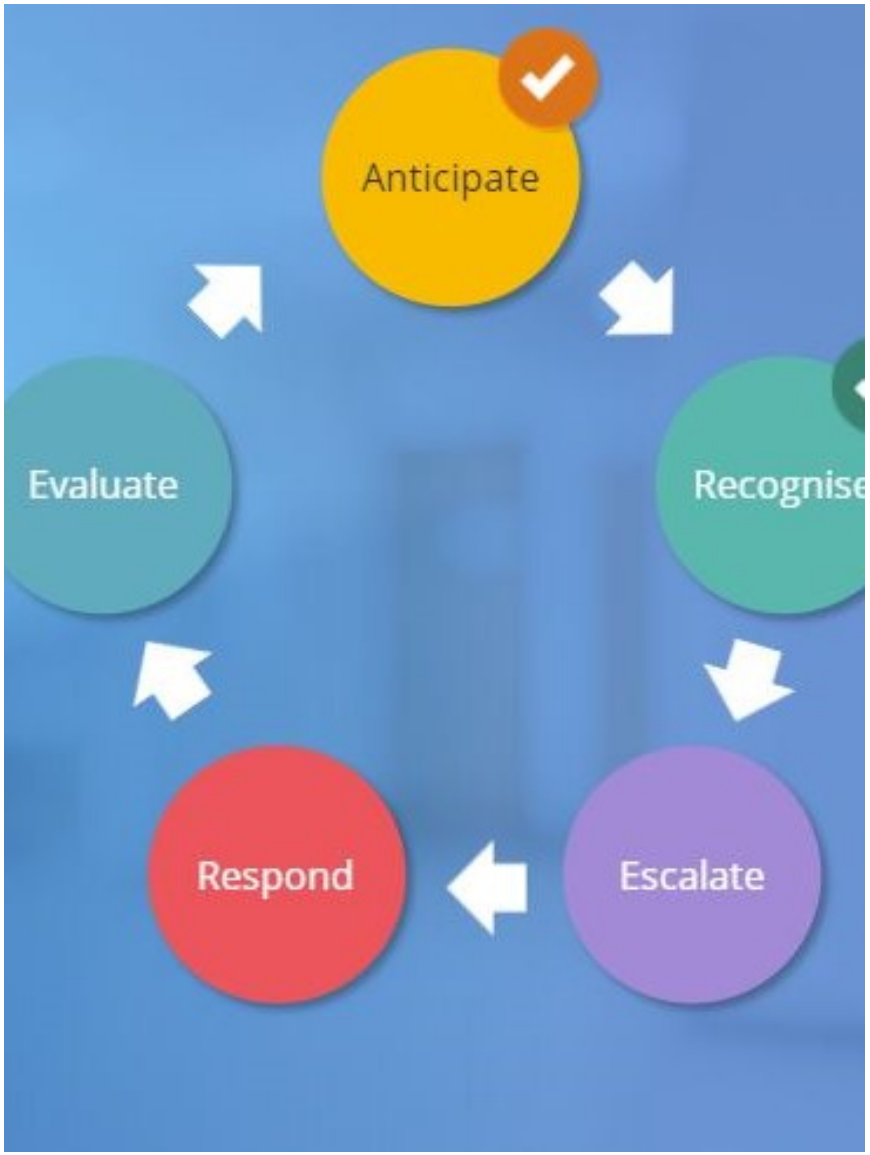
Identify clinical context-specific ‘cues for caution’ e.g. patient with known medical co-morbidities; patients on complex medication regimens

Recognise

Clinical judgment plus…

1. Patient assessment

2. Supported by the bedside track-and-trigger tool i.e. the **INEWS patient observation chart**

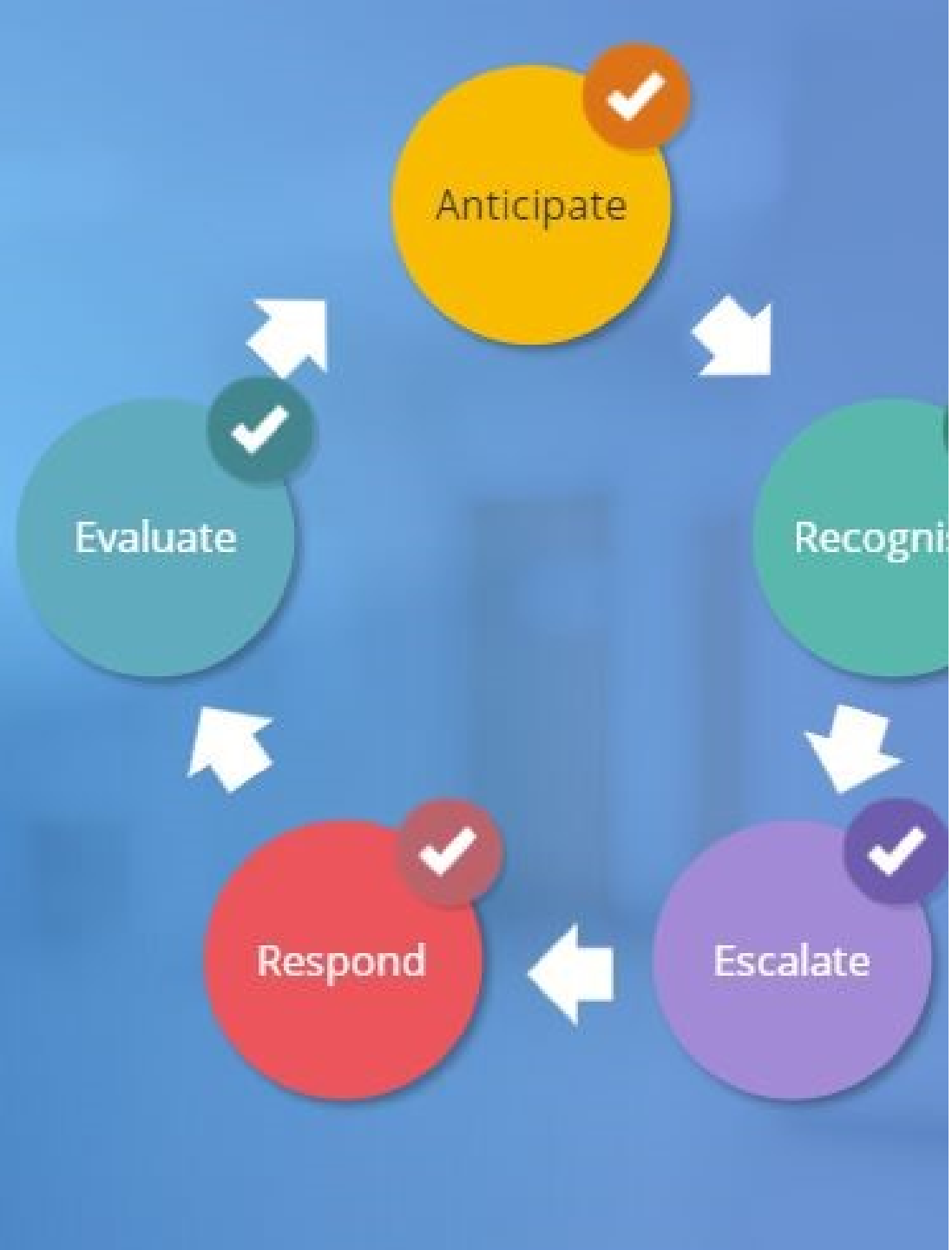


Escalate & Respond

INEWS Escalation and Response Protocol to guide decisions on escalation for nursing or medical review

Provision of a structured mechanism for a tiered clinical response - bedside, urgent or emergency response

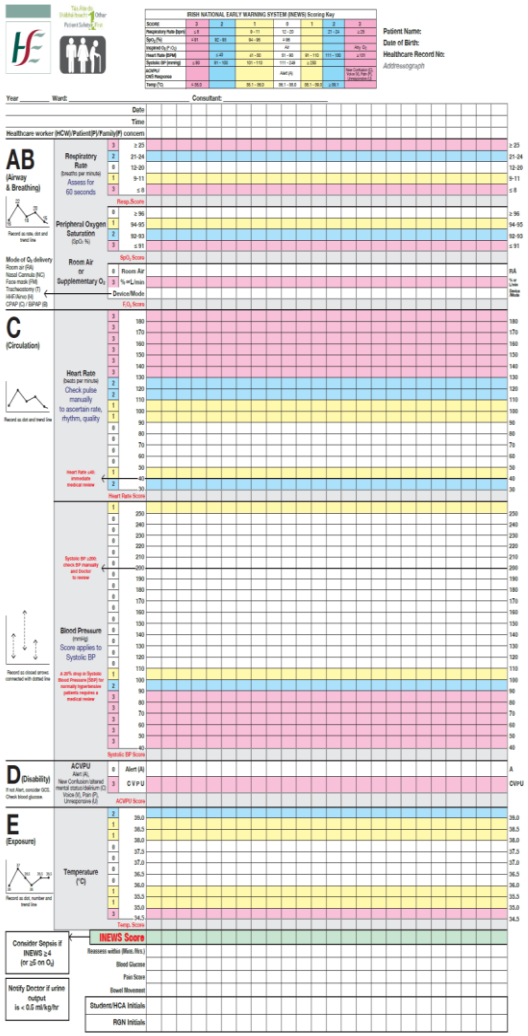
A move towards an ANP-response service



Evaluate

INEWS V2 supports a **closed loop governance system** involving:

- Bedside clinical evaluation of the **effectiveness of treatment** interventions
- System-wide evaluation of the management of patient deterioration e.g after-action review, cycles of audit and improvement



The INEWS physiological observations are:

- Respiratory rate
- SpO_2
- FiO_2 (Room air or supplemental O_2)
- Heart rate
- Blood pressure
- Neurological response (or ACVPU, where C = new confusion)
- Temperature

The INEWS Scoring Key

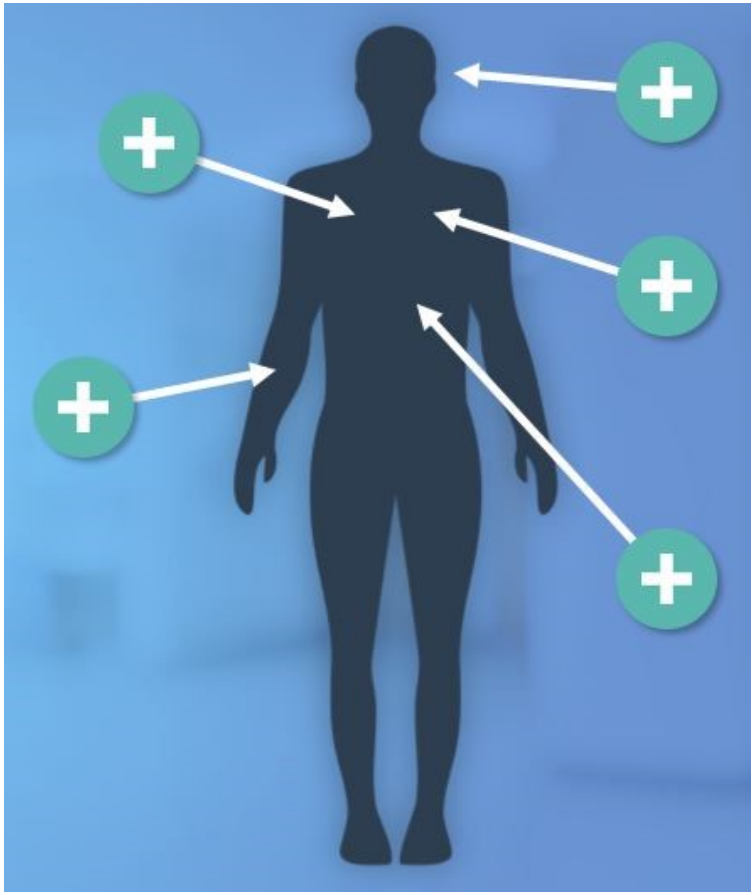
- INEWS allocates 0-3 points to measurements of each of the 7 physiological parameters.
- A score of 0 represents least risk while a score of 3 represents highest risk
- **About recognising small changes**
- Documentation of observations over time demonstrates the patient's individual baseline and trends, which assist in the recognition of the small changes that may signal early deterioration.

Irish National Early Warning System (INEWS) Scoring Key							
SCORE	**3**	**2**	**1**	**0**	**1**	**2**	**3**
Respiratory Rate (bpm)	≤ 8		9 - 11	12 - 20		21 - 24	≥ 25
SpO_2 (%)	≤ 91	92 - 93	94 - 95	≥ 96			
Inspired O_2 (Fi O_2)				Air			Any O_2
Heart Rate (BPM)		≤ 40	41 - 50	51 - 90	91 - 110	111 - 130	≥ 131
Systolic BP (mmHg)	≤ 90	91 - 100	101 - 110	111 - 249	≥ 250		
ACVPU/CNS Response				Alert (A)			Confusion (new) (C), Voice (V), Pain (P), Unresponsive (U)
Temp (°C)	≤ 35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥ 39.1	

Quick review of physiological changes during deterioration

- A systems approach to patient assessment helps ensure that you don't miss any of the subtle changes associated with deterioration

- **INEWS V2 emphasises changes in respiratory rate and new confusion/altered mental status/delirium as key early signs of deterioration**



Respiratory Rate (RR)

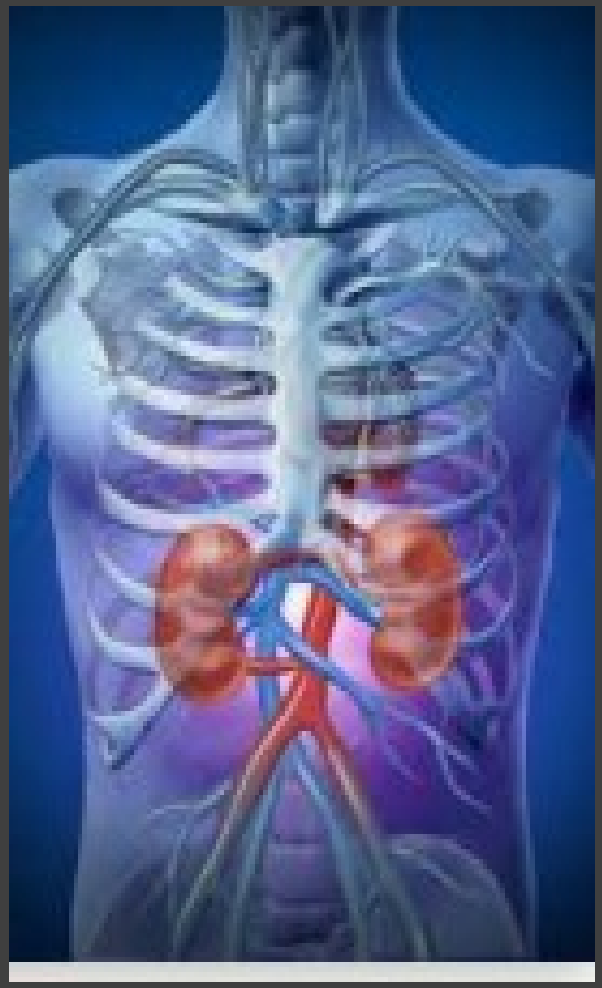
- Most **neglected** vital sign
- Often *estimated* by clinicians rather than counted
- Any change may be an **early sign of deterioration**
- Changes can be seen up to **24 hrs prior** to cardiac arrest
- During early stages of deterioration SpO_2 may remain within normal range while RR may change

RR may be affected by

- Some medications (e.g. opiates)
- Altered level of consciousness

Thermoregulation system

- Both pyrexia and hypothermia are significant
- Immunocompromised and older persons may not produce a fever
- Patients with sepsis can present with any temperature
- Caution if anti-pyretic medication is given as it can mask signs of infection



Renal system

- Decreasing urine output (<0.5mL/kg/hr) is a sign of deterioration
- Monitor renal profile blood results

Knowledge check

Which of these observations are the best predictors of deterioration?

- Altered mental state, such as new confusion or delirium
- Increase or decrease in temperature
- Altered respiratory rate
- Change in urine output

Determinants for escalating care:

- Clinical judgement
- Healthcare worker, patient or family concern
- Intuition/gut-feeling
- INEWS score
- Escalation and Response Protocol

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Healthcare worker (HCW), patient, family or carer concern

New in INEWS V2

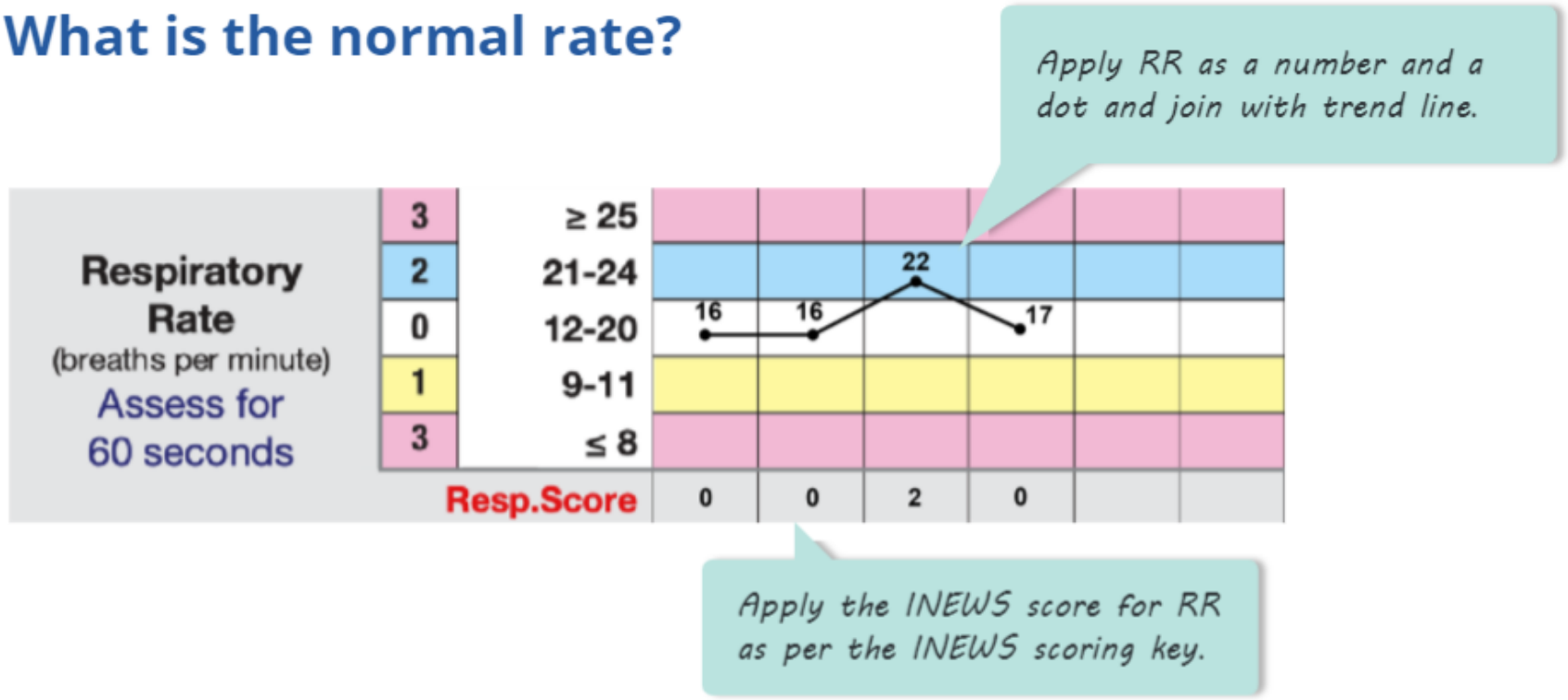
- Concern is not scored but triggers patient review by a nurse or escalation for medical review, regardless of a low or no INEWS score. *Insert 'HCW' or 'H', 'P' or 'F' as appropriate*
- If a HCW, patient, family or carer reports concern, a full assessment and a complete set of INEWS observations should be undertaken

Respiratory rate (RR)

Changes in RR are the earliest sign of deterioration:

- Consider affect of patient position on respiration
- Count the RR for ***a full 60 seconds***
- Assess work of breathing including use of accessory muscles
- Is the chest moving bilaterally?
- Look at trends in RR
- Know the patient's baseline rate

What is the normal rate?

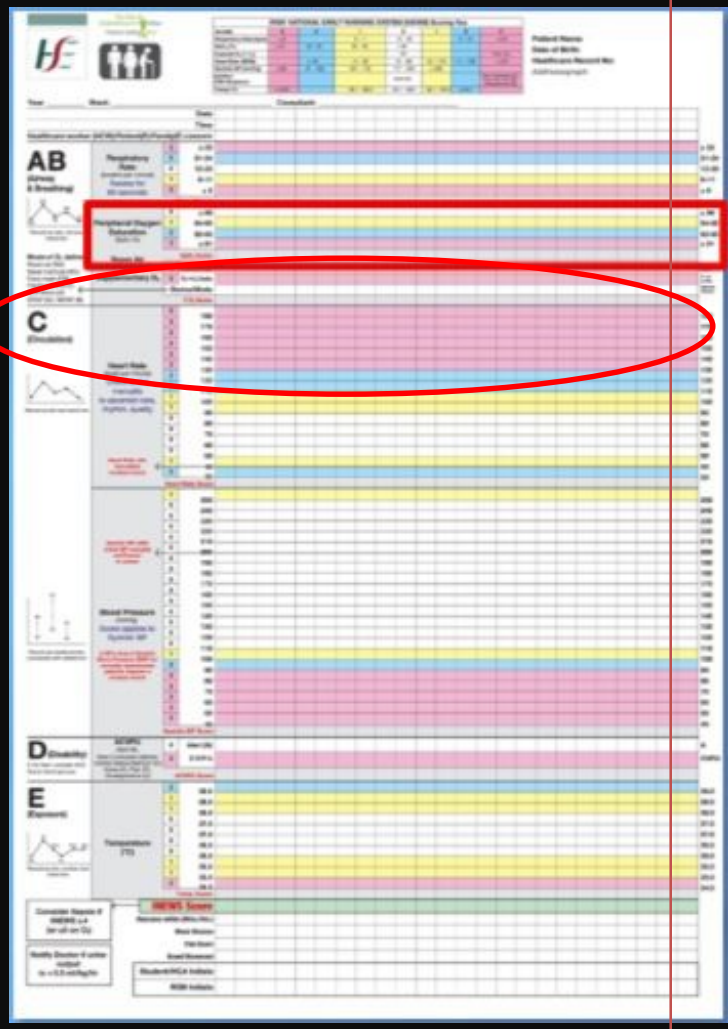


The normal respiratory rate in adults (as per INEWS parameter ranges) is 12-20 breaths per minute. Some patients with a confirmed diagnosis of chronic respiratory conditions may have a higher baseline respiratory rate.

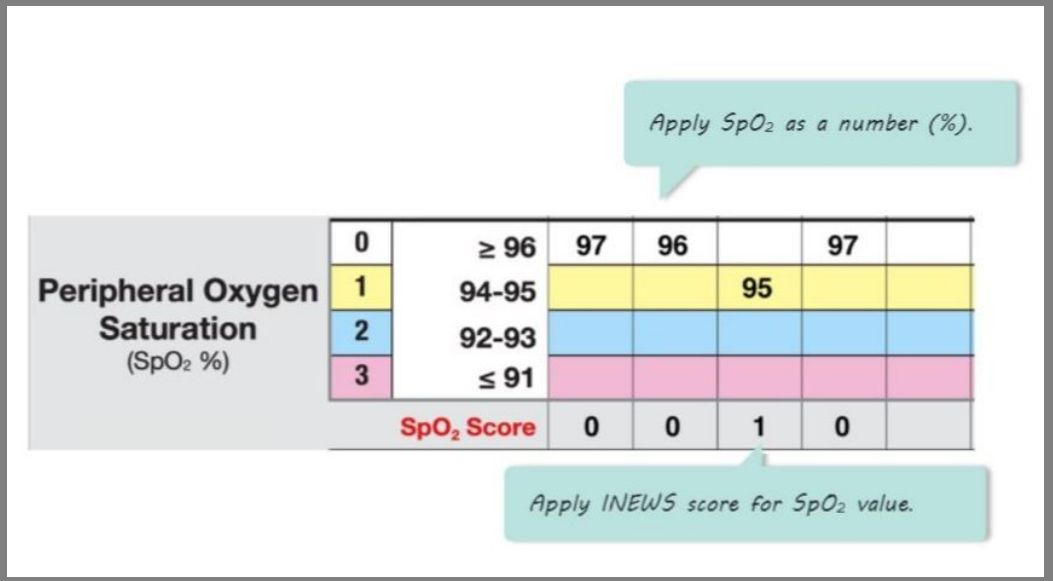
SpO_2

O_2 saturation (SpO_2) is recorded here

- SpO_2 is the '5th vital sign' and should be checked by trained staff using pulse oximetry in all breathless and acutely ill patients
- Increasing supplemental O_2 to maintain targeted SpO_2 indicates deterioration and should be escalated without delay



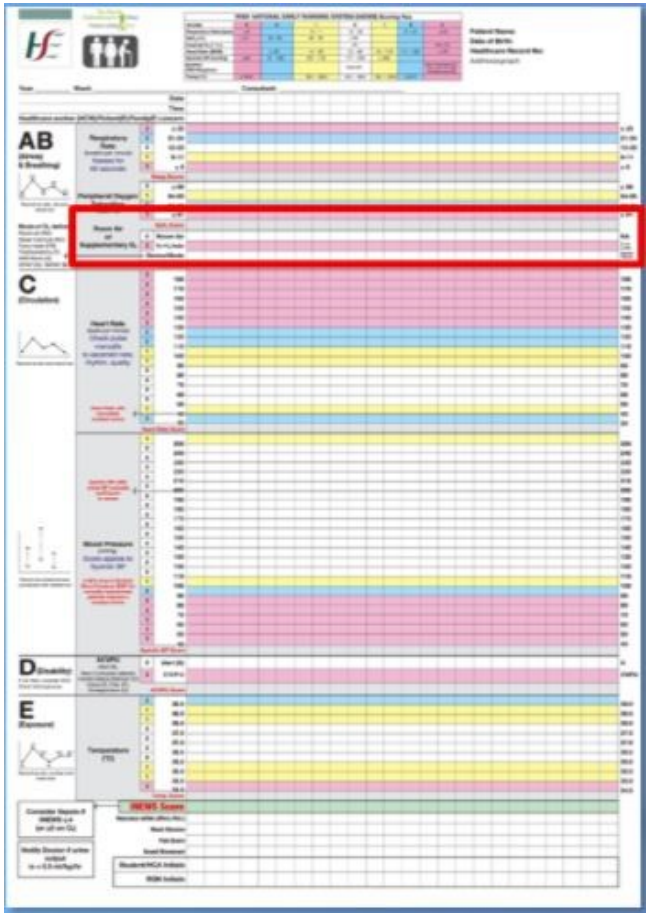
Recording the SpO_2

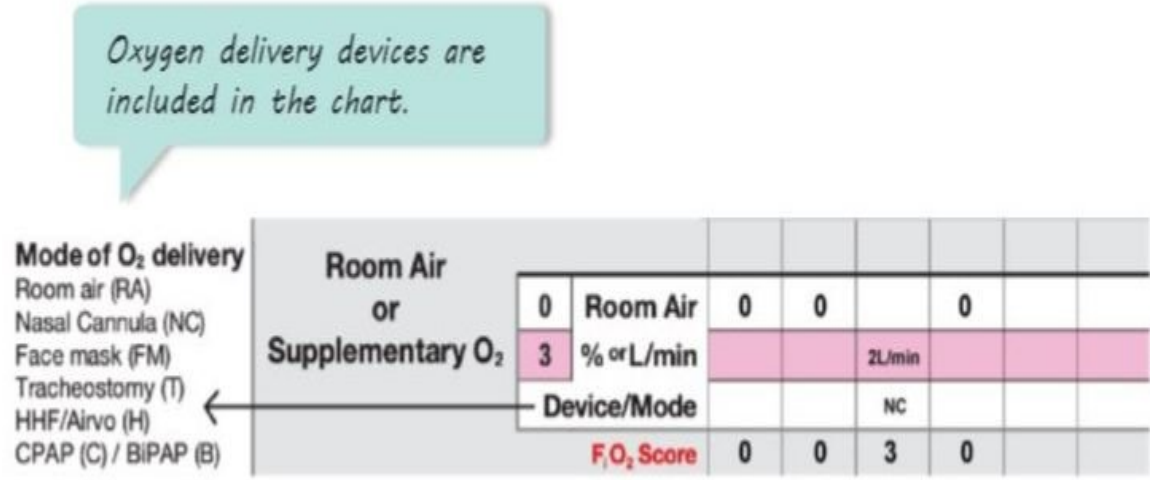


- INEWS parameters identify normal SpO_2 as ≥96%
- Some patients with confirmed diagnosis of chronic respiratory conditions may have lower baseline SpO_2 levels and a specific plan of care may be required

Room Air/Supplemental O_2

Room air/Supplemental O_2 is recorded here.





- All deteriorating patients should receive supplemental oxygen
- INEWS assigns a score of '3' to 'any O_2'
- The mode of O_2 delivery is documented
- When O_2 is prescribed the target SpO_2 should also be prescribed on the drug chart.

Measuring the heart rate

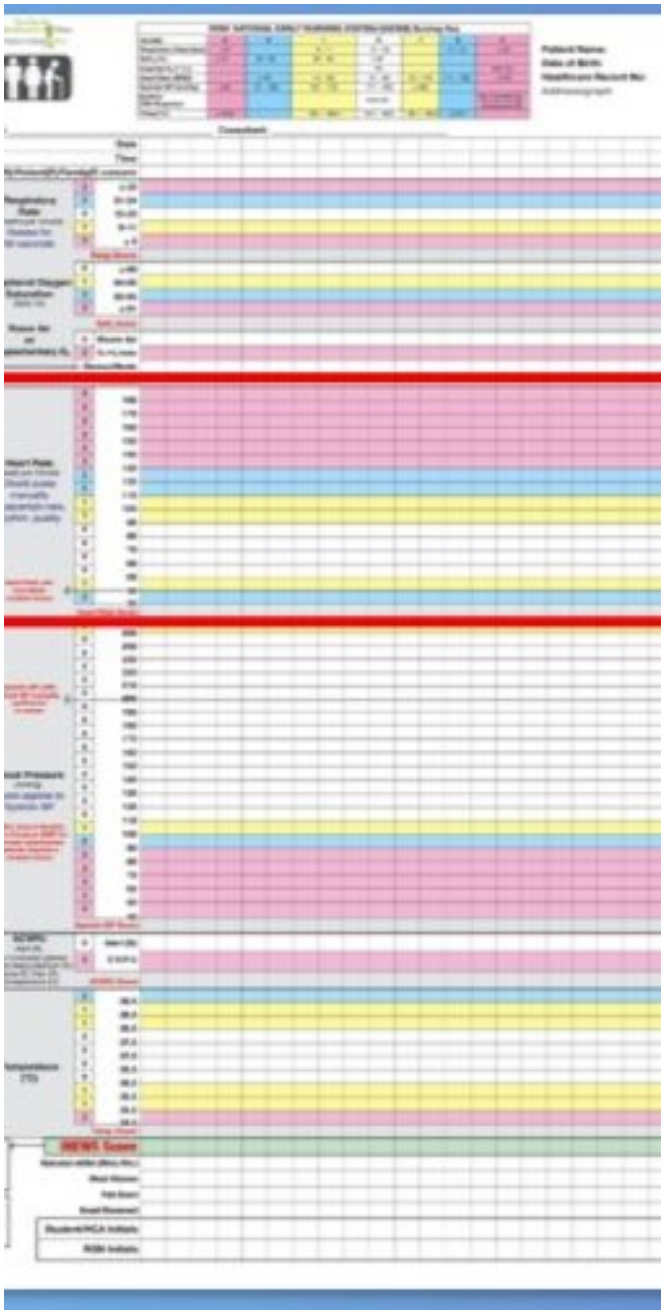
Count for 60 seconds.

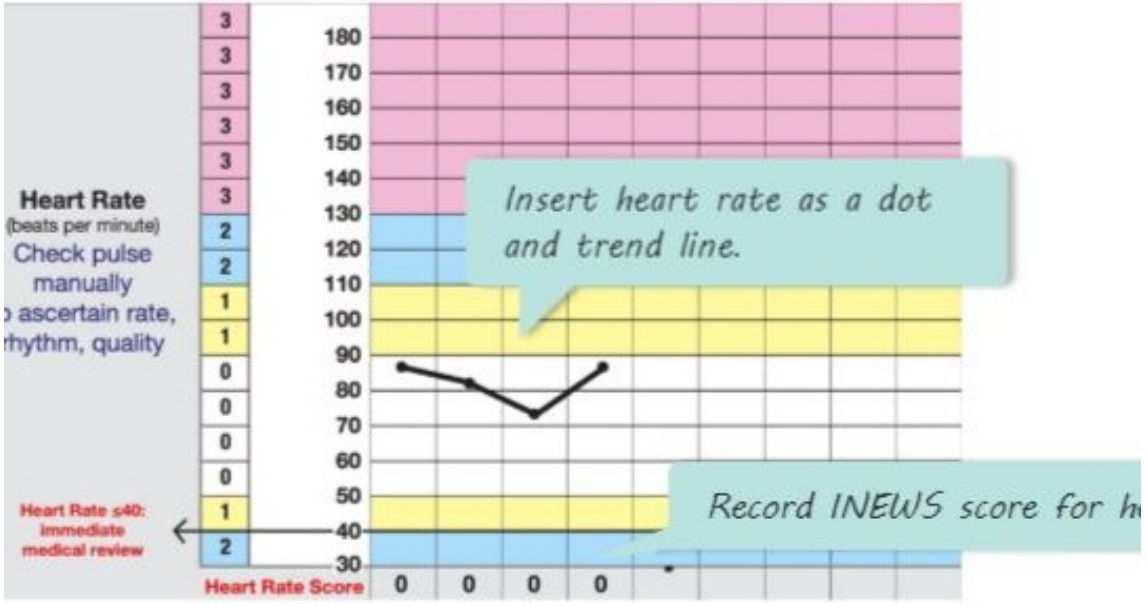
Consider factors such as:

- Rhythm
- Volume
- Pulse quality (irregular, bounding or weak)
- Skin condition (dry, sweaty or clammy)

Measuring the heart rate

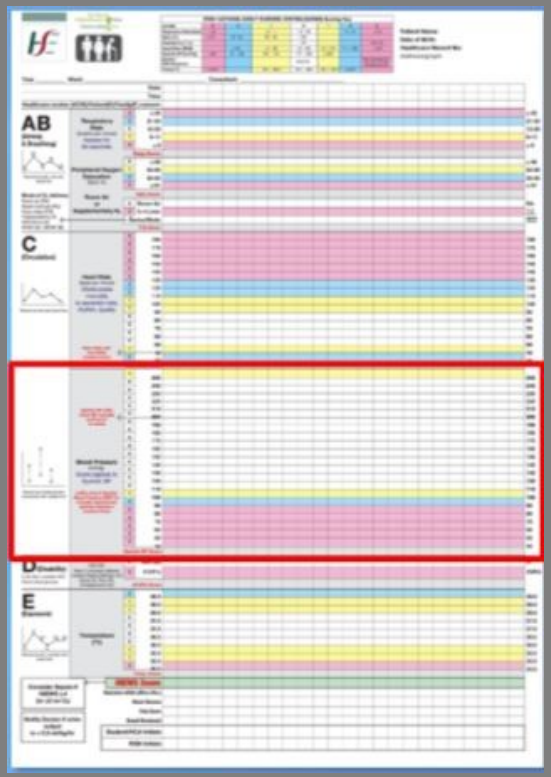
- Bradycardia of ≤40 requires immediate medical review and more frequent monitoring
- Patients being monitored electronically should have their HR checked manually on a regular basis to determine amplitude and volume (as well as rate and rhythm)





Heart rate

Heart rate is recorded here

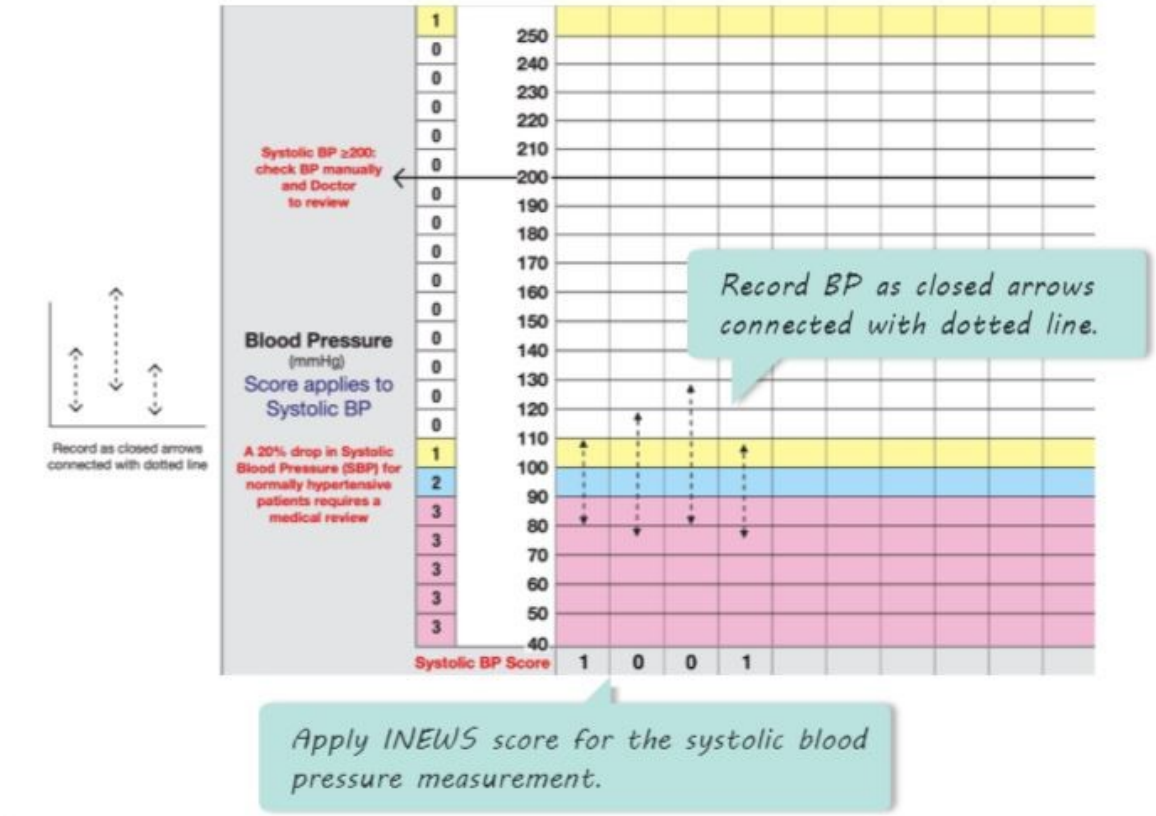


Blood Pressure

- **BP is recorded here**
  - Establish baseline and identify trends over time
  - A normally hypertensive patient may be relatively hypotensive even if their SBP is within normal INEWS parameters
  - If systolic BP is ≥ 200 mmHg, urgent medical review is needed

Blood Pressure

- Patients having BP measured electronically should have BP checked manually on a regular basis
- Refer to primary physician for guidance on response to lying and standing BP recordings
- Following two failed attempts at electronic BP measurement, a manual BP should be measured
- Ensure correct cuff size



Blood Pressure

Disability (Neurological response)

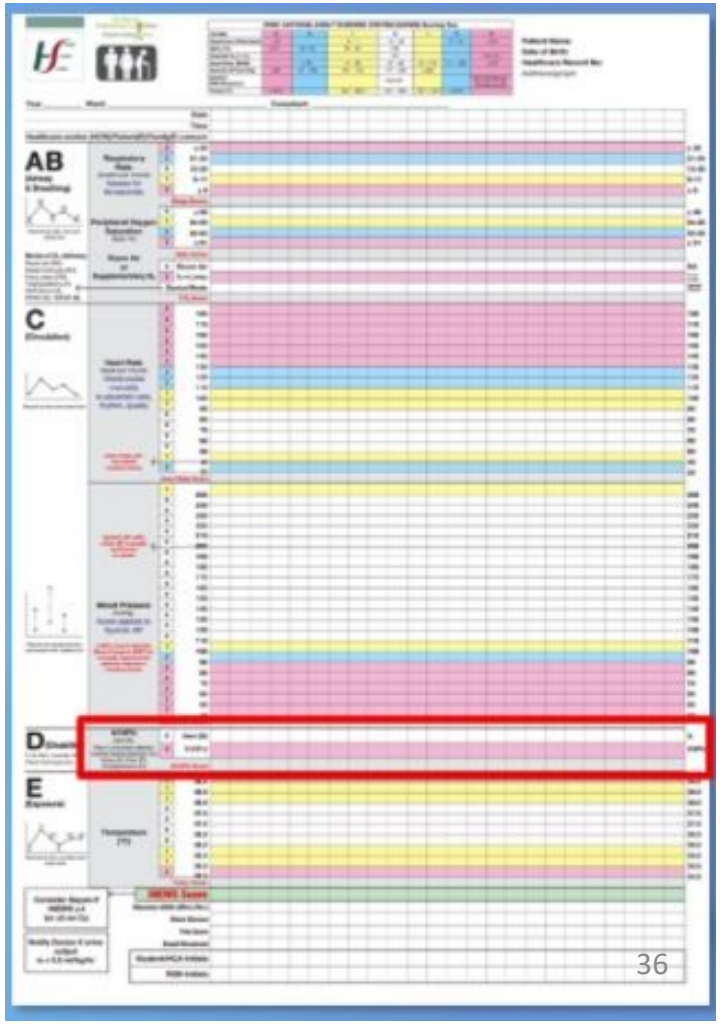
New in INEWS V2

ACVPU (C = new confusion)

Neurological response is measured here.

- ‘New’ confusion, altered mental status or delirium is a common finding in acute illness
- Hypoxia can cause confusion or depressed level of consciousness
- Check blood glucose
- Think Sepsis

Use ACVPU scale to assess neurological response. If ACVPU scores 3 complete the Glasgow Coma Scale



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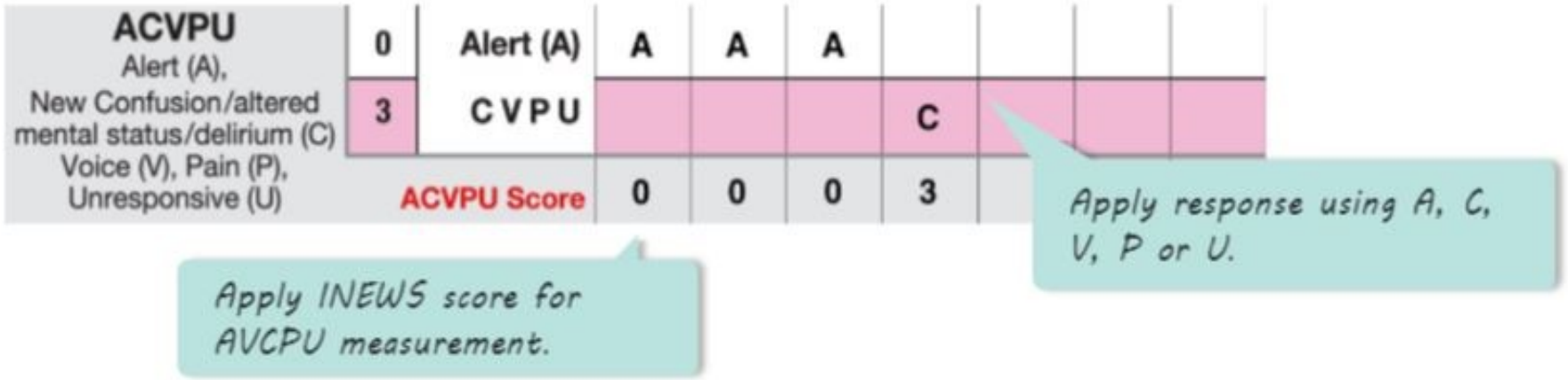
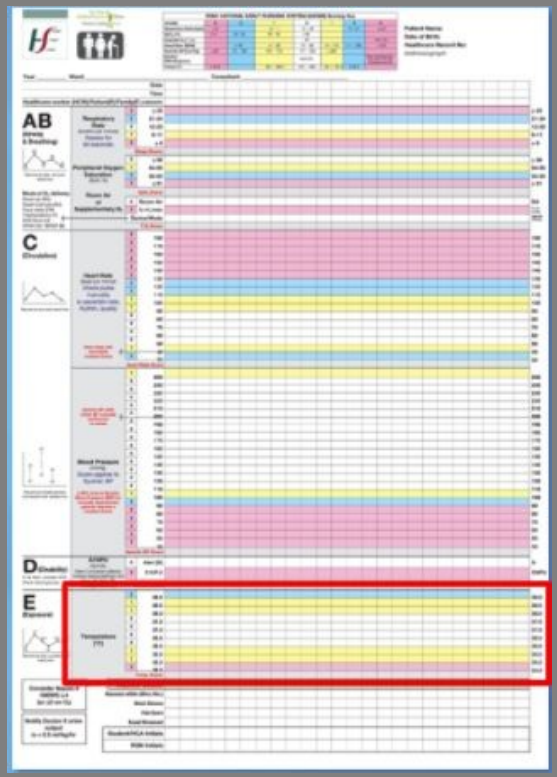


Notes about neurological response:

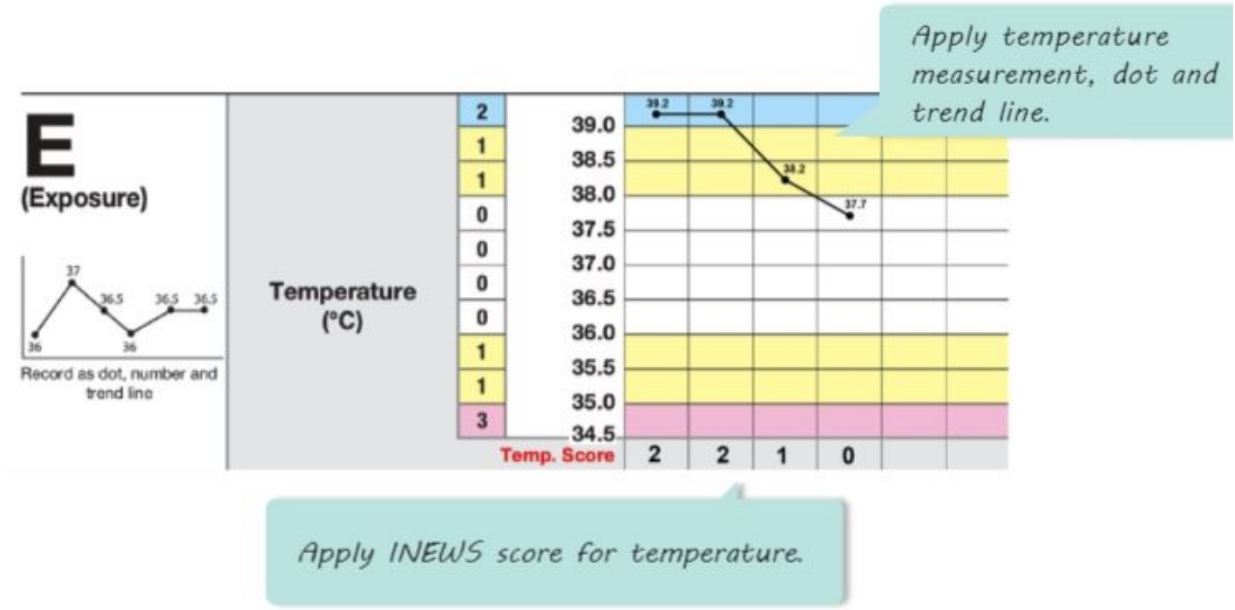
- **A (Alert):** Patient is alert and oriented to person, place, time and event.
- **C**: New confusion or altered mental status or delirium has been identified as an early sign of deterioration and is thus now included as 'C' in ACVPU. Consult family to establish the patient's baseline and assume the patient has new confusion until proven otherwise. A patient may respond to questions coherently, i.e., they may be orientated in person, place and time, but may still be confused or have altered mental status and/or agitation. If a patient's baseline is confirmed as 'confusion' (pre-existing/persistent) this is taken as their normal status and they are scored accordingly.
- **V (Voice)**: The patient responds to verbal stimuli only.
- **P (Pain)**: The patient responds to painful stimuli only with a purposeful or non-purposeful movement.
- **U (Unresponsive)**: The patient does not respond to stimuli.



Temperature

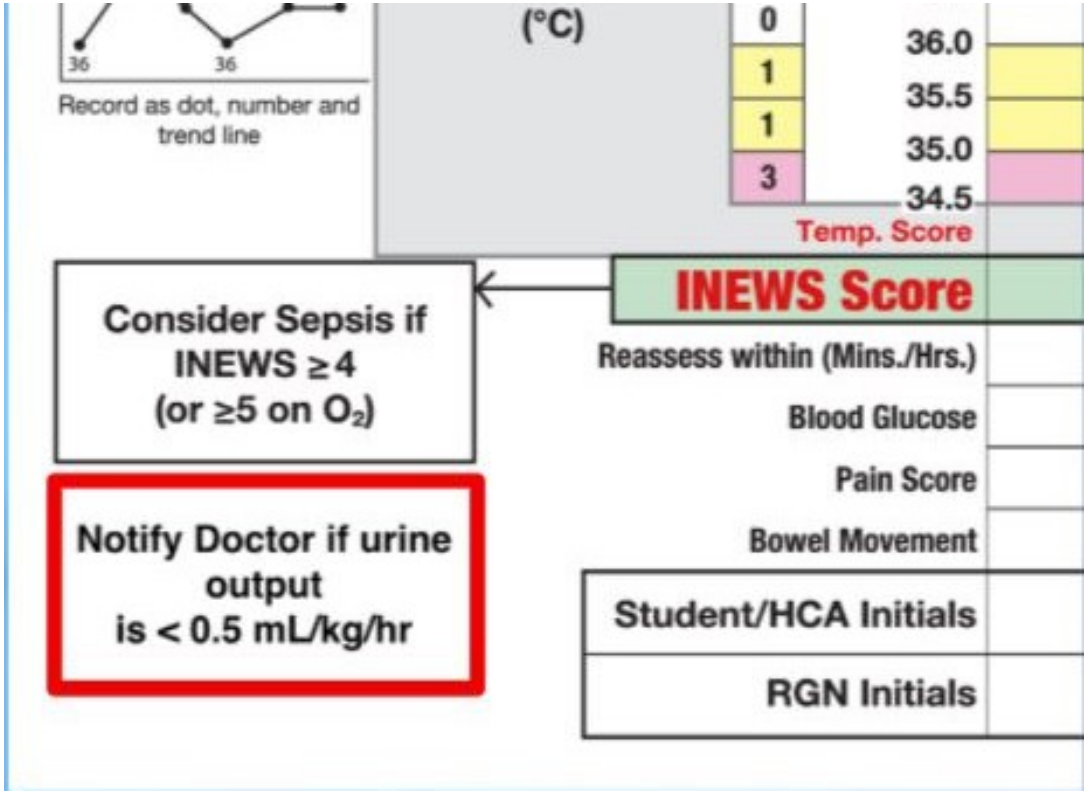
- **Temperature is recorded here.**

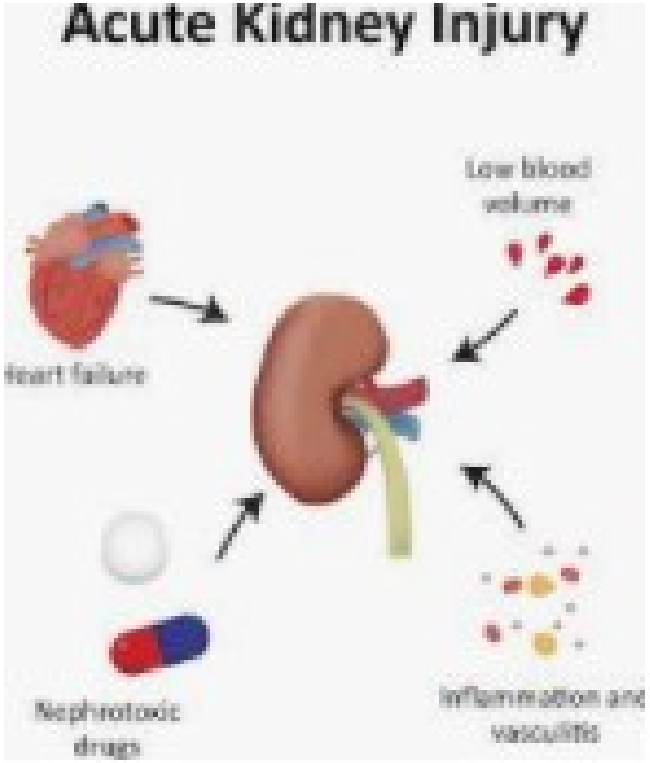
- INEWS temperature parameter ranges are as follows
  - **Normal range** is 36.1°C - 38°C
  - **Hypothermia:** Core temperature of <35°C
  - **Hyperthermia** extends from low grade pyrexia (38.1°C) to hyperpyrexia (≥40°C)



Temperatures should be recorded at the appropriate site (e.g tympanic, axillary etc) according to your local hospital/acute setting guidelines. Ideally the same site should be used to allow for comparison.

Temperature





Urine Output

- Small window of opportunity to recognise Acute Kidney Injury (AKI) to prevent acute renal failure
- Monitor fluid balance accurately

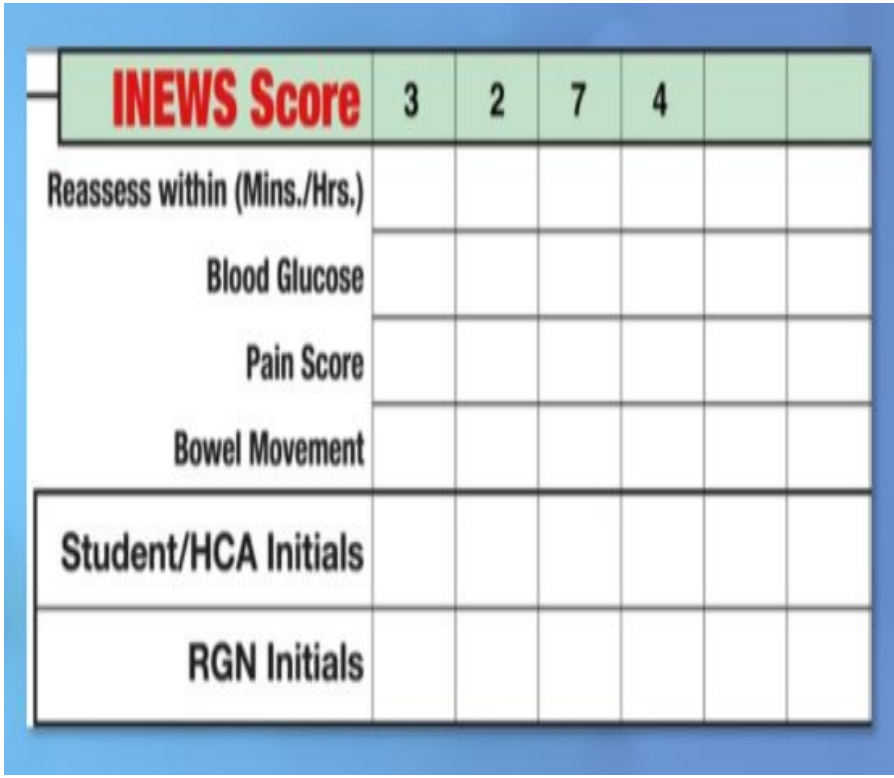
Reassess within (Mins/Hrs)

Frequency of patient monitoring is determined by:

- Patient's clinical condition
- Clinical judgement
- INEWS score

Document:

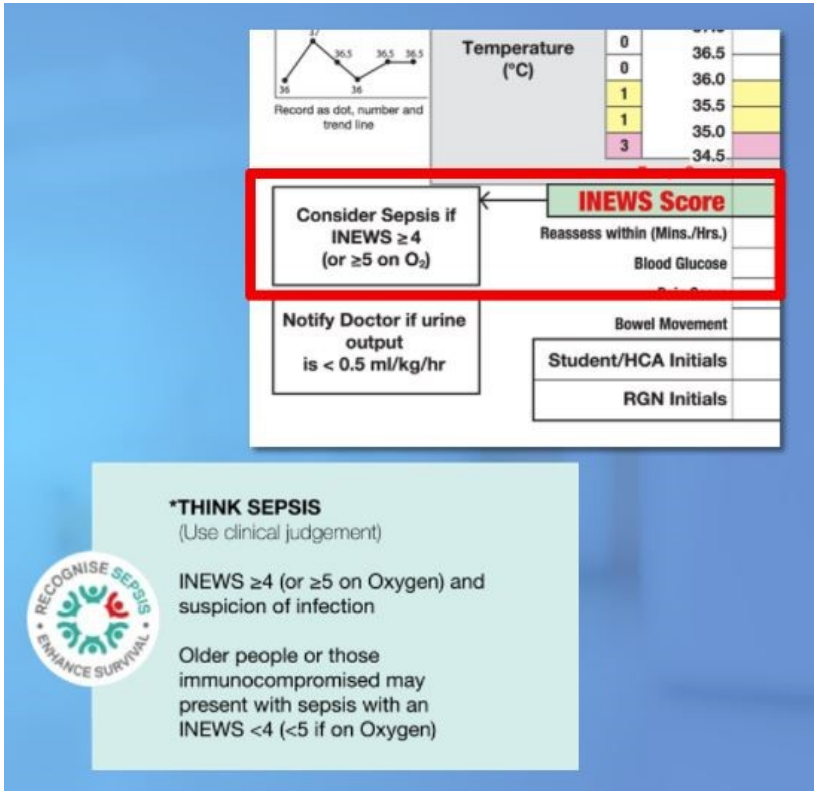
- When the next patient assessment is due



INEWS Score	3	2	7	4		
Reassess within (Mins./Hrs.)						
Blood Glucose						
Pain Score						
Bowel Movement						
Student/HCA Initials						
RGN Initials						

Knowledge check

- **Which of the following statements are true?**
- a. Normal respiratory rate in adults as per INEWS is 12-20 breaths per minute
- b. Normal SpO_2 is ≥96%
- c. For FiO_2 if a patient is on any inspired oxygen, a score of 1 is inserted
- d. When measuring heart rate, count for 30 seconds
- e. If systolic BP is ≥ 200 mmHg, an urgent medical review is required
- f. Normal temperature range is 36.1°C - 38°C



When to think Sepsis

- **Think sepsis if there is an INEWS score ≥4 (or ≥5 if on O_2) and a suspicion of infection**
- Use clinical judgement, particularly for older patients or immunocompromised patients as they can have sepsis despite an INEWS of <4 (or < 5 if on O_2)

Summary

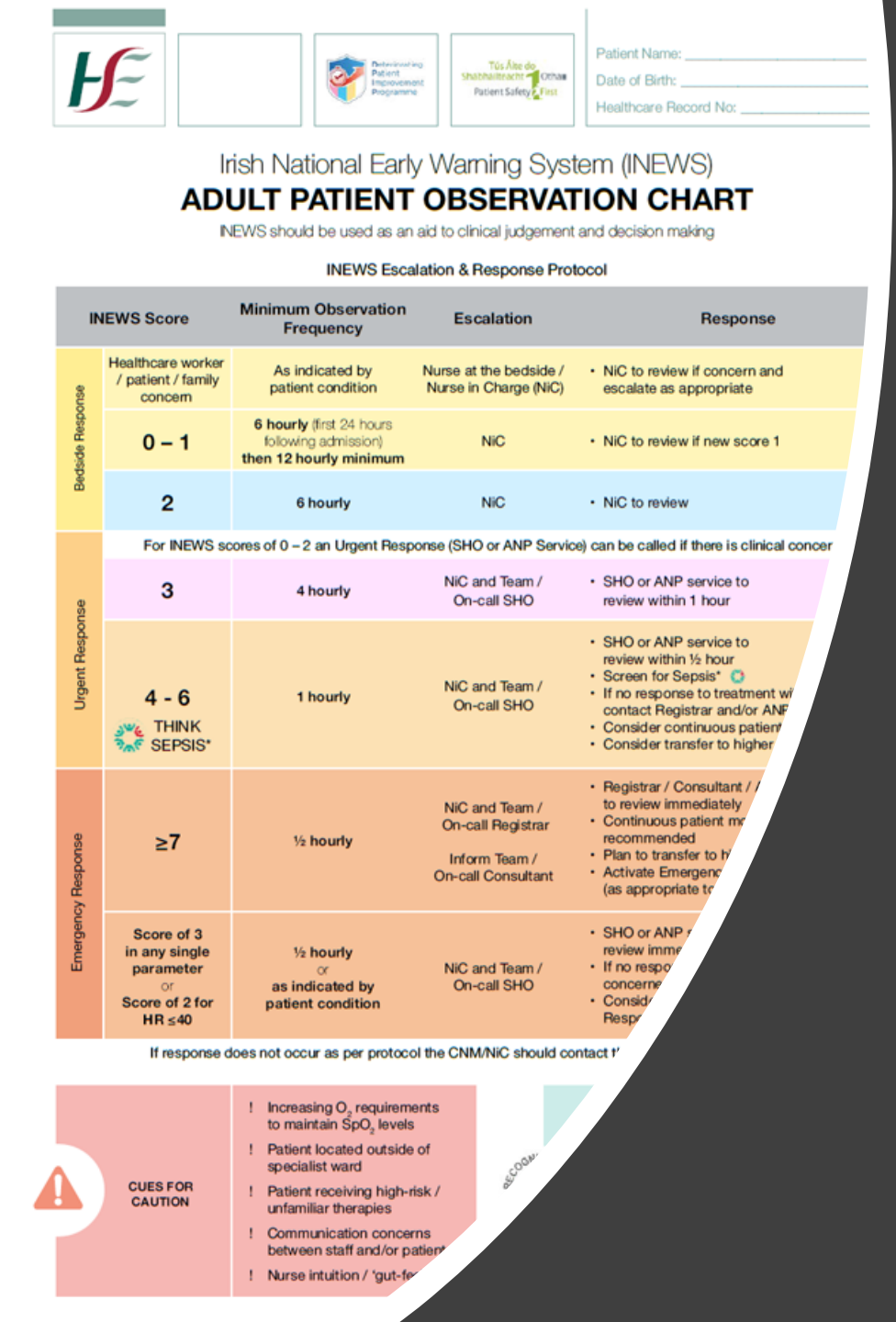
Healthcare worker/patient/family/carer concern is an important indicator of patient deterioration

Early indicators of deterioration are changes in respiratory rate and new confusion/altered mental status/delirium

An increasing requirement for supplemental oxygen to maintain target SpO_2 levels is a clear sign of deterioration and requires immediate medical review

There is a small window of opportunity to recognise Acute Kidney Injury (AKI) to prevent acute renal failure; monitor urine output accurately

Accurate measurement and calculation of the INEWS score are critical to improving patient outcomes



Patient Name: _____
Date of Birth: _____
Healthcare Record No: _____

Irish National Early Warning System (INEWS)

ADULT PATIENT OBSERVATION CHART

INEWS should be used as an aid to clinical judgement and decision making

INEWS Escalation & Response Protocol

	INEWS Score	Minimum Observation Frequency	Escalation	Response
Bedside Response	Healthcare worker / patient / family concern	As indicated by patient condition	Nurse at the bedside / Nurse in Charge (NiC)	• NiC to review if concern and escalate as appropriate
	0 – 1	**6 hourly** (first 24 hours following admission) **then 12 hourly minimum**	NiC	• NiC to review if new score 1
	2	**6 hourly**	NiC	• NiC to review
Urgent Response	For INEWS scores of 0 – 2 an Urgent Response (SHO or ANP Service) can be called if there is clinical concer			
	3	**4 hourly**	NiC and Team / On-call SHO	• SHO or ANP service to review within 1 hour
	4 - 6 THINK SEPSIS*	**1 hourly**	NiC and Team / On-call SHO	• SHO or ANP service to review within ½ hour • Screen for Sepsis* • If no response to treatment wi contact Registrar and/or ANP • Consider continuous patien • Consider transfer to higher
Emergency Response	**≥7**	**½ hourly**	NiC and Team / On-call Registrar Inform Team / On-call Consultant	• Registrar / Consultant / to review immediately • Continuous patient mo recommended • Plan to transfer to h • Activate Emergenc (as appropriate to
	Score of 3 in any single parameter or **Score of 2 for HR ≤40**	**½ hourly** or **as indicated by patient condition**	NiC and Team / On-call SHO	• SHO or ANP review imme • If no respo concerne • Consid Resp

If response does not occur as per protocol the CNM/NiC should contact t

CUES FOR CAUTION	! Increasing O_2 requirements to maintain SpO_2 levels ! Patient located outside of specialist ward ! Patient receiving high-risk / unfamiliar therapies ! Communication concerns between staff and/or patien ! Nurse intuition / 'gut-fe

INEWS Escalation and Response

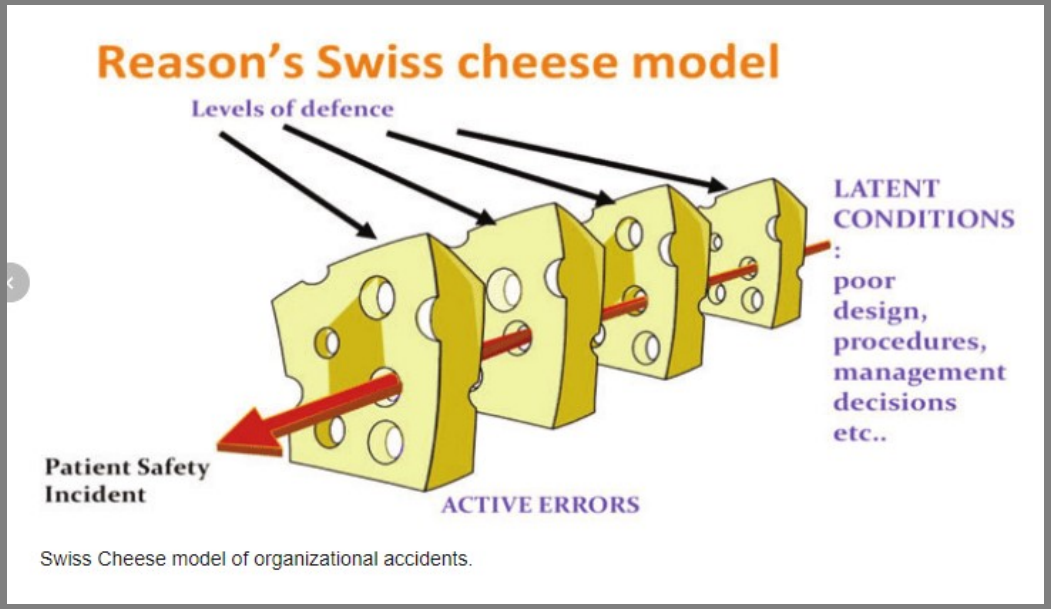
INEWS Escalation & Response Protocol

	INEWS Score	Minimum Observation Frequency	Escalation	Response
Bedside Response	Healthcare worker / patient / family concern	As indicated by patient condition	Nurse at the bedside / Nurse in Charge (NiC)	• NiC to review if concern and escalate as appropriate
	0 – 1	**6 hourly** (first 24 hours following admission) **then 12 hourly minimum**	NiC	• NiC to review if new score 1
	2	**6 hourly**	NiC	• NiC to review
Urgent Response	For INEWS scores of 0 – 2 an Urgent Response (SHO or ANP Service) can be called if there is clinical concern			
	3	**4 hourly**	NiC and Team / On-call SHO	• SHO or ANP service to review within 1 hour
	4 - 6 THINK SEPSIS*	**1 hourly**	NiC and Team / On-call SHO	• SHO or ANP service to review within ½ hour • Screen for Sepsis* • If no response to treatment within 1 hour, contact Registrar and/or ANP service • Consider continuous patient monitoring • Consider transfer to higher level of care
Emergency Response	**≥7**	**½ hourly**	NiC and Team / On-call Registrar Inform Team / On-call Consultant	• Registrar / Consultant / ANP service to review immediately • Continuous patient monitoring recommended • Plan to transfer to higher level of care • Activate Emergency Response System (as appropriate to hospital model)
	Score of 3 in any single parameter or **Score of 2 for HR ≤40**	**½ hourly** or **as indicated by patient condition**	NiC and Team / On-call SHO	• SHO or ANP service to review immediately • If no response to treatment or if still concerned, contact Registrar/Consultant • Consider activating Emergency Response System

If response does not occur as per protocol the CNM/NiC should contact the Registrar or Consultant

Deteriorating Patient Improvement Programme

Closed Loop Governance



Swiss Cheese model of organizational accidents.

- **Bedside -**
  - Post-escalation/awaiting response team: maintain monitoring and surveillance of patient
  - Post-response: re-evaluate interventions to determine effectiveness
  - Avoid 'cycle of clinical futility' – escalate to more senior clinician if no or limited response to intervention(s)
- **Organisational -**
  - Consultant clinical champion to provide clinical leadership
  - Deteriorating Patient Committee reporting to Hospital Executive Management Team
  - Agree schedule of audit
  - Consider outcomes to be measured e.g. transfer to HLOC, cardiopulmonary arrest
  - Agree education and training schedule

Cycle of Clinical Futility

- A ***'cycle of clinical futility'*** is when a patient is deteriorating, and they are reviewed on a number of occasions but despite the patient not responding to interventions they are not escalated for senior medical review i.e. a lot of activity with no improvement - and even dis-improvement - in patient condition
- Hierarchical culture in hospitals can lead to reluctance of junior staff to escalate upwards to senior colleagues
- INEWS escalation and response protocol prompts escalation to Registrar or Consultant if patient does not respond to initial treatment

New in INEWS V2

Modified Escalation and Response Protocol

Recommendation 7: ***A patient's INEWS score or the INEWS physiological parameter ranges must not be altered.***

However, some patients' lived baseline observations will fall outside INEWS normal parameter ranges. To respond to these individuals' care needs INEWS V2 introduces the Modified Escalation and Response Protocol for use by a Consultant or Registrar once a patient has been admitted for 24 hours or longer ie has established a baseline observations trend.

New in INEWS V2

Modified INEWS Escalation and Response Protocol – minimum content

- Rationale for modification of escalation and response
- Timeframe for review of patient and modified response protocol (minimum 24 hourly review)
- Information about further action(s) and/or escalation.

(Note: For the majority of patients the standard Escalation and Response Protocol will be appropriate)

Modified INEWS Escalation and Response Protocol (to be completed by Consultant or Registrar only)
Not for use within first 24 hours of admission

	Date Year: 2020	Time (use 24hr clock)	Rationale and Instructions/Interventions	Next medical review	Doctor (Signature and MCRN)
Start	05 / 03	1800	Imp: Chest infection, admitted > 24 hours ago Stable with RR 20, SpO2 96%, O2 2L/min via nasal cannulae (INEWS score 3) Escalate if change in RR or increased O2 requirement to maintain SpO2 treatment target of ≥ 96%*	First thing tomorrow morning or earlier if patient condition deteriorates (increase in RR or if requires an increase in supplemental O2 to maintain target SpO2) or if clinical concern.	Dr. A, Medical Registrar MCRN 1234567
End	/				
Start	/				
End	06 / 03	1000			
Start	/				
End	/				
Start	06 / 03	1000	Reviewed. Discontinue O2. Seek review by Medical Registrar or Consultant if change in RR or if O2 required again.	24 hours or sooner if concern	Dr. A, Medical Registrar MCRN 1234567
End	07 / 03	1000			
Start	/				
End	/				

**Text within sections above is provided as example only - please write over the watermark*

Example of a Modified Escalation and Response Protocol

Modified INEWS Escalation and Response Protocol (to be completed by Consultant or Registrar only)
Not for use within first 24 hours of admission

	Date Year: 2020	Time (use 24hr clock)	Rationale and Instructions/Interventions	Next medical review	Doctor (Signature and MCRN)
Start	05 / 03	1800	Imp: Chest infection, admitted > 24 hours ago Stable with RR 20, SpO2 96%, O2 2L/min via nasal cannulae (INEWS score 3) Escalate if change in RR or increased O2 requirement to maintain SpO2 treatment target of ≥ 96%*	First thing tomorrow morning or earlier if patient condition deteriorates (increase in RR or if requires an increase in supplemental O2 to maintain target SpO2) or if clinical concern.	Dr. A, Medical Registrar MCRN 1234567
End	/				
Start	/				
End	06 / 03	1000			
Start	/				
End	/				
Start	06 / 03	1000	Reviewed. Discontinue O2. Seek review by Medical Registrar or Consultant if change in RR or if O2 required again.	24 hours or sooner if concern	Dr. A, Medical Registrar MCRN 1234567
End	07 / 03	1000			
Start	/				
End	/				

*Text within sections above is provided as example only - please write over the watermark

New in INEWS V2

Deferred escalation by an RGN

An RGN using their clinical judgement and working within their scope of professional practice may decide against immediate escalation…when they believe that immediate simple measures are likely to reduce the INEWS score over a short period of observation within or up to a maximum period of 30 minutes (Recommendation 11).

Deferred escalation should be followed by:

- Reassessment ≤30 minutes, escalating if no improvement
- Documentation of decision to defer escalation on the INEWS chart

Deferred Escalation (to be completed by Registered General Nurse (RGN))

Date/Time (use 24hr clock)	Rationale and Interventions	Review at 30 minutes	Nurse (Signature and NMBI PIN)
25 / 05 / 20 @ 0400	Imp: Decrease in SpO2 to 94% on 2L/min O2 via n/prongs, patient lying flat, stated they feel okay. Intervention: patient repositioned and n/prongs adjusted. Repeat observations and review decision at 30 minutes. NIC informed.	0430 hours: SpO2 back to 96% on 2 L/min O2, no need for escalation.	Nurse Brown (PIN 12345)
/ / @			
/ / @			
/ / @			

Text within sections above is provided as example only - please write over the watermark

ISBAR Communication Tool → **I**dentify **S**ituation **B**ackground **A**ssessment **R**ecommendation

Modified Escalation and Response Protocol

Which of these statements in relation to the modified INEWS Escalation and Response protocol are correct?

- The rationale for modification of the INEWS Escalation and Response Protocol must be documented.
- Information about further action(s) and /or escalation must be detailed.
- The fact that the patient is on a modified protocol should be included in ward clinical handovers and safety huddles.
- There is no need to include a timeframe for review of the patient as the Modified INEWS Escalation and Response Protocol will be reviewed in 24 hours.
- Nurse Slattery should use the information contained in the modified protocol to guide his nursing care and documentation.
- While this modified INEWS Escalation & Response Protocol is still in place, there is no need to escalate the patient.

Summary

- INEWS is used to aid clinical judgement and clinical decision-making. If worried about a patient, escalate care regardless of the INEWS score
- When escalating care, use the ISBAR tool.
- Adhere to the INEWS Escalation & Response Protocol
- A Registered General Nurse may defer escalation for a short period if immediate simple measures are likely to resolve patient symptoms
- A Consultant or Registrar may decide to document a modified INEWS Escalation & Response Protocol

Summary

INEWS as a system

- encompasses the anticipation, recognition, escalation, response and evaluation of the deteriorating patient.

INEWS consists of:

- Clinical judgement (anticipation, recognition and assessment)
- A track and trigger tool (the revised INEWS patient observation chart)(recognition and assessment)
- An escalation and response protocol (escalation of care for nursing or medical review and structured appropriate clinical response mechanism)
- Closed loop governance (evaluation of patient and process)

Extend My Learning

Useful resources and additional reading to help you apply what you have learned to your practice

NCEC NCG No. 1 Irish National Early Warning System (INEWS) 2020 available at :
https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/?referrer=/national-patient-safety-office/ncec/national-clinical-guidelines/#national-early-warning-score-news

NCEC NCG No. 4 Irish Maternity Early Warning System (IMEWS) V2 available at:
https://www.gov.ie/en/collection/517f60-irish-maternity-early-warning-system-imews-version-2/

NCEC NCG No. 6 Sepsis Management 2020 available at:
https://www.gov.ie/en/collection/c9fa9a-national-clinical-guidelines/?referrer=/national-patient-safety-office/ncec/national-clinical-guidelines/#sepsis-management

NCEC NCG No. 11 Communication (Clinical Handover) in Acute and Children's Hospital Services available at:
https://www.gov.ie/en/collection/006e63-clinical-handover-in-acute-and-childrens-hospital-services/

NCEC NCG No. 12 Paediatric Early Warning System (PEWS) available at:
https://www.gov.ie/en/collection/f14e5c-paediatric-early-warning-system-pews/

NCEC NCG No. 18 Emergency Medicine Early Warning System (EMEWS) available at:
https://www.gov.ie/en/collection/bd79b1-emergency-medicine-early-warning-system-emews/

Additional reading

INEWS Systematic review of the literature (2019) HRB- CICER
https://assets.gov.ie/87924/6c2bcd02-9abc-4a29-b0dc-033423a36e81.pdf

Nurse worry/concern

- Douw, G., van Zanten, A.R., van der Hoeven, J.G. and Schoonhoven, L., 2016. Nurses worry as predictor of deteriorating surgical ward patients: a prospective cohort study of the Dutch-Early-Nurse-Worry-Indicator-Score. International journal of nursing studies, 59, pp.134-140.
- Romero-Brufau, S., Gaines, K., Nicolas, C.T., Johnson, M.G., Hickman, J. and Huddleston, J.M., 2019. The fifth vital sign? Nurse worry predicts inpatient deterioration within 24 hours. JAMIA Open.

Additional reading

Quality Improvement & Patient Safety

- Brady, P.W., Muething, S., Kotagal, U., Ashby, M., Gallagher, R., Hall, D., Goodfriend, M., White, C., Bracke, T.M., DeCastro, V. and Geiser, M., 2013. Improving situation awareness to reduce unrecognized clinical deterioration and serious safety events. Pediatrics, 131(1), pp.e298-e308.
- Fitzsimons, J. and Pentony, M., 2019. Paediatric Early Warning Systems in 2019: What We Know and What We've Yet to Learn. Current Treatment Options in Pediatrics, 5(4), pp.315-325.

Oxygen administration

- Irish Guidelines on the Administration of Oxygen Therapy in the Acute Clinical Setting in Adults 2017

Situation Awareness

- Team STEPPS: https://www.ahrq.gov/teamstepps/index.html

INEWS Resources

Education & Training Resources include

- INEWS National Clinical Guideline https://www.gov.ie/en/collection/cc5faa-national-early-warning-score-news/
- HRB-CICER systematic review of the literature for INEWS V2 https://assets.gov.ie/87924/6c2bcd02-9abc-4a29-b0dc-033423a36e81.pdf
- INEWS e-learning programme www.hseland.ie (located within the Clinical Skills catalogue)
- The revised INEWS patient observation chart https://www.hse.ie/eng/about/who/cspd/ncps/deteriorating-patient-improvement-programme/inews-patient-observation-chart.pdf
- Guidance on completing the INEWS patient observation chart https://www.hse.ie/eng/about/who/cspd/ncps/deteriorating-patient-improvement-programme/how-to-use-the-inews-patient-observation-chart.pdf
- INEWS/COMPASS User Manual https://www.hse.ie/eng/about/who/cspd/deteriorating-patient-improvement-programme/inews-education-compress-training-manual.pdf
- QI Tools and resources
- Facilitators slide-deck for local use