Place hospital logo here

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

Deteriorating Patient Improvement Programme

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
	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 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

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)

RECOGNISE SEPSIS • ENHANCE SURVIVAL

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)

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:	Time (use 24hr clock)	Rationale and Instructions/Interventions	Next medical review	Doctor (Signature and MCRN)
Start	20/05	0400	Imp: Chronic COPD, admitted > 24 hours ago Stable with RR 22, SpO_2 92%, O_2 2L/min (INEWS score 7) Escalate if change in RR or increased O_2 requirement to maintain SpO_2 treatment target of 92%*	Maximum 6 hours (10am) or at ward round or sooner if concern	Dr. A Medical Registrar MCRN 1234567
End	20/05	1000			
Start	20/05	1000	Reviewed – continue as above.	24 hours or sooner if concern	Dr. A Medical Registrar MCRN 1234567
End	21/05	1000			
Start	/				
End	/				
Start	/				
End	/				
Start	/				
End	/				

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

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 SpO_2 to 94%, on 2L/min O_2 via n/prongs, patient lying flat, patient states they feel okay. Intervention: patient repositioned and n/prongs adjusted. Repeat observation and review decision at 30 minutes. NIC informed.*	0430 hours: SpO_2 back up to 96% on 2L/min O_2. No need for escalation.	Nurse Brown (PIN 12345)
/ / @			
/ / @			
/ / @			

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

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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 (F_iO_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)			New Confusion (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	

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

Year __________ **Ward:** ______________________________ **Consultant:** ______________________

		Score		Right margin
			Date	
			Time	
			Healthcare worker (HCW)/Patient(P)/Family(F) concern	
AB (Airway & Breathing)	Respiratory Rate (breaths per minute) Assess for 60 seconds	3	≥ 25	≥ 25
		2	21-24	21-24
		0	12-20	12-20
		1	9-11	9-11
		3	≤ 8	≤ 8
Record as rate, dot and trend line			Resp.Score	
	Peripheral Oxygen Saturation (SpO_2 %)	0	≥ 96	≥ 96
		1	94-95	94-95
		2	92-93	92-93
		3	≤ 91	≤ 91
			SpO_2 Score	
Mode of O_2 delivery: Room air (RA), Nasal Cannula (NC), Face mask (FM), Tracheostomy (T), HHF/Airvo (H), CPAP (C) / BiPAP (B)	Room Air or Supplementary O_2	0	Room Air	RA
		3	% or L/min	% or L/min
			Device/Mode	Device /Mode
			F_iO_2 Score	
C (Circulation)	Heart Rate (beats per minute) Check pulse manually to ascertain rate, rhythm, quality	3	180	180
		3	170	170
		3	160	160
		3	150	150
		3	140	140
		3	130	130
		2	120	120
		2	110	110
		1	100	100
		1	90	90
Record as dot and trend line		0	80	80
		0	70	70
		0	60	60
		0	50	50
	Heart Rate ≤40: immediate medical review	1	40	40
		2	30	30
			Heart Rate Score	
	Blood Pressure (mmHg) Score applies to Systolic BP	1	250	250
		0	240	240
		0	230	230
		0	220	220
		0	210	210
	Systolic BP ≥200: check BP manually and Doctor to review	0	200	200
		0	190	190
		0	180	180
		0	170	170
		0	160	160
		0	150	150
		0	140	140
		0	130	130
Record as closed arrows connected with dotted line		0	120	120
	A 20% drop in Systolic Blood Pressure (SBP) for normally hypertensive patients requires a medical review	1	110	110
		2	100	100
		3	90	90
		3	80	80
		3	70	70
		3	60	60
		3	50	50
			40	40
			Systolic BP Score	
D (Disability) If not Alert, consider GCS. Check blood glucose.	ACVPU Alert (A), New Confusion/altered mental status/delirium (C) Voice (V), Pain (P), Unresponsive (U)	0	Alert (A)	A
		3	C V P U	CVPU
			ACVPU Score	
E (Exposure)	Temperature (°C)	2	39.0	39.0
		1	38.5	38.5
		1	38.0	38.0
		0	37.5	37.5
		0	37.0	37.0
Record as dot, number and trend line		0	36.5	36.5
		0	36.0	36.0
		1	35.5	35.5
		1	35.0	35.0
		3	34.5	34.5
			Temp. Score	
Consider Sepsis if INEWS ≥ 4 (or ≥5 on O_2)			**INEWS Score**	
			Reassess within (Mins./Hrs.)	
			Blood Glucose	
			Pain Score	
Notify Doctor if urine output is < 0.5 mL/kg/hr			Bowel Movement	
			Student/HCA Initials	
			RGN Initials	

NEUROLOGICAL OBSERVATIONS

GLASGOW COMA SCALE			Date / Time
	Best Eye Response		
Eyes closed by swelling = C	Open spontaneously	4	
	Open to verbal command	3	
	Open to pain	2	
	No eye opening	1	
	Best Verbal Response		
Endotracheal = ET, Tracheostomy = TT, Dysphasia = D	Orientated	5	
	Confused	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	No verbal response	1	
	Best Motor Response		
Record the best arm response. Paralysed = P	Obeys commands	6	
	Localising pain	5	
	Normal flexion to pain	4	
	Abnormal flexion to pain	3	
	Extension to pain	2	
	No motor response	1	
	TOTAL GCS		

Pupil Scale (mm) 1 2 3 4 5 6 7 8

Pupils	+ Reacting, – No Reaction, S = Sluggish, C = Closed	Right	Size (mm)
			Reaction
		Left	Size (mm)
			Reaction

LIMB MOVEMENT	Record each limb if, there are significant differences. R = Right, L = Left, P=Paralysed, #= Fracture	ARMS	Normal Power
			Mild Weakness
			Severe Weakness
			Spastic Flexion
			Extension
			No Response
		LEGS	Normal power
			Mild Weakness
			Severe Weakness
			Spastic Flexion
			Extension
			No response
			Initials
			Grade
			NMBI Pin

Can be replaced with local Neurological Observation Chart

Numerical Pain Assessment Scale

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Directions: On a scale of 0-10, how would you rate your pain now, if 0 is no pain and 10 is the worst pain imaginable.