1. Purpose

To ensure early identification of clinical deterioration in patients and timely escalation of care through defined physiological parameters, Early Warning Scores (EWS), and a structured communication mechanism in order to improve patient safety and clinical outcomes.

2. Scope

This policy applies to:

- All in-patients, day care patients, and emergency patients
- All clinical areas including wards, ICU, Emergency Department, and specialty units
- All medical, nursing, and allied healthcare staff

3. Policy Statement

Inodaya Hospital ensures that clinical deterioration is identified early through regular monitoring of defined physiological parameters and use of Early Warning Scores. The parameters are tailored according to specialty and age group. A structured escalation mechanism is in place to ensure prompt communication to appropriate medical personnel and initiation of timely and appropriate clinical interventions, in compliance with NABH COP 5 and COP.6 standards.

4. Definitions

- **Clinical Deterioration:** Worsening of a patient's physiological status that may result in increased morbidity or mortality if not promptly addressed.
- **Early Warning Score (EWS):** A standardized scoring system based on physiological parameters used to identify early signs of patient deterioration.
- **Escalation of Care:** A predefined process of communication and clinical response when deterioration is identified.

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Prepared by:	Verified by:	Approved by:
Dr.Gowthamkrishna	Mrs.G..Lakshmi Lavanya	Dr.G.Rammohan
Medical Director	Accreditation Coordinator	Managing Director

2.1 Roles and Responsibilities

Role	Responsibility
Medical Director	Responsible for the development, review and monitoring of this procedure and practice standards in physical healthcare and for the provision of appropriate training and education to support the Delivery of physical healthcare.
Medical Staff (including Physical Healthcare Practitioners where available)	• Reviewing Early Warning Score charts on a regular basis. • Discuss frequency of recording and requirements to re-set individual patient triggers as part of treatment/care formulation and Multi- Disciplinary Team (MDT) report outs. • Responding to any staff concerns and to see the patient:- If the score remains 1-4afterhours • Immediately if score 5 and above on call medical staff if not onsite must respond promptly and consider

Physiological Parameters for Monitoring

The following parameters are routinely monitored and documented:

- Vital signs (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation)
- Airway patency and breathing effort
- Circulatory status and urine output
- Neurological status (level of consciousness, pupil response)
- Pain and discomfort
- Any concern raised by the patient or family members

The monitoring frequency and parameter thresholds are **customized based on patient age, specialty, and clinical condition** (adult, pediatric, neonatal, obstetric, ICU patients).

Prepared by:	Verified by:	Approved by:
Dr.Gowthamkrishna	**Mrs.G..Lakshmi Lavanya**	**Dr.G.Rammohan**
Medical Director	Accreditation Coordinator	Managing Director

	Advising staff to call emergency services if appropriate. Attend relevant training to this procedure.
Ward Managers /Nurse Supervisors	Ensuring that staff has appropriate training and that the National Early Warning Score process is adhered to and that the National Early Warning Score is discussed regularly at report outs/ward rounds. Attend relevant training to this procedure.
Registered Nurses	• Ensure the appropriate completion of the Early Warning Score as per this procedure. • Follow the procedure for escalating high scores • Attend relevant training to this procedure.

1. **Procedure**

Physiologicalobservation	Howtomeasure	Howtorecord
RespirationRate	Countrespirationsfor1minute.Trynottolet patientknowyouarecountingasthismayaff ectrate.	Enterratein numbers.
OxygenSaturations(Sats /SpO_2)	Usingpulseoximeter.	Enterpercentage Enter tick forpatienton O_2
Temperature	Using digital equipment: tympanicthermometerornon-contactinfrared digitalthermometer.	Enter actualfigure s

SystolicBloodPressure(BP)	Usingdigitalormanualequipment(theNEWSiscalculatedusingthesystolicreading-thetop number).	Enter actualfigures
HeartRate(Pulse)	Heart rate and rhythm is recorded manually bycounting the beats felt at the wrist for oneminute. Although a digital BP and Sats monitorwill record a heart rate, manual recording isthepreferredstandard.	Enter actualfigures. Indicateregularrate (r)and irregularwith(i)

Level of Consciousness(ACVPU = Alert, NewConfusion,Voice,Pain, Unresponsive)	The patient is alert. The patient displays newconfusionor agitation. **V**- The patient responds to verbal stimulation.**P**- The patient responds to painful stimulation(squeezepartofthetrapeziusmuscle inthe patient'sshoulder). **U**-Thepatientiscompletelyunresponsive.	Tick appropriatebox

EARLYWARNINGSCORES –ADULT

Physiological Parameters	3	2	1	0	1	2	3
Respiratory Rate(permin)	≤8		9-11	12-20		21-24	≥25
SpO2 ScaleSaturatio	≤91	92-93	94-95	≥96			

Prepared by:	Verified by:	Approved by:
Dr.Gowthamkrishna	**Mrs.G..Lakshmi Lavanya**	**Dr.G.Rammohan**
Medical Director	Accreditation Coordinator	Managing Director

n1(%)							
SpO2 ScaleSaturation2(%)	≤83	84-85	86-87	88-92 ≥93 onair	93-94 onOxygen	95-96on Oxygen	≥97 onoxygen
Airoroxygen?		Oxygen		Air			

Temperature(°C)	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	
Systolic BP(mmHg)	≤90	91-100	101-110	111-219			≥220
Heart Rate/Pulse(permin)	≤40		41-50	51-90	91-110	111-130	≥131
Level ofConsciousness (Responseto)				A			CVPU

(**A:**ThepatientisAlert

C:Thepatientdisplaysneworincreased**Confusion** /Newdisorientationornewagitation.

V:The patient response to **Verbal Stimulation** only **P:**

Prepared by:	Verified by: G. Lakshmi Lavanya	Approved by:
Dr.Gowthamkrishna	**Mrs.G..Lakshmi Lavanya**	**Dr.G.Rammohan**
Medical Director	Accreditation Coordinator	Managing Director

The patient response to **Painful al Stimulation** only

EWScore	Frequency ofmonitoring	Clinicalresponse
0	Minimum12hourly	ContinueroutineEWSmonitoring
Total1-4	Minimum4–6hourly	• Inform registered nurse, who must assessthepatient. • Registerednursedecideswhetherincreased frequency of monitoring and/or escalation ofcareisrequired
		ent of acutely ill patients and in recognizingwhentheescalationofcareto a criticalcareteam isappropriate
Aggregatescore5–6	Medium	Key threshold for urgent response by a clinician orteam with competence in the assessment andtreatmentof acutelyillpatients andinrecognizingwhen the escalation of care to a critical care teamis appropriate
Aggregatescore7or more	High	Urgent or emergency response team must alsoincludestaff withcriticalcareskills,including airway management Or activation of MET/ RapidResponseTeam

U: The patient is completely **unresponsive**)

3 in Single Parameter	Minimum1hourly	Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 -6Urgentr esponseT hreshold	Minimum1hourly	• Registerednursetoimmediatelyinformthem edicalteam caring forthepatient. • Registered nurse to request urgentassessment by a clinician or team with corecompetencies in the care of acutely illpatients. • Provide clinical care in an environment withmonitoringfacilities.
Total7orMore **Emergencyres ponseThreshol d**	Continuous monitoringof Vital Signs.	• Registerednursetoimmediatelyinformthem edicalteam caring forthepatient /activating the METor Rapid Response teambycalling "9". • Emergency assessment by a team withcritical care competencies, includingpractitioner(s) with advanced airwaymanagementskills. • Consider transfer of care to a level 2 or 3clinical care facility, ie higher-dependencyunit orICU. • Clinical care in an environment withmonitoringfacilities

EARLYWARNINGSCORES –OBSTETRIC

SCORE	0	1	2	3
CONSIOUSLEVEL	Alert	Responds to voice	Response to pain	Unres ponsive
RESPIRATION (Breaths/min)	9-20	21-24	25-29	<8OR>30
PULSE (Beats/min)	60-100	101-110	41-60OR 111 TO129	<40OR>130
SYSTOLICBP (mmofhg)	100-140	141-160	91TO99	<90OR>161
DIASTOLICBP (mmofhg)	70To 90	91TO99	100 TO109	<40OR>110
TEMPERATURE (°C)	36 -37	≤35.5OR ≥37.5	≤35OR ≥38	<34.5OR >39
O_2 SATURATION(%)	>96	94-95	91-94	<90

URINEOUTPUT	Has passed urineinlast4hrs	Has not passed urine last 3 hrs	Has not passed urineinlast4 hrs	Has not passedurine in last 6hrs
URINEPROTEIN	No	+	++	≥+++
AMNIOTICFLUID	Clear/Pale	Red/Mild Green	Dark green	Foulsmelling
FHR	120-160b/min	110-120/160-170	<100->170	<90and>180
UTERUS	firm and well contracted uterus	High fundus, bleed ing continues when massage isstopped	Flaccid and boggy uterus	Atonicuterus
BLEEDING	Minimalbleeding	Moderate bleeding>500 ML.H/O bleedingdisorders, Looksunwell	Large clots and>1000ML	Severeble edingwith >1500ml

3.1 Recording the Early Warning Score.

3.4.1 Documentation:

- **To facilitate standardization of recording, a color coded EWS chart must be completed.**
- New Early Warning Score Chart (Adults) all entries must be dated and time recorded in the24hours format.

3.4.2 Frequency of Monitoring

As a standard the following principles when deciding the frequency of recording EWS, however each patient should be assessed on an individual basis.

- The EWS **must** be completed for all patients on admission to Inpatient Units including ICU's, HDU and wards in order to establish a baseline. All patients will have EWS recorded twice daily until reviewed by the Rapid Response Team / MET team.
- The Rapid Response Team/MET team and/or Primary Consultant/Treating consultant /consultant will agree frequency of monitoring which will form part of an individual intervention plan.
- Increasethefrequencyofmonitoringwhenapatientdisplaysanychangeinphysi calormental health giving cause for concern.
- Increase the frequency of monitoring in accordance with the table on the back of the EWS chart.
- For patients confirmed to have hyper c apnic respiratory failure prior to or during their current hospital admission, and are requiring supplemental oxygen, a prescribed oxygen saturation target range of 88-92% is recommended. In such circumstances the dedicated SpO2 scoring scale (Scale2)on the EWS chart should be used to record and score the oxygen saturation for the EWS.

- ThedecisiontouseScale2shouldbemadebyacompetentclinicaldecisionmakerand should be recorded in the patient's clinical notes.
- In all other circumstances, the regular EWS SpO2(Scale1)should be used.
- For the avoidance of doubt, the SpO2 scale not being used should be clearly crossed out on the chart

3.4.3 Additional Considerations when Monitoring and Interpreting EWS

- Always consider the patient's normal baseline observations and the views of the clinical team to assist your clinical judgment.
- Remember the NEWS is only one way of detecting early deterioration inpatient's physical health. There are other scoring systems such as the Glasgow Coma Scale(GCS)
- EWSshouldbecalculatedevenifallsixphysiologicalobservationscannotbe measured as individual scores can also be an early warning sign of deterioration.
- Patients may refuse to have their physiological observations measured for a variety of reasons. This should be recorded on the EWS chart and further monitoring attempts must be recorded in Physical Health case-note.
- It is important to clearly document and report a recorded high bloodpressuretoamemberofthemedicalteamforfurtherreview(over140/90although this may not trigger a score on the EWS chart). Medical staff and/or Doctors to follow cardiovascular risks (Hypertension and High Cholesterol)Guideline for treatment advice
- **Consider Sepsis (infection) as a cause for deterioration**. Sepsis is a life-threateningconditionthatariseswhenthebody'sresponsetoaninfectioninjures its own tissues and organs. Sepsis affects all age groups and can present in any clinical area therefore staff vigilances critical.

Signs of Sepsis include:

- **S**lurred speech
- **E**xtreme muscle pain
- **P**assing no urine
- **S**evere breathlessness
- **I**"feeIl mightdie"
- **S**kin mottled or discolored
- Assesstemperature,heartrate,respiratoryrate,bloodpressure,levelofconsciousness and oxygen saturation in young people and adults with suspected sepsis and complete the EWS.

- IfEWSis5oraboveTHINKSEPSISandescalateaccordingly

- Examine people with suspected sepsis for mottled or ashen appearance, cyanosis of the skin, lips or tongue, non-blanching rash of the skin, any breach of skin integrity (for example, cuts, burns or skin infections) or other rash indicating potential infection

3.2 Interpretation and Response to EWS

3.5.1 Interpretation of EWS

- Once the physiological observations have been recorded and documented on the appropriate EWS chart, an individual score for each of the six physiological observations is generated which when added together will provide the overall Early Warning Score. The EWS system categories and colour codes the scores as either:-

Low score(Yellow)	Colors represent severity of decline in physical health and should determine urgency of clinical response.
Medium score(Orange)	
High score(Red)	

- A table representing the EWS scoring system can be found on the back page of each of the appropriate EWS chart. If there is any doubt about the score seek additional guidance from a medical or nursing colleague or Quality Department
- A single score of 3 on one of the six physiological observations **must** trigger urgent medical attention.
- Patients receiving supplementary oxygen at the time of monitoring should have 2added to the overall Early Warning Score. Oxygen can be applied in an emergency situation if oxygen saturation is 93% or less. This should be administered using a non-re-breathe mask (with reservoir at 15 liters per minute). In an emergency situation oxygen may be administered under the Protocol for Administration of Oxygen in an Emergency Situation by any member of staff who has undertaken First Response Training. The Ambulance Service must be called when a patient requires emergency oxygen.
- Ifapatientdisplaysnewconfusion,whichincludesdisorientation,agitation,delirium,or any new alteration to mental state at the time of monitoring, a 3 should be added to the overall Early Warning Score

3.5.2 Response to EWS Total

A Early Warning Score total may hit an agreed threshold and trigger a response. There are agreed clinical responses for over all scores (see back of EWS chart).

Should the score trigger a response and if you are concerned, there are3 additionalconsiderationsthatcanbemadeandshouldbedocumentedonParis (see below):

Additional Considerations if NEWS Triggers
Pain assessment(ask the patient)
BM(blood glucose)
Passed urine(ask the patient)

Document response on the EWS chart (escalation plan)

3.5.3 Principles for Using Situation, Background, Assessment, Recommendation and Decision (SBARD) Tool within NEWS Procedure

- When communicating concerns with another member of staff, the SBARD tool should be used as standard and documented in the Physical Health Case note/ Case Sheet.
- The SBARD tool is based on the following principles:
  - This is a nationally recognized tool for rapid, effective communication during urgent situations.
  - The tool has been incorporated onto the back page of each of the EWS charts.
  - Inadequate verbal or written communication is recognized as being the most common root cause of serious clinical errors. Therefore including are cognized communication tool within a EWS chart is critical.

- Using the SBARD tool can help prevent breakdowns in verbal and written communication by building a common language platform for communicating critical events, thereby reducing barriers to communication between healthcare professionals.

3.3 **Recognize and Respond to the Deteriorating Patient: Quick Reference Guide** T he standards for recognizing and responding to the deteriorating patient have been in corporated into a visual quick reference guide to be displayed withinin patient areas (clinic room). This can also be used as a tool when supporting staff with implementing the procedure (Appendix2).

2. Definitions

Term	Definition
Ambulatory	Capable of walking and not bedridden.
Cardio Vascular Disease(CVD)	CVD is a general term that describes a disease of the heart or blood vessels. Blood flow to the heart, brain or body can be reduced as the result of a blood clot (thrombosis), or by a build- up of fatty deposits inside an artery that cause the artery to harden and narrow(atherosclerosis).There are Four main types of CVD: coronary heart disease, stroke, peripheral arterial disease and aortic disease.
Chronic Obstructive Pulmonary Disease(COPD)	COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema. People with COPD have difficulty breathing, primarily due to The narrowing of their airways.
Diabetes	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main typesofdiabetes–type1diabetesandtype2diabetes

Early Warning Score(EWS)	The Early Warning Score is based on a simple scoring system in which a score is allocated to six physiological observations. Each individual observation generates ascore.Whenallsixscoresareaddedtogether,thisprovidesth eoverallNational Early Warning Score which is set to trigger when a patient is acutely unwell or has abnormal physiology.
Glasgow Coma Scale(GCS)	The Glasgow Coma Scale or GCS is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as Subsequent assessment.
Narcoleptic Naive	A person who has never taken anti psychotic medication before.
Parenteral Administration	Taken into the body or administered in a manner other than through the digestive tract, as by intravenous or intra muscular injection.
Physiological Observation	Physiological observations are essential requirements for patient assessment and the recognition of clinical deterioration.
Sepsis	Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis can lead to septic shock , multiple organ failure and death especially if not recognized early and treated promptly.

Situation,Background ,Assessment,Recommendationand Decision (SBARD)communicationtool	Nationally recognized tool for rapid, effectivecommunicationduringurgentsituations.

3. References:

National Institute for Health and Care Excellence (2007) Acutely ill patients in hospital. Recognition and response to acute illness in adults in hospital. London: NICE

NationalInstituteforHealthandCareExcellence(2016)Sepsis:recognition,diagnosisand early detection. London: NICE.

Jackson, L. et al. (2007) *Blood pressure centiles for Great Britain*. National Centre for Biotechnology information

Patient Safety First (2008) The 'How to Guide' for Reducing Harm from Deterioration

Royal College of Physicians (2012) National Early Warning Score (NEWS).Standardizing the assessment of acute-illness severity in the NHS. Report of a Working Party

Royal College of Physicians (2017) National Early Warning Score (NEWS) 2.Standardizing the assessment of acute-illness severity in the NHS. Updated Report of a Working Party: Executive Summary and Recommendations

Prepared by:	Verified by:	Approved by:
Dr.Gowthamkrishna	**Mrs.G..Lakshmi Lavanya**	**Dr.G.Rammohan**
Medical Director	Accreditation Coordinator	Managing Director

RAPIDRESPONSETEAM:/METTeam

All though based on patient's age, physiological parameters and Early Warning Score, RN shall appropriately respond and shall escalate the issue to the CONSULTANT/Physician on duty, we have a separate team for identifying early warning signs of clinical deterioration for initiating prompt intervention during their rounds in wards daily.

Team members constitute.

1. Intensivist on Duty
2. Doctor on duty
3. Nursing superintendent
4. Incharge Nurse
5. Pharmacist

Annexure: 1 – Early Warning Score sheet
Annexure: 2 – EWS Monitoring SheetAnnexure:3-GlasgowComaScaleChartAnnexure:4 - SBAR

Document Revision History

DOCUMENT REVISION HISTORY		
Version	**Date of issue**	**Reason for Revision**
Original version - 1		
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Prepared by:	Verified by:	Approved by:
Dr.Gowthamkrishna	**Mrs.G..Lakshmi Lavanya**	**Dr.G.Rammohan**
Medical Director	Accreditation Coordinator	Managing Director