NHS LOTHIAN

Standard Operating Procedure: EHSCP

Physiological Observations of Patients in the Community Setting

1. Introduction

To standardise the type and frequency of observations to be taken on adult patients in the community setting within their own homes by:

- Staff identifying deteriorating patients early by observation
- Understanding the use of NEWS scoring to highlight changes in patients' condition
- Advising staff when and who to inform of patient deterioration

2. Purpose & Scope

Assist all clinical staff including registered and skilled non-registered nursing staff in community setting to:

- Support the use of the National Early Warning Score (NEWS) to guide clinical decision making
- Reinforce the communication standard of when to seek help using Situation Background Assessment Recommendation-Decision (SBAR-D)

3. Competencies required

This pertains to registered nurses/skilled non-registered practitioners that have been deemed competent in the skills of undertaking and recording clinical observations

Professional Responsibilities

- Staff should have a sound knowledge of the normal range of physical observations. Staff should also be able to recognise and confidently take appropriate action if results are abnormal
- Staff must have completed an appropriate programme of education and be deemed competent in the use of NEWS and SBAR-D. The minimum standard of education is the NEWS e-learning module appropriate to staff role. In addition, face to face training is also available

- Every 2 years staff should undertake the basic life support (BLS) e-learning module on learnPro and attend a practical resuscitation training session at an appropriate level for their role
- Practice must always be in accordance with local policies and procedures
- All staff are accountable for their own practice
- None registered staffs must undertake 2 yearly competencies of recording physiological observations

4. Patients Covered

All patients under district nursing clinical care

5. Baseline Observations

All patients should have two sets of observations including; temperature, pulse, respiration rate, blood pressure, oxygen saturations, and AVPU with total NEWS score to provide baseline measurement.

Baseline observations should be added to Trak/KIS and Vision/EMIS

6. Frequency of Observations

The frequency of observations should be agreed after the patient has had their initial two sets of baseline observations and a rationale documented in the patients records and care plan

7. Early Warning Observation Chart

Physical Observations required include:

- Temperature
- Systolic Blood pressure
- Heart Rate
- Respiratory rate
- Oxygen saturations
- Inspired Oxygen (Percentage of Oxygen given)
- Conscious level (Alert, Verbal, Pain, Unresponsive) *
- Early warning score total

- A conscious level chart (Glasgow Coma Scale) is available on the NEWS chart to be completed when clinically indicated by registered nurses

*Please note unregistered staff can only complete AVPU for conscious level assessment

7.1 All Early Warning Observations charts must be

- Dated
- Timed
- Initial signed

Additional observations that may be clinically relevant include: blood glucose, pain score and urine output. **Please note:** additional observations do not count toward the total NEWs score but do still require further action if outside normal limits

7.2 The early warning observations chart is colour coded to help identify when a clinical parameter is out-with the normal range. A physical observation score of 0-3 is allocated for each parameter

8. Escalation and Seeking Help

If you are in any doubt about what to do, your competency to deal with the situation, or concerned the patient may deteriorate further seek help as soon as possible. A high NEWS score and/or staff concern should prompt escalation. Any concerns about the patient must be relayed to the district nurse and/ or advanced nurse practitioner/GP/OOH

- **A NEWS score of 4 or more** may indicate that a patient is deteriorating and an appropriate response using the escalation procedure required. Physical observation scores should **NOT** replace sound clinical judgement
- **A NEWS score of 7 or more** may indicate that a patient is acutely unwell and requires immediate medical team review. Immediate action and appropriate escalation should take place if there are any concerns regarding a patient's clinical condition

9. Limited Reversibility

Planning should be in place to identify patients with limited reversibility. In situations where we anticipate possible deterioration, agreeing goals of care and referring early to appropriate services or, where death is considered inevitable then have conversations with patients and families about likely progression of disease including planning for end of life care. Management plans should include:

- Key issues
- Anticipated outcomes
- Resuscitation status
- Discussion with the multidisciplinary team
- Discussion with the patient and family which may include; uncertain recovery, medical plan, preferred place of care and concerns and wishes
- Patients with palliative diagnosis may continue to benefit from assessment of physiological observation as part of symptom management

11. Completing the NEWS chart

As with any other scoring or screening tool, it is important to use NEWS as an adjunct to clinical judgment in the recognition of deteriorating patients

- Numerals should be written on the observation chart
- A score should be attributed to each individual parameter
- A total NEWS score should be recorded for each set of observations
- All elements of physiological observations should be completed at each set
- If possible the patient's normal observations should be noted for comparison

12. SBAR – D and Structured Response Tool

When escalating a patient, whether based on NEWS of 4 or more or clinical concern, staff should use the SBAR-D format or the Structured Response Tool (appendix 1). Remember simple early measures can often prevent further deterioration of the patient's condition.

- **S**ituation: Who you are calling about, give patient details. Describe your concern and reason for your call, and include the results of the patient's observations

- **B**ackground: State any relevant events leading up to this event; provide further details on patient status including diagnosis, anticipatory care plans and resuscitation status
- **A**ssessment: State patient's current physical observations, clinical impression/concerns, for example, "I believe the patient may have developed sepsis"
- **R**ecommendations: Be specific, explain what you expect the clinician to do, make suggestions, clarify expectations, and confirm actions to be taken for example attend immediately; attend within one hour...
- **D**ecision: What has been agreed with the clinician you have escalated to

13. Assessing the patient

Vital signs and NEWS scoring will give an indication of the patient's condition. If the patient is deteriorating, a more comprehensive assessment is warranted.

The ABCDE model of assessment is recommended as it gives a rapid, initial assessment of the patient's condition:

- A = Airway
- B = Breathing
- C = Circulation
- D = Disability
- E = Environment

Basic guidance on ABCDE is part of Basic Life Support training

Appendix One: Escalation