Adult observations and use of Early Warning Score (EWS) policy

Describes the requirements for vital sign monitoring and early detection of patient deterioration.

NOTE: Also see eVitals on CWS.

Who is this policy for?

All Southern Cross Healthcare clinical staff (you).

Purpose

The purpose of this policy is to support 'you' to undertake vital sign monitoring, early detection and appropriate and timely management of clinical deterioration of all adult inpatients in a Southern Cross hospital.

- HQSC Te māwhenga tūroro/Patient Deterioration program
- HQSC Maternity early warning score (MEWS) Implementation Guide
- Adult Observation Chart and NZ Early Warning Score Chart (EWS) with Sepsis (2020)

Points of Note

- The EWS system is a tool used to recognise and respond to patient deterioration and does not replace skilled clinical assessment and decision-making.
- Although an EWS score does not need to be calculated in order to increase the frequency of vital sign observations or to escalate concerns, it does provide some objective basis to communicate concerns and support nursing actions.
- The EWS score is calculated for every full set of vital signs, and appropriate escalation must occur for the corresponding score. If the nurse decides not to escalate as per the EWS escalation pathway, they must document their clinical assessment and rationale for this in the patient clinical notes. The frequency of the vital signs may be increased and concerns escalated regardless of the EWS score.
- If you, the patient, family and whānau are concerned about the patient's condition you must inform the medical specialist, even if the EWS score does not require this. This can be supported by a tick in the WORRIED area in evitals card
- All patients must have their vital signs entered into eVitals in CWS. EWS uses only those vital signs directly related to detecting clinical deterioration. Any other patient monitoring required (e.g. for PCA/ PCEA/ spinal surgery/ blood glucose/ neurovascular observations) can be recorded on supplementary charts. There is no expectation of double-charting i.e. recording the same vital sign in two areas.
- If CWS is unavailable e.g. an outage, refer to the CWS emergency guideline and paper Adult Observation form (above)

Note: For non-CWS hospitals these principles still apply.

Guidelines

Adult Observation Vital Signs	The vital sign set required to calculate an EWS score includes: • Respiratory rate • Supplemental oxygen rate • Oxygen saturations • Heart rate • Blood pressure • Temperature • Level of consciousness Other patient assessment information can be recorded within eVitals but is not required to calculate a EWS score. These include: • Oxygen flow rate and supplement method - e.g. high flow/low flow • A tick if oxygen is humidified • A tick option if heart rate is irregular • Orthostatic BP measurements, and a tick option if mean arterial pressure has been measured • Pain score - at rest and on movement

	• Phlebitis score and an option for leur site
A complete set of vital signs must be recorded:	• On pre-admission/admission. • Immediately prior to transfer from PACU to the ward or day-stay. • At a frequency directed by the patient's clinical condition, EWS score, and escalation response, hospital protocol/clinical pathway, and the medical specialist or nurse practitioner's written instructions. • As close to discharge as practicable, but within 4 hours prior to discharge. Where the discharge vital signs are outside the accepted parameters for that patient, e.g. the patient has been febrile, a further set of vital signs must be performed immediately prior to discharge and the discharge decision reviewed if necessary. • For inpatients, after the initial post-op monitoring regime is completed and the EWS score is 0 for >24 hours, the recommended minimum frequency is at the beginning of every shift and at least once in every 8 hour period thereafter. This must be increased to a minimum of every 4 hours if there are changes in the clinical condition, and until the patient is stable again
Professional judgement is used:	• In accurately assessing observations, and includes consideration of the patient's individual factors, current medications, medical/surgical history, clinical pathway instructions, the complexity or issues relating to the procedure, and any other relevant factors. • To increase or decrease frequency of observations. • To elevate concerns and/or request assistance from the on-duty in charge, on-call nurse manager, nurse practitioner and/or the patient's medical specialist.
Early warning score (EWS)	• Use the EWS system as part of your assessment process to detect clinical deterioration. • To obtain an accurate score, each of the seven core vital signs required must be taken. • EVERY TIME that a full set of vital signs is recorded, a total EWS score is calculated and appears on the EWS tab, vitals card on patient summary and electronic whiteboard; actions must be implemented and documented in the patients clinical record. This is especially important if there is a clinical decision not to escalate as per the EWS • Escalation of care is triggered either by an aggregated EWS calculated from all seven core vital signs, or from a single significantly abnormal parameter. Any vital sign that falls into a zone indicating significant deviation from the norm (i.e. in the red or blue zones) triggers the action required for that zone. For example, if the total EWS is 5 but a single parameter is in the 'red zone' on the chart, the action associated with the red zone is to be taken • Any patient with a EWS of three or above, and/or looks unwell, require assessment for sepsis using the sepsis screening tool
Instigate an Emergency Call if any of the following occur:	• ANY observation in the blue area on the chart • Airway threat • Sudden decrease in O2 saturations <90% • Sudden decrease in level of consciousness • Unexpected or prolonged seizure • You are seriously worried about the patient but they do not fit the above criteria (the 'worried' criterion) NOTE: The type of Emergency Call instigated is based on the specific hospital context including (but not limited to) the type and level of skill of any on-duty coverage available.
Modifications to vital signs	The purpose of the modifications section is to allow NZEWS triggers to be individualised for patients with chronic disease or known vital sign abnormalities that are not representative of clinical deterioration. Modifications may be made to single or multiple vital sign parameters. For example, a marathon runner with a resting heart rate of 45bpm may have a heart rate modification relevant for duration of admission and which is time unlimited. Modifications may also be required for patients' vital signs temporarily outside normal parameters, e.g. a patient with lower blood pressure following spinal anaesthetic may have a temporary modification which is time limited. Modifying triggers carries the risk of normalising abnormal vital signs and should be reserved for instances where deranged physiology has been recognised, investigated and treatment has commenced but improvement is expected to lag behind. When making modifications the clinician must consider the clinical

	risk to the patient if vital sign abnormality is normalised. Clinical risk can be mitigated by ensuring modifications are discussed with medical specialists and reviewed at regular intervals, so they remain appropriate as the patient's condition changes. Modifications to NZEWS triggers: • Must be made by Medical Specialists or Nurse Practitioners. • May be taken by phone order and entered into eVitals by two registered nurses. • Must include the date and time the modification is activated. • Must include the duration the modification remains active. • Must include the reason for modification. • Must include contact details for the modifying specialist/practitioner. There should be a low threshold for escalating concerns relating to any patients with modifications to EWS triggers. Nurses must consult the Medical Specialist or Nurse Practitioner if there is concern about a patient's condition, regardless of the EWS score.
Escalating and documenting concerns	• Nurses must call the medical specialist or Nurse Practitioner if they, the patient or their family or whānau are worried about the patient's condition, regardless of vital signs and the EWS score. • If you feel that the concerns are not being acted on appropriately, it is expected that you escalate above that person. For guidance refer to Contacting On-Call Nurse Manager Advice and or Attendance After Hours and Contacting Doctors/Medical Specialists for Advice and or Attendance • The SBAR framework is available in eNotes to support documentation • and can be used as a prompt for communications with the on-duty nurse in charge, clinical nurse specialist, nurse practitioner, medical specialist, or on-call nurse managers. Document all concerns, actions and communication in the patient's clinical record Complete an event form in SafeHub if required.
Equipment	• General Managers are responsible for ensuring vital signs and patient assessment equipment is available and fit for purpose including valid evidence of current calibration, correct time (daylight saving time adjusted), biomedical electrical safety checks, and general cleaning and maintenance. • Users are responsible for using the equipment according to the manufacturer's instructions.

Education and competence	All clinical staff will:
	
	• Complete initial education on:
	  ○ SCH standard for vital sign monitoring, specifically related to detection of clinical deterioration
	  ○ Use of the EWS system, including required escalation and associated actions
	  ○ Use of the SBAR communication system
	  ○ Complete sepsis learning package
	  ○ Associated processes (as designated in this document)
	• Complete refresher training on the EWS process when:
	  ○ There is any change to the process
	  ○ Any individual issue is identified by performance management processes or incident/event review
	  ○ A trend is identified by incident/event review or audit
	  ○ A hospital/area or the organisation elects to provide additional education

Audit	Clinical staff's ongoing competence will be determined by:
	
	• Current organisational processes including:
	  ○ Performance review
	  ○ Adverse event management or complaints management
	  ○ Audit programme
	• A focused clinical audit that may be undertaken locally

Associated documents

Contacting the on-call nurse manager after hours

Contacting the on-call nurse manager for advice and/or attendance after hours.

Contacting medical practitioners for advice and or attendance

Transfer of patients between healthcare facilities procedure

SBAR communication tool

This tool provides a template for objective communication when contact with medical specialist is required. CWS provides a documentation template in the SBAR format

Adverse event reporting and management policy

Credentialling and Practice Guide – Access privileges for health practitioners

Sets out the rules for access to and ongoing practice at Southern Cross Healthcare hospitals.

Sepsis: recognition, diagnosis and early management guidelines

This guideline supports the process required for early recognition and treatment of sepsis

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Authorised By: **Regional General Manager, Central & South**

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