Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Tús Áite do Shábháilteacht Othar
Patient Safety First

Hospital Name:

.....

Document Number during this Admission [ ]

Patient Name:

Date of Birth:

Healthcare Record No:

Addressograph

NATIONAL EARLY WARNING SCORE
ADULT PATIENT OBSERVATION CHART

Escalation Protocol Flow Chart

Total Score	Minimum Observation Frequency	ALERT	RESPONSE
1	12 Hourly	Nurse in charge	Nurse in charge to review if new score1
2	6 Hourly	Nurse in charge	Nurse in charge to review
3	4 Hourly	Nurse in charge & Team/On-call SHO	1. SHO to review within 1 hour
4-6	1 Hourly	Nurse in charge & Team/On-call SHO	1. SHO to review within ½ hour 2. If no response to treatment within 1 hour contact Registrar 3. Consider continuous patient monitoring 4. Consider transfer to higher level of care
≥ 7	½ Hourly	Nurse in charge & Team/On-Call Registrar Inform Team/On-Call Consultant	1. Registrar to review immediately 2. Continuous patient monitoring recommended 3. Plan to transfer to higher level of care 4. Activate Emergency Response System (ERS) *(as appropriate to hospital model)*
Note: Single Score triggers			
Score of 2 HR ≤ 40 (Bradycardia)	½ Hourly	Nurse in charge & Team/On-call SHO	1. SHO to review immediately
*Score of 3 in any single parameter	½ Hourly or as indicated by patient's condition	Nurse in charge & Team/On-call SHO	1. SHO to review immediately 2. If no response to treatment or still concerned contact Registrar 3. Consider activating ERS

*In certain circumstances a score of 3 in a single parameter may not require ½ hourly observations i.e. some patients on O_2.

- When communicating patients score inform relevant personnel if patient is charted for supplemental oxygen e.g. post-op.
- Document all communication and management plans at each escalation point in medical and nursing notes.
- Escalation protocol may be stepped down as appropriate and documented in management plan.

IMPORTANT:

1. If response is not carried out as above CNM/Nurse in charge must contact the Registrar or Consultant.
2. If you are concerned about a patient escalate care regardless of score.

Adapted from CJCDRU chart

CONSIDER SEPSIS

Sepsis = Known or Suspected Infection & Systemic Inflammatory Response Syndrome (SIRS)

Defined as the presence of 2 or more of the following

Temperature > 38°C or < 36°C
Respiratory Rate > 20 breaths per min
$PaCO_2$ < 4.3 kPa
Heart Rate > 90 beats per min
White Cell Count > 12 or < 4

Diagnosed Sepsis

Intervention:
Action within One Hour
COMPLETE SEPSIS SIX

1. High Flow Oxygen
2. Lactate Check
3. Fluid Challenge
4. Urine Monitoring
5. Cultures*
6. Antimicrobial Therapy

(* blood, wounds, invasive line sites, sputum, urine etc as appropriate)

Adapted from CJCDRU chart

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Early Warning Score System

0	1	2	3

Consultant:

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

Ward:

Year _____

Frequency of observations
Date
Time

ABCDE Assessment

A

RESPIRATORY DISTRESS

Consider:
- Airway
- Hypoxia
- Acidosis

Intervention:
- Immediate medical review
- ABCDE assessment
- Give Oxygen to target: 90% in COPD patients, 96% or more in all other patients
- Request CXR & ABG
- Airway Obstruction: activate Emergency Response System
- Respiratory Acidosis: Consider early non-invasive ventilation

C

HYPERTENSION

Consider:
- Pain
- Hypercapnia

Intervention:
- Immediate medical review
- 12-lead ECG

HYPOTENSION

Consider:
- Bleeding
- Myocardial Infarction
- Sepsis

Intervention:
- Immediate medical review
- Check BP manually
- 12-lead ECG
- If no heart failure, stat IV fluids - 500ml
- If no improvement after 20ml/kg: immediate review by doctor
- Systolic BP ≤ 90: consider activating ERS

TACHYCARDIA

Consider:
- Seagull Sign**
- Loss of conciousness
- Myocardial ischaemia on ECG
- Heart failure. If YES – consider activating ERS

Intervention:
- Immediate medical review
- ACLS Algorithm as appropriate

BRADYCARDIA

Consider:
- Electrolyte Disturbance
- Drug Side-effect
- Complete Heart Block

Intervention:
- Immediate medical review
- 12-lead ECG
- Telemetry
- Heart Rate ≤ 40: consider activating ERS
- Document irregular Heart Rate

D

NEUROLOGICAL DETERIORATION

Consider:
- Hypoglycaemia
- Acute brain injury
- Pupil response

Intervention:
- Immediate medical review
- Capillary glucose
- Sudden fall in level of consciousness: consider activating ERS

E

PYREXIA OR HYPOTHERMIA

Consider:
- Sepsis

Intervention:
- Immediate medical review
- C-Reactive protein
- Two or more Sepsis indicators present
- Commence SEPSIS SIX Regimen

Respiratory Rate (breaths per minute)	≥ 25		≥ 25
	21-24		21-24
	12-20		12-20
	9-11		9-11
	≤ 8		≤ 8
Respiration Score			
SpO_2 %	≥ 96		≥ 96
	94-95		94-95
	92-93		92-93
	≤ 91		≤ 91
SpO_2 Score			
F_IO_2	Room Air		RA
	% or L/min		% or L/min
F_IO_2 Score			
Blood Pressure (mmHg)	250		250
	240		240
	230		230
	220		220
	210		210
	200 (Systolic BP ≥ 200: Doctor to review)		200
	190		190
	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
	50		50
	40		40
BP Score			
Heart Rate (beats per minute)	180		180
	170		170
	160		160
	150		150
	140		140
	130		130
	120		120
	110		110
	100		100
	90		90
	80		80
	70		70
	60		60
	50		50
	40 (Heart Rate ≤ 40: Immediate medical review)		40
	30		30
Heart Rate Score			
AVPU	Alert (A)		(A)
	Voice (V)		(V)
	Pain (P)		(P)
	Unresponsive (U)		(U)
AVPU Score			
Temperature (°C)	39.0		39.0
	38.5		38.5
	38.0		38.0
	37.5		37.5
	37.0		37.0
	36.5		36.5
	36.0		36.0
	35.5		35.5
	35.0		35.0
	34.5		34.5
Temp Score			
Total EWS			
Blood Glucose			
Bowel Movement			
Weight (kg)			
Initials			

Urine Output: If there are concerns about urine output (< 0.5 ml/kg/hr), contact Doctor for review

National Early Warning Score Key (ViEWS)

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
Systolic BP (mmHg)	≤ 90	91 - 100	101 - 110	111 - 249	≥ 250		
Heart Rate (BPM)		≤ 40	41 - 50	51 - 90	91 - 110	111 - 130	≥ 131
AVPU/CNS Response				Alert (A)			Voice (V), Pain (P), Unresponsive (U)
Temp (°C)	≤ 35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥ 39.1	

Note: Where systolic blood pressure is ≥ 200mmHg, request Doctor to review.

Patient Name:

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This Section is for reference only. Where Glasgow Coma Score is required, please use separate sheet.

Glasgow Coma Scale

			Date:	GCS					
			Time:						
		Spontaneously	4						
COMA SCALE	Eyes open	To Speech	3						Eyes closed by swelling = C
		To Pain	2						
		None	1						
	Best verbal response	Orientated	5						
		Confused	4						Endotracheal tube or tracheostomy =T
		Inappropriate words	3						
		Incomprehensible sounds	2						
		None	1						
	Best motor response	Obey commands	6						
		Localize Pain	5						Usually record the best arm response
		Flexion to Pain	4						
		Abnormal Flexion	3						
		Extension to Pain	2						
		No Response	1						
		Total G.C.S.							
PUPILS	right	Size							+ reacts – no reaction C eyes closed
		Reaction							
	left	Size							
		Reaction							
LIMB MOVEMENT	ARMS	Normal power							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness							
		Severe weakness							
		Spastic flexion							
		Extension							
		No response							
	LEGS	Normal power							
		Mild weakness							
		Severe weakness							
		Extension							
		No response							
			Initials						

Pupil scale (m.m.): 1, 2, 3, 4, 5, 6, 7, 8

With kind permission of Beaumont Hospital

Please use this space for additional monitoring charts, e.g. Pain Score Chart

**** Seagull Sign: This is when the Heart Rate is above the Systolic Blood Pressure**

Note: The National Early Warning Score has adopted the VitalPAC™ Early Warning Score (ViEWS) parameters.

Acknowledgements: A modified version of the CYCORU Vital Signs Record was reproduced with permission from its developers. Support and advice was provided by the Health Directorate, ACT Government, Australia.