



National Early Warning Score (NEWS) 2

Standardising
the assessment
of acute-illness
severity in the NHS

Additional
implementation
guidance

Update: March 2020

Clarification around implementation in addition to the existing recommendations within the 2017 publication

NEWS2: Standardising the assessment of acute-illness severity in the NHS

www.rcplondon.ac.uk/news2

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Introduction

NEWS2: Standardising the assessment of acute-illness severity in the NHS was published in December 2017.¹ Since then there has been considerable learning through widespread implementation across the UK and internationally.

Particular elements of implementing NEWS2 in hospitals have proven more challenging, and clinicians have raised a number of questions. To support clinicians to deliver consistent best practice, the RCP is publishing this additional implementation guidance to provide clarification.

The trigger (threshold) for escalation is normally set at a single score of 3, or a composite score of 5 and 7. However, this threshold can be adapted for individual patients following clinical assessment.

New confusion

2017 recommendations

Patients with acute illness may develop an acutely altered mental state, manifesting as new confusion, delirium or a Glasgow Coma Scale (GCS) <15. This is an important sign of acute clinical deterioration requiring urgent clinical assessment. Acutely altered mentation may occur because of sepsis, hypoxia, hypotension or metabolic disturbances, either alone or in combination.

- > We recommend that new confusion, delirium or acutely altered mentation scores 3 on the NEWS2 chart, indicating a code red (for a single score of 3), ie that the patient requires urgent assessment.
- > We recommend that if it is unclear whether a patient's confusion is new or their normal state, the confusion should be assumed to be new until confirmed to be otherwise.

Additional guidance

New confusion can be assessed by asking the question 'Is this patient more confused than usual/before?'.^{*} This can be asked of staff or relatives.

If this is positive, it will trigger clinical response and assessment including the 4 'A's Test (4AT)² for delirium, and further investigation and management by a competent responding clinician.

Following this assessment:

- > if the confusion is then determined **not** to be more than usual, subsequent scoring will return to normal
- > the outcome of the assessment will also determine the ongoing appropriate trigger score (threshold) for the individual patient
- > ongoing daily assessment will determine whether the confusion is a significant component of the patient's condition in this presentation and contributing to the risk of deterioration, or is stable and therefore whether scoring as new confusion should continue at the patient's current level of confusion.

^{*} Note that this is a validated Single Question identifying Delirium (SQiD).³

Escalation/response guidance

2017 recommendations

We recommend that the locally agreed response to each NEWS trigger level should define:

- > the speed/urgency of response – to include an escalation process to ensure that a response always occurs
- > who responds? ie the seniority and clinical competencies of the responder(s)
- > the frequency of subsequent clinical monitoring of the patient
- > the appropriate clinical setting for ongoing acute care.

We recommend that local arrangements should ensure that:

- 1 the urgency and competency of response to acute illness are guaranteed 24/7
- 2 there are appropriate settings, facilities and trained staff in place for ongoing care when it is necessary to escalate care to higher-dependency settings.

We recommend that the frequency of monitoring should be increased to a minimum of every hour for those patients with an aggregate NEWS score of 5–6, or a red score of 3 in a single parameter.

While any patient can be considered for continuous monitoring, it is essential for patients with a score of 7 or more.

Escalation/response guidance

Additional guidance

For patients in hospital:

A NEWS2 score of 5 or 6 **that is new for the patient, unless an alternative escalation threshold has been previously determined**, indicates that:

- > the patient should be monitored hourly initially
- > the registered practitioner is to urgently inform a clinician competent in the assessment of acutely ill patients – this will be decided locally and could be the emergency response team (dependent on skill mix), ward doctor etc
- > assessment is expected within 60 minutes
- > moving the patient to an environment with monitoring facilities should be considered.

A NEWS2 score of 7 or above **that is new for the patient, unless an alternative escalation threshold has been previously determined**, indicates that:

- > the patient should be monitored every 30 minutes initially
- > the registered practitioner is to urgently inform a clinician competent in the assessment of acutely ill patients – this will be decided locally and could be the emergency response team (dependent on skill mix), ward doctor etc
- > assessment is expected within 30 minutes
- > if there is no improvement, senior clinician review (as locally defined) is expected within 60 minutes
- > moving the patient to an environment with monitoring facilities should be considered.

A structured clinical assessment should be documented that includes:

- > time of escalation
- > time and grade of clinical response
- > clinical assessment and plan, including treatment plan and the individualised trigger score (threshold) for further response.

Examples of structured documents of clinical response to deterioration can be found on the NEWS2 pages of the **RCP website**.

For patients in community settings:

Thresholds for actions have not been determined. Further research is required. However, the addition of NEWS2 scores to clinical judgement may help the assessing clinician to determine necessary urgency of assessment and actions.

Oxygen scales

2017 recommendations

2017 recommendations:

The new SpO₂ scoring Scale 2 is for patients with a prescribed oxygen saturation requirement of 88–92% (eg in patients with hypercapnic respiratory failure).

This should only be used in patients confirmed to have hypercapnic respiratory failure on blood gas analysis on either a prior, or their current, hospital admission.

- The decision to use the new SpO₂ scoring Scale 2 should be made by a competent clinical decision maker and should be recorded in the patient's clinical notes.
- In all other circumstances, the regular NEWS SpO₂ scoring scale (Scale 1) should be used.
- For the avoidance of doubt, the SpO₂ scoring scale not being used should be clearly crossed out across the chart.

Additional guidance

We recognise that the 2017 guidance is not consistently implemented and that patients with COPD without a history or evidence of hypercapnic respiratory failure are often monitored on Scale 2.

This is not in line with NEWS2 guidance.

We also recognise that competent clinical decision makers, ie those who can determine the history or presence of hypercapnic respiratory failure, may not currently be involved in the initial decision to use Scale 2, and/or that this decision is commonly not documented. **This is not in line with NEWS2 guidance.**

Patients with a known history of hypercapnia should have this recorded on local record systems so that the appropriate scoring scale can be used from presentation.

For patients with chronic respiratory failure who therefore chronically score positive for hypoxia on either oxygen scale, an individualised threshold for escalation should be determined on initial and daily assessment by a competent clinical decision maker.

Agreeing a target oxygen saturation for a patient is a separate clinical decision from deciding which NEWS2 scale is used. These may coincide if the patient has a history of hypercapnia.

Acute receiving of patients to hospital

2017 recommendations

2017 recommendations:

The NEWS should be used in the prehospital assessment of acutely ill patients by ‘first responders’, eg ambulance services, primary care and community hospitals, to identify and improve the assessment of acute illness, triage and the communication of acute-illness severity to receiving hospitals.

The NEWS should be used as an aid to clinical assessment – it is not a substitute for competent clinical judgement. Any concern about a patient’s clinical condition should prompt an urgent clinical review, irrespective of the NEWS.

Additional guidance

NEWS2 and its component parts should be used as a common language supplementing clinical judgement in acute care.

Clinical teams receiving information on patients who will transfer between teams should request NEWS2 scores and, if raised, the components

that are raised. This, together with the clinical judgement of the person who has assessed the patient, will aid decisions on clinical urgency for transfer, assessment on arrival, and best location for initial receiving.

Incomplete NEWS2 parameters

2017 recommendations

No specific 2017 recommendations.

Additional guidance

If one of the physiological measures cannot be obtained because of no equipment, the score should still be calculated and documented as **incomplete**. A patient may trigger on a single measure, or on an aggregate score even if incomplete. Clinical judgement is particularly important here and might trigger a response at a lower threshold as the score is incomplete.

If one of the physiological measures is not obtainable despite the equipment being used, **this should trigger an immediate response.**

Conclusion

We hope you found this additional guidance helpful. For further NEWS2 information please visit www.rcplondon.ac.uk/news2, or to ask NEWS2-related questions please contact NEWS@rcplondon.ac.uk.

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References

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- 2 MacLulich A, Ryan T, Cash H. The 4AT. www.the4at.com [Accessed 19 March 2020].
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