CNS OBSERVATION CHART

CNS

Name | CHI

Date

Time

GLASGOW COMA SCALE

Eyes Open	Spontaneously	Eyes close by swelling = C
	To speech	
	To pain	
	None	
Best verbal response	Orientated	Endotracheal tube or tracheostomy = T
	Confused	
	Inappropriate words	
	Incomprehensible sounds	
	None	
Best motor response	Obey commands	Usually record the best arm response
	Localise to pain	
	Flexion to pain	
	Abnormal flexion	
	Extends to pain	
	None	

Pupil Scale mm 1 2 3 4 5 6 7 8

Right Pupil	Size	+ reacts, - no reaction, c. eye closed
	Reaction	
Left Pupil	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	

Seizure Recording Chart

Time	General/Partial	Description of Attack	Duration	Post-Ictal State	Comments

Supportive and Palliative Care Indicators Tool (SPICT™)

SPICT™

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg.The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia / Frailty

Unable to dress, walk or eat without help

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological Disease

Progressive deterioration in physical and /or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia, breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart / Vascular Disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe inoperable peripheral vascular disease

Respiratory Disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney Disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver Disease

Cirrhosis with one or more complications in the past year:
- diuretic resistant ascites
- hepatic encephalopathy
- hepatoneral syndrome
- bacterial peritonitis
- recurrent variceal bleeds.

Liver transplant is not possible.

Other conditions

Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Acknowledgement - NHS Lothian www.spict.org.uk

ZAP001 CGD 170760

AIOC

Private & Confidential

Adult Inpatients Observation Chart

NHS Grampian

This observation chart is to be used for **ALL** Adult Inpatients

Patient Details

Surname

Forename

Community Health Index (CHI)

affix end of bed label here

Consultant

Ward

Regardless of NEWS always escalate if concerned about a patient's condition

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring
Total 1-4	Minimum 4 hourly	Inform registered nurse, who must assess the patient Registered nurse decides whether increased frequency of monitoring and / or escalation of care is required
3 in single parameter	Minimum 1 hourly	Continue routine NEWS monitoring
Total 5 or more Urgent response threshold	Minimum 1 hourly	Registered nurse to immediately inform the medical team caring for the patient Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills Consider transfer of care to a level 2 or 3 clinical care facility, i.e. higher-dependency unit or ICU Clinical care in an environment with monitoring facilities

Exclusion Criteria

In some settings, patients will have an impaired level of consciousness as a consequence of sedation, ie, following surgical procedures. This, the assessment of consciousness level and the necessity to escalate care should be considered in the time-limited context of the appropriateness of the consciousness level in relation to recent sedation.

For patients with known hypercapnoeic respiratory failure due to COPD, recommended British Thoracic Society target saturations of 88-92% should be used. These patient's will still "score" if their SpO2 are below 92% unless the score is "reset" by a competent clinical decision-maker. These patients will then use the Chronic Hypoxia (Chr Hyp) alternate SpO2 scoring. This should be amended on the NEWS chart as appropriate.

AIOC Version 4 May 2018

Observation Chart for the National Early Warning Score 2

Name		Date of Birth	dd	mm	yy	CHI

NEWS KEY: 0 | 1 | 2 | 3

Parameter	Range	Score
	Date	
	Time	
A+B Respirations Breaths/min	≥25	3
	21-24	2
	18-20	
	15-17	
	12-14	
	9-11	1
	≤8	3
A+B SpO2 Scale 1 Oxygen saturation (%)	≥96	
	94-95	1
	92-93	2
	≤91	3
SpO2 Scale 2* O2 saturation (%) Use Scale 2 if target range is 88-92% eg in hypercapnic respiratory failure. * Only use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3
	95-96 on O_2	2
	93-94 on O_2	1
	≥93 on Air	
	88-92	
	86-87	1
	84-85	2
	≤83%	3
AIR or OXYGEN?	A = Air	
	O_2 L/min	2
	Device	
C BLOOD PRESSURE mmHg Score uses systolic BP only	≥ 220	3
	201-219	
	181-200	
	161-180	
	141-160	
	121-140	
	111-120	
	101-110	1
	91-100	2
	81-90	
	71-80	
	61-70	3
	51-60	
	≤ 50	
C PULSE Beats per minute	≥ 131	3
	121-130	
	111-120	2
	101-110	
	91-100	1
	81-90	
	71-80	
	61-70	
	51-60	
	41-50	1
	31-40	3
	≤ 30	
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert	
	Confusion	
	V	3
	P	
	U	
E Temperature °C	≥ 39.1°	2
	38.1-39.0°	1
	37.1-38.0°	
	36.1-37.0°	
	35.1-36.0°	1
	≤ 35.0°	3
NEWS TOTAL SCORE		TOTAL
Monitoring Frequency		Monitoring
Escalation of care Yes / No		Escalation
Blood Glucose		Blood Glucose
Pain Score (0-4)		Pain
Nausea (0-3)		Nausea
Spict Considered		Spict
Initials		Initials

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Initials		Initials

SEPSIS

SEPSIS Screening Tool

Patient Triggering NEWS ≥ 5 or Clinical Concern
Neutropaenia Suspected

Look for two or more general indicators of deteriorating health

Is this likely to be due to Infection

Cough / Sputum Abdominal pain / distension / diarrhoea Line Infection Endocarditis	Dysuria Cellulitis Headache with neck stiffness Wound Infection

YES — Escalate to Doctor / ANP with "suspected sepsis". Prepare giving set / IV fluids

NO — Escalate to Doctor / ANP. Repeat NEWS in maximum 60 minutes → **ASSESS FOR OTHER CAUSES OF TRIGGERING**

Two people work together to deliver the Sepsis 6 within 60 minutes of patient first triggering

Correct / Hypoxia Take blood cultures Give IV antibiotics according to NHS G Protocol	Measure whole blood Lactate Measure Urine output Start IV fluids 20ml/kg, minimum 500mls in the first hour

Collect Appropriate Microbiology and consider Source control

ASSESS FOR SEPSIS

Are there any high risk factors?

Hypotension (SBP <90 or MAP <65 after fluid challenge) Unexplained INR > 1.5 Bilirubin >34	Lactate > 4 aPTT > 60s Platelets < 100

YES — **This is SEPSIS**
- Contact middle grade Doctor for immediate review
- Catheter mandatory if evidence of AKI

NO — **Access response to Sepsis 6**
- Continue regular NEWS

Codes for Recording Oxygen Delivery on NEWS Chart

Code	Delivery	Code	Delivery
A	Breathing Air	RM	Reservoir Mask
N	Nasal Cannula	TM	Tracheostomy Mask
SM	Simple Mask	CP	CPAP Mask
V	Venturi mask and percentage eg V24, V35, V40, V80	H	Humidified oxygen and percentage eg H28, H35, H40, H60
NIV	patient on NIV system	OTH	Other specify