Guidance on the use of National Early Warning Score (NEWS) in Acute Mental Health Services

Clinical Investigations supporting COVID-19

Throat and nose swab virology are the commonest form of diagnosis. Where there is a high clinical index of suspicion for COVID- 19 (e.g. during facility outbreak), non-detectable viral load through nose / throat swab does not exclude possibility of COVID -19 infection

- On confirmation of a positive diagnosis of COVID - 19 further investigations may be considered appropriate to assist with management. E.g. FBC, UEC, LFTs, CXR
- Investigations to out rule underlying non-COVID-19 related conditions may be appropriate
- Clinical discretion and judgement should be used regarding further investigation and in particular in identifying whether same will alter overall patient management and risks posed by transfer to and from acute hospital facilities for same.

Clinical Monitoring Using National Early Warning Score (NEWS) with Service Users with suspected or confirmed COVID - 19 status

1. Complete a full set of NEWS observations for the service user.
   - A full set of NEWS observations is as follows: Respiratory rate, peripheral oxygen saturation, FiO2 (room air or supplemental oxygen), blood pressure, heart rate, neurological responsiveness using AVPU and temperature.
2. Calculate baseline NEWS score as per the NEWS observation chart. Please clink on links to see presentation and factsheet which explains how to use NEWS.
   How to complete the NEWS observation chart
   Presentation to provide information about how to use NEWS for staff in acute settings
   Patient observation chart
   Links can be found on the HSE webpage **Physical Health Supports for Mental Health Services.**
3. Record the normal baseline health and NEWS score of the service user.
4. Be alert to any changes of the normal baseline in the service user.
5. Commence 24 hourly observations monitoring on all service users in acute mental health adult inpatient approved units for the duration of the COVID 19 outbreak.
6. If service user requires more frequent observations continue with same.

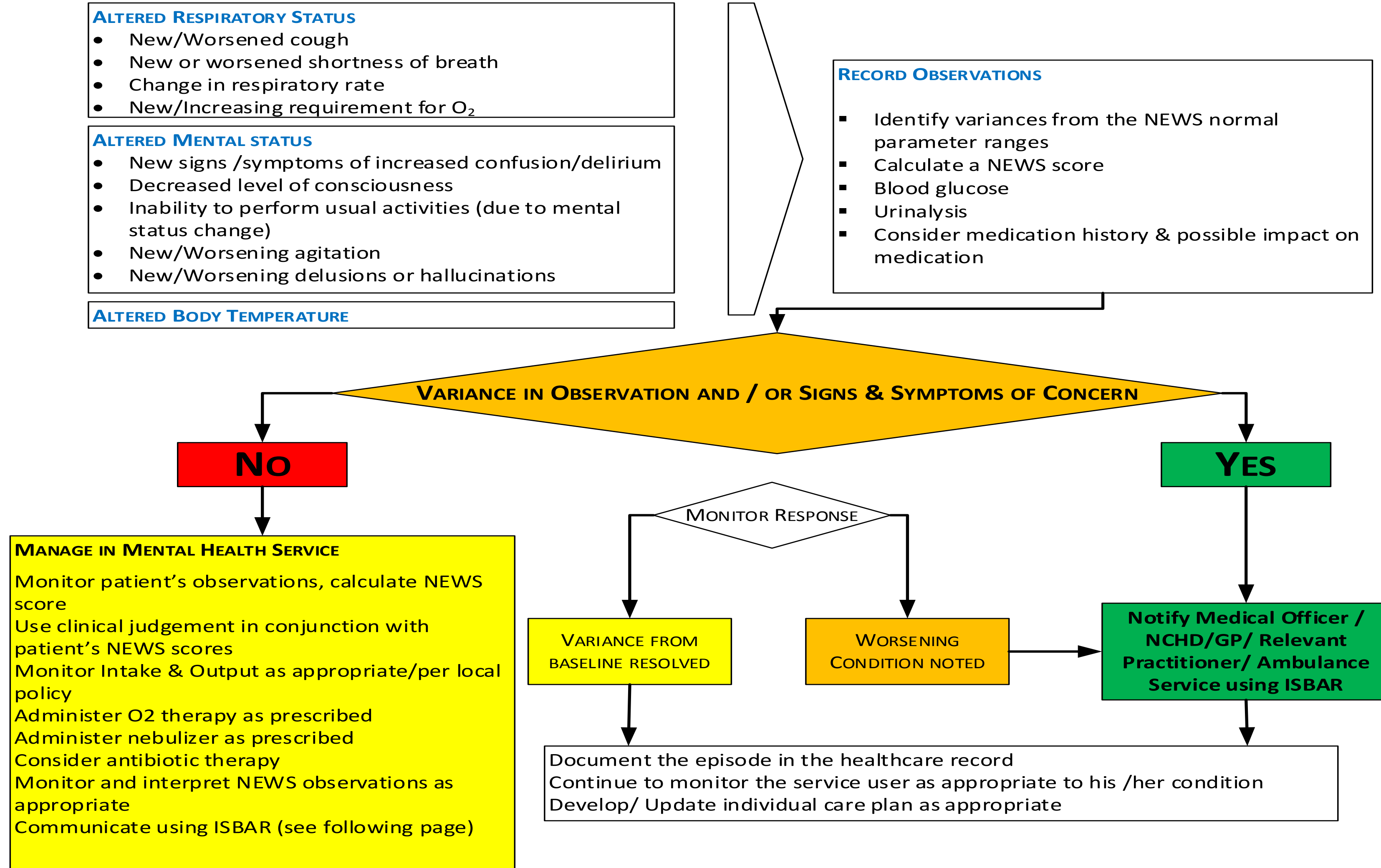
Decision algorithm in regards to escalation reflecting anticipatory guidance

The following anticipatory decision log is to offer guidance to doctors and nurses who may not be familiar with the Service User as to what approach to take in the event of their acute deterioration. This document cannot cover all clinical eventualities but it may act as a guide in deciding the appropriateness of certain interventions. It is not prescriptive. The treating clinician should use their discretion to provide whatever treatment they see fit, depending on the clinical scenario.

Intervention	Date	Date	Date	Date	Date	Date
Attempt CPR	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
IV/SC Fluids	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Antibiotics	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms
Transfer to Acute Hospital	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Other						

National Early Warning Score-

(In-patient services-Adult Acute Approved Centres **including admission, continuing care and special care or secure wards**)



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ISBAR Communication Tool

I **Identify**	**Identify: You, Doctor, Patient** Is this Dr. _______________? This is _________________ *(e.g Mary, I am team leader on 7A)* I am calling about ________________ *(e.g Mr David Jones)*
S **Situation**	**Situation: Why are you calling?** I am calling because ________________ *(e.g Total NEWS score of 6)* Resp Rate _________ Sats _________ O_2 Delivery _________ Temp ___________ Heart Rate _______ BP _______ Urinary Output ______ AVPU _______ *(only use abnormal reading initially)*
B **Background**	**Background: What is relevant background?** They are _________ years old Admitted for ________________ Recent surgery or procedures _____________ Relevant past medical/surgical history _____________ They currently have ______________ *(e.g. IV fluids, Urinary Catheter, O_2)*
A **Assessment**	**Assessment: What do you think is the problem?** I think ___________________________ *(e.g they are in respiratory distress)* *(you can skip this if they don't know what is wrong)*
R **Recommendation**	**Recommendation: What do you want them to do?** I would like you to ___________________________ *(e.g come and review him please)* Is there anything you would like me to do before you get here?

Red Flags to clinically look out for with COVID-19

RR > 30breathes/min	Severe respiratory distress	New onset SpO2 < 90% on room air
New onset confusion	Hypotension	Oliguria (decreased output of urine) > 12 hours
Initial NEWS ≥ 7	Clinically deteriorating patient with NEWS ≥ 5	

Complete observation on the NEWS observation chart. Please see form here: Patient observation chart and score as per score sheet below.

National Early Warning System Scoring (NEWS) Key							
SCORE	**3**	**2**	**1**	**0**	**1**	**2**	**3**
Respiratory Rate (bpm)	≤		9	12 - 20		21 - 24	≥ 25
SpO_2 (%)	≤ 91	92 - 93	9	≥ 96			
Inspired O2 (Fi O2)				Air			Any
Systolic BP (mmHg)	≤ 90	91 - 100	101 -	111 -	≥ 250		
Heart Rate (BPM)		≤ 40	4	51 - 90	91 -	111 -	≥ 131
AVPU/CNS Response				Alert (A)			Voice (V), Pain (P), Unrespon sive (U)
Temp (°C)	≤ 35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥ 39.1	

Response to NEWS scores

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	1. NCHD to review within 1 hour
4-6	1 Hourly	Nurse in charge & Team/On-call NCHD/SHO	1. NCHD to review within hour 2. Screen for Sepsis 3. If no response to treatment within 1 hour contact Senior doctor /Acute Medical Doctor 4. Consider continuous patient monitoring 5. Consider transfer to higher level of care
7	Hourly	Nurse in charge & Team/On-Call Registrar Inform Acute Medical Team/On-Call Consultant	1. Senior Doctor/ Acute Medical Doctor 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)	Hourly	Nurse in charge & Team/On-call NCHD/SHO	1. NCHD to review immediately
*Score of 3 in any single parameter	Hourly or as indicated by patient's condition	Nurse in charge & Team/On-call NCHD/ SHO	1. NCHD to review immediately 2. If no response to treatment or still concerned contact Registrar/acute medical doctor 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.

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.