



# Patient Safety Alert

## Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)

25 April 2018

Alert reference number: NHS/PSA/RE/2018/003

### Resource Alert

Failure to recognise or act on signs that a patient is deteriorating, for example changes in systolic blood pressure or pulse rate, is a key patient safety issue.<sup>1</sup> In 2017, the National Reporting and Learning System (NRLS) received 100 reports where deterioration may not have been recognised or acted on and the patient died. Although these patients may not have survived even with prompt action, the care provided did not give them the best possible chance of survival.

A typical incident reads: "Patient transferred from AMU at 21:00 and found unresponsive at 21:15. Patient had scored 8 at 14:00 on AMU and no review ..... documented in the medical or nursing documentation. Next observations recorded at 16:30 as MEWS 2 urine scored as 0 but no urine output recorded on fluid balance. No further observations recorded until cardiac arrest."

Recognising and responding to patient deterioration relies on a whole systems approach and the revised National Early Warning Score (NEWS2),<sup>2</sup> published by the Royal College of Physicians in December 2017, reliably detects deterioration in adults,\* triggering review, treatment and escalation of care where appropriate. NEWS2 is an improvement on the original NEWS, in use since 2012, in key areas including:<sup>2</sup>

- better identification of patients likely to have sepsis
- improved scoring for patients with hypercapnic respiratory failure
- recognising the importance of new-onset confusion or delirium.

Currently, around two-thirds of healthcare providers use the original NEWS for adult patients, with the rest using adapted versions or locally devised early warning scores. Harm could result from having different scoring systems in use across the NHS when patients or staff move between services. The adoption of NEWS2 is vital to standardise how adult patients who are acutely deteriorating are identified and responded to, and to streamline communication across the NHS.<sup>2</sup>



NHS England's aim is for all acute hospital trusts and ambulance trusts to fully adopt NEWS2 for adult patients by March 2019. This alert is issued to highlight the resources that support adoption of NEWS2<sup>2-5</sup> and to signpost additional support to ensure trusts can adopt NEWS2 as promptly, safely and effectively as possible. This support will be provided through the establishment of a virtual community network of NEWS2 champions who will: receive regular bulletins including information on the latest training; have opportunities to share challenges and best practice via regular webinars; and be given access to resources via an online repository. The implementation of NEWS2 is also associated with a new CQUIN indicator published by NHS England.<sup>6</sup>

This focused support for the adoption of NEWS2 links to the wider support for improving recognition and response to patient deterioration provided by the Patient Safety Collaboratives.<sup>7</sup>

### Actions

**Who:** All acute hospital trusts and ambulance trusts caring for adult patients

**When:** To start immediately and to be completed by 21 June 2018

-  1 Bring this alert to the attention of all those with a leadership role in responding to patient deterioration, including critical care outreach teams
-  2 Identify a NEWS2 champion to act as the main contact with NHS England and an active member of the NEWS2 network. Email their contact details to [england.clinicalpolicy@nhs.net](mailto:england.clinicalpolicy@nhs.net)
-  3 Identify or establish a new board reporting committee with the required representation to plan the adoption of NEWS2, including membership from wider local workstreams that support safer care for deteriorating patients, including those with sepsis
-  4 Identify actions required to ensure, by March 2019, there is trust-wide adoption of NEWS2; and share examples of local challenges and best practice with the NEWS2 network on request

See page two for references, stakeholder engagement and advice on who this alert should be directed to.

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Alert stage: Two - Resources

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### NRLS search dates and terms

Incidents reported to the NRLS with an incident date between 1 January 2017 and 31 December 2017, if reported to the NRLS by 31 January 2018 and extracted on 9 March 2018, where routine clinical review had categorised as adult deterioration and the original reporter had reported with degree of harm of 'death'.

### Note

\*The RCP states that NEWS2 "should not be used in children (ie aged under 16 years) or in women who are pregnant" and "may be unreliable in patients with spinal cord injury."

### References

1. NHS Improvement, July 2016. Patient Safety Alert: Supporting safer care where patients are deteriorating (adults and children) <https://improvement.nhs.uk/news-alerts/resources-support-safer-care-deteriorating-patient-adults-and-children/>
2. Royal College of Physicians, December 2017. National Early Warning Score (NEWS) 2 <https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2>
3. NHS Improvement, July 2016. Resources for the detection and management of deterioration in adult patients <https://improvement.nhs.uk/resources/detection-and-management-deterioration-adult-patients/>
4. NHS Improvement, June 2017. Improving quality and safety in healthcare: assessing and responding to patient risks <https://improvement.nhs.uk/resources/improving-quality-and-safety-healthcare-safety-culture-assessing-responding-patient-risks/>
5. National Early Warning Score (NEWS) online training resource <https://tfnews.ocbmedia.com>
6. NHS England, April 2018. CQUIN: Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/>
7. Patient Safety Collaboratives <https://improvement.nhs.uk/resources/patient-safety-collaboratives/>

### Stakeholder engagement

- NHS England medical directorate Clinical Policy Unit
- National Patient Safety Response Advisory Panel (for a list of members and organisations represented on the panel, see [improvement.nhs.uk/resources/patient-safety-alerts/](https://improvement.nhs.uk/resources/patient-safety-alerts/))

### Advice for Central Alerting System officers and risk managers

This alert asks for a systematic approach to deciding how your organisation identifies an appropriate NEWS2 champion and therefore needs co-ordinated implementation rather than separate action by individual teams or departments. The NEWS2 champion is likely to be selected by your medical director or director of nursing, so you should ensure this alert reaches them with this requirement highlighted. If you are unsure which individuals have a 'leadership role in responding to deteriorating patients', in acute hospital trusts seek initial advice from the critical care outreach team leader, and in ambulance trusts from clinical training leaders; they will be able to identify the key individuals needed to lead and co-ordinate implementation.