ADULT National Early Warning Scoring System

NHS
The Leeds Teaching Hospitals
NHS Trust

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9 - 11	12 - 20		21 - 24	≥25
SpO_2 Scale 1 (%)	≤91	92 - 93	94 - 95	≥96			
SpO_2 Scale 2 (%)	≤83	84 - 85	86 - 87	88 - 92 ≥93 on air	93 - 94 on oxygen	95 - 96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91 - 100	101 - 110	111 - 219			≥220
Pulse (per minute)	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Consciousness	New Confusion VPU			Alert			New Confusion VPU
Temperature (°C)	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	

If at any point you are concerned about a patient contact a doctor to review patient

NEWS2 GRADED RESPONSE STRATEGY

NEWS SCORE	FREQUENCY OF MONITORING	CLINICAL RESPONSE
0	Minimum 12 hourly	• Continue routine NEWS2 monitoring
Total 1 - 4	Minimum 4 - 6 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 a single parameter	Minimum 1 hourly	• Registered nurse to **immediately** inform the medical team caring for the patient, who will review and decide whether escalation of care is necessary • THINK SEPSIS! Complete sepsis screening tool
Total 5 or greater	Minimum 1 hourly	• Registered nurse to **immediately** inform the medical team caring for the patient using SBAR • If no response within 30 minutes, escalate to a senior doctor • THINK SEPSIS! Complete sepsis screening tool • Consider and document escalation care plan and resuscitation status
Total 7 or greater Emergency response threshold	1 hourly monitoring of vital signs and consider continuous monitoring	• Registered nurse to **immediately** inform the medical team caring for the patient - this should be at specialist registrar level or above • EMERGENCY medical assessment. If no response within 20 minutes, escalate to consultant • Refer to Critical Care Outreach • THINK SEPSIS! Complete sepsis screening tool and start BUFALO (Sepsis 6) • Consider and document escalation care plan and resuscitation status • Consider intensivist review and transfer of care to higher-dependency unit or ICU

NEWS2 is a tool and may not always reflect the severity of a patient's condition.

PAEDIATRIC Advanced Warning Scoring System

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Parameter	Score	Value
CRT	0	<3
	1	3 - 4
	3	≥5
	10	
Temp	0	35.1 - 38.9
	1	
	3	≤35
	3	≥39
	10	
AVPU	0	A
	1	V
	3	
	10	P or U
SpO_2 on air	0	95 - 100%
	1	90 - 94%
	3	86 - 89%
	10	<86%
SpO_2 on O_2	0	
	1	95 - 100
	3	90 - 94%
	10	<90%

	Score	Term - 11 months	12 - 23 months	2 - 3 years	4 - 7 years	8 - 16 years
BP	0					
	1					
	3	>115	>120	>125	>130	>140
	10	<65	<70	<80	<85	<90
HR	0	116 - 155	106 - 135	91 - 125	81 - 110	66 - 100
	1	101 - 115 156 - 165	96 - 105 136 - 145	81 - 90 126 - 140	71 - 80 111 - 120	56 - 65 101 - 110
	3	81 - 100 166 - 190	76 - 95 146 - 180	66 - 80 141 - 160	51 - 70 121 - 150	41 - 55 111 - 130
	10	≤80 ≥191	≤75 ≥181	≤65 ≥161	≤50 ≥151	≤40 ≥131
RR	0	35 - 54	27 - 44	23 - 34	19 - 26	15 - 22
	1	27 - 34 55 - 58	23 - 26 45 - 48	19 - 22 35 - 38	15 - 18 27 - 28	13 - 14 23 - 26
	3	21 - 26 59 - 70	19 - 22 49 - 60	15 - 18 39 - 50	13 - 14 29 - 40	11 - 12 27 - 30
	10	≤20 ≥71	≤18 ≥61	≤14 ≥51	≤12 ≥41	≤10 ≥31

GCS / Modified Paediatric Coma Scale

Adult / Child according to usual ability	Child / Infant according to usual ability
Eye Opening	**Eye Opening**
E4 Spontaneous **E3** To verbal stimuli **E2** To painful stimuli **E1** None to painful stimuli **C** Eyes closed by swelling / bandag	As for older child
Verbal	**Verbal**
V5 Orientated *(person, place)* **V4** Confused **V3** Inappropriate words **V2** Inappropriate sounds **V1** None	**V5** Alert, babbles, coos, words, to usual ability **V4** Less than usual ability / spontaneous irritable cry **V3** Cries inappropriately **V2** Occasionally whimpers or moans **V1** None
Grimace (use in children if no verbal response)	**Grimace (use in children if no verbal response)**
G5 Spontaneous normal facial / oro-motor activity **G4** Less than usual spontaneous ability or responds to touch **G3** Vigouous grimace to pain **G2** Mild grimace to pain **G1** No response to pain **NA** Not applicable	As for older children
Motor	**Motor**
M6 Obeys commands **M5** Localise to painful stimuli **M4** Withdraws to painful stimuli **M3** Abnormal flexion to pain *(decorticate)* **M2** Abnormal extension to pain *(decerebrate)* **M1** No response to pain **NA** Not applicable	**M6** Or normal spontaneous movement **M5** Or withdraws to touch **M4** As for older children As above As above As above As above
Pupils:	
Size	**Reaction**
P Pinpoint **S** Small **M** Moderate **D** Dilated	**B** Brisk **S** Sluggish **F** Fixed **C** Unable to test
Motor Strength	**Pain Score**
5 Normal against resistance **4** Weak against resistance **3** MVT against gravity **2** MVT against resistance **1** Flicker of movement	**0** No pain **1** Little pain **2** Some pain **3** A lot of pain **4** Worst pain ever **3** A lot of pain