Royal Cornwall Hospitals
NHS Trust

Recording Physiological Observations and NEWS2 in Adults Clinical Policy

V7.0

November 2025

Summary

The undertaking of recording and monitoring adult physiological vital signs is a guide to quickly determine the degree of illness in patients.

NEWS2 supersedes NEWS providing an updated system to standardise the assessment and response to acute illness.

The key revisions are:-

1. Aligning the physiological parameters with the Resuscitation Council ABCDE sequence.

2. The ranges for the boundaries of each parameter score are now shown on the chart.

3. A dedicated section (SpO2 Scale 2) for use in patients with hypercapnic respiratory failure.

4. The section of the chart for recording the rate of (L/min) and method/device for supplemental oxygen delivery has been improved.

5. The importance of considering serious sepsis in patients with known or suspected infection, or at risk of infection, is emphasised. A NEW score of 5 or more is the key trigger threshold for urgent clinical review and action.

6. The addition of ‘new confusion’ (which includes disorientation, delirium or any new alteration to mentation) to the AVPU score, which becomes ACVPU (where C represents confusion).

7. The chart has a new colour scheme, reflecting the fact that the original red–amber–green colours were not ideal for staff with red/green colour blindness.

This document outlines the process for monitoring, recording and escalation of observations in adults at Royal Cornwall NHS Trust.

Action	Accountability
Standardised approach to assessing and documenting patient physiological observations using NEWS2.	All staff
All observations for inpatients will be recorded using the nerve centre system with the exception of Theatre and critical care.	Nursing staff
Minimum observations for all inpatients will be 4 hourly for the first 24hrs of admission and following step down from higher level care, and minimum 12 hourly there after unless dictated by NEWS2 or medical plan.	Nursing and medical staff
All medical staff to be logged onto eObs at the start of their shift. New devices and mandating of device use expected with introduction of eCare (June 2026).	Senior clinicians
Nursing staff to be logged on appropriately.	Ward managers
All clinical staff can access appropriate monitoring equipment including manual sphygmomanometers and stethoscopes.	Senior managers / Matrons / Ward managers
Staff must consistently monitor the renal function of the patient when carrying out physiological observations and adhere to the RCHT Fluid Balance Guidelines.	Nursing staff
In addition to level of consciousness new onset of confusion will be assessed and scored.	Nursing staff
A score of 3 in a single parameter will escalate to the RN and a decision made to escalate to the medical team.	Nursing staff
The chart has a dedicated section SP02 scale for use in patients with Hypercapnic respiratory failure who have clinically recommended oxygen saturations of 88-92%.	All staff
A new score of 5 or more is the key trigger threshold for urgent clinical review and action.	All staff

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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1. Introduction

1.1. The principal aim of the National early warning score (NEWS2) was to standardise clinical monitoring and embed it into the routine culture of the NHS – to trigger an appropriate clinical response, in time, person and place.

1.2. NEWS2 is the updated version by the Royal College of Physicians to provide a common tool standardising the approach, to eliminate confusion by variations in practice leading to compromised patient safety. In addition, to continue to improve the safety and outcomes for patients with acute illness, there has been recent national and international focus on the need to improve the detection and treatment of sepsis. The NEWS2 is a standardised physiological assessment tool, designed to monitor and track acutely and critically ill patients, which enforces the necessity of early escalation and clinical review.

1.3. The NEWS2 is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital.

1.4. Six simple physiological parameters form the basis of the NEWS2 scoring system: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness or new onset of confusion. The patient has new-onset confusion, disorientation and/or agitation, where previously their mental state was normal – this may be subtle. The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation.

1.5. A score is allocated to each as they are measured, the magnitude of the score reflecting how extreme the parameter varies from the norm.

1.6. The score is then aggregated. The score is uplifted for people requiring oxygen. (RCP 2017).

This policy states the minimum standards required from clinical staff that undertake, record and monitor adult patient physiological vital signs. Patients admitted to the Royal Cornwall Hospitals NHS Trust (RCHT) will feel confident that if they are acutely unwell or their condition deteriorates, they are in the best place to receive prompt, effective and safe care.

1.7. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. This policy enables the Royal Cornwall Hospital (RCHT) to adhere to the Royal College of Physicians National Early Warning Score (NEWS2) standardising the assessment of acute illness severity in the NHS (2017)and NICE guidance NG51 ‘Sepsis recognition’, diagnosisand early management Sept 2017.

2.2. The Royal College of Physicians (2017) principle for standardisation encourages; a single system for early detection of acute illness, determines illness severity to support consistent clinical decision making and response, standardisation of training, standardisation of scoring system throughout the hospital not solely in the context of acute clinical deterioration but also for continuous monitoring of all patients.

2.3. This policy aims to outline the scoring system, thresholds and triggers for escalation of care for all adults over 16yrs excluding maternity and paediatric patients, which have their own dedicated track and trigger systems.

2.4. Practitioners are also directed to additional standards and parameters that may apply in addition to routine monitoring in specific clinical circumstances. Frequency of observations may differ in some patients. All locally agreed guidelines must be followed in these instances.

For example:

- Patients on transfusions of blood products.
- Patients with any type of analgesia infusions.
- Patients during the first 24 hours post-operatively.
- Patients on drug infusions requiring specific observations.
- Patients nursed in Theatres.
- Patients nursed in level 2/3 (High Dependency/Critical Care) bed.
- Maternity. From 20 weeks gestation patients nursed in a general ward MUST be monitored using a MEOWS chart. Paper chart available from Maternity.
- Paediatrics.

3. Scope

3.1. This policy applies to all clinical staff regardless of grade or profession who undertake patient assessments, record, interpret and monitor patient physiological vital signs for inpatients admitted and cared for in their clinical area.

3.2. This includes permanent, temporary, locum and bank health care staff working in clinical areas.

4. Definitions / Glossary

- DNAR – Do Not Attempt Cardiopulmonary Resuscitation order.
- RDR – Resuscitation Decision Record.
- TEP - Treatment Escalation Plan.

- Track and Trigger – A scoring system designed to efficiently identify and initiate.
- FI02: Fraction of inspired oxygen.
- GCS: Glasgow coma score.
- ACVPU: Level of responsiveness Alert, new onset Confusion, responds to Voice.
- Nerve centre / eObs / eObservations – is the: primary electronic tool to capture observations.
- ESR: Electronic Staff record.

5. Ownership and responsibilities

5.1. Role of the Nominated Director

The nominated Director is responsible for authorising final approval of the policy.

5.2. Role of the managers

- Senior Clinical staff have overall clinical responsibility for patients. The Consultant will supervise medical staff in training to ensure that all patients have a documented medical management plan including frequency of Observations.
- The Consultant will be responsible for setting goals and acceptable parameters to guide other clinical staff in their role of monitoring, interpreting and acting upon abnormal parameters.
- Matrons and Sisters/Charge Nurses are responsible for ensuring this policy is disseminated to clinical staff in their areas of responsibility. They must ensure that adverse clinical incidents in relation to physiological monitoring in their clinical areas are reported and investigated and action plans produced to prevent further occurrence.
- Matrons and Sisters/Charge Nurses have a responsibility to ensure that any staff responsible for taking, recording and monitoring observations are competent and provide adequate training to ensure that staff can recognise the signs of the deteriorating patient and escalate accordingly.
- Matrons and Sisters/Charge Nurses have a responsibility to ensure that all clinical staff can access to appropriate monitoring equipment including manual sphygmomanometers and stethoscopes.
- Sisters/Charge Nurses must ensure all their staff are logged into Nervecentre appropriately.
- Sisters/Charge Nurses must ensure shared mobile devices are adequately curated in clinical area including ensuring they are signed in and out every shift, kept adequately charged and any defects with devices immediately reported to the CITS Service Desk.

- Sisters/Charge Nurses following reports from the monthly reports from the e-Health team are responsible for monitoring their staff's usage of the system to ensure that it is being used appropriate and address any training and competency issues that are identified.

- Senior Clinicians must ensure all doctors are logged into Nervecentre appropriately from the start of their shift.

5.3. Role of Individual Staff

All staff members involved in obtaining, monitoring, recording, interpreting or acting on adult physiological observations have a personal and professional responsibility to ensure:

- They are competent, within their scope of professional practice, to accurately undertake physiological vital signs in accordance with this policy.

- They document all physiological signs and frequency of vital signs in a manner that complies with the policy.

- Doctors, registered nurses and other health care staff looking after inpatients in areas where Nervecentre is deployed must carry a mobile device and be logged in for the entirety of their shift with the correct patient cohort selected. The device must also be recorded as in their possession via the mobile device sign in/out sheet.

- They are competent to interpret vital signs and must acknowledge any limitations in their knowledge and competence and seek further training as appropriate.

- They report physiological abnormalities or concerns to a more senior member of the team where appropriate. This should be using the escalation function within Nervecentre except in certain circumstances (see section 6.1 below).

- They are competent in the use of all equipment necessary for the taking and recording of adult physiological observations, including manual sphygmomanometers and take appropriate actions where faulty equipment is identified.

- They are knowledgeable in the use of NEWS2 and of the actions needed by the range of scores generated.

- They report any untoward incident that occurs by not adhering to this policy by informing their line manager and reporting the incident using the Trust risk management system (Datix).

6. Standards and Practice

6.1. Nerve centre

6.1.1. Nervecentre is an electronic system and the Trust's primary tool for the capture of observations, NEWS2 calculation and automated escalation of deteriorating patients.

6.1.2. All observations for adult inpatients (with the exception of in theatre and critical care) must be recorded using the Nervecentre system.

6.2. Simple Observation Capture

Every effort has been made to ensure the entry of observations is as simple as possible, whilst preventing entry of invalid data. Observations can only be entered on the mobile devices, but data is viewable on the mobile devices and PCs.

6.3. Immediate Alerts

6.3.1. Observation values that require immediate attention, such as very low oxygen saturations, will be highlighted and an advice message will be displayed.

6.3.2. Due and Overdue Reminders.

6.3.3. Observation frequency is automatically set based upon NEWS2 value, with notifications to nursing and healthcare staff of due and overdue observations.

6.4. Cascading Escalations

6.4.1. Registered Nurses must ensure that they contact responsible medical team via phone or bleep as it is not guaranteed a clinician will be logged in to review Nervecentre escalations. The system will cascade intelligently to ensure the quickest and most appropriate response, day or night. For this to work effectively, staff must always ensure they have a charged, signed-for device in their possession with the correct cohort of patients selected.

6.4.2. Escalation of a deteriorating patient should be completed through the escalation screens within Nervecentre, except in the following cases:

- Escalation of patients is not required through Nervecentre when appropriate staffs are either with the patient or on the ward providing they are informed of the deterioration verbally. Staff can select "team is present" within Nervecentre.

- If there is a clearly documented plan in the notes that indicates escalation is not required, "plan in place" can be selected,

- If the patient's NEWS2 has decreased "patient improving" can be selected.

6.5. Observation Frequency

6.5.1. The frequency of observations is set to increase or decrease in conjunction with the NEWS2. This however can and should be overridden in patients newly admitted, at risk of deterioration and patients recently discharged from the Critical Care Unit.

6.5.2. All adult patients attended/admitted into the Royal Cornwall Hospitals NHS Trust including patients in Emergency Department and Outpatients* will have physiological observations recorded at the time of their arrival/admission both on Nervecentre eObs and Oceano. *Outpatients will only require Observations to be recorded via Nervecentre once a decision to admit has been made.

6.5.3. Transferring patients between clinical areas or hospitals carries increased risk. Patients should have a full set of observations recorded within 15 minutes of arrival to a new clinical area. Safe Transfer of Patients Between Care Areas Or Hospitals Policy

6.6. The score should be determined from seven parameters (six physiological plus one weighting score for supplemental oxygen): Six physiological parameters routinely recorded:

1. Respiratory rate.
2. Oxygen saturations.
3. Temperature.
4. Systolic blood pressure.
5. Pulse rate.
6. Level of consciousness or new confusion.

6.7. In addition, a weighting score of 2 should be added for any patient requiring supplemental oxygen by whatever delivery system as patients requiring supplemental oxygen are at greater clinical risk of deterioration.

6.8. Staff must consistently monitor the renal function of the patient when carrying out physiological observations and adhere to the Fluid Balance for Adult Inpatients Clinical Guideline 2023 for supporting optimal hydration in adults during their hospital stay. Fluid balance charts can be added if close monitoring is required, and the decision documented in the medical and nursing notes.

6.9. In specific clinical circumstances additional monitoring must be considered and the decision documented clearly within the medical notes. For example:

- Blood Sugar.
- Pain assessment.
- Neurological Observation Chart (Glasgow Coma Score).

- Observations must be carried out by an appropriately trained health care professional.

6.10. A clear monitoring and management plan must be completed by the admitting or reviewing practitioner. Whilst observation frequency is automatically generated by EOBS, decision of frequency is to be based upon the individual patient and their clinical need. This is to be documented in both medical and nursing notes.

6.11. All adult patients admitted to RCHT deemed medically fit or in a rehabilitation environment must have observations undertaken 12 hourly as a minimum standard unless a decision is made at a senior level to increase or decrease this frequency for an individual patient / group of patients. Any alteration to the minimum standard must be documented clearly and recorded in patient medical notes. If this is the case, observations can be "skipped" in Nervecentre and "monitoring plan agreed in notes" selected.

6.12. Other minimum standards include all adult patients admitted via Emergency Department, who must have their full set of observations recorded a minimum of 4 hourly for the first 24 hours of admission unless specified otherwise by senior staff, and patients discharged from a higher level of care e.g. Critical Care to have their observations recorded a minimum of 4 hourly and a strict fluid balance monitoring for the first 48 hours on a General Ward. (NICE 2007).

6.13. Concern about a patient's clinical condition should always override the NEWS2 if the attending healthcare professional considers it necessary to escalate care.

6.14. If a patient refuses to allow clinical observations to be taken, registered nurses should record the reason why, and update whether they are clinically concerned or not in Nervecentre. If there is clinical concern the patient should be escalated using normal channels of communication.

6.15. Exceptions to minimum standards must be considered at an early stage and established for patients who are acutely ill but will not benefit from an escalation of therapy beyond ward-based care, any decisions must be clearly documented in the medical notes. If a decision has been made that therapy will not be escalated beyond ward-based care and even with maximum medical management, the patient continues to deteriorate then a decision must be made:

- On the patient's Resuscitation status.

- Commence the RCHT End of Life Care Plan: End of Life Care Plan and Symptom Assessment Chart Clinical Guideline

6.16. "Ward based care" and "End of life care" charts can be set by medical staff in Nervecentre for these patients as appropriate.

6.17. Please refer to the appropriate Trust Policies for the above.

Score	Frequency of Monitoring	Clinical Response
Score 0 (post admission 24 hours)	Minimum of 12 hours	• Continue routine NEWS2 monitoring with every set of observations.
Low Score 1-4	Minimum of 4-6 hourly	• Inform registered nurse who must assess the patient and decide if increased frequency of monitoring and / or escalation of clinical care is required.
3 in a single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for patient who will review and decide if escalation of care is necessary.
Medium Score 5 or more Urgent response threshold	Minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient. • Urgent assessment by a clinician with core competencies to assess acutely ill patients clinical care in an environment with monitoring facilities.
High Score 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 level. • Assessment by senior parenting team, followed by, escalation to critical care if appropriate. • Critical Care Outreach Team notified. Offering assistance with patient deterioration or additional clinical skills if required.

6.18. When a patient begins to trigger on NEWS2 the escalation process must be followed as indicated in the table above and as per section 5.2 except in the following cases – the team is present, there is a documented plan in the notes, or the patient is improving. These options are available within Nervecentre to select when choosing not to escalate the patient (“Team Present”, “Plan in Place” and “Patient Improving”).

6.19. In the event of a server issue, a printed observation chart with the summary of above actions is available.

6.20. All entries on the Nervecentre eObservations system will:

- Specify the actual time the observations were undertaken (via a date and time stamp).
- Be initialled by the person carrying out the observations (via a username stamp).
- For NEWS2 above 3, entries made by Health care support workers (HCSW) and student nurses will require authorisation to prior to submission by a registered nurse, who must also choose the escalation path as required.
- Include the respiratory rate counted over one minute.
- Include the target oxygen saturation.
- Include the actual oxygen saturation.
- The FIO2 if the patient is on supplemental oxygen.

6.21.1. Supplemental oxygen should be prescribed to achieve a target saturation of 94-98% for most acutely unwell patients or 88-92% for those at risk of hypercapnic respiratory failure. Refer to Prescription, Administration and Monitoring of Oxygen in Adults Policy Prescription, Administration and Monitoring of Oxygen in Adults Policy

6.21.2. A manual pulse should be taken over one minute to assess the characteristics of the rhythm.

6.21.3. Include the systemic blood pressure. In cases of hypotension (90mmHg and below) or where the heart rate is irregular, electronic devises will be inaccurate and a manual blood pressure using a sphygmomanometer must be carried out. Manual sphygmomanometers are available to all areas and staff should be competent to use them.

6.21.4. Include temperature. Method of temperature recording will be assumed to be tympanic unless stated.

6.21.5. Include level of consciousness using the ACVPU score.

6.21.6. The patient has new onset of confusion, disorientation and/or agitation, where previously their mental state was normal – this may be subtle. The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation. This would score 3 or 4 on the GCS (rather than the normal 5 for verbal response), and scores 3 on the NEWS2 system.

6.21.7. Patient scoring a V, P or U on NEWS2 must be given medical help immediately as their airway may be at risk.

6.21.8. All patients who are asleep must be woken to establish their neurological status. On waking, if the patient responds appropriately and normally, they are then deemed alert and will score 0.

6.21.9. A Trust neurological observation chart (Glasgow Coma Score/GCS) must be commenced for patients scoring a V, P or U.

6.21. If neurological observations are required, the RCHT Adult neurological observation chart must be used and can be accessed in the additional charts section of the eObs app.

6.22. All patients who have sustained a head injury before or during admission to RCHT must also have neurological observations commenced unless a decision had been made by a senior Medical Practitioner that this is not required. If Neurological Observations are required, these must be carried out by a Registered Nurse or Medical Doctor.

6.23. Decision on the frequency of neurological observations will be decided by the Medical Practitioner in conjunction with the Registered Nurse. The NICE guidelines Head injury: assessment and early management | Guidance | NICE 2014 (CG176) recommend:

- Perform and record observations on a half hourly basis until GCS = 15.
- When GCS = 15, minimum frequency of observations is:
  - Half hourly for 2 hours.
  - One hourly for 4 hours.
  - Then 2 hourly thereafter.

6.24. Any deviation from this minimum standard must be documented in the medical management plan.

- Patients with a GCS 13 or below must be scored 5 and immediate escalation action taken as per NEWS2.
- Patients with a GCS 12 or below must be scored at 7 and immediate escalation action taken as per NEWS2.

6.25. In certain clinical conditions a patient's normal physiological parameters could trigger inappropriately on NEWS2, indicating an unnecessary increase in the frequency of observations. In these cases, a variance to the minimum standard should be authorised and agreed between the medic and registered nurse in charge of the ward / unit. This frequency and the rationale must be documented in the patient medical notes. This will guide staff taking and recording observations in these particular patients when to increase or decrease the frequency of observations and when to escalate their care. The variance for the adult NEWS2 can be found in the set special circumstances area of the e-Obs app.

6.26. Fluid Balance Charts must be completed for the following patients unless a decision has been made otherwise by a Medical Practitioner or a Registered Nurse.

The variance must be documented in the patient's medical notes or nursing notes.

- Scoring 4 or more on the NEWS2.
- Patients discharged from Critical Care Unit (for a minimum of 48 hours post transfer).
- Individuals who are nil by mouth for more than 12 hours.
- Individuals with diarrhoea and / or excessive vomiting.
- Post-operative patients as part of routine post-surgery patient management.
- Patients with potential for any excessive fluid loss such as from surgical /cavity drains, free drainage NG, wounds, VAC therapy.
- Individuals on intravenous fluids/drugs, enteral feeding i.e. NG, NJ, PEG, PEG-J, RIG.
- Individuals on a restricted fluid intake, with known or suspected renal impairment or cardiac conditions i.e. electrolyte imbalance, or upward trending urea and creatinine etc.
- Patients with urinary catheters, except for those patients with long term catheters who do not have an acute onset of illness.
- All sickle cell disease patients should have a carefully maintained Fluid Balance Chart for the duration of their admission (NCEPOD, 2008).
- Patients who are not catheterised and it is documented on the observation chart that they have not passed urine within 12 hours.

6.27. This is not an exhaustive list and there may be other indications for starting a Fluid Balance Chart such as:

- Patients with a temperature greater than 38º Centigrade.
- Patients with sepsis.

6.28. Completion of the Fluid Balance Chart must follow the standard outlined in the RCHT Fluid Balance Guidelines.

6.29. It must be emphasised that the NEWS2 system may not trigger a score in some patients who are acutely unwell. It is vital that clinical staff use their clinical judgment in deciding the frequency of observations recorded especially when there is any clinical concern that the patient is becoming unwell. If a patient is causing clinical concern at any time, then follow the procedures for patients scoring 5 or more. If there is a delay in specialist team response or worsening deterioration, bleep CCOT directly. If family have concerns about a noticeable change or deterioration in condition, to follow call 4 concern pathway (c4c). www.rcht2059callforconcern.pdf

6.30. A Medical Doctor must urgently assess and review patients who score 5 or more. If the patient scores 7 or more immediate assessment by a Medical Doctor who is at least Specialist level should take place.

6.31. Patients scoring 3 in any parameter on the NEWS2 Tool is at risk of rapid deterioration. The healthcare practitioner undertaking the patient's physiological observations must immediately alert the registered nurse in charge who is responsible for reviewing the patient and initiating referral for urgent medical assessment.

6.32. If there is any delay in getting a medical review or there is no appropriate medical management plan, Critical Care Outreach should be contacted.

6.33. The medical management plan must be reviewed and refined by the senior doctor if appropriate and consideration must be made whether the patient needs a higher level of care (i.e. transfer to Critical Care).

6.34. Senior members of the medical team may decide that a higher level of care may not be appropriate and not in the patient's best interests. In these cases, a decision should be made on maximum levels of intervention and treatment, frequency of observations and NEWS2 recording. A Treatment Escalation Plan (TEP) form should be completed and discussed with the patient and family. This may involve implementing a DNAR and staff should be guided by the RCHT Treatment Escalation Planand Resuscitation Decision Record policy Treatment Escalation Plan and Resuscitation Decision Record / Allow Natural Death Policy (In relation to adult patients over 18 years)

6.35. Please note that a DNAR order does not mean that full medical management stops.

6.36. It should only be considered where instituting cardiopulmonary resuscitation would be futile or not in the best interests of the patient. The TEP should identify an appropriate ceiling of care which may be for full escalation.

7. Dissemination and Implementation

7.1. This document will be implemented and disseminated through the organisation immediately following ratification and will be published on the organisations Intranet site (document library). This document replaces previous versions.

7.2. Dissemination will include staff notification via daily bulletin and posters. Heads of Nursing and Clinical Matrons will be informed of document ratification at the weekly Senior Leadership Team meeting. and will be responsible for communicating / notifying staff working in their areas of responsibility. A robust competency framework for recording patient observations and NEWS2 is available through the Learning and Development Department.

7.3. Access to this document is open to all staff.

7.4. For non-registered and registered staff, implementation of the policy contents will be delivered by the Learning and Development Department and is available by application.

7.5. All health care support workers will be required to complete the Trust competency framework for recording patient observations and NEWS2. A period of supervised practice and completion of the workbook must be achieved prior to undertaking patient observations and NEWS2 independently. A record of competence will be maintained on the electronic staff records.

7.6. The nurse in charge of the clinical area must ensure that non-registered staff (including bank staff) hold the appropriate competency outlined above before delegating the task. This includes recognition and verbalisation of deterioration, alongside gaining the authorisation of observations to allow submission, by the accountable registered staff member.

8. Monitoring compliance and effectiveness

Monitoring will include the use of incidents, complaints and patient safety reviews as a resource for monitoring practice. Actions identified from root-cause analysis will determine whether speciality, care group or corporate learning needs to be shared, and changes implemented.

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	All adult patients admitted to RCHT to have clinical monitoring via the Trust's NEWS2 tool either via Nervecentre or paper-based charts. Compliance with the electronic version of NEWS2 will be monitored via the eHealth Team and exceptions reported as necessary against the following criteria: • All entries completed as per policy content. • Frequency of Observations. • Response to escalations. Where the paper version of NEWS2 is used the elements to be monitored will include: • Patient observations are recorded clearly and in graph form. • All entries completed as per policy content. • Patient Identification. • Frequency of Observations. • NEWS2 score is totalled correctly (based on all required entries) and initialled. • Response to escalations**.**
Lead	Sisters/Charge Nurses. Deteriorating Patient Operational Group (DPOG). Mortality Review Outcome Group.

Information Category	Detail of process and methodology for monitoring compliance
Tool	Nervecentre – electronic version of NEWS2 audits. Quanta audit for paper-based version. Thematic review of incidents via DPOG. Case note review completed by Mortality Review Group.
Frequency	eHealth Team to report on a six-weekly basis to the attendees at DPOG compliance with NEWS2 and Nervecentre. Mortality Review Group to identify any deficiencies in clinical practice and submit an incident to initiate an initial incident report if required.
Reporting arrangements	Non-compliance with NEWS2 and Nervecentre to be escalated via either medical or nursing hierarchy. Quanta exceptions are reported to the HON by the Clinical Matron. The Mortality Review Outcome Group report its findings through the Care Groups Governance systems on a six-monthly basis. Report shared with Deteriorating Patient and Oversight Group (Six Weekly).
Acting on recommendations and Lead(s)	The Care Group Governance systems are responsible for interrogating required actions and to designate a named lead where appropriate. This is documented in meeting minutes.
Change in practice and lessons to be shared	Designated Leads will forward, where appropriate, the lessons to be shared with all the relevant stakeholders.

9. Updating and Review

9.1. This document will be reviewed every three years unless best practice dictates otherwise. The author remains responsible for the policy document review. Should they no longer work in the organisation or in the relevant practice area then an appropriate practitioner will be nominated to undertake the document review by Care Group governance lead following discussion at the Care Group governance meeting.

9.2. Revision activity will be recorded in the Versions Control Table to ensure robust document control measures are maintained.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Recording Physiological Observations and NEWS2 in Adults Clinical Policy V7.0
This document replaces (exact title of previous version):	Recording Physiological Observations and NEWS2 in Adults Clinical Policy V6.0
Date Issued/Approved:	September 2025
Date Valid From:	November 2025
Date Valid To:	November 2028
Directorate / Department responsible (author/owner):	Jon Davies, Sophie Medlyn, Fay Mills (Senior Nurse Practitioners Critical Care Outreach Team). Care Group - Anaesthetics, Critical care and Theatres.
Contact details:	01872 252469
Brief summary of contents:	This policy states the minimum standards required from clinical staff that undertake, record and monitor adult patient physiological vital signs and actions to take for escalating care.
Suggested Keywords:	Patient observations; Vital Signs, NEWS, NEWS2, Early Warning Score.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Dual Chief Nursing Officer / Deputy CEO RCHT
Approval route for consultation and ratification:	Deteriorating Patient and Oversight Group
General Manager confirming approval processes:	Lisa Niemand Head of Nursing ACCT
Name of Governance Lead confirming approval by specialty and care group management meetings:	Suzanne Barber Interim
Links to key external standards:	None

Related Documents:	http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CorporateClinical/TreatmentEscalationPlanAndResuscitationDecisionRecordPolicy.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Forms/FormsToPrint/Specialty/CriticalCareAndResuscitation/CHA2311TEPAdults.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CorporateClinical/SafeTransferOfPatientsBetweenCareAreasOrHospitalsPolicy.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Forms/FormsToPrint/Specialty/NeurologyAndStroke/CHA38NeurologicalObservationsChart.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CorporateClinical/SepsisInAdultPatientsClinicalGuideline.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CriticalCareAndResuscitation/CardiopulmonaryResuscitationPolicy.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/MidwiferyAndObstetrics/SepsisManagementOfMaternalSepsisClinicalGuideline.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Respiratory/PrescriptionAdministrationAndMonitoringOfOxygenInAdultsPolicy.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Dietetics/FluidBalanceForAdultInpatientsClinicalGuideline.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Corporate

Information Category	Detailed Information
	Clinical/FallsPreventionAssessmentAndEffectiveManagementPolicyForTheInpatientSetting.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/CriticalCareAndResuscitation/CriticalCareOutreachServiceOperationalPolicy.pdf http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Haematology/CareOfSickleCellAnaemiaPatientsFastFactsAppendix6MobileGuidelineSummary.pdf
Related Documents:	The Fifth Report from the Patient Safety Observatory: safer Care for the Acutely Ill Patient: learning from serious incidents. PSO/05. NPSA. Nov. 2007. London Patient Safety First campaign (2008) – The "how to guide" for reducing harm from deterioration. Royal College of Physicians (2012) National Early Warning Score (NEWS) Standardising the assessment of acute illness severity in the NHS. NHS Improvement (2016) The adult patient who is deteriorating: sharing literature, incident reports and root cause analysis investigations. London Royal College of Physicians December 2017. National early warning score 2 (NEWS 2) Standardising the assessment of acute illness severity in the NHS. NICE guidance sepsis, recognition, diagnosis and early management (Sept 2017). https://www.nice.org.uk/guidance/ng51
Training Need Identified?	Yes – NEWS2 eLearning update available on the ESR. Learning and Development. Team to administrate and record evidence of training.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Critical Care and Resuscitation

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
1 March 2007	V1.0	New Document	Sandra Arnold, Practice Development
1 August 2008	V2.0	Revised MEWS chart – document changed to reflect observation chart changes	Amanda Thompson, Clinical Practice Educator
11 May 2011	V3.0	Document changes to incorporate minimum standards for patient observations within the MEWS policy and escalation. Reformat as per RCHT template.	Sandra Arnold, Matron for Practice Development
23 May 2011	V3.1	Reformatted to comply with Policy on Policies.	Peter Johnson, Critical Care
13 March 2013	V4	Reformatted to incorporate NEWS.	Amanda Thompson, Learning and Development. Peter Johnson, Critical Care.
9 July 2013	V4.1	Page 5, para 6.3 – supplemental oxygen weighting. Page 6, para 6.8 – over-riding NEWS score Page 8, para 6.13 – Assessing AVPU for sleeping patients. Page 10, para 7.4 – NLMS course	Amanda Thompson, Learning and Development. Peter Johnson, Critical Care.
Not known	V4.2 and V4.3	Updated. References added	Claire Blake, Clinical Matron Critical Care and Outreach.
Not known	V4.4	Section 5 - Nervecentre. Other pages – added in additional information for when using Nervecentre.	Tamzin Elford, eHealth Nurse Specialist. Frazer Underwood, Associate Director of Nursing. Ian Nicholls, eHealth Transformation Manager.

Date	Version Number	Summary of Changes	Changes Made by
19 March 2019	V5	Updated with NEWS2	Louise Pratley, Senior Nurse Practitioner Critical Care Outreach
28 April 2020	V5.1	Updated 6.5.2 to reflect ED use eObs	Claire Blake, Head of Nursing, ACCT
1 March 2022	V6.0	Updated 6.5.3, 6.9 and Appendix 1	Lynne Donohue and Louise Pratley, Senior Nurse Practitioners Critical Care Outreach Team
October 2025	V7.0	Updated 2.4 5.2, 6.4.1, 6.10, 6.15, 6.18,6.20,6.27,6.28,6.30,7.4,7.6. Appendix 1. Removed: 4 (CCU – critical care unit).	Fay Mills, Jon Davies and Sophie Medlyn, Senior Nurse Practitioners Critical Care Outreach Team

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

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Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Recording Physiological Observations and NEWS2 in Adults Clinical Policy V7.0
Directorate and service area:	Critical Care and Resuscitation, ACCT
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Fay Mills, Sophie Medlyn and Jonathan Davies Senior Nurse Practitioners, Critical Care Outreach team
Contact details:	01872 252469

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To set the standards required for the recording, documentation and monitoring of patients physiological vital signs (including NEWS2 scoring) in the hospital setting.
2. Policy Objectives	To assist staff in the early detection of clinical deterioration. To facilitate the appropriate and timely management of clinical deterioration and to reduce clinical risk associated with inconsistent, inappropriate clinical vital signs monitoring.
3. Policy Intended Outcomes	To increase the early identification and early treatment of signs of sepsis in patients who suffer deterioration in clinical condition whilst in hospital care.
4. How will you measure each outcome?	Confidence in Caring Metrics. Mortality Review Case Notes. Complaints, Datix incidents, Patient safety reviews Incidents.
5. Who is intended to benefit from the policy?	All users.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	Workforce: Yes Patients/ visitors: No Local groups/ system partners: No External organisations: No Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Nursing, Midwifery and Allied Health Professionals Nursing Forum. Quality and Patient Safety Improvement Programme Leads. Learning and Development Department.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Fay Mills, Sophie Medlyn and Jonathan Davies, Senior Nurse Practitioners Critical Care Outreach Team.

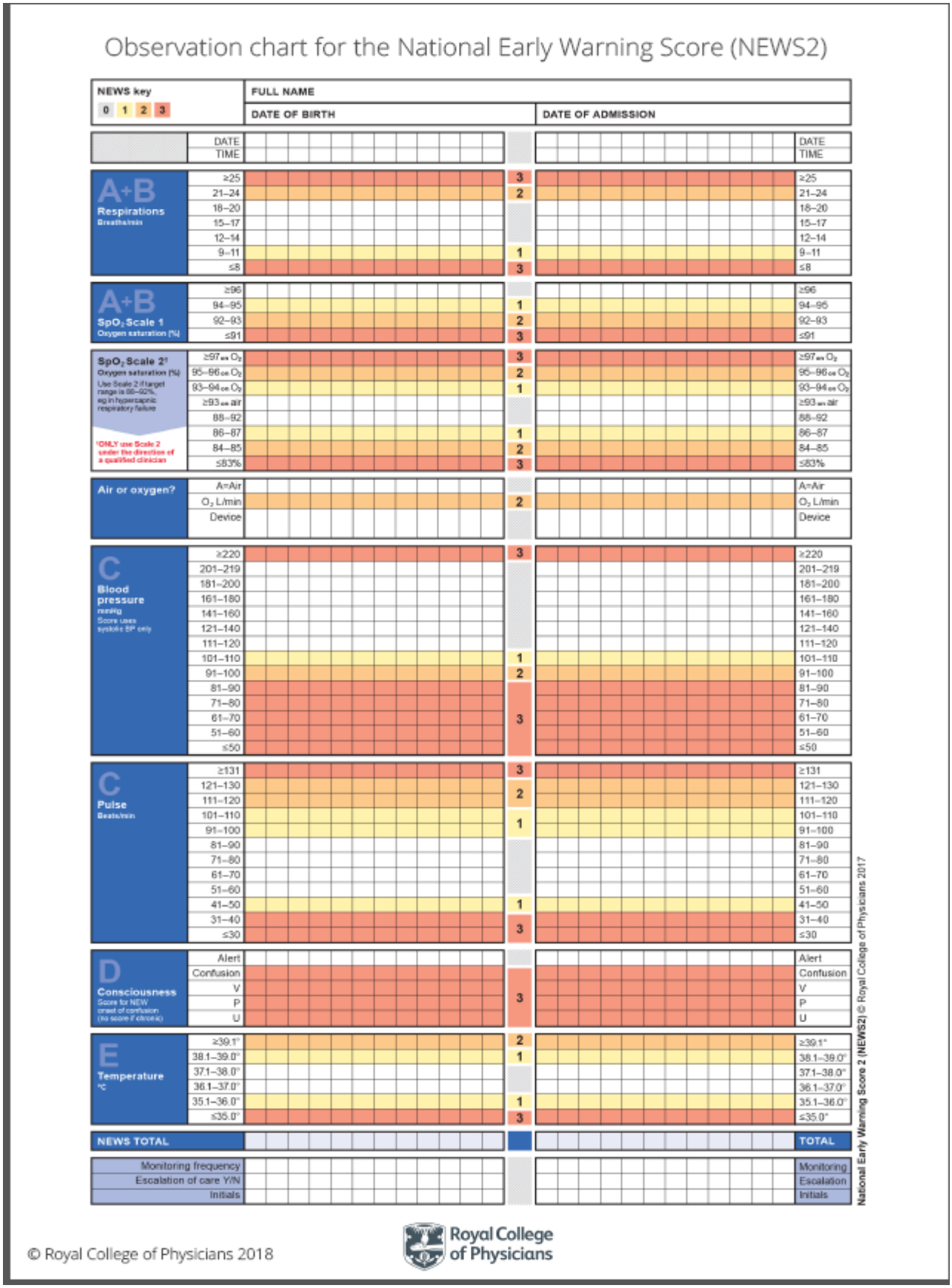
If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Clinical Response to the NEWS2 Trigger Thresholds

Chart 4: Clinical response to the NEWS trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS 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 single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
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, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

Appendix 4. Observation Chart for the National Early Warning Score(NEWS22)



Observation chart for the National Early Warning Score (NEWS2)

NEWS key 0 1 2 3	FULL NAME		DATE OF ADMISSION	
	DATE OF BIRTH			
	DATE TIME			DATE TIME
A+B Respirations Breaths/min	≥25	3		≥25
	21–24	2		21–24
	18–20			18–20
	15–17			15–17
	12–14			12–14
	9–11	1		9–11
	≤8	3		≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96			≥96
	94–95	1		94–95
	92–93	2		92–93
	≤91	3		≤91
SpO_2 Scale 2† Oxygen 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		≥97% on O_2
	95–96% on O_2	2		95–96% on O_2
	93–94% on O_2	1		93–94% on O_2
	≥93% on air			≥93% on air
	88–92			88–92
	86–87	1		86–87
	84–85	2		84–85
	≤83%	3		≤83%
Air or oxygen?	A=Air			A=Air
	O_2 L/min	2		O_2 L/min
	Device			Device
C Blood pressure mmHg Score uses systolic BP only	≥220	3		≥220
	201–219			201–219
	181–200			181–200
	161–180			161–180
	141–160			141–160
	121–140			121–140
	111–120			111–120
	101–110	1		101–110
	91–100	2		91–100
	81–90	3		81–90
	71–80			71–80
	61–70			61–70
	51–60			51–60
	≤50			≤50
C Pulse Beats/min	≥131	3		≥131
	121–130	2		121–130
	111–120			111–120
	101–110	1		101–110
	91–100			91–100
	81–90			81–90
	71–80			71–80
	61–70			61–70
	51–60			51–60
	41–50	1		41–50
	31–40	3		31–40
	≤30			≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert			Alert
	Confusion	3		Confusion
	V			V
	P			P
	U			U
E Temperature °C	≥39.1°	2		≥39.1°
	38.1–39.0°	1		38.1–39.0°
	37.1–38.0°			37.1–38.0°
	36.1–37.0°			36.1–37.0°
	35.1–36.0°	1		35.1–36.0°
	≤35.0°	3		≤35.0°
NEWS TOTAL				TOTAL
Monitoring frequency				Monitoring
Escalation of care Y/N				Escalation
Initials				Initials

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

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Appendix 5. National Early Warning Score (NEWS2)

National Early Warning Score (NEWS2)

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				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

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Appendix 6. Clinical Response to the NEWS2 trigger Thresholds

Clinical response to the NEWS2 trigger thresholds

NEW score	Frequency of monitoring	Clinical response
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