Neurological Observation Chart

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

				Date / Time
Pupil Scale (mm): 10mm, 9mm, 8mm, 7mm, 6mm, 5mm, 4mm, 3mm, 2mm, 1mm	COMA SCALE	EYES OPEN	4 SPONTANEOUSLY	
			3 TO SPEECH	
			2 TO PAIN	
			1 NONE	
		BEST VERBAL RESPONSE	5 ORIENTATED	
			4 CONFUSED	
			3 INAPPROPRIATE WORDS	
			2 INCOMPREHENSIBLE SOUNDS	
			1 NONE	
		BEST MOTOR RESPONSE	6 OBEY COMMANDS	
			5 LOCALISE TO PAIN	
			4 WITHDRAWS TO PAIN	
			3 FLEXION TO PAIN	
			2 EXTENSION TO PAIN	
			1 NONE	
			COMA SCALE SCORE	
✓ Reacts ✓̸ Sluggish — None	LIMB MOVEMENTS	ARMS	NORMAL POWER	
			MILD WEAKNESS	
			SEVERE WEAKNESS	
			FLEXION	
			EXTENSION	
			NONE	
If limb power differs indicate R = Right L = Left		LEGS	NORMAL POWER	
			MILD WEAKNESS	
			SEVERE WEAKNESS	
			FLEXION	
			EXTENSION	
			NONE	
	PUPILS	R	C = CLOSED SIZE	
			REACTION	
		L	C = CLOSED SIZE	
			REACTION	
			Pain / Sedation 3	
			2	
			Pain as X 1	
			Sedation as O 0	
			Nausea Y = Yes / N = No	
			Mean Arterial Pressure (MAP)	
			Central Venous Pressure (CVP)	
			Intracranial Pressure (ICP)	
			✓when checked: Wound	
			Drain	
			Arterial line	
			Angio/embolism ✓when checked: Stab site	
			Pedal pulse	
			Colour	
			Movement	
			Sensation	
			Registered nurse initials	

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Addressograph

NEWS CHART

Ward / Dept

Score	1	2	3

Date		
Time of Observation		
Frequency of Observations		
Respiratory Rate	≥25	
	21-24	
Accept < ..... / >.....	12-20	
	9-11	
Signed:	≤8	
O2 Saturations	≥96%	
	94-95	
Accept < ..... / >.....	92-93	
Signed:	≤91	
Inspired Oxygen		
Temperature	≥39.1	
	38.1-39	
	36.1-38	
	35.1-36	
	≤35	
Blood Pressure	≥220	
	210-219	
	200-209	
	190-199	
	180-189	
	170-179	
	160-169	
	150-159	
	140-149	
	130-139	
	120-129	
	111-119	
	101-110	
	91-100	
	80-90	
	70-79	
	60-69	
	50-59	
	40-49	
Heart Rate	≥131	
	121-130	
	111-120	
	101-110	
	91-100	
	81-90	
	71-80	
	61-70	
	51-60	
	41-50	
	≤40	
Neuro	Alert	
	Voice	
	Pain	
	Unresponsive	

Note record both systolic and diastolic pressures but use systolic only to score
Note: In atrial fibrillation measure the BP manually

Accept systolic BP of ..... For this patient

Signed:

Accept Heart rate of .....bpm for as normal for this patient

Signed:

Consider Glasgow Coma Score if any Neurological concerns

NEWS total score	
OBS Performed by Initials	
Qualified Nurse Initials	

Cardiff and Vale Resuscitation Service

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

NEWS CHART

	Physiological Parameters	3	2	1	0	1	2	3
A	Respiratory Rate (bpm)	≤ 8		9-11	12-20		21-24	≥ 25
B	O2 Saturations (%)	≤ 91	92-93	94-95	≥ 96			
	Any supplemental Oxygen		YES		NONE			
C	Systolic BP (mmHg)	≤ 90	91-100	101-110	111-219			≥ 220
	Pulse (BPM)	≤ 40		41-50	51-90	91-110	111-130	≥ 131
D	AVPU score				ALERT			VPU
E	Temperature (°C)	≤ 35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥ 39.1	

Concern about a patient should lead to escalation, regardless of the score.

NEWS	MINIMUM MONITORING	ALERT	REVIEW
Score 0-2	12 Hourly	If concerned inform Nurse in Charge (NIC)	
Score 3-5 **3 = THREAT!**	4 Hourly Increase frequency dependant on patient response	Inform Nurse in Charge, then immediately inform designated nurse/doctor	Review in 1 hour. SBAR
Score 6-8 **6 = SICK!**	1 Hourly	Inform Nurse in Charge, then immediately inform most senior designated nurse and doctor	Review within 30 minutes. SBAR
Score 9+ **9= NOW!**	30 mins	Inform Nurse in Charge, then Call Resuscitation Team via 2222	Immediate SBAR

The Nurse in Charge of each shift must ensure that the designated nurse/doctor names and bleep numbers are updated and clearly displayed on a Patient Status at a Glance Board (PSAG).

Frequency of Observations are increased in relation to the patients condition.
If there is any concern, please escalate regardless of the NEWS score.

SEPSIS SCREENING / AWARENESS

Suspect sepsis if 2 of the following criteria are present - go to sepsis tool

- ☐ Temperature <36°C or >38.3°c
- ☐ Pulse >90bpm
- ☐ WCC>12 or <4x10⁹/1
- ☐ Respiratory rate >20/min
- ☐ Acutely altered mental status
- ☐ Hyperglycaemia in the absence of diabetes

START SEPSIS CARE / MONITORING PATHWAY	CONTINUE MONITORING OBSERVATIONS & NEWS REGULARLY AS PLANNED

Cardiff and Vale Resuscitation Service

Neurological observations

Frequency: Refer to individual care plan **and** discuss with medical team **daily** or **each time the patient is reviewed.**

Patient changes requiring review

Any of the following examples of neurological deterioration should prompt urgent review by the supervising doctor:

- Development of agitation or abnormal behaviour.
- A sustained (that is, for at least 30 minutes) drop of 1 point Glasgow Coma Scale (greater weight should be given to a drop of 1 point in the motor response score).
- Any drop of 2 or more points of the Glasgow Coma Scale.
- Development of severe headache or persistent vomiting.
- New or evolving neurological signs or symptoms such as:
  - Pupil inequality / speed of reaction
  - Asymmetry of limb or facial movement
  - Seizures

Special instructions regarding neurological observations

Signed: *Date:*

Pain assessment / observations

Frequency:

- Any patient receiving new IM / SC / Oral opiates must have **BP, P, Resps, Sedation score** and **Pain score** before each administration and 2 hourly thereafter.
- **PCA** – Obs as above, 2 hourly for 48 hours then 4 hourly thereafter if observations within acceptable parameters.
- Sedation score must be recorded if the patients GCS is not being recorded.
- Pain must be assessed and recorded each time the observations are recorded (even if patients are not on opiates).

Pain assessment score

Ask the patient: "Which words best describe the pain you have when you move?"

No pain	0
Mild pain	1
Moderate pain	2
Severe pain	3

Sedation score

If the patient is on opiates but is not having their GCS recorded, a sedation score must be recorded. Look at the patient and decide which of the following apply

Awake	0
Dozing intermittently	1
Mostly sleeping	2
Difficult to waken	3
Normal sleep record as	S

If the patient has a PCA / received opiates and resps <8/min +/- sedation score 2 or more:

- Contact acute pain team or obstetric anaesthetist.
- Administer 15L O2 via reservoir mask.
- Dilute 1ml Naloxone (400mcg) with 3ml Normal Saline (=total 4ml).
- Give 0.5ml (50mcg) increments until patient's resps > 12 and sedation score 0-1.