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**Recognising and Managing the Deteriorating Person Policy**

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| **Situations in this policy may result in death if not treated appropriately. If you are working outside of your scope of practice, seek senior input immediately or call 111/999 depending on the severity of the emergency.****This Policy is to be read in conjunction with the Resuscitation Policy which includes anaphylaxis.**  |

# Introduction

Clinical deteriorationis unpredictable and can occur at any stage of a client’s illness or care process. In 2007 NICE stated that:

*The recognition of acute illness is often delayed, and its subsequent management may be inappropriate. This may result in late referral and avoidable admissions to critical care, and may lead to unnecessary patient deaths, particularly when the initial standard of care is suboptimal.*

Early recognition and implementation of an appropriate treatment plan helps to provide greater continuity of care, enable a client to remain in familiar surroundings, reduce the risk of hospital acquired infections and enhance practitioner’s health assessment skills.

# Policy Statement

[Company Name] recognises that clients at risk of clinical deterioration must be identified before a serious adverse incident occurs. This will be achieved through:

* The systematic and accurate assessment of those in our care who are acutely unwell.
* Timely clinical observations in order to detect when a client’s condition requires additional intervention from an appropriately skilled healthcare professional or staff member.

This policy outlines [Company Name]’s standards for the prevention, recognition and management of the deteriorating client and aims to:

* Reduce the harm associated with an adverse change in an individual’s physical or psychological wellbeing.
* Improve quality outcomes.
* Enhance safety of its clients.
* Provide effective and compassionate person-centred care.

# Scope

This policy and the procedures apply to all staff involved in direct client care.

The Registered Manager is responsible for ensuring that staff follow the procedures laid out in this policy to ensure that all clients in our care, who are acutely ill or at risk of deterioration, are always identified and responded to promptly and appropriately. They are also responsible for ensuring that staff are appropriately trained, supported and competent when assessing an acutely unwell client.

# Definitions

**Clinical Deterioration** - When a person moves from their normal clinical state to a worse clinical state.

**Clinical Assessment -** The processes followed to ensure accurate, holistic assessment of a client’s clinical condition which, used in conjunction with clinical judgement, informs an appropriately devised plan of care.

**Clinical Observations** – Are an essential part of the clinical assessment process. They are also referred to as “Vital Signs” and include blood pressure, heart/pulse, temperature, oxygen saturation level, blood glucose level, neurological observations/level of response (i.e., Glasgow Coma Scale (GCS) or Alert, Voice, Pain and Unresponsive level of consciousness (AVPU) (where appropriate)) and pain.

**Sepsis -** The body’s overwhelming and life-threatening response to infection, which can lead to tissue damage, organ failure and death (Sepsis Alliance 2016).

**Anaphylaxis -** A severe, life-threatening generalised or systemic hypersensitivity reaction. It is characterised by rapidly developing life-threatening airway and/or breathing and/or circulation problems. It may occur without typical skin features or circulatory shock.

**SBAR** **(Situation, Background, Assessment, Recommendation)** - is an easy to remember communication tool that can be used to frame conversations, aiding clarity and providing a systematic approach to communication.

# Emergency Situations

Client safety is paramount and if their condition dictates a need, or the staff member is working outside of their competence, NHS 111/or emergency services 999 will be used immediately. Any client that requires further treatment or monitoring will be referred to the relevant service or healthcare professional.

Staff at [Company Name] will follow evidence-based guidelines in responding to client deterioration. Sources will include The UK Resuscitation Council, NICE and other condition specific, regulatory or professional bodies.

Staff are responsible for working within their scope of practice and for ensuring that they are aware of when a client’s condition should be escalated to a senior colleague. All non-registered care workers are responsible for informing the Registered Nurse in charge of the results of all observations that they have taken in order for them to evaluate and interpret.

# Escalation of Concerns

# Procedures

Early signs of physical “unwellness” can often be recognised intuitively by healthcare workers. In addition, carers without training, but who are familiar with the person’s usual behaviour and habits, can often sense a problem resulting in them reporting that the relative or client in their care “just isn’t themselves”.

Soft sign indicators of clinical deterioration can include:

* breathlessness/chestiness
* changes in usual drinking or dietary habits (e.g., no appetite)
* reduced mobility
* new or increased confusion, agitation, anxiety or pain
* changes to the usual level of alertness/consciousness or sleeping more
* offensive smelling urine, dark/concentrated urine, difficulty passing urine or reduced urine output
* diarrhoea, vomiting or dehydration
* appearing withdrawn
* tiredness or exhaustion
* visual signs of weight loss over a short period of time and abnormal for the client
* changes to skin colour (e.g., skin appearing mottled, red, bluish or pallor).

A combination of the following is critical to defining client outcomes and planning an effective clinical response to acute illness:

* Early detection
* Timeliness of response
* Competency of response.

It is vital that where a client in our care has been identified as being acutely unwell, a clinical assessment is carried out immediately to reduce the risk of further deterioration and possible cardio-respiratory arrest.

# Assessment

**Staff should only perform an assessment within the scope of their training and understanding, for those not trained in the following approaches, advice should be sought from a more senior member of staff, NHS 111 or the emergency services (999).**

An assessment should follow the principal of the ABCDE approach. Firstly:

* Ensure personal safety and apply PPE as appropriate.
* Look for general unwellness and ask how the client is. If they are unconscious or have collapsed, shake them and ask, “Are you alright?” Failure to respond normally may suggest breathing problems and a failure to respond is a clear marker of critical illness.
* This first rapid ‘Look, Listen and Feel” of the client should take about 30 seconds and will often indicate if they are critically ill and there is a need for urgent help. Seek this immediately.
* If the client is unconscious, unresponsive, and is not breathing normally commence CPR in line with Resuscitation Council 2021 guidelines and the Resuscitation Policy.
* Where available, monitor vital signs early.



**Airway**

**Airway obstruction is an emergency. Get expert help immediately. Untreated, airway obstruction causes hypoxia and risks damage to the brain, kidneys and heart, cardiac arrest and death.**

Check for signs of airway obstruction:

* ‘See-saw’ respirations - paradoxical chest and abdominal movements and the use of accessory muscles are indicative of obstruction.
* Central cyanosis is a late sign of airway obstruction.
* Either no breath sounds or diminished and noisy air entry.

In most cases simple methods of airway clearance will be sufficient (e.g., airway opening manoeuvres) and this should be tried in this first instance.

If suitably trained and equipment is available, apply oxygen at high concentration through a mask with an oxygen reservoir, aiming for oxygen saturations of 94–98% or 88–92% in those at risk of hypercapnic respiratory failure.

**Call for immediate assistance if airway obstruction is identified.**

**Breathing**

**During the immediate assessment of breathing, it is vital to diagnose and treat immediately life-threatening conditions (e.g., acute severe asthma, pulmonary oedema, tension pneumothorax, and massive haemothorax).**

Look, listen and feel for the general signs of respiratory distress.

* Count the respiratory rate.
* Assess the depth and pattern of breathing, including whether there is equal chest expansion.
* Note any chest deformity, look for a raised jugular venous pulse (JVP) (e.g., in acute severe asthma or a tension pneumothorax).
* Monitor SpO2.
* Listen for abnormal breath sounds (e.g., rattling airway noises indicative of airway secretions or stridor or wheeze suggesting partial, but significant, airway obstruction.
* If training allows, consider more complex assessments such as percussion, auscultation, tracheal deviation and feeling the chest wall.

As above, if suitably trained and equipment is available, apply oxygen at high concentration through a mask with an oxygen reservoir, aiming for oxygen saturations of 94–98% or 88–92% in those at risk of hypercapnic respiratory failure.

Where depth or rate of breathing is inadequate and equipment is available, use bag-mask or pocket mask ventilation to improve oxygenation and ventilation.

**Call for immediate assistance if airway obstruction is identified.**

**Circulation**

* Look at the colour of the hands and digits: are they blue, pink, pale or mottled?
* Assess the limb temperature by feeling the client’s hands: are they cool or warm?
* Measure the capillary refill time (CRT). Prolonged CRT suggests poor peripheral perfusion, but be aware that other factors (e.g., cold surroundings, poor lighting, old age) can also prolong this.
* Count the pulse and assess for presence, rate, quality, regularity and equality. Barely palpable suggests poor cardiac output, whereas bounding is indicative of sepsis.
* Measure blood pressure A low diastolic could indicate anaphylaxis or sepsis. A narrowed difference between systolic and diastolic pressures (normally 35–45 mmHg) could suggest cardiogenic shock or hypovolaemia and may occur with rapid tachyarrhythmia.
* Assess veins, underfilled or collapsed occurs with hypovolaemia.
* Reduced consciousness and low urine output also suggest poor cardiac output.
* Search for signs of blood loss.
* Check for primary chest pain suggestive of acute coronary syndrome.

**Any signs suggesting poor cardiac output must be treated as an emergency and immediate assistance should be sought.**

**Disability**

Common causes of unconsciousness include profound hypoxia, hypercapnia, cerebral hypoperfusion, or the recent administration of sedatives or analgesic drugs.

* Check the Medicines Administration Record for reversible drug-induced causes of depressed consciousness.
* Examine the pupils (size, equality and reaction to light).
* Assess conscious level using either AVPU or the Glasgow Coma Scale score, depending on training and ability. Painful stimuli should be given by applying supra-orbital pressure (at the supraorbital notch).
* Measure blood glucose levels to exclude hypoglycaemia.
* Move into a lateral position if unconscious and the airway is not protected as per the Resuscitation Policy.

**Exposure**

To ensure a complete examination, full exposure of the body may be necessary. The client’s privacy and dignity must be maintained at all times and every effort should be made to minimise heat loss.

# Clinical Observations

Assessing staff must be able to recognise the importance of recording clinical observations in a timely and appropriate manner and interpret any abnormal results that may indicate a deteriorating person. The staff member should then understand how to escalate appropriately.

In order to ascertain what is abnormal in relation to clinical observations, it is important for a baseline result to be obtained. Therefore, upon being accepted by the service all clients must have a set of clinical observations recorded. The interval of these will then be dependent upon:

* Diagnosis and reason for care provision
* Presence of comorbidities
* Agreed care plan
* Clinical condition.

If a client is identified as being unwell and potentially deteriorating, the following clinical observations should be undertaken:

* Respiratory Rate (RR per minute)
* Oxygen Saturations (SpO2)
* Temperature
* Heart Rate (HR)
* Systolic Blood Pressure
* Altered State of Consciousness
* Blood Glucose
* Urinary Output.

Vital sign parameters can be found in Appendices I and II.

**Respiratory Rate**

Respiratory Rate must be monitored over a minimum of 30 seconds and should include a visual check for accessory muscle use, ease of breathing, abnormal sounds (e.g., wheezing) and the level of bilateral chest inflation/deflation.

Very slow or very rapid breathing may be a sign of deoxygenation or an underlying physiological change. Tachypnoea (a respiratory rate greater than 20 breaths per minute) can be indicative of asthma, pulmonary embolism (PE), pneumonia, acute respiratory distress, anaphylaxis, heart failure and shock.

Bradypnoea (a decreased but regular respiratory rate) can suggest, but are not exclusive of, opiate narcotics, certain medication groups and reduced levels of consciousness.

**Oxygen Saturations (SpO2)**

Staff should be aware that finger probe SpO2 results can be misleading in those with poor peripheral perfusion, anaemia, arrhythmias and carbon monoxide exposure.

It must be taken into account that if peripheral oxygen saturation is difficult to measure in a client with suspected sepsis, this may indicate poor peripheral circulation because of shock.

**Temperature**

Pyrexia

There are 3 grades of pyrexia (abnormally raised body temperature):

* Low Grade (37.5–38°C)
* Moderate of High Grade (38–40°C)
* Hyperpyrexia (40°C and above).

Causes can include but are not exclusive to infection, tissue/inflammatory injury and heat exhaustion.

Hypothermia

A temperature of less than 35°C that causes metabolic rate to decrease. It can be classified as:

* Mild (32–35°C)
* Moderate (28–32°C)
* Severe (less than 28°C)

Causes include environmental exposure, medications (e.g., paracetamol, alcohol, hypoglycaemia, adrenal insufficiency and surgery).

**Systolic Blood Pressure**

NB. if using an automated machine to record blood pressure and the result is suspected to be inaccurate then it should be repeated with a manual sphygmomanometer.

Hypotension

A fall in cardiac output, vascular resistance or both can lead to a fall in blood pressure. Hypotension has the following effects on the body:

* **Renal system** – acute renal failure may develop
* **Brain** – altered level of consciousness including symptoms of light-headedness, drowsiness, confusion, agitation, syncope and coma
* **Heart** – can lead to myocardial ischaemia
* **Gastrointestinal tract** – can lead to bowel ischaemia
* **Skin** – peripheral ischaemia can develop.

Hypotension is a symptom of shock and is common in the critically ill. Shock is a life-threatening condition and left untreated it will lead to organ dysfunction, organ failure and eventually death.

Hypertension

Hypertension can be an acute or chronic physiological response and can be a temporary response to fever, physical exertion or stress.

**Heart Rate**

The radial pulse should be palpated over a period of one minute while checking its volume and regularity.

Tachycardia is often one of the first signs of clinical deterioration and is a common finding in acute illnesses, including pulmonary embolism, pneumonia, acute respiratory distress, anaphylaxis, heart failure, shock and thyrotoxicosis.

Bradycardia may be a feature of life-threatening heart block (AV) or a precursor of asystole (when the heart stops beating). Other causes of bradycardia include myocardial infarction, hypothermia, hypoxia, hypothyroidism, hypovolaemia and raised intracranial pressure.

**Altered State of Consciousness**

Any change in consciousness is another sensitive indicator of clinical deterioration and it is described as the degree of arousal and awareness. It can present in different ways including confusion, drowsiness, vagueness and aggressive behaviour and is common in the critically ill. It is also associated with potentially life-threatening airway compromise. Causes include hypoxia, hypercapnia (high levels of CO² in the blood), medication (such as sedatives or analgesia), hypoglycaemia, stroke, subarachnoid haemorrhage, convulsions, alcohol, drug overdose and head injury.

**AVPU** - A quick and easy method to assess level of consciousness: **A**lert: responds to **V**oice: responds to **P**ain: **U**nresponsive.

**Glasgow Coma Scale** – should be used as part of a full assessment if there is a need to measure the level of consciousness more specifically. It should be used when assessing clients with actual and suspected head injuries (e.g., after an unwitnessed fall).

**Blood Glucose**

In acutely unwell clients blood glucose should always be checked even if there is no history of diabetes, as:

* Hypoglycaemia (low blood glucose) can cause disorientation, convulsions, unconsciousness and shock.
* Hyperglycaemia (raised blood glucose) can cause confusion, lethargy, cardiac events and coma.

**Urinary Output**

Poor urine output (oliguria) can be a sign that a client is acutely ill and deteriorating. It is often associated with poor fluid intake or excessive fluid loss and early intervention can prevent progression to renal failure.

Causes of poor urinary output can include pre-renal (e.g., hypovolaemia, hypotension), renal (e.g., acute tubular necrosis) and post renal (e.g., ureteric stone and retention of urine).

In clients with a urinary catheter, ensure oliguria is not caused by a blocked or kinked catheter tubing. Urinary retention should also be excluded as a cause.

# National Early Warning Score 2 (NEWS2)

NEWS2 allocates a score to each physiological parameter (respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness or new confusion and temperature), with the magnitude of the score reflecting how extreme the parameters variation is from the norm. The score is aggregated and uplifted by 2 points for client’s requiring supplemental oxygen.

NEWS2 provides five threshold response categories, ranging from 0 (No change to treatment required) to 7 or more (emergency response). Information on NEWS2 charts, threshold triggers, parameters and suggested responses can be found on the Royal College of Physicians website for the National Early Warning Score (NEWS) 2 [National Early Warning Score (NEWS) 2 | RCP London](https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2). Separate guidance on using NEWS2 to manage deterioration in clients with COVID-19 can also be found on the link above.

# Hypoglycaemia

Clients with hypoglycaemia should be administered glucose, with the route depending on the conscious level of the client.

Oral glucose replacement options as available, if the client is safe to swallow/conscious:

* Four to six pieces of hard sweet (not sugar-free), 1/2 cup fruit juice, 1 cup skim milk, 1/2 cup soft drink (not sugar-free), 1 tablespoon honey (put it under the tongue for faster absorption), 3-4 Glucose Tablets or Glucose Gel.

Intra-muscular (IM) Glucagon replacement will be required if the client is unsafe to swallow/unconscious. Do not try to give an unconscious person anything orally they may choke.

If IM Glucagon is unavailable emergency services (999) should be contacted immediately upon identifying the client is hypoglycaemic.

Specialist input/follow up will be required as to prevent future deranged blood glucose occurrences.

# Sepsis

Sepsis results from the body’s response to infection where the immune system goes into overdrive, attacking its own tissues and organs and setting off a series of reactions, including widespread inflammation. This is a life-threatening condition that can cause a significant decrease in blood pressure, leading to multiple organ failure and death, if not recognised early and treated quickly. Where a client presents with signs or symptoms that indicate a possible infection, staff should always think, ‘could this be sepsis?’.

Sepsis may present in a non-specific and non-localised manner, without pyrexia. Therefore, any sudden changes and/or concerns from family/carers should be accounted for and considered.

If a client’s condition makes it inappropriate to consider active interventions and/or transfer to emergency care, for instance if they are terminal and/or end of life with a signed do not escalate and/or resuscitate order, then continue and consider treatment and/or monitoring at a level appropriate for their condition and situation, in line with their GP’s or a 111 clinician’s advice. Alternatively, where concern of infection exists, and the client is continuing to receive active interventions, staff should follow the pathways as normal.

**Initial assessment**

Complete a full set of observations using an early warning scoring system, including temperature, heart rate, respiratory rate, blood pressure, level of consciousness and oxygen saturations. Staff must then assess for:

* a possible source of infection
* factors that increase the risk of sepsis:
	+ the very young (under 1 year) adults >75 years or very frail and women who are pregnant, have given birth or had a termination of pregnancy or miscarriage in the past 6 weeks
	+ recent trauma, surgery or invasive procedures within the last 6 weeks
	+ impaired immunity due to illness or drugs (e.g., chemotherapy, diabetes, long term steroids, etc.)
	+ indwelling lines, catheters, intravenous (IV) drug misusers or any breach of skin integrity.
* any indications of clinical concern, such as new onset abnormalities of behaviour, circulation or respiration
* client appearance, including mottled or ashen skin; cyanosis of the skin, lips or tongue and/or a non-blanching rash of the skin
* reduced frequency of urination in the previous 18 hours.

Sepsis can be especially hard to spot in:

* people with dementia
* people with a learning disability
* people who have difficulty communicating.

For adults over the age of 12 the UK Sepsis Trust’s Assessment Tool for Community Nursing should be followed as found in Appendix II: <https://sepsistrust.org/wp-content/uploads/2020/08/Sepsis-Community-12-Version-1.3.pdf>

**Clinical judgement**

Certain clinical presentations may indicate other conditions or not be a reliable predictor for sepsis. Examples include:

* Temperature, fever or hypothermia should not be used as a sole predictor of sepsis as the following client may not develop a pyrexia, and a rise in temperature could also relate to an unrelated physiological response:
	+ the old or very frail
	+ those having treatment for cancer
	+ those who are severely ill with sepsis
* Heart rate should only be taken in context:
	+ baseline heart rates may be lower in younger persons and those who are fitter
	+ baseline heart rate in pregnancy is 10–15 beats per minute more than normal
	+ older persons with an infection may not develop an increased heart rate
	+ older persons may develop a new arrhythmia in response to infection rather than an increased heart rate
	+ heart rate response may be affected by medicines, such as beta-blockers.
* Blood pressure should be reviewed in line with the individual’s normal levels
* Confusion, mental state and cognitive state should be assessed in the context of their normal function, with any changes, even subtle ones, being treated as significant
* Peripheral oxygen saturations may be difficult to measure and could indicate poor peripheral circulation due to shock.

**Management of sepsis**

Management of sepsis will follow the pathway as detailed within the initial assessment section above.

All clients with suspected sepsis should be assessed to attempt to determine:

* A definitive diagnosis
* Whether the client can be treated safely outside of an acute hospital environment.

**Any client with a ‘Red Flag’ criteria or suspected neutropenic sepsis should be immediately referred to emergency care, with a 999 call, blue light transfer and a ‘Red Flag Sepsis’ communication.**

**Client’s with ‘Amber Flag’ criteria only, should receive a same day urgent assessment by their GP or a 111 clinician to consider whether hospital transfer is necessary and appropriate and to agree and document an ongoing plan of care with agreed review intervals.**

# Handover

All escalation of care should be handed over in a succinct but comprehensive manner. This should include all the relevant and assessment information and follow either the ATMIST (Age, Time, Mechanism, Injury, Signs and Symptoms and Treatment) or SBARD (Situation, Background, Assessment, Recommendation and Decision) formats, as per the Continuity of Care and Handover Policy.

# Monitoring

The effectiveness of this policy will be monitored through routine auditing, along with additional investigations into any incidents, adverse events, poor outcomes and client transfers resulting from unexpected deterioration.

# Related Policies

* Continuity of Care Policy
* First Aid Policy
* Governance and Risk Policy
* Handover Policy
* Incident Management Policy
* Management of Seizures Policy
* Oxygen Therapy Policy
* Resuscitation (Adult) Policy

# Legislation and Guidance

**Guidance**

* Boulanger, C. and Toghill, M., 2009. How to measure and record vital signs to ensure detection of deteriorating clients: <https://www.nursingtimes.net/clinical-archive/critical-care/how-to-measure-and-record-vital-signs-to-ensure-detection-of-deteriorating-patients-30-11-2009/>
* Cooper, G. 2020. Using Soft Signs to Identify Deterioration a White Paper <https://wessexahsn.org.uk/img/projects/Soft%20Signs%20White%20Paper%20GC%20WPSC%20Final%201.1.pdf>
* National Institute of Clinical Excellence (NICE) (2016) Sepsis: recognition, diagnosis and early management. <https://www.nice.org.uk/guidance/ng51>
* National Patient Safety Agency (2007) Recognising and responding appropriately to early signs of deterioration in hospitalised patients: <https://www.patientsafetyoxford.org/wp-content/uploads/2018/03/NPSA-DeteriorPatients.pdf>
* Resuscitation Council UK (2021) <https://www.resus.org.uk/library/2021-resuscitation-guidelines>
* Royal College of Physicians: National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017: <https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2>
* Sepsis Alliance (2016) Definition of sepsis: <http://www.sepsis.org/sepsis/definition/>
* The Royal Marsden Hospital Manual of Clinical Nursing Procedures (2020) 10th edition: <https://www.rmmonline.co.uk/>
* Sepsis Trust, The Sepsis Manual, 2020, <https://sepsistrust.org/wp-content/uploads/2020/01/5th-Edition-manual-080120.pdf>

# Summary of Review

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