Nursing & Midwifery Council

Test of Competence: Supporting Documents

V.6.1 Updated January 2026

Contents

Purpose

This document contains some supporting documents which may be used in the NMC Test of Competence (ToC 21). It is intended for candidates to have the opportunity to become familiar with these supporting documents prior to them taking the ToC 21.

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: **Forename(s):** **Date of birth:** **NHS number:**	**Address:** **Height (m):** **Weight (kg):** **Body mass index (BMI) (kg/m^2):**
GP Name:	**Surgery address:**

Number of prescription records	**Chart 1☐ 2 ☐ 3 ☐ of 1 ☐ 2 ☐ 3 ☐**

Details of prescribers: must be completed by ALL prescribers			
NAME	**GMC/NMP Number**	**Signature**	**Contact details**

Details of person administering medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/substance			**Effect(s)**		
IF NO KNOWN ALLERGIES TICK BOX ☐					
Signature:		**Contact number**	Tel:	**Date:**	
Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.					

MEDICATION RISK FACTORS			
Pregnancy ☐	**Renal impairment ☐**	**Impaired oral access ☐**	**Diabetes ☐**
Other high-risk conditions ☐ – specify		**Patient self-medicating ☐**	

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

Surname: **Forename(s):** **Date of birth:** **NHS number:**	**Address:** **Height (m):** **Weight (kg):** **Body mass index (BMI) (kg/m^2):**
GP Name:	**Surgery address:**

Information for prescribers:	**Medicine non-administration/self-administration:**	
Write in BLOCK CAPITALS using black or blue ink. Sign and date and include bleep number.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign the entry.	
Record detail(s) of any allergies.	1. Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2.Patient not present at time of administration
Sign and date allergies box. Tick box if no allergies know.	3.Self-administration	4.Unable to administer – INFORM DOCTOR (alternative route required?)
Different doses of the same medication must be prescribed on different lines.	5.Stat dose given	6.Prescription incorrect/unclear
Cancel by putting a line across the prescription and sign and date.	7.Patient refused	8. Nil by mouth (on doctor's instruction only)
Indicate the start and finish date where appropriate.	9. Low pulse and/or low blood pressure	10. Other – state in nursing notes including action taken

COMMUNITY PATIENT-SPECIFIC DIRECTION

Check allergies/sensitivities and patient identity

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
Instruction/Indication:									

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
Instruction/Indication:									

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
Instruction/Indication:									

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
Instruction/Indication:									

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GP Name:	**Surgery address:**

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
Instruction/Indication:									

Date	Drug	Dose	Route	Time	Frequency	End date	Prescriber name & date	Given by: Sign date & time	Pharmacy check
Instruction/Indication:									

OMITTED DOSES OF MEDICINE AND DELAYED DOSES								
Check allergies/sensitivities and patient identity								
Date	**Time**	**Drug**	**Dose**	**Route**	**Instructions**	**Reason for omission or delay >2 hours**	**Signature**	**Pharmacy check**

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: **Forename(s):** **Date of birth:** **Hospital/NHS number:**	**Height (m):** **Weight (kg):** **Body mass index (BMI) (kg/m^2):**
Ward:	**Consultant:**
Date of admission:	**Time of admission:**

Number of prescription records	**Chart 1 ☐ 2 ☐ 3 ☐ of 1 ☐ 2 ☐ 3 ☐**

All prescribers MUST complete the signature record							
NAME	**GMC/NMC Number**	**Signature**	**Bleep**	**NAME**	**GMC/NMC Number**	**Signature**	**Bleep**

Details of person administrating medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/substance				**Effect(s)**	
IF NO KNOWN ALLERGIES TICK BOX					
Signature:		**Bleep number:**		**Date:**	
Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.					

Medication risk factors			
Pregnancy ☐	**Renal impairment ☐**	**Impaired oral access ☐**	**Diabetes ☐**
Other high-risk conditions ☐ – specify			
Patient self-medicating ☐			

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Ward:	**Consultant:**
Date of admission:	**Time of admission:**

Information for prescribers:	**Medicine non-administration/self-administration:**	
Write in BLOCK CAPITALS using black or blue ink. Sign and date and include bleep number.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign the entry.	
Record detail(s) of any allergies.	1.Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2.Patient off ward
Sign and date allergies box. Tick box if no allergies know.	3.Self-administration	4.Unable to administer – INFORM DOCTOR (alternative route required?)
Different doses of the same medication must be prescribed on different lines.	5.Stat dose given	6.Prescription incorrect/unclear
Cancel by putting a line across the prescription and sign and date.	7.Patient refused	8.Nil by mouth (on doctor's instruction only)
Indicate the start and finish date where relevant.	9.Low pulse and/or low blood pressure	10.Other – state in nursing notes including action taken

ONCE-ONLY MEDICINES, PREMEDICATION, ANTIBIOTIC PROPHYLAXIS AND PATIENT GROUP DIRECTIONS									
Check allergies/sensitivities and patient identity									
Date	**Drug**	**Dose**	**Route**	**Time required**	**Instructions**	**Prescriber's signature, print name & bleep number**	**Time given**	**Signature given**	**Pharmacy check**

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Ward:	**Consultant:**
Date of admission:	**Time of admission:**

PRESCRIBED OXYGEN						
For most chronic conditions, oxygen should be prescribed to achieve a target saturation of 94–98% (or 88–92% for those at risk of hypercapnic respiratory failure i.e. CO_2 retainers.) Is the patient a known CO_2 retainer? Yes ☐ No ☐						
Continuous oxygen therapy ☐ 'When required' oxygen therapy ☐ Target O_2 saturation 88-92% ☐ Target O_2 saturation 94-98% ☐ Other saturation range: _____ Saturation not indicated e.g. end-of-life care (state reason) _____ ☐		If oxygen is in progress, check and record flow rate (FR) during clinical observations.				
Starting device and flow rate:		Administrator's signature:	Print name:	Date	Time	FR/D
	Start date:					
Prescriber's signature:	Stop date:					
Print name:	Pharmacy check:					

Codes for starting device and modes of delivery			
Air not requiring oxygen or weaning or PRN oxygen	A	Humidified oxygen at 28% (add% for other flow rate)	H28
Nasal cannula	N	Reservoir mask	RM
Simple mask	M	Tracheostomy mask	TM
Venturi 24	V24	Venturi 35	V35
Venturi 28	V28	Venturi 40	V40
Venturi 60	V60	Patient on CPAP system	CP
Patient on NIV system	NIV	Other device (specify)	

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Date of admission:	**Time of admission:**

ANTIMICROBIALS								
Check allergies/sensitivities and patient identity								
Review IV after 24-48 hours – Review oral after 5-7 days								
1.Drug					Signature of nurse administering medications and code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**
Today								
Start date		Indication/ Organism						
Finish date		Cultures sent?	Yes No					
Prescriber's signature and bleep					Print name			

Check allergies/sensitivities and patient identity								
2.Drug					Signature of nurse administering medications and code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**
Today								
Start date		Indication/ Organism						
Finish date		Cultures sent?	Yes No					
Prescriber's signature and bleep					Print name			

Check allergies/sensitivities and patient identity								
3.Drug					Signature of nurse administering medications and code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**
Today								
Start date		Indication/ Organism						
Finish date		Cultures sent?	Yes No					
Prescriber's signature and bleep					Print name			

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: **Forename(s):** **Date of birth:** **Hospital/NHS number:**	**Height (m):** **Weight (kg):** **Body mass index (BMI) (kg/m^2):**
Ward:	**Consultant:**
Date of admission:	**Time of admission:**

REGULAR MEDICINES									
Check allergies/sensitivities and patient identity									
1.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions / indication							Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep					Print name				Supply at home ☐

Check allergies/sensitivities and patient identity									
1.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions / indication							Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep					Print name				Supply at home ☐

Check allergies/sensitivities and patient identity									
1.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions / indication							Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep					Print name				Supply at home ☐

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: **Forename(s):** **Date of birth:** **Hospital/NHS number:**	**Height (m):** **Weight (kg):** **Body mass index (BMI) (kg/m^2):**
Ward:	**Consultant:**
Date of admission:	**Time of admission:**

‘AS-REQUIRED’ MEDICINES									
Check allergies/sensitivities and patient identity									
1.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions / indication:							Amended ☐
Finish date									Unchanged ☐
Prescriber’s signature and bleep					Print name				Supply at home ☐

Check allergies/sensitivities and patient identity									
2.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions / indication:							Amended ☐
Finish date									Unchanged ☐
Prescriber’s signature and bleep					Print name				Supply at home ☐

Check allergies/sensitivities and patient identity									
3.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions / indication:							Amended ☐
Finish date									Unchanged ☐
Prescriber’s signature and bleep					Print name				Supply at home ☐

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: **Forename(s):** **Date of birth:** **Hospital/NHS number:**	**Height (m):** **Weight (kg):** **Body mass index (BMI) (kg/m^2):**
Ward:	**Consultant:**
Date of admission:	**Time of admission:**

INFUSIONS

Check allergies/sensitivities and patient identity

Bolus IN injections should be prescribed on the standard section of the drug chart. If no additive is to be used, enter 'nil' in the 'drug added' column.

Date	INFUSION FLUID			DRUG ADDED		Duration or rate	Prescriber's signature	Pharmacy check	Given by	Checked by	Start time	Stop time	Vol given (ml)
	Name / strength	Volume (ml)	Route (IV/SC)	Name	Dose								

OMITTED DOSES OF MEDICINE AND DELAYED DOSES

Check allergies/sensitivities and patient identity

Date	Time	Drug	Dose	Route	Instructions	Reason for omission or delay >2 hours	Signature	Pharmacy check

NEWS key	FULL NAME	
0 1 2 3	DATE OF BIRTH	DATE OF ADMISSION

Parameter	Left label	Score	Right label
	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	≥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
†ONLY use Scale 2 under the direction of a qualified clinician	≤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

Royal College of Physicians

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

NHS

0 to 11 months

National Paediatric Early Warning System Observation and Escalation Chart

0
1
2
4

0-11 Months

Patient Name: _____

Hospital No. _____

NHS No. _____

Date of Birth: _____

Consultant: _____

Have you set your alarm limits?
RR
SpO2
HR
BP
Other
Type of monitor

Does your patient have any additional risk factors? ☐ NOT APPLICABLE

Risk Factor	THINK!
☐ Baseline vital signs outside of normal reference ranges	Always score the relevant PEWS value even if this is normal for the patient (e.g. cardiac patient) — Vital sign: ____ Patient's normal value: ____
☐ Tracheostomy/Airway Risk	Do you need additional help in an airway emergency?
☐ Invasive/Non-Invasive Ventilation/High Flow	Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery
☐ Neutropenic/Immunocompromised	Sepsis recognition and escalation has a lower threshold
☐ <40 weeks corrected gestation	Sepsis recognition and escalation has a lower threshold (beware hypothermia)
☐ Neurological condition (ie meningitis, seizures)	Remember to check pupillary response if anything other than Alert on AVPU
☐ Outlier	Do you need support from home ward/team?

This chart is solely intended for recording an inpatient paediatric patient's PEWS. The components of the chart should not be amended.

Carer question: Ask your parent/carer: How is your child different since I last saw them? You decide if their response means:
W - Worse | S - Same | B - Better | A – Parent/Carer Asleep | U – Unavailable

Airway and Breathing

Respiratory distress

Mild
- Nasal flaring
- Subcostal recession

Moderate
- Head bobbing
- Tracheal tug
- Intercostal recession
- Inspiratory or expiratory noises

Severe
- Sternal recession
- Grunting
- Exhaustion
- Impending respiratory arrest

Respiratory support device (RSD)
HF = High Flow
BIP = BIPAP
CP = CPAP
Scores the maximum of 4

Other delivery methods
NP = nasal prongs
FM = face mask
HB = head box
NRB = Non-rebreather
Score as per oxygen

Circulation

Record position of BP taken by inserting relevant initials above systolic arrow

LA - Left Arm
RA - Right Arm
LL - Left Leg
RL - Right Leg

Derogation Code if required:

Not attempted (No concern) - NCO (this scores 0)

Unsuccessful Attempt (No Concern) - U0 (this scores 0)

Unsuccessful attempt (Concern) - U4 (this scores 4)

Disability and Exposure

If V or less do GCS
A = Alert
V = Responsive to voice
P = Responsive to pain
U = Unresponsive

If asleep with no reason for altered conscious state (e.g. sepsis) write 'asleep'.

Clinical Intuition
If you're feeling that the patient is 'just not right' despite a low PEWS or natural carer concern *(Y/N)

Trigger criteria
Cause(s) for escalation:
SC = Specific Concern
CQ = Carer Question
CI = Clinical Intuition
P = PEWS
0 = None

	Date	Time	Frequency	W/S/B/A/U	Value	Respiratory Rate • RR/min	Respiratory Distress	SpO_2	SpO_2 probe change	RSD CODE (maximum score is 4)	Oxygen (Oxygen as per POD or prescription box, of 100% oxygen. Mark % with a 'x' and L/min with an 'O')	Document 'Air' or Value	Delivery method /RSD flow rate	Value	Heart Rate • HR/min	BP Value or Code	Blood Pressure (Score systolic only) • mean systolic > < diastolic (no score)	CRT Record in seconds	PEWS	AVPU	Blood glucose	Pain score (as per local policy)	Value	Temperature °C A=Axilla T=Tympanic S=Skin	New suspicion of sepsis or septic shock (Y/N)	Clinical Intuition (Y/N)	Trigger criteria	Escalation level	Escalated (Y/Plan)	Time NIC informed	Time clinician informed	Time clinician arrived	PICU/transport team called	Signature

ESCALATION LEVEL	LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
TRIGGER CRITERIA: Respond as per the highest level based on CHANGE in ANY ONE of these criteria — Specific concern (neurology, sepsis, or pre-existing risk factor)		New suspicion of sepsis	AVPU: Change to AVPU - V 'Responsive only to Voice' or New suspicion of septic shock	AVPU: Change to AVPU - P or U 'Responsive only to Pain' or 'Unresponsive' OR Abnormal pupillary response
Clinical Intuition	Nurse/clinician concern that patient needs increased monitoring despite low PEWS	Nurse/clinician concern that patient needs a medical review irrespective of PEWS	Nurse/clinician concern that patient needs a 'Rapid Review' irrespective of PEWS	Nurse/clinician concern that patient needs emergency review for life-threatening situation
Carer Question	Carer uses words that suggests the child needs increased monitoring or intervention despite the low PEWS	Carer uses words that suggests the child needs a clinical review irrespective of PEWS	Carer uses words that suggests the child needs a 'Rapid Review' irrespective of PEWS	Carer uses words that suggests the child has collapsed or significantly deteriorated
Paediatric Early Warning Score	1-4	5-8	9-12	≥13
Communication & response (use ISBAR Framework)	Inform Nurse-in-charge	Review by Nurse-in-charge for potential escalation (and/or Outreach nurse or equivalent)	Immediate review by Nurse-in-charge for potential escalation	Immediate 2222 call: "Paediatric Medical Emergency" and review by Nurse-in-charge
Medical plan for stabilisation Structured medical plan to be documented including: 1. specific actions to be taken 2. expected outcome 3. outcome deadline 4. escalation if outcome not met by deadline.	Consider Medical Review by ST3+ or equivalent Bedside nurse to feed back plan to parents	Request Medical Review by ST3+ or equivalent Stabilisation plan to be considered Bedside nurse to feed back plan to parents	Call for 'Rapid Review': Medical incl. airway skills ST3+ or equivalent and outreach nurse (if available or equivalent) Stabilisation plan to be discussed with consultant Senior nurse to feed back plan to parents	Consultant informed urgently to confirm stabilisation plan Senior nurse to support and feedback to parents [In specialist environments rapid review can replace 2222 but only with prior agreement between consultant and nurse-in-charge]
Medical review timings	As agreed with medical team	Within 30 minutes	Within 15 minutes	Immediate
Minimal observations — Repeated escalation if remaining in one level not required but ongoing plan must be clearly documented in notes.	Must reassess within 60 minutes (and then document ongoing plan)	Must reassess within 30 minutes (and then document ongoing plan) Continuous Oxygen Saturation monitoring needed	Every 30 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU	Every 15 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU or abnormal pupillary response

FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL 2222 AND STATE "PAEDIATRIC MEDICAL EMERGENCY"

THINK! Could this be sepsis?

Think sepsis if any of the following are present:
- Neutropenia or immunocompromised (call medical professional for immediate review)
- Known or suspected infection
- Temperature ≥38°C or <36°C
- Increasing oxygen requirement
- Unexplained tachypnoea/ tachycardia
- Altered mental state (e.g. lethargy/floppy)
- Prolonged CRT, mottled or ashen appearance

If suspicion of sepsis, inform nurse-in-charge. Escalate to patient's own or on-call team.

I	Hello, I am staff nurse (xx) from Ward (xx), I am calling about (xx).
S	I am calling because (e.g. PEWS increased to xx, carer is concerned because xx). The last observations were (xx).
B	They are (age), admitted on (date) for (reason). They recently had surgery (xx); treatment (xx).
A	I think they are (e.g. hypovolaemic). I don't know what is wrong with them but I am/carer is very concerned.
R	I would like you to (e.g. review in xx minutes please).

DATE & TIME	COMMENTS

DATE & TIME	COMMENTS

Based on the original design from Birmingham Women's and Children's NHSFT with contributions from other English charts and amendments from National SPOT Programme.

0 to 11 months

National Paediatric Early Warning System Observation and Escalation Chart

0 1 2 4

1-4 years

Patient Name: _____
Hospital No. _____
NHS No. _____
Date of Birth: _____
Consultant: _____

Have you set your alarm limits?
RR
SpO2
HR
BP
Other
Type of monitor

Does your patient have any additional risk factors? ☐ NOT APPLICABLE

Risk Factor	THINK!
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☐ Neurological condition (ie meningitis, seizures)	Remember to check pupillary response if anything other than Alert on AVPU
☐ Outlier	Do you need support from home ward/team?

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W - Worse | S - Same | B - Better | A – Parent/Carer Asleep | U – Unavailable

Airway and Breathing

Respiratory distress

Mild
- Nasal flaring
- Subcostal recession

Moderate
- Head bobbing
- Tracheal tug
- Intercostal recession
- Inspiratory or expiratory noises

Severe
- Sternal recession
- Grunting
- Exhaustion
- Impending respiratory arrest

Respiratory support device (RSD)
HF = High Flow
BIP = BIPAP
CP = CPAP
Scores the maximum of 4

Other delivery methods
NP = nasal prongs
FM = face mask
HB = head box
NRB = Non-rebreather
Score as per oxygen

Date
Time
Frequency
W/S/B/A/U
Value

Respiratory Rate
• RR/ min
>60 60 50 40 30 20 10 <10

Respiratory Distress
Severe / Moderate / Mild / None

SpO_2
≥95%
92% - 94%
≤91%
SpO_2 probe change (✓)

Oxygen
Oxygen as per FiO2 or percentage of oxygen
Mark % with a 'x' and L/min with a 'X'
ISID CDDK (maximum score is 4)
100% 90% 80% 70% 60% 50% 40% 30% 28% 24% <21%
Document 'Air' or Value
Delivery method
/RSD flow rate

Oxygen Delivery (NOT High flow Delivery)
Litres per min (L/Min)
15 10 8 6 4 2 1 0.1 <0.01

Circulation

Record position of BP taken by inserting relavant initials above systolic arrow

LA - Left Arm
RA - Right Arm
LL - Left Leg
RL - Right Leg

Derogation Code if required:

Not attempted (No concern) - NCO (this scores 0)

Unsuccessful Attempt (No Concern) - U0 (this scores 0)

Unsuccessful attempt (Concern) - U4 (this scores 4)

Heart Rate
• HR/min
>190 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 <50

Blood Pressure
(Score systolic only)
• mean systolic >
< diastolic (no score)
BP Value or Code
>130 130 120 110 100 90 80 70 60 50 40 30 <30

CRT
Record in seconds
≥3 secs
≤2 secs

PEWS
AVPU
Blood glucose
Pain score (as per local policy)

Disability and Exposure

If V or less do GCS
A = Alert
V = Responsive to voice
P = Responsive to pain
U = Unresponsive

If asleep with no reason for altered conscious state (e.g. sepsis) write 'asleep'.

Temperature °C
A=Axilla
T=Tympanic
S=Skin
>39 39 38.5 38 37.5 37 36.5 36 35.5 35 34.5 <34.5

New suspicion of sepsis or septic shock (Y/N)
Clinical Intuition (Y/N)
Trigger criteria
Escalation level
Escalated (Y/Plan)
Time NIC informed
Time clinician informed
Time clinician arrived
PICU/transport team called
Signature

Clinical Intuition
If you're feeling that the patient is 'just not right' despite a low PEWS or natural carer concern *(Y/N)

Trigger criteria
Cause(s) for escalation:
SC = Specific Concern
CQ = Carer Question
CI = Clinical Intuition
P = PEWS
0 = None

ESCALATION LEVEL		LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
TRIGGER CRITERIA: Respond as per the highest level based on CHANGE in ANY ONE of these criteria	Specific concern (neurology, sepsis, or pre-existing risk factor)		Now suspicion of sepsis	AVPU: Change to AVPU - V 'Responsive only to Voice' or Now suspicion of septic shock	AVPU: Change to AVPU - P or U 'Responsive only to Pain' or 'Unresponsive' OR Abnormal pupillary response
	Clinical intuition	Nurse/clinician concern that patient needs increased monitoring despite low PEWS	Nurse/clinician concern that patient needs a medical review irrespective of PEWS	Nurse/clinician concern that patient needs a 'Rapid Review' irrespective of PEWS	Nurse/clinician concern that patient needs emergency review for life-threatening situation
	Carer Question	Carer uses words that suggests the child needs increased monitoring or intervention despite the low PEWS	Carer uses words that suggests the child needs a clinical review irrespective of PEWS	Carer uses words that suggests the child needs a 'Rapid Review' irrespective of PEWS	Carer uses words that suggests the child has collapsed or significantly deteriorated
	Paediatric Early Warning Score	1-4	5-8	9-12	≥13
Communication & response (use ISBAR Framework)		Inform Nurse-in-charge	Review by Nurse-in-charge for potential escalation (and/or Outreach nurse or equivalent)	Immediate review by Nurse-in-charge for potential escalation	Immediate 2222 call: "Paediatric Medical Emergency" and review by Nurse-in-charge
Medical plan for stabilisation Structured medical plan to be documented including: 1. specific actions to be taken 2. expected outcome 3. outcome deadline 4. escalation if outcome not met by deadline.		Consider Medical Review by ST3+ or equivalent Bedside nurse to feed back plan to parents	Request Medical Review by ST3+ or equivalent Stabilisation plan to be considered Bedside nurse to feed back plan to parents	Call for 'Rapid Review': Medical incl. airway skills ST3+ or equivalent and outreach nurse (if available or equivalent) Stabilisation plan to be discussed with consultant Senior nurse to feed back plan to parents	Consultant informed urgently to confirm stabilisation plan Senior nurse to support and feedback to parents [In specialist environments rapid review can replace 2222 but only with prior agreement between consultant and nurse-in-charge]
Medical review timings		As agreed with medical team	Within 30 minutes	Within 15 minutes	Immediate
Minimal observations Repeated escalation if remaining in one level not required but ongoing plan must be clearly documented in notes.		Must reassess within 60 minutes (and then document ongoing plan)	Must reassess within 30 minutes (and then document ongoing plan) Continuous Oxygen Saturation monitoring needed	Every 30 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU	Every 15 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU or abnormal pupillary response

FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL 2222 AND STATE "PAEDIATRIC MEDICAL EMERGENCY"

THINK! Could this be sepsis?

Think sepsis if any of the following are present:
- Neutropenia or Immunocompromised (call medical professional for immediate review)
- Known or suspected infection
- Temperature ≥38°C or <36°C
- Increasing oxygen requirement
- Unexplained tachypnoea/ tachycardia
- Altered mental state (e.g. lethargy/floppy)
- Prolonged CRT, mottled or ashen appearance

If suspicion of sepsis, inform nurse in charge. Escalate to patient's own or on-call team.

I	Hello, I am staff nurse (xx) from Ward (xx), I am calling about (xx).
S	I am calling because (e.g. PEWS increased to xx, carer is concerned because xx). The last observations were (xx).
B	They are (age), admitted on (date) for (reason). They recently had surgery (xx); treatment (xx).
A	I think they are (e.g. hypovolaemic). I don't know what is wrong with them but I am/carer is very concerned.
R	I would like you to (e.g. review in xx minutes please).

DATE & TIME	COMMENTS

DATE & TIME	COMMENTS

Based on the original design from Birmingham Women's and Children's NHSFT with contributions from other English charts and amendments from National SPOT Programme.

1-4 Years

5-12 Years

NHS

5-12 Years

National Paediatric Early Warning System Observation and Escalation Chart

0
1
2
4

Have you set your alarm limits?
RR
SpO2
HR
BP
Other
Type of monitor

Does your patient have any additional risk factors? ☐ NOT APPLICABLE

Risk Factor	THINK!
☐ Baseline vital signs outside of normal reference ranges	Always score the relevant PEWS value even if this is normal for the patient (e.g. cardiac patient) — Vital sign: / Patient's normal value:
☐ Tracheostomy/Airway Risk	Do you need additional help in an airway emergency?
☐ Invasive/Non-Invasive Ventilation/High Flow	Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery
☐ Neutropenic/Immunocompromised	Sepsis recognition and escalation has a lower threshold
☐ <40 weeks corrected gestation	Sepsis recognition and escalation has a lower threshold (beware hypothermia)
☐ Neurological condition (ie meningitis, seizures)	Remember to check pupillary response if anything other than Alert on AVPU
☐ Neurodiversity or Learning Disability	Be aware of the range of responses to pain and physiological changes
☐ Outlier	Do you need support from home ward/team?

This chart is solely intended for recording an unpatient paediatric patient's PEWS. The components of the chart should not be amended.

Patient Name: _____

Hospital No. _____

NHS No. _____

Date of Birth: _____

5-12 years Consultant: _____

Carer question: Ask your parent/carer: How is your child different since I last saw them? You decide if their response means:

W - Worse | S - Same | B - Better | A – Parent/Carer Asleep | U – Unavailable

Airway and Breathing

Respiratory distress

Mild
- Accessory muscle use

Moderate
- Tracheal tug
- Intercostal recession
- Inspiratory or expiratory noises

Severe
- Tripoding
- Supraclavicular recession
- Grunting
- Exhaustion
- Impending respiratory arrest

Respiratory support device (RSD)
HF = High Flow
BIP = BIPAP
CP = CPAP
Scores the maximum of 4

Other delivery methods
NP = nasal prongs
FM = face mask
HB = head box
NRB = Non-rebreather
Score as per oxygen

Circulation

Record position of BP taken by inserting relevant initials above systolic arrow

LA - Left Arm
RA - Right Arm
LL - Left Leg
RL - Right Leg

Derogation Code if required:

Not attempted (No concern) - NCO (this scores 0)

Unsuccessful Attempt (No Concern) - UO (this scores 0)

Unsuccessful attempt (Concern) - U4 (this scores 4)

Disability and Exposure

If V or less do GCS
A = Alert
V = Responsive to voice
P = Responsive to pain
U = Unresponsive

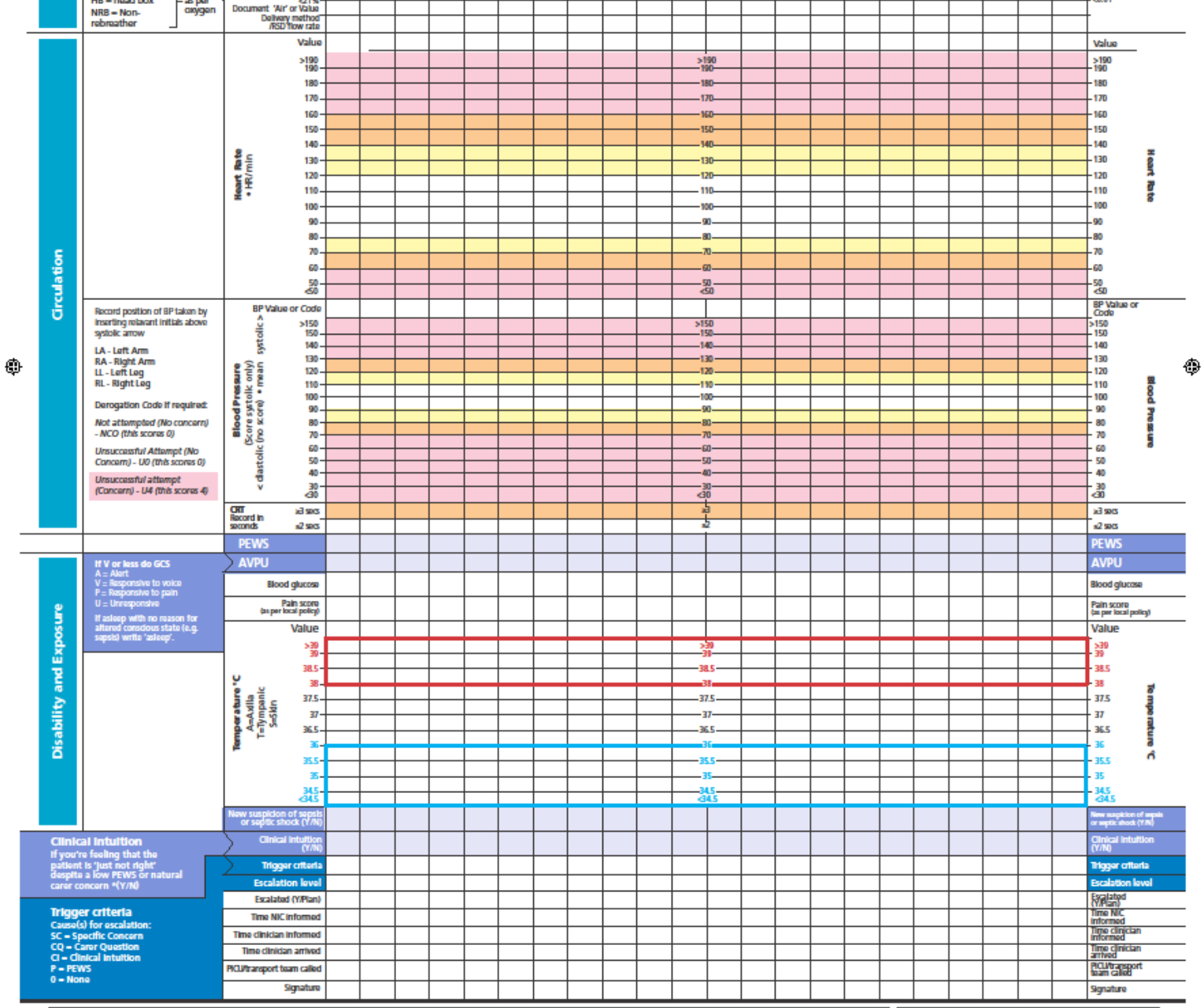
If asleep with no reason for altered conscious state (e.g. sepsis) write 'asleep'.

Clinical Intuition

If you're feeling that the patient is 'just not right' despite a low PEWS or natural carer concern *(Y/N)

Trigger criteria

Cause(s) for escalation:
SC = Specific Concern
CQ = Carer Question
CI = Clinical Intuition
P = PEWS
0 = None



ESCALATION LEVEL		LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
TRIGGER CRITERIA: Respond as per the highest level based on CHANGE in ANY ONE of these criteria	Specific concern (neurology, sepsis, or pre-existing risk factor)		New suspicion of sepsis	AVPU: Change to AVPU - V 'Responsive only to Voice' or New suspicion of septic shock	AVPU: Change to AVPU - P or U 'Responsive only to Pain' or 'Unresponsive' OR Abnormal pupillary response
	Clinical Intuition	Nurse/clinician concern that patient needs increased monitoring despite low PEWS	Nurse/clinician concern that patient needs a medical review irrespective of PEWS	Nurse/clinician concern that patient needs a 'Rapid Review' irrespective of PEWS	Nurse/clinician concern that patient needs emergency review for life-threatening situation
	Carer Question	Carer uses words that suggests the child needs increased monitoring or intervention despite the low PEWS	Carer uses words that suggests the child needs a clinical review irrespective of PEWS	Carer uses words that suggests the child needs a 'Rapid Review' irrespective of PEWS	Carer uses words that suggests the child has collapsed or significantly deteriorated
	Paediatric Early Warning Score	1-4	5-8	9-12	≥13
Communication & response (use ISBAR Framework)		Inform Nurse-in-charge	Review by Nurse-in-Charge for potential escalation (and/or Outreach nurse or equivalent)	Immediate review by Nurse-in-charge for potential escalation	Immediate 2222 call: "Paediatric Medical Emergency" and review by Nurse-in-charge
Medical plan for stabilisation Structured medical plan to be documented including: 1. specific actions to be taken 2. expected outcome 3. outcome deadline 4. escalation if outcome not met by deadline.		Consider Medical Review by ST3+ or equivalent Bedside nurse to feed back plan to parents	Request Medical Review by ST3+ or equivalent Stabilisation plan to be considered Bedside nurse to feed back plan to parents	Call for 'Rapid Review': Medical incl. airway skills ST3+ or equivalent and outreach nurse (if available or equivalent) Stabilisation plan to be discussed with consultant Senior nurse to feed back plan to parents	Consultant informed urgently to confirm stabilisation plan Senior nurse to support and feedback to parents [In specialist environments rapid review can replace 2222 but only with prior agreement between consultant and nurse-in-charge]
Medical review timings		As agreed with medical team	Within 30 minutes	Within 15 minutes	Immediate
Minimal observations Repeated escalation if remaining in one level not required but ongoing plan must be clearly documented in notes.		Must reassess within 60 minutes (and then document ongoing plan)	Must reassess within 30 minutes (and then document ongoing plan) Continuous Oxygen Saturation monitoring needed	Every 30 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU	Every 15 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU or abnormal pupillary response

FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL 2222 AND STATE "PAEDIATRIC MEDICAL EMERGENCY"

THINK! Could this be sepsis?

Think sepsis if any of the following are present:
- Neutropenia or Immunocompromised (call medical professional for immediate review)
- Known or suspected infection
- Temperature ≥38°C or <36°C
- Increasing oxygen requirement
- Unexplained tachypnoea/ tachycardia
- Altered mental state (e.g. lethargy/floppy)
- Prolonged CRT, mottled or ashen appearance

If suspicion of sepsis, inform nurse in charge. Escalate to patient's own or on-call team.

I	Hello, I am staff nurse (xx) from Ward (xx), I am calling about (xx).
S	I am calling because (e.g. PEWS increased to xx, carer is concerned because xx). The last observations were (xx).
B	They are (age), admitted on (date) for (reason). They recently had surgery (xx); treatment (xx).
A	I think they are (e.g. hypovolaemic). I don't know what is wrong with them but I am/carer is very concerned.
R	I would like you to (e.g. review in xx minutes please).

DATE & TIME	COMMENTS

DATE & TIME	COMMENTS

5-12 Years

Based on the original design from Birmingham Women's and Children's NHSFT with contributions from other English charts and amendments from National SPOT Programme

5-12 Years

National Paediatric Early Warning System Observation and Escalation Chart

0
1
2
4

Have you set your alarm limits?
RR
SpO2
HR
BP
Other
Type of monitor

Does your patient have any additional risk factors? ☐ NOT APPLICABLE

Risk Factor	THINK!
☐ Baseline vital signs outside of normal reference ranges	Always score the relevant PEWS value even if this is normal for the patient (e.g. cardiac patient) — Vital sign: / Patient's normal value:
☐ Tracheostomy/Airway Risk	Do you need additional help in an airway emergency?
☐ Invasive/Non-Invasive Ventilation/High Flow	Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery
☐ Neutropenic/Immunocompromised	Sepsis recognition and escalation has a lower threshold
☐ <40 weeks corrected gestation	Sepsis recognition and escalation has a lower threshold (beware hypothermia)
☐ Neurological condition (ie meningitis, seizures)	Remember to check pupillary response if anything other than Alert on AVPU
☐ Neurodiversity or Learning Disability	Be aware of the range of responses to pain and physiological changes
☐ Outlier	Do you need support from home ward/team?

This chart is solely intended for recording an inpatient paediatric patient's PEWS. The components of the chart should not be amended.

Patient Name: _____
Hospital No. _____
NHS No. _____
Date of Birth: _____
≥13 years Consultant: _____

Carer question: Ask your parent/carer: How is your child different since I last saw them? You decide if their response means:
W - Worse S - Same B - Better | A – Parent/Carer Asleep U – Unavailable

Airway and Breathing

Respiratory distress

Mild
- Accessory muscle use

Moderate
- Tracheal tug
- Intercostal recession
- Inspiratory or expiratory noises

Severe
- Tripoding
- Supraclavicular recession
- Grunting
- Exhaustion
- Impending respiratory arrest

Date / Time / Frequency / W/S/B/A/U

Respiratory Rate • RR/min — Value: >55, 55, 50, 45, 40, 35, 30, 25, 20, 15, 10, <10

Respiratory Distress: Severe / Moderate / Mild / None

SpO_2: ≥95% / 92% - 94% / ≤91% — SpO_2 probe change (✓)

Respiratory support device (RSD)
HF = High Flow
BIP = BIPAP
CP = CPAP
Scores the maximum of 4

Other delivery methods
NP = nasal prongs
FM = face mask
HB = head box
NRB = Non-rebreather
Score as per oxygen

Oxygen — Oxygen as per RSD or prescription box, of 100% oxygen. Mark % with a 'P' and L/min with an 'O'. Document 'Air' or Value / Delivery method / RSD flow rate

RSD CODE (maximum score is 4): 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 28%, 24%, ≤21%

Oxygen Delivery (NOT High flow Delivery) Litres per min (L/Min): 15, 10, 8, 6, 4, 2, 1, 0.1, <0.01

Circulation

Heart Rate • HR/min — Value: >150, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, <40

Record position of BP taken by inserting relevant initials above systolic arrow

LA - Left Arm
RA - Right Arm
LL - Left Leg
RL - Right Leg

Derogation Code if required:

Not attempted (No concern) - NCO (this scores 0)

Unsuccessful Attempt (No Concern) - UO (this scores 0)

Unsuccessful attempt (Concern) - U4 (this scores 4)

Blood Pressure (Score systolic only) • mean sytolic > < diastolic (no score) — BP Value or Code: >170, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, <30

CRT Record in seconds: ≥3 secs / ≤2 secs

PEWS

Disability and Exposure

If V or less do GCS
A = Alert
V = Responsive to voice
P = Responsive to pain
U = Unresponsive

If asleep with no reason for altered conscious state (e.g. sepsis) write 'asleep'.

AVPU

Blood glucose

Pain score (as per local policy)

Temperature °C — A=Axilla T=Tympanic Sc=Skin — Value: >39, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35, 34.5, <34.5

New suspicion of sepsis or septic shock (Y/N)

Clinical Intuition (Y/N)

Clinical Intuition
If you're feeling that the patient is 'just not right' despite a low PEWS or natural carer concern? *(Y/N)

Trigger criteria

Escalation level

Escalated (Y/Plan)

Time NIC informed

Time clinician informed

Time clinician arrived

PICU/transport team called

Signature

Trigger criteria
Cause(s) for escalation:
SC = Specific Concern
CQ = Carer Question
CI = Clinical Intuition
P = PEWS
0 = None

ESCALATION LEVEL		LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
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FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL 2222 AND STATE "PAEDIATRIC MEDICAL EMERGENCY"					

THINK! Could this be sepsis?

Think sepsis if any of the following are present:
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- Unexplained tachypnoea/ tachycardia
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A	I think they are (e.g. hypovolaemic). I don't know what is wrong with them but I am/carer is very concerned.
R	I would like you to (e.g. review in xx minutes please).

DATE & TIME	COMMENTS

DATE & TIME	COMMENTS

Based on the original design from Birmingham Women's and Children's NHSFT with contributions from other English charts and amendments from National SPOT Programme

≥13 Years

CS56015 NHSE 13 years PEWS Sept 2023 v2.indd 1 09/11/2023 16:15

PATIENT NAME:				HOSPITAL NO:										DATE:								DATE OF BIRTH:					
			TIME																								TIME
COMA SCALE	Eye opening (E)	Spontaneous	4																								Eyes closed by swelling = C
		To sound	3																								
		To pressure	2																								
		None	1																								
		Not testable	NT																								
	Verbal response (V)	Orientated	5																								Endotracheal Tube or tracheostomy = T
		Confused	4																								
		Words	3																								
		Sounds	2																								
		None	1																								
		Not testable	NT																								
	Best motor response (M)	Obeys commands	6																								Record the best arrival response
		Localising	5																								
		Normal flexion	4																								
		Abnormal flexion	3																								
		Extension	2																								
		None	1																								
		Not testable	NT																								
Temperature (°C)			40																								
			39																								
			38																								
			37																								
			36																								
			35																								
Blood pressure and pulse rate			230																								▪ 1
			220																								
			210																								● 2
			200																								
			190																								● 3
			180																								
			170																								● 4
			160																								
			150																								● 5
			140																								
			130																								● 6
			120																								
			110																								● 7
			100																								
			90																								● 8
			80																								
			70																								
			60																								
			50																								
			40																								
			30																								
			20																								
Respirations																											
Oxygen Saturations																											
PUPILS		Right	Size																								+ = reacts - = no reaction c = eye closed
			Reaction																								
		Left	Size																								
			Reaction																								
LIMB MOVEMENT	Arms	Normal power																									Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																									
		Severe weakness																									
		Spastic flexion																									
		Extension																									
		No response																									
	Legs	Normal power																									
		Mild weakness																									
		Severe weakness																									
		Extension																									
		No response																									
Total GCS Score																											
Initials:																											

PROMPT – MODIFIED OBSTETRIC EARLY WARNING SCORE CHART v3 (FOR MATERNITY USE ONLY)

Use identification label or: Name:
DOB:
Hospital No:

Ward: _____

Date:																		
Time:																		
Respirations (write rate in corresp. box)	>30																	>30
	21-30																	21-30
	11-20																	11-20
	0-10																	0-10
Saturations if applicable (write sats in corresp. box)	95-100%																	95-100%
	<95%																	<95%
Administered O_2 (L/min.)																		(L/min)
■ Temp	39																	39
	38																	38
	37																	37
	36																	36
	35																	35
■ Heart rate	170																	170
	160																	160
	150																	150
	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
Systolic blood pressure ←.....	200																	200
	190																	190
	180																	180
	170																	170
	160																	160
	150																	150
	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
Diastolic blood pressure .....→	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
Urine	passed (Y/N)																	passed (Y/N)
Proteinuria	protein ++																	protein ++
	Protein >++																	protein >++
Amniotic fluid	Clear (C) Pink (P)																	Clear (C) Pink (P)
	Green (G)																	Green (G)
Neuro response (√)	Alert																	Alert
	Voice																	Voice
	Pain																	Pain
	Unresponsive																	Unresponsive
Pain score (no.)	0-1																	0-1
	2-3																	2-3
Lochia	Normal (N)																	Normal (N)
	Heavy (H) Fresh (F) Offensive (O)																	Heavy (H) Fresh (F) Offensive (O)
Looks unwell	NO (√)																	NO (√)
	YES (√)																	YES (√)
Total number of amber boxes																		
Total number of red boxes																		
Monitoring frequency:																		
Escalation of care Y/N:																		
Initials:																		

Guidance for using Modified Obstetric Early Warning Score Chart

A – Alert	Alert and orientated
V – Voice	Drowsy but answers to name or some kind of response when addressed
P – Pain	Rousable with difficulty but makes response when shaken or mild pain is inflicted (e.g. rubbing sternum, pinching ears)
U - Unresponsive	No response to voice, shaking or pain

Pain scores: Record pain levels as follows:

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

Scoring and responding: Document all the scores for all parameters at bottom of the chart. Follow the escalation algorithm.

Key

Amber

Red

Identify the number of amber and/or red boxes

No Amber or Red Boxes

- Maintain frequency of observations

1 Amber Box

- Repeat observations
- Increasing frequency of observations to every 1 hour
- Seek advice from senior midwife/midwife in charge
- Consider obstetric review within 30 minutes if not settled

2 or more Amber Boxes or 1 Red Box

- Inform midwife in charge
- Immediate referral to obstetric registrar
- Increase frequency of observations to every 30 minutes
- Woman should be reviewed within 30 minutes
- Consider obstetric anaesthetist review
- Consider review by obstetric consultant

2 Red Boxes

- Inform midwife in charge
- Immediate referral to obstetric registrar/ anaesthetist
- Increase frequency of observations to every 15 minutes
- Transfer to high level of care
- Consider transfer to HDU
- Consider review by obstetric consultant

Glasgow Depression Scale Questionnaire | Name:

Instructions:

- Each question should be asked in two parts.
  First, the participant is asked to choose between a 'yes' and 'no' answer.
  If their answer is 'no', then the score in the 'no' column should be recorded as ('0').
  If their answer is 'yes', they should be asked if that is 'sometimes' or 'always', and the score recorded as appropriate.
- Supplementary questions (italics) may be used if the primary question is not understood completely.
- If a response is unclear, ask for specific examples of what the participant means, or talk with them about their answer until you feel able to score their response.

Introduction:

To establish a frame of reference for 'In the last week…' remind the person about a specific event that happened 1 week ago that can serve as a reference point.

Start the interview by saying:

'I am going to ask you about how you have been feeling in the past week or since [state specific event from 1 week ago].

	In the last week…	Never/No	Sometimes	Always/ A lot
1.	**Have you felt sad?** *Have you felt upset?* *Have you felt miserable?* *Have you felt depressed?*	0	1	2
2.	**Have you felt as if you are in a bad mood?** *Have you lost your temper?* *Have you felt as if you want to shout at people?*	0	1	2
3.	**Have you enjoyed the things you've done?** *Have you had fun?* *Have you enjoyed yourself?*	2	1	0
4.	**Have you enjoyed talking to people and being with other people?** *Have you liked having people around you?* *Have you enjoyed other people's company?*	2	1	0
5.	**Have you made sure you have washed yourself, worn clean clothes, brushed your teeth and combed your hair?** *Have you taken care of the way you look?* *Have you looked after your appearance?*	2	1	0
6.	**Have you felt tired during the day?** *Have you gone to sleep during the day?* *Have you found it hard to stay awake during the day?*	0	1	2
7.	**Have you cried?**	0	1	2
8.	**Have you been able to pay attention to things like watching TV?** *Have you been able to concentrate on things (like TV shows)?*	2	1	0
9.	**Have you found it hard to make decisions?** *Have you found it hard to decide what to wear, or what to do?* *Have you found it hard to choose between two things?*	0	1	2
10.	**Have you found it hard to sit still?** Have you fidgeted when you are sitting down? Have you been moving around a lot, like you can't help it?	0	1	2
11.	**Have you been eating too little or eating too much?** *Do people say you should eat more or less?* *[positive response for eating too much or too little is scored]*	0	1	2
12.	**Have you found it hard to get a good night's sleep?** *Have you found it hard to fall asleep at night?* *Have you woken up in the middle of the night and found it hard to get back to sleep?* *Have you woken up too early in the morning?*	0	1	2
13.	**Have you felt that life is not worth living?** *Have you wished you could die?* *Have you felt you do not want to go on living?*	0	1	2
14.	**Have you felt as if everything is your fault?** *Have you felt as if people blame you for things?* *Have you felt that things happen because of you?*	0	1	2

	In the last week…	Never/No	Sometimes	Always/ A lot
15.	**Have you felt that other people are looking at you, talking about you, or laughing at you?** *Have you worried about what other people think of you?*	0	1	2
16.	**Have you become very upset if someone says you have done something wrong or you have made a mistake?** *Do you feel sad if someone disagrees with you or argues with you?* *Do you feel like crying if someone disagrees with you or argues with you?*	0	1	2
17.	**Have you felt worried?** *Have you felt nervous?* *Have you felt tense/wound up/on edge?*	0	1	2
18.	**Have you thought that bad things keep happening to you?** *Have you felt that nothing nice ever happens to you anymore?*	0	1	2
19.	**Have you felt happy when something good happened?** *If nothing good has happened in the last week then ask: If someone gave you a nice present, would that make you happy?*	2	1	0
20.	**Totals**			
21.			**Grand total**	

SCORING INSTRUCTIONS

Note: At the conclusion of the interview, add up the scores. If you calculate a score of 13 or greater, please do one of the following:

1. seek a referral to the individual's general practitioner; or
2. seek the consultation of the psychologist on the interdisciplinary team.

Glasgow anxiety scale for people with an intellectual disability (GAS-ID)

	Questions	Never	Sometimes	Always
	Worries			
1	Do you worry a lot?	0	1	2
2	Do you have lots of thoughts that go round in your head?	0	1	2
3	Do you worry about your parents/family?	0	1	2
4	Do you worry about what will happen in the future?	0	1	2
5	Do you worry that something awful might happen?	0	1	2
6	Do you worry if you do not feel well?	0	1	2
7	Do you worry when you are doing something new?	0	1	2
8	Do you worry about what you are doing tomorrow?	0	1	2
9	Can you stop worrying?	0	1	2
10	Do you worry about death/dying?	0	1	2
	Specific fears			
11	Do you get scared in the dark?	0	1	2
12	Do you feel scared when you are high up?	0	1	2
13	Do you feel scared in lifts or on escalators?	0	1	2
14	Are you scared of dogs	0	1	2
15	Are you scared of spiders?	0	1	2
16	Do you feel scared going to see the doctor or dentist?	0	1	2
17	Do you feel scared meeting new people?	0	1	2
18	Do you feel scared in busy places?	0	1	2
19	Do you feel scared in wide open spaces?	0	1	2
	Physiological symptoms			
20	Do you ever feel hot and sweaty?	0	1	2
21	Does your heart beat faster?	0	1	2
22	Do your hands and legs shake?	0	1	2
23	Does your stomach ever feel funny, like butterflies?	0	1	2
24	Do you ever feel breathless?	0	1	2
25	Do you feel like you need to go to the toilet more than usual?	0	1	2
26	Is it difficult to sit still?	0	1	2
27	Do you feel panicky?	0	1	2
	Totals			
			Grand total	

SCORING INSTRUCTIONS

Note: At the conclusion of the interview, add up the scores. If you calculate a score of 13 or greater, please do one of the following:

1. seek a referral to the individual's general practitioner; or
2. seek the consultation of the psychologist on the interdisciplinary team.

Six-item cognitive impairment test (6CIT)

Patient's name:
Date of birth:

	Date: YESTERDAY	**Date:**	**Date:**
Question	**Score**	**Score**	**Score**
What year is it? Correct = 0 points Incorrect = 4 points			
What month is it? Correct = 0 points Incorrect = 3 points			
Remember this name and address: John Smith, 42 High Street, Bedford			
About what time is it, within one hour? Correct = 0 points Incorrect = 3 points			
Count backwards from 20 to 1 Correct = 0 points 1 error = 2 points >1 error = 4 points			
Say the months of the year in reverse Correct = 0 points 1 error = 2 points >1 errors = 4 points			
What was the name and address I asked you to remember? 1 error = 2 points 2 errors = 4 points 3 errors = 6 points 4 errors = 8 points 5 errors = 10 points			
Total score	/28	/28	/28

6CIT scoring

0-7 = normal	Referral not necessary
8-9 = mild cognitive impairment	Probably refer
10-28 = significant cognitive impairment	Refer

Kingshill version (2000) *Dementia screening tool*

The Patient Health Questionnaire (PHQ-9)

Patient name _____

NHS number _____

Date _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
Column totals				
Add totals together				

PHQ-9 score	Provisional diagnosis	Treatment recommendation *Patient preferences should be considered.*
5 – 9	Minimal symptoms	Support, educate to call if worse, return in one month
10 – 14	Minor depression Dysthymia Major depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15 – 19	Major depression, moderately severe	Antidepressant or psychotherapy
> 20	Major depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

'Malnutrition Universal Screening Tool'

BAPEN is registered charity number 1023927 www.bapen.org.uk

'MUST'

'MUST' is a five-step screening tool to identify **adults,** who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:

- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 'MUST' Steps

Step 1

Measure height and weight to get a BMI score using chart provided. *If unable to obtain height and weight, use the alternative procedures shown in this guide.*

Step 2

Note percentage unplanned weight loss and score using tables provided.

Step 3

Establish acute disease effect and score.

Step 4

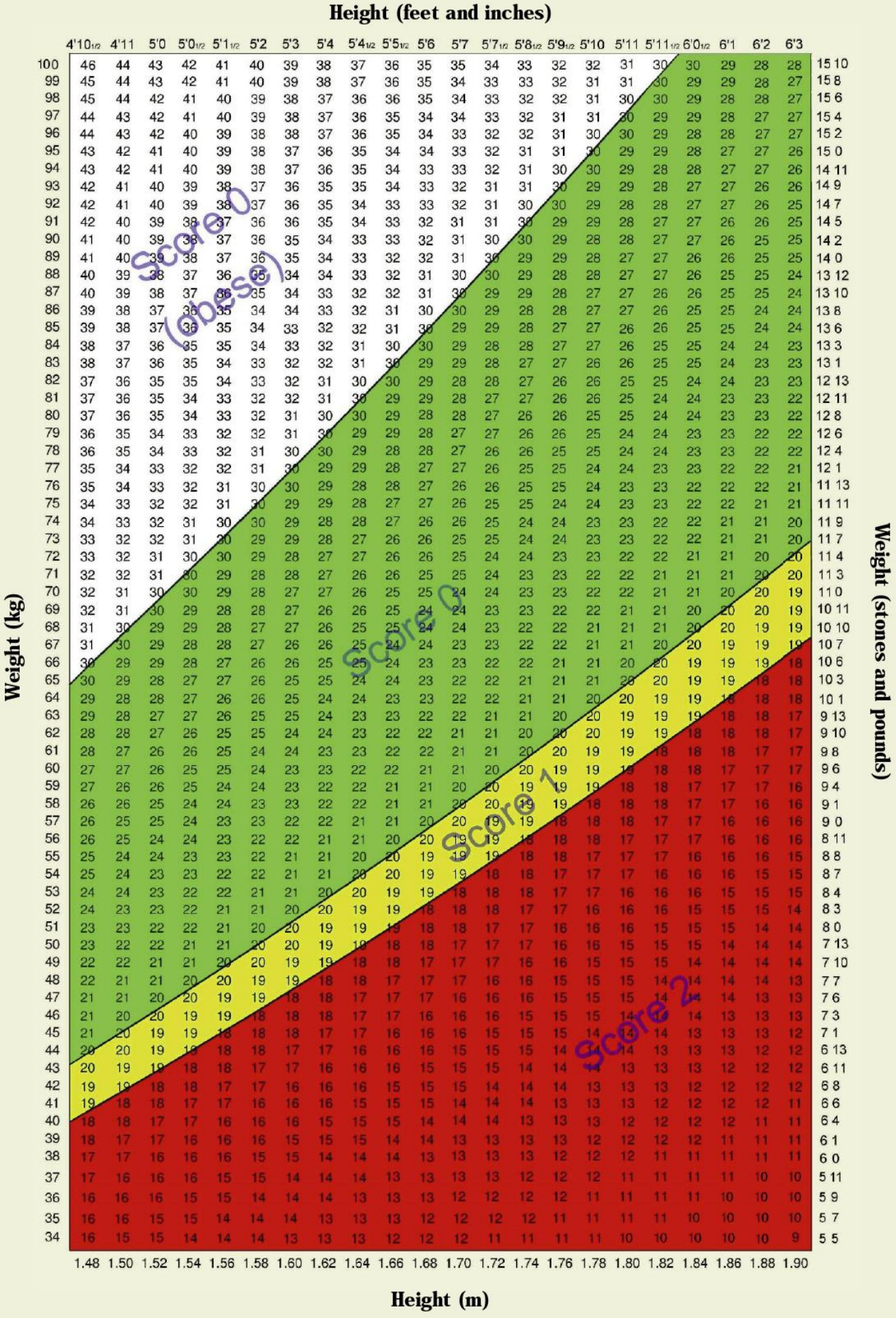
Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5

Use management guidelines and/or local policy to develop care plan.

Please refer to *The 'MUST' Explanatory Booklet* for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See *The 'MUST' Report* for supporting evidence. Please note that 'MUST' has not been designed to detect deficiencies or excessive intakes of vitamins and minerals and is of **use only in adults.**

Step 1 – BMI score (& BMI)



Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

Step 1 + Step 2 + Step 3

Step 1 — BMI score

BMI kg/m²	Score
>20(>30 Obese)	= 0
18.5-20	= 1
<18.5	= 2

Step 2 — Weight loss score

Unplanned weight loss in past 3-6 months

%	Score
<5	= 0
5-10	= 1
>10	= 2

Step 3 — Acute disease effect score

If patient is acutely ill **and** there has been or is likely to be no nutritional intake for >5 days

Score 2

If unable to obtain height and weight, see reverse for alternative measurements and use of subjective criteria

Step 4

Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition
Score 0 Low Risk Score 1 Medium Risk Score 2 or more High Risk

Step 5

Management guidelines

0 Low Risk

Routine clinical care

- Repeat screening
  Hospital – weekly
  Care Homes – monthly
  Community – annually
  for special groups
  e.g. those >75 yrs

1 Medium Risk

Observe

- Document dietary intake for 3 days if subject in hospital or care home
- If improved or adequate intake – little clinical concern; if no improvement – clinical concern - follow local policy
- Repeat screening
  Hospital – weekly
  Care Home – at least monthly
  Community – at least every 2-3 months

2 or more High Risk

Treat*

- Refer to dietitian, Nutritional Support Team or implement local policy
- Improve and increase overall nutritional intake
- Monitor and review care plan
  Hospital – weekly
  Care Home – monthly
  Community – monthly

* Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

All risk categories:

- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Record malnutrition risk category.
- Record need for special diets and follow local policy.

Obesity:

- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

Re-assess subjects identified at risk as they move through care settings

See *The 'MUST' Explanatory Booklet* for further details and *The 'MUST' Report* for supporting evidence.

Step 2 – Weight loss score

Weight before weight loss (kg)

	SCORE 0 Wt Loss < 5%	SCORE 1 Wt Loss 5-10%	SCORE 2 Wt Loss > 10%
34 kg	<1.70	1.70 – 3.40	>3.40
36 kg	<1.80	1.80 – 3.60	>3.60
38 kg	<1.90	1.90 – 3.80	>3.80
40 kg	<2.00	2.00 – 4.00	>4.00
42 kg	<2.10	2.10 – 4.20	>4.20
44 kg	<2.20	2.20 – 4.40	>4.40
46 kg	<2.30	2.30 – 4.60	>4.60
48 kg	<2.40	2.40 – 4.80	>4.80
50 kg	<2.50	2.50 – 5.00	>5.00
52 kg	<2.60	2.60 – 5.20	>5.20
54 kg	<2.70	2.70 – 5.40	>5.40
56 kg	<2.80	2.80 – 5.60	>5.60
58 kg	<2.90	2.90 – 5.80	>5.80
60 kg	<3.00	3.00 – 6.00	>6.00
62 kg	<3.10	3.10 – 6.20	>6.20
64 kg	<3.20	3.20 – 6.40	>6.40
66 kg	<3.30	3.30 – 6.60	>6.60
68 kg	<3.40	3.40 – 6.80	>6.80
70 kg	<3.50	3.50 – 7.00	>7.00
72 kg	<3.60	3.60 – 7.20	>7.20
74 kg	<3.70	3.70 – 7.40	>7.40
76 kg	<3.80	3.80 – 7.60	>7.60
78 kg	<3.90	3.90 – 7.80	>7.80
80 kg	<4.00	4.00 – 8.00	>8.00
82 kg	<4.10	4.10 – 8.20	>8.20
84 kg	<4.20	4.20 – 8.40	>8.40
86 kg	<4.30	4.30 – 8.60	>8.60
88 kg	<4.40	4.40 – 8.80	>8.80
90 kg	<4.50	4.50 – 9.00	>9.00
92 kg	<4.60	4.60 – 9.20	>9.20
94 kg	<4.70	4.70 – 9.40	>9.40
96 kg	<4.80	4.80 – 9.60	>9.60
98 kg	<4.90	4.90 – 9.80	>9.80
100 kg	<5.00	5.00 – 10.00	>10.00
102 kg	<5.10	5.10 – 10.20	>10.20
104 kg	<5.20	5.20 – 10.40	>10.40
106 kg	<5.30	5.30 – 10.60	>10.60
108 kg	<5.40	5.40 – 10.80	>10.80
110 kg	<5.50	5.50 – 11.00	>11.00
112 kg	<5.60	5.60 – 11.20	>11.20
114 kg	<5.70	5.70 – 11.40	>11.40
116 kg	<5.80	5.80 – 11.60	>11.60
118 kg	<5.90	5.90 – 11.80	>11.80
120 kg	<6.00	6.00 – 12.00	>12.00
122 kg	<6.10	6.10 – 12.20	>12.20
124 kg	<6.20	6.20 – 12.40	>12.40
126 kg	<6.30	6.30 – 12.60	>12.60

Weight before weight loss (st lb)

	SCORE 0 Wt Loss < 5%	SCORE 1 Wt Loss 5-10%	SCORE 2 Wt Loss > 10%
5st 4lb	<4lb	4lb – 7lb	>7lb
5st 7lb	<4lb	4lb – 8lb	>8lb
5st 11lb	<4lb	4lb – 8lb	>8lb
6st	<4lb	4lb – 8lb	>8lb
6st 4lb	<4lb	4lb – 9lb	>9lb
6st 7lb	<5lb	5lb – 9lb	>9lb
6st 11lb	<5lb	5lb – 10lb	>10lb
7st	<5lb	5lb – 10lb	>10lb
7st 4lb	<5lb	5lb – 10lb	>10lb
7st 7lb	<5lb	5lb – 11lb	>11lb
7st 11lb	<5lb	5lb – 11lb	>11lb
8st	<6lb	6lb – 11lb	>11lb
8st 4lb	<6lb	6lb – 12lb	>12lb
8st 7lb	<6lb	6lb – 12lb	>12lb
8st 11lb	<6lb	6lb – 12lb	>12lb
9st	<6lb	6lb – 13lb	>13lb
9st 4lb	<7lb	7lb – 13lb	>13lb
9st 7lb	<7lb	7lb – 13lb	>13lb
9st 11lb	<7lb	7lb – 1st 0lb	>1st 0lb
10st	<7lb	7lb – 1st 0lb	>1st 0lb
10st 4lb	<7lb	7lb – 1st 0lb	>1st 0lb
10st 7lb	<7lb	7lb – 1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb – 1st 1lb	>1st 1lb
11st	<8lb	8lb – 1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb – 1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb – 1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb – 1st 3lb	>1st 3lb
12st	<8lb	8lb – 1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb – 1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb – 1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb – 1st 4lb	>1st 4lb
13st	<9lb	9lb – 1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb – 1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb – 1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb – 1st 5lb	>1st 5lb
14st	<10lb	10lb – 1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb – 1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb – 1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb – 1st 7lb	>1st 7lb
15st	<11lb	11lb – 1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb – 1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb – 1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb – 1st 8lb	>1st 8lb
16st	<11lb	11lb – 1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb – 1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb – 1st 9lb	>1st 9lb

Alternative measurements and considerations

Step 1: BMI (body mass index)

If height cannot be measured

- Use recently documented or self-reported height (if reliable and realistic).
- If the subject does not know or is unable to report their height, use one of the alternative measurements to estimate height (ulna, knee height or demispan).

If height & weight cannot be obtained

- Use mid upper arm circumference (MUAC) measurement to estimate BMI category.

Step 2: Recent unplanned weight loss

If recent weight loss cannot be calculated, use self-reported weight loss (if reliable and realistic).

Subjective criteria

If height, weight or BMI cannot be obtained, the following criteria which relate to them can assist your professional judgement of the subject's nutritional risk category. Please note, use of these criteria is not designed to assign a score.

1. BMI

- Clinical impression – thin, acceptable weight, overweight. Obvious wasting (very thin) and obesity (very overweight) can also be noted.

2. Unplanned weight loss

- Clothes and/or jewellery have become loose fitting (weight loss).
- History of decreased food intake, reduced appetite or swallowing problems over 3-6 months and underlying disease or psycho-social/physical disabilities likely to cause weight loss.

3. Acute disease effect

- No nutritional intake or likelihood of no intake for more than 5 days.

Further details on taking alternative measurements, special circumstances and subjective criteria can be found in *The 'MUST' Explanatory Booklet*. A copy can be downloaded at www.bapen.org.uk or purchased from the BAPEN office. The full evidence-base for 'MUST' is contained in *The 'MUST' Report* and is also available for purchase from the BAPEN office.

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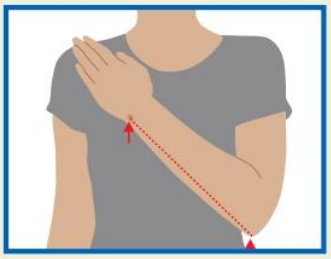
Alternative measurements: instructions and tables

If height cannot be obtained, use length of forearm (ulna) to calculate height using tables below. *(See The 'MUST' Explanatory Booklet for details of other alternative measurements (knee height and demispan) that can also be used to estimate height).*

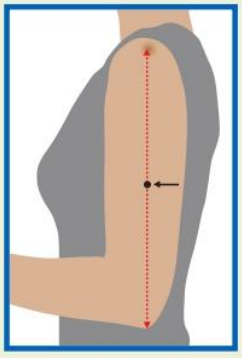
Estimating height from ulna length



Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

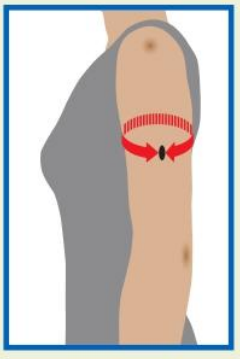
HEIGHT (m)	Men (<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
	Men (>65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
	Ulna length (cm)	32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
HEIGHT (m)	Women (<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
	Women (>65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
HEIGHT (m)	Men (<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
	Men (>65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
	Ulna length (cm)	25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
HEIGHT (m)	Women (<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
	Women (>65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

Estimating BMI category from mid upper arm circumference (MUAC)



The subject's left arm should be bent at the elbow at a 90 degree angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.

Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug but not tight.



If MUAC is < 23.5 cm, BMI is likely to be <20 kg/m^2.
If MUAC is > 32.0 cm, BMI is likely to be >30 kg/m^2.

The use of MUAC provides a general indication of BMI and is not designed to generate an actual score for use with 'MUST'. For further information on use of MUAC please refer to *The 'MUST' Explanatory Booklet.*

Oral health assessment tool

Resident: Completed by: Date:

Scores – You can circle individual words as well as giving a score in each category
(* if 1 or 2 scored for any category please organise for a dentist to examine the resident)
0 = healthy 1 = changes* 2 = unhealthy*

Lips:

Smooth, pink, moist	0
Dry, chapped, or red at corners	1
Swelling or lump, white, red or ulcerated patch; bleeding or ulcerated at corners	2

Dental pain:

No behavioural, verbal, or physical signs of dental pain	0
There are verbal and/or behavioural signs of pain such as pulling at face, chewing lips, not eating, aggression	1
There are physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal and/or behavioural signs (pulling at face, not eating, aggression)	2

Natural teeth Yes/No:

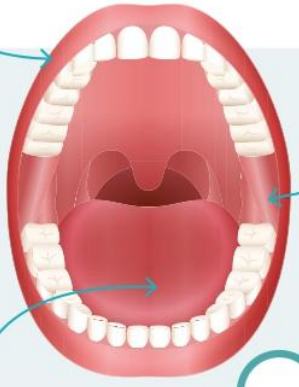
No decayed or broken teeth or roots	0
1–3 decayed or broken teeth or roots or very worn down teeth	1
4+ decayed or broken teeth or roots, or very worn down teeth, or less than 4 teeth	2

Oral cleanliness:

Clean and no food particles or tartar in mouth or dentures	0
Food particles, tartar or plaque in 1–2 areas of the mouth or on small area of dentures or halitosis (bad breath)	1
Food particles, tartar or plaque in most areas of the mouth or on most of dentures or severe halitosis (bad breath)	2

Dentures Yes/No:

No broken areas or teeth, dentures regularly worn, and named	0
1 broken area or tooth or dentures only worn for 1–2 hours daily, or dentures not named, or loose	1
More than 1 broken area or tooth, denture missing or not worn, loose and needs denture adhesive, or not named	2



Tongue:

Normal, moist roughness, pink	0
Patchy, fissured, red, coated	1
Patch that is red and/or white, ulcerated, swollen	2

Saliva:

Moist tissues, watery and free flowing saliva	0
Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth	1
Tissues parched and red, little or no saliva present, saliva is thick, resident thinks they have a dry mouth	2

Gums and tissues:

Pink, moist, smooth, no bleeding	0
Dry, shiny, rough, red, swollen, 1 ulcer or sore spot under dentures	1
Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures	2

- ☐ Organise for resident to have a dental examination by a dentist
- ☐ Resident and/or family or guardian refuses dental treatment
- ☐ Complete oral hygiene care plan and start oral hygiene care interventions for resident
- ☐ Review this resident's oral health again on date:

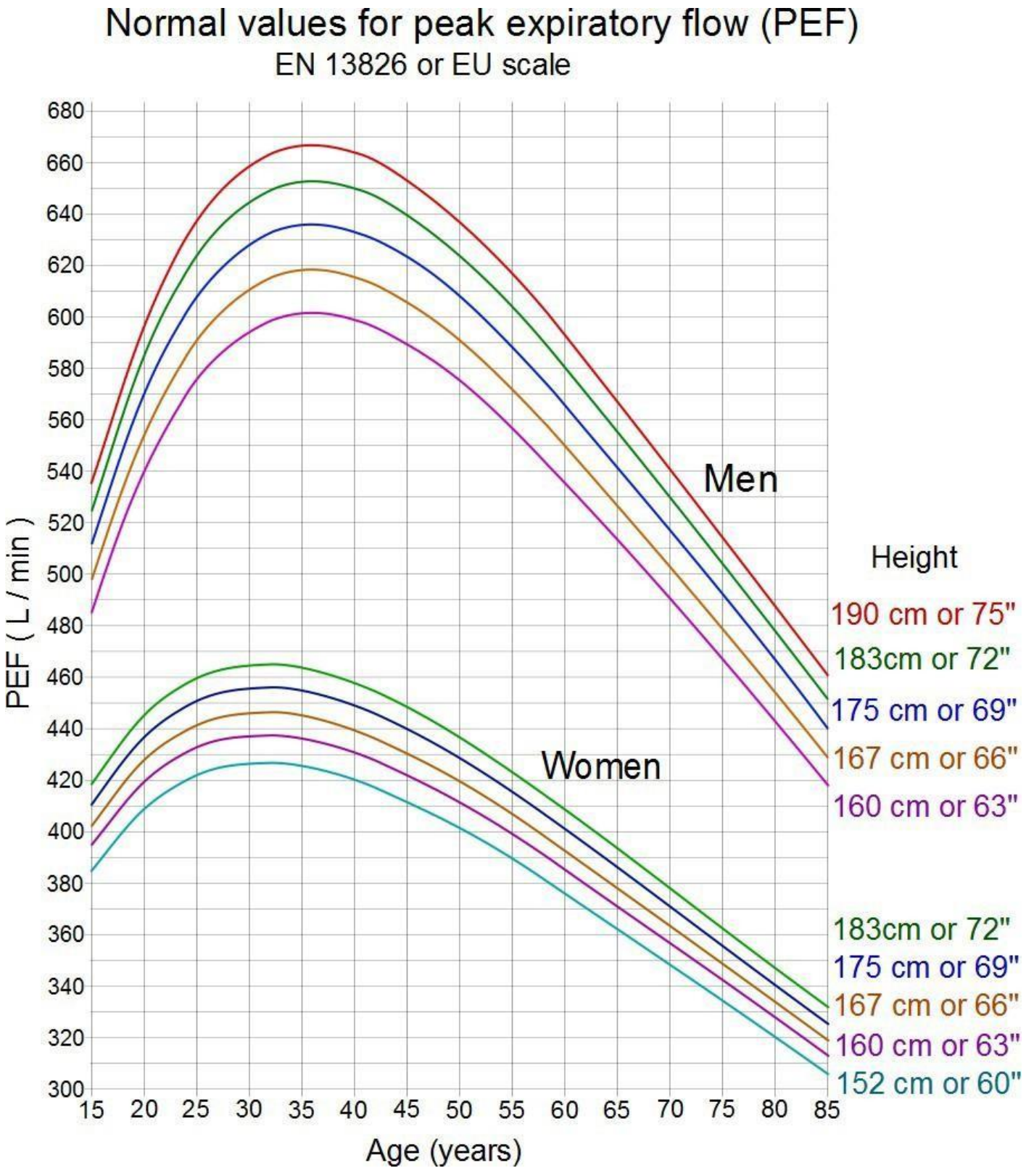
TOTAL:

SCORE: 16

With kind permission of the Australian Institute of Health and Welfare (AIHW). Source: AIHW Caring for oral health in Australian residential care (2009).
Modified from Kayser-Jones et al. (1995) by Chalmers (2004).

Peak expiratory flow rate chart:

Patient name:
D.O.B:
Address:



PAEDIATRIC NORMAL VALUES

PEAK EXPIRATORY FLOW RATE

For use with EU/ EN13826 scale PEF meters only

Height (m)	Height (ft)	Predicted **EU** PEFR (Umin)		Height (m)	Height (ft)	Predicted **EU** PEFR (Umin)
0.85	2'9"	87		**1.30**	4'3"	212
0.90	2'11"	95		**1.35**	4'5"	233
0.95	3'1"	104		**1.40**	4'7"	254
1.00	3'3"	115		**1.45**	4'9"	276
1.05	3'5"	127		**1.50**	4'11	299
1.10	3'7"	141		**1.55**	5'1	323
1.15	3'9"	157		**1.60**	5'3"	346
1.20	3'11"	174		**1.65**	5'5"	370
1.25	4'1"	192		**1.70**	5'7"	393

Normal PEF values in children correlate best with height; with increasing age, larger differences occur between the sexes. These predicted values are based on the formulae given in Lung Function by J.E. Cotes (Fourth Edition), adapted for EU scale Mini-Wright peak flow meters by Clement Clarke.

Mini-Wright™ PEAK FLOW METER

Date of preparation - 7th October 2004

Mini-Wright (Standard Range) EU scale
Blue text on a yellow background

Single Patient Use: Part Ref: 3103388
Multiple Patient Use: Part Ref: 3103387
NHS Logistics Code: FDD 609

Mini-Wright (Low Range) EU scale
Blue text on a yellow background

Single Patient use: Part Ref: 3104708
Multiple Patient Use: Part Ref: 3104710
www.peakflow.com

CLEMENT CLARKE INTERNATIONAL
Precision byTradition

Clement Clarke International Ltd. Edinburgh Way, Harlow, Essex. England CM20 2TT U.K.
Tel. +44 (0) 1279 414969 Fax. +44 (0) 1279 456304 www.peakflow.com email: resp@clement-clarke.com

v22

Distress and Discomfort Assessment Tool

Individual's name:	
Date of birth:	**Gender:**
NHS no.:	
Your name:	
Date completed:	
Names of others who helped to complete this form:	

THE DISTRESS PASSPORT

Summary of signs and behaviours when content and when distressed

	When CONTENT	When DISTRESSED
APPEARANCE • Face: • Jaw & tongue: • Eyes: • Skin:	• Passive/smiling • Relaxed • Limited eye contact • Normal	• Grimace/frightened • Rigid • Screwed up/no eye contact • Normal
VOCAL SOUNDS • Sounds: • Speech:	• Low, short, laugh • Unclear, slow, soft	• High, short, cry out • Unclear, fast, loud
HABITS & MANNERISMS • Habits: • Mannerisms: • Comfortable distance:	• Fidgety • Relaxed arm movements • Close, only if known	• Rock back and forward • Clenching fists and arms of chair • No-one allowed close
POSTURE & OBSERVATIONS • Posture: • Observations:	• Jerky – able to adjust position • Normal pulse, steady breathing. Sleeping and eating habits are good but eats quickly.	• Rigid and tense • Fast pulse with rapid breathing. Broken sleeping pattern and increased appetite, favouring sugary foods and drinks.

Known triggers of distress (write here any actions or situations that usually cause or worsen distress):

Distress and Discomfort Assessment Tool

Please take some time to think about and observe the individual under your care, especially their appearance and behaviours when they are both content and distressed. Use these pages to document these.

We have listed words in each section to help you to describe the signs and behaviours. You can circle the word or words that best describe the signs and behaviours when they are content and when they are distressed.

Your descriptions will provide you with a clearer picture of their 'language' of distress.

COMMUNICATION LEVEL *	Ring their level when well	unwell
This individual is unable to show likes or dislikes	Level 0	Level 0
This individual is able to show that they like or don't like something	Level 1	Level 1
This individual is able to show that they want more, or have had enough of something	Level 2	Level 2
This individual is able to show anticipation for their like or dislike of something	Level 3	Level 3
This individual is able to communicate detail, qualify, specify and/or indicate opinions	Level 4	Level 4

* This is adapted from the Kidderminster Curriculum for Children and Adults with Profound Multiple Learning Difficulty (Jones, 1994, National Portage Association).

FACIAL SIGNS

Appearance

What to do	Appearance when content	Appearance when distressed
Ring the words that best fit the facial appearance. Add your words if you want.	Passive Laugh Smile Frown Grimace Startled **In your own words:**	Passive Laugh Smile Frown Grimace Startled Frightened **In your own words:**

Jaw or tongue movement

What to do	Movement when content	Movement when distressed
Ring the words that best fit the jaw or tongue movement. Add your words if you want.	Relaxed Drooping Grinding Biting Rigid Shaking **In your own words:**	Relaxed Drooping Grinding Biting Rigid Shaking **In your own words:**

Appearance of eyes

What to do	Appearance when content	Appearance when distressed
Ring the words that best fit the appearance of the eyes. Add your words if you want.	Good eye contact Little eye contact Avoiding eye contact Closed eyes Staring Sleepy eyes 'Smiling' Winking Vacant Tears Dilated pupils **In your own words:**	Good eye contact Little eye contact Avoiding eye contact Closed eyes Staring Sleepy eyes 'Smiling' Winking Vacant Tears Dilated pupils **In your own words:**

BODY OBSERVATIONS: SKIN APPEARANCE

What to do	Appearance when content	Appearance when distressed
Ring the words that best fit the describe the appearance of the skin. Add your words if you want.	Normal Pale Flushed Sweaty Clammy **In your own words:**	Normal Pale Flushed Sweaty Clammy **In your own words:**

VOCAL SOUNDS (NB. The sounds that a person makes are not always linked to their feelings)

What to do	Sounds when content	Sounds when distressed
Ring the words that best describe the sounds *Write down* commonly used sounds (write it as it sounds; 'tizz', 'eeiow', 'tetetetete'): …… …… ……	**Volume**: high medium low **Pitch**: high medium low **Duration:** short intermittent long **Description of sound / vocalisation**: Cry out Wail Scream laugh Groan / moan shout Gurgle **In your own words:**	**Volume:** high medium low **Pitch:** high medium low **Duration**: short intermittent long **Description of sound / vocalisation**: Cry out Wail Scream laugh Groan / moan shout Gurgle **In your own words:**

SPEECH

What to do	Words when content	Words when distressed
Write down commonly used words and phrases. If no words are spoken, write NONE		
Ring the words which best describe the speech	Clear Stutters Slurred Unclear Muttering Fast Slow Loud Soft Whisper Other, eg. swearing:	Clear Stutters Slurred Unclear Muttering Fast Slow Loud Soft Whisper Other, eg.swearing:

HABITS & MANNERISMS

What to do	Habits and mannerisms when content	Habits and mannerisms when distressed
Write down the habits or mannerisms, eg. "Rocks when sitting"	Fidgety with relaxed arm movements	Rocks back and forward when sitting, clench fists
Write down any special comforters, possessions or toys this person prefers.	Stress ball	Stress ball
Please Ring the statement which best describes how comfortable this person is with other people being physically close by	Close with strangers Close only if known No one allowed close Withdraws if touched	Close with strangers Close only if known No one allowed close Withdraws if touched

BODY POSTURE

What to do	Posture when content	Posture when distressed
Ring the words that best describe how this person sits and stands.	Normal Rigid Floppy Jerky Slumped Restless Tense Still Able to adjust position Leans to side Poor head control Way of walking: Normal / Abnormal Other:	Normal Rigid Floppy Jerky Slumped Restless Tense Still Able to adjust position Leans to side Poor head control Way of walking: Normal / Abnormal Other:

BODY OBSERVATIONS: OTHER

What to do	Observations when content	Observations when distressed
Describe the pulse, breathing, sleep, appetite and usual eating pattern, eg. eats very quickly, takes a long time with main course, eats puddings quickly, “picky”.	**Pulse:** Normal limits **Breathing:** Steady **Sleep:** Uninterrupted **Appetite:** Good **Eating pattern:** Eats quickly	**Pulse**: Fast **Breathing:** Rapid **Sleep:** Broken **Appetite:** Increased **Eating pattern:** Eats quickly and favours sugary food and drink

Information and Instructions

DisDAT is

Intended to help identify distress cues in individuals who have severely limited communication.

Designed to describe an individual's usual content cues, thus enabling distress cues to be identified more clearly.

NOT a scoring tool. It documents what many carers have done instinctively for many years thus providing a record against which subtle changes can be compared.

Only the first step. Once distress has been identified the usual clinical decisions have to be made by professionals.

Meant to help you and the individual in your care. It gives you more confidence in the observation skills you already have, which in turn will give you more confidence when meeting other carers.

When to use DisDAT

When the carer believes the individual is NOT distressed

The use of DisDAT is optional, but it can be used as a
- baseline assessment document
- transfer document for other carers.

When the carer believes the individual IS distressed

If DisDAT has already been completed it can be used to compare the present signs and behaviours with previous observations documented on DisDAT. It then serves as a baseline to monitor change.

If DisDAT has not been completed:

a) When the person is well known DisDAT can be used to document previous content signs and behaviours and compare these with the current observations

b) When the person is new to a carer, or the distress is new, DisDAT can be used document the present signs and behaviours to act a baseline to monitor change.

How to use DisDAT

1. **Observe the individual** when content and when distressed- document this on the inside pages. *Anyone* who cares for them can do this.
2. **Observe the context** in which distress is occurring.
3. **Use the clinical decision distress checklist** on this page to assess the possible cause.
4. **Treat or manage** the likeliest cause of the distress.
5. **The monitoring sheet** is a separate sheet, which will help if you want to observe a pattern of distress or see how the distress changes over time. It's use is optional. There are three types to choose from the website- use whichever suits you best.
6. **The goal** is a reduction the number or severity of distress signs and behaviours.

Remember

- Most information comes from several carers together.
- The assessment form need not be completed all at once and may take a period of time.
- Reassessment is essential as the needs may change due to improvement or deterioration.
- Distress can be emotional, physical or psychological. What is a minor issue for one person can be major to another.
- If signs are recognised early then suitable interventions can be put in place to avoid a crisis.

Clinical decision distress checklist

Use this to help decide the cause of the distress

1. **Is the sign repeated rapidly?**
If in time with breathing: see 2 below.
If it comes and goes every few minutes: consider colic (bowel, bladder or period pain).
Consider: repetitive movement due to boredom or fear.

2. **Is the sign associated with breathing?**
Consider: rib damage or irritation of the lung's outer membrane (this will need a medical assessment).

3. **Is the sign worsened or precipitated by movement?**
Consider: movement-related pains.

4. **Is the sign related to eating?**
Consider: food refusal through illness, fear or depression, swallowing problems or nausea.
Consider: poor oral hygiene, indigestion or abdominal problems.

5. **Is the sign related to a specific situation?**
Consider: frightening or painful situations.

6. **Is the sign associated with vomiting?**
Consider: causes of nausea and vomiting.

7. **Is the sign associated with passing urine or faeces?**
Consider: urine infection or retention, diarrhoea, constipation, anal problems.

8. **Is the sign present in a normally comfortable position or situation?** *Consider:* anxiety, depression, pains at rest (eg. colic, neuralgia), infection, nausea.

If you require any help or further information regarding DisDAT please contact:
Lynn Gibson and Dorothy Matthews on
Dorothy.Matthews@cntw.nhs.uk
or Claud Regnard claudregnard@stoswaldsuk.org

For more information see
www.disdat.co.uk

Further reading

Regnard C, Matthews D, Gibson L, Clarke C, Watson B. Difficulties in identifying distress and its causes in people with severe communication problems. *International Journal of Palliative Nursing,* 2003, 9(3): 173-6.

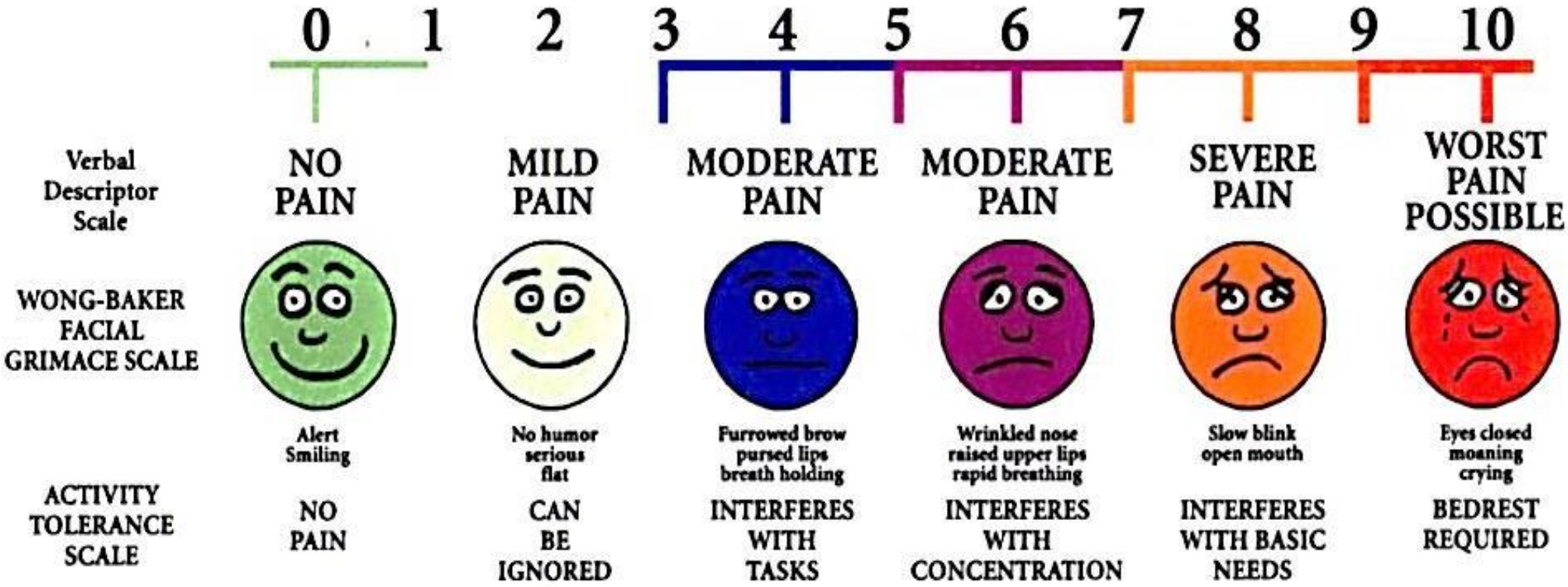
Regnard C, Reynolds J, Watson B, Matthews D, Gibson L, Clarke C. Understanding distress in people with severe communication difficulties: developing and assessing the Disability Distress Assessment Tool (DisDAT). J Intellect Disability Res. 2007; **51(4)**: 277-292.

**Distress may be hidden,
but it is never silent**

MODERATE

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.



Braden Risk Assessment Chart					
Patient Name:		**Evaluator's Name:**			**Date:**
					Score:
Sensory Perception - Ability to respond meaningfully to pressure related discomfort	**1.Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2.Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**3.Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4.No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort	
Moisture -Degree to which skin is exposed to moisture	**1.Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/ client is moved or turned.	**2.Very Moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3.Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4.Rarely moist** Skin is usually dry. Linen only requires changing at routine intervals.	
Activity -Degree of physical activity	**1.Bedfast** Confined to bed	**2.Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4.Walks Frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	
Mobility - Ability to change and control body position	**1.Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2.Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3.Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4.No Limitations** Makes major and frequent changes in position without assistance.	
Nutrition -Usual food intake pattern	**1.Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2.Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3.Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4.Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	
Friction and Shear	**1.Problem** Requires moderate to maximum assistance in moving.	**2.Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	**3.No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
				Total:	

Fluid Balance Chart

NAME:		HOSPITAL NUMBER:	
DATE:			

TIME	INPUT							OUTPUT					
	ORAL		PARENTERAL			HOUR TOTAL	TOTAL INPUT	URINE	GASTRIC LOSSES	BOWELS	DRAINS	HOUR TOTAL	TOTAL OUTPUT
0800													
0900													
1000													
1100													
1200													
1300													
1400													
1500													
1600													
1700													
1800													
1900													
2000													
2100													
2200													
2300													
0000													
0100													
0200													
0300													
0400													
0500													
0600													
0700													

PRINT NAME OF NURSE COMPLETING THE FLUID BALANCE CHART:

SIGNATURE OF NURSE COMPLETING THE FLUID BALANCE CHART:

TOTAL BALANCE:

(NEGATIVE/POSITIVE):

Phlebitis Score

All patients with an intravenous access device should have the IV site checked every shift for signs of infusion phlebitis. Tile subsequent score and action{s) taken (if any) must be documented on the cannula record form.

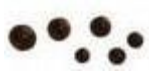
The cannula site must also be observed:
- Wilen bolus injections arc administered
- IV flow rates arc checked or altered
- Wilen solution containers are changed

With permission from Andrew Jackson – Consultant Nurse, Intravenous Therapy & Care, The Rotherham NHS Foundation Trust (Adapted from Jackson, 1998)

BIBRAUN
SHARING EXPERTISE

Overview and documentation
Bowel assessment

Candidate name: _____

Date	**Time**	**Type 1** Separate hard lumps like nuts (hard to pass) 	**Type 2** Sausage shaped but lumpy 	**Type 3** Like a sausage but with cracks on surface 	**Type 4** Like a sausage or snake, smooth and soft 	**Type 5** Soft blobs with clear-cut edges (passed easily) 	**Type 6** Fluffy pieces with ragged edges, a mushy stool 	**Type 7** Watery, no solid pieces (entirely liquid) 	**Bowels not opened**	**Comments** i.e. volume (small, medium, large) blood, mucous	**Staff initials**

Documentation
Blood glucose monitoring

Candidate name: _____

Patient details	Date & time	Blood glucose level mmol/L	Name & signature
Name:			
Address:			
Date of birth:			
Hospital number: Allergies: Consultant:			

Documentation
Mid-stream sample of urine and urinalysis

Candidate name:_____

Patient details:	Test strip:	Values:
Name: Address: Dateofbirth: Allergies: GP:	**Leucocytes**	
	Nitrates	
	Protein	
	pH	
	Blood	
	Specific gravity	
	Ketones	
	Glucose	

Documentation
Nutritional assessment

Candidate name: _____

Name: **Address**: **DoB:**						
		Step 1	**Step 2**	**Step 3**	**Step 4**	
Date	**Time**	**BMI score**	**Weight loss score**	**Acute disease effect score**	**Overall risk of malnutrition score**	**Staff name & initials**

Prescription
Administration of inhaled medication

Candidate name: _____

<table>
<tr><th>Patient details:</th><th>Medication:</th><th>Dose:</th><td rowspan="4">Signature:

Date:

Time:</td></tr>
<tr><td>Name:
Address:
Date of birth:
Hospital number:</td><td></td><td></td></tr>
<tr><td colspan="2">Allergies:</td><td>Weight:</td></tr>
<tr><td colspan="2">Prescriber:</td><td>Height:
Signature of doctor and date:</td></tr>
</table>

Inpatient Maternal Sepsis Screening Tool

To be applied to all women who are pregnant or up to six weeks postpartum (or after the end of pregnancy if pregnancy did not end in a birth) who have a suspected infection or have clinical observations outside normal limits

THE UK SEPSIS TRUST

Patient details:

Staff member completing form:

Date (DD/MM/YY):

Name (print):

Designation:

Signature:

1. Has MEOWS triggered? — Tick

OR does woman look sick?

OR is baby tachycardic (≥160 bpm)?

N → Low risk of sepsis. Use standard protocols, consider discharge with safety netting. Consider obstetric needs.

Y

2. Could this be an infection? — Tick

- Yes, but source unclear at present
- Chorioamnionitis/ endometritis
- Urinary Tract Infection
- Infected caesarean or perineal wound
- Influenza, severe sore throat, or pneumonia
- Abdominal pain or distension
- Breast abscess/ mastitis
- Other (specify):

N

Y

3. Is **ONE** maternal Red Flag present? — Tick

- Responds only to voice or pain/ unresponsive
- Systolic B.P ≤ 90 mmHg (or drop >40 from normal)
- Heart rate > 130 per minute
- Respiratory rate ≥ 25 per minute
- Needs oxygen to keep SpO_2 ≥92%
- Non-blanching rash, mottled/ ashen/ cyanotic
- Not passed urine in last 18 hours
- Urine output less than 0.5 ml/kg/hr
- Lactate ≥2 mmol/l

(note- lactate may be raised in & immediately after normal labour & delivery)

N

Y

4. Any Maternal Amber Flag criteria? — Tick

- Relatives concerned about mental status
- Acute deterioration in functional ability
- Respiratory rate 21-24 OR breathing hard
- Heart rate 100-130 OR new arrhythmia
- Systolic B.P 91-100 mmHg
- Not passed urine in last 12-18 hours
- Temperature < 36ºC
- Immunosuppressed/ diabetes/ gestational diabetes
- Has had invasive procedure in last 6 weeks (e.g. CS, forceps delivery, ERPC, cerclage, CVs, miscarriage, termination)
- Prolonged rupture of membranes
- Close contact with GAS
- Bleeding/ wound infection/ vaginal discharge
- Non-reassuring CTG/ fetal tachycardia >160

N

Y

	Time complete	Initials
Send bloods *if 2 criteria present, consider if 1* *Include lactate, FBC, U&Es, CRP, LFTs, clotting*		
Immediate call to ST3+ doctor/ Shift Leader *For review within 1hr*		
Time clinician/ Midwife attended		

Is Acute Kidney Injury (AKI) present? YES ☐ NO ☐

Y

	Time complete	Initials
Clinician to make antimicrobial prescribing decision within 3h		

Red Flag Sepsis!! Start Sepsis 6 pathway NOW

This is time critical, immediate action is required.

CANDIDATE NAME:				
Name:	Gravida:	Para:	Hospital number:	Blood Group:
Date of admission:	Time of admission:	Ruptured membranes:	Hours of membrane rupture:	

Hours	1	2	3	4	5														
Time																			

Fetal heart rate		
	200	
	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
	90	
	80	

Amniotic fluid		I = Intact
Moulding / = none		
Cervix (cm) [Plot X]	10	
	9	
	8	
	7	
	6	
	5	
	4	
	3	
	2	
	1	
	0	
Descent of PP in relation to ischial spines [Plot O]	-3	
	-2	
	-1	
	0	
	+1	
	+2	

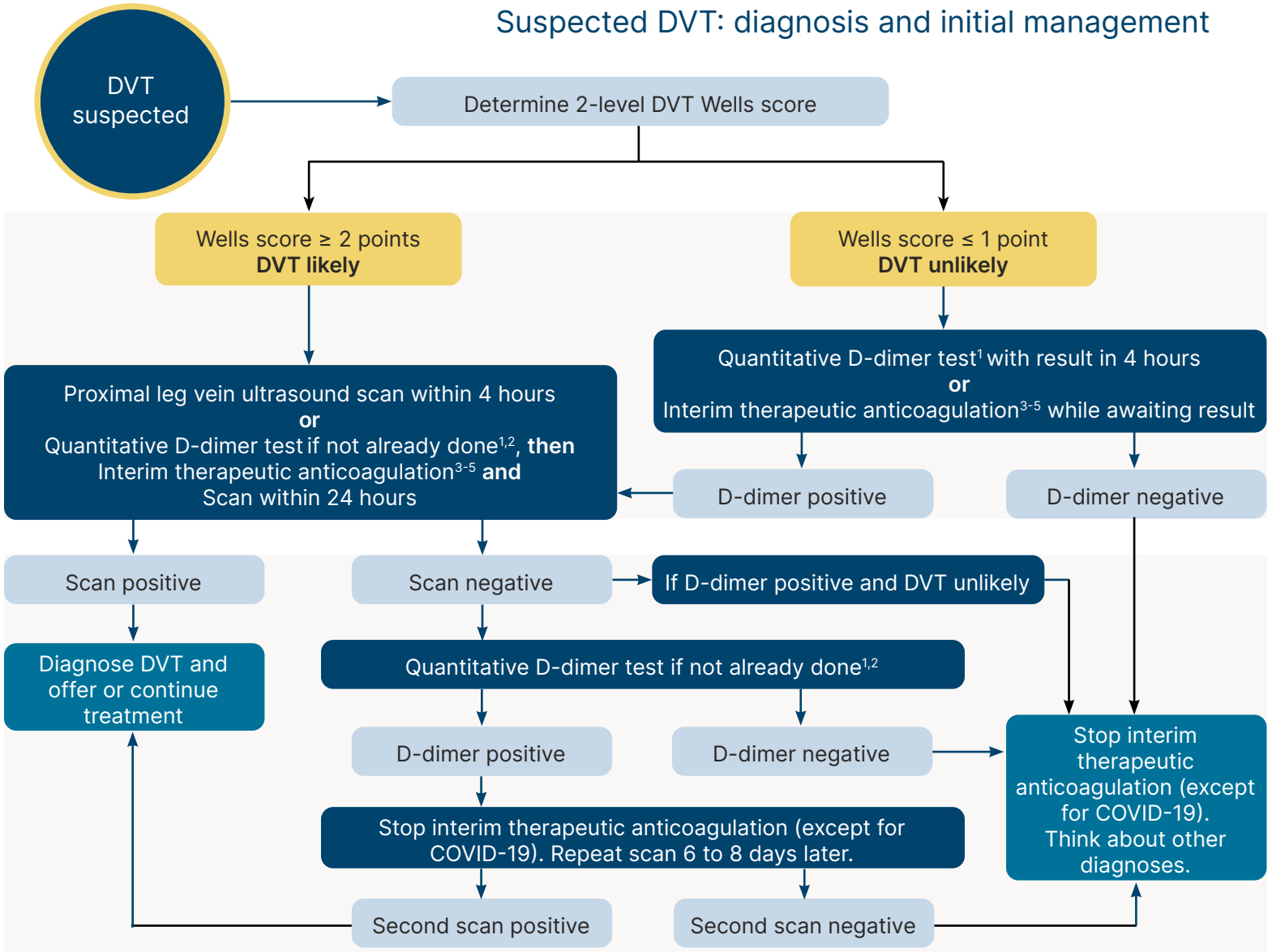
Contractions per 10 mins	5	
	4	
	3	
	2	
	1	
Oxytocin U/L		
mls/hr		

Hours	1	2	3	4	5													
Time																		

Drugs given and IV Fluids			N_2O+O_2 (Entonox)	N_2O+O_2 (Entonox)														
Pulse ● and BP	180																	
	170																	
	160																	
	150																	
	140																	
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
Temp °C																		
Urine	Protein																	
	Ketones																	
	volume																	
Signature																		

Venous thromboembolism: diagnosis and anticoagulation treatment

Suspected DVT: diagnosis and initial management



2-level DVT Wells score

Clinical feature	Points
Active cancer (treatment ongoing, within 6 months, or palliative)	1
Paralysis, paresis or recent plaster immobilisation of lower extremities	1
Recently bedridden for 3 days or more, or major surgery within 12 weeks requiring general or regional anaesthesia	1
Localised tenderness along the distribution of the deep venous system	1
Entire leg swollen	1
Calf swelling at least 3 cm larger than asymptomatic side	1
Pitting oedema confined to the symptomatic leg	1
Collateral superficial veins (non-varicose)	1
Previously documented DVT	1
An alternative diagnosis is at least as likely as DVT	-2
DVT likely: 2 points or more DVT unlikely: 1 point or less	

Adapted with permission from Wells et al. (2003)

Do not stop short-term anticoagulation when used for primary VTE prevention in people with COVID-19

See the recommendations on VTE prophylaxis in the NICE guideline on managing COVID-19

[1]Laboratory or point-of-care test. Consider age-adjusted threshold for people over 50
[2]Note that only one D-dimer test is needed during diagnosis
[3]Measure baseline blood count, renal and hepatic function, PT and APTT but start anticoagulation before results available and review within 24 hours
[4]If possible, choose an anticoagulant that can be continued if DVT confirmed
[5]Direct-acting anticoagulants and some LMWHs are off label for use in suspected DVT. Follow GMC guidance on prescribing unlicensed medicines