A Common Language Across Healthcare:

Using RESTORE2 & NEWS2 to identify the physically deteriorating patient in Care/Nursing Homes

Training Pack

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

NHS Parliamentary Awards
RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Joint national winner for 'Excellence in Primary Care'

Endorsed by Steven Brine MP for Winchester & Chandler's Ford

Objectives and Aims

Objective

- To provide staff with an overview of the RESTORE2 tool and the necessary skills and knowledge to apply the tool in practice

Aims

- To provide an understanding of the advantages of applying the RESTORE2 tool to recognise and react to the deteriorating resident
- Train staff on the steps and processes of applying the RESTORE2 tool in practice, including soft signs, recording observations, escalation and communication
- Provide staff with skills required to apply the RESTORE2 tool to their practice to ensure early and appropriate intervention
- Undertake scenarios to ensure that staff are comfortable with using the tool


What is
RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

RESTORE2 is a physical deterioration and escalation tool for care/nursing homes which includes the National Early Warning Score (NEWS2) and promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment

The RESTORE2™ Mini is a 'soft signs' only version of the RESTORE2™ tool for use in settings where it is not possible to take clinical observations.

RESTORE2*mini* - A Soft Signs approach to identifying Deterioration

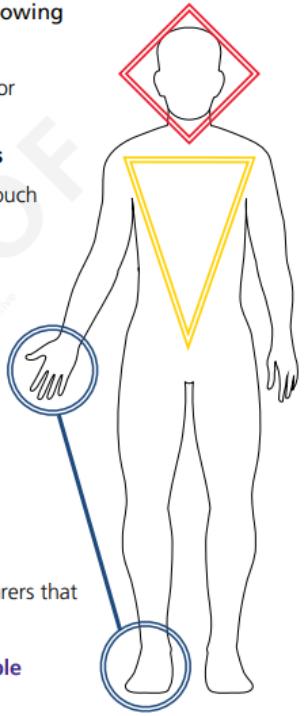
RESTORE2™ mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

Does your resident show any of the following **'soft signs'** of deterioration?

- Increasing **breathlessness, chestiness** or **cough/sputum**
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel **hot or cold** to touch
- Reduced mobility – **'off legs'** / less co-ordinated or **muscle pain**
- New or increased confusion / agitation / anxiety / pain
- Changes to usual level of **alertness / consciousness / sleeping** more or less
- **Extreme tiredness** or **dizziness**
- **'Can't pee'** or **'no pee'**, change in pee appearance
- **Diarrhoea, vomiting, dehydration**



Any **concerns** from the client / family or carers that the person is not as well as normal.

If purple signs are present, think possible COVID-19.

If YES to one or more of these triggers – take action!

Get your message across

Raise the Alert within your home e.g. to a senior carer, registered nurse or manager.

If possible, **record the observations** using a **NEWS2** based system.

Report your concerns to a health care professional e.g. Nurse/GP/GP HUB/111/999 **using the SBARD Structured Communication Tool.**

		Key prompts / decisions
S	**Situation** e.g. what's happened? How are they? NEWS2 score if available	
B	**Background** e.g. what is their normal, how have they changed?	
A	**Assessment** e.g. what have you observed / done?	
R	**Recommendation** 'I need you to...'	
D	**Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)	

Don't ignore your 'gut feeling' about what you know and see. Give any immediate care to keep the person safe and comfortable.

CS50656 NHS Creative 12/2019

RESTORE2*mini* - A Soft Signs approach to identifying Deterioration

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Signs someone may be unwell and what should I do?

Ask the person you support – how are you?

Does the person show any of the following **'soft signs'** of deterioration?

- Increasing **breathlessness, chestiness** or **cough/sputum**
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel **hot or cold** to touch
- Reduced mobility – **'off legs'** / less co-ordinated or **muscle pain**
- New or increased confusion / agitation / anxiety / pain
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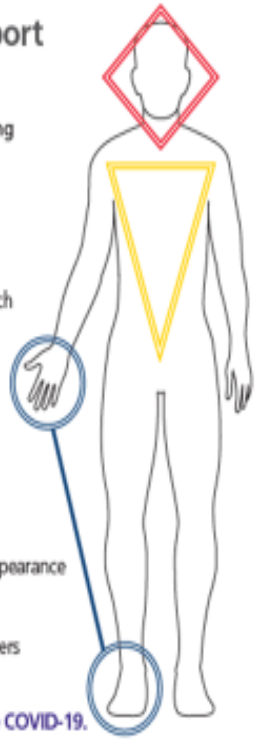

Any **concerns** from the person / family or carers that the person is not as well as normal.

If purple signs are present, think possible COVID-19.

If YES to one or more of these triggers – take action!

Get your message across

Person's name: NHS No. D.O.B.

Raise the alert. If you are a family carer or friend and are worried about the person you support talk to their nurse or GP. In an emergency you may need to call NHS 111 or 999. Support workers or home carers can also do this or consult a colleague or manager. **Try using the SBARD Structured Communication Tool** (below) to support reporting your concerns.

		Key prompts / decisions
S	**Situation** e.g. what's happened? How are they?	
B	**Background** e.g. what is their normal, how have they changed?	
A	**Assessment** e.g. what have you observed / done?	
R	**Recommendation** 'I need you to...'	
D	**Decision** what have you agreed?	

Name of person completing: Signature:

Today's date:

If you are worried about the person, don't just think about it, seek advice.

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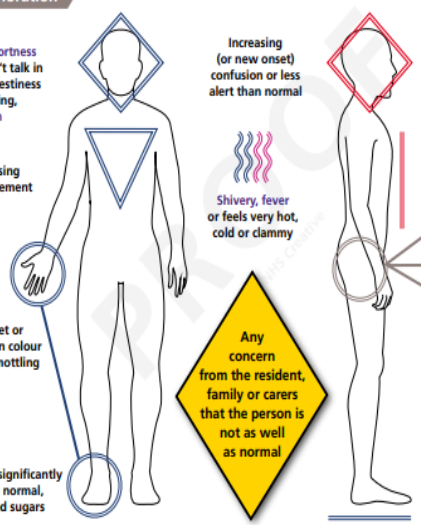
RESTORE2

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Adult Physiological Observation & Escalation Chart

Full Name:	
NHS No.	
DOB:	Room No.

Does Your Resident Have Soft Signs of Possible Deterioration



- Worse than normal lethargy or withdrawal or anxiety/agitation/ apprehension or not themselves
- Worsening shortness of breath (can't talk in sentences), chestiness or fast breathing, cough/sputum
- Increasing (or new onset) confusion or less alert than normal
- New or increasing oxygen requirement
- Shivery, fever or feels very hot, cold or clammy
- Extreme tiredness or dizziness
- Off food, reduced appetite, reduced fluid intake
- New offensive/ smelly urine or can't pee/reduced pee/reduced catheter output
- Diarrhoea, vomiting or dehydration (dry lips, mouth, sunken eyes, decreased skin tone)
- Cold hands/feet or worsening skin colour or puffiness, mottling or rash
- Observations significantly different from normal, including blood sugars
- Increased or new onset pain
- Can't walk or 'off legs', less mobile/ co ordinated or muscle pain

Any concern from the resident, family or carers that the person is not as well as normal

NEW ONSET OF:

Stroke (facial / arm weakness, speech problems)

Central Chest Pain / Heart Attack / Cardiac arrest

CALL 999 IMMEDIATELY

Resident specific soft-signs

e.g. changes to sleep patterns, not interested in usual/specific activities

If you answer YES to any of these triggers, your resident is at risk of deterioration.
If purple signs are present, think possible COVID-19

RECOGNISE SOFT SIGNS OF POSSIBLE DETERIORATION → TAKE COMPLETE SET OF OBSERVATIONS AND CALCULATE NEWS → ESCALATE USING ESCALATION TOOL AND SBARD COMMUNICATION

Full Name: **NHS No.**

How to use RESTORE2

RESTORE2 which includes the National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment. If you are concerned about the resident or if one observation has changed significantly ALWAYS ACT ON YOUR CONCERNS AND SEEK ADVICE from a competent clinical decision maker e.g. GP, Registered Nurse or AHP.

- This chart uses aggregated (total) NEWS - it is important that you understand the residents normal NEWS (the score when they are stable and as well as usual) to support appropriate escalation. You should try and establish what is normal for residents on admission with a member of the multi-disciplinary team (e.g. General Practitioner, frailty practitioner).
- **Only a Medical Professional can authorise use of the hypercapnic respiratory failure scale for residents who normally have low oxygen levels as part of a diagnosed condition (e.g. COPD)**
- Use this chart for all your routine observations as per your local policy. If your resident shows ANY of the soft signs of deterioration, record their observations and NEWS immediately on the chart and follow the escalation tool as appropriate, using SBARD to communicate
- There may be a need to re-consider what is normal for the resident following any sustained improvement in their condition or non-acute deterioration.

What's normal for this resident

Print name: Date: Signature:

What is the resident normally like? What observations and NEWS are reasonable and safe for them? When would their GP want you to call them? What escalation has been agreed with the resident (or their advocate)?

End of Life (EOL) or Agreed Limit of Treatment

- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed limit of treatment (e.g. not for hospital admission, not for resuscitation or not for intravenous antibiotics) to identify recoverable deterioration amenable to treatment. It is also useful for anticipating end of life to inform conversations with residents and their relatives - once the resident is on an EOL care pathway, RESTORE2 should be discontinued.

NEWS2 Escalation (get the right help early)

		Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0		Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	At least 12 hourly until no concerns
1		Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	At least 6 hourly
2		Immediate senior staff review, if no improvement in NEWS (or the same) **within 2 hours**, seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	At least 2 hourly
3-4	Single Observation 3	Repeat observations within **30 minutes**. If **observations = NEWS +3 or more**, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	At least every 30 minutes
5-6		Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	Every 15 minutes
7+		Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	Continuous monitoring until transfer

Full Name: NHS No.

Take observation + calculate NEWS

Authorising clinician

Signature & Date

		Date													
		Time													
A+B Respirations Breaths/min	≥25														3
	21-24														2
	18-20														
	15-17														
	12-14														
	9-11														1
	≤8														3
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96														
	94-95														1
	92-93														2
	≤91														3
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure *ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2														3
	95-96 on O_2														2
	93-94 on O_2														1
	≥93 on air														
	88-92														
	86-87														1
	84-85														2
	≤83%														3
Air or Oxygen?	A = Air														
	O₂ L/min														2
C Blood pressure mmHg Score uses systolic BP only	≥220														3
	201-219														
	181-200														
	161-180														
	141-160														
	121-140														
	111-120														
	101-110														1
	91-100														2
	81-90														3
	71-80														
	61-70														
	51-60														
	≤50														
C Pulse Beats/min	≥131														3
	121-130														2
	111-120														
	101-110														1
	91-100														
	81-90														
	71-80														
	61-70														
	51-60														
	41-50														1
	31-40														3
	≤30														
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert														
	Confusion														3
	V														
	P														
	U														
E Temperature °C	≥39.1														2
	38.1-39.0°														1
	37.1-38.0°														
	36.1-37.0°														
	35.1-36.0°														1
	≤35.0°														3
NEWS TOTAL															
Next observation due (Min/Hrs)															
Escalation of care Y/N															
Initials															

ACVPU KEY

A Alert awake & responding, eyes open

C Confusion New onset of confusion (Do not score if chronic)

V Verbal moves eyes / limbs or makes sounds to voice

P Pain responds only to painful stimuli

U Unresponsive unconscious

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

Full Name: NHS No.

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

SBARD Escalation Tool and Action Tracker
(get your message across)

REMEMBER TO SAY: The residents TOTAL NEWS SCORE is...

Name:

NHS No.

		Notes (Date, Time, Who)
S	**Situation** (briefly describe the current situation and give a clear, concise overview of relevant issues) (Provide address, direct line contact number) I am... from... (say if you are a registered professional) I am calling about resident... (Name, DOB) **The residents TOTAL NEWS SCORE is...** **Their normal NEWS/condition is...** I am calling because I am concerned that... (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)	
B	**Background** (briefly state the relevant history and what got you to this point) Resident XX has the following medical conditions... The resident does/does not have a care plan or DNACPR form / agreed care plan with a limit on treatment/hospital admission They have had... (GP review/investigation/medication e.g. antibiotics recently) Resident XX's condition has changed in the last XX hours The last set of observations was... Their normal condition is... The resident is on the following medications...	
A	**Assessment** (summarise the facts and give your best assessment on what is happening) I think the problem is XX And I have... (e.g. given pain relief, medication, sat the patient up etc.) **OR** I am not sure what the problem is but the resident is deteriorating **OR** I don't know what's wrong but I am really worried	
R -- D	**Recommendation** (what actions are you asking for? What do you want to happen next?) I need you to... Come and see the resident in the next XX hours **AND** Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services) **Decision** (what have you agreed) We have agreed you will visit/call in the next XX hours, and in the meantime I will do XX If there is no improvement within XX, I will take XX action.	**Actions I have been asked to take** (initial & time when actions completed) — Initials

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

The SBARD technique provides an easy-to-remember standardised framework for critical conversations, including what key information will be communicated about a resident's condition and what immediate attention and action is required. Record all your actions and conversations.

Communicate using SBARD

Name:

NHS No.

Notes (Date, Time, Who)	Notes (Date, Time, Who)	
		S
		B
		A
Actions I have been asked to take (initial & time when actions completed) — Initials	**Actions I have been asked to take** (initial & time when actions completed) — Initials	R -- D

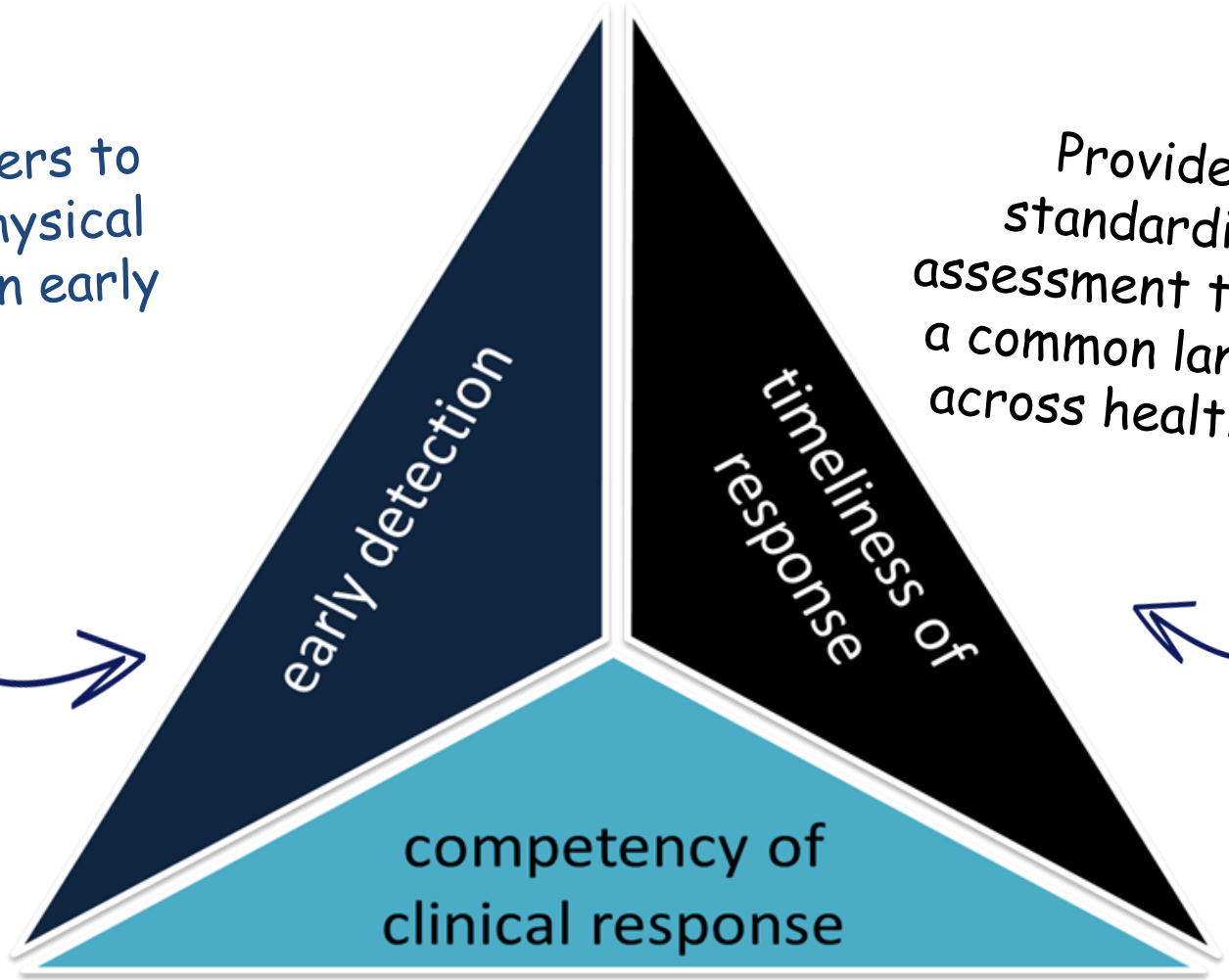
Photocopy this page if admitting/transferring resident or upload to ambulance EPR

RESTORE2 is a physical deterioration and escalation tool for care/nursing homes designed to support homes to:

- Recognise when a resident may be deteriorating or at risk of physical deterioration
- Act appropriately according to the residents care plan
- Obtain a complete set of physical observations to inform escalation and conversations with health professionals
- Speak with the most appropriate health professional in a timely way
- Provide a concise escalation history to health professionals to support their decision making
- Get staff and residents the right support in the right timescale

The Triad of Clinical Outcomes

Support carers to recognise physical deterioration early



Provide a standardised assessment tool and a common language across healthcare

Enable staff to communicate concisely with clinical decision makers to get an effective response

NHS West Hampshire Clinical Commissioning Group

The AHSN Network

RESTORE2 Recognise early soft-signs, Take observations, Respond, Escalate

Wessex Patient Safety Collaborative

NHS Parliamentary Awards 2019


Why do your residents need
RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Case Study **Lost Opportunities**

- 10am Resident Y developed ‘flu like symptoms - referred to the local GP practice who diagnosed a chest infection – prescribes antibiotics

Oxygen saturations 91% in air

Not engaging in rehab

More lethargic than previously

Chance to repeat observations and recognise potential for deterioration

NEWS would have been 3 if measured

Nursing Home – GP

Case Study **Lost Opportunities**

- 5pm Antibiotics have not arrived
- 00.10am Resident developed a fever and elevated heart rate and the nursing home contacted the Out of Hours GP service who advised paracetamol and fluids

worsening clinical picture

OOH GP did not do a NEWS

advised to wait until morning for antibiotics

NEWS would have been 8 if measured

Nursing Home – GP – Out of Hours GP

Case Study Lost Opportunities

- 03.30am Home contacted Out of Hours again because of concerns around falling blood pressure and oxygen levels in the blood

worsening clinical picture

Effects of paracetamol in reducing temperature not appreciated

NEWS would have been 7 if measured

Nursing Home – GP – Out of Hours GP

Case Study Lost Opportunities

- 04.00am Home call 999 as so concerned about the resident.
- The resident died in the emergency department at 09.30am due to sepsis

low mortality

NEWS Score	Mortality
0	0.5%
<5	5.5%

root causes

no-one recognised how sick the resident was

response from healthcare services was inadequate

high mortality

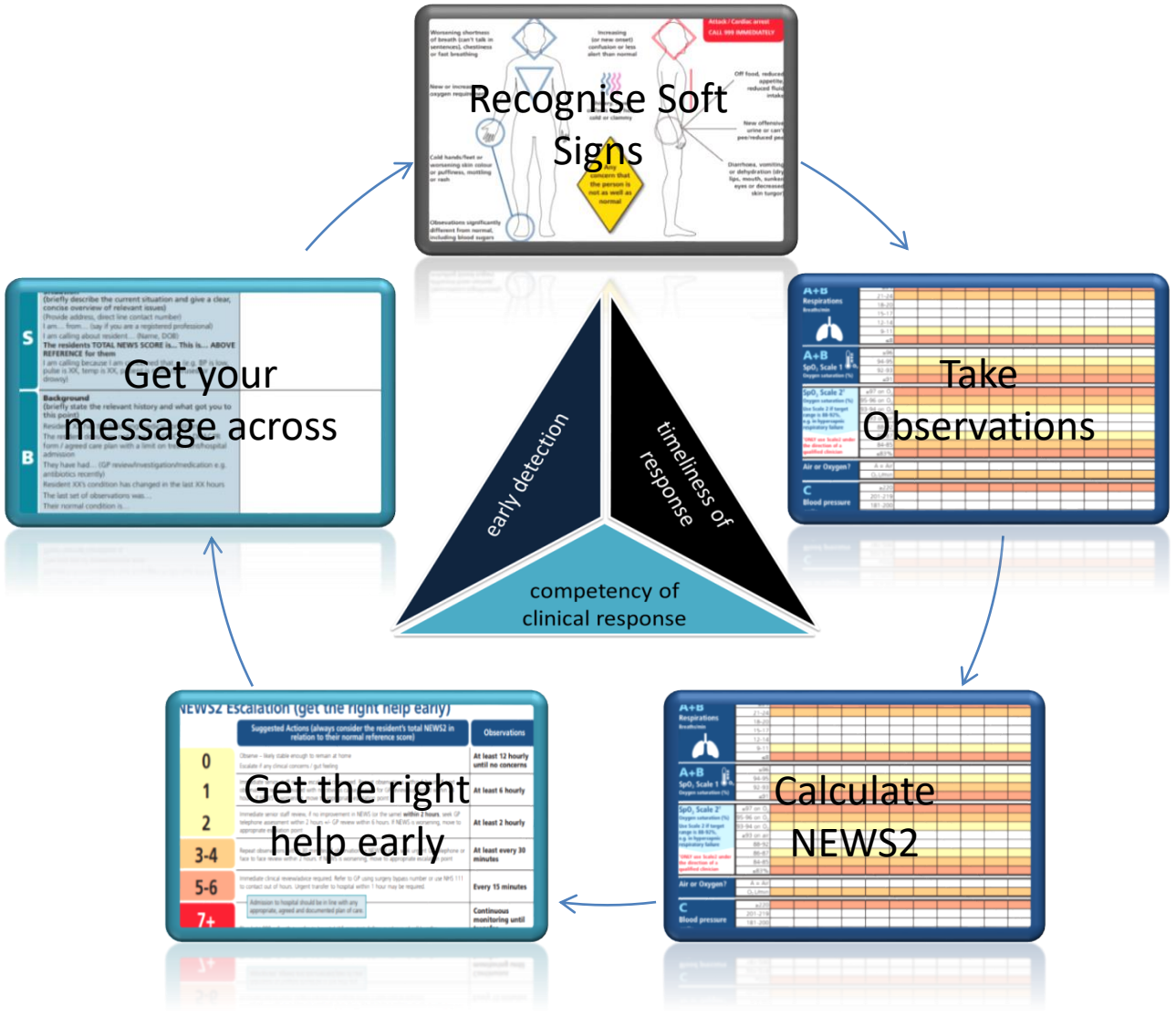
NEWS Score	Mortality
≥5	22%
≥7	27%
≥9	38%

home were unable to effectively communicate their concerns to healthcare professionals

Nursing Home – GP – Out of Hours GP – 999 - Hospital


How do you use
RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

- RESTORE2 combines soft signs with NEWS2, a clear escalation pathway designed around care homes and an SBARD communication tool and Action Tracker



Identifying the soft signs of deterioration

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RESTORE2 Recognise early soft-signs, Take observations, Respond, Escalate

Wessex Patient Safety Collaborative

NHS Parliamentary Awards 2019

What Are Soft Signs of Deterioration?

- Think about an occasion when you were unwell……
- How did you know you were unwell?
- How could you tell when it was getting worse?

- Now let's think about your residents.
- What "soft signs" could they present with?

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

Does your resident show any of the following **'soft signs'** of deterioration?

- = Increasing **breathlessness, chestiness** or **cough/sputum**
- = Change in **usual drinking / diet habits**
- = A **shivery fever** – feel **hot or cold** to touch
- = Reduced mobility – **'off legs'** / less co-ordinated or **muscle pain**
- = New or increased confusion / agitation / anxiety / pain
- = Changes to usual level of **alertness / consciousness / sleeping** more or less
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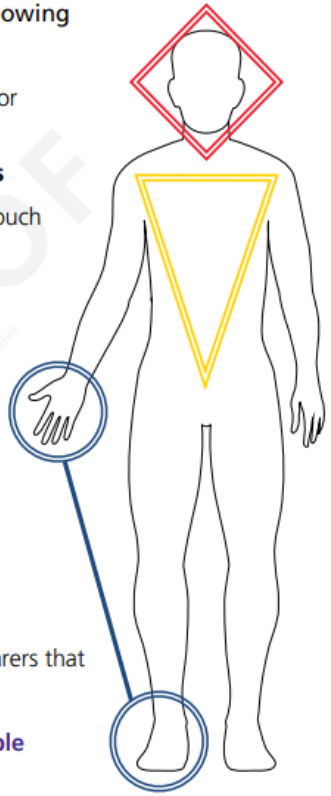

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If purple signs are present, think possible COVID-19.

If YES to one or more of these triggers – take action!

RESTORE2

Recognise Early Soft Signs, Take Observations, Respond, Escalate

NHS

Adult Physiological Observation & Escalation Chart

Full Name:	
NHS No.	
DOB:	Room No.

Does Your Resident Have Soft Signs of Possible Deterioration

Worse than normal lethargy or withdrawal or anxiety/agitation/ apprehension or not themselves

NEW ONSET OF:
Stroke (facial / arm weakness, speech problems)
Central Chest Pain / Heart Attack / Cardiac arrest
CALL 999 IMMEDIATELY

Worsening shortness of breath (can't talk in sentences), chestiness or fast breathing, cough/sputum

New or increasing oxygen requirement

Cold hands/feet or worsening skin colour or puffiness, mottling or rash

Observations significantly different from normal, including blood sugars

Increasing (or new onset) confusion or less alert than normal

Shivery, fever or feels very hot, cold or clammy

Any concern from the resident, family or carers that the person is not as well as normal

Increased or new onset pain

Can't walk or 'off legs', less mobile/ co ordinated or muscle pain

Extreme tiredness or dizziness

Off food, reduced appetite, reduced fluid intake

New offensive/ smelly urine or can't pee/reduced pee/reduced catheter output

Diarrhoea, vomiting or dehydration (dry lips, mouth, sunken eyes, decreased skin tone)

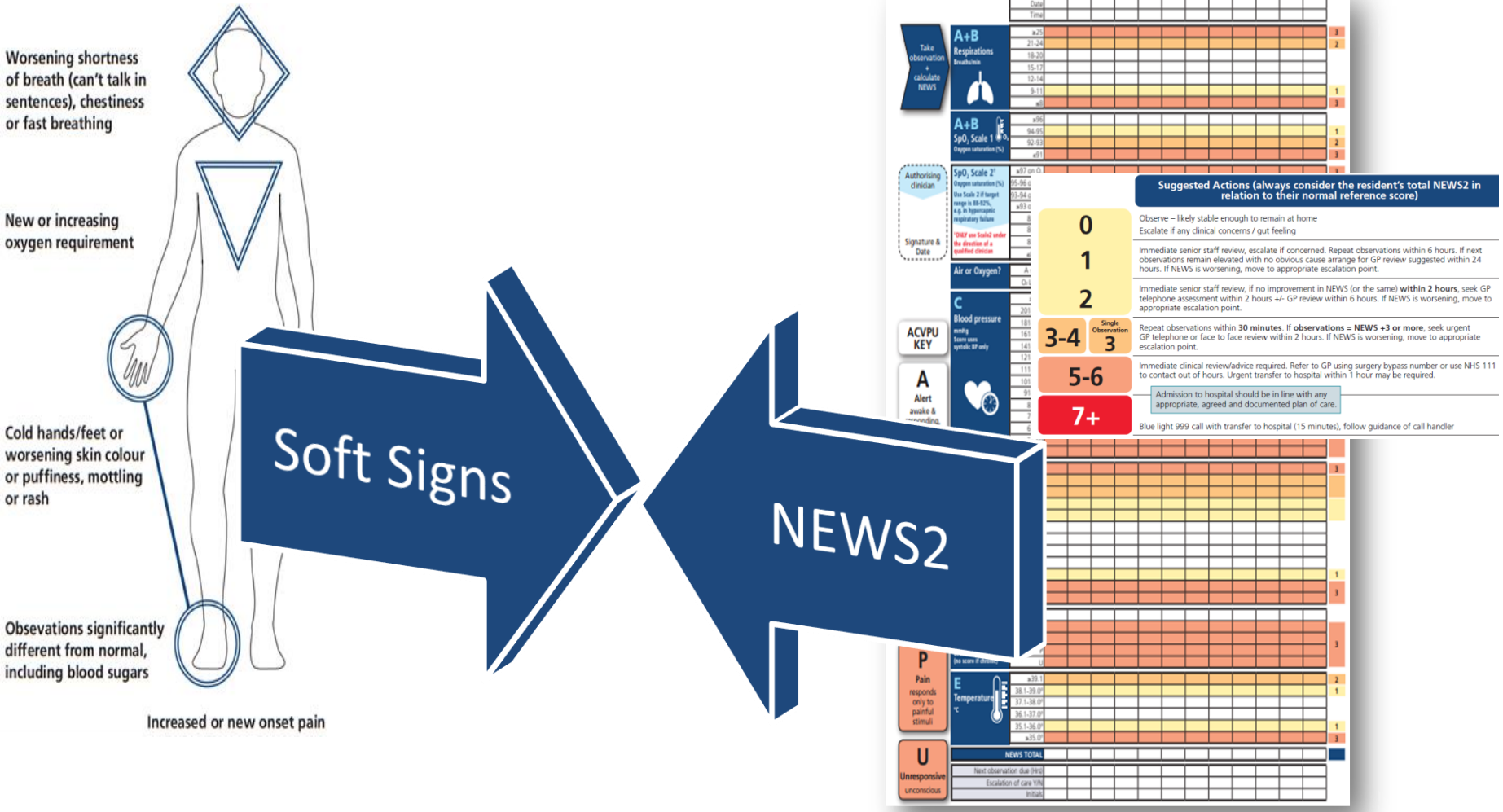
Resident specific soft-signs

e.g. changes to sleep patterns, not interested in usual/specific activities

If you answer YES to any of these triggers, your resident is at risk of deterioration.
If purple signs are present, think possible COVID-19

RECOGNISE SOFT SIGNS OF POSSIBLE DETERIORATION → **TAKE COMPLETE SET OF OBSERVATIONS AND CALCULATE NEWS** → **ESCALATE USING ESCALATION TOOL AND SBARD COMMUNICATION**

Making NEWS accessible + SBARD



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When to call 999

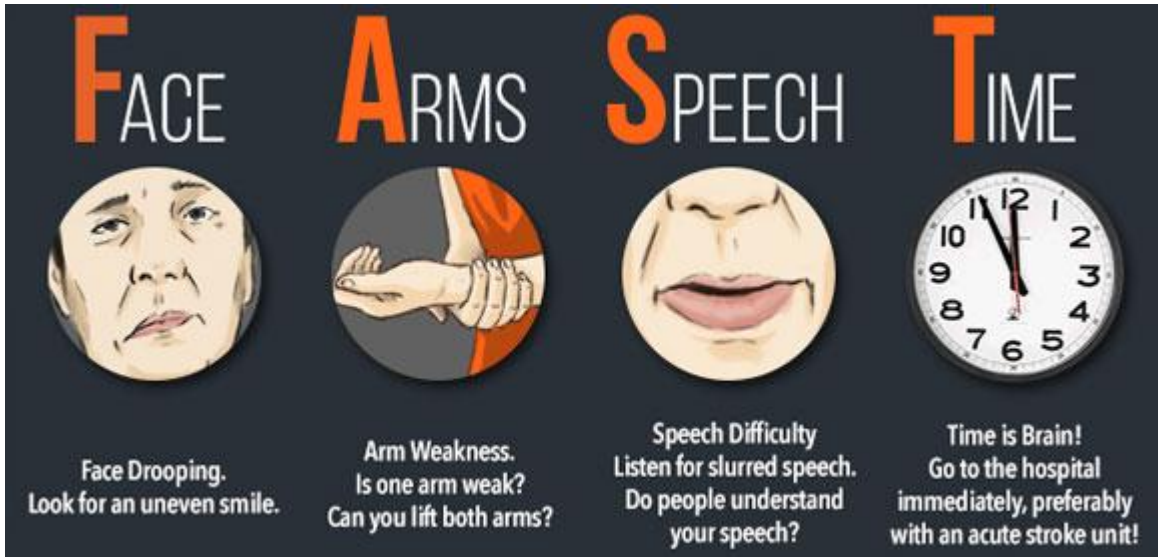
NEW ONSET OF:

Stroke (facial / arm weakness, speech problems)

Central Chest Pain / Heart Attack / Cardiac arrest

CALL 999 IMMEDIATELY

- A stroke is a brain attack. It happens when the blood supply to part of the brain is cut off. Without blood brain cells can be damaged or die – do not use RESTORE2 but call 999



When to call 999

NEW ONSET OF:

Stroke (facial / arm weakness, speech problems)

Central Chest Pain / Heart Attack / Cardiac arrest

CALL 999 IMMEDIATELY

- All chest pain should be investigated. Get immediate medical help if you think someone is having a heart attack– do not use RESTORE2 but call 999

Call 999 if you have sudden chest pain that:

- spreads to your arms, back, neck or jaw
- makes your chest feel tight or heavy
- also started with shortness of breath, sweating and feeling or being sick

You could be having a heart attack. Call 999 immediately as you need immediate treatment in hospital.

Understanding your Resident

- Homes are encouraged to understand what is normal for the resident and work with GP's or other teams (e.g. frailty teams) to define when another health professional would want to be informed of an event – this should include knowing what a normal set of physical observations looks like for the resident
- Any escalation should be with reference to the residents wishes and advanced care plan – if a plan does not exist it should be created with the resident or the appropriate person with Power of Attorney (health and welfare)
- Essential that there is evidence of a documented Capacity Assessment where Best Interests Decisions are being made and that decisions are made with others and are clearly articulated

Understanding your Resident

Reference NEWS2 (What's normal for this resident)

Edward is normally fit and active but is often mildly confused in the mornings before breakfast. Normally NEWS score is 0 but in the morning Edward may trigger the AVPU scale – only call a GP if the confusion continues to lunchtime. Edward is for full treatment and admission to hospital if required. Edward becomes agitated when he is becoming unwell which is a good soft sign for him.

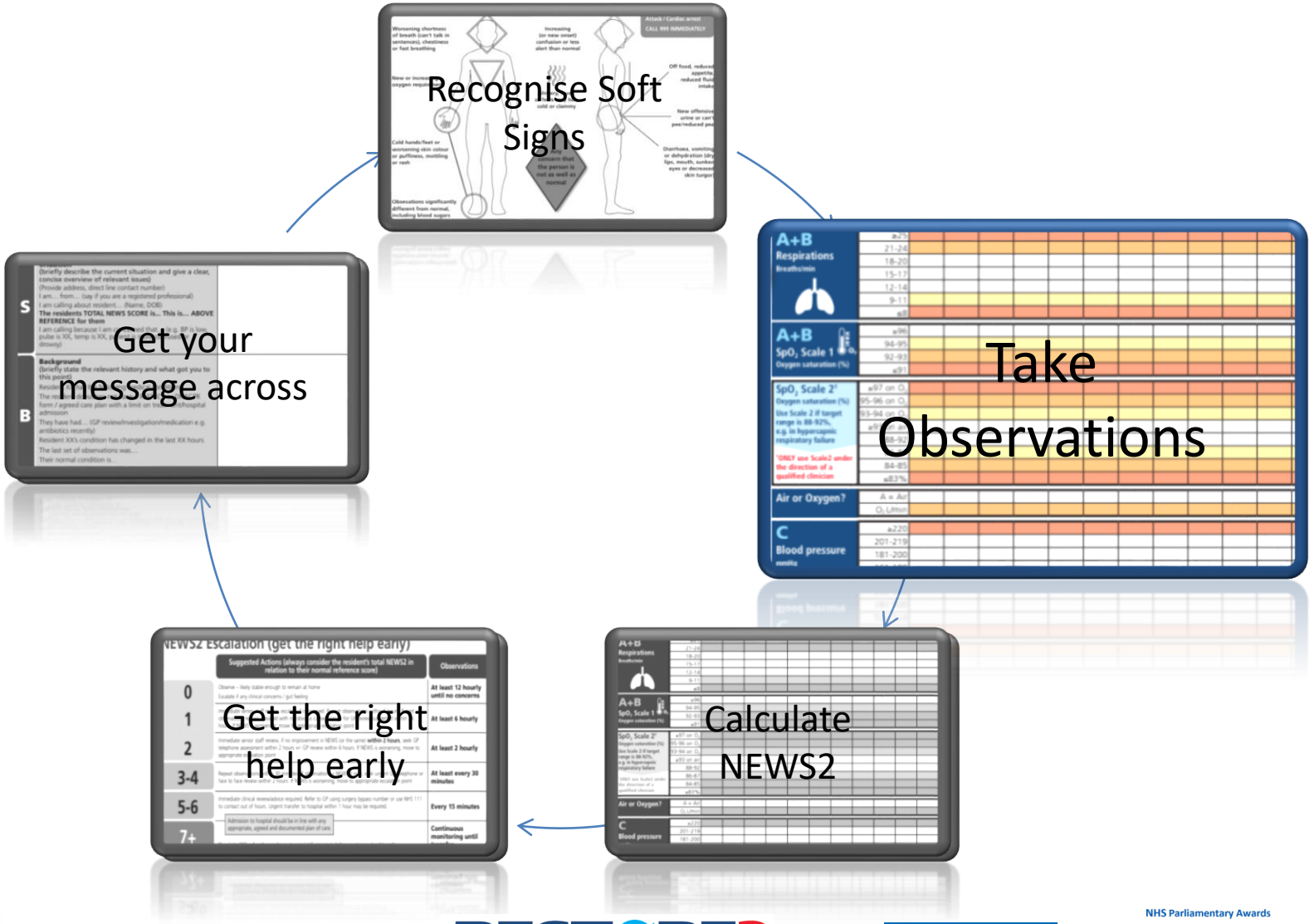
Print name: Dr. Davids Date: 12/4/18 Signature: DDAVIDS

What is the resident normally like? What observations are reasonable and safe for them? When would your GP want you to call them? What escalation has been agreed with the resident (or their advocate)?

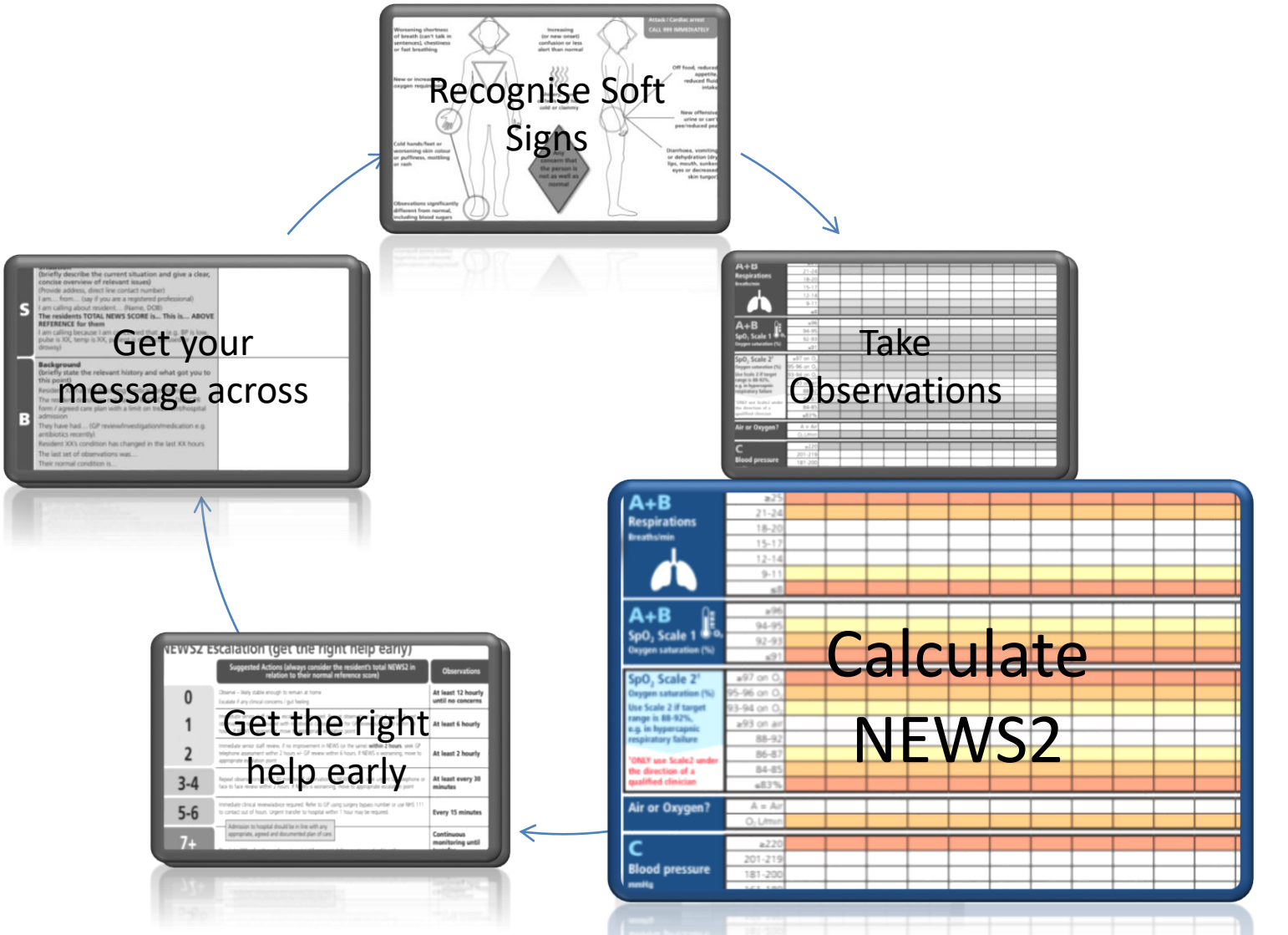
End of Life (EOL) or Agreed Limit of Treatment

- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed limit of treatment (e.g. not for hospital admission, not for resuscitation or not for intravenous antibiotics) to identify recoverable deterioration amenable to treatment. It is also useful for anticipating end of life to inform conversations with residents and their relatives - once the resident is on an EOL care pathway, RESTORE2 should be discontinued.

Take Observations

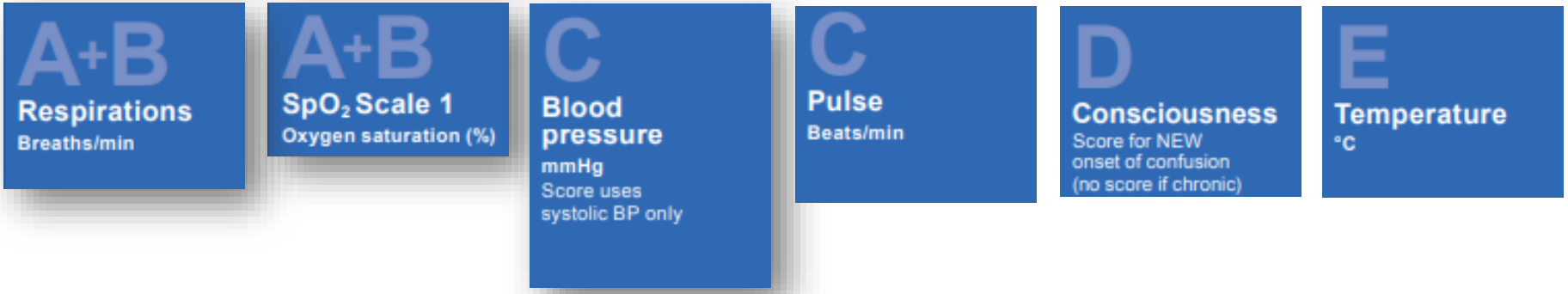


Calculate NEWS2



Physical Observations

- Validated tool widely used in acute care comprising six biological measurements:
  - Respiration Rate
  - Oxygen Saturations
  - Temperature
  - Systolic Blood Pressure
  - Heart Rate
  - Level of Consciousness (defined by ACVPU)



- Staff need to have had the appropriate training in taking physical observations
- Homes need to invest in quality equipment for observations and ensure that this is serviced and calibrated regularly
- Staff must take and document complete observations
- Recording should be made in black pen, be clear, dated, timed and signed

NEW

NEW

NEW (No Baseline)

Authorising clinician

Signature & Date

SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure †ONLY use Scale2 under the direction of a qualified clinician	≥97 on O_2													3
	95-96 on O_2													2
	93-94 on O_2													1
	≥93 on air													
	88-92													
	86-87													1
	84-85													2
	≤83%													3
Air or Oxygen?	A = Air													
	O_2 L/min													2
C Blood pressure mmHg Score uses systolic BP only	≥220													3
	201-219													
	181-200													
	161-180													
	141-160													
	121-140													
	111-120													
	101-110													1
	91-100													2
	81-90													3
	71-80													
	61-70													
	51-60													
	≤50													
P Pulse beats/min	≥131													3
	121-130													
	111-120													
	101-110													
	91-100													
	81-90													
	71-80													
	61-70													
	51-60													
	41-50													1
	31-40													3
	≤30													
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert													
	Confusion													3
	V													
	P													
	U													
E Temperature °C	≥39.1													2
	38.1-39.0°													1
	37.1-38.0°													
	36.1-37.0°													
	35.1-36.0°													1
	≥35.0°													3
NEWS TOTAL														
Next observation due (Hrs)														
Escalation of care Y/N														
Initials														

ACVPU KEY

A Alert awake & responding, eyes open

C Confusion New onset of confusion (Do not score if chronic)

V Verbal moves eyes / limbs or makes sounds to voice

P Pain responds only to painful stimuli

U Unresponsive unconscious

Respiration Rate

- RR is the most important parameter but the least recorded
- RR is thought to be the most sensitive indicator of a patient's physiological well-being
- RR reflects not only respiratory function as in hypoxia or hypercapnia, but cardiovascular status as is pulmonary oedema and metabolic imbalance i.e. DKA
- Elevated RR is a powerful sign of acute illness and distress, in all patients
- Generalised pain and distress
- Sepsis remote from the lungs
- CNS disturbance and metabolic disturbances such as metabolic acidosis
- Reduced RR is an important indicator of CNS depression and narcosis
- **Always take RR over 60 seconds**

Physiological parameter	Score						
	3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25

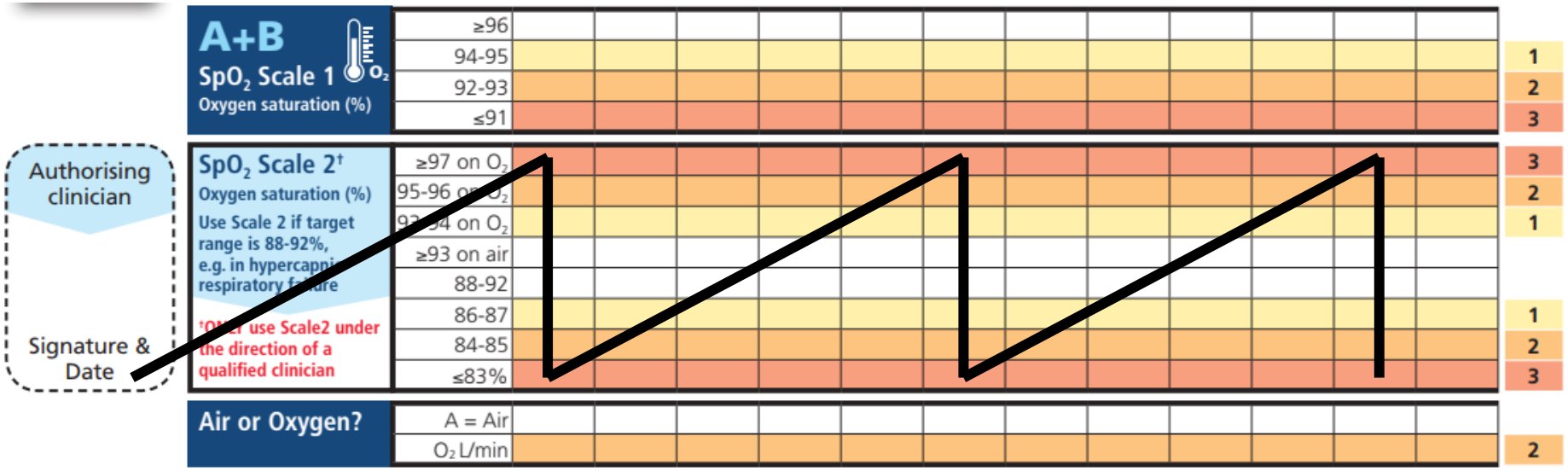
SpO_2 Scoring scales

- NEWS2 has two scoring scales for SpO_2

The new SpO_2 scoring Scale 2 is only for patients with a prescribed oxygen saturation requirement of 88–92% (e.g. in patients who normally retain Carbon Dioxide and need to do this to drive their respiratory effort (hypercapnic respiratory failure))

- This should only be used in patients **confirmed to have hypercapnic respiratory failure on blood gas analysis** on either a prior, or their current, hospital admission
- The decision to use the new SpO_2 scoring Scale 2 should be made by a competent clinical decision maker and should be recorded in the patient's clinical notes
- In all other circumstances, the regular NEWS SpO_2 scoring scale (Scale 1) should be used
- For the avoidance of doubt, the SpO_2 scoring scale not being used should be clearly crossed out

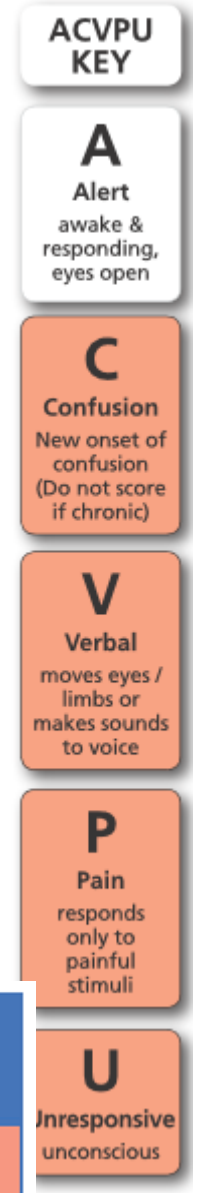
SpO_2 Scoring scales



Level of Consciousness

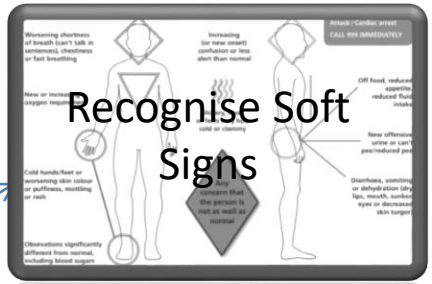
- Measured via ACVPU

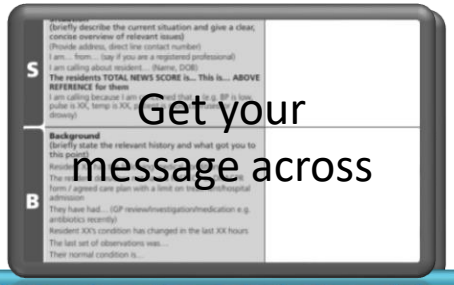
  (alert, new confusion, voice, pain, unresponsive)
- Alert – patient is active, responsive, interacting with people and surroundings, answers questions etc.
- New onset or worsening confusion is now included which excludes residents with confusion as part of their normal disease process
- Voice – responds to voice but not spontaneously interacting, may be drowsy, keeps eyes closed, may not speak coherently
- Pain – not alert and does not respond to verbal stimuli, responds to painful stimulus
- Unresponsive – unresponsive, unconscious

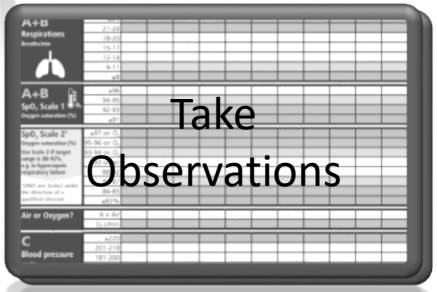


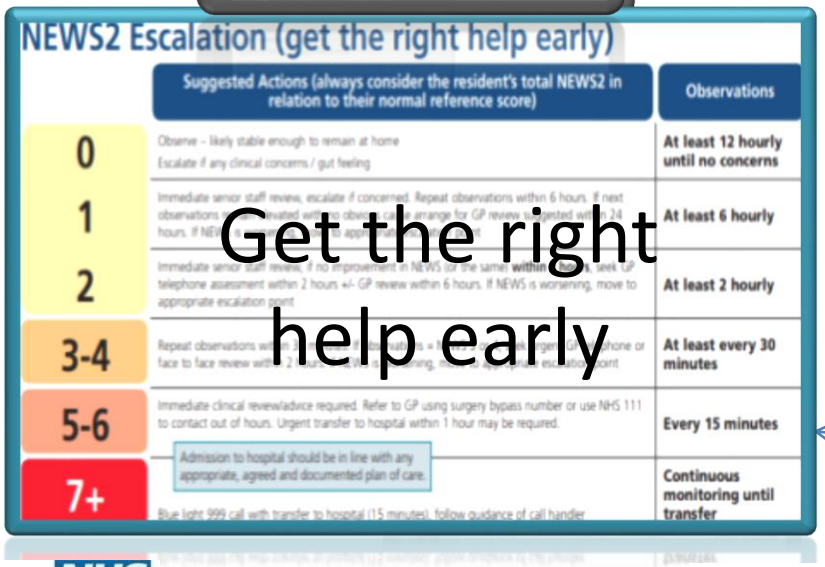
Physiological parameter	Score						
	3	2	1	0	1	2	3
Consciousness				Alert			CVPU

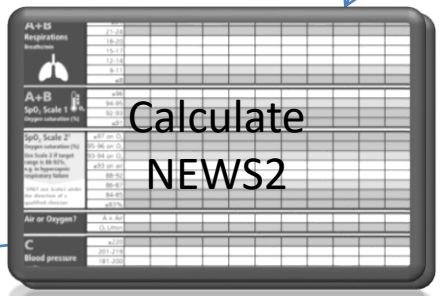
Escalation – get the right help











NHS West Hampshire Clinical Commissioning Group

The AHSN Network

RESTORE2 Recognise early soft-signs, Take observations, Respond, Escalate

Wessex Patient Safety Collaborative

NHS Parliamentary Awards 2019

Escalation – get the right help

Removes the element of personal interpretation

	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 6 hourly**
2	Immediate senior staff review, if no improvement in NEWS (or the same) **within 2 hours**, seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 2 hourly**
3-4 / Single Observation 3	Repeat observations within **30 minutes**. If **observations = NEWS +3 or more**, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	**At least every 30 minutes**
5-6	Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	**Every 15 minutes**
7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

Get your message across

- SBARD is a structured method for communicating critical information that requires immediate attention and action
- Five steps:
  - Situation
  - Background
  - Assessment
  - Recommendation
  - Decision

SBARD Escalation Tool and Action Tracker

(get your message across)

REMEMBER TO SAY:
The residents TOTAL NEWS SCORE is... This is... ABOVE REFERENCE for them

		1 Notes (including date and time of escalation)
S	**Situation** **(briefly describe the current situation and give a clear, concise overview of relevant issues)** (Provide address, direct line contact number) I am… from… (say if you are a registered professional) I am calling about resident… (Name, DOB) **The residents TOTAL NEWS SCORE is... This is... ABOVE REFERENCE for them** I am calling because I am concerned that… (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)	
B	**Background** **(briefly state the relevant history and what got you to this point)** Resident XX has the following medical conditions… The resident does/does not have a ReSPECT or DNACPR form / agreed care plan with a limit on treatment/hospital admission They have had… (GP review/investigation/medication e.g. antibiotics recently) Resident XX's condition has changed in the last XX hours The last set of observations was… Their normal condition is…	
A	**Assessment** **(summarise the facts and give your best assessment on what is happening)** I think the problem is XX And I have… (e.g. given pain relief, medication, sat the patient up etc.) **OR** I am not sure what the problem is but the resident is deteriorating **OR** I don't know what's wrong but I am really worried	
R	**Recommendation** **(what actions are you asking for? What do you want to happen next?)** I need you to… Come and see the resident in the next XX hours **AND** Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services) **Decision** **(what have you agreed)** …XX hours, and …ake XX action.	**Actions I have been asked to take** (initial & time when actions completed) — Initials

RESTORE2
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Using RESTORE2

lets do some scenarios

RESTORE2

Recognise early soft-signs, Take observations, Respond, Escalate

RESTORE2

Recognise early soft-signs, Take observations, Respond, Escalate

Case Study 2

Charlie

Charlie

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Charlie is 67 yrs old

Admitted to home as unable to cope and has reduced mobility

Full capacity No respiratory problems

Observations

Resps 16 per minute

Sats 96%

BP 125/90

P88

ACVPU= A

T 37

Normal News2 Score

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

- Normal NEWS 2 Score “0”
- Monthly observations stable for first 3 months of his stay

Soft Signs

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

One morning you notice that Charlie is reluctant to eat his breakfast and feels he needs to go back to bed for a rest

When you check on Charlie an hour later you feel his hands are colder than normal

WHAT DO YOU DO ?

Observations and reassess news

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Observations

Reps 20

Sats 95%

BP 115/80

P95

A- Alert

T 37.5

NEWS2

Score 2

WHAT DO YOU DO?

Escalation plan

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Refer to escalation plan	2 hrly obs
Request senior staff review Repeat observations 2 hrly	No change
	NEWS2 score 2
Document , Document , Document	**What do you do ?**

Escalation – get the right help

Removes the element of personal interpretation

	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 6 hourly**
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7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

Refer to escalation plan

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Repeat observations

Reps 22

Stats 95%

Bp 115/70

P 95

Alert

T 38

NEWS2 score now 4

What do you do ?

Refer to escalation plan

Next step

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

- Repeat observations every 30 minutes
- Seek Urgent GP advice
- How would you give the information to the GP

SBARD

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

- **Situation**

I am ringing because I am concerned regarding one of my residents

Charlie has been with the home for 3 months and is generally fit and well

I became concerned as he is off his food and unusually lethargic

His reference/normal NEWS2 score is 0

We have been monitoring his observations over the day and his NEWS2 Score has risen to 4

- **Background**

Charlie is 67yrs old and alert with full capacity

He is on medication for hypertension but no other medication

He has not required medical review since joining the home

His last set of observations are : Reps 22, Stats 95%, Bp 115/70, P 95 Alert ,T 38

SBARD

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

- **Assessment**

I am not sure what the problem is but he is deteriorating

- **Recommendation**

Please could you visit to review Charlie ?

Is there anything I can do whilst I am waiting for you ?

GP- Advice please give 1g of paracetamol and continue with observations

- **Decision**

GP – will visit in the next two hours after surgery

Continue with observations and call back if Charlies condition changes before the GP arrives

Outcome

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

- Charlie is reviewed by GP
- Antibiotics prescribed (UTI)
- Advised to continue observations in line with the escalation tool until Charlie returns to his “Normal”

Reflection

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

What did you do ?

- Recognised soft signs
- Monitored observations (as appropriate for your home)
- Used SBARD to communicate your concerns
- Achieved a GP review in a timely manner

Feedback

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

"Beneficial to have standardised tool for when agency nurses are on duty"

Angela from Cross and Passion said how energised she felt after the course and wanted to thank-you again"

Four staff members received the Restore2 training, including myself, we all found it very interesting and extremely helpful. The training makes you focus on your residents' general state of health, you learn to be so much more aware of signs that could mean deterioration and it gives you the confidence and knowledge, especially non-clinical staff, to discuss a deteriorating resident with a clinician. We all felt that the training is invaluable through the COVID19 pandemic, when residents' symptoms may not be obvious, but with base lines and observations embedded into care plans, I feel we are now much better equipped to monitor our residents"
Johannah Houghton Manager Sable Cottage

Staff are clear as to what is required of them. Some staff can lack confidence or experience when dealing with residents whom present as unwell. The Restore 2 document is user friendly and it is easy to interpret data / score / action required.

"Restore 2 is simple to use and is also a nationally recognised tool which is useful when liaising with paramedics"

"I have just attended the first virtual RESTORE2 training session. I just want to say that the training was excellent. My Deputy attended also. I intend to book more staff on the next two dates"

Recognition and endorsements

Guidance from the CQC, DHSC, NHSE and PHE (31/7/20) includes reference to RESTORE2™ in their Admission and care of residents in a care home during COVID-19.The guidance states that the NHS will be supporting care home professionals to use well evaluated tools such as RESTORE2™ and NEWS2, accompanied by support and access to specific equipment such as pulse oximeters, which can also help determine whether a resident is unwell and as a way of monitoring residents with symptoms.

The British Geriatrics Society have recommended the use of RESTORE2™ in their "COVID-19: Managing the COVID-19 pandemic in care homes" (BGS 25/3/2020) which states: "If taking vital signs, care homes should use the RESTORE2™ tool…" …"to recognise deterioration in residents, measure vital signs and communicate concerns to healthcare professionals."

Learning Disabilities Mortality Review (LeDeR) programme have recommended that NEWS2, as used in tools such as RESTORE2™ , is adapted and then adopted as a means to capture baseline and soft signs of acute deterioration in physical health for people with learning disabilities by:• Involving people with learning disabilities, their families and professional organisations. • Disseminating for use across acute, primary and community settings.2019 Annual report of the English Learning Disabilities Mortality Review (LeDeR) programme (LeDeR 16/7/20)The report can also be downloaded from the resources zone on this webpage.

Recognise early soft-signs, Take observations, Respond, Escalate