SEWS KEY

0	1	2	3

NAME _____ DOB _____

UNIT No. _____

SEWS KEY

0	1	2	3

																				Date:
Date:																				
Time:																				Time:
RESP. RATE	36+																			36+
	31-35																			31-35
	21-30																			21-30
	9-20																			9-20
	≤8																			≤8
SpO2	93+																			93+
Numerical Value	90-92																			90-92
	85-89																			85-89
	<85																			<85
Inspired O2%	%																			%
TEMP.	39°																			39°
	38°																			38°
	37°																			37°
	36°																			36°
	35°																			35°
	34°																			34°
BLOOD PRESSURE	210																			210
	200																			200
	190																			190
	180																			180
	170																			170
	160																			160
	150																			150
	140																			140
	130																			130
	120																			120
	110																			110
SEWS SCORE uses Systolic BP	100																			100
	90																			90
	80																			80
	70																			70
	60																			60
	50																			50
	40																			40
	150																			150
HEART RATE	140																			140
	130																			130
	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
	60																			60
	50																			50
	40																			40
	30																			30
	20																			20
NEURO RESPONSE	Alert																			Alert
	Verbal																			Verbal
	Pain																			Pain
	Unresponsive																			Unresponsive
URINE OUTPUT	PU/NPU:																			PU/NPU:
	UO<30mls/hr (3 hrs +)																			UO<30mls/hr
SEWS SCORE:	with all observations																			
PAIN refer to guideline p4	Severe 7-10																			7-10
	Moderate 4-6																			4-6
	Mild 1-3																			1-3
	None 0																			0
	N/V																			N/V

Pain Assessment & Management Guidelines

How to score pain: 0 — 10

No Pain — Worst Pain Imagineable

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (**must be** at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain: Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785**.

Acute pain: Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

Use Acute Pain Manual - distributed to all Operating Theatres areas and Surgical wards throughout Division. Also accessible on Intranet (via anaesthetic department homepage)

If no improvement in pain score contact CNS Pain Management on **page 1186/1157** at SGH and **page 3404/3101** at VI. On Call anaesthetist **page 1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting

For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38 blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:	Hypovolaemia	Cardiac	Obstructive	Distributive
	Dehydration	*Arryhthmia*	*PE*	*Sepsis*
	Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.

If BM<4 Check urgent blood glucose/IV dextrose or oral carbohydrate

SGH469

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

Name

Address

AFFIX PATIENT ID

Hospital No.

DOB

	Date	Ward	Consultant
Admitted			
Transferred			
Transferred			
Transferred			

This is Chart Number_____during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score.
If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying ***Change***
- If there is a worsening ***Trend***
- If concerned the patient looks ***Unwell***

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date												
Frequency												

For extra information such as wound, CSM etc. use slanted columns at bottom of page.