Halton Healthcare GEORGETOWN · MILTON · OAKVILLE	**Early Warning Signs Policy**	
	Program/Dept: Office of Professional Practice	Document Category: Patient Care
	Developed by: Quality and Patient Relations and Office of Professional Practice	Original Approval Date: Jan 2019
	Approved by: Department of Medicine, Department of Surgery, Milton Family Practice, GH Program Steering and the Office of Professional Practice	Reviewed Date: Jan 2022
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Purpose

To ensure a consistent and standardized approach for the use of a scoring system that provides early identification of a deteriorating patient.

To provide members of the healthcare team with guidance regarding clinical responses that support optimal patient outcomes to a given clinical situation.

Scope

All adult patients admitted to Halton Healthcare with the exception of patients in the Intensive Care Unit (ICU), Pediatrics, Special Care Nursery (SCN), Labour and Delivery/Birthing Suite, Emergency Department (ED), Pre Admission Clinic (PAC), Surgical Daycare, the Operating Room (OR) and the Post Anesthetic Care Unit (PACU).

Procedure

1. The Early Warning Signs (EWS) scoring is to be used as an adjunct to clinical judgment as well as current Halton Healthcare Policies and Procedures.
2. The EWS scoring system does not replace the Critical Care Outreach Team calling criteria.
3. Patient's vital signs will be assessed and documented, resulting in an EWS score.
   Vital signs will include:
   a. Heart Rate
   b. Blood Pressure (BP)
   c. Respiration Rate
   d. Temperature
   e. Oxygen Saturation (including oxygen flow rate or oxygen percentage)
   f. Neurological Status
4. Vital sign documentation:
   The timeliness of vital sign documentation is imperative to early identification of deteriorating patients.
5. Once the EWS score is calculated a series of clinical responses will be considered and activated as appropriate (Refer Appendix B for Escalation/Notifications).
6. Communication:
   a. Unless your clinical judgment or previous Physician order indicates otherwise, you do not need to notify the Physician if:
      i. A patient's EWS score decreases to a lower monitoring parameter (i.e. patient's score changes from a 5 to a 2).
   b. If the patient's EWS score increases to a higher monitoring parameter, follow the notification recommendations as per appendix B.
7. Document interventions as appropriate within the Vital Signs intervention and/or as an FDARP Progress Note.

Related Documents

Communication and Escalation Policy and Procedure
Professional Staff – Response Times Policy
Professional Staff – Most Responsible Physician Policy
CCOT Calling Criteria
Nursing Scope of Practice

Key Words: Early Warning Signs, CCOT, EWS, Escalation, Vital Signs

References

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Reviewed by/Consultation with:

Signed by: _____ (Archived Copy Only)

Title: _____

Appendix A
Early Warning Signs (EWS) Score

EWS Score	3	2	1	0	1	2	3
Heart Rate (Beats per minute)	Less than or equal to 40		41-50	51-100	101-110	111-130	Greater than 130
Systolic Blood Pressure (mmHg)	Less than or equal to 70	71-90		91-170		171-200	Greater than 200
Respiratory Rate (Per Minute)	Less than or equal to 8		9-11	12-20		21-29	Greater than or equal to 30
Temperature (Celsius)	Less than or equal to 35	35.1-36.0		36.1-38	38.1-39	Greater than or equal to 39.1	
Oxygen Saturation (SpO2)	Less than 85		85-91	Greater than or equal to 92			
Oxygen Saturation Scale when ordered as SpO2% 88-92%	Less than 83	84-85	86-87	88-92 and Greater than or equal to 93 on RA	93-94 on O2	95-96 on O2	Greater than or equal to 97 on O2
Oxygen Delivery				Room Air		Oxygen	
Neurological Status				Alert Pre-existing Confusion			New Confusion, Responds to Voice, Only Pain or Unresponsive

Appendix B

Early Warning Signs Clinical Trigger Threshold			
EWS Score	**Risk**	**Frequency of Vital sign and EWS Monitoring**	**Clinical Response**
0-2	Low	Routine	
3-4	Low-Medium	Q 4-6 hours and PRN	Notify CRN/CN Consider Nursing Scope of Practice Consider RRT Assessment
5-6	Medium	Q 1 hour and PRN	Immediately notify CRN/CN Consider RN as assigned nurse RN to complete comprehensive assessment Notify MRP for urgent assessment (SBAR) Notify RRT for urgent assessment (SBAR) Consider/Establish goals of care/alternate care setting with monitoring facilities
7 or more	High	Q 1 hour and PRN	Immediately notify CRN/CN Consider RN as assigned nurse Notify MRP for STAT assessment within 30 min (SBAR) Notify RRT for STAT assessment (SBAR) Consider/Establish goals of care/alternate care setting with monitoring facilities Notify CCOT where available
• Notify physician as indicated when EWS score crosses into a higher risk category			