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

**NEW ONSET OF:**

**Stroke** (facial / arm weakness, speech problems)

**Central Chest Pain / Heart Attack / Cardiac arrest**

**CALL 999 IMMEDIATELY**

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

Extreme tiredness or dizziness

New or increasing oxygen requirement

Shivery, fever or feels very hot, cold or clammy

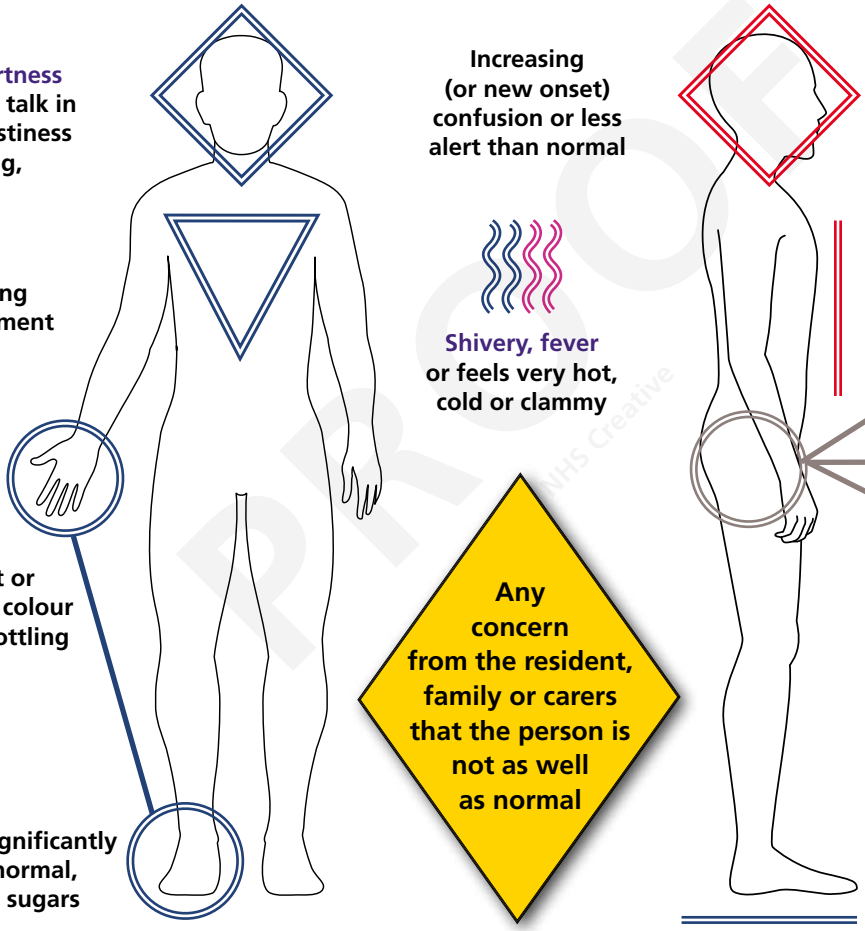
Off food, reduced appetite, reduced fluid intake

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

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

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

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

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

**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<br>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.<br>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 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 | | | | | | | | | | | | |
| **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 (Mins/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



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**Full Name:** _____ **NHS No.** _____

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | Date |
| | | | | | | | | | | | | Time |
| 3 | | | | | | | | | | | | ≥25 |
| 2 | | | | | | | | | | | | 21-24 |
| | | | | | | | | | | | | 18-20 |
| | | | | | | | | | | | | 15-17 |
| | | | | | | | | | | | | 12-14 |
| 1 | | | | | | | | | | | | 9-11 |
| 3 | | | | | | | | | | | | ≤8 |
| | | | | | | | | | | | | ≥96 |
| 1 | | | | | | | | | | | | 94-95 |
| 2 | | | | | | | | | | | | 92-93 |
| 3 | | | | | | | | | | | | ≤91 |
| 3 | | | | | | | | | | | | ≥97 on $O_2$ |
| 2 | | | | | | | | | | | | 95-96 on $O_2$ |
| 1 | | | | | | | | | | | | 93-94 on $O_2$ |
| | | | | | | | | | | | | ≥93 on air |
| | | | | | | | | | | | | 88-92 |
| 1 | | | | | | | | | | | | 86-87 |
| 2 | | | | | | | | | | | | 84-85 |
| 3 | | | | | | | | | | | | ≤83% |
| | | | | | | | | | | | | A = Air |
| 2 | | | | | | | | | | | | $O_2$ L/min |
| 3 | | | | | | | | | | | | ≥220 |
| | | | | | | | | | | | | 201-219 |
| | | | | | | | | | | | | 181-200 |
| | | | | | | | | | | | | 161-180 |
| | | | | | | | | | | | | 141-160 |
| | | | | | | | | | | | | 121-140 |
| | | | | | | | | | | | | 111-120 |
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| | | | | | | | | | | | | 61-70 |
| | | | | | | | | | | | | 51-60 |
| | | | | | | | | | | | | ≤50 |
| 3 | | | | | | | | | | | | ≥131 |
| 2 | | | | | | | | | | | | 121-130 |
| | | | | | | | | | | | | 111-120 |
| 1 | | | | | | | | | | | | 101-110 |
| | | | | | | | | | | | | 91-100 |
| | | | | | | | | | | | | 81-90 |
| | | | | | | | | | | | | 71-80 |
| | | | | | | | | | | | | 61-70 |
| | | | | | | | | | | | | 51-60 |
| 1 | | | | | | | | | | | | 41-50 |
| 3 | | | | | | | | | | | | 31-40 |
| | | | | | | | | | | | | ≤30 |
| | | | | | | | | | | | | Alert |
| | | | | | | | | | | | | Confusion |
| 3 | | | | | | | | | | | | V |
| | | | | | | | | | | | | P |
| | | | | | | | | | | | | U |
| 2 | | | | | | | | | | | | ≥39.1 |
| 1 | | | | | | | | | | | | 38.1-39.0° |
| | | | | | | | | | | | | 37.1-38.0° |
| | | | | | | | | | | | | 36.1-37.0° |
| 1 | | | | | | | | | | | | 35.1-36.0° |
| 3 | | | | | | | | | | | | ≤35.0° |
| | | | | | | | | | | | | NEWS TOTAL |
| | | | | | | | | | | | | Next observation due (Mins/Hrs) |
| | | | | | | | | | | | | Escalation of care Y/N |
| | | | | | | | | | | | | Initials |

**A+B**
**Respirations**
Breaths/min

**A+B**
**$SpO_2$ Scale 1**
Oxygen saturation (%)

**$SpO_2$ 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

**Air or Oxygen?**

**C**
**Blood pressure mmHg**
Score uses systolic BP only

**C**
**Pulse**
Beats/min

**D**
**Consciousness**
Score for NEW onset of confusion (no score if chronic)

**E**
**Temperature**
°C



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



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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 |

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