The National Early Warning Score 2 (NEWS2) – Elderly patients and training of nursing / allied healthcare professionals in using NEWS2

Editor – I read with interest, ‘The inclusion of delirium in version 2 of the National Early Warning Score will substantially increase the alerts for escalating levels of care: findings from a retrospective database study of emergency medical admissions in two hospitals’ by Mohammed et al and ‘The National Early Warning Score and the acutely confused patient’ by Bryan Williams. Being a geriatric medicine and general internal medicine higher specialist trainee, who has been working at the front lines and in the medical/surgical wards, my experiences resonate with the facts described in the above-mentioned articles. Although appearance of new confusion necessitates escalation of care among patients (285 years of age) with infection, there was a high prevalence of patients in this age group who did not have any evidence of underlying infection coinciding with development of new confusion. Infection is a major cause of delirium but other causes are as important to be considered and dealt with as well. In addition to the challenges described by Mohammed et al., one important issue to be recognised is staff (nursing and allied healthcare professionals (AHPs)) training to allow them to recognise delirium / new onset confusion in the elderly population (which is currently the main population cohort requiring medical attention) with or without background cognitive impairment. There must be a validated tool which nurses and AHPs should be able to use to recognise delirium / new confusion and then score that on the NEWS2 scale. One systematic review looked at 21 delirium screening tools described in 31 studies and found that confusion assessment method was the most used tool, with delirium rating scale giving best results in screening for delirium / new confusion. Both screening tools require teaching and training of staff using them for optimal results. Therefore, in order to streamline NEWS2’s implementation, decrease false positive alerts/escalations and improve its outcomes, we must train our nursing/AHP staff to use a validated screening tool to identify delirium / new confusion. And for this purpose, we must utilise the expertise of our geriatric medicine colleagues (physicians, clinical nurse specialists and registered nurses).

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References

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