

Stop and Watch—Early Warning Tool

If you have identified a change while caring for or observing a resident, Date: ____/____/____ Time: ____
please circle the letter, underline the change and notify the person in charge with a copy of this tool.

Name of resident: _____ Date of Birth ____/____/____ Room Number ____

- | | |
|---|---|
| S | Seems different to usual |
| T | Talks or communicates less |
| O | Oxygen-increased requirement, breathless, chest |
| P | Pain—new or worsening; Participates less in activities |
| A | Ate less |
| N | No bowel movement in 3 days; or diarrhoea |
| D | Drank less |
| W | Weight change |
| A | Agitated or more nervous than usual |
| T | Tired, weak, confused, drowsy |
| C | Change in skin colour or condition, high temp, low temp, clammy, rash |
| H | Help with walking, transferring or toileting more than usual, overall needs more help |

Describe the change you noticed: _____

Carer Name: _____

Senior Nurse reported to: _____

Observations: RR ____ SATS ____ BP ____ Pulse ____ ACVPU ____ Temp ____

Senior Nurse Actions

Repeat observations and record NEWS2 score overleaf (if applicable)

Reported to (circle): GP Rapid Response 111 999 not reported—Why? _____

Used SBAR format (overleaf) to communicate concerns : Y / N

Date: ____/____/____ Time (am/pm) _____

Outcome: ☐ Phone advice

☐ Treatment given in home (circle) GP Rapid Response Ambulance

☐ Transfer to hospital

☐ Other _____

In line with their preferred place of treatment / death? (circle) Y / N (if N please advise below)

Advance Care Plan: Y / N DNACPR/DNAR Y/N ReSPECT Form: Y / N (please circle as appropriate)

SBAR Communication Form

Before calling for help

Evaluate the resident: Complete relevant aspects of the SBAR form below

Review record: Recent progress notes, medications, other orders

Have relevant information available when reporting: (i.e. medical record, advance directives such as ReSPECT and other care limiting orders, allergies, medication list)

SITUATION

Date: ____ / ____ / ____ Time: ____

I am calling because I am worried about _____ Date of birth: ____ / ____ / ____

This started on ____ / ____ / ____

Since this started it has got: Worse ☐ Better ☐ Stayed the same ☐

BACKGROUND

Medical Conditions _____

Other medical history (e.g. medical diagnosis of CHF, DM, COPD)

Frailty Status (if known) _____

Advance Care Plan: Y / N DNACPR/DNAR Y/N ReSPECT Form: Y / N (please circle as appropriate)

ASSESSMENT

Identify the change(s) from the Stop and Watch tool

Repeat Observations: RR ____ SATS ____ BP ____ Pulse ____ ACVPU ____ Temp ____

NEWS2 Score (if applicable):

RECOMMENDATION

Responding Service Notified: _____ Date ____ / ____ / ____ Time (am/pm) _____

Actions you were advised to take: