

Maternal Early Warning Signs (MEWS) Protocol

1. Immediate action is required when any of the MEWS criteria are met (see table on page 2***)

Items that are not in the lower box should be confirmed, within 10 minutes, prior to calling the physician.

***Not applicable for BP systolic <90 when <=30 min post epidural and anesthesiologist present.

2. When immediate action is required:

- If the attending physician is immediately available, he/she will provide bedside evaluation of the patient within 10 minutes. The in-house OB will be notified to provide bedside evaluation if the attending physician is not at the bedside within 5 minutes.
- If the attending physician is not immediately available, the RN will call the in-house OB to provide bedside evaluation of the patient within 10 minutes. The attending physician or CNM will also be notified of the patient's status. If the CNM is notified, he/she will notify the attending physician.
- If in-house OB is called but not immediately available, he/she will receive a verbal report and determine what further action is necessary.

3. When called to the bedside, the physician will document by writing a note which includes but is not limited to:

- Differential diagnosis (the RN will provide this protocol and a differential diagnosis list to the bedside).
- Planned frequency of monitoring and re-evaluation.
- Criteria for immediate physician notification.
- Any diagnostic or therapeutic interventions.
- "Huddle" participants and summary of management plan.

The physician will communicate the assessment and plan via a "huddle." Huddle participants include the Primary RN, the Charge RN, the Anesthesiologist, the attending physician if present, and the in-house OB.

4. If MEWS conditions(s) persist after corrective measures undertaken, then MFM consult should be requested. Additionally, Intensivist consult &/or Rapid Response Team may be called.

5. Depending on the clinical evaluation, patient laboratory and diagnostic studies to consider include:

- ✓ Pulse oximeter
- ✓ CBC
- ✓ Type and screen or type and cross match if bleeding
- ✓ CMP
- ✓ Magnesium level
- ✓ EKG, particularly in the presence of tachycardia, bradycardia, or chest pain
- ✓ CT angiogram or perfusion scan in patients with acute chest pain
- ✓ CXR if the patient has SOB, particularly if pre-eclamptic
- ✓ Echocardiogram

6. If the primary RN and the charge nurse question any aspect of the patient's care and the issue is not resolved with the attending physician, another appropriate physician (MFM, Department Director or Associate Director, or the Chairman of the DQAIC committee) and a nurse in the Nursing Chain of Command (Nurse Manager, Clinical Practice Specialist, or Nursing Supervisor/AVP) will be notified.

Immediate Action Required

- Systolic BP; mmHg <90 or >160
 - Diastolic BP; mmHg >100
 - Heart rate; bpm <50 or >120
 - Respiratory rate; bpm <10 or >30
 - Oxygen saturation; % <95
 - Oliguria; ml/hr x 2h <35
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- ✓ Maternal agitation, confusion, or unresponsiveness
 - ✓ Patient with hypertension reporting a non-remitting headache or shortness of breath