CLINICAL PROTOCOL
Modified Early Warning Score (MEWS)
Observation Chart

RATIONALE
Modified early warning scores (MEWS) are now commonly used for the assessment of unwell patients; These simple observations can detect when a patient’s condition requires a more intense observation and should be a trigger for further investigation as early intervention can reduce morbidity and mortality in unwell patients (NICE 2007, NPSA 2007).

This tool promotes integration of care, and acts as a method for assessing the efficacy of medical interventions and can reduce the need for unnecessary hospital admissions. The modified early warning score (mews) is a tool that is based on physiological parameters and these observations should be recorded at an initial assessment for unwell patients or as part of routine monitoring were a patient’s medical condition dictates; heart rate, respiratory rate, blood pressure, level of consciousness and temperature (NICE 2007).

TARGET GROUP
All registered nurses employed by the Trust who provide clinical care for patients in the community setting, including bank staff are required to follow this protocol as part of their role and job description.

AIMS
This tool aims to assist the registered nurse to determine a course of action in the event of a patient becoming unwell or presenting with an abnormal physiological status

- To improve the quality of patient baseline observations and monitoring and allow for timely intervention or if needed admission to hospital
- To improve communication within the multidisciplinary team
- Support clinical judgement and aid in securing appropriate assistance for unwell patients
- Mews might also be a useful screening tool to triage patients who may require medical review and/or intervention

OUTCOMES
PROTOCOL FOR MODIFIED EARLY WARNING SCORE (MEWS)

All unwell patients will have their vital signs measured on admission to the caseload and these results will provide a baseline score. If a patient’s condition suddenly deteriorates or becomes increasingly unwell reassessment of their vital signs would provide an indication of the patient’s physiological status. This would require medical review by either a community matron and/or the patients General Practitioner for timely interventions, to prevent unavoidable hospital admissions or if redeemed necessary the patient may require admission to hospital.

TRAINING

The skills required to detect when a patient’s condition is deteriorating lie within the domain of basic nursing assessment skills for registered nurses.

KEY CLINICAL OBSERVATIONS

Nurses need to be alerted and act if:

- Respiratory Rate of 15 or above or below 8 breaths per minute
- Systolic blood pressure of < 80mmHg
- Heart Rate > 101 or < 50
- The patient is not fully alert and orientated
- Diastolic blood pressure >110

Not all patients will require the observation chart to be completed; the frequency and specifications of all observations should be documented in the patients care plan.

EXAMPLES OF INCLUSION CRITERIA

The following patients maybe considered being at high risk of developing abnormal observations and it should be considered best practice to commence these patients on a MEWS chart at the earliest opportunity. This includes:

- Patients with unstable medical condition
- Patients whose condition is causing concern and require frequent or an increased frequency of observations
- Patients with chronic unstable long term conditions
- Patients who have an infection e.g. wound, chest or urine infection who are not responding to treatment
- Post operative patients who are not progressing/improving

There are some patients where the MEWS may be inappropriate, for example:

- Patients requiring a single visit or intermittent service
- Patients who are terminally ill
PROTOCOL FOR MODIFIED EARLY WARNING SCORE (MEWS)

When taking the patient’s pulse do this manually, as a machine will not detect volume or rhythm. Respiratory rate is widely accepted as being the most sensitive basic observation in detecting deterioration in the patient’s condition.

Respiratory rate – normal rate 12-18 breaths per minute

Normal Oxygen saturation rate – above 90%

Normal heart rate is between 60-100 beats per minute

Blood Pressure: – normal range, systolic 100-160mmHg, Diastolic 60-85mmHg.

TRIGGER SCORES

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<th>MEWS SCORE</th>
<th>Actions</th>
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| 1 - 2      | • Observe patient and repeat observations as directed in care plan or following discussion with Community Matron (CM) Team Leader (TL) or General Practitioner (GP) if required  
• Document all discussions and actions taken in the home nursing records |
| 3 - 4      | • Continue to carry out observations and if needed increase frequency of observations  
• Inform CM, or GP of results and the health status of the patient, patient may require additional interventions if condition escalating e.g. Wirral Admission Prevention Service  
• Discuss with CM or GP the need for a home visit and treatment to manage underlying condition to prevent potential inappropriate hospital admission |
| 5 OR ABOVE | • Monitor observations regularly as directed by CM or GP  
• Contact CM or GP and/or request urgent visit to review patient due to deterioration of the patients health status  
• Discuss with patient the possible need for hospital admission if no improvement  
If patients condition deteriorates rapidly consider calling 999 |

RECORDING EARLY WARNING SCORES

Observations must be recorded on the standard observation chart; a decision to initiate an early warning referral for medical intervention must be recorded in patient’s home nursing records

• Report findings to General Practitioner
• Inform team leader/community matron/Senior nurse
• Record all actions in patients health records
• The observation chart must be dated/timed in all sections as the signing section confirms completion of all the sections of the documentation
PROTOCOL FOR MODIFIED EARLY WARNING SCORE (MEWS)

• Discuss results with patient/relative and treatment options
• Ring for emergency services if required

HOW WILL STAFF DEMONSTRATE PROTOCOL IS BEING ACHIEVED

• Health records will include evidence of observation charts
• Health records will demonstrate that patients condition has been monitored
• Health records will evidence how advice has been sought from the patients General Practitioner or other specialists when needed as required

MONITORING AND AUDIT
An ad hoc audit of the implementation of the early warning system will be undertaken by the Service Improvement Unit.

REFERENCES


CONSULTATION
All nursing policy and procedure group members
Infection Control
Nurse Managers
Wirral Admission Discharge Team