CRAWFORD MEMORIAL HOSPITAL

NURSING POLICIES & PROCEDURES

Title/Description: **Modified Early Obstetric Warning System (MEOWS)**

Page: 1 Filing No:

Effective Date: Last Revision Date:

Review Date: Approved By:

Applies To: OB Initials:

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Policy: The nurse will enter the vital signs and neurologic status of the patient on admission, each set of vitals and any deterioration of patient condition in to the selected screen in Centricity. The generated score will enable the nurse to identify patients who are deteriorating and who need urgent intervention. (See Table 1a for scoring and Table 2a for interventions)

Table 1a

Score	3	2	1	0	1	2	3
Resp Rate per minute	≤ 8		9-11	12-20	21-24	≥25	
Heart Rate per minute	≤ 40	41-59		60-100	101-110	111-129	≥ 130
Systolic Blood pressure	≤ 60	61-79	80-100	101-140	141-160		≥ 161
Diastolic Blood pressure	≤ 40	41-50		51-90	91-100	101-109	≥110
Temperature		< 35.0 C < 95.0 F	35.1-36 C 95.1-96.8 F	36.1-38 C 96.9-100.4 F	38.1-38.5 C 100.5-101.3 F	> 38.6 C >101.4 F	
SpO2	< 89	90-93	94-100				
LOC	Somnolent-Responds to pain	Drifts off during conversation-Responds to verbal command	Drowsy	Alert	Agitation or Confusion	New onset of agitation or confusion	

Score 0-1 Score 2-3 Score 4-5 Score 6 or >

*Measurement Artifact: A single abnormal vital sign can reflect measurement artifact. Verify isolated abnormal measurement heart rate, BP, resp rate, Sp02 or neurological state and re-evaluate.

Table 2a

Required Interventions:

Green (0-1)	Continue to monitor and document findings. Inform charge nurse and/or house supervisor
Yellow (2-3)	Review patient status with charge nurse, OB Director and/or house supervisor. Notify provider with concerns and increase monitoring to every 2 hours
Orange (4-5)	Immediately review patient status with charge nurse, OB director and/or house supervisor and patient's provider. Increase monitoring to every 15 minutes until score is 3 or less.
Red 6 or >	Call provider for urgent bedside evaluation and Rapid Response team IMMEDIATELY and prepare for imminent delivery or maternal rescue

Activation of Rapid Response Team:

Overhead page: Dial 451 and state "Rapid Response Team to room 40_" Give exact location.

- **The OB Nurse will:** Serve as team leader and delegates responsibilities to RRT responders.
  - ✓ Ensure physician has been notified of need for immediate bedside evaluation
  - ✓ Have chart at bedside
  - ✓ Give clear concise report of patients condition to RRT upon arrival using SBAR
    - S-Situation (What is going on with the patient)
    - B-Background (OB History)
    - A-Assessment (What does the nurse think the problem is?)
    - R-Recommendation (What does the nurse think the patient needs immediately?)
  - ✓ Stay with patient and assist RRT with assessment and interventions
  - ✓ Assure Hemorrhage cart in located in patients room if deterioration of condition was due to hemorrhage

- **Rapid Response Team responsibilities**:
  - ✓ Receive report from OB nurse
  - ✓ Assess patient
  - ✓ Discuss concerns/findings with OB nurse and physician
  - ✓ Document findings on RRT record sheet
  - ✓ Discuss on-going treatment of patient and appropriateness of transfer to SCU if indicated
- **Cardiopulmonary**
  - ✓ Assure the crash cart is outside of patient room
  - ✓ Receive report from OB nurse
  - ✓ Assess airway/assist with maintain ventilation as needed
  - ✓ Report findings to nurse and physician
  - ✓ Document findings on RRT record sheet

- **SCU/ER Nurse**
  - ✓ Receive report from OB nurse
  - ✓ Assist with assessment
  - ✓ Assist in obtaining additional equipment if needed
  - ✓ Assist with special procedures as needed
  - ✓ Report findings to OB nurse and physician
  - ✓ Document findings on RRT record sheet