Maternity Early Obstetric Warning Scoring System

NHS University Hospitals of Leicester NHS Trust

C16/2018

Contents

1. Introduction and Who Guideline applies to

For the vast majority of women, childbearing is a normal life event. Physiological adaptations enable safe pregnancy, childbirth and postnatal recovery. However, these physiological adaptations, combined with the relative rarity of severe maternal illness can come together to make recognition of impending maternal collapse difficult.

Implementation of an early warning scoring system, modified for pregnancy / postnatal period, offers the opportunity to recognise the early warning signs for impending maternal collapse (arrest) which can be very sudden, unexpected, or difficult to predict and initiate appropriate response.

The implementation of such a system is in line with numerous best practice recommendations (including CEMACH 2007 & MBRRACE-UK 2016).

This guideline applies to all staff (including those on bank contracts) working within UHL caring for pregnant or postnatal women. This includes care in all settings (midwifery led or shared care; community or hospital setting). This is likely to include midwives, obstetricians, anaesthetic, critical care staff and nursing and medical staff where pregnant or postnatal women are on non-maternity wards.

This guideline applies to all pregnant or postnatal women, irrespective of location Within UHL.

For the purpose of this guideline the postnatal period is considered to be from delivery up to 6 weeks after the birth of the baby (irrespective of gestation at delivery).

Related Documents

Intrapartum Care in Labour

Pyrexia and Sepsis in Labour- A guideline for management

Pregnant Women Admitted Outside Maternity Unit

Background:

Early Warning Scoring Systems are a simple, quick-to-use tool based on routine physiological observations. The scoring of these observations can provide an indication of the overall status of the patient's condition. Prompt action and urgent medical review when indicated, allow for appropriate management of women at risk of deterioration. This guideline therefore applies to all pregnant, labouring and postnatal women as identified in section 2.

There are other Early Warning Scoring Tools within UHL. The Trust now uses the National Early Warning Scoring tool (NEWS2) for all adult patients, within this there is a NEWS2 model for patients diagnosed with hypercapnia. Paediatrics use a PEWS version.

The Maternity Early Obstetric Warning System (MEOWS) tool has been specifically modified to reflect the physiological adaptations of normal pregnancy and should therefore be used for pregnant, labouring and postnatal.

2. When to use the maternity early warning scoring system

MEOWS assessments must be undertaken and documented, ***regardless of location***, on initial assessment and thereafter 12 hourly or as indicated by the score, for:

- All women in active labour and all women following delivery. Routine intrapartum observations should also be performed as per the intrapartum care guideline.
- All antenatal admissions to hospital
- All postnatal admissions to hospital
- All in-patients to have ongoing MEOWS assessments, regardless of the reason for admission / stay (see below)
- All non-routine and / or non-scheduled contacts, either antenatal or postnatal
- If any health problem is suspected at any time
- If the mother ever reports feeling 'unwell'

3. Who should perform MEOWS:

- This will usually be performed by Midwives
- It may also be performed by Maternity Care Assistants providing they have undergone the appropriate training as per the Training Needs Analysis
- It may also be performed by student midwives under the supervision (direct/indirect) of the midwife mentoring them providing they have been assessed competent to do so.

4. The Scoring System: Parameters

MEOWS assessments must be undertaken when indicated, as detailed in section 6.0, and documented on eObs on the Nervecentre platform (see Nervecentre user guide on InSite). Should Nervecentre not be available, the paper MEOWS assessment tool should be used (Appendix I). MEOWS paper assessment charts should be filed as follows:

- MEOWS charts generated during an in-patient episode are to be filed in the green maternity notes on discharge from hospital.

- MEOWS charts generated in the community are to remain with the mother, securely attached in the hand-held / post-natal record.

Scoring is based on the following parameters:

Score	3	2	1	0	1	2	3
Temp.		≤ 35	35.1-36	36.1-37.9	38-38.4	≥38.5	
Systolic BP	≤ 70	71-90	91-99	100-130	131-139	140-160	>160
Diastolic BP			≤ 49	50-89	90-99	100-109	>110
Pulse		≤ 40	41-59	60-100	101-110	111-129	>130
Respiratory Rate	*≤10			11-20	21-25	26-30	>30
Conscious level		New agitation/ confusion		A ALERT	V Responds to VOICE	*P Responds to PAIN	*U Unconscious

*key indicators

- Additionally, there are obstetric parameters on the chart which do not have a numerical score but may trigger actions if response falls into amber or red area.

5. The Scoring System: Actions (Dr to review if any RED scores)

Score 0:	- Repeat in twelve hours for all in patients - Community assessment for non-scheduled contact, score of 0 and **NO** other risk factors / indications: repeat not necessary. - Exercise professional judgement and document rationale
Score 1-2:	- Refer to Qualified/Registered Professional - Midwife devises plan & documents when to repeat (i.e. in 1 hour / 4 hours / 12 hours) - Continue with at least 12 hourly observations
Score 3:	- Refer to Qualified/Registered Professional - Increase frequency of observations to 4 hourly - Consider need to increase frequency of observations to intervals of less than 4 hours

Score 3 within 1 parameter:	- Refer to Qualified/Registered Professional to re-check observations - Observation frequency increased to at least hourly - Commence fluid balance monitoring, consider urinary catheter - Midwife to inform Medical staff of *at least* Middle Grade (Registrar) level: request to review as soon as possible and within 60 minutes - Consider transfer to delivery suite - Inform resident anaesthetist - Check oxygen saturations and administer oxygen as appropriate - Check for sepsis
Score 4-5	- Refer to Qualified/Registered Professional to re-check observations - Minimum of hourly observations - Commence fluid balance monitoring - Medical staff of *at least* Middle Grade (Registrar) level to review within 30 minutes - Registrar seeks senior advice - Inform resident anaesthetist - Transfer to delivery suite /inform delivery suite coordinator (if within Women's Unit) - Check oxygen saturations and administer oxygen as appropriate - Check for sepsis
Score 6 or more	- **Immediate transfer to delivery suite/inform delivery suite coordinator** - **Request immediate review by most senior resident doctor (within 30 minutes)** - **Senior resident doctor refers to Consultant Obstetrician and review within an hour** - **Inform resident anaesthetist** - **Anaesthetist to inform Anaesthetic Consultant** - **Contact Deteriorating Adult Response Team (DART) /consider direct contact with ITU** - **Observations documented at least every 15 minutes** - **Check oxygen saturations and administer oxygen as appropriate** - **Commence HDU chart where score >6** - **Check for sepsis**
Score ≥ 4 in Women admitted outside Maternity	- Please contact the delivery suite coordinator to plan care and contact Obstetric and Anaesthetic SpR on call

Please note that actions may need to deviate from the above in individual cases; where this applies, the management plan should be documented.

6. Ongoing Observations: Normal Scores (0):

- 'Normal' in a MEOWS context is a woman who has had two consecutive MEOWS scores of 0 and no additional indications.

- In-patients who have two consecutive MEOWS scores of 0 can have MEOWS observations reduced to once daily.

- If the woman reports any problems, feeling unwell, if score is >0, or any problem is suspected, then MEOWS frequency is increased back to 12 hourly (minimum, dependent on findings), until 'normal' again.

7. Education and Training

- Education will be provided for all clinical staff working with the UHL Maternity Services by the Maternity Education Team; this is detailed in the Training Needs Analysis and includes the use of MEOWS as a tool for the recognition of the severely ill woman and maternal resuscitation.

8. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
All MEOWS charts should be completed on initial assessment	Audit of the MEOWS charts	Midwifery Matrons	Monthly	Reported on the Clinical Dashboard
All MEOWS charts should be completed 12 hourly or as indicated by the score	Audit of the MEOWS charts	Midwifery Matrons	Monthly	Reported on the Clinical Dashboard
Appropriate action has been taken according to each score	Audit of the MEOWS charts	Midwifery Matrons	Monthly	Reported on the Clinical Dashboard

9. Supporting References

- MBRRACE-UK (2016) Saving Lives, Improving Mothers' Care
- NICE (2007) Acutely Ill patients in hospital: recognition of and response to acute illness in adults in hospital (clinical guideline 50)- updated 2014, reviewed 2020 – no changes
- Lewis G. (ed) 2007. The confidential Enquiry into Maternal and Child Health
- (CEMACH) Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH
- Centre for Maternal and Child enquiries (CEMACE). Saving mothers lives: reviewing maternal deaths to make motherhood safer 2006-08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom BJOG 2011
- National Patient Safety Agency (2007a) Recognising and Responding Appropriately to Early Signs of Deterioration in Hospitalised Patients. London: NPSA. www.npsa.nhs.uk
- Maternal collapse in pregnancy and puerperium RCOG green top guideline NO: 56, January 2011

- Gopalan PD, Muckhart DJ. The critically ill obstetric patient: what's the score? Int J Obstet Anesth 2004; 13:144–5
- Singh S, McGlennan A, England A, Simons R. A validation study of the CEMACH recommended modified early obstetric warning system (MEOWS)*. Anaesthesia 2012, 67, 12–18

10. Key Words

Assessment, Deterioration, Maternal, MEOWS, Observation

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Development and approval record for this document

Author / Lead Officer:	Original Working Party	**Job Title:**
Reviewed by:	A Akkad - Consultant	
Approved by:	Maternity Governance	**Date Approved: 19/05/2021**

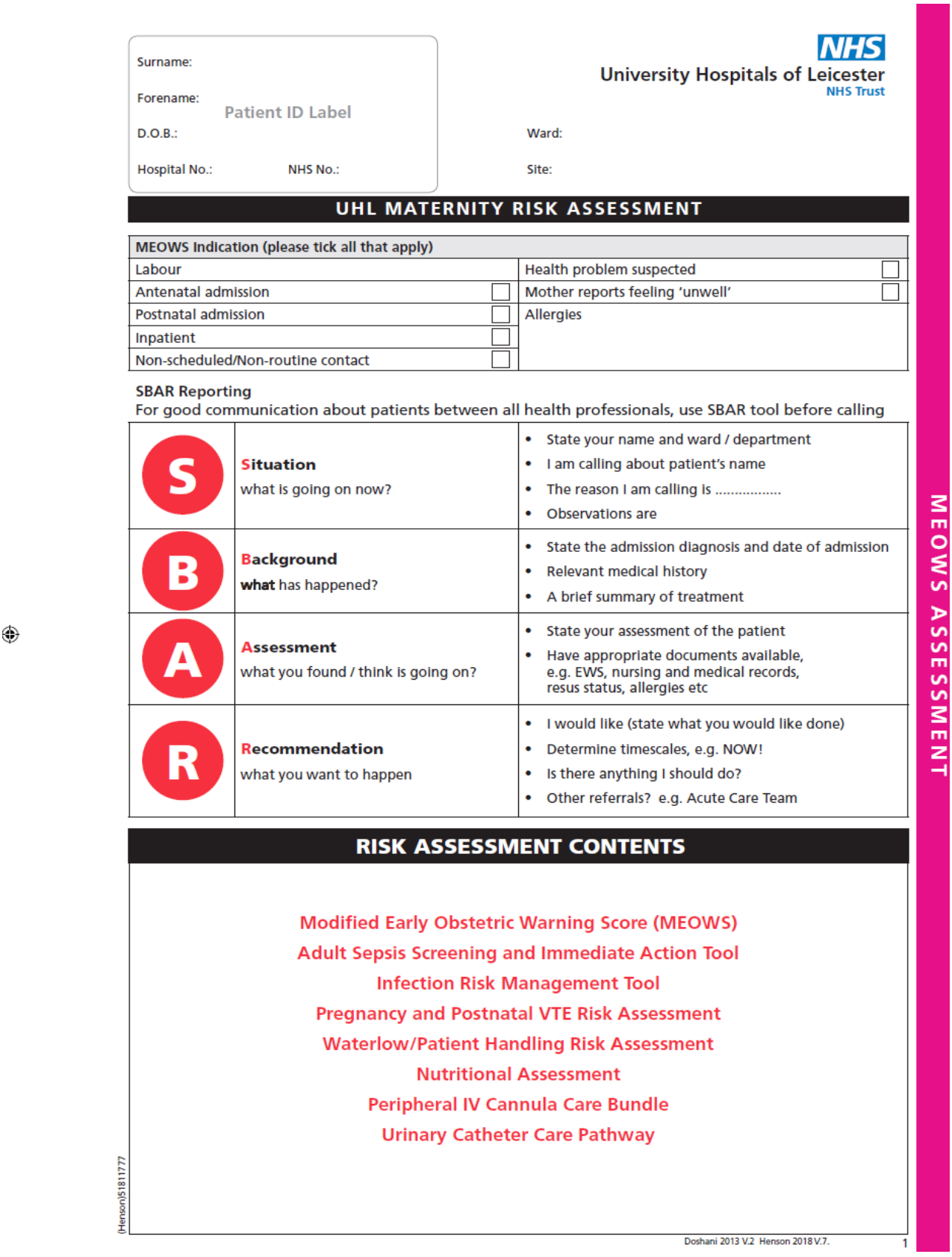
REVIEW RECORD

Date	Issue Number	Reviewed By	Description Of Changes (If Any)
May 2019	V3	R Henson	Parameters amended to come into line with latest observation chart and in readiness for E Obs. Latest observation chart added. Use of Critical care Outreach team added. Requirement to document in dots and not numbers added. Monitoring compliance added.
May 2021	V4	A Akkad	Meows to be documented on eObs on the nervecentre platform. Escalation to DART now when scoring 6 or more only. List of indications to consider when reducing frequency of observations when scoring two consecutive MEOWS scores of 0 removed. MEOWS Chart document updated References reviewed and updated
October 2021	V4.1	A Akkad	Minor amendment to reference to Trust EWS tools. Changed from 2 separate surgical & medical, now use NEWS2 for all adults

DISTRIBUTION RECORD:

Date	Name	Dept	Received
June 2021	Midwives Obstetricians Anaesthetists	Maternity/Obstetrics	

Appendix I: Modified Early Obstetric Warning Scoring Assessment Tool



Surname:

Forename:

Patient ID Label

D.O.B.:

Hospital No.: NHS No.:

NHS
University Hospitals of Leicester
NHS Trust

Ward:

Site:

MEOWS ASSESSMENT

UHL MATERNITY RISK ASSESSMENT

MEOWS Indication (please tick all that apply)			
Labour		Health problem suspected	☐
Antenatal admission	☐	Mother reports feeling 'unwell'	☐
Postnatal admission	☐	Allergies	
Inpatient	☐		
Non-scheduled/Non-routine contact	☐		

SBAR Reporting

For good communication about patients between all health professionals, use SBAR tool before calling

S	**Situation** what is going on now?	• State your name and ward / department • I am calling about patient's name • The reason I am calling is ..... • Observations are
B	**Background** **what** has happened?	• State the admission diagnosis and date of admission • Relevant medical history • A brief summary of treatment
A	**Assessment** what you found / think is going on?	• State your assessment of the patient • Have appropriate documents available, e.g. EWS, nursing and medical records, resus status, allergies etc
R	**Recommendation** what you want to happen	• I would like (state what you would like done) • Determine timescales, e.g. NOW! • Is there anything I should do? • Other referrals? e.g. Acute Care Team

RISK ASSESSMENT CONTENTS

Modified Early Obstetric Warning Score (MEOWS)

Adult Sepsis Screening and Immediate Action Tool

Infection Risk Management Tool

Pregnancy and Postnatal VTE Risk Assessment

Waterlow/Patient Handling Risk Assessment

Nutritional Assessment

Peripheral IV Cannula Care Bundle

Urinary Catheter Care Pathway

(Henson)51811777

Doshani 2013 V.2 Henson 2018 V.7. 1

MEOWS ASSESSMENT

ACTION

If any RED score, Doctor to review

Score 0	• Repeat in twelve hours for all in patients. • Community assessment for non-scheduled contact, score of 0 and **NO** other risk factors/ indications: repeat not necessary. Exercise professional judgement and document rationale
Score 1 - 2	• Refer to Qualified / Registered Professional • Midwife devises plan & documents when to repeat (i.e. in 1 hour / 4 hours / 12 hours) • Continue with at least 12 hourly observations
Score 3	• Refer to Qualified / Registered Professional to recheck observations • Increase frequency of observations to 4 hourly • Consider need to increase frequency of observations to intervals of less than 4 hours
Score 3 within 1 parameter ANY OBSERVATION	• Check oxygen saturations and administer oxygen as appropriate • Refer to Qualified / Registered Professional to recheck observations • Observation frequency increased to at least hourly • Commence fluid balance monitoring. Consider urinary catheter • Midwife to inform Medical staff of **at least** Middle Grade (Registrar) level: request to review within 60 minutes • If Doctor not available within time frame consider contacting Critical Care Outreach Team • Consider transfer to delivery suite • Inform resident anaesthetist • Check for Sepsis
Score 4 - 5	• Check oxygen saturations and administer oxygen as appropriate • Refer to Qualified/Registered Professional to recheck observations • Minimum of hourly observations • Commence fluid balance monitoring • Medical staff of **at least** Middle Grade (Registrar) level to review within 30 minutes • If Doctor unable to attend within time frame contact Critical Care Outreach Team and ask for review • Registrar seeks senior advice • Inform resident anaesthetist • Transfer to delivery suite / inform Delivery Suite Coordinator (if within the Women's Unit) • Check for Sepsis
Score 6 or more	• Check oxygen saturations an administer oxygen as appropriate • Immediate transfer to delivery suite / inform Delivery Suite Coordinator • Request immediate review by most senior resident doctor (within 30 minutes) • Senior resident doctor refers to Consultant and review within an hour • Inform resident anaesthetist • Anaesthetist to inform Anaesthetic Consultant • Contact Critical Care Outreach Team / consider direct contact with ITU • Observations documented at least every 15 minutes • Commence HDU chart where score is greater than 6 • Check for Sepsis
Score ≥4 in women admitted outside Maternity	• Please contact the delivery suite co-ordinator to plan care and contact Senior Obstetric Reg and Anaesthetic SpR on call.

Please note that actions may need to deviate from the above in individual cases; where this applies, the management plan should be documented.

KEY:

Pain
3 - Severe
2 - Moderate
1 - Mild
0 - None

MOTOR BLOCK

0 = Full power / sensation
1 = Abnormal power / sensation

Any woman with a score greater than 6 should be commenced on an HDU chart

Please assess the additional red scores as a minimum twice a day, unless otherwise indicated

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Title: Maternity Early Warning Scoring System V4.1
Reviewed by: A Akkad
Approved by: Maternity Governance Group: 19/05/2021 Next Review: May 2024
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MEOWS ASSESSMENT

MEOWS key: 0 1 2 3

Date:																			
Time:																			
Resp.	>30									3									>30
	26 - 30									2									26 - 30
	21 - 25									1									21 - 25
	11 - 20																		11 - 20
	≤10									3									≤10
Temp.	≥39									2									≥39
	38 - 38.9									1									38 - 38.9
	37 - 37.9									0									37 - 37.9
	36 - 36.9																		36 - 36.9
	35 - 35.9									1									35 - 35.9
	≤34.9									2									≤34.9
Heart Rate	≥170									3									≥170
	160 - 169									3									160 - 169
	150 - 159									3									150 - 159
	140 - 149									3									140 - 149
	130 - 139									3									130 - 139
	120 - 129									2									120 - 129
	110 - 119									2									110 - 119
	100 - 109									1									100 - 109
	90 - 99																		90 - 99
	80 - 89																		80 - 89
	70 - 79																		70 - 79
	60 - 69																		60 - 69
	50 - 59									1									50 - 59
	40 - 49									1									40 - 49
	≤39									2									≤39
Systolic Blood Pressure	≥200									3									≥200
	190 - 199									3									190 - 199
	180 - 189									3									180 - 189
	170 - 179									3									170 - 179
	160 - 169									3									160 - 169
	150 - 159									2									150 - 159
	140 - 149									1									140 - 149
	130 - 139									0									130 - 139
	120 - 129																		120 - 129
	110 - 119																		110 - 119
	100 - 109																		100 - 109
	90 - 99									1									90 - 99
	80 - 89									2									80 - 89
	70 - 79									2									70 - 79
	60 - 69									3									60 - 69
	50 - 59									3									50 - 59
	≤49									3									≤49
Diastolic Blood Pressure	≥130									3									≥130
	120 - 129									3									120 - 129
	110 - 119									3									110 - 119
	100 - 109									2									100 - 109
	90 - 99									1									90 - 99
	80 - 89																		80 - 89
	70 - 79																		70 - 79
	60 - 69																		60 - 69
	50 - 59																		50 - 59
	40 - 49									1									40 - 49
	≤39									1									≤39
Neuro Response	Alert																		Alert
	Voice									1									Voice
	Pain									2									Pain
	Unresponsive									3									Unresponsive
MEOWS																			
Pain score (no.)	3																		3
	1 - 2																		2
	0																		0
Saturation	95 - 100%																		95 - 100%
	91 - 94%																		91 - 94%
	≤90%																		≤90%
O_2 conc	%																		%
Motor block	1																		1
	0																		0
Passed urine	Y or N																		Y or N
Proteinuria	2+																		2+
	>2+																		>2+
Liquor	Clear / Pink																		Clear / Pink
	Green																		Green
Lochia	Normal																		Normal
	Heavy / Foul																		Heavy / Foul
Signs of infection	Yes																		Yes
	No																		No
TOTAL RED SCORES																			
Initial / signature																			

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MEOWS ASSESSMENT

Adult Sepsis Screening and Immediate Action Tool

Complete and file in medical record

Name:

Date of Birth:

Hospital Number:

Affix Hospital Label if available

NHS University Hospitals of Leicester NHS Trust

Caring at its best

Kettering General Hospital NHS Foundation Trust

1. At least **one** of the following present?

- ☐ Early Warning Score 3 or more OR
- ☐ Patient looks unwell OR
- ☐ Concern regarding acute change in mental state

N → **Low Risk of SEPSIS**

Treat to local protocols, review if patient deteriorates. Consider other diagnoses. ☐

Y

2. Is the clinical picture suggestive of an infection? ☐ YES

If there is a high probability of a non-infective explanation for clinical features (eg AMI, PE, liver failure, pancreatitis or stroke) then manage as low risk of sepsis

- ☐ Chest
- ☐ Urinary Tract
- ☐ Cellulitis, necrotizing fasciitis
- ☐ Abdominal
- ☐ Bone or joint
- ☐ Meningitis
- ☐ Device related (eg catheter, line)
- ☐ Other, state:
- ☐ Yes, but source unclear

N → **Moderate Risk of SEPSIS**

Sepsis Likely / Present ☐

- Inform responsible clinician
- Consider Sepsis Six interventions (see overleaf)
- Begin at least hourly observations
- Act on early warning score triggers
- Send appropriate microbiological samples (including blood culture)
- Send blood samples for FBC, CRP, U&E, LFT coagulation, Blood gas (venous or arterial) Glucose, ensure **results are reviewed**
- Source specific antimicrobial prescribing based on local policy (e.g. 4hr CAP bundle)

If EWS 4 or more **AND** Lactate ≥ 2 or AKI ≥ 2 ☐
If YES Then treat as RED FLAG SEPSIS
Time zero = Time of abnormal blood results availability

Y

Perform rapid ABCDE assessment

3. At least one red flag present?

- Assessment **MUST** allow for patients usual chronic baseline
- Obstetric patients: use corresponding red MEOWS triggers

A ☐ Respiratory rate **25/min** or more

B ☐ New need for >40% O_2 to keep saturations over **91%** (saturations > 87% in COPD)

☐ Systolic BP < 91mmHg or fall of 40 from normal

C ☐ HR >130/min

☐ No urine output for 16hrs or UO<10ml/hr

D ☐ New onset delirium

☐ Responds only to voice or pain / unresponsive

E ☐ Non-blanching rash/ mottled / ashen / cyanotic

☐ Neutropenia or chemotherapy within last 6 weeks

N → **HIGH Risk of SEPSIS**

Red Flag Sepsis ☐

This is a time critical condition, immediate action is required!

Start Sepsis 6 bundle NOW (see overleaf)

- ☐ Inform resident senior doctor
- ☐ Inform outreach team (ward patients): BLEEP LRI 5293 / GH 2808 / LGH 3457
- ☐ Inform Sepsis Team (ED): CALL # 6826

Time Zero: _____ (ED, time of admission. Ward, time of first red flag)

Target Time: _____ (Time when sepsis six to be complete. Time zero plus 1 hr)

Delivery of Sepsis Six by junior staff must not be delayed. Resident senior doctor review can stop the process on the following grounds:

- ☐ Patient is End of Life
- ☐ Patient low suspicion of infection
- ☐ Red Flag due to chronic disease

STOP

SURNAME & GRADE	SIGNATURE	DATE & TIME

PRINT NAME: Title: Date: Time:

UHL Sepsis Pathway for Adult Patients approved by UHL Sepsis Working Party- April 2017 Contact: John Parker, UHL Sepsis Lead
Latest version approved by UHL Policy and Guidelines Committee- May 2017, Trust Ref: B11/2014 Version No 3. Next Review May 2020
NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents

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Sepsis Six Bundle

Complete in one hour.

Actions should be carried out simultaneously.

Use sepsis box / pack to support delivery of sepsis six

THE UK SEPSIS TRUST

Supporting Resources

Sepsis
Frequently Asked Questions

How to:
Take a blood culture
Draw up meropenem
Use a sepsis box

- Use sepsis box/pack to support delivery of sepsis six

		Time Started	Name	Reason not administered
1	**Administer supplementary oxygen (if required)** • Aim to keep saturations > 94% COPD: Adjust target saturations to 88-92%			

		Time Taken	Name	Reason not taken
2	**Blood Culture & Source Management** • Take blood cultures (before IV antibiotic) • Think source confirmation and control! • Consider also sputum, urine, CSF, line culture/removal • involve appropriate surgical team / radiologist as indicated • For Community Acquired Pneumonia start 4 hr CAP Bundle			

		Time Given	Name	Reason for departure from prescribing guidance
3	**Give IV antibiotics** PRESCRIBE STAT (TIMED). GIVE YOURSELF OR MAKE SURE SOMEONE DOES • Red Flag Sepsis: Meropenem IV 1g stat (+/- second dose at 8hrs) and review at first inpatient consultant assessment (microbiology advice may be needed at this stage) • Sepsis: According to local antimicrobial policy			

		Time Given	Name	Reason not given
4	**Give a fluid challenge** Check and monitor response If SBP <90mmHg or Lactate >2 • Give 500mls Hartmann's or 0.9% NaCl over 15 mins, repeat once if necessary • Senior resident doctor review to exclude other causes of shock before giving up to 30 ml/kg If SBP >90mmHg and Lactate <2 consider IV fluids			

		Time Taken	Name	Reason not done
5	**Measure lactate** • Obtain blood gas - venous or arterial • If lactate >4mmol/L refer to critical care • Ensure samples are sent for FBC, CRP, U+E, LFT, coag screen • Repeat lactate after fluid challenge			

		Time Started	Name	Reason not started
6	**Measure urine output** • Ensure hourly fluid balance chart commenced • Catheterise if AKI / SBP <90 / Lactate >2 • Monitor Vital Signs at 15-30mins intervals until EWS below 3			

		Time Referred	Name of Referrer	Reason NOT Referred:
Escalation	**Critical Care Medical Team** refer if patient: • SBP <90 and lactate >2 after fluid resuscitation • Has Red Flag Sepsis and lactate >4 • Has Red Flag Sepsis and requires >50% O_2 • Has Red Flag Sepsis and significant respiratory/ cardiovascular/ CNS or renal dysfunction.		Name of ICU Doctor	

UHL Sepsis Pathway for Adult Patients approved by UHL Sepsis Working Party- April 2017 Contact: John Parker, UHL Sepsis Lead
Latest version approved by UHL Policy and Guidelines Committee- May 2017, Trust Ref: B11/2014 Version No 3. Next Review May 2020
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MEOWS ASSESSMENT

(HENSON)AltMEOWSAssessmentChart51811777.indd 7 02/05/2018 14:34

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MEOWS ASSESSMENT

ADMITTING WARD: Date: Moved to: Date:

Moved to: Date: Moved to: Date:

INITIAL PLAN FOLLOWING FIRST MEOWS TOTAL

Name:	Hospital No.	Ward	Site

Date: Time: : Total MEOWS

Plan: Frequency of Obs.:

Signature: Print Name:

SUMMARY OF PLANS

Date: Time: : Total MEOWS

Plan:

Signature: Print Name:

Date: Time: : Total MEOWS

Plan:

Signature: Print Name:

Date: Time: : Total MEOWS

Plan:

Signature: Print Name:

Date: Time: : Total MEOWS

Plan:

Signature: Print Name:

Date: Time: : Total MEOWS

Plan:

Signature: Print Name:

Date: Time: : Total MEOWS

Plan:

Signature: Print Name:

Any woman with a score of 4 or 5 on more than two occasions MUST go on the HDU chart

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(HENSON)AltMEOWSAssessmentChart51811777.indd 8 02/05/2018 14:34

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