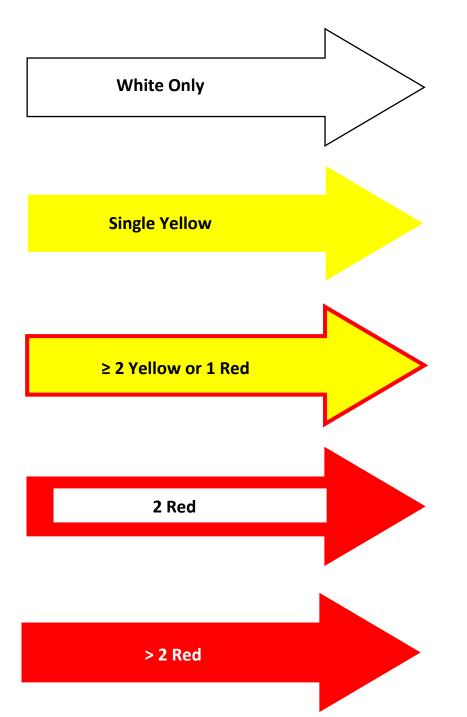
Obstetric Early Warning Score Chart - Maternity Use Only

Addressograph Label Name Consultant							Month Year Ward								Booking BP mmHg BMI Kg/m²							HSC			He Sc	Health and Social Care		
Hosp No						· · · · · · · · · · · · · · · · · · ·							BMI Kg/m²											Diagon tiel, halann				
Date:																											Please tick below Early Pregnancy	
Frequency of O																											A/N	
Time 24hr clock																											P/N	
Resps	>30 21-30 10-20																										>30 21-30 10-20	
% O2	<10 91-100%																										<10 91-100	
Saturation	≤90%																										≤90	
Inspired O2/RA	%																										%	
Temp	39 38																										39 ————————————————————————————————————	
remp	37 36																										37 —— —— 36 ——	
	35																											
	150																										150	
	140																										140	
	130 120																										130 — — 120 —	
Heart Rate	110 100																										 110 	
	90																										100 90	
	80																											
	70 60																										70 60	
	50																											
	40																										40	
	190 180																										190 180	
	170																										 	
	160 150																										— 160 — — 150 —	
	140																										140	
Systolic	130 120																										130 120	
Blood Pressure	120																										110 —	
riessuie	100																										100	
	90																										90 80	
	70 60																										70	
	60 50																										60 — 50 —	
	130																										130	
	120																											
Diastolic	110 100																										110 100	
Blood Pressure	90																										<u> </u>	
	80 70																										80 70	
	60																										 60 	
	50 40																										50 40	
Early Pregnancy	No																										No	
PV blood loss Amniotic	Yes Clear																										Yes Clear	
Fluid If ROM	Pink/red/green Offensive																										Pink/red/green Offensive	
	Odourless																										Odourless	
A/N PV Bleed	Brown Red																										Brown Red	
A/N Uterine Tone	Normal Tense																										Normal Tense	
Lochia	Normal Trickle																										Normal Trickle	
- (Heavy or Foul																										Heavy or Foul	
P/N Uterine Tone	Contracted High Fundus Relaxed/Atonic																										Contracted High Fundus Relaxed/Atonic	
Wound – Ooze/red/swollen /pain	Yes No																										Yes No	
Neuro	Alert																										Alert	
Response	Voice Pain																										Voice Pain	
Pain Score	Unresponsive 0-1																										Unresponsive 0-1	
Nausea	2-3 0-1																										2-3 0-1	
	2-3																										2-3	
Looks Unwell	No Yes																										No Yes	
Total Yellow Scor																											NA – Not	
Total Red Scores: Signature (initials																											applicable	
- Gillian S (illicials	•																											

ACTION PROTOCOL

The Early Warning Scoring System and Action Protocol are designed to help identify deterioration in the woman and ensure appropriate early intervention. All action taken **must** be fully documented in case notes. Staff should use their clinical judgement, and seek advice if they have concerns about any woman, regardless of the score.

If an OEWS chart is being commenced in a freestanding midwife led unit the parent obstetric unit needs to be informed and transfer protocols commenced



- Continue observations as before
 - Inform the Midwife/Nurse in Charge
- Recheck observations in 1 hour (or more frequently if clinically indicated)
- Inform Midwife/Nurse in Charge
- Immediately contact the on-call obstetric SHO/Reg, using a structured communication approach e.g SBAR, to review the woman within 30 minutes.
- Recheck observations in 30 minutes (or more frequently if clinically indicated)
- Inform Midwife/Nurse in Charge
- Immediately contact the on-call obstetric SHO/Reg, using a structured communication approach e.g SBAR, to review the woman within 20 minutes.
- Recheck observations in 15 minutes (or more frequently if clinically indicated)
- Inform Midwife/Nurse in charge
- Immediately contact the on-call obstetric Reg, using a structured communication approach e.g SBAR, to review the woman within 20 minutes.
- Discuss with Obstetric Consultant/Tutor
- Repeat observations in 15 minutes (or more frequently if clinically indicated)

Consider calling other specialties or Emergency Obstetric Team as appropriate

Interventions / Investigations

Airway - Breathing - Circulation

If appropriate, sit upright and administer oxygen

Consider need for IV access, review observation chart, fluid balance, hourly urometer, drug prescription chart and level of monitoring

Consider need for 12 lead ECG, Chest X-ray, arterial blood gas, CBC, U&E, Coag screen

Observations explanation								
Pain Score	Nausea Score							
0 = none	0 = no nausea							
1 = a little	1 = mild nausea							
2 = moderate	2 = severe nausea							
3 = severe	3 = vomiting							

P.V Loss

A standard maternity pad:

Partially stained = 30mls Saturated to capacity =100mls

A single absorbent incontinence pad (75x57cms):

Saturated will hold 250mls of blood.

Surgical Swabs:

Saturated small surgical swab (10cmsx10cms) = 60mls Saturated large surgical swab (45cmsx45cms) =350mls

A standard kidney dish:

Holds 500mls of blood

In Major cases consider weighing swabs

Ref: Bose P. Regan F. Paterson-Brown S. (2006) Improving the accuracy of estimated blood loss at obstetric haemorrhage using clinical reconstructions. British Journal of Obstetrics and Gynaecology