If vital signs need to be increased please indicate below giving reasons:

Baseline clinical observations and calculations of MEWS are to be recorded every 24 hours for the first 72 hours of admission unless more frequently recommended by the admitting doctor.

If baseline clinical observations are considered to be within normal range after 72 hours, observations must then be recorded as a minimum:

- Daily [ ]
- BD [ ]
- Weekly [ ]
- Other (please specify): 

<table>
<thead>
<tr>
<th>Date</th>
<th>Frequency of observations and any modification of thresholds for scoring</th>
<th>Reason for increase/modification</th>
<th>Signature of nurse/doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ESCALATION PROCEDURE**

The MEWS and escalation procedure have been designed to assist in identifying potential physical deterioration of the patient and acts as a trigger to ensure that appropriate interventions and management are commenced as soon as possible. Staff should always use their clinical judgement and seek advice from senior nursing / medical colleagues if there are any concerns about a patient, regardless of the calculated score.

- **Total Score 0**
  - Continue observation as before

- **Total Score 1 and above**
  - Inform the nurse in charge immediately.
    - The nurse in charge reviews the patient and:
    - Documents MEWS score
    - Alerts medical team if concerned
    - Determines frequency of further observations

- Any single score of 3 OR Total Score of 4 or above
  - Inform medical staff of patient deterioration, report and document using the SBAR tool
  - Assessment of patient within an agreed timeframe according to clinical urgency
# MODIFIED EARLY WARNING SCORING SYSTEM (MEWS)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>NHS No.</th>
<th>Date of Birth</th>
<th>Unit / Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF YOU ARE UNABLE TO CARRY OUT AN OBSERVATION, RECORD: R = Refused OR other code**

### Time (24hours)

<table>
<thead>
<tr>
<th>Date</th>
<th>3</th>
<th>240</th>
</tr>
</thead>
<tbody>
<tr>
<td>38 - 39.9</td>
<td>3</td>
<td>38 - 39.9</td>
</tr>
<tr>
<td>37.5 - 37.9</td>
<td>2</td>
<td>37.5 - 37.9</td>
</tr>
</tbody>
</table>

### Temperature

If refusing record skin colour code:

- F=flushed,
- B=pale / blue,
- N=no change.

### Blood Pressure

(Record both Systolic and Diastolic BUT Score Systolic only)

#### Score

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>≤35</th>
<th>≥190</th>
</tr>
</thead>
<tbody>
<tr>
<td>180 - 189</td>
<td>3</td>
<td>180 - 189</td>
</tr>
<tr>
<td>170 - 179</td>
<td>2</td>
<td>170 - 179</td>
</tr>
<tr>
<td>160 - 169</td>
<td>2</td>
<td>160 - 169</td>
</tr>
</tbody>
</table>

### Pulse Rate

<table>
<thead>
<tr>
<th>Pulse Rate</th>
<th>3</th>
<th>≤30</th>
</tr>
</thead>
<tbody>
<tr>
<td>121-130</td>
<td>2</td>
<td>121-130</td>
</tr>
<tr>
<td>111-120</td>
<td>2</td>
<td>111-120</td>
</tr>
<tr>
<td>101-110</td>
<td>1</td>
<td>101-110</td>
</tr>
</tbody>
</table>

### Respiration Rate

If refusing record: S=short of breath /wheezing, SG=sitting /standing, W=walking, N = No change.

#### Score

<table>
<thead>
<tr>
<th>Respiration Rate</th>
<th>≤93</th>
<th>≤8</th>
</tr>
</thead>
<tbody>
<tr>
<td>96 - 100</td>
<td>0</td>
<td>96 - 100</td>
</tr>
<tr>
<td>94 - 95</td>
<td>1</td>
<td>94 - 95</td>
</tr>
</tbody>
</table>

### Conscious Level

<table>
<thead>
<tr>
<th>Conscious Level</th>
<th>Alert</th>
<th>Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>C/V/P/U</td>
<td>C/V/P/U</td>
<td></td>
</tr>
<tr>
<td>C=New Confusion</td>
<td>C=New Confusion</td>
<td></td>
</tr>
</tbody>
</table>

### Score

**TOTAL MEWS SCORE**

**INITIALS**

**DR INITIALS WHEN MEWS ≥ 4 OR SINGLE SCORE 3**
Dehydration increases the risks of rapid tranquilisation, particularly cardiovascular and respiratory collapse. 
Physical symptoms may include: headache, dizziness, tiredness, fatigue, dry lips/mouth/eyes, cold hands/feet, sunken eyes, dark and infrequent urination, low blood pressure, rapid/weak pulse, fits. Mental symptoms may include: confusion, irritability, anxiety, agitation, reduced level of consciousness, hallucinations.

Record what you observe every 10 minutes. Ask the patient if they are thirsty and offer them a drink of water. Record the patient’s response and how much is consumed. Record urine output (if possible) and describe colour/odour. Record any of the symptoms noted above.
**NEUROLOGICAL OBSERVATION CHART**

On Older Adult Wards a GCS should be assessed on admission

Minimum frequency of neurological observations and MEWS post fall
½ hourly for 2 hours, 1 hourly for 4 hours then 2 hourly for 24 hours
(See Slips, Trips & Falls Guideline for more detail)

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GLASGOW COMA SCALE (GCS)**

<table>
<thead>
<tr>
<th>Eye opening</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneously</td>
<td>4</td>
</tr>
<tr>
<td>To sound</td>
<td>3</td>
</tr>
<tr>
<td>To pressure</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Non testable</td>
<td>NT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best verbal response</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientated</td>
<td>5</td>
</tr>
<tr>
<td>Confused</td>
<td></td>
</tr>
<tr>
<td>Words</td>
<td></td>
</tr>
<tr>
<td>Sounds</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Non testable</td>
<td>NT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best motor Response</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obey commands</td>
<td>6</td>
</tr>
<tr>
<td>Localising</td>
<td>5</td>
</tr>
<tr>
<td>Normal flexion</td>
<td>4</td>
</tr>
<tr>
<td>Abnormal flexion</td>
<td>3</td>
</tr>
<tr>
<td>Extension</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Non testable</td>
<td>NT</td>
</tr>
</tbody>
</table>

**Total Score**

**PUPILS (C=EYE CLOSED)**

<table>
<thead>
<tr>
<th>R</th>
<th>Size</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>+ or</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>L</th>
<th>Size</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>+ or</td>
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</tbody>
</table>

**LIMB MOVEMENT**

<table>
<thead>
<tr>
<th>Arms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal power</td>
<td></td>
</tr>
<tr>
<td>Mild weakness</td>
<td></td>
</tr>
<tr>
<td>Severe weakness</td>
<td></td>
</tr>
<tr>
<td>Spastic flexion</td>
<td></td>
</tr>
<tr>
<td>Extension</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal power</td>
<td></td>
</tr>
<tr>
<td>Mild weakness</td>
<td></td>
</tr>
<tr>
<td>Severe weakness</td>
<td></td>
</tr>
<tr>
<td>Spastic flexion</td>
<td></td>
</tr>
<tr>
<td>Extension</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td></td>
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</tbody>
</table>

**INITIALS**

<table>
<thead>
<tr>
<th>Pupil Scale (mm)</th>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
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<td>8</td>
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