CLINICAL PRACTICE GUIDELINE

The Irish Maternity Early Warning System
(I-MEWS)

Institute of Obstetricians and Gynaecologists,
Royal College of Physicians of Ireland
and
Directorate of Clinical Strategy and Programmes,
Health Service Executive

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Key Recommendations

1. The Irish Maternity Emergency Warning System (I-MEWS) should be used for women who are clinically pregnant or who were delivered within the previous 42 days.

2. I-MEWS should be used to complement clinical care and it is not designed to replace clinical judgement. Clinical concern about an individual woman should trigger a call to medical staff irrespective of the I-MEWS.

3. The timing of clinical observations will depend on the woman’s individual circumstances.

4. The blood pressure (BP) should be measured with the correct cuff size. In women with a mid-arm circumference (MAC) > 33 cms, the use of a standard cuff may overestimate the BP and lead to unnecessary interventions.

5. All maternity units should have effective communication systems in place to ensure that there is minimal delay between the triggering of a call for review and the arrival of a medical doctor.

6. The designation of who should be the senior doctor called should be agreed locally by the midwifery and medical senior management.

7. Depending on the acute illness, early consideration should be given to seeking professional assistance from other medical specialities either within or from outside the maternity unit.
1. Background

Critical illness is an uncommon but potentially devastating complication of pregnancy (Baskett, 2008). It may be devastating, not only for the woman who becomes ill, but also for her family and for those healthcare professionals responsible for her care. At its most extreme, critical illness may lead to the death of the woman during pregnancy or shortly afterwards. The Confidential Maternal Deaths Enquiry published in 2012 confirmed that Ireland continues to have a low maternal mortality ratio by international standards. However, there is no room for complacency and efforts to improve the quality of clinical care in the maternity services must be continually renewed.

Critical illness in pregnancy may be due to conditions unique to pregnancy, due to conditions exacerbated by pregnancy or due to coincidental conditions. This is reflected in the classification of maternal deaths into direct, indirect and coincidental deaths (CMACE, 2011). The conditions unique to pregnancy include obstetric haemorrhage, pre-eclampsia/eclampsia, pulmonary embolism (venous and amniotic fluid), chorioamnionitis/endometritis, uterine rupture, placenta accreta and acute fatty liver (Nelligan and Laffey 2011).

It has been estimated that for every maternal death there are nine women who develop severe maternal morbidity (Plaat and Naik, 2011). In a study of severe maternal morbidity for 2004/5 in the three Dublin maternity hospitals, the rate of severe maternal morbidity was 3.2 per 1,000 maternities (Murphy et al, 2009). The commonest cause was haemorrhage. A national review of postpartum haemorrhage in Ireland over 11 years between 1999 and 2009 found that there were increasing rates of atonic postpartum haemorrhage (Lutomski et al, 2011).

As critical care has evolved worldwide, attempts to identify early the clinically deteriorating patient has led to the introduction in hospitals of Early Warning Scores (Smith et al, 2013). In Ireland, this has led to the National Early Warning Score (NEWS) being developed in collaboration with the HSE Acute Medicine Clinical Care Programme. The NEWS was also the first guideline to be approved by the National Clinical Effectiveness Committee and it was launched in March of 2013 by the Minister for Health Dr James O’Reilly. It is notable, however, that the NEWS is not applicable to pregnant patients.

In 2008, a hospital report following a maternal death due to infection recommended the introduction in Our Lady of Lourdes Hospital, Drogheda of a Modified Early Obstetric Warning System (MEOWS). The use of MEOWS has also been recommended by the Confidential Maternal Enquiry Reports both in the UK and Ireland (McClure et al, 2011).

In April of 2012, it was agreed with Dr. Bairbre Golden, Clinical Lead for the National Clinical Programme in Anaesthetics and Dr. Michael Power, Clinical Lead for the National Clinical Programme in Critical Care to produce a joint report on Pathways for the Acutely Ill Patient in Obstetrics. A number of multidisciplinary meetings were held with representatives, not only from the Clinical Care Programmes, but also the HSE Office of Nursing and Midwifery Services Director, Neonatology, the Institute of Obstetricians and Gynaecologists, the College of Anaesthetists and the Irish Society of Obstetric Anaesthesia.
As part of the Pathways Project, it was decided that the maternity services needed to address the issue in EWS in obstetrics and Ms Eilish Croke from the NEWS project was invited to present at the National Clinical Programme in Obstetrics and Gynaecology’s National Working Party. An initial audit showed that MEOWS was being used in 10 of the 19 maternity units in the country. A number of issues, however, arose. The MEOWS used in Ireland were not standardised and differed from hospital to hospital. Their application was inconsistent across the specialty of obstetrics. Inadequacies in staff training were identified. To date, there has been no national audit of the use of MEOWSs in the maternity services.

A review of the literature found that MEOWS in pregnancy has not been fully validated in any country. More importantly, there are studies which have highlighted the limitations of MEOWS in women with chorioamnionitis or other serious infections during pregnancy (Lappen et al, 2010; Loughren et al, 2010). While the introduction of MEOWS was well intended and aimed at improving the quality of maternity care, there was a serious risk that the initiative would not succeed and may potentially increase the clinical risk for pregnant women. This was particularly likely to occur in circumstance where an overreliance was placed on the MEOWS. It is clear that any early warning system is only a complementary tool and should never be used to replace clinical judgment. Thus, it was agreed that the introduction of any standardised MEOWS nationally needed to be carefully planned.

In March of 2013 the Irish Maternity Early Warning System (I-MEWS) was completed by a Design Team and a multidisciplinary educational programme was implemented for all 19 maternity units. The I-MEWS was introduced nationally on April 2nd 2013.

2. Methodology

I-MEWS was developed as part of the HSE Directorate for Clinical Strategy Programme’s strategic plans for the acutely ill patient in obstetrics and gynaecology. It is a collaborative project between the Office of Nursing and Midwifery Director and the National Clinical Programmes in anaesthetics, critical care and obstetrics and gynaecology.

The Project Lead for I-MEWS was Professor Michael Turner, Clinical Lead for the National Clinical Programme in Obstetrics and Gynaecology.

The I-MEWS Project Design Team included: Ms Ina Crowley (Chairperson), Professor Michael Turner (Clinical Lead for the National Clinical Programme in Obstetrics and Gynaecology), Ms. Mary Doyle (Limerick), Ms. Triona Cowman (Centre for Midwifery Education), Ms. Marie Horgan (NEWS Team), Ms. Una Carr (Galway), Ms. Anna O’Connor (Coombe), Mr. Mikey O’Brien (Rotunda), Ms. Eilish Croke (National Lead for NEWS), and Dr. Paula Connolly (Anaesthetist).

The I-MEWS Reference Team included: Ms. Sheila Sugrue (Chairperson, National Lead Midwife), Professor Michael Turner (Clinical Lead for the National Clinical Programme in Obstetrics and Gynaecology), Dr. Paula Connolly (Anaesthetist), Ms. Ina Crowley (Chair of the Design Team), Ms. Geraldine Keohane (Director of
Midwifery), Ms. Eilish Croke (National Lead for NEWS), Dr. Ailis Quinlan (Clinical Indemnity Scheme), Dr. Karen Robinson (Clinical Indemnity Scheme), Ms. Mary Wynne (NMPD, Dublin Mid-Leinster), Ms. Patricia Hughes (Director of Midwifery), Mr. Brian Lee (National Programme Manager for the National Clinical Programme in Obstetrics and Gynaecology).

As part of the design work, multidisciplinary consultation meetings were held involving clinical staff from all 19 maternity units. The project also received strong support from Ms Eilish Croke and her team from the National Early Warning System (NEWS). Prior to introducing the I-MEWS, multidisciplinary educational workshops were conducted in March 2013.

The international literature on the application of early warning systems in obstetric care was reviewed. The use of Modified Obstetric Early Warning Systems (MEOWS) has been recommended but, however, it has not been standardised as it has not been well validated in pregnancy, particularly, for infection in pregnancy.

This guideline was developed by Ms. Anna O’Connor (Coombe).

The guideline was peer reviewed by Ms. Margurite Hogan (Therapy Professionals) Ms. Eithne Coen (NMPD, South East), Ms. Mary O’Reilly (Rotunda) and the Programme’s Clinical Advisory Group. The guideline was endorsed by the National Clinical Programme in Obstetrics and Gynecology’s Clinical Advisory Group and the National Working Party.

3. Definitions

**Early Warning Score (EWS)**
An early warning score is a bedside track and trigger system which midwifery / nursing staff calculate from the vital signs recorded, and aims to indicate early signs of a patients deterioration (HSE, 2012).

**I-MEWS Irish Maternity Early Warning System**
I-MEWS is a nationally agreed scoring system developed for early detection of life threatening illness in pregnancy and the postnatal period.

**ISBAR**
ISBAR is a communication tool, and the acronym stands for Identify, Situation, Background, Assessment, and Recommendation. This technique is used for prompt and appropriate communication within healthcare organisations. (See 9.0).

**Full set of Vital Signs**
Where a full set of vital signs is indicated, this includes recording respiratory rate, temperature, maternal heart rate, blood pressure, neurological response and pain score.
Urinalysis is required on admission. Thereafter, the frequency of urinalysis following admission depends on the clinical assessment, diagnosis and care plan for the woman.


The nationally agreed I-MEWS is included in Appendix 1. For convenience a sample antenatal observation sheet is included in Appendix 2 and a sample postnatal observation sheet is included in Appendix 3. These should be filed beside the I-MEWS in the maternity chart so that all clinical observations are easily accessible to the different disciplines. Some maternity hospitals may opt to individualise their observation sheets but this should be implemented in a way that prioritises clinical care and quality.

4.1 Respiration

- Respiratory rate is a mandatory observation as changes in respiratory rate have been identified as being the earliest and most sensitive indicator of deterioration in wellbeing (Johnson and Taylor, 2010). Respiratory rate should be recorded on all monitoring events.

- An assessment of respiration should be carried out for 60 seconds, following the assessment of heart rate, as making the woman aware of counting her respirations will cause her to be conscious of her breathing and lead to a false reading. If the wrist is supported across the woman’s chest, it is possible to count the pulse and then to either feel the rise and fall of the chest, or observe it, counting respirations. Factors such as sound, depth and regularity are observed at the same. If respirations are regular, the rate is counted for 30 seconds and doubled. If any abnormalities are detected, respiration is counted for a whole minute (Johnson & Taylor, 2010).

- The rate should be documented as a numerical value in the appropriate box e.g. respiratory rate of 16 per minute should be documented numerically in to the white box allocated to a respiratory rate of 10-19. Likewise, a respiratory rate of 20 should be documented numerically in the yellow box allocated to respiratory rate of 20-29.

- The accepted normal parameters for respiration rate on I-MEWS are 10-19 respirations/min.

- Tachypnoea is strong evidence of sepsis until proven otherwise (CMACE, 2011)

4.2 Oxygen Saturation

- Oxygen saturation levels reflect the percentage of arterial haemoglobin saturated with oxygen in the blood, and is referred to as SpO₂ (Johnson and Taylor, 2010).
• Oxygen saturation levels are not routinely measured on all women, and only measured in the following circumstances:
  o If the respiration rate is outside the normal parameters and within the ‘trigger’ red or yellow values
  o If a medical/obstetric condition necessitates measurement of oxygen saturation levels e.g. respiratory disorder, High Dependency Care.

• Accuracy of the measurement depends on an adequate flow of blood through the light probe i.e. if peripheral circulation has shut down and a woman is in a critical condition, the SpO\textsubscript{2} result may be inaccurate or unobtainable. Note: artificial nails and nail polish will also affect the accuracy of results.

• The SpO\textsubscript{2} should be documented as the percentage in the appropriate box i.e. SpO\textsubscript{2} of 94% should be documented numerically in the red box allocated to SpO\textsubscript{2} readings of ≤95%. Likewise the SpO\textsubscript{2} of 96% should be documented numerically in the white box allocated to 96-100%.

• The accepted parameters for SpO\textsubscript{2} on I-MEWS are 96-100%.

4.3 Temperature

• Temperature should be recorded at the appropriate site (i.e. oral, axilla, tympanic) according to local guidelines, ensuring correct use of the appropriate thermometer and equipment.

• The recorded temperature should be documented numerically in the appropriate box. Therefore, the temperature of 35.8°C should be documented numerically in the yellow box allocated to 35.1-35.9°C. Likewise 38.1 °C should be documented numerically in the red box allocated to ≥38°C.

• The accepted temperature parameters on the I-MEWS are 36-37.4°C.

• A fall or rise in temperature or swinging pyrexia may indicate sepsis.

• Hypothermia is a significant finding that may indicate infection and should not be ignored.

• Pyrexia may be masked if antipyretics have been administered.

• If pyrexial, a sepsis screen and appropriate antibiotic therapy should be considered at an early stage.
4.4 Heart Rate

- The most commonly used site to assess heart rate in the adult is the radial artery as it is readily accessible. The brachial artery is used in the measurement of blood pressure and the carotid and femoral arteries may be palpated in the case of collapse, where cardiac output cannot be detected in the peripheral circulation (Johnson & Taylor, 2010).

- The radial artery should be palpated using the index and middle finger, supporting the woman’s wrist across her chest, and the rate counted for 30 seconds and doubled if the rate is regular, or sixty seconds if irregular (Kozier et al, 1998).

- Pulse oximeters also give a heart rate reading. However, if the woman has a bradycardia or tachycardia detected electronically, the pulse should be assessed manually for noting rate, rhythm and strength.

- The heart rate should be documented numerically on the I-MEWS in the appropriate box i.e. heart rate of 86 bpm should be documented into the white box area allocated to 80-89 bpm. A heart rate of 102 bpm should be documented numerically in the yellow box allocated to 100-109 bpm.

- The accepted parameters for heart rate on I-MEWS are 60-99bmp

- Persistent tachycardia over 100bpm is an important sign that may indicate serious underlying disease and should be fully investigated.

4.5 Blood Pressure

- Systolic and diastolic blood pressure, are recorded separately to facilitate the appropriate triggers to be assigned to two separate results from one recording.

- Blood pressure must be measured using the correct cuff size, and the size of the cuff used should be documented in the woman’s notes.

- It is recommended that the mid-arm circumference (MAC) should be measured in all pregnant women particularly those with BMI > 29.9kg/m2 at their first antenatal visit. If the MAC is > 33 cms, a large cuff should be used for BP measurements subsequently (HSE, 2011).

- The mid-arm point is determined by measuring the length of the upper arm from the shoulder joint to the antecubital fossa. The mid arm point is taken as the point halfway between these two landmarks (Hogan et al, 2010).

- Systolic blood pressure should be documented at Korotkoff I or first clear sound, and the diastolic blood pressure at Korotkoff V, when sounds are no longer audible.
• Electronic recording of blood pressure can underestimate readings. It is recommended good practice that if a blood pressure is raised with an electronic reading, the BP should be rechecked manually at least once using an aneroid sphygmomanometer.

• Findings should be documented as a numerical value in the appropriate box i.e. systolic blood pressure of 156mmHg is written into the yellow box representing 150-159mmHg. The diastolic reading of 86mmHg should be documented numerically in the white box allocated to 80-89mmHg.

• It is recommended that a dotted line is used between the systolic and diastolic numbers is used, to display a graphic trend.

• The acceptable parameters for Systolic blood pressure on the I-MEWS are 100-139mmHg. The acceptable parameters for diastolic blood pressure on the I-MEWS are 50-89mmHg (i.e. 100/50mmHg to 139/89mmHg).

• Hypotension is a late sign of deterioration as it signifies decompensation. The physiological changes caused by pregnancy and childbirth can mean that early signs of impending collapse are not easily recognised.

• Hypertension: The conventional definition of hypertension in pregnancy is
  o Two readings of 140/90mmHg taken at least 4 hours apart, (NCCWCH, 2010)
  o An increase or 15mm/Hg above the booking blood pressure
  o One reading of 160/100mmHg of greater.

• Concerns regarding blood pressure readings should be discussed with the Obstetrician/A Anaesthetist as appropriate.

4.6 Urine

• Urinalysis of freshly voided urine should be undertaken for the purpose of screening, diagnosis or assessment of management and documented on the I-MEWS on the following occasions:
  o On admission to the hospital for any reason as a baseline observation
  o Specific maternal disorders or treatment, e.g. hypertensive disease, diabetes.
  o Clinical symptoms, e.g. dysuria

• The frequency of urinalysis following admission depends on the clinical assessment and diagnosis of the woman i.e.
  o An antenatal woman admitted with hypertensive disease or urinary tract infection may require a minimum of daily urinalysis or more frequently if her clinical condition deteriorates.
  o However, an antenatal or postnatal woman without risk factors may not require daily urinalysis.

• All urinalysis findings should be documented as they appear on the dipstick or urinalysis machine printout e.g., neg, trace, +, ++, ++++, +++++.
- **Proteinuria** may indicate infection, underlying renal disease which may be as a result of hypertension or may be a contaminated specimen (from liquor or vaginal discharge). Transient positive tests are usually insignificant, due to the physiological changes in pregnancy resulting in the presence of small amounts of albumin and globulin in the urine. To exclude infection a midstream specimen (MSU) should be obtained, tested and sent for laboratory analysis.

- **Glucose** is common in pregnancy due to the physiological changes of pregnancy resulting in altered renal function. However, glucose also appears in the urine
  - When blood glucose levels rise (hyperglycaemia).
  - If renal absorption lowers.
  - Transiently following the administration of corticosteroids e.g. Betamethasone / Dexamathesone.

- **Others:** (this list is not exhaustive)
  - **Ketones:** Mild ketonuria is a normal physiological change in pregnancy, and provided it is mild, is insignificant. However ketonuria is also indicative of women who are fasting, vomiting or with uncontrolled diabetes mellitus. Some drugs may also give a positive result.
  - **Blood:** Blood should not appear in the urine; its presence may be indicative of infection, trauma or calculi or may be due to contamination by blood from another part of the body, e.g. vaginal discharge or haemorrhoids. A positive result warrants further investigation.
  - **Nitrites:** Nitrites in the urine are indicative of urinary tract infection and an MSU should be sent for laboratory analysis.

### 4.7 Assessment of Neurological Response- AVPU Scale

- A neurological response is a measure of consciousness and the best response of the following should be measured and documented on all women using the AVPU scale, indicating
  - **A** - Alert and orientated to person, place, time and event.
  - **V** - Responds to voice / verbal stimuli (e.g. post op. recovery)
  - **P** – Responds to painful stimuli with a purposeful or nonpurposeful movement.
  - **U** – Unresponsive - The patient does not respond to any stimuli.

- The neurological response assessment should be documented in the appropriate box.
- **Alert (A):** white box (accepted neurological response parameter)
- **Responds to Voice (V):** Yellow box
- **Responds to Pain (P):** Red box
- **Unresponsive (U):** Red box.

- **Any fall in the level of consciousness (AVPU scale) should ALWAYS be considered significant and acted on IMMEDIATELY.**
4.8 Pain Score

- Women should be asked to score their pain on a scale of 0-10 (0: No pain, 10: extreme pain) when a full set of observations is recorded and the numerical value recorded on the I-MEWS. The following tools may also be used:

  ![Wong-Baker FACES Pain Rating Scale](image)


- Any concerns regarding pain management should be referred appropriately e.g. to the Midwife/Nurse in charge, Obstetrician, Anaesthetist.

4.9 Total Yellow/Red Scores

- All triggers should be added up and documented at the bottom of the I-MEWS each time observations are recorded.

- If the woman scores any yellow or red scores, the escalation guideline should be initiated (See 8.0).
• **IF CONCERNED ABOUT A WOMAN, ESCALATE CARE REGARDLESS OF TRIGGERS.**

4.10 Initials

• The initials of the person that has completed and recorded the observations should be clearly written in the initials box on the I-MEWS.

• An Initials/Signature Bank should be maintained in each hospital as per local guidelines.

4.11 Frequency of Recording Observations on the I-MEWS

• All women who present to or are admitted to a maternity unit should have a full set of vital signs recorded as a baseline on the I-MEWS.

• The I-MEWS should be used for all pregnant women with a confirmed clinical pregnancy and up to 42 days postnatal who are admitted or transferred to a general hospital.

• **The frequency that subsequent observations should be recorded is then determined by the results of the initial observations and the presenting clinical condition.**
# I-MEWS Frequency Table

<table>
<thead>
<tr>
<th>Clinical Situation</th>
<th>Minimum frequency of recording observations on I-MEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Low risk (inpatient) woman with an uncomplicated pregnancy</td>
<td>Full set of vital signs recorded on the I-MEWS on admission. Thereafter as clinically required.</td>
</tr>
<tr>
<td>Postnatal low risk inpatient woman with an uncomplicated pregnancy and birth</td>
<td>Full set of observations following the birth of the baby. Thereafter TPR, Pain Score and AVPU score recorded until discharge unless otherwise indicated.</td>
</tr>
<tr>
<td><strong>Antenatal or Postnatal</strong></td>
<td><strong>Minimum frequency of recording observations on I-MEWS</strong></td>
</tr>
<tr>
<td>• Hypertensive disorders of pregnancy</td>
<td>Full set of vital signs including urinalysis recorded daily. Thereafter Bp recorded 4 hourly.</td>
</tr>
<tr>
<td>• Suspected and/or confirmed maternal infection</td>
<td>Full set of vital signs recorded daily. Thereafter TPR, Pain Score and AVPU recorded 4 hourly.</td>
</tr>
<tr>
<td>Any other clinical concerns</td>
<td>Full set of vital signs recorded daily and thereafter as required.</td>
</tr>
<tr>
<td>Emergency situation</td>
<td>As clinically required</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>See local Blood Transfusion Guidelines</td>
</tr>
<tr>
<td><strong>Post Caesarean Section or Post Surgery during Pregnancy/Postnatal period (including recovery)</strong></td>
<td>Full set of vital signs (urinalysis only if applicable) to be recorded:</td>
</tr>
<tr>
<td>• Every 5 minutes for 15 minutes</td>
<td></td>
</tr>
<tr>
<td>• Thereafter, every 15 minutes for 1 hour</td>
<td></td>
</tr>
<tr>
<td>• Thereafter, every 30 minutes for 1 hour</td>
<td></td>
</tr>
<tr>
<td>• Thereafter, every hour for 2 hours</td>
<td></td>
</tr>
<tr>
<td>• Thereafter, every 4 hours for 48 hours</td>
<td></td>
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<tr>
<td>• Thereafter, daily until discharge</td>
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</tbody>
</table>
- Women in labour should have their vital signs recorded on the partogram. The I-MEWS should not be used for women in labour.

- The last set of observations recorded in the Labour Ward or in Recovery should be documented on the I-MEWS prior to transfer to the postnatal ward.
5. Escalation Guideline

**ALL I-MEWS TRIGGERS**
Consider context and complete full clinical assessment
Implement measures to reduce triggers if appropriate.
Complete a full set of observations on I-MEWS immediately.
Inform the Midwife in Charge.

**1 YELLOW**
Repeat full set of observations on I-MEWS after 30 minutes and before 60 minutes.

**2 YELLOWS OR 1 RED**
Call the Obstetrician to review.
Repeat a full set of observations after 30 minutes.

**≥2 YELLOWS OR ≥2 REDS**
Call the Obstetrician and request immediate review.
Repeat a full set of observations within 15 minutes or continuous monitoring.

**ALL I-MEWS TRIGGERS**
Liaise with the Midwife in Charge
Document all communication including:
Redefined plan of care
Ongoing frequency of observations

**Important**
1. If concerned about a woman, escalate care regardless of triggers.
2. If action is not carried out as above, CMM/Midwife in charge must contact the senior Obstetrician on duty.
3. Document all communication and management plans in notes.
6. Effective Communication and ISBAR

All maternity units should have effective communication systems in place to ensure that there is minimal delay between the triggering of a call for a review and the arrival of a medical doctor. The designation of who should be “senior doctor” called should be agreed locally by the midwifery and medical senior management and should be clearly communicated to staff members. The designation may depend on the availability of staff resources.

Depending on the acute illness, early consideration should be given to seeking professional assistance from other medical specialities such as an anaesthetist, haemotologist or microbiologist either from within or from outside the maternity unit. Once the patient is clinically stable, it may be necessary to transfer the patient to an Intensive Care Unit (ICU). If this is anticipated, early communications with the ICU is important.

Attention should also be paid to staff handovers in all disciplines. This is particularly important at weekends and holidays when staffing levels may be lower than usual.

A structured communication system for patients may be helpful, such as the ISBAR system. Further information on the ISBAR is also available from the Training Manual for the NEWS and can be downloaded as a smart app for the iPhone, iPod Touch and iPad available from https://itunes.apple.com/us/app/isbar-hd/id465890794

<table>
<thead>
<tr>
<th>ISBAR Communication Tool</th>
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<tbody>
<tr>
<td><strong>I</strong> Identify</td>
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<tr>
<td><strong>S</strong> Situation</td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>B</strong> Background</td>
</tr>
<tr>
<td><strong>A</strong> Assessment</td>
</tr>
<tr>
<td><strong>R</strong> Recommendation</td>
</tr>
</tbody>
</table>
7. References


8. Implementation Strategy
- Distribution of guideline to all members of the Institute and to all maternity units.
- Implementation through HSE Obstetrics and Gynaecology Programme local implementation boards.
- Distribution to other interested parties and professional bodies.

9. Key Performance Indicators
- Number of times I-MEWS is triggered annually.
- Number of cases of serious adverse clinical outcomes when the I-MEWS was not triggered.
- Clinical outcomes of adverse outcomes when I-MEWS was triggered.

10. Qualifying Statement
This guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. Clinical material offered in this guideline does not replace or remove clinical judgment or the professional care and duty necessary for each pregnant woman. Clinical care carried out in accordance with this guideline should be provided within the context of locally available resources and expertise.

This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible for:
- Discussing care with women in an environment that is appropriate and which enables respectful confidential discussion.
- Advising women of their choices and ensure informed consent is obtained.
- Meeting all legislative requirements and maintaining standards of professional conduct.
- Applying standard precautions and additional precautions, as necessary, when delivering care.
- Documenting all care in accordance with local and mandatory requirements.
11. Appendices
Appendix 1: I-MEWS Chart (Front and reverse side)
Appendix 2: Antenatal Observation Record (Front and reverse)
Appendix 3: Postnatal Observation Record (Front and reverse side)
Appendix 4: I-MEWS Information Leaflet
Appendix 1 – I-MEWS Chart

Irish Maternity Early Warning System (I-MEWS)

Escalation Guideline

ALL I-MEWS TRIGGERS
Consider context and complete full clinical assessment. Implement measures to reduce triggers if appropriate. Complete a full set of observations on I-MEWS immediately. Inform the Midwife in Charge.

1 YELLOW
Repeat full set of observations on I-MEWS after 30 and before 60 minutes.

2 YELLOWS OR 1 RED
Call the Obstetrician to review. Repeat a full set of observations after 30 minutes.

>2 YELLOWS OR >2 REDS
Call the Obstetrician and request immediate review. Repeat a full set of observations within 15 minutes or monitor continuously.

ALL I-MEWS TRIGGERS
Liaise with the Midwife in Charge
Document all communication including:
- Redefined plan of care
- Ongoing frequency of observations

IMPORTANT:
1. If concerned about a woman, escalate care regardless of triggers.
2. If action is not carried out as above, CMM/Midwife in charge must contact the senior Obstetrician on duty.
3. Document all communication and management plans in notes.
### Clinical Practice Guideline

**The Irish Maternity Early Warning System (I-MEWS)**

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**Patient Information**
- **Name:** [Redacted]
- **Date of Birth:** [Redacted]
- **Healthcare Record No.:** [Redacted]

**Addressograph**

---

**Document Number (eg. 1, 2):**
- Booking BP: [Redacted]
- Gestation at Booking: [Redacted] weeks

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<table>
<thead>
<tr>
<th>Year</th>
<th>Date</th>
<th>Time</th>
<th>BP (mmHg)</th>
<th>Temp (°C)</th>
<th>HR (bpm)</th>
<th>SPO2 (%)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;90/60</td>
<td>&lt;35.9</td>
<td>&lt;80</td>
<td>&lt;90</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>90-109</td>
<td>36.0-37.9</td>
<td>80-90</td>
<td>90-100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>110-119</td>
<td>38.0-39.9</td>
<td>90-100</td>
<td>90-100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>120-129</td>
<td>40.0-41.9</td>
<td>100-120</td>
<td>90-100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;130</td>
<td>&gt;42.0</td>
<td>&gt;120</td>
<td>&gt;100</td>
</tr>
</tbody>
</table>

---

**Contact appropriate doctor for early intervention if the woman triggers one RED or two YELLOW zones at any one time.**

---

**Initials:** [Redacted]
## Appendix 2 - ANTENATAL OBSERVATION RECORD (Sample)

<table>
<thead>
<tr>
<th>Agreed E.D.D.</th>
<th>Anti D Administered</th>
<th>Weight kgs B.M.I. kg/m²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) Date</td>
<td>(2) Date</td>
</tr>
</tbody>
</table>

### Vital Signs to be recorded on I-MEWS Chart

#### Abdominal Examination:

<table>
<thead>
<tr>
<th>Inspection</th>
<th>Palpation</th>
<th>Auscultation of Fetal Heart Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundal Height</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lie</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fifths palpable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged /Not</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Fetal Wellbeing:

**If SROM Please Record**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>hrs</th>
</tr>
</thead>
</table>

- Fetal Movement
- Membranes / Liquor/P.V.Loss
- CTG Recorded (√) (if applicable)

#### Maternal Wellbeing:

- Emotional State
- Sleep / Rest
- Eating & Drinking
- Intake Output chart required (Yes / No)
- Bowels
- Oedema
- Signature, PRINTED NAME, & Role

#### Investigations Performed (Please date and initial when investigations are performed)

- Ultrasound
- Scan/Dopplers
- FBC/Kleihauer
- U&E
- LFTs
- Coag
- Group & Antibodies
- Blood Cultures
- MSU
- 24 Hour Urine
- Total Protein
- HVS/LVS
- Other:
### Suggested Antenatal Observations (Reverse Side)

(This list is not exhaustive and is only intended for useful reference)

Any concerns / deviations from the norm should be reported to the appropriate Midwife / Obstetrician.

<table>
<thead>
<tr>
<th>Agreed EDD</th>
<th>Refer to agreed EDD (confirmed with early dating ultrasound scan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight / BMI</td>
<td>All women should have their weight, height and BMI calculated and documented at booking. Women with a BMI &gt; 29.9kg/m² should commence a pregnancy/obesity care pathway / action plan.</td>
</tr>
</tbody>
</table>

#### Vital Signs on I-MEWS

All physiological observations must be recorded on the Irish Maternity Early Warning System

#### Abdominal Examination

<table>
<thead>
<tr>
<th>Inspection</th>
<th>NAD, size, shape, scars, striae</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundal Height</td>
<td>Equal to dates, height measured in cms, small for dates / gestational age, large for dates / gestational age</td>
</tr>
<tr>
<td>Lie</td>
<td>Longitudinal, transverse, oblique, unstable</td>
</tr>
<tr>
<td>Presentation</td>
<td>Cephalic, breech, shoulder</td>
</tr>
<tr>
<td>Position</td>
<td>OA, LOA, ROA, LOT, ROT, OP, LOP, ROP</td>
</tr>
<tr>
<td>Palpation</td>
<td>Engaged, 1/5, 2/5, 3/5, 4/5, 5/5, ballotable, free</td>
</tr>
</tbody>
</table>

#### Auscultate:

| Fetal Heart Rate | Average rate measured in beats per minute with Pinard Stethoscope/ Doppler/CTG. |
| Fetal Movement | Normal pattern, increased activity, reduced fetal movements, absence of fetal movements |

| Membranes | Intact, ruptured, suspected ruptured membranes. |
| Liquor/P.V.Loss | Membrane intact, ruptured, suspected ruptured membranes. Liquor/P.V.Loss: Colour: clear, pink, blood stained, meconium, Volume: small / large amount, Odour: no odour, foul smelling |

#### Maternal Wellbeing:

| Emotional State | Coping well, anxiety, tearful, low mood. |
| Eating & Drinking | Normal intake, fasting, restricted fluid intake, reduced appetite, special diet, nausea, vomiting. |

| Intake/Output Chart required (Yes/No) | (Yes / No) if Intake/Output chart or Fluid Balance chart required. |
| Bowels | B.O (bowels opened), BNO (bowels not opened), constipation, diarrhoea, leakage, urgency, haemorrhoids |
| Sleep / Rest | Sleeping/resting well, insomnia, fatigue. |
| Oedema | NAD, Facial generalised leg, ankle. (Comment x 2 or indicate (L) Left & (R) Right) Mild, moderate, severe. |

#### Investigations Performed:

Document if any investigations are performed by inserting date and initials in the appropriate box
### Appendix 3 - Postnatal Observation Record: Mother (Sample)

**Orientation to Ward** *(carried out by the Midwife accepting the transfer to the postnatal ward)*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to Ward Layout</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on Baby Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting arrangements explained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal times explained</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion re expected date of discharge**

- Yes
- No

**Expected date of discharge**

___/___/___

**Signature** ____________________

**Special Requirements:**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti D Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR Required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes: ______/_____/______ date administered

**Signature** ____________________

**Postnatal Day**

<table>
<thead>
<tr>
<th>Day</th>
<th>Day</th>
<th>Day</th>
<th>Day</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>Legible ID Band</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vital Signs to be recorded on I-MEWS Chart**

- Wellbeing/mood
- Sleep
- Breasts
- Nipples
- Breastfeeding
- Uterus
- Wound
- Perineum
- P.V Loss/Lochia
- Micturition
- Bowels
- Legs
- Postnatal Exercise
- Bonding

**Signature, Printed Name & Job Title**

**Postnatal Education:**

- Yes
- No

*(See reverse for list of same to be completed)*

(If all complete) Signature ____________________ Date ____________________
Suggested Postnatal Observations  
(Reverse Side)
(This list is not exhaustive and is only intended for useful reference)

Any concerns / deviations from the norm should be reported to the appropriate Midwife / Obstetrician.

<table>
<thead>
<tr>
<th>Vital Signs:</th>
<th>All physiological observations must be recorded on the I-MEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellbeing / Mood:</td>
<td>Coping well, baby blues, excessive anxiety, postnatal depression.</td>
</tr>
<tr>
<td>Sleep:</td>
<td>Good, intermittent, little, none, excessive sleep, inability to get sleep, premature waking</td>
</tr>
<tr>
<td>Breasts:</td>
<td>Indicate (L) Left &amp; (R) Right or Comment x 2: Soft, filling, full, engorged, sore</td>
</tr>
<tr>
<td>Nipples:</td>
<td>Indicate (L) Left &amp; (R) Right or Comment x 2: NAD, cracked, bleeding, bruised, healing, sore,</td>
</tr>
<tr>
<td>Breastfeeding:</td>
<td>Confidence with positioning, attachment, support required, expressing, any problems?</td>
</tr>
<tr>
<td>Uterus:</td>
<td>W/C (well contracted), abdominal tenderness, involuting, sub- involution, boggy, high</td>
</tr>
<tr>
<td>Wound:</td>
<td>Clean and dry, healing, moist, inflammed, infected, suture / clip removal.</td>
</tr>
<tr>
<td>Perineum:</td>
<td>Soreness, bruising, swelling, sutures, infection</td>
</tr>
<tr>
<td>P.V.Loss/Lochia:</td>
<td>Type (rubra, serosa, alba), amount(minimal, average, heavy), colour (red, brown, pink), offensive odour, presence of clots</td>
</tr>
<tr>
<td>Micturition:</td>
<td>Pain on passing urine, leakage, stress incontinence, urgency. <em>Time and volume (mls) of first 2 voids to be documented.</em> If either of first 2 voids is less than 200mls, consult Bladder Care Guideline</td>
</tr>
<tr>
<td>Bowels:</td>
<td>B.O (bowels opened), BNO (bowels not opened), constipation, diarrhoea, leakage, urgency, haemorrhoids</td>
</tr>
<tr>
<td>Legs:</td>
<td>Comment x 2 or indicate (L) Left &amp; (R) Right, NAD, oedema, redness, swelling, pain, varicose veins, thrombophlebitis, cramps, deep vein thrombosis</td>
</tr>
<tr>
<td>Postnatal Exercises:</td>
<td>Explained and encouraged (Ex/ENC), doing them, not doing them</td>
</tr>
<tr>
<td>Bonding:</td>
<td>Good, reassured, mother expressing difficulty</td>
</tr>
</tbody>
</table>

**Postnatal Education**  
(Please provide this education from the time of admission and clearly document same below)

<table>
<thead>
<tr>
<th>Information Given and Discussed with Mother</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest/Hygiene/Nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postnatal “Blues” / Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding Support/Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccination/Immunisation/BCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Instruction on the safe use of formula (if required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing / Top and tail/Handling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of SIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs of effective feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plagiocephaly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin D Supplementation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 – Patient Information Leaflet

This leaflet was produced as a recommendation of a patient working group on ways to promote improved safety in patient care and to empower patients to take greater control over their health and well-being whilst in hospitals in Ireland.

Get involved!
Find out about how you can get involved in improving health services in Ireland.

The HSE is actively inviting service users to get involved in patient forums and quality improvement initiatives. To find out more contact:

National Advocacy Unit, HSE, Quality & Patient Safety Directorate, Health Service Executive, Oak House, Millennium Park, Naas, Co. Kildare

Tel: (045) 880 400
Email: yoursay@hse.ie
www.hse.ie

Find out about (I-MEWS)
Irish Maternity Early Warning System

people caring for people
To ensure that any change in your condition is picked up early, maternity hospitals in Ireland have an early warning system in place called I-MEWS. This system is used along with clinical assessment to detect any change in your condition and to improve the decision making about the care that you might need if you are ill during your pregnancy.

**Pregnancy is a normal healthy event**
Most healthy women have a normal pregnancy and birth and do not suffer any illness as a result of pregnancy. However, for a minority of women this is not the case. To ensure that any change in a woman’s condition is picked up early, maternity hospitals in Ireland have a system in place called the Irish Maternity Early Warning System (I-MEWS).

**Get involved!**
The responsibility for patient safety remains with your healthcare team. However, you also play a vital role in the decision making about your care. We encourage you to ask questions and become fully informed and involved in the decision making about your care. Remember - it's safer to ask.

**Your vital signs**
The maternity team assess your vital signs while you are in hospital. Vital signs are signs that are essential for life, for example breathing and heart rate.

**The maternity team:**
- Assess your breathing, your heart rate and your level of consciousness
- Take your blood pressure and temperature
- Assess the level of oxygen in your blood.

All of these measurements are recorded in your observation chart for ongoing monitoring.

**What is I-MEWS?**
I-MEWS is a system for the early detection of illness during pregnancy and after a woman has had a baby. This system is in place across all maternity hospitals in Ireland. Due to the changes which take place in a woman’s body during pregnancy and after the baby is born, it is often difficult to detect a severe illness. I-MEWS helps to detect earlier if a woman has developed a severe illness and it helps provide safe, high quality care in a timely manner for all women using our maternity services.

I-MEWS helps maternity teams to make decisions in relation to the care that women might need if they are ill during pregnancy. It also alerts the maternity team to:
- Carry out a full review of your condition
- Carry out tests or investigations
- Make a plan for ongoing care
- Make the right decision in relation to the type of care that is needed.

**Let your midwife know, if you are feeling unwell**
The midwifery/nursing staff will inform the doctor requesting that they intervene early to prevent your condition from getting worse.