Aneurin Bevan University Health Board

Physiological Observations in Maternity Services Guideline

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Version No	Approved	Author
5.1	14/05/2026	Hannah McLoughlin
5	16/03/2026	Rebecca Clement
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Policy on a Page: Key Messages

Aim:

This guideline aims to ensure that all patients (within the scope of this policy) receive appropriate monitoring of physiological observations and subsequent escalation of care, with a timely and appropriate response to reduce morbidity and mortality and mother/baby separation.

Key Requirements:

- MEWS supports but does not replace clinical judgement.
- Full observations within 2 hours of admission, 15 minutes in Triage; daily for all inpatients.
- Antenatal: BP only at routine appointments; full observations if unwell or admitted.
- Intrapartum: Follow NICE monitoring frequencies.
- Postnatal: Full observations at birth and daily for first 3 days.
- Post-operative: MEWS every 5 minutes for first 30 minutes, following local Monitoring After Spinal Anaesthetic guidance thereafter.
- All observations must be timed, documented, scored, and acted on.
- Escalate according to MEWS thresholds; delays require secondary escalation and documentation.
- Use Jump Call if timely review cannot be achieved.

Summary of key changes (for revised documents only):

- Update to align with implementation of standardised All-Wales MEWS system and alignment with contemporary practice.
- Version 5.1- Inclusion of All Wales Maternity Early Warning Score (MEWS) Pathway for Escalation from Community Settings (Maternity and Neonatal SSP Implementation Network, 2026).

Target Audience:

This policy is aimed at all healthcare professionals employed within ABUHB who are involved in the delivery of care to pregnant, birthing and postnatal patients.

Training:

Staff performing physiological observations for pregnant, birthing or postnatal women should, as a minimum, complete the Maternity Early Warning Score (MEWS) module via the Electronic Staff Record (ESR).

Contents

1. Introduction/Overview

Physiological observations or vital signs in combination with perceived clinical concern are fundamental to the identification of a patient's health status. They provide a baseline that facilitates the early identification of clinical deterioration through which it is possible to improve mortality outcomes (The National Patient Safety Agency, 2007). Within all healthcare environments, the monitoring, measurement, interpretation, and prompt response to physiological observations is one of the core roles undertaken by registered midwives, nurses, healthcare support workers (HCSW) and medical staff. This is particularly important in emergency and acute care settings. However, the recognition of the deteriorating patient could be delayed if observations are not recorded and if abnormal observations are not acted upon and communicated effectively (The National Patient Safety Agency, 2007; National Institute of Clinical Excellence (NICE), 2007; and Institute for Health Improvement, 2010).

A recurring theme in reports into maternity care including MBBRACE (2023), Maternity and neonatal services in East Kent (Department of Health and Social Care, 2022a), Review of Maternity Services in Cwm Taf (RCOG, 2019), Ockenden Report (Department of Health and Social Care, 2022b) is the combination of failures in the management of deterioration. These include failure to recognise signs of deterioration and failure to escalate concerns and respond to them.

Maternity Early Warning Scores (MEWS) are used extensively in hospitals in the UK and internationally by midwives and doctors to monitor the physiology of pregnant and postnatal women, identify signs of clinical deterioration, and potentially prevent morbidity or mortality (Robbins et al, 2019; Umar et al, 2019). Such systems use an aggregated weighted scoring system for each of the core elements of physiological observation including; blood pressure, pulse, temperature, respiratory rate and oxygen saturations. The culminating total of the scores provides an indication of

the patient’s overall clinical health status at that time and therefore acts as a trigger for taking appropriate intervention.

The overriding ethos of MEWS is to provide a simple physiological observation scoring system that can easily be calculated at the patient’s bedside. The system uses parameters which are measured routinely in the majority of maternity inpatients and can be used quickly to identify patients who are clinically deteriorating and require urgent intervention.

A standardised All-Wales MEWS system has been developed in collaboration with the National Institute for Health and Care Research (NIHR) and has been mandated for implementation on an all-Wales basis (Welsh Government, 2024). A copy of this is attached in the appendices (Appendix 1). The MEWS system directs the person recording the vital signs to any actions that must be taken in accordance with the score as indicated and includes a list of additional concerns which should prompt increased vigilance via increasing the frequency of observations, or increased level of escalation. The MEWS chart also includes a threshold and triggers section with recommended timeframes for review by the most appropriate clinician, whether that is the registered midwife responsible for the patient, the midwife in charge, an obstetrician, an anaesthetist, or an outreach practitioner.

However, it should be noted that due to the complexity of clinical assessment and appropriate treatment according to individual patient need, the MEWS protocol and its supporting documentation is unable to provide explicit guidance in terms of the specific clinical intervention that should be taken. This policy does provide explicit guidance on accessing promptly and appropriate clinical assessment, through the threshold and triggers section, which empowers health care professionals to escalate to a secondary contact when there is a delay in medical staff attending deteriorating patients.

2. Scope

This policy is aimed at all doctors, registered midwives, nurses, healthcare support workers and allied healthcare professionals employed within ABUHB who are involved in the delivery of care to pregnant, birthing and postnatal patients.

This policy applies to all pregnant women from conception up until 42 days after the birth who present as unwell in the community or receive care in the acute hospital setting within ABUHB. It also applies to postnatal women in the community up to 72-hours after birth who should have daily observations performed in response to a Regulation 28 report from Coroners and Justice Act 2009.

It is worth noting that some patients within the scope of this guideline may receive care in areas outside of maternity services, in which case the use of MEWS should be encouraged. Examples of these areas include, but may not be limited to; A&E, Gynaecology, MAU, SAU, SDEC and Minor Injury Units in the Royal Gwent Hospital, Nevil Hall Hospital and Ysbyty Ystrad Fawr. However, it is recognised that MEWS may not be the most appropriate tool in every clinical situation involving a pregnant or postnatal patient and the lead clinician should evaluate the safest course of action.

This policy also applies to women in labour, with the exception of those following the All-Wales Clinical Pathway for Normal Labour (AWCPNL), whose physiological observations will continue to be assessed against the nationally agreed criteria within the AWCPNL.

This policy constitutes the default standard for monitoring of physiological observations of pregnant or newly postnatal women at ABUHB. However, physiological observations monitoring should be considered on a case-by-case basis. Due to the diversity of disease and the complexity of clinical assessment, it is beyond the scope of this policy to provide an exhaustive reference source on the clinical management of patients. The scope of this policy is specifically to facilitate the prompt identification of clinically

deteriorating patients so that timely and appropriate review can be obtained.

The expectations outlined in this policy may not be suitable for patients in critical care or enhanced care areas. This might include patients on ITU or in theatres who are being continuously monitored. Vital signs for these patients should be performed as per local policy or as agreed by the clinician/team caring for the patient.

3. Statement/Background

The Health Board is committed to prompt and effective identification, escalation and response to deteriorating patients. This guideline will support all staff working within maternity services to promptly and reliably identify and escalate the unwell or deteriorating pregnant or newly postnatal patient and obtain a timely medical review, leading to improved outcomes for women and birthing people.

The term "woman/ women" will be used throughout this document however, it is recognised that this refers to all pregnant, birthing and postnatal people regardless of gender identification.

4. Aim

This guideline aims to ensure that all patients (within the scope of this policy) receive appropriate monitoring of physiological observations and subsequent escalation of care, with a timely and appropriate response to reduce morbidity and mortality and mother/baby separation.

This guideline aims to offer guidance to obstetricians, midwives and other healthcare staff for the following:

4.1 Performing the right observations

- The physiological observations (vital signs) that should be undertaken on women.

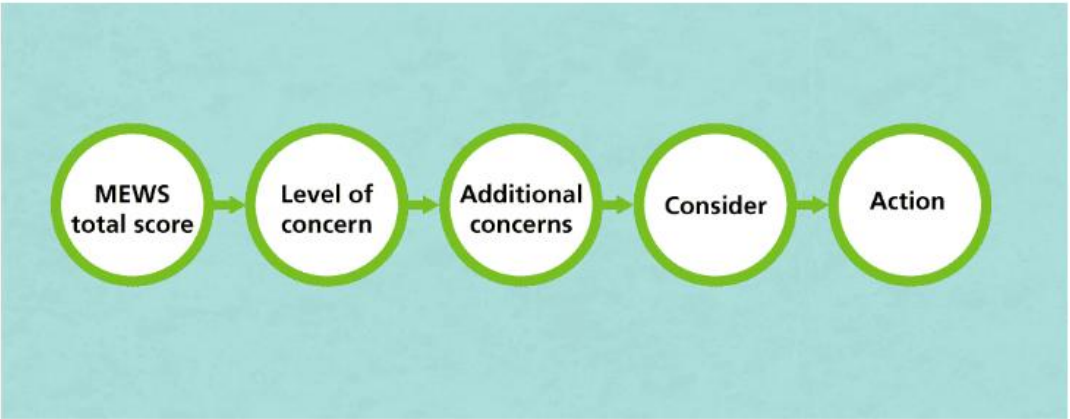
- The frequency of observations and when they should be stepped up or down.

4.2 Recognising the deteriorating patient

- How observations should be recorded and assessed.
- Using the MEWS (Maternity Early Warning Score) scoring system to guide clinical decision making (Appendix 1).
- The abnormal ranges of observations that should cause concern (guided by MEWS).

4.3 Initiating a response to the deteriorating patient

- The thresholds and triggers for requesting a review.
- How to request a review of an unwell or deteriorating patient using escalation tools AID (Appendix 4) and SBAR.
- Timeframes within which a review should be performed.
- Actions to be taken if a timely review cannot be achieved by the clinician listed as first point of escalation.
- If the clinician listed in the primary escalation cannot attend within the required timeframe, and there is ongoing concern, use the jump call procedure (ABUHB, 2026a).



5. Main Body

The following will provide guidance on use of the All-Wales MEWS chart. MEWS should be seen as a useful tool for identifying unwell women, and

should form part of a holistic assessment of each woman. The All-Wales MEWS chart and escalation and response guide should not become a replacement for the clinical skills of the healthcare professional.

There is no evidence for negative predictive value for MEWS and the additional importance of "midwife/patient/NOK concern" as a factor in predicting deterioration should not be underestimated. Any member of staff who is concerned about a patient or is informed or concerns about physical deterioration raised by the patient themselves or their family/NOK/carer should not hesitate to escalate these concerns.

Minimum Standards for Monitoring Physiological Observations

All women should have a full set of physiological observations (pulse, temperature, blood pressure, oxygen saturations and respiratory rate) undertaken within 2-hours of admission to hospital and plotted on the All-Wales MEWS chart. Women presenting to Maternity Triage should have a full set of observations recorded as part of their initial assessment within 15-minutes of arrival (as per ABUHB (2026b) *Maternity Triage Guideline*).

Women admitted for assessment under the AWCPNL should follow the recommendations for physiological observation monitoring described in that pathway.

Respiration rate must be observed for one full minute. If the patient is in receipt of oxygen therapy the percentage of oxygen being administered must also be checked at source and documented on the observation chart or electronic system.

Monitoring equipment must be kept in good working order with regular planned servicing and calibration in accordance with manufacturer's recommendations. Equipment must be available in a variety of sizes e.g., large, medium and small blood pressure cuffs, in order to support accurate monitoring of patients' physiological observations. Appropriate infection control measures are taken to prevent/minimise the risk of cross infection.

All inpatients must have at least one full set of observations recorded each day on the All-Wales MEWS chart.

Minimum Frequency of Observations for Maternity Patients

Antenatal

A full set of observations should not be routinely performed during scheduled antenatal appointments. However, the woman's blood pressure should be monitored at these appointments and recorded within the patient Badgernet record. The All-Wales MEWS chart should not be used to plot routine antenatal blood pressures.

Women who present in the community setting as unwell during the antenatal period may warrant having a full set of observations performed as part of a holistic midwifery assessment. In this case, the All-Wales MEWS chart should be utilised as a tool to aid decision-making regarding appropriate next steps.

The frequency of observations for the antenatal inpatient will be determined by their diagnosis and reason for admission. Individual management plans should be followed.

Intrapartum

As a minimum, women birthing under obstetric-led plans of care should receive observations at the below stated frequencies:

First stage of labour in accordance with NICE (2025) (Intrapartum Care, NG235)-

- Hourly: maternal pulse and oxygen saturations (which to be documented alongside pulse rate to enable a MEWS score to be calculated).
- 4-hourly: temperature, blood pressure and respiratory rate.

Second stage of labour in accordance with NICE (2025) (Intrapartum Care, NG235)-

- 30-minutely: maternal pulse oxygen saturations (which to be documented alongside pulse rate to enable a MEWS score to be calculated).
- Hourly: blood pressure.
- 4-hourly: temperature and respiratory rate.

Some women may require more frequent observations in labour depending on their medical condition and chosen method of pain relief. The timing of observations should be decided by the multi-disciplinary team and be based on an accurate clinical and physical assessment of the mother.

Women following the AWCPNL should have observations performed in line with those recommendations.

Postnatal

As a minimum, all women should have observations recorded upon completion of the third stage of labour (ABUHB (2021) Labour Ward Guidelines), and as part of the initial postnatal assessment (NICE (2025) Intrapartum Care NG235). Observations should be monitored earlier and more frequently if complications arise in the third stage of labour, such as postpartum haemorrhage (PPH) or retained placenta, or where antenatal or intrapartum plans of care stipulate more frequent observations.

Women birthing under obstetric-led plans of care should have their pulse, blood pressure, respiratory rate, temperature and oxygen saturations plotted on the MEWS chart. Women following the AWCPNL should have their immediate post-birth observations recorded and interpreted according to that guidance.

A full set of observations must be recorded as a minimum for the first 3 days following birth (day 1 will be day of birth) for all women, either by hospital or community midwives, as recommended by a Regulation 28

report. This should include pulse, blood pressure, temperature, respiratory rate and oxygen saturations (where available). Observations will be recorded on the All-Wales MEWS chart within all settings, including community.

Where oxygen saturation monitoring is not available in community settings, deterioration indicated by elevated scores for other parameters must still be recorded and escalated according to the All-Wales MEWS chart, including "Additional Concerns" section (Appendix 3).

Post-Operatively

Upon transfer into recovery, commence MEWS chart observations every 5-minutes for the first 30-minutes. The "Monitoring after Spinal Anaesthetic" (ABUHB, 2020) policy should be consulted for frequency and duration of ongoing observations in the post-operative period along with any patient-specific plans of care. Sedation, pain and Bromage scores should also be documented for these women.

Recording and Communicating the Results of Physiological Observations

All patient documentation will evidence the following standards within the patient record: -

- The exact time and date of the observations will be recorded on the observation chart or electronic MEWS chart (via BadgerNet).
- The MEWS score will be calculated correctly.
- A record of the actions taken e.g., midwifery action and monitoring, escalation/referral to doctors, critical care outreach team, commencement or discontinuation of treatment regimens will be documented.

• All entries on the observation chart will be signed (if using paper charts).

• All entries of observations to BadgerNet must be carried out using a personal log in and will be electronically signed as completed by that person.

• The observational results of all patients causing concern/ triggering on MEWS will be communicated to the Lead Midwife in addition to appropriate escalation to the obstetric team.

• All patients causing concern/triggering on MEWS will be highlighted at the ward handover/safety briefing.

• AID (Advice, Inform, Do) (Appendix 4) and SBAR (Situation, Background, Assessment, Recommendation) will be the format of choice for communicating information during the referral and escalation process.

•The MEWS score will be communicated during shift change and handover of care to another clinician.

Minimum Actions and Referral Route that Must be Taken in Accordance with the MEWS Scoring System

All patients in whom there is either a perceived deterioration or who trigger on MEWS will be referred for review by an appropriately qualified healthcare professional as per the All-Wales Thresholds and Triggers section below (Figure 2, Appendix 3). It should be noted that there is no evidence to support a negative predictive value for MEWS and that escalation should be considered for women with MEWS scores of 0-1 if midwives, family members, carers or the patient themselves have concerns about their condition. Escalation in this case could include increasing the frequency of observations or raising the MEWS score to the category above and requesting a review in line with the new score.

Clinicians should be aware that clinical concerns about a patient medically deteriorating may come from concerns raised by a relative, next-of-kin (NOK) or directly from the patient. These concerns should be documented and responded to in line with guidance. This is supported in the Additional Concerns section of the All-Wales MEWS chart below (Figure 1), which includes a list of additional concerns to be aware of in addition to the physiological observations performed.

Additional concerns	
If one or more of these additional concerns are present, consider: 1. Increasing the frequency of observations to a minimum of every 30 minutes 2. Escalate in line with a low-medium level of concern even if MEWS less than 2 3. Where MEWS is greater than 2 raising the level of concern to the next category.	Healthcare professional concerned Woman/family concerned Significant additional therapies (e.g. Oxygen) Increased pain (+/-or analgesic requirement) Significant vaginal bleeding Reduced urine output Decreased level of consciousness/responsiveness

Figure 1 Additional Concerns

When a patient is causing concern due to medical deterioration, the appropriate clinical professional (primary escalation) should be alerted immediately and attend the patient within the given timeframe as per MEWS thresholds and triggers section (Figure 2, Appendix 3).

Thresholds and triggers				
• The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation				
Level of concern	**Low**	**Low-medium**	**Medium**	**High**
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
• When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required • The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation • The section **pulse (from 48 hours after birth)** cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.				

Figure 2 Thresholds and Triggers

The name of the person who is being requested to attend (primary escalation), and the exact time that the request was made should be recorded within the healthcare record (Badgernet) by the person making the request. Any delay with the time frames stipulated in the MEWS threshold and trigger table must result in the secondary contact being requested to review the patient within the original timeframe for review.

To ensure ongoing patient safety the clinical professional reviewing the patient will make an accurate and sufficiently detailed note within the patient healthcare record which will include the following: -

- Exact date and time that the patient was reviewed
- Signed and printed signatures including bleep numbers for the reviewer.
- An accurate assessment of the patient's presenting clinical condition.
- A sufficiently clear and detailed treatment/action plan to facilitate the safe implementation of care/treatment/interventions. Using upper and lower parameters of measurement, or clinical indicators for further escalation or clinical review e.g., the thresholds for systolic and diastolic blood pressure readings.
- The time of the next planned review (pending that there is no further deterioration or increase in the MEWS within the interim).

Escalation from Community Settings

The *All Wales Maternity Early Warning Score (MEWS) Pathway for Escalation from Community Settings* (Maternity and Neonatal SSP Implementation Network, 2026) (Appendix 5) should be used to support clinical decision making and aid communication for all pregnancy and postnatal women up to 6 weeks postpartum if any of the stated criterion

are met in the community setting. Please refer to the thresholds and triggers as per Appendix 5.

When considering methods of maternity transfers from the community setting, please refer to the All Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Unit (Wales and Maternity and Neonatal Network, 2023).

Maximum Timeframe Within Which Escalation and Review of Deteriorating Patients Should Occur

Clinical Professionals (chiefly Doctors, Advanced Clinical Practitioners and Outreach Team Members) should respond and attend the patient within the timeframe as indicated within the MEWS thresholds and triggers section.

When a patient has been referred to a medical professional (primarily Obstetricians, but this may also include, Nurse Practitioners and Outreach Team Members) it is their responsibility to ensure that the patient is attended to within the recommended timeframe.

If a medical professional is requested to attend but unable to do so they must immediately inform the referrer who will then:

- Document the reason for non-attendance within the patient's case notes.
- Escalate the referral to another appropriate clinical professional.
- The handover should emphasise that the patent needs to be attended to and reviewed within the original timeframe.
- Use the Jump Call procedure for Maternity Services (ABUHB, 2026a).

6. Roles and Responsibilities

The Senior Midwifery and Obstetric Leadership teams are responsible for the implementation of the All-Wales MEWS chart, with support from the Acute Physical Deterioration Implementation Network (APDIN) Local

Implementation Lead and the Maternity and Neonatal Safety Support Programme (MatNeoSSP) Perinatal Improvement Lead and Maternity Improvement Specialist.

Role	**Responsibility**
All individuals undertaking, monitoring and recording of vital signs (including healthcare support workers and allied healthcare professionals)	Ensure that: • they have undertaken appropriate training and education and are competent and capable of performing this role (including use of associated equipment). • they understand the process for determining and recording the MEWS score and are compliant with the following standards: • the MEWS score is calculated correctly. • a record of the actions taken is recorded. • the digital MEWS chart on BadgerNet is used as the standard method of recording vital signs for patients within the scope of this policy. • where BadgerNet is unavailable in a clinical area or due to digital failure, a paper copy of the All-Wales MEWS chart is utilised and all entries on the chart are signed and the exact time and date of the vital signs are recorded on the chart. • they immediately escalate any perceived clinical concern or deterioration to the appropriate 1st escalation as detailed on the MEWS

	chart thresholds and triggers section and communicate this to the Lead Midwife for support and awareness. Additionally; it is the responsibility of the individual undertaking monitoring and recording of vital signs to ensure that they make known to the Lead Midwife for the shift any limitations in their practice that would prevent them from safely discharging their duty of care to the patient. This includes unfamiliarity with equipment or documentation to be used or lack of training in undertaking observation of vital signs. This is of particular relevance to Registered Midwives, Nurses and Doctors in terms of remaining accountable under their professional codes of conduct (NMC, 2018; GMC, 2024).
Registered Midwives/Nurses / Doctors /Allied Healthcare Professionals **delegating** the recording and monitoring of vital signs	Any staff delegating the recording and monitoring of vital signs MUST ensure that; • the person(s) to whom the task of recording and monitoring the observations has been delegated is able to carry out the instructions to the required standard. • junior staff/ team members are supported in performing the tasks required of them, and that they are able to do so within their individual level of competency and capability. • the confirmation and outcome of the observations are satisfactory and to

	ensure that the MEWS score is acted upon appropriately. • subsequent actions are documented, incorporating the standards of this policy. • where there is a delay in the attendance of the clinical professional listed under first escalation, that actions are taken to obtain a review of the patient from the secondary escalation contact and that these actions are recorded appropriately within the patient record.
Clinical Professionals (chiefly obstetricians and anaesthetists) who are **Requested to Respond** to a Deteriorating Patient / elevated MEWS Score	All staff responding to a deteriorating patient/ elevated MEWS score must ensure that; • they have undertaken appropriate training and education to be competent and capable of performing this role (including use of associated equipment). • they understand the process by which the MEWS score has been determined and that it is compliant with standards outlined in this policy. • they respond within the timeframe as indicated within the MEWS triggers and thresholds section. • when unable to attend due to competing pressures, the clinical professionals (chiefly Obstetricians, Anaesthetists) must escalate this to another appropriate clinical professional

	(including the Gynaecology Senior Resident Doctor and/or Consultant Obstetrician on duty/ on call), emphasising the need to attend within the original timeframe as specified within the MEWS thresholds and triggers section. • the clinical professional who is unable to attend immediately informs the referrer (usually the Midwife providing care for the patient) who will then document the reason for non-attendance within the patient case notes and inform the Lead Midwife for the shift. • when responding to requests to attend a deteriorating patient/ elevated MEWS score that the actions taken and the actions prescribed are both verbally communicated to the Midwife caring for the patient and clearly recorded within the patient's records.
Consultants/ Clinical Directors with Overall Clinical Responsibility for the Patient	The Consultant/Clinical Director with the overall clinical responsibility for the patient is accountable for the omissions and commissions of care afforded to the patient over their period of admission. It is therefore the Consultant's/ Clinical Director's responsibility to ensure that;

	• doctors in training are knowledgeable and competent in the interpretation of physiological vital signs. • doctors in training are supervised to ensure that all patients have a documented plan for physiological monitoring that includes the following; ○ exact date and time that the patient was reviewed by the reviewing clinical professional. ○ signed and printed signatures including bleep numbers for doctors and advanced nurse practitioners/ members of the outreach team. ○ an accurate assessment of the patient's presenting clinical condition. ○ a sufficiently clear and detailed treatment/ action plan to facilitate the safe implementation of care / treatment interventions, using upper and lower parameters of measurement, or clinical ○ indicators for further escalation or clinical review e.g., the thresholds for systolic and diastolic blood pressure readings etc. ○ the time of the next planned review (pending that there is no further deterioration or increase in the MEWS score within the interim).

	• all members of the Consultant's / Clinical Director's team understand their individual responsibilities in terms of responding to a request to attend to a deteriorating patient / elevated MEWS score within the given timeframe as specified within the MEWS triggers and thresholds section. • That the Divisional Director, Clinical Director and Patient Safety and Quality Representative are informed of all incidents arising from a failure to comply with the MEWS thresholds and triggers section.
Ward/Departmental Managers and Senior Midwife Responsibilities	Ward/Departmental Managers and Senior Midwives must ensure that the following within their areas of managerial accountability; • appropriate and Health Board compliant documentation is available for use by staff. • the required level of regular audit is undertaken and reported upon. • an equipment inventory is maintained which details the asset number, dates of planned maintenance etc as detailed within the Management of Medical Equipment Devices Policy (ABUHB, 2022). • staff working within their area of managerial accountability are aware that they are responsible for ensuring: - the prompt removal of defective equipment from clinical areas and ensuring that prompt arrangements are

	made for its repair or condemning as appropriate. - That DATIX incident reports are initiated where defective equipment has impacted on patient care. - That any deviation/non-compliance with the time frames stipulated in the MEWS thresholds and triggers section results in a DATIX incident form being completed. - All members of the midwifery team understand their individual responsibilities in terms of implementing the requirements of this policy and the MEWS thresholds and triggers section. • The Senior Midwifery Manager and Governance Lead Midwife are informed of all incidents arising from a failure to comply with the MEWS thresholds and triggers section.
Divisional Patient Safety & Quality Leads (Nursing/Medical), Divisional Directors & Divisional Nurses and Divisional Quality and Patient Safety Team	It is the responsibility of the Divisional Patient Safety & Quality Leads to ensure that: • members of the Midwifery and Medical Teams are aware of their responsibilities as outlined in this policy. • resources and deficits in service provision are managed and escalated appropriately in order to ensure the safe and effective delivery of care within the Division. Where appropriate they should be included within the Divisional Risk Register.

	• incident themes arising from a failure to appropriately implement this policy and the MEWS thresholds and triggers section are escalated to the Putting Things Right (PTR) Team, and Medical Director/ Executive Nurse for information and support as appropriate. Such incidents will be investigated appropriately so that lessons can be learnt, fed back and shared across the Health Board and wider health community as appropriate. • professionally accountable individuals who fail to implement the requirements of this policy are investigated under the disciplinary rules if considered appropriate by the Divisional / Executive Professional Lead.
Medical Director and Executive Nurse	It is the responsibility of the Medical Director and Executive Nurse to ensure that: - • services provided within the Health Board and its composite areas are fit for purpose and are providing safe and effective care which is patient centred and evidence based. • processes and systems are in place to ensure that documentation associated with the implementation of this policy (All-Wales MEWS chart, including threshold and trigger section are approved by the Health Board. • an Executive Lead is identified to oversee the investigation of Serious Incidents where appropriate, for example concerns that arise from a failure to implement this policy and the MEWS escalation and response guide, and to

	support the implementation of subsequent recommendations.

7. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics, midwifery and anaesthetics have been consulted with in the development of this policy.

8. Equality Impact Assessment

An Equality Impact Assessment was completed for the purpose of this policy update. The overall negative impact assessment risk score was noted as low.

9. Training Requirements

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

Staff performing physiological observations for pregnant, birthing or postnatal women should, as a minimum, complete the Maternity Early Warning Score (MEWS) module via the Electronic Staff Record (ESR).

Training records will be reviewed by the Practice Development Midwives and Senior Midwifery Management Team to ensure compliance within the midwifery and HCSW workforce. The Clinical Director will monitor the training compliance among the medical workforce.

10. Audit and Review

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

Maternal/ neonatal outcomes will be monitored via the local maternity dashboard. Adverse maternal/ neonatal outcomes will be reviewed on an individual basis via local governance arrangements.

Compliance with the standards described within this guideline will be audited using the audit tool developed by the Acute Physical Deterioration Implementation Network. This audit will comprise of retrospective review of 10 sets of case notes by the MEWS implementation team weekly until this change has successfully been embedded in practice.

11. References

Aneurin Bevan University Health Board (2020) *Obstetric Anaesthesia in GUH: Protocols and Guidelines* [Online]. Available at: https://nhswales365.sharepoint.com/sites/ABB_Pulse_Anaesthetics/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FABB%5FPulse%5FAnaesthetics%2FShared%20Documents%2FObstetrics%2FGUH%20Obstetric%20Anaesthesia%20Guidelines%20%28hyperlinked%29%20Nov%2018%202020%20%28MT%29%2Epdf&parent=%2Fsites%2FABB%5FPulse%5FAnaesthetics%2FShared%20Documents%2FObstetrics (Accessed 17/03/2026).

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12. Appendices

Appendix 1- Maternity Early Warning Score (MEWS)

GIG Cymru NHS Wales | Y Weithrediaeth Executive

Maternity Early Warning Score (MEWS)

(NHS England, 2024)

Hospital sticker with patient details

MEWS score: 0 | 1 | 2 — A score for each vital sign is required at each entry

Parameter		Score
	DATE	
	TIME	
Respirations Breaths/min	>=25	2
	22-24	1
	18-21	
	13-17	0
	9-12	
	7-8	1
	<=6	2
SpO_2 Oxygen saturation (%)	>=95	0
	93-94	1
	<=92	2
Temperature °C	>=37.5	2
	37.3-37.4	1
	36.8-37.2	0
	36.2-36.7	
	35.7-36.1	1
	<=35.6	2
Pulse Beats/min	>=131	2
	122-130	2
	113-121	1
	99-112	
	86-98	0
	71-85	
	63-70	1
	<=62	2
Pulse - from 48 hours post birth ONLY Beats/min (Date & time to commence monitoring)	>=108	2
	99-107	1
	85-98	
	71-84	0
	58-70	
	51-57	1
	<=50	2
Systolic blood pressure mmHg	>=175	2
	160-174	2
	145-159	2
	136-144	1
	121-135	
	111-120	0
	101-110	
	94-100	1
	77-93	2
	61-76	2
	<=60	2
Diastolic blood pressure mmHg	>=110	2
	97-109	2
	89-96	1
	80-88	
	70-79	0
	62-69	
	57-61	1
	<=56	2
MEWS TOTAL		

Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.

Healthcare professional concerned	
Woman/family concerned	
Significant additional therapies (e.g. Oxygen)	
Increased pain (analgesic requirement)	
Significant vaginal bleeding	
Reduced urine output	
Altered level of consciousness/responsiveness	
Monitoring frequency	
Escalation of care YES/NO	
Initials	

Refer to back page for thresholds and triggers

"Any edits or modifications to this tool must be agreed through the Maternity and Neonatal Strategic Network"

2025

Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

		Score				
		2	1	0	1	2
Vital Sign	**Respirations** Breaths/min	<=6	7-8	9-21	22-24	>=25
	SpO_2 Oxygen saturation (%)	<=92	93-94	>=95	-	-
	Temperature °C	<=35.6	35.7-36.1	36.2-37.2	37.3-37.4	>=37.5
	Pulse Beats/min	<=62	63-70	71-112	113-121	>=122
	Pulse (from 48 hours post birth) Beats/min	<=50	51-57	58-98	99-107	>=108
	Systolic blood pressure mmHg	<=93	94-100	101-135	136-144	>=145
	Diastolic blood pressure mmHg	<=56	57-61	62-88	89-96	>=97

+

Additional concerns	
If one or more of these additional concerns are present, consider: 1. Increasing the frequency of observations to a minimum of every 30 minutes 2. Escalate in line with a low-medium level of concern even if MEWS less than 2 3. Where MEWS is greater than 2 raising the level of concern to the next category.	Healthcare professional concerned Woman/family concerned Significant additional therapies (e.g. Oxygen) Increased pain (+/-or analgesic requirement) Significant vaginal bleeding Reduced urine output Decreased level of consciousness/responsiveness

↓

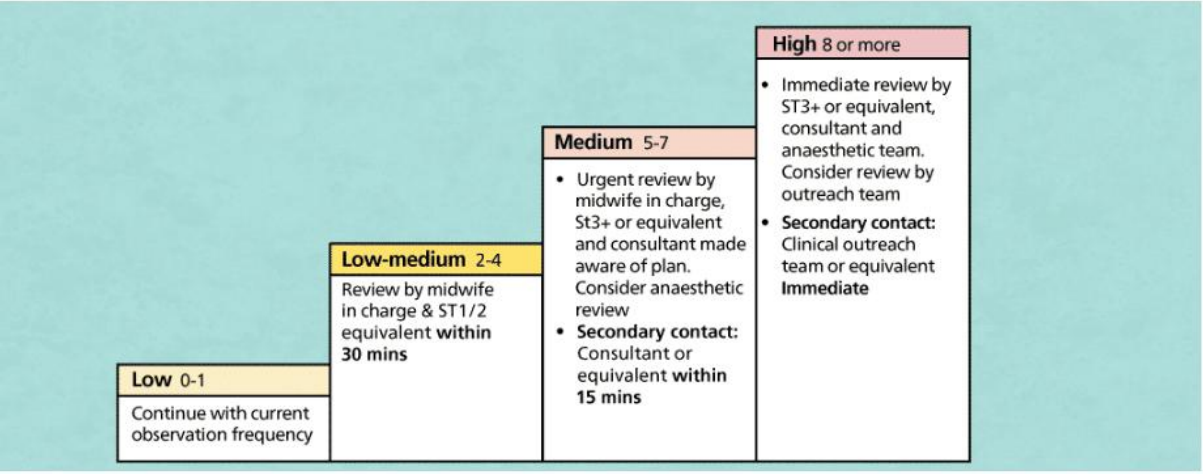
Thresholds and triggers

- The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation

Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent

- When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required
- The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation
- The section **pulse (from 48 hours after birth)** cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.

Appendix 2- MEWS Escalation



Appendix 3- Additional Concerns

Additional concerns
Healthcare professional concerned
Woman/family concerned
Significant additional therapies (e.g. Oxygen)
Increased pain (+/or analgesic requirement)
Significant vaginal bleeding
Reduced urine output
Decreased level of consciousness/responsiveness

Appendix 4- AID Toolkit (RCOG, 2022)

each baby counts + learn & support

Royal College of Midwives

Royal College of Obstetricians & Gynaecologists

IDENTIFY COMMUNICATE ACT

STILL CONCERNED - ESCALATE FURTHER

Escalating a clinical situation? Frame what you need to say with safety critical language.
Here are some examples of how you might usually communicate, then how you can use AID:

ADVICE

✗ 'Nadia in room 7 is fully dilated and wants to use the pool?'

✓ 'I am asking for your ADVICE, around using the birth pool for Nadia in room 7 as she has a borderline BP'

INFORM

✗ 'Just to let you know Aaliya in room 4 is fine now.'

✓ 'I am INFORMING you - that Aaliya in room 4 had a kiwi at 05:30 and a PPH of 1000mls but is stable now'

DO

✗ 'Maggie is fully and pushing with a dodgy CTG'

✓ 'I need you to (DO) come straightaway to review the CTG in room 2 which is deteriorating'

We would like to introduce 'AID' throughout the department. If you have a clinical concern to escalate please frame your communication:

I am asking for ADVICE...
I am INFORMING you...
I need you to (DO)...

Appendix 5- All Wales Maternity Early Warning Score (MEWS) Pathway for Escalation from Community Settings

GIG CYMRU NHS WALES | Perfformiad a Gwella Performance and Improvement

GIG CYMRU NHS WALES | Rhwydwaith Gweithredu RhCD Mamolaeth a Newyddenedigol Maternity and Neonatal SSP Implementation Network

All Wales Maternity Early Warning Score (MEWS) Pathway for Escalation from Community Settings

CRITERIA FOR USE OF MEWS IN COMMUNITY SETTINGS

This escalation pathway should be used to support clinical decision making and aid communication for all pregnant and postnatal women up to 6 weeks postpartum if any of the below criteria are met in a community setting. The pathway is *not* intended to replace clinical judgement and should be used in conjunction with any relevant risk assessment and/ or clinical guidelines.

- **Presenting unwell**
- **Pain (other than contractions)**
- **Antenatal bleeding/ abnormal lochia**
- **Upon exit of the All-Wales Clinical Pathway for Normal Labour**
- **Woman, family or healthcare professional concern (to align with Call for Concern)**

THRESHOLDS AND TRIGGERS

The thresholds and triggers below broadly align with the escalation on the reverse of the MEWS tool, although recommended action differs due to there already being a clinical concern or indication to utilise a MEWS tool.

*** If the woman, family, or midwife remain concerned, consider increasing frequency of the observations, escalating regardless of the MEWs score and raising the level of concern to the next category***

Level of Concern	**Low**	**Medium**	**High**
MEWS SCORE	**0-1**	**2-4**	**5 or more**
Minimum vital signs- record until ongoing review.	Repeat observations as clinically indicated. Document ongoing plan.	Repeat observations every 30 minutes Document ongoing plan.	Consider continuous observations until arrival of emergency ambulance. Document ongoing plan.
Primary escalation and response (use AID and	If woman, family or midwife are no longer	Review by the most appropriate Healthcare	**IMMEDIATE**

SBAR frameworks to support communication)	concerned, safety netting advice should be given. If appropriate, for medical concern, refer to GP for assessment (eg. suspected wound infection). If ongoing concern of woman, family or midwife and/ or obstetric concern, refer to maternity triage.	professional within maximum of 2 hours. Consider mode of transport - refer to All Wales Transport document. Use clinical judgement.	**TRANSFER** to obstetric care for urgent review. Initiate 999 call, answer 'yes' to high-risk complication and state 'Elevated Maternity Early Warning score' along with primary clinical concern.
Review Secondary contact (For additional advice, support or if further escalation is required).	Primary Care / Maternity triage as appropriate to clinical picture. Maternity Co-ordinator	Maternity triage. Obstetrician	INFORM Maternity Co-ordinator of expected admission using SBAR. WAST – During the 999 call if the prioritisation is not agreed, ask for a clinician call back.
If the primary team member(s) contacted is unable to be reached within the expected time for the level of clinical concern, escalation to the secondary contact is required.			

All Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units:
wisdom.nhs.wales/all-wales-guidelines/all-wales-guidelines/all-wales-guideline-for-transfers-from-community-and-fmu/

This escalation pathway has been developed to align with the Call for Concern pathways currently in development by the Acute Physical Deterioration Implementation Network.