

# Modified Early Warning System (MEWS)

## This is policy at LGH.

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MEWS aggregates the patient's individual vital signs and LOC values into one overall score. Documented vital signs and selection of assessed LOC are displayed in the electronic medical record (EMR) and e-Health automatically assigns a score of 0, 1, 2, or 3 to vital signs and LOC.

# How often do I review and acknowledge a MEWS score? Good question!

- during comprehensive and focused patient assessments
- during bedside handoff (PCNR)
- with any decline in patient condition

This tool alone will not always highlight whether a patient is deteriorating and should be used to guide best practice. **Clinical judgment must be used with the MEWS at all times.** The RN should never hesitate to contact the physician or call a Rapid Response on a single system decline.

ALL of these components MUST be included for EPIC to give you an ACCURATE MEWS score. (RR is the most commonly missing value.)

**MODIFIED EARLY WARNING SYSTEM (MEWS) - NRSG**

	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>Heart Rate</b>		≤ 40	41-50	51-100	101-110	111-129	≥ 130
<b>Systolic Blood pressure</b>	≤70	71-80	81-100	101-159	160-199	200-220	>220
<b>Respiratory Rate</b>		≤ 7	8	9-17	18-20	21-29	≥ 30
<b>Temperature</b>		< 95 F	95.0-96.8 F	96.9-100.4 F	100.5-101.3	≥101.4 F	
<b>Conscious Level</b>	Unresponsive	Responds to Pain	Responds to Verbal	Alert	New Agitation New Confusion		

What to do with the MEWS score?

**Actions to prevent patient deterioration:** Depending on the total MEWS, the nurse should consider the following actions to prevent deterioration:

- **#1: Verify that all components have been entered so you know your score is accurate.**
- **Normal = MEWS 0 to 1:** No additional action steps/interventions required by the nurse.
- **LOW = ● MEWS 2 to 3:** Nurse reviews patient's condition and discusses findings with provider during rounds. MEWS of 3 nurse considers increasing patient vital signs monitoring and MEWS to 2-hour intervals. If patient remains with MEWS of 3 for three consecutive readings, nurse considers reviewing patient assessment with facilitator.

What to do with the MEWS score?

Actions to prevent patient deterioration: Depending on the total MEWS, the nurse should consider the following actions to prevent deterioration

- **MEDIUM = ● MEWS 4 to 6:** Nurse reviews patient's condition with facilitator and considers discussing findings with provider during rounds versus more immediate provider notification. Nurse considers increasing patient vital signs monitoring and MEWS to 1-hour intervals.
- **HIGH = ● MEWS 7 to 8:** Nurse reviews patient's condition with facilitator and/or nursing colleagues. Nurse considers immediate provider notification. Nurse considers activating Rapid Response. Nurse considers increasing patient vital signs monitoring (including oximetry) to every 15-30 minutes or more frequently until patient's vital signs and/or MEWS stabilize and/or patient transferred to a higher level of care.

What to do with the MEWS score?

**Actions to prevent patient deterioration:** Depending on the total MEWS, the nurse should consider the following actions to prevent deterioration

- **Critical = ● MEWS > 8:** This potentially constitutes a clinical emergency. Nurse reviews patient's condition with facilitator and/or nursing colleagues. Rapid Response strongly recommended. Immediate provider communication strongly recommended. Nurse considers close (every 5-10 minute) vital signs monitoring (including oximetry) until patient's vital signs and/or MEWS stabilize and/or patient transferred to a higher level of care.

**Additional Considerations when assessing clinical deterioration include:**

- o Communication and collaboration with providers
- o Calling a Rapid Response
- o Code Blue