Maternity and Neonatal

NHS University College London Hospitals NHS Foundation Trust

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Implementing MEWS Beyond Maternity

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Insight from UCLH on planning Trust-wide rollout and implementation of the MEWS tool

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Background

As UCLH prepares to implement the updated **Maternity Early Warning Score (MEWS)**, one of the most important lessons learnt is that success depends on looking beyond maternity services alone.

Within our Trust, implementation planning highlighted that maternity staff are already familiar with observation and escalation processes. The greater challenge was ensuring that pregnant and recently pregnant women are recognised and managed appropriately when they present outside maternity services.

National maternal mortality reviews consistently show that some of the women at highest risk are those who are not actively within maternity care pathways. These include women in early pregnancy, women experiencing miscarriage or termination of pregnancy, and women presenting weeks after birth. These patients often access care through emergency departments, acute medicine, surgical services and other non-maternity settings.

The implementation therefore focused not only on introducing a new scoring tool, but on creating a whole-system approach to safeguarding pregnant and postnatal women wherever they present.

Key Learning: Think Beyond Maternity

A major learning from the implementation process was the importance of collaboration across departments.

Many pregnant and recently pregnant women will first present to:

- Emergency Departments
- Acute Medical Units
- Surgical Services
- Gynaecology Services
- Assessment Units
- Community Services.

This includes:

- Women in very early pregnancy
- Women with pregnancy complications before maternity triage accepts referrals
- Women following miscarriage or termination of pregnancy
- Women up to four weeks postnatal
- Women who have delivered at another organisation but present locally.

These are often the women most vulnerable to deterioration because they may not be recognised as maternity patients.

A key planning principle was therefore:

"We are not just implementing MEWS within maternity. We are implementing MEWS across the entire hospital."

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Building a Collaborative Implementation Model

One of the greatest successes to date was developing strong partnerships across the organisation.
Rather than viewing MEWS as a maternity project, it became a system-wide patient safety initiative involving:

- Maternity teams
- Emergency Department clinicians
- Acute medical teams
- Gynaecology services
- Digital and informatics teams
- Governance leads
- Clinical educators
- Executive leadership.

This collaborative approach helped teams understand:

- Which patients should be managed using MEWS
- When escalation should occur
- Who should be contacted for specialist advice
- How maternity services would support non-maternity staff.

The process also improved understanding of how different departments use the same electronic patient record system and highlighted opportunities to strengthen interoperability across services.

Prior to going live, the team hosted a MEWS Hazard workshop with multiple stakeholders. During the session, they reviewed the end-to-end workflow, demonstrating how MEWS would appear and function in different clinical contexts. They covered scenarios, such as adding a pregnancy record when a patient attends a non-maternity service, and recording previous pregnancies that resulted in miscarriage or termination at another hospital. This helped ensure staff were familiar with the process, and to support a smooth and safe rollout.

Making the Digital System Work for Staff

A critical success factor for engagement was ensuring that the electronic patient record supported clinical decision-making rather than relying solely on staff remembering the process.

Working closely with the digital team and EPIC developers, significant attention was given to system design.

The philosophy was simple:

"The system should do some of the work."

This included considering:

- How pregnancy status is identified
- How postnatal patients are recognised
- How escalation prompts are generated
- How additional concern criteria are flagged
- How staff are directed to the correct escalation pathway.

This was particularly important because many non-maternity clinicians encounter only a small number of pregnant patients each year.

The aim was to make safe decision-making as straightforward as possible, reducing reliance on individual knowledge and creating stronger system safeguards.

Key Change: Responding to Additional Concern

One of the most significant changes within MEWS is the introduction of escalation triggered by additional clinical concern, requiring escalation to move up one level.

While the scoring framework itself is relatively straightforward, this cultural shift requires staff to recognise that concern alone can justify a higher level of response, even when physiological observations may not yet appear significantly abnormal.

Implementation therefore focused heavily on:

- Education
- Clinical scenarios
- Escalation exercises
- Case-based learning
- Human factors principles.

This supported consistent understanding across all professional groups.

Governance and Assurance

Another important lesson was the need for clear oversight and assurance mechanisms.

Implementation teams recognised that simply launching a guideline and sending periodic reminders would not provide sufficient assurance that the correct observations and escalation processes were being used.
Instead, robust governance arrangements were developed, including:

- Executive oversight
- Guideline approval processes
- Committee scrutiny
- Audit and reporting mechanisms
- Clear accountability for compliance
- Ongoing monitoring of implementation.

This recognised that maternity services retain a responsibility for pregnant and postnatal women even when they present elsewhere in the hospital.

Strong governance ensures that risks can be identified early and addressed proactively.

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Recommendations for Organisations Planning MEWS Implementation

1. Treat MEWS as a Whole-Hospital Project

Do not limit implementation planning to maternity services.

2. Engage Non-Maternity Departments Early

Emergency medicine, acute medicine, gynaecology, surgery and digital teams should be involved from the outset.

3. Focus on Vulnerable Groups

Consider pathways for:

- Early pregnancy
- Miscarriage
- Termination of pregnancy
- Postnatal women
- Women presenting after birth elsewhere.

4. Build System Safeguards

Use electronic systems to support identification, scoring and escalation whenever possible.

5. Establish Clear Governance

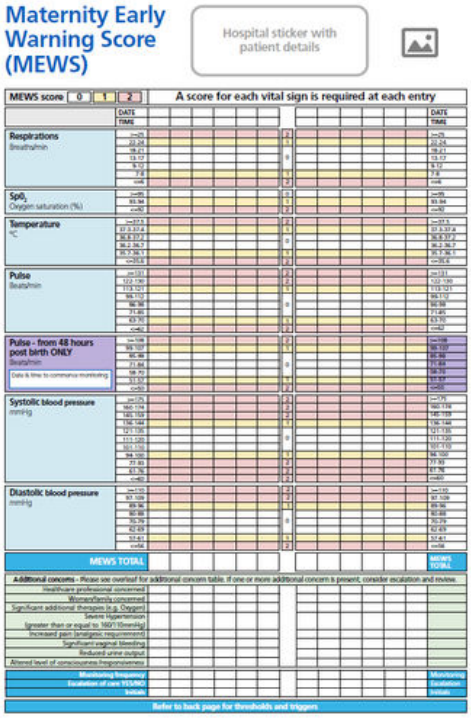
Develop audit, monitoring and reporting structures before go-live.

6. Educate Around Additional Concern

Ensure staff understand that escalation is not solely dependent on physiological observations.

7. Maintain Shared Responsibility

Maternity services should work collaboratively with other departments to ensure women receive safe care wherever they present.


Maternity Early Warning Score (MEWS)

Hospital sticker with patient details

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

DATE / TIME

Respirations Breaths/min

SpO2 Oxygen saturation (%)

Temperature °C

Pulse Beats/min

Pulse - from 48 hours post birth ONLY Beats/min

Systolic blood pressure mmHg

Diastolic blood pressure mmHg

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)

Severe Hypertension (greater than or equal to 160/110mmHg)

Increased pain (analgesic requirement)

Significant vaginal bleeding

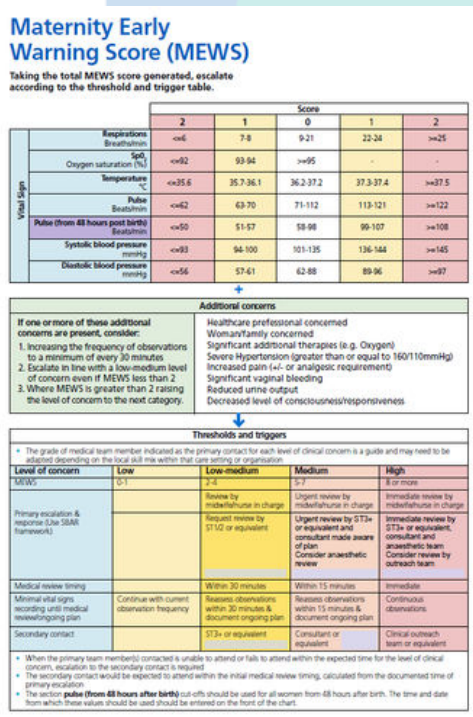
Reduced urine output

Altered level of consciousness/responsiveness

Monitoring frequency

Escalation of care (ST1/ANP) Initials

Refer to back page for thresholds and triggers


Maternity Early Warning Score (MEWS)

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

Vital Sign	2	1	Score 0	1	2
Respirations Breaths/min	<=6	7-8	9-21	22-24	>=25
SpO2 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) Severe Hypertension (greater than or equal to 160/110mmHg) 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/nurse in charge	Urgent review by midwife/nurse in charge	Immediate review by midwife/nurse 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.

Conclusion

Successful MEWS implementation requires much more than introducing a new chart or scoring system. It demands strong multidisciplinary collaboration, robust governance, digital support and a clear understanding that pregnant and recently pregnant women may enter the healthcare system through many different routes.

By focusing on the patients most at risk of being missed and creating systems that support staff to identify and escalate concerns early, organisations can strengthen safety across the entire hospital and ensure that maternity expertise reaches women wherever they access care.

We plan to launch later this year, and hope that our thorough implementation processes ensure smooth transition to the new MEWS chart adoption trust wide.