

Vital signs and other observations used to detect deterioration in pregnant women: an analysis of vital sign charts in consultant-led maternity units

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STRUCTURED ABSTRACT

Background

Obstetric early warning systems are recommended for monitoring hospitalised pregnant and postnatal women. We decided to compare (i) vital sign values used to define physiological normality (ii) symptoms and signs used to escalate care, (iii) type of chart used, and (iv) presence of explicit instructions for escalating care.

Methods

One hundred and twenty obstetric early warning charts and escalation protocols were obtained from consultant-led maternity units in United Kingdom and Channel Islands. These data were extracted: values used to determine normality for each maternal vital sign; chart colour-coding; instructions following early warning system triggering; other criteria used as triggers.

Results

There was considerable variation in the charts, warning systems and escalation protocols. Of 120 charts, 89.2% used colour; 69.2% used colour-coded escalation systems. Forty-one (34.2%) systems required the calculation of weighted scores. Seventy-five discrete combinations of 'normal' vital sign ranges were found, the most common being: heart rate = 50-99; respiratory rate = 11-20; blood pressure, systolic = 100-149mmHg, diastolic = \leq 89mmHg; S_pO_2 = 95-100%; temperature = 36.0-37.9°C; and AVPU assessment = Alert. Most charts (90.8%) provided instructions about who to contact following triggering, but only 41.7% gave instructions about subsequent observation frequency.

Conclusions

The wide range of 'normal' vital sign values in different systems suggests a lack of equity in the processes for detecting deterioration and escalating care in hospitalised pregnant and postnatal women. Agreement regarding 'normal' vital sign ranges is urgently required and would assist the development of a standardised obstetric early warning system and chart.

Keywords: Obstetric Emergency Team; Patient Safety; Standards of Care; Trigger Tools; Maternity; Women's health.

INTRODUCTION

Early warning systems are recommended for monitoring the condition of hospitalised pregnant and postnatal women, to facilitate the early detection and management of clinical deterioration.¹⁻⁶ Some maternity units use systems designed primarily for the non-pregnant population.⁷ Others employ obstetric-specific systems comprising 'calling criteria' based on maternal vital sign measurements, symptoms and clinical signs, and conditions that commonly cause maternal morbidity and mortality.⁸⁻¹⁰ The regular measurement of a woman's vital signs is a universal feature of obstetric early warning systems (ObsEWS) and choosing the correct normal ranges for measured variables is fundamental to their appropriate, safe and efficient use.¹¹ However, publications suggest that ObsEWS vary with respect to the included vital signs and the physiological values used to reflect normality.¹⁻¹⁰

Several types of ObsEWS exist. Some trigger a clinical response by a midwife, obstetrician or rapid response team,¹² when one or more abnormal observations are identified.³ Others trigger the same response when one or more markedly abnormal, or two or more mildly abnormal, observations are present.^{13,14} These systems are frequently used alongside charts featuring colour-coded shading to highlight the markedly and mildly abnormal vital signs ranges, often shaded in red and yellow, respectively (Figure 1).^{1,15} A third type of ObsEWS allocates points in a weighted manner, based on the derangement of a woman's measured vital signs from pre-defined 'normal' ranges (Table 1).^{16,17} The sum of these points, known as the early warning score (EWS), is used to direct subsequent care. Some hospitals use combinations of the three systems.

We decided to analyse early warning charts in routine use in consultant-led maternity units in the UK and Channel Islands to establish the vital sign values used to determine normality in ObsEWS. We also identified other items used as triggers for escalating care (e.g., maternal symptoms, clinical signs and conditions), the type of vital signs chart used and the presence of explicit instructions for escalating care.

METHODS

We wrote to all lead consultant anaesthetists registered with the Obstetric Anaesthetists' Association (OAA) to request participation in an analysis of obstetric early warning charts, ObsEWS and

associated escalation protocols used in consultant-led maternity units in the UK and Channel Islands. Contact details were provided by the OAA. We requested a copy of the vital signs/ObsEWS chart and associated escalation protocol used in each unit. Invitees were asked to send these by email or mail (a stamped-addressed envelope was provided). Invitees were assured that all data would remain confidential, and no hospital identifiers would be revealed during presentations or publications arising from the study. The study extended two earlier OAA-approved surveys (N^{os} 76 & 135) into UK ObsEWS and escalation policies, undertaken by members of our group.^{8,9}

Non-responding leads/units were contacted again via telephone, follow-up letter and email. All were contacted a minimum of seven times (one telephone call, three letters and three emails). All documentation received by the study group was scanned, given a unique hospital identifier (N^o 1-194) and uploaded to a secure database for analysis.

Analysis

Two members of the research team (GS and RI) analysed each chart individually, and created a spreadsheet containing the amalgamated data. Where opinions differed the charts were re-checked to establish a single result for each data item.

We documented whether each obstetric early warning chart was colour-coded, and if the chart identified: (i) who to call upon ObsEWS triggering; and (ii) the frequency of vital signs monitoring expected after activation. We identified the items used as triggers for escalation (i.e., vital signs, maternal symptoms, clinical signs, and conditions) from the chart alone, or, where necessary, from the chart and the associated EWS. For each maternal vital sign parameter studied (i.e., respiratory rate (RR), heart rate (HR), systolic blood pressure (sBP), diastolic blood pressure (dBP), mean blood pressure (mBP), temperature (T), AVPU (Alert-Voice-Pain-Unresponsive) and S_pO₂), we noted (a) whether it was used as a component of the ObsEWS, and (b) the values used to determine physiological normality on the vital signs chart or, if used, in the EWS. Similarly, we did the same for Glasgow Coma Score (GCS), maternal urine output and maternal oxygen administration. In addition, we noted whether other observations, criteria or abnormalities (e.g., presence of maternal proteinuria; uterine tone; maternal pain) were used as triggers in the early warning system.

Research Ethics

In line with guidance from the NHS Health Research Authority, this service evaluation did not require ethical review by an NHS or Social Care Research Ethics Committee or management permission through the NHS R&D office. Approval for the study was obtained from the Obstetric Anaesthetists' Association (OAA) Audit Subcommittee.

RESULTS

A total of 194 lead obstetric anaesthetists were invited to contribute obstetric early warning charts and escalation protocols from their unit(s). Charts were returned by 127 (65.5%) but seven (3.6%) were unusable (e.g., poor quality photocopy, black and white photocopy where colour-coding was used). Of the 120 charts available for analysis, 88 were from England; 15 from Scotland; 11 from Wales; 5 from Northern Ireland and 1 from the Channel Islands.

Type of chart and escalation system

There was considerable variation in the design of obstetric early warning charts. Of the 120 usable charts, 107/120 (89.2%) used colour in some way, but only 83/120 (69.2%) used a colour-coded escalation system. Two different systems were used to escalate care to more experienced staff, or to advise subsequent clinical actions. A colour-coded triggering system similar to that developed in Scotland and described in the 2007 Confidential Enquiry into Maternal and Child Health (CEMACH) report,¹ was used in 79/120 (65.8%) (Figure 1). A system that required staff to calculate an EWS from an aggregate weighted system was used in 41/120 (34.2%). Where a colour-coded system based on the presence of one or more abnormal observations (red/yellow) was used (n=79), all except one (triggering score not stated) escalated care in the presence of either two yellow vital signs values or one red value. Where an aggregate weighted EWS was used to escalate care (n=41), the lowest aggregate score that triggered a bedside assessment by a doctor was 2 (4/41), 3 (15/41) 4 (15/41), 5 (4/41) and 6 (3/41).

Vital signs and other parameters used in ObsEWS

Table 2 shows the aggregated data for the vital signs and related measurements used as a component of the trigger system - specifically, number of discrete 'normal' ranges in use across the

units surveyed for each individual vital sign; lowest and highest value in any 'normal' range; most commonly used 'normal' range; number of charts using the most commonly used 'normal' range; and whether the parameter was (i) used as a component of the triggering system, (ii) recorded but not used in the triggering system, or (iii) not recorded nor used.

The variation in vital signs ranges used to define 'normality' for each of: HR, RR, sBP, dBP, SpO₂ and T are shown in Supplementary Figures 1-6. For HR, RR, sBP and SpO₂, the most commonly chosen 'normal' range was used in only ~50% units (Table 2). The most commonly used combination of 'normal' ranges was that described in the CEMACH report¹ [HR, 50-99 bpm; RR, 11-20 bpm; sBP, 100-149 mmHg; dBP, ≤89 mmHg; SpO₂, 95-100%; T, 36.0-37.9°C; and AVPU, A], however, this was used in only 16/120 (13.3%) units. Of the 120 charts assessed, 102 (85%) included all seven vital signs that appear on the CEMACH chart (i.e., HR; RR; sBP; dBP; SpO₂; T; AVPU). However, there were 75 discrete combinations of 'normal' ranges in use for these seven vital sign sets. We could find no evidence that any unit used a different ObsEWS for different stages of pregnancy or in the postpartum period.

Table 3 shows the range of maternal symptoms and signs, and other clinical observations or measurements used as components of the ObsEWS reviewed. Whilst many of these supplementary observations formed part of a colour-coded chart and triggering system, some of these items contributed weightings to an aggregate EWS value.

Escalation instructions

The baseline frequency for recording vital signs was not always recorded on the ObsEWS charts. Where recorded, it varied between units and was usually every 12 hours or more frequent. Only 50/120 (41.7%) provided instructions about changes in the vital sign measurement frequency once vital sign abnormalities were identified. In these circumstances, the subsequent vital signs measurement frequency was increased to a variable extent, usually to every 15-30 minutes. Usually, the frequency was determined by the degree of physiological derangement observed. Most charts (109/120; 90.8%) provided instructions about who to contact once the ObsEWS had triggered.

DISCUSSION

We found a lack of agreement amongst the ObsEWS employed in consultant-led maternity units in the UK and Channel Islands regarding the most appropriate vital sign parameters to measure and the vital sign values regarded as 'normal' values for each parameter. These disparities probably exist because there is a paucity of knowledge regarding which vital signs, or combination of vital signs, are predictive of maternal deterioration during and after pregnancy, and this makes it difficult to obtain agreement on the necessary appropriate vital signs to measure routinely or to include in an ObsEWS. Similarly, although it is known that pregnancy alters maternal physiology,¹⁸ data are lacking regarding the normal maternal vital sign ranges for each stage of pregnancy, labour and the post-partum period.¹¹

The uncertainties arising from these knowledge gaps result in potential conflicts in maternal care. The vital sign normal ranges in several ObsEWS studied lie outside the recently published reference ranges in healthy term pregnant women undergoing caesarean section.¹⁹ More than 20% units which include S_pO_2 in their ObsEWS use an S_pO_2 'normal' range with a lower limit below 94%, i.e., below the British Thoracic Society recommended lower limit for target S_pO_2 during pregnancy.²⁰ The normal ranges used for some parameters overlap with those used to highlight possible sepsis,²¹⁻²³ which is especially concerning as sepsis is a significant direct cause of maternal mortality and morbidity.²⁴ There are also examples of blood pressure 'normal' ranges overlapping with those used by the National Institute for Health and Care Excellence to define mild diastolic and severe systolic hypertension in pregnancy.²⁵ In addition, the parameters and normal values used in units in the UK and Channel Islands are also different to those being used in iMEWS in Ireland² and in the Maternal Early Warning Criteria recommended in the USA.³ Data collection to establish a set of 'normal' vital signs ranges for pregnancy is currently underway¹¹ and may lead to the resolution of some of these uncertainties and disparities.

The determination of a set of 'normal' vital signs ranges for pregnancy would facilitate the development of a single validated ObsEWS for the UK and Channel Islands, although a particular challenge will be the identification of suitable clinical outcomes against which the ObsEWS can be validated. It would also be important to identify whether it is necessary or feasible to introduce a different ObsEWS for each phase of pregnancy. Introducing a different ObsEWS for each phase

might be impractical since introducing just a single standardised ObsEWS can be challenging.^{26,27}

There was also variation in the ObsEWS and the vital signs charts used in the 120 units. Most units use a chart similar to that in the CEMACH report of 2007, employing a two-colour triggering system, but in many units the chart has been modified. The remainder used an aggregate weighted triggering system requiring the calculation of an EWS. There was also variation concerning when and how to escalate care. Currently two-thirds of units use an ObsEWS that triggers when one or more markedly abnormal (red), or two or more mildly abnormal (yellow), observations occur. Superficially, these systems appear different to those based on aggregate weighted scoring systems. However, they can be considered aggregate weighted scoring systems with a triggering value of 2 (if red observations score 2 points & yellow score 1). Therefore, the issues that require resolution are (i) agreement on the range of weightings (i.e., 0-2 or 0-3), and (ii) the aggregate EWS at which care escalation occurs. These questions can only be answered following the collection and analysis of one or more large databases of maternal observations and outcomes. The design of a suitable ObsEWS chart is beyond the scope of our article.

The 2007 CEMACH report indicated that there was “...an urgent need for the routine use of a national obstetric early warning chart, similar to those in use in other areas of clinical practice...” and suggested an auditable standard for such a chart to be developed and piloting started by the end of 2008.¹ The 2011 publication by the Maternal Critical Care Working Group⁴ also recommended the introduction of a standard early warning system and chart for obstetrics. These guidelines are currently being updated and are expected to recommend the use of a standard ObsEWS incorporating six physiological parameters - respiratory rate, S_pO_2 , temperature, systolic BP, diastolic BP, and pulse rate.²⁸ These parameters would seem to have face validity because they are almost identical to those previously recommended by anaesthetists⁹ and midwives.¹⁰

There is evidence that the majority of UK obstetric anaesthetists support the need for a standardised, validated tool to prompt midwives and medical staff to summon help.^{8,9} The benefits of standardising aspects of healthcare include reduced staff confusion and misunderstanding, consistency in clinical decision-making, reduced error rate, improved reliability, transferability across organisations and the opportunity for uniform staff training.²⁹ Despite this and the validation of the CEMACH chart in 2012,¹³

there has been little progress in getting universal agreement on systems for detecting maternal deterioration in UK obstetric population. This may be because standardised systems are often perceived as a challenge to professional autonomy and jurisdiction.²⁶ Midwives may be reluctant to adopt ObsEWS, because they can see no inherent value.^{10,27} Midwives also felt that clinical judgement was superior to the ObsEWS and that informing a doctor when the ObsEWS recommended escalation was unnecessary, if the midwife believed that the woman was well.²⁷ We found no evidence that maternal concern about their perceptions of being at risk was included as a formal component of any ObsEWS triggering system.³⁰

The study has several strengths and weaknesses. It is the largest and most detailed study of ObsEWS to date. Two researchers used a common, objective, systematic approach to interrogate the early warning system charts independently, and the analysis was not subject to influence by participating centres. The assistance of the contributing units contacted was essential. However, despite trying to contact leads/units multiple times, only 65.5% of contacted units provided charts and a few were unusable. In addition, not all maternity units in the UK and Channel Islands are represented in the OAA database. Consequently, our data may be subject to non-response and volunteer bias, implying that the results may not necessarily reflect the actual use of ObsEWS in other centres. Nevertheless, the findings of variation in the design, type and structure of vital signs charts, ObsEWS and escalation systems in the units studied would be unchanged (other than in magnitude) by data from additional units.

SUMMARY

There is a lack of consensus regarding the vital sign values used to reflect physiological normality in ObsEWS used in consultant-led UK and Channel Island maternity units. Improving agreement would facilitate the introduction of a standardised national obstetric early warning chart, ObsEWS and escalation system, but this requires further research. Standardisation would improve the equality of maternal care across units.

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COMPETING INTERESTS

GBS was a co-developer of the VitalPAC clinical software system, a collaborative development of The Learning Clinic Ltd (TLC) and Portsmouth Hospitals NHS Trust (PHT). GBS was an employee of PHT until 31/03/2011. The VitalPAC software charts patient vital sign measurements and provides decision support to bedside clinical staff regarding the need for the escalation of care. GBS was a member of the following groups: Royal College of Physicians of London's National Early Warning Score Development and Implementation Group; National Institute for Health and Care Excellence Guideline Development Group on 'Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital'; National Patient Safety Agency Observatory group considering 'Deterioration not recognised or not acted on'; Department of Health Emergency Care Strategy Team's 'Competencies for Recognising and Responding to Acutely Ill Patients in Hospital'; National Cardiac Arrest Audit Steering Committee; Executive Committee of the Resuscitation Council (UK); and the RC (UK) Immediate Life Support (ILS) course working group. GBS was also a paid expert adviser to South Eastern HSC Trust concerning the Report of the Northern Ireland Audit of Physiological Early Warning Scoring Systems (2010). GBS is a co-recipient of an NIHR Health Service and Delivery Research grant into 'Nurse staffing levels, missed vital signs observations and mortality in hospital wards'. GBS is the current President of the International Society for Rapid Response Systems. DB is part funded by NIHR CLAHRC South London.

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REFERENCES

1. Lewis, G (ed). The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH, 2007.
2. National Clinical Effectiveness Committee. National clinical guideline no. 4. The Irish maternity early warning system. Dublin: Department of Health.
3. Mhyre JM, D'Oria R, Hameed AB, et al. The Maternal Early Warning Criteria: A Proposal From the National Partnership for Maternal Safety. *Obstet Gynecol* 2014; 124: 782-6
4. The Maternal Critical Care Working Group. Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman. Royal College of Anaesthetists. London, 2011.
5. American College of Obstetricians and Gynecologists Committee on Patient Safety and Quality Improvement. ACOG Committee Opinion No. 487: Preparing for clinical emergencies in obstetrics and gynecology. *Obstet Gynecol* 2011; 117: 1032-4
6. Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health. Standards for Maternity Care. Report of a Working Party. RCOG Press, London 2008.
7. Austin DM, Sadler L, McIntock C, et al. Early detection of severe maternal morbidity: A retrospective assessment of the role of an Early Warning Score System. *Aust NZ J Obstet Gyn* 2014; 54: 152-5.
8. Swanton RDJ, Al-Rawi S, Wee MYK. A national survey of obstetric early warning systems in the United Kingdom. *Int J Obstet Anesth* 2009; 18: 253-7.
9. Isaacs RA, Wee MYK, Bick DE, et al. A national survey of obstetric early warning systems in the United Kingdom: the current picture five years on. *Anaesthesia*. 2014; 69: 687-92.
10. Bick DE, Sandall J, Furuta M, et al. A national cross sectional survey of heads of midwifery services of uptake, benefits and barriers to use of obstetric early warning systems (EWS) by midwives. *Midwifery* 2014; 30: 1140-6.
11. Loerup L, Pullon RM, Birks J, Fleming S, Mackillop LH, Watkinson PJ. Trends of vital signs with gestational age in normal pregnancies: a systematic review protocol. *BMJ Open* 2016; 6: e008769. doi:10.1136/bmjopen-2015-008769.
12. Gosman GG, Baldisseri MR, Stein KL, et al. Introduction of an obstetric-specific medical

- emergency team for obstetric crises: implementation and experience. *Am J Obstet Gynecol* 2008; 198: 367.e1-367.e7.
13. Singh S, McGlennan A, England A, Simons R. A validation study of the CEMACH recommended modified early obstetric warning system (MEOWS). *Anaesthesia* 2012; 67: 128.
 14. Maguire PJ, O'Higgins AC, Power KA, Daly N, McKeating A, Turner MJ. Maternal bacteremia and the Irish maternity early warning system. *Int J Gynec Obstet* 2015; 129: 142-5.
 15. Banfield P, Roberts C. The early detection of maternal deterioration in pregnancy. Health Foundation, London, 2015.
 16. Carle C, Alexander P, Columb M, Johal J. Design and internal validation of an obstetric early warning score: secondary analysis of the Intensive Care National Audit and Research Centre Case Mix Programme database. *Anaesthesia* 2013; 68: 354-67.
 17. Behling DJ, Renaud M. Development of an Obstetric Vital Sign Alert to Improve Outcomes in Acute Care Obstetrics. *Nurs Womens Health* 2015; 19: 128-41.
 18. Yanamandra N, Chandrabaran E. Anatomical and physiological changes in pregnancy and their implications in clinical practice. In *Obstetric and Intrapartum Emergencies: A Practical Guide to Management*. Eds., Chandrabaran E, Arulkumaran S. Cambridge University Press, Cambridge 2013.
 19. Dennis AT, Hardy L. Defining a reference range for vital signs in healthy term pregnant women undergoing caesarean section. *Anaesth Intensive Care* 2016; 44: 752-7.
 20. O'Driscoll BR, Howard LS, Davison AG. BTS guideline for emergency oxygen use in adult patients. *Thorax* 2008; 63(Suppl. 6): vi1-68.
 21. Bone RC, Balk RA, Cerra FB, et al. Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. The ACCP/SCCM consensus conference committee. American College of Chest Physicians/Society of Critical Care Medicine. *Chest* 1992; 101: 1644-55.
 22. Maguire PJ, Power KA, Downey AF, O'Higgins AC, Sheehan SR, Turner MJ. Evaluation of the systemic inflammatory response syndrome criteria for the diagnosis of sepsis due to maternal bacteremia. *Int J Gynec Obstet* 2016; 133: 116-9.
 23. Singer M, Deutschman CS, Seymour CW, et al. The third international consensus definitions for sepsis and septic shock (Sepsis-3). *JAMA*. 2016; 315: 801-10.
 24. Acosta CD, Kurinczuk JJ, Lucas N, et al. Severe Maternal Sepsis in the UK, 2011-2012: A

- National Case-Control Study. *PLoS Med* 11(7): e1001672. doi:10.1371/journal.pmed.1001672
25. National Institute for Health and Care Excellence: Hypertension in pregnancy: diagnosis and management. NICE guidelines [CG107]. London; 2010, updated 2011.
 26. Mackintosh N, Watson K, Rance S, Sandall J. Value of a modified early obstetric warning system (MEOWS) in managing maternal complications in the peripartum period: an ethnographic study. *BMJ Qual Saf* 2014; 23: 26-34.
 27. Martin RL. Midwives' experiences of using a modified early obstetric warning score (MEOWS): a grounded theory study. *Evidence Based Midwifery* 2015; 13: 59-65.
 28. Quinn AC, Meek T, Waldmann C. obstetric early warning systems to prevent bad outcome. *Curr Opin Anesthesiol* 2016; 29: 268-72.
 29. Leotsakos A, Zheng H, Croteau R, et al. Standardization in patient safety: the WHO High 5s project, *Int J Qual Health Care* 2014; 26: 109-16.
 30. Rance S, McCourt C, Rayment J, et al. Women's safety alerts in maternity care: is speaking up enough? *BMJ Qual Saf* 2013;22: 348-55.

LEGENDS FOR FIGURES and TABLES:

Figure 1: Obstetric early warning chart described in the CEMACH report of 2007. Reproduced with permission of Dr.F Mcilveney, Forth Valley Royal Hospital.

Table 1: A typical obstetric early warning score

Table 2: Vital signs and other related measurements used to trigger early warning system escalation.

Table 3: Maternal symptoms and signs, and other clinical observations or measurements used as a component of obstetric early warning systems.

1 Table 1

2

	3	2	1	0	1	2	3
Breathing rate (bpm)	<10			10-14	15-20	21-30	>30
SpO2 (%)	<94			>94			
Temperature (°C)		<35.0	35.0–35.9	36.0-38.0		>38.0	
Systolic blood pressure (mmHg)	<80	80-90	91-100	101-140	141-150	151-159	>160
Diastolic blood pressure (mmHg)				<90	91-100	101-110	>110
Heart rate (bpm)	<40	41-50	51-60	61-100	101-110	111-130	>130
Level of consciousness				Alert	Responds to Voice	Responds to Pain	Unconscious

3

4

5 Table 2:

6

	HR (beats per minute)	RR (breaths per minute)	sBP (mmHg)	dBp (mmHg)	mBP (mmHg)	SpO2 (%)	T (°C)	AVPU	Use of O ₂	Urine Output (mls per hr.)	GCS
Number of discrete 'normal' ranges in use across the units surveyed for each individual vital sign.	16	14	21	15	2	12	7	2	-	-	-
Lowest value used in any 'normal' range	40	8	80	40	0	90	35.0	A or V	-	-	-
Highest value used in any 'normal' range	109	20	199	100	≤124	100	38.0	A	-	-	-
Most commonly used 'normal' range	50-99	11-20	100-149	≤89	≤124	95-100	36.0-37.9	A	-	>30	-
No. (%) using most common range	62/120 (51.7%)	64/120 (53.3%)	59/120 (49.2%)	88/117 (75.2%)	6/7 (85.7%)	59/112 (52.7%)	74/119 (62.2%)	109/112 (97.3%)	-	13/48 (27.1%)	1/1 (100%)
Used as a component of the escalation system	120/120 (100%)	120/120 (100%)	120/120 (100%)	117/120 (97.5%)	7/120 (5.8%)	112/120 (93.3%)	119/120 (99.2%)	112/120 (93.3%)	8/120 (6.6%)	48/120 (40.0%)	1/120 (0.8%)
Recorded but not used	0/120 (0%)	0/120 (0%)	0/120 (0%)	0/120 (0%)	14/120 (11.7%)	7/120 (5.8%)	1/120 (0.8%)	0/120 (0%)	101/120 (84.2%)	55/120 (45.8%)	0/120 (0%)
Not recorded or used	0/120 (0%)	0/120 (0%)	0/120 (0%)	3/120 (2.5%)	99/120 (82.5%)	1/120 (0.8%)	0/120 (0%)	8/120 (6.7%)	11/120 (9.2%)	17/120 (14.2%)	119/120 (99.2%)

7

8 HR, heart rate; RR, respiratory rate; sBP, systolic blood pressure; dBp, diastolic blood pressure; mBP, mean blood pressure; T, temperature; AVPU, (Alert-Voice-

9 Pain-Unresponsive); GCS, Glasgow Coma Scale.

10

11 Table 3:

	Recorded on vital signs charts and used as component of triggering system [n, (%)]	Recorded on vital signs charts, but not used as component of triggering system [n, (%)]	Not recorded on vital signs charts nor used as component of triggering system [n, (%)]	Used as a component of aggregate EWS [n, (%)]
Maternal pain score	76 (63.3%)	24 (20.0%)	20 (16.7%)	3 (2.5)
Characteristics of lochia	68 (56.7%)	9 (7.5%)	43 (35.8%)	0
Proteinuria	65 (54.2)	12 (10.0)	43 (35.8)	7 (5.8)
Mother looks unwell	63 (52.5%)	-	57 (47.5%)	2 (1.7)
Characteristics of amniotic fluid	47 (39.2%)	5 (4.2%)	68 (56.7%)	1 (0.8)
Presence of nausea	13 (10.8%)	25 (20.8%)	82 (68.3%)	0
Drains/blood loss	12 (10.0)	7 (5.8%)	101 (84.2%)	1 (0.8)
Uterine tone	11 (9.2%)	6 (5.0%)	103 (85.8%)	0
Sedation level	3 (2.5%)	12 (10.0)	105 (87.5%)	1 (0.8)
Briskness of maternal neuroreflexes	3 (2.5%)	7 (5.8%)	110 (91.7%)	0
Level of epidural-related motor block	3 (2.5)	5 (4.2)	112 (93.3)	0
Level of epidural-related sensory block	2 (1.7%)	6 (5.0)	112 (93.3)	0
Maternal blood glucose level	2 (1.7%)	18 (15.0)	100 (83.3)	0

12