



MEWS case review

Introduction

It can be valuable to complete a brief case review to monitor the effectiveness of the maternity recognition and response system for women. All women admitted to an intensive care (ICU) or high dependency unit (HDU) should have a detailed case review using the *Maternal morbidity review toolkit for maternity services*¹ at which time a review of the maternity vital signs chart including escalation and response should be included.

In addition to ICU or HDU admission cases, reviews are recommended for:

- women who received a total MEWS score of 8 or 9
- where there were complaints from women or whānau members about failures to recognise or respond to the woman's deterioration
- women identified through chart audit activities where recognition, escalation or response did not occur appropriately.

When available, documentation from case notes and vital sign charts should be reviewed for at least the 24 hours before the incident occurred. The key focus of the review is to determine if the maternity vital signs chart and score was used responded to appropriately.

Data and themes from case reviews should be reported for discussion and action by groups such as local quality improvement teams, the recognition and response system clinical governance committee, education and training providers, speciality morbidity and mortality meetings, or grand rounds. Individual cases may be useful as stories to engage clinicians in understanding their role in the recognition and response system, or as teaching tools in scenario-based education.

If case review identifies adverse events that have not been previously reported and/or where an open disclosure process is warranted, the usual organisational reporting guidelines must be followed including the use of the *Maternal morbidity review toolkit for maternity services*. If individual performance issues are identified, these must be referred to the appropriate clinical leader for follow up.

This template was informed by the National Confidential Enquiry into Patient Outcome and Death 'time to intervene?' review tool.²

¹ Maternal Morbidity Working Group. 2018. *Maternal morbidity review toolkit for maternity services*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3604.

² National Confidential Enquiry into Patient Outcome and Death. 2012. Cardiac arrest procedures: time to intervene? Data comparison tool. URL: www.ncepod.org.uk/2012report1/toolkit/CAP%20Data%20comparison%20tool.pdf.

Case review template

Event type	
Women who received a total MEWS score of 8 or 9	8 Tick: <input type="checkbox"/> 9 Tick: <input type="checkbox"/>
Rapid response call	Tick: <input type="checkbox"/>
Unplanned transfer to higher acuity care	Circle: ICU/CCU/HDU/other hospital
Adverse event	Circle: SAC1/SAC2/SAC3
Cardiorespiratory arrest (required CPR)	Tick: <input type="checkbox"/>
Unexpected death of the woman (death of a woman in hospital with a shared goal of care (SGOC) A or B)	Tick: <input type="checkbox"/>
Other	Specify:
Event details	
Date	__/__/__
Time	24h clock: __:__
Day of week	Circle: Mon/Tue/Wed/Thu/Fri/Sat/Sun
Woman's demographics	
Age	Years:
Ethnicity (List all identified ethnicities as per front sheet or NHI database)	Write:
Did the woman speak English as a first language? If no, was a professional interpreter involved in the 24 hours before the event?	Circle: Yes/No Circle: Yes/No
Did the woman have documented mental disability?	Circle: Yes/No
Did the woman have documented altered level of consciousness or delirium?	Circle: Yes/No
Did the woman have documented chronic mental illness?	Circle: Yes/No
Was there a valid SGOC form completed before the event?	Circle: Yes/No
Was the woman in a single room?	Circle: Yes/No
Maternity vital signs chart	
How many sets of vital signs were documented in the 24 hours before the event?	Number: _____
Was the core vital sign set documented every time? (Core vital sign set includes respiratory rate, supplemental oxygen requirement, oxygen saturation, systolic and diastolic pressures, heart rate, level of consciousness and temperature)	Circle: Yes/No
Was the MEWS score calculated correctly (with or without modification) with every set of vital signs? If no – how many sets of vital signs had an incorrectly calculated MEWS score? If no – which vital signs were not recorded?	Circle: Yes/No Number: _____ Missing signs: _____
What was the highest total MEWS score in the 24 hours before the event?	Score: _____

<p>Were any modifications to the MEWS made?</p> <ul style="list-style-type: none"> • Was clinical justification provided? • Did modification delay or prevent timely escalation? 	<p>Circle: Yes/No Circle: Yes/No Circle: Yes/No</p>
<p>Were there any acute fetal concerns that escalated maternal assessment?</p>	<p>Circle: Yes/No</p>
<p>Was care escalated in accordance to the pathway every time a MEWS score trigger was reached?</p> <p>If no – was there a documented reason for not following the escalation pathway?</p>	<p>Circle: Yes/No Circle: Yes/No</p>
<p>If care was escalated in the 24 hours before the event, was the response:</p> <ul style="list-style-type: none"> • timely (per the escalation pathway)? • appropriate (the right responder)? • effective (the interventions, treatments and ongoing plan met the woman's immediate clinical needs and any necessary follow-up was provided)? 	<p>Circle: Yes/No Circle: Yes/No Circle: Yes/No</p>
<p>Were there barriers to complete and effective response to care?</p> <p>If yes, comment (eg, high acuity, woman's choice, obstetrician in theatre).</p>	<p>Circle: Yes/No Comment:</p>
Global review questions	
<p>In your opinion, without hindsight bias, were there warning signs that the woman was at risk of deterioration in the 24 hours before the event?</p> <p>If yes, were these signs:</p> <ul style="list-style-type: none"> • recognised? • acted on? • communicated to the appropriate seniority and speciality of clinician? 	<p>Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No</p>
<p>Was there documented evidence of the woman or whānau concern in the 24 hours before the event?</p> <p>If yes, in your opinion, was this concern:</p> <ul style="list-style-type: none"> • recognised? • acted on? • communicated to the appropriate seniority of clinician? 	<p>Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No</p>
<p>Did the lead maternity carer (LMC) or responsible clinical team review the woman in the 24 hours before the event?</p> <p>If yes, in your opinion, did the plan of care demonstrate:</p> <ul style="list-style-type: none"> • appropriate recognition of the severity of illness? • documented discussion with the woman and her whānau? • an appropriate plan for monitoring the woman? • a clear plan for required interventions and treatments? • appropriate indications for further review? 	<p>Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No Circle: Yes/No</p>
<p>Does the case review team identify any system, process, or clinical issue not identified above that contributed to the event? (For example, equipment failure, communication failure, availability of staff.)</p>	<p>Specify:</p>

Abbreviations used in this template

CCU = critical care unit; HDU = high dependency unit; ICU = intensive care unit; NHI = National Health Index; MEWS = Maternity early warning score; SAC = severity assessment criteria; SGOC = shared goals of care.

New Zealand Government