Pregnancy and Postpartum 2017
Maternal Early Warning Signs Identification, Notification, Evaluation and Escalation Reference

Verify single abnormal values, do complete VS including MAP, and increase monitoring (VS and systems/OB assessments) frequency q 5-15 min until stable and concerns resolved.

Maternal Early Warning Signs

-Temp: < 96.8 F (36C)or >100.4 F (38C)
-Pulse: persistent maternal HR <=50 or >120
-Respiratory rate (RR): <10 or >=24
-BP: Systolic <90 mmHg or >=160 mmHg
Diastolic <45 or >=105
-SaO2 < 95%
-Oliguria:<35 mL for 2 hours, or <0.5 mL/Kg/hr for 2 hours

Provider bedside evaluation:

If provider evaluation is non diagnostic or the abnormal VS or S/S are felt to reflect normal physiology for that patient, a plan for subsequent patient monitoring, re-notification, and re-evaluation plan should be communicated and documented by the provider use dot phrase : OB PROVIDER BEDSIDE EVALUATION .

Maternal Signs/Symptoms:

-Visual changes
-Epigastric pain, upper right quadrant pain
-Absent DTR's on magnesium sulfate
-Agitation
-Patient with preeclampsia reporting a non-remitting headache or shortness of breath
-Significant bleeding (weigh blood loss) or suspected internal bleeding (see PPH checklist and move to OR if >1500 cc blood loss and not resolved);
- persistent maternal tachycardia
- abdominal pain or distention
- hypotension

-**Concern for infection with abnormal VS (temp and RR as above, Pulse >120, and/or WBC >15 or < 4): complete OB sepsis screen**
-MAP <70 (Mean arterial pressure = 1/3 pulse pressure + diastolic)
-Severe abdominal pain
-Hypertensive emergency (follow orderset) not controlled within 30 min, provider to the bedside by 1 hr if not controlled.

Notify provider. Provider to reassess within 1 hour if s/s not resolved

-Notify Charge Nurse as soon as concerns are recognized
-Notify provider, prompt beside evaluation for persistent signs/symptoms or positive OB sepsis screen. Document assessments, interventions, and communications (urgent concerns call OB Hospitalist- if available)

Provider notification using SBAR, prompt beside evaluation & documentation

Rapid Response (Code Blue as indicated), Call OB Hospitalist, and Anesthesia and notify primary provider

- □ Chest Pain
- □ Suspected Sepsis (complete OB sepsis screening tool)
- □ Shortness of breath
- □ Unresponsiveness
- □ Change in neuro status including;
  - Confusion
  - Focal neuro deficits
  - Seizure
  - Suspected stroke
- □ Unwitnessed fall or fall with suspected injury
- □ Concern for maternal stability