(Affix patient identification label here)

Queensland Government
Queensland Health

General Observation Chart

The Prince Charles Hospital

Admission Weight	URN:
Height	Family name:
	Given names:
BMI	Address:
	Date of Birth: Sex: ☐ M ☐ F

NOT A VALID DOCUMENT UNLESS IDENTIFIERS PRESENT

Modified Early Warning Scores	0	1	2	3	Observation chart number:	1	2	3	4	5

Date																						
Time																						
Resp Rate Breaths / min	≥ 36																					
	31 – 35																					
	21 – 30																					
	9 – 20																					
	≤ 8																					
RR Score																						
Delivery mode																						
FiO_2 or l/min																						
SaO_2 (%)	≥ 93																					
	90 – 92																					
	85 – 89																					
	≤ 84																					
$Sp0_2$ Score																						
Temp (oC)	≥ 39.6																					
	38.6 – 39.5																					
	38 – 38.5																					
	37 – 37.9																					
	36.1 – 36.9																					
	35.1 – 36																					
	34.1 – 35																					
	≤ 34																					
Temp Score																						
(↔) Blood Pressure (mm Hg) & **Heart Rate (•)** (beats / min) **Usual SBP:**	200																					
	190																					
	180																					
	170																					
	160																					
	150																					
	140																					
	130																					
	120																					
	110																					
	100																					
	90																					
	80																					
	70																					
	60																					
	50																					
	40																					
Rhythm																						
Score HR																						
Score BP (see back)																						
Sedation Score (see back)	0																					
	S																					
	1																					
	2																					
	3																					
Sedation Score																						
Urine for 4hrs (ml)	> 800																					
	120 – 800																					
	80 – 119																					
	< 80																					
Urine Score																						
TOTAL MEWS																						

DO NOT WRITE IN THIS BINDING MARGIN

FRT378 07/09

General Observation Chart

General Observation Chart.indd 1 17/07/09 6:29 AM

Date																							
Time																							
Pain Score	At rest																						
	Movement																						
Nausea / Vomiting																							
Bowels																							
Weight																							

Delivery Mode
RA = Room air
NP = Nasal prongs
H = Hudson mask
V = Venturi mask
R = Non re-breather
B = Bi-level
C = CPAP

Rhythm
R = regular
I = irregular
or monitored rhythm

Sedation Score
0 = awake & alert
S = normal sleep, responds to stimuli
1 = mild, occasionally drowsy, easy to rouse
2 = moderate, rousable but not able to stay awake
3 = severe, difficult to rouse or unrousable

Pain Score
0 = No pain
10 = Worst pain

Nausea Score
0 = no nausea/ vomiting
1= occasional n/v
2 = persistent n/v
3 = n/v during last hour

Glasgow Coma Scale (GCS)

Eyes opening	4 = spontaneously 3 = to speech 2 = to pain 1 = nil
Verbal response	5 = oriented 4 = confused 3 = inappropriate words 2 = incomprehensible sounds 1 = none
Motor response to pain	6 = obeys 5 = localises 4 = withdraws 3 = abdominal flexion 2 = extension 1 = nil

Other Information
- Breath sounds
- Heart sounds
- Perfusion pulse R-L temp
- Pupils size R-L reaction
- GCS
- Urinalysis
- IV cannula
- ICC - swing
  - air loss
  - drainage/obs
  - total drainage
  - suction

Circle patient's usual Systolic Blood Pressure

Current Blood Pressure (mm Hg)	Usual SBP	190	180	170	160	150	140	130	120	110	100	90	80
	200s	0	0	1	1	2	2	2	3	3	4	5	5
	190s	0	0	0	1	1	1	2	2	3	3	4	4
	180s	0	0	0	0	0	1	1	2	2	3	3	4
	170s	1	0	0	0	0	1	1	2	2	3	3	3
	160s	1	1	0	0	0	0	0	1	1	2	2	2
	150s	1	1	1	0	0	0	0	0	1	1	2	2
	140s	2	1	1	1	0	0	0	0	0	1	1	1
	130s	2	2	1	1	0	0	0	0	0	0	0	1
	120s	2	2	2	1	1	0	0	0	0	0	0	0
	110s	3	2	2	2	1	1	0	0	0	0	0	0
	100s	3	3	3	2	2	2	1	1	0	0	0	0
	90s	4	3	3	3	2	2	2	2	1	1	0	0
	80s	4 (MET)				3 (MET)				2 (MET)		1	0
	70s											1 (MET)	

MET Criteria

Consider if MEWS ≥ 8

Threatened Airway

RR < 8 or > 36 breaths / min

New drop in SpO_2 < 90%

Pulse < 40 or > 140 beats / min

New Systolic BP < 90 mm Hg

Sudden fall in level of consciousness, fall of GCS > 2

Repeated or prolonged seizures

Any patient you are seriously worried about that does not fit the above criteria. Discussed with team leader

Date/Time	**Modification to MEWS**	Signature

Nurse Action if MEWS ≥ 4 (Document details in progress notes)

Date/Time	MEWS	**Escalation** e.g. called RMO at 0230	Signature

DO NOT WRITE IN THIS BINDING MARGIN

Adapted with permission from "ACT Health COMPASS"

General Observation Chart.indd 2 17/07/09 6:29 AM