
TITLE	Observations - Minimum Standards
DESCRIPTION	Outlines the minimum standards required for performing observations
TARGET AUDIENCE	All Medical and Nursing Staff
FACILITY/SERVICE	The Prince Charles Hospital

Purpose.

Identify the minimum required timeframes and measurement standards for performing and documenting patient observations for clinical staff.

Principle.

Measurable physiological abnormalities occur prior to adverse events such as cardiac arrest, unanticipated admission to intensive care and unexpected death. Regular measurement, interpretation and documentation of observations are an essential requirement in recognising clinical deterioration.

Minimum Standards for Assessment and Documentation of Observations.

Observations should be taken on all patients in an acute care setting. The frequency of observations should be consistent with the clinical situation and condition of the patient.

- Acute inpatients at TPCH are to have their observations assessed on admission and at least four times daily. (E.g. at 0600, 1100, 1600, and 2100hours. These times optimise patient assessment, consider shift changes, and allow for patient rest after lunch and overnight.)
- Alternative timing for the frequency of observations can be dictated by work unit guidelines, clinical pathways or specific medical orders.
- Inpatient Mental Health patients are to have their observations assessed a minimum of once daily. If the patient is either > 60 years or Indigenous and > 45 years the minimum observations are increased to twice daily.

The frequency of observations should be consistent with clinical assessment. Therefore, additional observations should be performed if the observations are abnormal or if there are any concerns regarding the patient.

Documentation

The patient's observations are documented on the Observation Chart (MEWS). The relevant scores are written in the green 'score line'. All the scores are added together to provide a total Modified Early Warning Score (MEWS) on the blue 'score line'. The MEWS allocates a score which represents the physiological abnormality and is used to identify the escalation pathway for review.

For information refer to procedure [TPCHS10085 Modified Early Warning Score \(MEWS\), Escalation and ISBAR.](#)

Observations to be Assessed.

Observations are to be documented on the relevant General Observation Chart (MEWS). Observations to be recorded are as follows:

1. Heart Rate (beats/min)

- Assessed by palpation of radial artery. Do not use pulse oximetry equipment to record pulse.

- Count pulse for 30 seconds and then double it to get beats/min.
- If a patient has an irregular pulse then the heart rate should be counted over 60 seconds **and** checked by auscultation of the apex beat.

2. Respiratory Rate

- Pretend to count the radial pulse for another 30 seconds but instead count the respiration rate by visualising chest movement (rise and fall). Double this number to get breaths/min.

3. Oxygen Saturation: Routinely measured with other observations.

4. Blood Pressure

Use a manual sphygmomanometer:

- For the first set of observations i.e. on admission, after procedures and after operations.
- If systolic blood pressure is less than 100mmHg.
- When a patient has a change in heart rhythm and/or deteriorates.

The Blood pressure is charted on the graph, but scored using the table on page 2 of General Observation Chart (MEWS). The usual or target BP necessary for scoring the systolic BP can be sourced from entries in:

- Preadmission Clinic.
- Outpatient clinics.
- Previous admissions.
- Information from the patient, family or General Practitioner.
- A reading from the Emergency Department if the patient's condition is stable.
- If uncertain consult with a medical officer.

5. Temperature: Method of measurement appropriate for the patient's clinical condition.

6. Sedation: Document the level of sedation as outlined on page 2 of the General Observation Chart.

7. Urine Output (mls/4hrs).

- This should only be documented and scored on the observation chart when there is an accurate collection over the previous four (4) hours.
- This can be either IDC measures (over previous four (4) hours) in a catheterised patient
or
- Timed natural urine collection (only if over four (4) hours).
- Write the number of mLs in the appropriate box. Do not tick the box.
- If a timed collection is not available, it is acceptable to document urine out put as PUIT (Passed Urine in Toilet) vertically in the relevant column.

Clinicians may choose to also document other observations and assessments to support the timely recognition of deterioration in the patient's status.

REVIEW OF DOCUMENT

Version Update Changes

New Document

MARKETING/COMMUNICATION

Marketing/Communication Responsibility

NM Policy & Procedure - Facility

Marketing/Communication Strategy

- Email Notification to Nursing Gr. 7-9, Medical Directors, Medical HOD & Medical Consultants for dissemination to all staff
- Publish on QHEPS
- Note at Program Management Meetings
- Inclusion in Orientation for all wards/units

AUDIT STRATEGY

Level of Risk

Medium

Audit Strategy

Monitoring

Audit Tool Attached

No

Audit Date

12 monthly with annual review

Audit Responsibility

Medical Director Patient Safety

Key Elements/Indicators/Outcomes

- Ward/Unit Weekly Audit MEWS score accuracy & completion

REVIEW STRATEGY

Minor Review Date 1

31 Dec 2011

Minor Review Date 2

31 Dec 2012

Major Review Date

31 Dec 2013

Review Responsibility

Medical Director of Patient Safety

PUBLISHING INFORMATION

Version

V1

Version Date

16 Dec 2010

Effective Date

16 Dec 2010

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Replacement For

New Document

Information Source

Australian Commission on Safety and Quality in Health Care - National consensus statement: Essential elements for recognizing & responding to clinical deterioration (22 April 2010)
School of Psychology, The University of Queensland – Developer's Guide for Observation and Response Charts (Oct 2010)

SEARCH INFORMATION

Key Words

Observations, Vital Signs, MEWS, Modified Early Warning Score, Assessment, Documentation

EQuIP and other Standards

Clinical 1.1.1, 1.1.4, 1.1.8 Support 2.3.1

Approval

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