

1 Good Practice Paper No. 12

3 Implementing Safe and Effective Handover in Maternity and Gynaecology

5 This is the second edition of this guidance. It replaces the previous edition published in December
6 2010 under the title *Improving Patient Handover*.

8 This guidance is for healthcare professionals who care for women, non-binary and trans people in
9 maternity and gynaecology.

11 Within this document we use the terms woman and women's health. However, it is important to
12 acknowledge that it is not only women for whom it is necessary to access women's health and
13 reproductive services in order to maintain their gynaecological health and reproductive wellbeing.
14 Obstetric and gynaecological services and care must therefore be appropriate, inclusive and
15 sensitive to the needs of those individuals whose gender identity does not align with the sex they
16 were assigned at birth.

18 1. Purpose

20 Handover of care is recognised as an area requiring improvement to ensure provision of safe care.¹
21 There is a wide variation in practice among units in the UK, with no general agreed consensus on
22 what constitutes a gold standard.

24 This paper aims to provide a framework for those working in women's health to handover clinical
25 data and key safety information in an effective and efficient way.

27 2. Introduction

29 Effective handovers form the backbone of continuity of patient care and are crucial for patient
30 safety. Changing working patterns and rotas have led to an increase in the number of healthcare
31 professionals involved in the care of each patient. This makes it even more vital that consistent,
32 accurate, and timely information is transferred between outgoing and incoming teams. Optimising
33 this communication is essential to mitigate risk and safeguard patients.

35 Structured handovers are essential to facilitate appropriate clinical decision making and to plan
36 future management, resulting in continuity of care across progressive shifts.^{2,3} They reduce the
37 likelihood of clinical errors and, in maternity care, contribute to a decrease in negligence claims and
38 the associated financial burden on healthcare services.⁴

40 While handovers can present valuable opportunities for learning, their primary purpose is the safe
41 and effective transfer of care. Educational input should therefore be concise and purposeful, so as
42 not to compromise the safety, efficiency, or clarity of the process.

44 How handover is undertaken will vary across services, but all women's health teams are
45 multiprofessional.⁵ Commonly midwifery, nursing, anaesthesia, obstetric, and gynaecology
46 handovers occur at different times because of operational differences. Nonetheless, the information
47 shared across these disciplines must be consistent and integrated to support seamless care.

49 Several national and international organisations have published guidance on safe handover
50 practice.^{6–8}

- The British Medical Association *Safe Handover: Safe Patients*, which advocates for structured handovers supported by standardised proformas and appropriate information technology (IT) systems.⁶
- The National Institute for Health and Care Excellence (NICE) guideline [NG94] *Emergency and acute medical care in over 16s: service delivery and organisation*, which highlights that structured handovers can reduce adverse events such as data omissions and near misses.⁷
- The World Health Organization (WHO), which includes actions on care transitions, such as handovers, in its Global Patient Safety Action Plan 2021–30.⁸

Inadequate handovers compromise patient safety. At-risk patients may be missed, there may be delayed recognition of deteriorating patients, postoperative and peripartum complications, medication errors, prolonged admissions, patient dissatisfaction, and missed follow-ups. Senior clinicians, such as consultants and midwife or nurse in charge, should be directly involved during formal handovers on labour ward (typically 08:00/13:00/evening) and at the end of gynaecology shifts in order to mitigate such risks. Informal handovers between staff may not require presence of senior staff, but the principles of safe and effective communication outlined in this paper should be followed. **Clinicians must also acknowledge concerns expressed by the women and their families and ensure that these are noted in the handovers.**

Both ‘huddles’ and handovers are recommended to enhance patient safety, but they are different processes:

- **Handover:** The purpose is to share clinical information with the aim of transferring clinical responsibility for ongoing care.⁵
- **Huddle:** The purpose is to improve patient safety through enhanced situational awareness and usually involves a broader set of information.⁵ Huddles can be initiated anytime during a shift when there is a concern about losing situational awareness.

3. Key principles of effective handover

For effective handovers local units should develop a set of localised expectations for multiprofessional team members. This should involve the team deciding on a set of core principles (for example, RCOG/RCM Each Baby Counts: Learn & Support ‘Team of the Shift’⁹) to ensure handover is as efficient and safe as possible. All trusts/health boards should have a policy or standard operating procedure on effective handover that individual sites can adapt to ensure handover is fit for purpose in each unit.⁴ Table 1 outlines five key elements of effective handover. Table 2 provides further detail on the individual components.

Table 1: Elements of effective handover (adapted from Till et al.¹⁰).

WHO	should be involved?
WHEN	should it take place?
WHERE	should it occur?
HOW	should it happen?
WHAT	needs to be handed over?

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Table 2: Maternity and gynaecology considerations for an effective handover.

	General guidance	Maternity	Gynaecology
WHO	<ul style="list-style-type: none"> • Agree appropriate multiprofessional presence. <ul style="list-style-type: none"> ○ Consider a sign in sheet to document attendance and create an audit trail. • The handover leader (designated clinician) should: <ul style="list-style-type: none"> ○ Start by asking all team members to introduce themselves. ○ Confirm instructions about how each member can be contacted throughout the shift (e.g. check bleeps are working). • Should be aware of any new members of the team and that adequate arrangements are in place to familiarise them with local systems and hospital geography. 	<ul style="list-style-type: none"> • Obstetric consultants and residents, midwives, anaesthetic consultants and residents, and where appropriate neonatal doctors and theatre teams. • Following the Ockenden review, consultant obstetric presence is expected twice a day at maternity handovers and ward rounds.¹¹ 	<ul style="list-style-type: none"> • Where appropriate, key personnel, including incoming and outgoing consultants, residents, and gynaecology nurses. • Consultants must be involved in the care given to women who have prolonged admissions, recurrent attendances or those for whom there is not a clearly established diagnosis.¹² This is in line with RCOG recommendations that all patients should be reviewed by a consultant within 12–14 hours of admission.^{12,13}
WHEN	<ul style="list-style-type: none"> • Handover should have start promptly at specified times (e.g. 08:00/20:00). In many units, there are additional handovers throughout the day (e.g. morning consultant handing over to afternoon consultant, day registrar handing over to afternoon registrar, midwifery and nursing staff handovers, handovers for breaks and at the start/end of shift]). • The time of handover should be known to all staff and interruptions should be minimised, unless in emergency circumstances. • There should be adequate time set aside for handover (up to 30 minutes depending on list size) and this should be included in ‘working time’.⁵ 		
WHERE	<ul style="list-style-type: none"> • Delivering effective and safe maternity and gynaecology handover is a clinical governance issue and trusts/health boards must 	<ul style="list-style-type: none"> • Ideally, trusts/health boards should designate a dedicated room for maternity handovers located on or close to area of maternity workload, such as Delivery Suite. 	<ul style="list-style-type: none"> • Ideally, trusts/health boards should designate a dedicated room for gynaecology handovers located close to area of high gynaecology workload, such as Early Pregnancy Assessment Unit

	<p>mandate an appropriate environment for this.</p> <ul style="list-style-type: none"> • A designated room to ensure patient confidentiality. • Staff should only be called out if there is an emergency. • The designated location should have access to laboratory and imaging results, clinical information, internet/intranet and telephones. 	<ul style="list-style-type: none"> • ‘Handover in progress’ sign should be displayed on room door.⁵ • Midwifery coordinator to give drug cupboard keys to senior outside staff and make clear the name of the member of staff who has the keys.⁵ 	<p>(EPAU) or gynaecology triage. Acknowledging that in smaller units a single consultant may be responsible for both obstetrics and gynaecology, if a dedicated room is not available because of logistics, the handover should be conducted in an environment free from distractions.</p>
HOW	<ul style="list-style-type: none"> • Preferably using a standardised electronic handover database accompanied by verbal handover. Clinical information should be conveyed using a structured communication tool such as SBAR (Situation, Background, Assessment and Recommendation).^{14–16} • When available, an electronic handover database can be used to produce an audit trail. An example of a recommended handover template for gynaecology can be seen in Appendix I. 		
WHAT	<ul style="list-style-type: none"> • Risk stratifying patients who need to be seen more urgently to enable the incoming team to formulate action plans and task allocations in priority order. <ul style="list-style-type: none"> ○ Those inpatients whose ‘early warning scores’ are deteriorating, as determined by a traffic light system (NEWS2 or locally adapted MEWS/MEOWS to include CTG concerns) – see Appendices III and IV.^{16–18} 	<ul style="list-style-type: none"> • All women on labour ward using the structured communication tool. • The following information should be handed over to allow prioritisation of activity: <ul style="list-style-type: none"> ○ Inductions of labour awaiting transfer to labour ward. ○ Inductions of labour awaiting commencement. ○ Neonatal unit capacity (open or closed to admissions). ○ Activity in maternity triage and any women likely to be admitted or readmitted to labour ward. ○ Planned caesarean list activity (even if a separate team covers ‘elective’ cases, the on call team should be made aware of any complexities anticipated). 	<ul style="list-style-type: none"> • Accurate location of all women, especially outliers (as many units now do not have ringfenced gynaecology beds). • Accepted and referred women to be assessed. • Women who are scheduled for planned emergency Confidential Enquiries into Perioperative Deaths (CEPOD) theatre should be discussed in a structured manner detailing how much of the preoperative preparation has already been undertaken to enable smooth transition of care. The use of checklists might help in the care of these women. • Women who have attended EPAU or gynaecology triage who are scheduled for surgical procedures or further management. Stable cases presenting

		<ul style="list-style-type: none"> • Women awaiting theatre for non-elective delivery or other procedures with details of what preoperative preparation has been undertaken. The use of checklists might help in the care of these women. • Admissions and planned reviews of outliers (e.g. pregnant women with medical comorbidities admitted to other wards). • For handover on antenatal/postnatal wards, safe handover and appropriate senior input is important. Complex antenatal/postnatal patients or postnatal readmissions should be reviewed by a consultant promptly. 	<ul style="list-style-type: none"> overnight with early pregnancy complications and needing EPAU assessment the following morning can be discharged home, but electronic handover database information including the woman’s details and contact number should be shared with EPAU staff. • Complex postoperative cases that may need further review.
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Peer Review

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97 *3.1 Situation, Background, Assessment and Recommendation (SBAR) tool*

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99 The SBAR (Situation, Background, Assessment, and Recommendation) tool is used to share critical
100 clinical information that requires attention and action. Standardised communication improves
101 efficiency, allow problems to be escalated, promote safety culture and enable expressions of
102 concern.¹⁶

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104 In the context of handover, SBAR may be applied as follows:

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- 106 • **Situation:** this is the ‘headline’ news highlighting the immediate situation. For example, on
107 labour ward it should answer the question: why is the woman here and what is happening to her
108 now?
- 109 • **Background:** this comprises the woman’s obstetric/gynaecological and, when relevant, medical
110 history, which may include date of admission, current medications, allergies, investigations,
111 progress during admission and imaging results.
- 112 • **Assessment:** clinical assessment e.g. observations, recent treatment/management and detailed
113 expression of concerns.
- 114 • **Recommendation:** this involves the management plan, making suggestions and being specific
115 about requests and time frame.

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117 **4. Documentation and information management**

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119 Written or electronic handover tools are essential for documenting information, serving as a reliable
120 reference for incoming teams and reducing dependence on memory. It is incumbent upon the on-
121 call team to maintain up-to-date and accurate patient records that reflect current status and care
122 plans. While printed copies may be provided to team members for further annotation, storing a
123 copy in electronic form creates an audit trail of the information handed over.

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125 To maximise efficiency and accuracy,¹⁹ it is recommended that if an electronic handover tool is used,
126 that it should be fully integrated with other clinical information systems. This enables auto-
127 population and update of patient locations and important clinical information, eliminating the need
128 for manual data entry of test results.

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130 **5. Training and education**

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132 The clinical handover process can provide a learning opportunity for any team member. However,
133 this should not negatively impact the primary purpose of the handover as previously described, and
134 the 30 minutes recommended for handover should not substitute formal teaching.

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136 A well-structured handover typically begins with a brief introductory session to enhance situational
137 awareness among team members. It is the leader's responsibility to foster an environment of open
138 communication, encouraging interaction and questions from all participants. This enhances
139 comprehensive information transfer and promotes active learning and critical thinking among
140 members with training needs.

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142 Identifying learning needs and objectives of every team member at the outset can enhance the
143 educational value of handovers. The RCOG ‘Team of the Shift’ initiative explores this in greater
144 detail.⁹ Task allocation should be undertaken using closed-loop communication.

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146 The importance of handovers in medical training is recognised by regulatory bodies such as the
 147 General Medical Council, which includes questions about handovers in its National Training Survey.
 148 This underscores the significance of handovers as both a clinical and educational tool in the
 149 development of O&G and other residents.

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 151 **6. Human factors**

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 153 It is now well recognised that human factors play a crucial role in effective and safe handovers.
 154 While not exhaustive or definitive, handover teams should be aware of the following domains:
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- 156 • Using closed-loop communication.
- 157 • Using a formal handover structure, e.g. SBAR.
- 158 • Having a broad 'helicopter view' to avoid fixation errors.²⁰
- 159 • Fostering a shallow authority gradient work environment,²¹ where all members of the team are
 160 empowered to share their views and seniors to actively listen.
- 161 • Rudeness in handovers can make the whole team lose focus and fosters disrespectful
 162 relationships. Conversely, promoting a civil and collegiate handover ensures that crucial clinical
 163 information can be shared effectively.²²
- 164 • Managing and prioritising work.
- 165 • Minimising distractions ('sterile cockpit approach'). This is a concept practised by aviation where
 166 during 'take off' and 'landing', the cockpit is locked to prevent any distractions from other staff
 167 members. A similar approach should be adopted during handover to avoid distractions and
 168 ensure a streamlined transfer of information.
- 169 • Use of checklists (rather than relying on memory).
- 170 • Psychological and physical safety of the outgoing team: ensure that the outgoing members are
 171 debriefed (if necessary) and can get home safely (e.g. not too exhausted to drive).

172
 173 **7. Quality assurance and improvement**

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 175 Currently there is wide variation in practice in relation to clinical handovers in O&G, which this
 176 guidance aims to reduce, while acknowledging the practical challenges of achieving standardisation.
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178 It is important to emphasise that delivering a structured handover is not an innate skill; training is
 179 essential to ensure its benefits are fully realised.
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181 To continuously improve the process, regular feedback should be used to identify areas for
 182 enhancement. A template for feedback of a daily handover is included in Appendix II, based on a UK
 183 study by Banerjee et al.²³ This could be adapted for both maternity and gynaecology services. A list
 184 of auditable standard is included below.
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186 In order to facilitate sustainable change, there must be support from users and hospital
 187 management boards.
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189 **8. Mitigating common challenges**

<p>Increased patient list size</p>	<p>Consider fluidity with staffing ratio in the on-call team to meet clinical demands.</p> <p>In trusts/health boards with no separate consultant rotas for obstetrics and gynaecology, there must be a risk assessment</p>
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	and escalation protocol for periods of competing workload. This must be agreed at board level. ¹¹
Multiple frequency changes of lead/on-call consultant	For complex cases, consultant to consultant handover should be undertaken.
Lack of consultant presence at handover	<p>In maternity, national recommendations mandate twice daily consultant-led ward rounds which are better facilitated following standardised handover models.¹¹</p> <p>Incorporate gynaecology handover presence into job plans and ensure discussion in the consultants' meeting.²³</p> <p>This might be an issue in units where obstetric consultants also cover gynaecology on-call services, particularly on weekends, and hence there should be agreed systems in place to ensure consultant presence at handover taking this issue into account.</p>
Handing over in theatres	<p>On-call team to regularly update the theatre teams of any emergencies to ensure timely prioritisation of emergencies with minimal disruption of elective work.</p> <p>Individual units should have strategies, e.g., dedicated resident, to ensure prebooked semi-elective work is carried out independent of the on-call team ensuring time for handover.</p> <p>Devise checklist for women awaiting theatre so that night team complete it before morning handover. This will likely ensure investigations and pre-theatre arrangements are up-to-date.</p>
Handing over urgent outstanding results for those who are discharged	There should be a local process to hand over urgent investigations that need to be followed up. These should include women on the maternity and gynaecology wards, outlier women admitted under other teams or recently discharged women with outstanding investigations (e.g. ultrasound imaging), or urgent results that would inform a recently discharged patient (e.g. swab results to inform antibiotic choice). These need to be documented on the handover list to ensure the incoming team is aware of outstanding tasks.

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9. Conclusion

Effective multiprofessional handovers are integral to women's healthcare in all settings. Collaboration across professional boundaries is essential to develop local tools and processes to enhance handover of care. Strong senior leadership, constructive behaviours and values respected across all trusts/health boards are required to embed these practices locally for the benefit of staff, women, and their families.

200 List of auditable standards

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Standard	Description	Target	Audit method
Twice daily multiprofessional handover	Multiprofessional team handovers must occur twice daily on labour ward.	≥ 90%	Attendance logs, handover record
Timely start of handover	Handovers must begin promptly at scheduled times (e.g. 08:00/20:00), excluding emergency delays.	≥ 90%	Direct observation/staff feedback
Documentation of attendance	A sign-in sheet must be used to document attendance at every formal handover.	≥ 90%	Review of attendance records
Consultant presence at handover	A named consultant must lead or be present at least twice daily for maternity and gynaecology handovers.	≥ 90%	Consultant rotas, handover sheets
Use of structured format (e.g. SBAR)	All clinical handovers must follow a structured format.	100%	Spot-check audit of handover databases
Identification of women at high risk	Women at high risk must be clearly flagged and handed over using the standard template.	≥ 90%	Template review, audit of case notes
Inclusion of staffing and escalation plans	Each handover must include a discussion of staffing levels, known risks and escalation plans.	≥ 90%	Review of handover records or staff survey
Handover records	All handovers must be recorded in an auditable system to ensure continuity and traceability.	≥ 90%	Handover database audit

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Appendix I Daily handover proforma for quality assurance (reproduced from Banerjee et al. 2024²³)
(select appropriate sections for obstetric or gynaecology handover)

Date:

Time:

A. Team presence

1. Day Consultant – Yes/No
2. Night Registrar – Yes/No
3. Night SHO – Yes/No
4. Midwifery or Nursing staff – Yes/No
5. Day Registrar – Yes/No
6. Day SHO – Yes/No
7. Anaesthetist for delivery suite – Yes/No

B. Inpatient handed over in SBAR format – Yes/No

C. Sick/septic patients handed over – Yes/No

D. Patient awaiting CEPOD theatre handed over – Yes/No

E. Maternity outliers handed over- Yes/No

F. Pending referrals handed over – Yes/No

G. New admissions handed over – Yes/No

H. Unit capacity that may influence patient flow handed over – Yes/ No

If No to any answer, the reason behind: _____

Appendix III: Traffic light triage system to determine urgency of assessment and intervention (adapted from Hodge et al. 2018¹⁷)

GREEN
NEWS2 0–4 and does not meet criteria for sepsis
AMBER
NEWS2 ≥ 5 or ≥ 3 in one parameter and does not meet criteria for sepsis Or clinical judgement that green is not appropriate
RED
NEWS2 ≥ 7 or meets criteria for sepsis Or immediate review is appropriate given presenting complaint Or due for emergency theatre imminently

NEWS2, National Early Warning Score

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Appendix IV: Maternal Early Obstetric Warning Score (MEOWS) system to facilitate prioritisation of reviews following maternity handovers.^{18,24}

Maternity Early Warning Score (MEWS)

Hospital sticker with patient details



MEWS score	0	1	2	A score for each vital sign is required at each entry														
	DATE						DATE											
	TIME						TIME											
Respirations Breaths/min	≥25						2						≥25					
	22-24						1						22-24					
	18-21						0						18-21					
	13-17												13-17					
	9-12												9-12					
	7-8						1						7-8					
≤6						2						≤6						
SpO₂ Oxygen saturation (%)	≥95						0						≥95					
	93-94						1						93-94					
	≤92						2						≤92					
Temperature °C	≥37.5						2						≥37.5					
	37.3-37.4						1						37.3-37.4					
	36.8-37.2						0						36.8-37.2					
	36.2-36.7												36.2-36.7					
	35.7-36.1						1						35.7-36.1					
	≤35.6						2						≤35.6					
Pulse Beats/min	≥131						2						≥131					
	122-130						2						122-130					
	113-121						1						113-121					
	99-112												99-112					
	86-98						0						86-98					
	71-85												71-85					
	≤62						1						≤62					
Pulse - from 48 hours post birth ONLY Beats/min	≥108						2						≥108					
	99-107						1						99-107					
	85-98												85-98					
	71-84						0						71-84					
	58-70												58-70					
	≤50						1						≤50					
Date & time to commence monitoring:																		
Systolic blood pressure mmHg	≥175						2						≥175					
	160-174						2						160-174					
	145-159						2						145-159					
	136-144						1						136-144					
	121-135												121-135					
	111-120						0						111-120					
	101-110												101-110					
	94-100						1						94-100					
	77-93						2						77-93					
	≤60						2						≤60					
Diastolic blood pressure mmHg	≥110						2						≥110					
	97-109						2						97-109					
	89-96						1						89-96					
	80-88												80-88					
	70-79						0						70-79					
	62-69												62-69					
	57-61						1						57-61					
	≤56						2						≤56					
MEWS TOTAL												MEWS TOTAL						
Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.																		
Healthcare professional concerned																		
Woman/family concerned																		
Significant additional therapies (e.g. Oxygen)																		
Increased pain (analgesic requirement)																		
Significant vaginal bleeding																		
Reduced urine output																		
Altered level of consciousness/responsiveness																		
Monitoring frequency												Monitoring frequency						
Escalation of care YES/NO												Escalation of care YES/NO						
Initials												Initials						

Refer to back page for thresholds and triggers

Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	<=6	7-8	9-21	22-24	>=25
	SpO ₂ Oxygen saturation (%)	<=92	93-94	>=95	-	-
	Temperature °C	<=35.6	35.7-36.1	36.2-37.2	37.3-37.4	>=37.5
	Pulse Beats/min	<=62	63-70	71-112	113-121	>=122
	Pulse (from 48 hours post birth) Beats/min	<=50	51-57	58-98	99-107	>=108
	Systolic blood pressure mmHg	<=93	94-100	101-135	136-144	>=145
	Diastolic blood pressure mmHg	<=56	57-61	62-88	89-96	>=97

+

Additional concerns	
<p>If one or more of these additional concerns are present, consider:</p> <ol style="list-style-type: none"> 1. Increasing the frequency of observations to a minimum of every 30 minutes 2. Escalate in line with a low-medium level of concern even if MEWS less than 2 3. Where MEWS is greater than 2 raising the level of concern to the next category. 	<ul style="list-style-type: none"> Healthcare professional concerned Woman/family concerned Significant additional therapies (e.g. Oxygen) Increased pain (+/- analgesic requirement) Significant vaginal bleeding Reduced urine output Decreased level of consciousness/responsiveness

↓

Thresholds and triggers				
<ul style="list-style-type: none"> The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation 				
Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent
<ul style="list-style-type: none"> When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation The section pulse (from 48 hours after birth) cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart. 				

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The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in 20XX, unless otherwise indicated.

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This means that RCOG guidance is unlike protocols or guidelines issued by employers, as it is not intended to provide prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.