Vital Signs	Date / Time (24 hour)	EWS	Date / Time (24 hour)
Respiratory Rate (breaths/min) *write value in box*	> 35	MET	> 35
	25-35	3	25-35
	21-24	2	21-24
	12-20	0	12-20
	9-11	1	9-11
	5-8	3	5-8
	< 5	MET	< 5
Supplemental O_2	*write value* L/min	2	L/min
O_2 Saturation (%) *write value in box*	≥ 96	0	≥ 96
	94-95	1	94-95
	92-93	2	92-93
	≤ 91	3	≤ 91
Temperature (°C) *mark with X* *write value if off scale*	≥ 39s	2	≥ 39s
	38s	1	38s
	37s	0	37s
	36s		36s
	35s	1	35s
	≤ 34s	2	≤ 34s
Blood Pressure (mmHg) *score systolic value only*	Write ≥ 220	3	Write ≥ 220
	210s		210s
	200s		200s
	190s		190s
	180s		180s
	170s		170s
	160s	0	160s
	150s		150s
	140s		140s
	130s		130s
	120s		120s
	110s		110s
	100s	1	100s
	90s	2	90s
	80s	3	80s
	70s		70s
	60s	MET	60s
	50s		50s
Heart Rate (bpm) *mark with X*	Write ≥ 140	MET	Write ≥ 140
	130s	3	130s
	120s	2	120s
	110s		110s
	100s	1	100s
	90s		90s
	80s	0	80s
	70s		70s
	60s		60s
	50s		50s
	40s	2	40s
	30s	MET	30s
Level of Consciousness ✓	Alert	0	Alert
	Voice / Pain	3	Voice / Pain
	Unresponsive	MET	Unresponsive
EARLY WARNING SCORE TOTAL			**EWS TOTAL**

Pain	*write score (0-10)*	Move / Rest	Move / Rest
Urine Output ✓	Catheter	> 100mls / 4h	> 100mls / 4h
		< 100mls / 4h	< 100mls / 4h
	No catheter	PU last 8h	PU last 8h
		Not PU last 8h	Not PU last 8h

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Surname: .... NHI: ....
First Names: ....
Date of Birth: ..../......./........ Sex: ....
PLACE PATIENT ID HERE

Wellington Adult Vital Signs Chart

Medical Staff Modification to Early Warning Score (EWS) Triggers

The EWS can be changed to prevent chronic disease incorrectly triggering escalation. This can only be authorised by a Consultant or Registrar and should be regularly reviewed by the primary team. **Ignore any modification that is not signed & dated.**

Vital Sign	Accepted Values & Modified EWS	Date & time	Doctors name, designation & contact details
		/ / :	
		/ / :	
		/ / :	
		/ / :	
NOT FOR CPR ☐	NOT FOR MET ☐	/ / :	

All limitations must be documented in the patient's clinical record.

Mandatory Early Warning Score Escalation Pathway

Total Early Warning Score	Mandatory Action	
EWS 1-5 *or* any vital sign in yellow zone	▪ Manage pain, fever or distress ▪ Increase frequency of vital sign monitoring	
EWS 6-7 *or* any vital sign in orange zone Acute illness or unstable chronic disease	House officer review within 60 minutes	▪ Inform nurse in charge ▪ Refer to Patient At Risk (PAR) nurse #6785 ▪ Increase frequency of vital signs ▪ Document plan including intervention, escalation & review timeframe
EWS 8-9 *or* any vital sign in red zone Likely to deteriorate rapidly	Registrar review within 20 minutes & suggest ICU referral	
EWS 10+ *or* any vital sign in blue zone Immediately life threatening critical illness	▪ **Dial 777** ▪ **State '*Medical Emergency Team*' & give your location** ▪ **Support Airway, Breathing & Circulation**	

CALL 777 FOR ANY PATIENT YOU ARE WORRIED ABOUT REGARDLESS OF VITAL SIGNS OR EWS

A full set of vital signs with corresponding EWS must be taken & calculated each time at the frequency stated in the *'Essential Vital Sign Measurement - Adult Inpatients'* protocol. If there is no timely response to your request for review, escalate to the next coloured zone

Each vital sign is scored according to the coloured zone it falls within (see key below)
Any patient receiving supplemental oxygen *automatically scores 2*, regardless of rate

Early Warning Score Colour Key

0	1	2	3	MET: MEDICAL EMERGENCY TEAM