Wellington Adult Vital Signs Chart
NEUROLOGICAL

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

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

Vital Signs	Date / Time (24 hour)										EWS
Respiratory Rate (breaths/min) *write value in box*	> 35										MET
	25-35										3
	21-24										2
	12-20										0
	9-11										1
	5-8										3
	< 5										MET
Supplemental O_2	*write value* L/min										2
O_2 Saturation (%) *write value in box*	≥ 96										0
	94-95										1
	92-93										2
	≤ 91										3
Temperature (°C) *mark with X*	≥ 39s										2
	38s										1
	37s										0
	36s										
	35s										1
	≤ 34s										2
Blood Pressure (mmHg) *score systolic value only*	Write ≥ 220										3
	210s										
	200s										
	190s										
	180s										
	170s										
	160s										0
	150s										
	140s										
	130s										
	120s										
	110s										
	100s										1
	90s										2
	80s										3
	70s										
	60s										MET
	50s										
Heart Rate (bpm) *mark with X*	Write ≥ 140										MET
	130s										3
	120s										2
	110s										
	100s										1
	90s										
	80s										
	70s										0
	60s										
	50s										
	40s										2
	30s										MET
GLASGOW COMA SCALE (GCS) **Eye Opening** ✓ Write 'NT' if not testable	4	Spontaneous									0
	3	To sound									1
	2	To pressure									2
	1	None									3
EARLY WARNING SCORE TOTAL											
Verbal Response ✓ Write 'NT' if not testable	5	Orientated									
	4	Confused									
	3	Words									
	2	Sounds									
	1	None									
Motor Response ✓ *best arm response usually recorded* Write 'NT' if not testable	6	Obeys commands									
	5	Localising									
	4	Normal flexion									
	3	Abnormal flexion									
	2	Extension									
	1	None									
		TOTAL GCS									

Pupils *brisk: ++ sluggish: + no reaction: – closed: C*	**Left**	Size									
		Reaction									
	Right	Size									
		Reaction									
Arms *Record left (L) and right (R separately if there is a difference between the two sides*	Normal power										
	Mild weakness										
	Severe weakness										
	Flexion										
	Extension										
	No response										
Legs *Record left (L) and right (R separately if there is a difference between the two sides*	Normal power										
	Mild weakness										
	Severe weakness										
	Flexion										
	Extension										
	No response										
Pain *write score (0-10)*	Move / Rest										
Urine Output ✓ Catheter	> 100mls / 4h										
	< 100mls / 4h										
No catheter	PU last 8h										
	Not PU last 8h										

ADMISSION	Height: cm
Date: / /	Weight: kg

Medical Staff Modification to 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 EWS Escalation Pathway

Total EWS	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 60min	▪ 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**	

Notify Registrar if:

- **Total GCS drops by 2 or more *or***
- **Motor score drops by 1**

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

Pupil Size (mm)							
1	2	3	4	5	6	7	8
•	•	•	•	•	•	•	•

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