KPJ KLANG SPECIALIST HOSPITAL

NURSING SERVICES
ADULT OBSERVATION CHART
EARLY WARNING SIGNS & RESPONSE
EWS_1A

Name :
MRN :
D.O.B :
Sex :
Ward :
Bed No : Date & Time :

Date																								
Time																								
Temperature (°C)	Write ≥ 39.1																							Write ≥ 39.1
	38.5 - 38.9																							38.5 - 38.9
	38.0 - 38.4																							38.0 - 38.4
	37.5 – 37.9																							37.5 – 37.9
	37.0 – 37.4																							37.0 – 37.4
	36.5 – 36.9																							36.5 – 36.9
	36.0 – 36.4																							36.0 – 36.4
	35.5 – 35.9																							35.5 – 35.9
	Write ≤ 35.4																							Write ≤ 35.4
Pulse Rate (beats/ min**)**	Write ≥ 140																							Write ≥ 140
	130s																							130s
	120s																							120s
	110s																							110s
	100s																							100s
	90s																							90s
	80s																							80s
	70s																							70s
	60s																							60s
	50s																							50s
	40s																							40s
	Write ≤ 30																							Write ≤ 30
Respiratory Rate (breaths/ min**)**	Write ≥ 35																							Write ≥ 35
	30 – 34																							30 – 34
	25 –29																							25 –29
	20 – 24																							20 – 24
	15 – 19																							15 – 19
	10 – 14																							10 – 14
	5 - 9																							5 - 9
	Write ≤ 4																							Write ≤ 4
Blood Pressure (mm/ Hg**)** ∨ ∧	Write ≥ 200																							Write ≥ 200
	190s																							190s
	180s																							180s
	170s																							170s
	160s																							160s
	150s																							150s
	140s																							140s
	130s																							130s
	120s																							120s
	110s																							110s
	100s																							100s
	90s																							90s
	80s																							80s
	70s																							70s
	60s																							60s
	50s																							50s
	Write ≤ 40																							Write ≤ 40
Consciousness Wake patient before scoring	Alert																							Alert
	Voice																							Voice
	Pain																							Pain
	Unresponsive																							Unresponsive
O_2 Saturation (%)	≥ 98																							≥ 98
	95 - 97																							95 - 97
	90 – 94																							90 – 94
	Write ≤ 89																							Write ≤ 89
O_2 Flow Rate (L/ min) Write value	≥ 7																							≥ 7
	5 - 6																							5 - 6
	1 - 4																							1 - 4
Pain Score	8 – 10																							8 – 10
	5 – 7																							5 – 7
	0 - 4																							0 - 4
Intervention (√)																								
Signature/ Initials																								

GENERAL INSTRUCTIONS
You must record appropriate observations: • On admission • At a frequency appropriate for the patient's clinical state but not less than once/ shift for acute inpatients As per local procedures with a minimum of once daily for patients waiting discharge placement.
You must record a set of observations including a minimum of temperature, pulse rate, respiratory rate, blood pressure, pain score and oxygen saturation, and level of consciousness • If the patient is deteriorating or an observation is in a shaded area • Whenever you are worried about the patient Review is required for unrelieved and unexpected pain that continues to trigger escalation for 2 consecutive values despite medication administration.
When graphing observations, place a dot (•) in the centre of the box which includes the current observation in its range of values and connect it to the previous dot with a straight line. If observations fall above or below graphic parameters, write the value in relevant box.
For blood pressure, use the symbol indicated on the graphic chart "˅ ˄" Please note, only SYSTOLIC blood pressure is used for colour coding.
Whenever an observation falls within a shaded area, you must initiate the actions required for that colour, unless a modification has been made.
Tick when interventions are done and document in nursing notes.

CLINICAL REVIEW REQUIRED	
Response Criteria • Unrelieved chest pain • Any one observation in the pink area • Any observation in the green area • You are worried about the patient	**Actions Required** • Medical Officer/ Consultant to review patient • Increase frequency of observations

EMERGENCY – RRT CALL	
Response criteria • Any observation in a pink area • Airway threat • Respiratory or cardiac deterioration/arrest • New drop in O2 saturation < 90% • Sudden fall in level of consciousness • Seizure • You are worried about the patient but they do not fit the above criteria	**Actions required** • Activate RRT call and specify location • Initiate basic/advanced life support • Notify patient's Consultant • Increase frequency of observation post intervention

CALL CODE BLUE if patient has collapsed

Request for Clinical Review ***(please tick)***

Date	Time	Consultant (√)	Medical Officer (√)	Remarks