The Shrewsbury and Telford Hospital NHS Trust

Modified Early Obstetric Warning Score (MEOWS) Guideline

VERSION 6.1

Lead Person(s)	:	Dorreh Charlesworth
Care Group	:	Women and Children's
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Written by	:	Dorreh Charlesworth
Consultation	:	Deteriorating Adult Team, Labour Ward Forum, Maternity Governance, Obstetric Anaesthetists
Comments	:	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

Version	Implementation Date	History	Ratified By	Full Review Date
1	June 2010 as pilot	New guideline in line with CNST Recommendations	MGG	October 2010
2	January 2011	Revisions after pilot	MGG	January 2014
3	12th April 2011	Minor amendment to monitoring statement	MGG	April 2014
3.1	8th September 2011	Minor changes of wording and format	GC Authorisation	September 2014

3.2	21st December 2011	Minor change to Appendix 2 wording	GC Authorisation	December 2014
3.3	26th July 2012	Minor review – clarification on guidance for MEWS, frequency guidance appendix & consideration for SEPSIS	MGG	December 2014
3.4	8th November 2012	CNST Level 3 requirements	GC Authorised	December 2014
3.5	14th March 2013	Updated auditable Standards/ Monitoring & Audit Section Revision to escalation added Appendix 3a	GC Authorised	December 2014
3.6	11th June 2013	Inclusion of process for plotting MEWS in the community	MGG	December 2014
3.7	20th September 2013	Fresh eyes for audit process and clarification in section 5.3	GC Authorised	December 2014
4	7th November 2014	Full review. Escalation process modified (Appendix 3, 3a), revised MEWS chart (Appendix 2), Change with regard to temperature recording as at 5.2.4	MGG Maternity Governance	November 2017
4.1	11th January 2016	Addition to Section 4.0 and Pain Score Revision to section 5.2.1 for introduction of Triage	GC Authorised	November 2017
5	February 2019	Full Review to include NHSi recommendations. MEWS parameters to be undertaken in accordance with new guidance apart from the SaO2 component in Community (Postnatal) - SaO2 monitors ordered and guideline to be fully implemented on 1st April 2019.	MGG GE Authorisation by HOM S Jamieson	February 2024
6	21st August 2023	Full Review	Maternity Governance	August 2026
6.1	19th April 2024	Amendment to change PN high risk period from 4 weeks to 6 weeks.		

Contents

1.0 Introduction

The 2021 MBRRACE-UK report revealed no statistically significant difference in the maternal mortality rate in comparison to data from 2010-2012.

Key findings from the report revealed similar themes to those found elsewhere (such as Each Baby Counts, UKOSS, PMRT, HSIB, etc.).

These themes included the recognition that:

- Risk profiles are dynamic and require regular review and update
- Physiology of pregnancy is poorly understood by healthcare professionals, and often leads to incorrect normalisation of abnormal signs
- Escalation occurs at the point of decompensation rather than at the point of compensated deterioration
- Hierarchy and loss of situational awareness remain significant barriers to achieving optimal escalation when concerns persist

These factors are most markedly seen when looking at data for pregnant women from a BAME (Black, Asian, Minority Ethnic) background who demonstrated up to four times the maternal mortality and morbidity rate in comparison to other pregnant women.

Currently there is no national deteriorating pregnant woman or maternity early warning score (MEWS) system for obstetric patients.

Confidential enquiries have demonstrated a significant need for such a system to be founded, and work is under way in this area, starting with the establishment of an evidence-based baseline for normal physiological parameters (Pregnancy Physiology Pattern Prediction – 4P Study 2017).

This guideline uses a Modified Obstetric Early Warning Score (MEOWS) based on heuristic data collected from the study of information from Confidential Enquiries, UKOSS studies, local incident investigations, the Scottish national MEWS, and teaching packages such as MOET/PROMPT.

The parameters have been presented at various governance meetings for local agreement – both obstetric/gynaecological and anaesthetic – and they have also been presented to The SaTH Trust Deteriorating Adult Group for review.

The tools within this guideline are designed to facilitate the management of women in keeping with the 'PIER' safety model:

- Prevention - of deterioration in the pregnant/postnatal woman
- Identification – of the deteriorating pregnant/postnatal woman prior to decompensation
- Escalation – of the deteriorating pregnant/postnatal woman prior to decompensation
- Response – to the deteriorating pregnant/postnatal woman prior to decompensation

Of significant difference to previous models, is the emphasis of this system on identification of deterioration **prior** to decompensation, rather than identification at the point of significant associated morbidity/mortality.

This tool will therefore trigger early for all reviews, but especially for senior review.

It will also clearly define quality standards for when reviews should be performed, and an escalation pathway for when these standards cannot be met.

It is important to note that whilst this system has been shown to help identify deteriorating patients who require urgent clinical review, **it does not provide a diagnosis nor determine management**.

Rather, the MEOWS provides a standardised approach to escalation that hopefully prevents the aforementioned identified barriers to timely intervention.

2.0 Aims

The hope is that this guideline will:

- Guide the clinician on the circumstances in which a MEOWS should be calculated
- Provide a framework for escalation of the deteriorating obstetric adult patient
- Empower all healthcare professionals, independent of hierarchy and acuity, to continue to raise concerns when these persist
- Prevent variation in practice
- Prevent late escalation to senior review
- Enable a consistent 'language' between departments
- Enable audit and assurance of both the PIER model and heuristic data on which this guideline is based
- Enable acuity data for staffing models

3.0 Objectives

3.1 To layout when a MEOWS should be completed for a patient
3.2 To enable identification of the deteriorating obstetric adult patient
3.3 To enable escalation of the deteriorating obstetric adult patient in a consistent and timely manner

4.0 Definitions

MEOWS	Modified early obstetric warning score
MEWS	Maternity early obstetric warning score
NEWS	National early warning score
EPAS	Early Pregnancy Assessment Service
GATU	Gynaecology Assessment and Treatment Unit
DAU	Maternity Day Assessment Unit
EmANC	Emergency Antenatal clinic

Tier system:

- Tier 1 FY2, GPVTS 1-2, CM/CS/ST1-2, or equivalent/higher
- Tier 2 CM/CS/ST3-7, or equivalent/higher
- Tier 3 Consultant

5.0 Process

5.1 Guideline on a Page

All MEOWS should be completed **in full**. Measurement of one parameter alone does not provide sufficient information to detect a deteriorating patient. On BadgerNet, a MEOWS score will not generate unless all parameters are complete.

MEOWS frequencies should be set as follows:

- Base frequency: by the clinician reviewing the patient or relevant guideline (e.g. caesarean section, postpartum haemorrhage, etc.)
- When score positive: by the relevant escalation policy – see appendix 3

A MEOWS and sepsis screen must be commenced with every patient presentation to an acute portal, on patient admission, and when a new deterioration is suspected.

Additionally, it is important not to forget that when observations performed for routine indications (in labour, antenatal clinic, community visit, etc.) score positive, they will form only part of the MEOWS. In these circumstances, a full MEOWS should be completed, a MEOWS chart started, and the appropriate escalation performed.

Escalation of the pregnant woman should follow tools as below:

- MEOWS and sepsis screen **negative** – baseline care as determined by reviewing team
- MEOWS screen **positive**, sepsis screen **negative** – follow **MEOWS** escalation
- Sepsis screen **positive** (MEOWS screen negative/positive) – follow **sepsis** escalation

Full guidance for escalation of the deteriorating patient and sepsis can be found in the guidelines 'Maternal Sepsis in the Antenatal, Intrapartum, and Postnatal Period' and 'The Deteriorating Obstetric Adult and Maternal Collapse'.

Please be aware that MEOWS and pregnancy sepsis screening tools apply from the start of pregnancy and up to 6 weeks postnatally. These differ from the general adult NEWS and sepsis screening tools in operation within the Trust, which should not be used in pregnant women or within 6 weeks into the postnatal period unless the pregnancy ended within the first 16 weeks.

There are other tools in use within the division – such as those used in Maternity Triage. The escalation guidelines within this, the deteriorating obstetric adult, and the obstetric sepsis guidelines take precedence over all others.

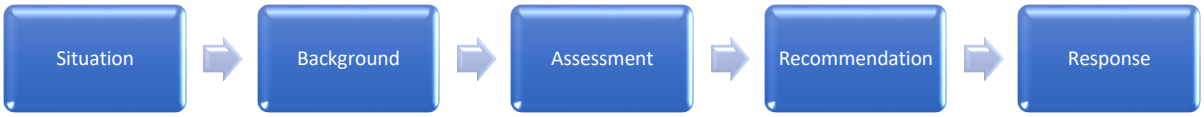
There are **TWO** MEOWS scales in use, reflecting the changing physiology of pregnant women after birth. **Scale 1** is for use in all **pregnant** women up to delivery, and **Scale 2** is for use in **postnatal women** up to 6 weeks post-delivery. BadgerNet will switch between these tools automatically. However, if using paper charts, be aware there are therefore 2 sepsis and 6 MEOWS tools available – this reflects the different escalation policies depending on gestation and location of the patient. **Ensure your patient is on the right chart** – the score itself may change and how you escalate differs, when you escalate will not change.

Where escalation of a woman is required, refer to the escalation chart on the back of the MEOWS tool for details – key contacts can be found later in this guideline, or in appendix 1 where all charts

can be seen. Further information to support escalation can be found in the 'Deteriorating Obstetric Adult' Guideline.

The time of any escalation should be documented clearly using either an appropriate **escalation sticker** (appendix 2 - **DO NOT** use the general adult escalation sticker for pregnant women or those up to 6 weeks postnatal) or the SBAR tool on the BadgerNet electronic record.

All handovers should use the SBAR-R format (see appendix 2):



5.2 When to Perform a MEOWS

The MEOWS tool (and not the NEWS tool) should be completed for any pregnant patient from conception to 6 weeks postnatal unless a miscarriage has occurred < 16 weeks gestation

For patients who miscarry < 16 weeks gestation, the NEWS should be used, and escalation would follow the gynaecology pathway if required – appendix 3.

MEOWS are indicated for any patient who:

- Presents through an acute portal
- Is admitted to hospital
- Deteriorates/develops symptoms or signs of possible pathology, even if on a routine pathway admission

- Presents to DAU

- Presents to ANC/MLU/community and the routine observations (BP, urine) are outside the normal range (it is permissible for the MEOWS to be completed in Triage/ward areas rather than the community/clinic if referred in)

- Is on a MEOWS baseline plan following routine or acute admission after review by a clinician
    - All admission routine or acute should have frequency of MEOWS, fetal monitoring, fluid balance, etc. clearly documented by the reviewing clinician in the ongoing management plan

- Is on a MEOWS baseline plan as part of a routine pathway set by another guideline (e.g. postnatal care, post postpartum haemorrhage, post caesarean section, etc.)
    - For the purposes of audit/assurance, these patients will be audited as part of the guidelines from which the baseline plan originated
    - **Be aware that if the MEOWS triggers positive, this guideline will then take precedence over the originating guideline**

Where a MEOWS is positive, a MEOWS chart should be commenced if not on BadgerNet, and the escalation procedure followed.

5.3 How to Perform a MEOWS

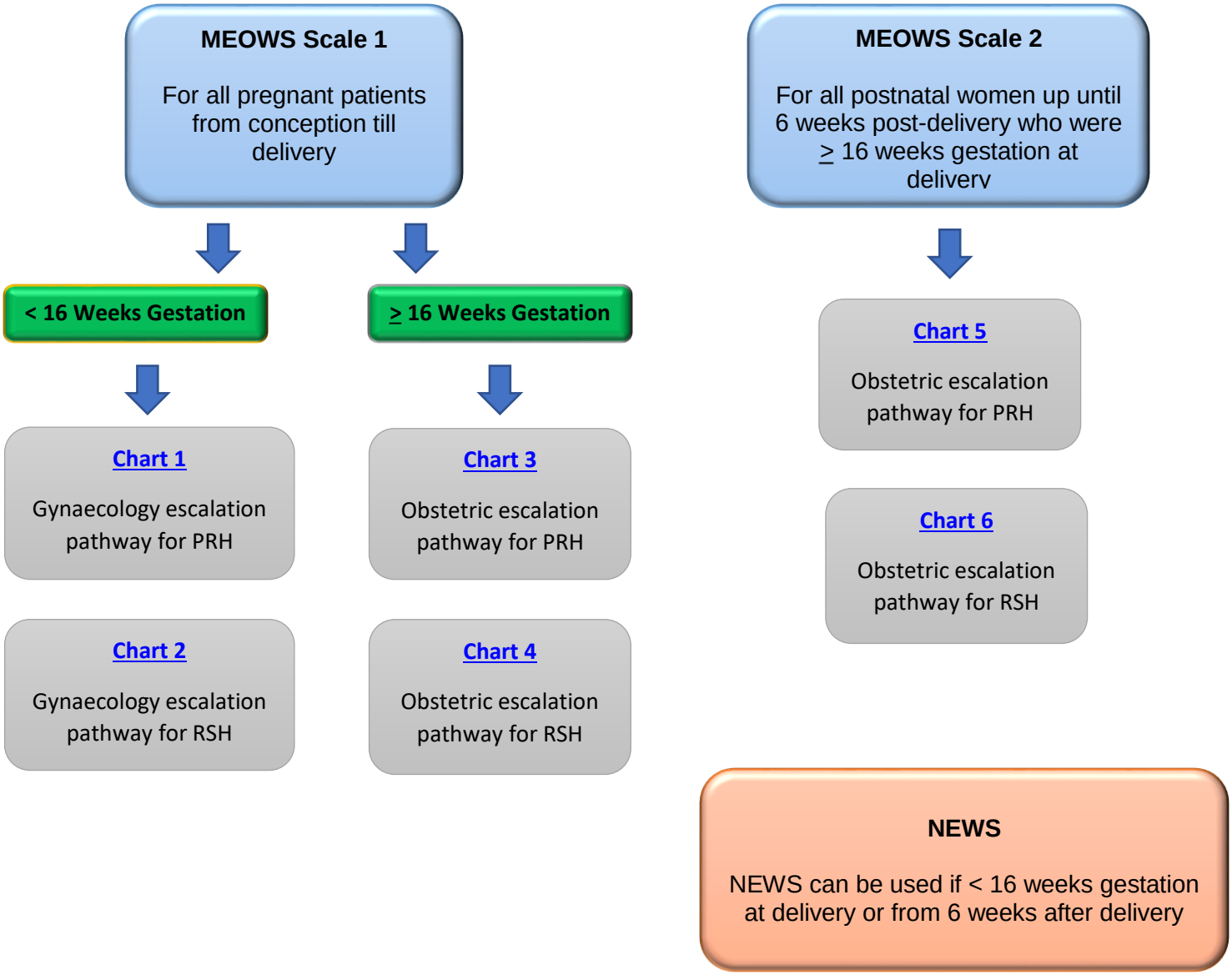
There are two ways of recording a MEOWS:

1. On the BadgerNet electronic system
2. On a paper MEOWS chart

The BadgerNet electronic system is set up to record the MEOWS by gestation specific scoring. It will give a correct score for all antenatal and postnatal patients without need to adjust any settings.

For women located in an area without BadgerNet access, 6 MEOWS charts exist. These reflect the significant differences in physiology between antenatal and postnatal pregnant women, as well as the area in which these women are located.

The diagram below shows which forms should be used at which gestations/locations:



To obtain a MEOWS, a complete set of observations are required which will include all the following.

A+B	C	D	E
Respirations in breaths per minute – measured over 60 seconds The oxygen saturation level Recording of whether the patient is receiving oxygen	Heart rate in beats per minute - measured over 60 seconds Blood pressure in mmHg - systolic and diastolic Urine output if on a fluid balance chart	Level of consciousness using the ACVPU scoring system A Alert C New onset confusion V Responds to voice P Responds to pain U Unresponsive	Temperature in ^{0}C Recording of whether the patient appears unwell

The MEOWS can then be calculated as follows using the MEOWS charts/BadgerNet:

- As a **score**:
  - Score 0 for all values in a **white** box
  - Score 1 for all values in a **yellow** box
  - Score 2 for all values in an **orange** box
  - Score 3 for all values in a **red** box

- As a **colour**:
  - White
  - Yellow
  - Orange
  - Red

Proteinuria in Pregnancy

Proteinuria is not part of the MEOW scoring, but it is flagged as a warning at the bottom of the charts. If detected in pregnancy (defined as a urine dipstick level of Protein 1+ or more) this needs discussion with an obstetrician/gynaecologist.

Please be advised that we have taken a decision within the division to deviate from the proposed national MEWS parameters for diastolic blood pressure recordings. Both the NEWS and Scottish MEWS do not contain flags for low diastolic readings, whilst the proposed national MEWS suggests scoring 1 for a diastolic of 57-61 and 2 for a reading $\leq$ 56 (be aware that these scorings are specific to the national proposed charts not those in use within SaTH). At these ranges a large number of our patients who are well would score positive on their MEOWS and this could lead to escalation fatigue and divert resources from an unwell patient. We have therefore made the decision to follow the NEWS and Scottish parameters.

BadgerNet will calculate MEOWS scores automatically **if fully completed** and display an action box.

5.4 Escalating a Positive MEOWS

Refer to the Deteriorating Pregnant Adult Guideline for more detailed escalation details.

When the MEOWS score is positive, escalation will occur in the first instance **to the team looking after the patient**. This may not always be obstetrics/gynaecology. Where escalation to obstetrics/gynaecology is required, as a rule, any patient < 16 weeks is escalated to gynaecology and any ≥ 16 weeks to obstetrics.

Pregnancy ≥ 16 weeks gestation now or at delivery

Obstetric Consultant

24-hour bleep - 334

Pregnancy < 16 weeks gestation now or at delivery

Gynaecology Consultant

24-hour mobile – via switchboard

MEOWS scores are designed to trigger senior escalation early. Please do not hesitate to ask for review and **escalate** if this review is not occurring. Put simply, pregnant patients mask symptoms well, are already functioning at near capacity for buffering/compensation mechanisms, and deteriorate rapidly.

REMEMBER – there is no emergency obstetric/gynaecology/neonatal service at RSH. Early escalation is essential as you may need to stabilise and transfer to PRH if these services are required or await staff/resources to be transferred from PRH to RSH – this will take time.

The deteriorating pregnant adult guideline contains some useful ways of approaching difficulties encountered in unsuccessful escalation and contains escalation contact details (these can also be located on the back of paper MEOWS charts - appendix 1 – and in appendix 3). All escalations should follow the SBAR-R format and be documented using either BadgerNet or an escalation sticker (see appendix 2).

The following tables represent the expected escalation for the various MEOWS scores. The more simplified version is presented first and can be located on the back of all MEOWS charts.

MEOWS Trigger	Initial Escalation	MEOWS Frequency	Further Escalation	Ongoing Review With Improvement
Any 1 yellow trigger	Midwife/nurse review 30-minute response time	30 minutely	No improvement at 1 hour 30-minute response time	Back to baseline plan
Any 2-3 yellow triggers Any 1 orange trigger	Tier 1 review 30-minute response time	30 minutely	No improvement at 1 hour 30-minute response time	Full review at 2 hours to make baseline plan
Any MEOWS score ≥ 4 Any 1 red trigger	Tier 2 review 15-minute response time Sepsis Screening Tool	15 minutely	No improvement at 1 hour 15-minute response time	Full review at 2 hours to make baseline plan

EMERGENCY CALL IF RAPID DETRIORATION - (DIAL 2222)				
MEOWS Trigger	**Initial Escalation**	**MEOWS Frequency**	**Further Escalation**	**Ongoing Review With Improvement**
Any 1 yellow trigger	Midwife/Nurse review 30-minute response time	30 minutely	At every hour if there has been no improvement refer to next Tier Next Tier should respond within 30-minutes or escalation to next Tier is warranted Deterioration should escalate immediately to next Tier.	Back to baseline plan At this MEOWS it is possible for a **Tier 2** to stand the escalation policy down so long as adequate mitigation is in place and they have performed an in-person review
Any 2-3 yellow triggers Any 1 orange trigger	Tier 1 review 30-minute response time	30 minutely	As above	Full review at 2 hours to make a baseline plan At this MEOWS it is possible for a **Tier 3** to stand the escalation policy down so long as adequate mitigation is in place and they have performed an in-person review
Any MEOWS score ≥ 4 Any 1 red trigger	Tier 2 review 15-minute response time Sepsis Screening Tool If outlying ward to obstetrics/gynaecology, escalate to obstetric/gynaecology Tier 3	15 minutely	**If sepsis screen positive, defer to sepsis policy**	
			As above but response time is reduced to 15-minutely **If this patient is under obstetrics, they need transfer to enhanced care if MEOWS remains ≥ 4 after 1 hour or at MEOWS ≥ 6**	Full review at 2 hours to make a baseline plan It is **not** possible to stand down the escalation policy at this MEOWS except by **Tier 3 lead MDT decision**

Please note that patients with the below scores are transferred to Labour Ward for enhanced care if the patient has been admitted under obstetrics – see 'Maternal Enhanced and Critical Care Operational Policy'

- Persistent MEOWS of $\geq$ 4 after 1 hour
- MEOWS of $\geq$ 6

Clinicians caring for women outside of obstetrics are advised to consider if their patients also require escalation for Level 1, 2 or 3 care (see below) and if this requires transfer to another unit, hospital, or location (such as CCU, HDU, ITU).

- **Level 1:** Patients at risk of their condition deteriorating and needing a higher level of observation and input because there is a risk of deterioration or those recently relocating from higher levels of care (enhanced care).
- **Level 2:** Patients requiring invasive monitoring/intervention that includes support for a single failing organ system (excluding advanced respiratory support)
- **Level 3:** Patients requiring advanced respiratory support (mechanical ventilation) alone or basic respiratory support along with support of at least one additional organ

5.5 Documentation

After an initial MEOWS is calculated for a patient, the team looking after the patient should formulate a baseline plan which clearly documents as applicable the MEOWS frequency thereafter and details for escalation. If any other escalation tools are to be used (such as fluid balance charts), these should also be listed, frequencies stated, and escalation details recorded.

Where the patient is on an outlying ward to obstetrics/gynaecology, it is the responsibility of the reviewing obstetric/gynaecology clinician to document a comprehensive plan in the patient notes and the **management section** on the BadgerNet electronic system to include **contact details for obstetrics/gynaecology**, triggers for escalation, MEOWS frequency, frequency of fetal/neonatal monitoring where relevant, and any other escalation tool parameters. This may mean just copying what the admitting team have documented or may mean advising a change to the admitting team plan as dictated by their knowledge of obstetrics. Documentation in both areas is key to ensuring correct handover and oversight.

The BadgerNet system will automatically store details of completed MEOWS and allow escalation to be documented via the SBAR handover tool.

For those on the paper-based charts:

- Ensure all fields are completed in full
- If a MEOW score is negative, no further documentation beyond completing all fields on the chart is required
- If a MEOW score is positive, the score should be noted in the patient record and the relevant actions documented, including the filling in of an escalation sticker where indicated.

Responsibilities for documentation/escalation are as follows:

HCA/WSA	If trained to perform a full set of MEOWS, are responsible for performing this action and reporting/escalating their findings to the nurse/midwife responsible for the patients care immediately.

NURSE/MIDWIFE	Responsible for documenting the MEOWS and escalation. If the responding clinician is unable to attend the patient within the designated review period, the nurse/midwife is responsible for enacting and following the escalation policy until the patient is reviewed.
DOCTOR	A doctor will not be expected to escalate a patient to the next tier if they are unable to review themselves - they do not have the necessary information to perform an SBAR-R handover. This responsibility will remain with the referrer. They are however responsible for informing the referrer of when they will be attending to review the patient and being honest and realistic in their response. **Where they are unable to attend within the designated period, the doctor should pause and consider whether they are at risk of losing situational awareness and need to escalate their workload to the next tier**

6.0 Training

Staff will be made aware at their induction of how to access trust guidelines via the trust Intranet facility.

Sepsis training will be undertaken by all staff in maternity in line with trust requirements. This training compromises of annual completion of an e-learning package by all staff caring for pregnant patients, and additional training provided by the Maternity Education and Training Team as part of the PROMPT training schedule to all maternity staff.

Both PROMPT and live skills drills will form part of the Maternity skills drill scenario sets and will utilise MEOW scoring.

7.0 Monitoring/Audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out against the auditable standards and the results of the audit will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

8.0 References

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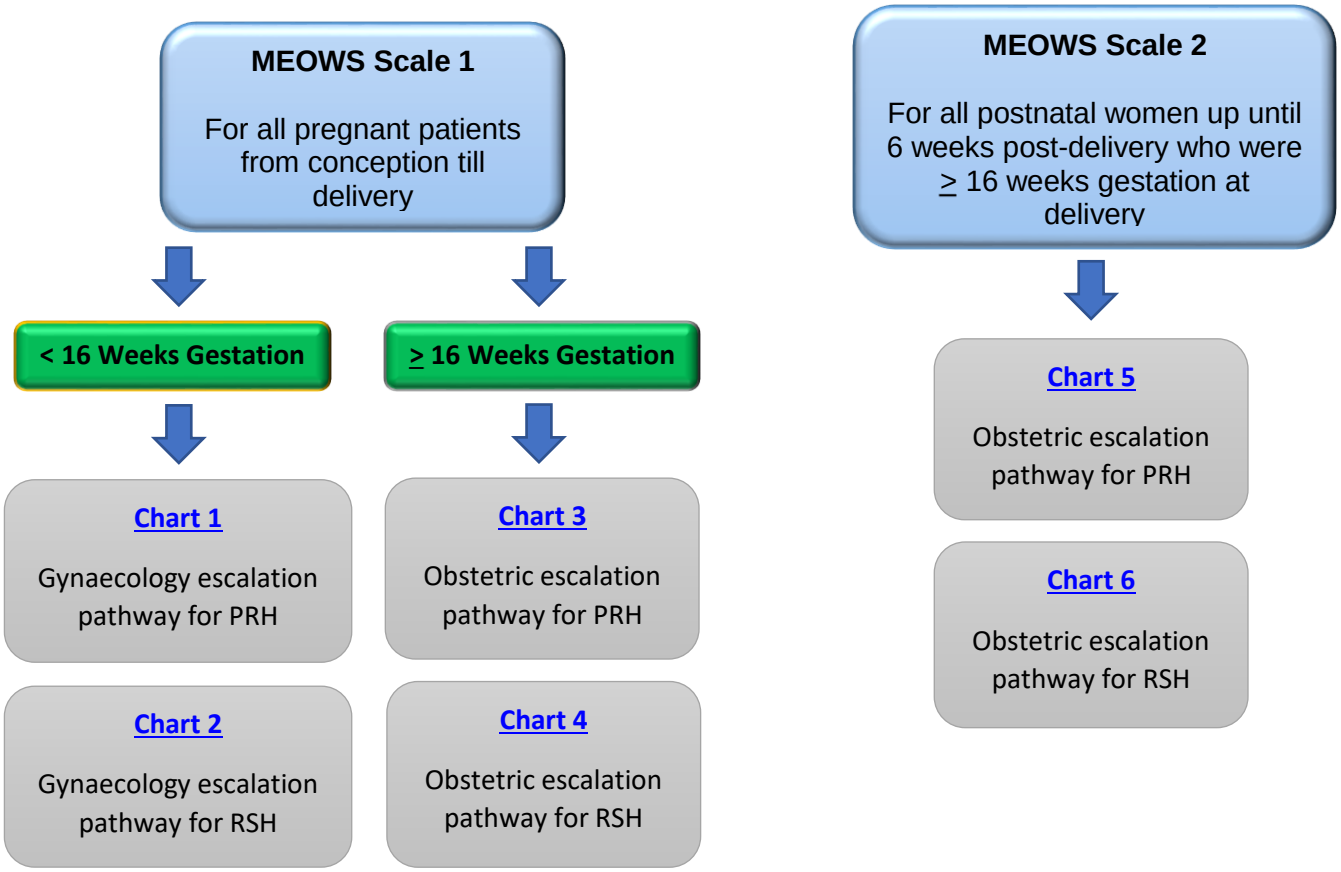
16. Kumar F, Kemp J, Edwards C, Pullon RM, Loerup L, Triantafyllidis A, Salvi D, Gibson O, Gerry S, MacKillop LH, Tarassenko L, Watkinson PJ. Pregnancy physiology pattern prediction study (4P study): protocol of an observational cohort study collecting vital sign information to inform the development of an accurate centile-based obstetric early warning score. BMJ Open. 2017 Sep 1;7(9):e016034. doi: 10.1136/bmjopen-2017-016034. PMID: 28864695; PMCID: PMC5589023

9.0 Appendices

1. MEOWS charts 1-6
2. SBAR-R and escalation sticker
3. Escalation within obstetrics/gynaecology and other useful contacts
4. Quality standards for PSIRF audit

Appendix 1 - MEOWS Charts

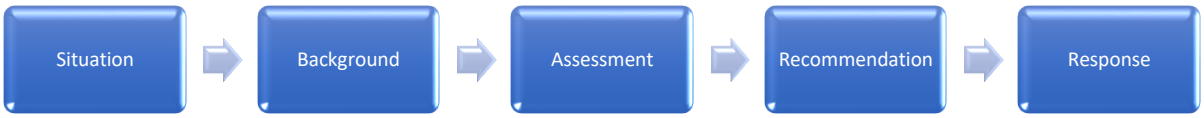


NEWS

NEWS can be used if < 16 weeks gestation at delivery or from 6 weeks after delivery.

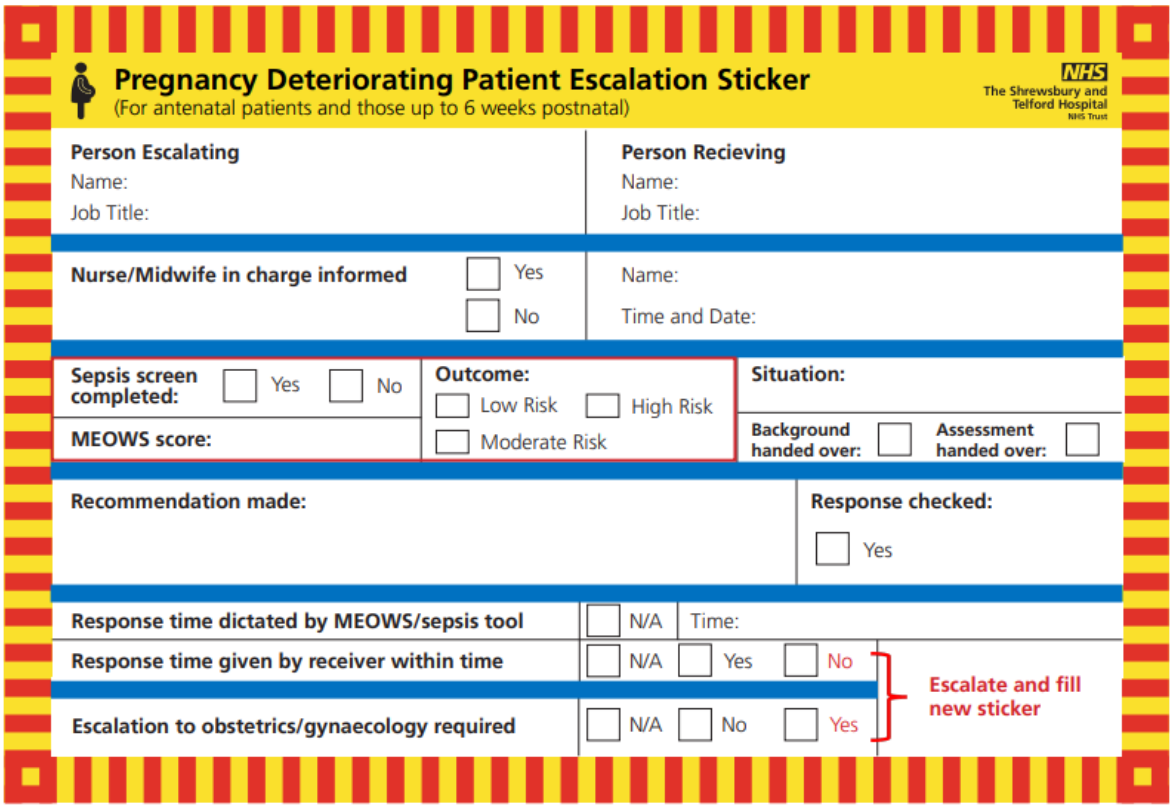
Appendix 2 – SBAR-R and Escalation Sticker

All handovers should use the SBAR-R format.



It is the responsibility of the health care professional performing the handover to ensure the SBAR is documented either on an escalation sticker or on the BadgerNet electronic system.

STAGE	DESCRIPTION
Prepare	Before calling assess the patient and ensure you have all the relevant details to hand for your handover Drug charts, observation charts, investigation results, etc.
Identify and AID	1. Introduce yourself by name, designation, and area 2. Introduce your patient by name and identifier Clearly specify your intent by starting with **one** of the following: • I am calling to ask **advice** about …. (A) • I am calling to **inform** you of …. (I) • I am calling because I need you to **do** …. (D)
Situation	State the situation clearly • What is it • When did it start • Quantify the severity
Background	Give key background information • Admission diagnosis • History to this point • Previous medical history • Allergies, medications • Investigation results to date • ReSPECT status • TEP status
Assessment	State your assessment findings • Most recent MEOWS observations and any changes to previous • Key examination findings • Key fetal findings – growth, EFM, etc.
Recommendation	Make a clear recommendation for what you need
Response	1. Ask for the receiver to repeat back what you have said 2. Clarify any questions **3. Obtain an expected response time – you will need this to know when to escalate** **4. Document your SBAR using an escalation sticker (appendix 3) or the SBAR tool on BadgerNet**



Pregnancy Deteriorating Patient Escalation Sticker
(For antenatal patients and those up to 6 weeks postnatal)

The Shrewsbury and Telford Hospital NHS Trust

Person Escalating Name: Job Title:	**Person Recieving** Name: Job Title:
Nurse/Midwife in charge informed ☐ Yes ☐ No	Name: Time and Date:
Sepsis screen completed: ☐ Yes ☐ No **MEOWS score:**	**Outcome:** ☐ Low Risk ☐ High Risk ☐ Moderate Risk
Situation: **Background handed over:** ☐ **Assessment handed over:** ☐	
Recommendation made:	**Response checked:** ☐ Yes
Response time dictated by MEOWS/sepsis tool	☐ N/A Time:
Response time given by receiver within time	☐ N/A ☐ Yes ☐ No
Escalation to obstetrics/gynaecology required	☐ N/A ☐ No ☐ Yes

Escalate and fill new sticker

Appendix 3 – Escalation Within Obstetrics/Gynaecology and Other Useful Contacts

Pregnancy < 16 weeks gestation now or at delivery

Gynaecology Consultant

24-hour mobile – via switchboard

Pregnancy ≥ 16 weeks gestation now or at delivery

Obstetric Consultant

24-hour bleep - 334

ESCALATION POLICY FOR GYNAECOLOGY	ESCALATION POLICY FOR GYNAECOLOGY	ESCALATION POLICY FOR OBSTETRICS	ESCALATION POLICY FOR OBSTETRICS
PRH	**RSH**	**PRH**	**RSH**

BEWARE – THERE IS NO GYNAECOLOGY OR OBSTETRIC COVER AT RSH ROUTINELY

ESCALATE EARLY AND PREPARE TO EITHER TRANSFER OR STABILISE UNTIL HELP ARRIVES

Useful numbers for advice/escalation:

DESIGNATION	PRH	RSH
Critical care outreach team	Bleep 037 (07.30-20.00 only)	Bleep 502 (07.30-20.00 only)
ITU Tier 2 on call	Bleep 032	Bleep 845
ITU	Ext 4500/4501	Ext 3718
Medical Tier 2 on call	Bleep 102	Bleep 607
Hospital at Night Clinical Support Worker	Bleep 310	Bleep 446
Hospital at Night Nurse Practitioner	Bleep 271	Bleep 440
Surgical Tier 2 on call	Bleep 208 (08.00-17.00 Mon – Fri) Mobile via switchboard (All other times)	Bleep 603
Obstetric Tier 3 on call	Bleep 334	As per PRH but not on site
Obstetric Tier 2 on call	Bleep 331	As per PRH but not on site
Gynaecology Tier 3 on call	Mobile via switchboard	As per PRH but not on site
Gynaecology Tier 2 on call	Bleep 328 (08.00 – 19.00 Mon-Fri, bleep switched off outside these hours and Obstetric Tier 2 takes over)	As per PRH but not on site
Blood Bank	Ext. 4305/6 (09.00-17.30 Mon – Fri) Bleep 115 (All other times)	Ext. 3556/3542 (09.00-17.30 Mon – Fri) Bleep 512 (All other times)
Main Theatre Coordinator	Bleep 242 (08.00-18.00) Via Switchboard otherwise	Bleep 590 (08.00-18.00) Via Switchboard otherwise
Obstetric Theatre ODP	Bleep 348 Ext 4518	NA

Neonatal T3 On Call	Bleep 876 (08.30-17.30) Via Switchboard otherwise	As per PRH but not on site
Neonatal Tier 2 On Call	Bleep 840	As per PRH but not on site
Neonatal Tier 1	Bleep 772	As per PRH but not on site
Neonatal Nurse Coordinator	Bleep 883	As per PRH but not on site

Appendix 4 – Quality Standards

To be set once policy ratified