



# MEWT Frequently Asked Questions

## Implementation

### 1) What are the first steps to begin MEWT implementation?

The first step is to review the MEWT program commitment letter and obtain necessary signatures. Submit this form electronically to WSHA. Second, gather team members and take the survey monkey (this will be emailed to you) on your maternity unit baseline MEWT practices. Third, read through the implementation guide and workbook. Then sign up for the WSHA Webinar on October 12<sup>th</sup>, where we will go over this guide in detail. If the webinar has already taken place, the recording will be posted on our website under MEWT resources.

## Screening Tool

### 2) What does the tool screen for?

The tool was designed to screen for four main diagnosis groups: sepsis, cardiovascular dysfunction, severe preeclampsia-hypertension and obstetrical hemorrhage.

### 3) How do you use the tool?

Patients are screened based on vital signs, pain, mental status, fetal heartrate status and nursing clinical concern. It is recommended that each facility determine the frequency and timing of when to screen patients.

### 4) Who uses the screening tool?

Typically, the nurse is responsible to complete the assessment and the evaluation of triggers. However, providers may find using the tool and algorithms helpful in completing their differential diagnosis.

### 5) How does a patient screen positive and what do you do?

To screen positive a patient must have >20 minutes of a sustained trigger, either 1 severe or 2 other triggers. A positive screen requires urgent bedside evaluation (exact timing expectation to be determined by facility) by a physician or other clinician, who can order and provide necessary

emergent interventions and tests. It is vital that a communication escalation plan be developed to support urgent bedside evaluation with a positive trigger by a provider.

**6) What is an escalation plan? Is it different than a chain of command?**

An escalation plan needs to identify WHO and HOW to call with a positive trigger and HOW and WHEN to activate the chain of command to facilitate assessment, diagnosis and treatment for the patient. An example is provided in the toolkit.

**7) How often will patients screen positive? How many more phone calls will I receive?**

In a large pilot study (32,832 deliveries) using the MEWT tool, 1 in every 50 patients had a positive screen and 1 in 8 of those were admitted to the ICU. The sepsis pathway had 72% of positive screens (Shields, Wiesner, Klein, Pelletreau and Hedriana 2016).

**8) What if the patient doesn't meet criteria for a positive MEWT, but the nurse is clinically uncomfortable with the patient status?**

According to the MEWT screening tool, a nurse who is clinically uncomfortable with the patient status serves as a single severe abnormal trigger and requires immediately bedside evaluation. It is vital for leadership to support this within the maternity unit to promote a culture of safety.

## Algorithms: Infection, Cardiopulmonary, Hypertension, Obstetric Hemorrhage

**9) Should the hospital protocols be changed to reflect the recommendations within the algorithms**

Hospitals should aim to have their protocols up to date with current evidence-based recommendations. The algorithms serve as guidance but are not exhaustive. Providers should use them to guide their diagnosis and interventions.

**10) Clarification of hypertension pathway activation**

Doctors should be notified of sBP >155 or dBP >105 and should initiate treatment with BP medication, magnesium sulfate and laboratory testing. However, In Dr. Larry Shields' study (2016), the hypertension pathway was not considered activated with blood pressure alone, but required accompaniment of another trigger or symptom.

**11) Clarification of sepsis**

If an abnormal temperature was serving as a single trigger, the OB provider should be notified but the sepsis pathway was not automatically initiated. For the activation of the Sepsis pathway, a patient requires an abnormal maternal temperature and an additional 2 or more triggers. Fetal tachycardia, as defined by a baseline of >160bpm sustained for at least 20 mins, is considered a possible trigger in the sepsis pathway.

**12) Clarification of hemorrhage pathway**

The obstetrical hemorrhage pathway can be activated by the presence of observed bleeding or abnormal vital signs and symptoms. The latter is especially helpful to improve recognition time for

intrabdominal bleeding. Once activated, the bedside staff should follow the hospital's OB hemorrhage protocol. If the patient's heartrate is  $>110$  (in the absence of fever),  $MAP < 65$  and bleeding or recent surgery, the patient should be considered in a stage 3 hemorrhage. Appropriate labs and blood products should be ordered at this time, if not already done.

### **13) Clarification of cardiopulmonary pathway**

The cardiopulmonary is the least likely to be triggered with the obstetric patient population. However, early identification can dramatically improve the outcomes for a patient's cardiopulmonary dysfunction. Overlap should be considered for this pathway with sepsis and hypertension. Altered mental status, elevated respiratory rate, decreased oxygen saturation,  $MAP < 65$  or  $HR > 110$  are the clinical markers for this pathway.

## **EMR/Paper tool**

### **14) Paper tool vs EMR**

Building an automated trigger system into the electronic medical record takes time and resources. While your unit is waiting for this to be a reality, use the paper tool to screen patients for MEWT triggers. It is simple and intuitive to use. One option with the paper tool is to print the screening tool on one side and the algorithms on the other side for easy reference. Other facilities post the algorithms in a team room space and print the tools separately.