NAME: CHI NO:

Date:	
Time:	0800
Location	Ward
Prescribed frequency of observations:	15 min

Respiratory Rate — example

70		70
60		60
50		50
40		40
30	•	30
20		20
10		10
0		0
actual	30	actual

RR

SpO2

94+		94+
92 - 93	•	92 - 93
less than 92		less than 92
actual	92	actual

SpO2

Oxygen

air		air
l/min	4L	l/min
Mode of Delivery eg facemask, nasal cannulae	FM	Mode of Delivery

O2

Heart Rate — example

170		170
160		160
150	•	150
140		140
130		130
120		120
110		110
100		100
90		90
80		80
70		70
60		60
50		50
40		40
actual	146	actual

HR

Blood Pressure
(Plot systolic and diastolic but **score SYSTOLIC** only)

BP cuff size:

170		170
160		160
150		150
140		140
130		130
120		120
110		110
100	↑	100
90		90
80		80
70	↓	70
60		60
actual	110/70	actual

BP

Capillary return (central in seconds)

less than 2 secs	•	less than 2 secs
2 - 4 secs		2 - 4 secs
more than 4 secs		more than 4 secs

CRT

Conscious level (if V / P / U complete GCS chart) — example

Alert	•	Alert
Asleep		Asleep
Verbal		Verbal
Pain		Pain
Unresponsive		Unresponsive

AVPU (if V / P / U complete GCS chart)

Temperature °C — example

40		40
39		39
38		38
37	•	37
36		36
35		35
34		34
actual	36.8	actual

Temp °C

Staff or Carer Concerns (Staff = S, Carer = C, None = N) — C — (Staff= S, Carer = C, None = N)

PEWS	6	PEWS
Initials	ABC	Initials
Time of medical review if score elevated	08.15	Time of medical review if score elevated
Pain Score	0	Pain Score
Blood Glucose	4.6	Blood Glucose

0

1

3

>12 YEARS

NHS SCOTLAND

PAEDIATRIC EARLY WARNING SCORE (PEWS) >12 YEARS

(To be used from 12 years and above)

Name.....

DOB.....

CHI .....

Affix Patient ID label

Ward..... Consultant.....

Chart Number.....

Date.....

PEWS is a tool to aid recognition of sick and deteriorating children. PEWS should be calculated every time observations are recorded.

How to calculate score:

- Record observations at intervals as prescribed
- Record observations in black pen with a dot
- Score as per the colour key

  0 | 1 | 3
- Add total points scored
- Record total score in PEWS box at bottom of chart
- Action should be taken as below

PEWS	Level of escalation	Action to be taken
Regardless of PEWS always escalate if concerned about a patient's condition		
0	0	
1-2	1	
3-4 or any in red zone	2	
5 or more	3	
Bradycardia, cardiac or respiratory arrest		

→

Concerns include, but are not restricted to;

- **gut feeling**
- **looks unwell**
- **apnoea**
- **airway threat**
- **increased work of breathing,**
- **significant ↑ in O^2 requirement**
- **Poor perfusion / blue / mottled / cool peripheries**
- **seizures**
- **confusion / irritability / altered behaviour**
- **hypoglycaemia**
- **high pain score despite appropriate analgesia**

If observations are as expected for patient's clinical condition, please note below accepted parameters for future calls					
Acceptable parameters	RR	O^2 saturation	HR	BP	Temperature °C
Upper acceptable					
Normal range					
Lower acceptable					
Doctor's signature	Date & Time				

PAEDIATRIC SEPSIS 6
Recognition: Suspected or proven infection + 2 of:

- Core temperature < 36°C >38°C
- Inappropriate Tachycardia
- Altered mental state: sleepy / irritable / floppy
- Peripheral perfusion, CRT >2 sec, cool, mottled

Lower threshold in vulnerable groups

Think could this be sepsis? IF NOT then why is this child unwell?

→

If YES respond with Paediatric Sepsis 6 within 1 hour:

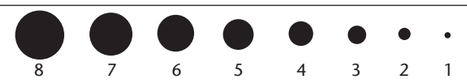
- Give high flow oxygen
- IV or IO access and blood cultures, glucose, lactate
- Give IV or IO antibiotics
- Consider fluid resuscitation
- Consider inotropic support early
- Involve senior clinicians/ specialists EARLY

Neurological Observations

				Time																							
COMA SCALES	Eyes Open	Spontaneously	4																								Eyes closed by swelling = C
		To Speech	3																								
		To Pain	2																								
		None	1																								
	Best Verbal Response	Orientated	5																								Endotracheal tube or tracheostomy = T
		Confused	4																								
		Innapropriate words	3																								
		Incomprehensible words	2																								
		No response	1																								
	Best Motor Response	Moves purposefully and spontaneously	6																								Usually record the best arm response
		Withdraw to touch	5																								
		Withdraws in response to pain	4																								
		Flexion to pain	3																								
		Extension to pain	2																								
		None	1																								
		Score																									

Pupils		Right	Size																									Reacts + No reaction - Eye closed c
			Reaction																									
		Left	Size																									
			Reaction																									
LIMB MOVEMENT	ARMS	Normal power																										Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																										
		Severe weakness																										
		Spastic flexion																										
		Extension																										
		No response																										
	LEGS	Normal power																										
		Mild weakness																										
		Severe weakness																										
		Extension																										
		No response																										

Pupil Scale (m.m.)



Assessment of Acute Pain in Children

	No Pain	Mild Pain	Moderate Pain	Severe Pain
Faces Scale Score				
Ladder Score	0	1-3	4-6	7-10
Behaviour	* Normal activity * No ↓movement * Happy	* Rubbing affected area * Decreased movement * Neutral expression * Able to play/talk normally	* Protective of affected area * ↓movement/quiet * Complaining of pain * Consolable crying * Grimaces when affected part moved/touched	* No movement or defensive of affected part * Looking frightened * Very quiet * Restless/unsettled * Complaining of lots of pain * Inconsolable crying

Developed by Healthcare Improvement Scotland