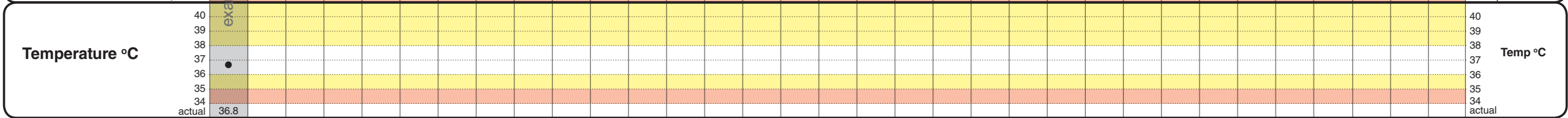
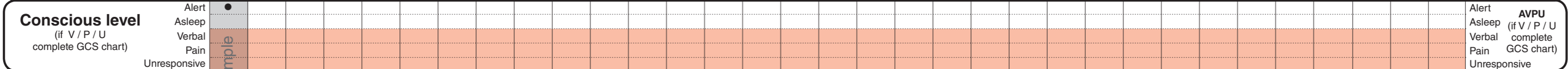
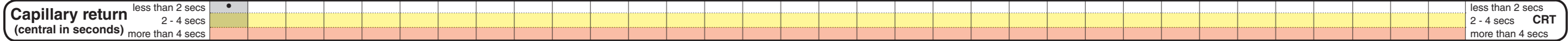
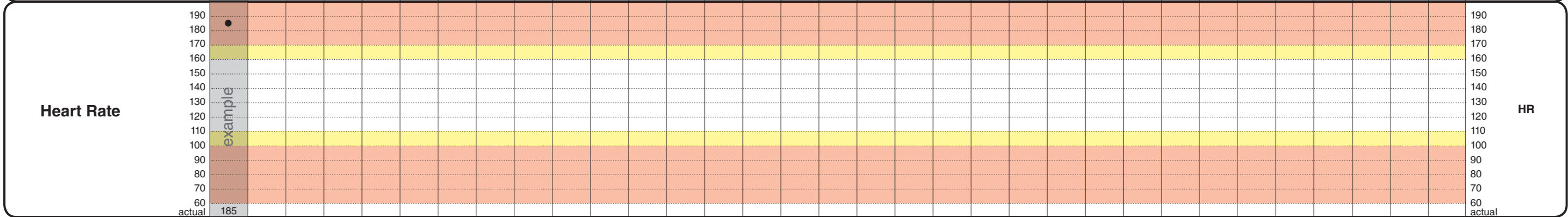
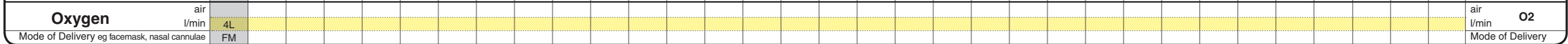
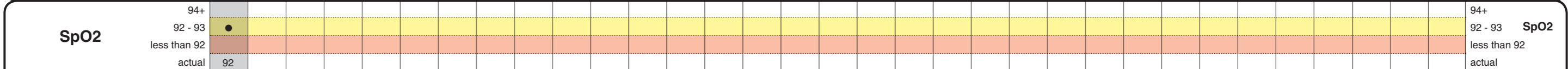
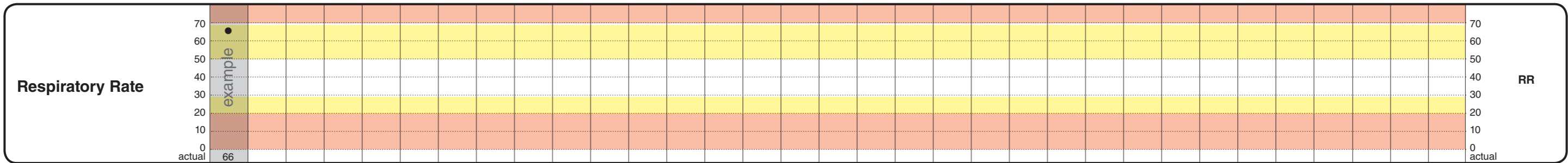


NAME:

CHI NO:

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



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

(Staff = S, Carer = C, None = N)

PEWS	6																																				
Initials	ABC																																				
Time of medical review if score elevated	08.15																																				

PEWS Initials

Time of medical review if score elevated

Pain Score	0																																			
Blood Glucose	4.6																																			

Pain Score

Blood Glucose

0

1

3

0-11 MONTHS





PAEDIATRIC EARLY WARNING SCORE (PEWS) 0 – 11 MONTHS

(To be used from birth until day before 1st birthday)
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



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

Name

DOB

CHI Affix Patient ID label

Ward..... Consultant

Chart Number

Date

PEWS	Level of escalation	Action to be taken
Regardless of PEWS always escalate if concerned about a patient's condition		
0	0	Do not decrease frequency until at least 3 consecutive scores of 0. Children can score 0 even when sick. Escalate to Level 2 response if concerned despite a low score.
1-2	1	Treat as prescribed. Repeat observations in 60 mins. Escalate to level 2 if not responding.
3-4 or any in red zone	2	Review within 15 mins. Treat as prescribed. Repeat Observations in 30 mins or continuous monitoring. If not responding level 3 escalation.
5 or more	3	Level 3 review immediately. Consider 2222 if unable to review immediately.
Bradycardia, cardiac or respiratory arrest		Call 2222. Paediatric Emergency

Concerns include, but are not restricted to;

- gut feeling
- looks unwell
- apnoea
- airway threat
- increased work of breathing,
- significant ↑ in O² 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	Alert, Coos and babbles, words to usual ability	5															Endotracheal tube or tracheostomy = T
		Irritable cries, less than normal ability	4															
		Cries in response to pain	3															
		Moans to pain	2															
	Best Motor Response	No response	1															Usually record the best arm response
		Moves purposefully and spontaneously	6															
		Withdraw to touch	5															
		Withdraws in response to pain	4															
	Flexion to pain	3																
	Extension to pain	2																
	None	1																
	Score																	
Pupils	Right	Size Reaction															Reacts + No reaction - Eye closed c	
	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																
	LEGS	Extension																
		No response																
		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