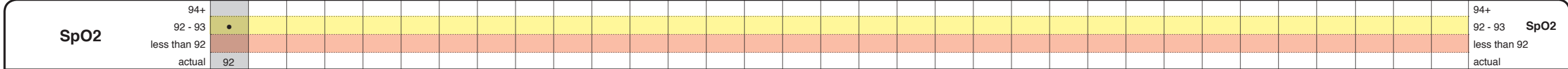
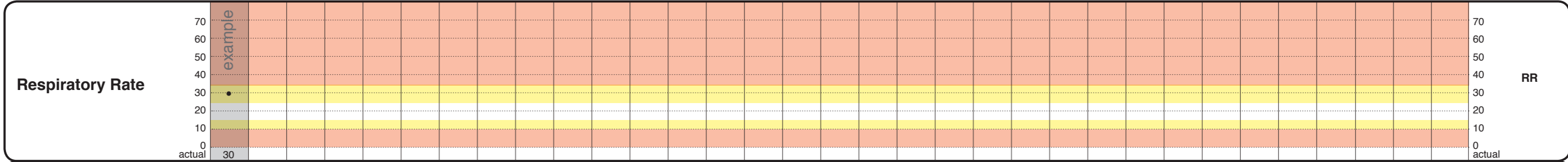


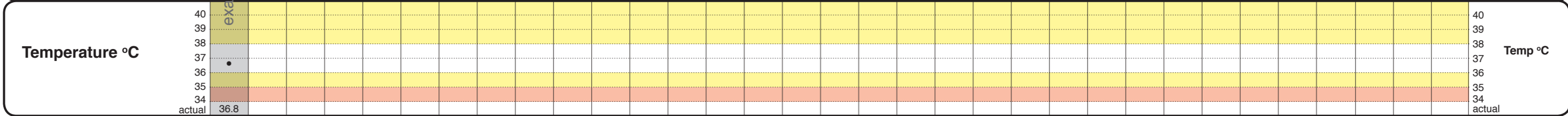
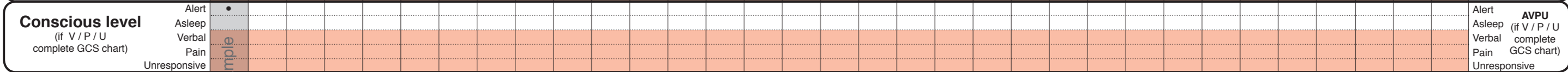
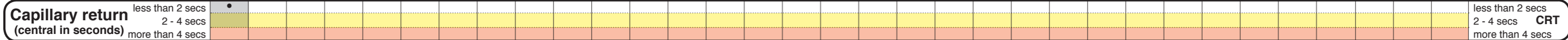
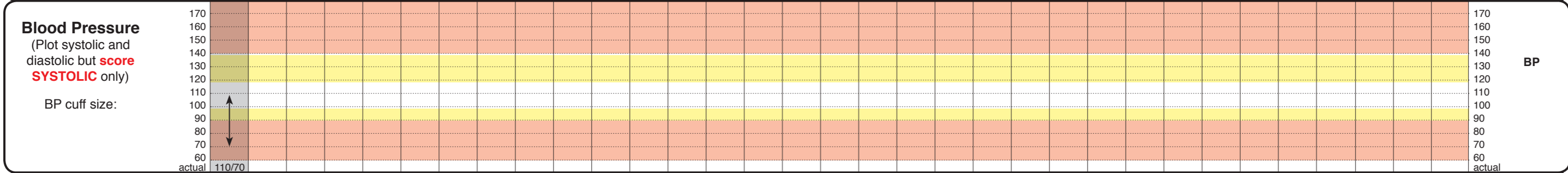
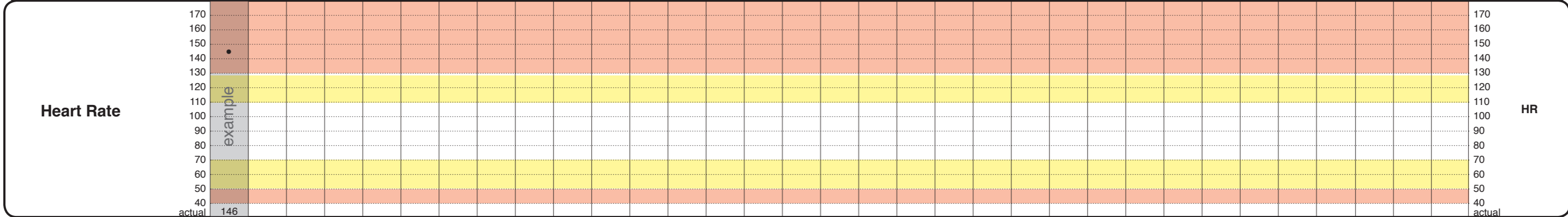
NAME:

CHI NO:

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



Oxygen	air	O2
	l/min	l/min
Mode of Delivery eg facemask, nasal cannulae	FM	Mode of Delivery



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



>12 YEARS





**(To be used from 12 years and above)**

**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

Name.....  
DOB.....  
CHI ..... Affix Patient ID label  
  
Ward..... Consultant.....  
**Chart Number**.....  
**Date**.....

PEWS	Level of escalation	Action to be taken
<b>Regardless of PEWS always escalate if concerned about a patient's condition</b>		
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  $\uparrow$  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 <sup>2</sup> 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																	
<b>COMA SCALES</b>	Eyes Open	Spontaneously	4																
		To Speech	3																
		To Pain	2																
		None	1																
	Best Verbal Response	Orientated	5																
		Confused	4																
		Innapropriate words	3																
		Incomprehensible words	2																
		No response	1																
	Best Motor 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																	

		Right	Size Reaction															
Pupils																		
<b>LIMB MOVEMENT</b>	ARMS	Normal power																
		Mild weakness																
		Severe weakness																
		Spastic flexion																
		Extension																
	LEGS	No response																
		Normal power																
		Mild weakness																
		Severe weakness																
		Extension																
		No response																



**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 $\downarrow$ movement * Happy	* Rubbing affected area * Decreased movement * Neutral expression * Able to play/talk normally	* Protective of affected area * $\downarrow$ 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