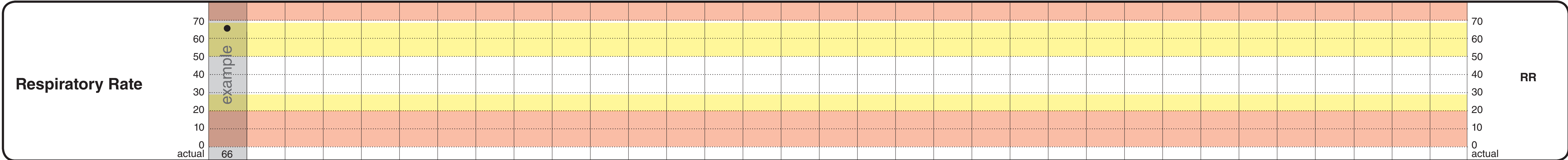
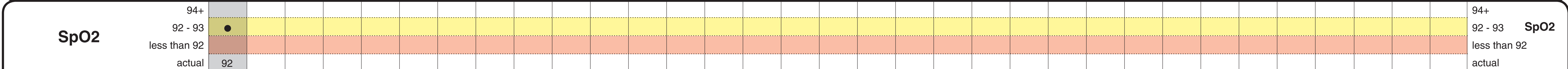
NAME: CHI NO:

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



Respiratory Rate (RR)

70, 60, 50, 40, 30, 20, 10, 0 — actual: 66 (example)



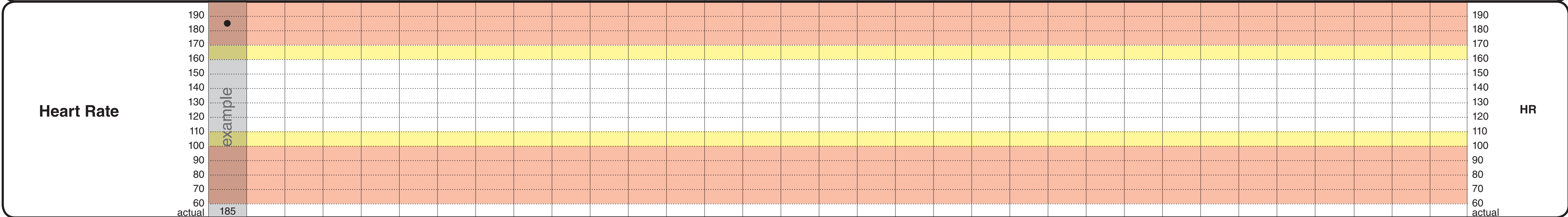
SpO2

94+, 92 - 93, less than 92 — actual: 92

Oxygen (O2)

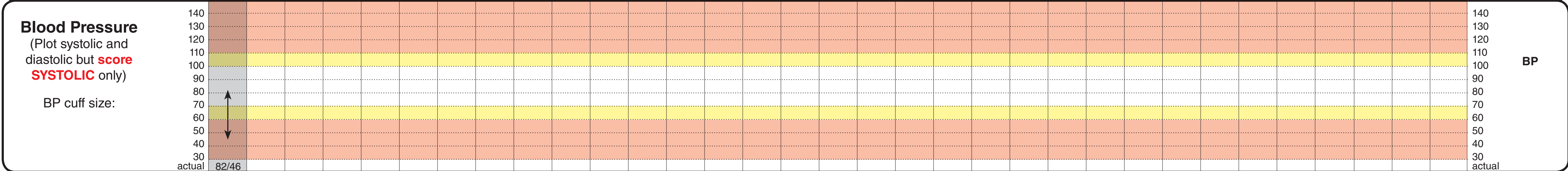
air, l/min: 4L

Mode of Delivery eg facemask, nasal cannulae: FM



Heart Rate (HR)

190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60 — actual: 185 (example)

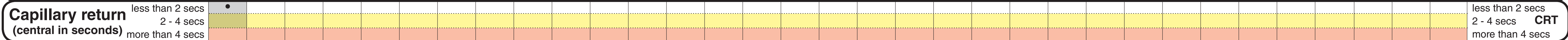


Blood Pressure (BP)

(Plot systolic and diastolic but score SYSTOLIC only)

BP cuff size:

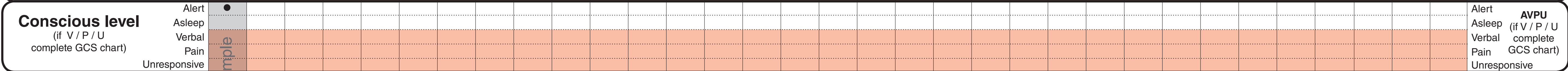
140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30 — actual: 82/46



Capillary return (CRT)

(central in seconds)

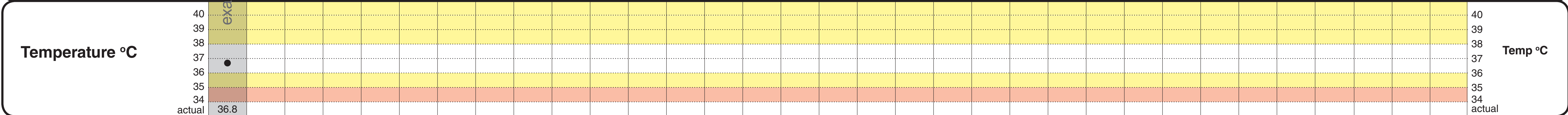
less than 2 secs, 2 - 4 secs, more than 4 secs



Conscious level (AVPU)

(if V / P / U complete GCS chart)

Alert, Asleep, Verbal, Pain, Unresponsive



Temperature °C (Temp °C)

40, 39, 38, 37, 36, 35, 34 — actual: 36.8 (example)

Staff or Carer Concerns (Staff = S, Carer = C, None = N)	C
PEWS	6
Initials	ABC
Time of medical review if score elevated	08.15
Pain Score	0
Blood Glucose	4.6

Score key: 0 | 1 | 3

0-11 MONTHS

NHS SCOTLAND

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	
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	Notes
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		
		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.) 8 7 6 5 4 3 2 1

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
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