NAME: **CHI NO:**

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

Respiratory Rate

70																																	
60	●																																
50																																	
40	example																																
30																																	
20																																	
10																																	
0																																	
actual	56																																

SpO2

94+																																	
92 - 93	●																																
less than 92																																	
actual	92																																

Oxygen

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

Heart Rate

190																																	
180	●																																
170																																	
160																																	
150																																	
140																																	
130	example																																
120																																	
110																																	
100																																	
90																																	
80																																	
70																																	
60																																	
actual	185																																

Blood Pressure

(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 (central in seconds)

less than 2 secs	●																																
2 - 4 secs																																	
more than 4 secs																																	

Conscious level

(if V / P / U complete GCS chart)

Alert	●																																
Asleep																																	
Verbal																																	
Pain	example																																
Unresponsive																																	

Temperature °C

40																																	
39																																	
38	example																																
37	●																																
36																																	
35																																	
34																																	
actual	36.8																																

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																																

0

1

3

12-23 MONTHS

NHS SCOTLAND

PAEDIATRIC EARLY WARNING SCORE (PEWS)

12 – 23 MONTHS

(To be used from 12 months until day before 2nd 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

  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
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	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 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																											
		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