NAME: **CHI NO:**

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

Respiratory Rate

70 / 60 / 50 / 40 / 30 / 20 / 10 / 0 actual — example ● — actual 35 — **RR**

SpO2

94+ / 92 - 93 / less than 92 / actual — ● — actual 92 — **SpO2**

Oxygen

air / l/min — 4L — **O2**

Mode of Delivery eg facemask, nasal cannulae — FM — Mode of Delivery

Heart Rate

170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 actual — ● example — actual 146 — **HR**

Blood Pressure

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

BP cuff size:

170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 actual — ↕ — actual 100/60 — **BP**

Capillary return (central in seconds)

less than 2 secs / 2 - 4 secs / more than 4 secs — ● — **CRT**

Conscious level

(if V / P / U complete GCS chart)

Alert / Asleep / Verbal / Pain / Unresponsive — ● example — **AVPU** (if V / P / U complete GCS chart)

Temperature °C

40 / 39 / 38 / 37 / 36 / 35 / 34 actual — example ● — actual 36.8 — **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

5-11 YEARS

NHS SCOTLAND

PAEDIATRIC EARLY WARNING SCORE (PEWS) 5 – 11 YEARS

Name .....

DOB .....

CHI .....

Affix Patient ID label

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

Chart Number .....

Date .....

(To be used from 5 years until day before 12th 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

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 continous 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 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.)

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