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 • 30

RR

SpO2

94+ / 92 - 93 / less than 92 / actual

• 92

SpO2

Oxygen

air / l/min

4L

Mode of Delivery eg facemask, nasal cannulae

FM

O2

Heart Rate

170 160 150 140 130 120 110 100 90 80 70 60 50 40 actual

example • 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

example ↕ 110/70

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 • 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

>12 YEARS

NHS SCOTLAND

PAEDIATRIC EARLY WARNING SCORE (PEWS) >12 YEARS

(To be used from 12 years and above)

Name.....

DOB.....

CHI .....

Affix Patient ID label

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

Chart Number.....

Date.....

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	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Innapropriate words	3																						
		Incomprehensible words	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.)

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