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: ● at 40; actual 46

RR

SpO2

94+ · 92 - 93 · less than 92 · actual

example: ● at 92 - 93; actual 92

SpO2

Oxygen

air · l/min

example: 4L

Mode of Delivery eg facemask, nasal cannulae

example: FM

O2

Mode of Delivery

Heart Rate

190 · 180 · 170 · 160 · 150 · 140 · 130 · 120 · 110 · 100 · 90 · 80 · 70 · 60 · actual

example: ● at 160; actual 165

HR

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

example: ↕ 90 to 56; actual 92/56

BP

Capillary return (central in seconds)

less than 2 secs · 2 - 4 secs · more than 4 secs

example: ● at less than 2 secs

CRT

Conscious level

(if V / P / U complete GCS chart)

Alert · Asleep · Verbal · Pain · Unresponsive

example: ● at Alert

AVPU (if V / P / U complete GCS chart)

Temperature °C

40 · 39 · 38 · 37 · 36 · 35 · 34 · actual

example: ● at 37; 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

2-4 YEARS

NHS SCOTLAND

PAEDIATRIC EARLY WARNING SCORE (PEWS)

2 – 4 YEARS

(To be used from 2 years until day before 5th birthday)

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	
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:

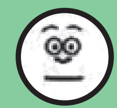
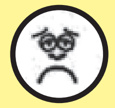
- Give high flow oxygen
- IV or IO access and blood cultures, glucose, lactate
- Give IV or IO antibiotics
- Consider fluid resuscitation
- Consider inotropic support early
- Involve senior clinicians/ specialists EARLY

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 / 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