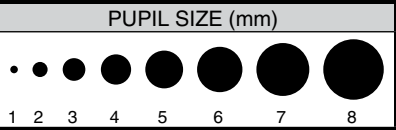


Patient label

Date:	Initials:																			
	Time:																			
Care	Sepsis Screen																			
	Screen for sepsis if PEWS score increases by 2, or temperature is > 38°C or < 36.0°C, or critical heart rate. (Indicate with a ✓ and document findings and actions in Nurses' Notes.)																			
	Tool: _____ Pain Score																			
	Location of pain																			
	Arousal Score																			
PRAM Score (Asthma Patients Only)																				
EtCO2 (mmHg)																				
Glucometer (mmol/L)																				
Neurological	PUPILS <small>B = Brisk S = Sluggish F = Fixed</small>	Size	Right																	
		Left																		
	Reaction	Right																		
		Left																		
	EYES	Spontaneous	4																	
		To speech	3																	
		To pain	2																	
		None	1																	
	VERBAL	Coos/Oriented	5																	
		Irritable cry/Confused	4																	
		Cries to pain/Inappropriate	3																	
		Moans to pain/Incomprehensible	2																	
	MOTOR	None	1																	
		Normal spontaneous/Obeys	6																	
		Withdraws to touch/Localized	5																	
		Withdraws to pain/Withdraws	4																	
Abnormal flexion		3																		
Abnormal extension	2																			
	Flaccid	1																		
TOTAL SCORE GCS																				
Muscle Strength <small>Refer to rating scale below Rate 0 – 5</small>	Right Arm																			
	Left Arm																			
	Right Leg																			
	Left Leg																			
Colour, Warmth, & Sensation of Extremities <small>✓ = Normal NN = Nurse's Notes</small>	Right Arm																			
	Left Arm																			
	Right Leg																			
	Left Leg																			
Bladder Function <small>✓ = Normal NN = Nurse's Notes</small>																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score 0 – 1	Continue to monitor and document as per orders & routine protocols.	Score 3	Increase frequency of assessments and documentation as per plan from consultation.	Score 4 and/or score increases by 2 after interventions	Notify MRP/delegate. Consider pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments. Reassess adequacy of resources and escalate to meet deficits.	Score 5 – 13 or score of 3 in any one category	Immediate assessment by MRP/delegate or pediatrician, or emergency room physician. MRP/delegate to communicate a plan of care. Increase nursing care with increasing interventions as per plan. Consider internal or external transfer to higher level of care.
Score 2 or any one of 5 Situational Awareness Factors	Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.						



MUSCLE STRENGTH GRADING SYSTEM

0/5	No movement	3/5	Movement overcoming gravity, but not against resistance
1/5	Trace movement	4/5	Movement overcoming gravity and some resistance
2/5	Movement only (not against gravity)	5/5	Normal strength against resistance

LEVEL OF AROUSAL SCORE

1	2	3	4	5
Awake and alert, oriented	Normal sleep, easy to arouse to verbal stimulation	Difficult to arouse to verbal stimulation	Responds only to physical stimulation	Does not respond to verbal or physical stimulation

PRINTED NAME	SIGNATURE	INITIALS