CHILD HEALTH BC

Date: _____

PEWS Vital Sign Record
1 – 3 YEARS

Patient identification

PEWS Scoring Legend: 0 | 1 | 2 | 3

	Initials:																						
	Time:																						
Respiratory	**Respiratory Rate (1 minute)** Resp: ●	70																					70
		60																					60
		50																					50
		40																					40
		30																					30
		20																					20
	O_2 Saturation (%)																						
	Supplemental O_2 Concentration Delivered	<3L or 30%																					
		≥3L or 30%																					
		≥6L or 40%																					
		≥8L or 50%																					
	Mode of Delivery																						
	Respiratory Distress	None																					
		Mild																					
		Moderate																					
		Severe																					
	PEWS Score for Respiratory (record most severe score, max 3)																						
Cardiovascular	**Heart Rate (1 minute) & Blood Pressure** Systolic: ∨ Diastolic: ∧ **(Do not score blood pressure)**	190																					190
		180																					180
		170																					170
		160																					160
		150																					150
		140																					140
	Normal Parameters:	130																					130
	Systolic (mmHg): 85 – 109	120																					120
		110																					110
	Diastolic (mmHg): 37 – 67	100																					100
		90																					90
	Apex: ● Monitor: *	80																					80
		70																					70
	If heart rate is critical – PEWS score of 3, screen for sepsis	60																					60
		50																					50
		MAP																					
	Capillary Refill Time	1 – 2 seconds																					
		3 seconds																					
		4 seconds																					
		≥ 5 seconds																					
	Skin Colour	Pink																					
		Pale																					
		Grey/Cyanotic																					
		Grey & Mottled																					
	PEWS Score for Cardiovascular (record most severe score, max 3)																						
Behaviour		Playing/Appropriate																					
		Sleeping																					
		Irritable																					
		Lethargic/Confused																					
		Reduced response to pain																					
	PEWS Score for Behaviour (record most severe score, max 3)																						
	Persistent vomiting following surgery																						
	Bronchodilator every 20 minutes																						
PEWS	**Total PEWS Score** (max 13) R + C + B + vomitting + bronchodilator = PEWS Score																						
Situational Awareness Factors	Patient/Family/Caregiver concern																						
	Unusual therapy																						
	Watcher patient																						
	Communication breakdown																						
	PEWS Score ≥2																						
	PEWS Escalation Process Activated (time) **See NN**																						
Temperature °C	● A – Axilla R – Rectal O – Oral T – Temporal E – Esophageal	40																					40
		39																					39
		38																					38
		37																					37
	If temperature is less than 36°C or above 38°C, **screen for sepsis**	36																					36
	Source of Temperature																						

Revised 01 2026

CHILD HEALTH BC

PEWS Vital Sign Record
1 – 3 YEARS

Patient identification

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 B = Brisk S = Sluggish F = Fixed — **Size** Right																				
	Size Left																				
	Reaction Right																				
	Reaction Left																				
	EYE — Spontaneous 4																				
	To speech 3																				
	To pain 2																				
	C = Closed — None 1																				
	VERBAL — Coos/Oriented 5																				
	Irritable cry/Confused 4																				
	Cries to pain/Inappropriate 3																				
	Moans to pain/Incomprehensible 2																				
	None 1																				
	MOTOR — 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																				
Spinal	**Muscle Strength** *Refer to rating scale below* Rate 0 – 5 — Right Arm																				
	Left Arm																				
	Right Leg																				
	Left Leg																				
	Colour, Warmth, & Sensation of Extremities √ = Normal NN = Nurse's Notes — Right Arm																				
	Left Arm																				
	Right Leg																				
	Left Leg																				
	Bladder Function √ = Normal NN = Nurse's Notes																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score 0 – 1
Continue to monitor and document as per orders & routine protocols.

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.

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.

PUPIL SIZE (mm)

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

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