CHILD HEALTH BC

Date: _____

PEWS Vital Sign Record
4 – 11 MONTHS

Patient identification

PEWS Scoring Legend: 0 | 1 | 2 | 3

	Initials:																					
	Time:																					
Respiratory	**Respiratory Rate (1 minute)** Resp: ●	80																				80
		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) Normal Parameters: **Systolic (mmHg):** 82 – 105 **Diastolic (mmHg):** 46 – 68 Apex: ● Monitor: * If heart rate is critical – PEWS score of 3, screen for sepsis	190																				190
		180																				180
		170																				170
		160																				160
		150																				150
		140																				140
		130																				130
		120																				120
		110																				110
		100																				100
		90																				90
		80																				80
		70																				70
		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 + vomiting + 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 If temperature is less than 36°C or above 38°C, screen for sepsis	40																				40
		39																				39
		38																				38
		37																				37
		36																				36
	Source of Temperature																					

Revised 01 2026

CHILD HEALTH BC

PEWS Vital Sign Record
4 – 11 MONTHS

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

Revised 01 2026