CHILD HEALTH BC

PEWS Vital Sign Record

4 – 6 YEARS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

Date: **Initials:**

Time:

Respiratory

Respiratory Rate (1 minute)
Resp: ●
50 / 40 / 30 / 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)

Cardiovascular

Heart Rate (1 minute) & Blood Pressure
Systolic: V
Diastolic: Λ
(Do not score blood pressure)
Normal Parameters:
Systolic (mmHg): 91 – 114
Diastolic (mmHg): 50 – 74
Apex: ●
Monitor: ✱
If heart rate is critical – PEWS score of 3, screen for sepsis
160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 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)

Behaviour

Playing/Appropriate
Sleeping
Irritable
Lethargic/Confused
Reduced response to pain

PEWS Score for Behaviour
(record most severe score)

PEWS

Persistent vomiting following surgery
Bronchodilator every 20 minutes

Total PEWS Score
(R + C + B + vomiting + bronchodilator)

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 / 39 / 38 / 37 / 36

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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																				
	Left																				
	Reaction Right																				
	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.

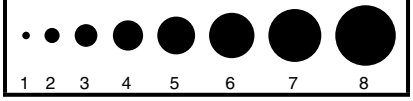
Score 2 or any one of 5 Situational Awareness Factors
Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

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