CHILD HEALTH BC

Date: _____

PEWS Vital Sign Record
7 – 11 YEARS

Patient identification

PEWS Scoring Legend: 0 | 1 | 2 | 3

	Initials:																				
	Time:																				
Respiratory	**Respiratory Rate (1 minute)** 40																				40
	30																				30
	20																				20
	Resp: ● 10																				10
	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) 150																				150
	140																				140
	130																				130
	120																				120
	110																				110
	Normal Parameters: Systolic (mmHg): 96 - 121 100																				100
	90																				90
	Diastolic (mmHg): 57 - 80 80																				80
	70																				70
	Apex: ● Monitor: * 60																				60
	50																				50
	If heart rate is critical – PEWS score of 3, screen for sepsis 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 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																				

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PEWS Vital Sign Record
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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 Size Right																				
	PUPILS Size Left																				
	PUPILS Reaction Right (B = Brisk, S = Sluggish, F = Fixed)																				
	PUPILS Reaction Left																				
	EYE Spontaneous 4																				
	EYE To speech 3																				
	EYE To pain 2																				
	EYE None 1 (C = Closed)																				
	VERBAL Coos/Oriented 5																				
	VERBAL Irritable cry/Confused 4																				
	VERBAL Cries to pain/Inappropriate 3																				
	VERBAL Moans to pain/Incomprehensible 2																				
	VERBAL None 1																				
	MOTOR Normal spontaneous/Obeys 6																				
	MOTOR Withdraws to touch/Localized 5																				
	MOTOR Withdraws to pain/Withdraws 4																				
	MOTOR Abnormal flexion 3																				
	MOTOR Abnormal extension 2																				
	MOTOR Flaccid 1																				
	TOTAL SCORE GCS																				
Spinal	Muscle Strength (Refer to rating scale below, Rate 0 – 5) Right Arm																				
	Muscle Strength Left Arm																				
	Muscle Strength Right Leg																				
	Muscle Strength Left Leg																				
	Colour, Warmth, & Sensation of Extremities Right Arm (√ = Normal, NN = Nurse's Notes)																				
	Colour, Warmth, & Sensation of Extremities Left Arm																				
	Colour, Warmth, & Sensation of Extremities Right Leg																				
	Colour, Warmth, & Sensation of Extremities 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.

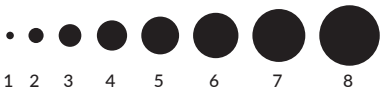
Score 2 or any one of 5 Situational Awareness Factors
Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

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