BC PEWS QI AUDITS FOR INPATIENT AND EMERGENCY SETTINGS
FREQUENTLY ASKED QUESTIONS

WHY ARE WE ASKING YOU TO COMPLETE PEWS AUDITS?

The PEWS system is only effective if used consistently and accurately. Completing regular chart audits allows the sites and the regional health authorities to identify opportunities for additional education and/or changes in processes, resources, etc. to ensure we are maximizing the potential benefits of the system.

The goal is to have a PEWS score completed for every pediatric patient at each assessment and reassessment. This means that all PEWS components need to be completed to ensure an accurate score.

HOW MANY CHARTS?

Randomly choose 20 charts for pediatric patients seen during the audit period (typically within the past 3-4 months). For sites with low volumes of pediatric patients, your total number of charts may be less than 20, in this case audit all available charts for the audit period.

Some sites audit patients as they come into the unit, some track MRNs and pull the charts retrospectively and others utilize data analysts to generate a random list of 20 charts from the audit period. All approaches are effective. If selecting charts from active patients, choose a flowsheet from a completed 24-hour period (for inpatients) or a patient that has been discharged or transferred out (for ED). **Audit only one flowsheet/ vital sign record for each patient**. Ensure you are auditing charts documented by different nurses.

WHERE DO I FIND THE AUDIT TOOLS?

The audit tools are available here: Pediatric Early Warning System (PEWS) | CHBC navigate to the purple "Clinical Support Tools" bar and scroll down to "Audit Tools". **Please ensure you select the correct tool: inpatient or emergency department; electronic or paper-based site.** Some Health Authorities have direct data-entry electronic versions. Please connect with your CHBC Coordinator regarding access.

HOW DO I CALCULATE THE NUMBER OF VITAL SIGNS ASSESSED?

Knowing how many times the patient was assessed allows us to see if there were any missed opportunities to complete a PEWS score. To capture those missed PEWS scores, we need to count every time the nurse completed an assessment, even when some components of the PEWS score are missing.

Include all times that vital signs and PEWS components were completed or partially completed; except for collecting or rechecking one parameter. If the nurse is only documenting Heart Rate (HR) and Oxygen Saturation (SpO_2) from an ongoing monitor, these can be excluded from the total count of assessments.

Examples:

1. If a nurse assesses their patient by taking a Respiratory Rate (RR), SpO_2 and HR (even from a monitor) - this is counted as an assessment that requires a PEWS score.

**This was an opportunity for the nurse to collect the other components—such as capillary refill, skin colour, and behavior—and calculate a PEWS score to support early identification of patient deterioration through trend monitoring.*

2. If the patient had an abnormal RR and the nurse goes in 15 minutes later to recheck it – this does not need to be counted. The nurse is completing a follow up/focused assessment of one parameter.

**If the RR is still high, then the nurse's clinical judgement would dictate whether a more complete assessment is warranted. If they proceed with additional assessments, then this should be counted (and a PEWS score should then be repeated).*

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WHAT SHOULD BE INCLUDED IN THE "NUMBER OF TIMES PEWS SCORE DONE"?

Any time a PEWS score is recorded, it should be counted (even if it is only based on partial vital signs and therefore not correct). This lets us know that staff are aware of the need to complete a PEWS score and are attempting to do so. If the score is incorrect, this will be captured in the accuracy section.

The number of PEWS scores can never be higher than the number of vital signs assessed: if partial vital signs are collected and a PEWS score is calculated based on the partial vital signs-this should be included under the vital sign assessment section.

HOW DO YOU DETERMINE PEWS SCORE ACCURACY?

Inaccurate PEWS scores can be the result of several factors: adding all the components of a section instead of taking the highest score, not adding up the numbers correctly, missing components (such as failing to note skin color or capillary refill) or adding additional components that should not be counted (such as counting blood pressure in the score).

The auditor needs to review how each PEWS score component is calculated to check for accuracy:

- Ensure all PEWS components are documented
- Ensure each section is added correctly and that the total score is correct

The auditor should note what errors are occurring in the comments section of the audit tool. This information can be used to provide feedback to individuals and to identify common errors, which may require education support.

WHAT IS EVIDENCE OF DOCUMENTATION OF ESCALATION OF CARE?

When a PEWS score is 4 or higher there should be evidence on the chart that steps have been taken to escalate care. This can include a noted time of escalation, charting in the nurse's notes indicating that a physician or other care provider was notified, steps taken to transfer the patient and/or increased observation**. Nurses should also document their reasoning if they have chosen not to escalate care.**

DOCUMENTING SITUATIONAL AWARENESS?

On the audit tool, indicate **YES** for each situational awareness factor documented. Indicate **NC** for "not completed" if left blank, and **NO** if assessed and determined not to be present. We do not need to capture how many times a factor was recorded.

It can be difficult to determine if situational awareness factors are being used appropriately. Look for trends - are certain factors always being overlooked? Are some being overused? Are you seeing any evidence of escalation of care based on identified risk factors?

For more information, please contact your CHBC Regional Coordinator or Child Health BC.
All PEWS resources can be found on the Child Health BC Website.