## PEWS Vital Sign Record
### 0 – 3 MONTHS

<table>
<thead>
<tr>
<th>Date:</th>
<th>Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
</tr>
</tbody>
</table>

### Respiratory

<table>
<thead>
<tr>
<th>Respiratory Rate (1 minute)</th>
<th>Resp:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>O₂ Saturation (%)</th>
<th>Supplemental O₂ Concentration Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 3L or 30%</td>
<td>≥ 3L or 30%</td>
</tr>
<tr>
<td>≥ 6L or 40%</td>
<td>≥ 8L or 50%</td>
</tr>
</tbody>
</table>

### Mode of Delivery

- None
- Mild
- Moderate
- Severe

### PEWS Score for Respiratory

- Heart Rate (1 minute) & Blood Pressure
  - Systolic: V
  - Diastolic: A
- Normal Parameters:
  - Systolic (mmHg):
    - 60 – 84 (0 – 28 days)
    - 72 – 105 (1 – 3 mos)
  - Diastolic (mmHg):
    - 30 – 53 (0 – 28 days)
    - 36 – 68 (1 – 3 mos)
- Apex: *
- Monitor: *
- If heart rate is critical – PEWS score of 3, screen for sepsis

### Cardiovascular

- MAP
  - 1 – 2 seconds
  - 3 seconds
  - 4 seconds
  - ≥ 5 seconds

- Capillary Refill
  - Pink
  - Pale
  - Grey/Cyanotic
  - Grey & Mottled

### PEWS Score for Cardiovascular

### Behaviour

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

### PEWS Score for Behaviour

### PVS

- 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

### PEWS Scoring Legend: 0 1 2 3
**PEWS Vital Sign Record**

**0 – 3 MONTHS**

**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.)

- **Pain Score**
  - Location of pain
  - Arousal Score

**PRAM Score (Asthma Patients Only)**

- **EtCO2 (mmHg)**
- **Glucometer (mmol/L)**

**Muscle Strength**

- **Right Arm**
- **Left Arm**
- **Right Leg**
- **Left Leg**

**Colour, Warmth, & Sensation of Extremities**

- **Normal**
- **Nurse’s Notes**

**Spinal**

- **Pupil Size**
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8

**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.

- **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.

**LEVEL OF AROUSAL SCORE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Level of Arousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Awake and alert, oriented</td>
</tr>
<tr>
<td>2</td>
<td>Normal sleep, easy to arouse to verbal stimulation</td>
</tr>
<tr>
<td>3</td>
<td>Difficult to arouse to verbal stimulation</td>
</tr>
<tr>
<td>4</td>
<td>Responds only to physical stimulation</td>
</tr>
<tr>
<td>5</td>
<td>Does not respond to verbal or physical stimulation</td>
</tr>
</tbody>
</table>

**PRINTED NAME**

**SIGNATURE**

**INITIALS**

Revised Sept 2018