### PEWS Vital Sign Record

**7 – 11 YEARS**

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

#### Respiratory

<table>
<thead>
<tr>
<th>Respiratory Rate (1 minute)</th>
<th>Resp:</th>
<th>O₂ Saturation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>≤3L or 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>≥3L or 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>≥6L or 40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>≥8L or 50%</td>
</tr>
</tbody>
</table>

#### Supplemental O₂ Concentration Delivered

- ≤3L or 30\%
- ≥3L or 30\%
- ≥6L or 40\%
- ≥8L or 50\%

#### Mode of Delivery

- None
- Mild
- Moderate
- Severe

#### PEWS Score for Respiratory

(Record most severe score)

#### Heart Rate (1 minute) & Blood Pressure

<table>
<thead>
<tr>
<th>Heart Rate (1 minute)</th>
<th>Systolic: V</th>
<th>Diastolic: A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Do not score blood pressure)</td>
</tr>
</tbody>
</table>

**Normal Parameters:**

<table>
<thead>
<tr>
<th>Systolic (mmHg):</th>
<th>Diastolic (mmHg):</th>
</tr>
</thead>
<tbody>
<tr>
<td>96 – 121</td>
<td>57 – 80</td>
</tr>
</tbody>
</table>

**Apex:**

- 70

**Monitor:**

- 60

<table>
<thead>
<tr>
<th>If heart rate is critical – PEWS score of 3, screen for sepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
</tr>
</tbody>
</table>

**Cardiovascular**

<table>
<thead>
<tr>
<th>Capillary Refill Time</th>
<th>1 – 2 seconds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 seconds</td>
</tr>
<tr>
<td></td>
<td>4 seconds</td>
</tr>
<tr>
<td></td>
<td>≥5 seconds</td>
</tr>
</tbody>
</table>

#### Skin Colour

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

#### PEWS Score for Cardiovascular

(Record most severe score)

#### Behaviour

<table>
<thead>
<tr>
<th>PEWS Score for Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing/Appropriate</td>
</tr>
<tr>
<td>Sleeping</td>
</tr>
<tr>
<td>Irritable</td>
</tr>
<tr>
<td>Lethargic/Confused</td>
</tr>
<tr>
<td>Reduced response to pain</td>
</tr>
</tbody>
</table>

#### Peps

- 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 Escalation Process

Activated (time)

#### PEWS Score

- ≥2

#### Temperature

<table>
<thead>
<tr>
<th>°C</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Axilla</td>
</tr>
<tr>
<td>R - Rectal</td>
</tr>
<tr>
<td>O - Oral</td>
</tr>
<tr>
<td>T - Temporal</td>
</tr>
<tr>
<td>E - Esophageal</td>
</tr>
</tbody>
</table>

#### PEWS Scoring Legend:

- 0
- 1
- 2
- 3
**Pediatric Early Warning System (PEWS) Vital Sign Record**

**7 – 11 YEARS**

**Date:**

**Initials:**

**Time:**

**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)**

**Size**

- Right
- Left

**B = Brisk**

**S = Sluggish**

**F = Fixed**

**Reaction**

- Right
- Left

**Spontaneous**

**To speech**

**To pain**

**C = Closed**

**None**

**Coos/Oriented**

**Irritable cry/Confused**

**Cries to pain/Inappropriate**

**Moans to pain/Incomprehensible**

**Normal spontaneous/Obeys**

**Withdraws to touch/Localized**

**Withdraws to pain/Withdraws**

**Abnormal flexion**

**Abnormal extension**

**Muscle Strength**

Refer to rating scale below

<table>
<thead>
<tr>
<th>Right Arm</th>
<th>Left Arm</th>
<th>Right Leg</th>
<th>Left Leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>0/5 No movement</td>
<td>3/5 Movement overcoming gravity, but not against resistance</td>
<td>1/5 Trace movement</td>
<td>4/5 Movement overcoming gravity and some resistance</td>
</tr>
<tr>
<td>2/5 Movement only (not against gravity)</td>
<td>5/5 Normal strength against resistance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Muscle Strength Grading System**

**Level of Arousal Score**

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

**Spinal Neurological**

**TOTAL SCORE GCS**

**Score 0 – 1**

Continue to monitor and document as per orders & routine protocols.

**Score 2**

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.

**Printed Name**

**Signature**

**Initials**

Revised Sept 2018