CHILD HEALTH BC

PEWS Vital Sign Record

4 – 11 MONTHS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

Date:	**Initials:**	
	Time:	

Respiratory

Respiratory Rate (1 minute)
Resp: ●
80 / 70 / 60 / 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): 82 – 105
Diastolic (mmHg): 46 – 68
Apex: ●
Monitor: ✱
If heart rate is critical – PEWS score of 3, screen for sepsis
190 / 180 / 170 / 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 (C = Closed) Spontaneous 4																					
To speech 3																					
To pain 2																					
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.

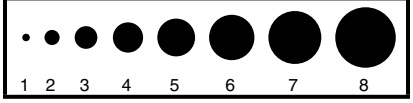
Score 2 or any one of 5 Situational Awareness Factors
Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

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