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

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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, health authorities and Child Health BC (CHBC) 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 of the PEWS components need to be completed in order 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 on the Child Health BC website: www.childhealthbc.ca . Go to the "Our initiatives" section, select PEWS, navigate to the purple "clinical support tools" bar and down to "audit tools". **Please ensure you select the correct tool: inpatient or emergency department; electronic site or paper based site.** Some Health Authorities have direct data-entry electronic versions (IHA & NHA). 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. In order 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 observations were completed or partially completed; with the exception of collecting or rechecking one parameter (for example temp or HR only). If the nurse is only documenting Heart Rate (HR) and 0xygen (O2) stats from an ongoing monitor, these can also be excluded from the total count of assessments.

Examples:

1. If a nurse assesses their patient by taking a Respiratory Rate (RR), notes 02 and HR (even from a monitor) - this is counted as an assessment that requires a PEWS score.

**This is an opportunity where the nurse should have taken the time to collect the other components and calculate a PEWS score. Taking the time to complete a capillary refill, note skin colour, behavior etc. will allow for the ongoing trending of the PEWS score and improve the quality of care.*

2. If the patient had an abnormal RR and the nurse goes in 15 minutes later to recheck – 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 or not 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 vitals 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. Are they from incorrect adding up of components? Scoring BP? Missing components? This information should then be used to provide feedback to individual nurses and to identify common errors, which may require education support. By documenting these errors, CHBC can also review for potential provincial educational opportunities.

WHAT IS EVIDENCE OF DOCUMENTATION OF ESCALATION OF CARE?

When a PEWS 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 on the flowsheet, charting in the nurse's notes indicating that a physician or other care provider was notified, steps taken to transfer patient and/or increased observation**. Nurses should also document their reasoning if they have chosen not to escalate care.** We want to ensure that a high PEWS score is addressed in some way and that there is documentation to support the decision-making.

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 (this is a function in some electronic health records). 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?

HOW DO THE SITES RECEIVE THEIR AUDIT ANALYSIS?

Your CHBC Regional Coordinator will collate the Health Authority data quarterly and provide site and health authority data back to your leadership contacts for use in quality improvement initiatives and/or ongoing education. In addition, we strongly encourage you to share your audit results with your staff and provide teaching to help address any issues noted on audit.

For more information, please contact your CHBC Regional Coordinator or Child Health BC.

All PEWS resources can be found on the CHBC website: https://www.childhealthbc.ca/initiatives/pediatric-early-warning-system-pews