5-12 Years

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

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National Paediatric Early Warning System Observation and Escalation Chart

0
1
2
4

5-12 years

Patient Name: _____

CITO Id. _____

NHS No. _____

Date of Birth: _____

Unit/Team: _____

Have you set your alarm limits?
RR
SpO2
HR
BP
Other
Type of monitor

Does your patient have any additional risk factors? ☐ NOT APPLICABLE

Risk Factor	THINK!
☐ Baseline vital signs outside of normal reference ranges	Always score the relevant PEWS value even if this is normal for the patient (e.g. cardiac patient) — Vital sign: ____ Patient's normal value: ____
☐ Tracheostomy/Airway Risk	Do you need additional help in an airway emergency?
☐ Invasive/Non-Invasive Ventilation/High Flow	Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery
☐ Neutropenic/Immunocompromised	Sepsis recognition and escalation has a lower threshold
☐ <40 weeks corrected gestation	Sepsis recognition and escalation has a lower threshold (beware hypothermia)
☐ Neurological condition (ie meningitis, seizures)	Remember to check pupillary response if anything other than Alert on AVPU
☐ Neurodiversity or Learning Disability	Be aware of the range of responses to pain and physiological changes
☐ Outlier	Do you need support from home ward/team?

This chart is solely intended for recording an inpatient paediatric patient's PEWS. The components of the chart should not be amended.

Carer question: Ask your parent/carer: How is your child different since I last saw them? You decide if their response means:

W - Worse | A - Parent/Carer Asleep
S - Same | U - Unavailable
B - Better

Date / Time / Frequency / W/S/B/A/U

Airway and Breathing

Respiratory distress

Mild
- Accessory muscle use

Moderate
- Tracheal tug
- Intercostal recession
- Inspiratory or expiratory noises

Severe
- Tripoding
- Supraclavicular recession
- Grunting
- Exhaustion
- Impending respiratory arrest

Respiratory Rate • RR/ min — Value: >50, 50, 45, 40, 35, 30, 25, 20, 15, 10, <10

Respiratory Distress — Severe / Moderate / Mild / None

SpO_2 — ≥95% / 92% - 94% / ≤91% / SpO_2 probe change (✓)

Respiratory support device (RSD)
HF = High Flow
BiP = BiPAP
CP = CPAP
Scores the maximum of 4

Other delivery methods
NP = nasal prongs
FM = face mask
HB = head box
NRB = Non-rebreather
Score as per oxygen

Oxygen — Oxygen as per PGD or prescription box, of 100% oxygen. Mark % with a ● and L/min with an 'X'. RSD CODE (maximum score is 4). 100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 28%, 24%, <21%. Document 'Air' or Value Delivery method /RSD flow rate

Oxygen Delivery (NOT High Flow Delivery) Litres per min (L/Min) — 15, 10, 8, 6, 4, 2, 1, 0.1, <0.01

Circulation

Heart Rate • HR/ min — Value: >190, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, <50

Record position of BP taken by inserting relavant initials above systolic arrow

LA - Left Arm
RA - Right Arm
LL - Left Leg
RL - Right Leg

Derogation *Code* if required:

Not attempted (No concern) - NCO (this scores 0)

Unsuccessful Attempt (No Concern) - U0 (this scores 0)

Unsuccessful attempt (Concern) - U4 (this scores 4)

Blood Pressure (Score systolic only) • mean < diastolic (no score) systolic > — BP Value or *Code*: >150, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, <30

CRT Record in seconds — ≥3 secs / ≤2 secs

PEWS

AVPU

Blood glucose

Pain score (as per local policy)

Disability and Exposure

If V or less do GCS
A = Alert
V = Responsive to voice
P = Responsive to pain
U = Unresponsive

If asleep with no reason for altered conscious state (e.g. sepsis) write 'asleep'.

Temperature °C A=Axilla T=Tympanic S=Skin — Value: >39, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35, 34.5, <34.5

New suspicion of sepsis or septic shock (Y/N)

Clinical intuition
If you're feeling that the patient is 'just not right' despite a low PEWS or natural carer concern *(Y/N)

Clinical intuition (Y/N)

Trigger criteria

Escalation level

Escalated (Y/Plan)

Time NIC informed

Time clinician informed

Time clinician arrived

PICU/transport team called

Signature

Trigger criteria
Cause(s) for escalation:
SC = Specific Concern
CQ = Carer Question
CI = Clinical Intuition
P = PEWS
0 = None

Escalation / Graded Response to PEWS

0-4	**If on respite or short stay unit:** Continue to monitor (minimum hourly) for minimum duration of 4hours – if remains high after 4 hours contact paediatric professional via 111 **If community:** Inform duty nurse/medic and discuss plan, consider GP/A&E/111 review
5-6	**If on respite or short stay unit:** Inform nurse in charge/clinical lead and increase observations (frequency as clinically indicated - minimum twice / hour). AND Obtain medical advice from paediatric professional via 111 **If community:** Inform duty nurse/medic and support access to hospital (A&E) within 1 hour
7+	**If on respite or short stay unit:** Continuous monitoring discuss with paediatric professional (at nearest hospital) and consider phoning for ambulance and transfer to emergency department **If community: Stay with patient and monitoring every 15 mins.** Inform duty nurse/medic and on-call paediatric professional (at nearest hospital) and create plan considering transfer to emergency department
4 in a single parameter	A single score of 4 on one of the physiological observations **must** trigger urgent medical attention **If on respite or short stay unit:** Inform nurse in charge/clinical lead and increase observations (frequency as clinically indicated - minimum twice / hour). AND Obtain medical advice from paediatric professional via 111 **If community:** Inform duty nurse/medic and support access to hospital (A&E) within 1 hour

A	The patient is alert
V	The patient responds to verbal stimulation only
P	The patient responds to painful stimulation only
U	The patient is completely unresponsive

New Confusion- The patient displays new confusion or agitation.

Some patients may have impaired level of consciousness as a consequence of sedation. This must be taken into consideration when acting upon high scores

Additional consideration if PEWS triggers
Pain assessment (ask the patient)
BM (blood glucose)
Passed urine (ask the patient)

Consider SEPSIS as a cause for deterioration! If YES to the 3 questions below – THINK SEPSIS
Is PEWS 5 or above?
Does the patient have signs of infection?
Is the patient known to be susceptible to infections?

SBARD

S — Situation:
I am (nurse X) on ward (X),
I am calling about patient (X), I am calling because I am concerned that…… (e.g. patient's mood is very low and expressing suicidal ideation)

B — Background:
Patient (X) was admitted on (X date) following (X) but has until today been well.
Patient has a diagnosis of (X condition) and their Mental Health Act status is (X) and he/she is receiving (medication/ therapy)
The patient has deteriorated in the last (X) AND/ OR following (X)

A — Assessment:
I think the problem is (X) and I have (e.g. Put the patient on higher level observation)
OR I am not sure what is wrong but patient (X)'s mental state has deteriorated and I am worried they are at higher risk of X
OR
I do not know what is wrong but I am worried and concerned

R — Recommendation:
I need you to (eg. come and see the patient by X time) in order to (X)

D — Decision:
So we have agreed you will visit the ward in the next (X mins), and in the meantime we will (X) (eg. Place the patient on enhanced observation and engagement)

Ask receiver to repeat key information to ensure understanding

Date:	Time:	PEWS risk score:	Action:	Signature and designation

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Based on the original design from Birmingham Women's and Children's NHSFT with contributions from other English charts and amendments from National SPOT Programme
This tool has been amended by Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV) to include escalation/graded response, SBARD and additional prompts appropriate for a mental health Trust - see TEWV policy CLIN-0098-v3

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