journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

# Procedure for Using the Paediatric Early Warning Score (PEWS) for the Early Detection and Management of the Deteriorating Patient in CAMHS

Aged 1 to 4 Years

Aged 5 to 12 Years

Aged ≥ 13 Years

# Ref: CLIN-0098-v3

**Status: Approved**
**Document type: Procedure**
**Overarching policy: Physical Health and Wellbeing Policy**

## Contents

# 1 Introduction

This procedure is based on the national PEWS that was published November 2023.

The Trust is committed to improving the physical health of its patients and reducing incidents of harm. This clinical procedure will outline how staff can promote the early detection, prevention and management of physical health deterioration.

Physical health deterioration can occur at any stage of a patient's pathway. Within a mental health and learning disability Trust there are certain periods when our patients may be more vulnerable such as:

- during the onset of infection or illness
- during procedures such as dental interventions
- administration of rapid tranquilisation
- during changes of medication
- after a fall
- during a period of deterioration of their mental health
  - Including, but not limited to, as a consequence of self-induced and accidental deterioration secondary to mental health e.g., overdose, ingestion of noxious substances, self- injury wounds, tying of ligatures.
- During an exacerbation of a physical long-term condition e.g. Diabetes, Asthma, Cystic Fibrosis.

Patients who physically deteriorate present with abnormalities that are detectable by simple measurement of physiological observations. Vigilant clinical staff who are trained to recognise and respond to these signs, can prevent further deterioration (Royal College of Physicians 2012).

**For most children and young people cared for within community mental health teams primary care services are responsible for physical health monitoring.**

## 1.1 Background to the development of a National Early Warning Score (NEWS) for over 16year olds and introduction to the Paediatric Early Warning Score (PEWS) for under 16year olds

In 2012 the Royal College of Physicians in partnership with the Royal College of Nursing, standardised the assessment and scoring of six simple physiological observations to be used in all NHS Trusts. This standardised approach would assist practitioners to monitor a patient's physical wellbeing.

The effectiveness of embedding an early warning score system is based on two assumptions:-

1. Registered Nurses and Healthcare Assistants have the knowledge and skills to regularly record physiological observations using an agreed EWS observation chart.
2. If a patient deteriorated, the Registered Nurse appropriately refers using an agreed track and trigger response system.

Benefits of using an Early Warning Scoring system: -

- Improves the quality of patient observation and monitoring
- Improves communication within the MDT

- Allows for timely discussions to support clinical judgement
- Aids securing appropriate assistance for poorly patients
- Gives a good indication of physiological trends
- Provides a sensitive indicator of abnormal physiology

NHS England published the national scoring system for under-16s' in November 2023, and the above benefits remain true for health services supporting children and young people.

The National Paediatric Early Warning System (PEWS) allows for consistency, across different hospital sites, in how deterioration of physical health in children is recognised.

The escalation/graded response and SBARD tool for PEWS had to be revised for a mental health Trust and this was developed and ratified via TEWV governance processes.

This procedure supports Our Journey to Change as set out in the Physical Health and Wellbeing Policy.

# 2 Purpose

Following this procedure will help the Trust to: -

- Standardise practice for all clinical staff within CAMHS in the early recognition and response in the deteriorating patient, through adoption of optimal PEWS tools.
- Facilitate early detection by using a PEWS tool for the appropriate and timely management of clinical deterioration for individuals who are: 1-4years; 5-12years; ≥ 13years or in some cases when clinically indicated and agreed following assessment of BMI and physicality those aged 16 to 18.
- Reduce clinical risks associated with inappropriately managed clinical conditions.

# 3 Who this procedure applies to

This clinical procedure applies to all clinical staff employed by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) providing care delivered to young people (as specified in sections 5.2.3 & 5.2.4) aged 1-4years; 5-12years; ≥ 13years of age and in some cases, where the clinical assessment has indicated, 16-18 years.

## 3.1 Roles and Responsibilities

| Role | Responsibility |
|---|---|
| Chief Nurse | • Responsible for the development, review and monitoring of this procedure and practice standards in physical healthcare and for the provision of appropriate training and education to support the delivery of physical healthcare. |
| Medical Staff (including Physical Healthcare Practitioners where available) | • Short stay/Respite units – see escalation table on PEWS charts<br>• Community teams – consult with medic.<br>• Respond to staff concerns.<br>• Assess, as required/indicated, clinical need |

| | |
|---|---|
| | • Attend relevant training to this procedure. |
| Unit/Team Managers / Clinical Leads | • Ensuring that<br>  ○ Staff have appropriate training<br>  ○ The Paediatric Early Warning Score process is adhered to<br>  ○ The Paediatric Early Warning Score is discussed regularly at report outs, ward rounds or the appropriate, routine MDT review point, and at all transfers of care.<br>  ○ Attend relevant training to this procedure. |
| Registered Nurses and Healthcare Assistants | • Ensure the appropriate completion of the Paediatric Early Warning Score as per this procedure.<br>• Follow the procedure for escalating high scores using the agreed communication tool.<br>• Attend relevant training to this procedure.<br>• Health Care Assistants should report any escalation to a Registered Nurse but do have authority to call for medical assistance or emergency services if they have sufficient concern about any patient. |

# 4 Related Documents

This procedure describes what you need to do to implement the Physical Health Assessment and Ongoing Monitoring section of the Physical Health and Wellbeing Policy.

The Physical Health and Wellbeing Policy defines standards which you must read, understand and be trained in before carrying out the procedure described in this document.

This procedure also refers to (all found at Policies, procedures and legislation | TEWV Intranet )

- ✓ Pharmacological Management of Severe Agitation MSS21
- ✓ Prescribing and Administration of Medication in Section 136 suites
- ✓ Physical Health and Wellbeing Policy (inpatients and community)
- ✓ Physical health monitoring flowchart
- ✓ Physiological Assessment Procedure redirection
- ✓ Diabetes Management for Inpatients
- ✓ Resuscitation Policy
- ✓ Mental Capacity Act 2005
- ✓ Consent to Examination or Treatment Policy
- ✓ Oxygen administration in an emergency MSS10
- ✓ Oxygen and other medical gases – Administration, Prescribing, Storage Safety
- ✓ NEWS and the Early Detection and Management of the Deteriorating Patient age 16 and above
- ✓ Sepsis Screening Tool: Non-Pregnant Adults, Young People and Children
- ✓ TEWV Pharmacy Pain management
  TEWV Pharmacy-medicines-optimisation-interactive-guidepdf

- ✓ Distress and Discomfort Assessment Tool (DisDAT) v22
  disdat Assess tool 09.pdf
- ✓ Interpreting and Translation Guidance
  Interpreting and Translation guidance

# 5 Procedure

## 5.1 What is an Early Warning Score

The Paediatric Early Warning Score is based on a simple scoring system in which a score is allocated to physiological observations (see below). Each individual observation generates a score. When all scores are added together, this provides the overall Paediatric Early Warning Score which is set to trigger when a patient is acutely unwell or has abnormal physiology.

| Physiological observation | | How to measure | How to record (use black ink) |
|---|---|---|---|
| **Airway & Breathing (AB)** | Respiration Rate | Count respirations for 1 minute. Try not to let patient know you are counting as this may affect rate. | Enter rate in numbers. |
| | Oxygen Saturations (Sats /$SpO_2$) | Using pulse oximeter. | Enter percentage<br><br>Enter figure for patient on $O_2$ |
| | Respiratory Distress | Respiratory Effort Criteria Table 1. | Enter figure according to code |
| | Oxygen Therapy | Yellow Score 1 given if receiving oxygen therapy | Enter Yes or No |
| **Circulation (C)** | Heart Rate (Pulse) | Heart rate and rhythm is recorded manually by counting the beats felt at the wrist for one minute. Although a digital BP and Sats monitor will record a heart rate, manual recording is the preferred standard. | Enter figure<br>Indicate regular rate (r) and irregular with (i) |
| | Systolic Blood Pressure (BP) | Using digital or manual equipment – while Blood pressure is measured and recorded.<br>It does **not** form part of the PEW score but can add to the overall clinical picture. | Enter figures |
| **Disability (D)** | Level of Consciousness (AVPU = alert, voice, pain, unresponsive) | **A**- The patient is alert.<br>**V**- The patient responds to verbal stimulation.<br>**P**- The patient responds to painful | Tick appropriate box |

| | | | |
|---|---|---|---|
| | | stimulation. (squeeze part of the trapezius muscle in the patient's shoulder).<br>**U**- The patient is completely unresponsive.<br>**New Confusion**- The patient displays new confusion or agitation. | |
| **Exposure (E)** | Temperature | Using digital equipment: tympanic thermometer or<br>Non-contact infrared digital thermometer. | Enter figure |
| **Pain** | Either self-reported or by observation | Use DisDAT (a rating scale for those with Learning Disabilities or communication difficulties) to support and inform clinical decision making - alongside the PEW Score. | Enter score |

## 5.2 Recording the Early Warning Score

### 5.2.1 Documentation

To facilitate standardisation of recording – a printed/hard copy, colour coded PEWS chart must be completed.

TEWV Foundation Trust will use three PEWS charts which include the required track and trigger responses (Appendices 3-5).

- Early Warning Score chart (Young People 1 to 4 years of age)
- Early warning score chart (Young People 5 to 12 years of age)
- Early warning score chart (Young People ≥ 13years

All entries on the PEWS chart must be dated and the time recorded in the 24-hour format.

These scores must then be recorded in the EPR (electronic patient record).

### 5.2.2 Frequency of monitoring

As a standard the Trust have agreed the following principles when deciding the frequency of recording PEWS in CAMHS, however each patient should be assessed on an individual basis.

The PEWS **must** be completed for all patients on admission to bed-based services (ie In-patient Units, Short stay/Respite Units) in order to establish a baseline measure.

### 5.2.3 Regular monitoring in bed based settings

In Short stay/Respite Unit setting:

- ✓ All patients will have PEWS recorded on admission.
- ✓ The qualified staff on duty and / or Physical Healthcare Practitioner will agree frequency of monitoring which will form part of an individual care plan.
- ✓ Increase the frequency of monitoring when a patient displays any change in physical or mental health-giving cause for concern.
- ✓ Increase the frequency of monitoring in accordance with the table on the back of the PEWS chart.
- ✓ Patients cared for
    - with significant comorbid pre-existing physical health needs

  will require more intensive monitoring and staff within the service will need to ensure that they follow their service specific policies and guidelines or reference to the individual care plan.

### 5.2.4 Monitoring in other settings/community teams

- ✓ Patients cared for:
    - within an Eating Disorder Service
    - who require both prescribed medication and physical health monitoring as part of their care

  may require more intensive monitoring and staff within the service will need to ensure that they follow their service specific policies and guidelines or reference to the individual intervention plan
- ✓ As required - Patients will have PEWS recorded as per care plan and physical health monitoring guidance
- ✓ As required - Increase the frequency of monitoring when a patient displays any change in physical or mental health-giving cause for concern.
- ✓ As required - Increase the frequency of monitoring in accordance with the table on the back of the PEWS chart or signpost to GP/A&E/111.
- ✓ **For most children and young people cared for within community mental health teams primary care services are responsible for physical health monitoring.**

### 5.2.5 Triggers, High baseline scores and care plan review

Individual triggers and care plans must be determined as part of a care plan review : adopting a Triangle of Care approach with family and carers, a medic or GP and other external professionals as appropriate. .

High baseline scores may be present in some patients with co-existing long term physical conditions such as Cystic fibrosis. This may warrant further action if the score remains consistently high, a review of the triggers will be appropriate and documented on the special notes section of the individual PEWS chart and also in Physical Health Case note on electronic patient record.

### 5.2.6 Rapid Tranquilisation

- ✓ Following administration of rapid tranquilisation (RT), patients **must** have their physical health and level of consciousness monitored.
- ✓ Monitoring physiological observations should continue even if the patient is asleep post rapid tranquilisation.
- ✓ Physiological observations should be monitored every 10 minutes for 1 hour
- ✓ If all PEWS cannot be recorded in full, or observations refused, monitor breathing as a minimum, observe for pallor, cyanosis, shiver and increased confusion.
- ✓ The post RT recoding template should be pasted into the patient electronic record detailing the incident observations and debrief.

### 5.2.7 Additional consideration when monitoring and interpreting PEWS

- ➢ Always consider the patient's normal baseline observations and the views of the clinical team to assist your clinical judgement.
- ➢ Remember the PEWS is only one way of detecting early deterioration in a patient's physical health. There are other scoring systems such as the Coma Scale (CS).
- ➢ PEWS should be calculated even if all physiological observations cannot be measured as individual scores can be early warning signs of deterioration.
- ➢ Patients may refuse to have their physiological observations measured for a variety of reasons. This should be recorded on the PEWS chart and further monitoring attempts must be recorded in Physical Health Case note on the electronic patient record.
- ➢ It is important to report a recorded high blood pressure to a member of the medical team.

### 5.2.8 Consider Sepsis (infection) as a cause for deterioration.

THINK SEPSIS - **TEWV Sepsis Screening Tool: Non-Pregnant Adults, Young People and Children (age 12 and above)** OR **Sepsis Screening Tool Children (Aged 5 – 11)**

Consider Sepsis (infection) as a cause for deterioration. Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis affects all age groups and can present in any clinical area therefore staff vigilance is critical.

Signs of Sepsis include:

- **S**lurred speech
- **E**xtreme muscle pain
- **P**assing no urine
- **S**evere breathlessness
- **I** "feel I might die"
- **S**kin mottled or discoloured

Assess temperature, heart rate, respiratory rate, blood pressure, level of consciousness and oxygen saturation in young people and adults with suspected sepsis and complete the PEWS.

Examine people with suspected sepsis for mottled or ashen appearance, cyanosis of the skin, lips or tongue, non-blanching rash of the skin, any breach of skin integrity (for example, cuts, burns or skin infections) or other rash

indicating potential infection (Suspected sepsis: recognition, diagnosis and early management (2016) NICE guideline NG51)

## 5.3 Interpretation and response to PEWS Score

Once the physiological observations have been recorded and documented on the appropriate PEWS chart, an individual score for each of the physiological observations is generated which when added together will provide the overall Paediatric Early Warning Score. The PEWS scoring system categorises and colour codes the scores as either: -

| **Colours represent severity of decline in physical health and should determine urgency of clinical response.** |
|---|
| No Score (No colour) |
| Low score (Yellow) |
| Medium score (Orange) |
| High score (Red) |

A table representing the PEWS scoring system can be found on the back page of each of the appropriate PEWS charts. If there is any doubt about the score seek additional guidance from a medical or nursing colleague.

**A single score of 4 on one of the physiological observations must trigger urgent medical attention.**

### 5.3.1 Oxygen

Patients receiving supplementary oxygen at the time of monitoring should have 1 added to the overall Paediatric Early Warning Score.

Oxygen can be applied in an emergency situation if oxygen sats are 91% or less or an early warning score of 4 or more. This should be administered using a non-rebreathe mask (with reservoir at 15 litres per minute).

In an emergency situation oxygen may be administered under the Protocol For Administration of Oxygen in an Emergency Situation by any member of staff who has undertaken First Response Training. The Ambulance Service must be called when a patient requires emergency oxygen.

## 5.4 Response to PEWS Score

A Paediatric Early Warning Score total may hit an agreed threshold and trigger a response. TEWV have agreed and outlined the appropriate clinical response for a low, medium and high score (see back of PEWS chart). Should the PEWS score trigger a response and if you are concerned, there are 3 additional considerations for recording on the PEWS observation chart (see below):

| Additional considerations if PEWS triggers | How to record |
|---|---|
| Pain assessment (ask the patient or your knowledge of patient) | Insert Yes (Y) or No (N) |
| BM (blood glucose) | Insert numerical value |
| Passed urine (ask the patient or monitor incontinence pads) | Insert Yes (Y) or No (N) |

Document response on the PEWS chart (escalation plan) and record the score and actions in the Physical Health Casenote on ELECTRONIC PATIENT RECORD.

## 5.5 Principles for using Situation, Background, Assessment, Recommendation and Decision (SBARD) Tool within PEWS procedure

The escalation/graded response and SBARD tool for PEWS had to be revised for a mental health Trust and this was developed and ratified via TEWV governance processes.

When communicating concerns with another member of staff, the SBARD tool should be used as Trust standard and documented in the Physical Health case note on electronic patient record.

The SBARD tool is based on the following principles:

- It is based on a nationally recognised tool for rapid, effective communication during urgent situations.
- The tool has been incorporated on to the back page of each of the PEWS charts. Inadequate verbal or written communication is recognised as being the most common root cause of serious clinical errors. Therefore, including a recognised communication tool within the PEWS chart is critical.
- Using the SBARD tool can help prevent breakdowns in verbal and written communication by building a common language platform for communicating critical events, thereby reducing barriers to communication between healthcare professionals.

## 5.6 Recognise and Respond to the Deteriorating Patient: Quick Reference Guide

The standards for recognising and responding to the deteriorating patient have been incorporated into a visual quick reference guide to be displayed within inpatient areas (clinic room). This can also be used as a tool when supporting staff with implementing the procedure (Appendix 5).

# 6 Definitions

| Term | Definition |
|---|---|
| Ambulatory | Capable of walking and not bedridden. |
| Cardio Vascular Disease (CVD) | CVD is a general term that describes a disease of the heart or blood vessels. Blood flow to the heart, brain or body can be reduced as the result of a blood clot (thrombosis), or by a build-up of fatty deposits inside an artery that cause the artery to harden and narrow (atherosclerosis). There are four main types of CVD: coronary heart disease, stroke, peripheral arterial disease and aortic disease. |
| Chronic Obstructive Pulmonary Disease (COPD) | COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulty breathing, primarily due to the narrowing of their airways. |
| Coma Scale (CS) | The Coma Scale or CS is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment.<br>The *Glasgow* Coma Scale is intended for use with adults, so the Coma Scale included in this procedure is slightly amended for use with children and young people. |
| Cyanosis | For individuals who have black or brown skin cyanosis presents as grey or whitish (not bluish) skin around the mouth, and the conjunctivae may appear grey or bluish. Assess the conjunctiva of the eye or the mucous membranes - looking at the roof of the mouth.<br>In light-skinned patients, cyanosis presents as a dark bluish tint to the skin and mucous membranes (which reflects the bluish tint of unoxygenated haemoglobin). |
| Diabetes | Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes – type 1 diabetes and type 2 diabetes. |
| DisDAT | Intended to help identify distress cues in people who because of cognitive impairment or physical illness have severely limited communication. Designed to document a person's usual content cues, thus enabling distress cues to be identified more clearly.<br>NOT a scoring tool. It documents what many staff have done instinctively for many years thus providing a record against which subtle changes can be compared. This information can be transferred with the client or patient to any environment. |

| | |
|---|---|
| | Meant to help you and your client or patient. It gives you more confidence in the observation skills you already have which in turn will help you improve the care of your client or patient.<br>Useable by any carer - both lay and professional carers find they can use this tool.<br>A means of providing a clearer picture of a client's 'language' of distress. |
| Neuroleptic Naive | A person who has never taken antipsychotic medication before. |
| New Early warning score 2 (NEWS2) | The New Early Warning Score is the nationally agreed tool for persons 16 and above. This may be used for some service users but will be dependent on a full clinical physical assessment. |
| Parenteral Administration | Taken into the body or administered in a manner other than through the digestive tract, as by intravenous or intramuscular injection. |
| Paediatric Early Warning Score (PEWS) | The Paediatric Early Warning Score is based on a simple scoring system in which a score is allocated to physiological observations. Each individual observation generates a score. When all scores are added together, this provides the overall Paediatric Early Warning Score which is set to trigger when a patient is acutely unwell or has abnormal physiology. |
| Physiological Observation | Physiological observations are essential requirements for patient assessment and the recognition of clinical deterioration. |
| Sepsis | Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly. |
| Situation, Background, Assessment, Recommendation and Decision (SBARD) communication tool | Nationally recognised tool for rapid, effective communication during urgent situations. |

# 7 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.
- Staff will comply with Trust training relating to this procedure.

## 7.1 Training needs analysis

| Staff/Professional Group | Type of Training | Duration | Frequency of Training |
|---|---|---|---|
| All staff who do PEWS recording | On line ESR training | 15 mins | One off and as required for personal refresh |

# 8 How the implementation of this procedure will be monitored

| | Auditable Standard/Key Performance Indicators | Frequency/Method/Person Responsible | Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). |
|---|---|---|---|
| 1 | Assessment of compliance with the procedure and staff competency in taking, recording and interpreting readings. | Annual service specific audits will be conducted by Matrons | Local Service Improvement and Development Groups (SIDG's) responsible for the Service. |

# 9 References

**National paediatric early warning system (PEWS)** (November 2023)

Suspected sepsis: recognition, diagnosis and early management (2016) NICE guideline NG51

Scenario: Management | Management | Sepsis | CKS | NICE

Overview | Acutely ill adults in hospital: recognising and responding to deterioration | Guidance | NICE

Overview | Suspected sepsis: recognition, diagnosis and early management | Guidance | NICE

Jackson, L. et al. (2007) Blood pressure centiles for Great Britain. National Centre for Biotechnology information.

Patient Safety First (2008) The 'How to Guide' for Reducing Harm from Deterioration.

Royal College of Physicians (2012) National Early Warning Score (NEWS). Standardising the assessment of acute-illness severity in the NHS. Report of a Working Party. News Report

The Royal Marsden Manual of Clinical Nursing Procedures Tenth Edition (Online) Available from: http://www.rmmonline.co.uk/. (Accessed 21st November 2021).

TEWV Medicines Overarching Framework – in particular @Patient group Directives' & 'Homely Remedies'. Pharmacy, Medicines and our Medicines Optimisation Interactive Guide | TEWV Intranet

# 10 Document control (external)

To be recorded on the policy register by Policy Coordinator

| Required information type | Information |
|---|---|
| Date of approval | 03 November 2025 |
| Next review date | 03 November 2028 |
| This document replaces | PEWS Procedure v2 |
| This document was approved by | CAMHS physical health Subgroup |
| This document was approved | 12 August 2025 |
| This document was ratified by | Physical Health Group (Trustwide) |
| This document was ratified | 03 November 2025 |
| An equality analysis was completed on this policy on | 03 Feb 2025 ah |
| Document type | Public |
| FOI Clause (Private documents only) | n/a |

**Change record**

| Version | Date | Amendment details | Status |
|---|---|---|---|
| 1 | 22 Jan 2019 | • EWS procedure (CLIN-0076-V3) split in to NEWS2 adult (age 16 and above) version (CLIN-0099) and child version (CLIN-0098) | Withdrawn |

| | | | |
|---|---|---|---|
| | | • Reviewed and updated to be CAMHS specific due to introduction of NEWS2 for all adult services and no changes to EWS for CAMHS | |
| 2 | 05 Oct 2021 | • Changes to reflect age range in CAMHS and use of EWS/NEWS2/PEWS | Withdrawn |
| 3 | 03 Nov 2025 | Full review with changes including:<br>• updated PEWS Policy with National PEWS grids including escalation pathways;<br>• updated language to reference national guidance;<br>• updated to reflect organisational change;<br>• updated to reflect current Equality Diversity Inclusion and Human Rights perspective.<br>• Review of escalation grids, local clinical processes and role responsibilities | Published |
| | | | |

# Appendix 1 - Equality Impact Assessment Screening Form

**Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet**

| Section 1 | Scope |
|---|---|
| Name of service area/directorate/department | CAMHS Trustwide |
| Title | Procedure for Using the Paediatric Early Warning Score (PEWS) for the Early Detection and Management of the Deteriorating Patient in CAMHS |
| Type | Procedure |
| Geographical area covered | Trustwide |
| Aims and objectives | To improve the quality of patient observation and monitoring<br>To improve communication within the clinical team<br>To allow for timely discussions to support clinical judgement<br>To aid securing appropriate assistance for poorly patients<br>To give a good indication of physiological trends<br>To provide a sensitive indicator of abnormal physiology |
| Start date of Equality Analysis Screening | 10 Jan 2025 |
| End date of Equality Analysis Screening | 03 Feb 2025 |

| Section 2 | Impacts |
|---|---|
| Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit? | Children and Young People under 16yrs old |
| Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications? | • **Race** (including Gypsy and Traveller) **NO**<br>• **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO**<br>• **Sex** (Men and women) **NO**<br>• **Gender reassignment** (Transgender and gender identity) **NO**<br>• **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO**<br>• **Age** (includes, young people, older people – people of all ages) **NO**<br>• **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO**<br>• **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO**<br>• **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO**<br>• **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO**<br>• **Human Rights Implications NO** (Human Rights - easy read) |
| Describe any negative impacts / Human Rights Implications | None |
| Describe any positive impacts / Human Rights Implications | Fulfil individual human rights (The right to Life) |

| Section 3 | Research and involvement |
|---|---|
| What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.) | National PEWS<br>NEWS<br>Human Rights |
| Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups? | Yes |
| If you answered Yes above, describe the engagement and involvement that has taken place | CAMHS Physical Health group<br>Trustwide Physical Health group |
| If you answered No above, describe future plans that you may have to engage and involve people from different groups | N/A |

| Section 4 | Training needs |
|---|---|
| As part of this equality impact assessment have any training needs/service needs been identified? | Yes |
| Describe any training needs for Trust staff | Training re use of PEWS |
| Describe any training needs for patients | N/A |
| Describe any training needs for contractors or other outside agencies | N/A |

**Check the information you have provided and ensure additional evidence can be provided if asked.**

# Appendix 1b – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

| Title of document being reviewed: | Yes / No / Not applicable | Comments |
|---|---|---|
| **1. Title** | | |
| Is the title clear and unambiguous? | Y | |
| Is it clear whether the document is a guideline, policy, protocol or standard? | Y | |
| **2. Rationale** | | |
| Are reasons for development of the document stated? | Y | |
| **3. Development Process** | | |
| Are people involved in the development identified? | Y | |
| Has relevant expertise has been sought/used? | Y | |
| Is there evidence of consultation with stakeholders and users? | y | Nationally developed tool with national consultation<br>05 Feb 2025 – full trustwide consultation<br>4 April 2025 Reviewed feedback from consultation and escalation grids, local clinical processes and role responsibilities with CAMHS Matrons |
| Have any related documents or documents that are impacted by this change been identified and updated? | Y | |
| **4. Content** | | |
| Is the objective of the document clear? | Y | |
| Is the target population clear and unambiguous? | Y | |
| Are the intended outcomes described? | Y | |
| Are the statements clear and unambiguous? | Y | |
| **5. Evidence Base** | | |

| | | |
|---|---|---|
| Is the type of evidence to support the document identified explicitly? | Y | |
| Are key references cited? | Y | |
| Are supporting documents referenced? | Y | |
| **6. Training** | | |
| Have training needs been considered? | Y | |
| Are training needs included in the document? | Y | |
| **7. Implementation and monitoring** | | |
| Does the document identify how it will be implemented and monitored? | Y | |
| **8. Equality analysis** | | |
| Has an equality analysis been completed for the document? | Y | |
| Have Equality and Diversity reviewed and approved the equality analysis? | Y | 03/02/2025 ah |
| **9. Approval** | | |
| Does the document identify which committee/group will approve it? | Y | |
| **10. Publication** | | |
| Has the policy been reviewed for harm? | y | No harm |
| Does the document identify whether it is private or public? | y | public |
| If private, does the document identify which clause of the Freedom of Information Act 2000 applies? | N/A | |
| **11. Accessibility** (See intranet accessibility page for more information) | | |
| Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors) | Y | |
| Do all pictures and tables have meaningful alternative text? | Y | |
| Do all hyperlinks have a meaningful description? (do not use something generic like 'click here') | Y | |

# Appendix 2 – Recognise and respond to the deteriorating patient: Quick Reference Guide

## Recording the PEWS

| Regular Monitoring | Rapid Tranquilisation |
|---|---|
| • On admission to bed based services (ie Respite/ Short stay Unit) and as required in other settings<br>• The qualified staff on duty will agree frequency of monitoring which will form part of the individual care plan<br>• Patient displays change in physical or mental health, causing concern<br>• Following a fall/head injury<br>• Changes to medication | Monitor physiological observation<br>• Parenteral (injectable) – every 10 minutes for one hour.<br>• Then every 30 minutes until patient is ambulatory or for 3 hours – whichever is first.<br><br>Monitor observations even if patient is asleep and monitor breathing as a minimum. |

Are you able to complete observations?

**Yes**

**No** → Score on PEWS chart & further monitoring attempts must be recorded on physical health casenotes on electronic health record

## Interpretation & Response to

1. Document recording on appropriate Paediatric Early Warning Score Chart (PEWS)
2. Add each physiological score together to get an overall Early Warning Score
3. Interpret score and respond accordingly to scoring system

Should the Early Warning Score trigger a response, document on the PEWS chart and record the score and the response in physical health casenote in the electronic health record.

A single score of 4 on any of the parameters must trigger urgent medical response

Additional considerations if PEWS triggers: Pain Assessment. Blood Glucose. Passed urine.

Additional considerations when monitoring patients PEWS:

Consider Sepsis (infection) as a cause of the deterioration

Report a high blood pressure to a medic or GP

Patients receiving supplementary oxygen at the time of the measurement should have a 1 added to their total score

Individualised triggers must be determined as part of a MDT review

## Action

When communicating concerns about a patient with another member of staff use the Trust standardised **SBARD** communication tool.

**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, **D**ecision.

# Appendix 3 - TEWV PEWS 1 – 4 years Observation and escalation chart

Please note this chart is 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.

(TEWV PEWS 1-4 years National Paediatric Early Warning System Observation and Escalation Chart TEWV – link to chart)

# Appendix 4 – TEWV PEWS 5 – 12 years Observation and escalation chart

Please note this chart is 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.

(TEWV PEWS 5 - 12 years National Paediatric Early Warning System Observation and Escalation Chart TEWV – link to chart)

# Appendix 5 – TEWV PEWS ≥ 13years Observation and escalation chart

Please note this chart is 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.

(TEWV PEWS ≥ 13 years National Paediatric Early Warning System Observation and Escalation Chart TEWV – link to chart)