Hospital Logo

PAEDIATRICS

Paediatric Observation Chart
1-4 Years

Addressograph

Ward

Consultant

Escalation Guide

PEWS does not replace an emergency call

Score	Minimum Observations	Minimum Alert	Minimum Response
1	4 hourly	Nurse in Charge	Any trigger should prompt increase in observation frequency as clinically appropriate
2	2 - 4 hourly		
3*	1 hourly	Nurse in Charge + Doctor on call	Nurse in Charge review
4-5	30 minutes		Urgent medical review
6	Continuous	Nurse in Charge + Doctor on call + Senior Doctor + Consultant	Urgent SENIOR medical review
≥7	Continuous	**URGENT PEWS CALL**	Immediate local response team

*** Pink score in any parameter merits review**

PEWS does not replace clinical concern

ISBAR Communication Tool

Identify **S**ituation **B**ackground **A**ssessment **R**ecommendation

Medical Escalation Suspension

Date / Time	Suspension Conditions	Next Medical Review	Doctor Signature/Print name /MCRN
Start Date: Start Time: End Date: End Time:			
Start Date: Start Time: End Date: End Time:			
Start Date: Start Time: End Date: End Time:			

Paediatric Sepsis 6

Recognition

2 or more of the following

- Core temperature <36°C or >38.5°C
- Inappropriate tachypnoea
- Inappropriate tachycardia
- Reduced peripheral perfusion
- Altered mental status
- Consider co-morbidities

Suspected or proven sepsis

TAKE 3 <60 Mins.
- IV or IO access and take blood samples
- Urine output measurement
- **Early SENIOR input**

Within 60 minutes

GIVE 3 <60 Mins.
- High flow oxygen
- IV/IO fluids & consider early inotropic support
- Broad spectrum IV/IO antimicrobials

Version N3 | 2016

Event Record for PEWS score ≥6				
Date	Time	PEWS	Nurse Initials & NMBI	Alert

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Assessment of Respiratory Effort

	Mild	Moderate	Severe
Airway	• Stridor on exertion/crying	• Mild stridor at rest	• Stridor at rest
Behaviour and feeding	• Normal • Talks in sentences	• Some/intermittent irritability • Difficultly talking/crying • Difficultly feeding or eating	• Increased irritability and/or lethargy • Looks exhausted • Unable to talk or cry • Unable to feed or eat
Respiratory rate	• Mildly increased	• Respiratory rate in blue zone	• Respiratory rate in pink zone • Increased or markedly reduced respiratory rate as the child tires
Accessory muscle use	• Mild intercostal and suprasternal recession	• Moderate intercostal and suprasternal recession • Nasal flaring	• Marked intercostal, suprasternal and sternal recession
Oxygen	• No oxygen requirement	• Mild hypoxemia corrected by oxygen • Increasing oxygen requirement	• Hypoxemia may not be corrected by oxygen
Other			• Gasping, grunting • Extreme pallor, cyanosis • Apnoea

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1-4 Years

PAEDIATRICS

PEWS Score Key

0	1	2	3

Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

Patient Safety First

Chart Date DD / MM / YY

Parameter Amendment For Chronic Conditions

Date / Time	Clinical Parameters	New Acceptable Range	Next Medical Review	Doctor Signature/Print name /MCRN

Addressograph

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Core Parameters

Year — Date: 12/12

Time: 18:45

Frequency of observations: 4⁰

Clinician / Family Concern

Concern Score: 0

AB
AIRWAY & BREATHING

Respiratory Rate (breaths per minute) — Assess for 60 seconds

60 / 50 / 40 / 30 / 20 / 15

RR Number: 34

RR Score: 0

Respiratory Effort: Severe / Moderate / Mild / Normal

RE Score: 0

Mode of O_2 delivery
Room air (RA)
Nasal Cannula (NC)
Face mask (FM)
Tracheostomy (T)
HHFNC (H)
CPAP (C) / BiPAP (B)

Oxygen Therapy (L/Mins.): Mode: RA / Pressure / >2L / ≤2L

O_2 T Score: 0

SpO_2 (%): ≥94% / 90-93% / 86-89% / ≤ 85%

SpO_2 Score: 0

C
CIRCULATION

If HR scores 1 or more consider central CRT and BP and refer to **Sepsis 6 Protocol**

*HR <60 with no signs of life - begin CPR and call the emergency team

Heart Rate (beats per minute) — Assess for 60 seconds

170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50

HR Number: 115

HR Score: 0

Central Capillary Refill Time (seconds): >2 / ≤2

CRT Score: 0

Blood Pressure (mmHg) — Score systolic BP

Cuff Size: _____

140 / 130 / 120 / 110 / 100 / 90 / 80 / 70

BP Number: 107

BP Score: 0

Skin Colour: PK

PK - pink M - mottled
P - pale C - cyanosed

D
DISABILITY

Score '-' if not assessed and put a vertical line through column

If not Alert, consider GCS

AVPU: Alert / Voice / Pain / Unresponsive

AVPU Score: 0

E
EXPOSURE

Consider sepsis if temperature <36⁰C or >38.5⁰C

Notify doctor if urine output is <1mL/Kg/hr

Temperature (°C) — Record as graph

≥40.0 / 39.0 / 38.0 / 37.0 / 36.0 / ≤35.0

Total PEWS score: 0

Reassess within (Mins.)

Pain Score

Pain scale in use (✔):
FLACC ☐
Faces ☐
Numeric ☐

Nurse/NMBI

Core Parameters

Concern

60 / 50 / 40 / 30 / 20 / 15

RR Score

Severe / Moderate / Mild / Normal

RE Score

Mode / Pressure / >2L / ≤2L

O_2 T Score

≥94% / 90-93% / 86-89% / ≤ 85%

SpO_2 Score

170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50

HR Score

>2 / ≤2

CRT Score

140 / 130 / 120 / 110 / 100 / 90 / 80 / 70

BP Score

Colour

A / V / P / U

AVPU Score

≥40.0 / 39.0 / 38.0 / 37.0 / 36.0 / ≤35.0

Total PEWS

Reassess within