NHS

0 to 11 months

National Paediatric Early Warning System Observation and Escalation Chart

0-11 Months

Patient Name: _____

Hospital No. _____

NHS No. _____

Date of Birth: _____

Consultant: _____

0
1
2
4

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

Airway and Breathing

Respiratory distress

Mild
- Nasal flaring
- Subcostal recession

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

Severe
- Sternal recession
- Grunting
- Exhaustion
- Impending respiratory arrest

Respiratory Rate • RR/ min

Value: >90, 90, 80, 70, 60, 50, 40, 30, 20, 10, <10

Respiratory Distress: Severe / Moderate / Mild / None

SpO₂: ≥95% / 92% - 94% / ≤91% / SpO₂ 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*: >130, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, <30

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

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'.

PEWS																								PEWS
AVPU																								AVPU
Blood glucose																								Blood glucose
Pain score (as per local policy)																								Pain score (as per local policy)

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)																								New suspicion of sepsis or septic shock (Y/N)
Clinical intuition (Y/N)																								Clinical intuition (Y/N)
Trigger criteria																								Trigger criteria
Escalation level																								Escalation level
Escalated (Y/Plan)																								Escalated (Y/Plan)
Time NIC informed																								Time NIC informed
Time clinician informed																								Time clinician informed
Time clinician arrived																								Time clinician arrived
PICU/transport team called																								PICU/transport team called
Signature																								Signature

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

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

ESCALATION LEVEL		LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
TRIGGER CRITERIA: Respond as per the highest level based on **CHANGE** in **ANY ONE** of these criteria	**Specific concern** (neurology, sepsis, or pre-existing risk factor)		**New** suspicion of sepsis	AVPU: Change to AVPU - V ' Responsive only to Voice' **or** **New suspicion of septic shock**	AVPU: Change to AVPU - P or U 'Responsive only to Pain' or 'Unresponsive' OR Abnormal pupillary response
	Clinical Intuition	Nurse/clinician concern that patient needs increased monitoring despite low PEWS	Nurse/clinician concern that patient needs a medical review irrespective of PEWS	Nurse/clinician concern that patient needs a 'Rapid Review' irrespective of PEWS	Nurse/clinician concern that patient needs emergency review for life-threatening situation
	Carer Question	Carer uses words that suggests the child needs increased monitoring or intervention despite the low PEWS	Carer uses words that suggests the child needs a clinical review irrespective of PEWS	Carer uses words that suggests the child needs a 'Rapid Review' irrespective of PEWS	Carer uses words that suggests the child has collapsed or significantly deteriorated
	Paediatric Early Warning Score	**1-4**	**5-8**	**9-12**	**≥13**
Communication & response (use ISBAR Framework)		Inform Nurse-in-charge	Review by Nurse-in-charge for potential escalation (and/or Outreach nurse or equivalent)	Immediate review by Nurse-in-charge for potential escalation	Immediate 2222 call: "Paediatric Medical Emergency" and review by Nurse-in-charge
Medical plan for stabilisation Structured medical plan to be documented including: 1. specific actions to be taken 2. expected outcome 3. outcome deadline 4. escalation if outcome not met by deadline.		Consider Medical Review by ST3+ or equivalent Bedside nurse to feed back plan to parents	Request Medical Review by ST3+ or equivalent Stabilisation plan to be considered Bedside nurse to feed back plan to parents	Call for 'Rapid Review': Medical incl. airway skills ST3+ or equivalent and outreach nurse (if available or equivalent) Stabilisation plan to be discussed with consultant Senior nurse to feed back plan to parents	Consultant informed urgently to confirm stabilisation plan Senior nurse to support and feedback to parents [In specialist environments rapid review can replace 2222 but only with prior agreement between consultant and nurse-in-charge]
Medical review timings		As agreed with medical team	Within 30 minutes	Within 15 minutes	Immediate
Minimal observations Repeated escalation if remaining in one level not required but ongoing plan must be clearly documented in notes.		Must reassess within 60 minutes (and then document ongoing plan)	Must reassess within 30 minutes (and then document ongoing plan) Continuous Oxygen Saturation monitoring needed	Every 30 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU	Every 15 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU or abnormal pupillary response

FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL 2222 AND STATE "PAEDIATRIC MEDICAL EMERGENCY"

THINK! Could this be sepsis?

Think sepsis if any of the following are present:
- Neutropenia or immunocompromised (call medical professional for immediate review)
- Known or suspected infection
- Temperature ≥38°C or <36°C
- Increasing oxygen requirement
- Unexplained tachypnoea/ tachycardia
- Altered mental state (e.g. lethargy/floppy)
- Prolonged CRT, mottled or ashen appearance

If suspicion of sepsis, inform nurse-in-charge. Escalate to patient's own or on-call team.

I	**Hello, I am staff nurse (xx) from Ward (xx), I am calling about (xx).**
S	**I am calling because (e.g. PEWS increased to xx, carer is concerned because xx). The last observations were (xx).**
B	**They are (age), admitted on (date) for (reason). They recently had surgery (xx); treatment (xx).**
A	**I think they are (e.g. hypovolaemic). I don't know what is wrong with them but I am/carer is very concerned.**
R	**I would like you to (e.g. review in xx minutes please).**

DATE & TIME	COMMENTS

DATE & TIME	COMMENTS

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.

0 to 11 months