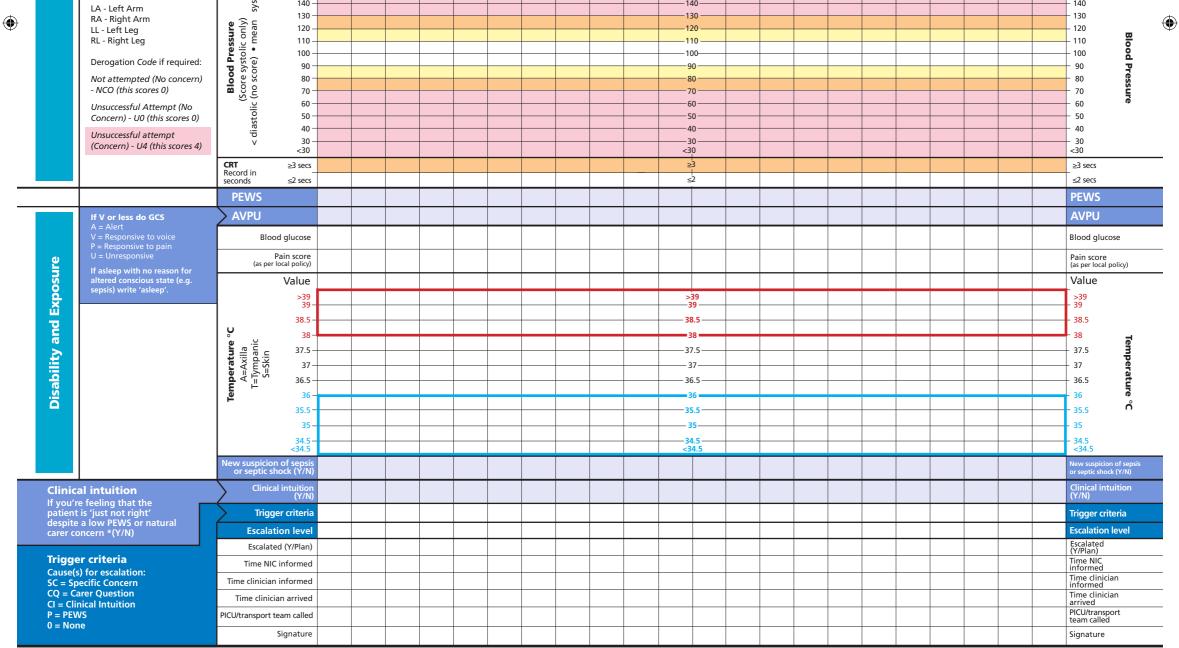
5-12 Years

NHS

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5-12 Years

National Paediatric Early						0 Have you set your alarm limits?			Does your patient have any additional risk factors? NOT APPLICABLE Risk Factor THINK!					inpa- ents of				
Warning System Observation					n	2	RR			Baseline vital signs outside of normal reference ranges			Always score the	Always score the relevant PEWS value even if this is pormal				
and Escalation Chart						4	SpO2								for the patient (e.g. Patient's		recording an The compone	
/							HR				Tracheostomy/Airway Risk				Do you need additional help in an airway emergency?			
Patient Name:					— į	BP Other Type of monitor				Invasive/Non-Invasive Ventilation/High Flow Neutropenic/Immunocompromised			High Flow/BiPaP and	Do you need additional netp in an anway enlergency? Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery Sepsis recognition and escalation has a lower threshold Sepsis recognition and escalation has a lower threshold (beware hypothermia) Remember to check pupillary response if anything other than Alert on AVPU Be aware of the range of responses to pain and physiological changes Do you need support from home ward/team?				
Hospital No.																		
					 <40 weeks corrected gestation Neurological condition (ie meningitis, seizures) Neurodiversity or Learning Disability 													
5-	2 years Consultant:					— ; [Outlier			Do you need suppor	Do you need support from home ward/team?			
Carer o	uestion:_Ask your parent/carer:		Date															Date
How is	your child different since I last saw You decide if their response means:		Time															Time
W - Worse A – Parent/Carer Asleep S - Same U – Unavailable		·	equency															Frequency
B - Bett		> W/9	S/B/A/U															W/S/B/A/U
	Respiratory distress		Value_ >50										>50					Value >50
	• Accessory muscle use	e e	50 — 45 —										50 45					- 50 - 45
		/ Rate in	40—										40					
	Moderate Tracheal tug Intercostal recession Inspiratory or expiratory 	R/ mi	35 — 30 —										35 30					40 Respiratory 35 30 25
		Respiratory • RR/ min	30 – 25 –										25					25
	noises	Re	20 —										20					20 Rate
	Severe • Tripoding • Supraclavicular recession		15 — 10 —										15 10					- 15 - 10
စ္			<10 Severe										<10					<10 Severe
ţ	 Grunting Exhaustion Impending respiratory 	Respiratory Distress	Moderate															Severe Distress Moderate Mild None
d Breathing	arrest		Mild															Mild rato
		1	None ≥95%															None ₹ ≥95%
/ and		Sp02	92% - 94%															92% - 94% So
Airway		SpO, probe change (✓)													≤91% N SpO, probe change (√)			
Air	Respiratory support device (RSD) HF = High Flow BiP = BiPAP CP = CPAP	RSD CODE (maximum score is 4)															change (✓) RSD CODE (maximum score is 4)	
		eu	100%-															-
			90%- 80%-															(NOT High Flow Delivery) Litres per min (L/Min)
			70%-															
		xyge as per l x, of 1 % with in wit	60%- 50%-															6 FIO
	Other delivery methods NP = nasal prongs FM = face mask HB = head box NRB = Non- rebreather	Oxygen as per PGD or Oxygen as per PGD or escription box, of 100% oxyg Mark % with a '•' and L/min with an 'X'	40%-															
			30%- 28%-															
			24%- <21%-															0.1
		Document 'Ai Delive	ir' or Value ery method D flow rate															
		/RSI	D flow rate Value															Value
			>190										>190					>190
Circulation			190 — 180 —										190 180					— 190 — 180
			170 —										170					- 170
			160 — 150 —										160 150					- 160 - 150
		Heart Rate • HR/ min	140 -										140					- 140
			130 -															130 Heart Reart Rate
			120 — 110 —										120 110					120 7 110 2
			100 —										100					- 100
			90 — 80 —										90 — 90 — 90 — 90 — 90 — 90 — 90 — 90 —					
			80 — 70 —															- 70
			60 —										60					- 60
			50 — <50										50 <50					- 50 <50
	Record position of BP taken by inserting relavant initials above		ie or Code >150										>150					BP Value or Code >150
	inserting relavant initials above systolic arrow LA - Left Arm	systolic >	150 —										150					- 150
		sys	140 —										140					- 140



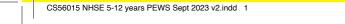
	ESCALATION LEVEL	LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)	THINK! Could this be sepsis?		
RITERIA:	Specific concern (neurology, sepsis, or pre-existing risk factor)		New suspicion of sepsis	AVPU: Change to AVPU - V ' Responsive only to Voice' or New suspicion of septic shock	AVPU: Change to AVPU - P or U 'Res- ponsive only to Pain' or 'Unresponsive' OR Abnormal pupillary response	Think sepsis if any of the following are present: Neutropenia or immunocompromised (call medical 		
Respond as per the nighest evel	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	professional for immediate review) • Known or suspected infection • Temperature ≥38°C or <36°C		
	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	 Increasing oxygen requirement Unexplained tachypnoea/ tachycardia Altered mental state (e.g. lethargy/floppy) Prolonged CRT, mottled or ashen appearance 		
riteria	Paediatric Early Warning Score	1-4	5-8	9-12	≥13	• Prolonged CKI, mottled of ashen appearance		
Communication & response (use ISBAR Framework) 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. Medical review timings Minimal observations Repeated escalation if remaining in one level not required but ongoing plan must be clearly documented in notes.		Inform Nurse-in-charge Consider Medical Review by ST3+ or equivalent Bedside nurse to feed back plan to parents	Review by Nurse-in-charge for potential escalation (and/or Outreach nurse or equivalent) Request Medical Review by ST3+ or equivalent Stabilisation plan to be considered Bedside nurse to feed back plan to parents	Immediate review by Nurse-in-charge for potential escalation 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	Immediate 2222 call: "Paediatric Medical Emergency" and review by Nurse-in-charge 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]	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).		
		As agreed with medical team	Within 30 minutes	Within 15 minutes	Immediate	B They are (age), admitted on (date) for (reason). They recently had surgery (xx); treatment (xx).		
		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	 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). 		
		FOR EMERGENCY OR LIFE-THRI	ATENING SITUATIONS: CALL 2222 AND STATE	'PAEDIATRIC MEDICAL EMERGENCY"				

DATE & TIME	COMMENTS	DATE & TIME	COMMENTS

5-12 Years

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

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5-12 Years

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