1 to 4 years

NHS

1 to 4 years

Patient Name: ______________________ Date of Birth: ______________________

Hospital No. ______________________ Consultant: ______________________

NHS No. ______________________

Emergency Department NPEWS 0 1 2 4

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

W - Worse
S - Same
B - Better

A - Parent/Carer Asleep
U - Unavailable

At initial assessment ask the parent/carer: How is your child different since the decision to bring them here?

W - Worse S - Same B - Better

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 support device (RSD)

HF = High Flow
BiP = BiPAP
CP = CPAP

Other delivery methods

NP = nasal prongs
FM = face mask
HB = head box
NRB = Non-rebreather

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: Option for skipping Blood Pressure

Observation
1. Not Attempted (No Concern) (NCO) – **Scores 0**
2. Unsuccessful Attempt (No Concern) (U0) – **Scores 0**
3. Unsuccessful Attempt (Concern) (U4) – **Scores 4**
4. Not Attempted (Concern) – **Scores 4**

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'.

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

TRIAGE, ASSESSMENT AND INITIAL OBSERVATIONS (left half) | **ONGOING OBSERVATIONS** (right half)

ED

Section	Parameter	Left scale	Right scale
	Date		Date
	Time		Time
	Frequency		Frequency
	W/S/B/A/U		W/S/B/A/U
Airway and Breathing	Respiratory Rate • RR/ min	Value	Value
		>60	>60
		60	60
		50	50
		40	40
		30	30
		20	20
		10	10
		<10	<10
	Respiratory Distress	Severe	Severe
		Moderate	Moderate
		Mild	Mild
		None	None
	SpO_2	≥95%	≥95%
		92% - 94%	92% - 94%
		≤91%	≤91%
		SpO_2 probe change (✓)	SpO_2 probe change (✓)
	Oxygen – Oxygen as per PGD or prescription box, of 100% oxygen. Mark % with a '●' and L/min with an 'X' / Oxygen Delivery (NOT High Flow Delivery) Litres per min (L/Min)	RSD CODE	RSD CODE
		100%	
		90%	
		80%	15
		70%	10
		60%	8
		50%	6
		40%	4
		30%	2
		28%	1
		24%	0.1
		<21%	<0.01
		Document 'Air' or Value	Document 'Air' or Value
		Delivery method /RSD flow rate	Delivery method /RSD flow rate
Circulation	Heart Rate • HR/ min	Value	Value
		>190	>190
		190	190
		180	180
		170	170
		160	160
		150	150
		140	140
		130	130
		120	120
		110	110
		100	100
		90	90
		80	80
		70	70
		60	60
		50	50
		<50	<50
	Blood Pressure (Score systolic only) < diastolic • mean systolic > / < diastolic (no score) • mean systolic >	BP Value or *Code*	BP Value or *Code*
		>130	>130
		130	130
		120	120
		110	110
		100	100
		90	90
		80	80
		70	70
		60	60
		50	50
		40	40
		30	30
		<30	<30
	CRT Record in seconds	≥3 secs	≥3 secs
		≤2 secs	≤2 secs
	PEWS		PEWS
	AVPU/GCS		AVPU/GCS
Disability and Exposure	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	Value
		>39	>39
		39	39
		38.5	38.5
		38	38
		37.5	37.5
		37	37
		36.5	36.5
		36	36
		35.5	35.5
		35	35
		34.5	34.5
		<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)
	Signature		Signature

Time															
Escalation Level															
Acuity Level															
Trigger Criteria															
Escalated (E) or Plan in place (P)															
Time NIC informed															
Time ED Clinician informed															
Time ED Clinician arrived															
Time Paediatric / Specialist Team informed															
Time Paediatric / Specialist Team arrived															
Time PICU arrived															
Signature															
? Other															

Escalation Level: No (N), Low (L), Medium (M), High (H) or Emergency (E)
Trigger Criteria: None (0), PEWS (P), Specific Concern (SC), Carer Question (CQ), Clinical Intuition (CI)

		Date																		
		Time																		
		Initials																		
	Care	Oral/Nasopharyngeal suction																		
		Nasal pressure care																		
Glasgow Coma Scale (record the best response)	Eye opening	Spontaneous																		4
		To speech																		3
		To pain																		2
		None																		1
	Verbal response	Orientated																		5
		Confused																		4
		Inappropriate																		3
		Incomprehensible																		2
		None																		1
	Motor response	Obey command																		6
		Localise pain																		5
		Withdrawal																		4
		Flexion																		3
		Extension																		2
		None																		1
	GCS total																			
Pupillary reaction	R	Size																		**R** Reacts **NR** No reaction **SL** Sluggish **EC** Eye closed **UN** Unrecordable
		Reaction																		
	L	Size																		
		Reaction																		
Limb movement	Arms	Normal power																		Record Right (**R**) and Left (**L**) separately if there is a difference
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		Fractured limb																		
		No response																		
		Unmeasurable																		
	Legs	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		Fractured limb																		
		No response																		
		Unmeasurable																		
	Vomiting																			Yes (**Y**)
	Involuntary movements																			No (**N**)

	Adult	Child	Non-Verbal	Notes
5	Orientated	Alert, babbles, coos, uses words or sentences to normal ability	Spontaneous oro-facial activity	
4	Disorientated	Less than usual or spontaneous irritable cry		A child may no longer be able to use recognisable words / sentences when using them before
3	Inappropriate	Cries inappropriately or cries only to pain	Vigorous grimace to painful stimuli	
2	Incomprehensible sounds	Occasional whimper/moan	Mild grimace only to painful stimuli	
1	None	None	None	
1	Intubated	Intubated		

CS58888 NHS Creative 2026