≥ 13 years

NHS

≥ 13 years

Patient Name: _____ Date of Birth: _____

Hospital No. _____ Consultant: _____

NHS No. _____

Emergency Department NPEWS 0 1 2 4

Carer/ young person question: Ask your parent / carer or young person: **How is your child / are you different since I last saw them / you?**

W - Worse
S - Same
B - Better

A - Parent/Carer Asleep
U - Unavailable

At initial assessment, ask the parent/ carer or young person: How is your child / are you different since the decision to bring them / come here?
W - Worse S - Same B - Better

Respiratory distress

Mild
- Accessory muscle use

Moderate
- Tracheal tug
- Intercostal recession
- Inspiratory or expiratorynoises

Severe
- Tripoding
- Supraclavicular 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)

Airway and Breathing

Circulation

Disability and Exposure

TRIAGE, ASSESSMENT AND INITIAL OBSERVATIONS
ONGOING OBSERVATIONS

ED

Date																			**Date**
Time																			**Time**
Frequency																			**Frequency**
W/S/B/A/U																			W/S/B/A/U
Value																			Value
Respiratory Rate • RR/ min																			**Respiratory Rate** • RR/ min
>55																			>55
55																			55
50																			50
45																			45
40																			40
35																			35
30																			30
25																			25
20																			20
15																			15
10																			10
<10																			<10
Respiratory Distress																			**Respiratory Distress**
Severe																			Severe
Moderate																			Moderate
Mild																			Mild
None																			None
SpO_2																			**SpO_2**
≥95%																			≥95%
92% - 94%																			92% - 94%
≤91%																			≤91%
SpO_2 probe change (✓)																			SpO_2 probe change (✓)
RSD CODE																			RSD CODE
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)
100%																			15
90%																			10
80%																			8
70%																			6
60%																			4
50%																			2
40%																			1
30%																			0.1
28%																			<0.01
24%																			Document 'Air' or Value
<21%																			Delivery method /RSD flow rate
Document 'Air' or Value																			
Delivery method /RSD flow rate																			
Value																			Value
Heart Rate • HR/ min																			**Heart Rate** • HR/ min
>150																			>150
150																			150
140																			140
130																			130
120																			120
110																			110
100																			100
90																			90
80																			80
70																			70
60																			60
50																			50
40																			40
<40																			<40
BP Value or *Code*																			**BP Value or *Code***
Blood Pressure (Score systolic only) < diastolic • mean systolic >																			**Blood Pressure (Score systolic only) < diastolic (no score) • mean systolic >**
>170																			>170
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
40																			40
30																			30
<30																			<30
CRT Record in seconds																			**CRT** Record in seconds
≥3 secs																			≥3 secs
≤2 secs																			≤2 secs
PEWS																			**PEWS**
AVPU/GCS																			**AVPU/GCS**
Blood glucose																			**Blood glucose**
Pain score (as per local policy)																			Pain score (as per local policy)
Value																			Value
Temperature °C A=Axilla T=Tympanic S=Skin																			**Temperature °C** A=Axilla T=Tympanic S=Skin
>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		

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