SHORT STAY PAEDIATRIC VITAL SIGNS CHART – 1-4 YEARS

REF NUMBER

Vital Signs	Date / Time (24 hour)							PEWS
Respiratory Rate (breaths/min) *mark* **RR** *with* **X**	≥ 55							4
	50-54							2
	45-49							
	40-44							1
	35-39							0
	30-34							
	25-29							
	20-24							
	18-19							1
	15-17							2
	10-14							4
	5-9							
	≤ 4							RRT
Respiratory Distress *mark* **RD** *with* **X**	Severe							4
	Moderate							2
	Mild							1
	Nil							0
Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%							4
	< 4L or < 35%							2
	Room air **X**							0
	Mode							
	High flow rate							
Oxygen Saturation (%) *write* **SpO_2**	≥ 95							0
	91-94							1
	≤ 90							2
Heart Rate (bpm) *mark* **HR** *with* **X** *write value if off scale*	≥ 180							4
	170s							
	160s							
	150s							2
	140s							1
	130s							0
	120s							
	110s							
	100s							
	90s							
	80s							1
	70s							2
	60s							4
	≤ 59							RRT
Central Capillary Refill *mark* **CR** *with* **X**	≥ 3 sec							4
	< 3 sec							0
Blood Pressure (mmHg) *score systolic* **BP** *value only write value if off scale*	≥ 160							4
	150s							2
	140s							
	130s							
	120s							
	110s							1
	100s							0
	90s							
	80s							1
	70s							2
	60s							4
	50s							RRT
	40s							
	≤ 39							
PEWS TOTAL								
Whānau concern: Y/N/A								
Level Of Consciousness *mark* **LOC** *with* **X**	Alert							
	Voice							
	Pain							
	Unresponsive							RRT
Temperature (°C) *mark* **Temp** *with* **X** *write value if off scale*	≥ 40							
	39s							
	38s							
	37s							
	36s							
	≤ 35							
Pain Score *write score (0-10)*	Rest / Movement							
Initials								

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE.

Date of Birth: _____ NHI#: _____

ESCALATE CARE FOR ANY PATIENT YOU OR THEIR WHĀNAU ARE WORRIED ABOUT, REGARDLESS OF VITAL SIGNS OR PEWS

Mandatory escalation pathway NAME OF DHB		
Total PEWS	**Action**	
PEWS 1-3		
PEWS 4-5		
PEWS 6-7		
PEWS 8+		
Any vital sign in the blue zone		

Any treatment limitations must be documented in the patient's clinical record. A full set of vital signs must be taken, with corresponding PEWS calculated each time, at a frequency stated in hospital policy. If there is no timely response to your request for review, escalate to the next zone.

Modification to PEWS triggers

The PEWS can be changed to prevent inappropriate escalation. All modifications must be made in line with hospital policy and regularly reviewed by the primary team. **Query any modification that is not signed and dated.**

Vital sign (use abbr)	Accepted values and modified PEWS	Date and time	Duration (hours)	Name and contact details
		/ / :		
Reason:				
END OF LIFE PATHWAY		/ / :		

National tools

Revised FLACC observational pain tool			
Categories	**Scoring**		
	0	**1**	**2**
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; *distressed looking face; expression of fright or panic*
			Individualised behaviour described by family:
Legs	Normal position or relaxed; usual muscle tone and motion to arms and legs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; *marked increase in spasticity; constant tremors or jerking*
			Individualised behaviour described by family:
Activity	Lying quietly, normal position, moves easily; regular rhythmic breaths (respiration)	Squirming, shifting back and forth, tense or guarded movements; mildly agitated (head back and forth, aggression); shallow, splinting breaths (respirations); occasional sighs	Arches, rigid, or jerking; *severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting*
			Individualised behaviour described by family:
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; *repeated outbursts; constant grunting*
			Individualised behaviour described by family:
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or 'talking to'; can be distracted	Difficult to console or comfort; *pushing away caregiver; resisting care or comfort measures*
			Individualised behaviour described by family:
Rate the child in each of the five measurement categories, add together, and document total pain score (0 – 10).			
Children who are awake:	Observe for at least 1-2 minutes. Observe legs and body uncovered. Reposition child or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.		
Children who are asleep:	Observe for at least 2 minutes or longer. Observe legs and body uncovered. If possible, reposition the child. Touch the body and assess for tenseness and tone.		
This tool can be used for all non-verbal children. The additional descriptors (in italics) are validated in children with cognitive impairment. The nurse can review with parents/caregivers the descriptors within each category. Ask the parents/caregivers if there are additional behaviours that are better indicators of their child experiencing pain. Add these behaviours to the tool in the appropriate category.			

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE.

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Assessment of respiratory distress guide			
	Mild	**Moderate**	**Severe**
Airway	• Stridor on exertion or crying • Wheeze present	• Some stridor at rest • Wheeze marked	• Stridor at rest • New onset of stridor • Wheeze severe • Silent chest
Behaviour and feeding	• Normal • Talks in sentences	• Some or intermittent irritability • Difficulty talking or crying • Difficulty feeding or eating	• Increased irritability and/or lethargy • Looks exhausted • Unable to talk or cry • Unable to feed or eat
Accessory muscle use	• Mild intercostal and suprasternal recession	• Moderate intercostal and suprasternal recession • Tracheal tug • Nasal flaring • Head bobbing	• Marked intercostal and suprasternal recession
Other		• May have brief apnoea	• Gasping, grunting • Extreme pallor, cyanosis • Increasingly frequent or prolonged apnoea
Score at the level of severest sign. Note that not all features are relevant to all conditions.			

Respiratory support mode		
NP = Nasal prongs	M = Face mask	HF = High flow
R = Non-rebreather mask	C = CPAP	B = BiPaP
TH = Tracheostomy humidification	HO_2 = Humidified oxygen	

Scan for PVSC educational materials