Family Name:
Given Name:
Gender:
Date of Birth:
NHI#:
AFFIX PATIENT LABEL HERE.

REF NUMBER

PAEDIATRIC VITAL SIGNS CHART
0-11 MONTHS

HQSC PVSC 0-11m v1

Vital Signs	Date / Time (24 hour)												PEWS												Date / Time (24 hour)
Respiratory Rate (breaths/min) *mark* **RR** *with* **X**	≥ 80												4												≥ 80
	70s																								70s
	60s												2												60s
	50s												1												50s
	40s												0												40s
	30s																								30s
	20s												1												20s
	10s												2												10s
	≤ 9												4												≤ 9
													RRT												
Respiratory Distress *mark* **RD** *with* **X**	Severe												4												Severe
	Moderate												2												Moderate
	Mild												1												Mild
	Nil												0												Nil
Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%												4												≥ 4L or ≥ 35%
	< 4L or < 35%												2												< 4L or < 35%
	Room air **X**												0												**X** Room air
	Mode																								Mode
	High flow rate																								High flow rate
Oxygen Saturation (%) *write* **SpO_2**	≥ 95												0												≥ 95
	91-94												1												91-94
	≤ 90												2												≤ 90
Heart Rate (bpm) *mark* **HR** *with* **X** *write value if off scale*	≥ 200												4												≥ 200
	190s																								190s
	180s																								180s
	170s												2												170s
	160s												1												160s
	150s												0												150s
	140s																								140s
	130s																								130s
	120s																								120s
	110s																								110s
	100s												1												100s
	90s																								90s
	80s												2												80s
	70s												4												70s
	60s																								60s
	≤ 59												RRT												≤ 59
Central Capillary Refill *mark* **CR** *with* **X**	≥ 3 sec												4												≥ 3 sec
	< 3 sec												0												< 3 sec
Blood Pressure (mmHg) *score systolic* **BP** *value only write value if off scale*	≥ 150												4												≥ 150
	140s												2												140s
	130s																								130s
	120s																								120s
	110s												1												110s
	100s																								100s
	90s												0												90s
	80s																								80s
	70s												1												70s
	60s												2												60s
	50s												4												50s
	40s												RRT												40s
	30s																								30s
	20s																								20s
	≤ 19																								≤ 19
PEWS TOTAL																									**PEWS TOTAL**
Whānau concern: Y/N/A																									**Y/N/A**
Level Of Consciousness *mark* **LOC** *with* **X**	Alert																								Alert
	Voice																								Voice
	Pain																								Pain
	Unresponsive												RRT												Unresponsive
Temperature (°C) *mark* **Temp** *with* **X** *write value if off scale*	≥ 40																								≥ 40
	39s																								39s
	38s																								38s
	37s																								37s
	36s																								36s
	≤ 35																								≤ 35
Pain Score *write score (0-10)*	Rest / Movement																								Rest / Movement
Initials																									

Family Name:
Given Name: Gender:
AFFIX PATIENT LABEL HERE.
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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 abbreviation)	Accepted values and modified PEWS	Date and time	Duration (hours)	Name and contact details
		/ / :		
Reason:				
		/ / :		
Reason:				
		/ / :		
Reason:				
END OF LIFE PATHWAY		/ / :		

Local tools

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: _____

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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