

Family Name:

PAEDIATRIC VITAL SIGNS CHART

Family Name:	
Given Name:	Gender:

Date of Birth:

NHI#:

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

ory escalation pathway					
WS	Action				
1-3					
4-5					
6-7					
0,					

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**

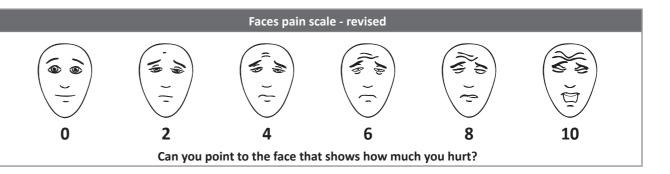
The PEWS can be changed to prevent inappropriate escalation. All modifications must be made in line with hospital policy and regularly reviewed by the primary team. Query any modification that is not signed and dated.

<b>gn</b> ation)	Accepted values and modified PEWS	Date and time	Duration (hours)	Name and contact details
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# Local tools

# National tools

	Revised FLAC	C observationa	l pain tool	Family Name:					
		Scoring	5	Given Name:	Gender:			er:	
Categories	0	1	2		AFFIX PATIENT LABEL HERE.				
	No expression or smile or frown, withdrawn,	Frequent to constant frown, clenched jaw, quivering chin; <i>distressed</i> <i>looking face; expression of</i>	Date of Birth:	۵۶۶۹۶۶۳۹	ont of res	NHI#:	guide		
Face		disinterested; appears sad or	fright or panic Individualised behaviour	,	Assessment of respiratory distres Mild Moderate			_	
	Normal Uneasy.	described by family: Kicking, or legs drawn	Airway	<ul> <li>Stridor exertion crying</li> </ul>	on n or	<ul> <li>Moderate</li> <li>Some stridor at rest</li> <li>Wheeze marked</li> </ul>	Severe  • Stridor at rest • New onset of stridor		
	position or relaxed; usual muscle tone	Uneasy, restless, tense; occasional tremors	up; marked increase in spasticity; constant tremors or jerking		Wheeze present     Normal		Some or	Wheeze severe     Silent chest     Increased	
Legs	and motion to arms and legs	Squirming	Individualised behaviour described by family: Arches, rigid, or jerking;	Behaviour and feeding	Talks in sentences		<ul> <li>intermittent</li> <li>irritability</li> <li>Difficulty talking or crying</li> <li>Difficulty feeding</li> <li>crying</li> </ul>	<ul> <li>irritability and/or lethargy</li> <li>Looks exhausted</li> <li>Unable to talk or cry</li> </ul>	
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 sighsNo cry (awake or asleep)Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Arches, rigid, or jerking, severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting	Accessory	Mild intant and sup recession	prasternal	<ul> <li>Moderate intercostal and suprasternal recession</li> </ul>	Unable to feed or eat     Marked intercostal and suprasternal		
		and forth, aggression); shallow,	Individualised behaviour described by family:	muscle use			<ul><li>Tracheal tug</li><li>Nasal flaring</li><li>Head bobbing</li></ul>	recession	
		(respirations); occasional sighs					<ul> <li>May have brief apnoea</li> </ul>	<ul> <li>Gasping, grunting</li> <li>Extreme pallor, cyanosis</li> </ul>	
		Crying steadily, screams or sobs, frequent complaints; repeated outbursts; constant grunting	Other				<ul> <li>Increasingly frequent or prolonged</li> </ul>		
Cry		verbal outburst	Individualised behaviour described by family:	Score at the level of severest sign. Note that not all features are relevant to all conditions.		apnoea			
	Content,	Reassured by	Difficult to console or						
	relaxed	occasional	comfort; pushing away		Re	spiratory	support mode		
Consolability	touching, hugging, or 'talking to'; can be distracted	caregiver; resisting care or comfort measures Individualised behaviour described by family:	NP = Nasal pro	ongs	M = Fac	ce mask HF	= High flow		
			R = Non-rebr mask		C = CP		= BiPaP		
Rate the child in each of the five measurement categories, add together, and document total pain score $(0 - 10)$ .		TH = Tracheos humidific		HO <sub>2</sub> = Hu oxy	midified ygen				
Children who are awake:	Reposition child o		rve legs and body uncovered. sess body for tenseness and f needed.						
Children who are asleep:		sible, reposition the o	er. Observe legs and body child. Touch the body and						
are validated in parents/caregive there are addition	children with cogn vers the descriptors ional behaviours that	itive impairment. The within each category	Iditional descriptors (in italics) e nurse can review with y. Ask the parents/caregivers if rs of their child experiencing te category.						





Scan for PVSC educational materials