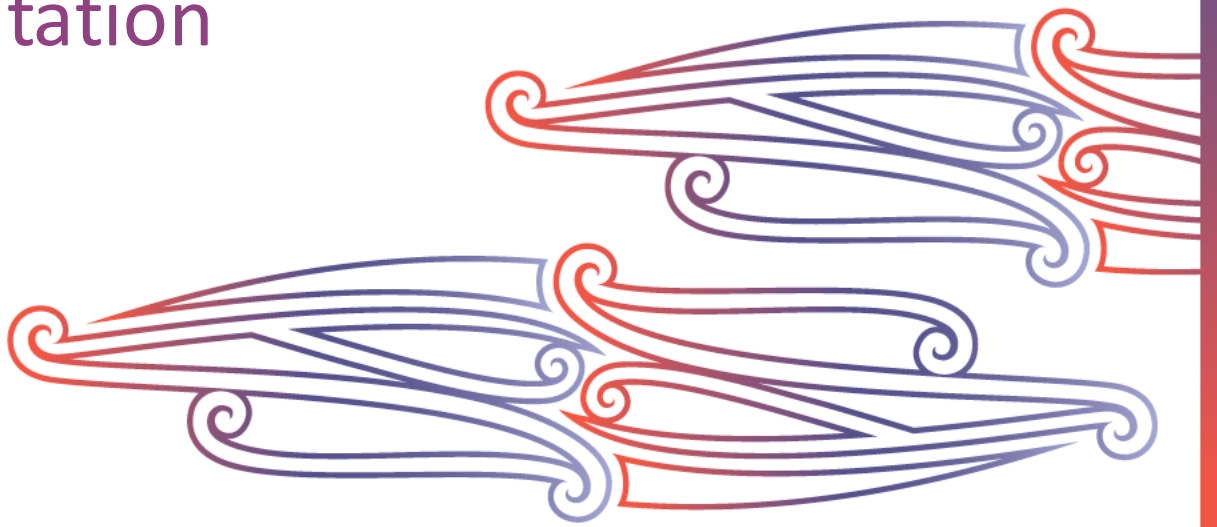
Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

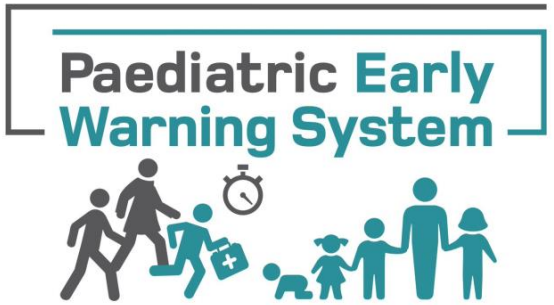
National paediatric early warning system

Education for implementation



October 2022

Learning outcomes



By the end of the session staff will be able to:

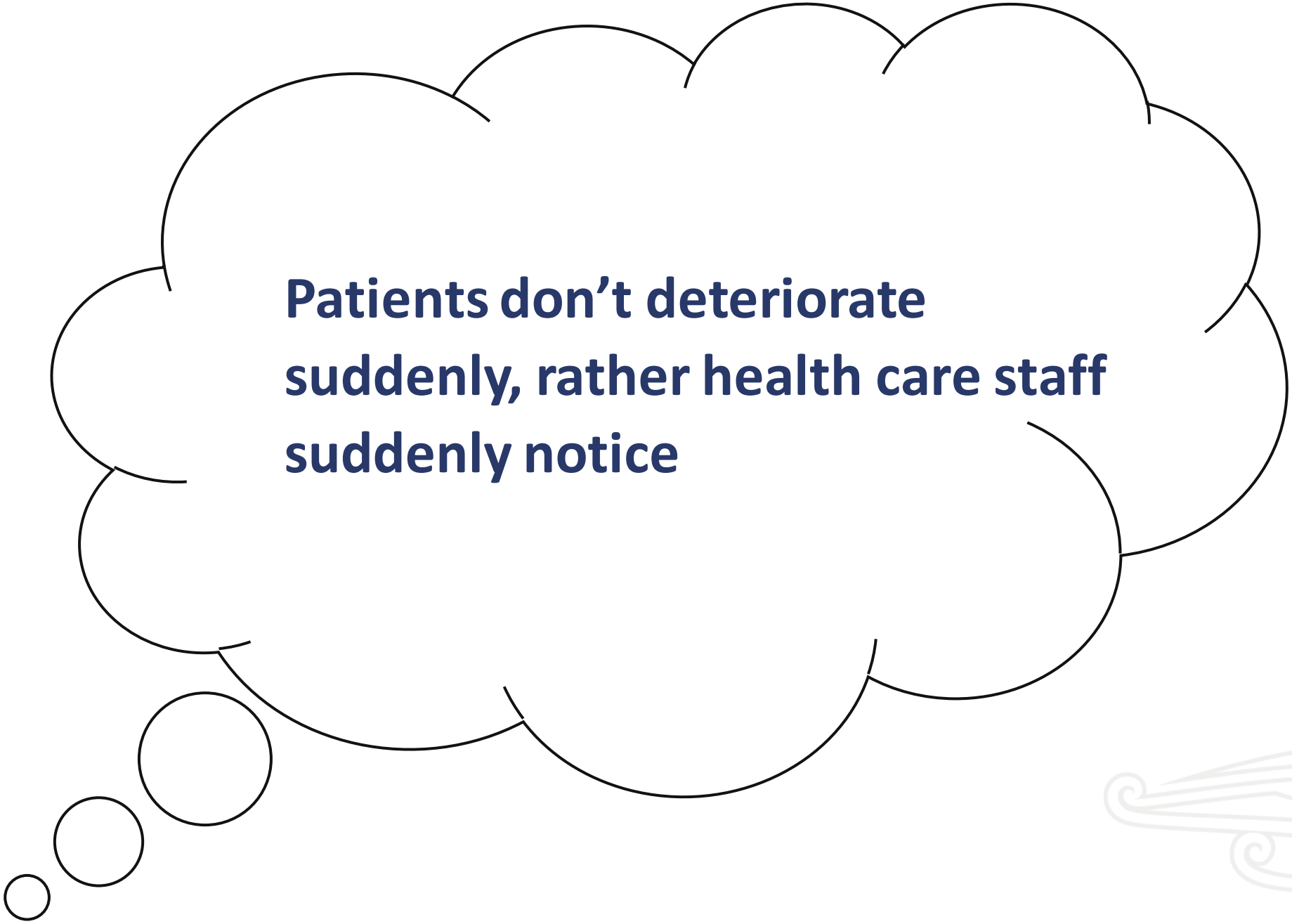
- describe the components of a paediatric early warning system
- distinguish between the four paediatric vital sign charts (PVSC) and the individual components making up each chart
- use the national tools on the back of the PVSC to assess vital signs
- describe steps within the escalation pathway in relation to the deteriorating tamariki
- modify vital sign parameters in the modifications section (medical staff)
- apply changes made in the modifications section of the PVSC

Abbreviations

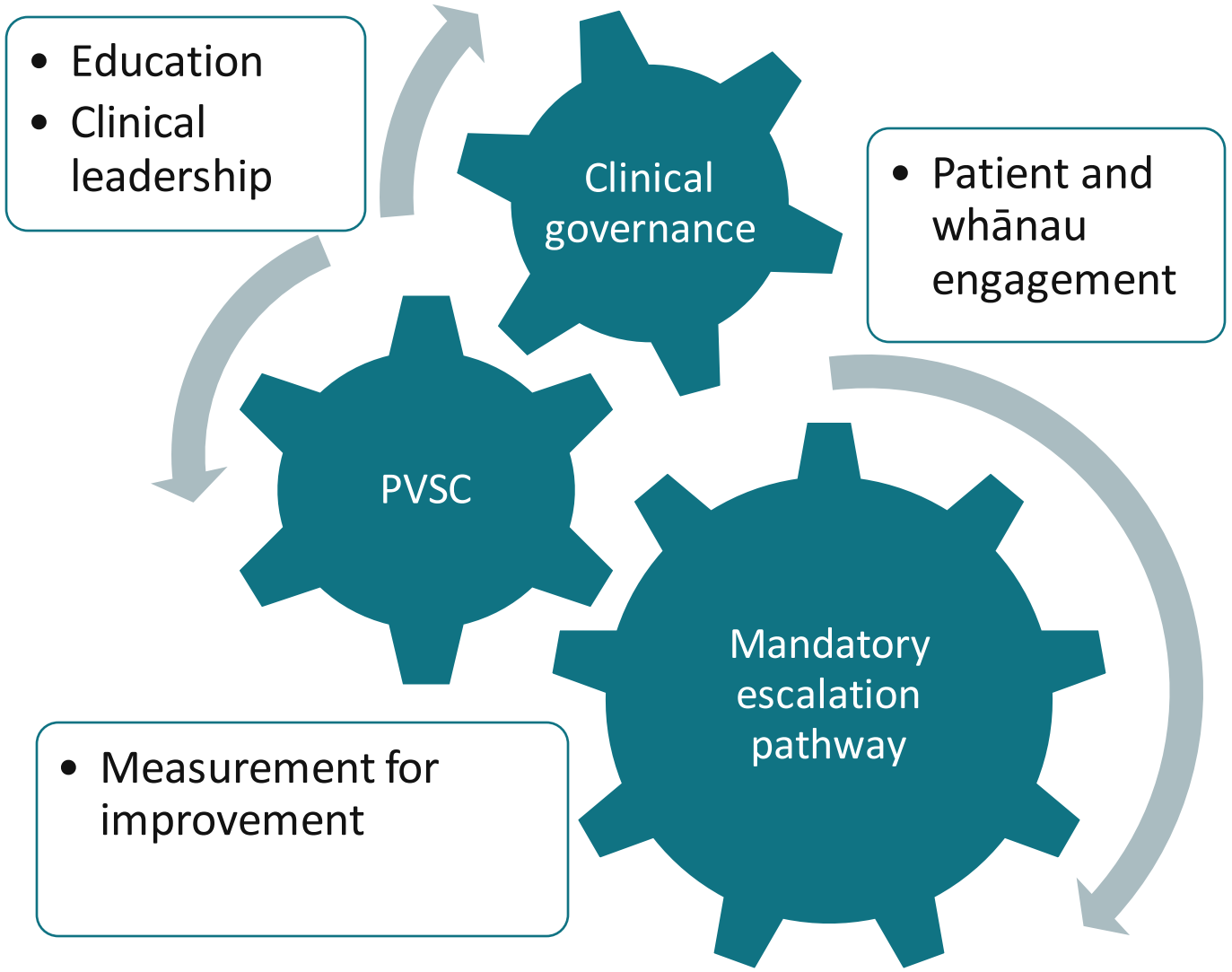
- PEWS – paediatric early warning system
- PEW score – paediatric early warning score
- PVSC – paediatric vital signs chart

Why we need a PEWS

The aim of the **system** is to improve the early recognition of and response to acutely deteriorating tamariki in hospital

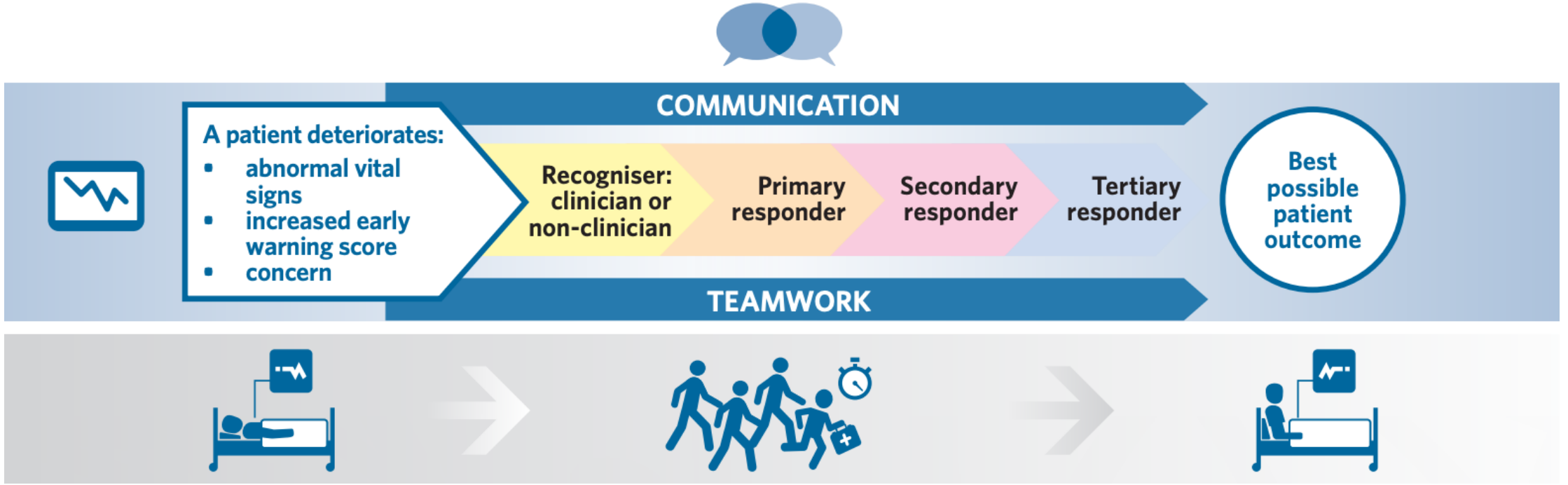

Patients don’t deteriorate suddenly, rather health care staff suddenly notice

Components of PEWS



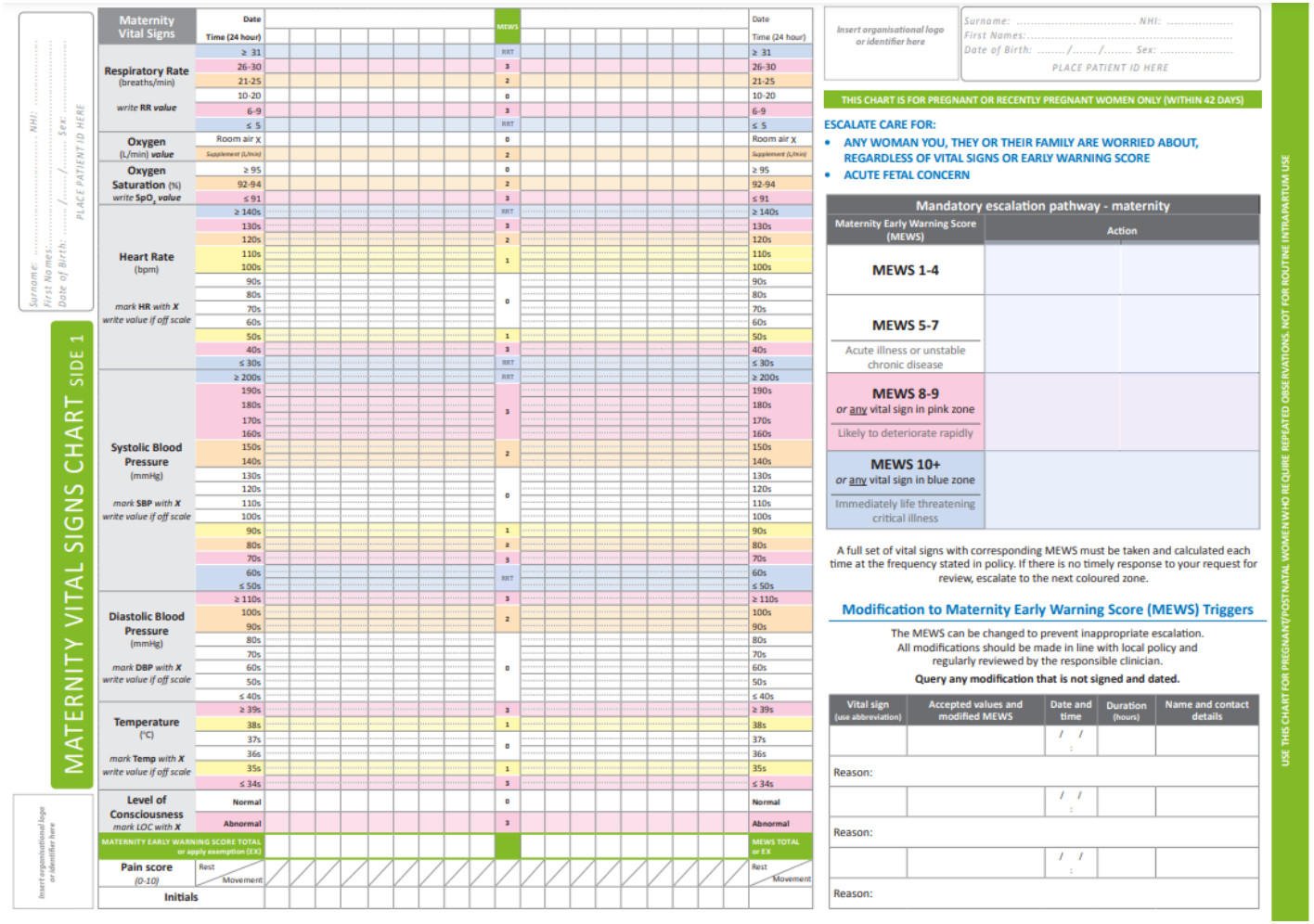
Recognition and response systems can save lives

Measure vital signs, escalate care and work together to provide a timely and appropriate clinical response



Health Quality & Safety Commission. 2017. *Capabilities for recognising and responding to acute deterioration in hospital*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/patient-deterioration/publications-and-resources/publication/3528.

Background


MATERNITY VITAL SIGNS CHART SIDE 1

Maternity Vital Signs

THIS CHART IS FOR PREGNANT OR RECENTLY PREGNANT WOMEN ONLY (WITHIN 42 DAYS)

ESCALATE CARE FOR:

- ANY WOMAN YOU, THEY OR THEIR FAMILY ARE WORRIED ABOUT, REGARDLESS OF VITAL SIGNS OR EARLY WARNING SCORE
- ACUTE FETAL CONCERN

Mandatory escalation pathway - maternity

Maternity Early Warning Score (MEWS)	Action
MEWS 1-4	
MEWS 5-7 — Acute illness or unstable chronic disease	
MEWS 8-9 — or any vital sign in pink zone — Likely to deteriorate rapidly	
MEWS 10+ — or any vital sign in blue zone — Immediately life threatening critical illness	

A full set of vital signs with corresponding MEWS must be taken and calculated each time at the frequency stated in policy. If there is no timely response to your request for review, escalate to the next coloured zone.

Modification to Maternity Early Warning Score (MEWS) Triggers

The MEWS can be changed to prevent inappropriate escalation. All modifications should be made in line with local policy and regularly reviewed by the responsible clinician.

Query any modification that is not signed and dated.

Vital sign (use abbreviation)	Accepted values and modified MEWS	Date and time	Duration (hours)	Name and contact details
		/ / :		
Reason:				
		/ / :		
Reason:				
		/ / :		
Reason:				

USE THIS CHART FOR PREGNANT/POSTNATAL WOMEN WHO REQUIRE REPEATED OBSERVATIONS. NOT FOR ROUTINE INTRAPARTUM USE

- EWS
- MEWS
- NOC/NEWS
- Paediatric Society of New Zealand
- Health Quality & Safety Commission

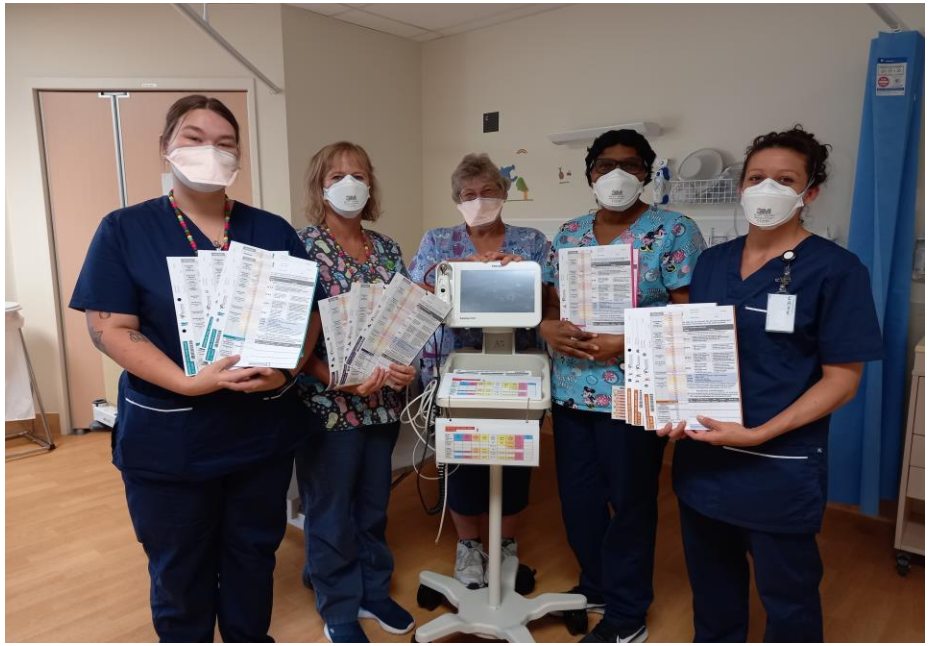
Why we need a national PEWS

- To provide equal access to an up-to-date PEWS
- To provide one PEWS that is familiar to patients and staff who move between districts
- To support the study of PEWS

Development process

- PEWS working group
- Testing from August 2021:
  - Starship oncology and general paediatric wards
  - Bay of Plenty District Health Board
  - Nelson Marlborough District Health Board


BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI
TAURANGA HOSPITAL
10




STAR WARDS
PEW · PEW · PEW
PEWS CHAMPION
STAR WARDS
PEW · PEW · PEW
PEWS CHAMPION
SUPER USER
PEWS CHAMPION


STAR WARDS
PEW · PEW · PEW
PEW
CHAMP
STAR WARDS
PEW · PEW · PEW
PEWS

PAEDIATRIC VITAL SIGNS CHART 0-11 MONTHS

Family Name: Given Name: Gender: Date of Birth: NHI#:

AFFIX PATIENT LABEL HERE.

LOGO UPLOAD

REF NUMBER

BARCODE UPLOAD

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	4	10s
	≤ 9	RRT	≤ 9
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			

HQSC PVSC 0-11m v1

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

Paediatric vital signs charts and escalation pathway

Paediatric Early Warning System

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

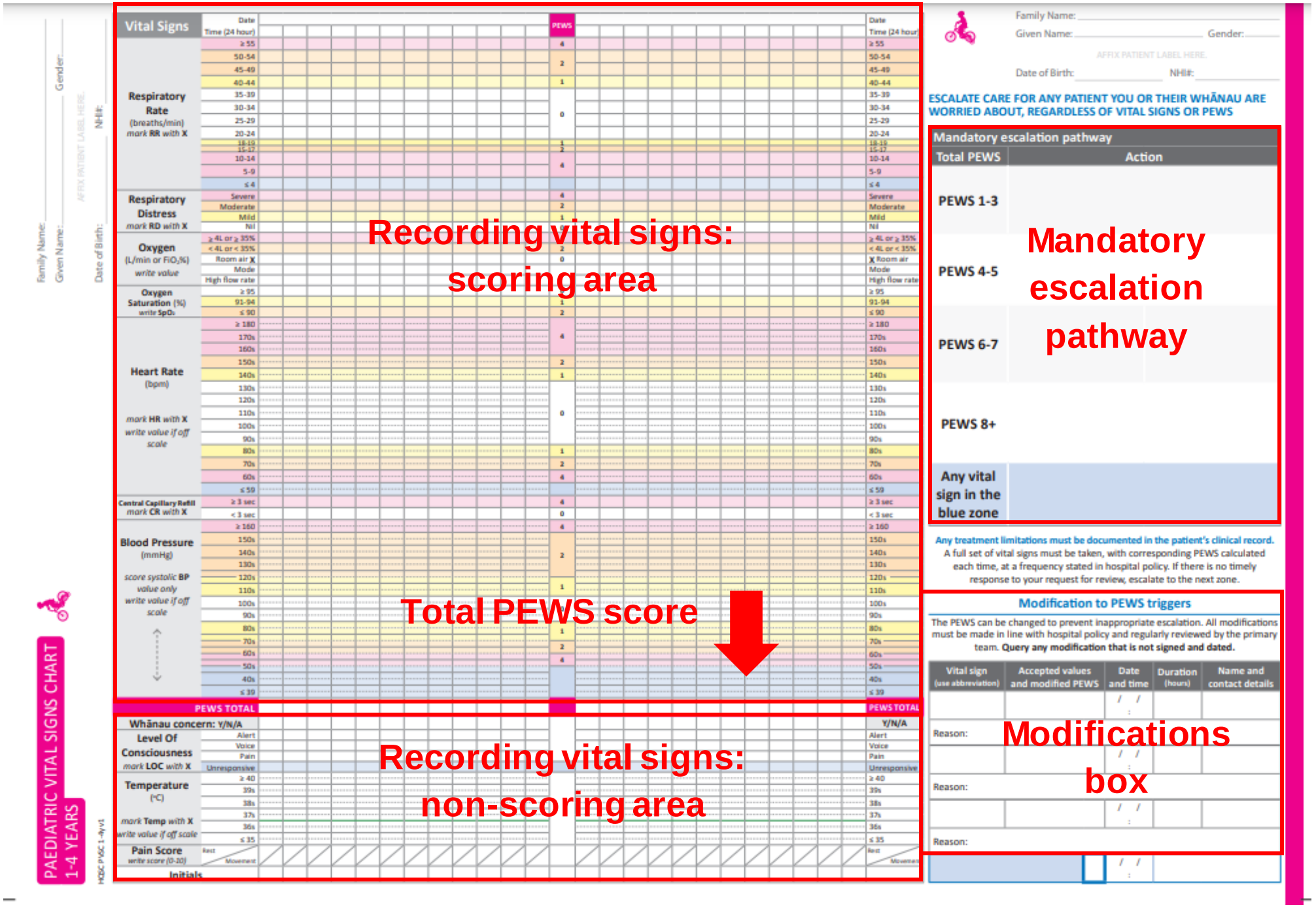
- Begin the PVSC for any tamariki who is assessed as requiring measurement and recording of vital signs
- The physiology of tamariki alters as they age, impacting on the normal ranges for vital signs
- There are four age-based PVSC, which must be used for the correct age group

PAEDIATRIC VITAL SIGNS CHART
0-11 MONTHS

PAEDIATRIC VITAL SIGNS CHART
1-4 YEARS

PAEDIATRIC VITAL SIGNS CHART
5-11 YEARS

PAEDIATRIC VITAL SIGNS CHART
12+ YEARS


Recording vital signs: scoring area
Total PEWS score
Recording vital signs: non-scoring area
Mandatory escalation pathway
Modifications box
PAEDIATRIC VITAL SIGNS CHART 1-4 YEARS
Vital Signs
Respiratory Rate (breaths/min) mark RR with X
Respiratory Distress mark RD with X
Oxygen (L/min or FiO2%) write value
Oxygen Saturation (%) write SpO2
Heart Rate (bpm) mark HR with X write value if off scale
Central Capillary Refill mark CR with X
Blood Pressure (mmHg) score systolic BP value only write value if off scale
PEWS TOTAL
Whānau concern: Y/N/A
Level Of Consciousness mark LOC with X
Temperature (°C) mark Temp with X write value if off scale
Pain Score write score (0-10)
Initials
Family Name:
Given Name:
Gender:
Date of Birth:
NHI#:
AFFIX PATIENT LABEL HERE
ESCALATE CARE FOR ANY PATIENT YOU OR THEIR WHĀNAU ARE WORRIED ABOUT, REGARDLESS OF VITAL SIGNS OR PEWS
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:
HQSC PVSC 1-4y v1

Local tools

Local tools
editable section

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

Date of Birth: _____ NHI#: _____

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 = BPaP
TH = Tracheostomy humidification	HO_2 = Humidified oxygen	

National tools

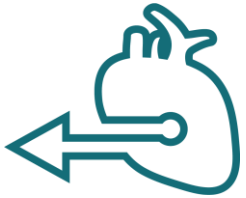
Faces pain scale - revised

Can you point to the face that shows how much you hurt?

Scan for PVSC educational materials

The seven scoring vital signs

Systolic blood pressure



Respiratory rate

Central capillary refill

Oxygen

Heart rate

Respiratory distress

%

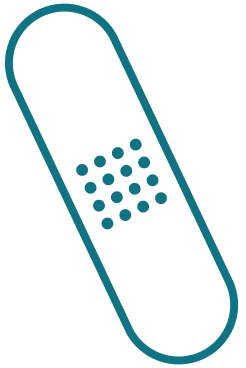
Oxygen saturation

Non-scoring vital signs

Whānau concern

Level of consciousness

Temperature



Pain

The PEWS: a calculated score

Paediatric early warning score colour key				
0	1	2	4	RRT: rapid response team

- Each vital sign parameter has coloured zones associated with a score
- The scores for each of the seven vital sign parameters are added together to give a total PEWS
- The total PEWS is used to trigger action

Respiratory rate

Respiratory Rate (breaths/min) *mark* **RR** *with* **X**	
	≥ 80
	70s
	60s
	50s
	40s
	30s
	20s
	10s
	≤ 9

Respiratory rate
(example taken from 12+ years PVSC)

Respiratory Rate (breaths/min) *mark* **RR** *with* **X**		
	≥ 35	
	30-34	
	25-29	
	20-24	
	15-19	X
	12-14	
	10-11	
	5-9	
	≤ 4	

Respiratory Rate (breaths/min) *mark* **RR** *with* **X**		
	≥ 35	
	30-34	
	25-29	X
	20-24	
	15-19	
	12-14	
	10-11	
	5-9	
	≤ 4	

Respiratory distress

Respiratory Distress *mark* **RD** *with* **X**	Severe	
	Moderate	
	Mild	
	Nil	

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.			

Oxygen

Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%	
	< 4L or < 35%	
	Room air **X**	
	Mode	
	High flow rate	

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

Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%	
	< 4L or < 35%	
	Room air **X**	x
	Mode	
	High flow rate	

A tamariki on no respiratory support.

This parameter scores 0.

Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%	
	< 4L or < 35%	28 %
	Room air **X**	
	Mode	HF
	High flow rate	14L

A 7 kg tamariki on high flow therapy with an FiO_2 requirement of 28%.

This parameter scores 2.

Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%	
	< 4L or < 35%	21%
	Room air **X**	
	Mode	HF
	High flow rate	14L

A 7 kg tamariki on high flow therapy with an FiO_2 requirement of 21%.

This parameter scores 2.

Please note that 21% in this context is not referring to room air. The tamariki is on high flow therapy and requires respiratory support.

Oxygen (L/min or FiO_2%) *write value*	≥ 4L or ≥ 35%	5L
	< 4L or < 35%	
	Room air **X**	
	Mode	M
	High flow rate	

A tamariki receiving 5 L/min of oxygen via a mask.

This parameter scores 4.

Oxygen saturation %

Oxygen Saturation (%) *write* **SpO_2**	≥ 95	
	91-94	
	≤ 90	

Document the numerical value for oxygen saturation in the relevant box of the scoring area

Heart rate

Heart Rate (bpm) *mark* **HR** *with* **X** *write value if off scale*	
	≥ 200
	190s
	180s
	170s
	160s
	150s
	140s
	130s
	120s
	110s
	100s
	90s
	80s
	70s
	60s
	≤ 59

Heart Rate (bpm) *mark* **HR** *with* **X** *write value if off scale*	
	≥ 150
	140s
	130s
	120s
	110s
	100s
	90s
	80s
	70s
	60s
	50s
	40s
	≤ 39

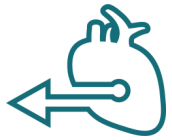
Heart Rate (bpm) *mark* **HR** *with* **X** *write value if off scale*	≥ 180	
	170s	
	160s	
	150s	
	140s	
	130s	
	120s	
	110s	
	100s	
	90s	X
	80s	
	70s	
	60s	
	≤ 59	

Heart Rate (bpm) *mark* **HR** *with* **X** *write value if off scale*	≥ 180	
	170s	
	160s	
	150s	
	140s	
	130s	
	120s	
	110s	
	100s	
	90s	
	80s	X
	70s	
	60s	
	≤ 59	

Central capillary refill

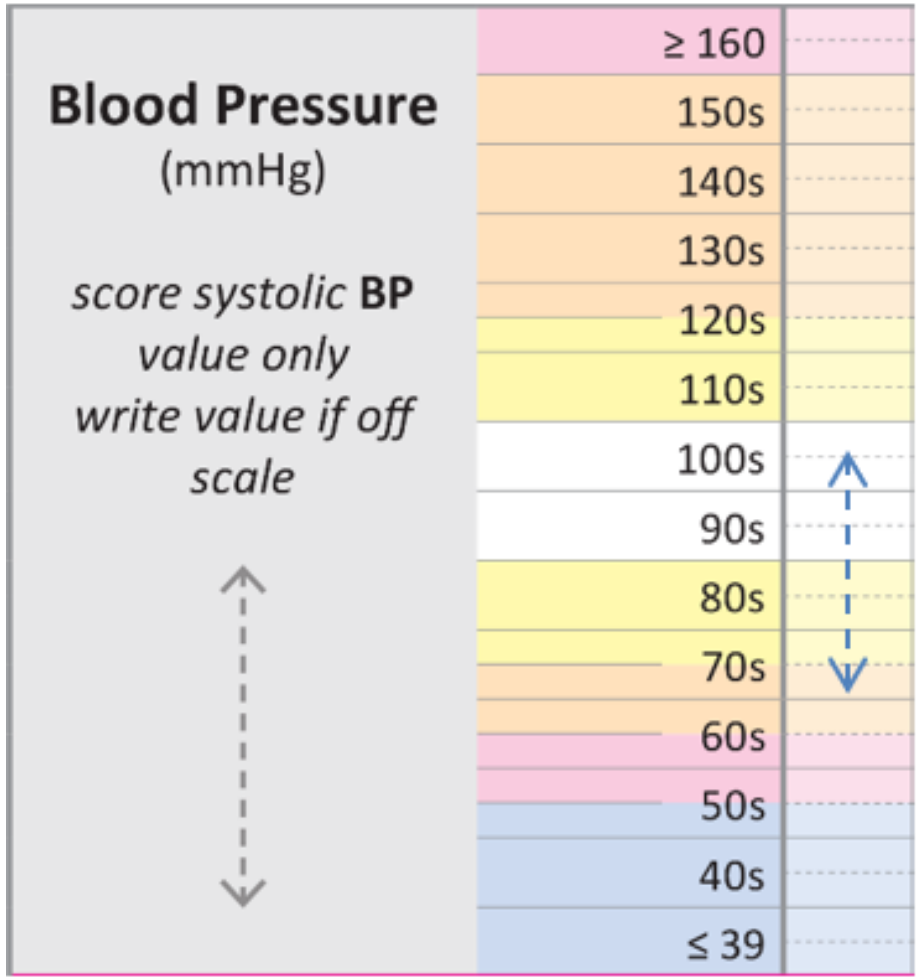
Central Capillary Refill *mark* **CR** *with* **X**	≥ 3 sec	
	< 3 sec	X

Blood pressure

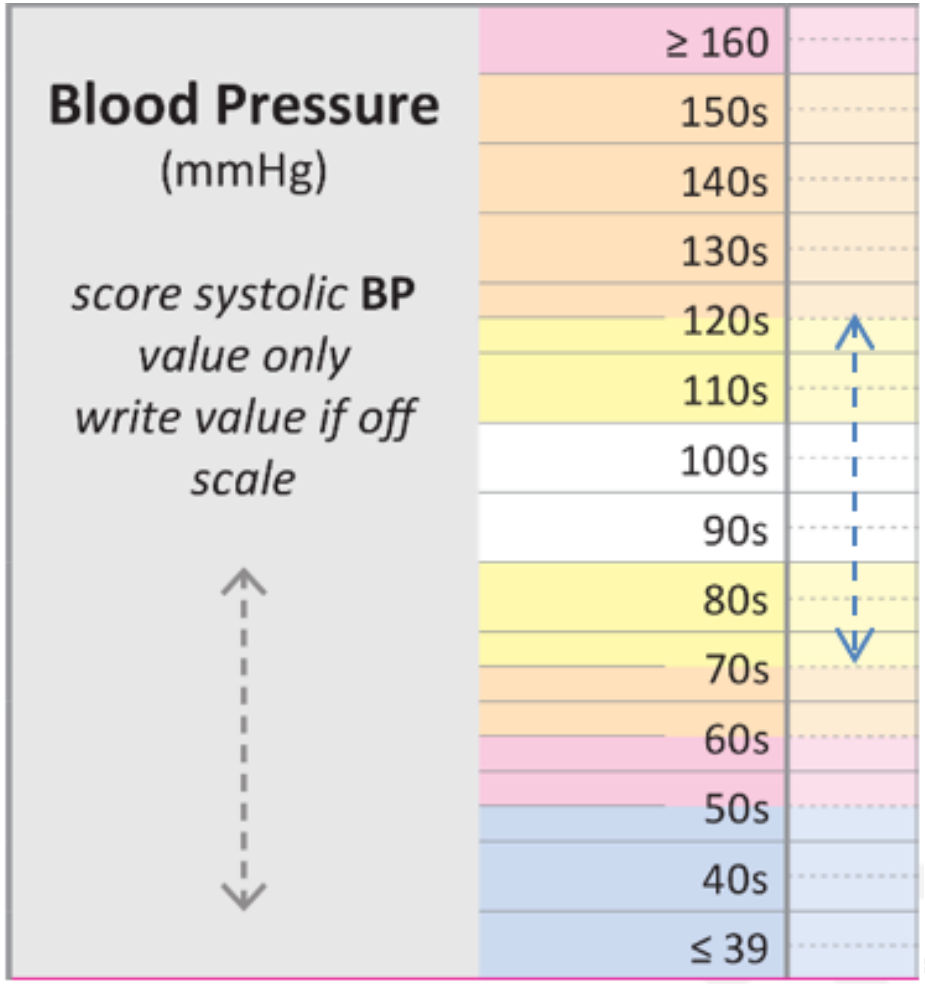


Blood Pressure (mmHg)	
score systolic **BP** *value only write value if off scale*	≥ 150
	140s
	130s
	120s
	110s
	100s
	90s
	80s
	70s
	60s
	50s
	40s
	30s
	20s
	≤ 19

Blood Pressure (mmHg)	
score systolic **BP** *value only write value if off scale*	≥ 190
	180s
	170s
	160s
	150s
	140s
	130s
	120s
	110s
	100s
	90s
	80s
	70s
	60s
	50s
	40s
	≤ 39



BP = 105/70, white zone, score 0



BP = 125/75, orange zone, score 2

Modifications box

Vital sign (use abbreviation)	Accepted values and modified PEWS	Date and time	Duration (hours)	Name and contact details
Oxygen saturation	≥ 91% score = 0 85–90% score = 1 ≤ 85% score = 2	20/ 3 /21 11:30 am	Throughout admission	N. Rivera #6132
Reason:	Normal saturations for child is 91% due to cyanotic congenital heart disease			

Vital sign (use abbreviation)	Accepted values and modified PEWS	Date and time	Duration (hours)	Name and contact details
HR	50–109 score = 0 40–49, score = 1 30–39, score = 2 < 30 score = 4	20/ 3 /21 11:30 am	Until discharge	D. Ramoray #2611
Reason:	Competitive rower, resting HR of 50 when well			

Modifications

- Shouldn’t be used to stop an unwell tamariki continuing to generate an elevated PEW score
- Usually only made to one parameter at a time
- Relevant to all staff using the charts
- Should be made following local procedure
- Usually be at the direction of the SMO

Modifications

END OF LIFE PATHWAY		/ / :	

Whānau concern

PEWS TOTAL			
Whānau concern: Y/N/A			

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

Level of consciousness

Level Of Consciousness *mark* **LOC** *with* **X**		
	Alert	X
	Voice	
	Pain	
	Unresponsive	

Level Of Consciousness *mark* **LOC** *with* **X**		
	Alert	Asleep
	Voice	
	Pain	
	Unresponsive	

Temperature

Temperature (°C) *mark* **Temp** *with* **X** *write value if off scale*	≥ 40
	39s
	38s
	37s
	36s
	≤ 35

Pain

Pain Score *write score (0-10)*	Rest Movement	

Age-based PVSC	Numerical	Faces pain scale	Revised FLACC
0–11 months	No	No	Yes
1–4 years	No	Yes	Yes
5–11 years	Yes	Yes	Yes
12+ years	Yes	Yes	Yes

National tools

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 = BPaP
TH = Tracheostomy humidification	HO_2 = Humidified oxygen	

Numerical rating scale

On a scale of 0 -10, with 0 being no pain and 10 being the worst pain you can imagine, what number are you feeling right now on movement and at rest?

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.			

Faces pain scale - revised

Can you point to the face that shows how much you hurt?

Escalation pathway

PEWS TOTAL	3	4

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

Partial set of observations

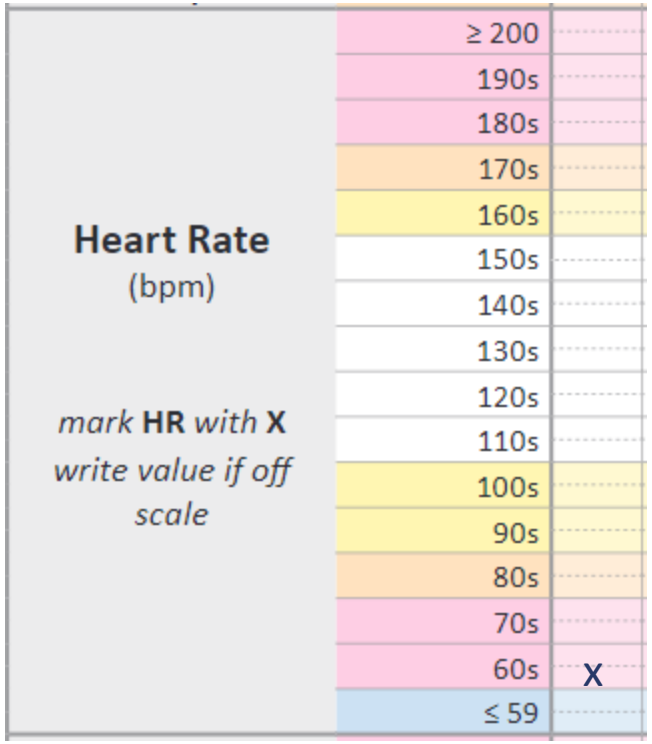
Mark with a plus+

PEWS TOTAL	3+	4	4

Still apply to the escalation pathway

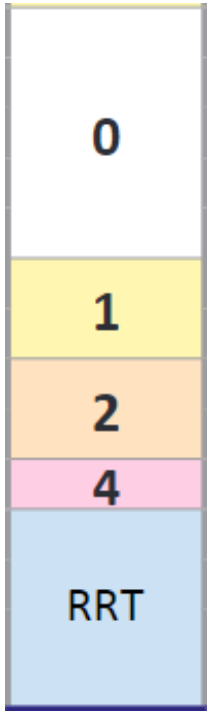
This should be an exception

Rapid response team calls



If any of the tamariki's vital signs fall into the blue rapid response team (RRT) zone, it is a **mandatory** requirement for you to make a RRT call **immediately**

[Insert details of your local RRT calling process]



Questions

- What are the differences between the new chart and what we currently have?
- How do we educate users of the charts to any changes?