

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









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: <u>www.hqsc.govt.nz/our-programmes/patient-deterioration/publications-and-resources/publication/3528</u>.

Background





• 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















Paediatric vital signs charts and escalation pathway

Paediatric Early Warning System



- 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 12+ YEARS



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Local	1.000	-
LOCA	100	s

National tools

Revised FLACC observational pain tool

Family Name:

Local tools editable section

Categories 0 1 2 Res We manifered were result Description <			Scoring		Given Name:			Ge	nde	r:
Res	Categories									
Normal marked bases Normal marked bases Umenant marked bases U		No expression or smile	Occasional grimace or frown, withdrawn, disinterested:	Frequent to constant frown, clenched jaw, quivering chin; distressed looking foce; expression of fright or panic	Date of Birth:	Assessme	ent of res	NHI#:	:55 gl	uide
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	L									

The seven scoring vital signs



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 (example taken from 12+ years PVSC)

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

Respiratory distress

Respiratory	Severe	
Respiratory	Moderate	
Distress	Mild	
mark RD with X	Nil	

P	ssessment of res	piratory distress g	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 <mark>f</mark> eeding	 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



	\geq 4L or \geq 35%	
Oxygen	< 4L or < 35%	
(L/min or FiO₂%)	Room air X	
write value	Mode	
wince value	High flow rate	

Re	Respiratory support mode					
NP = Nasal prongs	M =	Face mask	HF = High flow			
R = Non-rebreather mask	C =	CPAP	B = BPaP			
TH = Tracheostomy humidification	H0 ₂ =	Humidified oxygen				

	≥ 4L or ≥ 35%	
Oxygen	< 4L or < 35%	
(L/min or FiO ₂ %)	Room air X	x
write value	Mode	
White Value	High flow rate	

A tamariki on no respiratory support.

This parameter scores 0.

	≥ 4L or ≥ 35%	
Oxygen	< 4L or < 35%	28 %
(L/min or FiO ₂ %)	Room air X	
write value	Mode	HF
write value	High flow rate	14L

A 7 kg tamariki on high flow therapy with an FiO₂ requirement of 28%.

This parameter scores 2.

	≥ 4L or ≥ 35%	
Oxygen	< 4L or < 35%	21 %
(L/min or FiO ₂ %)	Room air X	
write value	Mode	HF
WITCE VUIUE	High flow rate	141

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.

	≥ 4L or ≥ 35%	5L.
Oxygen	< 4L or < 35%	
(L/min or FiO ₂ %)	Room air X	
write value	Mode	м
white value	High flow rate	

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

This parameter scores 4.

Oxygen saturation %

Oxygen	≥ 95	
Saturation (%)	91-94	
write SpO ₂	≤ 90	

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





	≥ 200	
	190s	
	180s	
	170s	
Lleast Date	160s	
Heart Kate	150s	
(mqd)	140s	
	130s	
an and UD with Y	120s	
mark HR with X write value if off scale	110s	
	100s	
	90s	
	80s	
	70s	
	60s	
	< 59	

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



	> 180		> 180
	2 180		170
	170s		1705
	160s		160s
U.S. A. D. A.	150s	Heart Data	150s
Heart Rate	140s		140s
(bpm)	130s	(mqa)	130s
	120s		120s
mark HR with X write value if off	110s	mark HR with X write value if off	110s
	100s		100s
	90sX		90s
scale	80s	scale	80s
	70s		70s
	60s		60s
	≤ 59		≤ 59

Central capillary refill



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



Blood pressure



	≥ 150	
	140s	
Blood Pressure	130s	
(mmHg)	120s	
	110s	
score systolic BP	100s	
write value if off	90s	
scale	80s	
Start	7 0s	
<u>л</u>	60s	
	50s	
	40s	
	30s	
V	20s	
	≤ 19	

	= 100
	180s
	170s
Blood Pressure	160s
(mmHg)	150s
score systelic PD	140s
score systolic BP	130s
write value if off	120s
scale	110s
	100s
	90s
	80s
	70s
	60s
v	50s
	40s
	≤ 39

> 190





	≥ 160			≥ 160	
Blood Pressure	150s		Blood Pressure	150s	
(mmHg)	140s		(mmHg)	140s	
	130s			130s	
score systolic BP	120s		score systolic BP	120s	A
write value if off	110s		write value if off	110s	
scale	100s	A	scale	100s	
	90s			90s	
<u>^</u>	80s		 ↓	80s	
	70s	w.		70s	V
	60s		1	60s	
	50s			50s	
	40s			40s	
	≤ 39			≤ 39	

BP = 105/70, white zone, score 0

BP = 125/75, orange zone, score 2

Modifications box

Vital sign	Accepted values	Date	Duration	Name and
(use abbreviation)	and modified PEWS	and time	(hours)	contact details
Oxygen saturatíon	≥91% score = 0 85−90% score = 1 ≤85% score = 2	20/3/21 11:30 am	Throughout admíssíon	N. Rívera #6132

Reason: Normal saturations for child is 91% due to cyanotic congenital heart disease

Vital sign	Accepted values	Date	Duration	Name and
(use abbreviation)	and modified PEWS	and time	(hours)	contact details
HR	50—109 score = 0 40—49, score = 1 30—39, score = 2 < 30 score = 4	20/3/21 11:30 am	untíl díscharge	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







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



Level of consciousness

Level Of	Alert	Х
Compaignee	Voice	
Consciousness	Pain	
mark LOC with X	Unresponsive	

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





	≥ 40
Temperature	39s
(°C)	38s
mark Tomp with V	37s
mark temp with K	36s
write value if off scale	≤ 35







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 res	piratory distress	guide	
	Mild	Moderate	Severe	0
Airwey	Strider on exertion or crying Wheeze present	 Some stridor at rest Wheeze marked 	Some stridor at rest Wheese marked Stridor at rest New chief of stridor Wheese severe Silent chest	
Behaviour and feeding	Normal Talks in sentences	Some or intermittent invitability Difficulty talking or crying Difficulty feeding or eating	Increased irritability and/or lethargy Looks exhausted Unable to talk or cry Unable to feed or cell	Fac
Accessory muscle use	Mild intercostal and suprasternal recession	Moderate intercostal and suprasternal recession Tracheal tug Nessi flaring Head babbing	Moderate - Marked intercostal and suprasternal recession - Tracheal tug Nasal flaring	
Other		 May bee brief apnoes 	Gasping, grunting Extreme pallor, cyanosis Increasingly frequent or prolonged apnoes	Act
NP = Nasal pr R = Non-reb	Respirator	y support mode ace mask HF	= High flow	cη
mask TH = Tracheo humidif	stomy H0, = H ication o Numeric	umidified xygen al rating scale	DPar	Cor
No pain 0	1 2 3 4	5 6 7 8	Worst pain	Rat
On a scale worst pai	e of 0 -10, with 0 in you can imagin	being no pain and e, what number a	10 being the re you feeling	dos Chi are
	right now of mi	wentent and at re	3417	Chil are par the par
			Faces pai	n scale - re
	(i i	(3)	53	6

	Revised FLAO	C observational	pain tool		
	Scoring				
regories					
	No expression or smile	Occasional grimace or frown, withdrewn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chine, oldrassed looking foce; expression of fright or panie Individualised behaviour described by family:		
	Normal position or relaxed; usual muscle tone and motion to arms and legs	Uneasy, restless, tense; occasional tremors	kloking, or legs drawn up; marked increase in spasicity; constant tremore or jerking individualised behavlour described by family;		
wity	Lying quiety, normal position, moves easily; regular mythmic treaths (respiration)	Squirming, shifting back and forth, tense or guarded movements: midly agitated (head back and forth, aggression): shallow, splinting breaths (resplintbons): occasional sizes	Arches, rigid, or jenting: avver optation; hood bonging; shivering (not rigoris; breath holding, gasping, or sharp; intoke of breaths; savere splinting individualised behaviour described by family;		
	No cry (swake or askep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent compleints; repeated outpursts; constant grunding individualised behaviour described by family:		
solability	Content, relaxed	Reessured by occasional touching, hugging, or 'taking to'; can be distracted	Dimoult to console or comfort: pushing dway coregiver, resisting care or comfort measures individualised behaviour described by family:		
the child in each of the five measurement categories, add together, and ment total pain score (0 = 10).					
dren who awake:	n who Reposition child or observe activity, assess body for tanseness and their instate consoling interventions if needed.				
dren who 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.				
tool can be validated in ints/caregiv e are additi . Add these	used for all non-ve- children with segni ers the descriptors i onal behaviours that behaviours to the s	rbai children. The ad the impairment. The within each category it are better indicato tool in the appropriat	ditional descriptors (in Italics) a nurse can review with y. Ask the parents/caregivers if rs of their child experiencing te category.		





Escalation pathway

PEWS TOTAL	3	4

landatory es	calation pathway NAME OF DHB		
otal PEWS	Action		
PEWS 1-3	Local escalation steps		
PEWS 4-5	Local escalation steps		
PEWS 6-7			
PEWS 8+			
Any vital ign in the plue zone			
		C	

Partial set of observations

Mark with a plus+



Still apply to the escalation pathway

This should be an exception

Rapid response team calls

	≥ 200	
	190s	
	180s	
	170s	
U.s. and Dista	160s	
Heart Kate	150s	
(bpm)	140s	
	130s	
1	120s	
mark HR with X	110s	
write value if off	100s	
scale	90s	
	80s	
	70s	
	60s	x
	≤ 59	

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]

0	
1	
2	
4	
RRT	



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?



