# | | | |

Date of Birth:

Given Name:

PAEDIATRIC VITAL SIGNS CHART

Date **Vital Signs** Time (24 hour) Time (24 hour) ≥ 35 4 ≥ 35 30-34 30-34 25-29 25-29 Respiratory 20-24 20-24 Rate 0 15-19 15-19 (breaths/min) 12-14 10-11 mark **RR** with **X** 5-9 5-9 ≤ 4 ≤ 4 Severe Severe 4 Respiratory Moderate **Distress** Mild Mild mark **RD** with **X** Nil Nil ≥ 4L or ≥ 35% ≥ 4L or ≥ 35% 4 Oxygen < 4L or < 35% 2 < 4L or < 35% Room air X **X** Room air (L/min or FiO<sub>2</sub>%) Mode Mode write value High flow rate High flow rate ≥ 95 0 ≥ 95 Oxygen Saturation (%) 91-94 91-94 write SpO<sub>2</sub> ≤ 90 ≤ 90 ≥ 150 ≥ 150 140s 140s 130s 130s 2 120s 120s **Heart Rate** 110s 110s (bpm) 100s 100s 90s 90s 80s 80s mark HR with X 70s 70s write value if off scale 60s 60s 2 50s 50s 40s 4 40s ≤ 39 ≤ 39 Central Capillary Refill ≥ 3 sec 4 ≥3 sec mark CR with X < 3 sec < 3 sec ≥ 190 4 ≥ 190 180s 180s 170s 170s **Blood Pressure** 160s 160s (mmHg) 150s 150s 140s 140s score systolic BP 130s 130s value only 120s 120s write value if off 110s 110s scale 100s 100s 90s 90s 80s 80s 70s 70s 60s 60s 50s 50s 40s 40s ≤ 39 ≤ 39 **PEWS TOTAL PEWS TOTAL** Whānau concern: Y/N/A Y/N/A Alert Level Of Voice Voice Consciousness Pain Pain mark **LOC** with **X** Unresponsive Unresponsive ≥ 40 ≥ 40 Temperature 39s 39s (°C) 38s 38s 37s 37s mark **Temp** with **X** 36s 36s write value if off scale ≤ 35 ≤ 35 Pain Score write score (0-10) **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		
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 PEV		Date and time	Duration (hours)	Name and contact details
			/ / :		
eason:					
			/ / :		
eason:		·			
			/ / :		
eason:	_				
			/ /		

## Local tools

## **National tools**

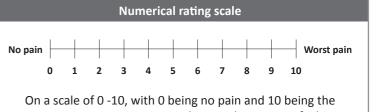
Revised FLACC observational pain tool			
C-4	Scoring		
Categories	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; distressed looking face; expression of fright or panic Individualised behaviour described by family:
	Normal position or	Uneasy, restless, tense;	Kicking, or legs drawn up; marked increase
	relaxed; usual muscle tone	occasional tremors	in spasticity; constant tremors or jerking
Legs	and motion to arms and legs		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	Arches, rigid, or jerking; severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting
		and forth, aggression); shallow, splinting breaths (respirations); occasional sighs	Individualised behaviour described by family:
	No cry (awake or asleep)	Moans or whimpers, occasional complaint;	Crying steadily, screams or sobs, frequent complaints; repeated outbursts; constant grunting
Cry		occasional verbal outburst or grunt	Individualised behaviour described by family:
-	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:
	n each of the five m pain score (0 – 10).	•	ies, add together, and
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			

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.

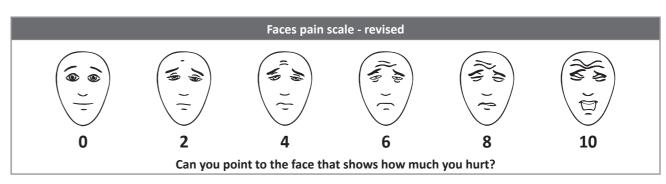
Family Name:	
Given Name:	Gender:
	AFFIX PATIENT LABEL HERE.
Date of Birth:	NHI#:

Assessment of respiratory distress guide			
	Mild	Moderate	Severe
Airway	Stridor on exertion or crying     Wheeze present	<ul><li>Some stridor at rest</li><li>Wheeze marked</li></ul>	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	<ul> <li>Gasping, grunting</li> <li>Extreme pallor, cyanosis</li> <li>Increasingly frequent or prolonged apnoea</li> </ul>
Score at the level of Note that not all fe	f severest sign. atures 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 <sub>2</sub> = Humidified oxygen		



worst pain you can imagine, what number are you feeling right now on movement and at rest?





Scan for PVS educational materials