



Vital Signs	Date						PEWS
	Time (24 hour)						
Respiratory Rate (breaths/min) <i>mark RR with X</i>	≥ 45						4
	40-44						2
	35-39						2
	30-34						1
	25-29						0
	20-24						0
	15-19						1
	12-14						2
	10-11						2
	5-9						4
Respiratory Distress <i>mark RD with X</i>	≤ 4						
	Severe						4
	Moderate						2
	Mild						1
	Nil						0
Oxygen (L/min or FiO ₂ %) <i>write value</i>	≥ 4L or ≥ 35%						4
	< 4L or < 35%						2
	Room air X						0
	Mode						
	High flow rate						
Oxygen Saturation (%) <i>write SpO₂</i>	≥ 95						0
	91-94						1
	≤ 90						2
Heart Rate (bpm) <i>mark HR with X</i> <i>write value if off scale</i>	≥ 170						4
	160s						4
	150s						2
	140s						2
	130s						1
	120s						
	110s						
	100s						0
	90s						
	80s						
	70s						1
	60s						2
	50s						4
	≤ 49						
Central Capillary Refill <i>mark CR with X</i>	≥ 3 sec						4
	< 3 sec						0
Blood Pressure (mmHg) <i>score systolic BP value only</i> <i>write value if off scale</i>	≥ 170						4
	160s						
	150s						2
	140s						
	130s						1
	120s						
	110s						
	100s						0
	90s						
	80s						1
	70s						2
	60s						4
	50s						
	40s						
	≤ 39						
PEWS TOTAL							
Whānau concern: Y/N/A							
Level Of Consciousness <i>mark LOC with X</i>	Alert						
	Voice						
	Pain						
	Unresponsive						
Temperature (°C) <i>mark Temp with X</i> <i>write value if off scale</i>	≥ 40						
	39s						
	38s						
	37s						
	36s						
	≤ 35						
Pain Score <i>write score (0-10)</i>	Rest						
	Movement						
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 abbr)	Accepted values and modified PEWS	Date and time	Duration (hours)	Name and contact details
		/ / :		
Reason:				
		/ / :		

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; <i>distressed looking face; expression of fright or panic</i>
			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; <i>marked increase in spasticity; constant tremors or jerking</i>
			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; <i>severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting</i>
			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; <i>repeated outbursts; constant grunting</i>
			Individualised behaviour described by family:
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or 'talking to'; can be distracted	Difficult to console or comfort; <i>pushing away caregiver; resisting care or comfort measures</i>
			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 = BiPaP
TH = Tracheostomy humidification	HO ₂ = Humidified oxygen	



Scan for PVSC educational materials