

Family Name: _____ Gender: _____
 Given Name: _____

NHI#: _____
 Date of Birth: _____



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



PAEDIATRIC VITAL SIGNS CHART
1-4 YEARS

HQSC PVSC 1-4y v1

Vital Signs	Date	PEWS												Date	
	Time (24 hour)													Time (24 hour)	
Respiratory Rate (breaths/min) <i>mark RR with X</i>	≥ 55													≥ 55	
	50-54													50-54	
	45-49													45-49	
	40-44													40-44	
	35-39													35-39	
	30-34													30-34	
	25-29													25-29	
	20-24													20-24	
	18-19													18-19	
	15-17													15-17	
Respiratory Distress <i>mark RD with X</i>	10-14													10-14	
	5-9													5-9	
	≤ 4													≤ 4	
	Severe													Severe	
Oxygen (L/min or FiO ₂ %) <i>write value</i>	Moderate													Moderate	
	Mild													Mild	
	Nil													Nil	
	Room air X													X Room air	
Oxygen Saturation (%) <i>write SpO₂</i>	Mode													Mode	
	High flow rate													High flow rate	
	≥ 95													≥ 95	
Heart Rate (bpm) <i>mark HR with X</i> <i>write value if off scale</i>	91-94													91-94	
	≤ 90													≤ 90	
	≥ 180													≥ 180	
	170s													170s	
	160s													160s	
	150s													150s	
	140s													140s	
	130s													130s	
	120s													120s	
	110s													110s	
Blood Pressure (mmHg) <i>score systolic BP</i> <i>value only</i> <i>write value if off scale</i>	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
Level Of Consciousness <i>mark LOC with X</i>	Alert													Alert	
	Voice													Voice	
	Pain													Pain	
	Unresponsive													Unresponsive	
Temperature (°C) <i>mark Temp with X</i> <i>write value if off scale</i>	≥ 40													≥ 40	
	39s													39s	
	38s													38s	
	37s													37s	
	36s													36s	
Pain Score <i>write score (0-10)</i>	≤ 35													≤ 35	
	Rest													Rest	
Initials															

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 PEWS	Date and time	Duration (hours)	Name and contact details
		/ / : :		
Reason:				
		/ / : :		
Reason:				
		/ / : :		
Reason:				
		/ / : :		

Local tools

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.			

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Assessment of respiratory distress guide			
	Mild	Moderate	Severe
Airway	<ul style="list-style-type: none"> Stridor on exertion or crying Wheeze present 	<ul style="list-style-type: none"> Some stridor at rest Wheeze marked 	<ul style="list-style-type: none"> Stridor at rest New onset of stridor Wheeze severe Silent chest
Behaviour and feeding	<ul style="list-style-type: none"> Normal Talks in sentences 	<ul style="list-style-type: none"> Some or intermittent irritability Difficulty talking or crying Difficulty feeding or eating 	<ul style="list-style-type: none"> Increased irritability and/or lethargy Looks exhausted Unable to talk or cry Unable to feed or eat
Accessory muscle use	<ul style="list-style-type: none"> Mild intercostal and suprasternal recession 	<ul style="list-style-type: none"> Moderate intercostal and suprasternal recession Tracheal tug Nasal flaring Head bobbing 	<ul style="list-style-type: none"> Marked intercostal and suprasternal recession
Other		<ul style="list-style-type: none"> May have brief apnoea 	<ul style="list-style-type: none"> 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	

