

**Aotearoa New Zealand national  
paediatric early warning system   
 and paediatric vital signs chart**

**User guide**

March 2023 (updated September 2025)

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# The New Zealand Government logo is made up the words Te Kāwanatanga o Aotearoa in bold letters alongside it, with New Zealand Government written beneath.

Document purpose

This user guide is for any health professional implementing and improving paediatric early warning systems within Aotearoa New Zealand hospitals. It explains how to complete and use the draft paediatric vital signs chart.

1. Introduction and scope

The national paediatric vital signs chart (PVSC) and paediatric early warning system (PEWS) are tools for detecting clinical deterioration in tamariki receiving hospital care in Aotearoa New Zealand. This user guide explains how to complete and use the PVSC correctly.

Begin the PVSC for any tamariki who is assessed as requiring measurement and recording of vital signs.

Tamariki physiology alters as they age, impacting on the normal ranges for vital signs. As such, there are four age-based PVSCs, which must be used for the correct age group:

* 0–11 months
* 1–4 years
* 5–11 years
* 12+ years.

Tamariki who need to receive care in an intensive care unit or high-dependency unit may not require a PVSC because these units usually have their own specific charts. The PVSC can be used in these settings; however, for consistency, the same parameters and scoring cut-offs for each vital sign should be used.

Before tamariki are transferred from an intensive care unit or high-dependency unit to a ward area, chart the most recent set of vital signs on an age-appropriate PVSC and include a plan to address any ongoing abnormalities in a set timeframe.

The total paediatric early warning score (PEW score) is calculated using measurements taken across seven vital sign parameters. The score increases as the vital signs deviate further from the normal zone. The total score triggers an escalating clinical response, so clinicians with the right skills can intervene and manage any deterioration promptly.

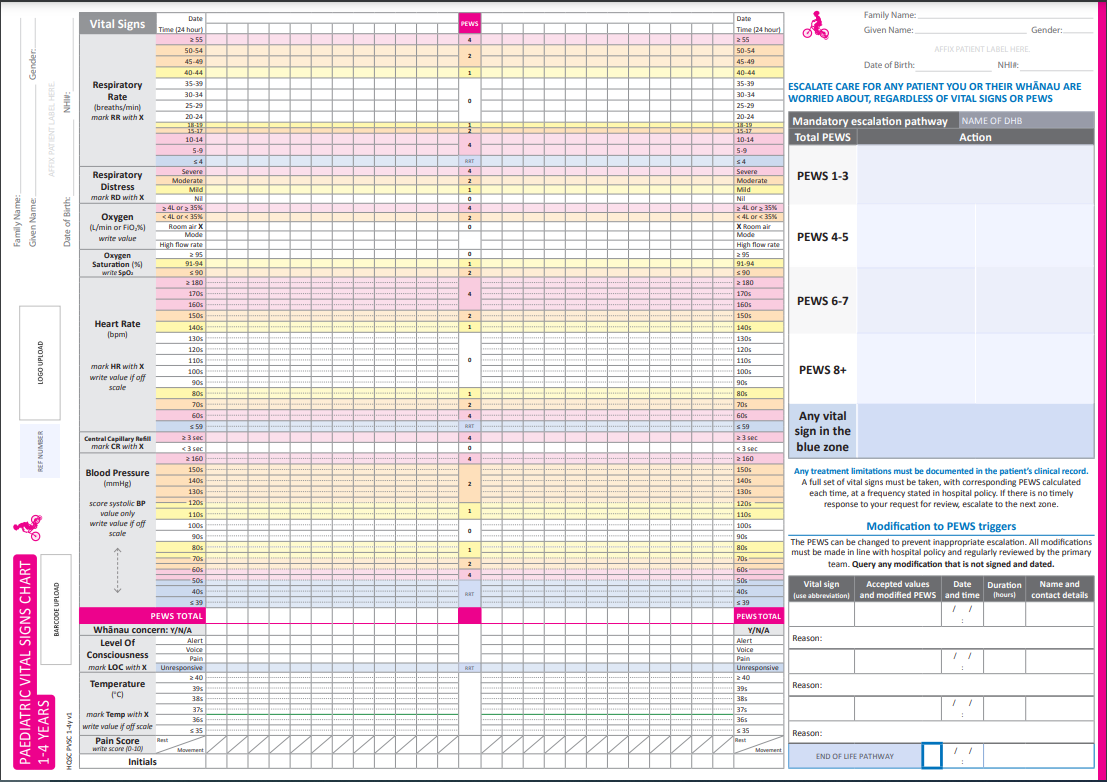
The Health Quality & Safety Commission developed the PVSC and PEWS based on the best available human factors and clinical evidence.

1. Chart overview

The PVSC is a two-sided document, printed front and back. Figure 1 and Figure 2 illustrate the main areas of both sides. The four age-based PVSCs all have the same layout. The vital sign parameter ranges differ by age, as does some of the content on the back.

This section provides a brief overview of each chart area. For more detail about the clinical use of the PVSC, see [Section 3](#S3) of this guide.

Figure 1: Overview of the front of the paediatric vital signs chart



**Total PEW score**

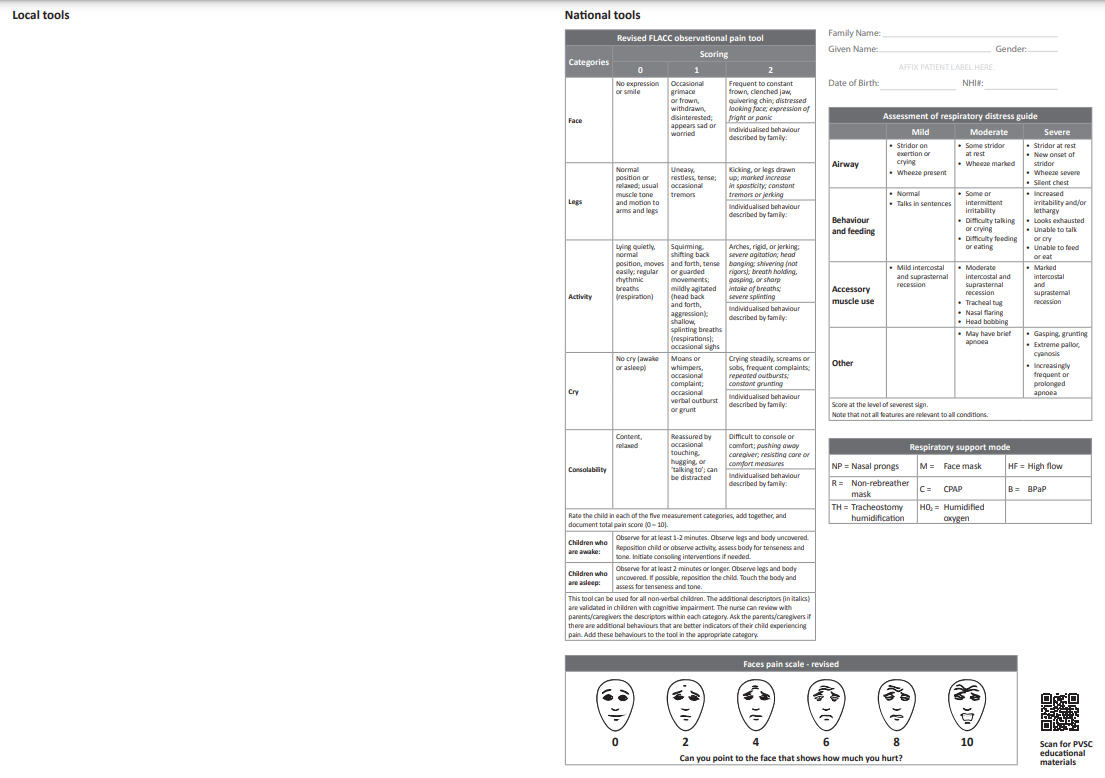
**Recording vital signs:  
scoring area**

**Recording vital signs:  
non-scoring area**

**Mandatory  
escalation  
pathway**

**Modifications  
box**

Figure 2: Overview of the back of the paediatric vital signs chart



**Local tools  
editable section**

**National tools**

* 1. Recording vital signs: scoring area

The purpose of the scoring area is to document the vital sign measurements of the core parameters that contribute to the total PEW score. The vital signs included for scoring are based on Bedside PEWS.[[1]](#footnote-2) These seven parameters are:

* respiratory rate
* respiratory distress
* oxygen
* oxygen saturation
* heart rate
* central capillary refill
* blood pressure.

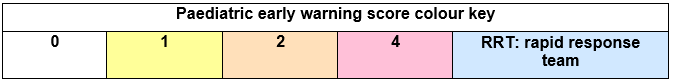
Where the observation plots on the chart determines its score: 0,1, 2 or 4. The score increases as the observation becomes more abnormal.

When documentation in the scoring area is done in a clear and consistent manner, it is easy to detect trends indicating improvement or deterioration. It is easier to visualise trends if you record using a symbol such as an ‘X’ rather than writing a numerical value (the exception being the oxygen saturation parameters, where the numerical value is marked on the chart). However, if a measured value falls outside the range able to be plotted on the chart, it can still be recorded by writing the numerical value at the upper or lower margin of the chart area for that parameter.

Scores for the individual parameters are then added to calculate the total PEW score, which is documented in the bottom row of the scoring area. Abnormal vital signs associated with a given score are also identified by the differently coloured zones on the chart. Individual vital sign parameters in blue zones trigger escalation actions that the escalation pathway sets out, **regardless of the total score.**

The total PEW score reflects the sum of the scores from seven vital signs. As it is not always possible or necessary to obtain a complete set of observations, for example, blood pressure in distressed tamariki, there needs to be a way of indicating that an incomplete set of observations has been used to generate a score. The convention on this chart is to add a plus (+) to the value recorded in the PEWS Total box, eg, 3+. See [Section 3.3](#S3p3) for more detail.

Figure 3: Paediatric early warning score colour key



* 1. Recording vital signs: non-scoring area

The purpose of the non-scoring area is to document the vital sign parameters that do not contribute to the total PEW score. These parameters are:

* whānau concern
* level of consciousness
* temperature
* pain score.

There is also space for the staff member recording the observations to enter their initials. More detailed documentation in the clinical notes will include name and designation.

* 1. Mandatory escalation pathway

The escalation pathway states the actions to be taken when a particular total PEW score is reached, or a blue zone observation occurs. An increasing total PEW score indicates a higher risk of deterioration. Each organisation defines for their own location what the response to each level of the escalation pathway will be, reflecting available resources and processes of care. This includes determining the correct emergency response terminology for the blue zone, for example, rapid response team (RRT).

* 1. Modifications box

The modifications box is used to individualise escalation triggers for tamariki with chronic disease or vital sign abnormalities that do not necessarily represent clinical deterioration. Modifications are usually only required for one vital sign parameter but can be made to several. They can be made for the duration of admission or can be time limited. They should be made after considering the potential risks associated with altering the score an abnormal parameter will generate. The process for making modifications, including who can make them, is defined locally.

For example, tamariki with a known cardiac condition resulting in lower oxygen saturation levels may inappropriately trigger escalation of care unless a single parameter modification for oxygen saturation is made.

**Caution: This area is not to be used to modify an overall score; it is only for individual vital sign parameters.** [See Section 3.5](#S3p5) for more information.

* 1. National and local tools

The back of the PVSC is divided into two sections: national and local tools.

For sites using an electronic patient observation system, the method of accessing these tools needs to be locally determined if they cannot be incorporated into the electronic system. For example, this may include posters in the clinical environment or laminated cards at computer stations.

The national tools are a non-editable set of resources to support the consistent use, completion and interpretation of vital signs on the front of the chart. The national tools are:

* assessment of respiratory distress guide
* respiratory support mode abbreviations
* pain scores.

The pain scoring tools vary between age-banded charts to reflect the appropriate tools to use for different age groups.

The local tools section is editable, and the content is defined locally. It can be used to document non-scoring observations such as weight, blood sugar level, phlebitis score or pressure injury assessment. Associated guidance that explains how these observations are defined may be included. The multidisciplinary team will need to consider carefully what to include, if anything, in this space; it must be clinically relevant and enhance the care provided to tamariki. If you are adding elements to this section, you will need support from your local communications team or design team.

1. Clinical use of the PVSC

This section describes clinical use of the PVSC and includes:

* documenting vital signs
* modifying PEWS triggers
* calculating PEW scores
* mandatory escalation of care.

1. 1. Documenting scoring vital signs

Instructions for documenting each vital sign parameter, the accepted abbreviation and the unit of measurement appear in the grey column to the left of the scoring area of the PVSC. Where measurements exceed the range on the chart, write the numerical value on the chart at the upper or lower margin of the chart area for that parameter.

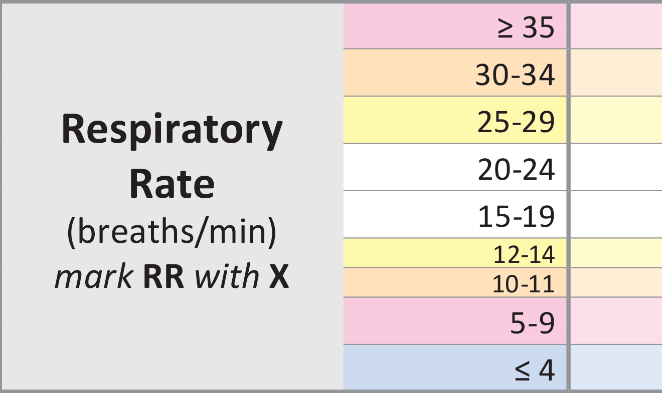
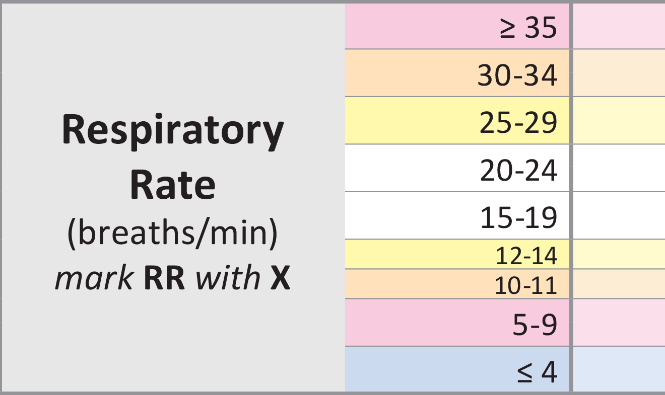
Date and time

The top two rows of the PVSC provide space for recording the date and time that each set of observations was taken. Use the 24-hour clock format for the time. Be aware that the columns are evenly spaced across the chart but the time interval between observations may vary.

Respiratory rate

Each row of the scoring area for respiratory rate (Figure 4) represents a range associated with varying severity of abnormality. Note that the vital sign parameters vary between charts, so pay careful attention to ensure the correct score is generated.

Figure 4: Respiratory rate (example from 12+ years PVSC)

**X**

**X**

Respiratory rate = 18 breaths/minute, white zone, score 0 Respiratory rate = 27 breaths/minute, yellow zone, score 1

Respiratory distress

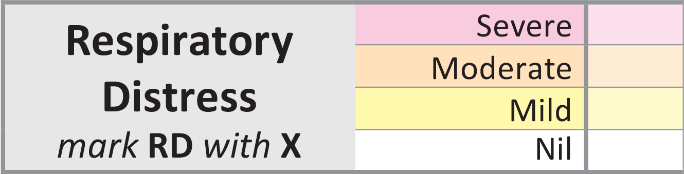
Assess the level of respiratory distress using the ‘Assessment of respiratory distress guide’ on the back of the chart (Figure 5), which is based on a tool developed by the Royal Children’s Hospital Melbourne.[[2]](#footnote-3) It is the same across all four age-based PVSC and is **scored at the level of the most severe sign**.

Figure 5: Assessment of respiratory distress guide from the back of the PVSC



The level of respiratory distress can then be marked with an ‘X’ in the appropriate box (Figure 6). There are four levels of respiratory distress: nil, mild, moderate and severe.

Figure 6: Example of documenting respiratory distress



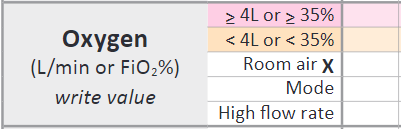
**X**

Oxygen

Tamariki receive a variety of oxygen therapies and modes of respiratory support. The challenge is to provide a format that captures information correctly and accurately reflects the oxygen therapy in use. The oxygen score is based mainly on the FiO2, where an increasing oxygen requirement indicates a deterioration.

In some tamariki, for example those receiving nasal prong oxygen, the flow rate is varied but the FiO2 remains unchanged at 100%. In another example, tamariki may have high-flow oxygen therapy in place, in which case the flow rate is stable and the FiO2 is varied. This information can be recorded on the PVSC to generate a score for the oxygen parameter, and by recording the numerical value on the chart, the trend in the amount of respiratory support needed is visible. Tamariki on room air only are marked with an ‘X’ (Figure 7). Room air refers to no respiratory support at all.

Figure 7: Oxygen



X

Record the mode of oxygen delivery using the abbreviations from the ‘Respiratory support mode’ panel on the back of the chart (Figure 8).

Figure 8: Respiratory support mode key as it appears on the back of all four PVSC

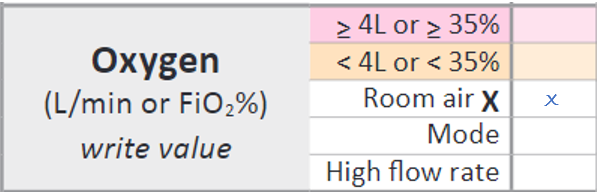
|  |  |  |
| --- | --- | --- |
| **Respiratory support mode** | | |
| NP = nasal prongs | M = face mask | HF = high flow |
| R = non-rebreather mask | C = CPAP | B = BiPAP |
| TH = tracheostomy humidification | HO2 = humidified  oxygen |  |

When tamariki are receiving high-flow oxygen therapy, the weight-based flow rate is recorded in the high-flow rate row. This allows the correct flow rate to be confirmed. The numerical value of the FiO2 being delivered while on high-flow therapy can be recorded in either one of the two top boxes in the oxygen section, as appropriate.

We have not allocated space to record the pressure (in cmH2O) being delivered to tamariki on CPAP (continuous positive airway pressure), although know that this may be varied during treatment. This is because it is uncommon for tamariki to receive CPAP outside a higher acuity area, where there is likely to be a different chart in use, and also due to space constraints on the chart.

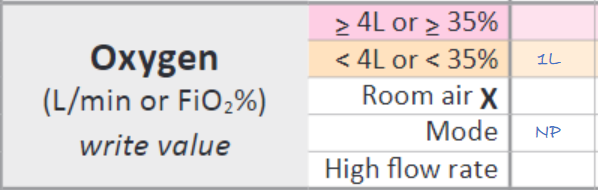
Examples of different oxygen therapies and how to record them are shown in Figure 9.

**Figure 9: Examples of oxygen documentation**



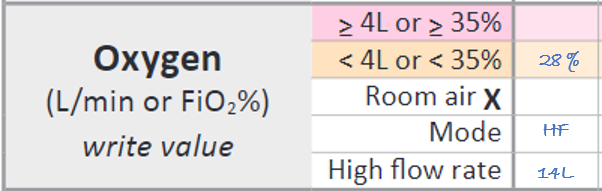
Tamariki on no respiratory support.

This parameter scores 0.



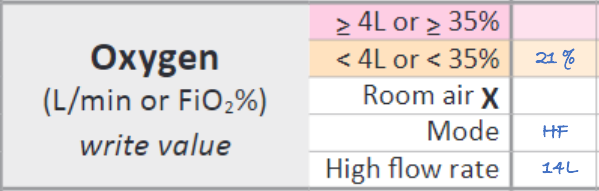
Tamariki on 1 L/min of oxygen via nasal prongs.

This parameter scores 2.



Tamariki weighing 7 kg on high-flow therapy with an FiO2 requirement of 28%.

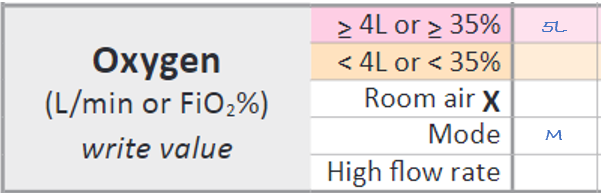
This parameter scores 2.



Tamariki weighing 7 kg on high-flow therapy with an FiO2 requirement of 21%.

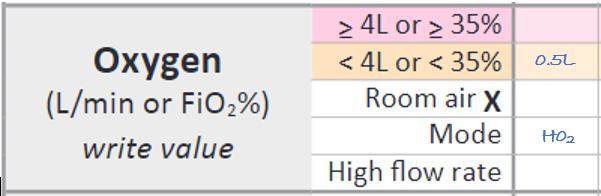
This parameter scores 2.

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



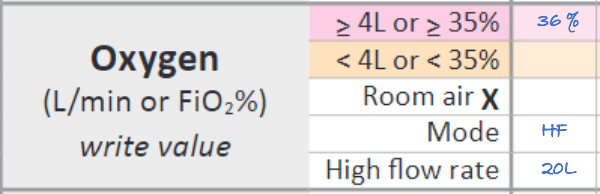
Tamariki receiving 5 L/min of oxygen via a mask.

This parameter scores 4.



Tamariki receiving 0.5 L/min of humidified oxygen.

This parameter scores 2



Tamariki weighing 10 kg on high-flow therapy with an FiO2 requirement of 36%.

This parameter scores 4.

Continuous positive airway pressure (CPAP)

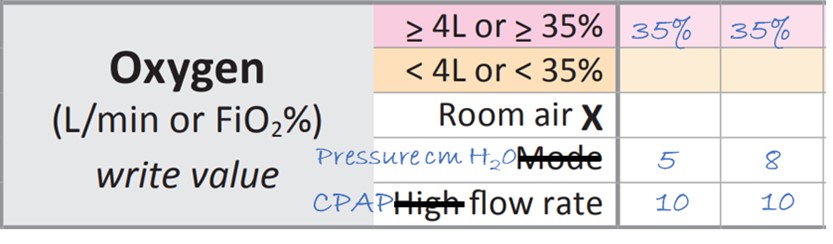
If tamariki are receiving CPAP in the ward setting, the PVSC can be adapted to record settings and generate a score. Do this by changing the name of some of the rows to reflect what you need to record on CPAP.

CPAP generates a score based on the FiO2. Record this on the chart in the same way you would for tamariki on high flow.

The positive end expiratory pressure (PEEP) is measured in cmH2O and can be recorded in the ‘mode’ row. Cross out ‘mode’ and write ‘Pressure cmH2O’.

The CPAP flow is measured in litres per minute and can be recorded in the ‘high flow rate’ row. Cross out ‘high’ and write CPAP (see Figure 10).

Figure 10: CPAP example

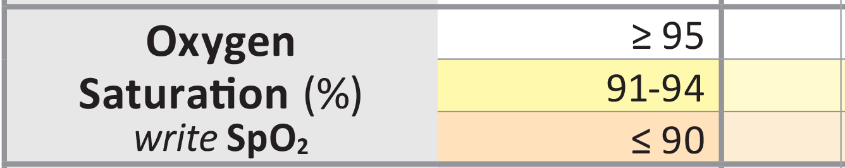


Oxygen saturation

Document the numerical value for oxygen saturation in the relevant box of the scoring area (Figure 11).

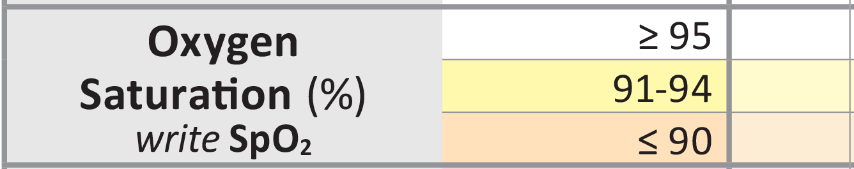
Figure 11: Oxygen saturation examples

**96**



Oxygen saturation = 96%

Scores 0



**93**

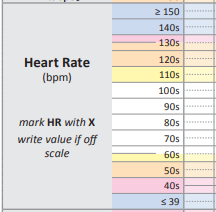
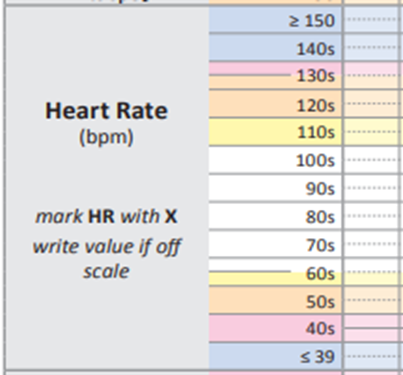
Oxygen saturation = 93%

Scores 1

Heart rate

Document heart rate by placing an ‘X’ in the relevant box of the scoring area (Figure 12). At times, coloured zones change in the middle of a row as in Figure 12, where the zone change is 65. That is, 64 is in the yellow and 65 is in the white. If the observation plots on the line, score according to the colour above.

Figure 12: Heart rate examples

**X**

**X**

Heart rate = 96, white zone, score 0 Heart rate = 64bpm, yellow zone, score 1

Central capillary refill

When looking at skin perfusion as a marker of cardiovascular status, the most accurate assessment is made by determining central capillary refill.[[3]](#footnote-4) This is obtained by pressing a finger on the central chest, holding for 5 seconds and releasing. The white blanched area should fully regain colour in under 3 seconds. The observation is marked with an ‘X’ according to the time taken (Figure 13).

Figure 13: Example of documentation of a central capillary refill of 3 or more seconds



**X**

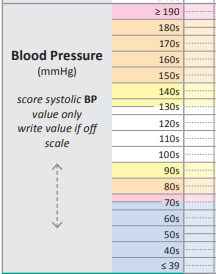
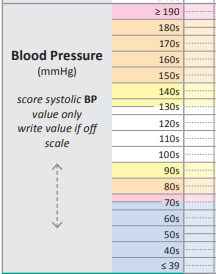
Blood pressure

The systolic blood pressure is the measurement used to generate a score for this vital sign. Document both systolic and diastolic pressure on the chart as this is important clinical information.

Measure blood pressure using an appropriate size of cuff and document the cuff size on their care plan.

Each row of the scoring area for blood pressure. At times, coloured zones change in the middle of a row as in Figure 14, where the zone change is 135. That is, 134 is in the white and 135 is in the yellow. If the observation plots on the line, score according to the colour above.

Figure 14: Blood pressure examples



BP = 105/70, white zone, score 0 BP = 135/100, yellow zone, score 1

* 1. Documenting vital signs that do not contribute to the PEWS

Whānau concern

Y = Yes N = No A = away/asleep/unavailable

This section requires staff to check in with whānau as to whether they have any concerns about the condition of their tamariki. Asking regularly gives whānau the opportunity to speak up and voice concerns. Sharing the PVSC with whānau as part of the admission and orientation process, and when completing observations, supports communication, helps understanding and encourages partnership.

If there is concern, mark with a **Y** on the chart. Escalation of this concern can occur, even if the other observations and the total PEW score are normal. Staff may find that, with listening to the concern, explanation or further discussion alleviates it. Document detail in the progress notes, including any action taken because of the concern being raised.

If there is no concern, mark with an N.

If whānau members are away, asleep or unavailable, mark with an **A**. This can then act as a reminder for other staff to check in with whānau when they are next available.

The whānau concern section of the PVSC needs to link in with local organisation policy regarding Kōrero mai[[4]](#footnote-5) processes to support patient, family and whānau escalation of concerns.

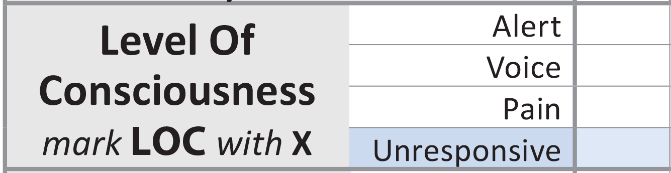
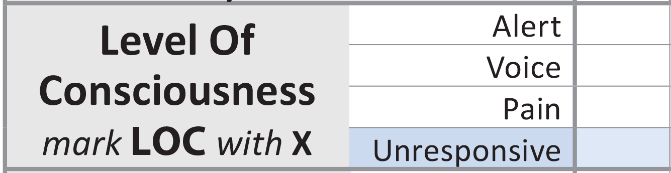
Level of consciousness

Assess level of consciousness using the alert, voice, pain or unresponsive (AVPU) scale. Document your assessment by placing an ‘X’ in the relevant box of the scoring area (Figure 15). If tamariki are asleep, this can also be noted. Once you have assessed tamariki and determined them to be sleeping normally, annotate ‘Asleep’ on the chart within the alert section of ‘Level of consciousness’. An example of this is when you enter the room you see a baby stir to the noise but not wake fully. It is important to assess tamariki closely and not assume they are sleeping.

Figure 15: Level of consciousness examples

Asleep

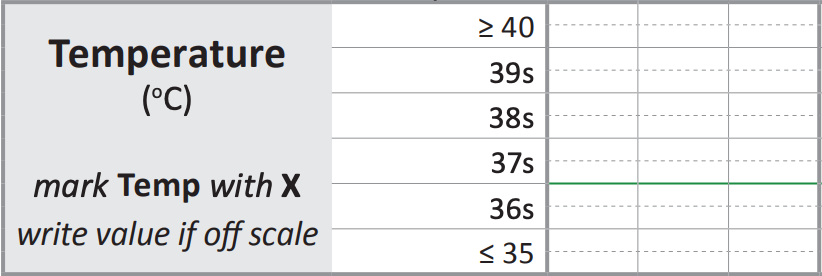
X

Temperature

Measure temperature using a consistent method each time (eg, oral, axillary, tympanic), and record the method in the care plan. Document temperature by placing an ‘X’ in the relevant position on the chart. Figure 16 shows the documentation of 38.5°C. You may also choose to write the actual value, to one decimal place, on the chart, but if doing so always write it above the X. For temperatures that are outside the plottable area, write the actual value, to one decimal place, on the chart.

Figure 16: Temperature example



X

Pain score

Record pain on the PVSC to help interpret abnormal vital signs and manage pain effectively.

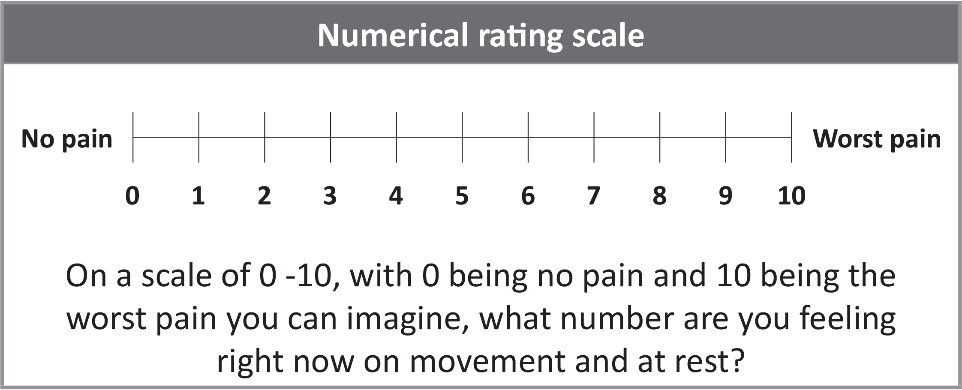
The PVSC includes three pain scoring tools: the Numerical rating scale, Faces pain scale – revised[[5]](#footnote-6) and the revised FLACC observation pain tool.[[6]](#footnote-7) The score is documented at rest and with movement.

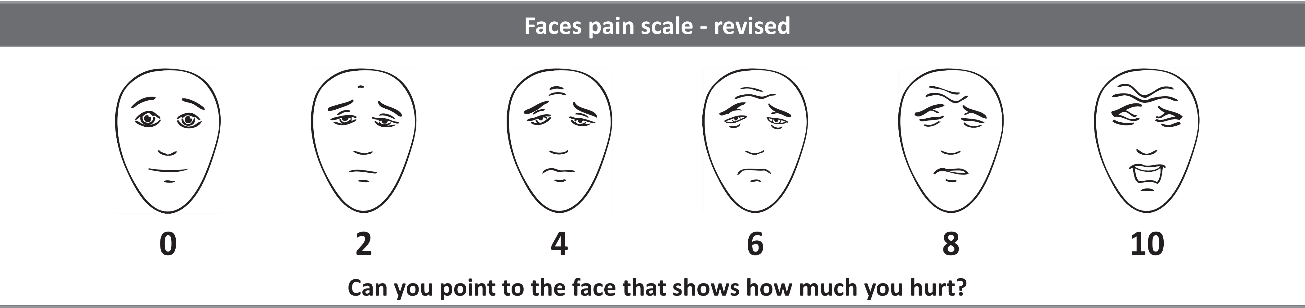
Many clinicians will be familiar with the FLACC observational pain tool, but note the **revised** version is included here. This is an objective tool that has been validated for use in non-verbal and cognitively impaired tamariki. Therefore, it can be used both for a 4-month-old baby and 7-year-old tamariki with global developmental delay, for example.

The tool used depends in part on age of the tamariki (Figure 17). The age reflects the required cognitive ability of tamariki to be able to use the numeric and Faces tool. The tool being used can be documented in their care plan.

Figure 17: Assessment of pain tools on each chart

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |







3.3 Partial PEWS

Some sets of observations will not include measurement of all the parameters required to calculate a total PEW score. The risk of not indicating that a score is based on an incomplete set of observations is that the user may underestimate how unwell tamariki are and use an escalation pathway lower than what is required.

In this situation, the PEW score from an incomplete set of observations is indicated by a plus (+) (Figure 18), and the user should act on the escalation pathway mandated by this score. They should also consider whether any other actions need to be taken, including completing the full set of observations, and follow local monitoring policy on what observations are required for specific circumstances.

Multiple sets of partial observations may occur in certain circumstances, for example, taking a series of blood pressure measurements after adjustment of medication. However, this practice should be the exception rather than the rule, to maintain the value of the PEW score

Figure 18: PEW score recorded from an incomplete set of observations



3+

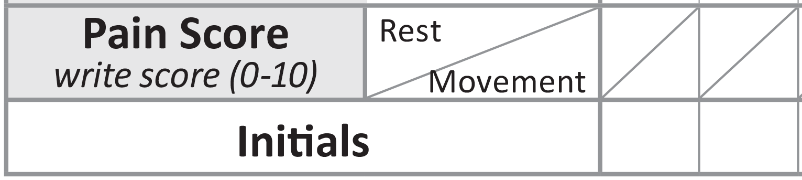
4

4

3.4. Accountability

To fulfil documentation requirements, the clinician who undertook the observations must place their initials at the bottom of the chart (Figure 19).

Figure 19: Initialling the chart



AL

1

3

3.5. Modifying PEWS triggers

It is possible to modify the PEWS triggers for tamariki when chronic disease or abnormal vital sign parameters are present that do not necessarily represent clinical deterioration. This section of the chart is to capture what is ‘normally abnormal’. Individual vital sign parameters are altered, not total PEW scores.

When making modifications, consider the clinical risk to tamariki of normalising an abnormal vital sign. This risk is mitigated by discussing modifications with a senior clinician and reviewing them at regular intervals, so they remain appropriate as the condition of tamariki changes. Document the duration for which modifications apply to ensure there is a timely clinical review.

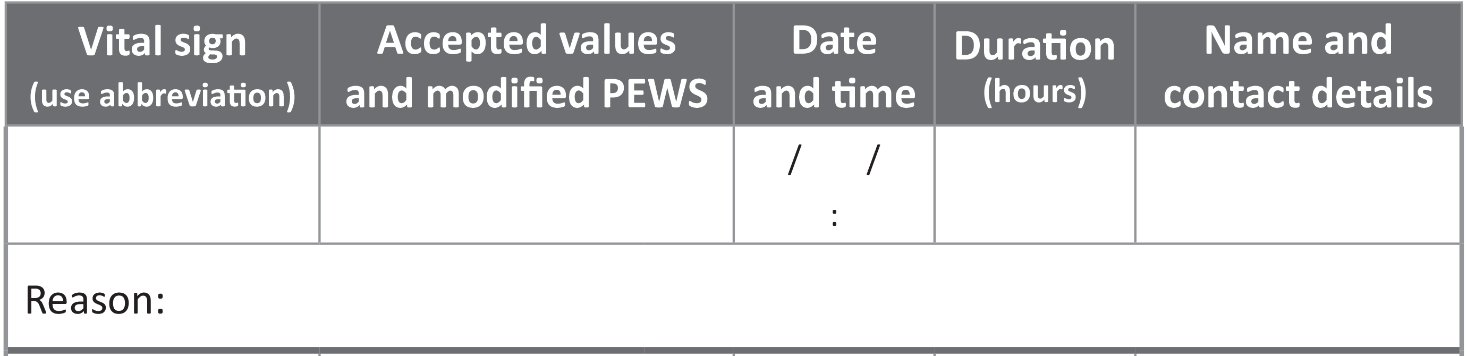
Local policy on modifying PEWS triggers should be in place to ensure practice is appropriate for your local population and hospital context. This includes identifying which clinicians can make a modification and how often modifications need to be reviewed. Please ensure that clinicians tasked with making modifications have received appropriate education.

When a new PVSC is used, the modifications will need to be reviewed, redocumented and signed if they are still applicable. Staff should not just assume modifications remain in place. Figure 20 and Figure 21 give examples of appropriate documentation.

**Note:** If tamariki are generating high PEW scores, the scores are likely to remain high until treatment takes effect. In this situation, do not use the modification section to stop escalation. Rather, the review generated by the high PEW score should result in an understanding of why the PEW score is elevated and clear documentation in the patient notes of a treatment plan. This should include specific signs of further deterioration that should be notified, who should be called and a recommended time for the next review.

Having a modification in place should not stop staff calling a clinical emergency if a parameter enters the blue zone or if staff feel a significant deterioration is imminent.

Figure 20: Example of modification due to chronic condition



Oxygen saturation

≥ 91% score = 0

85−90% score = 1

≤ 85% score = 2

Throughout admission

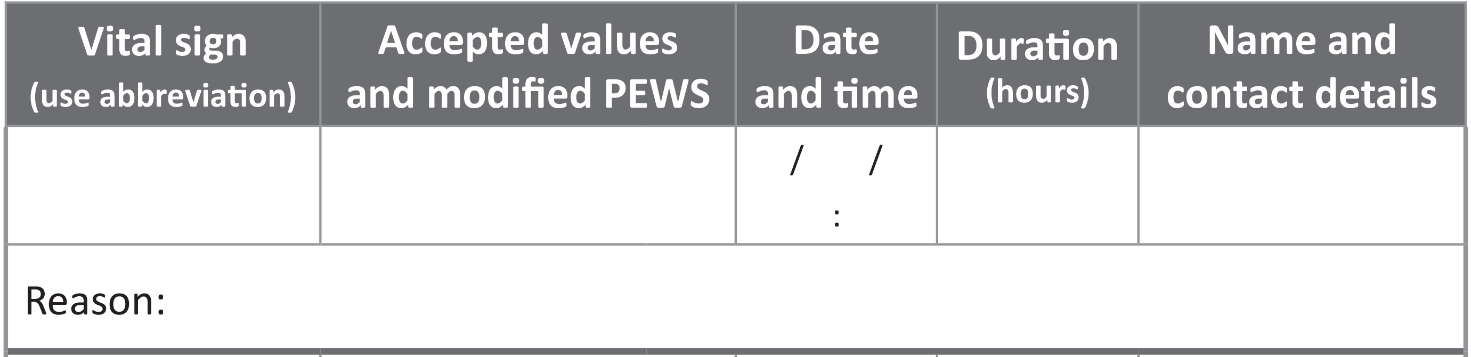
N. Rivera #6132

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

11 30 am

20 3 21

Figure 21: Example of modification for a teenager with athletic bradycardia



D. Ramoray #2611

50−109 score = 0

40−49, score = 1

30−39, score = 2

< 30 score = 4

11 30 am

20 3 21

Competitive rower, resting HR of 50 when well

HR

Until

discharge

There is also a space to accommodate tamariki receiving palliative care. Underneath the modification section is the ability to identify if tamariki are on an end-of-life pathway (Figure 22). This section is editable to reflect the terminology and pathway that reflects the organisational policy.

Figure 22: Space to indicate if tamariki have an end-of-life pathway plan



3.6. Calculating the total score and using single-parameter  
triggers

Each scoring vital sign parameter has coloured zones (white, yellow, orange and red) that are associated with a score of 0, 1, 2 or 4, respectively. Add together the score for each of the seven vital sign parameters to get a total PEW score. The total score can trigger action according to the escalation pathway.

The PVSC has single parameter triggers, which are any observations falling in the blue zone. The blue zone is not associated with a score because any parameter in the blue zone indicates severe deterioration and requires an emergency response.

Table 1 illustrates the PEWS score matrix across the four charts.

Table 1: PEWS score matrix

PEWS matrix: 0‒11 months

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Score** | **RRT** | **4** | **2** | **1** | **0** | **1** | **2** | **4** | **RRT** |
| **Zone** | **Blue** | **Red** | **Orange** | **Yellow** | **White** | **Yellow** | **Orange** | **Red** | **Blue** |
| Respiratory rate | ≤ 9 | 10‒19 | 20‒24 | 25‒29 | 30‒49 | 50‒54 | 55‒69 | ≥ 70 |  |
| Respiratory distress |  |  |  |  | Nil | Mild | Moderate | Severe |  |
| Oxygen |  |  |  |  | Room air |  | < 4 L/min or  < HF 35% | ≥ 4 L/min or  ≥ HF 35% |  |
| Oxygen saturation |  |  | ≤ 90 | 91‒94 | ≥ 95 |  |  |  |  |
| Heart rate | 50‒59 | 60‒79 | 80‒89 | 90‒109 | 110‒159 | 160‒169 | 170‒179 | ≥ 180 |  |
| Capillary refill time |  |  |  |  | < 3 sec |  |  | ≥ 3 sec |  |
| Blood pressure | ≤ 49 | 50‒54 | 55‒64 | 65‒74 | 75‒99 | 100‒119 | 120‒149 | ≥ 150 |  |

HF = high flow; RRT = rapid response team.

PEWS matrix: 1‒4 years

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Score** | **RRT** | **4** | **2** | **1** | **0** | **1** | **2** | **4** | **RRT** |
| **Zone** | **Blue** | **Red** | **Orange** | **Yellow** | **White** | **Yellow** | **Orange** | **Red** | **Blue** |
| Respiratory rate | ≤ 4 | 5‒14 | 15‒17 | 18‒19 | 20‒39 | 40‒44 | 45‒54 | ≥ 55 |  |
| Respiratory distress |  |  |  |  | Nil | Mild | Moderate | Severe |  |
| Oxygen |  |  |  |  | Room air |  | < 4 L/min or  < HF 35% | ≥ 4 L/min or  ≥ HF 35% |  |
| Oxygen saturation |  |  | ≤ 90 | 91‒94 | ≥ 95 |  |  |  |  |
| Heart rate | 50‒59 | 60‒69 | 70‒79 | 80‒89 | 90‒139 | 140‒149 | 150‒159 | ≥ 160 |  |
| Capillary refill time |  |  |  |  | < 3 sec |  |  | ≥ 3 sec |  |
| Blood pressure | ≤ 54 | 55‒64 | 65‒74 | 75‒89 | 90‒109 | 110‒124 | 125‒159 | ≥ 160 |  |

HF = high flow; RRT = rapid response team.

PEWS matrix: 5‒11 years

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Score** | **RRT** | **4** | **2** | **1** | **0** | **1** | **2** | **4** | **RRT** |
| **Zone** | **Blue** | **Red** | **Orange** | **Yellow** | **White** | **Yellow** | **Orange** | **Red** | **Blue** |
| Respiratory rate | ≤ 4 | 5‒11 | 12‒14 | 15‒19 | 20‒29 | 30‒34 | 35‒44 | ≥ 45 |  |
| Respiratory distress |  |  |  |  | Nil | Mild | Moderate | Severe |  |
| Oxygen |  |  |  |  | Room air |  | < 4 L/min or  < HF 35% | ≥ 4 L/min or  ≥ HF 35% |  |
| Oxygen saturation |  |  | ≤ 90 | 91‒94 | ≥ 95 |  |  |  |  |
| Heart rate | ≤49 | 50‒59 | 60‒69 | 70‒79 | 80‒129 | 130‒139 | 140‒154 | ≥ 155 |  |
| Capillary refill time |  |  |  |  | < 3 sec |  |  | ≥ 3 sec |  |
| Blood pressure | ≤59 | 60‒69 | 70‒79 | 80‒89 | 90‒119 | 120‒139 | 140‒169 | ≥ 170 |  |

HF = high flow; RRT = rapid response team.

PEWS matrix: 12+ years

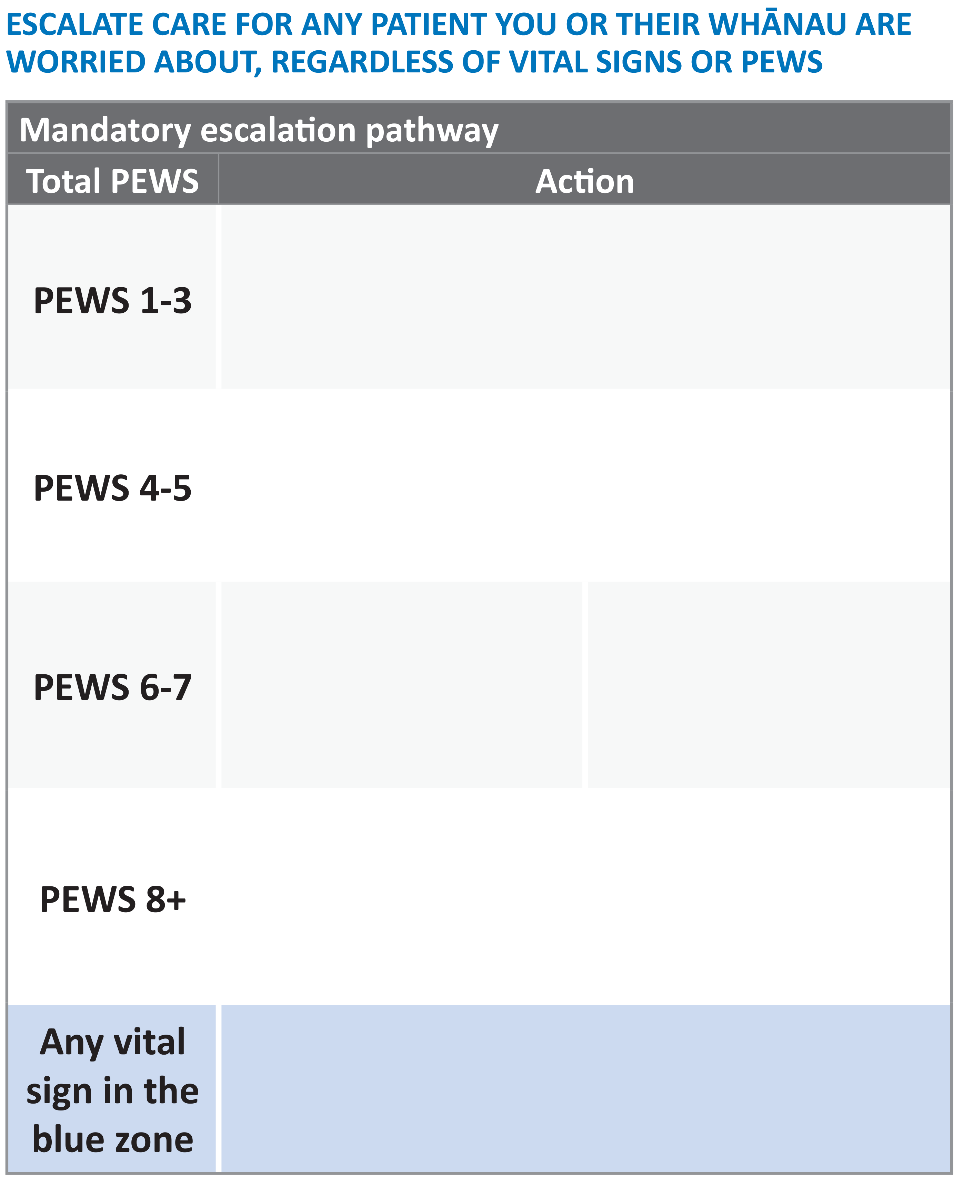
|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Score** | **RRT** | **4** | **2** | **1** | **0** | **1** | **2** | **4** | **RRT** |
| **Zone** | **Blue** | **Red** | **Orange** | **Yellow** | **White** | **Yellow** | **Orange** | **Red** | **Blue** |
| Respiratory rate | ≤ 4 | 5‒9 | 10‒11 | 12‒14 | 15‒24 | 25‒29 | 30‒34 | ³ 35 |  |
| Respiratory distress |  |  |  |  | Nil | Mild | Moderate | Severe |  |
| Oxygen |  |  |  |  | Room air |  | < 4 L/min or  < HF 35% | ≥ 4 L/min or  ≥ HF 35% |  |
| Oxygen saturation |  |  | ≤ 90 | 91‒94 | ≥ 95 |  |  |  |  |
| Heart rate | ≤39 | 40‒49 | 50‒59 | 60‒64 | 65‒109 | 110‒119 | 120‒134 | 135‒139 | ≥140 |
| Capillary refill time |  |  |  |  | < 3 sec |  |  | ≥ 3 sec |  |
| Blood pressure | ≤74 | 75‒79 | 80‒89 | 90‒99 | 100‒134 | 135‒149 | 150‒189 | ≥ 190 |  |

HF = high flow; RRT = rapid response team.

3.7. Escalating care

An increase in the total PEW score indicates the potential for or an actual deterioration in the condition of tamariki and warrants an escalation in their care. The PVSC displays locally determined mandatory escalation pathways depending on the total PEW score (Figure 23). However, care can be escalated regardless of the total PEW score, including activating an emergency response, if there is significant whānau or staff concern.

Figure 23: Escalation pathway



1. Design and printing information

This section provides information about design and print requirements for the PVSC.

Your organisation needs to develop an escalation pathway appropriate to your local area before you can use it clinically. You can make a few other amendments according to locally agreed policy and practice. The details that follow cover:

* required amendments
* allowable amendments
* print specifications.
  1. Required amendments

The escalation pathways should be developed with the clinicians using the PVSC and reflect local systems and practice. The pathway should use unambiguous language and briefly and clearly state expected actions and responses for each range of PEW score.

Enter the pathway in the ‘Action’ area of the chart (provided as an editable PDF). Use the guidance document, *Paediatric early warning system escalation mapping tool*,[[7]](#footnote-8)to develop the response for each level of physiological abnormality.

* 1. Allowable amendments

Table 2 sets out the amendments you may make to the PVSC.

Table 2: Allowable amendments to the PVSC

|  |  |
| --- | --- |
| **Chart area** | **Allowable amendment** |
| Left-hand margin | For scanning purposes, you may add a barcode or QR code. |
| Left-hand margin | You may add a black-and-white version of the organisational logo below the patient label. **Do not use coloured logos** because they add visual clutter and distract from the main purpose of the chart. |
| Central column of the scoring area | You may replace ‘RRT’ with a locally relevant number or acronym, eg, ‘777’. Note, there is space for only three characters. |
| Beside ‘Mandatory escalation pathway’ heading | If you have different escalation pathways for different hospitals, you can add the name of the hospital next to this heading. |
| Right-hand bottom corner | You can replace ‘End-of-life pathway’ with your relevant local terminology. |
| Back of chart:  ‘Local tools’ | This space can be edited to include locally defined parameters or tools. Do this in conjunction with your communications team or design team. |

* 1. Print specifications

The chart must be professionally printed to the following specifications:

* paper size A3 landscape
* double-sided (front and back)
* minimum paper quality 150 gsm (uncoated stock)
* fold: chart is creased twice at 205 mm and 310 mm (from the left-hand edge) and then
* Z-folded in front along these creases (Figure 24)
* hole-punched left-hand side with two holes
* no print offset required.

Figure 24: Z-fold demonstrated with the PVSC

#### 

* 1. Colour specifications

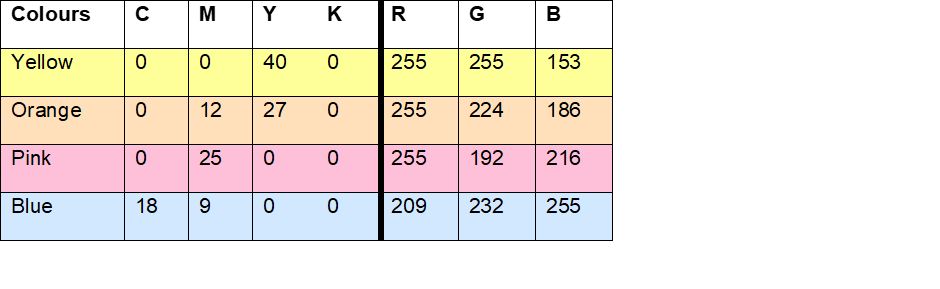
CMYK (cyan, magenta, yellow and black) and RGB (red, green, blue) are two different ways of achieving a particular colour. Most printers print in CMYK, and most screens display RGB.

The PVSC was designed using CMYK colour because it is intended for print use. The CMYK colour values listed in Table 3 are used at 60 percent tint on the scoring area of the chart to enable clear documentation with a black or blue ballpoint pen. The colour values are used at 100 percent tint in the other sections of the chart, such as the columns to the right and left of the scoring area and the left-hand column of the escalation pathway.

If you want to use the colours in a screen display format, the CMYK values will need to be converted to RGB values (see Table 3). The CMYK and RGB colours have been used to shade the boxes in Table 3, and you will see there are minor differences. This is to be expected.

You can select RGB values in Word documents using the ‘More colors’ option in the shading or font colours tabs. Open ‘More colors’ then select ‘Custom’ and insert the RGB values.

Table 3: Colour specifications for the PVSC



1. Parshuram CS, Hutchison J, Middaugh K. 2009. Development and initial validation of the Bedside Paediatric Early Warning System score. *Crit Care* 13:R135. URL: <https://doi.org/10.1186/cc7998>. [↑](#footnote-ref-2)
2. The Royal Children’s Hospital Melbourne. 2019. *Observation and continuous monitoring* (Clinical Guidelines (Nursing)). Melbourne: The Royal Children’s Hospital. URL: [www.rch.org.au/rchcpg/hospital\_clinical\_guideline\_index/Observation\_and\_continuous\_monitoring/](http://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Observation_and_continuous_monitoring/) (accessed 27 July 2021). [↑](#footnote-ref-3)
3. Royal College of Nursing. 2017. Standards for assessing, measuring and monitoring vital signs in infants, children and young people*.* London: Royal College of Nursing. [↑](#footnote-ref-4)
4. Health Quality & Safety Commission. Kōrero mai – patient, family and whānau escalation. Wellington: Health Quality & Safety Commission. URL: [www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/patient-family-and-whanau-escalation/](http://www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/patient-family-and-whanau-escalation/). [↑](#footnote-ref-5)
5. Hicks CL, von Baeyer CL, Spafford P, et al. 2001. The Faces Pain Scale – Revised: Towards a common metric in pediatric pain measurement. *PAIN* 93: 173‒83. [↑](#footnote-ref-6)
6. Malviya S, Vopel-Lewis T, Burke C, et al. 2006. The revised FLACC observational pain tool: improved reliability and validity for pain assessment in children with cognitive impairment. *Pediatric Anaesthesia* 16: 258‒65. [↑](#footnote-ref-7)
7. Available at: [www.hqsc.govt.nz/our-programmes/patient-deterioration/publications-and-resources/publication/4350/](http://www.hqsc.govt.nz/our-programmes/patient-deterioration/publications-and-resources/publication/4350/). [↑](#footnote-ref-8)