

0

1

3

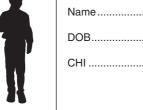
5-11 YEARS





PAEDIATRIC EARLY WARNING SCORE (PEWS)

5 - 11 YEARS



(To be used from 5 years until day before 12th birthday)

PEWS is a tool to aid recognition of sick and deteriorating children. **PEWS** should be calculated every time observations are recorded.

How to calculate score:

- · Record observations at intervals as prescribed
- Record observations in black pen with a dot
- Score as per the colour key

0	



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•	Add to	otal po	ints	scored

- · Record total score in PEWS box at bottom of chart
- · Action should be taken as below

Name	
DOB	
CHIAffix Patient ID label	I
WardConsultant	
Chart Number	
Date	

PEWS	Level of escalation	Action to be taken
Regardless of PE	NS always es	calate if concerned about a patient's condition
0	0	
1-2	1	
3-4 or any in red zone	2	
5 or more	3	
Bradycardia, cardiac or respiratory arrest		

Concerns	include,	but are no
restricted t	to;	

- gut feeling
- looks unwell
- apnoea
- airway threat
- · increased work of breathing,
- significant ↑ in O² requirement
- Poor perfusion / blue / mottled / cool peripheries
- seizures
- confusion / irritability / altered behaviour
- hypoglycaemia
- high pain score despite appropriate analgesia

f observations are as expected for patient's clinical condition, please note below accepted parameters for future calls												
Acceptable parameters	RR	O ² saturation	HR	BP	Temperature °C							
Upper acceptable												
Normal range												
Lower acceptable												
Doctor's signature	Date & Time											

PAEDIATRIC SEPSIS 6
Recognition: Suspected or prover
infection + 2 of:

- Core temperature < 36°C >38°C
- Inappropriate Tachycardia
- Altered mental state: sleepy / irritable / floppy
- Peripheral perfusion, CRT >2 sec, cool, mottled

Lower threshold in vulnerable groups	
Think could this be sepsis?	

IF NOT then why is this child unwell?



If YES respond with Paediatric Sepsis 6 within 1 hour:

- · Give high flow oxygen
- IV or IO access and blood cultures, glucose, lactate
- Give IV or IO antibiotics
- Consider fluid resuscitation
- Consider inotropic support early
- Involve senior clinicians/ specialists EARLY

Neurological Observations

		Time																			
		Spontaneously	y 4																		
	F O	To Speech	3													E	Eyes clos by swellin C				
	Eyes Open	To Pain	2													— ру					
		None	1																		
		Alert, Coos and babbles, word usual ability	ds to 5													En	ıdotra				
COMA SCALES	Best Verbal	Irritable cries, than normal a															tub or				
\leq	Response	Cries in respons	se to pain 3													tra	cheo: = 1				
S		Moans to pair	n 2																		
S		No response	1																		
LES		Moves purpos and spontane																			
		Withdraw to t	touch 5																		
	Best Motor Response	Withdraws in response to pa	4 ain													the bes	e bes	ally recore best arm esponse			
		Flexion to pair	n 3																		
		Extension to p	oain 2																		
		None	1																		
		Score																			
		Right	Size Reaction														React				
	Pupils	Left	Size Reaction														o reac /e clo				
		Normal power			+		\dashv									+					
		Mild weakness			+		\dashv								+	\dashv					
Ξ	_ L ⊾ I	Severe weaknes	SS		+		\dashv														
≦	ARMS	Spastic flexion					\neg									Reco	cord righ				
<		Extension			+		\dashv										and l				
Ō		No response					\dashv									separatel					
LIMB MOVEMENT		Normal power			T		\dashv									difference between two s					
₹		Mild weakness					\neg														
Ż	LEGS	Severe weakness														_					
_	. S	Extension			T		\dashv														
		No response			T		\dashv								$\neg \vdash$	\dashv					
	Pupil Scal	le (m.m.)							•	•	•										
			8	7	6	5	4	ł	3	2	1	I									

Assessment of Acute Pain in Children

	No Pain	Mild Pain	Moderate Pain	Severe Pain
Faces Scale Score	®		***	(38)
Ladder Score	0	1-3	4-6	7-10
Behaviour	* Normal activity * No ↓movement * Happy	* Rubbing affected area * Decreased movement * Neutral expression * Able to play/talk normally	* Protective of affected area * ↓movement/quiet * Complaining of pain * Consolable crying * Grimaces when affected part moved/touched	* No movement or defensive of affected part * Looking frightened * Very quiet * Restless/unsettled * Complaining of lots of pain * Inconsolable crying

