PEWS Vital Sign Record

0 – 3 MONTHS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

Section	Parameter	Row	Scale
	Date:	Initials:	
		Time:	
Respiratory	Respiratory Rate (1 minute) Resp: ●	80	80
		70	70
		60	60
		50	50
		40	40
		30	30
		20	20
		O_2 Saturation (%)	
	Supplemental O_2 Concentration Delivered	≤3L or 30%	
		≥3L or 30%	
		≥6L or 40%	
		≥8L or 50%	
		Mode of Delivery	
	Respiratory Distress	None	
		Mild	
		Moderate	
		Severe	
	PEWS Score for Respiratory *(record most severe score)*		
Cardiovascular	Heart Rate (1 minute) & Blood Pressure Systolic: V Diastolic: Λ (Do not score blood pressure) Normal Parameters: Systolic (mmHg): 60 – 84 (0 – 28 days) 73 – 105 (1 – 3 mos) Diastolic (mmHg): 30 – 53 (0 – 28 days) 36 – 68 (1 – 3 mos) Apex: ● Monitor: ★	190	190
		180	180
		170	170
		160	160
		150	150
		140	140
		130	130
		120	120
		110	110
		100	100
		90	90
		80	80
		70	70
		60	60
		50	50
		MAP	
	Capillary Refill Time	1 – 2 seconds	
		3 seconds	
		4 seconds	
		≥5 seconds	
	Skin Colour	Pink	
		Pale	
		Grey/Cyanotic	
		Grey & Mottled	
	PEWS Score for Cardiovascular *(record most severe score)*		
Behaviour		Playing/Appropriate	
		Sleeping	
		Irritable	
		Lethargic/Confused	
		Reduced response to pain	
	PEWS Score for Behaviour *(record most severe score)*		
PEWS		Persistent vomiting following surgery	
		Bronchodilator every 20 minutes	
	Total PEWS Score (R + C + B + vomiting + bronchodilator)		
Situational Awareness Factors		Patient/Family/Caregiver concern	
		Unusual therapy	
		Watcher patient	
		Communication breakdown	
		PEWS Score ≥2	
	PEWS Escalation Process Activated *(time)* See NN		
Temperature °C	● A – Axilla R – Rectal O – Oral T – Temporal E – Esophageal	40	40
		39	39
		38	38
		37	37
		36	36

CHILD HEALTH BC

PEWS Vital Sign Record

0 – 3 MONTHS

Patient label

Section	Item																				
	Date: Initials:																				
	Time:																				
Care	Sepsis Screen																				
Care	Tool: ____________ Pain Score																				
Care	Location of pain																				
Care	Arousal Score																				
Care	PRAM Score (Asthma Patients Only)																				
Care	**EtCO2 (mmHg)**																				
Care	**Glucometer (mmol/L)**																				
Neurological	PUPILS **Size** Right																				
Neurological	PUPILS Left																				
Neurological	PUPILS **Reaction** Right (B = Brisk, S = Sluggish, F = Fixed)																				
Neurological	PUPILS Left																				
Neurological	EYE Spontaneous **4**																				
Neurological	EYE To speech **3**																				
Neurological	EYE To pain **2**																				
Neurological	EYE (C = Closed) None **1**																				
Neurological	VERBAL Coos/Oriented **5**																				
Neurological	VERBAL Irritable cry/Confused **4**																				
Neurological	VERBAL Cries to pain/Inappropriate **3**																				
Neurological	VERBAL Moans to pain/Incomprehensible **2**																				
Neurological	VERBAL None **1**																				
Neurological	MOTOR Normal spontaneous/Obeys **6**																				
Neurological	MOTOR Withdraws to touch/Localized **5**																				
Neurological	MOTOR Withdraws to pain/Withdraws **4**																				
Neurological	MOTOR Abnormal flexion **3**																				
Neurological	MOTOR Abnormal extension **2**																				
Neurological	MOTOR Flaccid **1**																				
Neurological	**TOTAL SCORE GCS**																				
Spinal	**Muscle Strength** *Refer to rating scale below* Rate 0 – 5 — Right Arm																				
Spinal	Left Arm																				
Spinal	Right Leg																				
Spinal	Left Leg																				
Spinal	**Colour, Warmth, & Sensation of Extremities** √ = Normal NN = Nurse's Notes — Right Arm																				
Spinal	Left Arm																				
Spinal	Right Leg																				
Spinal	Left Leg																				
Spinal	**Bladder Function** √ = Normal NN = Nurse's Notes																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score 0 – 1: Continue to monitor and document as per orders & routine protocols.

Score 2 or any one of 5 Situational Awareness Factors: Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

Score 3: Increase frequency of assessments and documentation as per plan from consultation.

Score 4 and/or score increases by 2 after interventions: Notify MRP/delegate. Consider pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments. Reassess adequacy of resources and escalate to meet deficits.

Score 5 – 13 or score of 3 in any one category: Immediate assessment by MRP/delegate or pediatrician, or emergency room physician. MRP/delegate to communicate a plan of care. Increase nursing care with increasing interventions as per plan. Consider internal or external transfer to higher level of care.

PUPIL SIZE (mm)

1 2 3 4 5 6 7 8

MUSCLE STRENGTH GRADING SYSTEM			
0/5	No movement	3/5	Movement overcoming gravity, but not against resistance
1/5	Trace movement	4/5	Movement overcoming gravity and some resistance
2/5	Movement only (not against gravity)	5/5	Normal strength against resistance

LEVEL OF AROUSAL SCORE				
1	2	3	4	5
Awake and alert, oriented	Normal sleep, easy to arouse to verbal stimulation	Difficult to arouse to verbal stimulation	Responds only to physical stimulation	Does not respond to verbal or physical stimulation

PRINTED NAME	SIGNATURE	INITIALS

PEWS Vital Sign Record

4 – 11 MONTHS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

	Date:	Initials:																					
		Time:																					
Respiratory	Respiratory Rate (1 minute)	80																					80
		70																					70
		60																					60
		50																					50
	Resp: ●	40																					40
		30																					30
		20																					20
		O_2 Saturation (%)																					
	Supplemental O_2 Concentration Delivered	≤3L or 30%																					
		≥3L or 30%																					
		≥6L or 40%																					
		≥8L or 50%																					
		Mode of Delivery																					
	Respiratory Distress	None																					
		Mild																					
		Moderate																					
		Severe																					
		PEWS Score for Respiratory *(record most severe score)*																					
Cardiovascular	Heart Rate (1 minute) & Blood Pressure	190																					190
		180																					180
		170																					170
		160																					160
	Systolic: V	150																					150
	Diastolic: Λ	140																					140
	(Do not score blood pressure)	130																					130
	Normal Parameters:	120																					120
	Systolic (mmHg):	110																					110
	82 – 105	100																					100
	Diastolic (mmHg):	90																					90
	46 – 68	80																					80
	Apex: ●	70																					70
	Monitor: *	60																					60
		50																					50
		MAP																					
	Capillary Refill Time	1 – 2 seconds																					
		3 seconds																					
		4 seconds																					
		≥5 seconds																					
	Skin Colour	Pink																					
		Pale																					
		Grey/Cyanotic																					
		Grey & Mottled																					
		PEWS Score for Cardiovascular *(record most severe score)*																					
Behaviour		Playing/Appropriate																					
		Sleeping																					
		Irritable																					
		Lethargic/Confused																					
		Reduced response to pain																					
		PEWS Score for Behaviour *(record most severe score)*																					
PEWS		Persistent vomiting following surgery																					
		Bronchodilator every 20 minutes																					
		Total PEWS Score (R + C + B + vomiting + bronchodilator)																					
Situational Awareness Factors		Patient/Family/Caregiver concern																					
		Unusual therapy																					
		Watcher patient																					
		Communication breakdown																					
		PEWS Score ≥2																					
		PEWS Escalation Process Activated *(time)* **See NN**																					
Temperature °C	●	40																					40
	A – Axilla R – Rectal	39																					39
	O – Oral	38																					38
	T – Temporal	37																					37
	E – Esophageal	36																					36

CHILD HEALTH BC

PEWS Vital Sign Record

4 – 11 MONTHS

Patient label

Section	Item	Date: Initials:																				
		Time:																				
Care		Sepsis Screen																				
Care	Tool: ____________	Pain Score																				
Care		Location of pain																				
Care		Arousal Score																				
Care		PRAM Score (Asthma Patients Only)																				
Care		**EtCO2 (mmHg)**																				
Care		**Glucometer (mmol/L)**																				
Neurological	PUPILS **Size**	Right																				
Neurological	PUPILS **Size**	Left																				
Neurological	PUPILS **Reaction** (B = Brisk, S = Sluggish, F = Fixed)	Right																				
Neurological	PUPILS **Reaction**	Left																				
Neurological	EYE	Spontaneous **4**																				
Neurological	EYE	To speech **3**																				
Neurological	EYE	To pain **2**																				
Neurological	EYE (C = Closed)	None **1**																				
Neurological	VERBAL	Coos/Oriented **5**																				
Neurological	VERBAL	Irritable cry/Confused **4**																				
Neurological	VERBAL	Cries to pain/Inappropriate **3**																				
Neurological	VERBAL	Moans to pain/Incomprehensible **2**																				
Neurological	VERBAL	None **1**																				
Neurological / Spinal	MOTOR	Normal spontaneous/Obeys **6**																				
Neurological / Spinal	MOTOR	Withdraws to touch/Localized **5**																				
Neurological / Spinal	MOTOR	Withdraws to pain/Withdraws **4**																				
Neurological / Spinal	MOTOR	Abnormal flexion **3**																				
Neurological / Spinal	MOTOR	Abnormal extension **2**																				
Neurological / Spinal	MOTOR	Flaccid **1**																				
Neurological / Spinal		**TOTAL SCORE GCS**																				
Neurological / Spinal	**Muscle Strength** *Refer to rating scale below* Rate 0 – 5	Right Arm																				
Neurological / Spinal	**Muscle Strength**	Left Arm																				
Neurological / Spinal	**Muscle Strength**	Right Leg																				
Neurological / Spinal	**Muscle Strength**	Left Leg																				
Neurological / Spinal	**Colour, Warmth, & Sensation of Extremities** √ = Normal, NN = Nurse's Notes	Right Arm																				
Neurological / Spinal	**Colour, Warmth, & Sensation of Extremities**	Left Arm																				
Neurological / Spinal	**Colour, Warmth, & Sensation of Extremities**	Right Leg																				
Neurological / Spinal	**Colour, Warmth, & Sensation of Extremities**	Left Leg																				
Neurological / Spinal	**Bladder Function**	√ = Normal, NN = Nurse's Notes																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score 0 – 1: Continue to monitor and document as per orders & routine protocols.

Score 2 or any one of 5 Situational Awareness Factors: Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

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Score 4 and/or score increases by 2 after interventions: Notify MRP/delegate. Consider pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments. Reassess adequacy of resources and escalate to meet deficits.

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PUPIL SIZE (mm)

1 2 3 4 5 6 7 8

MUSCLE STRENGTH GRADING SYSTEM

0/5	No movement	3/5	Movement overcoming gravity, but not against resistance
1/5	Trace movement	4/5	Movement overcoming gravity and some resistance
2/5	Movement only (not against gravity)	5/5	Normal strength against resistance

LEVEL OF AROUSAL SCORE

1	2	3	4	5
Awake and alert, oriented	Normal sleep, easy to arouse to verbal stimulation	Difficult to arouse to verbal stimulation	Responds only to physical stimulation	Does not respond to verbal or physical stimulation

PRINTED NAME	SIGNATURE	INITIALS

CHILD HEALTH BC

PEWS Vital Sign Record

1 – 3 YEARS

Patient label

PEWS Scoring Legend:

0	1	2	3

Section	Parameter	Date: / Initials:																			
		Time:																			
Respiratory	Respiratory Rate (1 minute) Resp: ●	70																			
		60																			
		50																			
		40																			
		30																			
		20																			
		O_2 Saturation (%)																			
	Supplemental O_2 Concentration Delivered	≤3L or 30%																			
		≥3L or 30%																			
		≥6L or 40%																			
		≥8L or 50%																			
		Mode of Delivery																			
	Respiratory Distress	None																			
		Mild																			
		Moderate																			
		Severe																			
	PEWS Score for Respiratory *(record most severe score)*																				
Cardiovascular	Heart Rate (1 minute) & Blood Pressure. Systolic: V Diastolic: Λ (Do not score blood pressure) Normal Parameters: Systolic (mmHg): 85 – 109 Diastolic (mmHg): 37 – 67 Apex: ● Monitor: ★	190																			
		180																			
		170																			
		160																			
		150																			
		140																			
		130																			
		120																			
		110																			
		100																			
		90																			
		80																			
		70																			
		60																			
		50																			
		MAP																			
	Capillary Refill Time	1 – 2 seconds																			
		3 seconds																			
		4 seconds																			
		≥5 seconds																			
	Skin Colour	Pink																			
		Pale																			
		Grey/Cyanotic																			
		Grey & Mottled																			
	PEWS Score for Cardiovascular *(record most severe score)*																				
Behaviour		Playing/Appropriate																			
		Sleeping																			
		Irritable																			
		Lethargic/Confused																			
		Reduced response to pain																			
	PEWS Score for Behaviour *(record most severe score)*																				
PEWS		Persistent vomiting following surgery																			
		Bronchodilator every 20 minutes																			
	Total PEWS Score (R + C + B + vomiting + bronchodilator)																				
Situational Awareness Factors		Patient/Family/Caregiver concern																			
		Unusual therapy																			
		Watcher patient																			
		Communication breakdown																			
		PEWS Score ≥2																			
	PEWS Escalation Process Activated *(time)* See NN																				
Temperature °C	● A – Axilla R – Rectal O – Oral T – Temporal E – Esophageal	40																			
		39																			
		38																			
		37																			
		36																			

CHILD HEALTH BC

PEWS Vital Sign Record
1 – 3 YEARS

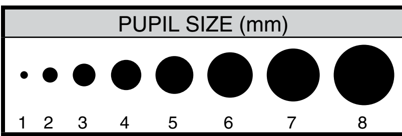
Patient label

Section		Date: Initials:																				
		Time:																				
Care		Sepsis Screen																				
Care	Tool: ____________	Pain Score																				
Care		Location of pain																				
Care		Arousal Score																				
Care		PRAM Score (Asthma Patients Only)																				
		EtCO2 (mmHg)																				
		Glucometer (mmol/L)																				
Neurological	PUPILS	**Size** Right																				
Neurological	PUPILS	Left																				
Neurological	PUPILS B = Brisk S = Sluggish F = Fixed	**Reaction** Right																				
Neurological	PUPILS	Left																				
Neurological	EYE	Spontaneous **4**																				
Neurological	EYE	To speech **3**																				
Neurological	EYE	To pain **2**																				
Neurological	EYE C = Closed	None **1**																				
Neurological	VERBAL	Coos/Oriented **5**																				
Neurological	VERBAL	Irritable cry/Confused **4**																				
Neurological	VERBAL	Cries to pain/Inappropriate **3**																				
Neurological	VERBAL	Moans to pain/Incomprehensible **2**																				
Neurological	VERBAL	None **1**																				
Neurological / Spinal	MOTOR	Normal spontaneous/Obeys **6**																				
Neurological / Spinal	MOTOR	Withdraws to touch/Localized **5**																				
Neurological / Spinal	MOTOR	Withdraws to pain/Withdraws **4**																				
Neurological / Spinal	MOTOR	Abnormal flexion **3**																				
Neurological / Spinal	MOTOR	Abnormal extension **2**																				
Neurological / Spinal	MOTOR	Flaccid **1**																				
Neurological / Spinal		**TOTAL SCORE GCS**																				
Neurological / Spinal	**Muscle Strength** *Refer to rating scale below* Rate 0 – 5	Right Arm																				
Neurological / Spinal		Left Arm																				
Neurological / Spinal		Right Leg																				
Neurological / Spinal		Left Leg																				
Neurological / Spinal	**Colour, Warmth, & Sensation of Extremities** √ = Normal NN = Nurse's Notes	Right Arm																				
Neurological / Spinal		Left Arm																				
Neurological / Spinal		Right Leg																				
Neurological / Spinal		Left Leg																				
Neurological / Spinal	**Bladder Function**	√ = Normal NN = Nurse's Notes																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score	Action
Score 0 – 1	Continue to monitor and document as per orders & routine protocols.
Score 2 or any one of 5 Situational Awareness Factors	Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.
Score 3	Increase frequency of assessments and documentation as per plan from consultation.
Score 4 and/or score increases by 2 after interventions	Notify MRP/delegate. Consider pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments. Reassess adequacy of resources and escalate to meet deficits.
Score 5 – 13 or score of 3 in any one category	Immediate assessment by MRP/delegate or pediatrician, or emergency room physician. MRP/delegate to communicate a plan of care. Increase nursing care with increasing interventions as per plan. Consider internal or external transfer to higher level of care.

PUPIL SIZE (mm)



MUSCLE STRENGTH GRADING SYSTEM

0/5	No movement	3/5	Movement overcoming gravity, but not against resistance
1/5	Trace movement	4/5	Movement overcoming gravity and some resistance
2/5	Movement only (not against gravity)	5/5	Normal strength against resistance

LEVEL OF AROUSAL SCORE

1	2	3	4	5
Awake and alert, oriented	Normal sleep, easy to arouse to verbal stimulation	Difficult to arouse to verbal stimulation	Responds only to physical stimulation	Does not respond to verbal or physical stimulation

PRINTED NAME	SIGNATURE	INITIALS

CHILD HEALTH BC

PEWS Vital Sign Record

4 – 6 YEARS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

Section	Parameter	Scale / Option	Right scale
	Date: Initials:		
		Time:	
Respiratory	Respiratory Rate (1 minute) Resp: ●	50	50
		40	40
		30	30
		20	20
	O_2 Saturation (%)		
	Supplemental O_2 Concentration Delivered	≤3L or 30%	
		≥3L or 30%	
		≥6L or 40%	
		≥8L or 50%	
	Mode of Delivery		
	Respiratory Distress	None	
		Mild	
		Moderate	
		Severe	
	PEWS Score for Respiratory *(record most severe score)*		
Cardiovascular	Heart Rate (1 minute) & Blood Pressure	160	160
		150	150
		140	140
	Systolic: V Diastolic: Λ	130	130
		120	120
	(Do not score blood pressure)	110	110
	Normal Parameters: Systolic (mmHg): 91 – 114	100	100
		90	90
	Diastolic (mmHg): 50 – 74	80	80
		70	70
	Apex: ●	60	60
	Monitor: *	50	50
		MAP	
	Capillary Refill Time	1 – 2 seconds	
		3 seconds	
		4 seconds	
		≥5 seconds	
	Skin Colour	Pink	
		Pale	
		Grey/Cyanotic	
		Grey & Mottled	
	PEWS Score for Cardiovascular *(record most severe score)*		
Behaviour		Playing/Appropriate	
		Sleeping	
		Irritable	
		Lethargic/Confused	
		Reduced response to pain	
	PEWS Score for Behaviour *(record most severe score)*		
PEWS		Persistent vomiting following surgery	
		Bronchodilator every 20 minutes	
	Total PEWS Score (R + C + B + vomiting + bronchodilator)		
Situational Awareness Factors		Patient/Family/Caregiver concern	
		Unusual therapy	
		Watcher patient	
		Communication breakdown	
		PEWS Score ≥2	
	PEWS Escalation Process Activated *(time)* See NN		
Temperature °C	● A – Axilla R – Rectal O – Oral T – Temporal E – Esophageal	40	40
		39	39
		38	38
		37	37
		36	36

CHILD HEALTH BC

PEWS Vital Sign Record

4 – 6 YEARS

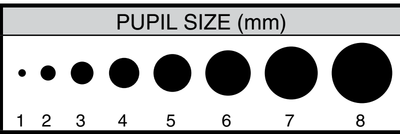
Patient label

Date: Initials:																				
Time:																				
Care – Sepsis Screen																				
Tool: ____________ Pain Score																				
Location of pain																				
Arousal Score																				
PRAM Score (Asthma Patients Only)																				
EtCO2 (mmHg)																				
Glucometer (mmol/L)																				
Neurological – PUPILS **Size** Right																				
PUPILS **Size** Left																				
PUPILS **Reaction** Right (B = Brisk, S = Sluggish, F = Fixed)																				
PUPILS **Reaction** Left																				
EYE – Spontaneous **4**																				
EYE – To speech **3**																				
EYE – To pain **2**																				
EYE – None **1** (C = Closed)																				
VERBAL – Coos/Oriented **5**																				
VERBAL – Irritable cry/Confused **4**																				
VERBAL – Cries to pain/Inappropriate **3**																				
VERBAL – Moans to pain/Incomprehensible **2**																				
VERBAL – None **1**																				
MOTOR – Normal spontaneous/Obeys **6**																				
MOTOR – Withdraws to touch/Localized **5**																				
MOTOR – Withdraws to pain/Withdraws **4**																				
MOTOR – Abnormal flexion **3**																				
MOTOR – Abnormal extension **2**																				
MOTOR – Flaccid **1**																				
TOTAL SCORE GCS																				
Spinal – **Muscle Strength** (*Refer to rating scale below*, Rate 0 – 5) Right Arm																				
Muscle Strength Left Arm																				
Muscle Strength Right Leg																				
Muscle Strength Left Leg																				
Colour, Warmth, & Sensation of Extremities (√ = Normal, NN = Nurse's Notes) Right Arm																				
Colour, Warmth, & Sensation Left Arm																				
Colour, Warmth, & Sensation Right Leg																				
Colour, Warmth, & Sensation Left Leg																				
Bladder Function (√ = Normal, NN = Nurse's Notes)																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score	Action
Score 0 – 1	Continue to monitor and document as per orders & routine protocols.
Score 2 or any one of 5 Situational Awareness Factors	Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.
Score 3	Increase frequency of assessments and documentation as per plan from consultation.
Score 4 and/or score increases by 2 after interventions	Notify MRP/delegate. Consider pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments. Reassess adequacy of resources and escalate to meet deficits.
Score 5 – 13 or score of 3 in any one category	Immediate assessment by MRP/delegate or pediatrician, or emergency room physician. MRP/delegate to communicate a plan of care. Increase nursing care with increasing interventions as per plan. Consider internal or external transfer to higher level of care.

PUPIL SIZE (mm)



MUSCLE STRENGTH GRADING SYSTEM

0/5	No movement	3/5	Movement overcoming gravity, but not against resistance
1/5	Trace movement	4/5	Movement overcoming gravity and some resistance
2/5	Movement only (not against gravity)	5/5	Normal strength against resistance

LEVEL OF AROUSAL SCORE

1	2	3	4	5
Awake and alert, oriented	Normal sleep, easy to arouse to verbal stimulation	Difficult to arouse to verbal stimulation	Responds only to physical stimulation	Does not respond to verbal or physical stimulation

PRINTED NAME	SIGNATURE	INITIALS

CHILD HEALTH BC

PEWS Vital Sign Record

7 – 11 YEARS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

Section	Parameter	Scale / Option
	Date:	Initials:
		Time:
Respiratory	Respiratory Rate (1 minute) Resp: ●	50
		40
		30
		20
		O_2 Saturation (%)
	Supplemental O_2 Concentration Delivered	≤3L or 30%
		≥3L or 30%
		≥6L or 40%
		≥8L or 50%
		Mode of Delivery
	Respiratory Distress	None
		Mild
		Moderate
		Severe
	PEWS Score for Respiratory *(record most severe score)*	
Cardiovascular	Heart Rate (1 minute) & Blood Pressure Systolic: V Diastolic: Λ (Do not score blood pressure) Normal Parameters: Systolic (mmHg): 96 – 121 Diastolic (mmHg): 57 – 80 Apex: ● Monitor: ✱	150
		140
		130
		120
		110
		100
		90
		80
		70
		60
		50
		MAP
	Capillary Refill Time	1 – 2 seconds
		3 seconds
		4 seconds
		≥5 seconds
	Skin Colour	Pink
		Pale
		Grey/Cyanotic
		Grey & Mottled
	PEWS Score for Cardiovascular *(record most severe score)*	
Behaviour		Playing/Appropriate
		Sleeping
		Irritable
		Lethargic/Confused
		Reduced response to pain
	PEWS Score for Behaviour *(record most severe score)*	
PEWS		Persistent vomiting following surgery
		Bronchodilator every 20 minutes
	Total PEWS Score (R + C + B + vomiting + bronchodilator)	
Situational Awareness Factors		Patient/Family/Caregiver concern
		Unusual therapy
		Watcher patient
		Communication breakdown
		PEWS Score ≥2
	PEWS Escalation Process Activated *(time)* See NN	
Temperature °C	● A – Axilla R – Rectal O – Oral T – Temporal E – Esophageal	40
		39
		38
		37
		36

Patient label

CHILD HEALTH BC

PEWS Vital Sign Record

7 – 11 YEARS

Section	Item																				
	Date: **Initials:**																				
	Time:																				
Care	Sepsis Screen																				
Care	Tool: ____________ Pain Score																				
Care	Location of pain																				
Care	Arousal Score																				
Care	PRAM Score (Asthma Patients Only)																				
Care	**EtCO2 (mmHg)**																				
Care	**Glucometer (mmol/L)**																				
Neurological	PUPILS **Size** Right																				
Neurological	PUPILS **Size** Left																				
Neurological	PUPILS (B = Brisk, S = Sluggish, F = Fixed) **Reaction** Right																				
Neurological	PUPILS **Reaction** Left																				
Neurological	EYE Spontaneous **4**																				
Neurological	EYE To speech **3**																				
Neurological	EYE To pain **2**																				
Neurological	EYE (C = Closed) None **1**																				
Neurological	VERBAL Coos/Oriented **5**																				
Neurological	VERBAL Irritable cry/Confused **4**																				
Neurological	VERBAL Cries to pain/Inappropriate **3**																				
Neurological	VERBAL Moans to pain/Incomprehensible **2**																				
Neurological	VERBAL None **1**																				
Neurological	MOTOR Normal spontaneous/Obeys **6**																				
Neurological	MOTOR Withdraws to touch/Localized **5**																				
Neurological	MOTOR Withdraws to pain/Withdraws **4**																				
Neurological	MOTOR Abnormal flexion **3**																				
Neurological	MOTOR Abnormal extension **2**																				
Neurological	MOTOR Flaccid **1**																				
Neurological	**TOTAL SCORE GCS**																				
Spinal	**Muscle Strength** *Refer to rating scale below* Rate 0 – 5 — Right Arm																				
Spinal	Muscle Strength — Left Arm																				
Spinal	Muscle Strength — Right Leg																				
Spinal	Muscle Strength — Left Leg																				
Spinal	**Colour, Warmth, & Sensation of Extremities** √ = Normal, NN = Nurse's Notes — Right Arm																				
Spinal	Colour, Warmth, & Sensation of Extremities — Left Arm																				
Spinal	Colour, Warmth, & Sensation of Extremities — Right Leg																				
Spinal	Colour, Warmth, & Sensation of Extremities — Left Leg																				
Spinal	**Bladder Function** √ = Normal, NN = Nurse's Notes																				

Pediatric Early Warning System (PEWS) Escalation Aid

Score 0 – 1: Continue to monitor and document as per orders & routine protocols.

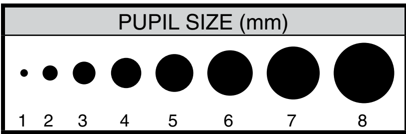
Score 2 or any one of 5 Situational Awareness Factors: Review with more experienced healthcare professional. Escalate if further consultation required or resources do not allow. Continue to monitor as per orders/protocols.

Score 3: Increase frequency of assessments and documentation as per plan from consultation.

Score 4 and/or score increases by 2 after interventions: Notify MRP/delegate. Consider pediatrician consult. MRP/delegate to communicate a plan of care. Increase assessments. Reassess adequacy of resources and escalate to meet deficits.

Score 5 – 13 or score of 3 in any one category: Immediate assessment by MRP/delegate or pediatrician, or emergency room physician. MRP/delegate to communicate a plan of care. Increase nursing care with increasing interventions as per plan. Consider internal or external transfer to higher level of care.

PUPIL SIZE (mm)



MUSCLE STRENGTH GRADING SYSTEM

0/5	No movement	3/5	Movement overcoming gravity, but not against resistance
1/5	Trace movement	4/5	Movement overcoming gravity and some resistance
2/5	Movement only (not against gravity)	5/5	Normal strength against resistance

LEVEL OF AROUSAL SCORE

1	2	3	4	5
Awake and alert, oriented	Normal sleep, easy to arouse to verbal stimulation	Difficult to arouse to verbal stimulation	Responds only to physical stimulation	Does not respond to verbal or physical stimulation

PRINTED NAME	SIGNATURE	INITIALS

PEWS Vital Sign Record

12+ YEARS

Patient label

PEWS Scoring Legend: 0 | 1 | 2 | 3

Section	Parameter	Scale / Option
	Date:	Initials:
		Time:
Respiratory	Respiratory Rate (1 minute) Resp: ●	40
		30
		20
		10
		O_2 Saturation (%)
	Supplemental O_2 Concentration Delivered	≤3L or 30%
		≥3L or 30%
		≥6L or 40%
		≥8L or 50%
		Mode of Delivery
	Respiratory Distress	None
		Mild
		Moderate
		Severe
	PEWS Score for Respiratory *(record most severe score)*	
Cardiovascular	Heart Rate (1 minute) & Blood Pressure Systolic: V Diastolic: Λ (Do not score blood pressure) Normal Parameters: Systolic (mmHg): 105 – 136 Diastolic (mmHg): 62 – 87 Apex: ● Monitor: ✶	140
		130
		120
		110
		100
		90
		80
		70
		60
		50
		MAP
	Capillary Refill Time	1 – 2 seconds
		3 seconds
		4 seconds
		≥5 seconds
	Skin Colour	Pink
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CHILD HEALTH BC

PEWS Vital Sign Record

12+ YEARS

Patient label

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Time:																				
Care – Sepsis Screen																				
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PUPIL SIZE (mm)

1 2 3 4 5 6 7 8

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