

MUST ATTACH PATIENT LABEL HERE

Source: *Author's calculations*.

POSTMASTER: Please send address changes to *Journal of Management Inquiry*, 2200 Central Expressway, Suite 200, Thousand Oaks, CA 91320.

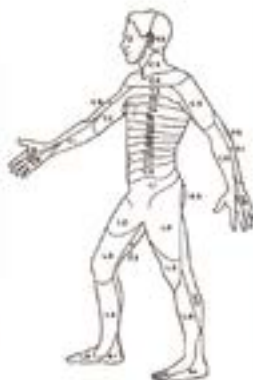
2009

Please ensure you attach the correct visit patient label

Date: _____

Guide to Level of Respiratory Distress for PEWS scoring

Mild	Moderate - Severe	Very Severe
<ul style="list-style-type: none"> • Stridor on exertion • Expiratory wheeze • Mild recession/indrawing 	<ul style="list-style-type: none"> • Stridor at rest • Inspiratory and expiratory wheeze • Moderate recession/indrawing • Tracheal tug • Nasal flaring • Head bobbing 	<ul style="list-style-type: none"> • New onset of stridor • Severe recession/indrawing • Grunting • Gasping • "Silent" chest • Exhaustion • Change in consciousness



Epidural Dermatozoic Levels

Respiratory Support / O₂ Delivery Mode

NP = Nasal Prongs	M = Face Mask	HF = High Flow
C = CPAP	V = VPAP	B = BiPAP

Date _____

Time

Respiratory Support

Wall C, Flow

Airyo air flow

Pressure

Pain Assessments

(10-53) at Rest

10-901 with activity

NI = Nilai

Y = Venting

Epidural Assessments

Discussion

Level

Interventions (Record intervention administered here and note number in appropriate time column over page)

1

2

3

4

5

[illegible]

Modified GlamorganTM Scale
Paediatric Pressure Injury Risk Assessment Scale

[illegible]

Patient Clinical Care Reviews

Patient Status and Care Reviews							Care Reviews
	Time	Time	Time	Time	Time	Time	As outlined in the Nursing Care Delivery Model
	Initial (x2)	Initial (x2)	Initial (x2)	Initial (x2)	Initial (x2)	Initial (x2)	
Date							Patient Status is assessed: <ul style="list-style-type: none"> • PEWS • Pain • Pressure relief • Pharmacy - Medications/infusions - checked, lines and sites reviewed
Date							Patient Comfort is ensured: <ul style="list-style-type: none"> • Patient position – comfort levels assessed • Parental concerns and reassurance • Patients' needs and environment
Date							Patient Nursing Care is evaluated and discussed: <ul style="list-style-type: none"> • The need for elevation of patient status • Anticipate care planning needs and actions • Reassess care requirements to be shared
Date							Parental (caregiver) and Patient Care: <ul style="list-style-type: none"> • Plan and negotiate cares together • Patient's normal routines are assisted • Parental (caregiver) breaks are offered and planned
Date							



0-11 Months

Date
TimeRespiratory Rate
(breaths/min)

Respiratory Distress

O₂ (L/min)SpO₂ (%)Heart Rate
(beats/min)Blood Pressure
(mmHg)

Score Systolic BP

Capillary Refill Time

Total PEWS

Staff / Family Concern

Level of Consciousness

Temperature
(°C)

Interventions

Signature (initials)

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SURNAME

DOB

FIRST NAMES

DOB

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MODIFICATION (in consultation with Consultant/Fellow)

Document a modification below if any of this child's observations are expected to sit outside the accepted parameter range due to clinical condition

Vital Sign	Accepted value	Date and Time	Duration	Name and Contact Details

Document a modification below if this child requires less frequent vital sign documentation due to physiological stability

Vital Sign	Frequency	Date and Time	Duration	Name and Contact Details

Reason:

Goals of care:
Advanced Care plan (Te Wha Aroha)
completedNot for Code
PinkNot for Code
Blue

Paediatric Early Warning Score

0 1 2 4 E

Score E = Place Code Blue Call

Recommended actions based on PEWS

Total Score 0-3

- Notify nurse in charge at ward safety briefing
- Assess child and record PEWS 4 hourly
- Manage pain, fever, distress and anxiety
- Routine Doctor review

Total Score 4-5

- Notify nurse in charge within 1 hour
- Assess child and record PEWS 1 - 2 hourly
- Manage pain, fever, distress and anxiety
- Doctor review within 4 hours

Total Score 6-7

- Notify nurse in charge immediately
- Manage pain, fever, distress and anxiety
- Notify PaR NS if concerned (021 829 402) [review within 60 minutes]
- Assess child and record PEWS every 30 - 60 minutes
- Doctor review within 2 hours
- Senior doctor review within 4 hours
- Document plan, including interventions and review timeframe
- Consider continuous monitoring
- Consider Code Pink

Total Score 8+

- Notify nurse in charge immediately
- Manage pain, fever, distress and anxiety
- Notify PaR NS ASAP (021 829 402)
- Assess child and record PEWS every 15 minutes initially and then every 15-60 minutes after review
- PaR NS review within 30 minutes
- Doctor review within 30 minutes
- Senior doctor review within 60 minutes
- Document plan, including interventions and review timeframe
- Consider continuous monitoring
- Consider Code Pink

Recommended action for staff or family serious concern

- Discuss with nurse in charge immediately
- Consider Urgent Clinical Review
- Consider Code Pink

PEWS
0
1
2
4
E

(0-11 Months)

CR3604 - 02/19