Escalation Guide

PEWS does not replace an emergency call

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<thead>
<tr>
<th>Score</th>
<th>Minimum Observations</th>
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<tr>
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<td>4 hourly</td>
<td>Nurse in Charge</td>
<td>Any trigger should prompt increase in observation frequency as clinically appropriate</td>
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<tr>
<td>2</td>
<td>2 - 4 hourly</td>
<td>Nurse in Charge + Doctor call</td>
<td>Nurse in Charge review</td>
</tr>
<tr>
<td>3*</td>
<td>1 hourly</td>
<td>Nurse in Charge + Doctor on call</td>
<td>Urgent medical review</td>
</tr>
<tr>
<td>4-5</td>
<td>30 minutes</td>
<td>Nurse in Charge + Doctor on call + Senior Doctor +/- Consultant</td>
<td>Urgent SENIOR medical review</td>
</tr>
<tr>
<td>≥7</td>
<td>Continuous</td>
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<td>Immediate local response team</td>
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* Pink score in any parameter merits review

PEWS does not replace clinical concern

**ISBAR Communication Tool**
- **Identify**
- **Situation**
- **Background**
- **Assessment**
- **Recommendation**

Medical Escalation Agreement

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<th>Date / Time</th>
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**PEWS does not replace an emergency call**

**Assessment of Respiratory Effort**

<table>
<thead>
<tr>
<th></th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway</td>
<td>• Stridor on exertion/crying</td>
<td>• Mild stridor at rest</td>
<td>• Stridor at rest</td>
</tr>
<tr>
<td>Behaviour and feeding</td>
<td>• Normal</td>
<td>• Some/intermittent irritability</td>
<td>• Increased irritability and/or lethargy</td>
</tr>
<tr>
<td></td>
<td>• Talks in sentences</td>
<td>• Difficulty talking/crying</td>
<td>• Looks exhausted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Difficulty feeding or eating</td>
<td>• Unable to talk or cry</td>
</tr>
<tr>
<td>Respiratory rate</td>
<td>• Mildly increased</td>
<td>• Respiratory rate in blue zone</td>
<td>• Respiratory rate in pink zone</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Increased or markedly reduced respiratory rate as the child tires</td>
</tr>
<tr>
<td>Accessory muscle use</td>
<td>• Mild intercostal and suprasternal recession</td>
<td>• Moderate intercostal and suprasternal recession</td>
<td>• Marked intercostal, suprasternal and sternal recession</td>
</tr>
<tr>
<td>Oxygen</td>
<td>• No oxygen requirement</td>
<td>• Mild hypoxemia corrected by oxygen</td>
<td>• Hypoxemia may not be corrected by oxygen</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>• Increasing oxygen requirement</td>
<td>• Gasping, grunting</td>
</tr>
</tbody>
</table>
<pre><code>                          |                             |                               | • Extreme pallor, cyanosis   |
                          |                             |                               | • Apnoea                    |
</code></pre>

Paediatric Sepsis 6

**Recognition**
- 2 or more of the following
  - Core temperature <36°C or >38.5°C
  - Inappropriate tachypnoea
  - Inappropriate tachycardia
  - Reduced peripheral perfusion
  - Altered mental status
  - Consider co-morbidities

**Suspected or proven sepsis**

**TAKING 3 <60 Mins.**
- IV or IO access and take blood samples
- Urine output measurement
- Early SENIOR input

**Within 60 minutes**
- High flow oxygen
- IV/IO fluids & consider early inotropic support
- Broad spectrum IV/IO antimicrobials

**GIVE 3 <60 Mins.**
- • Core temperature <36°C or >38.5°C
- • Inappropriately tachycardia
- • Reduced peripheral perfusion
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Amendment</th>
<th>For Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Parameters</td>
<td>New Acceptable Range</td>
<td>Next Medical Review</td>
</tr>
<tr>
<td>Date/Time</td>
<td>Year Date Time</td>
<td>Senior Doctor</td>
</tr>
<tr>
<td></td>
<td>Initials / MCRN / Designation</td>
<td>Addressograph</td>
</tr>
<tr>
<td>Consultant</td>
<td>Ward</td>
<td></td>
</tr>
</tbody>
</table>

**BP Score**
- Systolic: 115
- Diastolic: 72

**SpO2 Score**
- 90-93%
- ≥94%

**O2 T Score**
- ≤2L

**CRT Score**
- ≥40.0
- ≥35.0

**AVPU Score**
- Alert
- Voice
- Pain
- Unresponsive

**Total PEWS Score**
- 0

**Mode of O2 delivery**
- Room air (RA)
- Nasal Cannula (NC)
- Face mask (FM)
- Tracheostomy (T)
- HHFNC (H)
- CPAP (C) / BiPAP (B)

**Cuff Size**
- ____________

**PEWS Score Key**

**Chart Date**
- DMMYY

**Addressograph**

**Pain Score**
- Nurse/NMBI

**AB AIRWAY & BREATHING**

**Respiratory Rate**
- 15

**SpO2 Score**
- ≥94%

**Skin Colour**
- PK - pink
- P - pale
- M - mottled
- C - cyanosed

**Total PEWS**
- 0

**Reassess within (Mins.)**
- 0

---

The image contains a detailed clinical parameters form for assessing patients. It includes sections for various clinical parameters such as blood pressure (BP), oxygen saturation (SpO2), respiratory rate (RR), heart rate (HR), central capillary refill time (CRT), and more. Each parameter has a range within which it is considered normal or acceptable. The form also includes sections for recorded values, observations, and medical reviews. The form is designed to help healthcare professionals monitor and assess patients' conditions over time.
Streamline your critical care decision-making process with the updated PAEDiatrics Observation Chart (5-11 Years). This chart provides a structured approach to escalating care based on the Pediatric Early Warning Score (PEWS) and the ISBAR communication tool. Here are the key elements:

**Escalation Guide**

**PEWS does not replace an emergency call**

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**PEWS does not replace clinical concern**

**ISBAR Communication Tool**

- **Identify**: Recognize the patient's condition
- **Situation**: Assess the patient's environment
- **Background**: Gather patient history
- **Assessment**: Evaluate patient status
- **Recommendation**: Plan and act

**Medical Escalation Agreement**

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**Paediatric Sepsis 6**

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  - Altered mental status
  - Consider co-morbidities

**Suspected or proven sepsis**

- **TAKE 3**<60 Mins.
  - IV or IO access and take blood samples
  - Urine output measurement
  - Early SENIOR input

- **GIVE 3**<60 Mins.
  - High flow oxygen
  - IV/IQ fluids & consider early inotropic support
  - Broad spectrum IV/IQ antimicrobials

**Event Record for PEWS score ≥6**

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<tr>
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**Assessment of Respiratory Effort**

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**PEWS**

- Score Minimum Alert Minimum Observations Minimum Response
- 1 4 hourly Nurse in Charge Any trigger should prompt increase in observation frequency as clinically appropriate
- 2 2 - 4 hourly Nurse in Charge Nurse in Charge review
- 3* 1 hourly Nurse in Charge + Doctor on call Urgent medical review
- 4-5 30 minutes Nurse in Charge review
- 6 Continuous Nurse in Charge + Doctor on call Urgent SENIOR medical review
- ≥7 Continuous URGENT SENIOR CALL Immediate local response team

**Medical Escalation Agreement**

**ISBAR Communication Tool**

- **Identify**: Recognize the patient's condition
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### AWAY & BREATHING

#### Respiratory Rate
- Airways: Evaluate for presence of respirations.
- Breathing: Assess heart rate and respiratory rate.

#### Central Venous Pressure (CVP)
- Measure CVP to assess volume status.
- Ensure proper positioning for accurate measurement.

#### Oxygen Therapy
- Choose the appropriate mode of oxygen delivery.
- Monitor SpO2 levels to ensure adequate oxygenation.

#### Blood Pressure (BP)
- Monitor systolic and diastolic pressures regularly.
- Observe for any trends or changes in BP.

#### Core Parameters
- Review and document patient's core parameters regularly.
- Ensure that all necessary assessments are performed.

### CIRCULATION

#### Heart Rate (HR)
- Assess HR for regularity and rate.
- Consider HR scores of 1 or more severe.

#### Cardiovascular Support
- Monitor central CRT and BP to assess for sepsis.

### DISABILITY

#### AVPU Score
- Assess for responsiveness to calls, voice, pain, and unresponsive states.

#### AVPU Score
- Monitor for changes in patient's level of consciousness.

### EXPOSURE

#### Temperature
- Record temperature to monitor for fever or hypothermia.
- Consider temperature changes as a potential indicator of infection.

#### Pain Score
- Evaluate patient's pain level using appropriate scales.
- Monitor changes in pain intensity and severity.

### Total PEWS Score
- Calculate the total PEWS score to assess overall clinical status.
- Reassess within the specified time frame.

### Addressograph
- Document patient's addressograph information.
- Confirm patient's identity and current status.

### Chart Date
- Record date and time of assessment.
- Update chart with relevant information.

### Nurse/NMBI
- Document observations and interventions.
- Collaborate with medical team for timely interventions.

---

**PEWS Score Key**
- Mild: 1-3
- Moderate: 4-6
- Severe: 7-9
- Critical: 10

**Concern Score**
- 0: No concern
- 1: Low concern
- 2: Moderate concern
- 3: High concern

**SpO2 Score**
- 90-100%
- 80-89%
- 70-79%
- 60-69%
- ≤60%

**BP Score**
- 90-100 mmHg
- 80-89 mmHg
- 70-79 mmHg
- 60-69 mmHg
- ≤60 mmHg

**Heart Rate (HR) Score**
- 60-90 bpm
- 50-59 bpm
- 40-49 bpm
- 30-39 bpm
- ≤30 bpm

**Respiratory Rate (RR) Score**
- 0-9 breaths per minute
- 10-14 breaths per minute
- 15-19 breaths per minute
- ≥20 breaths per minute

**SpO2 Score Range**
- ≤90%
- 91-94%
- 95-97%
- 98-100%

**Temperature Range**
- 35.0-37.0°C
- 37.1-38.0°C
- 38.1-39.0°C
- ≥39.1°C

**AAU Score**
- ≤2
- >2

---

**Further Actions**
- Implement necessary interventions based on PEWS score.
- Notify medical team for escalation of care.

---

**Additional Information**
- Document all relevant observations and interventions.
- Ensure timely communication with healthcare providers.

---

**Staff/Journey**
- Document staff responsible for care.
- Note the journey of care for efficient and effective patient management.
Escalation Guide

PEWS does not replace an emergency call

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- Altered mental status
- Consider co-morbidities

**Suspected or proven sepsis**

**TAKE 3**

- IV or IO access and take blood samples
- Urine output measurement
- Early SENIOR input

Within 60 minutes

- High flow oxygen
- IV/IO fluids & consider early inotropic support
- Broad spectrum IV/IO antimicrobials

**GIVE 3**

- <60 Mins.

**Event Record for PEWS score ≥6**

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<td>Severe</td>
<td>Stridor at rest</td>
<td>Increased irritability and/or lethargy, looks exhausted, unable to talk or cry, unable to feed or eat</td>
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**Other**

- Gasping, grunting
- Extreme pallor, cyanosis
- Apnoea
### AB - AIRWAY & BREATHING

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<tr>
<th>Parameter</th>
<th>Normal Range</th>
<th>Concern Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>RR Number</td>
<td>15-40</td>
<td>0</td>
</tr>
<tr>
<td>HR Number</td>
<td>60-100</td>
<td>0</td>
</tr>
<tr>
<td>Oxygen Therapy</td>
<td>Room air (RA)</td>
<td>0</td>
</tr>
<tr>
<td>SpO₂ Score</td>
<td>θ 90-93%</td>
<td>0</td>
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</tbody>
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**Pain Score**
- FLACC: [ ]
- Faces: [ ]
- Numeric: [ ]

### C - CIRCULATION

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<tr>
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<tbody>
<tr>
<td>HR Number</td>
<td>60-100</td>
<td>0</td>
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<tr>
<td>CRT Score</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>110/70</td>
<td>0</td>
</tr>
<tr>
<td>SpO₂ Score</td>
<td>θ 90-93%</td>
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**Concern Score**
- Score '-' if not assessed and put a vertical line through column
- Notify doctor if urine output is <1mL/Kg/hr

### D - DISABILITY

<table>
<thead>
<tr>
<th>Parameter</th>
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<th>Concern Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVPU Score</td>
<td>Unresponsive</td>
<td>0</td>
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**Pain Score**
- FLACC: [ ]
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### E - EXPOSURE

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<tr>
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<tbody>
<tr>
<td>Temperature</td>
<td>&gt;38.0°C</td>
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**Pain Score**
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### Total PEWS Score

**Total PEWS Score**

**Reassess within (Mins.):**

**Nurse/NMBI:**
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<td>Normal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some intermittent irritability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty talking/crying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty feeding or eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mildly increased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory rate in blue zone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessory muscle use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild intercostal and suprasternal recession</td>
<td></td>
<td></td>
<td>Marked intercostal, suprasternal and sternal recession</td>
</tr>
<tr>
<td>Nasal flaring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No oxygen requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild hypoxemia corrected by oxygen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing oxygen requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gasping, grunting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Extreme pallor, cyanosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Apnoea</td>
</tr>
</tbody>
</table>

**ISBAR Communication Tool**

**Medical Escalation Agreement**

**Paediatric Sepsis 6**

**Recognition**

2 or more of the following

- Core temperature <36°C or >38.5°C
- Inappropriate tachypnoea
- Inappropriate tachycardia
- Reduced peripheral perfusion
- Altered mental status
- Consider co-morbidities

**Suspected or proven sepsis**

**TAKE 3**

- IV or IO access and take blood samples
- Urine output measurement
- Early SENIOR input

**Within 60 minutes**

- High flow oxygen
- IV/O fluids & consider early inotropic support
- Broad spectrum IV/O antimicrobials

**GIVE 3**

- <60 Mins.

---

**Date / Time PEWS Nurse Initials & NMBI Alert**

---

**Event Record for PEWS score ≥6**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>PEWS</th>
<th>Nurse Initials &amp; NMBI</th>
<th>Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PEWS Score Key

- **0**: Normal
- **1**: Mild
- **2**: Moderate
- **3**: Severe

### Clinical Parameters

<table>
<thead>
<tr>
<th>Parameter</th>
<th>New Acceptable Range</th>
<th>Next Medical Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Parameters</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temp (℃)</td>
<td>≤38.0</td>
<td></td>
</tr>
<tr>
<td>SpO2 (%)</td>
<td>&gt;90.0</td>
<td></td>
</tr>
<tr>
<td>Heart Rate (bpm)</td>
<td>60-100</td>
<td></td>
</tr>
<tr>
<td>CRT (seconds)</td>
<td>≥2</td>
<td></td>
</tr>
<tr>
<td>BP Number (mmHg)</td>
<td>90/60</td>
<td></td>
</tr>
<tr>
<td><strong>AB - Airway &amp; Breathing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate (bpm)</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>CRT (seconds)</td>
<td>≥2</td>
<td></td>
</tr>
<tr>
<td>RR Number</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td><strong>C - Circulation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR Number</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Central Capillary Refill Time (seconds)</td>
<td>≥2</td>
<td></td>
</tr>
<tr>
<td><strong>D - Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AVPU Score</td>
<td>Unresponsive</td>
<td></td>
</tr>
<tr>
<td><strong>E - Exposure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature (℃)</td>
<td>≥38.0</td>
<td></td>
</tr>
<tr>
<td><strong>Total PEWS Score</strong></td>
<td>0</td>
<td>Reassess within</td>
</tr>
</tbody>
</table>

### Concern Score

- **Mild**
- **Moderate**
- **Severe**

### Mode of O₂ delivery

- Room air (RA)
- Nasal Cannula (NC)
- Face mask (FM)
- Tracheostomy (T)
- HFNC (H)
- CPAP (C) / BiPAP (B)

### Colour

- P - pale
- M - mottled
- C - cyanosed
- A - alert
- V - voice
- U - unresponsive

### Chart Date

- **DD/MM/YY**

### Addressograph

- **Consultant**
- **Ward**

### Frequency of observations

- **12/12**

### 4-11 Months

<table>
<thead>
<tr>
<th>PEWS Score</th>
<th>Pain Score</th>
<th>Reassess within (Mins.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Notes

- **HR <60 with no signs of life - begin CPR and call the emergency team**
- Notify doctor if urine output is <1mL/Kg/hr

---

**Total PEWS Score**

- **0**

**Pain Score**

- **0**

**Reassess within (Mins.):**

- **0**

---

**PEWS Score Key**

- **0**: Normal
- **1**: Mild
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Paediatric Observation Chart

0-3 Months

Escalation Guide

PEWS does not replace an emergency call

<table>
<thead>
<tr>
<th>Score</th>
<th>Minimum Observations</th>
<th>Minimum Alert</th>
<th>Minimum Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4 hourly</td>
<td>Nurse in Charge</td>
<td>Any trigger should prompt increase in observation frequency as clinically appropriate</td>
</tr>
<tr>
<td>2</td>
<td>2 - 4 hourly</td>
<td>Nurse in Charge</td>
<td>Urgent medical review</td>
</tr>
<tr>
<td>3*</td>
<td>1 hourly</td>
<td>Nurse in Charge + Doctor on call</td>
<td>Immediate local response team</td>
</tr>
<tr>
<td>4-5</td>
<td>30 minutes</td>
<td>Nurse in Charge + Doctor on call</td>
<td>Urgent SENIOR medical review</td>
</tr>
<tr>
<td>6</td>
<td>Continuous</td>
<td>Nurse in Charge + Doctor on call + Senior Doctor +/- Consultant</td>
<td>Urgent SENIOR medical review</td>
</tr>
<tr>
<td>≥7</td>
<td>Continuous</td>
<td>URGENT PEWS CALL</td>
<td>Urgent SENIOR medical review + Senior Doctor +/- Consultant</td>
</tr>
</tbody>
</table>

* Pink score in any parameter merits review

PEWS does not replace clinical concern

Medical Escalation Agreement

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Maximum Duration</th>
<th>Following clinical assessment, if appropriate, state clinical impression, permitted parameters &amp; calling criteria. Document clearly in clinical notes.</th>
<th>Senior Doctor (e.g: NCH / Designate)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IMPRESSION:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IMPRESSION:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IMPRESSION:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IMPRESSION:</td>
<td></td>
</tr>
</tbody>
</table>

Assessment of Respiratory Effort

<table>
<thead>
<tr>
<th>Score</th>
<th>Minimum Alert</th>
<th>Minimum Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Stridor at rest</td>
<td>Stridor at rest</td>
</tr>
<tr>
<td>Moderate</td>
<td>Increased irritability and/or lethargy</td>
<td>Increased irritability and/or lethargy</td>
</tr>
<tr>
<td>Severe</td>
<td>Increased respiratory rate in pink zone</td>
<td>Increased respiratory rate in pink zone</td>
</tr>
</tbody>
</table>

Paediatric Sepsis 6

Recognition
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- Core temperature <36°C or >38.5°C
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- Broad spectrum IV/O antimicrobials

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### 0-3 Months

**Gestational age:** Corrected: **Y/N**

**Addressograph**
- **Ward**
- **Consultant**

<table>
<thead>
<tr>
<th>Parameter Amendment</th>
<th>Date / Time</th>
<th>Clinical Parameters</th>
<th>New Acceptable Range</th>
<th>Next Medical Review</th>
<th>Senior Doctor</th>
<th>Initials / MCRN / Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Parameters</strong></td>
<td><strong>Year</strong></td>
<td><strong>Date</strong></td>
<td><strong>Time</strong></td>
<td><strong>Frequency of observations</strong></td>
<td><strong>Clinician / Family Concern</strong></td>
<td><strong>Concern Score</strong></td>
</tr>
<tr>
<td>0-3 Months</td>
<td>12/12</td>
<td>18:45</td>
<td></td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**AB: AIRWAY & BREATHING**

- **Respiratory Rate**
- **Respiratory Effort**
- **Oxygen Therapy**
- **SpO₂**

**C: CIRCULATION**

- **Heart Rate**
- **Blood Pressure**
- **Cuff Size**
- **BP Number**

**D: DISABILITY**

- **AVPU**
- **Unresponsive**

**E: EXPOSURE**

- **Temperature**
- **Record**

**Total PEWS Score**

- **Pain Scale in use:**
  - FLACC
  - Numeric

**Nurse/NMBI**