PED Pediatric Early Warning Scale (PEWS)

Beginning December 11, 2012, Acute Care inpatient Areas, including ED staff caring for patients in queued for a bed, will begin utilizing the PEWS Scale. Nurses caring for Acute Care status patients will chart PEWS Assessments with vital signs in HED and will provide care based on the PEWS score and corresponding recommended action. The PEWS tool assigns designated scores for the following areas of the patient assessment:

- Neuro/Behavior
- Cardiac
- Respiratory
- < 24 hours of admission
- Transfer from ED

Based on the results of the patient assessment, an objective score is given with a corresponding ACTION PLAN for the score that provides the nurse assistance in determining the needed level of care for the patient.

The corresponding action as a result of the PEWS score may include: more frequent reassessment, notifying the Clinical Staff Leader (CSL)/Charge Nurse (CN), Primary Medical Team, or activating a Rapid Response.

There is an indicator on the dashboard that will be the color of the designated PEWS score for the patient (red, orange, yellow or green). This will assist both the nursing and physician staff to become familiar with PEWS scoring and the Action Plan. For patients who are due for a PEWS assessment there will be a colored coded “?” displayed in place of the PEWS color, indicating that an assessment is overdue. The color of the “?” will correspond to the prior PEWS score.

Please see the attached PEWS Scoring Tool and Action Plan Algorithm for more information. To communicate changes in patient condition accurately, it is essential that nursing staff be specific in the details of their patient assessment.

When the bedside nurse notifies the CSL or Primary Medical Team, he/she should specify why the assessment was abnormal. For example, the bedside nurse may say “I’m concerned about this patient because of _______ and their PEWS score is ___. I am activating a Rapid Response.” The bedside nurse should not page and only give the PEWS score with no assessment data to support.

A PEWS score should NOT be documented for DNR/DNI patients. A drop down box will be provided within the PEWS charting field that allows the nurse to identify frequency of Vital Signs or DNR/DNI, which will correspond with dashboard indicators. Please see the following pages for algorithm and HED Charting screen shots.

<table>
<thead>
<tr>
<th>Color</th>
<th>Notification/Action</th>
<th>Acute Care Indicator</th>
<th>Acute Care Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Assessed within min. time frame.</td>
<td>With overdue Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Background=Green &lt;8h Yellow &lt;4h Orange/Red &lt;2h</td>
<td>? retains prev. color Green ?? &gt;8h Yellow ?? &gt;4h Orange/Red ?? &gt;2h</td>
</tr>
<tr>
<td>Green</td>
<td>None</td>
<td>3</td>
<td>??</td>
</tr>
<tr>
<td>Yellow</td>
<td>Charge RN</td>
<td>5</td>
<td>??</td>
</tr>
<tr>
<td>Orange</td>
<td>above + Resident Team</td>
<td>10</td>
<td>??</td>
</tr>
<tr>
<td>Red</td>
<td>above + RRT</td>
<td>15</td>
<td>??</td>
</tr>
<tr>
<td>White</td>
<td>None (not applicable i.e. DNR)</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>
Patient assessed at start of shift/admission/transfers of care

PEWS score 0-4

Acceptable to transfer patient to OBS

Consult PED CN to confirm score

CN and PED attending determine if pt stable for OBS transfer

If transferred to OBS:

Reassess q 4hrs or more frequently based on nursing judgment

Notify admit team and PED attending with any changes in patient's condition

If queued for Acute Care admission:

Bedside assessment by PED attending or Team MD required

Notify admit team and PED attending

PED CN, PED Attending and Admit Team will determine stability for admission to Acute Care Setting

Initiate continuous cardiorespiratory monitoring

PEWS score 5-7

Consult PED CN to confirm score

CN and PED attending determine if pt stable for OBS transfer

If transferred to OBS:

Reassess q 4hrs or more frequently based on nursing judgment

Notify admit team and PED attending with any changes in patient's condition

Reassess/rescore q2 hrs or more frequently based on clinical judgment

PEWS score 8-11 OR a score of 3 in Neuro or Cardio category

Consult PED CN to confirm score

Remain in PED core OR Transfer to PED OBS or Acute Care Setting with PED APPROVAL

If queued for Acute Care admission:

Bedside assessment by PED attending or Team MD required

Notify admit team and PED attending

PED CN, PED Attending and Admit Team will determine stability for admission to Acute Care Setting

Initiate continuous cardiorespiratory monitoring

If transferred to OBS:

Notify admit team and PED attending with any changes in patient's condition

Notify admit team and PED attending with any changes in patient's condition

PEWS score >= 12

Consult PED charge nurse to confirm score

Notify PED attending First, then admit team

Bedside assessment required

Interventions as ordered

Initiate admission to PCCU

Notify admit team and PED attending

Initiate continuous monitoring initiating q 1hr PEWS assessments

If queued for Acute Care admission:

Bedside assessment by PED attending or Team MD required

Perform Interventions as ordered

PED CN, PED Attending and Admit Team will determine stability for admission to Acute Care Setting

Initiate continuous cardiorespiratory monitoring

Reassess/rescore q2 hrs or more frequently based on clinical judgment
Take Home Points

- Complete PEWS score with vital signs
- Real time charting of vital signs
- Drop down box in PEWS tool to choose frequency of vital signs which will coincide with indicator
- Close communication loop between with CP
- PEWS indicator based on time assessment completed not charted
- If patient has score of 3 in Neuro or Cardio, RN should choose PEWS color of orange and follow algorithm
- PEWS score may be completed more frequently for concerning patients, but not less frequently than algorithm indicates
- Provide clear, concise communication to Medical Team