

### Acute Care Pediatric Early Warning Scale (PEWS)

Beginning December 11, 2012, Acute Care inpatient Areas, including ED staff care for patients queued for a bed, will begin utilizing the PEWS Scale. Nurses caring for patients located in Acute Care inpatient areas 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
- Previous Rapid Response in within 24 hours
- Transfer from ED/PACU/PICU/PCICU/clinic or within 24 hours of admission

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.

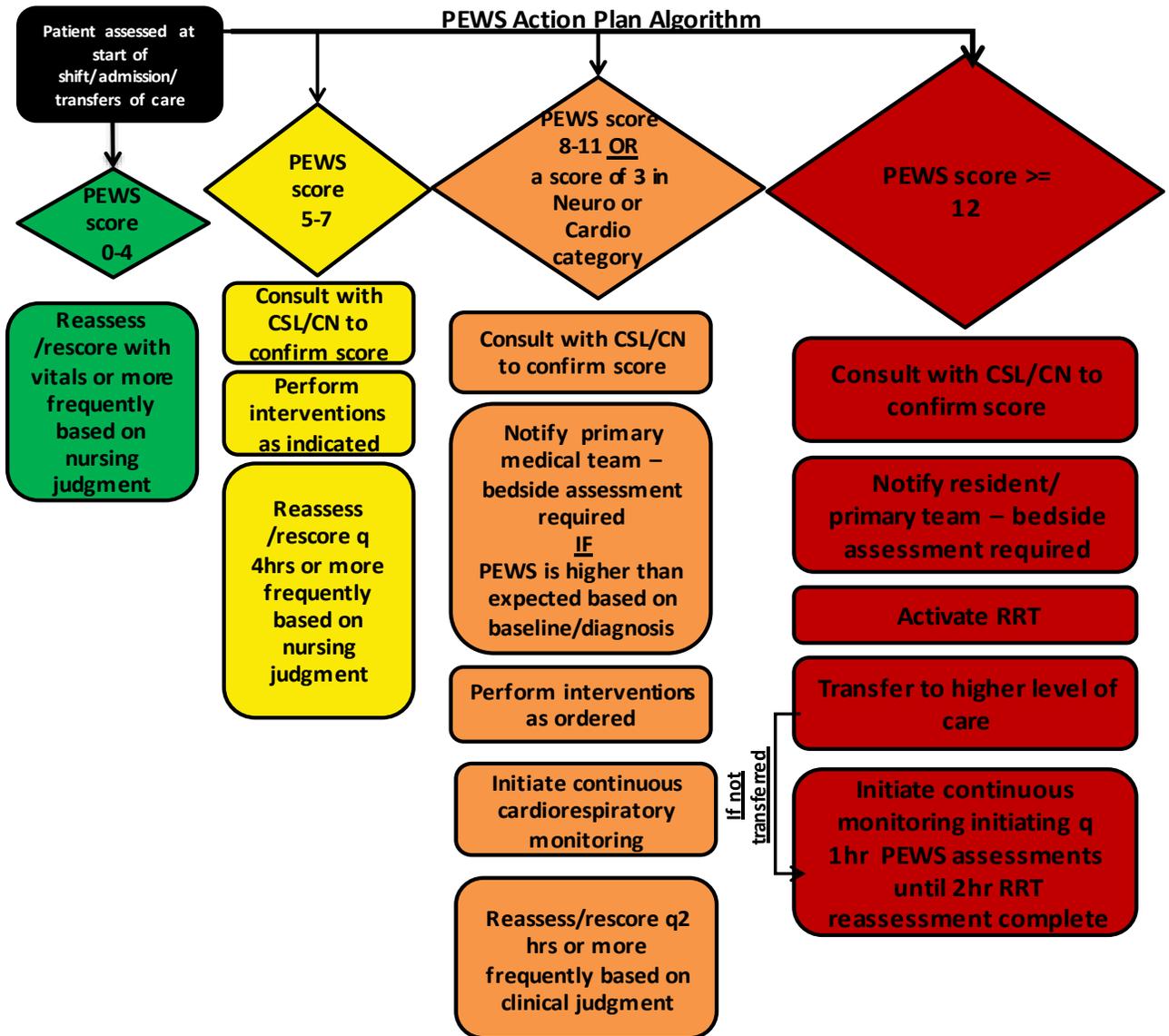
There is an indicator on the dashboard that will be the color of the designated PEWS score for the patient (red, orange, yellow or green). This will assist both the nursing and physician staff to become familiar with PEWS scoring and the Action Plan. **For patients who are due for a PEWS assessment there 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.

Color	Notification/ Action	Acute Care Indicator Assessed within min. time frame. Background= Green <8h Yellow <4h Orange/Red <2h	Acute Care Indicator With overdue Assessment <b>? retains prev. color</b> Green?? >8h Yellow?? >4h Orange/Red?? >2h
Green	None	3	??
Yellow	Charge RN	5	??
Orange	above + Resident Team	10	??
Red	above + RRT	15	??
White	None (not applicable i.e. DNR)	na	na



# 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 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