Acacium Group PEWS Policy

Policy Reference | CLIN 53

Version | 3.1

Policy Name	PEWS Policy
Purpose of Document	This policy aims to improve detection and response of clinical deterioration for patients/clients/service us
Target Audience	All Acacium Group Staff
Version	V3.1
Author	Joanna Cousins
Date of Approval	December 2020
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Lead Director	Karen Matthews-Shard
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Last Reviewed	November 2024
Next Review Date	November 2026
Risk and Resource Implications	Training costs
Associated Strategies and SOPs	CLIN 06 Consent Policy CLIN 13 Record Keeping CLIN 14 Health Record Management CLIN 50 Sepsis Policy CORP 11 Risk Management Strategy Policy IG 13 Collection and Recording of Client Data SOP GEN 23 Vital Signs and Observations Policy
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	Date	Changes made/comments	By whom
V1	Aug 2019	First draft of new policy	JMC
V1.1	Mar 2020	Review of Draft policy	Clinical Advisory Group
V1.2	Dec 2020	Review	Clinical Advisory Group
V1.3	Jan 2021	Update re Rebrand 2	CC
V1.4	Apr 2021	Added CHS brand	CC
V2.0	Mar 2023	Review and updated	Clinical Advisory Group
V3.0	Jan 2024	Rebrand	Clinical Advisory Group
V3.1	Nov 2024	Review and updated	Clinical Advisory Group

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1. Introduction

1.1 To ensure that every worker, that has direct client contact with patients / clients / service users, can undertake PEWS observations and understand the thresholds and triggers. The care plan will indicate if PEWS is used for community service users. The National Paediatric Early Warning System or PEWS allows for consistency in how deterioration in children is recognised.

2. Definitions

2.1 The National Paediatric Early Warning Score (PEWS) was introduced to improve communication of the deteriorating child, it is an objective assessment tool that uses a track and trigger score. This was developed by RCN, NHSE and RCPCH in 2018.

2.2 Paediatric Early warning Score tools are internationally used and therefore there are a number of PEWS tools available with no agreed consensus on which one is the optimal tool to use we consequently require you to familiarise yourself with the locally agreed PEWS scoring system on your first shift.

2.3 The PEWS has also been endorsed as the recommended early warning system to detect acute clinical illness/deterioration which could be due to sepsis in paediatric patients with an infection or at risk of infection.

2.4 Paediatric Early Warning Score (PEWS), first produced in June 2018, which advocates a system to standardise the assessment and response to acute illness.

2.5 The PEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Seven simple physiological parameters form the basis of the scoring system:

1. Respiration
2. Oxygen saturation
3. Systolic Blood Pressure
4. Pulse Rate
5. Level of consciousness or new confusion
6. Temperature
7. Capillary refill time, perfusion status e.g. cyanosis, pallor

2.6 Failure to recognise or act on signs that a patient is deteriorating is a key patient safety issue. It can result in missed opportunities to provide the necessary care to give the best possible chance of recovery and survival.

3. Roles & Responsibilities

3.1 The following table outlines the responsibilities of the key people involved in this Policy.

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.

Line Managers / Appropriate Others	Are responsible for: • ensuring that any relevant equipment is provided • ensuring the workers access training, supervision, and support, relevant to their roles and responsibilities monitoring compliance with this Policy.
Individual Workers	Must: • be aware of, and comply with, the Acacium Group PEWS policy • record any PEWS scores on relevant system/charts • take part in training, including attending updates so that they maintain their skills and are familiar with PEWS • keep a personal record of any training attended maintain an environment that minimises the risk of infection to clients.
Clinical Advisory Group (CAG)	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

4. General Guidelines

4.1 Assessment of risk

4.1.1 Assessment of risk and planning are integral to safe management of resuscitation and all workers will be expected to contribute to these processes. See the Acacium Group Clinical Risk Management Policy.

4.2 Consent

4.2.1 Whilst undertaking clinical observations, the worker providing care must make decisions based on the best interests of the client/patient. Carers and relatives are not in a position to make decisions based on the best interests of the client unless there is an LPA health and wellbeing though they may be consulted. See also the Acacium Group Consent Policy for Adults and Children.

5. PEWS Procedure

5.1 The National Paediatric Early Warning Score (PEWS) was introduced to improve communication of the deteriorating child, it is an objective assessment tool that uses a track and trigger score. Observations recorded on the Paediatric Early Warning Score (PEWS) include respiratory rate, heart rate, blood pressure, oxygen saturation, temperature, level of consciousness and capillary refill time. A non-physiological parameter which is scored is oxygen therapy.

5.2 What is PEWS

5.2.1 The **P**aediatric **E**arly **W**arning **S**ystem (PEWS) helps us identify patients who may be deteriorating by using clinical signs that are entered onto the observations chart. Once treatment is initiated it can also assist with assessing a patient's response to this treatment if the PEWS score improves – decreases.

5.2.2 Clinical signs fall outside of normal parameters for that age group – the higher the score the more deranged the signs.

5.2.3 Higher scores should prompt action to be taken and therefore supporting clinical judgement.

5.3 PEWS triggers and actions

5.3.1 Escalation plan if there is a nurse or parental concern about the clinical condition of the patient at any time consider escalating or placing a **2222 or 999** call regardless of the PEWS. If you are clinically concerned about your assessment of the child you should not rely solely on the PEWS score.

5.3.2 The scoring system may vary from Trust to Trust and we ask you familiarise yourself with the observations charts and PEWS scoring system at the beginning of your first shift.

Here is an example **scoring system below:**

	ESCALATION LEVEL	LOW (L)	MEDIUM (M)	HIGH (H)	EMERGENCY (E)
TRIGGER CRITERIA: Respond as per the highest level based on **CHANGE in ANY ONE** of these criteria	**Specific concern** (neurology, sepsis, or pre-existing risk factor)		**New** suspicion of sepsis	AVPU: Change to AVPU - V ' Responsive only to Voice' **or** **New suspicion of septic shock**	AVPU: Change to AVPU - P or U 'Responsive only to Pain' or 'Unresponsive' OR Abnormal pupillary response
	Clinical Intuition	Nurse/clinician concern that patient needs increased monitoring despite low PEWS	Nurse/clinician concern that patient needs a medical review irrespective of PEWS	Nurse/clinician concern that patient needs a 'Rapid Review' irrespective of PEWS	Nurse/clinician concern that patient needs emergency review for life-threatening situation
	Carer Question	Carer uses words that suggests the child needs increased monitoring or intervention despite the low PEWS	Carer uses words that suggests the child needs a clinical review irrespective of PEWS	Carer uses words that suggests the child needs a 'Rapid Review' irrespective of PEWS	Carer uses words that suggests the child has collapsed or significantly deteriorated
	Paediatric Early Warning Score	1-4	5-8	9-12	≥13
Communication & response (use ISBAR Framework)		Inform Nurse-in-charge	Review by Nurse-in-charge for potential escalation (and/or Outreach nurse or equivalent)	Immediate review by Nurse-in-charge for potential escalation	Immediate 2222 call: "Paediatric Medical Emergency" and review by Nurse-in-charge
Medical plan for stabilisation Structured medical plan to be documented including: 1. specific actions to be taken 2. expected outcome 3. outcome deadline 4. escalation if outcome not met by deadline.		Consider Medical Review by ST3+ or equivalent Bedside nurse to feed back plan to parents	Request Medical Review by ST3+ or equivalent Stabilisation plan to be considered Bedside nurse to feed back plan to parents	Call for 'Rapid Review': Medical incl. airway skills ST3+ or equivalent and outreach nurse (if available or equivalent) Stabilisation plan to be discussed with consultant Senior nurse to feed back plan to parents	Consultant informed urgently to confirm stabilisation plan Senior nurse to support and feedback to parents [In specialist environments rapid review can replace 2222 but only with prior agreement between consultant and nurse-in-charge]
Medical review timings		As agreed with medical team	Within 30 minutes	Within 15 minutes	Immediate
Minimal observations Repeated escalation if remaining in one level not required but ongoing plan must be clearly documented in notes.		Must reassess within 60 minutes (and then document ongoing plan)	Must reassess within 30 minutes (and then document ongoing plan) Continuous Oxygen Saturation monitoring needed	Every 30 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU	Every 15 minutes and continuous monitoring of Respiratory Rate / Oxygen Saturation / ECG GCS recording if change in AVPU or abnormal pupillary response
FOR EMERGENCY OR LIFE-THREATENING SITUATIONS: CALL 2222 AND STATE "PAEDIATRIC MEDICAL EMERGENCY"					

5.4 Why do we need PEWS if our patients are stable?

5.4.1 Children can deteriorate rapidly and unexpectedly and even the most experienced Nurse could overlook signs a patient condition is getting worse. PEWS provides a safeguard to ensure children, whose clinical signs are outside of the normal range, are reviewed in a timely manner.

5.4.2 A **P**aediatric **E**arly **W**arning **S**ystem (PEWS) should be calculated every time clinical observations are recorded on the observation chart and if triggers a score the correct action must be taken.

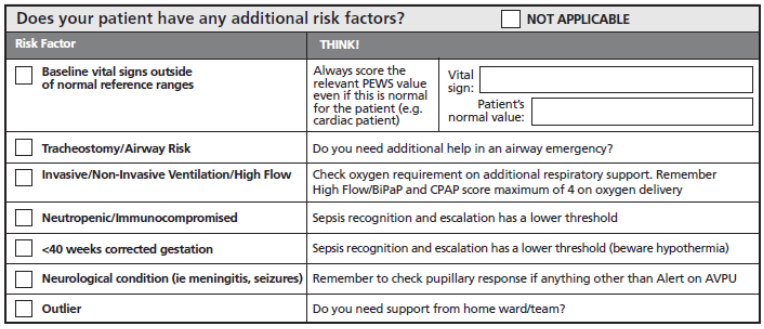
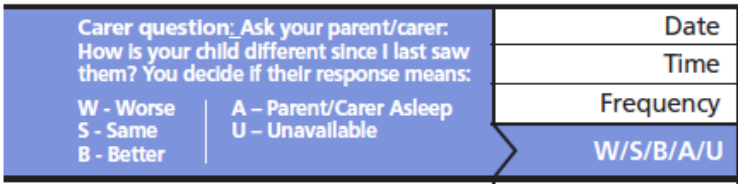
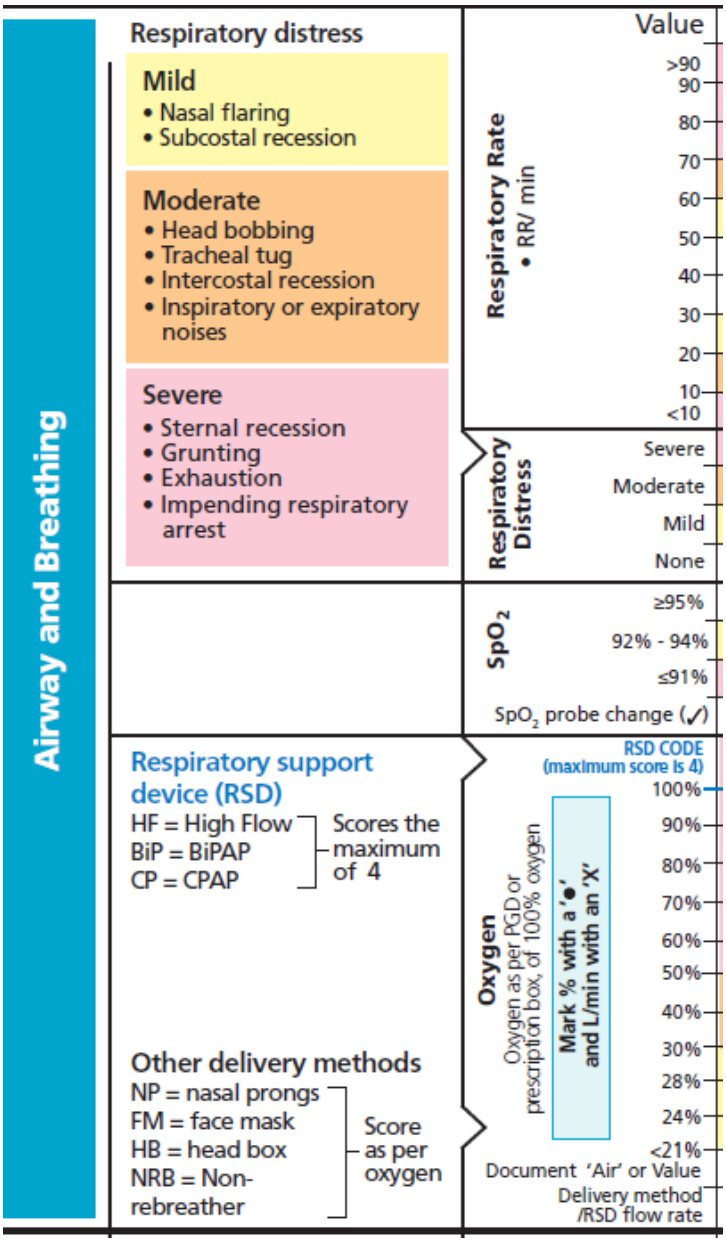
5.4.3 A full set of clinical observations must be recorded including Blood pressure.

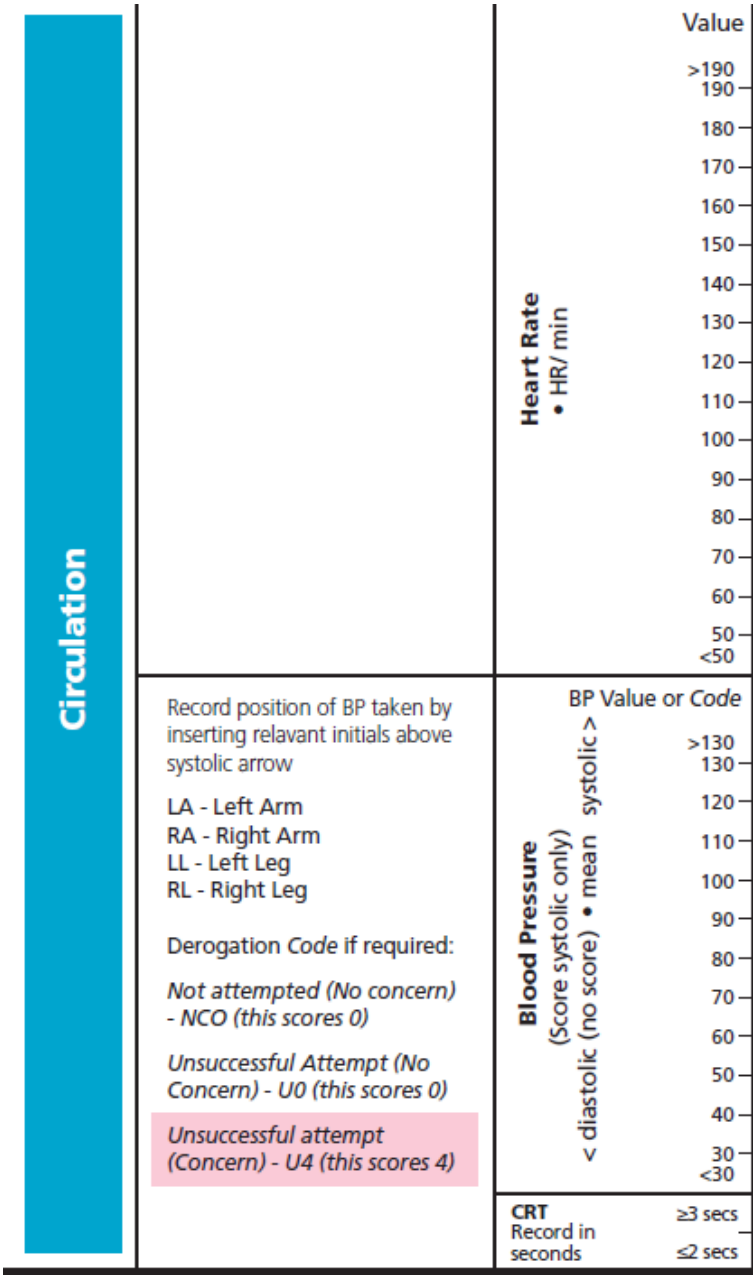
5.4.4 The AVPU (**A**lert, **V**oice, **P**ain, **U**nresponsive) is required with every set of observations.

5.4.5 If you are concerned about the patient's conscious state a Glasgow Coma Scale may be required.

5.4.6 PEWS is not there to replace clinical judgement but support it. If you are concerned about a patient's condition or PEWS score CALL FOR HELP

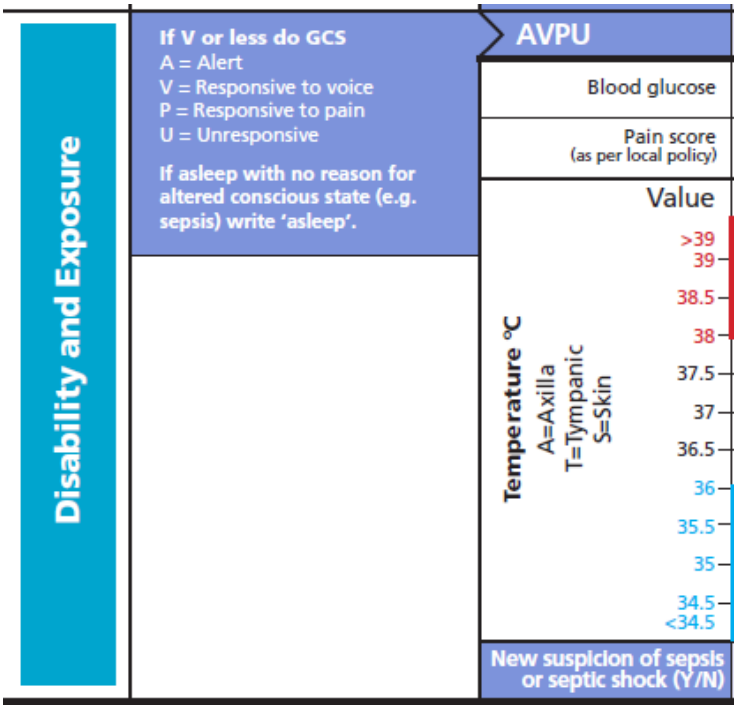
5.5 There are different elements to the new PEWS chart which was introduced in November 2023. The main difference is that parental views and clinical intuition is now included in the score. The table below goes through the individual elements.

 Does your patient have any additional risk factors? ☐ NOT APPLICABLE Risk Factor / THINK! ☐ Baseline vital signs outside of normal reference ranges — Always score the relevant PEWS value even if this is normal for the patient (e.g. cardiac patient) — Vital sign: ____ Patient's normal value: ____ ☐ Tracheostomy/Airway Risk — Do you need additional help in an airway emergency? ☐ Invasive/Non-Invasive Ventilation/High Flow — Check oxygen requirement on additional respiratory support. Remember High Flow/BiPaP and CPAP score maximum of 4 on oxygen delivery ☐ Neutropenic/Immunocompromised — Sepsis recognition and escalation has a lower threshold ☐ <40 weeks corrected gestation — Sepsis recognition and escalation has a lower threshold (beware hypothermia) ☐ Neurological condition (ie meningitis, seizures) — Remember to check pupillary response if anything other than Alert on AVPU ☐ Outlier — Do you need support from home ward/team?	This section is to identify any additional risk factors that need to be considered
 Carer question: Ask your parent/carer: How is your child different since I last saw them? You decide if their response means: W - Worse S - Same B - Better A – Parent/Carer Asleep U – Unavailable Date Time Frequency W/S/B/A/U	This section ensures that you ask the parent/guardian/carer about their opinion on the child's condition
 Airway and Breathing Respiratory distress Mild • Nasal flaring • Subcostal recession Moderate • Head bobbing • Tracheal tug • Intercostal recession • Inspiratory or expiratory noises Severe • Sternal recession • Grunting • Exhaustion • Impending respiratory arrest Respiratory support device (RSD) HF = High Flow BiP = BiPAP CP = CPAP Scores the maximum of 4 Other delivery methods NP = nasal prongs FM = face mask HB = head box NRB = Non-rebreather Score as per oxygen Value Respiratory Rate • RR/ min >90 90 80 70 60 50 40 30 20 10 <10 Respiratory Distress Severe Moderate Mild None SpO_2 ≥95% 92% - 94% ≤91% SpO_2 probe change (✓) RSD CODE (maximum score is 4) Oxygen Oxygen as per PGD or prescription box, of 100% oxygen Mark % with a '●' and L/min with an 'X' 100% 90% 80% 70% 60% 50% 40% 30% 28% 24% <21% Document 'Air' or Value Delivery method /RSD flow rate	This section is where you assess the child's airway and breathing status, the support they are requiring will influence the score.



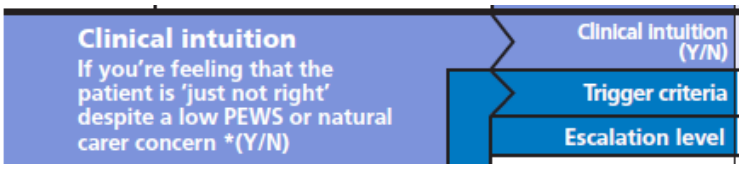
This section is where you assess the child's circulation and cardiac stability.

Note the 'Unsuccessful attempts' category is split into concern/no concern.

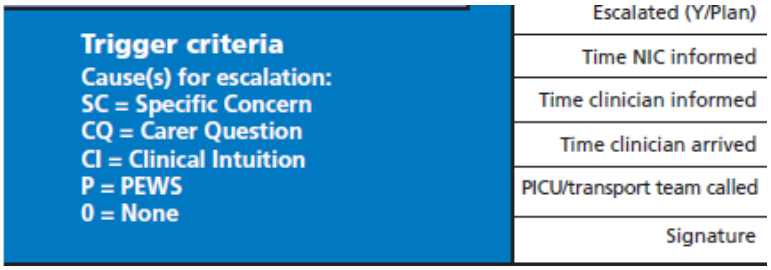


This section assesses the child's conscious level and temperature.

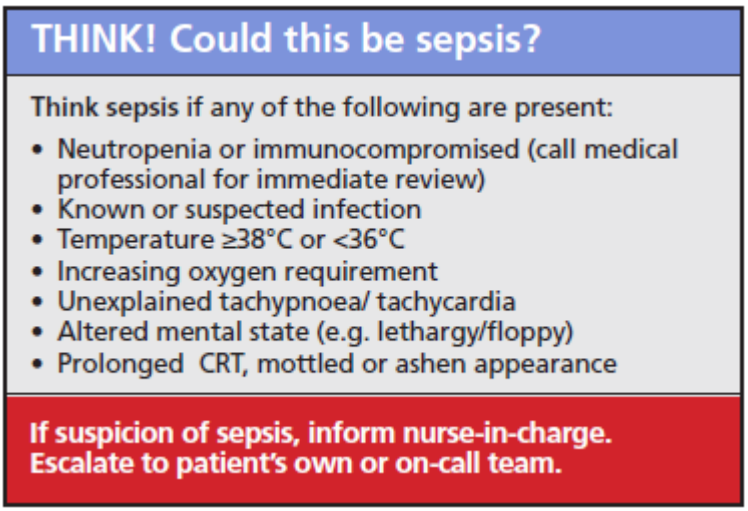
Note there is an additional section for if sepsis is indicated. – please also refer to the 'Think Sepsis' section at the bottom of this table.



This section is new – it documents your clinical intuition.



This section documents the trigger criteria.



Always think sepsis.

6. Martha's Rule

6.1 In response to this and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

6.2 The 3 proposed components of Martha's Rule are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient. This is where PEWS should be in place
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

7. PEWS

7.1 To facilitate a standardised and nationally unified approach to recording vital signs data, a colour-coded clinical chart (the PEWS chart – see Appendix D) was developed for use across the NHS to record routine clinical data and track a patient's clinical condition. This has been widely deployed.

7.2 The PEWS chart is specific to certain age ranges:

- 0-11 months
- 1-4 years
- 5-12 years
- 13 years and above

7.3 The purpose of this tracking system is to alert the clinical team to any untoward clinical deterioration and to monitor clinical recovery. The PEWS should determine the urgency and scale of the clinical response.

7.4 A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extremely the parameter varies from the norm. The score is then aggregated. The score is uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation.

7.5 This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart – the PEWS chart at Appendix D.

7.6 An elevated PEWS score does not provide a diagnosis; it helps identify a sick patient who requires urgent clinical review in a standardised way.

7.7 The Royal College of Physicians (RCP) recommend that sepsis should be considered in any patient with a PEWS score of 5 or more – 'think sepsis'. However, PEWS should be used alongside clinical judgement as a high score for some individuals, i.e. those at the end of their life may need to be interpreted differently.

8. Training

8.1 All workers with clinical responsibilities must participate in PEWS training to ensure that they are competent and have reached an agreed standard of proficiency. This is a core skill required upon commencement of employment. The training will be proportionate, and relevant, to the roles and responsibilities of each worker. This is a core skill for all acute settings.

8.2 It is the responsibility of the central training team to organise and publicise educational sessions, and to keep records of attendance.

8.3 All workers that care for children are expected to be proficient in undertaking clinical observations and understanding the early warning score thresholds.

8.4 The PEWS provides the basis for standardising the training and credentialing of all staff engaged in the care of patients in hospitals and the prehospital assessment of patients. We recommend that this should be extended to undergraduate education for all medical, nursing and allied healthcare professionals. The/PEWS is supported by an online training module and certification of completion of training (link to eLearning module).

9. Associated Policies / SOPs

Policies
CLIN 06 Consent Policy
CLIN 13 Record Keeping
CLIN 14 Health Record Management
CLIN 50 Sepsis Policy
CORP 11 Risk Management Strategy Policy
IG 13 Collection and Recording of Client Data

SOPs
SOP GEN 23 Vital Signs and Observations Policy

10. References

- Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017.
- NHS Improvement: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) 25th April 2018. Updated 16th January 2019. Alert Reference No NHS/PSA/RE/2018/003
- NHS England website. https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/
- NICE Guidelines Acutely ill adults in hospital: recognising and responding to deterioration; updated April 2019 https://www.nice.org.uk/guidance/cg50
- NEWS score systems that alert to deteriorating adult patients in hospital February 2020
- PEWS Education Pack (ihub.scot)

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla Part of Acacium Group	Ellea Nursing Part of Acacium Group	CHS Healthcare Part of Acacium Group
DUNN REGULATORY ASSOCIATES Part of Acacium Group		

Appendix B: Legislation

1. This Policy is based on the Resuscitation Council guidance for basic life support, legislation and national guidance, as set out in the table below.

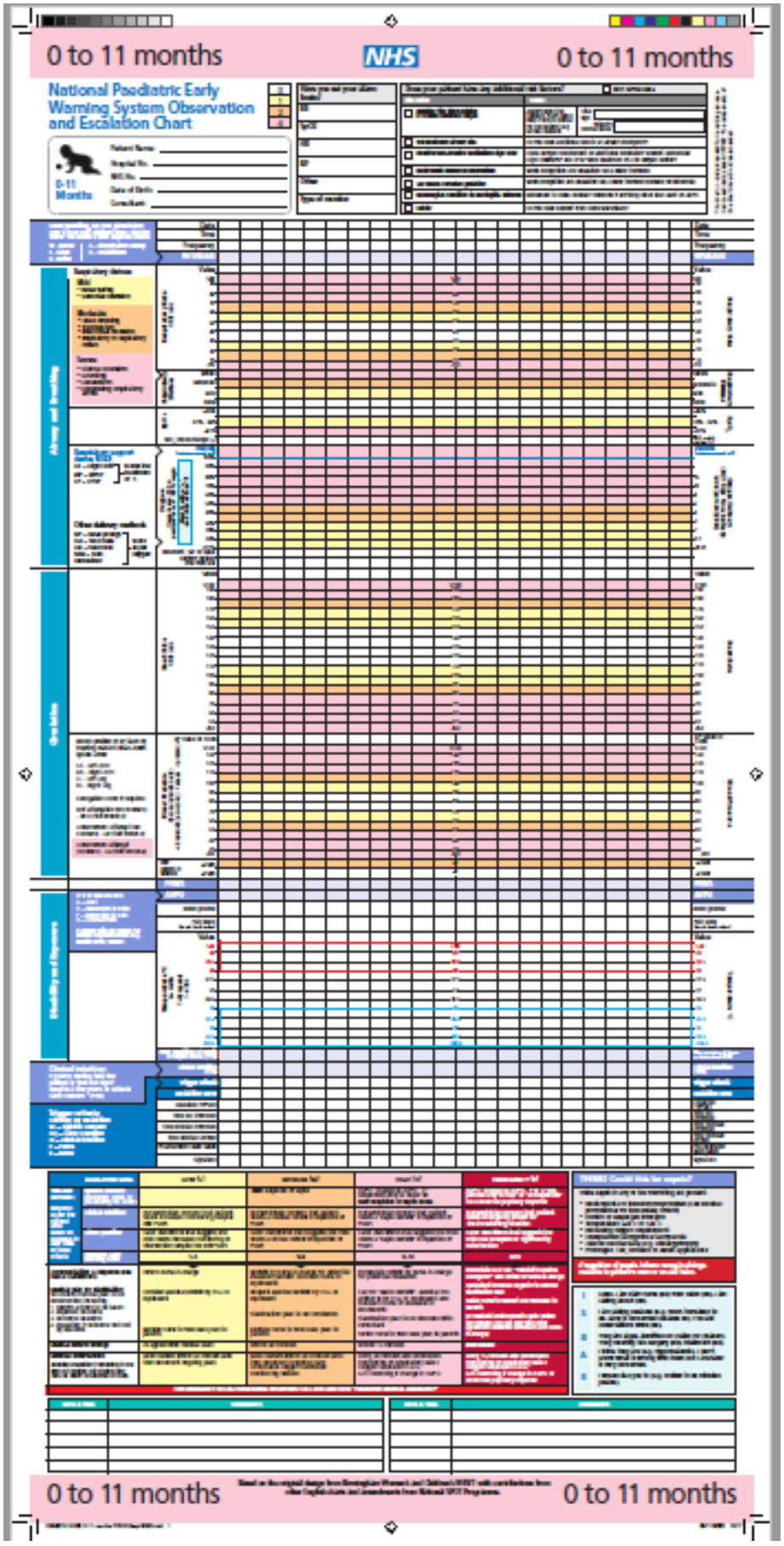
Act, National Policies, Guidance and Legislation	Explanation
Mental Capacity Act (2005) (MCA)	Provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. A client who does not have the necessary mental capacity to take a treatment decision must receive treatment that is in his / her best interests.
Human Rights Act (1998) (HRA)	All UK national legislation is underpinned by the Human Rights Act 1998, which came into full effect in 2000. The Human Rights Act has implications for providers of healthcare. Human rights are about ensuring that clients and workers are safe in healthcare settings, have their privacy and confidentiality safeguarded, and are treated with fairness, dignity and respect.
Health & Safety at Work Act 1974 (HASAWA)	Acacium Group has a duty to ensure the health and safety of its workers who in turn must ensure they make full use of the provisions made by Acacium Group for their health and safety.
The Social Care Act (2018)	The relevant part of the HSCA to this Policy is the introduction of the Care Quality Commission which is an integrated regulator for health and adult social care, bringing together existing health and social care regulators under one regulatory body. The CQC has new powers to ensure safe and high-quality services.
Control of Substances Hazardous to Health (COSHH)	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

2. Equality and diversity

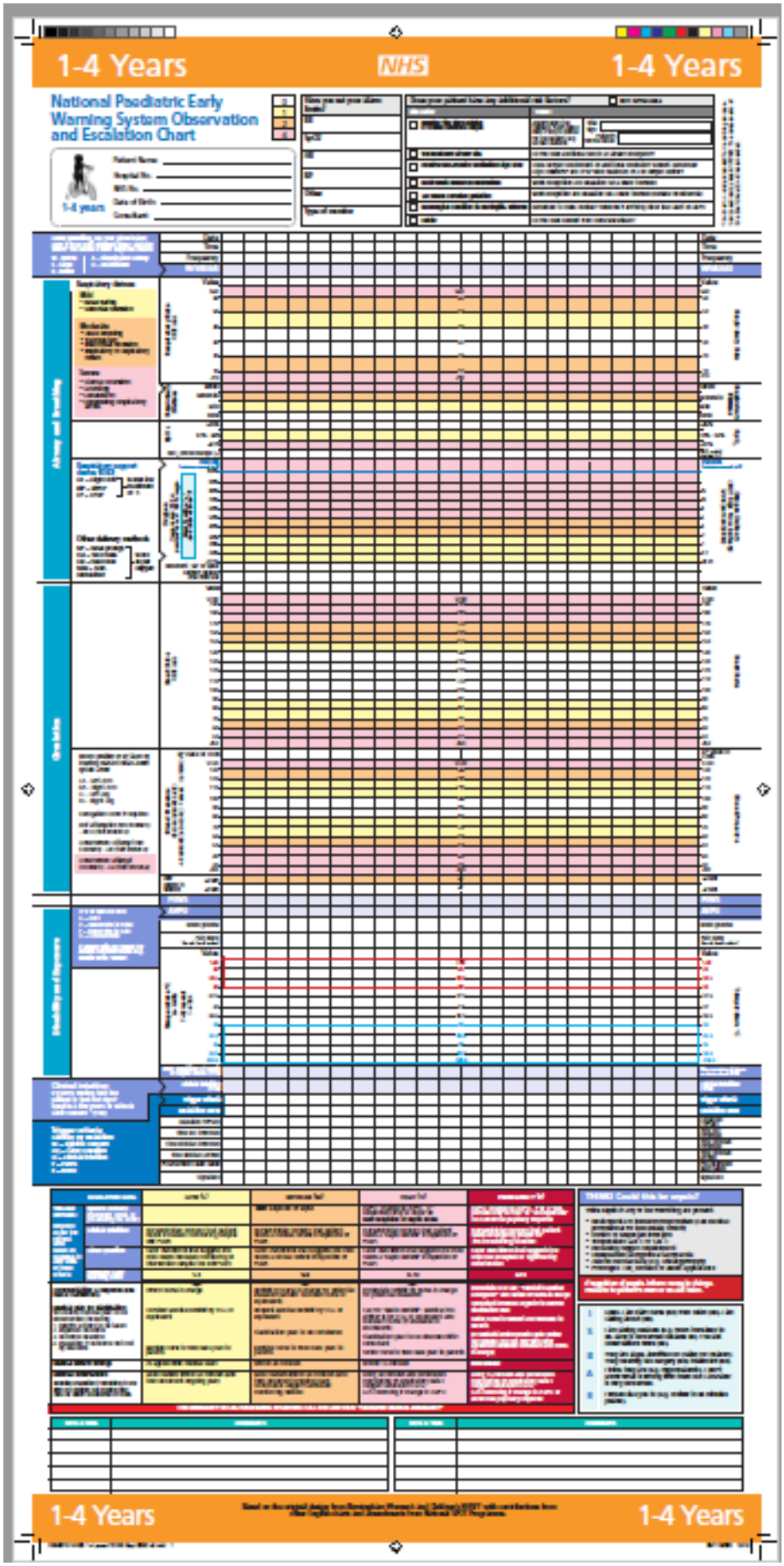
Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: PEWS Chart

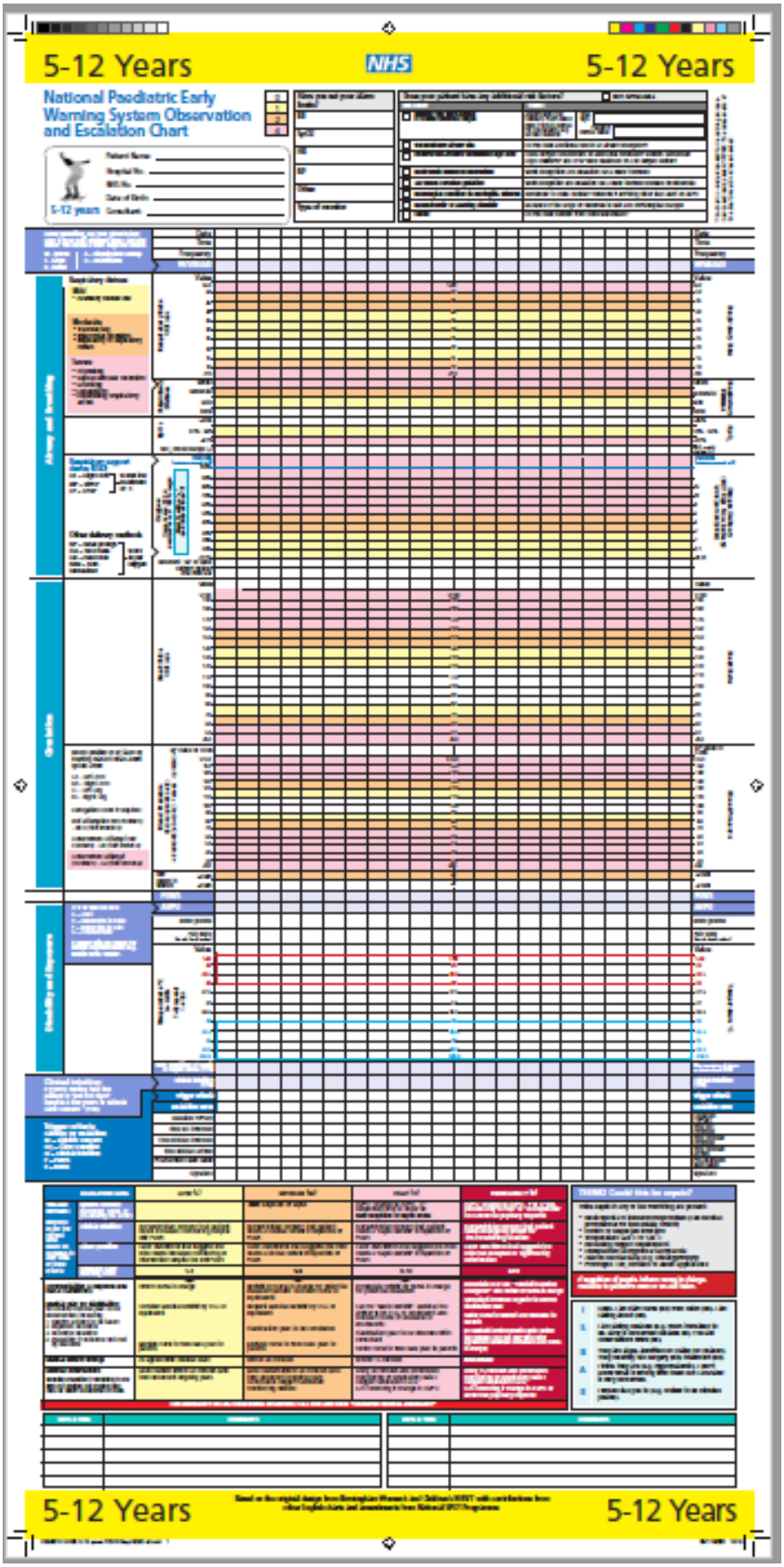
0-11 months



1-4 Years


1-4 Years
NHS
1-4 Years
National Paediatric Early Warning System Observation and Escalation Chart
1-4 years
1-4 Years
1-4 Years

5-12 years


5-12 Years
NHS
5-12 Years
National Paediatric Early Warning System Observation and Escalation Chart
5-12 years
5-12 Years
5-12 Years

13 years and above