Paediatric Advanced Warning Score Assessment Standards

Assessment standards for performing, monitoring, and reporting clinical observations in infants, children and young people.

This policy document has been produced by the Paediatric Critical Care Network within Yorkshire and the Humber region for practitioners using the PAWS tool.

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1.0 Background

- The performance of clinical observations is an important basic skill for all practitioners working with infants, children and young people (RCN 2007). These clinical observations provide information about the child's condition to aid diagnosis, guide treatment and evaluate trends in their clinical condition.

- There is increasing evidence from the adult literature to suggest that poor recognition of at-risk patients leads to deterioration in their condition and admission to intensive care (NPSA 2007, NCEPOD 2005, Vincent et al 2001, McGloin et al 1999).

- The importance of clinical observations is often overlooked and is sometimes seen as a task with a low status in the clinical setting (NPSA 2005). On occasion, the tasks have been handed down to health care assistants (practitioners), who may have inadequate training to undertake assessment or to recognise abnormal values.

- A recent report by the Confidential Enquiry into Maternal and Child Health, *Why children die: a pilot study 2006,* identified the need for health professionals to identify a sick child and promoted the awareness and use of advanced warning scoring systems.

- Early or advanced warning tools are designed to detect deterioration in the physiological status of patients and to alert staff to take appropriate action. Observations which are outside normal parameters are allocated a point, which are then added to give a score. This score provides a mechanism to trigger early intervention and initiation of treatment.

- In adult services key documents have been published to improve the assessment and recognition of seriously ill adults in hospital (NICE 2008, Department of Health 2008). These documents have recommended the use of advanced warning scores and provide a framework of competencies for assessing, recognising and responding to acutely ill patients. Whilst the widespread implementation of these tools has been recommended nationally in practice, Mc Gaughey et al (2007) demonstrated their poor methodological quality without any evidence of a reduction of overall mortality.

- A research study commissioned by the Paediatric Critical Care Network of the Yorkshire and Humber Strategic Health Authority to develop a paediatric advanced warning track and trigger tool (Paediatric Advance Warning Score – PAWS) identified deficiencies in the performance and recording of observations in children across the region (Morgan et al. unpublished 2008). These deficiencies have led to recommendations from clinicians and senior nurses

from the region to standardise assessment and observation of the sick child using clearly defined methods.

- Clinical observations are fundamental to ensuring the child's safety, early recognition of the deteriorating patient and to timely and effective treatment (CEMACH 2008).

- Recommendations to introduce the PAWS tool throughout the region include the requirement for standardised assessment and observation of the sick child.

1.1 Scope

Throughout this document, infants, children and young people are referred to as children.

This policy applies to children admitted to emergency departments and paediatric hospital wards within the Yorkshire and Humber region, with the exception of those receiving intensive care.

The policy outlines the standards to which clinical observations should be performed, recorded and reported in all children admitted to hospital or seen in the A&E department.

1.2 Aims to

- Clearly define the standards by which clinical observations on children are performed, recorded and reported.

- Ensure practice is evidenced based and consistent.

- Improve the recording and documentation of observations.

- Define the responsibilities of groups of staff in relation to recognising recording and responding to abnormal observations.

- Support the introduction and implementation of the Paediatric Advanced Warning Score (PAWS) within the network.

1.3 Limitations

This policy

- Refers to children (up to their 19th birthday) in paediatric hospital wards and emergency departments.

- Is not intended for young people admitted to adult hospital wards. On these wards the adult advanced warning tools should be used.

- Does not include assessment of the pre term infant or neonate.

- Is based on best available evidence and expert clinical opinion at the time of writing.

- It is not intended to replace the structured approach advocated by paediatric advanced life support algorithms (RCUK 2006, ALSG 2005).

2.0 Assessment

Assessment of health involves recording of both clinical observations (heart/pulse rate, respirations, temperature and blood pressure) and broader observations of visual inspection (general appearance), palpation (touch) and olfactory stimulus (smell) (RCN 2007). In addition the assessment of health should include listening, communicating (observing both verbal and non verbal cues), and noting the child's interaction and reaction to its physical surroundings (Aylott 2006). This includes taking note of the views of parents/ carers.

2.1 Standards for physiological observations

All children admitted to hospital should have a full assessment of the following clinical observations within 1 hour of admission:-

- Temperature
- Heart Rate
- Capillary Refill Time
- Oxygen saturations (in air or oxygen)
- Respiratory rate
- Blood pressure
- Neurological status (AVPU)
- PAWS score

Acutely ill children require an initial assessment of the above observations by a qualified nurse. The frequency of these observations should increase if their abnormal physiological observation highlights a problem and demands an action (see section 5.0 PAWS assessment tool).

It is recommended that assessment of the child is made at least 12 hourly. The only exceptions to this are those children who have entered a palliative care pathway and whose medical staff and parents have agreed to discontinue observations because they are too intrusive.

Where children are admitted for conditions and procedures supported by local or national protocols such as blood transfusions, head injury or post operative management, (including epidural / opiate infusions), the nurse should perform observations at the intervals described within the protocol.

Children receiving the following interventions will require more frequent observations:

- Oxygen therapy.
- Continuous monitoring.
- Certain drug therapies.
- Post procedure for example liver biopsy.

After admission, as a minimum, children who are not included in any of the above groups and whose initial PAW score of 2 or less must have temperature, pulse, respiratory rate and an assessment of conscious level performed and documented 12 hourly. If any values score a PAW score of 1 or more, a full set of observations must be performed.

The frequency and type of observations should be agreed in consultation between the senior nurse and admitting doctor recorded on the observation chart and in the notes. The frequency of physiological observations should be reviewed at each shift change by the senior nurse unless the child is admitted for a procedure supported by a protocol which describes the frequency of observations. Any changes must be documented on the observation chart and in the notes.

A child's observations must be reviewed at:
- Handover
- Transfer to another ward
- Transfer to another hospital / organisation

In order to evaluate trends and guide treatment.

3.0 Competency of assessment

All registered nurses, nursing students and health care assistants (practitioners) who perform observations in children, should be trained and competent. National Vocational Qualification (NVQ) level 3 training or equivalent competency based training will be required for the non registered workforce. All registered staff should be able to demonstrate competency in practice criteria (see appendix) and the use of PAWS tool.

Practitioners are expected to take appropriate action (see section 5.0) in response to their findings.

Where continuous electrocardiogram (ECG) and pulse oximetry are used practitioners must be trained and competent in their use and know the limitations and risks associated with these devices.

All staff undertaking observations must have training in the use of the PAWS assessment tool.

Registered nurses must comply with NMC standards for maintaining their knowledge and skills (NMC 2008).

4.0 Assessing and performing observations

Prior to performing the child's observations their psychological needs should be recognised and appropriate action taken.

A systematic process must be used when performing observations using clearly defined methods.

Visual observation, palpation (touch), listening and communication, are used when assessing and measuring observations. This includes eliciting and taking note of the views of parents / carers.

Clear explanation should be given to parents / carers and where possible the child, concerning performance of observations and the data collected.

The child and /or parent /carer should consent to the performance and measurement of observations. Where a child under 16 is unaccompanied, local policies should be followed.

Where appropriate, the child and parent/ carer should assist the practitioner in performing and measuring of observations.

The child must be positioned correctly and comfortably prior to the procedure.

Actions to restrain the child must comply with best practice guidance.

4.1 Observations

Respiratory rate

- Respirations must be counted for one minute.
- The pattern, effort and rate of breathing must be observed.
- Skin colour must be observed.
- Abdominal movements must be counted for children less than seven years of age because these children are predominately abdominal breathers.
- Signs of respiratory distress e.g. nasal flaring, grunting, wheezing, dyspnoea, recession, the use of accessory and intercostal muscles, chest shape and movement should be noted by looking and listening.
- If apnoea monitoring is in use the nurse must respond immediately when an alarm sounds and check the child’s respiratory rate.
- Respiratory rates must not be recorded from monitoring equipment.

Saturation monitoring

- Oxygen saturation monitors must not be used for assessment of heart rates.
- The practitioner must understand the use and limitations of using oxygen saturation monitoring.
- The oxygen saturations may be inaccurate in children with poor peripheral perfusion.

- A child who is wriggling or moving may cause movement artefact which can render measurements inaccurate.

- When using continuous oxygen saturation monitoring alarm parameters must be set and checked each shift. The nurse must respond to an alarm immediately and check to identify the cause.

- Disposable probes are for single use only.

- Probe sites must be checked and changed at least four hourly for pressure sores if using continuous oxygen saturation monitoring.

Heart Rate

- Where possible ensure the child is settled before measuring the heart rate.

- The heart rate can be measured by:
  Palpation of a central or peripheral pulse **or**
  Auscultation of the heart with a stethoscope.

- Heart rates must be counted for one minute.

- The pulse rate should be consistent with the apex beat.

- The heart rate must be auscultated:
  In infant's and children less than two years of age.
  If a peripheral pulse cannot be palpated (felt).

- When using an electro cardio gram (ECG) monitor for continuous heart rate monitoring the electronic data should be cross checked by auscultation or palpation at least 4 hourly, or immediately if level of consciousness alters.

- Electrodes and leads must be placed in an appropriate position and changed regularly in order to minimise the risk of damage to the infant child's skin.

- Alarm limits should be set and checked each shift.

- Monitoring should not preclude manual heart rate measurement.

Blood pressure

- Every child must have a blood pressure undertaken on admission to hospital. If the results of this are within the normal range, the frequency of further assessment will depend on the reason for admission and severity of illness.

- The right arm should be used for measuring blood pressure as the pressure is generally 5mmHg greater than the left, but when this is not possible the child's lower leg can be used.

- The arm should be well supported and positioned at the level of the heart.

- If the forearm is higher than the heart then an underestimation will occur. Overestimation will occur if the forearm is lower than the heart (Lockwood et al 2004).
- The correct size of the cuff is necessary for gaining an accurate recording.
    - The cuff should be wide enough to cover 2/3 of the upper arm circumference.
    - Cuffs too narrow results in overestimation whilst too large results in underestimation.
    - The cuff bladder length should cover 80 - 100% of the circumference of the arm.
      (Mitchell et al 2007, Lockwood et al 2004, Roccella et al 2004, Arafat, Mattoo, 1999).

- The cuff must be applied so that
    - Its lower border is two finger breadths above the elbow crease, except in infants.
    - The arrow on the cuff lines up with the brachial pulse.

- Sucking, crying and eating can influence the blood pressure measurements and should be noted.

- Movement can affect the accuracy of automated blood pressure monitors.

- The first reading of automated monitors should be disregarded, allow one to two minutes before repeating the measurement (Blood Pressure Association).

- Blood pressure readings from an electronic non invasive device are less accurate at either end of the high / low spectrum. If a blood pressure reading is consistently high / low on an automated monitor over a period of time it should be re-measured using a manual non-mercury sphygmanometer.

- Manual blood pressure should be documented exactly the same as any other blood pressure with manual written in the column, to distinguish between the two.

Capillary refill time

- Measuring capillary refill time is recommended when assessing the circulation of sick children (RCUK 2006, Steiner et al 2004). The

capillary refill time is the rate at which blood returns to the capillary bed after it has been compressed digitally.

- The capillary refill time should be assessed using the skin of the forehead, chest (sternum) or peripheral digits. The forehead and sternum are the preferred sites.

- If peripheral digits are used, the practitioner should elevate the hand to the level of the heart.

- Pressure should be applied for five seconds then released.

- The practitioner should count the time in seconds that it takes for the skin to return to its normal colour.

- The skin normally re-perfuses in less than two seconds in children and less than three in neonates.

- The choice of site used to assess capillary refill time the time taken for the skin to return to its normal colour should be documented.

Temperature

- A child's temperature must be taken on admission to hospital and at least 12 hourly or more frequently as clinically indicated unless overridden by local protocol.

- If the temperature is high on admission the measurement must be reassessed 1 hour following antipyretic therapy and then hourly until it is within the normal range.

- A child's temperature should be assessed if the child feels hot or cold to touch.

- The temperature must be measured at least every 4 hours if the child is receiving IV therapy (drug or fluid), has a potential site of infection such as chest drain, wound etc., or has a central line in situ.

- There must be clear guidance for practitioners on the accurate use of the equipment available in each organisation for measurement of temperature in children.

- Mercury thermometers are hazardous and should not be used.

- Oral and rectal routes should not be routinely used to measure the body temperature in children aged between 0 – 5 years (NICE 2007). A tympanic membrane thermometer or axilla thermometer or electronic / chemical dot thermometer should routinely be used.

- In infants under the age of four weeks axillary temperature should be measured using an electronic thermometer in the axilla.

- The thermometer should be left in position for sufficient time to gain an accurate reading according to the manufacturer's instructions.

Neurological assessment

- The AVPU is a coma score. As part of the initial assessment on admission of a child to the ward the practitioner should assess if the child is:
  A alert.
  V responding to verbal stimuli.
  P responding only to pain.
  U or unresponsive.

- The child must be woken to perform this observation to ensure an assessment of their conscious level is made.

- If the child does not respond to verbal stimulation or touch in infants, the practitioner must assess the child's airway, breathing and circulation and call for assistance.

- A formal Glasgow Coma Score should be undertaken for any child who is not alert unless there is evidence that this is the child's normal condition.

- Neurological assessment of a child should be undertaken using the policy for *The Assessment of level of consciousness in children* (PCC Network regional guidelines).

- If the child requires neurological assessment, this must be performed by two nurses at the handover of shifts and whenever the patient is transferred to a different ward / organisation to ensure an agreed level of consciousness has been determined and agreed.

5.0 Policy for the use of Paediatric Acute Warning Score (PAWS)

Observations and PAW scores do not over-ride clinical experience of staff or parental concerns. If you or the child's parent are worried that a child is not well, act as appropriate for the severity of the concern.

If, on performing your observations any of the parameters score **10** (**RED**)

DO NOT COMPLETE YOUR OBSERVATIONS AT THIS POINT.
CALL FOR HELP, CHECK ABC

and then complete observations.

PAWS can be used in two ways:

1. As a triggering system, where a single score highlights a problem and demands an action.

2. As a tracking system, where scores over a period of time can be used to follow a child's progress or response to treatment.

5.1 Triggering

Actions depend on the original set of observations.

PAWS 0-2

The patient is probably stable

- Continue with routine care.
- Perform observations as per guidelines or as directed by senior staff, with a maximum interval of 12 hourly.

PAWS 3-5

The patient may be unwell or beginning to deteriorate.

- Notify nurse in charge.
- Document PAWS calls, reviews, interventions and actions.
- To be reviewed by ward doctor or advanced nurse practitioner within 1 hour.
- Increase the frequency of observations to hourly until the patient has been reviewed by the doctor and further instructions have been given.
- If previous observations did not include oxygen saturations or capillary refill time, perform now and re-calculate PAWS.

If the patient is scoring because:
  - Pulse rate is elevated or
  - Capillary refill time is prolonged

then measure and record the blood pressure.

Any patient who is not alert must have a formal assessment of their conscious level performed.

PAWS 6-9

The child is probably unwell and may need urgent treatment.

- Notify nurse in charge.
- Document PAWS calls, reviews, interventions and actions.
- Urgent medical review by middle grade or consultant, within 15 minutes.
- Continue full observations at least every hour.
- Start continuous monitoring – oxygen saturations, ECG and (if indicated) regular NIBP.
- Review medication (analgesia, antipyretics, oxygen)

PAWS 10 or more

The child may be about to arrest.

- Call for help.
- Review Airway, Breathing and Circulation and treat as necessary.
- Urgent medical review by middle grade or consultant, within 15 minutes.
- Crash call - 2222.
- Start continuous monitoring – SpO_2 ECG and regular NIBP.
- Start / increase oxygen therapy

5.2 Tracking

PAWS can also be used to anticipate deterioration in a child who is already under your care. If a prior set of observations has been performed then the PAWS must be compared to the last set of values.

A rising PAWS suggests that the child's condition is deteriorating and an increase of PAWS of 2 or more points will put the child into the next score group. For example, the child whose admission score is 3 and who scores 5 points an hour later should be treated as if their score was 6 or more.

5.3 Exceptions

Some children have pre-existing abnormalities that make one or more of their observations fall outside the normal range (e.g. A low saturation in a child with cyanotic congenital heart disease or abnormal neurology in a child with previous brain injury).

The decision that an abnormal observation is normal for that child must be made:

- by the admitting doctor or a senior nurse (Band 5 or above)
- based on their knowledge of the child's medical problem and physiology
- documented on the chart.

The doctor or senior nurse completing the exception area of the chart must document the pre-existing condition that is the cause of the abnormality, and decide on two sets of upper and lower limits for the variable concerned.

- The first of these limits should represent a threshold at which he/she would expect to institute a change in the child's treatment (e.g. increase oxygen concentration, review medications, start of IV fluids) and will be given a PAWS value of 3.
- The second limit should represent the values at which urgent review of the child should become necessary and will be given a PAWS value of 10.

Observation	Normal for this child	Lower limit 1* PAWS=3	Upper limit 1 PAWS=3	Lower limit 2* PAWS=10	Upper Limit 2 PAWS=10	Condition	Date	Time	initial

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Appendix

Practice criteria

Registered nurses, nursing students and health care assistants will have undergone theoretical and practical training in the following:-

- Legal and professional issues relating to accountability, confidentiality, equality and diversity.
- Anatomy and physiology.
- Normal / abnormal parameters for clinical observations in children.
- Methods of assessing and measuring observations in children.
- Obtaining consent for the measurement of observations.
- Preparing the child.
- Therapeutic holding.
- Maintaining privacy and dignity during assessment and measurement of observations.
- Communicating with the child and family and other health personnel.
- Indicators of deterioration.
- Charting recording and reporting of clinical observations.
- Record keeping.
- Medical devices indications for use, limitations. Alarms and safety.
- Paediatric advanced warning score.
- Adverse incident reporting.
- Infection prevention and control.

PAWS

Paediatric Advanced Warning Score

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1. Perform initial observations TPR, SpO2, CRT, BP, AVPU. Score each observation

0	1	3	10

2. Add Cumulative score

3. Suggested Action

Respiratory Rate (per minute)

	≤ 8	9- 10	11- 12	13- 14	15- 16	17- 18	19- 20	21- 22	23- 24	25- 26	27- 28	29- 30	31- 32	33- 34	35- 36	37- 38	39- 40	41- 42	43- 44	45- 46	47- 48	49- 50	51- 52	53- 54	55- 56	57- 58	59- 60	61- 62	63- 64+
1 - 11 months																													
1 - 2 years																													
3 - 4 years																													
5 - 11 years																													
12 + years																													

Either:

Oxygen Saturation In Air

(see notes below)

Greater than 94%	90 - 94%	86 - 89%	less than 86%

Or:

Oxygen Saturation in Any Oxygen

(see notes below)

Greater than 94%	90 - 94%	less than 90%

Heart Rate (bpm)

	≤ 50	51- 55	56- 60	61- 65	66- 70	71- 75	76- 80	81- 85	86- 90	91- 95	96- 100	101- 105	106- 110	111- 115	116- 120	121- 125	126- 130	131- 135	136- 140	141- 145	146- 150	151- 155	156- 160	161- 165	166- 170	171- 175	176- 180	181- 185	186- 200+
1 - 11 months																													
1 - 2 years																													
3 - 4 years																													
5 - 11 years																													
12 + years																													

Systolic Blood Pressure

	≤ 50	51- 55	56- 60	61- 65	66- 70	71- 75	76- 80	81- 85	86- 90	91- 95	96- 100	101- 105	106- 110	111- 115	116- 120	121- 125	126- 130	131- 135	136- 140	141- 145	146- 150	151- 155	156- 160	161- 165	166- 170	171- 175	176- 180	181- 185	186- 200+
1 - 11 months																													
1 - 2 years																													
3 - 4 years																													
5 - 11 years																													
12 + years																													

Capillary Refill Time (seconds)

Less than or equal to 2 seconds	Greater than 2 but less than 4 seconds	4+ seconds

Temperature (°C)

Less than 35	35 - 37.9	More than 37.9

Neurological Status (AVPU)

Alert (A)	Responds to verbal stimuli (V)	Responds to painful stimuli (P)	Unresponsive (U)

Score 0-2

Continue observations as per protocol or 12hrly RR, HR,temp, AVPU.

Score 3 - 5

Notify nurse in charge. Review by doctor. Increase frequency of observations to hourly until doctor review Include SpO2 and CRT and recalculate PAWS

Score 6 - 9

Notify nurse in charge.
Seek urgent medical review
Perform fullobservations hourly RR ,HR, temp, BP, AVPU, SpO2 and CRT.
Start continuous monitoring ECG, SpO2 , NIBP
Review medication (O2, analgesia, antipyretics)

Score 10 or greater

URGENT MEDICAL REVIEW
CALL FOR HELP
Review ABC -treat as necessary
CRASH CALL 2222
Start continuous monitoring
Start / increase O2 therapy.

NOTES:

1. Oxygen saturations refer to patients without known cyanotic disease
2. Record oxygen saturations in AIR or Oxygen as appropriate. **DO NOT** stop Oxygen therapy to record oxygen saturation in Air.
3. If oxygen saturation is less then 94% increase oxygen flow.

TOTAL:

Your clinical judgment is paramount. PERI-ARREST situations DO NOT require a PAWS score. If you are in any doubt, seek senior support / medical review