

PRESENTATION

INITIAL
ASSESSMENT

SCORE

NURSING INSTRUCTIONS

Pediatric patient
age ≤ 18 years
admitted as
inpatient

Nurse to calculate PEWS
by assessing¹ pediatric
patient’s:

- Behavior
- Cardiovascular system
- Respiratory system

PEWS
0-2

Reassess and calculate score every 4 hours

PEWS
3-4

- Consult with another RN to confirm score
- Notify Charge RN
- Reassess and calculate score every 2 hours

PEWS
5

- Consult with Charge RN and PICU Resource RN to confirm score
- Notify:
 - In-house 1st Call Provider from primary service
 - Pediatric MERIT²
- Perform intervention(s) as ordered
- Reassess and calculate score every 1 hour

PEWS ≥ 6 **or**
a score of 3 in any single category

- Immediate consult with Charge RN and PICU Resource RN to confirm score
- Notify:
 - Pediatric MERIT²
 - In-house 1st Call Provider from primary service
- Perform intervention(s) as ordered
- Reassess and calculate score every 30 minutes

PEWS = Pediatric Early Warning Score
PICU = Pediatric Intensive Care Unit

¹ See [Appendix A](#) for Modified PEWS tool. Score should be documented in the patient’s medical record.
² For patients on G9, call 832-748-6478. For all other patients, call 713-792-7090.

APPENDIX A: Modified PEWS Tool

	Score ¹			
	0	1	2	3
Behavior	<ul style="list-style-type: none">• Playing• Appropriate	<ul style="list-style-type: none">• Irritable, but consolable	<ul style="list-style-type: none">• Irritated, but not consolable	<ul style="list-style-type: none">• Lethargic• Confused• Reduced response to pain
Cardiovascular System:				
Rate	<ul style="list-style-type: none">• Within normal parameters for age	<ul style="list-style-type: none">• Tachycardia < 20 above normal for age	<ul style="list-style-type: none">• Tachycardia 20-29 above normal for age	<ul style="list-style-type: none">• Tachycardia ≥ 30 above or bradycardia ≥ 10 below normal for age
Color	<ul style="list-style-type: none">• Pink	<ul style="list-style-type: none">• Pale or dusky	<ul style="list-style-type: none">• Mottled	<ul style="list-style-type: none">• Gray
Perfusion	<ul style="list-style-type: none">• Capillary refill 1-2 seconds	<ul style="list-style-type: none">• Capillary refill 3 seconds	<ul style="list-style-type: none">• Capillary refill 4 seconds	<ul style="list-style-type: none">• Capillary refill ≥ 5 seconds
Respiratory System:				
Rate	<ul style="list-style-type: none">• Within normal parameters for age	<ul style="list-style-type: none">• Tachypnea 10-19 above normal parameters for age	<ul style="list-style-type: none">• Tachypnea ≥ 20 above normal parameters for age with retractions	<ul style="list-style-type: none">• Bradypnea ≥ 5 below normal parameters for age with retractions
Effort	<ul style="list-style-type: none">• No retractions	<ul style="list-style-type: none">• Mild retractions/accessory muscle use	<ul style="list-style-type: none">• Moderate retractions/accessory muscle use (including tracheal tugging)	<ul style="list-style-type: none">• Severe retractions/accessory muscle use (including tracheal tugging) and grunting
Oxygen	<ul style="list-style-type: none">• N/A	<ul style="list-style-type: none">• Oxygen required to maintain normal² oxygen saturation<ul style="list-style-type: none">◦ Fraction of inspired oxygen (FiO₂) 24-39%◦ 2 L/minute of oxygen• Any assisted ventilation³ or initiation of oxygen	<ul style="list-style-type: none">• Oxygen required to maintain normal² oxygen saturation<ul style="list-style-type: none">◦ FiO₂ 40-49%◦ Oxygen ≥ 3 L/minute	<ul style="list-style-type: none">• Oxygen required to maintain normal² oxygen saturation<ul style="list-style-type: none">◦ FiO₂ ≥ 50%

¹ Add 2 extra points if patient requires frequent interventions (e.g., suctioning, positioning, change in oxygen needs, multiple IV attempts required, **or** every 15-minute or continuous nebulized treatments) **or** has persistent post-op vomiting

² As defined in patient’s orders

³ Includes home bilevel positive airway pressure (BiPAP)/continuous positive airway pressure (CPAP) or home ventilator at baseline settings

Department of Clinical Effectiveness V5
Approved by the Executive Committee of the Medical Staff on 08/20/2024

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS

- Akre, M., Finkelstein, M., Erickson, M., Liu, M., Vanderbilt, L., & Billman, G. (2010). Sensitivity of the Pediatric Early Warning Score to identify patient deterioration. *Pediatrics*, 125(4), e763-e769. <https://doi.org/10.1542/peds.2009-0338>
- Chapman, S. M., & Maconochie, I. K. (2019). Early warning scores in paediatrics: An overview. *Archives of Disease in Childhood*, 104(4), 395-399. <https://doi.org/10.1136/archdischild-2018-314807>
- Fraser, D. D., Singh, R. N., & Frewen, T. (2006). The PEWS score: Potential calling criteria for critical care response teams in children's hospitals. *Journal of Critical Care*, 21(3), 278-279. <https://doi.org/10.1016/j.jcrc.2006.06.006>
- Mandell, I. M., Bynum, F., Marshall, L., Bart, R., Gold, J. I., & Rubin, S. (2015). Pediatric Early Warning Score and unplanned readmission to the pediatric intensive care unit. *Journal of Critical Care*, 30(5), 1090-1095. <https://doi.org/10.1016/j.jcrc.2015.06.019>
- Monaghan, A. (2005). Detecting and managing deterioration in children. *Paediatric Nursing*, 17(1), 32-35. Retrieved from <https://www.proquest.com/scholarly-journals/detecting-managing-deterioration-children/docview/218880723/se-2>
- Skaletzky, S. M., Raszynski, A., & Totapally, B. R. (2012). Validation of a modified Pediatric Early Warning System Score: A retrospective case-control study. *Clinical Pediatrics*, 51(5), 431-435. <https://doi.org/10.1177/0009922811430342>
- Soeteman, M., Kappen, T. H., van Engelen, M., Marcelis, M., Kilsdonk, E., van den Heuvel-Eibrink, M. M., . . . van Asperen, R. M. W. (2023). Validation of a modified bedside Pediatric Early Warning System score for detection of clinical deterioration in hospitalized pediatric oncology patients: A prospective cohort study. *Pediatric Blood & Cancer*, 70(1), e30036. <https://doi.org/10.1002/pbc.30036>
- Soeteman, M., Lekkerkerker, C. W., Kappen, T. H., Tissing, W. J., Nieuwenhuis, E. E., & Wösten-van Asperen, R. M. (2022). The predictive performance and impact of pediatric early warning systems in hospitalized pediatric oncology patients: A systematic review. *Pediatric Blood & Cancer*, 69(5), e29636. <https://doi.org/10.1002/pbc.29636>

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DEVELOPMENT CREDITS

This practice consensus statement is based on majority opinion of the Pediatric experts at the University of Texas MD Anderson Cancer Center for the patient population. These experts included:

Core Development Team Leads

Shehla Razvi, MD (Pediatrics)
Jennifer Rea, MSN, RN, CPHON (Nursing)

Workgroup Members

Ali Haider Ahmad, DO (Pediatrics)
Wendy Garcia, BS♦
Mary Katherine Gardner, MSN, APRN (Pediatrics)
Rodrigo Mejia, MD (Pediatrics)
Jessica Morrow, BS, RN (Nursing)
Demetrios Petropoulos, MD (Pediatrics)
Jaison V. Philip, BSN, RN (Nursing-Pediatrics)
Maritza Salazar-Abshire, MEd, RN (Nursing Education)
Janet Smith, MSN, RN (Nursing)
Mary Lou Warren, DNP, APRN, CNS-CC♦

♦Clinical Effectiveness Development Team