Document ID 00290

Children's Early Warning Tool (CEWT), Use of
Children's Health Services

Custodian/Review Officer: Patient Safety and Quality Unit

Version no: 1.0

Applicable To: All Clinical CHS staff

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Authority: Children's Health Services

Approving Officer: Chief Operating Officer

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Signature

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Accreditation References: EQuIP 5 criteria: 1.1.1, 1.1.8, 2.1.1.

1. Purpose

Early recognition of clinical deterioration, followed by prompt and effective action, can minimise the occurrence of adverse events and may mean that a lower level of intervention is required to stabilise patients. [1,2]

Ensuring that patients whose condition deteriorates in hospital receive appropriate and timely care requires an approach that focuses on the needs of the patient across the complex systems that underpin the delivery of health care. This includes:

- Measurement and documentation of observations
- Escalation of care in response to recognition and deterioration via early warning and response systems (CEWT)
- Clinical communication
- Accurate documentation of CEWT on an age appropriate form
- Appropriate handover processes.[1,2]

2. Scope

This procedure relates to all Clinical Children's Health Services (CHS) staff.

3. Front page of chart

Indicate if other charts are in use:

- Neurological. If using another chart with vital signs eg TPR, it is recommended that the observations be crossed out and see CEWT chart written across that area. Then utilise the other section of the neurological chart.
- All standard vital signs (Respiratory rate, Temperature, Heart rate, Blood Pressure etc) are documented only on CEWT.
- To access other chart utilise the clinical forms catalogue

General Instructions:

It is important to read the general instructions for the charts:

You must perform a full set of observations:

- On admission - this allows for a baseline set of observations
- If the patient is deteriorating (increasing score or you are concerned about the patient)

Modifications:

This is utilised if the patient has observations that for them are normal but if documented on CEWT will indicate deterioration.

It is the responsibility of the medical officer (registrar and higher) to document this and sign before modifications are activated.

e.g. cardiac children who have oxygen saturations of 84% normally will indicate a CEWT score of 3. If modifications are documented then the clinician will not need to include the score unless it goes outside of the documented parameter. Rescoring commences if this occurs.

Interventions:

This is used to assist clinicians with a history of interventions that have been performed for their patient in conjunction with the observations.

4. Middle Pages

Patient Identification:

All three pages must have appropriate patient identification – either identification label or hand written if necessary.

Reference Ranges:

Different ages are indicative of differing observation ranges in paediatrics. CEWT has four charts to choose from:

- Less than 12 months
- 1-4 years
- 5-11 Years
- Greater than 12 years.

Ensure that the right chart is chosen for the right age.

There are a number of visual indicators which will assist with the right choice of chart.

Observations:

Record a full set of vital signs on admission or if there is an indication of deterioration.

Total CEWT Score:

Ensure that a total CEWT score (cumulative) is documented for all sets of vital signs, including zero if within normal parameters.

Interventions:

This is used to assist clinicians with a history of what interventions have been performed for their patient in conjunction with the observations. So at change of shift or handover there will be a record of all interventions

Ensure that interventions are documented as required in the time of the observations taken.

Actions:

There are a number of actions to be activated depending on the CEWT Score. Actions are dependant on severity of illness of the patient.

Total CEWT Score 1–3

- Obtain a full CEWT score
- Carry out and document appropriate interventions as prescribed
- Increase frequency of observations
- Manage anxiety / fever / pain (pain tool overleaf)
- Review oxygen requirement
- Consider informing team leader.

Total CEWT Score 4–5

- Obtain a full CEWT score
- Ward doctor to review within 30 minutes
- Notify team leader Obtain a full CEWT score after interventions
- If no review within 30 minutes, escalate to registrar review.

Total CEWT Score 6–7

- Obtain a full CEWT score
- Registrar to review patient—response within 15 minutes
- If no review within 15 minutes, or if clinically concerned, initiate emergency call
- Notify team leader
- Obtain a full CEWT score after interventions
- Registrar to ensure consultant is notified
- Ward doctor to attend.

Total CEWT Score 8+

- Initiate emergency call
- Registrar to attend
- Ensure consultant is notified.

5. Back Page of chart

Pain Scale:

Make certain that the most appropriate tool is selected for each patient based on age and developmental level. Document the pain tool used and if possible use the same tool throughout the patient's admission for consistency.

Pain must be documented:

- On admission
- As reported by the patient; if the patient is unable to self-report utilise behavioural pain tool eg. FLACC scale, and involve the parents/carers
- Before and after an intervention to relieve pain eg. if analgesia is given.

Document the pain score in the appropriate section, using the scale of 0 (no pain) -10 (worst pain). Activate and document the appropriate actions as indicated on the CEWT form.

6. Supporting Documents

Authorising Policy and Standard/s:

- Considerations for Observations - Pulse, Blood Pressure, Neurological, Neurovascular, Pain, Respiratory and Spinal in Children CHS NS 00253
- CHS NS 00252 Paediatric Patient - Foundations of Nursing Care
- CHS NS 00250Nursing Handover of Patient Care
- CHS NS 00241 Clinical Assessment of the Paediatric Patient - Rapid Assessment / Primary & Secondary Survey / Vital Signs
- CHS NS 11302 Post Anaesthetic Paediatric Pt, Care of
- CHS Procedure 00190 Patient Identification

7. References and Suggested Reading

1. Australian Commission on Safety and Quality in Health Care – national consensus statement: essential elements on recognising and responding to clinical deterioration
2. Recognition and Management of the Deteriorating Patient – Core Strategy Options Paper
3. Australian Commission on Safety and Quality in Health Care – Recognising and Responding to Clinical Deterioration website

8. Consultation

Key stakeholders who reviewed this version are:

- Nurse Practitioner – Acute Pain Service
- Acting Director Patient Safety and Quality Unit
- Clinical Nurse Consultant - Nursing Standards and Evidence Base Practice
- Principal Project Officer – Recognition and Management of the Deteriorating Patient Program (Patient Safety and Quality Improvement Service)

9. Procedure Revision and Approval History

Version No	Modified by	Amendments authorised by	Approved by
1.0	Patient Safety Officer	Patient Safety and Quality Committee	Chief Operating Officer

10. Audit / Evaluation Strategy

Level of risk	Medium
Audit strategy	Annually
Audit tool attached	No
Audit date	July
Audit responsibility	Patient Safety Officer – Patient Safety and Quality Unit
Key Elements / Indicators / Outcomes	Clinical Incidents (clinical incident reporting system PRIME) – Recognition and Management of the Deteriorating Patient Either an increase or decrease in ■ unplanned admission to Intensive Care Unit ■ deaths ■ medical emergency responses Reviews via Morbidity and Mortality Committee