## **Older Child 6-12 Years**

Δ:	Date				 								 					
threat is a medical	Γime																	
emergency Sco Looks Unwell	re↓ 1																	1
	0																	0
<b>B</b> 55	0																	-
50	3	İ																3
Breathing 45	2																	2
35		ļ				_												<u> </u>
Respiratory Rate 30	1																	1
25	0	H																0
Write the number if 20	١Ť																	١Ť
>55 or <10 <b>15</b>	1																	1
10	Е																	E
>96	0																	0
SaO <sub>2</sub> % 95-90 89-86	1																	1
<85	2 <b>E</b>																	2 <b>E</b>
Oxygen Flow Rate >10L	3																	3
3-10L	2	İ																2
Mask oxygen rate <2L	1																	1
must be >5L/min None	0																	0
Mode: N.Prongs/Mask	_																	Ļ
Respiratory Distress: Moderate	2																	2
See the back of this Mild	1																	1
chart None	0																	0
	3																	3
•																		
Circulation 150	2																	2
100		<u> </u>				-		-										_
140																		-
Heart Rate	1	$\vdash$				-												1
130																		Ė
Write the number if >160 or <50	0	İ																0
100																		
100		<u> </u>				-									-			<u> </u>
80	1																	1
	-	1																H.
<b>E</b> = Emergency	2																	2
60																		
60	3																	3
50																		_
, 4 accorde	<b>E</b>																	<b>E</b>
Capillary >4 seconds 2-3 seconds		H																1
Refill Time 2-3 seconds <2 seconds		1																0
A.L. I.	0																	0
<b>D</b> Alert Voice																		2
Disability Pain																		3
Unresponsive	E																	E
	0	$\vdash$				-	+	-							-			0
Exposure 38.5	Ť	$\vdash$					+											٣
		i i																
Temperature 37.5	0																	0
36.5																		<u> </u>
Write the number if		├	-	-		-	1	-						-	-	-		₩
>39.0 or <35.5		$\vdash$	1			-		+							+	-		$\vdash$
Blood Sugar Level >10	2																	2
(4.0-8.0)																		0
Call Dr urgently if 3.5-4.0	2	İ																2
Emergency call to Dr if <2.0	Е																	Е
Total K-CEWS score																		
		t					1											
Pathway Actions: Done ✓		<u> </u>		_			1	_							_	_		₩
Weight kg																		
Pain Score 0-10																		
1 an 30010 U-10	ı	I					1							1		1	1	1

## **Mandatory Escalation Pathway:**

If Total K-CEWS score:	Do these Actions:												
1-3: Normal to low level response to an illness	Assess your patient and manage pain, fever or distress. Repeat the vitals in 30 minutes: If K-CEWS still 1-3 discuss with SNO and consider increasing the frequency of taking vitals, otherwise continue at minimum of 4 hourly vitals.  Document the plan of care from your discussion in the patients notes												
4-5: Unstable acute illness		Repeat the vitals in 15 minutes, if K-CEWS remains 4-7 also discuss patient with SNO or Nurse in Charge if after hours. Document this discussion and											
6-7: Patient likely to deteriorate quickly		request for review Dr review the patients notes. Increase frequency of vitals (30 minutely, 1, 2 or 4 hourly). Dr to document their review and plan											
8+ Or any vital sign in some: Patient critical. <b>E=Emergency</b>	Call for help from a doctor immediately. Stay with the patient Support Airway, Breathing and Circulation. Give oxygen and start CPR/Advanced Life Support as needed Document outcome in patients notes												
Drs additional instructions:													

Modificat existing		o K-CEV lical cor																											
Vital Sign		New aconew K-C					nd	_	Time and Date							atio	n				Name and contact details								
Reason:	Reason:																												
Reason:																													
Reason:																													
Blood Pre	ssur	e (recor	d ar	nd sc	ore	e w	hen	ne	ede	d)																			
		Date																							_	_			
Blood Pressure	ə:	7ime >130s 120s 110s	3 2 1																							3 2 1			
Score (	$\widehat{\wedge}$	100s 90s	0																							0			
systolic (	<i>"</i>	80s 70s	1 3																							1 3			
	Ψ	60s <50s	8																							2			
<b>Modified</b> Date	Glas	gow Co	ma	Scor	e: (	Old	er C	hile	d																				
Time																													
Pupil Size	_	esponse			4																				$\equiv$				
		normally to speech	ormally o speech/touch																						-				
React to	to pain			2																									
	_	sponse Il Respons	e		1																								
• 3		ated, spea			5																								
		ally/approp sed/disorie			4																		-		-				
		ropriate wo		;u	3																								
· · · · · · · · · · · · · · · · · · ·	_	s no sense			2																				<u> </u>				
<b>•</b> 5	None	s, facial gri	mace	iS .	1																								
	Best Motor Res																								_				
6	i	s/usual mo ses painfu			6 5																								
	Withdraws from				4																								
		mal flexior mal extens			2																				_				
7		sponse	51011		1																								
Pupil Response:		Score																							$oxed{oxed}$				
(R)Reactive	Pupil	Size Response			L																				-				
(S)Sluggish (F)Fixed	Pupil	Size			R																								
Any other		Response ea/vomiting			R																				_				
signs of	Heada		9																										
altered status (✔)		phobia																											
		e vision	1000		on:	-																							
Respirato Observe	,, y DI	311 C33 F	Mild		CII					М	Moderate								Severe										
Behaviour									Some intermittent irritability								Increasing irritability and/or tiring												
Respiratory rate Mildly increased (yellow '1						1' zo	ne)		Increased (peach coloured						ne)	Mar	ked i	ncrea	ase (p	ink '3									
Use of accessory muscles N			-							So -	Some in-drawing seen at: - Trachea							or a marked decrease Severe in-drawing and effort to breathe noted in same places as Moderate.											
	-	- Below the sternum - Between the ribs - Below the ribs Nasal flaring								Marked nasal flaring Grunting heard when breathing out																			
Apnoeic episodes			None								May have a brief apnoea once Increa									easing, frequent or prolonged									
Feeding			Normal							-	7									le to feed or latch									
Face Face	FLACC Pain Scale Score 0 Face Relaxed facial express					ecio-	1/cm	iloc	-			arimo	000	r frow	m		Score 2 Frequent frown/clenched jaw												
Legs				xea tad nal pos		_		1/3III	1152			onai ( //restl	•			/11			d leg		ı ı/CIE	i ici ie	u jav	,					
Activity			Mov	es easi				/ in n	orma	l M	oving	arou	nd b	ed a	lot, n	•	9	Tight body, rigid arms or legs, lying very still											
Cry			posit No c							-		or legs /whin			and f	orth		Cn/i	na et	eadil	v								
Consolablity				tent/rel	axe	<u>d</u>				_			•		t mea	sures	<b>.</b>	Crying steadily Difficult to comfort											

Consolablity