Infant 0-3 Months

Fathers Name .....
First Name .....
DOB/Age .....
Gender .....
Ward .....
Weight .....

			Date / Time / Score ↓																								
A Any airway threat is a medical emergency																											
Looks Unwell		1																									1
B **Breathing**	80	📞																									📞
	75	3																									3
	70	2																									2
	65	1																									1
Respiratory Rate	**60**	0																									0
Write the number if >80 or <20	**50**																										
	40																										
	30	1																									1
	25	3																									3
	20	**E**																									**E**
SaO_2 %	>92	0																									0
	91-89	1																									1
	88-86	2																									2
	<85	**E**																									**E**
Oxygen Flow Rate	>2L	3																									3
	2L	2																									2
	<2L	1																									1
	None	0																									0
Mode: N.Prongs/High Flow HF																											
Respiratory Distress: see the back of this chart	Severe	3																									3
	Moderate	2																									2
	Mild	1																									1
	None	0																									0
C **Circulation**	200	📞																									📞
	190																										
	180	3																									3
Heart Rate	170	2																									2
Write the number if >195 or <80	**160**	1																									1
	140	0																									0
	120																										
E = Emergency	**100**	2																									2
	90	3																									3
	80	**E**																									**E**
Capillary Refill Time	>4 seconds	2																									2
	2-3 seconds	1																									1
	<2 seconds	0																									0
D **Disability**	Alert/normal	0																									0
	Voice/drowsy	2																									2
	Pain/irritable	3																									3
	Unresp/poor tone	**E**																									**E**
E **Exposure**	39.0																										
	38.5	0																									0
Temperature	37.5																										
	36.5	0																									0
Write the number if >39.0 or <35.5	<35.5																										
Blood Sugar Level	>7.0	2																									2
	3.0-6.9	0																									0
Call Doctor urgently if 2.0-3.0		2																									2
Emergency call to Dr if <2.0		**E**																									**E**
K-CEWS Total Score:																											
Pathway Actions:	Done ✔																										
Weight	kg																										
Cord Painted ✔																											
Breast Feed ✔	Well/Poorly																										

Mandatory Escalation Pathway:

If K-CEWS Total 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	Call Intern to review within 60 minutes Use ISOBAR to discuss patient & 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 request for Dr review in the patients notes. Increase frequency of vitals (30 minutely, 1, 2 or 4 hourly). Dr to document their review and plan
6-7: Patient likely to deteriorate quickly	Call Registrar to review within 30 minutes. Use ISOBAR to discuss patient
8+ Or any vital sign in 📞 zone: Patient critical. **E=Emergency**	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:	

Anytime you are concerned about your patient call a Dr or talk to your SNO, regardless of vital signs or K-CEWS

Modification to K-CEWS: A Doctor can adjust the acceptable parameter based on specific treatments or pre-existing medical conditions. Modifications must NEVER be used to normalise a clinically unstable patient				
Vital Sign	**New accepted values and new K-CEWS score**	**Time and Date**	**Duration**	**Name and contact details**
Reason:				
Reason:				
Reason:				

Blood Pressure (record and score as needed)

	Date																									
	Time																									
Blood Pressure: Score systolic only	>120s	3																								3
	110s	2																								2
	100s	1																								1
	90s	0																								0
	80s																									
	70s	1																								1
	60s	3																								3
	50s																									
	<40s	📞																								📞

Modified Glasgow Coma Score: Infant

Date																									
Time																									
Pupil Size 1 2 3 4 5 6 7	**Eye Response**																								
	Open normally	4																							
	React to speech/soft touch	3																							
	React to firm touch, pain	2																							
	No response	1																							
	Verbal Response																								
	Normal sounds or cries appropriately	5																							
	Cries but is consolable	4																							
	Irritable or inconsolable	3																							
	Moans, facial grimaces	2																							
	None	1																							
	Best Motor Response																								
	Spontaneous movement	6																							
	Localise stimuli	5																							
	Withdraws from pain	4																							
	Abnormal flexion	3																							
	Abnormal extension	2																							
	No response	1																							
Pupil Response: (R)Reactive (S)Sluggish (F)Fixed	**Total Score**																								
	Pupil Size	L																							
	Pupil Response	L																							
	Pupil Size	R																							
	Pupil Response	R																							
Any other signs of altered status (✔)	Nausea/vomiting																								
	Headache																								
	Photophobia																								
	Double vision																								

Respiratory Distress Assessment

Observe	**Mild**	**Moderate**	**Severe**
Behaviour	Normal	Some intermittent irritability	Increasing irritability and/or tiring
Respiratory rate	Mildly increased (yellow '1' zone)	Increased (peach coloured '2' zone)	Marked increase (pink '3' zone) or a marked decrease
Use of accessory muscles	Nil to mild chest wall in-drawing	Some in-drawing seen at: - Trachea - Below the sternum - Between the ribs - Below the ribs Nasal flaring	Severe in-drawing and effort to breathe noted in same places as Moderate. Marked nasal flaring Grunting heard when breathing out
Apnoeic episodes	None	May have a brief apnoea once	Increasing, frequent or prolonged
Feeding	Normal	Feeding poorly/less than normal	Unable to feed or latch
FLACC Pain Scale	**Score 0**	**Score 1**	**Score 2**
Face	Relaxed facial expression/smiles	Occasional grimace or frown	Frequent frown/clenched jaw
Legs	Normal position/relaxed	Uneasy/restless/tense	Kicking/rigid legs
Activity	Moves easily/lying quietly in normal position	Shifting head, arms and legs back and forth, can't settle in usual position	Arched or tight body/rigid arms or legs
Cry	No cry	Moans/whimpers	Crying steadily
Consolablity	Content/relaxed	Reassured by comfort measures	Difficult to comfort