Purpose
Pediatric Early Warning Scores have been in existence for over 10 years now. During this time, many individuals and hospitals worldwide have adapted the PEWS to meet their specific needs to assess pediatric patient populations for deterioration (similar to the MEWS – Modified Early Warning Scores, used in the adult population). The PEWS score is used to evaluate appropriate level of care. Currently in this community hospital, the PEW Score is not used and over 30% of the patients admitted needed transfer to a higher level of care in less than 12 hours. The goal is to prevent any delays in providing critical care to a pediatric patient.

Design
The project is an Evidence Based Practice project to review the PEW Score in assessing pediatric patients in the emergency department to determine appropriate transition of care. Should the patient be admitted to the community hospital or transferred to a higher level of care?

Setting
The hospital is a Community hospital with a 42 bed Emergency Department that is a designated Heart and stroke Center. The annual Emergency Department patient census is 52,000.

Participants/Subjects
All ED and Pediatric staff (100 people) participated in this project. The patients were all patients that presented to the ED that were 18 years of age or younger which was 305 patients.

Methods
• An interprofessional team from both the emergency department and pediatrics respiratory diagnosis.
• The pediatric RN and respiratory therapist would come to the emergency department and do bedside handoff which included a PEWS score.
• Any pediatric patient with a PEWS score of greater than 3 would require the emergency department attending to reassess the patient.
• Prior to implementation, the interprofessional team was educated about the Pew Score as well as their role in the care of the pediatric patient.

Results/Outcomes
The pilot program was initiated June 7th 2017 after education was provided to all ED and Pediatric staff (100 people). The patients admitted needed transfer to a higher level of care in less than 12 hours. The goal was to start before the fall with the increase of respiratory patients admitted with asthma and influenza. 10 patients were admitted, all with a PEWS score of 1.
Two patients were transferred out for a higher level of care with a PEWS score of 5.
No patients were transferred from the pediatric floor to a higher level of care within 12 hours.

Implications
• Both the pediatric and emergency department staff had a positive response to bedside handoff utilizing the PEWS score prior to transfer to the pediatric floor.
• During this pilot, no pediatric patients required transfer to the PICU within 6 hours of admission to the pediatric floor. Whereas, during 2016, 6 patients were transferred to the floor and required transferring to the children’s hospital for critical care shortly after arriving to the floor.
• This resulted in delay of care which makes the PEWS score an essential tool for the deposition of the pediatric patient in community hospitals.
• Both ED and Pediatric staff feel the communication and teamwork between the floors has improved which results in more timely critical care to a pediatric patient.

References