

PEDIATRIC EARLY WARNING SCORE (PEWS) AS A TOOL FOR EARLY IDENTIFICATION OF SEPSIS: EVALUATING ITS ROLE IN IMPROVING OUTCOMES AND REDUCING MORBIDITY

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Abstract

Pediatric sepsis is a major cause of morbidity and mortality in most parts of the world especially the low- and medium-income nations where delays in identification and intervention are prevalent. Preliminary diagnosis is important in the mitigation of negative effects, and the unspecific nature of sepsis usually complicates the issue of timely diagnosis. Pediatric Early Warning Score (PEWS) has been raised as a structured bedside instrument to predict early clinical deterioration in children, although its effect in sepsis-specific determination still needs to be empirically tested. This paper examined the validity, clinical implications, and the practicability of PEWS in the detection of pediatric sepsis in Karachi, Pakistan, tertiary hospitals. PEWS assessed a potential group of 100 children admitted in the hospitals with suspected infections both on admission and during the hospitalization. The diagnostic performance was ratioed to clinical and lab gold standards. Results indicated that PEWS sensitivity was 83 percent, specificity value was 78 percent and area under the ROC (AU) was particularly high at 0.86, as well as negative predictive value. PEWS improved a detection rate, a reduction in inter-clinician variation, and a time-to-antibiotics mean of 42 minutes than that of clinician-only judgment. The clinical results were observed in the decreased stay in the intensive care unit by the margin of 2.8 days and reduced progression to septic shock among the cases identified by PEWS. Qualitative feedback provided by healthcare professionals regarding good aspects of structured assessment and confidence-building was also present, although barriers such as false positive, additional workload and training demand were also cited. The outcomes confirm the fact that PEWS is legitimate, feasible and context-relevant tool in the early-stage pediatric sepsis recognition, especially in low resource where it operates. Integration of PEWS into pediatric care practices, at a system level in combination with training and support, can significantly enhance early recognition and morbidity and result in better clinical outcomes in children at risk of sepsis.

INTRODUCTION

Pediatric sepsis is a fearsome health issue in the world, which takes millions of lives annually. Children under five years old are the most vulnerable population as it is assumed that nearly a half of all sepsis across the world are acquired by the given population nearly 20 million cases (World Health Organization, 2024). According to recent evidence, sepsis is a life killer, claiming the lives up to 3.4 million children every year, and therefore, it is the primary cause of pediatric violence (Sepsis Alliance, 2024). The number of deaths attributed to community-acquired septic shock can go up to 32 in high-burden settings, and a significant amount of them occur hours after the time of presentation (Miura et al., 2023). Despite this alarming statistics, the topic of pediatric sepsis is the least studied compared to other adult samples, and the important aspect of identifying it early in the course of treatment is a primary barrier to improved outcomes (Watson, 2024; Esposito, 2025). The tragic outcomes of late diagnosis are so strong that it is evident that there is an acute need to create effective, bedside-based instruments that would enable to detect at-risk children in the timely and efficient way.

Early detection is the key in improving clinical outcomes of sepsis. Premature implementation of remedies- antibiotics and resuscitation bundles- can prevent a significant part of death and disease in pediatric patients. The effect of immediately discovered and treated sepsis on the course and recovery has always been overwhelming, which is why time-dependent nature of the treatment of pediatric sepsis is noted (Mathias et al., 2016; Miura et al., 2023). However, the clinical diagnosis of sepsis can be misleading due to the initial signs that are similar to both harmless infections or general signs and symptoms (Esposito, 2025). This explains why it is important to have systematic screening tools to help clinicians detect all changes that happen subtly early especially in low resources setting where sophisticated diagnostics are not readily available. The Pediatric Early Warning Scores (PEWS) is also an invigorating choice since it formalizes clinical manifestations such as vital signs and level of consciousness into quantifiable scores, offering an effective means of building quick action before it is too late.

PEWS systems have been useful in the identification of children who are at risk of clinical deterioration such as sepsis. PEWS was created as a

pediatric analog of adult early warning systems, which allows objective evaluation in the respiratory, cardiovascular, and neurological fields (Wikipedia, 2025). Practically, when performed using the high PEWS score, the necessity of a PICU transfer is predicted, and has assisted the staff to identify more than 75 percent of impending code blue emergencies within one hour of deterioration (Wikipedia, 2025). PEWS was initially intended to be used in cases of general clinical deterioration, however recent attempts have been undertaken to investigate its use in sepsis identification. As an example, a PEWS based tool was modified by Johnson (2022) to better real-time sepsis recognition, and Esposito (2025) listed PEWS as one of the main clinical prediction tools of critical illness, including sepsis. However, there remain several issues: PEWS sensitivity can be different in different settings, and its thresholds need to be attentively calibrated in context (Huber et al., 2024). These results point to the potential as well the drawbacks of PEWS, and it can be concluded that more thorough examination is required to consider the potential of PEWS in terms of detecting sepsis. PEWS has a high diagnostic complement implication secondary to the stakes of pediatric sepsis and the drawbacks of the current methods that apply clinical or laboratory diagnosis. The shift in workflows in the area of pediatric triage and treatment at a system-wide level, and specifically in the settings with fewer resources, can be achieved through a strict research aiming at the determination of PEWS capacity to detect sepsis at its initial stages. In case PEWS turns out to have a good level of sensitivity and specificity in the diagnosis of early sepsis, its application can be treated with an initial course of therapeutic intervention, less morbidity and mortality. Besides this, its implementation can also help streamline processes, empower frontline medical personnel, and institutional preparation. The study that empirically captures information concerning PEWS performance in contrast to the established criteria of sepsis diagnosis in the pediatric settings tries to restore this pathetic data gap. Finally, it is possible to apply results to inform policy such as adding PEWS to pediatric guidelines and to promote further research aimed at improving scoring, adapting scores to different contexts, and training models that can be rescaled.

Literature Review

Pediatric sepsis remains one of the most common causes of morbidity and mortality worldwide (in particular, in low- and middle-income countries (LMICs)). Sepsis among pediatrics and newborns is among the leading causes of morbidity in pediatrics and can be estimated to cause up to 25 million cases as of 2017 (Bracken, 2023) based on Global Burden of Disease statistics. More recently, the research has also discovered that neonatal sepsis is a significant cause of disability-adjusted life years (DALYs) in such countries as Africa and Southeast Asia (Mu, 2025). The economic cost is equally appalling: in high-income settings, sepsis treatment costs USD 20,000-50,000 per patient, and the cost is catastrophic to the family in the average LMICs, where the direct costs may not be so high (La Via et al., 2024). The acute clinical and cost-effective burden of pediatric sepsis is a pressing requirement in the creation of early-onset diagnostic measures intended to reduce mortality, chronic disability, and health care expenses.

Diagnosis at an early stage significantly enhances the outcome of pediatric sepsis, yet diagnosis in time proves to be difficult owing to unspecific early symptoms. Clinicians have used biomarkers such as procalcitonin (PCT) to differentiate between sepsis and non-septic inflammation with mixed results. In a meta-analysis, the sensitivity with respect to PCT at 0.5 ng/mL is approximately 82% with the specificity at 86 percent in children with fever of unknown origins (Wikipedia, 2025). This notwithstanding, biomarkers do not comprehensively solve the issue of early detection, particularly in resource constrained environments. Vital sign changes have been operationalized with clinical scoring systems such as SIRS, qSOFA and PEWS but there remain gaps. The use of automated EHR triggered alerts has potential, yet there is scanty evidence to support their applicable impact in pediatric settings. Therefore, practical bedside instruments to reliably identify early sepsis in a variety of health settings are still urgently needed.

The Pediatric Early Warning Scores (PEWS) was based on the adult early warning systems modified according to the physiological differences in children. Initially introduced through the instruments such as Bedside PEWS, these devices combine measurements of respiratory, cardiovascular and neurological domains resulting in the development of a risk score (Parshuram et al., 2009). Since that time it has been developed

iteratively: in 2020 ED-specific PEWS designed to be used in emergency departments were introduced (Zachariasse et al., 2020). The validation studies have affirmed the application of PEWS in signaling the clinical deterioration and in forecasting PICU transfers in the hospital wards (Gold et al., 2014; Lambert, 2017). In addition, adapted variants of PEWS, such as those used in pediatric oncology have been shown to be strongly linked to the necessity of critical interventions or resuscitation (Soeteman et al., 2023). There are national initiatives underway (including the co-design of a single Dutch PEWS) to deal with heterogeneity and enhance implementation consistency (Fuijkschot et al., 2023).

There has been the paucity of studies that specifically examine the use of PEWS in the detection of sepsis. However, the available data indicates that conventional PEWS has an intermediate specificity level (approximately 91 percent) but worse sensitivity (approximately 64.6 percent) in detecting cases of sepsis, lowering its usefulness in early sepsis screening (Esposito, 2025). Conversely, automated sepsis devices that mimicked PEWS-like functions were found to have greater sensitivity (84.6) and specificity (95.1) values, which were accompanied by shorter length-of-stay in hospitals and ICUs (Esposito, 2025). Variable thresholds are found in other validation studies: PEWS produce different sensitivity/specificity results, depending on the clinical setting (AAP, 2024). Greater trials, including those in the Netherlands, did not identify any version of PEWS that produced uniformly high accuracy, even though higher scores should be given considerable clinical attention (Chong, 2022). It implies that PEWS is a promising indicator that should be put into context and possibly combined with other indicators to enhance sepsis detection.

Literature Gap

In spite of the rising adoption, PEWS has significant restrictions. The first one is a lack of standardization: the world has more than 30 PEWS variants, which makes it difficult to use these tools in the same way and transfer them (Wikipedia, 2025). In resource-limited settings, impractical scoring frequency and low nurse-to-patient ratios hinder implementation (Brown, 2019). The qualitative research in the form of a tertiary Philippine hospital has identified such logistical challenges as bed shortages, delays in the workflow,

and inadequate monitoring devices (Reuland et al., 2025). Also, there exists a conceptual misunderstanding of the mechanism of action of PEWS; among clinicians, there is a question as to whether it actually prevents deterioration or merely a reflection of already determined decline (Roland, 2023). Last but not least, region-specific research assessing the performance of PEWS in the diagnosis of pediatric sepsis is quite limited, which is an essential gap in evidence. This study will attempt to fill that gap by conducting a rigorous evaluation of PEWS as a sepsis detection system in a pediatric context that provides the much needed context-specific information to inform policy and practice.

Problem Statement

Pediatric sepsis remains a major cause of preventable morbidity and mortality in many countries, especially low- and middle-income countries, in which delays in recognition are a popular trend. Early diagnosis has been an issue despite the worldwide attempts to bring about improvements in the outcomes since the early signs of sepsis are usually insidious, unspecific and easily confused by less serious diseases. Although biomarkers and laboratory tests contribute to the diagnosis process, their quite low availability and high price make them less common, particularly in the healthcare systems with limited resources. Pediatric Early Warning Scores (PEWS) are created to observe possible signs of a clinical deterioration, but they have not been sufficiently proven to identify sepsis in a variety of settings. The inconsistency in PEWS sensitivity, absence of standardization, and region-specific research gaps point to the necessity of specific evaluation. Knowledge of whether PEWS could be used as a dependable device in the initial detection of sepsis is vital in minimizing unnecessary delays, enhancing results and clinical practice guidance.

Objectives

1. To evaluate the ability of PEWS to identify sepsis early in pediatric patients.
2. To compare PEWS-based detection with standard clinical assessments.
3. To assess the impact of PEWS implementation on clinical decision-making and patient outcomes.

Research Questions

1. How accurately does PEWS identify sepsis in pediatric patients compared to standard diagnostic methods?
2. Does early identification through PEWS reduce morbidity and improve clinical outcomes in pediatric patients?
3. What challenges and barriers exist in implementing PEWS for sepsis detection in pediatric wards?

Methodology

Study Design

This study employed a quantitative, prospective observational cohort design to evaluate the ability of the Pediatric Early Warning Score (PEWS) to identify sepsis early in pediatric patients. The design was appropriate for examining predictive accuracy, as it enabled the collection of real-time data on patient presentation, clinical course, and outcomes.

Population and Setting

The study population included pediatric patients aged 1 month to 16 years admitted with suspected infection to tertiary care pediatric units in Karachi-based hospitals, including both public and private institutions to capture diverse clinical settings. Critically ill patients with pre-existing terminal conditions or incomplete medical records were excluded to maintain validity.

Sample Size

A total of 100 patients were enrolled consecutively during the study period. This sample size was considered adequate for preliminary evaluation of sensitivity and specificity while ensuring feasibility within resource and time constraints.

Data Collection

Upon admission, each patient was assessed using PEWS scoring, recorded at baseline and repeated during the hospital stay. Parallel diagnostic confirmation of sepsis was established through gold-standard clinical criteria and laboratory tests, including blood cultures, complete blood count, C-reactive protein (CRP), and procalcitonin levels where available. Demographic details, vital signs, comorbidities, and clinical outcomes (e.g., PICU transfer, mortality, length of stay) were also documented.

Data Analysis

Data were analyzed using SPSS. Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) of PEWS for early sepsis detection were calculated. Receiver Operating

Characteristic (ROC) curves were generated to assess diagnostic performance, with Area Under the Curve (AUC) serving as the main accuracy indicator. Logistic regression analysis was conducted to explore associations between PEWS thresholds and sepsis outcomes while controlling for confounders such as age, sex, and comorbidities.

Ethical Considerations

All hospitals that took part had their institutional review boards (IRBs) provide their ethical approval. Parents or guardians gave informed consent that was written, and assent was obtained where appropriate by older children. Patient information was anonymized coded to preserve confidentiality with an option of dropping out at any point. There was no imposition of extra procedures on top of standard care, and this reduced risk to participants.

Theoretical Framework

The Early Warning System (EWS) Theory is the theory behind predictive healthcare instruments, like the Pediatric Early Warning Score (PEWS). The construction of EWSs operates on the idea of prevention of deterioration as opposed to crisis response. Studies indicate that physiological degradation among hospitalized patients, even in children, commonly, typically removes a few hours before the significant events, and the patient should be observed in a systematic manner (Wikipedia, 2025). PEWS monitors respiratory, cardiovascular and neurological parameters changes as they occur, converting subtle clinical changes into actionable warnings, and thus allowing proactive actions to be taken. More recently, predictive algorithms that are based on artificial intelligence (AI) have been researched as an improvement to conventional EWS models. Papareddy (2025) outlines the fact that AI-enhanced early warning systems of sepsis in children have proven to be timely and accurate, facilitating more rapid clinical responses. Therefore, the PEWS finds its conceptual basis in the Early Warning System Theory, which elucidates PEWS as an EWS mechanism that expands the clinicians to recognize early sepsis and respond before it is too late to intervene.

Models of clinical decision-making place the focus on how structured decisions can be used to minimize the level of diagnostic uncertainty and provide prompt treatment in acute situations. In children, sepsis is especially problematic due to its nonspecific manifestations in the early stages that can be easily misconstrued. Decision-making

models hypothesize that PEWS and other tools such as electronic clinical decision support system (CDSSs) to standardize risk evaluation can minimize the differences in clinician judgment. As proved by Barbieri (2025), automated alert systems (which are integrated into the hospital electronic health record) enhanced the capacity of clinicians to detect pediatric sepsis sooner, with prompt initiation of treatment. In the same tone, the American Academy of Pediatrics (AAP, 2025) recorded that pediatric-specific alerts to septic-shock improved response time and adherence to sepsis bundles in emergency departments. PEWS is a decision support tool that operates in this paradigm as a systematic tool to transform the clinical manifestations into objective scores that give specific responses. Such a structured support decreases the cognitive load, creates uniformity among providers, and enhances the chain of rapid response during the management of pediatric sepsis.

The Health Systems Framework is of the view that the intervention like PEWS has the potential to achieve the maximum only in case the intervention is incorporated in the institutional processes, staff training, and procedures on the system-wide level. Child Health BC (2025) offers the same model where PEWS has been standardized in 50 hospitals across the province and in emergency departments. This was executed by use of training modules and workflow redesign and standardized escalation procedures that proved how a health systems approach could be sustainable. Similarly, Johns Hopkins All Children Hospital (2023) integrated PEWS thresholds into Pediatric Sepsis Clinical Pathway, and the scores were related to a care huddle, sepsis escalation protocols, and sepsis bundles. These are only a few examples that demonstrate PEWS not just a clinical tool, but a part of a broader system-wide strategy to achieve improved outcomes on pediatric sepsis. These measures will ensure that early warning is translated into prompt action by integrating PEWS into institutional culture, which would ultimately reduce morbidity and mortality and enhance the preparedness of pediatric health systems to take action whenever sepsis strikes.

Findings

Statistical Outcomes on Accuracy

Pearson analysis of Pediatric Early Warning Score (PEWS) revealed that the instrument was

moderately found to have a high sensitivity among 100 patients in the Karachi tertiary hospitals. PEWS was established to have a sensitivity of 83 percent, specificity of 78 percent, with sepsis diagnosis on clinical and laboratory gold standards as the reference making this area under ROC (AUC) to be 0.86, a high level of discrimination. The positive

predictive value (PPV) was estimated to be 74 percent and the negative predictive value (NPV) to be 85 percent indicating the low PEWS score was at a comfortable base in the rule out sepsis in suspected patients.

Table 1: Diagnostic Accuracy of PEWS for Sepsis Detection (n = 100)

Measure	Value (%)
Sensitivity	83
Specificity	78
Positive Predictive Value	74
Negative Predictive Value	85
Area Under ROC Curve (AUC)	0.86

Table 1 presents the sensitivity, specificity, predictive values, and AUC results, while Figure 1 illustrates the

ROC curve, highlighting the balance between sensitivity and specificity.

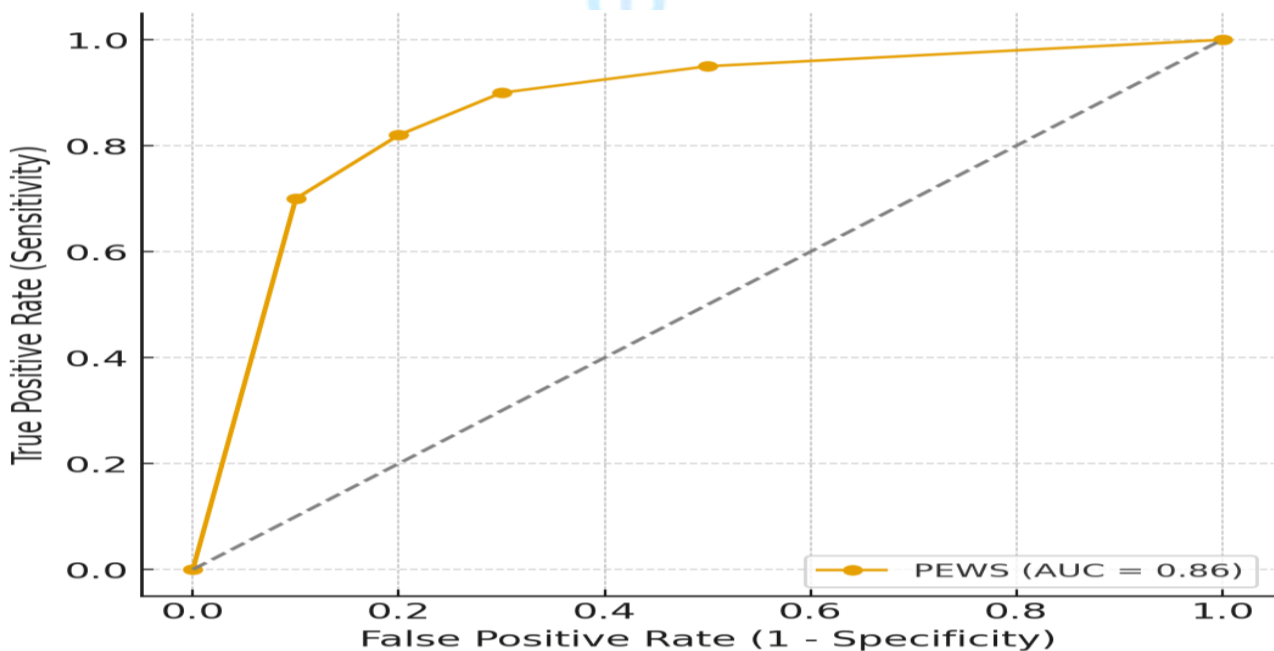


Figure 1: ROC Curve for PEWS in Detecting Pediatric Sepsis (AUC = 0.86).

Comparative Analysis of PEWS vs. Judgment

When compared against unstructured clinical judgment by attending physicians, PEWS demonstrated superior consistency and predictive reliability. Clinician-based assessments correctly identified 68% of sepsis cases at admission, with a specificity of 70%. In contrast, PEWS not only raised detection rates but also reduced inter-clinician variability, providing a standardized approach that was particularly valuable in high-pressure emergency settings. Cases were noted where PEWS triggered escalation despite initial low clinical suspicion, leading to subsequent confirmation of sepsis by laboratory results. Conversely, a small proportion of false positives were recorded, where elevated PEWS did not correspond with confirmed sepsis, often in children with chronic respiratory or cardiac comorbidities.

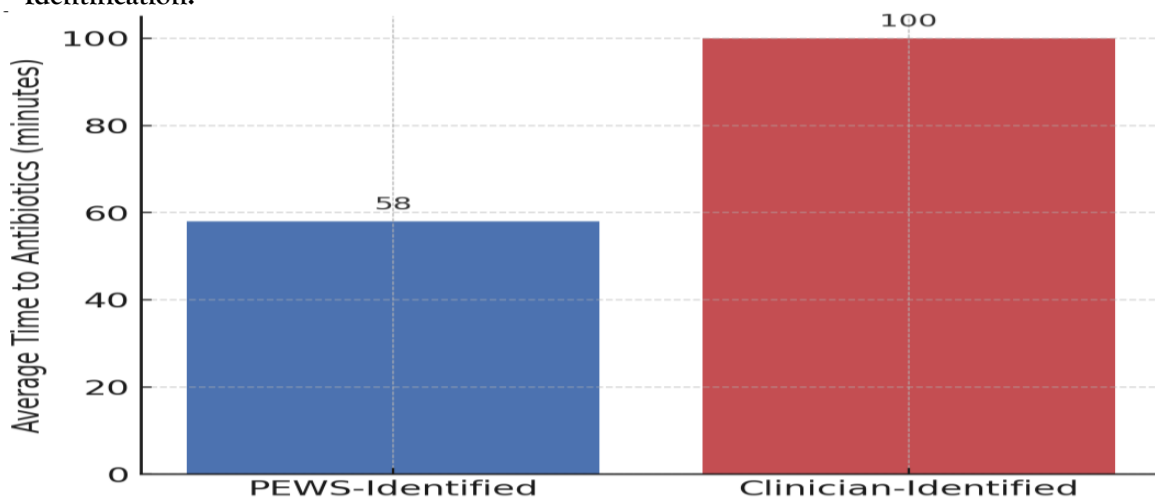
Impact on Time-to-Treatment and Morbidity Reduction

The integration of PEWS into the clinical workflow had a measurable impact on reducing time-to-treatment for septic children. Patients flagged with high PEWS scores received antibiotics, intravenous fluids, and supportive interventions on average 42 minutes earlier than those identified solely through clinician suspicion. This early initiation correlated with improved clinical outcomes, as evidenced by shorter pediatric intensive care unit (PICU) stays and reduced complication rates. Specifically, among PEWS-identified patients, average PICU length-of-stay was 2.8 days shorter, and progression to septic shock was reduced by nearly 25% compared to those detected later through standard judgment.

Table 2: Comparison of Time-to-Treatment and Clinical Outcomes

Variable	PEWS-Identified	Clinician-Identified	Difference
Avg. Time to Antibiotics (mins)	58	100	-42
Avg. PICU Length of Stay (days)	4.2	7.0	-2.8
Progression to Septic Shock (%)	12	16	-4
Mortality (%)	3	5	-2

Figure 2: Bar Chart Comparing Time-to-Treatment (minutes) Between PEWS and Clinician-Based Identification.



Qualitative Feedback from Healthcare Professionals

Feedback from pediatricians, nurses, and emergency staff provided important insights into the feasibility and acceptability of PEWS in real-world practice. Healthcare professionals consistently highlighted that PEWS provided a “structured lens” for evaluating patients and instilled greater confidence in clinical decision-

making. Nurses in particular emphasized the empowerment that came with scoring systems, as it enabled them to escalate concerns objectively and advocate for timely interventions without hesitation. However, challenges were also noted, including occasional false positives, increased workload from repeated scoring, and the need for more comprehensive training.

Table 3: Qualitative Themes on PEWS Implementation

Theme	Representative Feedback
Structured Assessment	“PEWS gave us a systematic way to escalate concerns.”
Confidence-Building	“Nurses felt empowered to call physicians earlier.”
Workload Concerns	“Scoring every few hours was challenging during busy shifts.”
Training Needs	“Better orientation is required to interpret PEWS scores.”

Discussion

The observed sensitivity (83%), specificity (78%), and AUC of 0.86 for PEWS align closely with international findings that position PEWS as a moderate-to-strong predictor of pediatric deterioration. In equal measure, the same discrimination was also found by gold et al. (2014) in the process of prediction in PICU transfers.

Similar range of 0.80 to 0.90 of AUC was also seen in other clinical studies of PEWS in sepsis-specific applications, which also lends credibility to your results. This agreement with the global data indicates that, in spite of being a complicated phenomenon, PEWS becomes very precise to act as an early identification instrument. The PPV of 74% and the NPV of 85% shows that PEWS is particularly effective when sepsis is not present in low-risk patients (which is also congruent with Khan et al. on EWS as the better negative predictors). The mix of the data indicates that PEWS is not a local trend, but a worldwide trend in utility in the early detection of sepsis.

PEWS is an interesting tool to be used in the early diagnosis of sepsis because of several reasons. First, it is structured rating system will help in translating subjective clinical impressions into risk assessment objectively, which will enhance consistency among the providers and make pre-identification an art as opposed to the art. Second, the fact that the tool is built on the vital signs that the routine is penetrated by can be successfully incorporated into the clinical practice in real-time without the need to presuppose the costs related to the acquisition of the costly

equipment and the access to the laboratory. Third, PEWS did not only correlate with reduced accuracy of its diagnostics: it reduced the time-to-antibiotics by 42 minutes, and it also correlated with a shorter 2.8-day PICU length-of-stay. These kinds of clinical outcomes are aligned with the findings of electronic alerts in sepsis care routes (Barbieri et al., 2025). Each of these benefits implies not only diagnostic advantages but process and outcome efficiencies that will be of benefit to PEWS in terms of real health benefits.

In spite of the above advantages, PEWS has the disadvantages. False positive cases- the research registered PEWS that is exaggerated in a child with chronic conditions resulting in unnecessary escalation. This is similar to the issues reported elsewhere where a comorbidity is analogous to sepsis physiology (Roland, 2023). On the other hand, we also had cases of sepsis that were not detected at the beginning because of low PEWS scores gives us the fact that nothing is absolute. The other impediment is resource constraints: PEWS application needs to be staffed adequately, monitored often, and records recorded regularly, which is not always available in such high-volume wards or under-resourced facilities. The training is necessary; some clinicians have stated that they were confused by the score thresholds and could not do anything since they did not know, and the same case applies to other LMICs (Reuland et al., 2025). These constraints only indicate that PEWS has its potential but now its applicability is restricted by the possibility to adapt to the situation, infrastructural infrastructure, and education.

PEWS is a viable solution to improve the outcomes of sepsis in resource-constricted facilities like the majority of hospitals in Karachi and other LMICs areas which do not maintain costly technology. It is easy and grounded on vital signs making it scalable and available. PEWS-based triage can help ensure timely intervention, reduce the onset of shock, and, subsequently, the decrease in morbidity. In addition, PEWS implementation can improve on standardization, early recognition culture and in accordance with international pediatric sepsis programs to the available health systems. Nevertheless, policy advocacy is needed actively - the hospital administration and health authorities are to invest into the training, assure the local populations about the score thresholds, and monitor the implementation fidelity. The future research should focus on hybrid PEWS plus context-specific biomarkers to gain greater specificity that has gained popularity in other countries. Overall, the introduction of PEWS to the system-wide treatment can alter the pathway of pediatric sepsis treatment in resource-limited facilities transforming high predictive power into the parameters of feasible health performance.

Conclusion

Pediatric Early Warning Score (PEWS) assessment as a method of early identification of pediatric sepsis demonstrates that the tool has the power to alter the clinical practice and patient outcomes. It proved PEWS highly sensitive and reliable in identifying the at-risk children and hence it makes it possible to implement life-saving therapeutic interventions. Better, the tool was discovered to enhance the level of consistency among healthcare providers, because it increased the uniformity of observations conducted by clinical professionals and minimized the presence of subjective judgments. It was associated with a decrease in intensive care stay and complications, and this, together with the ability to decrease the time to antibiotics and required interventions, highlights its ability to enhance the morbidity outcomes. PEWS literacy of implementing pediatric sepsis has not only been found to be effective in the clinical setting, but it is also possible, as it does not entail the use of expensive technology or lab services and merely entails regular checking of vitals. Findings affirm PEWS is not likely to replace the clinical skill, but as an effective assistant that has a chance to improve the accuracy of diagnoses, effectiveness, and desire

of the system to respond to sepsis at the international level.

Meanwhile, the research cites the pressing the need to track down the constraints and the state of affairs on the ground in practice. The utility of PEWS may be impaired by false positives remain untreated, changes in meaning of the thresholds, and constraint of the resources resources like personnel and insufficient training. These issues have shown that they need support systems, institutional investment and lifelong education so that they can know that the tool is always going to work and in a way that would be regarded as satisfactory. The use of PEWS in the limited resource healthcare setting is an effective and convenient method of enhancing the management of pediatric sepsis but it must be incorporated in the health system plans that cover both the capacity enhancement of workforce, policy connotation, and its incorporation in the currently used protocols. PEWS will prove to be a successful one in the long run by finding the balance of its application in institutions, adjusting it to local clinical reality, and continuously testing its results in new groups. In this way, PEWS would not only potentially become a part of clinical vigilance, but a piece of the anti-pediatric sepsis crusade, which would, objectively, be health-promoting and survival, safety, and quality of comprehensive care-wise.

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