

Student Name: \_\_\_\_\_ Unit: \_\_\_\_\_ Date: \_\_\_\_\_

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| <b>GENERAL APPEARANCE</b><br><b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished<br><input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br><b>Developmental age:</b><br><input type="checkbox"/> Normal <input type="checkbox"/> Delayed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>CARDIOVASCULAR</b><br><b>Pulse:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready<br><input type="checkbox"/> Murmur <input type="checkbox"/> Other _____<br><b>Edema:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Location _____<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><b>Capillary Refill:</b> <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R _____ L _____<br>Lower R _____ L _____<br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None                                                                                                            | <b>PSYCHOSOCIAL</b><br><b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying<br><input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless<br><input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br><b>Social/emotional bonding with family:</b><br><input type="checkbox"/> Present <input type="checkbox"/> Absent                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>NEUROLOGICAL</b><br><b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless<br><input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive<br><b>Oriented to:</b><br><input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event<br><input type="checkbox"/> Appropriate for Age<br><b>Pupil Response:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____<br><b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat<br><input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed<br><b>Extremities:</b><br><input type="checkbox"/> Able to move all extremities<br><input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right _____ Left _____<br>Pushes: Right _____ Left _____<br>S=Strong W=Weak N=None<br><b>EVD Drain:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____<br><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                   | <b>ELIMINATION</b><br><b>Urine Appearance:</b> _____<br><b>Stool Appearance:</b> _____<br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>IV ACCESS</b><br><b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br>Type/Location: _____<br><b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling<br><input type="checkbox"/> Red <input type="checkbox"/> Swollen<br><input type="checkbox"/> Patent <input type="checkbox"/> Blood return<br><b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Fluids:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>RESPIRATORY</b><br><b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br><b>Breath Sounds:</b><br>Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: _____ L/min<br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Cough:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color _____<br>Consistency _____<br><b>Suction:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____<br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> _____ | <b>GASTROINTESTINAL</b><br><b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended <input type="checkbox"/> Guarded<br><b>Bowel Sounds:</b> <input type="checkbox"/> Present X _____ quads<br><input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br><b>Nausea:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Vomiting:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Passing Flatus:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br><input type="checkbox"/> Suction Type: _____ | <b>SKIN</b><br><b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced<br><input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt<br><b>Condition:</b> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br><b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br><b>Skin:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations<br><input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown<br>Location/Description: _____<br><b>Mucous Membranes:</b> Color: _____<br><input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>NUTRITIONAL</b><br><b>Diet/Formula:</b> _____<br><b>Amount/Schedule:</b> _____<br><b>Chewing/Swallowing difficulties:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>PAIN</b><br><b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces<br><b>Location:</b> _____<br><b>Type:</b> _____<br><b>Pain Score:</b><br>0800 _____ 1200 _____ 1600 _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>MUSCULOSKELETAL</b><br><input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling<br><input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping<br><input type="checkbox"/> Spasms <input type="checkbox"/> Tremors<br><b>Movement:</b><br><input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All<br><b>Brace/Appliances:</b> <input type="checkbox"/> None<br>Type: _____                                                                                                                                                                                                                                                                           | <b>WOUND/INCISION</b><br><input type="checkbox"/> None<br><b>Type:</b> _____<br><b>Location:</b> _____<br><b>Description:</b> _____<br><b>Dressing:</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>MOBILITY</b><br><input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms<br><input type="checkbox"/> Ambulatory with assist _____<br>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>TUBES/DRAINS</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br>Site: _____<br>Type: _____<br>Dressing: _____<br>Suction: _____<br>Drainage amount: _____<br>Drainage color: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

Student Name: \_\_\_\_\_

Unit: \_\_\_\_\_

Date: \_\_\_\_\_

| INTAKE/OUTPUT        |    |    |    |    |    |    |    |    |    |    |    |    |       |
|----------------------|----|----|----|----|----|----|----|----|----|----|----|----|-------|
| PO/Enteral Intake    | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| PO Intake            |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Intake – PO Meds     |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Enteral Tube Feeding |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Enteral Flush        |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Free Water           |    |    |    |    |    |    |    |    |    |    |    |    |       |
|                      |    |    |    |    |    |    |    |    |    |    |    |    |       |
| IV INTAKE            | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| IV Fluid             |    |    |    |    |    |    |    |    |    |    |    |    |       |
| IV Meds/Flush        |    |    |    |    |    |    |    |    |    |    |    |    |       |
|                      |    |    |    |    |    |    |    |    |    |    |    |    |       |
| OUTPUT               | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| Urine                |    |    |    |    |    |    |    |    |    |    |    |    |       |
| # of immeasurable    |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Stool                |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Urine/Stool mix      |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Emesis               |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Other                |    |    |    |    |    |    |    |    |    |    |    |    |       |

| Children's Hospital Early Warning Score (CHEWS)<br>(See CHEWS Scoring and Escalation Algorithm to score each category) |                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Behavior/Neuro                                                                                                         | Circle the appropriate score for this category:                                                                                                                                                                                                                                |
|                                                                                                                        | 0    1    2    3                                                                                                                                                                                                                                                               |
|                                                                                                                        |                                                                                                                                                                                                                                                                                |
|                                                                                                                        |                                                                                                                                                                                                                                                                                |
| Cardiovascular                                                                                                         | Circle the appropriate score for this category:                                                                                                                                                                                                                                |
|                                                                                                                        | 0    1    2    3                                                                                                                                                                                                                                                               |
|                                                                                                                        |                                                                                                                                                                                                                                                                                |
|                                                                                                                        |                                                                                                                                                                                                                                                                                |
| Respiratory                                                                                                            | Circle the appropriate score for this category:                                                                                                                                                                                                                                |
|                                                                                                                        | 0    1    2    3                                                                                                                                                                                                                                                               |
|                                                                                                                        |                                                                                                                                                                                                                                                                                |
| Staff Concern                                                                                                          | 1 pt - Concerned                                                                                                                                                                                                                                                               |
| Family Concern                                                                                                         | 1 pt - Concerned or absent                                                                                                                                                                                                                                                     |
| <b>CHEWS Total Score</b>                                                                                               |                                                                                                                                                                                                                                                                                |
| CHEWS Total Score                                                                                                      | Total Score (points) _____                                                                                                                                                                                                                                                     |
|                                                                                                                        | Score 0-2 (Green) – Continue routine assessments                                                                                                                                                                                                                               |
|                                                                                                                        | Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications                                                                |
|                                                                                                                        | Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications |

**CHEWS Scoring and Escalation Algorithm**

|                       | <b>0</b>                                                                                                                                      | <b>1</b>                                                                                                                                                                                                                                                                                                                                                                 | <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>3</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Behavior/Neuro</b> | <ul style="list-style-type: none"> <li>- Playing/sleeping appropriately <b>OR</b></li> <li>- Alert, at patient's baseline</li> </ul>          | <ul style="list-style-type: none"> <li>- Sleepy, somnolent when not disturbed</li> </ul>                                                                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>- Irritable, difficult to console <b>OR</b></li> <li>- Increase in patient's baseline seizure activity</li> </ul>                                                                                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>- Lethargic, confused, floppy <b>OR</b></li> <li>- Reduced response to pain <b>OR</b></li> <li>- Prolonged or frequent seizures <b>OR</b></li> <li>- Pupils asymmetrical or sluggish</li> </ul>                                                                                                                                                                                                                                                                                                                                                   |
| <b>Cardiovascular</b> | <ul style="list-style-type: none"> <li>- Skin tone appropriate for patient</li> <li>- Capillary refill <math>\leq 2</math> seconds</li> </ul> | <ul style="list-style-type: none"> <li>- Pale <b>OR</b></li> <li>- Capillary refill 3-4 seconds <b>OR</b></li> <li>- Mild tachycardia <b>OR</b></li> <li>- Intermittent ectopy or irregular HR (not new)</li> </ul>                                                                                                                                                      | <ul style="list-style-type: none"> <li>- Grey <b>OR</b></li> <li>- Capillary refill 4-5 seconds <b>OR</b></li> <li>- Moderate tachycardia</li> </ul>                                                                                                                                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>- Grey and mottled <b>OR</b></li> <li>- Capillary refill <math>&gt; 5</math> seconds <b>OR</b></li> <li>- Severe tachycardia <b>OR</b></li> <li>- New onset bradycardia <b>OR</b></li> <li>- New onset/increase in ectopy, irregular HR or heart block</li> </ul>                                                                                                                                                                                                                                                                                 |
| <b>Respiratory</b>    | <ul style="list-style-type: none"> <li>- Within normal parameters</li> <li>- No retractions</li> </ul>                                        | <ul style="list-style-type: none"> <li>- Mild tachypnea/increased WOB (flaring, retracting) <b>OR</b></li> <li>- Up to 40% supplemental oxygen <b>OR</b></li> <li>- Up to 1L NC <math>&gt;</math> patient's baseline need <b>OR</b></li> <li>- Mild desaturations <math>&lt;</math> patient's baseline <b>OR</b></li> <li>- Intermittent apnea self-resolving</li> </ul> | <ul style="list-style-type: none"> <li>- Moderate tachypnea/increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) <b>OR</b></li> <li>- 40-60% oxygen via mask <b>OR</b></li> <li>- 1-2 L NC <math>&gt;</math> patient's baseline need <b>OR</b></li> <li>- Nebs Q 1-2 hour <b>OR</b></li> <li>- Moderate desaturations <math>&lt;</math> patient's baseline <b>OR</b></li> <li>- Apnea requiring repositioning or stimulation</li> </ul> | <ul style="list-style-type: none"> <li>- Severe tachypnea <b>OR</b></li> <li>- RR <math>&lt;</math> normal for age <b>OR</b></li> <li>- Severe increased WOB (i.e. head bobbing, paradoxical breathing) <b>OR</b></li> <li>- <math>&gt; 60\%</math> oxygen via mask <b>OR</b></li> <li>- <math>&gt; 2</math> L NC more than patient's baseline need <b>OR</b></li> <li>- Nebs Q 30 minutes – 1 hour <b>OR</b></li> <li>- Severe desaturations <math>&lt;</math> patient's baseline <b>OR</b></li> <li>- Apnea requiring interventions other than repositioning or stimulation</li> </ul> |
| <b>Staff Concern</b>  |                                                                                                                                               | - Concerned                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Family Concern</b> |                                                                                                                                               | - Concerned or absent                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| <b>Green = Score 0-2</b>                                                         | <b>Yellow = Score 3-4</b>                                                                                                                                                                                                                                                                  | <b>Red = Score 5-11</b>                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- Continue Routine Assessments</li> </ul> | <ul style="list-style-type: none"> <li>- Notify charge nurse or LIP</li> <li>- Discuss treatment plan with team</li> <li>- Consider higher level of care</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul> | <ul style="list-style-type: none"> <li>- Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation</li> <li>- Notify attending physician</li> <li>- Discuss treatment plan with team</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul> |

**A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE**  
**Use SBAR communication**

**Reference:** McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), <http://dx.doi.org/10.1016/j.pedn.2016.10.005>