

Student Name: Madison Gage Unit: 3N Pt. initials: \_\_\_\_\_ Date: 11/20/2021

| GENERAL APPEARANCE  | CARDIOVASCULAR   | PSYCHOSOCIAL   |
|---|--|--|
| <b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished<br><input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br><b>Developmental age:</b><br><input type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed   | <b>Pulse:</b> <input checked="" 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 checked="" 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 checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R <u>3+</u> <u>13+</u><br>Lower R <u>3+</u> <u>13+</u><br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None  | <b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input checked="" 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 checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br><b>Social/emotional bonding with family:</b><br><input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent   |
| NEUROLOGICAL  | ELIMINATION  | IV ACCESS  |
| <b>LOC:</b> <input checked="" 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 checked="" 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 checked="" 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 <u>N</u> Left <u>N</u><br>Pushes: Right <u>N</u> Left <u>N</u><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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><u>Bilat blind, would not open eyes</u>  | <b>Urine Appearance:</b> <u>Clear/yellow</u><br><b>Stool Appearance:</b> <u>Yellow/brown</u><br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy  | <b>Site:</b> _____ <input type="checkbox"/> INT <input checked="" 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> _____   |
| RESPIRATORY   | GASTROINTESTINAL   | SKIN   |
| <b>Respirations:</b> <input checked="" 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 checked="" type="checkbox"/> Right <input checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> No Type _____<br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> <u>99%</u> | <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 checked="" type="checkbox"/> Present X <u>4</u> quads<br><input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br><b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Tube:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NGT</u><br>Location <u>R</u> Inserted to <u>21</u> cm<br><input type="checkbox"/> Suction Type: _____ | <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 checked="" type="checkbox"/> Natural for Pt<br><b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br><b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br><b>Skin:</b> <input checked="" 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: <u>head</u><br><b>Mucous Membranes:</b> Color: _____<br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| MOBILITY  | NUTRITIONAL  | PAIN   |
| <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> In Arms<br><input type="checkbox"/> Ambulatory with assist _____<br><b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden  | <b>Diet/Formula:</b> <u>Breastmilk</u><br><b>Amount/Schedule:</b> <u>110 q3</u><br><b>Chewing/Swallowing difficulties:</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><u>NGT</u>  | <b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> PACC <input type="checkbox"/> Faces<br><b>Location:</b> _____<br><b>Type:</b> _____<br><b>Pain Score:</b><br>0800 <u>0</u> 1200 <u>0</u> 1600 <u>0</u>   |
|   | WOUND/INCISION   | TUBES/DRAINS   |
|   | <input type="checkbox"/> None<br><b>Type:</b> <u>SX, lacerations</u><br><b>Location:</b> <u>head</u><br><b>Description:</b> <u>lacerations</u><br><b>Dressing:</b> <u>none</u>   | <input type="checkbox"/> None<br><input checked="" type="checkbox"/> Drain/Tube<br><b>Site:</b> <u>R</u><br><b>Type:</b> <u>VP shunt</u><br><b>Dressing:</b> _____<br><b>Suction:</b> _____<br><b>Drainage amount:</b> _____<br><b>Drainage color:</b> _____   |

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| INTAKE/OUTPUT        |     |    |    |     |     |    |    |    |    |    |    |    |        |
|----------------------|-----|----|----|-----|-----|----|----|----|----|----|----|----|--------|
| PO/Enteral Intake    | 07  | 08 | 09 | 10  | 11  | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total  |
| PO Intake            |     |    |    |     |     |    |    |    |    |    |    |    |        |
| Intake – PO Meds     |     | 5  |    |     |     |    |    |    |    |    |    |    | 5 ml   |
| Enteral Tube Feeding | 110 |    |    | 110 |     |    |    |    |    |    |    |    | 220 ml |
| Enteral Flush        |     |    |    |     |     |    |    |    |    |    |    |    |        |
| Free Water           |     |    |    |     |     |    |    |    |    |    |    |    |        |
| <hr/>                |     |    |    |     |     |    |    |    |    |    |    |    |        |
| IV INTAKE            | 07  | 08 | 09 | 10  | 11  | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total  |
| IV Fluid             |     |    |    |     |     |    |    |    |    |    |    |    |        |
| IV Meds/Flush        |     |    |    |     |     |    |    |    |    |    |    |    |        |
| <hr/>                |     |    |    |     |     |    |    |    |    |    |    |    |        |
| OUTPUT               | 07  | 08 | 09 | 10  | 11  | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total  |
| Urine                |     |    |    |     |     |    |    |    |    |    |    |    |        |
| # of immeasurable    |     |    | 1  |     |     |    |    |    |    |    |    |    | 1      |
| Stool                |     |    |    |     | 75g |    |    |    |    |    |    |    | 75 g   |
| 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:<br>0 1 <u>2</u> 3  |
| Cardiovascular   | Circle the appropriate score for this category:<br><u>0</u> 1 2 3  |
| Respiratory  | Circle the appropriate score for this category:<br><u>0</u> 1 2 3  |
| Staff Concern  | 1 pt - Concerned   |
| Family Concern   | 1 pt - Concerned or absent   |
| CHEWS Total Score  |  |
| CHEWS Total Score  | Total Score (points) <u>2</u>  |
|  | 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 |