

Student Name: MICHAEL Aranda Unit: \_\_\_\_\_ Pt. initials: A.T. Date: 08/25/21

| GENERAL APPEARANCE   | CARDIOVASCULAR   | PSYCHOSOCIAL  |
|--|--|---|
| <b>Appearance:</b> <input checked="" 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 checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed   | <b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input checked="" 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 checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R <u>3+</u> L <u>3+</u><br>Lower R <u>3+</u> L <u>3+</u><br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None  | <b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input checked="" 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 Withdrawn 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 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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input checked="" 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 checked="" type="checkbox"/> Able to move all extremities<br><input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right <u>5</u> Left <u>5</u><br>Pushes: Right <u>5</u> Left <u>5</u><br>S=Strong W=Weak N=None<br><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____<br><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <b>Urine Appearance:</b> _____<br><b>Stool Appearance:</b> <u>tan brown</u><br><input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy  | <b>Site:</b> <u>AC</u> <input type="checkbox"/> ANT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br>Type/Location: _____<br><b>Appearance:</b> <input checked="" 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 checked="" 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 checked="" 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 type="checkbox"/> No Type _____<br><b>Pulse Ox Site:</b> <u>index finger</u><br><b>Oxygen Saturation:</b> <u>97%</u> | <b>Abdomen:</b> <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded<br><b>Bowel Sounds:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> 4 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br><input type="checkbox"/> Suction Type: _____ | <b>Color:</b> <input checked="" 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: _____<br><b>Mucous Membranes:</b> Color: _____<br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| NUTRITIONAL  | MUSCULOSKELETAL  | PAIN  |
| <b>Diet/Formula:</b> <u>clear liquid</u><br><b>Amount/Schedule:</b> _____<br><b>Chewing/Swallowing difficulties:</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <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 checked="" type="checkbox"/> All<br><b>Brace/Appliances:</b> <input type="checkbox"/> None<br>Type: _____  | <b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces<br><b>Location:</b> <u>Abdomen</u><br><b>Type:</b> _____<br><b>Pain Score:</b><br>0800 _____ 1200 _____ 1600 <u>2</u>  |
| MOBILITY   | WOUND/INCISION   | TUBES/DRAINS  |
| <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input 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   | <input checked="" type="checkbox"/> None<br><b>Type:</b> _____<br><b>Location:</b> _____<br><b>Description:</b> _____<br><b>Dressing:</b> _____  | <input checked="" type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br><b>Site:</b> _____<br><b>Type:</b> _____<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            |    |    |    |    |    |    |    | 0   | 250 | 0  | 0  | 0  | 250   |
| Intake – PO Meds     |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| Enteral Tube Feeding |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| Enteral Flush        |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| Free Water           |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| <b>IV INTAKE</b>     |    |    |    |    |    |    |    |     |     |    |    |    |       |
| IV Intake            | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14  | 15  | 16 | 17 | 18 | Total |
| IV Fluid             |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| IV Meds/Flush        |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| <b>OUTPUT</b>        |    |    |    |    |    |    |    |     |     |    |    |    |       |
| Output               | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14  | 15  | 16 | 17 | 18 | Total |
| Urine                |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| # of immeasurable    |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| Stool                |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| Urine/Stool mix      |    |    |    |    |    |    |    | 390 | 0   | 0  | 0  | 0  | 390   |
| Emesis               |    |    |    |    |    |    |    | 0   | 0   | 0  | 0  | 0  |       |
| Other                |    |    |    |    |    |    |    |     |     |    |    |    |       |

| Children's Hospital Early Warning Score (CHEWS)                     |  |
|---|--|
| (See CHEWS Scoring and Escalation Algorithm to score each category) |  |
| Behavior/Neuro  | Circle the appropriate score for this category:<br>0 1 2 3   |
| Cardiovascular  | Circle the appropriate score for this category:<br>0 1 2 3   |
| Respiratory   | Circle the appropriate score for this category:<br>0 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>0</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 |