

# IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age:

Patient Weight: kg

Student Name:

NADIA BALDARAS

Unit:

Pt. Initials:

Date: Click here to enter a date.

08/25/21

**1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference):**

Asthma  
 - inflammation of the pulmonary airways & bronchial hyperresponsiveness

**2. Factors for the Development of the Disease/Acute Illness:**

Family history  
 - viral respiratory infections  
 - Allergies  
 - Air pollution  
 - obesity

**3. Signs and Symptoms:**

- shortness of breath  
 - chest tightness or pain  
 - wheezing  
 - coughing

**4. Diagnostic Tests Pertinent or Confirming of Diagnosis:**

- Spirometry  
 - Peak flow  
 - chest x-ray  
 - sputum eosinophils

**5. Lab Values That May Be Affected:**

- Blood gases  
 - CBC

**6. Current Treatment (Include Procedures):**

- Bipap  
 - Albuterol  
 - sedation

[www.labtestsonline.org/asthma](http://www.labtestsonline.org/asthma)

[www.pubmed.ncbi.nlm.gov](http://www.pubmed.ncbi.nlm.gov)

[www.mayoclinic.org/diseases-conditions/asthma](http://www.mayoclinic.org/diseases-conditions/asthma)

[www.wing.org/wing-health-diseases/asthma](http://www.wing.org/wing-health-diseases/asthma)

Student Name: NADIA BALDEKAT Unit: \_\_\_\_\_ Pt. initials: \_\_\_\_\_ Date: 08/25/21

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>3</u> L <u>3</u> Lower R <u>3</u> L <u>3</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>3</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>N</u> Left <u>N</u> Pushes: Right <u>N</u> Left <u>N</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>yellow</u> <b>Stool Appearance:</b> <u>not assessed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>DAL, PICC</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>DS 1/2 NS + 20k @ 63</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input checked="" type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input checked="" type="checkbox"/> BiPap/CPAP: <u>cpap-4 ipap-12</u> <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>-10 foot</u> <b>Oxygen Saturation:</b> <u>99%</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present <input checked="" type="checkbox"/> <u>A</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown <b>Location/Description:</b> _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>NPO</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 <u>0</u> 1200 <u>0</u> 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None Type: <u>pt. is sedated</u>	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>pt. is sedated</u> <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

Student Name: NADIA BALDERAS Unit: \_\_\_\_\_ Pt. initials: \_\_\_\_\_ Date: 04/25/21

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	41	41	61	61	100	100							304
IV Meds/Flush	59	59	39	39									196
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	30	60	15	75	60	48							288
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
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:
	<u>0</u> 1 2 3
Cardiovascular	Circle the appropriate score for this category:
	<u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category:
	0 1 <u>2</u> 3
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
<b>CHEWS Total Score</b>	
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

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age:

Patient Weight: kg

<p><b>Student Name:</b> NADIA BALDARAS</p>		<p><b>Date:</b> Click here to enter a date. 08/25/21</p>
<p><b>1. Disease Process &amp; Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference):</b> Hydrocephalus - An imbalance in the production &amp; absorption of CSF in the ventricular system</p>	<p><b>2. Factors for the Development of the Disease/Acute Illness:</b> - Head injuries - Brain tumor - Brain bleed - Meningitis or other infection of the brain or spinal cord</p>	<p><b>3. Signs and Symptoms:</b> - Abnormal enlargement of head - Soft spot on top of head - vomiting - sleepiness - irritability - downward deviation of eyes - bulging scalp veins</p>
<p><b>4. Diagnostic Tests Pertinent or Confirming of Diagnosis:</b> - CT scan - MRI</p>	<p><b>5. Lab Values That May Be Affected:</b> - N/A - verified with Mr. Burdey</p>	<p><b>6. Current Treatment (Include Procedures):</b> - MRI - EEG (24 hrs)</p>

<b>Student Name:</b> NADIA BALDARAS		<b>Date:</b> Click here to enter a date. 08/25/21
<b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b>  1. coloring  2. watching cartoons  <b>*List All Pain/Discomfort Medication on the Medication Worksheet</b> Click here to enter text. morphine 0.7mg Tylenol 200mg	<b>8. Calculate the Maintenance Fluid Requirement (Show Your Work):</b> $100 \times 10 = 100$ $90 \times 4.5 = 225$ $\frac{325}{24} = 13.5$  <b>Actual Pt MIVF Rate:</b> N/A  <b>Is There a Significant Discrepancy?</b> Choose an item. N/A  <b>Why?</b> NO IV SITE	<b>9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</b> $1.0 \text{ ml/Kg/hr}$ $14.9 \times 1 = 14.9$  <b>Actual Pt Urine Output:</b> unmeasured
<b>10. Growth &amp; Development: List the Developmental Stage of Your Patient For Each Theorist Below and Document 2 OBSERVED Developmental Behaviors for Each Theorist. If Developmentally Delayed, Identify the Stage You Would Classify the Patient:</b>  <b>Erickson Stage:</b> Autonomy vs. shame + doubt 1. Pt. wanted to put on BP cuff himself. 2. Pt. wanted to use my stethoscope.  <b>Piaget Stage:</b> sensorimotor period 1. Pt. wanted to help me put vital machine away. 2. Pt. knew taking off pulse ox. would stop the "dinging".		

<b>Student Name:</b> MADIA BALDEKAS		<b>Date:</b> Click here to enter a date. 08/25/21
<b>11. Focused Nursing Diagnosis:</b> RISK FOR FALL	<b>15. Nursing Interventions related to the Nursing Diagnosis in #11:</b> 1. Provide signs at door that state pt. is a fall risk. <b>Evidenced Based Practice:</b> Prevents falls + promotes pt. safety.	<b>16. Patient/Caregiver Teaching:</b> 1. Teach family about fall reduction measures (clutter, etc.) 2. Teach family how to correct identified hazards. (gate for stairs) 3. Teach family signs of change in mental status. (confusion, etc.)
<b>12. Related to (r/t):</b> hydrocephalus	2. Keep bed at lowest position. <b>Evidenced Based Practice:</b> Reduces the risk of falls + serious injury.	
<b>13. As evidenced by (aeb):</b> - intracranial pressure enlargement of head	3. Keep the room clutter free. <b>Evidenced Based Practice:</b> Reduces the risk of pt. tripping over something + falling.	
<b>14. Desired patient outcome:</b> child will remain free of falls from 0700 to 1230 on 08/24.		<b>17. Discharge Planning/Community Resources:</b> 1. Assess home environment for threats to safety 2. Notify HCP of any seizures 3. Kids with large heads + poor head control, should not be placed in forward facing car safety regardless of age.

Student Name: NADIA BALDERRAS Unit: \_\_\_\_\_ Pt. initials: \_\_\_\_\_ Date: 08/24/21

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <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 <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically <b>Grips:</b> Right <u>S</u> Left <u>S</u> <b>Pushes:</b> Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>yellow</u> <b>Stool Appearance:</b> <u>stool not assessed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>NO IV SITE</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>A</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input checked="" type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown <b>Location/Description:</b> <u>face, eyes, arm</u> <b>Mucous Membranes:</b> Color: <u>PINK</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
<b>Diet/Formula:</b> <u>regular</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None Type: _____	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 <u>0</u> 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None <b>Type:</b> <u>head incision</u> <b>Location:</b> <u>(R) side of forehead</u> <b>Description:</b> <u>3 stitches</u> <b>Dressing:</b> <u>N/A</u>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: NADIA SAUD QAS Unit: \_\_\_\_\_ Pt. initials: \_\_\_\_\_ Date: 08/29/21

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		240											240
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				2									2
Stool				1									1
Urine/Stool mix													
Emesis													
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: 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
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