

Student Name: STEPHANIE PIGG Unit: PICU Pt. initials: WB Date: 9-8-21

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <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 _____ Edema: <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+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: 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	Social Status: <input type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input 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 Withdrawn 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 Social/emotional bonding with family: <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>2</u> Fontanel: (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>5</u> Left <u>5</u> Pushes: Right <u>5</u> Left <u>5</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>DARK AMBER</u> Stool Appearance: <u>NOT OBSERVED</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>LT CAPH</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>DS 1/2 NS + 20 KCAL</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Retractions (type) <u>SUBCOSTAL & INTERCOSTAL</u> <input type="checkbox"/> Labored Breath Sounds: Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input checked="" type="checkbox"/> Right <input checked="" 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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input checked="" type="checkbox"/> Vent: ETT size <u>3</u> @ <u>10</u> cm <input type="checkbox"/> Other: _____ Trach: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size <u>3</u> Type <u>CUFFED</u> Obturator at Bedside <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>YLW/TAN</u> Consistency <u>MOD. THICK</u> Suction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>CONTINUOUS</u> Pulse Ox Site: <u>RT FOOT</u> Oxygen Saturation: <u>100%</u>	Abdomen: <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NG</u> Location <u>RN</u> Inserted to <u>25</u> cm <input checked="" type="checkbox"/> Suction Type: <u>CONTINUOUS</u>	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input checked="" type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input checked="" type="checkbox"/> Skin Breakdown Location/Description: <u>LIPS/ABD</u> Mucous Membranes: Color: <u>GREY/PINK</u> <input type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formulas: <u>NPO/NG</u> Amount/Schedule: <u>NONE FOR NOW</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <u>CPOT</u> Location: _____ Type: _____ Pain Score: 0800 <u>1</u> 1200 <u>1</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 Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: <u>LT MEDIAL</u> Location: <u>RT ABD</u> Description: <u>YLW/CLEAR DRAINAGE</u> Dressing: <u>TRANSPARENT FILM</u>
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Bedridden	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>RT UPPER ABD</u> Type: <u>JP</u> Dressing: <u>TRANSPARENT FILM</u> Suction: <u>HIGH/FULL CHARGE</u> Drainage amount: <u>5-1</u> Drainage color: <u>YLW/CLEAR</u>

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INTAKE/OUTPUT																		
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	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	16.48	16.32		32.8									65.6					
IV Meds/Flush			9										9					
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total					
Urine			12										12					
# 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	<u>1</u>	2
			3
Staff Concern	1 pt - Concerned		
Family Concern	1 pt - Concerned or absent		
CHEWS Total Score			
Total Score (points) <u>2</u>			
Score 0-2 (Green) - Continue routine assessments			
Score 3-4 (Yellow) - Notify charge nurse or LP, 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 Total Score			