

Student Name: Hailey Cowley Unit: PEDI Pt. initials: \_\_\_\_\_ Date: 5/11/22

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" 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 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 Withdrawn 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 checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" 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 <u>3mm</u> <b>Fontanel: (Pt &lt; 2 years)</b> <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" 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>5</u> Left <u>5</u> <b>Pushes:</b> Right <u>5</u> Left <u>5</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 observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <input checked="" type="checkbox"/> 22g AC <input checked="" type="checkbox"/> NT <input type="checkbox"/> None <input 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 checked="" 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>165mL DS 1/2 NS E</u> <u>20KCL</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 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> <u>finger</u> <b>Oxygen Saturation:</b> <u>99.1</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 X <u>4</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 checked="" type="checkbox"/> Yes <input 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 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 checked="" type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown <b>Location/Description:</b> <u>abd sutures</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>Appropriate for age</u> <b>Amount/Schedule:</b> <u>advance as tolerated</u> <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 checked="" type="checkbox"/> None Type: _____	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces <b>Location:</b> <u>Abdomen</u> <b>Type:</b> <u>ache/sore</u> <b>Pain Score:</b> 0800 <u>2</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>Sutures w/ gauze ster.</u> <b>Location:</b> <u>Abdominal</u> <b>Description:</b> <u>3 sutures</u> <b>Dressing:</b> <u>gauze, steristrips</u>	<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> _____

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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
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		1000											1000ml
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													
# of immeasurable			1										1
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: <input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 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