

Pedi - Wednesday

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 7

Patient Weight: 30.7 kg

<p>Student Name: Kennedi Blount</p>	<p>Unit: Pedi Pt. Initials:</p>	<p>Date: Click here to enter a date. 9/7/2022</p>
<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference): Asthma exacerbation - airway becomes swollen & inflamed. The muscles around the airways contract & the airways produce extra mucus, causing breathing tubes to narrow. Pt. may cough, wheeze, & struggle to breathe. Episodes can be triggered by allergens, exercise, stress, etc.</p>	<p>2. Factors for the Development of the Disease/Acute Illness: - Past severe asthma attacks (P) - Previous intubation for asthma - Pollen, pets, mold, dust mites - Upper respiratory infections - tobacco smoke - inhaling cold, dry air - GERD - stress</p>	<p>3. Signs and Symptoms: - Severe shortness of breath (P) - chest tightness (P) - coughing/wheezing (P) - inability to speak d/t SOB</p>
<p>4. Diagnostic Tests Pertinent or Confirming of Diagnosis: - lung function tests - H&P • recurrent dry cough • rhonchus • wheezing • chest tightness • shortness of breath</p>	<p>5. Lab Values That May Be Affected: - ABG → respiratory alkalosis - allergy panel (for triggers)</p>	<p>6. Current Treatment (Include Procedures): - rescue inhalers (P) - short-acting beta agonist (P) - oral corticosteroids (P) - ipratropium - intubation/mechanical ventilation - oxygen (P)</p>

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7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.

1. sitting up straight to allow for minimal resistance in breathing.
 2. Distraction - cartoons, toys, playroom
- *List All Pain/Discomfort Medication on the Medication Worksheet
Click here to enter text.
- acetaminophen

8. Calculate the Maintenance Fluid Requirement (Show Your Work):

$$10 \times 100 = 1000$$

$$10 \times 50 = 500$$

$$10.7 \times 20 = 214$$

$$\frac{1000 + 500 + 214}{24} = 71 \text{ mL/hr}$$

Actual Pt MIVF Rate: none

Is There a Significant Discrepancy?

Choose an item.

Why?

Pt was not on MIVF. He was taking adequate oral fluids.

10. Growth & 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:

Erickson Stage: Industry v. Inferiority

1. Pt. told me he does not like to play soccer bc he doesn't run fast.

2. Pt states "I help my friends build things w my legos alot bc i'm really good at it."

Piaget Stage: Concrete operational

1. classification - I came into the room & found him sorting his legos.

2. Logic - Pt. told me "If I don't drink water they said they have to put water in my IV. So, I'm drinking lots of water."

9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):

$$0.5 \times 30.7 = 15.35 \text{ mL/hr}$$

$$15.35 \times 24 \text{ hrs} = 368.4 \text{ mL}$$

Actual Pt Urine Output:

1130 mL / 12 hrs
~ 2,260 mL / 24 hrs

ent Name:

11. Focused Nursing Diagnosis:

~~Ineffective breathing~~

~~pattern~~

Ineffective breathing
pattern

12. Related to (r/t):

swelling/spasms of bronchial
tubes in response to inhaled
irritants

13. As evidenced by (aeb):

tachypnea, shallow
respirations

14. Desired patient outcome:

Pt. will maintain normal
respiratory rate & pattern
without difficulty.

15. Nursing Interventions related to the Nursing

Diagnosis in #11:

1. Allow periods of rest between
activities.

Evidenced Based Practice:

Fatigue can result from
labored breathing. Pt. may tire easily.

2. Teach pursed-lip breathing

Evidenced Based Practice:

Pursed-lip breathing improves
breathing control & encourages breathing

3. Encourage the Pt to sit
upright

Evidenced Based Practice:

This allows for max lung
expansion.

16. Patient/Caregiver Teaching:

1. USE ~~caregiver~~ RESCUE inhaler
as soon as symptoms appear.
2. Proper administration of
inhaler.
3. Limit dust/smoke Pt. is
around when possible.

breathing in O2 through NC.

17. Discharge Planning/Community Resources:

1. Resources for cost of inhalers
& other meds.
2. Transportation/availability
for follow up appointments.
3. Ensure child has adequate
documentation needed for
school.

Student Name: _____ Unit: Pedi Pt. Initials: _____ Date: _____

<p>GENERAL APPEARANCE</p> <p>Appearance: <input checked="" 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</p>	<p>CARDIOVASCULAR</p> <p>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</p>	<p>PSYCHOSOCIAL</p> <p>Social Status: <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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p>NEUROLOGICAL</p> <p>LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" 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 type="checkbox"/> Size <u>3mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" 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>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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</p>	<p>ELIMINATION</p> <p>Urine Appearance: <u>not observed</u> Stool Appearance: <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p>IV ACCESS</p> <p>Site: <u>AC</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>22g</u> 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: _____</p>
<p>RESPIRATORY</p> <p>Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: 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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>3</u> L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input 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 _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: _____</p>	<p>GASTROINTESTINAL</p> <p>Abdomen: <input checked="" type="checkbox"/> Soft <input 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____</p>	<p>SKIN</p> <p>Color: <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 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 checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ Mucous Membranes: Color: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
<p>NUTRITIONAL</p> <p>Diet/Formula: <u>regular</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>MUSCULOSKELETAL</p> <p><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: _____</p>	<p>PAIN</p> <p>Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 <u>0</u></p>
<p>MOBILITY</p> <p><input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input 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 type="checkbox"/> Bedridden</p>	<p>WOUND/INCISION</p> <p><input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____</p>	<p>TUBES/DRAINS</p> <p><input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____</p>

Student Name: _____ Unit: _____ Pt. initials: _____ Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake					240	240	680	100					
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				150		380	100			150	350		
# 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:
	<input checked="" type="radio"/> 0 1 2 3
Cardiovascular	Circle the appropriate score for this category:
	<input checked="" type="radio"/> 0 1 2 3
Respiratory	Circle the appropriate score for this category:
	<input checked="" type="radio"/> 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

GENERAL APPEARANCE
 Appearance: Healthy/Well Nourished
 Neat/Clean Emaciated Unkept
 Developmental age:
 Normal Delayed

NEUROLOGICAL
 LOC: Alert Confused Restless
 Sedated Unresponsive sleeping
 Oriented to:
 Person Place Time/Event
 Appropriate for Age
 Pupil Response: Equal Unequal
 Reactive to Light Size _____
 Fontanel: (Pt < 2 years) Soft Flat
 Bulging Sunken Closed
 Extremities:
 Able to move all extremities
 Symmetrically Asymmetrically
 Grips: Right S Left S
 Pushes: Right S Left S
 S=Strong W=Weak N=None
 EVD Drain: Yes No Level _____
 Seizure Precautions: Yes No

RESPIRATORY
 Respirations: Regular Irregular
 Retractions (type) _____
 Labored
 Breath Sounds:
 Clear Right Left
 Crackles Right Left
 Wheezes Right Left
 Diminished Right Left
 Absent Right Left
 Room Air Oxygen
 Oxygen Delivery:
 Nasal Cannula: _____ L/min
 BIPap/CPAP: _____
 Vent: ETT size _____ @ _____ cm
 Other: _____
 Trach: Yes No
 Size _____ Type _____
 Obturator at Bedside Yes No
 Cough: Yes No
 Productive Nonproductive
 Secretions: Color _____
 Consistency _____
 Suction: Yes No Type _____
 Pulse Ox Site (R) 2nd toe
 Oxygen Saturation: 98

CARDIOVASCULAR
 Pulse: Regular Irregular
 Strong Weak Thready
 Murmur Other _____
 Edema: Yes No Location _____
 1+ 2+ 3+ 4+
 Capillary Refill: < 2 sec > 2 sec
 Pulses:
 Upper R 3+ L 3+
 Lower R 3+ L 3+
 4+ Bounding 3+ Strong 2+ Weak
 1+ Intermittent 0 None

ELIMINATION
 Urine Appearance: yellow
 Stool Appearance: _____
 Diarrhea Constipation
 Bloody Colostomy

GASTROINTESTINAL
 Abdomen: Soft Firm Flat
 Distended Guarded
 Bowel Sounds: Present X 4 quads
 Active Hypo Hyper Absent
 Nausea: Yes No
 Vomiting: Yes No
 Passing Flatus: Yes No
 Tube: Yes No Type NG 8F
 Location (R) nare Inserted to 36 cm
 Suction Type: _____

NUTRITIONAL
 Diet/Formula: NPO
 Amount/Schedule: _____
 Chewing/Swallowing difficulties:
 Yes No

MUSCULOSKELETAL
 Pain Joint Stiffness Swelling
 Contracted Weakness Cramping
 Spasms Tremors
 Movement:
 RA LA RL LL All
 Brace/Appliances: None
 Type: _____

MOBILITY
 Ambulatory Crawl In Arms
 Ambulatory with assist _____
 Assistive Device: Crutch Walker
 Brace Wheelchair Bedridden

PSYCHOSOCIAL
 Social Status: Calm/Relaxed Quiet
 Friendly Cooperative Crying
 Uncooperative Restless
 Withdrawn Hostile/Anxious
 Social/emotional bonding with family:
 Present Absent

IV ACCESS
 Site: _____ INT None
 Central Line
 Type/Location: _____
 Appearance: No Redness/Swelling
 Red Swollen
 Patent Blood return
 Dressing Intact: Yes No
 Fluids: _____

SKIN
 Color: Pink Flushed Jaundiced
 Cyanotic Pale Natural for Pt
 Condition: Warm Cool Dry
 Diaphoretic
 Turgor: < 5 seconds > 5 seconds
 Skin: Intact Bruises Lacerations
 Tears Rash Skin Breakdown
 Location/Description: _____
 Mucous Membranes: Color: _____
 Moist Dry Ulceration

PAIN
 Scale Used: Numeric FLACC Faces
 Location: _____
 Type: _____
 Pain Score:
 0800 _____ 1200 _____ 1600 0

WOUND/INCISION
 None
 Type: _____
 Location: _____
 Description: _____
 Dressing: _____

TUBES/DRAINS
 None
 Drain/Tube
 Site: (R) nare
 Type: NG
 Dressing: N/A
 Suction: N/A
 Drainage amount: _____
 Drainage color: _____

Student Name: _____ Unit: _____ Pt. initials: _____ Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake			120										
Intake - PO Meds													
Enteral Tube Feeding						60	60	60	100	150	150		
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													
Stool													
Urine/Stool mix										20			
Emesis													
Other													

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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
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CHEWS Total Score

CHEWS Total Score	Total Score (points) <u>0</u>
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Student Name:

Kennedi Blount

Unit:

PICU

Pt. Initials:

Date: Click here to enter a date.

9/6/2022

1. Disease Process & Brief Pathophysiology

(Identify Key Concepts to Your Patient and

Include Reference):

Osteomyelitis - Inflammation

caused by an infecting organism in the bone. It can reach the bone through blood or through trauma such as surgery, foreign bodies, etc. It is extremely painful & requires strong courses of antibiotics and sometimes surgery. Often caused by Staphylococcus aureus.

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

- Trauma
- Surgery

- foreign bodies

- Placement of prostheses that disrupt bony integrity

* In this pt, we are not aware of the cause. He came in w/ knee pain ~~that~~ that was NEW ONSET.

3. Signs and Symptoms:

- fever (P)
- Pain & tenderness in affected area (P)
- swelling in affected area (P)
- redness in affected area (P)
- warmth in affected area (P)
- difficulty moving the joint (P)

4. Diagnostic Tests Pertinent or Confirming of

Diagnosis:

H & P ✓

blood cultures ✓

X-rays ✓

MRI / CT

biopsies

CBC ✓

5. Lab Values That May Be Affected:

↑ WBC (P)

↑ ESR

↑ CRP

6. Current Treatment (Include Procedures):

- I & D of @ knee
- drains in @ knee
- antibiotics
- bedrest
- X-rays
- pain management

Student Name: Kennedi Blount Unit: PICU Pt. initials: _____ Date: 9-6-22

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location <u>knee</u> <u>middle</u> <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input checked="" type="checkbox"/> 3+ <input type="checkbox"/> 4+ <u>finger</u> Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" 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 type="checkbox"/> Size <u>3 mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>N</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>yellow, Foley</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>RT IJ</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 checked="" type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input 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 checked="" type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen	Abdomen: <input checked="" type="checkbox"/> Soft <input 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <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 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 checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>3</u> L/min <input type="checkbox"/> BiPAP/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site <u>middle toe</u> Oxygen Saturation: <u>92</u>	Diet/Formula: <u>regular</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>"everywhere"</u> Type: _____ Pain Score: 0800 _____ 1200 <u>0</u> 1600 <u>4</u>
	MUSCULOSKELETAL	WOUND/INCISION
	<input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Joint Stiffness <input checked="" type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input checked="" type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input 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 knee</u> Type: <u>JP</u> Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

① AC 20g
② forearm 22g

Student Name: _____ Unit: _____ Pt. initials: _____ Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		250											
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	100	100	100	100	100	100	100	100	100	100	100	100	
IV Meds/Flush		250				100				250			
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine			250	75		350	250	150	250				
# 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:
	0 <u>1</u> 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 2 <u>3</u>
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent

CHEWS Total Score

CHEWS Total Score	Total Score (points) <u>4</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