

Student Name: MEREDITH EDWARDS Unit: PF(2) Pt. Initials: IW Date: 09/21/22

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 ( <u>FTT Dx</u> )	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input 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>2+</u> L <u>2+</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 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 Withdrawn 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 ( <u>MOM HELD</u> )
NEUROLOGICAL	ELIMINATION	SKIN
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: ( <u>BABY ASLEEP</u> ) <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Slit 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 type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>N/A</u> Left <u>N/A</u> Pushes: Right <u>N/A</u> Left <u>N/A</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 ( <u>PT. ASLEEP</u> )	Urine Appearance: <u>LIGHT YELLOW</u> Stool Appearance: <u>GREEN</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy ( <u>CLAY LIKE</u> )	IV ACCESS ( <u>BABY</u> ) Site: <u>FOREARM</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>N/A</u>
RESPIRATORY	GASTROINTESTINAL	PAIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) <u>N/A</u> <input type="checkbox"/> Labored Breath Sounds: Clear <input 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 <input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ 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 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 <u>N/A</u> Pulse Ox Site ( <u>R FOOT</u> ) Oxygen Saturation: <u>97</u>	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 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 6.5 FR</u> Location <u>UNPA</u> inserted to <u>22</u> cm <input type="checkbox"/> Suction Type: <u>N/A</u>	Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input type="checkbox"/> Warm <input checked="" 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>ASLEEP</u> ) <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MUSCULOSKELETAL	NUTRITIONAL	WOUND/INCISION
<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input 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 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: <u>N/A</u>	Diet/Formula: <u>3-5 OZ</u> Amount/Schedule: <u>302 EVERY 4 HRS</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 Location: <u>N/A BABY ASLEEP</u> Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 _____
MOBILITY	TUBES/DRAINS	
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>N/A</u> Assistive Device: <input type="checkbox"/> Crutch <input checked="" 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 Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____	

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INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake									53				53 mL
Intake - PO Meds													
Enteral Tube Feeding									37				37 mL
Enteral Flush													
Free Water													
<u>(NO MEDS TAKEN)</u>													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													↓
IV Meds/Flush													↓
<u>(NO STOOL PASSED)</u>													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													120
# 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 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