

Pt 1

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

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
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	Pulse: <input 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 <u>N/A</u> Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location <u>N/A</u> <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 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 Withdrawn 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
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 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 type="checkbox"/> Size <u>4</u> Fontanel: (Pt < 2 years) <input 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>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 type="checkbox"/> No	Urine Appearance: <u>Yellow</u> Stool Appearance: <u>Brown, T-pen</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>Right Chest</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Port</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 type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>NS 10hr</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input 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 checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: <u>N/A</u> /min <input type="checkbox"/> BiPap/CPAP: <u>N/A</u> <input type="checkbox"/> Vent: ETT size <u>M</u> @ <u>M</u> /cm <input type="checkbox"/> Other: <u>N/A</u> Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>N/A</u> Type <u>N/A</u> 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 <u>N/A</u> Consistency <u>N/A</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> Pulse Ox Site <u>N/A</u> Oxygen Saturation: <u>N/A</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 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 type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> 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 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 type="checkbox"/> Skin Breakdown Location/Description: <u>N/A</u> Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>breast</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <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 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: _____	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>N/A</u> Type: _____ Pain Score: 0800 <input checked="" type="checkbox"/> 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 Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None Type: <u>Right chest, sub</u> Location: _____ Description: _____ Dressing: <u>CDI</u>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pt 1

Student Name: kincaid J Unit: CSON Pt. initials: _____ Date: 09/20/22

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		100	90			20							430
Intake - PO Meds		5											5
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid					4								
IV Meds/Flush					22								22
OUTPUT													
Urine	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine				25									25
# 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

P12

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

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 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>S+</u> L <u>3+</u> Lower R <u>2+</u> L <u>0+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	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
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input 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 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 type="checkbox"/> Closed Extremities: <input checked="" 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>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 type="checkbox"/> No	Urine Appearance: <u>yellow/clar</u> Stool Appearance: <u>Brown, soft</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>LEFT FA CDE</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>LEFT FA 205</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: <u>N/A</u>
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 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 Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: <u>W/L</u> L/min <input type="checkbox"/> BiPap/CPAP: <u>N/A</u> <input type="checkbox"/> Vent: ETT size <u>N/A</u> @ <u>N/A</u> cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>N/A</u> Type <u>N/A</u> 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 <u>N/A</u> Consistency <u>NA</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> Pulse Ox Site _____ Oxygen Saturation: _____	Abdomen: <input 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 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> 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 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 type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: _____ Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: _____ 0800 <input type="checkbox"/> 1200 <input type="checkbox"/> 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: _____ Location: _____ Description: _____ Dressing: _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input checked="" 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	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

P+2

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

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		30			180								210
Intake - PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													—
IV Meds/Flush													
OUTPUT													
Urine	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine						400							400
# 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