

Student Name: Jamie Livesay Unit: PICU Pt. initials: 12 Date: 10/5/22

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 type="checkbox"/> Normal <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location <u>head</u> <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec	<b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input 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>3 mm</u> <b>Fontanel:</b> (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input 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>W</u> Left <u>W</u> <b>Pushes:</b> Right <u>W</u> Left <u>W</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>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>Site:</b> _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>Wall, PEN</u> <b>Pulse Ox Site</b> <u>C big toe</u> <b>Oxygen Saturation:</b> <u>100</u>	<b>Urine Appearance:</b> <u>yellow, red</u> <b>Stool Appearance:</b> <u>brown, soft</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<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 checked="" 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 checked="" type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown <b>Location/Description:</b> <u>forehead</u> <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NG</u> Location <u>D</u> Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> <u>0800</u> <u>0</u> <u>1200</u> <u>0</u> <u>1600</u>
	MUSCULOSKELETAL	WOUND/INCISION
	<b>Diet/Formula:</b> <u>Gentlease</u> <b>Amount/Schedule:</b> <u>22 mL/hr</u> <b>Chewing/Swallowing difficulties:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" 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 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													
Intake – PO Meds													
Enteral Tube Feeding	22	22	22	24	25	25							140
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					76								76
# 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 <b>2</b> 3
Cardiovascular	Circle the appropriate score for this category: <b>0</b> 1 2 3
Respiratory	Circle the appropriate score for this category: <b>0</b> 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>2</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

## CHEWS Scoring and Escalation Algorithm

	0	1	2	3
<b>Behavior/Neuro</b>	<ul style="list-style-type: none"> <li>- Playing/sleeping appropriately</li> <li><b>OR</b></li> <li>- Alert, at patient's baseline</li> </ul>	<ul style="list-style-type: none"> <li>- Sleepy, somnolent when not disturbed</li> </ul>	<ul style="list-style-type: none"> <li>- Irritable, difficult to console <b>OR</b></li> <li>- Increase in patient's baseline seizure activity</li> </ul>	<ul style="list-style-type: none"> <li>- Lethargic, confused, floppy <b>OR</b></li> <li>- Reduced response to pain <b>OR</b></li> <li>- Prolonged or frequent seizures <b>OR</b></li> <li>- Pupils asymmetrical or sluggish</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>- Skin tone appropriate for patient</li> <li>- Capillary refill <math>\leq</math> 2 seconds</li> </ul>	<ul style="list-style-type: none"> <li>- Pale <b>OR</b></li> <li>- Capillary refill 3-4 seconds <b>OR</b></li> <li>- Mild tachycardia <b>OR</b></li> <li>- Intermittent ectopy or irregular HR (not new)</li> </ul>	<ul style="list-style-type: none"> <li>- Grey <b>OR</b></li> <li>- Capillary refill 4-5 seconds <b>OR</b></li> <li>- Moderate tachycardia</li> </ul>	<ul style="list-style-type: none"> <li>- Grey and mottled <b>OR</b></li> <li>- Capillary refill <math>&gt;</math> 5 seconds <b>OR</b></li> <li>- Severe tachycardia <b>OR</b></li> <li>- New onset bradycardia <b>OR</b></li> <li>- New onset/increase in ectopy, irregular HR or heart block</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>- Within normal parameters</li> <li>- No retractions</li> </ul>	<ul style="list-style-type: none"> <li>- Mild tachypnea/increased WOB (flaring, retracting) <b>OR</b></li> <li>- Up to 40% supplemental oxygen <b>OR</b></li> <li>- Up to 1L NC <math>&gt;</math> patient's baseline need <b>OR</b></li> <li>- Mild desaturations <math>&lt;</math> patient's baseline <b>OR</b></li> <li>- Intermittent apnea self-resolving</li> </ul>	<ul style="list-style-type: none"> <li>- Moderate tachypnea/increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) <b>OR</b></li> <li>- 40-60% oxygen via mask <b>OR</b></li> <li>- 1-2 L NC <math>&gt;</math> patient's baseline need <b>OR</b></li> <li>- Nebs Q 1-2 hour <b>OR</b></li> <li>- Moderate desaturations <math>&lt;</math> patient's baseline <b>OR</b></li> <li>- Apnea requiring repositioning or stimulation</li> </ul>	<ul style="list-style-type: none"> <li>- Severe tachypnea <b>OR</b></li> <li>- RR <math>&lt;</math> normal for age <b>OR</b></li> <li>- Severe increased WOB (i.e. head bobbing, paradoxical breathing) <b>OR</b></li> <li>- <math>&gt;</math> 60% oxygen via mask <b>OR</b></li> <li>- <math>&gt;</math> 2 L NC more than patient's baseline need <b>OR</b></li> <li>- Nebs Q 30 minutes – 1 hour <b>OR</b></li> <li>- Severe desaturations <math>&lt;</math> patient's baseline <b>OR</b></li> <li>- Apnea requiring interventions other than repositioning or stimulation</li> </ul>
<b>Staff Concern</b>		- Concerned		
<b>Family Concern</b>		- Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
<ul style="list-style-type: none"> <li>- Continue Routine Assessments</li> </ul>	<ul style="list-style-type: none"> <li>- Notify charge nurse or LIP</li> <li>- Discuss treatment plan with team</li> <li>- Consider higher level of care</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul>	<ul style="list-style-type: none"> <li>- Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation</li> <li>- Notify attending physician</li> <li>- Discuss treatment plan with team</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul>

**A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE**  
Use SBAR communication

**Reference:** McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), <http://dx.doi.org/10.1016/j.pedn.2016.10.005>