

Student Name: Jahna Oliver

Unit: PTU

Date: 3-28-22

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 checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location <u>feet</u> <input checked="" type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <u>bilat</u> Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: <u>Cap N/A, Polish</u> 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 checked="" 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 Withdrawn 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 type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3</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 checked="" 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 checked="" type="checkbox"/> No	Urine Appearance: <u>yellow, cloudy</u> Stool Appearance: <u>no stool</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>Per, phemas</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Right</u> Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input 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 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: _____ 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 type="checkbox"/> No Type _____ Pulse Ox Site: _____ Oxygen Saturation: _____	Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded Bowel Sounds: <input type="checkbox"/> Present <input checked="" type="checkbox"/> <u>4</u> quads <input type="checkbox"/> Active <input checked="" 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 _____ 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 checked="" type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input checked="" type="checkbox"/> Diaphoretic Turgor: <input type="checkbox"/> < 5 seconds <input checked="" type="checkbox"/> > 5 seconds Skin: <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 Location/Description: <u>Rt temporal</u> Mucous Membranes: Color: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>NPO</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces Location: <u>Abdomen</u> Type: _____ Pain Score: 0800 <u>10</u> 1200 _____ 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input checked="" 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 checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input checked="" type="checkbox"/> RL <input checked="" type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: _____ Location: <u>Incision</u> Description: <u>Midline</u> Dressing: <u>No redness, drainage or signs of itx</u>
	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>Nose</u> Type: <u>nasogastric</u> Dressing: <u>taped on cheek</u> Suction: _____ Drainage amount: <u>100 ml</u> Drainage color: <u>greenish, brown</u>

Student Name: _____

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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													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	30	70 145											
IV Meds/Flush		30	100										
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	48	235											
# 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) _____
	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