

## IM5 Clinical Worksheet – Pediatric Floor Day 2

<p><b>Student Name: Cheyanne Roberson</b> <b>Date: 9/27</b></p>	<p><b>Patient Age: 3</b> <b>Patient Weight: 15.5 kg</b></p>
<p><b>1. Admitting Diagnosis:</b> Ruptured appendix, post op appendectomy.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b> Abdomen assessment. Pain assessment Fever , general vitals.</p>
<p><b>3. Signs and Symptoms:</b> Abdominal pain Vomiting and Diarrhea Lethargy Decreased appetite Fever , tachycardia.</p>	<p><b>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:</b>  CT done in midland Texas.</p>
<p><b>5. Lab Values That May Be Affected:</b> WBC may be elevated with appendicitis. CBC may be ordered to maintain baseline bloodwork for patient .</p>	<p><b>6. Current Treatment (Include Procedures):</b> 14 days of IV antibiotics.</p>
<p><b>7. Pain &amp; Discomfort Management:</b> <b>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <p>1. Put patient in comfortable position.</p> <p>2. Patient has iPad present for distraction.</p>	<p><b>8. Patient/Caregiver Teaching:</b></p> <p>1. No baths.</p> <p>2. Monitor fever at home.</p> <p>3. Continue oral antibiotics at home.</p> <p><b>Any Safety Issues identified:</b>  N/A</p>

<p><b>Student Name: Cheyanne Roberson</b> <b>Date: 9/27</b></p>	<p><b>Patient Age: 3</b> <b>Patient Weight: 15.5 kg</b></p>
<p><b>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</b></p> <p>15.5 kg.    <math>10 \times 100</math>                   <math>5.5 \times 50 = 1275 \text{mls}</math></p> <p><b>Actual Pt MIVF Rate:</b></p> <p><b>Patient is on 12ml/hr</b></p> <p><b>Is There a Significant Discrepancy Between Calculated and Actual Rate? Yes patient is slowly coming off fluids. Fluids are significantly lower than maintenance.</b></p> <p><b>If Yes, Why is There a Discrepancy?</b> Doctor just wanted to help keep patient hydrated but didn't want fluid overload. Mostly KVO for antibiotics.</p>	<p><b>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</b></p> <p><math>.5 \text{mL/kg/hr} = 7.75 \text{ml/hr}</math></p> <p><b>Actual Urine Output During Your Shift (mL/hr):</b></p> <p>Patient was in pull-ups parents were actively changing them, 5 pull-ups were changes no totals amount weighed in room. Parents felt child was urinating significantly.</p>
<p><b>11. Growth &amp; Development:</b></p> <p><b>*List the Developmental Stage of Your Patient For Each Theorist Below.</b></p> <p><b>*Document 2 OBSERVED Developmental Behaviors for Each Theorist.</b></p> <p><b>*If Developmentally Delayed, Identify the Stage You Would Classify the Patient:</b></p> <p><b>Erickson Stage:</b></p> <ol style="list-style-type: none"> <li>1. He showed autonomy vs guilt. He kicked his mother and got in trouble and immediately showed remorse for his behavior.</li> <li>2. Patient showed trust in his parents by allowed them to soothe him to allow us to remove dressings on his abdomen.</li> </ol> <p><b>Piaget Stage:</b></p> <ol style="list-style-type: none"> <li>1. He showed make believe with his toys. This was showing pre-operational stage.</li> <li>2. He would say " boo boo gone" after the dressings were removed really showcasing his intelligence for his age.</li> </ol>	

**Student Name: Cheyanne Roberson**  
**Date: 9/27**

**Patient Age: 3**  
**Patient Weight: 15.5 kg**

**Please list any medications you administered or procedures you performed during your shift:**

**The only medication I administered was Zosyn and IV antibiotic.**

## Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <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 _____ <b>Edema:</b> <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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>4+</u> L <u>3+</u> Lower R <u>4+</u> L <u>4+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" 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 <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input checked="" type="checkbox"/> soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed <b>Extremities:</b> <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 <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>Urine Appearance:</b> <u>clear</u> <b>Stool Appearance:</b> <u>soft</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>Left hand</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Left hand 2+</u> <b>Appearance:</b> <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>renal dialysis</u> <u>with 20-30 mL AC</u>
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 <input checked="" type="checkbox"/> 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 Base <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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>right foot</u> <b>Oxygen Saturation:</b> <u>98%</u>	<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>1</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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <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 <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input 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 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: _____ <b>Mucous Membranes:</b> Color: <u>red</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>Overseas Diet</u> <b>Amount/Schedule:</b> <u>at 12</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
	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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None Type: _____	<input type="checkbox"/> None <b>Type:</b> <u>4 fragments sites</u> <b>Location:</b> <u>right hand 1st-4th</u> <b>Description:</b> <u>teardrop shape</u> <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input checked="" 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: _____

### Pediatric Floor Patient #1

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake								20ml					20
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						n	—————→						T2
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine							5	pullup3		removed.			
# of immeasurable													Nurse notifying to track output
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: <div style="display: flex; align-items: center; gap: 10px;"> <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">0</span> <span>1</span> <span>2</span> <span>3</span> </div>
Cardiovascular	Circle the appropriate score for this category: <div style="display: flex; align-items: center; gap: 10px;"> <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">0</span> <span>1</span> <span>2</span> <span>3</span> </div>
Respiratory	Circle the appropriate score for this category: <div style="display: flex; align-items: center; gap: 10px;"> <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">0</span> <span>1</span> <span>2</span> <span>3</span> </div>
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">0</span>
	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

## Pediatric Floor Patient #2

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input 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 _____ <b>Edema:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Location _____ <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>Pulses:</b> Upper R _____ L _____ Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <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 <b>Social/emotional bonding with family:</b> <input type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input 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 type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right _____ Left _____ Pushes: Right _____ Left _____ S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Urine Appearance:</b> _____ <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <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 type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input 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 type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input 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 type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <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 <b>Condition:</b> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <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: _____ <b>Mucous Membranes:</b> Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MUSCULOSKELETAL	NUTRITIONAL	PAIN
<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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None Type: _____	<b>Diet/Formula:</b> _____ <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	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 type="checkbox"/> Bedridden	<input type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<input type="checkbox"/> None <b>Drain/Tube</b> Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

**Pediatric Floor Patient #2**

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													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													
# 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



## CHEWS Scoring and Escalation Algorithm

	0	1	2	3
<b>Behavior/Neuro</b>	<ul style="list-style-type: none"> <li>- Playing/sleeping appropriately <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>