Children's Hospital and Health System
Patient Care Policy and Procedure

This policy applies to the following entity(s):
☒ CHW - Milwaukee ☒ CHW - Surgicenter

Subject: Assessment, Reassessment, Documentation of a Patient

PURPOSE:

Every child and family is assured of receiving a defined level of comprehensive, quality care as specified by the core philosophies of patient care and nursing. Care, treatment, and services are provided in an interdisciplinary, collaborative manner as appropriate to the needs of the patient. Patient outcomes are prioritized and a mutual plan of care is developed in collaboration with the patient and family. The assessment process will be used throughout the patient's care encounter to support continuity of care. Refer to CHW P&P "Philosophy of Patient Care" and "Philosophy of Nursing".

This policy highlights common areas of assessment, reassessment, and documentation. It is NOT inclusive of all assessments/reassessments/documentation. If you have questions or concerns, please consult with your department/area leadership team.

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Formerly: Standards for Documentation 05/04, Documentation – Patient Care, 4/92, 4/95, 7/95, 8/98, 8/01, "Doc. – Plan of Care 03/04 , Assessment – Reassessment of Patient: 09 2003. Standards for Patient Care Documentation and Assessment and Reassessment of Care
Reviewed: 01/2004, 07/2004, 02/2007, 06/2008
Revised: 05/2013, 09/2013: nutritional assessment added; 02/2014: minor update

POLICY & PROCEDURE

Patient care staff performs assessments and completes documentation for all patients who receive care and treatment based on presenting needs within their scope of practice per procedure outlined below. Refer to CHW P&P "Clinical Delegation by Registered Nurses".

NOTE: This policy does NOT apply to provider documentation. Provider documentation is governed by the Bylaws, Procedures, Rules and Regulations of the Medical Staff. Refer to the "Bylaws, Procedures, Rules and Regulations of the Medical Staff of Children's Hospital of Wisconsin").

Prioritization of Care Needs

As patient care needs are identified it is the responsibility of the healthcare team to prioritize the care and services delivered to assure that the patient's most urgent needs are met. While the provider is recognized as responsible for the prioritization of medical care, each discipline establishes priorities among their interventions and collaboratively among all disciplines involved in the patient's care.

Prioritization of care needs is in order of importance:

1. Emergent or life-threatening conditions
2. Needs that if left unaddressed would become emergent or life-threatening in nature
3. Needs necessary to assure:
    - The safety of the patient
    - The psychosocial stability of the patient
    - The development of the patient to be an appropriate and active participant in their health care needs; and other specified care needs and requests

Purpose of Documentation

Documentation of care in a patient's health record serves multiple purposes:

1. Provides a method for safe, accurate, and collaborative communication among members of the health care team caring for the patient and family.
2. Provides a basis for evaluating the adequacy and appropriateness of care.
3. Provides a record of care as required by regulatory agencies.
4. Protects the legal interests of the patient/family, the facility, and the healthcare providers.
5. Provides data to substantiate insurance claims.
6. Provides clinical data for research and education.

Specific Documentation Information

1. All information contained in the patient record is confidential and in compliance with all state and federal requirements. Refer to CHW P&P "HIPAA Security Policy Standards".

2. Information is documented as soon as possible after observation/intervention/evaluation of the patient.

3. A medical order is required for all care and services which are not within the scope of the independent practice of the health care professional who is carrying out the order. Refer to CHW P&P "Medical Orders-Prescribing Medical Care."

4. Health care providers may only document assessments/interventions they perform except in situations in which a recorder is used, e.g. Code Blue. Refer to CHW P&P "Code Blue for Cardiac/Respiratory Arrest or Emergent Situations".

- This does not pertain to “Make Me the Author” functionality for Ambulatory settings.
- This does not pertain to using a recorder while obtaining vitals in the EDTC in non-emergent situations.
- This does not pertain to specific flow sheet rows designed to capture patient charges for respiratory care supplies and procedures. The respiratory leaders or designee will adjust the charge rows to reflect the documented respiratory activities provided; an explanatory comment is entered to signify why the change was entered.

5. Abbreviations and symbols in documentation are discouraged and may only be used if approved by CHW. Refer to CHW P&P “Abbreviations”.

6. All documentation is entered into the EHR, with the exception of signed, paper consents/forms or during a downtime of the system. All paper consents/forms will be retained in the patient’s skinny chart and scanned into the EHR after discharge. Refer to the CHW P&P “Consent For Treatment.”

7. All consents and forms will include the patient’s name, medical record number and visit number.

8. All paper documentation must be legible and include patient labels.

9. All care providers making entries into the EHR must use their unique assigned name and password. Refer to CHW P&P “Information Services Security”.

10. All care providers making an entry in the EHR will have an auto-populated date, time signature, and documentarian’s credentials.

11. Only the author of a clinical entry may modify or correct the clinical entry, with the exception of
    a. “Chart Correction” which is explained on page 4 of this document.
    b. “Make Me the Author” in ambulatory clinics.

Documentation errors

1. All non-medication documentation errors will be corrected by the documentarian that created the error as soon as the error is recognized.
2. If the documentarian has left their shift, it may be completed by them during their next shift.
3. It is recommended to add a comment in the EHR with a reason for the modification of the documentation.
4. All of these corrections are traceable in the EHR.

Exception: There are specific flow sheet rows designed to capture patient charges for respiratory care supplies and procedures. The respiratory leaders or designee will adjust the charge rows to reflect the documented respiratory activities provided; an explanatory comment is entered to signify why the change was entered.

2. Medication documentation errors
    - Within 72 hours of error: If a medication is entered in error or omitted in error and identified within 72 hours, the documentarian must communicate with an area leader and then proceed in correcting the error on the Medication

Administration Record (MAR). The documentarian must add comments to the MAR to indicate the late entry and add supporting details.

- Not within 72 hours of error: If a medication is entered in error or omitted in error and 72 hours has past, documentation must be completed by using the chart correction tab on the MAR within the encounter that the error occurred. The documentarian must communicate with an area leader and, they together, will perform chart correction. Chart Correction workflow must be followed and is outlined in detail in Addendum B.
- Medication errors should be communicated to a department leader and rectified as soon as possible**.**
- If the medication error involves a controlled substance, the error must be rectified within 24 hours of discovery.
- Chart Correction does not pertain to ambulatory clinics.

Patient Assessment & Required Documentation

Initial data will be gathered at the point of entry into the CHW system and completed within specified time frames.

Admission Assessments and Documentation

- The Consent for Treatment Form (CHW form #C1654N) is required for all patients in both inpatient and outpatient areas. Refer to CHW P&P "Consent for Treatment".
- Full vital signs (temperature, heart rate, respirations, blood pressure, and SpO_2), head to toe assessment, allergies, weight, and height must be documented within **2 hours** of admission to an inpatient unit or within 24 hours of an ambulatory visit. Focused assessments are conducted in ambulatory clinics and the EDTC.
- The complete admission assessment is to be completed within 24 hours of admission to an inpatient unit. Refer to CHW P&P "Admission of a Patient".
- Several screening elements are required based on individualized patient criteria. For specific documentation requirements for an admission refer to the CHW P&P "Admission of a Patient to the Hospital."
- The purpose of the **initial assessment** completed is to:
  1. Identify the patient's immediate and emerging needs relative to physiological status, including pain, nutritional, psychological, social, spiritual, learning, and communication/language needs;
  2. Determine the care the patient requires, as well as the type, scope and breadth of any further or subsequent assessments;
  3. Determine the appropriate patient placement and level of care;
  4. Identify abnormal findings or risk criteria which may trigger consultation with, or referral to, appropriate team members for more in-depth assessment.
- In completing the assessment process all clinical disciplines will consider the following:
  - Parameters outlined in their respective scope of practice;
  - State licensure laws and all other applicable regulations, standards and laws;
  - Setting in which the discipline provides care and services;
  - Age of the patient populations for which the disciplines provide care and services; and
  - Patient populations with special needs.

NOTE: For the EDTC an initial assessment (Airway, Breathing, Circulation, Disability) is conducted on every patient upon arrival. Further assessments are focused based on findings and chief complaint.

Shift Assessments and Documentation

- Ongoing vital signs and assessments will occur at least at the frequency ordered and whenever there is deterioration in patient status. Less frequent assessments may only occur with a provider's order. For example, if a parent doesn't want their child disturbed overnight, a provider's order is needed.
- Full vital signs = temperature, heart rate, respirations, blood pressure, and SpO_2.
- The elements in each assessment and reassessment will be documented in the EHR.
- Care decisions will be based upon data and information gathered in the assessments and reassessments. The data will be utilized in seeking the appropriate goals and interventions in an efficient and effective manner.
- The care provided to each patient is based upon a determination of the patient's needs, the patient and family's agreement with the interprofessional plan of care, and the ability of the hospital to provide the necessary services.
- The patient's plan of care is developed using an interprofessional, collaborative process involving the patient and patient's family/significant others.
- Collaboration among all disciplines will be achieved through the use of the patient's medical record, progress notes, interprofessional rounds, interprofessional care plans, verbal communications and care conferences.
- Assessment and reassessment are individualized to the patient's needs and include but are not limited to:
  - Emotional, behavioral, cognitive, communication, learning, social and daily activity needs. Refer to the CHW P&P "Care of the Patient with Behavioral Outbursts".
  - Developmental age, length or height, head circumference (if less than 2 years of age or diagnosis specific) and weight;
  - Effect on the family or guardian based on the patient's illness or condition and effect of the illness on the patient's family;
  - Family or guardian expectations for and involvement in the patient's assessment, initial treatment and continuing care.
- Standard shift documentation at CHW includes:
    - Pain score at a minimum of 8 hours. If patient is in pain, assessment and documentation is required a minimum of every 2 hours. If patient has received an intervention for pain, assessment and documentation is required 30-60 minutes after the intervention.
    - Alarms set at a minimum of hourly for monitored patients
    - Arm band on at a minimum of every shift
    - Emergency equipment at bedside at a minimum of every shift
    - Care Plan goals outcomes at a minimum of every shift
    - Personal cares at a minimum of every shift
- For Synergy documentation refer to page 10 of this document.

Patient Required Documentation

There may be individualized required documentation for a patient based on individualized patient needs. For in-patient nursing, please refer to the required documentation report to assist in determining specific patient requirements.

Discharge Assessments and Documentation

- Discharge needs will be identified through assessment and reassessment and documented by all disciplines, relevant to scope. Identification of discharge needs will begin upon patient admission.

- The complexity of the discharge plan will depend on individual physical and psychosocial needs of the patient.
- For specific documentation requirements for discharge of a patient refer to the CHW P&P "Transition Planning - Discharge of a Patient."

Ambulatory Clinic Assessments and Documentation

Patient assessment and documentation includes but is not limited to the following:

1. Visit information – chief complaint
2. Physical growth parameters are assessed when relevant to the management of the patient
3. Pain – The clinic assistant (CA) or Medical Assistant (MA) may screen for the presence of pain by asking if the patient is having pain. If the response is No, document response in the pain assessment section in the EHR. If the response is yes, the CA or MA must communicate this to the RN or provider for further pain assessment. Refer to the CHW P&P "Pain Assessment and Management".
4. Safety – AMB Safety Concern Screen (IPV).
5. Allergies/Contraindications.
6. Medications – Review list with patient/family. Add any new medications as reported by patient/family. Refer to CHW P&P "Medication Reconciliation". Indicate medications on the list that are no longer being taken/given.
7. Immunizations. Refer to the CHW P&P "Immunizations".
8. History – Review pertinent history that is individualized to the patient's needs
    a. Medical
    b. Surgical
    c. Social
    d. Developmental
    e. LDAs
9. Patient Education – Verify or document learning assessment on primary learner
    a. Identify education needs, abilities, barriers, preferences, and readiness to learn
10. Transition planning as appropriate to patient care
11. Plans for follow up.

Note: For patients receiving ambulatory services in the same clinic three or more visits per month, review and update chief complaint, allergies, medications, and pertinent history at each encounter.

Reassessment

Reassessment of the patient determines the patient's response to care. Reassessment is ongoing and occurs specifically at the following:

1. Significant changes in the patient's condition or diagnosis;
2. Determining the patient's response to treatment;
3. Change in level of care or transfer between units or caregivers;
4. At specified intervals in the course of the patient's treatment according to established department time frames;
5. Pain scores will be reassessed at least once every shift, and within 30-60 minutes of the appropriate pharmacologic intervention, when there is a patient or parent verbal report of pain, when there are changes in vital signs or behavior suggestive of pain, and after a painful procedure;
6. Documentation of reassessment results is timely and integrated into the patient's medical record in the interprofessional notes and the integrated plan of care.

Within Defined Limits

1) Within Defined Limits (WDL): for a given body system, the set of normal assessment parameters as determined by the organization. Refer to Addendum 1 and row information for each body system in the EHR.

2) Not all areas/units utilize WDL functionality. This section only pertains to areas where the functionality exists, for example but not limited to, in-patient units and EDTC.

   Documenting "Within Defined Limits" or "WDL" means:

   - If "WDL" is entered when the physical assessment is documented and signed, it will indicate that **all defined components** have been assessed and found to be "WDL."
   - WDL is not meant to reflect a specific individual patient's baseline or variance.
     - Example: patient may have low oxygen saturations at baseline for their medical condition. While this is "normal" for this patient, it is not within the defined limits as set by the organization.

3) Within Defined Limits (WDL) **Except**: exceptions that fall out of the body system WDL assessment parameters as determined by the organization and outlined in row information. This is noted by entering an "X" into the flow sheet row.

   Documenting "WDL Except" by entering "X" into a flow sheet row means:

   - Documenting an "X" triggers additional rows to appear on the flow sheet for the nurse to document assessment findings that fall outside of WDL parameters.
     - Example: Respiratory assessment is completed. All values meet the WDL definition except for subcostal retractions. A value for "retractions" is entered and the remainder of the items that meet the WDL definition are left blank to indicate they have met the WDL definition parameters. The clinician only needs to document on rows outside the defined values.

   Charting a "WDL Except" assessment finding: Return to normal: If a patient at reassessment meets the organization's WDL parameters, the clinician enters the "normal" finding for that assessment finding previously documented as "WDL Except" and leaves the other parameters for that body system blank to indicate they meet the WDL definition parameters.

     - Example: Respiratory assessment is completed. All assessment findings meet the WDL definition. The previous assessment had an exception for "retractions". An assessment finding of "none" is now entered into the retractions row and the remainder of the items that meet the WDL definition are left blank to indicate they met have met the WDL definition parameters. Breath sounds that were previously recorded as "coarse" are now clear upon auscultation. "Clear" is entered to return to normal.

   Charting a body system return to WDL: After all the "WDL Except" assessment findings for a body system have been returned to normal, if the next assessment continues to meet the WDL definition parameters, then a WDL value can be entered into the body system flow sheet row.

In sections that do not offer a WDL option, leaving an assessment row blank means that this parameter was not assessed.

Exceptions that fall out of the organization's WDL parameters must be documented.

Patient care staff will update documentation to reflect a change in the patient's status.

For EDTC: In addition to the "WDL" and the "WDL X" the opportunity to document a "Focused Assessment" exists. This option is used when only certain elements of a given body system are assessed and not all that are included within the WDL assessment.

Unable to Assess (UTA)
Unable to Assess (UTA): an attempt to complete an assessment was made and the reason the practitioner was unable to assess is documented as per the following reasons on the drop down list:

1. Off the unit
2. Area or parameter not available for assessment e.g. sterilely draped, casting, dressing, equipment
3. Patient receiving end of life care or altered code status
4. Other (Comment)

Charting Unable to Assess (UTA) may not be documented for the following examples:

1. Sleeping
2. Nighttime
3. Lights off
4. Parent/Patient request without a provider order

Unable to Assess (UTA) for the following requires a Provider Order:

1. Parent/Patient refusal
2. Unsafe for patient condition (e.g. injury related, instability)

Copy Forward
Copy Forward functionality allows the clinician to import previously recorded documentation when available as an option.

1. If Copy Forward is available as an option, it will appear when you right click on a flow sheet header or an individual cell.
2. Copy Forward can be used when the clinician's current assessment matches components of a previous assessment.
3. Copied information must be reconfirmed and revised as necessary to accurately reflect the clinician's current assessment.
4. Documentation created by this method must be reviewed for all components to be accurate and complete and reflective of the clinician's current assessment.
5. Clinicians are responsible for the total content of their documentation, whether the content is original or copied forward.

The following types of information may be copied forward:

1. WDL-type assessments (e.g. head to toe assessments, ICU Assessment, NICU Full Assessment)
2. Numeric settings (ex. vent settings, PCA settings, alarm limits)
3. LDA (Lines, Drain, Airways {IVs, NG Tubes, Central Lines, ETT}) assessments
4. Intervention/procedure documentation (ex: complex dressing changes, burn care tub procedure, wound appearance, serial procedures requiring complex documentation)

The following types of rows SHOULD NOT be copied forward:

1. Numerical measured data (vitals, exhaled tidal volume, PCA injections/attempts, BPEWS, pain, Braden, falls)

2. Volume-based measurements (intake and output)

LDA (Lines, Drains, Airway)
An LDA can be a line, drain, airway, tube, incision or wound. Examples of items that are documented in an LDA include but are not limited to:

1. CVL placement date, location & time.
2. Size of catheter, tube, drain
3. Balloon sizes
4. Internal device that is skin covered, cannot be visualized but can be accessed/programmed/manipulated i.e. Mediport or Ventricular Peritoneal shunt
5. Inserted by
6. Comfort measures during insertion and patient tolerance
7. Site & dressing assessments
8. Interventions performed for the LDA.
9. Date change
10. Removal date, time, reason.

An LDA is NOT an area of covered, intact skin free from erythema and breakdown. Examples of non-LDAs include, but are not limited to:

- Freckles
- Healed, old scar(s)
- Internal things that cannot be assessed such as orthopedic hardware or ear tubes
- Intrathecal medication or LP site without evidence of skin breakdown
- Procedures performed on a natural orifice that does not include an incision or remaining hardware i.e. bronchoscopy or rectal EUA

All nursing and respiratory staff has access to enter LDAs. Only anesthesia providers have access to enter LDAs, therefore, nursing will enter LDAs for all other providers. The non-anesthesia providers will document procedures in a progress or procedural note. When entering an LDA the documentarian will only complete the information they know to be true.

To be able to document against a new LDA, it needs to be entered in order for the appropriate rows to appear on the flow sheet. For example in the inpatient setting, the nurse will typically enter the LDA using the information documented by the provider in the procedure note. In another example, the EDTC would document an LDA on behalf the EMS team who placed a line prior to the patient arriving.

Minimum documentation for an LDA includes:

1. Initial LDA entry into EHR
2. Date
3. Location
4. Size
5. Type
6. All properties to the best of documentarian's knowledge. If #1-#5 are unknown to the documentarian, the fields should be left blank.

Assessment
1. Applicable flowsheet documentation
2. Date & Time

Discontinuation
1. Reason
2. Date & Time
3. Name of person discontinuing the LDA

Discontinuation of an LDA after the event: There may be situations in which an LDA was not discontinued in the EHR immediately. In those cases, it is acceptable practice for whoever detects the need to discontinue the LDA. The documentarian will complete a final assessment of the LDA and then remove the LDA from the EHR.

Flowsheet Documentation

a. Utilized to present large volumes of data in an organized fashion
b. Useful for sequentially tracking data such as vital signs and physical assessment
d. Does not allow for effective documentation of most qualitative data (such as the psychological/emotional status of a patient)

Vitals and Head to Toe Assessment Standards

Vitals must be completed and documented at least as frequently as the provider order. Patient needs and nursing assessment may determine an increase in the frequency of vitals and assessments.

Some areas have standard frequencies of vitals. Below are areas with vitals standards that may, however, be subject to change based on the patient's needs.

- West 3, West 4, & West 5: hourly unless deemed stable by the nurse and then may be every 2 hours providing they are at least as frequent as the provider order.
- Acute Care units: every 8 hours unless ordered more frequently by the provider
- NICU: clustered with other cares based on the neonates needs
- EDTC: upon triage then based on patient acuity

For inpatients, head to toe assessments must be completed for inpatients with every change of shift. Additional head to toe and/or focused assessments may be completed according to a provider order or if a nurse deems more frequent assessments are necessary due to a patient situation.

I&O Assessment & Documentation

For I&O documentation, RNs are responsible for:

1. Documenting accurate and up to date information
2. Verifying that any pumps, pump orders, and documentation match
3. Clearing the pumps at a minimum of every 8 hours and documenting a volume infused at the time the pump in cleared, with the exception of PCAs, Epidurals, and nerve blocks.

   Nurses will not document hourly volumes unless the pump is cleared hourly. Nurses may clear pumps more frequently based on provider order or patient need but may not clear pumps less frequently than the provider order.

Interprofessional Progress Notes

1. Utilized by all disciplines providing care
2. Provides a comprehensive chronology of the patient's diagnoses, plan, response and evaluation of care
3. Used to capture qualitative data that is not captured in the flowsheet documentation.
4. The preferred format for the Progress Notes is the Data – Action – Response – Plan (DARP) format.

Care Plans

Care plans are interprofessional, patient pathways that have pre-built, evidence-based interventions and patient/family goals. Nursing diagnoses, interprofessional plan of care, interventions, goals, outcomes, and evaluation will all be captured in the care plan.

All inpatients will have a general care plan auto-populated in the EHR. The nurse is responsible for:

1. Adding patient specific care plans based on the patient's needs, nursing diagnoses, or medical diagnoses at admission and throughout hospitalization.
2. Selecting specific patient interventions and goals as individualized for the patient on admission and throughout the hospitalization.
3. Reviewing and updating the care plan every shift and as needed.
4. Removing interventions that do not apply to the patient.

Synergy

The Synergy Model of Care Delivery provides a framework for comprehensive nursing practice and patient care delivery at CHW.

All inpatients will have documentation of Synergy levels in the EHR. The nurse is responsible for:

1. Using the Synergy flowsheet tab to evaluate the patient based on each Synergy patient characteristic, identifying the patient's level (1, 3, or 5) and providing rationale for the level after completing the admission assessment and once per shift.
2. Incorporating the nurse's assessment of the patient's Synergy levels during handoff to describe the status of the patient along with additional data on the handoff tool in the EHR.

Bedside Pediatric Early Warning System (BedsidePEWS)
BedsidePEWS is a scoring system that is part of care delivery for all patients on acute care units. BedsidePEWS is not validated for use in the PICU, NICU or EDTC.

A. **Calculating a BedsidePEWS Score**
Patient vital sign parameters (heart rate, systolic blood pressure, respiratory rate, and oxygen saturation) and assessment finding parameters (oxygen requirement, respiratory effort, and capillary refill) will be assigned a sub score based on age. Each parameter sub score is included in the total BedsidePEWS score, ranging from 0 to 26 (refer to Addendum 3, BedsidePEWS Scoring Tool).
1. A total BedsidePEWS score is calculated at the same frequency that vital signs are ordered. For example, if vital signs are ordered every 4 hours, then scores are totaled a minimum of every 4 hours.
2. If there is an order to measure vital signs less frequently than q4h, then it is acceptable to calculate a BedsidePEWS score at that frequency.
3. Ideally, a BedsidePEWS score will include all seven parameter sub scores. However, if based on the patient's clinical status, a blood pressure and/or oxygen saturation are not measured, it is acceptable to calculate a BedsidePEWS score without a blood pressure and/or oxygen saturation.
    - **If the total Bedside PEWS score is four or greater, a blood pressure AND oxygen saturation must be measured and included in the total BedsidePEWS score.**
4. A total BedsidePEWS score including blood pressure and oxygen saturation should be calculated at least once per shift.

B. **BedsidePEWS Care Recommendations**
The BedsidePEWS Care Recommendations (refer to Addendum 4) will be used to guide frequency of reassessment, notification of health care team members, and other interventions.
1. If the BedsidePEWS Care Recommendations suggest that scoring should be more frequent than the vital signs order, follow the Care Recommendations for how frequently a patient assessed and scored.
2. **"Initial" recommendations** are applied for an initial score upon admission/transfer to the unit or when the patient's condition changes and the score falls into a different scoring category from the previous BedsidePEWS score. For example, if the patient's last score was 2 and their current score is a 4, this places the patient in a new scoring category and "initial" recommendations should be followed.
3. **"Subsequent" recommendations** are applied when a score remains in the same scoring category as the previous BedsidePEWS score. The subsequent recommendations account for patients that are stable with the same score after reassessment. For example, if the patient's last score was a 4 and their current score is a 4, the subsequent recommendations would be applied.
4. **Escalation of Care Recommendations** are to be used at the discretion of the bedside health care providers. They are not intended to replace clinical judgement, but rather to augment it. Escalation of care interventions could include the Rapid Response Team, Code Blue or other critical care resources.

C. **BedsidePEWS Progress Notes and Other Documentation**

1. A BedsidePEWS score should be included in the admission progress note, along with any applicable interventions as guided by the BedsidePEWS Care Recommendations
2. **A BedsidePEWS progress note and/or Clinician Notification must be documented for an initial score of 5 or greater.** This progress note should include interventions as guided by the BedsidePEWS Care Recommendations and should also include the patient's response to interventions and reassessment of a BedsidePEWS score.
3. For further information on documenting BedsidePEWS scores and BedsidePEWS progress notes in the electronic health record, refer to "Bedside Pediatric Early Warning System (BPEWS) Documentation Fact Sheet" on the CHW Intranet.

Patient/Family Education Documentation

1. Utilized by all disciplines providing education to patients and families.
2. Provides a complete assessment of current knowledge, preferred learning style, barriers to learning, teaching interventions, and evaluation of teaching effectiveness
3. Specific education points may be prompted by orders or care plan interventions. Some specific required education will be noted on the inpatient RN's required documentation report but is not all inclusive of required elements.

ADDENDUM/APPENDIX

Addendum 1 – CHW Minimum Physical Assessment Documented as Within Defined Limits (WDL)
Addendum 2 - Chart Correction Workflow
Addendum 3 – BedsidePEWS Scoring Tool
Addendum 4 – BedsidePEWS Care Recommendations

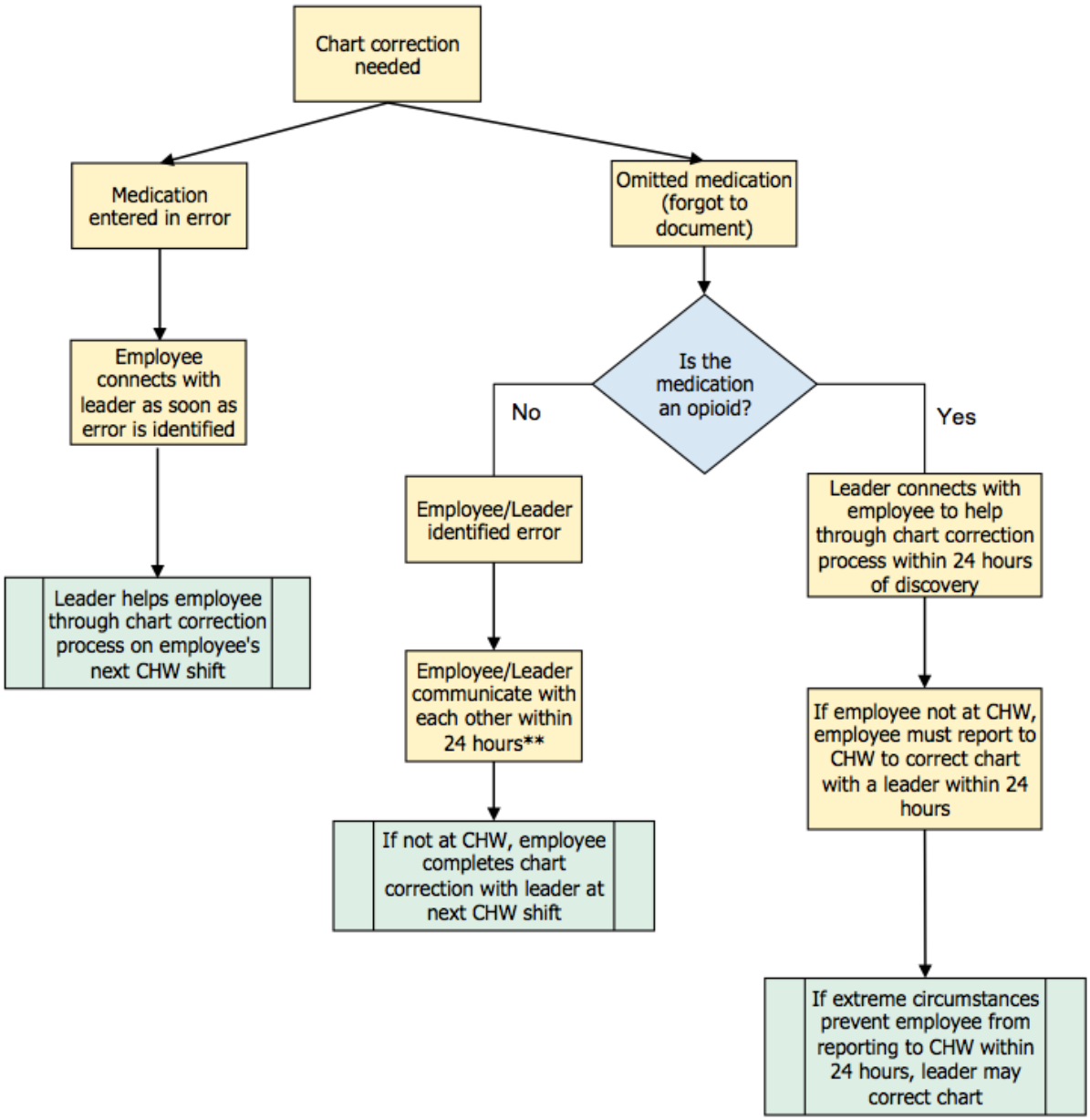
Approval at Joint Clinical Practice Council on 05/2013,11/2013, 02/2014

Addendum 1
CHW Minimum Physical Assessment documented as Within Defined Limits (WDL)

Body System	WDL Detail
Neurological	- Spontaneous arousal - Awareness as appropriate for age - Moves all extremities equally and spontaneously
Musculoskeletal	- All four extremities symmetrical and in alignment. - No spinal curvature - No joint swelling
Respiratory	- Spontaneous symmetrical unlabored respirations - Absence of retractions, nasal flaring, grunting, or accessory muscle use - Breath sounds clear and equal - Absence of supplemental oxygen or artificial airway
Cardiovascular	- Regular rate - Moist pink mucous membrane - Peripheral pulses = 2+ - Capillary refill less than or =3 sec - Extremities warm to touch and well perfused
Cardiac	- Regular rate - Moist pink mucous membrane
Vascular	- Peripheral pulses = 2+ - Capillary refill less than or =3 sec - Extremities warm to touch and well perfused
Integumentary	- Skin warm, dry and appropriate color for race
Gastrointestinal	- Abdomen soft and non-tender, non-distended - Bowel sounds normoactive - Absence of nausea and vomiting
Genitourinary	- Absence of urinary devices - Urine clear and pale yellow (if able to assess) - Continence appropriate for age/developmental level
Psychosocial	-Social interaction appropriate for developmental age -Interaction with environment appropriate for developmental age -Active family support and involvement in care

Addendum 2 –
Medication Chart
Correction Flow

Chart Correction Flow

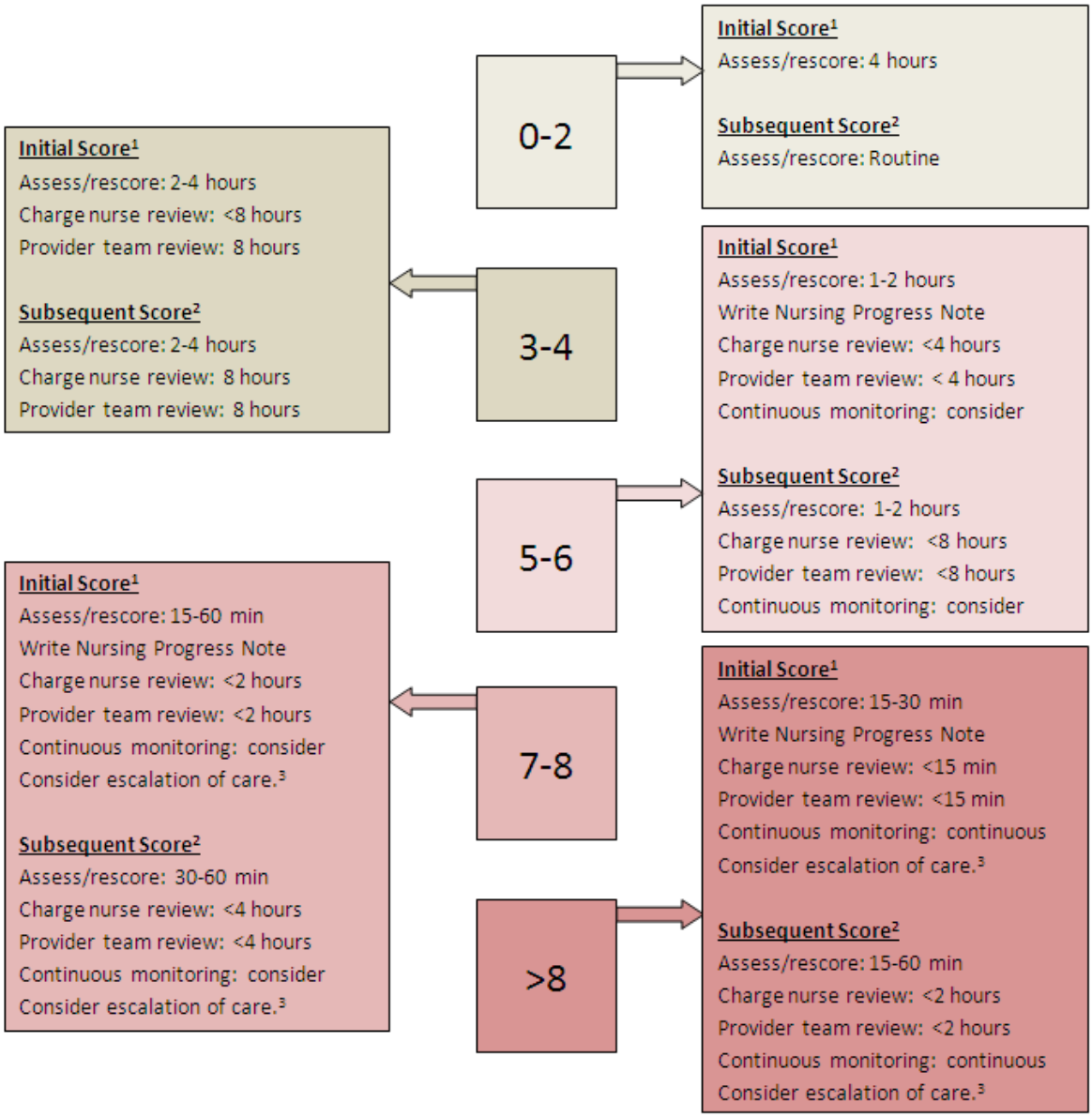


** If specific area leader is unavailable when an employee recognizes an error, the employee must communicate with the Patient Care Manager on call.

Addendum 3 – **BedsidePEWS Scoring Tool**

Age	HR	SBP	RR	O2 Therapy	Sats	Resp Effort	CRT	Points
0 up to 3 mo	110-150	60-80	29-61	RA	>94%	NO retractions, nasal flaring, grunting, etc.	< 3 sec	0
	91-109 or 151-179	50-59 or 81-100	19-28 or 62-81		91-94%	Mild retractions and/or nasal flaring		1
	80-90 or 180-190	45-49 or 101-130	15-18 or 82-91	O2 up to 4L/min	< or = 90%	Mod. retractions and/or nasal flaring		2
	< 80 or > 190	< 45 or > 130	<15 or > 91	O2 > 4L/min or HFNC at any L/min		Severe retractions, head bobbing, grunting, gasping or apnea >20sec	> or = 3 sec	4
3 mo up to 1 yr	100-150	80-100	24-51	RA	>94%	NO retractions, nasal flaring, grunting, etc.	< 3 sec	0
	80-99 or 151-169	70-79 or 101-120	19-23 or 52-71		91-94%	Mild retractions and/or nasal flaring		1
	70-79 or 170-180	60-69 or 121-150	15-18 or 72-81	O2 up to 4L/min	< or = 90%	Mod. retractions and/or nasal flaring		2
	<70 or > 180	<60 or >150	< 15 or > 81	O2 > 4L/min or HFNC at any L/min		Severe retractions, head bobbing, grunting, gasping or apnea >20sec	> or = 3 sec	4
1 yr up to 5 yr	90-120	90-110	19-41	RA	>94%	NO retractions, nasal flaring, grunting, etc	< 3 sec	0
	70-89 or 121-149	75-89 or 111-125	15-18 or 42-61		91-94%	Mild retractions and/or nasal flaring		1
	60-69 or 150-170	65-74 or 126-160	12-14 or 62-71	O2 up to 4L/min	< or = 90%	Mod. retractions and/or nasal flaring		2
	< 60 or > 170	<65 or >160	<12 or > 71	O2 > 4L/min or HFNC at any L/min		Severe retractions, head bobbing, grunting, gasping or apnea >20sec	> or = 3 sec	4
5 yr up to 12 yr	70-110	90-120	19-31	RA	>94%	NO retractions, nasal flaring, grunting, etc.	< 3 sec	0
	61-69 or 111-129	80-89 or 121-140	14-18 or 32-41		91-94%	Mild retractions and/or nasal flaring		1
	50-60 or 130-150	70-79 or 141-170	10-13 or 42-51	O2 up to 4L/min	< or = 90%	Mod. retractions and/or nasal flaring		2
	<50 or >150	<70 or >170	<10 or >51	O2 > 4L/min or HFNC at any L/min		Severe retractions, head bobbing, grunting, gasping or apnea >20sec	> or = 3 sec	4
12 yrs and up	60-100	100-130	12-17	RA	>94%	NO retractions, nasal flaring, grunting, etc.	< 3 sec	0
	50-59 or 101-120	85-99 or 131-150	10-11 or 18-23		91-94%	Mild retractions and/or nasal flaring		1
	40-49 or 121-140	75-84 or 151-190	9 or 24-30	O2 up to 4L/min	< or = 90%	Mod. retractions and/or nasal flaring		2
	<40 or >140	<75 or >190	<9 or >30	O2 > 4L/min or HFNC at any L/min		Severe retractions, head bobbing, grunting, gasping or apnea >20sec	> or = 3 sec	4

Addendum 4 – **BedsidePEWS Care Recommendations**



1: Initial recommendations are intended to be applied when a patient either has their initial Bedside PEWS score calculated on admission to the unit, or when the patient's condition is changing when assessed by their recent Bedside PEWS scores.

2: Subsequent recommendations are intended to assist level of care decision-making for children who after review have a Bedside PEWS score remaining in the same category.

3: Escalation of care interventions could include the Rapid Response Team or other critical care resources. These are recommendations to be used at the discretion of bedside health care providers. They are not intended to replace clinical judgment, but rather to augment it.

Addendum 5 **- Respiratory Care Practitioner (RCP) Assessment/Reassessment Guidelines**

***Full RCP Assessment*:** Respiratory assessment including breath sounds, respiratory pattern and effort, retractions, heart rate, respiratory rate, SpO_2, and $EtCO_2$ if available

***Partial RCP Assessment*:** A respiratory assessment that can be visualized without disturbing the patient to include monitor vitals, any observable respiratory/work of breathing cues and assessment of device function.

Therapy – medication assessments: Assessment frequencies are defined within each modality procedure. In general, full assessments are indicated before and after all interventions/medications regardless of location. PRN assessments are performed during interventions.

NICU and PICU Specific RCS Assessments.
Admissions: Full assessment within 30 minutes (maximum) of arrival to ICU with higher acuity patients seen as soon as possible.

Device related assessments:

- **Manual Resuscitator:** Partial assessment at change of caregiver & PRN
- **High Flow Nasal Cannula:** Full assessment at change of caregiver & PRN, Partial assessment Q4
- **Oxygen (PICU only):** Full assessment once every 12 hour shift & PRN. Partial assessment Q4.
- **Oxygen (NICU only):** Full assessment once daily on night shift & PRN. Partial assessment Q4.
- **Ventilator, NIV, CPAP and BiPAP:** Full assessment Q4 & PRN

Considerations:

- Every effort should be made to adhere to assessment guidelines.
- Consider bundling cares with nursing/providers to minimize patient interruptions.
- RCP discretion may be used to modify the recommendations for individual patient situations, such as minimal stimulation guidelines, end of life care, surgical or other procedures, and touchy/sleep deprived patients. In these situations, at least one full assessment should be performed every shift or per above assessment guidelines.
- If unit activity prevents an RCP from adhering to the guidelines (or if it is anticipated that unit activity will prevent the RCP from adhering to the guideline), the charge RCP should be notified as soon as possible to see if they can redirect staff to the area.