

Student Name: Meritt McCrehee

Unit: PF & PICU

Pt. Initials: _____

Date: _____

Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: _____

ICU
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Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?	If not, why?			
Amikacin	anti-infective	Bactericidal	600mg/ 50mL IVPB Q8	yes		IVPB - NS - 30min	dizzy, HA, Diarrhea, hypersensitivity	<ol style="list-style-type: none"> 1. Monitor bowel function 2. may get bitter/metallic taste 3. report signs of super infection 4. notify if excess drying of skin occurs
Janidina (Clonidine)	H ₂ antagonist	antibiotic agent	20mg/ 2mL IVP BID	yes		NS, 2mL 2-5min	Confusion dizzy HA, N/V/D anemia	<ol style="list-style-type: none"> 1. Take full course of med 2. may cause GI upset 3. report onset of black tarry stool 4. notify if difficulty swallowing
Zosyn (piperacillin/tazobactam)	extended spectrum penicillin	anti-infective	2.25g/ 50mL IVPB Q4H	yes		100mL/hr - NS - 50mL	Pain, CD/DL, N/V, HA, itching	<ol style="list-style-type: none"> 1. obtain culture & sensitivity before therapy 2. Assess skin for reactions 3. monitor bowel function 4. evaluate renal function
Ketorolac	pyrozilic Carboxylic acid	nonopioid analgesic	4mg IVP PRN	yes			drowsy, HA, nausea, HF, stroke, throat irritation	<ol style="list-style-type: none"> 1. Monitor blood pressure 2. may ↑ BUN, potassium, serum Creatinine 3. Avoid NSAIDs 4. do not take longer than 5 days unless prescribed
								<ol style="list-style-type: none"> 1. 2. 3. 4.

Student Name: Mari H McKee Unit: PF2 Pt. initials: J Date: 3-10-21

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 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 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>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 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 checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input 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 _____ 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 checked="" type="checkbox"/> No	Urine Appearance: <u>not observed</u> Stool Appearance: <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input 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: _____
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 checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>finger</u> Oxygen Saturation: <u>97%</u>	Abdomen: <input 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 checked="" 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 _____ 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 checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input 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	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>regular</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 checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>none</u> Type: <u>none</u> Pain Score: 0800 <u>0</u> 1200 <u>0</u> 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 checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: Meritt McLahee Unit: PF2 Pt. initials: J Date: 3-10-21

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													
<i>Not monitoring intake & output</i>													
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: <input checked="" type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 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

Student Name:

Meritt Macdowell

Date: Click here to enter a date.

3-10-21

1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference):

While the exact cause of asthma is unknown, it is related to both genetic and environmental factors causing bronchial hyper-responsiveness. The airway epithelium irritate & lose ciliary mucociliary blanket & mucus glands increase. Secretory mucous is increased. The inflammatory cascade leads to asthma (Holt & Rowe, 2015)

2. Factors for the Development of the Disease/Acute Illness:

An asthma attack at work by something that elicits an immune response such as: animal dander, dust mites, mold, smoke, cold air, medications, pollen, food, stress, strong emotions.

3. Signs and Symptoms:

SOB, chest tight/pain, wheezing when exhaling, trouble sleeping due to SOB

4. Diagnostic Tests Pertinent or Confirming of Diagnosis:

Sputum
Peak flow meter
Chest Xray
Nitric oxide test

5. Lab Values That May Be Affected:

Allergy testing
Eosinophils
FeNO

6. Current Treatment (Include Procedures):

Long term: inhaled corticosteroids, leukotriene modifiers, Theophylline
Short term: SABA, anticholinergic agents, oral & IV corticosteroids
Allergy shots
Bronchial thermoplasty

Student Name: _____

Unit: _____

Pt. Initials: _____

Date: _____

Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: _____

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/contraindications, Etc.)
				Is med in therapeutic range?	If not, why?			
Lasix (furosemide)	Diuretic	Control of hypertension	12 units PO BID	Yes			rash, pruritus insulin resistance insulin allergy	1. Assess BG before admin 2. rotate sites 3. Admin daily at same time 4. Do not mix w other insulin
Humalog (insulin lispro)	anti-diabetic	control of hyperglycemia	10 units Subcutaneous BID	Yes			rash, pruritus insulin resistance insulin allergy	1. Assess BG before admin 2. eat within 15 min of admin 3. rotate injection sites 4. Assess for hypoglycemia
								1. 2. 3. 4.
								1. 2. 3. 4.
								1. 2. 3. 4.

Student Name: Marill McKehee Unit: P200 Pt. initials: JA Date: 3-9-21

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Alert/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 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>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 checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input 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 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 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 _____ 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 checked="" type="checkbox"/> No	Urine Appearance: <u>light yellow</u> Stool Appearance: <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>Left NP</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <u>LP</u> Type/Location: _____ Appearance: <input 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: _____
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 type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input checked="" type="checkbox"/> Right <input checked="" 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 Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>2</u> 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site <u>left finger</u> Oxygen Saturation: <u>91%</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 <input checked="" type="checkbox"/> X <u>4</u> quads <input checked="" 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 checked="" type="checkbox"/> Yes <input 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 type="checkbox"/> Pale <input checked="" 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	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>V8 to 1/2 cups</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input 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 type="checkbox"/> None Type: _____	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>pt was intubated</u> Type: <u>until 2 was about to leave</u> Pain Score: 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 <u>waiting for pt post intubation</u>	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

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

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	60	60	60	60	60	60	60	60	60	60	60	60	720
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine					500 mL								500 mL via cath
# 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 <input checked="" type="radio"/> 2 3
Cardiovascular	Circle the appropriate score for this category:
	<input checked="" type="radio"/> 1 2 3
Respiratory	Circle the appropriate score for this category:
	0 1 <input checked="" type="radio"/> 3
Staff Concern	1 pt - Concerned
Family Concern	<input checked="" type="radio"/> pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>4</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

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 10

Patient Weight: 46.6 kg

<p>Student Name: Moritz Mckehe</p>		<p>Date: Click here to enter a date.</p>
<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference): T1DM is the culmination of lymphatic insulinitis + destruction of beta cells. as beta cell mass declines insulin secretion decreases until complete insulin deficiency causing endogenous to maintain normal blood glucose levels. (Khardori 2021)</p>	<p>2. Factors for the Development of the Disease/Acute Illness: genetic predisposition plus a trigger event</p>	<p>3. Signs and Symptoms: Polyuria, Polydipsia, polyphagia, hyperglycemia, rapid weight loss, dry skin, irritable, drowsy, fatigue, Abdominal discomfort, Ketoacidosis</p>
<p>4. Diagnostic Tests Pertinent or Confirming of Diagnosis: 8 hr fasting blood glucose ≥ 126 mg/dl RPG1 ≥ 200 w clearance 5/5 Oral glucose ≥ 200 mg/dl HGA1C $\geq 6.5\%$</p>	<p>5. Lab Values That May Be Affected: Blood glucose level HGA1C</p>	<p>6. Current Treatment (Include Procedures): Rapid, short, intermediate, & long acting insulin therapy</p>

<p>Student Name:</p>	<p>Date: Click here to enter a date.</p>	<p>9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> <p>$0.5 \times 16.6 = 23.3$</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ol style="list-style-type: none"> 1. Warm finger prior to stick 2. distraction while giving shot <p>*List All Pain/Discomfort Medication on the Medication Worksheet Click here to enter text.</p> <p>no pain meds ordered</p>	<p>8. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> <p>$10 \times 100 = 1000$ $10 \times 50 = 500$ $20 \times 26.6 = 532$</p> <p>$= 2,032 \text{ ml/24hrs}$ 44.7 ml/hr</p> <p>Actual Pt MIVF Rate: pt had no IV access</p> <p>Is There a Significant Discrepancy? Choose an item. Why?</p>	<p>Actual Pt Urine Output:</p> <p>pt output not being monitored because it was put in a cup to be sent to lab for ketones every time</p>
	<p>10. Growth & Development: List the Developmental Stage of Your Patient For Each Theorist Below and Document 2 OBSERVED Developmental Behaviors for Each Theorist. If Developmentally Delayed, Identify the Stage You Would Classify the Patient:</p> <p>Erickson Stage:</p> <ol style="list-style-type: none"> 1. motivated to complete a task = she was very eager in learning how to treat her T1DM 2. self esteem = she was very proud of herself & how brave she was being when she had to get poked. <p>Piaget Stage:</p> <ol style="list-style-type: none"> 1. concrete operation logic - she was able to try to defer from what was considered a carb & what wasn't 2. conservation - she was doing mental math to help calculate how much of certain things she planned to eat vs how much insulin she needed 	<p>10. Growth & Development: List the Developmental Stage of Your Patient For Each Theorist Below and Document 2 OBSERVED Developmental Behaviors for Each Theorist. If Developmentally Delayed, Identify the Stage You Would Classify the Patient:</p>

<p>Student Name:</p> <p>11. Focused Nursing Diagnosis: deficient knowledge</p> <p>12. Related to (r/t): lack of information about T1DM</p>	<p>15. Nursing Interventions related to the Nursing Diagnosis in #11:</p> <p>1. I will teach in small increments</p> <p>Evidenced Based Practice: helps prevent distraction & helps increase learning.</p> <p>2. I will include as many family members as possible.</p> <p>Evidenced Based Practice: In T1DM education it will be safer for the child & she will have more support.</p> <p>3.</p> <p>Evidenced Based Practice:</p> <p>B. I will have the child demonstrate proper use of insulin injection.</p> <p>. This will help the nurse understand that the pt will be able to manage her condition upon returning home.</p>	<p>Date: Click here to enter a date.</p> <p>16. Patient/Caregiver Teaching:</p> <p>1. I will teach the patient how to count calories & how to refer that to insulin</p> <p>2. I will teach proper admin of insulin</p> <p>3. I will teach sickday rules & the importance of still taking insulin & urine ketones</p>
<p>13. As evidenced by (aeb): newly diagnosed, lots of questions about whats going on. getting confused with grandmas T1DM as opposed to her T1DM.</p> <p>14. Desired patient outcome: the pt & mom will show proper dietary & insulin management by 3-10-21</p>	<p>17. Discharge Planning/Community Resources:</p> <p>1. I will get them set up on an insulin money saving plan</p> <p>2. I will give info on T1DM support groups.</p> <p>3. I will get the pt a medical alert bracelet she can wear in case of an emergency</p>	