

Student Name: Piscilla Maza

Unit: _____

Pt. Initials: _____

Date: 8/31/21

Allergies: NKA

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

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?	If not, why?			
Dextrose 5% + Sodium Chloride 0.45% + KCl 30 meq / 1000 mL		Isotonic / Hypotonic / Hypertonic						
Keppra	Anticonvulsant	Treat seizures (epilepsy)	270mg PO Q12H	Yes			Drowsy, dizzy, unusual tiredness or weakness	<ol style="list-style-type: none"> 1. For waste: Place Partially used in black container. 2. Don't get up w/out assistance. 3. Do not stop taking abruptly - if miss dose take it ASAP but if too close to next dose skip it. 4. If too close to next dose skip it.
Peppid	H2 blocker	Treat in ulcers, stomach + prevent intestinal bleeding	20mg (2ml) IVP Q12H	Yes			HA, constipation, diarrhea, pain/redness @ IV site	<ol style="list-style-type: none"> 1. Let nurse know if pain @ IV site 2. Don't share med 3. DO NOT double dose to catch up. 4. Before use tell dr. about any chronic illness.
Morphine	Opioid Analgesic	Treat severe pain	2.5mg (0.125ml) IVP Q3H	Yes	5 min dilute NS 5ml		constipation, slow/shallow breathing, drowsy, N/V	<ol style="list-style-type: none"> 1. Severe pain (7-10) 2. Risk for abuse 3. Check resp. before admin 4. Hold if resp. < 10
Motrin Ibuprofen	NSAID	Relieve pain	305mg (18.5mg) PO Q12H	Yes			upset stomach, N/V, HA, diarrhea, constipation	<ol style="list-style-type: none"> 1. Pain mod 4-6 2. Black box warning 3. Take as directed 4. If stomach upset take w/ food, milk, antacid.

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 15 months

Patient Weight: 10.1 kg

Student Name:

NKA

Date: Enter a date.

<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference): RSV bronchiolitis Highly communicable acute viral infection with max effect at the bronchiolar level. Bronchiolitis is an inflammation of bronchioles that cost production of techniques that occludes bronchioles tubes + small bronchioles.</p>	<p>2. Factors for the Development of the Disease/Acute Illness: Resp. failure Hypoxia</p>	<p>3. Signs and Symptoms: cough difficult breathing hypoxemic cyanosis grunting wheezing crackles acute distress</p>
<p>4. Diagnostic Tests Pertinent or Confirming of Diagnosis: Resp. culture - Pseudomonas respiratoria CRSA XR</p>	<p>5. Lab Values That May Be Affected: CBC (WBC) Chemistry ABG - VBG w/ Lytes, metab CMP (K+)</p>	<p>6. Current Treatment (Include Procedures): TUBE feeding Hgn Fl0 Nc Intubation Suctioning CPAP NaCl Nebulizer 3% Painmozyme Nebulized</p>

Student Name: Priscilla Meza Unit: PICU Pt. initials: _____ Date: 9-01-21

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 type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input checked="" 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 checked="" 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 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 type="checkbox"/> Person <input type="checkbox"/> Place <input 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 checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>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 type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>yellow</u> Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>DUQ</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>1ea CVC TL</u> Appearance: <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>NS + 0.9% NS KCl</u>
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 checked="" type="checkbox"/> Right <input checked="" 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 checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>4</u> L/min <input type="checkbox"/> BiPAP/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: <u>High FIO</u> 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 checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>clear</u> Consistency _____ Suction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>toe</u> Oxygen Saturation: _____	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input checked="" 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 type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Type <u>GI tube</u> Location <u>L</u> Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input checked="" 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 checked="" 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 checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>ELC CARE</u> Amount/Schedule: <u>continuous</u> Chewing/Swallowing difficulties: <u>40ml/hr</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: _____ 0800 _____ 1200 <u>0</u> 1600 _____
	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 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: _____	<input type="checkbox"/> None Type: <u>GI tube / ompa/ao/ce/c</u> Location: <u>GI</u> Description: _____ Dressing: <u>Aquaseal</u>
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" 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 <input checked="" type="checkbox"/> Drain/Tube Site: <u>GI tube DUQ</u> Type: <u>GI tube</u> Dressing: <u>open to air</u> Suction: _____ Drainage amount: _____ Drainage color: _____