

Student Name: Elizabeth O. Unit: PICU Pt. initials: _____ Date: 12/14/21

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Heat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" 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> <u>L3+</u> Lower R <u>3+</u> <u>L3+</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 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 Withdrawn 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 type="checkbox"/> Present <input checked="" 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 checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input 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 checked="" 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 _____ Left _____ Pushes: Right _____ Left _____ S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>Yellow</u> Stool Appearance: <u>N/A</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>Foot</u> Oxygen Saturation: <u>98.9%</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 checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NG</u> Location <u>Naso</u> Inserted to <u>26</u> 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 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: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>Cravage/both</u> Amount/Schedule: <u>9 2x</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>None</u> Type: _____ Pain Score: 0800 _____ 1200 _____ 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 checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	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 checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: Elizabeth O Unit: PICU Pt. initials: _____ Date: 12/14/21

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake					40 mL		25 mL		23 mL				88 mL
Intake - PO Meds													0
Enteral Tube Feeding					20 mL		35 mL		31 mL				92 mL
Enteral Flush													0
Free Water													0
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													0
IV Meds/Flush													0
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine					102 mL		38 mL						140 mL
# of immeasurable													0
Stool													0
Urine/Stool mix													0
Emesis													0
Other													0

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: <u>0</u> 1 2 3
Cardiovascular	Circle the appropriate score for this category: <u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category: <u>0</u> 1 2 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

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 2M

Patient Weight: 2.46kg

<p>Student Name: Elizabeth Oroscio</p>	<p>Unit: PICU Pt. Initials:</p>	<p>Date: 12/14/2021</p>
<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference): Failure to Thrive. "Failure to thrive (FTT) is a common term used to describe lack of adequate weight gain in pediatric patients. Accepted definitions include a weight for age less than 5th percentile on standardized growth charts, a decrease in weight percentile of more than two major percentile lines on the growth chart, or less than 80 percentile of median weight for height ratio weight/length ratio. This can result in developmental delays or other long term effects for the developing child. It is a lack of necessary calories for adequate growth. This could be from not taking in enough calories, losing too many calories, or increased caloric demand. (Ncbi.nlm.nih.gov)</p>	<p>2. Factors for the Development of the Disease/Acute Illness: Hypocalcemia (P) Abuse Neglect (P) Chromosomal abnormalities Loss of emotional bond between parent/infant Blood Related Issues Chronic infections Complications during pregnancy Lack of digestive enzymes Major organ system defects Food intolerance Metabolic Disorders</p>	<p>3. Signs and Symptoms: Height and weight are smaller than standard (P) Poor Sucking Delay in Physical skills Immobility Stiff or floppy Muscles Weak cry Irritability</p>

Student Name: Elizabeth Orosco	Unit: PICU Pt. Initials:	Date: 12/14/2021
4. Diagnostic Tests Pertinent or Confirming of Diagnosis: Growth Charts Health History Physical Exam (P) Blood Test Urinalysis/urine culture T4, TSH PPD Stool tests HIV Testing	5. Lab Values That May Be Affected: WBC RBC (p) low HGB (p) low HCT (p) low Renal Function (electrolytes, BUN, Creatine) Liver Function Calcium Levels (P) low	6. Current Treatment (Include Procedures): Gavage left over feeding (P) High Calorie Formula/Food Nutritional Supplements Feeding tubes
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. 2. *List All Pain/Discomfort Medication on the Medication Worksheet Click here to enter text.	8. Calculate the Maintenance Fluid Requirement (Show Your Work): Actual Pt MIVF Rate: Is There a Significant Discrepancy? Choose an item. Why?	9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): Actual Pt Urine Output:

Elizabeth Orosco

References

Smith, A. E. (2021, August 12). *Failure to thrive*. StatPearls [Internet]. Retrieved December 17, 2021, from <https://www.ncbi.nlm.nih.gov/books/NBK459287/>

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
n/a	Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	n/a	n/a	n/a

Student Name: Elizabeth Oroasco		Unit: PICU	Patient Initials: Click here to enter text.		Date: 12/14/2021	Allergies: NKDA	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	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,
No medication for patient	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.

Adopted: August 2016

Student Name: Elizabeth O. Unit: Ped Floor 3 Pt. initials: _____ Date: 12/15

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 checked="" 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 type="checkbox"/> Present <input checked="" 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 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 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 checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>N/A</u> Stool Appearance: <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>R. ACUBITANT</u> <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Fluids: <u>Dextrose 5% + Sodium Chloride 0.9% + KCl 20meq</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 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 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 checked="" type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>None</u> Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site <u>left finger</u> Oxygen Saturation: <u>99%</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 checked="" type="checkbox"/> Present X <u>4</u> quads <input 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 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 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: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formulas: <u>Peds diet (12-18yrs)</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>NO PAIN</u> Type: _____ Pain Score: 0800 _____ 1200 _____ 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 checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	MOBILITY	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 <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: Elizabeth O Unit: Pedi Floor 3 Pt. initials: _____ Date: 12/15/21

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													0
Intake - PO Meds													0
Enteral Tube Feeding													0
Enteral Flush													6
Free Water													0
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
								187 ml	1				187ml
IV Meds/Flush								175 ml					175ml
OUTPUT													
Urine	07	08	09	10	11	12	13	14	15	16	17	18	Total
													0
# of immeasurable													0
Stool													0
Urine/Stool mix													0
Emesis													0
Other													0

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) <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

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
Dextrose 5% Sodium Chloride 0.9% +KCL 20 MEQ/L 1,000ML. 100 ML/HR Q10H	Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input checked="" type="checkbox"/>	For fluid and electrolyte replenishment and caloric supply as a source of water, electrolytes, and calories	Sodium, potassium, and chloride,	Leg pain/swelling, rapid weight gain swelling, cramping, stomach bloating high blood pressure, shortness of breath, arrhythmias

Student Name: Elizabeth Oroasco		Unit: Pedi Floor 3	Patient Initials: 2 patients	Date: 12/15/2021	Allergies: NKDA for both patients		
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	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,
Medroxyprogesterone (Provera)	Progesterone Hormone	Ovarian hormone replacement	20 mg (2 tab) PO TID	Yes Click here to enter text.	N/A	Hypotension, thromboembolism, gingival swelling or tenderness	1. Can cause bleeding abnormalities 2. Can cause dizziness, so call for help before getting out of bed 3. Certain blood tests can be affected 4. Caution female who vomits within 1 hour of taking it to contact HCP/nurse
NEXT PATIENT DOWN BELOW				Click here to enter text.		Click here to enter text.	1. 2. 3. Click here to enter text. 4. Click here to enter text.

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

Student Name: Elizabeth Orosco		Unit: Pedi Floor 3	Patient Initials: 2 patients		Date: 12/15/2021	Allergies: NKDA for both patients	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? if not, why?	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,
Propranolol Soln (Inderal Soln)	Beta Blocker	Treats high blood pressure and irregular heart beats	4 mG/1 mL PO Q8HR	Yes Click here to enter text.	N/A	Click here to enter text.	<ol style="list-style-type: none"> 1. Can cause dizziness, tell patient to ca before getting out of bed 2. Monitor Blood pressure and apical pr 3. Monitor fluid intake and output with daily weight before and after 4. Do not stop abruptly contact HCP
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	<ol style="list-style-type: none"> 1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	<ol style="list-style-type: none"> 1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	<ol style="list-style-type: none"> 1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 15 yr

Patient Weight: 78.6 kg

<p>Student Name: Elizabeth Orosco</p>	<p>Unit: Pedi floor Pt. Initials:</p>	<p>Date: 12/15/2021</p>
<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference): Pancytopenia. "Pancytopenia is a hematologic condition characterized by all three peripheral blood cell lines. It is characterized by the hemoglobin of less than 11.5 g/dL in women, platelets of less than 150,000 per mL, and leukocytes of less than 4000 per mL." (https://www.ncbi.nlm.nih.gov) "Occurs when there is a problem with blood forming stem cells in the bone marrow." (cancer.gov)</p>	<p>2. Factors for the Development of the Disease/Acute Illness: Heredity Medications Idiopathic (p) autoimmune environmental contaminant pregnancy family history of blood disorders</p>	<p>3. Signs and Symptoms: Dizziness (P) Lightheadness (P) Fatigue Unexplained bleeding (P) Nose and gum bleeding Shortness of Breath Excessive bleeding without an apparent cause(P) High fever rapid heart rate Uterine Bleeding (p)</p>
<p>4. Diagnostic Tests Pertinent or Confirming of Diagnosis: CBC (P) Bone marrow biopsy</p>	<p>5. Lab Values That May Be Affected: RBC (p) WBC(p) Platelets(p)</p>	<p>6. Current Treatment (Include Procedures): Blood transfusions (p) Platelet transfusion(p) Immunosuppressant drugs Epoetin Alfa Bone marrow transplant</p>

Student Name: Elizabeth Oroasco	Unit: Pedi floor Pt. Initials:	Date: 12/15/2021
<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. Patient reports NO Pain 2. Patient reports No Pain <p>*List All Pain/Discomfort Medication on the Medication Worksheet Patient reports NO Pain</p>	<p>8. Calculate the Maintenance Fluid Requirement (Show Your Work): $10 \text{ kg} \times 100 = 1,000$ $10 \text{ kg} \times 50 = 500$ $58.6 \text{ kg} \times 20 = 1,172$</p> <p>$1,000 + 500 + 1,172 = 2,672 / 24 = 111.3 \text{ ml/hr}$</p> <p>Actual Pt MIVF Rate: 100 ml/hr</p> <p>Is There a Significant Discrepancy? Yes</p> <p>Why? The 111.3 and the 100ml are close, but not exact</p>	<p>9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): 0.5 ml/kg/hr $0.5 \text{ ml} / 78.6 / \text{hr}$ $0.5 \times 78.6 = 39.3$ or 39 ml/hr or 470ml per 12 hour shift</p> <p>Actual Pt Urine Output: Patient had no documented or any ouput during the clinical rotation</p>

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	<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: Identity vs. Role Confusion</p> <ol style="list-style-type: none"> 1. New body 2. New thoughts and emotions <p>Piaget Stage: Formal Operational Thought</p> <ol style="list-style-type: none"> 1. Imagines everyone is focused on his/her behavior and appearance 2. Adolescent egocentrism nobody understands 	
<p>11. Focused Nursing Diagnosis: Fatigue</p>	<p>15. Nursing Interventions related to the Nursing Diagnosis in #11:</p> <ol style="list-style-type: none"> 1. Assist the patient in developing a schedule for daily activity and rest. <p>Evidenced Based Practice: "Energy reserves may be depleted unless the client respects the body's need for increased rest. A plan that balances periods of activity with rest periods can help the client complete desired activities without adding fatigue levels." (nurselabs)</p>	<p>16. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. Pt. may get dizzy, call the nurse when getting out of bed to prevent any falls 2. Do not take any aspirin or NSAIDS due to these medicines causing you to bleed more easily 3. Use a soft washcloth and a soft toothbrush to keep you from bleeding
<p>12. Related to (r/t): Decreased hemoglobin and diminished oxygenated blood</p>	<ol style="list-style-type: none"> 2. Anticipate the need for the transfusion of RBC's <p>Evidenced Based Practice:</p>	

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13. As evidenced by (aeb): Report of fatigue and dizziness	"Packed RBC's increase the oxygen - carrying capacity of the blood." (nurselabs) 3. Provide supplemental oxygen therapy when needed Evidenced Based Practice: "oxygen saturation should be in the 90's or greater" (nurselabs)	17. Discharge Planning/Community Resources: 1. Follow up with your HCP for any concerns and blood tests 2. The american cancer society 3. Community groups
14. Desired patient outcome: The patient will not feel dizzy when going to the restroom and coming back to her bed by december 22nd. The patient will have a hemoglobin level of 12-16 gm/dl by December 22nd.		

Elizabeth Orosco

References

- Chiravuri, S. (2021, August 30). *Pancytopenia*. StatPearls [Internet]. Retrieved December 17, 2021, from <https://www.ncbi.nlm.nih.gov/books/NBK563146/>
- miraji, Z. suleiman, Magwira, A., Rosettee, N. K., seneti, J., & yegon, D. (2021, August 30). *Nursing care plan guide for anemia*. Nurseslabs. Retrieved December 17, 2021, from <https://nurseslabs.com/anemia-nursing-care-plans/>
- NCI Dictionary of Cancer terms*. National Cancer Institute. (n.d.). Retrieved December 17, 2021, from <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/pancytopenia>
- Staff, H. E. (2021, January 16). *Pancytopenia*. Healthgrades. Retrieved December 17, 2021, from <https://www.healthgrades.com/right-care/blood-conditions/pancytopenia>