Student Name: Ashlynn Cunningham **Unit:** 3N **Pt. Initials:** CC **Date:** 3-2-22

S

Pt Initials: Room: 380 DOB: Admit Date:
Admit Wt: Current Wt: Ht: (M) F
Primary Dx: Febrile Neutropenia
Secondary Dx: COVID

Physician:
Consults (Ex: Speech, PT/OT, Surgery, Neuro)

B

History
Hodgkin's Lymphoma

NV

Allergies (reactions)
Sulfa, Lorazepam, Peach
R H P

Code status
(FULL) DNR/AND
Advance directive: Y N

Isolation:
Restraints: Y N
Type:
Fall risk
Vaccine- PNA Flu

A

Neuro: LOC/Hand Grips/Pulls & Pushes/Pupil Rx/ Pupil Size/ GCS
WNL

Vital Signs: BP/HR/RR/Temp/SpO2
98.6 111/71
100.1.
P=153

Cardiac: Peripheral pulses/Edema/Heart sounds/Rhythm – Regular or Irregular
WNL

Pain 10 at 3 at rest
Pain scale Numerical
Location chemo rash - anus, 10/3

Pulmonary: Breath sounds/Secretions
WNL

Oxygen: ____L O2
NC 100NRB VM

Accu checks: Frequency
Results

GI: BS Last BM: 9:00 NGT OGT
↳ Chemo rash on bottom

Diet Regular: hasn't eaten since monday
Breakfast % eaten: none Lunch % eaten: none

Skin:
Wounds/Drainage
Staples /Drains
Location

GU: Void Foley ____ FR Placed on:

IV Peripheral INT IV ____gauge Site:
IV Fluid type: D5NS Rate: 100
Central- type/site (subclavian)/port/broviac) PICC@____
(L) 3/1/22

Psych Social
mom, dad present

Intake Total: mL Parenteral 600 Enteral 0
Output Total: mL Void ____mL Emesis ____mL
Balance: mL (Positive or negative) What does this mean for your pt?

Pending orders (ex: CBC, specimen)

Na	Cl	Bun	Gluc	Mg	Other
135↓	107	5	115		
K	**Co**	**Cr**	**Ca**	**Phos**	**Other**
3.5↓		0.30	7.6↓		

ANC [WBC x (% Neutrophils + % Bands) x 10]
3.78

Labs Pending:

Hct 14.9↓
WBC 0.06↓
Plt 24↓
Hgb 5.3↓

UA
Cultures

Diagnostic Test Results:
CT
CXR
MRI
Echo

R

***Nursing Interventions & Teaching: (use your Critical Thinking Map)
DC Plan. Is pt informed of plan? Y N 24 hour orders reviewed Day 1 ☐ Day 2 ☐
What does the patient need when they are discharged?

Shift goals: Met Unmet Revise

Adopted: August 2016

iron deficient

bleed risk

Student Name: Ashlynn Cunningham Unit: 3N Pt. initials: CC Date: 3.2.22

GENERAL APPEARANCE

Appearance: ☒ Healthy/Well Nourished ☒ Neat/Clean ☐ Emaciated ☐ Unkept
Developmental age:
☐ Normal ☐ Delayed

NEUROLOGICAL

LOC: ☒ Alert ☐ Confused ☐ Restless ☐ Sedated ☐ Unresponsive
Oriented to:
☒ Person ☒ Place ☒ Time/Event ☒ Appropriate for Age
Pupil Response: ☐ Equal ☐ Unequal ☐ Reactive to Light ☐ Size _____
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat ☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☒ Able to move all extremities
☒ Symmetrically ☐ Asymmetrically
Grips: Right 5 Left 5
Pushes: Right 5 Left 5
S=Strong W=Weak N=None
EVD Drain: ☐ Yes ☒ No Level _____
Seizure Precautions: ☐ Yes ☐ No

RESPIRATORY

Respirations: ☒ Regular ☐ Irregular ☐ Retractions (type) _____ ☐ Labored
Breath Sounds:
Clear ☒ Right ☒ Left
Crackles ☐ Right ☐ Left
Wheezes ☐ Right ☐ Left
Diminished ☐ Right ☐ Left
Absent ☐ Right ☐ Left
☒ Room Air ☐ Oxygen
Oxygen Delivery:
☐ Nasal Cannula: ____L/min
☐ BiPap/CPAP: _____
☐ Vent: ETT size_____@_____cm
☐ Other: _____
Trach: ☐ Yes ☒ No
Size _____ Type _____
Obturator at Bedside ☐ Yes ☐ No
Cough: ☐ Yes ☒ No ☐ Productive ☐ Nonproductive
Secretions: Color clear
Consistency frothy
Suction: ☐ Yes ☒ No Type _____
Pulse Ox Site _____
Oxygen Saturation: _____

CARDIOVASCULAR

Pulse: ☒ Regular ☐ Irregular ☒ Strong ☐ Weak ☐ Thready ☐ Murmur ☐ Other _____
Edema: ☐ Yes ☒ No Location _____ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Capillary Refill: ☒ < 2 sec ☐ > 2 sec
Pulses:
Upper R 3+ L 3+
Lower R 3+ L 3+
4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None

ELIMINATION

Urine Appearance: yellow
Stool Appearance: liquid stool
☒ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☒ Soft ☐ Firm ☐ Flat ☐ Distended ☐ Guarded
Bowel Sounds: ☒ Present X 4 quads ☐ Active ☐ Hypo ☐ Hyper ☐ Absent
Nausea: ☐ Yes ☒ No
Vomiting: ☐ Yes ☒ No
Passing Flatus: ☒ Yes ☐ No
Tube: ☐ Yes ☒ No Type _____
Location _____ Inserted to _____cm
☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: regular
Amount/Schedule: normal schedule
Chewing/Swallowing difficulties:
☐ Yes ☒ No

MUSCULOSKELETAL

☐ Pain ☐ Joint Stiffness ☐ Swelling ☐ Contracted ☐ Weakness ☐ Cramping ☐ Spasms ☐ Tremors
Movement:
☐ RA ☐ LA ☐ RL ☐ LL ☒ All
Brace/Appliances: ☐ None
Type: _____

MOBILITY

☒ Ambulatory ☐ Crawl ☐ In Arms ☐ Ambulatory with assist _____
Assistive Device: ☐ Crutch ☐ Walker ☐ Brace ☐ Wheelchair ☐ Bedridden

PSYCHOSOCIAL

Social Status: ☒ Calm/Relaxed ☐ Quiet ☒ Friendly ☐ Cooperative ☐ Crying ☐ Uncooperative ☐ Restless ☐ Withdrawn ☐ Hostile/Anxious
Social/emotional bonding with family:
☒ Present ☐ Absent

IV ACCESS

Site: _____ ☐ INT ☐ None
☐ Central Line
Type/Location: (L) subclavian
Appearance: ☒ No Redness/Swelling ☐ Red ☐ Swollen
☐ Patent ☒ Blood return
Dressing Intact: ☒ Yes ☐ No
Fluids: _____

SKIN

Color: ☐ Pink ☐ Flushed ☐ Jaundiced ☐ Cyanotic ☒ Pale ☐ Natural for Pt
Condition: ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic
Turgor: ☐ < 5 seconds ☐ > 5 seconds
Skin: ☐ Intact ☐ Bruises ☐ Lacerations ☐ Tears ☐ Rash ☐ Skin Breakdown
Location/Description: _____
Mucous Membranes: Color: _____
☐ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☒ Numeric ☐ FLACC ☐ Faces
Location: anal rash
Type: burning
Pain Score:
0800 10 1200 3 1600 ____

WOUND/INCISION

☒ None
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

☒ None
☐ Drain/Tube
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount: _____
Drainage color: _____

Covenant School of Nursing
Instructional Module 5
Pediatric Assessment Tool

Student Name: Ashlynn Cunningham Unit: 3N Pt. Initials: CC Date: 3-2-22

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	100	100	100	100	100								
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													

pot measuring 2

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) 2
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	- Playing/sleeping appropriately **OR** - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed	- Irritable, difficult to console **OR** - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy **OR** - Reduced response to pain **OR** - Prolonged or frequent seizures **OR** - Pupils asymmetrical or sluggish
Cardiovascular	- Skin tone appropriate for patient - Capillary refill ≤ 2 seconds	- Pale **OR** - Capillary refill 3-4 seconds **OR** - Mild tachycardia **OR** - Intermittent ectopy or irregular HR (not new)	- Grey **OR** - Capillary refill 4-5 seconds **OR** - Moderate tachycardia	- Grey and mottled **OR** - Capillary refill > 5 seconds **OR** - Severe tachycardia **OR** - New onset bradycardia **OR** - New onset/increase in ectopy, irregular HR or heart block
Respiratory	- Within normal parameters - No retractions	- Mild tachypnea/ increased WOB (flaring, retracting) **OR** - Up to 40% supplemental oxygen **OR** - Up to 1L NC > patient's baseline need **OR** - Mild desaturations < patient's baseline **OR** - Intermittent apnea self-resolving	- Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) **OR** - 40-60% oxygen via mask **OR** - 1-2 L NC > patient's baseline need **OR** - Nebs Q 1-2 hour **OR** - Moderate desaturations < patient's baseline **OR** - Apnea requiring repositioning or stimulation	- Severe tachypnea **OR** - RR < normal for age **OR** - Severe increased WOB (i.e. head bobbing, paradoxical breathing) **OR** - > 60% oxygen via mask **OR** - > 2 L NC more than patient's baseline need **OR** - Nebs Q 30 minutes – 1 hour **OR** - Severe desaturations < patient's baseline **OR** - Apnea requiring interventions other than repositioning or stimulation
Staff Concern		- Concerned		
Family Concern		- Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
- Continue Routine Assessments	- 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	- 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

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), http://dx.doi.org/10.1016/j.pedn.2016.10.005

Student Name: Ashlynn Cunningham Unit: 3N Pt. Initials: CC Date: 3-2-22

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

Allergies: ~~egg, milk, tree nut~~ Sulka, Lorazepam, Peaches

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
~~D5NS + 40K @ 30mL/hr~~ D5NS @100	Isotonic/ Hypotonic/ Hypertonic	~~hypokalemia~~ F+E replacement / caloric intake↑	~~K+~~ Na, K	Severe dehydration

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? 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, Etc.)
Maxipime Inj (Cefepime)	Antibiotic, Cephalosporin (4th gen)	treat a wide range of bacterial infections	2000mg IVP Q8h	Y	NS, D5W or Lidocaine hydrochloride 50mL over 30min	easy bruising/ bleeding, unusual tiredness, uncontrollable movements	1. May ↓ effect of live vaccine 2. Monitor renal function 3. Observe S/S anaphylaxis 1st dose 4. Test C. diff if diarrhea occurs
Hep-Lock flush		keep IV catheter open + flowing smoothly	50 unit (5mL) Flush Q12h		NON Admin	bleeding, HIT, pain/loss of feeling in arms/ legs	1. 2. 3. 4.
Protonix (pantoprazole)	PPI	Stomach/ esophagus problems (acid reflux)	40mg/ IEC-tab PO daily	Y	NA	head ache, diarrhea	1. Monitor diarrhea (C-diff) 2. Do not chew 3. may ↑ risk enteric infection 4. May cause false + THC test
Peridex Liq	Abx oral rinse	↓ mouth sores in people with weakened immune systems	15mL swish/ spit BID	Y	NA	Tooth/ tongue staining, dry mouth, change in taste of food	1. Do not swallow 2. AM/PM use after brushing teeth 3. Teach importance of dentist visit 4. Do not rinse, eat, brush teeth immediately after use
Benadryl (diphenhydramine)			50mg 2 capsules Q8hr PRN nausea		Not administered	drowsiness, dizziness, constipation	1. 2. 3. 4.

Student Name: Ashlynn Cunningham Unit: 3N Pt. Initials: CC Date: 3-2-22

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

Allergies: Sulfa, Lorazepam, Peach

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? Is med in therapeutic range? If not, why?	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.)
melatonin	dietary supplement	insomnia	3mg/1 tab PO QHS PRN insomnia	Y	NA	headache, dizziness, shaking nausea, abdominal cramps	1. may cause low Blood Sugar 2. may not contain what product label claims 3. sleep candy/juice near by (low BS) 4. Extra caution: Chemo
Miralax		Constipation	17g (1 packet) PO daily for constipation		Not administered		1. 2. 3. 4.
Zofran ODT	antiemetic	nausea/ vomiting	8mg/2 orally dis. tabs PO Q8Hr PRN N/V	Y	NA	constipation, fatigue	1. Avoid if abnormal electrolytes 2. Food may ↓ absorption 3. take without regard to food 4. Do not take with QT int ↑ drugs
Boudreauxs Paste 16%	Antihemorrhoidal topical skin protectant	Rash	1 appl 1g topical BID PRN rash	Y	NA	local irritation	1. Teach signs of reaction 2. Notify Dr if no Δ 7 days 3. May stain clothing/fabric 4. Cleanse/dry area before use
Ofirmev IV 1000mg in sol 100mL	Analgesic Nonopioid	mild-moderate pain + fever	As directed 900mg IVPB once	Y	undiluted / 15 min	Pain at inj site, N/V trouble sleeping	1. do not exceed max dose/day 2. do not use with other acetaminophen products 3. Can cause liver injury 4. monitor infusion site

Lexicomp

D5NS+40K

Student Name: [redacted] **Unit:** 3N **Pt. Initials:** MF **Date:** 3-2-22

S

Pt Initials: Room: 318 DOB: Admit Date: 3-1-22 22:18
Admit Wt: 8.94 Current Wt: 8.68 Ht: 68cm (M) F
Primary Dx: Anemia
Secondary Dx:

Physician:

Consults (Ex: Speech, PT/OT, Surgery, Neuro)
Hematology

B

History
Significant allergic reaction over weekend - use of epipen: ED → "pancake milk" ×3
- pallor + diarrhea @ discharge FU lab Hgb 6.7 (one@home 2@ED)
stomach bug + URI in past few weeks
- mom, dad, 2 older siblings were also symptomatic

Allergies (reactions)
R R Ana
Egg, milk, tree nuts

Code status
FULL DNR/AND
Advance directive: Y N

Isolation:
Restraints: Y N
Type:
Fall risk
Vaccine- PNA Flu

A

Neuro: LOC/Hand Grips/Pulls & Pushes/Pupil Rx/ Pupil Size/ GCS
WNL

Vital Signs: BP/HR/RR/Temp/SpO2
~~Febrile overnight~~
98.6 at noon
111D/49 P121 O2 100

Cardiac: Peripheral pulses/Edema/Heart sounds/Rhythm – Regular or Irregular
WNL

Pain 0
Pain scale FLACC
Location

Pulmonary: Breath sounds/Secretions
WNL

Oxygen: ____L O2
NC 100NRB VM

Accu checks: Frequency
Results

GI: BS Last BM: 11:45 liquid stool NGT OGT

Diet
Breakfast % eaten: Lunch % eaten:

Skin:
Wounds/Drainage
Staples /Drains
Location

GU: Void Foley ____ FR Placed on:

IV Peripheral INT IV ____gauge Site: (L) AC IV Fluid type: ~~NS~~ D5NS+40K Rate: 36
3/01/22
Central- type/site (subclavian/port/broviac) PICC@____

Psych Social
mom present

Intake Total: mL Parenteral 216 Enteral 0
Output Total: mL Void _____mL Emesis _____mL
Balance: mL (Positive or negative) What does this mean for your pt?

Pending orders (ex: CBC, specimen)

Na	Cl	Bun	Gluc	Mg	Other
141	111↑	7	97		
K	**Co**	**Cr**	**Ca**	**Phos**	**Other**
2.3↓		0.20↓	6.9	154	

ANC [WBC x (% Neutrophils + % Bands) x 10]

Labs Pending:

Hct 19.1↓
WBC 7.0 | Plt 610↑
Hgb 6.7↓

UA
Cultures

Diagnostic Test Results:
CT
CXR
MRI
Echo

R

***Nursing Interventions & Teaching: (use your Critical Thinking Map)
DC Plan. Is pt informed of plan? Y N 24 hour orders reviewed Day 1 ☐ Day 2 ☐
What does the patient need when they are discharged?

Shift goals: Met Unmet Revise

Adopted: August 2016

clot risk
iron deficient

Student Name: Ashlynn Cargle Unit: 3N Pt. initials: MF Date: 3-2-22

GENERAL APPEARANCE

Appearance: ☒ Healthy/Well Nourished ☒ Neat/Clean ☐ Emaciated ☐ Unkept
Developmental age:
☒ Normal ☐ Delayed

NEUROLOGICAL

LOC: ☒ Alert ☐ Confused ☐ Restless ☐ Sedated ☐ Unresponsive
Oriented to:
☐ Person ☐ Place ☐ Time/Event ☒ Appropriate for Age
Pupil Response: ☒ Equal ☐ Unequal ☒ Reactive to Light ☐ Size 3
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat ☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☒ Able to move all extremities ☒ Symmetrically ☐ Asymmetrically
Grips: Right 5 Left 5
Pushes: Right 5 Left 5
S=Strong W=Weak N=None
EVD Drain: ☐ Yes ☒ No Level _____
Seizure Precautions: ☐ Yes ☒ No

RESPIRATORY

Respirations: ☒ Regular ☐ Irregular ☐ Retractions (type) _____ ☐ Labored
Breath Sounds:
Clear ☒ Right ☒ Left
Crackles ☐ Right ☐ Left
Wheezes ☐ Right ☐ Left
Diminished ☐ Right ☐ Left
Absent ☐ Right ☐ Left
☒ Room Air ☐ Oxygen
Oxygen Delivery:
☐ Nasal Cannula: ____L/min
☐ BiPap/CPAP: _____
☐ Vent: ETT size____@____cm
☐ Other: _____
Trach: ☐ Yes ☒ No
Size _____ Type _____
Obturator at Bedside ☐ Yes ☐ No
Cough: ☐ Yes ☒ No ☐ Productive ☐ Nonproductive
Secretions: Color none
Consistency _____
Suction: ☐ Yes ☒ No Type _____
Pulse Ox Site L great toe
Oxygen Saturation: 100%

CARDIOVASCULAR

Pulse: ☒ Regular ☐ Irregular ☒ Strong ☐ Weak ☐ Thready ☐ Murmur ☐ Other _____
Edema: ☐ Yes ☒ No Location _____ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Capillary Refill: ☒ < 2 sec ☐ > 2 sec
Pulses:
Upper R 3+ L 3+
Lower R 3+ L 3+
4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None

ELIMINATION

Urine Appearance: yellow, clear
Stool Appearance: not visualized ☐ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☒ Soft ☐ Firm ☐ Flat ☐ Distended ☐ Guarded
Bowel Sounds: ☒ Present X____ quads ☒ Active ☐ Hypo ☐ Hyper ☐ Absent
Nausea: ☐ Yes ☒ No
Vomiting: ☐ Yes ☒ No
Passing Flatus: ☒ Yes ☐ No
Tube: ☐ Yes ☒ No Type _____
Location _____ Inserted to _____cm
☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: Regular diet
Amount/Schedule: regular meal times
Chewing/Swallowing difficulties:
☐ Yes ☒ No snack q2hr

MUSCULOSKELETAL

☐ Pain ☐ Joint Stiffness ☐ Swelling ☐ Contracted ☐ Weakness ☐ Cramping ☐ Spasms ☐ Tremors
Movement:
☒ RA ☒ LA ☐ RL ☐ LL ☒ All
Brace/Appliances: ☐ None
Type: _____

MOBILITY

☐ Ambulatory ☒ Crawl ☐ In Arms ☒ Ambulatory with assist _____
Assistive Device: ☐ Crutch ☐ Walker ☐ Brace ☐ Wheelchair ☐ Bedridden

PSYCHOSOCIAL

Social Status: ☒ Calm/Relaxed ☐ Quiet ☒ Friendly ☒ Cooperative ☐ Crying ☐ Uncooperative ☐ Restless ☐ Withdrawn ☐ Hostile/Anxious
Social/emotional bonding with family:
☒ Present ☐ Absent

IV ACCESS

Site: (L) AC ☐ INT ☐ None
☐ Central Line
Type/Location: _____
Appearance: ☒ No Redness/Swelling ☐ Red ☐ Swollen ☐ Patent ☐ Blood return
Dressing Intact: ☒ Yes ☐ No
Fluids: _____

SKIN

Color: ☒ Pink ☐ Flushed ☐ Jaundiced ☐ Cyanotic ☐ Pale ☐ Natural for Pt
Condition: ☒ Warm ☐ Cool ☐ Dry ☐ Diaphoretic
Turgor: ☒ < 5 seconds ☐ > 5 seconds
Skin: ☒ Intact ☐ Bruises ☐ Lacerations ☐ Tears ☐ Rash ☐ Skin Breakdown
Location/Description: _____
Mucous Membranes: Color: pink
☒ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☐ Numeric ☒ FLACC ☐ Faces
Location: None
Type: None
Pain Score:
0800 0 1200 0 1600 ____

WOUND/INCISION

☒ None
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

☒ None
☐ Drain/Tube
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount: _____
Drainage color: _____

Student Name: Ashlynn Cunningham Unit: 3N Pt. initials: MF Date: 3-2-22

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake	~~72~~	~~36~~	~~36~~	~~36~~	~~36~~								
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	72	36	36	36	36								
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													

not measured

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) (0)
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	– Playing/sleeping appropriately **OR** – Alert, at patient's baseline	– Sleepy, somnolent when not disturbed	– Irritable, difficult to console **OR** – Increase in patient's baseline seizure activity	– Lethargic, confused, floppy **OR** – Reduced response to pain **OR** – Prolonged or frequent seizures **OR** – Pupils asymmetrical or sluggish
Cardiovascular	– Skin tone appropriate for patient – Capillary refill ≤ 2 seconds	– Pale **OR** – Capillary refill 3-4 seconds **OR** – Mild tachycardia **OR** – Intermittent ectopy or irregular HR (not new)	– Grey **OR** – Capillary refill 4-5 seconds **OR** – Moderate tachycardia	– Grey and mottled **OR** – Capillary refill > 5 seconds **OR** – Severe tachycardia **OR** – New onset bradycardia **OR** – New onset/increase in ectopy, irregular HR or heart block
Respiratory	– Within normal parameters – No retractions	– Mild tachypnea/ increased WOB (flaring, retracting) **OR** – Up to 40% supplemental oxygen **OR** – Up to 1L NC > patient's baseline need **OR** – Mild desaturations < patient's baseline **OR** – Intermittent apnea self-resolving	– Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) **OR** – 40-60% oxygen via mask **OR** – 1-2 L NC > patient's baseline need **OR** – Nebs Q 1-2 hour **OR** – Moderate desaturations < patient's baseline **OR** – Apnea requiring repositioning or stimulation	– Severe tachypnea **OR** – RR < normal for age **OR** – Severe increased WOB (i.e. head bobbing, paradoxical breathing) **OR** – > 60% oxygen via mask **OR** – > 2 L NC more than patient's baseline need **OR** – Nebs Q 30 minutes – 1 hour **OR** – Severe desaturations < patient's baseline **OR** – Apnea requiring interventions other than repositioning or stimulation
Staff Concern		– Concerned		
Family Concern		– Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
– Continue Routine Assessments	– 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	– 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

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), http://dx.doi.org/10.1016/j.pedn.2016.10.005

Student Name: Ashlynn Cunningham Unit: 3N Pt. Initials: MF Date: 3.2.22

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

Allergies: egg, milk, tree nut – anaphylaxis (rash)

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5NS + 40K @ 36	Isotonic/ Hypotonic/ Hypertonic	hypokalemia	K+	

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? 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, Etc.)
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.

Adopted: August 2016