

Signs & Symptoms

- Vomiting
- ABD pain
- ABD distention
- Intipation

Pathophysiology

- Dilation of the small Bowel and build up of gases and fluid

Diagnostics/Labs

- CT scan
- XRAY

Small Bowel Obstruction

Treatment/Medication

- IV fluids
- NPO
- NG Tube
- Antiemetics
- Pt: had surgery
- Post op: slowly increasing formula

Nursing Interventions

- Abdominal Assessment

Patient Teaching

- Small amounts of food more frequently
- Cut Solids into small pieces
- Soft foods at first
- Slowly increase appropriate for age

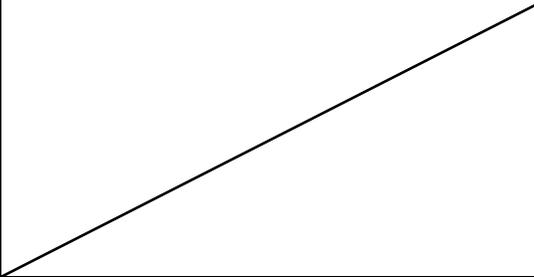
Other

Priority Nursing Diagnosis

**Risk for malnutrition**

Student Name frances Cerna

<p><b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <ol style="list-style-type: none"><li>1. Pacifier w/sugar water</li><li>2. Cocomelon - learning T.V show</li></ol> <p><b>*List All Pain/Discomfort Medication on the Medication Worksheet</b></p> <p>Acetamenophine 160mg</p>	<p><b>8. Calculate the Maintenance Fluid Requirement (Show Your Work):</b> Patient Wt: <u>10.4</u> kg</p> $\begin{array}{r} 10 \times 100 = 1,000 \\ 0.4 \times 50 = 20 \\ \hline 1,020 / 24 \end{array}$ <p>Calculated Fluid Requirement: <u>42.5</u> ml/hr</p> <p>Actual Pt MIVF Rate: <u>20</u> ml/hr</p> <p>Is There a Significant Discrepancy?</p> <p>Why?</p>	<p><b>9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</b></p> $\begin{array}{r} \text{kg} \times 1 \\ 10.4 \times 1 = 10.4 \end{array}$ <p>Calculated Min. Urine Output: <u>10.4</u> ml/hr</p> <p>Actual Pt Urine Output: <u>6.7</u> ml/hr</p>
<p><b>10. Growth &amp; 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:</b> Patient age: <u>20 months</u></p> <p><b>Erickson Stage:</b></p> <ol style="list-style-type: none"><li>1. Autonomy vs Shame &amp; Doubt</li><li>2.</li></ol> <p><b>Piaget Stage:</b></p> <ol style="list-style-type: none"><li>1. Anal stage   Toilet Training</li><li>2. Oral stage</li></ol>		

<p>11. Focused Nursing Diagnosis:</p> <ul style="list-style-type: none"> <li>· Risk for dehydration</li> </ul>	<p>15. Nursing Interventions related to the Nursing Diagnosis in #11:</p> <ol style="list-style-type: none"> <li>1.</li> </ol> <p>Evidenced Based Practice:</p> <ul style="list-style-type: none"> <li>· Offer Pedialyte &amp; Popsicles</li> </ul>	<p>16. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> <li>1. · Encourage fluids even w/out ques</li> <li>2. Teach s/s of dehydration (dry membranes, ↓ wet diapers)</li> <li>3. 3-4 wet diapers w/in 24 hours</li> </ol>
<p>12. Related to (r/t):</p> <ul style="list-style-type: none"> <li>· Small Bowel Obstruction</li> </ul>	<ol style="list-style-type: none"> <li>2.</li> </ol> <p>Evidenced Based Practice:</p> <ul style="list-style-type: none"> <li>· IV hydration as ordered</li> </ul>	<p>17. Discharge Planning/Community Resources:</p> <ol style="list-style-type: none"> <li>1. Case management</li> <li>2. Offer water frequently</li> <li>3. Resources on Small Bowel Obstruction   dehydration prevention</li> </ol>
<p>13. As evidenced by (aeb):</p> 	<ol style="list-style-type: none"> <li>3.</li> </ol> <p>Evidenced Based Practice:</p> <ul style="list-style-type: none"> <li>· Strict Intake &amp; output</li> </ul>	
<p>14. Desired patient outcome:</p> <ul style="list-style-type: none"> <li>· U or Q4H by discharge date/time</li> </ul>		

Student Name: Frances Cerna-main pt

Unit: Pedi floor

Date: 01/31/23

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <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 _____ <b>Edema:</b> <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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> 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	<b>Social Status:</b> <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 <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed <b>Extremities:</b> <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 <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>yellow, clear</u> <b>Stool Appearance:</b> <u>green</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <input checked="" type="checkbox"/> <u>AC</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Peripheral</u> <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>DS 1/2 NS + KCL 20</u> <u>20 ml/hr</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> 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 <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: <u>NA</u> L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>R+DE</u> <b>Oxygen Saturation:</b> <u>98.1</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <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 <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <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 <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <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: _____ <b>Mucous Membranes:</b> Color: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>Formula</u> <b>Amount/Schedule:</b> <u>300 4hr</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>X</u> <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 <u>D</u>
	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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ <b>Assistive Device:</b> <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 <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

Student Name: Frances Cerna

Unit: Pedi Floor

Date: 1/31/23

<p><b>GENERAL APPEARANCE</b></p> <p><b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished  <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p><b>Developmental age:</b>  <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p><b>CARDIOVASCULAR</b></p> <p><b>Pulse:</b> <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 _____</p> <p><b>Edema:</b> <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+</p> <p><b>Capillary Refill:</b> <input checked="" type="checkbox"/> &lt; 2 sec <input type="checkbox"/> &gt; 2 sec</p> <p><b>Pulses:</b>  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</p>	<p><b>PSYCHOSOCIAL</b></p> <p><b>Social Status:</b> <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</p> <p><b>Social/emotional bonding with family:</b>  <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p><b>NEUROLOGICAL</b></p> <p><b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless  <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p><b>Oriented to:</b>  <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event  <input checked="" type="checkbox"/> Appropriate for Age</p> <p><b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal  <input checked="" type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>5</u></p> <p><b>Fontanel:</b> (Pt &lt; 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat  <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed</p> <p><b>Extremities:</b>  <input checked="" type="checkbox"/> Able to move all extremities  <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically</p> <p>Grips: Right <u>S</u> Left <u>S</u>  Pushes: Right <u>S</u> Left <u>S</u>  S=Strong W=Weak N=None</p> <p><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____</p> <p><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>ELIMINATION</b></p> <p><b>Urine Appearance:</b> <u>NA</u></p> <p><b>Stool Appearance:</b> <u>NA</u>  <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><b>IV ACCESS</b></p> <p><b>Site:</b> _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None  <input type="checkbox"/> Central Line  Type/Location: _____</p> <p><b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling  <input type="checkbox"/> Red <input type="checkbox"/> Swollen  <input type="checkbox"/> Patent <input type="checkbox"/> Blood return</p> <p><b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Fluids:</b> <u>NA</u></p>
<p><b>RESPIRATORY</b></p> <p><b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <input type="checkbox"/> Retractions (type) _____  <input type="checkbox"/> Labored</p> <p><b>Breath Sounds:</b>  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</p> <p><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p><b>Oxygen Delivery:</b>  <input type="checkbox"/> Nasal Cannula: _____ L/min  <input type="checkbox"/> BiPap/CPAP: _____  <input type="checkbox"/> Vent: ETT size _____ @ _____ cm  <input type="checkbox"/> Other: _____</p> <p><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Size _____ Type _____  Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p><b>Secretions:</b> Color _____  Consistency _____</p> <p><b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____</p> <p><b>Pulse Ox Site</b> <u>@ index finger</u></p> <p><b>Oxygen Saturation:</b> <u>99%</u></p>	<p><b>GASTROINTESTINAL</b></p> <p><b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat  <input type="checkbox"/> Distended <input type="checkbox"/> Guarded</p> <p><b>Bowel Sounds:</b> <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</p> <p><b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____  Location _____ Inserted to _____ cm  <input type="checkbox"/> Suction Type: _____</p>	<p><b>SKIN</b></p> <p><b>Color:</b> <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</p> <p><b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry  <input type="checkbox"/> Diaphoretic</p> <p><b>Turgor:</b> <input checked="" type="checkbox"/> &lt; 5 seconds <input type="checkbox"/> &gt; 5 seconds</p> <p><b>Skin:</b> <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: _____</p> <p><b>Mucous Membranes:</b> Color: <u>Pink</u>  <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
	<p><b>NUTRITIONAL</b></p> <p><b>Diet/Formula:</b> <u>Regular</u></p> <p><b>Amount/Schedule:</b> _____</p> <p><b>Chewing/Swallowing difficulties:</b>  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>PAIN</b></p> <p><b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces</p> <p><b>Location:</b> <u>NA</u></p> <p><b>Type:</b> <u>NA</u></p> <p><b>Pain Score:</b> <u>1400 - 0</u>  0800 <u>1200</u> 1600</p>
	<p><b>MUSCULOSKELETAL</b></p> <p><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</p> <p><b>Movement:</b>  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All</p> <p><b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None  Type: _____</p>	<p><b>WOUND/INCISION</b></p> <p><input checked="" type="checkbox"/> None</p> <p><b>Type:</b> _____</p> <p><b>Location:</b> _____</p> <p><b>Description:</b> _____</p> <p><b>Dressing:</b> _____</p>
	<p><b>MOBILITY</b></p> <p><input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms  <input type="checkbox"/> Ambulatory with assist _____</p> <p><b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker  <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p><b>TUBES/DRAINS</b></p> <p><input checked="" type="checkbox"/> None</p> <p><input type="checkbox"/> Drain/Tube  Site: _____  Type: _____  Dressing: _____  Suction: _____  Drainage amount: _____  Drainage color: _____</p>

Student Name: Frances Cerna Unit: Pedi floor Date: \_\_\_\_\_

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake			90ml						90ml				180ml
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													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine			122ml		40ml								162 ml
# of immeasurable													
Stool						100	60						160 ml
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 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>1</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: Frances Cerna

Unit: Pedi floor

Pt. Initials: A.D

Date: \_\_\_\_\_

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

Allergies: NKDA pt weight: 10.16 kg

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5 1/2 NS + KCl 20 meq	Isotonic/ Hypotonic/ <b>Hypertonic</b>	· Electrolyte ? Fluid Replacement	· UA · potassium	· ↑ K <sup>+</sup> levels · ↓ kidney fx · Allergic rxn

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?			
Acetaminophen	· Analgesic	· Pain reliever · Post OP	PRN Q4h 160mg orally	Range: 10-15 mg/kg Pt: 101.6 - 159 · Yes	_____	· Stomach pain · ↓ appetite · tiredness · itching · Dark urine · Clay colored stool	1. No more than 5 doses of recommended dose daily 2. 3. Monitor for allergic rxn 4.
famotidine	· H2 antagonist	· Decreases acid in the stomach	6mg BID IVP	Range: 0.5 mg/kg/BID max: 40 mg BID Pt range: 5-3 · No, dose is slightly above	· IVP over 2 min · Admin 0.6 ml · Dilute 8ml NS w/2ml NS	· Agitation · Headache · Dizziness	1. Take 30 min before meals 2. may interact w/multivitamins 3. 4.
Ceftriaxone	· Cephalosporin	· Antibiotic	800mg Daily IVPB	Range: 50mg/kg/dose Pt: 530mg/kg/dose No dose is above range	IVPB 800mg 40 ml/hr	· Diarrhea · Warmth @ site · Rash · Vaginal itching/ discharge	1. Encourage fluids for kidney function 2. Finish full dose 3. Monitor for flank pain 4.
							1. 2. 3. 4.
							1. 2. 3. 4.

### CHEWS Scoring and Escalation Algorithm

	0	1	2	3
<b>Behavior/Neuro</b>	<ul style="list-style-type: none"> <li>- Playing/sleeping appropriately <b>OR</b></li> <li>- Alert, at patient's baseline</li> </ul>	<ul style="list-style-type: none"> <li>- Sleepy, somnolent when not disturbed</li> </ul>	<ul style="list-style-type: none"> <li>- Irritable, difficult to console <b>OR</b></li> <li>- Increase in patient's baseline seizure activity</li> </ul>	<ul style="list-style-type: none"> <li>- Lethargic, confused, floppy <b>OR</b></li> <li>- Reduced response to pain <b>OR</b></li> <li>- Prolonged or frequent seizures <b>OR</b></li> <li>- Pupils asymmetrical or sluggish</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>- Skin tone appropriate for patient</li> <li>- Capillary refill <math>\leq</math> 2 seconds</li> </ul>	<ul style="list-style-type: none"> <li>- Pale <b>OR</b></li> <li>- Capillary refill 3-4 seconds <b>OR</b></li> <li>- Mild tachycardia <b>OR</b></li> <li>- Intermittent ectopy or irregular HR (not new)</li> </ul>	<ul style="list-style-type: none"> <li>- Grey <b>OR</b></li> <li>- Capillary refill 4-5 seconds <b>OR</b></li> <li>- Moderate tachycardia</li> </ul>	<ul style="list-style-type: none"> <li>- Grey and mottled <b>OR</b></li> <li>- Capillary refill &gt; 5 seconds <b>OR</b></li> <li>- Severe tachycardia <b>OR</b></li> <li>- New onset bradycardia <b>OR</b></li> <li>- New onset/increase in ectopy, irregular HR or heart block</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>- Within normal parameters</li> <li>- No retractions</li> </ul>	<ul style="list-style-type: none"> <li>- Mild tachypnea/ increased WOB (flaring, retracting) <b>OR</b></li> <li>- Up to 40% supplemental oxygen <b>OR</b></li> <li>- Up to 1L NC &gt; patient's baseline need <b>OR</b></li> <li>- Mild desaturations &lt; patient's baseline <b>OR</b></li> <li>- Intermittent apnea self-resolving</li> </ul>	<ul style="list-style-type: none"> <li>- Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) <b>OR</b></li> <li>- 40-60% oxygen via mask <b>OR</b></li> <li>- 1-2 L NC &gt; patient's baseline need <b>OR</b></li> <li>- Nebs Q 1-2 hour <b>OR</b></li> <li>- Moderate desaturations &lt; patient's baseline <b>OR</b></li> <li>- Apnea requiring repositioning or stimulation</li> </ul>	<ul style="list-style-type: none"> <li>- Severe tachypnea <b>OR</b></li> <li>- RR &lt; normal for age <b>OR</b></li> <li>- Severe increased WOB (i.e. head bobbing, paradoxical breathing) <b>OR</b></li> <li>- &gt; 60% oxygen via mask <b>OR</b></li> <li>- &gt; 2 L NC more than patient's baseline need <b>OR</b></li> <li>- Nebs Q 30 minutes – 1 hour <b>OR</b></li> <li>- Severe desaturations &lt; patient's baseline <b>OR</b></li> <li>- Apnea requiring interventions other than repositioning or stimulation</li> </ul>
<b>Staff Concern</b>		<ul style="list-style-type: none"> <li>- Concerned</li> </ul>		
<b>Family Concern</b>		<ul style="list-style-type: none"> <li>- Concerned or absent</li> </ul>		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
<ul style="list-style-type: none"> <li>- Continue Routine Assessments</li> </ul>	<ul style="list-style-type: none"> <li>- Notify charge nurse or LIP</li> <li>- Discuss treatment plan with team</li> <li>- Consider higher level of care</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul>	<ul style="list-style-type: none"> <li>- Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation</li> <li>- Notify attending physician</li> <li>- Discuss treatment plan with team</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul>

**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>