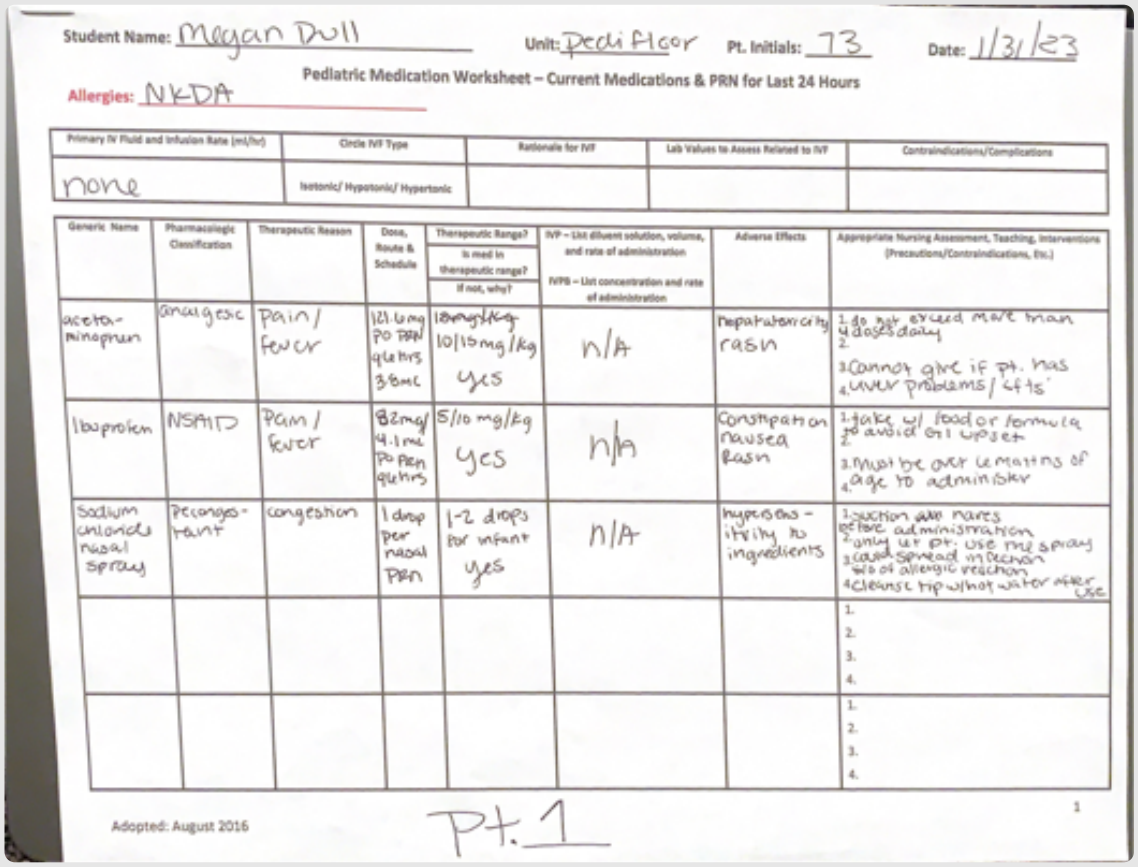
pedi Floor Paperwork



Student Name: Megan Dull Unit: Pedi Floor Pt. Initials: TJ Date: 1/31/23

Allergies: NKDA

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
none	Isotonic/ Hypotonic/ Hypertonic			

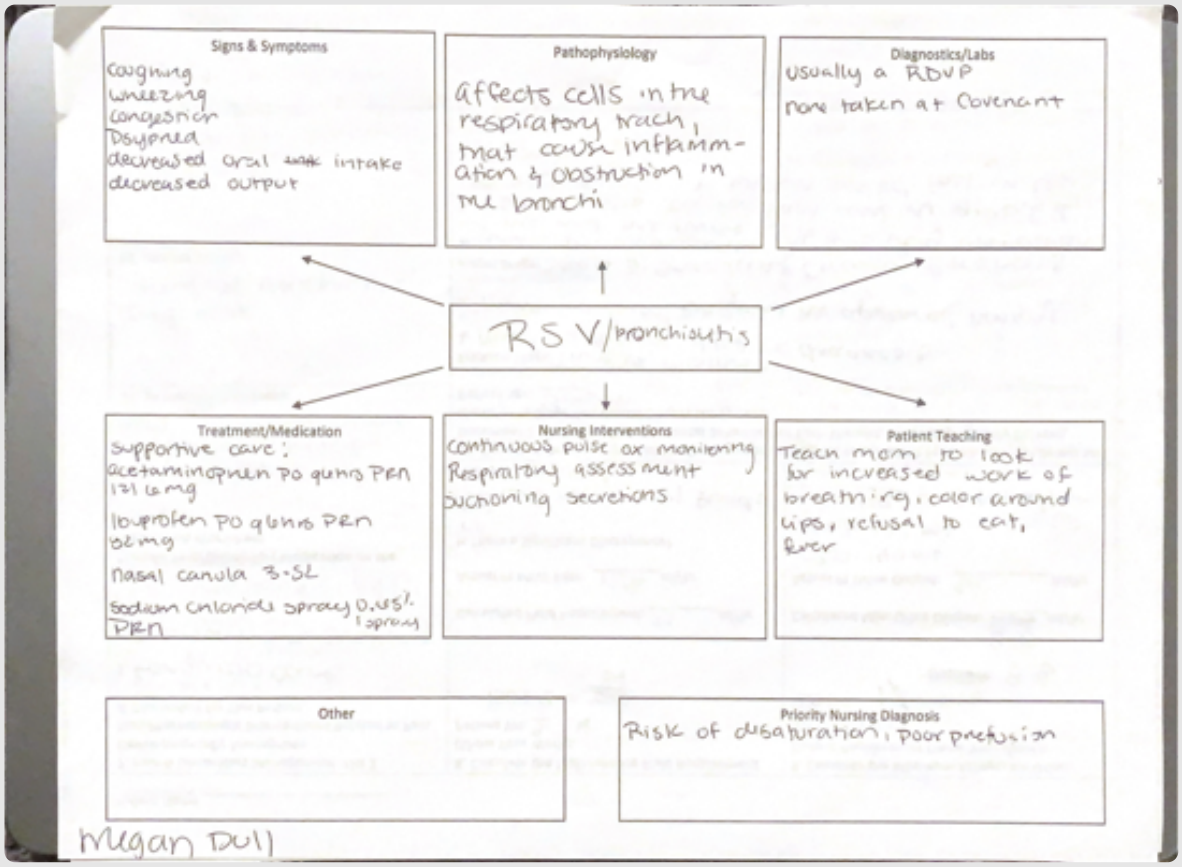
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? Is med in therapeutic range? If not, why?	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
acetaminophen	analgesic	pain/ fever	121.6mg PO PRN q6hrs 3.8mL	~~10mg/kg~~ 10/15mg/kg yes	n/A	hepatotoxicity rash	1. do not exceed more than 4 doses daily 2. 3. Cannot give if pt. has liver problems / CF ts. 4.
Ibuprofen	NSAID	Pain / fever	82mg/ 4.1mL PO PRN q6hrs	5/10 mg/kg yes	n/A	constipation nausea Rash	1. take w/ food or formula to avoid GI upset 2. 3. Must be over 6 months of age to administer 4.
Sodium chloride nasal spray	Decongestant	congestion	1 drop per nasal PRN	1-2 drops for infant yes	n/A	hypersensitivity to ingredients	1. suction and nares before administration 2. only use pt. use nasal spray 3. could spread infection w/o allergic reaction 4. cleanse tip w/hot water after use
							1. 2. 3. 4.
							1. 2. 3. 4.

Adopted: August 2016

Pt. 1

1

Signs & Symptoms



Signs & Symptoms
coughing
wheezing
congestion
Dyspnea
decreased oral ~~intake~~ intake
decreased output

Pathophysiology
affects cells in the respiratory track, that cause inflammation & obstruction in the bronchi

Diagnostics/Labs
usually a RDVP
now taken at Covenant

RSV/bronchiolitis

Treatment/Medication
supportive care:
acetaminophen PO q4hrs PRN 121.6mg
ibuprofen PO q6hrs PRN 82mg
nasal canula 3-5L
Sodium chloride spray 0.65% 1 spray PRN

Nursing Interventions
continuous pulse ox monitoring
Respiratory assessment
suctioning secretions

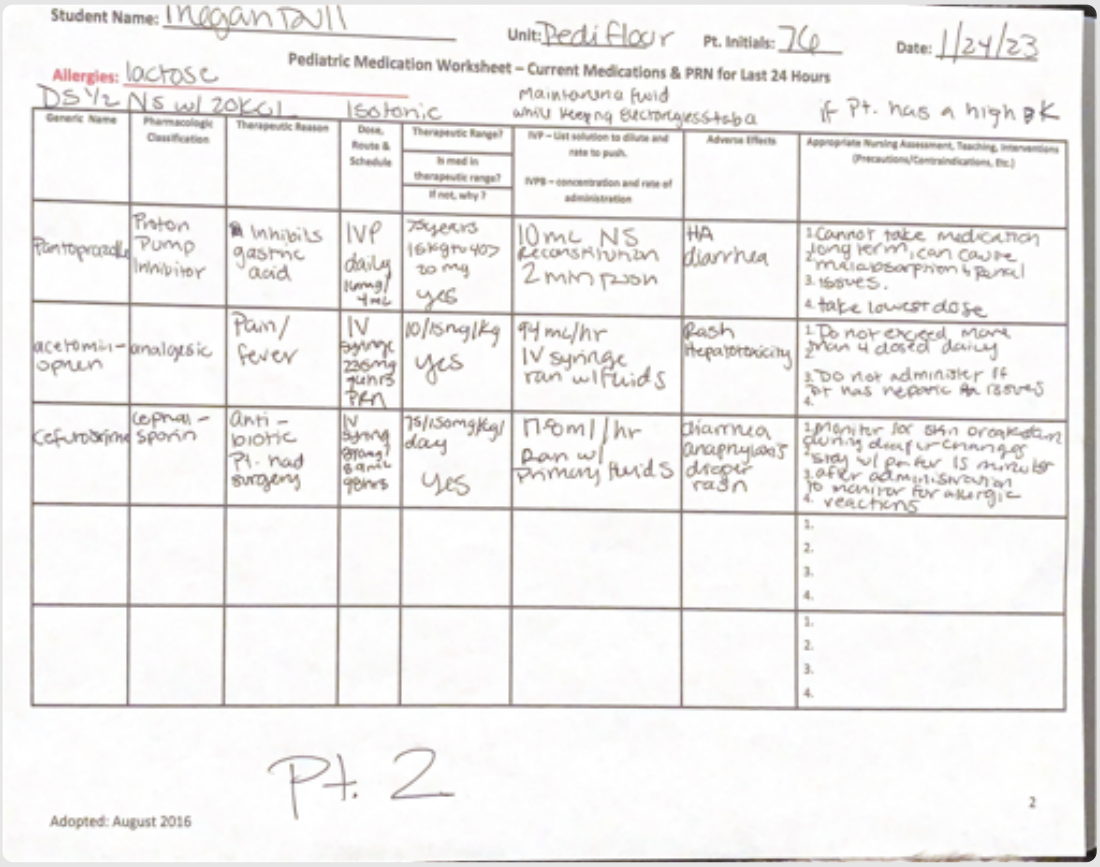
Patient Teaching
Teach mom to look for increased work of breathing, color around lips, refusal to eat, fever

Other

Priority Nursing Diagnosis
Risk of desaturation; poor perfusion

Megan Dull

Generic Name



Student Name: Megan Dill Unit: Pediflour Pt. Initials: JG Date: 11/24/23

Allergies: lactose

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

D5 1/2 NS w/ 20KCl Isotonic maintenance fluid while keeping electrolytes stable If Pt. has a high βK

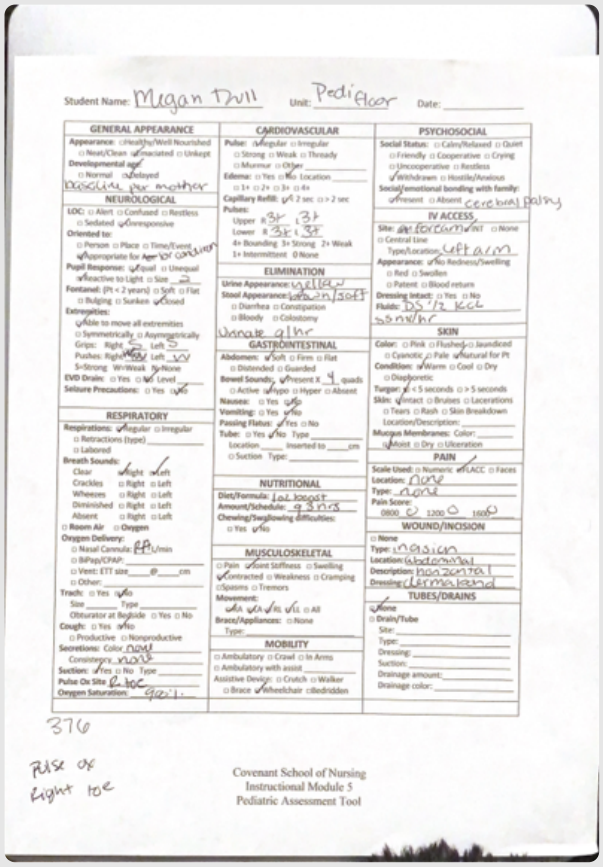
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? Is med in therapeutic range? If not, why?	IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Pantoprazole	Proton Pump Inhibitor	Inhibits gastric acid	IVP daily 1mg/1mL	2 years 16kg to 40.7 20 mg yes	10mL NS reconstitution 2 min push	HA diarrhea	1. Cannot take medication long term, can cause malabsorption & renal issues. 4. take lowest dose
acetaminophen	analgesic	Pain/fever	IV syringe 230mg q4hrs PRN	10/15mg/kg yes	94 mL/hr IV syringe ran w/ fluids	Rash Hepatotoxicity	1. Do not exceed more than 4 doses daily 3. Do not administer if pt has hepatic issues 4.
Cefuroxime	cephalosporin	anti-biotic Pt. had surgery	IV syringe 750mg q8hrs	75/150mg/kg/day yes	150 mL/hr ran w/ primary fluids	diarrhea anaphylaxis drop in rash	1. Monitor for skin breakdown during dressing changes 2. stay w/ pt for 15 minutes 3. after administration to monitor for allergic 4. reactions
							1. 2. 3. 4.
							1. 2. 3. 4.

Pt. 2

Adopted: August 2016

2

GENERAL APPEARANCE



Student Name: Megan Dill Unit: Pediatrics Date: _____

GENERAL APPEARANCE
Appearance: ☐Healthy/Well Nourished ☐Neat/Clean ☑Emaciated ☐Unkept
Developmental age: ☐Normal ☑Delayed
Discuss w/ mother
NEUROLOGICAL
LOC: ☐ Alert ☐ Confused ☐ Restless ☐ Sedated ☑Unresponsive
Oriented to: ☐ Person ☐ Place ☐ Time/Event ☑Appropriate for Age or circumstances
Pupil Response: ☑Equal ☐ Unequal ☑Reactive to Light ☐ Size 2
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat ☐ Bulging ☐ Sunken ☑Closed
Extremities: ☑Able to move all extremities ☐ Symmetrically ☐ Asymmetrically
Grips: Right 5 Left 5
Pushes: Right WNL Left WNL
5=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: RA 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 none
Suction: ☑Yes ☐ No Type _____
Pulse Ox Site R hand
Oxygen Saturations: 96% RA
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: brown/soft ☐ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy
Urinate q1hr
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: Lactose
Amount/Schedule: q 3 hrs
Chewing/Swallowing difficulties: ☐ Yes ☑No
MUSCULOSKELETAL
☐ Pain ☑Joint Stiffness ☐ Swelling ☑Contracted ☐ Weakness ☐ Cramping ☐ Spasms ☐ Tremors
Movement: WFL WFL WFL WFL ☐ 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 cerebral palsy
IV ACCESS
Site: ☑Peripheral ☐ PICC ☐ None ☐ Central Line
Type/Location: Left arm
Appearance: ☑No Redness/Swelling ☐ Red ☐ Swollen ☐ Patent ☐ Blood return
Dressing Intact: ☐ Yes ☐ No
Fluids: D5 1/2 KCL 55 ml/hr
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: none
Type: none
Pain Score: 0800 0 1200 0 1600 0
WOUND/INCISION
☐ None
Type: incision
Location: abdominal
Description: horizontal
Dressing: clean/dry
TUBES/DRAINS
☑None ☐ Drain/Tube
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount: _____
Drainage color: _____

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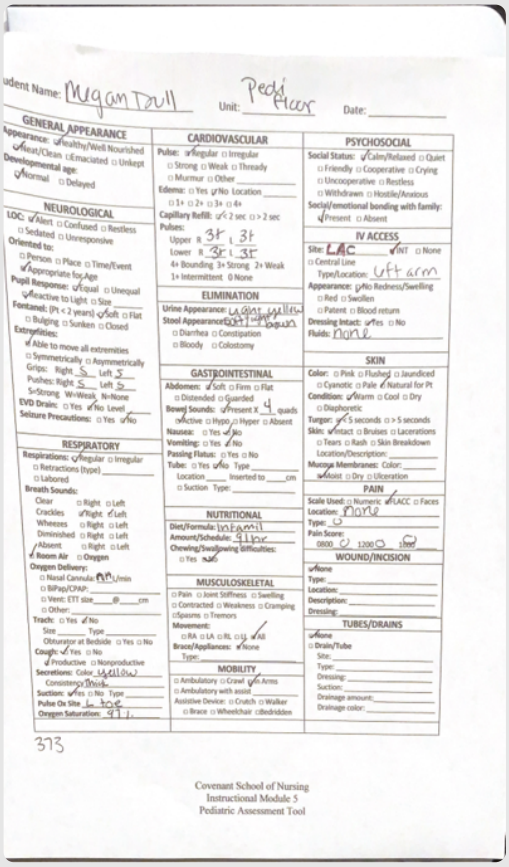
Rise of Right toe

Covenant School of Nursing
Instructional Module 5
Pediatric Assessment Tool

GENERAL APPEARANCE



udent Name: Megan Doll Unit: Peds Acer Date: _____

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 S Left S
Pushes: Right S Left S
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 Yellow
Consistency Thick
Suction: ✓Yes □ No Type _____
Pulse Ox Site Lt toe
Oxygen Saturation: 97%

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: Light yellow
Stool Appearance: Soft - brown
□ 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: Infamil
Amount/Schedule: 91 mL
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 ✓Lifts 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: LAC ✓INT □ None
□ Central Line
Type/Location: Lft arm
Appearance: ✓No Redness/Swelling □ Red □ Swollen □ Patent □ Blood return
Dressing Intact: ✓Yes □ No
Fluids: none

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: none
Type: _____
Pain Score:
0800 ☺ 1200 ☺ 2000 ☺

WOUND/INCISION
✓None
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS
✓None
□ Drain/Tube
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount: _____
Drainage color: _____

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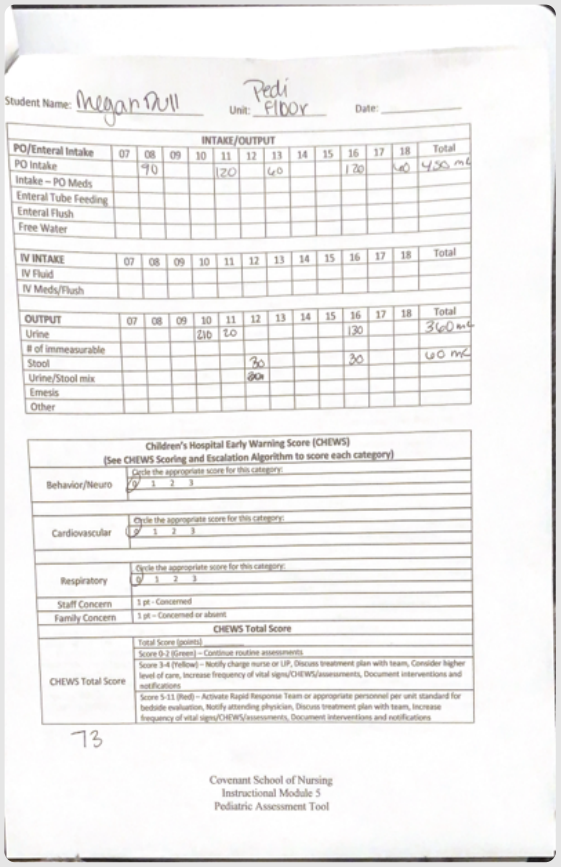
Covenant School of Nursing
Instructional Module 5
Pediatric Assessment Tool

Pedi



Student Name: Megan Null Unit: Pedi Floor Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		90			120		60			120		60	450 mL
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				210	20					130			360 mL
# of immeasurable													
Stool						30				30			60 mL
Urine/Stool mix						30							
Emesis													
Other													

Children's Hospital Early Warning Score (CHEWS) (See CHEWS Scoring and Escalation Algorithm to score each category)	
Behavior/Neuro	Cycle the appropriate score for this category: (0) 1 2 3
Cardiovascular	Cycle the appropriate score for this category: (0) 1 2 3
Respiratory	Cycle 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):
	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

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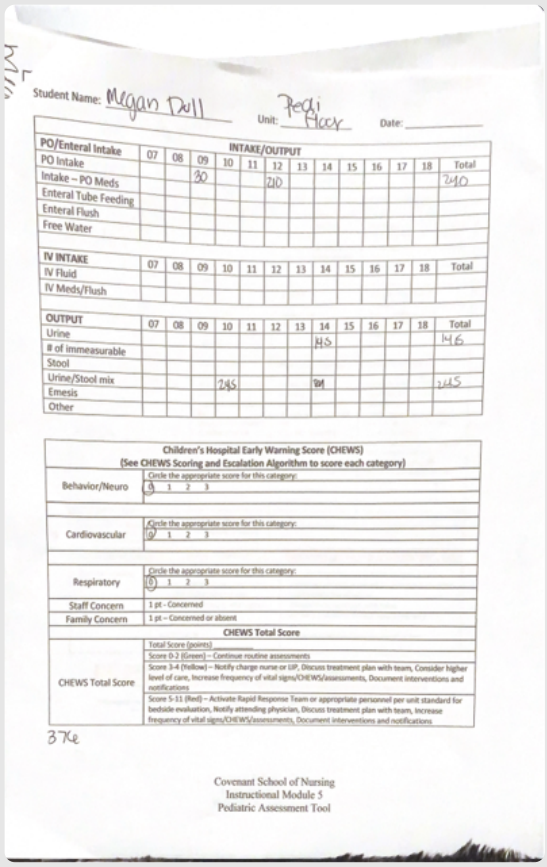
Covenant School of Nursing
Instructional Module 5
Pediatric Assessment Tool

PO/Enteral Intake



Student Name: Megan Dull Unit: Peds Heart Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
Intake – PO Meds			30			210							240
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								145					145
# of immeasurable													
Stool													
Urine/Stool mix				245				100					245
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) _____ 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

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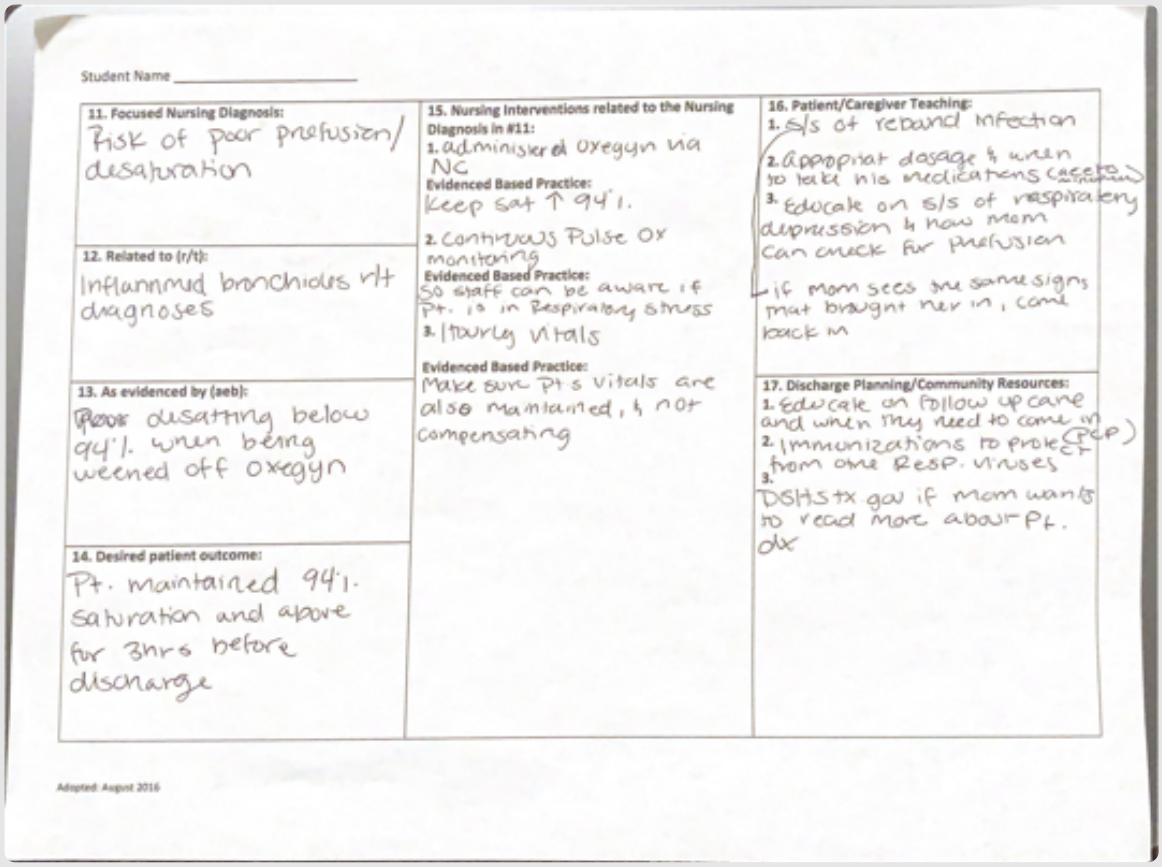
Covenant School of Nursing
Instructional Module 5
Pediatric Assessment Tool

Student Name

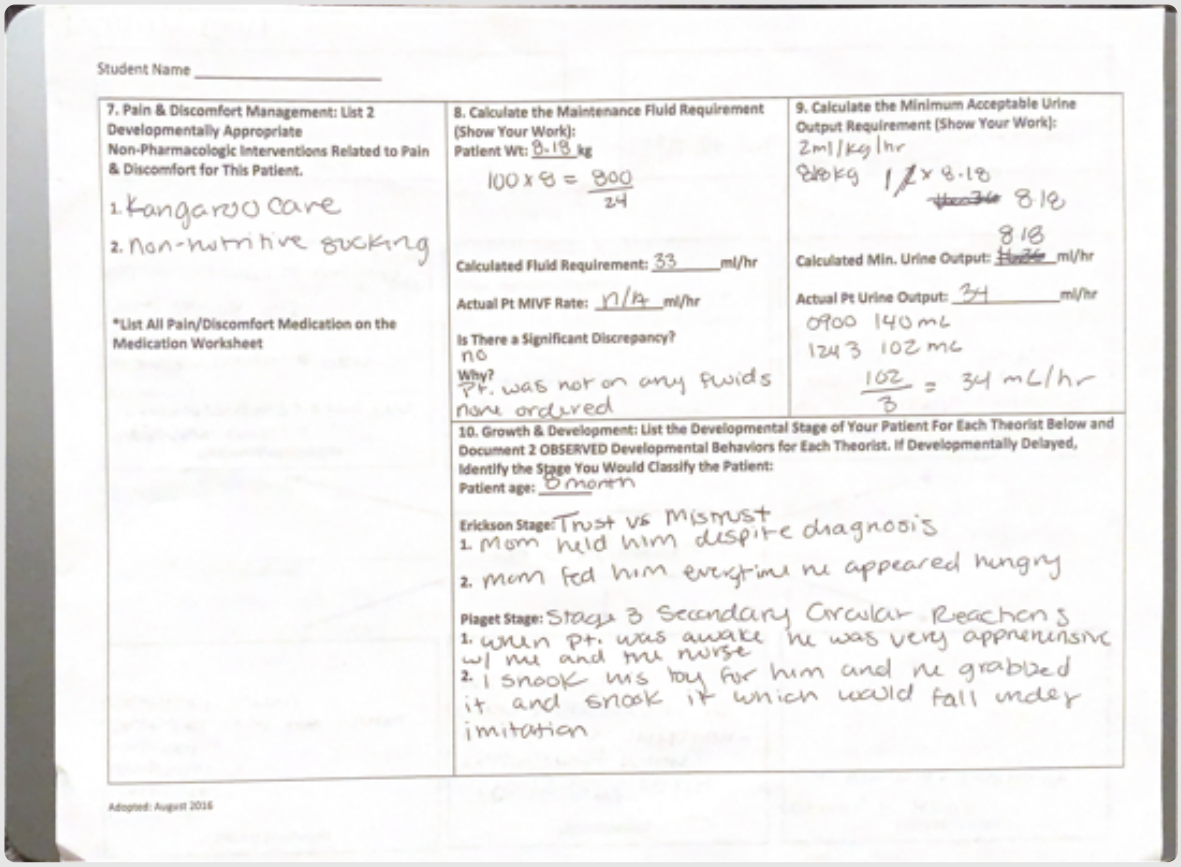


Student Name _____

11. Focused Nursing Diagnosis:	15. Nursing Interventions related to the Nursing Diagnosis in #11:	16. Patient/Caregiver Teaching:
Risk of poor profusion/ desaturation	1. administered Oxygen via NC Evidenced Based Practice: Keep sat ↑ 94'1.	1. S/s of rebound infection 2. Appropriat dosage & when to take his medications (accepts) 3. Educate on s/s of respiratory depression & how mom can check for profusion ↳ if mom sees the same signs that brought her in, come back in
12. Related to (r/t):	2. continuous Pulse Ox monitoring Evidenced Based Practice: So staff can be aware if Pt. is in Respiratory stress	
Inflammed bronchioles r/t diagnoses	3. Hourly Vitals Evidenced Based Practice: Make sure Pt's vitals are also maintained, & not compensating	
13. As evidenced by (aeb):		**17. Discharge Planning/Community Resources:**
Poor desatting below 94'1. when being weened off Oxegyn		1. Educate on follow up care and when they need to come in 2. Immunizations to protect (RSV) from one Resp. Viruses 3. DSHS tx gov if mom wants to read more about Pt. dx
14. Desired patient outcome:		
Pt. maintained 94'1. saturation and above for 3hrs before discharge		

Adopted: August 2016

Student Name



Student Name _____

7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.

1. Kangaroo care
2. Non-nutritive sucking

*List All Pain/Discomfort Medication on the Medication Worksheet

8. Calculate the Maintenance Fluid Requirement (Show Your Work):
Patient Wt: 8.18 kg

$100 \times 8 = 800$
$800 / 24$

Calculated Fluid Requirement: 33 ml/hr

Actual Pt MIVF Rate: N/A ml/hr

Is There a Significant Discrepancy?
no
Why?
Pt. was not on any fluids none ordered

9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):
2ml/kg/hr
8.18kg 1×8.18
~~Use 36~~ 8.18
8.18

Calculated Min. Urine Output: ~~Use 36~~ ml/hr

Actual Pt Urine Output: 34 ml/hr
0900 140 mL
1243 102 mL
$102 / 3 = 34$ mL/hr

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:
Patient age: 8 month

Erickson Stage: Trust vs Mistrust
1. Mom held him despite diagnosis
2. mom fed him everytime he appeared hungry

Piaget Stage: Stage 3 Secondary Circular Reactions
1. when pt. was awake he was very apprehensive w/ me and the nurse
2. I shook his toy for him and he grabbed it and shook it which would fall under imitation

Adopted: August 2016