

(PRIMARY PT)

Student Name: Mildred Omondi Unit: Pediatric

Date: 02/14/2023

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/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 type="checkbox"/> < 2 sec <input checked="" type="checkbox"/> > 2 sec Pulses: Upper R <u>2+</u> L <u>2+</u> Lower R <u>2+</u> L <u>2+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input 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 checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>2mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" 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>yellow</u> Stool Appearance: <u>NA</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>No stool passed on my shift</u>	Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>Subclavian</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input checked="" type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>NS 70 mL/hr</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 Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: <u>2</u> 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 <u>NA</u> Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>Left toe</u> Oxygen Saturation: <u>100%</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 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 type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input type="checkbox"/> No Passing Flatus: <input checked="" type="checkbox"/> Yes <input 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 type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input checked="" 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>pale</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>Regular diet</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>NA</u> Type: <u>NA</u> Pain Score: 0800 _____ 1200 _____ 1600 <u>0</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 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 type="checkbox"/> None Type: <u>incision</u> Location: <u>Right lower back</u> Description: <u>Bone marrow aspiration</u> Dressing: <u>clean dry and intact</u>
	MOBILITY	TUBES/DRAINS
	<input 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: _____

Unit: _____

Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake											120		120 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									70	70	70	70	280 mL
IV Meds/Flush									6				
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine									#	#	#	#	
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

pt was in pull ups

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	<input checked="" type="checkbox"/> pt - Concerned
Family Concern	<input checked="" type="checkbox"/> pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>4</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

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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 type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt < 2 years) <input checked="" 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 checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>Yellow</u> Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>NO BM passed prior to assessment</u>	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: <u>NK</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 <input type="checkbox"/> Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left <input 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 type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>NK</u> Consistency <u>kg</u> Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>left toe</u> Oxygen Saturation: <u>100%</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 type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input checked="" type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input type="checkbox"/> No Passing Flatus: <input checked="" type="checkbox"/> Yes <input 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 checked="" 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>Breastmilk</u> Amount/Schedule: <u>q 3hr</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 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 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: _____

Unit: _____

Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake									30				30mL
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									40				40mL
# of immeasurable													
Stool													
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 <u>1</u> 2 3
Cardiovascular	Circle the appropriate score for this category: 0 <u>1</u> 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>2</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: Mildred Omondi

Unit: Pediatric

Pt. Initials: P.S

Date: 02/14/23

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

Allergies: NKDA

Primary

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	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.)
				Is med in therapeutic range? If not, why?			
Allopurinol	Xanthine Oxidase Inhibitor	Prevention of nephropathy	20mg/mL suspension 104mg PO	10mg/kg/day x 31kg 104mg QID	NA	Stevens Johnson syndrome Anaphylaxis	1. Assess pt for signs of rash or hypersensitivity 2. Monitor for signs of DRESS 3. Tell mom to do routine follow up 4. To monitor effectiveness
Cefepime	4th gen Cephalosporin	Anti Infective	IV 150mg QID	40mg/mL/76mL		C-diff Nephropathy Serum	1. Observe pt for signs of anaphylaxis 2. Monitor bowel function for C-diff 3. Monitor injection site for phlebitis 4. Tell family to notify HCP if fever develops
Dexamethasone	Corticosteroid	Suppression of Inflammation & no immune response	PO 2mg	3mg/m ² x 1.02 3mg 12		Peptic ulcers Thrombocytopenia	1. Assess for changes to LOC during therapy 2. Monitor serum glucose during therapy due to ↑ 3. Standard precautions due ↓ Immunity
Famotidine	Anti Histamine	Anticancer ↓ SI & GERD	PO 40mg/15mL	0.5mg/kg (QD)		Arrhythmias Aplastic Anemia	1. Monitor CBC periodically during therapy 2. May cause dizziness. Pt is caffeine 3. Don't get out of bed w/o assistance 4. Tell pt to notify HCP for black stools
Ondansetron	5-HT ₃ Antagonist	Antiemetic	IV	4.7mg once 0.15mg/kg/31		Torsades des Pointes Serotonin Syndrome	1. Monitor ECG in SI of Serotonin 2. Syndrome 3. Notify HCP if pt displays signs of irregular heartbeat 4. Irregular heartbeat

Student Name: Mildred Omond

Unit: PF(a)

Pt. Initials: BH

Date: 02/14/2023

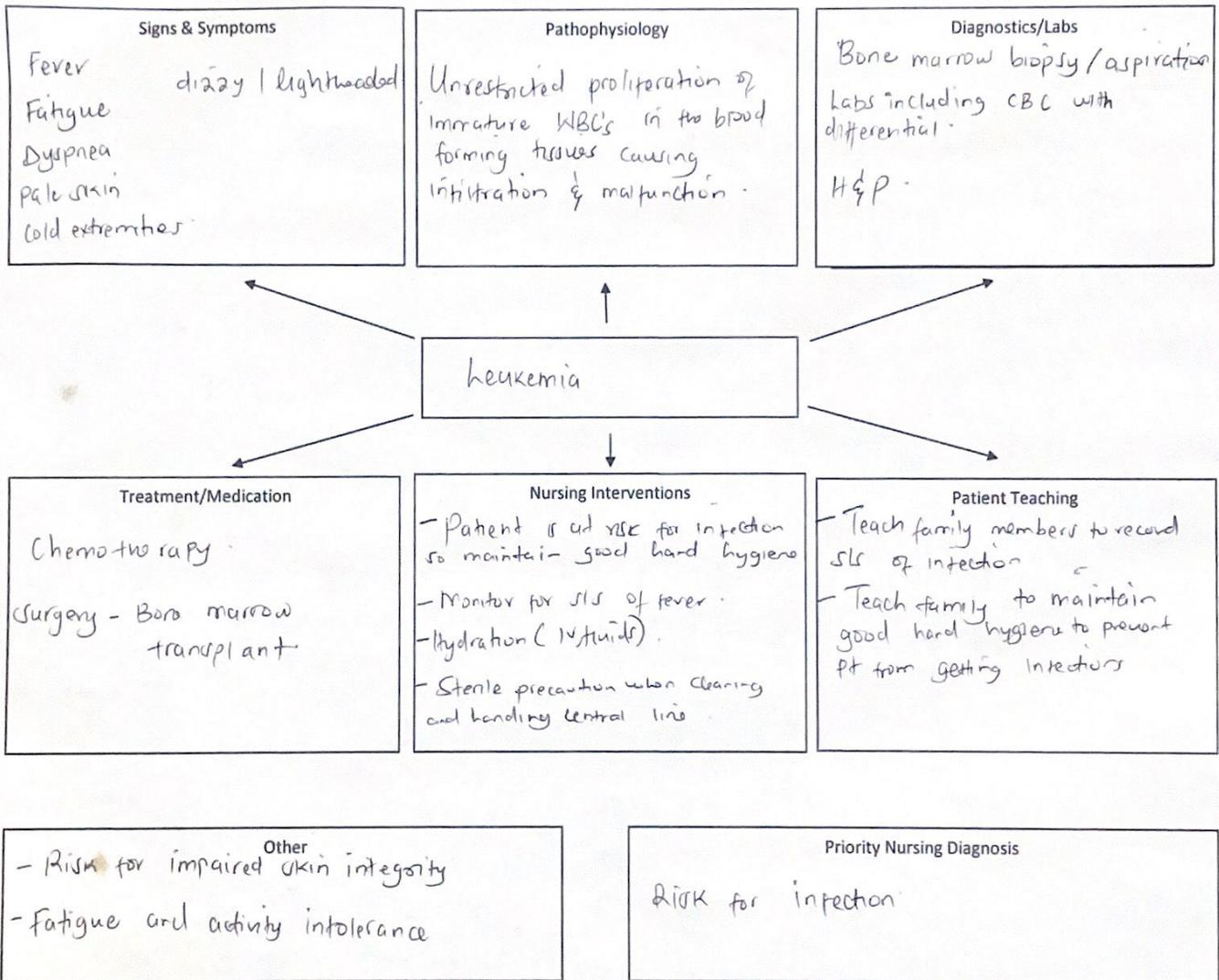
Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKDA

Secondary

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
	Isotonic/ Hypotonic/ Hypertonic			

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	IVP – List diluent solution, volume, and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)	
				Is med in therapeutic range?				IVPB – List concentration and rate of administration
				If not, why?				
Levothyroxine	Thyroid preparations	Hormone Replacement	PO (X1) 1x 0.5mg tablet	25mcg/day Med in Therapeutic Range	NA	Risk for Cardiac failure in infants	1. Assess apical pulse and BP prior to administration. 2. Teach parent the need for routine follow up to ensure correct development. 3. Let parent know that therapy is "lifelong".	
Sodium Citrate-citric acid (Bicitra)	diuretic alkalinizing agents	Antiarthritic	PO 3mL BID	5-15mL solution diluted in H ₂ O BID	NA	Fluid overload Hypernatremia Metabolic alkalosis	1. Monitor pt for fluid overload 2. Monitor pH (urine) if used to alkalinize urine 3. Peab more to avoid mixing doses 4.	
Amoxicillin (Amoxil)	Amino Penicillins	400mg/5mL ordered dose 15mg/kg/day Admin.	PO 472mg	Ordered dose 15mg/kg/day x 31.4kg = 472mg	NA	Stevens Johnson's Syndrome Seizures ESIF, Anaphylaxis	1. Monitor for s/s of anaphylaxis. 2. Obtain specimens for culture and therapy prior to therapy. 3. Therapy. 4. Do not miss/drop doses. Teach parent	
							1. 2. 3. 4.	
							1. 2. 3. 4.	



Student Name _____

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

1. Distraction through use of iPad.
2. Child life

***List All Pain/Discomfort Medication on the Medication Worksheet**

- No pain medication was ordered for patient during this time.

8. Calculate the Maintenance Fluid Requirement (Show Your Work):

Patient Wt: 31.9 kg

$$10 \times 100 = 1000 \quad = \frac{1738}{24} = 72.4$$

$$10 \times 50 = 500$$

$$11.9 \times 20 = 238$$

Calculated Fluid Requirement: 72 ml/hr

Actual Pt MIVF Rate: 70 ml/hr

Is There a Significant Discrepancy? NO

Why? The numbers are close.

9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):

$$0.5 / \text{kg} / \text{hr}$$

$$0.5 / 31.9$$

Calculated Min. Urine Output: 15.95 ml/hr

Actual Pt Urine Output: NA ml/hr

~~40 ml urine output on my chart~~
patient was in pull ups after coming out from the procedure.

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 years old. Pt is developmentally delayed due to ~~Prader-Willi~~ ^{Down's syndrome}
Child was non-verbal so difficult to communicate with.

Erickson Stage: C

1. Transitional Object - iPad. Pt kept playing with iPad after he woke up from anesthesia.
2. Did not associate much with parents.

Piaget Stage: (pre-operational)

1. Concentration → Pt was focused on watching his iPad; a cartoon show that took most of his attention.
- 2.

Student Name _____

<p>11. Focused Nursing Diagnosis: Risk for Infection</p>	<p>15. Nursing Interventions related to the Nursing Diagnosis in #11: 1. Standard precautions Evidenced Based Practice: ↓ 2. Good hand hygiene before and after handling patient Evidenced Based Practice: ② Maintain skin integrity Evidenced Based Practice: Turning patient to avoid pressure sores. Helping pt to the bathroom as needed. ③ Good nutrition. Evidenced by- Having a well balanced diet to eat.</p>	<p>16. Patient/Caregiver Teaching: 1. Wash hands often before and after touching patient 2. Teach parents to monitor s/s of infection 3. Avoid large crowds due to decreased immunity</p>
<p>12. Related to (r/t): Primary diagnosis of Leukemia - Decreased immunity</p>		<p>17. Discharge Planning/Community Resources: 1. Family support for parents with leukemia (pediatric patients) 2. Support centers for visiting children with down's syndrome 3. Respite care to allow or give parents time to take care of their other children.</p>
<p>13. As evidenced by (aeb): Labs, diagnosis, H&P</p>		
<p>14. Desired patient outcome: - Infection free - Able to play - Good nutrition</p>		