

Haylee

Pediatric ED Reflection Questions

1. What types of patients (diagnoses) did you see in the PED?
RSV; undiagnosed abdominal pain (RLQ); occluded J-tube; back injury
2. The majority of the patients who came in to the PED were from which age group? Was this what you expected?
30mo; 21 mo.; 7 years; 16 years
It was not what I expected completely, speaking on the 16 year old, as he looked like an adult!
3. Was your overall experience different than what you expected? Please give examples.
Yes, it was much slower than expected! I did enjoy going into the trauma room with the nurse & learning about everything in there.
4. How did growth and development come into play when caring for patients (both in triage and in treatment rooms)?
5. What types of procedures did you observe or assist with?
6. What community acquired diseases are trending currently?
7. What community mental health trends are being seen in the pediatric population?
8. What patient population is the most vulnerable?
9. What is the process for debriefing after a traumatic event?
The goals for debriefing are to discuss the actions and thought processes involved in any particular clinical situation to encourage reflection, and incorporate improvement into future performance.
10. If someone donated \$100 million to the PED, what would you change?
11. What is the process for triaging patients in the PED?
12. What role does the Child Life Specialist play in the PED?
Childlife helps promote coping through play, preparation, education, and self-expression.
They help provide emotional support, information & guidance during some of the toughest times in a child & families life!

IM5 Clinical Worksheet – Pediatric Floor

Student Name: Haylee CRUE Date: 10/31/23	Patient Age: 4 years Patient Weight: 16.5 kg
1. Admitting Diagnosis: Acute appendicitis with localized peritonitis	2. Priority Focused Assessment You Will Perform Related to the Diagnosis: <input type="checkbox"/> GI
3. Signs and Symptoms: Severe abdominal pain Nausea/Vomiting Fever Distended abdomen Decreased/absent bowel sounds	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: <input type="checkbox"/> Ultrasound <input type="checkbox"/> CT Scan <input type="checkbox"/> CBC
5. Lab Values That May Be Affected: <input type="checkbox"/> WBCs <input type="checkbox"/> CRP	6. Current Treatment (Include Procedures): <input type="checkbox"/> Appendectomy <input type="checkbox"/> Antibiotic therapy <input type="checkbox"/> Pain management <input type="checkbox"/> Fluid replacement
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Sensory Techniques: cuddling, rocking, visual distractions 2. Cognitive/Behavioral Therapies: a toy, songs/nursery rhymes, pop-up books, puppets, videos	8. Patient/Caregiver Teaching: 1. Frequent, small walks should be encouraged. 2. Avoid processed, fried, fatty junk foods as they can irritate the digestive system. 3. Complete all antibiotics as prescribed. Any Safety Issues identified: <input type="checkbox"/> limit sports & strenuous activities for 2-4 weeks <input type="checkbox"/> do not submerge in water until incisions are fully healed <input type="checkbox"/> monitor for signs of infection

Student Name: Hayley Cruz

Date: 10/31/23

Patient Age: 4 years

Patient Weight: 16.5 kg

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

$$100\text{ mL} \times 10\text{ kg} = 1,000\text{ mL}$$

$$50\text{ mL} \times 6.5\text{ kg} = 325\text{ mL}$$

$$16.5\text{ kg} = 1,325\text{ mL/day}$$
$$= \boxed{55\text{ mL/HR}}$$

Actual Pt MIVF Rate:

80 mL/HR

Is There a Significant Discrepancy Between Calculated and Actual Rate? yes

If Yes, Why is There a Discrepancy?
possibly due to patient being post-op

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

$$0.5\text{ mL/kg/HR}$$

$$0.5\text{ mL} \times 16.5\text{ kg} = \boxed{8.25\text{ mL/HR}}$$

Actual Urine Output During Your Shift (mL/hr):

not observed.

Patients father educated on the importance of fluid documentation & encouraged to allow us to empty the patients urinary. :)

11. Growth & Development:

*List the Developmental Stage of Your Patient For Each Theorist Below.

*Document 2 OBSERVED Developmental Behaviors for Each Theorist.

*If Developmentally Delayed, Identify the Stage You Would Classify the Patient:

Erickson Stage: Initiative v. Guilt

1. Taking Initiative - even though he felt crummy, my patient made it a point to walk down the hall because he "knows it will make him better"
2. Self confidence - after being weighed, he was so excited to show off to me his brand new shoes with his favorite dinosaurs on them.

Piaget Stage: Preoperational Period

1. Fear of body mutilation - when flushing the child's IV line, he was scared and thought since we had a syringe, that we were going to hurt him.
2. magical thinking - seeing how the power of a new "magical bandage" (dressing) helped him think he was invincible.

Please list any medications you administered or procedures you performed during your shift:

I observed all meds being given - acetaminophen, famotidine, & maintenance fluid D5Lk.
I assisted with an IV dressing change.

Student Name: Hayden Cruz

Unit: Pod 3

Pt. Initials: _____

Date: 10/31/23

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

Allergies: NKDA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5LR 80ml/hr	Isotonic/ Hypotonic/ <u>Hypertonic</u>	indicated as a source of electrolytes, calories & hydration	Glucose, Electrolytes	CHF, renal insufficiency/failure, edema, hyperkalemia

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	antipyretic	analgesic	250mg IVPB Q10H	10-15mg/kg/dose ↓ 165-248mg/dose no, it is slightly higher	25ml = 250mg of 10mg/ml 100ml/hr	constipation nausea/vomiting pruritis	1. Contraindicated in pts. with severe hepatic impairment or active liver disease. 2. Do not exceed max daily limit or in combination with other products that contain acetaminophen. 3. Caution in patients with severe hypotension or chronic malnutrition. 4. Report to HCP if experiencing any hypersensitivity reaction (itching, rash or swelling in the face/throat)
famotidine	antiulcer agent (H ₂ Antagonist)	gastric ulcer inhibitor	8.3mg IVP BID	0.25-0.5mg/kg/dose ↓ 4.1-8.3mg/dose yes	Dilute 2ml famotidine with 8ml of NS to a final concentration of 2mg/ml 0.83ml = 8.3mg of 10mg/ml push over 2 minutes	constipation diarrhea headache	1. Hypersensitivity reactions (bronchospasm, hives, pruritis, rash) can occur. 2. CNS adverse effects have been reported in patients with impaired renal function. 3. May experience abdominal discomfort, dry mouth, nausea or vomiting. 4. Report treatment of gastric ulcers, and avoid. Do not take longer than 8 weeks.
piperacillin-tazobactam	Beta-lactamase inhibitors	antibiotic	1.648mg IVPB Q8H	80-100mg/kg/dose ↓ 580-1150mg/dose yes	1.648mg of piperacillin in 20.16ml Sodium chloride 0.9%	allergic reaction diarrhea constipation nausea seizure	1. Signs of allergic reaction include: hives, difficulty breathing, swelling in face or throat, rash 2. Common side effects include: nausea, vomiting, diarrhea, headache, constipation & insomnia 3. Do not take if you are allergic to any type of penicillin, cephalosporin or tazobactam. 4. Contact HCP if you experience confusion, muscle twitching, seizures, low potassium or WBC counts
morphine	narcotic analgesic	used to treat moderate to severe pain	0.82mg IVP Q3H PRN-Pain	0.05mg-0.1mg/kg ↓ 0.83-1.65mg no, it is slightly under	Dilute with 5ml NS push over 5 minutes	overdose respiratory depression CNS depression	1. Always have Naloxone available, monitor for signs of overdose such as hyperventilation, HR, ↓ O ₂ 2. Can cause constipation, nausea or vomiting, take with stool softener to prevent constipation. 3. Contraindicated in pts with hypersensitivity to morphine, pts with bronchial asthma, or pulmonary disease 4. may cause blurred vision, dizziness or drowsiness. frequent assess tangle with ambulation.
ondansetron	5-HT ₃ antagonist	antiemetic	1.66mg IVP Q10H PRN-nausea	0.1-0.3mg/kg/dose ↓ 1.65-4.95mg/dose yes	Dilute with 5ml NS push over 2-5 minutes	allergic reaction diarrhea constipation drowsiness	1. Notify HCP if you notice severe constipation, stomach pain, or bloating 2. Caution of serotonin syndrome, which can occur while taking with opioid medication. signs include 3. agitation, ↑HR, fever, hallucinations, ↑loss & decreased 4. Notify HCP if you experience blurred vision or vision loss, ocular reflexes, fainting or jaw

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" 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>3mm</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>clear yellow</u> Stool Appearance: <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <input checked="" type="checkbox"/> <u>Wrist</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Peripheral</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>DSUE</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 checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>RT Hand</u> Oxygen Saturation: <u>98%</u>	Abdomen: <input type="checkbox"/> Soft <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input 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 checked="" 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	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>clear liquid</u> Amount/Schedule: <u>no restriction</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<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: _____	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces Location: <u>abdomen</u> Type: _____ Pain Score: <u>2</u> <input checked="" type="checkbox"/> 0800 <input type="checkbox"/> 1200 <input type="checkbox"/> 1600
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None Type: <u>incision</u> Location: <u>umbilical area</u> Description: <u>liposuction puncture</u> Dressing: <u>tegaderm</u>	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pediatric Floor Patient #1

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake				45									45ml
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	80	80	80	80	80								400 mL
IV Meds/Flush	25	30	5										60 mL
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													undocumented
# of immeasurable				1									1 occurrence
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 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

Pediatric Floor Patient #2

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>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 checked="" type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> Fontanel: (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>5</u> Left <u>5</u> Pushes: Right <u>5</u> Left <u>5</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>clear yellow</u> Stool Appearance: <u>liquid</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input checked="" type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <input checked="" type="checkbox"/> WRIST <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>peripheral</u> 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>no fluids running</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 checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>TOE</u> Oxygen Saturation: <u>97%</u>	Abdomen: <input 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 _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input checked="" type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" 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>clear liquid</u> Amount/Schedule: <u>no restriction</u> 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: _____ Type: _____ Pain Score: <u>0</u> 0800 1200 1600
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input checked="" 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: _____

Pediatric Floor Patient #2

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		80z			30z								330 ml
Intake – PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE													
IV Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT													
Output	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine		60		60									120 ml
# of immeasurable													
Stool													
Urine/Stool mix				240									240 ml
Emesis													
Other													

* Pt had no fluids or medications ordered

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
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CHEWS Total Score	
CHEWS Total Score	Total Score (points) 0
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