

IM5 Clinical Worksheet – Pediatric Floor

|   |  |
|---|--|
| <p>Student Name: <u>Destiny Barua</u><br/>Date: <u>11/7</u></p>   | <p>Patient Age: <u>4 months</u><br/>Patient Weight: <u>5 kg</u></p>  |
| <p>1. Admitting Diagnosis:<br/><u>bronchitis</u><br/><u>+ rhinovirus</u></p>  | <p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:<br/><u>Respiratory</u></p>  |
| <p>3. Signs and Symptoms:<br/><u>difficulty breathing</u><br/><u>clear nasal mucus</u><br/><u>Wheeze lung sounds</u><br/><u>(congestion in chest)</u></p>   | <p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:<br/><u>Rhinovirus testing</u><br/><u>sputum test</u></p>   |
| <p>5. Lab Values That May Be Affected:<br/><u>WBC</u></p>   | <p>6. Current Treatment (Include Procedures):<br/><u>Oxygen 0.2 L</u><br/><u>NC w/ humidifier</u></p>  |
| <p>7. Pain &amp; Discomfort Management:<br/>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <p>1. <u>push, pull toys</u><br/><u>light up toys</u></p> <p>2. <u>mom holding infant (cuddle)</u><br/><u>non nutritive sucking</u><br/><u>(pacifier)</u></p> | <p>8. Patient/Caregiver Teaching:</p> <p>1. <u>provide objects to comfort</u><br/><u>(pacifier)</u></p> <p>2. <u>monitor respirations, sit baby up</u></p> <p>3. <u>test/treat others in the</u><br/><u>household (brother has same</u><br/><u>symptoms)</u></p> <p>Any Safety Issues identified:<br/><u>risk for aspiration</u><br/><u>DN mucus</u></p> |
| <p>9. Calculate the Maintenance Fluid Requirement</p>   | <p>10. Calculate the Minimum Acceptable Urine</p>  |

IM5 Clinical Worksheet – PICU

|   |  |
|---|--|
| <p>(Show Your Work):</p> <p style="text-align: center;"><math>5 \text{ kg}</math></p> <p style="text-align: center;"><math>100 \times 5 = 500 \text{ mL/day}</math></p> <p style="text-align: center;"><math>20.8 \text{ mL/hr}</math></p> <p>Actual Pt MIVF Rate:</p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate? <i>NO KLINDAS</i></p> <p>If Yes, Why is There a Discrepancy?</p> | <p>Output Requirement (Show Your Work):</p> <p style="text-align: center;"><math>1 \times 5 = 5 \times 24 = 120</math></p> <p style="text-align: center;"><math>5 \times 6 = 30 \text{ mL/hr}</math><br/>(shift)</p> <p>Actual Urine Output During Your Shift (mL/hr):</p> <p style="text-align: center;"><math>20 \text{ mL / weighed}</math><br/><i>diaper</i></p> |
|---|--|

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: *trust vs mistrust*

1. *Unstability of care: mother relationship w/ infant*
2. *Egocentrism - stimulated by others (laughed w/ us, cried when needed diaper change)*

Piaget Stage: *Sensorimotor*

1. *Urinary reactions*  
*Yelled for my fingers; stretch core*
2. *Greater awareness of the environment*  
*looked around when she heard us in room*

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

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |

35 min  
w/last  
FLA  
Pediatric Floor Patient #1

| INTAKE/OUTPUT        |    |    |    |    |    |    |    |    |    |    |    |    |         |
|----------------------|----|----|----|----|----|----|----|----|----|----|----|----|---------|
| PO/Enteral Intake    | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total   |
| PO Intake            |    |    | 60 |    |    |    |    |    |    |    |    |    | 60 + 35 |
| 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                |    |    |    | 70 |    |    |    |    |    |    |    |    | 70 + 10 |
| # of immeasurable    |    |    |    |    |    |    |    |    |    |    |    |    |         |
| Stool                | 1  |    |    |    |    |    |    |    |    |    |    |    |         |
| Urine/Stool mix      |    |    |    |    |    |    |    |    |    |    |    |    |         |
| Emesis               |    |    |    |    |    |    |    |    |    |    |    |    |         |
| Other                |    |    |    |    |    |    |    |    |    |    |    |    |         |

min  
w/last  
FLA

10 + 1  
Other  
Urine

| 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:<br>0 1 2 3  |
| Cardiovascular  | Circle the appropriate score for this category:<br>0 1 2 3  |
| Respiratory   | Circle the appropriate score for this category:<br>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) 1  |
|   | 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 *608*

*When Awake*

| GENERAL APPEARANCE  | CARDIOVASCULAR  | PSYCHOSOCIAL   |
|---|---|--|
| <b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished<br><input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br><b>Developmental age:</b><br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed   | <b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready<br><input type="checkbox"/> Murmur <input type="checkbox"/> Other _____<br><b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><b>Capillary Refill:</b> <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R _____ L _____<br>Lower R _____ L _____<br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None  | <b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying<br><input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless<br><input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br><b>Social/emotional bonding with family:</b><br><input 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<br><input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive<br><b>Oriented to:</b><br><input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event<br><input checked="" type="checkbox"/> Appropriate for Age<br><b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____<br><b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat<br><input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed<br><b>Extremities:</b><br><input checked="" type="checkbox"/> Able to move all extremities<br><input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right _____ Left _____<br>Pushes: Right _____ Left _____<br>S=Strong W=Weak N=None<br><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____<br><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <b>Urine Appearance:</b> _____<br><b>Stool Appearance:</b> _____<br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy   | <b>Site:</b> <i>LEFT AC</i> <input type="checkbox"/> INT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br>Type/Location: <i>peripheral</i><br><b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling<br><input type="checkbox"/> Red <input type="checkbox"/> Swollen <i>24g</i><br><input type="checkbox"/> Patent <input type="checkbox"/> Blood return<br><b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Fluids:</b> _____  |
| RESPIRATORY   | GASTROINTESTINAL  | SKIN   |
| <b>Respirations:</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored <i>some apnea</i><br><b>Breath Sounds:</b><br>Clear <input type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br>Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: _____ L/min<br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color _____<br>Consistency _____<br><b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br><b>Pulse-Ox Site:</b> _____ | <b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended <input type="checkbox"/> Guarded<br><b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <i>4</i> quads<br><input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br><b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br>Suction Type: _____ | <b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced<br><input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt<br><b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br><b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br><b>Skin:</b> <input type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations<br><input type="checkbox"/> Tears <input checked="" type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown<br>Location/Description: <i>face, upper &amp; lower extremities</i><br><b>Mucous Membranes:</b> Color: _____<br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration<br><b>PAIN</b> <i>dry lips</i> |
| NUTRITIONAL   | MUSCULOSKELETAL   | WOUND/INCISION   |
| <b>Diet/Formula:</b> <i>formula</i><br><b>Amount/Schedule:</b> _____<br><b>Chewing/Swallowing difficulties:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling<br><input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping<br><input type="checkbox"/> Spasms <input type="checkbox"/> Tremors<br><b>Movement:</b><br><input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All<br><b>Brace/Appliances:</b> <input type="checkbox"/> None<br>Type: _____   | <b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces<br><b>Location:</b> _____<br><b>Type:</b> _____<br><b>Pain Score:</b><br>0800 _____ 1200 _____ 1600 _____  |
| MOBILITY  | TUBES/DRAINS  |  |
| <b>Site:</b> _____  | <input type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br><b>Site:</b> _____  |  |

*4022*

|                              |   |   |
|------------------------------|---|---|
| Oxygen Saturation: <u>94</u> | <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> In Arms<br><input type="checkbox"/> Ambulatory with assist<br>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden | Type: _____<br>Dressing: _____<br>Suction: _____<br>Drainage amount: _____<br>Drainage color: _____ |
|------------------------------|---|---|

Pediatric Floor Patient #2

*1 bottle of formula milk (2 oz)*

| INTAKE/OUTPUT            |    |    |    |    |    |    |    |    |    |    |    |    |       |
|--------------------------|----|----|----|----|----|----|----|----|----|----|----|----|-------|
|                          | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| <b>PO/Enteral Intake</b> |    |    |    |    |    |    |    |    |    |    |    |    |       |
| PO Intake                |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Intake - PO Meds         |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Enteral Tube Feeding     |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Enteral Flush            |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Free Water               |    |    |    |    |    |    |    |    |    |    |    |    |       |
| <b>IV INTAKE</b>         |    |    |    |    |    |    |    |    |    |    |    |    |       |
| IV Fluid                 |    | 10 |    |    |    |    |    |    |    |    |    |    |       |
| IV Meds/Flush            |    |    |    |    |    |    |    |    |    |    |    |    |       |
| <b>OUTPUT</b>            |    |    |    |    |    |    |    |    |    |    |    |    |       |
| Urine                    |    |    |    |    |    |    |    |    |    |    |    |    |       |
| # 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:<br>0 1 2 3 |
| Cardiovascular  | Circle the appropriate score for this category:<br>0 1 2 3 |
| Respiratory   | Circle the appropriate score for this category:<br>0 1 2 3 |
| Staff Concern   | 1 pt - Concerned   |
| Family Concern  | 1 pt - Concerned or absent                                 |
| <b>CHEWS Total Score</b> <u>0</u>                                   |  |

IM5 Clinical Worksheet - PICU

Start monitoring

|   |  |
|---|--|
| Student Name: <u>Destiny Garcia</u><br>Date: <u>11/8</u>  | Patient Age: <u>21</u><br>Patient Weight: <u>61.5 kg</u>   |
| 1. Admitting Diagnosis: <u>anorexia nervosa</u><br><u>binge eating / purging</u>  | 2. Priority Focused Assessment R/T Diagnosis:<br><u>130, Cardio, weight eating</u>   |
| 3. Signs and Symptoms:<br><u>Vertigo</u><br><u>bradycardia</u><br><u>hypotension</u>  | 4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:<br><u>dexcom, insulin pump</u><br><u>EXR, labs</u>  |
| 5. Lab Values That May Be Affected:<br><u>glucose - DMI</u><br><u>albumin ↓</u>   | 6. Current Treatment (Include Procedures):<br><u>Eating disorder protocol (11 days)</u><br><u>30 min eating w/ sitter</u><br><u>&amp; phone, TV, shower</u><br><u>"blind" weights</u>  |
| 7. Pain & Discomfort Management:<br>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.<br><br>1. <u>distraction: arts; crafts, journaling, puzzles</u><br>2. <u>relaxation techniques</u><br><u>deep breathing</u> | 8. Patient/Caregiver Teaching:<br>1. <u>Notified us to help out of bed</u><br>2. <u>Frequent self glucose checks (self)</u><br>3. <u>Outcomes for compliance</u><br><br>Any Safety Issues Identified:<br><u>possible fall risk w/ orthostatic hypotension</u><br><u>friction possibility: frequent</u> |
| 9. Calculate the Maintenance Fluid Requirement (Show Your Work):<br>$10 \times 100 = 1000$<br>$10 \times 50 = 500$<br>$41.5 \times 20 = 830$<br><u>2330 mL/day</u><br>Combined Total Intake for Your Pt (mL/hr):<br>$2330 / 24 = 97 \text{ mL/hr}$                                | 10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):<br>$0.5 \times 61.5$<br>$30.75 \times 6 = 184.5$<br>Actual Urine Output During Your Shift (mL/hr):<br><u>30.75 mL/hr</u> <u>184.5 mL / 6 hours</u>   |
| Please list any medications you administered or procedures you performed during your shift:<br>PO: <u>Multivitamin</u><br><u>Tums</u><br><u>Probal</u><br>IVP <u>Zofran</u><br>(not my pt)  |  |

PICU

| GENERAL APPEARANCE   | CARDIOVASCULAR   | PSYCHOSOCIAL  |
|--|--|---|
| <b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished<br><input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br><b>Developmental age:</b><br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed   | <b>Pulse:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready<br><input type="checkbox"/> Murmur <input type="checkbox"/> Other _____<br><b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____<br><input type="checkbox"/> 1+ <input checked="" type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><b>Capillary Refill:</b> <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R <u>2</u> L <u>2</u><br>Lower R <u>2</u> L <u>2</u><br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None   | <b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying<br><input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless<br><input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br><b>Social/emotional bonding with family:</b><br><input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent <i>social w/ staff</i>  |
| <b>NEUROLOGICAL</b><br><b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless<br><input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive<br><b>Oriented to:</b><br><input checked="" type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event<br><input type="checkbox"/> Appropriate for Age<br><b>Pupil Response:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____<br><b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat<br><input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed<br><b>Extremities:</b><br><input checked="" type="checkbox"/> Able to move all extremities<br><input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right <u>S</u> Left <u>S</u><br>Pushes: Right <u>S</u> Left <u>S</u><br>S=Strong W=Weak N=None<br><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____<br><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <b>ELIMINATION</b><br><b>Urine Appearance:</b> <u>Not seen</u><br><b>Stool Appearance:</b> <u>no output</u><br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy   | <b>IV ACCESS</b><br><b>Site:</b> <u>PAC</u> <input type="checkbox"/> INT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br><b>Type/Location:</b> <u>peripheral</u><br><b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling<br><input type="checkbox"/> Red <input type="checkbox"/> Swollen<br><input type="checkbox"/> Patent <input type="checkbox"/> Blood return<br><b>Dressing Intact:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Fluids:</b> <u>none running</u>   |
| <b>RESPIRATORY</b><br><b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br><b>Breath Sounds:</b><br>Clear <input checked="" type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: _____ L/min<br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color _____<br>Consistency _____<br><b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> _____ | <b>GASTROINTESTINAL</b><br><b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended <input type="checkbox"/> Guarded<br><b>Bowel Sounds:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> 4 quads<br><input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br><b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>observ.</i><br><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br><input type="checkbox"/> Suction Type: _____ | <b>SKIN</b><br><b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced<br><input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt<br><b>Condition:</b> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br><b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br><b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations<br><input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown<br>Location/Description: _____<br><b>Mucous Membranes:</b> Color: <u>PINK</u><br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| <b>MUSCULOSKELETAL</b><br><input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling<br><input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping<br><input type="checkbox"/> Spasms <input type="checkbox"/> Tremors<br><b>Movement:</b><br><input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All<br><b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None<br>Type: _____   | <b>NUTRITIONAL</b><br><b>Diet/Formula:</b> <u>diabetic</u><br><b>Amount/Schedule:</b> _____<br><b>Chewing/Swallowing difficulties:</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>normal</i><br><u>schedule (+ 3 snacks)</u>  | <b>PAIN</b><br><b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces<br><b>Location:</b> <u>NO PAIN</u><br><b>Type:</b> _____<br><b>Pain Score:</b><br>0800 _____ 1200 _____ 1600 _____  |
|  | <b>MOBILITY</b><br><input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms<br><input type="checkbox"/> Ambulatory with assist _____<br><b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden<br><u>stnr to bed per protocol</u>  | <b>WOUND/INCISION</b><br><input checked="" type="checkbox"/> None<br><b>Type:</b> _____<br><b>Location:</b> _____<br><b>Description:</b> _____<br><b>Dressing:</b> _____<br><b>TUBES/DRAINS</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br><b>Site:</b> _____<br><b>Type:</b> _____<br><b>Dressing:</b> _____<br><b>Suction:</b> _____<br><b>Drainage amount:</b> _____<br><b>Drainage color:</b> _____  |

*no family present social w/ staff*

Finished 1/2  
by time  
we left

PICU

breakfast: 100% eaten 0900  
591 ML

snack: 100% eaten 1045

| INTAKE/OUTPUT                             |    |    |    |    |    |       |    |    |    |    |    |    |          |
|---|----|----|----|----|----|-------|----|----|----|----|----|----|----------|
| PO/Enteral Intake                         | 07 | 08 | 09 | 10 | 11 | 12    | 13 | 14 | 15 | 16 | 17 | 18 | Total    |
| PO Intake                                 |    |    |    |    |    |       |    |    |    |    |    |    |          |
| Intake - PO Meds                          |    |    |    |    |    |       |    |    |    |    |    |    |          |
| Enteral Tube Feeding                      |    |    |    |    |    |       |    |    |    |    |    |    |          |
| Enteral Flush                             |    |    |    |    |    |       |    |    |    |    |    |    |          |
| Free Water                                |    |    |    |    |    | 296.5 |    |    |    |    |    |    | 296.5 ML |
| NO FLUIDS                                 |    |    |    |    |    |       |    |    |    |    |    |    |          |
| IV INTAKE                                 | 07 | 08 | 09 | 10 | 11 | 12    | 13 | 14 | 15 | 16 | 17 | 18 | Total    |
| IV Fluid                                  |    |    |    |    |    |       |    |    |    |    |    |    |          |
| IV Meds/Flush                             |    |    |    |    |    |       |    |    |    |    |    |    |          |
| NO NO WHOLE SNIFF: NIGHT SNIFF SAID 75 ML |    |    |    |    |    |       |    |    |    |    |    |    |          |
| OUTPUT                                    | 07 | 08 | 09 | 10 | 11 | 12    | 13 | 14 | 15 | 16 | 17 | 18 | Total    |
| Urine                                     |    |    |    |    |    |       |    |    |    |    |    |    | 0 ML     |
| # 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:<br>0 1 2 3<br><u>0</u>   |
| Cardiovascular  | Circle the appropriate score for this category:<br>0 <u>1</u> 2 3<br>bradycardia<br>hypotension  |
| Respiratory   | Circle the appropriate score for this category:<br><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>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: ALSTIN Unit: PCU Pt. Initials: GH Date: 11/7

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

Allergies: NKA NO IV FLUIDS RUNNING

| Generic Name                                | Pharmacologic Classification     | Therapeutic Reason  | Dose, Route & Schedule | Therapeutic Range?           |              | Lab Values to Assess Related to IVF | Contraindications/Complications |
|---|----------------------------------|---|------------------------|------------------------------|--------------|-------------------------------------|---------------------------------|
|   |                                  |   |                        | Is med in therapeutic range? | If not, why? |                                     |                                 |
| HAULT<br>MULTI-VITAMINIC<br>CALCIUM<br>TRAC | MULTI-VITAMIN                    | PROVIDE VITAMINS NOT TAKEN thru diet                        | 1 TAB PO DAILY         |                              |              |                                     |                                 |
| CAVOCATE<br>TRAC                            | ANTACID                          | RELIEVE HEARTBURN, ACID INDIGESTION, UPPER GASTROINTESTINAL | 500 mg PO              |                              |              |                                     |                                 |
| PRAC  | DIURETIC<br>SALININE<br>DIURETIC | TYLAT MAY BE ABOVE SIVL DISORDER                            | 20 mg PO DAILY         |                              |              |                                     |                                 |
|   |                                  |   |                        |                              |              |                                     |                                 |
|   |                                  |   |                        |                              |              |                                     |                                 |

  

| Generic Name                                | Pharmacologic Classification     | Therapeutic Reason  | Dose, Route & Schedule | Therapeutic Range? | Lab Values to Assess Related to IVF | Contraindications/Complications |
|---|----------------------------------|---|------------------------|--------------------|-------------------------------------|---------------------------------|
| HAULT<br>MULTI-VITAMINIC<br>CALCIUM<br>TRAC | MULTI-VITAMIN                    | PROVIDE VITAMINS NOT TAKEN thru diet                        | 1 TAB PO DAILY         |                    |                                     |                                 |
| CAVOCATE<br>TRAC                            | ANTACID                          | RELIEVE HEARTBURN, ACID INDIGESTION, UPPER GASTROINTESTINAL | 500 mg PO              |                    |                                     |                                 |
| PRAC  | DIURETIC<br>SALININE<br>DIURETIC | TYLAT MAY BE ABOVE SIVL DISORDER                            | 20 mg PO DAILY         |                    |                                     |                                 |
|   |                                  |   |                        |                    |                                     |                                 |
|   |                                  |   |                        |                    |                                     |                                 |

**Pediatric Floor Patient #1** *68*  
*bronchitis*

| GENERAL APPEARANCE   | CARDIOVASCULAR   | PSYCHOSOCIAL   |
|--|--|--|
| <b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished<br><input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br><b>Developmental age:</b><br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed  | <b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready<br><input type="checkbox"/> Murmur <input type="checkbox"/> Other _____<br><b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R _____ L _____<br>Lower R _____ L _____<br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None  | <b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying<br><input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless<br><input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br><b>Social/emotional bonding with family:</b><br><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<br><input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive<br><b>Oriented to:</b><br><input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event<br><input checked="" type="checkbox"/> Appropriate for Age<br><b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____<br><b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Flat<br><input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed<br><b>Extremities:</b><br><input checked="" type="checkbox"/> Able to move all extremities<br><input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right _____ Left _____<br>Pushes: Right _____ Left _____<br>S=Strong W=Weak N=None<br><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____<br><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <b>Urine Appearance:</b><br><i>clear yellow 20</i><br><b>Stool Appearance:</b><br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy  | <b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br>Type/Location: _____<br><b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling<br><input type="checkbox"/> Red <input type="checkbox"/> Swollen <i>N/A</i><br><input type="checkbox"/> Patent <input type="checkbox"/> Blood return<br><b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Fluids:</b> _____   |
| RESPIRATORY  | GASTROINTESTINAL   | SKIN   |
| <b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br><b>Breath Sounds:</b> <i>Wheez</i><br><input type="checkbox"/> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Crackles <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br><input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: <i>0.2 L/min</i><br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color <i>clear</i><br>Consistency _____<br><b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <i>nasal</i><br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> <i>97%</i><br><i>sneezing</i> | <b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended <input type="checkbox"/> Guarded <i>4</i><br><b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <i>4</i> quads<br><input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br><b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>spitting food up (milk)</i><br><b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br><input type="checkbox"/> Suction Type: _____ | <b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced<br><input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt<br><b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br><b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br><b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations<br><input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown<br>Location/Description: _____<br><b>Mucous Membranes:</b> Color: <i>pink</i><br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| RESPIRATORY  | NUTRITIONAL  | PAIN   |
| <b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br><b>Breath Sounds:</b> <i>Wheez</i><br><input type="checkbox"/> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Crackles <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br><input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: <i>0.2 L/min</i><br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color <i>clear</i><br>Consistency _____<br><b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <i>nasal</i><br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> <i>97%</i><br><i>sneezing</i> | <b>Diet/Formula:</b> <i>breast/formula</i><br><b>Amount/Schedule:</b> <i>when she is hungry</i><br><b>Chewing/Swallowing difficulties:</b> <i>hungry (not satisfied)</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>not wanting to eat. skills at</i>   | <b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> LACC <input type="checkbox"/> Faces<br><b>Location:</b><br><i>not showing any s/c of pain</i><br><b>Type:</b> _____<br><b>Pain Score:</b><br>0800 <i>0</i> 1200 1600   |
| RESPIRATORY  | MUSCULOSKELETAL  | WOUND/INCISION   |
| <b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br><b>Breath Sounds:</b> <i>Wheez</i><br><input type="checkbox"/> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Crackles <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br><input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: <i>0.2 L/min</i><br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color <i>clear</i><br>Consistency _____<br><b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <i>nasal</i><br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> <i>97%</i><br><i>sneezing</i> | <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling<br><input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping<br><input type="checkbox"/> Spasms <input type="checkbox"/> Tremors<br><b>Movement:</b><br><input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input checked="" type="checkbox"/> LL <input type="checkbox"/> All<br><b>Brace/Appliances:</b> <input type="checkbox"/> None<br>Type: _____  | <input checked="" type="checkbox"/> None<br><b>Type:</b> _____<br><b>Location:</b> _____<br><b>Description:</b> _____<br><b>Dressing:</b> _____  |
| RESPIRATORY  | MOBILITY   | TUBES/DRAINS   |
| <b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br><b>Breath Sounds:</b> <i>Wheez</i><br><input type="checkbox"/> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Crackles <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br><input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: <i>0.2 L/min</i><br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color <i>clear</i><br>Consistency _____<br><b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <i>nasal</i><br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> <i>97%</i><br><i>sneezing</i> | <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> In Arms<br><input type="checkbox"/> Ambulatory with assist<br><b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden   | <input checked="" type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br><b>Site:</b> _____<br><b>Type:</b> _____<br><b>Dressing:</b> _____<br><b>Suction:</b> _____<br><b>Drainage amount:</b> _____<br><b>Drainage color:</b> _____  |

*better now w/ O2*