

## IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: <i>Victoria Forney</i>          Date: <i>11.7.23</i></p>	<p>Patient Age: <i>7y1F</i>          Patient Weight: <i>38.1</i> kg</p>
<p>1. Admitting Diagnosis:  <i>Observation - Peritonsillar abscess</i></p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: <i>Respiratory</i></p>
<p>3. Signs and Symptoms: <i>Sore throat, fever, pain when swallowing</i></p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: <i>MR1</i></p>
<p>5. Lab Values That May Be Affected: <i>WBC</i></p>	<p>6. Current Treatment (Include Procedures):  <i>unasyn to shrink the fluid</i></p>
<p>7. Pain &amp; Discomfort Management:          List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <p><i>1. Parental / caregiver touch and care</i></p> <p><i>2. play to distract the patient</i></p>	<p>8. Patient/Caregiver Teaching:</p> <p><i>1. fever- notify the physician</i></p> <p><i>2. pain management</i></p> <p><i>3. respiratory distress</i></p> <p>Any Safety Issues identified:  <i>NO</i></p>

<p>Student Name: Victoria Forney Date: 11-7-23</p>	<p>Patient Age: 7y 1F Patient Weight: 38.1 kg</p>
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> <p>38.1 kg  <math>10 \times 100 = 1000</math>  <math>10 \times 50 = 500</math>  <math>18.1 \times 20 = 362</math></p> <hr/> <p><math>1862 / 24 = 77.6 \text{ mL/hr}</math>  Actual Pt MIVF Rate: 75 mL/hr</p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate?  The actual rate is lower  If Yes, Why is There a Discrepancy?  To avoid fluid overload</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> <p>0.5 mL/kg/hr</p> $\frac{0.5 \text{ mL}}{1 \text{ kg}} \times \frac{38.1 \text{ kg}}{38.1 \text{ kg}} = 19.05 \text{ mL/hr}$ <p>Actual Urine Output During Your Shift (mL/hr):  100 mL every 3 hours</p>
<p>11. Growth &amp; Development:</p> <p>*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:</p> <p>Erickson Stage: industry vs inferiority</p> <ol style="list-style-type: none"> <li>1. very confident in communicating with staff</li> <li>2. uncomfortable answering questions regarding bowel and bladder</li> </ol> <p>Piaget Stage: concrete operational</p> <ol style="list-style-type: none"> <li>1. Slept and carried her bunny with her every where</li> <li>2. followed tasks without confusion or being too literal</li> </ol>	
<p>Please list any medications you administered or procedures you performed during your shift:  none</p>	

**Pediatric Floor Patient #1**  
*patient 160*

<p align="center"><b>GENERAL APPEARANCE</b></p> <p>Appearance: <input checked="" type="checkbox"/> Healthy/ Well Nourished  <input type="checkbox"/> Neat/ Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p>Developmental age:  <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p align="center"><b>CARDIOVASCULAR</b></p> <p>Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready  <input checked="" type="checkbox"/> Murmur <input type="checkbox"/> Other _____</p> <p>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+</p> <p>Capillary Refill: <input checked="" type="checkbox"/> &lt; 2 sec <input type="checkbox"/> &gt; 2 sec</p> <p>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</p>	<p align="center"><b>PSYCHOSOCIAL</b></p> <p>Social Status: <input checked="" type="checkbox"/> Calm/ Relaxed <input checked="" type="checkbox"/> Quiet  <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying  <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless  <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/ Anxious</p> <p>Social/emotional bonding with family:  <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p align="center"><b>NEUROLOGICAL</b></p> <p>LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless  <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p>Oriented to:  <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/ Event  <input checked="" type="checkbox"/> Appropriate for Age</p> <p>Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal  <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u></p> <p>Fontanel: (Pt &lt; 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat  <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed</p> <p>Extremities:  <input checked="" type="checkbox"/> Able to move all extremities  <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically</p> <p>Grips: Right <u>5</u> Left <u>5</u>  Pushes: Right <u>5</u> Left <u>5</u>  S=Strong W=Weak N=None</p> <p>EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____</p> <p>Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p align="center"><b>ELIMINATION</b></p> <p>Urine Appearance: <u>yellow light</u></p> <p>Stool Appearance: <u>soft brown</u></p> <p><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p align="center"><b>IV ACCESS</b></p> <p>Site: <u>AC 20g</u> <input type="checkbox"/> INT <input type="checkbox"/> None  <input type="checkbox"/> Central Line</p> <p>Type/ Location: _____</p> <p>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</p> <p>Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: <u>76ml/hr</u></p>
<p align="center"><b>RESPIRATORY</b></p> <p>Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <input type="checkbox"/> Retractions (type) _____  <input type="checkbox"/> Labored</p> <p>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</p> <p><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p>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: _____</p> <p>Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Size _____ Type _____  Obturator at Bedside <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p>Secretions: Color _____  Consistency _____</p> <p>Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____</p> <p>Pulse Ox Site: <u>R finger</u></p> <p>Oxygen Saturation: <u>94% RA</u></p>	<p align="center"><b>GASTROINTESTINAL</b></p> <p>Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat  <input type="checkbox"/> Distended <input type="checkbox"/> Guarded</p> <p>Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads  <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p>Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Passing Flatus: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____  Location _____ Inserted to _____ cm  <input type="checkbox"/> Suction Type: _____</p>	<p align="center"><b>SKIN</b></p> <p>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</p> <p>Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry  <input type="checkbox"/> Diaphoretic</p> <p>Turgor: <input checked="" type="checkbox"/> &lt; 5 seconds <input type="checkbox"/> &gt; 5 seconds</p> <p>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</p> <p>Location/ Description: _____</p> <p>Mucous Membranes: Color: <u>pink</u>  <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
	<p align="center"><b>NUTRITIONAL</b></p> <p>Diet/Formula: <u>Regular</u></p> <p>Amount/Schedule: <u>3x a day</u></p> <p>Chewing/Swallowing difficulties:  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p align="center"><b>PAIN</b></p> <p>Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p>Location: <u>neck</u></p> <p>Type: <u>no pain present</u></p> <p>Pain Score:  0800 _____ 1200 <u>0</u> 1600 <u>0</u></p>
	<p align="center"><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling  <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping  <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors</p> <p>Movement:  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All</p> <p>Brace/Appliances: <input checked="" type="checkbox"/> None  Type: _____</p>	<p align="center"><b>WOUND/INCISION</b></p> <p><input checked="" type="checkbox"/> None</p> <p>Type: _____</p> <p>Location: _____</p> <p>Description: _____</p> <p>Dressing: _____</p>
	<p align="center"><b>MOBILITY</b></p> <p><input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms  <input type="checkbox"/> Ambulatory with assist _____</p> <p>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker  <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p align="center"><b>TUBES/DRAINS</b></p> <p><input checked="" type="checkbox"/> None</p> <p><input type="checkbox"/> Drain/Tube  Site: _____  Type: _____  Dressing: _____  Suction: _____  Drainage amount: _____  Drainage color: _____</p>

**Pediatric Floor Patient #1**

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake							100z		80z				240z
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							76mL	→					376mLs
IV Meds/ Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine						100mL				100mL			200mL
# 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 1 2 3
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 2 3
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>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

Pediatric Floor Patient #2

patient 71

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/ Well Nourished <input type="checkbox"/> Neat/ Clean <input type="checkbox"/> Emaciated <input checked="" type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location: <u>2 hand</u> <input checked="" type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>2+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/ Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/ Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/ Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>W</u> Left <u>W</u> Pushes: Right <u>W</u> Left <u>W</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Urine Appearance:</b> <u>YELLOW</u> <b>Stool Appearance:</b> <u>BROWN SOFT</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>AC 24g</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/ Location:</b> _____ <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/ Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>100mls / wk</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/ min <input type="checkbox"/> BiPap/ CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>2 finger</u> <b>Oxygen Saturation:</b> <u>98% RA</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown <b>Location/ Description:</b> _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	PAIN	
<b>Diet/Formula:</b> <u>NPO</u> <b>Amount/Schedule:</b> <u>NPO</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>hip</u> <b>Type:</b> <u>numeric 8/10</u> <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 <u>8/10</u>	
MUSCULOSKELETAL	WOUND/INCISION	
<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None <b>Type:</b> _____	<input type="checkbox"/> None <b>Type:</b> <u>dressing</u> <b>Location:</b> <u>hip</u> <b>Description:</b> <u>drain removal</u> <b>Dressing:</b> <u>drain</u>	
MOBILITY	TUBES/DRAINS	
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input checked="" type="checkbox"/> Ambulatory with assist <u>X1</u> <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____	

**Pediatric Floor Patient #2**

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													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid							100ml	→					500ml
IV Meds/ Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine							200ml	→					200ml
# 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: <input checked="" type="radio"/> 0    1    2    3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Staff Concern	1 pt - Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>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

## CHEWS Scoring and Escalation Algorithm

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

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

**A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE**  
Use SBAR communication

**Reference:** McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), <http://dx.doi.org/10.1016/j.pedn.2016.10.005>

Student Name: Victoria Forney

Unit: Pedi FI

Pt. Initials: KW

Date: 11-7-23

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
D5 1/2 KCl 20 100ml/hr	<u>Isotonic</u> Hypotonic/ Hypertonic	prevent dehydration & balance electrolytes	Sodium, potassium	fluid overload

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	for mild pain and fever	1000mg PO Q6h	325-1000mg yes	N/A	dizziness, hepatotoxicity, disorientation, rash	<ol style="list-style-type: none"> <li>1. get up slowly and walk with assistance to avoid falls</li> <li>2. raise from laying position slowly and sit on the edge of bed to get feet flat</li> <li>3. increase fluids to flush kidneys and promote organ function</li> <li>4. warm compress on irritated skin</li> </ol>
Ketorolac	NSAID	for moderate pain	30mg IV Q6h PRN	25mg 0.5mg/kg no to manage pain	N/A	dizziness, GI pain, headache, constipation	<ol style="list-style-type: none"> <li>1. get up slowly and walk with assistance to avoid falls</li> <li>2. increase fluid intake to help stool pass and GI pain</li> <li>3. soothing music and dim lights to treat headache</li> <li>4. increase ambulation to help stool movement</li> </ol>
Midazolam	GABA Receptor	for anxiety, prior to MRI	2mg IV Q4h PRN	25-50mcg/kg no to treat anxiety	N/A	drowsiness, nausea, vomiting, headache	<ol style="list-style-type: none"> <li>1. increase fluid intake to help relieve headache</li> <li>2. rest when needed to help drowsiness</li> <li>3. increase fluid intake to help relieve nausea</li> <li>4. try mint to help relieve nausea/vomiting.</li> </ol>
Morphine Sulfate	narcotic agonist-analgesic	for severe pain	3mg IV Q2h PRN	0.05-0.2mg/kg yes	N/A	Respiratory distress, constipation, vomiting, headache	<ol style="list-style-type: none"> <li>1. if difficulty breathing occurs, notify physician or care giver immediately</li> <li>2. increase fluids to help with vomiting</li> <li>3. increase ambulation to help bowel and stool movement</li> <li>4. dim lights and play soft music for headache</li> </ol>
Ceftriaxone	Cephalosporin	for infection treatment	2g IV Q12h	1-2g IV Q12h yes	sterile water 100mg/ml push for 5 minutes	diarrhea, rash, dizziness, phlebitis	<ol style="list-style-type: none"> <li>1. increase fluids to help replenish balance after diarrhea</li> <li>2. notify caregiver if pain occurs where the IV is located</li> <li>3. warm compress on site of rash</li> <li>4. walk with assistance to avoid falls</li> </ol>

Student Name: Victoria Forney

Unit: Pedi Fl

Pt. Initials: AC

Date: 11-7-23

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

Allergies: NKDA

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?			
ampicillin-sulbactam	penicillin and beta-lactamase inhibitors	for infection treatment	3g IVPB Q6h	200mg/kg/day yes	Sodium chloride 0.9% 200 mL/hr	diarrhea, rash, fatigue, headache	<ol style="list-style-type: none"> <li>1. warm compress to relieve rash</li> <li>2. increase fluids to replenish balance after diarrhea</li> <li>3. rest during the day to help fatigue</li> <li>4. dim lights to help ease headache</li> </ol>
acetaminophen	antipyretic	for pain and fever	320mg PO Q4h	10-16mg/kg/dose yes	n/a	dizziness, hepatotoxicity, disorientation, rash	<ol style="list-style-type: none"> <li>1. get up slowly and walk with assistance to avoid falls</li> <li>2. raise from laying position slowly and sit on the edge of bed to get feet</li> <li>3. increase fluids to flush kidneys and promote organ function</li> <li>4. warm compress on irritated skin</li> </ol>
Ibuprofen	NSAID	for fever and mild pain	260mg PO Q6h PRN	4-10mg/kg/dose yes	n/a	constipation, nausea, dizziness, GI upset	<ol style="list-style-type: none"> <li>1. get up slowly and walk with assistance to avoid falls</li> <li>2. increase fluid intake to help stool pass and GI pain</li> <li>3. soothing music and dim lights to treat headache</li> <li>4. increase ambulation to help stool movement</li> </ol>
							<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>
							<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>