

## **Pediatric ED Reflection Questions**

### **1. What types of patients (diagnoses) did you see in the PED?**

A couple of the diagnoses I saw come in were; pain on the buttocks which was confirmed to be a pilonidal cyst, asthma, fever with a patient who had leukemia, two SI/Code with a 12 y/o and 14 y/o, abdominal pain, and a persistent nosebleed.

### **2. The majority of the patients who came in to the PED were from which age group? Was this what you expected?**

There was no specific age group of children that came into the ED which did not surprise me. There were different ages of children from infants to adolescents. The age ranges I had that day were from 6 months - 14 years old. It seemed as if we would get a young child then the next patient that would come in was an adolescent. I had also asked the nurse I was following if there was a specific age group of kids they saw more than the other, and she said the age ranges and varies so much and changes days to day.

### **3. Was your overall experience different than what you expected? Please give examples.**

PED surprised me, I honestly wasn't expecting a lot, but it exceeded my expectations. I was expecting the PED to be super slow and boring with nothing to do, also because that is what my other classmates had passed around. My experience was completely different. I was excited I got to see a variety of diagnoses from the mildest cases to the most severe. It really impacted my learning and helped to put what I have learned in class, and apply it to the clinical setting.

### **4. How did growth and development come into play when caring for patients (both in triage and in treatment rooms)?**

Growth and development really played a role during communication during vitals. There were times I would have to communicate to the children that I was going to put the bloodpressure cuff around them and it was going to give their arm a really tight hug. Or another example of when I was going to see how

tall they were to get their height, a lot of the kids were excited to see how tall they were. There were times i saw the children's idea of body mutilation come into play, one of my patients had asked if the adhesive pulse ox was going to go inside him because he's seen something like that go inside his mom, I told him it was not going to hurt and it was just a sticker that was going to be wrapped on his finger. A lot of teh younger children offends brought their traditional objects with them and felt comfort when their comfort items were in their lap at all times.

**5. What community acquired diseases are trending currently?**

The diseased they have seen to be trending in the hospital were STD's, enterorhinal and surprisingly not much flu or RSV this year so far.

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

### NO FLUIDS RUNNING FOR PICU PATIENT ONLY FLUIDS CONTINUOUS FOR PEDI FLOOR PT

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
DS5 ½ NS + KCl 20mEq/L  Continuous infusion — 40ml/hr	Hypertonic	Compensation for NPO status, the patient was put on NPO. Necessary to maintain, maintain nutrients and electrolyte balance when oral intake is restricted	<ul style="list-style-type: none"> <li>- WBC</li> <li>- CBC</li> <li>- BUN/Creatine</li> </ul>	<ul style="list-style-type: none"> <li>● hyperkalemia</li> <li>● Renal impairment                             <ul style="list-style-type: none"> <li>○ Solution has potassium in it</li> </ul> </li> </ul>

Student Name:		Unit:	Patient Initials:		Date:	Allergies: NKDA	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	IVP – List diluent solution, volume, and rate of administration  IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
NYSTATIN	antifungal	prevent sepsis in the baby	400,000 mg dose QID	yes		nausea and vomiting	<ol style="list-style-type: none"> <li>1. watch for any adverse reactions such as; hives, itching and difficulty breathing which can be signs of an allergic reaction.</li> <li>2. Can cause GI upset such as —N/V/D</li> <li>3. Redness, skin irritation or rash — skin reactions</li> <li>4. Oral irritation — itching or mild burning in the mouth</li> </ol>
ERYTHROMYCIN	antibiotic	to treat any infection prophylactically	200mg/ 5mL Q 6HR	yes		nausea and vomiting	<ol style="list-style-type: none"> <li>1. finish all antibiotics — prevent the cause of the superbug by finishing all antibiotics</li> <li>2. GI distress — Nausea, vomiting, diarrhea, are a common side effect</li> <li>3. Liver function — can cause reversible liver enzyme elevations; s/s of jaundice, yellowing of eyes or skin</li> <li>4. Hearing loss — rare but an see permanent hearing loss especially with with usage of high doses</li> </ol>

#1

IMS Clinical Worksheet - Pediatric Floor - ~~58-13 MO~~  
58 - 13 MO.

<p>Student Name: <b>Aniella Torres</b> Date:</p>	<p>Patient Age: <b>13 MONTHS</b> <b>DAILY WT</b> Patient Weight: <b>9.08 Kg</b> <b>→ 9.38</b></p>
<p>1. Admitting Diagnosis: <b>Delayed Gastric Emptying</b></p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Dietary Modifications + meds to aid in digestion, infants require more fluid + intake for growth</p>
<p>3. Signs and Symptoms: <b>Abdominal pain + vomiting (chronic)</b> ↳ patient has vomit 3x prior to current visit</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: *UGI - (11/10) showed no abnormalities *Gastric Emptying Study - (11/07) - reveals significant delayed gastric emptying w/ solid meals - 6.5hr</p>
<p>5. Lab Values That May Be Affected: - electrolyte levels - blood glucose levels - CBE - Nutrient levels - LFT</p>	<p>6. Current Treatment (Include Procedures): - Nystatin q 4x a day - Erythromycin q 6 hours</p>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient. 1. Sit the patient upright 30' every feeding 2. Small frequent feedings ↳ to prevent regurgitation</p>	<p>8. Patient/Caregiver Teaching: 1. Stop feedings when baby is stressed 2. Sit baby up 30 min at 30' after feeding 3. burp baby every 15 mL administered  Any Safety Issues identified: No; prevent aspiration</p>
<p>9. Calculate the Maintenance Fluid Requirement</p>	<p>10. Calculate the Minimum Acceptable Urine</p>

(Show Your Work):

$$9.38 \times 100 = 938 \text{ mL/day}$$

$$938 / 24 = 39.08 \text{ mL/hr}$$

Actual Pt MIVF Rate:

WFLuids @ 40 mL/hr

Is There a Significant Discrepancy Between Calculated and Actual Rate?

If Yes, Why is There a Discrepancy?

NO.

Output Requirement (Show Your Work):

$$9.38 \times 0.5 = 4.69 \text{ mL/hr}$$

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

484 mL + 210cc

Output for the shift I was present, the patients prognosis was only getting better each day.

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:

1. TRUST

↳ expected MOM to be there in all situations

2. NARCISSISM

↳ baby was upset that his own needs weren't being met.

Piaget Stage:

1. Separation Anxiety.

↳ once mom left, baby became irritable + started crying

2. Symbols/mental representation

↳ baby remembered nystatin med + got eager to use it again

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

- Nystatin: 400,000 units/dose Q 4x day

- Erythromycin: 200mg/5mL suspension Q 6 hours

bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

13 MONTH OLD / Male

Pediatric Floor Patient #1 - 58

#1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input 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 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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>3</u> L <u>3</u> Lower R _____ L _____ 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 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 type="checkbox"/> Person <input type="checkbox"/> Place <input 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 type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> <b>Fontanel:</b> (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input 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>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>X1 diaper yellow</u> <b>Stool Appearance:</b> <u>N/A LBM: 11/06</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>IV pentafid</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> <u>RT Hand</u> <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>D5 1/2 NS + 20 kcal @ 40 mL/hr</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 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 type="checkbox"/> Yes <input checked="" 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>LT toe</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 type="checkbox"/> Present <input checked="" type="checkbox"/> 4 quads <input checked="" type="checkbox"/> Active <input 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 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 <b>Condition:</b> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input 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 Location/Description: _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MOBILITY	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>regular diet</u> <b>Amount/Schedule:</b> <u>As tolerated</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>table food - reg diet</u>	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>Not applicable</u> <b>Type:</b> <u>Not applicable</u> <b>Pain Score:</b> 0800 <u>0</u> 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 <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 Type: _____	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	TUBES/DRAINS	
	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____	

Daily WT: 9.38 kg

last stool output: 11/06

Oxygen Saturation: 100%  
RA

Ambulatory  Crawl  In Arms  
 Ambulatory with assist \_\_\_\_\_  
 Assistive Device:  Crutch  Walker  
 Brace  Wheelchair  Bedridden

Type: N/A  
 Dressing: \_\_\_\_\_  
 Suction: \_\_\_\_\_  
 Drainage amount: \_\_\_\_\_  
 Drainage color: \_\_\_\_\_

NPO diet → Clear liquid diet 11/08 0900 → as tolerated (gastroparesis diet)

**Pediatric Floor Patient #1**

DS 1/2 NS + 20 KCl - continuous fluids

11/8 C1030

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake			210										210cc
Intake - PO Meds			4ml										4ml
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	40	40	40	40	40								200ml
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine			280										280ml
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

1 diaper output

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
<b>CHEWS Total Score 0</b>	

8:00 vitals

#2

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input 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 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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>3</u> L <u>3</u> Lower R <u>—</u> L <u>—</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 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 type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input 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 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>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>clear/yellow</u> <b>Stool Appearance:</b> <u>NIA</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <u>CPM</u> <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>11/07</u>	<b>Site:</b> <u>IV line</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <u>periph</u> <b>Type/Location:</b> <u>LT AC 20g</u> <b>Appearance:</b> <input 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>DS NS + 20 KCl @ 83ml/hr</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 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 type="checkbox"/> Yes <input checked="" 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>LT Hand</u> <b>Oxygen Saturation:</b> <u>98%</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 <input type="checkbox"/> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" 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 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 <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 Location/Description: _____ <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> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>NPO - due to possible surgery</u>	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>No N applicable</u> <b>Type:</b> <u>Not applicable</u> <b>Pain Score:</b> 0800 <u>0</u> 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 <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 Type: _____	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ <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> _____

Daily WT: 43.3 Kg

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Pediatric Floor Patient # 2

NPO-diet

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													
<b>IV INTAKE</b>	<b>07</b>	<b>08</b>	<b>09</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>Total</b>
IV Fluid	83	83	83	83	83								415 mL
IV Meds/Flush													
<b>OUTPUT</b>	<b>07</b>	<b>08</b>	<b>09</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>Total</b>
Urine				X1									X1 output
# 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)
	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