

Mariza

## Pediatric ED Reflection Questions

1. What types of patients (diagnoses) did you see in the PED?  
*Pt. came in w/ seizures, lots of RSV and strep.*
2. The majority of the patients who came in to the PED were from which age group? Was this what you expected? *The majority of patients I saw were school-age, I expected this.*
3. Was your overall experience different than what you expected? Please give examples.  
*Yes! It was super busy and I got to see a trauma I was not expecting that!*
4. How did growth and development come into play when caring for patients (both in triage and in treatment rooms)? *Growth and development came into play for how we talked to and explained what we were doing to the patient.*
5. What types of procedures did you observe or assist with?  
*Helped hold pts ~~for~~ when giving IV's, helped hang fluids, vital signs*
6. What community acquired diseases are trending currently?
7. What community mental health trends are being seen in the pediatric population?
8. What patient population is the most vulnerable?
9. What is the process for debriefing after a traumatic event?
10. If someone donated \$100 million to the PED, what would you change?
11. What is the process for triaging patients in the PED?
12. What role does the Child Life Specialist play in the PED?

**Pediatric Floor Patient #1**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input 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>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying <input checked="" type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <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 <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 checked="" type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <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 checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Urine Appearance:</b> <u>yellow</u> <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>Dorsal hand</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <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 type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>0.5 NS + KCl 20 @</u> <u>45 mL/hr</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input checked="" type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input checked="" type="checkbox"/> Nasal Cannula: <u>12</u> 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" 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>L7a</u> <b>Oxygen Saturation:</b> <u>92</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 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 type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>Regular</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <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 Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

**Pediatric Floor Patient #1**

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
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										45	45	45	135
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
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: <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: 0 <input checked="" type="radio"/> 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>    </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 Medication Worksheet – Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5NS + KCL 20	Isotonic <input checked="" type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	Maintenance fluid	Potassium, Chloride, Sodium	Potassium Overload, decreased awareness, high blood sugar, sweats, headache.

  

Student Name:	Unit:	Patient Initials:	Date:	Allergies:
Mariza Cordova	Pedi Med-surg	J.J.	12/5/2023	NKDA
Generic Name	Therapeutic Reason	Dose, Route & Schedule	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects
Acetaminophen	Pain and fever relief	124.8mg PO q4 hrs prn pain/fever	N/A	Dizziness, Rash, Disorientation
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Do not give more than 6 doses/24hrs 2. Assist child in moving if dizzy 3. Notify nurse if rash with itching develops 4. If patient is disoriented notify nurse
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.

<p>Student Name: <i>Mariza Cordova</i>  Date: <i>12/5/23</i></p>	<p>Patient Age: <i>3y.0</i>  Patient Weight: <i>12.2kg</i></p>
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> <p><i>10 x 100 = 1000</i>  <i>2.2 x 50 = 110</i>  <i>1110 mL/24hrs</i>  <i>46.25 mL/hr</i></p> <p>Actual Pt MIVF Rate: <i>45 mL/hr</i></p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate?  <i>No</i></p> <p>If Yes, Why is There a Discrepancy?</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> <p><i>0.5 mL/kg/hr</i></p> <p>Actual Urine Output During Your Shift (mL/hr):</p> <p><i>Unable to obtain due to mom throwing away diapers</i></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: <i>Autonomy vs. Shame + Doubt</i></p> <ol style="list-style-type: none"> <li><i>Wanting to put blanket on by herself</i></li> <li><i>She had her own special blanket</i></li> </ol> <p>Piaget Stage: <del>S</del> <i>Preoperational</i></p> <ol style="list-style-type: none"> <li><i>The child thinks that everytime we entered her room we were going to hurt her</i></li> <li><i>Getting mad at the blood pressure cuff for being too tight</i></li> </ol>	
<p>Please list any medications you administered or procedures you performed during your shift:</p> <p><i>Acetaminophen oral</i>  <i>D5NS+KCL 20</i></p>	

## IM5 Clinical Worksheet – Pediatric Floor

<b>Student Name:</b> Mariza Cordova <b>Date:</b> 12/5/23	<b>Patient Age:</b> 3y-0 <b>Patient Weight:</b> 12.2kg
<b>1. Admitting Diagnosis:</b> RSV - Acute Resp. Failure	<b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b> Respiratory
<b>3. Signs and Symptoms:</b> Tachypnea ↑ Work of breathing Shortness of breath ↓ O <sub>2</sub> Sats Fever	<b>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:</b> CBC Chest x-ray Pulse ox Blood culture
<b>5. Lab Values That May Be Affected:</b> WBC Electrolytes (dehydration)	<b>6. Current Treatment (Include Procedures):</b> Oxygen supplementation Management of pain & fever fluid management
<b>7. Pain &amp; Discomfort Management:</b> <b>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b> 1. Having mom hold pt for comfort 2. Distraction by having pt. watch Paw Patrol	<b>8. Patient/Caregiver Teaching:</b> 1. Avoid going around sick people 2. Proper hand washing techniques 3. Management of fever/pain with Tylenol + Motrin <b>Any Safety Issues identified:</b> Pt. wanted to keep pulling at her NC, we had to try our best to keep her from injuring herself

Admit wt: 19.6kg 007  
107cm tall  
Tonsillectomy

Pediatric Floor Patient #2

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>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input 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 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 checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <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 checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None <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> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>L dorsal hand</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <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>10 5 1/2 NS @ 50ml/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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input checked="" type="checkbox"/> Nasal Cannula: <u>2</u> L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <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>L thumb</u> <b>Oxygen Saturation:</b> <u>97</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 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 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>Clear</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <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 type="checkbox"/> None <b>Type:</b> <u>Adenoids/tonsils</u> <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> <u>Open to air</u>
	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 Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

**Pediatric Floor Patient #2**

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
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						50	50	50	50	50	50	50	350
IV Meds/Flush									10				10
									+ 3+3				
<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													
# 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>0</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 Medication Worksheet – Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5 1/2 NS	Maintenance fluid	Electrolytes	decreased awareness, high blood sugar, swelling, headache.

Student Name: Mariza Cordova		Unit: Pedi Med-surg	Patient Initials:	Date: 12/5/2023	Allergies: NKDA
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	Adverse Effects
Morphine	Opioid	Pain Relief	Morphine 0.98mg IV q2hrs PRN pain	Choose an item. Yes	Constipation, Vomiting, Headache, Respiratory Depression
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.

**Appropriate Nursing Assessments, Teaching, Interventions (Precautions/Contraindications, Etc.)**

1. Possible stool softener  
 2. Possible antiemetic  
 3. Notify nurse if patient slows breathing (First dose)  
 4. Abdominal assessment

1. Click here to enter text.  
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