

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>S</u> L <u>S</u> Lower R <u>S</u> I <u>S</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input 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 EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>clear yellow</u> Stool Appearance: <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>Right AC</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>DC NS w/KCl 20 mg</u> <u>24ml/hr</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>left finger</u> Oxygen Saturation: <u>98</u>	Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input 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 Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input 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: <u>incision abd</u> Mucous Membranes: Color: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>Regular diet</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: <u>Abd incision</u> Location: <u>left abd</u> Description: <u>laparoscopic appendectomy</u> Dressing: <u>Open to air, adhesive</u>
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Janice Balaba Date: 3.4.0</p>	<p>Patient Age: 3.4.0 M Patient Weight: 29.1 kg 13.4 Kg</p>
<p>1. Admitting Diagnosis: Acute appendicitis Nausea & vomiting in pediatric PT Fever Strepococcal sore throat</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Abd examination Pain assessment G.I</p>
<p>3. Signs and Symptoms: abdominal pain vomiting Fever Loss of appetite changes in behavior (irritability, restlessness) abd tenderness guarding</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: CT scan 1/20 Laparoscopic appendectomy (1/27)</p>
<p>5. Lab Values That May Be Affected: Electrolytes due to vomiting</p>	<p>6. Current Treatment (Include Procedures): Surgical Patholog exam 1/27/24 CT abd Pelvis 1/20/24 Famotidine 6.8 mL/hr IV Piperacillin (Zosyn) 34.2 mL/hr IV</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ol style="list-style-type: none"> 1. Age appropriate distractions such as toys, bubbles, or favorite cartoon to divert pain. (Allow favorite stuffed animal) 2. Play soothing music or sing lullabies to create calming environment 	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. Use simple language to explain that the child appendix needs medical attention 2. Educate sign and symptoms of potential complications such as infection or unusual pain. 3. Discuss temporary restrictions on physical activities <p>Any Safety Issues identified: Incision site care Emphasize meticulous care of incision sites to prevent infection.</p>

<p>Student Name: Jany Balaba Date: Jan. 20th 2024</p>	<p>Patient Age: 3.4 y.o Patient Weight: kg 13.3 kg</p>
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> $10 \times 100 = 1000$ $9.3 \times 50 = 465$ $\frac{1000}{465}$ <p>Actual Pt MIVF Rate: 214 mL/hr</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> $1 \times 13.3 = 13.3$ $13.3 \times 24(\text{hr}) = 319.2$ <p>Actual Urine Output During Your Shift (mL/hr): 300 mL</p>
<p>Is There a Significant Discrepancy Between Calculated and Actual Rate? No</p> <p>If Yes, Why is There a Discrepancy? NONE</p>	
<p>11. Growth & Development:</p> <ul style="list-style-type: none"> * 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>Erickson Stage: Autonomy vs Shame & Doubt</p> <p>1. Initiating simple task like putting his shoes on with minimal help</p> <p>2. He was able to decide which show to watch and choose the games he wants to play on the cellphone.</p> <p>Piaget Stage: Preoperational Stage</p> <p>1. The little boy show growth in language skills and able to form more complex words.</p> <p>2. He keeps a small stuffed animal in his bed using it as a transitional object.</p> <p>Please list any medications you administered or procedures you performed during your shift:</p> <p>Riperacllin Zosyn 32.4 ml/hr</p> <p>Focused assessment</p>	

Student Name: Jamice Balaba Unit: P0 Floor Pt. Initials: J.J Date: 01-31-24

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

Allergies: NKA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
<u>D5 NS w/KCl 20 mEq 24 ml/hr</u>	<u>Isotonic/Hypotonic/Hypertonic</u>	<u>Caloric supply source of water & electrolytes</u>	<u>Na, Glucose</u>	<u>Hyperglycemia, Fluid overload</u>

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range? if not, why?	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration		
<u>Famotidine</u>		<u>Nausea, Vomiting</u>	<u>6.94 mg q 24h IV</u>	<u>yes</u>	<u>2 mins</u>	<u>headache dizziness fatigue</u>	<u>1. Instruct the patient on the correct dosage and timing 2. Can be taken with or without food. 3. Avoid spicy or acidic foods 4. Educate pt potential side effects such as headache</u>
<u>Piperacillin Zosyn</u>		<u>Antibiotic</u>	<u>32.4 ml/hr q 8h IV</u>	<u>yes</u>	<u>30 mins - 2 hr</u>	<u>Nausea / Vomiting severe anaphylaxis</u>	<u>1. Educate PT the importance of med adherence 2. Advise PT to inform healthcare providers of any allergies 3. Explain the risk of developing GI diff 4. Take the medication on time</u>
<u>PRN meds Morphine</u>		<u>Severe pain</u>	<u>IV q 4h</u>	<u>yes</u>	<u>5 mins</u>	<u>headache respiratory depression</u>	<u>1. Monitor signs of excessive sedation 2. Be vigilant for adverse effect 3. Implement measures to prevent fall 4. Make sure PT is taking enough fluid to prevent constipation</u>
							<ol style="list-style-type: none">
							<ol style="list-style-type: none">

PT 51

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input type="checkbox"/> < 2 sec <input checked="" type="checkbox"/> > 2 sec Pulses: Upper R <u>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: _____ Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>Basilic Vein</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Picc line basilic medial side of arm</u> Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>Right Finger</u> Oxygen Saturation: <u>97 100</u>	Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input 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 Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NGT</u> Location <u>R-tray</u> Inserted to <u>19 FR</u> cm <input checked="" type="checkbox"/> Suction Type: _____	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input 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: <u>abd incision</u> Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MUSCULOSKELETAL	NUTRITIONAL	PAIN
<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	Diet/Formulas: <u>TPN / NPO</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>abd</u> Type: <u>abd pain when pressed hard</u> Pain Score: 0800 _____ 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None Type: <u>incision</u> Location: <u>abd medial line</u> Description: <u>incision abd</u> Dressing: <u>gauge w/tegaderm</u>	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>Right nose</u> Type: <u>NGT suction</u> Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: <u>light green</u>

Student Name: Jany Balaba Unit: PD Floor Pt. Initials: S.S Date: 1-31-24

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
DSNS w/KCl 20 mEq 85ml/hr	Isotonic/ Hypotonic/ Hypertonic	Fluid maintenance for hydration & electrolytes	Na, Glucose	Hyperglycemia, Fluid overload

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range? if not, why?	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration		
Acetaminophen		non narcotic Non opioid for mild pain	IVPB 200ml/hr q6h	yes	200 ml/hr	headache dizziness Vomiting	1. Explain to PT that this med is a pain reliever & fever reducer used to alleviate mild pain 2. Emphasize the importance of following the rec dose 3. Monitor side effects or allergic reactions (rash, itching) 4. Make sure PT is drinking enough fluid.
Famotidine		Nausea Vomiting	20 mg IV 2x day	yes	2 mins	headache dizziness Fatigue	1. Explain to PT that this med is used to reduce stomach acid production. 2. Emphasize consistency in taking the med at the same time each day. 3. Can be taken with or without food 4. Avoid certain foods such as spicy foods, citrus and caffeinated drinks.
Piperacillin tazobactam		Antibiotic	200ml/hr q8h IV	yes	200ml/hr	Nausea Vomiting Anaphylaxis	1. Explain that this med is an antibiotic and emphasize importance of completing the full course. 2. Take the medication as prescribed. 3. Take the missed dose as soon as they remember 4. Emphasize the importance of staying well hydrated to support kidney function.
PRN meds		Severe pain	2mg IV q2h	yes	5 mins	Respiratory depression Nausea/Vomiting Constipation	1. Drink enough fluid to prevent constipation 2. Report any difficulty in breathing 3. Add fruits and veggies in their daily meals 4. Encourage early ambulation and movement.
Morphine		to prevent bleed clot formation	1mg IV	yes	2 mins	Bleeding hypotension Nausea Vomiting	1. Reports any sign of unusual bleeding 2. Use soft bristle toothbrush to prevent bleeding 3. Don't blow nose too hard. 4. Move slowly when positioning. Always call for help when in getting up

