

Student Name: Isaac Ariza

Unit: PICU

Pt. Initials: _____

Date: 2/14/24

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
	Isotonic/ Hypotonic/ Hypertonic			

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?			
Clindamycin in dextrose	Antibiotic	Prevent infection	13.3mg/kg IV Q8	Yes		Upset stomach	<ol style="list-style-type: none"> 1. redness, swelling, or pain notify provider possible signs of thrombophlebitis 2. diarrhea may occur so make sure diaper changes are frequent to prevent skin breakdown 3. this medication may cause itching 4. report any signs of redness, swelling, or difficulty breathing could be a signs of allergic reaction
Erythromycin	Antibiotic	Prevent infection	Q3 with meals via G-tube	Yes		Upset stomach	<ol style="list-style-type: none"> 1. report any signs of redness, swelling, or difficulty breathing could be a signs of allergic reaction 2. diarrhea may occur so make sure diaper changes are frequent to prevent skin breakdown 3. notify provider if yellowing of the skins or eyes occurs this medication can be hard on the kidneys 4. possible kidney damage notify provider of any yellowing of skin or eyes

Student Name: Isaac Ariza Date: 2/13/24	Patient Age: 11 m.o. Patient Weight: 5.1 kg
1. Admitting Diagnosis: <i>post ventriculoperitoneal shunt</i> COVID-19	2. Priority Focused Assessment R/T Diagnosis: <i>lung assessment</i> <i>o/sat</i>
3. Signs and Symptoms: <i>stridor</i> <i>coughing</i> <i>grunting</i>	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: <i>CT</i> <i>X-ray</i>
5. Lab Values That May Be Affected: <i>BUN</i> <i>WBC</i> <i>HRH</i>	6. Current Treatment (Include Procedures): <i>Ventriculoperitoneal shunt</i> <i>NPO/tube feeding</i> <i>PICC left saphenous</i>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. <i>1. dark/quiet environment</i> <i>2. Clustered care</i>	8. Patient/Caregiver Teaching: 1. <i>signs of infection</i> 2. <i>isolation precaution teachings (airborne/droplet)</i> 3. <i>how to suction</i> Any Safety Issues Identified: <i>none</i>
9. Calculate the Maintenance Fluid Requirement (Show Your Work): $5.1 \times 10 = \frac{510}{24}$	10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): $5.1 \times 1 = 5.1$
Combined Total Intake for Your Pt (mL/hr): <i>21.25 mL/hr</i>	Actual Urine Output During Your Shift (mL/hr): <i>5.1 mL/hr</i>
Please list any medications you administered or procedures you performed during your shift: <i>Clindamycin in dextrose</i> <i>erythromycin</i> <i>head, chest, ab circumference</i> <i>bed bath</i> <i>daily weighs</i>	

PICU

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	140												140
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	46												46
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other EVD	10												10

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 <u>1</u> 2 3
Cardiovascular	Circle the appropriate score for this category: <u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 <u>2</u> 3
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>5</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

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input checked="" type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input checked="" 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 checked="" type="checkbox"/> < 2 sec <input 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 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 checked="" 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 type="checkbox"/> Alert <input checked="" type="checkbox"/> Confused <input checked="" 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 _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input checked="" type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <input checked="" type="checkbox"/> Left <input checked="" type="checkbox"/> Pushes: Right <input checked="" type="checkbox"/> Left <input checked="" type="checkbox"/> S=Strong W=Weak N=None EVD Drain: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Level <u>18</u> Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Urine Appearance: <u>clear</u> Stool Appearance: <u>NA</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>PICC Saghenous, left</u> 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: _____
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input checked="" type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input checked="" type="checkbox"/> Right <input checked="" 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 Oxygen Delivery: <input 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: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>NA</u> Type <u>NA</u> Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color <u>clear</u> Consistency <u>thick/stringy</u> Suction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Type _____ Pulse Ox Site <u>left foot</u> Oxygen Saturation: <u>100%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded 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 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 <u>NA</u> Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>G-tub</u> Location <u>ab</u> Inserted to _____ cm <input checked="" type="checkbox"/> Suction Type: <u>wall suction</u>	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 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>ab/head</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 checked="" 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/Formula: <u>lactulose</u> Amount/Schedule: <u>1.67g BID</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>head/ab</u> Type: <u>NA</u> Pain Score: _____ 0800 _____ 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>NA</u> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Bedridden	<input type="checkbox"/> None Type: <u>EVD</u> Location: <u>head</u> Description: <u>drain</u> Dressing: <u>occlusive dressing</u>	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>right cranial</u> Type: <u>EVD</u> Dressing: <u>clear</u> Suction: <u>NA</u> Drainage amount: <u>5ml/hr</u> Drainage color: <u>pink</u>