

IM5 Clinical Worksheet – Pediatric Floor

1600 VS Gordy
 All scheduled Meds
 PRN in 24 h
 56990 Lauren
 11011 376-382
 MR 1011
 TPM pedi MS

<p>Student Name: Katelynn Van Iew Date: 2/14/24</p>	<p>Patient Age: 20m F Patient Weight: 12.2kg</p>
<p>1. Admitting Diagnosis: Hypoxia Respiratory Distress Pneumonia RSV Croup Milk baby</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Respiratory</p>
<p>3. Signs and Symptoms: ↑ Heart rate ↑ Respirations ↓ Oxygenation Cyanosis, retraction, nasal Flare irritability, lethargy</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: Chest X-ray</p>
<p>5. Lab Values That May Be Affected: ABG's</p>	<p>6. Current Treatment (Include Procedures): Antibiotics Iron infusion O2 therapy</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. Positioning to help breathing. 2. Breathing and coughing techniques; Blowing bubbles Playing games. 	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. How to monitor at home. 2. Infection prevention 3. Iron diet/supplements, milk intake <p>Any Safety Issues identified: NO</p>

Student Name: Katelynn Van Liew

Date: 2/14/24

Patient Age: 20m

Patient Weight: 12.2 kg

9. Calculate the Maintenance Fluid Requirement (Show Your Work):

$$\begin{aligned} 10\text{kg} \times 100\text{mL} &= 1000\text{mL} \\ 2.2\text{kg} \times 50\text{mL} &= \frac{100\text{mL}}{1100\text{mL}/24\text{h}} \end{aligned}$$

Actual Pt MIVF Rate:

1100 mL/24h

Is There a Significant Discrepancy Between Calculated and Actual Rate? no

If Yes, Why is There a Discrepancy?

10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):

$$\begin{aligned} 2\text{mL}/\text{kg}/\text{h} \\ 2 \times 12.2 &= 24.4\text{mL}/\text{h} \end{aligned}$$

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

No urine output.

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: Autonomy vs Shame and doubt

1. She chose what she wanted to drink.

2.

Piaget Stage: Sensorimotor.

1.

2.

The patient was sleeping each time we went into the room she woke up once crying for juice.

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

Pediatric Floor Patient #1

<p>GENERAL APPEARANCE</p> <p>Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" 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>CARDIOVASCULAR</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 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"/> < 2 sec <input type="checkbox"/> > 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>PSYCHOSOCIAL</p> <p>Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input 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</p> <p>Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p>NEUROLOGICAL</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 type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age</p> <p>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></p> <p>Fontanel: (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input 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>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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>ELIMINATION</p> <p>Urine Appearance: <u>N/A</u></p> <p>Stool Appearance: <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p>IV ACCESS</p> <p>Site: <u>Right foot</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>24 g</u></p> <p>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</p> <p>Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: _____</p>
<p>RESPIRATORY</p> <p>Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: <u>Ronchi R & L</u> 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 type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen</p> <p>Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>1</u> 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 type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" 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 _____</p>	<p>GASTROINTESTINAL</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 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>SKIN</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 type="checkbox"/> Natural for Pt</p> <p>Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic</p> <p>Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 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 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>RESPIRATORY</p> <p>Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: <u>Ronchi R & L</u> 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 type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen</p> <p>Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>1</u> 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 type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" 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 _____</p>	<p>NUTRITIONAL</p> <p>Diet/Formula: <u>Pedigo 1-2</u></p> <p>Amount/Schedule: <u>Routine</u></p> <p>Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>PAIN</p> <p>Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p>Location: _____</p> <p>Type: _____</p> <p>Pain Score: 0800 <u>1</u> 1200 <u>0</u> 1600 <u>0</u></p>
<p>RESPIRATORY</p> <p>Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: <u>Ronchi R & L</u> 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 type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen</p> <p>Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>1</u> 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 type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" 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 _____</p>	<p>MUSCULOSKELETAL</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>WOUND/INCISION</p> <p><input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____</p> <p>Dressing: _____</p>
<p>RESPIRATORY</p> <p>Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: <u>Ronchi R & L</u> 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 type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen</p> <p>Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>1</u> 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 type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" 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 _____</p>	<p>MOBILITY</p>	<p>TUBES/DRAINS</p> <p><input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____</p>

Raise OA site left hand
 Oxygen Saturation: 98

- Ambulatory
 Crawl
 In Arms
 Ambulatory with assist _____
 Assistive Device:
 Crutch
 Walker
 Brace
 Wheelchair
 Bedridden

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													
IV Meds/Flush					20.5								20.5
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)

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

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<p><input checked="" type="checkbox"/> GENERAL APPEARANCE</p> <p>Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p><input checked="" type="checkbox"/> CARDIOVASCULAR</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 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</p>	<p><input checked="" type="checkbox"/> PSYCHOSOCIAL</p> <p>Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p><input checked="" type="checkbox"/> NEUROLOGICAL</p> <p>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 checked="" 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 type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>5</u> Left <u>5</u> Pushes: Right <u>5</u> Left <u>5</u></p>	<p><input checked="" type="checkbox"/> ELIMINATION</p> <p>Urine Appearance: <u>Clear yellow</u> Stool Appearance: <u>No BM</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><input checked="" type="checkbox"/> IV ACCESS</p> <p>Site: <u>left hand</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>22 gage</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: <u>Dextrose 5% NS w/</u> <u>20 KCl</u></p>
<p>GASTROINTESTINAL</p>	<p>SKIN</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 type="checkbox"/> Natural for Pt</p>	

S=Strong W=Weak N=None
 EVD Drain: Yes No Level _____
 Seizure Precautions: Yes No

RESPIRATORY

Respirations: Regular Irregular
 Retractions (type) _____
 Labored
 Breath Sounds:
 Clear Right Left
 Crackles Right Left
 Wheezes Right Left
 Diminished Right Left
 Absent Right Left
 Room Air Oxygen
 Oxygen Delivery:
 Nasal Cannula: _____ L/min
 BiPap/CPAP: _____
 Vent: ETT size _____ @ _____ cm
 Other: _____
 Trach: Yes No
 Size _____ Type _____
 Obturator at Bedside Yes No
 Cough: Yes No
 Productive Nonproductive
 Secretions: Color _____
 Consistency _____
 Suction: Yes No Type _____
 Pulse Ox Site Right hand
 Oxygen Saturation: 9a%

Abdomen: Soft Firm Flat
 Distended Guarded
 Bowel Sounds: Present X 4 quads
 Active Hypo Hyper Absent
 Nausea: Yes No
 Vomiting: Yes No
 Passing Flatus: Yes No
 Tube: Yes No Type _____
 Location _____ Inserted to _____ cm
 Suction Type: _____

NUTRITIONAL

Diet/Formula: Clear
 Amount/Schedule: SIPS + chips
 Chewing/Swallowing difficulties:
 Yes No

MUSCULOSKELETAL

Pain Joint Stiffness Swelling
 Contracted Weakness Cramping
 Spasms Tremors
 Movement:
 RA LA RL LL All
 Brace/Appliances: None
 Type: _____

MOBILITY

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

Cyanotic Pale Normal Pt
 Condition: Warm Cool Dry
 Diaphoretic
 Turgor: < 5 seconds > 5 seconds
 Skin: Intact Bruises Lacerations
 Tears Rash Skin Breakdown
 Location/Description: _____
 Mucous Membranes: Color: _____
 Moist Dry Ulceration

PAIN

Scale Used: Numeric FLACC Faces
 Location: Abdomen
 Type: incisions
 Pain Score:
 0800 _____ 1200 0 1600 _____

WOUND/INCISION

None
 Type: Incision
 Location: Abdomen
 Description: Trochar X3
 Dressing: gauze

TUBES/DRAINS

None
 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													0
Intake - PO Meds													0
Enteral Tube Feeding													0
Enteral Flush													0
Free Water													0

IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	40	40	40	40	80	80	80	80	80	40	40		640
IV Meds/Flush						100							100
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine		1											
# of immeasurable		1					2						3
Stool													
Urine/Stool mix													
Emesis	1												1 occurrence
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

CHEWS Scoring and Escalation Algorithm

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

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
<ul style="list-style-type: none"> - Continue Routine Assessments 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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

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>

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
INT				

Student Name: Katelynn Vanilew		Unit: Pedi Med-Surg	Patient Initials: SS		Date: 2/14/24	Allergies: NKA		
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.)
Ampicillin	Penicillin Antibiotic	Treat bacterial infections.	610mg IVP	Choose an item. Click here to enter text.	(30mg/ml) 81.3mL Sterile water 3-5 Min		Rash, Fever, Black hairy tongue, Dizziness, Headache, NV&D	<ol style="list-style-type: none"> 1. Do not take if allergic to penicillins 2. Finish all medication 3. Signs of allergic reactions 4. Do not take with dairy products <p>My patient was admitted the morning of clinical. She was only given the one med.</p>