

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: <u>Vanette Martinez</u>          Date: <u>4/2/23</u>  <u>NEDA</u></p>	<p>Patient Age: <u>8y0 M</u>          Patient Weight: <u>kg41kg</u></p>
<p>1. Admitting Diagnosis:          - Acute appendicitis          - perit. Append</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:          Abdominal Assessment</p>
<p>3. Signs and Symptoms:          Pain on @ abdomen          Abd firm and distended</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:          Ultrasound          X-ray          CT scan</p>
<p>5. Lab Values That May Be Affected:          Elevated C-reactive protein (CRP)          Elevated WBC 3/28 19.45↑</p>	<p>6. Current Treatment (Include Procedures):          Lop Append 3/29          X-ray</p>
<p>7. Pain &amp; Discomfort Management:          List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <ol style="list-style-type: none"> <li>Use iPad to ask questions about his show that he was watching to cope w/ pain</li> <li>Use bubbles to have him blow and breath deep</li> </ol>	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> <li>Ambulate TID</li> <li>have ice chips/popsicles in moderation</li> <li>Do not remove dressings on @ abd.</li> </ol> <p>Any Safety Issues identified:</p> <ul style="list-style-type: none"> <li>- Fall injury risk</li> <li>- Pain Acute</li> <li>- Infection</li> <li>- Risk for bowel obstruction</li> <li>- Inadequate I&amp;O</li> </ul>

Student Name: <u>Vanette Martinez</u> Date: <u>4/2/24</u>	Patient Age: <u>8yo M</u> Patient Weight: <u>kg 44kg</u>
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> <p style="text-align: center;"><u>44kg</u></p> <p>(DS NS + KCL 20) <math>10 \times 100 = 1000</math>  <math>10 \times 50 = 200</math>  <math>24 \times 20 = 480</math></p> <p style="text-align: center;"><u>1980</u></p> <p>Actual Pt MIVF Rate: <u>83ml/hr</u></p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate? <u>no</u></p> <p>If Yes, Why is There a Discrepancy?</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> <p><u>44</u>  <math>\times .5ml</math>  <u>22ml</u></p> <p>Actual Urine Output During Your Shift (mL/hr):  <u>Not observed</u></p>
<p>11. Growth &amp; Development:</p> <p>*List the Developmental Stage of Your Patient For Each Theorist Below.</p> <p>*Document 2 OBSERVED Developmental Behaviors for Each Theorist.</p> <p>*If Developmentally Delayed, Identify the Stage You Would Classify the Patient:</p> <p>Erickson Stage: <u>Industry vs inferiority</u></p> <ol style="list-style-type: none"> <li>The patient wanted to have a meal but wasn't able to do so, his diet was to have ice chips and poppers in the machine so that made him feel sad because he couldn't do much.</li> <li>The child was discouraged because he couldn't do much tasks since he was <u>very adjust to recovery.</u></li> </ol> <p>Piaget Stage: <u>preconcrete to concrete</u></p> <ol style="list-style-type: none"> <li>The children was learning to adjust to the hospital environment</li> <li>He had the concept of how the IV made him relieve his pain 4 on a 0-10 scale.</li> </ol>	
<p>Please list any medications you administered or procedures you performed during your shift:</p> <ol style="list-style-type: none"> <li>famotidine (pepcid) injection - prevent gastric acid <u>4. piperacillin-tazobactam (Zosyn)</u></li> <li>ketorolac (toradol) injection - med pain <u>Assisted removing his dressing and molans are everything looked fine.</u></li> <li>Acetaminophen IVPB</li> </ol>	

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 type="checkbox"/> Strong <input checked="" 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>42</u> L <u>42</u> Lower R <u>42</u> L <u>42</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 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 <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>2mm</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input 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>Not observed</u> <b>Stool Appearance:</b> <u>Not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <input checked="" type="checkbox"/> Posterior hand <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>22G</u> <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>NS + 30 kcal @ 83ml/hr</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input checked="" type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input type="checkbox"/> Warm <input checked="" 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: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
<b>Diet/Formula:</b> <u>ICE chips/popsicles</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>w/ exception of dry foods</u>	<b>Pain</b> <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: _____	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>(4) Abd</u> <b>Type:</b> <u>Sharp</u> <b>Pain Score:</b> <u>4</u> 0800 <input checked="" type="checkbox"/> 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 _____ <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 type="checkbox"/> None <b>Type:</b> <u>wound</u> <b>Location:</b> <u>(4) Abd</u> <b>Description:</b> _____ <b>Dressing:</b> _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake						120							
Intake - PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT													
Urine	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	Not observed												
# of immeasurable													
Stool	Diarrhea												
Urine/Stool mix													
Emesis													
Other													

**Children's Hospital Early Warning Score (CHEWS)**  
(See CHEWS Scoring and Escalation Algorithm to score each category)

Behavior/Neuro	Circle the appropriate score for this category: 0 1 2 3
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 2 3
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
<b>CHEWS Total Score</b>	
CHEWS Total Score	Total Score (points) _____
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for 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
<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 type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input checked="" 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>2</u> L <u>2</u> Lower R <u>2</u> L <u>2</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <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 <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input 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 <u>3mm</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>u</u> Left <u>u</u> Pushes: Right <u>u</u> Left <u>u</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>Amber 500ml</u> <b>Stool Appearance:</b> <u>Not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>RA</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>206</u> <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
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 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 checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input 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 type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input checked="" type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input 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: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>clear diet</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>no pain</u> <b>Type:</b> _____ <b>Pain Score:</b> <input type="checkbox"/> _____ 0800 _____ 1200 _____ 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<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 <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 type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input checked="" 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: _____

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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													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine			500										
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

Children's Hospital Early Warning Score (CHEWS)	
(See CHEWS Scoring and Escalation Algorithm to score each category)	
Behavior/Neuro	Circle the appropriate score for this category: 0 1 2 3
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 2 3
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points)
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for 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
<b>Behavior/Neuro</b>	- Playing/sleeping appropriately OR - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed	- Irritable, difficult to console OR - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish
<b>Cardiovascular</b>	- Skin tone appropriate for patient - Capillary refill $\leq$ 2 seconds	- Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new)	- Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia	- 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
<b>Respiratory</b>	- Within normal parameters - No retractions	- 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	- 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	- 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
<b>Staff Concern</b>		- Concerned		
<b>Family Concern</b>		- Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
- Continue Routine Assessments	- 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	- 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>

Student Name: Vanette Martinez

Unit: Pediatric Floor

Pt. Initials: \_\_\_\_\_

Date: 4/2/23

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

Allergies: NICOA

Primary IV Fluid and Infusion Rate (ml/hr)		Circle IVF Type		Rationale for IVF		Lab Values to Assess Related to IVF		Contraindications/Complications	
<u>NSF 20kCl @ 83ml/hr</u>		<u>Isotonic/ Hypotonic/ Hypertonic</u>							
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? 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.)		
Famotidine	H2 Blocker	Prevent Gastric acid	20mg Daily	yes		Constipation Dizziness HA	1. Drink fluids to prevent constipation 2. Get up from bed slowly to prevent falling 3. Take before meals to prevent GI upset. 4. Take w/ or w/o food.		
Ketorolac	Nonsteroidal Anti-inflammatory	Moderate pain (pain 4)	15mg Q6	yes		Blacking Stomach pain HA Irritation	1. Take med w/ food to prevent GI upset. 2. Do not lay down after taking med to prevent irritation 3. Get up from bed slowly to prevent falling 4. Take w/ a full glass of water		
Ondansetron	Antiemetic	Prevent N/V	4mg Q6	yes		Diarrhea HA Blurred vision	1. Have some fluid to decrease if diarrhea prevent 2. Drink lots of fluids to prevent dehydration 3. Do not take med on larger amounts 4. If cyclical diarrhea let the nurse know		
piperacillin/tazobactam (Zosyn)	Antibiotic	treat infection	3.375g in 50 Q6	yes	IVB – Sodium chloride 0.9% 100ml Q6	HA N/V Diarrhea Constipation	1. Get some fluid to help w/ diarrhea 2. Drink fluid to prevent dehydration 3. Get up slowly to prevent falling 4. Blot feet to prevent swelling		
Albuterol	Bronchodilator	wheezing	2 puff Q6	Respiratory save this		Sore throat Chest pain Diarrhea	1. Keep pulse on or to monitor RR 2. Monitor BP to make sure it has good 3. Make sure the lungs sounds are clear before administering it 4. Drink fluid		

IMS Clinical Worksheet - PICU

Student Name: <u>Vinette Martinez</u> Date: <u>4/3/24</u>	Patient Age: <u>5</u> Patient Weight: <u>17 kg</u>
1. Admitting Diagnosis: <u>Asthma</u>	2. Priority Focused Assessment R/T Diagnosis: <u>Respiratory</u>
3. Signs and Symptoms: <u>warmth body</u> <u>Using Accessory muscles to breath</u> <u>fast breathing</u> <u>Trouble breathing</u>	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: <u>X-ray</u>
5. Lab Values That May Be Affected: <u>ABG</u> <u>pH Arterial 7.11 (7.35-7.45) Acidotic</u> <u>pH Venous 7.09</u> <u>Re-peat lab in one hour</u>	6. Current Treatment (Include Procedures): <u>Intubated</u> <u>NG tube/suction</u> <u>Catheter</u> <u>Femoral line</u>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. The patient was sedated, and wasn't showing any signs of pain but was using accessory muscles to breath. 1. place a pillow under her neck to keep the head comfortable 2. Try to move her extremities since she is bedridden	8. Patient/Caregiver Teaching: 1. Do not pull any of the lines 2. Try not to hold the baby due to all of the lines and tubes 3. Any Safety Issues Identified: - Aspiration - Irritation - Could possible be an infection?
9. Calculate the Maintenance Fluid Requirement (Show Your Work): D5NS 55ml/hr $\begin{array}{r} 10 \ 100 \ 1000 \\ 10 \ 50 \ 500 \\ \hline 35 \ 36 \ 700 \\ \text{ml/hr} \end{array}$ Combined Total Intake for Your Pt (mL/hr): <u>90ml/hr</u>	10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): $\begin{array}{r} 17 \\ \times 5 \\ \hline 85 \end{array}$ Actual Urine Output During Your Shift (mL/hr): Not observed but we administered/placed a catheter
Please list any medications you administered or procedures you performed during your shift: fentanyl 20mg ketamin 20mg paralytic 2mg Rocuron 80mg Assisted to watch a femoral central line be placed by the Dr, NG tube w/ suction, Catheter, start 2 IV's.	

PICU

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input checked="" type="checkbox"/> Unkept <b>Developmental age:</b> <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed	<b>Pulse:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input checked="" 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 type="checkbox"/> < 2 sec <input checked="" type="checkbox"/> 2 sec	<b>Social Status:</b> <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 <b>Social/emotional bonding with family:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input checked="" type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input type="checkbox"/> Equal <input checked="" type="checkbox"/> Unequal <input 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 type="checkbox"/> Closed <b>Extremities:</b> <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically <b>Grips:</b> Right <u>N</u> Left <u>N</u> <b>Pushes:</b> Right <u>N</u> Left <u>N</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 checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>Clear</u> <b>Stool Appearance:</b> <u>Not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>Femora @</u> <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>DS 55ml/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 type="checkbox"/> Right <input type="checkbox"/> Left Absent <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: <u>Intubated</u> <b>Trach:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input checked="" type="checkbox"/> Yes <input 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 <u>White</u> Consistency _____ <b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>D four</u> <b>Oxygen Saturation:</b> <u>90%</u> <u>Intubated</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NG/Suction</u> Location <u>NOSE</u> Inserted to _____ cm <input checked="" type="checkbox"/> Suction Type: <u>Salem</u>	<b>Color:</b> <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 <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input 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>Reddish</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> _____ <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>NG tube</u>	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>N/A</u> <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 checked="" 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 type="checkbox"/> All <b>Brace/Appiances:</b> <input type="checkbox"/> None Type: <u>Restraints</u>	<input type="checkbox"/> None <b>Type:</b> <u>Femoral Central line</u> <b>Location:</b> <u>@ leg</u> <b>Description:</b> _____ <b>Dressing:</b> <u>Intact</u>
	MOBILITY	TUBES/DRAINS
	<input 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 checked="" type="checkbox"/> Bedridden	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube <b>Site:</b> <u>NOSE</u> <b>Type:</b> <u>NG tube</u> <b>Dressing:</b> _____ <b>Suction:</b> <u>Salem</u> <b>Drainage amount:</b> _____ <b>Drainage color:</b> <u>White</u>

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													
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: 0 1 2 3
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 2 3
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) _____
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

- The patient was sedated  
 - CPAP but then switch to get the patient intubated

55  
54  
53  
52  
51

### CHEWS Scoring and Escalation Algorithm

	0	1	2	3
<b>Behavior/Neuro</b>	- Playing/sleeping appropriately OR - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed	- Irritable, difficult to console OR - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish
<b>Cardiovascular</b>	- Skin tone appropriate for patient - Capillary refill $\leq 2$ seconds	- Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new)	- Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia	- 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
<b>Respiratory</b>	- Within normal parameters - No retractions	- 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	- 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	- 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
<b>Staff Concern</b>		- Concerned		
<b>Family Concern</b>		- Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
- Continue Routine Assessments	- 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	- 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>

fentanyl 20mg  
ketamin 20mg  
paralytic 2mg  
Rocphin 80mg

Student Name: Vanessa McInerz

Unit: PICU

Pt. Initials: \_\_\_\_\_

Date: \_\_\_\_\_

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

Allergies: \_\_\_\_\_

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IV Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
DS	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?			
Fentanyl	Opiate		20mg				Respiratory depression	<ol style="list-style-type: none"> <li>1. Assess respiratory</li> <li>2. If O2 sat from hypoxia notify HCP</li> <li>3. Bibl Bxyl Administration</li> <li>4. Alleviate pain w/ VS</li> </ol>
Ketamin	Schedule III non-narcotic		20mg				Cloudy urine burning white urination	<ol style="list-style-type: none"> <li>1. If blood noted in the catheter is</li> <li>2. Get up slowly if can make a pr dirty</li> <li>3. Drink fluids she it can make you</li> <li>4. Do not use (water if can make you sweat)</li> </ol>
Paralytic			2ns				DIZZINESS Chest pain	<ol style="list-style-type: none"> <li>1. Eat some fiber to prevent diarrhea</li> <li>2. Drink lots of fluids to prevent dehydration</li> <li>3. Let the nurse know if diarrhea happens</li> <li>4. Allowly mental labs she it can be hard on the liver</li> </ol>
Rocphin	Antibiotic		840mg					

not sure which one they use