

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: David Oliva Date: 04/02/24</p>	<p>Patient Age: 9 yrs Patient Weight: 28.4 kg</p>
<p>1. Admitting Diagnosis: Appendicitis</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Abdominal</p>
<p>3. Signs and Symptoms: Abd pain guarding fever N/V</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: CBC for ↑ WBC, Imaging - XRay MRI CT Ultrasound</p>
<p>5. Lab Values That May Be Affected: ↑ WBCs ↑ CRP</p>	<p>6. Current Treatment (Include Procedures): Appendectomy</p>
<p>7. Pain & Discomfort Management: List 2 <u>Developmentally Appropriate</u> Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ol style="list-style-type: none"> Guided Imagery Tactile Stimulation - Buzzy Bee 	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> have adequate rest after procedure to aid in recovery ↑ Fluids → prevent dehydration + constipation Avoid lifting heavy objects <p>Any Safety Issues Identified:</p>

<p>Student Name: David Olive Date: 04/02/2024</p>	<p>Patient Age: 9 yrs Patient Weight: 28.4 kg</p>
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work): 28.4 kg 10 kg x 100 = 1000 ml 10 kg x 50 = 500 ml → 1668 ml/day 8.4 kg x 20 = 168 ml → 169.5 ml/hr</p> <p>Actual Pt MIVF Rate: 70 ml/hr</p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate? NO</p> <p>If Yes, Why Is There a Discrepancy?</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): 0.5 mL/kg/hr 0.5 x 28.4 = 14.2 ml/hr</p> <p>Actual Urine Output During Your Shift (mL/hr): I did not see any urine output on the shift myself nor on the chart</p>
<p>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:</p> <p>Erickson Stage: Industry vs. Inferiority</p> <ol style="list-style-type: none"> 1. Complete tasks - Shower 2. ↑ self esteem - happiness when ambulating <p>Piaget Stage: Concrete - pre operational</p> <ol style="list-style-type: none"> 1. Humor - understand jokes told in TV shows he was watching 2. Logically organizes things in logical order - pain numeric scale 	
<p>Please list any medications you administered or procedures you performed during your shift:</p> <ul style="list-style-type: none"> - Head-to-toe Assessment - Prepared pt + caregiver to give shower - Daily weight 	

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 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 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
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 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 _____ 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 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 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>type 4, brown</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <input checked="" type="checkbox"/> AC <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/ Location: <u>2g</u> Appearance: <input checked="" type="checkbox"/> No Redness/ Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>D5NS + ACU 20</u>
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>Index finger</u> Oxygen Saturation: <u>97%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input 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 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 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 checked="" 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 checked="" type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/ Description: <u>dry</u> Mucous Membranes: Color: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>regular</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>@ leg</u> 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 type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: <u>incision</u> Location: <u>umbilical LLTA</u> Description: <u>laparoscopic incision</u> Dressing: <u>gauze tape</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 checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pediatric Floor Patient #2

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
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 type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed	Pulse: <input 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 _____ L _____ Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" 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 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 _____ 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 Extremities: <input 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>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>Green, soft</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 type="checkbox"/> Central Line Type/ Location: _____ 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 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>R foot</u> Oxygen Saturation: <u>97%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input 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 type="checkbox"/> No Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>G1</u> Location <u>Abd</u> Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	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 checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds 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: _____ Mucous Membranes: Color: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>NIUT + Migen</u> Amount/Schedule: <u>190 ml</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>Q Leg</u> Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input checked="" 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 checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input checked="" type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: <u>G-tube</u> Location: <u>Abd</u> Description: <u>G-tube feeding</u> Dressing: _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" 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 checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pediatric Floor Patient #2

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
Intake - PO Meds													
Enteral Tube Feeding		190											190
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		42											42
# of immeasurable		1											1
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) 0
	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 #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	70	70		70									2100
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 <u>0</u>
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3 <u>0</u>
Respiratory	Circle the appropriate score for this category: 0 1 2 3 <u>0</u>
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

Student Name: David Oliva

Unit: PE01-FL

Pt. Initials: SL

Date: 8/02/24

Allergies: NKDA

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

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?			
Acetaminophen 0.1g/ml	Analgesic antipyretic	V Fever & Control Pain	426mg 96hrs IV	296mg-429mg yes		10 mg/ml Infused over 15min	BBW - Nestability if given too much	1. monitor LFTs 2. monitor Temperature 3. Notify of any dark urine 4. Notify if yellowing skin/eyes
Diclofenac	Antiinfective	NIV Control	PRN IV 2.86mg 94hrs	0-1mg/kg yes		2mg/ml Undiluted 1-5 min	Mild Case H/A	1. monitor BP 2. Notify of abnormal Heartbeat 3. Notify of Chest Pain 4. Notify of Confusion/hallucinations
Dexamethasone	Glucocorticoid	Anti-inflammatory	PRN IV	8.55mg - 57.2		4mg/ml Push / 4min	Severe HA increased Heartbeats	1. monitor Hemoglobin 2. monitor K+ 3. Notify of intense HA 4. Ween/ taper off (DO NOT STOP abruptly)
Formaldehyde paracetid	H2 Antagonist	GI Ulcer Prosthetics	14.3mg 2 times daily IV	14.3-28.6 yes		10mg/ml Push 72 min	Anxiety Blood in urine Fast, regular HR	1. monitor Gastric pH 2. Notify of any Fast HR 3. Notify of any black stools 4. Notify Cause HA

Student Name: David Oliva

Unit: PEDI-EL

Pt. Initials: N.R.

Date: 04/02/24

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

Allergies: _____

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
<u>No Fluids</u>	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?			
<u>Enoxaparin</u>	<u>Anti coagulant</u>	<u>DVT Prophylaxis</u>	<u>7.8mg Sub Q q 12hrs</u>	<u>1mg/kg</u>	<u>yes</u>		<u>BCU, Hemorrhage</u>	<ol style="list-style-type: none"> 1. Do not Admin I/M 2. Do not rub injection site 3. monitor PH ct 4. Switch S/S's any m/s.
<u>Glycopyrrolate</u>	<u>Anticholinergic U/L or drugs</u>	<u>Reduce secret drooling</u>	<u>0.02mg/kg NG tube q 8hrs</u>	<u>1.154mg</u>	<u>yes</u>		<u>dry diapers fussiness</u>	<ol style="list-style-type: none"> 1. Do not use if Urinary Problems 2. Avoid Hot temperatures 3. ↑ Fluids 4. may cause
<u>levetiracetam (Keppra)</u>	<u>Anti convulsant</u>	<u>Prevent seizures</u>	<u>200mg PO q 12hrs</u>	<u>154-231</u>	<u>yes</u>		<u>Stile S/S's, Somnolence</u>	<ol style="list-style-type: none"> 1. monitor Liver function 2. Monitor RBCs 3. Notify of rash on skin 4. May cause dizziness
<u>Polyethylene glycol</u>	<u>Laxatives</u>	<u>Softens stool</u>	<u>4.25g orally Feeding tube</u>	<u>1.54-11.55</u>	<u>yes</u>		<u>Electrolyte imbalance N/V/D</u>	<ol style="list-style-type: none"> 1. monitor Electrolytes 2. may take a few days to see effect 3. Notify of any vomiting 4. Notify of watery stools
<u>Pretaminipren (Dione)</u>	<u>Analgesic</u>	<u>Pain for Control of DHP</u>	<u>76.8mg for GI tube q 6hrs PRN</u>	<u>77-115.5kg</u>	<u>NO</u>		<u>BBU, Hepatotoxicity</u>	<ol style="list-style-type: none"> 1. monitor LFTs 2. monitor temperature 3. notify about urine 4. Notify of yellowing skin/eyes

Adopted: August 2016

0.4 average of 7.68 x 9

David

Pediatric ED Reflection Questions

1. What types of patients (diagnoses) did you see in the PED?
Asthma, Allergic Reaction
2. The majority of the patients who came in to the PED were from which age group? Was this what you expected? Adolescence, not what I expected, ~~I~~ expected more toddlers, there was still some
3. Was your overall experience different than what you expected? Please give examples.
A little bit, expected more chaos
4. How did growth and development come into play when caring for patients (both in triage and in treatment rooms)?
The way you talk to the pt, the way they act, siblings act
5. What types of procedures did you observe or assist with?
6. What community acquired diseases are trending currently?
7. What community mental health trends are being seen in the pediatric population?
SI - teens - Adolescence - >12 yrs
8. What patient population is the most vulnerable?
9. What is the process for debriefing after a traumatic event?
10. If someone donated \$100 million to the PED, what would you change?
11. What is the process for triaging patients in the PED?
12. What role does the Child Life Specialist play in the PED?

Suicidal
Idiation