

### IM5 Clinical Worksheet – PICU

<b>Student Name:</b> Joe Moreno <b>Date:</b> 04/16/24	<b>Patient Age:</b> 7 <b>Patient Weight:</b> 11 kg
<b>1. Admitting Diagnosis:</b> Seizures	<b>2. Priority Focused Assessment R/T Diagnosis:</b> Neuro assessment
<b>3. Signs and Symptoms:</b> • twitching/jerking of body	<b>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:</b> EEG
<b>5. Lab Values That May Be Affected:</b> • Serum electrolytes	<b>6. Current Treatment (Include Procedures):</b> KEPRA TRILEPTAC Oxygen Suction PRN
<b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.  1. Mom @ bedside  2. Padding	<b>8. Patient/Caregiver Teaching:</b> 1. turn on side if vomiting occurs 2. support head 3. nothing placed in mouth during seizure.  <b>Any Safety Issues Identified:</b> N/A
<b>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</b> $\begin{array}{r} 10 \times 100 \\ 1 \times 50 \end{array} = \frac{1000}{50} = 20$ $20 + 24 = 44 \text{ mL/hr}$ <b>Combined Total Intake for Your Pt (mL/hr):</b> 75 mL/hr	<b>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</b> $0.5 \times 11 = 5.5 \text{ mL/hr}$ <b>Actual Urine Output During Your Shift (mL/hr):</b> N/A • no output seen.
<b>Please list any medications you administered or procedures you performed during your shift:</b> N/A	

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 type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location <u>Right Knee</u> <input checked="" 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>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	<b>Social Status:</b> <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 <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" 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 type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input type="checkbox"/> Equal <input 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 checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right _____ Left _____ Pushes: Right _____ Left _____ 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Urine Appearance:</b> _____ <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>Right PIC</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> _____ <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 type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input checked="" 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 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 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 _____ Consistency _____ <b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>Oral</u> <b>Pulse Ox Site:</b> <u>finger</u> <b>Oxygen Saturation:</b> <u>98</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 checked="" 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 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 <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: <u>pink</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 type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 <u>0</u> 1200 <u>0</u> 1600 <u>0</u>
	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 <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 type="checkbox"/> None Type: _____	<input 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 <u>vision deficit</u> <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 <input checked="" type="checkbox"/> Drain/Tube <b>Site:</b> <u>Trachea</u> <b>Type:</b> <u>Tracheal Intubation</u> <b>Dressing:</b> _____ <b>Suction:</b> <u>Oral</u> <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													
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						45	45	45	45				180
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) <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

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Joe Moreno Date: 04/17/24</p>	<p>Patient Age: 14 mo Patient Weight: 9.4 kg</p>
<p>1. Admitting Diagnosis: Hypoxia secondary to Human Metapneumovirus</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Respiratory</p>
<p>3. Signs and Symptoms: • Low O<sub>2</sub> reading <sup>contact/droplet iso.</sup> • cyanosis?</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: Pulmonary function Test Pulse Oximetry.</p>
<p>5. Lab Values That May Be Affected: O<sub>2</sub> levels</p>	<p>6. Current Treatment (Include Procedures): 3L NC Antibiotics</p>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient. 1. Mom @ bedside 2. non-nutritive sucking w/ pacifier</p>	<p>8. Patient/Caregiver Teaching: 1. S/S of hypoxia (cyanosis) 2. no petroleum-based products 3. Elevation of head to allow chest expansion Any Safety Issues identified: * visitor did not apply CPE equipment before entering Room</p>

Student Name: Date:	Patient Age: Patient Weight:      kg
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> $9.4 \times 100 = 940$ $\frac{940}{24}$ $39 \text{ mL/hr}$ <p>Actual Pt MIVF Rate:</p> <p>60 mL</p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate?</p> <p>If Yes, Why is There a Discrepancy?</p> <p>bottle intake</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> <p>9.4 mL/hr</p> <p>Actual Urine Output During Your Shift (mL/hr):</p> <p>0</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: Trust vs. Mistrust</p> <ol style="list-style-type: none"> <li>1. Patient cried for bottle; mom provided</li> <li>2. Patient was kept warm by mom.</li> </ol> <p>Piaget Stage: Sensorimotor</p> <ol style="list-style-type: none"> <li>1. Patient hitting bottle against frame</li> <li>2. Grasping for bottle when out of reach</li> </ol>	
<p>Please list any medications you administered or procedures you performed during your shift:</p> <p>N/A</p>	

## Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" 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 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>8+</u> L <u>3+</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 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 <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" 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 type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input checked="" 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>N</u> Left <u>N</u> Pushes: Right <u>N</u> Left <u>N</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 type="checkbox"/> No	<b>Urine Appearance:</b> _____ <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input 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 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 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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input checked="" type="checkbox"/> Nasal Cannula: <u>3</u> 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> <u>100</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 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 <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 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 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>Prep App Regular</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>8oz</u>	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 <u>0</u> 1200 <u>0</u> 1600 <u>0</u>
	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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input checked="" type="checkbox"/> LL <input 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 checked="" 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 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> _____

**Pediatric Floor Patient #1**

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**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						202	202						120 ml
<b>IV INTAKE</b>	<b>07</b>	<b>08</b>	<b>09</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>Total</b>
IV Fluid													
IV Meds/Flush													0
<b>OUTPUT</b>	<b>07</b>	<b>08</b>	<b>09</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>Total</b>
Urine													
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													0

**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) <u>2</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**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input 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 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>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	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" 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 type="checkbox"/> Equal <input 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 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>Clear</u> <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>Right ext</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> <u>Wrist</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>dextrose 5% &amp; Sodium Chloride 0.9% with KCL 20meq/L</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 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 checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> <u>96</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 checked="" 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 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 <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: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>Clear liquid</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 <u>0</u> 1200 <u>0</u> 1600 <u>0</u>
	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 <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 checked="" 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 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> _____

## 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													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						100	100	100	100				240 mL
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine						12 mL		1 mL					18 mL
# 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) <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: De Moreno

Unit: Pedi

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

Date: 04/17/24

Allergies: NKA

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
N/A	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?			
Cefdinir	3 <sup>rd</sup> gen cephalo-sporin	Antibiotic	PO 125mg daily	120.4mg/24hr	Yes	X	GI upset Diaper rash	1. Monitor for severe watery diarrhea. 2. taken w or w/o food 3. take full course 4. NO shaving of medication.
Aceta-minophen	misc. Analgesics	Pain & Fever Reliever	PO 140.8mg q 4hr PRN	≤ 5 doses in 24hr	Yes	X	Nausea Vomiting Constipation	1. Taken w/ food to ↓ GI upset 2. Shave before use 3. never give more than 5 doses 4. Avoid food w/ acetaminophen included (cold/flu)
Ibuprofen	NSAIDS	Pain & Fever Reliever	PO 94mg q 6hr or PRN	70.5-94	yes	X	HEA w/v ↑ bleeding	1. Take w/ food to ↓ GI upset 2. Monitor for GI bleeding 3. Gentle oral care 4. Never exceed 4 doses in 24 hr period
								1. 2. 3. 4.

Student Name: \_\_\_\_\_

Unit: \_\_\_\_\_

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

Date: 04/17/24

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

Allergies: Hazelnut

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Intervention (Precautions/Contraindications, Etc.)
				Is med in therapeutic range? If not, why?				
Aceta- minophen	Misc. Analgesics	Pain Reliever	IV 150-200mg q 4hrs	≤ 5 doses per 24hr NO? *to 10 24hr		X	N/V constipation *usually none	1. Never give more than 5 doses in 24hr. 2. Avoid other products containing acetaminophen (cold/flu) 3. Take as directed - taking longer can cause liver, kidney issues 4. Monitor for pain relief
Ondans- etron	5HT3 receptor antagonists	Nausea Vomiting Relief	IV 1.0mg q 8hr or PRN	1.7mg/hr Yes		X	Drowsiness Diarrhea Constipation	1. Taken w or w/o food 2. may need laxatives if constipation 3. Avoid getting around w/o assistance (fall) 4. Monitor bowel function.
Zinc Oxide Cod Liver Oil lanolin 40% paste	Misc. topical agents	Diaper Rash	Topical PRN	Yes; Apply liberally as needed		X	Worsening of diaper Rash	1. Apply thick layer 2. touch irritated skin as little 3. have rash open as possible 4. keep dryness as possible
Pexmose 0.9% dium chloride w/ Zonta KCl	Intravenous nutritional products	fluid & electrolyte replacement	IV 100mg/hr contin- uous	Yes		X	irritation/ infection @ site	1. frequent electrolyte monitoring 2. Monitor for signs of fluid overload 3. keep site dry & intact 4. Monitor site w/ gloves / technique