

Student Name: Rosalina

Unit: PFD-2

Pt. Initials: RT

Date: 04-30-2024

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

Allergies: WKA

| Primary IV Fluid and Infusion Rate (ml/hr) | Circle IVF Type | Rationale for IVF | Lab Values to Assess Related to IVF | Contraindications/Complications | | | |
|--|------------------------------|--------------------------|-------------------------------------|---|---|---|---|
| D5NS + 20K | Isonic/Hypotonic/Hypertonic | Stabilize BP & nutrients | Na+, K+ | Fluid overload / Do not use in DKA, or impaired kidney function | | | |
| Generic Name | Pharmacologic Classification | Therapeutic Reason | Dose, Route & Schedule | Therapeutic Ranges? 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.) |
| Albuterol | Bronchodilator | Asthma | 5mg/ml 2.5mg BID | 1.75-5mg/ml yes | | ↑ blood glucose ↓ K+ oral intake | 1. Rinse mouth after IVPB 2. Notify at any heartbeats 3. Keep nearby 4. may cause nausea |
| Cloxacillin in clearance | Antibiotic | Pharyngitis | 300mg 50-1 96h | 6/14mg - 1128mg/day pos. SR Randomly | 300mg/50ml 100ml/hr | BW: may cause C-diff. cause diarrhea | 1. notify of urinary stools 2. notify yellowing of eyes 3. notify any pain in IV site 4. may cause N/V |

Student Name: D. Oliver

Unit: PR2

Pt. Initials: 384

Date: April 30, 2024

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

Allergies: _____

NO MEDS

| 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, Interventions (Precautions/Contraindications, Etc.) |
|--------------|------------------------------|--------------------|------------------------|--|--|--|-----------------|--|
| | | | | Is med in therapeutic range? If not, why? | | | | |
| | | | | | | | | 1. 2. 3. 4. |
| | | | | | | | | 1. 2. 3. 4. |
| | | | | | | | | 1. 2. 3. 4. |
| | | | | | | | | 1. 2. 3. 4. |

| | |
|---|--|
| Student Name: David Olive Date: 04-30-2024 | Patient Age: 9 Patient Weight: 37.5 kg |
| <p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> $10 \times 100 = 1000$ $10 \times 50 = 500$ $11.5 \times 20 = 230$ $= 1,730 \text{ ml/day}$ $= 72 \text{ ml/hr}$ <p>Actual Pt MIVF Rate: 75</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> 0.5 /kg/hr 15.75 ml <p>Actual Urine Output During Your Shift (mL/hr):</p> |
| <p>11. Growth & Development:</p> <p>*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: <u>Industry vs. Inferiority</u></p> <ol style="list-style-type: none"> 1. <u>Dislikes real achievement</u> 2. <u>motivated to complete tasks</u> <p>Piaget Stage: <u>Concrete Operational</u></p> <ol style="list-style-type: none"> 1. <u>organizing in logical order</u> 2. <u>Has Humor!</u> | |
| <p>Please list any medications you administered or procedures you performed during your shift:</p> <p>- Assisted in changing PICC line caps</p> | |

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 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 checked="" type="checkbox"/> Restless <input checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/ Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent |
| NEUROLOGICAL | ELIMINATION | IV ACCESS |
| LOC: <input type="checkbox"/> Alert <input checked="" type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" 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 <u>2mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>5</u> Left <u>5</u> Pushes: Right <u>5</u> Left <u>5</u> 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: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy | Site: <input checked="" type="checkbox"/> <u>RA</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/ Location: <input checked="" type="checkbox"/> <u>brachial</u> Appearance: <input checked="" type="checkbox"/> No Redness/ Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____ |
| RESPIRATORY | GASTROINTESTINAL | SKIN |
| Respirations: <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <input checked="" type="checkbox"/> <u>Porter finger</u> Oxygen Saturation: <u>93%</u> | Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 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 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: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| NUTRITIONAL | MUSCULOSKELETAL | WOUND/INCISION |
| Diet/Formula: <u>regular</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <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: _____ | Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 _____ 1200 <u>0</u> 1600 _____ |
| 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 #1

| INTAKE/OUTPUT | | | | | | | | | | | | | | | | | | |
|----------------------|-----|----|----|----|-----|-----|----|----|-----|----|----|----|-------|--|--|--|--|--|
| PO/Enteral Intake | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total | | | | | |
| PO Intake | | | | | | | | | 175 | | | | 25 | | | | | |
| 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 | | | | | | | 39 | 75 | 75 | 75 | 75 | | 337 | | | | | |
| IV Meds/ Flush | | | | | | | 50 | | | | | | 50 | | | | | |
| | | | | | | | | | | | | | | | | | | |
| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total | | | | | |
| Urine | 120 | | | | 100 | 120 | | | | | | | 340 | | | | | |
| # of immeasurable | | | | | | | | | | | | | | | | | | |
| Stool | | | | | | | | | | | | | | | | | | |
| Urine/ Stool mix | | | | | | | | | | | | | | | | | | |
| Emesis | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |

75ml

| 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>4</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 |
|---|---|--|
| Appearance: <input type="checkbox"/> Healthy/ Well Nourished <input 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 type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec | Social Status: <input 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 Social/emotional bonding with family: <input 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 <u>2mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>3</u> Left <u>3</u> Pushes: Right <u>5</u> Left <u>5</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 type="checkbox"/> No | Urine Appearance: _____ Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy | Site: <u>4</u> <u>palmar</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input checked="" type="checkbox"/> No Redness/ Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____ |
| RESPIRATORY | GASTROINTESTINAL | SKIN |
| Respirations: <input type="checkbox"/> Regular <input 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 _____ Oxygen Saturation: _____ | 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 checked="" 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 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: <u>pink</u> <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 type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ 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 type="checkbox"/> All Brace/Appliances: <input type="checkbox"/> None Type: _____ | <input type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____ |
| | MOBILITY | TUBES/DRAINS |
| | <input 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

| INTAKE/OUTPUT | | | | | | | | | | | | | |
|----------------------|----|----|----|----|----|-----|----|----|----|----|----|----|-------|
| PO/Enteral Intake | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| PO Intake | | | | | | 150 | | | | | | | 150 |
| 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 | 96 | 96 | 36 | | | | | | | | | | 408 |
| IV Meds/ Flush | | 17 | | | | | | | | | | | 17 |
| 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 <u>GREEN</u> | 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 |