

Student Name: Bryanna Moreho
Date: 9/3

Patient Age: 5 months
Patient Weight: 5.48kg

1. Admitting Diagnosis and Pathophysiology
(State the pathophysiology in own words)

Failure to Thrive

2. Priority Focused Assessment R/T Diagnosis:

Abdominal
assessment

3. Identify the most likely and worst possible complications.

- damage to nervous system
- developmental delays
- behavior problems
- feeding intolerance

4. What interventions can prevent the listed complications from developing?

- daily wt
- parent education
- resources to buy formula

5. What clinical data/assessments are needed to identify these complications early?

- hx & physical
- observe feeding patterns
- wt & ht

6. What nursing interventions will the nurse implement if the anticipated complication develops?

- increase caloric & fluid intake
- schedule meals
- parental education on proper feeding

7. Pain & Discomfort Management:

List 2 Developmentally Appropriate
Non-Pharmacologic Interventions Related to
Pain & Discomfort for This Patient.

1. Non-nutritive sucking

2. parent involvement
with: holding, swaddling,
rocking

8. Patient/Caregiver Teaching:

1. don't supplement formula with juice - it has no nutritional value
2. hold the baby upright during feedings
3. feed less quantities more frequently

Any Safety Issues Identified:

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

- Acetaminophen

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input 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 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 type="checkbox"/> < 2 sec <input checked="" type="checkbox"/> > 2 sec Pulses: 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	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" 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 checked="" 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 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 checked="" type="checkbox"/> Soft <input checked="" 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>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>yellow</u> Stool Appearance: _____ <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 type="checkbox"/> Regular <input checked="" 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 finger</u> Oxygen Saturation: <u>92.1</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <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 Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input checked="" type="checkbox"/> Yes <input 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>clear</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MUSCULOSKELETAL	NUTRITIONAL	PAIN
<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 checked="" type="checkbox"/> None Type: _____	Diet/Formula: <u>Similac sensitive</u> Amount/Schedule: <u>6oz</u> 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>FLACC</u> Type: _____ Pain Score: <u>0</u> 0800 <u>X</u> 1200 1600
MOBILITY	WOUND/INCISION	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 Type: _____ Location: _____ Description: _____ Dressing: _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed			177ml										177ml
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													0
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)						
$5.48 \text{ kg} \times 20 = 109 \div 24 \text{ hr} = 4.6 \text{ mL/hr}$							177 mL/hr						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper			200ml	100ml									300ml
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$1 \text{ mL/kg} \times 5.48 \text{ kg} = 5.48 \text{ mL/hr}$ $24 \text{ hr} \times 5.48 = 132 \text{ mL/d}$							300 mL						

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>3</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

no meds (in 24 hrs)

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed				260mL									260mL
Intake – PO Meds			86.25mL (GI-tube)										86.25mL
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid			20mL										20mL
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work)						Actual Pt IV Rate							
53.1 kg						Rationale for Discrepancy (if applicable)							
$10 \times 100 = 1,000$ $10 \times 50 = 500$ $33.1 \times 20 = 662$ $2162 \div 24 = 90 \text{ mL/hr}$													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper			900mL										900mL
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output						Average Urine Output During Your Shift							
$0.5 \text{ mL/kg} \times 53.1 = 26.55 \text{ mL/hr}$ $24 \text{ hr} \times 26.55 = 637 \text{ mL/day}$						900 mL							

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>9</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

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 type="checkbox"/> Normal <input checked="" 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 type="checkbox"/> < 2 sec <input checked="" type="checkbox"/> > 2 sec Pulses: 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	Social Status: <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 checked="" type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Unresponsive Oriented to: N/A <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 type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Level <u>5</u> Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>yellow</u> Stool Appearance: <u>watery, brown</u> <input checked="" type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>L FOREARM</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 checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Pressing 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 type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Room Air <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size <u>6.5</u> Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>clear</u> Consistency <u>mucoous</u> Suction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>Left big toe</u> Oxygen Saturation: <u>96.1</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" 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 checked="" type="checkbox"/> No Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>GI-tube</u> Location <u>LUQ</u> Inserted to <u>18</u> 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 type="checkbox"/> Intact <input checked="" type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: <u>bruises @ L Forearm</u> Mucous Membranes: Color: <u>clear</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MUSCULOSKELETAL	NUTRITIONAL	PAIN
<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 checked="" type="checkbox"/> None Type: _____	Diet/Formula: <u>alpha mino jr</u> Amount/Schedule: <u>3x/d</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: _____ Type: <u>FLACC</u> Pain Score: 0800 <u>0</u> 1200 _____ 1600 _____ WOUND/INCISION <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____ TUBES/DRAINS <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: Bryanna Moreno
Date: 9/4

Patient Age: 10
Patient Weight: 53 kg

1. Admitting Diagnosis and Pathophysiology
(State the pathophysiology in own words)

Rhinovirus/Enterovirus
~ Respiratory infection

2. Priority Focused Assessment You Will
Perform Related to the Diagnosis:

Respiratory assessment

3. Identify the most likely and worst possible
complications.

- Asthma attack
- Bronchiolitis
- Bronchitis
- If long term: brain injury
- atelectasis

4. What interventions can prevent the listed
complications from developing?

- hand hygiene
- maintain airway
- IV fluids
- respiratory therapy
- O₂ therapy

5. What clinical data/assessments are needed to
identify these complications early?

- auscultate lungs
- pulmonary function test
- chest x-ray
- arterial blood gas test

6. What nursing interventions will the nurse
implement if the anticipated complication
develops?

- IV hydration
- nasal decongestants
- antihistamines, NSAIDs
- incentive spirometer
- O₂ therapy

7. Pain & Discomfort Management:

List 2 Developmentally Appropriate

Non-Pharmacologic Interventions Related to Pain
& Discomfort for This Patient.

1. movies/music
2. toys/fidget toys
for hands

8. Patient/Caregiver Teaching:

1. Use incentive spirometer -
to increase lung capacity
2. raise head of bed if they
are having SOB
3. increase fluid intake
to optimize oxygenation

Any Safety Issues identified:

Student Name: Bryanna Moreno Patient Age: 10
 Date: 9/4 Patient Weight: 53.1kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
albumin	3.0 ↓	
catc		
Platelet	142 ↓	increases the risk of bleeding
Metabolic Panel Labs		
albumin	3.0 ↓	malnutrition, liver disease + kidney disease
calcium	8.5 ↓	seizures, cardiac issues, muscle aches
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
Lab TRENDS concerning to Nurse?		
- decreased platelet count, albumin, cat		

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:

Pt is developmentally delayed,
 Erickson Stage: Trust vs. Mistrust

1. Pt depended solely on care giver
2. Pt displayed egocentrism + wanted their needs met

Piaget Stage: Sensorimotor

1. Pt displayed repetitive, imitation behaviors, especially with their hands
2. Pt had object permanence with their ipad

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

Acetaminophen IV syringe

Student Name: Bryanna M.

Unit: PICU

Pt. Initials: _____

Date: 9/3

Allergies: iodine + adhesive tape

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

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?			
				Ace-taminophen	analgesic anti-pyretic			
							1. 2. 3. 4.	
								1. 2. 3. 4.
								1. 2. 3. 4.
								1. 2. 3. 4.