

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 <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	N/A	N/A	N/A

Student Name:	Unit:	Patient Initials:	Date:	Allergies:
Kota Kyser	PF-2	C.C., & B.W. (56 & 57)	10/29/2024	56 - NKDA. 57 - Lactose intolerant.

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	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.)
Ibuprofen (56)	NSAID	Given to reduce Pain/fever	100 mg, PO, PRN	Yes 5-10 mg/kg/dose 56.5-113 mg/dose	N/A	GI bleed, ulceration, and perforation.	<ol style="list-style-type: none"> Do not exceed 565 mg/day to minimize the risk of adverse reactions. If GI upset occurs, this medication can be given with food. This medication is contraindicated for patients with asthma, so be sure to double check with the physician when prescribed this medication. This medication is hard on the kidneys (nephrotoxicity), so be sure to stay hydrated by drinking water frequently (if not NPO).
Acetaminophen (56)	Analgesic, Antipyretic.	Given to reduce Pain/fever	166.4 mg, PO, PRN	Yes 10-15 mg/kg. (113mg-169.5mg)	N/A	Severe skin reaction, anemia, thrombocytopenia.	<ol style="list-style-type: none"> Do not exceed 847.5 mg/day (peds dose: max of 75 mg/kg/day) to minimize the risk of following complications. BLACK BOX WARNING: ensure accuracy when dispensing and administering this medication because overdoses could cause death.

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

Student Name: Kota Kyser		Unit: PF-2	Patient Initials: C.C., & B.W. (56 & 57)		Date: 10/29/2024	Allergies: 56 - NKDA. 57 - Lactose intolerant.	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	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.)
							<p>3. BLACK BOX WARNING: This medication is hard on the liver (hepatotoxicity), and may cause acute liver failure.</p> <p>4. This medication has a risk of causing skin reactions, such as itching or rashes. Let the caregiver(s) know if this is found and lotion or other interventions may be provided.</p>
Albuterol (56)	Adreni bronchodilator.	Given to relax and open the airway to allow for better breathing.	2.5 mg/3 mL, Nebulizer, PRN	Yes 0.1 - 0.2 mg/dose 1.13 - 2.26 mg/dose	N/A	Tremor, Angina, HTN	<p>1. Do not exceed 135.6 mg/day to minimize risk adverse effects.</p> <p>2. Thie medication may cause headaches and dizziness, so be sure to ask for help if you need to get up for any reason.</p> <p>3. This medication may cause muscle cramps, so stretching or ice may be used to relax the affected muscles.</p> <p>4. This medication may cause insomnia. Avoid taking this medication close to bed time to minimize the risk of insomnia.</p>

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

Student Name: Kota Kyser		Unit: PF-2	Patient Initials: C.C., & B.W. (56 & 57)		Date: 10/29/2024	Allergies: 56 - NKDA. 57 - Lactose intolerant.	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	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.)
Patient in 57 had no meds to write up.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Choose an item. Click here to enter text.	Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.

IM5 Clinical Worksheet – Pediatric Floor

57

<p>Student Name: Keta Rysor Date: 10/29/24</p>	<p>Patient Age: 3 1/6 Patient Weight: 17.0 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</p> <p>admitted for a sleep study w/ EEG. Dx of Epilepsy, but still on EEG for sleep study. Seizure-like activity.</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>Neurologic assessment</p>
<p>3. Identify the most likely and worst possible complications.</p> <p>Seizures leading to injury would be the worst. Most likely outcome is that the cause of the seizures is found & treated.</p>	<p>4. What interventions can prevent the listed complications from developing?</p> <p>Seizure precautions.</p>
<p>5. What clinical data/assessments are needed to identify these complications early?</p> <p>EEG, Neuro assessments.</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <p>Seizure precautions, RR team.</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate <u>Non-Pharmacologic Interventions</u> Related to Pain & Discomfort for This Patient.</p> <p>1. Distraction through watching coloring videos. 2. Playing w/ transitional object.</p>	<p>8. Patient/Caregiver Teaching:</p> <p>1. Sleeping w/ fewer or no blankets. tuck-in. 2. Padding on bed railing. 3. Mats given on schedule (if prescribed).</p> <p>Any Safety Issues identified:</p> <p>• no padding currently on railing. • 2 blankets in bed.</p>

Ryser

Pediatric Floor Patient #1

57

10/24/2024

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 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 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 <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 checked="" 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 type="checkbox"/> No	Urine Appearance: <u>clear, yellow</u> Stool Appearance: <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>LB M 10/28/24, PM.</u>	Site: _____ <input type="checkbox"/> INT <input checked="" 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 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 great toe.</u> Oxygen Saturation: <u>97%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input 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 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: <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: <u>regular (9, 12, 18)</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces Location: _____ Type: <u>Wong</u> Pain Score: <u>0 @ 14:21</u> 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 checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	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: _____

LB M: Monday, 10/28/24

Student Name: <i>Kota Nyser</i> Date: <i>10/21/24</i>	Patient Age: <i>3Y</i> Patient Weight: <i>17.0kg</i>
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Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
Lab TRENDS concerning to Nurse?		
<i>No labs drawn or ordered.</i>		

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:

Erickson Stage:

- Autonomy*
1. ~~Initiative~~ vs. Shame & Doubt
 2. Initiative vs. Guilt.

Piaget Stage:

1. Sensorimotor
2. Pre-operational Period

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

None. I did watch the nurse set up a platelet in fusion though.

Ky54

10/21/24

Pediatric Floor Patient #1

INTAKE/OUTPUT													
	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO/Enteral Intake													
PO Intake/Tube Feed							15	-	-	15	-	-	30
Intake - PO Meds							-	-	-	-	-	-	0
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													0
IV Meds/Flush													0
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$10 \times 100 = 1000$ $7 \times 50 = 350$ $\frac{1350}{24} = 56.25 \text{ mL/hr}$ $1350/\text{day}$							None. Rationale for Discrepancy (if applicable) None.						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper				200			-	-	-	-	-	-	200
Stool													0
Emesis													0
Other													0
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$17 \text{ kg} \times 0.5 = 8.5 \text{ mL/hr}$ 0.5 mL/kg/hr							$200 \text{ mL} / 8 \text{ hr} = 25 \text{ mL/hr}$ 28.57 mL/hr						

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: <input checked="" type="radio"/> 0 1 2 3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0 1 2 3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 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

IM5 Clinical Worksheet – PICU

Student Name: <i>Kata Kysor</i> Date: <i>10/30/24</i>	Patient Age: <i>27</i> Patient Weight: <i>11 kg</i>
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) <i>Altered Neuro status; Malnutrition. Severe abuse</i>	2. Priority Focused Assessment R/T Diagnosis: <i>Neuro/Pain.</i>
3. Identify the most likely and worst possible complications. <i>Most Likely: BP & HR too low. Worst: Malnutrition leads to his passing. Pain.</i>	4. What interventions can prevent the listed complications from developing? <i>TPN, Epi, Vasopressors.</i>
5. What clinical data/assessments are needed to identify these complications early? <i>Neurological assessment Pain assessment Social history data (family)</i>	6. What nursing interventions will the nurse implement if the anticipated complication develops? <i>administer medications to raise BP/HR, administer PRN pain meds meds.</i>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. <i>Distraction w/ toys.</i> 2. <i>Distractions w/ other family (Play)</i>	8. Patient/Caregiver Teaching: 1. <i>Teach Parent not to be abusive.</i> 2. <i>Proper hand nutrition, specifically for his age.</i> 3. <i>wound care for back-of-head wound</i> Any Safety Issues Identified: <i>Father & the Step mother</i>
Please list any medications you administered or procedures you performed during your shift: <i>I saw the & took the patient to an MRI ART blood draw</i>	

PICU

R777

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input checked="" type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input type="checkbox"/> Delayed <i>Sedated</i>	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input checked="" type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ 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>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 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 (<i>But sedated</i>)
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" 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>4</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>N</u> Left <u>N</u> Pushes: Right <u>N</u> Left <u>N</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>N/A</u> <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>Enema to be given later</u>	Site: <u>Distal Perit. L</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input checked="" 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 Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>NS @ 30 ml/hr, Lots of med.</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input checked="" type="checkbox"/> Retractions (type) <u>Subcostal</u> <input checked="" type="checkbox"/> Labored Breath Sounds: <u>could not assess</u> 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 checked="" type="checkbox"/> Vent: ETT size <u>4</u> @ <u>14.5</u> 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 checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NG</u> Pulse Ox Site: <u>@ great toe.</u> Oxygen Saturation: <u>100%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input checked="" 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>NG</u> <input checked="" type="checkbox"/> Location <u>@ nose</u> Inserted to <u>4</u> cm <input checked="" type="checkbox"/> Suction Type: <u>low</u>	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input type="checkbox"/> Warm <input checked="" type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input type="checkbox"/> < 5 seconds <input checked="" type="checkbox"/> > 5 seconds Skin: <input type="checkbox"/> Intact <input checked="" type="checkbox"/> Bruises <input checked="" type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: <u>Back of head</u> Mucous Membranes: Color: <u>pink-grey</u> <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>TPN</u> Amount/Schedule: <u>continuous</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input 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 checked="" 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>Wound</u> Location: <u>Back of head/occipital</u> Description: <u>deep, gash-like</u> Dressing: <u>gauze</u>
	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 checked="" type="checkbox"/> Bedridden	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>Left naze.</u> Type: <u>NG</u> Dressing: <u>tape</u> Suction: <u>low</u> Drainage amount: <u>520ml @ 16:00</u> Drainage color: <u>clear</u>

too many tubes, leads, and dressings.

sedated, on a lot of pain meds. many wounds.

Patient was sedated the whole time to varying levels.

PICU

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed	[Handwritten scribbles]												-
Intake - PO Meds	[Handwritten scribbles]												-
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	[Handwritten scribbles]												40
IV Meds/Flush	[Handwritten scribbles]												35
													125
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)						
$\begin{array}{r} 10 \times 160 = 1000 \\ 1 \times 50 = 50 \\ \hline 1050 \\ 24 \end{array}$ 43.75 mL/hr (43.8 mL/hr)							$\frac{125}{4} = 31.25 \text{ mL/hr}$ (31.3 mL/hr)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	[Handwritten scribbles]												31
Stool	[Handwritten scribbles]												-
Emesis	[Handwritten scribbles]												-
Other	[Handwritten scribbles]												-
													31
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$\frac{1 \text{ mL}}{1 \text{ kg}} \times 11 \text{ kg} = 11 \text{ mL/hr}$							$\frac{31}{4} = 7.75 \text{ mL/hr}$						

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 <u>3</u> Lethargic
Cardiovascular	Circle the appropriate score for this category: 0 <u>1</u> 2 3 Mild tach. relative to pt's normal.
Respiratory	Circle the appropriate score for this category: 0 1 2 <u>3</u> Vent
Staff Concern	<u>1</u> pt - Concerned
Family Concern	<u>1</u> 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