

## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Gillian Cardenas <b>Date:</b> 11/20/2024</p>	<p><b>Patient Age:</b> 4 months <b>Patient Weight:</b> 5.08 kg</p>
<p><b>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</b> RSV – Infects the cells that line the airway. This causes inflammation, mucous, and swelling which can cause difficulty breathing. Enterovirus – virus that infects cells in respiratory or stomach. This virus spreads in the bloodstream causing inflammation.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b> Respiratory assessment</p>
<p><b>3. Identify the most likely and worst possible complications.</b> Pneumonia  Respiratory failure/death</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b>  Monitor VS (O2 and respiratory rate), adequate hydration and nutrition, Respiratory support</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b> Watching vital signs. Respiratory panel, x-ray of chest.</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b> Start Antibiotics. Encourage deep breathing, Increasing oxygen. Infection control</p>
<p><b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <p>1. Pacifier</p> <p>2. Bottle of milk/ breast feeding on mom</p>	<p><b>8. Patient/Caregiver Teaching:</b></p> <p>1. Teach them to look for worsening signs of respiratory distress. Faster breathing than normal. Flaring nostrils, cyanosis</p> <p>2. Encourage parent to keep baby well hydrated/fed especially if baby is breast fed.</p> <p>3. Teaching them proper hand hygiene to try to prevent the spread of RSV.</p> <p><b>Any Safety Issues identified: None</b></p>

<b>Student Name:</b> Gillian Cardenas <b>Date:</b> 11/20/2024	<b>Patient Age:</b> 4 months <b>Patient Weight:</b> 5.08 kg
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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)	_____	_____
RSV _____	Detected	Knowing the virus the is making the child sick _____
Enterovirus _____	Detected	Knowing the virus that is making the child sick _____
Lab TRENDS concerning to Nurse?		
_____		

**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:** Trust vs Mistrust

1. Crying when taking medicine. Mom held baby after she was finished, and the baby calmed down immediately.
2. Every time we walked in the mom was holding the baby and she was always content and happy. This shows the trust the baby had in mom.

**Piaget Stage:** Sensorimotor stage

1. The baby was playing with a small rattle toy. She would smile each time it made a sound.
2. Rooting when she was hungry and being promptly fed by mom.

Please list any medications you administered or procedures you performed during your shift:  
 Enema, DC IV, Vital signs.

**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 type="checkbox"/> < 2 sec <input checked="" 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 checked="" 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 <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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> <b>Fontanel:</b> (Pt < 2 years) <input checked="" 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 type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>W</u> Left <u>W</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 checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>Clear/yellow</u> _____ <b>Stool Appearance:</b> <u>Brown Type 3</u> _____ <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 type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" 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>0.1</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 checked="" type="checkbox"/> No <b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color <u>clear</u> _____ Consistency <u>thin</u> _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>Big toe on left foot</u> _____ <b>Oxygen Saturation:</b> <u>92%</u> _____	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present X <u>1</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 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 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 type="checkbox"/> < 5 seconds <input checked="" 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>Nutramigen</u> <b>Amount/Schedule:</b> <u>2oz every 3-4hrs</u> <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"/> LACC <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 checked="" 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 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/Tube Feed	—	—	—	—	60	60	—	—	—	—	—	—	120ml
Intake – PO Meds	—	—	—	—	—	—	5	—	—	—	—	—	5 ml
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	—	—	—	—	—	—	—	—	—	—	—	—	—
IV Meds/Flush	—	—	—	—	—	—	—	—	—	—	—	—	—
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate _____						
5.0 kg $5.0 \text{ kg} \times 100 = 500 \text{ mL} / 24 \text{ hrs}$							Rationale for Discrepancy (if applicable) _____						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	—	—	—	—	—	—	66	—	—	—	—	—	66ml
Stool	—	—	—	—	—	—	66	—	—	—	—	—	66ml
Emesis	—	—	—	—	—	—	—	—	—	—	—	—	—
Other	—	—	—	—	—	—	—	—	—	—	—	—	—
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
1 mL/kg/hr $\frac{1 \text{ mL}}{1 \text{ kg}} = \frac{x}{5.0 \text{ kg}} = 5 \text{ mL/hr}$							$5.5 \text{ mL/hr}$						

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 _____ <input checked="" type="radio"/> 0   1   2   3 _____ _____
Cardiovascular	Circle the appropriate score for this category: 0 _____ <input checked="" type="radio"/> 0   1   2   3 _____ _____
Respiratory	Circle the appropriate score for this category: 1 _____ 0 <input checked="" type="radio"/> 1   2   3 _____ _____
Staff Concern	<input checked="" type="checkbox"/> 1 pt – Concerned _____
Family Concern	<input type="checkbox"/> 1 pt – Concerned or absent _____
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>2 (green)</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

<b>Student Name: Gillian Cardenas</b> <b>Date: 11/19/2024</b>	<b>Patient Age: 5 months</b> <b>Patient Weight: 7.38 kg</b>
<b>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</b> Closed fracture on the left side occipital bone. A break in the bone at the back of the head. This type of fracture doesn't penetrate the skin. But the Fracture can cause edema and swelling.	<b>2. Priority Focused Assessment R/T Diagnosis:</b>  Neurological assessment and Pain
<b>3. Identify the most likely and worst possible complications.</b>  Most likely complication is swelling and bruising.  Worst possible is TBI for a young child.	<b>4. What interventions can prevent the listed complications from developing?</b> - keep head elevate - Pain meds to reduce the pain and stress the child might be in - Watch all vital signs
<b>4. What clinical data/assessments are needed to identify these complications early?</b> Repeating the neurological assessment. . Watching the swelling of head. MRI or CT scan of brain	<b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b> - Give pain meds and meds to help with inflammation. - Call doctor if edema gets bigger - Watch respiratory system and give oxygen if breathing is affected
<b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b>  1. Mom had baby in a swaddle – the baby was quiet and sleeping.  2. Baby used a pacifier while BP was taking, and he never once cried. Was very content with Pacifier.	<b>8. Patient/Caregiver Teaching:</b> <b>1. Safe handling: This fall happen because dad dropped baby. Teach Dad how to safely handle child and keep baby safe.</b>  <b>2. Teach parent what signs and symptoms to watch for if neurological gets affected or worsens</b>  <b>3. Educate parent on the S/S of a fracture on the head will do when healing and all the abnormal S/S to bring child back to hospital</b>  <b>Any Safety Issues Identified: None</b>
<b>Please list any medications you administered or procedures you performed during your shift:</b> Took out a catheter	

PICU

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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location <u>Bulk head</u> <input checked="" type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input type="checkbox"/> < 2 sec <input checked="" 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 checked="" 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 <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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> <b>Fontanel:</b> (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 <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input checked="" 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 checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>Clear / yellow</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>left Antecubital</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <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>D5 1/2 NS + KCl 20</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 checked="" 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> <u>Big toe on Right foot</u> <b>Oxygen Saturation:</b> <u>95</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input 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 checked="" 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 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 type="checkbox"/> < 5 seconds <input checked="" 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>Breast milk</u> <b>Amount/Schedule:</b> <u>ad lib</u> <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"/> LACC <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 checked="" 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 Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

PICU

INTAKE/OUTPUT													
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed	—	—	—	125	38	—	—	—	—	—	—	—	163ml
Intake – PO Meds	—	—	—	—	—	—	—	—	—	—	—	—	—
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	30	30	30	30	30	30	—	—	—	—	—	—	180ml
IV Meds/Flush	—	—	—	—	—	—	—	—	—	—	—	—	—
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Combined Total Intake for Pt (mL/hr)</b>						
7.1 kg $7.1 \times 100 = 710 \text{ mL} / 24 \text{ hr}$							8.16 ml/24hr						
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	—	—	—	21	71	—	—	—	—	—	—	—	92ml
Stool	—	—	—	—	—	—	—	—	—	—	—	—	—
Emesis	—	—	—	—	—	—	—	—	—	—	—	—	—
Other	—	—	—	—	—	—	—	—	—	—	—	—	—
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>						
$\frac{1 \text{ mL}}{1 \text{ kg}} = \frac{x}{7.1 \text{ kg}} = 7.1 \text{ mL/hr}$							13.14 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: <u>0</u> _____ 0 1 2 3 _____ _____
Cardiovascular	Circle the appropriate score for this category: <u>0</u> _____ 0 1 2 3 _____ _____
Respiratory	Circle the appropriate score for this category: <u>0</u> _____ 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>0-green</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 Medication Worksheet – Current Medications & PRN for Last 24 Hours

Student Name: Gilian Cardenas		Unit: PEDI MEDSURG	Patient Initials: AM		Date: 11/20/2014	Allergies: NKDA	
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.)
Acetaminophen	Analgesic & antipyretic	For pain or fever	PRN 80 mg/2.5ml Q6hr PO	Yes	N/A	Liver failure, allergic reaction, GI upset, sedation for young child	<ol style="list-style-type: none"> <li>1. Watching fever and not letting it get too high. I would inform patients on S/S of a child experiencing fever and let them inform you if they notice anything different</li> <li>2. Offer adequate hydration and check hydration status</li> <li>3. Let parents know that GI upset is a known S/S and its normal if baby experiences some</li> <li>4. Use non pharmacological approach first or in addition to keep pain and fever down</li> </ol>
Ceftriaxone	Antibiotic	Pneumonia infection	250mg/0.9ml IM once	Yes	N/A	GI upset, rash, N/V, Abdominal pain	<ol style="list-style-type: none"> <li>1. Bring child life when giving IM injection. Teach parent to stay calm for child</li> <li>2. Let parent know the site will be sore for the child but shouldn't cause any other issues. The parent should assess the injection site and watch for any redness</li> <li>3. Inform parent of Allergic reaction S/S in a baby and to inform nurse if such reactions occur</li> <li>4. Let parents know that GI upset is normal</li> </ol>

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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.)
							and baby may have lose stroll due to the antibitoics
Cefinir	Antibitotic	Pneumonia Infection	37.5 mg/1.5ml BID PO	Yes	N/A	GI upset, N/V, abdominal pain, allergic reation, SJS	<ol style="list-style-type: none"> <li>1. S/S of respiratory distress. And to inofrm nurse if such event happens</li> <li>2. Lose stools are normal but if pt has more than 5 in a day let nurse/doctor know</li> <li>3. Patient should complete the rest of this antibitotic when at home. Shouldn't stop just cause symptoms stop</li> <li>4. Encourage parents to PO hydrate the child and let baby eat when hungry</li> </ol>
				No			<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>
				No			<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>