

11:20 LMA
Chill
(Low flow Air Cap)
Cynthia Card

Pediatric Floor Patient #1

12:15

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: IV Pal 3+ Upper R _____ L 3+ Lower R 3+ L 3+ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious 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 type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input 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 type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <input checked="" type="checkbox"/> Left <input checked="" type="checkbox"/> Pushes: Right _____ Left _____ S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Diapht	Urine Appearance: <u>Yellow</u> Stool Appearance: <u>Brown</u> <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>R 24 gey</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 checked="" type="checkbox"/> Retractions (type) <u>abdominal</u> <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 checked="" type="checkbox"/> Right <input checked="" 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 checked="" type="checkbox"/> Nasal Cannula: <u>3</u> L/min <input checked="" type="checkbox"/> BiPap/CPAP: <u>High flow Vent</u> <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 type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>Big Toe</u> 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 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: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>Similar Sensation</u> Amount/Schedule: <u>6oz q 3/4 hrs</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: _____ Type: _____ Pain Score: 0800 <u>5</u> 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 checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	MOBILITY	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 <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

IMS Clinical Worksheet - Pediatric Floor

<p>Student Name: <u>Cynthia Cento</u> Date: <u>1-28-25</u></p>	<p>Patient Age: <u>8 months</u> Patient Weight: <u>kg 9.84</u></p>
<p>Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) <u>roup - Bury Cough</u> <u>Influenza A -</u></p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: <u>Respiratory -</u></p>
<p>Identify the most likely and worst possible complications. <u>Respiratory Distress if patient doesn't respond to treatment</u> <u>Seizure (Coughing spells)</u></p>	<p>4. What interventions can prevent the listed complications from developing? <u>Oxygen Therapy</u> Bronchodilators <u>Racemic Epi (bracketed treatment)</u></p>
<p>What data/assessments are needed to identify complications early? <u>- HR, RR, O2 sats</u> <u>sound</u> <u>of breathing</u> <u>for</u></p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Call charge nurse - <u>Move up on oxygen - due to demand</u> <u>If I need to move up 2L, let charge nr. know</u></p>
<p>Management: <u>Appropriate Interventions Related to Pain</u> <u>patient.</u></p>	<p>8. Patient/Caregiver Teaching: 1. <u>Good handwashing</u> 2. <u>Avoid making them cry, if at all possible</u> 3. <u>Observe.</u> <u>Head of bed up -</u> Any Safety Issues identified: Lots <u>Pt. also has flu</u></p>

99.9 Temp R_{ga} 44
~~T_{ax} 98~~ O₂ - ~~100~~ 98
 BP 92/77
 M_{ax} 83

Cynthia Cerda

Pediatric Floor Patient #1

9.84

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed	/	/	/										
Intake - PO Meds	/	/	/	60									
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	3	40	40	40	40								
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$9.84 \times 100 = 988 \text{ mL} \times$ $\frac{\quad}{24 \text{ hrs}} = 41 \text{ mL}$							40 mL/hr Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper		1		1									
Stool	/	/	/	/	/								
Emesis	/	/	/	/	/								
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$3 \times \text{diaper (wet)} \approx 2 \text{ scd}_2$ 0.5 mL/kg/hr $0.5 \text{ mL} / 9.8 = 4.9 \text{ mL/hr}$							$3 \times \text{diaper wet}$ 3.6 mL						

Pt
NPO
until
1000

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>2</u>
	Score 0-2 (Green) - Continue routine assessments
	Score 3-4 (Yellow) - Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) - Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications