

IM5 Clinical Worksheet – Pediatric Floor

| | |
|--|--|
| <p>Student Name: Lisette Guerrero Date: February 5, 2025</p> | <p>Patient Age: 2 y/o Patient Weight: 14.6 kg</p> |
| <p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</p> <p>Oral cyanosis: The bluish discoloration of the oral cavity's lips, tongue and mucous membranes. It is a sign of low oxygen levels in the blood.</p> | <p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>Respiratory</p> |
| <p>3. Identify the most likely and worst possible complications.</p> <p>Respiratory failure</p> | <p>4. What interventions can prevent the listed complications from developing?</p> <p>Oxygen therapy Breathing treatments Rescue inhaler</p> |
| <p>5. What clinical data/assessments are needed to identify these complications early?</p> <p>Monitor VS: HR, RR, O2 Sats Monitor lung sounds and oral cavity</p> | <p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <p>Notify the physician, RT, and charge nurse. Call a rapid response or a code if necessary.</p> |
| <p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <p>1. Sitting on dad's lap when getting VS or holding his hand.</p> <p>2. Having a toy. She liked her stuffed animal.</p> | <p>8. Patient/Caregiver Teaching:</p> <p>1. have the pt take breaks when doing any activities.</p> <p>2. Signs of respiratory failure: use of accessory muscles, labored breathing, and retractions.</p> <p>3. breathing exercises.</p> <p>Any Safety Issues identified:</p> |

| | |
|---------------------------------------|--------------------------------|
| Student Name: Lisette Guerrero | Patient Age: 2 y/o |
| Date: February 5, 2025 | Patient Weight: 14.6 kg |

| 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?

| |
|--|
| |
|--|

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 vs. shame/doubt

1. She was able to choose on which side she wanted us to take her blood pressure.
2. She told her dad that she wanted to put her shoes on herself and go to the playroom.

Piaget Stage: preoperational stage

1. She had gave animism to her stuffed animal.
2. When in the playroom you could see she was sorting some blocks into color groups.

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

| |
|--|
| |
|--|

Pediatric Floor Patient #1

| 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 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 type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input 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 checked="" 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 checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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>normal, soft loose</u> <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 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 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>left foot</u> Oxygen Saturation: <u>97%</u> | 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 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 type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| | NUTRITIONAL | PAIN |
| | Diet/Formula: <u>regular</u> Amount/Schedule: <u>Q3-4hrs</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>0</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 checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden | <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____ |

Pediatric Floor Patient #1

| INTAKE/OUTPUT | | | | | | | | | | | | | |
|---|----|----|----|----|----|----|--|----|----|----|----|----|-------|
| PO/Enteral Intake | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| PO Intake/Tube Feed | - | - | - | 60 | - | - | - | - | - | - | - | - | 60 |
| Intake - PO Meds | - | - | - | - | - | - | - | - | - | - | - | - | - |
| IV INTAKE | | | | | | | | | | | | | |
| IV Fluid | - | - | - | - | - | - | - | - | - | - | - | - | - |
| IV Meds/Flush | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Calculate Maintenance Fluid Requirement (Show Work) 10x100=1000mL 4.6x50=230mL 1230mL/24hrs= 51.25mL/hr | | | | | | | Actual Pt IV Rate n/a Rationale for Discrepancy (if applicable) n/a | | | | | | |
| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| Urine/Diaper | - | - | - | 55 | - | - | - | - | - | - | - | - | 55 |
| Stool | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Emesis | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Other | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Calculate Minimum Acceptable Urine Output 0.5mLx14.6kg=7.3 mL/hr | | | | | | | Average Urine Output During Your Shift 55mL/6 hrs 9mL/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 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>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 |

CHEWS Scoring and Escalation Algorithm

| | 0 | 1 | 2 | 3 |
|-----------------------|---|--|---|--|
| Behavior/Neuro | <ul style="list-style-type: none"> - Playing/sleeping appropriately OR - Alert, at patient's baseline | <ul style="list-style-type: none"> - Sleepy, somnolent when not disturbed | <ul style="list-style-type: none"> - Irritable, difficult to console OR - Increase in patient's baseline seizure activity | <ul style="list-style-type: none"> - Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish |
| Cardiovascular | <ul style="list-style-type: none"> - Skin tone appropriate for patient - Capillary refill ≤ 2 seconds | <ul style="list-style-type: none"> - Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new) | <ul style="list-style-type: none"> - Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia | <ul style="list-style-type: none"> - Grey and mottled OR - Capillary refill > 5 seconds OR - Severe tachycardia OR - New onset bradycardia OR - New onset/increase in ectopy, irregular HR or heart block |
| Respiratory | <ul style="list-style-type: none"> - Within normal parameters - No retractions | <ul style="list-style-type: none"> - Mild tachypnea/increased WOB (flaring, retracting) OR - Up to 40% supplemental oxygen OR - Up to 1L NC $>$ patient's baseline need OR - Mild desaturations $<$ patient's baseline OR - Intermittent apnea self-resolving | <ul style="list-style-type: none"> - Moderate tachypnea/increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) OR - 40-60% oxygen via mask OR - 1-2 L NC $>$ patient's baseline need OR - Nebs Q 1-2 hour OR - Moderate desaturations $<$ patient's baseline OR - Apnea requiring repositioning or stimulation | <ul style="list-style-type: none"> - Severe tachypnea OR - RR $<$ normal for age OR - Severe increased WOB (i.e. head bobbing, paradoxical breathing) OR - $> 60\%$ oxygen via mask OR - > 2 L NC more than patient's baseline need OR - Nebs Q 30 minutes – 1 hour OR - Severe desaturations $<$ patient's baseline OR - Apnea requiring interventions other than repositioning or stimulation |
| Staff Concern | | - Concerned | | |
| Family Concern | | - Concerned or absent | | |

| Green = Score 0-2 | Yellow = Score 3-4 | Red = Score 5-11 |
|--|--|---|
| <ul style="list-style-type: none"> - Continue Routine Assessments | <ul style="list-style-type: none"> - 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 | <ul style="list-style-type: none"> - 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 |

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), <http://dx.doi.org/10.1016/j.pedn.2016.10.005>

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

| | | | | |
|---|---|-------------------|-------------------------------------|---------------------------------|
| Primary IV Fluid and Infusion Rate (m/hr) | Circle IVF Type Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/> | Rationale for IVF | Lab Values to Assess Related to IVF | Contraindications/Complications |
| n/a | | | n/a | n/a |

| | | | | | | | | |
|--|-------------------------------------|---------------------------|-----------------------------------|--|--|---|----------------------------|---|
| Student Name: Lisette Guerrero | | Unit: P3N | Patient Initials: C.T | | Date: 2/5/2025 | Allergies: Cinnamon: Rash | | |
| 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.) |
| Rm 63: NO meds | | | | Choose an item. | | | | <ol style="list-style-type: none"> 1. 2. 3. 4. |
| Rm 69: Ampicillin | Penicillins | Antibiotic for the mass | 570mg IV Q6hrs via Syringe push | Yes | It is pushed over 30 minutes. No diluent needed. | | N/V, Rash, diarrhea, fever | <ol style="list-style-type: none"> 1. If the child gets diarrhea, do NOT use any otc antidiarrhea meds. It will make it worse. 2. If any testing is necessary, inform the provider that the child is taking this med, it can alter test results. 3. Drink plenty of fluids while taking this medication. 4. If this medication is needed for long term, routine testing will need to be done to test the liver and kidney fx. |

IM5 Clinical Worksheet – PICU

| | |
|---|--|
| Student Name: Lisette Guerrero Date: 2/4/25 | Patient Age: 4 mths Patient Weight: 4.2 kg |
| 4. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Flu A & Pneumonia Flu: a result of inflammation in the respiratory tract caused by a viral infection. Pneumonia: An infection of the lungs that may be caused by bacteria, viruses, or fungi. | 5. Priority Focused Assessment R/T Diagnosis: Respiratory |
| 6. Identify the most likely and worst possible complications. Respiratory failure | 4. What interventions can prevent the listed complications from developing? Oxygen therapy Breathing treatments Corticosteroid inhalers |
| 5. What clinical data/assessments are needed to identify these complications early? Monitor VS: HR RR, O2 Sats | 6. What nursing interventions will the nurse implement if the anticipated complication develops? Notify the physician, RT, and charge nurse. Call a rapid response or a code if necessary. |
| 7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 3. Swaddling 4. Positioning | 8. Patient/Caregiver Teaching: 1. Have pt upright so lungs can expand. 2. Frequent breaks in between any activities. 3. Oral suctioning with bulb syringe. Any Safety Issues Identified: |
| Please list any medications you administered or procedures you performed during your shift: | |

PICU

| INTAKE/OUTPUT | | | | | | | | | | | | | |
|--|----|-----|----|----|----|----|---|----|----|----|----|----|-------|
| PO/Enteral Intake | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| PO Intake/Tube Feed | 23 | 23 | 23 | 23 | 23 | - | - | - | - | - | - | - | 115 |
| Intake - PO Meds | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | | | | | | | | | | | | | |
| 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) | | | | | | | Combined Total Intake for Pt (mL/hr) | | | | | | |
| 4.2kgx100mL= 420 mL 420mL/24hrs= 17.5mL/hr | | | | | | | 23mL/hr | | | | | | |
| | | | | | | | | | | | | | |
| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| Urine/Diaper | - | 121 | - | - | - | - | - | - | - | - | - | - | 121 |
| Stool | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Emesis | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Other | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | | | | | | | | | | | | | |
| Calculate Minimum Acceptable Urine Output | | | | | | | Average Urine Output During Your Shift | | | | | | |
| 1mL/kg/hr= 1x4.2= 4.2mL/hr | | | | | | | 121mL/6hrs= 20.2mL/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 3 |
| | |
| Cardiovascular | Circle the appropriate score for this category: (0) 1 2 3 |
| | |
| Respiratory | Circle the appropriate score for this category: 0 1 2 (3) |
| | |
| Staff Concern | 1 pt - Concerned |
| Family Concern | 1 pt - Concerned or absent |
| CHEWS Total Score | |
| CHEWS Total Score | Total Score (points) <u>4</u> |
| | Score 0-2 (Green) - Continue routine assessments |
| | Score 3-4 (Yellow) - Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and |

CHEWS Scoring and Escalation Algorithm

| | 0 | 1 | 2 | 3 |
|-----------------------|---|--|---|---|
| Behavior/Neuro | <ul style="list-style-type: none"> - Playing/sleeping appropriately OR - Alert, at patient's baseline | <ul style="list-style-type: none"> - Sleepy, somnolent when not disturbed | <ul style="list-style-type: none"> - Irritable, difficult to console OR - Increase in patient's baseline seizure activity | <ul style="list-style-type: none"> - Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish |
| Cardiovascular | <ul style="list-style-type: none"> - Skin tone appropriate for patient - Capillary refill \leq 2 seconds | <ul style="list-style-type: none"> - Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new) | <ul style="list-style-type: none"> - Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia | <ul style="list-style-type: none"> - Grey and mottled OR - Capillary refill $>$ 5 seconds OR - Severe tachycardia OR - New onset bradycardia OR - New onset/increase in ectopy, irregular HR or heart block |
| Respiratory | <ul style="list-style-type: none"> - Within normal parameters - No retractions | <ul style="list-style-type: none"> - Mild tachypnea/increased WOB (flaring, retracting) OR - Up to 40% supplemental oxygen OR - Up to 1L NC $>$ patient's baseline need OR - Mild desaturations $<$ patient's baseline OR - Intermittent apnea self-resolving | <ul style="list-style-type: none"> - Moderate tachypnea/increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) OR - 40-60% oxygen via mask OR - 1-2 L NC $>$ patient's baseline need OR - Nebs Q 1-2 hour OR - Moderate desaturations $<$ patient's baseline OR - Apnea requiring repositioning or stimulation | <ul style="list-style-type: none"> - Severe tachypnea OR - RR $<$ normal for age OR - Severe increased WOB (i.e. head bobbing, paradoxical breathing) OR - $>$ 60% oxygen via mask OR - $>$ 2 L NC more than patient's baseline need OR - Nebs Q 30 minutes – 1 hour OR - Severe desaturations $<$ patient's baseline OR - Apnea requiring interventions other than repositioning or stimulation |
| Staff Concern | | - Concerned | | |
| Family Concern | | - Concerned or absent | | |

| Green = Score 0-2 | Yellow = Score 3-4 | Red = Score 5-11 |
|--|--|---|
| <ul style="list-style-type: none"> - Continue Routine Assessments | <ul style="list-style-type: none"> - 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 | <ul style="list-style-type: none"> - 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 |

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), <http://dx.doi.org/10.1016/j.pedn.2016.10.005>

PICU

| 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 checked="" 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 checked="" type="checkbox"/> Calm/Relaxed <input checked="" 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 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 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 checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input checked="" 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>S</u> Left <u>S</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, clear</u> Stool Appearance: <u>green, soft</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy | Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>PICC, RLE</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input checked="" type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____ |
| RESPIRATORY | GASTROINTESTINAL | SKIN |
| Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input checked="" 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 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>3.5</u> @ <u>10</u> cm <input type="checkbox"/> Other: _____ Trach: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size <u>3.5</u> Type <u>endotracheal</u> Obturator at Bedside <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color <u>clear</u> Consistency <u>thick</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>all</u> Pulse Ox Site: <u>left foot</u> Oxygen Saturation: <u>100%</u> | 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>NG</u> Location <u>NOSE</u> Inserted to _____ cm <input checked="" type="checkbox"/> Suction Type: <u>oral suction</u> | Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ Mucous Membranes: Color: <u>PINK</u> <input type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| | NUTRITIONAL | PAIN |
| | Diet/Formula: <u>entamil</u> Amount/Schedule: <u>23ml/hr</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>1</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: _____ |

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

| | | | | |
|--|---|-------------------|-------------------------------------|---------------------------------|
| Primary IV Fluid and Infusion Rate (ml/hr) | Circle IVF Type Isotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/> | Rationale for IVF | Lab Values to Assess Related to IVF | Contraindications/Complications |
| n/a | Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/> | n/a | n/a | n/a |

| Student Name: Lisette Guerrero | Unit: PICU | Patient Initials: E.R | Date: 2/4/2025 | Allergies: NKDA | Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.) |
|-----------------------------------|------------------------------|--------------------------|------------------------|---|---|
| Generic Name | Pharmacologic Classification | Therapeutic Reason | Dose, Route & Schedule | Is med in therapeutic range? If not, why? | Adverse Effects |
| Rm 6: NO meds | | | | Yes | IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration 1. 2. 3. 4. |
| Rm 11: NO meds | | | | Yes | 1. 2. 3. 4. |
| | | | | Choose an item. | 1. 2. 3. 4. |
| | | | | Choose an item. | 1. 2. 3. 4. |