

Student Name: Martino Cedeno Unit: PF2 Pt. Initials: _____ Date: _____

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

Allergies: Adhesive / lactose intolerance

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		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.)
				Is med in therapeutic range?	If not, why?			
DSNS 120 kcal		Isotonic/ Hypotonic/ <u>Hypertonic</u>			replenish fluid loss Hypometa/neurocurus	BGL / K ⁺ / Na ⁺		fluid overload / ↑ BGL / ↑ K ⁺
NO meds given during the time I was there.								1. 2. 3. 4.
								1. 2. 3. 4.
								1. 2. 3. 4.
								1. 2. 3. 4.

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					no								no
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	25	25	25	25	25								125
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work) $12.3 \text{ kg} \times 100 = 1000$ $2.3 \times 20 = 46$ $1,046 / 24 \text{ hr} = 44 \text{ mL/hr}$							Actual Pt IV Rate 25 mL/hr Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	180		70		150								400
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output $0.5 \text{ mL/kg} = 0.5 \times 12.3 = 6.15 \text{ mL/hr}$							Average Urine Output During Your Shift 80 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: 0 <input checked="" type="radio"/> 1 2 3
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>3</u>
	Score 0-2 (Green) - Continue routine assessments
	Score 3-4 (Yellow) - Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) - Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

Student Name: Date:	Patient Age: 4 Patient Weight: 12.3 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)		
Lab TRENDS concerning to Nurse?		
NO labs were Abnormal		

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:

1. Trust vs. Mistrust - while assessing the pt he started to cry, the mom went to comfort him & he stopped crying
2. Trust vs. Mistrust - the pt was calm w/ both parents @ bedside. The mother stepped out to answer the phone & the pt started screaming for 5 minutes

Piaget Stage: the mom, she didn't come back in the rm for 5 minutes

1. Separation anxiety - mother left the rm & the pt started to cry their eyes out
2. Stranger anxiety - pt did not like the care givers at all

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

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input 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 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 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>2</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left _____ Pushes: Right _____ Left _____ 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 <u>Pt unable to squeeze/push</u>	Urine Appearance: <u>Yellow</u> Stool Appearance: <u>Didn't have BM</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>① AC</u> <input checked="" type="checkbox"/> TNT <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: <u>DSNS + 20KCl</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input type="checkbox"/> Regular <input checked="" 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 checked="" type="checkbox"/> Right <input checked="" 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 checked="" type="checkbox"/> Nasal Cannula: <u>0.3</u> 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>Green</u> Consistency <u>Thick</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>① Big toe</u> Oxygen Saturation: <u>92%</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 checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ Mucous Membranes: Color: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>AS tolerated</u> Amount/Schedule: <u>Whenever Much/Whenever</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>Pt refusing to eat/drink</u>	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>None</u> Type: <u>None</u> 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 checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input checked="" type="checkbox"/> RL <input checked="" 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: _____

IM5 Clinical Worksheet – PICU

Student Name: <i>Marcelino Lopez</i> Date:	Patient Age: <i>17</i> Patient Weight: <i>66.9 kg</i>
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) <i>Orbital fracture & Blunt trauma / Broken eye socket & Bleeding in the skull</i>	2. Priority Focused Assessment R/T Diagnosis: <i>Neuro assessment</i>
3. Identify the most likely and worst possible complications. <i>Headache - most likely</i> <i>Decreased in Brain function - worst possible</i>	4. What interventions can prevent the listed complications from developing? <i>Frequent neuro assessments.</i>
5. What clinical data/assessments are needed to identify these complications early? <i>CT & MRI</i>	6. What nursing interventions will the nurse implement if the anticipated complication develops? <i>Send the pt for another scan.</i> <i>Make sure pt has an airway</i>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. <i>Dim the lights</i> 2. <i>Don't talk loud</i>	8. Patient/Caregiver Teaching: 1. <i>avoid looking at your phone for long periods of time</i> 2. <i>Avoid bright rooms</i> 3. <i>Don't listen to loud music</i> Any Safety Issues Identified: <i>Report any change in LOC</i>
Please list any medications you administered or procedures you performed during your shift: <i>Ampicillin</i> <i>Acetaminophen</i> <i>Neuro Assessment</i>	

Orbital fracture, open, initial encounter

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	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 checked="" type="checkbox"/> Time/Event <input checked="" 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 <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>Brown/Firm</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>QAC</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: <u>DSNS + 20kcl</u>
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	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 type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input 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 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 checked="" type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: <u>QAC QAC</u> Mucous Membranes: Color: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
Oxygen Delivery:	NUTRITIONAL	PAIN
<input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____	Diet/Formula: <u>Dysphagia/Mod. Thick</u> Amount/Schedule: <u>NO amount/Schedule</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>Head</u> Type: <u>Throb</u> Pain Score: <u>7</u> 0800 <u>7</u> 1200 _____ 1600 _____
Trach:	MUSCULOSKELETAL	WOUND/INCISION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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 type="checkbox"/> None Type: <u>LAC</u> Location: <u>eyebrow</u> Description: <u>NO signs of infection</u> Dressing: <u>open to air</u>
Cough:	MOBILITY	TUBES/DRAINS
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive	<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: _____
Secretions:		
Color: _____ Consistency: _____ Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>index toe</u> Oxygen Saturation: <u>95%</u>		

PICU

INTAKE/OUTPUT													
	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO/Enteral Intake													NPO
PO Intake/Tube Feed													
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	50	50	50										150
IV Meds/Flush	50	100											150
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)						
66.9 kg $10 \times 100 = 1000$ $10 \times 50 = 500$ $46.9 \times 20 = 938$ $= 2,438 / 24 = 102 \text{ mL/hr}$							102 mL/hr						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper				600	400								1000
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$0.5 \times 66.9 = 33.45 \text{ mL/hr}$							200 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>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

Student Name: Mariela Gadsby

Unit: ICU

Pt. Initials: JM

Date: 04/15/2015

Pediatric Medication Worksheet - Current Medications & PRN for Last 24 Hours | CO

Allergies: NKA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
<u>DSAs + 20KCl 50ml/hr</u>	Isotonic/Hypotonic/ <u>Hypertonic</u>	<u>replenish fluid + K</u>	<u>Glucose Potassium Sodium</u>	<u>Fluid overload / AKI</u>

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		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.)
				Is med in therapeutic range?	If not, why?			
<u>Ampicillin - Sulbactam (Unasyn)</u>	<u>Antibiotic</u>	<u>Treat Infection</u>	<u>1500mg IV q6hrs</u>	<u>Yes</u>		<u>Sterile water 100ml/hr 30mins</u>	<u>C.Diff</u>	<ol style="list-style-type: none"> 1. Report any diarrhea can be C.Diff 2. Monitor urine output can cause 3. DO NOT take if you have an allergic to Penicillin 4. Monitor for spasms after admin. for possible
<u>Fentanyl</u>		<u>Pain + fever</u>	<u>1000mg IV q6hrs 10mg/ml</u>	<u>Yes</u>		<u>100ml 400mg/hr 15mins</u>	<u>Liver failure</u>	<ol style="list-style-type: none"> 1. Monitor liver function for acute hepatotoxicity 2. Monitor urine output oliguria is high in Pediatrics 3. DO NOT use w/ PTs that have liver damage 4. DO NOT Exceed 46/Day
								<ol style="list-style-type: none"> 1. 2. 3. 4.
								<ol style="list-style-type: none"> 1. 2. 3. 4.
								<ol style="list-style-type: none"> 1. 2. 3. 4.