Student Name: Amaya Jones
Date: 9/10/25

Patient Age: 10mo
Patient Weight: 7 kg

1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)

Hypoglycemia occurs when blood glucose levels decline and remain below what is needed to sustain the body.

2. Priority Focused Assessment You Will Perform Related to the Diagnosis:

Neuro assessment will be the priority assessment to perform due to hypoglycemia causing altered neural status.

3. Identify the most likely and worst possible complications.

The worst possible complications would be seizures and coma. Irregular heartbeats is another likely complication.

4. What interventions can prevent the listed complications from developing?

Regularly monitor BG levels, recognize signs of hypoglycemia, and eat regular meals.

5.What clinical data/assessments are needed to identify these complications early?

Tremors, Tachycardia, Confusion, dizziness, Blurred vision.

6. What nursing interventions will the nurse implement if the anticipated complication develops?

Monitor blood glucose levels and provide fast-acting carbohydrates such as juice.

7. Pain & Discomfort Management:
List 2 Developmentally Appropriate *Non-Pharmacologic Interventions* Related to Pain & *Discomfort for This Patient.*

1. Rocking the infant
2. Music

8. Patient/Caregiver Teaching:

1. Regularly monitor the infant's blood glucose
2. Make sure infant is eating enough Protein and Carbohydrates
3. Carry glucagon incase of emergency

Any Safety Issues identified:
N/A

Student Name: Amaya Jones	Patient Age:
Date:	Patient Weight: kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
N/A	–	N/A
N/A	–	N/A
N/A	–	N/A
Metabolic Panel Labs	–	N/A
N/A	–	N/A
N/A	–	N/A
N/A	–	N/A
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		N/A
POC Glucose	89	Pt hx of hypoglycemia.

Lab TRENDS concerning to Nurse?

N/A

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. The infant was consistently held by her parents

2. After BG checks, the infant cried and was promptly soothed by her mother

Piaget Stage:

1. The infant would follow the nurse with her eyes

2. The infant often reached out in front of her and would touch on her parents arms or legs

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

N/A - Patient did not have any medications during shift.

I checked BG levels.

GENERAL APPEARANCE

Appearance: ☑ Healthy/Well Nourished ☑ Neat/Clean ☐ Emaciated ☐ Unkept

Developmental age: ☑ Normal ☐ Delayed

NEUROLOGICAL

LOC: ☑ Alert ☐ Confused ☐ Restless ☐ Sedated ☐ Unresponsive

Oriented to: ☐ Person ☐ Place ☐ Time/Event ☑ Appropriate for Age

Pupil Response: ☑ Equal ☐ Unequal ☐ Reactive to Light ☐ Size _____

Fontanel: (Pt < 2 years) ☑ Soft ☐ Flat ☐ Bulging ☐ Sunken ☐ Closed

Extremities: ☑ Able to move all extremities ☐ Symmetrically ☐ Asymmetrically

Grips: Right N Left N

Pushes: Right N Left N

S=Strong W=Weak N=None

EVD Drain: ☐ Yes ☑ No Level _____

Seizure Precautions: ☐ Yes ☐ No

RESPIRATORY

Respirations: ☑ Regular ☐ Irregular ☐ Retractions (type) _____ ☐ Labored

Breath Sounds:

Clear	☑ Right	☑ Left
Crackles	☐ Right	☐ Left
Wheezes	☐ Right	☐ Left
Diminished	☐ Right	☐ Left
Absent	☐ Right	☐ Left

☑ **Room Air** ☐ **Oxygen**

Oxygen Delivery: ☐ Nasal Cannula: ____L/min ☐ BiPap/CPAP: _____ ☐ Vent: ETT size_____@_____cm ☐ Other: _____

Trach: ☐ Yes ☑ No Size _____ Type _____ Obturator at Bedside ☐ Yes ☑ No

Cough: ☐ Yes ☑ No ☐ Productive ☐ Nonproductive

Secretions: Color _____ Consistency _____

Suction: ☐ Yes ☑ No Type _____

Pulse Ox Site _____

Oxygen Saturation: 99

CARDIOVASCULAR

Pulse: ☑ Regular ☐ Irregular ☑ Strong ☐ Weak ☐ Thready ☐ Murmur ☑ Other _____

Edema: ☐ Yes ☑ No Location _____ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

Capillary Refill: ☑ < 2 sec ☐ > 2 sec

Pulses:

Upper R 3+ L 3+

Lower R 3+ L 3+

4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None

ELIMINATION

Urine Appearance: yellow, clear

Stool Appearance: _____ ☐ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☑ Soft ☐ Firm ☐ Flat ☐ Distended ☐ Guarded

Bowel Sounds: ☑ Present X 4 quads ☑ Active ☐ Hypo ☐ Hyper ☐ Absent

Nausea: ☐ Yes ☑ No

Vomiting: ☐ Yes ☑ No

Passing Flatus: ☑ Yes ☐ No

Tube: ☐ Yes ☑ No Type _____ Location _____ Inserted to _____cm ☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: Regular

Amount/Schedule: _____

Chewing/Swallowing difficulties: ☐ Yes ☑ No

MUSCULOSKELETAL

☐ Pain ☐ Joint Stiffness ☐ Swelling ☐ Contracted ☐ Weakness ☐ Cramping ☐ Spasms ☐ Tremors

Movement: ☐ RA ☐ LA ☐ RL ☐ LL ☑ All

Brace/Appliances: ☑ None Type: _____

MOBILITY

☐ Ambulatory ☐ Crawl ☑ In Arms ☐ Ambulatory with assist _____

Assistive Device: ☐ Crutch ☐ Walker ☐ Brace ☐ Wheelchair ☐ Bedridden

PSYCHOSOCIAL

Social Status: ☐ Calm/Relaxed ☑ Quiet ☐ Friendly ☐ Cooperative ☐ Crying ☐ Uncooperative ☐ Restless ☐ Withdrawn ☐ Hostile/Anxious

Social/emotional bonding with family: ☑ Present ☐ Absent

IV ACCESS

Site: L+ hand peripheral #23 ☐ INT ☐ None ☐ Central Line

Type/Location: peripheral

Appearance: ☑ No Redness/Swelling ☐ Red ☐ Swollen ☐ Patent ☐ Blood return

Dressing Intact: ☐ Yes ☐ No

Fluids: D10 1/4 @ 80 mL/hr

SKIN

Color: ☐ Pink ☐ Flushed ☐ Jaundiced ☐ Cyanotic ☐ Pale ☑ Natural for Pt

Condition: ☑ Warm ☐ Cool ☐ Dry ☐ Diaphoretic

Turgor: ☑ < 5 seconds ☐ > 5 seconds

Skin: ☑ Intact ☐ Bruises ☐ Lacerations ☐ Tears ☐ Rash ☐ Skin Breakdown

Location/Description: _____

Mucous Membranes: Color: Pink ☐ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☐ Numeric ☑ FLACC ☐ Faces

Location: -

Type: -

Pain Score:

0800 0 1200 0 1600 0

WOUND/INCISION

☑ **None**

Type: _____

Location: _____

Description: _____

Dressing: _____

TUBES/DRAINS

☑ **None**

☐ **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						50		30					80
Intake – PO Meds													

IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						14	14	14	14	14			70
IV Meds/Flush													

Calculate Maintenance Fluid Requirement (Show Work)

7kg

7 · 100 = 700 mL $\frac{700}{24}$ = 29 mL/hr

Actual Pt IV Rate

14 mL/hr

Rationale for Discrepancy (if applicable)

During shift, Parenteral order was decreased

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper						20		40					60 mL
Stool													
Emesis													
Other													

Calculate Minimum Acceptable Urine Output

~~5~~ 1 mL/1kg ~~1~~/hr = 7 mL/hr

Average Urine Output During Your Shift

20 + 40 = 60 mL ~~7 mL~~ AS

60 ÷ 2hr = 30 mL/hr

Children's Hospital Early Warning Score (CHEWS)
(See CHEWS Scoring and Escalation Algorithm to score each category)

Behavior/Neuro	Circle the appropriate score for this category: (0) 1 2 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) 0
	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