

Student Name: Kimbera Rodriguez Unit: Ped Med Surg Pt. Initials: \_\_\_\_\_ Date: 11-11-2025  
 Allergies: NKA Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? Is med in therapeutic range? If not, why?	IVF – List diluent solution, volume, and rate of administration NPO – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (precautions/contraindications, etc.)	Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
								Isonic/ Hypotonic/ Hypertonic				
Albuterol	Bronchodilator Beta-2 agonist	Improve airflow	Medrol 2mg Q 3 hrs	Yes	-	Fever Anxiety Headache Nausea Irritability	1. Correct inhaler use 2. Breathe mouth after using 3. Report chest pain, guerdain, wheezing 4. Monitor HE-lung sounds, RR					
Conazepam	Barbiturate Anticonvulsant Anxiolytic	Control seizures	0.25mg 5 times daily	Yes	-	Drowsiness Irritability Eyes depression Behavioral changes	1. Avoid other CNS depressants 2. Monitor EP + LOC 3. Teach parent/pt to report unusual behavior 4. Monitor for excessive sedation					
Mupirocin	Topical antibiotic	Treats skin abscesses	2% topical ointment 3 times daily	Yes	-	Local irritation Burning Pain	1. Clean area before use 2. Wash hands before & after 3. Apply thin layer 4. Report redness + swelling					

IMS Clinical Worksheet – Pediatric Floor

<p>Student Name: Kimbra Rodriguez Date: 11-11-2025</p>	<p>Patient Age: 8 years old Patient Weight: <del>8 kg</del> 23.9 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</p> <p>Asthma exacerbation. Sudden inflammation and narrowing of airways with bronchial constriction, increased mucus production, and decreased airflow due to a triggering event.</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>Respiratory assessment, - Assess lung sounds, monitor RR &amp; effort, monitor O<sub>2</sub> sats, chest assessment.</p>
<p>3. Identify the most likely and worst possible complications.</p> <p>Most likely: SOB, ↓ O<sub>2</sub> sats</p> <p>worst possible: Respiratory failure + Status asthmaticus</p>	<p>4. What interventions can prevent the listed complications from developing?</p> <p>Albuterol treatment, slow deep breathing, monitoring for decreased breathing and sleepiness</p>
<p>5. What clinical data/assessments are needed to identify these complications early?</p> <ul style="list-style-type: none"> <li>- Continuous pulse OX monitoring</li> <li>- Respiratory assessment every 2-4 hrs</li> <li>- Monitor for tachycardia (albuterol or respiratory distress)</li> <li>- Mental status checks</li> </ul>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <ul style="list-style-type: none"> <li>- Notify dr of worsening respiratory distress</li> <li>- Administer bronchodilator treatments</li> <li>- Oxygen therapy</li> <li>- Corticosteroid administration</li> </ul>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <p>1. Calm reassurance and explain treatments in age appropriate terms</p> <p>2. Distraction methods like coloring, electronics, and hand holding</p>	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> <li>1. Proper inhaler use</li> <li>2. Signs + symptoms of asthma attack (cough, SOB, wheezing)</li> <li>3. Avoiding + recognizing triggers (dust, smoke, weather)</li> </ol> <p>Any Safety Issues identified:</p> <ul style="list-style-type: none"> <li>- Emergency inhaler accessible</li> <li>- Medication side effects</li> </ul>

Student Name: Kimbra Rodriguez  
 Date: 11-11-2025  
 Patient Age: 8 years  
 Patient Weight: 23.9kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
XR Chest		L lower lobe bronchiolitis w/ focal consolidation

Lab TRENDS concerning to Nurse?  
 2/11/2025: 11:00 AM - 12:00 PM  
 2/11/2025: 12:00 PM - 1:00 PM  
 2/11/2025: 1:00 PM - 2:00 PM  
 2/11/2025: 2:00 PM - 3:00 PM  
 2/11/2025: 3:00 PM - 4:00 PM  
 2/11/2025: 4:00 PM - 5:00 PM  
 2/11/2025: 5:00 PM - 6:00 PM

11. Growth & Development: School Aged (6-Puberty)  
 \*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: Industry vs. Inferiority

1. Patient played with his toys with me, and took initiative with what we played.
2. Watched his IV removal with interest

Piaget Stage: ~~Formal~~ Concrete Thought

1. Knew we were on 3rd floor and said if meant he was higher up.
2. Gave thumbs up to tell me how he felt (symbolic meaning) + constantly asked for legos (logical play)

Please list any medications you administered or procedures you performed during your shift:  
 2/11/2025 9:00 AM - 12:00 PM

<p><b>GENERAL APPEARANCE</b></p> <p>Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished  <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept                  Developmental age:  <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p><b>CARDIOVASCULAR *</b></p> <p>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 type="checkbox"/> &lt; 2 sec <input type="checkbox"/> &gt; 2 sec                  Pulses:                  Upper R <u>S3</u> L <u>S1</u>                  Lower R <u>S4</u> L <u>S2</u>                  4+ Bounding 3+ Strong 2+ Weak                  1+ Intermittent 0 None</p>	<p><b>PSYCHOSOCIAL</b></p> <p>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</p>
<p><b>NEUROLOGICAL</b></p> <p>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 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 _____                  Fontanel: (Pt &lt; 2 years) <input 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 type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically                  Grips: Right <u>5</u> Left <u>5</u>                  Pushes: Right <u>5</u> Left <u>5</u>                  S=Strong W=Weak N=None                  EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____                  Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>ELIMINATION</b></p> <p>Urine Appearance: <u>Clear, yellow</u>                  Stool Appearance: <u>Brown</u>  <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><b>IV ACCESS</b></p> <p>Site: <u>Right AC</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: _____</p>
<p><b>RESPIRATORY</b></p> <p>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 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>Right index finger</u>                  Oxygen Saturation: <u>99%</u></p>	<p><b>GASTROINTESTINAL *</b></p> <p>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: _____</p>	<p><b>SKIN *</b></p> <p>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"/> &lt; 5 seconds <input type="checkbox"/> &gt; 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: <u>Rashes on arms</u>                  Mucous Membranes: Color: <u>pink</u>  <input type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
	<p><b>NUTRITIONAL</b></p> <p>Diet/Formulas: <u>Regular</u>                  Amount/Schedule: _____                  Chewing/Swallowing difficulties:  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>PAIN</b></p> <p>Scale Used: <input checked="" type="checkbox"/> Numeric <input checked="" type="checkbox"/> FACES <input type="checkbox"/> Faces                  Location: _____                  Type: _____                  Pain Score: <u>0</u>                  0800 _____ 1200 _____ 1600 _____</p>
	<p><b>MUSCULOSKELETAL</b></p> <p><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 type="checkbox"/> None                  Type: _____</p>	<p><b>WOUND/INCISION</b></p> <p><input checked="" type="checkbox"/> None                  Type: _____                  Location: _____                  Description: _____                  Dressing: _____</p>
	<p><b>MOBILITY</b></p> <p><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</p>	<p><b>TUBES/DRAINS</b></p> <p><input type="checkbox"/> None  <input type="checkbox"/> Drain/Tube                  Site: _____                  Type: _____                  Dressing: _____                  Suction: _____                  Drainage amount: _____                  Drainage color: _____</p>

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					30ml								
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)							Actual Pt IV Rate						
$10 \times 100$ $10 \times 50 = 1578 / \text{day} = 65.7 / \text{hr}$ $3 \times 20$							N/A						
							Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper					1x								
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$0.5 / \text{kg/hr}$ $11.95 / \text{hr}$							$11.95 \times 5.5 = 65.7 \text{ mL}$						

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
<b>CHEWS Total Score</b>	
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

### CHEWS Scoring and Escalation Algorithm

	0	1	2	3
<b>Behavior/Neuro</b>	<ul style="list-style-type: none"> <li>- Playing/sleeping appropriately OR</li> <li>- Alert, at patient's baseline</li> </ul>	<ul style="list-style-type: none"> <li>- Sleepy, somnolent when not disturbed</li> </ul>	<ul style="list-style-type: none"> <li>- Irritable, difficult to console OR</li> <li>- Increase in patient's baseline seizure activity</li> </ul>	<ul style="list-style-type: none"> <li>- Lethargic, confused, floppy OR</li> <li>- Reduced response to pain OR</li> <li>- Prolonged or frequent seizures OR</li> <li>- Pupils asymmetrical or sluggish</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>- Skin tone appropriate for patient</li> <li>- Capillary refill <math>\leq 2</math> seconds</li> </ul>	<ul style="list-style-type: none"> <li>- Pale OR</li> <li>- Capillary refill 3-4 seconds OR</li> <li>- Mild tachycardia OR</li> <li>- Intermittent ectopy or irregular HR (not new)</li> </ul>	<ul style="list-style-type: none"> <li>- Grey OR</li> <li>- Capillary refill 4-5 seconds OR</li> <li>- Moderate tachycardia</li> </ul>	<ul style="list-style-type: none"> <li>- Grey and mottled OR</li> <li>- Capillary refill <math>&gt; 5</math> seconds OR</li> <li>- Severe tachycardia OR</li> <li>- New onset bradycardia OR</li> <li>- New onset/increase in ectopy, irregular HR or heart block</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>- Within normal parameters</li> <li>- No retractions</li> </ul>	<ul style="list-style-type: none"> <li>- Mild tachypnea/increased WOB (flaring, retracting) OR</li> <li>- Up to 40% supplemental oxygen OR</li> <li>- Up to 1L NC <math>&gt;</math> patient's baseline need OR</li> <li>- Mild desaturations <math>&lt;</math> patient's baseline OR</li> <li>- Intermittent apnea self-resolving</li> </ul>	<ul style="list-style-type: none"> <li>- Moderate tachypnea/increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) OR</li> <li>- 40-60% oxygen via mask OR</li> <li>- 1-2 L NC <math>&gt;</math> patient's baseline need OR</li> <li>- Nebs Q 1-2 hour OR</li> <li>- Moderate desaturations <math>&lt;</math> patient's baseline OR</li> <li>- Apnea requiring repositioning or stimulation</li> </ul>	<ul style="list-style-type: none"> <li>- Severe tachypnea OR</li> <li>- RR <math>&lt;</math> normal for age OR</li> <li>- Severe increased WOB (i.e. head bobbing, paradoxical breathing) OR</li> <li>- <math>&gt; 60\%</math> oxygen via mask OR</li> <li>- <math>&gt; 2</math> L NC more than patient's baseline need OR</li> <li>- Nebs Q 30 minutes - 1 hour OR</li> <li>- Severe desaturations <math>&lt;</math> patient's baseline OR</li> <li>- Apnea requiring interventions other than repositioning or stimulation</li> </ul>
<b>Staff Concern</b>		- Concerned		
<b>Family Concern</b>		- Concerned or absent		
<b>Green = Score 0-2</b>	<b>Yellow = Score 3-4</b>		<b>Red = Score 5-11</b>	
<ul style="list-style-type: none"> <li>- Continue Routine Assessments</li> </ul>	<ul style="list-style-type: none"> <li>- Notify charge nurse or LIP</li> <li>- Discuss treatment plan with team</li> <li>- Consider higher level of care</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul>		<ul style="list-style-type: none"> <li>- Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation</li> <li>- Notify attending physician</li> <li>- Discuss treatment plan with team</li> <li>- Increase frequency of vital signs / CHEWS / assessments</li> <li>- Document interventions and notifications</li> </ul>	

**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>