Student Name: Brock Fitzgerald Unit: Ped Med-Surg Pt. Initials: HN (66) Date: 02/17/2026

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

Allergies: NKDA (primary pt was CM (68), but did not have meds)

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
N/A	Isotonic/ Hypotonic/ Hypertonic	—	—	—

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? 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.)
(0945) Acetaminophen (did not give this)	Antipyretic/ Analgesic	Fever 100.4°F or greater PRN Q6hr	99.2mg/3.1mL PO PRN Q6hr (fever)	Yes 7.16kg 80mg–120mg (2.5mL – 3.75mL)	N/A	Hepatotoxicity GI irritation ↳ N/V/D Rash Hypersensitivity rxn	1. Taking more than the recommended dose can cause an acute liver injury → yellow eyes + skin 2. May give this medication with a feeding due to it being irritating to the stomach 3. Monitor the skin for any irritation or rash as this may be an allergic rxn; call HCP 4. Do not leave this medicine in the vicinity of young children; can accidentally overdose
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.

Adopted: August 2016

IM5 Clinical Worksheet – Pediatric Floor

Student Name: Brock Fitzgerald
Date: 02/17/2026

Patient Age: 13
Patient Weight: 37.5 kg

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

CC: Abdominal pain → trichobezoar
dx:

The accidental or deliberate eating of hair that caused a matted mass of food/hair, which progressed into a bowel obstruction.

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

The priority assessment for this pt is an abdominal assessment, and a pain assessment.

3. Identify the most likely and worst possible complications.

Likely: The bezoar causes an obstruction and causes distention, which is followed by pain + N/V.
Worst: Perforation occurs due to obstruction and that leads to infection/sepsis &/or hemorrhage.

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

Focused abdominal assessments in conjunction with imaging would help to prevent this mass from becoming an obstruction.

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

Abdominal + pain assessments

Abd: bowel sounds, palpation, + visualization
↳ bowel habits + s/s of nausea/vomiting

Pain: PQRST screen on pt to help identify source(s) of pain/discomfort

6. What nursing interventions will the nurse implement if the anticipated complication develops? An obstruction or perforation will require at minimum some form of an invasive procedure/surgery.

Pre-op preparation, education, + consent
Post-op care/VS, education, + pain control
Misc.: request a psych consult + social work

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

1. Heating pack over the abdomen to help relax the muscles in the area + soothe any spasms.
2. Guided imagery with the pt will help to distract the patient from the pain. Having the pt find their "happy place" + describe all their perceptual stimulus will help them 'let go' of their pain.

8. Patient/Caregiver Teaching:

1. Recommend seeking CBT/carseling for possible anxiety, OCD, + trauma/abuse (involve social worker)
2. Hair Management: Keeping the hair shorter makes pulling it out less satisfying/harder; keeping hair up
3. Parent needs to monitor for hair loss, weight loss/malnourished, unexplained abdominal pain, early fullness when eating, + halitosis (bad breath).

Any Safety Issues identified:

If this continues, the likelihood of another surgery is greatly increased. A repeated obstructional injury here could make perforating easier next time. This would lead to an infection/sepsis quickly.

Student Name: Brock Fitzgerald Date: 02/17/2024	Patient Age: 13 Patient Weight: 37.5 kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
	N/A	
	N/A	
	N/A	
Metabolic Panel Labs		
Chloride	111 ↑	Fluid/Electrolyte balance issue
Calcium	8.3 ↓	Regulator/homeostasis of heart, nerves, + muscles ↳ slight deficiency
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)	N/A	
Albumin	2.8 ↓	Loss of protein +/or malnutrition'
Protein	6.1 ↓	Indicative of malnutrition + muscle wasting
Lab TRENDS concerning to Nurse?		
The low albumin and protein levels may indicate the sustained state of malnourish -ment, + this could be due to the growing "hair ball" in the GI tract.		

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: Identity vs Role Confusion

1. Observed the pt on FaceTime with her friends at school. She did not talk much, but seemed to enjoy the daily update.

2. Pt was visibly upset when I introduced myself about her reason for being their. She was frustated with herself and kept the somber mood for the rest of the day.

Piaget Stage: Formal Operational Thought

1. The pt and mother were planning and prepping for what all she needed to do to catch up on school work and be able to go to a dance.

2. The pt mentioned hesistancy about returning to school, even though she would only have a surgical incision with a dressing under her clothes. Bits and pieces of 'personal fable' were being displayed.

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

Ambulated one patient, and helped D/C a patient. I did not pass any meds.

B. Fitzgerald 02/17/26

Pediatric Floor Patient #1

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GENERAL APPEARANCE

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

Developmental age: ☒ Normal ☐ Delayed

low weight, but seemed healthy

NEUROLOGICAL

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

Oriented to: ☒ Person ☒ Place ☒ Time/Event ☒ Appropriate for Age

Pupil Response: ☒ Equal ☐ Unequal ☒ Reactive to Light ☐ Size 2mm

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

Extremities:
☒ Able to move all extremities
☒ Symmetrically ☐ Asymmetrically
Grips: Right 5 Left 5
Pushes: Right 5 Left 5
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 L. index finger

Oxygen Saturation: 96-100%

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 2+ L 2+
Lower R 2+ L 2+
4+ Bounding 3+ Strong 2+ Weak
1+ Intermittent 0 None

ELIMINATION

Urine Appearance: clear, yellow

Stool Appearance: N/A
☐ 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 NGT
Location L. Nair Inserted to _____cm
☒ Suction Type: Continuous

Guarding around surgical site

NUTRITIONAL

Diet/Formula: NPO

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 X1
Assistive Device: ☐ Crutch ☐ Walker ☐ Brace ☐ Wheelchair ☐ Bedridden

X1 assist just in case

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. dorsal hand ☐ INT ☐ None ☐ Central Line
Type/Location: _____

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

Dressing Intact: ☒ Yes ☐ No

Fluids: 78 mL/hr D5 NS + 20 mEq of KCl - continuous

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: except for surgical site

Mucous Membranes: Color: pink ☒ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☒ Numeric ☐ FLACC ☐ Faces
Location: Abdomen
Type: dull pain
Pain Score: 3
0800____ 1200____ 1600 ✓

WOUND/INCISION

☐ None
Type: Surgical
Location: Mid upper quadrant of abdomen
Description: adhered, Ø redness
Dressing: _____

TUBES/DRAINS

☐ None
☒ **Drain/Tube**
Site: NGT - L. Nair
Type: NGT
Dressing: Tape & pad on nose
Suction: Continuous
Drainage amount: 540 mL
Drainage color: green

B. Fitzgerald 02/17/2026

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						200			250				450mL
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid					11	78	78	78	78	78	78		468
IV Meds/Flush													

Calculate Maintenance Fluid Requirement (Show Work)

37.5 kg

10 x 100 = 1,000
10 x 50 = 500
17.5 x 20 = 350
= 1,850 mL
↳ ~77 mL/hr

Actual Pt IV Rate 78 mL/hr

Rationale for Discrepancy (if applicable)

N/A – pt is recieving ideal maintenance fluid

* 1145 **OUTPUT**	07	08	09	10	11*	12	13	14	15	16	17	18	Total
Urine/Diaper					100			120					220mL
Stool													
Emesis													
Other										540mL NGT			540 mL

Calculate Minimum Acceptable Urine Output

37.5 x 0.5 mL = 18.75 mL/hr

(0.5 mL/kg/hr)

Average Urine Output During Your Shift

42 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) 1 I believe this pt could use a psych consult
	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

Brock Fitzgerald 02/19/2026

pt may need psych consult/social worker

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	- Playing/sleeping appropriately **OR** - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed ✓	- Irritable, difficult to console **OR** - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy **OR** - Reduced response to pain **OR** - Prolonged or frequent seizures **OR** - Pupils asymmetrical or sluggish
Cardiovascular	- Skin tone appropriate for patient - Capillary refill ≤ 2 seconds ✓	- Pale **OR** - Capillary refill 3-4 seconds **OR** - Mild tachycardia **OR** - Intermittent ectopy or irregular HR (not new)	- Grey **OR** - Capillary refill 4-5 seconds **OR** - Moderate tachycardia	- 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	- Within normal parameters - No retractions ✓	- 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	- 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	- 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
- Continue Routine Assessments Pt score: 1	- 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	- 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

B. Fitzgerald 02/17/2020

Pediatric ED Reflection Questions

1. What types of patients (diagnoses) did you see in the PED?

(Multiple) Playground injuries, one fracture, two pilonidal cysts, one foreign object removal, a few respiratory cases (RSV/croup) + a syncopal episode.

2. The majority of the patients who came into the PED were from which age group? Was this what you expected? 18 months to 12 years of age were what we saw the most of today. I expected to see more infants/toddlers with respiratory issues, but that was not the case.

3. Was your overall experience different than what you expected? Please give examples.

Overall, I highly enjoyed the entirety of the staff in Ped ER. Today for clinical was a tad underwhelming as we were slow or empty for most of the day. I was able to observe several bedside procedures.

4. How did growth and development come into play when caring for patients (both in triage and in treatment rooms)? Growth and development were huge with obtaining vital signs and establishing baselines. Also, when explaining injuries and why they 'hurt' was another lesson to be learned with growth and development.

5. What types of procedures did you observe or assist with?

I was able to assist with splinting a fractured wrist and D/C a few IV lines. I assisted on the foreign object removal from the nose. I observed two pilonidal cysts being drained.

6. What community acquired diseases are trending currently?

RSV and Influenza have been the most consistent diseases they have seen lately. In addition, while not a disease, the ER has seen a trend in syncopal episodes due to the start of track season.

7. What community mental health trends are being seen in the pediatric population?

According to my nurse the mental health issues they have seen the most is suicidal ideation stemming from behavioral disorders like ODD.

8. How does the staff debrief after a traumatic event? Why is debriefing important?

The staff either debriefs in the trauma room or nurse's station depending on the presence of family for the patient(s) in question. They discuss strengths + weaknesses, and how they could improve next time. My nurse debriefing is a useful coping tool to avoid burn out and continue working in the ED.

9. What is the process for triaging patients in the PED?

Establishing a baseline for the patient based on their vital signs, appearance, and chief complaint. Then using nursing judgement to determine acquity and placement. Most acute/sick are seen first and those who are placed in the lobby.

10. What role does the Child Life Specialist play in the PED?

The CCLS has a special role in multiple procedure set ups, whether they are particulary painful or not. They prepare the patients with developmentally appropriate language, followed by anticipatory guidance and aiding in atraumatic care. Being able to see how the CCLS works with multiple patients of varying ages was interesting and educational.