

IM5 Clinical Worksheet – Pediatric Floor

Student Name: Brandon Scott Date: 02/25/26	Patient Age: 4 days old Patient Weight: 1.75 kg → 2.5 # kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) hypothermia sepsis suspected ^{infection} asystemic spread the body's temperature drops below an ideal temperature for organ function	2. Priority Focused Assessment You Will Perform Related to the Diagnosis: cardiac assessments (pulses) skin assessment (temp) respiratory assessment (respirations)
3. Identify the most likely and worst possible complications. most likely to have tachycardia, worst possible complications are temperature irregularities hypo + hyper thermia	4. What interventions can prevent the listed complications from developing? provide heat by thermoregulation with warming lamp, snuggler monitor pt temp continuously
5. What clinical data/assessments are needed to identify these complications early? assess temperature, monitor for pallor, track WBC increase for indication of infection	6. What nursing interventions will the nurse implement if the anticipated complication develops? The patient will be snuggled and warmed if their temp drops. The pt will receive antibiotics to fight infection & prevent spread
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. snuggling 2. holding, chest to chest once core temp is stable	8. Patient/Caregiver Teaching: 1. monitor for signs of pale skin or temperature drops ↓ 2. report any vomiting and diarrhea 3. encourage feeding to prevent dehydration from the sickness. Any Safety Issues Identified: temperature reader on infant was not reading accurately, was lower than actual temp. Needed to change out with a new one, could have caused hypothermia because the heat lamp adjust based on the real temperature from

Pediatric Floor Patient #1

4 day old

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 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 checked="" type="checkbox"/> Quiet <input 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 Pupils Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>1mm</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 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 <u>/</u> Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>yellow</u> Stool Appearance: <u>type 6</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>ychmar</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>periphera</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input 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) <u>/</u> <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: <u>/</u> L/min <input type="checkbox"/> BiPap/CPAP: <input type="checkbox"/> Vent: ETT size <u>/</u> @ <u>/</u> cm <input type="checkbox"/> Other: Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>/</u> Type <u>/</u> 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 checked="" type="checkbox"/> Nonproductive Secretions: Color <u>/</u> Consistency <u>/</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>/</u> Pulse Ox Site: <u>left foot</u> Oxygen Saturation: <u>95 9402</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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>/</u> Location <u>/</u> Inserted to <u>/</u> cm <input type="checkbox"/> Suction Type: <u>/</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: <u>/</u> Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MOBILITY	MUSCULOSKELETAL	WOUND/INCISION
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>n/a</u> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	Diet/Formula: <u>breast milk</u> Amount/Schedule: <u>6-8/day</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: <u>n/a</u> Type: <u>n/a</u> Pain Score: 0800 <u>0</u> 1200 <u>0</u> 1600 <u>0</u>
RESPIRATORY	MOBILITY	TUBES/DRAINS
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) <u>/</u> <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: <u>/</u> L/min <input type="checkbox"/> BiPap/CPAP: <input type="checkbox"/> Vent: ETT size <u>/</u> @ <u>/</u> cm <input type="checkbox"/> Other: Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>/</u> Type <u>/</u> 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 checked="" type="checkbox"/> Nonproductive Secretions: Color <u>/</u> Consistency <u>/</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>/</u> Pulse Ox Site: <u>left foot</u> Oxygen Saturation: <u>95 9402</u>	<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: _____
RESPIRATORY	MOBILITY	TUBES/DRAINS
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) <u>/</u> <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: <u>/</u> L/min <input type="checkbox"/> BiPap/CPAP: <input type="checkbox"/> Vent: ETT size <u>/</u> @ <u>/</u> cm <input type="checkbox"/> Other: Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>/</u> Type <u>/</u> 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 checked="" type="checkbox"/> Nonproductive Secretions: Color <u>/</u> Consistency <u>/</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>/</u> Pulse Ox Site: <u>left foot</u> Oxygen Saturation: <u>95 9402</u>	<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: _____

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	—	90ml	—	—	—								
Intake – PO Meds	—	—	—	—	—								
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	10	10	10	10	10								
IV Meds/Flush	16.7	—	—	—	—								
Calculate Maintenance Fluid Requirement (Show Work) $2.5 \times 100 = 250 \text{ mL}$							Actual Pt IV Rate 10 mL/hr Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	—	—	1	—	1								
Stool	—	—	90	—	90								
Emesis	—	—	—	—	—								
Other	—	—	—	—	—								
Calculate Minimum Acceptable Urine Output $6.45 \text{ mL/hr over } 5 \text{ hours}$							Average Urine Output During Your Shift 32 mL/hr including stool						

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>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: <u>Brandon Scott</u>	Patient Age: <u>4 day old</u>
Date: <u>12/12/26</u>	Patient Weight: <u>2.58 kg</u>

Abnormal Relevant Lab Tests	Current	Clinical Significance
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Complete Blood Count (CBC) Labs		
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<u>WBC growth absent</u>	<u>-</u>	<u>indicates active infections, none present</u>
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Metabolic Panel Labs		
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<u>W/A</u>	<u>-</u>	<u>W/A</u>
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Misc. Labs		
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Absolute Neutrophil Count (ANC) (if applicable)		
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<u>W/A</u>		<u>W/A</u>
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Lab TRENDS concerning to Nurse?

no bad lab trends, consistent & WNL

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: Trust vs. Mistrust

- requirement of warmth - the baby required stable and constant care because it couldn't take care of himself
- requirement of comfort - baby was uncomfortable with being held at first, but began to trust after a while

Piaget Stage: Sensorimotor

- The baby exhibited reflexive actions very often with sucking on his pacifier
- The baby would also display rooting when I put my finger in his grasp area

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

- levo 20 50% w/ 20 mg q 1L
- acyclovir
- ampicillin
- cefazidime
- 40 5 1/2 N's cathwas

Diene

IM5 Clinical Worksheet – PICU

<p>Student Name: Brandon Galt Date: 02/24/26</p>	<p>Patient Age: 16 y/o F Patient Weight: 46 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Asthma (Environmental/Allergens)</p>	<p>2. Priority Focused Assessment R/T Diagnosis: Respiratory Assessment</p>
<p>3. Identify the most likely and worst possible complications. most likely is wheezing, chest tightness. next possible is closure of airway, oxygen desaturation.</p>	<p>4. What interventions can prevent the listed complications from developing? management of asthma with rescue inhaler & avoiding triggers such as dusty area, scents, illness</p>
<p>5. What clinical data/assessments are needed to identify these complications early? focused respiratory assessment listen to wheezing, & look for S₃, intercostal / subcostal retractions</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? provide supplemental O₂ after using bronchodilator & corticosteroids to reduce inflammation</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. encourage exercise & diet adjustment guided imagery 2. deep breathing calm environment</p>	<p>8. Patient/Caregiver Teaching: 1. avoid being out in dusty/allergenic areas / environments 2. use rescue inhaler as instructed when experiencing dyspnea 3. wash hands thoroughly, practice aseptic technique. Any Safety Issues Identified: Pt infection exposure to mother & aunt (no mask in contact + droplet isolation)</p>
<p>Please list any medications you administered or procedures you performed during your shift: nothing administered none.</p>	

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 <u>tachycardia</u> 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>2+</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		
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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>2 mm</u> Fontanel: (Pt < 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"/> Asymmetrically <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	ELIMINATION Urine Appearance: _____ Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	IV ACCESS Site: <u>peripheral</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>permar 22 G AC</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>Neuro 50 cc H₂O</u> <u>U CI 200 cc Eq IL infusion</u>
GASTROINTESTINAL		
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> quadrants <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input checked="" type="checkbox"/> Yes <input 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 type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	NUTRITIONAL Diet/Formula: <u>pediatric diet</u> Amount/Schedule: <u>Q4</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	SKIN 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
RESPIRATORY		
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Retractions (type) <u>intercostals</u> <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 checked="" type="checkbox"/> Right <input checked="" 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	MUSCULOSKELETAL <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 <u>WNL</u>	PAIN Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>NA</u> Type: <u>NA</u> Pain Score: 0800 <u>0</u> 1200 _____ 1600 _____
WOUND/INCISION		
Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: <u>NA</u> L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size @ _____ cm <input checked="" type="checkbox"/> Other: <u>mask @ 11 L</u> 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>hand</u> Oxygen Saturation: <u>94%</u>	MOBILITY <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	TUBES/DRAINS <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

INTAKE/OUTPUT																		
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total					
PO Intake/Tube Feed	—	—	—	—	—													
Intake – PO Meds	—	—	—	—	—													

IV INTAKE																		
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total					
	68.75	125	125	125	125													
IV Meds/Flush	—	—	1mL	—	—													

Calculate Maintenance Fluid Requirement (Show Work)

$$\begin{aligned}
 84.4 \quad & 10 \times 100 = 1000 \\
 & 10 \times 50 = 500 \\
 & 64.6 \times 20 = 1292 \\
 & = 2792 \text{ mL required}
 \end{aligned}$$

Combined Total Intake for Pt (mL/hr)

$$568.75 \text{ mL/hr}$$

OUTPUT																		
Urine/Diaper	07	08	09	10	11	12	13	14	15	16	17	18	Total					
	0	—	—	—	—													
Stool	—	—	—	—	—													
Emesis	—	—	—	—	—													
Other	—	—	—	—	—													

Calculate Minimum Acceptable Urine Output

$$\begin{aligned}
 428 \text{ mL/hr} \times 5 &= 2115 \text{ mL} \\
 42.3 &\text{ over 8 hours}
 \end{aligned}$$

Average Urine Output During Your Shift

0 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

CHEWS Total Score

Total Score (points) 2

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 Total Score