




**WABERBURY HOSPITAL HEALTH CENTER
PEDIATRIC EMERGENCY NURSING DOCUMENTATION
AGE 1 DAY TO 16 YEARS**

Date: _____ Time: _____ Time initial blood-work drawn: _____

VALUABLES

none retained at bedside
 taken by patient or designated recipient valuables envelope # _____
 name: _____ relationship to pt: _____

(addressograph)

<p>AIRWAY</p> <input type="checkbox"/> Patent <input type="checkbox"/> Non-patent Airway adjunct _____ <input type="checkbox"/> See Team Pediatric Critical Flowsheet for documentation	<p>RESPIRATORY</p> <p>BREATHING</p> <input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Grunting <input type="checkbox"/> Retractions <input type="checkbox"/> Wheezing <input type="checkbox"/> Stridor	<p>CIRCULATION</p> <p>PULSE</p> <input type="checkbox"/> Brachial <input type="checkbox"/> Carotid <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	<p>NEUROLOGICAL</p> <p>PUPILS</p>  <p>Size: R _____ L _____ <input type="checkbox"/> Equal <input type="checkbox"/> Fixed & dilated <input type="checkbox"/> Dysconjugate <input type="checkbox"/> Nystagmus <input type="checkbox"/> Deviated</p>
	<p>BREATH SOUNDS</p> <p>L R</p> <input type="checkbox"/> Clear <input type="checkbox"/> <input type="checkbox"/> Crackles <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Diminished <input type="checkbox"/> <input type="checkbox"/> Absent <input type="checkbox"/>	<p>CAPILLARY REFILL</p> <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec	<p>BLEEDING</p> <input type="checkbox"/> None (visible) <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled Location: _____
		<p>MUCOUS MEMBRANES</p> <input type="checkbox"/> Pink <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Moist <input type="checkbox"/> Dry	<p>FONTANEL</p> <input type="checkbox"/> N/A <input type="checkbox"/> Flat <input type="checkbox"/> Depressed <input type="checkbox"/> Bulging
		<p>SKIN</p> <input type="checkbox"/> Warm <input type="checkbox"/> Mottled <input type="checkbox"/> Hot <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pink <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Tenting <input type="checkbox"/> Cool <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Flushed	<p>URINARY OUTPUT</p> <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Increased Last void or wet diaper: _____ Last ate or drank: _____
<p>PAIN</p> Is child currently experiencing pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Pain scale used: (see sheet) _____ Pain score: _____ ONSET <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual DURATION <input type="checkbox"/> Consistent <input type="checkbox"/> Intermittent Location: _____ Provokes pain: _____ Relieves pain: _____ Last med: _____ Time given: _____	<p>GI/GU/GYN</p> <p>ABDOMEN</p> <input type="checkbox"/> Normal <input type="checkbox"/> Distended <input type="checkbox"/> Guarding <input type="checkbox"/> Rigid	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> Edema Location: _____ <input type="checkbox"/> Discoloration Location: _____ <input type="checkbox"/> Deformity Location: _____ CSM <input type="checkbox"/> Altered circulation Location: _____ <input type="checkbox"/> Altered sensation Location: _____ <input type="checkbox"/> Altered motor function Location: _____	<p>PSYCHOSOCIAL</p> <p>EYE CONTACT</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>AFFECT</p> <input type="checkbox"/> Normal <input type="checkbox"/> Flat <p>MOTOR BEHAVIOR</p> <input type="checkbox"/> Cooperative <input type="checkbox"/> Restless <input type="checkbox"/> Agitated <p>SPEECH</p> <input type="checkbox"/> Normal for age <input type="checkbox"/> Abnormal for age <p>SUPPORT SYSTEMS</p> <input type="checkbox"/> Family/significant others present <input type="checkbox"/> Language barrier <input type="checkbox"/> Heard of hearing <p>IDEATIONS</p> <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Harmful to self <input type="checkbox"/> Harmful to others
	<p>TENDERNESS</p> <input type="checkbox"/> LUQ <input type="checkbox"/> RUQ <input type="checkbox"/> LLQ <input type="checkbox"/> RLQ <input type="checkbox"/> Epigastric		
	<p>BOWEL SOUNDS</p> <input type="checkbox"/> None <input type="checkbox"/> Present <input type="checkbox"/> Last BM _____ <input type="checkbox"/> Frequency of BM _____		
	<p>GU</p> <input type="checkbox"/> Flank pain L R <input type="checkbox"/> Dysuria <input type="checkbox"/> Hematuria <input type="checkbox"/> Frequency		<p>BEST VERBAL</p> <input type="checkbox"/> 5 coos, bables, speaks <input type="checkbox"/> 4 irritable <input type="checkbox"/> 3 cries to pain <input type="checkbox"/> 2 moans to pain <p>BEST MOTOR</p> <input type="checkbox"/> 6 normal <input type="checkbox"/> 5 withdraws to touch <input type="checkbox"/> 4 withdraws to pain <input type="checkbox"/> 3 abnormal flexion <input type="checkbox"/> 2 abnormal extension <input type="checkbox"/> 1 none Total Score: _____
		<p>TETANUS</p> <input type="checkbox"/> Up to date Last had _____	<p>IMMUNIZATIONS</p> <input type="checkbox"/> Up to date <input type="checkbox"/> Not up to date
			<p>VISUAL ACUITY</p> <input type="checkbox"/> NA L _____ / R _____

See Team Pediatric Critical Flowsheet
 Plan of care explained to patient/guardian. Patient/guardian verbalized Plan of Care.

Time initial nursing assessment completed: _____ Signature/title: _____

INTAKE									OUTPUT		
TIME	AMT/SOLUTION ADDITIVE	SIZE	SITE	RATE	INSERTED BY	ABSORBED	DC'D/SITE	REMOVED BY	TIME	TYPE/RTE	AMT
TOTAL SCORE: _____											

INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE

WATERBURY HOSPITAL HEALTH CENTER



- Discharge Instructions reviewed with Patient/Guardian.
- Patient verbalizes understanding of Instructions and aftercare.

TIME	VITAL SIGNS				RESPIRATORY		CARDIAC RHYTHM	ACCU-CHECK (mg/dl)	PAIN SCALE Pre-intervention	MEDICATIONS			RESPONSE		INITIALS
	T	P	R	BP	SaO2 %	Breath Sounds				Med	Dose	Route	PAIN SCORE	COMMENT/ MODIFIED RAMSEY	

PEDIATRIC PAIN SCORES				ACUTE ILLNESS OBSERVATION SCORE									
		NUMERIC SCALE	OBSERVATION ITEM		1 NORMAL	3 MODERATE IMPAIRMENT	5 SEVERE IMPAIRMENT						
			WONG-BAKER SCALE	Color	Pink	Acrocyanosis	Cyanotic, pale, gray						
SEE PAIN SCALE REFERENCE FORM			NEONATAL INFANT PAIN SCALE (NIPS)	Hydration	Turgor, eyes, MM nl	MM dry	Skin doughy OR tented AND dry MM AND/OR eyes sunken						
<table border="1"> <tr> <td>0</td> <td>1</td> <td>2</td> </tr> <tr> <td>Awake or Awakening</td> <td>Follows commands/ intermittent arousal</td> <td>Unresponsive</td> </tr> </table>				0	1	2	Awake or Awakening	Follows commands/ intermittent arousal	Unresponsive	MODIFIED RAMSEY SCALE	Cry Quality	Strong/normal tone or NOT crying	Whimpering/ sobbing
0	1	2											
Awake or Awakening	Follows commands/ intermittent arousal	Unresponsive											
				State Variation	If awake, stays awake OR if asleep – wakens easily	Eyes close briefly/ awake OR awakens with prlonged stimulation	Falls to sleep or unresponsive						
				Engagability	Smiles or alerts	Brief smile OR alerts briefly	No smile, face anxious, dull, expressionless OR no alerting						
				Initial Score: _____ Time: _____									
				Signature: _____									