KEY
N/A - Not Applicable
NIC – Not in Chart
UTD – Unable to Determine
Ø - None

KINGSBOROUGH COMMUNITY COLLEGE
DEPARTMENT OF NURSING

PEDIATRIC

NURSING ASSESSMENT

STUDENT_____ CLIENT INITIALS _____
INSTRUCTOR_____ ROOM NO_____
AGENCY/SECTION_____ DATES OF CARE _____

DIRECTIONS: Please fill in each line/space. Nothing should be left blank.

DATA COLLECTION: HISTORY & HEALTH ASSESSMENT

PRESENT ILLNESS - Chief Complaint (Admission date, reason for seeking care, pt. explanation)

_____
_____
_____

HISTORY OF PRESENT ILLNESS - (When started, description of problem, location, character, severity, timing, aggravating or relieving factors, associated factors, client's perception of what the symptom means)

_____
_____
_____

MEDICAL DIAGNOSIS:_____

CONCURRENT HEALTH PROBLEMS: _____

PAST MEDICAL HISTORY:

Childhood Illness_____
Infectious Diseases _____
Immunizations (Childhood, Hep B, Influenza, Pneumococcal, last Tetanus & TB test) _____
Prior Hospitalizations (Reason, Treatment, Length of Stay)

_____
_____

History of: Anemia, Asthma, Cancer, Cardiac Disease, CVA (stroke) Diabetes Mellitus, Emphysema, Kidney Disease, Falls, Fractures,Genetic Disease, Hepatitis, Hypertension, Mental Illness, Sexually Transmitted Diseases, Tuberculosis.

_____
_____
_____

PAST SURGICAL HISTORY: (Type, Date, Place, Length of Stay)

_____
_____
_____

TRANSFUSIONS (Dates)_____ **REACTIONS** (Describe) _____

MEDICATIONS PRIOR TO ADMISSION: (Prescribed, Over the Counter, Vitamins, Herbs, dose and frequency)

_____
_____
_____

ALLERGIES:

Medications:_____

_____

Reactions _____ _____

DRUG USE:Tobacco - # packs/day _____ # years used _____ Alcohol Use - type/amount ___frequency ___

Recreational Drugs -_____ frequency _____ IVDA - frequency _____ sharing needles ___

FAMILY HISTORY: (Illness in family, mother, father, siblings)

_____

_____

SOCIAL HISTORY: Language Spoken _____ Major loss/change in past year _____

Age: _____ Sex: _____ Marital Status: _____ Developmental Level: _____ Role/Position in Family: _____

Family Constellations (#, Ages): _____ Support System: _____

Education: _____ Occupation: _____

Religious beliefs/practices : _____

Cultural/Ethic Background: _____Pertinent Cultural Practice: _____

Living Arrangements (# rooms, people, adequate heat/hot water, etc.,) _____

Health Insurance: _____ Financial Concerns: _____

NUTRITIONAL HISTORY: Special diet/Supplements _____ Appetite _____

Number of meals/day: _____ Who prepares meals: _____ Food likes/Dislikes: _____

Religious requirements: _____ Eats alone or with others: _____

Dentition/Dentures/Dominant Hand:

_____

Recent Weight Gain/Loss: _____ Dysphagia: _____ Food Allergies: _____ Reaction: _____

Bowel Habits (frequency, consistency of stool, use of laxatives): _____

Urinary elimination (frequency, dysuria, complaints): _____

REST/SLEEP/ACTIVITY:

Usual #hrs/night: _____ Naps (time of day/length): _____ Nocturia_____ Developmental stage Variations _____

Use of meds to sleep: _____ Sleep rituals: _____ Hobbies: _____ Excercise: _____

Need for Assistance with ADL's: _____ Bathing: _____ Toileting: _____ Dressing: _____Feeding: _____

Ambulating _____ Transferring _____ Stair Climbing _____ Shopping _____ Cooking _____ Home Maintenance:_____

(S = self, A = assist, T = total care)

DISCHARGE PLANNING:

Lives: Alone _____ With _____ No known residence _____

Intended Destination Post Discharge _____ Home _____ Undetermined _____ Other _____

Previous Utilization of Community Resources:

___ Home care/Hospice ____ Adult day care ___ Church groups ____ Other ____ Meals on Wheels_____ Homemaker/Home health aide

____ Community support group

Post-discharge Transportation: _____ Car _____ Ambulance _____ Bus/Taxi _____ Unable to determine at this time

Anticipated Financial Assistance Post-discharge?: ____ No____ Yes Anticipated Problems with Self-care Post-discharge?:____ No ____ Yes

Assistive Devices Needed Post-discharge?: ____ No ___ Yes

Referrals: Discharge coordinator _____ Home Health _____ Social Service _____ V.N.A._____ Other Comments _____

TEACHING NEEDS: (Client, Family/Readiness to learn/Barriers to Learning) _____

_____

PEDIATRIC NURSING HISTORY

General Information

Primary Caregiver_____

Source of Information _____

Child=s Nickname _____

School Grade (if applicable) _____

School Performance _____

Coping Strategies for Hospitalization_____

Nutrition

Foutannels _____

Head Circumference _____

Method of Feeding _____

Feeds Self?_____

Elimination

Toilet trained? _____

a) bowel _____

b) bladder _____

c) day _____

d) night _____

Bedwetting _____

Words used for: stool _____

urine _____

Sleep

Type of Bed _____

Routine (blanket, toy, story) _____

Fears/ Bad Dreams _____

Hygiene

Bathes self _____

Dresses self _____

Brushes teeth _____

Combs hair _____

Safety

Temper Tantrums _____

ID band _____

Environment (toys, equipment) _____

Siderails _____

SCHEDULE OF IMMUNIZATIONS, U.S. 2001

AGE	AGENT
Birth - 2 months	Hepatitis B-1 _____
1 month	Hepatitis B-2 _____
2 months	Dtap _____IPV _____Hib_____PCV_____
4 months	Dtap _____IPV _____Hib_____PCV_____
6 months	Dtap _____Hib _____PCV_____
6 - 18 months	Hepatitis B-3 _____IPV _____
12 - 15 months	Hib _____PCV_____MMR _____
12 - 18 months	Var _____
15 - 18 months	Dtap _____
4 -6 years	Dtap _____IPV_____MMR _____
11 - 12 years	MMR _____ Hepatitis B _____Var _____Td _____
14 - 18 years	Td _____
24 months - 18 years	Hepatitis A_____

Others: (Pneumoccal, Influenza, PPD or tine test, etc.)_____

_____

Comments: (Assess child=s current status and explain why if not received)

_____

_____

_____

_____

Vaccines

1. Hepatitis B
2. Diphtheria, Tetanus, Pertussis
3. H influenza type b
4. Inactivated polio
5. Pneumococcal conjugate
6. Measles, Mumps Rubella
7. Varicella
8. Hepatitis A

Approved by the Advisory Committee on Immunization and the American Academy of Pediatrics.

Developmental Assessment

Expected Behavior	Day 1	Day 2
Stage of Development (Erikson)		
Physical Development (PTA)* Gross Motor		
Fine Motor		
Cognitive Development (Piaget) Language, Social		
Moral Development (Kohlberg)		
Family Relationships (Duvall)		

*PTA = prior to admission

NOTE: The nursing diagnosis of Growth & Development must be done for every child.

DATA COLLECTION	PHYSICAL			ASSESSMENT	
General Appearance	DAY 1			DAY 2	
Systemic Assessment - circle/describe **A. Neurological** Mental Status**:** LOC: alert/drowsy/ lethargic/stuporous/comatose/ restless/confused					
Orientation: time/place/person/recent memory					
Thought Process: reality/delusions/ hallucinations/attention span					
Headaches: Location/frequency					
Eyes: glasses/diplopia/pain/discharge/perla Sclera: red/yellow/clear					
Ears: Hearing loss/tinnitus/vertigo/ deformities					
Speech: Clear/slurred/coherent					
Ability to Swallow:					
Gait:					
Parasthesia:					
Weakness:					
Coordination:					
B. Cardiovascular					
B/P: site/position; Body Temperature & route					
Apical Pulse: rate/rhythm/quality					
Respirations: rate/labored/unlabored Pulse oximetry: O_2 Sat					
Pain: location/frequency/duration/intensity on a scale of 0 - 10/provokes/palleates/quality/ radiates					
fatique/dizziness/chest pain/numbness/ tingling in extremeties					
		Right	Left	Right	Left
Arterial Pulses	Carotid				
0 – absent	Brachial				
1+ - barely palpable	Radial				
2+ - decrease	Femoral				
3+ - full (normal)	Popliteal				
4+ - bounding	Posterior Tibial				
Symmetry	Dorsalis pedis				

	PHYSICAL		ASSESSMENT	
	DAY 1		DAY 2	
B. Cardiovascular (continued) Capillary refill (norm less than 3 seconds) color/temperature/movement/sensation	TOES R	FINGERS R		
	L	L		
	symmetry	symmetry		
Homan's Sign (pain upon dorsiflexion)	R	L		
Skin color/temp/diaphoresis/edema				
Cardiac Monitoring:				
C. Respiratory Breath Sounds: Describe all auscultated lung sounds/clear/decreased/absent	Anterior: RUL			
Adventitious: rales/rhonci/wheeze	LUL			
Respiratory rate/rhythm/depth/quality/effort of breathing/dyspnea/SOB	RLL			
	LLL			
	Posterior RUL			
	LUL			
	RML			
	RLL			
Cough/Productive (describe sputum) Non-productive (frequency/precipitation factors/relief measures)				
Chest Symmetry: equal/unequal				
Chest tube: location/drainage				
Oxygen Therapy:				
Mode (type)				
Percentage				
Liter flow rate				
Ventilator FIO2 TV RR				
Ventilator FIO2 TV RR				
CMV, SIMV, CPAP				
PEEP				
Pressure Support				

DATA COLLECTION	PHYSICAL		ASSESSMENT	
D. Integumentary - Skin:	DAY 1		DAY 2	
Color: pale/cyanotic/flushed/mottled/jaundice				
Temperature: warm/cold/moist				
Turgor/texture				
Mucous Membrane: Color/moisture/integrity				
Rashes/petechiae/ecchymosis/ulcerationss cars/scaling/flaking/purpura/pruritis/ integrity				
Wound: location/approximation/odor, discharge				
Decubitus Ulcers: location/type/size/shape/stage				
Dressings: location/ drainage/ odor				
E. Gastrointestinal:				
Height/Weight:				
Diet/Appetite/Tolerance:				
Nausea/Vomiting:				
Lips: color/moisture/lumps				
Gums & Teeth: swelling/bleeding/discoloration/retraction/ inflammation/loose/missing or carious teeth				
Last Bowel Movement/consistency/color				
Continence/diarrhea/constipation				
Bowel Sounds: present/ absent, hyper/hypo active	RUQ	LUQ	RUQ	LUQ
	RLQ	LLQ	RLQ	LLQ
Abdomen: soft/distended/tenderness/colostomy				
Parenteral Fluids:				
IV:				
Solution:				
Location:				
Rate:				
Site appearance:				

DATA COLLECTION	PHYSICAL		ASSESSMENT	
E. Gastrointestinal:				
Hyperalimentation:				
Solution:				
Location:				
Rate:				
Site appearance:				
Gavage: (NG, PEG):				
Type:				
route:				
amount:				
frequency:				
residual:				
F. Genitourinary				
Continence:				
Voiding: frequency/ color/clarity/ odor/amount/dysuria/urgency				
Bladder distention:				
Vaginal/Penile Drainage:				
Catheter: type/patency/drainage/				
G. Musculoskeletal Extremities: deformities/nodules/atrophy/joint stability				
ROJM:	upper	lower	upper	lower
	R	R	R	R
	L	L	R	R
Muscle Tonus/Strength:				
Coordination/Gait/Balance:				
Pain/Tenderness/Edema:				
Supportive Devices:				
Casts/Traction:				
H. Endocrine/Reproductive:				
Fatigue/wt. change/temperature intolerance				
Hair distribution/ulcers/herpes/warts/ Polydipsia/Polyuria/Polyphagia:				
Breast (masses/dimpling/ discharge/ pain)				

DATA COLLECTION	PHYSICAL	ASSESSMENT
	DAY 1	DAY 2
H. Endocrine/Reproductive: (continued)		
Last Mammogram/results:		
LMP/last pap smear & results:		
Gravida/Para:		
Penis: location of meatus/chancres/discharge/ tenderness/swelling		
Scrotum: lumps/swelling/ulcers/tenderness/ testicles		
Last Prostate exam & results:		

TEXTBOOK PICTURE (Definition, Major S/S, Tx)

DATA COLLECTION: PHYSICIAN ORDERS	
Date:	ORDERS:
Diet:	
Activity:	
Lab/Diagnostic Tests:	
Treatment/Therapies	
Medications:	

PHARMACOLOGY DATA ANALYSIS

Trade Name	Generic Name	Classification	Normal Dosage	Action	Side Effects

DATA COLLECTION: **(document results of admission & current result & significance)**	**Diagnostic & Lab Tests**	
Normal: Include normal parameters for assigned clinical agency.	**Admission Date** **Current Date**	**Significance: Circle only the appropriate significant finding or enter the reason if not printed.**
Complete Blood Count		
WBC		↑Inflammatory and infectious processes, leukemia. ↓Aplastic anemia, viral infections.
RBC		↑ ↓Below NR – indicates anemia, hemorrhage
Hgb		↑COPD, high altitudes, polycythemia. ↓Anemia hemmorhage, overhydration.
Hct		↑Dehydration, high altitudes, polycythemia. ↓Anemia, hemmorhage, overhydration.
MCV		↑Macrocytic anemia ↓Microcytic anemia
MCH		↑Macrocytic anemia ↓Microcytic anemia
MCHC		↑Spherocytosis ↓Hypochromic Anemia
Platelet		↑Acute infections, chronic granulocytic leukemia, chronic pancreatitis, cirrhosis, collagen disorders, polycythemia, postsplenectomy ↓Acute leukemia, DIC, thrombocytopenic pupura.
Differential Band Neutrophils		↑ Acute infections
Esonophils		↑Allergic reactions, esinophilic and chronic granulocitic leukemia, parasitic disorders, Hodgkin's disease. ↓Steroid therapy
Basophils		↑Hyperthyroidism, ulcerative colitis, mycloproliferative diseases ↓Hyperthyroidism, stress
Lymphocytes		↑Chronic infections, lymphocytic leukemia mononucleosis, viral infections ↓Adrenocortical Steroid therapy, whole body irradiation.
Monocytes		↑Chronic inflammatory disorders, malaria, monocytic leukemia, acute infections, Hodgkins disease. ↓Steroid therapy

DATA COLLECTION: **(document results of admission & current result & significance)**	**Diagnostic & Lab Tests**	↑ Warfarin therapy, deficiency of factors I, II, V, VII, and X, vitamin K deficiency, liver disease.
Normal: Include normal parameters for assigned clinical agency	**Admission Date** **Current Date**	**Significance: Circle only the appropriate significant finding or enter the reason if not printed.**
Pt Control **INR**		↑ Warfarin therapy, deficiency of factors I, II, V, VII, and X, vitamin K deficiency, liver disease.
Ptt Control		↑Deficiency of factors, I,II, V, VII, IX and X, XI, <II; hemophilia; liver disease, heparin therapy.
Serum Electrolytes Na		↑Dehydration, impaired renal function, primary aldosteronism, steroid therapy. ↓Addison's disease, diabetic ketoacidosis, diuretic therapy, excessive loss from gastrointestinal tract, excessive perspiration, water intoxication.
K		↑Addison's disease, diabetic ketosis, massive tissue destruction, renal failure. ↓Cushing's syndrome, severe diarrhea, diuretic therapy, gastrointestinal fistula, pyloric obstruction, starvation, vomiting.
Cl		↑Cardiac decompensation, metabolic acidosis, respiratory alkalosis, steroid therapy, uremia . ↓Addison's disease, diarrhea, metabolic alkalosis, respiratory acidosis, vomiting.
BUN		↑Increase in protein catabolism (fever, distress), renal disease, UTI. ↓Malnutrition, sever liver damage.
Creatinine		↑Active rheumatoid arthritis, biliary obstruction, hyperthyroidism, renal disorders, severe muscle disease ↓Diabetes Mellitus.
Glucose		↑Acute stress, cerebral lesions, Cushing's disease, Diabetes M., hyperthyroidism, pancreatic insufficiency. ↓Addison's disease, hepatic disease, hypothyroidism, insulin overdosage, pancreatic tumor, pituitary hypofunction, postgastrectrectomy dumping syndrome.
CO_2		↑Compensated respiratory acidosis, metabolic alkalosis ↓Compensated respiratory alkalosis, metabolic acidosis
Mg		↑Addison's disease, hypothyroidism, renal failure ↓ Chronic alcoholism hyperparathyroidism, hyperthyroidism, hypoparathyroidism, severe malabsorption.
Ca		↑ Acute osteoporosis, hyperparathyroidism, Vitamin D intoxication, multiple myeloma. ↓ Acute pancreatitis, hypoparathyroidism, liver disease, malabsorption syndrome, renal failure, Vitamin D deficiency.

DATA COLLECTION: **(document results of admission & current result & significance)**	**Diagnostic & Lab Tests**	
Normal: Include normal parameters for assigned clinical agency	**Admission Date** **Current Date**	**Significance: Circle only the appropriate significant finding or enter the reason if not printed**
Albumin		↑Dehydration ↓ Chronic liver disease, malabsorption, malnutrition, nephrotic syndrome, pregnancy
Total Protein		↑Burns, cirrhosis (globulin fraction) dehydration. ↓Congenital agammaglobulinemia, liver disease, malabsorption
Urinalysis Color Straw		
Specify gravity		↑Albuminuria, dehydration, glycosuria ↓Diabetes insipidus.
Ph		↑Chronic renal failure, compensatory phase of alkalosis, salicylate intoxication, vegetable diet ↓Compensatory phase of acidosis, dehydration, emphysema
Glucose (negative)		↑Diabetes M. low renal threshold for glucose resorption, physiologic stress, pituitary disorders.
Ketones (negative)		↑Marked ketonuria
Blood (negative)		↑Infection in urinary tract/ See RBC
Protein (negative)		↑Congestive heart failure, nephritis, nephrosis, physiologic stress.
Bile (negative)		↑Hepatitis
Casts (absent)		↑Renal alterations
RBC (negative)		↑Damage to glomerulus or tubules, trauma, disease of lower urinary tract.
WBC (negative)		↑Infection in urinary tract

DATA COLLECTION: **(document results of admission & current result & significance)**	**Diagnostic & Lab Tests**	↑ Warfarin therapy, deficiency of factors I, II, V, VII, and X, vitamin K deficiency, liver disease.
	Admission Date **Current Date**	**Significance: Circle only the appropriate significant finding or enter the reason if not printed.**
EKG		
Chest X-ray		
Arterial Blood Gases		
ph (7.35 – 7.45)		
pCO_2 (35 - 45)		
pO_2 (80 - 100)		
HCO_3 (22 – 26)		
$o_2$sat (90 – 100)		
Other tests/procedures related to client hospitalization (include normal, client results and significance).		

DATA ANALYSIS:	NURSING DIAGNOSIS	
DATA SOURCE	SIGNIFICANT FINDINGS	NURSING DX: Write all applicable in PES format.
1. Nursing History		
2. Physical Assessment		
3. Diagnostic/Lab Assessment		
4. Physician's Orders		

Student _____ Date(s) Experience _____

Client's Initials_____

NURSING CARE PLAN

Nursing Diagnosis	Expected Outcome & Criteria for Measuring	Nursing Actions	Rationale	Evaluation of Outcome

Problem: Etiology (related to) Signs & Symptoms (as evidence by)				

Student _____ Date(s) Experience _____

Client's Initials_____

NURSING CARE PLAN

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NURSING CARE PLAN

Nursing Diagnosis	Expected Outcome & Criteria for Measuring	Nursing Actions	Rationale	Evaluation of Outcome

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Student _____ Date(s) Experience _____

Client's Initials_____

Student's Nurse's Progess Note Day 1

Student's Nurse's Progress Note Day 2

STUDENT SELF-EVALUATION

Directions: Take time to do a realistic evaluation of your abilities in the areas listed below. Reflect on your overall performance for the course. What can you identify as support/barriers to your performance. Cite specific examples from your clinical experiences.

9. NURSING PROCESS:

A. Assessment –

What was your ability to gather data? Did you assess the client's cultural, developmental, emotional, physical, psychological, and spiritual needs? Did you use all sources ex. client, family, staff, medical record etc.

_____

_____

_____

B. Analysis/Diagnosis -

Did you identify significant findings and cluster the data to arrive at diagnosis? Did you use your Nursing Diagnosis book to select the diagnostic label? Did you identify contributing/risk factors for your patient? Did you use the PES format?

_____

_____

_____

C. Planning –

Did you prioritize your diagnoses? Were outcomes stated with specific criteria for measurement? Were nursing actions clear, did you include patient medications and teaching needs?

_____

_____

_____

D. Implementation –

Did you carry out the plan, maintain a safe environment, provide patient/family teaching, collaborate with others?

_____

_____

_____

E. Evaluation –

Were the outcomes met, how? Did you state specific outcome criteria? Does the plan need to be continued or changed?

_____

_____

_____

10. THERAPEUTIC INTERVENTIONS

What psychomotor skills did you perform? What do you need improvement with? What skills would you like to perform?

_____

_____

_____

11. COMMUNICATION ABILITIES

Did you use therapeutic techniques? How effective was your verbal/non-verbal communication with the client/family, staff, peers, instructor? How would you describe your participation and contributions to pre and post conference? Was your written documentation organized clear, concise and complete? Did you complete the flow sheet, I & O, Medex etc?

_____

_____

_____

12. MANAGEMENT

Did you manage your time well? Was all care given? Were your priorities correct?

_____

_____

_____

5. CRITICAL THINKING

Did you apply theoretical knowledge? Can you explain and support the thinking behind the actions you chose? Did you consider . . . What if something goes wrong? or What if we try . . . ? Did you recognize your biases? What would you do differently? Did you have self-confidence? Did you demonstrate good clinical judgement?

_____

_____

_____

NURSING ASSESSMENT AND CARE PLAN EVALUATION CRITERIA

Please note: All elements of the nursing process must be completed in order to receive a satisfactory grade of 75.

ASSESSMENT	**(20)**
Data is logically summarized:	
a) History and Health Assessment	4
b) Physical Assessment	4
c) Physician's Orders	2
d) Textbook Picture	2
e) Pharmacology Data Analysis	4
f) Diagnostic and lab tests	4
DIAGNOSING (DATA ANALYSIS)	(**25)**
Clusters Data	5
Identifies **ALL** Significant Findings	10
Identifies **ALL** relevant nursing diagnoses using the PES format	10
PLANNING (Develops Plan for 4 highest priority diagnoses – 3 physiological/1 psychological)	**(15)**
Prioritizes all identified diagnoses as HI-MED-LOW	5
Identifies appropriate client goals/desired outcomes	5
States criteria for evaluation of client goals/outcomes	5
IMPLEMENTATION	**(30)**
Identifies independent interventions to accomplish the top priorities for care (including teaching when appropriate)	7
Identifies interdependent interventions to accomplish the top priorities of care (including medications when appropriate)	7
Cites references for interventions	2
Explains scientific rationale for each intervention	7
Documents nursing activities on appropriate flow sheets and nurses' notes	7
EVALUATION	**(10)**
Evaluates outcomes for 4 top priority diagnoses using stated criteria for evaluation	5
Evaluates (self) performance of care	1
Correct grammar is used throughout document	2
Paper is legible	2
Total Points possible	**100**

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