The Clinical Education Center is packed with new clinical content and nursing application
Please prepare for the simulation scenarios as you would for a clinical day.
Be prepared to provide knowledgeable, effective, and safe patient care in each of the simulation scenarios today. You will need to prepare for simulation in advance.

Please prepare before this experience:
- Complete the Care Plan 5 Column tool and medication cards utilizing the patient data for simulation patient Cody Hall.
- There is a great Bates video to review pediatric assessment available through the library online. Feel free to review as needed.

Please read before this experience:
- This workbook
- Selected procedures
- The 2 assigned articles:

Please bring to this experience:
- This workbook, please review the simulation in detail. You should be familiar with the patient’s PMH, admitting diagnosis, possible interventions which include medications
- Completed Care Plan tool
- Stethoscope
- Clinical resources i.e. pen, penlight, clipboard
- Davis Drug book
- Enthusiasm and the thirst to acquire nursing knowledge😊
Clinical Education Center

Activity #1
Basic Assessment and Vital Signs on Children

45 minutes

Your role as a student nurse: Complete a basic assessment on a child and obtain a set of vital signs.

Review Jarvis pg. 146-148

Critical Thinking Exercise: Use the space below to document your findings. Then reflect- are these values within the normal range? What techniques helped you be more successful with your assessment?

HR___ BP_____ Resp.___ O2____ Temp.___
Head/Neuro: ____________________________________________
Respiratory: ____________________________________________
Cardiac: _______________________________________________
Abdominal/GI/GU: _______________________________________
Extremities: ____________________________________________

Activity #2
G-tube Considerations

20 minutes

Your role as a student nurse: Become familiar with mickey buttons and other devices used for tube feedings. Understand rationale for and perform site care.

Critical Thinking Exercise: As a parent of a child with special feeding needs, how would you feel? As a nurse, how can you help alleviate some of these concerns?

Activity #3
Nutrition

20 minutes

Your role as a student nurse: Understand some of the different formulas given to children and their rationales. Also understand the different types of feedings (continuous vs. bolus) and why they are used.

Review the article about “How to perform a subjective global nutrition assessment in children.” (link on page 1)

Critical Thinking Exercise: What teaching would you do with the child and the parents to help them be successful with a new feeding regimen?

Activity #4
Elimination

20 minutes

Your role as a student nurse: Become familiar with different elimination devices for example: straight caths, sample bags, diaper scales, and ostomies and how they are different for pediatrics.

Critical Thinking Exercise: Why is it important to obtain accurate intake and output with the pediatric population? How will these devices help you?
Simulation

Your role as a student nurse: Be prepared to work for 15 minutes in groups of 3 to complete objectives for each scenario. Three students will actively participate in simulation and 3 students will actively observe having comments to share with the group regarding nursing interventions, assessment, and safety. All 6 students will actively participate for 15 minutes with an instructor guided debrief.

Please review this workbook including each scenario, the patient's medical orders, MAR, and admission report. Review the article about “Bruises in children: normal or child abuse?” (see link on page 1)

General Patient Medical Information for Scenario 1 and 2

Primary Medical Diagnosis: Recurrent Bronchitis, history of Esophageal Atresia with gastrostomy tube

Situation: Lily has had multiple hospital admissions for recurrent bronchitis, and was admitted this morning through the emergency department at 0600 with a fever of 103.4°F (39.7°C).

Background: Lily Peterson is a 7 month old Caucasian female diagnosed with severe Esophageal Atresia which has required her to have gastrostomy tube (G-tube) feedings since birth.

Assessment: ED assessment prior to transfer: A&O x4. S1 S2 no murmurs. Respiratory effort labored with crackles throughout, dry cough at times. BS active x 4 quads, g-tube in place, skin intact.

Recommendations: Please see each scenario for specific objectives

Scenario #1-New Admission

Recommendations: It is now 10:00 am. Admit Lily Peterson to your unit by verifying orders, implementing orders, and educating the patient and family on the plan of care. As a team please admit this patient to your unit and provide any nursing care she may need.

At minimum please complete:

- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Provide patient and family education to hospital process and care, orders, and overall plan of care.
- Verify admission orders, verify MAR, and verify TF
- Also provide any nursing care for patient and communication to provider as needed

Scenario #2 New admission-1 hour later

Recommendations: It is now 1100 and Lily Peterson seems to be feeling ill. Please perform a basic assessment and as a team provide her with any nursing care and medications she may need.

At minimum please complete:

- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Verify TF and provide patient any medications as needed
- Provide any nursing care for patient and communication to provider as needed
Lily Peterson  
DOB 3/21  
MRN: 48980094

**Situation**

Date: **Today**  
Time: **Now**  
Room #: **Sim**  
MD: **Trefler**  
Diagnosis or Chief Complaint: **Acute Bronchitis**

**Admission History:**  
Yes  
No  
Isolation Required:  
Yes  
No  
Type: 

**Background**

7 month old female with acute bronchitis. Came in with fever of 103.4F (39.7°C) and cough.  
PMH: Esophageal Atresia with gastrostomy tube  
Allergy: Iodine

**Assessment**

**Admission History**  
Yes  
No  
Isolation Required:  
Yes  
No  
Type: 

**Elderly female with acute bronchitis. Came in with fever of 103.4F (39.7°C) and cough.**  
PMH: Esophageal Atresia with gastrostomy tube  
Allergy: Iodine

**Backgroun**

7 month old female with acute bronchitis. Came in with fever of 103.4F (39.7°C) and cough.  
PMH: Esophageal Atresia with gastrostomy tube  
Allergy: Iodine

**Assignment**

**Vital Signs on Admission to ED**

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp.</td>
<td>39.7°F</td>
</tr>
<tr>
<td>Pulse</td>
<td>130/2/min</td>
</tr>
<tr>
<td>Resp.</td>
<td>34/min</td>
</tr>
<tr>
<td>O2 Sat.</td>
<td>93%</td>
</tr>
<tr>
<td>RA/BO</td>
<td>105/56</td>
</tr>
</tbody>
</table>

**Physical Assessment**

- **Neuro:**  
  - A/O x4  
  - Alert  
  - Awake  
  - LOC  
  - Lethargic  
  - Comatose  
  - Fluctuating  
  - Agitated  
  - Confused  
  - Combative

**Integumentary:**  
- Skin: W/D  
- Color: WNL  
- Cap Refill < 3 sec

**Respiratory:**  
- Unlabored  
- Labored  
- Tachypneic

**GI:**  
- BS: Present  
- Hypoactive  
- Hyperactive  
- Abd. Distended

**MS:**  
- No deficits  
- Contracted  
- cachetic

**Input & Output**

- Admission IV Fluid:  
- IV Location/Size:  
  - 1. 24g  
  - 2. N/A

**Interventions**

**Labs:**  
- See attached lab results sheet  
- CBC, CMP/BMP, TROP, UA, Other

**Radiology:**  
- CT, XR, U/S Type:  
- Abnormal/Pertinent Results:  
- Acute Bronchitis, no pneumonia

**Tubes:**  
- Foley Size: N/A  
- NGT Size: N/A

**Social Assessment**

- Activity:  
  - Independent  
  - With Assistance  
  - Dependant

- Pt lives:  
  - W/Family  
  - Alone  
  - Homeless  
  - Caregiver

- Deficits:  
  - Deaf/HOH  
  - Blind/Vision Impaired  
  - Other

- Nursing Swallow Evaluation:  
  - Pass  
  - Fail  
  - N/A  
  - Not done

- Medications

**Meds given in ED:**  
- Tylenol 100mg @ 0600; Albuterol neb. @ 0600; Ampicillin 720 mg IV @ 0630

**Antibiotic Started:**  
- Yes  
- No  
- N/A

**Recommen**

**Precautions:**  
- none

**Care Issues:**  
- MOC helps with tube feedings and cares

**Special Equipment Needed:**  
- Pt has her own extension tubing for tube feedings.

**Goals/Things to watch out for:**

- Decrease fever, control breathing

**Labs or Medications to be done soon:**

- See orders
Signatures (PRINT)
ED RN Completing Report: Sue Swanson RN ___________________ Ext. 7234__ Staff Confirming Fax Receipt: _____ Time: _______
Pt. Transported By tech ________________________ Patient Received By: _______ Time: _______

Pediatrics  Day 1 CEC/Sim Workbook
5
**Lily Peterson**  
D.O.B. – 3/21  
MRN: 48980094

<table>
<thead>
<tr>
<th>SIGNATURE/TITLE</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Treffer MD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**DATE:** Today  
**TIME:** 0800

**ATTENDING PHYSICIAN:** Dr. Treffer  
**UPI ID #:** 3456

**ORDERING HEALTHCARE PROVIDER:**  
Dr. Treffer  
GME/UPI  
3456

**SERVICE:** Pediatrics  
**CODE STATUS:** Full

**PAGER:** 3567

**ALLERGIES:** Iodine

1. Admit to Pediatrics
2. Admit height: 26"  Admit weight: 7.2 Kg
3. Diagnosis: Acute Bronchitis
4. PMH: Esophageal Atresia with Gastrostomy tube
5. Vital Signs q 8 hours and pm, Continuous Pulse oximetry
6. Call HO: Temp ≥ 38.3 C or ≤ 35,  
SBP ≥ 155 or ≤ 70,  
HR ≥ 140 or ≤ 60,  
RR ≥ 30 or ≤ 18
7. Intake and Output q 4 hours
8. Oxygen as needed for SpO2 < 92%
9. Activity: OOB 3x daily as tolerated, HOB<30 degrees
10. Diet: Complete peptide based elemental nutrition for children at 48mL/hr for 16 hrs starting at 2000 and off at 1300. Oral fluids as tolerated.
11. Begin feedings now until 1300 today.
12. Daily chest x-rays
13. IV Access: Saline lock, maintain access
14. Gentamicin 18 mg IV every 8 hours
15. Ampicillin 720 mg IV every 8 hours
16. Acetaminophen elixir 100 mg via gastrostomy tube every 4 hours PRN mild pain or fever greater than 100.5 F (38C)
17. Ibuprofen elixir 70 mg via gastrostomy tube every 6 hours PRN mild pain or fever greater than 100.5F (38C)
18. Ranitidine suspension 29 mg via gastrostomy tube every 12 hours
19. Lansoprazole suspension 15 mg via gastrostomy tube once per day
20. Nutrition Consult
21. Pulmonary Consult

---

**Verified by:**
Medication Administration Record (MAR)

Name: Lily Peterson
MRN: 48980094
Date of Birth: 03/21
Allergies: Iodine
Admit height: 26"  Admit weight: 7.2 kg

<table>
<thead>
<tr>
<th>Scheduled Medications</th>
<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentamicin 18 mg IV q 8 hours</td>
<td>0800 1600 0000</td>
<td>0800 KW</td>
<td></td>
</tr>
<tr>
<td>Ampicillin 720 mg IV every 8 hours</td>
<td>0600 1400 2200</td>
<td>Given @ 0630 in ED by SS</td>
<td></td>
</tr>
<tr>
<td>Ranitidine suspension 29 mg via gastrostomy tube every 12 hours</td>
<td>0700 1900</td>
<td>0700 KW</td>
<td></td>
</tr>
<tr>
<td>Lansoprazole suspension 15 mg via gastrostomy tube once per day</td>
<td>2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature       | Initial |
----------------|---------|
Sue Swanson RN  | SS      |
Katie Welland RN| KW      |
### Medication Administration Record (MAR)

**Name:** Lily Peterson  
**MRN:** 48980094  
**Date of Birth:** 03/21  
**Allergies:** Iodine  
**Admit height:** 26”  
**Admit weight:** 7.2 Kg

<table>
<thead>
<tr>
<th>PRN Medications</th>
<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen elixir 100 mg via gastrostomy tube every 4 hours PRN mild pain or fever greater than 100.5°F (38°C)</td>
<td>PRN</td>
<td>Given in ED @ 0600 by SS</td>
<td></td>
</tr>
<tr>
<td>Ibuprofen elixir 70 mg via gastrostomy tube every 6 hours PRN mild pain or fever greater than 100.5°F (38°C)</td>
<td>PRN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature**  
**Initial**  
**Signature**  
**Initial**  
**Signature**  
**Initial**

Sue Swanson RN  
SS
General Patient Medical Information for Scenario 3

**Primary Medical Diagnosis:** Distal radial/ulnar fracture

**Situation:** Pt admitted from ED before scheduled surgery

**Back Ground:** Pt fell onto outstretched arm from trampoline while in care of MOC boyfriend. FOC voices concern regarding story.

**Assessment:** ED assessment: A & O x 4. Normal RRR, S1 S2 no murmurs. Respiratory effort unlabored with clear breath sounds throughout. BS active x 4 quads. Left wrist with obvious boney abnormality, CMS intact with 2+ pulse. Other extremities unremarkable. Right AC with 22 gauge PIV.

Please see each scenario for specific assessment changes.

**Recommendations:** Please see each scenario for specific objectives.

---

**Scenario #3 Cody Hall**

**Recommendations:** Admit Cody Hall to your unit by verifying orders, implementing orders, and educating the patient and family on the plan of care. As a team please admit this patient to your unit and provide any nursing care he may need. The time is 1100.

At minimum please complete:

- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Provide patient education to hospital process and care, orders and overall plan of care.
- Verify admission orders, verify MAR, and verify IVF along with review what medications the patient received in ED.
- Also provide any nursing care for patient and communication to provider as needed.
Cody Hall  
DOB: 7/19  
MRN: 48980118

**Date:** Today  
**Time:** Now  
**Room #:** Sim  
**MD:** Parker

**Diagnosis or Chief Complaint:** Distal radial/ulnar fracture

**Admission History:** □ Yes  □ No  
**Isolation Required:** □ Yes  □ No  
**Type:**

---

**Background:**

7 year old male who fell from a trampoline onto his outstretched arm. Confirmed fracture via xray.

**ASSessment:**

<table>
<thead>
<tr>
<th>Vital Signs on Admission to ED</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Temp. 37.2  
O2 Sat. 91%  
Height: 56 inches  
Weight: 22kg | Labs: See attached lab results sheet |
| Pulse Rate/Rhythm 88 / Reg  
Resp: 28  
RA/O2 RA B/P 108/52 | CBC, CMP/BMP, TROP, UA, Other: |
| **Physical Assessment** | Abnormal/Pertinent Results: __See Labs__ |
| Neuro: □ A/O x4  
□ Alert  
□ Awake  
□ LOC  
□ Lethargic  
□ Comatose  
□ Fluctuating  
□ Agitated  
□ Confused  
□ Combative | Radiology: CT, XR, U/S Type: __3 view wrist__ |
| □ Other: | Abnormal/Pertinent Results: __lt distal radial/ulnar fx__ |
| Integumentary □ Skin WD  
□ Color WNL  
□ Cap Refill < 3 sec | Tubes: Foley Size N/A  
□ NGT Size N/A |
| □ Other: | Chest Tube: □ R  
□ L  
Air Leak  
□ Crepitus  
□ Drainage Color |
| Respiratory: □ Unlabored  
□ Labored  
□ Tachypneic  
□ Clear  
□ Wheezes  
□ Crackles  
□ Diminished  
□ Other: | Other: |
| □ 2+ pulses  
□ 1+ pulses  
□ Doppler pulses  
□ Absent pulses | |
| Gt: BS □ Present  
□ Hypoactive  
□ Hyperactive  
□ Abd. Distended  
□ Other: | Input & Output |
| □ Other: | Admission IV Fluid: __See orders__ |
| MS: □ No deficits  
□ Contracted  
□ Cachetic  
□ Amputation  
□ Pt with sling in place | IV Location/Size: 1. __22g / R AC__  
2. _______ / _______ |
| □ Other: | Input: Oral __N/A__ cc's  
□ IV __N/A__ cc's  
□ Other: __N/A__ cc's |
| Pain Management | Output: Urine __N/A__ cc's  
□ Emesis __N/A__ cc's  
□ NGT __N/A__ cc's  
□ CT Drainage __N/A__ cc's  
□ Other: __N/A__ cc's |
| Pain level before meds: 5 / 10  
Location of Pain: arm | Social Assessment |
| Pain level now: 2 / 10  
Location of Pain: arm | Activity: □ Independent  
□ With Assistance  
□ Dependant |
| Pain Medication: __Fentanyl 25mcg__  
Last Dose Given At: 12:30 | Pt lives: □ W/ Family  
□ Alone  
□ Homeless, □ Caregiver |
| Pain Goal: less than 3 / 10 | Deficits: □ Deaf/HOH  
□ Blind/Vision Impaired  
□ Other: |
| **Meds given in ED:** __Fentanyl 50mcg since admission__ | Nursing Swallow Evaluation: □ Pass  
□ Fail  
□ N/A  
□ Not done |
| Antibiotic Started: □ Yes  
□ No  
□ N/A  
□ Type___________ Time __________ |

---

See triage note for list of home meds  
**Medications**
<table>
<thead>
<tr>
<th>Precautions: none</th>
<th>Goals/Things to watch out for: Pain control, monitor CSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Issues: Difficulty ambulating due to pain</td>
<td>Labs or Medications to be done soon: Set orders</td>
</tr>
<tr>
<td>Special Equipment Needed: None</td>
<td></td>
</tr>
</tbody>
</table>

**Signatures (PRINT)**

ED RN Completing Report: Sue Swanson RN Ext 7234 Staff Confirming Fax Receipt: Time:  
Pt. Transported By tech Patient Received By: Time:
**Dispensing by non-proprietary name under formulary system is permitted, unless checked here:**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today</td>
<td>1100</td>
</tr>
</tbody>
</table>

**ATTENDING PHYSICIAN:** Dr. Miller  
UPI ID #3469

**ORDERING HEALTHCARE PROVIDER:**
Dr. Parker  
GME/UPI 3458

**SERVICE:** Pediatrics  
**CODE STATUS:** Full

**PAGER:** 3558

**ALLERGIES:** Iodine

1. Admit to Pediatrics
2. Admit height: 56 inches  Admit weight: 22 Kg
3. Diagnosis: Left distal radial/ulnar fx
4. PMH: Negative
5. Vital Signs q 8 hours and prn, Continuous Pulse oximetry
6. Call HO: Temp ≥ 38.3°C or ≤ 35, SBP ≥ 160 or ≤ 80, HR ≥ 160 or ≤ 50, RR ≥ 30 or ≤ 10
7. Intake and Output q 4 hours
8. Oxygen as needed for SpO2 < 92%
9. Activity: OOB as tolerated, Diet: NPO
10. CBC prior to OR
11. IV Access: Saline lock, maintain access
12. D5 ½ NS at weight based maintenance/hour
13. Cefazolin 600mg on call to OR
14. Morphine 1-2 mg IV every 4 hours PRN mod-severe pain 4-10
15. Acetaminophen 325mg PO every 4 hours PRN mild pain or fever greater than 100.5°F (38°C)
16. Zofran 2mg IV q 8 hours PRN nausea
17. 

**SIGNATURE/TITLE**
Dr. Parker MD

<table>
<thead>
<tr>
<th>Verified by:</th>
<th>Title:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Scenario #4- Cody Hall

**Primary Medical Diagnosis:** Distal radial/ulnar fracture

**Situation:** Pt admitted from PACU after scheduled surgery

**Back Ground:** Pt fell onto outstretched arm from trampoline while in care of MOC boyfriend. FOC voices concern regarding story. Pt to OR for internal fixation of distal radial/ulnar fx

**Assessment:** PACU assessment: A & O x 4. Normal RRR, S1 S2 no murmurs. Respiratory effort unlabored with clear breath sounds throughout. BS hypoactive x 4 quads. Left wrist with cast in place, CMS intact with 2+ pulse. Other extremities unremarkable. Right AC with 22 gauge PIV. Antibiotics given at 2000.

**Recommendations:** Please see each scenario for specific objectives

---

Scenario #4 Cody Hall

**Recommendations:** It is now 2300. Admit Cody Hall back to your unit by verifying orders, implementing orders, and educating the patient and family on the plan of care. As a team please admit this patient to your unit and provide any nursing care he may need. At minimum please complete:

- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Provide patient education to hospital process and care, orders and overall plan of care.
- Verify admission orders, verify MAR, and verify IVF along with review what medications the patient received in ED.
- Also provide any nursing care for patient and communication to provider as needed.
### Medications

<table>
<thead>
<tr>
<th>Page 1 of 1</th>
<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
</table>

Dispensing by non-proprietary name under formulary system is permitted, unless checked here: ☐

**DATE:** Today  
**TIME:** 2300

**ATTENDING PHYSICIAN:** Dr. Miller  
**UPI ID #**: 3469

**ORDERING HEALTHCARE PROVIDER:**
- Dr. Parker  
- GME/UPI 3458

**SERVICE:** Pediatrics  
**CODE STATUS:** Full

**PAGER:** 3558

**ALLERGIES:** Iodine

1. Admit to Pediatrics
2. Admit height: 56 inches, Admit weight: 22 Kg
3. Diagnosis: s/p internal fixation lt wrist distal radial/ulnar fx
4. PMH: Negative
5. Vital Signs q 30 minutes x 2 q 1 hour x 1 and q 4 hours and prn, Continuous Pulse oximetry
6. Call HO: Temp $\geq$ 38.3 C or $\leq$ 35,  
SBP $\geq$ 160 or $\leq$ 80,  
HR $\geq$ 160 or $\leq$ 50,  
RR $\geq$ 30 or $\leq$ 10
7. Intake and Output q 4 hours
8. Oxygen as needed for SpO2 < 92%
9. Activity: OOB as tolerated,
10. Diet: sips and chips, advance as tolerated
11. IV Access: Saline lock, maintain access
12. D5½ NS at weight based maintenance/hour. Cap when tolerating PO
13. Cefazolin 600mg Q 6 hours
14. Morphine 1-2 mg IV every 4 hours PRN mod-severe pain 4-10
15. Acetaminophen 325mg PO every 4 hours PRN mild pain or fever greater than 100.5 F (38C)
16. Zofran 2mg IV Q 8 hours PRN nausea
17. 
18. 
19. 
20. 
21. 
22.

**SIGNATURE/TITLE**
**Dr. Parker MD**

**Verified by:**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

**Cody Hall**  
**DOB:** 7/19  
**MRN:** 48980118

---

Pediatrics
Day 1 CEC/Sim Workbook

14
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Route</th>
<th>Frequency</th>
<th>On call to OR</th>
<th>Initial</th>
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</thead>
<tbody>
<tr>
<td>Cefazolin 600mg IVPB x 1 dose</td>
<td></td>
<td></td>
<td>On call to OR</td>
<td></td>
</tr>
<tr>
<td>Morphine 1-2mg IV Q 4 hours PRN pain &gt;4</td>
<td></td>
<td></td>
<td>PRN</td>
<td></td>
</tr>
<tr>
<td>Acetaminophen 325mg PO Q 4 hours pain &lt;4 and fever &gt;38C</td>
<td></td>
<td></td>
<td>PRN</td>
<td></td>
</tr>
<tr>
<td>Ondansetron 2mg IV Q8 hours PRN nausea</td>
<td></td>
<td></td>
<td>PRN</td>
<td></td>
</tr>
<tr>
<td>D5 ½ NS @ per hour maintenance</td>
<td></td>
<td></td>
<td>1100</td>
<td></td>
</tr>
</tbody>
</table>

Signature

Pediatrics  Day 1 CEC/Sim Workbook

15
<table>
<thead>
<tr>
<th>Medications</th>
<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cefazolin 600mg IVPB x 1 dose</td>
<td>0200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0800</td>
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<tr>
<td></td>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine 1-2mg IV Q 4 hours PRN pain &gt;4</td>
<td>PRN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen 325mg PO Q 4 hours pain &lt;4 and fever &gt;38C</td>
<td>PRN</td>
<td></td>
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<tr>
<td>Ondansetron 2mg IV Q8 hours PRN nausea</td>
<td>PRN</td>
<td></td>
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<tr>
<td>D5 ½ NS @ per hour maintenance</td>
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Pediatrics  Day 1  CEC/Sim Workbook