

## IM5 Clinical Worksheet – Pediatric Floor

<b>Student Name:</b> Ashley S. Barraza <b>Date:</b> 9-26-23	<b>Patient Age:</b> 3y/0 M <b>Patient Weight:</b> 16.1 kg
<b>1. Admitting Diagnosis:</b> Acute appendicitis w/ perforation & localized peritonitis	<b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b> Pain
<b>3. Signs and Symptoms:</b> Pain at incision site Fever N/V infection, loss of appetite	<b>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:</b> CT scan
<b>5. Lab Values That May Be Affected:</b> WBC	<b>6. Current Treatment (Include Procedures):</b> pain management
<b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.	<b>8. Patient/Caregiver Teaching:</b> <ol style="list-style-type: none"> <li>1. Review pain meds w/ family</li> <li>2. Monitor incision sites</li> <li>3. Report any N/V</li> </ol>
<ol style="list-style-type: none"> <li>1. Reading a book</li> <li>2. Coloring</li> </ol>	<b>Any Safety Issues identified:</b>

<p>Student Name: Ashley S. Barraza Date: 9-26-23</p>	<p>Patient Age: 3y/0 M Patient Weight: 16.1 kg</p>
<p>9. Calculate the Maintenance Fluid Requirement (Show Your Work): 16.1 Kg</p> $10 \cdot 100 = 1000$ $6.1 \cdot 50 = 305$ $\frac{1305}{24} = 54.375$ <p>Actual Pt MIVF Rate: 25 mL/hr</p> <p>Is There a Significant Discrepancy Between Calculated and Actual Rate? yes</p> <p>If Yes, Why is There a Discrepancy? to keep child hydrated due to surgery &amp; unable to eat</p>	<p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): 16.1 Kg</p> $16.1 \text{ Kg} \cdot 0.5 \text{ mL} = 8.05 \text{ mL/hr}$ <p>Actual Urine Output During Your Shift (mL/hr): x2 &amp; unable to measure; parents flushed down toilet</p>
<p>11. Growth &amp; Development:</p> <p>*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:</p> <p>Erickson Stage: Initiative VS. Guilt</p> <ol style="list-style-type: none"> <li>1. Energetic when explaining why he was Spiderman</li> <li>2. Self-confidence in himself</li> </ol> <p>Piaget Stage: preoperational</p> <ol style="list-style-type: none"> <li>1. pt loved Spider-man &amp; stated he had "Spidermans Super powers"</li> <li>2. He also stated his Spiderman doll would only talk to him because of his powers</li> </ol>	
<p>Please list any medications you administered or procedures you performed during your shift: Ofirmev</p>	

**Pediatric Floor Patient #1**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <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 _____ <b>Edema:</b> <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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> 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	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input 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 <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> _____ <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>Hand 24g</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <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 <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>D5NS 20KCL</u> <u>@ 25ml/hr</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> 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 <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded <b>Bowel Sounds:</b> <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 <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <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 <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input 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: _____ <b>Mucous Membranes:</b> Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
<b>Diet/Formula:</b> <u>Regular</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None Type: _____	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> <u>Abdomen</u> <b>Description:</b> _____ <b>Dressing:</b> _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

Pediatric Floor Patient #1

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake					200			100		50			350
Intake – PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid					25	25	25	25	25	25			150
IV Meds/Flush													
OUTPUT													
Urine	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine						X1			X1				X2
# of immeasurable													X2
Stool													
Urine/Stool mix													
Emesis													
Other													

**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
<b>CHEWS Total Score</b>	
CHEWS Total Score	Total Score (points) <u>0</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

**GENERAL APPEARANCE**

Appearance:  Healthy/Well Nourished  
 Neat/Clean  Emaciated  Unkept

Developmental age:  
 Normal  Delayed

**NEUROLOGICAL**

LOC:  Alert  Confused  Restless  
 Sedated  Unresponsive

Oriented to:  
 Person  Place  Time/Event  
 Appropriate for Age

Pupil Response:  Equal  Unequal  
 Reactive to Light  Size \_\_\_\_\_

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

Extremities:  
 Able to move all extremities  
 Symmetrically  Asymmetrically

Grips: Right S Left S  
Pushes: Right S Left S  
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 \_\_\_\_\_

Oxygen Saturation: \_\_\_\_\_

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

**ELIMINATION**

Urine Appearance: \_\_\_\_\_

Stool Appearance: \_\_\_\_\_  
 Diarrhea  Constipation  
 Bloody  Colostomy

**GASTROINTESTINAL**

Abdomen:  Soft  Firm  Flat  
 Distended  Guarded

Bowel Sounds:  Present X \_\_\_\_\_ quads  
 Active  Hypo  Hyper  Absent

Nausea:  Yes  No

Vomiting:  Yes  No

Passing Flatus:  Yes  No

Tube:  Yes  No Type \_\_\_\_\_  
Location \_\_\_\_\_ Inserted to \_\_\_\_\_ cm  
 Suction Type: \_\_\_\_\_

**NUTRITIONAL**

Diet/Formula: TPN

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 \_\_\_\_\_

Assistive Device:  Crutch  Walker  
 Brace  Wheelchair  Bedridden

**PSYCHOSOCIAL**

Social Status:  Calm/Relaxed  Quiet  
 Friendly  Cooperative  Crying  
 Uncooperative  Restless  
 Withdrawn  Hostile/Anxious

Social/emotional bonding with family:  
 Present  Absent

**IV ACCESS**

Site: \_\_\_\_\_  INT  None  
 Central Line  
Type/Location: Broviac

Appearance:  No Redness/Swelling  
 Red  Swollen  
 Patent  Blood return

Dressing Intact:  Yes  No

Fluids: TPN

**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: \_\_\_\_\_

Mucous Membranes: Color: \_\_\_\_\_  
 Moist  Dry  Ulceration

**PAIN**

Scale Used:  Numeric  FLACC  Faces

Location: \_\_\_\_\_

Type: \_\_\_\_\_

Pain Score:  
0800 \_\_\_\_\_ 1200 6 1600 6

**WOUND/INCISION**

None

Type: \_\_\_\_\_

Location: \_\_\_\_\_

Description: \_\_\_\_\_

Dressing: \_\_\_\_\_

**TUBES/DRAINS**

None

Drain/Tube  
Site: LUG  
Type: Enterostomy tube  
Dressing: \_\_\_\_\_  
Suction: \_\_\_\_\_  
Drainage amount: \_\_\_\_\_  
Drainage color: \_\_\_\_\_

Pediatric Floor Patient #2

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
Intake – PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush							10	10					20
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													
# of immeasurable													
Stool													
Urine/Stool mix					X	X	X	X	X	X			X
Emesis													
Other													

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 <u>2</u> 3
Cardiovascular	Circle the appropriate score for this category: <u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category: <u>0</u> 1 2 3
Staff Concern	1 pt - Concerned
Family Concern	<u>1</u> pt - Concerned or absent
<b>CHEWS Total Score</b>	
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: Ashley S. Barroza

Unit: Pedi Floor

Pt. Initials: J.H. #370

Date: 9-20-23

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

Allergies: NKDA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5NS 20KCL 25ml/hr	Isotonic/ Hypotonic/ Hypertonic	hydration	electrolytes	fluid overload

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Ranges?		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.)
				Is med in therapeutic range?	If not, why?			
Propofol/ Fentanyl Zosyn	extended spectrum Penicillins	1 SIS of infection w/ appendicitis & peritonitis	1520mg IV syringe 38ml/hr Q8h	yes		IV syringe 38ml/hr over 0.5hrs	C.D.H	1. Report BM such as diarrhea 2. Report pain @ IV site 3. Report rash 4. May cause N/V
Metamorphon Oximev	antipyretic non opioid analgesic	pain management	10mg/ml 320mg IV syringe Q8h	yes		IV syringe 92ml/hr over 15min	Hepatotoxicity	1. DO NOT exceed recommend dose in q8hrs 2. may cause constipation 3. may cause N/V 4.
								1. 2. 3. 4.
								1. 2. 3. 4.