

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Eric Andrade Date: 2/6/24</p>	<p>Patient Age: 12yr Patient Weight: 40 kg</p>
<p>1. Admitting Diagnosis:</p> <p>Ruptured appendix</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>GI Assessment Pain scale JP Drain care</p>
<p>3. Signs and Symptoms:</p> <ul style="list-style-type: none"> • weakness • Pain • Edema 	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:</p> <ul style="list-style-type: none"> • Blood test for infections • Ultra sounds • CT scan
<p>5. Lab Values That May Be Affected:</p> <ul style="list-style-type: none"> • elevated WBC • CRP Level 	<p>6. Current Treatment (Include Procedures):</p> <ul style="list-style-type: none"> • Surgery • JP drain
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ol style="list-style-type: none"> 1. Playing video games 2. Playing with toys 	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. Stay hydrated 2. Avoid heavy lifting 3. Rest <p>Any Safety Issues identified:</p> <p>Look for infection at incision site</p>

Pediatric Floor Patient #1

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 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 type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>3</u> L <u>3</u> Lower R _____ L _____ 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	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 checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input 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 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 type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: _____ Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>(R)Hand</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ 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>DS NS</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <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: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: _____	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input checked="" 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Pale <input 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 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: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: _____ Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>RLQ, LLQ</u> Type: <u>Dull</u> Pain Score: 0800 _____ 1200 <u>X</u> 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<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 type="checkbox"/> None Type: <u>Appendix</u> Location: <u>RLQ</u> Description: _____ Dressing: _____
	MOBILITY	TUBES/DRAINS
	<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	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>RLQ</u> Type: <u>JP Drain</u> Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: <u>Red</u>

Pediatric Floor Patient #2

Did not get much of an assessment due to discharge

<p style="text-align: center;">GENERAL APPEARANCE</p> <p>Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p>Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p>Pulse: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____</p> <p>Edema: <input type="checkbox"/> Yes <input type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+</p> <p>Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec</p> <p>Pulses: Upper R _____ L _____ Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None</p>	<p style="text-align: center;">PSYCHOSOCIAL</p> <p>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</p> <p>Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p style="text-align: center;">NEUROLOGICAL</p> <p>LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p>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</p> <p>Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____</p> <p>Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed</p> <p>Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right _____ Left _____ Pushes: Right _____ Left _____ S=Strong W=Weak N=None</p> <p>EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____</p> <p>Seizure Precautions: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">ELIMINATION</p> <p>Urine Appearance: _____</p> <p>Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p style="text-align: center;">IV ACCESS</p> <p>Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____</p> <p>Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return</p> <p>Dressing Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: _____</p>
<p style="text-align: center;">RESPIRATORY</p> <p>Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: Clear <input type="checkbox"/> Right <input 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</p> <p><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p>Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____</p> <p>Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p>Secretions: Color _____ Consistency _____</p> <p>Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____</p> <p>Pulse Ox Site _____</p> <p>Oxygen Saturation: _____</p>	<p style="text-align: center;">GASTROINTESTINAL</p> <p>Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded</p> <p>Bowel Sounds: <input type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p>Nausea: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vomiting: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Passing Flatus: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____</p>	<p style="text-align: center;">SKIN</p> <p>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</p> <p>Condition: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic</p> <p>Turgor: <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds</p> <p>Skin: <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: _____</p> <p>Mucous Membranes: Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
<p style="text-align: center;">NUTRITIONAL</p> <p>Diet/Formula: _____</p> <p>Amount/Schedule: _____</p> <p>Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">MUSCULOSKELETAL</p> <p><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</p> <p>Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All</p> <p>Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____</p>	<p style="text-align: center;">PAIN</p> <p>Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p>Location: _____</p> <p>Type: _____</p> <p>Pain Score: 0800 _____ 1200 _____ 1600 _____</p>
<p style="text-align: center;">MOBILITY</p> <p><input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____</p> <p>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p style="text-align: center;">WOUND/INCISION</p> <p><input type="checkbox"/> None</p> <p>Type: _____</p> <p>Location: _____</p> <p>Description: _____</p> <p>Dressing: _____</p>	<p style="text-align: center;">TUBES/DRAINS</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____</p>

Student Name: Eric Andrade

Unit: Pedi Floor

Pt. Initials: _____

Date: 2/6/24

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

Allergies: Penicillin, Rocephin

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
	Isotonic/ Hypotonic/ Hypertonic			

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	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?			
Ibuprofen	NSAID	Moderate pain	200mg PO Q6hrs			<ul style="list-style-type: none"> feeling sick H/A Tarry stools 	<ol style="list-style-type: none"> Notify the HCP of itchy skin If feeling dizzy, do not get up alone Notify The HCP of unusual bleeding
Zofran	Anti-emetic	Nausea and vomiting	3.5 mg IV Q6 HR			<ul style="list-style-type: none"> fever Palpitations Diarrhea 	<ol style="list-style-type: none"> Notify the HCP of yellowing of the skin Do not get up if onset of blurred vision Notify the HCP of fast or pounding heartbeats
							<ol style="list-style-type: none">
							<ol style="list-style-type: none">
							<ol style="list-style-type: none">