



## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Latonya Esquivel</p> <p><b>Date:</b></p>	<p><b>Patient Age:</b> 3 months</p> <p><b>Patient Weight:</b> 7.9 kg</p>
<p><b>1. Admitting Diagnosis and Pathophysiology</b> (State the pathophysiology in own words)</p> <p>Stridor - narrowing of the upper airway.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b></p> <p>Respiratory focused assessment.</p>
<p><b>3. Identify the most likely and worst possible complications.</b></p> <p>The worst complication would be her oxygen dropping and not able to keep it up which may require mechanical vent.</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b></p> <p>Breathing treatments to keep airways open. No added stress or for patient calm environment.</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b></p> <p>Continuous oxygen sat. monitor patient for respiratory distress.</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b></p> <p>Place patient on oxygen to keep sats at appropriate level.</p>
<p><b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <ol style="list-style-type: none"> <li>1. Sit in bathroom with steam to open up airway.</li> <li>2. Keep patient from using snot to keep airway open.</li> </ol>	<p><b>8. Patient/Caregiver Teaching:</b></p> <ol style="list-style-type: none"> <li>1. Identify respiratory distress.</li> <li>2. Calm environment for patient to keep patient from getting worked up and making it hard to breathe.</li> <li>3. take small breaks during feeding to let patient breathe.</li> </ol> <p><b>Any Safety Issues identified:</b></p> <p style="text-align: center;">N/A</p>

Student Name:		Patient Age:
Date:		Patient Weight:      kg
Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
Disproportionate panel	pos	enterohemorrhagic
Lab TRENDS concerning to Nurse?		
N/A		

**11. Growth & Development:**

\*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:

**Erickson Stage:**

1. Patient had a bowel movement and cried until her parent changed her diaper.
2. When patient cried, she needed to be fed and her parent was there to feed her.

**Piaget Stage:**

1. Patient would grab for bottle when being fed.
2. Patient would grasp my finger when I put it in her hand.

Please list any medications you administered or procedures you performed during your shift:

N/A

**Pediatric Floor Patient #1**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" 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 type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input checked="" 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 type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input checked="" 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 checked="" type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right _____ Left _____ 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> <u>dark yellow</u> <b>Stool Appearance:</b> <u>yellow</u> <input checked="" type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>DAC</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input checked="" type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>N/A</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>big toe</u> <b>Oxygen Saturation:</b> <u>91</u>	<b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" 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 checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <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: _____ <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>Boiled</u> <b>Amount/Schedule:</b> <u>4oz</u> <b>Chewing/Swallowing difficulties:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>Due to narrow airway</u>	<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 checked="" type="checkbox"/> None Type: _____	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> <u>uncomfortable/hard to breathe</u> <b>Pain Score:</b> 0800 <u>5</u> 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" 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 checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Bottle  
170mL

Pediatric Floor Patient #1

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed	402												
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$7.9 \text{ kg} \times 100 = 790 / 24 = 32.9 \text{ mL/hr}$							N/A Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	1												
Stool	1												
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$1 \text{ mL} \times 7.9 \text{ kg} = 7.9 \text{ mL/hr}$													

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>5</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