IM5 Clinical Worksheet – Pediatric Floor

Student Name: Jovana Suarez **Date: 8/28/24**	**Patient Age:** 3 y/o **Patient Weight: 11.6 kg**
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) - **Admitting diagnosis: Patient was unable to tolerate feedings given from G-tube. This could be a possibly that feedings are being given way to quick at one single time** - **Patient was also having spontaneous seizures resulting in eye twitching; patient has brain injury and certain cognitive deficits which could be a result** - **Patient was swabbed for any bacterial infections and was found to have MRSA (methicillin-resistant staphylococcus aureus) due to increased fevering**	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** - I observed, listened, and palpated the abdomen and looked at the G-tube to make sure there was no redness or discoloration. - I looked at mucosal membranes because the patient had poor skin turgor and dry lips; patient was also being suctioned by mother at bed side. Mucosal membranes were pink. - LOC and neuro assessment q 4; patient was having frequent seizures and eye twitching. Seizures did not result in any jerky movements but observed decrease of muscle tone - Assessment on musculoskeletal; patient has naturally arched back due congenital defect according to parent at bedside. No abnormal rashes or lacerations. Skin was intact
3. Identify the most likely and worst possible complications. - **Patient chokes/aspirates** - **Patient gets bedsores due to being bedbound and mobility issues** - **Seizures that cause head injury or more lack of LOC** - **Discoloration around Gtube resulting in hypoxemia/hypoxia/lack of blood perfusion to site**	**4. What interventions can prevent the listed complications from developing?** - Moving the patient every hour and allowing for comfortable repositioning due to bedbound - Staff needs to put patient on seizure precautions - Patient needs to be suctioned by nurse or parent (for family-centered care) - Must check color of G-tube site and assess for any discoloration; must monitor O2 saturation
5.What clinical data/assessments are needed to identify these complications early? - continuous monitoring of O2 saturation to identify any lack of O2 - Check LOC frequently	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** - ensure patent airway and maintain suction supplies nearby in patient's room

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- make frequent rounds to patient room to observe if seizure is taking place - put in an EEG room w/ video and sound recorded; so far mother was the only one observing seizure(s) but was unable to give approximate of how long they were - check blood glucose frequently to see how patient is tolerating feeds	- loosen any tight clothing on patient in case of seizing - monitor glucose levels - observe stools when patient has a BM; patient is given feeds through G-tube and has hx of bad diarrhea - maintain fluids and electrolytes if patient is experiencing diarrhea - check LOC for any neuro changes if patient ever experiences hypoglycemia or hyperglycemia
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** **1.** Using FLACC scale to determine pain level. Pain level is approximately a 5 from initial assessment **2.** Patient is unable to facilitate moving or turning side to side without assistance. Turning and moving patient; using comfortable positioning and allowing patient's mother to help with turning and moving patient.	**8. Patient/Caregiver Teaching:** **1. Parent should stay with the patient or have nurse in the room if parent must leave in case patient has spontaneous seizure** **2. monitor blood glucose w/ glucometer before and after feeds to check if patient is within normal glucose levels** **3. Make sure to always suction mouth before the nose and give breaks in between suctioning. Look for signs of distress from the patient because patient is nonverbal. This education was given with nurse.** **Any Safety Issues identified:** - **Aspiration/choking due to frequent seizures** - **Possible skin shearing due to bed-bound and decrease mobility** - **Hyperglycemia from feed given via G-tube**

	Abnormal Relevant Lab Tests	**Current**	**Clinical Significance**
	Complete Blood Count (CBC) Labs		
1	RBC	4.9	WNL
	WBC	5.2	Lower I think due to poor immune system and getting over MRSA infection. Pt is no longer receiving antibiotics
	Hematocrit	12.6	WNL
	Metabolic Panel Labs		
	calcium	9.3 mg/dL	WNL; I checked calcium because pt has poor muscle tone
	sodium	141 mEq/L	Pt is on IV fluids of NS 0.9% infusion 50 mL/Hr
	glucose	68 mg/dL	Lower side especially since child is receiving 100 ml of

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		formula every hour (100ml/hr)
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
N/A	N/A	N/A
Lab TRENDS concerning to Nurse?		
Glucose should be concerning to nurse; on the lower side and if left untreated, pt may become hypoglycemic		

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. **My patient is developmentally delayed so I would classify him in the infant stage of trust vs mistrust**

2. **Patient would only respond (nonverbally) when mom would be talking, touching, or holding. Patient is blind but was using more senses such as sound in his environment; any sound would startle or cause him to arouse more.**

Piaget Stage:

1. **My patient is developmentally delayed so I would classify him in the Sensorioperative stage.**
2. **My patient is blind so he uses his other senses such as sound to orient him in his environment**
3. **He is unable to use his reflexes and is completely bed-bound but is able to non-verbally express when he does not want to be moved or touched (this is expressed through his behavior); he would let us know when he let out high pitched cries when anyone else (the nurse and I) touch him other than his mother.**

<u>Please list any medications you administered or procedures you performed during your shift:</u>

- **I did not perform any procedures or give medications to my chosen patient due to my nurses' judgement; complications associated with my patient were severe, so my nurse allowed me to observe.**
- **I observed her crush meds and dilute them to put in the G tube**
- **I observed her suction the patient's mouth secretions**
- **I did an abdominal assessment and learned about the G-tube from my nurse**

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 – concern due to seizure precautions
Family Concern	1 pt – Concerned or absent – mother concerned
CHEWS Total Score	
CHEWS Total Score	Total Score (points) _____ 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

- Patient needed to be put on seizure precautions
- Patient's parent (mother) is at bedside
- Patient was being taken off of contact precautions for MRSA

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	- Playing/sleeping appropriately **OR** - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed	- Irritable, difficult to console **OR** - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy **OR** - Reduced response to pain **OR** - Prolonged or frequent seizures **OR** - Pupils asymmetrical or sluggish
Cardiovascular	- Skin tone appropriate for patient - Capillary refill ≤ 2 seconds	- Pale **OR** - Capillary refill 3-4 seconds **OR** - Mild tachycardia **OR** - Intermittent ectopy or irregular HR (not new)	- Grey **OR** - Capillary refill 4-5 seconds **OR** - Moderate tachycardia	- Grey and mottled **OR** - Capillary refill > 5 seconds **OR** - Severe tachycardia **OR** - New onset bradycardia **OR** - New onset/increase in ectopy, irregular HR or heart block
Respiratory	- Within normal parameters - No retractions	- Mild tachypnea/ increased WOB (flaring, retracting) **OR** - Up to 40% supplemental oxygen **OR** - Up to 1L NC > patient's baseline need **OR** - Mild desaturations < patient's baseline **OR** - Intermittent apnea self-resolving	- Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) **OR** - 40-60% oxygen via mask **OR** - 1-2 L NC > patient's baseline need **OR** - Nebs Q 1-2 hour **OR** - Moderate desaturations < patient's baseline **OR** - Apnea requiring repositioning or stimulation	- Severe tachypnea **OR** - RR < normal for age **OR** - Severe increased WOB (i.e. head bobbing, paradoxical breathing) **OR** - > 60% oxygen via mask **OR** - > 2 L NC more than patient's baseline need **OR** - Nebs Q 30 minutes – 1 hour **OR** - Severe desaturations < patient's baseline **OR** - Apnea requiring interventions other than repositioning or stimulation
Staff Concern		- Concerned		
Family Concern		- Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
- Continue Routine Assessments	- 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	- 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

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), http://dx.doi.org/10.1016/j.pedn.2016.10.005