

IM5 Clinical Worksheet - Pediatric Floor

<p>Student Name: Lindsey McCormack Date: 09/03/2024</p>	<p>Patient Age: 2 months Patient Weight: 5 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Diagnosis: Shaken Baby Syndrome (Abusive Head Trauma) Patho: Serious form of physical abuse caused by violently shaking infants and children. The violent shaking causes the brain to rotate within the skull resulting in the damage of blood vessels and neurons.</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Neuro assessment Imaging : MRI, CT, X-Ray of long bones</p>
<p>3. Identify the most likely and worst possible complications.</p> <p>Intracranial bleeding Bilateral retinal hemorrhages Fractures of ribs, possible fractures of long bones</p>	<p>4. What interventions can prevent the listed complications from developing?</p> <p>Anticipatory Guidance for the caregivers</p>
<p>5. What clinical data/assessments are needed to identify these complications early? If the infant or child is showing signs of: -poor feeding -vomiting -apnea -bradycardia -seizures -altered LOC</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Immediate medical treatment: Breathing support- the child may be intubated to provide respiratory support Surgery- for the possible brain bleed</p>

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7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Non-nutritive sucking 2. Swaddling		8. Patient/Caregiver Teaching: 1. Discuss the developmental behavior for this child, that they are at the age where they tend to cry a lot and it is normal. 2. If they are feeling angry or upset to take a breath, step away for a few minutes to regroup. 3. Teaching the parents about the long term effects of shaken baby syndrome: irreversible brain damage, learning disabilities, blindness, seizures and possible death Any Safety Issues identified: N/A	
Abnormal Relevant Lab Tests		Current	Clinical Significance
Complete Blood Count (CBC) Labs			
RHgb	7.6	Anemia	
WBC	12.67	Inflammation	
HCT	22.90	dehydration	
Metabolic Panel Labs			
N/A			
Misc. Labs			
Absolute Neutrophil Count (ANC) (if applicable)			
N/A			
Lab TRENDS concerning to Nurse?			
WBC			

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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. Trust vs Mistrust 2. Mistrust: the infants needs were not consistently met	
Piaget Stage: 1. Sensorimotor Period 2. The infant does not have the reflex behavior due to the head trauma	
Please list any medications you administered or procedures you performed during your shift: Methadone: 0.1mg PO	

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input checked="" 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 checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec	Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input checked="" type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless <input checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
NEUROLOGICAL LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age Pupil Response: <input type="checkbox"/> Equal <input checked="" type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>NA</u> Fontanel: (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input type="checkbox"/> Able to move all extremities	Pulses: Upper R <u>2</u> L <u>2</u> Lower R <u>2</u> L <u>2</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None ELIMINATION Urine Appearance: ___clear/yellow___ Stool Appearance: ___green___	IV ACCESS Site: ___Clavical___ <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: _____ Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: ___TPN___

<input type="checkbox"/> Symmetrically <input checked="" type="checkbox"/> Asymmetrically Grips: Right <u>N</u> Left <u>N</u> Pushes: Right <u>N</u> Left <u>N</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy GASTROINTESTINAL Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input 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: _____	SKIN Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" 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: ____NA____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
RESPIRATORY Respirations: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input checked="" type="checkbox"/> Right <input checked="" 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_NA _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site <u>R</u> foot _____ Oxygen Saturation: <u>98%</u>	NUTRITIONAL Diet/Formula: ____formula____ Amount/Schedule: <u>34</u> mL/hr Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No MUSCULOSKELETAL <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____ MOBILITY <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>NA</u> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	PAIN Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: ____NA____ Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 _____ WOUND/INCISION <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____ TUBES/DRAINS <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

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						32	32	32	32	32	32		192
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush									0.1				0.1mg

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	<ul style="list-style-type: none"> - Playing/sleeping appropriately OR - Alert, at patient's baseline 	<ul style="list-style-type: none"> - Sleepy, somnolent when not disturbed 	<ul style="list-style-type: none"> - Irritable, difficult to console OR - Increase in patient's baseline seizure activity 	<ul style="list-style-type: none"> - Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish
Cardiovascular	<ul style="list-style-type: none"> - Skin tone appropriate for patient - Capillary refill ≤ 2 seconds 	<ul style="list-style-type: none"> - Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new) 	<ul style="list-style-type: none"> - Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Within normal parameters - No retractions 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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
<ul style="list-style-type: none"> - Continue Routine Assessments 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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>