# IM5 Clinical Worksheet – Pediatric Floor

| | |
|---|---|
| **Student Name: Jordan Colley**<br>**Date: 9/3/2024** | **Patient Age:** 5 years old<br>**Patient Weight: 20.4kg** |
| **1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)**<br>Acute appendicitis with perforation and generalized peritonitis.<br><br>The patients appendix ruptured causing infected matter to travel to the abdomen causing the lining of the abdominal cavity to become infected causing a great amount of inflammation. | **2. Priority Focused Assessment You Will Perform Related to the Diagnosis:**<br>Gastrointestinal assessment |
| **3. Identify the most likely and worst possible complications.**<br><br>Due to the patients appendix already rupturing and causing peritonitis, they have gone through the most common complications for appendicitis. However, if the patient did not seek emergent medical attention quick enough, they could have suffered from an abscess. The worst possible complication would be sepsis, from the rupture and peritonitis, leading to death. | **4. What interventions can prevent the listed complications from developing?**<br>- Antibiotic therapy<br>- Seek medical attention as quickly as possible<br>- should be kept NPO<br>- Fluids |
| **5.What clinical data/assessments are needed to identify these complications early?**<br>- gastrointestinal assessment (bowel habits, palpation)<br>- pain assessment (where, type and how long)<br>- CBC (white blood cell count for infection)<br>- x-rays, ultrasounds, CT scan | **6. What nursing interventions will the nurse implement if the anticipated complication develops?**<br>- Finding a comfortable position for the patient to relieve a little bit of pain Non pharmacologically.<br>- deliver antibiotics and pain medication on time<br>- thoroughly assess and monitor patients' vital signs<br>- assess nutrition, intake and output as well as hydration<br>- educating patients and family on diagnosis and signs and symptoms to be aware of<br>- support (physical, emotional) for patient and family |

| | |
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| **Student Name: Jordan Colley**<br>**Date: 9/3/2024** | **Patient Age:** 5 years old<br>**Patient Weight: 20.4kg** |
| **7. Pain & Discomfort Management:**<br>**List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.**<br><br>**1.** Singing or playing music<br><br>**2. Objects that move or change shapes such as kaleidoscopes, pinwheels or even videos** | **8. Patient/Caregiver Teaching:**<br><br>**1. What is their/ their child's diagnosis and signs and symptoms to be aware of**<br><br>**2. Importance of timely antibiotic administration**<br><br>**3. Activity restriction (no heavy lifting or strenuous activities) until permission has been given by doctor**<br><br>**Any Safety Issues identified:**<br>**No safety issues were identified at the time of clinical rotation** |

| **Abnormal Relevant Lab Tests** | **Current** | **Clinical Significance** |
|---|---|---|
| Complete Blood Count (CBC) Labs | | |
| | | |
| | | |
| | | |
| Metabolic Panel Labs | | |
| | | |
| | **NO CURRENT LABS** | |
| | | |
| Misc. Labs | | |
| Absolute Neutrophil Count (ANC) (if applicable) | | |
| | | |
| | | |
| Lab TRENDS concerning to Nurse? | | |
| | | |

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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:** Initiative vs. Guilt

1. **While doing my physical assessment on the child they wanted to see what my pupils did with the pen light, so they took initiative and examined my eyes. When the child didn't see anything happen they fell sad, but after trying again they did see my pupil constrict which made them feel very accomplished and happy.**

2. **The patient had to get their NG tube removed and originally demonstrated initiative wanting to get it out and help with the process, but changed their mind and did not want to help resulting in them feeling "less than" and sad.**

**Piaget Stage:** Pre-operational Period

1. **Patient presented animism by giving her barbie dolls lifelike qualities such as talking and playing**

2. **Patient presented centration when an electronic was taken just for a moment so an assessment could be done and then receive the electronic again. Patient was only focused about not having the electronic in front of them anymore.**

**Please list any medications you administered or procedures you performed during your shift:**
**I was only able to observe**

**Pediatric Floor Patient #1**

| **GENERAL APPEARANCE** | **CARDIOVASCULAR** | **PSYCHOSOCIAL** |
|---|---|---|
| **Appearance**: ☐ Healthy/Well Nourished ☐ Neat/Clean ☐ Emaciated ☐ Unkept<br>**Developmental age**:<br>☐ Normal ☐ Delayed | **Pulse:** ☐ Regular ☐ Irregular ☐ Strong ☐ Weak ☐ Thready ☐ Murmur ☐ Other _____<br>**Edema:** ☐ Yes ☐ No Location _____ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+<br>**Capillary Refill:** ☐ < 2 sec ☐ > 2 sec<br>**Pulses:** | **Social Status:** ☐ Calm/Relaxed ☐ Quiet ☐ Friendly ☐ Cooperative ☐ Crying ☐ Uncooperative ☐ Restless ☐ Withdrawn ☐ Hostile/Anxious<br>**Social/emotional bonding with family:** ☐ Present ☐ Absent |
| **NEUROLOGICAL** | | **IV ACCESS** |
| **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 _____ Left _____
Pushes: Right _____ Left _____
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** R hand pointer
**Oxygen Saturation:** 96-7%

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

## ELIMINATION

**Urine Appearance:**
_____yellow_____
**Stool Appearance:**
_____N/A_____
□ Diarrhea □ Constipation
□ Bloody □ Colostomy

## GASTROINTESTINAL

**Abdomen:** ☑ Soft □ Firm ☑ Flat
□ Distended □ Guarded
**Bowel Sounds:** □ Present X 3 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:** clear liquid
**Amount/Schedule:** N/A
**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 x1
Assistive Device: □ Crutch □ Walker
□ Brace □ Wheelchair □Bedridden

**Site:** _____ □ INT □ None
□ Central Line
Type/Location: _____
**Appearance:** □ No Redness/Swelling
□ Red □ Swollen
□ Patent □ Blood return
**Dressing Intact:** □ Yes □ No
**Fluids:** _____

## 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: pink
☑ Moist □ Dry □ Ulceration

## PAIN

**Scale Used:** □ Numeric ☑ FLACC □ Faces
**Location:** _____no
pain_____
**Type:**
____none_____
**Pain Score:**
0800 NA 1200 0 1600 0

## WOUND/INCISION

□ **None**
**Type:** incision
**Location:** abdomen
**Description:** _____
**Dressing:** vernacal steri strips, dry/intact

## TUBES/DRAINS

☑ **None**
□ **Drain/Tube**
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount:_____
Drainage color: _____

parent | nurse

**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 | | | NONE | | | | | | | | | | |
| Intake – PO Meds | | | | | | | | | | | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **IV INTAKE** | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| IV Fluid | | | | | | 60 | 60 | 60 | 60 | 60 | 60 | | 360 |
| IV Meds/Flush | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

**Calculate Maintenance Fluid Requirement (Show Work)**

100(10) = 1000
50(10) = 500
20(0.4) = 8
: 1508 / 24
63 mL/hr

**Actual Pt IV Rate**

60mL/hr

**Rationale for Discrepancy (if applicable)**
**Patient was replenishing fairly quickly so they kept the IV rate at a very basic level**

| **OUTPUT** | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Urine/Diaper | | | | | | 400 | | | | 100 | | | 500 |
| Stool | | | | | | | | | | | | | |
| Emesis | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

**Calculate Minimum Acceptable Urine Output**

**20.4kg (0.5) = 10.2mL/ hr.**

**Average Urine Output During Your Shift**
**400+100 =500/2= 250**

| **Children's Hospital Early Warning Score (CHEWS)**<br>**(See CHEWS Scoring and Escalation Algorithm to score each category)** | |
|---|---|
| Behavior/Neuro | Circle the appropriate score for this category:<br>(0) 1 2 3 |
| | |
| Cardiovascular | Circle the appropriate score for this category:<br>(0) 1 2 3 |
| | |
| Respiratory | Circle the appropriate score for this category:<br>(0) 1 2 3 |
| | |
| Staff Concern | 1 pt – Concerned |
| Family Concern | 1 pt – Concerned or absent |
| **CHEWS Total Score** | |
| CHEWS Total Score | Total Score (points) 0 |
| | 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 |

## CHEWS Scoring and Escalation Algorithm

| | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| **Behavior/Neuro** | - Playing/sleeping appropriately **OR**<br>- Alert, at patient's baseline | - Sleepy, somnolent when not disturbed | - Irritable, difficult to console **OR**<br>- Increase in patient's baseline seizure activity | - Lethargic, confused, floppy **OR**<br>- Reduced response to pain **OR**<br>- Prolonged or frequent seizures **OR**<br>- Pupils asymmetrical or sluggish |
| **Cardiovascular** | - Skin tone appropriate for patient<br>- Capillary refill ≤ 2 seconds | - Pale **OR**<br>- Capillary refill 3-4 seconds **OR**<br>- Mild tachycardia **OR**<br>- Intermittent ectopy or irregular HR (not new) | - Grey **OR**<br>- Capillary refill 4-5 seconds **OR**<br>- Moderate tachycardia | - Grey and mottled **OR**<br>- Capillary refill > 5 seconds **OR**<br>- Severe tachycardia **OR**<br>- New onset bradycardia **OR**<br>- New onset/increase in ectopy, irregular HR or heart block |
| **Respiratory** | - Within normal parameters<br>- No retractions | - Mild tachypnea/ increased WOB (flaring, retracting) **OR**<br>- Up to 40% supplemental oxygen **OR**<br>- Up to 1L NC > patient's baseline need **OR**<br>- Mild desaturations < patient's baseline **OR**<br>- Intermittent apnea self-resolving | - Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) **OR**<br>- 40-60% oxygen via mask **OR**<br>- 1-2 L NC > patient's baseline need **OR**<br>- Nebs Q 1-2 hour **OR**<br>- Moderate desaturations < patient's baseline **OR**<br>- Apnea requiring repositioning or stimulation | - Severe tachypnea **OR**<br>- RR < normal for age **OR**<br>- Severe increased WOB (i.e. head bobbing, paradoxical breathing) **OR**<br>- > 60% oxygen via mask **OR**<br>- > 2 L NC more than patient's baseline need **OR**<br>- Nebs Q 30 minutes – 1 hour **OR**<br>- Severe desaturations < patient's baseline **OR**<br>- 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<br>- Discuss treatment plan with team<br>- Consider higher level of care<br>- Increase frequency of vital signs / CHEWS / assessments<br>- Document interventions and notifications | - Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation<br>- Notify attending physician<br>- Discuss treatment plan with team<br>- Increase frequency of vital signs / CHEWS / assessments<br>- 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