IM5 Clinical Worksheet – Pediatric Floor

Student Name: Jordan Magee Date: 9/25/24	Patient Age: 13 y/o F Patient Weight: 43.3kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Splenic cyst (splenic cystectomy) — A benign growth of a cyst on the spleen can lead to pain and abdominal symptoms. The cyst may need to be surgically removed	2. Priority Focused Assessment You Will Perform Related to the Diagnosis: GI assessment
3. Identify the most likely and worst possible complications. Most likely - infection Worst possibe — rupture, which could lead to life-threatening internal bleeding	4. What interventions can prevent the listed complications from developing? Splenic cystectomy Partial or complete splenectomy Marsupialization Laparoscopic puncture Analgesics for pain
5. What clinical data/assessments are needed to identify these complications early? GI / abdominal assessment — palpate, assess pain, listen for bowel sounds, assess N/V Monitor VS — RR, HR, BP Monitor for tenderness in ULQ, lightheadedness, or dizziness	6. What nursing interventions will the nurse implement if the anticipated complication develops? Call physician immediately Start IV PICC line Give antibiotics, O_2 therapy Control pain, prepare pt for surgery
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. TV - to watch a movie or show 2. Book - she likes to read so giving her something that she would enjoy to get her mind off pain	8. Patient/Caregiver Teaching: 1. Know S/S of ruptured splenic cyst 2. After surgery, advance the diet slowly as tolerated 3. Notify the nurse of tenderness, bleeding, redness, extreme pain at site & signs of infection Any Safety Issues identified: None

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Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Hgb	10.4 ↓	Probably due to bleeding from incision
HCt	32.2 ↓	Most likely due to bleeding from incision
Metabolic Panel Labs		
[redacted]	[redacted]	
Bilirubin	0.5 ↓	Most likely due to medications
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)	N/A	
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: Identity vs Role Confusion

1. Pt was sad to be missing school to be in the hospital and wanted to be with her peers
2. Pt indepently responded to the nurse, but also turned to mom and dad for help answering questions.

Piaget Stage: Formal Operational Thought

1. Pt understood what occurred during surgery and the steps to recovery.
2. Pt looked forward to the future in returning back to hornalcy and school with her friends.

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

Lacosamide
Lorazepam
Methadone
Morphine
Acetaminophen
Polyethylene glycol

I helped give NG tube feedings and started primary and secondary fluids

Pediatric Floor Patient #1

GENERAL APPEARANCE

Appearance: ☑ Healthy/Well Nourished ☑ Neat/Clean ☐ Emaciated ☐ Unkept

Developmental age: ☑ Normal ☐ Delayed

NEUROLOGICAL

LOC: ☑ Alert ☐ Confused ☐ Restless ☐ Sedated ☐ Unresponsive

Oriented to: ☑ Person ☑ Place ☑ Time/Event ☑ Appropriate for Age

Pupil Response: ☑ Equal ☐ Unequal ☑ Reactive to Light ☑ Size 3

Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat ☐ Bulging ☐ Sunken ☑ Closed

Extremities: ☑ Able to move all extremities ☑ Symmetrically ☐ Asymmetrically

Grips: Right 5 Left 5

Pushes: Right 5 Left 5

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 Left finger

Oxygen Saturation: 97%

CARDIOVASCULAR

Pulse: ☑ Regular ☐ Irregular ☑ Strong ☐ Weak ☐ Thready ☐ Murmur ☐ Other —

Edema: ☐ Yes ☑ No Location — ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

Capillary Refill: ☑ < 2 sec ☐ > 2 sec

Pulses:

Upper R 2+ L 2+

Lower R 2+ L 2+

4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None

ELIMINATION

Urine Appearance: Clear, yellow

Stool Appearance: None ☐ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☑ Soft ☐ Firm ☐ Flat ☐ Distended ☑ Guarded

Bowel Sounds: ☑ Present X 4 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: Regular

Amount/Schedule: ad lib

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

PSYCHOSOCIAL

Social Status: ☑ Calm/Relaxed ☑ Quiet ☑ Friendly ☑ Cooperative ☐ Crying ☐ Uncooperative ☐ Restless ☐ Withdrawn ☐ Hostile/Anxious

Social/emotional bonding with family: ☑ Present ☐ Absent

IV ACCESS

Site: (L) AC ☐ INT ☐ None ☐ Central Line

Type/Location: —

Appearance: ☑ No Redness/Swelling ☐ Red ☐ Swollen ☑ Patent ☑ Blood return

Dressing Intact: ☑ Yes ☐ No

Fluids: D5 NS + KCl 20 @ 30mL/hr

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: Surgical site

Mucous Membranes: Color: pink ☑ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☑ Numeric ☐ FLACC ☐ Faces

Location: LLQ and LUQ

Type: Sharp pain

Pain Score: 0800 — 1200 8 1600 8

WOUND/INCISION

☐ None

Type: Splenic cystectomy

Location: Midline to (L) abdomen

Description: —

Dressing: CDI

TUBES/DRAINS

☑ None ☐ 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							120			120			240
Intake – PO Meds													0
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						30	30	30	30	30	30		180
IV Meds/Flush								50					50
													230mL

+240 mL
=470mL

Calculate Maintenance Fluid Requirement (Show Work)

100 x 10 = 1,000
50 x 10 = 500
20 x 23.2 = 466
1000 + 500 + 466 = 1,966mL/24hrs → 82mL/hr

Actual Pt IV Rate

30 mL/hr

Rationale for Discrepancy (if applicable)

Pt is also able to drink water on her own to maintain her fluid intake

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper						400	100			150			650
Stool													0
Emesis													0
Other													0
													650mL

Calculate Minimum Acceptable Urine Output

0.5mL x 43.3 kg = 21.65 mL/hr

Average Urine Output During Your Shift

650mL ÷ 6 hrs = 108mL/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
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