

## IM5 Clinical Worksheet – Pediatric Floor

<b>Student Name:</b> Kim Zertuche <b>Date:</b> 9/24/24	<b>Patient Age:</b> 13y/F <b>Patient Weight:</b> 46.4kg
<b>1. Admitting Diagnosis and Pathophysiology</b> (State the pathophysiology in own words) splenic cyst, requiring splenectomy to drain spleen	<b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b> - abdominal - pain (post-op)
<b>3. Identify the most likely and worst possible complications.</b> bleeding post-op	<b>4. What interventions can prevent the listed complications from developing?</b> close monitoring, VS assessments
<b>5. What clinical data/assessments are needed to identify these complications early?</b> VS - HR, RR, SpO <sub>2</sub> , BP	<b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b> fluids, blood transfusion, OR
<b>7. Pain &amp; Discomfort Management:</b> <b>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b> 1. heat packs 2. positioning	<b>8. Patient/Caregiver Teaching:</b> 1. report dizziness or feeling faint, could mean bleeding internally 2. report bleeding to incision sites, could require OR intervention 3. Although Acetaminophen could help with pain, it could also increase risk of bleeding <b>Any Safety Issues identified:</b> 

<b>Student Name:</b> Kim Zepfuche <b>Date:</b> 9/24/24	<b>Patient Age:</b> 12 yr F <b>Patient Weight:</b> 46.0kg
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Abnormal Relevant Lab Tests	Current	Clinical Significance
<b>Complete Blood Count (CBC) Labs</b>		
Total Hemoglobin	10.4 ↓	possible blood loss
Hematocrit	32.2 ↓	possible blood loss
<b>Metabolic Panel Labs</b>		
chloride	109 ↑	IVF administration of D5NS + KCl 20

<b>Misc. Labs</b>		
Absolute Neutrophil Count (ANC) (if applicable)		

N/A

**Lab TRENDS concerning to Nurse?**  
 Decreasing H+H post-op that could signify bleeding

**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. exploring independanc
2. has personal values

**Piaget Stage:** formal operations

1. able to think and reason
2. able to hypothetically think

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

**Pediatric Floor Patient #1**

<p><b>GENERAL APPEARANCE</b></p> <p><b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished  <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p><b>Developmental age:</b>  <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p><b>CARDIOVASCULAR</b></p> <p><b>Pulse:</b> <input 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 _____</p> <p><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+</p> <p><b>Capillary Refill:</b> <input checked="" type="checkbox"/> &lt; 2 sec <input type="checkbox"/> &gt; 2 sec</p> <p><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</p>	<p><b>PSYCHOSOCIAL</b></p> <p><b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet  <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying  <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless  <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious</p> <p><b>Social/emotional bonding with family:</b>  <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p><b>NEUROLOGICAL</b></p> <p><b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless  <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p><b>Oriented to:</b>  <input type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input type="checkbox"/> Time/Event  <input checked="" type="checkbox"/> Appropriate for Age</p> <p><b>Pupil Response:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal  <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3</u></p> <p><b>Fontanel:</b> (Pt &lt; 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat  <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed</p> <p><b>Extremities:</b>  <input checked="" type="checkbox"/> Able to move all extremities  <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically  Grips: Right <u>S</u> Left <u>S</u>  Pushes: Right <u>S</u> Left <u>S</u>  S=Strong W=Weak N=None</p> <p><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____</p> <p><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>ELIMINATION</b></p> <p><b>Urine Appearance:</b> <u>0</u></p> <p><b>Stool Appearance:</b> <u>0</u></p> <p><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><b>IV ACCESS</b></p> <p><b>Site:</b> <u>LAC 22G</u> <input type="checkbox"/> INT <input type="checkbox"/> None  <input type="checkbox"/> Central Line  Type/Location: _____</p> <p><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</p> <p><b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Fluids:</b> <u>DS NS + 144 70</u></p>
<p><b>RESPIRATORY</b></p> <p><b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <input type="checkbox"/> Retractions (type) _____  <input type="checkbox"/> Labored</p> <p><b>Breath Sounds:</b>  Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left  Crackles <input type="checkbox"/> Right <input 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</p> <p><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p><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: _____</p> <p><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</p> <p><b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p><b>Secretions:</b> Color _____  Consistency _____</p> <p><b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____</p> <p><b>Pulse Ox Site:</b> <u>L hand</u></p> <p><b>Oxygen Saturation:</b> <u>98%</u></p>	<p><b>GASTROINTESTINAL</b></p> <p><b>Abdomen:</b> <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat  <input type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded</p> <p><b>Bowel Sounds:</b> <input type="checkbox"/> Present X <u>4</u> quads  <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p><b>Nausea:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____  Location _____ Inserted to _____ cm  <input type="checkbox"/> Suction Type: _____</p>	<p><b>SKIN</b></p> <p><b>Color:</b> <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced  <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt</p> <p><b>Condition:</b> <input type="checkbox"/> Warm <input checked="" type="checkbox"/> Cool <input type="checkbox"/> Dry  <input type="checkbox"/> Diaphoretic</p> <p><b>Turgor:</b> <input checked="" type="checkbox"/> &lt; 5 seconds <input type="checkbox"/> &gt; 5 seconds</p> <p><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: _____</p> <p><b>Mucous Membranes:</b> Color: _____  <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
	<p><b>NUTRITIONAL</b></p> <p><b>Diet/Formula:</b> <u>Clear Liquid</u></p> <p><b>Amount/Schedule:</b> _____</p> <p><b>Chewing/Swallowing difficulties:</b>  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>PAIN</b></p> <p><b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p><b>Location:</b> <u>abd</u></p> <p><b>Type:</b> <u>Surgical</u></p> <p><b>Pain Score:</b>  0800 _____ 1200 _____ 1600 <u>0</u></p>
	<p><b>MUSCULOSKELETAL</b></p> <p><input checked="" 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</p> <p><b>Movement:</b>  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All</p> <p><b>Brace/Appliances:</b> <input type="checkbox"/> None  Type: _____</p>	<p><b>WOUND/INCISION</b></p> <p><input type="checkbox"/> None</p> <p><b>Type:</b> <u>laparoscopic surgical incisions</u></p> <p><b>Location:</b> <u>abdomen x 4</u></p> <p><b>Description:</b> <u>acute</u></p> <p><b>Dressing:</b> <u>CDI</u></p>
	<p><b>MOBILITY</b></p> <p><input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms  <input checked="" type="checkbox"/> Ambulatory with assist <u>x2</u></p> <p><b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker  <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p> <p><u>IV pole</u></p>	<p><b>TUBES/DRAINS</b></p> <p><input checked="" type="checkbox"/> None</p> <p><input type="checkbox"/> Drain/Tube  Site: _____  Type: _____  Dressing: _____  Suction: _____  Drainage amount: _____  Drainage color: _____</p>

Student Name: Kim Zerkuche Unit: P2 Pt. Initials: AK #308 Date: 9/24/21

Pediatric Medication Worksheet - Current Medications & PRN for Last 24 Hours

Allergies: NEBA

4/11/21

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
DS NS + KCl 20	Isotonic/ Hypotonic/ <del>Hypertonic</del>	post-op - analgesia	electrolytes	AK AK

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Ranges?		IVP - List diluent solution, volume, and rate of administration IVPB - List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range? If not, why?				
acetaminophen (ofirmev)	analgesic	pain	swamp 200ml/hr q6 IV	yes	max dose	IVP - <del>100-200ml</del> IVPB - 80mg/80ml NaCl over 1hr	↑ risk of bleeding toxicity ulcers	1. Do not exceed max dose, can cause renal toxicity 2. can cause increased bleeding + bruising 3. can cause GI bleeding, report dark or bloody stools 4. can cause stomach ulcers, report hx of gastric ulcers
morphine	opioid	pain	2mg IV B2 BID	yes	100-200mcg	IVP - diluent in 80ml sterile water IVPB - 8	↓ CNS	1. can cause respiratory depression, may require IVS required due to decrease in CNS function 2. frequent IVS required due to decrease in CNS function 3. can cause constipation 4. long term use can lead to increase tolerance and/or dependency
ondansetron (Zofran)	antiemetic	nausea	7mg PO q8 PRN also 1mg/kg	yes	2mg-4mg no weight based	IVP - 8 IVPB - 8	arrhythmias	1. may cause arrhythmias, report any cardiac hx 2. can cause drowsiness or dizziness 3. call for help before getting out of bed 3. cardiac mb monitoring may be required 4. can cause constipation, report abd. discomfort
								1. 2. 3. 4.

Student Name: Kim Zernicke

Unit: P2

Pt. Initials: PC #376

Date: 9/24/24

Pediatric Medication Worksheet - Current Medications & PRN for Last 24 Hours

Allergies: NEDD

0.5N kg

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
<u>DS NS + KCl 20</u>	Isotonic/ Hypotonic/Hypertonic	<u>dehydration</u>	<u>electrolytes</u>	<u>PE CIA</u>

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP - List diluent solution, volume, and rate of administration IVPB - List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?	If not, why?			
<u>ondansetron (Zospan)</u>	<u>antiemetic</u>	<u>NAUSEA</u>	<u>0.15mg/kg 1.44mg q6 PRN IV</u>	<u>2mg-4mg yes</u>		<u>IVP - diluent over 15min IVPB - 0</u>	<u>cardiac arrhythmias</u>	<ol style="list-style-type: none"> <li>1. may cause arrhythmias, report any cardiac hx</li> <li>2. can cause drowsiness, ask for help before getting out of bed</li> <li>3. can cause constipation, report abdominal pain</li> <li>4. cardiac monitoring may be required</li> </ol>
<u>acetaminophen</u>	<u>antipyretic, pain reliever</u>	<u>pain, fever</u>	<u>15mg/kg 140mg PO q6 PRN</u>	<u>10-15mg/kg yes</u>		<u>IVP - 0 IVPB - 0</u>	<u>A RISK OF BLEEDING TOXICITY - NICEPS</u>	<ol style="list-style-type: none"> <li>1. Do not exceed max dose, can cause renal toxicity</li> <li>2. can cause increased bleeding + bruising</li> <li>3. can cause GI bleed, report dark tarry stools</li> <li>4. can cause gastric ulcers, report any hx of ulcers</li> </ol>
								<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>
								<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>

**Pediatric Floor Patient #1**

INTAKE/OUTPUT													
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed							50		50				100
Intake – PO Meds													
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid				86	86	86	86	86	86	86			402
IV Meds/Flush													
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Actual Pt IV Rate</b>						
$\begin{array}{r} 20 \times 100 \\ 10 \times 50 \\ \hline 26.4 \times 20 \\ \hline 2020 / 24 = 84.5 \end{array}$							Actual Pt IV Rate 84 Rationale for Discrepancy (if applicable) Rounding						
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper		750											
Stool													
Emesis													
Other													
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>						
$1 \text{ mL/kg/hr} \\ 46.4 \times 24 = 1113.6$							750 mL						

1000  
500  
520  
845

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) _____
	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

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