

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: <u>Jasmine Luna</u> Date: <u>1/29/25</u></p>	<p>Patient Age: <u>16 y.o.</u> Patient Weight: <u>71.5 kg</u></p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) <u>ABD pain → pt experiencing pain in the midepigastic region, describing the pain as a stabbing sensation.</u></p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <ul style="list-style-type: none"> - <u>ABDOMINAL assessment</u> - <u>inspect, Auscultate, Percussion</u> - <u>Pain assessment</u> <p><small>*IF PAIN IS SEVERE. DO NOT PERFORM. Further studies needed</small></p>
<p>3. Identify the most likely and worst possible complications.</p> <ul style="list-style-type: none"> - <u>Electrolyte</u> - <u>Acute pain imbalance</u> - <u>Infection</u> - <u>Impaired nutrition</u> - <u>Weight loss</u> 	<p>4. What interventions can prevent the listed complications from developing?</p> <ul style="list-style-type: none"> - <u>Analgiesics</u> - <u>Antibodies</u> - <u>IV Fluids</u> - <u>Nutritional support</u> - <u>Feeding (tolerable)</u>
<p>5. What clinical data/assessments are needed to identify these complications early?</p> <ul style="list-style-type: none"> - <u>Pain assessment</u> - <u>WBC level</u> - <u>Daily weight</u> - <u>I/O</u> 	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <ul style="list-style-type: none"> - <u>Medication administration</u> - <u>Monitor for signs of infection</u> - <u>Measure I/O & weight</u> - <u>Administer IV Fluids</u>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ul style="list-style-type: none"> 1. <u>Distract teen w/ movies or video games</u> 2. <u>Play patient's favorite music</u> 	<p>8. Patient/Caregiver Teaching:</p> <ul style="list-style-type: none"> 1. <u>Medication administration (Side effects, interventions, etc.)</u> 2. <u>Signs/Symptoms of infection</u> 3. <u>Do not submerge monitor in water that is calibrated to the gastric</u> <p>Any Safety Issues identified: <u>Stomach pain</u></p> <ul style="list-style-type: none"> • <u>Hand hygiene</u>

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" 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 _____ 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 checked="" 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light Size <u>2mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <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 EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>1128 AM Yellow</u> Stool Appearance: <u>1127 PM Hard</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>Left Antecubital</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Peripheral IV</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: Yes <input type="checkbox"/> No Fluids: <u>D5NS + 20 KCl @ 115ml/m</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: 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 <input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> Other: <u>Room air</u> 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 _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site <u>R Finger</u> Oxygen Saturation: <u>98%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" 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: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	PAIN	
Diet/Formula: <u>clear liquid</u> Amount/Schedule: <u>unit 1015</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>MIDDLE ABD</u> Type: <u>stabbing sensation</u> Pain Score: 0800 <u>0</u> 1200 _____ 1600 _____	
MUSCULOSKELETAL	WOUND/INCISION	
<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 type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____	
MOBILITY	TUBES/DRAINS	
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____	

Pediatric Floor Patient #1

INTAKE/OUTPUT													
	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO/Enteral Intake													0
PO Intake/Tube Feed													0
Intake - PO Meds													0
IV INTAKE													Total
IV Fluid	115	115	115	115	115								575mL
IV Meds/Flush													0mL
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
71.5 Kg							115 mL / HOUR						
10 x 100 = 1,000							Rationale for Discrepancy (if applicable)						
10 x 50 = 500							Pt NPO / ABDPAIN → Prevent						
51.5 x 20 = 1,030							Dehydration						
2,530 mL / Day													
2,530 mL / 24 hrs =													
105.416 ≈ 105 mL/hr													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													0
Stool													0
Emesis													0
Other													0
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
0.5 mL / Kg / hr x 71.5 Kg =							—						
35.75 mL/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

Student Name: Jasmine Luna Patient Age: 16
 Date: 4/29/25 Patient Weight: 7/5kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
MCHC	1/24/25 29.0	36.0 → 37.0 → High hemoglobin
Metabolic Panel Labs		
Chloride	1/24/25 97	107 mmol/L → 110 mmol/L → High chloride
Creatinine	1/24/25 7.18	mg/dL → 30 mg/dL → High levels of creatine
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		↳ Renal

Lab TRENDS concerning to Nurse?

Chloride	Bilirubin
1/8 - 111 1/13 - 112 1/15 - 116 1/24 - 110	1/8 - 0.4 1/13 - 0.5 1/15 - 0.2 1/24 - 0.3

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*

- Feelings of anger when father asked pt to wake up → Rebellious
- Ignoring some questions when asked by nurse

Piaget Stage: *Formal Operational Stage*

- Patient evaluated what medication worked for him when given a choice between Ketorolac/acetaminophen
- Asked if he was able to eat so he can feel better

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

- Sucralfate (med admin)
- Hydroxine (med admin)
- Head to to assessment
- Patient education