

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Marissa Torres Date: 1/28/25</p>	<p>length 66cm Patient Age: 7 months Patient Weight: kg 10.44 22.14 lb</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</p> <ul style="list-style-type: none"> • hypoxia observation reduced oxygen perfusion to the tissues and rest of the body. • RSV 	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Respiratory. goal is to keep oxygen saturation above 88%.</p>
<p>3. Identify the most likely and worst possible complications.</p> <p>most likely = acute otitis media, upper/lower resp. tract infection.</p> <p>worst = respiratory failure, CO₂ build up due to inadequate gas exchange.</p> <ul style="list-style-type: none"> • mechanical ventilation, sedation, sepsis. 	<p>4. What interventions can prevent the listed complications from developing?</p> <ul style="list-style-type: none"> • positioning • percussion therapy • breathing treatments. • adequate hydration. • timely suctioning • focused hourly resp assessments
<p>5. What clinical data/assessments are needed to identify these complications early?</p> <p>Sputum culture I + O repeat C-XR Respiratory</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <p>abx admin. [protect airway] reassess frequently for improvement in lung fxn. managing symptoms, suction, etc.</p> <ul style="list-style-type: none"> • inform CN about status changes.
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ol style="list-style-type: none"> 1. Rocking/swaying while patting and humming or singing. 2. Toys that make noise for distraction. <ul style="list-style-type: none"> - Non-nutritive sucking - light swaddling 	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. Importance of washing bottles. [bacteria] 2. Proper bulb syringe suction. 3. Signs of dehydration or further respiratory decline. <p>Any Safety Issues identified: N/A</p>

Patient Name: Age:	Patient Age: 7 months Patient Weight: kg 10.44
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Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
		NOT applicable NO testing done on blood.
Metabolic Panel Labs		
		N/A
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		N/A
Lab TRENDS concerning to Nurse?		
NOT applicable.		

11. Growth & Development:

- *List the Developmental Stage of Your Patient For Each Theorist Below. **INFANCY**
- *Document 2 OBSERVED Developmental Behaviors for Each Theorist.
- *If Developmentally Delayed, Identify the Stage You Would Classify the Patient: **Birth-12mos.**

Erickson Stage:

1. Tactile stimulation - boredom. baby was crying and mom kept trying to feed him. he wasn't hungry, he just needed to be stimulated. he was laying flat, wide awake.
2. consistency of care, mom + dad were inconsistent with basic interaction. combined w/ discomfort, he was hard to console.

Piaget Stage: sensormotor

1. stranger anxiety. baby wanted moms interaction. just hearing her speak to dad seemed to quiet him. vs. when we spoke, he cried.
2. Increased affect baby seemed to recognize shaking of formula being mixed with feet kicks and coo vs cry.

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

PO tylenol 4.7 ml
 10 mg/15ml
 • wall suction for secretions

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input 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 Pulses: 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	Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless <input checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL		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 type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>2</u> Fontanel: (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input checked="" 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 checked="" 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		Site: _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input 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 type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____
	ELIMINATION	SKIN
	Urine Appearance: <u>pale yellow</u> Stool Appearance: <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Color: <input checked="" 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 type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration
RESPIRATORY	GASTROINTESTINAL	PAIN
Respirations: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input checked="" type="checkbox"/> Retractions (type) <u>mild</u> <input checked="" type="checkbox"/> Labored <u>sub-costal</u> 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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>1.5</u> L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____	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 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: _____	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>unknown origin</u> Type: <u>irritability</u> Pain Score: 0800 _____ 1200 _____ 1600 _____
Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>pale yellow</u> Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>R FOOT</u> Oxygen Saturation: <u>96%</u>	NUTRITIONAL	WOUND/INCISION
	Diet/Formula: <u>Similac advance</u> Amount/Schedule: <u>802 on demand</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	MUSCULOSKELETAL	TUBES/DRAINS
	<input type="checkbox"/> Pain <input checked="" 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 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 <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____
	MOBILITY	

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				2mL	4mL								6mL
Intake – PO Meds		5 mL											5mL
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
N/A (NO IV access)							None						
							Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper				40mL									
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
1 mL/kg/Hr 62.64 mL minimum.							40 mL						

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) 4
	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: MARISSA TORRES

Unit: PF-1

Pt. Initials:

Date: 1-28

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

Allergies: NKDA

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?			
				If not, why?			
#54 acetaminophen [Tylenol]	anti-pyretic analgesic	Pain relief	4.7ml PO Q6H PRN	325-650mg yes	N/A	hepatotoxicity Rash Nausea Constipation	1. This can take up to 60min to work. 2. may cause drowsiness. 3. report skin rash -itching. 4. report if irritability worsens.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
second pt: ROOM # 65							1. 2. 3. 4.
#105 [Firmen] acetaminophen	analgesic	Pain relief (NPO)	1000mg/100ml IVPB Q6H	650-1000mg IV Q6H	IVPB 1000mg/100ml administer over 15 minutes.	N/V agitation itching headache	1. call don't fall, causes dizziness. 2. report unusual abd pain. 3. skin rash is rare, report blisters. 4. report if pain is not of less within 30 minutes.

#54

#105

reference - eprocrates app.