

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: JULIE BOREN Date: 01/28/24</p>	<p>Patient Age: 13 F Patient Weight: kg 46.9 KG</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) MEASLES / PNEUMONIA</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: RESPIRATORY</p>
<p>3. Identify the most likely and worst possible complications.</p> <ul style="list-style-type: none"> • ENCEPHALITIS, OTITIS MEDIA • BLINDNESS • PNEUMONIA, RESP. DISTRESS • RESP. FAILURE • DIARRHEA 	<p>4. What interventions can prevent the listed complications from developing?</p> <ul style="list-style-type: none"> • ANTIBIOTICS • O₂ • FLUIDS
<p>5. What clinical data/assessments are needed to identify these complications early?</p> <ul style="list-style-type: none"> • CBC • RESP. ASSESSMENT 	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <ul style="list-style-type: none"> • INCREASE O₂ • RAISE HOB • ANTIBIOTICS
<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. COMFORT ITEMS FROM HOME (BLANKETS, PILLOW) 2. LPT'S OWN CLOTHING 	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. MONITOR O₂ SATS AT HOME & CALL PCP FOR SAT < 90%. 2. ENCOURAGE CHILD TO NOT SCRATCH RASH. (RISK OF SCARFING) 3. AVOID SUNLIGHT (SKIN & EYES WILL BE SENSITIVE.) <p>Any Safety Issues identified: N/A</p>

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 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 checked="" type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input checked="" 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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ 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 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	Urine Appearance: <u>YELLOW, CLEAR</u> Stool Appearance: <u>SOFT, BROWN</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>RT HAND</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>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: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>DS NS w/ 20K</u> <u>100 ML/Hr</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 type="checkbox"/> Left Crackles <input 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 type="checkbox"/> Oxygen Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>.5</u> L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>clear</u> Consistency <u>thin</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>RT FINGER</u> Oxygen Saturation: <u>92% NA</u>	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 type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location <u>0</u> Inserted to <u>0</u> cm <input type="checkbox"/> Suction Type: _____	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 checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>NORMAL DIET</u> Amount/Schedule: _____ 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>N/A</u> Type: <u>N/A</u> Pain Score: 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
	MUSCULOSKELETAL	WOUND/INCISION
	<input 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 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: <u>N/A</u>	<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 <u>N/A</u> 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: _____

Student Name: JULIE BOREN
Date: 01/28/2025

Patient Age: 13
Patient Weight: kg 46.9

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC	6.85	WNL
RBC	4.14	WNL
Metabolic Panel Labs		
N/A		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)	6.10	
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. HAS MANY FRIENDSHIPS IN HER SCHOOL & COMMUNITY.
2. CHILD IS INDEPENDENT & RELIES ON PARENT VERY LITTLE.

Piaget Stage:

1. PT HAS A GOOD GRASP OF THE SITUATION.
2. PT ASKS RELEVANT QUESTIONS REGARDING HER HEALTH.

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

N/A

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								300					300
Intake – PO Meds													
IV INTAKE	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						
$10 \times 100 = 1000$ $2038 \text{ mL} / 24 \text{ HR}$ $10 \times 50 = 500 =$ $84.9 \text{ mL} / \text{HR}$ $26.9 \times 20 = 538$							Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper								300					300
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$0.5 \text{ mL} \times 46.9 \text{ kg} = 23.4 \text{ mL} / \text{HR}$							$600 \text{ mL} / \text{HR}$						

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) <u>0</u>
	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: JULIE BOHREN

Unit: _____

Pt. Initials: A

Date: 01/28/25

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

Allergies: NIL/0A

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?			
<u>NONE</u>								<ol style="list-style-type: none">1.2.3.4.
								<ol style="list-style-type: none">1.2.3.4.
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