

## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Magy Hernandez <b>Date:</b> 02-05-2025</p>	<p><b>Patient Age:</b> 4 y.o. <b>Patient Weight:</b> 13.1 kg</p>
<p><b>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</b></p> <p>Vesicoureteral Reflux: This is when the urine flows back from the bladder into the ureters instead of going out.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b></p> <p>Abdominal assessment</p>
<p><b>3. Identify the most likely and worst possible complications.</b></p> <p>Most common complication is hypertension since the kidneys are not able to filter the waste in the bloodstream. The worst complication is kidney damage due to the multiple UTIs.</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b></p> <p>Antibiotics can be given to treat UTI to prevent kidney scarring or damage. In severe cases, like my patient, surgical intervention is needed. They will get a urethral implantation to fix the valve between the bladder and the ureter.</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b></p> <p>Urinalysis, abdominal assessment, voiding cystourethrogram (gold standard for diagnosis), signs and symptoms of UTI (flank pain, cloudy urine, pain with urination, fever, frequent urination)</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b></p> <p>Hypertension: encourage a DASH diet, physical activity, limit screen time</p> <p>Kidney damage: daily weight, monitor electrolyte, BUN, creatinine, monitor I&amp;O</p>
<p><b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <ol style="list-style-type: none"> <li>1. Play some music while he tries to use the restroom or put on his favorite TV show.</li> <li>2. Rubbing his back and have parents there for comfort.</li> </ol>	<p><b>8. Patient/Caregiver Teaching:</b></p> <ol style="list-style-type: none"> <li>1. Signs and Symptoms of UTI: flank pain, cloudy urine, pain with urination, fever, frequent urination</li> <li>2. Bladder training: have scheduled times of when to go void to decrease the likelihood of developing a UTI</li> <li>3. Drink plenty of fluids and continuously follow up with a healthcare provider</li> </ol> <p><b>Any Safety Issues identified:</b></p> <ul style="list-style-type: none"> <li>• Infection due to the urine flowing back</li> </ul>

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Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		

Lab TRENDS concerning to Nurse?

**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: Initiative vs. Guilt**

- When giving the patient his oral medication he wanted to push the syringe himself.
- The patient was told he was allowed to pee in the bed if he felt more comfortable like that, but he stated he wanted to try in the toilet.

**Piaget Stage: Preoperational**

- Anytime we walked into the room the patient thought we were going in to do something to him.
- When we covered the patients IV with a bag to get him in the shower, the patient pretended his hand was a hammer.

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

Administered Tylenol

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <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 _____ <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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <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	<b>Social Status:</b> <input checked="" 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 checked="" type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>4</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically <b>Grips:</b> Right <u>S</u> Left <u>S</u> <b>Pushes:</b> Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>Red</u> <b>Stool Appearance:</b> <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input checked="" type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>R posterior dorsal</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <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 <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <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: _____ <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 <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>right hand</u> <b>Oxygen Saturation:</b> <u>96%</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <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 <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input 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: _____ <b>Mucous Membranes:</b> Color: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
<b>Diet/Formula:</b> <u>General</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Pain:</b> <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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None Type: _____	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>4</u>
MOBILITY	TUBES/DRAINS	WOUND/INCISION
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<b>None</b> <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____	<b>Wound/Incision:</b> <input type="checkbox"/> None <b>Type:</b> <u>Incision</u> <b>Location:</b> <u>abdomen</u> <b>Description:</b> <u>clean, dry, intact</u> <b>Dressing:</b> <u>gauze &amp; tergiderm</u>

**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							75%						
Intake - PO Meds										6ml			6ml
<b>IV INTAKE</b>	<b>07</b>	<b>08</b>	<b>09</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>Total</b>
IV Fluid													
IV Meds/Flush													

**Calculate Maintenance Fluid Requirement (Show Work)**

$10 \times 100 = 1000$   
 $3.1 \times 50 = 155$   
 $1155 - 24 \text{ hrs}$

**48 ml/hr**

**Actual Pt IV Rate**

**Rationale for Discrepancy (if applicable)**

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper					50ml	1	1		1	1			50ml X 4 occurrences
Stool													
Emesis													
Other													

**Calculate Minimum Acceptable Urine Output**

$13.1 \times 0.5 = 6.55 \text{ ml/hr}$   
 $157.2 (24 \text{ hr})$

**Average Urine Output During Your Shift**

4 urine occurrences  
 (3 in bed, 1 in toilet)

**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    **no concern**

Family Concern    1 pt - Concerned or **absent**    **no concern**

**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

**CHEWS Total Score**

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
N/A	Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>			

Student Name: Magy Hernandez	Unit: Pediatric Medsurg	Patient Initials: H.F.	Date: 2/5/2025	Allergies: NKA
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Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	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.)
Acetaminophen (Tylenol)	Analgesic	Decrease pain	195.2mg, Oral, Q6	Yes		Nausea, Vomiting, Abdominal pain, Constipation	<ol style="list-style-type: none"> <li>1. Parents should check concentration of the OTC acetaminophen to ensure they are giving the proper dosage based on the child's weight.</li> <li>2. If nausea or abdominal pain occur have the child take the medication with food.</li> <li>3. Do not give more than 5 doses in 24 hours as it can lead to liver damage.</li> <li>4. If the child has a rash, blisters, or reddening skin, stop medication as this could be an allergic reaction.</li> </ol>
				Choose an item.			<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>