

Pediatric Floor Patient #1

| GENERAL APPEARANCE  | CARDIOVASCULAR  | PSYCHOSOCIAL   |
|---|---|--|
| Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished<br><input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br>Developmental age:<br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed  | Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready<br><input type="checkbox"/> Murmur <input type="checkbox"/> Other _____<br>Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br>Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br>Pulses:<br>Upper R <u>3+</u> L <u>3+</u><br>Lower R <u>3+</u> L <u>3+</u><br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None  | Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input checked="" type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying<br><input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless<br><input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br>Social/emotional bonding with family:<br><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<br><input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive<br>Oriented to:<br><input checked="" type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event<br><input checked="" type="checkbox"/> Appropriate for Age<br>Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____<br>Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat<br><input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed<br>Extremities:<br><input checked="" type="checkbox"/> Able to move all extremities<br><input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right <u>S</u> Left <u>S</u><br>Pushes: Right <u>S</u> Left <u>S</u><br>S=Strong W=Weak N=None<br>EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____<br>Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | Urine Appearance: <u>Clear yellow</u><br>Stool Appearance: <u>Brown soft</u><br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy   | Site: <u>RT hand</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br>Type/Location: <u>249</u><br>Appearance: <input checked="" type="checkbox"/> No Redness/Swelling<br><input type="checkbox"/> Red <input type="checkbox"/> Swollen<br><input type="checkbox"/> Patent <input type="checkbox"/> Blood return<br>Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Fluids: <u>DS NS w KCl 20 mg</u>  |
| RESPIRATORY   | GASTROINTESTINAL  | SKIN   |
| Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input type="checkbox"/> Labored<br>Breath Sounds:<br>Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Crackles <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br>Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen<br>Oxygen Delivery:<br><input type="checkbox"/> Nasal Cannula: _____ L/min<br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br>Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive<br>Secretions: Color _____<br>Consistency _____<br>Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br>Pulse Ox Site <u>lt foot toe</u><br>Oxygen Saturation: <u>94</u> | Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended <input type="checkbox"/> Guarded<br>Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads<br><input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br>Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br><input type="checkbox"/> Suction Type: _____ | Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced<br><input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt<br>Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br>Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br>Skin: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations<br><input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown<br>Location/Description: _____<br>Mucous Membranes: Color: <u>pink</u><br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
|   | NUTRITIONAL   | PAIN   |
|   | Diet/Formula: <u>Reg</u><br>Amount/Schedule: _____<br>Chewing/Swallowing difficulties:<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces<br>Location: _____<br>Type: _____<br>Pain Score: <u>0</u><br>0800 _____ 1200 _____ 1600 _____  |
|   | MUSCULOSKELETAL   | WOUND/INCISION   |
|   | <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling<br><input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping<br><input type="checkbox"/> Spasms <input type="checkbox"/> Tremors<br>Movement:<br><input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All<br>Brace/Appliances: <input checked="" type="checkbox"/> None<br>Type: _____  | <input checked="" type="checkbox"/> None<br>Type: _____<br>Location: _____<br>Description: _____<br>Dressing: _____  |
|   | MOBILITY  | TUBES/DRAINS   |
|   | <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms<br><input type="checkbox"/> Ambulatory with assist _____<br>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden   | <input checked="" type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br>Site: _____<br>Type: _____<br>Dressing: _____<br>Suction: _____<br>Drainage amount: _____<br>Drainage color: _____  |

IM5 Clinical Worksheet – Pediatric Floor

|  |   |
|--|---|
| <p>Student Name: Breanne Torres<br/>Date: 2/18</p>   | <p>Patient Age: 23 Months<br/>Patient Weight: 11.1 kg</p>   |
| <p>1. Admitting Diagnosis and Pathophysiology<br/>(State the pathophysiology in own words)</p> <p>Hypoxia, Flu A<br/>pts O2 sats were low and mucous states<br/>lips were blue.</p>                                | <p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>Respiratory</p>   |
| <p>3. Identify the most likely and worst possible complications.</p> <p>Pt weaned of O2 at discharge<br/>Worst: ↓ O2 requiring intubation</p>  | <p>4. What interventions can prevent the listed complications from developing?</p> <p>Supplemental O2</p>   |
| <p>5. What clinical data/assessments are needed to identify these complications early?</p> <p>VS O2 sats</p>   | <p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <p>Raise O2 levels</p>                                    |
| <p>7. Pain &amp; Discomfort Management:<br/>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <p>1. Favorite show<br/>2. Coloring book</p> | <p>8. Patient/Caregiver Teaching:</p> <p>1. Teach s/s of hypoxia<br/>2. Risk factors for flu<br/>3. Immunizations</p> <p>Any Safety Issues identified:<br/>NO</p> |

Student Name: Breanna Torres  
Date: 2/18

Patient Age: 23 months  
Patient Weight: 11.1 kg

| Abnormal Relevant Lab Tests                     | Current | Clinical Significance |
|---|---------|-----------------------|
| Complete Blood Count (CBC) Labs                 |         |                       |
| WBC   | 13.42   | No signs of infection |
|   |         |                       |
| 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:**

1. Autonomy vs shame & doubt
2. Pt wanted to take out her own IV instead of the nurse

**Piaget Stage:**

1. Preoperational stage
2. Pt had trouble understanding she needed her IV out in order to go home.

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

Pt d/c, so no meds were given

**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                                 |    | 90 |    |    |    |    |   |    |    |    |    |    |       |
| 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   |    |    |    |    |    |       |
| $1700 \times 10 = 1000$<br>$1.2 \times 20 = 22$     |    |    |    |    |    |    | $540 \text{ mL} / 12 \text{ hrs}$<br>$1022 \text{ mL} / 24 \text{ hrs}$<br>$42.5 \text{ mL/hr}$ |    |    |    |    |    |       |
|   |    |    |    |    |    |    | $45 \text{ mL/hr}$<br>Rationale for Discrepancy (if applicable)<br>Pt was on PO fluids for d/c  |    |    |    |    |    |       |
| OUTPUT  | 07 | 08 | 09 | 10 | 11 | 12 | 13  | 14 | 15 | 16 | 17 | 18 | Total |
| Urine/Diaper  |    |    |    |    |    |    |   |    |    |    |    |    |       |
| Stool   |    |    |    |    |    |    |   |    |    |    |    |    |       |
| Emesis  |    |    |    |    |    |    |   |    |    |    |    |    |       |
| Other   |    |    |    |    |    |    |   |    |    |    |    |    |       |
| Calculate Minimum Acceptable Urine Output           |    |    |    |    |    |    | Average Urine Output During Your Shift  |    |    |    |    |    |       |
| $133.2 \text{ mL for } 12 \text{ hrs}$              |    |    |    |    |    |    | None before d/c   |    |    |    |    |    |       |

| 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:<br>(0) 1 2 3   |
| Cardiovascular  | Circle the appropriate score for this category:<br>0 1 2 3   |
| Respiratory   | Circle the appropriate score for this category:<br>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>1</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: Brianna Torres

Unit: PEA

Pt. Initials: \_\_\_\_\_

Date: 2/18

Allergies: \_\_\_\_\_

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

*Pt discharged, no meds given*

| Generic Name | Pharmacologic Classification | Therapeutic Reason | Dose, Route & Schedule | Therapeutic Range?           |              | IVP – List solution to dilute and rate to push.<br>IVPB – concentration and rate of administration | Adverse Effects | Appropriate Nursing Assessment, Teaching, Intervention (precautions/Contraindications, Etc.) |
|--------------|------------------------------|--------------------|------------------------|------------------------------|--------------|--|-----------------|--|
|              |                              |                    |                        | Is med in therapeutic range? | If not, why? |  |                 |  |
|              |                              |                    |                        |                              |              |  |                 | 1.<br>2.<br>3.<br>4.   |
|              |                              |                    |                        |                              |              |  |                 | 1.<br>2.<br>3.<br>4.   |
|              |                              |                    |                        |                              |              |  |                 | 1.<br>2.<br>3.<br>4.   |
|              |                              |                    |                        |                              |              |  |                 | 1.<br>2.<br>3.<br>4.   |