IM5 Clinical Worksheet – Pediatric Floor

Student Name: Meaghan Rose **Date:** 04/22/2025	**Patient Age:** 13 **Patient Weight:** 50.1 kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) High fever 105 degrees Fahrenheit, severe headache, hyperpyrexia, cellulitis of the right eye, maxillary sinusitis and ethmoid sinusitis, subgalea and epidural abscesses Sepsis caused by the sinuses. The initial infection began in the sinuses and spread locally to the maxillary and ethmoid sinuses. From there, the infection penetrated deeper, leading to the formation of subgalea and epidural abscesses. These abscesses increased the risk of systemic infection as bacteria and toxins enter the bloodstream, causing sepsis.	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** Neurological Assessment would be the top priority because of the risk for increased ICP, brain abscess progression, and potential herniation.
3. Identify the most likely and worst possible complications. 1. Bacteremia – infection can enter the bloodstream, leading to systemic inflammation and sepsis 2. Sepsis – symptoms could include high fever, severe headache, localized infection, hypotension, tachycardia, and altered perfusion 3. Orbital cellulitis or abscess – since the infection involves the eye area, it could lead to swelling, vision disturbances, and impaired eye movement 4. Septic shock- without timely intervention, can cause dangerously low blood pressure, multi-organ failure, and death 5. Neurological deficits – swelling or damage from the abscesses may result in long-term issues like seizures, motor deficits, or cognitive impairments. 6. Brain abscess rupture – if a galeal or epidural abscess ruptures, it could lead to acute herniation or severe brain damage 7. Venous sinus thrombosis – infection in the sinus and brain areas may lead to clot formation in the cerebral venous sinuses, compromising blood drainage from the brain 8. Death – without aggressive treatment, complications like septic shock or ruptured brain abscesses could be fatal	**4. What interventions can prevent the listed complications from developing?** Early focused interventions, early and aggressive antibiotic therapy, frequent neurological assessments, monitor vital signs and trends, fluid resuscitation, place on seizure precautions, monitor labs, place on strict intake and output, manage fever and pain, family education, and patient and family support.

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5.What clinical data/assessments are needed to identify these complications early? - Temperature, heart rate, respiratory rate, blood pressure, oxygen saturation, LOC, pupil reaction, headache severity, seizure activity, eye assessment, sinus tenderness or pressure, CBC, CT, MRI, blood cultures, CRP, lactate levels, Capillary refill, urine output, and behavioral changes	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** Activate sepsis protocol, administer IV fluids, administer prescribed IV antibiotics, monitor vitals closely, check lactate levels and blood cultures, support oxygenation, monitor urine output, keep neck neutral, minimize stimulation, monitor neuro status and pupils, focused assessments frequently, provide emotional support to family, and communicate clearly and efficiently with charge nurse and other members of the healthcare team.
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** **1.** Music Therapy – Mom said that music therapy has really been helping the patient during their stay in the hospital. **2.** iPad and TV distraction – talking to friends and family back home by using FaceTime, playing games on Ipad and watching YouTube. Mom said these things have also helped tremendously during their stay as well	**8. Patient/Caregiver Teaching:** **1.** Recognizing early signs of worsening infection or sepsis **2.** Medication adherence and keep follow up appointments **3.** Report and neuro and/or behavioral changes **Any Safety Issues identified:** - Risk for falls and seizures

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? - Monitoring MRI, wanting to see a decrease of edema in the brain		

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- Nurse states that labs have not been a concern; they are more focused on what the MRI is showing
- Current MRI from 4/21/2025 impression decreasing ventriculomegaly and decreasing transependymal edema

- *Blood work was not concerning, all levels looked normal. The concern is what the MRI is indicating. I looked over the labs with the nurse, and she stated that there wasn't any abnormal labs. I looked at Epic myself and didn't see any lab values that stood out to be either high or low*

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. Struggle with body image, fear of missing out, feeling "not normal" due to his illness

2. Disruption of normal development – feeling isolated, scared, and confused about his identity, and feels different from his peers

Piaget Stage: Formal Operational Stage

1. Internalizing anxiety or imagining worst-case scenarios

2. Asking deeper questions about his illness and outcomes

Please list any medications you administered or procedures you performed during your shift:
Labetalol 100mg oral tablet crushed, mixed in 5mL of sterile water, pill was crushed and given through patient's G-tube. Gave medication because 1600 vitals the systolic was greater than 140.

Pediatric Floor Patient #1

*****Sent paper in another attachment, wrote down**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL

Appearance: ◻Healthy/Well Nourished
◻ Neat/Clean ◻Emaciated ◻ Unkept
Developmental age:
◻ Normal ◻ Delayed

NEUROLOGICAL

LOC: ◻ Alert ◻ Confused ◻ Restless
◻ Sedated ◻ Unresponsive
Oriented to:
◻ Person ◻ Place ◻ Time/Event
◻ Appropriate for Age
Pupil Response: ◻ Equal ◻ Unequal
◻ Reactive to Light ◻ Size _____
Fontanel: (Pt < 2 years) ◻ Soft ◻ Flat
◻ Bulging ◻ Sunken ◻ Closed
Extremities:
◻ Able to move all extremities
◻ Symmetrically ◻ Asymmetrically
Grips: Right _____ Left _____
Pushes: Right _____ Left _____
S=Strong W=Weak N=None
EVD Drain: ◻ Yes ◻ No Level _____
Seizure Precautions: ◻ Yes ◻ No

RESPIRATORY

Respirations: ◻ Regular ◻ Irregular
◻ Retractions (type) _____
◻ Labored
Breath Sounds:
Clear ◻ Right ◻ Left
Crackles ◻ Right ◻ Left
Wheezes ◻ Right ◻ Left
Diminished ◻ Right ◻ Left
Absent ◻ Right ◻ Left
◻ Room Air ◻ Oxygen
Oxygen Delivery:
◻ Nasal Cannula: ____L/min
◻ BiPap/CPAP: _____
◻ Vent: ETT size_____@_____cm
◻ Other: _____
Trach: ◻ Yes ◻ No
Size _____ Type _____
Obturator at Bedside ◻ Yes ◻ No
Cough: ◻ Yes ◻ No
◻ Productive ◻ Nonproductive
Secretions: Color_____
Consistency_____
Suction: ◻ Yes ◻ No Type _____
Pulse Ox Site _____
Oxygen Saturation: _____

Pulse: ◻ Regular ◻ Irregular
◻ Strong ◻ Weak ◻ Thready
◻ Murmur ◻ Other _____
Edema: ◻ Yes ◻ No Location _____
◻ 1+ ◻ 2+ ◻ 3+ ◻ 4+
Capillary Refill: ◻ < 2 sec ◻ > 2 sec
Pulses:
Upper R _____ L _____
Lower R _____ L _____
4+ Bounding 3+ Strong 2+ Weak
1+ Intermittent 0 None

ELIMINATION

Urine Appearance: _____
Stool Appearance: _____
◻ Diarrhea ◻ Constipation
◻ Bloody ◻ Colostomy

GASTROINTESTINAL

Abdomen: ◻ Soft ◻ Firm ◻ Flat
◻ Distended ◻ Guarded
Bowel Sounds: ◻ Present X ____ quads
◻ Active ◻ Hypo ◻ Hyper ◻ Absent
Nausea: ◻ Yes ◻ No
Vomiting: ◻ Yes ◻ No
Passing Flatus: ◻ Yes ◻ No
Tube: ◻ Yes ◻ No Type _____
Location _____ Inserted to _____cm
◻ Suction Type: _____

NUTRITIONAL

Diet/Formula: _____
Amount/Schedule: _____
Chewing/Swallowing difficulties:
◻ Yes ◻ No

MUSCULOSKELETAL

◻ Pain ◻ Joint Stiffness ◻ Swelling
◻ Contracted ◻ Weakness ◻ Cramping
◻Spasms ◻ Tremors
Movement:
◻ RA ◻ LA ◻ RL ◻ LL ◻ All
Brace/Appliances: ◻ None
Type: _____

MOBILITY

◻ Ambulatory ◻ Crawl ◻ In Arms
◻ Ambulatory with assist _____
Assistive Device: ◻ Crutch ◻ Walker
◻ Brace ◻ Wheelchair ◻Bedridden

Social Status: ◻ Calm/Relaxed ◻ Quiet
◻ Friendly ◻ Cooperative ◻ Crying
◻ Uncooperative ◻ Restless
◻ Withdrawn ◻ Hostile/Anxious
Social/emotional bonding with family:
◻ Present ◻ Absent

IV ACCESS

Site: _____ ◻ INT ◻ None
◻ Central Line
Type/Location: _____
Appearance: ◻ No Redness/Swelling
◻ Red ◻ Swollen
◻ Patent ◻ Blood return
Dressing Intact: ◻ Yes ◻ No
Fluids: _____

SKIN

Color: ◻ Pink ◻ Flushed ◻ Jaundiced
◻ Cyanotic ◻ Pale ◻ Natural for Pt
Condition: ◻ Warm ◻ Cool ◻ Dry
◻ Diaphoretic
Turgor: ◻ < 5 seconds ◻ > 5 seconds
Skin: ◻ Intact ◻ Bruises ◻ Lacerations
◻ Tears ◻ Rash ◻ Skin Breakdown
Location/Description: _____
Mucous Membranes: Color: _____
◻ Moist ◻ Dry ◻ Ulceration

PAIN

Scale Used: ◻ Numeric ◻FLACC ◻ Faces
Location: _____
Type: _____
Pain Score:
0800_____ 1200_____ 1600 _____

WOUND/INCISION

◻ None
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

◻ None
◻ Drain/Tube
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount:_____
Drainage color: _____

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	N/A	N/A	N/A	N/A	N/A	0	0	0	0	240mL	N/A	N/A	240mL
Intake – PO Meds	N/A	N/A	N/A	N/A	N/A	0	0	0	0	5mL	N/A	N/A	5mL
Patient received 5mL of sterile water with medication at 1600 and patient drank 240mL of a smoothie around 1620 = 245mL intake during my observation of patient today													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	0	0	0	0	0	0	0	0	0	0	0	0	0
IV Meds/Flush	0	0	0	0	0	0	0	0	0	0	0	0	0

Calculate Maintenance Fluid Requirement (Show Work) **10 X 100 = 1000** **10 X 50 = 500** **30.1 X 20 = 602** **Total = 2,102** **Divided by 24 hours = 88mL/hr**	**Actual Pt IV Rate** - Fluids should be running at 88mL/hr if IV fluids were infusing **Rationale for Discrepancy (if applicable)** - The patient was not receiving IV fluids, patient did not have an IV in place

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	N/A	N/A	N/A	N/A	N/A	The nurse threw away the diaper	0	0	0	0	N/A	N/A	Wasn't measured
Stool	N/A	N/A	N/A	N/A	N/A	The nurse threw away the diaper	0	0	0	0	N/A	N/A	Wasn't measured
Emesis	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A	0
Other	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A	0

Calculate Minimum Acceptable Urine Output 0.5mL X 50.1 kg X 24hrs = 601mL/day	**Average Urine Output During Your Shift** 0.5mL X 50.1kg X 5hrs = 125.25mL/hr The patient was not on strict intake and output, so output was not weighed. The nurse changed the patient's diaper, and it was thrown in the trash, so it was not able to be measured.

Children's Hospital Early Warning Score (CHEWS)
(See CHEWS Scoring and Escalation Algorithm to score each category)

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	- Playing/sleeping appropriately **OR** - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed	- Irritable, difficult to console **OR** - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy **OR** - Reduced response to pain **OR** - Prolonged or frequent seizures **OR** - Pupils asymmetrical or sluggish
Cardiovascular	- Skin tone appropriate for patient - Capillary refill ≤ 2 seconds	- Pale **OR** - Capillary refill 3-4 seconds **OR** - Mild tachycardia **OR** - Intermittent ectopy or irregular HR (not new)	- Grey **OR** - Capillary refill 4-5 seconds **OR** - Moderate tachycardia	- Grey and mottled **OR** - Capillary refill > 5 seconds **OR** - Severe tachycardia **OR** - New onset bradycardia **OR** - New onset/increase in ectopy, irregular HR or heart block
Respiratory	- Within normal parameters - No retractions	- Mild tachypnea/ increased WOB (flaring, retracting) **OR** - Up to 40% supplemental oxygen **OR** - Up to 1L NC > patient's baseline need **OR** - Mild desaturations < patient's baseline **OR** - Intermittent apnea self-resolving	- Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) **OR** - 40-60% oxygen via mask **OR** - 1-2 L NC > patient's baseline need **OR** - Nebs Q 1-2 hour **OR** - Moderate desaturations < patient's baseline **OR** - Apnea requiring repositioning or stimulation	- Severe tachypnea **OR** - RR < normal for age **OR** - Severe increased WOB (i.e. head bobbing, paradoxical breathing) **OR** - > 60% oxygen via mask **OR** - > 2 L NC more than patient's baseline need **OR** - Nebs Q 30 minutes – 1 hour **OR** - Severe desaturations < patient's baseline **OR** - Apnea requiring interventions other than repositioning or stimulation
Staff Concern		- Concerned		
Family Concern		- Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
- Continue Routine Assessments	- 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	- 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

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), http://dx.doi.org/10.1016/j.pedn.2016.10.005