IM5 Clinical Worksheet – Pediatric Floor

Student Name: Juliana Adams Dogoy **Date:** 4/23	**Patient Age:** 12 days **Patient Weight:** 3.52kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Patent foramen ovale (PFO): there is an opening between the atria and it remains open after birth	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** Cardiovascular assessment
3. Identify the most likely and worst possible complications Worst likely: massive ischemic stroke Most likely: ischemic stroke	**4. What interventions can prevent the listed complications from developing?** Preventing an emboli, PFO closure, antithrombotic therapy such as antiplatelet therapy or anticoagulation, DVT prevention
5.What clinical data/assessments are needed to identify these complications early? Do neuro assessment such as observing if theres hemiparesis, check for signs of DVT, assess for oxygen saturation changes, monitor for loss of skills	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** Perform frequent neuro assessment, ensure airway patency, monitor VS, administer appropriate meds
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** 1. Swaddling to provide a sense of security 2. Pacifier to help reduce pain	**8. Patient/Caregiver Teaching:** 1. Teach them the s/s of stroke 2. Tell caregiver that infants 3. Explain to caregiver how this is related to PFO **Any Safety Issues identified:**

Student Name: Juliana Adams Pogoy Date: 4/23	Patient Age: 12 days Patient Weight: 3.52 kg

Abnormal Relevant Lab Tests **Current Clinical Significance**

Complete Blood Count (CBC) Labs

Metabolic Panel Labs

Chloride: 110
Total protein: 5.5
Creatinine: <0.20
Bilirubin: 10.9

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: Trust vs mistrust

1. Newborn is constantly given tactile stimulation

2. There is consistency of care between mother and child

Piaget Stage: Sensorimotor

1. When I placed my finger on the baby's hand, she reflexively grasped it
2. The newborn would constantly turn ~~their~~ her head whenever she hears a sound

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

No meds

GENERAL APPEARANCE

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 W Left W
Pushes: Right W Left W
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: 0.2 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 Right big toe
Oxygen Saturation: 99%

CARDIOVASCULAR

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 2+ L 2+
Lower R 2+ L 2+
4+ Bounding 3+ Strong 2+ Weak
1+ Intermittent 0 None

ELIMINATION

Urine Appearance: clear
Stool Appearance: yellow
☑ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☑ Soft ☐ Firm ☑ Flat ☐ Distended ☐ Guarded
Bowel Sounds: ☐ Present X 4 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: breastfeeding
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

PSYCHOSOCIAL

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

IV ACCESS

Site: ⓒ Antecubital ☐ 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: pink ☑ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☐ Numeric ☑ FLACC ☐ Faces
Location: _____
Type: _____
Pain Score:
0800 _____ 1200 _____ 1600 0

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													
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)

10 x 100 = 1000 mL

1000 ÷ 24 = 41.6 → 42 mL/hr

Actual Pt IV Rate

Rationale for Discrepancy (if applicable)

Intake was not measured

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper							50mL						
Stool		80mL											
Emesis													
Other													

Calculate Minimum Acceptable Urine Output

1mL x 3.52kg = 3.52 mL/hr

Average Urine Output During Your Shift

~~80 + 50 = 130 mL ÷~~

50 ÷ 5 = 10 mL ~~DKV~~

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
	Circle the appropriate score for this 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

Cardiovascular (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) 3
	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