IM5 Clinical Worksheet – Pediatric Floor

Student Name: Kaitlyn Diaz **Date/04/24/2025**	**Patient Age:** 4 years **Patient Weight: 21.6kg**
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Admitted Diagnosis: Pneumonia of Right Lower Lobe due to infectious organism. The pneumonia that the patient got was due to a sedentary lifestyle 2 weeks after the patient had an appendectomy.	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** First would be a respiratory assessment and second would be to assess the patient's drain and tubing.
3. Identify the most likely and worst possible complications. The most likely complication would be that the patient would have to stay even longer to the amount of fluid in the Right Lung. The worst would be the pneumonia getting worse and the drain wouldn't be enough to get the amount of fluid off the patient's lungs. Which would result to death for the patient.	**4. What interventions can prevent the listed complications from developing?** Documenting how much fluid is coming out of the tube frequently. Documenting fluid color and pain level. Another intervention would be to make sure the patient is using his incentive spirometer.
5.What clinical data/assessments are needed to identify these complications early? Respiratory assessment Chest x-rays could also show if the treatment is working and if the fluid is coming out of the lungs.	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** One would be to make sure the patient's head of the bed is up to relieve the pressure off the lungs. Another would be supplementing oxygen.

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7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** **1.** Raise the head of the bed. **2. Adjust the position of the patient to make them more comfortable.**	**8. Patient/Caregiver Teaching:** **1. The education I would teach them would be signs and symptoms of respiratory distress.** **2. What color we are looking for in the fluid that is coming out of the drain and what color we would be alarmed of if we saw it.** **3. The last thing I would teach the parent would be on how important it is for the patient to take deep breaths and to use the incentive spirometer.** **Any Safety Issues identified:**

Abnormal Relevant Lab Tests	**Current**	**Clinical Significance**
Complete Blood Count (CBC) Labs		
RRBC	3.36	If low this could indicate the rest of the body including organs are not receiving enough oxygen
Metabolic Panel Labs		
Albumin	2.7	Keeps the fluid in the blood and not leaking out which if it does leak out could mean a build up of fluid in the lungs
BUN	1	Bun is an indication of how well the kidneys are functioning
Potassium	3.5	Low potassium could cause muscle weakness and abnormal heart rhythms.
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
Lab TRENDS concerning to Nurse?		
All the ones that are listed would be concerning for the nurse because it could cause excess fluid build up on the lungs and can effect the heart as well.		

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1. 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

1. **When I was showing the patient my moo light pen the patient wanted to take the initiative to use it himself and try it out on his father.**

2. **An example of Guilt would be when the patient saw me walk in and he hissed at me and the mother got on to the patient and I could see the patient put his head down and start to frown.**

Piaget Stage: Preoperational Stage

1. **When we walked in, the mother was asking questions to the patient and he would mimic his mother. When he wasn't he was constantly saying no (negativism).**
2. **After giving the pen light to the patient, he had given the light a name and pretended the pen could talk which would be animism.**

Please list any medications you administered or procedures you performed during your shift: none

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: ◻Healthy/Well Nourished ◻ Neat/Clean ◻Emaciated ◻ Unkept **Developmental age**: ◻ Normal ◻ Delayed	**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 ___3+__ L _3+____ Lower R __3+___ L _3+____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	**Social Status:** ◻ Calm/Relaxed ◻ Quiet ◻ Friendly ◻ Cooperative ◻ Crying ◻ Uncooperative ◻ Restless ◻ Withdrawn ◻ Hostile/Anxious **Social/emotional bonding with family:** ◻ Present ◻ Absent
NEUROLOGICAL	**ELIMINATION**	**IV ACCESS**
LOC: ◻ Alert ◻ Confused ◻ Restless ◻ Sedated ◻ Unresponsive **Oriented to:** ◻ Person ◻ Place ◻ Time/Event ◻ Appropriate for Age **Pupil Response:** ◻ Equal ◻ Unequal ◻ Reactive to Light ◻ Size ___2____ **Fontanel:** (Pt < 2 years) ◻ Soft ◻ Flat ◻ Bulging ◻ Sunken ◻ Closed **Extremities:** ◻ Able to move all extremities	**Urine Appearance:** ____clear and yellow_____ **Stool Appearance:** __brown and diarrhea_____	**Site:** _Right lower arm_____ ◻ INT ◻ None ◻ Central Line Type/Location: ____IV Line_____ **Appearance:** ◻ No Redness/Swelling ◻ Red ◻ Swollen ◻ Patent ◻ Blood return **Dressing Intact:** ◻ Yes ◻ No **Fluids:** _____

☐ Symmetrically ☐ Asymmetrically
Grips: Right __S___ Left __S___
Pushes: Right ___S__ Left __S___
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:
___91%_____

☐ 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 ____Chest tube_____
Location __right side chest___ Inserted to _n/a cm
☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: ___regular diet_____
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 __X1_____
Assistive Device: ☐ Crutch ☐ Walker
☐ Brace ☐ Wheelchair ☐Bedridden

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__0___ 1600 _0____

WOUND/INCISION

☐ **None**
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

☐ **None**
☐ **Drain/Tube**
Site: __Right side chest _____
Type: _____pig tail_____
Dressing: _dressing over site, dry and intact_____
Suction: _____
Drainage amount:___70mL_____
Drainage color: __pinkish_____

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							120mL	20mL					140mL
Intake – PO Meds													0
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													0
IV Meds/Flush													0

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