

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Nylan Steele Date: 4/22/25</p>	<p>Patient Age: 3 months Patient Weight: 6.8 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Bronchiolitis / dehydration</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Respiratory assessment</p>
<p>3. Identify the most likely and worst possible complications. Most likely = respiratory distress Worst possible = respiratory failure</p>	<p>4. What interventions can prevent the listed complications from developing? Keep airway open such as suctioning, sitting upright, and use oxygen if needed</p>
<p>5. What clinical data/assessments are needed to identify these complications early? Earliest sign is tachypnea and others include nasal flaring, grunting, and O<sub>2</sub> sats dropping</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Suction the nose and mouth, supply oxygen, check cap refill, skin color, and HR</p>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient. 1. Keep pt hydrated 2. position them upright for lung expansion</p>	<p>8. Patient/Caregiver Teaching: 1. Watch for difficulty breathing, poor feeding, and nasal flaring 2. Use a cool-mist humidifier to help loosen mucus 3. Keep child away from large crowds Any Safety Issues identified:</p>

**Pediatric Floor Patient #1**

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 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 type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input 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 type="checkbox"/> Person <input type="checkbox"/> Place <input 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 type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input 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>NIA</u> <b>Stool Appearance:</b> <u>NIA</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>DAC</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input checked="" 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> <u>No fluids</u>
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 type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input checked="" 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 checked="" type="checkbox"/> No <b>Cough:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color <u>NIA</u> Consistency _____ <b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>D foot</u> <b>Oxygen Saturation:</b> <u>94</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 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 checked="" 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 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 checked="" 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: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
<b>Diet/Formula:</b> <u>Regular breast and</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"/> 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 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 <u>0</u> 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" 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	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

**Pediatric Floor Patient #1**

INTAKE/OUTPUT													
	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO/Enteral Intake													30mL
PO Intake/Tube Feed		50mL											
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						
$100\text{mL/kg/day} \times 6.88\text{kg} = 688\text{mL/day}$ $\frac{688}{24} = 28.7\text{mL/hr}$							Rationale for Discrepancy (if applicable)						
OUTPUT													
	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	90mL												90mL
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$6.88 \times 1 = 6.88\text{mL/hr}$							90mL						

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
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>0</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: Nylan Stelle  
Date: 4/22/25

Patient Age: 5m  
Patient Weight: 6.22 kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
RSU	positive	respiratory infection
Mycoplasma pneumoniae	positive	atypical pneumonia
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. Mom breast-fed and did skin-to-skin to help with nurturing physical contact
2. When mom put baby ~~down~~ down to weigh he cried for her

Piaget Stage: Sensorimotor stage

1. Sucked his fingers while sleeping
2. pulled feet back when trying to get blood pressure

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

N/A

Student Name: Nyan

Unit: Pedi

Pt. Initials: BR

Date: 4/22/25

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

Allergies: penicillin/morphine

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Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	IVP – List solution to dilute and rate to push.  IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?			
				If not, why?			
amlodipine			5mg per ft tube 2x daily	yes		HA, dizziness, edema, abdominal pain	1. Check BP and HR before and after administration 2. Assess peripheral vascular system 3. Stand slowly when getting up 4. Elevate legs if edema occurs
esfenitropram			5mg per ft tube daily	yes		NIV, dry mouth, increased sweating, insomnia	1. Do not stop abruptly 2. Track appetite and weight loss 3. monitor changes in mood/behavior 4. may take 2-4 weeks to see improvement
gabapentin			300mg per ft tube 3x daily	yes		drowsiness, ataxia, tremor, weight gain, swelling	1. Use appropriate pain scale before and after administration 2. Weigh pt to check for weight changes 3. Stand slowly when getting up 4. do not stop abruptly
clonidine			1 patch weekly	yes		constipation, fatigue, lightheadedness, hypotension	1. Check BP and HR before administration 2. Keep fluids and stay hydrated 3. Rise slowly / fall precautions 4. rotate sites and check for skin irritation
							1. 2. 3. 4.

Student Name: Nylan Stelle

Unit: \_\_\_\_\_

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

Date: 4/21/15

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

Allergies: NKA

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Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
	Isotonic/ Hypotonic/ Hypertonic			

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		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.)
				Is med in therapeutic range?	If not, why?			
<u>acetaminophen</u>	<u>Pain Reliever</u>	<u>Used to ease pain and fever</u>	<u>99.2mg Oral q4 PRN</u>	<u>Yes</u>			<u> upset stomach trouble sleeping, HTA, constipation</u>	<ol style="list-style-type: none"> <li>1. Regularly assess child's pain/fever</li> <li>2. Primary assessment for difficulty breathing</li> <li>3. Cover eye nose on crib no weight</li> <li>4. Adequate fluid intake</li> </ol>
<u>Sodium chloride</u>	<u>electrolyte Supplement</u>	<u>Restoration of sodium/ acute viral hemorrhoids</u>	<u>1 drop each 4 PRN</u>	<u>Yes</u>			<u>burning or eye irritation</u>	<ol style="list-style-type: none"> <li>1. Do not allow to prevent irritation</li> <li>2. Wipe nozzle after each spray</li> <li>3. Hold head slightly forward</li> <li>4. Check for nasal irritation</li> </ol>
<u>Zinc oxide</u> <u>oil-tiner</u> <u>oil-tinolin</u>	<u>skin protectant</u>	<u>help relieve of burning by itching</u>	<u>1app topical PRN</u>	<u>Yes</u>			<u>irritation changes in the skin</u>	<ol style="list-style-type: none"> <li>1. Ensure proper application and avoid abuse</li> <li>2. Make sure diaper area is clean</li> <li>3. Avoid contact with overmoisture</li> <li>4. Do not use on broken skin</li> </ol>