

IM5 Clinical Worksheet – Pediatric Floor

| | |
|--|---|
| Student Name: Lily Bagwell Date: 4/29/25 | Patient Age: 17 Patient Weight: 50 kg |
| 1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Chest Pain and elevated troponin level. These two things combined could indicate cardiac dysfunction. | 2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Cardiac Assessment |
| 3. Identify the most likely and worst possible complications. Heart Attack Myocarditis Damage to the heart Pericarditis | 4. What interventions can prevent the listed complications from developing? Allow the heart to rest and treat underlying condition that caused high troponin |
| 5. What clinical data/assessments are needed to identify these complications early? Presence of chest pain, weakness, arm pain, elevated troponin. | 6. What nursing interventions will the nurse implement if the anticipated complication develops? Manage pain, give oxygen therapy, allow for rest. |
| 7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Use distraction, watching a show, reading a book. 2. Dim the lights and play calming music | 8. Patient/Caregiver Teaching: 1. Know signs of heart attack chest pain etc. 2. Come to hospital if experiencing 3. symptoms Allow for rest & fluids. Any Safety Issues identified: can cause severe heart damage |

Student Name: Lillian Bagwell
 Date: 4/29
 Patient Age: 17
 Patient Weight: 50 kg

| Abnormal Relevant Lab Tests | Current | Clinical Significance |
|---|---------|-------------------------------------|
| Complete Blood Count (CBC) Labs | | |
| | | |
| Metabolic Panel Labs | | |
| Troponin | 554 | indicative of possible heart attack |
| | | |
| Misc. Labs | | |
| Absolute Neutrophil Count (ANC) (if applicable) | | |
| | | |

Lab TRENDS concerning to Nurse?
 Troponin level could indicate possible heart attack or cardiac distress

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. She had her nails done which shows her expressing her identity
 2. She was answering questions about her health while still having her parents there for support.

Piaget Stage: Formal operations
 1. She was demonstrating that she had left sided weakness
 2. She was able to state the type and degree of her pain.

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

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 <i>N/A</i> | 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 | | | | | | |
| <i>50 kg 1,000 + 500 + 600</i> | | | | | | | <i>N/A</i> | | | | | | |
| <i>87.5 mL/hr</i> | | | | | | | Rationale for Discrepancy (if applicable) | | | | | | |
| | | | | | | | | | | | | | |
| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| Urine/Diaper | <i>1 mL</i> | | | | | <i>1 mL</i> | | | | <i>400 mL</i> | | | |
| Stool | <i>N/A</i> | | | | | | | | | | | | |
| Emesis | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | |
| Calculate Minimum Acceptable Urine Output | | | | | | | Average Urine Output During Your Shift | | | | | | |
| <i>25 mL/hr</i> | | | | | | | <i>400 mL</i> | | | | | | |

| 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: <input checked="" type="radio"/> 0 1 2 3 |
| Cardiovascular | Circle the appropriate score for this category: <input checked="" type="radio"/> 0 1 2 3 |
| Respiratory | Circle the appropriate score for this category: <input checked="" type="radio"/> 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) <i>0 (Green)</i> |
| | 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 |

Pediatric Floor Patient #1

| GENERAL APPEARANCE | CARDIOVASCULAR | PSYCHOSOCIAL |
|---|---|--|
| Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed | Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <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+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>4</u> L <u>4</u> Lower R <u>2</u> L <u>2</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None | Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <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 <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>W</u> Pushes: Right <u>S</u> Left <u>W</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Urine Appearance: <u>clear, yellow</u> Stool Appearance: <u>N/A last BM</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <u>soft brown</u> <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy | Site: <u>Left AC</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Left AC</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>N/A</u> |
| RESPIRATORY | GASTROINTESTINAL | SKIN |
| Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input 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 Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>finger</u> Oxygen Saturation: <u>98</u> | Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>3</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____ | Color: <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 Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <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: _____ Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| | NUTRITIONAL | PAIN |
| | Diet/Formula: <u>Regular Diet</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>Chest</u> Type: <u>aches</u> Pain Score: 0800 _____ 1200 _____ 1600 <u>6</u> |
| | MUSCULOSKELETAL | WOUND/INCISION |
| | <input checked="" type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input type="checkbox"/> None Type: _____ | <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____ |
| | MOBILITY | TUBES/DRAINS |
| | <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <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 <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____ |