IM5 Clinical Worksheet

Student Name: Sadie burrow **Date: 4/30/25**	**Patient Age:** 8 wk.o infant **Patient Weight: 2.44 kg**
1. **Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)** Failure to thrive – a condition that can be caused when nutrition needs are unmet, and the infant is having delayed development and growth. This can occur by poor calorie intake or absorption or low supply of breast milk.	**2. Priority Focused Assessment R/T Diagnosis:** - **Priority assessments for a infant with FTT would be strict I&Os, check weight shiftily and labs drawn to show if there is an underlying reason** - **Skin assessment is also very important because these patients are so tiny**
3. Identify the most likely and worst possible complications. Infections – most likely Developmental delay – worst possible	**4. What interventions can prevent the listed complications from developing?** Can be prevented by seeking help to figure out what nutritional needs help the baby most and figure out a routine and formula that works for the baby
5. What clinical data/assessments are needed to identify these complications early? - watch for S/S of infection (fever, reduced appetite, respiratory distress, tachypnea, low bp) - monitor feeding interactions, watch for delays when rolling over, grasping, watch for difficulty recognizing caregiver	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** - provide positive feeding environment - Introduce new foods slowly - Weigh patient regular - Document how the patient is doing during feedings - contacting lactation specialist
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** **1.** Breastfeeding, non-nutritive sucking **2. Skin to skin contact**	**8. Patient/Caregiver Teaching:** **1. Tell dr if patient is starting to have unusual behaviors during feedings** **2. Alert dr if patient is starting to lose weight again** **3. Keeping a record of what infant is eating and how they are tolerating it to bring to appointments.** **Any Safety Issues Identified:**
Please list any medications you administered or procedures you performed during your shift: **PATIENT HAD NO IV FLUIDS OR ANY MEDS TO BE GIVEN!!!!**	

PICU

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 _____ 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: _____

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 _____ 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

PSYCHOSOCIAL

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: _____

PICU

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)							**Combined Total Intake for Pt (mL/hr)**						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							**Average Urine Output During Your Shift**						

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) _____
	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

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