

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Jasmine Abalos Date: 8-26-25</p>	<p>Patient Age: 22 mo Patient Weight: 15.7 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</p> <p>Respiratory Distress: Alveoli in the lungs are filled with fluid causing lower oxygen levels making it hard to breathe.</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>Respiratory Assessment - VS, auscultate, pain scale</p>
<p>3. Identify the most likely and worst possible complications.</p> <p>- Scarred/Damaged Lungs from increased force on the lungs - Respiratory Failure could happen if pt goes untreated</p>	<p>4. What interventions can prevent the listed complications from developing?</p> <p>- Oxygen therapy - Broncho dilators - Preventative care (staying healthy)</p>
<p>5. What clinical data/assessments are needed to identify these complications early?</p> <p>- VS - O2 sat, HR, RR - listening to breath sounds - assessing abd, retractions, etc - S/S of distress: flared nose, cyanosis</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <p>- Promote breathing with proper positioning (HOB up, Fowlers) - Alert charge nurse & rapid response</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <p>1. Toys, patient likes Spiderman plushy</p> <p>2. Comfort Positions with Mom, while doing VS child wanted to sit in moms lap</p>	<p>8. Patient/Caregiver Teaching:</p> <p>1. Recognize & avoid triggers 2. Bronchodilator / Proper med use education 3. Promote hand hygiene, avoid smoke</p> <p>Any Safety Issues identified: - O2 saturation / Pulse OX kept falling off of pt finger ("unsticking?")</p>

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Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		

Lab TRENDS concerning to Nurse?

NO labs done, tested (-) for COVID, FlU, + Strep

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: Autonomy vs Shame/Doubt

1. PT held Spiderman toy while I did his VS. (transitional / comfort object)
2. Mom stated PT didnt want chicken, but instead spaghetti. (his favorite, ritualism)

Piaget Stage: Pre-Operational / Sensorimotor (19-24mo)

1. Animism = listening to Spiderman toys' heart & lungs before I listened to pt.
2. Centration: PT focused on the fact that he wasn't eating his favorite food instead of what was already there.

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

N/A

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>+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	Social Status: <input type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input checked="" 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 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 type="checkbox"/> Person <input type="checkbox"/> Place <input 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>2mm</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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>yellow</u> Stool Appearance: <u>brown/firm</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input 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 type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____
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 type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input checked="" type="checkbox"/> Right <input checked="" 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 checked="" type="checkbox"/> No Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>finger</u> Oxygen Saturation: <u>93%</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>4</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 checked="" type="checkbox"/> Yes <input 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: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>regular diet</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Pain <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 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 checked="" type="checkbox"/> None Type: _____	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: <u>N/A</u> Pain Score: 0800 _____ 1200 _____ 1600 <u>0</u>
MOBILITY	WOUND/INCISION	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 Type: _____ Location: _____ Description: _____ Dressing: _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> 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							25%						25% of meal
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
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$10 \times 100 = 1000$ $5.7 \times 50 = 285$ $1000 - 285 = 715$ $715 / 24 = 29.8$ 53.5 mL/hr							No IV Rationale for Discrepancy (if applicable) _____						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper							240						240
Stool							1						
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$1 \text{ mL/kg/hr} = 1 \text{ mL} \cdot 15.7 \text{ kg} =$ 15.7 mL/hr							$240 \div 6 \text{ hr} =$ 40 mL/hr						

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

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
n/a		n/a	n/a	n/a

Student Name: Jasmine Abalos	Unit: Pedi Floor	Patient Initials: Z.Z.	Date: 8/26/2025	Allergies: NKDA	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration
Insulin Glargine	Antidiabetic /Hormone	Long acting insulin to lower blood sugar	1 unit nightly	Yes Click here to enter text.	IVPB – List concentration and rate of administration
Insulin Lispro	Antidiabetic /Hormone	Rapid acting insulin to lower blood sugar	0-5 units tid	Yes Click here to enter text.	Hypoglycemia
					<ol style="list-style-type: none"> 1. Rotate inj sites to avoid poor absorption 2. Glargine works slowly 3. Report s/s hypoglycemia: sweating, dizzy, confused, shaky 4. Click here to enter text. <ol style="list-style-type: none"> 1. Make sure to eat soon after admin (don't want to get hypoglycemic, acts fast) 2. Report s/s hypoglycemia: sweating, dizzy, confused, shaky 3. Click here to enter text. 4. Click here to enter text.

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Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
n/a		n/a	n/a	n/a

Student Name: Jasmine Abalos		Unit: Pedi Floor	Patient Initials: A.A.		Date: 8/26/2025	Allergies: NKDA	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Is med in therapeutic range? If not, why?	IVP – List diluent solution, volume, and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Albuterol	Bronchodilator	Short acting bronchodilator, tx sob/cough	2.5mg/3mL nebulizer q3hr PRN	Yes Click here to enter text.	n/a	Bronchospasm and Hypokalemia	<ol style="list-style-type: none"> 1. "Rescue med" used for immediate relief, wont prevent an attack 2. Report if breathing/symptoms worsens after using med 3. Ensure pt knows how to properly use inhaler/nebulizer 4. Common side effects: fast hr, shakiness
Click here to	Click here to	Click here to	Click here to	Choose an	Click here to enter text	Click here to	1. Click here to enter text.