

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Osvaldo Colmenero Date: 3-26-25</p>	<p>Patient Age: 22 mo Patient Weight: 15.5 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Respiratory Distress</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. Respiratory failure Hypoxia</p>	<p>4. What interventions can prevent the listed complications from developing? Supplemental O₂ Suction PRN Keep patient warm</p>
<p>5. What clinical data/assessments are needed to identify these complications early? Breath sounds O₂ Sat Monitor retractions, grunting, and nasal flares</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Assess airway and clear if needed. Begin compressions or give O₂ if needed</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <p>1. HOB >30° for easier respirations</p> <p>2. Distractions, like toys or games</p>	<p>8. Patient/Caregiver Teaching:</p> <p>1. Hydrate to thin mucous in airway 2. Don't pull on or play w/ the NC 3. Report any troubles breathing</p> <p>Any Safety Issues identified:</p>

Student Name:	Patient Age:
Date:	Patient Weight: kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC	8000	Recent viral infection caused ↓WBC
Metabolic Panel Labs		
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)		
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: Autonomy vs. Shame/Doubt

1. Feeds self
2. Wanted to take NC off himself

Piaget Stage: Pre-Operational

1. Egocentrism: Talked only in relation to self
2. Animism: Played + talked w/ toys as if they were alive

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	Social Status: <input 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 Social/emotional bonding with family: <input 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 _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input checked="" 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 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 type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pulses: Upper R <u>t3</u> L <u>t3</u> Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Site: _____ <input type="checkbox"/> INT <input 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 checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input checked="" 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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input checked="" type="checkbox"/> Nasal Cannula: <u>1</u> 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 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 checked="" type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: _____	Urine Appearance: <u>WNL</u> Stool Appearance: <u>WNL</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Color: <input checked="" 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>Full diet</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input 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 type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 <u>0</u> 1200 <u>0</u> 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													
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						
$\begin{array}{r} 1000 \\ +275 \\ \hline 1275 \div 24 = 53 \text{ mL/hr} \end{array}$							Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													0
Stool													0
Emesis													0
Other													0
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
15.5 mL													

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:
	0 <input checked="" type="radio"/> 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>1</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