

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Lillian Nguyen Date: 9/3/25</p>	<p>Patient Age: 17 y/o Patient Weight: 65.6 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Campylobacter: A bacteria from raw/undercooked poultry, meat, or unpasteurized dairy being consumed causing N/V/D, fever, and abdominal pain.</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <ul style="list-style-type: none"> - I + O - GI Assessment - BP
<p>3. Identify the most likely and worst possible complications. 1) N/V/D worst: Guillain-Barre syndrome</p>	<p>4. What interventions can prevent the listed complications from developing?</p> <ul style="list-style-type: none"> - food safety - hand hygiene/cross contamination - proper hydration
<p>5. What clinical data/assessments are needed to identify these complications early? 1) GI Assessment 2) stool cultures 3) Monitor VS and possible systems of Guillain-Barre</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <ul style="list-style-type: none"> 1) fast + easy access to restroom/commode 2) emesis bags 3) observation + VS
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <ul style="list-style-type: none"> 1. Staying hydrated due to Diarrhea + Vomitting. 2. Calm and dim environment to promote rest. 	<p>8. Patient/Caregiver Teaching:</p> <ul style="list-style-type: none"> 1. Hand hygiene 2. Food safety 3. Counting I + O <p>Any Safety Issues identified:</p>

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 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 checked="" type="checkbox"/> Calm/Relaxed <input 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 checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input 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 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>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>Clear yellow</u> Stool Appearance: <u>liquidy brown</u> <input checked="" type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <input checked="" type="checkbox"/> <u>AC</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>D5NS + KCl 20mEq</u> <u>125/hr</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 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: <input checked="" type="checkbox"/> <u>Index finger</u> Oxygen Saturation: <u>100%</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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Vomiting: <input checked="" type="checkbox"/> Yes <input 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: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>Reg astal + liquid</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Pain: <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 type="checkbox"/> None Type: _____	Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>0</u> Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 _____
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 type="checkbox"/> None <input checked="" 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													0
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						125	0	0	125	125	125		500 mL
IV Meds/Flush									8				
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$16\text{kg} \times 100 = 1000$ $10\text{kg} \times 50 = 500$ $43.4\text{kg} \times 20 = 868$ $= 2,368 \text{ mL/day}$ 99 mL/hr							125 mL/hr Rationale for Discrepancy (if applicable) 99 mL/hr						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper								750					
Stool								1					
Emesis						1	1						
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
787.2 mL/day 32.8 mL/hr							150 mL/hr 750 total						

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:
	<u>0</u> 1 2 3
Cardiovascular	Circle the appropriate score for this category:
	<u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category:
	<u>0</u> 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: Lillian Nguyen

Unit: 30 PEDI

Pt. Initials: N.L

Date: 9/3/25

Allergies: Bee Venom

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

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
DSW+0.9% NS+KCl 20mEq	Isotonic/Hypotonic/Hypertonic	Hydration due to vomiting & diarrhea	Potassium	Potassium increases hypervolemia

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?				
Ondansetron	Serotonin 5-HT ₃ receptor antagonist	NAUSEA	4mg IV push Q6PRN	0.15/0.5/kg = 9mg	Yes			-dizzy -fast Q/bent -headache -confusion	1. Call don't fall may be 2. Report irregular Q/bent 3. Report chest pain/dysrhythmia 4. Seizure precautions
Promethazine	Phenothiazine	Nausea/Vomiting	12.5mg IV push Q6PRN	25mg/day 0.5mg/2.2kg	Yes			-respiratory distress -seizures -dry mouth	1. Report SOB, distress may occur. 2. Assess airway & circulation 3. Report fast Q/bent/difficulty 4. Seizure/Fall precautions
Capsaicin	Topical Pain Relief	abdominal Pain	0.025% cream Q4 PRN	Yes				-intense burn -swelling -↑ BP	1. Call don't fall/drowsy may occur. 2. Report fast Q/bent and fluttering heart/cough/pneumonia 3. Report sore throat/cough/pneumonia 4. Assess nervous system - ↑ fever, ↑ HR
Haloperidol	Antipsychotic	Agitation	2mg IV push Q4 PRN					-↓ WBC -drowsy	1. Sweating, confusion 2. 3. 4.