IM5 Clinical Worksheet – Pediatric Floor

Student Name: Hannah McRight **Date: 9/2/25**	**Patient Age:** 7 year old **Patient Weight: 20.12 kg**
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Nephrotic Syndrome: the kidneys are filtering correctly and leaking too much protein which causes swelling, in face, legs or stomach.	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** Monitor daily weights, intake and output. Measure abdominal growth, listen to lungs for crackles, and monitor blood pressure and heart rate.
3. Identify the most likely and worst possible complications. Most likely: Infections and blood clots Worst: Kidney failure	**4. What interventions can prevent the listed complications from developing?** Some interventions are hand hygiene, vaccinations, educate on proper nutrition, proper hydration, anticoagulants, monitoring kidney function (BUN, creatinine, electrolytes, albumin)
5.What clinical data/assessments are needed to identify these complications early? You can use vital signs like temp and heart rate, asses extremities for swelling, labs like WBC, platelet count, and PT/PTT.	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** Give antibiotics, monitor vital signs closely, give fluids, continue to monitor labs, watch for signs of bleeding. For kidney failure watch fluid balance very closely, give medication, monitor labs and may need to administer dialysis.
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** 1. Art Activities like coloring books, or drawing. 2. Storytelling and visual education like storybooks, visual charts or medical play	**8. Patient/Caregiver Teaching:** **1.** Watch for signs of swelling in the eyes, abdomen or ankles. Daily weights **2.** Need to try hard to prevent infection, Wash hands, watch for fever and avoid crowded places during sick seasons. **3.** Watch urine output, if it becomes less than normal, if the color changes or if it started to smell different. **Any Safety Issues identified:** Risk of infection, fluid overload, electrolyte imbalances, high blood pressure.

Student Name: Hannah McRight **Date: 9/2/25**	**Patient Age:** 7 year old **Patient Weight: 20.12 kg**

Abnormal Relevant Lab Tests **Current Clinical Significance**

Complete Blood Count (CBC) Labs
Platelet count- 449

Metabolic Panel Labs
Chloride- 112
BUN- 21
Albumin- 1.2
Bilirubin- 0.2

Misc. Labs
Absolute Neutrophil Count (ANC) (if applicable)

Lab TRENDS concerning to Nurse?
Kidney function

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: Industry vs. Inferiority

1. My patient showed independence when he wanted to push the syringe of medicine into his mouth by himself.

2. Got really excited when he was given crafts and finished them as fast as he could.

Piaget Stage: Concrete Operational Stage

1. He was not happy about having to stop playing with his toys to take his medicine but the nurse said he could have ice cream after he took them all and he got excited and took his medication really well

2. When the nurse was asking questions about how he was feeling and if he needed anything he made sure to ask his mom is she was ok also. Anytime we asked if he needed something he would turn and ask his mom.

Student Name: Hannah McRight **Date: 9/2/25**	**Patient Age:** 7 year old **Patient Weight: 20.12 kg**
Please list any medications you administered or procedures you performed during your shift: Albumin, famotidine, and prednisolone	

Pediatric Floor Patient #1

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				240									
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush				25 ml									
Calculate Maintenance Fluid Requirement (Show Work)							**Actual Pt IV Rate** **Rationale for Discrepancy (if applicable)**						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	325												
Stool													
Emesis													
Other													

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

Calculate Minimum Acceptable Urine Output 0.5/20.1/24= 241.2ml/day	**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) ____1_____
	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