IM5 Clinical Worksheet – Pediatric Floor

<table>
<tr><td>Student Name: Torrey Hogan
Date: 09/ 09/ 2025</td><td>Patient Age: 13 y/o
Patient Weight: 232.3lbs kg: 105.6</td></tr>
<tr><td>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)
- Exacerbation of acute glomerulonephritis (Henoch Schoenlein Purpura (HSP), AKI, nephritis, & HTN)
- CC: abdominal pain, sore throat, vomiting, diarrhea
- DX: Group A strep pharyngitis, Hep A (9/6)
- Patho: Autoimmune disease that is usually triggered by an infection. Fluid issue that causes the body to retain fluid (edema). Kidneys are unable to function properly & cannot excrete waste/ urine. S/S: include edema, hematuria/ proteinuria (same amount), oliguria, HTN, dark tea-like urine
- Triad S/S: red/ purple bruises (petechiae), abdominal pain, & joint pain</td><td>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:
- I&O, daily weight, VS, & monitor fluid status
o Mainly HR & BP
o I still wonder why pt is on continuous IV fluids
- Respiratory assessment: monitor for crackles & diminished lung sounds
- Assess capillary refill in bilateral upper & lower extremities; edema in all extremities, including the face.</td></tr>
<tr><td>3. Identify the most likely and worst possible complications.
- Worsening of glomerulonephritis (grade), weight gain, pitting edema, tachycardia & hypertension, hyperkalemia</td><td>4. What interventions can prevent the listed complications from developing?
- Continue to assess I&O, edema, & daily weights
- Monitor HR & BP Q4hrs
- Watch lab values for trends (mainly Na+ & K+) -> kidneys that are not functioning will hold on to K+ & excrete Na+ causing hyperkalemia & potential lethal cardiac arrhythmias
- Continue to keep on fluid, Na+, & K+ diet restrictions</td></tr>
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5.What clinical data/assessments are needed to identify these complications early? - Na+ & K+ lab value trends - Daily weights are used to identify fluid status -> gain weight = fluid retention/ kidneys not excreting fluid - VS monitoring (correct size BP cuff & manual radial pulse assessment)	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** - Fluid restrictions, take the pt off IV fluids - ECG monitoring - Elevate affected extremities, SCD on BLE - With the progression, surgery might be an option for this patient if health decline continues
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** **1.** Non- pharmacologic therapies such as stretching, moving around, & continuing to work with PT **2.** Pharmacological management might include NSAIDs or other anti-inflammatory medications	**8. Patient/Caregiver Teaching:** **1.** Continue to monitor BP, HR, daily weight, & I&O after discharge, notify the HCP if any changes are noted **2.** Dark, tea-colored urine is a normal finding in this disease process. Blood & protein are being excreted from the body in the urine; however, the urine should start to clear up **3.** It is important that Na+ & K+ are restricted in the diet to 2gm/ day. Normal diets are followed, but do not add salt, “no salt”, or K+ containing products to the foods. K+ rich foods include bananas, sweet potatoes, potatoes, & avocados. **Any Safety Issues identified:** - Low fall risk -> pt can move around independently, but ensure safety by just keeping an eye on him if he hasn’t moved around much.

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Abnormal Relevant Lab Tests	**Current**	**Clinical Significance**
Complete Blood Count (CBC) Labs		
WBC	20.1 (high)	Pt is on steroid therapy & is recovering from strep. Pt has a decreased immune system
Absolute neutrophil count	17. 95 (high)	The body is still trying to fight off a previous infection & the kidneys are also not able to rid the body of extra waste. The higher this number is, the more likely a pt is to obtain an infection
Metabolic Panel Labs		
BUN	83 (high)	Kidneys are not functioning properly; in some, it is an indication of dehydration, but usually when both BUN & creatinine are elevated = kidneys are bad
Creatinine	2.3 (high)	The best indicator that the kidneys are poorly working, the higher the number, the worse the kidneys are
Proteinuria (hourly/ 24hrs)	1,917 (high), 25,400 (high)	Although this is a fluid issue, the kidneys are damaged are allowing big protein molecules to pass through into the urine. For reference, normal protein in urine should be 0-12, while in 24 hours it should be 0-150 (better to be none)
Misc. Labs		
Absolute Neutrophil Count (ANC) (if applicable)	17.95 (high)	
Albumin	1.2 (low)	Since the protein is being deposited into the urine, there is not enough in the bloodstream (hypoalbuminemia)
Lab TRENDS concerning to Nurse?		
K+ is trending up from 4.9 to 5.3; daily weights have increased by +800 in the past day		

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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: Identity vs Role Confusion

1. Imaginary audience -> pt did not appear to be confident when speaking with me. He was very quiet & reserved. The poor boy was so sick though, so I don't blame him.

2. The pt might believe that he is alone or that no one understands him, since he might be the only person he knows who has these issues going on at his age

Piaget Stage: Formal Operational Thinking

1. Adolescent Egocentrism -> seemed very down & quiet; presented with a "why me?" attitude

2. The pt's friend was at the bedside throughout the entire shift, interacting with peers in a key during the adolescent developmental stage

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

1. Clonidine (Catapres) 0.2mg/ 24hr transdermal patch
2. Mycophenolate (Cellcept) 1000mg cap PO BID (x4 250mg caps)
3. Nifedipine (Adalat CC) ER 60mg PO tab Q12hrs (BID)
4. Pantoprazole (Protonix) DR 40mg PO tab daily before breakfast
5. Petrolatam ointment (Aquaphor) topical BID applied on petechiae rash
6. Prednisone (Deltasone) 30mg PO tabs BID

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	222	0	222	0	-	-	-	-	-	-	-	444mL
Intake – PO Meds	0	0	0	0	0	-	-	-	-	-	-	-	0mL
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total

IV Fluid	50	50	50	50	50	-	-	-	-	-	-	-	250mL
IV Meds/Flush	0	0	0	0	0	-	-	-	-	-	-	-	0mL

Calculate Maintenance Fluid Requirement (Show Work)
10kg x 100 = 1000
10kg x 50 = 500
85.6kg x 20 = **1,712 mL/ 24hrs**
1,712mL / 24 = **71.3 mL/hr**

Actual Pt IV Rate
NS 50mL/ hr continuously

Rationale for Discrepancy (if applicable)
I wish I could tell you the reason why, but I was trying to figure that out myself. I personally believe they should take him off the IV fluids, especially if the patient has been gaining daily weight.

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	0	0	0	0	0	-	-	-	-	-	-	-	0mL
Stool	0	0	0	0	0	-	-	-	-	-	-	-	0mL
Emesis	0	0	0	0	0	-	-	-	-	-	-	-	0mL
Other	-	-	-	-	-	-	-	-	-	-	-	-	-

Calculate Minimum Acceptable Urine Output
0.5mL x 105.6kg = **52.8mL/hr**
0.5 mL x 105.6kg x 12hr = **633.6mL/ 12hrs (shift)**

Average Urine Output During Your Shift
0 -> yeah, not good

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