

Allyson Jordan

9/10/25

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input 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 checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input checked="" 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 Withdrawn 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
<b>NEUROLOGICAL</b> 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 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>5</u> Left <u>5</u> Pushes: Right <u>5</u> Left <u>5</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	<b>ELIMINATION</b> Urine Appearance: <u>clear yellow</u> Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>IV ACCESS</b> Site: <input checked="" type="checkbox"/> Hand <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 type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>DS NB + 2.0 mL</u> <u>KUA</u>
<b>RESPIRATORY</b> 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 <input type="checkbox"/> Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> 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 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: <u>99%</u>	<b>GASTROINTESTINAL</b> 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 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: _____	<b>SKIN</b> 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
<b>WOUND/INCISION</b> <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____ <b>TUBES/DRAINS</b> <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____	<b>PAIN</b> Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: <u>0800</u> <u>1200</u> <u>0</u> <u>1600</u> <u>0</u>	<b>NUTRITIONAL</b> Diet/Formula: <u>very liquids</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>MUSCULOSKELETAL</b> <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/Appiances: <input type="checkbox"/> None Type: _____ <b>MOBILITY</b> <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	<b>MUSCULOSKELETAL</b> <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/Appiances: <input type="checkbox"/> None Type: _____ <b>MOBILITY</b> <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	<b>WOUND/INCISION</b> <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____ <b>TUBES/DRAINS</b> <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Alyson Jordan Date: 9/10/25</p>	<p>Patient Age: 5y10 Patient Weight: 21.4kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) infected Urachal Remnant - tube that does not connect between bladder &amp; belly button</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: abdominal</p>
<p>3. Identify the most likely and worst possible complications. most likely - infections (UTI) worst possible - malignancy</p>	<p>4. What interventions can prevent the listed complications from developing? surgicam removal of remnant</p>
<p>5. What clinical data/assessments are needed to identify these complications early? detailed H&amp;P ↳ tenderness in abdomen evaluation of clinical manifestations</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? assess/monitor symptoms &amp; treat w/ medication if necessary</p>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient. 1. hydration - jello, ice cream, etc. 2. warm compress</p>	<p>8. Patient/Caregiver Teaching: 1. monitor for s/s of infection - fever, chills, malaise 2. hydration - encourage avoid irritants - citrus fruits, soda, artificial sweeteners Any Safety Issues identified:</p>

Student Name: Allyson Jordan

Patient Age: 5 y/o

Date: 9/10/25

Patient Weight: 21.4 kg

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?		

NIA

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: Initiative vs. Guilt

1. patient wanted to use the bathroom by himself
2. ?

Piaget Stage: Preoperational

1. patient's stuffed animal had an "IV" - animism
2. patient expected me to like "sonic the hedgehog" because he does

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

- IV Acetaminophen (Ofirmev)
- IVPB Piperacillin (Zosyn)

Allyson Jordan

9/10/25

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													
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid							59	59	59	59	59		295
IV Meds/Flush							29			50			79
Calculate Maintenance Fluid Requirement (Show Work) $10 \times 100 = 1,000$ $1,520 \text{ mL/day}$ $10 \times 50 = 500$ $1.4 \times 20 = 28$ $63.6 \text{ mL/hr}$													
Actual Pt IV Rate $59 \text{ mL/hr}$ Rationale for Discrepancy (if applicable)													
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper							400				200		600
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output $0.5 \text{ mL/kg/hr}$ $10.7 \text{ mL/hr}$ $0.5 \text{ mL} \times 21.4 \text{ kg/hr}$ $10.7 \text{ mL/hr}$													
Average Urine Output During Your Shift													
100 mL/hr													

**Children's Hospital Early Warning Score (CHEWS)**  
 (See CHEWS Scoring and Escalation Algorithm to score each category)

Circle the appropriate score for this category:

Behavior/Neuro      0    1    2    3

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Circle the appropriate score for this category:

Cardiovascular      0    1    2    3

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Circle the appropriate score for this category:

Respiratory      0    1    2    3

Staff Concern      1 pt - Concerned

Family Concern      1 pt - Concerned or absent

**CHEWS Total Score**

Total Score (points)      0

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: Alllyson Jordan

Unit: Pedi

Pt. Initials: M

Date: 9/10/25

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

Allergies: NKDA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
DS NS + KCL 20 (59ml/hr)	Isotonic/ Hypotonic/ <u>Hypertonic</u>	fluid/electrolyte replacement	K+, Na+	

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?			
IV Acetaminophen	Analgesic	Pain Management	290mg IV syringe Q6	YES		29ml over 15min	liver problems - dark urine, yellow skin, etc.	<ol style="list-style-type: none"> <li>Do not take other acetaminophen-containing products due to risk of overdose</li> <li>Watch for signs of an allergic reaction - swelling, itching, hives</li> </ol>
Piperacillin/tazobactam	Antibiotic	Infected Urachal Remnant	2.25g IVPB Q8	YES		2.25g/50ml 100ml/hr	diarrhea insomnia	<ol style="list-style-type: none"> <li>Let us know if there is any blood in stool - could be c-diff</li> <li>Watch for s/s of an allergic reaction - hives, swelling, difficulty breathing</li> </ol>
								<ol style="list-style-type: none"> <li></li> <li></li> <li></li> <li></li> </ol>
								<ol style="list-style-type: none"> <li></li> <li></li> <li></li> <li></li> </ol>
								<ol style="list-style-type: none"> <li></li> <li></li> <li></li> <li></li> </ol>