

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Andrea Fabela Date: 9-24-25</p>	<p>Patient Age: 8 yrs. Patient Weight: 30.2 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Fecal impaction - hardened stool that is stuck in the rectum or lower colon due to chronic constipation</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: Focusing on bowel habits & abdominal s/s (V, D)</p>
<p>3. Identify the most likely and worst possible complications. Most likely - Bowel Perforation Worst - Peritonitis</p>	<p>4. What interventions can prevent the listed complications from developing? Preventing Constipation ↳ eating fiber, laxatives ↑ fluid intake ↳ Drinking lots of fluid</p>
<p>5. What clinical data/assessments are needed to identify these complications early? Abdominal pain fever s/s of bowel obstruction Passing hard, dry, or lumpy stool</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Assess bowel sounds, Abd. pain Administer ordered Meds.</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <p>1. Coloring books 2. TV</p>	<p>8. Patient/Caregiver Teaching:</p> <ol style="list-style-type: none"> 1. Look out for any abdominal pain, cramping, bloating 2. N/A 3. Sudden onset of watery stool or diarrhea leaking around blockage <p>Any Safety Issues identified: N/A</p>

Student Name: Andrea Fabela
Date: 9-24-25

Patient Age: 8 yrs.
Patient Weight: 30.2 kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
		NO labs drawn
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: Industry v.s. inferiority

1. taking initiative in activities
2. giving up easily due to pain

Piaget Stage: concrete operational

1. Classification & Categorization
2. perspective taking

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

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								90					90
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid							70	70	70				210
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$10 \times 100 = 1,000$ $10 \times 50 = 600$ $10.2 \times 20 = 204$ $\frac{1,704}{24} = 71 \text{ ml/hr}$							70 ml/hr Rationale for Discrepancy (if applicable) pt was receiving fluids but were DIC.						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper								250					250
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$0.5 \text{ mL} \times 30.2 \text{ kg/hr} = 15.1 \text{ mL/hr}$							250 mL $250 \text{ mL} / 6 \text{ hr} = 41.7 \text{ mL/hr}$						

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: <input checked="" type="radio"/> 0 1 2 3
Staff Concern	1 pt – Concerned
Family Concern	<input checked="" type="radio"/> 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

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 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 type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" 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
NEUROLOGICAL 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 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 checked="" type="checkbox"/> Size <u>3mm</u> 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 checked="" 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	ELIMINATION Urine Appearance: <u>dark yellow</u> Stool Appearance: <u>constipated</u> <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	IV ACCESS Site: <u>(R) forearm</u> <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>(R) AC 22g</u> 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>discontinued</u>
RESPIRATORY 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 <input checked="" 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: <u>left foot</u> Oxygen Saturation: _____	GASTROINTESTINAL Abdomen: <input 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 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 checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>nasal/oral</u> Location <u>(L) nostril</u> inserted to <u>42</u> cm <input type="checkbox"/> Suction Type: _____	SKIN 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: _____ <input type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL Diet/Formula: <u>regular diet</u> Amount/Schedule: <u>random</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	MUSCULOSKELETAL <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 checked="" type="checkbox"/> None Type: _____	PAIN Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 <u>0</u>
MOBILITY <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	WOUND/INCISION <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____	TUBES/DRAINS <input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>left nostril</u> Type: <u>nasal/oral tube</u> Dressing: <u>tape</u> Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: Andrea Fabela

Unit: PEDI FLOOR

Pt. Initials: #71, 73

Date: 9-24-25

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

Allergies: NKA

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?			
				If not, why?			
NO meds were given for #71, 73							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.