

## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Alina Elizarraraz <b>Date:</b> 9/24</p>	<p><b>Patient Age:</b> 17 <b>Patient Weight:</b>     kg                               78.2</p>
<p><b>1. Admitting Diagnosis and Pathophysiology</b> (State the pathophysiology in own words)</p> <p>Anemia. Your body is lacking RBC. This can be from lack of iron, vitamin B12, folate, or a problem with your bone marrow.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b></p> <p>Oxygen, cardiopulmonary, skin(bleeding)</p>
<p><b>3. Identify the most likely and worst possible complications.</b></p> <p>Common: fatigue, SOB, heart palpitation, pale, weak immune system.</p> <p>Sever: untreated can cause HF &amp; heart attack, hemorrhagic shock, or stroke</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b></p> <p>Provide O2, dietary change, supplements, blood transfusion, bone marrow transplant.</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b></p> <p>VS: tachycardia, low BP, numbness, tingling, irritability, pale skin, black tarry stool, low H&amp;H, low RBC.</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b></p> <p>Fall precautions, anticipate blood transfusion, IV iron, maintain O2, teach breathing exercises, prevent infection.</p>
<p><b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</p> <p>1. Deep breathing exercises</p> <p>2. Provide warmth</p>	<p><b>8. Patient/Caregiver Teaching:</b></p> <p>Iron rich foods, vitamin supplements,</p> <p>1. B12 intake,</p> <p>2. Watch for sign of bleeding bloody gums, black tarry stool, hematuria, unexplained bruising</p> <p>3. Contact HCP if you are SOB, dizzy/light head, bleeding occurs</p> <p>Any Safety Issues identified: Falls &amp; Bleeding</p>

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Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
Hemoglobin	5.3	May be low
Hematocrit	38.6	May be low
RBC	4.5	May be low
Metabolic Panel Labs		

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

<b>Lab TRENDS concerning to Nurse?</b>
No they seem to be well. The anemia is not the reason he is currently in the hospital.

**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. He talked a lot about what he was planning to do after high school when I asked
2. He had a hard time making decisions. This could be because he was shy, but he mostly answered with “it does not matter”.

**Piaget Stage: Formal**

1. When we talked to him about his discharge plan he stated “what ifs” to find out what would occur if something different happened.
2. He had a high level of thinking and understanding. He was reading and working on school work, and some of it looked complicated.

<b>Please list any medications you administered or procedures you performed during your shift:</b>  Vancomycin
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*Alina Elizarraraz*

<p><b>GENERAL APPEARANCE</b></p> <p>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</p>	<p><b>CARDIOVASCULAR</b></p> <p>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"/> &lt;2 sec <input type="checkbox"/> &gt;2 sec          Pulses:          Upper R <u>2+</u> L <u>2+</u>          Lower R <u>2+</u> L <u>2+</u>          4+ Bounding 3+ Strong 2+ Weak          1+ Intermittent 0 None</p>	<p><b>PSYCHOSOCIAL</b></p> <p>Social Status: <input checked="" 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</p>
<p><b>NEUROLOGICAL</b></p> <p>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 type="checkbox"/> Equal <input type="checkbox"/> Unequal  <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u>          Fontanel: (Pt &lt; 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</p>	<p><b>ELIMINATION</b></p> <p>Urine Appearance: <u>Orange, dark</u>          Stool Appearance: <u>Soft, brown LBM: 9/10</u>  <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><b>IV ACCESS</b></p> <p>Site: <input checked="" type="checkbox"/> AC <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: _____</p>
<p><b>RESPIRATORY</b></p> <p>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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive          Secretions: Color <u>N/A</u>          Consistency _____          Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____          Pulse Ox Site <input checked="" type="checkbox"/> index          Oxygen Saturation: <u>94%</u></p>	<p><b>GASTROINTESTINAL</b></p> <p>Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" 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 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____          Location _____ Inserted to _____ cm  <input type="checkbox"/> Suction Type: _____</p> <p><b>NUTRITIONAL</b></p> <p>Diet/Formula: <u>Regular diet</u>          Amount/Schedule: <u>whatever he wants</u>          Chewing/Swallowing difficulties:  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>SKIN</b></p> <p>Color: <input checked="" 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"/> &lt; 5 seconds <input type="checkbox"/> &gt; 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</p>
	<p><b>MUSCULOSKELETAL</b></p> <p><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: _____</p>	<p><b>PAIN</b></p> <p>Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces          Location: _____          Type: _____          Pain Score:          0800 _____ 1200 <u>0</u> 1600 <u>0</u></p>
	<p><b>MOBILITY</b></p> <p><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</p>	<p><b>WOUND/INCISION</b></p> <p><input checked="" type="checkbox"/> None          Type: _____          Location: _____          Description: _____          Dressing: _____</p> <p><b>TUBES/DRAINS</b></p> <p><input checked="" type="checkbox"/> None  <input type="checkbox"/> Drain/Tube          Site: _____          Type: _____          Dressing: _____          Suction: _____          Drainage amount: _____          Drainage color: _____</p>

Blind @ eye

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/ Tube Feed							100%						100%
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid										100	100		200
IV Meds/ Flush								250					250
Calculate Maintenance Fluid Requirement (Show Work)							Actual Pt IV Rate						
$10(100) = 1000$ $10(50) = 500$ $58.2(20) = 1164$ $\frac{2664}{24} = 111 \text{ ml/hr}$							$100 \text{ ml/hr}$ Rationale for Discrepancy (if applicable)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/ Diaper								300					300
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$0.5(78.2) = 39.1 \text{ ml/hr}$							$60 \text{ ml/hr}$						

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: 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) _____
	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

