

IM5 Clinical Worksheet - Pediatric Floor

Student Name: Date:	Patient Age: Patient Weight: kg
1. Admitting Diagnosis:	2. Priority Focused Assessment You Will Perform Related to the Diagnosis:
3. Signs and Symptoms:	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:
5. Lab Values That May Be Affected:	6. Current Treatment (Include Procedures):
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. 2.	8. Patient/Caregiver Teaching: 1. 2. 3. Any Safety Issues identified:

Pediatric Floor Patient #1

<p style="text-align: center;">GENERAL APPEARANCE</p> <p>Appearance: <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p>Developmental age: <input type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p>Pulse: <input 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 _____</p> <p>Edema: <input type="checkbox"/> Yes <input type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+</p> <p>Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec</p> <p>Pulses: Upper R _____ L _____ Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None</p>	<p style="text-align: center;">PSYCHOSOCIAL</p> <p>Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious</p> <p>Social/emotional bonding with family: <input type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p style="text-align: center;">NEUROLOGICAL</p> <p>LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p>Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age</p> <p>Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____</p> <p>Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed</p> <p>Extremities: <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right _____ Left _____ Pushes: Right _____ Left _____ S=Strong W=Weak N=None</p> <p>EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____</p> <p>Seizure Precautions: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">ELIMINATION</p> <p>Urine Appearance: _____</p> <p>Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p style="text-align: center;">IV ACCESS</p> <p>Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None</p> <p><input type="checkbox"/> Central Line Type/Location: _____</p> <p>Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return</p> <p>Dressing Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: _____</p>
<p style="text-align: center;">RESPIRATORY</p> <p>Respirations: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: Clear <input type="checkbox"/> Right <input 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 Absent <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p>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: _____</p> <p>Trach: <input type="checkbox"/> Yes <input type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p>Secretions: Color _____ Consistency _____</p> <p>Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____</p> <p>Pulse Ox Site _____</p> <p>Oxygen Saturation: _____</p>	<p style="text-align: center;">GASTROINTESTINAL</p> <p>Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded</p> <p>Bowel Sounds: <input type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p>Nausea: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vomiting: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Passing Flatus: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____</p>	<p style="text-align: center;">SKIN</p> <p>Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt</p> <p>Condition: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic</p> <p>Turgor: <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds</p> <p>Skin: <input 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: _____</p> <p>Mucous Membranes: Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
<p style="text-align: center;">NUTRITIONAL</p> <p>Diet/Formula: _____</p> <p>Amount/Schedule: _____</p> <p>Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">MUSCULOSKELETAL</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</p> <p>Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All</p> <p>Brace/Appliances: <input type="checkbox"/> None Type: _____</p>	<p style="text-align: center;">PAIN</p> <p>Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p>Location: _____</p> <p>Type: _____</p> <p>Pain Score: 0800 _____ 1200 _____ 1600 _____</p>
<p style="text-align: center;">MOBILITY</p> <p><input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____</p> <p>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p style="text-align: center;">WOUND/INCISION</p> <p><input type="checkbox"/> None</p> <p>Type: _____</p> <p>Location: _____</p> <p>Description: _____</p> <p>Dressing: _____</p>	<p style="text-align: center;">TUBES/DRAINS</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____</p>

Pediatric Floor Patient #1

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
Intake - PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

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

Pediatric Floor Patient #2

<p style="text-align: center;">GENERAL APPEARANCE</p> <p>Appearance: <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p>Developmental age: <input type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p>Pulse: <input 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 _____</p> <p>Edema: <input type="checkbox"/> Yes <input type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+</p> <p>Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec</p> <p>Pulses: Upper R _____ L _____ Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None</p>	<p style="text-align: center;">PSYCHOSOCIAL</p> <p>Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious</p> <p>Social/emotional bonding with family: <input type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p style="text-align: center;">NEUROLOGICAL</p> <p>LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p>Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age</p> <p>Pupil Response: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____</p> <p>Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed</p> <p>Extremities: <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right _____ Left _____ Pushes: Right _____ Left _____ S=Strong W=Weak N=None</p> <p>EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____</p> <p>Seizure Precautions: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">ELIMINATION</p> <p>Urine Appearance: _____</p> <p>Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p style="text-align: center;">IV ACCESS</p> <p>Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None</p> <p><input type="checkbox"/> Central Line Type/Location: _____</p> <p>Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return</p> <p>Dressing Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: _____</p>
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<p style="text-align: center;">MOBILITY</p> <p><input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____</p> <p>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p style="text-align: center;">WOUND/INCISION</p> <p><input type="checkbox"/> None</p> <p>Type: _____</p> <p>Location: _____</p> <p>Description: _____</p> <p>Dressing: _____</p>	<p style="text-align: center;">TUBES/DRAINS</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____</p>

Pediatric Floor Patient #2

INTAKE/OUTPUT													
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PO Intake													
Intake - PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
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# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

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

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	<ul style="list-style-type: none"> - Playing/sleeping appropriately OR - Alert, at patient's baseline 	<ul style="list-style-type: none"> - Sleepy, somnolent when not disturbed 	<ul style="list-style-type: none"> - Irritable, difficult to console OR - Increase in patient's baseline seizure activity 	<ul style="list-style-type: none"> - Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish
Cardiovascular	<ul style="list-style-type: none"> - Skin tone appropriate for patient - Capillary refill \leq 2 seconds 	<ul style="list-style-type: none"> - Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new) 	<ul style="list-style-type: none"> - Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Within normal parameters - No retractions 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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
<ul style="list-style-type: none"> - Continue Routine Assessments 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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>