IM5 Clinical Worksheet – Pediatric Floor

Student Name: Elii **Date:** 2/4/25	**Patient Age:** 2 **Patient Weight:** 13.5 kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) RSV Infection that destroys epithelial cells in the bronchioles. Thus causing inflammation: obstruction	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** • lung • Respiratory Stats (SpO2) • Heart
3. Identify the most likely and worst possible complications. • Pneumonia can develop • Acute respiratory distress	**4. What interventions can prevent the listed complications from developing?** • RSV vaccine • Having vaccines up to date such as flu, Pneumonia to prevent other respiratory infections
5. What clinical data/assessments are needed to identify these complications early? • Physical lung assessment • Swab test • Chest xray	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** • Placing Pt on O2 • IV fluids (for mucous) • Antipyretics • Rounding q hr
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Pad time to distract: comfort 2. Having the parents at bedside	**8. Patient/Caregiver Teaching:** 1. Encourage Parents to get the RSV vaccine 2. Proper handwashing 3. S:S of Respiratory Distress (cyanosis, retractions, ↑ Heart rate) **Any Safety Issues identified:** NA

Student Name: Eliset Campos Date: 2/4/25	Patient Age: 2 Patient Weight: 13.5 kg

Abnormal Relevant Lab Tests **Current Clinical Significance**

Complete Blood Count (CBC) Labs

NA

Metabolic Panel Labs

NA

Misc. Labs

Absolute Neutrophil Count (ANC) (if applicable)

NA

Lab TRENDS concerning to Nurse?

NO

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: Autonomy vs Shame; Doubt

1. Negativism (Frequent No!)

2. Transitional

Piaget Stage: Preoperational Stage

1. Centration

2. Egocentrism

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

NA

Pediatric Floor Patient #1

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				30		60							90
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						~~45~~ 45	23						68
IV Meds/Flush													

Calculate Maintenance Fluid Requirement (Show Work)

100 X 10 kg = 1,000
50 X 3.5 kg = 175 +
1,175 / 24 = 48.95

49 mL/hr

Actual Pt IV Rate

~~Dex~~ D5W ½NS @ 45 mL/hr

Rationale for Discrepancy (if applicable)

NA

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper			300							240			540
Stool													
Emesis													
Other													

Calculate Minimum Acceptable Urine Output

13.5 X 0.5 = 6.75 mL/hr

Average Urine Output During Your Shift

540 mL

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
	Circle the appropriate score for this category:

GENERAL APPEARANCE

Appearance: ☑ Healthy/Well Nourished
☑ Neat/Clean ☐ Emaciated ☐ Unkept
Developmental age:
☑ Normal ☐ Delayed

NEUROLOGICAL

LOC: ☑ Alert ☐ Confused ☐ Restless
☐ Sedated ☐ Unresponsive
Oriented to:
☐ Person ☐ Place ☐ Time/Event
☑ Appropriate for Age
Pupil Response: ☑ Equal ☐ Unequal
☑ Reactive to Light ☐ Size 6
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat
☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☑ Able to move all extremities
☐ Symmetrically ☐ Asymmetrically
Grips: Right 5 Left 5
Pushes: Right 5 Left 5
S=Strong W=Weak N=None
EVD Drain: ☐ Yes ☑ No Level ____
Seizure Precautions: ☐ Yes ☑ No

RESPIRATORY

Respirations: ☐ Regular ☑ Irregular
☐ Retractions (type) ____
☐ Labored
Breath Sounds:
Clear ☐ Right ☐ Left
Crackles ☐ Right ☐ Left
Wheezes ☑ Right ☐ Left
Diminished ☐ Right ☐ Left
Absent ☐ Right ☐ Left
☐ **Room Air** ☑ **Oxygen**
Oxygen Delivery:
☐ Nasal Cannula: 0.5 L/min
☐ BiPap/CPAP: NA
☐ Vent: ETT size NA @ NA cm
☐ Other: ____
Trach: ☐ Yes ☑ No
Size NA Type NA
Obturator at Bedside ☐ Yes ☑ No
Cough: ☑ Yes ☐ No
☑ Productive ☐ Nonproductive
Secretions: Color Clear
Consistency Thin
Suction: ☐ Yes ☑ No Type ____
Pulse Ox Site Ⓓ Thumb
Oxygen Saturation: 92 %

CARDIOVASCULAR

Pulse: ☑ Regular ☐ Irregular
☑ Strong ☐ Weak ☐ Thready
☐ Murmur ☐ Other NA
Edema: ☐ Yes ☑ No Location NA
☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Capillary Refill: ☑ < 2 sec ☐ > 2 sec
Pulses:
Upper R 3+ L 3+
Lower R 3+ L 3+
4+ Bounding 3+ Strong 2+ Weak
1+ Intermittent 0 None

ELIMINATION

Urine Appearance: Clear Yellow
Stool Appearance: Brown
☐ Diarrhea ☐ Constipation
☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☑ Soft ☐ Firm ☐ Flat
☑ Distended ☐ Guarded
Bowel Sounds: ☐ Present X 4 quads
☑ Active ☐ Hypo ☐ Hyper ☐ Absent
Nausea: ☐ Yes ☑ No
Vomiting: ☐ Yes ☑ No
Passing Flatus: ☐ Yes ☑ No
Tube: ☐ Yes ☑ No Type NA
Location NA Inserted to NA cm
☐ Suction Type: NA

NUTRITIONAL

Diet/Formula: Regular
Amount/Schedule: ____
Chewing/Swallowing difficulties:
☐ Yes ☑ No

MUSCULOSKELETAL

☐ Pain ☐ Joint Stiffness ☐ Swelling
☐ Contracted ☐ Weakness ☐ Cramping
☐ Spasms ☐ Tremors
Movement:
☐ RA ☐ LA ☐ RL ☐ LL ☐ All
Brace/Appliances: ☑ None
Type: ____

MOBILITY

☑ Ambulatory ☐ Crawl ☐ In Arms
☐ Ambulatory with assist ____
Assistive Device: ☐ Crutch ☐ Walker
☐ Brace ☐ Wheelchair ☐ Bedridden

PSYCHOSOCIAL

Social Status: ☐ Calm/Relaxed ☐ Quiet
☐ Friendly ☐ Cooperative ☑ Crying
☐ Uncooperative ☑ Restless
☐ Withdrawn ☐ Hostile/Anxious
Social/emotional bonding with family:
☑ Present ☐ Absent

IV ACCESS

Site: Ⓓ Antecubital Primary ☐ INT ☐ None
☐ Central Line
Type/Location: Peripheral IV
Appearance: ☑ No Redness/Swelling
☐ Red ☐ Swollen
☐ Patent ☐ Blood return
Dressing Intact: ☑ Yes ☐ No
Fluids: ____

SKIN

Color: ☑ Pink ☐ Flushed ☐ Jaundiced
☐ Cyanotic ☐ Pale ☐ Natural for Pt
Condition: ☑ Warm ☐ Cool ☐ Dry
☐ Diaphoretic
Turgor: ☑ < 5 seconds ☐ > 5 seconds
Skin: ☑ Intact ☐ Bruises ☐ Lacerations
☐ Tears ☐ Rash ☐ Skin Breakdown
Location/Description: ____
Mucous Membranes: Color: Pinkish, Red
☑ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☐ Numeric ☑ FLACC ☐ Faces
Location: During Insperation
Type: ____
Pain Score:
0800 ____ 1200 5 1600 ____

WOUND/INCISION

☑ **None**
Type: ____
Location: ____
Description: ____
Dressing: ____

TUBES/DRAINS

☑ **None**
☐ **Drain/Tube**
Site: ____
Type: ____
Dressing: ____
Suction: ____
Drainage amount: ____
Drainage color: ____

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	- Playing/sleeping appropriately **OR** - Alert, at patient's baseline	- Sleepy, somnolent when not disturbed	- Irritable, difficult to console **OR** - Increase in patient's baseline seizure activity	- Lethargic, confused, floppy **OR** - Reduced response to pain **OR** - Prolonged or frequent seizures **OR** - Pupils asymmetrical or sluggish
Cardiovascular	- Skin tone appropriate for patient - Capillary refill ≤ 2 seconds	- Pale **OR** - Capillary refill 3-4 seconds **OR** - Mild tachycardia **OR** - Intermittent ectopy or irregular HR (not new)	- Grey **OR** - Capillary refill 4-5 seconds **OR** - Moderate tachycardia	- 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	- Within normal parameters - No retractions	- 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	- 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	- 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
- Continue Routine Assessments	- 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	- 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

Cardiovascular	(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