

## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Ginevie Martinez <b>Date:</b> 8/28/25</p>	<p><b>Patient Age:</b> 10 <b>Patient Weight:</b> 26.9 kg</p>
<p><b>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</b></p> <p>Hemangioblastoma tumor in the brain – this is a noncancerous brain tumor that is slow growing and it originates from cells lining the blood vessels in the brain.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b></p> <p>Q1 neuro assessment – check cranial nerves, LOC, PERRLA, head movement, and seizure precautions</p>
<p><b>3. Identify the most likely and worst possible complications.</b></p> <p>Cerebellar swelling, Hydrocephalus, and intracranial hemorrhage</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b></p> <p>Frequent neuro checks, monitor for s/s of increased ICP, administer medication and fluids as prescribed, and pain management</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b></p> <p>Q1 focused neuro assessment, checking strength and coordination, and closely monitoring vital signs</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b></p> <p>Try to maintain airway, supply O2, raise HOB, administer analgesics, and notify HCP immediately</p>
<p><b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <ol style="list-style-type: none"> <li>1. Guided imagery and relaxation techniques</li> <li>2. videogames/cartoons/ music</li> </ol>	<p><b>8. Patient/Caregiver Teaching:</b></p> <ol style="list-style-type: none"> <li>1. Recognize s/s of increased ICP</li> <li>2. Limited activity / asking for assistance when getting up</li> <li>3. Calling immediately for any pain</li> </ol> <p><b>Any Safety Issues identified:</b> Seizure and fall precautions</p>

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Abnormal Relevant Lab Tests	Current	Clinical Significance
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Complete Blood Count (CBC) Labs		
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WBC - 13.89	8-21	Hospital aquired infection
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Hematocrit - 36.0	8-21	Infenction, nutrition, and limited mobility
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Metabolic Panel Labs		
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Misc. Labs		
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Absolute Neutrophil Count (ANC) (if applicable) 8.88	8-21	The bodies ability to fight infection – WBCs low, body immune response is low
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Lab TRENDS concerning to Nurse?		
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Labs are low but expected and patient is progressing		
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**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 vs inferiority

1. Pt wanted to learn how to administer her medications and fluids through her G tube
2. Pt was able to walk us through how to change her clothing around her trach

**Piaget Stage:** Concrete operational stage

1. Pt understood why she had to have a trach and G tube placed after surgery
2. Pt stayed very positive with her diagnosis and understanding that progress is to come

<b>Student Name:</b> Ginevie Martinez <b>Date:</b> 8/28/25	<b>Patient Age:</b> 10 <b>Patient Weight:</b> 26.9 kg
<b>Please list any medications you administered or procedures you performed during your shift:</b>  Docusate sodium - 50mg per G tube daily Keppra 100mg/mL liquid 500 mg Q12hr per G tube	

**Pediatric Floor Patient #1**

<b>GENERAL APPEARANCE</b> <b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>CARDIOVASCULAR</b> <b>Pulse:</b> <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 _____ <b>Edema:</b> <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+ <b>Capillary Refill:</b> <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R _____ L _____ Lower R _____ L _____ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>PSYCHOSOCIAL</b> <b>Social Status:</b> <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 <b>Social/emotional bonding with family:</b> <input type="checkbox"/> Present <input type="checkbox"/> Absent
<b>NEUROLOGICAL</b> <b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <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 <b>EVD Drain:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>ELIMINATION</b> <b>Urine Appearance:</b> _____ <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>IV ACCESS</b> <b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
<b>RESPIRATORY</b> <b>Respirations:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> 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 <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>GASTROINTESTINAL</b> <b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>SKIN</b> <b>Color:</b> <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 <b>Condition:</b> <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <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: _____ <b>Mucous Membranes:</b> Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
<b>NUTRITIONAL</b> <b>Diet/Formula:</b> _____ <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input 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 <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None	<b>PAIN</b> <b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 _____
<b>WOUND/INCISION</b> <input type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<b>TUBES/DRAINS</b> <input type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____	

<input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> _____	Type: _____	Type: _____
	<b>MOBILITY</b>	Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____
	<input 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	

**Pediatric Floor Patient #1**

INTAKE/OUTPUT														
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total	
PO Intake/Tube Feed	60	60		60									180mL	
Intake – PO Meds														
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total	
IV Fluid														
IV Meds/Flush			30										30mL	
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Actual Pt IV Rate</b>							
							<b>Rationale for Discrepancy (if applicable)</b>							
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total	
Urine/Diaper			500										500g	
Stool														
Emesis														
Other														
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>							
67.5							Urine was not fully measured as pt was only changed once which included stool in diaper							

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
<b>CHEWS Total Score</b>	
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
<b>Behavior/Neuro</b>	<ul style="list-style-type: none"> <li>– Playing/sleeping appropriately <b>OR</b></li> <li>– Alert, at patient’s baseline</li> </ul>	<ul style="list-style-type: none"> <li>– Sleepy, somnolent when not disturbed</li> </ul>	<ul style="list-style-type: none"> <li>– Irritable, difficult to console <b>OR</b></li> <li>– Increase in patient’s baseline seizure activity</li> </ul>	<ul style="list-style-type: none"> <li>– Lethargic, confused, floppy <b>OR</b></li> <li>– Reduced response to pain <b>OR</b></li> <li>– Prolonged or frequent seizures <b>OR</b></li> <li>– Pupils asymmetrical or sluggish</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>– Skin tone appropriate for patient</li> <li>– Capillary refill ≤ 2 seconds</li> </ul>	<ul style="list-style-type: none"> <li>– Pale <b>OR</b></li> <li>– Capillary refill 3-4 seconds <b>OR</b></li> <li>– Mild tachycardia <b>OR</b></li> <li>– Intermittent ectopy or irregular HR (not new)</li> </ul>	<ul style="list-style-type: none"> <li>– Grey <b>OR</b></li> <li>– Capillary refill 4-5 seconds <b>OR</b></li> <li>– Moderate tachycardia</li> </ul>	<ul style="list-style-type: none"> <li>– Grey and mottled <b>OR</b></li> <li>– Capillary refill &gt; 5 seconds <b>OR</b></li> <li>– Severe tachycardia <b>OR</b></li> <li>– New onset bradycardia <b>OR</b></li> <li>– New onset/increase in ectopy, irregular HR or heart block</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>– Within normal parameters</li> <li>– No retractions</li> </ul>	<ul style="list-style-type: none"> <li>– Mild tachypnea/ increased WOB (flaring, retracting) <b>OR</b></li> <li>– Up to 40% supplemental oxygen <b>OR</b></li> <li>– Up to 1L NC &gt; patient’s baseline need <b>OR</b></li> <li>– Mild desaturations &lt; patient’s baseline <b>OR</b></li> <li>– Intermittent apnea self-resolving</li> </ul>	<ul style="list-style-type: none"> <li>– Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) <b>OR</b></li> <li>– 40-60% oxygen via mask <b>OR</b></li> <li>– 1-2 L NC &gt; patient’s baseline need <b>OR</b></li> <li>– Nebs Q 1-2 hour <b>OR</b></li> <li>– Moderate desaturations &lt; patient’s baseline <b>OR</b></li> <li>– Apnea requiring repositioning or stimulation</li> </ul>	<ul style="list-style-type: none"> <li>– Severe tachypnea <b>OR</b></li> <li>– RR &lt; normal for age <b>OR</b></li> <li>– Severe increased WOB (i.e. head bobbing, paradoxical breathing) <b>OR</b></li> <li>– &gt; 60% oxygen via mask <b>OR</b></li> <li>– &gt; 2 L NC more than patient’s baseline need <b>OR</b></li> <li>– Nebs Q 30 minutes – 1 hour <b>OR</b></li> <li>– Severe desaturations &lt; patient’s baseline <b>OR</b></li> <li>– Apnea requiring interventions other than repositioning or stimulation</li> </ul>
<b>Staff Concern</b>		– Concerned		
<b>Family Concern</b>		– Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
<ul style="list-style-type: none"> <li>– Continue Routine Assessments</li> </ul>	<ul style="list-style-type: none"> <li>– Notify charge nurse or LIP</li> <li>– Discuss treatment plan with team</li> <li>– Consider higher level of care</li> <li>– Increase frequency of vital signs / CHEWS / assessments</li> <li>– Document interventions and notifications</li> </ul>	<ul style="list-style-type: none"> <li>– Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation</li> <li>– Notify attending physician</li> <li>– Discuss treatment plan with team</li> <li>– Increase frequency of vital signs / CHEWS / assessments</li> <li>– Document interventions and notifications</li> </ul>