IM5 Clinical Worksheet – Pediatric Floor

Student Name: Hannah McRight **Date: 9/10/25**	**Patient Age:** 5 yo M **Patient Weight: 20.3 kg**
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Leukocytosis w/ fever	**2. Priority Focused Assessment You Will Perform Related to the Diagnosis:** Take temp, monitor VS and draw labs to see WBC
3. Identify the most likely and worst possible complications. Infections Septic shock	**4. What interventions can prevent the listed complications from developing?** Monitor VS, watch for decreased urine output, treat infections
5.What clinical data/assessments are needed to identify these complications early? Get a CBC, physical assessment and monitor VS, PT. History	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** Give medication to treat infection. Give oxygen, IV fluids, antibiotics, monitor VS, neuro checks
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** 1. Have toys, games or coloring pages available for them to use. 2. **Parents at bedside to help with distraction**	**8. Patient/Caregiver Teaching:** **1. Watch for symptoms like fever, fatigue, SOB** **2. Take meds as prescribed** **3. Infection prevention is very important. Have good hand washing and avoid areas that could increase the risk of infections.** **Any Safety Issues identified:** **Risk of sepsis, higher risk of infections**

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Abnormal Relevant Lab Tests **Current Clinical Significance**

Complete Blood Count (CBC) Labs
WBC: 21.56
Platelet: 446
Hematocrit: 31.5

Metabolic Panel Labs

Misc. Labs
Absolute Neutrophil Count (ANC) (if applicable)
14.23

Lab TRENDS concerning to Nurse?
WBC

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: Initiative VS. Guilt

1. **He was very curious about everything the nurse was doing.**

2. **He was coming up with stories about the superhero he was coloring.**

Piaget Stage: Pre-operational Stage

1. **He kept asking why he was getting any medication, why he had fluids, pretty much anything the nurse did he was asking why.**

2. **He had a dinosaur and would pretend the dinosaur was talking to the nurse**

Please list any medications you administered or procedures you performed during your shift:
Ceftriaxone (Rocephin)
Acetaminophen (Tylenol)

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													
Intake – PO Meds							5ml						
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						60	60	60	60	60	60		360
IV Meds/Flush													
Calculate Maintenance Fluid Requirement (Show Work) **10/100=1,000** **10/50=500** **.3/20=6** **1,506** **———** **24= 62.75mls**							**Actual Pt IV Rate** **60ml/hr** **Rationale for Discrepancy (if applicable)**						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper							175 mls						
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output **0.5/20.3/5hr=50.75**							**Average Urine Output During Your Shift** **175mls**						

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:

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) ____**0**_____
	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

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 _____
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat
☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☒ Able to move all extremities
☐ Symmetrically ☐ Asymmetrically
Grips: Right S Left S
Pushes: Right S Left S
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
98% RA
☒ **Room Air** ☐ **Oxygen**
Oxygen Delivery:
☐ Nasal Cannula: ____L/min
☐ BiPap/CPAP: _____
☐ Vent: ETT size_____@_____cm
☐ Other: _____
Trach: ☐ Yes ☒ No
Size _____ Type _____
Obturator at Bedside ☐ Yes ☐ No
Cough: ☐ Yes ☒ No
☐ Productive ☐ Nonproductive
Secretions: Color N/A
Consistency_____
Suction: ☐ Yes ☒ No Type _____
Pulse Ox Site Right Index finger
Oxygen Saturation: 98%

CARDIOVASCULAR

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

ELIMINATION

Urine Appearance: Clear, yellow
Stool Appearance: Brown, firm
☐ Diarrhea ☐ Constipation loaf
☐ 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 _____
Location _____ Inserted to _____cm
☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: Reg diet
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: ~~PIC~~ per peripheral ☐ INT ☐ None
☐ Central Line
Type/Location: Left anteccubital 24 gauge
Appearance: ☒ No Redness/Swelling
☐ Red ☐ Swollen
☒ Patent ☐ Blood return
Dressing Intact: ☒ Yes ☐ No
Fluids: D5NS 60ml/hr

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: Pink
☒ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☒ Numeric ☐ FLACC ☐ Faces
Location: Throat
Type: Pain when swallowing
Pain Score:
0800 _____ 1200 3 1600 _____

WOUND/INCISION

☒ **None**
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

☒ **None**
☐ **Drain/Tube**
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount: _____
Drainage color: _____