

IM5 Clinical Worksheet - Pediatric Floor

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|--|---|
| <p>Student Name: Alexis Pennington Date: 11-18-2025</p> | <p>Patient Age: 4 y/o Patient Weight: kg 22.7</p> |
| <p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</p> <p>Closed displaced oblique fracture of shaft of left femur.</p> | <p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</p> <p>Peripheral neurovascular</p> |
| <p>3. Identify the most likely and worst possible complications.</p> <p>Worst: compartment syndrome Most likely: increased pain & inability to heal due to poor positioning of leg & injury</p> | <p>4. What interventions can prevent the listed complications from developing?</p> <p>Frequent neurovascular checks, elevation & appropriate cast care. Immobilization & pain management</p> |
| <p>5. What clinical data/assessments are needed to identify these complications early?</p> <p>Neurovascular assessment Pain assessment X-ray</p> | <p>6. What nursing interventions will the nurse implement if the anticipated complication develops?</p> <p>Compartment syndrome - don't elevate limb, loosen bandages & wraps. Report to physician ↑ Pain - prepare pt for surgical intervention. Administer analgesics & comfort measures</p> |
| <p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <p>1. Play therapy on iPad or w/ transition object 2. Parent proximity during procedures or transfers</p> | <p>8. Patient/Caregiver Teaching:</p> <p>1. Cast care: check toes, assess for odor or heat, keep cast clean & dry 2. Normal amount of swelling & pain vs abnormal 3. Signs of infection or compartment syndrome</p> <p>Any Safety Issues identified: Swelling. Pain not relieved by medication</p> |

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|---------------------------------------|--------------------------------|
| Student Name: <i>Aaris Demingston</i> | Patient Age: <i>4y10</i> |
| Date: <i>11-18-25</i> | Patient Weight: <i>kg 22.7</i> |

| Abnormal Relevant Lab Tests | Current | Clinical Significance |
|---|---------|-----------------------|
| Complete Blood Count (CBC) Labs | | |
| | | |
| | | |
| Metabolic Panel Labs | | |
| | | |
| | | |
| Misc. Labs | | |
| Absolute Neutrophil Count (ANC) (if applicable) | | |
| | | |
| | | |
| Lab TRENDS concerning to Nurse? | | |
| | | |

no labwork done on pt

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*

- Asked a lot of questions*
- Nurse gave high five for letting her prep him for transfer w/surgery team*

Piaget Stage: *Preoperational*

- Explained pain to nurse in vague terms*
- Nurse described transfer procedure in plain terms to pt.*

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

Prepped child & mom for transfer to surgery. Assessed W.

Pt was transferred very early in the clinical shift off to floor, so a full assessment was not performed. But from the nurses assessment before transfer of my

Observation

| GENERAL APPEARANCE | CARDIOVASCULAR | PSYCHOSOCIAL |
|---|---|---|
| Appearance: <input 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 | 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 type="checkbox"/> <2 sec <input type="checkbox"/> >2 sec Pulses: Upper R ___ L ___ Lower R ___ L ___ 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None | 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent |
| NEUROLOGICAL | ELIMINATION | IV ACCESS |
| 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 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 type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt <2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right ___ Left ___ Pushes: Right ___ Left ___ 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 | Urine Appearance: _____ Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy | Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input 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 type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____ |
| RESPIRATORY | GASTROINTESTINAL | SKIN |
| Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored 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 <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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: <u>100%</u> | Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input type="checkbox"/> Present X ___ quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location ___ Inserted to ___ cm <input type="checkbox"/> Suction Type: _____ | Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input checked="" 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"/> <5 seconds <input type="checkbox"/> >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 type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration |
| NUTRITIONAL | MUSCULOSKELETAL | PAIN |
| Diet/Formula: <u>NPO</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input checked="" 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 checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input checked="" type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All Brace/Appliances: <input type="checkbox"/> None Type: _____ | Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces Location: <u>left leg</u> Type: _____ Pain Score: 0800 ___ 1200 <u>3</u> 1600 ___ |
| MOBILITY | WOUND/INCISION | TUBES/DRAINS |
| <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 checked="" type="checkbox"/> Bedridden | <input type="checkbox"/> None Type: <u>Structure</u> Location: <u>left leg</u> Description: <u>excised</u> Dressing: _____ | <input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____ |

| 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 | | | | | | | | | | | | | |
| IV INTAKE | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| IV Fluid | | | | | | | | | | | | | |
| IV Meds/Flush | | | | | | | | | | | | | |
| Calculate Maintenance Fluid Requirement (Show Work) | | | | | | | Actual Pt IV Rate | | | | | | |
| | | | | | | | Rationale for Discrepancy (if applicable) | | | | | | |
| | | | | | | | | | | | | | |
| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| Urine/Diaper | | | | | | | | | | | | | |
| Stool | | | | | | | | | | | | | |
| Emesis | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | |
| Calculate Minimum Acceptable Urine Output | | | | | | | Average Urine Output During Your Shift | | | | | | |
| | | | | | | | | | | | | | |

PO/Enteral Intake
 no IV fluids
 output not charted

| 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) <u>0</u> |
| | 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>