

## IM5 Clinical Worksheet – Pediatric Floor

Student Name: Madie McKinney Date: 2/25/26	Patient Age: 14 y.o. Patient Weight: 65.4 kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) The appendix became infected & swollen, causing pressure to build up until it burst. When it ruptured, bacteria spread into the abdomen & caused a serious infection.	2. Priority Focused Assessment You Will Perform Related to the Diagnosis:  <h3 style="text-align: center;">Abdominal</h3>
3. Identify the most likely and worst possible complications.  most: Peritonitis, post-op infection, abscess formation, ileus worst: Sepsis, septic shock, multi-organ failure	4. What interventions can prevent the listed complications from developing?  most: IV abx, monitor temp + WBC, early ambulation, sterile dressing changes, monitor bowel sounds worst: frequent VS, monitor for sepsis, maintain fluids, strict I+O, notifying provider of changes
5. What clinical data/assessments are needed to identify these complications early? Temp trends, WBC, HR + BP, Abd assessment, I+O, drain output	6. What nursing interventions will the nurse implement if the anticipated complication develops? Notify provider, admin abx, O2 admin, cardiac monitoring, cultures + labs
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.  1. Guided Imagery/music  2. Positioning w/ pillow support + splinting abd when coughing/sneezing	8. Patient/Caregiver Teaching:  1. Finish all prescribed abx 2. Monitor incision for redness, swelling, drainage 3. Report fever > 100°F, worsening pain, vomiting  Any Safety Issues identified: Fall-risk Infection risk

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

**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:**

1. Developing independence
2. Concerned abt body image + peer perception

**Piaget Stage:**

1. Able to think abstractly
2. Understands cause + effect of illness + treatment

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

Acetaminophen IVPB, Piperacillin/Tazobactam IVPB, VS

**Pediatric Floor Patient #1**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <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 _____ <b>Edema:</b> <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+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" 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 checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>4mm</u> <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 checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>clear, yellow</u> <b>Stool Appearance:</b> <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>L Forearm</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>22g</u> <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input checked="" type="checkbox"/> Red <input checked="" type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input checked="" type="checkbox"/> Right <input checked="" 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 <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 checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site</b> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present <input checked="" type="checkbox"/> <u>4</u> quads <input type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <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: _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
<b>Diet/Formula:</b> <u>clear</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input checked="" 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 checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None Type: _____	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>Abdomen</u> <b>Type:</b> <u>aching</u> <b>Pain Score:</b> 0800 <u>X</u> 1200 <u>2</u> 1600 <u>2</u>
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input type="checkbox"/> None <b>Type:</b> <u>surgical incision</u> <b>Location:</b> <u>umbilical, lower pubic</u> <b>Description:</b> <u>clean, dry, intact</u> <b>Dressing:</b> <u>dermabond, OTA</u>	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube <b>Site:</b> <u>LLQ</u> <b>Type:</b> <u>JP drain</u> <b>Dressing:</b> <u>gauze</u> <b>Suction:</b> _____ <b>Drainage amount:</b> <u>20ml</u> <b>Drainage color:</b> <u>serous, yellowish pink</u>

**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	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	0	0	0	120	0	0	—	120mL
Intake – PO Meds	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	0	0	0	0	0	0	—	N/A
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	50	50	50	50	50	50		300mL
IV Meds/Flush	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	100mL	0	0	0	0	0		100mL
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Actual Pt IV Rate</b>						
$100 \times 10 = 1,000$ $10 \times 50 = 500$ $45.4 \times 20 = 908$ <b>2,408 mL/day</b> <b>100.33 mL/hr</b>							<b>50 mL/hr</b> <b>Rationale for Discrepancy (if applicable)</b> <b>Diet is fluids only</b>						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	0	400	0	0	0	0	—	400mL
Stool	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	0	0	0	0	0	0	—	0mL
Emesis	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	<del>_____</del>	0	0	0	0	0	0	—	0mL
Other													
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>						
$0.5 \times 65.4 \text{kg} = 32.7 \text{mL/hr}$							$400 \text{mL} / 6 \text{hr} = 66.7 \text{mL/hr}$						

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: <input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 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

Student Name: Madie McKinney Unit: PF Pt. Initials: LR Date: 2/05/20

Allergies: NKA

Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
				Is med in therapeutic range?	If not, why?			
Piperacillin tazobactam (Zosyn)	Broad-spectrum Abx	Treatment of suspected bacterial infection	3.375g in 100ml NS Q6	yes		IVP – List diluent solution, volume, and rate of administration 200 mL/hr	Potassium, Na <sup>+</sup> , BUN, Creatinine, glucose	Renal Failure, Hypokalemia, uncontrolled diabetes, fluid volume overload
Acetaminophen	Non-opioid analgesic/antipyretic	Pain relief	1000mg IVPB Q6hr PRN	yes		IVP – List diluent solution, volume, and rate of administration 400 mL/hr 100 mL NS		

Student Name: Madie McKinney

Unit: PF

Pt. Initials: AV

Date: 2/25/26

Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5NS + 20meq KCl	25ml/hr Isotonic/Hypotonic/Hypertonic	Provides hydration, glucose for energy, K <sup>+</sup> replacement	K <sup>+</sup> , Na <sup>+</sup> , BUN, Creatinine, glucose	renal failure, hyperkalemia, uncontrolled diabetes, fluid volume overload

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?	If not, why?			
Famotidine (Pepcid)	Histamine-2 receptor antagonist	GI Prophylaxis	3mg IV syringe BID	yes		IV syringe 2mg/mL over 2 min 1.5mL	HA, dizziness, Bradycardia, constipation or diarrhea	1. Assess abd pain or GI bleeding 2. Admin slowly to prevent bradyc 3. Monitor renal fxn 4. Educate on purpose of acid reduction
Acetaminophen	non-opioid analgesic	pain relief	100mg IV syringe Q6hr PRN	yes		IV syringe? 10mL NS over 5 mins	hepatotoxicity, hypotension, Nausea, Rash	1. Assess pain level before & after 2. Monitor total daily acetaminophen dose 3. Monitor liver fxn tests 4. Avoid other acetaminophen containing
								1. 2. 3. 4.
								1. 2. 3. 4.