

### IM5 Clinical Worksheet – PICU

<b>Student Name:</b> Rebecca Harvey <b>Date:</b> 11/14/23	<b>Patient Age:</b> 14 <b>Patient Weight:</b> 63.6kg
<b>1. Admitting Diagnosis:</b> intentional diphenhydramine OD, altered mental status	<b>2. Priority Focused Assessment R/T Diagnosis:</b> I/O, Continuous monitor for suicide precautions.
<b>3. Signs and Symptoms:</b> Nausea, Vomiting Altered mental status	<b>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:</b> ECG - prolonged QT interval
<b>5. Lab Values That May Be Affected:</b> CMP BUN Creatinine	<b>6. Current Treatment (Include Procedures):</b> Dextrose 5% and Sodium Chloride 0.45% @ 20mg/L KCl (DS 1/2 NS + KCl 20) @ 100 mL/hr Suicide precautions Monitor I/O to assure the kidney are functioning, and medications are being flushed.
<b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.  1. My patient was experiencing no physical pain or distress.  2. Counseling services were offered and pt referred to inpatient rehab facility for mental health.	<b>8. Patient/Caregiver Teaching:</b> 1. Caregiver needs to take extra precaution for safety by locking up all medications, and other items the adolescent could harm themselves with. 2. Teach patient how taking that many pills could damage her heart & kidneys and why we need to continue to flush the medicine out of her body. 3. Providing a safe place for them to express their feelings, and getting them additional mental health services. Any Safety Issues Identified: : Patient is on suicide precautions. Paper scrubs, paper eating utensils, no social media, no phone, cannot leave room, and can only have immediate family as visitors.
<b>9. Calculate the Maintenance Fluid Requirement (Show Your Work):</b> 63.6kg $\begin{array}{r} 63.6 \\ - 20 \\ \hline 43.6 \end{array}$ $10 \times 100 = 1000$ $10 \times 50 = 500$ $43.6 \times 20 = 872$ $\hline 2,372 \text{ / day}$ <b>Combined Total Intake for Your Pt (mL/hr):</b>	<b>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</b>  <b>Actual Urine Output During Your Shift (mL/hr):</b>
<b>Please list any medications you administered or procedures you performed during your shift:</b> NO medications were ordered for this patient. Continuous I/O to flush system listed on #6 @ 100mL/hr. We did a 12 lead ECG that showed prolonged QT intervals, likely caused by the overdose of benodryl.	

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INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake							40z	/	/	/	/		40z
Intake – PO Meds							/	/	/	/	/		
Enteral Tube Feeding							/	/	/	/	/		
Enteral Flush							/	/	/	/	/		
Free Water							/	/	/	/	/		
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						100	100	100	100	100	100		600
IV Meds/Flush						/	/	/	/	/	/		
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine							/	750mL	/	/	/		750mL
# of immeasurable							/	/	/	/	/		
Stool							/	/	/	/	/		
Urine/Stool mix							/	/	/	/	/		
Emesis							/	/	/	/	/		
Other							/	/	/	/	/		

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    1    2    3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Staff Concern	1 pt – Concerned
Family Concern	<input checked="" type="radio"/> 1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>  1  </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

PICU

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 checked="" 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 type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input checked="" 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 type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>2mm</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically <b>Grips:</b> Right <u>5</u> Left <u>5</u> <b>Pushes:</b> Right <u>5</u> Left <u>5</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>hematuria</u> <b>Stool Appearance:</b> <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>Current menses</u>	<b>Site:</b> <u>Rt A/C 100ml/hr</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> <u>BF 42 NS w 20mg KCl/l</u> <u>@ 100 mL/hr</u>
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 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 <u>N/B</u> Consistency <u>N/B</u> <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>Rt index finger</u> <b>Oxygen Saturation:</b> <u>95%</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present <input checked="" type="checkbox"/> <u>4</u> quads <input checked="" type="checkbox"/> Active <input 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 type="checkbox"/> Pink <input checked="" 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 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 <b>Location/Description:</b> _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MOBILITY	NUTRITIONAL	PAIN
<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	<b>Diet/Formula:</b> <u>Regular</u> <b>Amount/Schedule:</b> <u>3x meals</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
MUSCULOSKELETAL	MOBILITY	WOUND/INCISION
<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 checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None Type: _____	<b>WOUND/INCISION</b> <input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<b>TUBES/DRAINS</b> <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____