

PICU

| GENERAL APPEARANCE   | CARDIOVASCULAR   | PSYCHOSOCIAL  |
|--|--|---|
| <b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished<br><input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept<br><b>Developmental age:</b><br><input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed  | <b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready<br><input type="checkbox"/> Murmur <input type="checkbox"/> Other _____<br><b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec<br><b>Pulses:</b><br>Upper R <u>2+</u> L <u>3+</u><br>Lower R <u>3+</u> L <u>3+</u><br>4+ Bounding 3+ Strong 2+ Weak<br>1+ Intermittent 0 None   | <b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet<br><input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying<br><input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless<br><input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious<br><b>Social/emotional bonding with family:</b><br><input type="checkbox"/> Present <input type="checkbox"/> Absent  |
| NEUROLOGICAL   |  |   |
| <b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless<br><input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive<br><b>Oriented to:</b><br><input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event<br><input type="checkbox"/> Appropriate for Age<br><b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal<br><input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____<br><b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat<br><input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed<br><b>Extremities:</b><br><input checked="" type="checkbox"/> Able to move all extremities<br><input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically<br>Grips: Right <u>S</u> Left <u>S</u><br>Pushes: Right <u>S</u> Left <u>S</u><br>S=Strong W=Weak N=None<br><b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____<br><b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <b>ELIMINATION</b><br><b>Urine Appearance:</b> <u>yellow</u><br><b>Stool Appearance:</b> <u>type 3</u><br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy  | <b>IV ACCESS</b><br><b>Site:</b> <u>peripheral</u> <input type="checkbox"/> INT <input type="checkbox"/> None<br><input type="checkbox"/> Central Line<br><b>Type/Location:</b> _____<br><b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling<br><input type="checkbox"/> Red <input type="checkbox"/> Swollen<br><input type="checkbox"/> Patent <input type="checkbox"/> Blood return<br><b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Fluids:</b> <u>NS</u>  |
| RESPIRATORY  |  |   |
| <b>Respirations:</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular<br><input type="checkbox"/> Retractions (type) _____<br><input checked="" type="checkbox"/> Labored<br><b>Breath Sounds:</b><br>Clear <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Wheezes <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left<br>Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left<br>Absent <input type="checkbox"/> Right <input type="checkbox"/> Left<br><input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen<br><b>Oxygen Delivery:</b><br><input type="checkbox"/> Nasal Cannula: _____ L/min<br><input type="checkbox"/> BiPap/CPAP: _____<br><input type="checkbox"/> Vent: ETT size _____ @ _____ cm<br><input type="checkbox"/> Other: _____<br><b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Size _____ Type _____<br>Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive<br><b>Secretions:</b> Color _____<br>Consistency _____<br><b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br><b>Pulse Ox Site</b> _____<br><b>Oxygen Saturation:</b> _____ | <b>GASTROINTESTINAL</b><br><b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat<br><input type="checkbox"/> Distended <input type="checkbox"/> Guarded<br><b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads<br><input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent<br><b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____<br>Location _____ Inserted to _____ cm<br><input type="checkbox"/> Suction Type: _____ | <b>SKIN</b><br><b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced<br><input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt<br><b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry<br><input type="checkbox"/> Diaphoretic<br><b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds<br><b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations<br><input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown<br>Location/Description: _____<br><b>Mucous Membranes:</b> Color: <u>pink</u><br><input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration<br><b>PAIN</b><br>Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces<br>Location: _____<br>Type: _____<br>Pain Score: _____<br>0800 _____ 1200 _____ 1600 _____ |
| NUTRITIONAL  |  |   |
|  | <b>Diet/Formula:</b> <u>normal</u><br><b>Amount/Schedule:</b> _____<br><b>Chewing/Swallowing difficulties:</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | <b>WOUND/INCISION</b><br><input checked="" type="checkbox"/> None<br>Type: _____<br>Location: _____<br>Description: _____<br>Dressing: _____  |
| MUSCULOSKELETAL  |  |   |
|  | <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling<br><input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping<br><input type="checkbox"/> Spasms <input type="checkbox"/> Tremors<br><b>Movement:</b><br><input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All<br><b>Brace/Appliances:</b> <input type="checkbox"/> None<br>Type: _____  | <b>TUBES/DRAINS</b><br><input checked="" type="checkbox"/> None<br><input type="checkbox"/> Drain/Tube<br>Site: _____<br>Type: _____<br>Dressing: _____<br>Suction: _____<br>Drainage amount: _____<br>Drainage color: _____  |
| MOBILITY   |  |   |
|  | <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms<br><input checked="" type="checkbox"/> Ambulatory with assist _____<br>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker<br><input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden   |   |

7 11  
Lauren

IM5 Clinical Worksheet – PICU

|  |  |
|--|--|
| <p>Student Name: <u>Kylie Bennett</u><br/>Date: <u>1-30-24</u></p>   | <p>Patient Age: <u>14</u><br/>Patient Weight: <u>kg 41.7</u></p>   |
| <p>1. Admitting Diagnosis: <u>(severe) asthma exacerbation</u></p>   | <p>2. Priority Focused Assessment R/T Diagnosis: <u>respiratory</u></p>  |
| <p>3. Signs and Symptoms:<br/><u>-shortness of breath</u><br/><u>-use of accessory muscles</u><br/><u>-O2 sat</u><br/><u>-increased pulse and resp.</u></p>  | <p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis:<br/><u>none really</u><br/><u>O2 sats, ABG's</u></p>   |
| <p>5. Lab Values That May Be Affected:<br/><u>ABG's</u> <u>no lab values necessary</u><br/><u>resp. rate</u><br/><u>HR</u><br/><u>O2 sats</u></p>  | <p>6. Current Treatment (Include Procedures):<br/><u>steroids</u><br/><u>continuous albuterol</u></p>  |
| <p>7. Pain &amp; Discomfort Management:<br/>List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.<br/><u>1. mom distracting her</u><br/><u>2. listening to music</u></p>   | <p>8. Patient/Caregiver Teaching:<br/><u>1. leave O2 on</u><br/><u>2. raise HOB</u><br/><u>3. take breathing treatments as prescribed</u><br/>Any Safety Issues Identified:<br/><u>none that were seen</u></p>             |
| <p>9. Calculate the Maintenance Fluid Requirement (Show Your Work):<br/><u><math>10 \times 100 \div 24 = 80.6 \text{ mL/hr}</math></u><br/><u><math>10 \times 50 = 21.7 \text{ mL/hr}</math></u><br/>Combined Total Intake for Your Pt (mL/hr):<br/><u>100 mL this was maint. fluids she had O2 on so never drank anything</u></p> | <p>10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):<br/><u><math>41.7 \text{ mL/hr}</math></u> <u>1 mL/kg/hr</u><br/>Actual Urine Output During Your Shift (mL/hr):<br/><u>53 mL/hr</u></p> |
| <p>Please list any medications you administered or procedures you performed during your shift:<br/><u>I did not administer any medications</u></p>   |  |

PICU

| INTAKE/OUTPUT        |    |    |    |    |    |    |     |     |     |     |     |    |                                   |
|----------------------|----|----|----|----|----|----|-----|-----|-----|-----|-----|----|-----------------------------------|
| PO/Enteral Intake    | 07 | 08 | 09 | 10 | 11 | 12 | 13  | 14  | 15  | 16  | 17  | 18 | Total                             |
| PO Intake            |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |
| Intake – PO Meds     |    |    |    |    |    |    | 125 |     | 100 |     |     |    | <del>100</del> <del>100</del> 225 |
| 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 |    | 500 mls                           |
| IV Meds/Flush        |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |
|                      |    |    |    |    |    |    |     |     |     |     |     |    |                                   |
| OUTPUT               | 07 | 08 | 09 | 10 | 11 | 12 | 13  | 14  | 15  | 16  | 17  | 18 | Total                             |
| Urine                |    |    |    |    |    |    | 52  | 48  | 42  | 58  | 66  |    | 266                               |
| # of immeasurable    |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |
| Stool                |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |
| Urine/Stool mix      |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |
| Emesis               |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |
| Other                |    |    |    |    |    |    |     |     |     |     |     |    | —                                 |

| Children's Hospital Early Warning Score (CHEWS)<br>(See CHEWS Scoring and Escalation Algorithm to score each category) |  |
|--|--|
| Behavior/Neuro   | Circle the appropriate score for this category:<br>0 1 2 3   |
| Cardiovascular   | Circle the appropriate score for this category:<br>0 1 2 3   |
| Respiratory  | Circle the appropriate score for this category:<br>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) <u>2</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 |