

Student Name: <u>Vivie Veitjow</u>	Patient Age: <u>4</u>
Date: <u>4-10-24</u>	Patient Weight: <u>15.4 kg</u>
Please list any medications you administered or procedures you performed during your shift:  <u>None</u>	

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 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 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 Withdrawn 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 <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 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 type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>3</u> Left <u>3</u> Pushes: Right <u>3</u> Left <u>3</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</u> <b>Stool Appearance:</b> <u>not seen</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: _____ <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>NS</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input 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 _____ <b>Obturator at Bedside:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present X <u>4</u> quads <input 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 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 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: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>Regular Diet</u> <b>Amount/Schedule:</b> <u>when asked</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input checked="" type="checkbox"/> Faces <b>Location:</b> <u>none</u> <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
	MUSCULOSKELETAL	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 checked="" type="checkbox"/> RA <input checked="" type="checkbox"/> LA <input checked="" type="checkbox"/> RI <input checked="" type="checkbox"/> LI <input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
		TUBES/DRAINS

Productive    Nonproductive  
 Secretions: Color \_\_\_\_\_  
 Consistency \_\_\_\_\_  
 Suction:  Yes    No   Type \_\_\_\_\_  
 Pulse Ox Site: right index  
 Oxygen Saturation: 97%

Brace/Appliances:  None  
 Type: \_\_\_\_\_

**MOBILITY**

Ambulatory    Crawl    In Arms  
 Ambulatory with assist  
 Assistive Device:  Crutch    Walker  
 Brace    Wheelchair    Bedridden

None  
 Drain/Tube  
 Site: \_\_\_\_\_  
 Type: \_\_\_\_\_  
 Dressing: \_\_\_\_\_  
 Suction: \_\_\_\_\_  
 Drainage amount: \_\_\_\_\_  
 Drainage color: \_\_\_\_\_

PICU

INTAKE/OUTPUT														Total
	07	08	09	10	11	12	13	14	15	16	17	18		
<b>PO/Enteral Intake</b>							30							30
PO Intake														
Intake – PO Meds														
Enteral Tube Feeding														
Enteral Flush														
Free Water														
<b>IV INTAKE</b>														Total
	07	08	09	10	11	12	13	14	15	16	17	18		
IV Fluid						20	20	20	20					80
IV Meds/Flush							30							30
<b>OUTPUT</b>														Total
	07	08	09	10	11	12	13	14	15	16	17	18		
Urine														
# 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)

Circle the appropriate score for this category:

**CHEWS Scoring and Escalation Algorithm**

	0	1	2	3
<b>Behavior/Neuro</b>	- 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
<b>Cardiovascular</b>	- Skin tone appropriate for patient - Capillary refill $\leq 2$ 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
<b>Respiratory</b>	- 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 LNC $>$ 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 - $> 2$ LNC 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
<b>Staff Concern</b>		- Concerned		
<b>Family Concern</b>		- Concerned or absent		
<b>Green = Score 0-2</b>	<b>Yellow = Score 3-4</b>		<b>Red = Score 5-11</b>	
- 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:** McLeilan, 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>

Behavior/Neuro	(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
<b>CHEWS Total Score</b>	
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

R  
R  
P  
0

Diane

IM5 Clinical Worksheet - PICU

Student Name: <u>Uma Vergara</u>	Patient Age: <u>4</u> Patient Weight: <u>15.4 kg</u>
Date: <u>4-11-24</u>	
1. Admitting Diagnosis: <u>Leukemia</u>	2. Priority Focused Assessment R/T Diagnosis: <u>Respiratory</u>
3. Signs and Symptoms: <u>SCB</u> <u>stomach pain</u> <u>N&amp;V</u>	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: <u>Bone marrow</u> <u>Aspiration</u>
5. Lab Values That May Be Affected: <u>WBC</u> <u>Neutrophils</u>	6. Current Treatment (Include Procedures): <u>Chemotherapy</u>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. <u>Patient stays with mom</u> 2. <u>Distraction with toys</u>	8. Patient/Caregiver Teaching: 1. <u>no live vaccines</u> 2. <u>no flowers in room</u> 3. <u>avoid crowds</u> Any Safety Issues Identified:
9. Calculate the Maintenance Fluid Requirement (Show Your Work): <u>10 x 100</u> <u>5 x 50</u> <u>1295 / 12</u> Combined Total Intake for Your Pt (mL/hr): <u>800 ml / hr</u>	10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): <u>15.4 x .5</u> <u>7.7</u> <u>7.7 x 12</u> <u>92.4</u> Actual Urine Output During Your Shift (mL/hr): <u>0</u>