

IM5 Clinical Worksheet – PICU

Student Name: Emma Martin Date: 04/23/24	Patient Age: 16 yr Patient Weight: 117.6 kg
1. Admitting Diagnosis: Renal Failure; non-functioning PD cath HD cath placed	2. Priority Focused Assessment R/T Diagnosis: GU assessment, GI assessment
3. Signs and Symptoms: Anuria, ↓ urinary output, Swelling, nausea, Fatigue, SOB.	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: BUN + Creatinine Creatinine clearance Kidney Ultrasound
5. Lab Values That May Be Affected: BUN, Creat, K ⁺ , Na ⁺ , P ⁻ , Cl ⁻ , Mg ⁺ , Ca ⁺	6. Current Treatment (Include Procedures): • HD every other day on the odd days. • Labetalol • acetaminophen 650mg q 6hr PRN
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.	8. Patient/Caregiver Teaching: 1. Fluid restriction to 1200ml/day 2. Renal diet 2g Na/day, 3g K/day, 100g - P/day 3. PD; HD cath care Any Safety Issues Identified: Do not pull at the catheters. Keep dressings clean dry and intact. Change when dirty or q 7 days
9. Calculate the Maintenance Fluid Requirement (Show Your Work): no iv fluids	10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): $0.5 / 117.6 \text{ kg} / 12 \text{ hr}$ <div style="border: 1px solid black; padding: 5px; display: inline-block; margin: 5px 0;">59 ml/hr</div>
Combined Total Intake for Your Pt (mL/hr): 1200ml/day (restricted)	Actual Urine Output During Your Shift (mL/hr): Anuric

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

Did not give meds.

Flushed INT

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PICU

<p>GENERAL APPEARANCE</p> <p>Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input checked="" type="checkbox"/> Unkept</p> <p>Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p>CARDIOVASCULAR</p> <p>Pulse: <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 _____</p> <p>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+</p> <p>Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec</p> <p>Pulses: Upper R <u>2+</u> L <u>2+</u> Lower R <u>2+</u> L <u>2+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None</p>	<p>PSYCHOSOCIAL</p> <p>Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" 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</p> <p>Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p>NEUROLOGICAL</p> <p>LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p>Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age</p> <p>Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u></p> <p>Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed</p> <p>Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically</p> <p>Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None</p> <p>EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____</p> <p>Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>ELIMINATION</p> <p>Urine Appearance: <u>Anuric</u></p> <p>Stool Appearance: <u>"brown" "soft"</u></p> <p><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p>IV ACCESS</p> <p>Site: <u>RAU 20g</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line</p> <p>Type/Location: _____</p> <p>Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return</p> <p>Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: _____</p>
<p>RESPIRATORY</p> <p>Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored</p> <p>Breath Sounds: 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</p> <p><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p>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: _____</p> <p>Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p>Secretions: Color _____ Consistency _____</p> <p>Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____</p> <p>Pulse Ox Site <u>Index Finger</u></p> <p>Oxygen Saturation: <u>98%</u></p>	<p>GASTROINTESTINAL</p> <p>Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded</p> <p>Bowel Sounds: <input type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent</p> <p>Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Passing Flatus: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>PD</u> Location <u>RLQ</u> Inserted to <u>N/A</u> cm <input type="checkbox"/> Suction Type: _____</p>	<p>SKIN</p> <p>Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input checked="" type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt</p> <p>Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic</p> <p>Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds</p> <p>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</p> <p>Location/Description: _____</p> <p>Mucous Membranes: Color: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
	<p>NUTRITIONAL</p> <p>Diet/Formula: <u>Regular Diet</u></p> <p>Amount/Schedule: <u>3x 6 days</u></p> <p>Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>PAIN</p> <p>Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p>Location: <u>General</u></p> <p>Type: <u>PD</u></p> <p>Pain Score: 0800 <u>0</u> 1200 _____ 1600 _____</p>
	<p>MUSCULOSKELETAL</p> <p><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</p> <p>Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All</p> <p>Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____</p>	<p>WOUND/INCISION</p> <p><input checked="" type="checkbox"/> None</p> <p>Type: _____</p> <p>Location: _____</p> <p>Description: _____</p> <p>Dressing: _____</p>
	<p>MOBILITY</p> <p><input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____</p> <p>Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p>TUBES/DRAINS</p> <p><input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube</p> <p>Site: <u>RLQ</u></p> <p>Type: <u>PD</u></p> <p>Dressing: <u>CDI</u></p> <p>Suction: <u>none</u></p> <p>Drainage amount: <u>none</u></p> <p>Drainage color: <u>none</u></p>

PICU

INTAKE/OUTPUT

PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake	0	0	0	0	0	/	/	/	/	/	/	/	0
Intake – PO Meds	0	0	0	0	0	/	/	/	/	/	/	/	
Enteral Tube Feeding	0	0	0	0	0	/	/	/	/	/	/	/	0
Enteral Flush	0	0	0	0	0	/	/	/	/	/	/	/	0
Free Water	0	0	0	0	0	/	/	/	/	/	/	/	0

IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	0	0	0	0	0	/	/	/	/	/	/	/	0
IV Meds/Flush	0	0	0	0	0	/	/	/	/	/	/	/	0

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	0	0	0	0	0	/	/	/	/	/	/	/	0
# of immeasurable	0	0	0	0	0	/	/	/	/	/	/	/	0
Stool	0	0	0	0	0	/	/	/	/	/	/	/	0
Urine/Stool mix	0	0	0	0	0	/	/	/	/	/	/	/	0
Emesis	0	0	0	0	0	/	/	/	/	/	/	/	0
Other	0	0	0	0	0	/	/	/	/	/	/	/	0

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

On HD every other day on the odd days.
 Fluid restricted 1200ml.
 Anuria.

Student Name: Emma Martin Unit: PICU Pt. Initials: _____ Date: _____

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

Allergies: _____

Primary IV Fluid and Infusion Rate (ml/hr)		Circle IVF Type		Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications		
<p><u>No meds given</u></p>		<p>Isotonic/ Hypotonic/ Hypertonic</p>	<p>Dose, Route & Schedule</p>	<p>Therapeutic Reason</p>	<p>Therapeutic Range? Is med in therapeutic range? If not, why?</p>	<p>IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration</p>	<p>Adverse Effects</p>	<p>Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)</p>