IM5 Clinical Worksheet – PICU

Student Name: Jovana Suarez **Date: 9/3/24**	**Patient Age:** 14 y/o **Patient Weight:** 63.3 kg

1. **Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)** Admitting Diagnosis: Pt presented to ED w/ fever and swelling in left lower extremity; diagnosed with reoccurring cellulitis secondary to diagnosis of lymphedema. Pt. also had s/s r/t sepsis • Fever • Leg was warm/hot to the touch, but the rest of unaffected skin was clammy • High HR • Oliguria • Low to normal BP	2. **Priority Focused Assessment R/T Diagnosis:** - Palpation/touch of affected extremity and skin assessment - Heart assessment – pulses were weak and thready - Continuous monitoring VS - ROM assessment
3. **Identify the most likely and worst possible complications.** - Sepsis - Bacterial infection, skin infections, poor wound healing - Hypoxia to affected extremity - Poor skin turgor/dehydration r/t fever (F&E imbalances) - Lymphorrhea and fluid leaking into interstitial spaces - DVTs due to lack of movement/ROM and hypoxia	4. **What interventions can prevent the listed complications from developing?** - Identify any cut on the skin that can allow for bacteria to enter body - Cover wounds/sores w/ sterile gauze to prevent moisture and bacteria from entering cut - Keep up to date w/ immunizations – look at Pt.'s immunization record - Avoid needle sticks in any affected swollen areas - Check to see if swelling is appearing in other parts of body - No BP cuffs placed on affected extremities - Use antipyretics for fever and pain management - Practice good hand hygiene/handwashing
5. **What clinical data/assessments are needed to identify these complications early?** - trends in VS - maintain adequate oral and IV fluids to prevent dehydration - give cool packs for fever or warm skin - monitor skin appearance, color, and temperature - identify any cuts, abrasions, and open wounds and treat as soon as identified - if possible, provide ROM exercises	6. **What nursing interventions will the nurse implement if the anticipated complication develops?** - monitor VS - Give prn antipyretics to lower fever - give adequate IV fluids - Ensure patent and open airway - continuous oxygenation and O2 supplementation if needed - monitor CBC count (especially WBCs) - continue to monitor skin and keep skin clean - do not allow for any tight fighting clothing that might aggravate swelling

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7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** 1. Having family or **friends** (Pt is 14 y/o who appreciates and values peer support) as support at bedside during visitor hours and allowing for family-centered care 2. Leave lights off due to photosensitivity from medications and provide adequate rest 3. Give ice packs/cool compresses on swollen affected extremity	**8. Patient/Caregiver Teaching:** **1.** Identify any cuts or open wounds and clean w/ antibacterial soaps to prevent infection **2.** Get all immunizations up to date to limit bacterial/viral infections **3.** keep and maintain hygiene including appropriate handwashing to prevent any infection **Any Safety Issues Identified:** - ROM: Pt just wanted to sleep and not move the affected extremity due to pressure of swelling - We wanted to help w/ prevention of DVTs, so we encouraged active ROM of affected extremity in bed - Pressure sores due to patient not moving and remaining in supine position in bed

Please list any medications you administered or procedures you performed during your shift:
- Vancomycin IVPB 250 mL diluted w/ NS 0.9%
- 2 Acetaminophen tablets 500mg each PO
- Diphenhydramine capsule 25 mg PO

PICU

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: ☒Healthy/Well Nourished ☒ Neat/Clean ☐Emaciated ☐ Unkept **Developmental age:** ☒ Normal ☐ Delayed **NEUROLOGICAL**	**Pulse:** ☐ Regular ☐ Irregular ☐ Strong ☒ Weak ☒ Thready ☐ Murmur ☐ Other _____ **Edema:** ☒ Yes ☐ No Location **_L leg_____** ☐ 1+ ☒ 2+ ☐ 3+ ☐ 4+ **Capillary Refill:** ☐ < 2 sec ☒ > 2 sec **Pulses:** Upper R __2___ L __2___ Lower R __2___ L ___2__ 4+ Bounding 3+ Strong 2+ Weak	**Social Status:** ☒ Calm/Relaxed ☐ Quiet ☒ Friendly ☒Cooperative ☐ Crying ☐ Uncooperative ☐ Restless ☐ Withdrawn ☒ Hostile/Anxious = Pt would express a bit of anxiousness when both the nurse and I went into the room; HR would increase from 68 to 94 as soon as we entered **Social/emotional bonding with family:** ☒ Present Grandpa was present at bedside ☐ Absent

LOC: ☑ Alert ☐ Confused ☐ Restless
☐ Sedated ☐ Unresponsive
Oriented to:
☑ Person ☑ Place ☑ Time/Event
☑ Appropriate for Age
Pupil Response: ☑ Equal ☐ Unequal
☑ Reactive to Light ☐ Size
__3mm_____
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat
☐ Bulging ☐ Sunken ☑ Closed
Extremities:
☐ Able to move all extremities
☐ Symmetrically ☑ Asymmetrically
Grips: Right _s____   Left __s___
Pushes: Right __s____   Left ___w__
S=Strong W=Weak N=None
EVD Drain: ☐ Yes ☑ No Level
___N/A___
Seizure Precautions: ☐ Yes ☑ No

RESPIRATORY

Respirations: ☑ Regular ☐ Irregular
☐ Retractions (type)
___N/A_____
☐ Labored
Breath Sounds:
Clear   ☑ Right ☐ Left
Crackles   ☐ Right ☐ Left
Wheezes   ☐ Right ☐ Left
Diminished ☐ Right ☐ Left
Absent   ☐ Right ☐ Left
☑ **Room Air SpO2 95%** ☐ **Oxygen**
Oxygen Delivery:
☐ Nasal Cannula: _N/A____L/min
☐ BiPap/CPAP:
___N/A_____
☐ Vent: ETT
size_N/A____@_N/A____cm
☐ Other:
__N/A_____
Trach: ☐ Yes ☑ No
Size __N/A_____ Type
_____N/A_____
Obturator at Bedside ☐ Yes ☑ No
Cough: ☐ Yes ☑ No
☐ Productive ☐ Nonproductive
Secretions:
Color_____N/A_____

Consistency_____N/A_____
_
Suction: ☐ Yes ☑ No Type
____N/A_____ **suction set up at
bedside for precaution****
**Pulse Ox Site ____R pointer
finger_____
Oxygen Saturation: __95%
RA_____**

1+ Intermittent   0 None

ELIMINATION

Urine Appearance: ___dark yellow Pt
voided at around 0900_____
Stool Appearance: __no BM observed
but when asked Pt said last BM was 9/2
and it was brown and sausage-
like_____
☐ Diarrhea ☐ Constipation
☐ Bloody   ☐ Colostomy

Pt asked about constipation and
said he has had none

GASTROINTESTINAL

Abdomen: ☑ Soft ☐ Firm ☐ Flat
☐ Distended ☐ Guarded
Bowel Sounds: ☐ Present X _4___
quads
☑ Active ☐ Hypo ☐ Hyper ☐ Absent
Nausea: ☑ Yes ☐ No
Vomiting: ☐ Yes ☑ No
Passing Flatus: ☑ Yes ☐ No
Tube: ☐ Yes ☑ No Type
___N/A_____
Location ___N/A__ Inserted to
_N/A____cm
☐ Suction Type:
___N/A_____

NUTRITIONAL

Diet/Formula: ___normal/regular
diet_____
Amount/Schedule: __3 meals at
hospital w/ mom providing snacks
_____
Chewing/Swallowing difficulties:
☐ Yes ☑ No

MUSCULOSKELETAL

☑ Pain ☑ Joint Stiffness ☑ Swelling
☐ Contracted ☑ Weakness ☑ Cramping
☐Spasms ☐ Tremors
**Movement: able to move all
extremities minus LL**
☑ RA ☑ LA ☑ RL ☐ LL ☐ All
Brace/Appliances: ☑ None
Type:
___N/A_____

MOBILITY

☐ Ambulatory ☐ Crawl ☐ In Arms
☑ Ambulatory with assist ___Pt said he
was able to use a wheelchair when
being transferred to PICU, but it hurts to
walk w/affected LL extremity due to
swelling and stiffness he is
experiencing_____
Assistive Device: ☐ Crutch ☐ Walker
☐ Brace ☑ Wheelchair ☐Bedridden

IV ACCESS

Site: _____R AC __20g IV_____ ☐
INT ☑ None
☐ Central Line
Type/Location:
__N/A_____
Appearance: ☑ No Redness/Swelling
☐ Red ☐ Swollen
☑ Patent ☐ Blood return – No IVP
meds were given so no blood aspiration
was observed
Dressing Intact: ☑ Yes ☐ No
Fluids: ___100 ml/Hr NS 0.9% + 20 K+
_mEq_____

SKIN

Color: ☑ Pink ☐ Flushed ☐ Jaundiced
☐ Cyanotic ☐ Pale ☑ Natural for Pt
Condition: ☑ Warm ☐ Cool ☐ Dry
☑ Diaphoretic
Turgor: ☑ < 5 seconds ☐ > 5 seconds
Skin: ☑ Intact ☐ Bruises ☐ Lacerations
☐ Tears ☐ Rash ☐ Skin Breakdown
Location/Description: __Skin on LL
was a bit **brownish** but no open sores
were detected on any part of body or
affected extremity_____
Mucous Membranes: Color:
__pink_____
☑ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☑ Numeric ☐FLACC ☐ Faces
Location: __Pt was at a 2-laying supine
in bed_____
Type: ____swelling and increased
pressure__in
LL_____
Pain Score:
0800__2/10___   1200___N/A__
1600 _N/A_____

WOUND/INCISION

☑ **None**
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

☑ **None**
☐ **Drain/Tube**
Site: _____
Type: _____
Dressing: _____
Suction: _____
Drainage amount:_____
Drainage color: _____

PICU

INTAKE/OUTPUT												
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed	30 mL of H2O	30 mL of H2O		30 mL of H2O									90 mL
Intake – PO Meds	25 mg				1000 mg								1025 mg
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	100 ml				100 ml								200 ml
IV Meds/Flush		250 ml											250 ml

Calculate Maintenance Fluid Requirement (Show Work)	Combined Total Intake for Pt (mL/hr)
Calculate Maintenance Fluid Requirement (Show Work) **10 (10)kg = 1000 ml** **10 (50)kg = 500 ml** **1500 + >20kg/kg = ?** **1500 + >20kg/43 = ?** **1500 + 860 = 2360 ml per 24 hours**	**Combined Total Intake for Pt (mL/hr)** **1500 + 860 = 2360 ml per 24 hours** **2360/24 = ? Hr** **= 98 ml per hour**

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper			650 mL of urine										650 mL
Stool – Pt did not pass a BM in AM**			N/A										N/A
Emesis – No emesis observed**			N/A										N/A
Other			N/A										N/A
			N/A										N/A

Calculate Minimum Acceptable Urine Output	Average Urine Output During Your Shift
Calculate Minimum Acceptable Urine Output **0.5 (63kg)/mL?** **0.5 (63)/Hr = 31.5 mL**	**Average Urine Output During Your Shift** **Pt diuresis was 650 mL; I believe it was because Pt was give a lot of IV fluid the day before w/ antibiotics diluted w/ 250 mL NS 0.9%**

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	– 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
Cardiovascular	– Skin tone appropriate for patient – Capillary refill ≤ 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
Respiratory	– 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 L NC > 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 L NC 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
Staff Concern		– Concerned		
Family Concern		– Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
– 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: McLellan, 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