

IM5 Clinical Worksheet – PICU

| | |
|--|---|
| Student Name: <u>Chantal N</u> Date: <u>9/11/24</u> | Patient Age: <u>14 y 10</u> Patient Weight: <u>kg 72.4 Kg</u> |
| 1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) <u>ICP placement (post op)</u> <u>arachnoid cyst</u> | 2. Priority Focused Assessment R/T Diagnosis: <u>Neuro assessment</u> <u>pain assessment</u> |
| 3. Identify the most likely and worst possible complications. Most likely: <u>surgical site infection</u> Worst possible: <u>permanent brain / nerve damage</u> | 4. What interventions can prevent the listed complications from developing? <u>Monitor ICP</u> <u>Monitor CBC / WBC labs</u> <u>Continue neuro checks</u> <u>Monitor ICP's</u> |
| 5. What clinical data/assessments are needed to identify these complications early? <u>- visual assessment of surgical site</u> <u>- CBC / WBC labs</u> <u>- continuous neuro checks</u> <u>- MRI scans</u> | 6. What nursing interventions will the nurse implement if the anticipated complication develops? <u>- aseptic techniques</u> <u>- elevate HOB to 30°</u> <u>- prevent fluid overload</u> <u>- monitor ICP closely</u> |
| 7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. <u>TV show (dance moms)</u> 2. <u>making bead bracelets</u> | 8. Patient/Caregiver Teaching: 1. <u>Keep ICP incision clean</u> 2. <u>Report pain at incision site</u> 3. <u>Report any headaches, nausea, vomiting</u> Any Safety Issues Identified: |
| Please list any medications you administered or procedures you performed during your shift: <u>Bethanechol PO 10mg</u> <u>ketorolac IV PRN (12M 10)</u> | |

1. Pathophysiology:

Arachnoid cyst

- non cancerous fluid filled sac that grows in the brain

- ICP monitoring: measures pressure inside the

skull, device is placed inside the head to do this.

Kyle

PICU

| INTAKE/OUTPUT | | | | | | | | | | | | | |
|---|----|----|----|----|-----|----|---|-----|----|----|----|----|-------|
| PO/Enteral Intake | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| PO Intake/Tube Feed | | | | | | | | | | | | | |
| Intake - PO Meds | | | | | | | | | | | | | |
| IV INTAKE | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| IV Fluid | | | | | | | | | | | | | |
| IV Meds/Flush | | | | | | | | | | | | | |
| Calculate Maintenance Fluid Requirement (Show Work) <i>Fluid D/C @ 1000</i> | | | | | | | Combined Total Intake for Pt (mL/hr) | | | | | | |
| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| Urine/Diaper | | | | | 400 | | | 100 | | | | | |
| Stool | | | | | | | | | | | | | |
| Emesis | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | |
| Calculate Minimum Acceptable Urine Output $72.4 \times 0.5 = 36.2 \text{ mL/hr}$ | | | | | | | Average Urine Output During Your Shift <i>250 mL</i> | | | | | | |

| 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) <i>0</i> |
| Score 0-2 (Green) - Continue routine assessments | |

PICU

| GENERAL APPEARANCE | CARDIOVASCULAR | PSYCHOSOCIAL |
|---|--|---|
| Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed | 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 _____ 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+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec 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 | Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent |
| NEUROLOGICAL | ELIMINATION | IV ACCESS |
| LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive 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 Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Urine Appearance: <u>yellow</u> Stool Appearance: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy | Site: <u>Palmar</u> <input checked="" type="checkbox"/> Ant <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>18g</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>DSN + KCL 20</u> <u>D/C @ 1000 9/11/24</u> |
| RESPIRATORY | GASTROINTESTINAL | SKIN |
| Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input 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 checked="" type="checkbox"/> Oxygen 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: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>foot</u> Oxygen Saturation: <u>98%</u> | Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____ | Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds 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 Location/Description: _____ Mucous Membranes: Color: _____ <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 _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden | Diet/Formula: <u>Normal</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>neck</u> Type: _____ Pain Score: 0800 _____ 1200 <u>7</u> 1600 <u>2</u> |
| WOUND/INCISION | MUSCULOSKELETAL | TUBES/DRAINS |
| <input type="checkbox"/> None Type: <u>incision</u> Location: <u>head (scalp)</u> Description: <u>TOP monitor</u> Dressing: <u>skin glue no drainage</u> | <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 Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input type="checkbox"/> None Type: _____ | <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____ |

Student Name: Chantal

Unit: RICU

Pt. Initials: _____

Date: 9/11/24

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

Allergies: N/A

| Primary IV Fluid and Infusion Rate (ml/hr) | | Circle IVF Type | | Rationale for IVF | | Lab Values to Assess Related to IVF | | Contraindications/Complications | | | | | | | |
|--|------------------------------|--------------------------------------|--------------------------------------|------------------------------|--------------|---|--|---|----|----|----|----|----|----|----|
| <u>Quid D/C</u> | | Isotonic/ Hypotonic/ Hypertonic | | | | | | | | | | | | | |
| Generic Name | Pharmacologic Classification | Therapeutic Reason | Dose, Route & Schedule | Therapeutic Range? | | IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration | Adverse Effects | Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.) | | | | | | | |
| | | | | Is med in therapeutic range? | If not, why? | | | | | | | | | | |
| <u>Dethanechol</u> | <u>cholinergic agonist</u> | <u>treat urinary retention</u> | <u>10mg po 3x daily before meals</u> | | | | <u>urinary urgency diarrhea nausea</u> | <u>1. MONITOR I&D 2. Take 1hr before or 2hrs after meals 3. Report bladder spasms 4. or painful urination</u> | | | | | | | |
| <u>Ibuprofen</u> | <u>NSAID</u> | <u>treat moderate to severe pain</u> | <u>15mg IV q 6hrs PRN</u> | | | | <u>nausea stomach pain drowsiness</u> | <u>1. Assess IV site 2. Monitor pain level 3. Do not take with food or rough ^{edible} edible 4. Monitor I&D</u> | | | | | | | |
| | | | | | | | | 1. | 2. | 3. | 4. | 1. | 2. | 3. | 4. |
| | | | | | | | | 1. | 2. | 3. | 4. | 1. | 2. | 3. | 4. |