

PICU

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" 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 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 Withdrawn 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 <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 type="checkbox"/> Person <input type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" 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>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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 type="checkbox"/> No	<b>Urine Appearance:</b> <u>yellow/clear</u> <b>Stool Appearance:</b> <u>NA</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>200 mL</u>	<b>Site:</b> <u>UA IV leg</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input 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> _____
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input 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 _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>index finger</u> <b>Oxygen Saturation:</b> <u>100%</u>	<b>Abdomen:</b> <input checked="" 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 checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Vomiting:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input 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: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>Regular</u> <b>Amount/Schedule:</b> <u>3x day</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 type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 _____
	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 type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None Type: _____	<input type="checkbox"/> None <b>Type:</b> <u>ICE monitor</u> <b>Location:</b> <u>R Frontal</u> <b>Description:</b> _____ <b>Dressing:</b> <u>NO</u>
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

9/12/24 FL injection for CT myelogram  
 LP & imaging to show if dye is flowing  
 to arachnoid cyst.

## IM5 Clinical Worksheet – PICU

<b>Student Name:</b> Audrie Gomez <b>Date:</b> 9/11/24	<b>Patient Age:</b> 14yo <b>Patient Weight:</b> 72.4 kg
<b>1. Admitting Diagnosis and Pathophysiology</b> (State the pathophysiology in own words) N/V, anarchooid cysts. anarchooid cyst formed during development.	<b>2. Priority Focused Assessment R/T Diagnosis:</b> Neuro checks, VS
<b>3. Identify the most likely and worst possible complications.</b> Restricted blood flow to brain	<b>4. What interventions can prevent the listed complications from developing?</b> ICP monitoring VS checks Neuro checks
<b>5. What clinical data/assessments are needed to identify these complications early?</b> Imaging ICP monitor Pain	<b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b> Pain management comfort positions
<b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.  1. Distraction- tablet, movies  2. music	<b>8. Patient/Caregiver Teaching:</b> 1. Get up slowly, turn to side of bed, non-slip hgs... 2. Perform everyday activities as @ home (need to monitor ICP): position of sleep, walk, ... 3. ↑ fluid intake to prevent dehydration  <b>Any Safety Issues Identified:</b> Fall precautions, possible dehydration
<b>Please list any medications you administered or procedures you performed during your shift:</b> bethanechol (wrecholine) PO Pantoprazole (Protonix) PO ondansetron (Zofran) IV	

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>Fluids d/c</i>							Combined Total Intake for Pt (mL/hr)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper				200									
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output $0.6 \text{ mL} \times 72.4 \text{ kg} \times 12 = 432$							Average Urine Output During Your Shift						

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) _____
	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

Student Name: Audrie

Unit: PICU

Pt. Initials: LG

Date: 9/11/24

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

Allergies: NKDA

Primary IV Fluid and Infusion Rate (ml/hr)		Circle IVF Type		Rationale for IVF		Lab Values to Assess Related to IVF		Contraindications/Complications	
<u>NS - sodium chloride</u>		<u>Isotonic</u>						<u>Fluid overload</u>	
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>bethanechol</u>	<u>cholinergic agonist</u>	<u>nausea gastritis</u>	<u>PO <del>TID</del> QHS 10mg</u>	<u>yes</u>			<u>dizziness N/V headache</u>	<ol style="list-style-type: none"> <li>1. Take on empty stomach</li> <li>2. Take 1 to 2 hrs before meals</li> <li>3. Take as directed</li> <li>4. Get up out of bed slowly</li> </ol>	
<u>ondansetron</u>	<u>anti-emetic</u>	<u>N/V</u>	<u>IV PRN 8mg</u>	<u>yes</u>			<u>myocardial ischemia</u>	<ol style="list-style-type: none"> <li>1. Can be taken w/ or w/o food</li> <li>2. Report any chest pain</li> <li>3. Report any N/V</li> <li>4. Report any trouble breathing</li> </ol>	
<u>panproprazole</u>	<u>PPI</u>	<u>gastritis</u>	<u>40mg PO AC/BHS</u>	<u>yes</u>	<u>40mg / 2min</u>		<u>N/V joint pain HA abd. pain</u>	<ol style="list-style-type: none"> <li>1. Take as directed do not stop</li> <li>2. Avoid foods that cause GI irritation</li> <li>3. Report any chest, jaw, shoulder pain</li> <li>4. Avoid taking report black tarry stools</li> </ol>	
								<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	
								<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	