# IM5 Clinical Worksheet – PICU

| | |
|---|---|
| **Student Name:** Lindsey McCormack<br>**Date:** 10/29/24 | **Patient Age:** 5 y/o<br>**Patient Weight:** 39.5 kg |
| 1. **Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)**<br>Admitting Diagnosis: positive for Rhinovirus<br><br>Patho:<br>Rhinovirus- most common cause of the common cold; an inflammatory response that results in increased vascular permeability and increased mucus secretion | 2. **Priority Focused Assessment R/T Diagnosis:**<br><br>Priority focused assessment: Respiratory |
| 3. **Identify the most likely and worst possible complications.**<br><br>Most likely complications: Otitis Media, sinusitis, bronchiolitis and bronchitis<br><br>Worst complications: Asthma exacerbation and pneumonia | 4. **What interventions can prevent the listed complications from developing?**<br><br>- Stay up to date with immunizations<br>- Good hand hygiene<br>- Cover mouth when coughing and sneezing<br>- Disinfect surfaces |
| 5. **What clinical data/assessments are needed to identify these complications early?**<br><br>Sore throat, runny nose, coughing, sneezing, body aches, fever | 6. **What nursing interventions will the nurse implement if the anticipated complication develops?**<br>- administer IV fluids<br>- analgesics, decongestants, antipyretics<br>- cool mist humidifier to help with breathing |
| 7. **Pain & Discomfort Management:**<br>**List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.**<br><br>1. Warm compress to help with headache and sore throat<br><br>2. **Drink a lot of fluids to help loosen congestion** | 8. **Patient/Caregiver Teaching:**<br>1. **Disinfect surfaces (counters, toys, tables)**<br><br>2. **Allow for plenty of rest**<br><br>3. **Use a humidifier to relieve the congestion**<br><br>**Any Safety Issues Identified:**<br>**N/A** |
| **Please list any medications you administered or procedures you performed during your shift:**<br>**Lorazepam** ||

# PICU

## GENERAL APPEARANCE

**Appearance:** □ Healthy/Well Nourished  ■ Neat/Clean □ Emaciated □ Unkept
**Developmental age:**
□ Normal  ■ Delayed

## NEUROLOGICAL

**LOC:** □ Alert □ Confused ■ Restless
□ Sedated □ Unresponsive
**Oriented to:**
■ Person □ Place □ Time/Event
□ Appropriate for Age
**Pupil Response:** ■ Equal □ Unequal
■ Reactive to Light □ Size
_2mm_____
**Fontanel:** (Pt < 2 years) ■ Soft ■ Flat
□ Bulging □ Sunken □ Closed
**Extremities:**
■ Able to move all extremities
□ Symmetrically □ Asymmetrically
Grips:   Right _W____  Left __W___
Pushes: Right ___W__  Left __W___
S=Strong  W=Weak  N=None
**EVD Drain:** □ Yes ■ No Level _____
**Seizure Precautions:** □ Yes ■ No

## RESPIRATORY

**Respirations:** ■ Regular □ Irregular
□ Retractions (type) _____
□ Labored
**Breath Sounds:**
Clear       ■ Right ■ Left
Crackles    □ Right □ Left
Wheezes     □ Right □ Left
Diminished  □ Right □ Left
Absent      □ Right □ Left
□ **Room Air**    □ **Oxygen**
**Oxygen Delivery:**
□ Nasal Cannula: ____L/min
■ BiPap/CPAP: ___FiO2:
50%_____
□ Vent: ETT size_____@_____cm
□ Other: _____
**Trach:** □ Yes ■ No
Size _____ Type _____
Obturator at Bedside □ Yes □ No
**Cough:** □ Yes ■ No
□ Productive □ Nonproductive
**Secretions:**
Color___NA_____

## CARDIOVASCULAR

**Pulse:** ■ Regular □ Irregular
□ Strong □ Weak □ Thready
□ Murmur □ Other _____
**Edema:** □ Yes ■ No  Location _____
□ 1+ □ 2+ □ 3+ □ 4+
**Capillary Refill:** ■ < 2 sec □ > 2 sec
**Pulses:**
Upper  R __3+___  L __3+___
Lower  R ___3+__  L __3+___
4+ Bounding  3+ Strong  2+ Weak
1+ Intermittent  0 None

## ELIMINATION

**Urine Appearance:**
__yellow/clear_____
**Stool Appearance:**
____NA_____
□ Diarrhea □ Constipation
□ Bloody □ Colostomy

## 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 _____
Location _____ Inserted to _____cm
□ Suction  Type: _____

## NUTRITIONAL

**Diet/Formula:**
____NPO_____
**Amount/Schedule:** _____
**Chewing/Swallowing difficulties:**
□ Yes □ No

## MUSCULOSKELETAL

□ Pain □ Joint Stiffness □ Swelling
□ Contracted □ Weakness □ Cramping
□ Spasms □ Tremors
**Movement:**
■ RA □ LA □ RL □ LL ■ All
**Brace/Appliances:** □ None
Type: _____

## PSYCHOSOCIAL

**Social Status:** □ Calm/Relaxed □ Quiet
□ Friendly □ Cooperative □ Crying
■ Uncooperative ■ Restless
■ Withdrawn ■ Hostile/Anxious
**Social/emotional bonding with family:**
■ Present □ Absent

## IV ACCESS

**Site:** __RUA PICC_____ ■ INT
□ None
□ Central Line
Type/Location:
_PICC_____
**Appearance:** ■ No Redness/Swelling
□ Red □ Swollen
□ Patent □ Blood return
**Dressing Intact:** ■ Yes □ No
**Fluids:** __D5NS +
20K_____

## 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: _____
**Mucous Membranes:** Color:
__NA_____
□ Moist □ Dry □ Ulceration

## PAIN

**Scale Used:** □ Numeric ■ FLACC □ Faces
**Location:**
__NA_____
**Type:**
____NA_____
**Pain Score:**
0800___0__ 1200___0__ 1600
__0___

## WOUND/INCISION

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

## TUBES/DRAINS

■ **None**
□ **Drain/Tube**
Site: _____

| | | |
|---|---|---|
| Consistency_____<br>**Suction:** □ Yes ■ No  Type _____<br>**Pulse Ox Site __R**<br>**toe**_____<br>**Oxygen Saturation:**<br>__99%_____ | **MOBILITY**<br>□ Ambulatory □ Crawl □ In Arms<br>■ Ambulatory with assist _____<br>Assistive Device: □ Crutch □ Walker<br>　□ Brace □ Wheelchair □Bedridden | Type: _____<br>Dressing: _____<br>Suction: _____<br>Drainage amount:_____<br>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 | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Intake – PO Meds | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| **IV INTAKE** | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
| IV Fluid | | | | | 80 | 80 | 80 | 80 | 80 | 80 | 80 | | 560mL |
| IV Meds/Flush | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

| Calculate Maintenance Fluid Requirement (Show Work) | Combined Total Intake for Pt (mL/hr) |
|---|---|
| **10x100= 1000**<br>**10x50= 500**<br>**20x20= 400**<br>**Total: 1900/24 = 79mL/hr** | **560mL/hr** |

| OUTPUT | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Urine/Diaper | | | | | | | | 75 | | 75 | | | 150 |
| Stool | | | | | | | | | | | | | |
| Emesis | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

| Calculate Minimum Acceptable Urine Output | Average Urine Output During Your Shift |
|---|---|
| **0.5x40= 20mL/hr** | **150mL** |

| 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:<br>0　　1　　2　　**3** | |
| | | |
| Cardiovascular | Circle the appropriate score for this category:<br>**0**　　1　　2　　3 | |
| | | |

# CHEWS Scoring and Escalation Algorithm

|  | 0 | 1 | 2 | 3 |
| --- | --- | --- | --- | --- |
| **Behavior/Neuro** | – Playing/sleeping appropriately **OR** <br> – Alert, at patient's baseline | – Sleepy, somnolent when not disturbed | – Irritable, difficult to console **OR** <br> – Increase in patient's baseline seizure activity | – Lethargic, confused, floppy **OR** <br> – Reduced response to pain **OR** <br> – Prolonged or frequent seizures **OR** <br> – Pupils asymmetrical or sluggish |
| **Cardiovascular** | – Skin tone appropriate for patient <br> – Capillary refill ≤ 2 seconds | – Pale **OR** <br> – Capillary refill 3-4 seconds **OR** <br> – Mild tachycardia **OR** <br> – Intermittent ectopy or irregular HR (not new) | – Grey **OR** <br> – Capillary refill 4-5 seconds **OR** <br> – Moderate tachycardia | – Grey and mottled **OR** <br> – Capillary refill > 5 seconds **OR** <br> – Severe tachycardia **OR** <br> – New onset bradycardia **OR** <br> – New onset/increase in ectopy, irregular HR or heart block |
| **Respiratory** | – Within normal parameters <br> – No retractions | – Mild tachypnea/ increased WOB (flaring, retracting) **OR** <br> – Up to 40% supplemental oxygen **OR** <br> – Up to 1L NC > patient's baseline need **OR** <br> – Mild desaturations < patient's baseline **OR** <br> – Intermittent apnea self-resolving | – Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) **OR** <br> – 40-60% oxygen via mask **OR** <br> – 1-2 L NC > patient's baseline need **OR** <br> – Nebs Q 1-2 hour **OR** <br> – Moderate desaturations < patient's baseline **OR** <br> – Apnea requiring repositioning or stimulation | – Severe tachypnea **OR** <br> – RR < normal for age **OR** <br> – Severe increased WOB (i.e. head bobbing, paradoxical breathing) **OR** <br> – > 60% oxygen via mask **OR** <br> – > 2 L NC more than patient's baseline need **OR** <br> – Nebs Q 30 minutes – 1 hour **OR** <br> – Severe desaturations < patient's baseline **OR** <br> – 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 <br> – Discuss treatment plan with team <br> – Consider higher level of care <br> – Increase frequency of vital signs / CHEWS / assessments <br> – Document interventions and notifications | – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation <br> – Notify attending physician <br> – Discuss treatment plan with team <br> – Increase frequency of vital signs / CHEWS / assessments <br> – 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