

IM5 Clinical Worksheet - PICU

Student Name: <u>Isaias Lopez</u> Date:	Patient Age: <u>6</u> Patient Weight: <u>24 kg</u>
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) <u>Closed head injury w/ LOC</u>	2. Priority Focused Assessment R/T Diagnosis: <u>Neuro &amp; Respiratory</u>
3. Identify the most likely and worst possible complications. <u>Permanent brain damage,                  Complications of seizures                  Head aches/Pain,                  Respiratory Depression</u>	4. What interventions can prevent the listed complications from developing? <u>Frequent assessments,                  Continuous monitors, O<sub>2</sub> therapy,                  maintain sedative state, patent                  airway</u>
5. What clinical data/assessments are needed to identify these complications early? <u>A&amp;O, Neuro assessments Q1                  hr, pupillary exam, Ster                  Coordination assessments</u>	6. What nursing interventions will the nurse implement if the anticipated complication develops? <u>Resp- Code Blue                  Seizure-administer anticonvulsant                  HT &amp; Pain-analgesia admin                  Brain-Prevent further w/ safe environment</u>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. <u>1. Once awake; Using distractions                  Such as drawing/coloring                  2. Having the parent present for                  reassurance works as well.</u>	8. Patient/Caregiver Teaching: <u>1. Slowly build to original level of                  play.                  2. Opioid use timely followed w/ stool                  softener and tapered off.                  3. After DC-monitor for sis of seizures                  or neuro deficits</u> Any Safety Issues Identified: <u>School-Aged child - Lots of play,                  possibility of non-compliance due                  to level of activity</u>
Please list any medications you administered or procedures you performed during your shift: <u>No Meds at this time - Fentanyl on continuous drip                  MRI Performed</u>	

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 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	Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input 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
<b>NEUROLOGICAL</b> LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input 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 <u>same 4mm</u> 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>3</u> Left <u>3</u> Pushes: Right <u>3</u> Left <u>3</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input type="checkbox"/> No Level _____ Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Pulses: Upper R <u>4</u> L <u>4</u> Lower R <u>3</u> L <u>3</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>IV ACCESS</b> Site: <u>R. Ant. AC</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ 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 Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>D5NS 20mg KCl</u>
<b>RESPIRATORY</b> 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 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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPAP/CPAP: _____ <input checked="" type="checkbox"/> Vent: ETT size <u>5.5</u> @ <u>17.5</u> cm <input type="checkbox"/> Other: _____ Trach: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>yellow</u> Consistency <u>thick</u> Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type <u>INT</u> Pulse Ox Site <u>L toe</u> Oxygen Saturation: <u>96</u>	<b>ELIMINATION</b> Urine Appearance: <u>Clear Yellow</u> Stool Appearance: <u>green</u> <input checked="" type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>SKIN</b> Color: <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 Condition: <input type="checkbox"/> Warm <input checked="" type="checkbox"/> Cool <input 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 checked="" type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: <u>no face/temporal</u> Mucous Membranes: Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	<b>GASTROINTESTINAL</b> 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 checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>PAIN</b> Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: <input checked="" type="checkbox"/> 0 0800 _____ 1200 <input checked="" type="checkbox"/> 1600 _____
	<b>NUTRITIONAL NPO</b> Diet/Formula: _____ Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>WOUND/INCISION</b> <input type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	<b>MUSCULOSKELETAL</b> <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: _____	<b>TUBES/DRAINS</b> <input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>Center of mouth</u> Type: <u>ETT</u> Dressing: <u>clear/dry</u> Suction: _____ Drainage amount: _____ Drainage color: _____
	<b>MOBILITY</b> <input 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 checked="" type="checkbox"/> Bedridden	

MPO

INTAKE/OUTPUT														
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total	
PO Intake/Tube Feed														
Intake - PO Meds														
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total	
IV Fluid	65	65	65	65	65	65	65	65	<del>65</del>	<del>65</del>	<del>65</del>	65		520
IV Meds/Flush	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4					45.2
					134									565.2
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)							
$10 \times 100 = 1000$ $10 \times 50 = 500$ $4 \times 20 = 80$ $1580 / 24 = 65.8 \text{ mL/hr}$							$565.2 / 8$ $70.65 \text{ mL/hr}$							
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total	
Urine/Diaper	20	25	35	35	12	35	25	25						212
Stool	-	-	-	-	-	-	-	-						
Emesis														
Other														70
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift							
$0.5 \text{ mL/kg/hr}$ $0.5 \text{ mL} / 24 \text{ kg/hr} = 12 \text{ mL/hr}$							$26.5 / \text{hr}$							

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 0
Family Concern	1 pt - Concerned or absent 0
<b>CHEWS Total Score</b>	
CHEWS Total Score	Total Score (points) 6
	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

11/12/24  
 No Needs Give Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type <input type="checkbox"/> Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
Click here to enter text.		Click here to enter text.	Click here to enter text.	Click here to enter text.

Student Name:	Unit:	Patient Initials:	Date:	Allergies:	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Click here to enter text.	
Click here to enter text.	Click here to enter text.	Click here to enter text.	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.
Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.			
Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.			
Click here to enter text.	Click here to enter text.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.			