

Student Name: Penel HallUnit: P12Pt. Initials: NSGDate: 12/3/24

S	Pt Initials: <u>NSG</u> Room: <u>3</u> DOB: <u>12/10/07</u> Admit Date: <u>11/30/24</u> Admit Wt: <u>34.5 kg</u> Current Wt: <u>34.5 kg</u> Ht: <u>4'1"</u> (M) F Primary Dx: <u>acute resp. failure</u> Secondary Dx:		Physician: <u>Anand</u> Consults (Ex: Speech, PT/OT, Surgery, Neuro)						
	B History <u>Down syndrome</u> <u>Lennox gestaut</u> <u>mitochondrial disease</u> <u>Autism</u>		Allergies (reactions) <u>NKDA</u> Code status <u>FULL</u> DNR/AND Advance directive: Y N	Isolation: <u>CONTACT</u> Restraints: <u>Y</u> N Type: <u>SOFT</u> Fall risk Vaccine: PNA Flu					
A	Neuro: LOC/Hand Grips/Pulls & Pushes/Pupil Rx/ Pupil Size/ GCS <u>intubated/sedated</u> <u>Imm reactive 3</u> <u>equal</u>		Vital Signs: BP/HR/RR/Temp/SpO2 BP: <u>107/46</u> RR: <u>12</u> <u>(bb)</u> O2: <u>97</u> HR: <u>75</u> T: <u>36.5</u>						
	Cardiac: Peripheral pulses/Edema/Heart sounds/Rhythm - <u>Regular</u> or Irregular <u>Strong peripheral pulses</u> <u>S1, S2 audible</u>		Pain Pain scale Location						
	Pulmonary: Breath sounds/Secretions <u>Clear regular breath sounds</u>	Oxygen: <u>L O2</u> NC <u>100NR VM</u>	Accu checks: Frequency Results						
	GI: BS Last BM: <u>12/03/24</u> NGT OGT	Diet <u>G-tube, Pediasure Peptidol</u> Breakfast % eaten: Lunch % eaten:	Skin: Wounds/Drainage Staples /Drains Location						
	GU: Void <u>(Foley)</u> <u>12</u> FR Placed on: <u>11/30/24</u>		Psych Social <u>intubated</u>						
	IV Peripheral <u>INT</u> <u>AL 20g</u> <u>Downst 20g</u> IV gauge Site: <u>medial side of arm</u> IV Fluid type: <u>PICC@1035</u> Rate: <u>11/30/24</u> Central- type/site (subclavian/port/broviac)		Pending orders (ex: CBC, specimen)						
	Intake Total: mL Parenteral _____ Enteral <u>237 mL</u> (on HMDs) Output Total: mL Void _____ mL Emesis _____ mL Balance: mL (Positive or negative) What does this mean for your pt?								
Na <u>140</u>	Cl <u>98</u>	Bun <u>9</u>	Gluc <u>91</u>	Mg <u>0.70</u>	Other <u>8.7</u>	Labs Pending:	Hct <u>27.6</u> WBC <u>9.40</u> Plt <u>254</u> Hgb <u>9.8</u>	UA	Diagnostic Test Results: CT CXR <u>lower lung atelectasis/pneumonia</u> MRI Echo
R ***Nursing Interventions & Teaching: (use your Critical Thinking Map) DC Plan. Is pt informed of plan? Y N 24 hour orders reviewed Day 1 ☐ Day 2 ☐ What does the patient need when they are discharged?								Shift goals: <u>Met</u> Unmet Revise	

IM5 Clinical Worksheet - PICU

Student Name: Renee Hall Date: 12/3/24	Patient Age: 16 Patient Weight: 34.5kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) acute resp. failure	2. Priority Focused Assessment R/T Diagnosis: respiratory
3. Identify the most likely and worst possible complications. Pt. is intubated - worst possible complications	4. What interventions can prevent the listed complications from developing? can't prevent being intubated if needing to be
5. What clinical data/assessments are needed to identify these complications early? O ₂ sats respiratory assessment	6. What nursing interventions will the nurse implement if the anticipated complication develops? keep comfortable CPR
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Positioning 2. comfort measures	8. Patient/Caregiver Teaching: 1. what yellow/red waves mean on vent 2. 3. Any Safety Issues Identified:
Please list any medications you administered or procedures you performed during your shift:	

Student Name: _____

Unit: PEL

Pt. Initials: _____

Date: _____

PICU

intubated/sedated

PSYCHOSOCIAL

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

IV ACCESS

Site: _____ ☐ INT ☐ None
☐ Central Line
Type/Location: PVC @ middle
Appearance: ☒ No Redness/Swelling
☐ Red ☐ Swollen
☐ Patent ☐ Blood return
Dressing Intact: ☒ Yes ☐ No
Fluids: _____

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: pink
☒ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☐ Numeric ☐ FLACC ☐ Faces
Location: _____
Type: _____
Pain Score: _____
0800 _____ 1200 _____ 1600 _____

WOUND/INCISION

☒ None
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

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

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 1
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat
☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☐ Able to move all extremities
☐ Symmetrically ☐ Asymmetrically
Grips: Right _____ Left _____
Pushes: Right _____ Left _____
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: _____
☒ Vent: ETT size 6 @ _____ cm
☐ Other: _____
Trach: ☐ Yes ☒ No
Size _____ Type _____
Obturator at Bedside ☐ Yes ☐ No
Cough: ☐ Yes ☒ No
☐ Productive ☐ Nonproductive
Secretions: Color _____
Consistency _____
Suction: ☐ Yes ☐ No Type _____
Pulse Ox Site _____
Oxygen Saturation: _____

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: clear yellow
Stool Appearance: brown, mushy
☐ 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 G-tube
Location: midline inserted to _____ cm
☒ Suction Type: in line

NUTRITIONAL

Diet/Formula: Pediasure PePhden 1.0
Amount/Schedule: 137ml continuous
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: intubated/sedated

MOBILITY

☐ Ambulatory ☐ Crawl ☐ In Arms
☐ Ambulatory with assist _____
Assistive Device: ☐ Crutch ☐ Walker
☐ Brace ☐ Wheelchair ☐ Bedridden

intubated/sedated

PICU

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/ Tube Feed	82	82	82	82	82	82	82	82	82	82	82		820
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	3.86	3.86	3.86	3.86	3.86	6.34	5.7	5.7	13.6				
IV Meds/ Flush													
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/ Diaper	150							325					
Stool													
Emesis													
Other													
Calculate Minimum Acceptable Urine Output							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 <u>3</u>
Cardiovascular	Circle the appropriate score for this category: <u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 2 <u>3</u>
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>8</u>
	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