IM5 Clinical Worksheet – PICU

Student Name: Mayci wood **Date:** 12/3/24	**Patient Age:** 5 months **Patient Weight:** 4.07 kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) NICU baby who never really improved (premie)	**2. Priority Focused Assessment R/T Diagnosis:** Lungs Respiratory hx: Pulmonary HTN
3. Identify the most likely and worst possible complications. She could get a trach or die. Potentially be blind	**4. What interventions can prevent the listed complications from developing?** · Prenatal care · Monitor closely · Watch her O_2 & CO_2 (ECMO)
5. What clinical data/assessments are needed to identify these complications early? Monitor for Resp. distress *Protect the lungs*	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** educate on trach & NG tube care & CPR
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Positioning 2. Comfort measures ↳ holding stuffed bear, blanket	**8. Patient/Caregiver Teaching:** 1. Teach about signs of infection (temp, red, warm) 2. Watch for sighns of Resp. distress (Cyanotic, Rapid breathing) 3. Explain what ECMO does for the child. **Any Safety Issues Identified:** Tubes, Keeping all tubes out of sight/reach to Prevent any dislodging of equipment
Please list any medications you administered or procedures you performed during your shift: None	

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PICU

sedated

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 Sedated
Pupil Response: ☐ Equal ☐ Unequal ☐ Reactive to Light ☐ Size _____
Fontanel: (Pt < 2 years) ☑ Soft ☐ Flat ☐ Bulging ☐ Sunken ☐ Closed
Extremities: Sedated ☐ 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
Sedated

ECMO

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 3½ @ 21½ cm 3½
☐ Other: _____
Trach: ☐ Yes ☑ No
Size _____ Type _____
Obturator at Bedside ☐ Yes ☐ No
Cough: ☐ Yes ☑ No ☐ Productive ☐ Nonproductive
Secretions: Color none
Consistency _____
Suction: ☑ Yes ☐ No Type Nline
Pulse Ox Site _____
Oxygen Saturation: _____

CARDIOVASCULAR

Pulse: ☑ Regular ☐ Irregular ☐ Strong ☐ Weak ☐ Thready ☐ Murmur ☐ Other ECMO
Edema: ☐ Yes ☑ No Location _____ ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Capillary Refill: ☑ < 2 sec ☐ > 2 sec
Pulses:
Upper R 1+ L 1+
Lower R 1+ L 1+
4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None

ELIMINATION

Urine Appearance: yellow/clear
Stool Appearance: none observed
☐ Diarrhea ☐ Constipation ☐ Bloody ☐ Colostomy

GASTROINTESTINAL

Abdomen: ☑ Soft ☐ Firm ☐ Flat ☐ Distended ☐ Guarded
Bowel Sounds: ☐ Present X ____ quads ☐ Active ☑ Hypo ☐ Hyper ☐ Absent
Nausea: ☐ Yes ☑ No
Vomiting: ☐ Yes ☑ No
Passing Flatus: ☐ Yes ☑ No not w/ me
Tube: ☑ Yes ☐ No Type NG
Location nose Inserted to _____ cm
☐ Suction Type: N-line

NUTRITIONAL

Diet/Formula: Kangaroo
Amount/Schedule: 20mL/hr
Chewing/Swallowing difficulties: ☑ Yes ☐ No intubated/Sedated

MUSCULOSKELETAL

☐ Pain ☐ Joint Stiffness ☐ Swelling ☐ Contracted ☐ Weakness ☐ Cramping ☐ Spasms ☐ Tremors
Movement: Sedated
☐ RA ☐ LA ☐ RL ☐ LL ☐ All
Brace/Appliances: ☑ None
Type: Sedated

MOBILITY

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

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: R & L femoral
Appearance: ☑ No Redness/Swelling ☐ Red ☐ Swollen ☐ Patent ☐ Blood return
Dressing Intact: ☑ Yes ☐ No
Fluids: NS

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: Sedated
Pain Score:
0800 ____ 1200 ____ 1600 ____

WOUND/INCISION

☐ None 11/27/24
Type: Pressure wound
Location: Forehead
Description: _____
Dressing: dry/intact

TUBES/DRAINS

☐ None OG
☑ Drain/Tube
Site: nose
Type: OG
Dressing: none
Suction: ~~yes~~ N/A
Drainage amount: N/A
Drainage color: N/A
for feeding

* ECMO & Sedated

40-60% O2

13: Cisatracurium R femoral line

PICU

20mL/Hr Kangaroo 1 0.1 1.6 1 mg/mL

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed	20	20	20	20	20	20	20	20	20	20			200 w/me
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid							1	3.7					
IV Meds/Flush													

Calculate Maintenance Fluid Requirement (Show Work)	**Combined Total Intake for Pt (mL/hr)**
	20mL/hr

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper Cath.													
Stool N/A													
Emesis N/A													
Other													

urinary Cath. 1110 mL @3:35

Calculate Minimum Acceptable Urine Output	**Average Urine Output During Your Shift**
0.5x4.07 48.84?	1130/6hrs = 188.3mL/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 1
Family Concern	1 pt – Concerned or absent 1
CHEWS Total Score	
CHEWS Total Score	Total Score (points) 11
	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