IM5 Clinical Worksheet – PICU

Student Name: Jasmine Luna
Date: 1/28/25

Patient Age: 8 y o
Patient Weight: 30 kg

1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)
Acute resp distress d/t virus
↳ on ventilator

2. Priority Focused Assessment R/T Diagnosis:
Respiratory Focus Assessment

3. Identify the most likely and worst possible complications.
- Hypoxia
- constipation
- Cyanosis
- DVT
- Hypercapnia
- Resp distress
- Acidosis
- Aspiration
- Tachycardia
- Infection UTI
- Pneumonia

4. What interventions can prevent the listed complications from developing?
- Turn q 2hrs
- Skin care
- Stool softners
- Hygiene
- Fluids
- Turn cough. Deep breath
- Oral care
- Medication
- Suction
- O2 Administration

5. What clinical data/assessments are needed to identify these complications early?
- Vital signs
  - Respiratory. Pulse
- Trend Ventilator data
- Oxygen therapy

6. What nursing interventions will the nurse implement if the anticipated complication develops?
- O2 therapy
- Peri care
- Med admin
- Fowler (semi)
- Stool softners
- O2 Sat
- Enoxaparin
- Suction / Trach care

7. Pain & Discomfort Management:
List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.

1. Sensory techniques
   ↳ Distraction Stimulation
   ↳ Objects that move/ change shape & color
2. Tactile Stimulation
   ↳ Buzzy bee, hand holding

8. Patient/Caregiver Teaching:
1. Medication Administration
2. Trach care
3. General ADL Care
   ↳ Position. ROM. Oral care

Any Safety Issues Identified:
- Keep bed low position
- Sanitze hands upon arriving/ leaving

Please list any medications you administered or procedures you performed during your shift:

ADMINISTERED:
Tizanidine, Enoxaparin. Montelukast. Clobazam. Nitrofurantoin

PERFORMED/ASSISTED:
Oral care. bed bath. linen change feeding. parent education pain assessment. head to toe assessment. Vital signs; TPN education

OBSERVED:
Trach care

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 _____
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat
☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☐ Able to move all extremities
☐ Symmetrically ☑ Asymmetrically
Grips: Right W Left W
Pushes: Right N Left N
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 6.0 @ ____cm
☐ Other: Bivona trach
Trach: ☑ Yes ☐ No
Size 6.0 Type Bivona
Obturator at Bedside ☑ Yes ☐ No
Cough: ☑ Yes ☐ No
☑ Productive ☐ Nonproductive
Secretions: Color clear mucus
Consistency Liquid, thick
Suction: ☑ Yes ☐ No Type Oral
Pulse Ox Site Right Toe (Digit)
Oxygen Saturation: 95%

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 2+ L 2+
Lower R 2+ L 2+
4+ Bounding 3+ Strong 2+ Weak
1+ Intermittent 0 None

ELIMINATION

Urine Appearance: Yellow/Clear
Stool Appearance: Soft, firm
☐ Diarrhea ☐ Constipation
☐ Bloody ☐ Colostomy
Urostomy

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 LABD Inserted to _____cm
☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: Pediatric Complete 0.6 @ 40
Amount/Schedule: 40 mL/hr
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: _____

MOBILITY

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

PSYCHOSOCIAL

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

IV ACCESS

Site: L Subclavian Port ☐ INT ☐ None
☐ Central Line
Type/Location L Subclavian Port
Appearance: ☑ No Redness/Swelling
☐ Red ☐ Swollen
☐ Patent ☐ Blood return
Dressing Intact: ☑ Yes ☐ No
Fluids: D5NS + 20 KCl @ 40 mL/hr

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: LLQ ABD
Mucous Membranes: Color Pink
☑ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☐ Numeric ☑ FLACC ☐ Faces
Location: _____
Type: _____
Pain Score:
0800 5 1200 ____ 1600 ____

WOUND/INCISION

☑ None
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

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