

PICU

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed					31	31	31	31	31	31	31		217
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid					5	5	5	5	5	5	5		35
IV Meds/Flush					1	1	1	1	1	1	1		7
Calculate Maintenance Fluid Requirement (Show Work)						Combined Total Intake for Pt (mL/hr)							
$1-6.1 \text{ kg} \times 100 = 610$ $24 \overline{)610}$ $= 25.42 \text{ mL/hr}$						$259 \div 7 = 37 \text{ mL/hr}$							
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper					0	58	0	didn't get					58
Stool								8					8
Emesis													
Other													
Calculate Minimum Acceptable Urine Output						Average Urine Output During Your Shift							
$6.1 \text{ mL/hr}$ $1 \text{ mL/kg/hr}$						$58/7$ $8.29 \text{ mL/hr}$							

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
Family Concern	1 pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>10</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

Student Name: Hannah Holland  
 Allergies: NEA

Unit: PICU  
 Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Pt. Initials: \_\_\_\_\_  
 Date: 2/11/25

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?	If not, why?			
chlorothiazide	diuretic	fluid retention	50mg IVP q12hrs	yes		dextrose 5% IV syringe (10mg/mL)	weakness cramps vomiting diarrhea	1. watch for skin rash w/ peeling skin 2. watch for bleeding or bruising 3. watch for problems breathing/ swallowing 4.
								1.
								2.
								3.
								4.
								1.
								2.
								3.
								4.

PICU

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input checked="" type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location <u>BLE</u> <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>2+</u> L <u>2+</u> Lower R <u>2+</u> L <u>2+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" 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 <b>Social/emotional bonding with family:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3 mm</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically <b>Grips:</b> Right <u>W</u> Left <u>W</u> <b>Pushes:</b> Right <u>N</u> Left <u>N</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>yellow/clear</u> <b>Stool Appearance:</b> <u>yellow/water</u> <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <u>arterial, central</u> <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input checked="" type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input checked="" type="checkbox"/> Right <input checked="" 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 type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input checked="" type="checkbox"/> BiPap/CPAP: <u>40%</u> <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size <u>3</u> Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>left foot</u> <b>Oxygen Saturation:</b> <u>98%</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>feeding</u> Location <u>left nostril</u> Location inserted to <u>8</u> cm <input checked="" type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" 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 <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown <b>Location/Description:</b> _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MOBILITY	NUTRITIONAL	PAIN
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<b>Diet/Formula:</b> <u>NPO, neosure</u> <b>Amount/Schedule:</b> <u>31 mL/hr</u> <b>Chewing/Swallowing difficulties:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Scale Used:</b> <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> LACC <input type="checkbox"/> Faces <b>Location:</b> <u>N/A</u> <b>Type:</b> <u>N/A</u> <b>Pain Score:</b> 0800 _____ 1200 <u>0</u> 1600 <u>0</u>
WOUND/INCISION	MUSCULOSKELETAL	TUBES/DRAINS
<input type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None <b>Type:</b> _____	<input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube <u>feeding</u> <b>Site:</b> <u>left nostril</u> <b>Type:</b> <u>Naso/oral</u> <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> <u>None</u> <b>Drainage color:</b> <u>None</u>

central double lumen subclavian vein, right also ↑↑ but left arterial - left femoral

mechanical vent

IM5 Clinical Worksheet – PICU

covid →

<b>Student Name:</b> Hannah Holland <b>Date:</b> 2/11/25	<b>Patient Age:</b> 4 mo <b>Patient Weight:</b> 6.1kg
<b>1. Admitting Diagnosis and Pathophysiology</b> (State the pathophysiology in own words) acute hypoxic resp. failure	<b>2. Priority Focused Assessment R/T Diagnosis:</b> Lung assessment
<b>3. Identify the most likely and worst possible complications.</b> most common: pneumonia →	<b>4. What interventions can prevent the listed complications from developing?</b> O <sub>2</sub> therapy, abx, mechanical ventilation,
worst: respiratory failure	HFNC, breathing tube, prone positioning
<b>5. What clinical data/assessments are needed to identify these complications early?</b> pulse ox, CXR, vitals (HR, RR, temp)	<b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b> abx, oxygen therapy, hydration, rest, incentive spirometry
ABG, watch color, pulse ox, retractions, nasal flare	O <sub>2</sub> therapy, mechanical ventilation, bronchodilator
<b>7. Pain &amp; Discomfort Management:</b> List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.  1. change position q 2hrs to prevent skin breakdown 2. pacifier for comfort	<b>8. Patient/Caregiver Teaching:</b> 1. prone positioning 2. secondhand smoke exposure 3. up to date on vaccines  <b>Any Safety Issues Identified:</b> I saw no safety issues!
<b>Please list any medications you administered or procedures you performed during your shift:</b> chlorothiazide 50 mg in dextrose 5% IV syringe (10mg/mL) q 12hrs	

~~acute hypoxic resp. failure w/ influenza pneumonia~~