IM5 Clinical Worksheet – PICU

Student Name:
Date: 2/19

Patient Age: 9 M
Patient Weight: 10.1 kg

1. **Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)**
Hypoxemia, RSV, Rhinovirus,

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

3. **Identify the most likely and worst possible complications.**
respiratory distress

4. **What interventions can prevent the listed complications from developing?**
adequate Oxygenation

5. **What clinical data/assessments are needed to identify these complications early?**
Vital Signs → O_2 Sat

6. **What nursing interventions will the nurse implement if the anticipated complication develops?**
longer PICU stay

7. **Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.**
1. ~~DD~~ Vital Signs increased or going up
2. fussing or inconsolability

8. **Patient/Caregiver Teaching:**
1. Hand washing
2. Infection prevention - w/ other kids
3. Infection management.

Any Safety Issues Identified:
NO

Please list any medications you administered or procedures you performed during your shift:
Ativan 2mg every 2 PRN

PICU

GENERAL APPEARANCE

Appearance: X Healthy/Well Nourished □ Neat/Clean □ Emaciated □ Unkept
Developmental age:
X Normal □ Delayed

CARDIOVASCULAR

Pulse: □ Regular □ Irregular □ Strong □ Weak □ Thready □ Murmur □ Other _____
Edema: □ Yes □ No Location _____ □ 1+ □ 2+ □ 3+ □ 4+
Capillary Refill: X < 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

PSYCHOSOCIAL

Social Status: X Calm/Relaxed □ Quiet □ Friendly □ Cooperative □ Crying □ Uncooperative □ Restless □ Withdrawn □ Hostile/Anxious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

NEUROLOGICAL

LOC: X Alert □ Confused □ Restless □ Sedated □ Unresponsive
Oriented to: mom !

IV ACCESS

MUSCULOSKELETAL

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

Dressing: _____

TUBES/DRAINS

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

MOBILITY

☐ Ambulatory ☒ Crawl ☐ In Arms
☒ Ambulatory with assist approp. for age
Assistive Device: ☐ Crutch ☐ Walker
☐ Brace ☐ Wheelchair ☐ Bedridden

PICU

INTAKE/OUTPUT

PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed									1 bottle 120mLs				
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													
Stool													
Emesis													
Other													

Calculate Maintenance Fluid Requirement (Show Work)

10.1 kg X 1 ≈ 10 mL

Combined Total Intake for Pt (mL/hr)

1,050 / 24 = 44 mL/HR fluid req. ☆

Calculate Minimum Acceptable Urine Output

Average Urine Output During Your Shift

MOM took S changed baby. S baby was being discharged

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) 0 green
	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

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	– Playing/sleeping appropriately OR – Alert, at patient's baseline	– Sleepy, somnolent when not disturbed	– Irritable, difficult to console OR – Increase in patient's baseline seizure activity	– Lethargic, confused, floppy OR – Reduced response to pain OR – Prolonged or frequent seizures OR – Pupils asymmetrical or sluggish
Cardiovascular	– Skin tone appropriate for patient – Capillary refill ≤ 2 seconds	– Pale OR – Capillary refill 3-4 seconds OR – Mild tachycardia OR – Intermittent ectopy or irregular HR (not new)	– Grey OR – Capillary refill 4-5 seconds OR – Moderate tachycardia	– Grey and mottled OR – Capillary refill > 5 seconds OR – Severe tachycardia OR – New onset bradycardia OR – New onset/increase in ectopy, irregular HR or heart block
Respiratory	– Within normal parameters – No retractions	– Mild tachypnea/ increased WOB (flaring, retracting) OR – Up to 40% supplemental oxygen OR – Up to 1L NC > patient's baseline need OR – Mild desaturations < patient's baseline OR – Intermittent apnea self-resolving	– Moderate tachypnea/ increased WOB (i.e. flaring, retracting, grunting, use of accessory muscles) OR – 40-60% oxygen via mask OR – 1-2 L NC > patient's baseline need OR – Nebs Q 1-2 hour OR – Moderate desaturations < patient's baseline OR – Apnea requiring repositioning or stimulation	– Severe tachypnea OR – RR < normal for age OR – Severe increased WOB (i.e. head bobbing, paradoxical breathing) OR – > 60% oxygen via mask OR – > 2 L NC more than patient's baseline need OR – Nebs Q 30 minutes – 1 hour OR – Severe desaturations < patient's baseline OR – Apnea requiring interventions other than repositioning or stimulation
Staff Concern		– Concerned		
Family Concern		– Concerned or absent		

Green = Score 0-2	Yellow = Score 3-4	Red = Score 5-11
– Continue Routine Assessments	– 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	– 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

A PEDIATRIC CODE CAN BE ACTIVATED AT ANYTIME BY ANYONE
Use SBAR communication

Reference: McLellan, M.C., et al., Validation of the Children's Hospital Early Warning System for Critical Deterioration Recognition, Journal of Pediatric Nursing (2016), http://dx.doi.org/10.1016/j.pedn.2016.10.005

□ Person □ Place □ Time/Event
X Appropriate for Age
Pupil Response: X Equal □ Unequal
X Reactive to Light □ Size 2mm
Fontanel: (Pt < 2 years) X Soft □ Flat
□ Bulging □ Sunken X Closed
Extremities:
X 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 X No Level _____
Seizure Precautions: □ Yes X No

□ pt. was an infant

Site: _____ □ INT X None
□ Central Line
Type/Location: _____
Appearance: □ No Redness/Swelling
□ Red □ Swollen
□ Patent □ Blood return
Dressing Intact: □ Yes □ No
Fluids: _____

ELIMINATION

Urine Appearance: yellow
Stool Appearance: last BM 2/10 NOT observed. Mom changes pt.
□ Diarrhea □ Constipation
□ Bloody □ Colostomy

GASTROINTESTINAL

Abdomen: X Soft □ Firm □ Flat
□ Distended □ Guarded
Bowel Sounds: X Present X 4 quads
X Active □ Hypo □ Hyper □ Absent
Nausea: □ Yes X No
Vomiting: □ Yes X No
Passing Flatus: □ Yes □ No UNK
Tube: □ Yes X No Type _____
Location _____ Inserted to _____cm
□ Suction Type: _____

SKIN

Color: □ Pink □ Flushed □ Jaundiced
□ Cyanotic □ Pale X Natural for Pt
Condition: X Warm □ Cool □ Dry
□ Diaphoretic

Turgor: X < 5 seconds □ > 5 seconds
Skin: X Intact □ Bruises □ Lacerations
□ Tears □ Rash □ Skin Breakdown
Location/Description: _____
Mucous Membranes: Color: PINK
X Moist □ Dry □ Ulceration

RESPIRATORY

Respirations: X Regular □ Irregular
□ Retractions (type) _____
□ Labored
Breath Sounds:
Clear □ Right X Left
Crackles X Right □ Left
Wheezes □ Right □ Left
Diminished □ Right □ Left
Absent □ Right □ Left
□ **Room Air** X **Oxygen**
Oxygen Delivery:
X Nasal Cannula: 4 L/min
□ BiPap/CPAP: _____
□ Vent: ETT size____@____cm
□ Other: _____
Trach: □ Yes X No
Size _____ Type _____
Obturator at Bedside □ Yes □ No
Cough: □ Yes X No
□ Productive □ Nonproductive
Secretions: Color_____
Consistency_____
Suction: □ Yes X No Type _____
Pulse Ox Site R foot
Oxygen Saturation: _____

pneumonia of R lung (upper)

→ mid shift, moved to RA, O_2 sats staying consist. 91, 92, 97, 98

not heard/observed!

PAIN

Scale Used: □ Numeric X FLACC □ Faces
Location: _____
Type: _____
Pain Score:
0800 0 1200 0 1600 0

NUTRITIONAL

Diet/Formula: _____
Amount/Schedule: _____
Chewing/Swallowing difficulties:
□ Yes X No

WOUND/INCISION

X None
Type: _____
Location: _____
Description: _____

Student Name: Trinity Culpepper Unit: PICU Pt. Initials: UKN Date: 2/19

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

Allergies: NKDA

NO IVF going!

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? / Is med in therapeutic range? / If not, why ?	IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Ativan Lorazepam	benzodiazepines	anti-anxiety	2 mLs every 2HRS PRN	.5/1mL	IVP, diluted with 2mLs of Sterile water	Respiratory depression	1. ↓↓ sedation, unresponsiveness 2. slowly ween off... consult dr. 3. ~~HR~~, low & slow 4. Overdosage—dizzy, loss of coord.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.