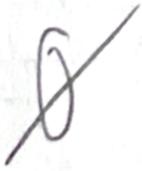


IM5 Clinical Worksheet – PICU #14

<p>Student Name: Kindal King Date: 4.30.25</p>	<p>Patient Age: 15 Patient Weight: <del>65.5</del> 63.5 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Excessive weight loss (ED)</p>	<p>2. Priority Focused Assessment R/T Diagnosis: Cardiovascular</p>
<p>3. Identify the most likely and worst possible complications. Likely: low electrolytes &amp; dehydration Worst: cardiovascular collapse or seizure from &amp; electrolytes</p>	<p>4. What interventions can prevent the listed complications from developing? Watching labs &amp; diet modification</p>
<p>5. What clinical data/assessments are needed to identify these complications early? Monitor labs</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Supplementation</p>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient. 1. Going on a walk around nurse's station 2. Legos / games</p>	<p>8. Patient/Caregiver Teaching: 1. Supervised meals 2. diet importance &amp; daily weights 3. supervised bathroom trips Any Safety Issues Identified:</p>
<p>Please list any medications you administered or procedures you performed during your shift: </p>	

PICU #14

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 checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input checked="" type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input checked="" type="checkbox"/> Other <u>brady cardiac</u> <b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <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 checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL		
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" 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 Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</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>ELIMINATION</b> <b>Urine Appearance:</b> <u>clear yellow</u> <b>Stool Appearance:</b> _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>IV ACCESS</b> <b>Site:</b> <u>Left AG</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <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> _____
	GASTROINTESTINAL	<b>SKIN</b> <b>Color:</b> <input 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 type="checkbox"/> Warm <input checked="" type="checkbox"/> Cool <input 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 Location/Description: _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
<b>RESPIRATORY</b>	<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 <input checked="" type="checkbox"/> <u>4</u> quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input checked="" 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location <u>X</u> Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>PAIN</b> <b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 - 1200 - 1600 <u>0</u>
<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 checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input 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 checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input 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 checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>L pointer finger</u> <b>Oxygen Saturation:</b> <u>99%</u>	<b>NUTRITIONAL</b> <b>Diet/Formula:</b> <u>general</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>WOUND/INCISION</b> <input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MUSCULOSKELETAL	<b>TUBES/DRAINS</b> <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____
	MOBILITY	
	<input checked="" 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	

PICU #14

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed						0	0	500ml	0	0			
Intake - PO Meds						0	0	0	0	0			
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						0	0	0	0	0			
IV Meds/Flush						10ml	0	0	0	0			
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)						
$10 \times 100 = 1,000$ $10 \times 50 = 500$ $43.5 \times 20 = 870$ $\rightarrow = 2,370 \text{ ml/day}$ $\downarrow$ $98.75 \text{ /hr}$							510 ml						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper						750	0	0	0	<del>1000</del>			~ 750
Stool						0	0	0	0	0			
Emesis						0	0	0	0	0			
Other						0	0	0	0	0			
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$.5 \times 63.5 \text{kg} = 31.75 \text{ mL/hr}$							~ 750 mL (estimate)						

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
<b>CHEWS Total Score</b>	
CHEWS Total Score	Total Score (points) <u>0</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