IM5 Clinical Worksheet – PICU

Student Name: Synthia Gomez **Date:** May 6, 2025	**Patient Age:** 9 years old **Patient Weight:** 26.4 **kg**
1. **Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)** **Meningitis**: is an infection and swelling of the fluid and membranes around the brain and spinal cord.	**2. Priority Focused Assessment R/T Diagnosis:** NEURO ASSESSMENT
3. **Identify the most likely and worst possible complications.** Most likely: Trouble with vision or Seizures Worst possible: Brain damage or Death	**4. What interventions can prevent the listed complications from developing?** VACCINES Washing hands and practicing good hygiene. Visit pediatrician for possible bacterial infections (Strep)
5. What clinical data/assessments are needed to identify these complications early? Confusion, vomiting, headache that does not go away, fever, decreased appetite	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** More frequent Neuro assessments, fluid management and electrolyte balance, low stimulation and low light room
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** **1.** Low stimulation in patient's room/ simple card games **2.** Naps/rest if not contraindicated	**8. Patient/Caregiver Teaching:** **1.** Wash hands frequently **2.** Report any headaches **3.** It may take weeks to months to fully recover from bacterial meningitis, slowly increase activity as tolerated **Any Safety Issues Identified: N/A**
Please list any medications you administered or procedures you performed during your shift: I did not administer medications during the afternoon.	

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 __**2mm**__
Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat
☐ Bulging ☐ Sunken ☐ Closed
Extremities:
☐ Able to move all extremities
☐ Symmetrically ☐ Asymmetrically
Grips: Right __**S**___ Left __**S**___
Pushes: Right __**S**___ Left __**S**___
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_____@_____cm
☐ Other: _____
Trach: ☐ Yes ☐ No
Size _____ Type _____
Obturator at Bedside ☐ Yes ☐ No
Cough: ☐ Yes ☐ No
☐ Productive ☐ Nonproductive
Secretions: Color_____
Consistency_____
Suction: ☐ Yes ☐ No Type _____
Pulse Ox Site _Right Big Toe_____
Oxygen Saturation: ___98 %_____

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

ELIMINATION

Urine Appearance: __Clear Yellow____
Stool Appearance: ___Soft brown____
☐ Diarrhea ☐ Constipation
☐ Bloody ☐ Colostomy

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 _____
Location _____ Inserted to _____cm
☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: ___Regular diet _____
Amount/Schedule: __TID_____
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: __Right arm____ ☐ INT ☐ None
☐ Central Line
Type/Location: **_Right PICC line____**
Appearance: ☐ No Redness/Swelling
☐ Red ☐ Swollen
☐ Patent ☐ Blood return
Dressing Intact: ☐ Yes ☐ No
Fluids: __INT 0.9% 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: _____
Pain Score:
0800_____ 1200__**0**__ 1600 __**0**__

WOUND/INCISION

☐ **None**
Type: _____
Location: _____
Description: _____
Dressing: _____

TUBES/DRAINS

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

PICU

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed						60				380			440
Intake – PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													

Calculate Maintenance Fluid Requirement (Show Work)	**Combined Total Intake for Pt (mL/hr)**
(26.4 kg) 10x100=1000 10x50= 500 6.4x20= 128 =1628/ 24 hours = 67.8mL	**440 mL**

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper							1						
Stool													
Emesis													
Other													

Calculate Minimum Acceptable Urine Output	**Average Urine Output During Your Shift**
26.4kg x 0.5= 13.2 mL/hr	Was not collecting urine output. Patient had 1 occurrence during 6 hours.

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**_____ 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