

IMS Clinical Worksheet - PICU

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<p>Student Name: Hanna Wells Date: 09/03/25</p>	<p>Patient Age: 12 Patient Weight: kg 119 kg</p>
<p>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Pt has DKA/HHS from type 2 diabetes 3. Identify the most likely and worst possible complications. DKA/HHS → Nonfunctional hypoglycemic episode</p>	<p>2. Priority Focused Assessment R/T Diagnosis: Neuro, VS, urinary</p>
<p>5. What clinical data/assessments are needed to identify these complications early? RR - kussmauls or no? Neuro - Hand grasp/responding? Skin - cool/clamy? Hot/sweaty? GU - Polyuria yes or no?</p>	<p>4. What interventions can prevent the listed complications from developing? * Take insulin when prescribed, if low sugars, then correct low sugars. good diet - low salt Exercise - 30 min 5x/week</p>
<p>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient. 1. Touch - helps redirect mind 2. calm/quiet words - doesn't scare the child extra A Fan! helps keep her cool!</p>	<p>6. What nursing interventions will the nurse implement if the anticipated complication develops? Giving fluids w/ Dextrose Giving insulin Neurochecks @ 4hr Insert Foley Check O2; Apply NC if needed</p>
<p>Please list any medications you administered or procedures you performed during your shift: None, All meds are given at night &amp; other meds are continuous Performed sugar checks, Foley checks, VS Q 1hr</p>	<p>8. Patient/Caregiver Teaching: 1. Take insulin when necessary (check sliding scale) 2. Eat good/balanced diet to help prevent DKA + maintain insulin 3. Call 911 if experiencing DKA/SIS → cool clamping Any Safety Issues Identified: Neuro issues, RR/HR ↑, fall/seizure precautions, restraints to prevent lines from being pulled out, infection</p>

Hanna Weber

PICU

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		INTAKE/OUTPUT																
		07	08	09	10	11	12	13	14	15	16	17	18	Total				
PO/Enteral Intake																		
PO Intake/Tube Feed Intake - PO Meds																		
IV INTAKE																		
IV Fluid																		
IV Meds/Flush																		
Calculate Maintenance Fluid Requirement (Show Work)																		
10 X 100 = 1000																		
10 X 50 = 500																		
99 X 20 = 1980																		
= 3480																		
3480 / 24 = 145 ml/hr																		
Combined Total Intake for Pt (ml/hr)		7 - 9.47 = 44.84 ml 660.97 Total fluids																
OUTPUT																		
Urine/Diaper																		
Stool																		
Emesis																		
Other																		
Calculate Minimum Acceptable Urine Output																		
0.5 X 119 = 59.5 ml/hr																		
Average Urine Output During Your Shift		142 ml/hr																

NO

found total on EPIC  
NO NUDS

119 kg

Children's Hospital Early Warning Score (CHEWS)

(See CHEWS Scoring and Escalation Algorithm to score each category)

Circle the appropriate score for this category:

Behavior/Neuro: 0 (1) 2 3

Cardiovascular: 0 (1) 2 3

Respiratory: 0 (1) 2 3

Staff Concern: 0 (1) 2 3

Family Concern: 0 (1) 2 3

CHEWS Total Score: 3 CHEWS

CHEWS Total Score

Total Score (points):  
 Score 0-2 (Green) - Continue routine assessments  
 Score 3-4 (Yellow) - Notify charge nurse or LPJ. 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.

11/19/99

Hanna  
MWB

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PICU

<p><b>GENERAL APPEARANCE</b> *</p> <p>Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished  <input type="checkbox"/> Heat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept  Developmental age: <input type="checkbox"/> Normal <input type="checkbox"/> Delayed</p>	<p><b>CARDIOVASCULAR</b> *</p> <p>Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready  Murmur <input type="checkbox"/> Other _____  Edema: <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+  Capillary Refill: <input type="checkbox"/> &lt; 2 sec <input checked="" type="checkbox"/> &gt; 2 sec  Pulses: _____  Upper R <u>3+</u> L <u>3+</u>  Lower R <u>3+</u> L <u>3+</u>  4+ Bounding 3+ Strong 2+ Weak  1+ Incontinent 0 None</p>	<p><b>PSYCHOSOCIAL</b> *</p> <p>Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet  <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying  <input checked="" type="checkbox"/> Uncooperative <input type="checkbox"/> Restless  <input checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious  Social/emotional bonding with family:  <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent</p>
<p><b>NEUROLOGICAL</b></p> <p>LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input checked="" type="checkbox"/> Restless  <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Unresponsive</p> <p>Oriented to: _____  Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event  Appropriate for Age <input type="checkbox"/> Unequal  Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal  Reactive to Light: <input checked="" type="checkbox"/> Size <u>4</u>  Fontanel: (Pt &lt; 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat  <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed</p> <p>Extremities:  <input checked="" type="checkbox"/> Able to move all extremities  <input checked="" type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically  Grips: Right <u>N</u> Left <u>N</u>  Pushes: Right <u>N</u> Left <u>N</u>  S=Strong W=Weak N=Normal  EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____  Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>ELIMINATION</b> *</p> <p>Urine Appearance: <u>CLAY</u> <u>YELLOW</u>  Stool Appearance: <u>NORMAL</u>  <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><b>IV ACCESS</b> *</p> <p>Site: <u>UMBILICAL</u> <input type="checkbox"/> INT <input type="checkbox"/> None  Central Line _____  Type/Location: <u>RIGHT UMBILICAL</u>  Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/>  <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Firm  Patent <input checked="" type="checkbox"/> Blood return <input type="checkbox"/> No  Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  Fluids: <u>D&amp;W</u> <u>100</u> <u>100</u> <u>100</u></p>
<p><b>RESPIRATORY</b> *</p> <p>Respirations: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular  <input type="checkbox"/> Retractions (type) <u>None</u>  <input type="checkbox"/> Labored <u>None</u>  Breath Sounds:  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  Room Air <input type="checkbox"/> Oxygen _____  Oxygen Delivery:  <input checked="" type="checkbox"/> Nasal Cannula: <u>1</u> L/min  <input type="checkbox"/> BiPAP/CPAP: _____ @ _____ cm  <input type="checkbox"/> Vent: ETT site: _____ @ _____ cm  <input type="checkbox"/> Other: _____</p>	<p><b>GASTROINTESTINAL</b> *</p> <p>Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat  <input type="checkbox"/> Distended <input type="checkbox"/> Guarded  Bowel Sounds: <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent  <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent  Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Passing Flatus: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  Tubes: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ inserted to _____ cm  <input type="checkbox"/> Suction Type _____</p>	<p><b>SKIN</b> *</p> <p>Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced  <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt  Conditions: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry  <input type="checkbox"/> Diaphoretic  Turgor: <input checked="" type="checkbox"/> &lt; 5 seconds <input type="checkbox"/> &gt; 5 seconds  Skin: <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: _____  Mucous Membranes: Color: _____  <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
<p><b>MUSCULOSKELETAL</b> *</p> <p>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  Movement:  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All  Brace/Applicances: <input checked="" type="checkbox"/> None  Type: _____  <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms  <input type="checkbox"/> Ambulatory with assist <input type="checkbox"/> Walker  <input type="checkbox"/> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker  <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p><b>NUTRITIONAL</b> *</p> <p>Diet/Formula: <u>NPO</u>  Amount/Schedule: <u>NPO</u>  Chewing/Swallowing difficulties:  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>WOUND/INCISION</b> *</p> <p>Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> PAINC <input type="checkbox"/> Faces  Location: <u>None</u>  Type: <u>None</u>  Pain Score: _____  0800 <u>0</u> 1700 _____ 1600 _____</p>
<p><b>TUBES/DRAINS</b> *</p> <p><input type="checkbox"/> None  <input checked="" type="checkbox"/> Drain Tube  Site: <u>UMBILICAL</u>  Type: <u>UMBILICAL</u>  Dressing: _____  Drainage amount: _____  Drainage color: <u>yellow</u> <u>white</u> <u>clear</u></p>	<p><b>MUSCULOSKELETAL</b> *</p> <p>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  Movement:  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All  Brace/Applicances: <input checked="" type="checkbox"/> None  Type: _____  <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms  <input type="checkbox"/> Ambulatory with assist <input type="checkbox"/> Walker  <input type="checkbox"/> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker  <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p><b>WOUND/INCISION</b> *</p> <p>Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> PAINC <input type="checkbox"/> Faces  Location: <u>None</u>  Type: <u>None</u>  Pain Score: _____  0800 <u>0</u> 1700 _____ 1600 _____</p>
<p><b>SECRETIONS</b></p> <p>Consistency: _____  Color: _____  Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>EMILIX</u>  Pulse On Site <u>1</u> <u>UMBILICAL</u> <u>EMILIX</u>  Oxygen Saturation: <u>91</u></p>	<p><b>MUSCULOSKELETAL</b> *</p> <p>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  Movement:  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All  Brace/Applicances: <input checked="" type="checkbox"/> None  Type: _____  <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms  <input type="checkbox"/> Ambulatory with assist <input type="checkbox"/> Walker  <input type="checkbox"/> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker  <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p>	<p><b>WOUND/INCISION</b> *</p> <p>Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> PAINC <input type="checkbox"/> Faces  Location: <u>None</u>  Type: <u>None</u>  Pain Score: _____  0800 <u>0</u> 1700 _____ 1600 _____</p>

Last BS: 291

9/12/99 = 1892  
1298

D.O.B. 01/14/25      08/8  
 Gestational Age 24      Adjusted Gestational Age 29.5  
 Birthweight      lbs.      oz. / 10 grams  
 \* Current weight      lbs.      oz. /      grams

NICU Disease  
 Process Map  
 Disease Name: Perforated Bowel  
NECs

What is happening in the body?  
Perforated Bowel. A hole in the wall of the digestive tract

How will you know your patient is improving?  
Pt will have a soft, non-discolored abdomen on assessment increased ostomy function, X-rays will show improvement

What are risk factors for the diagnosis?  
Necrotizing Enterocolitis (NECs)  
 Premature Birth (low birth wt (not fully formed) (No good gut health)  
 ↓ immune system

What trends and findings are expected?  
Abdominal distension, tenderness, palpable mass  
 ↓ feeding, blood in stool, lethargy, changes in HR & RR (apnea)  
 bile in stomach (discoloration to abd.)

What patient teaching for management and/or prevention can the nurse do?  
Probiotics & Standardized feeding  
 Slow feeding progression  
 Use breastmilk rather than formula  
 Early assessment/interventions  
 Advocate for pt

What medications and nursing interventions/treatments will you anticipate?  
X-RAYS, Abx, ostomy care/surgery when baby is older,  
 blood draws (CBC / labs & Probiotics, IV nutrition