

IM5 Clinical Worksheet – PICU

Student Name: Alina Elizarraraz Date: 9/17/26	Patient Age: 2 yr Patient Weight: 20.6 kg
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Leukemia (ALL): this is a cancer that begins in the bone marrow. It is extremely fast growing and your body begins producing large amounts of lymphoblastic.	2. Priority Focused Assessment R/T Diagnosis: Bleeding & Bruising: nose bleeds, petechiae, bleeding gums, abnormal bruising, etc...
3. Identify the most likely and worst possible complications. Anemia: WBC overwhelm our healthy cells and can decrease RBC Thrombocytopenia: WBC overwhelm our healthy cells and can decrease platelets Infections: WBC will decrease and the immune system will become weak.	4. What interventions can prevent the listed complications from developing? Blood transfusions, medications, infection control, lifestyle precautions, vaccinations, monitoring, & screening
5. What clinical data/assessments are needed to identify these complications early? CBC, fever, hepatosplenomegaly, pallor, bruising, petechiae, blood cultures	6. What nursing interventions will the nurse implement if the anticipated complication develops? Rest, O2, nutrition, blood products, bleeding precaution, administer platelets medications, Abx.,
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Distraction & play: we can use transitional objects, iPad, dinosaurs, music anything to relieve pain & discomfort 2. Massage & heat/cold therapy: this can trick your brain to help relieve that pain	8. Patient/Caregiver Teaching: 1. HH: wash hands frequently especially caring for the patient 2. Encourage small frequent meals: This can allow for patient to receive more nutrients in their food 3. Reduce fall risks: allow for home modifications, Allow things used on a daily basis easily accessible Any Safety Issues Identified: Risk for bleeding & infection
Please list any medications you administered or procedures you performed during your shift: <p style="text-align: center;">I did not physically give anything myself, but I did observe my nurse give 25% Albumin, Maxipime, Decadron, Zofran, & a continuous infusion of 1/2 NS 50 mEq Na Acetate with 20 mEq Na Bicarbonate</p>	

PICU

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/ Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input checked="" type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input type="checkbox"/> <2 sec <input type="checkbox"/> >2 sec Pulses: Upper R <u>3+</u> L <u>3+</u> Lower R <u>2+</u> L <u>2+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input type="checkbox"/> Calm/ Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying <input checked="" type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input checked="" type="checkbox"/> Hostile/ Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL		
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input checked="" type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input type="checkbox"/> Time/ Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3mm</u> Fontanel: (Pt <2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <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 EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	ELIMINATION Urine Appearance: <u>amber, clear</u> Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	IV ACCESS Site: _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>(R) femoral</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>1L NS 50meq NA acetate with 20meq NA bicarb.</u>
RESPIRATORY		
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored 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 <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: <u>Blow by O2</u> Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>none</u> Consistency <u>none</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site: <u>(L) toe</u> Oxygen Saturation: <u>99</u>	GASTROINTESTINAL Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____ NUTRITIONAL Diet/Formula: <u>Renal Diet</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	SKIN Color: <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 Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> <5 seconds <input type="checkbox"/> >5 seconds Skin: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input checked="" 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
MUSCULOSKELETAL		
	MUSCULOSKELETAL <input checked="" type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input checked="" type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input 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 checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____ MOBILITY <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Bedridden	PAIN Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 <u>1</u> 1200 <u>0</u> 1600 _____ WOUND/INCISION <input type="checkbox"/> None Type: <u>Hemodialysis Cath.</u> Location: <u>(R) internal jugular</u> Description: _____ Dressing: <u>Clean, dres, intact</u> TUBES/DRAINS <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Surgical closure
 LUB, lower thoracic
 @ iliac crest
 Clean, dres, intact

20

Seated during my Time

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/ Tube Feed													
Intake - PO Meds													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	60	60	60	60	60								300
IV Meds/ Flush	25		25	200									250
Calculate Maintenance Fluid Requirement (Show Work)							Combined Total Intake for Pt (mL/hr)						
$10(100) = 1000$ $10(50) = 500$ $0.6(20) = 12$ 1512							$300 + 250 = 550$ for 4hr. 137.5 mL/hr						
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper	10												
Stool													
Emesis		4											
Other													
Calculate Minimum Acceptable Urine Output							Average Urine Output During Your Shift						
$1(20.6) = 20.6$ mL/hr.							10 mL/4hr						

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 <u>2</u> 3
Cardiovascular	Circle the appropriate score for this category: <u>0</u> 1 2 3
Respiratory	Circle the appropriate score for this category: 0 <u>1</u> 2 3
Staff Concern	<u>1</u> pt - Concerned
Family Concern	<u>1</u> pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>5</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

CHEWS Scoring and Escalation Algorithm

	0	1	2	3
Behavior/Neuro	<ul style="list-style-type: none"> - Playing/sleeping appropriately OR - Alert, at patient's baseline 	<ul style="list-style-type: none"> - Sleepy, somnolent when not disturbed 	<ul style="list-style-type: none"> - Irritable, difficult to console OR - Increase in patient's baseline seizure activity 	<ul style="list-style-type: none"> - Lethargic, confused, floppy OR - Reduced response to pain OR - Prolonged or frequent seizures OR - Pupils asymmetrical or sluggish
Cardiovascular	<ul style="list-style-type: none"> - Skin tone appropriate for patient - Capillary refill \leq 2 seconds 	<ul style="list-style-type: none"> - Pale OR - Capillary refill 3-4 seconds OR - Mild tachycardia OR - Intermittent ectopy or irregular HR (not new) 	<ul style="list-style-type: none"> - Grey OR - Capillary refill 4-5 seconds OR - Moderate tachycardia 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Within normal parameters - No retractions 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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
<ul style="list-style-type: none"> - Continue Routine Assessments 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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>