IM5 Clinical Worksheet – PICU

Student Name: Allyson Jordan **Date:** 9/16/25	**Patient Age:** 11 yrs **Patient Weight:** 49.2kg
1. **Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)** Closed head injury	2. ***Priority Focused Assessment R/T Diagnosis:*** neuro respiratory
3. **Identify the most likely and worst possible complications.** most likely - brain bleeding, swelling worst possible - permanent brain damage, death	4. ***What interventions can prevent the listed complications from developing?*** monitoring ICP, placement of EVD
5. What clinical data/assessments are needed to identify these complications early? ICPs Pupillary response (PERRLA)	**6. What nursing interventions will the nurse implement if the anticipated complication develops?** monitor ICPs, report to physician if ICP >8
7. Pain & Discomfort Management: **List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.** 1. parental presence 2. ↑ CHI	**8. Patient/Caregiver Teaching:** 1. understanding of condition & knowing it is a process 2. keep talking to patient 3. monitor for signs of distress/pain **Any Safety Issues Identified:** importance of being careful around ETT
Please list any medications you administered or procedures you performed during your shift: N/A	

Allyson Jordan PICU 9/16/25

GENERAL APPEARANCE

Appearance: ☐ Healthy/Well Nourished ☒ Neat/Clean ☐ Emaciated ☐ Unkept

Developmental age: ☐ Normal ☐ Delayed

CHI

NEUROLOGICAL

LOC: ☐ Alert ☐ Confused ☐ Restless ☐ Sedated ☐ Unresponsive

Oriented to: ☐ Person ☐ Place ☐ Time/Event ☐ Appropriate for Age

Pupil Response: ☒ Equal ☐ Unequal ☐ Reactive to Light ☐ Size 4mm

CHI

Fontanel: (Pt < 2 years) ☐ Soft ☐ Flat ☐ Bulging ☐ Sunken ☐ Closed

Extremities: ☐ Able to move all extremities ☐ Symmetrically ☐ Asymmetrically

Grips: Right _____ Left _____

Pushes: Right _____ Left _____

S=Strong W=Weak N=None

EVD Drain: ☒ Yes ☐ No Level clamped

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 6 @ 20 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 (R) Toe

Oxygen Saturation: 99%

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: yellow

Stool Appearance: N/A

☐ 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 NG

Location _____ Inserted to _____cm

☐ Suction Type: _____

NUTRITIONAL

Diet/Formula: Pediasure Peptide

Amount/Schedule: _____

Chewing/Swallowing difficulties: ☒ Yes ☐ No

MUSCULOSKELETAL

☐ Pain ☐ Joint Stiffness ☐ Swelling ☐ Contracted ☐ Weakness ☐ Cramping ☐ Spasms ☐ Tremors

Movement:

CHI

☐ RA ☐ LA ☐ RL ☐ LL ☐ All

Brace/Appliances: ☐ None

Type: _____

MOBILITY

☐ Ambulatory ☐ Crawl ☐ In Arms

CHI

☐ 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

CHI

IV ACCESS

Site: (L) Arm 20G ☐ INT ☐ None

☒ Central Line

Type/Location: PICC (R) Medial Triple Lumen

Appearance: ☒ No Redness/Swelling ☐ Red ☐ Swollen ☐ Patent ☐ Blood return

Dressing Intact: ☒ Yes ☐ No

Fluids: D5 NS + KCl 20

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: incision on Head

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: Pressure Injury

Location: Chin

Description: _____

Dressing: open to air

TUBES/DRAINS

☐ None

☒ **Drain/Tube**

Site: Brain

Type: EVD

Dressing: open to air

Suction: _____

Drainage amount: _____

Drainage color: clamped

Allyson Jordan

PICU

9/16/25

INTAKE/OUTPUT

PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed						[illegible]	[illegible]						
Intake – PO Meds													

IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						80mL	80mL	80mL	80mL	80mL			400mL
IV Meds/Flush						5mL	10mL						15mL

Calculate Maintenance Fluid Requirement (Show Work)

10 x 100 = 1,000
10 x 50 = 500
29.2 x 20 = 584
2,084mL/24hr

96.8mL/hr

Combined Total Intake for Pt (mL/hr)

415mL

69.2mL/hr

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper								275mL					275mL
Stool													
Emesis										75mL			75mL
Other													

Calculate Minimum Acceptable Urine Output

0.5mL/kg/hr

24.6mL/hr

Average Urine Output During Your Shift

275mL

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) 6
	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