

IM5 Clinical Worksheet – PICU

FBD  
maybe UC  
flare

Student Name: <u>Miranda Millman</u> Date: <u>9/24/25</u>	Patient Age: <u>14yo F</u> Patient Weight: <u>100kg 48kg - 105lb 130z</u>
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) A TON of air Toxic Megacolon: trapped in colon	2. Priority Focused Assessment R/T Diagnosis: Abdominal (causing inflammation/infection)
3. Identify the most likely and worst possible complications. <ul style="list-style-type: none"> <li>Abdominal Pain</li> <li>Bowel Obstruction or Sepsis</li> </ul>	4. What interventions can prevent the listed complications from developing? <ul style="list-style-type: none"> <li>Notifying severe pain ASAP.</li> <li>Clearing the infection</li> </ul>
5. What clinical data/assessments are needed to identify these complications early? <ul style="list-style-type: none"> <li>Identify pain in depth / Bowel sounds</li> </ul>	6. What nursing interventions will the nurse implement if the anticipated complication develops? <ul style="list-style-type: none"> <li>Pain meds</li> <li>IV fluids</li> <li>NGT</li> </ul>
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. <ol style="list-style-type: none"> <li>Video Games / TV</li> <li>Coloring Books / Puzzles</li> </ol>	8. Patient/Caregiver Teaching: <ol style="list-style-type: none"> <li>Take all cxy as prescribed to clear infection.</li> <li>Stay on top of pain.</li> <li>If pain intensifies, notify HCP ASAP!</li> </ol> Any Safety Issues Identified: - Not using the restroom bc abdominal pain
Please list any medications you administered or procedures you performed during your shift: morphine (not this pt) <del>oxycodone</del> - this pt metronidazole in saline D/C IV-INT	

Krebs Cycle - Hydrogen gas (neg charge ion) = body is acidic (metabolic)  
 ↳ DKA mimimum Blood gas CO2  
 7.35-7.45 7.35-7.45  
 Bicarb 12-18  
 Oxygen 80-100  
 Kussmaul tachypnea lungs are buffer  
 Ninja Nord.  
 Kussmaul Ph Bicarb

Water/ATP / Hydroxyen / Acetylase

Student Name: Miranda Millman

Unit: PICU

Pt. Initials: BL

Date: 9/24/25

Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKDA

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		IVP – List solution to dilute and rate to push.  IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?				
				If not, why?				
Morphine	Opioid Analgesic	Pain	2mg/2ml IVP PRN	0.05mg/kg - 0.2mg/kg	Yes	IVP - pushed 1ml/5min	Resp Dep. Hypotn Constipation	1. Assess HR, RR, BP, Pain b4 give. 2. May cause drowsy/dizzy 3. Advise parents on S/S of abuse/withdrawl. 4. Alert HCP if pain worsens!
<del>metronidazole</del> metronidazole	Anti-infective	preop Prophylactic for pt w/ Colorectal Surgery	<del>500mg</del> 500mg/100ml IVPB q8hr	30mg/kg/day		IVPB 500mg/100ml 1hr	dizzy HA Asept emngits Abdom pain	1. may cause dizzy/lighthead 2. Alert HCP if having foul smell stools. 3. Take med as directed even if feeling better to avoid super infect. 4. Notify HCP ASAP if rash forms.
								1. 2. 3. 4.
								1. 2. 3. 4.
								1. 2. 3. 4.

PICU

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <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 _____ <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>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input checked="" type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input checked="" type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<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 type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input 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>Urine Appearance:</b> <u>not seen</u> <b>Stool Appearance:</b> _____ <input checked="" type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <input checked="" type="checkbox"/> PIVT <input type="checkbox"/> FOLW <input 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 type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
RESPIRATORY	GASTROINTESTINAL	SKIN
<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> _____ <b>Oxygen Saturation:</b> _____	<b>Abdomen:</b> <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input checked="" type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Vomiting:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" 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 checked="" type="checkbox"/> Warm <input 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: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
MOBILITY	NUTRITIONAL	PAIN
<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	<b>Diet/Formula:</b> <u>liquid</u> <b>Amount/Schedule:</b> <u>BRN</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>abdomen</u> <b>Type:</b> <u>ache, cramp, squeeze</u> <b>Pain Score:</b> 0800 _____ 1200 <u>5</u> 1600 _____
WOUND/INCISION	MUSCULOSKELETAL	TUBES/DRAINS
<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None <b>Type:</b> _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

PICU

INTAKE/OUTPUT													
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed						150							150
Intake – PO Meds						<del>100</del>							
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid						88	88	88	88	88	88		528
IV Meds/Flush						100							100
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Combined Total Intake for Pt (mL/hr)</b>						
<p>10 x 100 10 x 50 28 x 20</p> $\frac{1000 + 500 + 560}{2060} = 24 = 89.8 \approx 86 \text{ mL/hr}$													
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													
Stool											1x		1x
Emesis							1x		1x				2x
Other													
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>						
<p>48kg <math>24 \text{ /hr} = 576 \text{ mL/day}</math></p> <p>0.5 mL/kg/hr</p>													

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