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 3
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 R hand
Oxygen Saturation: 96

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 2+ L 2+
Lower R 2+ L 2+
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: 1.5 Shake
Amount/Schedule: 55ml/hr
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☑ Withdrawn ☐ Hostile/Anxious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: L Wrist ☑ INT ☐ None
☐ Central Line
Type/Location: ____
Appearance: ☑ No Redness/Swelling
☐ Red ☐ Swollen
☐ Patent ☐ Blood return
Dressing Intact: ☑ Yes ☐ No
Fluids: ____

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: ____
☑ Moist ☐ Dry ☐ Ulceration

PAIN

Scale Used: ☑ Numeric ☐ FLACC ☐ Faces
Location: ____
Type: ____
Pain Score:
0800 ____ 1200 ____ 1600 ____

WOUND/INCISION

☑ None
Type: ____
Location: ____
Description: ____
Dressing: ____

TUBES/DRAINS

☑ None
☐ Drain/Tube
Site: ____
Type: ____
Dressing: ____
Suction: ____
Drainage amount: ____
Drainage color: ____

IM5 Clinical Worksheet – PICU

Student Name: Jyssian Escandon Date: 11/5/2025	Patient Age: ~~FF~~ 17 Patient Weight: ~~[illegible]~~ kg ~~54.9~~ 40.4
1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words) Chest pain, bradycardia ~~overdose, tylenol + aspirin~~ 2 eating disorder	2. Priority Focused Assessment R/T Diagnosis: nutrition, bradycardia
3. Identify the most likely and worst possible complications. malnutrition, bradycardia	4. What interventions can prevent the listed complications from developing? increase nutrition & fluid intake via NG
5. What clinical data/assessments are needed to identify these complications early? labs & cardiac monitoring electrolytes	6. What nursing interventions will the nurse implement if the anticipated complication develops? for labs ↑ nutrition and fluids to increase HR
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Relaxation techniques (coloring, journaling) 2. distraction or expressive art, listening to music	8. Patient/Caregiver Teaching: 1. nutritional needs 2. mental health 3. talking & expressing feelings. Any Safety Issues Identified: making sure pt is eating and not trying to actively lose wt.

Please list any medications you administered or procedures you performed during your shift:

i did not personally give medications, my nurse gave them.

PICU

INTAKE/OUTPUT

PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed								[illegible]	20	[illegible]			70
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)

10×100 = 1000
10×50 = 500 = 1900
20×20 = 400

79.17 ml/hr

Combined Total Intake for Pt (mL/hr)

240 ml
70 NG + 80 H_2O
~~78 ml~~ 310

OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper								210		600			810
Stool													
Emesis													
Other													

Calculate Minimum Acceptable Urine Output

.5×40.4 = 20.2 ml/hr

Average Urine Output During Your Shift

810 ml

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