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PLACE LABEL HERE.
JUNE 2010 FORM NO. 050560
 IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PICU SYSTEMS ASSESSMENT

RN assessments occur every 12 hours or more frequently determined by patient acuity.

Date: _____ Time: _____ Type of Assessment: Standard New Admission Post Operative Transfer

Check boxes that apply. Circle items that apply. Add comments prn.

NEUROLOGICAL: Alert Arousable Drowsy Lethargic Sedated Comatose Paralyzed
 Oriented: Person Place Date Disoriented: Occ Freq Constantly At baseline
 Behavior / Affect: Appropriate Flat Agitated Anxious Able to communicate needs: Yes No
 Swallow: Intact Impaired Pupils: 2 3 4 5 6 7 8 Equal Unequal Brisk Sluggish
 Non reactive Focus Track Follow
 Fontanels: Anterior: Open Closed Flat Sunken Full Bulging Overriding
 Posterior: Open Closed Flat Sunken Full Bulging Overriding
 Reflexes: Babinski Palmar Plantar Rooting Suck Moro Protective: Cough Gag Blink
 Motor: Spontaneous movement of all extremities Purposeful to pain No movement Jittery/tremorous
 Posturing: Decerebrate Decerebrate Tone: Normal Flaccid Hyper Rigid
 ICP Ventriculostomy: Pressures: _____ External drain @ _____ cm above the ear Cervical Collar
 Comments:

PAIN ASSESSMENT: Is the patient currently having pain? No, pain not an issue No, patient reports pain management effective Yes

Pain Scale Used: UVA Pain Scale (Standard) Faces FLACC Other: _____

ASSUME PAIN PRESENT (APP) for behaviors noted and there is reason to suspect pain in a nonverbal patient.

For nonverbal patients, describe pain behaviors: _____
 Pain rating: _____ Location/radiation of pain: _____
 Duration: Chronic Acute Constant Intermittent Other: _____
 Character: Stabbing Burning Sharp Dull Ache Shooting Grabbing Other: _____
 Is patient satisfied with level of comfort? Yes No Is Patient able to perform expected functional activity? Yes No
Pain Management Plan: Scheduled Analgesia PRN Analgesia Non-pharmacologic Analgesia Regional PCA
 Epidural/Spinal Block Other: _____
 Comments:

RESPIRATORY: Spont.respirations: Regular Irregular None Unlabored Labored Retractions Grunting Nasal Flaring
 Symmetrical Asymmetrical IS use: Volume _____ Bubbles Other:
 Oxygen Required: Yes No Nasal Cannula Vapotherm Face Tent Venti-mask Non-rebreather Trach Collar
 CPAP Ventilator Bag/mask/suction @ bedside ETT size _____ / _____ cm @ _____ Trach tube size: _____
 Stoma: Intact Pink Red Excoriated Cuff: Inflated Deflated N/A Extra trach @ bedside
 Pleural CT: Right: set @ _____ cm suction or Water seal Left: set @ _____ cm sx or Water seal Drainage: None Serous Serosanguinous
 Chylous Blood
 Breath Sounds: Right Clear Base Decreased Rales Rhonchi Wheezes Left Clear Bases Decreased Rales Rhonchi Wheezes
 Sputum/suction: None Small Mod Large Describe: _____
 Comments:

CARDIOVASCULAR: Monitor alarm limits on and verified
 Monitored: NSR Sinus-brady Sinus-tach SVT JET A-fib A-flutter Paced
 Heart tones: S1/S2/S3/S4: Clear Muffled Distant Rub Murmur Click
 Open chest Medistinal Chest tube set @ _____ cm sx Strip & Seal Drainage: None Serous Serosanguinous Chylous
 Pacing Wires: Epicardial Transvenous A-wires V-wires Disconnected Attached to pacer If paced: Mode: _____ Rate _____ MA _____
 Pulses: Radial R _____ L _____ Brachial R _____ L _____ DP R _____ L _____ PT R _____ L _____ Cap Refill Time: RUE _____ sec LUE _____ sec RLE _____ sec LLE _____ sec
 Edema: None Face Neck Extremities General Liver palpated @ _____ cm Below right costal margin Unable to palpate
 Deferred CVP _____ On ECMO/Perfusion
 Comments:

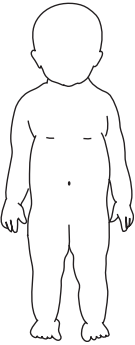
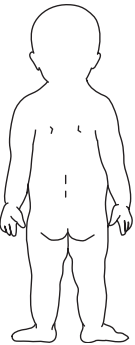
MUSCULOSKELETAL / MOBILITY: N/A Infant
 Gait: Steady Ataxic Type of Assistive Device: _____
 Movement: Rolls Sits up Crawl Cruise Walks Unable Rom: Full Limited
 Transfers: Independent Standby Assist Mod assist Max Assist Bed mobility: Independent Mod assist Max assist
 Diligent Equipment in Use: Yes No Type: Encore Tempo Maxi Slides Transfer Tube Tenor
 Cast - location: _____ Splints - location: _____
 Comments:

GASTROINTESTINAL:
 Abdomen: Soft Firm NonDistended Distended Bowel Sounds: Active Hypoactive None Flatus: Yes No
 Nutrition: PO Diet NPO Tube Feeding TPN Stool: Continent Incontinent Last BM: _____
 NG/Salem Sump/Size: Feeding tube/Dubhoff/Size _____ PEG/J
 Patent Non-Patent Clamped Suction Gravity Sumping
 Drainage: Clear Green Brown Bloody
 Stoma: Ileostomy Colostomy Location: _____ Pink Maroon Dusky Appliance Intact: Yes No
 Comments:

GENITOURINARY: Diapered Walks to bathroom BSC Bed pan foley Size: _____ fr Reason: _____ Date inserted: _____
 Nephrostomy tube Supra-pubic I&O cath Vesicostomy Anuric
 Urine: Yellow Amber Bloody Clear Cloudy Diuretic Therapy _____
 Dialysis: Peritoneal (home choice) Peritoneal (manual) CVVH Hemodialysis by renal unit
 Comments:

INTEGUMENTARY: Warm Cool Normal Dry Moist Skin Color: Normal Pale Jaundiced Cyanotic Reddened Mottled
 Breakdown: describe _____

Right ANTERIOR Left Left POSTERIOR Right

#1. _____ #2. _____ #3. _____ #4. _____ #5. _____ #6. _____ #7. _____ #8. _____ #9. _____ #10. _____			#1. _____ #2. _____ #3. _____ #4. _____ #5. _____ #6. _____ #7. _____ #8. _____ #9. _____ #10. _____
CVL: Insertion date: _____ Date last dressing changed: _____ Dsg: <input type="checkbox"/> clean, dry & intact <input type="checkbox"/> Biopatch <input type="checkbox"/> will be changed today PIV: <input type="checkbox"/> dsg intact <input type="checkbox"/> zero redness or swelling at site			

Pediatric Braden Q Scale for Prediction Pressure Sore Risk: (Complete with each assessment)

Circle the number in each category; total at bottom

SENSORY PERCEPTION	4. No Impairment	3. Slightly Limited	2. Very Limited	1. Completely Limited
MOISTURE	4. Rarely Moist	3. Occasionally Moist	2. Very Moist	1. Constantly Moist
ACTIVITY	4. Too young to walk frequently	3. Walks Occasionally	2. Chairfast	1. Bedfast
MOBILITY	4. No Limitations	3. Slightly Limited	2. Very Limited	1. Completely Immobile
NUTRITION	4. Excellent	3. Adequate	2. Probably Inadequate	1. Very Poor
FRICTION AND SHEAR	4. No Apparent Problem	3. Potential Problem	2. Problem	1. Significant
TISSUE PERFUSION & OXYGENATION	4. Excellent	3. Adequate	2. Compromised	1. Very Compromised

SCORE: _____ < 16 = Skin Breakdown Risk (Select Intervention Below Based on Score)

Interventions: Incontinence skin cleansing/protection Scheduled turning Provide pressure relief Facilitate mobility Reduce friction/shear
 Interventions according to the Pressure Ulcer Prevention Algorithm (doorside Chart)

PSYCHOSOCIAL: Concerns expressed regarding sexuality, culture, religious beliefs or ethnicity: Yes No

Patient/parents express coping: Yes No Support Needs Identified: Emotional Support Family Support Other

Family active in care: Yes No if yes, Who?

Suicide precautions in place

Suicide Assessment: "You have been placed on suicide precautions. Do you feel like hurting yourself now?" Yes No

Suicide interventions: 1:1 observation maintained Constant observation maintained

Comments:

SAFETY: Bed alarm Bed low position Bed appropriate for developmental level Crib rails up according to developmental needs

Call bell within reach Restraints ID band location: 1 _____ 2 _____ ID band# _____

Name & Birthdate/MRN verified on 2 sources (aka PTP & ID band)

Humpty Dumpty Falls© Assessment (Used with permission)			Parameter	Criteria	Score		
Age	Criteria	Score	Environmental Factors (continued)	Patient Placed in Bed	2		
	Less than 3 years old	4		Outpatient Area	1		
	3 to less than 7 years old	3		Response to Surgery/ Sedation/ Anesthesia	Within 24 hours	3	
	7 to less than 13 years old	2			Within 48 hours	2	
13 years and above	1	More than 48 hours/none	1				
Gender	Male	2	Medication usage	Multiple use of: Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives/Diuretics Narcotic	3		
	Female	1					
Diagnosis	Neurological Diagnosis	4				One of the meds listed above	2
	Alterations in Oxygen (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc)	3					
	Psych/Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3				Other medications/None	1
	Forgets Limitations	2					
	Oriented to own ability	1					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4	Total				
	Patient Uses assistive devices or Infant-Toddler in crib or Furniture/ Lighting	3	<input type="checkbox"/> At Risk: (score 12 or greater) <input type="checkbox"/> Not at Risk (score < 12) <input type="checkbox"/> Not at Risk: (score > 12) Explain: _____ <input type="checkbox"/> Care Plan – "At Risk - Fall"				

RRN completing systems assessment signature: _____

Date / Time: _____