

# IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 14yo

Patient Weight: 40kg

40

Student Name: Marissa Hernandez

Unit: PICU

Pt. Initials: NA

Date: Click here to enter a date.

6/8/2021

<p><b>1. Disease Process &amp; Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference):</b></p> <p><b>Anorexia nervosa</b> An eating disorder defined by a refusal to maintain a minimally normal body weight and by severe weight loss in the absence of obvious physical causes. This disorder has social, psychological, behavioral, cultural, and physiologic components.</p> <p><i>Nona's essentials of pediatric nursing</i></p>	<p><b>2. Factors for the Development of the Disease/Acute Illness:</b></p> <ul style="list-style-type: none"> <li>• Gender: female (P)</li> <li>• Picky eating in early childhood</li> <li>• Personality: Perfectionism, anxiety (P), obsessive</li> <li>• Competitive athletics</li> <li>• Academically high achievers</li> </ul> <p><i>Nona's essentials of pediatric nursing</i></p>	<p><b>3. Signs and Symptoms:</b></p> <ul style="list-style-type: none"> <li>• Severe weight loss (P)</li> <li>• Secondary amenorrhea</li> <li>• Primary amenorrhea</li> <li>• Sinus bradycardia (P)</li> <li>• Low body temp</li> <li>• Hypotension (P)</li> <li>• Intolerance to cold</li> <li>• Dry skin &amp; brittle nails</li> <li>• Lanugo hair</li> <li>• Thinning hair</li> <li>• Muscle wasting (P)</li> <li>• Fatigue, lightheaded</li> </ul> <p><i>Nona's essentials of pediatric nursing</i></p>
<p><b>4. Diagnostic Tests Pertinent or Confirming of Diagnosis:</b></p> <ul style="list-style-type: none"> <li>• Based on clinical manifestations and conformity to criteria established by American Psychiatric Association</li> <li>• History &amp; physical</li> <li>• Bone density study</li> </ul>	<p><b>5. Lab Values That May Be Affected:</b></p> <ul style="list-style-type: none"> <li>• Na - hyponatremia</li> <li>• K<sup>+</sup> - hypokalemia</li> <li>• Urea - low</li> <li>• LFT</li> <li>• Phosphate</li> <li>• CBC to eval. for anemia</li> <li>• ESR</li> <li>• CRP</li> <li>• Calcium low (P)</li> <li>• Magnesium</li> <li>• Phosphorus</li> <li>• BUN</li> <li>• Creatinine</li> <li>• Urinalysis</li> </ul>	<p><b>6. Current Treatment (Include Procedures):</b></p> <ul style="list-style-type: none"> <li>• Daily weight</li> <li>• VS Q4</li> <li>• Has to drink 64 oz of water - encouraging oral fluid intake</li> <li>• Constant observer</li> <li>• Strict meal times - 30 mins to eat, observed for 30 mins after meal, can't go to bathroom for 1 hour after meal.</li> <li>• Snacks between each meal</li> </ul>

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INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake	NA	NA	500	500ml									500ml
Intake – PO Meds													NA
Enteral Tube Feeding													NA
Enteral Flush													NA
Free Water													NA
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid	NA												NA
IV Meds/Flush	NS	15ml											15ml
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	0600 350	<del>250</del>		300									650
# of immeasurable													NA
Stool													NA
Urine/Stool mix													NA
Emesis													NA
Other													NA

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: <input checked="" type="radio"/> 0   1   2   3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0   1   2   3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 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) <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

Student Name: MARISA HERNANDEZ

Unit: PIU

Pt. Initials: \_\_\_\_\_

Date: 6/8/21

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

Allergies: NKA

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?			
Flurazepam (Prozac)	Anti-depressants	For Anxiety	10mg, PO daily	Y		N/A	insomnia, N/V/D, HT, Anorexia, nervousness, dizziness, rash, constipation	<ol style="list-style-type: none"> <li>1. Teach pt. to report HT</li> <li>2. Teach pt. to report if has S/S constipation</li> <li>3. Teach pt. to <del>report</del> report N/V/D</li> <li>4. intervention - observe site for rash</li> </ol>
Sodium Chloride (NS flush)	Flush	Sodium replacement	10ml flush	Y		0.9% NS Flush flushed with 10ml due to blood backing up	fluid overload, electrolyte imbalance - if given continuously, pain @ site	<ol style="list-style-type: none"> <li>1. Teach pt. to report pain @ inj. site</li> <li>2. Teach pt. S/S of fluid overload</li> <li>3. intervention - observe site for rxn</li> <li>4. Teach pt. / encourage fluid intake</li> </ol>
								<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>



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GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input checked="" type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" 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 checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input 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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>4</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <u>NA</u> <b>Extremities:</b> <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 <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>Yellow/clear</u> <b>Stool Appearance:</b> <u>Brownish/green</u> <input type="checkbox"/> Diarrhea <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> <input checked="" type="checkbox"/> AC 22g <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> <u>no fluids running</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) <u>N/A</u> <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: <u>N/A</u> L/min <input type="checkbox"/> BiPap/CPAP: <u>N/A</u> <input type="checkbox"/> Vent: ETT size <u>N/A</u> @ _____ cm <input type="checkbox"/> Other: <u>N/A</u> <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>N/A</u> Type <u>NA</u> Obturator at Bedside <input type="checkbox"/> Yes <input checked="" 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 <u>NA</u> Consistency <u>N/A</u> <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> <b>Pulse Ox Site:</b> <input checked="" type="checkbox"/> Index finger <b>Oxygen Saturation:</b> <u>100%</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present <input checked="" type="checkbox"/> <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>NA</u> Location <u>N/A</u> Inserted to <u>N/A</u> cm <input type="checkbox"/> Suction Type: <u>NA</u>	<b>Color:</b> <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 <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: <u>NA</u> <b>Mucous Membranes:</b> Color: <u>Pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>ped's diet eating disorder</u> <b>Amount/Schedule:</b> <u>breakfast, snack, lunch</u> <b>Chewing/Swallowing difficulties:</b> <u>As with snack</u> <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>NA</u> <b>Type:</b> <u>Pt. says has no pain</u> <b>Pain Score:</b> 0800 <u>1</u> 1200 <u>N/A</u> 1600 <u>N/A</u>
	MUSCULOSKELETAL	WOUND/INCISION
	<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 checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<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 <u>NA</u> <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<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> _____