

IM5 (Pediatrics) Critical Thinking Worksheet

Patient Age: 4 yrs. 8m Patient Weight: 25.9 kg

Student Name:

PNSALLA MEZA

Date: ~~8/19/21~~ Enter a date.

<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference):</p> <p>Increase intracranial Pressure. Brain injury or another medical condition can cause growing pressure inside skull.</p>	<p>2. Factors for the Development of the Disease/Acute Illness:</p> <p>Trauma to brain</p>	<p>3. Signs and Symptoms:</p> <p>Ⓡ Weakness Drowsy Increased sleeping HA Lethargic Inability to follow simple commands Nausea</p>
<p>4. Diagnostic Tests Pertinent or Confirming of Diagnosis:</p> <p>CT - Cervical spine CT Chest / Abd / Head MRI w/ + w/out contrast + MRA/MRV Carotid Arteriogram</p>	<p>5. Lab Values That May Be Affected:</p> <p>CBC Blood gas</p>	<p>6. Current Treatment (Include Procedures):</p> <p>Kepra Aldrete score phase I (8/19/21) Spinal cord assessment + OT / PT Speech therapy EM BM</p>

<p>Student Name:</p>	<p>Unit: Pt. Initials:</p>	<p>Date: Click here to enter a date.</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient.</p> <p>1. Relaxation</p> <p>2. Distraction</p> <p>* List All Pain/Discomfort Medication on the Medication Worksheet</p> <p>Click here to enter text.</p> <p>Morphine</p> <p>Morphin</p>	<p>8. Calculate the Maintenance Fluid Requirement (Show Your Work):</p> $10kg \times 100 = 1000$ $10kg \times 50 = 500$ $5.9kg \times 20 = 118$ $\frac{1618}{24} = 67.42 \text{ mL} + 24$ <p>Actual Pt MIVF Rate: none</p> <p>Is There a Significant Discrepancy? yes ^{no} an item.</p> <p>Why? ON Oral fluids.</p>	<p>9. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work):</p> $0.5 \times 25.9 = 12.95 \text{ mL/hr}$ <p>Actual Pt Urine Output:</p> <p>none observed.</p>
<p>10. Growth & Development: List the Developmental Stage of Your Patient For Each Theorist Below and Document 2 OBSERVED Developmental Behaviors for Each Theorist. If Developmentally Delayed, Identify the Stage You Would Classify the Patient:</p> <p>Erickson Stage: Autonomy vs. Shame & Doubt.</p> <p>1. She would wet the bed & feel bad so we put a diaper.</p> <p>2. She wanted to get in the wagon by herself but she was @ side wheeliness, so she needed help.</p> <p>Piaget Stage: Preoperational period.</p> <p>1. I used animism when talking her vitals by telling her my fingers were going to jump to check her pulse.</p> <p>2. I was grabbing her sternum ^{hand} when she was mainly nonverbal & would laugh when I made vitals a bit fun & tickled her feet.</p>		

Student Name:		Unit:	Pt. Initials:	Date: Click here to enter a date.
11. Focused Nursing Diagnosis: Ineffective Tissue Perfusion	15. Nursing Interventions related to the Nursing Diagnosis in #11: 1. Provide oxygen therapy as needed. Evidenced Based Practice: Decreases hypoxemia levels which may improve cerebral vasodilation + blood vol. 2. Provide non-stimulating environment + adequate rest Evidenced Based Practice: Continued activity + stimulation may increase ICP. 3. Assess neurological status	16. Patient/Caregiver Teaching: 1. Teach pt. to watch out for any swelling on legs, feet, hand + when to call HCP. 2. Do not exceed activity intolerance 3. Elevate HOB 30°		
12. Related to (r/t): increased intracranial pressure	Evidenced Based Practice: will determine changes in child's neurological condition related to ICP.	17. Discharge Planning/Community Resources: 1. Follow up w/ appointments. 2. Avoid lifting heavy obj. 3. Refer them to websites for more info about condition.		
13. As evidenced by (aeb): lethargic				
14. Desired patient outcome: Demonstrate improved brain function as evidence by improvement of alertness + no further deterioration in LOC.				

Student Name: Pascilla Meza Unit: Pedi Floor Pt. initials: _____ Date: 8/31/21

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input 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 _____ Edema: <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+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: 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	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <u>Non-verbal</u> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>W</u> Left <u>S</u> Pushes: Right <u>W</u> Left <u>S</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Urine Appearance: <u>None</u> Stool Appearance: <u>observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ Appearance: <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left <input type="checkbox"/> Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ <input type="checkbox"/> Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: _____	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input checked="" type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <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 Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <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: _____ Mucous Membranes: Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>Reg</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 _____ 1200 <u>0</u> 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input type="checkbox"/> None Type: _____	<input type="checkbox"/> None Type: <u>EVD</u> Location: <u>Scalp</u> Description: _____ Dressing: <u>Dermabond open to air</u>
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>mom</u> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Student Name: _____ Unit: _____ Pt. initials: _____ Date: _____

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake													
Intake – PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
<i>None observed</i>													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

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