

IMS (Pediatrics) Critical Thinking Worksheet

Patient Age: 2yr

Patient Weight: 10.9 kg

Student Name:

Mariah Rayburn

Date: [Click here to enter a date.](#)

<p>1. Disease Process & Brief Pathophysiology (Identify Key Concepts to Your Patient and Include Reference):</p> <p>Communicating hydrocephalus is when the ventricles dilate because there is an obstruction of CSF flow out of the ventricular system. This usually occurs post-hemorrhagic or by inadequate reabsorption of CSF.</p>	<p>2. Factors for the Development of the Disease/Acute Illness:</p> <ul style="list-style-type: none"> • Lesions or tumors in the brain or spinal cord • CNS infections • Subdural hematomas P • Premature Delivery P • Inappropriate fetal development P 	<p>3. Signs and Symptoms:</p> <ul style="list-style-type: none"> • N/V • Lethargy P • Irritability • Seizures P • Eyes sun-setting • Poor Eating
<p>4. Diagnostic Tests Pertinent or Confirming of Diagnosis:</p> <ul style="list-style-type: none"> • CT P • MRI P • LP P • Fundoscopic Exam • Ultrasound 	<p>5. Lab Values That May Be Affected:</p> <ul style="list-style-type: none"> • ↑ Na • ↓ K • ↑ glucose • ↑ ICP P • ↑ WBC P • ↑ Procalcitonin P 	<p>6. Current Treatment (Include Procedures):</p> <ul style="list-style-type: none"> • VP Shunt • ETV • EVD P

Student Name: Moriah Rayburn Unit: PICU Pt. initials: J.E. Date: 3/30/22

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input type="checkbox"/> Normal <input type="checkbox"/> Delayed <u>Sedated</u>	Pulse: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input checked="" 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 type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>1+</u> L <u>1+</u> Lower R <u>1+</u> L <u>1+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input 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 type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <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 <u>3mm</u> 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 type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>N</u> Left <u>N</u> Pushes: Right <u>N</u> Left <u>N</u> S=Strong W=Weak N=None EVD Drain: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Level <u>0</u> Seizure Precautions: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ELIMINATION Urine Appearance: <u>yellow/clear</u> Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	IV ACCESS Site: <u>L femoral</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input checked="" type="checkbox"/> Central Line Type/Location: <u>4 Fr</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: _____
RESPIRATORY 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 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 type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input checked="" type="checkbox"/> Vent: ETT size <u>4.0 @ 11.5 cm</u> <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site: <u>left big toe</u> Oxygen Saturation: <u>97%</u>	GASTROINTESTINAL Abdomen: <input type="checkbox"/> Soft <input checked="" 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 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>G tube</u> Location _____ Inserted to _____ cm <input checked="" type="checkbox"/> Suction Type: _____	SKIN Color: <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 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: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL Diet/Formula: <u>Ketogenic NG</u> Amount/Schedule: <u>40ml/hr</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	MUSCULOSKELETAL <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input checked="" type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input checked="" type="checkbox"/> Spasms <input checked="" type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All Brace/Appiances: <input checked="" type="checkbox"/> None Type: _____	PAIN Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 <u>0</u> 1200 <u>0</u> 1600 <u>0</u>
MOBILITY <u>bedrest</u> <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Bedridden	WOUND/INCISION <input type="checkbox"/> None Type: <u>Incision</u> Location: <u>Right side of head</u> Description: _____ Dressing: <u>Yes</u>	TUBES/DRAINS <input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>R side of head</u> Type: <u>EVD</u> Dressing: <u>Yes</u> Suction: _____ Drainage amount: <u>500ml</u> Drainage color: <u>clear-yellow</u>

Sedated

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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	57		32			114		76		95	82		456
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush	135					80							93.5
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine	47	52	36		49	43		25		43			289
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other	25					143				25	9		202

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) <u>10</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