

Overall, my experience in the PICU has been good! Sydnee has been an amazing preceptor and I have learned a lot. In total, I've had four patients with vents and/or oscillators, an NAT, and family drama for two patients. The patient that stood out to me the most though was our NAT patient.

Patient AC is a 7m/m admitted on 3/26 after falling off the bed onto carpeted floor. The mother said that she found him on the floor unresponsive, so she called 911. She claimed that they were taking too long, so she drove him to an emergency room in Seminole. Upon arrival the patient did not have a pulse, so they began CPR and it continued for about 11 minutes. After they found a pulse and stabilized him, they intubated the patient and transferred him to us. CPS was consulted, but they ruled out a NAT because the only injury they found at the time was a ligament injury in the neck which they said was a possibility. However, they ran MRI and CT scans and they found that he had bilateral retinal hemorrhages and subdural bleeds.

I had this patient on 3/28, and the family was at the bedside. The mother had bruises on her face and arms, so it is suspected that this is a domestic violence situation. During the day, the patient started having seizures as well. He was put on continuous EEG monitoring where he had continuous seizures throughout the afternoon and evening. By that point, CPS finally agreed that this was not an accident and came to remove the family. I only had him on 3/28, but he was extubated on 3/29 and was placed in a foster home earlier this week.

Although we have had NAT's before in the past, this is the first time I have actively been involved in the patient care. The first issue for me was figuring out how to appropriately communicate with the family before they were removed. Logically knowing that this was not an accident but not having "the proof" that, that was the case was hard. It was difficult knowing that we couldn't do anything for the mother and that we still had to be professional with the father. Communicating with CPS was also interesting. Dr. Anand was trying to tell them the severity, but they were convinced that it was an accident for too long. Being the patient advocate on the nursing side was both frustrating and rewarding at the same time.

3/28 was a busy day overall. Between both patients, Sydnee and I were running around and trying to keep up with care. Trying to balance that out was more difficult than I anticipated it to be. We had to travel back and forth for our other patient's scans all while this baby was seizing. Because of the acuity level, I saw just how well the team worked together to get everything situated. Putting everything we learned in class together was a good learning opportunity too. In the past, clinicals have been so focused on skills that focusing on one or two patients and getting to critically think was a good experience.