Final Clinical Reflection

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What feelings did you experience?

Overall, I have had positive feelings. My preceptor gave me full autonomy over my preceptorship. One of the first things we established was what I wanted out of this experience. I told him I wanted to do it all and by the end, I wanted to perform interventions without being coached to do so, identify issues and generate solutions, and overall be confident in the leadership role of the nurse.

Which cases stood out?

Doing my preceptorship in PICU has provided me the opportunity to care for complex patients with unique cases. I cared for a life gift 6mo infant with anoxic brain injury. I cared for him before life gift took over so I got to witness the process our providers take when determining when a patient is brain dead. Our big focus for the infant after life gift took over was managing his gtts and maintaining his blood pressor within normal limits to perfuse his organs. I also taken care of two boys who were a car vs ped admission. One of them had several craniotomies and had an EVD placed so our focus was managing/monitoring his EVD/ICP. The other had multiple fractures, abdominal surgery, hip surgery, ARDS, and multiple abrasions. Our focus for him when I cared for him was wound care, managing his nerve pain, weaning him off HFNC, and bladder training because I DCd' his foley. With respiratory season starting, I also cared for several patients admitted for RDS secondary to Rhino Virus, Pneumonia, and Status Asthmaticus. Almost all were on HFNC and one had to get a chest tube placed which I got to help assist with in IR. On my last day, I got assigned two kids who were on complete opposite sides of the BMI percentile curve. One who was in the 1 percentile admitted for malnourishment/refeeding syndrome and the other who was in the 99th percentile.

What issues were identified? What interventions were performed?

One of my patients couldn't generate full responses but was experiencing intermittent spells of pain on his left side (specifically his leg). The night nurse said he couldn't tolerate SCDs so they chose not to use them. During one of his spells, I noticed him trying to reach for his calve. He had hip surgery recently so initially I thought DVT. During rounds, we mentioned his intermittent spells and voiced our concern. The provider then ordered an US test to rule out a DVT.

The same patient was on HFNC and sounded very congested and could only cough with assist. I noticed his respirations were elevated from the monitor outside so I went into his room. He appeared very agitated and sounded very congested so I tried to assist him in coughing. However, he was not adequately coughing up secretions, so I grabbed the nearest RT and asked if they could perform a deep suction. The RT grabbed supplies and entered the room quickly to perform deep suctioning. He coughed up a large amount of secretions and appeared relieved with no signs of respiratory distress.

On another occasion, there was an infant who was not assigned to me, but just had an EVD placed. My preceptor and I both assumed his nurse was in his room. However, he gave out a loud high-pitched cry that did not sound like his typical normal cry. My preceptor and I both stood up and went immediately into their room to see what was going on. The infant was still, but his face was fixed to the left side. We assessed his pupils and the left pupil was fixed. The nurse taking care of the infant came in and we told her he might be having a seizure. We notified the provider taking care of the infant. The provider came by and said he most likely was having a seizure due to all the medications given during his surgery causing his seizure threshold to lower.

What did you learn?

Hypovolemic shock; generally, our providers will start with crystalloids (less expensive) before starting colloids (more expensive) and then will start inotropes. Check calcium lvls during massive blood transfusions because blood products contain citrate which binds to calcium, making it less accessible in the blood.

Management over gtts. Specifically, pressors and knowing when another inotrope needs to be added to the patients care.

Ventilator settings; pediatric patients need a tidal volume of 7-9ml per kg. A plateau pressure >30cmH20 for individuals with ARDS is associated with lower mortality rates. Lowering the plateau pressure can be obtained by reducing VT if >30cmH20. Knowing when a patient is riding the vent by assessing wave forms. If the circuit fills with droplets in certain places, the vent will think the patient is taking spontaneous breaths when they really aren't and will not adequately vent the patient.

When performing one task, you must know how to do it several different ways depending on the child's cognitive and development level. Involving parents in participating in care for the patient is crucial.

I learned how to determine agitation vs pain and when to use prn anxiolytic vs analgesic on a client who can't voice what they need.

Trouble shooting issues with nursing interventions before notifying charge and physician

During bedside report, we assessed our patient's chest tube insertion sight/ dressing and noticed a couple sutures came undone. We quickly reenforced her dressing, checked the drainage system for signs of a potential leak, and listened to her lung sounds. Lung sounds were clear in all quadrants, and there were no air bubbles in our suction chamber. We notified our charge nurse, called hospital list to notify/order a chest x-ray to check placement and to come by and assess need for re-suturing at the insertion sight. Hospital list came by and determined we reinforced the dressing well enough to keep the tube in place and told us to keep monitoring the sight and drainage. Later, they ordered to clamp the chest tube over night because we had zero drainage all day, AM imaging looked good, patient was tolerating room air trials, and they were planning on discontinuing the chest tube the next day.