

Nama :

Tanggal Lahir :

No RM :

NIK :

RM 19.e

**ASESMEN KEPERAWATAN PASIEN ICU**

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| **Pengkajian :**  **Riwayat Kesehatan Yang Lalu**   |  |  |  | | --- | --- | --- | | * Kondisi kesehatan sebelumnya | **:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | * Pernah dirawat dengan kasus yang sama | **:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | * Riwayat Alergi | **:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | * Riwayat masalah emosi / psikiater | **:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |   **Sistem Pernafasan**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 1. Jalan nafas | **:** | * Bersih | * Sumbatan atau berupa | * Sputum | * Darah |  1. Pernafasan  |  |  |  |  |  | | --- | --- | --- | --- | --- | | * RR | : ………………………… x / menit | | |  | | * Penggunaan otot bantu nafas | | * Ya | * Tidak |  | | * Terpasang ETT | | * Ya | * Tidak |  | | * Irama | | * Teratur | * Tidak Teratur |  | | * Kedalaman | | * Dalam | * Tidak dalam |  | | * Sputum | | * Putih | * Kuning | * Hijau | | * Konsistensi | | * Kental | * Tidak kental |  | | Suara Nafas | | | * Ronchi | * Wheezing | * Vesikuler |  1. Sirkulasi Jantung :  |  |  |  | | --- | --- | --- | | * Irama | * Teratur | * Tidak Teratur | | * Nyeri dada | * Ya | * Tidak | | * Bunyi Jantung | * Murmur | * Gallop |  1. Perdarahan  |  |  | | --- | --- | | * Area Perdarahan : Jumlah Perdarahan …Cc/jam |  |   **Sistem Gastrointestinal**   |  |  |  |  | | --- | --- | --- | --- | | * Distensi | * Ya dan lingkar perut : …….. cm | | * Tidak | | * Nyeri | * Ya | * Tidak |  | | * Peristaltik | * Teratur | * Tidak Teratur |  | | * Defaksi | * Dalam | * Tidak dalam |  |   **Sistem Perkemihan**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | * Warna |  | * Bening | * Kuning | * Merah | * kecoklatan | | * Peristaltik |  | * + Ya | * + TIdak |  |  | | * Defaksi |  | * + Ya | * + Tidak |  |  | | * Jumlah:…. ..c/jam |  | Penggunaan Catheter Urine | | * Ya | * Tidak |   **Sistem Syaraf Pusat**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | * Tingkat Kesadaran : | | * GCS : Eye : \_\_\_\_ Motorik \_\_\_\_ Verbal \_\_\_\_\_ | | |  | | * Pupil |  | * + Isokor | * + Anisokor | * Miosis | * Midriasis | | * Kekuatan Otot : \_\_\_\_\_\_\_\_\_\_\_\_ Koordinasi Motorik : \_\_\_\_\_\_\_\_\_ | | | |  |  |   **Sistem Muskulosceletal dan Integumen**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | * Turgor Kulit |  | * Elastik | * Tidak elastis |  |  | | * Terdapat luka |  | * Ya , lokasi luka : …………………… | | * Tidak |  | | * Fraktur |  | * + Ya , dimana | | * Tidak |  | | * Kesulitan bergerak : | | * + Ya | * + Tidak |  |  | | Penggunaan alat bantu | | * Ya Menggunakan : …………… | | * + Tidak |  | | Lokasi luka / lesi lain | | * Ya ………………………………… | | * + Tidak |  |   **Risiko Cedera/jatuh**   |  |  | | --- | --- | | * Tidak | * Ya , bila ya , isi form monitoring pencegahan jatuh |   **Status Fungsional**   |  |  |  |  | | --- | --- | --- | --- | | Nyeri / tidak nyaman : | * Ya | * Tidak | * Nyeri di \_\_\_\_\_\_\_\_ score \_\_\_\_\_\_\_ | | Nyeri / tidak nyaman : | * Ya | * Tidak | * Nyeri di \_\_\_\_\_\_\_\_ score \_\_\_\_\_\_\_ |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **BPS**  SIKAP DAN PERILAKU PASIEN | **KETERANGAN** | **Resiko Jatuh** Resiko Jatuh Dewasa | | | |  | Behavior Pain Scale | * Ringan 0 -24 | * Sedang 25 – 44 | * Berat ≥45 | | Ekspresi Wajah |  |  |  | | 1. Tenang : 1 |  | | | | 1. Menyerinyit : 2 | Resiko Jatuh Anak (Humpty Dumpty) | | | | 1. Muka Menegang : 3 | * Rendah 7 - 11 | * Resiko Tinggi t ≥ 12 | | | 1. Wajah menyeringai : 4 |  |  |  | | Pergerakan |  |  |  | | 1. Tenang : 1 | Resiko Jatuh Geriatri | | | | 1. Menekuk sebagian daerah siku : 2 | * Rendah 0 - 3 | * Resiko Tinggi ≥ 4 | | | 1. Menekuk Total & jari mengepal : 3 |  |  |  | | 1. Menekuk total terus menerus : 4 | Nyeri mempengaruhi : | |  | | Toleransi terhadap ventilasi mekanik |  |  |  | | Dapat mengikuti pola ventilasi : 1 | * Tidur | * Aktifitas fisik |  | | Batuk tetapi dapat mengikuti pola:2 | * Emosi | * Nafsu makan |  | | Melawan pola ventilasi :3 | * Konsentrasi |  |  | | Pola ventilasi tidak toleransi : 4 |  |  |  |   **Alat Invasif yang digunakan**   |  |  |  |  | | --- | --- | --- | --- | | Drain/WSD | * Ya | * Tidak , warna : …………… | Jumlah : …………………..cc/jam | | Drain Kepala | * Ya | * Tidak , warna : ……………. | Jumlah : …………………..cc/jam | |  | * Merah | * Serosa | * Lain – lain | | Terpasang folley Catheter | * Ya | * Tidak , warna : …………… | Jumlah : …………………..cc/jam | | NGT | * Ya | * Tidak , warna : ……………. | Jumlah : …………………..cc/jam |   **Pengkajian Aspek Budaya/Kultural dan Spiritual**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Aspek Budaya** | **Aspek Spiritual** | | | | | Hal-hal yang berkaitan dengan budaya, agama, keyakinan/ kepercayaan (makanan, bahasa dll): …………………………………………………………  ………………………………………………………… | Kemampuan beribadah: | | | | | Wajib Ibadah | * Baligh | * Belum baligh | * Halangan lain | | Thoharoh | * Berwudlu | * Tayamum | * ……… | | Sholat | * Berdiri | * Duduk | * berbaring |   **Perencanaan Pasien Pulang (*Discharge Planning*)**   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Kebutuhan Pelayanan** | **Ya** | **Tidak** | **Kebutuhan pelayanan** | **Ya** | **Tidak** | **Kebutuhan pelayanan** | **Ya** | **Tidak** | | Perlu pelayanan home care |  |  | Penggunaan alat bantu |  |  | Dirujuk ke tim terapis |  |  | | Perlu edukasi pasien / keluarga |  |  | Perlu pemasangan inplan |  |  | Dirujuk ke ahli gizi |  |  | | Telah dilakukan pemasangan alat |  |  | Perlu pendampingan spiritual |  |  | Perlu inform concent |  |  | | Di rujuk ke komunitas tertentu |  |  | ……………………………….. |  |  | ………………………. |  |  |   **Daftar Masalah Keperawatan**   |  |  | | --- | --- | | **Masalah Keperawatan** | **Tujuan Target Terukur** | |  |  |  * Disusun rencana Keperawatan   Tanggal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pukul \_\_\_\_\_\_\_\_\_\_  Perawat Penanggung Jawab Pasien  (………………………………) |