

Student Name: Alyssa Vitella

Medical Diagnosis/Disease: Crohn's Disease

**NCLEX IV (8): Physiological Integrity/Physiological Adaptation**

Anatomy and Physiology

Normal Structures

The gastrointestinal tract consists of the oral cavity, pharynx, esophagus, stomach, small intestine, and large intestine. The accessory organs are the teeth, tongue, and glandular organs such as salivary glands, liver, gallbladder, and pancreas. The function of the GI tract is to process ingested food by mechanical and chemical means, extract nutrients and excrete waste products. The organs that take in food and liquids and break them down into substances that the body can use for energy, growth, and tissue repair. Waste products the body cannot use leave the body through bowel movements.

Pathophysiology of Disease

Crohn's disease is a chronic inflammatory disease of the gastrointestinal tract. Inflammation extends all the way through the intestinal wall from mucosa to serosa. Crohn disease begins with crypt inflammation and abscesses, which progress to tiny focal aphthoid ulcers. These mucosal lesions may develop into deep longitudinal and transverse ulcers with intervening mucosal edema, creating a characteristic cobblestoned appearance to the bowel. Crohn's disease and ulcerative colitis are characterized by enhanced recruitment and retention of effector macrophages, neutrophils and T cells into the inflamed intestine, where they are activated and release proinflammatory cytokines.

**NCLEX IV (7): Reduction of Risk**

Anticipated Diagnostics

Labs

HH  
CBC, Serum iron, Albumin, B12

Additional Diagnostics

CT, upper GI series, intestinal endoscopy, colonoscopy

**NCLEX II (3): Health Promotion and Maintenance**

Contributing Risk Factors

Age  
Ethnicity, family history, smoking, nsaid

Signs and Symptoms

Diarrhea, fever, fatigue, abd pain, blood in stool, mouth sores, reduced appetite, weight loss, pain/ drainage around anus

**NCLEX IV (7): Reduction of Risk**

Possible Therapeutic Procedures

Non-surgical

Rest, medicines, comfort care

Surgical

Bowel resection with or without stoma, stricturoplasty

Prevention of Complications

(What are some potential complications associated with this disease process)

Bowel obstruction, ulcers, fistula, malnutrition, cancer, blood clots

**NCLEX IV (6): Pharmacological and Parenteral Therapies**

Anticipated Medication Management

Steroids  
Analgesics

**NCLEX IV (5): Basic Care and Comfort**

Non-Pharmacologic Care Measures

Healthy diet, adequate fluids, basic care, skin care!!! Commode or bed pain near.

**NCLEX III (4): Psychosocial/Holistic Care Needs**

What stressors might a patient with this diagnosis be experiencing  
Body image, anxiety, depression

Client/Family Education

NCLEX I (1): Safe and Effective Care Environment

List 3 potential teaching topics/areas

- Avoid problem foods
- Specific diet to relieve abd pain
- importance of rest.

Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)

GI doctor, surgeon, home health, Nutritionist

**Potential Patient Problems (Nursing Diagnoses)**

List two potential patient problems you will be addressing along with clinical reasoning, goals/expected outcomes, assessments, and priority nursing interventions. The patient problems must be in priority order.

Problem # 1: Imbalanced Nutrition: less than body requirements

Clinical Reasoning: Crohn's disease: malabsorption, restricted intake, diarrhea.

Goal/EO: will maintain weight within the normal BMI range for height and weight, during time of my care.

Ongoing Assessments: Assess weight daily, Assess diet, eating habits and choices daily, Monitor I and O q 8hr.  
Assess for signs and symptoms affecting nutrition.

- NI:
1. Encourage a diet of high protein TID.
  2. Administer supplements as prescribed q 4hr.
  3. Encourage adequate fluids BID
  4. Educate on foods to avoid during flares (avoid ETOH, spicy food, caffeine) during my time of care.
  5. Encourage to keep a meal diary daily.
  6. Offer multiple dietary selections applicable daily.

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Problem # 2 Diarrhea

Clinical Reasoning: Crohn's Disease: Inflammation of GI tract, irritation of the bowel.

Goal/EO: will have a decreased urgency and frequency of stools less than 3 per day during my time of care.

Ongoing Assessments: Assess each bowel movement daily, Inspect stool color PRN daily, Monitor for bowel sounds q4hr.

- NI:
1. Encourage and maintain adequate hydration q 2hr.
  2. Promote relaxation and bed rest BID.
  3. Encourage a low fiber diet daily.

4. Administer corticosteroids as ordered PRN, q 4hr.

5. Administer Acetaminophen as ordered PRN q4hr.

6. Encourage a clear liquid diet during my time of care.

### ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:

a. Esther, RN

b. Bonnie RN, Charge

2) What were some steps the nursing team demonstrated that promoted patient safety?

a. **Rechecking vital signs when noticeable signs of change were appearing.**

\_\_\_\_\_

b. **Assessing pain, PQRST**

\_\_\_\_\_

c. **3 rails up, call bell in reach, ID band on.**

\_\_\_\_\_

3) Do you feel the nurse and medical team utilized therapeutic communication techniques when interacting with individuals, families, and health team members of all cultural backgrounds?

a. If **yes**, describe: Yes Yes, they used therapeutic communication while speaking to one another. When the nurse had to give blood to Esther, she thanked her for it and was very kind.

### Reflection

1) Go back to your Preconference Template:

a. Indicate (circle, star, highlight, etc.) the components of your preconference template that you saw applied to the care of this patient.

2) Review your Nursing Process Form: Did you select a correct priority nursing problem?

a. If **no**, write what you now understand the priority nursing problem to be: Ineffective health maintenance

3) Review your Patient Problem Form: Did you see many of your anticipated nursing assessments and interventions used?

a. Were there interventions you included that *were not* used in the scenario that could help this patient?

i. If **yes**, describe: Yes Yes, there was a lot of education on nutrition for the patient which was important in her case. They did a lot of assessments that I anticipated such as monitoring for bowel sounds, checking the clients pain often and promoting her to rest while she was ill.

\_\_\_\_\_  
\_\_\_\_\_

4) After completing the scenario, what is your patient at risk for developing?

a. GI bleed, exacerbation of Crohn's Disease.

\_\_\_\_\_

b. Why? \_\_\_\_\_improper diet, stress, not understanding how to prevent her disease from worsening.

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5) What was your biggest “take-away” from participating in the care of this patient? How did this impact your nursing practice?

\_\_\_I understand how important it is for patients to understand their own disease. Patient education is a vital factor in preventing the decline in health for patients with medical issues. Diet and nutrition are also very important for GI cases. Certain food can exacerbate their illness so again, education for them will be key in their care.

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**Priority Patient Problem #1: \_\_\_\_\_ Ineffective health maintenance behaviors**

<p><b><u>Subjective:</u></b></p> <p><i>This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.</i></p>	<p><b>History Present Illness (HPI):</b> Presented in ED with weakness and dizziness, serosanguineous fluid in ostomy bag. Skin is pale and dry, Voided 500mL, and hemocult stool sent to lab. Has IV running NS 1000mL at 150mL/hr, 700mL left to run. VS: 98.8, 114bpm, RR22, 100/60, 95%, on 2L/min NC O2</p> <p><b>PMH: Crohn's Disease with intermittent gastritis, ileostomy.</b></p> <p><b>Allergies: Sulfa</b></p> <p><b>Current Medications: Infliximab, Ibuprofen, Morphine, Acetaminophen</b></p>
<p><b><u>Objective:</u></b></p> <p><i>This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.</i></p>	<p><b>Vital Signs: 1/8 at 1500: T 37.0, 110bpm, RR26, BP 94/56, 95%, 2L/min O2.</b></p> <p><b>Labs:</b> <b>1/18: CBC: RBC: 2.7, Hgb: 7, Hct: 21%, MCV: 105, MCHc:48, WBC 600, Plt, 162,000, PTT 21 sec, PT 12.2, INR: 0.7</b> <b>Diagnostics: Fecal occult blood positive.</b></p>
<p><b><u>Assessment:</u></b></p> <p><i>Focused assessments on your priority problem.</i></p>	<p><b>Assess diet.</b> <b>Assess pain (abd) PQRST.</b> <b>Assess coping skills for stress.</b> <b>Assess knowledge of disease</b> <b>Assess lifestyle.</b> <b>Assess H and H.</b></p>
<p><b><u>Plan</u></b></p> <p><b>*Based on priority problem only</b></p> <p><i>Include what your plan is for the client. What treatments or medications are needed? You can include procedures, consults, labs/diagnostics, etc. What nursing interventions are being performed?</i></p>	<p><b>Plan:</b> <b>Packed RBC transfusion to increase HH levels</b> <b>Auscultate and palpate abd</b> <b>Treatment of pain with morphine and inflammatory med Infliximab</b> <b>Stop Ibuprofen.</b> <b>CBC and hemocult on stool</b></p> <p><b>Teaching &amp; Resources:</b> <b>Education on disease and medication regimen.</b></p>

