Student Name: Elani Russell

Medical Diagnosis/Disease: Crohn's Disease

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

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

Anatomy and Physiology Normal Structures	Pathophysiology of Disease	Anticipated Diagnostics Labs Stool for occult blood, serum chemistries, cbc, erythrocyte sedimentation rate Additional Diagnostics H and p Capsule endoscopy Sigmoidoscopy and or colonoscopy with biopsy Radiologic studies with barium contrast
The large intestine is larger in diameter than the small intestine. It begins at the ileocecal junction, where the ileum enters the large intestine, and ends at the anus. The large intestine consists of the colon, rectum, and anal canal. The wall of the large intestine has the same types of tissue that are found in other parts of the digestive tract but there are some distinguishing characteristics. The mucosa has a large number of goblet cells but does not have any villi. The longitudinal muscle layer, although present, is incomplete. The longitudinal muscle is limited to three distinct bands, called teniae coli, that run the entire length of the colon. Contraction of the teniae coli exerts pressure on the wall and creates a series of pouches, called haustra, along the colon. Epiploic appendages, pieces of fat-filled connective tissue, are attached to the outer surface of the colon. Unlike the small intestine, the large intestine produces no digestive enzymes. Chemical digestion is completed in the small intestine before the chyme reaches the large intestine. Functions of the large intestine include the absorption of water and electrolytes and the elimination of feces.	Crohn disease is an autoimmune 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.	

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

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

Contributing Risk Factors	Signs and Symptoms	Possible Therapeutic Procedures	Prevention of Complications
Diet, smoking, and stress.	Diarrhea, weight loss, abdominal pain, rectal bleeding	Non-surgical Nutritional therapy Surgical Resection Anastomosis of intestine Stricture plasty	(What are some potential complications associated with this disease process) Hemorrhage, strictures, perforation, abscesses, fistulas, CDI, and colonic dilation

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

Anticipated Medication Management

Aminoacylates'
antimicrobials
Biologic therapy
Corticosteroids
Immunosuppressants

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

Non-Pharmacologic Care Measures

High caorie, high vitamin, high protein, low residue, lactose free diet
Elemental diet or PN
Physical and emotional stress
Referral for counseling
Surgical therapy

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

What stressors might a patient with this diagnosis be experiencing?

Stress
Weight loss
Disturbed body image

Client/Family Education

List 3 potential teaching topics/areas

• smoking cessation

• high protein diet

•lactose free diet

NCLEX I *(1)*: Safe and Effective Care Environment

Multidisciplinary Team Involvement

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

Nutritionist, nurse, counselor, physician

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:Impaired nutritional status
Clinical Reasoning: weight loss, inadequate intake

Goal/EO: client will eat greater than or equal to 50% of all meals during my time of care.

Ongoing Assessments: assess nutritional intake q shift, assess % intake during breakfast, lunch and dinner, assess weight q shift, assess lab values q shift.

NI: 1. Educate on body's nutritional needs q shift

2. Provide additional snack between meals.

3. Provide companionship during mealtime

4.Ensure pleasant environment q shift

5. Ensure proper patient positioning during mealtimes.

6. Provide good oral hygiene BID

Problem # 2 Chronic pain
Clinical Reasoning: abdominal pain 8/10 on numeric scale, facial grimacing

Goal/EO: Client will have a 6/10 pain score or less on a numeric scale during my time of care.

Ongoing Assessments:Assess PQRST of pain q 4 hr, assess HR, BP, RR q4hr

NI: 1. Encourage deep breathing q hour, PRN

2. Apply heating pad q 4hr.

3. Administer Infliximab IV as ordered.

4. Administer Morphine IV as ordered.

5. Encouage diversional activities like watching tv q 2 hour.

6. Educate to report signs and symptoms of pain q shift.

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:
    a. **Dr. March**
    b. **Esther**
2) What were some steps the nursing team demonstrated that promoted patient safety?
    a. **Noticing when patient is not looking like herself.**
    b. **Asking client if there has been any previous reactions with a blood infusion before to prevent any reoccurring one.**
    c. **Verifying patient name and DOB prior to administering anything.**
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, all the medical team used polite language when speaking to each other and to the patient. They all showed examples of therapeutic communication no matter who they were speaking with.
    b. If **no**, describe:
    _____
    _____

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 **yes,** write it here: _____
    b. If **no,** write what you now understand the priority nursing problem to be: **I would expect the priority nursing problem to be acute pain.**
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, vital signs were obtained, also analgesics were administered.
        ii. If **no,** describe:
        _____
        _____
4) After completing the scenario, what is your patient at risk for developing?
    a. Bowel obstruction or an ulcer.
    b. Why? During the endoscopy a bleed was found which could form a blood clot and cause an obstruction if it gets worse. Or from the inflammation an ulcer could form.

_____

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

My biggest take away was understanding the signs and symptoms of a possible blood transfusion reaction. I know now when to realize the patient is having a reaction and to stop the transfusion immediately. Another take away was understanding the proper dosages of morphine, learning in it a simulation is more beneficial so now I can understand what to do and what not to do in clinical.

SOAP Note Based on Priority Problems

Priority Patient Problem #1: Acute Pain

Subjective: *This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.*	**History Present Illness (HPI):** Crohn's disease with intermittent gastritis and 6 months ago she had surgery and ileostomy. Traces of serosanguineous effluent were present in her ostomy bag upon arrival. Blood type is A-, Hemo is seven milligrams per deciliter, and hemat is 21%.6/10 pain score, sore pain in top of abdomen, stress makes pain worse. **PMH: Crohn's disease with intermittent gastritis and 6 months ago she had surgery and ileostomy.** **Allergies: Sulfa** **Current Medications: Morphine sulfate, NSS**
Objective: *This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.*	**Vital Signs: Vital signs were 98.8 pulse is 114 and RR is 22, BP is 100/60, o2 sat is 96%.** **Labs:CBC 2.7, RBS 7, Hemat 21%, MCV 105, MCHc 48,WBC 6,000, Platelet 162,000, PTT 21 sec, PT 12.2 sec, INR 0.7, Blood in stool positive** **Diagnostics: endoscopy, that showed a GI bleed.**
Assessment: *Focused assessments on your priority problem.*	**Vital signs every 15 minutes. Assessing bowel sounds and complete PQRST of pain. Assessing what starts the pain and subsides it. Assess signs and symptoms of any reactions or increased fever.**

Plan ***Based on priority problem only** *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?*	**Plan:** **Administering analgesics, obtaining VS frequently, the nursing interventions that were performed was stopping the blood transfusion when she started having symptoms of a blood transfusion reaction. Normal Saline should be given to KVO, 30 ml per hour. Acetaminophen is to be administered to reduce her pain and reduce her fever.** **Administering morphine for her increased pain after her endoscopy.** **Teaching & Resources:** **Teaching about why the transfusion was stopped. Teaching about endoscopic procedure.** **Nutrition resource, gastroenterologist.**