Student Name: Logan Clark

Medical Diagnosis/Disease: Crohn's Disease

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

Anatomy and Physiology

Normal Structures

The GI tract is a series of hollow organs that are connected to each other from mouth to anus. The organs that make up your GI tract include your mouth, esophagus, stomach, small intestine, large intestine, and anus. The mouth is the beginning of the digestive tract. When chewing your food into pieces that are more easily digested. Saliva mixes with the food to begin to break it down into a form that the body can use. The esophagus receives food from your mouth when you swallow. Muscular contractions within the esophagus called peristalsis delivers food to your stomach. The stomach holds food while it is being mixed with stomach enzymes. These enzymes continue the process of breaking down food into a usable form. After the contents are processed, the are released into the small intestine. The small intestine break downs food using enzymes that are released by the pancreases and bile from liver. The small intestine is made up of 3 segments including duodenum, jejunum, and ileum. Next, the pancreas secretes digestive enzymes into the duodenum that break down protein, fats, and carbohydrates. It also produces insulin. The liver processes the nutrients absorbed from the small intestine. The gallbladder stores bile from the liver. It releases it into the duodenum in the small intestine to help absorb and digest fats. The colon processes waste. It is made up of cecum, ascending, transverse, and descending colon. Next, the rectum receives stool from the colon. Lastly, the anus allows up to control the movement of stool out of our body. It has 2 sphincters that allows us to hold our stool, and finally relaxes when we go to the bathroom

NCLEX IV *(7)*: Reduction of Risk

Pathophysiology of Disease

This disease occurs anywhere in GI tract from mouth to anus. It most often involves distal ileum and proximal colon. Segments of normal bowel can occur between diseased portions. It involves all layers of bowel wall. Ulcerations are deep, longitudinal, penetrate between islands of inflamed edematous mucosa. Crohn's disease has a cobblestone appearance and strictures may develop fistulas in an active flare. It is a type of inflammatory bowel disease that causes swelling/ inflammation of the tissues in your digestive tract, which can lead to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition. There are periods of remission and exacerbation. There are no known causes of Crohn's but factors such as autoimmune disease, genes, and smoking can increase your risk

Anticipated Diagnostics

Labs

CBC

Chem 7

Stool testing (occult blood)

Additional Diagnostics

Colonoscopy

CT

MRI

Capsule endoscopy

Double contrast barium swallow/enema

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

Contributing Risk Factors

Autoimmune diseases

Genetic

Smoking

Immune response

Age (normally diagnosed before 30)

Family hx

NSAIDS

NCLEX IV *(7)*: Reduction of Risk

Signs and Symptoms

Diarrhea

Fever

Fatigue

Abd pain/cramping

Blood in stool

Decreased appetite

Weight loss

Pain/drainage near anus

Rectal bleeding (not often)

Possible Therapeutic Procedures

Non-surgical

Bowel rest

Diet

Steroids

Aminoacylates

Surgical

Strictureplasty

Segmental bowel resection with reanastomosis

(not curative)

Colostomy

Ileostomy

Prevention of Complications

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

Hemorrhage

Strictures

Perforation

Abscesses

Fistulas

C. diff infection

Colonic dilation

Increased risk of colorectal cancer

Bowel obstruction

Ulcers

Malnutrition

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

Anticipated Medication Management

Corticosteroids

5- amnio salicylates

Immunosuppressants

Biologic therapies

Antimicrobials for secondary infection

Pain relivers

Vitamins for nutritional support

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

Non-Pharmacologic Care Measures

Bowel rest

Correct malnutrition

Provide symptomatic relief

Improve quality of life

Hospitalization for severe exacerbations or complications

Healthy diet

Adequate nutrition

Fluid/electrolyte balance

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

What stressors might a patient with this diagnosis be experiencing?

$

Job/working

Paying medical bills

Finding a treatment to help with disease

Client/Family Education

List 3 potential teaching topics/areas

- Encourage a low residue or low fiber diet to reduce risk of blockages in the intestines and decrease # of stools
- Encourage adequate fluid intake to prevent dehydration
- Educate importance to maintain disease to prevent flare ups from occurring and induce remission if possible

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)

PCP

Gastroenterologist

CT/MRI tech

Phlebotomy

General surgery team

Patient Problems (Nursing Diagnoses)

List two potential patient problems you will be addressing as part of your nurse's notes, along with clinical reasoning, goals/expected outcomes, assessments, and priority nursing interventions. The patient problems must be in priority order. Six nursing interventions for each priority problem must be completed.

Problem # 1: Deficient Fluid Volume: r/t blood loss due to GI bleed
Clinical Reasoning: Low hemoglobin and hematocrit levels, hypotension, tachycardic, increased RR

Goal/EO: Mrs. L will maintain a normal hemoglobin and hematocrit levels as well as normal blood pressure, heart rate and respiration rate during my time of care

Ongoing Assessments: 1. Assess stool color, amount, and consistency q4hrs/prn 2. Assess medication history such as use of NSAIDS on admission 3. Assess ETOH use on admission 4. Monitor vital signs q4hrs/prn 5. Monitor intake and output q8hrs 6. Assess UO q2hrs 7. Monitor Hgb/Hct levels daily 8. Monitor platelet count daily 9. Assess mucus membranes q8hrs 10. Assess electrolyte levels daily

NI: 1. Administer blood transfusion products such as RBC as needed

2. Administer/maintain IV fluids 0.9% NS as needed

3. Encourage adequate fluid intake (2000ml) daily/prn

4. Administer antipyretics for fevers as needed

5. Promote oral hygiene BID/PRN

6. Educate importance of maintaining nutritional status by the use of a clear liquid diet until able to tolerate solid foods

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Problem # 2: Acute Pain: abdominal area
Clinical Reasoning: Active GI bleed and history of Crohn's disease

Goal/EO: Mrs. L will report a pain level of 4 or less using a 0-10 numeric pain scale during my time of care

Ongoing Assessments: 1. Assess PQRST of pain q4hrs 2. Assess location of pain q4hrs 3. Determine pain perception of patient daily/prn 4. Assess vital signs q4hrs/prn 5. Assess willingness to control pain daily 6. Assess pain scale/score q4hrs/prn 7. Assess pain scale/score 30mins-1hr after medication administration 8. Assess guarding, facial, or expression behaviors q4hrs/prn

NI: 1. Administer IV Morphine 2.5-5mg (Ms. L dose 4mg) q4hrs as needed

2. Encourage use of non-pharmacologic pain management strategies such as distraction or guided imagery q4hrs/prn

3. Encourage ambulation followed by rest periods q2hrs/prn

4. Provide a warm compress to abdominal area q1hr in 20 minute increments

5. Provide a calm environment as needed

6. Perform and provide cluster care to help optimize comfort as needed

ACTIVE LEARNING TEMPLATE: *Medication*

STUDENT NAME Logan Clark

MEDICATION Infliximab (Remicade) REVIEW MODULE CHAPTER

CATEGORY CLASS TNF blocking agent, antirhemuatic, GI immunosuppresant

PURPOSE OF MEDICATION

Expected Pharmacological Action

Binds to TNF inhibiting functional activity of TNF (induction of proinflammatory cytokines, enhanced leukocytic migration, activation of neutrophills/eosinophills

Therapeutic Use

Prevents disease and allows for diseased joints to heal

Complications

Headache, nausea, fatigue, fever, fever/chills during infusion, pharyngitis, vomiting, pain, dizzness, cough, pruritus, back pain

Medication Administration

Crohn's disease: 5mg/kg followed by additional doses at 2 and 6 weeks after first infusion, then q8weeks thereafter. For adults who respond then lose respond 10mg may be considered for treatment

RA: 3mg/kg followed by additonal doses at 2 and 6 wks after first infusion then q8weeks range is 3-10mg/kg

Contraindications/Precautions

Hypersensitivity, moderate-severe HF, sensitivty to murine proteins, sepsis, active infection, hematologic abnormalities, hx of COPD, CNS disorders, seziures, mild HF, reccurent infections, TB exposure, hep B virus

Nursing Interventions

Monitor urinalysis, ESR, BP. Monitor for signs of infection, Monitor daily stool pattern/stool consistency. In Crohn's pts: monitor CRP, frequency of stools, abd pain. In RA, montiro CRP, pain, decreased swollen joints/stiffness

Interactions

Anakinra, anti-TNF agents, baricitinib, pimecrolimus, rituximab, tarcolimus, tocilizumab, BCG, live vaccines, herbals such as echinacea, may increase serum alkaline phosphate, ALT, AST, bilirubin levels

Client Education

Report fever, cough, abd pain, swelling of ankles or feet. Tx may depress immune system and reduce ability ro fight infection. Report symptoms of infection such as body aches, chills, cough, fatigue, fever. Do not receive live vaccines, expect frequent TB screenings, Report travel plans

Evaluation of Medication Effectiveness

Reduce signs and symptoms of Crohn's diease. Maintain remission in adult patients with moderately to severely active Crohn's disease who haven't responded well to other therapies

ACTIVE LEARNING TEMPLATE: *Medication*

STUDENT NAME Logan Clark

MEDICATION Morphine REVIEW MODULE CHAPTER _____

CATEGORY CLASS Opioid agonist (schedule II), Opioid analgesic

PURPOSE OF MEDICATION

Expected Pharmacological Action

Binds with opioid receptors within CNS inhibiting ascending pain pathways

Therapeutic Use

Alters pain perception and emotional response to pain

Complications

Nausea, vomiting, sedation, decreased Bp (orthostatic hypotension in some cases), diaphoresis, facial flushing, consitpation, dizziness, drowsiness, allergic reaction, dyspnea, confusion, tremors, urinary rention

Contraindications/Precautions

Hypersensitivty, acute/severe asthma, gi obstruction, known or suspected paralytic ileus, concurrent used of MAOIS within 14 days, severe respirtory depression, COPD, cor pulmonale, hypoxia, hypercapnia, head injury, IICP, severe hypotension, addison disease, CV diease, hx of drug abuse, seziures, depression

Interactions

Alcohol, CNS depressants (lorazepam & gabapentin), MAOIs (phenelzine), herbals with sedative properties, may increase serum amylase, lipase

Evaluation of Medication Effectiveness

Relief of moderate-severe, acute or chronic pain

Analgesia during labor, pain due to MI, dyspnea from pulmonary edema

Medication Administration

IV: 2.5-5mg q3-4hrs as needed. Repeated doses (1-2mg) may be given more frequently (every hr) if needed

IV continous: 0.8-10mg/hr Range 20-50mg.hr

PCA IV: 1mg/ml demand dose 1mg lockout interval 5-10mins

Nursing Interventions

Monitor VS 5-10mins after IV admin, 15-30mins after SQ/IM. Be alert for decreased RR, BP. Check adequate voiding. Monitor daily bowel pattern, stool consistency, avoid constipation, Initiate deep breathing/coughing exercises, assess for clinical improvement, record onset of pain relief. Screen for drug abuse

Client Education

Change postions slowly to avoid orthostatic hypotension, avoid taks that require alertness until response to drug is established, avoid alcohol/cns depressants, tolerance/dependence may occur with high doses, report ineffective pain control, constipation, or urinary retention

Module Report

Tutorial: Real Life RN Medical Surgical 4.0

Module: GI Bleed

Individual Name: **Logan Clark**

Institution: **Margaret H Rollins SON at Beebe Medical Center**

Program Type: **Diploma**

Standard Use Time and Score

	Date/Time	Time Use	Score
GI Bleed	5/8/2023 1:49:01 PM	43 min	Strong

Reasoning Scenario Details

GI Bleed - Use on 5/8/2023 1:06:31 PM

Reasoning Scenario Performance Related to Outcomes:

*See Score Explanation and Interpretation below for additional details.

Body Function	Strong	Satisfactory	Needs Improvement
Cardiac Output and Tissue Perfusion	100%		
Cognition and Sensation	100%		
Ingestion, Digestion, Absorption & Elimination	100%		
Regulation and Metabolism	100%		

NCLEX RN	Strong	Satisfactory	Needs Improvement
RN Management of Care	100%		
RN Health Promotion and Maintenance	100%		
RN Psychosocial Integrity	100%		
RN Pharmacological and Parenteral Therapies	100%		
RN Reduction of Risk Potential	100%		
RN Physiological Adaptation	100%		

QSEN	Strong	Satisfactory	Needs Improvement
Safety	100%		
Patient-Centered Care	100%		
Evidence Based Practice	100%		

Decision Log:

Optimal Decision	
Scenario	Nurse Esther listens to bowel sounds.
Question	Nurse Esther listens to Ms. Lieberman's abdomen in all four quadrants and determines Ms. Lieberman's bowel sounds are hyperactive. Listen to the four audio clips. Which of the following sounds is an expected finding for Ms. Lieberman?
Selected Option	Option C: Audio clip of bowel sounds occurring 45 times in 1 min.
Rationale	Bowel sounds are clicks and gurgles heard in the abdomen. Bowel sounds within the expected reference range are irregular sounds that occur five to 35 times a minute. This finding indicates hyperactive bowel sounds. Therefore, this is the expected finding for this client.

Optimal Decision	
Scenario	Ms. Lieberman reports she feels lightheaded and dizzy.
Question	Ms. Lieberman states she is feeling lightheaded and dizzy. Her skin color is pale. Which of the following should be Nurse Esther's priority action?
Selected Option	Measure Ms. Lieberman's vital signs.
Rationale	The client is at risk for hypovolemic shock due to the loss of extracellular fluid and blood. Clinical manifestations of hypovolemic shock include hypotension and tachycardia. Therefore, the nurse should assess the client's status by obtaining her vital signs.

Optimal Decision	
Scenario	Nurse Esther obtains Ms. Lieberman's vital signs after she reports feeling faint.
Question	Ms. Lieberman reports feeling worse and her vital signs are: BP 94/56 mm Hg, pulse 110/min, respirations 26/min, and SaO2 94%. Nurse Esther starts oxygen at 2 L/min. Which of the following should be Nurse Esther's priority action?
Selected Option	Lower the head of the bed.
Rationale	Using the ABC priority-setting framework, the priority response is to promote improved circulation by lowering the head of the bed and elevating the client's feet. This action can prevent hypovolemic shock until adequate blood volume is restored.

Optimal Decision

Scenario	The unit of packed RBCs for Ms. Lieberman arrives on the unit.
Question	Nurse Esther is preparing to administer a unit of packed RBCs to Ms. Lieberman. Which of the following actions should Nurse Esther perform prior to administering the blood?
Selected Option	Ask Ms. Lieberman if she has experienced a reaction with any previous blood transfusions.
Rationale	A transfusion reaction can be caused by the development of antibodies to the donor leukocytes. This reaction is more likely to occur when a client has had blood transfusions before, as well as a history of prior blood transfusion reactions. Therefore, this is the appropriate action for the nurse to take.

Optimal Decision	
Scenario	Nurse Esther is ready to administer the first unit of packed RBCs.
Question	Identify the correct sequence of actions for blood administration after Nurse Esther performs hand hygiene and applies gloves. (Reorder the steps by dragging them into the desired sequence.)
Selected Ordering	Spike and prime the Y-set tubing with the 0.9% sodium chloride solution.Attach the tubing to the IV catheter and begin to infuse the 0.9% sodium chloride solution.Gently rotate the bag of packed RBCs.Attach the packed RBCs bag to the Y-set tubing.Turn off the 0.9% sodium chloride solution.Begin to infuse the packed RBCs.
Rationale	The first action the nurse should do is insert one of the spikes of the Y-set into the 0.9% sodium chloride solution bag, prime the tubing with the 0.9% sodium chloride solution, and start slowly infusing the solution into the client's IV. Next, the nurse should gently rotate the bag to mix the blood cells with the plasma. Then, the nurse should spike the blood bag with the remaining spike on the Y-set tubing and turn off the 0.9% sodium chloride solution by closing the clamp. Lastly, the nurse needs to open the clamp to allow the blood to infuse.

Optimal Decision	
Scenario	Ms. Lieberman is restless, her face is flushed, and she reports having a headache.
Question	Nurse Esther notes Ms. Lieberman is restless, her face is flushed, and she reports having a headache. Her vital signs include: temperature 38.8° C (101.8° F), pulse 96/min, respirations 22/min, and BP 103/60 mm Hg. Which of the following is an appropriate action for Nurse Esther to take?
Selected Option	Stop the blood transfusion.
Rationale	In the presence of a febrile reaction, the client's blood is sensitive to some component of the donor's blood. To prevent further exposure to the sensitizing component, the transfusion should be stopped immediately.

Scenario	Using an SBAR format, write the information Nurse Esther should give to Ms. Lieberman's provider when calling about her response to the blood. Refer to the EMR documents for needed information.

Question	Using an SBAR format, write the information Nurse Esther should give to Ms. Lieberman's provider when calling about her response to the blood. Refer to the EMR documents for needed information. (Enter your response, then click on the submit button at the bottom of the screen. Compare your response to the one provided.)
Selected Option	JL 36 year old female presented to ER with a GI bleed. She is allergic to sulfa. On admission her vital signs were stable. On admission her Hgb was 7 and her Hct was 21%. She does have a history of Crohn's disease and gastritis. 6 months ago she had a ileostomy placed. She also started Infliximab IV every 8weeks with her last infusion being 7 weeks ago. Due to her Hgb/Hct levels, RBC were ordered. She received one bag and part of the second bag but it had to be stopped due to increased temperature 101.8. I think that a blood transfusion reaction may be occurring. As of right now her infusion is stopped. Her vitals are as followed RR: 26, O2: 97%, BP: 110/70. She now has NS running . What would you like to order next? Anything for fever? or her reaction?
Rationale	The following information should be shared with Ms. Lieberman's provider when calling about her response to the blood. Situation: Dr. McGuire, this is Esther - RN. I am taking care of Ms. Lieberman in room 5206. She is a 36-year-old client admitted from the ED today for a GI bleed. She's had one unit of packed RBCs and part of the second unit of blood. I stopped the second unit because I believe she is having a transfusion reaction. Her baseline temperature was 98.6 and is now 101.8. Ms. Lieberman reports having a headache, chills, and is restless. She does not have any evidence of a rash at this time.Background: Ms. Lieberman has a history of Crohn's disease and intermittent gastritis. Six months ago she had an ileostomy and started on infliximab IV every 8 weeks. Her last infusion was 7 weeks ago.Assessment: Her hemoglobin was 7 g/dL and her hematocrit was 21% in the ED. When she arrived to the medical surgical unit, her BP was 94/56 and her pulse 110, but now her BP is 110/70 and her pulse is 110. At this time, her respirations are 26, her SaO2 is 97%, and her temperature is 101.8. I have discontinued the second unit of blood and plan to send both the bags of blood to the lab per protocol. I hung a new bag of 0.9% sodium chloride to keep the line open.Recommendations: Ms. Lieberman is requesting ibuprofen for her headache, which would also bring her fever down. Could I have an prescription for an antipyretic, and do you want to continue the IV infusion of 0.9% sodium chloride at 150 mL/hr?

Optimal Decision	
Scenario	Dr. March tells Ms. Lieberman that he recommends an endoscopy. Ms. Lieberman is informed about the procedure. She agrees to the procedure and signs the consent form.
Question	Nurse Esther is reinforcing teaching with Ms. Lieberman, who is scheduled for an endoscopy in the morning. Which of the following should Nurse Esther include in the teaching?
Selected Option	"A medication to reduce oral secretions may be administered."
Rationale	The nurse could administer atropine (Sal-Tropine), a muscarinic antagonist, to inhibit salivary and bronchial secretions.

Optimal Decision

Scenario	Nurse Esther is calculating the number of milliliters of morphine sulfate to administer.
Question	Nurse Esther is preparing to administer morphine 4 mg IV. Available is morphine 8 mg/mL. How many mL should the nurse administer? (Round the answer to the nearest tenth.).
Selected Option	0.5
Rationale	**Follow these steps for the Ratio and Proportion method of calculation:** Step 1: What is the unit of measurement the nurse should calculate? mL Step 2: What is the dose the nurse should administer? Dose to administer = Desired 4 mg Step 3: What is the dose available? Dose available = Have 8 mg Step 4: Should the nurse convert the units of measurement? No Step 5: What is the quantity of the dose available? 1 mL Step 6: Set up an equation and solve for X. *HaveDesired = QuantityX8 mg4 mg = &#1601 mLX mL* *X mL = 0.5 mL* *Step 7: Round if necessary.* *Step 8: Determine whether the amount to administer makes sense. If there are 8 mg/mL and the prescription reads 4 mg, it makes sense to administer 0.5 mL. The nurse should administer morphine 0.5 mL IV.* ***Follow these steps for the Desired Over Have method of calculation:*** *Step 1: What is the unit of measurement the nurse should calculate? mL* *Step 2: What is the dose the nurse should administer? Dose to administer = Desired 4 mg* *Step 3: What is the dose available? Dose available = Have 8 mg* *Step 4: Should the nurse convert the units of measurement? No* *Step 5: What is the quantity of the dose available? 1 mL* *Step 6: Set up an equation and solve for X.* *Desired × QuantityX = Have4 ~~mg~~ × 1 mLX mL = &#1608 ~~mg~~* *X mL = 0.5 mL* *Step 7: Round if necessary.* *Step 8: Determine whether the amount to administer makes sense. If there are 8 mg/mL and the prescription reads 4 mg, it makes sense to administer 0.5 mL. The nurse should administer morphine 0.5 mL IV.* ***Follow these steps for the Dimensional Analysis method of calculation:*** *Step 1: What is the unit of measurement the nurse should calculate? (Place the unit of measure being calculated on the left side of the equation.)* *X mL =* *Step 2: Determine the ratio that contains the same unit as the unit being calculated. (Place the ratio on the right side of the equation, ensuring that the unit in the numerator matches the unit being calculated.)* *1 mLX mL = &#1608 mg* *Step 3: Place any remaining ratios that are relevant to the item on the right side of the equation, along with any needed conversion factors, to cancel out unwanted units of measurement.* *1 mL4 ~~mg~~X mL = × &#1608 ~~mg~~1* *Step 4: Solve for X.* *X mL = 0.5 mL* *Step 5: Round if necessary.* *Step 6: Determine whether the amount to administer makes sense. If there are 8 mg/mL and the prescription reads 4 mg, it makes sense to administer 0.5 mL. The nurse should administer morphine 0.5 mL IV.*

Optimal Decision	
Scenario	Nursing considerations Nurse Esther takes when administering morphine.
Question	Nurse Esther is preparing to administer 4 mg of morphine IV bolus to Ms. Lieberman. Which of the following actions should Nurse Esther take?
Selected Option	Infuse morphine at a rate of 1 mg/min.
Rationale	To prevent serious adverse reactions, such as respiratory arrest, the nurse should inject the medication at a rate of 1 mg/min.

Optimal Decision	
Scenario	Nurse Esther talks to Ms. Lieberman about needing several drinks after work to relax.
Question	Ms. Lieberman tells Nurse Esther she has a stressful job working in the city as a stockbroker, and that sometimes at night she has up to five drinks. Which of the following is an appropriate statement made by Nurse Esther?
Selected Option	"Tell me more about the stress you are feeling."
Rationale	Providing an open-ended statement, along with active listening, allows the client to express her thoughts and feelings. It also establishes trust.

Scenario	Identify five stress management strategies Nurse Esther should recommend to Ms. Lieberman to promote a healthier lifestyle.
Question	Identify five stress management strategies Nurse Esther should recommend to Ms. Lieberman to promote a healthier lifestyle. (Enter your response, then click on the submit button at the bottom of the screen. Compare your response to the one provided.)
Selected Option	1. Decrease alcohol intake 2. Use relaxation techniques 3. Exercise regularly 4. Evaluate current job status 5. Adequate sleep
Rationale	Identify five stress management strategies Nurse Esther should recommend to Ms. Lieberman to promote a healthier lifestyle.1. Perform light, regular exercise.2. Write in a journal.3. Listen to music.4. Consider a pet.5. Get adequate sleep.6. Promote relaxation through use of progressive muscle relaxation, guided imagery, massage therapy, humor, and/or yoga.7. Enhance her social support system, such as an ostomy support group, AA, and/or coping support group.8. Evaluate current job, lifestyle, and home location.

Optimal Decision	
Scenario	Nurse Esther discusses diet with Ms. Lieberman.
Question	Nurse Esther is reinforcing diet teaching with Ms. Lieberman. Which of the following dietary recommendations should she make?
Selected Option	Eat foods that are high protein.
Rationale	Clients who have Crohn's disease are at risk for malnutrition because they may attempt to control symptoms by restricting their diet. Additionally, clients who have Crohn's disease are at risk for malabsorption of nutrients. The client should be instructed to maximize her nutrition by eating foods high in protein.

Optimal Decision	
Scenario	Nurse Esther provides Ms. Lieberman with educational material to take home.
Question	Nurse Esther provides Ms. Lieberman with information about health promotion. Which of the following should she include in the teaching?
Selected Option	Advise Ms. Lieberman to avoid the use of ibuprofen.
Rationale	Clients who have Crohn's disease should not take nonsteroidal anti-inflammatory drugs (NSAIDs) because they can cause gastrointestinal bleeding.

Score Explanation and Interpretation
Individual Performance Profile

REASONING SCENARIO INFORMATION

Reasoning Scenario Information provides the date, time and amount of time use, along with the score earned for each attempt. The percentage of students earning a Scenario Performance of Strong, Satisfactory, or Needs Improvement is provided. In addition, the Scenario Performance for each student is provided, along with date, time, and time use for each attempt. This information is also provided for the Optimal Decision Mode if it has been enabled.

If a detrimental decision is made during a Real Life scenario, the scenario will diverge from the optimal path and potentially end prematurely, in which case an indicator will appear on the score report.

REASONING SCENARIO PERFORMANCE SCORES

Strong	Exhibits optimal reasoning that results in positive outcomes in the care of clients and resolution of problems.
Satisfactory	Exhibits reasoning that results in mildly helpful or neutral outcomes in the care of clients and resolution of problems.
Needs Improvement	Exhibits reasoning that results in harmful or detrimental outcomes in the care of clients and resolution of problems.

REASONING SCENARIO PERFORMANCE RELATED TO NURSING COMPETENCY OUTCOMES

A performance indicator is provided for each outcome listed within the nursing competency outcome categories. Percentages are based on the number of questions answered correctly out of the total number of questions that were assigned to the given outcome. Outcomes have varying numbers of questions assigned to them. Also, due to divergent paths within the branching simulation, the outcomes encountered and the number of questions for each outcome can vary. The above factors cause limitations related to comparing scores across students or groups of students.

NCLEX® CLIENT NEED CATEGORIES

Management of Care	Providing integrated, cost-effective care to clients by coordinating, supervising, and/or collaborating with members of the multi-disciplinary health care team.
Safety and Infection Control	Incorporating preventative safety measures in the provision of client care that provides for the health and well-being of clients, significant others, and members of the health care team.
Health Promotion and Maintenance	Providing and directing nursing care that encourages prevention and early detection of illness, as well as the promotion of health.
Psychosocial Integrity	Promoting mental, emotional, and social well-being of clients and significant others through the provision of nursing care.
Basic Care and Comfort	Promoting comfort while helping clients perform activities of daily living.
Pharmacological and Parenteral Therapies	Providing and directing administration of medication, including parenteral therapy.
Reduction of Risk Potential	Providing nursing care that decreases the risk of clients developing health-related complications.
Physiological Adaptation	Providing and directing nursing care for clients experiencing physical illness.

Score Explanation and Interpretation
Individual Performance Profile

QUALITY AND SAFETY EDUCATION FOR NURSES (QSEN)

Safety	The minimization of risk factors that could cause injury or harm while promoting quality care and maintaining a secure environment for clients, self, and others.
Patient-Centered Care	The provision of caring and compassionate, culturally sensitive care that is based on a client's physiological, psychological, sociological, spiritual, and cultural needs, preferences, and values.
Evidence Based Practice	The use of current knowledge from research and other credible sources, upon which clinical judgment and client care are based.
Informatics	The use of information technology as a communication and information gathering tool that supports clinical decision making and scientifically based nursing practice.
Quality Improvement	Care related and organizational processes that involve the development and implementation of a plan to improve health care services and better meet the needs of clients.
Teamwork and Collaboration	The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes.

BODY FUNCTION

Cardiac Output and Tissue Perfusion	The anatomical structures (heart, blood vessels, and blood) and body functions that support adequate cardiac output and perfusion of body tissues.
Cognition and Sensation	The anatomical structures (brain, central and peripheral nervous systems, eyes and ears) and body functions that support perception, interpretation, and response to internal and external stimuli.
Excretion	The anatomical structures (kidney, ureters, and bladder) and body functions that support filtration and excretion of liquid wastes, regulate fluid and electrolyte and acid-base balance.
Immunity	The anatomic structures (spleen, thymus, bone marrow, and lymphatic system) and body functions related to inflammation, immunity, and cell growth.
Ingestion, Digestion, Absorption, and Elimination	The anatomical structures (mouth, esophagus, stomach, gall bladder, liver, small and large bowel, and rectum) and body functions that support ingestion, digestion, and absorption of food and elimination of solid wastes from the body.
Integument	The anatomical structures (skin, hair, and nails) and body functions related to protecting the inner organs from the external environment and injury.
Mobility	The anatomical structures (bones, joints, and muscles) and body functions that support the body and provide its movement.
Oxygenation	The anatomical structures (nose, pharynx, larynx, trachea, and lungs) and body functions that support adequate oxygenation of tissues and removal of carbon dioxide.
Regulation and Metabolism	The anatomical structures (pituitary, thyroid, parathyroid, pancreas, and adrenal glands) and body functions that regulate the body's internal environment.
Reproduction	The anatomical structures (breasts, ovaries, fallopian tubes, uterus, vagina, vulva, testicles, prostate, scrotum, and penis) and body functions that support reproductive functions.

DECISION LOG

Information related to each question answered in a scenario attempt is listed in the report. A brief description of the scenario, question, selected option and rationale for that option are provided for each question answered. The words "Optimal Decision" appear next to the question when the most optimal option was selected.

The rationale for each selected option may be used to guide remediation. A variety of learning resources may be used in the review process, including related ATI Review Modules.

If a detrimental decision that could result in grave harm to the client is made during a Real Life scenario, the scenario ends immediately and an indicator that a detrimental decision has been made appears in the score report.
A detrimental decision indicates the need to remediate the related topic area to prevent detrimental outcomes in the future.

EX_RealLife_Ind

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. Dr. March (Provide, Gastroenterologist)
2) What were some steps the nursing team demonstrated that promoted patient safety?
    a. The ER nurse provided a through report to the new nurse Esther who would be receiving Mrs. Lieberman. When moving the patient from the ER, the ER nurse promoted safety care by making sure got to her new room safely. Once in room, the ER nurse explained and showed the Esther her ileostomy that was place prior to this admission. She also explained other necessary medical information before leaving the room.
    b. Nurse Esther obtained vital signs when patient stated that she was feeling dizzy and felt like she was going to faint. This is important to make sure due to hypovolemic shock does not occur.
    c. Nurse Esther placed 2L of oxygen on patient after measuring vital signs and finding O2 sat was 94%. She then lowered her HOB to improve circulation.
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, I feel as if the nurse and the medical team used therapeutic communication techniques when interacting with the patient and other health team members. The nursing staff and the doctor explained everything that they were doing thoroughly and answered any questions that the patient may have had during her medical care. I think that the doctor could have maybe explained the endoscopy a little bit more in depth. Nurse Esther and the patient connected well. The patient trusted nurse Esther throughout her care and even at the end when she was teaching about healthy lifestyle choices.

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: Deficient fluid volume: r/t too blood loss due to GI bleed

3. Review your Patient Problem Form: Did you see many of your anticipated nursing assessments and interventions used?
    b. Were there interventions you included that *were not* used in the scenario that could help this patient?
        i. If **yes,** describe: I did see both assessments and interventions used for both of my patient problems that I chose such as assessing her hgb and hct level, assessing her BP/HR/RR, assessing her medication use at home such as NSAIDs. She administered blood transfusion products, maintained/administered NS fluids, The nurse also asked for an antipyretic for the fever that Ms. L was experiencing, and at the very end of the scenario when Ms. L was feeling much better, she discussed her diet and lifestyle at home which is very important. I also saw Nurse Esther assess her pain scale, administer morphine, provided a calm environment, and as well assessing her vital signs. Some interventions that were not used in this scenario that

potentially could have helped this patient include encouraging adequate fluid intake, promoting oral hygiene, educating importance of a clear liquid diet, full liquid diet, etc.. even though she did educate importance of protein foods at the end of the scenario. For acute pain that Ms. L was experiencing, Nurse Esther could have used interventions such as use of other pain medications to maintain her pain level below the 8 that she was experiencing before the morphine was given. Maintaining her pain is important because it should get to the point where it is so severe she cannot handle it. In addition, rest periods, ambulation, clustering care, and non-pharmacological strategies to decrease pain could have been used as well.

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

a. Hypovolemic shock due to hypotension, reaction to blood transfusion, and blood loss from the gi bleed. She was also starting to feel dizzy and felt as if she was going to faint. She also had a fever.

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 from participating in the care of this patient is that nursing judgement and critical thinking skills are important to patient care. For an example, the patient in this scenario started to have signs and symptoms of a blood transfusion reaction. Without hesitation, the nurse stopped the blood transfusion first and then called the provider about her presenting symptoms. She put the safety of the patient first by stopping the blood transfusion. If the blood transfusion continued to run, there would most likely have been further complications and could have ran into bigger issues such as hypovolemic shock. I also observed great communication between the patient and the nurse throughout the scenario which allowed for the patient to trust the nurse with her care. This scenario impacted my nursing practice by showing me the importance of nursing judgement and critical thinking skills. The nurse is with the patient more than anyone else so they are the first person to see changes occur within the patient. It is important to make quick but safe choices to benefit a patients medical care and prevents them from further complications. In addition to just nursing care, I also learned to not box myself in when thinking about patient problems. During this entire scenario, I was thinking about all possible options that I could choose to focus on not only for my patient problem form but, when providing nursing care as well. Another big one that I saw was anxiety. Ms. L had a lot of stress and anxiety that lead to her increased consumption of alcohol which was one of her risk factors with the GI bleed.

SOAP Note Based on Priority Problems

Priority Patient Problem #1: Deficient Fluid Volume: r/t too blood loss due to GI bleed

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):** Active GI bleed. Seen in ED for abdominal pain, bloody stools, dizziness **PMH:** Crohn's disease since 19 and intermittent gastritis. In 2009, had a severe exacerbation leading to surgery and ileostomy performed. Frequent OTC anti-inflammatory meds and alcohol use. **Allergies:** Sulfa **Current Medications:** Infliximab IV q8 weeks, Frequent use of OTC anti-inflammatory meds, Morphine 4mg IV bolus q2hr PRN for pain, 0.9% sodium chloride 150ml/hr. No other prescribed medications
Objective: *This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.*	**Vital Signs:** @1500: T: 98.6 HR: 110 RR: 26 BP: 94/56 O2 Sat: 95% 2L @1530: T: 98.8 HR: 114 RR: 22 BP: 100/60 O2 Sat: 95% 2L **Labs:** Hgb: **7** Hct: 21% RBC: 2.7 MCHc: 48 Blood type: A (RH negative) Blood in stool = positive Type and cross for 2 units of PRBC **Diagnostics:** Endoscopy in am
Assessment: *Focused assessments on your priority problem.*	**Assessments:** CC: abdominal pain, bloody stools, dizziness Alert and oriented x3 36 yr old thin female Skin is fair/pale Nail beds are pink and capillary refill is normal Mouth and throat is pink, mucosa is dry, no lesions present Uvula rises on phonation HR elevated, S1&S2 present and normal Breath sounds clear Abd soft and flat Hyperactive bowel sounds Moderate overall abd tenderness Ileostomy present of LRQ draining semi liquid stool with red streaks y Intake 400ml UO: 500ml

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**: Endoscopy in am Follow up CBC (hgb, hct, rbc, mchc) Monitor ileostomy output and stools for blood q1hr Administer Morphine 4mg IV bolus q2hr/prn for pain Monitor I&O Clear liquid diet Administer 2 units of RBC as soon as available Monitor VS q4hrs or as needed Call provider if O2 sat is less than 92% Administer 0.9% NS 150ml/hr Transfer to med surg unit for transfusion and monitoring of stools **Teaching & Resources:** Limit alcohol intake Increase protein in diet Avoid high fiber foods that could cause obstructions Exercise frequently Avoid stress if possible r/t to occupation