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Medical Diagnosis/Disease: Crohn's disease

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology

Normal Structures

GI tract: mouth (*ingestion, mastication, deglutition*), pharynx (*swallowing reflex, transport food from mouth to esophagus, epiglottis covers trachea to prevent aspiration*), esophagus (*uses peristalsis wave motions to move food down into stomach, controls food entering using UES and leaving LES*), stomach (*store food, mix food with gastric secretions, empty into small intestine in small boluses*), small intestine {duodenum, jejunum, ileum} (*absorption of vitamins, minerals, electrolytes, fatty acids, amino acids, water, and monosaccharides, and digestion*), large intestine {ascending colon, transverse colon, descending colon, sigmoid colon} (*absorb water and electrolytes, form stool, reservoir for stool until it is defecated*), rectum (*defecation*), anus (*defecation*)

Pathophysiology of Disease

IBD: chronic inflammation of the GI tract with periods or remission and exacerbation. Crohn's is segmental, including all of GI tract: mouth to anus
Autoimmune response to person's own GI tract. From overactive, inappropriate, or sustained immune response to environment or bacterial triggers.
Most common site is distal ileum
Entire thickness of bowel wall

NCLEX IV (7): Reduction of Risk

Anticipated Diagnostics

Labs

CBC- iron deficient anemia, infection
BMP- lytes

Stool analysis & culture
CRP

Additional Diagnostics

Double contrast barium enema

Small bowel series
Transabdominal US

CT, MRI

Colonoscopy

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors

Diet (high refined sugar, total fats, polyunsaturated fatty acids, omega-6 fatty acids. Eating a lot of raw fruits/veggies, omega-3 rich foods, and dietary fibers)
smoking
stress
NSAID use
ABX use
Oral contraceptives

Signs and Symptoms

Abdominal pain and cramping
Diarrhea
Fever
Malabsorption and nutrient deficiency
Weight loss
Rectal bleeding

NCLEX IV (7): Reduction of Risk

Possible Therapeutic Procedures

Non-surgical

Surgical

Fix cx mostly
Bowel resection
Strictureplasty

Prevention of Complications

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

Small bowel CA
Colorectal CA
C. Diff perforation
abscess or fistula
short bowel syndrome

NCLEX IV (6): Pharmacological and Parenteral Therapies

Anticipated Medication Management

5- ASA (amino salicylic acid)
Corticosteroids
Immunosuppressants
Methotrexate

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures

Nutritional therapy

NCLEX III (4): Psychosocial/Holistic Care Needs

What stressors might a patient with this diagnosis be experiencing?

Pain
Unable to eat/drink a lot
Surgery
Hospitalization
Bills

Client/Family Education

List 3 potential teaching topics/areas

- **Dietary changes**
- Prevention of complications
- surgical pre and post op care

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)

gastroenterologist
surgeon/surgical team
nurses
CM
hospitalist

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: Acute pain: abdomen

Clinical Reasoning: Crohn's disease

Goal/EO: Pt will rate pain less than 4/10 on numerical scale during my time of care.

Ongoing Assessments: pain PQRST q4h, pain goal q shift, pain relief measure success 30 mins after admin, bowel sounds q6h, VS (HR, BP, RR) q4h

- NI:
1. Administer analgesic as ordered PRN pain.
 2. Apply heating pad q2h intermittently.
 3. Encourage mindfulness and distraction techniques including music, TV and books q4h PRN pain.
 4. Encourage ambulation q3h.
 5. Administer immunosuppressants as ordered.
 6. Educate on dietary changes such as small, frequent meals and increasing dietary fiber q shift.
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Problem # 2 Diarrhea

Clinical Reasoning: Chron's disease

Goal/EO: Pt will pass formed stool during my time of care.

Ongoing Assessments: bowel sounds q4h, patterns of BM q shift, abdominal cramping/pain q4h, characteristics of stool q BM, perianal skin q shift

- NI:
1. Administer antidiarrheal medications PRN as ordered.
 2. Encourage fluids (2L in 24 hrs plus 200ml per loose stool) q2h.
 3. Educate to avoid foods that can trigger diarrhea including caffeine, fresh fruits, and vegetables q shift.
 4. Encourage frequent toileting q2h.
 5. Encourage BRAT diet (banana, rice, apple, toast) q shift.
 6. Educate on importance of perianal hygiene between BM q shift.

ATI Virtual Clinical Questions and Reflection:

- 1) Identify two members of the healthcare team collaborating in the care of this patient:
 - a. **Esther**
 - b. **Kari**
- 2) What were some steps the nursing team demonstrated that promoted patient safety?
 - a. **Having the patient state their name and DOB before administering the blood**
 - b. **Stopping the transfusion**
 - c. **Asking if she had any prior reactions to blood transfusions.**
- 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, by using SBAR, open ended questions, and expressing sympathy and empathy for the patient's concerns, therapeutic communication was used.
 - 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: Acute pain: abdomen
 - b. If **no**, write what you now understand the priority nursing problem to be:

- 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:

 - ii. If **no**, describe:

I think they used the appropriate interventions in this situation, for example the analgesic, teaching dietary changes, and giving mindfulness techniques even though they were more for stress. I think the others that I included would not have been beneficial to the patient.
- 4) After completing the scenario, what is your patient at risk for developing?
 - a. Obstructed bowel/ ileostomy

b. Why? Crohn's exacerbation along with her current diet.

- 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 is to not just focus on the patient problem that were previously decided and to always keep an open mind when looking at patient symptoms. Making sure not to try to mold the symptoms into pre thought out problems, instead looking at all the symptoms and seeing where problems match. Also I think seeing the reaction made me realize how important vital signs can be in indicating a problem is about to happen, or something just happened and to figure out the best way to help the patient.

SOAP Note Based on Priority Problems

Priority Patient Problem #1: acute pain: abdomen

<p>Subjective:</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>History Present Illness (HPI): CC: abdominal pain, bloody stool, and dizziness</p> <p>PMH: Crohn's disease with intermittent gastritis. Ileostomy due to exacerbation of Crohn's.</p> <p>Allergies: Sulfa</p> <p>Current Medications: Remicade every 8 weeks, last dose 7 weeks ago. Frequent OTC anti-inflammatory meds and alcohol use.</p>
<p>Objective:</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>Vital Signs: 37.0°, HR: 114, RR: 22, BP: 100/60, SpO2: 95% on 2L 1200: HR: 110, RR: 26, BP: 94/56. 1600: HR: 106, RR: 24, BP: 98/58 Labs: fecal occult blood: positive</p> <p>Diagnostics:</p>
<p>Assessment:</p> <p><i>Focused assessments on your priority problem.</i></p>	<p>Sore crampy abdomen 6/10 pain, hyperactive bowel sounds, feel faint, lightheaded, dizzy Abdomen tender, cramps, discomfort, pain 8/10</p>
<p>Plan</p> <p>*Based on priority problem only</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>Plan:</p> <p>MEDS: Morphine sulfate 4mg IV bolus q2h PRN pain Acetaminophen 650mg PO now and q4h PRN fever and pain</p> <p>Procedures, labs, dx: endoscopy, colonoscopy, CBC, BMP, CT/MRI, stool analysis and culture</p> <p>NI: administer pain meds, help identify and treat cause of pain, relieve stressors, teach stress relief methods, educate on alternative pain management (TV, books, movies, music, repositioning, etc), position pt to comfort</p> <p>Teaching & Resources: Dietary changes, stress relief, alternate pain managements, nutritionist/dietician</p>