Student Name: Isabelle Azar
Medical Diagnosis/Disease: Crohn's disease

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

Anatomy and Physiology
Normal Structures

Digestion starts in the mouth where saliva acts as a chemical digestant and your teeth mechanically digest food by breaking it into smaller pieces. The food is then swallowed where it enters the esophagus. Peristalsis passes the food down past the lower esophageal into the stomach where it is further digested with acids present. The food is then passed into the duodenum where it travels to the small intestine. The small intestine is responsible for absorbing nutrients from the food through the lining into the bloodstream. The three parts of the small intestines in order are the duodenum jejunum, and ileum. The food is then further processed into the large intestines. The large intestine is responsible for absorbing water and eliminating waste. The parts of the large intestine in order are the ascending intestine on the RLQ, transverse colon, descending colon on the LLQ, and sigmoid colon. The waste is then eliminated through the rectum and out the anus.

Pathophysiology of Disease

Crohn's is a type of inflammatory bowel disease that causes inflammation and ulceration of the gastrointestinal tract, often at the distal ileum. All bowel layers can be involved, and the lesions are sporadic. May be caused by genetics, environmental, or immune system factors. Chronic inflammation of GI tract characterized by periods of remission and exacerbation. Thought to be an autoimmune disease. The exact pathophysiology is unknown but mostly believed to result from an abnormal immune response to the gastrointestinal tract. Inflammation causes thickening of the intestinal walls and these lead to the ulcerations mentioned above. Over time these lead to complications such as strictures, fistulas, and abscesses. Crohn's disease is different from ulcerative colitis as it can occur anywhere along the GI tract, involves all layers of the bowel wall, and fistulas are common.

NCLEX IV *(7)*: Reduction of Risk

Anticipated Diagnostics

- **Labs Cbc/Chem**
- **Stool examined for blood, pus, mucus, and organisms leading to infection.**
- **Blood Occult testing**
- **C reactive protein**
- **ESR**

Additional Diagnostics

- **Double-contrast barium swallow/enema**
- **CT/MRI**
- **Colonoscopy**
- **Capsule endoscopy**
- **Stool culture**
- **US**

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

Contributing Risk Factors

- Stress
- Smoking
- Diet
- Age
- Ethnicity

Signs and Symptoms

- **Pain in LRQ**
- **Diarrhea**
- **Weight loss**
- **Abdominal pain**

NCLEX IV *(7)*: Reduction of Risk

Possible Therapeutic Procedures
Non-surgical

- Hydration (IVF)
- Nutritional support

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

- **Hemorhage**

	• **Fever** • **Fatigue** • **Rectal bleeding (uncommon)** • **Weight loss from malabsorption**	Surgical • **Strictureplasty** • **Colectomy** • **Ostomy**	• **Strictures** • **Perforation** • **Abscesses** • **Fistulas** • **C diff infections** • **Colonic dilation** • **Colorectal cancer**

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

Anticipated Medication Management

- **Steroids**
- **Immunomodulators**
- **Biologics**
- **5-ASAs**

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

Non-Pharmacologic Care Measures

- **Bowel rest**
- **Small frequent meals**
- **High protein, high calorie, low fiber diet**
- **Avoid alcohol, caffeine, and smoking**
- **Manage stress levels**

NCLEX III *(4)*: **Care Needs**

What stressors might a patient with this diagnosis be experiencing?

- **Stress associated with having to change diet to prevent flare-ups**
- **Stress of increased risk of colorectal cancer**
- **Financial stress of hospital stays**
- **Loss of independence**

Client/Family Education

List 3 potential teaching topics/areas

 Adhere to low fiber, high protein, and high calorie diet

 NSAIDs, caffeine, and alcohol can all be potential triggers.

 Managing stress can reduce the frequency and intensity of flare-ups

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)

- **Case management**
- **Gastroenterologist**
- **Radiologist**
- **Dietitian**
- **Nurse**

Potential Patient Problems (Nursing Diagnoses)

To Be Completed Before the Simulation

Anticipated Patient Problem: Impaired bowel elimination

Clinical Reasoning: Diarrhea, weight loss, cramping abdominal pain,

Goal 1: Stool will be more formed and solid, with no evidence of blood by the end of my TOC

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframes.	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Monitor bowel frequency, stool consistency, and color for evidence of blood PRN	Promote bed rest and bowel rest throughout my TOC
Assess current labs for electrolyte imbalances, especially potassium Qshift	Administer and maintain IVF as prescribed throughout my TOC
Assess for signs of dehydration such as tenting skin turgor and dry mucus membranes Q4	Encourage clear liquid oral intake throughout my TOC
Assess B/P, HR, Q4	Educate on the dangle method to prevent orthostatic hypotension and falls PRN
Monitor I&O's throughout my TOC	Provide bedside commode for easy toileting throughout my TOC
Assess for signs of malnutrition such as fatigue and muscle weakness Qshift	Educate the client to eat high-protein, high-calorie, low-fiber foods PRN

Goal 2: Will report less frequency of bowel movements < 3/day by the end of my TOC

To Be Completed Before the Simulation

Anticipated Patient Problem: Acute Pain

Clinical Reasoning: Reports a pain level of ≥ 6 on a standardized pain scale

HR≥100 BPM, BP ≥ 120/80

Goal 1: Patient utilizes effective distraction measures throughout my time of care such as the TV, a book, or calming music throughout my TOC

Goal 2: Reports a pain level of < 4/10 on a standardized pain scale by the end of my TOC

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframes.	**Multidisciplinary Team Intervention** (Prework) What will you do if your assessment is abnormal?
Assess pain characteristics and score on a standardized scale Q4 hours	Administer prescribed Morphine for pain PRN
Monitor for non-verbal signs of pain such as grimacing, guarding, moaning, Q4 hours	Educate on mindfulness activities such as meditating and deep breathing PRN
Evaluate preferred pain management techniques and distraction measures at the beginning of the shift	Provide preferred pain management techniques and distraction measures such as offering TV, a book, or calming music throughout my TOC
Monitor VS such as HR, BP, RR, Q4 hours	provide a comfortable environment with minimum stimuli to promote relaxation, closed doors, dim lights, quiet PRN
Assess for any factors that may alleviate pain throughout my TOC	Provide emotional support and therapeutic communication addressing all fears and concerns PRN
Assess response to opioid pain management Q administration	Assist with positioning and comfort measures to alleviate pain Q2 hours

To Be Completed During the Simulation:

Actual Patient Problem: Deficient fluid volume

Clinical Reasoning: BP 103/60, HR 96, Pallor, restlessness

Goal: B/P is ≥120/80, no pallor noted, cap refill <3 seconds, skin warm and dry by the end of my TOC — Met: ☑ Unmet: ☐

Goal: No s/s of hypovolemic shock such as restlessness, confusion and AMS by the end of my TOC — Met: ☑ Unmet: ☐

Actual Patient Problem: Acute Pain

Clinical Reasoning: Pain ≥ 6/10, restless, grimicing and gaurding stomach

Goal: Reports a pain score of ≤ 4 on a standardized pain scale by end of my TOC — Met: ☑ Unmet: ☐

Goal: Utilizes effective coping methods for pain such as calming music or therapeutic communication by the end of my TOC — Met: ☐ Unmet: ☑

Additional Patient Problems: Ineffective coping

Below will be your notes, add more lines as needed. **Relevant Assessments:** Indicate pertinent assessment findings. **Multidisciplinary Team Intervention:** What interventions were done in response to your abnormal assessments? **Reassessment/Evaluation:** What was your patient's response to the intervention?

Patient Problem	Time	Relevant Assessments	Time	Multidisciplinary Team Intervention	Time	Reassessment/ Evaluation
Deficient fluid volume	1500	States "I feel like I'm going faint" B/P 94/56, HR 110, RR 26, O^2 94% on 2L/min	1630	Lowered HOB to prevent hypovolemic, administered 2L/min O^2	1900	BP 103/60, RR 22 O^2 95% on 2L O^2 therapy
Deficient fluid volume	1630	Abd pain, bloody stools, dizziness	1640	Administered 2 units PRBC's	1940	Developed chills, fever, adverse reaction to packed RBC transfusion
Deficient fluid volume	1645	Feels "chilly", headache and body aches.	1900	Stopped the blood infusion	1900	Stated "I feel awful"
Acute Pain	1930	States "I can really use that ibuprofen"	1930	Administered 650mg acetaminophen PO	2000	states "I feel better", no grimacing or gaurding noted.
Next day → Acute Pain	0800	Colonoscopy in A done, reports cramping and discomfort in stomach, grimicing/gaurding	0800	Administered Morphine 4mg IV bolus Q2 for pain	0900	Rates 3/10 pain scale, no grimicing or gaurding noted
Ineffective coping	1600	States "I drink up to 5 drinks after work to relieve stress"	1600	Talked about alternative coping methods to relieve stress such as music or a pet	1600	Listened to recommendations, didnt confirm weither they will use alternatives

1) Identify two members of the healthcare team collaborating in the care of this patient:
    a. **Nurse**
    b. **Gastroenterologist**
2) What were some steps the nursing team demonstrated that promoted patient safety?
    a. **Educated on the appropriate diet to prevent future exacerbations.**
    b. **Listened to patient every time they felt worse or felt like something was wrong.**
    c. **Immediately recognized adverse reaction to blood transfusion and stopped it.**
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: **The nurse didn't judge the patient's use of alcohol as a de-stressor, but therapeutically communicated alternative options.**

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: **Only one was right but it wasn't the priority problem, (ACUTE PAIN)**
    b. If **no,** write what you now understand the priority nursing problem to be: **Deficient fluid volume**
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: **I included the interventions of promoting oral liquid intake, providing a bedside commode for easy toileting, and educating on the dangle method to prevent orthostatic hypotension from hypovolemia.**
4) After completing the scenario, what is your patient at risk for developing?
    a. Another exacerbation of Crohn's
    b. Why? **Crohn's is an incurable and progressive disease, if she continues to have alcohol intake and doesn't know how to manage her stress along with continued use of ibuprofen for her headaches, she may cause another exacerbation of Crohn's.**
5) What was your biggest "take-away" from participating in the care of this patient? How did this impact your nursing practice?

My takeaway from participating in the care of this patient is to always believe the client when they say they feel worse, or something is wrong, and always take immediate action to address the issue. This also impacted my nursing practice as I will also always remember to closely monitor patients that are receiving blood transfusions for any adverse reactions, as they could be life threatening. Crohn's disease in a real patient and in a real life scenario is much different than seeing all the symptoms written on paper, I feel like it will be easier to understanding communicate with these patients.