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Medical Diagnosis/Disease: Crohns Disease

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

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

Anatomy and Physiology Normal Structures	Pathophysiology of Disease	Anticipated Diagnostics
Digestive system utilizes nutrients by ingestion, digestion, absorption, and excretion. The mouth is where food enters and is broken down and then swallowed. The pharynx moves the food down to the esophagus. It then connects to the stomach that breaks down food with secretions and then empties into the small intestine. This is made up of the duodenum, jejunum, and ileum that absorb the nutrients from the food. Then the material moves to the large intestine where water and electrolyte is absorbed and then feces is formed. Finally, it moves to the rectum and then excreted by the anus.	Chrons disease is an autoimmune disease that causes an inflammatory bowel disease of the gastrointestinal tract with periods of remission and exacerbation. This disease can come from genetics of someone's family history, but exact cause is unclear. The inflammation can occur anywhere in the gastrointestinal tract and injure the healthy tissue of all layers of the tract. This inflammation can ultimately create ulcerations in the walls. Then fistulas can form between other organs or to the surface of the body. This disease can not be cured.	Labs CBC Chem Stool examination Double contrast barium swallow/enema CT MRI Colonoscopy Capsule endoscopy Additional Diagnostics

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 (What are some potential complications associated with this disease process)
Abx NSAIDs Poor diet Stress Smoking High fat diet	Diarrhea Weight loss Abd pain Fever Fatigue Cramping	Non-surgical Medication Surgical Resection surgery Laparoscopy Strictureplasty	Fistulas Bowel obstruction Abscess Hemorrhage Peritonitis Strictures

NCLEX IV *(6)*: **Pharmacological and Psychosocial/Holistic Parenteral Therapies**

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

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

Anticipated Medication Management	Non-Pharmacologic Care Measures	What stressors might a patient with this diagnosis be experiencing?
Corticosteroids Steroids Abx Anti-inflammatory Biologics	Bowel rest Control inflammation Combat infection Correct malnutrition Symptomatic relief	Fear Anxiety Depression Irritation Pain

Client/Family Education

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

List 3 potential teaching topics/areas	Multidisciplinary Team Involvement (Which other disciplines do you expect to share in the care of this patient)
• Diet management • Reduce stress • Medication adherence/knowledge	CM, surgeon, pharmacist, gastroenterologist

Potential Patient Problems (Nursing Diagnoses)

To Be Completed Before the Simulation

Anticipated Patient Problem: Diarrhea

Clinical Reasoning: more than 3 loose stools per day, hyperactive bowel sounds, abd pain and cramping

Goal 1: Report less than 3 loose stools per day

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 for frequency of bowel movements q 4 hr PRN	Promote or assist in skin hygiene q 4 hr
Assess for abdominal pain q 2 hr	Promote relaxing environment for stress relief PRN
Assess fluid/electrolyte balance q 6 hr	Encourage high fluid intake q 4 hr
Assess bowel sounds q 2 hr	Educate on bland and low fiber diet q 4 hr
Obtain stool culture PRN	Administer antidiarrheal medications PRN
Assess characteristic of stools q 4 hr PRN	Educate on medications that are contraindicated (laxatives/stool softeners) q 6 hr

Goal 2: Report relief of abdominal pain, gas, or cramping

To Be Completed Before the Simulation

Anticipated Patient Problem: Acute Pain

Clinical Reasoning: abdominal pain, cramping, grimacing

Goal 1: Will report pain ≤ 3 out of 10 by the end of my care

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 (PQRST) q 4 hr	Administer pain medication PRN
Assess risk factors/Hx for acute pain PRN	Educate on using pain medication for effectiveness and prevent acute pain q 6 hr
Assess self-interventions for controlling pain q 6 hr	Encourage diversion activities and relaxation techniques q 2 hr
Assess rate of pain 1-10 q 2 hr	Encourage deep breathing techniques q 2 hr
Assess expectations for pain relief q 6 hr	Educate on reporting pain relief after interventions q 4 hr
Assess environmental stressors that may contribute to pain q 6 hr	Promote relaxing environment q 4 hr

Goal 2: Will implement nonpharmacologic pain relief measures during my care

To Be Completed During the Simulation:

Actual Patient Problem: #1 Deficient fluid volume

Clinical Reasoning: serosanguineous fluid in ostomy bag, chills, hyperactive bowel sounds

Goal: will have BP within normal limits (120/80) by the end of my care Met: ☐ Unmet:☐

Goal: Will have normal bowel sounds by end of my care Met: ☐ Unmet:☐

Actual Patient Problem: #2 Acute pain

Clinical Reasoning: headaches, body aches, abdominal pain, cramps, pain 8 out of 10

Goal: Will report pain ≤ 3 out of 10 by the end of my care Met: ☐ Unmet:☐

Goal: Will report ways to reduce stressors and risk factors contributing to pain by the end of my care Met: ☐ Unmet:☐

Additional Patient Problems:

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
#1		Serosanguineous fluid in ostomy bag		Administered blood		"I was feeling chilly, Im just so cold, headache and body aches"
#1		RR 26 bp 94/56 "feels cold, headache, body ache"		Stopped blood transfusion		RR 22 BP 100/60
#2		Pain 8 out of 10 "cramping and discomfort in stomach"		Administered Acetaminophen 650mg PO q4hr PRN		Pain 2/3 out of 10
#2		"stressful job and up to five drinks sometimes at night"		Educated on managing stress and diet		"I feel so much better having a plan at home"

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:
    a. **_Bonnie (Charge Nurse)**
    b. **Dr. March (gastroenterologist)**
2) What were some steps the nursing team demonstrated that promoted patient safety?
    a. **Lowered HOB**
    b. **Stopped blood transfusion**
    c. **Endoscopy was performed**
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 the whole medical team utilized therapeutic communication techniques. All communication was focused around adhering to protocol, working together, and most importantly prioritizing patient care. The effective communication was most prevalent talking to the patient. Being able to address her health problems to gather the relevant information, treat effectively, and provide resources for the patient to be successful outside the hospital.
    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
    b. If **no,** write what you now understand the priority nursing problem to be: The correct nursing problem would be deficient fluid volume because of the serosanguineous fluid leaking from her ostomy bag. This became one of the pain priority problems that lead to other health problems to develop if left untreated.
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: For assessments I did not see was self-interventions for specifically controlling the pain and expectations for pain relief. For interventions what I did not see was educating on breathing techniques and promoting a calm environment. The other assessments and interventions that were not included were not pertinent to my patient's priority problems.

4) If **no**, describe: For the acute pain I saw the nurse used my assessments of assessing pain characteristics, rating the pain, and asking about environmental stressors/history/risk factors that preceded the pain. The nurse also assessed bowel sounds. There were other assessments not done but that was because it was not related to my patient's actual problem. For my interventions I saw pain medication being administered. The promotion of relaxing techniques and reducing stressors. As well as reporting relief of pain after interventions and educating on medication to relieve pain.

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

    a. Hypovolemic Shock

    b. Why? The patient had a gastrointestinal bleed leading to her to lose a lot of fluid. When the blood transfusion was initiated, she had a reaction thus not completing the transfusion. Any additional fluid loss could have led her to go into shock if it was not treated.

6) 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 being prepared when caring for a patient. I think it comes down to two essential components. One would be having adequate foundational knowledge to be able to assess your patient properly, intervene using proper technique, and awareness to determine a clients status change from baseline and what those findings could indicate as well as the responses to them. The second part would be to have the clinical judgement/critical thinking to not only choose the right decision to make in caring for your patient but to be confident in what you decide to do. The nurse in the simulation was not only confident in her assessment but her interventions and when to reach out to her team members. Another aspect that I found very important was the relationship she built with her patient during her care. This allowed her to provide effective teaching and gave her patient a better outlook leaving the hospital. This impacts my nursing practice by instilling the drive to learn more to be better prepared, but also the confidence, critical thinking, and judgement comes with experience and failure to learn and improve for the future.