

Student Name: Jocelyn Holden

Medical Diagnosis/Disease: Crohn's Disease

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

##### Anatomy and Physiology

###### Normal Structures

The GI tract extends around 30 feet from the mouth to the anus. There are many layers one being the mucosa lining to submucosal lining which contains glands blood vessels and lymph nodes three the muscle and four serosa. The main function of the GI system is to supply nutrients to the body cells the process of which ingestion, digestion, and absorption. Ingestion starts at the mouth using mastication. The pharynx is the route for food from the mouth to the esophagus then from the esophagus into the stomach. Digestion and absorption happen in the stomach storing food mixing food with gastric secretions and emptying content into the small intestine. The three main parts of the stomach are the fundus, body, and antrum. The stomach wall has four layers the serous, muscular, mucosal and submucosal layer. The intrinsic factor is needed for vitamin B12 absorption within the stomach. The primary functions of the small intestine are digestion and absorption. The small intestine is composed of the duodenum, jejunum, and ileum. The ileocecal valve prevents reflux of large intestine contents into the small intestine. The functional units of the small intestine are villi. Villi contain epithelial cells that produce the intestinal digestive enzymes. The digestive enzymes chemically breakdown nutrients for absorption. Digestion is the physical and chemical breakdown of food into absorbable substances. The process of digestion begins in the

##### Pathophysiology of Disease

Crohn's disease is a chronic, progressive, inflammatory bowel disease (IBD). Affecting any portion of the gastrointestinal tract from mouth to anus. The digestive tract becomes swollen and irritated. Causing many abnormal abdominal symptoms. About 1.3 Americans have IBD. It often begins during the teenage years into early adulthood. There is no exact cause, it is an autoimmune disease. Crohn's disease is a lifelong condition that cannot be cured.

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

##### Anticipated Diagnostics

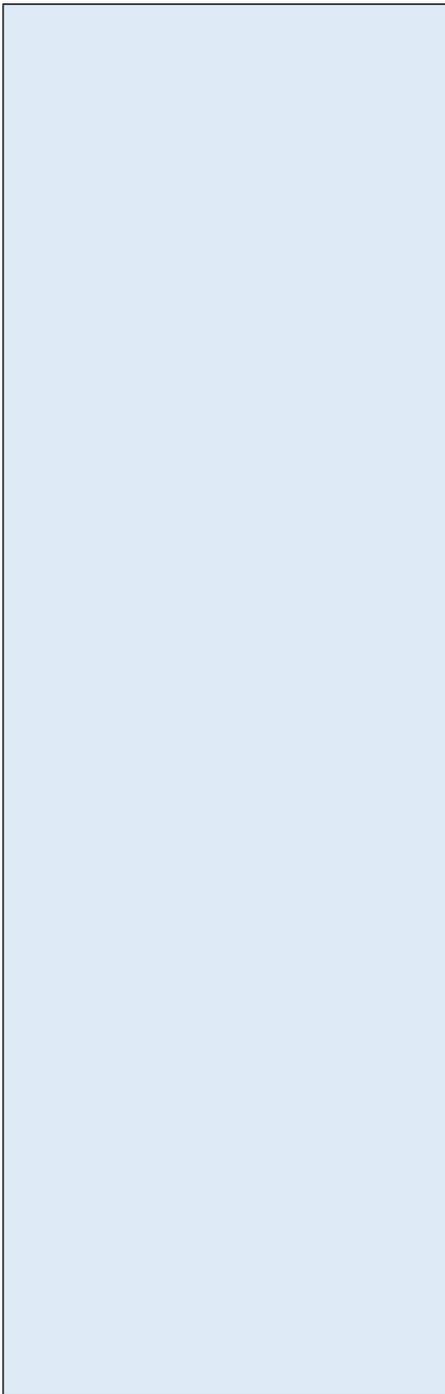
###### Labs

- CBC
- CRP
- ESR
- WBC
- CMP
- Serum albumin
- Vitamin

###### Additional Diagnostics

- Abdominal x-rays
- Ultrasound
- Barium x-ray of small bowel
- Upper endoscopy
- CT and MR enterorrhaphy
- Ileocolonoscopy/colonoscopy

mouth where food is chewed mechanically broken down and mixed with saliva. An individual makes about one liter of saliva each day. Saliva contains amylase which breaks down starches to maltose. In the stomach, muscle action mixes the food with gastric secretions to form chyme which then starts absorption. This stomach's acidic environment results in conversion of pepsinogen to pepsin which then breaks down proteins. The stomach also serves as a reservoir for food releasing it slowly into the small intestine. Carbohydrates are broken down into monosaccharides, fats to glycerol and fatty acids, and proteins to amino acids. The elimination process starts at the large intestine. The large intestine forms feces and serves as a reservoir for the fecal mass until defecation occurs. Feces are composed of water 75%, bacteria, unabsorbed materials, undigested foods, bile, and desquamated epithelial cells.



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

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

- Contributing Risk Factors
- History of or current cigarette smoking (risk if doubled)
  - Family history of Crohn's Disease
  - Oral contraceptive use

- Signs and Symptoms
- Crampy abdominal pain
  - Diarrhea
  - Weight loss
  - Fatigue
  - Fever and chills
  - Abdominal tenderness, rebound, guarding,

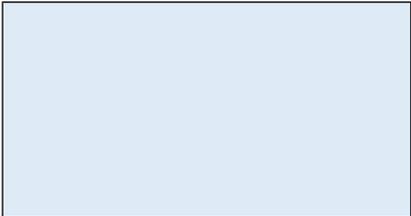
- Possible Therapeutic Procedures
- Non-surgical
- Symptom management
- Surgical
- Colorectal surgery
  - Ostomy
  - Fistula removal/repair

- Prevention of Complications
- Malnutrition and micronutrient deficiencies
  - Fistulas, abscesses, peritonitis
  - Strictures, bowel obstruction/perforation
  - Perianal disease
  - Osteopenia, osteoporosis, and bone fracture
  - Cancer

- Diets high in animal protein, sugars, oils, fish, and dietary fat

- palpable mass
- Fistulas, fissures, perianal lesions

- Proctocolectomy
- Bowel resection
- Strictureplasty



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

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

**NCLEX III (4):**

**Parenteral Therapies**

**Care Needs**

- Anticipated Medication Management
- Antidiarrheal
  - Antispasmodics
  - Analgesics
  - Proton pump inhibitors
  - H2 receptor blockers

- Non-Pharmacologic Care Measures
- Nutritional supplements
  - Smoking cessation
  - Stress management
  - Dietary changes

- What stressors might a patient with this diagnosis be experiencing?
- Prognosis
  - Financial burden
  - Lifestyle changes
  - Cognitive changes
  - Family concerns
  - Lack of education

**Client/Family Education**

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

- List 3 potential teaching topics/areas
- Preventing exacerbations should focus on avoiding or quitting smoking and diet modification
  - Medication adherence and avoid certain medications (ex. NSAIDs)
  - Dietary changes to avoid flare-ups

- Multidisciplinary Team Involvement
- General practitioner
  - Gastroenterologist
  - Dietician
  - Pharmacist
  - Colorectal surgeon

**Potential Patient Problems (Nursing Diagnoses)**

**To Be Completed Before the Simulation**

Anticipated Patient Problem: Dehydration

Clinical Reasoning: Loss of Blood due to GI bleed

Goal 1: Hemoglobin and hematocrit will be within range during my time of care

Goal 2: Will intake at least 450 mL of fluids during my time of care

**To Be Completed Before the Simulation**

<b>Relevant Assessments</b>	<b>Multidisciplinary Team Intervention</b>
(Prewrite) What assessments pertain to your patient's problem? Include timeframes.	(Prewrite) What will you do if your assessment is abnormal?
Monitor hemoglobin and hematocrit Q12H	Collaborative care to administer blood transfusion Q12H
Assess skin turgor, mucous membranes and capillary refill Q6H	Educate on the importance of maintaining fluid intake and adequate nutrition Q6H
Assess intake and output Q8H	Encourage oral intake, if not achievable administer continuous IV fluids Q8H
Monitor electrolytes Q12H	Administer electrolytes as needed based on lab results Q6H, PRN electrolyte depletion
Monitor vital signs Q4H	Administer continuous IV fluids, apply oxygen, etc. Notify provider if any vital signs are critically high Q6H
Monitor for signs and symptoms of bleeding PRN, bleeding	Control bleeding, avoiding excessive bleeding, and notify provider PRN, bleeding

<p align="center"><b>Relevant Assessments</b></p> <p>(Prewrite) What assessments pertain to your patient's problem? Include timeframes.</p>	<p align="center"><b>Multidisciplinary Team Intervention</b></p> <p>(Prewrite) What will you do if your assessment is abnormal?</p>
<p align="center">Assess pain level, location, severity and subject data Q4H, PRN pain</p>	<p align="center">Administer Oxycodone Q6H</p>
<p>Perform a history and physical, including length of pain symptoms, what enhances the pain and what relieves the pain Q12H</p>	<p>Provide access to what relieves the pain, such as ice or heat and avoid what enhances the pain Q6H, PRN pain</p>
<p align="center">Assess vital signs Q4H</p>	<p>Provide oxygen therapy, raise HOB, further monitor vital signs closely Q4H</p>
<p>Assess preferred adjunctive pain management Q4H, PRN pain</p>	<p>Provide adjunctive therapies such as TV, uninterrupted periods of rest, ice or heat, etc.</p>
<p>Abdominal Assessment: Palpate abdomen for tenderness, auscultate bowel sounds Q12H</p>	<p>Encourage repositioning alleviating discomfort or tenderness, notify provider for any abnormal assessments Q6H</p>
<p>Assess comorbidities which may lead to increase pain level Q12H</p>	<p align="center">Manage symptoms of comorbidities Q6H</p>

Anticipated Patient Problem: Acute Pain

Clinical Reasoning: Abdominal Pain

Goal 1: Will not have pain > 3 during my time of care

Goal 2: Will verbalized an adjunctive therapy used to decrease pain during my time of care

**To Be Completed During the Simulation:**

<b>Actual Patient Problem:</b> Dehydration	
<b>Clinical Reasoning:</b> GI bleed, Fecal Occult Blood +, BP 110/60, HR 114, Hgb 7 g/dL, Hct 21%	
Goal: Hgb and Hct will be within range after blood administration during my time of care	Met: <input type="checkbox"/> Unmet: <input checked="" type="checkbox"/>
Goal: Will intake at least 650 mL of fluids during my time of care	Met: <input checked="" type="checkbox"/> Unmet: <input type="checkbox"/>
<b>Actual Patient Problem:</b> Acute Pain	
<b>Clinical Reasoning:</b> Abdominal Pain	
Goal: Will not have pain > 3 during my time of care	Met: <input type="checkbox"/> Unmet: <input checked="" type="checkbox"/>
Goal: Will verbalized an adjunctive therapy used to decrease pain during my time of care	Met: <input checked="" type="checkbox"/> Unmet: <input type="checkbox"/>
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
Dehydration	1507	Hemoglobin 7 g/dL & Hematocrit 21%	1845	Administered two units PRBC	01/19 0600	Hemoglobin 8 g/dL & Hematocrit 24%
Dehydration	1530	HR 114, RR 22, BP 100/60, O2 Sat 95% 2L NC	1530	Maintained oxygen therapy 2L NC	1800	Oxygen saturation remain > 92% 2L NC
Acute Pain	1540	"Stress" enhances the abdominal pain	01/19 1000	Discussed job and number of alcoholic beverages consumed to relax	01/19 1015	Provided teach-back with stress relieving activities "Take walks in the park"
Dehydration	1600	Fecal Occult Blood: Blood in Stool +	1650	Collaborative care, Dr. March Scheduled endoscopy	01/19 0730	Procedure showed active internal bleeding, resolved during procedure
Dehydration	1610	Increase lightheaded and dizzy, "I feel like I am going to faint"	1615	Initiated oxygen therapy 2L NC, lowered HOB	1700	Lightheaded and dizzy subsided, O2 Sat 95% 2L NC
Dehydration	1700	Flushed appearance and reports headache	1705	Stopped administration of PRBC, notified provider	1720	Continued 0.9% sodium chloride, KVO 30 mL/hr.
Acute Pain	01/19 0800	8/10 abdominal pain post-op	01/19 0815	Administered Morphine sulfate	01/19 0845	2-3/10 abdominal pain, "I actually feel

				4 mg IV bolus Q2H		pretty good now"
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## 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 (Gastroenterologist)**
- 2) What were three steps the nursing team demonstrated that promoted patient safety?
  - a. **Two patient identifiers (Name & DOB)**
  - b. **Double checked blood administration with charge nurse**
  - c. **Received orders from provider and read orders back to provider to double check the following orders were correct**
- 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, the nurse and medical team utilized therapeutic communication techniques throughout the entire process. Ms. Leiberman was involved in all aspects of care that were provided.**
  - 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) What was the priority nursing problem? Provide rationale.

**Dehydration – Due to the GI bleed and low hematocrit and hemoglobin levels. Blood administration was initiated due to low H&H then Ms. L has a reaction to infusion, so blood administration was stopped. An endoscopy was preformed then to resolve the GI bleed.**
- 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, I included an intervention for electrolyte depletion. An individual who has an active GI bleed can become electrolyte depleted. However, Ms. Leiberman did not seem to be electrolyte depleted but could have very well happened.**
    - ii. If **no**, describe:
- 4) After completing the scenario, what is your patient at risk for developing?
  - a. **Ms. Leiberman is at risk of developing another GI bleed**
  - b. Why? **Lifestyle modifications must be implemented to decrease the risk for another GI bleed. Such not taking NSAIDs or Ibuprofen due to the irritation caused to the GI track.**

**Along with diet modification such as increasing fiber. Most importantly in Ms. L situation she lives a stressful life and drinks alcohol on a regular basis. Avoid or limiting alcohol can be very beneficial when at risk for developing another GI bleed.**

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

**The biggest take away I had from this experience was seeing Ms. L present with certain symptoms then being able to unfold while working with different team members to diagnosis the patient. Many of the symptoms Ms. L presented with led me to the idea of a GI bleed. Seeing how to treat a GI bleed was interesting as they don't immediately go into surgery as I thought they would. Treating symptoms seemed to come first then do an endoscopy to then resolve the GI bleed.**