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Medical Diagnosis/Disease: Crohn's Disease

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

NCLEX IV (7): Reduction of Risk

Anatomy and Physiology
Normal Structures

GI tract is a continuous tube starting from the mouth and ending at the anus.

Mouth

- Teeth: Mechanically break down food.
- Tongue: Helps mix food and push it for swallowing.
- Salivary Glands: Secrete saliva containing enzymes (amylase) that begin carbohydrate digestion.

Pharynx: The throat, passage for air + food. Swallowing moves food into the esophagus

Esophagus: a muscular tube that moves food from the pharynx into the stomach with peristalsis

Stomach

- A muscular organ that churns food and mixes it with gastric juices.

Secretes: Hydrochloric Acid (HCl)= Kills bacteria and activates pepsin, Pepsin= Begins protein digestion, Mucus= Protects the stomach lining.

Small Intestine

Main site of digestion and absorption

Three parts: Duodenum, Jejunum, and Ileum.

- Receives bile from the liver (for fat digestion) and enzymes from the pancreas.
- Villi & Microvilli: Increase surface area for nutrient absorption.

Large Intestine (Colon)

Pathophysiology of Disease

Crohn's Disease is a form of inflammatory bowel disease.

There's no known cause:

thought to be an autoimmune reaction to a person's own immune system mistakenly attacking the healthy tissues in the digestive tract, leading to inflammation.

- There is no known cure
Often beginning during the teenage years and early adulthood. Can involve any segment of the GI tract from mouth to the anus. Most commonly affects the distal ileum and proximal colon. Segments of normal bowel can occur between diseased portions (skip lesions). The inflammation involves all layers of the bowel wall which can cause leakage of bowel contents into the peritoneal cavity (can cause peritonitis). Typically, ulcerations are deep, longitudinal, and penetrate between portions of inflamed edematous mucosa, causing a cobblestone like appearance. Strictures can occur causing obstruction.
- More common in Rural areas with White and Ashkenazic Jewish origin. Strongest risk is family hx

Anticipated Diagnostics

Labs

- CBC
- CMP
- LFTs
- CRP + Sed Rate
- Stool Culture

Additional Diagnostics

- Double-Contrast Barium Enema
- Small bowel series
- Transabdominal Ultrasound
- CT
- MRI
- Colonoscopy
- Endoscopy

Parts: Cecum, Colon (Ascending, Transverse, Descending, Sigmoid), Rectum.
 Functions: Absorbs water and electrolytes, forms and stores feces.

- houses gut bacteria that help in digestion.

Rectum & Anus

- Store and eliminate waste (feces).

Accessory Digestive Organs

Liver: produces bile, store nutrients and detoxifies the blood

Gallbladder: Stores and releases bile into small intestine

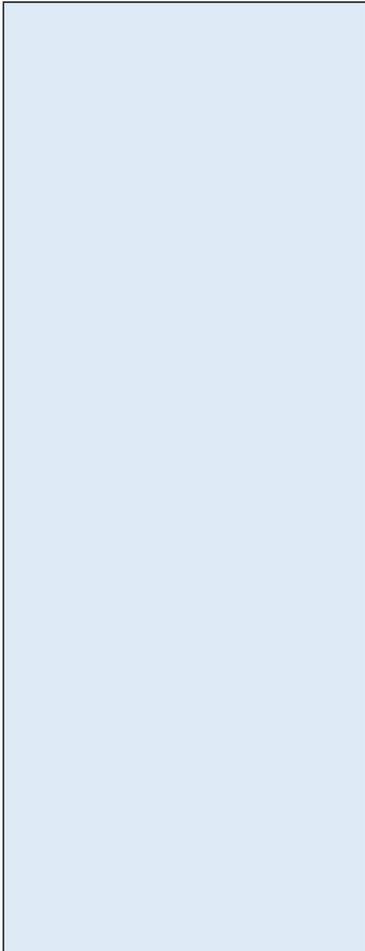
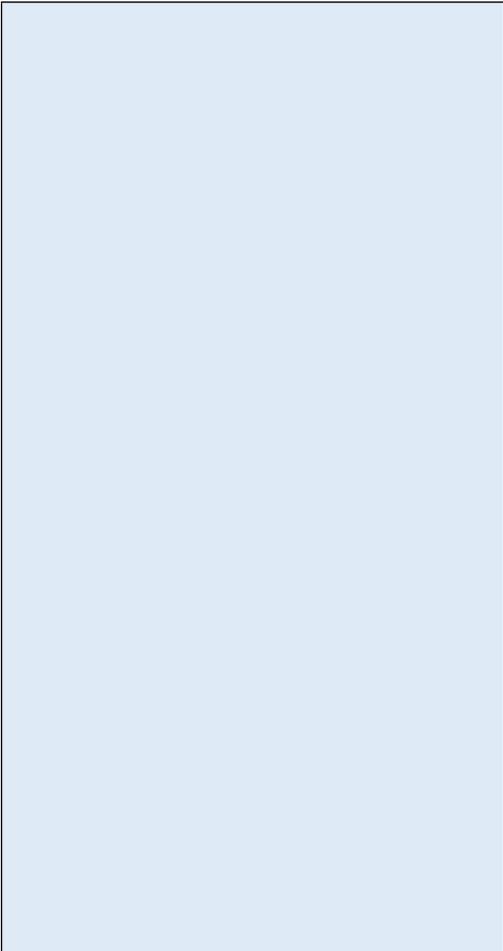
Pancreas: produce digestive enzymes, secrete bicarbonate to neutralize stomach acid

Salivary Glands: secrete saliva with enzymes to begin breakdown/digestion

Ingestion - Digestion

(Mechanical and Chemical) -

Absorption - Defecation



NCLEX II (3): Health Promotion and Maintenance (7): Reduction of Risk

NCLEX IV

Contributing Risk Factors

- White and Ashkenazic Jewish origin
- Family hx
- Smoking and stress
- High intake of refined sugar, total fats, polysaturated fatty acids, and omega-6 fatty acids
- Long term use of NSAIDS, abx, and oral contraceptives

Signs and Symptoms

- Diarrhea
- Weight loss
- Abdominal pain
- Fever
- Fatigue
- Rectal bleeding
- Malaise
- Anorexia
- Increased stool count
- Anemia
- Dehydration
- Tachycardia
- N/V

Possible Therapeutic Procedures

Non-surgical

- Nutritional Therapy
- Physical/Emotional Rest
- Smoking cessation
- Exercise

Surgical

- Bowel Resection
- Strictureplasty
- Colectomy
- Proctocolectomy
- Fistula Removal
- Abscess drainage

Prevention of Complications

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

- Bowel Obstruction
- Peritonitis
- Fistulas
- Hemorrhage
- Strictures
- Perforation
- Abscesses
- CDI
- Toxic megacolon
- Liver disease
- Malabsorption
- Osteoporosis
- GI Bleeds

NCLEX IV (6): Pharmacological and NCLEX III (4): Psychosocial/Holistic

NCLEX IV (5): Basic Care and Comfort

Parenteral Therapies

Care Needs

Anticipated Medication Management

- Aminosaliculates
- Antimicrobials
- Corticosteroids
- Immunomodulators
- Biologic therapies

Non-Pharmacologic Care Measures

- Diet: FODMAP, rich in veggies/fruits, soluble fiber
- Exercise
- Acupuncture
- Pro/prebiotics
- Yoga + Meditation

What stressors might a patient with this diagnosis be experiencing?

- Body image due to weight fluctuations
- Social Isolation
- Concerns towards maintain diet
- Uncertainty of managing disease
- Fear of flare ups
- Financial

Client/Family Education Effective Care Environment

NCLEX I (1): Safe and

List 3 potential teaching topics/areas

- Medications to help treat the condition
- How to prevent triggers
- How to better plan meals/nutrition

Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)

Gastroenterologists, Surgeons, Nurses, CNAs, Pharmacists, IBD Nurse Specialists, Psychologists and Dietitians

Potential Patient Problems (Nursing Diagnoses)

To Be Completed Before the Simulation

Anticipated Patient Problem: Impaired Gastrointestinal Motility

Clinical Reasoning: The inflammatory process of Chron's Disease, Presence of diarrhea or constipation, disease effects all layers of the bowel wall

Goal 1: Patient will remain free of abdominal discomfort during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes.	(Prewrite) What will you do if your assessment is abnormal?
Assess bowel patterns and characteristics (color, consistency) q 4hrs + prn	Administer antidiarrheals as prescribed, encourage a low-fiber diet q 8hrs
Monitor for abdominal distention q 4 hrs + prn	Administer antispasmodics as prescribed, recommend small, frequent meals every shift

Assess for food intolerances, nausea, or vomiting q 8hrs + prn	Administer antiemetics as prescribed, encourage fluid intake of at least 2-3L/day and FODMAP diet BID
Assess for pain and discomfort q 4hrs + prn	Teach and encourage relaxation techniques (mindfulness, coloring, breathing exercises) q 4hrs + prn, Administer pain medication as prescribed
Monitor for absence of flatus q 8hrs	Notify Provider prn, Perform an abdominal massage, Promote activity q 4hrs
Assess bowel sounds q 4hrs + prn	Promote 30 minutes of walking/day, avoid prolonged sitting once a shift, Notify provider prn

Goal 2: Patient will have no more than two formed, brown stools during my time of care.

To Be Completed Before the Simulation

Anticipated Patient Problem: Imbalanced Nutrition: Less Than the Body Requirements

Clinical Reasoning: Malabsorption, decreased appetite, diarrhea, nausea/vomiting, possible weight loss

Goal 1: Patient will maintain their weight from admission during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes.	(Prewrite) What will you do if your assessment is abnormal?
Assess dietary intake q 8hrs	Promote high calorie + protein diet TID, Encourage meals from home to be brought in if needed
Assess weight daily	Collaborate with a dietitian and/or nutritionist for specialized diet, recommend small, frequent meals, Provide oral care before and after meals
Assess for signs of malnutrition (weakness, dry skin, brittle nails) BID	Provide supplements with and between meals (magic cup, ensure, protein shakes), Encourage and educate about a high-protein diet TID
Assess CBC, CMPs, Prealbumin prn	Administer IV fluids and riders as needed, contact PCP if iron, B12, folic acid are low
Assess for emotional factors effecting eating pattern q 8hrs + prn	Provide a comfortable space and encouragement of diagnoses outcomes prn, Provide company during meal times
Assess for dehydration (slow skin recoil, dizziness, extreme thirst, dry mucous membranes)	Encourage hydration q 2hrs, Provide electrolyte supplements with meals

Goal 2: Patient will consume a caloric intake that meets or exceeds their nutritional demands during my time of care.

To Be Completed During the Simulation:

Actual Patient Problem: Acute Anemia

Clinical Reasoning: 2.7 RBC, 7 Hgb, 21% Hct, c/o lightheaded and dizzy, going to faint... throw up”

Goal: Patient will show improving CBC results of RBCs between 4.2-5.4, Hgb 12-15, and a Hct of 36-48% by the end of my care. Met: Unmet:

Goal: Patient will verbalize a decrease of fatigue, as evidenced by reporting of increased energy by the end of my care. Met: Unmet:

Actual Patient Problem: Acute Pain

Clinical Reasoning: c/o “chills. Headache, body aches all over”, cramping and discomfort in the stomach” grimacing and guarding stomach upon touch, 8/10 pain, 110 HR, 26 RR

Goal: Patient will report a decrease in pain to a 2/10 on a numeric scale by the end of my care. Met: Unmet:

Goal: Patient will display improved well-being by a heart rate between 60-100 bpm and respiration rate between 16-20 bpm by the end of my care. Met: Unmet:

Additional Patient Problems: Risk for dehydration

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
Risk for Dehydration	1630	c/o “lightheaded and dizzy, going to faint... throw up” Auscultated bowel sounds- hyperactive in all four quadrants	1635	Administered 2L NC, gave emesis bin, applied cool damp towel	1645	No signs of dyspnea or clammy skin, 94% SpO2 on 2L NC, 20 RR, 104 HR, 98/60 BP
Acute Anemia	1630	94% O2 RA, 94/56 BP, 110 HR, 37.0 temp, 26 RR	1635	Lowered head of bed, elevated feet	1650	Skin warm, dry to touch, resting with eyes closed
Acute Anemia	1507	2.7 RBC, 7 Hgb, 21% Hct 37 C, 104 HR, 22 RR, 98/60 BP, 95% SpO2 NC	1640	Administered one unit of blood	1700	No signs of reaction to transfusion, resting with eyes closed, 37.1 C, 100 HR, 20 RR, 98/62, 94% SpO2 2L NC
Acute Anemia	1925	c/o “chills. Headache, body aches all over”,	1930	Stopped the blood infusion	2015	Skin normal for ethnicity, warm, dry

		38.8 C, 96 HR, 22 RR, 102/62 BP, 92% SpO2 on 2L NC				to touch, 37.7 C, 94 HR, 20 RR, 102/62 BP, 94% SpO2 2L NC
Acute Pain	2015	Requesting an ibuprofen for headache, 101.8 fever, 22 RR	2030	Administered 650mg Acetaminophen PO	2105	98.6 temperature, 22 RR, no report of headache
Risk for Dehydration	2030	IV running at 150ml/hr of 0.9% Sodium chloride, no blood infusion, complaining of n/v	2030	Slowed rate to 30mL/hr	2105	IV bag infusing at correct rate, no signs of infiltration, vein patent
Acute Pain	2100	c/o of "cramping and discomfort in the stomach" 8/10 pain in the abdomen after eating, Pallor skin, grimacing and guarding upon touch	2100	Administered 0.5mL IV Morphine	2135	"I feel so much better", 2/10 pain score, No signs of pallor or grimacing or guarding abdomen

ATI Virtual Clinical Questions and Reflection:

- 1) Identify two members of the healthcare team collaborating in the care of this patient:
 - a. CNA
 - b. Doctors: GI
- 2) What were three steps the nursing team demonstrated that promoted patient safety?
 - a. Doing a full examination of abdomen and vital signs when pt. complaining of pain
 - b. Confirming name, DOB, blood type prior to blood infusion
 - c. Taking vital signs every 15 minutes to monitor patient status while infusing blood
- 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 used open-ended questions when assessing pain, history, and stress management skills that all maintained trust and dignity of the patient.**
 - 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.

Ms. Lieberman's priority problem would be her Acute Anemia. Her labs needed to be tested to find the source of bleeding. This GI bleed was causing her pain, fevers, and n/v. This needed to be controlled to prevent hypovolemic shock and possibly death from bleeding. She needed her endoscopy to find the source of bleeding and treat it and her blood transfusion to replace the volume she lost.
- 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 went on a different route for Crohn's Disease than what this patient showed. So, most of my assessments and interventions didn't apply to Ms. Leiberman.
 - ii. If **no**, describe:

Ms. Leiberman was given antiemetics and educated on a high-protein diet and exercise.
- 4) After completing the scenario, what is your patient at risk for developing?
 - a. Bowel Obstruction/Crohn's Flare Up

- b. Why? Ms. Lieberman has an ileostomy and was admitted for a GI Bleed most likely due to dietary habits. She needs to change her diet immensely and that can come with trial and error. She uses alcohol as a stress reliever and doesn't implement many fruits, vegetables, or protein into her meals.

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 that every patient is different. I went into this scenario with a very different expectation of what this patient would be experiencing. This showed me that each patient has a different journey with their diagnoses. It also showed me that the complications from Crohn's Disease can be extremely severe and life-threatening; to always monitor closely and treat the whole patient not just their symptoms.