Student Name: Camryn Tesch
Medical Diagnosis/Disease: Crohn's Disease

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

Anatomy and Physiology

Normal Structures

-The **Gastrointestinal System** consists of the mouth, esophagus, stomach, small bowel, large bowel (colon), the rectum, and the anus.
-Digestion starts in the **mouth**, where the **salivary glands** secrete **saliva** which helps to break down the food **chemically** and **mechanically** through chewing (**mastication**). Then food is passed down the **esophagus**, which is where involuntary muscle movements (**peristalsis**) take over to move the food down to the **stomach**. After being broken down by **hydrochloric acid** secreted in the stomach to break down food chemically, the food passes through the **pylorus** of the stomach and begins to move though the **small bowel**, which is where **most nutrition reabsorption occurs.** The **pancreas**, **gallbladder**, and **liver** play a role in this part of digestion by secreting **insulin**, stored **glucose**, breaking down food with **bile**, and processing nutrients to be reabsorbed into the body. After passing through the entirety of the small bowel, including the **duodenum**, **jejunum**, and **ileum**, the food passes into the **large bowel**, where most of the **water reabsorption occurs**. This is where the food is formed into what we know stool (feces) normally looks like. It then passes into the **rectum**, where **sphincter** muscles hold it until the person is ready to defecate, which causes the stool to pass through the **anus** and be eliminated.

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

Pathophysiology of Disease

-Patches of inflammation that can be found ANYWHERE along the bowel.
-**Skip lesions** occur, which is a pattern of health and diseased bowel, making Tx and symptomatic control difficult.
-Typically causes pain in the RLQ.
-Ulcers penetrate several layers (the entire thickness) of the abdominal lining.
-Since they can occur anywhere along the bowel, where they occur affects the symptoms: including stool characteristics, nutrition, and pain location.
The disease can be caused by autoimmune disorder in which the body's immune system attacks the lining of the bowels.

Anticipated Diagnostics

Labs

-CBC – anemia
-Chemistry – malabsorption
-Stool Cx/sample - examined for blood, pus, mucus, and organisms leading to infection

Additional Diagnostics

-Double contrast barium swallow and enema
-CT/MRI

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

Contributing Risk Factors

-Age: young. Most pts develops before or around 30 years old.
-Family Hx
-Ethnicity: white people at highest risk, esp. eastern European
-Cigarette smoking
-Chronic NSAID use
-Moderate-heavy alcohol consumption
-Certain autoimmune disorders

Signs and Symptoms

-Diarrhea
-Cramping/abdominal pain
-If in small intestine – malabsorption and weight loss
-Fever
-Fatigue
-Sometimes – joint pain if related to autoimmune disease.

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

Possible Therapeutic Procedures

Non-surgical

-Double contrast barium swallow and enema.

Surgical

-Colonoscopy
-Capsule endoscopy
-Drainage of abdominal abscesses
-Fistulas
-Bowel resection - Ostomy

Prevention of Complications

(What are some potential complications associated with this disease process)
-Risk for colorectal cancer
-C-diff infections
-Fistulas
-Strictures/ Comin dilation
-For those with ostomy placed – increased risk of obstruction for 30 days post-op.
-Short bowel syndrome
-Weight loss from malabsorption of nutrients (if in the small intestine)

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

Anticipated Medication Management

-Abx to prevent infection
-Biologics (severe)
-Immunomodulators
-Steroids
-5-ASAs (Amino-salicylic acids) (first line)
-Analgesics

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

Non-Pharmacologic Care Measures

-Bowel rest (make pt NPO)
-Control inflammation
-Combat infection
-Correct malnutrition
-Provide symptomatic relief

NCLEX III *(4)*: **Psychosocial/Holistic Care Needs**

What stressors might a patient with this diagnosis be experiencing?

-Stress surrounding nutrition, including what they can eat.
-Disturbed body imagine due to weight loss from lack of nutrition.
-Pain management
-Length of hospital stay due home and job responsibilities

Client/Family Education

List 3 potential teaching topics/areas

- Foods they should eat and foods they should avoid. **EAT**: high protein and probiotics. **AVOID**: fatty and gas-producing foods, and high fiber foods.
- Eat small, frequent meals, and ensure adequate hydration.
- Avoid alcohol and caffeine products as they can irritate the bowel.

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)
RN, CNA, provider, nutritionist, Chaplain (if applicable), case management, pharmacists.

Potential Patient Problems (Nursing Diagnoses)

To Be Completed Before the Simulation

Anticipated Patient Problem: **Impaired Intestinal Elimination**

Clinical Reasoning: Skip lesions caused by inflammation along the small and large bowel, impaired nutrient absorption.

Goal 1: Will eliminate stool that is brown, of normal (soft) consistency, and that is not excessively foul during my care.

Goal 2: Will report 0/10 pain with passing stool during 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 bowel activity and stool consistency at least once a day.	Encourage ambulation and ROM exercises 2-3 times/day to promote peristalsis.
Monitor for signs of constipation or diarrhea (bloating, abdominal pain/distention, straining, or stools that are loose) q2hrs.	Provide privacy and a comfortable environment for stooling.
Monitor I&Os q8hrs	Collaborate with provider to obtain an order to make NPO to promote bowel rest.
Inspect, auscultate, and palpate abdomen for distention, tenderness, or abnormal bowel sounds q2-4hrs.	Administer prescribed anti-inflammatory medications (steroids, biologics, immunosuppressants) as ordered.
Assess for signs of malnutrition (muscle wasting, weight loss, and vitamin deficiencies) q8hrs.	Promote a diet that is high in protein and probiotics but avoid spicy/gas producing/fatty foods.
Monitor hydration status (skin turgor, moist/dry mucous membranes, and urine output) q4-8hrs.	Encourage adequate hydration of 2-3 L/day (unless contraindicated)

To Be Completed Before the Simulation

Anticipated Patient Problem: **Risk for Impaired Skin Integrity**

Clinical Reasoning: Persistent diarrhea due to Crohn's disease.

Goal 1: Will not have skin breakdown on the bottom, sacrum, or around the anus during my care.

Goal 2: Will always remain clean and dry during 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 skin in the perineal area for erythema, irritation, excoriation, or breakdown q4hrs and after each bowel movement	Provide skin care and perineal hygiene to prevent irritation at least once a shift and after each bowel movement.
Monitor frequency, consistency, and urgency of diarrhea q8hrs and PRN.	Use absorbent, moisture wicking under pads to bed when soiled and at least once per shift. Also provide frequent toileting (ask upon purposeful hourly rounding).
Check for signs of infection (pain, edema, purulent drainage, foul odor, or fever) q4hrs.	Educate on proper perineal hygiene, including washing gently with soap and warm water, patting dry, and proper application of barrier cream.
Evaluate condition/effectiveness of skin protection measures (barrier cream and incontinence pads) q8hrs.	Apply barrier cream or petroleum jelly after perineal care and at least once a shift.
Assess the ability to provide perineal hygiene independently.	Assist in perineal hygiene to ensure the area is getting cleaned properly.
Monitor nutritional and hydration status (albumin levels and signs of dehydration) q8hrs.	Ensure proper intake of fluid and protein rich foods during mealtimes and throughout the day.

To Be Completed During the Simulation:

Actual Patient Problem: Inadequate Fluid Volume – Risk for Hypovolemia

Clinical Reasoning: Experiencing a GI bleed, feeling like she is going to faint and throw up.

Goal: B/P will be WNL (SBP <120 and >100 mmHg; DBP <70 and > 50 mmHg) during my care. Met: ☐ Unmet: ☑

Goal: Will not faint during my care. Met: ☑ Unmet: ☐

Actual Patient Problem: Acute Pain (Abdominal)

Clinical Reasoning: GI bleed, Crohn's disease, reports pain scores of 6-8/10 in the right epigastric region.

Goal: Will report a pain score of < 5/10 during my care. Met: ☑ Unmet: ☐

Goal: Will not exhibit signs of pain (grimacing, guarding) during my care. Met: ☐ Unmet: ☑

Additional Patient Problems: Ineffective Home Maintenance Behaviors.

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 Hypovolemia		C/O, "very sore and crampy" pain in the abdomen, reported a pain score of 6/10. Stated pain was in the epigastric region. Reported that stress worsens it as well as eating unhealthy foods. Bowel sounds hyperactive upon auscultation. Reported feeling very dizzy and lightheaded and, "like I'm going to faint."		Took a set of vital signs immediately and applied supplemental O2 at 2 L/min.		Her VS were: B/P 94/56 mmHg, pule 110 bpm, RR 26/min, and SpO2 94%. States, "I feel like I'm going to pass out and throw up."
Risk for Hypovolemia		Her VS were: B/P 94/56 mmHg, pule 110 bpm, RR 26/min, and SpO2 94%. Stated, "I feel like I'm going to pass out and throw up."		Provided with an emesis basin, hung packed RBCs infusion.		C/O feeling cold and feeling worse.
Risk for Hypovolemia		C/O feeling cold and having a headache, asked for Ibuprofen. Her face was flushed. VS: B/P 103/60 mmHg, HR 96 bpm, RR 22/min, and T 38.8°C (101.8° F).		Stopped the blood transfusion.		Stated, "I feel awful, what's going on?"
Acute Pain		Stated, "I feel awful, what's going on?" Asked again for Ibuprofen.		Educated on blood transfusion rejection, and notified provider of blood reaction, and educated that she did not have an order for Ibuprofen but would speak with provider about how she is feeling.		Stated she feels, "ok."
Acute Pain		Post-operatively of the endoscopy, she presents ill-appearing. C/O being, "tender," as well as feeling a lot of, "cramping and discomfort." Reported a pain score of 8/10 in the right epigastric region. Tenderness noted on palpation. She had just finished breakfast when the pain began.		Administered IV Morphine 4 mg at 1 mg/min.		Reported she feels, "so much better." And reported a pain score of a 2-3/10, and no soreness or cramping.
Ineffective Home Maintenance Behaviors		Discussed that she has 5-6 drinks per night to relieve stress, since she works a high stress job. Went over her dietary choices.		Educated that high protein and high calorie diet is important, low fiber, and less caffeine. Also, that Ibuprofen can irritate the gastric lining.		Verbalizes understanding and states, "I definitely won't be taking Ibuprofen anymore."

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:

    a. **Gastroenterologist**

    b. **Charge RN**

2) What were three steps the nursing team demonstrated that promoted patient safety?

    a. **Confirming blood transfusion with another RN prior to infusion.**

    b. **Stopping the blood transfusion immediately when the temperature started to rise.**

    c. **Taking a set of vital signs as soon as the patient complained of not feeling okay.**

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: I feel that the medical team used therapeutic technique when talking to the patient because they elicited informational responses from her through communication that led her to trust the team and open up about alcohol consumption, lifestyle and activity level, and diet.

    b. If **no**, describe: **N/A**

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.

My priority nursing problem was risk for hypovolemia. My rationale was that my patient was experiencing a GI bleed, and she was unable to finish her blood transfusion due to blood transfusion reaction. My secondary priority problem was acute pain, and my rationale was that she complained of a 6-8/10 pain until relieved with IV morphine, and she exhibited signs of grimacing and guarding.

3) Review your Patient Problem Form: Did you see many of your anticipated nursing assessments and interventions used? No, my two priority problems changed completely.

    a. Were there interventions you included that *were not* used in the scenario that could help this patient?

        i. If **yes**, describe: It could have been helpful to continue to assess ostomy output. I don't think any interventions were needed for that, since the output was a result of the GI bleed, which was ligated during the endoscopy.

        ii. If **no**, describe: **N/A**

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

    a. Another GI bleeds.

    b. Why? She has Crohn's disease, and since she is prescribed Infliximab, a biologic agent for severe cases related to autoimmune disorders, her body/immune system are attacking her bowels. This can cause more of the mucosal lining to be ulcerated, and lead to another bleed. Also, if she does not stop taking NSAIDs and drinking alcohol/caffeine, she could irritate the gastric lining further.

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

    Therapeutic communication was my biggest takeaway. Throughout my patient care, there were many interventions done to keep the patient as comfortable as possible, but what stuck out to me the most was the meaningful conversation that took place at discharge. Discharge education is important when trying to prevent further injury to the patient and potential readmission to the hospital. It is vital to make the patient feel safe and trusting when talking about sensitive lifestyle choices, including alcohol consumption, activity level, and diet. This depiction of therapeutic communication will help me in the future when having difficult conversations with my patient.