Answers

CHAPTER 34 NURSING CARE OF PATIENTS WITH LOWER GASTROINTESTINAL DISORDERS

AUDIO CASE STUDY

Tara and Gastrointestinal Bleeding

1. Use of aspirin, two tablets, four times a day for her arthritis pain.
2. Bloody stools and was light-headed and seeing spots.
3. Intravenous (IV) fluids, laboratory work, and packed red blood cells.

VOCABULARY

Sample sentences will vary for the Vocabulary problems.

1. (**12**)
2. (**10**)
3. (**2**)
4. (**11**)
5. (**1**)
6. (**4**)
7. (**8**)
8. (**9**)
9. (**3**)
10. (**5**)
11. (**7**)
12. (**6**)

OSTOMIES

*Corrections are in **boldface.***

1. Michelle Braun is a 36-year-old with ulcerative colitis. She is taking cortisone. She is on a **low**-residue diet. She has just been admitted to the hospital for a **total proctocolectomy.** The nurse monitors her intake and output, daily weights, and electrolytes. The nurse also monitors for signs of inflammation in her joints, skin, and other parts of her body. The nurse teaches her to **increase** fluids following surgery, **but it is not possible** to limit the number of stools she has daily.
2. James Key is a 46-year-old with a new sigmoid colostomy. Following surgery, the nurse monitors his stoma each shift to ensure that it remains **pink** and **moist**. The nurse explains that the stool will be **formed**. The nurse contacts the dietitian to provide a list of the high-fiber foods that he should **avoid**.

PRIORITIZATION

(**5, 6, 4, 3, 7, 8, 2, 1**) is the correct ranking. The patient is exhibiting signs of low blood pressure and potentially is going into shock. For safety, the patient should be quickly assisted back to bed with additional staff assistance and covered with warm blankets. Intravenous fluids are essential to replace lost fluid, so after moving the patient, it is important you quickly verify that the intravenous site is patent and the normal saline is infusing while data is collected. You must collect data to report to the health-care provider immediately. Obtain vital signs, level of consciousness, and perform rapid head-to-toe assessment to identify signs and symptoms. Notify the health-care provider immediately with collected data. Ideally, if not already on-site, the health-care provider is being contacted as data is being collected.

CRITICAL THINKING AND CLINICAL JUDGMENT

1. Because Mrs. Hendricks has arthritis, she may not be getting much exercise. Lack of teeth probably prevents her from eating many fresh fruits or vegetables. Poor fluid intake and certain medications may also be factors.
2. You should collect data on Mrs. Hendricks's abdomen, including bowel sounds, distention, tenderness, and other signs of problems such as impaction, as well as her diet, exercise, fluid intake, and other possible factors that may have caused constipation.
3. You should intervene to prevent the problem from becoming worse. Mrs. Hendricks is only 1 day behind her normal bowel movement schedule. Unrelieved constipation can lead to fecal impaction, megacolon, and complications related to use of Valsalva maneuver.
4. Before giving Mrs. Hendricks more Milk of Magnesia, you can try giving her some prune juice, have her ambulate in the halls if she is able, and have her sit on the toilet or bedside commode (avoid use of bedpan) to attempt to have a bowel movement. Placing her feet on a footstool while sitting on the toilet can be helpful.
5. Prevention is the best treatment for constipation. You can place Mrs. Hendricks on a regimen of 2 g bran with her cereal each morning. Include pureed fresh fruits and vegetables as much as possible in her diet. Encourage fluids and assist her to walk in the halls several times

each day. Establish a regular time each day (or two) for Mrs. Hendricks to have privacy in the bathroom for a bowel movement. Offer a warm drink such as a cup of coffee or tea or warm water before this time. If these measures do not work, add Metamucil to her daily regimen. Use Milk of Magnesia (magnesium hydroxide mixture), senna (Senokot), and enemas only as necessary. Continue use of footstool when using toilet.

6. Develop an SBAR communication for Mrs. Sheffield for communicating to the next shift.
   S: Mrs. Millie Hendricks is a 90-year-old with constipation today.
   B: She has a history of severe osteoarthritis, no teeth, and normally has a bowel movement every other day. She has not had a BM for 3 days.
   A: She was 1 day behind in her bowel movements. Today we gave her some prune juice and helped her walk, and she also had pureed fruits and vegetables. She was able to have a bowel movement, but she needs a prevention plan for constipation.
   R: I recommend that she have bran with her cereal in the morning, pureed fresh fruits and vegetables, and encourage her to drink more. She will need help ambulating in the halls several times a day. She needs a bowel schedule once or twice a day with privacy. You can offer warm liquids prior to the bowel schedule. We can try this plan before giving her more ordered medications.

REVIEW QUESTIONS

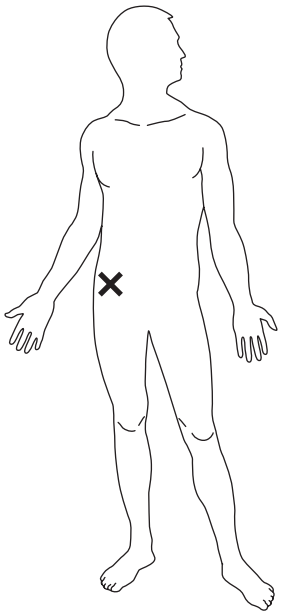
*The correct answers are in **boldface.***

1. (**3**) is correct. The LVN/LPN should notify the registered nurse of the data indicating dehydration. (1, 2, 4) These will be completed, but the registered nurse should be notified first.
2. (**2, 3, 4, 5**) are correct. Coughing and deep breathing, incentive spirometer, and early ambulation all help prevent atelectasis and pneumonia. Providing pain control allows the patient to complete the interventions. (1) Bedrest can lead to respiratory complications such as atelectasis and pneumonia by not allowing full expansion of the lungs.
3. (**1**) is correct. Fresh fruits are high in fiber and can increase diarrhea. In general, foods that irritate the patient should be avoided such as high-fiber foods, caffeine, spicy foods, and milk products. (2, 3, 4) These are low-fiber foods that generally do not irritate a patient who has ulcerative colitis.
4. (**1, 2, 3, 4, 6**) are correct. The patient with small bowel obstruction (SBO) can have decreased fluid volume, and the nurse should monitor intake and output, heart rate, and blood pressure. SBO causes a lot of pain, and pain levels and trends should be assessed. Infection can develop in SBO, so the nurse should assess the temperature. An SBO causes distention and firmness due to the blockage. (5) Most patients with SBO have fluid deficits.
5. (**3**) is correct. Parenteral nutrition is the only way to adequately feed a person for an extended period without using the gut. (1, 2) both require a functional bowel. (4) provides inadequate nutrition for an extended period.
6. (**2, 3, 4**) are correct. A patient with diverticulosis can use acetaminophen for pain if needed. It is important to prevent constipation. Regular exercise and drinking plenty of fluids can help prevent constipation. (1, 5) The patient should have a high-fiber diet to prevent constipation. The patient should have normal stools, not hard as with constipation or watery as with diarrhea.
7. (**3**) is correct. A bowel obstruction can cause nausea and vomiting, which can decrease fluid volume. (1, 2, 4) would not apply to a bowel obstruction.
8. (**4**) is correct. The stomas can be temporary and returned to the abdomen and reconnected after the resected area of bowel has healed. (1) The colostomy does not usually drain constant liquid stool. (2) There is no such thing as a looped bag. (3) The colostomy will drain stool from the proximal stoma, and the distal stoma will not drain stool.
9. (**1**) is correct. Fluids are needed to replace those lost in liquid stools. (2, 3, 4) can all increase liquid stools and fluid loss.
10. (**3, 5, 6**) are correct. These are the selections that do not contain a type of grain that must be avoided. (1, 2, 4) These items all contain gluten (oatmeal, waffle, and wheat cereal) and must be avoided with celiac disease. Grains certified as gluten free can be eaten.
11. (**1, 3, 4**) are correct. Treatment for anal fissures involves measures to ensure soft stools to allow fissures time to heal. Instructions to prevent constipation include 2 to 3 L of fluid a day to promote regular bowel movements. A side effect of opioid analgesics is constipation, which needs to be avoided; anesthetic suppositories and nonopioid analgesics may be ordered for comfort. (2) This would be the desired response for effective teaching, as pain may be so severe that the patient delays defecation, leading to further constipation and worsening symptoms. (5) Sitz baths may be used to promote circulation to the area to aid healing and comfort. (6) A high-fiber diet helps prevent constipation.
12. (**3**) is correct. Black, tarry stools could indicate bleeding, and the nurse should assess the vital signs first before completing the other interventions. (1, 2, 4) The nurse should complete the vital signs first to gather data about fluid status from the potential bleeding.
13. (**4**) is correct. A dusky color indicates impaired circulation and requires immediate medical treatment to restore blood flow. (1, 2, 3) A dusky stoma should be reported immediately; these options are not the priority and can be completed after contacting the HCP.
14. (**2**) is correct. The patient is having difficulty passing gas after abdominal surgery and ambulating can help. (1, 3, 4) The narcotic can slow down peristalsis even more and is not needed for mild pain. The stoma should be monitored but will not have any effect on passing flatus. If the pain gets worse or there are no bowel sounds, then the HCP should be notified.

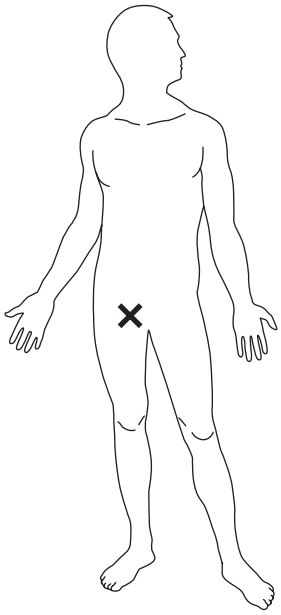
15. (**4**) is correct. Convert mg to gram: 0.5 grams = 500 mg tablet.

    1 tablet/0.5 grams × X/1 gram = 2 tablets

16. The area where the pain localizes in appendicitis.



17. The area where the nurse would view the surgical site for the repair of a right inguinal hernia.



18. The area where the nurse would observe the stoma.