

Case Scenario #2
Adult Acute Care - Surgical

INSTRUCTIONS: For this case study, you will develop a Nursing Care Plan using SNL, the Standardized Nursing Languages of NANDA, NOC and NIC (NNN).). Complete the Nursing Care Plan that accompanies this scenario.

- Mrs. Smith is being admitted to your unit post-op. She is a 52-year-old-female who is s/p ® hemicolectomy with a temporary colostomy. She has a history of Chron's disease with severe exacerbations over the past few days. She has unintentionally lost 15 pounds over the past month. Her abdominal dressing is clean, dry, and intact. She expresses ambivalence about having "a bag" and the ability to care for her colostomy. Vicodin i p.o. q 6 hours prn was being used to manage her discomfort prior to surgery. Her PCA is not effectively relieving her pain.

Functional Health Patterns

- Nursing assessment data is organized in **Functional Health Patterns**. Functional Health Patterns can help direct the choice of Nursing Diagnoses. The eleven functional health patterns are *Health Perception-Health Management; Cognitive-Perceptual; Nutritional-Metabolic; Elimination; Activity-Exercise; Sleep/Rest; Self-Perception/Self-Concept; Role/Relationship; Sexuality/Reproductive; Coping/Stress/Tolerance; and Value/Belief.*
- The **Functional Health Patterns** that are relevant for Mrs. Smith are:
 - Nutrition-Metabolic
 - Cognitive-Perceptual
 - Coping/Stress/Tolerance
 - Elimination
 - Self-Perception/Self-Concept
 - Health Perception-Health Management
- **Health Perception-Health Management** is the most affected functional health pattern for Mrs. Smith.

Step 1. Choosing the Nursing Diagnosis (es)

These nursing diagnoses are appropriate for this patient. In practice, you may select additional nursing diagnoses.

Nursing Diagnosis: Knowledge deficit - care of colostomy

Defining Characteristics: Verbalization of the problem, expressed ambivalence

Related Factors: Lack of exposure (new colostomy), unfamiliarity with resources regarding colostomy devices.

Nursing Diagnosis: Body Image Disturbance

Defining Characteristics: Verbalized ambivalence about having "a bag" & negative view of physical appearance

Related Factors: Surgical procedure - ® hemicolectomy

- While both nursing diagnoses are appropriate, for the purposes of this exercise let's use

Knowledge Deficit - Care of Colostomy

- On the nursing care plan form, write in the nursing diagnosis, and check the defining characteristics (signs and symptoms) and related factors (etiology).

Step 2. Choosing the Nursing Outcomes (NOCs)

- The next step is to select nursing outcomes that can best affect this nursing diagnosis.
- Listed below are two appropriate nursing outcomes for Mrs. Smith.

Nursing Outcomes

Knowledge: Treatment Procedure (Colostomy Care)

Indicators: Description of steps in the procedure
Description of proper care of equipment
Description of appropriate action to take for complications
Performance of procedure

Knowledge: Treatment Regimen

Indicators: Description of prescribed diet
Selection of foods recommended in diet
Description of prescribed activity
Performance of self-monitoring
Description of self care in emergency situations

- Select one of the above listed **nursing outcomes** for this care plan exercise, go to the nursing care plan and check the indicators that you think will best measure your patient's progress towards

the outcome that you've chosen. You will need to **rate** you patient's current status for each indicator.

- Now that you have chosen your outcome for Mrs. Smith, you will need to select the interventions that will best meet this outcome.

Step 3. Choosing the Nursing Interventions

- If you have chosen **Knowledge: Treatment Procedure (Colostomy Care)**, continue below to select your interventions and activities.
- If you have chosen **Knowledge: Treatment Regimen**, continue on page 4 to select your interventions and activities.

NOC - Knowledge: Treatment Procedure (Colostomy Care)

The following two Nursing Interventions are appropriate for this patient. Review the activities listed below each **NIC** and select 5. Write these five on the care plan in the activity section for each **NIC**.

Remember that many activities are necessary and that as the Standard Nursing Care Plans are developed, these activities will be listed for you to make selections.

NIC - Ostomy Care

Activities (NIC³ pg. 483)

Mark the skin for stoma placement	Instruct patient/significant other in the use of ileostomy/colostomy equipment	Assist patient in providing ostomy/ileostomy self-care
Have patient/significant other demonstrate use of equipment	Apply appropriately-fitting ostomy appliance, as needed	Monitor for incision/stoma healing
Encourage patient/significant other to express feelings and concerns about changes in body image	Encourage visitation to client by persons from such support groups as ileostomy/colostomy clubs	Irrigate colostomy, as appropriate
Assist patient in obtaining ostomy/ileostomy equipment	Instruct patient on mechanisms to reduce odor	Instruct patient/significant other in appropriate diet and expected changes in elimination function
Provide and assistance, while client develops skill in caring for stoma/surrounding tissue	Monitor stoma/surrounding tissue healing and adaptation to ostomy equipment	Change/empty ostomy bag, as appropriate
Encourage participation in ostomy support groups after hospital discharge		

The second NIC for the **NOC - Knowledge: Treatment Procedure (Colostomy Care)** is **Skin Surveillance**. Again, review the activities listed below the NIC and select 5. Write these five on the care plan in the activity section for **Skin Surveillance**

NIC – Skin Surveillance

Activities (NIC³ pg. 601)

Inspect condition of surgical incision, as appropriate	Observe extremities for color, warmth, swelling, pulses, texture, edema, and ulcerations	Inspect skin and mucous membranes for redness, extreme warmth, or drainage
Monitor skin for areas of redness and breakdown	Monitor for sources of pressure and friction	Monitor for infection, especially of edematous areas
Monitor skin for rashes and abrasions	Monitor skin for excessive dryness and moistness	Inspect clothing for tightness
Monitor skin color	Monitor skin temperature	Note skin or mucous membrane changes
Institute measures to prevent further deterioration, as needed	Instruct family member/caregiver about signs of skin breakdown, as appropriate	

The second NOC is - Knowledge: Treatment Regimen

The following two Nursing Interventions are appropriate for this patient. Review the activities listed below each NIC and select 5. Write these five on the care plan in the activity section for each NIC.

Remember that many activities are necessary and that as the Standard Nursing Care Plans are developed, these activities will be listed for you to make selections.

NIC - Teaching: Prescribed Diet (NIC³ pg., 649)

Appraise the patient's current level of knowledge about prescribed diet	Determine the patient's/significant other's feelings/attitude toward prescribed diet and expected degree of dietary compliance	Instruct the patient on the proper name of the prescribed diet
Explain the purpose of the diet	Inform the patient about how long the diet should be followed	Instruct the patient about how to keep a food diary, as appropriate
Instruct the patient on allowed and prohibited foods	Inform the patient of possible drug/food interactions, as appropriate	Assist the patient to accommodate food preferences into the prescribed diet
Assist the patient in substituting ingredients to conform favorite recipes to the prescribed diet	Instruct the patient about how to read labels and select appropriate foods	Observe the patient's selection of foods appropriate to prescribed diet
Instruct the patient about how to plan appropriate meals	Provide written meal plans, as appropriate	Recommend a cookbook that includes recipes consistent with the diet, as appropriate
Reinforce information provided by other health care team members, as appropriate	Refer patient to dietitian/nutritionist, as appropriate	Include the family/significant others, as appropriate

The second **NIC** for the **NOC - Knowledge: Treatment Regimen**

is **Teaching: Prescribed Activity/Exercise**. Again, review the activities listed below the **NIC** and select 5. Write these five on the care plan in the activity section for **Teaching: Prescribed Activity/Exercise**.

NIC - Teaching: Prescribed Activity/Exercise (NIC³, pg.648)

Appraise the patient's current level of exercise and knowledge of prescribed activity/exercise	Inform the patient of the purpose for, and the benefits of, the prescribed activity/exercise	Instruct the patient how to perform the prescribed activity/exercise
Instruct the patient how to monitor tolerance of the activity/exercise	Instruct the patient how to keep an exercise diary, as appropriate	Inform the patient what activities are appropriate based on physical condition
Instruct the patient how to safely progress activity/exercise	Caution the patient on the dangers of overestimating capabilities, as appropriate	Warn the patient of the effects of extreme heat and cold, as appropriate
Instruct the patient on methods to conserve energy, as appropriate	Instruct the patient how to warm up and cool down before and after activity/exercise and the importance of doing so, as appropriate	Instruct the patient on good posture and body mechanics, as appropriate
Observe the patient perform the prescribed activity/exercise	Provide information on available assistive devices that may be used to facilitate performance of required skill, as appropriate	Instruct the patient on the assembly, use, and maintenance of assistive devices, as appropriate
Assist the patient to incorporate activity/exercise regimen into daily routine/life style	Assist the patient to properly alternate periods of rest and activity	Refer the patient to physical therapist/occupational therapist/exercise physiologist, as appropriate
Reinforce information provided by other health care team members, as appropriate	Include the family/significant others, as appropriate	Provide information on available community resources/support groups to increase the patient's compliance with activity/exercise, as appropriate
Refer the patient to a rehabilitation center, as appropriate		

Congratulations!

You have successfully completed your first nursing care plan using the standard nursing language vocabularies of **NANDA**, **NOC**, and **NIC**.

1. If you wish to received CE for this educational activity, please complete the evaluation form and return along with \$10 to:

Carol Williams, MS, RN, C
 Educational Services for Nursing
 University of Michigan Health System
 300 North Ingalls, 6B12
 Ann Arbor, Michigan 48109-0436

2. If you are working with a coordinator please give your quiz, evaluation and completed nursing care plan to your coordinator.

NICs (interventions) ACTIVITIES

MODIFICATIONS:

Ostomy Care	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	DATE/TIME				

ACTIVITIES:

MODIFICATIONS:

Skin Surveillance	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	DATE/TIME				

ACTIVITIES:

MODIFICATIONS:

Teaching: Prescribed Diet	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	DATE/TIME				

ACTIVITIES:

MODIFICATIONS:

Teaching: Prescribed Activity/Exercise	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	DATE/TIME				

OTHER INTERVENTIONS:

SIGNATURE BOXES:

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