Student Name: Alyssa Vitella

Medical Diagnosis/Disease: UTI

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

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

Anatomy and Physiology
Normal Structures

Kidneys: organ located posterior and later above the hips, filters and removes waste and water from blood= urine. Balance bodies fluid.
Ureters: thin tubes carry urine from the kidneys to the bladder. Muscles relax and tighten forcing urine downward.
Bladder: sack like stores urine.
Urethra: carries urine from bladder to outside the body. Brain sends signals to bladder muscles to tighten= urine comes out.
Sphincter muscles: keep urine from leaking into bladder.

Pathophysiology of Disease

Can involve urethra, kidneys, or bladder. The invasion of bacteria into the urinary system causes a UTI. Urine normally moves through the body without contamination. Bacteria enters causing infection and inflammation. When an infection occurs the inflammation will cause pain around the affected area. Infections are more common in women due to the shorter urethra allowing a shorter route for bacteria into the body. Can be blood born(prior to urinary tract). Most common: Gram – bacilli.

Anticipated Diagnostics

Labs
Urinalysis (bacteria, WBC)
Urine Culture
BUN, creatinine

Additional Diagnostics
CT, MRI, ultrasound, cystoscopy

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

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

Contributing Risk Factors

Age
DM
Obesity
Poor hygiene
Menopause
Suppressed immune system
Multiple sex partners
Catheter
Voiding dysfunction

Signs and Symptoms

Pain burning during urination
Frequent urination
Strong odor of urine
Cloudy urine

Possible Therapeutic Procedures

Non-surgical
Antibiotics
Increase Fluid

Surgical
Cystoscopy

Prevention of Complications

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

Permeant kidney damage
Deliver premature baby
Narrowed ureter.
Sepsis, death

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

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

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

Anticipated Medication Management

Antibiotic therapy
Analgesic

Non-Pharmacologic Care Measures

Maintain fluid intake
Hot/cold compress
Med admin (Pain)
Ambulation assistance
Rest
Cath/ Perineal care
Proper hygiene

What stressors might a patient with this diagnosis be experiencing?

Pain
Difficulty coping
Role changes
Fear

Client/Family Education

List 3 potential teaching topics/areas

- Proper hand hygiene
- Importance of med compliance
- Preventative measures for UTI reoccurrence

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)

Urologist
Gynecologist
Cardiologist

Potential Patient Problems (Nursing Diagnoses)

List two potential patient problems you will be addressing along with clinical reasoning, goals/expected outcomes, assessments, and priority nursing interventions. The patient problems must be in priority order.

Problem # 1: Acute pain
Clinical Reasoning: UTI: frequent urination, reflux, burning during urination.

Goal/EO: Will report satisfactory pain control at a level less than 4 on a 0 to 10 pain scale during the time of my care.

Ongoing Assessments: Assess PQRST of pain BID, Assess HR, BP, RR q4 hr, assess need for pain relief q4hr, Assess pain goal daily.

NI: 1. Administer analgesics as ordered during time of my care.

2. Encourage increased oral fluid intake q 2hr.

3. Instruct to avoid coffee, tea, spices and ETOH TID.

4. Provide rest periods to facilitate comfort, sleep and relaxation TID.

5. Respond immediately to reports of pain during my time of care.

6. Apply hot compress to lower abd are TID, during times of pain exacerbation.

Problem # 2 Impaired Urinary Elimination
Clinical Reasoning: UTI: frequent urination, urgency, hesitancy

Goal/EO: Will achieve a normal urinary elimination pattern as evidenced by absent signs of urinary disorders (urgency, oliguria, dysuria) during my time of care.

Ongoing Assessments: Assess presence of elimination q 2hr, assess the urine q2hr, assess pain and urinations daily.

NI: 1. Cleanse perineal area and keep dry, provide catheter care PRN q 4hr.

2. Encourage Hygiene, hand washing and perineal care TID.

3. Administer antibiotic as ordered during time of my care.

4. Encourage adequate fluid intake during my time of care.

5. Teach Importance of antibiotic tx, proper hygiene BID.

6. Encourage ambulation TID.

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:
    a. **_____Debbie RN_____**
    b. **_____Angela RN_____**
2) What were some steps the nursing team demonstrated that promoted patient safety?
    a. **___Proper therapeutic communication was used with the patient. _____**
    b. **__Medication reconciliation with pharmacy _____**
    c. **_Call bell within reach_____**
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 I believe therapeutic communication as used with the patient, families and team members. The nurses always introduced themselves thanked the patient for their time and were efficient in communicating to their coworkers. _____

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) Review your Nursing Process Form: Did you select a correct priority nursing problem?
    a. If **no,** write what you now understand the priority nursing problem to be: **_Decreased cardiac output_**
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 **no,** describe: ___I saw more interventions and assessments based around her difficulty breathing. The nurse placed O2 on her via NC when she was having trouble catching her breath. Assessments were done for her hypoxemia, such as auscultating the lungs, BP and SPO2._____
4) After completing the scenario, what is your patient at risk for developing?
    a. ____Heart failure _____
    b. Why? She is experiencing extreme hypoxemia and decreased CO. She was presenting cold which is a manifestation of the hypoxemia. She has decreased urine output, Spo2 of 89 on 2L NC.
5) What was your biggest “take-away” from participating in the care of this patient? How did this impact your nursing practice?

_____The biggest takeaway I had from the care of this patient was to always dig deeper in your assessment. Just because a patient comes in with one problem does not mean that they could have another serious life-threatening problem going on too. She presented with more issues relating to her heart failure and hypoxemia than she did for a UTI. I originally had interventions to teach about perineal care but it would not be

appropriate to teach her about that at this time due to her decline. This impacted my nursing care by showing me that you have to be ready to change your nursing care plan.

SOAP Note Based on Priority Problems

Priority Patient Problem #1: ____Decreased CO_____

Subjective: *This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.*	**History Present Illness (HPI): 78 year old female came into the ED for urosepsis. The patient is experiencing chills and reports a pain level of 4/10.** **PMH: Diabetes and Heart failure** **Allergies: NKA** **Current Medications: Potassium chloride, furosemide, isosorbide, digoxin.**
Objective: *This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.*	**Vital Signs: HR: 98, RR:28, BP: 130/94, T38.1, SPO2: 89% on 2L NC. At 0833.** **Labs: WBC: 13,000, BUN: 21, UA: Slightly amber color and cloudy. 2 protein, 1.039 specific gravity. ABG: ph: 7.28, Co2 35, HCO3 20.** **Diagnostics:** **None relating to priority problem.**
Assessment: *Focused assessments on your priority problem.*	**RR 32, and shallow respirations. Pt reports chills and stated, "I'm cold I don't feel so good". Foley bag cloudy, 100ml urine output since transfer to med surg.**
Plan ***Based on priority problem only** *Include what your plan is for the client. What treatments or medications are needed? You can include procedures, consults, labs/diagnostics, etc. What nursing interventions are being performed?*	**Plan:** **Push IV antibiotics, Continue IVF NS 150ml /hr, maintain 02 6L via NC and titrate as needed, UA, continue monitoring CBC, administer Digoxin 0.25mg PO daily for CHF, administer 20mg Furosemide daily for HF, Administer albuterol q4 hr PRN for difficulty breathing.**

	Teaching & Resources: **Educate on signs and symptoms of UTI, Septic shock.** **Refer to case management (home health)**