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Medical Diagnosis/Disease: UTI

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

NCLEX IV *(7)*: Reduction of Risk

Anatomy and Physiology Normal Structures	Pathophysiology of Disease	Anticipated Diagnostics
The upper urinary tract consists of 2 kidneys, and 2 ureters, and the lower urinary system consists of a bladder and urethra. The kidneys are bean shaped organs, that's primary function is to filter the blood and maintain the body's internal homeostasis. Urine formation occurs as well. The ureters are tubes that carry urine from the renal pelvis to the bladder at a specific angle that prevents any backflow. The bladder serves as a reservoir for urine and waste products. The bladder expands when filled and contracts when empty. The urethra, which is shorter in females, is a small tube that controls voiding and serves as a conduct for urine from the bladder to the outside of the body. Together, all these parts work to expel urine from the contraction and relaxation of the bladder and sphincters and muscles.	The urinary tract above the urethra is considered sterile, and the body encompasses several mechanisms that aid in the maintenance of sterility and prevention of infection. These mechanisms include normal voiding with complete emptying of the bladder, ureterovesical junction competence, and ureteral peristaltic activity that propels urine towards the bladder. The high PH of urine allows for the interference of the growth of bacteria. The most common causes of UTI's originate from the perineum and are introduced via ascending route, usually by urologic instrumentation that allows bacteria present at the opening of the urethra to enter the bladder.	Labs Dipstick urinalysis Urine culture and sensitivity Additional Diagnostics H&P, CT, US, cystoscopy

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

NCLEX IV *(7)*: Reduction of Risk

Contributing Risk Factors	Signs and Symptoms	Possible Therapeutic Procedures	Prevention of Complications
Catheters Urinary Retention Renal Impairment Obstruction Aging Diabetes HIV infection Shorter urethra Obesity Urinary tract stones Voiding disfunction Poor personal hygiene Multiple sexual partners Pregnancy	Dysuria Frequency Sudden desire to void Suprapubic discomfort Diminished urine stream hematuria cloudy urine Upper- fever, chills, flank pain	Non-surgical n/a Surgical n/a	(What are some potential complications associated with this disease process) Kidney infection Sepsis Pregnancy issues HTN

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

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

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

Anticipated Medication Management	Non-Pharmacologic Care Measures	What stressors might a patient with this diagnosis be experiencing?
Antibiotics Analgesics	Increased fluid intake Wiping front to back Urination after sexual intercourse	Frequent wakening during the night, nocturia

Client/Family Education

List 3 potential teaching topics/areas

- Take full course of antibiotics, even when feeling better
- Increase fluids
- Practice wiping front to back

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)

HCP
RN
Family
Urologist
Lab
Pharmacy

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: burning with urination, suprapubic discomfort, infection

Goal/EO: Client will have a pain rating on the numeric pain scale of a 3/10 or less by the end of my shift.

Ongoing Assessments: pain rating, RR, pulses, BP, VS, Facial grimacing, PQRST of pain

NI:
1. Administer pain medications as ordered
2. Respond immediately to reports of pain PRN
3. Encourage the use of a sitz bath PRN
4. Provide rest periods to facilitate comfort and relaxation q shift
5. Educate on s/sx to report the HCP PRN
6. Apply heating pad to the suprapubic area or lower back PRN

Problem # 2 Impaired Urinary Elimination
Clinical Reasoning: dysuria, diminished urine stream

Goal/EO: Client will be clear of UTI as evidenced by clear, non-foul-smelling urine, pain-free urination, normal WBC count, and absence of fever, chills, flank pain, and suprapubic pain by the end of my shift.

Ongoing Assessments: urine color, odor, I&Os, frequency of urination

NI: 1. Encourage adequate fluid intake q shift

2. Encourage cranberry juice or vitamin C 500-1000mg /day q shift

3. Educate on avoiding coffee, teas, alcohol, and sodas PRN

4. Educate on the importance of completing antibiotic therapy q shift

5. Encourage frequent voiding q shift

6. Educate on wiping front to back to prevent further infection or complications urinating q 4 hrs.

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:
    a. **_HCP_____**
    b. **_RN_____**
2) What were some steps the nursing team demonstrated that promoted patient safety?
    a. **___Check name and DOB_____**
    b. **__assisted when call bell dropped to prevent falls_____**
    c. **____kept bed in lowest position _____**
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 when the assistive personnel told nurse Craig that his patient was having trouble breathing in a timely manner
    _____
    _____
    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) Review your Nursing Process Form: Did you select a correct priority nursing problem?
    a. If **yes,** write it here: _____
    b. 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 **yes,** describe: _education about medications
      _____
      _____

      ii. If **no,** describe:
      _____
      _____

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

   a. __Septic Shock,
   Infection_____

   b. Why? __Increased confusion, Restlessness, Coccyx skin breakdown
   ulcer_____

   _____

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

   __Completing a focused assessment is very important to implement the nursing interventions needed to help the patients problems right away, even if they are not what you anticipated at first
   _____
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SOAP Note Based on Priority Problems

Priority Patient Problem #1: ___Decreased Cardiac Output

_____

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): Urosepsis** **PMH: DM, CHF** **Allergies: NKA** **Current Medications: Glyburide 2.5mg Po daily with breakfast, Levofloxacin 250mg IV bolus q12 hrs, Acetaminophen 325mg PO q4hrs for fever greater than 37.7, Lorazepam 2mg PO q6hr PRN for agitation and restlessness, 1000ml LR IV 30ml/hr,**
Objective: *This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.*	**Vital Signs: T-37.2, P- 88, RR- 22, BP-128/84, o2- 91%** **Labs: CBC- hgb-11.3, hct-33%, WBC-13,000** **Blood chemistry- BUN- 21, Cholesterol- 225** **Urinalysis- cloudy, slight amber, protein-2mg, Leukocytes esterase-positive, WBC-10, RBC- 4-6, RBC casts-positive** **Diagnostics: radiology- n/a**

Assessment: *Focused assessments on your priority problem.*	**Assess spO2 q2 hrs for oxygenation status** **Assess cap refill q2 hrs for extremity perfusion status** **Assess and measure strict I&Os for kidney perfusion status** **Assess O2 NC and adjust PRN** **Assess LOC q2hrs for brain perfusion status** **Assess HR for the rate the heart is pumping, to see how hard its working** **Assess RR for labored and impaired breathing**
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: Give 0.25mg of digoxin PO as ordered, Furosemide 20mg IV push, Albuterol 0.5% solution via nebulizer q6hrs and q2hrs PRN for breathing difficulty, Get Chest XR, monitor blood glucose** **Teaching & Resources:** **CHF education, teach importance of low sodium, heart healthy diet, s/sx to report to HCP, Urologist, Cardiologist**