N431 Care Plan

Lakeview College of Nursing

Justine Funneman

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10-18-19	J.W.	89	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
caucasian	retired	married	Aspirin, sulfasalazine, tape
Code Status	**Height**	**Weight**	
DNR	5'4	61.6 kg	

Medical History (5 Points)

Past Medical History: depression, dementia, GERD, hypertension

Past Surgical History: patient cannot tell me due to her dementia. It was also not located in her chart

Family History: father-blood clots

Social History (tobacco/alcohol/drugs): patient denies use of alcohol, drugs, or tobacco

Assistive Devices: patient uses a walker

Living Situation: Patient lives in a nursing home

Education Level: Patient is a high school graduate

Admission Assessment

Chief Complaint (2 points): fever, lethargy, and confusion

History of present Illness (10 points): An 89 year old female with a Past medical history of depression, dementia, GERD, and hypertension came to the ED from the nursing home with a fever and complaints of lethargy and confusion. The staff stated they found the patient with a fever of 102F and said she was not acting like herself. The urine was tested in the ED and infection was found. The patient's creatine level was also increased. She was given Ceftriaxone by IV in the ED and then was admitted.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): UTI

Secondary Diagnosis (if applicable): Dementia

Pathophysiology of the Disease, APA format (20 points):

A urinary tract infection is when bacteria invades the bladder or urinary tract. The bacteria cells gather and attach to the epithelium of the urinary tract. When the attach to the epithelium that prevents them from being voided out and start to become inflamed. UTI's can come from fecal organisms coming from the perineum to the urethra and the bladder and then attaching to the mucosal surfaces.

Risk factors contributing to UTIs are being a female, having diabetes, pregnancy, neurological disorders, gout, altered status caused by incomplete emptying of the bladder and urinary stasis, inflammation or abrasion of the urethral mucosa, or obstructed urinary flow. My patient had a few of these risk factors including being female, and having the neurological disorder of dementia. My patient was also on Oxybutynin Chloride so she has a problem with urinary incontinence making it easier for bacteria to grow.

Clinical manifestations of Urinary Tract Infections depend on what kind of infection it is, an upper or lower infection. Lower tract infection symptoms include burning when urinating, frequent urination, urgency, nocturia, incontinence, pelvic pain, back pain, and hematuria. My patient showed signs such as extreme pain on her pelvic and radiating to her back. She had a urinary catheter while she was in the hospital so she could not express to me if she was having pain while urinating.

The best way to diagnose a patient with a urinary tract infection is with a urinalysis. The Urinalysis will check for nitrites/nitrates, leukoesterase, and WBC count to determine whether the patient does have an infection. Once the infection is found they will do a urine culture to determine what kind of bacteria is causing the infection. After they find out they will be able to

tell which antibiotic will work best on that certain bacteria. My patients urinalysis came back positive with a WBC count of greater than 100 which is significantly high. It also showed a trace (A) of ketones and also a 2+ protein. The urinalysis results came back as gram - bacilli. For the infection the patient was given Ceftriaxone (Rocephin) IV piggyback in the ED.

Pathophysiology References (2) (APA):

Hinkle, J. L., Brunner, L. S., Cheever, K. H., & Suddarth, D. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Philadelphia: Lippincott Williams & Wilkins.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.8-5.41**	**3.78**	**3.03**	**Urinary tract infections can cause RBCs to be destroyed in your body system. (carenow.com)**
Hgb	**11.3-15.2**	**11.1**	**8.7**	**Hemoglobin is a part of the RBCs that the UTI is destroying. (carenow.com)**
Hct	**33.2**	**33.4**	**27.2**	**Hematocrit goes along with Hemoglobin when being destroyed by the UTI. (carenow.com)**
Platelets	**149-393**	**167**	**140**	**The patient is on a couple PPI's which can cause a low platelet count. (ncbi.nlm.nih.gov)**
WBC	**4-11.7**	**8.9**	**5.6**	
Neutrophils	**45.3-79**	**82**	**N/A**	**The neutrophil count is high to show the infection in the patient's body. (Medscape.com)**
Lymphocytes	**11.5-45.9**	**11.5**	**N/A**	
Monocytes	**4.4-12**	**5.6**	**N/A**	

Eosinophils	**0-6.3**	**.4**	**N/A**	
Bands	**0-1**	**.4**	**N/A**	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145**	**142**	**141**	
K+	**3.5-5.1**	**3.6**	**3.8**	
Cl-	**98-107**	**103**	**103**	
CO2	**21-31**	**29**	**22**	
Glucose	**74-109**	**115**	**87**	**Hyperglycemia in patients who are hospitalized is usually the result of delays in eating. (Cheever and Hinkle 2018 pg1479)**
BUN	**7-25**	**52**	**23**	**BUN can be high in patients with kidney damage. Kidney damage can occur in patients with hypertension. (uofmhealth.org)**
Creatinine	**.5-.9**	**2.39**	**1.25**	**Creatinine can also be high in patients with kidney damage. Kidney damage can occur in patients with hypertension. (uofmhealth.org)**
Albumin	**3.5-5.2**	**3.6**	**2.6**	
Calcium	**8.6-10.3**	**9.5**	**9.5**	
Mag	**1.5-2.5**	**N/A**	**N/A**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	
Bilirubin	**0.3-1**	**.5**	**.3**	

Alk Phos	**35-105**	**58**	**48**	
AST	**0-32**	**16**	**23**	
ALT	**0-33**	**12**	**13**	
Amylase	**23-85**	**N/A**	**N/A**	
Lipase	**0-160**	**N/A**	**N/A**	
Lactic Acid	**0.5-1**	**N/A**	**N/A**	
Troponin	**0-30**	**0/017**	**N/A**	
CK-MB	**0-4.3**	**<1.00**	**N/A**	
Total CK	**20-180**	**65**	**N/A**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**2-3**	**N/A**	**N/A**	
PT	**11-13.5**	**N/A**	**N/A**	
PTT	**60-70**	**N/A**	**N/A**	
D-Dimer	**<.5**	**N/A**	**N/A**	
BNP	**<450**	**N/A**	**N/A**	
HDL	**40-59**	**N/A**	**N/A**	
LDL	**<100**	**N/A**	**N/A**	
Cholesterol	**<200**	**N/A**	**N/A**	
Triglycerides	**<150**	**N/A**	**N/A**	
Hgb A1c	**4-5.6**	**N/A**	**N/A**	

TSH	**0.4-4**	**N/A**	**N/A**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow/clear**	**Amber/hazy**	**Yellow/hazy**	**Shows the possibility of infection in the urine.**
pH	**5-8**	**7**	**6**	
Specific Gravity	**1.005-1.034**	**1.016**	**1.013**	
Glucose	**Normal**	**N/A**	**N/A**	
Protein	**Negative**	**N/A**	**N/A**	
Ketones	**Negative**	**Trace**	**N/A**	
WBC	**<5**	**>100**	**>100**	White blood cells are present most commonly with infection. Since the patient has a Urinary Tract Infection the WBC levels will be very elevated. (Sorenson, Quin, Klein pg 1126)
RBC	**0-3**	**35**	**54**	**Blood can be increased in the urine as a sign of damage from the infection. (carenow.com)**
Leukoesterase	**Negative**	**+1**	**+3**	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	**N/A**	**N/A**	
PaO2	**75-100**	**N/A**	**N/A**	
PaCO2	**35-45**	**N/A**	**N/A**	
HCO3	**22-28**	**N/A**	**N/A**	
SaO2	**93-97**	**N/A**	**N/A**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**N/A**	**N/A**	
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**negative**	**N/A**	**N/A**	

Lab Correlations Reference (APA):

Sorenson, Matthew, et al. *Pathophysiology: Concepts of Human Disease*. Pearson Education, 2019.

Hinkle, J. L., Brunner, L. S., Cheever, K. H., & Suddarth, D. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Philadelphia: Lippincott Williams & Wilkins.

Kallam, A., Singla, A., & Silberstein, P. (2015). Proton pump induced thrombocytopenia: A case report and review of literature. Retrieved October 24, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/25207666.

Hemoglobin/Hematocrit. (n.d.). Retrieved October 24, 2019, from https://www.carenow.com/patient-services/medical-tests/hemoglobin-hematocrit.dot.

How is a CBC count used in the diagnosis of urinary tract infection (UTI)? (2019, October 20). Retrieved October 24, 2019, from https://www.medscape.com/answers/233101-3246/how-is-a-cbc-count-used-in-the-diagnosis-of-urinary-tract-infection-uti.

Blood Urea Nitrogen. (n.d.). Retrieved October 24, 2019, from https://www.uofmhealth.org/health-library/aa36271.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Head CT

Patient has a history of dementia, they ordered a head CT just to double check nothing else was wrong with the patient. Head CT came back negative.

Diagnostic Test Correlation (5 points):

Diagnostic Test Reference (APA): Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Lasix (Furosemide)**	**Omeprazole (Prilosec)**	**Xyzal (levocetirizine)**	**Oxybutynin Chloride (Ditropan XL)**	**Propranolol (Inderal)**
Dose	**20mg**	**20mg**	**5mg**	**5mg**	**20mg**
Frequency	**Daily**	**Daily**	**PRN**	**Daily**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**diuretic**	**PPI**	**piperazines**	**Anticholinergics**	**Beta blocker**

Mechanism of Action	**Inhibits the reabsorption of sodium and chloride for the loop of Henle and distal renal tubule**	**Binds to an enzyme on gastric parietal cells**	**Antagonizes the effects of histamines**	**Inhibits the action of acetylcholine at postganglionic receptors**	**Blocks stimulation of Beta1 and beta2 receptor cells**
Reason Client Taking	**Patient is taking for her hypertension**	**Client is taking for her GERD**	**Client is taking for seasonal allergies**	**Client is taking for bladder incontinence**	**Client takes for her hypertension**
Contraindications (2)	**Cross sensitive with thiazides** **Hepatic coma**	**Hypersensitivity** **Liver disease**	**Renal impairment** **Hypersensitivity to Cetirizine**	**Uncontrolled angle glaucoma** **Urinary retention**	**Uncompensated HF** **Pulmonary edema**
Side Effects/Adverse Reactions (2)	**Blurred vision** **Hearing loss**	**Abdominal pain** **Chest pain**	**Weakness** **Dry mouth**	**Dizziness** **Constipation**	**Fatigue** **Erectile dysfunction**
Nursing Considerations (2)	**Assess fluid status** **Monitor BP and pulse**	**Monitor bowel function** **Administer before meals in the morning**	**Assess allergy symptoms** **Assess lung sounds**	**Monitor voiding patterns** **Assess for anticholinergic effects**	**Monitor BP and pulse** **Assess for rash regularly on patient**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor electrolytes, renal, and hepatic function**	**Monitor CBC**	**Can cause false negative on allergy skin testing**	**Urinalysis**	**Assess BUN, serum lipoprotein, potassium, triglyceride, and uric acid levels**

Client Teaching needs (2)	**Change positions slowly** **Daily weights**	**Notify health care professional of dark, tarry stools** **May cause drowsiness or dizziness**	**Do not increase dose because it can cause increased drowsiness** **Be cautious of drowsiness**	**Can cause drowsiness or blurred vision so do not drive** **Rinsing mouth, good oral hygiene, and sugarless candy can help with dry mouth**	**Teach patient and family how to check pulse and BP** **Do not abruptly stop medications**

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Ceftriaxone (Rocephin)	Citalopram (Celexa)	Lovastatin (Altoprev)	Pantoprazole (protonix)
Dose	650mg/2 tab	50mL	20mg	20mg	40mg
Frequency	PRN	Q24 hrs	Daily	HS	Daily
Route	PO	IV piggyback	PO	PO	PO
Classification	analgesic	Antibiotic	SSRI	HMG-CoA reductase inhibitor	PPI
Mechanism of Action	Inhibits the enzyme of cyclooxygenase	Interferes with bacterial cell wall synthesis	Inhibits the reuptake of serotonin	Lowers the total LDL cholesterol and triglycerides	Binds to an enzyme in the presence of acidic gastric pH
Reason Client Taking	For patient's fever/ mild pain	To treat pts UTI	Depression	Taking for hypertension	Patient is taking to prevent heartburn from hospital stay
Contraindications (2)	Hepatic impairment	Calcium containing IV	Long QT syndrome	Active liver disease	Patients using high doses for over a

	hypersensitivity	solutions Iv solutions containing lidocaine	Bradycardia	Unexplained persistent elevations in AST and ALT	year Hypersensitivity
Side Effects/Adverse Reactions (2)	Hypoglycemic coma Abdominal pain	C. Diff Acute renal failure	Insomnia Confusion	Abdominal cramps constipation	Headache Pseudomembranous colitis
Nursing Considerations (2)	Preform liver function tests for chronic use Monitor renal function	Do not give calcium containing products within 48 hours Protect powder from light	Monitor mood changes Assess for suicidal tendencies	Obtain diet history Monitor liver function	Monitor bowel function Antacids may be used concurrently
Key Nursing Assessment(s)/Lab(s) Prior to Administration	assess patients pain to check the effectiveness of the medication	Monitor WBC for a baseline to check med effectiveness.	Monitor electrolytes	Monitor CPK levels	Auscultate the bowel sounds
Client Teaching needs (2)	Tabs may be crushed or swallowed Caution pts not to exceed recommended dose	Do not exceed recommended daily K intake Do not crush or chew	Take missed dose as soon as possible Do not drive or operate machinery until you know how it affects you	Do not skip or double up on doses Notify health care professional of unexplained muscle pain	Take meds for full course of the prescribed therapy Notify health care partner immediately if rash or abdominal cramping occurs

Medications Reference (APA):

Up-to-Date Drug Information. (n.d.). Retrieved October 10, 2019, from https://www.drugguide.com/ddo/.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: sitting up in bed** **Orientation: x4** **Distress: no acute distress** **Overall appearance: good mood and haooy to be talking to her son**	Patient was awake, sitting up in bed eating breakfast. She is A&O x4. Patient was well nourished and in no acute distress.
INTEGUMENTARY (2 points): **Skin color: caucasion** **Character: dry and pink** **Temperature: warm to touch** **Turgor: good** **Rashes: N/A** **Bruises: N/A** **Wounds: N/a** **Braden Score: 19** **Drains present: Y☐ N ☒** **Type: N/A**	Patient is Caucasian. Patients skin was warm, dry, and pink to the touch. No rashes or lesions. Patients hair is grey in color. No rashes or bruises
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes: glasses** **Nose:** **Teeth: denture**	Head is normocephalic and midline. Hair is mix between white and grey. Ears have no drainage and have a pearly grey tympanic membrane. Noted PERRLA. Patient wears glasses and dentures. No presence of deviated septum with bilateral equal turbinates. There is no sinus tenderness. Oral mucosa is moist and pink.

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: strong** **Capillary refill: <3** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	Patient heart was auscultated with an S1 S2 heart sound at a normal heart rate at a regular rhythm. Patient has no edema. Good capillary refill <3. No neck vein distention noted. Radial and pedal pulses were assessed at a 1+ bilaterally.
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Accessory muscles were used while patient was breathing. Patient's trachea was midline with no deviations. Patient does not have a wheeze or labored breathing. When patient's lungs were auscultated, lung sounds were clear in all lobes.
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet Regular** **Height: 5'** **Weight: 61.6 kg** **Auscultation Bowel sounds: active all 4 quadrants** **Last BM: 10/19** **Palpation: Pain, Mass etc.: N/A** **Inspection:** **Distention: nondistended** **Incisions: N/A** **Scars: N/A** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N ☒** **Type: N/A**	Patient is on a regular diet. Patient abdomen is soft, nondistended. Patient has active bowel sounds in all 4 quadrants. No masses or palpable hernias present. Patient's last BM was 10/19. No ostomy, NG tubes, or feeding tubes.

GENITOURINARY (2 Points): **Color: yellow** **Character: hazy** **Quantity of urine: 500cc** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: normal** **Catheter: Y ☒ N ☐** **Type: indwelling** **Size: 16**	Patient did not have to ambulate to the bathroom because she had an indwelling catheter. Her urine was yellow/hazy in color. When in the ER the patient voided, and her urine was amber/hazy. Patient did not express pain with urinating. She did not have hematuria. Patient has history of urinary incontinence. No genital abnormalities noted.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: normal** **Supportive devices: walker** **Strength: normal and equal** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 70** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Fall Risk: 70** **U**pper and lower extremities show normal ROM. Patient uses a walker as an assistive device to move around. Patient is a fall risk. No tenderness or swelling in extremities. Patient lives at a nursing home.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: x4** **Mental Status: dementia, anxiety, depression** **Speech: no deficits** **Sensory: no deficits** **LOC: awake and sitting up on bed**	Patient was awake, sitting up in bed eating breakfast. She is A&O x4. She showed no acute distress and felt sensation with light touch. Patient speaks English well. When having a conversation with the patient she liked to repeat what she has already due to her dementia. Patient's strength was equal in his arms and legs.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): listening to music** **Developmental level: appropriate for age** **Religion & what it means to pt.: Protestant** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient was cooperative during physical assessment. Her mood and affect were appropriate. Patient use to be a music teacher. Patient denies drinking drug use, or smoking. Patient copes by listening to music. Patient's religion is Protestant. Her support are her two sons.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	68	116/67	20	37.4	92
1030	64	107/51	18	37.7	94

Vital Sign Trends: Vital signs stayed steady throughout the time I was there. Blood pressure went down, but not a significant amount.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	R arm and lower back	5	Sharp	Repositioned patient
1-30	Numeric	R arm and lower back	4	Sharp	Given tylenol

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV: R forearm** **Date on IV: 10/19** **Patency of IV: patent** **Signs of erythema, drainage, etc.: No drainage or erythema present** **IV dressing assessment: dry and intact**	Patient was saline locked. There was no phlebitis or infiltration resent, catheter present.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
460mL	1000mL

Nursing Care

Summary of Care (2 points)

Overview of care: Care of patient was good. She was taken care of very well by the staff. She asked a lot of the same questions because of her dementia, but the staff did not hesitate to answer them as many times as she needy without problem.

Procedures/testing done: Urinalysis and head CT

Complaints/Issues: Patient had a lot of questions because of her dementia, but it was handled properly.

Vital signs (stable/unstable): vitals were stable

Tolerating diet, activity, etc.: Patient tolerates diet

Physician notifications: N/A

Future plans for patient: Patient will continue to receive antibiotics and return to the nursing home for continued care.

Discharge Planning (2 points)

Discharge location: Back to the nursing home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: Patient was educated on the importance of urinary retention and proper hygiene to prevent UTI's

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
● Include full nursing diagnosis with "related to" and "as evidenced by"	● Explain why the nursing diagnosis was chosen		● How did the patient/family respond to the nurse's actions? ● Client response, status

components			of goals and outcomes, modifications to plan.
1. **Risk for acute pain related to bladder spasms caused by Urinary Tract Infection as evidenced by patient stating she was in pain. (Swearingen, 2016, pg 240)**	**Urinary tract infections can cause pain from the buildup of bacteria in the urinary tract causing the bladder to spasm and the have abdominal pain.**	1. **Create a pain scale to keep track of severity and location of pain.** 2. **Encourage fluids**	**Patient expressed pain but was given Tylenol to help. The pain started to decreased as seen by the numeric scale when she rated her pain a 4 when it was a 5 before.**
2. **Risk for fall related to weakness caused by UTI as evidenced by lethargy. (Swearingen, 2016, 241)**	**Related to overall weakness of the body that the patient has all the time.**	**1. Always provide call light.** **2. Put bed rails up.**	**· Patient was pleased with the nurse and others, who came in and made sure she wouldn't fall.** **Status of the goal worked well, no falls in the hospital.**
3. **Impaired skin integrity related to weakness caused by UTI related to lethargy and older age.** **(Swearingen, 2016, pg 245)**	**This is in relation to the patient being weak, not being able to walk well.**	**1.Cleanse skin gently and in a patting motion.** **2. Use mild soap, tepid water, and a soft cloth. Rinse the area and pat it dry.**	**Patient had no complaints towards the nurses action.** **Client was happy someone was able to help her. Keep these goals, and she should have no skin issues.**
4. **Acute Pain related to pain symptoms or bladder spasms caused by the UTI related to urinary tract infection symptoms.**	**Related to the patient experiencing urinary tract infection symptoms.**	**1. Do an accurate assessment of pain.** **2.Patient's self-report should be the primary source of pain**	**Performed pain checks every two hours and handled properly.** **As long as we manage pain up until discharge, patient will be going home pain free.**

(Swearingen, 2016, pg 246)		**assessment.**	

Other References (APA): Swearingen, P. L., & Wright, J. D. (2016). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

Concept Map (20 Points):

Subjective Data

My patient showed signs such as extreme pain on her pelvic and radiating to her back. She had a urinary catheter while she was in the hospital so she could not express to me if she was having pain while urinating.

Nursing Diagnosis/Outcomes

Risk for infection-client should follow education given and not be at risk for a

Risk for impaired skin integrity-follow proper skin care due to weakness, no

Risk for fall-related to overall body weakness, providing proper care decrea

Acute Pain-following appropriate measures, doing appropriate assessments proper outcome of pain relief

Objective Data

IN a UTI there can be signs of infection through the urinalysis which showed <100. The urine was amber and hazy. Abnormal vital signs can show infection as well, but my patients BP was low instead of High

Patient Information

An 89 year old female with a Past medical history of depression, dementia, GERD, and hypertension came to the ED from the nursing home with a fever and complaints of lethargy and confusion. The staff stated they found the patient with a fever of 102F and said she was not acting like herself. The urine was tested in the ED and infection was found. The patient's creatine level was also increase. She was given Ceftriaxone by IV in the ED and then was admitted.

Nursing Interventions

Educate on how to avoid UTI's

Promote fluids

ncourage voiding

void indwelling catheters

Wash correctly