

Concept Map #2

Mikkel Darzhmeniak

Assessment finding:

- 1) BP:73/54, Pulse:117, T:98.1, O2: 99%.
- 2) Lung sounds are clear no adventitious sounds.
- 3) Heart sounds are remarkable, no S3, S4, no murmurs.
- 4) Skin: warm to touch, capillary refill less than 2 second.

Medical Diagnosis: Urinary tract infection
Key assessment: Assess skin integrity, assess for pain,
Medication: IV fluids D5, Rocephin
Past history: N/A

Nursing Dx: Acute pain, secondary to Urinary tract infection as evidence by inflammation of the genitalia.

Nursing Interventions:

- 1) Assess the skin integrity and look for signs of edema, redness, and warmth every 2 hours
- 2) Apply Zin oxide 2 times at day as per provider order.
- 3) Monitor vitals signs especially temperature every 4 hours.
- 4) Educate the parents about methods that they can use to sooth the baby during pain by the end of the shift.

Expected Outcome: The patient maintains demonstrate satisfactory pain control by the end of the shift.

Evaluation: The patient demonstrates no sign of pain during pain assessment and during voiding by the end of the shift.

Nursing Dx: Imbalance nutrition less than body requirements, secondary to low calorie intake as evidence by low weigh of the child.

Nursing Interventions:

- 1) Assess patient weight and calorie intake throughout the shift.
- 2) Promote semi-fowler or full fowlers position during every eating.
- 3) encourage the parent to utilize breast milk and formula as a method to increase the calorie intake of the child during every feeding.
- 4) educate the parents about the importance of increase feeding frequency throughout the shift.

Expected Outcome: The patient report satisfactory increment of calorie intake by the end of the shift,

Evaluation: The patient slowly increased calorie intake but the goal was not met, continue to monitor the patient.

Nursing Dx: Risk for impaired urinary elimination related to urinary infection.

Nursing interventions:

- 1) Monitor the patient's pattern of elimination throughout the shift.
- 2) Palpate the patient's bladder every 4 hours.
- 3) weight every diaper to monitor the voided amount throughout the shift.
- 4) Educate the parents about the importance to wipe the genitalia front to back as a mechanism to prevent infection throughout the shift.

Expected outcome: The patient exhibits effective urinary elimination throughout the shift.

Evaluation: The patient maintained effective urinary elimination throughout the shift.

Nursing Dx: Deficient knowledge related to unfamiliarity of urinary tract infection, as evidenced by Patient's mom said, "I do not understand how my daughter contracted a urinary infection."

Nursing Interventions:

- 1) Educate the parent about UTI, related complications and safety considerations for the patient by the end of the shift.
- 2) Demonstrate to the parent how to monitor the patient temperature, and to looks for signs of complications throughout the shift.
- 3) Inform the parent about the benefits wiping front to back when changing the diapers and handwashing as methods to preven infections process by the end of the shift.
- 4) Encourage the parent to ask questions to reinforce and clarify information every 2-3 hours.

Expected Outcome:

The mother recognizes signs/symptoms of UTI, such skin redness, increase in warmth, increase in temperature, irregular voiding pattern or lack of voiding by the end of the shift.

Evaluation: The mother stated three signs and symptoms that she needed to report immediately to the healthcare provider by the end of the shift.

References

Herdman, H., & Kamitsuru, S. (2019). Supplement to NANDA International Nursing Diagnoses: Definitions and Classification, 2018-2020 (11th Edition) (1st ed.). Thieme. Retrieved from <https://www.perlego.com/book/964105/supplement-to-nanda-international-nursing-diagnoses-definitions-and-classification-20182020-11th-edition-new-things-you-need-to-know-pdf>