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Urinary tract infection Initial assessment

Adult Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

35-year-old woman with urinary symptoms. Care stage: At the first supervised assessment.

Medical history: Dysuria and frequency started during the current illness. No recurrent urinary infection is reported; pregnancy possibility must be assessed where relevant. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Burning urination, frequency and suprapubic discomfort.

Objective findings and required checks: Urinary symptoms with clinical assessment for systemic infection and pregnancy where relevant.

Physical examination and investigations: Review urine testing or culture when indicated, allergies and features of upper-tract infection.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Urinary tract infection: Microbial infection causes inflammation in the urinary tract.

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Medical / surgical management

Support comfort and permitted fluids; obtain indicated specimens and administer the prescribed antimicrobial.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed urinary antibiotic	Treat the identified or likely infection	Check pregnancy status when relevant, allergy, renal considerations and response
prescribed analgesic	Relieve discomfort	Review persistent pain.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Burning urination, frequency and suprapubic discomfort. Urinary symptoms with clinical assessment for systemic infection and pregnancy where relevant. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize urinary elimination affected by illness or obstruction; pain interfering with rest or activity; vulnerability to infection or worsening infection; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Support comfort and permitted fluids; obtain indicated specimens and administer the prescribed antimicrobial. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about dysuria, urgency, retention and usual urinary pattern. Assess: Assess output, discomfort, bladder findings and relevant urine tests.	Urinary elimination affected by illness or obstruction. Possible factors: altered bladder function, irritation or drainage difficulty. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Urine drainage and comfort improve within the agreed review interval. Longer-term: Before the clinically approved transition or agreed follow-up: Explains hygiene, catheter instructions if applicable and follow-up needs.	1. Measure urine trends and assess pain, retention or blocked drainage promptly. Rationale: Obstruction and low output may require urgent intervention. 2. Support privacy and indicated hygiene while avoiding unnecessary catheterization. Rationale: Comfort and infection prevention support recovery. 3. Collect ordered samples correctly and implement prescribed treatment. Rationale: Reliable assessment guides targeted management. 4. Support comfort and permitted fluids; obtain indicated specimens and administer the prescribed antimicrobial. Rationale: Microbial infection causes inflammation in the urinary tract. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about pain site, onset, severity, quality and the	Pain interfering with rest or activity. Possible	Short-term: After the first indicated intervention, at the	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	documented review time: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about exposure, wound symptoms and recent invasive devices. Assess: Inspect relevant sites and monitor systemic findings and investigation trends.	Vulnerability to infection or worsening infection. Possible factors: disrupted barriers, exposure or reduced host defence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Aseptic care is maintained and any new signs of infection are escalated promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates relevant hygiene and explains the infection-prevention plan.	1. Use hand hygiene and risk-based standard or transmission precautions. Rationale: Interrupting transmission protects the patient, staff and other patients. 2. Review invasive device need with the team and maintain indicated aseptic care. Rationale: Unnecessary devices and barrier breaks increase infection exposure. 3. Monitor for systemic deterioration and administer prescribed antimicrobials on schedule. Rationale: Early escalation and timely indicated treatment reduce avoidable harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: After the first indicated intervention, at the documented review time:	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach medicine use as prescribed, hygiene, follow-up for recurrence and warning symptoms. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach medicine use as prescribed, hygiene, follow-up for recurrence and warning symptoms.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Fever with flank pain, vomiting, sepsis features or deterioration requires prompt escalation.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Microbial infection causes inflammation in the urinary tract.

- Priority concerns: Urinary elimination affected by illness or obstruction; Pain interfering with rest or activity; Vulnerability to infection or worsening infection; Learning needs about the condition and care plan.

- Fever with flank pain, vomiting, sepsis features or deterioration requires prompt escalation.

- Teach medicine use as prescribed, hygiene, follow-up for recurrence and warning symptoms.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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