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Pain interfering with rest or activity Urinary catheter care

Nursing Foundation | Focused diagnosis-based template

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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.

Clinical assessment

Subjective: Concerned about the drainage bag and mild discomfort when moving.

Objective findings and required checks: Closed drainage system present; tubing needs secure support and unobstructed flow.

Physical examination and investigations: Review catheter indication, urine output, insertion documentation and symptoms; culture only when clinically indicated.

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

Clinical focus and pathophysiology

Urinary catheter care: A catheter bypasses normal barriers and can introduce infection or cause trauma.

Medical / surgical management

Maintain a closed, dependent drainage system, secure the catheter and request daily review of necessity.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
No routine prophylactic antibiotic	Antibiotics are not automatically indicated for a catheter	Treat only according to clinical assessment
prescribed analgesic	Manage assessed discomfort	Evaluate cause rather than masking retention or obstruction.

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

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Focused nursing-problem template

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 pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: 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.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication 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. 4. Maintain a closed, dependent drainage system, secure the catheter and request daily review of necessity. Rationale: A catheter bypasses normal barriers and can introduce infection or cause trauma. 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.

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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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Health education and continuing care

Teach hand hygiene, bag positioning and avoiding traction or disconnection; explain the removal plan.

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

Report fever with deterioration, suprapubic pain, blocked drainage, hematuria or accidental removal.

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

- A catheter bypasses normal barriers and can introduce infection or cause trauma.
- Priority concerns: Pain interfering with rest or activity.
- Report fever with deterioration, suprapubic pain, blocked drainage, hematuria or accidental removal.
- Teach hand hygiene, bag positioning and avoiding traction or disconnection; explain the removal plan.

Exam / viva: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

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https://www.indiannursingcouncil.org/gazette-notification

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