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Urinary elimination affected by illness or obstruction Urinary tract infection

Adult Health Nursing | 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: 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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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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 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: At the next patient-specific reassessment: 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.

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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 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.
- 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: 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/

Health Alterations - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/healthalts/

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

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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