

Urinary Tract Infection Nursing Care Plan

A five-column UTI plan that pairs symptom management with the intervention that actually prevents the next infection: daily catheter necessity review and nurse-driven removal.

QUICK ANSWER

For UTI, prioritize: impaired urinary elimination → acute pain → hyperthermia → risk for progression to pyelonephritis/urosepsis → deficient knowledge. Core interventions are culture before the first antibiotic dose, daily catheter necessity review with prompt removal, closed-system catheter care, 2–3 L/day fluids with scheduled voiding, analgesia, monitoring for flank pain/rigors/confusion, and not treating asymptomatic bacteriuria outside pregnancy or urologic procedures.

Assessment (subjective + objective)

Subjective: burning on urination for 2 days, urinary frequency and urgency, suprapubic pressure, "my urine smells strong"; in the older adult, new confusion and a fall rather than classic symptoms.

Objective: temp 38.4 °C, HR 96, suprapubic tenderness, no CVA tenderness; urinalysis with positive leukocyte esterase and nitrites, WBC 45/hpf, bacteria present; urine culture > 10⁵ CFU/mL *E. coli*; indwelling catheter in place day 6 with no documented indication.

Priority NANDA-I diagnoses

1. **Impaired urinary elimination** related to infectious inflammation of the bladder mucosa AEB dysuria, frequency, urgency, and WBC 45/hpf.

2. **Acute pain** (suprapubic and dysuria) AEB self-report 6/10 and suprapubic tenderness.
3. Hyperthermia related to infectious process AEB temp 38.4 °C.
4. **Risk for infection progression (pyelonephritis / urosepsis)** AEB fever with a bacteriuric indwelling catheter.
5. Deficient knowledge regarding hydration, perineal hygiene, and post-coital voiding.
6. Risk for acute confusion in the older adult.

NOC outcomes (SMART)

- Afebrile (< 37.5 °C) within 48 h of appropriate antibiotic therapy.
- Dysuria and urgency resolved or $\leq 2/10$ by 72 h.
- Fluid intake $\geq 2,000$ mL/24 h (unless restricted) with urine output ≥ 0.5 mL/kg/h.
- Unnecessary indwelling catheter removed within 24 h of identification.
- Patient states three recurrence-prevention behaviours before discharge.
- No progression to pyelonephritis or sepsis: no flank pain, no rigors, lactate within normal limits.

NIC interventions and rationale

- **Obtain the culture before the first antibiotic dose, then start empiric therapy promptly and de-escalate on sensitivities** — a culture drawn after antibiotics may be falsely negative and prevents targeted therapy.
- **Review catheter necessity every shift and remove as soon as the indication ends** — duration of catheterization is the dominant CAUTI risk factor; daily review with nurse-driven removal is the highest-yield intervention on this plan.
- **Maintain a closed drainage system, bag below bladder level and off the floor, secured tubing, no dependent loops, hand hygiene before and after any contact** — prevents retrograde bacterial migration.

- **Encourage 2–3 L/day fluids unless contraindicated and scheduled voiding every 2–3 h** — mechanical flushing lowers bacterial load and relieves symptoms.
- **Treat pain with acetaminophen ± NSAID and, if ordered, phenazopyridine; warn the patient about orange urine and staining of contact lenses.**
- **Monitor for progression: flank pain, rigors, vomiting, hypotension, tachycardia, altered mentation; escalate for sepsis screening** — the older adult with new confusion may present without fever.
- **Do not treat asymptomatic bacteriuria (except in pregnancy or before urologic instrumentation)** — treating it drives resistance and *C. difficile* without improving outcomes.
- **Teach prevention: front-to-back wiping, void after intercourse, avoid douches and spermicides, complete the full antibiotic course, and hydrate.**

Evaluation

By hour 48: temp 37.1 °C, dysuria 1/10, intake 2,400 mL/24 h with output 1,900 mL, catheter removed at hour 14 with successful voiding trial, no flank pain or rigors, patient states three prevention behaviours. Antibiotic narrowed to cephalexin on sensitivities. All outcomes met.

Frequently Asked Questions

Should asymptomatic bacteriuria be treated? 

How does UTI present differently in older adults? 

What is the difference between a UTI and a CAUTI? 

Which NANDA diagnosis is best for a UTI? 

Impaired urinary elimination is the primary diagnosis, supported by acute pain, hyperthermia, risk for infection progression, and deficient knowledge. 'UTI' itself is a medical diagnosis and cannot be the nursing diagnosis.

Sources & Further Reading

1. **Centers for Disease Control and Prevention.** Guideline for Prevention of Catheter-Associated Urinary Tract Infections (updated).
2. **Nicolle, L. E., et al..** Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria. Clinical Infectious Diseases, 68(10), e83–e110.

Related Resources

→ Full nursing care plan library → Sepsis care plan → Post-operative care plan → NANDA-I diagnosis list