ADULT CASE STUDY

In accordance with the Nursing and Midwifery Council's guidance on confidentiality (2004) all information that may enable identification of the patient has been altered or withheld.

Mrs Jones is a 24 year old lady who attended the out of hours GP service with a report of painful micturition. After welcoming Mrs Jones into the room and ensuring our positioning facilitated good eye contact and interpretation of non verbal cues I began by asking her how I could help today. During this initial stage I ensured I did not interject with any further questions as such interruptions can be detrimental to clinical outcomes (Dains et al 2012, Harrison et al 2007). Mrs Jones stated that she thought she had a urinary tract infection and that urinary frequency was the most troublesome symptom as she was a PE teacher so was not always near to toilet facilities. She had therefore attended today to see if she could get some antibiotics to alleviate the symptoms. I acknowledged that in the circumstances that must be difficult and that following some further questions we would work out the best course of action for her. By showing an interest in the effect the illness has on a patient, demonstrating care and sympathy during the consultation and involving the patient in the treatment plan the level of patient satisfaction is improved. This in turn can lead to a reduction in symptom burden and even duration of symptoms (Harrison et al 2007, Little et al 2001, Smith 2004).

Further questioning revealed that Mrs Jones had a 2 day history of offensive smelling urine along with painful micturition, polyuria and suprapubic tenderness. Whilst these symptoms were strongly suggestive of a lower urinary tract infection (Shah and Goundrey-Smith 2013) I needed a more detailed history to not only ensure other possible causes were ruled out, but also to aid in formulating an appropriate treatment plan. As it was established that Mrs Jones had no vaginal discharge or itching, no history of pain or bleeding after sexual intercourse, no external pain around the genitalia and

had not had a recent change in sexual partner I was satisfied that causes such as a sexually transmitted disease, vaginosis and candidiasis were unlikely (NICE 2012). I also confirmed that Mrs Jones had not had any recent fevers or chills, had no history of flank pain or nausea/vomiting and felt well in herself so pyelonephritis was also unlikely (Johnson and Hill-Smith 2012). I established that Mrs Jones was not sexually active at present, her last menstrual period was approximately 10 days ago and she had a regular cycle with no associated problems. These questions were asked to establish whether there was a possibility of pregnancy as this would require different management (NICE 2012) or whether there were any signs of gynaecological causes. She confirmed that other than a tonsillectomy in childhood she had no other medical or surgical history. Mrs Jones took no medications regularly and had no known allergies. She had been taking paracetamol regularly over the past 2 days which had eased the suprapubic pain to a mild discomfort and confirmed that she had not had any urinary tract infections in the past.

Through the history and my visual observation of Mrs Jones I was reassured that she appeared well with good pallor, no clamminess, was alert and well perfused and had a normal gait and posture and most likely had an uncomplicated lower urinary tract infection. As a result there was no indication that this patient required a full set of observations, instead I checked her temperature which was normal and examined her loins which were non tender (Johnson and Hill-Smith 2012) and supported my view that an upper urinary tract infection was unlikely. As Mrs Jones' UTI had resulted in 4 symptoms it was determined she had a moderate infection and therefore a dipstix test of the urine was not indicated (HPA 2012, Mishra et al 2012, Shah and Goundrey-Smith 2013, SIGN 2012). The current evidence supports empirical antibiotic use based on symptoms because near patient testing is an unreliable indicator of a UTI and for some with a negative urine culture antibiotics will still shorten the length of their symptoms (Little et al 2009, Mishra et al 2012, Richards et al 2005) I informed Mrs Jones that it was clear she had a urinary tract infection so testing her urine was not necessary and that I advised a course of antibiotics (please see copy of prescription

attached). I explained that urinary tract infections are common in women, often with a cause not being identified, and that they usually resolve within about a week. As with all medications I advised Mrs Jones to read through the information leaflet before commencing them for full details on the drug and its side effects. However I did explain that she would be prescribed one capsule twice daily, to be taken at regular intervals with or after food and that they may cause discolouration of her urine which would resolve once the medication was stopped (British National Formulary 2013).

I told Mrs Jones that I just wanted to return to her original complaint regarding the effect the polyuria was having on her during her work to see if there were any suggestions I could offer. I asked her tell me more about the severity of her polyuria in order to ensure the consultation was both patient centred and met her expectations (Little et al 2001, Silverman et al 1998). She revealed that a friend had told her she needed to drink lots in order to “flush out the germs” and “get rid of the infection quicker”, but that this had resulted in her needing to use the toilet even more frequently which was particularly difficult at work. No randomised controlled trials (RCT) have been found on the effect of increasing fluid intake on the prevention or treatment of urinary tract infections (Beetz 2003, NICE 2012) and so the advice I gave to Mrs Jones was that an adequate fluid intake was important but there was no evidence drinking more than usual would help with her symptoms or shorten the duration of the infection, news which pleased her. There have also been no RCTs on the use of analgesics in UTIs but as Mrs Jones had found paracetamol effective and it’s indication for use is in mild / moderate pain I suggested she continue using this as necessary (NICE 2012). I explained that her symptoms should improve significantly following the course of antibiotic and completely within the next 5-6 days (Johnson and Hill-Smith 2012) and that if they hadn’t then she should see her minor illness nurse/GP as she will need a urine sample sending to the lab and further assessment/treatment (SIGN 2012, NICE 2012). I also advised that she see her GP if she begins to suffer with recurrent symptoms of a UTI (Johnson and Hill – Smith 2012), Mrs Jones was happy with this plan and had no further questions or concerns. Mrs

Jones was reassured that she could contact her own surgery or the out of hours service if her condition changed or worsened, specifically if she developed a fever, loin pain or began to feel systemically unwell (NICE 2012). This information was given in a positive, warm manner so as to make Mrs Jones feel comfortable seeking help if she's concerned (Little et al 2001). For the purposes of this case study I asked if Mrs Jones would mind me contacting her in 5 days to see how she was doing, which she agreed to. She revealed during this conversation that her symptoms had resolved after 4 days (6 days from first symptom) and that she had managed much better during her PE lessons after reducing her fluid intake to her normal level. She had developed no new symptoms during the course of the illness and had suffered no side effects from the nitrofurantoin.

On reviewing the consultation I felt the history taking was sufficient to reach the correct diagnosis and the advice and treatment plan was evidence based and satisfactory to Mrs Jones. However, on reflection I feel that I could have explained to Mrs Jones that whilst not all UTIs will require antibiotics hers did on *this* occasion. Had I done this, I feel Mrs Jones would be more likely to understand and agree future management plans that, on the surface, seem to be in contradiction to how similar illnesses may have been treated in the past. Experience has shown that some patients' expectations are that antibiotics are necessary purely because they had them last time and they worked so I think we have a duty to take every opportunity possible to educate patients on the benefits and risks of antibiotic use. Since reflecting on this I have made the effort to explain to patients the rationale for antibiotic use and how we determine whether they will be of benefit. Overall, I felt my consultation was safe and effective and I felt my communication style ensured Mrs Jones felt satisfied with the outcome.

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