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|  | Resident Label |
| **S** | **Situation - Clinical Assessment and Communication Tool Template for Suspected UTI**I am concerned about a suspected UTI for the above resident. |
| **B** | **Background**Indwelling catheter □Yes □No If yes, □ Urethral □ Suprapubic Incontinence □Yes □No If yes, is this new or worsening □Yes □NoUTI in last 6 months □Yes □No If yes, Date: Organism: Treatment: Active diagnosis (especially bladder, kidney, genitourinary conditions; diabetes; receiving dialysis, anticoagulants): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advance directives for limiting treatment (especially antibiotic use): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **A** | **Assessment:** Vital signs: BP\_\_\_\_ /\_\_\_\_ HR\_\_\_\_\_ Resp. rate\_\_\_\_\_ Temp.\_\_\_\_\_ 02 Sats.\_\_\_\_\_

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|  **Resident WITH indwelling catheter**The criteria are met to initiate antibiotics AND obtain UA/UC if **one** of the following are selected:No Yes□ □ Fever of 100°F (38°C) or repeated temperatures of 99°F (37°C) □ □ New back or flank pain□ □ Rigors / shaking / chills□ □ New onset delirium (new dramatic change in mental status) □ □ Hypotension (significant change in baseline BP or SBP <90) □ □ Acute suprapubic pain □ □ Acute pain, swelling or tenderness of the scrotal area   | **Resident WITHOUT indwelling catheter**Criteria are met to obtain UA/UC and initiate antibiotics if **one** of the three situations are met:No Yes□ □ Any one of the following two: □ Acute dysuria alone (pain or burning while urinating) □ Acute pain, swelling or tenderness of the scrotal area───────────────── *OR* ────────────────── □ □ Single temp of 100°F (38°C) or 2°F above baseline and at least one new or worsening of the following: □ Urgency □ Suprapubic pain □ Frequency  □ Gross hematuria □ Back or flank pain □ Urinary incontinence□ severe dementia unable to communicate but no “other” infection───────────────── *OR* ────────────────── □ □ No fever, **but two** or more of the following symptoms:  □ Urgency □ Suprapubic pain □ Frequency □ Gross hematuria □ Urinary incontinence  |

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| **R** | **Recommendation**□ Facility Best Practice criteria **met**. Resident require UA and urine culture and UTI treatment unless other cause of fever clear□ Facility Best Practice **criteria are NOT met to start antibiotic or obtain a UA/UC**. Stewardship program guidance supports watchful waiting/hydration and resident **DOES NOT** need immediate antibiotic or UA/UC, but may need additional observation. |
|  | **Nurse’s Signature:** **Date/Time:** □ **Notification of Family/POA Name: Date/Time:** **□ Faxed or □ Called to:** **By:** **Date/Time:**  |
| **Physician Orders/Response (Please check all that apply)**□ I have reviewed the above **SBAR**. |
| □ Urinalysis and urine culture (if indicated)□ Encourage 4oz of cranberry juice or another liquid ( \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) TID, until symptoms resolve□ Record fluid intake & output until symptoms resolve (output can also be measured from urinal or by weighing diapers, etc.) □ Assess vital signs, including temp; every hours for hours□ Monitor and notify PCP if symptoms worsen or unresolved in hours □ Other: □ For antibiotic orders (if needed) please complete– note duration best practice for uncomplicated UTI is 3-5 days depending on antibiotic:Drug: Dose: Route: Frequency: Duration: Indication:  |

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| **Physician Signature:** | **Date/Time:** |

**Please Fax Back To:** or□ **Telephone Order**

*File Under Physician Order/Progress Notes*