|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SBAR Protocol for Diagnosing UTI in Long Term Care** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| Resident's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |  | |  | | |  | | |
| Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |  | |  | | |  | | |
|  | | |  | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| **S - Situation** | | | | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| I am contacting you about a suspected UTI for the above resident. | | | | | | | | | | | | | | | | |  | | |  | |  | |  |  | |
|  | | | Vital signs: BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Resp rate \_\_\_\_\_ Temp.\_\_\_\_\_ | | | | | | | | | | | | | | | | |  | |  | |  |  | |
|  | | |  | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| **B - Background** | | | | | | | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| Results of urine dip if done: Nitrites  Positive  Negative | | | | | | | | | | | | | | | | | Sp. Gravity: \_\_\_\_\_\_\_ | | | | |  | |  |  | |
|  | | |  | |  | | Leukocyte esterase  Negative  trace  1+  2+ | | | | | | | | | | | | | | |  | |  |  | |
|  | | |  | |  | | WBC  None  1+  2+  3+ | | | | | | | | | | pH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  | |  |  | |
|  | | |  | |  | | Blood  None  1+  2+  3+ | | | | | | | | | |  | | |  | |  | |  |  | |
| Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
| Resident is diabetic:  No  Yes | | | | | | | | | |  | | |  | |  | |  | | |  | |  | |  |  | |
| Resident is on warfarin (Coumadin)  No  Yes | | | | | | | | | | | | |  | |  | |  | | |  | |  | |  |  | |
| Advance directive for limiting treatment (especially antibiotics):  No  Yes | | | | | | | | | | | | | | | | | | | |  | |  | |  |  | |
|  | | |  | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | |
| **A- Assessment** | | | | | | | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | |
| Resident **WITH** indwelling catheter | | | | | | | | | | | Resident **WITHOUT** indwelling catheter | | | | | | | | | | | | | | | | | | | | |  |
| The criteria are met to initiate antibiotics if one of the below are selected: | | | | | | | | | | | Criteria are met if one of the three situations are met: | | | | | | | | | | | | | | | | | | | | |  |
| No | Yes | | |  | | | | | | | No | | Yes |  | | | | | | | | | | | | | | | | | |  |
| □ | □ | | | Fever of 100 degrees F (38\*C) or repeated temperatures of 99f (37C)\* | | | | | | | □ | | □ | 1. Acute dysuria alone   **OR** | | | | | | | | | | | | | | | | | |  |
| □ | □ | | | New back or flank pain | | | | | | | □ | | □ | 1. Single temperature of 100 F (38 C) **and** at least one new or worsening of the following: | | | | | | | | | | | | | | | | | |  |
| □ | □ | | | Acute Pain | | | | | | |  | |  |  | | □ urgency | | | | | □ suprapubic pain | | | | | | | | | | |
| □ | □ | | | Rigors/shaking chills | | | | | | |  | |  |  | | □ frequency | | | | | □ gross hematuria | | | | | | | | | | |
| □ | □ | | | New dramatic change in mental status | | | | | | |  | |  |  | | □ back or flank pain | | | | | □ urinary incontinence | | | | | | | | | | |  |
| □ | □ | | | Hypotension (significant change from baseline BP or a systolic BP <90) | | | | | | | □ | | □ | **OR**   1. No fever, but two or more of the following symptoms: | | | | | | | | | | | | | | | | | |  |
|  |  | | |  | | | | | | |  | | | | | □ urgency | | | | | □ suprapubic pain | | | | | | | | | | |
|  |  | | |  | | | | | | |  | | | | | □ frequency | | | | | □ gross hematuria | | | | | | | | | | |
|  |  | | |  | | | | | | |  | | | | | □ incontinence | | | | |  | | | | | | | | | | |
| \*For residents who regularly run a lower temperature, use a temperature of 2 F (1 C) above the baseline as a definition of fever. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **R - Provider Recommendation** | | | | | | | | | | | | |  | | |  | |  | |  | | |  | |  | | |  | | |
|  Order UA w/C&S if indicated | | | | | | |  | | |  Encourage fluids | | | | | | | | | | | | | |  |  | |
|  Assess vital signs, including temp every \_\_\_\_ hours for \_\_\_\_ hours | | | | | | | | | | | | | | | | |  | | |  | |  | |  |  | |
|  Notify Physician if symptoms worsen or if unresolved in \_\_\_\_ hours | | | | | | | | | | | | | | | | |  | | |  | |  | |  |  | |
|  Antibiotic (include dose and duration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |  | |  |  | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ordered on Meditech | | | | | | | | | | | | | | | | | | | | | |  | |  |  | |
| **Diagnosis/sign/symptom for treatment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |  | |  |  | |
|  | | |  | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| ***Nursing***: Information reviewed with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
| Telephone order received by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |  | |  | | |  | | |
| Family/POA notified: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
|  | | |  | | |  | |  | |  | | |  | | |  | |  | |  | | |  | |  | | |  | | |
| **Physician signature:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |  | |  | | |  | | |
| Patient Label | | |  | | |  | | **Boundary Community Hospital & Nursing Home**  **6640 Kaniksu Street**  **Bonners Ferry, ID 83805**  **(208)267-3141** | |  | | |  | | |  | | **SBAR Protocol for Diagnosing UTI in LTC**  \*PO.WRITTEN\*  11/06/2017/lmh/BOU-255 | |  | | |  | |  | | |  | | |