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| **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 |  |  |  |  |