SBAR for Suspected Urinary Tract Infection (UTI)

Resident Name	DOB	Unit/Wing, Room	Completed by:

S

Situation:

I am reaching out to you regarding the resident above having a suspected UTI.

B

Background:

PMH (especially existing renal disease, diabetes, anticoagulation, etc.): _____

Indwelling urinary catheter? ☐YES ☐NO If yes: ☐Urethral ☐Suprapubic

Incontinence? ☐YES ☐NO If yes, new or worsening? ☐YES ☐NO

Receiving dialysis? ☐YES ☐NO

History of UTI/recurrent UTI? ☐YES ☐NO If yes: Organism: _____ Last Treatment: _____

Advance directives? ☐YES ☐NO If yes, specify: _____

Medication allergies: _____

A

Assessment:

Vital Signs: BP: _____/_____ mmHg HR: _____ beats/min RR: _____ breaths/min Temp: _____°F/_____°C

Resident <u>WITH</u> indwelling urinary catheter

Criteria to initiate antibiotics are met if 1 of the following situations are selected:

- ☐ Temp of >100°F (38°C), or ≥2°F (1.1°C) above baseline, or repeated temps of >99°F (37°C)
- ☐ New flank pain or costovertebral angle tenderness
- ☐ Rigors / shaking / chills
- ☐ New onset delirium (new, dramatic change from baseline)
- ☐ Hypotension (significant change in baseline BP or SBP <90)
- ☐ Acute suprapubic pain
- ☐ Acute pain, swelling, or tenderness of the testes, epididymis, or prostate

Resident <u>WITHOUT</u> indwelling urinary catheter

Criteria to initiate antibiotics are met if at least 1 of the three following situations are selected:

- ☐ Acute dysuria

<u>OR</u>

- ☐ Single temp of >100°F (38°C), or ≥2°F (1.1°C) above baseline, or repeated temps of >99°F (37°C) **<u>and</u>** at least one of the following new or worsening symptoms:
  - ☐Urinary urgency ☐Suprapubic pain ☐Urinary frequency
  - ☐Gross hematuria ☐Back or flank pain ☐Urinary incontinence

<u>OR</u>

- ☐ No fever, but two or more of the following new or worsening symptoms:
  - ☐Urinary urgency ☐Suprapubic pain ☐Urinary frequency
  - ☐Gross hematuria ☐Urinary incontinence

R

Recommendation(s):

The above resident:

☐ **Does meet criteria to initiate antimicrobial therapy for a UTI at this time:** See Physician/Prescriber Response section below

☐ **Does <u>NOT</u> meet criteria to initiate antimicrobial therapy for a UTI at this time:** Resident may require more frequent monitoring and/or physician/prescriber assessment

Nurse Signature: _____ Date/Time: _____

☐Faxed or ☐Called to: _____ Date/Time: _____

Family/POA Notified (name): _____ Date/Time: _____

[Facility Logo]

Physician/Prescriber Response

☐ I have reviewed the resident SBAR above

Please obtain the following (check all that apply):

☐ BMP ☐ BUN/SCr ☐ CBC with differential ☐ UA ☐ Urine Culture

Note: UA and urine culture should be collected prior to giving antibiotics

☐ Continue monitoring vital signs and temps; every _____ hours for _____ days

☐ Encourage continued fluid intake; _____ oz of fluid every _____ hours until symptoms resolve

☐ Monitor/record fluid intake and output

Please initiate the following selected antibiotic regimen for the corresponding diagnosis:

Acute Uncomplicated Cystitis

Females:

☐ Nitrofurantoin 100mg PO BID x 5 days

☐ TMP/SMX 1 DS tab PO BID x 3 days

☐ Cephalexin 500mg PO BID x 7 days

☐ Levofloxacin 250mg PO Daily x 3 days

☐ Cefdinir 300mg PO BID x 5 days

Males:

☐ Nitrofurantoin 100mg PO BID x 7 days

☐ TMP/SMX 1 DS tab PO BID x 7 days

☐ Cephalexin 500mg PO BID x 7 days

☐ Levofloxacin 250mg PO Daily x 5 days

☐ Cefdinir 300mg PO BID x 7 days

Acute Uncomplicated Pyelonephritis

☐ Levofloxacin 750mg PO Daily x 7 days

☐ Ceftriaxone 1gm IM Daily x 3 days, followed by Levofloxacin 750mg PO Daily x 4 days

☐ Ceftriaxone 1gm IM Daily x 3 days, followed by TMP/SMX 1 DS tab PO BID x 7 days

☐ Ceftriaxone 1gm IM Daily x 3 days, followed by Cefixime 400mg PO Daily x 7 days

Complicated/Catheter-related Cystitis or Pyelonephritis

☐ Levofloxacin 750mg PO Daily x 14 days

☐ TMP/SMX 1 DS tab PO BID x 14 days

☐ Ceftriaxone 1gm IM Daily x 3 days, followed by Levofloxacin 750mg PO Daily x 11 days

☐ Ceftriaxone 1gm IM Daily x 3 days, followed by TMP/SMX 1 DS tab PO BID x 11 days

☐ Pharmacist to renally dose adjust antibiotic(s) (Requires BUN/SCr, at minimum, to be ordered)

☐ Notify me once culture identification and susceptibilities have resulted. Will adjust antibiotics as needed.

☐ Notify me if symptoms worsen or do not resolve within _____ hours after initiating antibiotics

☐ Resident to be considered for hospital admission due to severity of disease and/or the need for IV antibiotics

Order(s) provided via: ☐ Fax ☐ Phone ☐ In-person ☐ Other: _____

Physician/Prescriber Signature:	**Date/Time:**

Please return fax to: (____)____--_____

Document to be filed under Physician/Prescriber Order or Progress Note