Sample SBAR Tool for Suspected Urinary Tract Infection

[Facility Logo]	Resident Label

S — Situation

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 □No

UTI 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._____ 0_2 Sats._____

Resident WITH indwelling catheter

The criteria are met to initiate antibiotics if one of the following are selected:

No Yes

□ □ Fever of 100°F (38°C), or 2°F (1.1°C) above baseline, 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 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 (1.1°C) above baseline, or repeated temperatures of 99°F (37°C) **and** at least one of the following new or worsening symptoms:
- □ Urgency □ Suprapubic pain □ Frequency
- □ Gross hematuria □ Back or flank pain □ Urinary incontinence

OR

□ □ No fever, but two or more of the following new or worsening symptoms:
- □ Urgency □ Suprapubic pain □ Frequency
- □ Gross hematuria □ Urinary incontinence

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R — Recommendation

□ **Protocol criteria met**. Resident may require UA and urine culture or an antibiotic.

□ **Protocol criteria are NOT met**. Resident **DOES NOT** need immediate antibiotic 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**.

□ 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 script below:

Drug: _____ Dose: _____ Route: _____ Frequency: _____ Duration: _____ Indication: _____

Physician Signature:	**Date/Time:**

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

File Under Physician Order/Progress Notes

ASAP