When to Test Urine – Nursing Tool

Wisconsin Healthcare-Associated Infections in LTC Coalition

Resident Change in Condition

Complete Nursing Assessment (Box A)

Localizing Urinary S/S (Box B)

Yes → Warning Signs Present (Box D)

Yes → Consult Provider See Script 1

No → Non-localizing S/S – Nonspecific Geriatric S/S (Box C)

Yes → Warning Signs Present (Box D)

Yes → Consult Provider See Script 3

No → Consult Provider See Script 4

Consult Provider See Script 4

Observe / Monitor 24-48 hours

Worse → Consult Provider See Script 5

Improved → No Urine Testing Necessary See Script 7

No Change → Consult Provider See Script 6

Monitor per Medical Director Protocol

Box A
Nursing Assessment\(^1,2\)
Complete Nursing Assessment
See Nursing Assessment on reverse side of this tool

Box B
Localizing Urinary S/S\(^3,4\)
- Acute dysuria
- New or worsening frequency
- New or worsening urgency
- New or worsening incontinence
- Gross hematuria
- Suprapubic pain
- Costalvertebral angle pain
- New scrotal / prostate pain
- Urethral purulence

Box C
Non-localizing / Non-Specific Geriatric S/S\(^1,5,6,7\)
- Behavior Changes
- Fever
- Functional Decline
- Mental Status Change
- Falls
- Restlessness
- Fatigue
- “Not Being Her-Himself”

Box D
Warning Signs Present\(^6\)
- Fever
- Clear-cut Delirium
  - Altered LOC
  - Disorganized Thinking
  - Psychomotor Retardation
- Rigors (shaking chills)
- Hemodynamic Instability
  - Hypotension
  - Tachycardia
When to Test Urine – Nursing Tool

### Box A – Nursing Assessment \(^1,^2\)
Fever defined as Single oral temperature > 100°F; or repeated oral temperatures >99°F or rectal temperature >99.5°F; increase in temperature of >2° above baseline.

<table>
<thead>
<tr>
<th>Measure vital signs to include:</th>
<th>Assessment to include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Temperature</td>
<td>• Conjunctiva</td>
</tr>
<tr>
<td>• Heart rate</td>
<td>• Oropharynx</td>
</tr>
<tr>
<td>• Blood pressure</td>
<td>• Chest</td>
</tr>
<tr>
<td>• Respiratory rate</td>
<td>• Heart</td>
</tr>
<tr>
<td>• Oxygen saturation</td>
<td>• Abdomen</td>
</tr>
<tr>
<td>• Finger stick glucose</td>
<td>• Skin (including sacral, perineum, and perirectal area)</td>
</tr>
</tbody>
</table>

2. INTERACT Care Paths - [https://interact2.net/tools_v4.html](https://interact2.net/tools_v4.html) Accessed 08/25/15

### Box B - Localizing Urinary S/S \(^3,^4\)


### Box C – Non-localizing / Non-specific Geriatric S/S


### Box D – Warning Signs