When to Test Urine – Nursing Tool

Wisconsin Healthcare-Associated Infections in LTC Coalition

Residents 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 → Consult Provider See Script 2

Non-localizing S/S – Nonspecific Geriatric S/S (Box C)

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 → Consult Provider See Script 6

Monitor per Medical Director Protocol

No Urine Testing Necessary

See Script 7

Yes → Consult Provider See Script 1

No → Consult Provider See Script 2

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

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Box A – Nursing Assessment

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)

Measure vital signs to include:
- Temperature
- Heart rate
- Blood pressure
- Respiratory rate
- Oxygen saturation
- Finger stick glucose

Assessment to include:
- Conjunctiva
- Oropharynx
- Chest
- Heart
- Abdomen
- Skin (including sacral, perineum, and perirectal area)
- Mental status
- Functional status
- Hydration status
- Indwelling devices if present
- Medication review

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

Box B - Localizing Urinary S/S


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


Box D – Warning Signs