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

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

Observe / Monitor 24-48 hours

Improved

No Urine Testing Necessary See Script 7

Worse

Consult Provider See Script 5

No Change

Consult Provider See Script 6 Monitor per Medical Director Protocol
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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