Assessment and Recognition

1. As part of the initial assessment, the physician will help identify individuals who have a history of symptomatic urinary tract infections, and those who have risk factors (for example, an indwelling urinary catheter, urinary outflow obstruction, etc.) for UTIs.

2. The staff and practitioner will identify individuals with signs and symptoms suggesting a possible UTI.
   a. Nurses should observe, document, and report signs and symptoms (for example, fever or hematuria) in detail and avoid premature diagnostic conclusions.
   b. There is no consistent, clear presentation of symptomatic UTIs. New onset of nonspecific symptoms alone (change in mental status, decline in appetite, etc.) is not a reliable indicator of a UTI, unless there are other general or localized symptoms. Urine odor and cloudiness do not necessarily indicate bacteriuria or a UTI.
   c. Refer to current guidelines (e.g., SHEA Surveillance Definitions of Infections in Long-Term Care Facilities) for criteria that define a urinary tract infection for surveillance purposes. Clinical definitions of UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team.
   d. Acute deterioration in previously stable chronic symptoms may indicate an acute infection. Multiple concurrent findings, such as fever with hematuria or catheter obstruction, are more likely to reflect a urinary source.
   e. A positive urine culture in someone with chronic genitourinary symptoms is not enough to diagnose a symptomatic UTI. The presence of pyuria or a positive leukocyte esterase test is not enough to prove that the individual has a UTI, but the absence of pyuria or a negative leukocyte esterase test is a good indicator that a UTI is not present.

Cause Identification

1. The physician will help nursing staff interpret the significance of signs, symptoms, and lab test results.
   a. Before diagnosing a UTI or urosepsis and ordering antibiotics, the physician should consider a resident’s overall picture including specific evidence that helps confirm or refute the diagnosis of a UTI (as discussed above).

2. The physician will help identify causes of, and factors contributing to, bacteriuria or UTIs such as bladder outlet obstruction, kidney stones, neurological impairments, and medications that can cause urinary retention.

Treatment/Management

1. The physician will order appropriate treatment for verified or suspected UTIs based on a pertinent assessment.
   a. Empirical treatment should be based on a documented description of an individual’s symptoms and on consideration of relevant test results, co-existing illnesses and conditions, and pertinent risk factors.
   b. Generally, symptomatic UTIs should be treated. Bacteriuria alone (an “asymptomatic UTI”) should not be treated routinely, because treating it does not materially change outcomes, improve longevity, or correct underlying problems.

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c. In select situations, empirical antimicrobial therapy may be warranted for afebrile individuals with non-specific symptoms.

2. The physician and staff will weigh relevant factors before treating asymptomatic individuals whose urine is colonized with yeast or with multidrug-resistant organisms such as methicillin-resistant Staphylococcus aureus or enterococcus.

3. Unless the colonized individual presents a significant infection control risk, antibiotic treatment may not be warranted.

4. The physician should consider stopping antibiotics or switching parenteral to oral antibiotics in individuals with uncomplicated UTIs who have been afebrile and asymptomatic for at least 48 hours.

5. The physician will help the staff identify cases of suspected septicemia (sepsis) related to a UTI and identify whether hospitalization may be warranted.

6. Fever and change in mental status alone do not automatically warrant hospitalization, nor is there compelling evidence that hospitalization improves the ultimate outcomes in individuals with symptomatic UTIs.

**Monitoring**

1. The physician and nursing staff will review the status of individuals who are being treated for a UTI and adjust treatment accordingly.

2. Decisions should be made primarily on the basis of clinical signs and symptoms. The goal of treatment in most cases is to control signs and symptoms of infection, not to eliminate bacteriuria.

3. Follow-up urine cultures after antibiotic treatment are not indicated routinely, but may be helpful if the symptoms are not resolving or complications are present.

4. When someone’s urinary tract infection persists or recurs after treatment with an initial course of antibiotics, the physician should review the situation carefully with the nursing staff and possibly examine the individual before prescribing repeated courses of antibiotics.

5. Physicians should justify continuing or resuming antibiotic treatment beyond an initial course of treatment, especially if based solely on a positive culture result.
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