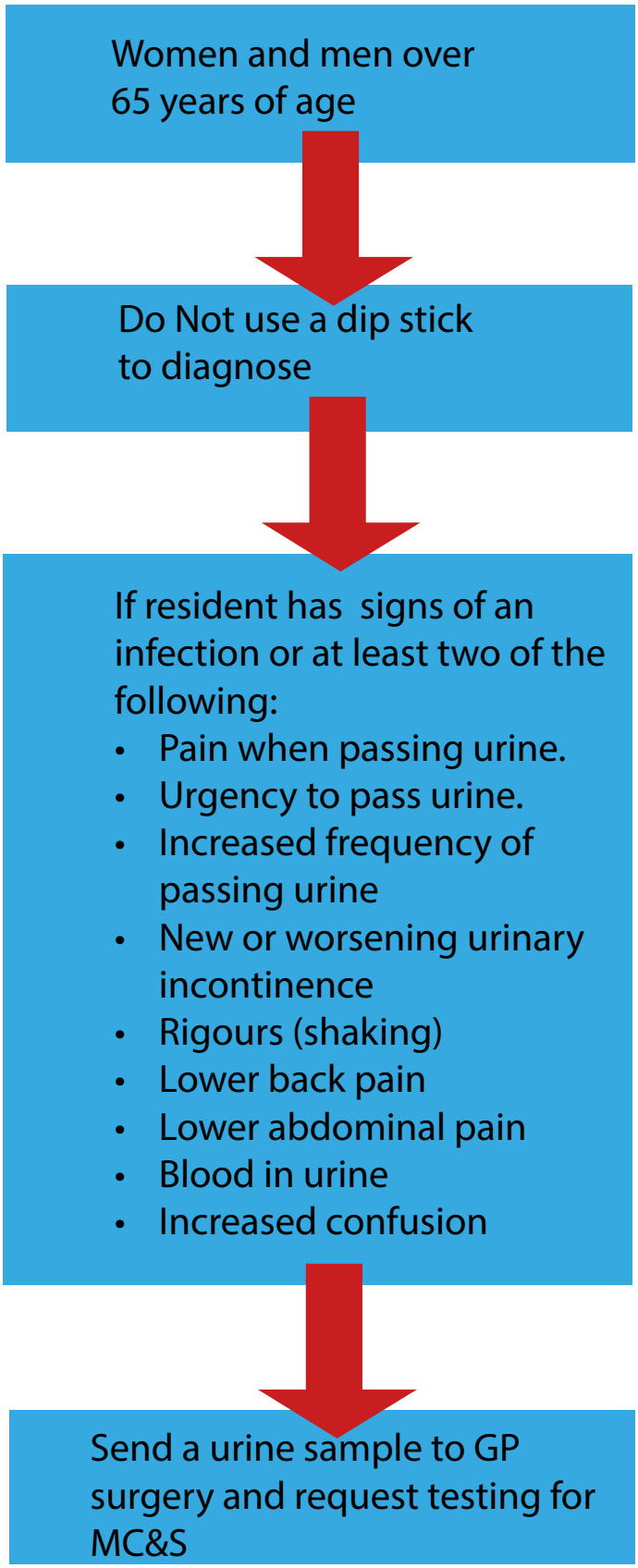
Section four
Bladder and Bowel

Suspected Urinary Tract Infection



Patient:.....

DOB:.....

Nursing Home:.....

Date:.....**Carer**:.....

Older patients (>65) with suspected UTI (urinary tract infection)

Guidance for Care Home staff

NHS
Bristol CCG
North Somerset CCG
South Gloucestershire CCG

- Complete **1)** to **4) and patient details** and fax to GP - original to patient notes
- **DO NOT PERFORM URINE DIPSTICK** – NOT recommended in pts >65 years
- CLEAR URINE – UTI highly unlikely
- **Send MSU** particularly if treatment failure or ≥ 2 signs of infection (especially dysuria, Temp>38°C or **new** incontinence)

1) Catheter **N / Y** Reason for catheter:.....

2) Signs of any other infection source? **N / Y** **Circle any NEW symptoms**

Cough Shortness of breath Sputum production Nausea/vomiting Diarrhoea Abdominal pain Red/warm/swollen area of skin

3) Patients who can communicate symptoms: **Y / N**

NEW ONSET Sign/Symptom	What does this mean?	Tick if present
Dysuria	Pain on urinating	
Urgency	Need to pass urine urgently/new incontinence	
Frequency	Need to urinate more often than usual	
Suprapubic tenderness	Pain in lower tummy/above pubic area	
Haematuria	Visible blood in urine	
Polyuria	Passing bigger volumes of urine than usual	
Loin pain	Lower back pain	

4) All Patients:

Sign/Symptom	Tick if present
Temperature above 38.3°C or below 36°C or shaking chills (rigors)in last 24 hours	
Heart Rate >90 beats/min	
Respiratory rate >20 breaths/min	
Diabetic ? Y / N If N - Blood glucose >7.7 mmol/L	
Bloods taken? N / Y If Y - WCC >12/µL or < 4/µL	
New onset or worsening confusion or agitation	

Any other information: .....

5) GP Management Decision - circle all which apply:

(a) Review in 24 hours
(b) Mid Stream Urine specimen (MSU) – particularly if ≥ 2 signs of infection (especially dysuria, Temp>38°C or new incontinence) or failed treatment
(c) Uncomplicated lower UTI
(d) Pyelonephritis
(e) Antibiotic prescribed:.....

Other action: ..... Signed: .....Date: .....
Prescribing guidance at http://www.bnssgformulary.nhs.uk/5-Infections-Guidelines/

March 2017 Kind acknowledgements to NHS BANES CCG guidance Mandy Slatter/Elizabeth Beech from which this was adapted. Approved by BNSSG DTC May 2017 Contact Michelle.Jones7@nhs.net or Lisarees1@nhs.net

National Early Warning Score

This chart should be used in adult patients 16 years and Over. This chart is not suitable in children under 16 or in women who are pregnant.

NSCP National Early Warning Score (NEWS) Chart

Patient name: .....

NHS no: .....

DOB: .....

Admission date: dd/mm/yy Team:

Monitoring frequency																			
Date																			
Time																			
Temperature	39°								2										39°
	38°								1										38°
●	37°								0										37°
	36°								0										36°
	35°								1										35°
									3										
Blood Pressure	220								3										220
Record Systolic	210								0										210
& Diastolic	200								0										200
Score Systolic	190								0										190
BP only	180								0										180
	170								0										170
	160								0										160
	150								0										150
	140								0										140
	130								0										130
	120								0										120
	110								1										110
	100								2										100
	90								3										90
	80								3										80
	70								3										70
	60								3										60
	50								3										50
									3										
Heart Rate	140								3										140
	130								3										130
	120								2										120
	110								2										110
	100								1										100
	90								1										90
	80								0										80
●	70								0										70
	60								0										60
	50								0										50
	40								1										40
	30								3										30
									3										
Resp Rate	≥25								3										≥25
	21-24								2										21-24
	12-20								0										12-20
●	9-11								1										9-11
	≤8								3										≤8
Sp0₂	≥96								0										≥96
	94-95								1										94-95
	92-93								2										92-93
●	≤91								3										≤91
	Inspired O_2% (L/min/%)								2										%
Conscious Level AVPU	Alert								0										
	V/P/U								3										
NEWS score																			
Initial/sign																			
Additional Parameters	BG																		
	Pain Score (0-10)																		

If measurements are on line please refer to chart bottom of page 2

0 1 2 3

Based on NHS Patient obs chart January 2012 - reproduced with kind permission from Royal Devon and Exeter NHS Foundation Trust in conjunction with the NEWS chart produced by RCP.

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National Early Warning Score (NEWS) Escalation Procedure

Low: 0		**Stable**
Low: **Aggregate 1-3**		**Score 1** - inform senior nurse in charge (Community Hospital), Community Matron /GP (Community) **Score 2-3** - increased frequency of observation to at least twice daily. Inform senior nurse in charge (Community Hospital), Community Matron/ GP (Community)
Medium: **3 in one parameter** **Aggregate 4 or more**		**Medium-score group** Inform senior nurse in charge (Community Hospital), Community Matron /GP (Community). Repeat observations. If no improvement in vital signs in one hour or if serious concern, inform GP/Out of Hours GP using SBAR
High **Aggregate 6 or more**		**High-score group** Contact duty doctor/GP immediately Consider 999 ambulance for transfer to acute hospital

Escalation Parameters can be altered by a Registered Nurse in consultation with a GP/Clinical Lead/Senior Nurse (Community Hospital)

Date and Time	**Change to escalation procedure** (NB if only want a change to a trigger in one parameter, please state which one)	**Rationale for change to escalation procedure**	**Planned review date**	**Signature, designation and in consultation with (if applicable)**
Example: *22.04.16 12.30 am/pm*	*$Sp0_2$ normal. 88-92% Alert if outside of these parameters.*	*Chronic Obstructive Pulmonary Disease measurement 'normal' within stated range*	*3 months*	*J. Smith Band 5 Registered Nurse in Consultation with A. Brown Community Matron*

National Early Warning Score (NEWS)*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

*The NEWS initiative flowed from the Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) report, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation

Please see next page for explanatory text about this chart.

Royal College of Physicians

NHS Training for Innovation

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Catheter Problems

Blocked catheter:
Eliminate simple mechanical obstruction e.g. constipation, kinked tubing, crossed legs, restrictive clothing, over full drainage bag, position of bag higher than bladder or much lower than bladder.

Catheter still blocked?
Contact District Nurses immediately!

Leaking catheter/bypassing:
Constipation? When was the last bowel movement? Is the leg bag properly positioned below bladder? Is catheter positioned securely on leg and catheter not stretched?

Catheter still leaking/bypassing?
Contact district nurses

Catheter trauma:
1. Catheter has been pulled out and bleeding is profuse?
Contact emergency services immediately. Stay with the patient. Keep patient calm, appoint a member of staff to stay with patient.

2. Blood seen in catheter bag following catheter being pulled?
Check bag position is correct and secure and encourage oral fluids. Blood in urine should resolve in 24 hours. Contact District Nurses if it hasn't.

Frequency Volume Chart 2 (Drinks in, Urine out)

This form is to:

- Record the amount you drink, and when you drink.
- Record when you pass urine, or when you visit the toilet but don't pass urine (T)
- Record the amount you pass (please measure in mls)
- Record the times you leak urine and the amount. + = DAMP. ++ = WET. +++ = SOAKING.
- If you wear a pad please record when you change it with a "C"

Name: NHS Number: Product Used:	Address:

Time	Day One		Day Two		Day Three	
	IN Drinks, type amount in mls	OUT Urine in mls, leaks or pad change	IN Drinks, type amount in mls	OUT Urine in mls, leaks or pad change	IN Drinks, type amount in mls	OUT Urine in mls, leaks or pad change
6 - 7am						
7 - 8am						
8 - 9am						
9 - 10am						
10 -11am						
11 -12am						
12 - 1pm						
1 - 2pm						
2 - 3pm						
3 - 4pm						
4 - 5pm						
5 - 6pm						
6 - 7pm						
7 - 8pm						
8 - 9pm						
9 - 10pm						
10 -11pm						
11-12pm						
12 - 1am						
1 - 2am						
2 - 3am						
3 - 4am						
4 - 5am						
5 - 6am						
Total						

Please complete this chart as fully as possible. Without it your treatment may be delayed.
Please contact your nurse/carer if you need help completing the chart.

Suspected Constipation:

Normal bowel habits can vary from three times a day to three times a week and should resemble stage 3-4 on 'Bristol Stool Chart'

Resident complaining of any of below
vomiting, abdominal pain, distended abdomen, not being able to have bowels opened
NB liquid stools or smearing of underwear can be a sign of constipation

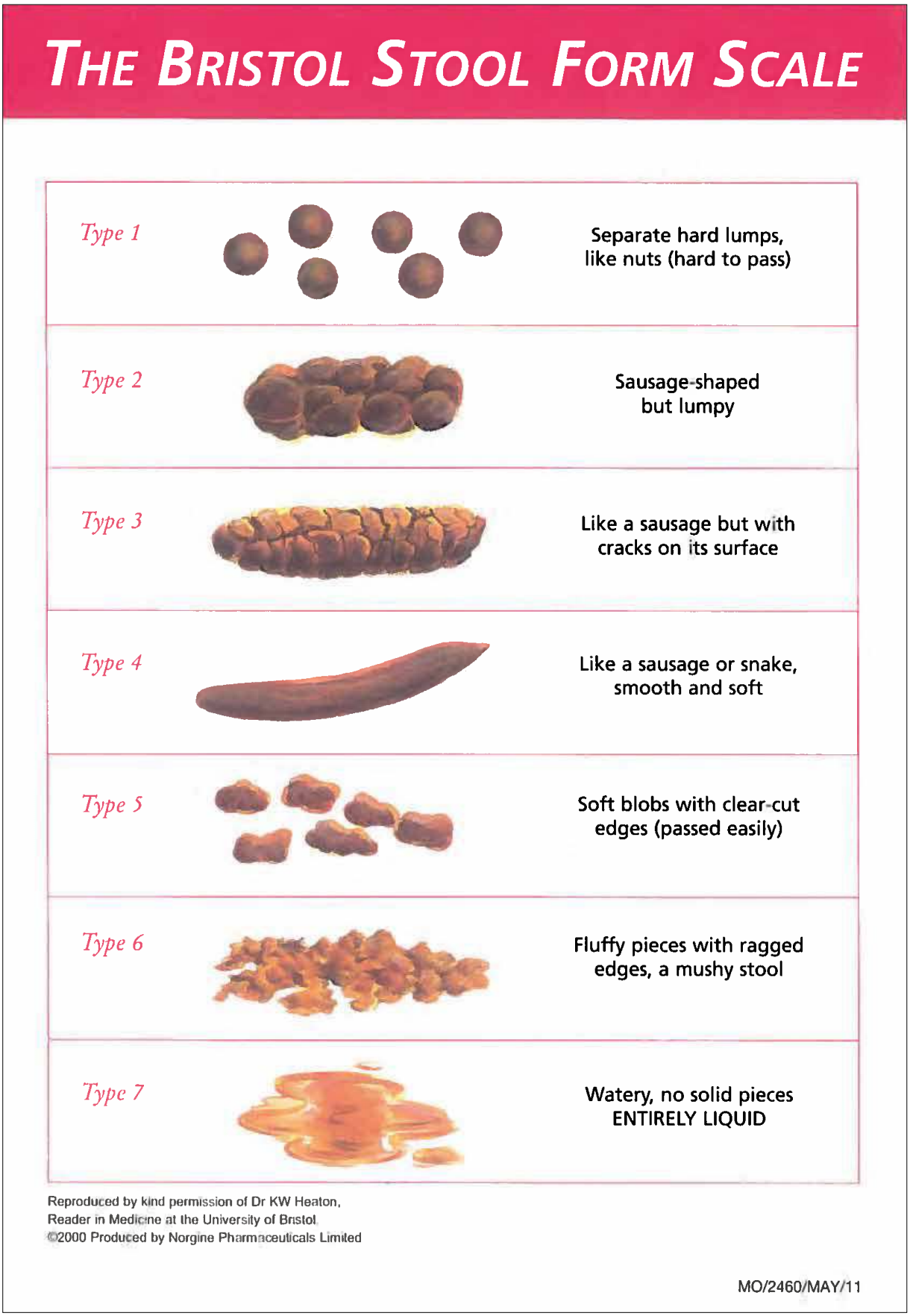
Encourage oral fluids
Encourage increase in fruit/vegetables/fibre
Encourage mobility
Maintain privacy and dignity when using the toilet
Ensure resident able to access toilet
Implement bowel records
Contact GP to request prescription for a laxative

Problem resolved within two days
No further intervention required. Recommend continuing with high fibre diet and good fluid intake.

Remains problematic after 2-3 days
Contact District Nurses for further bowel management.

Recurrent Constipation
Contact RHST for full assessment and medication review.

The Bristol Stool Form Scale



Correct Position For Opening Your Bowels

Correct position for opening your bowels

Step one

Knees higher than hips

Step two

Lean forwards and put elbows on your knees

Step three

Bulge out your abdomen
Straighten your spine

Correct position

Knees higher than hips
Lean forwards and put elbows on your knees
Bulge out your abdomen
Straighten your spine

Reproduced by the kind permission of Ray Addison, Nurse Consultant in Bladder and Bowel Dysfunction.
Wendy Ness, Colorectal Nurse Specialist.

Produced as a service to the medical profession by Norgine Pharmaceuticals Limited MO/05/0514, January 2005

Constipation Pathway

Constipation

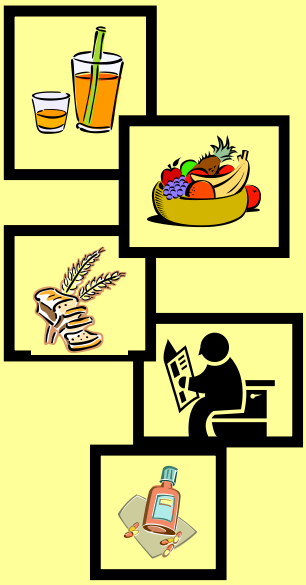
Is the resident complaining of constipation?

Or showing signs of constipation?

- No bowel movement for several days
- or Bristol Stool Chart type 1 or 2?
- Feeling bloated or bloated tummy
- Stomach ache or back ache
- Reduced appetite, feeling sick, furred tongue?

YES

Treat and prevent constipation



Increase fluids

- Give an early morning drink of warm water
- Aim for an intake of 150mls per hour,

if the resident cannot drink large amounts try regular small sips

- Use a larger cup- they are likely to drink more than from a small cup

Alter the diet

- High fibre cereal breakfast, wholemeal bread instead of white
- Substitute small fruit snacks instead of biscuits

Get things moving

- Give the prescribed laxative, allow privacy and time to use the toilet or commode
- Encourage the resident to walk or move about as much as they are able

Ask for a Medication Review:

Some pain killers cause constipation, alternatives may be available.

The resident may need a different laxative, suppositories, enema or high fibre dietary supplement

Monitor mental and physical state for 48 hours, record fluid intake and bowel movements

Has the resident improved?

YES

Prevent further constipation:
Fluids, Fibre, Foot work!
Aim for Bristol Stool Chart type 3 or type 4

NO

Complete an up to date delirium checklist
Call the GP and use the checklists to describe the symptoms

STOP DELIRIUM © 2007

