Urinary Tract Infections

Advice for Care Homes

Recognising a UTI in Non Catheterised Residents

* Does the resident have a temperature greater than 37.9˚C and 2 or more of the following symptoms?

Recognising a UTI in Non Catheterised Residents

* Burning or pain on passing urine
* New or increased frequency of passing urine
* New or increased incontinence
* New or increased urgency in passing urine
* If yes seek GP/Nurse advice and obtain a urine sample for laboratory testing.

Recognising a UTI in Catheterised Residents

* If the resident has a temperature and any of the following symptoms seek GP/Nurse advice and obtain a urine sample for laboratory testing.
* New or increased confusion
* Visible blood in the urine
* Flank or suprapubic pain
* Shaking chills (rigors)

How to obtain a urine sample from a catheter

* If no urine visible in catheter tubing: wash/decontaminate physically clean hands with alcohol rub, don apron and apply non-sterile gloves prior to manipulating the catheter tubing.
* Apply non-traumatic clamp a few centimetres distal to the sampling port.
* Wash hands with bactericidal soap and water, or decontaminate physically clean hands with alcohol rub and don gloves.
* Wipe sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allow drying for 30 seconds.
* insert syringe firmly into centre sampling port (according to manufacturer's guidelines), aspirate the required amount of urine and remove syringe.
* Transfer an adequate volume of the urine specimen (approx. 10 mL) into a sterile container immediately.
* Discard syringe into sharps container.
* Wipe the sampling port with an alcohol wipe and allow to dry.
* Unclamp catheter tubing.
* Dispose of waste, remove apron and gloves and wash hands.
* Label sample and complete microbiological request form including relevant clinical information, such as signs and symptoms of infection, antibiotic therapy.
* Dispatch sample to laboratory immediately (within 4 hours) or refrigerate at 4°C.

(Royal Marsden Guidelines 2018)

What happens after a urine sample is taken?

* The sample is sent to the laboratory and is tested for bacteria.
* If any bacteria are found, the lab staff then determine which antibiotics are needed to treat the infection.
* If a GP has started treatment, this test will determine if the correct antibiotics have been prescribed.
* If not, the GP should change the prescription.
* If antibiotics have been started but no infection has been found, the treatment should be discontinued.

To Dip or not to Dip?

Did you know?

- Dipstick testing alone should never be used to diagnose UTI as the results can be unreliable. The results often suggest that the patient has an infection when subsequent laboratory testing confirms that there is in fact no infection present.

- Unnecessary antibiotic treatment of **asymptomatic** UTI's and CAUTI's is associated with an increased risk of developing *Clostridium difficile (C.diff)*, methicillin-resistant staphylococcus aureus (MRSA) and multi-drug resistant UTI's and CAUTI's.

- Therefore 2 consecutive urine samples should be sent to confirm if a patient has a UTI or CAUTI.

- And antibiotic therapy should not be used to treat asymptomatic UTI.

(NICE) 2015

HOUDINI

STOP! THINK PATIENT!

Does your patient require a catheter?

Do they have.....

- **H** Haematuria
- **O** Obstruction
- **U** Urological surgery
- **D** Decubitus (open sacral / perineal wounds)
- **I** Input / Output monitoring
- **N** Not to be resuscitated
- **I** Immobility

Prevention of Urinary Tract Infection (UTI)

* Hand hygiene/Personal protective equipment (PPE)
* Toileting/personal hygiene
* Catheter care

Hand hygiene / Personal protective equipment (PPE)

* Adhere to good hand hygiene practices
* Observe the important moments of hand hygiene
* Use the appropriate PPE for each task
* Dispose of all used items correctly

Your 5 Moments for Hand Hygiene

Toileting/personal hygiene

* Using the toilet
* Maintain residents personal hygiene
* Correct use of incontinence pads
* Avoid constipation

Catheter care

* Hand Hygiene/PPE
* Correct use of leg bags
* Correct use and disposal of night bags

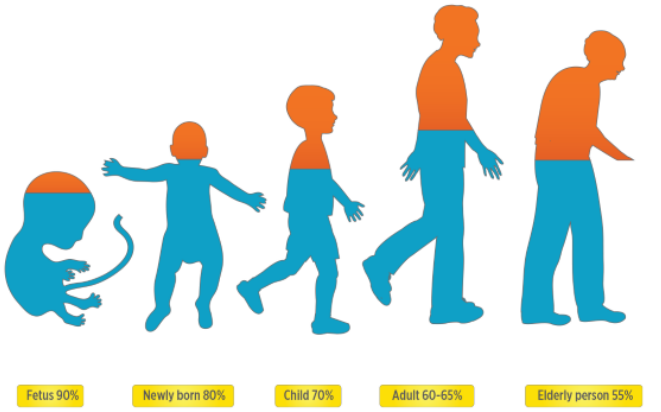
Hydration

CQC hydration standards focus on identification, assessment, monitoring fluid intake and care.

These include:-

- Staff identify when a person is at risk of dehydration
- Those identified as at risk have their fluid intake monitored
- Hydration requirements are identified and reviewed, and communicated
- The care plan identifies how the risks will be managed

Water in the body



- Maintains a constant body temperature
- Circulation
- Helps with eating & digestion
- Waste removal
- Maintains volume of bodily fluids

Causes of dehydration

- Low-intake - not drinking enough to replace fluid loss (sweat, respiration, urine, faeces) - Prevalent in older people living in care homes.
- Excess loss - salt & water deficit - occurs in diarrhoea, vomiting or excess sweating

Identifying dehydration using the 5 senses

Sight

* Does the resident's – legs, hands, forearms look dry? (flakes of skin can look grey, or ashy).
* Are they drowsy?
* Do they have:
  * Few or no tears?
  * Low urine output which is more yellow/orange than normal?

Taste/mouth

* Do they have a dry mouth, cracked lips, rough and dry tongue, and sores around the mouth?
* Is eating and swallowing difficult? A dry throat makes choking more common.
* Is there increased thirst?
* Are there food cravings for chocolate, a salty snack, or sweets?

Hearing

* Is the resident:
* Confused, complaining of a headache?
* Feeling dizzy?
* Complaining of being itchy?
* Do they have a dry mouth?
* (makes it difficult to talk).

Identifying dehydration using the 5 senses – cont.

Smell

* Do they have bad breath?
* Dehydration can prevent the body from making enough saliva.
* Saliva flushes food particles from the teeth and washes acid away.

Touch

* Does the resident's skin feel dry?
* Dry skin is often felt more than it's seen.
* *Do the skin test*

Using 2 fingers gently pinch the skin on the back of the hand and then let it go. The skin should spring back to its normal position in less than a couple of seconds. If it takes longer they may be dehydrated.

Hy5 ~ Identifying dehydration in care home residents using the 5 senses

Does the resident's – legs, hands, forearms look dry? (flakes of skin can look grey, or ashy).
Some medications, including diuretics, and antihistamines, may dry out the skin.
Are they drowsy?
Do they have:
Few or no tears?
Low urine output which is more yellow/orange than normal?

Do they have a dry mouth, cracked lips, rough and dry tongue, and sores around the mouth?
Is eating and swallowing difficult?
Lack of salivation can make the tongue burn.
Saliva helps to taste and digest food.
A dry throat makes choking more common.
Is there increased thirst?
Are there food cravings for chocolate, a salty snack, or sweets?

Do they have bad breath?
Dehydration can prevent the body from making enough saliva.
Saliva flushes food particles from the teeth and washes acid away.

Does the resident's skin feel dry?
Dry skin is often felt more than it's seen.
Do the skin test
Using 2 fingers gently pinch the skin on the back of the hand and then let it go. The skin should spring back to its normal position in less than a couple of seconds.
If it takes longer they may be dehydrated.

Is the resident:
Confused, complaining of a headache?
Feeling dizzy?
Complaining of being itchy?
Do they have a dry mouth?
(makes it difficult to talk).

How dehydrated are they?

A quick way to test how well the resident is hydrated is to check the colour of their urine.
Use this colour chart as a guide.

Preventing dehydration

Food
Swap dry snacks with prepared fresh/frozen fruit (melon, watermelon, strawberries, tomatoes).
Provide snacks of cut vegetables with a high water content – cucumber, celery, lettuce and leafy greens, courgettes, and peppers.
Eat yogurt or drink smoothies.
Aim to make half their plate fruit and vegetables.
Sip drinks during meals.

Drink
Offer a drink at least every half hour.
Increase cup size – using a sports bottle may be easier to hold for some residents.
Avoid alcohol, including beer and wine.
Consider flavoured ice lollipops and popsicles.
Have a drink handy – if the cup is nearby it is easier to sip without even realising it.
Adding fruit juice to water can make it more enjoyable to drink.
Try different flavoured teas.
Drink room temperature or cooler water.

Clothing in hot weather
Wearing one layer of lightweight, light-coloured clothing reduces the risk of dehydration.
Change into dry clothing as soon possible if clothes get wet.

Activity
Active people get dehydrated quicker so make sure that the residents who walk a lot are hydrated.
Discourage activity if feeling dizzy, lightheaded, or very tired.

For more information
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http://www.lancashire.gov.uk/practitioners/health/infection-prevention-and-control.aspx

Blackburn with Darwen Borough Council

Lancashire County Council

comms 5447

Things to consider

- Offer drinks in cups/glasses which residents can hold.
- Cup size – do they like a cup or a mug
- Type of cup – china or chunky, sports bottle, glass and straws
- Colour of cup – do they have different coloured cups?
- Offer preferred drinks more often
- Residents rely on routines – make sure they happen frequently.
- Offer drinks overnight and before breakfast.
- Encourage substantial drinks with medication.
- Residents may be reluctant to drink to avoid needing the toilet.
- Most types of drinks provide fluid (except strong alcohol!).

Further information

* https://www.lancashire.gov.uk/practitioners/health-and-social-care/infection-prevention-and-control/infection-prevention-resources/

* https://www.nhs.uk/conditions/urinary-tract-infections-utis/