

# Management of Infections in Long Term Care (Diagnosis & Treatment)

- Criteria**
- ▶ Resident Flushed/  
Warm → Fever  
OR
  - ▶ Staff observation  
of possible other  
infection  
symptoms  
OR
  - ▶ Resident verbalizes  
OR
  - ▶ Resident's  
roommate states  
concern  
▶ Etc.

**Suspect  
Infection**

YES

**Perform Nursing Assessment**

- Assesment Areas (Ex)**
- ▶ Vital signs
  - ▶ Assess - Respiratory, Skin,  
& Urinary
  - ▶ Observe for change in -  
cognition/behavior,  
ADL/functional status,  
food/fluid intake, bowel  
function, etc.
  - ▶ Signs of infection/Associated  
Symptoms - swelling, redness,  
heat, drainage/pus, odor, etc.

- DOCUMENTATION**
- V/S  
Review Flow/treatment  
sheets for trends  
Perform a full physical  
assessment and  
document results  
Communicate with  
physician & family,  
Document steps taken to  
manage symptoms  
Above clinical data must  
be found in the  
resident's clinical  
record

Contact Attending Physician

- Checklist for Nurse to provide to Physician**  
(HAVE RESIDENT CLINICAL RECORD IN  
HAND WHEN CALLING PHYSICIAN)
- ▶ Diagnoses, Allergies
  - ▶ B/P, Resp., Temp. & Pulse
  - ▶ Vomiting/diarrhea
  - ▶ Constipation
  - ▶ ↓ Function/activity
  - ▶ Change in Food/fluid intake
  - ▶ Results of skin, resp., & urine assessment
  - ▶ Other associated symptoms of infection
  - ▶ Recent Lab values
  - ▶ Drug List
  - ▶ Behavior/cognition

Physician Orders Received

Facility staff proceeds with Phy. Orders  
(ex: lab, meds, etc)  
Staff provides - Supportive Care  
Staff continues to observe, assess  
(V/S, Symptoms), and treat  
based on orders and care  
plan

**Adjust Care Plan**

If symptoms continue with no improvement, notify physician & family, in order to consider other treatment options