Royal Cornwall Hospitals
NHS Trust

Urinary Tract Infections in Adults Clinical Guideline

V4.0

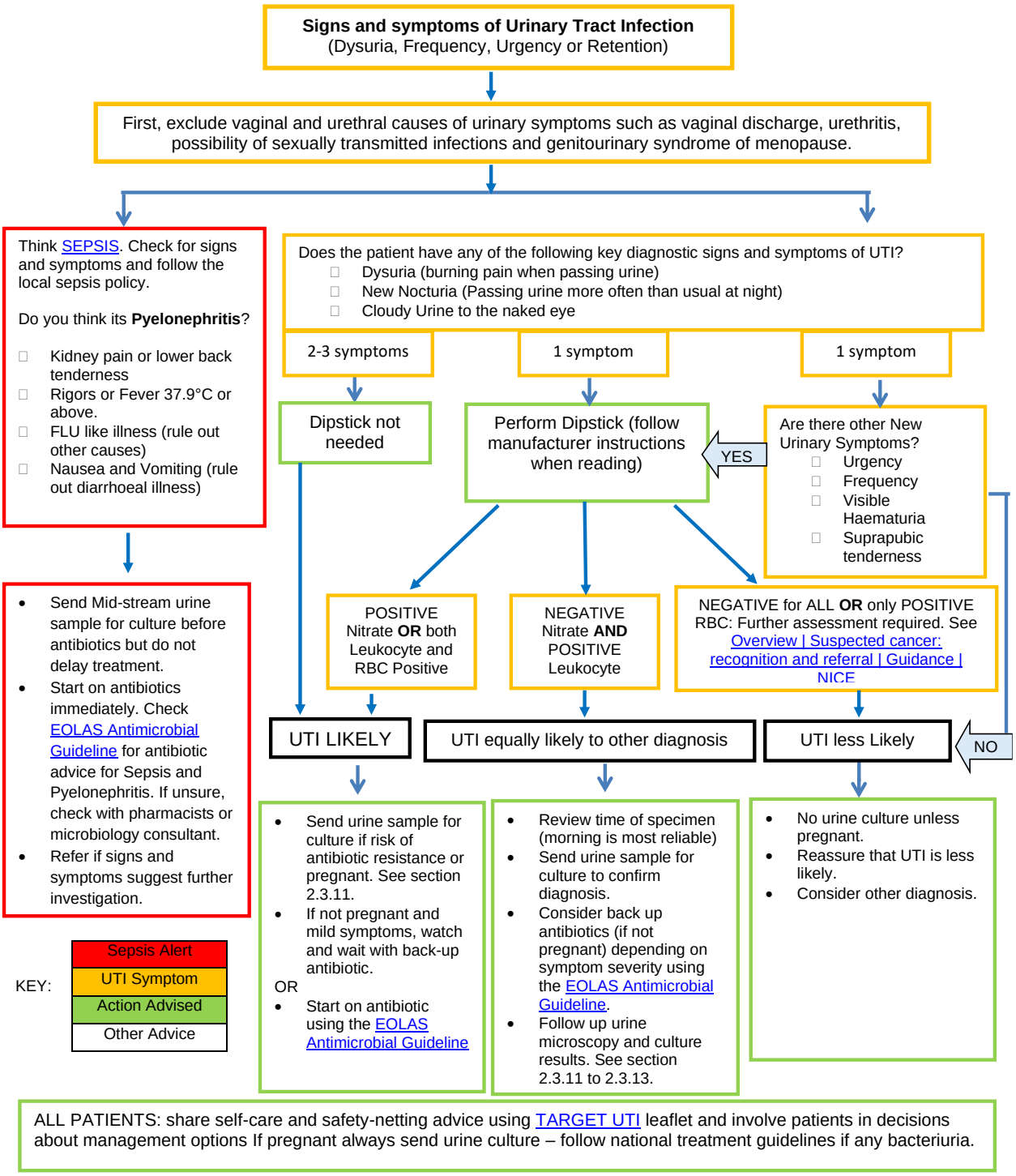
June 2025

Summary

A. Management of Suspected UTI in Women Under 65 years (not pregnant, not catheterised).

Do not treat asymptomatic bacteriuria in non-pregnant women as it does not reduce mortality or morbidity. UTI is diagnosed on signs and symptoms.

Excludes women with recurrent UTI (two episodes of UTI in the last six months or three episodes in the last twelve months).

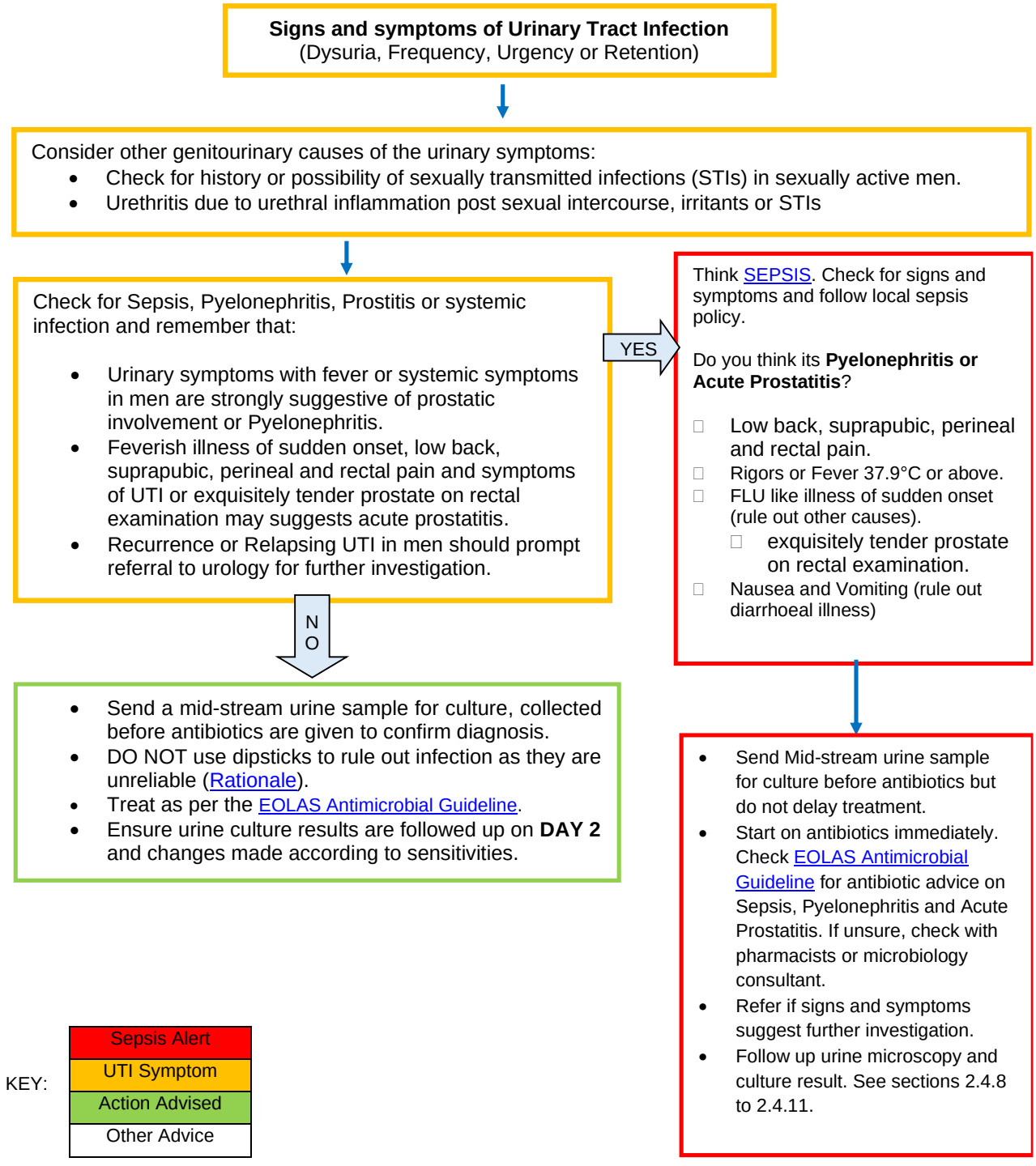


Source: UKHSA (2025) *Diagnosis of urinary tract infections: quick reference tools for primary care - GOV.UK*

B. Management of Suspected UTI in Men Under 65 years (not catheterised)

Asymptomatic bacteriuria is rare in men under 65 years. Consider other genitourinary causes of the urinary symptoms.

Do not use dipsticks to rule out UTI.

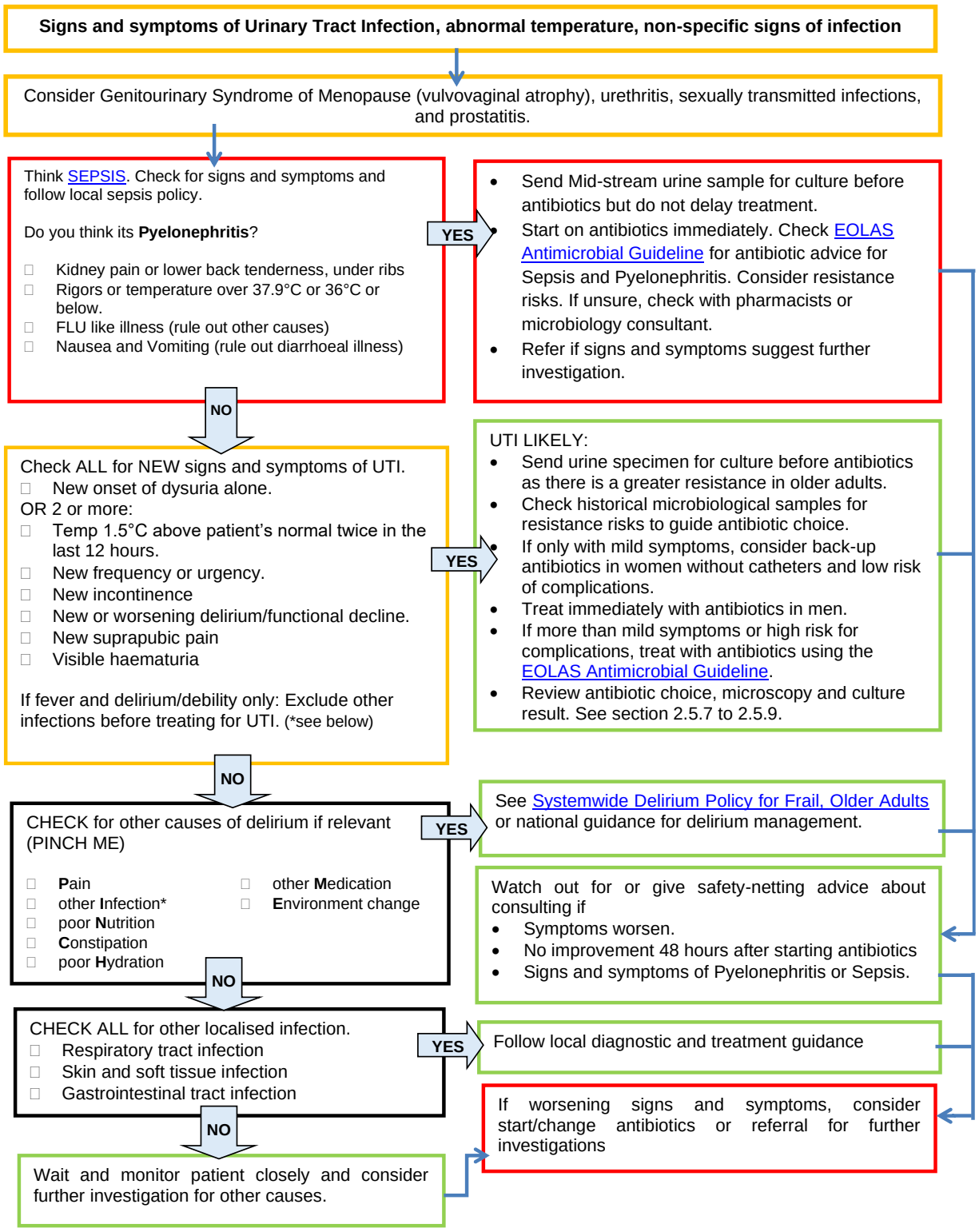


Source: UKHSA (2025) *Diagnosis of urinary tract infections: quick reference tools for primary care - GOV.UK*

C. Management of Suspected UTI in Adults Over 65 years (not catheterised)

This tool is for adults over the age of 65 with suspected uncomplicated UTI. It excludes those with a recurrent UTI (defined as 2 episodes in the last 6 months or 3 episodes in the last 12 months; see rationale) and excludes those who have a urinary catheter.

Do not perform urine dipsticks to diagnose UTI in adults over 65 years of age. Use signs and symptoms of UTI to determine the most appropriate management.

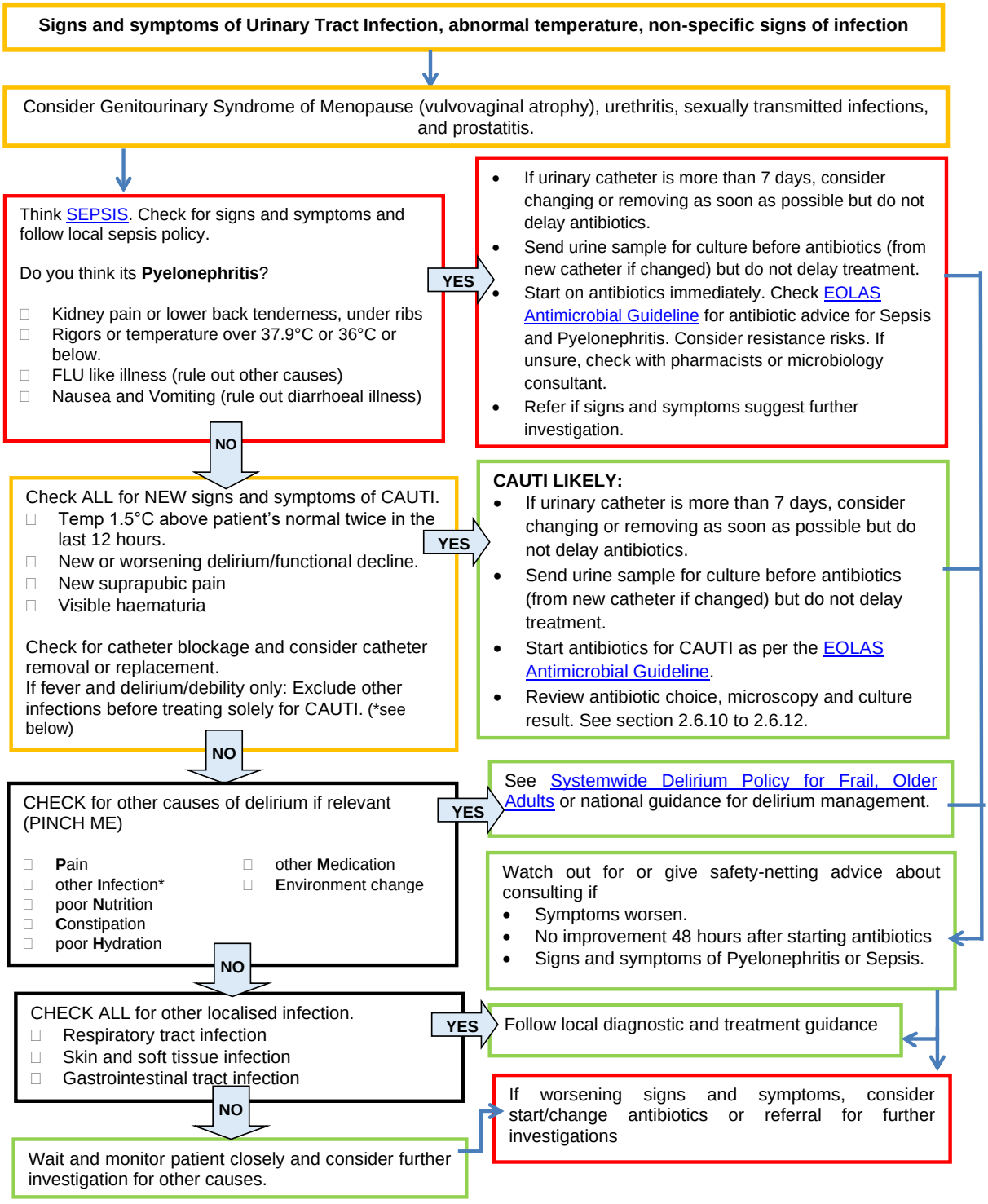


Source: UKHSA (2025) *Diagnosis of urinary tract infections: quick reference tools for primary care - GOV.UK*

Management of Suspected Catheter associated UTI (CAUTI) in Adult patients

CAUTI is defined as the presence of symptoms or signs compatible with a UTI in people with a catheter with no other identified source of infection plus significant levels of bacteria in a catheter specimen taken from the sample port (or a midstream urine specimen when the catheter has been removed within the previous 48 hours) (see rationale)

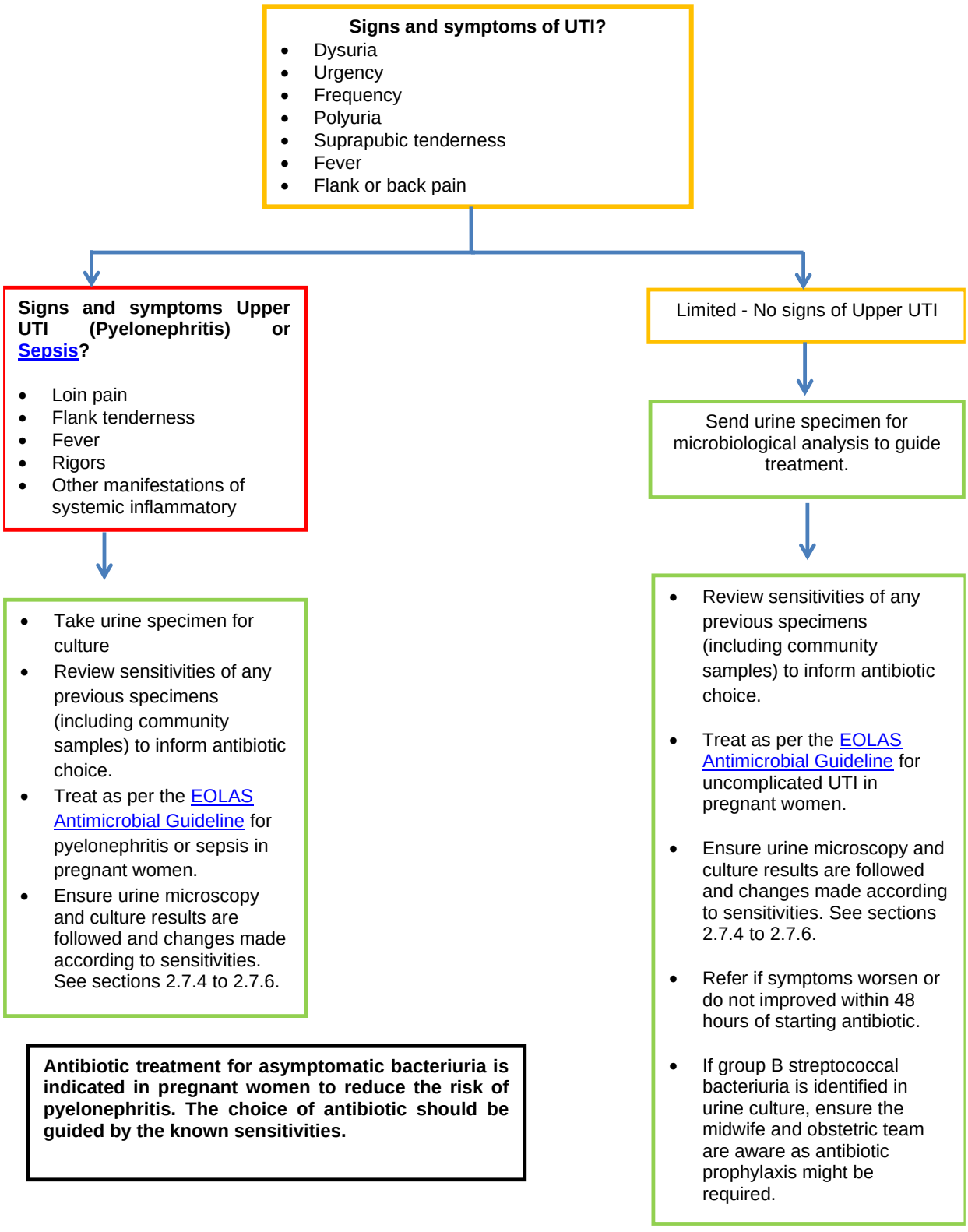
In patients with spinal cord injury, increased spasticity, autonomic dysreflexia, or sense of unease are also compatible with catheter-associated UTI.



Source: UKHSA (2025) *Diagnosis of urinary tract infections: quick reference tools for primary care - GOV.UK*

Management of Suspected UTI in Pregnant Women

Antibiotic treatment for asymptomatic bacteriuria is indicated in pregnant women to reduce the risk of pyelonephritis.



Source: NICE (2025) Scenario: UTI in pregnancy (no visible haematuria) | Management | Urinary tract infection (lower) - women | CKS | NICE

1. Aim/Purpose of this Guideline

1.1. To provide information to clinical staff on the correct management of adults (excluding pregnant women) with suspected bacterial urinary tract infection.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

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Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Background

Urinary tract infection (UTI) is the second most common clinical indication for empirical antimicrobial treatment in primary and secondary care. Healthcare practitioners often have to make decisions about prescription of antibiotics for urinary tract infection. The criteria for the diagnosis of urinary tract infection vary greatly in the UK, depending on the patient and the context.

Urinary tract infections are caused by the presence and multiplication of microorganisms in the urinary tract. A urinary tract infection can result in several clinical syndromes, including acute and chronic pyelonephritis (infection of the kidney and renal pelvis), cystitis (infection of the bladder), urethritis (infection of the urethra), epididymitis (infection of the epididymis) and prostatitis (infection of the prostate gland). Infection may spread to surrounding tissues (for example, perinephric abscess) or to the bloodstream. A urinary tract infection is defined by a combination of clinical features and the presence of bacteria in the urine.

Asymptomatic bacteriuria (ASB) is common and is defined as the occurrence of bacterial growth of >105 cfu/ml in midstream urine without causing symptoms in two consecutive samples in women and in a single sample in men (Kranz et al. 2024). Antibiotic treatment of ABU is not usually recommended and should only be considered in cases of proven benefit for the patient. Persistent ABU should be investigated to rule out possible of prostate diseases in men and possible of stone formation in the urinary tract (Kranz et al. 2024).

When symptoms occur because of bacterial growth in urine this is referred to as symptomatic bacteriuria.

In people aged 65 years and over, asymptomatic bacteriuria is common but is not associated with increased morbidity. The diagnosis of urinary tract infection is particularly difficult in older people, who are more likely to have asymptomatic bacteriuria. The prevalence of bacteriuria may be so high that urine culture ceases to be a reliable diagnostic test.

Prudent antibiotic prescribing is a key component of the UK's action plans for reducing antimicrobial resistance. Unnecessary antibiotic treatment of asymptomatic bacteriuria is associated with significantly increased risk of clinical adverse events, including Clostridioides difficile or Methicillin-resistant Staphylococcus aureus infections, infection with multi-drug-resistant gram-negative organisms including extended-spectrum beta-lactamase organisms and carbapenem-resistant Enterobacteriaceae, and the development of antibiotic-resistant urinary tract infections.

In people with an indwelling urethral catheter, antibiotics do not generally eradicate asymptomatic bacteriuria.

2.2. **The European Association of Urology (2024) categorises urinary tract infections.**

A. **Uncomplicated UTIs:** Acute, sporadic, or recurrent cystitis limited to nonpregnant women with no known relevant anatomic or functional abnormalities in the urinary tract and no comorbidities.

B. **Complicated UTIs:** All UTIs which are not defined as uncomplicated, meaning UTIs in a patient with an increased chance of a complicated course: i.e. all men, pregnant women, patients with relevant anatomical or functional abnormalities of the urinary tract, indwelling urinary catheters, renal diseases, and/or with other concomitant immunocompromising diseases, for example diabetes.

C. **Recurrent UTIs:** Are recurrences of uncomplicated and/or complicated UTIs, with a frequency of at least three UTIs in a year or two UTIs in the last six months.

D. **Catheter-associated UTIs:** Refers to UTI occurring in an individual whose urinary tract is currently catheterised or has been catheterised within the past 48 hours.

2.3. **Management of Suspected UTI in Adult Women Aged Under 65 years (not catheterised or pregnant).**

This guidance is for management of UTI in adult women under 65 years of age, not pregnant or catheterised. Furthermore, this doesn’t include recurrent UTI. For recurrent UTIs, management can be accessed here.

2.3.1. Use clinical presentations and urine dipstick to help diagnose UTI in this category. Do not treat asymptomatic bacteriuria (ASB) in non-pregnant women as it does not reduce mortality or morbidity and may even cause harm.

2.3.2. Exclude other genitourinary causes of the urinary symptoms before deciding to treat for UTI. The rationale for this can be accessed here. Consider that 75% to 80% of individuals with vaginal discharge will not have UTI. Explore sexual history for sexually transmitted infections (STIs) in those who are sexually active. Also consider genitourinary symptoms of menopause, and urethritis (urinary symptoms may be due to urethral inflammation post sexual intercourse, irritants or STIs).

2.3.3. Think SEPSIS and check symptoms as per Sepsis in Adult Patients Clinical Guideline and follow recommendations stated.

2.3.4. Check for any new symptoms or signs of Pyelonephritis.

- Kidney pain or lower back tenderness.
- Rigors or Fever 37.9°C or above.
- FLU like illness (rule out other causes).
- Nausea and Vomiting (rule out diarrhoeal illness).

If pyelonephritis is suspected, send urine cultures and manage as per the EOLAS ANTIMICROBIAL GUIDELINE. Do not delay treatment. If unsure, seek advice from pharmacists or consultant microbiologists.

2.3.5. The following are the key diagnostic signs and symptoms of UTI in women under 65 years of age that will guide treatment:

- Dysuria (burning pain when passing urine).
- New Nocturia (passing urine more often than usual at night).
- Cloudy Urine to the naked eye.

2.3.6. If two (2) or more of the above symptoms are present and the patient does not have vaginal discharge or irritation, UTI is likely. Empirical antibiotics may be appropriate following collection of a urine specimen for culture. Manage as per EOLAS ANTIMICROBIAL GUIDELINE.

2.3.7. If the patient has one (1) of the above symptoms, perform a urine dipstick following manufacturer's instructions to increase diagnostic certainty.

2.3.8. Where there are none of these three (3) symptoms, a UTI is less likely. Only perform urine dipstick test if there are other urinary symptoms are present: urgency, frequency, visible haematuria, and suprapubic tenderness.

2.3.9. Actions to be taken on dipstick result:

- **Positive nitrite, leucocytes and blood or nitrite alone**: UTI likely. If non-pregnant and mild symptoms – watch and wait OR manage as per EOLAS Antimicrobial Guideline. Send urine specimen for culture.
- **Negative nitrite, positive leucocyte:** UTI or other diagnosis equally

likely. If non-pregnant and mild symptoms – watch and wait. Review time of specimen (morning sample is more reliable). Consider back up antibiotic or treat if with severe symptoms using the EOLAS Antimicrobial Guideline. Send urine for culture.

- **Negative nitrite, leucocytes and RBC or negative nitrite and leucocyte but positive RBC or protein**: UTI less likely. Consider further assessment/ referral for women with symptoms (see Overview | Suspected cancer: recognition and referral | Guidance | NICE). Urine culture not advised, reassure patient that UTI is less likely.

2.3.10. For all patients treated for suspected UTI, a pre-treatment mid-stream specimen of urine should be sent, and previous microbiology results reviewed prior to prescribing antibiotics. Do not delay treatment. Utilise the EOLAS Antimicrobial Guideline for antibiotic prescription.

2.3.11. If urine sample is sent for urine culture, it will undergone urine microscopy first. Follow up urine microscopy result on Day 1, and if negative and patient is not on the risk group category, urine culture will not be conducted. Consider other diagnosis in this instance.

2.3.12. If urine culture is conducted, follow up urine culture results on **Day 2** and review antibiotics with changes made according to sensitivities.

2.3.13. Where microscopy is negative and culture is conducted because of the risk group, a positive culture may still indicate contamination so results should still be interpreted in the light of clinical risk factors and progress.

2.3.14. Patients with recurrent UTIs may be more likely to have resistant organisms due to repeated exposure to antibiotics. Assessment for possible underlying urinary tract abnormalities should be considered and urology referral made if appropriate. Prophylaxis for recurrent UTI should not be routinely started. If considering prophylaxis, then discussion with the Microbiologist and/or Urologist is required with regards to choice of agent and follow-up.

2.4. Management of Suspected UTI in Adult Men Aged Under 65 years (not catheterised)

2.4.1. Asymptomatic bacteriuria is rare in men under 65 years. Consider other genitourinary causes of the urinary symptoms. See the rationale for diagnostic points for men (under 65 years) with suspected UTI here.

- Sexual history for Sexually Transmitted Infections (STIs) in sexually active men.
- Urethritis due to urethral inflammation post sexual intercourse, irritants or STIs).

2.4.2. The following are the signs and symptoms of UTI in men.

- Dysuria.
- Frequency.

- Urgency.
- Retention.

2.4.3. Check for sepsis, pyelonephritis, prostatitis, systemic infection, or suspected sepsis and remember that:

- Urinary symptoms with fever or systemic symptoms in men are strongly suggestive of prostatic involvement or Pyelonephritis.
- Feverish illness of sudden onset, low back, suprapubic, perineal, and rectal pain and symptoms of UTI or exquisitely tender prostate on rectal examination may suggests acute prostatitis.
- Recurrence or Relapsing UTI in men should prompt referral to urology for further investigation.

2.4.4. Follow the sepsis guideline here if sepsis is suspected and refer to the EOLAS Antimicrobial Guideline for treatment advice on acute prostatitis and pyelonephritis. See the flowchart in the summary section of this document for signs and symptoms of acute prostatitis and pyelonephritis.

2.4.5. In men with UTI symptoms as detailed above, collect and send a midstream specimen of urine (MSU) for culture before starting on antibiotic treatment.

2.4.6. DO NOT use dipsticks to rule out infection as they are unreliable.

2.4.7. Review previous microbiology results urine cultures to check sensitivities to inform antibiotic choice. Treat as per the EOLAS ANTIMICROBIAL GUIDELINE.

2.4.8. If urine sample is sent for urine culture, it will undergone urine microscopy first. Follow up urine microscopy result on Day 1, and if negative and patient is not on the risk group category, urine culture will not be conducted. Consider other diagnosis in this instance.

2.4.9. If urine culture is conducted, follow up urine culture results on **Day 2** and review antibiotics with changes made according to sensitivities.

2.4.10. Where microscopy is negative and culture is conducted because of the risk group, a positive culture may still indicate contamination so results should still be interpreted in the light of clinical risk factors and progress.

2.5. **Management of Suspected UTI in Adults Over 65 years (not catheterised)**

2.5.1. Do not perform urine dipsticks to diagnose UTI in adults over 65 years of age. Use signs and symptoms of UTI to determine the most appropriate management. Signs and symptoms of UTI include:

- New onset dysuria, incontinence, or urgency.
- Temperature (38°C or above, 36°C or below, 1.5°C above normal twice in the last 12 hours).

- Non-specific signs of infection, for example, delirium, loss of diabetic control.

2.5.2. Consider genitourinary syndrome of menopause (vulvovaginal atrophy) as a potential cause of symptoms as this can present with dysuria.

2.5.3. First, consider Sepsis or Pyelonephritis. Think SEPSIS follow actions detailed in *Sepsis in Adult Patients Clinical Guideline*. Also check for any new symptoms and signs of pyelonephritis including the following:

- New Kidney pain or tenderness in back, under ribs
- New or different myalgia or flu-like symptoms
- Nausea and vomiting (exclude diarrhoeal infections)
- Rigors or temperature over 37.9°C or 36°C or below.

Send urine culture before antibiotics and assess antibiotic resistance risk. Do not delay antibiotics and treat sepsis and pyelonephritis as per the EOLAS ANTIMICROBIAL GUIDELINE.

2.5.4. If sepsis or pyelonephritis is ruled out, check all for new signs/symptoms of UTI.

- New onset dysuria alone.

Or 2 or more of the following signs and symptoms:

- Temperature 1.5°C above patient's normal twice in the last 12 hours.
- New frequency or urgency.
- New incontinence.
- New or worsening delirium or functional decline.
- New suprapubic pain.
- Visible haematuria.

If fever and delirium or functional decline only, exclude other infections before treating for UTI (see section 2.4.8).

2.5.5. If UTI is suspected, a pre-treatment mid-stream specimen of urine (MSU) should be sent, and previous microbiology results reviewed prior to prescribing antibiotics.

2.5.6. If mild symptoms and low risk of complications, consider back-up antibiotics in women with low risk of complications or offer immediate antibiotics for lower UTI and offer immediate antibiotics in men.

2.5.7. If urine sample is sent for urine culture, it will undergone urine microscopy first. Follow up urine microscopy result on Day 1, and if negative and patient is not on the risk group category, urine culture will

not be conducted. Consider other diagnosis in this instance.

2.5.8. If urine culture is conducted, follow up urine culture results on **Day 2** and review antibiotics with changes made according to sensitivities.

2.5.9. Where microscopy is negative and culture is conducted because of the risk group, a positive culture may still indicate contamination so results should still be interpreted in the light of clinical risk factors and progress.

2.5.10. If patient presents with fever and delirium or functional decline only consider other causes before treating for UTI. Using 'PINCH ME' can help identify other potential causes of delirium superimposed on dementia. Consider other local or national guidance for delirium management.

- **P**ain.
- Other **I**nfection.
- Poor **N**utrition.
- **C**onstipation.
- Poor **H**ydration.
- Other **M**edication.
- **E**nvironmental change.

2.5.11. If worsening signs and symptoms, consider to start/change antibiotics and consult with microbiologists. Check for signs and symptoms suggesting other infections such as respiratory tract infection, gastrointestinal tract infection and skin and soft tissue infection and treat accordingly.

2.6. Management of Suspected Catheter- associated UTI (CAUTI) in Adult Patients

2.6.1. Do not perform urine dipstick to diagnose UTI. Use signs and symptoms to determine the most appropriate management. Between 2-7% of patients with indwelling urethral catheters acquire bacteriuria each day, even with the application of best practice for insertion and care of the catheter. All patients with a long-term indwelling catheter are bacteriuric, often with two or more organisms.

2.6.2. Signs and symptoms compatible with CAUTI include:

- temperature – 38°C or above; 36°C or below; 1.5°C above normal twice in the last 12 hours
- localised symptoms or signs of a UTI if a catheter has been recently removed, including:
  - new onset dysuria; incontinence; urgency.

- non-specific signs of infection – for example, delirium; loss of diabetic control.

See rationale.

2.6.3. In patients with spinal cord injury, increased spasticity, autonomic dysreflexia, or sense of unease are also compatible with catheter associated UTI.

2.6.4. Consider potential for sepsis see *Sepsis in Adult Patients Clinical Guideline*, and exclude Pyelonephritis by checking for any one sign:

- Kidney pain or tenderness in back, under ribs
- New or different myalgia, or flu-like symptoms
- Nausea or vomiting (excluding gastrointestinal infection)
- Shaking chills (rigors) or temperature over 37.9°C or 36°C or below.

2.6.5. If there is no other urinary symptoms or kidney pain or tenderness in the back but patient is showing signs of sepsis or pyelonephritis, rule out other localised infection and see Section 2.4.8.

2.6.6. If urinary catheter is more than 7 days, consider changing or removing as soon as possible. Do not delay antibiotic treatment.

2.6.7. Collect urine specimen before antibiotic treatment to inform definitive treatment. If catheter is changed, collect sample from the new catheter, or obtain an MSU if catheter is removed. Ensure to label the urine specimen with accurate clinical information including urinary catheter use.

2.6.8. Start antibiotic for upper UTI (Pyelonephritis) or sepsis using the EOLAS ANTIMICROBIAL GUIDELINE.

2.6.9. Consider antibiotic resistance risk by checking previous microbiological specimen result and history.

2.6.10. If urine sample is sent for urine culture, it will undergone urine microscopy first. Follow up urine microscopy result on Day 1, and if negative and patient is not on the risk group category, urine culture will not be conducted. Consider other diagnosis in this instance.

2.6.11. If urine culture is conducted, follow up urine culture results on **Day 2** and review antibiotics with changes made according to sensitivities.

2.6.12. Where microscopy is negative and culture is conducted because of the risk group, a positive culture may still indicate contamination so results should still be interpreted in the light of clinical risk factors and progress.

- Urinary catheter management considerations include checking for catheter blockage and consider catheter removal if indwelling urinary catheter for over 7 days.

- Check bag positioning and constipation.
- Consider time-limited antibiotic prophylaxis for people with a history of symptomatic UTI after catheter change or an experience of trauma (frank haematuria after catheterisation or 2 or more attempts of catheterisation)
- Complete a urinary catheter care plan. Check the catheter at least twice daily and review indication.
- Ensure patient with urinary catheter are given a urinary catheter passport.

2.6.13. Do not treat catheterised patients with asymptomatic bacteriuria with an antibiotic. Only send urine samples for laboratory culture if the patient has clinical sepsis, not because the appearance or smell of the urine suggests that bacteriuria is present.

2.7. **Management of Suspected UTI in pregnant women.**

2.7.1. Urinary tract infections occur commonly during pregnancy. UTIs include acute cystitis, pyelonephritis, and asymptomatic bacteriuria (positive urine culture in an asymptomatic woman). Approximately 1–4 % of pregnant women experience acute cystitis and the incidence of asymptomatic bacteriuria during pregnancy ranges from 2–10 %. Asymptomatic bacteriuria during pregnancy has been associated with an increased risk of pre-term delivery and low birth weight. In addition, if untreated, 20–40% of pregnant women with asymptomatic bacteriuria may develop pyelonephritis later in pregnancy. Antibiotic treatment for asymptomatic bacteriuria is therefore indicated in pregnant women to reduce the risk of pyelonephritis. The choice of antibiotic should be guided by the known sensitivities.

2.7.2. Pregnant women with acute cystitis commonly present with symptoms of dysuria, urgency, and frequency, without evidence of systemic illness. In such cases a urine specimen must be sent for culture and treatment commenced. Review sensitivities of any previous specimens (including community samples) to inform antibiotic choice. Treat as per the EOLAS ANTIMICROBIAL GUIDELINE.

2.7.3. Acute pyelonephritis should be suspected if signs or symptoms of a urinary tract infection (for example, dysuria, frequency, urgency) accompanied by any new signs or symptoms of pyelonephritis (including fever, nausea, vomiting, or flank pain) are present. A urine specimen must be sent for culture. Review sensitivities of any previous specimens (including community samples) to inform antibiotic choice. See EOLAS ANTIMICROBIAL GUIDELINE for treatment of Pyelonephritis.

2.7.4. If urine sample is sent for urine culture, it will undergone urine microscopy first. Follow up urine microscopy result on Day 1, and if negative and patient is not on the risk group category, urine culture will not be conducted. Consider other diagnosis in this instance.

2.7.5. If urine culture is conducted, follow up urine culture results on **Day 2** and

review antibiotics with changes made according to sensitivities.

2.7.6. Where microscopy is negative and culture is conducted because of the risk group, a positive culture may still indicate contamination so results should still be interpreted in the light of clinical risk factors and progress.

2.7.7. Seek microbiologist advice if required.

2.7.8. A follow-up urine culture can be requested one to two weeks after the antibiotic course has been completed to ensure eradication.

2.7.9. Paracetamol can be used to relieve pain associated with acute cystitis.

3. Monitoring compliance and effectiveness

This part must provide information on the processes and methodology for monitoring compliance with, and effectiveness of, the policy using the table below.

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Diagnosis of UTIs based on signs and symptoms and not on inappropriate urine dip stick use.
Lead	Antibiotic stewardship team.
Tool	Audit and review tool on a word or excel spreadsheet.
Frequency	Six monthly audit to be included in the antibiotic stewardship section of the annual Infection Prevention Control report.
Reporting arrangements	Infection Prevention and Control Committee.
Acting on recommendations and Lead(s)	The Antibiotic Stewardship Committee to co-ordinate the required actions from the audit.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a month. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Urinary Tract Infections in Adults Clinical Guideline V4.0.
This document replaces (exact title of previous version):	Urinary Tract Infections in Adults Clinical Guideline V3.1.
Date Issued/Approved:	28 May 2025.
Date Valid From:	June 2025.
Date Valid To:	June 2028.
Directorate/Department responsible (author/owner):	Rashima Hamdan, Senior IPAC Specialist Practitioner.
Contact details:	01872 254969.
Brief summary of contents:	Guidance on the appropriate assessment, treatment and management of adults presenting with suspected urinary tract infection.
Suggested Keywords:	Urinary Tract Infection, UTI.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Nursing Officer.
Approval route for consultation and ratification:	IPAC Committee.
Manager confirming approval processes:	Rashima Hamdan, Senior IPAC Specialist Practitioner.
Name of Governance Lead confirming consultation and ratification:	Joanne Taylor.
Links to key external standards:	None required.
Related Documents:	Health Improvement Scotland (2012) SIGN 88 Management of suspected bacterial urinary tract infection in adults. http://www.sign.ac.uk/pdf/sign88.pdf

Information Category	Detailed Information
	NICE (2015) Urinary tract infections in adults. Quality Standard (https://www.nice.org.uk/guidance/qs90) European Association of Urology Guidelines on Urological Infections: Summary of the 2024 Guidelines (https://www.europeanurology.com/article/S0302-2838(24)02263-2/fulltext) UKHSA (2025) Diagnosis of UTI: Quick Reference Tools for Primary Care (https://www.gov.uk/government/publications/urinary-tract-infection-diagnosis) RCHT *Sepsis in Adult Patients Clinical Guideline* NICE (2018) Urinary tract Infection (lower): antimicrobial prescribing (https://www.nice.org.uk/guidance/ng109) RCHT EOLAS Antimicrobial Guideline (https://app.eolasmedical.com/access-link/38552d71-5c2d-4eb1-9d66-678fd95ab454) NICE (2025) Recurrent UTI (no haematuria, not pregnant or catheterised) (https://cks.nice.org.uk/topics/urinary-tract-infection-lower-women/management/recurrent-uti-no-haematuria-not-pregnant-or-catheterized/)
Training Need Identified?	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical/Corporate Clinical.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
29.07.2016	V1.0	New guidelines.	Louise Dickinson Consultant Nurse. Richard Bendall Microbiologist.
01.04.2019	V2.0	Guidance in line with PHE 2018 UTI management document.	Ronan Sheehan and Neil Powell, Pharmacist.
08.04.2022	V3.0	Updated guideline as per PHE UTI diagnosis 2020.	Rashima Hamdan, Staff Nurse.
08.04.2022	V3.1	Minor amendment to Summary, swapped advice paragraph and title.	Rashima Hamdan, Staff Nurse.
07.05.2025		Full review in line with the UKHSA Diagnosis of urinary tract infections: quick reference tools for primary care published May 2025, and NICE guidelines. Updated the diagnostic flowcharts. Added and updated hyperlinks within the document. Added link to the EOLAS Antimicrobial Guideline. Updated UTI in pregnant women as per NICE Guidelines 2025. Added advice to follow up urine microscopy and culture results. Updated approval route. Reformatted in line with current Trust template.	Rashima Hamdan, Senior IPAC Specialist Practitioner

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All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Urinary Tract Infections in Adults Clinical Guideline V4.0.
Directorate and service area:	Corporate Clinical.
Is this a new or existing Policy?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Rashima Hamdan, Senior IPC Specialist Practitioner.
Contact details:	01872 254969.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To ensure patients presenting with symptoms of Urinary Tract Infections are assessed and treated appropriately.
2. Policy Objectives	To provide guidance to medical and nursing staff on the correct management of patients with suspected Urinary Tract Infections.
3. Policy Intended Outcomes	To treat patients with suspected urinary tract infections appropriately.
4. How will you measure each outcome?	Six monthly audits.
5. Who is intended to benefit from the policy?	Patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Microbiologists, Eldercare team, Pharmacists, Urology, Gynaecology.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	Infections may affect any age.
Sex (male or female)	No	Infections may affect any gender.
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	Infections may affect all people.
Race	No	Infections may affect any groups.
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Infections may affect all regardless of disability.
Religion or belief	No	Infections may affect any religion.
Marriage and civil partnership	No	Infections may affect all people – married or otherwise.

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	Infections may affect people in pregnancy.
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	Infections may affect all regardless of sexual orientation.

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Rashima Hamdam, Senior IPAC Specialist Practitioner.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis