

Introduction

At least 25 percent of antibiotic prescriptions in nursing homes do not meet clinical guidelines for prescribing. This use and overuse of antibiotics results in side effects and drug-resistant bacteria. The Communication and Decisionmaking for Four Infections toolkit aims to reduce inappropriate prescribing for the four infections for which antibiotics are most frequently prescribed in nursing homes:

- (1) Urinary tract infections (UTIs)
- (2) Lower respiratory tract infections
- (3) Skin and soft tissue infections
- (4) Gastrointestinal infections

Source: <https://www.ahrq.gov/nhguide/toolkits/determine-whether-to-treat/toolkit2-communications-and-decisionmaking.html>

Determine Whether To Treat

Nursing Home Antimicrobial Stewardship Guide
 Toolkit 2. Common Suspected Infections: Communication and Decisionmaking for Four Infections

Tool 3. QI Meetings Tip Sheet

Having a Quality Improvement (QI) Team and QI team meetings is important to successfully implement and oversee progress being made

in relation to antibiotic use, infection control, and care practices related to communication with medical care providers using the Medical Care Referral Form or MCRF) and residents and their families (using tools from the Toolkit to Educate and Engage Residents and Family Members).

Based on successful models of QI, it is recommended that:
 Team meetings be held monthly to review progress.
 All individuals responsible for the QI program attend the meetings.
 A team leader be identified who is responsible to:

- Provide an update on progress:
 - how often the MCRF has been used.
 - reviewing changes based on the infection log.
- Convene the meetings and review information from the last month.
- Follow-up on matters identified during the meeting.
- Train or delegate training new staff in the Common Suspected Infections: Tools to Improve Communication and Decision making toolkit.
- Work with staff to assure that all current residents and families, new residents, and those considering hospice receive information about antibiotics. Sample information tools are provided in the Toolkit to Educate and Engage Residents and Family Members.

Meeting Considerations

- Who will complete the MCRF
- When monthly meetings will be held
- Other

Core Elements of Antibiotic Stewardship

Summary of Core Elements for Antibiotic Stewardship in Nursing Homes

- Leadership commitment**
 Demonstrate support and commitment to safe and appropriate antibiotic use in your facility
- Accountability**
 Identify physician, nursing and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities in your facility
- Drug expertise**
 Establish access to consultant pharmacists or other individuals with experience or training in antibiotic stewardship for your facility
- Action**
 Implement **at least one** policy or practice to improve antibiotic use
- Tracking**
 Monitor **at least one** process measure of antibiotic use and **at least one outcome** from antibiotic use in your facility
- Reporting**
 Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff
- Education**
 Provide resources to clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improving antibiotic use

Where Systemic Antibiotics Generally Not Indicated



12 Common Nursing Home Situations in Which Systemic Antibiotics are Generally Not Indicated

1. Positive urine culture in an asymptomatic resident.
2. Urine culture ordered solely because of change in urine appearance.
3. Nonspecific symptoms or signs not referable to the urinary tract, such as falls or mental status change (with or without a positive urine culture).
4. Upper respiratory infection (common cold).
5. Bronchitis or asthma in a resident who does not have COPD.
6. "Infiltrate" on chest x-ray in the absence of clinically significant symptoms.
7. Suspected or proven influenza in the absence of a secondary infection (but DO treat influenza with antivirals).
8. Respiratory symptoms in a resident with advanced dementia, on palliative care, or at the end of life.
9. Skin wound without cellulitis, sepsis, or osteomyelitis (regardless of culture result).
10. Small (<5cm) localized abscess without significant surrounding cellulitis (drainage is required of all abscesses).
11. Decubitus ulcer in a resident at the end of life.
12. Acute vomiting and/or diarrhea in the absence of a positive culture for shigella or salmonella, or a positive toxin assay for Clostridium difficile

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