UW TASP tele-antimicrobial stewardship program | echo

The Big Goal in Stewardship: Behavior Change

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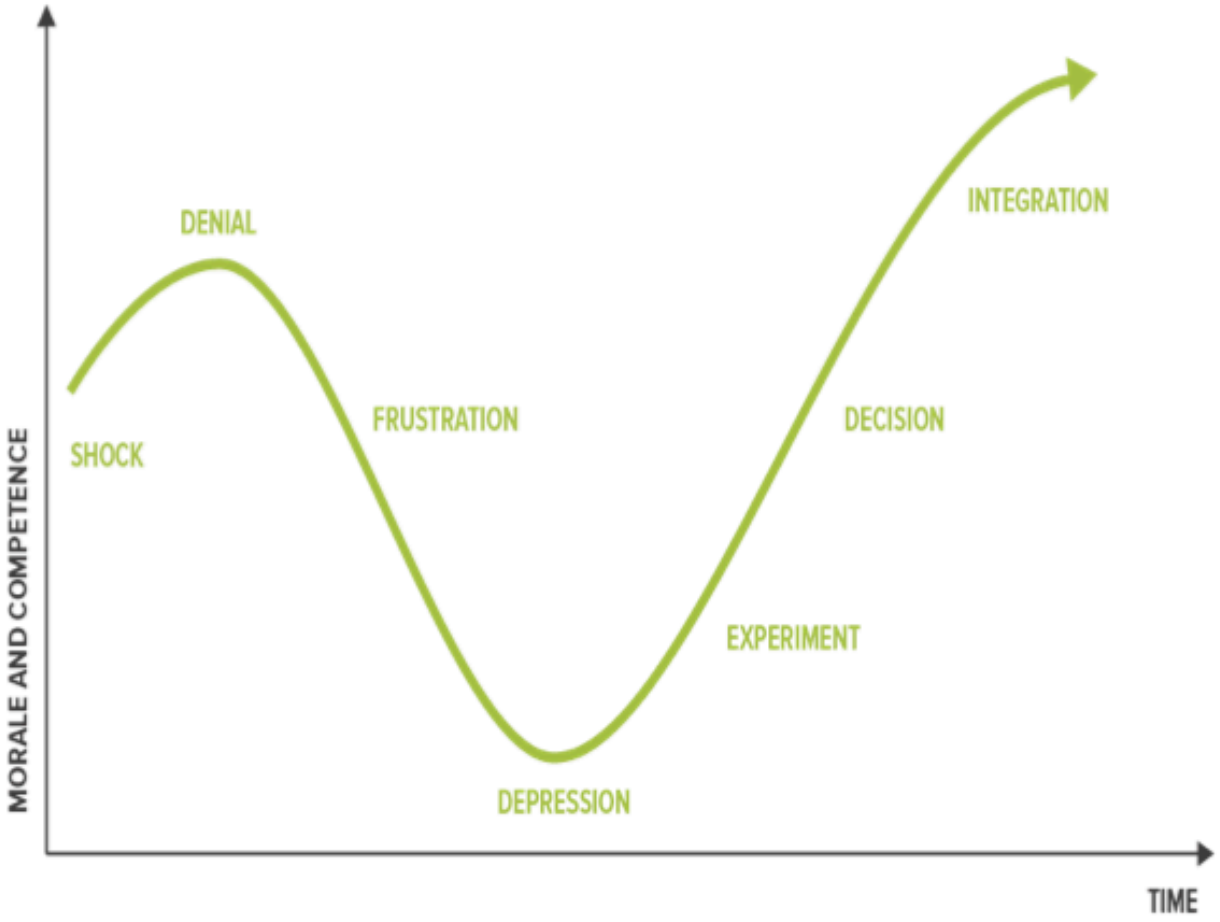
The Stewardship Team

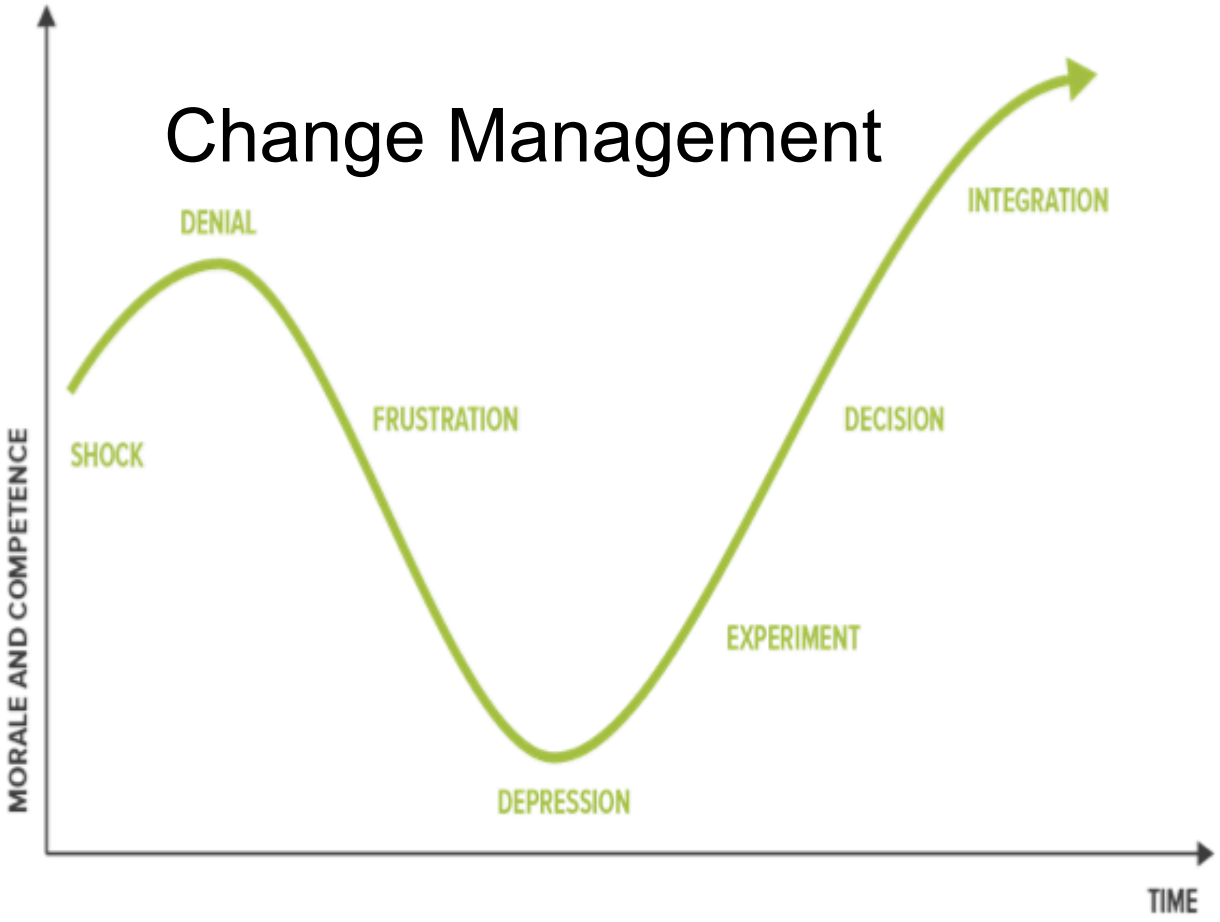
We may run the ASP, but everyone who pays for, takes, orders, reviews, fills, delivers, and administers is an antimicrobial steward.

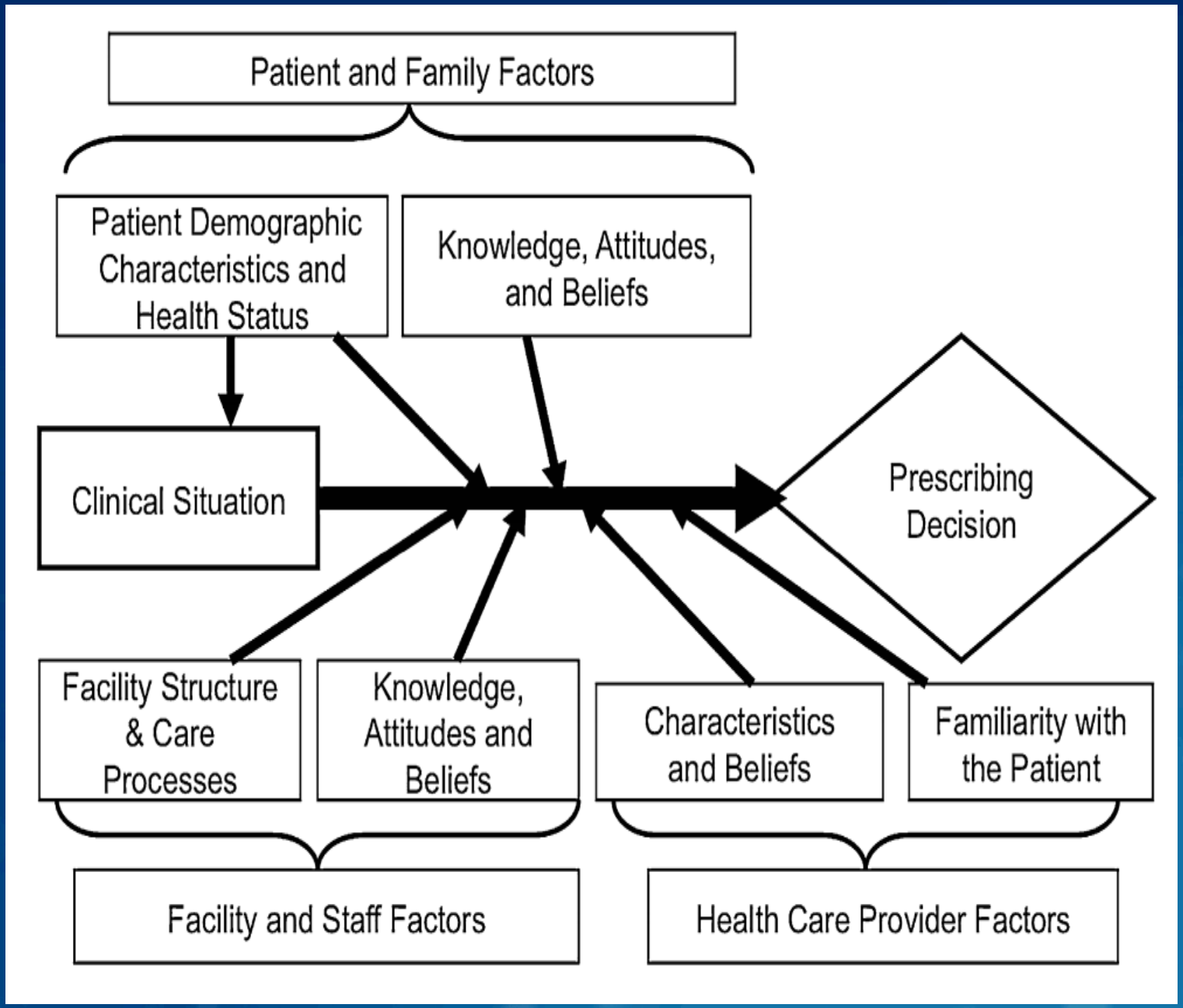
- **Prescribers**
  - Follow site specific guidelines where possible or other guidelines
  - Differentiate between true MDRO risk and being “really sick”
  - De-escalate antibiotics ASAP based on data
  - Listen to the team clinical pharmacist
- **Non-prescribers**
  - Pharmacists have to be leaders and content experts on antimicrobials, have to be able to interpret micro data and de-escalate
  - Microbiologists need to produce timely results and have to explore newer technologies with quicker turn around times
  - Infection control practitioners should provide quality surveillance data
  - Administrators must recognize the value of great pharmacists, microbiologists, and ICPs, and support their participation in the ASP
- **Patients & Families**

Kubler-Ross Curve



Kubler-Ross Curve





Crnich, Drugs Aging, 2015

Antibiotic Prescribing Behavior (etiquette)

The APB of healthcare professionals is governed by a set of cultural rules. Antimicrobial prescribing is performed in an environment where **the behavior of clinical leaders or seniors influences practice of junior doctors**. **Senior doctors consider themselves exempt** from following policy and practice within a culture of perceived autonomous decision making that relies more on personal knowledge and experience than formal policy. Prescribers identify with the clinical groups in which they work and adjust their APB according to the prevailing practice within these groups. **A culture of "noninterference" in the antimicrobial prescribing practice of peers prevents intervention into prescribing of colleagues**. These sets of cultural rules demonstrate the existence of a "prescribing etiquette," which dominates the APB of healthcare professionals. Prescribing etiquette creates an environment in which professional hierarchy and clinical groups act as key determinants of APB.

Chirani, Clin Infec Dis, 2013

IDWEEK 2015

164. Overtreatment of Asymptomatic Bacteriuria: A Qualitative Study

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Results. In the 21 interviews, the following thematic rationales for antibiotic overtreatment of ASB were reported (in order of reporting frequency): (1) Treating laboratory findings without taking the clinical picture into account (n = 17); (2) Psychological factors such as anxiousness, overcautiousness or anticipated positive impact on patient outcomes (n = 13); (3) External pressors such as institutional culture, peer pressure, patient expectation, and excessive workload that interferes with proper decision-making (n = 9); 4) Difficulty with interpreting clinical signs and symptoms (n = 8).

Conclusion. In this qualitative study we identified both physician-centered factors (e.g. overcautiousness) and external pressors (e.g. excessive workload) as motivators for prescribing unnecessary antibiotics. Also, we interpreted the frequently cited practice of treating asymptomatic patients based on laboratory findings alone as lack of awareness of evidence-based best practices.

Case Study

Dear Dr. X,

I am emailing on behalf of the HMC SCIP Committee and am cc'ing your chair as requested. I wanted to touch base on a SCIP antibiotic fall-out. It was an was an elective left total knee replacement you performed on April 1st on a patient (H#) with a h/o MRSA, but only cefazolin was given as prophylaxis. Any thoughts on why vancomycin wasn't given as in addition to cefazolin?

Thanks, John

Case Study

Hi Dr. Y,

I wanted to follow-up with you on Mr. P (H#), a patient you did a left hemicolectomy on 4/1/15. From our reports, it looks like his antibiotic prophylaxis was continued for 3 days after leaving the OR. I don't see any concerns for infection in the chart but wanted to check with you as well. Unfortunately, as you know, in the absence of infection, this counts as a SCIP fall-out, hence this email.

Much appreciated, John

Case Study

- 65 year old female is admitted to the ICU with septic shock with presumed community-acquired pneumonia (CAP).
- The overnight physician starts meropenem and vancomycin for CAP.
- Your hospital recently put together order sets for CAP that recommend ceftriaxone +/- vancomycin.

How do you approach this physician?

Case Study

- You are staffing in the pharmacy. The doctor stops by and wants to prescribe linezolid 600mg PO BID x 21 days.
- You scan his med list, and notice the pt already taking aspirin and escitalopram. His insurance will cover 20% of the cost of the antibiotics.
- Your thoughts?

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Case Study

- You are staffing in the inpatient pharmacy. An angry anesthesiologist calls asking why cefazolin was sent on his patient who has a penicillin allergy.

- How do you handle this phone call?

Case Study

- An RN in the MICU pages you asking for antibiotic orders on her patient.
- Huh?
- The MD's orders say "antibiotics per pharmacy."
- How do you handle this?

Case Study

- A critically-ill patient in the ICU develops ventilator-associated pneumonia (VAP).
- The MD orders Pip-Tazo, Metro, and Clinda for “presumed aspiration.”
- You are concerned that this coverage may be inappropriate…. The MD wants to hear none of it.
- How do you handle this?

Case Study

- You recommend a dose of gentamicin 1mg/kg every 12 hours with ampicillin.
- The clinical pharmacist working with the primary team recommended a gentamicin dose of 7mg/kg/daily.
- How do you manage this conflict of opinion with your colleague?

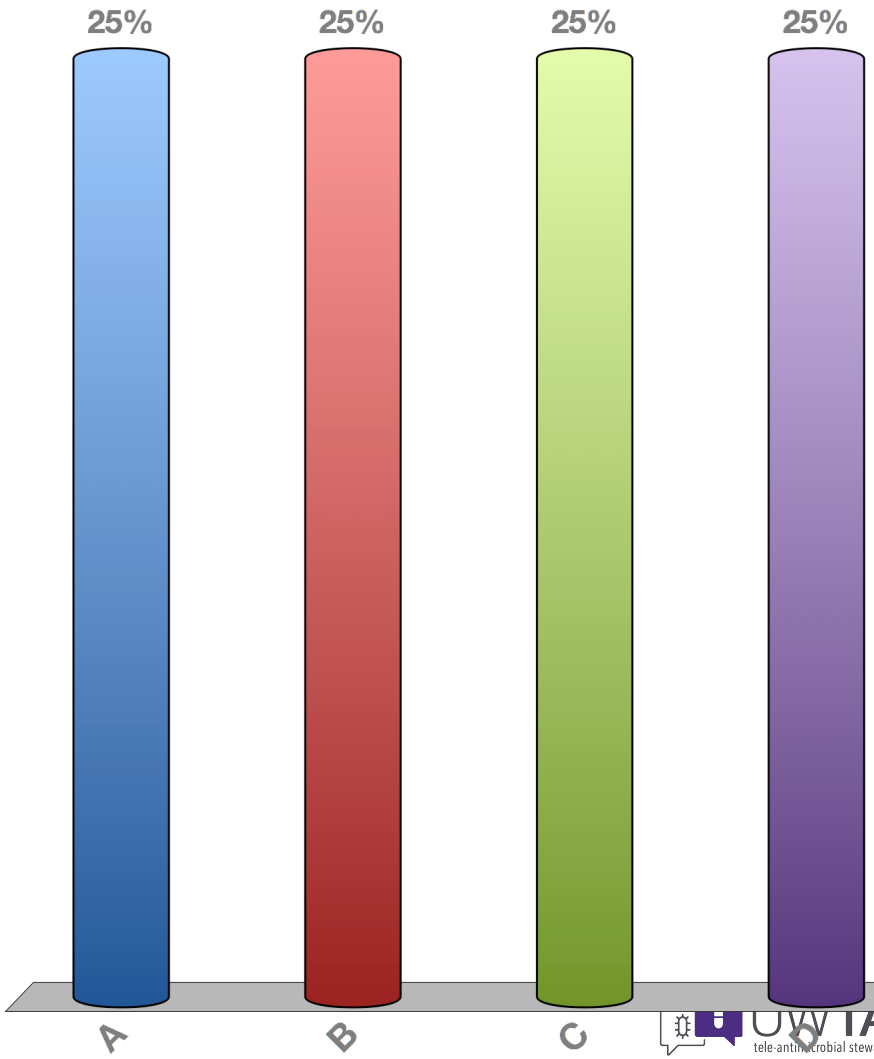
Last Case…

- The head of P&T Committee corners you in the elevator:

- MDR pathogens have increased each of last 6 years in MICU & SICU
- “Shouldn’t we cycle the formulary in order to reduce emergence of resistance?

What is Your Role?

A. Agree
B. Disagree
C. Get off elevator at next stop…
D. “Good question… I’m not sure… let’s set up a meeting to discuss this.”



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Tips for Effective Collaboration

- Know your stuff
- Provide unbiased information
- Make concrete recommendations
- Be concise
- Be confident
- Be aware that you may not know the whole story….humility is KEY
- Keep the lines of communication open
- Focus on building long-term relationships