North Carolina SPICE
Statewide Program for Infection Control & Epidemiology

North Carolina Clinical Antibiotic Stewardship Partners

LONG-TERM CARE COMMUNITIES ANTIBIOTIC STEWARDSHIP SESSION #2

March 15, 2022

CONFLICT OF INTEREST DISCLOSURES

- The views and opinions expressed in this series are those of the speakers and do not reflect the official policy or position of any agency of the U.S. or NC government or UNC.
- Our speakers have the following financial relationships with the manufacturer(s) and/or provider(s) of commercial services discussed in this activity:
  - Dr. Kistler served as a consultant for Base10, Inc on their UTI embedded clinical support tool and received funding from Pfizer to study pneumococcal carriage.
  - Dr. Willis has performed contracted research with: Pfizer (pediatric nirmatrelvir-ritonavir and maternal RSV vaccine), Novavax (pediatric COVID-19 vaccine), and Merck (monoclonal antibody for RSV prevention)
  - Ms. Doughton owns individual Gilead stock.
- The speakers do not intend to discuss an unapproved/investigative use of a commercial product/device in this series, and all COI have been mitigated.
- These slides contain materials from a variety of colleagues, Drs Philip Sloane and David Weber, as well as the CDC, WHO, AHRQ, etc.

OUTLINE OF TODAY'S SESSION

1. NC CLASP reminders
2. Let's Review Smart Aims
3. Small Group Discussion
4. Didactics on Education for Staff, Family, and Prescribers
5. Clinical Case
6. Share your story

SESSION REMINDERS

- This time is for you and your learning.
- Please turn on your videos!
  - Cameras on
  - Stay muted unless speaking
- Use the chat
- Let’s use and share our learning, but not in a way that identifies protected information.

SESSION GREETINGS!

Please put your name, nursing home community, and location in the chat!

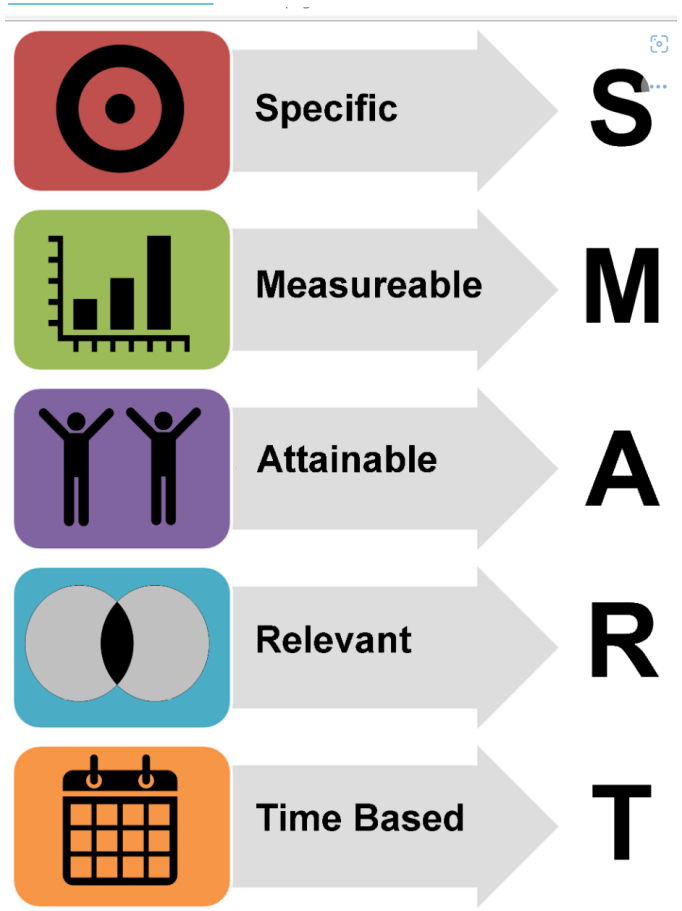
NC CLASP REMINDERS

- If you need to get a hold of us, please email:
  - Danielle.Doughman@unchealth.unc.edu
- Complete our survey- it will help us help you!

SMART AIMS AND RELIABLE PROCESSES

GOAL: IMPROVE COMMUNICATION WITH FAMILIES AND RESIDENTS ABOUT APPROPRIATE ANTIBIOTIC USE.

FROM GENERAL TOPIC TO SMART AIM



Specific: What will the goal accomplish? Who is the target population?

Measurable: How much change? Increase or decrease? How will you know whether you reached your goal?

Attainable: Is it possible in the time you have specified? Does your team have the resources to do it?

Relevant: Is the goal in line with your organization's mission/vision? Does it pass the 'so what' test?

Time-based: By when?

GOAL: IMPROVE COMMUNICATION WITH FAMILIES AND RESIDENTS ABOUT APPROPRIATE ANTIBIOTIC USE.

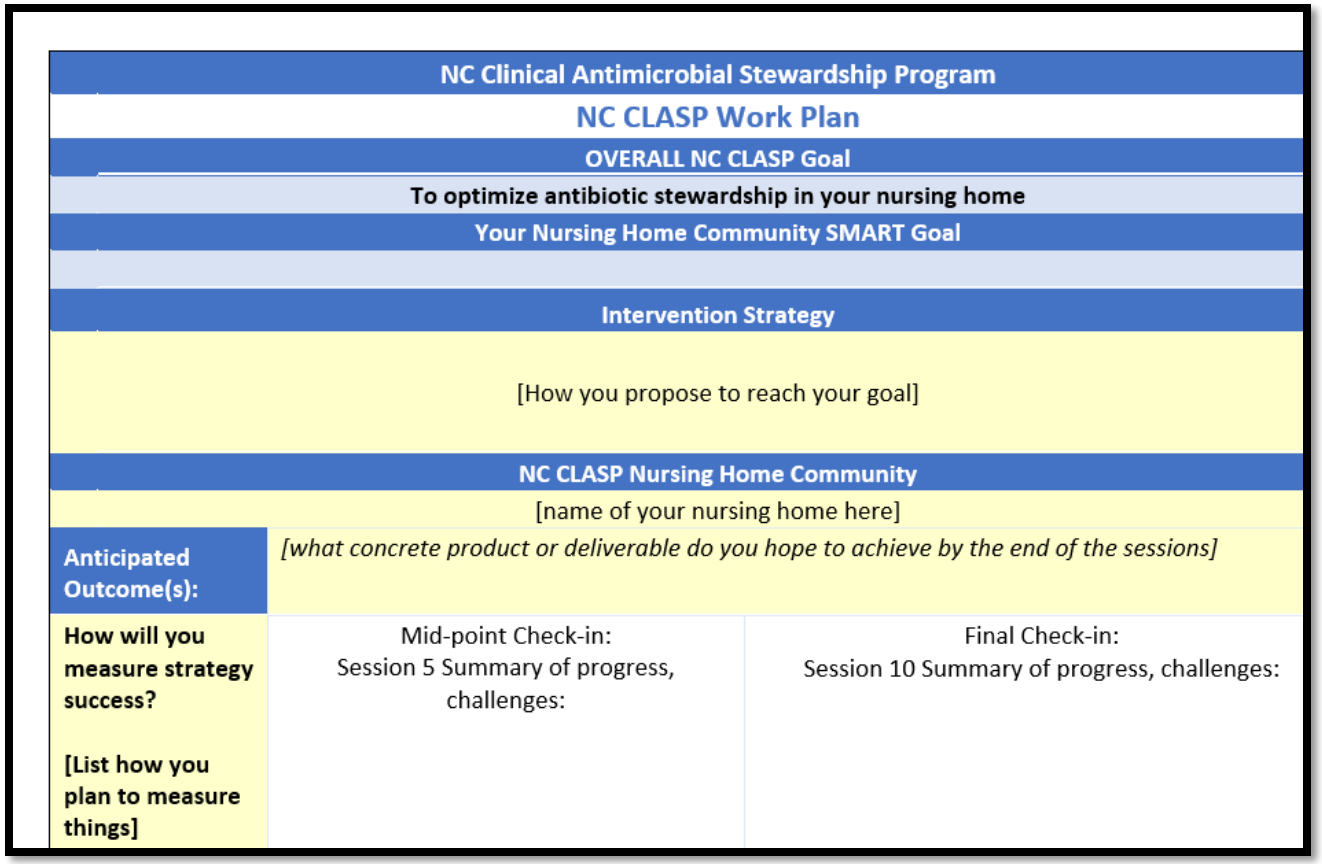
The goal statement helps to identify a measurable goal that is to be achieved during a given time period.

S	**Specific**	Identify the exact process you are targeting, including what/who is included or specifically excluded.	
M	**Measurable**	Identify at least one or more specific measurement that will tell you change was an improvement.	
A	**Attainable**	Ensure the improvement can be completed in the time allotted with the resources available.	
R	**Relevant**	Ensure the project is strategically aligned and the appropriate parties are accountable to the work.	
T	**Time-Bound**	Always include the deliverable or end date.	

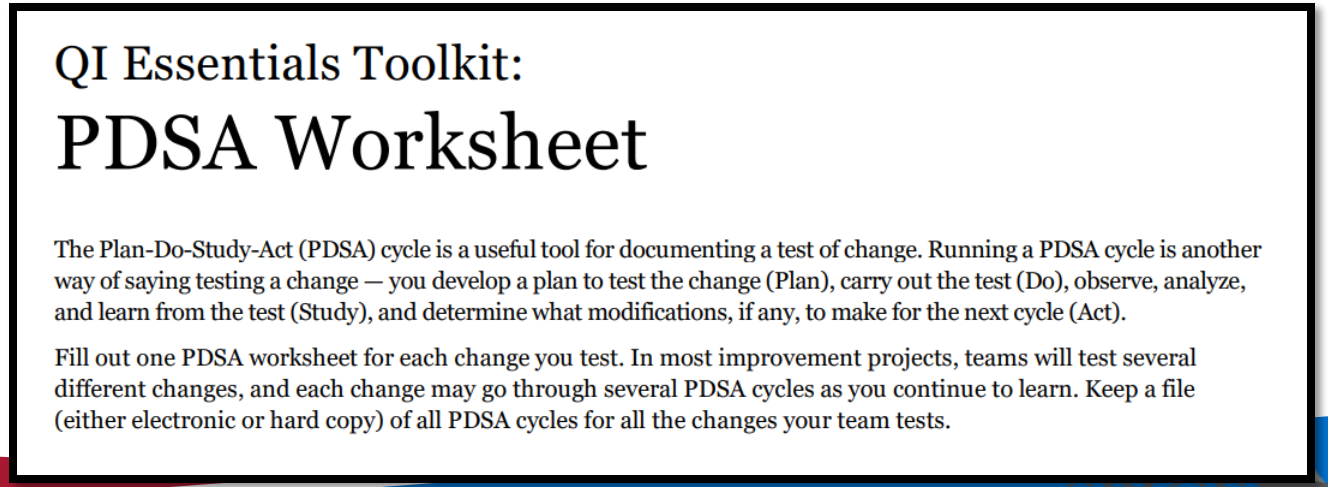
NC CLASP WORK PLAN

- Worksheet to help document goals, activities, and outcomes
- Tool to help share learning and progress, not for judgment!!

https://spice.unc.edu/ncclasp/nursinghomes/



NC Clinical Antimicrobial Stewardship Program		
NC CLASP Work Plan		
OVERALL NC CLASP Goal		
To optimize antibiotic stewardship in your nursing home		
Your Nursing Home Community SMART Goal		
Intervention Strategy		
[How you propose to reach your goal]		
NC CLASP Nursing Home Community		
[name of your nursing home here]		
Anticipated Outcome(s):	*[what concrete product or deliverable do you hope to achieve by the end of the sessions]*	
How will you measure strategy success? **[List how you plan to measure things]**	Mid-point Check-in: Session 5 Summary of progress, challenges:	Final Check-in: Session 10 Summary of progress, challenges:



QI Essentials Toolkit:

PDSA Worksheet

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change — you develop a plan to test the change (Plan), carry out the test (Do), observe, analyze, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Fill out one PDSA worksheet for each change you test. In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file (either electronic or hard copy) of all PDSA cycles for all the changes your team tests.

COMMUNITY SMART AIM

- We are very grateful for Kristen Murray, MSN, RN from Trinity Oaks for sharing her SMART aim!

WHAT IS OUR *CURRENT* PROCESS FOR COMMUNICATING WITH RESIDENTS AND FAMILIES ABOUT APPROPRIATE USE OF ANTIBIOTICS?

Ask 5 staff				
WHO does it	WHEN should it be done	WHERE is it done	HOW is it done	WHAT is needed to do it

If all staff can provide consistent answers high likelihood it is reliable

WHAT IS OUR CURRENT PROCESS FOR COMMUNICATING WITH RESIDENTS AND FAMILIES? IS IT RELIABLE?

Common failure

(More than 1 of the 5 Cannot Articulate the Process)

- Don't rely too heavily on education as THE FIX
- Get CURIOUS to determine WHY this is occurring
- Inform staff on the WHY:
  - WHY is this process important
  - WHY do we do it this way
- Get CURIOUS – WHY is the process NOT being followed???
- Develop a plan to fix ONE attribute
- Keep it SIMPLE!

Infrequent failure

(Only 1 of the 5 Cannot Articulate the Process)

- Infrequent does NOT mean you have a bad process.
- Don't try to make it perfect – you will use up too many precious resources.
- Talk to that one person to reeducate or determine WHY it is occurring.
  - Determine if there is a simple fix
- MOVE ON to focus on another process

SPICE

GOAL: IMPROVE COMMUNICATION WITH FAMILIES AND RESIDENTS ABOUT APPROPRIATE ANTIBIOTIC USE.

If you have a current process that does NOT work so well...

Determine if it is a COMMON or INFREQUENT failure.

OBSERVE the process or review 3 recent cases to see where the failure points occurred.

Fix ONE Attribute (who, when, where, how, what) at a time

Remember-- Keep it simple!

It's more important to have a standard process than a perfect process—when you design for perfection, you get overly complex protocols.

What is your current process for communicating with residents and families about use of antibiotics? (Who, when, where, what, how?)

Is it reliable?

What changes can you make to standardize and improve the process?

SMALL GROUP DISCUSSION

POLL EVERYWHERE

- Does your facility provide educational resources and materials about antibiotic resistance and opportunity for improving antibiotic use?

❑ Yes

❑ No

If yes, indicate which of the following are being tracked (select all that apply)

- ❑ Clinical providers (e.g., MDs, NPs, PAs, PharmDs)
- ❑ Nursing staff (e.g., RNs, LPNs, CNAs)
- ❑ Residents and families ❑ Other:_____

EDUCATION

- Disease specific education
  - •for staff (in services etc)
  - •residents/families on the diagnosis and management of disease specific infections (handouts or presentations)
  - •physicians/APPs
- Harms of antibiotic use and overuse
  - •for staff
  - •residents/families on the harms of antibiotic use and overuse
  - •physicians/APPs

STAFF

- Disease specific education
  - Communication tips from AHRQ

https://www.ahrq.gov/antibiotic-use/long-term-care/best-practices/posters.html

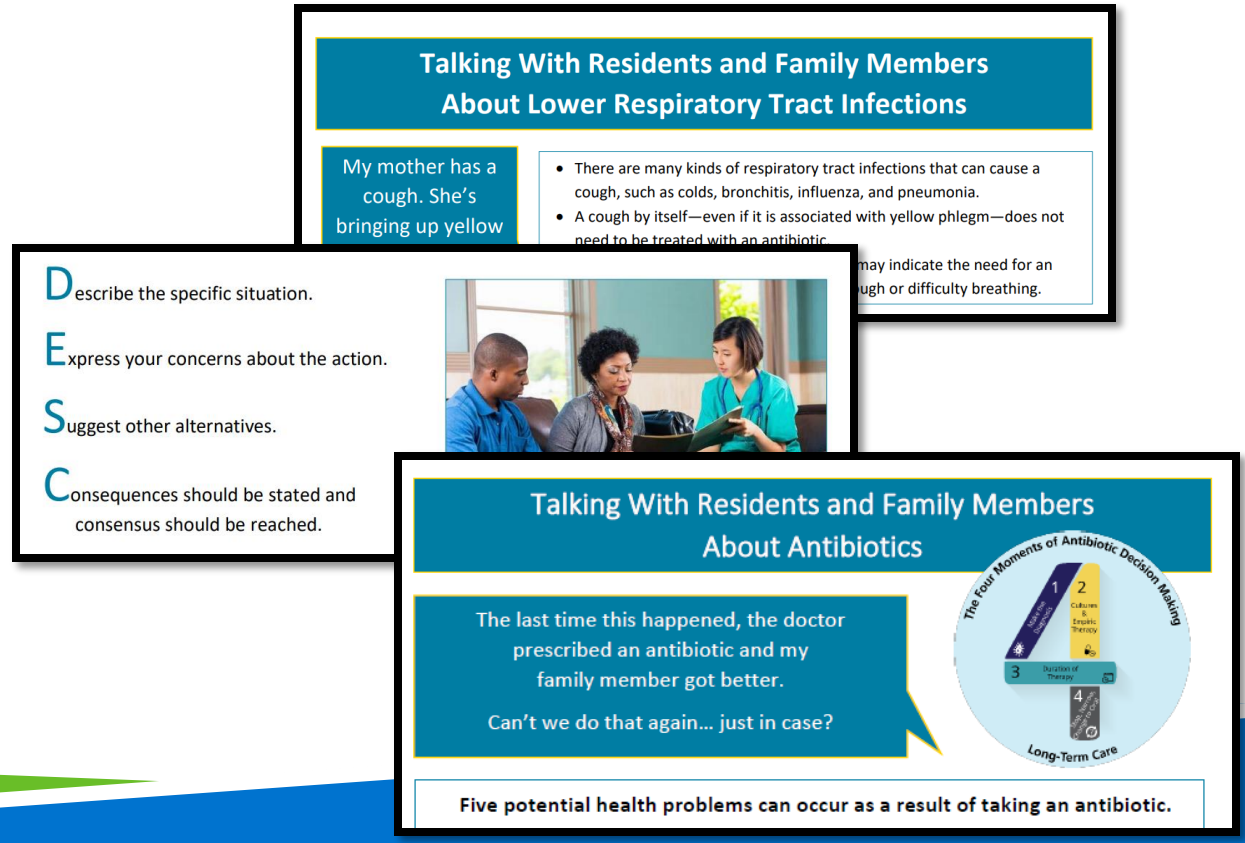
https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes/implementation.html

  - Conflict mediation
  - "How to" information
    - How to collect a culture, etc
  - Treatment Guidelines

https://www.rochesterpatientsafety.com/index.cfm?Page=For%20Nursing%20Homes

- Antibiotic harm education

https://www.ahrq.gov/antibiotic-use/long-term-care/improve/discuss-family.html



RESIDENTS AND FAMILIES

- Disease specific education

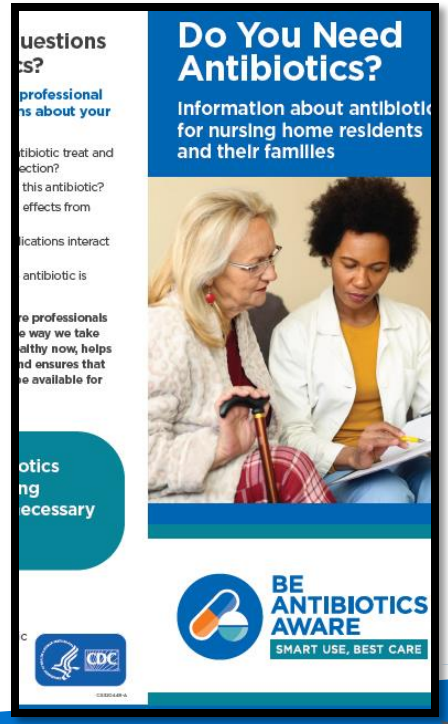
https://www.cdc.gov/antibiotic-use/common-illnesses.html

https://www.ahrq.gov/antibiotic-use/long-term-care/improve/discuss-family.html

- Antibiotic harm education

https://www.cdc.gov/antibiotic-use/

  - US Antibiotic Awareness week is November 18-24th.



MEDICAL PRESCRIBERS

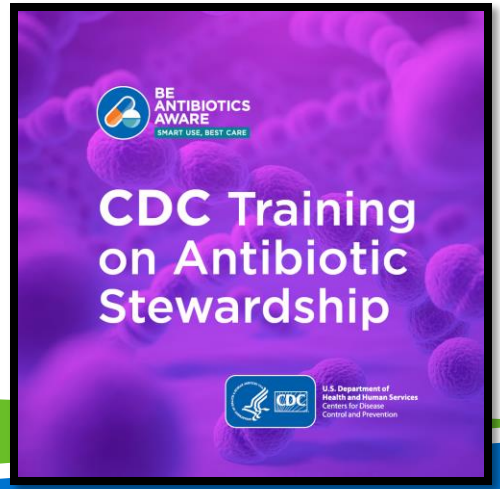
- Disease specific education

https://www.train.org/cdctrain/training_plan/3697

  - Several hours of free CME for physicians

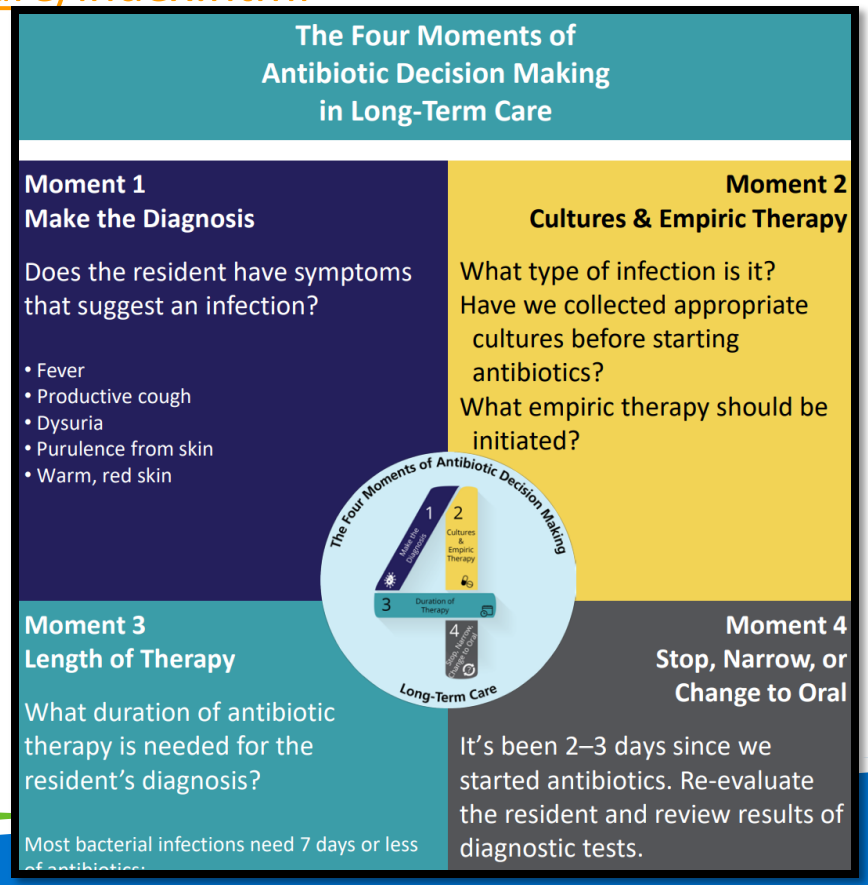
- Pocket cards and one-pagers for health care providers

https://www.ahrq.gov/antibiotic-use/long-term-care/best-practices/posters.html



- Antibiotic harm education

https://www.ahrq.gov/antibiotic-use/long-term-care/index.html



Mrs. Smith's son is concerned his mother did not sound like herself on the phone. He is worried that his mother may have a UTI and needs an antibiotic.

CLINICAL CASE- FROM EVENT TO OUTCOME

Clinical Event

Son calls NH and complains to RN about her possible UTI.

WHAT WOULD YOU DO?

Evaluation by R.N. or M.D.

RN evaluates resident. She is less talkative today. No complaints of dysuria or urgency, no other sxs suggestive of an infection. Exam negative for fever, lung findings, or abdominal tenderness. Her urine is dark and cloudy.

WHAT WOULD YOU DO?

Decision To Prescribe Antibiotic

Leading diagnosis is dehydration. Communicate this to RN and son. Tell son that abx won't help but instead we will push oral hydration, consider IV fluids, and monitor her closely for the next 24 hours. Son is angry about this news.

WHAT WOULD YOU DO?

Outcome

WHAT DO YOU WANT TO HAPPEN? WHAT DO YOU DO?

Discuss contingency plans; discuss timed toileting, reassessing daily

PRESCRIPTIVE

POST-PRESCRIPTIVE

SPICE

PLEASE TYPE IN THE CHAT ONE POTENTIAL EDUCATIONAL INTERVENTION FOR ANTIBIOTIC STEWARDSHIP THAT YOU CAN TACKLE IN YOUR NURSING HOME.

1. PLEASE COMPLETE THE SURVEY

2. SIGN-UP FOR CASE STUDY OR TO PRESENT YOUR SMART GOALS

(GET A FREE TOTE BAG IF YOU VOLUNTEER FOR THE NEXT SESSION! WE NEED A CASE!)