Medical Staff Education Modules

2015
The Case

• Increased activity with EMTALA Investigations in at least 6 CHS facilities in past 18 months.

• Provider education is requested at each survey.

• Current process: Medical Staff education is provided at MEC meetings, Challenges include: showing education for specific providers with current process, lack of accountability
The Solution

In an effort to satisfy the expectations of regulatory agencies, in conjunction with subject matter experts, Medical Staff Services developed four learning modules that are most frequently requested by surveyors. To ensure completion, modules will be attached to credentialing and re-credentialing. Learning modules include:

- EMTALA
- HIPPA
- Disaster planning
- Pain Management
The Solution

- Education modules will be attached to the new electronic initial and reappointment applications through the Medical Staff Services database.

- Providers will sign an attestation at the conclusion of each module confirming that they have read and understand the content in each module.

- Charlotte AHEC will host a link mapped to the module which will include CME’s.
Decision Points

1) Content Validation.

2) How to ensure that the modules require a minimum of 60 minutes for completion?

3) Is voiceover required?

4) Should it be required as a performance improvement document related to disciplinary actions?
EMTALA
Emergency Medical Treatment & Labor Act
Definition

Emergency Medical Treatment and Labor Act (EMTALA) was established in 1986 as part of COBRA law. It requires hospital Emergency Departments that accept payments from Medicare to provide an appropriate medical screening examination (MSE) to individuals seeking treatment for a medical condition, regardless of citizenship, legal status, or ability to pay. Participating hospitals may not transfer or discharge patients needing emergency treatment except with the informed consent, stabilization of the patient or when their condition requires transfer to a hospital better equipped to administer the treatment.
EMTALA is established to prevent uninsured patients from being sent to public facilities for care.
Emergency Medical Condition (EMC)

A condition which presents *acute symptoms of sufficient severity* (including severe pain) such that the absence of immediate medical attention could reasonably result in placing the individuals health or health of an unborn child in serious jeopardy, serious impairment of bodily functions or severe dysfunction of bodily organs.

*Pregnancy EMC* refers to a woman in labor and there is not enough time to safely transfer patient before delivery or transferring the patient could pose a threat to safety and health of patient or her unborn child.
Medical Screening Exam (MSE)

Any qualified medical personnel must determine whether patient has EMC. The exam includes giving physical exam, taking medical history, and ordering ancillary services, such as labs or imaging.

The MSE should be non-discriminatory and not be affected by individuals ability to pay.
A patient is determined “stable” when:

- The treating physician has determined the EMC has been resolved.
- No deterioration of the condition is likely to result from or occur during a transfer within reasonable medical probability.
Transfer of Unstable Patients

If EMC can not be stabilized, the patient can be transferred if all applicable resources have been exhausted to treat the EMC the patient must be transferred to a facility that has capacity and capability to treat patient.
Four Requirements for Transfer

1. Transferring hospital provides medical treatment within its capacity.
2. Receiving hospital agrees to accept patient.
3. Transferring hospital sends all medical records and relevant paperwork with the patient as well as completed transfer paperwork.
4. Qualified personnel and transportation equipment are used for the transfer.

**A Patient CANNOT Be transferred if:**

1. Medical benefits expected from transfer outweigh risks.
2. Patient request not to be transferred after being informed by hospital regarding need for transfer.
On-call Physicians Cannot:

- Refuse to see someone that has been terminated from their private practice.
- Wait until regular office hours to see patient.
- See only people from physician’s practice or only insured patients.
- If a patient is transferred because on call physician failed to take call or another physician had to be called in the on-call physician may be subject to penalties under law.
PENALTIES

• $50,000 fine for hospitals with 100 + beds per violation.

• $50,000 fine for a physician who examines, treats or transfers a patient in violation of EMTALA - not covered by malpractice insurance

• Possible termination from Medicare participation
Emergency Management
Emergency Management Objectives

• **Justification** – It is a Joint Commission Standard

• **Expectations** – To treat patients during an emergency, disaster, or catastrophic event

• **Emergency Response** – Knowing your role during a disaster
Justification

• **The Joint Commission** — EM.02.02.07 EP7 requires hospitals to train all staff assigned Emergency Response roles. EP8 requires that hospitals communicate in writing with each Licensed Independent Practitioner regarding their role(s) in emergency response and to whom they report during an emergency.

• **It’s the Right Thing To Do** - It is our responsibility to provide safe and effective patient care during an emergency event.
Definition of Emergency

An emergency is an unexpected or sudden event that disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand on the organization's services.

The Joint Commission- Emergency Management EM 01.01.01
Purpose Statement

• Organize how the hospital plans response to the effects of potential emergency events that fall on a continuum from disruptive to disastrous.

• The committee is established to uphold the Emergency Management Joint Commission standards by identifying potential hazards, threats and adverse events, mitigate those events and plan how to respond and recover from those events.

• The EM Program works with other entities such as Local and Federal Government, under Homeland Security, DHEC, OSHA, NIOSH (National Institute for Occupational Safety and Health), and NFPA (National Fire Protection Agency).
Expectation

• To report an observed Emergency

• To be available to respond to an Emergency

• Respond to the emergency by:
  – Treating patients within the physician’s scope of practice with available resources and capabilities
  – Provide patient care guidance to other teammates (nurses, CNAs, etc.)
  – Hospital Command Center will establish incident objectives to coordinate everyone’s response efforts
  – Physicians may be required to observe volunteers (Licensed and Non-Licensed) and assess competency levels
Overall Priorities

Incident objectives are established based on the following priorities:

1. Life Saving
2. Incident Stabilization
3. Property Preservation
Emergency Response

- **Emergency Alerts** – Incidents that interrupt daily activities or function of a facility or external disasters: i.e. Facility, Security and Medical Alert.
- **Emergency Notification** – Notified through paging system and/or overhead page
- **Hospital Incident Command (HICS)** - Is an expandable management system that integrates the activities of various agencies or departments during an incident/disaster to manage and guide the response and recovery
- **After Action Review** – Conducted after any emergency event to evaluate and develop strategies to lessen the impact of future similar events
Emergency Alerts

Facility Alerts
• Evacuation
• Fire alarm
• Hazardous materials spill
• Mass casualty
• Medical decontamination
• Utility/technology interruption
• Weather

Security Alerts
• Missing infant/child/adult
• Armed subject/active shooter
• Threat of violence
• Hostage situation
• Suspicious package/bomb threat
• Restricted access

Medical Alerts
• Code Blue = cardiac respiratory distress
Activation Levels

• **Alert Activation (Potential):** Alert Activation is appropriate for something having the potential to produce casualties or disrupt normal business operations, for which advance notice has been received but no impact is noted.

• **Priority 2 Activation (Minor Impact):** Priority 2 Activation is appropriate for an incident with a minor impact on operations. This type of activation typically occurs when an incident impacts one or two departments or a small part of operations, is limited in nature, and is of short duration.

• **Priority 1 Activation (Major Impact):** Priority 1 Activation is appropriate for an incident with significant impact on operations, including the potential for long duration. This type of activation is considered significant, meaning that nearly all normal activities are disrupted and the focus of leadership and teammates is on the incident.
Emergency Operations Plan (EOP)

• Provides a guideline for emergency response, and recovery.

• Supporting Documents:
  – Response Guides
  – Job Action Sheets
  – Hospital Incident Command
Disaster Response Team:
Caring About Patients Means Caring About Privacy
Why Care About Patient Privacy?

• Because you care about your patients.
  – Patients lose trust and confidence in providers who give them another patient’s information or share their information improperly.
  – If you don’t make sure you have the right patient every time, you could give someone the wrong medication, give out the wrong discharge instructions, or document in the wrong record. This could be both very dangerous to the patient and breach their privacy.
    • Remember, if a privacy incident rises to the level of a breach, we have to notify the patient and the government.

• Because you care about your reputation.
  – Being careless with privacy can damage your reputation with your colleagues and your patients.
  – For example, posting on social media about a care situation or making derogatory comments about a patient (even if you take out the name) is both unprofessional and a possible privacy violation. It’s your reputation – take care of it.
Why Care About Patient Privacy?

• Because you care about your medical staff privileges.
  – Inappropriate use, access, or disclosure of patient information will subject you to disciplinary action. This includes accessing patient records when there is no valid treatment relationship.
  – Sanctions for privacy violations by medical staff can include a Letter of Reprimand and even termination of privileges, depending on the situation.

• Because you care about your license.
  – Misusing or wrongfully disclosing patient information is more than a HIPAA violation – it could be grounds for a malpractice action or a complaint to the Medical Board or regulatory agency by a patient.
Why Care About Patient Privacy?

• Because someone may be listening or watching.
  – Be careful of incidental disclosures where someone may overhear what you are saying or where they may see patient information.
    • Lower your voice when in open areas or on the phone.
    • Clean up the patient information off your desk or turn over the papers so the information is not visible to those walking by.
    • Avoid conversations about patients in public places, such as hallways, waiting areas, elevators; be general and do not discuss specifics. Pay attention to who is around you, and use common sense.
  – Log off your computer when you step away. Patients or other people may see the information and share. Some may even start typing in the record – the log will show it was you, even if you weren’t there. Take 3 seconds to lock it down (Ctrl/Alt/Del). It’s worth it.
Why Care About Patient Privacy?

• Because patient information is for patient care, not personal interest.
  – Only use patient information to take care of your patients.
  – Do not access the medical record because you are curious, want to use the information for personal gain, or want to spy on someone.
  – Unless you are on the clinical team caring for the patient, do not use the EMR to access information on family or friends.
  • Get an Authorization from the patient and contact Health Information Management to access the information. This includes if you need information about your own parents, your adult child, or your spouse/partner.
  • If you want to see your own record or your child’s record, go through MyCarolinas, not the EMR. You are acting as a parent, not a provider, and the EMR is only for providers.
Why Care About Patient Privacy?

- **Because accidents happen.**
  - Schedules and notes can fall out of your pockets when you are walking through a facility. Make sure you keep them secure and only put the minimum information on them in case they are lost.
  - Look at every page you print before you hand it out – you may have accidentally picked up someone else’s print job. Don’t assume someone has gone before you and checked.
  - Make sure the right information is put into the right chart. If we release the record to the patient with someone else’s information, it could result in a breach, among other things.
  - Only throw patient information in a locked shred bin, **never** a regular trash can! This includes what’s in your provider mailbox – it may have patient information. Throw it in a shred bin!
  - Never leave patient information in your car or unattended – it could be stolen.
Why Care About Patient Privacy?

- Because your security matters too.
  - Do not send patient information to personal accounts, such as gmail or yahoo. They are not secure and someone could (or has) hacked into them. Use your professional work accounts, including your @carolinashealthcare.org account.
  - Do not click on suspicious links and **never** give out your password!
    - You may receive phishing emails that can allow cybercriminals to infiltrate your home or work accounts. They can then steal your information or your patients’ information, steal your money, and hold your information hostage.
  - Send only **encrypted** emails with patient information so they cannot be read if they are stolen in transit.
  - Do not put patient information on unencrypted thumb drives – you could lose them and create a privacy breach.
Why Care About Patient Privacy?

• Because patients have a right to say no.
  – Taking pictures or recordings of patients requires their consent. If you are using them for treatment, then that consent is in the forms they sign. If you are using it for education or a seminar or research, you will need a separate consent.
  – Be very careful of infection control, and only take pictures on a secure device so the information cannot be stolen if the device is lost.

• Because not everyone needs to know.
  – Patients don’t always want their family/friends to know what is going on with their care.
  – Give the patient a chance to object before talking in front of others. Better yet, clear the room and ask the patient if it’s okay to talk about their care in front of others.
Why Care About Patient Privacy?

- **Because you’re a patient too.**
  - Think about what you would want as a patient.
    - Would you feel that your provider cared about you if you went home with a stranger’s information?
    - Would you be comfortable seeing your provider on Facebook while you were in the hospital?
    - Would you have confidence in your provider if you received a letter saying your information had been stolen because it was sent to an unsecure inbox or left lying in the back seat of a car?
  - We are all patients somewhere. Take care of your patients’ privacy just as you would want yours to be cared for.
Overview of Pain Assessment & Management

2015 Annual Medical Staff Education
Objectives

- Discuss the prevalence of pain, economic impact and barriers that may prevent appropriate pain management

- Explain the pathophysiology of pain with focus on the types of pain and appropriate assessment of pain and recommendations for treatment

- Explore role of adjuvant or co-analgesic therapies in the management of pain
Definition of Pain

• Pain is a multifactorial and multidimensional experience that is unique to the individual (Core Curriculum for APHPC).

• Its an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

• Pain is always subjective....It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore also an emotional experience.
Prevalence of Pain

• **Prevalence:**
  – 116 million U.S. adults have chronic pain conditions
    • More than the number affected by heart disease, diabetes, and cancer combined.
    • Varies according to diagnosis and demographics
  – 50% of patients who die in the hospital experience pain at the end of life.
  – Estimated that 75% of cancer patients admitted to the hospital report pain on admission and approximately 30% of home cancer patients report daily pain

Economic Impact

• **Cost**
  – Annual cost is $560-635 billion
    • Cost of health care: $261-300 billion
    • Cost of lost productivity: $297-336 billion
  – In 2008 Medicare expenditure for pain was $65.3 billion
    • This was 14% of all Medicare cost

Outcome of Unmanaged Pain

• Longer hospital stays
• Increased rates of re-hospitalization
• Additional outpatient visits
• Reduced functional ability resulting in lost wages and insurance coverage
Barriers in Management of Pain

- Patient related barriers – reluctance to report pain, fear of addiction and/or side effects of medications, fear that “morphine” means imminent death

- Provider barriers – Not believing patient self-reporting of pain, lack of knowledge of pain assessment including understanding of addiction, pseudoaddiction, tolerance and physical dependence

- Health-System related barriers – pain often not considered a priority, limited access to pain management specialists
Key Pain Related Terms

• Addiction (Psychological Dependence) – characterized by behaviors that may include drug seeking, impaired control, craving and compulsive use, and continued use of a drug despite harm.

• Physiologic Dependence – Develops in patients on opiates for > 14 days characterized by physical symptoms that result due to abrupt cessation or rapid reduction of opiates.
Additional Pain Related Terms

• Tolerance – adaptation that occurs with continued exposure to a drug over time resulting in diminished effect

• Pseudoaddiction – Addictive-like behaviors by patient with inadequately controlled pain seeking pain relief. (e.g. mistaken assumption of addiction)

• Risk Assessment – steps taken to reduce the potential for opioid abuse, misuse, or diversion
Pain Assessment & Management

- 2001 the Joint Commission developed pain management standards
  - Recognized a patient’s right to appropriate assessment and management of pain
  - Screen patients for pain
  - Assessment, treatment, reassessment and follow-up
  - Training/Education for staff competency in pain assessment and management
  - Patient and family education
  - Incorporation of pain management in discharge planning.
Pathophysiology of Pain

- Nociceptive: Pain caused by activation of nerve receptors/endings or other pain sensitive structures as Somatic or Visceral

- Neuropathic: Pain associated with insult or injury to the peripheral or central nervous system.
Nociceptive Pain

Nociceptors are sensory receptors found in the skin, visceral, muscle and connective tissues which conduct and encode noxious stimuli.

Nociceptive Pain Classification

<table>
<thead>
<tr>
<th>Somatic Pain</th>
<th>Visceral pain</th>
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</thead>
<tbody>
<tr>
<td>Characteristics:</td>
<td>Characteristics:</td>
</tr>
<tr>
<td>• Sharp</td>
<td>• Diffuse</td>
</tr>
<tr>
<td>• Pressure-like</td>
<td>• Aching</td>
</tr>
<tr>
<td>• Well-localized</td>
<td>• Cramping</td>
</tr>
<tr>
<td>• Throbbing</td>
<td>Examples:</td>
</tr>
<tr>
<td></td>
<td>• Obstruction</td>
</tr>
<tr>
<td></td>
<td>• Ischemia</td>
</tr>
<tr>
<td></td>
<td>• Inflammation of abdominal or thoracic organs</td>
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</tbody>
</table>

Examples:
- Musculoskeletal
- Headache
- Laceration
Neuropathic Pain

- Caused by a lesion or disease affecting the somatosensory system

Neuropathic Pain Classification

<table>
<thead>
<tr>
<th>Peripheral neuropathic pain</th>
<th>Central neuropathic pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics:</td>
<td>Characteristics:</td>
</tr>
<tr>
<td>• Burning</td>
<td>• Burning</td>
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<tr>
<td>• Sharp</td>
<td>• Sharp</td>
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<tr>
<td>• Shooting</td>
<td>• Shooting</td>
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<tr>
<td>Examples:</td>
<td>Examples:</td>
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<tr>
<td>• Diabetic neuropathy</td>
<td>• Spinal cord injury</td>
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<tr>
<td>• Post-herpetic neuralgia</td>
<td>• Trigeminal neuralgia</td>
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<tr>
<td>• HIV sensory neuropathy</td>
<td>• Post-stroke syndromes</td>
</tr>
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<td></td>
<td>• Multiple sclerosis</td>
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</tbody>
</table>
Classification of Pain

• Acute Pain – characterized by pattern of onset with recognized precipitating cause and often accompanied by physiologic signs caused by hyperactivity of the CNS such as tachycardia or hypertension

• Chronic Pain – pain that persists longer than three months and often lacks the physiologic signs seen in acute pain
  – Often undertreated
  – May be vague and changing location(s)
Breakthrough Pain

• Transient pain of moderate or greater intensity occurring despite presence of baseline analgesia

• Three types:
  – Incident pain – associated with movement or activity
  – End of dose failure – marked worsening of pain typically at the end of dosing interval for regularly scheduled analgesics
  – Uncontrolled baseline pain – continued uncontrolled pain in the presence of regularly scheduled analgesics

• Core Curriculum for APHPC 2013
Essential Components of Pain History

Most reliable indicator of intensity and impact of pain is patient’s own report

• Onset, location, duration, quality, characteristics, aggravating/relieving factors
• Temporal aspects (e.g. acute, chronic, intermittent, breakthrough, or incident)
• Analgesic response to previous treatments and/or use of current analgesics
• Risk stratification for aberrant drug-taking behaviors
Psychological, Spiritual, Cultural Aspects of Pain

• Meaning or impact of pain to the patient
• Cultural beliefs surrounding pain and analgesics
• Knowledge base of patients and family regarding pain and treatment
• Psychological history
• Home environment
• Family support or lack of support
• Spiritual or religious implications surrounding pain and suffering
Pain Scales

• Pain assessment tools must include intensity of pain, relief of pain and psychological distress associated with pain (Journal of Pain and Symptom Management 2006)

• Tools used: Numeric or Visual scales

• Usually completed by patient

• May be adapted to special requirements of individual patient for example patients with cognitive impairment

• Used on ongoing basis with patient to assess/reassess adequacy of treatment
General Opioid Truths

• No Ceiling Effect (generally, continued effect w/ dose increase)

• Nociceptive Pain more responsive vs Neuropathic Pain

• Opiates not necessarily optimal treatment choice

• Oral route preferred

• Side effects usually subside with time (except constipation)

Pain Treatment

• Based on World Health Organization (WHO) Analgesic Ladder

  – Created in 1986 to provide a framework for addressing pain
  – Initial ladder was three steps including mild, moderate and severe with recommendations for management at each level
  – Adaptation of the ladder resulted in a fourth step and includes possible use of neurosurgical procedures to manage pain.
Modified WHO Analgesic Ladder

STEP 1
- Mild Pain
  - Non-opioid analgesics
  - NSAIDS
  - + Adjuvant

STEP 2
- Mild-to-moderate pain
  - Mild opioid
  - + NSAIDS + Adjuvant

STEP 3
- Moderate-to-Severe Pain
  - More potent opioid
  - Methadone
  - Oral administration
  - Transdermal patch
  - ± NSAIDS ± Adjuvant

STEP 4
- Severe Pain
  - Nerve Block
  - Epidurals
  - PCA Pump
  - Neurolytic block therapy
  - Spinal stimulators

STEP 4
Analgesic Treatment

- **Mild Pain**
  - Aspirin
  - Acetaminophen (Tylenol)
  - Non-steroidal (ibuprofen, naproxen, etc)

- **Moderate Pain**
  - Codeine (Tylenol #3)
  - Hydrocodone (Vicodin, Lortab)
  - Oxycodone (Percocet, Oxycontin)
  - Oral Morphine (MS Contin, Oramorph, Kadian, Roxanol)

- **Severe Pain**
  - IV Morphine
  - Hydromorphone (Dilaudid)
  - Fentanyl (Duragesic)
  - Methadone (Dolophine)
Invasive Interventions

- **Spinal analgesia**
  - Spinal, Epidural, Intrathecal, Subdural, & Subarachnoid

- **Neurolytic blockade**
  - Subarachnoid, Epidural, & Spinal Neurolysis
  - Brachial plexus block, suprascapular nerve block, sciatic & femoral nerve block
  - Peripheral nerves

Oxford Textbook of Palliative Medicine, 4th ed., 2009
Adjuvants Therapies or Co-Analgesics

• Medications that have a primary indication other than treatment of pain but may enhance primary analgesic agent

• Individual response to these medications may vary so sequential trials may be necessary to determine best response with the least side effects
Adjuvant Therapy for Neuropathic Pain

• Most commonly used in combination with an opioid for neuropathic pain
  – Tricyclic Antidepressants
  – SNRI
  – Calcium channel ligands
  – Topical Lidocaine
  – Benzodiazepines
  – GABA-ergic

• These drugs may have primary analgesic effect in certain pain syndromes
Adjuvant Therapies (cont.)

- **Corticosteroids**
  - Epidural spinal cord compression
  - Bone pain
  - Neuropathic pain
  - Visceral pain
  - Pain Crisis

- **Bisphosphonates**
  - Osteolytic bone pain
Nonpharmacologic Interventions

• Transepidermal nerve stimulator (TENS)
• Acupuncture
• Exercise
• Biofeedback
• Massage therapy
• Therapeutic touch
• Music
• Pet therapy
• Hypnosis
• Guided imagery

Primer of Palliative Care, 6th ed., 2014
Antimicrobial Stewardship
Objectives

• Discuss consequences of inappropriate antimicrobial prescribing and overuse

• Define antimicrobial stewardship and describe initiatives to improve antibiotic prescribing practices at Carolinas HealthCare System

• Apply principles of antimicrobial stewardship to patient care practice
A Global Crisis: Antimicrobial Resistance

- ↑ antibiotic resistance is associated with ↑ morbidity, mortality, and ↑ in healthcare associated infections
  - By 2050, multidrug resistant organisms (MDROs) will kill more patients than cancer
- ↑ antibiotic use has contributed to ↑ resistance and other consequences
  - 30% of C. difficile infection now occurs in the community
- Simultaneous ↓ in antimicrobial development
  - Lack of new antibiotics to address resistance
- Costly health care
  - $20 billion direct,
  - $35 billion indirect,
  - 8 million additional days
Antimicrobial Resistance: Contributing Factors

Up to 50% of antibiotic prescribing is inappropriate

Antimicrobial stewardship is KEY for slowing antimicrobial resistance

- Selection Pressure
- Invasive Medical Procedures
- Antibiotic use in animals
- Transfer between community and healthcare setting
- Breakdown of hand hygiene

Selection Pressure

Antimicrobial Prescribing Patterns
What is Antimicrobial Stewardship?

**Goals**

- Improve **individual patient outcomes** by:
  - Optimize treatment of infectious processes
  - Minimize risk of complications of therapy
  - Reduce length of stay
- Improve **collective population outcomes**
  - Reduce antimicrobial selection pressure to slow antimicrobial resistance because inappropriate antibiotic use in one patient impacts effectiveness in other patients

*Coordinated interventions designed to improve and measure the appropriate use of antibiotic agents by promoting the selection of the optimal antibiotic drug regimen including dosing, duration of therapy, and route of administration*
### Assessment
- Only prescribe antibiotics for bacterial infections; not viruses, colonization, or contamination
- When starting an antibiotic, use facility-specific empiric therapy guidelines
- Prescribe the narrowest spectrum antibiotic possible that avoids collateral damage
- Make every effort to obtain an accurate drug allergy history

### Antibiotic Order
- Administer the antibiotic in a timely manner
- Make sure cultures are ordered before giving antibiotics

### Outcomes
- Perform an antibiotic timeout at 48-72 hours: constantly assess the patient’s need for antibiotics
- Narrow or discontinue antibiotics based on culture results as soon as possible
- Monitor the patient for side effects, especially diarrhea
- Only administer antibiotics for the shortest duration necessary

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*You can impact antimicrobial resistance at every stage of antibiotic use*
For Prescribers: 3 Simple Habits to Adopt

1. Document antibiotic indication

2. Specify antibiotic duration of therapy

3. Routinely perform an antibiotic “timeout” at 48-72 hours of therapy to assess appropriateness of therapy:
   - The Right syndrome identified
   - The Right drug selected
   - Given at the Right dose
   - Via the Right route of administration
   - For the Right duration of therapy
Avoid these Common Mistakes to Help Slow Antimicrobial Resistance

Treating Asymptomatic Bacteriuria:
- Most patients with a positive urine culture but no symptoms do not need antibiotics
- Exceptions: pregnancy, urologic procedures
- Urine cultures should NOT be ordered based on urine appearance or smell!

Not Making Wise Antibiotic Choices:
- Avoid using agents that are too broad
  - Reserve carbapenems!
  - Patients with or at risk for ESBL infection
  - Overuse can promote CRE!
- Avoid excessive fluoroquinolone use
  - Often not recommended 1st line
  - High rates of gram-negative resistance
  - Strong association with C. difficile

Treating viral respiratory infections with antibiotics

Adverse Effects!
Stewardship at CHS Primary Enterprise Facilities: Antimicrobial Support Network (ASN)

Each CHS Division has dedicated ASN pharmacists that oversee antimicrobial stewardship in collaboration with ID physicians.

- Pharmacists perform a daily review of patients who meet criteria such as:
  - Antimicrobial duration at least 72 hours
  - 3 or more antimicrobials prescribed
  - Restricted/targeted antimicrobial
- After discussion with an ID physician, the pharmacist may contact prescribers to assist with the optimal selection, dosage and duration of antimicrobial therapy.
- Select high-risk antibiotics are restricted:
  - Ceftaroline, Polymyxin B, Daptomycin, Oritavancin, Dalbavancin, Doripenem, Tigecycline, Ceftazidime/avibactam, Ceftolozane/tazobactam*
- The pharmacy will dispense up to 24 hours of drug when ordered by a non-ID provider.
- Continuation requires ASN approval and/or ID consult.

**Central Division**
- CMC
- CMC-Mercy
- CR-Charlotte
- CR-Mt. Holly

**North Division**
- CHS-NorthEast
- CHS-University
- CHS-Lincoln
- CHS-Stanly

**South Division**
- CHS-Pineville
- Pineville Inpatient Rehab
- CHS-Cleveland
- CHS-Kings Mountain
- CHS-Union

**Pediatric Division**
- Levine Children’s Hospital
- Jeff Gordon Children’s Hospital
Antimicrobial Stewardship Resources

• ASN Website:
  http://physicianconnect.carolinas.org/stewardship

• Infectious Disease Guidelines:
  http://physicianconnect.carolinas.org/guidelines

• CHS Facility Antibiograms:
  http://physicianconnect.carolinas.org/antibiograms