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2019 November Infection Prevention & Control TOPIC # 10 – Antimicrobial Stewardship

Useful facts and practical tips relevant to General Practice - we can all do our bit

FACTS

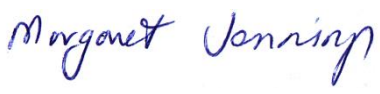
1. Antibiotic use is the driver of acquired antimicrobial resistance – simple as that.
2. Antibiotic use is four times greater than the rate of infection i.e. we are using antibiotics when patients don't have an infection.
3. We have seriously ill patients in our hospitals with bacterial infections caused by highly resistant bacteria and for whom there is now no effective antibiotic. Taking antibiotics unnecessarily has contributed to this.
4. Community acquired antibiotic resistance is now more common than hospital acquired resistance. We must control the unnecessary use of antibiotics in both types of health care facilities
5. 20% of those taking an antibiotic will have a side effect e.g. including C. difficile infection i.e. taking antibiotics changes the normal flora and may also cause reactions. Taking an antibiotic is not always safe

SOME OF THE RULES OF AMS

1. Establish that the patient has an infection, is likely bacterial and is unwell. (non immunocompetent pts are a special case).
2. Refer to the Therapeutic Guidelines – antibiotic. Commence patient on recommended regime while taking a specimen for the lab. This is called empiric prescribing and may involve a broad spectrum antibiotic initially but as soon as the result is known switch to a narrow spectrum immediately. (Broad spectrum antibiotics promote resistance so are not used any longer than necessary).
3. If the patient requires IV antibiotics then they move to oral as soon as they show improvement and can take oral. This is usually within a day or two.
4. The length of a course varies from one day to 7. Patients need to be reviewed within a day or two to see if they are getting better. The days of the repeat script are mostly over. Immunosuppressed are special cases.

COMMENTS

1. You might say the above looks more relevant to hospitals but then the question is "Why are we prescribing antibiotics for healthy immunocompetent patients who may have a viral infection?" Such patients need good pain management more than antibiotics as well as someone with them to observe changes.
2. When patients comment about their expectations before seeing the doctor, we don't say "I am sure the doctor will give you something for that". We need to start saying "I know your doctor will do what's best for you."
3. There are quite specific guidelines around whether to prescribe for ear infections e.g. suppurating vs non suppurating, and the same for UTIs that we need to be familiar with in order to support our GPs to take the pressure off them to prescribe.
4. One of the best examples of practical AMS I have seen is where a patient is given a form to sign at check in. It asks the patient to sign that they will not ask for antibiotics if the doctor determines it is a likely viral infection.
5. The delayed script i.e where the GP issues a script but asks the patient to only have it filled if they worsen etc. If a patient needs an antibiotic, they need it now and there is current debate about such a script.
6. Aged Care facilities that call for an over the phone script for a possible UTI. We need to ensure these facilities are not just doing a FWT without symptoms. There must be localised signs. Confusion is often as a result of dehydration. The use of antibiotics in Aged Care is definitely adding to antimicrobial resistance and this needs much tighter control. We must train our Aged Care staff in hydration, symptoms and specimen collection.



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