When the Family Demands Antibiotics

Dear Dr. Jeff: Our antibiotic stewardship efforts have led to a series of conflicts with involved family members. Typically, they are vociferously demanding antibiotics for presumed urinary tract infections which do not meet the McGeer criteria for antibiotic use. While the families are generally well-meaning, our attempts to follow guidelines, even when accompanied by copies and other instructional materials, have produced shouting with threats of hotline calls, lawsuits, resident transfers, or even violence. What more could we do to satisfy families that we are providing quality, evidence-based care?

Dr. Jeff responds: Inappropriate antibiotic usage — which means any order other than the right drug in the right dosage for the right indication and the right duration — theoretically increases the risk of inducing resistant organisms into the environmental bacterial milieu shared with other residents and staff. So antibiotic stewardship programs are often cast as a balancing of the interests of the individual against the interests of the group. The individual need is portrayed as a balancing of the interests of the facility as well. Urinary tract infections (UTIs), which are the most commonly diagnosed and treated infections in long-term care, are recorded in the Minimum Data Set (MDS) data and form the basis for quality metrics included in the Five Star System. Of course, MDS has its own criteria for identifying UTIs. If the resident had any kind of symptom that included fever or “confusion” as well as those referable to the urinary tract, and the resident is diagnosed with and treated for a UTI, then that treatment will be scored as a UTI for MDS purposes. Quality metrics and Star ratings may significantly affect a facility’s census or even financial viability. The administration has a major interest in lowering the measured UTI rates and is not simply a neutral party helping to weigh the needs of the resident and society as a whole.

Inappropriate treatment of asymptomatic bacteriuria remains common — as is treatment of a wide variety of behaviors with antibiotics and attributing those behaviors to the urinary tract. UTIs have been regarded as the low-hanging fruit for long-term care antibiotic stewardship programs. Programs to limit antibiotic use in questionable circumstances will thus have the support of both experts and administrators.

Applying Appropriate Surveillance

Clinicians should not rely on the McGeer criteria to make resident treatment decisions. These criteria do not prove or disprove the suspicion that a particular resident might have an infection — nor were they created for that purpose. Dr. Allison McGeer and colleagues used best available information to create criteria for infection surveillance. This is a vital part of infection control and prevention programs. For UTIs the criteria rely heavily on symptoms, which may be very difficult to elicit in frail and cognitively impaired residents. Laboratory tests may also be difficult to obtain, and in long-term care they generally have long turnaround times.

Infection surveillance helps to identify patterns of confirmed infection that might respond to infection control measures. For example, if one unit has a significantly higher rate of genuine UTIs than others, its staff might benefit from further training in handwashing or perineal care. If the facility has high rates, there might also be a need to revisit hydration programs. If one clinician is diagnosing a significantly higher percentage of infections that cannot be confirmed, there might be an opportunity for improved laboratory use or clinical updating, although this might simply reflect differences among patient panels. Both inadequate perineal care and impaired hydration with low urinary flow rates are risk factors for UTIs.

The revised McGeer criteria for UTIs lack the symptom of “confusion” and account for the low probability of the infection in residents without indwelling catheters if localized symptoms are not present. They also require microbiologic confirmation of diagnosis.

Laboratory data inconsistent with the diagnosis could negate it, but the decision to order specific tests is left to the clinician. Laboratory tests consistent with asymptomatic bacteriuria could still support the diagnosis.

Recognizing Community Care Patterns

Many residents are admitted with histories of frequent UTIs. Family members may be accustomed to community care patterns, which initiate antibiotics in the face of diverse physical and cognitive symptoms with or without other signs of infection. Often these regimens are authorized by well-meaning practitioners. Urinary specimens and blood tests are often difficult or impossible to obtain in the home setting or with uncooperative patients in the office. Laboratory confirmation is frequently not attempted. Antibiotics are prescribed by telephone, often from supplies already available in the home from prior treatment courses. Of course, most of these patients improved clinically with treatment, particularly if instructions included ensuring extra fluid intake while on antibiotics.

Most of these nonspecific symptoms reflect transitory conditions that would resolve regardless of treatment, but some may legitimately have been UTIs. When caregivers went the extra step of bringing a confused or agitated senior to an emergency department (ED), their suspicion of an underlying UTI was usually confirmed by the ED staff when the urine specimen contained three to five white blood cells or more, regardless of the absence of leukocytosis in blood tests or abnormals vital signs. Long-term care clinicians who try to hold the line on overtreatment of asymptomatic bacteriuria are often confounded when residents are brought to the hospital and treated with antibiotics or return with recommendations for antibiotics from less knowledgeable hospital clinical personnel. These scenarios reinforce the family’s expectations regarding antibiotic utilization.

Unfortunately, there is a valid fear that delaying treatment while appropriate testing is done has risks, even if it allows time for transitory symptoms to disappear. Frail seniors with impaired immunity may not mount a significant febrile response or other vital sign changes until sepsis has induced hypotension. Recent studies have confirmed that a delay in antibiotic administration for seniors...
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(average age of 77 years) with urinary infections increases the rate of sepsis and death (BMJ 2019;364:l525). Moreover, the resident is likely experiencing genuine discomfort from an unaddressed infection — whether it is manifesting as pain from an inflamed urethra exposed to frequent urination or excess cognitive deficits with impaired ability to participate in usual daily activities — should not have to experience a prolongation of their suffering simply to satisfy requirements for laboratory confirmation of infection.

Bringing Staff on Board

Nursing home floor staff frequently fuel antibiotic stewardship struggles with families. Although nursing leadership and clinical providers may generally accept the standard for diagnosis as requiring some evidence of infection and some symptom or finding suggesting a source in the urinary tract, the floor staff often have more traditional beliefs regarding UTIs.

For instance, if the evening or weekend nurse suggests that a resident’s lethargy “might” be a UTI, the certified nurse assistant (CNA) or licensed practical nurse (LPN) confirms “foul-smelling” urine, and the supervisor offers to call to see whether the practitioner wants to order an antibiotic, should we be surprised when the family is distressed by a refusal?

Staff are typically trying to provide good care and to keep families informed about their loved one’s status, but the effect of these communications reinforces the message from practically every other source that antibiotics are good for agitation and many other vague symptoms in frail seniors. Blaming the staff for well-intentioned communications is a poor strategy, particularly if they have no other choice to offer. Until CNAs and LPNs can routinely state that strong-smelling and dark-appearing urine are signs of concentrated urine and suggest the need for more fluids, the antibiotic wars with families are inevitable.

Bringing Families on Board

Although many antibiotic stewardship experts recommend distributing preprinted information sheets on appropriate antibiotic use to patients and families on admission, there is little evidence to believe that these are effective and even less reason to think that they would be. Putting aside concerns regarding health literacy and reading levels in general, and the significant language and visual acuity barriers that frequently exist, adding more documents to the extensive materials required for distribution on nursing home admission simply decreases the likelihood that any of them will be read or remembered.

When these pamphlets are offered as needed, they have not proven very effective either. Person-centered care is not guideline-driven care, and few families are satisfied with best practices, according to a government agency in Atlanta.

“Just say no” is a disastrously poor strategy. It didn’t work for marijuana or narcotics, and it is not good practice for antibiotics and UTIs either. Just as discussions about feeding tubes or advanced directives should not be framed around what we won’t do for a loved one, the dialog with the family should address what we think the real problem is and how we plan to address it.

If the resident is lethargic and irritable today, do the clinicians think that the problem is pain? Or is it inadequate sleep the prior night? Or being behind on fluids? Or experiencing a medication side-effect? Or depression or an occult pneumonia or constipation or...? What change in the patient’s plan is proposed if not antibiotics? We could order laxatives, or laboratory tests, or an afternoon nap, or intravenous hydration, or certain medications held/discontinued, or chocolate ice cream, or a chest X-ray. The plan could even include a single dose of an antibiotic while the workup is being completed.

Families are rarely as insistent on their proposed treatment course when the clinical expertise of the practitioner addresses the needs of the resident. But they are understandably irate when they perceive that the facility is using an external authority to deny their loved one needed treatment.

Keeping Our Goal in Mind

In the end, these battles should be put in perspective. Certainly our goal should always be the best possible care of our residents, a goal that certainly includes avoidance of unnecessary medications.

Unfortunately, most long-term care facilities are awash in polypharmacy and permit overtreatment of diabetes, gastric acid, hypertension, arteriosclerosis, and osteoporosis.

In this context, a three-day course of one of the typical oral UTI medications is pretty small beans. Genuine UTIs remain common, even after the falsely diagnosed are excluded. Antibiotics can be gastric irritants or decrease appetite, they may induce diarrhea, and they may produce fatigue or malaise on their own. But there is no evidence that antibiotic stewardship programs can reduce \textit{Clostridioides difficile} rates, hospitalizations, or nursing home mortality. (See the excellent review by Diana Feldstein, MD, MPH, and colleagues of the University of North Carolina, Chapel Hill, in \textit{J Am Med Dir Assoc} 2018;19:110–116.) Clinicians should certainly work to provide the best possible care. But a difference regarding a few days of an oral antibiotic should not produce a death struggle between the family and the facility.

Dr. Nichols is past president of the New York Medical Directors Association and a member of the Caring for the Ages editorial advisory board.