infection-related hospitalization was reviewed to ensure it was not hospital acquired. This study, however, was conducted among patients discharged from GDH, this selection bias may affect the generalizability of our results. However, our study results could be applied to similarly frail older adults in geriatric clinics and hospitals.

In conclusion, we found that nursing home residence is an independent risk factor for recurrent infection-related hospitalization in older adults. Enhanced infection control measures should be strengthened to reduce infection and the consequent hospitalization.

References


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An Antibiotic Prescription Induces Resistance at the Individual Level More Than the Group Level

To the Editor:

An unnecessary antibiotic prescription may be viewed as a time bomb that may detonate in the recipient as a Clostridium difficile or antibiotic-resistant infection in subsequent months. Antibiotic utilization selects multidrug-resistant bacteria in both the individual and the facility.1,2 Many practitioners view an antibiotic prescription as a benefit to the individual at the expense of the group. However, an unnecessary antibiotic prescription hurts the INDIVIDUAL. The intensity of the damage and disruption of bacterial flora may be greater in the individual who received the antibiotic than at the group level, according to data from a hospital ward and Scottish general practice.3,4 This is an important risk-benefit consideration when contemplating antibiotic therapy for an individual. For example, Rotjanapan et al5 found that 11 (12%) of 96 residents who received an antibiotic for suspected urinary tract infection (UTI) developed C difficile colitis within 3 weeks of treatment. Inpatient quinolone therapy in the preceding 30 days increased the odds that a symptomatic UTI was caused by a quinolone-resistant organism 16 times.6 Quinolone therapy during the prior 6 months increased the odds that a febrile UTI was caused by a quinolone-resistant organism 17.5 times in outpatients.7 Trimethoprim/sulfamethoxazole prophylaxis for 1 month in postmenopausal women increased resistant Escherichia coli in the stool from approximately 20% to 85%.8 Of interest, a recent study found that antibiotic treatment of asymptomatic bacteriuria in young women increased the risk of subsequent symptomatic UTI 3 times. Antibiotic treatment in this situation apparently replaced relatively benign colonizers with more virulent bacteria.9 In each of these studies, the use of antibiotics put patients at risk for adverse outcomes related to resistant microorganisms.

Antibiotic resistance is clearly associated with increased risk of fatal outcomes.10 This concern is greater in long term care facilities (LTCFs) than in the community because of the severity of underlying illness and increased frailty of LTC residents (which increase the risk of subsequent infectious illness), as well as “colonization pressure,” and serial contact care with the risk of transmission. In addition, antibiotic resistance increases the costs of care for both individuals and facilities.11,12 The selection of resistant pathogens, subsequent risk of a fatal outcome, and increased health care costs should be considered when determining if empiric therapy for nonspecific indications, such as falls or confusion, is justified, especially in the absence of fever, leukocytosis, or localizing findings pointing to a source of infection.13 Antibiotic resistance in LTCFs is a huge problem that requires aggressive antibiotic stewardship.1,2,5,10,12
Reductions of Antipsychotic and Hypnotic Medications in Namaste Care

To the Editor:

The number of persons with Alzheimer’s disease and other progressive dementias is increasing rapidly in all countries, fueled by increasing lifespan. A large percentage of these persons (35%–53%) survive into an advanced stage of dementia.1 At that stage, persons with dementia are very often institutionalized because their families can no longer provide care for them. In an institution, they are often unable to participate in activities provided for intact and mildly demented residents and end up placed in corridors or isolated in their rooms. A method of care, Namaste Care, was recently developed that provides improved quality of life for these individuals.2 Limited amount of research evaluating this method showed that residents in Namaste Care had decreased prevalence of symptoms indicating presence of delirium, agitation, and use of antianxiety medications.3 Recent introduction of Namaste Care in a Scottish nursing home as quality improvement initiative provided opportunity for further demonstration of Namaste Care benefits.

The program was implemented according to description in the book The End-of-Life Namaste Care Program for People with Dementia4 as a part of quality improvement activity. The program consisted of establishing a separate room (Coorie Inn) to which residents with advanced dementia were brought after breakfast and were transferred into comfortable chairs with blankets placed on their knees. The Namaste Care staff worked in the Coorie Inn from 9AM to 4PM every day providing comfort care; the residents had their hands and face washed, and given a hand massage with moisturizer applied to the residents’ hands, legs, and face. The men were shaved and also had some after shave lotion applied. When visitors arrived, they were encouraged to provide this care for their loved ones. Staff members sat and talked to the residents, perhaps reading the local paper or just stroking their hand. Drinks were provided throughout the morning: tea, juice, water, or milk. After lunch some of the residents went out for fresh air, even in the rain (that is what umbrellas are for). There is a chicken coop on the premises and the staff often took the residents to feed the chickens. For sensory activities, 2 paddling pools were used, 1 filled with water and the other with sand. Residents could put their hands and feet in the sand and the water. Currently, there are 13 residents in the Namaste Care program with 2 caregivers.

Participants in this study were 8 females and 1 male, who were enrolled in Namaste Care in a Scottish nursing home for at least 6 months. Their average age was 85.2 ± 8.7 years and average duration of institutionalization at the beginning of Namaste Care of 44.7 ± 38.3 months. Three of them had diagnosis of Alzheimer’s disease, 2 each diagnoses of vascular dementia and of nonspecific dementia, and 1 each diagnoses of dementia with Lewy bodies and of Parkinson’s disease.

Involvement in Namaste Care gradually decreased the use of antipsychotics and hypnotics (Figure 1). At the time of Namaste Care enrollment, 4 residents were receiving antipsychotics; 2 females received quetiapine 25 mg twice a day (one had been on this for 3 years, the other 1 year), 1 female received quetiapine 25 mg in the morning and 50 mg at night (been on this for 4 years). One female received haloperidol 0.5 mg twice a day and has been on this medication for 5 years. Antipsychotic medications were gradually reduced over a 4-month period and eventually discontinued. Families have commented on how their relatives were more content and did not look worried or afraid. They have seen smiles, laughter, and sometimes tears; they could make a connection with their loved one that they thought they had lost, even if the moment was short lived.

Three residents were receiving hypnotics at the beginning of the study: 2 women zopiclone 7.5 mg every night (one had been on it for 2 years, the other for 6 months), 1 woman was receiving zolpidem 5 mg every night (been on it for 6 years). We reduced the hypnotic medications over a 5-month period, until they were discontinued (Figure 1). Before the Namaste program, the residents appeared to sleep the night and day away; we now know that this

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References


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