DEPARTMENT: Pharmacy Division		**POLICY NUMBER:** DPOTMH-MPP-PHAR-P026-(01)	
TITLE/DESCRIPTION: **ANTIMICROBIAL STEWARDSHIP**			
EFFECTIVE DATE: December 30, 2023	**REVISION DUE:** December 29, 2026	**REPLACES NUMBER:** DPOTMH-J-P26	**NO. OF PAGES:** 1 of 21
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PURPOSE:

1. To achieve optimal clinical outcomes related to antimicrobial use and other adverse events, and to reduce the cost of health care for infections.
2. To promote the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration and route of administration in order to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.
3. To improve antimicrobial stewardship practices at Dr. Pablo O. Torre Memorial Hospital and to monitor outcomes and antimicrobial use (consumption).

DEFINITIONS:

Antimicrobial Stewardship- is a coordinated program that ensures the optimal selection, dose, and duration of an antimicrobial therapy that leads to the best clinical outcome for the treatment or prevention of an infection while producing the fewest toxic effects and the lowest risk for subsequent resistance. The Antimicrobial Stewardship Program is coordinated through an AMS Committee and Infection Prevention and Control Unit which is a multi-disciplinary work group that reports through Pharmacy and Therapeutics or a similar hospital committee on a monthly, bi-monthly or quarterly recurring schedule and is charged with the responsibility of promoting optimal antimicrobial utilization.

RESPONSIBILITY:

Pharmacy Departments, Nursing Service Division, Infection Prevention and Control Unit, Medical Staffs, Laboratory

POLICY:

1. Antimicrobial Stewardship implies to improve appropriate antimicrobial utilization.

2. Antimicrobial Stewardship Program shall improve patient outcomes through optimization of antimicrobial therapy by selection of appropriate antibiotic dose, route and duration of treatment. Potential benefits include the following:
   - 2.1 Improve patient safety by decreasing side effects and toxicity.
   - 2.2 Support the education of all healthcare providers, patients and families about antimicrobial stewardship practices including antimicrobial resistance and appropriate antimicrobial use.
   - 2.3 Minimize the development of antimicrobial resistance by appropriately selecting antibiotics.

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2.4 Reduce the rates of hospital-acquired infections.
2.5 Control of Clostridium difficile infections and the emergence of multi drug-resistant organisms.
2.6 Reduce length of stay and patient-associated hospitalization cost.
2.7 Reduce pharmacy expenditures on antimicrobials.

3. Antimicrobial stewardship shall be performed as an ongoing practice involving several disciplines throughout DPOTMH. The Antimicrobial Stewardship Committee will develop strategies and initiatives to promote appropriate antimicrobial use.

4. The antimicrobial stewardship program (Antimicrobial Stewardship Committee) will be responsible for the following:
   4.1 Coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services
   4.2 Documentation of the evidence-based use of antibiotics in all departments and services of the hospital
   4.3 Demonstration of improvements, including sustained improvements, in proper antibiotics use, such as through reductions in C. difficile infection and antibiotic resistance in all departments and services of the hospital
   4.4 Adherence to nationally recognized guidelines, as well as best practices, for improving antibiotic use
   4.5 Reflection of the scope and complexity of the hospital services provided
   4.6 Development or revision of existing policies, procedures, protocols and guidelines related to infectious diseases (e.g. restricted antimicrobials, treatment guidelines based on local susceptibilities)
   4.7 Development and distribution of an antibiogram on an annual basis as well as assessing trends of antimicrobial resistance within the facility
   4.8 Providing recommendations to the Pharmacy and Therapeutics Committee (PTC) about antimicrobial selection, dose, and duration of therapy
   4.9 Providing ongoing healthcare practitioner education (e.g. newsletters, in-services, and one-on-one interaction) regarding antimicrobial stewardship initiatives.
   4.10 Educating patients and their families as needed, regarding the appropriate use of

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antimicrobial medications including antibiotics.

4.11 Collecting, tracking and analyzing antimicrobial consumption through days of therapy, defined daily dose, or purchasing costs.

4.12 Collecting, tracking and analyzing resistance patterns.

4.13 Regularly reporting antimicrobial stewardship measures to relevant healthcare practitioners and hospital administration.

5. In accordance with the CDC Core Elements of Hospital Antibiotic Stewardship Program recommendations, all prescribers are required to perform the following:
   5.1 Document in the medical record or during order entry the following: antibiotic indication, antibiotic dose, and duration of antimicrobial therapy.
   5.2 Review appropriateness of any antibiotics prescribed after 48-72 hours from the initial orders (e.g. antibiotic time out).

6. Pharmacists are required to perform interventions approved by the PTC which include the following:
   6.1 Intravenous to oral conversion of antimicrobials
   6.2 Renal dosing of antimicrobials
   6.3 Therapeutic interchanges
   6.4 Antibiotic streamlining
   6.5 Antimicrobial restrictions

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PROCEDURE (SOP):

I. **Ordering/ Prescribing**

1. Antimicrobial-antibiotic Therapy- the following aspects must be considered before antimicrobial therapy:
   - 1.1 Does the patient have an infection to warrant antimicrobial therapy?
   - 1.2 Were ancillary measures to control infection such as abscess drainage, removal of infected catheters or prosthesis, local disinfection and cleaning of superficial wound implemented?
   - 1.3 Does the patient require empirical antibiotics before definite microbiological results are available?
   - 1.4 Which organism is the likely cause of the infection and what is their relative importance?
   - 1.5 What other steps are needed to improve diagnostic precision?
   - 1.6 Which drugs are active against the presumed pathogen? Is the antimicrobial spectrum appropriate, and what is the likelihood of drug resistance?
   - 1.7 What are the side effects and toxicity of the chosen agent/s, and how can this be balanced against the benefits of the therapy, with special attention to renal or liver toxicity?
   - 1.8 Prophylactic antibiotics should be limited to few effective drugs in operations which carry post operative infection risk.
   - 1.9 Narrow spectrum antibiotics are preferred as broad spectrum antibiotics encourage super infection and the development of resistant organisms.
   - 1.10 Combination of antibiotics is indicated to increase the spectrum of cover in severe or mixed infection but not for routine use.
   - 1.11 Cost should be considered in the selection of antibiotics with similar action.
   - 1.12 Antibacterials are not used for viral and fungal infections.
   - 1.13 Dosage regimens given apply to average adults.
   - 1.14 Dosage adjustment maybe needed for pregnant woman, elderly, pediatrics, neonates and patients with renal or liver impairment.
   - 1.15 Vancomycin should be prescribed with caution together with amino glycosides as their nephrotoxicity is cumulative; in such cases a safer alternative is preferred.
   - 1.16 Liver disease may alter the response of drugs, and therefore drug prescribing should be kept to a minimum in all patients with severe liver disease.
   - 1.17 Elderly patients require special care and considerations in prescriptions. They are apt to receive multiple drugs for their multiple diseases, thus greatly increasing the risk of drug

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interactions and adverse reactions. Avoid indiscriminate use of antibiotics such as cotrimoxazole which may cause bone marrow depression.

1.18 In renal failure, diminished excretion of drugs or their metabolites may increase toxicity and calculation of dosage should be maintained according to kidney function levels. Consultation with a nephrologist is strongly recommended.

2. Antimicrobial Restriction and Pre-authorization

2.1 Antibiotic prescribing should be aided and guided by the regular review of antibiotic sensitivity data. Susceptibility patterns of different isolated organisms should be made readily available to treating clinical staff by Microbiology Laboratory biannually.

2.2 Empirical antibiotic therapy should be given when bacterial infection is suspected and poses a sufficient health risk to demand immediate treatment. Where warranted, empirical regimens should be based on knowledge of the likely pathogens & their anti-microbial susceptibilities.

2.3 Prophylactic therapy should be discouraged unless there is good evidence to support its effectiveness in preventing infection.

2.4 Pre-authorization by an IDS or AMS Clinician is required for restricted antimicrobials.

2.4.1 All attending physicians, on prescribing any restricted antimicrobials (based on hospitals's antibiogram) in the patient's chart, must complete the Antimicrobial Stewardship Form (AMS) - Restricted Antimicrobials Order Section (*See Annex*).

2.4.2 The referring attending or resident physician shall immediately seek approval from the designated AMS Officer in the hospital (AMS clinician, ID specialist or ICC chair/ physician member) via a phone consult, detailing relevant patient history and indication requiring the use of the restricted antimicrobial. The outcome of the call, including approved duration of use, must be documented on the completed form in order for Pharmacy to dispense the approved doses. The AMS Officer shall verify the information entered and sign on the form to indicate his/her agreement at earliest time possible (no later than morning of next working day).

2.4.3 For life-threatening situations such as sepsis and bacterial meningitis, the first dose shall be given within 30 minutes to an hour without prior pre-authorization.

2.4.4 In the event when the approving AMS physician cannot be contacted despite repeated attempts, the referring resident physician shall document as such on the form and the pharmacy may dispense the first 24 hour doses of the restricted antimicrobial to minimize delay in drug administration. Subsequent doses shall be

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dispensed only after the order has been authorized by the designated approver and in accordance to the approved duration of use.

2.4.5 In an event that the infectious disease physician is the one who gave the order to use a restricted antimicrobial, pre-authorization is no longer required given that the ID physician approved and signed the order in the patient chart. Pharmacy can then dispense the ordered medication. The order should still be documented in the AMS form for monitoring and audit purposes.

2.4.6 This procedure shall be applicable at all times. The AMS committee and/or the PTC shall monitor the use of restricted antimicrobials and adherence to this policy; reports of non-compliance shall be submitted to the AMS Chairperson for corrective action.

3. Higher doses can be used in severe infections but attention must be paid to renal and liver functions.
4. Culture results from body sites colonized with normal microbiological flora e.g. sputum may be difficult to interpret. In this case other indicators of infection must be assessed as chest X-Ray films to differentiate actual infection from mere colonization of the upper airways.
5. Antibiotics will not prevent infections of I.V. lines, drains, catheters and shunts. These foreign bodies encourage infection, and local measures such as closed dressings, changing of insertion sites and their removal as soon as possible are more effective than antibiotics. This should be considered in cases of treatment failure.
6. Aminoglycosides should be avoided (but could be used with caution) after two weeks of therapy because of their nephrotoxicity and cumulative ototoxicity. Peak and through serum levels can be measured when possible after 3 doses.
7. No antibiotics should be prescribed for less than 4 days and certainly not for more than 10 days except with repeat Culture & sensitivity results.
8. Antimicrobial Stewardship (AMS) Form will be used in the following situations:
   - 8.1 Prolonged antibiotic therapy more than 7 days as part of the 7th day automatic stop order policy
   - 8.2 Use of Restricted Antimicrobials indicated on the hospital's list of restricted antimicrobials.
   - 8.3 Recommendation for IV-to-oral switching
   - 8.4 Therapeutic drug monitoring and dose optimization of antimicrobials

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II. **Monitoring**

1. Clinical and station pharmacists review orders that involve antimicrobials and record their recommendations if there are any in the Pharmacist's notes and Care Plan Form (See Clinical Pharmacy Services Policy).
   1.1 Clinical and station pharmacists are tasked to monitor the patient's antimicrobial consumption by counting the antimicrobial administration through reviewing the patient's Medication Administration Record. Counting of antibiotic days is done on a case to case basis based on the physicians' order. A 6th day notification sticker notifying the physician that the 7th day of antibiotic use is due the following day is placed in front of the patient's chart. The pharmacist notifies the nurse in-charge and/or the resident physician regarding discrepancies or recommendations regarding the patient's antibiotic use.
   1.2 A completed AMS form with the signature of an infectious disease physician is needed prior to dispensing of restricted antimicrobials and for the continuation of use of antibiotics beyond 7 days. If the infectious disease physician is the one who recommended the use of an antibiotic beyond 7 days, pharmacy can dispense the medication given that the order is completely written in the patient chart with the signature of the infectious disease physician.
   1.3 Nurses and residents physicians are advised to monitor the patient's antibiotic use as well.
2. The pharmacy department is tasked for providing data on antibiotic consumption and defined daily dose of restricted antimicrobials.
3. The AMS team consolidates antimicrobial use data and share information to the City Health officer/Municipal Health Officer. Data should be readily available in the establishment for monitoring of AMS Committee.

III. **Point-of-Care Interventions**

1. Seventh-day Automatic Stop Order
   1.1 Infections shall be treated with the shortest effective treatment duration at the same time healthcare provider at the primary care setting should ensure the shortest effective treatment duration based on existing clinical guidelines such as the National Antibiotic Guidelines and also ensure that patients comply with the prescribed antibiotics at the right dose, duration and timing of use.
   1.2 Prescribed antibiotics are to be dispensed only for the indicated number of days it was

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prescribed. All antimicrobial prescriptions may be dispensed by the pharmacy for a treatment period of up to seven (7) days, after which an antimicrobial stop procedure will be enforced. Upon the 6th day of antibiotic use, the clinical pharmacist or the nurse in charge shall notify the physician who prescribed the antibiotic. The AMS form shall be used to permit the continuation of an antibiotic beyond 7 days and this must be reviewed and signed by an IDS physician. Upon accomplishment of the form, the antibiotic can be continued for another 7 days or as permitted by the IDS physician. On the 14th day of antibiotic use, re-evaluation shall be done to determine if the antibiotic is to be continued.

1.3 Seventh day of antimicrobials are to be calculated as follows:

1.3.1 Antimicrobials administered once daily: day of first dose (day 1) plus 6 days.

1.3.2 Antimicrobials administered in divided doses or spaced more than 24 hours apart (e.g. Q48H): day of first dose (day 1) plus 7 days;

1.3.3 For patients transferred to the hospital with antimicrobials started from an outside healthcare facility, the initial/original start date shall be used for calculation of treatment duration;

1.3.4 Loading doses are included in the counting for the treatment period. Missed doses are not included in the counting and the total doses given shall be the basis in determining the number of days of use

1.3.5 When there is a change in routes of administration (e.g. IV-to-Oral switch) counting of days shall continue.

1.3.6 Counting of antimicrobial days will reset in cases of escalation and de-escalation given that the process is not IV-to-Oral switch.

1.4 Counting of antimicrobial days will reset if the order was discontinued or put on hold by the physician for more than 24 hours. This is calculated from time the last dose was given before the "discontinue" or "hold" order was written to the time the same antimicrobial was administered after the physician writes the order to resume it.

1.5 There is no need to fill out the 7th-day antimicrobial form when:

1.5.1 Total treatment duration is intended to be ≤7 days;

1.5.2 Use of the antimicrobial beyond 7 days has been recommended by the AMS clinician, IDS or IPC Chairperson (recommendation must be made in writing with accompanying signature as evidence for pharmacy to dispense and nurse to administer).

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2. **Dose Optimization**
   - 2.1 Empiric and/or targeted optimal dosing of antimicrobial agents shall be ensured throughout the course of all antimicrobial therapy by the prescriber.
   - 2.2 Pharmacists shall perform routine checks on antimicrobial dosing and intervene with the prescriber/attending physician shall dosing adjustment be required. All interventions shall be documented in the Pharmacist's chart under the Pharmacist's Notes and Care Plan Form.
   - 2.3 To enable proper diagnosis of infection and subsequent tailoring of antimicrobial therapy, microbiological samples for culture and sensitivity tests shall be taken (where possible)prior to the initiation of antimicrobials. Specimens shall be collected from relevant sites(as clinically indicated) in a manner that maximizes microbiological yield and minimize risk of contamination. This is the responsibility of the prescriber and nurse on duty.
   - 2.4 Attending physician shall review the patient 48 to 72 hours after the start of therapy for the possibility of de-escalation.
   - 2.5 In the event that a positive culture is detected by the microbiological laboratory:
     - 2.5.1 The microbiologist or technologist shall directly notify the attending physician soonest possible (e.g. via text or phone call) when (a) growth is detected for all cultures from sterile sites and (b) multi-drug resistant pathogens are isolated from any culture site. If feasible, efforts shall be made to notify attending physicians of microbiological culture and sensitivity results from all sites.
     - 2.5.2 The attending physician or resident shall follow up on the final culture and susceptibility results as soon as it is available.
     - 2.5.3 If a clinical microbiologist is available, he/she may provide advice on the best choice of antimicrobial(s) for de-escalation, following discussion of the case with the attending physician.
     - 2.5.4 In the event of negative culture, the prescriber/attending physician shall review the diagnosis of an infection and discontinue antimicrobials if there is no evidence of an infective process.

3. **IV-to-oral switch**

   - 3.1 All patients receiving IV antimicrobials with excellent oral bioavailability (see Figure 1) for indications that do not necessitate prolonged IV therapy shall be assessed for switch to PO therapy.

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3.2 Patients shall be reviewed early within 48 hours, and switched to PO therapy as soon as they meet the switch criteria (See Annex).

3.3 Patients who do not meet switch criteria at initial assessment, shall be continually reviewed against 24-hour interval.

3.4 Patients switched to PO antimicrobials shall be monitored for continued response to therapy.

IV. Audit, Intervention and Feedback

1. AMS Forms shall be used as an audit of restricted antibiotic on a regular basis.
2. Multi-drug Resistant Organisms (MDROs), Antimicrobial Resistance Rates, and Antimicrobials consumption are a joint collaboration of the AMS team.
3. Some nosocomial infections incidence rate (e.g. Surgical Site Infections (SSI), Hospital Acquired Pneumonia (HAP).
4. Microbiologist summarizes Antibiotic Utilization by a patient in serious condition or under prolonged antibiotic therapy.
5. These indicators will be assessed on regular basis by the PTC and the AMS team.
6. Nurses contribute by monitoring antimicrobial use, reporting to pharmacist and/or residents to accomplish AMS Forms as indicated by its criteria, and play an important role in patient education.
7. Clinical and station pharmacists counsel patients regarding the appropriate use antimicrobials.

V. Documentation

1. All Prescribers shall document all his/her findings in Progress Notes in e-doctor note area.
2. The clinical indication, duration or review date, route and dose are clearly documented in the patient's medical notes and on the drug chart.
3. Reasons for any deviations from empirical treatment guidelines such as the National Antibiotic Guidelines are recorded in the patient's medical notes.
4. Allergies are recorded in the medical records using the Adverse Drug Reaction and Adverse Drug Event form, along with the nature of the reaction.
5. Administration of antibiotic shall be documented in DOC in e-medical administration record (MAR) by the registered nurse. All antibiotics dispensed by the pharmacist shall be documented in the patient's medication profile.

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6. Defined daily doses of antimicrobials should be reported regularly in order to determine consumption.

VI. **Use of the Antibiogram**

1. All antibacterial micro-organisms isolated from the RMCI Laboratory Bacteriology Department in a specified period of time are counted according to the source and their resistance and sensitivity pattern determined.
2. Percent sensitivity to a particular antibiotic is then computed based on the following computations:

$$\frac{\text{Number of isolates sensitive to a particular antibiotic}}{\text{Total number of isolates counted}}$$

3. Results of percent sensitivity of an organism to a particular antibiotic is used as basis of recommendation for empirical management of infection where a particular organism is suspected to be the cause of infection.

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WORK INSTRUCTION:

KEY TASKS	PERSON RESPONSIBLE
1. Considers all aspects in ordering and prescribing antimicrobial to patients.	Prescribing Physicians
2. Ensures antibiotic prescribing is aided and guided by the regular review of antibiotic sensitivity data.	
3. Avoids prophylactic therapy unless there is good evidence to support its effectiveness in preventing infection.	
4. Secures pre-authorization from an IDS or AMS Clinician for restricted antimicrobials through the Clinical Pharmacist.	
5. Reviews the requests to use restricted antimicrobials to ensure the safety of the patients.	Infectious Disease Specialist or AMS Clinician
6. Seeks approval from the designated AMS Officer in the hospital (AMS clinician, ID specialist or ICC chair/ physician member) via a phone consult, detailing relevant patient history and indication requiring the use of the restricted antimicrobial.	Referring Attending or Resident Physician
7. Ensures that susceptibility patterns of different isolated organisms are made readily available to treating clinical staff biannually.	Laboratory- Microbiology Section
8. Monitors the use of restricted antimicrobials and adherence to this policy; reports of non-compliance shall be submitted to the AMS Chairperson for corrective action.	AMS committee and/or the PTC
9. Uses the AMS Form for proper documentation.	Nurses/ Clinical Pharmacists
10. Reviews orders that involve antimicrobials and record	Clinical and station Pharmacists

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their recommendations if there are any in the Pharmacist's notes and care plan form.	
11. Monitors the patient's antimicrobial consumption by counting the antimicrobial administration through reviewing the patient's Medication Administration Record.	Clinical and station Pharmacists
12. Notifies the nurse in charge and/or the resident physician regarding discrepancies or recommendations regarding the patient's antibiotic use.	Clinical and station Pharmacists
13. Requires a completed AMS form with the signature of an infectious disease physician prior to dispensing of restricted antimicrobials and for the continuation of use of antibiotics beyond 7 days.	Pharmacist
14. Provides data on antibiotic consumption and defined daily dose of restricted antimicrobials.	Pharmacy Department
15. Consolidates antimicrobial use data and share information to the City Health officer/Municipal Health Officer.	AMS Team
16. Performs routine checks on antimicrobial dosing and intervenes with the prescriber/ attending physician shall dosing adjustment be required.	Clinical Pharmacists
17. Notifies the attending physician soonest possible (e.g. via text or phone call) when (a) growth is detected for all cultures from sterile sites and (b) multi-drug resistant pathogens are isolated from any culture site.	Microbiologist or Medical Technologist
18. Reviews the diagnosis of an infection and discontinue antimicrobials if there is no evidence of an infective process In the event of negative culture.	Prescriber/ Attending Physician
19. Creates the Antibiogram.	Laboratory- Bacteriology Department

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20. Counts all antibacterial micro-organisms isolated from the RMCI Laboratory Bacteriology Department in a specified period of time according to the source and their resistance and sensitivity pattern determined.	Laboratory- Bacteriology Department

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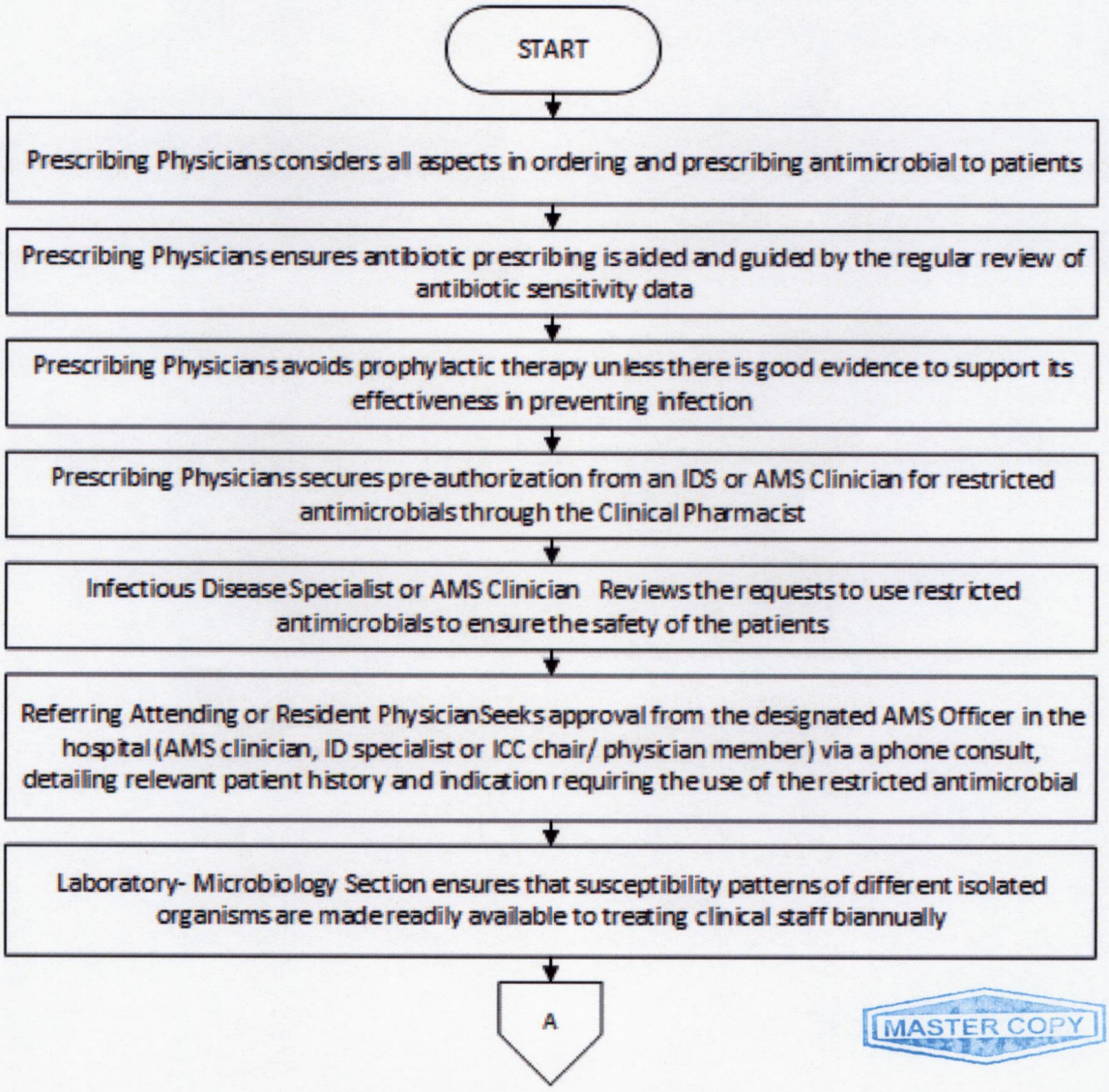
WORK FLOW:



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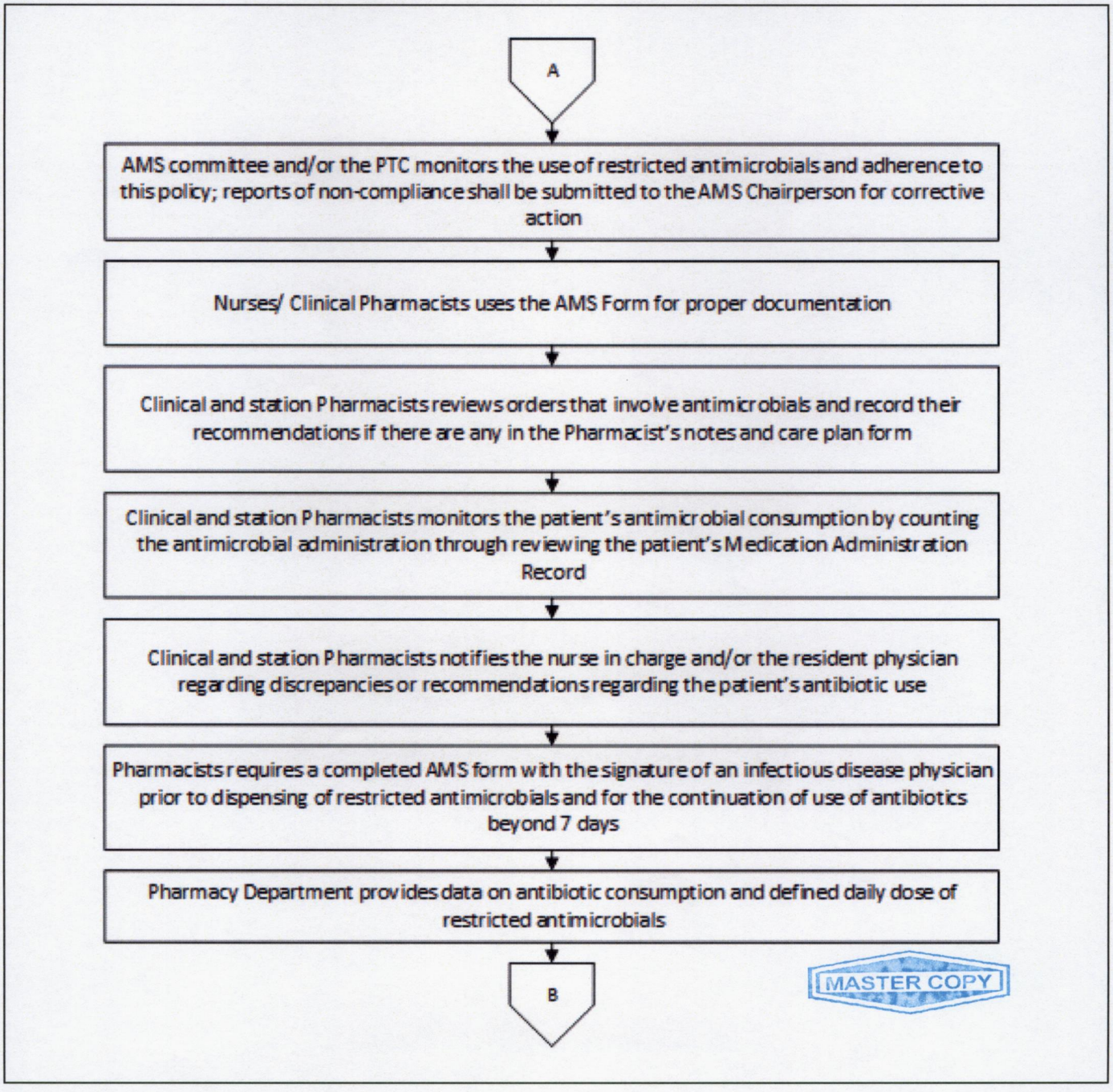

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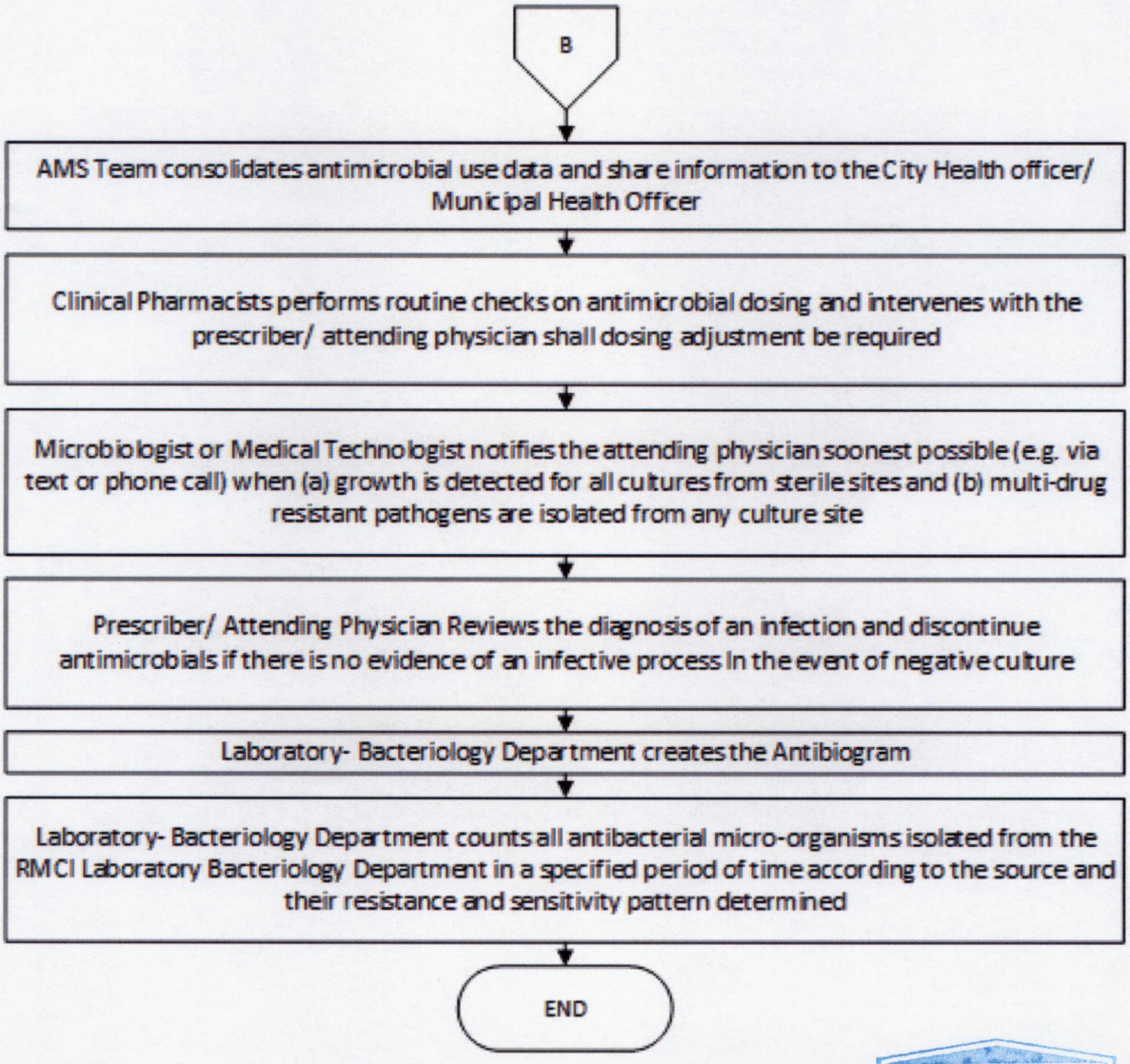
EFFECTIVE DATE: December 30, 2023	**REVISION DUE:** December 29, 2026	**REPLACES NUMBER:** DPOTMH-J-P26	**NO. OF PAGES:** 17 of 21
APPLIES TO: Pharmacy Departments, Nursing Service Division, Infection Prevention and Control Unit, Medical Staffs		**POLICY TYPE:** Multi Disciplinary	



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FORMS:

ANNEX

AMS Form

RIVERSIDE MEDICAL CENTER, INC.
Owner and Operator of the Dr. Pablo O. Torre Memorial Hospital
A proud member of the Metro Pacific Hospital Holdings, Inc.
DR. PABLO O. TORRE MEMORIAL HOSPITAL

ANTIMICROBIAL STEWARDSHIP FORM

Patient Name		Age		Gender		Room No.		Hospital No.		Body weight	
Allergy		Serum creatinine		Creatinine clearance		SGPT		Diagnosis			
Previous antibiotic use for the past 3 months		Previous Hospitalization for the past 3 months		Name of Institution:							
				Date of Admission and Discharge:							

I. Restricted Antimicrobial Order

Date	Antibiotic Requested	Dose and Frequency	# of Days for use	Indication for use	Site of Infection	Microbiology Report		Reg.Physician/ Contact#	INFECTIOUS DISEASE APPROVAL		Dose & Frequency	#of Days	Reason/s	Infectious Disease Consultant / Date / Name / Signature / Contact #
						Date	Result		Approved	Not Approved				

Indication for use: P – Prophylaxis; E-Empiric Therapy; D- Definitive Therapy
Site of Infection: B- Blood; CNS- Central Nervous System; GIT – Gastrointestinal Tract; SST – Skin Soft Tissues; CVS – Central Venous System; C- Catheter Related (Urine/IV); R- Respiratory; GUT- Genitourinary Tract; Rep-Reproductive; O- Others; Specify: _____

DPOTMH-PHARM-F035
Effective Date: 08-01-2022

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II. 7th Day STOP Order

Date	Antibiotic Requested	Dose and Frequency	# of Days for use	Indication for use	Site of Infection	Microbiology Report			INFECTIOUS DISEASE APPROVAL		Dose & Frequency	#of Days	Reason/s	Infectious Disease Consultant / Date / Name / Signature / Contact #
						Date	Result	Req.Physician/ Contact#	Approved	Not Approved				

*No need to refer to an infectious Disease Physician for Antibiotic Therapy of more than 7 days for the following cases:
*Deep seated infection (e.g. empyema, abscess) *Staphylococcus aureus bacteremia *Osteomyelitis *Infected implants or prosthesis *Meningitis or encephalitis *Endocarditis *Febrile Neutropenia
*Tuberculosis *Prophylaxis (e.g. TMP-SMZ for PCP, fluconazole for Fungal Infections)

*** For Antibiotic Therapy beyond 7 days specifically recommended by an infectious Disease Physician/ Infection Requiring more than 7 Days Treatment as mentioned above***

Date	Antibiotic Requested	Dose and Frequency	# of Days for use	Indication for use	Date Antibiotic was started	Date Antibiotic will due	Working Diagnosis	Recommending ID Doctor/ Attending Physician(Name / Signature / Contact #)	Carried out by (Date / Shift/ Name /Signature)

III. Intravenous to Oral Switch (for antimicrobials with the same bioavailability)

Date	IV Antibiotic	Date of Initiation	Working Diagnosis	Your patient must fulfill ALL of the following criteria to switch from IV to Oral		Compliance	Non-Compliance; Reason/s	Pharmacist (Name / Signature / Contact #)
				Clinical Stability	Able to tolerate oral intake			
				☐ Afebrile (Temp: _____) ☐ Downward trend or normalization of inflammatory markers (CRP, WBC, Procalcitonin) ☐ Stable Vital signs (no unexplained tachycardia, hypotension, tachypnea)	☐ Patient is on NPO ☐ Tolerating oral diet, medication and /or enteral feeds ☐ Oral absorption is not compromised (e.g.No vomiting or diarrhea, malabsorptive disorder)			
Antibiotic suitable for IV-to – PO Switch: (Bioavailability>90%) Azithromycin Fluoroquinolones: (Ciprofloxacin, Levofloxacin, Moxifloxacin) Clindamycin Linezolid Fluconazole Metronidazole								

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EQUIPMENT: N/A
REFERENCES: Department of Health, Antimicrobial Stewardship Program in Hospitals Manual of Procedures

RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

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APPROVAL:				
	Name/Title	**Signature**	**Date**	**TQM Stamp**
Prepared by:	**STEPHANIE CAMILLE O. SAMONTE** Inpatient Clinical Pharmacist		12/12/2023	
Reviewed by:	**RODEL J. LLAVE** Total Quality Division Head		12/12/2023	
Approved by:	**MIRIAM HOPE D. BRAVO** Inpatient Pharmacy Manager		12/12/23	TQD
	JEANETTE J. UMALI, MD Antimicrobial Stewardship Committee Chairman		12/15/2023	
	MA. ANTONIA S. GENSOLI, MD VP/Chief Medical Officer		12.18.23	
Final Approved by:	**GENESIS GOLDI D. GOLINGAN** President and Chief Executive Officer		12-20-23	

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