## Current and future status of jurisdictional antimicrobial stewardship initiatives

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>Professor Peter Collignon</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Dr Paul Curtis</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Dr Steven Fowler</td>
</tr>
<tr>
<td>Queensland</td>
<td>Dr Lisa Hall</td>
</tr>
<tr>
<td>South Australia</td>
<td>Ms Vicki McNeil</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Dr Alistair McGregor</td>
</tr>
<tr>
<td>Victoria</td>
<td>Ms Helen Leach</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Dr Paul Armstrong</td>
</tr>
<tr>
<td>Private Hospital Sector</td>
<td>Dr Chris Farmer</td>
</tr>
</tbody>
</table>
AMS in the ACT

Karlee Johnston
Current AMS activity in ACT

• Appointment of AMS Pharmacists
  – Business case for funding

• Formation of AMS committees
  – Multidisciplinary
  – Project plan

• Development of antimicrobial prescribing policy
  – Traffic Light System
    • Red (pre-approval)
    • Orange (approval if not prescribed according to guidelines)
    • Green
  – Approval for restricted antimicrobials

• Pre-implementation information
  – Point prevalence study
  – Analysis of usage data
  – Audits of antimicrobials

• Regular ICU rounds
Future/Planned AMS activity in ACT

- Implementation of antimicrobial prescribing policy
  - ID approval process (phone approval at Calvary)
  - Publishing of the restricted prescribing list (with criteria) on the intranet
- Education and specific campaigns
  - IV to Oral switch
  - De-escalation
- Possible implementation of electronic system
- Audit and review
Antimicrobial Stewardship Forum
7 April 2011
State Governance Committee

Healthcare Associated Infection Steering Committee

– Key strategy is antimicrobial stewardship
– Presentation of possible initiatives by ID Physician
– Review national directions and build on current
Policy Direction

Infection Control Policy: Prevention & Management of Multi-Resistant Organisms

Use of antimicrobials

- Protocols
- Access
- Policy
- Criteria for use – agents restricted under Drug & Therapeutic Committee guidance; accounting for local sensitivity patterns
Information Bulletin

Best Practice Prescribing of Aminoglycosides, March 2011

- Short and longer term therapy

Best Practice Prescribing of Aminoglycosides

March 2011

Information Bulletin

BEST PRACTICE PRESCRIBING OF AMINOGLYCOSIDES

PURPOSE

Updated advice on best practice prescribing of aminoglycosides and directed therapy (short term) for prescribing intravenous aminoglycosides based on Therapeutic Guidelines, Antibiotics (V.14).

EMPIRIC TREATMENT. SHORT TERM THERAPY - MAXIMUM THREE DOSES

Aminoglycosides (generally gentamicin or tobramycin) are the preferred choice for empirical hospital infections where a broad spectrum of organisms are a potential cause. These are usually used for short term therapy in a hospital setting. Aminoglycosides should not be used in patients who have a history of neomycin sensitivity or hypersensitivity.

Cautions: Dose needs to be reduced for patients with a creatinine clearance of 10 to 30 ml/minute and avoided in patients with a creatinine clearance less than 10 ml/minute.

PREVENT UNDERDOSE/OVERDOSE: CALCULATE DOSAGE BASED ON HEIGHT

The dose per kg per day will vary from 3 to 7 mg/kg/day according to patient age, indication and severity of infection. Refer to Table 2.4 in Therapeutic Guidelines, Antibiotics V.14. This does not mean that an upper limit is recommended for each dose per day.

Schedule the dose based on renal function (Table 1 below). Give all aminoglycosides initially as 0.9 litres of normal saline infused over 4 hours. Subsequent doses should be infused over 1 hour and administered according to local protocols (commonly 30 minutes).

Table 1: Aminoglycoside dosing intervals for subsequent empirical doses in adults and children (based on Therapeutic Guidelines, Antibiotics V.14, Table 2.4)

<table>
<thead>
<tr>
<th>Aminoglycoside</th>
<th>Dosing interval</th>
<th>Sodium level</th>
<th>Creatinine clearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobramycin</td>
<td>3.5 mg/kg/day</td>
<td>10 - 30 ml/min</td>
<td>Moderate</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>7 mg/kg/day</td>
<td>10 - 30 ml/min</td>
<td>Moderate</td>
</tr>
<tr>
<td>Streptomycin</td>
<td>5 mg/kg/day</td>
<td>&lt; 10 ml/min</td>
<td>Severe</td>
</tr>
<tr>
<td>Amikacin</td>
<td>7 mg/kg/day</td>
<td>&lt; 10 ml/min</td>
<td>Severe</td>
</tr>
</tbody>
</table>

- Prescribe intravenous aminoglycoside therapy on the appropriate medication chart for the patient (e.g. piperacillin-tazobactam or amoxicillin-clavulanate) with a target duration of therapy. The prescribed dose should be administered in normal saline and infused slowly according to local protocols (commonly 30 minutes).

- Confirm renal function on day two – measure plasma creatinine and calculate creatinine clearance using the Cockcroft-Gault formula.

- Consult the patient's pharmacist for route of administration and monitoring. Aminoglycosides are administered intravenously.

- Follow-up: Empirically treat patients on the basis of susceptibility results and replace with a guided therapy approach for resistant organisms. It is recommended that aminoglycosides be used as a last resort in patients with renal impairment. If creatinine levels are unavailable, review the prescribing guidelines and change to an alternative antibiotic when appropriate.
Current Progress

- Survey of governance, communication and education, antimicrobial restriction and audit and feedback
- Around 60% compliance

- **Best performance:**
  - Local best practice protocols (aligned with Therapeutic Guidelines)
  - Point of care interventions
  - Formulary management/restrictions

- **Areas for improvement:**
  - Reporting and staff education on local sensitivity patterns
  - Drug utilisation review and feedback to specialist clinicians
  - IT support
State level projects

CEC: Quality Use of Antimicrobials in ICU

– In ICUs antimicrobial usage rates & prevalence of infection with MROs higher than in other care settings

– QUAIC to help clinicians obtain the best possible results for patients while limiting the risk of contributing to the development of MROs
Antimicrobial Stewardship Forum

7 April 2011
Current AMS Activities in the Northern Territory

AMS starts in remote communities
- Contribution to the CARPA and Antibiotic Guidelines

Hospital
- Do not have an Antimicrobial Stewardship Team
- Antimicrobial Restriction list approved by Northern Territory Drugs and Therapeutics Committee.
  - Variation in adherence across NT hospitals
- Antimicrobial approval system
  - Major deficiencies
- Expert Advice is available 24 hours for Advice not for Antibiotic approvals
  - Poor utilisation for smaller hospitals
- Contribution to national data collection (ANZCOSS)

Incorporation of Novel treatments
- Artensunate introduction to Australia
Future Development AMS in the Northern Territory

- Continued contribution too and support of the Antimicrobial guidelines, CARPA manual national data collection
- Compile a business plan for the creation of an AMS team.
  - No new position creations for the next 12-18 months
- Small jurisdiction with a lack of capacity in coordinated quality improvement activities.
- National recommendations often implemented by staff with little extra resources or support
  - Hand hygiene
  - User applied labelling of injectable medicines, fluids and lines
Antimicrobial Stewardship Forum

7 April 2011
Queensland AMS Activities - Current

- Queensland Health Medicines Advisory Committee (QHMAC)
  - State-wide formulary (List of Approved Medicines): antimicrobial restrictions
  - Drug and Therapeutic Committees
- Antimicrobial Advisory Group
- MedTrx - database on ICU, facility, district, and state-wide antibiotic use
  - Reports available to be scheduled on demand
  - Reports written by CHRISP for QHMAC twice a year
- OrgTrx – database of ward, facility, district, and state-wide susceptibility patterns and profiles
  - Access to customisable antibiograms on demand
- Pathology Queensland
  - Selectively report susceptibility tests consistent with treatment guidelines
  - Annual facility-specific antimicrobial susceptibility data
- Large hospitals – Quality Use of Medicines, local guidelines
Queensland AMS Activities - Future

- Stakeholder consultation/ organisational change management approach:
  - Queensland antimicrobial stewardship forum July 2011
- Scope feasibility of “hub and spoke” model to ensure statewide coverage and governance
  - Especially important for regional facilities without ID support
- Expansion of leadership initiative – “Voices for Infection Prevention”, to influence prescriber education and behaviour
- Develop education framework for pharmacists involved in antimicrobial stewardship teams
- Value-added statistics:
  - Bayesian shrinkage plots of facility antibiotic use
  - Identify outliers to flag with District Executive
- Research
  - Correlation between antibiotic use and resistance patterns
  - Spatial epidemiology of multi-resistant organisms
Antimicrobial Stewardship Forum

7 April 2011
## Antimicrobial Stewardship in SA hospitals

<table>
<thead>
<tr>
<th>Snapshot of AMS in SA hospitals</th>
<th>Hospital 1</th>
<th>Hospital 2</th>
<th>Hospital 3</th>
<th>Hospital 4</th>
<th>Hospital 5</th>
<th>Hospital 6</th>
<th>Country Hospital 1</th>
<th>Country Hospital 2</th>
<th>Country Hospital 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMS program Y/N</td>
<td>Partial</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (informal but new 0.5FTE AMS pharmacist)</td>
<td>No (&quot;part of clinical pharmacy service&quot;)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Formulary / guidelines</td>
<td>Yes</td>
<td>Yes</td>
<td>Few</td>
<td>Yes</td>
<td>Not yet</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Multidisciplinary team</td>
<td>Not formal - under-resourced</td>
<td>Yes</td>
<td>Pharmacist and ID only</td>
<td>Yes</td>
<td>Not yet</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Within quality improvement governance</td>
<td>No</td>
<td>Yes</td>
<td>&quot;Yes and no&quot;</td>
<td>No</td>
<td>Not yet</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Links with D&amp;T committees</td>
<td>Yes</td>
<td>Yes</td>
<td>&quot;Yes and no&quot;</td>
<td>Yes</td>
<td>Just started</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Defined roles for AMS team + Training &amp; support for AMS team</td>
<td>No</td>
<td>Partial</td>
<td>&quot;Yes and no&quot;</td>
<td>Yes</td>
<td>Not yet</td>
<td>No (&quot;part of clinical pharmacy service&quot;)</td>
<td>No</td>
<td>No</td>
<td>Part of clinical pharmacist's role</td>
</tr>
<tr>
<td>Outcome indicators</td>
<td>Usage in DDD reported to D&amp;T</td>
<td>Not regularly</td>
<td>No</td>
<td>Yes, but variably, Under-resourced for this activity</td>
<td>No but about to undertake PP survey &amp; report to Exec</td>
<td>Usage patterns reported to D&amp;T</td>
<td>No</td>
<td>No</td>
<td>Ad hoc</td>
</tr>
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</table>
Other AMS Activities in SA – **SAAGAR**
(SA expert Advisory Group on Antimicrobial Resistance)

- Multidisciplinary group (ID physicians, pharmacists, ICPs, Director CDCB, private sector representation)
- Reports to Portfolio Executive, SA Health, through the ED of Public Health & Clinical Coordination
- Current activities –
  - Statewide formulary – review of current formularies
  - Statewide surgical prophylaxis guidelines
  - Aminoglycoside treatment and monitoring guidelines
- Future activities –
  - Finalise above
  - Develop a statewide strategic plan for AMS
  - Other guidelines, eg SAB, FN, for statewide use

SA Health
Other AMS Activities in SA

> Antimicrobial utilisation surveillance programs

• (NAUSP)
• SA AUSP -
  ▪ 13 metro hospitals (7 public and 6 private)
  ▪ data since 2001
  ▪ reports sent to CEs, GMs, D&T chairs, etc
• SA country hospitals –
  ▪ program ad hoc at present –
  ▪ 18 sites, range from ~40 to 100 available beds
• Future projects
  ▪ Paediatric usage surveillance (in grams only)
Antimicrobial Stewardship Forum

7 April 2011
AMS in Tasmania

Dr Alistair McGregor
Infectious Diseases Physician and Microbiologist
Royal Hobart Hospital
Medical Advisor
Tasmanian Infection Prevention and Control Unit (TIPCU)
Current AMS activities

• State
  – DHHS has purchased and tested “Guidance - MS” which is available for all hospitals /AHS to use in AMS programs should they wish
  – TIPCU coordinating surveillance of hospital antimicrobial usage
    • All 4 major public hospitals signed up to NAUSP
    • Raw data collected centrally RHH and TIPCU, forwarded to NAUSP
    • Results fed back to individual hospitals and TIPCU

• Regional
  – RHH has implemented a comprehensive AMS program utilising “Guidance”
  – LGH commencing formal program
  – NWRH would like to have one but lacks resources
Future AMS activities - wish list

• RHH program continues and becomes embedded

• Other acute care hospitals (LGH / NWR) progress / initiate programs

• TIPCU surveillance program established and embedded
  – Allow benchmarking, explore linkages with HAI (MRSA, VRE, CDI)

• National (‘Top down’”) approach drives an expansion of AMS into other sectors (private, LTCF)
Antimicrobial Stewardship Forum

7 April 2011
Antimicrobial Stewardship in Victoria

Helen Leach
Quality Use of Medicines Program Manager
Department of Health, Victoria
An overview of current AMS activity

Background: Victorian Infection Control Strategy:

1. prevention
2. consumer information and participation
3. detection and management

Multi-resistant organism consensus conference 8 December, 2005

Recommendations – all hospitals
- have a multidisciplinary DTC to guide and monitor antibiotic use
- develop antimicrobial policies (Therapeutic guidelines: antibiotic)
- establish education program to support best practice
- required to implement antibiotic approval and monitoring program
- establish access to pharmacy and antimicrobial advice
- educational material be available to consumers
Future AMS activity

• Collaboration between the Infection Control Program and the QUM Program to develop an AMS strategy for 2011, in alignment with the ACSQHC

• Understand current activity in AMS in Victoria

• Work with to develop a future strategy for AMS in Victoria, with a view to improving safe and effective prescribing and reducing antimicrobial resistance

• Develop a project plan to guide the steps from where we are now, to where we aim to be incorporating monitoring parameters
Antimicrobial Stewardship Forum

7 April 2011
Antimicrobial Stewardship
Western Australia

Dr Owen Robinson
Infectious Diseases Consultant
Chair Antimicrobial Stewardship Committee
Royal Perth Hospital
Antimicrobial Stewardship

• Creation of WAAAG in 2010….. But lack of support

• Fremantle:
  • No absolute commitment to ASC from all consultants
  • Lack of IT support

• SCGH:
  • Creation of an ASC based on RPH structure
  • Funding available for EDSS but lack of IT support
  • Beginning of support to peripheral hospitals
antimicrobial stewardship committee (ASC) at RPH

- written TOR

- chair: ID Physician / Clinical Microbiologist

- secretary: ID Pharmacist

- other members:
  » 2 x ID Physician / Microbiologists
  » ICU Physician
  » Renal Physician
  » ED Physician
  » Infection Control Practitioner
  » DUAG Officer

- reporting to
  » DTC (monthly)
  » Hospital Executive (yearly)
antimicrobial stewardship round

- restricted antimicrobial approved
- restricted antimicrobial prescribed without approval (or not entered)

- patient details and review date entered into database

- list of patients and microbiology results generated for the round

- patient “reviewed” by clinician and ID pharmacist
Followup Details
- Followup ID: 5063
- Adm Date: 27/01/2008
- Disch Date: 27/01/2008
- Ward: 9B

Followup Advice Details

Followup Drugs (Antimicrobials)

<table>
<thead>
<tr>
<th>Followup Drugs</th>
<th>Restricted</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Duration (days)</th>
<th>Ceased</th>
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</thead>
<tbody>
<tr>
<td>CIPROFLOXACIN 100mg INFUSION 50mL</td>
<td></td>
<td>200mg</td>
<td>IV</td>
<td>bd</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>CIPROFLOXACIN 500mg TABLETS</td>
<td></td>
<td>500mg</td>
<td>Oral</td>
<td>bd</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2 record(s)

Action Taken: Followed advice

General Comments:
- Improving - switch to oral

Followup Date: 30/01/2008
Followup Review Date: 13/02/2008

Cost Savings
- Estimated Days: 0
- Min (d): 0
- Max (d): 0
- Cost saving/day: 0.00

Comments: po to iv switch

Potential cost saving: False

Cost Increase: False
antimicrobial stewardship round: evaluation

- >5,000 patients reviewed since 2005
- 90% “fully” or “partially” adherent with advice
- estimated cost savings $130,000 / year
  - n=273, estimated savings = $85K (6-months), 87% of advice followed
- 2 complaints
- time consuming
flucloxacillin + vancomycin

Therapy rationalised early
CONSIDER CONVERSION FROM IV TO ORAL ANTIBIOTICS WHEN ALL THE FOLLOWING APPLY:

- temperature <38°C or improving over 24 hrs
- signs & symptoms improved or resolved
- oral / nasogastric intake tolerated & absorbed
- no diagnostic indication for IV therapy eg. endocarditis, febrile neutropenia, S. aureus bacteraemia, meningitis, osteomyelitis
- suitable oral alternative available
- patient likely to be adherent with oral therapy

<table>
<thead>
<tr>
<th>IV TO ORAL SWITCH REGIMENS</th>
<th>IV</th>
<th>ORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>AMOXYCILLIN 1-2g qid</td>
<td>AMOXYCILLIN 500mg-1g tds</td>
</tr>
<tr>
<td></td>
<td>AZITHROMYCIN* 500mg daily</td>
<td>ROXITHROMYCIN 300mg daily</td>
</tr>
<tr>
<td></td>
<td>BENZYLPCNILLIN 1.2-1.8g qid</td>
<td>AMOXYCILLIN 1g tds</td>
</tr>
<tr>
<td></td>
<td>CEFTRIAZONE* 1g daily</td>
<td>CEFUROXIME 500mg bd (chest inf)</td>
</tr>
<tr>
<td></td>
<td>CEPHAZOLIN 1-2g tds</td>
<td>CEPHALEXIN 500mg-1g tds-qid or</td>
</tr>
<tr>
<td></td>
<td>CIPROFLOXACIN* 200-400mg bd</td>
<td>CIPROFLOXACIN* 500-750mg bd</td>
</tr>
<tr>
<td></td>
<td>CLINDAMycin 450-600mg tds</td>
<td>CLINDAMycin 450mg tds</td>
</tr>
<tr>
<td></td>
<td>FLUCLOXACILLIN 1-2g qid</td>
<td>FLUCLOXACILLIN 500mg-1g qid</td>
</tr>
<tr>
<td></td>
<td>FLUCONAZOLE* 100-400mg daily</td>
<td>FLUCONAZOLE* 100-400mg daily</td>
</tr>
<tr>
<td></td>
<td>METRONIDAZOLE 500mg bd</td>
<td>METRONIDAZOLE 400mg bd</td>
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<td>MOXIFLOXACIN* 400mg daily</td>
<td>MOXIFLOXACIN* 400mg daily</td>
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<tr>
<td></td>
<td>TAZOCIN® 4.5g tds</td>
<td>AUGMENTIN DUO FORTE® 875/125mg bd (if Pseudomonas or resistant G-ve d/w MICRO/ID)</td>
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<tr>
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<td>TIMENTIN® 3.1g qid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMOXYCILLIN 1-2g qid plus GENTAMICIN 5mg/kg/day</td>
<td></td>
</tr>
</tbody>
</table>
RIFAMPICIN USE IN OPERATING THEATRES AT RPH
July 2008

RIFAMPICIN 600mg INJECTION
acquisition cost (July 2008) = $102.50 per vial
imprest stock level in operating theatres = 3 vials

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ANNUAL USAGE</th>
<th>ANNUAL EXPENDITURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>37 vials</td>
<td>$3,795</td>
</tr>
<tr>
<td>2006-07</td>
<td>38 vials</td>
<td>$3,899</td>
</tr>
<tr>
<td>2007-08</td>
<td>57 vials</td>
<td>$5,849</td>
</tr>
</tbody>
</table>
2.2 Recommendations

2.2.1 Hospitals have a list of restricted antimicrobial agents and criteria for their use that is consistent with Therapeutic Guidelines: Antibiotic.

2.2.2 Hospitals implement an antimicrobial approval system.

2.2.3 Compliance with the approval process is audited on a regular basis.

2.2.4 Expert advice is available 24 hours a day to guide clinicians in prescribing antimicrobials.
5.2 **Recommendations**

5.2.1 Antimicrobial usage data is collected and regularly reviewed to identify areas for improvement.

5.2.2 Quality indicators are monitored to assess appropriate prescribing practice and compliance with policy.

5.2.3 Information technology resources are available for:

- monitoring antimicrobial usage
- auditing process indicators
- measuring outcomes of the antimicrobial stewardship program.

5.2.4 Antimicrobial usage data is interpreted together with infection control and antimicrobial resistance data.
7.2 Recommendations

7.2.1 Hospitals have access to a clinical microbiology service that provides the following services:

» best-practice diagnostic testing for infection, including relevant rapid tests for common viral, fungal or bacterial pathogens that are reported to clinicians

» consultation on choice, nature, handling and testing of specimens for detection of infection, especially when there is a broad infectious differential diagnosis under consideration

» direct advice from specialist consultant or supervised registrar to clinicians at the time when bloodstream, meningeal or other critical infection is detected. This should occur seven days per week

» regular patient-specific liaison with clinicians (including infectious diseases physicians if they are not integrated with the clinical microbiology service) who care for patients at a high risk of infection (e.g. patients in intensive care, haematology and oncology units).
7.2.2 Regular analyses of antimicrobial resistance are provided to groups with responsibility for local antimicrobial guidelines (e.g. antimicrobial stewardship committee, drug and therapeutics committee) to inform local empirical therapy recommendations and formulary management.

7.2.3 Cascade reporting of antimicrobial susceptibility is consistent with the *Therapeutic Guidelines: Antibiotic*.

7.2.4 A national standard approach to antimicrobial susceptibility testing and cumulative analysis and reporting of antibiograms is developed, agreed and implemented by clinical microbiology services.
9.2 Recommendations

9.2.1 The antimicrobial stewardship team includes a pharmacist who has experience or is trained in antimicrobial stewardship and who is allocated time and resources for antimicrobial stewardship activities.

9.2.2 Pharmacists review antimicrobial orders for adherence to local guidelines and provide timely feedback (where applicable) to the prescriber.

9.2.3 Pharmacists are supported by the hospital in enforcing antimicrobial prescribing policies, including formulary restrictions and encouraging adherence to local prescribing guidelines.

9.2.4 Hospitals support training for pharmacists to equip them with the knowledge and skills required to effectively participate in antimicrobial stewardship activities.

9.4.5 Mechanisms are in place to allow pharmacists to seek expert advice from, and refer to, a clinical microbiologist or infectious diseases physician.
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Acknowledgements

Matt Rawlins, Pharmacist
Antibiotic Stewardship in Private Hospitals
Summary

• When Ghandi was asked what he thought of Western Civilisation he said “I think it would be a good idea”

• Private Hospitals do seem to have 2-3 times the DDD rate of similar public hospitals but…..

• Private hospitals aren’t the problem.
Sample

• Spoken to Hospital Pharmacy Services HPS pharmacists and their colleagues.
• ID physicians who attend all Adelaide private hospitals
• St Andrews approaches.
Findings

• Other than administrative review of high cost drugs there are no effective antimicrobial stewardship processes in Adelaide.

• Adelaide PH’s are much like the rest of the country.
Reasons.

• No clinical speciality service structures with enough influence to achieve compliance.

• Culture of the individual autonomous practitioner.

• Rebates are set to cover antibiotic costs.

• Not a “hospital” problem

• Private patients entitled to the most expensive antibiotics.
• No formularies.
• Sensitivities reported for expensive antibiotics.
• IPC staff deal with cases not prescribing habits.
• No internal monitoring and reporting systems.
• No organisational control processes.
• Cost effectiveness needs to be proven as hospital will need to fund.
• Current VRE epidemics originated in public services with lower DDD usage.

• Private hospitals have many more single rooms and infection rates generally lower so case for change harder to sustain.
Antimicrobial Stewardship Forum

7 April 2011