



Republic of the Philippines  
Department of Health  
**OFFICE OF THE SECRETARY**

JAN 17 2019

**ADMINISTRATIVE ORDER**

No. ~~2018-001~~ 2019-0002

**SUBJECT: Implementing Guidelines on the Philippine Antimicrobial Stewardship (AMS) Program for Hospitals**

**I. BACKGROUND**

Antimicrobial resistance (AMR) is a significant public health threat that causes major health and economic consequences both in human and veterinary health. It claims lives, prolongs illnesses, increases healthcare costs and financial burden, adversely affects trade, as well as threatens national and global security. In the Philippines, the *Antimicrobial Resistance Surveillance Program (ARSP)* found very alarming resistance rates among various pathogens.

In 2009, the Health Facilities Development Bureau (HFDB) formerly National Center for Health Facilities Development (NCHFD) of the Department of Health (DOH) published the National Standards in Infection Control for Healthcare Facilities to strengthen infection prevention and control (IPC) programs nationwide and prevent the occurrence of healthcare-associated infections (HAI) among patients. It also provided guidelines for the hospital management, service providers and support staff on the provision of quality services at various aspects of work and service delivery points in the hospital.

The Office of the President issued in 2014 the Administrative Order (AO) No. 42 entitled "*Creating an Inter-Agency Committee for the Formulation and Implementation of a National Plan to Combat Antimicrobial Resistance in the Philippines*" to bring together all key partners across many sectors towards identifying and implementing concrete efforts and plans to mitigate and control AMR. The Department of Health (DOH) led the finalization of "*The Philippine Action Plan to Combat Antimicrobial Resistance: One Health Approach*" through the Inter-Agency Committee on AMR (ICAMR) which was launched during the 1<sup>st</sup> Philippine AMR Summit in 2015. Stipulated in the action plan are the country strategies that focus on the following core areas: leadership and governance; surveillance and laboratory capacity; access to essential medicines of assured quality; awareness and promotion; infection prevention and control; rational antimicrobial use among humans and animals; and research and development.

In response to the prevailing epidemiologic trends of infectious diseases, AO No. 2016-0002 entitled "National Policy on Infection Prevention and Control in Healthcare Facilities" was issued by HFDB to further provide guidance and strengthen the implementation of IPC programs across hospitals. The AO No. 2016-0002 outlines 14 priority areas of IPC programs to be established in healthcare

facilities. Included in the list is the institutionalization of an Antimicrobial Stewardship (AMS) Program that aims to strengthen the knowledge, attitude and practices of involved stakeholders on rational prescribing, dispensing and use of antimicrobials; and, to improve patient outcomes by decreasing infections caused by resistant organisms.

The World Health Organization (WHO) defined AMS as a multidisciplinary, multi-intervention, coordinated approach to improve the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen to ensure that the right choice of antibiotic, right route of administration, right dose, right time, and right duration of treatment are strictly observed to minimize harm to the patients. To set the standards on the implementation of the AMS program in hospitals, the DOH hereby issues this Order.

## **II. OBJECTIVES**

### **General Objective:**

This Order aims to define the overall framework and strategic directions to implement the Philippine Antimicrobial Stewardship (AMS) Program in all hospitals nationwide towards improving the use of antimicrobials, mitigating, and preventing the emergence of antimicrobial resistance (AMR) in the Philippines.

### **Specific Objectives:**

The implementation of the Philippine AMS Program aims to:

1. Promote rational and optimal antimicrobial therapy;
2. Effect positive behaviour and institutional changes towards ensuring the optimal use antimicrobials by the prescribers, dispensers, other healthcare professionals, and patients in the hospitals;
3. Establish multidisciplinary leadership and commitment, clinical governance and accountability in antimicrobial management and control ensuring that interventions are sustainable and well-supported with necessary technical and financial resources;
4. Create an environment where healthcare professionals are supported with tools and systems to implement antimicrobial management;

## **III. SCOPE AND COVERAGE**

This Order shall be applicable to all Level 1, 2, and 3 hospitals in the Philippines, both in the public and private sector.

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#### IV. DEFINITION OF TERMS

1. **Antimicrobial Resistance (AMR)** – is the defense mechanism developed by a microorganism (including bacteria, viruses and some parasites) to an antimicrobial drug to which it was previously sensitive. AMR, which is a consequence of the use or misuse of an antimicrobial agent, ensues when a microorganism mutates or acquires a resistant gene. Resistant organisms withstand attack by antimicrobial or antiparasitic agents so that standard treatments become ineffective, allowing infections to persist and spread.
2. **AMR Surveillance** – is the tracking of changes in microbial populations which permits the early detection of resistant strains of public health performance resulting in the prompt notification and investigation of outbreaks.
3. **Antibiogram** – is an overall profile of antimicrobial susceptibility testing results of a specific microorganism to a battery of antimicrobial drugs.
4. **Antimicrobial Resistance Surveillance Program (ARSP)** – is a laboratory-based surveillance system in selected hospital sentinel sites that determines the current status and developing trends of resistance of selected bacteria to specific antimicrobials, with the Research Institute for Tropical Medicine (RITM) as the DOH national reference laboratory.
5. **Antimicrobial Stewardship (AMS)** – refers to a multidisciplinary, multi-intervention, coordinated approach to improve the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen to ensure the right choice of antibiotic, right route of administration, right dose, right time, and right duration to minimize harm to the patient and future patients.
6. **Antimicrobial Use (AMU) Surveillance** – is the act of tracing how and why antimicrobials are being used and misused by patients and healthcare providers.
7. **Automatic Stop-order** – refers to the method of appropriately limiting the duration of antimicrobial usage which can be employed for the use of empiric or therapeutic antimicrobials.
8. **De-escalation Therapy** – refers to the method of narrowing the spectrum of an empiric antimicrobial regimen which includes adjusting an empiric antibiotic regimen on the basis of culture results and other data; and, discontinuing empiric therapy if testing subsequently fails to demonstrate evidence of an infectious process.
9. **Dose Optimization** – refers to the method of ensuring that specific characteristics of the drug (e.g., concentration or time-dependent killing, toxicities), the infectious agent (e.g., minimum inhibitory concentration), the patient (e.g., weight, renal function), and the site of infection are all taken into account in the treatment.

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10. **Emerging Infectious Diseases (EIDs)** – are newly identified, previously unknown, or drug-resistant infections whose incidence in human has increased within the past two decades or whose incidence threatens to increase in the near future.
11. **Infection Control Committee (ICC)** – refers to a body that provides a forum for multidisciplinary input cooperation and information sharing tasked to ensure overall implementation of infection control strategies by formulating and updating infection control policies, guidelines and procedures. Representation includes management, physicians, and other healthcare workers from clinical microbiology, pharmacy, sterilizing service, housekeeping and training services.
12. **Infection Prevention and Control (IPC)** – refers to the discipline which comprises measures, practices, protocols and procedures all aimed at preventing and controlling the development of new infections acquired in healthcare settings.
13. **Intravenous to Oral Antimicrobial Therapy Switch** – refers to the method of changing from intravenously administered antimicrobials to orally administered antimicrobials used for antimicrobial agents with which similar concentrations are achieved whether administered intravenously or orally.
14. **National Antibiotic Guidelines Committee (NAGCom)** – is a technical committee at the DOH composed of specialists on infectious diseases created to develop antibiotic guidelines for health facilities aiming to provide information on the treatment of choice/ recommendations for selected pathogen-specific conditions based on recent evidences of clinical effectiveness, adverse effects, cost and patterns of resistance; and, necessary dosing and monitoring guidelines for specific antimicrobials.
15. **National External Quality Assessment Scheme (NEQAS)** – refers to the external evaluation of a laboratory's performance using proficiency panels which aims to evaluate the effectiveness of the quality assurance program.
16. **Philippine National Formulary (PNF)** – refers to the list of medicines prepared and periodically updated by the DOH that satisfy the priority health care needs of the population and which are selected based on evidence of their efficacy, safety and comparative cost-effectiveness. This serves as the national reference for quality and rational selection of the medicines which are vital in achieving the best health outcomes.
17. **Pharmacy and Therapeutics Committee (PTC)** – is the primary multi-disciplinary body of the hospital or government health unit that governs issues related to medicines such as evaluation, selection, rational use and other related matters.
18. **Point-of-care (POC) Interventions** – are interventions that occur at the ward level with the treating medical team, often soon after empirical therapy has been initiated. These provide direct feedback to the prescriber at the time of prescription or laboratory diagnosis, and provide an opportunity to educate clinical staff on appropriate prescribing.

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## V. GENERAL GUIDELINES

1. The national AMS program for hospitals shall be created as part of the overall comprehensive National Action Plan to Combat AMR, pursuant to AO 42 series of 2014. The program shall be headed by the Pharmaceutical Division (PD) of the DOH Central Office in partnership with the Health Facilities and Services Regulatory Bureau (HFSRB) and the Health Facility Development Bureau (HFDB).
2. The AMS program shall be based on six core elements stated in the implementing guidelines, namely: (1) leadership; (2) policies, guidelines, and pathways; (3) AMR and antimicrobial use (AMU) surveillance; (4) action; (5) education; and (6) performance evaluation. These shall provide a systematic approach to optimize the use of antimicrobials within the facility reducing adverse consequences of antimicrobial use which include AMR, toxicity and unnecessary healthcare costs.
3. The AMS Program shall be part of the overall initiatives in improving patient safety; quality of care; national policy for infection prevention and control; management of emerging infectious diseases; and the current hospital licensing standards of the DOH.
4. All hospitals shall establish an effective and efficient AMS program that involves a multidisciplinary, multi-intervention and coordinated strategy to optimize the use of antimicrobials. This shall be led by an AMS Committee in partnership with the Pharmacy and Therapeutics Committee (PTC), the Infection Control Committee (ICC) and the Patient Safety Committee to enable a holistic and coordinated approach in implementing AMS strategies. In cases where it cannot be instituted due to variations across the health facilities depending on available resources and expertise, hospitals are granted with flexibility where to place the AMS program considering existing hospital management structure, as long as accountabilities are clear and outputs are delivered.
5. An AMS Steering Committee composed of experts from key professional societies and representatives from relevant DOH units shall be created to develop the AMS Manual of Procedures (MOPs) and oversee the conduct of monitoring and evaluation of the AMS program implementation in all hospitals.
6. The DOH shall identify hospitals which shall serve as training hubs that shall provide infrastructure for multi-professional skills training and education on AMS programs in hospitals.

## VI. IMPLEMENTING GUIDELINES

The hospitals shall be governed by the six (6) AMS core pillars:

### A. Leadership

1. The Chief of Hospital and designated members of the hospital administration shall be responsible and accountable in implementing AMS in their facility

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and shall ensure leadership and management support through but not limited to the following:

- a. Dedicating sufficient funding and resources for AMS-related activities;
  - b. Allowing the staff to contribute to the AMS goals of the hospital through participation in the hospital stewardship program;
  - c. Supporting training and continuous education;
  - d. Ensuring accountability from all levels and across relevant clinical departments through continuous monitoring of performance; and,
  - e. Building an enabling environment to support AMS-related activities such as setting up an information technology (IT) system to monitor antibiotic use or antibiotic alert systems
2. The Chief of Hospital shall create a governance structure through an issuance that shall define the different roles and responsibilities, and job descriptions of all hospital staff in stewardship-related activities and other relevant initiatives on infection prevention and control.
  3. The AMS Committee shall be composed of an infectious disease specialist (IDS), medical microbiologist, AMS clinical pharmacist, representatives from the AMS Team, clinicians from key medical and surgical departments, and members of the hospital management, to include members of other related groups such as the PTC and ICC.
  4. The AMS Team shall be composed of an Infectious Disease Specialists (IDS) (Levels 2 and 3 hospitals), AMS-trained physician (Level 1 hospitals), AMS Clinical Pharmacist, and an Administrative Staff.

#### **B. Policies, Guidelines, and Clinical Pathways**

1. All hospitals shall have an antibiotic policy to promote rational prescribing and dispensing practices.
2. All hospitals shall adopt or adapt to their local context the National Antibiotic Guidelines to guide the clinicians in the management of infectious diseases.
3. The AMS Committee, together with the PTC and ICC, shall be responsible for the development, implementation and revisions of the hospital antimicrobial policy, standard guidelines and pathways, with the support and commitment from the hospitals administration.
4. The policy, guidelines, and pathways shall be reviewed regularly and updated as needed to determine if these are still effective based on the hospital's AMR rates and antimicrobial use data.

#### **C. Surveillance of AMU and AMR**

1. The AMS Committee shall ensure the regular Antimicrobial Use (AMU) monitoring which shall be reported to DOH-PD annually and to relevant hospital departments as well.

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2. All hospitals shall conduct AMR surveillance and develop annual institutional antibiogram (through the AMS Committee and the microbiology laboratory) for reportable pathogens which shall be identified in the AMS MOPs defined by the Antimicrobial Resistance Surveillance Program (ARSP) at least once a year, which shall be submitted annually to the Research Institute for Tropical Medicine (RITM). For hospitals without an on-site microbiology laboratory, microbiological culture and sensitivity results shall be obtained from external laboratories for their own set of patients so they can develop their own antibiogram.
3. The microbiology laboratory of the hospital shall participate and pass both the National External Quality Assessment Scheme (NEQAS) for microbiology and the Antimicrobial Resistance Surveillance Program Bacteriology Laboratory Accreditation for PhilHealth reimbursement of select antimicrobials in the Philippine National Formulary (PNF).
4. The hospital management shall strengthen the capacity for laboratory surveillance that shall allow monitoring of antimicrobial susceptibility patterns and detection of resistant pathogens.

#### **D. Action**

1. The hospital shall employ a comprehensive combination of persuasive and restrictive interventional strategies which shall be listed in the AMS MOPs to safeguard and ensure the optimal use of all antimicrobials used within the facility. These may include antimicrobial restriction and pre-authorization, seventh day automatic stop order, audit and feedback, and point-of-care (POC) interventions such as dose optimization, streamlining or de-escalation of antimicrobial therapy and intravenous to oral antimicrobial therapy switch.
2. All antimicrobials prescribed and used for admitted patients within the hospital shall be subjected to the interventions of the AMS program.

#### **E. Education**

1. The PD shall disseminate the AMS MOPs to all levels of hospital care.
2. All hospitals shall aim to provide training and continuous education to healthcare staff, who are in contact with patients on antibiotics. These include not only the prescribers (i.e. attending physicians), nurses, clinical pharmacists, microbiologists, and midwives, but also medical students and paramedical staff under training to ensure that the transfer of basic and advanced scientific knowledge and skills on the proper use of antibiotics occurs at an early stage.
3. The AMS Committee shall ensure that the above-mentioned hospital personnel attend the standard Training Course on AMS through an education program certified or recognized by the DOH.

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4. Hospitals, especially the teaching and training institutions, shall also develop training modules with clear learning outcomes and competencies on AMS covering microbiology, prevention and control of infectious diseases, clinical pharmacology, hospital pharmacy and patient communication skills and the prudent use of antibiotics.
5. AMS Practitioners shall continually update themselves on the newest developments in the area of microbiology, infectious disease management and prevention, pharmacotherapy, and AMS practice.
6. All hospitals shall ensure that systems are in place for patient education and counselling on how to take their prescribed antimicrobials correctly and use antimicrobials responsibly.
7. The DOH shall identify public and private hospitals which shall serve as the AMS training hubs and forge a partnership based on the existing rules and regulations. These institutions shall:
  - a. Facilitate and organize the conduct of the AMS training
  - b. Manage the administrative matters related to the conduct of the activity including the management and disbursement of funds, and coordination with the participants
  - c. Perform secretariat functions which are, but not limited to:
    - i. Preparation and organization of programme (based on the DOH prescribed content)
    - ii. Selection and invitation of resource persons
    - iii. Provision of logistical support
    - iv. Documentation of issues raised during the training program
    - v. Coordination with the DOH AMR secretariat for the pre- and post-training activities (including the preparation of necessary reports)
  - d. Submit sub-allotment utilization/liquidation report to the DOH-PD (for public training hubs only)

#### **F. Performance Evaluation**

1. An AMS Steering Committee (ASC) shall be created to oversee the conduct of monitoring and evaluation of the AMS program and provide relevant evidence-based recommendations to the DOH.
2. The AMS Committee of all hospitals shall submit to the DOH PD an annual AMS program monitoring report based on the tool developed (Annex A) for tracking of progress of the AMS Program.

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## **VII. ROLES AND RESPONSIBILITIES**

### **A. Department of Health Central Office**

#### **1. Pharmaceutical Division (PD)**

- a. Facilitate the development of the AMS MOPs which shall stipulate the details of the AMS implementation in the hospitals.
- b. Lead the overall monitoring of the implementation of the AMS program in hospitals in partnership with the HFDB and HFSRB.
- c. Provide technical assistance on the implementation of the program through the dissemination of the AMS MOPs and participation in the training roll-outs.
- d. Convene and provide technical and administrative support to the NAGCom in the updating of the national antibiotic guidelines and ASC in formulating their AMS program recommendations.
- e. Provide technical assistance on AMU surveillance and interpret antimicrobial consumption data submitted by the hospitals and publish annual report.
- f. Collect and analyze monitoring and evaluation reports from hospitals.

#### **2. Disease Prevention and Control Bureau (DPCB)**

- a. Identify DOH-accepted Clinical Practice Guidelines of infectious diseases that are of public health importance for adoption of the hospitals.
- b. Inform the relevant agencies on the updated treatment guidelines of the respective public health programs.
- c. Develop standards and protocols on managing emerging infectious diseases (EIDs) in partnership with EB, HFDB and RITM.

#### **3. Epidemiology Bureau (EB)**

- a. Provide technical assistance on epidemiology and surveillance for hospital-acquired infections (HAI), and AMR.
- b. Serve as the national collaborating center for the reported AMR cases in hospitals which include diseases of public health importance and these pathogens being monitored through the ARSP.

#### **4. Field Implementation and Coordination Team (FICT)**

- a. Ensure adherence of all hospitals to the guidelines of the AMS implementation.

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**5. Health Facility Development Bureau (HFDB)**

- a. Participate in the monitoring of AMS implementation in hospitals in partnership with the PD and HFSRB.
- b. Ensure that AMS program is aligned to the National Infection Prevention and Control Policy and, the overall quality of care and patient safety.

**6. Health Facilities and Services Regulatory Bureau (HFSRB)**

- a. Ensure that the institutionalization and effective implementation the AMS program, and integration of the AMS program and reporting of AMR surveillance data are part of the licensing and re-licensing requirements of hospitals.
- b. Ensure that ICC and PTC in hospitals are functional as part of the minimum licensing requirements and compliant with the DOH program policies on antimicrobial resistance.
- c. Perform corresponding regulatory actions for hospitals that will deviate from the timeline (Annex B) of AMS institutionalization in their facilities.

**7. Food and Drug Administration (FDA)**

- a. Ensure the safety, efficacy, and quality of antimicrobials available in the market.
- b. Advocate the standards on the good storage and distribution practices of antimicrobials within the hospital to ensure that their quality and integrity are maintained.
- c. Evaluate the reports received from the hospitals on antimicrobials that resulted in failure of therapy.

**8. Philhealth**

- a. Ensure reimbursement of antimicrobials listed in the PNF.

**9. Research Institute for Tropical Medicine (RITM)**

- a. Oversee the implementation of ARSP in hospitals.
- b. Monitor generation of data on AMR patterns in the hospitals.
- c. Provide technical assistance in maintaining AMR surveillance.
- d. Generate and disseminates countrywide ARSP data.

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## **B. DOH Regional Offices**

1. Ensure that all antimicrobials are rationally prescribed, dispensed and used by all healthcare professional and patients by practicing AMS at all levels of healthcare towards successfully combatting AMR in the region.
2. Provide technical support on the AMS implementation to the hospitals in their respective regions.
3. Furnish the DOH PD feedback report on the status of hospitals implementing the AMS program.

## **C. Hospitals**

1. **Chief of Hospital or Medical Director** together with the members of the hospital administration shall:
  - a. Ensure that a local framework for AMS program is in place.
  - b. Dedicate sufficient funding and resources for AMS-related activities for the operations of the AMS Team.
  - c. Establish an enabling environment to support AMS-related activities.
  - d. Allow staff to contribute to the AMS goals of the hospital through participation in the hospital AMS program.
  - e. Support AMS-related training and continuous education.
  - f. Ensure accountability from all levels and across relevant clinical departments through continuous monitoring of performance.
2. **AMS Committee**
  - a. Develop and maintain antimicrobial policies, formulary, and clinical practice guidelines for antimicrobial treatment and prophylaxis.
  - b. Supervise the overall implementation, monitoring of the effectiveness and championing the efforts to improve the hospital's AMS program and initiatives with direct accountability to the PD.
  - c. Ensure the availability of resources for the sustainability of the AMS program.
  - d. Collaborate with the Pharmacy and Therapeutics Committee (PTC) and Infection Control Committee (ICC) in promoting rational use of medicines.

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- e. Provide feedback to prescribers and conduct educational activities for medical, nursing and pharmacy staff on antimicrobial prescribing and AMS principles.
- f. Monitor antimicrobial usage and resistance.

### **3. AMS Team**

- a. Implement the AMS strategies and perform AMS interventions as needed.
- b. Develop and review standard treatment guidelines and prescribing policies.
- c. Regularly collect, analyze and report the progress of the AMS program to the hospital AMS Committee, administrators, and DOH.
- d. Educate healthcare staff on appropriate antimicrobial prescribing and resistance.
- e. Identify and design systems/processes to facilitate appropriate antimicrobial use.
- f. Provide expert advice on the development of policies related to appropriate use of antimicrobials and control of AMR in the hospital.

### **4. ICC and PTC**

- a. Maintain the antimicrobial policies and formulary, and ensure that they remain current and adhered to.
- b. Develop, maintain and disseminate the hospital program.
- c. Lead in the creation of evidence-based treatment and surgical prophylaxis guidelines that are incorporated into the antimicrobial policy.
- d. Monitor the process and outcome measures of antimicrobial policies.

### **5. Microbiology Laboratory Department**

- a. Ensure the timely identification of pathogens and the quality performance of routine antimicrobial susceptibility testing.
- b. Provide microbiological expertise in the development and review of standard treatment guidelines and formulary restrictions.
- c. Participate in the evaluation of AMU and AMR surveillance.
- d. Assist in infection prevention and control efforts.

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## **VIII. MONITORING AND EVALUATION**

- A. The DOH PD through the ASC shall be responsible for the implementation and monitoring of the AMS program in hospitals.
- B. The HFDB and HFSRB shall ensure that the health facilities are compliant with the prescribed standards necessary for the fulfilment of licensing and re-licensing requirements of hospitals.
- C. The monitoring and evaluation of the AMS program in hospitals shall be documented which shall always be available for public health purposes.

## **IX. FUNDING SOURCE**

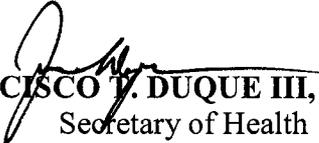
The budget for the national implementation of the AMS program shall be derived from the funds of the DOH PD and the resources provided by development partner organizations. The hospitals shall incorporate in their annual budget plan line items related to the AMS implementation and ensure the sustainability of the program.

## **X. REPEALING CLAUSE**

All previous Orders inconsistent in part or in whole to this Administrative Order are hereby rescinded or amended accordingly.

## **XI. EFFECTIVITY**

This Order shall take effect immediately.

  
**FRANCISCO T. DUQUE III, MD, MSc**  
Secretary of Health

# ANNEX A



Republic of the Philippines  
Department of Health  
**OFFICE OF THE SECRETARY**

## ANTIMICROBIAL STEWARDSHIP (AMS) MONITORING TOOL FOR HOSPITALS

Name of Hospital: \_\_\_\_\_

Region/Province: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Time started: \_\_\_\_\_

### A. Leadership

1. Is there an existing hospital policy for the implementation of the Antimicrobial Stewardship (AMS) program?

Yes

No

If yes, when was the AMS hospital policy signed? (dd/mm/yyyy): \_\_\_\_\_

If no, when does the hospital aim to issue a policy? \_\_\_\_\_

2. Which of the following handles the AMS program in your hospital?

Antimicrobial Stewardship Committee

Infection Control Committee (ICC)

Pharmacy and Therapeutics Committee (PTC)

Others (please specify): \_\_\_\_\_

*\*Request for the organizational structure of the AMS program within the facility. The AMS Committee may be independent or lodged with either the ICC or the PTC.*

3. Are the roles and responsibilities of the hospital staff involved in the stewardship-related activities stated in the policy?

Yes

No, why not? \_\_\_\_\_

4. Is there a trained AMS team at your hospital?

Yes

No, why not? \_\_\_\_\_

*\*Note: The 'AMS team' must be composed of more than one staff member who supports clinical decisions to ensure appropriate antimicrobial use.*

5. Is there a physician identified as a leader for AMS activities at your hospital?

Yes, who leads? \_\_\_\_\_

No

6. Are there sufficient funding and resources for AMS-related activities in your hospital?

Yes

No

If yes, how much? \_\_\_\_\_

If no, what resources are lacking? \_\_\_\_\_

7. Is there an IT system being utilized to support AMS-related activities in your hospital?

Yes

No

If yes, please identify the software/s being used by your hospital: \_\_\_\_\_

8. Kindly list the challenges encountered by your hospital in establishing the AMS program.

### B. Policy, Guidelines and Clinical Pathways

9. Does your hospital implement an antibiotic policy to promote rational antimicrobial prescribing and dispensing practices?

Yes

No

*\*If yes, request for a copy of the policy.*

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<p>10. Does your hospital keep a soft and hard (if downloaded) copy of the National Antibiotic Guidelines?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No</p>
<p>11. Does your hospital have facility-specific treatment recommendations based on local antimicrobial susceptibility to assist with antimicrobial selection for common clinical conditions?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No</p>
<p>12. Does your hospital follow clinical pathway/s in treating infections and syndromes?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No          If yes, please identify the infections and syndromes being addressed by these clinical pathways:</p>
<p>13. Does the facility have an approved hospital formulary list?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No, why not? _____  <i>*If yes, request for a copy of the hospital formulary list.</i></p>
<p><b>C. Antimicrobial Use and Antimicrobial Resistance Surveillance</b></p>
<p>14. Has your facility produced an antibiogram in the past year?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No</p>
<p>15. Who interprets your hospital antibiogram? _____</p>
<p>16. Is the antibiogram accessible to all healthcare staff?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No</p>
<p>17. Is there a platform for the monitoring of antimicrobial use (AMU) in your hospital?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No          If yes, please identify the tool being used for AMU surveillance: _____</p>
<p>18. Is there a pharmacist responsible for ensuring appropriate antimicrobial use at your facility?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No</p>
<p>19. Does your hospital conduct analysis of the antibiogram and AMU data?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No          If yes, please describe the methodology of analysis: <i>(Does the hospital correlate the laboratory data on resistant pathogens with AMU?)</i></p>
<p>20. Do you impose restricted antimicrobial list?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No, why not? _____</p>
<p><b>D. Action</b></p>
<p>21. Which of the following AMS interventions does your hospital implement? Check all applicable:  <input type="checkbox"/> Antimicrobial restriction and pre-authorization  <input type="checkbox"/> Seventh day automatic stop order  <input type="checkbox"/> Dose optimization  <input type="checkbox"/> Streamlining or de-escalation of antimicrobial therapy  <input type="checkbox"/> IV-to-PO antimicrobial therapy switch  <input type="checkbox"/> Audit and Feedback  <input type="checkbox"/> Others, please specify: _____</p>
<p>22. Does your facility have a written policy that requires prescribers to document an indication in the medical record or during order entry for all antimicrobial prescriptions?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No, why not? _____  <i>*If yes, request for a copy of the policy.</i></p>
<p>23. Is it routine practice for specified antimicrobial agents to be approved by a physician prior to use in your hospital?  <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No</p>

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24. Is there a formal procedure for a physician, pharmacist, or other staff member to review the appropriateness of an antimicrobial within or after 48 hours from the initial order?  
 Yes  
 No
25. Does your hospital monitor if the indication is captured in the medical record for all antimicrobial prescriptions?  
 Yes  
 No
26. Are the results of antimicrobial audits or reviews communicated regularly with prescribers?  
 Yes, how regular? \_\_\_\_\_  
 No

**E. Education**

27. Does your hospital conduct AMS-related trainings and seminars to all its staff?  
 Yes  
 No
28. Does your hospital promote collaboration among its healthcare professionals?  
 Yes  
 No
29. Does your hospital organize activities that will strengthen the knowledge of the patients and caregivers in on rational use of antimicrobials?  
 Yes  
 No
30. Which of the following does your hospital use to disseminate AMS-related information within the facility? Please check and describe all applicable:  
 Posters  
 Newsletters  
 Leaflets/pamphlets  
 Television  
 Others, please specify: \_\_\_\_\_

**F. Performance Evaluation**

31. How often does your hospital evaluate its AMS programs?  
 Annually  
 Biannually  
 Quarterly  
 Others, please specify: \_\_\_\_\_
32. Have you developed an annual report on antimicrobial stewardship in the past year?  
 Yes  
 No

**NOTES:**

_____ Name of Interviewer and Designation	_____ Name of Interviewee and Designation	
Time finished: _____		

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## ANNEX B

### Requirements and Timeline of Implementation of AMS Program by Level of Healthcare Facility

Core Elements	Level I	Level II	Level III
1. Leadership	AMS Team + AMS/ ICC Committee‡ 2020	AMS Team + AMS/ ICC Committee‡ 2018	AMS Team + AMS/ ICC Committee‡ 2018
2. Policy, Guidelines and Clinical Pathways	Policy – 2019 Guidelines and Pathways - 2020	Policy – 2018 Guidelines and Pathways - 2019	Policy – 2018 Guidelines and Pathways - 2019
3. Surveillance of AMU and AMR	AMU surveillance- 2020	AMU surveillance – 2019 AMR surveillance - 2019	AMU surveillance – 2018 AMR surveillance - 2019
4. Action: Restriction and Pre-authorization	2020	2018	2018
4. Action: Seventh Day Automatic Stop Order	2020	2018	2018
4. Action: Point-Of-Care interventions	NA*	2019	2019
4. Action: Audit-and-feedback	NA*	2022	2022
5. Education	2019	2018	2018
6. Performance Evaluation	2022	2022	2022
AMS Training Implementation	2019-2020	2018	2017
Full implementation of AMS Program in the hospital	Jan 2022	Jan 2022	Jan 2022
First performance evaluation report to be submitted to DOH	Jan 2021	Jan 2019	Jan 2018

‡ In the absence of an AMS committee, the AMS team may report to the ICC committee or any other formal hospital bodies with shared interest in antimicrobial use and resistance.

\* Level I healthcare facilities are encouraged to implement these actions if capability permits.

