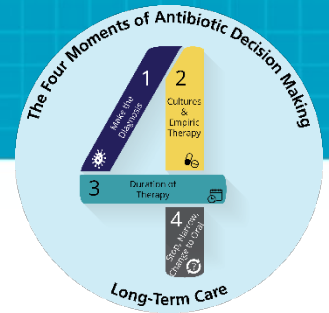




AHRQ Safety Program for Improving Antibiotic Use



Four Moments of Antibiotic Decision Making Form

The purpose of this form is to help your team incorporate the Four Moments of Antibiotic Decision Making into daily practice at your facility. It may also help identify opportunities to make changes that improve systems around antibiotic use. Please use the Completion Guide for the Four Moments of Antibiotic Decision Making Form to guide you through filling out this form.

DIRECTIONS: Use this form when a complete blood count (CBC), urinalysis/urine culture, or antibiotic is ordered for a resident in your facility. Review cases in real time or at a scheduled time once or twice each week with a goal of reviewing 5–10 cases a month.

MOMENT 1

DOES MY PATIENT HAVE AN INFECTION THAT REQUIRES ANTIBIOTICS?

1. Does the resident have signs or symptoms suggestive of an infection? Yes No

2. What are the signs/symptoms? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Wound with gross pus or drainage |
| <input type="checkbox"/> Increased oxygen requirements | <input type="checkbox"/> Red, hot, or swollen skin |
| <input type="checkbox"/> Increased respiratory rate | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sleepiness |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> New/worse incontinence | <input type="checkbox"/> Lack of cooperation with staff |

3. Were supportive measures attempted? Yes No

4. What were they?

- | | |
|--|--|
| <input type="checkbox"/> Pain medications | <input type="checkbox"/> Wound care |
| <input type="checkbox"/> Reassurance | <input type="checkbox"/> Nebulizer treatment |
| <input type="checkbox"/> Medication review | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Oral hydration | |



MOMENT 2

HAVE I ORDERED APPROPRIATE CULTURES BEFORE STARTING ANTIBIOTICS?
WHAT EMPIRIC THERAPY SHOULD I INITIATE?

5. Were antibiotics started? Yes No

(If YES, keep going.) (If NO, skip to question 11.)

6. What is the role of the prescriber?

- Hospital provider
- Long-term care provider
- Emergency department provider
- Specialist not at hospital or emergency department (i.e., output clinic provider)
- Other _____

7. Antibiotic regimen and indication:

Antibiotic: _____

Indication: _____

8. Were appropriate cultures ordered before antibiotics were started? Yes No

MOMENT 3

WHAT DURATION OF ANTIBIOTIC THERAPY IS NEEDED FOR RESIDENT'S DIAGNOSIS?

9. Has a planned duration been documented in the medical record? Yes No

(If YES, keep going.) (If NO, skip to question 11.)

10. Is the planned duration consistent with local guidelines?

(See general recommendations for treatment durations below.)

DISEASE PROCESS	DURATION OF THERAPY
Uncomplicated cystitis	3–5 days, depending on antibiotic
Complicated urinary tract infection/ pyelonephritis	7–14 days, depending on response to therapy
Lower respiratory tract infection	5–7 days
Skin and soft tissue infections	5 days

QUESTIONS 11–14 SHOULD BE ANSWERED FOR PATIENTS ON ANTIBIOTICS > 24 HOURS, IN ADDITION TO QUESTIONS ON THE LAST PAGES.

MOMENT 4

A DAY OR MORE HAS PASSED. CAN WE STOP ANTIBIOTICS? CAN WE NARROW THERAPY?

11. Are antibiotics still needed? Yes No
12. If antibiotics are not needed, will you stop them today? Yes No
13. If antibiotics are still needed, can you narrow therapy? Yes No
14. If antibiotics are still needed, can you switch from intravenous to oral? Yes No

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