72-Hour Antibiotic Time-Out Sample Template

Time-outs are a core practice in antibiotic stewardship, as they provide active assessment of an antibiotic prescription that occurs 48–72 hours after first administration, taking into account laboratory culture and sensitivity testing results, response to therapy, resident condition, and facility needs (e.g., outbreak situation). The following page includes a “72-Hour Antibiotic Time-Out” form that may be customized to incorporate facility antibiotic time-out policies. The information collected is meant to be used to reassess each resident’s antibiotic need, duration, selection, and de-escalation potential. Completion of an antibiotic time-out is recorded in the resident record.

Electronic health record (EHR) systems can facilitate the time-out process by any of the following:

▪ Providing automated alerts for each patient on antibiotics, timed for 72 hours post-initial administration
▪ Generating a list of all patients in need of a 72-hour antibiotic review on a given day
▪ Documenting the completion of an antibiotic time-out in the resident health record for assessment of staff compliance with time-out protocols

Major EHR systems have the capability to set alerts, generate user-defined reports, and include additional fields in resident health records. Work with facility staff experienced with your EHR system or contact your EHR vendor if you need assistance in setting up the above recommended management settings.

Minnesota Department of Health
Healthcare-Associated Infections & Antimicrobial Resistance Unit
PO Box 64975
St. Paul, MN 55164-0975
651-201-5414
health.stewardship@state.mn.us
www.health.state.mn.us

03/15/19

To obtain this information in a different format, call: 651-201-5414.
72-Hour Antibiotic Time-Out

Resident name: _____________________________ Date: ______________ Room #: ______________

Antibiotic(s) prescribed: ________________________________________________________________

Start date: _________ Dose: _________ Route: _________ Duration: _________ Stop date: _________

Prescriber name: ______________________________________________________________________

Facility where antibiotic prescribed: _______________________________________________________

☐ ER  ☐ Medical office  ☐ Hospital  ☐ Other: _______________________________________________

<table>
<thead>
<tr>
<th>Reason Antibiotic Prescribed</th>
<th>Culture</th>
<th>Date</th>
<th>X-Ray</th>
<th>Pathogen</th>
<th>Signs &amp; Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Wound</td>
<td>Cellulitis</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Urinary Tract Infection (UTI)</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Respiratory Infection (LRI)</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: ______________________</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Antibiotic Appropriateness

Does resident meet Loeb criteria?  ☐ Yes  ☐ No
What are the risk factors/concerns?  ☐ PVD  ☐ Wound  ☐ Diabetes  ☐ Catheter  ☐ Penicillin allergy

☐ Other: ____________________________________________

Does resident still have symptoms?  ☐ Yes  ☐ No
Are signs and symptoms improving?  ☐ Yes  ☐ No

Red Flags (select all that apply)  
☐ Antibiotic is ordered for more than 7 days
☐ Antibiotic inconsistent with organism sensitivities
☐ There is no stop date on antibiotic order
☐ No labs are available
☐ IV route  ☐ Catheter  ☐ Penicillin allergy

Actions to Take (select all that apply)  
☐ Inquire about lab diagnostic result if pending
☐ Remove catheter
☐ Update provider
☐ Notify nurse manager or facility supervisor
☐ No action needed
☐ Other: ____________________________________________

To Be Completed by Attending Provider (Check all that apply. Describe any changes.)

☐ Antibiotic prescribed is appropriate
☐ Antibiotic should be discontinued
☐ Change antibiotic to: ____________________________________________
☐ Change antibiotic route to:  ☐ IV  ☐ PO
☐ Change duration of antibiotic to:  ☐ Days of therapy: ____________  ☐ End date: ____________
☐ Transmission-based precautions:  ☐ Standard  ☐ Contact  ☐ Droplet  ☐ Airborne  ☐ None
☐ Other: ____________________________________________

Comments:

Provider’s Signature: _____________________________________________ Date: ______________

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