Source: https://negativespace.co

Objectives

- Identify 10 proven, easy-start stewardship interventions
- Prioritize 3–5 that fit your setting (inpatient or ambulatory)
- Know success metrics and how to report them in 90 days
- Leave with a one-page action plan

Quick Wins You Can Start This Month

Focus where effort is low and impact is high

Auto IV-to-PO Conversion (High-Bioavailability)

- Create a pharmacist-driven protocol for: levofloxacin, moxifloxacin, doxycycline, metronidazole, linezolid, fluconazole, TMP-SMX
  - Eligibility: tolerating PO, functioning GI tract, no malabsorption, hemodynamically stable
- Daily list of candidates from EHR report
- Measure: % eligible converted within 24h; DOT reduction; cost savings

Default Shorter Durations in Order Sets

- Embed evidence-based durations as order set defaults:
  - Uncomplicated cystitis: 3–5 days
  - CAP (non-ICU): 5 days with stability criteria
  - Cellulitis (non-purulent): 5–7 days
  - Post-op prophylaxis: single dose or ≤24h
- Add mandatory stop dates for all antibiotics
- Measure: median duration for common syndromes; % with documented stop date

Use MRSA Nares PCR to Stop Unneeded Vancomycin

- Standing order for rapid nares PCR when empiric MRSA coverage started
- If negative and no high-risk source: auto-discontinue vancomycin
- Measure: vancomycin DOT; AKI incidence; time on combo broad-spectrum

Eliminate Duplicate Anaerobe Coverage

- Hard-stop combinations: piperacillin-tazobactam + metronidazole; carbapenem + clindamycin/metronidazole
- Steer to single appropriate agent per syndrome
- Measure: % duplicate-coverage orders; pharmacist interventions

Target Fluoroquinolone Overuse

- Restrict outpatient/inpatient use to specific indications or failure/intolerance of alternatives
- Swap to safer, narrower options in UTI, bronchitis, sinusitis
- Measure: FQ prescriptions per 1,000 visits or DOT/1,000 PD; C. diff rates

Diagnostic Stewardship: Fewer False Alarms

- Urine cultures only with symptoms
- C. difficile testing only with unformed stool and no laxatives in 48h
- Respiratory panels: restrict to admitted/severe, immunocompromised, higher risk pts
- Measure: % ‘asymptomatic bacteriuria’ treated; CDI test positivity rate

Surgical Prophylaxis: Dose Right, Stop Early

- Weight-based dosing with intra-op redosing timers
- Remove ‘post-op day’ antibiotics from order sets; default ≤24h
- Measure: % cases with correct weight dosing; prophylaxis >24h

Penicillin Allergy: ‘Lite’ Delabeling

- Use a 1-question screen to identify low-risk histories (e.g., isolated GI upset, remote rash)
- Permit beta-lactam use per protocol or give direct oral challenge in clinic
- Measure: % low-risk labels removed; cefazolin use in OR; broad-spectrum avoidance

Prospective Audit & Feedback—Targeted

- Pick 5 drugs or 3 syndromes (e.g., CAP, SSTI, UTI) on 2 pilot units
- Daily 30-minute pharmacist-ID rounds; standardized note template
- Measure: acceptance rate; DOT per 1,000 PD on pilot vs. control unit

Tune Up Top 10 Order Sets

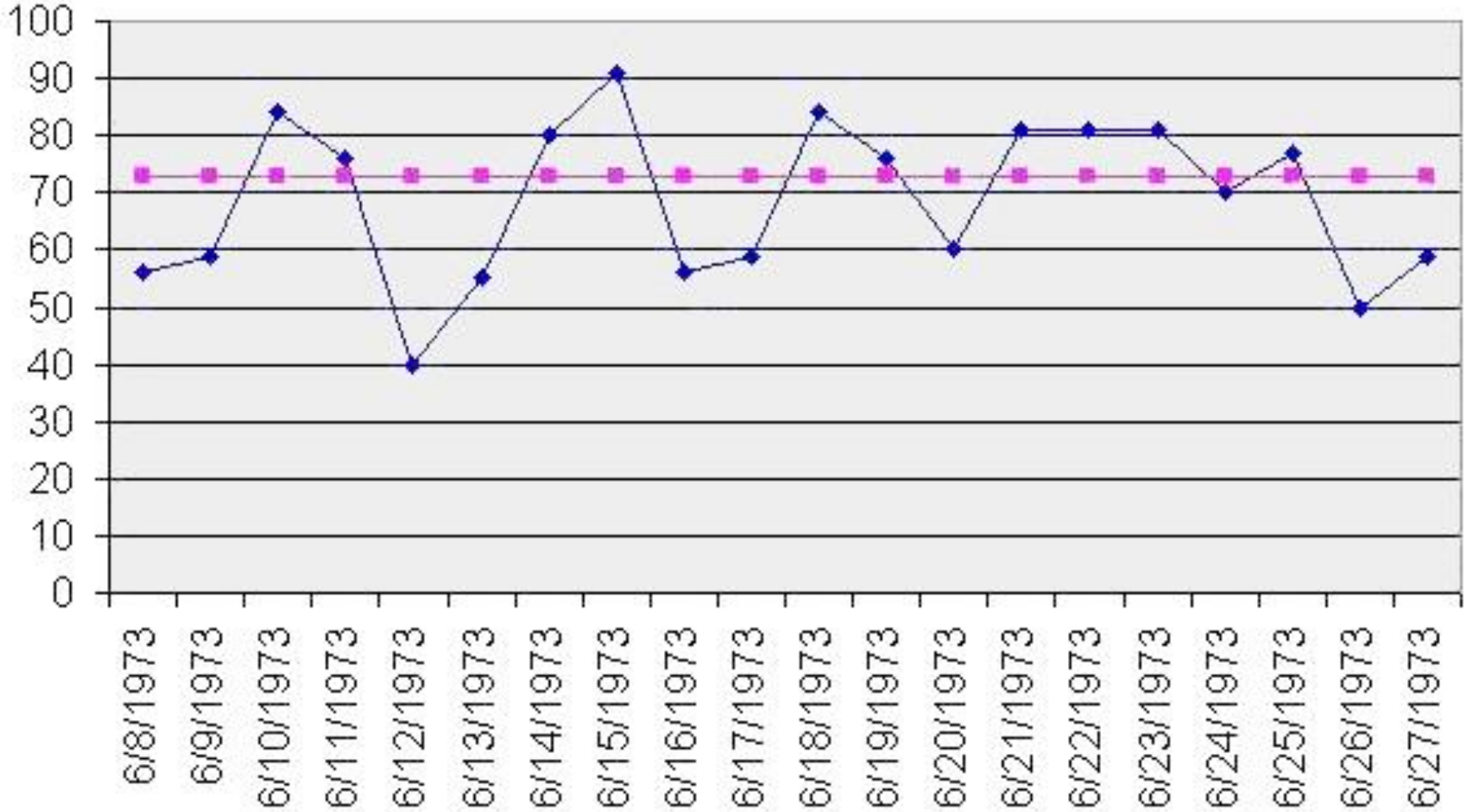
- Remove unnecessary labs, cultures, and duplicate antibiotics
- Embed duration, IV→PO, and de-escalation prompts
- Add discharge prescriptions with short durations as defaults

Ambulatory Quick Wins

- Delayed antibiotic prescriptions for viral URI/otitis media
- Patient education handouts in AVS (viral care, red flags)
- EHR smart phrases: no antibiotics for acute bronchitis/sinusitis
- Post-visit SMS with self-care links and return precautions
- Display clinic-level prescribing dashboards
- Peer comparison emails (top performers as anchors)
- Hard stops for fluoroquinolones unless criteria met
- Measure: antibiotic Rx per 100 visits; % guideline-concordant durations

Measure What Matters (and Report It Simply)

- Outcomes: DOT/1,000 patient-days; days of therapy per discharge; CDI rate
- Process: % with stop date; % IV→PO eligible converted; % time-outs completed
- Balancing: 30-day readmissions for index infections; return ED visits
- Monthly run chart to leadership and frontline teams



Source: https://en.wikipedia.org/wiki/Run_chart

People & Governance

- Executive sponsor + physician lead + pharmacist lead + data support
- Identify unit champions (RN, MD/APP) for pilot units
- Put quick-win approvals on a 1-page charter—no big committee needed

90-Day Implementation Plan

- Days 1–30: pick 3 wins, build protocols, update order sets, socialize
- Days 31–60: go live on 1–2 units/clinics, start weekly huddles
- Days 61–90: expand to hospital-wide, publish first run chart, tell stories

Common Barriers → Practical Fixes

- ‘Docs won’t change’: involve respected peers; show baseline data
- Alert fatigue: bundle nudges inside order sets
- Time constraints: pharmacist-driven protocols and batch reviews
- Fear of undertreatment: highlight safety/AKI/CDI benefits
- IT queue delays: request small, batched changes with clear specs
- Surgical pushback: frame as SSI prevention and cefazolin availability
- Allergy uncertainty: start with ‘lite’ rules and OR cohorts
- Data lag: start with simple numerators/denominators from pharmacy

Your One-Page Action Plan (Takeaway)

- Pick 3 interventions • Define simple metrics • Name owners
- Set start date • Schedule weekly 15-min huddle • Share first run chart
- Communicate wins to frontline and leadership

Bottom Line

- Start small, standardize in the EHR, and measure relentlessly
- IV→PO, short durations, time-outs, diagnostic stewardship = immediate impact
- Tell the story with data + patient safety wins