OBA-AMS-2026 | Workplace tool

Antimicrobial Stewardship: 'Finish the Course' Appears Nowhere in the Standard

Which source says so - a citation card

DOCUMENT CONTROL

- Programme: Antimicrobial Stewardship: 'Finish the Course' Appears Nowhere in the Standard (OBA-AMS-2026)
- Audience: Anybody who has to say where a rule comes from
- Version 1.0 | Issued 25/09/2026 | Review due 25/03/2027
- Provider: OBA Nursing Academy

Why this card exists

Five sources carry almost everything in this area, and TWO OF THE FIVE ARE THINGS THIS PROGRAMME DELIBERATELY DID NOT READ. Saying which one you are relying on - and saying when you are relying on none of them - is most of professional credibility here, because this is a field where confident statements about 'the guideline' are made constantly and checked rarely.

The five sources - and two of them are things this programme did not read

Source	What it settles
Antimicrobial Stewardship Clinical Care Standard (ACSQHC, November 2020)	The eight quality statements, the eleven indicators, the definitions, and what each statement asks of patients, clinicians and organisations. READ IN FULL for this build.
Therapeutic Guidelines: Antibiotic	WHICH antimicrobial, WHAT dose, WHAT route, HOW LONG - for an actual condition. The source the Standard defers to on every one of those. SUBSCRIPTION CONTENT, NOT READ FOR THIS BUILD, and therefore this programme names none of them.
Your own locally endorsed guideline, formulary and approval policy	What is restricted where you work, who approves it and how. These differ by organisation by design. NOT READ, AND NOT KNOWABLE FROM HERE.
NSQHS Preventing and Controlling Infections Standard	The accreditation obligation on the organisation. AMS is now ACTIONS 3.18 AND 3.19 - not 3.15 and 3.16, which is what the Clinical Care Standard cites and what has since moved.

Your employer's policies and your own scope	Who may take a specimen, who may withhold a dose, who may report to the TGA, what the escalation path is. Binding on you, and not present in any document above.

Things people say, and what actually settles them

What gets said	What settles it	What it actually is
'Always tell them to finish the whole course'	AMS Clinical Care Standard	The phrase does not appear in the Standard. Quality statement 5 asks for HOW TO USE THEM, HOW LONG, WHEN TO STOP, side effects AND A REVIEW PLAN. The word 'course' appears twice in 48 pages, once in a glossary definition of a different word and once in the list of INAPPROPRIATE uses.
'So it doesn't matter if they stop early'	AMS Clinical Care Standard	It does. The same list of inappropriate uses includes 'patients omitting doses or delaying administration' and 'patients NOT TAKING ANTIMICROBIALS AS PRESCRIBED by their clinician'. Both failures are on the list.
'We can't give the antibiotic until the blood cultures are back'	Quality statement 1	'Obtain clinical specimens as appropriate, BUT DO NOT DELAY ADMINISTRATION of antimicrobials AND DO NOT WAIT FOR RESULTS of investigations.'
'There's no point taking a specimen now, they're already on antibiotics'	Quality statement 4	The Standard says PREFERABLY BEFORE, and asks for samples 'as clinically indicated' - and quality statement 7 requires results to be used to decide whether to change or stop. The specimen taken before the first dose is the one worth most, which is the argument for taking it then, not for giving up afterwards.
'Penicillin allergy, it's in the notes'	Quality statement 3, Box 2	Six essential elements: the patient's description, the nature, the active ingredient, the assessment of likelihood, the severity, and the date and location. 'If any... are UNKNOWN, this should be EXPLICITLY DOCUMENTED.'
'An allergy is an allergy'	AMS Clinical Care Standard glossary	An ADVERSE REACTION is 'noxious and unintended' and 'may include, but is not limited to, nausea, allergy and anaphylaxis'. ALLERGY is the subset where 'a

		person's IMMUNE SYSTEM REACTS'. Nature and severity are two of the six elements for exactly this reason.
'It's the doctor's job to write the indication'	Quality statement 6, indicators 6a and 6b	It is. And two of the Standard's eleven indicators measure whether it was written, which is why noticing and asking is participating in the Standard rather than questioning anybody.
'We review antibiotics on the ward round'	Quality statement 7, indicator 7a	The indicator is a review AND AN UPDATED TREATMENT DECISION documented WITHIN 48 HOURS FROM THE FIRST PRESCRIPTION. A round that happened is not a decision that was recorded.
'The result came back days ago, someone will have seen it'	Quality statement 7	'REVIEW THE RESULTS WITHIN 24 HOURS OF THEM BEING AVAILABLE, and use this information to consider whether changing or stopping antimicrobials is appropriate.'
'We de-escalate when the cultures come back'	AMS Clinical Care Standard	The Standard never uses the word DE-ESCALATION - zero occurrences. It says SWITCHED TO A MORE NARROW-SPECTRUM AGENT. Worth using its phrase in a policy, because the other word means something different elsewhere in health care.
'IV is safer, we'll keep it going'	Quality statement 7	'If the patient is on intravenous agents, CONSIDER ORAL OPTIONS TO REDUCE HOSPITAL-ACQUIRED INFECTIONS.' The reason the Standard gives is infection, not cost.
'They had surgery, so they need a few days of antibiotics'	Quality statement 8	'AVOID PRESCRIBING ANTIMICROBIALS POST-PROCEDURALLY, as prolonged antimicrobial use is not usually required.' And for patients: 'after having a surgical procedure, antimicrobials are NOT USUALLY NEEDED UNLESS YOU HAVE AN INFECTION.'
'We use a wash and a paste in theatre, that counts as prophylaxis'	Quality statement 8	'TOPICAL ANTIMICROBIALS ARE NOT RECOMMENDED for surgical prophylaxis', and avoid

		'off-label routes... such as IRRIGATIONS, PASTES, WASHES OR TOPICAL APPLICATIONS... without evidence-based guidelines.'
'The urine grew something, so we treat it'	AMS Clinical Care Standard glossary	COLONISATION is 'the sustained presence of replicating infectious microorganisms on or in the body, WITHOUT PRODUCING AN IMMUNE RESPONSE OR DISEASE'. Whether a particular result is an infection is a clinical judgement this programme does not make.
'Our policy cites NSQHS 3.15 and 3.16'	NSQHS Preventing and Controlling Infections Standard	Those numbers now belong to WORKFORCE IMMUNISATION and WORKFORCE INFECTIONS. The antimicrobial stewardship actions are 3.18 AND 3.19. The Clinical Care Standard's citation was correct in November 2020 and has been overtaken.
'There's a benchmark we have to hit'	AMS Clinical Care Standard	'NO BENCHMARKS ARE SET FOR THESE INDICATORS.' They exist so a service can see its own number and watch it move.

The local things that have to exist

- The current Therapeutic Guidelines, and how you open it
- Your locally endorsed guideline - if there is one - and the committee that endorsed it
- The antimicrobial formulary, and the list of RESTRICTED antimicrobials in it
- The approval process for a restricted antimicrobial, including at three in the morning
- The process for getting a microbiology result to somebody who can act on it, overnight and at the weekend
- Where a new or suspected adverse reaction is reported, apart from the notes
- And the antimicrobial stewardship pharmacist or team, if your service has one

If you cannot find one of these, that is a finding about the service rather than about you - and it is a specific one you can raise.

SCOPE, CURRENCY AND THE LIMIT OF THIS PROGRAMME

• This programme is professional development. It states what the ACSQHC ANTIMICROBIAL STEWARDSHIP CLINICAL CARE STANDARD (November 2020) says, quotes it where the words matter, and cites the source every time. IT IS NOT CLINICAL ADVICE AND IT IS NOT A PRESCRIBING GUIDE. It names NO antimicrobial as the right one for any condition, and states no dose, no frequency, no route and no duration, because THERAPEUTIC GUIDELINES: ANTIBIOTIC WAS NOT READ FOR THIS BUILD - it is subscription content and it, not this programme, is the

source the Standard points to. Nothing here authorises anybody to start, withhold, change or cease an antimicrobial. Whether a particular nurse may do any of those things is set by their employer, by the authority under which the medicine is ordered, and by the law where they work. Decisions about an individual patient are for that patient and their treating practitioners.

- WHAT WAS READ, AND WHEN. The ANTIMICROBIAL STEWARDSHIP CLINICAL CARE STANDARD (ACSQHC, November 2020, ISBN 978-1-925948-87-5, 48 pages) was read IN FULL on 25/09/2026, and the word counts quoted in this programme were taken TWICE - once from the extracted text and once directly from the PDF, case-insensitively and on stems - because a count of ZERO is the kind of claim that has to be right. The Commission's own page still titles it 'Antimicrobial Stewardship Clinical Care Standard (2020)', so this is the current edition. ONE THING IN IT IS ALREADY OUT OF DATE, and the programme says so where it arises: the Standard cites antimicrobial stewardship as NSQHS Actions 3.15 and 3.16, and in the current Preventing and Controlling Infections Standard those numbers belong to workforce immunisation and workforce infections. The stewardship actions are now 3.18 and 3.19. Verified against the Commission's published action text on 25/09/2026.