DATA COLLECTION QUESTIONNAIRE

FIRST: SOCIO-DEMOGRAPHIC CHARACTERISTICS:

1. Age: ……. years
2. Gender: ☐ Male ☐ Female
3. Family status: ☐ Single ☐ Married
4. Nationality: ☐ Saudi ☐ Non-Saudi
5. Position: ☐ Supervisor ☐ Practitioner ☐ Both
6. Qualifications: ☐ Bachelor ☐ Diploma ☐ Master
   ☐ PhD ☐ Board ☐ Other (specify…….)
7. Healthcare facility: ☐ PHC center ☐ Hospital-outpatient clinic
   ☐ Hospital-emergency department ☐ Polyclinic
8. Work place: ☐ MOH ☐ University health services
   ☐ Military health services ☐ National guard health services
   ☐ Interior ministry health services ☐ Private sector
9. Years of experience (……)

SECOND PART: PHYSICIAN'S PARTICIPATION IN EFFICACY OF ASP

	Practice of physician	Response				
		Always	Often	Sometimes	Rarely	Never
1st: Enhancing infection prevention and control						
1	I prevent healthcare associated infections from occurring in the first place.					
2	I prevent transmission of healthcare associated infections when occur.					
2nd: Controlling source control						
1	I look for the septic source as early as possible.					
2	I control the verified source of infection as soon as possible.					
3rd: Prescribing antibiotics when they are truly needed						
1	I use the antibiotics after a treatable infection has been recognized.					
2	I use the antibiotics when there is a high degree of suspicion for infection.					
3	I provide advice on prudent antibiotic use to individuals.					
4	I have good negation skills to convince individuals about unnecessary antibiotic use.					
4th: Prescribing appropriate antibiotics with adequate dosages						
1	I Initiate empirical antibiotic therapy in patients need immediate treatment.					
2	I Initiate empirical antibiotic therapy based on local epidemiology.					
3	I Initiate empirical antimicrobial therapy based on individual patient risk factors for difficult to treat pathogens and clinical severity of infection.					
4	I Initiate empirical antibiotic therapy based on the infection source.					
5	I take in account the antibiotic resistance rates when initiate empirical antimicrobial therapy.					
6	I take in account the previous antibiotic when initiate empirical antimicrobial therapy.					

7	I establish antibiotic dosing regimen based on host factors and properties of antibiotic.					
5th: Reassessing antimicrobial treatment when culture results are available						
1	I reassess antibiotic therapy when the culture and susceptibility results are available.					
2	I expand antibiotic therapy if the empirical choice was too narrow.					
3	I de-escalation of antibiotic therapy if the empirical regimen was too broad.					
6th: Using the shortest duration of antibiotics based on evidence						
1	I establish antibiotic duration short as much as possible unless there are special circumstances e.g. immunosuppression, or ongoing infections.					
2	I use oral antibiotic as substitute IV agents as soon as the patient is tolerating an oral diet.					
3	when conversion to oral antibiotic I consider antibiotic having high oral bioavailability (e.g. fluoroquinolones)					
4	For patients who have signs of sepsis beyond 5 days of treatment I consider warrant aggressive diagnostic investigation to determine if an ongoing uncontrolled source of infection or antibiotic treatment failure is present.					
7th: Educating staff						
1	I get training /orientation in antimicrobial stewardship program (ASP).					
2	I get feedback to improve my prescribing behavior continuously.					
3	I have training that equip the required confidence, skills and expertise in the field of antibiotic management.					
8th: Supporting surveillance of AMR and HAIs and monitoring of antibiotic consumption						
1	I have a key role in supporting the antibiotic resistance control.					
2	I survey antimicrobial resistance(AMR).					
3	I survey healthcare-associated infections (HAIs).					
4	If I detect AMR and HAIs ; I notify to antimicrobial stewardship program (ASP) team members.					
9th: Supporting an interdisciplinary approach						

1	There is collaboration between all healthcare professionals to shared knowledge and practice to succeed ASP.					
2	Healthcare institution administration provides adequate support for both developing and sustaining an ASP.					
3	Infection control department/unit monitor and prevent healthcare-associated infections.					
4	Pharmacists are key actors for the design and implementation of the stewardship program.					
5	Pharmacists provide feedback to physician about prudent antibiotic use.					
6	The staff nurses integrate in antimicrobial stewardship.					
7	Timely and accurate reporting of microbiology susceptibility test results are available					
8	Surveillance data on antimicrobial resistance are provided periodically					

THIRD PART: Practice of physicians regarding a prescribing of antibiotics

	DAILY PRESCRIBING ANTIBIOTICS	**NUMBER**
1	Average number of infection cases you manage daily.	
2	Average number of infection cases you manage daily with symptomatic treatment (NO ANTIBIOTIC).	
3	Average number of infection cases you manage daily with delayed antibiotic prescribing treatment.	
4	Average number of infection cases you manage daily with initiated antibiotic prescribing treatment.	