**Adult Antibiotic IV to Oral Switch Therapy (IVOST) Guidance**

NHS logo

IV antibiotics must be reviewed daily. Document the patient’s progress and the full antibiotic plan within 24-72 hours.

The antibiotic plan should **document the reason** to: Stop antibiotics, Continue IV, IVOST, De-escalate therapy, Escalate therapy, OPAT.

**Is your patient ready for IVOST?**

CLINICAL IMPROVEMENT in signs of infection, resolving sepsis, improvement of NEWS observations and infection markers e.g. WCC and CRP (CRP does not reflect severity of illness or the need for IV antibiotics and may remain elevated as the infection improves. Do not use CRP in isolation to assess IVOST).

ORAL ROUTE is available and no concerns regarding absorption.

INFECTION DOES NOT require prolonged IV therapy e.g. deep abscess not amenable to drainage, bronchiectasis, cystic fibrosis, febrile neutropenia, endocarditis, meningitis, SAB, infection of a prosthetic device, vascular graft, bone/joint infection; **Seek Microbiology/infectious disease advice for antibiotic/oral switch plan for these indications.**

Review the need for IV therapy daily

Check microbiology results; can you narrow the spectrum of IV therapy?

NO

**Is the patient on IV gentamicin?**

* DO NOT continue IV gentamicin for longer than 3-4 days (except on the advice of Microbiology/ID). Longer courses should have a senior review and monitor for signs of renal & oto/vestibular toxicity
* Is Gram-negative cover still required? If not, stop gentamicin.
* Is there any positive microbiology? If so simplify.
* If IV therapy & Gram-negative cover are

still required and there is no positive microbiology, discuss with Microbiology/ID

Yes

Can you STOP antibiotics altogether? If no, then SWITCH to ORAL:

* Check the MICROBIOLOGY results; can you NARROW THE SPECTRUM based on cultures?
* If no positive microbiology and patient was treated with empiric IV therapy use table below
* Record the intended duration on the medicine kardex (**most infections require ≤ 7 days TOTAL (IV + oral) therapy)**.

The antibiotics tabled below have high oral bioavailability and achieve high serum concentrations. They are suitable for

IVOS once the initial bacterial burden has been sufficiently reduced by intravenous therapy. Use the maximum tolerated oral doses for these antibiotics so as to maximise drug exposure and avoid food/drug interactions that may impair absorption.

\*All doses are for normal renal/hepatic function. See BNF/SPC or seek pharmacy advice regarding dose adjustments or drug interactions.

Would the patient be suitable for outpatient IV antibiotic therapy (OPAT)?

(e.g. SSTI, bone/joint infection, SAB, endocarditis, resistant Gram-negative infection)

If Yes/don’t know: contact the OPAT Service on:

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| Indication | Empiric Oral Switch\*  (1st line) | Empiric Oral Switch\*  (Penicillin allergy, 2nd Line) | Total Duration  (IV + Oral) |
| Community Acquired Pneumonia |  |  |  |
| Hospital Acquired Pneumonia |  |  |  |
| Aspiration pneumonia |  |  |  |
| Infective Exacerbation COPD |  |  |  |
| Cellulitis |  |  |  |
| **Intra-abdominal/ Hepatobiliary**  infection |  |  |  |
| Spontaneous bacterial  peritonitis |  |  |  |
| **Upper urinary tract**  **infection/Pyelonephritis** |  |  |  |
| **Other?** |  |  |  |

Ratification