Adult Antibiotic Intravenous to Oral Switch Therapy (IVOST) Guidance



- Intravenous (IV) antibiotics must be reviewed daily.
- Stop antibiotics unless there is clear evidence of infection.
- Document the patient's progress and the full antibiotic plan within 24-72 hours.

Is your patient ready for IVOST?

DOES INFECTION REQUIRE PROLONGED IV THERAPY e.g. deep abscess not amenable to drainage, bronchiectasis, cystic fibrosis, febrile neutropenia, endocarditis, meningitis, Staphylococcus aureus bacteraemia (SAB), infection of a prosthetic device, vascular graft, bone/joint infection. Seek microbiology/infectious disease advice for antibiotic/oral switch plan for these indications. Patient may be a candidate for OPAT.

YES

Document planned duration of IV antibiotics on Prescription and Administration Record (PAR). Review the need for IV therapy daily if duration still unclear.

NO

CLINICAL IMPROVEMENT in signs of infection, resolving sepsis, improvement of National Early Warning Score (NEWS) observations and inflammatory markers e.g. WCC (White Cell Count) and CRP (C-reactive Protein)

Note: 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.

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

NO

YES []

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

- If positive microbiology results use these to guide antibiotic selection (use narrowest spectrum possible)
- If no positive microbiology and patient was treated with empiric IV therapy use table below for oral switch
- Record the intended duration on the Prescription & Administration Record (TOTAL (IV+ORAL) usually ≤ 7 days



Indication	Empiric Oral Switch* (1st line)	Empiric Oral Switch* (2nd Line)	Total Duration (IV + Oral)
Community Acquired Pneumonia (High severity-no previous antibiotic)	Doxycycline 100mg 12 hourly	Amoxicillin 1g 8 hourly plus Clarithromycin 500mg 12 hourly (until atypical excluded)	7-10 days
Community Acquired Pneumonia (High severity – previous antibiotics)	Doxycycline 100mg 12 hourly	Co-trimoxazole 960mg 12 hourly	7-10 days
Severe Hospital Acquired Pneumonia	Co-amoxiclav 625mg 8 hourly	Levofloxacin 500mg 12 hourly	7-10 days
Aspiration pneumonia	Amoxicillin 1g 8 hourly plus Metronidazole 400mg 8 hourly	Clarithromycin 500mg 12 hourly plus Metronidazole 400mg 8 hourly	7 days
Severe Infective Exacerbation of COPD	Co-trimoxazole 960mg 12 hourly OR Doxycycline 100mg 12 hourly	Clarithromycin 500mg 12 hourly	7 days
Pyelonephritis/Urosepsis	Co-trimoxazole 960mg 12 hourly		7 days (if urinary tract abnormality consider 10-14 days)
Intra-abdominal sepsis	Metronidazole 400mg 8 hourly plus Doxycycline 100-200mg daily	Metronidazole 400mg 8 hourly plus Co-trimoxazole 960mg 12 hourly	3-5 days
Biliary Sepsis	Doxycycline 100-200mg daily +/- Metronidazole 400mg 8 hourly	Co-trimoxazole 960mg 12 hourly +/- Metronidazole 400mg 8 hourly	7 days
Cellulitis (moderate to severe)	Flucloxacillin 1g 6 hourly	Doxycycline 100mg 12 hourly	7-14 days

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

The antibiotics tabled are suitable for IVOS once the initial bacterial burden has been sufficiently reduced by intravenous therapy.