

**Review need for IV antibiotics DAILY: review & document patient progress/the IVOST plan within 72 hours of IV antibiotic initiation**

**Are all of the following IVOST criteria met?**

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature  $\leq 37.9^{\circ}\text{C}$ , reduction in the PEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection; Cystic Fibrosis; Endocarditis; Bone/joint infection; Undrainable deep abscess; Bacteraemia.

**CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves.**

**DO NOT** use CRP in isolation to assess IVOST suitability. Most infections require  $\leq 7$  days TOTAL (IV + oral) therapy. Record the intended duration on HEPMA/Kardex

**YES**

**Can you STOP THERAPY?** If antibiotic therapy is still required → **SWITCH TO ORAL.**

First, check the **MICROBIOLOGY** results; can you **NARROW THE ANTIBIOTIC SPECTRUM** based on cultures?

**NO**

**Check the microbiology results. Can you NARROW THE SPECTRUM** of IV therapy?

**Is the patient on IV gentamicin?**

- DO NOT** continue IV gentamicin for longer than 4 days (except on the advice of an infection specialist - Microbiology/ID). Patients prescribed IV gentamicin for 4 days should have a senior review of their diagnosis, microbiology and clinical progress;
1. Is Gram-negative cover still required? If not, stop gentamicin.
  2. Is there any positive microbiology? If so rationalise.
  3. If IV therapy & Gram-negative cover are still required and there is no positive microbiology, discuss with Microbiology/ID.
  4. If gentamicin is required for longer (e.g. endocarditis) seek Microbiology/ID advice & monitor for signs of renal & oto/ vestibular toxicity.

If the patient is being treated in line with the Empiric Infection Management Guidelines **AND** there is **NO POSITIVE MICROBIOLOGY** to guide the change then switch to oral as outlined below;

**EMPIRIC ORAL SWITCH<sup>■</sup>**

DIAGNOSIS <sup>❖</sup>	1 <sup>ST</sup> LINE	2 <sup>ND</sup> LINE/PENICILLIN ALLERGY	TOTAL duration (IV + PO)
Resolving sepsis and source unknown	Discuss with micro/ID	Discuss with micro/ID	As per micro/ID
Community-acquired pneumonia (CAP)	Amoxicillin	Azithromycin	5 days. Give 3 days PO Azithromycin
Aspiration pneumonia	Amoxicillin	Clindamycin	5 - 10 days based on clinical improvement
Severe pneumonia/pneumonia complicating influenza	Co-amoxiclav	Discuss with Micro/ID	Discuss with Micro/ID
Acute mastoiditis	Co-amoxiclav	Clindamycin	14 days
Intra-abdominal sepsis	Co-amoxiclav	Ciprofloxacin & metronidazole	7 days if source control, if not discuss with Micro/ID
Upper tract UTI/Pyelonephritis	Cefalexin	Ciprofloxacin	7-10 days
Septic arthritis or Osteomyelitis	Co-amoxiclav (If $\geq 6$ yrs consider Flucloxacillin capsules)	Clindamycin	3 weeks for septic arthritis and 4-6 weeks for osteomyelitis
Cellulitis	Flucloxacillin	Clindamycin	7 days
Orbital/Peri-orbital cellulitis	Co-amoxiclav	Clindamycin	7-10 days

**❖ Consult an infection specialist (microbiology or infectious diseases) on the switch options for the complicated infections listed above OR where empiric IV antibiotic therapy differed from guideline on specialist advice.**

**■ Consult BNFC for dosing advice**

Antimicrobial	Oral bioavailability
Metronidazole	>90%
Clindamycin	>90%
Ciprofloxacin	80%