

## IV to ORAL SWITCH & 5 DAY STOP POLICY

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Implementation Date: July 2026

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*This document is part of antibiotic formulary guidance.  
Formulary guidance holds the same status as Trust policy*

## Summary of changes

Date	Changes	Author
May 2023	<ul style="list-style-type: none"><li>• Change of IVOS tool from ABCD to ACED</li><li>• Table 1 split into 48hr IVOS and 5 day stop exclusions; indications consolidated.</li><li>• Table 2 – Description for frequency of antimicrobial doses rationalised.</li></ul>	Larissa Claybourn
July 2026	<ul style="list-style-type: none"><li>• Table 2 – Added Cefazolin and Dalbavancin and updated advice on the appropriate oral switch option.</li><li>• Highlighted 5 highly bioavailable antibiotics that should always be prescribed via PO route where possible</li><li>• Restricted IV Clarithromycin to &lt;48h</li><li>• Restricted Gentamicin duration to 4 days</li><li>• Reference updated – Replaced the 2022 IVOS link with the latest UKHSA IVOS guidance (updated 25 Oct 2024).</li></ul>	Kar Loon Yee

## Introduction

There is a clear association between antibiotic use and the development of antibiotic-resistant infections and *Clostridium difficile* infection

IV to oral switch (IVOS) is an integral part of the UK Start Smart then Focus strategy and is one of the ‘antimicrobial prescribing decisions’ options at 48-72 hours of starting antibiotics.

### *Benefits of Early IVOS*

- Decreased risk of line-associated infections and thrombophlebitis
- Reduced costs (i.e. drug & equipment costs and medical & nursing time)
- Patient satisfaction (patient friendly and earlier discharge)

Most infections can be adequately treated with 5-7 days of therapy (3 days for a simple UTI in females). Exceptions to this are listed in Table 1 below.

### **Aim of policy**

To rationalise antibiotic use within the Trust by having a 5-7 day policy for all antibiotics and a 48 hour review policy for parenteral antibiotics. Patients with certain conditions will be excluded from this as outlined in the Table 1.

Critical Care units are exempt from this policy due to daily input from an infection specialist.

Appropriate samples must be sent, ideally before empiric treatment begins (do not delay antibiotics in life threatening situations) and ensure antibiotics are changed according to sensitivities.

### **IV to Oral Switch of Antibiotics**

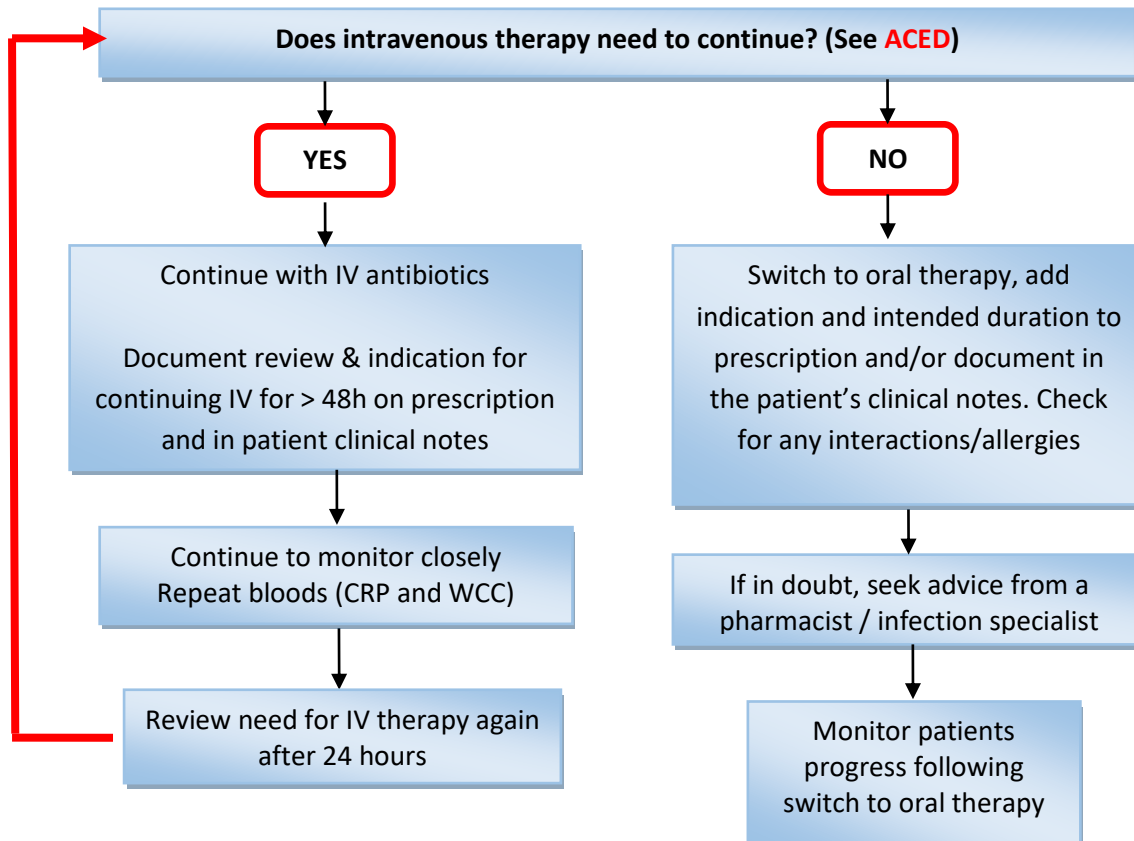
- All intravenous antibiotics should be reviewed within 48 hours of the first administered dose and daily thereafter. This should be documented clearly in the medical notes.
- If the patient has been afebrile for 24 hours and shown significant improvement, then an IV to oral switch should be considered. See chart below.

## Considerations for IV to oral switch – ACED tool

- A** - Afebrile >24 hours (haemodynamically stable with no signs of fever)
- patients temperature between 36-38°C in last 24 hours
- C** - Clinically improving
- Improving signs and symptoms of infection
  - Clinical markers improving (in past 24 hours)
    - Observations stable (BP, HR, RR) and reduction in NEWS2 score
    - WCC trending towards the normal range
    - Falling CRP
- E** - Eating and drinking,
- have a functional GI tract with no malabsorption
  - suitable enteral antimicrobial available
- D** - Deep-seated/high risk infection not present (see table 1)

Exceptions to the above include the infections in the table 1  
(Oral switch may be appropriate in some of these infections on a case by case basis)

### Intravenous to Oral Antimicrobial Therapy Review and Switch Process



To access a national IVOS decision aid tool which can be printed for individual patients, please go to:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1133525/Final IV to Oral Switch Decision Aid based on NationalCriteria UKHSA.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1133525/Final_IV_to_Oral_Switch_Decision_Aid_based_on_NationalCriteria_UKHSAs.pdf)

**Table 1:** Infections requiring special consideration

EXCEPTIONS TO 48hr IVOS	EXCLUSIONS FROM 5 DAY STOP POLICY
<ul style="list-style-type: none"> <li>• Undrained abscess</li> <li>• Bone/joint infection (e.g. osteomyelitis, discitis, septic arthritis)</li> <li>• Empyema</li> <li>• Bloodstream infection</li> <li>• Severe necrotising soft tissue infection</li> <li>• Meningitis / encephalitis</li> <li>• Endocarditis</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetic foot infection</li> <li>• Prostatitis, Epididymo-orchitis</li> <li>• Pyelonephritis</li> <li>• Pelvic inflammatory disease</li> <li>• Clostridium difficile</li> <li>• Infected implants/prosthesis</li> <li>• Exacerbation of cystic fibrosis/bronchiectasis</li> <li>• Atypical pneumonia /severe lobar pneumonia</li> <li>• Liver abscess</li> <li>• CR-BSI with line salvage strategy</li> <li>• All infections listed in left hand column</li> </ul>

**Table 2:** Suggested IVOS antimicrobials

***Always check for allergy, interactions, antibiotic sensitivity results and any monitoring requirements prior to prescribing.***

**Note:** This list is not exhaustive. For IV antibiotics with no oral formulations, the switch should be guided by advice from an infection specialist or as per antibiotic sensitivities.

IV ANTIBIOTIC	ORAL OPTION (Adjust dose according to renal and hepatic function)
<b>Amoxicillin</b>	Amoxicillin 500mg-1g, tds
<b>Aztreonam</b>	Switch depends on source of infection and should be based on sensitivities or discussion with infection specialist.
<b>Benzylpenicillin</b>	Amoxicillin 500mg-1g, tds or phenoxymethylpenicillin (Penicillin V) 500mg qds, only for Streptococcal throat infections
<b>Cefazolin</b>	Switch depends on source of infection and should be based on sensitivities or discussion with infection specialist.

<b>Cefuroxime</b>	<p><b>Switch based on sensitivities.</b> If no sensitivities:</p> <p>Cefaclor m/r 375mg bd (for respiratory tract indications)</p> <p>Cefalexin 500mg bd – tds (for other indications)*</p> <p><b>*If treating a complex or deep-seated infection or infection involving an abscess, bone or joints, discuss with Infection specialist.</b></p>
<b>Ceftazidime</b>	Switch depends on source of infection and should be based on sensitivities or discussion with infection specialist.
<b>Ceftriaxone</b>	
<b>Cefotaxime</b>	
<b>Ciprofloxacin</b>	Ciprofloxacin 500-750mg, bd (higher does if Pseudomonas spp. isolated)
<b>Clarithromycin</b>	Clarithromycin 500mg, bd. Do not prescribe IV Clarithromycin for >48h due to significant risk of chemical phlebitis.
<b>Clindamycin</b>	<p>Clindamycin 300-450mg, qds.</p> <p>Maximum dose 450mg qds in severe infection</p>
<b>Co-amoxiclav</b>	<p><b>Switch to narrow spectrum where possible, e.g. amoxicillin</b></p> <p>Co-amoxiclav 625mg tds</p>
<b>Co-trimoxazole</b>	Co-trimoxazole – use same dose
<b>Dalbavancin</b>	Oral switch usually not required for skin/soft tissue infections. If treating deep seated infection, seek Infection specialist advice.
<b>Flucloxacillin</b>	Flucloxacillin 500mg-1g qds (doses above 2g daily unlicensed)
<b>Fluconazole</b>	Fluconazole – use same dose
<b>Gentamicin</b>	Seek Infection specialist advice or as per antibiotic sensitivities. Do not continue high dose gentamicin for more than 4 days. Consider if gram negative cover still required.
<b>Levofloxacin</b>	<p>Levofloxacin – use same dose</p> <p>Doxycycline or co-trimoxazole may be a more appropriate oral option based on sensitivities (less risk of <i>Clostridium difficile</i>). Doses dependent on indication.</p>
<b>Linezolid</b>	Linezolid – use same dose
<b>Meropenem</b>	Seek Infection specialist advice or as per antibiotic sensitivities.
<b>Metronidazole</b>	Metronidazole 400mg tds

<b>Piperacillin/ Tazobactam</b>	<p><b>Switch based on sensitivities. There may not be an appropriate oral option.</b></p> <p><b>Seek Infection specialist advice</b> if any of the following apply:</p> <ul style="list-style-type: none"> <li>• recent course of co-amoxiclav;</li> <li>• pseudomonas species suspected;</li> <li>• piperacillin/tazobactam is being used outside of Trust guidelines</li> </ul> <p>If these do not apply and no sensitivities are available, co-amoxiclav may be used where an oral agent is required/appropriate</p>
<b>Rifampicin</b>	Rifampicin - use same dose. Should <b>NEVER</b> be used as a single agent, due to the risk of developing resistance.
<b>Teicoplanin</b>	Seek Infection specialist advice or as per antibiotic sensitivities.
<b>Temocillin</b>	Switch depends on source of infection and should be based on sensitivities or discussion with infection specialist.
<b>Vancomycin</b>	<p>Seek Infection specialist advice or as per antibiotic sensitivities.</p> <p>NB: Oral vancomycin NOT suitable for systemic infection (only indicated for <i>Clostridium difficile</i> Infection)</p>

**Please note:** The following antibiotics have virtually 100% oral bioavailability and should always be prescribed as PO unless the oral route is not available (e.g. NBM, not absorbing)

- Ciprofloxacin / Levofloxacin
- Metronidazole
- Cotrimoxazole
- Linezolid
- Rifampicin

### **5 day Stop for Antimicrobials**

- Most oral antibiotics on the electronic prescribing system have a default course length of 5 days, some are excluded from this.
- When changing from IV to oral therapy, ensure this course length is changed to account for the number of days of IV therapy to give a total course length of 5 days.
- Antibiotics should be stopped if a non-infective diagnosis is made, even if the course has not been completed.
- If in doubt about the course length required, discuss with a senior member of your team in the first instance or else the Consultant in Infection.
- The conditions listed in table 1 will require more than 5 days of treatment. The indication should be documented in the clinical notes and antimicrobial prescription annotated.

References:

1. UKHSA: National antimicrobial intravenous-to-oral switch (IVOS) criteria for prompt switch for adults. Last updated 25 October 2024.

Accessed online via [[National antimicrobial intravenous-to-oral switch \(IVOS\) criteria for prompt switch for adults - GOV.UK](#)] on 02/07/2026