Hospital Management of Community Acquired Pneumonia Clinical Guideline - Appendix 3. Pathway Guideline Summary

[Click here for the full guideline]

Key:

General Notes	GP/SWASFT
ED/MAU/SRU/Acute GP/Amb-Care	In-patient wards

Start

Is a community acquired pneumonia the most likely primary reason for presentation?

Suspected 'Chest Infection'

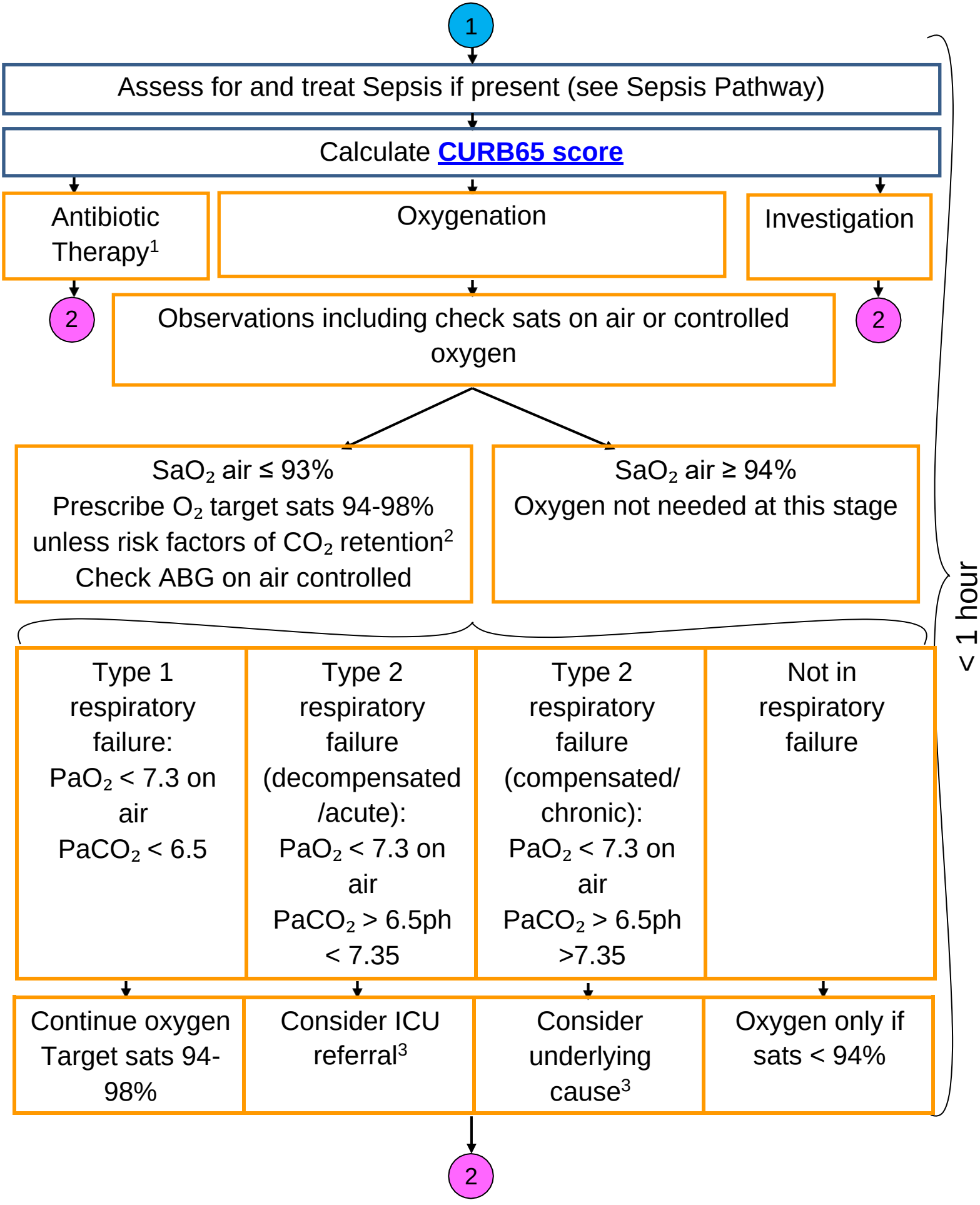
- Cough
- Breathlessness
- Sputum purulence/tenacity
- Pleuritic chest pain
- Systemic symptoms of infection

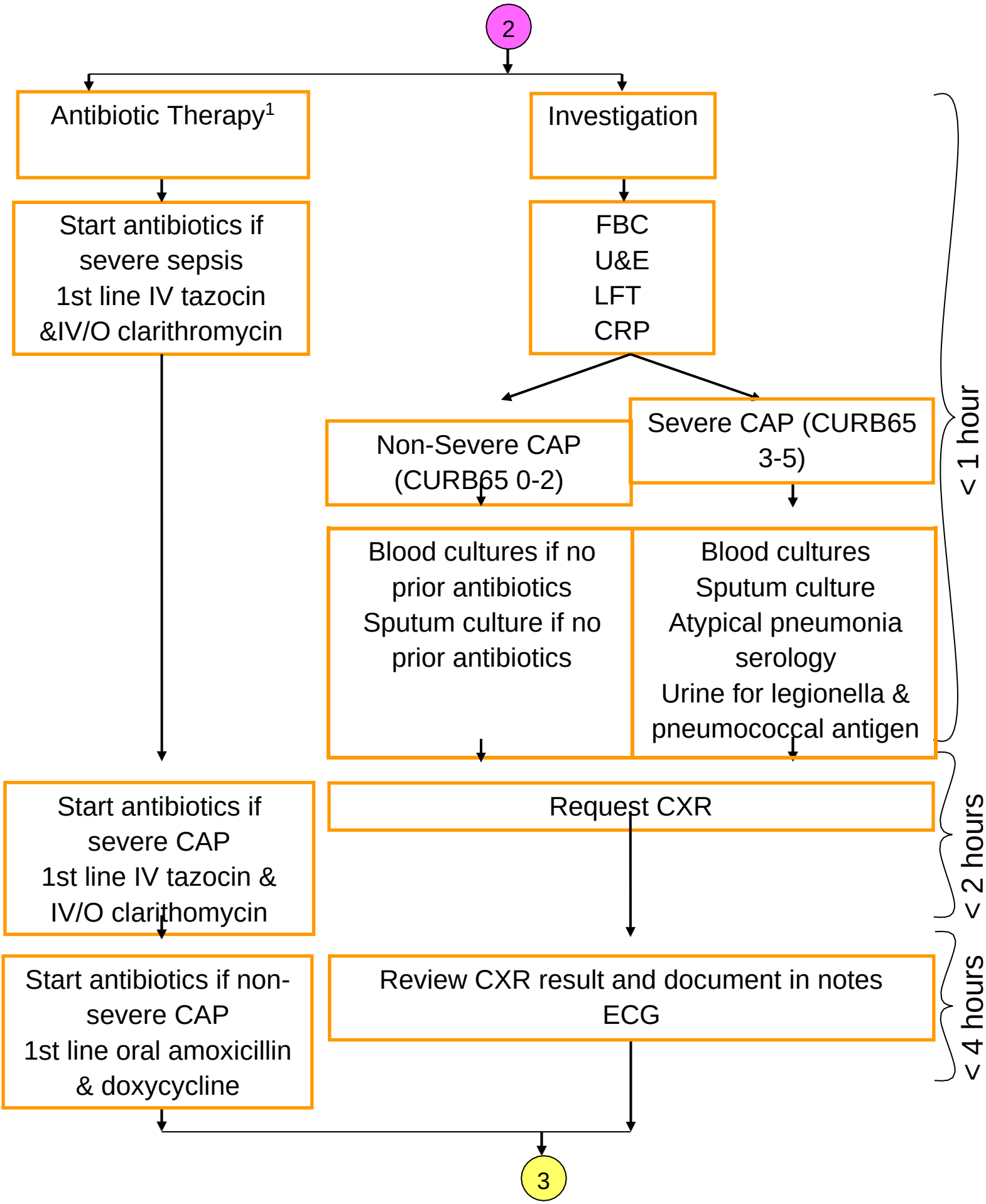
Chest X Ray showing **NEW** infiltrates
The CAP pathway can be initiated while awaiting CXR confirmation of consolidation. Consolidation in an exacerbation of COPD requires management of both conditions

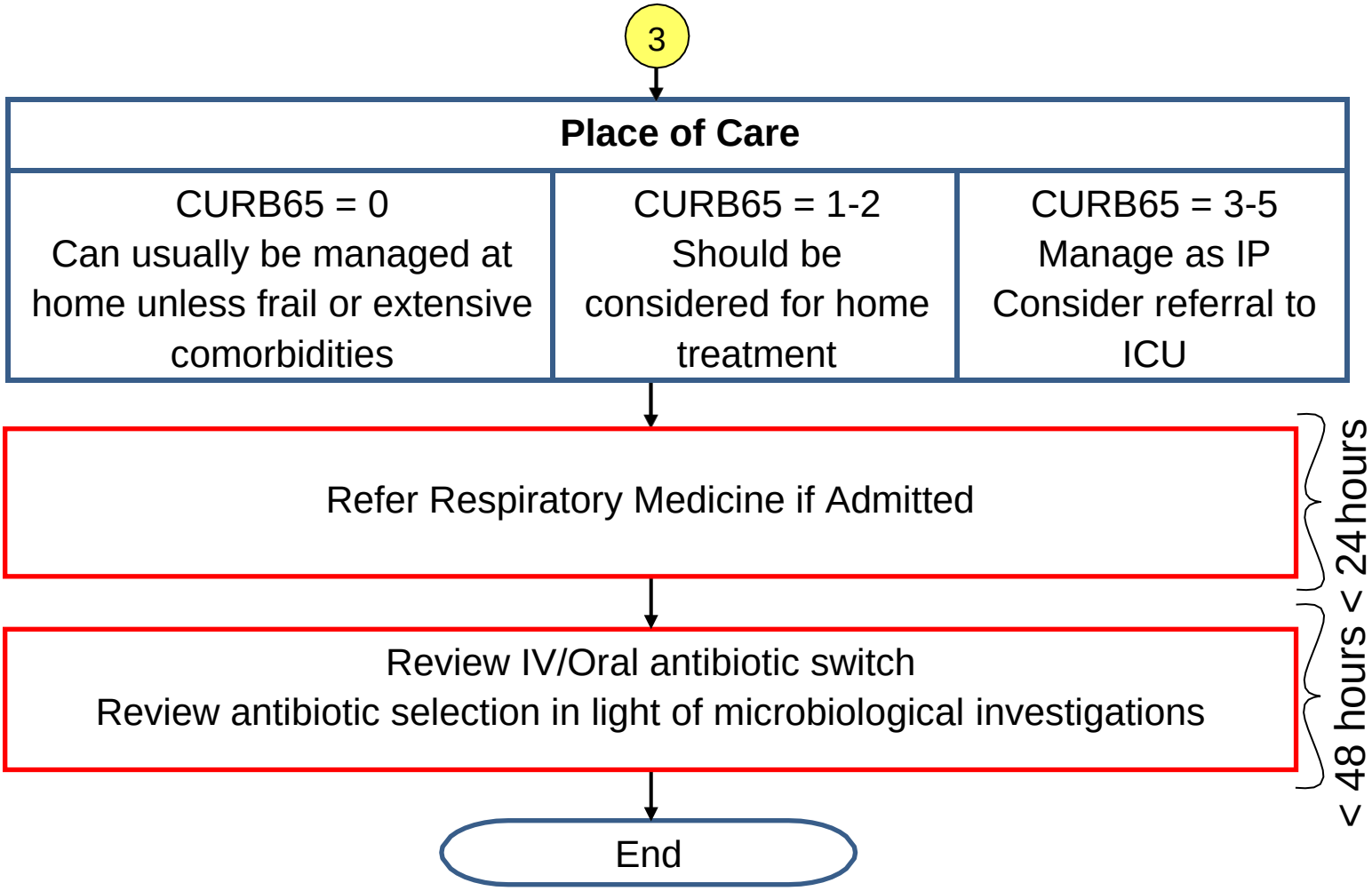
Does not apply in children or to patients with immunocompromise.
Onset of symptoms < 2 weeks after hospital discharge or > 48 hours after admission should be managed as Hospital acquired pneumonia
Consider other diagnosis e.g. PE/Heart Failure

Start CAP Bundle

1


1
Assess for and treat Sepsis if present (see Sepsis Pathway)
Calculate CURB65 score
Antibiotic Therapy1
Oxygenation
Investigation
2
Observations including check sats on air or controlled oxygen
2
SaO2 air ≤ 93%
Prescribe O2 target sats 94-98% unless risk factors of CO2 retention2
Check ABG on air controlled
SaO2 air ≥ 94%
Oxygen not needed at this stage
< 1 hour
Type 1 respiratory failure:
PaO2 < 7.3 on air
PaCO2 < 6.5
Type 2 respiratory failure (decompensated /acute):
PaO2 < 7.3 on air
PaCO2 > 6.5ph < 7.35
Type 2 respiratory failure (compensated/ chronic):
PaO2 < 7.3 on air
PaCO2 > 6.5ph >7.35
Not in respiratory failure
Continue oxygen Target sats 94-98%
Consider ICU referral3
Consider underlying cause3
Oxygen only if sats < 94%
2


2
Antibiotic Therapy[1]
Investigation
Start antibiotics if severe sepsis 1st line IV tazocin &IV/O clarithromycin
FBC
U&E
LFT
CRP
Non-Severe CAP (CURB65 0-2)
Severe CAP (CURB65 3-5)
Blood cultures if no prior antibiotics
Sputum culture if no prior antibiotics
Blood cultures
Sputum culture
Atypical pneumonia serology
Urine for legionella & pneumococcal antigen
< 1 hour
Start antibiotics if severe CAP 1st line IV tazocin & IV/O clarithomycin
Request CXR
< 2 hours
Start antibiotics if non-severe CAP 1st line oral amoxicillin & doxycycline
Review CXR result and document in notes
ECG
< 4 hours
3



Notes			
[1] Probiotics for high risk antibiotics Review PPI indication Indication and duration on EPMA for all antibiotics Refer to antibiotic guideline for updates on 1st line organism specific treatment. Consider drug interactions e.g. clarithomycin and warfarin, simvastatin	[2] Risks of CO_2 retention include known or suspected COPD, obesity, kyphoscoliosis, neuromuscular condition affecting respiratory muscles e.g. motor neurone disease, Guillain-Barre syndrome, muscular dystrophy	[3]NIV in CAP: This is not an evidence based treatment and may delay appropriate intubation. This should not be used outside ICU for patients suitable for escalation to ICU if they deteriorate. Its use as a ceiling of care should only be undertaken after careful consideration as to whether a palliative approach would be more appropriate as it is unlikely to be effective	Determine ceiling of care, escalation plan and resuscitation status