

**CLINICAL PATHWAY  
COMMUNITY ACQUIRED PNEUMONIA (Adult)**

**Inclusion Criteria:**

Age 18 or over. Community acquired pneumonia as defined by (A) and (B) and (C):  
 A) 2 clinical findings: cough/history of fever, pleuritic pain, crackles or bronchial breath sounds  
 B) 1 objective finding: temp greater than 37.5 degrees Celcius, WBC count great 10 x 10<sup>9</sup>/L, 'left shift' in WBC differential  
 C) Chest radiographic findings consistent with pneumonia (focal airspace consolidation, patchy increased interstitial markings)

**Exclusion Criteria:**

Any of the following clinical features: known active tuberculosis or underlying chronic suppurative lung disease (bronchiectasis, cystic fibrosis), immunosuppressed state (HIV, immunosuppressive or antineoplastic drugs, haematologic malignancy, organ transplant recipient), requiring invasive ventilation, nosocomially acquired infection (hospitalization within 10 days prior to presentation), possible lung abscess or cavitary pneumonia. Patients will be discontinued off the pathway if they are transferred to the ICU.

**ELOS:** \_\_\_\_\_

**Clinical Pathways are not considered a substitute for professional judgement**

Phase:	Acute Phase (estimated less than or equal to 3 days)	Transitional Phase
Date:		
<b>Patient Outcomes</b>	May progress to Transition Phase when the following outcomes have been met: - O2 sat greater than or equal to 93% on less than or equal to 4 L O2 _____ - temperature less than or equal to 38 degrees Celsius _____ - verbalizing improvement in symptoms _____ - progressing towards pre-admission activity level (heparin D/C) _____  All outcomes met _____ (initial) _____ / _____ / _____ (Date) _____ (Time)  <b>Clinical Indicator #1: Patient has received first dose of antibiotic within 8 hours of Triage (RN/Pharmacist)</b> Yes _____ No _____ If NO, reason: _____  Signature _____	May progress to Evaluation/Discharge Phase when the following outcomes have been met: - O2 sat greater than or equal to 93% on room air _____ - temperature less than or equal to 38 degrees Celsius _____ - progressing towards pre-admission nutritional intake _____ - able to initiate ADL _____ - verbalizing improvement in symptoms _____ - activity level improving _____  All outcomes met _____ (initial) _____ / _____ / _____ (Date) _____ (Time)  <b>Clinical Indicator #4: Has the patient been switched to po antibiotics (RN/Pharmacist)</b> Yes _____ No _____ If NO, reason: _____  Signature _____
<b>Teaching</b>	Patient and Family provided with patient education booklet _____ Review the following: - deep breathing & coughing exercises _____ - coping strategies _____ - medications _____ - self-care and self-monitoring (fever, changes in tolerance of activity, SOB) _____	Reinforce and assess patient's knowledge: - disease process and treatment _____ - deep breathing & coughing exercises _____ - coping strategies _____ - symptom monitoring _____ - medications _____ - importance of increasing activity _____
<b>Discharge Planning Criteria</b>	Patient advised re: ELOS as per physician order _____	Follow-up with identified referrals. Assess need for flu vaccine using Patient Assessment Form for Influenza Vaccine (Adults) - attached
<b>Pathway Reviewed with Patient/Family (initial):</b>	_____ Yes _____ No	_____ Yes _____ No
<b>Signatures:</b>	_____ _____	_____ _____
	_____ _____	_____ _____



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Phase:	Acute Phase (estimated less than or equal to 3 days)	Transitional Phase
Date:		
<b>INTERVENTIONS</b>	VS q4h and prn Chest auscultation q shift	VS bid and prn Chest auscultation q shift
<b>Assessments</b>	Report culture results or critical lab values to MRP Assess current living situation and need for CCAC and/or QRP assessment Assess need for physiotherapy consult (pts with compromised ventilation secondary to pain, underlying respiration or neuromuscular conditions +/- productive cough).	<b>Clinical Indicator #5: Has the Patient Assessment form for Influenza Vaccine (adults) been completed? (RN)</b> Yes ___ No ___
<b>Consults</b>	Physiotherapy, Dietitian, Speech Pathology, Social Work, CCAC and QRP prn All patients > 80 yrs and those admitted from Long Term Care facility: consult Speech Pathology for swallowing assessment. If outcomes not met by day 3, inform MRP for consideration of Respiriology or Infectious Disease consult (consider TB in high risk groups)	Patient care discussed at Multidisciplinary rounds and documented in chart
<b>Tests</b>	Blood culture x 2 (C&S) Sputum culture if available CBC + differential, electrolytes, LFT, Urea, Creatinine if not obtained already Urinalysis, Chest Xray During flu season: NP swab for rapid testing for influenza / RSV and viral culture Repeat CBC on Day 3 If outcomes not met by day 3, inform MRP for consideration of repeat Chest Xray & urine antigen test for legionella	Repeat CBC on Day 3
<b>Treatments</b>	Oxygen Protocol	Oxygen Protocol
<b>Medications</b>	IV and/or saline lock prn Antibiotics per CVH Guidelines for the Empiric Treatment of Community Acquired Pneumonia Acetaminophen 325-975mg po (650 mg PR) q4h prn (max.4000mg/day) Dimenhydrinate 50mg IM/po (25-50mg IV) q4h prn Heparin 5000 units sc bid Patient specific medications Contact MRP to switch to oral antibiotics if: able to eat & drink, temperature less than or equal to 38 degrees Celcius, resp rate less than or equal to 24/min, pulse less than or equal to 100, blood cultures negative  <b>Clinical Indicator #2: Were the patient's initial antibiotics prescribed according to the CVH Community Acquired Pneumonia Guidelines? (Pharmacist)</b> Yes ___ No ___ If NO, reason: _____ Antibiotic Patient Medication sheets provided _____	D/C IV and/or saline lock po antibiotics per CVH Guidelines for the Empiric Treatment of Community Acquired Pneumonia Acetaminophen 325-975mg po q4h prn (max. 4000 mg/day) Dimenhydrinate 50mg IM/po (25-50mg IV) q4h prn Patient specific medications
<b>Nutrition</b>	Regular diet or as ordered	Regular diet or as ordered
<b>Activity/Safety</b>	Activity as tolerated Ambulation within 12 hours of admission prn then ambulates bid Promote self care if non-ambulatory: - up in chair x 30 minutes bid when possible - ROM lower extremities - repositioning q2h  <b>Clinical Indicator #3: Was the patient ambulated on Day 1? (within 24h of admission) (RN)</b> Yes ___ No ___ If NO, reason: _____ Signature _____	Patient demonstrates a daily increase in activity level (eg. frequency, length of time and/or distance)



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Phase:	Evaluation / Discharge Phase
Date:	

<b>Patient Outcomes</b>	Patient has achieved pre-admission nutritional intake ____ Patient has achieved pre-admission activity level ____ Patient accomplishes ADL with minimal SOB ____ Temperature less than or equal to 38 degrees Celcius ____ Patient on oral medications ____ Able to D/C Oxygen protocol ____ Patient verbalizes understanding of disease process ____  <b>All outcomes met</b> _____ <b>(Initial)</b> ____ / ____ / ____ <b>(Date)</b> _____ <b>(Time)</b> _____						
<b>Teaching</b>	Reinforce and assess patient's knowledge: -- disease process and treatment ____ - deep breathing & coughing exercises ____ - symptom monitoring ____ - medications ____ - importance of increasing activity ____						
<b>Discharge Planning</b>	Chest xray booked in 4-6 weeks if patient is: greater than or equal to 55 years ____ greater than or equal to 45 years and smokes ____ If immunized, immunization card provided ____ Prescription for antibiotics provided (total of 7-10 days except for Azithromycin (total 3 days) ____ Discharge instructions in patient education booklet reviewed ____						
<b>Inerventions</b>	VS bid and prn Chest auscultation q shift						
<b>Assessments</b>							
<b>Consults</b>	Multidisciplinary team involved in discharge planning						
<b>Treatments</b>	Oxygen Protocol						
<b>Medications</b>	po antibiotics as per CVH Guidelines for the Empiric Treatment of Community Acquired Pneumonia Acetaminophen 325-975mg po q4h prn (max. 4000 mg/day) Flu vaccine 0.5mL IM x 1 prior to discharge if indicated by Patient Assessment Form for Influenza Vaccine (Adults) Patient specific medications						
<b>Nutrition</b>	Regular diet as ordered						
<b>Activity/Safety</b>	Patient demonstrates a daily increase in activity level (e.g. length of time and/or distance)						
<b>Pathway Reviewed with Patient/Family (initial):</b>	____ Yes    ____ No    _____ (Patient or Family Signature)						
<b>Signatures:</b>	<table border="1"> <tr> <td>_____</td> <td>Initials</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	_____	Initials	_____	_____	_____	_____
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