RECOMMENDATIONS

These recommendations have been formed by a consensus exercise involving all those listed in the acknowledgements. The recommendations have been independently edited by medical editors experienced in developing recommendations for healthcare audiences to act on.

The recommendations highlight areas that are suitable for regular local clinical audit and quality improvement initiatives by those providing care to this group of patients. The results of such work should be presented at quality or governance meetings and action plans to improve care should be shared with executive boards. Quality Improvement tools provided with this report are provided to support you in doing this.

The recommendations in this report support those previously by other organisations, so for added value should be read alongside:

NICE: **Clinical Guideline 191 - Pneumonia in adults: diagnosis and management**
NICE: **Quality standard 110 - Pneumonia in adults**
BTS: **Guidelines for the management of community acquired pneumonia**
GIRFT: **Respiratory report**

	Executive boards are ultimately responsible for supporting the implementation of these recommendations. Suggested target audiences to action recommendations are listed in italics under each recommendation.
1	Consider community-acquired pneumonia as a possible diagnosis when patients present with new onset confusion without a clear cause, even in the absence of typical symptoms, such as a cough, fever, and breathlessness. This is particularly important for older patients and those who are frail. ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in emergency medicine, respiratory medicine, medicine for the care of older people, general medicine, and nursing leads*
2	Undertake a chest X-ray in patients with suspected community-acquired pneumonia: ▪ Within four-hours of arrival at hospital* ▪ Provide a formal report within 12 hours of the X-ray.** **This supports NICE QS110 Quality Statement 3* *** This supports Diagnostic Imaging Reporting Turnaround Times* ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia, and radiologists* ***Supported by:*** *Clinical directors in radiology, and emergency medicine*
3	Use clinical support tools such as CURB65* and NEWS2, in combination with clinical judgement to determine: ▪ The most appropriate pathway of care for patients with community-acquired pneumonia – ambulatory or inpatient

	▪ Which investigations are needed ▪ Antibiotics to use as initial treatment ▪ Treatment escalation decisions **This supports NICE QS 110 Quality Statement 4* ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in emergency medicine, respiratory medicine, medicine for the care of older people, general medicine, and nursing leads*
4	Use the results of essential investigations (e.g. chest X-ray or blood results) to review the provisional diagnosis and severity of community-acquired pneumonia for patients admitted to hospital who have started treatment to change/adjust antibiotics as necessary. *N.B. A tool such as Start Smart then Focus for antimicrobial stewardship may help* ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in emergency medicine, respiratory medicine, medicine for the care of older people, general medicine, and nursing leads*
5	Arrange microbiological investigations according to the level of community-acquired pneumonia severity. *This support NICE CG191 and British Thoracic Society guidelines for the management of community acquired pneumonia (2009)* ***Primary target audience:*** *All healthcare professionals who provide care to patients with pneumonia* ***Supported by:*** *Clinical directors in emergency medicine, respiratory medicine, medicine for the care of older people, general medicine, microbiology, and nursing leads*
6	Prescribe antibiotics for pneumonia according to the level of clinical severity, using the narrowest spectrum of activity, and follow your hospital antibiotic guidelines. Review the antibiotic to ensure it is the most appropriate and is the best mode of delivery. *N.B. A tool such as Start Smart then Focus for antimicrobial stewardship may help* ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in emergency medicine, respiratory medicine, medicine for the care of older people, general medicine, pharmacy, and nursing leads*
7	Ensure a treatment escalation plan is in place following diagnosis of community-acquired pneumonia. This should be agreed in discussion with the patient and their family, considering a combination of factors such as age, frailty, and comorbidities. ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in respiratory medicine, medicine for the care of older people, general medicine, and nursing leads*
8	Record smoking status in patients admitted with community-acquired pneumonia. Offer brief advice, nicotine replacement therapy, and referral to a tobacco dependency specialist to support the group of patients who smoke, while they are in hospital and, after discharge.* **This supports NICE Guideline 209 1.14.13* ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in respiratory medicine, medicine for the care of older people, general medicine, and nursing leads*

9	Use admission to hospital with community-acquired pneumonia as an opportunity to address a patient's general health and wellbeing.* **This supports NICE Guideline 16 and Making Every Contact Count* ***Primary target audience:*** *All healthcare professionals who review patients with pneumonia* ***Supported by:*** *Clinical directors in respiratory medicine, medicine for the care of older people, general medicine, and nursing leads*
10	At discharge from hospital after an episode of community-acquired pneumonia: ▪ Provide patients with written information about pneumonia ▪ Provide patients with a clear plan for clinical follow-up. ▪ Arrange a chest X-ray at six-weeks for patients who smoke, those over 50 years of age or where symptoms persist.* If the chest X-ray is not undertaken document the reason why. **This supports the British Thoracic Society guidelines for the management of community acquired pneumonia (2009)* ***Primary target audience:*** *All healthcare professionals who treat patients with pneumonia* ***Supported by:*** *Clinical directors in respiratory medicine, radiology, medicine for the care of older people, general medicine, and nursing leads*
11	Review the infrastructure for, and leadership of, hospital pneumonia services. Aim for one specialist pneumonia nurse per 400 admissions and a clinical lead with responsibility for the pneumonia service.* **This supports the GIRFT (Getting it Right First Time) respiratory report (published March 2021)* ***Primary target audience:*** *Chief medical and nursing officers, clinical directors in respiratory medicine, respiratory nursing and, radiology*
12	Differentiate community-acquired pneumonia from hospital-acquired pneumonia by including the ICD-10 code for nosocomial infections (Y95) in addition to the pneumonia code for hospital-acquired pneumonia. ***Primary target audience:*** *Clinical coders in hospitals*