



SCREENING: Include patients aged >16 with a **primary discharge diagnosis** of pneumonia if **all** the following criteria apply:

- New infiltrates on CXR within 24hrs of admission
- Acute onset of symptoms and signs of LRTI
- **Not** transferred from another hospital
- **No** Hospital admissions within last ten days
- **Not** Immunocompromised
- **Not** treated for aspiration pneumonia

Details about excluded patients should be recorded on the separate screening datasheet

Section 1. Patient Information				
1.1	Local identifier <i>Please do not enter NHS or hospital numbers. This is an optional field for local use and will be deleted when records are committed.</i>	1.11	Please give the discharge codes, if known (please enter the full code e.g. J18.1)	
1.2	N/A (Scotland and Northern Ireland)	a	Primary diagnosis code:	
1.3	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	b	Secondary diagnosis code:	
1.4	Age (yrs):	c	Other diagnosis code:	
1.5	Has a clinician reviewed the CXR image or report to confirm diagnosis of pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No	d	Other diagnosis code:	
1.6a	Admission date* DD/MM/YYYY	e	Other diagnosis code:	
1.6b	Admission time* __:__	f	Other diagnosis code:	
* Please give the date and time of presentation at the hospital e.g. A&E booking time or time of arrival at unit/ward for direct admissions. Patients seen in A&E only should not be included.		1.12	Presenting Symptoms (tick all that apply)	
1.7	Source of admission: <input type="checkbox"/> Emergency Department <input type="checkbox"/> GP referral <input type="checkbox"/> Other <input type="checkbox"/> No data / No data recorded	<input type="checkbox"/> Cough – purulent (yellow/green) <input type="checkbox"/> Cough – non-purulent (clear/white) <input type="checkbox"/> Cough – dry <input type="checkbox"/> Dyspnoea <input type="checkbox"/> Wheeze <input type="checkbox"/> Pleuritic pain <input type="checkbox"/> Haemoptysis <input type="checkbox"/> Fever <input type="checkbox"/> Rigors <input type="checkbox"/> Fall <input type="checkbox"/> Fatigue <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Other major presenting symptoms <input type="checkbox"/> None of the above		
1.8	Was the patient admitted from residential care? <input type="checkbox"/> Yes – nursing home <input type="checkbox"/> Yes – residential home <input type="checkbox"/> No <input type="checkbox"/> No data or Not recorded	1.13	Has the patient received antibiotics in the 7 days prior to admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known	
1.9	Did the patient die while an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data <i>If No, please answer 1.10a, if Yes, please answer 1.10b</i>	1.14	Smoking status: <input type="checkbox"/> Current <input type="checkbox"/> Ex-smoker (at least 3 months) <input type="checkbox"/> Never <input type="checkbox"/> Not recorded	
1.10a	Discharge date: DD/MM/YYYY			
1.10b	Length of Stay (days)			
Section 2. Admission				
2.1	Time of initial chest x-ray: __:__	2.9	Which elements of the CURB65 score were present at admission (whether or not CURB65 score was used): New mental confusion: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data Urea > 7mmol/l: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data Resp rate >= 30/min: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data SBP < 90mmHg or DBP <= 60mmHg: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data	
2.2	Date of initial chest x-ray: DD/MM/YYYY			
2.3	Time of first antibiotic in hospital: __:__			
2.4	Date of first antibiotic in hospital: DD/MM/YYYY			
2.5	Was the chest x-ray taken and community acquired pneumonia confirmed within 4 hours of presentation to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data	2.10		Co-morbid illness (tick all that apply): <input type="checkbox"/> Congestive Cardiac Failure (CCF) <input type="checkbox"/> Other chronic heart disease (exc. hypertension) <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Liver disease <input type="checkbox"/> Renal disease <input type="checkbox"/> Active malignancy <input type="checkbox"/> COPD <input type="checkbox"/> Other chronic lung disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Dementia <input type="checkbox"/> Severe obesity (BMI >40) <input type="checkbox"/> Other <input type="checkbox"/> None of the above
2.6	Was the chest x-ray obtained and reviewed BEFORE antibiotics were given in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data	2.11	On admission was oxygen saturation <94% on room air (or <88% if COPD patient)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data on room air <input type="checkbox"/> Oxygen not assessed	
2.7	If Yes, please indicate the time interval between the chest x-ray and the first dose of antibiotics: <input type="checkbox"/> <2 hours <input type="checkbox"/> 2-4 hours <input type="checkbox"/> >4 hours <input type="checkbox"/> No data / Not recorded	2.12		
2.8	Was CURB 65 severity score recorded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not recorded			

Section 3. Antibiotics			
3.1	Please indicate all initial antibiotics prescribed: <input type="checkbox"/> Amoxicillin (oral) <input type="checkbox"/> Co-amoxiclav (intravenous) <input type="checkbox"/> Amoxicillin (intravenous) <input type="checkbox"/> Co-trimoxazole (oral) <input type="checkbox"/> Benzylpenicillin (intravenous) <input type="checkbox"/> Co-trimoxazole (intravenous) <input type="checkbox"/> Cephalosporin (oral) <input type="checkbox"/> Doxycycline (oral) <input type="checkbox"/> Cephalosporin (intravenous) <input type="checkbox"/> Erythromycin (oral) <input type="checkbox"/> Clarithromycin (oral) <input type="checkbox"/> Erythromycin (intravenous) <input type="checkbox"/> Clarithromycin (intravenous) <input type="checkbox"/> Gentamicin (intravenous) <input type="checkbox"/> Co-amoxiclav (oral) <input type="checkbox"/> Levofloxacin (oral)	<input type="checkbox"/> Levofloxacin (intravenous) <input type="checkbox"/> Meropenem (intravenous) <input type="checkbox"/> Moxifloxacin (oral) <input type="checkbox"/> Moxifloxacin (intravenous) <input type="checkbox"/> Tazocin (intravenous) <input type="checkbox"/> No data / not recorded <input type="checkbox"/> No antibiotics prescribed <input type="checkbox"/> Other*, please specify:	
<i>* For Ceftriaxone, Cefuroxime, Cefalexin etc. please use the Cephalosporin box with the appropriate use</i>			
3.2	Were initial antibiotics in line with local CAP Guidelines preferred recommendations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data	
3.3	What was the total uninterrupted duration of the first hospital course of intravenous antibiotics?	<input type="checkbox"/> <24 hrs <input type="checkbox"/> >24 hrs but <72 hrs <input type="checkbox"/> >72 hrs <input type="checkbox"/> None given <input type="checkbox"/> not known	
3.4	From admission, what was the total intended duration of oral and IV antibiotics prescribed for this episode of CAP, including those to be taken following discharge? <i>Please do not include subsequent courses of antibiotics given in hospital for another diagnosis.days</i>		
Section 4. Microbiology investigations			
4.1	Pneumococcal urinary antigen performed? <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not performed <input type="checkbox"/> Not recorded	4.4	Sputum cultures performed within the first 72 hrs? <input type="checkbox"/> No growth <input type="checkbox"/> Respiratory commensals only <input type="checkbox"/> Positive <input type="checkbox"/> Not performed <input type="checkbox"/> Not recorded
4.2	Legionella urinary antigen performed? <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not performed <input type="checkbox"/> Not recorded	4.5	Blood cultures performed within the first 24 hrs? <input type="checkbox"/> Performed – no growth <input type="checkbox"/> Performed – positive culture <input type="checkbox"/> Performed – probable contaminant <input type="checkbox"/> Not performed <input type="checkbox"/> Not recorded
4.3	Respiratory viral testing performed? <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not performed <input type="checkbox"/> Not recorded		
Section 5. Outcome			
5.1a	Senior review - how many hours from admission? <input type="checkbox"/> < 6 hours <input type="checkbox"/> Between 6 and 12 hours <input type="checkbox"/> Between 12 and 24 hours <input type="checkbox"/> > 24 hours <input type="checkbox"/> No data / not recorded	5.3	Was the patient admitted to critical care area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not recorded
5.1b	Specialty of the consultant seeing the patient on the initial post-take ward round? <input type="checkbox"/> Respiratory medicine <input type="checkbox"/> Care of the elderly medicine <input type="checkbox"/> Acute medicine <input type="checkbox"/> Other <input type="checkbox"/> No data / not recorded	5.4	Did the patient receive any of the following (tick all that apply): <input type="checkbox"/> NIV <input type="checkbox"/> CPAP <input type="checkbox"/> IPPV <input type="checkbox"/> Inotropes <input type="checkbox"/> Nasal high flow oxygen <input type="checkbox"/> None of the above
5.2	Did the patient receive critical care advice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data or not recorded	5.5	Was the patient readmitted within 30 days of discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data or not recorded
		5.6	Did the patient die within 30 days of discharge after the index admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data or not recorded
Section 6. Discharge and Follow up (not applicable for patients who died during the admission)			
6.1	Were observations performed in the 24 hours prior to discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data or not recorded	6.3	What follow up arrangements were made for the patient on discharge? <input type="checkbox"/> Hospital physician led outpatient clinic <input type="checkbox"/> Hospital nurse led outpatient clinic <input type="checkbox"/> Chest x-ray only <input type="checkbox"/> GP follow up <input type="checkbox"/> No follow up arranged <input type="checkbox"/> Not recorded
6.2	If yes, what were the last patient observations prior to discharge: Temperature (°C) Heart rate (beats per minute) Respiratory rate (breaths per minute) Systolic blood pressure (mmHg) Diastolic blood pressure (mmHg) Oxygen saturation (%)	6.4	Was a follow up CXR arranged? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No data