**Assessment of Appropriateness of Antibiotics for   
Community-Acquired Pneumonia (CAP)**

Definition

1. Was the patient hospitalized in an acute care hospital for > 2 days within 90 days of the diagnosis of pneumonia?

2. Did the patient reside in a nursing home or long-term care facility at the time of diagnosis?

3. Did the patient receive intravenous antibiotic therapy, intravenous chemotherapy, wound care or attend a hemodialysis clinic within 30 days of diagnosis?

4. Did the patient have a documented pulmonary infiltrate on chest radiograph or other chest imaging?

**(IF YOU ANSWERED YES TO QUESTION 1, 2, OR 3, OR NO TO QUESTION 4, THE PATIENT DOES NOT MEET CRITERIA FOR COMMUNITY-ACQUIRED PNEUMONIA AND SHOULD BE EXCLUDED)**

Diagnostics

5. Was the patient admitted to an ICU due to complications of CAP? (If **No** please skip to  
question 6)

A. If **Yes**, were blood cultures sent?

B. If **Yes**, was a sputum and/or endotracheal aspirate sent for Gram stain and culture?

C. If **Yes**, were cultures sent before antibiotics were administered?

D. If **Yes**, were urinary antigen tests sent for *Legionella pneumophila* and *Streptococcus pneumoniae*?

Therapeutics

6. Were initial antibiotics consistent with institutional/national guidelines?

72 hour Reassessment

7. Was an organism isolated by culture within 72 hours of the first dose of antibiotics?

8. If an organism was isolated by culture, was it susceptible to the prescribed antibiotic?

**(PRINT ANTIBIOTIC SUSCEPTIBILITY REPORT)**

9. Were antibiotics changed after culture results were available?

If **YES**, please document antibiotic change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Was the patient initially prescribed an intravenous (IV) antibiotic with good oral bioavailability (See Appendix A)?

A. If **YES**, was the antibiotic changed to an oral formulation (PO), or was the patient started on a different oral antibiotic within 24 hours of being eligible for oral medications? (See Appendix B for criteria)

11. Total planned duration of antibiotics?

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

\_\_\_\_\_\_

No

No

No

No

No

No

No

No

No

No

No

No

No

No

No

Days

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Appendix A:

Amoxicillin

Amoxicillin/Clavulanate

Azithromycin

Cefpodoxime

Ciprofloxacin

Clindamycin

Doxycycline

Levofloxacin

Linezolid

Moxifloxacin

Trimethoprim/Sulfamethoxazole

Appendix B:

1. Patients must meet the following criteria:

A. Receiving oral or gastric tube intake.

B. Taking other oral medications.

2. Patients are considered inappropriate for IV to PO conversion if any of the following are present:

A. Mucositis.

B. Malabsorption syndrome or gastrointestinal motility disorder.

C. Severe nausea, vomiting or diarrhea.

D. Continuous nasogastric suctioning.

E. Continuous enteral feeds are contraindicated with oral ciprofloxacin, levofloxacin or moxifloxacin.