National Asthma and COPD Audit Programme (NACAP)
Adult asthma secondary care audit – Frequently asked questions (FAQs)
Version 2.0: September 2020

There are also guidance documents available for the technical aspects of the web tool.

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General Information
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• What are the contact details for the asthma audit team?
  o You can contact us at 020 3075 1526, or asthma@rcplondon.ac.uk. Our help desk is open from 9am – 5pm, Monday to Friday.
  o Our address is: The National Asthma and COPD Audit Programme, The Royal College of Physicians, 11 St Andrew’s Place, Regent’s Park, London, NW1 4LE.

• Does the audit programme have a Twitter account?
  o Yes, it does. The team post updates regularly, so please do follow us, our twitter handle is @nacapaudit.

• What resources are available for the audit and where can I download them from?
  o The following resources are available:
    o datasets,
    o data collection sheet,
    o guidance documents,
    o patient information sheet, and
    o patient information poster.
  o These are available on both the web tool’s ‘Downloads’ page at www.nacap.org.uk (available to select from the top menu bar of the homepage of the audit once you are logged in), and on our website (https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult).

• Can I obtain a participation certificate in exchange for helping with my local audit?
  o Yes. If members of your local audit team would like participation certificates to recognise their contribution to the audit, please contact your local audit lead so that they can request a certificate for you from the audit team.

• Is there information explaining the audit available for patients?
  o Patient information documentation (poster and leaflet) are available to download from the audit web tool’s ‘Downloads’ page as well as our website (https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult).
  o The poster should be displayed in all areas where asthma patients may be treated.

• Does this audit collect patient identifiable data?
  o Yes. This audit has Section 251 approval from the Health Research Authority Confidentiality Advisory Group (reference number: CAG-8-06(b)/2013) and approval from the Public Benefit and Privacy Panel for Health and Social Care in Scotland (reference number: 1718-0134).
o This allows identifiable data to be collected and processed without patient consent. However, if a patient informs you that they do not wish to be included in the audit, please make this clear in the patient’s notes and do not enter their data into the audit.

o If you would like more information about our information governance arrangements please see our information governance FAQs, which can be downloaded from the audit web tool’s ‘Downloads’ page as well as our website (https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult).

Using the web tool

Login and registration

- Where can I find the asthma audit web tool?
  o It can be found at this website: www.nacap.org.uk.

- Do I have a login for the web tool?
  o If you were registered, you should have received an email from helpdesk@crownaudit.org. This may have gone through to your junk mail.
  o The email will contain your username, and details on how to reset your password.
  o If you have not received this email, but believe that you should have, please contact the audit team.

- How do I register more users on the web tool?
  o If you have a login for the web tool yourself, you can create new logins for your colleagues.
  o Once you are logged in, please follow the last option on the top menu bar ‘Support’, then select ‘New user’ from the left-hand menu that appears and follow the instructions.
  o If you are the lead for the audit at your hospital, then you can approve new user requests.
  o If you are not the lead, the lead will need to approve the new user request. The lead will automatically be sent an approval request via email.
  o Once the request has been approved, an email will be sent to your colleague, asking them to complete the login process.
  o Please be careful when entering in names, telephone numbers and especially email addresses, when creating new accounts. Errors will mean that the account will have to be deleted and started again.

Viewing patient records

- Can I view the patient records entered for my hospital?
  o Yes. By selecting ‘Patients’ from the menu bar, you will be able to view which patients have been entered onto the web tool.
• Can I search through the patient record list by NHS/CHI number?
  o On draft records, completed records and all records screens, you will be able to go to a specific
    NHS number if you enter it into the ‘Jump to NHS number’ box and click ‘Go’.
  o Your web browser search function can also be used to search for an NHS/CHI number (hit ‘Ctrl’
    and ‘F’, and then enter in the text you are searching for).
  o Remember, we are auditing readmissions, so it is quite likely that you will see the same NHS/CHI
    number multiple times – this does not mean that the record is a duplicate. Duplicates are
    automatically captured by the web tool using a combination of patient’s NHS/CHI number, date of
    birth, admission date, and postcode.

• What is an ‘Artemis ID’?
  o This is a code automatically assigned to every patient entered on the web tool, which serves to
    anonymise the data. It is presented as a long sequence of letters and numbers such as,
    5C920511992C579B32C378DF34B8AFBB. Please use this if you wish to discuss particular patient
    records with either the NACAP team or Crown.
  o Please do not, under any circumstances, send/provide NHS/CHI numbers, or any other form of
    patient identifier (name, date of birth etc), to any member of the NACAP audit team.

Deletion of patient records

• What do I do if I have entered the same patient twice?
  o If you attempt to validate or save a record which has already been entered (i.e. the NHS/CHI
    number, date of birth, gender and date of admission match), the web tool will flag this up and you
    will not be able to save the duplicate.

• I want to delete a patient record, what do I do?
  o If you would like to delete a patient record, open the patient record and you will see a ‘Delete’
    button on the top right of the page. Click this button and the record will be deleted.
  o Alternatively, please contact the audit team who will be able to help.
  o Please have the ‘Artemis ID’ for the patient to hand. This can be accessed by clicking the ‘Patients’
    option in the menu bar, and then opening the required patient record.
  o The Artemis ID is presented as a long sequence of letters and numbers such as,
    5C920511992C579B32C378DF34B8AFBB in the information ‘i’ tab.
  o Please do not, under any circumstances, send/provide NHS/CHI numbers, or any other form of
    patient identifier (name, date of birth etc), to any member of the NACAP audit team.

Adding/removing custom fields

• How can I add in/remove custom fields?
  o ‘Custom fields’ is a function of the web tool that allows you to add additional data field(s) to the
    patient records should you wish to audit other elements of care at a local level. If you add custom
fields, these will not be exported for national or site-level reporting – this facility is provided for your local internal auditing purposes only.

- If you wish to add in custom fields to your dataset, then please select ‘Custom fields’ from the top menu bar once you are logged into the web tool, and follow the instructions on the left hand bar.
- You can request to delete a custom field only if there is no data stored against it. If there is data against the custom field, but you still wish to remove it, you are able to ‘disable’ for local use.
- To disable a custom field, select ‘Custom fields’ from the top menu bar, then click on the name of the field you wish to disable. Click on the ‘Edit’ button in the top right hand corner and then select ‘No’ for the ‘Include this field in your records?’ option.
- Please note that custom fields cannot be imported. Please refer to the separate import guidance documents (available on the web tool and on our website) for more information.

**Importing and exporting data**

- Can I upload/import patient data in bulk?
  - Yes, you will be able to bulk upload data in a suitably formatted .CSV file.
  - Guidance on how to format these files is available on both the web tool’s ‘Downloads’ page at [www.nacap.org.uk](http://www.nacap.org.uk) (available to select from the top menu bar of the homepage of the audit once you are logged in), and on our website ([https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult](https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult)).

- Can I export the clinical data for my own hospital?
  - Yes. Once you are logged into the web tool, select ‘Exports’ from the menu bar and then follow the instructions to export your site level data as a .CSV file.

**Clinical audit**

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**Data entry deadlines**

- When did the adult asthma clinical audit start?
  - Data collection began on 1 November at and is running continuously until at least February 2021.

- Are there any deadlines for entering data?
  - The next data entry deadline for the adult asthma audit can be found below. This deadline will also be made available via the web tool homepage ([www.nacap.org.uk](http://www.nacap.org.uk)) and the NACAP webpages ([https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult](https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-secondary-care-workstream-adult)).
• Can I have an extension on data deadlines?
  o Unfortunately, we cannot offer extensions on the data deadlines under any circumstances. A six-week data entry period has been provided to support teams to enter eligible cases onto the web tool to ensure the maximum number of records are included in national and site-level reporting.
  o It is important that records are added within the deadlines provided to ensure that any Quality Improvement activity taking place at a local level is informed by up-to-date data.

• How many cases should we be entering?
  o All adult (16 and over, if admitted on adult wards) patients admitted with an asthma attack should be included. Please note that we are not auditing patients for whom asthma is a comorbidity, but only those where an asthma attack is their primary diagnosis.
  o If you are concerned about this, please contact the audit team to discuss what support is available to you to help you participate in the audit.

• Are we expected to enter retrospective data for patients discharged between April and December 2020?
  o We appreciate that many hospitals across the country are still trying to get back to normal following the impact of COVID-19. In addition, data entry for the adult asthma audit stopped at the start of May in order to allow the NACAP team to make necessary changes to the dataset. As such audit teams are not expected to enter retrospective data into the audit web tool, however if you want to/feel able to enter cases for patients discharged from 1 April 2020 this data will be included in national reporting.

• Are draft records included in any of the asthma audit reports? (E.g. national, site level, STP).
  o No, draft records are not included in any asthma audit reports. Please ensure all records are saved fully prior to data entry deadlines.

Eligibility criteria

• What are the inclusion criteria for the clinical audit?
  o Include patients:
    o who are 16 years and over on the date of arrival
who have been admitted* to hospital adult services
who have a primary diagnosis of asthma attack
where an initial, or unclear, diagnosis is revised to asthma attack.

*We define an ‘admission’ as:
An episode in which a patient with an asthma attack is admitted to a ward and stayed in hospital for 4 hours or more (Emergency Medicine Centres, Medical Admission Units, Clinical Decision Units, short stay wards or similar, but excludes patients treated transiently before discharge from the Emergency Department).

• What if a patient developments an asthma attack whilst already admitted for a different reason?
  o You should only include patient that were originally admitted due to an asthma attack. Please discount patients that developed an asthma attack whilst already admitted for an alternative issue.

• How do I identify cases for inclusion?
  o We suggest that cases should be identified prospectively. Identifying cases prospectively may involve regular review of medical admission sheets and/or electronic admission records. A number of specific local examples of prospective identification of cases taken from the Asthma Audit Development Project (AADP) pilot include:
    o meeting with relevant members of the MDT to understand how and where information can be obtained.
    o involving members of the MDT in the identification of cases and informing the necessary team members responsible for data collection.
    o use of automated hospital alert systems (whereby patient details and location are sent to a respiratory support team inbox, for instance).
    o incorporating the data collection sheet in the patient file for completion at point of discharge

Further details can be found in the AADP appendices document:
https://www.rcplondon.ac.uk/projects/outputs/asthma-audit-development-project-aadp-phase-2-final-report

  o Any gaps should then be checked retrospectively by checking of cases which have been coded with the following ICD-10 codes in the primary position of the first episode of care:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.0</td>
<td>Predominantly allergic asthma</td>
</tr>
<tr>
<td>J45.9</td>
<td>Asthma, unspecified</td>
</tr>
<tr>
<td>J46.X</td>
<td>Status asthmaticus (&lt;i&gt;Includes: Acute severe asthma&lt;/i&gt;)</td>
</tr>
</tbody>
</table>
You can also find local examples of case identification in the Good Practice Repository for the COPD secondary care audit available at: https://www.rcplondon.ac.uk/projects/outputs/national-asthma-and-copd-audit-programme-nacap-copd-secondary-care-good-practice

If there is doubt over the inclusion or exclusion of an individual case, it is reasonable to check with the clinician leading the audit at your site.

**What are the exclusion criteria for the clinical audit?**

- Exclude patients:
  - in whom an initial diagnosis of an asthma attack is revised to an alternative at a later stage,
  - who are between 16 and 18 but seen on a paediatric ward
  - who have had a stay in hospital of less than 4 hours (who would be classed as a non-admission).

**How is it best to manage the audit?**

- We suggest you form a team to undertake the audit. Note that many patients eligible for inclusion in this audit are managed on non-respiratory wards, so it is vital the audit pilot is not restricted to respiratory departments.
- The audit should be led by a senior respiratory clinician (consultant physician/nurse consultant/respiratory nurse specialist/respiratory physiotherapist), and the team should ideally include any of the following:
  - consultant respiratory physician/respiratory SpR
  - acute physician/acute medicine SpR
  - emergency department consultant/emergency medicine SpR
  - respiratory nurse specialist/asthma nurse
  - interested junior doctors
  - respiratory physiotherapists
  - local audit staff
  - Trust management.
- Consider involving those who might help embed change within the organisation to support quality improvement activities that arise through the continuous audit.
Clinical audit dataset
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Patient data

- A patient is from overseas and therefore does not have an NHS/CHI number. How do I create a records for the patient on the web tool without this?
  - If a patient resides permanently outside the UK and therefore does not have an NHS/CHI number, they should not be included in the audit.

- A patient is from overseas and therefore does not have a recognised postcode. How do I complete the ‘home postcode’ section of the dataset for this record?
  - Overseas patients should not be included in the audit.

- A patient lives in the UK but does not have a registered address/home postcode. How do I complete the ‘home postcode’ section of the dataset for this record?
  - If a patient does not have a permanent residence, but lives in the UK, please enter ‘[NFA]’. Square brackets are essential when using this code.

- Smoking status is not documented in the patient notes. How do I answer Q2.5 *(What was the smoking status of the patient, as documented for the current admission)*?
  - Where smoking status is not recorded in the patient notes, please select ‘Not recorded’.

- What do you define as an ‘Ex-smoker’, ‘Current smoker’, ‘Current vaper’ in relation to Q2.5 *(What was the smoking status of the patient, as documented for the current admission)*?
  - If the patient stopped smoking or vaping at least 4 weeks prior to this admission, please select ‘Ex-smoker’.
  - If the patient has stopped smoking or vaping within 4 weeks of the current admission, please select ‘Current smoker’ or ‘Current vaper’.
  - This the term ‘smoker’ does not just refer to tobacco smokers, regular smokers of any substance (i.e. including cannabis or heroin but excluding vaping) should also be counted as ‘current smokers’.
  - Also, patients who smoke and vape should be categorised as ‘current smoker and current vaper’.
  - Patients are classed as current smokers/vapers if they smoke/vape at least once a week

Acute observations

- First recorded heart rate and/or respiratory rate are not recorded in the patient notes. How do I answer Q3.1/Q3.2 *(What was the first recorded heart rate for the patient following arrival at hospital?/What was the first recorded respiratory rate for the patient following arrival at hospital?)* in order to complete the record?
First recorded heart rate and first recorded respiratory rate are essential acute observations that should be documented in the patient notes and therefore a ‘Not recorded’ option is unavailable.

If these are not recorded, we advise that hospital teams use this as a quality improvement exercise to ensure regular recording of the acute observations in the patient notes.

Please note that if these fields are left blank the patient record will remain as a draft and will not be included in any reporting outputs.

**A patient’s first recorded peak flow measurement following arrival to hospital is not within the 60-800 L/min range. How do I answer Q3.4 (What was the first recorded peak flow measurement (PEF) for the patient following arrival at hospital)?**

- If the first recorded peak flow measurement is below 60 L/min, please enter ‘60’.
- If the first recorded peak flow measurement is above 800 L/min, please enter ‘800’
- Please note that this guidance also applies to the following questions should the peak flow measurements be outside the 60-800 L/min range:
  - Q3.5 (What was the patient’s previous best PEF?)
  - Q3.5a (If previous best PEF = ‘Not recorded’ please give predicted PEF)

**If the patient’s previous best is not recorded in the notes for the current admission, can we provide this value from other known sources in order to answer Q3.5 (What was the patient’s previous best PEF)?**

- Yes. Previous best PEF can be obtained from sources including the asthma action plan, previous lung function tests or as reported by the patient.

**Acute treatment**

The dataset asks whether the patient was reviewed by a respiratory specialist during their admission (Q4.1). What do you define as a ‘respiratory specialist’?

- Please select ‘Yes’ for this question if the patient was seen by any respiratory health professional deemed competent at seeing and managing patients with acute asthma attacks at any point during their admission. This may vary at a local level but may include respiratory consultants, respiratory trainees of ST3 or above, respiratory specialist nurses or asthma nurses.

**Review and discharge**

What date of discharge do I provide if the patient was transferred to another hospital, early discharge scheme, hospital at home or community scheme?

- Please select the date of discharge from your hospital and not the scheme for Q5.2a (Date of discharge/death).

What do you define as a discharge bundle?

- Please select ‘Yes’ for Q5.3 (Was a discharge bundle completed for this admission?) if there is evidence of a care bundle record in the patient notes. For instance, this may take the form of a
bundle sheet or sticker, or a check box in an electronic patient record. An example of a discharge bundle is the British Thoracic Society (BTS) care bundle for asthma.¹ This includes:
- inhaler technique check
- assessment of medications
- creation/assessment of a written asthma action plan
- discussion about triggering and exacerbating factors
- provision of follow-up care in the community and referral to specialist care

- Do the elements of good practice that form a discharge bundle have to be given to the patient at discharge to count as being issued?
  - Not necessarily. If the patient has received elements of good practice care at any during the course of their admission and this has been checked at discharge, then this will still count as being received.

- A patient was very recently readmitted for an asthma attack and during their previous admission received a discharge bundle. Am I able to state that this was provided due to the proximity of the admissions?
  - No. Please only answer ‘Yes’ if the discharge bundle was provided for the current admission. This applies regardless of the time between admissions to the same hospital.

**Stereoids and referral for hospital review**

- How do I answer Q6.1 *(Was the patient in receipt of inhaled steroids at discharge)?*
  - You should select ‘Yes’ if the patient was prescribed inhaled steroids either alone OR in combination with long acting beta-agonist.
  - You should select ‘Not prescribed for medical reasons’ only if it is documented in the notes why steroids are not required.

- How do I answer Q6.2 *(Was the patient prescribed at least 5 days of oral steroids for treatment of their asthma attack)?*
  - You should select ‘Yes’ if the patient:
    - completed at least 5 days of oral steroids during their admission,
    - has been discharged with oral steroids to complete the minimum 5 day treatment period,
    - is on long term steroids and had an appropriate increase in steroid dose to manage this attack of at least the minimum 5 day period.
  - You should select ‘No’ if the patient:

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¹ The BTS care bundle for asthma has been provided as an example. A discharge bundle is a structured way of improving discharge processes, the elements of which are based on evidence based interventions and actions. We understand that the elements of good practice care included may differ if hospital-specific discharge bundles are used. Therefore, if a formal hospital-specific discharge bundle is used, please select ‘Yes’ when answering ‘Was a discharge bundle completed for this admission?’
- did not complete at least 5 days of oral steroids during their admission,
- has not been discharged with oral steroids to complete the minimum 5 day treatment period, or
- is on long term steroids and did not have an appropriate increase in steroid dose to manage this attack of at least the minimum 5 day period.