National Respiratory Audit Programme (NRAP)

Adult asthma audit: User guide

Secondary Care

Version 0.3 June 2023

Contents

Introduction to NRAP

More than 9 million people are living with a diagnosis of asthma or COPD in the UK.
The National Respiratory Audit Programme (NRAP) is run by the Royal College pf Physicians (RCP) and aims to improve the quality of their care, services, and clinical outcomes.
We do this by supporting and training clinicians, informing policy, and empowering people living with asthma and COPD, as well as their carers.
We have a track record of delivery and are critical to assessing progress against the NHS Long Term Plan.
Visit our website to find out more about the Programme and its four audit workstreams.

Overview of the adult asthma audit

The adult asthma continuous clinical audit collects information on all people admitted to hospital in England and Wales with an asthma attack.
All hospitals in England and Wales that provide adult asthma care can participate in the audit by entering admission data from patient care case notes into a secure and bespoke audit web tool. The data collection period for the adult asthma clinical audit started in November 2018 and runs continuously.

How this document will support you

This document is a resource for adult asthma secondary care teams submitting data to the NRAP webtool. All headings in the contents page are linked to the appropriate chapter for ease of navigation. It is advised that users take the time to read through the whole document to gain a better understanding of the process of data submission to improve the quality of the data submitted and to become familiar with the tools and documents available on the website to help improve respiratory services.

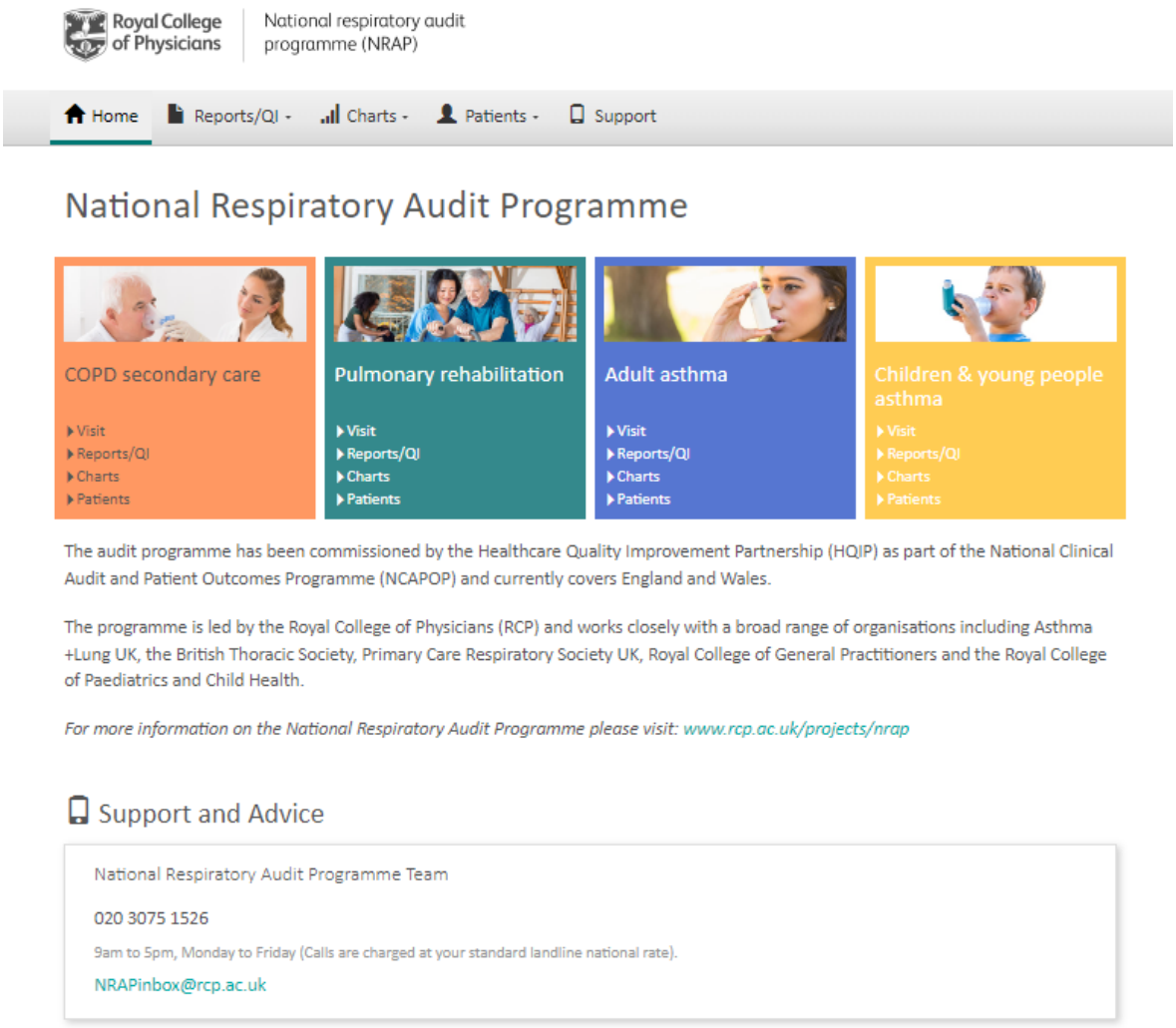
"Data are fundamental to informing services, both in terms of understanding where we are now and monitoring quality improvement (QI) going forward. Paramount to this is accurate data entry."
(Professor Jenni Quint, respiratory consultant and professor of respiratory epidemiology)

Registering for the audit

All hospitals in England and Wales who admit adult patients following an asthma attack are eligible to participate. Visit the workstream's resources page to download a copy of the registration form.

Accessing the audit webtool

The adult asthma audit web-tool can be reached via www.NRAP.org.uk:

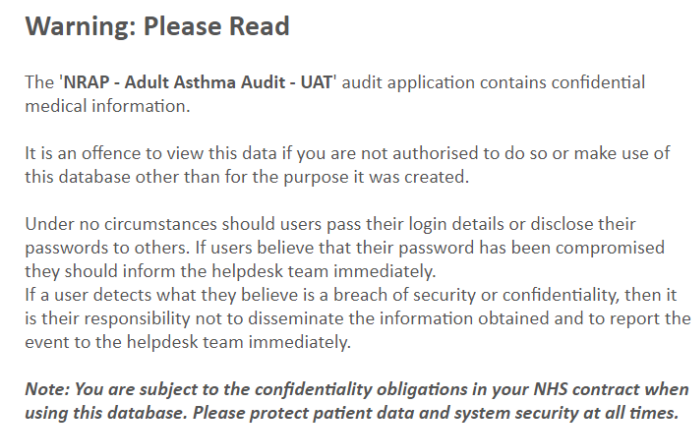


Audit reports and quality improvement (QI) support are publicly available. To submit and review your service's data, you must log in to the webtool.

Every individual that enters data to the audit should have a unique login.

Logging into the database

Once you have reached the webpage, please click **'Visit'** to log into the web tool. Enter your own username and secure password. **Do not** use someone else's details. A pop-up box will appear as follows:



Warning: Please Read

The '**NRAP - Adult Asthma Audit - UAT**' audit application contains confidential medical information.

It is an offence to view this data if you are not authorised to do so or make use of this database other than for the purpose it was created.

Under no circumstances should users pass their login details or disclose their passwords to others. If users believe that their password has been compromised they should inform the helpdesk team immediately.
If a user detects what they believe is a breach of security or confidentiality, then it is their responsibility not to disseminate the information obtained and to report the event to the helpdesk team immediately.

Note: You are subject to the confidentiality obligations in your NHS contract when using this database. Please protect patient data and system security at all times.

Once you have read the text, click **'I agree'**. This is an information governance procedure necessary for participating in the audit.

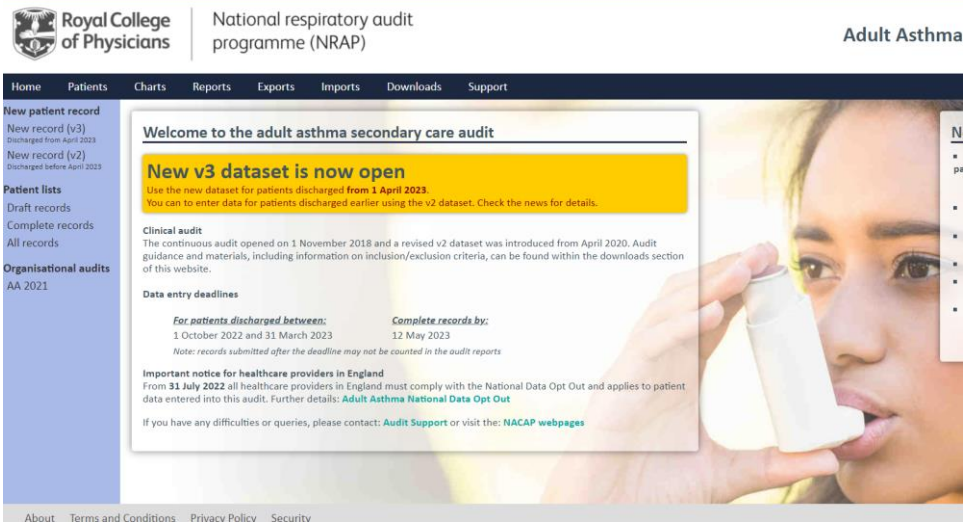
Creating new users

Any registered user that already has login details can create new logins for additional users. Click on **'Support'** from the home page, and once the page loads click **'New user'** on the left-hand side. Click **'Create user'** and follow all instructions to complete registration.

Forgotten password

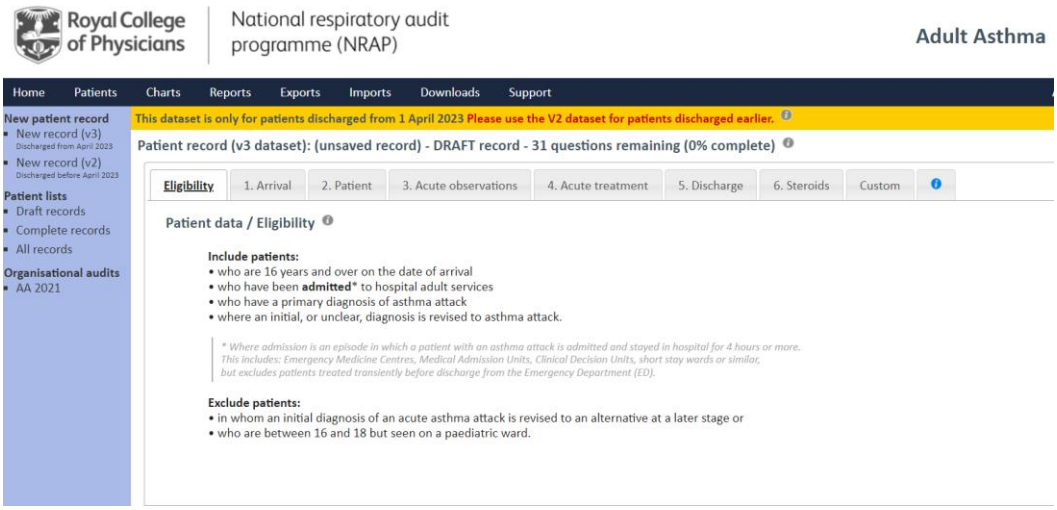
You can also reset your password via the support tab.
Click on '**Support'** within the home page, and then click on '**Password reset'.** Follow all instructions to change your password.

Navigating the adult asthma audit homepage



- The following features are available from the homepage of the adult asthma audit web tool:
- **'New record (v3)'** - Here is where to enter a patient who is discharged after 1 April 2023.
- **'Home'** - This will take you back to the adult asthma audit homepage.
- **'Downloads'** - Supporting documents are available to download here (e.g. guidance documents, data collection sheets, etc.).
- **'Support'** - Further support is available here (e.g. new user creation, password reset).
- **'Patients'** - This page shows you the list of patients from your hospital that have been entered onto the web-tool.
- **'Charts and Reports'** - This page will show you run-charts and reports based on the adult asthma clinical audit data.
- **'Imports'** - From here you can upload suitably formatted CSV files of patient records in bulk.
- **'Exports'** - From here, you can export all the patient records entered onto the web-tool into an Excel spreadsheet.
- **'Custom fields'** -You can create custom fields for local use.
- **'News/Events'** - Here you will find key workstream updates to support you and your team take part in the audit.

Entering data



- Navigate through questions using the tabs at the top of the page or the '**Next**' and '**Prev**' buttons at the bottom of the page.
- Help notes are available by clicking on the 'i' icon next to the question.
- Use '**Save**' to save the current record. This will also validate the record and if it does not comply with validation rules it will be highlighted in red and saved as incomplete. Incomplete records can be returned to and completed at a later date. Incomplete records will not be included in any audit reporting.
- Use '**Close**' to close the current record. You can return and edit a record at any point whilst the audit is open, provided it has been saved **before** closing.

Custom fields

Please note that this feature is only available to hospitals using the webtool to submit data on a patient-by-patient basis. It is not available for hospitals that undertake bulk uploads of data in CSV format.

We are aware that individual hospitals may wish to collect additional data for local analysis and as such we have provided the facility to create custom fields to append the dataset.

A maximum of 20 additional fields are available and each additional field created will appear under the **'Other'** tab in the patient record.

How to create a new custom field

1. From the main home page, click on the **'Support'** tab at the top of the screen
2. Click on **'Create new field'** on the left-hand menu**,** which opens a new page

3. Enter the field label, which is the description of what data you wish to record in this field
4. Choose field name from the dropdown box, e.g. *Userfield 1*
5. Enter field type - the options are text, number, date, or drop-down list. Choose the option most preferable to your service. Customs are for local use only and are not used by NRAP.

   If you select drop down list, enter the options you wish to be available. The field will default to the first answer in this list, so you are advised to have a blank option at the top of the list to avoid confusion and ensure that users have to choose the correct option. Use the space bar for the first option, hit the return key to move to the next line and type the second option in. Enter all the options like this.

6. Specify whether you want this field included in your records
7. For the field order, choose the appropriate number from the drop-down menu that corresponds with the field name, i.e. *Userfield 1* should have field number 1

'Field help, comments or notes' is a free text box to help users fill in the custom field (this can be left blank).

8. Click **'save'** and **'close'**.

The additional custom field will now appear in each new record created. In addition, when you export data, you will have the option to include the custom field in your export. More information about exports is available later in this guide.

If at any time you turn off a custom field (by selecting 'no' to 'Include this field in your records?'), the information will remain on records already submitted whilst that custom field was active.

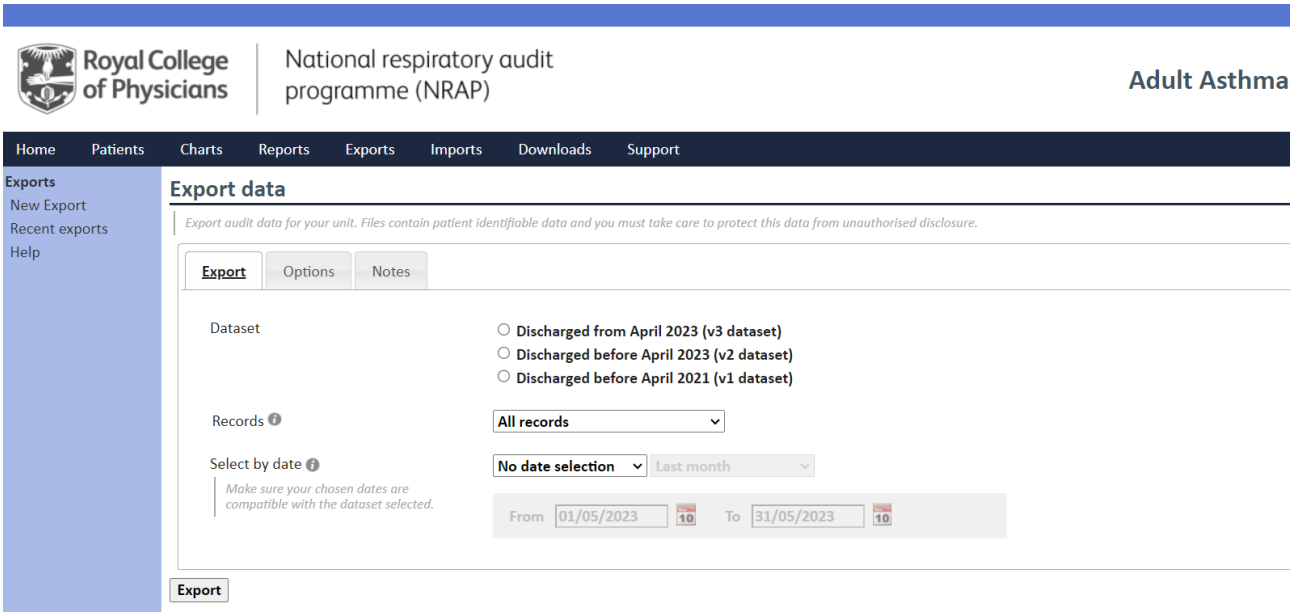
Please note that once a custom field has been created it cannot be changed. If you wish to delete a custom field, you will need to contact the Crown helpdesk (helpdesk@crownaudit.org). If a custom field is removed completely, all data recorded in that field while it was active will be lost.

Importing data

You can bulk upload data in a suitably formatted .csv file. Guidance on how to format these files is available on the web tool's **'Downloads'** page once you are logged in.

Exporting data

1. Click on '**Exports**' in the top bar of the homepage to be taken to the exports page. Then select **'new export'** from the bar on the left-hand side



2. Select **'Dataset'** to export (v2 or v3)
3. In the **'Options tab'**, tick **'Include calculated data'** to include automatically calculated data fields such as *'length of stay'* and **'Include custom fields'** to include any custom items that you have created
4. Choose whether you would like to include **'All records'**, **'Completed records only'** or **'Incomplete records only'**
5. Select records by **arrival date**, **admission date** or **discharge date**: this enables you to view data from a given time period.
6. When you are ready to export, click the '**Export**' button and your export will appear. Double click to open the file in Microsoft Excel (if you have this installed on your machine).

NB Please note that some aspects of the exports may be subject to change e.g. dataset numbers/columns, corrections of spelling errors or similar. As such, if you wish to upload export files onto external systems, those systems may need to be adapted accordingly.

Viewing patient records

It is possible to view the patient records already entered by selecting **'Patients'** from the menu bar. You will be able to view which patients have been entered onto the web tool.

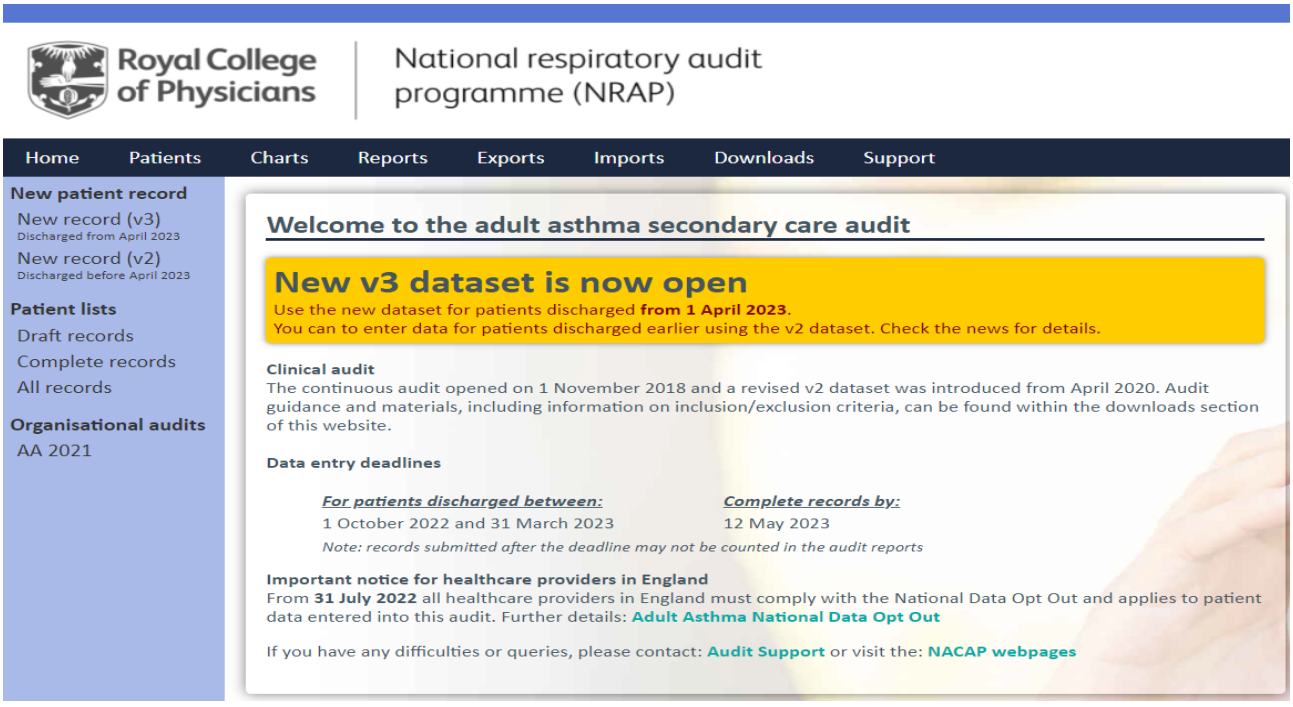
Every patient entered on the web tool is assigned an *'Artemis ID'*, which serves to anonymise the data. It is presented as a long sequence of letters and numbers such as 5C920511992C579832C378DF34B8AFBB. Please use this if you wish to discuss particular patient records with the helpdesks.

Please do not, under any circumstances, send patient identifiable information including names, NHS or hospital numbers, dates of birth or postcodes to any member of the NRAP audit team.

For more information about NRAP's information governance framework, please see the information governance section of this guide.

It is not currently possible to search through the patient record list by NHS number. However, your web browser search function (hit 'Ctrl' and 'F', and then enter in the text you are searching for) will work on this page. It is likely that you will see the same NHS number multiple times as patient readmissions are entered as separate records. Duplicates are automatically captured by the web tool using a combination of patient's NHS number, date of birth, admission date, and postcode.

Deleting patient records

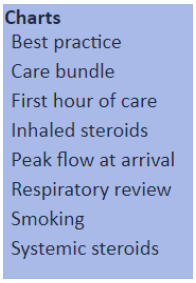


In order to delete a record log, click either **'complete records'**, **'draft records'** or **'all records'** from the left-hand bar. Now select the NHS number you wish to delete.

You will be taken to a screen which has a delete button near the top right. This will remove the entry from your records.

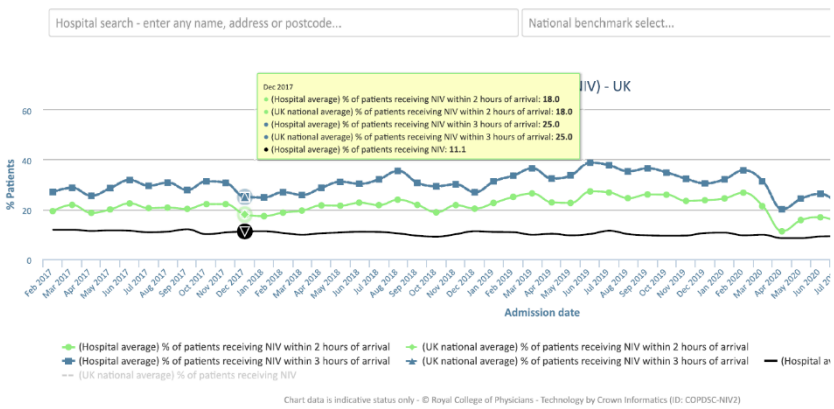
Online run charts

Click on the 'Charts & Reports' tab on the homepage to access your service's charts. On the menu on the left of the screen, click on each chart to view.



Use the 'About this chart' option to see what each chart shows, what data are used, and definitions of all the lines.

If you hold your mouse over any point on a line on the chart, a yellow box will appear, giving the numbers shown at that point in time.



How to customise charts

1. Toggle each line on or off by clicking on the line's label underneath the chart
2. Zoom in on a particular time period by clicking and dragging your mouse on the chart, across the time you would like to view. To revert to the original view, click 'Reset zoom' in the top right corner.

How to download charts

1. Click on the menu button in the top right corner and select the format you want to export it in.

How often are the charts updated?

The run charts are updated every hour so when you add or amend a record, it will be included as the charts are refreshed. They update based on the date of patient contact with the service, **NOT** when the data was entered. The charts show data up to the last complete month but one to give time for data checking by inputters and to avoid displaying small numbers. The national percentile lines are updated every six months.

Organisational audit

A snapshot organisational audit of COPD and asthma care will run in Spring 2024 and will collect information on how services are organised, and what resources they have.

This audit should reflect your respiratory services as a whole, so asthma and COPD teams are encouraged to work together to complete one questionnaire per service.

The organisational audit will run from February-March 2024 and will be available on the webtool when you log in.

Reporting

Annual: The adult asthma annual reports are available on the home page of the NRAP website and you do not need to log in to access them. The latest adult asthma annual report was published in January 2023. The reports are aimed primarily at clinicians, managers, chief executives and policymakers and present analysis of participating sites' performance against NICE guidelines and quality standards whilst providing recommendations for clinicians.

The next editorial report will be published in June 2024 and will include key data and recommendations for care in COPD, adult, children and young people's asthma and pulmonary rehabilitation.

Regional: NRAP has also produced 6-monthly regional reports. All data are reported at both Integrated Care Service (ICS)/Local Health Board and individual hospital level for the following key adult asthma audit indicators:

- Patients receiving respiratory review within 24 hours of arrival
- Patients with a Peak flow (PEF) measurement taken within 1 hour of arrival
- Patients in receipt of five British Thoracic Society (BTS) discharge bundle elements
- Patients administered systemic steroids within 4 hours of arrival
- Current smokers with tobacco dependency addressed
- Patients in receipt of inhaled steroids at discharge

Previous regional reporting outputs are available here. The next regional report will follow the May 2023 data deadline – regional reports will then be replaced by real-time benchmarking tables, accessible via the webtool.

Information Governance

This audit has Section 251 Approval from the Health Research Authority Confidentiality Advisory Group (reference number 23/CAG/0045). This allows identifiable data to be collected and processed without patient consent. If a patient has applied for National Data Opt-out **do not enter their data** into the audit.

Personal confidential data items for this audit are processed by Crown Informatics under section 251 approval prior to anonymisation and transfer to Imperial College London for analysis. Reported data and data files released under government transparency guidance are managed in line with UK statistics authority guidance on the handling of small numbers to prevent the identification of individuals. Data included in adult asthma reporting outputs can be found at data.gov.uk.

For more information, please see our information governance FAQs in the **'Downloads'** tab on the website homepage when you log in.

Information for patients

Information for patients is available from the **'Downloads'** tab on the homepage when you log in. This should be displayed in all areas where asthma patients may be treated.

Adult asthma inclusion and exclusion criteria

When entering data to the audit webtool, you should only include patients that were **originally** admitted due to an AECOPD. Please discount patients that develop an exacerbation whilst already admitted for an alternative issue.

Include patients:

- 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.

*Where admission is an episode in which a patient with an asthma attack is admitted to a ward and stayed in hospital for 4 hours or more (this includes 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 (ED)).

Please refer to the quick guide below for specific ICD-10* codes and positions eligible for inclusion in the adult asthma clinical audit.

Patients with the following ICD-10 codes in the first episode of care are eligible for inclusion in the audit:

J45.0	Predominantly allergic asthma
J45.9	Asthma, unspecified
J46.X	Status asthmaticus (*Includes:* Acute severe asthma)

Retrospectively identifying patients who have been miscoded

To ensure that all eligible patients are included in the audit, NRAP recommends that if resources allow, clinical leads should periodically review patients lists. If any patients have been miscoded, and their correct code is shown in fig. 1 in the primary position, they should retrospectively be included in the 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 are seen on a paediatric ward.

Dataset review

The adult asthma dataset is reviewed annually to ensure that only data pertinent to patient care at each service are collected. Each field in the dataset is important to help hospitals evaluate the service they provide, discover any shortfalls and monitor improvements in care. Most fields have help buttons beside them to provide further information. This guide and the help buttons are designed to enable the submission of high-quality data.

Arrival

	Field	Notes
1.1a/b	Date and time of arrival at your hospital Patient transferred from another hospital?	Please record the date and time the patient arrived at your hospital. It is important to record the arrival time because this is the first point of contact with the organisation. Date and time of arrival to hospital must still be completed if the **'Patient transferred from another hospital'** is selected. The point of arrival is often the Emergency Department (ED) or Medical Admissions Unit (MAU), though patients occasionally come from home/elsewhere into other wards. These cases must also be included. For patients arriving by ambulance the time of arrival at hospital should be used, not the time of handover to the ED team. The arrival time will be used as the start-point when determining the time to acute treatment (steroids, β2 agonists etc). Time is best determined from the ambulance transfer sheet, the A&E/ED record or MAU/ward arrival record. For service's whose ED is in a different hospital, please still record the date and time the patient arrived at the current hospital. We recommend that you add custom fields to the dataset to record where aspects of care have been affected due to the patient's transition between sites. This will not be included NRAP's national reporting outputs but will be useful for your service's internal performance review.

1.2	Which **department** did the patient receive their first review and treatment in?	Please record the area of the hospital in which the patient underwent their first review and treatment

Patient information

	Field	Notes
2.1	NHS number	The field will accept valid NHS numbers which are ten digits long. Optionally, you can enter spaces or dashes or 3-3-4 format. Please use 'OVERSEAS' for patients that reside permanently outside the UK. Permission has been granted to use the NHS number as a patient identifier. This will be used to determine: • case-mix, • length of stay, • readmission rate, • mortality. The NHS number is essential to create a Patient Record. It should only consist of digits. • It may be formatted as 000 000 0000 (spaces) or 000-000-0000 (dashes) • It should contain exactly 10 digits. • NHS Numbers start with a 4, 6 or 7 • A warning will be given if the number appears invalid. Use '[NONNHS]' for patients that reside in the UK, but do not have an NHS number.
2.2	Date of birth	dd/mm/yyyy **Do not include** asthma patients under the age of 16 or patients between the ages of 16-18 (on date of arrival) treated on a paediatric unit/ward **Only include** patients of 16 years of age or above who have been treated on an adult ward.
2.3	Gender	Please enter the patient's gender as it appears in the notes/referral information The 'Other' should be used for patients who do not recognise themselves as either male, female, or transgender.

		If the gender for the patient cannot be determined 'Not recorded/Preferred not to say' should be selected.
2.4	Home postcode	Please enter the full postcode. For patients with no fixed abode use '[NFA]' and for patients visiting from abroad please use 'OVERSEAS'. Square brackets must be used where specified Permission has been given to facilitate case-mix adjustment and understand local referral trends.
2.5	Ethnicity	Please enter the patient's ethnicity as it appears in the notes. It is not expected that services ask patients about their ethnicity. Please answer this question based on the information recorded in the patient notes.
2.6	Does this patient have a current mental illness or cognitive impairment recorded?	It is not expected that services ask patients about their mental health status. Please answer this question based on the information recorded in the patient notes. Select all that apply 'Other' should be used where the patient is considered to have a mental health illness or cognitive impairment, but this does not appear in the options given.
2.7	Does the patient currently smoke, or have they a history of smoking any of the following substances?	Tobacco (including cigarettes (manufactured or rolled), pipe or cigars), shisha, cannabis or other illicit substances? Please select never, ex or current based on the smoking status recorded in the patient notes Select all that apply *This question aligns to:* • *NICE 2011 QS 5, NICE 2013 (Smoking: Supporting People to Stop) QS43. https://www.nice.org.uk/guidance/qs43* • *BTS/SIGN 2016 (Management of asthma) guidelines 6.2.3 and 7.2.6* • *NRAD 2014 (Why asthma still kills), recommendation 2 of patient factors and perception of risk.*
2.8	What is the patient's current vaping status?	***Select one option only*** **Radio buttons four options*:*** • Current vaper • Ex-vaper

		• Never vaped • Not recorded

Acute observations

	Field	Notes
3.1	What was the first recorded heart rate for the patient following arrival at hospital?	Record as a whole number only, within the range of 0-200 BPM. *This question aligns to* • *BTS/SIGN 2019 (Management of asthma) guideline 9.2.3* • *NICE 2013 QS25 (Asthma) [QS7]*
3.2	What was the first recorded respiratory rate for the patient following arrival at hospital?	Record as a whole number, within the range of 0-60 BPM. *This question aligns to* • *BTS/SIGN 2019 (Management of asthma) guideline 9.2.3* • *NICE 2013 QS25 (Asthma) [QS7]*
3.3	What was the first recorded oxygen saturation (SpO2) measurement for the patient following arrival at hospital?	Record as a whole number, within a range of 60 – 100%. *This question aligns to:* • *BTS/SIGN 2019 (Management of asthma) guideline 9.2.3* • *NICE 2013 QS25 (Asthma) [QS7]*
3.3a	Was this measurement taken whilst the patient was on supplementary oxygen?	
3.4	Was a peak flow measurement taken at any point during the patient's admission?	Please record the first patient peak flow measurement after arrival. Please answer **'No'** if no peak flow value is recorded in the notes. Please answer **'No - Patient unable to do PEF'** if the patient is either too unwell or unable to perform the measurement for other reasons.
3.4a	If yes (to Q3.4), what was the first recorded peak flow measurement?	Record as a whole number within a range of 60-800. The pre-bronchodilator value should be recorded in L/min.

		Where the PEF value is below 60 L/min, please enter '60'. Where the PEF value is above 800 L/min, please enter '800'. *These questions align to:* • *BTS/SIGN 2019 (Management of asthma) guideline 9.2.3 and guideline 9.2.6* • *NICE 2013 QS25 (Asthma) [QS7]*
3.4b	If yes (to Q3.4), what was the date of the first recorded peak flow measurement?	dd/mm/yyyy
3.4c	If yes (to Q3.4), what was the time of the first recorded peak flow measurement?	24hr clock 00 : 00
3.5	What was the patient's previous best PEF?	Record as a whole number. If 'Not recorded', enter predicted. Range for both should be 60-800. Previous best according to Personalised Asthma Action Plan (PAAP), patient notes or the patient themselves is to be given to accompany PEF on arrival. If previous best is not available, predicted should be entered. Where the previous best PEF is below 60 L/min, please enter '60'. Where the previous best PEF is above 800 L/min, please enter '800'.
3.5a	If previous best PEF = 'Not recorded' please give predicted PEF:	Record as a whole number within a range of 60-800. Where the predicted PEF is below 60 L/min, please enter '60'. Where the predicted PEF is above 800 L/min, please enter '800'.
3.6	Did the patient experience any of the following below during admission?	• Partial arterial pressure of oxygen (PaO_2) < 8 kPa • 'Normal' partial arterial pressure of carbon dioxide ($PaCO_2$) (4.6–6.0 kPa)

		• Raised $PaCO_2$ and/or the need for mechanical ventilation with raised inflation pressures • Inability to complete sentences in one breath. • Silent chest • Cyanosis • Poor respiratory effort • Hypotension • Exhaustion • Altered conscious level This question aligns to the following guidance: • *https://bnf.nice.org.uk/treatment-summaries/asthma-acute/* • *NICE/BTS/SIGN joint Guideline for the Diagnosis, Monitoring and Management of Chronic Asthma - https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/*

Acute Treatment

	Field	Notes
4.1	Was the patient reviewed by a respiratory specialist during their admission?	Respiratory specialist team members may be defined locally to include respiratory health professionals deemed competent at seeing and managing patients with acute asthma attacks. These staff members might include: respiratory consultant, respiratory trainee of ST3 or above, respiratory specialist nurse or asthma nurse. *This question aligns to:* • *NICE 2013 QS25 (Asthma) [QS9]* *NRAD 2014 (Why asthma still kills), recommendation 2 of medical and professional care*
4.1a	Date of first review by a member of the respiratory team	dd/mm/yyyy
4.1b	Time of first review by a member of the respiratory team	24hr clock 00:00
4.2	Was oxygen prescribed to a target range?	*This question aligns to:*

		• *BTS/SIGN 2019 (Management of asthma) guideline 9.3.1* *BTS 2017 (Guideline for oxygen use in healthcare and emergency settings*
4.2a	Date of oxygen prescription:	Dd/mm/yyyy
4.2b	Time of oxygen prescription:	24 hour clock 00:00
4.3	Was oxygen administered to the patient at any point during their admission?	*This question aligns to:* • *BTS/SIGN 2019 (Management of asthma) guideline 9.3.1* *BTS 2017 (Guideline for oxygen use in healthcare and emergency settings)*
4.4	Was the patient administered systemic steroids (including oral or IV) following arrival at hospital?	Please record the date and time of the first administration of systemic steroids i.e. any corticosteroid administered orally or intravenously upon arrival at hospital for this attack *This question aligns to:* • *BTS/SIGN 2019 (Management of asthma) guideline 2.7.1 and 9.3.3* • *NICE 2013 QS25 (Asthma) [QS8]* If patient is on regular maintenance steroids and the dose was increased, please select the "Yes" option. If no change was made to maintenance steroids then please select the "Not administered" option. If there is no steroid prescription please select the 'Not administered' option.
4.4a/b	Date and time steroids first administered:	
4.5	Was the patient administered systemic steroids in the 24 hours prior to their arrival at hospital for this asthma attack?	Please select 'Yes' if the patient received systemic steroids in the 24 hours prior to hospital arrival for this asthma attack. This may have been in the community (by a GP or nurse), in the ambulance, or via self-administration. This excludes steroids administered as part of regular maintenance dose of oral steroids, unless the dose was increased to manage this asthma attack. Please answer 'No' if no record of systemic steroids in the 24 hours prior to arrival is available in the notes.

4.6	Was the patient administered β2 agonists prior to their arrival at hospital for this asthma attack?	Please select 'Yes' if the patient was administered additional β2 agonists for this asthma attack in the 1 hour prior to their arrival at hospital e.g. in the ambulance, primary care or self-administered. Please answer 'No' if no record of β2 agonists in the hour prior to arrival is available in the notes. *This question applies to B2 agonists administered via nebuliser or 10 puffs or more via spacer. This information may be available in ambulance sheets or triage notes from patient's admission*
4.7	Was the patient administered β2 agonists (including nebulised and MDI with spacers) following arrival at hospital?	Please record the date and time of the first administration of β2 agonists upon arrival at hospital for this attack. If there is no beta-agonist prescription, please select the 'Not administered' option. *This question aligns to BTS/SIGN 2019 (management of asthma) 2.6.1, 9.3.2.*
4.7a/b	Date and time of β2 agonists	

Review and discharge

	Field	Notes
5.1	Was the patient alive at discharge from your hospital?	
5.2	Date and time of discharge /death	The date of discharge is usually found at the end of the admission record, or on the discharge summary. If the patient was discharged to another hospital, early discharge scheme, hospital at home or community asthma scheme, please give the date of **discharge from your hospital and not the scheme**. If the patient self-discharged, use date of self-discharge.
5.2a	Date of discharge/death	dd/mm/yyyy
5.2b	time of discharge/death	24hr clock 00:00
5.3	Was a discharge bundle completed for this admission?	To answer 'Yes' to this question there must be objective evidence of a care bundle record in the notes. This may include a bundle sheet or sticker in the notes or a check box in an electronic patient record. If 'No' or 'Self-discharge' are selected please still complete what elements of good practice were completed for this patient in Q 5.4.

		A discharge bundle is a structured way of improving discharge processes and care leading to improved patient outcomes. It is based on evidence based clinical interventions or actions. BTS care bundle for asthma. *This question aligns to* • *BTS/SIGN 2019 (Management of asthma) guideline 5.2.2, 5.3.2, 9.6.2, and 9.6.3*
5.4	Which of the following specific elements of good practice care were undertaken as part of the patient's discharge?	If any of the good practice care elements have not been completed and/or are not applicable please do not select them. If no elements have been completed please select 'None'. If 'No' or 'Self-discharge' are selected (Q 5.3) please select which elements of good practice care were completed for this patient. **Follow up requests** Communication directly with a named individual responsible for asthma care within the practice counts as a request for follow-up. If the patient has been asked and/or been provided with the necessary information they need to make/request the follow up appointment(s) themselves within the recommended time frame, please select that the component was completed. If the patient already has an appointment to be seen in a secondary care clinic within 4 weeks, please select the **'specialist review requested within 4 weeks'** option. **PAAP = Personalised Asthma Action Plan** *This question aligns to:* • *BTS/SIGN 2019 (Management of asthma) guideline 5.2.2, 5.3.2, 9.6.2, and 9.6.3* • *NICE 2018 QS25 (Asthma) [QS4, QS5]*
6.1	Was the patient in receipt of inhaled steroids at discharge?	Answer 'Yes' to this question if the patient was prescribed inhaled steroids either alone or in combination with long acting beta-agonist.

		Only use 'Not prescribed for medical reasons' if it is documented in the notes why inhaled steroids are not required. *This question aligns to:* *BTS/SIGN 2019 (Management of asthma) Annex 5*
6.2	Was the patient prescribed at least 5 days of oral steroids for treatment of their asthma attack?	e.g. prednisolone or equivalent Select 'Yes' if the patient: • has completed at least 5 days of oral steroids during their admission, • has been discharged with oral steroids to complete the minimum 5 days treatment period • Is on long term steroids and has also had an appropriate increase in steroid dose to manage this attack of at least the minimum 5 days period recommended in the guidelines. Please select 'No' if prescription of oral steroids at discharge is not recorded in the patient's notes. *This question aligns to:* *BTS/SIGN 2019 (Management of asthma) Annex 5*
6.3	Has the patient been prescribed more than 2 courses of oral (rescue/emergency) steroids in the last 12 months?	E.g. prednisolone or equivalent. This should be the 12 months prior to the date of admission. Rescue refers to courses of steroids at higher doses than their usual regime. Please also select **'Yes'** if the patient is on long-term maintenance steroids. *This question aligns to:* *NRAD 2014 (Why asthma still kills) recommendation 2 of organisation of NHS services*

Contact us

You can contact us at 020 3075 1526, or asthma@rcp.ac.uk. Our help desk is open from 9am – 5pm, from Monday to Friday.

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