Improve care for your COPD patients !

Take part in the 1st European COPD Audit

ERS copdaudit

European Respiratory Society/British Thoracic Society

European COPD Audit 2010

Data collection instructions for participating respiratory departments

The audit should be overseen by a consultant respiratory physician. It is anticipated that a respiratory trainee will assist with data collection and entry.

National Data collection period: The national data collection period for the European COPD Audit 2010 is 25 October to 19 December 2010.

There are two parts to the audit:

Part 1: data on the organisation of care within the hospital. One record is required per hospital and this record must be completed within the data collection period.

Part 2: All cases admitted to hospital during the data collection period should be recorded prospectively if they meet the case definition criteria below.

Case definition: The admission date for the following patients must fall within this period:

- Patients admitted to hospital for a stay of 12 hours or longer for an acute exacerbation of COPD (as diagnosed by a senior clinician and confirmed at discharge by the clinician/audit lead on the basis of the patient notes);

Or

- Patients admitted to hospital for 12 hours or longer with a respiratory cause of admission as referred by the discharge report and a history compatible with COPD. This includes one of the following:
  Respiratory infection without consolidation
  Respiratory insufficiency
  Right heart insufficiency
  Bronchitis
  Bronchosconstriction
  and
  Historical diagnosis of COPD
  A documented FEV1/FVC ratio of <0.7 in the absence of any other obstructive disease such as asthma or bronchiectasis.

Previous spirometric confirmation of airflow obstruction is not required to confirm entry eligibility if the patient is considered to have an exacerbation of COPD (ie first category above) as the availability of a spirometry record is one of the audited quality standards.

Specific situations requiring further clarity: patients admitted with exacerbation of COPD who subsequently are found to have evidence of radiological consolidation or malignant disease should still be included but the abnormality noted within the database radiology section.

A prospective record should be kept of all consecutive cases admitted to the hospital which meet the above criteria. Following discharge (or at the end of the data collection period) the patient notes for these patients should be obtained and the individual patient data sheet completed retrospectively for each patient.

Please note that it is important to note down all cases that meet the above inclusion criteria and record these on the online system. If a case is subsequently found not to be COPD then the case is marked as withdrawn (see below) and a response is not needed for the full set of audit questions.

90 day Follow-up: for each case recorded in the audit, the outcome at 90 days following admission should be obtained.
Please note that to obtain outcome information it is suggested that the patient's GP should be contacted by telephone (using the NHS number used to confirm identity).
Readmission and inpatient mortality can be found through the hospital records.
Under no circumstances should direct contact be made with the patient.

Data on clinical cases should be added to the online data collection form as follows:

Add a new case
Please note that an online case identification number will be allocated automatically to each case you enter. Keep a record of the online case number on the patient data collection sheet against the patient record number from the patient notes for local identification purposes only (this will be needed to locate the correct record when the 90 day follow up information is added to the record or if the record needs editing). **Do not include the local patient record number on the online system.**

Enter the details required from the patient notes.

When 90 days from the admission date have elapsed, obtain outcomes information (see above) and enter this on the form.

Validation: a case can be validated (added to the database) when all the fields have been completed including 90 day follow up information.

Withdraw a case: a case should be added to the online system if it is identified as meeting the inclusion criteria as laid out above. If the case is subsequently found to not have had an

exacerbation of COPD (for example the discharge notes record that it is NOT COPD) then the case should be withdrawn (not deleted).

Deleting a case: A case should be deleted only if it has been incorrectly added to the system (ie it did not meet the inclusion criteria set out above).

Maximum number of records required
Enter up to a maximum of 60 validated cases (ie those where the diagnosis of COPD is confirmed at discharge). Cases that are not confirmed with a diagnosis of COPD at discharge should be entered on the system but should be marked as withdrawn rather than validated.

Exclusion criteria
An admission diagnosis that is not an exacerbation of COPD. The most common differential diagnosis in such cases includes pneumonia, cardiac failure and pulmonary embolus. Patients who have COPD but where the admission diagnosis is not an exacerbation of COPD should not be entered.

Other useful information

Transfer between hospitals:
In the event that a patient is admitted to one hospital with an exacerbation of COPD (or suspected COPD), and then transferred to another hospital, the case should be recorded on the online form, and then marked as withdrawn. The case should not be included in the audit at the second hospital as this is not an emergency admission for COPD.

Any queries should be sent to: audittools@brit-thoracic.org.uk

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