Royal College of Physicians | National respiratory audit programme (NRAP)

National Respiratory Audit Programme (NRAP)

Children and young people (CYP) asthma audit: Frequently Asked Questions (FAQs)

Version 1.0: August 2023

There is also a guidance document available for the technical aspects of the web tool.

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National Respiratory Audit Programme (NRAP)
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General Information

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What are the contact details for the asthma audit team?

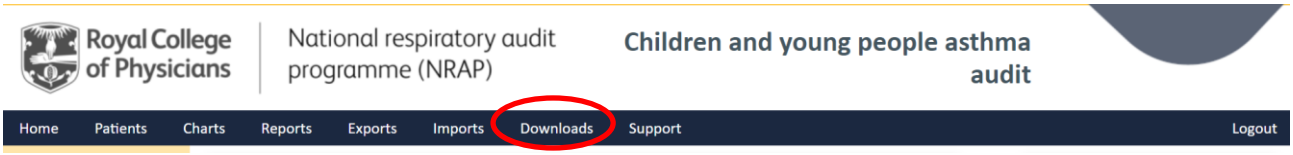
- You can contact us at via our helpdesk on 020 3075 1526, or email asthma@rcp.ac.uk. Our helpdesk is open from 9am – 5pm, Monday to Friday (excluding Bank Holidays).
- Our address is: The National Respiratory Audit Programme, The Royal College of Physicians, 11 St Andrews Place, Regent's Park, London, NW1 4LE.

Does the audit programme have a Twitter account?

- Yes, it does. Our handle is @NRAPaudit. The team post regular updates; please do follow us.

What resources are available for the audit and where can I download them?

- The following resources are available for the CYP asthma audit:
  - Clinical dataset and data collection sheet
  - Guidance documents; information on fair processing, information governance FAQs, and technical guidance
- These are available to download on the web tool 'Downloads' page (available to select from the top menu bar of the homepage of the audit once you are logged in), and on NRAP's webpages.



Is there information explaining the audit available for patients?

- Although patients do not need to be asked for their consent to be included in the audit, hospitals must carry out **fair processing activities** in order to inform patients and parents/carers; these include:

- Displaying the **patient information poster** in all areas where patients with asthma may be treated.
- If a patient or their parent/carer asks for further information, they must provide them with a copy of the most relevant **patient information leaflet.**
- Copies of both the poster and patient information leaflets (parent carer, 4-7 year old, 8+ year old) are available to download from the children and young people asthma audit resources webpage.

Can I obtain a participation certificate in exchange for entering data into the audit?

- If members of the local audit team would like participation certificates to recognise their contribution to the audit, they should contact the audit lead for the service.
- If the audit lead feels that the individual contribution merits a certificate, then they should contact the NRAP team via telephone or email to acquire one.

Does this audit collect patient identifiable data?

- Yes. This audit has Section 251 approval from the Health Research Authority Confidentiality Advisory Group (ref: 19/CAG/0001) for England and Wales.
- This allows identifiable data to be collected and processed without patient consent. However, if a patient informs you that they **do not want their data to be included in the audit**, please make this clear in the patient's notes and **do not enter their data** into the audit. Alternatively, patients can contact the NRAP helpdesk via asthma@rcp.ac.uk or 020 3075 1526 to ask that their information not be included. NRAP will then contact the relevant hospital audit department to pass on the opt-out request.
- 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.

Using the web tool

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Login and registration

Where can I find the CYP asthma audit web tool?

- It can be found at this website: www.nrap.org.uk

Do I have a login for the web tool?

- If you are registered for the CYP asthma audit you should have received an email from helpdesk@crownaudit.org. This may have gone through to your junk mail.
- The email will contain your username, and details on how to reset your password.
- If you have not received this email, but think you should have, please contact the NRAP team.

How do I register more users on the web tool?

- If you have a login for the web tool yourself, you can create new logins for your colleagues.
- 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.
- If you are the lead for the audit at your hospital, then you can approve new user requests.
- 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.
- Once the request has been approved, an email will be sent to the new user asking them to set a password to complete the process.
- Please be careful when entering names, phone numbers, and email addresses when creating new accounts. Errors will mean the account will have to be deleted and the process started again.
- Please note that only colleagues with appropriate organisational rights to access patient data should be added to the service/hospital web tool.

Viewing patient records

Can I view the patient records entered for my service?

- Yes. By selecting 'Patients' from the menu bar, you will be able to view which patients have been entered onto the web tool.
- You can search for a patient by using their NHS number.

- Duplicates will be automatically checked by the web tool using a combination of the patient's NHS number (date of birth and gender if an overseas patient) and arrival date.
- You will be alerted if a duplicate is identified- please refer to the 'duplicate management' section of the technical guidance (available to download from our resources webpage for more information).

What is an 'Artemis ID'?

- Please use this ID if you wish to discuss individual patient records with the NRAP team/Crown.
- 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:

e.g. (5C920511992C579832C378DF34B8AFBB) – please note that the brackets are an essential element of the code and are there to prevent errors when sharing the code.

Please DO NOT, under ANY circumstances, send/provide NHS numbers or any other form of patient identifier (name, date of birth etc.) to any member of the NRAP team at the RCP/Crown.

Deletion of patient records

I want to delete a patient record, what do I do?

- To delete a patient record:
  - open the record you wish to delete;
  - click the delete button in the upper right-hand of the form;
  - after confirming the deletion reason, the record will be deleted and moved to the 'deleted records' list;
  - you can restore the deleted record or it will be removed after 30 days; to restore a deleted record, choose the record from the deletions list and then click the restore button in the upper right-hand of the form.

Importing and exporting data

Can I upload/import patient data in bulk?

- Yes, the importing function is now available and can be found under the imports section of the web tool.

Can I export the clinical data for my own service?

- 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.

Custom fields

How can I add in/remove custom fields?

- Custom fields are additional data field(s) you can add to the dataset, should you wish to audit additional elements of care at a local level.
- If you do 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, 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.

Data entry

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When did the CYP asthma secondary care audit start?

- The audit launched on 1 June 2019 and will run continuously until at least May 2026.

Can I have an extension on data deadlines?

- 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 audit reports.
- 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.
- Hospitals teams should also ensure that they have enough time to screen and apply their patient's national data opt out preference.

Is this (deadline on the web tool) a hard deadline? Can I still enter in data past this deadline?

- All deadlines on the web tool are fixed but you can still enter data after the deadline has passed. Any record entered into the web tool after data has been extracted for regional reporting will not be included in the regional report but will still be included in your run chart and in the annual national report. We encourage you to use your run charts as much as possible to monitor your performance against the key measures presented.

How many cases should we be entering?

- As many records as possible should be included for CYP aged 1 – 18 admitted to a paediatric ward with a primary or secondary diagnosis of an asthma attack or, in addition for 1-5 year olds, primary diagnosis of wheeze (please refer to the eligibility criteria in the next section for details).
- Please note that any patient who may have asthma that is not their primary or secondary diagnosis for that admission should not be included in the audit e.g., if a child is admitted for a broken limb and also has asthma, they should not be included in the audit.
  i.e. only patients that have come into hospital with an asthma attack or non-viral wheeze should be included in the audit (please refer to the eligibility criteria in the next section for details).
- If you are concerned about this, please contact the NRAP audit team to discuss what support is available to help you participate in the audit.

Are draft records included in any of the asthma audit reports?

- No, draft records are not included in **any** asthma audit reports; please ensure all records are saved fully prior to data entry deadlines.

Clinical dataset

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Eligibility Criteria

Who should I include in the audit?

- **Include patients:**
  - who are between 1 and 5 years old on the date of arrival and have been admitted* to a hospital paediatric service with a primary diagnosis of an asthma attack OR a primary diagnosis of wheeze AND a secondary diagnosis of asthma (include patients where this was initially unclear, but later identified as an asthma attack/wheeze AND asthma attack)
  - who are between 6 and 18 years old on the date of arrival and have been admitted* to a hospital paediatric service with a primary diagnosis of an asthma attack.

***Where admission is an episode in which a patient with an asthma attack is admitted and stayed in hospital for 4 hours or more** (this includes Medical Admission Units (MAU), Clinical Decision Units/Children's Observation Units, short stay wards or similar, but excludes patients treated transiently before discharge from the Emergency Department (ED)).

Only CYP who have been coded with the following ICD-10 codes should be entered into the audit.

CYP aged 1-5 (**primary diagnosis**)	CYP aged 6-18 (**primary diagnosis**)
• J45.0 - Predominantly allergic asthma • J45.1 - Nonallergic asthma • J45.8 - Mixed asthma • J45.9 - Asthma, unspecified • J46 - Status asthmaticus (Includes.: Acute severe asthma) • R06.2 - Wheezing (**primary diagnosis**) **AND** any of the asthma codes listed above as a secondary diagnosis	• J45.0 – Predominantly allergic asthma • J45.1 – Nonallergic asthma • J45.8 – Mixed asthma • J45.9 – Asthma, unspecified • J46 – Status asthmaticus (Includes.: Acute severe asthma)

• **NEW (01/04/23)** B34.9 – Viral infection (**primary diagnosis**) **AND** R06.2 – Wheezing (**secondary diagnosis**) **AND** any of the asthma codes listed above as a third diagnosis	

- **Exclude patients:**
  - under the age of 1 (due to the complex nature of diagnosing asthma in this age group);
  - in whom an initial diagnosis of an asthma attack was revised to an alternative diagnosis at a later stage of the admission;
  - who are between 16 and 18 years old but are managed on an adult ward.

What if a patient has an asthma attack whilst already admitted for a different reason?

- Only include patients in the audit that were originally admitted due to an asthma attack (Or non-viral wheeze for patients ages 1-5 years). Exclude patients that had an asthma attack whilst already admitted for an alternative issue.

Should a patient be included in the audit if they have a previous asthma diagnosis, but on this occasion have presented with a viral induced wheeze?

- If the patient is aged 1 to 5 years old you can include them in the audit if they have a viral infection (B34.9) in the primary diagnosis position AND wheezing (R06.2) in the secondary diagnosis position AND any of the asthma codes listed within the inclusion criteria table (see above) in the third diagnosis position.
- Do not include patients aged 6 to 18 years old in the audit if they have presented with a viral induced wheeze. For this age group all primary diagnosis must be one of the asthma codes listed within the inclusion criteria table (see above).

See the table below:

Diagnosis	Include in the CYP asthma audit?
For 1 – 5 years	
Primary diagnosis – Asthma (See codes above) Secondary diagnosis - None	**Yes**
Primary diagnosis – Asthma Secondary diagnosis – Any other condition	**Yes**
Primary diagnosis – Any other condition (Excluding Wheezing (R06.2)) Secondary diagnosis – Asthma	**No**
Primary diagnosis – Wheezing (R06.2) Secondary diagnosis – Asthma	**Yes**
Primary diagnosis – Wheezing Secondary diagnosis – Viral induced wheeze	**No**
Primary diagnosis – Wheezing (R06.2) Secondary diagnosis – None or Other condition	**No**
Primary diagnosis – Viral infection (B34.9) Secondary diagnosis – Wheezing (R06.2) Third diagnosis – Any asthma codes (see above)	**YES**
Primary diagnosis – Viral induced wheeze Secondary diagnosis – Asthma	**No**
For 6 - 18 years	
Primary diagnosis – Asthma (See codes above) Secondary diagnosis – None	**Yes**
Primary diagnosis – Asthma Secondary diagnosis – Any other condition	**Yes**
Primary diagnosis – Any other condition Secondary diagnosis – Asthma	**No**
Secondary diagnosis – Asthma Primary diagnosis – Wheezing (R06.2) ***(These criteria only apply to 1-5 years)***	**No**

Patient data

Are all questions relevant for different age groups?

- No:
  - Q3.1 (*smoking status of patient*) is not applicable to children under the age of 11 on the date of arrival;
  - Q4.4, Q4.4a and Q4.4b (*peak flow*) are not applicable to children under the age of 6 on the date of arrival.
- The web tool will automatically calculate the patient's age on arrival and will block or enable access to the above questions as appropriate.

A patient is from overseas and therefore does not have an NHS number; how do I create a record for the patient on the web tool without this?

- If a patient resides permanently outside the UK and therefore does not have an NHS number, please enter 'OVERSEAS' in place of this when creating the record on the web tool.

A patient resides in the UK but does not have an NHS number; how do I create a record for the patient on the web tool without this?

- If a patient resides in the UK and does not have an NHS number, please enter '[NONNHS]' in place of this when creating the record on the web tool.

Smoking status

Smoking status is not documented in the patient notes; how do I answer Q3.1?

Q. 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'.
- This question will only be available for patients aged 11 years and over on the date of arrival.

Exposure to second hand smoke is not documented in the patient notes; how do I answer Q3.2?

Q. Is the patient regularly exposed to second-hand smoke?

- If exposure to second hand smoke is not recorded in the patient notes, please select 'Not recorded'.
- This question is applicable to all patients regardless of their age.

What do you define as 'regularly exposed' in relation to Q3.3?

Q. Is the patient regularly exposed to second hand smoke?

- Please select 'Yes' if the patient is exposed to second hand smoke in the home/a place where they spend significant periods of time (e.g. with extended family members) at least weekly.
- Please select 'No' if exposure stopped at least four weeks prior to admission.
- This question is applicable to all patients regardless of their age.

Acute observations

First recorded heart rate and/or respiratory rate are not recorded in the patient notes; how do I answer Q4.1/Q4.2 in order to complete the record?

Qs. 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?

- 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 the audit or any reporting outputs.

A patient's first recorded peak flow measurement following arrival to hospital is not within the 30-800 L/min range; how do I answer Q4.4?

Q. 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 30 L/min, please enter '30'.
- 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 30-800 L/min range:
    - Q4.4a *(What was the patient's previous best PEF*?)
    - Q4.4b *(If previous best PEF = 'Not recorded' please give predicted PEF)*
- This question will only be available for patients aged 6 years and over on the date of arrival.

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 Q4.4a?

Q. What was the patient's previous best PEF?

- Yes. Previous best peak flow measurement (PEF) can be obtained from sources including the asthma action plan, previous lung function tests or as reported by the patient.
- If the previous best PEF is 'Not recorded,' you can use the predicted peak flow calculator; the tool will prepopulate with age and gender, and you will need to manually enter the patient's height.
- This question will only be available for patients aged 6 years and over on the date of arrival.

Acute treatment

Q5.1 asks whether the patient was reviewed by a member of the multidisciplinary team (MDT) trained in asthma care; who does this include?

Q. Was the patient reviewed by a member of the MDT trained in asthma care during their admission?

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

Review and discharge

What date of discharge do I provide if the patient was put onto to an early discharge scheme, hospital at home or community scheme for Q6.2a?

Q. Date of discharge/transfer/death

- Please select the date of discharge from your hospital and not the scheme.

What do I do if the patient is transferred to another hospital?

- If the patient fits the eligibility criteria for the audit at your hospital but is then transferred to another hospital, please answer 'Patient transferred to another hospital' in Q6.3 (*Was a discharge bundle completed for this admission?*).
- Question 6.4 onwards will then be greyed out.
- Please contact the NRAP team if you have any further questions about transfers.

What do you define as a discharge bundle for Q6.3?

Q. Was a discharge bundle completed for this admission?

- Please select 'Yes' 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

[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?'*

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 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.

Steroids and referral for hospital review

How do I answer Q6.5?

Q. 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 a long-acting beta-agonist.
- You should select 'No, not medically indicated' only if it is documented in the notes why inhaled steroids are not required.
- If you can't find any evidence of the reason why inhaled steroids were not prescribed, select 'No, reason not given'.