Key data

1. Audit record number

2. Hospital number

3. Date of birth

4. Gender

male ❑
female ❑

5. First part of patient's postcode

6. Date of this admission to hospital

7. Did the patient die during this admission

yes ❑
no ❑

If yes, was the recorded cause of death

COPD or complications of COPD ❑
other cause(s) ❑
not recorded ❑

8. Date of discharge from hospital (or death if applicable)

9. Was the patient accepted by an early discharge (or hospital at home) scheme?

yes ❑
no ❑
not applicable ❑

10. Prior to this admission, has the patient previously been admitted to hospital for COPD or accepted onto an early discharge scheme?

yes ❑
no ❑

History/patient characteristics

11. What is the patient's smoking status?

current smoker ❑
ex smoker (stopped more than 3 months) ❑
life long non-smoker ❑
not recorded ❑

If current or ex-smoker,

how many cigarettes smoked per day? ☐
or
pack years? ☐

don't know ❑

12. Does the patient have any significant co-morbidities?

Please tick all that apply

none ❑
heart disease ❑
hypertension ❑
stroke ❑
locomotor problems ❑
neurological problems ❑
diabetes ❑
visual impairment ❑
depression/anxiety ❑
other ❑

13. What are the patient's social circumstances?

lives alone, no support ❑
lives alone with social service support ❑
lives with spouse or close relative ❑
lives in nursing/residential home ❑
lives in warden controlled (sheltered) housing ❑

Admission

14. At admission, was there a record of

level of breathlessness	increased	❑
	not increased	❑
	not recorded	❑
level of sputum	increased	❑
	not increased	❑
	not recorded	❑
changes in colour of sputum	changed	❑
	not changed	❑
	not recorded	❑
sputum colour	white or grey	❑
	yellow or green	❑
	no sputum	❑
	not recorded	❑

15. Was the patient's dyspnoea rating (e.g. on the MRC dyspnoea scale) recorded

yes	❑
no	❑

16. What is the patient's performance status?

normal activity	❑
strenuous activity limited	❑
limited activity but self care	❑
limited self care	❑
bed/chair bound, no self care	❑
not known	❑

17. Was a chest X-ray taken?

yes	❑
no	❑

If yes, is the X-ray report in the notes?

yes	❑
no	❑

18. Was respiratory rate measured

yes ❑
no ❑

If yes, what was the first reading after admission [ ] per minute

19. Were blood gases taken? yes ❑ no ❑

If yes, what was the first recorded (after admission) value for?

pH [ ] or: H^+ (mmol/l) [ ] not recorded ❑

PCO_2 (kPa) [ ] or: mmHg [ ] not recorded ❑

PO_2 (kPa) [ ] or: mmHg [ ] not recorded ❑

Was level of O_2 to be given stipulated in notes/on chart? yes ❑ no ❑

20. Was an ECG performed? yes ❑ no ❑

21. Was urea recorded? yes ❑ no ❑

If yes, what was the first recorded (after admission) value?

[ ] mmol/l

not recorded ❑

22. Was serum albumin recorded? yes ❑ no ❑

If yes, what was the first recorded (after admission) value?

[ ] mmol/l

not recorded ❑

23. Was there a record of medications being taken at time of admission?

yes ❑
no ❑

If yes, were there 5 or more medications recorded?

yes ❑
no ❑

24. What was the patient's temperature at admission?

[ ] not recorded ❑

25. Is there a spirometry reading in the notes for this admission?

Yes ❑
No ❑

If yes what is the FEV_1 level
(if more than one, give most recent) [ ]

not recorded ❑

26. Is there a record of peripheral oedema?

yes - present ❑
yes – not present ❑
not recorded ❑

If present, was it?

leg/ ankles ❑
sacral ❑
not recorded ❑

Initial management

27. Was a course of antibiotics prescribed?

yes ❑
no ❑

28. Were nebulised bronchodilators prescribed?

yes ❑
no ❑

29. Did the patient receive systemic corticosteroids?

yes ❑
no ❑

30. How many sets of arterial blood gases results are in the records for this stay?

[ ]

31. Did the patient have a pH less than 7.35 at any time during this stay?

yes ❑
no ❑

If yes, did they receive ventilatory support?

respiratory stimulant (e.g. doxapram) ❑
non-invasive ❑
invasive ❑
none ❑

If the patient had a pH of less than 7.35 and did not receive ventilatory support, is it noted why not?

patient refused ❑
no facilities ❑
not appropriate ❑
failed ❑
other (please state) ❑

[ ]

not recorded ❑

Pre-discharge phase

32. Was oximetry (O_2 saturation levels) undertaken, after acute phase but prior to discharge?

yes ❑
no ❑
not recorded ❑

If yes, what were the results? [ ] % not recorded ❑

33. If a current smoker, was help toward smoking cessation given

referred to smoking cessation programme ❑
advice given and recorded ❑
nothing recorded ❑
not applicable (because non-smoker) ❑

34. Was there an assessment of the patient's home circumstances and their ability to cope?

yes ❑
no ❑
not recorded ❑

35. Where was the patient discharged to?

own home – independent of help ❑
own home – with additional social support ❑
sheltered housing or living with relative ❑
nursing or residential care ❑
not applicable – died in hospital ❑

36. Is there a letter to the patient's primary care team?

yes ❑
no ❑
not recorded ❑

If yes, did the letter include a clear list of the patient's medication?

yes ❑
no ❑
not recorded ❑

37. Which type of consultant was the patient under at time of discharge?

respiratory physician ❑
care of elderly physician ❑
general physician ❑
other ❑
not recorded ❑