

9 Audit Criteria

The National Clinical Guidelines for COPD makes many specific recommendations concerning the management of COPD. These deal with diagnosis and assessment, and management of stable COPD and management of exacerbations. There are far too many recommendations to monitor them all but the GDG and CRG identified seven key areas where it was felt that recommendations were likely to have the biggest impact on the management of COPD (see section 5.1). The audit criteria in the following table relate to these key areas on the management of COPD in primary and secondary care. Two additional audit criteria relating to a sentinel event audit, that links with data collected as part of the national audit of COPD exacerbations⁴⁸¹, and a patient-centred audit have also been included.

One of the criteria (non-invasive ventilation) relates specifically to secondary care and two relate to management in primary care (diagnosis and smoking cessation). The remainder should be applied in both primary and secondary care settings. It is anticipated that the standards will be detailed in local delivery plans in England and service and financial frameworks in Wales, but it is important that these targets reflect the development of a high quality service for people with COPD. Year-on-year improvements in the results of the audit criteria is important, an comparison with other local health care communities may be helpful in setting realistic milestones towards the target standard. There should be locally agreed plans to facilitate the achievement of the targets.

The “exception” boxes list the circumstances where applying the criterion would be inappropriate for an individual patient. It is recognised that there will be other situations where a clinical decision may be taken not to follow the guideline (for example taking into account the informed patient’s wishes), and interpretation of performance should take these factors into account. COPD disease registers are a necessary pre-requisite for performing these audits. They are needed to establish the denominator and to facilitate accurate data collection, and are also one of the quality markers in the contract for General Practitioners.

The criteria that relate to key recommendations are all process criteria. The sentinel event audit of patients readmitted within 28 days of discharge following an exacerbation of COPD is also to some extent an outcome audit, but it is important to note that it would be unrealistic to expect a routine audit to differentiate between an ‘avoidable’ and an ‘unavoidable’ admission. Nevertheless this sentinel audit reflects the fact that frequent exacerbations are associated with worse health status and more rapid decline in lung function. Exacerbations are also a major factor in determining the cost of caring for people with COPD and result in significant hospital bed occupancy.

The patient-centred audit involves asking people with COPD to record their experience of services.

The advantages of this approach are:

- it ensures a comprehensive coverage of all services
- it reflects patient experience directly
- it can be used to stimulate a general interest in services locally.

Chronic Obstructive Pulmonary Disease: National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care

The disadvantages are:

- it is anecdotal, just giving specific instances and not a statistical result
- it generates huge amounts of data
- specific standards cannot be set or checked
- it may be difficult for patients to criticise the team that cares for them.

A potential problem with the criteria proposed is that general practices that have low identification rates of COPD (perhaps because of poor coding, or under investigation) may apparently perform very well against these criteria. Therefore, it is proposed that an additional data item that should be reported in general practice is age-specific prevalence of COPD. This would allow the standards achieved to be interpreted against the practice specific prevalence.

SENTINEL EVENTS AUDIT

The recommendations above concern monitoring services as routinely delivered. A second approach to audit is to use adverse events to highlight particular areas of low quality service. This requires identification of agreed 'sentinel events'. In people with COPD readmission to hospital with one month of an admission with an exacerbation of COPD may represent such an event.

Criterion

Percentage of patients readmitted to hospital with an exacerbation of COPD within 28 days of discharge

PATIENT-CENTRED AUDIT

Finally it is recommended that health care commissioning organizations should consider using a patient-centred audit approach intermittently, to investigate the totality of services and identify particular areas that need further development.

Suggested audit criteria for implementation

Key Priority	Criterion: data item needed	Exception
<p>1. Diagnose COPD</p> <p>A diagnosis of COPD should be considered in patients over the age of 35 who have a risk factor (generally smoking) and who present with exertional breathlessness, chronic cough, regular sputum production, frequent winter 'bronchitis' or wheeze. The presence of airflow obstruction should be confirmed by performing spirometry. All health professionals managing patients with COPD should have access to spirometry and be competent in the interpretation of the results.</p>	<p>Percentage of smokers over the age of 35 consulting with a chronic cough and/or breathlessness who have had spirometry performed</p> <p>Percentage of patients with a diagnosis of COPD who have had spirometry performed</p>	<p>Patients who are unable to perform spirometry, for example because of facial paralysis</p>
<p>2. Stop smoking</p> <p>Encouraging patients with COPD to stop smoking is one of the most important components of their management. All COPD patients still smoking, regardless of age should be encouraged to stop, and offered help to do so, at every opportunity.</p>	<p>Percentage of patients with COPD who are current smokers recorded in the general practice records as having been offered smoking cessation advice and or therapy</p>	
<p>3. Effective inhaled therapy</p> <p>Long-acting inhaled bronchodilators should be used to control symptoms and improve exercise capacity in patients who continue to experience problems despite the use of short-acting drugs. Inhaled corticosteroids should be added to long-acting bronchodilators in patients with an $FEV_1 \leq 50\%$ predicted who have had two or more exacerbations requiring treatment with antibiotics or oral corticosteroids in a 12-month period in order to decrease exacerbation frequency.</p>	<p>Percentage of patients $FEV_1 \leq 50\%$ predicted who have had two or more exacerbations requiring treatment with antibiotics or oral corticosteroids in a 12-month period who are prescribed inhaled steroid therapy.</p>	<p>Patients who decline inhaled steroid therapy</p>
<p>4. Pulmonary rehabilitation for all who need it</p> <p>Pulmonary rehabilitation should be made available to all appropriate patients with COPD.</p>	<p>Percentage of patients with COPD who have undergone pulmonary rehabilitation</p>	<p>Patients who decline rehabilitation</p>
<p>5. Use non-invasive ventilation</p> <p>Non-invasive ventilation (NIV) should be used as the treatment of choice for persistent hypercapnic ventilatory failure during exacerbations not responding to medical therapy. It should be delivered by staff trained in its application, experienced in its use and aware of its limitations. When patients are started on NIV, there should be a clear plan covering what to do in the event of deterioration and ceilings of therapy should be agreed.</p>	<p>Percentage of patients presenting with acute hypercapnic ventilatory failure who have received NIV</p>	<p>Patients who decline NIV</p>
<p>6. Manage exacerbations</p> <p>The frequency of exacerbations should be reduced by appropriate use of inhaled corticosteroids and bronchodilators, and vaccinations. The impact of exacerbations should be minimised by:</p> <ul style="list-style-type: none"> • giving self-management advice on responding promptly to the symptoms of an exacerbation • starting appropriate treatment with oral steroids and or antibiotics • use of non-invasive ventilation when indicated • use of hospital-at-home or assisted-discharge schemes 	<p>Percentage of patients with exacerbations receiving appropriate steroid and/or antibiotics</p>	<p>Patient choice</p>



Audit criteria

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