CMP Quiz
Welcome to the CMP Quiz!

This is your chance to test your knowledge of the CMP dataset. The aim of this quiz is to go over some of the key points that we cover in the Data Collection Training workshops. Please give the quiz a try, share it with colleagues and let us know what you think.

Each question has two options and we want you to circle the option that you think is correct. There is also a reason box for you to put down some ideas as to why you think that answer is correct.

There is also a separate answer page for each question which, along with the answers, gives an explanation about the reasoning behind each answer.

If you have any questions about either the questions themselves, or the explanations behind the answers, please give your Case Officer a call.
**Admission Questions:**

**Question 1:**
Ms Y came into hospital to have a splinter removed. She was admitted to your unit for twenty minutes due to bed pressures.  
*Do you record this admission?*

- Yes
- No

**Why?**

**Question 2:**
Mr W attended A&E at another hospital. He was transferred to your hospital for an MRI scan. After this, he went to Theatre & recovery and was then admitted to your unit.  
*What do you record as the ‘Prior location (in)’?*

- "Other intermediate care area"
- "Not in hospital"

**Why?**
Reason:
Data are collected for all admissions to your unit regardless of age, severity of illness, reason for admission or length of stay. It is important to include such admissions as they represent work for your unit.

Question 1:
Ms Y came into hospital to have a splinter removed. She was admitted to your unit for twenty minutes due to bed pressures.

Do you record this admission?
Yes

Reason:
‘Location (in)’, is where the patient was immediately before admission to your unit, in this case Theatre & recovery. The other locations in this example are also transient and are therefore not recorded. The ‘Prior location (in)’ should be the last non-transient location, in this case “not in hospital”.

“Other intermediate care area” is a non-transient location and does not represent A&E.

Question 2:
Mr W attended A&E at another hospital. He was transferred to your hospital for an MRI scan. After this, he went to Theatre & recovery and was then admitted to your unit.

What do you record as the ‘Prior location (in)’?
“Other intermediate care area”

“Not in hospital”

Reason:
‘Location (in)’, is where the patient was immediately before admission to your unit, in this case Theatre & recovery. The other locations in this example are also transient and are therefore not recorded. The ‘Prior location (in)’ should be the last non-transient location, in this case “not in hospital”.

“Other intermediate care area” is a non-transient location and does not represent A&E.
**Question 3:**
Ms V was urgently admitted to your unit after her elective hip replacement was abandoned due to anaphylaxis on the induction of general anaesthetic.

**Reason:**
- **Primary:** Hip-related condition (surgical)
- **Secondary:** Anaphylaxis (non-surgical)

**Question 4:**
Mr A was admitted to your unit and treated for suspected pneumonia in the first 24 hours. Multiple tests were carried out. After 40 hours, these test results came back negative for pneumonia, but identifying a primary lung tumour.

**Reason:**
- **Primary:** Lung tumour (non-surgical)
- **Secondary:** Pneumonia (non-surgical)
- **Ultimate primary:** Lung tumour (non-surgical)
Reasons for Admission Answers:

Question 3:
Ms V was urgently admitted to your unit after her elective hip replacement was abandoned due to anaphylaxis on the induction of general anaesthetic.

*What reasons for admission do you record?*

- **Primary:** Hip-related condition (surgical)
- **Secondary:** Anaphylaxis (non-surgical)

Reason:
The Anaphylaxis was the *reason the patient was brought to your unit*, so is the ‘Primary reason for admission’. If a general anaesthetic has been induced, then the condition that was planned to be operated on is recorded in the ‘Secondary reason for admission’ with a surgical code (even though the surgery was not completed).

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*What reasons for admission do you record?*

- **Primary:** Lung tumour (non-surgical)
- **Secondary:** Pneumonia (non-surgical)
- **Ultimate primary:** Lung tumour (non-surgical)

Reason:
The ‘Primary reason for admission’ should reflect what was known within the first 24 hours on your unit. Therefore if a condition was suspected and treated accordingly, this will need to be recorded as the ‘Primary reason for admission’. If more information comes to light after the first 24 hours, this can be recorded using the ‘Ultimate primary reason for admission’ field.
Question 5:
Mr U completed a course of chemotherapy four months ago. Since then, he has received daily doses of corticosteroids (0.5 mg kg\(^{-1}\)).
What should you record in the past medical history?

Past Medical History:
- Severe Respiratory Disease

Other Condition in PMH:
- Acute Myocardial Infarction

Question 6:
Mrs B suffers from serious COPD, and before admission she could only walk 100 metres on level ground before shortness of breath. She also had a Myocardial Infarction last year.
What do you record in the past medical history?

Past Medical History:
- None

Other Condition in PMH:
- COPD
Question 5:
Mr U completed a course of chemotherapy four months ago. Since then, he has received daily doses of corticosteroids (0.5mg kg⁻¹).

What do you record in the past medical history?

Reason:
Conditions in the past medical history must have been evident in the six months prior to admission to your unit. For Steroid treatment, the admission must have received $\geq 0.3$ mg kg⁻¹ of steroids, daily for six months prior to admission to your unit.

Question 6:
Mrs B suffers from serious COPD, and before admission she could only walk 100 metres on level ground before shortness of breath. She also had a Myocardial Infarction last year.

What do you record in the past medical history?

Reason:
For a patient to meet the criteria of Severe Respiratory Disease, they must have shortness of breath walking 20 metres on level ground. COPD does not always meet the criteria for Severe Respiratory Disease, but can be recorded using the ‘Other condition in past medical history’ field. This field should only be used for ongoing chronic conditions.
Physiology Questions:

**Question 7:**
Mr T has blood samples taken once during his eight-hour stay in your unit. His creatinine value is 1001 and his serum sodium is 123.

**How do you record these blood values?**
- As both the lowest and the highest values
- As the lowest values only

**Why?**

**Question 8:**
Mrs S is sedated on admission. Sedation was stopped after 16 hours. She was not judged clinically free from the effects of sedation for a further six hours.

**After what time could a valid Glasgow Coma Score be assessed?**
- After 16 hours
- After 22 hours

**Why?**
Reason:
If only one physiology value is measured during the first 24 hours, then record this as the lowest value only irrespective of how high it is. Inputting the same value twice (as the lowest and the highest values) will be interpreted as two or more separate measurements being made with identical values.

Question 7:
Mr T has blood samples taken once during his eight-hour stay in your unit. His creatinine value is 1001 and his serum sodium is 123.

How do you record these blood values?

As both the lowest and the highest values

As the lowest values only

Reason:
The Glasgow Coma Score (GCS) forms an important part of the physiology score. The GCS should only be assessed when the admission is clinically judged to be free from effects of sedation/sedative agents. For self-sedated patients (e.g. overdose), the sedation is seen as part of the critical illness and the GCS can be assessed and recorded.

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Infection Questions:

Question 9:
Ms C was admitted to your unit at 09:00 on 14/02/2015. Swab samples were taken at 09:02 on 15/02/2015. Results were returned at 11:30 on 16/02/2015 and were positive for VRE.

How do you record this infection?

"Admission VRE"

"Unit-Acquired VRE"

Why?

Question 10:
Miss R has blood samples taken on her sixth day in ICU. Yeast was cultured in two bottles, MRSA was cultured in one.

What do you record as the 'Main organism causing unit-acquired infection in blood'?

"MRSA"

"Yeast"

Why?
**Question 9:**
Ms C was admitted to your unit at 09:00 on 14/02/2015. Swab samples were taken at 09:02 on 15/02/2015. Results were returned at 11:30 on 16/02/2015 and were positive for VRE.

**How do you record this infection?**

**“Admission VRE”**

**Reason:**
If a sample is taken less than 48 hours after admission to your unit, the infection will be classed as admission, regardless of when the results are received back. VRE can be assessed from any sample taken for microbiological examination.

**“Unit-Acquired VRE”**

**Question 10:**
Miss R has blood samples taken on her sixth day in ICU. Yeast was cultured in two bottles, MRSA was cultured in one.

**What do you record as the ‘Main organism causing unit-acquired infection in blood’?**

**“MRSA”**

**Reason:**
Where more than one organism is isolated: if two organisms are present in both bottles, then select the organism higher up the ranking of organisms in the Data Collection Manual. If one organism is present in both bottles and the other is only present in one bottle, then select the organism present in both bottles, except for MRSA. MRSA will take priority over all other organisms isolated, even if it is only present in one bottle.

**“Yeast”**
Question 11:
For the entirety of his admission, Mr Q received basic respiratory, basic cardiovascular and gastrointestinal monitoring and support. What do you record as the Level of care?

Level 3

Why?

Level 2

Question 12:
Mr D was admitted to your unit following cardiac arrest. He received advanced cardiovascular support, but no other organs were supported. What do you record as the Level of care?

Level 3

Why?

Level 2
Question 11:
For the entirety of his admission, Mr Q received basic respiratory, basic cardiovascular and gastrointestinal monitoring and support. What do you record as the Level of care?

Level 2

Reason:
Admissions solely receiving basic respiratory and basic cardiovascular monitoring and support due to an acute illness are Level 2. Gastrointestinal monitoring and support is not included does not contribute to determining level of care. These are Department of Health CCMDS definitions.

Level 3

Question 12:
Mr D was admitted to your unit following cardiac arrest. He was given multiple IV vasoactive drugs and met the criteria for advanced cardiovascular support, but no other organs were supported. What do you record as the Level of care?

Level 2

Reason:
Admissions receiving solely advanced cardiovascular support are Level 2. Admissions post cardiac arrest do not automatically count as receiving advanced cardiovascular support. They must receive specific treatment meeting the definition as given in the Data Collection Manual.

Level 3
Question 13: Mr O was discharged from your unit to recovery as his bed was required for a more urgent admission. In recovery he was managed by ICU staff. He returned to your unit the following day.

How many admissions to your unit do you record for the CMP?

Question 14: On discharge from your hospital, Mrs N stayed at a family friend’s house until she fully recovered.

How do you record the ‘Residence post-discharge’?
Outcome Answers:

**Question 13:**
Mr O was discharged from your unit to recovery as his bed was required for a more urgent admission. In recovery he was managed by ICU staff. He returned to your unit the following day.

**How many admissions to your unit do you record for the CMP?**

**Reason:**
The CMP accounts for each admission to a bed in your unit. By recording two separate admissions for this patient, we can report true and accurate workload/activity/occupancy within your unit. To identify these important cases, you need to record them in this way. This facilitates the collection of comparable data across all units within the CMP.

**Question 14:**
On discharge from your hospital, Mrs N stayed at a family friend’s house until she fully recovered.

**How do you record the ‘Residence post-discharge’?**

**Reason:**
The Residence field indicates the type of accommodation a patient has returned to. The “no fixed address/abode” option is used for those who are either homeless or in a temporary hostel. “Home” is broadly defined as any owner occupied/rented property or living with relatives/friends.