Background
This audit tool asks about assessments, discharge planning and aspects of care received by people with dementia during their stay in hospital. Standards have been drawn from national and professional guidance.

Before completing this tool, please read the guidance document and have your hospital code to hand.

Patient Sample
The patient sample is drawn from a long list of eligible patients already identified using ICD10 coding discharged during the period 1st April 2016 to 30th April 2016. The sample must be drawn from consecutive discharges. Please see guidance about what to do when a casenote is not eligible. The minimum casenotes is 50 and the maximum is 100. If you have fewer than 50, please continue to identify casenotes from May.

Entering the data
Data from each set of eligible casenotes should be entered individually, in date order of discharge, earliest first. Please follow the instructions in the guidance document carefully.

At the end of each section you will find a comment box. Use this to make any further comments on your answers to the questions.

Enter your hospital code:

This is the code allocated by the project team and is held by the audit lead contact. It will consist of 2 letters and 2 numbers, e.g. XY11. If you do not know the hospital code, please get in touch with the audit lead from your hospital or contact the project team on 020 3701 2697 or 020 3701 2688.

Has the patient been in hospital for 72 hours or longer?

This includes the date of admission. If the patient has NOT been in hospital for 72 hours or longer, they are not eligible for audit.

☐ Yes
☐ No  ⇒ This casenote is not eligible and you cannot continue
Enter number for this patient:

This is the number allocated for audit eg 01, 02, 03 etc. Please refer to the guidance document on how to select case notes for audit. If case note is a data reliability check please add 'Rel' at the end of the number. For example, if you are re-auditing case note number 5, please enter 05rel.

Has this casenote been selected as a data reliability check?

Please refer to the guidance document on how to select case notes for data reliability check. If this case note is one of the five case notes that has been chosen for the inter-rater reliability checks, please select “yes”.

☐ Yes
☐ No

In case we need to contact you regarding this entry, please provide us with your contact details:

Name, Job title: 

Email address: 

Telephone: 

SECTION 1: INFORMATION ABOUT THE PATIENT

1. Enter the age of the patient:

This is the age of the patient in whole years at discharge. To calculate age using date of birth, you can use this website: http://www.mathcats.com/explore/age/calculator.html

2. Select the gender of the patient:

☐ Male
☐ Female

3. Select the ethnicity of the patient:

☐ White/White British
☐ Black/Black British
☐ Mixed
☐ Other
☐ Asian/Asian British
☐ Chinese
☐ Not documented
4. Select the first language of the patient:

- [ ] English
- [ ] Welsh
- [ ] Other European Language
- [ ] Asian Language
- [ ] Not Documented
- [ ] Other

5. Please identify the speciality of the ward that this patient spent the longest period on during this admission:

- [ ] Cardiac
- [ ] Critical Care
- [ ] Nephrology
- [ ] Oncology
- [ ] Stroke
- [ ] Other Medical
- [ ] Care of the Elderly
- [ ] General Medical
- [ ] Obstetrics/Gynaecology
- [ ] Orthopaedics
- [ ] Surgical
- [ ] Other – please specify

6. What is the primary diagnosis/cause of admission?
   
   E.g. Fractured femur, stroke

7. Did the patient die while in hospital?

- [ ] Yes
- [ ] No

8. Did the patient self-discharge from hospital?

- [ ] Yes
- [ ] No

9. Is the discharge marked as ‘fast track discharge’/ ‘discharge to assess’/ ‘transfer to assess’/ expedited with family agreement for recorded reasons?

- [ ] Yes
- [ ] No

10. Was the patient receiving end of life care/on an end of life care plan?

- [ ] Yes
- [ ] No
11. What was the date of admission and the date of discharge?

Please enter in DD/MM/YYYY format. The discharge date should fall between 01/04/2016 and 30/04/2016.

If the patient died while in hospital, please enter the date of death in the discharge box.

Admission date:  
Discharge date:  
(or date of death if the patient died while in hospital)

12. Please indicate the place in which the person was living or receiving care before admission:

"Own home" can include sheltered or warden controlled accommodation. "Transfer from another hospital" means any hospital other than the one for which you are submitting this case note.

☐ Own home  ☐ Respite care  
☐ Rehabilitation  ☐ Psychiatric ward  
☐ Carer's home  ☐ Intermediate care  
☐ Residential care  ☐ Nursing home  
☐ Palliative care  ☐ Transfer from another hospital  
☐ Long stay care

Q13 is not applicable if Q7 = “Yes” (the patient died)

13. Please indicate the place in which the person was living or receiving care after discharge:

"Own home" can include sheltered or warden controlled accommodation. "Transfer to another hospital" means any hospital other than the one for which you are submitting this case note.

☐ Own home  ☐ Respite care  
☐ Rehabilitation  ☐ Psychiatric ward  
☐ Carer's home  ☐ Intermediate care  
☐ Residential care  ☐ Nursing home  
☐ Palliative care  ☐ Transfer to another hospital  
☐ Long stay care

Do you have any comments to make on Section 1: Information about the patient?
SECTION 2: ASSESSMENT

This section asks about the assessments carried out during the admission episode (or pre-admission evaluation), or during the patient’s stay.

A multi-disciplinary assessment can be carried out on or after admission, i.e. once the patient becomes well enough. Elements of assessment may also have been carried out immediately prior to admission, in A&E.

**N.B.** elements of assessment may be found in places such as nursing notes and OT assessments as well as in medical notes.

### MULTIDISCIPLINARY ASSESSMENT

14. An assessment of mobility was performed by a healthcare professional:

This refers to an assessment of gait, balance, mobility carried out by a doctor, nurse or other qualified professional, e.g. physiotherapist, occupational therapist.

- Yes
- No
- Could not be assessed for recorded reasons

15. An assessment of nutritional status was performed by a healthcare professional:

Assessment carried out by a doctor, nurse or other qualified professional, e.g. dietician.

- Yes  ⇒ Go to Q15a
- No  ⇒ Go to Q16
- Could not be assessed for recorded reasons  ⇒ Go to Q16

15a. The assessment of nutritional status includes recording of BMI (Body Mass Index) or weight:

Please select third option if, for example, patient was too frail to be weighed and other action was taken e.g. referral to dietician.

- Yes, there is a recording of the patient’s BMI or weight
- No, there is no recording of the patient’s BMI or weight
- Other action taken

16. Has a formal pressure ulcer risk assessment been carried out and score recorded?

This should be assessment using a standardised instrument such as Waterlow.

- Yes
- No
17. As part of the multidisciplinary assessment has the patient been asked about any continence needs?

This can be the initial nursing assessment (a trigger question which prompts full bowel and bladder assessment where necessary and the patient’s understanding/acceptance of the question is assessed. See Essence of Care - benchmarks for continence and bladder and bowel care, Indicator Factor 3). Answer "Yes“ if family member, GP etc has been asked on behalf of the patient.

☐ Yes
☐ No
☐ Could not be assessed for recorded reasons

18. As part of the multidisciplinary assessment has the patient been assessed for the presence of any pain?

Answer "Yes“ where the notes show that there has been an assessment of pain using a tool suitable for people with dementia (e.g. the Abbey Pain Scale), or the patient, family member or GP has been asked about any pain and response recorded.

☐ Yes
☐ No
☐ Could not be assessed for recorded reasons

19. Has an assessment of functioning been carried out?

☐ Yes, a standardised assessment has taken place
☐ Yes, an occupational therapy assessment has taken place
☐ Yes, a physiotherapy assessment has taken place
☐ Yes, other – please specify
☐ No
☐ Could not be assessed for recorded reasons

Do you have any comments to make on multidisciplinary assessment?
MENTAL STATE ASSESSMENT

20. Has a standardised mental status test been carried out?

This should be assessment using a standardised instrument such as Abbreviated mental test score (AMTS), 6-Item cognitive impairment test (6CIT), General practitioner assessment of cognition (GPCOG), or other standardised tool.

☐ Yes
☐ No
☐ Could not be assessed for recorded reasons

21. Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?

This refers to the assessment at presentation set out in NICE CG103 Delirium Guideline which specifies that people at risk should be assessed for indications of delirium. This includes people with dementia/cognitive impairment. See http://www.nice.org.uk/cg103

☐ Yes, and there were indications that delirium may be present ⇒ Go to Q21a
☐ Yes, but there was no indication that delirium may be present ⇒ Go to Q22
☐ No assessment has been carried out ⇒ Go to Q22

21a. Has the patient been clinically assessed for delirium by a healthcare professional?

This refers to the full clinical assessment when indicators of delirium are identified, as specified in the CG103 Delirium Guideline. See http://www.nice.org.uk/cg103

☐ Yes
☐ No

Do you have any comments to make on mental health assessment?

INFORMATION ABOUT THE PERSON WITH DEMENTIA

This sub section looks at whether there is a formal system in place for collating information about the person with dementia necessary to their care. N.B. this system need not be in use only for patients with dementia.

This could be an assessment proforma, or prompted list of questions for a meeting with the carer or next of kin, producing information for the care plan. It could also be a personal information document (e.g. “This is Me”, patient passport).
22. Does the care assessment contain a section dedicated to collecting information from the carer, next of kin or a person who knows the patient well?

- **Yes** ⇒ Go to Q22a
- **No** ⇒ Go to Section 3

22a. Has information been collected about the patient regarding personal details, preferences and routines?

This could include details of preferred name, need to walk around at certain times of day, time of rising/retiring, likes/dislikes regarding food etc.

Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer “Unknown” if this information is usually recorded in a document which accompanies the patient (e.g. “This is Me” or patient passport) and no copy is available in the notes.
Answer “N/A” if there is no carer/relative/friend and information is not available and recorded as such.

- **Yes**
- **No**
- **Unknown**
- **N/A**

22b. Has information been collected about the patient’s food and drink preferences?

Answer "No” if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer “Unknown” if this information is usually recorded in a document which accompanies the patient (e.g. “This is Me” or patient passport) and no copy is available in the notes.
Answer “N/A” if there is no carer/relative/friend and information is not available and recorded as such.

- **Yes**
- **No**
- **Unknown**
- **N/A**
22c. Has information been collected about the patient regarding reminders or support with personal care?

This could include washing, dressing, toileting, hygiene, eating, drinking, and taking medication.

Answer "No" if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. “This is Me” or patient passport) and no copy is available in the notes.
Answer “N/A” if there is no carer/relative/friend and information is not available and recorded as such.

☐ Yes
☐ No
☐ Unknown
☐ N/A

22d. Has information been collected about the patient regarding recurring factors that may cause or exacerbate distress?

This could include physical factors such as illness or pain, and/or environmental factors such as noise, darkness.

Answer "No” if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer “Unknown” if this information is usually recorded in a document which accompanies the patient (e.g. “This is Me” or patient passport) and no copy is available in the notes.
Answer “N/A” if there is no carer/relative/friend and information is not available and recorded as such.

☐ Yes
☐ No
☐ Unknown
☐ N/A
22e. Has information been collected about the patient regarding support or actions that can calm the person if they are agitated?

This could include information about indicators especially non-verbal, of distress or pain; any techniques that could help with distress e.g. reminders of where they are, conversation to distract, or a favourite picture or object.

Answer “No” if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer “Unknown” if this information is usually recorded in a document which accompanies the patient (e.g. “This is Me” or patient passport) and no copy is available in the notes.
Answer “N/A” if there is no carer/relative/friend and information is not available and recorded as such.

☐ Yes
☐ No
☐ Unknown
☐ N/A

22f. Has information been collected about the patient regarding life details which aid communication?

This could include family situation (whether living with other family members, spouse living, pets etc), interests and past or current occupation.

Answer “No” if sections of the form are left blank/there is no way of identifying whether information has been requested.
Answer “Unknown” if this information is usually recorded in a document which accompanies the patient (e.g. “This is Me” or patient passport) and no copy is available in the notes.
Answer “N/A” if there is no carer/relative/friend and information is not available and recorded as such.

☐ Yes
☐ No
☐ Unknown
☐ N/A

Do you have any comments to make on information about the person with dementia?
SECTION 3: DISCHARGE

This section does not apply to all patients, please read carefully the information below before continuing.

If any of the responses below apply, you will not be asked any questions in the Discharge Section and can progress to the end of the form:

Q7 = “Yes” (patient died in hospital)
Q8 = “Yes” (patient self-discharged from hospital)
Q10 = “Yes” (patient was receiving end of life/on end of life plan)
Q9 = “Yes” (patient on fast track discharge/discharge to assess/transfer to assess/expedited with family agreement)
Q13 = “Transferred to another hospital” OR “Psychiatric ward” OR “Palliative care” OR “Intermediate care” OR “Rehabilitation”

ASSESSMENT BEFORE DISCHARGE

This section asks about appropriate discharge planning and procedures including support and information for patients and carers.

23. At the point of discharge the patient's level of cognitive impairment, using a standardised assessment, was summarised and recorded:

This should be a cognitive screen carried out subsequent to any carried out during initial assessment or pre-admission assessment, and whilst assessing readiness for discharge, e.g. Abbreviated mental test score (AMTS), 6-Item cognitive impairment test (6CIT), General practitioner assessment of cognition (GPCOG) or other standardised tool.

☐ Yes
☐ No – Go to 23a

23a. Please comment.

24. At the point of discharge the cause of cognitive impairment was summarised and recorded:

This could be a condition diagnosed before this admission to hospital or identified during the admission.

☐ Yes
☐ No
25. Have there been any symptoms of delirium?

This refers to symptoms noted during the admission.

Answer “Yes” if symptoms present during admission are noted. Answer “No” if there is no record.

☐ Yes ⇒ Go to Q25a
☐ No ⇒ Go to Q26

25a. Have the symptoms of delirium been summarised for discharge?

☐ Yes
☐ No

26. Have there been any persistent behavioural and psychiatric symptoms of dementia (wandering, aggression, shouting) during this admission?

This refers to symptoms noted during the admission.

Answer “Yes” if symptoms present during admission are noted. Answer “No” if there is no record.

☐ Yes ⇒ Go to Q26a
☐ No ⇒ Go to Q27

26a. Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?

This includes details of future assessment/management

☐ Yes
☐ No

27. Is there a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence?

☐ Yes ⇒ Go to Q27a
☐ No ⇒ Go to Q27b
☐ N/A (no change in residence was proposed) ⇒ Go to Q27b
27a. If yes...

<table>
<thead>
<tr>
<th>There are documented concerns about the patient’s capacity to consent to the referral and...</th>
<th>There are no documented concerns about the patient’s capacity to consent to the referral and...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient had capacity on assessment and their consent is documented</td>
<td>The patient lacked requisite capacity and evidence of a best interests decision has been recorded</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>There is no record of either consent or best interest decision making</td>
<td>There is no record of the patient’s consent</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

27b. Do you have any comments to make on Q27?


Do you have any comments to make on assessment before discharge?


DISCHARGE COORDINATION AND MDT INPUT

28. Did a named person/identified team coordinate the discharge plan?

*E.g. the person or team that coordinated the plan for this individual is identifiable.*

□ Yes

□ No

□ There is no discharge plan

29a. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the person with dementia?

*This can be together as a summary or recorded as separate discussions.*

Answer “N/A” if the person with dementia has refused discussion and this is recorded or it has not been possible to carry this out for another documented reason.

□ Yes

□ No

□ N/A
29b. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the person's carer/relative?

This can be together as a summary or recorded as separate discussions.

Answer "N/A" if the carer/relative has refused discussion and this is recorded or it has not been possible to carry this out for another documented reason OR there is no carer.

☐ Yes
☐ No
☐ N/A

29c. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the consultant responsible for the patient’s care?

This can be together as a summary or recorded as separate discussions.

☐ Yes
☐ No

29d. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with other members of the multidisciplinary team?

This can be together as a summary or recorded as separate discussions.

☐ Yes
☐ No

30. Has a single plan/summary for discharge with clear updated information been produced?

This refers to the discharge plan with summarised information for the use of the patient, carer, GP and community based services. The question asks whether nursing and medical/surgical information has been put together as a single plan and mental health information is included.

☐ Yes
☐ No
31. Are any support needs that have been identified documented in the discharge plan/summary?

This asks about whether the referrals and recommendations about future care, treatment and support are contained in the discharge plan or summary, e.g. help needed with Activities of Daily Living, referral to Occupational Therapy. 
Answer “N/A” if no discharge plan or summary has been produced.

☐ Yes
☐ No
☐ N/A

32. Has the patient and/or carer received a copy of the plan/summary?

Answer “Yes” if there is a single plan and the patient/carer has received a copy OR if there is a “GP version” with information about medicines to be taken, referrals, etc, and the patient or carer has received a copy.
Answer “No” if the only information recorded as given to the patient/carer is not specific to their ongoing care and treatment (e.g. generic leaflets about social services) OR if the patient or carer receives no information.
Answer “N/A” if there is no carer and the patient could not be given the information.

☐ Yes
☐ No
☐ N/A

33. Was a copy of the discharge plan/summary sent to the GP/primary care team on the day of discharge?

Answer “N/A” if no discharge plan or summary has been produced.

☐ Yes
☐ No
☐ N/A

Do you have any comments to make on discharge co-ordination and MDT input?
34. Was discharge planning initiated within 24 hours of admission?

This includes planning for transfer to another care setting. Answer “N/A” if there is a recorded reason why discharge planning could not be initiated within 24 hours of admission.

- Yes ⇒ Go to Q35
- No ⇒ Go to Q35
- N/A ⇒ Go to Q34a

34a. Please select the recorded reason why discharge planning could not be initiated within 24 hours:

- Patient acutely unwell
- Patient awaiting history/results
- Patient presenting confusion
- Patient transferred to another hospital
- Patient being discharged to nursing/residential care
- Patient awaiting assessment
- Patient awaiting surgery
- Patient on end of life plan
- Patient unresponsive
- Other (please specify)

SUPPORT FOR CARERS AND FAMILY

35. Carers or family have received notice of discharge and this is documented:

Carers or family here refers to relative, friend or next of kin named as main contact or involved in caring for the patient. It does not refer to the patient’s case worker from social services or residential care. Answer, indicating notice period, regardless of the destination of the patient on discharge.

- Less than 24 hours
- 25 – 48 hours
- No notice at all
- Not documented
- 24 hours
- More than 48 hours
- No carer, family, friend
- Patient specified information withheld

36. An assessment of the carer’s current needs has taken place in advance of discharge:

Answer “N/A” if the carer did not want, or did not need to meet about this (e.g. has had a recent assessment, all support services already in place, or the person they care for is moving to another place of care) OR there is no carer.

- Yes
- No
- N/A
**Do you have any comments to make on discharge planning?**

If you have any queries, please contact the project team:

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