

## National Audit of Dementia Audit of Casenotes 2023 PART TWO - ASSESSMENT AND PLANNING

Thank you for participating in the National Audit of Dementia.  
For this audit you will be submitting casenote audit data via the new platform CaseCapture on Netsolving. The [guidance documents](#) outline how to find your sample, navigate the data collection tool and submit data for the audit. If you have any queries please contact [nad@rcpsych.ac.uk](mailto:nad@rcpsych.ac.uk).

**This is Part TWO of the casenote audit. For this part of the audit you will take the first 40-100 patients (see guidance) admitted to your hospital over the period 14 August – 10 September and submit information about assessment and planning. Deadline for all data entry for Parts One AND Two is 13 November 2023.**

\*Please see guidance if you intend to split your sample between this data collection period and the optional Spring period. 40 patients must be submitted in the mandatory period.

**Entering the data: You can save and return to each record entered.**

**2.1 What is the audit number allocated for this patient (must be same as Part One).**

### Screening and diagnosis of delirium

**2.2 Have any of the following screening assessments been carried out for this patient to identify recent changes or fluctuation in behaviour that may indicate the presence of delirium?**

**a. Single Question in Delirium (SQiD)**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**b. History taken from someone who knows the patient well in which they were asked about any recent changes in cognition/behaviour**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**c. 4AT (Rapid Clinical Test for delirium)**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**d. CAM (Confusion Assessment Method)**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**e. OSLA**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**f. Other (please specify)**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**i. Other details**

**2.3 Please enter the date of the first assessment identified above**

**2.4 Did the initial assessment selected above find evidence that delirium may be present?**

- Yes, delirium may be present
- No evidence of delirium

**(If found that delirium may be present):**

**2.5 Was a diagnosis of delirium confirmed?**

- Yes, the patient was diagnosed with delirium
- Suspected – delirium was suspected but not definitely confirmed
- No, it was confirmed that the patient did not have delirium
- No, no further investigation took place

**(If delirium diagnosis confirmed OR suspected):**

**2.6 Was a management plan (for investigation and treatment) for delirium put in place?**

- Yes
- No

**2.7 Was a care plan (for nursing care) for delirium put in place?**

- Yes
- No

## PAIN ASSESSMENT

**2.8 Has the patient been assessed for the presence of any pain?**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No
- Could not be assessed for recorded reasons

**a. (if yes) Enter the date of the pain assessment**

**b. (if yes) What pain assessment tool was used:**

- The Abbey Pain scale
- Pain assessment in advanced dementia (PAINAID)
- Checklist of nonverbal pain indicators (CNPI) observation score
- Question only
- Other

**i. (If other) Please specify**

**2.9 Was pain reassessed?**

- Yes, within 24 hours of first pain assessment
- Yes, more than 24 hours after first pain assessment
- No

**a. Date pain was first reassessed?**

**b. (if yes) Was this using:**

- The Abbey Pain scale
- Pain assessment in advanced dementia (PAINAID)
- Checklist of nonverbal pain indicators (CNPI) observation score
- Question only
- Other

**i. (If other) Please specify**

## DISCHARGE PLANNING

**2.10 Were the required actions to prepare for discharge identified?**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**a. Please give the date that you began to identify these actions**

**2.11 Has an expected date of discharge been recorded?**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**2.12 Was a named member of staff (nurse/consultant/discharge coordinator) or named team responsible clearly identified to coordinate discharge?**

- Yes, within 24 hours of admission
- Yes, more than 24 hours after admission
- No

**2.13 If the discharge planning was not initiated within 24 hours of admission, please select the recorded reason why?**

- Patient acutely unwell
- Patient awaiting assessment
- Patient awaiting history/results
- Patient awaiting surgery

- o Patient presenting confusion
- o Patient on end-of-life plan
- o Patient transferred to another hospital
- o Patient unresponsive
- o Patient being discharged to nursing/ residential care
- o Other (please specify)
- o No reason recorded

**i. Other details**

**END OF PART TWO**