## Casenote Audit Round 3 and Round 4 National Results

\* = a statistically significant difference between R3 and R4 (p<0.05)

### Information about the patient

| **Question** | **Responses** | **National****Audit****Round 4****%****Num/Den** | **National Audit****Round 3****%****Num/Den** |
| --- | --- | --- | --- |
| 1. Enter the age of the patient | Min-65 | **2.3%**228/9782 | **2.2%**221/10047 |
| 66-80 | **24.4%**2386/9782 | **24.3%**2445/10047 |
| 81-100 | **73.0%**7146/9782 | **73.0%**7332/10047 |
| 101-108 | **0.2%**19/9782 | **0.4%**39/10047 |
| Unknown | **0%**3/9782 | **0.1%**10/10047 |
| 2. Select the gender of the patient | Male | **41.4%**4054/9782 | **40.1%**4029/10047 |
| Female | **58.6%**5728/9782 | **59.9%**6018/10047 |
| 3. Select the ethnicity of the patient  | White/White British | **80.7%\***7898/9782 | **82.1%**8250/10047 |
| Asian/Asian British | **2.5%\***245/9782 | **1.9%**193/10047 |
| Black/Black British | **1.5%**150/9782 | **1.2%**123/10047 |
| Mixed | **0.1%**14/9782 | **0.1%**11/10047 |
| Chinese | - | **0.1%**10/10047 |
| Not documented | **13.0%\***1274/9782 | **2.1%**210/10047 |
| Other | **2.1%\***201/9782 | **12.4%**1250/10047 |
| 4. Select the first language of the patient | English | **77.7%**7602/9782 | **77.4%**7778/10047 |
| Welsh | **0.6%**62/9782 | **0.6%**61/10047 |
| Other European language | **0.8%**77/9782 | **1.0%**96/10047 |
| Asian language | **1.7%**169/9782 | **1.4%**144/10047 |
| Other | **0.7%**70/9782 | **0.6%**59/10047 |
| Not documented | **18.4%**1802/9782 | **19%**1909/10047 |
| 5. Please identify the speciality of the ward that this patient spent the longest period on during this admission | Cardiac | **2.6%**250/9782 | **2.5%**248/10047 |
| Care of the elderly | **42.8%**4184/9782 | **41.1%**4125/10047 |
| Critical care | **0.3%**27/9782 | **0.2%**23/10047 |
| General medical | **22.9%**2239/9782 | **23.5%**2359/10047 |
| Nephrology | **0.5%**45/9782 | **0.5%**52/10047 |
| Obstetrics/gynaecology | **0.3%**32/9782 | **0.4%**41/10047 |
| Oncology | **0.2%**24/9782 | **0.2%**22/10047 |
| Orthopaedics | **9%**881/9782 | **8.9%**892/10047 |
| Stroke | **4.3%**417/9782 | **4.5%**456/10047 |
| Surgical | **5.3%**520/9782 | **6.8%**681/10047 |
| Other medical | **8.5%\***829/9782 | **9.9%**999/10047 |
| Other – please specify: | **3.4%\***334/9782 | **0.1%**13/10047 |
| 6. What is the primary diagnosis/cause of admission? | Hip dislocation | **6.4%\***627/9782 | **7.5%**754/10047 |
| Respiratory | **19.1%**1862/9782 | **19.9%**1999/10047 |
| Stroke | **3.2%**316/9782 | **3.8%**380/10047 |
| Urinary/renal | **8.7%**849/9782 | **9.0%**900/10047 |
| Fall | **14.8%**1449/9782 | **13.2%**1329/10047 |
| Cardiac Vascular | **6.4%\***629/9782 | **5.1%**515/10047 |
| Delirium/confusion | **6.2%**604/9782 | **6.0%**604/10047 |
| Other fractures | **1.9%**184/9782 | **1.0%**97/10047 |
| Dehydration | **1.4%**134/9782 | **1.4%**142/10047 |
| Dementia | **1.6%**160/9782 | **1.9%**194/10047 |
| Haematology | **1.5%**143/9782 | **1.2%**116/10047 |
| Psychiatric behaviour | **0.3%**32/9782 | **0.4%**42/10047 |
| Social | **0.3%**34/9782 | **1.6%**161/10047 |
| Liver related/hepatology | **0.9%**92/9782 | **0.8%**84/10047 |
| Oral/Visual | **0.4%**39/9782 | **0.4%**45/10047 |
| Rheumatic | **0.5%**52/9782 | **0.4%**45/10047 |
| Cancer | **0.7%**70/9782 | **1.0%**96/10047 |
| Skin lacerations or lesions | **2.1%**202/9782 | **2.0%**204/10047 |
| Brain/neurological | **2.5%\***238/9782 | **3.6%**364/10047 |
| Endocrine or metabolic | **1.5%**146/9782 | **1.1%**112/10047 |
| Sepsis | **6.0%**586/9782 | **6.3%**633/10047 |
| Impaired consciousness | **1.7%**166/9782 | **2.0%**200/10047 |
| Surgical/non-surgical procedure | **0.5%**50/9782 | **0.9%**86/10047 |
| Pain swelling | **1.8%\***177/9782 | **0.8%**85/10047 |
| Gastrointestinal | **4.5%\***442/9782 | **5.9%**596/10047 |
| Injury/trauma | **0.2%**16/9782 | **0.2%**24/10047 |
| Adverse reaction/ allergy | **0.4%**37/9782 | **0.3%**28/10047 |
| Unable to cope/frailty | **1.8%**172/9782 | **1.6%**160/10047 |
| Other | **2.2%**218/9782 | **1.9%**191/10047 |
| Not documented/unknown | **0.6%**60/9782 | **0.2%**21/10047 |
| 6a. Please say whether this is an emergency or elective admission | Emergency | **98.7%**9654/9782 | New for R4 |
| Elective | **1.3%**128/9782 |
| 7. Did the patient die while in hospital? | Yes | **11.2%\***1100/9782 | **12.8%**1285/10047 |
| 8. Did the patient self-discharge from hospital? | Yes | **0.2%**15/8683 | **0.1%**12/8764 |
| 9. Is the discharge marked as ‘fast track discharge’/ ‘discharge to assess’/ ‘transfer to assess’/ expedited with family agreement for recorded reasons? | Yes | **6.9%\***597/8668 | **5.5%**482/8752 |
| 10. Was the patient receiving end of life care/on an end of life care plan? | Yes | **12.5%**1227/9782 | **13.0%**1302/10047 |
| 11. What was the date of admission and the date of discharge? *(Shown as length of stay)* | 2-10 days | **47.7%\***4662/9782 | **45.3%**4553/10047 |
| 11-20 days | **25.8%**2523/9782 | **25.5%**2559/10047 |
| 21-30 days | **11.5%**1127/9782 | **11.3%**1132/10047 |
| 31-40 days | **6.3%**613/9782 | **6.7%**671/10047 |
| 41-50 days | **3.3%\***319/9782 | **4.2%**418/10047 |
| 51-60 days | **2.2%**212/9782 | **2.3%**230/10047 |
| 61-70 days | **1.4%**134/9782 | **1.7%**168/10047 |
| 71-80 days | **0.7%**70/9782 | **1.0%**102/10047 |
| 81-90 days | **0.5%**46/9782 | **0.6%**62/10047 |
| 91 days or more | **0.8%\***76/9782 | **1.5%**152/10047 |
| 12. Please indicate the place in which the person was living or receiving care before admission | Own home | **59%**5776/9782 | **57.7%**5793/10047 |
| Respite care | **0.8%**74/9782 | **0.8%**80/10047 |
| Rehabilitation ward | **0.3%**31/9782 | **0.4%**37/10047 |
| Psychiatric ward | **0.5%**46/9782 | **0.5%**48/10047 |
| Carer’s home | **1.4%\***138/9782 | **2.1%**212/10047 |
| Intermediate/community rehabilitation care | **0.7%**73/9782 | **0.3%**27/10047 |
| Residential care | **17.9%**1753/9782 | **16.9%**1701/10047 |
| Nursing home | **18.1%**1775/9782 | **19.7%**1981/10047 |
| Palliative Care | **0.0%**3/9782 | **0.0%**5/10047 |
| Transfer to another hospital | **0.9%**90/9782 | **1.4%**145/10047 |
| Long stay care | **0.2%**23/9782 | **0.2%**18/10047 |
| 13. Please indicate the place in which the person was living or receiving care after discharge | Own home | **42%\***3648/8683 | **40.2%**3519/8762 |
| Respite care | **1.5%**134/8682 | **1.6%**136/8762 |
| Rehabilitation ward | **1.6%\***135/8684 | **2.4%**207/8762 |
| Psychiatric ward | **0.6%**51/8684 | **0.7%**62/8762 |
| Carer’s home | **1.3%\***114/8684 | **2.1%**181/8762 |
| Intermediate/community rehabilitation care | **4.3%\***373/8684 | **2.0%**172/8762 |
| Residential care | **19.9%**1723/8684 | **17.7%**1551/8762 |
| Nursing home | **25.8%\***2241/8684 | **28.7%**2511/8762 |
| Palliative Care | **0.6%**51/8684 | **0.6%**54/8762 |
| Transfer to another hospital | **2.1%\***185/8684 | **3.9%**343/8762 |
| Long stay care | **0.3%**27/8684 | **0.3%**26/8762 |

### Assessment

| **Question** | **Responses** | **National Audit****Round 4****%****Num/Den** | **National Audit****Round 3****%****Num/Den** |
| --- | --- | --- | --- |
| 14. An assessment of mobility was performed by a healthcare professional | Yes | **93.7%**8451/9024 | **93.8%**8558/9126 |
| 15. An assessment of nutritional status was performed by a healthcare professional | Yes | **92.5%**8824/9538 | **89.8%**8832/9837 |
| 15a. The assessment of nutritional status includes recording of BMI (Body Mass Index) or weight | Yes | **85.1%**7506/8824 | **85.9%**7580/8822 |
| Other action taken | **3.2%**281/8824 | **4.0%**352/8822 |
| 16. Has a formal pressure ulcer risk assessment been carried out and score recorded? | Yes | **95.7%**9362/9782 | **95.5%**9590/10044 |
| 17. As part of the multidisciplinary assessment has the patient been asked about any continence needs? | Yes | **89.1%**8429/9457 | **88.0%**8572/9744 |
| 18. As part of the multidisciplinary assessment has the patient been assessed for the presence of any pain? | Yes | **85.4%\***8201/9600 | **83.2%**8185/9840 |
| 19. Has an assessment of functioning been carried out? (Tick all that apply) | Yes, a standardised assessment has taken place | **52.1%\***4795/9199 | **45.3%**4212/9294 |
| Yes, an occupational therapy assessment has taken place | **43.6%\***4015/9199 | **42.8%**3977/9294 |
| Yes, a physiotherapy assessment has taken place | **55.6%\***5115/9199 |
| Yes, other – please specify | **7.6%\***697/9199 | **1.7%**161/9294 |
| 20. Has cognitive testing, using a validated structured instrument, been carried out? | Yes | **54.3%**4603/8475 | **54.0%**4684/8682 |
| 21. Were any of the following screening assessments carried out to assess for recent changes or fluctuation in behaviour that may indicate the presence of delirium? (Tick all that apply). | Single Question in Delirium (SQiD) | **7.3%**710/9753 | New for R4 |
| History taken from someone who knows the patient well in which they were asked about any recent changes in cognition/behaviour | **30.5%**2977/9753 |
| 4AT | **10%**978/9753 |
| Other, please specify: | **7%**680/9753 |
| 21a. If Yes, initial assessment above found: | Evidence that delirium may be present | **50.7%**2445/4822 | **58.3%**2603/4466 |
| No evidence of delirium | **49.3%**2377/4822 | **41.7%**1863/4466 |
| 22. Did a healthcare professional (who is trained and competent in the diagnosis of delirium) complete any of the following assessments for delirium? (Tick all that apply) | 4AT | **9.4%**621/6623 | New for R4 |
| Confusion Assessment Method (CAM) – short or long form | **5.3%**351/6623 |
| Other, please specify: | **14.9%**988/6623 |
| 22a. From this assessment(s), was a diagnosis of delirium confirmed? | Yes | **80.5%**1524/1892 | New for R4 |
| 23. 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 | **60.9%\***5955/9784 | **57.2%**5727/10010 |
| 23a. Has information been collected about the patient regarding personal details, preferences and routines? | Yes | **49.4%\***2889/5851 | **47.4%**2669/5626 |
| Unknown | **31.1%**1819/5851 | **33.1%**1865/5626 |
| 23b. Has information been collected about the patient’s food and drink preferences? | Yes | **48.1%\***2810/5845 | **44.1%**2476/5616 |
| Unknown | **30.8%\***1800/5845 | **34.1%**1916/5616 |
| 23c. Has information been collected about the patient regarding reminders or support with personal care? | Yes | **56.8%**3326/5852 | **55.3%**3116/5631 |
| Unknown | **28.3%**1654/5852 | **29.9%**1685/5631 |
| 23d. Has information been collected about the patient regarding recurring factors that may cause or exacerbate distress? | Yes | **36.1%\***2101/5822 | **32.6%**1818/5583 |
| Unknown | **35.1%**2041/5822 | **37.8%**2110/5583 |
| 23e. Has information been collected about the patient regarding support or actions that can calm the person if they are agitated? | Yes | **31.8%**1841/5794 | **28.2%**1564/5539 |
| Unknown | **36%**2085/5794 | **39.1%**2167/5539 |
| 23f. Has information been collected about the patient regarding life details which aid communication? | Yes | **47.7%\***2784/5838 | **43.1%**2413/5598 |
| Unknown | **31.3%**1825/5838 | **35.3%**1977/5598 |

### Discharge

| **Question** | **Responses** | **National Audit****Round 4****%****Num/Den** | **National Audit****Round 3****%****Num/Den** |
| --- | --- | --- | --- |
| 24. At the point of discharge, was cognitive testing, using a validated structured instrument carried out? | Yes | **10.7%\***771/7211 | **22.4%**1639/7329 |
| 24a. Why was this not completed? | Patient too unwell (including advanced dementia making assessment inappropriate) | **12.5%\***806/6440 | **5.2%**299/5690 |
| Not documented/unknown | **79.6%**5125/6440 | **78%**4444/5690 |
| Other, please specify | **7.9%**509/6440 | **10.8%**616/5690 |
| 25. At the point of discharge the cause of cognitive impairment was summarised and recorded: | Yes | **70.6%**5092/7211 | **69.1%**5067/7329 |
| 26. Have there been any symptoms of delirium at any time during this admission? | Yes | **36%\***2594/7211 | **32.3%**2367/7329 |
| 26a. Has the presence of delirium been noted in discharge correspondence? | Yes | **46.6%**1210/2594 | **47.9%**1133/2367 |
| 27. Have there been any persistent behavioural and psychological symptoms of dementia (wandering, aggression, shouting) during this admission? | Yes | **18%**1299/7211 | **19.4%**1422/7329 |
| 27a. Have the symptoms of behavioural and psychological symptoms of dementia been summarised for discharge? | Yes | **44.2%**574/1299 | **44.5%**635/1426 |
| 28. Is there a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence? | Yes | **59.7%\***1444/2419 | **65.5%**1649/2519 |
| 28ai. If yes:There are documented concerns about the patient’s capacity to consent to the referral and: | The patient had capacity on assessment and their consent is documented | **11%**110/1003 | **11.9%**138/1161 |
| The patient lacked requisite capacity and evidence of a best interests decision has been recorded | **71.5%**717/1003 | **69.9%**811/1161 |
| There is no record of either consent or best interest decision making | **17.5%**176/1003 | **18.3%**212/1161 |
| 28aii.There are no documented concerns about the patient’s capacity to consent to the referral and: | The patient’s consent was requested and this is documented | **27.7%**122/441 | **29.1%**142/488 |
| There is no record of the patient’s consent | **72.3%**319/441 | **70.9%**346/488 |
| 29. Did a named person/identified team coordinate the discharge plan? | Yes | **85.3%\***5950/6975 | **82.0%**5807/7083 |
| 30a. 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? | Yes | **56.5%\***3386/5994 | **53.9%**3327/6169 |
| 30b. 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? | Yes | **83.1%\***5613/6754 | **80.7%**5597/7329 |
| 30c. 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? | Yes | **76.5%**5514/7211 | **75.1%**5501/7329 |
| 30d. 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? | Yes | **85.1%\***6134/7211 | **81.5%**5971/7329 |
| 31. Has a single plan/summary for discharge with clear updated information been produced? | Yes | **85.8%**5988/6975 | **85.1%**6234/7329 |
| 32. Are any support needs that have been identified documented in the discharge plan/summary? | Yes | **61.5%**4288/6975 | **60.2%**4211/6995 |
| 33. Has the patient and/or carer received a copy of the plan/summary? | Yes | **88.1%\***5886/6679 | **80.6%**5621/6975 |
| 34. Was a copy of the discharge plan/summary sent to the GP/primary care team on the day of discharge? | Yes | **94.3%**6575/6975 | **93.6%**6701/7156 |
| 35. Was discharge planning initiated within 24 hours of admission? | Yes | **51.3%\***2665/5191 | **47.4%**2483/5242 |
| 35a. Please select the recorded reason why discharge planning could not be initiated within 24 hours: | Patient acutely unwell | **61.3%**1239/2020 | **62.5%**1306/2088 |
| Patient awaiting assessment | **8.8%**177/2020 | **9.1%**127/2088 |
| Patient awaiting history/results | **7.7%**156/2020 | **6.1%**127/2088 |
| Patient awaiting surgery | **9.6%**193/2020 | **9.6%**200/2088 |
| Patient presenting confusion | **5.8%**118/2020 | **5.7%**120/2088 |
| Patient on end of life plan | **0%**1/2020 | **0.0%**1/2088 |
| Patient transferred to another hospital | **0.2%**5/2020 | **0.1%**2/2088 |
| Patient unresponsive | **0.3%**7/2020 | **0.3%**6/2088 |
| Patient being discharged to nursing/residential care | **5.0%**100/2020 | **6.5%**136/2088 |
| Other (please specify) | **1.2%**24/2020 | **0.0%**0/2088 |
| 36. Carers or family have received notice of discharge and this is documented: | Less than 24 hours | **20.7%**1493/7211 | **19.5%**1432/7329 |
| 24 hours | **12.3%**889/7211 | **12.2%**897/7329 |
| 25-48 hours | **15.8%**1140/7211 | **14.7%**1075/7329 |
| More than 48 hours | **26.3%**1897/7211 | **27.1%**1985/7329 |
| No notice at all | **0.5%**37/7211 | **0.5%**35/7329 |
| No carer, family, friend | **1.7%**124/7211 | **1.7%**127/7329 |
| Not documented | **22.6%**1627/7211 | **24.2%**1770/7329 |
| Patient specified  | **0.1%**4/7211 | **0.0%**3/7329 |
| Not contacted | **-** | **0.1%**5/7329 |
| 37. An assessment of the carer’s current needs has taken place in advance of discharge: | Yes | **68.6%**2478/3611 | **67.3%**2605/3868 |