National Audit of Dementia
Round 4 (2018)
Guidance for the Casenote Audit Questions

April 2018

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# Timeline for data collection

The data collection period will be staggered as shown below. This is guidance for the casenote audit.

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<th>Month</th>
<th>Organisational checklist</th>
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<td>March</td>
<td>Guidance issued</td>
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<td>April</td>
<td>Data collection opens 16 April</td>
<td>Guidance issued</td>
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<tr>
<td>May</td>
<td>Data collection opens 21 May (collecting data for discharges from April 2018)</td>
<td>Guidance issued</td>
<td>Guidance issued</td>
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<td>June</td>
<td>Deadline: 15 June</td>
<td>Data collection opens 4 June</td>
<td>Data collection opens 4 June</td>
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For any queries please contact the project team:

nad@rcpsych.ac.uk

Website:

www.nationalauditofdementia.org.uk

Or you may contact the team individually:

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Please note that when contacting the project team about your casenotes, do not at any time disclose any identifiable data about the patient (e.g. name, NHS number). The Project Team are not allowed to have this information.
Before you begin:

Please make sure you TEST the online data collection link before data collection opens:

http://rcop.formic.com/webforms/

This brings up Formic Web Forms. Click the Login button in the top left of the page to get to the login page. You will then need to enter the unique username and password for your hospital. These will be sent via post to your nominated audit lead.

If you cannot access the Formic Web Forms page, this is probably due to your local IT settings and you will need to contact your IT department to ask them to approve the link.

Anyone entering data for the organisational checklist or casenote audit, as well as all staff accessing the staff questionnaire online will need access to this website, so please do arrange for this as soon as possible.

IDENTIFY the key people you are going to work with. This is a complex audit which should not be carried out by a single lead. The guidance for each tool gives some suggestions of colleagues who could help you to collect and co-ordinate the return of the different types of data required.

Let us know if we can help. We are available to answer queries within office hours, or you can email us, and we will respond as soon as we can.

We look forward to working with you.
Completing the casenote audit

Each hospital site is expected to submit an audit of casenotes of patients discharged with dementia, identified through ICD10 coding (see sampling guidance document on the website). One form is to be submitted online per set of notes audited.

Data collection opens 21 May with a deadline of 21 September 2018.

Each hospital will be asked for:

1) The total number of eligible patients discharged from the hospital in April 2018. Please note this is a separate form to the casenote audit form.

2) An audit return of eligible casenotes, for which the minimum sample will be 50, and the maximum 100 patients. This will give larger hospitals the opportunity to return a larger sample. If your hospital cannot identify 50 patients discharged in April, you may continue to identify patients discharged in May.

Input will be required from:

- Your local audit lead;
- The lead for dementia or a senior clinician working in this area;
- Staff who normally undertake casenote audit, i.e. audit department or information services staff, junior doctors, dementia champions or nursing staff.

A printable version of the data collection form can be downloaded from our website to aid in data collection. Data can be submitted online by persons other than the auditors. Please note that some of the information required for this audit may be found in nursing notes or therapy assessments as well as in the medical notes.

Estimated time to complete:

We predict that 2-3 hours will be required to identify the sample and each casenote will take between 15 minutes and 50 minutes to submit, with the first couple of sets taking the longest to do, according to feedback from hospitals.

Organising your sample

For information on organising your sample, please go to the Round 4 web page and view the Sampling guidance for the casenote audit.
How to enter data online

To access the casenote audit tool, you will need to login to your hospital specific account. More than one person can access this account at the same time so please make sure you are aware of other people using the account to avoid duplication.

To login, follow this link: http://rcop.formic.com/webforms/ and enter the username and password sent to the NAD lead at your hospital. You will also need your 4 character hospital code. If you are not able to obtain these details from your local audit lead, contact the project team on 020 3701 2681 or 020 3701 2707.

Step by step guidance on using the web forms is available on the website.

Please note: when entering data in free text comment boxes, please avoid the use of paragraph breaks (enter on the keyboard) and commas. This affects the download data function.

Question routing

Some questions on the casenote audit are routed, depending on previous answers. This means that some will not appear if a particular response to a previous question is chosen. The routing of questions is detailed on the printable PDF form which you can find on the website.

When submitting data online you will be prompted to return and answer any mandatory questions that have been missed. All questions are mandatory unless marked as optional.

Saving a questionnaire

You can save an incomplete questionnaire and go back to it by clicking “Save” at any point.

You can access all saved forms when you login by clicking on the text that says "You have X partially completed copies of this form". All saved forms will then appear below (please see image below).

![Web Forms Image]

Please click here
You can continue to work on and save a form until it is ready to submit. If you are leaving a form inactive for more than 5 minutes, we recommend you save the form to come back to later. The website will automatically time out after 20 minutes of inactivity.

**Please be very careful when saving forms and returning to them, to ensure you do not enter half of one casenote and half of another.**

When you have completed the form, and are happy to send off the data, please press “submit” to send the casenote audit to the Project Team. We cannot see any saved forms, only those which have been submitted.

**Please note:** submission is final, and data can no longer be retrieved or amended once the casenote audit has been submitted. **All data must be submitted by 21 September.**

**Downloading your data**

You can download submitted forms to view in an Excel spreadsheet by selecting ‘Download data’. **Please note:** submitted forms cannot be amended.

Forms which have been saved but have not been submitted, cannot be downloaded.

Please carefully check your data before submission.

If after submission you notice changes that need to be made, please contact the NAD project team at nad@rcpsych.ac.uk. Please tell us: the record ID number, question number for the change and the change to be made. Changes will be made during data cleaning, after data collection has closed. This means, changes requested will not be viewable in the data you download.

All data must be submitted by 21 September. Following this we will ask you to view and check your cases, and we may send you some data queries.
Guidance for questions

Guidance to individual questions is provided in the tool. Supplementary guidance is below. If you need any further guidance before answering a question, please contact the project team (see page 3).

Primary diagnosis/cause of admission (Q6)

This will be the main reason for admission and treatment. If more than one primary reason is given, enter all.

Fast track discharge (Q9)

Terms in use may vary, but this question is intended to identify those patients where discharge was expedited under an agreed local procedure geared to the best interests of the patient – patients in these circumstances may have had their usual discharge assessment and write ups in the community.

It does not refer to patients discharged before expected assessments and arrangements for other reasons, e.g. operational.

Assessment questions (General)

Please note that details of assessments may be found in nursing and therapy notes, as well as in medical notes. MDT assessment may have been carried out on or after admission, i.e. once the patient becomes well enough.

If there has been no intention to carry out the assessment at any point during the admission and there is no discernible reason, then “No” should be answered.

Cognitive assessment (Q20)

Answer this in relation to validated instruments recommended for cognitive testing – see link in tool for NICE guidance.

Screening or initial assessment for delirium (Q21) and Healthcare professional assessment for delirium (Q22)

Please note: these questions have been reworded and restructured since Round 3, based on feedback from hospitals taking part in Round 3 and the spotlight module on delirium assessment and recording (carried out in 2017).

Please contact the Project Team if you are unclear on how to answer these two questions.
**Initial screening assessment (Q21)**

Q21 asks about any initial screening assessments for delirium. A screening assessment may be undertaken by any (qualified or unqualified) healthcare staff.

If a screening assessment suggests no delirium present (Q21a), you will not be asked Q22. However, if the screening tool suggests there may be delirium present, you will be asked whether a healthcare professional, trained in diagnosing delirium, assessed the person for delirium.

You can use the “other” option to indicate other screening tools for delirium which you may use in your hospital.

**Assessment for delirium by a healthcare professional (Q22)**

In this round of audit, you will also be able to answer that no initial screening assessment took place, but a healthcare professional did complete an assessment for delirium (i.e. you can answer no to Q21 and still answer Q22). This can be used to indicate for example where a healthcare professional suspected delirium (without use of a screening tool) and went straight to undertaking an assessment to establish whether delirium was present or not.

In Q22, you may use the “other” option to indicate other tools which may have been used in a diagnosis. This option can also be used to indicate “clinical judgement” where a healthcare professional, trained in diagnosing delirium, reviewed the results of the screening assessment and diagnosed (or confirmed no delirium) using their experience and by talking to the patient.

**4AT in Q21 and 22**

The 4AT tool has been included in both the screening assessment question and the assessment by a healthcare professional to reflect the fact that hospitals use the 4AT in both situations.

If the 4AT was completed once by a healthcare professional (trained in diagnosing delirium) to establish the presence of delirium, you should answer no to Q21 (if no other screening took place) and 4AT to Q22. If it was completed initially by one member of staff, and then additionally by a healthcare professional trained in diagnosing delirium, you should answer 4AT to both Q21 and Q22.

Delirium screening or assessment (in the case that the screening stage is skipped, see Q22 above) will be taken into account in the overall assessment score.

**Information: Response option “Unknown” is provided in this round (Q23a-23f)**

This can be answered where it is expected that the information was collected but the document is returned to the patient on discharge and a copy is not kept with the notes.
**Consent and capacity (Q28a)**

This question looks at consent and capacity in the case of referral to a social worker regarding a proposed change in residence after discharge. Response options are based on whether the patient’s consent was gained, or whether capacity to consent was assessed and correct procedure followed (information on NHS website). You do not need to access social care notes to answer this question, as it is concerning the referral to a social worker, and not the outcome of the meeting.

**Quality assurance in the casenote audit**

Quality assurance for the casenote audit is provided through inter-rater reliability checking (see sampling guidance document on the website) and additionally through random quality assurance visits. These visits will be to five randomly selected sites following the close of data submission. They will be carried out by a clinician, plus a member of the Project Team. During the visit, a limited number of audit items in a small, randomly selected sample of records audited will be compared with the data return.

This measure provides additional assurance of audit validity, and also serves to provide insight into any difficulties that exist in accessing data for an audit of this kind, for reflection in reporting and future audit.

You will find comment boxes provided at the end of each section. These can be used for any clarifications or queries you have about your responses. During data cleaning, we may contact you if any further information is needed about these comments.