

National Audit of Dementia

Audit of Casenotes

Fourth round of audit

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 2018 to 30th April 2018. The sample must be drawn from consecutive discharges. Please see guidance about what to do when a casenote is not eligible. The minimum number of 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, after the sample has been selected and numbered according to date order of discharge. **NB** Once you have identified your sample correctly, it does not matter in which order they are entered. 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 2707 or 020 3701 2681.

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:

- | | |
|--|--|
| <input type="checkbox"/> White/White British | <input type="checkbox"/> Asian/Asian British |
| <input type="checkbox"/> Black/Black British | <input type="checkbox"/> Mixed |
| <input type="checkbox"/> Not documented | <input type="checkbox"/> Other |

4. Select the first language of the patient:

- | | |
|--|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Welsh |
| <input type="checkbox"/> Other European Language | <input type="checkbox"/> Asian Language |
| <input type="checkbox"/> Not Documented | <input type="checkbox"/> Other |

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

- | | |
|--|---|
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Care of the Elderly |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> General Medical |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Obstetrics/Gynaecology |
| <input type="checkbox"/> Oncology | <input type="checkbox"/> Orthopaedics |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Surgical |
| <input type="checkbox"/> Other Medical | <input type="checkbox"/> Other – please specify |

6. What is the primary diagnosis/cause of admission?

E.g. Fractured femur, stroke

6a. Please say whether this is an emergency or elective admission:

- | |
|------------------------------------|
| <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Elective |

7. Did the patient die while in hospital?

- | |
|------------------------------|
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> No |

8. Did the patient self-discharge from hospital?

- | |
|------------------------------|
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> No |

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

- | |
|------------------------------|
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> No |

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

- | |
|------------------------------|
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> 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 01/04/2018 and 30/04/2018.

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 casenote.

- | | |
|---|--|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Rehabilitation ward | <input type="checkbox"/> Psychiatric ward |
| <input type="checkbox"/> Carer's home | <input type="checkbox"/> Intermediate/community rehabilitation care |
| <input type="checkbox"/> Residential care | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Palliative care | <input type="checkbox"/> Transfer to another hospital |
| <input type="checkbox"/> 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 casenote.

- | | |
|---|--|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Rehabilitation ward | <input type="checkbox"/> Psychiatric ward |
| <input type="checkbox"/> Carer's home | <input type="checkbox"/> Intermediate/community rehabilitation care |
| <input type="checkbox"/> Residential care | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Palliative care | <input type="checkbox"/> Transfer to another hospital |
| <input type="checkbox"/> Long stay care | |

Do you have any comments to make on Section 1: Information about the patient? (optional)

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. dietitian.

- 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? (Tick all that apply).

- 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? (optional)

COGNITIVE ASSESSMENT

NB Before answering this section, please look at the separate question guidance document

20. Has cognitive testing, using a validated structured instrument, been carried out?

For example, AMTS, or other validated brief structured cognitive instrument. See <https://www.nice.org.uk/guidance/GID-CG WAVE0792/documents/full-guideline-updated> (summary of recommendations p. 29).

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

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).

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>

- Single Question in Delirium (SQiD) ⇒ Go to 21a
- History taken from someone who knows the patient well in which they were asked about any recent changes in cognition/behaviour ⇒ Go to 21a
- 4AT ⇒ Go to 21a
- Other, please specify: ⇒ Go to Q21a
- No ⇒ Go to 22

21a. If Yes:

- Initial assessment above found evidence that delirium may be present ⇒ Go to Q22
- Initial assessment above found no evidence of delirium ⇒ Go to Q23

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 ⇒ Go to Q22a
- Confusion Assessment Method (CAM) - short or long form ⇒ Go to Q22a
- Other, please specify: ⇒ Go to Q22a
- No assessment for delirium was carried out by a healthcare professional ⇒ Go to Q23

22a. From this assessment(s), was a diagnosis of delirium confirmed?

- Yes
- No

Do you have any comments to make on cognitive assessment? (optional)

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).

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 [⇒ Go to Q23a](#)
- No [⇒ Go to Section 3](#)

23a. 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

23b. 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

23c. 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

23d. 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

23e. 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

23f. 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? (optional)

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 ward"

ASSESSMENT BEFORE DISCHARGE

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

24. At the point of discharge, was cognitive testing, using a validated structured instrument carried out?

For example, AMTS, or other validated brief structured cognitive instrument, see

<https://www.nice.org.uk/guidance/GID-CG WAVE0792/documents/full-guideline-updated> (summary of recommendations p. 29).

- Yes **⇒ Go to 25**
- No **⇒ Go to 24a**

24a. Why was this not completed?

- Patient too unwell (including advanced dementia making assessment inappropriate)
- Not documented/unknown
- Other, please specify

25. 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

26. Have there been any symptoms of delirium at any time during this admission?

Answer "Yes" if symptoms present during admission are noted.

Answer "No" if there is no record of any symptoms.

- Yes [⇒ Go to Q26a](#)
- No [⇒ Go to Q27](#)

26a. Has the presence of delirium been noted in discharge correspondence?

- Yes
- No

27. 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 of any symptoms.

- Yes [⇒ Go to Q27a](#)
- No [⇒ Go to Q28](#)

27a. Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?

This includes details of future assessment/management.

- Yes
- No

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 [⇒ Go to Q28a](#)
- No [⇒ Go to Q28b](#)
- N/A (no change in residence was proposed) [⇒ Go to Q28b](#)

28a. If yes...

*N.B. This question asks whether the person consented to the **referral** to a social worker to discuss a proposed change in residence. It does not ask whether the person consented to the proposed change in residence itself, which may only be available in social care notes.*

There are documented concerns about the patient's capacity to consent to the referral and...	There are no documented concerns about the patient's capacity to consent to the referral and...
The patient had capacity on assessment and their consent is documented	<input type="checkbox"/> The patients consent was requested and this is recorded <input type="checkbox"/>
The patient lacked requisite capacity and evidence of a best interests decision has been recorded	<input type="checkbox"/> There is no record of the patient's consent <input type="checkbox"/>
There is no record of either consent or best interest decision making	<input type="checkbox"/>

28b. Do you have any comments to make on Q28? (optional)

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

DISCHARGE COORDINATION AND MDT INPUT

29. 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 **⇒ Routes out Questions 31, 32, 33, 34**

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?

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

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?

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

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?

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

- Yes
- No

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?

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

- Yes
- No

31. 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

32. 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.

- Yes
- No

33. 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

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

- Yes
- No

Do you have any comments to make on discharge co-ordination and MDT input?

35. 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 Q36](#)
- No [⇒ Go to Q36](#)
- N/A [⇒ Go to Q35a](#)

35a. Please select the recorded reason why discharge planning could not be initiated within 24 hours:

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

SUPPORT FOR CARERS AND FAMILY

36. 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.

- | | |
|---|---|
| <input type="checkbox"/> Less than 24 hours | <input type="checkbox"/> 24 hours |
| <input type="checkbox"/> 25 – 48 hours | <input type="checkbox"/> More than 48 hours |
| <input type="checkbox"/> No notice at all | <input type="checkbox"/> No carer, family, friend |
| <input type="checkbox"/> Not documented | <input type="checkbox"/> Patient specified information withheld |

37. 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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