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**National Audit of Dementia**

**Information on the content of delirium screening and assessment**

**Spotlight audit 2017**

**Background**

The purpose of this spotlight audit is to collect information about the interpretation of questions included in the National Audit of Dementia casenote audit on delirium screening and delirium assessment. The audit will examine how this is interpreted for people with dementia discharged from hospital during April 2017. Patients should be identified using ICD10 coding. Please see guidance document Appendix B for codes.

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

**Patient Sample**

The patient sample is drawn from a long list of patients identified as having dementia discharged during the period 1st April 2017 to 30th April 2017, following an **emergency** (non-elective) admission. Please see guidance about what to do when a record is not eligible. Each hospital is expected to submit a sample of the first 20 patients to be discharged. If you have less than 20 eligible records, please contact the project team.

**Entering the data**

Data from each patient record should be entered individually, and may be entered in any order, as long as numbered in order of discharge. Please see the guidance document.

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**

**Was this patient admitted as an emergency/ non elective patient?**

**🞏 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 casenotes for audit. If a case note is a data reliability check please add 'Rel' at the end of the number. For example, if you are re-auditing casenote 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 casenotes for data reliability check*

*If this casenote is one of the five casenotes 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*](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 🞏 Asian/Asian British**

**🞏 Black/Black British 🞏 Chinese**

**🞏 Mixed 🞏 Not documented**

**🞏 Other**

**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 🞏 Care of the Elderly**

**🞏 Critical Care 🞏 General Medical**

**🞏 Nephrology 🞏 Obstetrics/Gynaecology**

**🞏 Oncology 🞏 Orthopaedics**

**🞏 Stroke 🞏 Surgical**

**🞏 Other Medical 🞏 Other – please specify:**

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**6. Did the patient die while in hospital?**

**🞏 Yes**

**🞏 No**

**7. Did the patient self-discharge from hospital?**

**🞏 Yes**

**🞏** **No**

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

**🞏 Yes**

**🞏** **No**

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

**🞏 Yes**

**🞏 No**

**10. What was the date of admission and the date of discharge?**

*Please enter in DD/MM/YYYY format. The discharge date should fall between 01/04/2017 and 30/04/2017.*

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

\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_

***Admission date:***

\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_

***Discharge date:***

**11. 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**

**Q12 is not applicable if Q6 = “Yes” (the patient died)**

**12. 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? (Optional)***

**SECTION 2A: *Delirium screening or assessment***

**13. What is the primary diagnosis/cause of admission?**

*E.g. Fractured femur, stroke - this will be the main reason for admission and treatment. If more than one* ***primary*** *reason is given, enter all.*

**14. Was delirium or acute confusion recorded during the initial presentation or within 24 hours of admission?**

**🞏 Yes**

**🞏 No**

**15. At or within 24 hours of admission, 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*](http://www.nice.org.uk/cg103)

🞏 **Yes, and there were indications that delirium may be present ⇒ Go to Q16**

🞏 **Yes, but there was no indication that delirium may be present ⇒ Go to Section 2B**

🞏 **No assessment has been carried out ⇒ Go to Section 2B**

**16. 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*](http://www.nice.org.uk/cg103)

🞏 **Yes**

🞏 **No**

**16a. If yes, please indicate timescale from admission:**

🞏 **Within 2 hours** 🞏 **Within 24 hours**

🞏 **Within 48 hours** 🞏 **Within 72 hours**

🞏 **Longer** 🞏 **Uncertain/Don’t know**

***Do you have any comments to make on Section 2A, delirium screening/ assessment? (Optional)***

**SECTION 2B: *Details of assessments carried out***

**At admission or within 24 hours of admission, please indicate whether there is evidence in the notes of any of the following. NB. Please answer yes if tests/ investigations were undertaken within 24 hours, even if the results were not available within this time period.**

**17. Was the Single Question in Delirium (SQiD: *Do you think [name of patient] has been more confused, sleepy or drowsy lately?*' (or a similar question regarding onset of behavioural change) asked?**

*See e.g. Healthcare Improvement Scotland* [*Delirium Toolkit*](http://www.healthcareimprovementscotland.org/our_work/person-centred_care/opac_improvement_programme/delirium_toolkit.aspx)

🞏 **Yes**

🞏 **No 🞏 Uncertain/Don’t know**

**18. Was a corroborative history obtained from someone who knows the patient well (i.e. information obtained from family or carers)?**

🞏 **Yes ⇒ Go to 19** 🞏 **Yes, BUT unsure when undertaken ⇒ Go to 19**

🞏 **No ⇒ Go to 19 🞏 Yes BUT not within 24 hours of admission ⇒ Go to 18a**

🞏 **Uncertain/Don’t know**

**18a. If yes but not within 24 hours of admission, how many hours after admission was this done?**

**19. Was a standardised confusion assessment method such as a CAM or 4AT undertaken?**

🞏 **Yes ⇒ Go to 20** 🞏 **Yes, BUT unsure when undertaken ⇒ Go to 20**

🞏 **No ⇒ Go to 20 🞏 Yes BUT not within 24 hours of admission ⇒ Go to 19a**

🞏 **Uncertain/Don’t know**

**19a. If yes but not within 24 hours of admission, how many hours after admission was this done?**

**20. Was a standardised cognitive test (such as AMTS, AMT4 or similar) undertaken?**

🞏 **Yes ⇒ Go to 21** 🞏 **Yes, BUT unsure when undertaken ⇒ Go to 21**

🞏 **No ⇒ Go to 21 🞏 Yes BUT not within 24 hours of admission ⇒ Go to 20a**

🞏 **Uncertain/Don’t know**

**20a. If yes but not within 24 hours of admission, how many hours after admission was this done?**

**21. Were any other cognitive tests, questions or assessment methods used during this initial period?**

🞏 **Yes ⇒ Go to 21b** 🞏 **Yes, BUT unsure when undertaken ⇒ Go to 21b**

🞏 **No ⇒ Go to 22 🞏 Yes BUT not within 24 hours of admission ⇒ Go to 21a**

🞏 **Uncertain/Don’t know**

**21a. If yes but not within 24 hours of admission, how many hours after admission was this done?**

**⇒ Go to 21b**

**21b.** **If yes,** **please say what these were:**

**22. Please indicate if any of the following investigations were undertaken at, or within 24 hours of, admission? (*Tick all that apply*)**

**Full Blood Count** 🞏

**Urea and electrolytes** 🞏

**Glucose** 🞏

**Liver function tests** 🞏

**Calcium level** 🞏

**C Reactive Protein**

*(or similar acute phase protein eg ESR)*🞏

**Blood cultures** 🞏

**Urinalysis/Mid Stream Urine Specimen** 🞏

**Chest X Ray** 🞏

**23. Was a full physical examination of the patient undertaken by a doctor at, or within 24 hours of, admission?**

🞏 **Yes ⇒ Go to Q23a**

🞏 **No ⇒ Go to 24**

**23a. If yes, which of** **the following systems were fully examined? (*Tick all that apply*)**

**Cardiac** 🞏

**Respiratory** 🞏

**Abdominal** 🞏

**Neurological** 🞏

**24. *Do you have any comments on the physical assessments performed with regard to assessment of delirium? (Optional)***

**25. Is there a nursing plan for delirium/ pathway for delirium in the notes?**

🞏 **Yes**

🞏 **No**

**26. Was the patient assessed for constipation as a possible cause of delirium at or within 24 hours of admission?**

🞏 **Yes**

🞏 **No**

**27. Was the patient assessed for pain as a possible cause of delirium, at or within 24 hours of admission?**

🞏 **Yes**

🞏 **No**

**28. Was a standardised cognitive test (such as AMTS, AMT4 or similar) repeated before the patient was discharged from hospital?**

🞏 **Yes**

🞏 **No**

🞏 **N/A – not done at any point of the admission**

**29. Was delirium or acute confusion during the initial presentation or within 24 hours of admission recorded on the discharge letter or summary?**

**🞏 Yes**

**🞏 No**

**🞏 N/A – no delirium or acute confusion**

**30. Whereabouts in the casenotes did you find the information to complete this audit form *(tick all that apply):***

**🞏 Nursing notes**

**🞏 Medical notes**

**🞏 Single electronic record and attachments**

**🞏 Other**

**If other,** **please specify**

**31. Once you had completed the whole form, did you want to change either of your answers to questions 15 and/or 16?**

**🞏 No**

**🞏 Yes, but I have left them unchanged ⇒ Go to comment box**

**🞏 Yes, I made changes ⇒ Go to comment box**

**PLEASE TELL US which questions you changed/ wanted to change**

***Do you have any further comments to make on Section 2: Details of assessments carried out? (Optional)***