National Audit of Dementia
Audit of Casenotes
Pilot audit 2021

Thank you for participating in the National Audit of Dementia pilot.

For the next part of the pilot you will be submitting casenote audit data via the new platform CaseCapture on Netsolving. The NAD team have created a comprehensive guidance document which you should have received via email outlining how to find your sample, navigate the data collection tool and submit data for the pilot. If you have not received this or have any queries please contact nad@rcpsych.ac.uk.

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

At the end of each record you will find a comment box. Use this to make any further comments on your answers to the questions.

1. Has the patient been in hospital for 24 hours or longer?

This includes the date of admission. If the patient has NOT been in hospital for 24 hours or longer, they are not eligible for audit.

☐ **Yes**
☐ **No**

SECTION 1: DEMOGRAPHICS & ADMISSION

1.2 Age at admission

To calculate age using date of birth, you can use this website: http://www.mathcats.com/explore/age/calculator.html

1.3 Gender:

☐ **Male**
☐ **Female**
☐ **Non-binary/Other**
☐ **Unknown/Not documented**

1.4 Ethnicity:

☐ **Asian or Asian British (Includes any Asian background, e.g. Bangladeshi, Chinese, Indian, Pakistani)**
☐ **Black African, Black British or Caribbean (Includes any Black background)**
☐ **Mixed or multiple ethnic groups (includes any mixed background)**
☐ **White (includes any White background**
☐ **Other (includes any other ethnic background, e.g. Arab)**
☐ **Unknown/Not documented**

1.5 First Language:

☐ **English**	☐ **Welsh**
☐ **Other European Language**	☐ **Any Asian Language**
☐ **Unknown/Not Documented**	☐ **Other**

1.6 Date of admission:

1.7 Primary diagnosis/ cause of admission?

☐ **Cancer**
☐ **Cardiac/vascular/chest pain**
☐ **Dehydration/nutrition**
☐ **Delirium/confusion/ cognitive impairment**
☐ **Dementia**
☐ **Endocrine/metabolic condition**
☐ **Fall**
☐ **Gastrointestinal**
☐ **Haematology related**
☐ **Hepatology/liver related**
☐ **Hip fracture/dislocation**
☐ **Other Fracture/dislocation**
☐ **Impaired consciousness/reduced responsiveness/drowsiness or dizziness**
☐ **Neurological problem/seizure/head injury/headache**
☐ **Psychiatric/psychological/behavioural problems**
☐ **Respiratory**
☐ **Sepsis**
☐ **Skin problems/lacerations/lesions**
☐ **Stroke or related**
☐ **Surgical/non-surgical procedure**
☐ **Urinary/urogenital/renal**
☐ **Unable to cope/frailty**
☐ **Other – please specify**
☐ **Unknown/not documented**

a. Other details

1.8 Please say whether this is an emergency or elective admission:

- ☐ **Emergency**
- ☐ **Elective**

1.9 Was delirium noted as part of the admitting condition?

- ☐ **Yes**
- ☐ **No**

1.10 Dementia status:

- ☐ **Known dementia**
- ☐ **Concerns about cognition**

1. What is the subtype of dementia?

- ☐ **Alzheimer's Disease (F00, G30)**
- ☐ **Dementia in Alzheimers disease, atypical or mixed type (F00.2)**
- ☐ **Vascular Dementia (F01)**
- ☐ **Dementia with Lewy bodies (G31.9)**
- ☐ **Fronto-temporal Dementia (G31.8)**
- ☐ **Dementia in Parkinson's disease (F02.3)**
- ☐ **Delirium due to known psychological condition, including delirium superimposed on dementia**
- ☐ **Unspecified dementia (F03)**
- ☐ **Dementia subtype unknown/not documented**

1.11 Place in which the person was living or receiving care before admission

- ☐ **Own home**
- ☐ **Rehabilitation ward**
- ☐ **Carer's home**
- ☐ **Residential care**
- ☐ **Palliative care**
- ☐ **Long stay care**
- ☐ **Respite care**
- ☐ **Psychiatric ward**
- ☐ **Intermediate/community rehabilitation care**
- ☐ **Nursing home**
- ☐ **Transfer to another hospital**

1.12 On the date of submission, what ward/unit is the person admitted to?

- ☐ **Care of the elderly**
- ☐ **Cardiac**
- ☐ **Critical care**
- ☐ **General medical**
- ☐ **Nephrology**
- ☐ **Obstetrics/gynaecology**
- ☐ **Oncology**
- ☐ **Orthopaedics**
- ☐ **Stroke**
- ☐ **Surgical**
- ☐ **Other medical**
- ☐ **Other**

a. (if other) please specify

1.13 At the point of discharge was the patient based on the right ward for the responsible consultant specialty?

- ☐ Yes
- ☐ No

SECTION 2: SCREENING and diagnosis of delirium

2.1 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

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

i. Other details

2.2 Please enter the date of the first assessment identified above

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

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

(if delirium may be present):

2.4 Was a diagnosis of delirium confirmed?

- ☐ **Yes, the patient was diagnosed with delirium**
- ☐ **No, it was confirmed that the patient did not have delirium**

(if delirium diagnosis confirmed):

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

- ☐ **Yes**
- ☐ **No**

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

- ☐ **Yes**
- ☐ **No**

SECTION 3: PAIN

3.1 Has the patient been assessed for the presence of any pain?

- ☐ **Yes**
- ☐ **No**

a. Enter the date of the pain assessment

b. What pain assessment tool was used?

- ☐ **The Abbey Pain scale**
- ☐ **Pain assessment in advanced dementia (PAINAID)**
- ☐ **Checklist of nonverbal pain indicators (CNPI) observation score**
- ☐ **None**
- ☐ **Other**

i. (if other) Please specify

3.2 Was pain reassessed?

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

i. Date pain was first reassessed?

SECTION 4: DISCHARGE

4.1 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

4.2 Has an expected date of discharge been recorded?

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

4.3 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**

4.4 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**
- ☐ **Patient presenting confusion**
- ☐ **Patient on end of life plan**
- ☐ **Patient transferred to another hospital**
- ☐ **Patient unresponsive**
- ☐ **Patient being discharged to nursing/ residential care**
- ☐ **Other (please specify)**
- ☐ **No reason recorded**

i. Other details

4.5 Has the patient been discharged?

- ☐ **Yes**
- ☐ **No, the patient died**
- ☐ **No, still an inpatient**

4.6 Date of discharge

4.7 Place in which the person was living or receiving care after discharge

- ☐ **Own home**
- ☐ **Respite care**
- ☐ **Rehabilitation ward**
- ☐ **Psychiatric ward**
- ☐ **Carer's home**
- ☐ **Intermediate/Community rehabilitation care**
- ☐ **Residential care**
- ☐ **Nursing home**
- ☐ **Palliative care**
- ☐ **Transfer to another hospital**
- ☐ **Long stay care**

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

- ☐ **Yes**
- ☐ **No**

4.9 Do you have any additional comments about the data submitted and/or the tool?

If you have any queries, please contact the project team

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