National Audit of Dementia
Audit of Casenotes 2022
ASSESSMENT AND PLANNING

Thank you for participating in the National Audit of Dementia.
For this audit 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 audit. If you have not received this or have any queries please contact nad@rcpsych.ac.uk.

This is Part TWO of the casenote audit. For this part of the audit you will take patients consecutively admitted to your hospital over the 6 March – 5 April and submit information about assessment and planning. Deadline for all data entry for Part Two is 29 May. Your Part One data must also be completed by this deadline

*If you are collecting additional data in the flex period, your sample size is dependent on how many you have entered for the autumn period. Typically you will be adding 40 patients (if you have 40 in autumn) or 20 patients (if you have 60). Smaller hospitals may be aiming for a smaller overall total of 50-60.

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

2.1 Audit allocated ID number [must be as previously entered]

SCREENING and diagnosis of delirium

2.2 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)
o Yes, within 24 hours of admission
o Yes, more than 24 hours after admission
o No

b. History taken from someone who knows the patient well in which they were asked about any recent changes in cognition/behaviour
o Yes, within 24 hours of admission
o Yes, more than 24 hours after admission
o No

c. 4AT (Rapid Clinical Test for delirium)
o Yes, within 24 hours of admission
o Yes, more than 24 hours after admission
o No

d. CAM (Confusion Assessment Method)
o Yes, within 24 hours of admission

o Yes, more than 24 hours after admission
o No

e. OSLA
o Yes, within 24 hours of admission
o Yes, more than 24 hours after admission
o No

f. Other (please specify)
o Yes, within 24 hours of admission
o Yes, more than 24 hours after admission
o No

i. Other details

2.3 Please enter the date of the first assessment identified above

2.4 Did the initial assessment selected above find evidence that delirium may be present?
o Yes, delirium may be present
o No evidence of delirium

(If found that delirium may be present):

2.5 Was a diagnosis of delirium confirmed?
o Yes, the patient was diagnosed with delirium
o No, it was confirmed that the patient did not have delirium
o No, no further investigation took place

(If delirium diagnosis confirmed):

2.6 Was a management plan (for investigation and treatment) for delirium put in place?
o Yes
o No

2.7 Was a care plan (for nursing care) for delirium put in place?
o Yes
o No

PAIN ASSESSMENT

2.8 Has the patient been asked about, and/or has there been an assessment for presence of pain?
o Yes, within 24 hours of admission
o Yes, more than 24 hours after admission
o No
o Could not be assessed for recorded reasons

a. (if yes) Enter the date of the pain assessment

b. (if yes) What pain assessment tool was used:

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

i.(If other) Please specify

2.9 Was pain reassessed?

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

a.Date pain was first reassessed?

b. (if yes) Was this using:

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

i(If other) Please specify

DISCHARGE PLANNING

2.10 Were the required actions to prepare for discharge identified?

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

a. Please give the date that you began to identify these actions

2.11 Has an expected date of discharge been recorded?

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

2.12Was a named member of staff (nurse/consultant/discharge coordinator) or named team responsible clearly identified to coordinate discharge?

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

2.13 If the discharge planning was not initiated within 24 hours of admission, please select the recorded reason why?

- **o** Patient acutely unwell
- o 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

END OF PART TWO