



Irish National Audit of Dementia (care in general hospitals)

AUDIT OF CASE NOTES

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 first 30 consecutive cases discharged from the hospital between 01/07/2012 and 31/12/2012 that meet the following criteria:

1. Have a diagnosis of dementia. Note, the patient may have a diagnosis coded at any level, i.e. primary, secondary or subsidiary, or identified as having a current history of dementia (see [guidance document](#) for list of HIPE codes)
2. Have stayed at the hospital for at least 5 days.

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.

Adapted from the UK National Audit of Dementia, with permission: Copyright HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP, HQIP 2012

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 audit co-ordinator on 086 0285359

Has the patient been in hospital for 5 days or longer?

This includes the date of admission. If the patient has NOT been in hospital for 5 days or longer, they are not eligible for audit.

- Yes**
- No** ⇒ **This case note is not eligible and you cannot continue**

Enter number for this patient:

*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 5rel.*

Has this case note 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 Irish | <input type="checkbox"/> Any Other White Background |
| <input type="checkbox"/> Black | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Mixed Race | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Not documented | <input type="checkbox"/> Other Ethnic Group |

4. Select the first language of the patient:

- | | |
|--|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Irish |
| <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 Unit | <input type="checkbox"/> Surgical |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Intensive Care Unit |
| <input type="checkbox"/> Psychiatry of Old Age | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Palliative Care Bed |
| <input type="checkbox"/> Acute Medical Assessment Unit | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other Medical | |

6. Did the patient die whilst in hospital?

- Yes
- No

7. Did the patient self-discharge from hospital?

- Yes**
- No**

8. Was the patient receiving end of life care/on an end of life care pathway?

- Yes**
- No**

9. What was the date of admission and the date of discharge?

Please enter in DD/MM/YYYY format. The discharge date should fall between 01/07/2012 and 31/12/2012.

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

Admission date: / /

Discharge date: / /

(or date of death if the patient died whilst in hospital)

10. 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.

- | | |
|--|--|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Rehabilitation Unit | <input type="checkbox"/> Psychiatric ward |
| <input type="checkbox"/> Residential Care/Nursing Home/Community Hospital | <input type="checkbox"/> Palliative care |
| <input type="checkbox"/> Carer's home | <input type="checkbox"/> Transitional care |
| <input type="checkbox"/> Convalescent Care | <input type="checkbox"/> Transfer from another hospital |

Q11 is not applicable if Q6 = "Yes" (the patient died)

11. 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.

- | | |
|--|--|
| <input type="checkbox"/> Own home | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Rehabilitation Unit | <input type="checkbox"/> Psychiatric ward |
| <input type="checkbox"/> Residential Care/ Nursing Home/ Community Hospital | <input type="checkbox"/> Palliative care |
| <input type="checkbox"/> Carer's home | <input type="checkbox"/> Transitional care |
| <input type="checkbox"/> Convalescent Care | <input type="checkbox"/> Transfer to another hospital |

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

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.

12. Has the patient's mental health history been recorded - dementia or other conditions or symptoms?

Answer "Yes" if dementia or other conditions or symptoms (e.g. Alzheimer's disease, depression, memory problems, psychiatric disorder) are recorded as Mental Health History (or past psychiatric history, etc), or under past patient medical history.

Answer "No" if left blank

Answer "N/A" if section for mental health history is marked N/A and patient had not been diagnosed before this admission.

- Yes**
- No**
- N/A**

COMPREHENSIVE ASSESSMENT OF THE OLDER PERSON (COMPREHENSIVE GERIATRIC ASSESSMENT)

Also known as Comprehensive Geriatric Assessment. This 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 or during pre-admission assessment.

NB elements of assessment may be found in medical and in other notes, e.g. nursing assessment, OT assessment, or sometimes Social Worker interview, e.g. financial assessment, carer input.

MULTIDISCIPLINARY ASSESSMENT

13. The multidisciplinary assessment includes problem list:

- Yes
- No

14. The multidisciplinary assessment includes comorbid conditions:

Answer "N/A" if it was recorded that there were no comorbid conditions.

- Yes
- No
- N/A

15. The assessment includes a record of current medication, including dosage and frequency:

- Yes, there is a record of current medication that was being taken
- Yes, there is a record that no medication was being taken
- No record

16. 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.
Answer "N/A" if this could not be assessed for recorded reasons.

- Yes
- No
- N/A

17. An assessment of nutritional status was performed by a healthcare professional:

Assessment carried out by a doctor, nurse or other qualified professional, e.g. dietician. Answer "N/A" if this could not be assessed for recorded reasons.

- Yes** ⇒ **Go to Q17a**
- No** ⇒ **Go to Q18**
- N/A** ⇒ **Go to Q18**

17a. The assessment of nutritional status includes recording of BMI (Body Mass Index) or weight:

Answer "N/A" if this could not be assessed for recorded reasons, e.g. patient too unwell.

- Yes, there is a recording of the patients/ BMI or weight**
- No, there is no recording of the patients' BMI or weight**
- N/A**

17b. The assessment of nutritional status includes identification of any help needed with eating/drinking.

- Yes**
- No**

17c. If help needed with eating/drinking is identified, is this recorded in the care/management plan?

- Yes**
- No**

18. Has a formal pressure sore risk assessment been carried out and score recorded?

This should be assessment using a standardised instrument such as Waterlow.

- Yes**
- No**

19. 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) Answer "N/A" if this could not be assessed for recorded reasons.

- Yes**
- No**
- N/A**

20. As part of the multidisciplinary assessment has the patient been asked about the presence of any pain?

Answer "Yes" where the notes show that there has been an enquiry about any pain and response recorded.

Answer "N/A" if this could not be assessed for recorded reasons.

- Yes**
- No**
- N/A**

21. Has an assessment of functioning, using a standardised assessment, been carried out?

This should be assessment using a standardised instrument such as Barthel or other instrument. Answer "Yes" where this has been carried out and a score recorded.

- Yes**
- No**

MENTAL STATE ASSESSMENT

22. Has a standardised mental status test been carried out?

This should be assessment using a standardised instrument such as MMSE, AMT.

Answer "N/A" if this could not be assessed for recorded reasons.

- Yes**
- No**
- N/A**

23. Has a collateral/witness history been recorded indicating:

- | | | |
|---|-------------------------------------|------------------------------------|
| a) Confirmation of cognitive decline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Time since onset of memory problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Nature of progression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Evidence of loss of function | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

24. 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 (for example, as 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>)

- Yes, and there were indications that delirium may be present** ⇒ **Go to Q24a**
- Yes, but there was no indication that delirium may be present** ⇒ **Go to Q24b**
- No assessment has been carried out** ⇒ **Go to Q24b**

24a. 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>

- Yes**
- No assessment has been carried out**

24b. Has an assessment been carried out for recent changes in mood?

- Yes**
- No**

24c. Has an assessment been carried out for recent changes that may indicate the development of behavioural and psychological symptoms of dementia (BPSD)?

- Yes**
- No**

SOCIAL AND ENVIRONMENTAL ASSESSMENT

To answer the following questions on social and environmental assessment, you may need to access social worker notes.

25. Has a need for care assessment by a social worker been identified?

- Yes** **Go to 25a**
- No** ⇒ **Go to Q26**
- Already receiving input from a social worker** ⇒ **Go to Q26**
- Cannot get hold of this information** ⇒ **Go to Q26**

25a. Has a care assessment by a social worker been requested?

- Yes** ⇒ **Go to Q25b**
- No** ⇒ **Go to Q26**

25b. Has a care assessment by a social worker been carried out?

- Yes** ⇒ **Go to Q25b1**
- No** ⇒ **Go to Q26**

25b1. Did the assessment include an assessment of support provided to the person "informally"

E.g. from carers, family, friends.

Answer "Yes" if details of such support are recorded or it is recorded that there is no such support being provided.

Answer "No" if this has not been assessed.

Answer "N/A" if notes state that the patient didn't need or refused such an assessment

- Yes**
- No**
- N/A**

25b2. Did the assessment include a formal care provision assessment?

E.g. from care agencies, community team input.

Answer "N/A" if notes state that the patient didn't need or refused such an assessment, or information is already known and present in notes.

- Yes**
- No**
- N/A**

25b3. Did the assessment include a financial support assessment?

E.g. relevant disability benefits or other available support in place, or referral made to support/social worker to carry out such assessment (including assessment for carer's allowance, medical card etc).

Answer "N/A" if notes state that the patient didn't need or refused such an assessment, or information is already known and present in notes.

- Yes**
- No**
- N/A**

25b4. Did the assessment include a home safety assessment?

E.g. information requested from patient, relative, carer or GP regarding environment risk factors; request for OT follow up if required.

Answer "N/A" if notes state that the patient didn't need or refused such an assessment, information is already known and present in notes.

- Yes**
- No**
- N/A**

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. **NB** 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).

26. 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 Q26a**
- No** ⇒ **Go to Q27**

26a. 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 "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- Yes**
- No**
- N/A**

26b. 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 "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- Yes**
- No**
- N/A**

26c. 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 "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- Yes**
- No**
- N/A**

26d. 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 "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

- Yes**
- No**
- N/A**

26e. Has information been collected about the patient regarding details of 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 "Yes" if there is no carer/relative/friend and information is not available and recorded as such.

- Yes**
- No**
- N/A**

Q27 is only applicable if Q11 = Own home OR carer's home

27. Has information about support on discharge been given to the patient and/or the carer?

This is the local hospital information leaflet explaining the normal arrangements for discharge, follow up where required, what the patient and/or their carers need to do and what notice, support and advice they can expect.

Answer "No" if this is not recorded/not known.

- Yes**
- No**

DISTRESS, AGITATION AND BEHAVIOUR THAT CHALLENGES

The purpose of this section is to look at whether, and how, antipsychotics are used in managing symptoms of dementia. You may find information about the patient's medication on the on the drug chart or within the notes. See list below:

Antipsychotic drugs : Amisulpride, Aripiprazole, Asenapine, Benperidol, Chlorpromazine, Clozapine, Flupentixol, Fluphenazine, Haloperidol, Levomepromazine/methotrimeprazine, Olanzapine, Paliperidone, Pericyazine, Perphenazine, Pimozide, Prochlorperazine, Promazine, Quetiapine, Risperidone, Sertindole, Sulpiride, Trifluoperazine, Zotepine, Zuclopenthixol, Zuclopenthixol dihydrochloride. Please refer to BNF or MIMS for relevant drug trade names also.

28. Has this patient had antipsychotic drugs at any point during admission (whether or not prescribed in the hospital)?

This could be an existing prescription, a new prescription or via a PRN.

- Yes** ⇒ **Go to Q28a**
- No** ⇒ **Go to Comment box end of Section 2**
- Information cannot be found/drug chart missing** ⇒ **Go to Comment box end of Section 2**

28a. On admission, was the patient taking antipsychotics due to an existing regular prescription?

Answer "Yes" if up to the point of admission there was a prescription in place for an antipsychotic drug.

- Yes**
- No**
- Information cannot be found**

28b. Was a PRN prescription for antipsychotics in place for this admission?

Answer "Yes" if a PRN prescription has been put in place for use during the admission.

- Yes** ⇒ **Go to Q28b1**
- No** ⇒ **Go to Q28c**
- Information cannot be found** ⇒ **Go to Q28c**

28b1. Was an antipsychotic administered via PRN?

Answer "Yes" if an antipsychotic drugs have been administered under the PRN prescription.

- Yes**
- No**
- Information cannot be found**

28c. Was a new or additional prescription made for an antipsychotic?

Answer "Yes" where: an antipsychotic has been prescribed during the admission that is not regularly prescribed (other than PRN above) OR where an increased dosage has been prescribed of an antipsychotic regularly prescribed OR if any antipsychotic is prescribed and it is not known whether this is a new prescription.

- Yes**
- No**
- Information cannot be found**

Q29 + Q30a are only applicable if 28b1 = "Yes" OR 28c = "Yes"

29. Was a reason recorded for prescription of antipsychotics? Refer to medical record and drug prescription record.

- Yes** ⇒ **Go to Q29a**
- Not recorded in notes** ⇒ **Go to Comment box end of Section 2**

29a. What was the main or primary reason recorded for prescription of antipsychotics? *Tick one*

- Comorbid psychotic disorder
- Immediate risk of harm to self/others
- Severe distress not responsive to other intervention
- Need to carry out investigation and/or treatment and/or nursing care
- Agitation
- Anxiety
- Aggressive/threatening behaviour
- Disturbance through noise
- Disturbance through wandering, obsessive behaviour, mannerisms, tics
- Delirium
- Hallucinations
- Delusions
- End of life
- Depression/low mood
- Other

30. Was there more than one reason recorded for the prescription of antipsychotics?

- Yes ⇒ [Go to Q30a](#)
- No ⇒ [Go to Comment box end of Section 2](#)

30a. What are the other reasons recorded for prescription of antipsychotics?

Tick any that apply

- Comorbid psychotic disorder
- Immediate risk of harm to self/others
- Severe distress not responsive to other intervention
- Need to carry out investigation and/or treatment and/or nursing care
- Agitation
- Anxiety
- Aggressive/threatening behaviour
- Disturbance through noise
- Disturbance through wandering, obsessive behaviour, mannerisms, tics
- Delirium
- Hallucinations
- Delusions
- End of life
- Depression/low mood
- Other

Do you have any comments to make on Section 2: Assessment?

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 move onto Section 4:

Q6 = "Yes" (patient died in hospital)

Q7 = "Yes" (patient self-discharged from hospital)

Q8 = "Yes" (patient was receiving end of life/on end of life care pathway)

Q11 = "Transferred to another hospital" OR "Psychiatric ward" OR "Palliative Care" OR "Intermediate care" OR "Rehabilitation"

ASSESSMENT BEFORE DISCHARGE

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

31a. At the point of discharge the patient's level of cognitive impairment, using a standardised assessment, was summarised and recorded:

This should be a cognitive screen carried out subsequent to any carried out during initial assessment or pre-admission assessment, and whilst assessing readiness for discharge, e.g. MMSE, AMT. This includes discharge correspondance from nursing and medical staff.

- Yes**
- No**

31b. 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**

32. Have there been any symptoms of delirium?

This refers to symptoms noted during the admission.

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

Answer "no" if there is no record.

- Yes** ⇒ **Go to Q32a**
- No** ⇒ **Go to Q33**

32a. Have the symptoms of delirium been summarised for discharge?

- Yes**
- No**

33. 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.

- Yes** ⇒ **Go to Q33a**
- No** ⇒ **Go to Q34**

33a. Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?

- Yes**
- No**

Q34 is only applicable if Q28 = "Yes"

34. Is there any record in the discharge summary/notes that there is a prescription of antipsychotics that is being continued post discharge?

This refers to any antipsychotics the patient was taking whilst in hospital that were not stopped on discharge.

- Yes**
- No**

DISCHARGE COORDINATION AND MDT INPUT

35. Did a named person coordinate the discharge plan?

E.g. the person that coordinated the plan for this individual and signed it off.

- Yes**
- No**
- There is no discharge plan**

35a. Is there evidence in the notes that the discharge coordinator/person planning discharge has discussed appropriate 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**

35b. Is there evidence in the notes that the discharge coordinator/person planning discharge has discussed appropriate 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**

35c. Is there evidence in the notes that the discharge coordinator/person planning discharge has discussed appropriate 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**

35d. Is there evidence in the notes that the discharge coordinator/person planning discharge has discussed appropriate 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**

36. Has a single plan 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**

37. Are any support needs that have been identified documented in the discharge plan or 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. Answer "N/A" if no discharge plan or summary has been produced.

- Yes**
- No**
- N/A**

38. Has the patient and/or carer received a copy of the plan or 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/ 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/carer receives no information

- Yes**
- No**
- Unknown, information to answer this question is not available**

DISCHARGE PLANNING

39. Was discharge planning initiated within 24 hours of admission?

Answer "N/A" if there is a recorded reason why discharge planning could not be initiated within 24 hours of admission.

- Yes** ⇒ **Go to Q40**
- No** ⇒ **Go to Q40**
- N/A** ⇒ **Go to Q39a**

39a. 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 care |
| <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 |
| <input type="checkbox"/> Not recorded | |

SUPPORT FOR CARERS AND FAMILY

40. 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"/> 24 ± 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 | |

41. 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 Section 3: Discharge?

SECTION 4a: LIAISON PSYCHIATRY

This section is relevant to those patients who have been referred to a liaison psychiatry service during their stay.

42. Has any referral been made to psychiatric consultation/liaison?

Answer "No" if there was no referral made for this patient, or if the patient already had mental health input and so referral to the service was not necessary.

- Yes** ⇒ **Go to Q43**
- No** ⇒ **Go to Q42a**
- No liaison service available in the hospital** ⇒ **Go to Q42a**
- Not documented** ⇒ **Go to Comment box end of Section 4**

42a. Has any need for referral to liaison psychiatry been noted on admission or during further assessment?

- Yes**
- No**

42b. Has a follow up referral to community based mental health services been made on discharge?

Answer "N/A" is the patient is already in regular contact with community based mental health services, e.g. visited by outreach team, regularly attends appointments at a memory service.

- Yes** ⇒ **Go to Question 43**
- No** ⇒ **Go to Comment box end of Section 4**
- N/A** ⇒ **Go to Comment box end of Section 4**

43. Is it stated whether the referral was emergency, urgent or routine?

Guidance on the definitions in this question is drawn from the UK Psychiatric Liaison Accreditation Network Quality Standards for Liaison Psychiatry Services.

NB the use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge. If there is no indication of the level of urgency, select 'Not stated'.

- Emergency**
- Urgent**
- Routine**
- Not stated**

44. Please indicate time between admission and assessment:

This refers to the initial assessment (in the event that there has been more than one).

- | | |
|--|---|
| <input type="checkbox"/> Within 60 minutes | <input type="checkbox"/> Within 24 hours |
| <input type="checkbox"/> Within 24 - 48 hours | <input type="checkbox"/> Within 48 - 72 hours |
| <input type="checkbox"/> Within 72 - 96 hours | <input type="checkbox"/> Longer than 96 hours |
| <input type="checkbox"/> Not documented | <input type="checkbox"/> Patient died/was discharged |

45. What was the main reason given for referral? Tick only one

- Cognitive assessment or review/dementia
- Confusion
- Aggression/agitation/anxiety
- Delirium
- Depression/low mood
- Psychosis (e.g. delusions/hallucinations/paranoia)
- Risk to others/risk to self
- Capacity assessment
- Discharge planning (includes assessment for nursing homes)
- Diagnosis
- Other (e.g. wandering, not eating, non-compliance)
- Not documented

Do you have any comments to make on Section 4a: Liaison psychiatry?

SECTION 4b: PSYCHIATRY OF OLD AGE

This section is relevant to those patients who have been referred to a liaison Psychiatry of Old Age service during their stay.

46. Has any referral been made to Psychiatry of Old Age?

Answer "No" if there was no referral made for this patient, or if the patient already had mental health input and so referral to the service was not necessary.

- Yes** ⇒ **Go to Q47**
- No** ⇒ **Go to Q46a**
- No liaison service available in the hospital** ⇒ **Go to Q46a**
- Not documented** ⇒ **Go to Comment box end of Section 4b**

46a. Has any need for referral to Psychiatry of Old Age been noted on admission or during further assessment?

- Yes**
- No**

46b. Has a follow up referral to community based Psychiatry of Old Age services been made on discharge?

Answer "N/A" if the patient is already in regular contact with community based mental health services, e.g. visited by outreach team, regularly attends appointments at a memory service.

- Yes** ⇒ **Go to Question 47**
- No** ⇒ **Go to Comment box end of Section 4b**
- N/A** ⇒ **Go to Comment box end of Section 4b**

47. Is it stated whether the referral was emergency, urgent or routine?

Guidance on the definitions in this question is drawn from the UK Psychiatric Liaison Accreditation Network Quality Standards for Liaison Psychiatry Services.

NB the use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

If there is no indication of the level of urgency, select 'Not stated'.

- Emergency**
- Urgent**
- Routine**
- Not stated**

48. Please indicate time between admission and assessment:

This refers to the initial assessment (in the event that there has been more than one).

- | | |
|--|---|
| <input type="checkbox"/> Within 60 minutes | <input type="checkbox"/> Within 24 hours |
| <input type="checkbox"/> Within 24 - 48 hours | <input type="checkbox"/> Within 48 - 72 hours |
| <input type="checkbox"/> Within 72 - 96 hours | <input type="checkbox"/> Longer than 96 hours |
| <input type="checkbox"/> Not documented | <input type="checkbox"/> Patient died/was discharged |

49. What was the main reason given for referral? *Tick only one*

- Cognitive assessment or review/dementia**
- Confusion**
- Aggression/agitation/anxiety**
- Delirium**
- Depression/low mood**
- Psychosis (e.g. delusions/hallucinations/paranoia)**
- Risk to others/risk to self**
- Capacity assessment**
- Discharge planning (includes assessment for nursing homes)**
- Diagnosis**
- Other (e.g. wandering, not eating, non-compliance)**
- Not documented**

Do you have any comments to make on Section 4b:Psychiatry of Old Age?

SECTION 4c: GERIATRIC MEDICINE

This section is relevant to those patients who have been referred to a geriatric medicine service during their stay.

50. Has any referral been made to Geriatric Medicine?

Answer "No" if there was no referral made for this patient, or if the patient already had geriatric medicine input and so referral to the service was not necessary.

- Yes** ⇒ **Go to Q51**
- No** ⇒ **Go to Q50a**
- No liaison service available in the hospital** ⇒ **Go to Q50a**
- Not documented** ⇒ **Go to Comment box end of Section 4**

50a. Has any need for referral to Geriatric Medicine been noted on admission or during further assessment?

- Yes** **No**

50b. Has a follow up referral to geriatric medicine services been made on discharge?

Answer "N/A" is the patient is already in regular contact with geriatric medical services or regularly attends appointments at a memory service.

- Yes** ⇒ **Go to Question 51**
- No** ⇒ **Go to Comment box end of Section 4**
- N/A** ⇒ **Go to Comment box end of Section 4**

51. Is it stated whether the referral was emergency, urgent or routine?

The use of these definitions is not mandatory, and this question may be answered using the equivalent terms in use in your hospital/service.

Emergency: An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

Urgent: A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

Routine: All other referrals, including patients who require geriatric medicine assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

If there is no indication of the level of urgency, select 'Not stated'.

- Emergency**
- Urgent**
- Routine**
- Not stated**

52. Please indicate time between admission and assessment:

This refers to the initial assessment (in the event that there has been more than one)

- | | |
|--|---|
| <input type="checkbox"/> Within 60 minutes | <input type="checkbox"/> Within 24 hours |
| <input type="checkbox"/> Within 24 - 48 hours | <input type="checkbox"/> Within 48 - 72 hours |
| <input type="checkbox"/> Within 72 - 96 hours | <input type="checkbox"/> Longer than 96 hours |
| <input type="checkbox"/> Not documented | <input type="checkbox"/> Patient died/was discharged |

53. What was the main reason given for referral? *Tick only one*

- Cognitive assessment or review/dementia
- Confusion
- Aggression/agitation/anxiety
- Delirium
- Depression/low mood
- Psychosis (e.g. delusions/hallucinations/paranoia)
- Risk to others/risk to self
- Capacity assessment
- Discharge planning (includes assessment for nursing homes)
- Diagnosis
- Medical Advice
- Rehabilitation
- Other (e.g. wandering, not eating, non-compliance)
- Not documented

Do you have any comments to make on Section 4c: Geriatric Medicine?

SECTION 4d: PALLIATIVE CARE NEEDS

54 a) Was a decision for resuscitation (either for resuscitation or not for resuscitation) documented in the medical notes this admission?

- Yes No

54 b) Was a referral made to Palliative Care?

- Yes No

54 c) Was a referral made for the family/ carer for bereavement support?

This may include referral to a social worker, or to a specific bereavement support group.

- Yes
- No
- No with documentation that family/carer didn't need this, or refused it, or patient had no family/ carer

SECTION 4e: REFERRAL TO NEUROLOGY

55. If the patient is aged 64 years or younger, has any referral to Neurology been documented in the case notes?

If patient is aged 65 years or older, skip this question.

- Yes**
- No**
- No neurology service available in the hospital**

Do you have any comments to make on Section 4d/e: Palliative care needs and referral to neurology?

SECTION 5: RECORD KEEPING

This section looks at whether information about the patient's dementia and support needs is readily accessible.

56 .Is information about the person's dementia quickly found in a specified place in the file?

- Yes**
- No**

57. Is information about related care and support needs quickly found in a specified place in the file?

- Yes**
- No**

58. In your opinion, how would you rate the organisation of this case note?

- The notes are well organised and it was easy to find all the information that I needed**
- The notes are organised adequately, however it was not so easy to find all the information I needed**
- The notes were not well organised, and it was a struggle to find all the information that I needed**
- The notes were disorderly and it was extremely difficult to find any of the information I needed**

Do you have any comments to make on Section 5: Record keeping?

If you have any queries, please contact:

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