Second Irish National Audit of Dementia Care in Acute Hospitals (INAD-2)

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 patient sample is drawn from a long list of eligible patients already identified using ICD10 coding discharged during the period 1st January to 30th April 2019. The sample is 40 charts, drawn at random, from the eligible cases within that period. Please see guidance about what to do when a casenote is not eligible. If you have fewer than 40 charts within that time frame, please continue to identify casenotes from 1st November 2018 to 30th April 2019.

Entering the data

Data from each set of eligible casenotes should be recorded 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 the data are recorded. 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.

Adapted from the first INAD tool, which was in turn adapted from the UK National Audit of Dementia, with permission.

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 057-9318477

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 5rel.

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 case note is not eligible and you cannot continue**

What is the patient's dementia diagnosis? (See guidance document)

☐ **Alzheimer's Disease**
☐ **Parkinson's dementia**
☐ **Fronto-temporal dementia**
☐ **Other (please specify):**
☐ **Vascular dementia**
☐ **Lewy body dementia**
☐ **Mixed dementia**
☐ **Not specified**

In case we need to contact you regarding this entry, please provide us with your contact details:

Name, Job title:

Email address

SECTION 1: INFORMATION ABOUT THE PATIENT

1. Enter the month and year in which the patient was born:

Year of birth:

Month of birth: **January-June** **July-December**

2. Select the gender of the patient:

☐ **Male**
☐ **Female**

3. Select the ethnicity of the patient:

☐ **White Irish**
☐ **Black**
☐ **Mixed Race**
☐ **Not documented**
☐ **Any Other White Background**
☐ **Asian**
☐ **Other Ethnic Group**

4. Select the first language of the patient:

☐ **English**
☐ **Other European Language**
☐ **Not Documented**
☐ **Irish**
☐ **Asian Language**
☐ **Other**

5. Please identify the speciality of the ward that this patient spent the longest period on during this admission: (See guidance document)

- ☐ **Geriatric Medicine**
- ☐ **Surgical**
- ☐ **Orthopaedics**
- ☐ **Stroke**
- ☐ **General Medical**
- ☐ **Critical Care**
- ☐ **Intensive Care Unit**
- ☐ **Other**

5a. Please identify the speciality of care/consultant that this patient spent the longest period under during this admission:

- ☐ **Geriatrician**
- ☐ **Psychiatrist**
- ☐ **Other (please specify):**
- ☐ **Neurologist**
- ☐ **Surgeon**

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

- ☐ **Dementia was primary issue**
- ☐ **Stroke**
- ☐ **Respiratory infection**
- ☐ **Other, please specify**
- ☐ **Fall or fracture**
- ☐ **Urinary Tract Infection**
- ☐ **Other medical- not dementia related**

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

- ☐ **Emergency**
- ☐ **Elective**

8. Did the patient die whilst in hospital?

- ☐ **Yes**
- ☐ **No**

9. Did the patient self-discharge from hospital?

- ☐ **Yes**
- ☐ **No**

10. Was the patient receiving end of life care/on an end of life care pathway? (see guidance document)

- ☐ **Yes**
- ☐ **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 01/01/2019 and 30/04/2019.
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)

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 case note.*

- ☐ **Own home**
- ☐ **Respite care**
- ☐ **Rehabilitation Unit**
- ☐ **Residential Care/Nursing home**
- ☐ **Palliative care**
- ☐ **Transfer from another hospital**
- ☐ **Carer's home**
- ☐ **Transitional care**
- ☐ **Psychiatric ward**
- ☐ **Community Hospital**
- ☐ **Convalescent Care**

Q13 is not applicable if Q8 = "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 case note.

- ☐ **Own home**
- ☐ **Respite care**
- ☐ **Rehabilitation Unit**
- ☐ **Residential Care/Nursing home**
- ☐ **Palliative care**
- ☐ **Transfer from another hospital**
- ☐ **Carer's home**
- ☐ **Transitional care**
- ☐ **Psychiatric ward**
- ☐ **Community Hospital**
- ☐ **Convalescent Care**

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.

14. In the admission note (including post-take ward round record), is dementia or suspected dementia recorded?

- ☐ **Yes**
- ☐ **No**

ASSESSMENT OF PERSONAL ACTIVITIES OF DAILY LIVING

An assessment of personal activities of daily living 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.
***NB** elements of assessment may be found in places such as nursing notes and OT assessments, as well as in medical notes.*

15. 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 health and social care professional, e.g. physiotherapist, occupational therapist.This does not have to use a formal tool.

☐ **Yes**
☐ **No**
☐ **Could not be assessed for recorded reasons**

16. An assessment of nutritional status was performed by a healthcare professional:
Assessment carried out by a doctor, nurse or other health and social care professional, e.g. dietician.

☐ **Yes** ⇒ **Go to Q16a**
☐ **No** ⇒ **Go to Q17**
☐ **Could not be assessed for recorded reasons** ⇒ **Go to Q17**

16a. Which tool was used for assessment of nutritional status:

☐ **The Malnutrition Universal Screening Tool (MUST)**
☐ **The Mini Nutritional Assessment (MNA)**
☐ **Other, please specify:**
☐ **Formal assessment tool not used**

17. Has identified assistance required with eating/drinking been recorded.

☐ **Yes** ⇒ **Go to Q17a**
☐ **No** ⇒ **Go to Q18**

17a. If assistance required 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 "Yes" if family member, GP etc has been asked on behalf of the patient.

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

20. Has the patient or their carer/family member been asked about any requirement for assistance with toileting?

- ☐ **Yes**
- ☐ **No**

21. 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.

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

22. Has a standardised assessment of pain suitable for a patient with dementia been carried out (e.g. PAINAD, Abbey Pain Scale)

- ☐ **Yes**
- ☐ **No**
- ☐ **Could not be assessed for recorded reasons**
- ☐ **Not needed- patient self-reported presence or absence of pain**

23. Has an assessment of functioning (ability to perform activities of daily living) been carried out?

- ☐ **Yes, a standardised assessment has taken place** ⇒ **Go to Q23a**
- ☐ **No** ⇒ **Go to comment box**
- ☐ **Could not be assessed for recorded reasons** ⇒ **Go to comment box**

23a. Who performed this assessment?

- ☐ **Nurse**
- ☐ **Physiotherapist**
- ☐ **Occupational Therapist**
- ☐ **Other, please specify:**
- ☐ **Not specified**

Do you have any comments to make on multidisciplinary assessment?

COGNITIVE AND PSYCHOLOGICAL ASSESSMENT

24. Has cognitive testing, using a validated structured instrument, been carried out at any time during this admission?

- ☐ **4AT only**
- ☐ **MOCA**
- ☐ **ACE**
- ☐ **RUDAS**
- ☐ **Not assessed**
- ☐ **Could not be assessed for recorded reasons**
- ☐ **MMSE/sMMSE**
- ☐ **AMTS**
- ☐ **Assessment of Motor & Process Skills**
- ☐ **Other, please specify**

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

a) Confirmation of long standing cognitive decline	☐ **Yes**	☐ **No**
b) Time since onset of memory problems	☐ **Yes**	☐ **No**
c) Nature of progression	☐ **Yes**	☐ **No**
d) Evidence of loss of physical function	☐ **Yes**	☐ **No**
e) Recent deterioration in <u>cognitive</u> function (e.g. memory or language)	☐ **Yes**	☐ **No**
f) Recent deterioration in <u>non-cognitive</u> function (e.g. hallucinations, delusions responsive behaviour, BPSD: Behavioural and Psychological Symptoms of Dementia)	☐ **Yes**	☐ **No**

26. Was a delirium <u>screening</u> assessment carried out (using a validated tool) during this admission? (*see guidance document for Q26-27)

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

- ☐ **Within 24 hours of admission** ⇒ **Go to 26a**
- ☐ **Within 25-48 hours of admission** ⇒ **Go to 26a**
- ☐ **After this time** ⇒ **Go to 26a**
- ☐ **Not carried out at any time** ⇒ **Go to 27**

26a. Which screening assessment was used?

- ☐ **Single Question in Delirium (SQiD)** ⇒ **Go to 26b**
- ☐ **4AT** ⇒ **Go to 26b**
- ☐ **Confusion Assessment Method (CAM)** ⇒ **Go to 26b**
- ☐ **Other, please specify:** ⇒ **Go to 26b**

26b. If a screening assessment was carried out:

- ☐ **Initial delirium screening was positive** ⇒ **Go to 26c**
- ☐ **Initial screening was negative** ⇒ **Go to 27**

26c. If delirium screening was positive, did a healthcare professional who is trained and competent in the diagnosis of delirium (i.e. a doctor, ANP, dementia nurse specialist or specialist nurse in care of older persons) do an assessment to confirm the diagnosis of delirium?

☐ **Yes ⇒ Go to 26d**
☐ **No ⇒ Go to 27**

26d. From this assessment(s), was a diagnosis of delirium confirmed?

☐ **Yes ⇒ Go to 27b**
☐ **No ⇒ Go to 28**

27. Apart from as a result of screening, did a healthcare professional who is trained and competent in the diagnosis of delirium (i.e a doctor, ANP, dementia nurse specialist or specialist nurse in care of older persons) complete a formal assessment to diagnose delirium?

☐ **Yes**
☐ **No assessment for delirium was carried out by a healthcare professional ⇒ Go to 28**

27a. From this assessment, was a diagnosis of delirium confirmed?

☐ **Yes ⇒ Go to 27b**
☐ **No ⇒ Go to 28**

27b. If a diagnosis was confirmed, was there a clear plan for delirium management?

This may be recorded in the nursing care plan

☐ **Yes** ☐ **No**

28. Did the patient have daily delirium screening (e.g. using the 4AT or SQiD) for at least one week of admission?

☐ **Yes**
☐ **No, but done for at least 3 days**
☐ **Other formal tool used (e.g. CAM)**
☐ **No**

29. Has screening or assessment been carried out for recent changes in mood?

Answer yes if the patient and/or their family been asked directly about recent changes in mood or if the patient has been assessed for depression (e.g. using the Geriatric Depression Scale or Cornell Scale for Depression in Dementia)

☐ **Yes** ☐ **No**

Do you have any comments to make on cognitive and psychological 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 which supports the delivery of person-centred 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).

30. Does the care assessment contain a section dedicated to collecting information from the carer, family member or a person who knows the patient well?

- ☐ **Yes** ⇒ **Go to 31**
- ☐ **No** ⇒ **Go to 33**
- ☐ **Referenced in notes but not available** ⇒ **Go to 33**
- ☐ **Documented reason why impossible to collect this data** ⇒ **Go to 33**

31. Please specify the name of this section/document:

- ☐ **What matters to me**
- ☐ **This is me**
- ☐ **Other patient/personal passport**
- ☐ **List of questions**
- ☐ **Other, please specify:**

32a. 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**

32b. 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 "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

☐ **Yes** ☐ **No** ☐ **N/A**

32c. 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**

32d. 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**

32e. 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**

32f. 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 "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

☐ **Yes** ☐ **No** ☐ **N/A**

Do you have any comments to make on information about the person with dementia? (optional)

RESPONSIVE BEHAVIOURS

33. Was there documentation of "responsive behaviours" (e.g. wandering, calling out, pacing, aggression, hitting etc) in the case notes?

☐ **Yes**
☐ **No**

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:
Q8 = "Yes" (patient died in hospital)
Q9 = "Yes" (patient self-discharged from hospital)
Q10 ="Yes" (patient was receiving end of life/on end of life care pathway)
Q13 = "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.

34. At the point of discharge dementia was listed on the discharge letter:

☐ **Yes** ☐ **No**

35. If delirium was diagnosed during this admission, this was included in the discharge letter:

☐ **Yes** ☐ **No** ☐ **N/A**

36. If there were persistent non-cognitive symptoms (e.g. anxiety, apathy) or responsive behaviours (e.g. walking about, aggression, shouting), during this admission, this was noted in the discharge letter:

☐ **Yes** ☐ **No** ☐ **N/A**

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

DISCHARGE COORDINATION AND MDT INPUT

37. Is there evidence in the notes that a discharge planning meeting involving the person with dementia and/or their carer/relative took place?
Answer "N/A" if the person with dementia and/or their carer/relative has refused discussion and this is recorded OR this is not relevant OR it has not been possible to carry this out for another documented reason.

☐ **Yes** ☐ **No** ☐ **N/A**

38. Is a discharge summary available?
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⇒** **Go to 38a**
☐ **No⇒** **Go to 39**
☐ **N/A⇒** **Go to comment box**

38a. Does the discharge summary include details of: *(tick all that apply)*

☐ **Cognitive function**
☐ **Mobility needs**
☐ **Continence needs**
☐ **None of the above**

38b. 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.

☐ **Yes** ☐ **No** ☐ **N/A**

38c. Was a copy of the discharge plan/summary sent to the GP/primary care team/nursing home?
Answer yes if GP/primary care team/nursing home were CC'ed on discharge letter

☐ **Yes** ☐ **No** ☐ **N/A**

38d. Was a nursing-specific discharge letter sent to the Public Health Nurse (PHN)?

☐ **Yes**
☐ **No, but PHN was CC'ed on the discharge plan/summary**
☐ **No letter sent**
☐ **N/A as discharged to a nursing home**
☐ **N/A as no support needs relevant to the PHN documented**

39. Was there a follow-up arranged with any of the following dementia services: *Please tick all that apply*

☐ **Psychiatry of Old Age**
☐ **Geriatrician/Geriatric Medicine**
☐ **Nurse led dementia clinic/service**
☐ **Neurology**
☐ **Other, please specify:**
☐ **None of the above**

40. Was a follow-up appointment made with the team caring for the person in the hospital:

☐ **Yes** ⇒ **Go to 40a**
☐ **No** ⇒ **Go to Comment box at end of section**

40a. What indication was given for this follow-up appointment

- ☐ **Follow up on presenting complaint**
- ☐ **Repeat chest x-ray or blood test**
- ☐ **Follow up of delirium (needs to be specified)**
- ☐ **Other, please specify:**

Do you have any comments to make on discharge coordination and MDT input?

SUPPORT FOR CARERS AND FAMILY

Q41 is only applicable if Q13 = Own home OR carer's home

41. Has information about support on discharge/transition been given to the patient and/or the carer? *(tick all that apply)*
This needs to be explicitly documented rather than implied

- ☐ **Documentation of information given on presenting complaint and follow up**
- ☐ **Documentation of information given on dementia/delirium and follow up**
- ☐ **Neither of the above**

42. 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.

- ☐ **Less than or equal to 24 hours**
- ☐ **25-48 hours**
- ☐ **More than 48 hours**
- ☐ **No notice at all**
- ☐ **No carer, family, friend**
- ☐ **Not documented**
- ☐ **Patient specified that discharge information be withheld**

43. 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- Carer offered but declined**
- ☐ **N/A- No carer**
- ☐ **N/A- Other reason, please specify:**

Do you have any comments to make on discharge planning?

SECTION 4: PALLIATIVE CARE NEEDS

44. Was a decision for resuscitation (either for resuscitation or not for resuscitation) documented in the medical notes <u>this admission</u>?

☐ **Yes** ☐ **No**

45. Was a referral made to Palliative Care?

☐ **Yes** ☐ **No**

46. 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**

47. Was there any advanced care planning completed with the patient and/or their family? (see guidance document)

☐ **Prognosis discussed**
☐ **Appropriateness of re-admission discussed**
☐ **Ceilings of care discussed** (e.g. "For non-invasive ventilation but not to be intubated")
☐ **Advanced Healthcare Directive discussed**
☐ **None of the above completed**
☐ **Other, please specify:**
☐ **N/A as advanced care planning already in place on admission**

Do you have any comments to make on palliative care needs?

SECTION 5: USE OF ONE-TO-ONE OBSERVATION SERVICE

This relates to provision of one-to-one observation (i.e. specials or enhanced care) by a Health Care Assistant, porter or similar

48. Was a "one-to-one" observation service allocated to the patient at any point during their admission?

☐ **Yes** ⇒ **Go to 48a**
☐ **No** ⇒ **Go to Comment box at end of section**

48a. How many days was this service allocated to the patient?

48b. Was this service allocated on a one-to-one or cohort basis?

☐ **One-to-one**
☐ **Cohort**
☐ **Not recorded**

Do you have any comments to make on the use of one-to-one observation service?

SECTION 6: PRESCRIBING OF PSYCHOTROPIC MEDICATIONS

49. Was this person receiving psychotropic medication on admission to hospital?

☐ **Yes** ⇒ **Go to 49a**
☐ **No** ⇒ **Go to 50**

49a.If yes, please list name and dose:

50. Was any new psychotropic medication prescribed during the admission or was an increased dose of an existing psychotropic prescribed?

☐ **A new psychotropic medication was prescribed** ⇒ **Psychotropic audit tool must be completed**
☐ **Increased dose of existing psychotropic prescribed** ⇒ **Psychotropic audit tool must be completed**
☐ **Neither of the above** ⇒ **Not necessary to complete psychotropic audit tool**

If you have any queries, please contact:

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Second Irish National Audit of Dementia Care in Acute Hospitals (INAD-2)

PSYCHOTROPIC MEDICATIONS

Background
The following sections are only to be performed where the person with dementia received a new prescription for, or an increased dose of a psychotropic medication during their stay in hospital. The items are linked to the forthcoming national clinical guideline on appropriate psychotropic medication prescribing for non-cognitive symptoms in people with dementia. This baseline audit will help to inform the implementation of training and education to support healthcare professionals around the guideline. Before completing this tool, please read the user manual and have your hospital code to hand.

Patient Sample
The patient sample is drawn from the 30 charts included in INAD-2. Where the person was prescribed a **new** or **increased dose** of a psychotropic medication (audit item 50), you need to also complete this section for each and any new/increased dose psychotropic medication.

Entering the data
Data from each set of eligible casenotes should be recorded individually on this separate chart review document, using the **patient code from the audit tool for this patient.**

Enter your hospital code: ☐

Enter the chart code: ☐

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

If a person was prescribed more than one new antipsychotic (section C) more than one new antidepressant, benzodiazepine, etc (section D), during their admission please use duplicate sheets for this section, and securely attach to the main chart review document. NB please enter the hospital and chart code on these additional sections, where indicated on the sheet.

SECTION A: PRESCRIBING OF ANY NEW PSYCHOTROPIC MEDICATION

Prior to the prescribing of <u>ANY</u> new or increased dose psychotropic medication is there evidence that: *(if more than one, please answer for the <u>first</u> one)*

1. A comprehensive assessment of the person with dementia has been performed by a suitably trained healthcare professional

☐ **Yes**
☐ **No**
☐ **N/A**

2. Non-pharmacological interventions have been tried initially

Mark N/A if there is <u>documented</u> evidence of severe distress and/or an identifiable risk of harm to the person with dementia and/or others.

☐ **Yes** ⇒ **Please list all non-pharmacological interventions used in comment box and then go to 3**
☐ **No** ⇒ **Go to 3**
☐ **N/A** ⇒ **Go to 2a**

2a. Please tick which indication for not trialling non-pharmacological interventions initially applied:

☐ **Severe distress to the person with dementia**
☐ **Risk of harm to the person with dementia** ⇒ **Please specify type of harm**
☐ **Risk of harm to others** ⇒ **Please specify type of harm**

Do you have any comments to make on Section A?

SECTION B: PARENTERAL ADMINISTRATION OF PSYCHOTROPIC MEDICATION

3. Was any intramuscular or intravenous psychotropic medication prescribed during the admission?

☐ **No** ⇒ **Go to Section C**
☐ **Yes** ⇒ **Go to 3a**

3a. If yes, was this prescribed only for:

☐ **Seizures** ⇒ **Go to Section C**
☐ **End of life care** ⇒ **Go to Section C**
☐ **Usual depo injection given as per schedule** ⇒ **Go to Section C**
☐ **None of the above** ⇒ **Continue with Section B**

In prescribing parenteral psychotropic medication, is there evidence that:

4. Oral medication has been prescribed before parenteral medication (refer to person with dementia's drug kardex)

☐ **Yes**
☐ **No**
☐ **N/A**

5. Single intramuscular (IM) psychotropic agents have been administered prior to combination IM agents being administered

☐ **Yes**
☐ **No**
☐ **N/A**

6. Intramuscular agents (IM) have been prescribed prior to intravenous (IV) agents

☐ **Yes**
☐ **No**
☐ **N/A**

7. Where intravenous psychotropic medication has been prescribed, the indication for requiring IV treatment is documented

☐ **Yes**
☐ **No**
☐ **N/A**

Do you have any comments or clarifications to make on Section B?

SECTION C: PRESCRIPTION OF ANTIPSYCHOTIC MEDICATION

Was any new or increased dose antipsychotic medication prescribed during the admission?

☐ **Yes** ⇒ **Continue with Section C**
☐ **No** ⇒ **Go to Section D**

***If a person has been prescribed two or more antipsychotics during the admission, please complete "section C duplicate" for the second or subsequent antipsychotic. ***

If yes, is there evidence that:

8. There was an explicit, appropriate indication documented for the requirement of the antipsychotic medication?

☐ **No**
☐ **Yes** ***If yes, tick <u>all</u> indications that apply:***
- ☐ **Aggression**
- ☐ **Agitation**
- ☐ **Psychosis**
- ☐ **End of Life Care** ⇒ **Go to comment box and then Section D**
- ☐ **Delirium diagnosed by senior nurse or doctor** ⇒ **Go to Q 9**
- ☐ **Other indication(s), please specify:**

8a. There was documented severe distress, or an identifiable risk of harm to the person with dementia and/or others?

☐ **No**
☐ **Yes** ***If yes, tick <u>all</u> indications that apply:***
- ☐ **Severe distress to the person with dementia**
- ☐ **Risk of harm to the person with dementia**
- ☐ **Risk of harm to others**

9. The risks and benefits of the medication have been documented in the notes?

☐ **Yes**
☐ **No**
☐ **N/A**

9a. There is documentation that the risks and benefits of the medication have been discussed with the person with dementia and/or their family/relevant decision maker?

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

10. A second generation antipsychotic was prescribed?
Please refer to list of first and second generation antipsychotics in the user manual for chart review of appropriate prescribing of psychotropic medications

☐ **Yes**
☐ **No** ***If no, is there a documented reason for choosing a first generation drug?***

Please provide details:

11. The initial antipsychotic dose was at or close to the lowest available dose? *Please refer to list of common agents and doses*

☐ **Yes**
☐ **No**
☐ **N/A**

11a. There were no large increases in dose from one dose to the next?

☐ **Yes**
☐ **No**
☐ **N/A**

If necessary, explain here reason for judging to be non-compliant here

12. There was a review for effectiveness <u>and</u> side effects during the admission?

☐ **No review recorded ⇒ Go to 13**
☐ **Review for effectiveness recorded ⇒ Go to 13**
☐ **Review for side effects recorded ⇒ Go to 13**
☐ **Discharged within 48 hours of commencement <u>and</u> documented planned review post discharge ⇒ Go to 12a**

12a. When was this review planned for?

☐ ***Review planned for within 2 weeks of discharge***
☐ ***Review planned 2-4 weeks post discharge***
☐ ***Review planned 1-3 months post discharge***
☐ ***Review planned 3-6 months post discharge***
☐ ***Review planned for more than 6 months post discharge***

13. There was documentation that the antipsychotic was <u>effective</u>?

☐ **Yes**
☐ **No**
☐ **N/A**

14. There is evidence of a planned review date within 3 months of the first prescription?

☐ **No ⇒ Go to 15**
☐ **Yes** ***If yes, does this plan explicitly state the physician/service who is responsible for this review?***

☐ **Yes**
☐ **No**
☐ **N/A** *Mark N/A if an exception existed; record exception here:*

15. There is documentation that the antipsychotic was <u>ineffective?</u>

☐ **Yes** ⇒ **Go to 16**
☐ **No** ⇒ **Go to 17**
☐ **N/A** ⇒ **Please indicate reason why not applicable below, then go to 17**

If necessary, explain here reason for judging to be non-compliant or n/a

16. Is there evidence that:

☐ **The antipsychotic was stopped**
☐ **The antipsychotic was tapered down** *(i.e. dose reduced)*
☐ **No evidence of either of the above**

17. Was an <u>existing</u> antipsychotic tapered/withdrawn during the admission?

☐ **No** ⇒ **Go to comment box and then Section D**

☐ **Yes** ***If yes, was the usual dose (or close to usual dose) resumed during the admission?***

☐ **Yes** ⇒ **Go to comment box and then Section D**
☐ **No** ⇒ **Go to 17b.**

17b. Was there a review for possible symptom re-emergence prior to discharge?

☐ **Yes**
☐ **No**
☐ **N/A as person was discharged within 48 hours of dose reduction**
☐ **N/A as person within 48 hours of dose reduction**

17c. Was there a clear plan for review, within 4 weeks of discharge, for possible symptom re-emergence post discharge?

☐ **Yes**
☐ **No**
☐ **N/A as person with dementia died in hospital**

Do you have any comments or clarifications to make on Section C?

SECTION D: ADMINISTRATION OF OTHER PSYCHOTROPIC MEDICATION

If NO Acetylcholinesterase Inhibitor medication OR Memantine prescribed, proceed to item 26.

If a person has been prescribed two or more other psychotropic medications during the admission, please complete "section D duplicate" for the second medication.

18. Was an Acetylcholinesterase Inhibitor (galantamine, rivastigamine or donepezil) newly prescribed during the admission?

☐ **No ⇒ Go to 22**

☐ **Yes** ***If yes, is there evidence that this was for cognitive dysfunction?***

- ☐ **Yes ⇒ Go to 22**
- ☐ **No ⇒ Go to 19**

19. Is the person documented to have Parkinsons Disease Dementia (PDD) or Dementia with Lewy Bodies (DwLB) or Lewy Body Dementia (LBD)?

☐ **No ⇒ Go to 20**

☐ **Yes** ***If yes, is it documented that the person with dementia has:***

- ☐ **Severe distress**
- ☐ **Non-pharmacological interventions have been ineffective**
- ☐ **Neither of the above**

20. The risks and benefits of the medication have been discussed with the person with dementia and/or their family/decision supporter?

☐ **Yes**
☐ **No**
☐ **N/A ⇒ Please indicate reason why not applicable below.**

21. There is documentation of either a review during the admission or a plan for review?

☐ **Yes**
☐ **No**
☐ **N/A ⇒ Please indicate reason why not applicable below.**

22. Was memantine <u>newly</u> prescribed during this admission?

☐ **No** ⇒ **Go to 26**

☐ **Yes** ***If yes, is there evidence that:***

- ☐ **The person has documented moderate to severe dementia**
- ☐ **The person has mild dementia**
- ☐ **Severity of dementia not documented**

23. It is documented that the memantine was commenced for cognitive dysfunction, not for non-cognitive symptoms:

☐ **Memantine was prescribed for cognitive symptoms** ⇒ **Go to 26**
☐ **Memantine was prescribed for non-cognitive symptoms**
☐ **Indication was not documented**

24. The risks and benefits of the medication have been discussed with the person with dementia and/or their family/decision supporter

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

25. There is documentation of either a review or a plan for review of the memantine?

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

Do you have any comments or clarifications on acetylcholinesterase inhibitors or memantine?

26. Was a new or increased dose antidepressant medication prescribed during this admission?

☐ **No ⇒ Go to 29**

☐ **Yes** ***If yes, is there evidence that it was prescribed for pain:***

- ☐ **Yes ⇒ Go to 27**
- ☐ **No ⇒ Go to 26b**

26b. If not prescribed for pain, has the person: *tick all that apply*

☐ **Severe depression**

☐ **Moderate depression**

☐ **AND the depression has not responded to psychological treatment**

☐ **Severe non-cognitive symptoms**

☐ **Other, please specify:**

27. The risks and benefits of the antidepressant have been discussed with the person with dementia and/or their family/decision supporter?

☐ **Yes**

☐ **No**

☐ **N/A ⇒ Please indicate reason why not applicable below.**

28. There is documentation of either a review or a plan for review of the antidepressant?

☐ **Yes**

☐ **No**

☐ **N/A ⇒ Please indicate reason why not applicable below.**

Do you have any additional comments or clarifications on antidepressants?

29. Has a new or increased dose anticonvulsant been prescribed during this admission?

☐ **No** ⇒ **Go to 32**

☐ **Yes** ***If yes, is there evidence that the anticonvulsant has been prescribed for the treatment of:***

- ☐ **Seizures** ⇒ **Go to 32**
- ☐ **Pain** ⇒ **Go to 32**
- ☐ **Bipolar disorder** ⇒ **Go to 32**
- ☐ **Non-cognitive symptoms**
- ☐ **No indication given**
- ☐ **Other documented indication**

Please specify:

30. The risks and benefits of the medication have been discussed with the person with dementia and/or their family/decision supporter

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

31. There is documentation of either a review or a plan for review of the anticonvulsant:

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

Do you have any additional comments or clarifications on anticonvulsants?

32. Was a new or increased dose benzodiazepine prescribed during this admission?

☐ **No** ⇒ **Go to 35**
☐ **Yes** ***If yes, is there evidence that it was prescribed for the treatment of:***

- ☐ **Seizures** ⇒ **Go to 35**
- ☐ **Severe anxiety** ⇒ **Go to 33**
- ☐ **Non-cognitive symptoms** ⇒ **Go to 33a**
- ☐ **No indication given** ⇒ **Go to 34**
- ☐ **Other documented indication** ⇒ **Go to 34**

Please specify indication:

33. If prescribed for severe anxiety, is there a documented maximum duration of treatment?

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

33a. If prescribed for non-cognitive symptoms, is there a justification of why a benzodiazepine was chosen?

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

34. The risks and benefits of the benzodiazepine have been discussed with the person with dementia and/or their family/decision supporter

☐ **Yes**
☐ **No**
☐ **N/A** ⇒ **Please indicate reason why not applicable below.**

35. Was a new or increased dose Z type medication (or a benzodiazepine at night) prescribed during this admission?

- ☐ **No ⇒ Go to 36**
- ☐ **Z type medication prescribed ⇒ Go to 35a**
- ☐ **Benzodiazepine at night prescribed ⇒ Go to 35a**

35a. If a Z type medication (or a benzodiazepine at night) is prescribed is there evidence that a sleep regimen/care plan has been put in place <u>prior</u> to trial of the medication?

- ☐ **Yes, but medication was commenced later that night**
- ☐ **Yes, and medication commenced on next night or subsequently**
- ☐ **No**
- ☐ **N/A ⇒ Please indicate reason why not applicable below.**

36. Was melatonin newly prescribed during this admission?

- ☐ **No**
- ☐ **Yes** ***If yes, is there a note to justify this use?***
  - ☐ **Yes**
  - ☐ **No**

Do you have any additional comments or clarifications on benzodiazepines OR Z type medications OR melatonin?

End of audit

If you have any queries, please contact:

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