Second Irish National Audit of Dementia care in acute hospitals (INAD-2)

Case Note Audit Guidance Document

July 2019

Introduction

Thank you for taking part in the Second Irish National Audit of Dementia care in acute hospitals (INAD-2). All acute and orthopaedic hospitals in the Republic of Ireland are participating (N=38). The audit consists of three components;

- **Chart Audit**
- Organisational Audit
- Environmental Audit

This document has been prepared as a guide for people carrying out the chart audit, which will audit the records of 30 patients with a diagnosis or current history of dementia against a checklist of standards which have been drawn from national and international best practice.
Please see separate guidance document for the additional sections for psychotropic medications. These sections only need to be completed if the person received any new or increased dose of psychotropic medications during the admission.

INAD-2 Audit Team

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Completing the Case Note Audit

Each hospital is expected to submit an audit of 30 sets of case notes of patients discharged with a known diagnosis or current history of dementia, identified through HIPE coding. One case note audit form is to be filled in per set of notes audited. Where relevant, a psychotropic audit form should also be filled in (please see separate user manual).

Estimated time to complete:
This is a complex data set. Feedback suggests that the first set of case notes audited will take an hour or more. For subsequent sets the majority took less than one hour.

Inter rater reliability check
As part of the reporting process for this audit, the audit team we will be collecting inter rater data. This will involve re-audit by a HSE Quality Assurance and Verification auditor of six case note records. This will help to establish the reliability of data returned. Input from the original auditors will not be required in this process. To facilitate this process is it essential that the MRN is clearly recorded on the Case Note Coding Sheet and the patient code is recorded on the data collection form. This is an important part of the audit.
NB. Reliability (agreement between auditors) is not the same as validity (accuracy of measure). However establishing good agreement between auditors is an important part of the process of validation as valid data by definition will have to be reliable.

How to select your sample
This is a retrospective audit of the records of patients with a diagnosis of dementia, and admitted for 3 days or longer, discharged from your hospital (or died during admission) between 1st January and 30th April 2019.
40 charts will be pulled for audit by medical records, selected at random from all cases in the HIPE list for that period, and 30 of these will need to be audited using the case note audit tool.
Please only review the documentation for one admission. If a person has more than one admission during the audit period, the evidence is based on the most recent admission within the audit time period.

Exclusion
• Length of stay: please exclude patients whose admission was less than 3 days. Use the date of admission and date of discharge to do this (including both dates in the total length of stay). (Please note that there may be a second, valid length admission within the audit period – so please do look for other admissions with the audit period before discounting the notes)
• No diagnosis of dementia: please exclude patients whose notes have been incorrectly HIPE coded.

Choosing your sample
1) Ensure that all charts selected meet the inclusion criteria (diagnosis of dementia, minimum length of stay of 72 hours, discharged within specified time period)
2) Allocate each set of case notes a patient code number from the Case Note Coding List. This is the number you will use when entering “number for patient” in the data collection form. A copy of the Case Note Coding List for your hospital is available from the INAD-2 coordinator.
3) NB. Whenever a set of notes identified is found to be ineligible for this audit, e.g. length of stay less than 72 hours or wrongly coded, go on to the next set in the sequence, but do not reallocate the number. Replace excluded records with the next consecutively discharged patients in the total series, until there is a total return of 30 e.g. if number 2 is ineligible, go on to number 3, and make up the sample with number 31 on your list, and so on.

Guidance to questions
Guidance to individual questions is included in the tool. Further guidance to a number of specific questions is given in the table which follows. If you need any further guidance before answering a question please contact the INAD-2 Coordinator on 057-9318477.

Section	Question Number	Guidance
Introduction	Not numbered- dementia diagnosis	This may be listed in a clinic letter at the front of the chart, in the medical or nursing notes, or in a discharge letter from this or a previous admission- it doesn't have to be listed on admission note to be a valid diagnosis, once it appears somewhere in the chart.
Section 1	5, 5a	In cases where the speciality of the ward or consultant is not known, please enter the name of the ward or consultant and an INAD-2 auditor will select the speciality and remove the ward/consultant name when the data is returned.
Section 1	10	Being at end of life needs to be explicitly documented using terms such as "not for any active treatment", "for palliative care measures only", "treat as per end of life protocol", "dying", "actively dying", "moribund", or similar terms. Being referred to Specialist Palliative Care does not necessarily mean that the person was at end of life.
Section 2	26, 26a, 26b, 26c, 26d, 27, 27a, 27b	There are two important things which the audit aims to examine here: 1. Whether delirium screening was conducted within 24-48 hours of admission and, if positive, led to an assessment by a healthcare professional who can diagnose delirium (i.e. a doctor; or specialist dementia/delirium or Older Persons nurse- CNS or ANP) and 2. If delirium was diagnosed under any circumstances (i.e. following screening or not), was there a plan of action or follow-up. It is important to pay particular attention to the question routing for these questions so that all relevant information is recorded.
Section 4	47	'Ceiling of care' includes for example directions such as: • For non-invasive ventilation but not to be intubated • Fluids and IV antibiotics on ward but not for inotropes • Full treatment on ward but in event of deterioration, not to be transferred to ICU

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, particularly if you were unsure of how to answer a particular question. These comment boxes can also be used to record relevant anecdotal information relating to the persons dementia and care seen in the notes but not captured with the tool.

Question routing
Some questions on the case note form are routed, depending on previous answers. E.g. if you answer "No" to question 16, An assessment of nutritional status was performed by a healthcare professional, you will not be asked question 16a, which asks for further information about the nutritional assessment.

Data return
Completed audit forms and the Case Note Coding List should be returned to the Site Liaison for your hospital. If you are unsure of the name and contact details of the site liaison, please contact the audit coordinator Mairéad Bracken-Scally, on 057-9318477 or mbrackenscally@muh.ie

Timeline for data collection
All data should be collected and returned within 2 weeks of audit training.

Reporting
Local Reports: Local data will be made available to individual hospitals. Hospital group reports will be prepared and provided to the Hospital Group CEOs.
National Report: Key findings from collated anonymised data from the audit and recommendations will be presented in an overall report in Spring 2020.

List of Abbreviations

4AT:	Rapid assessment test for delirium
ACE:	Assessment of Comprehension and Expression
AMTS:	Abbreviated Mental Test Score
BPSD:	Behavioural and Psychological Symptoms of Dementia
CAM:	Confusion Assessment Method
GP:	General Practitioner
ICD-10:	International Classification of Disease- 10th revision
MMSE/sMMSE:	Mini Mental State Examination/Standardised Mini Mental State Examination
MOCA:	Montreal Cognitive Assessment
N/A:	Not Applicable
PAINAD:	Pain Assessment in Advanced Dementia Scale
RUDAS:	Rowland Universal Dementia Assessment Scale

Management of the Audit

This audit is a joint initiative between the National Dementia Office and the HSE Quality Assurance and Verification. A number of professional bodies are collaborating on the project through membership on the INAD-2 Steering Committee.