Clinical Audit Tool

Participant ID

_____

Date audit completed

_____

Auditor name/s and role/s

If the patient was >65yrs (>45yrs if Aboriginal or Torres Strait Islander), they were screened for cognitive impairment using a validated tool within 24hrs of presentation to hospital.
(QUALITY STATEMENT 1: A patient with any key risk factor for delirium is identified on presentation and a validated tool is used to screen for cognitive impairment or obtain a current score if they have known cognitive impairment. Before any planned admission, the risk of delirium is assessed and discussed with the patient, to enable an informed decision about the benefits and risks.)

◯ Yes
◯ No
◯ N/A

State name of the tool

◯ 4AT
◯ CAM
◯ NuDESC
◯ MMSE
◯ RUDAS
◯ Other

State name of other tool

_____

Delirium prevention interventions were provided.
(QUALITY STATEMENT 2: A patient at risk of delirium is offered a set of interventions to prevent delirium and is regularly monitored for changes in behaviour, cognition and physical condition. Appropriate interventions are determined before a planned admission or on admission to hospital, in discussion with the patient and their family or carer.)

◯ Yes
◯ No

If the patient had prior cognitive impairment or an acute change in behaviour or cognitive function, they were screened/assessed for delirium using a validated tool.
(QUALITY STATEMENT 4: A patient with cognitive impairment on presentation to hospital, or who has an acute change in behaviour or cognitive function during a hospital stay, is promptly assessed using a validated tool by a clinician trained to assess delirium. The patient and their family or carer are asked about any recent changes in the patient's behaviour or thinking. A diagnosis of delirium is determined and documented by a clinician working within their scope of practice.)

◯ Yes
◯ No
◯ N/A

State name of tool

◯ 4AT
◯ CAM
◯ NuDESC
◯ MMSE
◯ RUDAS
◯ Other

State name of other tool

_____

Patient-centred information about delirium prevention was provided to the patient and/or their family.
(QUALITY STATEMENT 3: A patient at risk of delirium and their family or carer are encouraged to be active participants in care. If a patient is at significant risk or has, delirium, they and their family or carer are provided with information about delirium and its prevention in a way that they can understand. When delirium occurs, they receive support to cope with the experience and its effects.)

◯ Yes
◯ No
◯ N/A

The patient had delirium during admission to the palliative care unit.

◯ Yes
◯ No

Comment on documentation that evidences delirium
(E.g. Coding, medical diagnosis, positive screening/assessment tools, clinical notes describing symptoms of delirium. Also note whether the delirium was present prior to admission to the PCU or occurred during admission to the PCU.)

NB: If the patient did not have delirium during admission, no further items apply.

Patient-centred information and support was provided to the patient and/or their family during delirium.
(QUALITY STATEMENT 3: A patient at risk of delirium and their family or carer are encouraged to be active participants in care. If a patient is at significant risk or has, delirium, they and their family or carer are provided with information about delirium and its prevention in a way that they can understand. When delirium occurs, they receive support to cope with the experience and its effects.)

◯ Yes
◯ No
◯ N/A

The patient was comprehensively assessed to investigate the cause/s of the delirium.
(QUALITY STATEMENT 5: A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment that includes relevant multidisciplinary consultation.)

◯ Yes
◯ No
◯ N/A

The patient received interventions to treat the identified cause(s) of the delirium.
(QUALITY STATEMENT 5: A patient with delirium is offered a set of interventions to treat the causes of delirium, based on a comprehensive assessment that includes relevant multidisciplinary consultation.)

◯ Yes
◯ No
◯ N/A

The patient was assessed for risk of other hospital complications (e.g., functional decline, dehydration, malnutrition, falls, pressure injuries).
(QUALITY INDICATOR 6a: A patient with delirium receives care to prevent functional decline, dehydration, malnutrition, falls and pressure injuries, based on their risk.)

◯ Yes
◯ No
◯ N/A

The patient experienced dehydration, malnutrition, fall resulting in fracture or other intracranial injury OR pressure injury during admission.
(QUALITY INDICATOR 6b: Proportion of patients with delirium who experienced dehydration, malnutrition, a fall resulting in fracture or other intracranial injury or a pressure injury during their hospital stay.)

◯ Yes
◯ No
◯ N/A

Antipsychotics were avoided during delirium.
(QUALITY STATEMENT 7: Antipsychotic medicines are not recommended to treat delirium. Behavioural and psychological symptoms in a patient with delirium are managed using non-drug strategies.)

◯ Yes
◯ No
◯ N/A

Benzodiazepines were avoided during delirium.
(QUALITY STATEMENT 7: Antipsychotic medicines are not recommended to treat delirium. Behavioural and psychological symptoms in a patient with delirium are managed using non-drug strategies.)

◯ Yes
◯ No
◯ N/A

The patient had individualised comprehensive care planning on discharge regarding the current or resolved episode of delirium.
(QUALITY STATEMENT 8: Before a patient with persistent or resolved delirium leaves hospital, an individualised comprehensive care plan is developed collaboratively with the patient and their family or carer. The plan describes the patient's post-discharge care needs and includes strategies to help reduce the risk of delirium and related complications, a summary of changes in medicines and any other ongoing treatment. This plan is provided to the patient and their family or carer before discharge, and to their general practitioner and other regular clinicians within 48 hours of discharge. QUALITY INDICATOR 8a: Proportion of patients with current or resolved delirium who had an individualised comprehensive care plan on discharge.)

◯ Yes
◯ No
◯ N/A as the patient died during the admission

The patient was readmitted to hospital for delirium within 10 days of discharge.
(QUALITY INDICATOR 8b: Proportion of patients aged 65 years or older or 45 years or older for Aboriginal and Torres Strait Islander people who experienced delirium in hospital and were readmitted for delirium within 10 days.)

◯ Yes
◯ No
◯ N/A as the patient died during the admission

Comments