CHOPs
Medical Record Audit

Age		Sex		

No.		Yes	No	Comment/N/A
1	Cognition screening			
1.1	Was a cognition screen attended on admission?			
1.2	Was a cognition screen attended within 24hrs of admission?			
1.3	Was a history of cognitive impairment documented?			
1.4	Was history about the person's baseline cognition and functioning obtained from family or other care provider to ascertain any changes or fluctuation?			
2	Risk Identification and prevention strategies			
2.1	Is there evidence of a risk assessment for Delirium (DRAT)			
2.2	Risk assessment completed for other clinical risks?			
	Falls			
	Pressure Injury			
	Nutrition			
	Other (please specify)			
2.3	Was Delirium risk identified?			
2.4	If Delirium risk identified, was there documentation of interventions being initiated? Eg pain assessment, hydration etc			
2.5	If risk not identified and documented were there risks present? Eg Hip fracture, heavy alcohol consumption, dementia, major illness			
2.6	Was there any evidence of delirium (cognitive, functional or behavioural change) during hospital stay? If yes – was the Cognitive screen repeated/completed?			
2.6	Did the patient fall during admission? If yes how many falls?			
2.7	Any other IIMS events noted? If yes please specify			
	***** If no confusion – delirium or dementia – Finish here*****			
3	Assessment of older people with confusion			
3.1	Was the cause of confusion investigated and documented?			
3.2	Was it documented as Dementia?			
3.3	Was it documented as delirium?			
3.4	If not documented – does the clinical information suggest delirium?			
	Dementia?			
	Delirium superimposed on dementia?			
4	Management			
4.1	Were delirium Dementia policy/procedures followed or was the Delirium Pathway used?			

4.2	Were recommended delirium screening investigations conducted?			
4.3	Were anti-psychotics or sedatives initiated on or during admission? *If so please specify*_____			
	If so were the anti-psychotics PRN?			
4.4	Were any physical /Mechanical restraint used?			
4.5	Was specialist assessment/input sort? If yes whom – CNC/NP, Snr nursing, allied Health Geriatrician, Psychiatry			
4.6	Was the patient nursed 1:1?			
5	Communication / Education			
	Was there documentation describing interaction with carer/family?			
6	Discharge			
	Was Delirium / dementia noted in discharge summary?			
	Was delirium / dementia coded in DRG/case mix data?			
	Was discharge destination a change from admission?			
	Did patient die?			
	Other comments…..			

Could be added to drop box if online