National Audit of Dementia

Audit of Casenotes: Third round of audit

RELIABILITY REPORT

The casenote audit asked about assessments, discharge planning and aspects of care received by people with dementia during their stay in hospital. The audit sample comprised eligible patients discharged between 1st April 2016 and 30th April 2016, and also from May 2016 for hospitals with fewer than 50 cases. Hospitals were also asked to 'double' audit or replicate their first five cases with another independent auditor so that reliability agreement could be assessed. In all, 163 hospitals submitted 806 'pairs' of records for the reliability assessment, with 121 submitting five cases, 15 submitting more than five cases, 19 submitting four cases and 8 submitting fewer than four cases. Two thirds (65%, 527/806) of re-audits were of hospital first five cases.

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. For categorical data the kappa statistic was used to measure agreement. Kappa values of 0.41 to 0.60 are said to indicate moderate agreement, values of 0.61 – 0.80 indicate good agreement whilst values of over 0.80 are very good. In practice any value of kappa much below 0.50 will indicate inadequate agreement.

The kappa statistic does not measure the nature of any disagreement between auditors and for this we need to inspect the raw data tables. Any future attempt to improve on reliability will bear most fruit if it focuses on the more frequent discrepancies in judgement. Sometimes the overall kappa value gives an assessment of agreement that is an amalgamation of separate components: (1) agreement between auditors as to whether or not they find the required information, (2) agreement as to whether information found is applicable and (3) agreement in the information reported by auditors when both have found information that applies.

McNemar/Bowker Tests: these test for systematic bias between main and repeat auditors in their responses to particular questions. A lack of significance for a question implies the data are consistent with there being no systematic shift or bias, which was the situation in all but one test - for Q29c (Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the consultant responsible for the patient's care, P=0.006) for which the duplicate auditor was more likely to indicate that discussions had taken place.

Summary

Agreement was generally 'reasonable' to 'good' with 78% of kappa values over 0.50 and 55% of kappa values over 0.60. A summary table is given on the next page.

The median kappa value was 0.61, IQR 0.52-0.72, n=51 variables.

Section 1 (Patient information): median 0.83, IQR 0.74-0.97, n=12.
Section 2 (Assessment): median 0.61, IQR 0.51-0.71, n=17.
Section 3 (Discharge): median 0.55, IQR 0.48-0.61, n=22.

The reliability levels reported here are similar to the last round of audit both overall and within the 3 sections.

There will be a need to exercise caution in particular when performing analyses that correlate one variable with another when one or both variables has less than good inter-auditor reliability – associations between them may dilute as a consequence.

Question	Variable label	Overall Kappa value	95% CI for Kappa
	SECTION 1: INFORMATION ABOUT THE PATIENT		
Q1	Age group	0.96	0.94-0.98
Q2	Gender	0.94	0.92-0.97
Q3	Ethnicity	0.63	0.56-0.70
Q4	First language	0.63	0.57-0.70
Q5	Ward speciality	0.74	0.70-0.78
Q7	Did the patient die while in hospital?	0.98	0.96-0.996
Q8	Did the patient self-discharge from hospital?	1.00	-
Q9	Is the discharge marked as fast track discharge/ discharge to assess/ transfer to assess/ expedited with family agreement for recorded reasons?	0.74	0.63-0.85
Q10	Was the patient receiving end of life care/on an end of life care plan?	0.83	0.78-0.89
Q11	Length of Stay group	0.94	0.93-0.96
Q12	Please indicate the place in which the person was living or receiving care before admission	0.82	0.79-0.85
Q13	Please indicate the place in which the person was living or receiving care after discharge	0.78	0.74-0.82
	SECTION 2: ASSESSMENT		
Q14	An assessment of mobility was performed by a healthcare professional:	0.50	0.43-0.58
Q15	An assessment of nutritional status was performed by a healthcare professional:	0.54	0.45-0.62
Q15a	The assessment of nutritional status includes recording of BMI (Body Mass Index)/weight	0.66	0.59-0.74
Q16	Has a formal pressure ulcer risk assessment been carried out and score recorded?	0.51	0.37-0.64
Q17	As part of the multidisciplinary assessment has the patient been asked about any continence needs?	0.46	0.38-0.54
Q18	As part of the multidisciplinary assessment has the patient been assessed for the presence of any pain?	0.41	0.33-0.48
Q19	Has an assessment of functioning been carried out?	0.49	0.44-0.53
Q20	Has a standardised mental status test been carried out?	0.70	0.65-0.74
Q21	Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?	0.52	0.47-0.58
Q21a	Has the patient been clinically assessed for delirium by a healthcare professional?	0.61	0.43-0.79
Q22	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?	0.60	0.54-0.65
Q22a	Has information been collected about the patient regarding personal details, preferences and routines?	0.71	0.65-0.77
Q22b	Has information been collected about the patient's food and drink preferences?	0.71	0.65-0.77
Q22c	Has information been collected about the patient regarding reminders or support with personal care?	0.65	0.58-0.72
Q22d	Has information been collected about the patient regarding recurring factors that may cause or exacerbate distress?	0.73	0.67-0.79
Q22e	Has information been collected about the patient regarding support or actions that can calm the person if they are agitated?	0.72	0.66-0.78
Q22f	Has information been collected about the patient regarding life details which aid communication?	0.67	0.61-0.73
	SECTION 3: DISCHARGE		
	Whether this section was applicable or not applicable?	0.89	0.85-0.92
Q23	At the point of discharge the patient's level of cognitive impairment, using a standardised assessment, was summarised and recorded:	0.56	0.47-0.66
Q24	At the point of discharge the cause of cognitive impairment was summarised and recorded:	0.55	0.47-0.63
Q25	Have there been any symptoms of delirium?	0.63	0.56-0.70
Q25a	Have the symptoms of delirium been summarised for discharge?	0.61	0.48-0.75
Q26	Have there been any persistent behavioural and psychiatric symptoms of dementia (wandering, aggression, shouting) during this admission?	0.61	0.52-0.70
Q26a	Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?	0.68	0.50-0.86
Q27	Is there a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence?	0.64	0.58-0.71
Q27a	(If yes to Q27) documented concerns about the patient's capacity to consent to the referral and.....	0.61	0.48-0.73
Q28	Did a named person/identified team coordinate the discharge plan?	0.54	0.46-0.63
Q29a	Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the person with dementia?	0.48	0.42-0.54
Q29b	Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the person's carer/relative?	0.55	0.48-0.63
Q29c	Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with the consultant responsible for the patient's care?	0.53	0.45-0.61
Q29d	Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed place of discharge and support needs with other members of the multidisciplinary team?	0.58	0.50-0.67
Q30	Has a single plan/summary for discharge with clear updated information been produced?	0.48	0.38-0.59
Q31	Are any support needs that have been identified documented in the discharge plan/summary?	0.48	0.41-0.54
Q32	Has the patient and/or carer received a copy of the plan/summary?	0.50	0.42-0.57
Q33	Was a copy of the discharge plan/summary sent to the GP primary care team on the day of discharge?	0.38	0.25-0.51
Q34	Was discharge planning initiated within 24 hours of admission?	0.54	0.48-0.60
Q34a	Please select the recorded reason why discharge planning could not be initiated within 24 hours	0.60	0.44-0.76
Q35	Carers or family have received notice of discharge and this is documented:	0.47	0.42-0.53
Q36	An assessment of the carer's current needs has taken place in advance of discharge:	0.47	0.41-0.54

Dates:

	Rate of agreement between auditors in dates given	
	Overall Exact Agreement	Further details about nature of disagreement
Admission date	91% (731/806)	50 (1 day), 15 (2-7 days), 4 (8-27 days), 5 (28-55 days), 1 (60 days)
Discharge / inpatient death date	95% (765/806)	21 (1 day), 14 (2-7 days), 3 (8-27 days), 1 (28-55 days), 2 (56-61 days)

Numerical data:

	Rate of agreement between auditors in data given	
	Overall Exact Agreement	Further details about nature of disagreement
Age (years)	88% (707/806)	76 (1 yr), 15 (2-4 yr), 1 (5-9 yr), 6 (10-19 yr), 1 (26 yr)
LOS (days)	86% (694/806)	68 (1 day), 28 (2-7 days), 7 (8-27 days), 6 (28-55 days), 3 (56-61 days)

DETAILED TABLES

KEY to reading the following tables of agreement
The main auditor data reads from Left to Right, i.e. across the table whilst the Repeat Auditor data runs down the table. Repeat auditor variable names all begin with the letter 'R'.

Has the patient been in hospital for 72 hours or longer? Both auditors said 'Yes' for all 806 patients.

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.

KAPPA=0.96		R Age of patient in whole years at discharge							
		<65	65-74	75-79	80-84	85-89	90-94	95+	Total
Age of patient in whole years at discharge	<65	17	1	-	-	-	-	-	18
	65-74	-	64	-	-	-	-	-	64
	75-79	-	2	115	1	-	-	-	118
	80-84	-	1	1	189	3	-	-	194
	85-89	-	-	1	2	211	4	-	218
	90-94	1	-	-	2	5	144	2	154
	95+	-	-	-	-	-	-	40	40
	Total	18	68	117	194	219	148	42	806

2. Select the gender of the patient:

KAPPA=0.94		R *Select the gender of the patient		
		Male	Female	Total
Select the gender of the patient	Male	298	12	310
	Female	10	486	496
	Total	308	498	806

3. Select the ethnicity of the patient:

KAPPA=0.63		R Select the ethnicity of the patient					
		White	Asian/ Asian British	Black/ Black British	Other	Not documented	Total
Select the ethnicity of the patient	White	633	-	-	31	5	669
	Asian/ Asian British	-	11	-	-	-	11
	Black/ Black British	2	-	12	-	-	14
	Mixed	1	-	-	1	-	2
	Other	41	-	-	52	4	97
	Not documented	-	1	1	-	11	13
	Total	677	12	13	84	20	806

4. Select the first language of the patient:

KAPPA=0.63		R Select the first language of the patient						Total
		English	Welsh	Other European language	Asian Language	Not documented	Other	
Select the first language of the patient	English	580	2	4	-	36	1	623
	Welsh	1	1	-	-	1	-	3
	Other European language	-	-	2	-	-	2	4
	Asian Language	-	-	-	8	1	-	9
	Not documented	55	-	-	-	104	2	161
	Other	-	-	-	-	-	6	6
	Total	636	3	6	8	142	11	806

5. Please identify the speciality of the ward that this patient spent the longest period on during this admission:

KAPPA=0.74		R Please identify the speciality of the ward that this patient spent the longest period on during this admission											Total
		Cardiac	Care of the Elderly/complex care	General Medical	Nephrology	Obstetrics/ Gynaecology	Oncology	Orthopaedics	Stroke	Surgical	Other Medical	Other	
Please identify the speciality of the ward that this patient spent the longest period on during this admission	Cardiac	20	1	2	-	-	-	-	-	-	-	-	23
	Care of the Elderly/complex care	3	294	20	-	1	-	3	4	7	-	3	335
	Critical Care	-	-	1	-	-	-	-	-	-	-	-	1
	General Medical	3	13	147	-	-	-	-	3	1	22	-	189
	Nephrology	-	-	-	5	-	-	-	-	-	-	-	5
	Oncology	-	-	-	-	-	1	-	-	-	1	-	2
	Orthopaedics	-	1	1	-	-	-	64	-	1	-	-	67
	Stroke	-	1	2	-	-	-	-	31	-	-	-	34
	Surgical	-	3	4	-	1	-	4	-	41	1	1	55
	Other Medical	2	3	29	-	-	-	-	-	2	43	1	80
	Other	-	4	5	-	-	-	-	-	-	3	2	14
	Unknown	-	-	-	-	-	-	-	-	1	-	-	1
	Total	28	320	211	5	2	1	71	38	53	70	7	806

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

E.g. Fractured femur, stroke

This was a free-text field and thus difficult to estimate reliability without categorization. All that has been done in this report is to compare the free text entries - see the appendix.

7. Did the patient die while in hospital?

KAPPA=0.98		R Did the patient die whilst in hospital?		
		Yes	No	Total
Did the patient die whilst in hospital?	Yes	118	3	121
	No	1	684	685
	Total	119	687	806

8. Did the patient self-discharge from hospital?

Applied if both auditors agreed that the patient did not die in hospital (N=684 from above table)

Total agreement		R Did the patient self-discharge from hospital?	
		No	Total
Did the patient self-discharge from hospital?	No	684	684
	Total	684	684

9. Is the discharge marked as 'fast track discharge'/ 'discharge to assess'/ 'transfer to assess'/ expedited with family agreement for recorded reasons?

Applied if both auditors agreed that the patient did not die in hospital (N=684 from above table)

KAPPA=0.74		R Is the discharge marked as fast track discharge/ discharge to assess/ transfer to assess/ expedited with family agreement for recorded reasons?		
		Yes	No	Total
Is the discharge marked as fast track discharge/ discharge to assess / transfer to assess/ expedited with family agreement for recorded reasons?	Yes	33	12	45
	No	9	630	639
	Total	42	642	684

10. Was the patient receiving end of life care/on an end of life care plan?

KAPPA=0.83		R Was the patient receiving end of life care/ on an end of life care plan?		
		Yes	No	Total
Was the patient receiving end of life care/ on an end of life care plan?	Yes	109	23	132
	No	13	661	674
	Total	122	684	806

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

KAPPA=0.94		R Length of stay						
		<5 days	5-9 days	10-14 days	15-19 days	20-29 days	30+ days	Total
Length of stay	<5 days	90	1	-	-	1	-	92
	5-9 days	4	223	1	-	-	-	228
	10-14 days	-	4	154	3	-	-	161
	15-19 days	-	-	3	88	4	-	95
	20-29 days	-	2	-	1	82	1	86
	30+ days	1	9	-	2	-	132	144
	Total	95	239	158	94	87	133	806

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.

KAPPA=0.82		R Please indicate the place in which the person was living or receiving care before admission									
		Own home	Respite care	Rehabilitation	Psychiatric ward	Carers home	Intermediate care	Residential care	Nursing home	Transfer from another hospital	Total
Please indicate the place in which the person was living or receiving care before admission	Own home	446	2	2	-	8	-	2	4	-	464
	Respite care	1	7	-	-	-	-	1	1	-	10
	Rehabilitation	1	-	2	-	-	-	-	-	1	4
	Psychiatric ward	1	-	-	2	-	-	-	-	-	3
	Carers home	3	-	-	-	10	-	1	1	-	15
	Intermediate care	-	-	-	-	-	2	-	1	-	3
	Residential care	2	-	-	-	2	-	112	16	-	132
	Nursing home	2	2	-	-	1	-	29	136	-	170
	Transfer from another hospital	1	-	-	-	-	-	-	-	2	3
	Long stay care	-	-	-	-	-	-	-	2	-	2
	Total	457	11	4	2	21	2	145	161	3	806

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.

Q13 is <u>not applicable</u> if Q7 = "Yes" (the patient died) -
Both auditors agreed for N=684 that the patient did not die as an inpatient

KAPPA=0.78		R Please indicate the place in which the person was living or receiving care after discharge											
		Own home	Respite care	Rehabilitation	Psychiatric ward	Carers home	Intermediate care	Residential care	Nursing home	Palliative care	Transfer to another hospital	Unknown	Total
Please indicate the place in which the person was living or receiving care after discharge	Own home	248	-	-	-	3	-	2	2	1	-	1	257
	Respite care	1	6	1	-	-	-	2	-	1	1	0	12
	Rehabilitation	2	-	15	-	1	2	1	1	-	1	0	23
	Psychiatric ward	-	-	-	5	-	-	-	-	-	1	0	6
	Carers home	3	-	-	-	5	-	1	1	-	-	0	10
	Intermediate care	-	2	4	1	1	9	1	2	-	-	0	20
	Residential care	4	1	2	-	1	1	99	20	-	-	0	128
	Nursing home	2	1	-	-	2	-	28	164	1	-	0	198
	Palliative care	-	-	-	-	-	-	1	1	3	1	0	6
	Transfer to another hospital	-	-	1	-	-	1	-	1	-	19	0	22
	Long stay care	-	-	-	-	-	-	-	2	-	-	0	2
	Total	260	10	23	6	13	13	135	194	6	23	1	684

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.

A multi-disciplinary assessment 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.

***N.B.** elements of assessment may be found in places such as nursing notes and OT assessments as well as in medical notes.*

MULTIDISCIPLINARY ASSESSMENT

14. 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.

KAPPA=0.50		R An assessment of mobility was performed by a healthcare professional			
		Yes	No	Could not be assessed for recorded reasons	Total
An assessment of mobility was performed by a healthcare professional	Yes	628	19	22	669
	No	22	18	7	47
	Could not be assessed for recorded reasons	34	9	47	90
	Total	684	46	76	806

15. 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.

KAPPA=0.54		R An assessment of nutritional status was performed by a healthcare professional			
		Yes	No	Could not be assessed for recorded reasons	Total
An assessment of nutritional status was performed by a healthcare professional	Yes	671	28	2	701
	No	33	48	5	86
	Could not be assessed for recorded reasons	9	5	5	19
	Total	713	81	12	806

15a. The assessment of nutritional status includes recording of BMI (Body Mass Index) or weight:

Please select third option if, for example, patient was too frail to be weighed and other action was taken e.g. referral to dietician.

KAPPA=0.66		R The assessment of nutritional status includes recording of BMI or weight			
		Yes	No	Other action taken	Total
The assessment of nutritional status includes recording of BMI or weight	Yes	542	18	10	570
	No	19	56	5	80
	Other action taken	4	4	12	20
	Could not be assessed for recorded reasons(new)	-	-	1	1
	Total	565	78	28	671

16. Has a formal pressure ulcer risk assessment been carried out and score recorded?

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

KAPPA=0.51		R Has a formal pressure sore risk assessment been carried out and score recorded?		
		1 Yes	2 No	Total
Has a formal pressure sore risk assessment been carried out and score recorded?	Yes	745	18	763
	No	21	22	43
	Total	766	40	806

17. 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. See Essence of Care - benchmarks for continence and bladder and bowel care, Indicator Factor 3). Answer "Yes" if family member, GP etc has been asked on behalf of the patient.

KAPPA=0.46		R As part of the multidisciplinary assessment has the patient been asked about any continence needs?			
		Yes	No	Could not be assessed for recorded reasons	Total
As part of the multidisciplinary assessment has the patient been asked about any continence needs?	Yes	610	41	12	663
	No	53	55	3	111
	Could not be assessed for recorded reasons	10	9	13	32
	Total	673	105	28	806

18. As part of the multidisciplinary assessment has the patient been assessed for the presence of any pain?

Answer "Yes" where the notes show that there has been an assessment of pain using a tool suitable for people with dementia (e.g. the Abbey Pain Scale), or the patient, family member or GP has been asked about any pain and response recorded.

KAPPA=0.41		R As part of the multidisciplinary assessment has the patient been assessed for the presence of any pain?			
		Yes	No	Could not be assessed for recorded reasons	Total
As part of the multidisciplinary assessment has the patient been assessed for the presence of any pain?	Yes	564	82	3	649
	No	59	74	4	137
	Could not be assessed for recorded reasons	8	4	8	20
	Total	631	160	15	806

19. Has an assessment of functioning been carried out?

KAPPA=0.49		R Has an assessment of functioning been carried out?						
		Yes, a standardised assessment has taken place	Yes, an occupational therapy assessment has taken place	Yes, a physiotherapy assessment has taken place	Yes, other please specify	No	Could not be assessed for recorded reasons	Total
Has an assessment of functioning been carried out?	Yes, a standardised assessment has taken place	156	24	15	18	8	9	230
	Yes, an occupational therapy assessment has taken place	29	71	17	10	2	2	131
	Yes, a physiotherapy assessment has taken place	30	12	99	14	8	2	165
	Yes, other please specify	27	22	10	70	2	2	133
	No	19	2	6	8	44	7	86
	Could not be assessed for recorded reasons	7	1	4	6	7	36	61
	Total	268	132	151	126	71	58	806

MENTAL STATE ASSESSMENT

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

This should be assessment using a standardised instrument such as Abbreviated mental test score (AMTS), 6-Item cognitive impairment test (6CIT), General practitioner assessment of cognition (GPCOG), or other standardised tool.

KAPPA=0.70		R Has a standardised mental status test been carried out?			
		Yes	No	Could not be assessed for recorded reasons	Total
Has a standardised mental status test been carried out?	Yes	340	39	14	393
	No	29	252	25	306
	Could not be assessed for recorded reasons	15	25	67	107
	Total	384	316	106	806

21. 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 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

KAPPA=0.52		R Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?			
		Yes, and there were indications that delirium may be present	Yes, but there was no indication that delirium may be present	No assessment has been carried out	Total
Has an assessment been carried out for recent changes or fluctuation in behaviour that may indicate the presence of delirium?	Yes, and there were indications that delirium may be present	152	17	49	218
	Yes, but there was no indication that delirium may be present	22	80	53	155
	No assessment has been carried out	50	37	346	433
	Total	224	134	448	806

21a. 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

This only applied to whether both auditors agreed that 'Yes, and there were indications that delirium may be present', N=152 from table above.

KAPPA=0.61		R Has the patient been clinically assessed for delirium by a healthcare professional?		
		1 Yes	2 No	Total
Has the patient been clinically assessed for delirium by a healthcare professional?	1 Yes	122	6	128
	2 No	9	15	24
	Total	131	21	152

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. **N.B.** 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).

22. 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?

KAPPA=0.60		R 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	No	Total
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	378	89	467
	No	70	269	339
	Total	448	358	806

The rest of Q22 (Q22a through Q22f) applied only for N=378 (above table) where both auditors agreed that the care assessment contained a section dedicated to collecting information from the carer next of kin or a person who knew the patient well.

22a. 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 "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. "This is Me" or patient passport) and no copy is available in the notes.
Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

KAPPA=0.71		R Has information been collected about the patient regarding personal details preferences and routines?				
		Yes	No	Unknown	N/A	Total
Has information been collected about the patient regarding personal details preferences and routines?	Yes	155	15	11	2	183
	No	7	55	7	-	69
	Unknown	15	9	97	1	122
	N/A	-	1	2	1	4
	Total	177	80	117	4	378

22b. 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 "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. "This is Me" or patient passport) and no copy is available in the notes.
Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

KAPPA=0.71		R Has information been collected about the patients food and drink preferences?				
		Yes	No	Unknown	N/A	Total
Has information been collected about the patients food and drink preferences?	Yes	134	8	12	4	158
	No	7	67	11	1	86
	Unknown	11	15	100	2	128
	N/A	1	-	1	4	6
	Total	153	90	124	11	378

22c. 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 "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. "This is Me" or patient passport) and no copy is available in the notes.
Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

KAPPA=0.65		R Has information been collected about the patient regarding reminders or support with personal care?				
		Yes	No	Unknown	N/A	Total
Has information been collected about the patient regarding reminders or support with personal care?	Yes	163	15	20	4	202
	No	8	45	7	-	60
	Unknown	17	6	86	1	110
	N/A	1	1	1	3	6
	Total	189	67	114	8	378

22d. 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 "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. "This is Me" or patient passport) and no copy is available in the notes.
Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

KAPPA=0.73		R Has information been collected about the patient regarding recurring factors that may cause or exacerbate distress?				
		Yes	No	Unknown	N/A	Total
Has information been collected about the patient regarding recurring factors that may cause or exacerbate distress?	Yes	94	8	7	2	111
	No	8	93	11	1	113
	Unknown	13	17	115	1	146
	N/A	1	-	1	6	8
	Total	116	118	134	10	378

22e. 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 "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. "This is Me" or patient passport) and no copy is available in the notes.
Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

KAPPA=0.72		R Has information been collected about the patient regarding support or actions that can calm the person if they are agitated?				
		Yes	No	Unknown	N/A	Total
information been collected about the patient regarding support or actions that can calm the person if they are agitated?	Yes	77	7	6	3	93
	No	10	97	15	1	123
	Unknown	7	16	119	1	143
	N/A	1	3	3	12	19
	Total	95	123	143	17	378

22f. 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 "Unknown" if this information is usually recorded in a document which accompanies the patient (e.g. "This is Me" or patient passport) and no copy is available in the notes.
Answer "N/A" if there is no carer/relative/friend and information is not available and recorded as such.

KAPPA=0.67		R Has information been collected about the patient regarding life details which aid communication?				
		Yes	No	Unknown	N/A	Total
Has information been collected about the patient regarding life details which aid communication?	Yes	119	17	9	3	148
	No	12	58	12	-	82
	Unknown	14	10	111	2	137
	N/A	2	1	1	7	11
	Total	147	86	133	12	378

SECTION 3: DISCHARGE

This section does not apply to all patients.

If <u>any</u> of the responses below apply, you will <u>not be asked</u> any questions in the Discharge Section and can progress to the end of the form:

Q7 = "Yes" (patient died in hospital)
Q8 = "Yes" (patient self-discharged from hospital)
Q10 = "Yes" (patient was receiving end of life/on end of life plan)
Q9= "Yes" (patient on fast track discharge/discharge to assess/transfer to assess/expedited with family agreement)
Q13 = "Transferred to another hospital" OR "Psychiatric ward" OR "Palliative care" OR "Intermediate care" OR "Rehabilitation"

KAPPA=0.89		R Rest of form applicable?		
		Applicable	Not applicable	Total
Rest of form applicable?	Applicable	536	14	550
	Not applicable	25	231	256
	Total	561	245	806

The discharge section applied to N=536 (above table) for which both auditors agreed that the Discharge section was relevant, according to their responses to Questions 7,8,9,10 & 13 as described above.

ASSESSMENT BEFORE DISCHARGE

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

23. 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. Abbreviated mental test score (AMTS), 6-Item cognitive impairment test (6CIT), General practitioner assessment of cognition (GPCOG) or other standardised tool.

KAPPA=0.56		R At the point of discharge the patients level of cognitive impairment using a standardised assessment was summarised and recorded		
		Yes	No	Total
At the point of discharge the patients level of cognitive impairment using a standardised assessment was summarised and recorded	Yes	62	41	103
	No	28	405	433
	Total	90	446	536

24. 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.

KAPPA=0.55		R At the point of discharge the cause of cognitive impairment was summarised and recorded		
		Yes	No	Total
At the point of discharge the cause of cognitive impairment was summarised and recorded	Yes	336	43	379
	No	54	103	157
	Total	390	146	536

25. 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.

KAPPA=0.63		R Have there been any symptoms of delirium?		
		Yes	No	Total
Have there been any symptoms of delirium?	Yes	141	38	179
	No	51	306	357
	Total	192	344	536

25a. Have the symptoms of delirium been summarised for discharge?

This applied to when both auditors agreed there had been symptoms of delirium (N=141 above table)

KAPPA=0.61		R Have the symptoms of delirium been summarised for discharge?		
		Yes	No	Total
Have the symptoms of delirium been summarised for discharge?	Yes	65	16	81
	No	11	49	60
	Total	76	65	141

26. 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.

KAPPA=0.61		R Have there been any persistent behavioural and psychiatric symptoms of dementia during this admission?		
		Yes	No	Total
Have there been any persistent behavioural and psychiatric symptoms of dementia during this admission?	Yes	69	28	97
	No	36	403	439
	Total	105	431	536

26a. Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?
This includes details of future assessment/management

This applied to when both auditors agreed there had been persistent behavioural and psychiatric symptoms of dementia during the admission (N=69 above table)

KAPPA=0.68		Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?		
		Yes	No	Total
Have the symptoms of behavioural and psychiatric symptoms of dementia been summarised for discharge?	Yes	25	7	32
	No	4	33	37
	Total	29	40	69

27. Is there a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence?

KAPPA=0.64		R Is there a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence?			
		Yes	No	N/A no change in residence was proposed	Total
Is there a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence?	Yes	90	5	17	112
	No	5	33	33	71
	N/A no change in residence was proposed	17	17	319	353
	Total	112	55	369	536

27a. If yes…

There are documented concerns about the patient's capacity to consent to the referral and…		**There are no documented concerns about the patient's capacity to consent to the referral and…**	
The patient had capacity on assessment and their consent is documented	☐	**The patients consent was requested and this is recorded**	☐
The patient lacked requisite capacity and evidence of a best interests decision has been recorded	☐	**There is no record of the patient's consent**	☐
There is no record of either consent or best interest decision making	☐		

This applied to when both auditors agreed there was a recorded referral to a social worker for assessment of housing and care needs due to a proposed change in residence? (N=90 above table)

KAPPA=0.61		R Q27a concerns?					
		1 Documented concerns: the patient had capacity on assessment and their consent is documented	2 Documented concerns: the patient lacked requisite capacity and evidence of a best interests decision has been recorded	3 Documented concerns: there is no record of either consent or best interest decision making	4 No documented concerns: The patients consent was requested and this is recorded	5 No documented concerns: There is no record of the patients consent	Total
Q27a concerns?	1 Documented concerns: the patient had capacity on assessment and their consent is documented	5	3	-	1	-	9
	2 Documented concerns: the patient lacked requisite capacity and evidence of a best interests decision has been recorded	2	30	3	-	3	38
	3 Documented concerns: there is no record of either consent or best interest decision making	-	3	11	-	2	16
	4 No documented concerns: The patients consent was requested and this is recorded	1	-	-	5	2	8
	5 No documented concerns: There is no record of the patients consent	1	-	3	2	13	19
	Total	9	36	17	8	20	90

28. Did a named person/identified team coordinate the discharge plan?

E.g. the person or team that coordinated the plan for this individual is identifiable.

KAPPA=0.54		R Did a named person /identified team coordinate the discharge plan?			
		Yes	No	There is no discharge plan	Total
Did a named person/ identified team coordinate the discharge plan?	Yes	377	34	6	417
	No	34	63	4	101
	There is no discharge plan	6	4	8	18
	Total	417	101	18	536

29a. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed 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.

KAPPA=0.48		R Evidence that the discharge coordinator has discussed place of discharge and support needs with the person with dementia?			
		Yes	No	N/A	Total
Evidence that the discharge coordinator has discussed place of discharge and support needs with the person with dementia?	Yes	171	42	20	233
	No	49	157	17	223
	N/A	16	27	37	80
	Total	236	226	74	536

29b. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed 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.

KAPPA=0.55		R Is there evidence in the notes that the discharge coordinator / person or team planning discharge has discussed place of discharge and support needs with the persons carer/relative?			
		Yes	No	N/A	Total
Is there evidence in the notes that the discharge coordinator / person or team planning discharge has discussed place of discharge and support needs with the persons carer/relative?	Yes	366	31	7	404
	No	32	68	5	105
	N/A	11	6	10	27
	Total	409	105	22	536

29c. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed 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.

KAPPA=0.53		R Evidence that the discharge coordinator has discussed place of discharge and support needs with the consultant responsible for the patients care?		
		Yes	No	Total
Evidence that the discharge coordinator has discussed place of discharge and support needs with the consultant responsible for the patients care?	Yes	328	38	366
	No	67	103	170
	Total	395	141	536

McNemar test p=0.006. This is the only evidence from across the dataset of a systematic shift between original and independent auditor, with the duplicate auditor more likely to indicate that discussions had taken place with the consultant.

29d. Is there evidence in the notes that the discharge coordinator/person or team planning discharge has discussed 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.

KAPPA=0.58		R Evidence that the discharge coordinator has discussed place of discharge and support needs with other members of the multidisciplinary team?		
		Yes	No	Total
Evidence that the discharge coordinator has discussed place of discharge and support needs with other members of the multidisciplinary team?	Yes	382	33	415
	No	43	78	121
	Total	425	111	536

30. Has a single plan/summary 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.

KAPPA=0.48		R Has a single plan/summary for discharge with clear updated information been produced?		
		Yes	No	Total
Has a single plan/summary for discharge with clear updated information been produced?	Yes	408	42	450
	No	35	51	86
	Total	443	93	536

31. Are any support needs that have been identified documented in the discharge plan/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.

KAPPA=0.48		R Are any support needs that have been identified documented in the discharge plan/summary?			
		Yes	No	N/A	Total
Are any support needs that have been identified documented in the discharge plan/summary?	Yes	224	51	12	287
	No	53	134	7	194
	N/A	15	20	20	55
	Total	292	205	39	536

32. Has the patient and/or carer received a copy of the plan/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 or 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 or carer receives no information.
Answer "N/A" if there is no carer and the patient could not be given the information.

KAPPA=0.50		R Has the patient and/or carer received a copy of the plan/summary?			
		Yes	No	N/A	Total
Has the patient and/or carer received a copy of the plan/summary?	Yes	348	38	19	405
	No	32	68	6	106
	N/A	9	6	10	25
	Total	389	112	35	536

33. Was a copy of the discharge plan/summary sent to the GP/primary care team on the day of discharge?

Answer "N/A" if no discharge plan or summary has been produced.

KAPPA=0.38		R Was a copy of the discharge plan/summary sent to the GP primary care team on the day of discharge?			
		Yes	No	N/A	Total
Was a copy of the discharge plan/summary sent to the GP primary care team on the day of discharge?	Yes	468	16	8	492
	No	16	12	1	29
	N/A	8	2	5	15
	Total	492	30	14	536

DISCHARGE PLANNING

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

This includes planning for transfer to another care setting. Answer "N/A" if there is a recorded reason why discharge planning could not be initiated within 24 hours of admission.

KAPPA=0.54		R Was discharge planning initiated within 24 hours of admission?			
		Yes	No	N/A	Total
Was discharge planning initiated within 24 hours of admission?	Yes	144	23	23	190
	No	28	146	26	200
	N/A	25	36	85	146
	Total	197	205	134	536

34a. Please select the recorded reason why discharge planning could not be initiated within 24 hours:

This applied to the N=85 (above table) that both auditors found a recorded reason for as to why discharge planning could not be initiated within 24 hours of admission.

KAPPA=0.60		R Please select the recorded reason why discharge planning could not be initiated within 24 hours							
		Patient acutely unwell	Patient awaiting assessment	Patient awaiting history/ results	Patient awaiting surgery	Patient presenting confusion	Patient being discharged to nursing/ residential care/waiting on place discharge	Other	Total
Please select the recorded reason why discharge planning could not be initiated within 24 hours	Patient acutely unwell	44	1	4	2	-	1	-	52
	Patient awaiting assessment	3	5	-	-	-	-	-	8
	Patient awaiting history/results	1	-	2	-	-	-	-	3
	Patient awaiting surgery	3	-	-	4	-	1	-	8
	Patient presenting confusion	1	1	-	-	3	-	-	5
	Patient being discharged to nursing/ residential care/waiting on place discharge	2	-	-	-	-	6	-	8
	Other	-	-	-	-	-	-	1	1
	Total	54	7	6	6	3	8	1	85

SUPPORT FOR CARERS AND FAMILY

35. 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.

KAPPA=0.47		R Carers or family have received notice of discharge and this is documented								
		Less than 24 hours	24 hours	25- 48 hours	More than 48 hours	No notice at all	No carer, family, friend	Not documented	Patient specified information to be withheld	Total
Carers or family have received notice of discharge and this is documented	Less than 24 hours	71	3	9	10	-	-	16	-	109
	24 hours	13	30	9	8	-	-	10	-	70
	25 - 48 hours	6	7	36	15	-	2	10	-	76
	More than 48 hours	11	5	7	100	1	2	17	-	143
	No notice at all	-	1	-	-	1	-	-	-	2
	No carer, family, friend	-	-	1	1	-	1	3	-	6
	Not documented	19	1-	6	19	1	1	73	-	129
	Patient specified information to be withheld	-	-	-	-	-	-	-	1	1
	Total	120	56	68	153	3	6	129	1	536

36. 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.

KAPPA=0.47		R An assessment of the carers current needs has taken place in advance of discharge			
		Yes	No	N/A	Total
An assessment of the carers current needs has taken place in advance of discharge	Yes	118	18	40	176
	No	27	46	24	97
	N/A	38	28	197	263
	Total	183	92	261	536

APPENDIX : Q6 WHAT IS THE PRIMARY DIAGNOSIS/CAUSE OF ADMISSION

	ORIGINAL AUDITOR	REPLICATION AUDITOR
1		SOB, general decline
2	Delirium sec to sepsis-CAP.	UTI
3	Known alcohol dependent. Feeling generaly unwelln with heavines in legs. Noted to be confused and jaundice.	Korsakoff's syndrome
4	? ACS	Musculoskeletal pain
5	? AKI ? GI neoplasm	?AKI, ?GI Neoplasm
6	? Chest infection - reduced appetite, not getting out of bed, more drowsy. minimal oral intake - 600mls water since friday evening, no food. S/B GP on friday - started on abx for possible chest infection (pyrexial)	sepsis, pneumonia
7	? GI bleed, chronic anaemia/CCF	?GI bleed, Chronic anaemia, CCF
8	?Abdominal pain ?Shortness of breath	Abdominal pain with derranged liver function tests
9	# distal femur	Right distal femur fracture
10	#NOF	#NOF
11	#NOF, Ca Lung	#NOF, Ca lung
12	#pubic	#pubic
13	Abdominal distension	Pseudo-obstruction
14	Abdominal hernia	abdominal hernia
15	Abdominal pain	Diverticulitis
16	Abdominal pain	Abdominal pain
17	abdominal pain and delirium	unwitnessed fall, abdominal pains and delirium
18	Abdominal pain, neuropathic pain diagnozed with shingles for the second time.	abdominal pain, shingles
19	Abdominal pains	abdominal pain urinary tract infection
20	Abnormal weight loss	Weight loss, age-related decline
21	Above knee amputation	Above knee amputation.
22	accidental fall	Unwitnessed Fall
23	ACS	ACS
24	ACS	UTI
25	Acute cholangitis	acute cholangitis
26	acute confusion	delirium/progressive dementia
27	Acute Confusion	Acute confusion
28	Acute confusion - Acapia	Vascular dementia
29	Acute confusion - Diagnosis, delirium and acute kidney injury, urosepsis.	Urosepsis
30	Acute confusion, UTI.	Acute Confusion
31	Acute confusion/vascular dementia	delirium/underlying dementia
32	acute confusional state	Delirium, AKI, CAP
33	Acute delirium, community acquired pneumonia	Chest sepsis, delirium
34	acute exacerbation of copd	Chronic Obstructive Pulmonary Disease
35	Acute gout anf cognitive decline likely Lewy Body dementia	Delirium, gout
36	Acute kidney injury	AKI
37	Acute kidney injury	Haematuria.AK1
38	Acute kidney injury	acute renal failure
39	Acute Kidney Injury	Acute Kidney Injury
40	Acute Kidney Injury	Unresponsive episode & AKI
41	Acute Kidney Injury	Reduced appetite, reduced conscious level, progression of dementia
42	Acute kidney injury urinary tract infection	Lewy Body Dementia ,Hypertension
43	Acute kidney injury, due to urinary retention and UTI.	Urinary retention, UTI, AKI stage II
44	acute kidney injury/dehydration	AKI, dehydration
45	acute limb ischaemia	ischaemic leg
46	Acute on chronic cholecystitis	Persistent cough and vomiting, acute on chronic cholecystitis
47	Acute on chronic renal failure	Chronic Leg Oedema, Acute kidney injury
48	Acute pancreatitis	Acute pancreatitis, Aspiration pneumonia
49	Acute Renal Failure	Delirium, fatigue, off legs
50	acute stroke	Stroke, dehydration.
51	ADMITTED WITH 4/7 INCREASED CONFUSION,WONDERING AND AGITATED FOUND TO BE CONSTIPATED,GIVEN ENEMA WITH A GOOD EFFECT	confusion, UTI
52	Admitted with cough and reduced responsiveness. Treated for Low respiratory tract infection and urinary retention.	Aspiration pneumonia

53	Advanced Alzheimer's Disease with poor oral intake	Urosepsis, Advanced alzheimers dementia with poor nutritional intake as a result
54	Advanced Dementia	Advanced dementia
55	Advanced Dementia	Advance Dementia
56	Advanced Parkinson's Disease, Parkinson's Disease Dementia	UTI, poor mobility, progression of parkinsons
57	AECOPD, back pain	Delirium, COPD and medication , UTI
58	AF, pneumonia, Alzheimers	Shortness of breath/chest pain. TIA, CKD3, Hypertension
59	AKI	AKi - acute kidney injury
60	AKI	AKI
61	AKI / Sepsis	Sepsis, AKI, Lung CA , Rigors,
62	AKI due to UTI and retention	aki, uti
63	AKI secondary to poor oral intake/dehdration	Hypoactive delirium
64	AKI, poor oral intake 2 dementia	Poor oral intake & AKI secondary to dementia
65	AKI, reduced mobility, dehydration	Acute Kidney Injury, Falls, Fraility
66	Alcohol withdrawal	Fall and confusion, secondary to alcohol intoxication
67	Alcohol withdrawal	Pulmonary oedema
68	Alcohol withdrawal symptoms seizures	seizures
69	Anaemia,Vascular Dementia	Anaemia
70	Aspiration	pneumonia
71	Aspiration - Pneumonia	Pneumonia
72	aspiration pneumonia	Aspiration Pneumonia
73	aspiration pneumonia	SOB , Chest pain
74	aspiration pneumonia	sepsis
75	Aspiration pneumonia	aspiration pneumonia
76	Aspiration pneumonia	Aspiration pneumonia
77	Aspiration pneumonia	Aspiration Pneumonia
78	Aspiration pneumonia	pneumonitis due to vomit
79	Aspiration pneumonia	Aspiration Pneumonia
80	Aspiration Pneumonia	Aspiration Pneumonia
81	Aspiration Pneumonia	Aspiration pneumonia
82	Aspiration Pneumonia	aspiration pneumonia / end stage dementia
83	ASPIRATION PNEUMONIA	SEPSIS SECONDARY TO ASPIRATION PNEUMONIA.
84	Aspiration Pneumonia and sepsis	aspirational pneumonia
85	Aspiration Pneumonia due to PEG feed	Aspiration Pneumonia
86	Aspiration pneumonia, E.coli bacteraemia, advanced dementia	Pneumonitis due to food and vomit.
87	Aspiration Pneumonia, Urosepsis	Aspiration pneumonia
88	asthma exacerbation	shortness of breath worsening over last 10 days
89	Back pain, abdominal pain, acopia	not coping/back pain/ main carer unwell
90	Back pain, reduced lower limb sensation and reduced mobility	Backpain- Cord compression and signs of myelopathy
91	Behavioural issues due to progression of dementia	behavioural and psychological symptoms related to dementia
92	Benign Neoplasm of Sygmoid Colon	Colonic polyp, diverticular disease, haemorrhoids
93	Bilateral chronic subdural hematoma with subacute bleed	Confusion, bilateral chronic subdural, CT Brain, haematoma with subcute bleed
94	bilateral pneumonia	Shortness of Breath and a cough
95	Bilateral Pneumonia	Infected Legs Cellultis
96	Bilateral pneumonia.	Pneumonia
97	biliary sepsis	biliary sepsis
98	biliary sepsis and gall bladder collection	billiary sepsis,gall bladder collection
99	Billiary sepsis	Biliary sepsis
100	Bowel Obstruction	Bowel obstruction
101	Brain metastases	Lung malignancy with cerebral metastases
102	bronchitis	Exacerbation of COPD, Rule out PE
103	bronchopneumonia	dehydration
104	Bronchopneumonia	Cellulitis
105	Bronchopneumonia, Vascular dementia, Myocardial Infarct	Bronchopneumonia, Vascular dementia, Myocardial Infarct
106	Bruising over left neck and Trapezius	Fracture Clavicle
107	c diff diarrohea	Acute kidney injury, dehydration, gastroenteritis
108	Cardiac failure	Aggression secondary to progressive dementia, hospital acquired pneumonia, clostridium difficile
109	Catheter Associated urinary tract infection	urinary tract infection
110	CCF	Congestive cardiac failure
111	CCF, R CAP	Community acquired pneumonia
112	CCF/AF/dementia	Sepsis UTI
113	cellulitis	Increased confusion, Cellulitis right leg
114	cellulitis	Sepsis secondary to cellulitis
115	cellulitis	Cellulitis
116	cellulitis	cellulitis
117	cellulitis	left leg cellulitis
118	Cellulitis	Cellulitis
119	Cellulitis and ulcers	Infected ischaemic foot ulcer & osteomylitis

120	Cellulitis of eye.	Cellulitus of eye
121	Cerebral infarction	Cerebral infarction
122	chest infection	SOB
123	Chest infection	Chest Infection
124	Chest infection	Chest infection
125	Chest infection	Admitted with productive cough, reduced oral intake Diagnosis: Left basal healthcare associated pneumonia
126	Chest infection	Delerium Chest infection
127	Chest infection	Chest infection
128	Chest infection	Chest infection
129	Chest infection	Reduced mobility
130	Chest infection	Chest Infection
131	Chest infection	Chest infection
132	Chest infection	feverish, recent discharge from hospital fro urosepsis and HAP
133	Chest infection	Chest infection
134	Chest infection	admitted following collapse Diagnosis: syncopal episode, treated for UTI
135	Chest Infection	Chest Infection
136	Chest Infection	Chest Infection
137	Chest Infection	LRTI
138	CHEST INFECTION	PNEUMONIA
139	CHEST INFECTION	Sepsis
140	Chest infection / UTI	Chest infection / UTI
141	chest pain	chest pain
142	chest pain	chest and back pain
143	Chest pain	Chest pain - non-ST-elevation MI
144	Chest pain	Lateral STEMI
145	Chest Pain	Chest Pain- Myocardial infarction
146	Chest pain and Pneumonia	Delirium and pneumonia
147	Chest pain and shortness of breath. Not managing at home.	chest pain ,shortness of breath
148	Chest pain.	Acute coronary syndrome.
149	chest sepsis	Pneumonia
150	Chest sepsis, complex partial seizures	Complex Partial Seizures, Pneumonia
151	chest wall haematoma large stroke	spontaneous anterior chest wall haematoma
152	CHOLANGITIS	UROSEPSIS.
153	cholecycstitis	acute cholecystitis
154	Cholecystitis Gastric cancer Acute kidney injury	Cholecystitis Gastric cancer Acute kidney injury
155	Cholecystitis and Biliary Sepsis	Sepsis
156	CHRONIC DIARRHOEA AND VOMITING	chronic diarrhoea and vomiting
157	Chronic pain	right upper quadrant pain
158	Clostridium difficile diarrhoea	Found unresponsive
159	Cognitive impairment /self neglect	Cognitive impairment
160	collapse	collapse
161	collapse	Collapse
162	Collapse	Postural hypotension
163	collapse / nose bleed	nose injury
164	Collapse, diarrhoea	Collapse, diarrhoea
165	Collapse, possible LOC	Collapse, possible LOC
166	COLLAPSED	Collapse, query cause
167	Community Acquired Pneumonia Upper GI bleed Lung cancer	Community acquired pneumonia Upper GI bleed Lung cancer
168	Community Acquired Pneumonia Upper GI bleed	Community Acquired Pneumonia Upper GI bleed
169	community acquired pneumonia	community acquired pneumonia
170	community acquired pneumonia	Pneumonia
171	community acquired pneumonia	pneumonia
172	community acquired pneumonia	CAP
173	community acquired pneumonia	no comment
174	community acquired pneumonia	community acquired pneumonia

175	Community acquired pneumonia	Community acquired pneumonia
176	Community acquired pneumonia	Community acquired pneumonia
177	Community acquired pneumonia	Community Acquired Pneumonia
178	Community acquired pneumonia	Community acquired pneumonia
179	Community acquired pneumonia	Haemoptysis
180	Community acquired Pneumonia	COMMUNITY AQUIRED PNEUMONIA
181	Community acquired Pneumonia	Pneumonia
182	Community Acquired Pneumonia	Community Acquired Pneumonia
183	Community Acquired Pneumonia	COMMUNITY AQUIRED PNEUMONIA
184	Community Acquired Pneumonia	Community Acquired Pneumonia
185	Community Acquired Pneumonia / Aspiration	Pneumonia
186	Community acquired Pneumonia, Acute Kidney Injury	pneumonia
187	Community Acquired Pneumonia, Reduced mobility, Acute Urinary Retention, Cognitive decline, Increased Care Needs	community ACQUIRED PNEUMONIA
188	Community acquired pneumonia, sepsis	Pneumonia
189	Community aqcuired pneumonia and COPD	COPD/CAP
190	community aquired pneumonia	pneumonia
191	community argized pneumonia	community acquired pnemonia
192	Confused and wandering, admitted to Psychiatric ward fell and fractured femur	Alzheimer's Dementia
193	Confusion	Confusion / heel sore / delirium relating to AKI
194	Confusion	Confusion
195	Confusion	? seizure
196	Confusion	Infection - source not identified
197	Confusion, likely secondary to worsening dementia	Confusion
198	Confusion, Vascular dementia	Acute on Chronic Confusion
199	Congestive cardiac failure	Heart failure
200	Congestive heart failure	Left ventricular failure
201	Congestive Heart Failure	Congestive Cardiac Failure, UTI
202	constipation	Constipation
203	COPD	Pneumonia
204	COPD	COPD
205	COPD	Infective exacerbation of COPD, UTI
206	COPD	COPD
207	COPD, Dementia, Decline in Function	COPD
208	Cough/Cold	Cough/cold.
209	CUA (stroke)	stroke
210	CVA	Left hemispheric partial anterior circulation stroke
211	CVA	?cva
212	CVA	Seizure, post stroke epilepsy
213	Decreased GCS, left toe infection, hospital acquired pneumonia	Sepsis
214	Decreased mobility secondary to flare of rheumatoid arthritis	Decreased mobility
215	dehydration	Dehydration
216	Dehydration	Dehydration, Sepsis
217	Dehydration	Dehydration and safeguarding issues
218	Dehydration	Acute kidney injury 2nd to poor oral intake 2nd to dementia
219	Dehydration	Pneumonia
220	Dehydration	Dehydration, hypernatraemia
221	Dehydration & LRTI	Dehydration
222	Dehydration AKI	DEHYDRATION
223	Dehydration end stage dementia	Dehydration
224	Dehydration on background of dementia	Dehydration
225	Dehydration secondary to dementia	dehydration secondary to dementia
226	Dehydration, hospital acquired pneumonia	generally unwell
227	Dehydration, Hypovolaemic hypernatraemia, Acute kidney injury	Dehydration and hypernatraemia secondary to diarrhoea
228	Delerium secondary to LRTI, chronic hyponatremia	Delerium secondary to LRTI, chronic hyponatremia
229	DELERIUM DUE TO INFECTION? SOURCE	Sepsis
230	delirium	DELIRIUM
231	delirium	Delirium
232	Delirium	Delirium - infection ?source
233	Delirium	Acute Confusion/Dementia
234	DELIRIUM	DELIRIUM ON BACKGROUND OF DEMENTIA, SECONDARY TO UTI.
235	DELIRIUM	DELIRIUM
236	Delirium (hypoactive)	Delirium, secondary to LRTI
237	Delirium and cellulitis	Delirium and cellulitis
238	Delirium and dementia.	Delirium, AKI, Hospital acquired pneumonia.
239	Delirium due to acute kidney injury	Collapse / delirium
240	Delirium due to infection	fall
241	delirium secondary to constipation	Confusion secondary to constipation
242	Delirium secondary to PD medications	increasing confusion, aggression & agitation ? secondary to

		Parkinson's medication
243	Delirium secondary to UTI	Delirium secondary to UTI
244	Delirium secondary to UTI and chest infection	Bronchopneumonia, mild dysphagia secondary to dementia, hypoactive delirium
245	Delirium, UTI.	UTI
246	Dementia	confusion
247	Dementia	Confusion
248	dementia crisis	dementia crisis
249	Dementia. Alcohol dependence	Acute confusional state
250	Deranged blood sugars	Diabetic ketoacidosis
251	Deterioration secondary to progression of malignancy, ? lung mets to brain	Malignancy
252	diarrhea, Vomiting, worsening dementia	Gastroenteritis, worsening dementia
253	Diarrhoea	Loose stools. Gastroenteritis.
254	Diarrhoea	Diarrhoea
255	Diarrhoea and vomiting.	Gastroenteritis, Community acquired pneumonia.
256	Diarrhoea. C. difficile	Clostridium difficile colitis
257	dislocation left hip, arthroplasty	dislocation of left hiphemiartroplasty
258	Diverticular abscess	diverticular abscess
259	Diverticulitis	Diverticulitis
260	DKA and poor Diabetic control	pyelonephritis
261	Drowsy, no cause found	Delirium
262	eczema, Symptomatic sinus node disease	suberthrodermic eczema DDDR pacemaker implantation
263	Elective repair of rectal prolapse	rectal prolapse
264	Emergency laparoscopic repair incarcerated hernia	Femoral Hernia
265	Emergency respite, main carer, wife became ill	admitted with his wife for respite care as the wife is main carer and was unwell. Looked after by physios on ward but no clear need for medical admission
266	Epileptic seizure and LRTI	Epileptic seizures and LRTI
267	exacerbation of COPD	COPD
268	Exacerbation of COPD	Infective exacerbation of COPD
269	Exacerbation of COPD	Exacerbation of COPD
270	Exacerbation of Parkinson's Disease	Fall
271	Exaserbation of copd.	Exacerbation of COPD
272	Failed renal transplant	Acute Kidney Injury on Chronic kidney disease Urinary tract infection
273	fall back pain	fall back pain
274	fall	Fall secondary to orthostatic hypotension
275	Fall	Fall
276	Fall	Fall
277	Fall	Fall
278	Fall	Fall
279	Fall	UTI
280	Fall	Postural hypotension/fall
281	Fall	Fall
282	Fall	Fall
283	Fall	Fall
284	Fall	Fall, Urinary retention, LRTI.
285	Fall	Fall
286	Fall	? sepsis and found to have multiple hepatic abscesses
287	Fall	Fall
288	Fall	Fall with head injury
289	Fall	Fall
290	Fall	Fall ?TIA
291	Fall	Proximal Humeral Fracture
292	Fall	Fall
293	Fall	Fall
294	Fall	Fall
295	Fall	Fall
296	Fall	Fall with head injury
297	Fall	Fall
298	Fall	Seizure
299	Fall	Fall
300	FALL	fall
301	FALL	Fall
302	Fall - fracture neck of femur	Fall; Fracture femur
303	Fall - leg pain	fall - painful leg
304	Fall - no injury	Fall
305	Fall / Back Injury	Fall / Back Injury

306	Fall / sepsis secondary to chest infection	Fall / sepsis secondary to chest infection
307	Fall and dark stools	Gastritis / Duodenitis
308	Fall Dementia CKD	Fall,Dementia,CKD
309	fall due to Fast AF	fall due to fast Atrial Fibrillation
310	fall fractured neck of femur	fall with fractured neck of femur
311	fall with fractured femur	fractured femur
312	Fall with fractured pubic rami	fall, pubic rami fracture
313	Fall with minor head injury	Head laceration/Fall
314	Fall with rib fractures Community acquired Pneumonia Hospital Acquired pneumonia	Fall with rib fractures Community acquired pneumonia Hospital acquired pneumonia
315	Fall with shoulder injury	Presented with fall Diagnosed with Right femoral DVT, acute kidney injury
316	Fall with traumatic subarachnoid and subdural haemorrhage (repatriation from another hospital)	traumatic subdural and subarachnoid haemorrhage
317	Fall- multifactoral	Falls
318	Fall, ? slurred speech	Symptomatic postural hyotension causing fall.
319	Fall, chest infection	Lower respiratory tract infection + falls
320	Fall, dementia, atrial fibrillation	Community acquired pneumonia
321	fall, fractured neck of femur, pneumonia	Fractured femur
322	Fall, fractured wrist and diarrhoea	fractured wrist
323	Fall, Gastro, R-humeral head fracture	Fall
324	Fall, left fibula fracture	Fall, UTI
325	Fall, personal hypotension	UTI
326	Fall, rhabdomyolysis due to 'long lie' on the ground, delirium due to lobar pneumonia, postural hypotension due to dehydration	Pneumonia
327	Fall, right hip pain, acute kidney injury.	Fall
328	Fall, swallowing problems, ankle injury no fraacture	Fall, swallowing difficulty
329	Fall, urosepsis	fall,urosepsis
330	Fall, UTI	UTI, Fall, AKI
331	Fall. Left sided weakness.	fall left sided weakness
332	Falls	Sprained ankle
333	Falls	Falls
334	Falls + long lie.	Falls, and associated fracture of ribs.
335	Falls and delirium	Falls, confusion, general decline
336	falls and sustained lacerations to head	fractured neck of femur
337	falls secondary to parkinsonism	Failure of Social Coping Mechanisms
338	Falls, multifactorial	Advanced dementia related falls
339	Falls, secondary postural hypotension	Fall - secondary postural hypotension
340	Fast AF, Decompensated Cogestive Cardiac Failure	Fast AF, Decompensated CCF
341	Fast atrial fibrilation, AKI	Acute Kidney Injury, Atrial Fibrillation
342	found unconscious on the floor	fall, urinary sepsis
343	fracture	fracture
344	Fracture 2nd cervical vertebra	Fracture of 2nd cervical vertebra
345	fracture Neck of Femur	Mechanical Fall
346	Fracture neck of femur, subdural haemorhage	fractured femur
347	Fracture Right neck of femur	-
348	Fracture- pubic rami	fall
349	fractured femur	fractured femor
350	fractured femur	Fractured femur
351	fractured femur	#femur
352	fractured femur	Fractured Femur
353	fractured femur	Femur #
354	fractured femur	Fractured Femur
355	fractured femur	fractured femur
356	fractured femur	Fractured femur
357	Fractured femur	fall hip fracture
358	Fractured femur	Fractured neck of femur
359	Fractured femur	Fractured femur
360	FRACTURED FEMUR	FRACTURED FEMUR
361	FRACTURED FEMUR	FRACTURED FEMUR
362	FRACTURED FEMUR	FRACTURED FEMUR
363	fractured hip	FRACTURED HIP
364	Fractured neck of	Fracture Femur
365	fractured neck of femur	fractured neck of femur
366	fractured neck of femur	fractured neck of femur
367	fractured neck of femur	Fractured neck of femur
368	Fractured neck of femur	#NOF
369	Fractured neck of femur	#NOF
370	Fractured neck of femur	Right neck of femur fracture, constipation, urinary retention

		secondary to constipation, fall
371	Fractured neck of femur	Fractured neck of femur
372	Fractured neck of femur	Fractured neck of femur
373	Fractured neck of femur	Fractured neck of femur
374	Fractured neck of femur	Fall, #NOF
375	Fractured Neck of Femur	fall fracture neck of femur
376	Fractured Neck of Femur	Right Intracapsular fractured neck of femur
377	FRACTURED NECK OF FEMUR	fractured neck of femur
378	Fractured neck of right femur and left acetabular fracture.	Fractured femur
379	Fractured NOF	fractured neck of femur
380	Fractured patella	Fractured patella
381	Fractured pubic ramus	fracture pubic ramus
382	fractured right ankle following fall	fall, with spinal wedge fractures and right ankle fracture
383	fractured right femur	Fractured neck of femur
384	FRACTURED RIGHT SIDED NECK OF FEMUR	fractured right neck of femur
385	frailty	sepsis , dehydration
386	Gangrenous toes	gangrenous left toes
387	Gastric Cancer, PE	Gastric Cancer
388	GASTRIC ULCER	REDUCED ORAL INTAKE-GASTRIC ULCER FOUND AFTER EXAMINATIONS
389	Gastroeneteritis	gastroenteritis, dysphagia
390	Gastroenteritis	Gastroenteritis and colitis, unspecified
391	Gastroenteritis	Gastroenteritis
392	Gastroenteritis	Gastroenteritis
393	Gastroenteritis	Gastroenteritis
394	Gastrointestinal bleed and pulmonary TB	Tuberculosis
395	General deterioration	General Deterioration
396	General frailty	fractured neck of femur, atrial fibrillation, hypertension, cognitive impairment
397	Generally Unwell	Pneumonia
398	generally unwell sepsis identified	urosepsis
399	Generally unwell; progression of Dementia, Severe frailty; Dehydration, Possible seizure	Generally unwell; Acute Kidney Injury, Possible Seizure, Dehydrated, lower respiratory infection, Advanced dementia
400	Generally unwell; sepsis likely chest; AKI	Acute kidney injury. Chest sepsis
401	Generally unwell. Abdominal pain and diarrhoea	Gastroenteritis / fall
402	GI Bleed	gastric bleed
403	GI Bleed	Upper GI Bleed
404	Gi Disturbance	Sepsis , Delirium , frailty , GI Disturbance Mild AKI
405	Haematemesis	admitted with coffee ground vomiting diagnosed with dehydration, acute kidney injury and left basal pneumonia
406	haematemesis, reduced mobility	haematemesis and reduced mobility
407	Haematoma to left leg	haematoma left leg
408	Haematuria	Haematuria
409	Haematuria secondary to bladder stone	Haematuria
410	Haematuria, ?cause	Haematuria
411	Haematuria, secondary to trauma	Haematuria with abdominal pain, secondary to trauma
412	Haematuria.	Haematuria
413	haemoptysis	haemoptysis
414	Haemorrhage	Unresponsive following a seizure
415	HAP	Chest pain / HAP
416	HAP and COPD	HAP & COPD
417	Head injury and genral decline	generally unwell
418	Healthcare Associated Pneumonia	Hospital Acquired Pneumonia
419	Heart failure	Decompensated Heart Failure, clostridium difficile infection.
420	Heart failure	Congestive cardiac failure
421	Heart failure	Heart failure
422	Heart failure - HAP	HAP / Heart failure
423	HEART FAILURE. ANAEMIA. COPD.	SOB due to anaemia
424	Hepatic encephalopathy	Hepatic encaphalopathy
425	Hip Fracture	Fractured femur
426	Hip pain	Right hip pain
427	Hip pain / confusion	Hip pain 2nd to previous surgery
428	Hip pain and General health decline	Hip pain
429	Hospital acquired pneumonia	HOspital Acquired pneumonia and Acute Kidney Injury
430	Hospital aquired pneumonia	Pneumonia
431	Hospital-acquired pneumonia	Pneumonia
432	Hyperglycaemia with poor diabetic control	Uncontrolled diabetes mellitus
433	Hypoactive delirium	Hypoactive delirium
434	hypoglycaemia	Hypoglycaemia
435	hypoglycaemia	hypoglycaemia
436	hypoglycaemia secondary to gliclazide	hypoglycaemia secondary to gliclazide

437	Hypoglycaemia, Seizure	Hypoglycaemia, Seizure
438	hypoglycemia	worsening alzheimers
439	Hyponatraemia	Hyponatremia
440	hyponatraemia / dehydration	dehydration - hyponatremia
441	hyponatraemia and confusion	delirium secondary to hyponatraemia
442	hyponatraemia secondary to community acquired pneumonia	Hyponatraemia secondary to Community acquired Pnuemonia
443	Hypothermia	Hypothermic
444	increased confusion	increased confusion
445	Increased confusion	Delirium
446	Increased confusion	Confusion
447	increased confusion and falls	Advanced Parkinson's disease dementia
448	Increasing shortness of breath	Increasing shortness of breath
449	Infected Leg Ulcers, Delirium, Recurrent Aspiration Pneumonia	Infected leg ulcers
450	Infected metalwork in right ankle + osteomyelitis	Right ankle inflammation due to infection
451	Infected pressure sore	Dehydration, poor oral intake
452	Infection	Pneumonia
453	Infection	Infection
454	Infection - LRTI	Infection
455	Infection- wound site	Blocked urinary catheter
456	Infective exacerbation of bronchitis	Inefective exacerbation of bronchitis
457	infective exacerbation of COPD	Infected exaserbation of copd.
458	Influenza A	Pneumonia H1N1
459	Injured hip and shoulder after fall	Injury left hip & shoulder due to fall
460	Intrascapsular neck of femur #	Intracapsular of femur fracture
461	ISCHAEMIC LEG	ISCHAEMIC LEG
462	ischaemic leg community acquired pneumonia	ischaemic leg cardiac and respiratory failure
463	Ischaemic stroke	ischaemic stroke
464	Ischaemic stroke	left sided facial droop
465	L #NOF	Left femur fracture
466	L femoral DVT	dvt
467	laceration to thigh and leg	thigh laceration
468	left #NOF	left#NOF
469	Left fracture neck of femure & HAP	Left fracture neck of femure & HAP
470	Left hip pen prosthetic fracture	Left hip periprosthetic fracture
471	left intertrochanteric fracture	fractured neck of femur
472	Left intertrochanteric fracture	Left intertrochanteric fracture
473	Left knee revision	Revision of knee replacement
474	Left lower lobe pneumonia, CURB-65=3.	Community acquired pneumonia
475	Left neck of femur fracture	#NOF
476	left pleural effusion with underlying bladder Ca	Breathlessness Chest pain
477	Left total hip replacement.	Fractured neck of femur.
478	Left ventricular failure	Left ventricular failure
479	leg haematoma	leg haematoma
480	leg ulcers	leg ulcers
481	leg weakness cause unclear	Leg Weakness
482	Likely progression of dementia	Progression of dementia
483	Lobar pneumonia	Aspiration Pneumonia
484	Lobar pneumonia	Lobar pneumonia
485	Lobar Pneumonia	Pneumonia
486	Low sats; poor fluid intake, ?constipation; unwell-drowsy	Generally unwell. Poor dietary intake.
487	Low sodium	Low Sodium
488	Lower Limb Cellulitis	Cellulitis
489	Lower respiratory chest infection	Cough and pyrexia
490	lower respiratory track infection	Lower respiratory Tract Infection
491	Lower respiratory tract infection	Lower respiratory tract infection
492	Lower Respiratory tract infection	lower respiratory tract infection
493	Lower Respiratory Tract Infection	Suspected pneumonia / confusion
494	Lower Respiratory Tract Infection	Lower Respiratory Tract Infection
495	Lower Respiratory Tract Infection	Lower respiratory tract infection
496	lower respiratory tract infection ild dehydration	Cellulitis
497	LRTI	pneumonia
498	LRTI	LRTI
499	LRTI	Pneumonia
500	LRTI	Delerium, LRTI
501	LRTI	LRTI
502	LRTI	LRTI
503	LRTI	LRTI
504	LRTI - Left respiratory tract infection	LRTI
505	LRTI & Seizures secondary to PD	LRTI & Seizures secondary to PD
506	LRTI, Accidental Therapeutic Excess of Mirtazapine	Lower respiratory tract infection
507	LRTI, CELULLITIS	cellulitis and chest infetion

508	LRTI, UTI	lower respiratory tract infection
509	Lung cancer	Acute Kidney Injury
510	LVF	Dementia and left ventricular failure
511	Malignant Neoplasm, Breast	Malignant neoplasm, breast
512	Mechanical fall	Mechanical fall
513	Melaena	G.I bleed
514	Memory impairment	Memory impairment
515	Metastatic Ca(liver mets) unknown primary	Anaemia, Likely GI bleed, Deranged LFTs
516	Mulit fractional Falls	Fall secondary to suspected stroke or fracture
517	Multifactorial fall	Multifactorial falls due to osteoarthritis, poor vision, sarcopenia, dementia. Severe aortic stenosis
518	Multifactorial fall, AKI, vacant episodes, diabetes management, conservative foot drop management	Multifactorial fall, AKI, vacant episodes, diabetes management, conservative foot drop management
519	Neck pain	Neck pain
520	Necrotic toe	Acute leg ischaemia
521	Nerve decompression	Decompression
522	non infective exacerbation of copd	copd not infective exacerbation
523	Norovirus & diarrhoea	Norovirus - vomiting and diarrhoea
524	not eating and drinking	cachexia, dehydration ? end of life
525	Not stated	Not recorded
526	NSTEMI	NSTEMI
527	NSTEMI	No ST elevation MI
528	NSTEMI	Acute Coronary Syndrome
529	Oesophagitis	Vomiting due to Oesophageal stricture
530	oral cavity infection	oral cavity infection reduced oral intake
531	Other unspecified convulsions	Other and unspecified convultions
532	over dose of paracetamol	Intentional OD
533	pacemaker insertion for sick sinus rhythm	Sick sinus syndrome
534	package of care insufficient, no acute medical issues	Shortness of breath
535	Pain in left arm and back	Pain in left arm and back
536	Pain on right hip	Fractured femur
537	pancreatritis	pancreatitis
538	paracetamol overdose	Paracetamol OD
539	Parkinson's Disease	Parkinson's disease
540	Paroxysmal atrial fibrillation	Paroxysmal atrial fibrillation
541	Patient Fall,Chest Sepsis,Vascular Dementia	Chest Sepsis
542	Patient found collapsed at home, increased confusion	Confusion
543	PE	PE
544	Pelvic fracture	Fractured pelvis
545	Periprosthetic fracture left hip	Fracture NOF
546	PHARANGEAL POUCH CAUSING SWALLOWING PROBLEMS.	Swallowing problems
547	Pharyngeal Pouch	Respiratory infection
548	pneumonia	pnuemonia
549	pneumonia	sepsis ?urinary tract infection ?Lower respiratory tract infection
550	pneumonia	pneumonia
551	pneumonia	pneumonia
552	pneumonia	pneumonia
553	pneumonia	Fall, delirium with chest infection
554	pneumonia	aspiration pneumonia
555	pneumonia	Lower respiratory tract infection
556	Pneumonia	Fall
557	Pneumonia	Parkinsonism, rapidly progressive dementia
558	Pneumonia	Aspiration pneumonia
559	Pneumonia	pneumonia
560	Pneumonia	Community Acquired Pneumonia
561	Pneumonia	pneumonia, urosepsis
562	Pneumonia	Pneumonia
563	Pneumonia	Pneumonia
564	Pneumonia	Pneumonia
565	Pneumonia	Pneumonia
566	Pneumonia	Pneumonia
567	Pneumonia	Pneumonia
568	Pneumonia	Pneumonia
569	Pneumonia	Pneumonia
570	Pneumonia	Right basal pneumonia
571	Pneumonia	Pneumonia
572	Pneumonia	Pneumonia
573	PNEUMONIA	General documentation
574	Pneumonia and fall	Fall, Community Acquired Pneumonia
575	PNEUMONIA AND INFECTED BURN	Delirium and reduced mobility secondary to LRTI and infected burn to foot.
576	Pneumonia, Fall	Pneumonia, Fall

577	Pneumonia, Hip Pain	Pneumonia, hip pain
578	pneumonia, Non ST-elevation MI, loose stools	Pneumonia, NSTEMI
579	Pneumonia, unspecified	Pneumonia, unspecified
580	Pneumonia, unspecified	Fall, pneumonia
581	Pnuemonia	pneumonia
582	Polymyalgia Rheumatica	Polymyalgia Rheumatica
583	Poor mobility	Reduced Mobility
584	poor oral intake	poor oral intake
585	Post-Stroke + BPSD	Behaviour Probs. 2nd degree dementia.
586	PR Bleed	PR Bleed
587	PR bleed & AKI	Severe AKI, UTI, advanced dementia
588	PR bleeding	pr bleed
589	Prductive cough 4/7	productive cough, chest infection
590	Presumed E Coli bacteraemia	Infection (recent chest infection)
591	presumed pneumonia and HAP	Pneumonia
592	Probable pseudo gout	Hallucinations and pseudogout
593	probable urosepsis	sepsis, uti
594	Progression dementia	?Stroke
595	progression of dementia	progression of dementia
596	progression of dementia	mechanical fall/progression of dementia
597	progression of dementia	Progression of dementia
598	Progression of dementia	Dementia
599	Progression of dementia	Progression of dementia
600	Progression of dementia, dehydration	Falls
601	Progression of lung cancer	Pneumonia
602	Progressive Dementia	Dehydration, UTI
603	Progressive lewy body dementia	Deterioration in mobility + twitching episode
604	Pseudogout	Urinary tract infection
605	Pseudoobstruction, pneumonia	Pseudo obstruction, pneumonia
606	psuedo-obstruction	Psuedoobstruction
607	Pubic ramus fracture, right leg swelling (no DVT)	Pubic ramus fracture, Right leg swelling
608	R Upper lobe pneumonia with multi-organ failure, Dementia	Pneumonia & dementia
609	Recent onset of confusion	2 week history of confusion
610	Rectal Bleeding	Upper GI bleed
611	Rectovaginal fistula	bleeding PV
612	Recurrent fall	fall
613	recurrent falls fractured hip	left greater trochanter fracture
614	recurrent falls	Fall
615	Recurrent falls	Fall with reduced mobility secondary to left hip pain
616	Reduced appetite and dehydration	severe urosepsis
617	reduced mobility - fraility	Fall
618	Reduced responsiveness	Reduced GCS
619	Renal Failure	renal failure
620	Respiratory distress	Respiratory distress
621	Retention of urine	Retention of urine
622	Revision L THR	hip dislocation
623	Right ankle fracture	Fracture
624	Right dynamic hip screw	Fractured Femur
625	Right LACS. bilateral malleolus fracture	Stroke
626	Right lateral femoral condyle fracture	minimally displaced lateral femoral condyle
627	Right parietal subdural haematoma	Unwitnessed fall with subdural haematoma
628	Right total knee replacement	total right knee replacement for painful right knee
629	S.O.B	S.O.B
630	Sacral ostomyelitis	Delirium
631	seizure	fits decreased GCS
632	Seizure	Sepsis,AKI,new seizures
633	Seizure	Seizure
634	Seizure	Seizure
635	Seizure and constipation	Confusion - possible seizure constipation
636	Seizure, atrial fibrillation with fast ventricular response, Hyponatraemia, Lower respiratory tract infection and sepsis, delirium, possible opiate toxicity	New onset seizures, ?stroke
637	Seizure, fall	Fall
638	seizures	fitting
639	Seizures on background of stroke	Left basal lobe pneumonia
640	Self neglect, dementia	self-neglect
641	sepsis	SEPSIS
642	sepsis	staph aureus/septicaemia
643	sepsis	Sepsis
644	sepsis	sepsis

645	sepsis	sepsis
646	Sepsis	chest sepsis
647	Sepsis	Sepsis
648	Sepsis	Treated as sepsis likely due to pneumonia
649	Sepsis	sepsis
650	Sepsis	Sepsis
651	Sepsis	Sepsis
652	Sepsis	Sepsis
653	Sepsis	chest infection
654	Sepsis	lower respiratory tract infection
655	Sepsis	Staph aureus sepsis - Unknown source
656	Sepsis	Sepsis
657	Sepsis	SEPSIS
658	Sepsis	Sepsis - urinary
659	Sepsis	Aspiration pneumonia
660	sepsis & Falls	sepsis
661	Sepsis secondary to UTI	Sepsis AKI/UTI
662	sepsis- secondary to pneumococcal bacteraemia	Sepsis secondary to pneumococcal bacteraemia
663	Sepsis, suspected Upper GI bleed	Sepsis ,? Upper GI bleed
664	SEPSIS, UTI, AKI	SEPSIS, UTI, AKI
665	Sepsis,bradycardia slow AF,metformine induced lactic accidosis and acute kidney injury	Urinary tract infection, Acute kidney injury and bradycardia
666	Sepsis,fever	LRTI
667	Sepsis/AKI	Acute kidney injury.
668	septicemia	sepsis
669	short of breath / cough	swallowing difficulties - aspiration pneumonia
670	Shortness of breath	Shortness of breath.
671	shortness of breath and cough, pueumonia	pneumonia
672	Sigmoid collitis with sepsis	Sigmoid colitis, Sepsis
673	Sinus bradycardia secondary to Memantine	Sinus bradycardia
674	situational syncope	sit syncope
675	Skeletal pain causing immobility	Fall injury
676	Skin tears and lacerations	Fall down 15 stairs
677	Skn allergy, dehyration	rash/dehydration
678	slow atrial fibrillation	atrial fibrillation
679	Small bowel obstruction	Requiring repair of right sided obstructor hernia and small bowel resection
680	Small vessel cerebrovascular ischaemia causing falls, progressive dementia, postural hypotension	Falls, advancing dementia
681	social admission	Acopia / social admission
682	Social admission	Social Concerns
683	Speech disturbance	UTI , hyypoglycaemia
684	spinal ligament repture cerivcal spine	cervical spine ligament rupture
685	Stone in CBP	Stone
686	stroke	stroke
687	stroke	Stroke
688	stroke	left occipital infarction, pituitary tumour, AF
689	stroke	Stroke
690	stroke	confusion
691	Stroke	Stroke
692	Stroke	Stroke
693	Stroke	Stroke
694	Stroke	Stroke
695	Stroke	Stroke
696	Stroke	Left total Anterior Circulation Infart
697	Stroke	Aspiration pneumonia
698	Stroke	stroke
699	Stroke	Stroke
700	Stroke	Stroke
701	Stroke	Stroke
702	Stroke	CVA
703	Subdural haematoma, dementia, frailty	Fall, subdural haematoma
704	Subdural Haemorrhage	Subdural haemorrhage
705	Subjective weakness of Left arm and legs to rule out CVA	?Cerebrovascular accident
706	Superficial injury to other parts of head	Superficial injury to other parts of head
707	Suspected UTI, vasovagal episode	Vasovagal, syncope
708	Swollen wrist	Septic arthritis
709	syncope & collapse	Syncope& collapse
710	Syptomatic slow AF	Symptomatic Atrial Fibrillation
711	TACs ?Sepsis	Hypoactive delirium secondary to infection.
712	Tendancy to fall, not elsewhere classified	Tendency to fall
713	Thrombocytopenia	Anaemia, thrombocytopaenia
714	TIA	Stroke

715	TIA	TIA
716	TIA	Stroke
717	TIA, confusion	Confusion ?TIA
718	Tonic Clonic Seizures	Epilepsy
719	Total Knee Replacement	right total knee replacement
720	Traumatic intracerebral haemorrhage	intercerebral haemorrhage
721	Ulcer of lower limb, not elsewhere classified	Ulcer of lower limb, not elsewhere classified
722	unable to cope at home	scopia/social admission
723	Unable to cope at home.	Unable to cope at home
724	uncontrolled hyperstension	Trifasicular block- required pacemaker insertion
725	Unexpected drowsiness	Sacral sore
726	unresponsive	NSTEMI
727	Unresponsive Karsakoff's Dementia, constipation	Hepatic encephalopathy , dementia
728	Unwitnessed fall	Multifractional Fall
729	UNWITNESSED FALL. DELIRIUM. COMMUNITY ACQUIRED PNEUMONIA. HEART FAILURE.	falls
730	Upper GI bleed	GI bleed
731	Upper GI bleeding, left base CAP, AKI/CKD	Coffee ground vomit
732	Urinary sepsis	Sepsis
733	Urinary Sepsis	Urinary Sepsis
734	urinary tract infection	Urosepsis and acute kidney injury
735	urinary tract infection	Increased confusion due to ?urinary tract infection and/or dehydration
736	Urinary tract infection	Catheter -associated Urinary tract infection
737	Urinary tract infection	urosepsis
738	Urinary tract infection	UTI
739	Urinary Tract Infection	Urinary Tract infection
740	Urinary Tract Infection	Urinary tract infection, unspecified site
741	Urinary Tract Infection	Delirium secondary to infection
742	Urinary Tract Infection	Delirium secondary to UTI
743	Urinary tract infection / frequent falls	Urinary Tract Infection
744	urinary tract infection and delirium	UTI, delirium
745	Urinary tract infection, anaemia seconday to suspected GI bleed	Suspected GI bleed / anaemia
746	Urinary Tract Infection, site not specified.	Fall, UTI
747	Uro Sepsis	Urosepsis - CAP (on death certificate)
748	urosepsis	Urosepsis, delirium
749	urosepsis	UTI
750	Urosepsis	Urosepsis
751	Urosepsis	Sepsis secondary to UTI/community acquired pneumonia
752	Urosepsis	Urosepsis
753	Urosepsis	Sepsis, ?chest infection
754	Urosepsis	Urosepsis
755	Urosepsis	?TIA
756	Urosepsis	Urosepsis
757	Urosepsis & Atrial Fibrillation	urosepsis & Atrial Fibrillation
758	Urosepsis AKI	AKI Urosepsis
759	Urosepsis, multi factonial falls and confusion	Urosepsis
760	Urosepsis, overanticoagulation	Generally unwell, urosepsis, Over anticoagulation
761	UROSEPSIS. DELIRIUM.	UTI and acute confusion
762	uti	uti /confusion
763	uti	UTI
764	UTI	UTI
765	UTI	UTI, Falls, Back Pain
766	UTI	Chest Infection
767	UTI	Delirium/Dementia
768	UTI	Delirium
769	UTI	UTI
770	UTI	Urosepsis
771	UTI	Urinary Tract Infection
772	UTI	UTI
773	UTI	Urinary tract infection
774	UTI	Urinary Tract infection
775	UTI	Uro sepsis
776	UTI	urosepsis. delirium
777	UTI	UTI ? Sepsis Dehydration
778	UTI	LRTI
779	UTI	uti
780	UTI	Urinary tract infection
781	UTI	UTI
782	UTI	UTI
783	UTI	UTI
784	UTI and meningoencephalitis	? meningeoencephalitis

785	UTI and sepsis	Urinary tract infection
786	UTI E coli, postural hypotension, liver cirrhosis with portal htn, pulmonary fibrosis, weight loss, diverticular disease	UTI - urinary retention
787	UTI primary bilary cirrhosis	UTI delirium
788	UTI with dehydration	UTI
789	UTI, AF	?urosepsis, AKI secondary to dehydration
790	UTI, AKI	Urosepsis
791	UTI, AKI	UTI, AKI
792	UTI, delirium	Confusion
793	UTI, hip pain	UTI, acute hip pain
794	UTI, reduced mobility, pain to left wrist and elbow post fall	Injury to left elbow, UTI, Reduced mobility
795	UTI, unable to cope	general deterioration
796	UTI/AKI	UTI,AKI
797	UTI/Sepsis	AKI, Sepsis
798	Vasovagal episode secondary to urinary tract infection	Urinary tract infection
799	viral gastroenteritis	Syncope secondary to dehydration (diarrhoea)
800	Vomiting	vomiting - unclear cause
801	vomiting and abdo pain	gastritis
802	Vomiting episode	adenocarcinoma of oesophagus
803	Wheeze; pain; viral URTI + Aspiratia Pneumonia	Deterioration of Dementia. Viral respiratory infection / aspiration pneumonia
804	Worsening confusion, probable dementia	Dementia
805	Worsening DeMentia	Fall; worsening dementia
806	Worsening heart failure	Heart Failure and SOB
Total	806	806