

## Appendix 8: CHART AUDIT – cebparac – resident is deceased

<b>Review date</b>	
<b>Reviewer</b>	
<b>Resident</b>	
<b>Facility name</b>	
<b>Gender</b>	
<b>DOB</b>	
<b>Admission Date</b>	
<b>Date of Death</b>	
<b>Place of death</b>	

### Section 1 - Diagnosis

<b>Diagnosis</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
<b>Cancer</b>			
<b>Cognitive impairment</b>			
<b>Dementia</b>			
<b>Cardiac</b>			
<b>Respiratory</b>			
<b>Neurological</b>			
<b>Muscoskeletal</b>			
<b>Other</b>			

**Section 2 – Advance care planning/care preferences**

<b>ACP</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
<b>Documented evidence on initial admission form for any information regarding end of life wishes</b>			
<b>Documented evidence that relatives or legal guardians were involved in end of life discussions</b>			
<b>Completion of legal AHD</b>			
<b>Completion of non-legal directive (may be form designed by the facility)</b>			
<b>Documentation of palliative care conference within 3 months of death</b>			
<b>Did care match wishes on ACP/AHD</b>			

**Section 3 – Physical care – one month prior to death**

<b>PAIN</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
<b>Did the resident have pain documented as a symptom</b>			
<b>Was a pain assessment tool used that was appropriate for the resident (cognitively intact self assessment or observed rating for non cognitively intact)</b>			
<b>Was there documented evidence that pain was assessed regularly</b>			
<b>Was there documented evidence of the effectiveness of pharmacological treatment</b>			
<b>Was there documented evidence of the effectiveness of non-pharmacological treatment</b>			
<b>Was the resident on regular analgesia</b>			
<b>Overall was there documented evidence that this analgesia was effective</b>			
<b>Was the resident on prn analgesia</b>			
<b>Overall was there documented evidence that this analgesia was effective</b>			
<b>If resident was prescribed an opioid medication was there a bowel management plan (including aperients)</b>			

<b>DYSPNOEA</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
<b>Did the resident have dyspnoea documented as a symptom</b>			
<b>Was dyspnoea assessed using a tool</b>			
<b>Was dyspnoea assessed regularly</b>			
<b>Was effectiveness of treatment documented</b>			
<b>Was the resident on medication for dyspnoea</b>			
<b>Overall was this medication effective</b>			
<b>Was oxygen provided</b>			
<b>Where non-pharmacological management strategies documented</b>			

<b>NUTRITON/HYDRATION/DYSPHAGIA</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
<b>Did the resident have issues concerning nutrition documented</b>			
<b>Did the resident have issues concerning hydration documented</b>			
<b>Was dysphagia documented as a symptom</b>			
<b>Was dysphagia assessed regularly</b>			
<b>Were referrals to other health professionals made to assess dysphagia</b>			
<b>Was effectiveness of treatment for dysphagia documented</b>			
<b>Was the person commenced on artificial hydration</b>			
<b>Is there documented evidence of a discussion regarding commencement of artificial hydration with the resident/family/legal guardian</b>			
<b>Was the person commenced on artificial nutrition</b>			
<b>Is there documented evidence of a discussion regarding commencement of artificial nutrition with the resident/family/legal guardian</b>			

<b>MOUTH CARE</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Is there an oral health assessment completed			
Is there documented evidence of an oral health care plan			
Is there documented evidence of the effectiveness of the oral health care plan			

<b>INFECTION/FEVER</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Did the resident have infection/fever documented as a symptom			
Was infection/fever assessed regularly			
Was effectiveness of treatment documented			
Were antibiotics given with a palliative intent			

**Section 4 – Psychological care – one month prior to death**

<b>DELIRIUM</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Did the resident have delirium documented as a symptom			
Was the CAM administered			
If delirium was present was a prn anti-psychotic ordered			
If delirium was present was the effectiveness of treatment documented			

<b>DEPRESSION</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Did the resident have depression documented as a symptom			
Was depression assessed using the Modified Cornell Scale for Depression			
If depression was present was an anti-depressant ordered			
If depression was present was the effectiveness of the antidepressant treatment documented			
If depression was present is there evidence of non-pharmacological treatment plan for depression			

**Section 5 – Family care**

<b>COMMUNICATION/CULTURAL CARE</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Is there documentation of relationships within the family			
Is there documentation of the family being made aware death is imminent			
Is there documentation that cultural issues were addressed			
Was there an assessment of bereavement risk prior to or following the residents death			
Where the family informed of the residents death			
Were the family informed of tasks required following the residents death			
Is there documentation of information to family following the death of the resident			

**Section 6 – Other services – month prior to death**

<b>REFERRALS</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Is there documentation of referral to a specialist palliative care service			
Is there documentation of consultation by a specialist palliative care service			
Is there referral to other specialist services – ie - pain clinic			

**Section 7 – Terminal care – LAST 72 HOURS ONLY**

<b>TERMINAL CARE</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
Was the resident commenced on an end of life care pathway			
Was there documentation to indicate agreement to commence the pathway by the GP and family			
Assessment of pain minimum of 4 hourly			
Assessment of nausea and vomiting minimum of 4 hourly			
Assessment of respiratory symptoms minimum of 4 hourly			
Assessment of agitation and restlessness minimum of 4 hourly			
Syringe driver check completed minimum of 4 hourly			
Comfortable position maintained minimum of 4 hourly			
Mouth care given minimum of 4 hourly			
Eye care given minimum of 4 hourly			
Skin care given minimum of 4 hourly			
Urinary continence care given minimum of 4 hourly			
Bowel care addressed minimum of 4 hourly			
Psychological support addressed during 24 hours			
Spiritual, religious, cultural needs/ rituals are facilitated during 24 hours			

**CHART AUDIT – cebparac**  
**LIVING RESIDENTS VERSION**

<b>Review date</b>	
<b>Reviewer</b>	
<b>Resident</b>	
<b>Facility name</b>	
<b>Gender</b>	
<b>DOB</b>	
<b>Admission Date</b>	
<b>Date of Death</b>	NA
<b>Place of death</b>	NA

**Section 1 - Diagnosis**

<b>Diagnosis</b>	<b>Yes</b>	<b>No</b>	<b>Comment</b>
<b>Cancer</b>			
<b>Cognitive impairment</b>			
<b>Dementia</b>			
<b>Cardiac</b>			
<b>Respiratory</b>			
<b>Neurological</b>			
<b>Muscoskeletal</b>			
<b>Other</b>			

**Section 2 – Advance care planning/care preferences**

<b>ACP</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
<b>Documented evidence on initial admission form for any information regarding end of life wishes</b>				
<b>Documented evidence that relatives or legal guardians were involved in end of life discussions</b>				
<b>Completion of legal AHD</b>				
<b>Completion of non-legal directive (may be form designed by the facility)</b>				
<b>Documentation of palliative care conference</b>				
<b>Did care match wishes on ACP/AHD</b>				

**Section 3 – Physical care – one month prior to chart audit**

<b>PAIN</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
<b>Did the resident have pain documented as a symptom</b>				
<b>Was a pain assessment tool used that was appropriate for the resident (cognitively intact self assessment or observed rating for non cognitively intact)</b>				
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<b>Overall was there documented evidence that this analgesia was effective</b>				
<b>Was the resident on prn analgesia</b>				
<b>Overall was there documented evidence that this analgesia was effective</b>				
<b>If resident was prescribed an opioid medication was there a bowel management plan (including aperients)</b>				

<b>DYSPNOEA</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
<b>Did the resident have dyspnoea documented as a symptom</b>				
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<b>Was effectiveness of treatment documented</b>				
<b>Was the resident on medication for dyspnoea</b>				
<b>Overall was this medication effective</b>				
<b>Was oxygen provided</b>				
<b>Where non-pharmacological management strategies documented</b>				

<b>NUTRITON/HYDRATION/DYSPHAGIA</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
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Is there documented evidence of an oral health care plan				
Is there documented evidence of the effectiveness of the oral health care plan				

<b>INFECTION/FEVER</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
Did the resident have infection/fever documented as a symptom				
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Were antibiotics given with a palliative intent				

**Section 4 – Psychological care – one month prior to chart audit**

<b>DELIRIUM</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
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<b>DEPRESSION</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
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Is there documentation of the family being made aware death is imminent				
Is there documentation that cultural issues were addressed				
Was there an assessment of bereavement risk prior to or following the residents death				
Where the family informed of the residents death			✓	
Were the family informed of tasks required following the residents death				
Is there documentation of information to family following the death of the resident			✓	

**Section 6 – Other services – month prior to chart audit**

<b>REFERRALS</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
Is there documentation of referral to a specialist palliative care service				
Is there documentation of consultation by a specialist palliative care service				
Is there referral to other specialist services – ie - pain clinic				

**Section 7 – Terminal care – LAST 72 HOURS ONLY**

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