*Continuous Quality Improvement*

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After-Death Audit for Residential Aged Care Facilities

*This audit can be undertaken as part of the evaluation for continuous quality improvement in your Residential Aged Care Facility to evidence quality clinical care in keeping with the Australian Government Aged Care Quality Standards, January 2019, particularly Standards One, Two and Four.*

***Palliative care***aims to improve the quality of life of residents and their families through early identification, assessment and treatment of physical, cultural, psychological, social and spiritual needs. It focuses on patient-centred care and includes, as a minimum three important clinical processes – advance care planning, case conferencing and terminal care management.

For purposes of this audit, an ***advance care plan*** is a document that outlines a resident’s future health care wishes should they become unable to participate in decision-making in the future.

A ***palliative care case conference*** is a meeting held between the resident (if able to attend), their family and/or friends, and the members of the care team. The aim is to discuss issues and raise concerns about the resident’s condition and/or care, to review the resident’s advance care planning and agree on clear goals of care for the resident as they inevitably deteriorate.

***Terminal care*** is appropriate when a resident is in the final days or week of life and care decisions may need to be reviewed more frequently. Goals are more sharply focused on a resident’s physical, emotional and spiritual comfort and support for the resident’s family.

A ***palliative care working party*** comprises facility staff that functions to encourage quality assurance and improvement that support end-of-life care e.g. regular after death audit review.

|  | | | **Resident** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | | **2** | | **3** | | **4** | **5** |
| 1. | | Date of death  ( dd / mm / yyyy ) |  | |  | |  | |  |  |
| 2. | | Was this an unexpected death with a rapid deterioration that occurred less than 24hrs before they died?  ( Y / N ) |  | |  | |  | |  |  |
| 3. | | Resident’s documented preferred place of death  1 = Residential aged care facility  2 = Hospital  3 = Other  4 = Not documented |  | |  | |  | |  |  |
| 4. | | Actual place of death  1 = Residential aged care facility  2 = Hospital  3 = Other |  | |  | |  | |  |  |
| 5. | | Were the resident’s preferences for end-of-life care documented (i.e. advance care planning)?   * ***N.B.*** *A will or documentation of a funeral provider is not sufficient to answer ‘Yes’ for this item*   ( Y / N ) |  | |  | |  | |  |  |
| 5a. | If answer to Q5 is ‘Yes’, which of the following documents were used? ( *list all that apply* )  1 = Advance Health Directive  2 = Enduring Power of Attorney  ( *Personal/ Financial Decisions* )  3 = Statement of Choices  4 = Other ( *please specify* ) | | |  | |  | |  |  |  |
| 6. | Was a palliative care case conference\* conducted within the last six months of the resident’s life?  *\* A palliative care case conference focuses on end-of-life issues, particularly the care plan to be followed when the resident inevitably deteriorates. The resident and/or family should attend.*  ( Y / N ) **If ‘No’, skip to question 8** | | |  | |  | |  |  |  |
| 7. | Date of palliative care case conference  ( dd / mm / yyyy ) | | |  | |  | |  |  |  |
| 8. | Was the resident commenced on an end-of-life (terminal) care pathway?  ( Y / N / N/A )  **If ‘Yes’, go to question 9**  **If ‘No’, skip to question 10**  **If ‘N/A’ (*i.e. if death was in hospital or not in RACF*), skip to question 10** | | |  | |  | |  |  |  |
| 9. | Date end-of-life care pathway was commenced  ( dd / mm / yyyy ) | | |  | |  | |  |  |  |
| 10. | Was the resident transferred to hospital in the last week of their life?  ( Y / N ) **If ‘No’, skip to question 13** | | |  | |  | |  |  |  |
|  | Principal reason for transfer to hospital  1 = Symptom management  2 = Sudden, unexpected deterioration or event  3 = Following a fall  4 = Request of resident and/or family  5 = Request of the general practitioner  6 = Other ( *please specify* ) | | |  | |  | |  |  |  |
| 12. | Length of hospital stay after transfer (days) | | |  | |  | |  |  |  |
| 13. | Is there documented evidence that advance care planning preferences were taken into consideration during end-of-life care?  ( Y / N ) | | |  | |  | |  |  |  |

Please return completed form to: [INSERT NAME AND CONTACT DETAILS]

**Thank you for taking the time to complete this survey.**

**The de-identified data is used for continuous improvement of quality clinical care.**