NSAP
Palliative Care Australia

NSAP Audit Tool 1

Documentation Audit

National Standards Assessment Program

Palliative Care Australia

This documentation audit tool is designed to be used by specialist palliative care services as part of the National Standards Assessment Program. The audit provides evidence that can be used to support the organisation's self-assessment against the Standards for Providing Quality Care for all Australians.

The results of the audits should be aggregated to provide an overall picture of the organisation's procedures and practices.

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Audit tool 1 – helpful information

Purpose:

to obtain factual information from patient records about assessment, reassessment, care planning and treatment of common causes of distress for patients with a life limiting illness.

Sample size:

at least 20 patient charts should be selected on a random basis for audit.

Sample selection:

details on sample selection are available in section 4 of the NSAP Guide.

Audit Questions

Q1. Does the patient record contain an assessment of the patient's needs, commenced within 48 hours of the patient's referral* to the service?

☐ YES ☐ NO

Q1a. If the assessment was conducted more than 48 hours after referral, how long after referral did the assessment occur?

☐ LESS THAN A WEEK ☐ A WEEK
☐ MORE THAN A WEEK ☐ N/A

Q2. Does the patient record contain evidence of regular+ reassessment of the patient's needs?

☐ YES ☐ NO

Q3. Does the patient record include a comprehensive^, needs based plan?

☐ YES ☐ NO

Q4. Does the patient record contain evidence of a discussion with patient/family regarding an Advance Care Plan?

☐ YES ☐ NO

Q5. Does the patient's record include a plan for the management of worsening or emergent dyspnea (where relevant to the patient's medical condition)?

☐ YES ☐ NO ☐ NO DYSPNEA

Q6. Does the patient record include documentation of the assessment of pain?

☐ YES ☐ NO

Q7. Has a validated tool been used to document pain?

☐ YES ☐ NO

* Referral = when an individual is transferred to service's care or service receives official request to provide care (does not include notification).
\+ Regular = within the timeframe specified by organisational policies and procedures.
^ Comprehensive = including aspects of care such as spiritual, emotional and physical needs.