RURAL MID NORTH COAST PALLIATIVE CARE PROJECT
BASE REVIEW

Centre Name:

Centre Type:

☐ Hospital ☐ Hospice ☐ Community ☐ Nursing Home

Patient Identifier:

Pat Age:

Gender (Please circle):

M F

Admit Date:

		-			-		

Death Date:

		-			-		

Primary Diagnosis – please refer to data dictionary (please tick only one)

Cancers:

- ☐ Bone (sarcoma)
- ☐ Breast
- ☐ Eye
- ☐ Meninges
- ☐ Brain
- ☐ Anus
- ☐ Colon
- ☐ Oesophagus
- ☐ Rectum
- ☐ Small Intestine
- ☐ Stomach
- ☐ Adrenal
- ☐ Carcinoid
- ☐ Neuroendocrine
- ☐ Thyroid
- ☐ ENT
- ☐ Female Genital Organs
- ☐ Leukaemia
- ☐ Lymphoma
- ☐ MDS
- ☐ Myeloma
- ☐ Gall Bladder
- ☐ Liver
- ☐ Pancreas
- ☐ Penis
- ☐ Prostate
- ☐ Testis
- ☐ Mesothelioma
- ☐ Other Connective/ soft tissue disorders
- ☐ Bronchus
- ☐ Non Small Cell Lung
- ☐ Small Cell Lung
- ☐ Trachea
- ☐ Malignant Melanoma
- ☐ Non Melanoma
- ☐ Bladder
- ☐ Kidney
- ☐ Ureter
- ☐ Cancer - Primary Multiple sites
- ☐ Unknown Primary
- ☐ Other Cancer

Non Cancers:

- ☐ Acute abdomen
- ☐ Arthritis
- ☐ MI, CCF
- ☐ Stroke
- ☐ Alzheimers
- ☐ Epilepsy
- ☐ Motor Neurone Disease
- ☐ MS
- ☐ Parkinsons Disease
- ☐ CNS: Other
- ☐ Hepatobiliary
- ☐ HIV/AIDS
- ☐ Renal
- ☐ Respiratory
- ☐ Vascular
- ☐ Other Non Cancer

For "Patient Identifier" please enter a number which uniquely identifies your patient. Please enter it on each page in proforma.

RURAL MID NORTH COAST PALLIATIVE CARE PROJECT

BASE REVIEW – Tool 2

Patient Identifier:

COMFORT MEASURES

1.1 Pats current medication assessed and non essentials discontinued ☐ Yes ☐ No

1.2 If other medication not discontinued was a documented reason given ☐ Yes ☐ No

2. Was as required (PRN) Prescribed subcutaneously: 2.1 Analgesic ☐ Yes ☐ No 2.2 Antiemetic ☐ Yes ☐ No 2.3 Anticholinergic ☐ Yes ☐ No 2.4 Sedative ☐ Yes ☐ No

2.5 If yes were drugs prescribed the ones recommended in your local formulary guidelines ☐ Yes ☐ No

3. Were the following interventions discontinued

3.1 Blood Tests ☐ Yes ☐ No ☐ Not Applicable

3.2 Antibiotics ☐ Yes ☐ No ☐ Not Applicable

3.3 Intravenous Fluids ☐ Yes ☐ No ☐ Not Applicable

3.4 Were do not resuscitate instructions documented ☐ Yes ☐ No ☐ Not Applicable

3.5 Were instructions re do not transfer to hospital documented ☐ Yes ☐ No ☐ Not Applicable

3a Were inappropriate nursing interventions discontinued:

3a1 Routine Turning Regime ☐ Yes ☐ No ☐ Not Applicable

3a2 Taking vital signs ☐ Yes ☐ No ☐ Not Applicable

3b Was a syringe driver set up within 4 hours of prescription ☐ Yes ☐ No ☐ Not Applicable

PSYCHOLOGICAL / INSIGHT ISSUES

4. Ability to communicate in English Assessed ☐ Yes ☐ No ☐ Not Applicable

5.1 Patient aware of diagnosis? ☐ Yes ☐ No

5.2 If no is there a documented reason ☐ Yes ☐ No ☐ Not Applicable

5.3 Patient aware s/he is dying? ☐ Yes ☐ No

5.4 Next of kin aware patient is dying? ☐ Yes ☐ No

RELIGIOUS NEEDS

6.1 Patients religious needs assessed ☐ Yes ☐ No ☐ Not Applicable

6.2 Patients religious needs met ☐ Yes ☐ No ☐ Not Applicable

COMMUNICATION WITH FAMILY – OTHERS – PRIMARY HEALTH CARE TEAM

7. Identified how family/others were to be contacted/ Informed of patients impending death? ☐ Yes ☐ No ☐ Not Applicable

8. Family/others given written information re facilities ☐ Yes ☐ No ☐ Not Applicable

9. Patients GP/Locum service aware that patient in dying Phase ☐ Yes ☐ No ☐ Not Applicable

10. Patients plan of care discussed with family/others ☐ Yes ☐ No ☐ Not Applicable

RURAL MID NORTH COAST PALLIATIVE CARE PROJECT

BASE REVIEW – Tool 3

Patient Identifier:

SECTION 2: ONGOING ASSESSMENTS

S2.1	Assessment of pain 4 hourly/each visit	☐ Yes ☐ No
S2.2	Was the patient in pain	☐ Yes ☐ No
S2.3	Was prn analgesia given	☐ Yes ☐ No
S2.4	Assessment of nausea & vomiting 4 hourly/each visit	☐ Yes ☐ No
S2.5	Was nausea & vomiting a problem	☐ Yes ☐ No
S2.6	Was prn antiemetic given	☐ Yes ☐ No
S2.7	Assessment of Agitation 4 hourly/each visit	☐ Yes ☐ No
S2.8	Was agitation a problem	☐ Yes ☐ No
S2.9	Was prn sedation given	☐ Yes ☐ No
S2.10	Assessment of excessive respiratory secretion 4 hourly/each visit	☐ Yes ☐ No
S2.11	Was excessive respiratory secretions a problem	☐ Yes ☐ No
S2.12	Was prn anticholinergic given	☐ Yes ☐ No
S2.13	Assessment of mouth care 4 hourly/each visit	☐ Yes ☐ No
S2.14	Assessment of Micturition problems 4 hourly/each visit	☐ Yes ☐ No
S2.15	If pressure relieving aids required were these provided	☐ Yes ☐ No
S2.16	Assessment of Bowel Care 12 hourly/each visit	☐ Yes ☐ No

CARE AFTER DEATH

S3.1	GP/Locum Service contacted re patients death	☐ Yes ☐ No
S3.2	Post Mortem discussed	☐ Yes ☐ No ☐ Not Applicable
S3.3	Special Needs identified / religions / infection needs	☐ Yes ☐ No
S3.4	Family/others informed of tasks following death	☐ Yes ☐ No
S3.5	Appropriate documentation given to family/others	☐ Yes ☐ No