RURAL MID NORTH COAST PALLIATIVE CARE PROJECT

Modified "*Liverpool End-of-Life Care Base Audit Tool*"

Patient Identifier

Chart review date:____/_____/_____ **Reviewer:** _____

Centre Name: _____ **Hospital** ☐ **Home** ☐ **RACF** ☐

DOB: / / **AGE:** ☐ **GENDER: Male** ☐ **Female** ☐

Admission Date: / / **Death Date: / /**

1. DIAGNOSIS

Primary Diagnosis	**YES**	**NO**	**ICD - Code**					
Cancer								
Cognitive impairment								
Cardiac								
Respiratory								
Neurological								
Musculoskeletal								
Respiratory								
Other								

Secondary Diagnosis	**YES**	**NO**	**ICD - Code**					
Cancer								
Cognitive impairment								
Cardiac								
Respiratory								
Neurological								
Musculoskeletal								
Respiratory								
Other								

2. DO NOT FOR RESUSCITATE (DNR) ORDERS

2.1 Documented DNR orders? ☐ Yes ☐ No ☐ No data

2.2 Scope of the DNR order defined and documented? ☐ Yes ☐ No ☐ No data

2.3 Documentation of discussion DNR order with patient ☐ Yes ☐ No ☐ No data

2.3 Documentation of discussion DNR order with family ☐ Yes ☐ No ☐ No data

2.4 If DNR not discussed, reason documented? ☐ Yes ☐ No ☐ No data

2.5 Documented advance care plan ☐ Yes ☐ No ☐ No data

Patient Identifier

3. PHYSICAL CARE

3.1 Classes of medication use 72 hours prior to death

☐ **Alimentary system**	☐ Hyperacidity, reflux & ulcers ☐ Anti-spasmodic ☐ Laxatives
☐ **Cardiovascular system**	☐ Antihypertensive ☐ Beta blockers ☐ Diuretics ☐ Anti-coagulants
	☐ Anti-angina ☐ Anti-arrhythmic ☐ Inotrophic ☐ Vassopresser ☐Other
☐**Central Nervous System**	☐ Sedatives ☐ Anti-anxiety agents ☐ Antipsychotic agents
	☐ Antidepressants ☐ Anticonvulsant ☐ Anti-emetic
☐ **Analgesics**	☐ Narcotics ☐ Simple ☐ Combination ☐ Adjuvant analgesics
☐ **Musculoskeletal system**	☐ NSAID ☐ Gout ☐ Muscle relaxants
☐ **Endocrine**	☐ Insulin ☐ Adrenal Steroid hormones ☐ Pituitary hormones
☐ **Genitourinary**	☐ Alkalinizes
☐ **Infections**	☐ Antibiotics ☐ Antifungal ☐ Antiviral
☐ **Neoplastic disorders**	☐ Chemotherapy ☐ Non-cytotoxic and supportive therapy
☐ **Respiratory system**	☐ Expectorants ☐ Bronco spasm ☐ Aerosols & inhalations ☐ Hyoscine ☐ Other
☐ **Other**	☐ Immunology ☐Allergic ☐ Antihistamines ☐ Eye ☐ Ear, nose & throat
	☐ Skin ☐ Nutrition

3.1.1 ☐ **Total number of medications in use at 72 hours**

3.2 Classes of medication use 24 hours prior to death

☐ **Alimentary system**	☐ Hyperacidity, reflux & ulcers ☐ Anti-spasmodic ☐ Laxatives
☐ **Cardiovascular system**	☐ Antihypertensive ☐ Beta blockers ☐ Diuretics ☐ Anti-coagulants
	☐ Anti-angina ☐ Anti-arrhythmic ☐ Inotrophic ☐ Vasso-presser ☐Other
☐**Central Nervous System**	☐ Sedatives ☐ Anti-anxiety agents ☐ Antipsychotic agents
	☐ Antidepressants ☐ Anticonvulsant ☐ Anti-emetic
☐ **Analgesics**	☐ Narcotics ☐ Simple ☐ Combination ☐ Adjuvant analgesics
☐ **Musculoskeletal system**	☐ NSAID ☐ Gout ☐ Muscle relaxants
☐ **Endocrine**	☐ Insulin ☐ Adrenal Steroid hormones ☐ Pituitary hormones
☐ **Genitourinary**	☐ Alkalinizes
☐ **Infections**	☐ Antibiotics ☐ Antifungal ☐ Antiviral
☐ **Neoplastic disorders**	☐ Chemotherapy ☐ Non-cytotoxic and supportive therapy
☐ **Respiratory system**	☐ Expectorants ☐ Bronco spasm ☐ Aerosols & inhalations ☐ Hyoscine ☐Other
☐ **Other**	☐ Immunology ☐Allergic ☐ Antihistamines ☐ Eye ☐ Ear, nose & throat
	☐ Skin ☐ Nutrition

3.2.1 ☐ **Total number of medications in use at 24 hours**

Patient Identifier

3.3 Was the person still able to swallow at 72 hours? ☐ Yes ☐ No ☐ Not Appropriate ☐ No data

3.4 Was the person still able to swallow at 24 hours? ☐ Yes ☐ No ☐ Not Appropriate ☐ No data

3.5 Non-essentials medications discontinued at 72 hours? ☐ Yes ☐ No ☐ Not Appropriate ☐ No data

3.6 The classes of drug ordered **regular s/c** during last 72 hours:

Key: Midazolam & Clonazepam = sedative, Lorazepam = anti-anxiety

☐ Analgesics ☐ Narcotics ☐ Central Nervous System ☐ Anti-anxiety ☐ Anti-psychotic

☐ Sedatives ☐ Anti-emetic ☐ Endocrine ☐ Adrenal steroid hormones ☐ Anti-muscarinics ☐ Other

3.7 The classes of drug ordered **prn s/c** during last 72 hours:

☐ Analgesics ☐ Narcotics ☐ Central Nervous System ☐ Anti-anxiety ☐ Anti-psychotic

☐ Sedatives ☐ Anti-emetic ☐ Endocrine ☐ Adrenal steroid hormones ☐ Anti-muscarinics ☐ Other

3.8 Were the following interventions discontinued?

3.8.1 Blood Tests	☐ Yes & date: …../……/…….	☐ No ☐ Not Applicable ☐ No data
3.8.2 Antibiotics	☐ Yes & date: …../……/…….	☐ No ☐ Not Applicable ☐ No data
3.8.3 Intravenous Fluids	☐ Yes & date: …../……/…….	☐ No ☐ Not Applicable ☐ No data
3.8.4 Monitoring BSL	☐ Yes & date: …../……/…….	☐ No ☐ Not Applicable ☐ No data
4.8.5 Taking vital signs	☐ Yes & date: …../……/…….	☐ No ☐ Not Applicable ☐ No data

4 CARE PREFERENCE

4.1 Were instructions re: do not transfer to hospital documented? ☐ Yes ☐ No ☐ No data

4.2 Was the patient's care reviewed by the palliative care team? ☐ Yes ☐ No ☐ No data

4.3 Was the patient's care reviewed at a multidisciplinary team meeting? ☐ Yes ☐ No ☐ No data

5 PSYCHOSOCIAL NEEDS

5.1 Patient aware of diagnosis? ☐ Yes ☐ No ☐ Not Applicable ☐ No data

5.2 Patient aware s/he is dying? ☐ Yes ☐ No ☐ Not Applicable ☐ No data

5.3 NOK aware patient is dying? ☐ Yes ☐ No ☐ Not Applicable ☐ No data

5.4. Patients GP aware that patient is dying ☐ Yes ☐ No ☐ Not Applicable ☐ No data

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

5.6. Identified how family/others were to be contacted? ☐ Yes ☐ No ☐ Not Applicable ☐ No data

5.7 Patients spiritual needs assessed ☐ Yes ☐ No ☐ Not Applicable ☐ No data

5.8 Patients spiritual goals identified ☐ Yes ☐ No ☐ Not Applicable ☐ No data

Patient Identifier

SECTION 2: ONGOING ASSESSMENTS

6 Symptom assessment and management

6.1 PAIN

6.1.1 Did the patient have episodes of pain? ☐ Yes ☐ No ☐ N/A, go to Q 9.2
6.1.2 Was a pain assessment tool used? ☐ Yes ☐ No ☐ No data
6.1.3 Was pain assessed every 4 hours/visit? ☐ Yes ☐ No ☐ No data
6.1.4 Was the patient given regular analgesics? ☐ Yes ☐ No ☐ No data
6.1.5 Were there episodes of uncontrolled pain? ☐ Yes ☐ No ☐ No data
6.1.6 Was break through analgesia given at this time? ☐ Yes ☐ No ☐ No data

6.2 NAUSEA AND/OR VOMITING

6.1.1 Did the patient have episodes of nausea/vomiting? ☐ Yes ☐ No ☐ N/A, go to Q 9.3
6.2.2 Was nausea & vomiting assessed each shift/visit? ☐ Yes ☐ No ☐ No data
6.2.3 Were there episodes of nausea/vomiting? ☐ Yes ☐ No ☐ No data
6.2.4 Was prn anti-emetic given at this time? ☐ Yes ☐ No ☐ No data

6.3 CONFUSION/DELIRIUM

6.3.1 Did the patient have episodes of confusion/delirium? ☐ Yes ☐ No ☐ N/A, go to Q 9.4
6.3.2 Was confusion/delirium assessed each shift/visit? ☐ Yes ☐ No ☐ No data
6.3.2 Were there episodes of confusion/delirium? ☐ Yes ☐ No ☐ No data
6.3.3 Was prn anti-psychotic given at this time? ☐ Yes ☐ No ☐ No data

6.4 RESTLESSNESS/AGITATION

6.4.1 Did the patient have episodes of restlessness/agitation? ☐ Yes ☐ No ☐ N/A go to Q 9.5
6.4.2 Assessment of restlessness/agitation each shift/visit? ☐ Yes ☐ No ☐ No data
6.4.3 Were there episodes of restlessness/agitation? ☐ Yes ☐ No ☐ No data
6.4.4 Other possible causes considered? ☐ Yes ☐ No ☐ No data
6.4.5 Was prn sedation given at this time? ☐ Yes ☐ No ☐ Not data

6.5 RESPIRATORY TRACT SECRETIONS

6.5.1 Did the patient have episodes of excessive secretions? ☐ Yes ☐ No ☐ N/A, go to Q 9.6
6.5.2 Assessment of secretions each shift? ☐ Yes ☐ No ☐ No data
6.5.2 Were there episodes of excessive secretions? ☐ Yes ☐ No ☐ No data
6.5.3 Was prn anti-cholinergic given at this time? ☐ Yes ☐ No ☐ No data

Patient Identifier

6.6 DYSPONEA

6.6.1 Did the patient have episodes of dysponea? ☐ Yes..☐ No ☐ N/A, go to Q 9.7
6.6.2 Assessment of dysponea shift/visit? ☐ Yes ☐ No ☐ No data
6.6.3 Were there episodes of dysponea? ☐ Yes ☐ No ☐ No data
6.6.4 Was prn opiate given at this time? ☐ Yes ☐ No ☐ No data
6.6.5 Was a prn anti-anxiety agent given at this time? ☐ Yes ☐ No ☐ No data
6.6.5 Was oxygen therapy given at this time? ☐ Yes ☐ No ☐ No data

6.7 GENERAL NURSING CARE, ASSESSMENTS OF:

6.7.1 Mouth care 4 hourly/each visit? ☐ Yes ☐ No ☐ No data
6.7.2 Voiding problems each shift/visit? ☐ Yes ☐ No ☐ No data
IDC used ☐ Yes ☐ No ☐ No data
Incontinence aids used ☐ Yes ☐ No ☐ No data
6.7.3 Were pressure relieving devices used? ☐ Yes ☐ No .☐ No data
Regular PAC ☐ Yes ☐ No ☐ No data

7 CARE AFTER DEATH

7.1 GP contacted re: patients death ☐ Yes ☐ No ☐ Not Applicable ☐ No data
7.2 Post mortem discussed ☐ Yes ☐ No ☐ Not Applicable ☐ No data
7.3 Special needs identified: religions/infection ☐ Yes ☐ No ☐ Not Applicable ☐ No data
7.4 Family/others informed of tasks following death ☐ Yes ☐ No ☐ Not Applicable ☐ No data
7.5 Appropriate documentation given to family/others ☐ Yes ☐ No ☐ Not Applicable ☐ No data

8 THERAPEUTIC INTERVENTION SCORE **SCORE**……

0 Died before anything done
1 Comfort care: (Pain control, social services, psychological support from nursing staff, s/c syringe driver)
2 Moderate level care: (Antibiotics, medications for chronic conditions, NGT feeds, IV - PCA)
3 High level care (Numerous medications for multiple active medical problems, blood transfusions, intrathecal)
4 Intensive level of care (Renal dialysis, ventilator assistance, hyper-alimentation, major surgery, IV vasopressors, intensive cardiac monitoring) (Adapted from Lowe and Kerridge, 1997, p. 380).

Patient Identifier

9 NOTES