Appendix 8: CHART AUDIT – cebparac – resident is deceased

Review date	
Reviewer	
Resident	
Facility name	
Gender	
DOB	
Admission Date	
Date of Death	
Place of death	

Section 1 - Diagnosis

Diagnosis	Yes	No	Comment
Cancer			
Cognitive impairment			
Dementia			
Cardiac			
Respiratory			
Neurological			
Muscoskeletal			
Other			

Section 2 – Advance care planning/care preferences

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

Section 3 – Physical care – one month prior to death

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

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

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

MOUTH CARE	Yes	No	Comment
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			

INFECTION/FEVER	Yes	No	Comment
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

DELIRIUM	Yes	No	Comment
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			

DEPRESSION	Yes	No	Comment
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

COMMUNICATION/CULTURAL CARE	Yes	No	Comment
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

REFERRALS	Yes	No	Comment
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

TERMINAL CARE	Yes	No	Comment
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

Review date	
Reviewer	
Resident	
Facility name	
Gender	
DOB	
Admission Date	
Date of Death	**NA**
Place of death	**NA**

Section 1 - Diagnosis

Diagnosis	**Yes**	**No**	**Comment**
Cancer			
Cognitive impairment			
Dementia			
Cardiac			
Respiratory			
Neurological			
Muscoskeletal			
Other			

Section 2 – Advance care planning/care preferences

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

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

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

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

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

MOUTH CARE	Yes	No	NA	Comment
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				

INFECTION/FEVER	Yes	No	NA	Comment
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 chart audit

DELIRIUM	Yes	No	NA	Comment
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				

DEPRESSION	Yes	No	NA	Comment
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

COMMUNICATION/CULTURAL CARE	Yes	No	NA	Comment
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 chart audit

REFERRALS	Yes	No	NA	Comment
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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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				