Safer Care Victoria - Palliative Care Clinical Network - Care of the Dying Person File Audit

Clinical Audit Questions

These questions are for a patient file audit. File audit is a mechanism for understanding how care of the dying is happening at the point of care.

We ask that you audit a maximum of 20 consecutive deaths from across the organisation (e.g. not all from one ward or area) between 1st May to the 31st October 2018. If there have not been 20 deaths in the time period, please audit all deaths in the organisation.

Please complete this survey for EACH file you are auditing.

1. Where was the patient located at time of death?

- ◯ Acute ward
- ◯ Subacute ward
- ◯ Specialist palliative care unit
- ◯ Emergency Department / Urgent Care area
- ◯ Intensive Care Unit
- ◯ Community service

2. What date did the patient die?

Date / Time

DD/MM/YYYY

3. Was there documented recognition that the patient was dying?

- ◯ Yes
- ◯ No

Other (please specify)

4. Was there documented evidence that a conversation around dying was carried out with (select all that apply):

- [ ] The patient
- [ ] The patient's family / carer / person of choice

Other (please specify)

5. Did the patient have a MET call during their admission?

- ◯ Yes, one
- ◯ Yes, multiple
- ◯ No

6. If there was a MET call, what was the date of the last MET call before death?

Date

DD/MM/YYYY

7. Was there documented evidence of: (check all that apply)

- [ ] Goals of care form/ documented conversation about goals of care
- [ ] Not for resuscitation/ CPR form or documented conversation about not for resuscitation/ CPR
- [ ] Preferred place of death
- [ ] Anticipatory prescribing / medications in place

8. Was a care plan used for this patient?

- ◯ Yes, the Care Plan for the Dying - Vic was used
- ◯ Yes, a locally developed care plan was used
- ◯ No, there was no care plan used

Other (please specify)

9. Was there documented evidence that the patient and /or the family was provided with bereavement support?

- ◯ Yes
- ◯ No