CLINICAL AUDIT: ADVANCE CARE PLAN

FACILITY NAME:		YEAR:	

1. This is a combined audit to be completed by nursing and medical team.
2. Monthly at least one case to be audited.
3. Ideally assess a discharged file or a patient who has been in the unit for at least 5 - 7 days.

Non-Compliant (NC):	<50% compliance. The required standard is not present or is present less than 50% of the time.
Partially Compliant (PC):	50 - 79% Compliance. The required standard is present but incomplete or present less than 80%.
Compliant (C):	80 - 100% Compliance. The required standard is completed fully or is present more than 80%.

PATIENT DETAILS		NC	PC	C	COMMENT
1	Name and initials wherever indicated				
2	Hospital number wherever indicated				
3	Date of birth wherever indicated				
4	Name and contact details of caregiver wherever indicated				
	PATIENT DETAILS TOTAL (4):				

PARTICIPANTS IN PLAN		NC	PC	C	COMMENT
5	Primary caregiver name documented				
6	Child's participation in plan documented if appropriate				
7	Any other family member involved in plan documented				
8	Name of staff involved in plan documented				
9	Date of care plan documented				
10	Date for review of plan documented				
11	All participants signed and dated care plan				
	PARTICIPANTS IN PLAN TOTAL (7):				

CARE PLAN CONTEXT AND TREATMENT LEVELS		NC	PC	C	COMMENT
12	Category of condition requiring palliative care selected appropriately				
13	Diagnosis recorded where indicated				
14	Current problems listed				
15	Management plan made for each problem				
16	Intervention level selected				
17	Intervention level and category of condition consistent				
18	Yes or no given for each intervention				
19	Extra details given where required for each intervention				
	CARE PLAN CONTEXT AND TREATMENT LEVELS TOTAL (8):				

PLANS MOVING FORWARD		NC	PC	C	COMMENT
20	Possible future problems documented				
21	Management plan given for each problem				
22	Possible end of life events documented				
23	Symptoms and management plan documented for each problem				
24	Ongoing goals of care recorded				
25	Planned place of care recorded				
26	Psychosocial plan documented				
27	Spiritual needs and care documented				
	PLANS MOVING FORWARD TOTAL (8):				

MEDICATION		NC	PC	C	COMMENT
28	Child's weight recorded				
29	Current medications listed with dosing, frequency and route				
30	Indications for each medication given and when to stop				
31	Possible future medications listed with dosing instructions				
32	Clear indications given for use of each future medication				
33	Syringe driver drugs recorded				
	MEDICATION TOTAL (6):				

FILE DOCUMENTATION AND COPIES		NC	PC	C	COMMENT
34	Counseling of caregivers (and child where appropriate) with regards to Advance Care Plan documented				
35	Copy of Care Plan in patient's file				
36	Documented that copy of Care Plan given to caregiver and sent to base hospital				
37	Care Plan updated on last visit				
	FILE DOCUMENTATION AND COPIES TOTAL (4):				

NB. Bring forward **ALL** subtotals.

SUBTOTALS BROUGHT FORWARD	PC	C	(Cx2)	Column A PC+ (Cx2)	Column B	A/B	X100
Patient details					8		%
Participants in plan					14		%
Care plan context & treatment levels					16		%
Plans moving forward					16		%
Medication					12		
File documentation and copies					8		
FINAL SCORE:					74		%

ASSESSED BY:			
Sign:		**Print:**	
Registration N^{o}		**Date:**	
Sign:		**Print:**	
Registration N^{o}		**Date:**	