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| **Quality Improvement Audit: Evidence for change of Palliative Care Phase** S:\CHSD Shared\AHSRI programs\PCOC\PCOC_Logo_Best.PNG |
| **Objective** | To identify areas for improvement in documentation of phase.  |
| **Rationale** | * Determine if clinical notes provide evidence for phase allocation or phase change
* Identify missing phase assessments
* Identify areas for education
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| **Instructions****This audit involved an ‘inter-rated reliability’ audit whereby an audit of one set of assessments is reviewed by two clinicians. In this way we can better assess the reliability and effectiveness of the phase tool.**  | 1. Select two clinicians to be involved in this audit.
2. Randomly select a minimum of 10 patient assessment forms and the corresponding clinical notes. Episodes should be closed either through discharge or death, i.e. audit is retrospective.
3. Print 20 audit forms and each clinician to independently complete one audit form per patient - Refer to the phase definitions (attached) to verify correct phase.
4. Print two audit tally sheets and each clinician to independently record the results and to provide feedback about areas for improvement and actions required.
5. Print one audit tally sheet (attached).
 |
| **Date/s and time of audit** |  |
| **Medical / Unique Record Number**  |  |
| **Audit completed by:** **Name and Position** |  |
| **Audit Items** | **Findings** |
| 1. How many phases were recorded for this patient?
 |  |
| 1. What was the first (admission) phase recorded?
 |  |
| 1. Does the first phase recorded reflect the corresponding clinical notes? (please tick)
 | Yes | No |
| If no, which phase should have been recorded? (as per phase definitions) |
| 1. Use this section to:
* list subsequent phase changes
* Identify evidence in the clinical notes for each of these phase changes
* Identify if phase change was applied correctly
 | Phases following first phase (max 5) | Was there evidence for this phase change (please tick)?  |  |
| Yes? (tick) | No? (tick) | If no, please document which phase should have been recorded: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total number incorrect** |  |
| 1. Were any phases missed that should have been documented?
 | List any phase/s missed: |
| **Please Total missing phases (not assessed)** |  |

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| **Tally Sheet: Evidence for change of Palliative Care Phase** |
| Total number of audits conducted |  |
| Total number of phases recorded (max 5 per patient) |  |
|  | **Tally Yes** | **Tally No** |
| First phase recorded was reflective of the corresponding clinical notes |  |  |
| Evidence of the reason for phase change was documented in the corresponding clinical notes |  |  |
| Total number of missed phases |  |
| Total number incorrect |  |
| Total missing phases  |  |
| **Notes on areas for improvement and action plan:** |

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## Phase Definitions

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| The palliative care phase identifies a clinically meaningful period in a patient’s condition. The palliative care phase is determined by a holistic clinical assessment which considers the needs of the patients and their family and carers. |
| **START** | **START** |
| **Stable** |
| Patient problems and symptoms are adequately controlled by established plan of care **and*** Further interventions to maintain symptom control and quality of life have been planned **and**
* Family/carer situation is relatively stable and no new issues are apparent.
 | The needs of the patient and / or family/carer increase, requiring changes to the existing plan of care. |
| **Unstable** |
| An urgent change in the plan of care or emergency treatment is required **because*** Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or**
* Patient experiences a rapid increase in the severity of a current problem; **and/or**
* Family/ carers circumstances change suddenly impacting on patient care.
 | * The new plan of care is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. patient is stable or deteriorating) **and/or**
* Death is likely within days (i.e. patient is now terminal).
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| **Deteriorating** |
| The care plan is addressing anticipated needs but requires periodic review **because*** Patients overall functional status is declining **and/or**
* Patient experiences a gradual worsening of existing problem **and/or**
* Patient experiences a new but anticipated problem **and/or**
* Family/carers experience gradual worsening distress that impacts on the patient care.
 | * Patient condition plateaus (i.e. patient is now stable) **or**
* An urgent change in the care plan or emergency treatment **and/or**
* Family/ carers experience a sudden change in their situation that impacts on patient care, and urgent intervention is required (i.e. patient is now unstable) **or**
* Death is likely within days (i.e. patient is now terminal).
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| **Terminal** |
| Death is likely within days. | * Patient dies **or**
* Patient condition changes and death is no longer likely within days (i.e. patient is now stable or deteriorating).
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| **Bereavement – post death support** |
| * The patient has died
1. Bereavement support provided to family/carers is documented in the deceased patient’s clinical record.
 | * Case closure

Note: If counselling is provided to a family member or carer, they become a client in their own right. |

M. Masso, S. Frederic. Allingham, M. Banfield, C. Elizabeth. Johnson, T. Pidgeon, P. Yates & K. Eagar, "Palliative care phase: inter-rater reliability and acceptability in a national study", Palliative