10 AUDIT STANDARDS FOR END OF LIFE CARE

1. Clear documentation that the patient is approaching end of life

2. Clear documentation that discussions have been held by a named senior clinician with the patient (if possible) and family/carer that the patient is approaching end of life

3. Clear documentation that discussions have been held with the patient (if possible) and family/carer around preferred place of care at end of life

4. Clear documentation that routine observations are to be discontinued and the rationale for this (e.g. may cause distress to the patient)

5. Prn crisis medications prescribed

6. If patient has syringe pump clear documentation that the rationale for this has been discussed with patient (if possible) and family/carer

7. Clear documentation of the efficacy of drugs given to control symptoms

8. All medications rationalised and unnecessary medications discontinued

9. Clear documentation that the patient is reassessed daily Monday to Friday by an appropriately trained Doctor and a plan of care made for out of hours

10. Clear documentation that mouth care, pressure area care and comfort measures are undertaken by an appropriately trained practitioner

Pat Lye (Hospital Palliative Care CNS, Team leader)