ELDAC
End of Life Directions for Aged Care

ELDAC After Death Audit (Version 2)

Please use a new form for each client.

Date Completed: DD/MM/YYYY	Client Identifier:

About the Client		
Question		**Response**
1.	Date of Birth	DD/MM/YYYY
2.	Date of admission to Home Care	DD/MM/YYYY
3.	Date of Death	DD/MM/YYYY
4.	Life-limiting conditions (tick all that apply)	☐ Cancer ☐ Dementia ☐ Frailty ☐ Neurological disease excluding Dementia (e.g. Stroke, MND, Progressive Supranuclear Palsy, Parkinson's, Huntington's) ☐ Heart/vascular disease (e.g. Heart Failure, Angina, Atrial Fibrillation, Peripheral Vascular Disease, Hypertension) ☐ Respiratory disease (e.g. COPD, Emphysema, Pneumonia) ☐ Kidney disease (e.g. Kidney failure) ☐ Liver disease ☐ Other condition or complications not listed above that are not reversible or where treatment will have a poor outcome (please state): ☐ Unknown
5.	Gender	☐ Male ☐ Female ☐ Non-Binary ☐ Not stated

6.	Client's preferred language	☐ English ☐ Other (please state): ☐ Unknown
7.	Country of Birth	☐ Australia ☐ Other (please state): ☐ Unknown

Aspects of Care		
Question		**Response**
8.	Was the client referred to other services in the 3 months before they died? (tick all that apply)	☐ No referrals ☐ General Practitioner ☐ After hours GP (Locum) ☐ Allied Health (e.g. Occupational Therapist, Physiotherapist, Podiatrist, Dietician, Exercise Physiologist, Social Worker, Speech Pathologist) ☐ Medical Specialist (including Geriatrician) ☐ Pharmacist ☐ Pathology ☐ Radiology ☐ Internal Specialist Palliative Care Provider ☐ External Specialist Palliative Care Service ☐ Dementia Support Australia ☐ Ambulance ☐ Extended Care Paramedics ☐ Geriatric Rapid Response ☐ Other (please state): ☐ Unknown
9.	Was the client admitted to hospital in the ***last week*** of life?	☐ Yes (complete Questions 10-13) ☐ No (skip to Question 14) ☐ Unknown (skip to Question 14)
10.	Person requesting transfer to hospital in the last week of life?	☐ Client ☐ Family ☐ General Practitioner ☐ Other Medical Practitioner ☐ Nursing Staff ☐ Ambulance ☐ Other (please state): ☐ Unknown

11.	Principal medical reason for hospitalisation in the last week of life?	☐ Symptom management (e.g. pain, shortness of breath, dehydration, urinary infection) ☐ Sudden unexpected deterioration ☐ Following a fall ☐ Abnormal pathology ☐ Abnormal radiology ☐ Other (please state): ☐ Unknown
12.	Was the hospital admission avoidable?	☐ Yes ☐ No ☐ Unsure Comment to support answer:
13.	Number of days in hospital in the last week of life?	☐ Days: ☐ Unknown

Advance Care Planning		
Question		**Response**
14.	Was there documented evidence of an Advance Care Plan (ACP) or Advance Care Directive (ACD)?	☐ Yes ☐ No ☐ Unknown
15.	Was there documented evidence that the client's ***diagnosis*** was discussed with the client and family?	☐ Yes ☐ No ☐ Unknown
16.	Was there documented evidence that the client's ***prognosis*** was discussed with the client and family?	☐ Yes ☐ No ☐ Unknown
17.	Was there documented evidence that CPR/ intubation versus comfort care was discussed with the client and family?	☐ Yes ☐ No ☐ Unknown
18.	Where did the client wish to be cared for should their condition deteriorate?	☐ Home ☐ Residential Aged Care ☐ Hospital ☐ Other (please state): ☐ Unknown

19.	Did the client appoint a Substitute Decision Maker (SDM)?	☐ Yes ☐ No ☐ Unknown

Care Planning		
Question		**Response**
20.	Was a Family Meeting/Case Conference (includes the family/SDM and/or client) discussing palliative and/or end of life care held within 6 months prior to the client's death?	☐ Yes (complete date) ☐ No ☐ Unknown Date: DD/MM/YYYY (If more than one case conference, use the date of the first occurrence within the six months.)
21.	Was a Team Case Conference (includes the team and other health professionals, but not client or family/SDM) discussing palliative and/or end of life care held within 6 months prior to the client's death?	☐ Yes (complete date) ☐ No ☐ Unknown Date: DD/MM/YYYY (If more than one case conference, use the date of the first occurrence within the six months.)
22.	Was the client commenced on an End of Life Care Pathway/Care Plan?	☐ Yes (complete date) ☐ No ☐ Unknown Date: DD/MM/YYYY

About the Client's Death		
Question		**Response**
23.	Place of Death	☐ Home ☐ Hospital ☐ Residential Aged Care ☐ Inpatient Palliative Care Unit ☐ Other (please state): ☐ Unknown
24.	Was this the client's preferred place of death?	☐ No preference stated ☐ Yes ☐ No ☐ Unknown

25.	Were the palliative care needs of the client met in the last week of life?	☐ Yes, fully ☐ Yes, partially ☐ No ☐ Unknown
26.	Were the family's palliative care needs met in the last week of life?	☐ Not applicable ☐ Yes, fully ☐ Yes, partially ☐ No ☐ Unknown
27.	Was the family assessed for bereavement risk? (specific bereavement tool not required)	☐ Not applicable ☐ Yes ☐ No ☐ Unknown
28.	Was the family referred to a bereavement service or other support after the client's death?	☐ Not applicable ☐ Yes ☐ No ☐ Unknown
29.	Barriers to effective palliative care (tick all that apply)	☐ No barriers to palliative care ☐ No ACP/ACD ☐ Did not recognise end of life ☐ Sudden death or acute event ☐ Conflicts around goals of care ☐ Unable to manage symptoms ☐ EOL medication (e.g. not prescribed, not available, no equipment) ☐ Registered Nurse unavailable ☐ Clinical review by GP/Nurse Practitioner unavailable when needed ☐ Home Care Package unable to support ☐ CHSP unable to support ☐ No Specialist Palliative Care support ☐ No Family Meeting/Case Conference ☐ Family needs not met ☐ Lack of bereavement services ☐ Absence of family/carer ☐ Staff not trained/confident in EOL ☐ Other (please state): ☐ Unknown