# ELDAC After Death Audit (Version 2)

Please use a new form for each resident.

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

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| 6. | Resident's preferred language | English<br>Other (please state):<br>Unknown |
| 7. | Country of Birth | Australia<br>Other (please state):<br>Unknown |

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

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

| Advance Care Planning | | |
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| **Question** | | **Response** |
| 14. | Was there documented evidence of an Advance Care Plan (ACP) or Advance Care Directive (ACD)? | Yes<br>No<br>Unknown |
| 15. | Was there documented evidence that the resident's ***diagnosis*** was discussed with the resident and family? | Yes<br>No<br>Unknown |
| 16. | Was there documented evidence that the resident's ***prognosis*** was discussed with the resident and family? | Yes<br>No<br>Unknown |
| 17. | Was there documented evidence that CPR/ intubation versus comfort care was discussed with the resident and family? | Yes<br>No<br>Unknown |
| 18. | Where did the resident wish to be cared for should their condition deteriorate? | Residential Aged Care<br>Private Home (i.e. not the facility)<br>Hospital<br>Other (please state):<br>Unknown |

| 19. | Did the resident appoint a Substitute Decision Maker (SDM)? | Yes<br>No<br>Unknown |
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| Care Planning | | |
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| **Question** | | **Response** |
| 20. | Was a Family Meeting/Case Conference (includes the family/SDM and/or resident) discussing palliative and/or end of life care held within 6 months prior to the resident's death? | Yes (complete date)<br>No<br>Unknown<br>Date: DD/MM/YYYY<br>(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 resident or family/SDM) discussing palliative and/or end of life care held within 6 months prior to the resident's death? | Yes (complete date)<br>No<br>Unknown<br>Date: DD/MM/YYYY<br>(If more than one case conference, use the date of the first occurrence within the six months.) |
| 22. | Was the resident commenced on an End of Life Care Pathway/Care Plan? | Yes (complete date)<br>No<br>Unknown<br>Date: DD/MM/YYYY |

| About the Resident's Death | | |
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| **Question** | | **Response** |
| 23. | Place of Death | Residential Aged Care<br>Hospital<br>Inpatient Palliative Care Unit<br>Private Home (i.e. not the facility)<br>Other (please state):<br>Unknown |
| 24. | Was this the resident's preferred place of death? | No preference stated<br>Yes<br>No<br>Unknown |

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