v10

Further information on the use of this tool can be obtained from
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quality time for everyone

Guidance for use of the Quality Assurance (QA) tool for Palliative Care Patients

A generic shared care document for all patients

September 2014

Purpose of the Tool

The Neuberger Review recommended that the Liverpool Care Pathway for the dying should be phased out. St. Oswald's Hospice took the opportunity to rethink how care should be monitored with two key principles:

1) Monitoring care should *not* be limited to the last hours and days of life

2) Patients and their partners and relatives should be included in the monitoring of care

All elements have been developed in-house and the key aim is to monitor and audit the care of individuals at any stage of their illness and to do so in partnership with the individual and their partner and/or family. The key features of the QA document are that it

- Emphasises the quality assurance aspect for the individual
- Is purposefully very short
- Is not a care plan, but a prompt to ensure an individualised care plan is created and monitored
- Requires a regular check for treatment opportunities
- Adds space to initial every entry to increase accountability
- Does not include drug advice
- Applies to all ages

How to use the tool

Only one page is used at any one time

There are two versions:

An Observational QA tool: for use in individuals who cannot contribute to their assessment.

A Shared Care QA tool: for those well enough to contribute or do their own assessment.

The QA document is divided into **two sections**: 1. Initial assessment and 2. Ongoing assessment A third section documents the care after death.

To be clear who is completing each entry you are asked to mark whether it is a patient (**P**), staff (**S**) or relative (**R**)

Any assessments or goals to which the answer is 'No' are potential problems. Any information related to initial assessment, ongoing care and care after death can be recorded on the reverse of the sheets.

Arrangement of documentation in notes

The *Initial assessment* is completed on first contact.

The *Ongoing Assessment* is completed at each review point.

Documentation: this is written on the reverse of each assessment sheet. Additional evaluation sheets can be added if necessary.

Initial Assessment

Key demographics in the left hand column consists of 16 key aspects to establish the plan of care promoting quality assurance for each individual patient.

This is completed at first contact.

Ongoing Assessment

This consists of up to 18 quality assurance prompts which support an individual approach to care. In outpatients all are assessed at each visit. For inpatients, nine of these are assessed up to six times every 24 hours and nine are assessed once daily.

Any responses should be recorded on the sheet as necessary. Any information related to ongoing care can be recorded on the reverse of the sheet.

Dying patients

Confirmation that an individual is dying is documented in the 'Confirmation' section.

Details of the death can be recorded in the 'Care after death' section of the document and should be completed by the Registered Nurse or Doctor as appropriate.