Observational Quality Assurance Tool for Palliative Care v15

This document is to be used for individuals unable to contribute to their care assessment

Name:	**NHS no:**
Address:	**Date of birth:**
Postcode:	**Place where this document was initiated:**
GP and practice:	

Initial assessment

S (Staff) **R** (Relative)

Write comments overleaf	Yes or No	Signature	S	R
1. Have a registered nurse and senior doctor have been allocated to oversee care? Nurse: Doctor:				
2. Have contact details of people important to the individual have been documented? eg. partners, relatives, parents, friends				
3. Are decisions in advance documented and filed in front of notes? (Ring:) advance statement ADRT DNACPR EHCP Lasting Power of Attorney				
4. Have the individual's current wishes and preferences, beliefs and values and been documented?				
5. Do the parents, partner or relative understand what is happening and do they have all the information they need?				
6. Has the individual's personal care plan been discussed with the parents, partner or relatives?				
7. The parents, partner and relative have been involved in decisions about current investigations and treatment				
8. Has the need for fluids (drinks) and food been reviewed and agreed with the parents, partner or relatives?				
9. Is the individual's preferred place of care known?				
10. Do the GP, hospital and palliative care teams know of the present situation?				
11. Are the parents, partner or relatives being included in decisions about the individual's care?				
12. Has any medication or equipment that may be required been prescribed and made available? (See local, regional or national formularies for drug advice)				
13. Can information about the individual be shared with others? If yes, who:				
14. If vital equipment is being used, has its continued use been discussed? Write type (eg. ICD, dialysis, ventilator):				
15. Can capacity be assumed?				**S**
16. Have senior doctors excluded reversible causes for this current condition?				**S**

List all those present at this initial assessment

Health care professional: Signature: Date & time:

Others:

Adapted from the original work by Ellershaw J (*Journal of Pain and Symptom Management.* 2001; **21**(1): 12 – 17.) This document has been produced for use at St. Oswald's Hospice and all elements have been developed in-house .

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Evaluation sheet

Date	Notes Use this to document all 'No' responses overleaf and any other additional information	Signature

Continue on further evaluation sheets if necessary