



ELDAC After Death Audit (Version 2)

Please use a new form for each client.

Date Completed: DD/MM/YYYY	Client Identifier:
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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. OT, Physio, Podiatrist, Dietician, EP, SW, Speech Path) 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
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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