Introduction:

High-quality end-of-life care can help people achieve the best possible quality of their life as they approach their death. QHealth has adopted a statewide strategy for end-of-life care (2015) to strengthen the capacity of Queensland health services to respond to the needs of those with a progressive life-limiting illness (at any life stage) through the delivery of services that prioritise patient goals for quality of life as key components of care. The strategy is intended to integrate end-of-life care as a core element of health services in Queensland.

One of four service directions in this strategy is: Earliest possible identification of patients who will or are anticipated to have shortened life expectancy as a result of known health conditions is routinely achieved, together with timely Advanced Care Planning (ACP) / Advance health directive (AHD) and the initiation of coordinated planning of end-of-life care.

Objective:

This study looks at whether health professionals from rural hospitals in Qld (Kingaroy, Warwick, Stanthorpe) identify patients nearing the end of their life and ensure advance care planning and advanced resuscitation planning is implemented.

Method:

Chart audit of all inpatients, 70 years and over, admitted to rural hospitals at Kingaroy, Stanthorpe and Warwick from 1/1/2016 until minimum 50 audited.

The audit will collect data on:

- Any reference to or information about ACP/AHD or Acute Resuscitation Plan (ARP) within patient current admission.
- The accessibility of this documentation if records indicated the patient had an ARP/AHD or ACP (formal, statement of choices, GP led)
- The number of SPICT clinical indicators present

Process:

1. Discuss the research project with your clinical supervisor. They will already have received information from Dr Martin Byrne, Director Clinical Governance, Toowoomba Hospital. If your supervisor has question or concerns please direct them to Dr Byrne or Dr Kay Brumpton.

2. Liaise with medical records to access charts of patient admissions aged 70 and over.

3. The medical record must be signed out by a clinician. You will need to liaise with your clinical supervisor as to your hospital’s protocol. At all times the charts must be kept on site and accessible if required for patient care whilst doing audit. Charts must be kept secure.
4. Data will be entered directly onto Excel spreadsheet.

5. Audit to be discussed at CBL and will be reviewed at Hub Days with comparisons between sites.