Auditing Care at the End of Life (ACE) Tool

Resident Code #: _____ **Facility Code:** _____

☐ Nursing Home (NH) ☐ Chronic Care **Audit Date:** ____ / ____ / ____ (dd / mm / yy)

Auditor Name/Classification: _____

Section 1. Demographics

1. **Date of Birth:** ____ / ____ / ____ (dd / mm / yy)
2. **Date of Death:** ____ / ____ / ____ (dd / mm / yy)
3. **Gender:** ☐ Male ☐ Female
4. **NH Admission Date:** ____ / ____ / ____ (dd / mm / yy)
5. **Length of NH Stay (in months):** _____

Section 2. Situation Around Death

6. **Indication on health record that death was expected?** ☐ No ☐ Yes
   (If not expected, select an alternate chart to audit)
7. **RAI Outcome CHESS Score (from last MDS assessment):** _____
   Date of last assessment: ____ / ____ / ____ (dd / mm / yy)
8. **Primary Cause of Death listed on death certificate:** _____
   ☐ Cause of Death unknown
9. **Place of Death:** ☐ NH ☐ Chronic Care ☐ Acute Care ☐ Palliative Care Unit
10. **Was the Resident transferred to acute care (emergency or for admission) in the last month of life?**
    ☐ No (skip to question 11) ☐ Yes (complete table below)

Date of Transfer	Reason for transfer	Away from facility longer than 24 hrs?	Was ACP level changed during hospitalization?

Section 3. Clear Decision-Making

11. Was there a Health Care Directive? ☐ No ☐ Yes

Describe Instructions:

12. Was there an Advance Care Plan (ACP)?

☐ No (skip to question 15) ☐ Yes

Goal of Care chosen:
- ☐ Medical Care and Interventions including Resuscitation
- ☐ Medical Care and Interventions excluding Resuscitation
- ☐ Medical Care and Interventions focus on Comfort
- ☐ ACP not up-dated in past year
- ☐ ACP not completed/missing
- ☐ Other

13. Date of last ACP review: _____ / _____ / _____
dd mm yy

14. Any changes to the ACP made at last review: ☐ No ☐ Yes

If yes, what and why:

Section 4. Preparation for Death

15. Is there evidence in the progress notes that staff recognized changes in the Resident's condition that acknowledged that end of life was near?

☐ No ☐ Yes

Describe: (for e.g. initiation of EOL care plan, documentation of EOL consults, team meeting)

16. Were there changes or adjustments made to the Resident's physician/NP orders in the last month of life?

☐ No ☐ Yes

Describe: (for e.g. medications discontinued, medications added, accu-checks discontinued, diet changes, tube feeds, hydration)

17. **Were there any medication changes made in the last week of life?**

☐ No ☐ Yes

Describe:

18. **Is there evidence in the progress notes of communication with family members or friends about EOL care?**

☐ No ☐ Yes

Describe:

19. **Is there evidence that psychosocial support was provided to family members or friends during the dying experience?**

☐ No ☐ Yes

Describe the involvement: (e.g., stayed overnight, food/beverages provided, comfort care basket, books)

Section 5. Spiritual Health and Cultural Aspects of Care

20. **Resident's spiritual health preferences documented:** ☐ No ☐ Yes

21. **Evidence of Resident's or family wishes regarding rites and rituals, or spiritual considerations acted upon (e.g., minister/pastor called, last rites administered):** ☐ No ☐ Yes

Section 6. Symptoms and Symptom Management through the Death

22. **Is there evidence that Pain was assessed?** ☐ No ☐ Yes

If yes, what tool as used:

a. WRHA NH Pain Assessment Tool ☐ FACES SCALE ☐ PAINAD

b. Other: _____

23. **Is there evidence that the WRHA NH Pain Monitoring Tool was used?** ☐ No ☐ Yes

24. **In the table below, indicate the presence of physical & psychological symptoms, and the care provided to the Resident that is documented at a minimum, in the last week of life. If you answer YES to any question below, indicate how symptoms managed/care provided and whether management/care effective.**

Care Domains	If Yes, describe the management (document all medications for pain and symptom management that *were administered,* including dose, route and frequency)	Evaluation of management (e.g., documentation that intervention was effective)
Physical Symptoms		
Pain ☐ No ☐ Yes		
Nausea ☐ No ☐ Yes		
Vomiting ☐ No ☐ Yes		
Constipation ☐ No ☐ Yes		
Diarrhea ☐ No ☐ Yes		
Dysphagia ☐ No ☐ Yes		
Dyspnea ☐ No ☐ Yes		
Respiratory Congestion ☐ No ☐ Yes		
Cough ☐ No ☐ Yes		
Dry Mouth ☐ No ☐ Yes		

Care Domains	If Yes, describe the management (document all medications for pain and symptom management that *were administered*, including dose, route and frequency)	Evaluation of management (e.g., documentation that intervention was effective)
Fever ☐ No ☐ Yes		
Skin Breakdown ☐ No ☐ Yes		
UTI ☐ No ☐ Yes		
Edema ☐ No ☐ Yes		
Seizures ☐ No ☐ Yes		
Other ☐ No ☐ Yes		
Psychosocial Symptoms		
Depression ☐ No ☐ Yes		
Anxiety ☐ No ☐ Yes		
Agitation/restlessness ☐ No ☐ Yes		
Delirium ☐ No ☐ Yes		
Other ☐ No ☐ Yes		

25. Personal Care/Comfort Provided in Last Week of Life?

a) Mouth Care ☐ No ☐ Yes

b) Bathing ☐ No ☐ Yes

c) Incontinence Care ☐ No ☐ Yes

d) Positioning ☐ No ☐ Yes

26. Evidence of the WRHA Care in Final Days Toolkit used? ☐ No ☐ Yes

If Yes: Was Step 1 of the Toolkit used? ☐ No ☐ Yes

Was Step 2 of the Toolkit used? ☐ No ☐ Yes

Was Step 3 of the Toolkit used? ☐ No ☐ Yes

27. Was a consult made in the last month of life to:

☐ WRHA Palliative Care Program: ☐ CNS/ or Physician

☐ Other MD/NP, specify _____

☐ WRHA LTC CNS

☐ Site CNS

☐ Therapeutic Recreation

☐ Hospice Palliative Care MB Volunteer

☐ Respiratory Therapist

☐ Facility Volunteers/Volunteer Program

☐ Pharmacist

☐ Other (specify) _____

☐ Speech Language Pathologist

☐ Social Work

☐ Spiritual Health Practitioner

☐ OT/PT/Rehab

☐ Registered Dietitian

☐ Manager of Food Services

☐ Information not Available

☐ Ethics Committee: If selected, please describe the reason for consult:

Summary comments on any notable findings from chart review: