

QNAV Hospice & Palliative Care (Customized with your hospice name)

Care Planning & Delivery

Complete audit after patient is discharged; enter data into QAPI Navigator system.

GENERAL INFORMATION

Patient ID Number: _____	Patient Full Name: _____
Admit Date (Date of election): ____ / ____ / ____	Discharge Date: ____ / ____ / ____ Type: <input type="radio"/> Death <input type="radio"/> Live Disch.
If the patient died, was the patient's death attended by hospice staff? <input type="radio"/> Yes <input type="radio"/> No	
Primary Diagnosis: <input type="radio"/> ALS <input type="radio"/> Cancer <input type="radio"/> Decline in Health Status <input type="radio"/> Dementia (Alzheimer's and Related Disorders)	
<input type="radio"/> Heart Disease <input type="radio"/> HIV Disease <input type="radio"/> Liver <input type="radio"/> Pulmonary Disease <input type="radio"/> Renal Disease	
<input type="radio"/> Stroke and Coma <input type="radio"/> Other (please specify): _____	
Team ID: _____	Primary Nurse/Case Manager: _____

COMPREHENSIVE ASSESSMENT COMPLETION

Date of completion of the comprehensive assessment: ____ / ____ / ____ ☐ Check here if not complete prior to discharge

OPIOID USE

Did the patient have opioid analgesics prescribed? ☐ Yes ☐ No Did patient have a bowel protocol initiated within 24 hr of the first opioid prescription? ☐ Yes ☐ No

PATIENT / FAMILY PREFERENCES FOR CARE

Preferences for hospitalization

On initial assessment: ☐ Avoid hospitalization ☐ OK to hospitalize ☐ Undecided ☐ No information on chart
Last recorded preference: ☐ Avoid hospitalization ☐ OK to hospitalize ☐ Undecided ☐ No information on chart
Was hospitalization documented at any time? (any inpatient bed – hospice or other) ☐ Yes ☐ No
Number of hospitalizations: _____
Were any hospitalizations unplanned? ☐ Yes ☐ No ☐ No information on chart

Preferences for CPR

On initial assessment: ☐ DNR ☐ Full Code ☐ Undecided ☐ No information on chart
Last recorded preference: ☐ DNR ☐ Full Code ☐ Undecided ☐ No information on chart
Was there a documented resuscitation? ☐ Yes ☐ No
If yes, was the resuscitation unplanned? ☐ Yes ☐ No ☐ No information on chart

Advance care planning

Was there a living will or documented surrogate decision-maker on the chart within 2 weeks of the date of election / admission? ☐ Yes ☐ No ☐ Date not available

SPIRITUAL CARE

Was there a documented discussion of spiritual/religious concerns, or documentation that patient/family did not want to discuss? ☐ Yes ☐ No

FACTORS AFFECTING CARE

Was patient or PCG deaf or a non-English speaker? ☐ Yes ☐ No ☐ No info on chart
If yes, was a non-family translator or interpreter used to communicate with the patient or PCG? ☐ Yes ☐ No ☐ No info on chart

SYMPTOM MANAGEMENT PROCESS

Symptom	Not identified in this patient	Date first identified	No intervention	Date first intervention documented for symptom
Symptom 1	<input type="radio"/>	____ / ____ / ____	<input type="radio"/>	____ / ____ / ____
Symptom 2	<input type="radio"/>	____ / ____ / ____	<input type="radio"/>	____ / ____ / ____
Symptom 3	<input type="radio"/>	____ / ____ / ____	<input type="radio"/>	____ / ____ / ____
Symptom 4	<input type="radio"/>	____ / ____ / ____	<input type="radio"/>	____ / ____ / ____

Select up to 4 symptoms from the following:

Anxiety	Insomnia
Constipation	Nausea
Depression	Pain
Diarrhea	Spiritual distress
Dyspnea	Skin impairment

Data element	Definition/Instruction
Patient ID	The unique ID assigned to the patient by your agency.
Patient Name	First name, last name.
Admission Date (Date of Election)	Date that the hospice became responsible for the patient; also called “start of care date.” For Medicare patients, it is the date of election of the Medicare Hospice Benefit.
Attended death	Indicate if hospice staff was present at the time of the patient’s death.
Diagnosis	The patient’s primary hospice diagnosis.
Team ID	The name or number for the care team assigned by your agency (choose from drop down menu).
1 ^o Nurse/Case Mgr	The RN assigned to manage the patient’s care (choose from drop-down menu).
Date of Completion of the Comprehensive Assessment	The earliest date that ALL elements of the patient’s comprehensive assessment are complete; <u>must include</u> Initial assessment, Comprehensive nursing assessment (with nature and condition causing admission, complications and risk factors that affect care planning, functional status, imminence of death, severity of symptoms/symptom screening), Drug profile/review, Initial bereavement assessment, Need for referrals and further evaluation; depending on the initial assessment findings, may include Comprehensive psychosocial assessment, Comprehensive spiritual assessment, assessments by ancillary providers. If comprehensive assessment was not completed prior to the patient’s discharge, check the box.
Opioid Use	<ol style="list-style-type: none"> 1. Indicate whether patient had opioid analgesics prescribed at any time during the course of care; fill in the date of the first prescription of opioids. (<i>Exclude opioids in a “comfort pack”.</i>) 2. Indicate whether patient had a bowel protocol (as defined by your hospice) initiated within 24 hr of the opioid prescription.
Preference for Hospitalization	<ol style="list-style-type: none"> 1. Indicate preference regarding hospitalization. <ul style="list-style-type: none"> • <u>On admission</u> means at the first assessment. • <u>Last recorded preference</u> means the preference recorded closest to the time of discharge; note that this may be the documentation at the first assessment or at any assessment update up to the day of discharge. 2. Indicate whether the patient was hospitalized at any time and the number of hospitalizations during the course of hospice care. Hospitalization includes any time spent in an inpatient setting <u>even if it was a hospice inpatient stay</u>; also includes hospitalization concurrent with discharge or revocation. 3. Indicate whether the hospitalization was planned; “planned” means that the hospice was involved in planning the transfer <u>before</u> the patient went to the inpatient setting.
Preference for CPR	<ol style="list-style-type: none"> 1. Indicate preference regarding resuscitation <ul style="list-style-type: none"> • <u>On admission</u> means at the first assessment • <u>Last recorded preference</u> means the preference recorded closest to the time of discharge; note that this may be the documentation at the first assessment or at any assessment update up to the day of discharge. 2. Indicate whether the patient was resuscitated at any time during the course of hospice care, no matter who conducted the CPR. 3. Indicate whether the resuscitation was planned; “planned” means that the hospice was involved in planning for the resuscitation (planning who would conduct it and how they would be called/notified) <u>before</u> the patient required CPR; a planned CPR cannot occur for a patient who is DNR on admission and for the duration of care.
Advance Care Planning Documentation	Answer “yes” only if chart contains copy of living will, or copy of surrogate designation form, or copy of a Durable Power of Attorney for Healthcare designation, or contact information for a designated surrogate/proxy decision-maker within the first two weeks of care.
Spiritual Care	Answer “yes” only if chart contains documentation of a discussion about spiritual issues or documentation showing that patient/Primary Caregiver/family declined to discuss.
Factors Affecting Care	<ol style="list-style-type: none"> 1. If either patient or Primary Caregiver (PCG) was deaf or did not speak English, answer “yes” to first question. 2. Answer “yes” to second question only if use of a <u>non-family member</u> translator (for non-English speakers) or interpreter (for deaf) was documented.
Symptom Management Process	<ol style="list-style-type: none"> 1. First column: check if the symptom was NEVER identified for the patient. 2. Second column: enter date that the symptom was first identified on an assessment form; may be nursing, psychosocial or spiritual assessment. 3. Third column: check if no interventions were documented for this symptom. 4. Fourth column: enter date that the first <u>delivery of any intervention</u> directed at this symptom is documented; may be on the plan of care, drug profile, or in clinical notes.