# WLSM case audit

|  |  |  |
| --- | --- | --- |
| DATE WLSM STARTEDYYYY / MM / DD | IDENTIFIER 1 | IDENTIFIER 2 |
| NAME | MRN | ⬜ DCD ⬜ No donation |

Cause of Death/Decision for WLSM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Event timing

|  |  |  |
| --- | --- | --- |
| Event | Time | Comments |
| Withdrawal of vasopressors | Start**:**Complete**:** |  |
| Withdrawal of mechanical ventilation | Start**:**Complete**:** |  |
| Withdrawal of supplemental oxygen | Start**:**Complete**:** |  |
| Extubation | **:** |  |
| Death | Date / TimeYYYY/MM/DD**:** |  |
| Transfer from unit prior to death.*If yes, document date and time.* | ⬜No | ⬜Yes |  |
| Date / TimeYYYY/MM/DD**:** |
| Bedside monitors | ⬜ ON ⬜ OFF |  |
| **Notes:** *(any missing item should be addressed in the action plan below)* |

Preparation for WLSM

*Location of documentation sough in the audit predefined by site. Do not include items suggested below if not routinely documented at your site. Location can be in nursing or physician’s notes or use of specific checklist completed for WLSM. A checklist is strongly recommended where items match the audit.*

|  |  |  |  |
| --- | --- | --- | --- |
| Which of the following are clearly *documented?* | **Yes** | **No** | **Comments** |
| Multidisciplinary care plan for WLSM |  |  |  |
| Notification of Organ Donation Organization |  |  |  |
| Patient/family offered the opportunity for organ and tissue donation |  |  |  |
| Pre-WLSM huddle of physician, RN, RT, social work, others |  |  |  |
| Explicit decision made regarding use of bedside monitors and in consultation with family |  |  |  |
| Signal/sign posted that WLSM is occurring |  |  |  |
| Spiritual/culture needs of patient and family discussed prior to WLSM |  |  |  |
| Spiritual/culture support offered to patient and family |  |  |  |
| Family encouraged and permitted to participate in patient care before, during and after WLSM |  |  |  |
| **Notes:** *(any missing item should be addressed in the action plan below)* |

Process of WLSM

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| --- | --- | --- | --- |
| Steps | **Yes** | **No** | **Comments** |
| Family present during WLSM |  |  |  |
| Concern noted regarding RN availability during WLSM |  |  |  |
| Concern noted regarding RT availability during WLSM |  |  |  |
| Concern noted regarding MD availability during WLSM |  |  |  |
| Standardized order set available and signed in advance of WLSM*Check documented times.* |  |  |  |
| **Notes:** *(any missing item should be addressed in the action plan below)* |

Assessment of distress and symptom relief during WLSM

*It is assumed each unit will use only one scoring system for symptoms.*

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| --- | --- | --- | --- | --- |
| Is the following documented in the RN notes? | **Consistently** | **Inconsistently** | **Not at All** | **Comments** |
| Pain score used |  |  |  |  |
| Sedation score used  |  |  |  |  |
| Respiratory distress score used  |  |  |  |  |
| Delirium score used  |  |  |  |  |
| Medication name(s) and dose(s) used to treat anticipated symptoms with documented rationale |  |  |  |  |
| For evident symptoms, administration of medication included documentation of:* score prompting use of medications
* dose
* response
 | **Consistently** | **Inconsistently** | **Not at All** | **Comments** |
|  |  |  |  |
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| **Notes:** *(any missing item should be addressed in the action plan below)* |

Following death

*The following items are suggestions. Documentation must be clear and a post WLSM checklist matching the items below is suggested.*

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| --- | --- | --- | --- |
| Follow up | **Yes** | **No** | **Comments** |
| Grief literation/information/support offered to family |  |  |  |
| Referral to community bereavement support |  |  |  |
| Suggestion whether to review case documented  |  |  |  |
| **Notes:** *(any missing item should be addressed in the action plan below)* |

**Case audit follow up action items and accountability**

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| --- | --- |
| **ACTION ITEM** | **ACCOUNTABILITY** |
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|  |  |  |
| --- | --- | --- |
| PERFORMED BY | DATEYYYY / MM / DD | TIME: |

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Case audit tool helped facilitate discussion: ⬜ Yes ⬜ No

Tool requires revision: ⬜ No ⬜ Yes – Feedback provided to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_