Quality Improvement Activity

Project Title: Patients in the unstable phase for longer than three days

Service Name: Gold Coast Health Community Palliative Care Service

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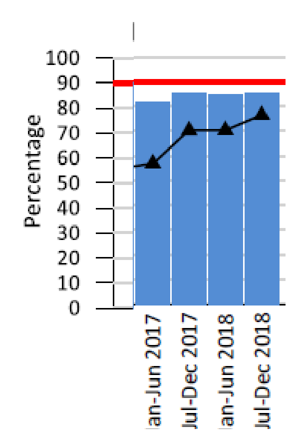
Clare Christiansen, Improvement Facilitator QLD – E: clare.christiansen@qut.edu.au

Project Completion or Finalized Date: January 2019

Benchmark or focus are: Unstable phase benchmark

Problem	Clients in the unstable phase for greater than 3 days (72 hours). There has been some improvement after the introduction of a PCOC communication board and a handover scrum each morning. However, we wanted to investigate if our model of care was having an effect on our results. The model of care of the Community Palliative Care service is predominately a five day per week consultative service, utilizing non-government organizations (NGOs) to deliver primary nursing care. The Gold Coast Hospital and Health Service (GCHHS) covers an area with a population greater than 600,000. The demand for the Community Palliative Care Service has grown significantly over the past few years.
PCOC evidence	As shown by the triangles in the graph to the right, the service's performance is significantly below the 90% benchmark for the unstable phase, and also below the national average for all community services (blue bars). Prior to the project commencement (January 2018) in the January to June 2017 reporting period the service had an average unstable phase length of 7.2 days, more than double the national community average of 3.1 days. In the same time period, 43% of unstable phases were not meeting the benchmark, representing 25 patients who were in an unstable phase for four days or more. 
Timeframe	After reviewing the results of the 2017 reports, the quality improvement activity was initiated in January 2018 and continued until January 2019.
Staff involved	Brian Everson - Clinical Nurse Andrew Broadbent – Medical Director Julie – Ann Brydon – Team Leader Joyce Glen – Allied Health Assistant All other staff members were involved in daily PCOC meetings
Interventions and processes	At an in-service the team reviewed the PCOC reports for 2017 and agreed to undertake a quality improvement project focussed on improving their results on the unstable phase outcome measure. The team hypothesised that the limitations of their five-day service might be impacting the ability to respond to urgent needs in a timely manner and requested additional PCOC supplementary data showing the day the unstable phase commenced. The CN then used this data to determine

<table>
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which unstable phases encompassed a weekend, and the proportion of patients that were potentially in an unstable phase for longer than three days because of the lack of service over a weekend. The results of this investigation on 2017 data showed that the proportion of patients affected by a weekend was minimal.

It was thus confirmed that the team needed to focus on processes and procedures to ensure that the unstable phase was being correctly assessed and documented. The CN used the 'Response to assessments' and 'Phase assessments' PCOC audit tools to help structure a comprehensive review of their practices around unstable phases.

The team reviewed the PCOC Board which they use to track unstable patients and noted that it lacked key information pertaining to length in the unstable phase: the date a client entered the unstable phase. The Board was thus redesigned to include this date and enable the team to monitor a patient's time in the unstable phase and prioritise care accordingly. At the morning PCOC scrums the team also decided to trial "PCOC Live" meaning that any phase changes were agreed upon as a team and made on the board during the scrum. It was anticipated that the outcome from these changes would minimise the number of patients in the unstable phase for longer than three days, with the exception of those with an unstable phase including a weekend for which the service is unable to meet the benchmark within the current resource model. While it was initially thought the PCOC scrum time of 15 minutes would be ample to make changes to PCOC data, it needed to be lengthened to complete the PCOC Live process.

Audits also revealed several other issues regarding the way PCOC data was being recorded and shared amongst team members who are situated across different offices. The Community team uses an electronic form which is saved on a specific hard drive to record patient information and assessment scores. It was assumed that all team members could access this drive however it became apparent that some clinicians, particularly Registrars were not routinely being granted access at the start of their rotation. Processes were thus put in place to ensure that these issues were resolved. PCOC Online Education for all clinicians was also added to the orientation and has been made mandatory for all staff, with a 12-monthly review.

Issues with missing PCOC documentation were also highlighted. For example, some patients were reviewed by a team member and while PCOC assessment scores and phase change data was recorded in their medical notes, this information was not recorded on the PCOC form. A small percentage of unstable clients also had missing discharge scores or phase change information as their community episode had ended with admission to a private hospital and the Community team was not notified of this at the time.

Following this process, the team created a documented titled, 'Work Instruction for the Collection and Completion of patient data for PCOC' to help standardise assessment processes and documentation.
</td></tr>
<tr><td>Results</td><td>
As shown in the table below, since the project commenced in 2018, there has been an overall improvement on the unstable phase benchmark. The average length of unstable phases is now much closer to the national average for community services.

The results indicate that this project has enabled the service to achieve the unstable benchmark for a greater proportion of clients between Monday to Friday than previously. It also highlights that more resources would be required to adequately address unstable patients after hours and over the weekends, confirming the limitations of the current model of care.

<table>
<tr><th>Indicator</th><th>Jan-Jun 2017</th><th>Jul-Dec 2017</th><th>Jan-Jun 2018</th><th>Jul-Dec 2018</th></tr>
<tr><td>Average unstable phase length (days)</td><td>7.2</td><td>3.4</td><td>4.2</td><td>3.2</td></tr>
<tr><td>% unstable phases >3 days as a proportion of all unstable phases</td><td>43%
(25/58)</td><td>39%
(39/101)</td><td>28%
(20/71)</td><td>22%
(22/98)</td></tr>
<tr><td>% patients potentially unstable for >3 days due to weekend as a proportion of all unstable phases >3 days</td><td>..</td><td>..</td><td>33%
(7/21)</td><td>60%
(14/23)</td></tr>
</table>
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Outcome	Improvement in the management of unstable clients and the identification of service-level changes that are required to meet client needs. We continue to refine our assessment processes and support staff to assess unstable clients. There is ongoing education and mentoring of team members.
Outputs	A document titled, '*Work Instruction for the collection and completion of patient data for PCOC'* under the GCHHS Community Supportive and Specialist Palliative Care team has been formalised. Permission has been given to share the document and it will be attached as an annex.

***PCOC 17.04.2020**

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Gold Coast Hospital & Health Service
Community Supportive & Specialist Palliative Care

Work Instruction for the collection & completion of patient data for PCOC

PCOC → Palliative Care Outcome Collaboration

PCOC is a national program that uses a cycle of routine assessment, measurement of patient outcomes and reporting and benchmarking to drive improvements in palliative care. Evidence shows that services can improve the clinical outcomes for palliative care patients by participating in routine collection and systematic feedback (Currow et al, 2014).

A set of standardised and validated clinical assessment tools capture clinically meaningful information at significant periods in a palliative patient's disease trajectory.

At the service level this information is used to drive improvement through:

- Providing feedback to individual services
- Identifying improvement opportunities
- Providing service-to-service benchmarking as part of routine clinical practice.

Community Supportive & Specialist Palliative Care

Purpose

This Work Instruction describes the steps for completing **PCOC Assessments** in the Community- Supportive & Specialist Palliative Care Service.

Scope

This work instruction applies to all staff / teams working in Community Supportive & Specialist Palliative Care Service.

Compliance with this Work Instruction is mandatory for ALL staff upon commencement with an Annual Refresher

See below link to complete → *Online Essentials Course*

https://ahsri.uow.edu.au/pcoc/4clinicians/essentials-course/index.html

PCOC – Evidence Based Improvement of Patient, Family & Carer Outcomes Orientation Video:

https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/mm/uow128306.mov

PCOC meeting:

Held every morning in the nurse's room. A Doctor must be present at all meetings.

- Outpatient Reviews discussed at PCOC meetings Thursday & Fridays

Where to find forms on K: Drive

K:\PalliativeCare\1 PalCare\2016\PCOC\COMMUNITY

- Patient Data 20…
- Alphabetical Order
- Ctrl C then Ctrl V to copy template for new referral - *please note* – RENAME the file & Surname first in CAPITALS

Administration

- Daily check of admission reports for GCUH and Robina Hospital to discharge on PCOC that episode of care.
    - Completed by SSPCS Allied Health Assistant
- Mortality reports to finalise End of Episode in PCOC.
    - Completed by SSPCS CN with notification to the relevant NGO's
- Admin support 1 day a week to complete PCOC data entry → Community Palliative Care, Clinical Liaison (Robina & GCUH) and Palliative Wards
    - Completed by Admin support person

Be mindful - this information needs to be accurate and complete:

- PCOC form to be completed on admission to the service and each subsequent contact →

  i.e. phone, face to face, outpatient (e.g. a HBCIS encounter)
- One assessment per "episode of care" is the minimum requirement
- Complete **ALL** patient data on ***page 1*** see below

Gold Coast Health
Building a healthier community

S&SPCS

PCOC
palliative care outcomes collaboration

(Complete or affix Addressograph Label here)
UR Click or tap here to enter text.
Surname Click or tap here to enter text.
Given Names Click or tap here to enter text.
Gender Male ☐ Female ☐ Other ☐
State QLD Postcode Click or tap here to enter text.

Community Patient Episode Information

Team name: SUPPORTIVE & SPECIALIST PALLIATIVE CARE SERVICE

Section 1 (Complete at start of episode)

Country of Birth ☐ Australia ☐ Other, specify ______

Preferred Language ☐ English ☐ Other, specify ______

Indigenous Status
☐ Aboriginal but not Torres Strait Islander origin
☐ Torres Strait Islander but not Aboriginal origin
☐ Both Aboriginal and Torres Strait Islander origin
☐ Neither Aboriginal nor Torres Strait Islander origin
☐ Not stated / inadequately described

Primary Diagnosis (principal life-limiting illness)

Malignant
☐ Bone & soft tissue ☐ Gynaecological ☐ Pancreas ☐ Other GIT
☐ Breast ☐ Haematological ☐ Prostate ☐ Other Urological
☐ CNS ☐ Head and Neck ☐ Skin ☐ Other Malignancy
☐ Colorectal ☐ Lung ☐ Unknown Primary

Non-malignant
☐ Cardiovascular disease ☐ Alzheimer's disease ☐ Diabetes & its complications
☐ HIV/AIDS ☐ Other dementia ☐ Sepsis
☐ End stage kidney disease ☐ Other neurological disease ☐ Multiple organ failure
☐ Stroke ☐ Respiratory failure ☐ Other non malignancy
☐ Motor Neurone Disease ☐ End stage liver disease

Referral Source (referring agency/facility)
☐ Public hospital palliative care unit/team ☐ Private hospital palliative care unit/team
☐ Public hospital oncology unit/team ☐ Private hospital oncology unit/team
☐ Public hospital medical unit/team ☐ Private hospital medical unit/team
☐ Public hospital surgical unit/team ☐ Private hospital surgical unit/team
☐ Public hospital emergency department ☐ Private hospital emergency department
☐ Community palliative care service ☐ Outpatient clinic
☐ Community generalist service ☐ General practitioner
☐ Specialist practitioner ☐ Residential aged care facility
☐ Self, carer(s), family or friends ☐ Other

COMMUNITY PATIENT EPISODE INFORMATION JULY 2014

Accurate Completion of ALL patient data is required

Page 2. see below

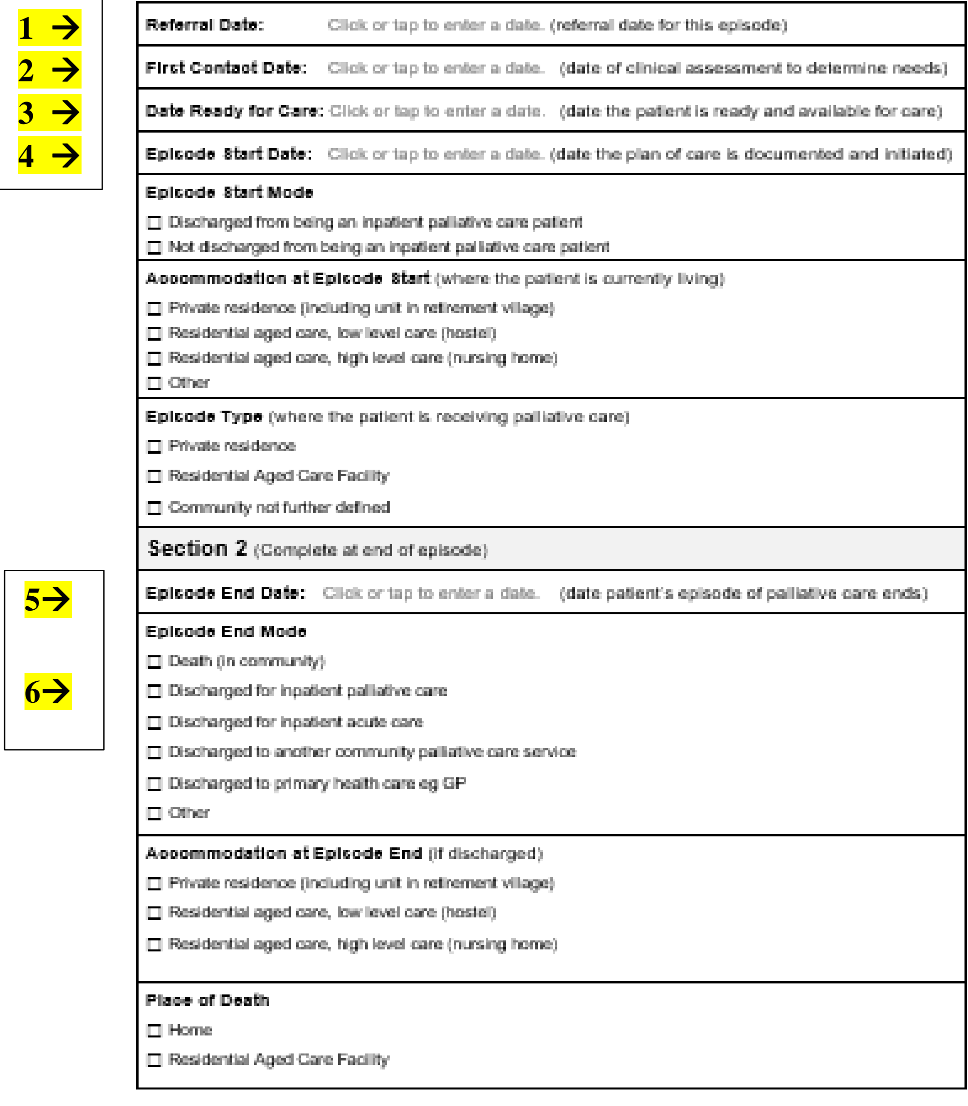
Be mindful - this information needs to be accurate and complete:

1. **Referral Date:** the date the referral is requested for the encounter(e.g.date of discharge from PCU)

***Please Note**: The referral date will change according to the number of encounters a patient has with the service.* (i.e. after each discharge from hospital)

2. **First Contact Date:** is the date patient is contacted post referral.

3. Date Ready for Care: is the date the patient agrees to be seen by Supportive & Specialist Palliative Care Services. If the patient states not ready for care (NRFC) then Date Ready will be the date the patient agrees to have Supportive & Specialist Palliative Care involvement.



1 →
2 →
3 →
4 →

Referral Date: Click or tap to enter a date. (referral date for this episode)

First Contact Date: Click or tap to enter a date. (date of clinical assessment to determine needs)

Date Ready for Care: Click or tap to enter a date. (date the patient is ready and available for care)

Episode Start Date: Click or tap to enter a date. (date the plan of care is documented and initiated)

Episode Start Mode
☐ Discharged from being an inpatient palliative care patient
☐ Not discharged from being an inpatient palliative care patient

Accommodation at Episode Start (where the patient is currently living)
☐ Private residence (including unit in retirement village)
☐ Residential aged care, low level care (hostel)
☐ Residential aged care, high level care (nursing home)
☐ Other

Episode Type (where the patient is receiving palliative care)
☐ Private residence
☐ Residential Aged Care Facility
☐ Community not further defined

Section 2 (Complete at end of episode)

5 →
6 →

Episode End Date: Click or tap to enter a date. (date patient's episode of palliative care ends)

Episode End Mode
☐ Death (in community)
☐ Discharged for inpatient palliative care
☐ Discharged for inpatient acute care
☐ Discharged to another community palliative care service
☐ Discharged to primary health care eg GP
☐ Other

Accommodation at Episode End (if discharged)
☐ Private residence (including unit in retirement village)
☐ Residential aged care, low level care (hostel)
☐ Residential aged care, high level care (nursing home)

Place of Death
☐ Home
☐ Residential Aged Care Facility

4. Episode Start Date: is the date patient is seen or triaged by phone.

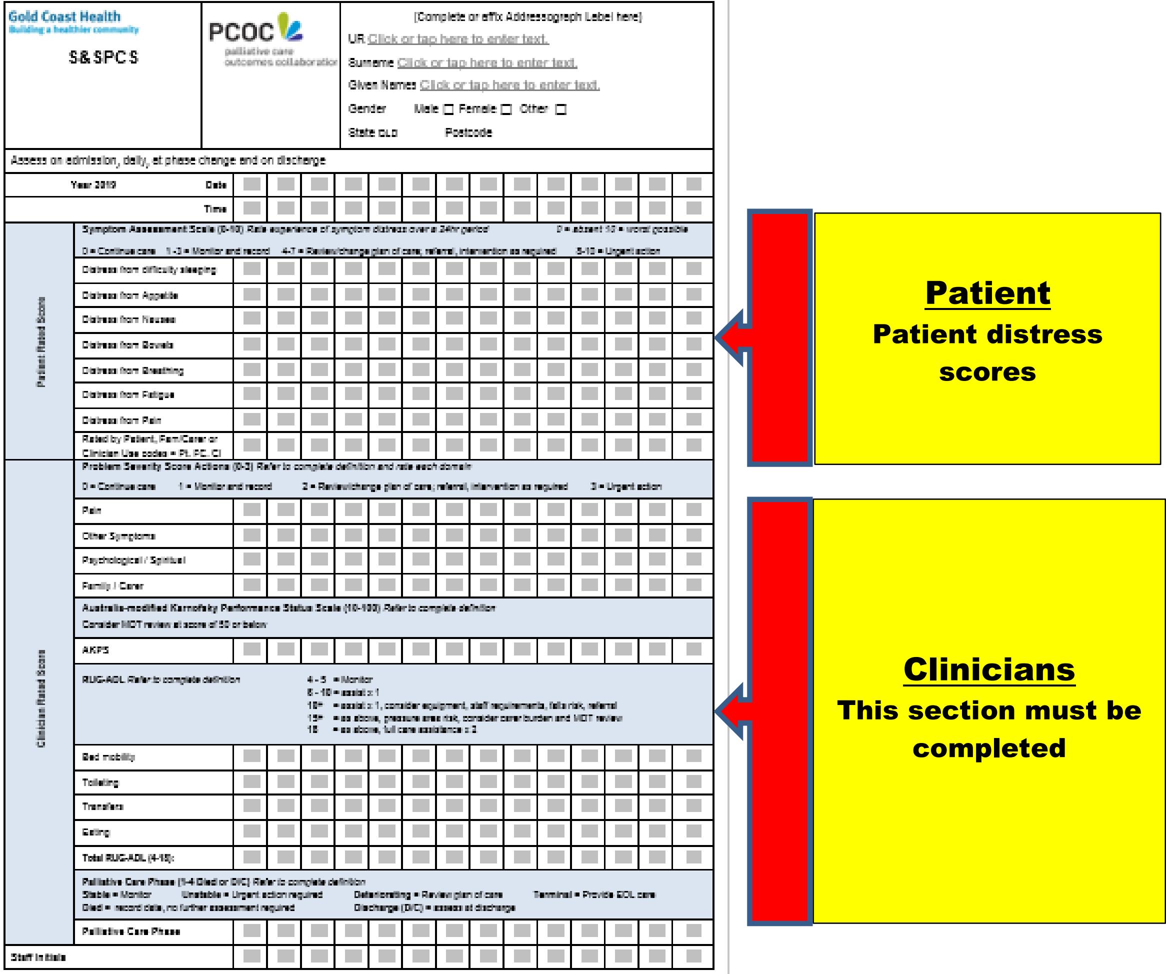
5. Episode End Date: is the date patient's episode of care ends

6.Episode End Mode: being discharged from community S&SPC because i.e. Hospital admission, Discharge to Hospice, other Palliative Care Service, RACF, GP Care or De

ASSESSMENT PROCESS

Page 3 see below → assessment form is required to be completed on <u>**ALL**</u> episodes of care.

- All clinicians rated scores must be completed – ***NO EXCEPTIONS***
- If a SAS score has not been completed, place a (-) in the box.


Gold Coast Health
Building a healthier community
S&SPCS
PCOC palliative care outcomes collaboration
[Complete or affix Addressograph Label here]
UR Click or tap here to enter text.
Surname Click or tap here to enter text.
Given Names Click or tap here to enter text.
Gender Male ☐ Female ☐ Other ☐
State QLD Postcode

Assess on admission, daily, at phase change and on discharge

Year 2019	Date	
	Time	
Patient Rated Score	Symptom Assessment Scale (0-10) Rate experience of symptom distress over a 24hr period 0 = absent 10 = worst possible 0 = Continue care 1-3 = Monitor and record 4-7 = Review/change plan of care, referral, intervention as required 8-10 = Urgent action	
	Distress from difficulty sleeping	
	Distress from Appetite	
	Distress from Nausea	
	Distress from Bowels	
	Distress from Breathing	
	Distress from Fatigue	
	Distress from Pain	
	Rated by Patient, Fam/Carer or Clinician Use codes = Pt, FC, Cl	
Clinician Rated Score	Problem Severity Score Actions (0-3) Refer to complete definition and rate each domain 0 = Continue care 1 = Monitor and record 2 = Review/change plan of care, referral, intervention as required 3 = Urgent action	
	Pain	
	Other Symptoms	
	Psychological / Spiritual	
	Family / Carer	
	Australia-modified Karnofsky Performance Status Scale (10-100) Refer to complete definition Consider MDT review at score of 50 or below	
	AKPS	
	RUG-ADL Refer to complete definition 4-5 = Monitor; 6-10 = assist x 1; 10+ = assist x 1, consider equipment, staff requirements, falls risk, referral; 15+ = as above, pressure area risk, consider carer burden and MDT review; 18 = as above, full care assistance x 2	
	Bed mobility	
	Toileting	
	Transfers	
	Eating	
	Total RUG-ADL (4-18):	
	Palliative Care Phase (1-4 Died or D/C) Refer to complete definition Stable = Monitor Unstable = Urgent action required Deteriorating = Review plan of care Terminal = Provide EOL care Died = record date, no further assessment required Discharge (D/C) = assess at discharge	
	Palliative Care Phase	
Staff Initials		

- Assessments are completed at each episode of care.
- Assessment scores are documented or recorded at point of care per episode.
- Assessment relates to the 24hr period prior and up to assessment.
- Assessments are completed directly by a community palliative care clinician. *(not a third party i.e. NGO's)*

PLEASE NOTE WHEN ENDING AN EPISODE OF CARE

- Ending of an Episode of Care is completed by the clinician that has been made aware of an admission to hospital or of a death.
- Ending Episodes of Care is also done by the Clinical Nurse or Allied Health Assistant when identified in the Palliative Care Admissions Reports or Mortality Reports.

PHASE DEFINITIONS

- The palliative care phase identifies a clinically meaningful period in a patient's condition.
- The palliative care phase is determined by a holistic clinical assessment which considers the needs of the patients and their family and carers.

START	END
Stable	
Patient problems and symptoms are adequately controlled by established plan of care **and** • Further interventions to maintain symptom control and quality of life have been planned **and** • Family/carer situation is relatively stable and no new issues are apparent.	The needs of the patient and / or family/carer increase, requiring changes to the existing plan of care.
Unstable	
An urgent change in the plan of care or emergency treatment is required **because:** • Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or** • Patient experiences a rapid increase in the severity of a current problem; **and/or** • Family/ carers circumstances change suddenly impacting on patient care.	• The new plan of care is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. patient is stable or deteriorating) and/or • Death is likely within days (i.e. patient is now terminal).
Deteriorating	
The care plan is addressing anticipated needs but requires periodic review **because:** • Patients overall functional status is declining **and/or** • Patient experiences a gradual worsening of existing problem **and/or** • Patient experiences a new but anticipated problem **and/or** • Family/carers experience gradual worsening distress that impacts on the patient care.	Patient condition plateaus (i.e. patient is now stable) **or** • An urgent change in the care plan or emergency treatment **and/or** • Family/ carers experience a sudden change in their situation that impacts on patient care, and urgent intervention is required (ie patient is now unstable) **or** • Death is likely within days (i.e. patient is now terminal).
Terminal	
• Death is likely within days.	• Patient dies or • Patient condition changes and death is no longer likely within days (i.e. patient is now stable or deteriorating).
Bereavement – post death support	
• The patient has died • Bereavement support provided to family/carers is documented in the deceased patient's clinical record.	• Case closure ***Note***: If counselling is provided to a family member or carer, they become a client in their own right.

<table>
<tr>
<td>Palliative Care Phase of Illness

Abbreviated Definition</td>
<td>Resource Utilisation Group – Activities of Daily Living
Abbreviated Definition</td>
</tr>
<tr>
<td>Clinician rated assessment
1. Stable Symptoms are adequately controlled by established management
2. Unstable Development of a new problem or a rapid increase in the severity of existing problems
3. Deteriorating Gradual functional decline and worsening of existing symptoms or the development of new but expected problems
4. Terminal Death likely in a matter of days

Complete Phase Definitions available on the PCOC website www.pcoc.org.au</td>
<td>Clinician rated assessment of dependency over 24hr period
For Bed Mobility, Toileting & Transfers
1. Independent or supervision only
3. Limited physical assistance
4. Other than two person physical assist
5. Two or more person physical assist
For Eating
1. Independent or supervision only
2. Limited assistance
3. Extensive assistance / total dependence / tube fed

Complete RUG-ADL definitions available on the PCOC website www.pcoc.org.au</td>
</tr>
<tr>
<td>Problem Severity Score

Complete Definition</td>
<td>Australia-modified Karnofsky Performance Status

Complete Definition</td>
</tr>
<tr>
<td>Clinician rated assessment of problems over a 24hr period
Global assessment of four palliative care domains to summarise palliative care needs and plan care.
The severity of problems are rated and responded to following using the scale:
0 = Absent; 1 = Mild; 2 = Moderate; 3 = Severe
Pain: overall severity of pain problems for the patient
Other Symptoms: overall severity of problems relating to one or more symptoms other than pain
Psychological / Spiritual: severity of problems relating to the patient's psychological or spiritual wellbeing. May be one or more issues.
Family / Carer: problems associated with a patient's condition or palliative care needs. Family / Carer do not need to be present to asses needs as written, verbal or observational information may be used.</td>
<td>Clinician rated assessment of performance relating to work, activity and self-care over a 24hr period

100. Normal, no complaints or evidence of disease
90. Able to carry on normal activity, minor signs or symptoms of disease
80. Normal activity with effort, some signs or symptoms of disease
70. Care for self, unable to carry on normal activity or to do active work
60. Occasional assistance but is able to care for most needs
50. Requires considerable assistance and frequent medical care
40. In bed more that 50% of the time
30. Almost completely bedfast
20. Totally bedfast & requiring nursing care by professionals and/or family
10. Comatose or barely rousable</td>
</tr>
<tr>
<td colspan="2">Symptom Assessment Scale

Complete Definition
Patient Rated distress relating to symptoms over a 24hr period</td>
</tr>
<tr>
<td>The Symptom Assessment Scale describes the patient's level of distress relating to individual physical symptoms. The symptoms and problems in the scale are the seven most common.
Usage:
1. Best practice is for the patient to rate distress either independent or with the assistance of a clinician or family/carer using a visual of the scale such as the Symptom Assessment Scale Form for Patients.
2. Symptom distress may be rated by proxy. This only occurs when the patient is unable to participate in conversation relating to symptom distress i.e. Terminal phase.</td>
<td>Proxy: a family / carer or clinician who rates symptom distress on behalf of the patient though observational assessment.
Instructions: patient to consider their experience of the individual symptom or problem over the last 24 hours and rate distress according to
A score of 0: means the symptom or problem is absent
A score of 1: means the symptom or problem is causing minimal distress.
A score of 10: means the symptom or problem is causing the worst possible distress.

SAS translations available on the PCOC website www.pcoc.org.au</td>
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</table>

Supporting Documents

Authorising Policy and Standard/s:

Resources

https://ahsri.uow.edu.au/pcoc/assessment-package/index.html

https://ahsri.uow.edu.au/pcoc/forms/index.html

https://ahsri.uow.edu.au/pcoc/4patients/pcoc-assessments/index.html

https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=31

https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=34

PCOC Clinical Manual

https://ahsri.uow.edu.au/pcoc/assessment-package/index.html

Orientation to Palliative Care Assessment

https://ahsri.uow.edu.au/pcoc/4patients/pcoc-assessments/index.html

Functional Assessment in Palliative Care (RUG-ADL & AKPS)

https://ahsri.uow.edu.au/pcoc/4patients/pcoc-assessments/index.html

Translation Resources (14 Languages)

https://ahsri.uow.edu.au/pcoc/sastranslations/index.html

https://ahsri.uow.edu.au/pcoc/forms/index.html

Procedures, Guidelines, Protocols

Assessment Protocol

https://ahsri.uow.edu.au/pcoc/assessment-package/index.html

Forms and templates

- https://ahsri.uow.edu.au/pcoc/4clinicians/forms/index.html
- https://ahsri.uow.edu.au/pcoc/assessment-package/index.html
- https://ahsri.uow.edu.au/pcoc/sastranslations/index.html
- https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=31
- https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=34

Definition of terms

Term	Definition	Source	See also
S&SPC	Specialist & Supportive Palliative Care		
PCOC	Palliative Care Outcome Collaboration		
NRFC	Not Ready for Care		
SAS	Symptom Assessment Scale		
PCPSS	Palliative Care Problem Severity Score		
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living		
AKPS	Australia-Modified Karnofsky Performance Status		
RACF	Residential Aged Care Facility		
NGO's	Non-Government Organisation		

References and Suggested Reading

- https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/mm/uow128306.mov
- https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow121057.pdf

Consultation

Key stakeholders *(name, position and business area*) who developed/reviewed this version are:

- Julie – Ann Brydon — Team Leader — S&SPC - Community
- Brian Everson — Clinical Nurse — S&SPC - Community
- Joyce Glen — Allied Health Assistant — S&SPC - Community

Committee Endorsement

- xxx Committee - DD/MM/YYY *(mandatory for clinical)*

OR

- N/A *(acceptable for non-clinical)*

Work Instruction Development / Revision and Approval History

Version No	Developed/Modified by	Content authorised by	Approved by	Date of Effect	Last Reviewed
1	Joyce Glen	Julie-Ann Brydon Brian Everson	Team Leader – Supportive & Specialist Palliative Care Clinical Nurse		

Audit Strategy (mandatory)

Level of risk	High, Medium or Low. *The risk if this work instruction is/has not been followed (refer to GCHHS Risk Analysis Matrix)*
Audit strategy	
Audit tool attached	
Audit date	
Audit responsibility	
Key Elements / Indicators / Outcomes	

Approval and Implementation

Delegate Lead: Julie-Ann Brydon

Responsible Authority: Team Leader

Approving Officer: Joanne Kanakis (A/Service Director)

....

Signature

Approval date:

Effective from:

Next Review Date:

Version No.:

Supersedes:

Keywords: *key words to describe the document*

Accreditation References:

- NSQHS, EQuIP and other criteria and standards
    - <<insert EQuIP National Standards>>
    - <<insert Mental Health Standards>>
    - <<insert any other applicable Standards>>

Appendices

-