Quick Notes: Guide to Completing a Death Screen

The Clinical Excellence Commission's Death Review database provides local health districts and specialty networks with a standardised best-practice method of screening all in-hospital patient deaths within 45 days. The review of each death aims to evaluate patient care, determine if the care was appropriate or could have been provided differently and identify opportunities to improve care in the future. In particular, the Admitted Patient Death Screening Tool in the database assists clinicians to identify deaths that require a more in-depth and focussed evaluation.

The screening tool or "death screen" establishes a minimum data set for commencement of the process of mortality review. Death screen data includes an admission profile, cause of death, end of life management, screening criteria, outcomes of screening and referrals for further review.

This guide provides database users with additional explanations and alignment with NSW Health policy, national accreditation standards, National Sentinel Events and legislative requirements to enable consistent and accurate completion of a death screen.

FIELD	GUIDE / POLICY / STANDARDS
Admission Details	
Admission Status	• Was the admission planned (elective) or unplanned (emergency)?
Admitting Specialty Discharge Specialty	• Describes primary clinical care (not location of care) at admission and at discharge/death • Measures the patient's clinical journey • Compares initial plan of care to outcome of care through specialty • Can assist in identifying CHASM and SCIDUA patients (use Surgery: XXXX codes where applicable)
Admitting Reason	• What was the primary reason for the hospital admission? • Compare to the causes of death recorded
Cause Of Death	
Coroner's case Coroner's report date Copy of Coroner's report	• Measures percentage of Coroner's cases • Records date of report • Where available, facilitates authorised access to the report
Death determined as unascertainable by Coroner	• Allows for no cause of death to be seen as a completed record
Cause of Death	• Records causes of death from the Medical Certificate of Cause of Death (MCCOD) or the Coroner's report • Used to identify any errors or omissions, including the recording of functions of death or modes of care as a cause of death • Compares the initial medical reason for care to cause of death *PD2010_054: Coroner's Cases and the Coroners Act 2009* *PD2015_040: Death – Verification of Death and Medical Certificate of Cause of Death*

FIELD	GUIDE / POLICY / STANDARDS
End Of Life Management Plan	
1. Advance Care Directive	• Contains instructions that consent to, or refuse, specified medical treatments in the future • Is completed by a patient with 'capacity', signed and witnessed • There is no mandated form, patients may simply write their wishes down in a letter • Used to assess the effectiveness and timing of end of life management *GL2005_056: Using Advance Care Directives* *GL2005_057: End-of-Life Care and Decision-Making - Guidelines* *PD2014_030 Using Resuscitation Plans in End of Life Decisions* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.8)*
2. Advance Care Plan	• Documents the outcomes of advance care planning. That is, the patient's values, preferences and treatment goals for future healthcare • Identifies the 'Person Responsible' for future healthcare decision-making when the patient's 'capacity' is lost • There is no mandated form, patients may simply write their wishes down in a letter or a plan • Should inform a Resuscitation Plan (Adult SMR020.056 and Paediatric SMR020.055) • Used to assess the effectiveness and timing of end of life management *GL2005_056: Using Advance Care Directives* *GL2005_057: End-of-Life Care and Decision-Making - Guidelines* *PD2014_030 Using Resuscitation Plans in End of Life Decisions* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.8)*
3. Resuscitation Plan	• A medically authorised order to use or withhold resuscitation measures and document other time-critical clinical decisions related to end of life (Adult SMR020.056 and Paediatric SMR020.055) • Patients must be 29 days and older • Used to assess the effectiveness and timing of end of life and resuscitation management *PD2014_030 Using Resuscitation Plans in End of Life Decisions* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.2, 9.8)*
Not for CPR Order	• Documented decisions to withhold CPR only. These decisions, in accordance with 2014 NSW Health policy, should be incorporated into a Resuscitation Plan (Adult SMR020.056 and Paediatric SMR020.055) • Used to assess the effectiveness and timing of end of life and resuscitation management *PD2014_030 Using Resuscitation Plans in End of Life Decisions* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.2, 9.8)*
4. Was the patient (with capacity) involved in the decision making process related to treatment plans and goals of care?	• Is there an indication that the patient was involved in decision-making regarding any change in treatment goal from active management to one of palliation, comfort and dignity? *GL2005_057: End-of-Life Care and Decision-Making Guidelines* *PD2014_030: Using Resuscitation Plans in End of Life Decisions* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.8)* Select N/A if the patient does not have capacity.

FIELD	GUIDE / POLICY / STANDARDS
End Of Life Management Plan Cont.	
If NO, was the substitute decision maker, family or carer involved in the decision making process related to treatment plans and goals of care?	• Is there an indication that the patient's family/carer was involved in decision making regarding any change in treatment goal from active management to one of palliation, comfort and dignity? *GL2005_057: End-of-Life Care and Decision-Making Guidelines* *PD2014_030: Using Resuscitation Plans in End of Life Decisions* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.8)*
5. Was the patient seen by the Specialist Palliative Care Team during this admission?	• Measures the inclusion of palliative care specialists in end of life care
End Of Life Care in Last 24-72 Hours	
1. Yellow Zone observations or additional criteria 2. Red Zone observations or additional criteria 3. Last recorded observations	• *Between the Flags* key performance indicators • Used to assess the effectiveness and timing of end of life and resuscitation management *PD2013_049: Recognition and Management of Patients who are Clinically Deteriorating* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.2)* Select N/A if a Clinical Review or Rapid Response is NOT required due to altered criteria or zone observations.
4. Any symptoms of patient discomfort or distress documented? If YES, were these symptoms managed by the treating team?	• Are there signs of patient distress or discomfort (including grimacing, pain behaviours, restlessness or agitation) recorded in the 48 hours prior to death and did the treating team manage them? *GL2005_057: End-of-Life Care and Decision-Making – Guidelines* *PD2014_030: Using Resuscitation Plans in End of Life Decisions*
5. Use of formal medication management plan/guide	• Measures tools used in end of life management Select N/A if there are no documented symptoms requiring medication management.
6. Use of standardised framework/guideline/plan If NO, the patient's symptoms and comfort were regularly assessed and appropriately managed/escalated?	• Measures tools used in end of life management Select N/A if there are no documented symptoms requiring management.
Screening Criteria	

Readmission within 28 days from previous hospitalisation	• HIE definition:
	 "Whether a patient was readmitted to the same or a different hospital within 28 days of completion of an inpatient stay".
	 This field is recorded in the Admission or stay table only
	 By definition, it does not included episodes of care in ED only
	 • Define reason due to:
	   o new or same problem
	   o avoidable or unavoidable
	 • Was there evidence of complications or failure to prevent, diagnose or treat the previous admitting diagnosis or directly related problems?
	 PD2014_004: Incident Management Policy

FIELD	GUIDE / POLICY / STANDARDS
Screening Criteria Cont.	

Unplanned transfer to ICU during admission	• Was the patient admitted to ICU:
	  o due to deterioration in condition appropriately
	  o after presentation to the emergency department (ED)
	  o after presentation from another hospital
	PD2014_004: Incident Management Policy

Under the care of a surgeon at the time of death	• Meets criteria for referral to CHASM if the patient was under a surgeon at the time of death even if NO operation was performed during the admission *Health Administration Act 1982, Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Committee, Terms of Reference.*
Operative procedure in the 30 days prior to death	• Meets criteria for referral to CHASM if the patient had an operative procedure performed by a surgeon within 30 days of death (except posthumous organ donation) *Health Administration Act 1982, Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Committee, Terms of Reference*
Unplanned return to theatre	• Includes any return visit to the operating room or delivery room for bleeding, infection, wound dehiscence or disruption, foreign body, or other complication caused by treatment *PD2014_004: Incident Management Policy*
Anaesthesia/sedation in the 24 hours prior to death	• Meets criteria for referral to SCIDUA if any medical practitioner administered an anaesthesia or sedation during a procedure, within 24 hours of death (except posthumous organ donation) *PD2014_036: Clinical Procedure Safety* *IB2015_019: Clinical Procedure Safety PD2014_036 - Revised Commencement Date* *Public Health Act 2010 No 127, s84*
Healthcare associated infection (note type)	• Patient records indicate that a healthcare associated infection may have been/was present • An infection is considered to be hospital acquired once the patient has been in hospital for forty eight hours or more *PD2007_036: Infection Control Policy* *PD2007_084: Infection Control Policy: Prevention & Management of Multi-Resistant Organisms (MRO)* *Standard 3: Preventing and Controlling Healthcare Associated Infections (3.2)*
Technical procedure	• An adverse event associated with a technical procedure including invasive line insertion, angiogram, bronchoscopy etc. *PD2014_004: Incident Management Policy*
Possible missed diagnosis	• Is there evidence of a possible missed diagnosis? For example, due to lack of follow up of tests *PD2014_004: Incident Management Policy*
Possible delay in diagnosis	• Is there evidence of a possible delay in diagnosis? *PD2014_004: Incident Management Policy*
Possible delay in treatment	• Is there evidence of a possible delay in the commencement or continuation of treatment? *PD2014_004: Incident Management Policy* *PD2014_032: Prevention of Venous Thromboembolism*
Possible clinical management error	• Is there evidence of a possible clinical management error? *PD2014_004: Incident Management Policy*

FIELD	GUIDE / POLICY / STANDARDS
Screening Criteria Cont.	
Transfer to higher level of care not activated	• Was there a need for transfer to higher level of care identified but process not activated/commenced? *PD2014_004: Incident Management Policy*
Retrieval problems	• Was there a delay or inability to retrieve or transfer patient? For example, transport problems, availability of personnel or unavailability of a bed at receiving facility *PD2014_004: Incident Management Policy* *PD2011_031: Inter-facility Transfer Process for Adults Requiring Specialist Care*
Fall	• Was there a fall during the admission? • Review IIMS record related to fall *PD2014_004: Incident Management Policy* *Standard 10: Preventing Falls and Harm from Falls (10.2)*
Venous thromboembolism (VTE)	• Is there evidence of venous thromboembolism (VTE) including both deep vein thrombosis (DVT) and/or pulmonary embolism (PE) *PD2014_004: Incident Management Policy* *PD2014_032: Prevention of Venous Thromboembolism* *Standard 4: Medication Safety (4.4, 4.5)*
Adverse drug event	• Is there evidence of an adverse drug event? For example, a medication error or a reaction to a drug, that caused deterioration in the patient's condition, or that caused injury • National Sentinel Event: Medication error leading to death *PD2014_004: Incident Management Policy* *PD2015_029: High-Risk Medicines Management Policy* *Standard 4: Medication Safety (4.4)*
Transfusion reaction	• Is there evidence of a reaction to blood or blood products? • National Sentinel Event: Haemolytic blood transfusion reaction *PD2014_004: Incident Management Policy* *PD2012_016: Blood - Management of Fresh Blood Components* *Standard 7: Blood and Blood Products (7.3, 7.6)*
Pregnancy, labour or within 365 days of pregnancy	• A maternal death includes pregnancy, labour or within 365 days of pregnancy. For example, ectopic pregnancy, following termination of pregnancy, any deaths with incidental pregnancy found • National Sentinel Event: Maternal death or serious morbidity associated with labour or delivery *PD2005_219: Reporting of Maternal Deaths to the NSW Department of Health* *PD2014_004: Incident Management Policy*
Perinatal	• Includes liveborn babies within 28 days of birth, regardless of gestational age at birth, and stillbirths at 20 weeks gestation or 400 grams birth weight *PD2011_076: Deaths - Review and Reporting of Perinatal Deaths*
IIMS completed	• Have any IIMS been completed during this admission? For example, fall, medication error *PD2014_004: Incident Management Policy* *Standard 1: Governance for Safety and Quality in Health Service Organisations (1.14)*
Under mental health care	• Did the patient receive care or treatment for a mental illness (check local policy for reporting timeframe) *PD2014_004: Incident Management Policy* *PD2010_054: Coroner's Cases and the Coroners Act 2009*

FIELD	GUIDE / POLICY / STANDARDS
Screening Criteria Cont.	
Suspected suicide	• Did the patient possibly suicide? • Did the patient receive care or treatment for a mental illness within 7 days prior to death? • National Sentinel Event: Suicide of an inpatient *PD2005_121: Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour* *PD2014_004: Incident Management Policy* *PD2010_054: Coroner's Cases and the Coroners Act 2009*
Other	• Are there other issues that require further review? • Do not use to repeat criteria enter above *PD2014_004: Incident Management Policy*
Outcomes Of Screening	
1. Death may have resulted from medical intervention	• Cases where death may have resulted from medical intervention • Cases where death is unrelated to the natural course of the illness and differing from the immediate expected outcome of patient management.

2. Death is unrelated to the natural course of the illness and differing from the immediate expected outcome of patient management
(If yes to 1 or 2 the case must be entered into IIMS and be referred to the appropriate department M&M meeting)
	• The death usually does not fulfil clinical or documentary evidence that the death was expected. In fact there may be documentation to suggest the unexpected nature of the event. Special attention should be paid to the following:
	  o A diagnosis that does not indicate a terminal nature to the disease
	  o Look for any signs that the patient's condition was deteriorating, e.g., biochemical parameters, physical signs etc., whether a medical officer was notified and attended in a timely fashion and what treatment, if any, was initiated.

3. Unexpected death not reasonably preventable with clinical intervention	• There is no medical intervention known that could prevent this death. This is the category where overwhelming traumas or injuries would be included.
4. Unexpected death despite known preventive measures taken in an adequate and timely fashion	• All aspects of the case reflect responsive and appropriate care but the death has occurred despite these interventions. This category includes unexpected deaths where care provided has been in accordance with a clinical pathway, for example sepsis, stroke etc.
5. Death following cardiac or respiratory arrest which occurred before patient's arrival at hospital	• Include patients who are "Dead on Arrival" • Patients receiving active resuscitation on arrival to hospital should be evaluated as an expected or unexpected death – do not use this category
6. Anticipated death due to disease progression	• Documentation in the notes is present to support this.
Open Disclosure	• Where a patient safety incident has occurred, there is a record of the patient and/or their support person(s) engaging in open disclosure discussions including an apology, a factual explanation of what happened, an opportunity to relate their experience, potential consequences and the steps being taken to manage the event and prevent recurrence *PD2014_028: Open Disclosure* *Standard 1: Governance for Safety and Quality in Health Service Organisations (1.16)*

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Referral Following Screening	
DMS/Facility Executive	• Nominated facility executives, which may include the Director of Medical Services, are responsible and integral in many of the key steps of incident management *PD2014_004: Incident Management Policy*
Clinical Review/Morbidity & Mortality Groups	• Refer to appropriate M&M group
Coroner referral arising from death screen	• Criteria for referral to the Coroner are contained in the Coronial Checklist *IB2010_058: Coronial Checklist* *PD2010_054: Coroners cases and the Coroners Act*
Collaborating Hospitals' Audit of Surgical Mortality (CHASM)	• Patient was under a surgeon at the time of death even if NO operation was performed during the admission • Patient had an operative procedure performed by a surgeon within 30 days of death (except posthumous organ donation) *Health Administration Act 1982, Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Committee, Terms of Reference.* *Referral/notification can be made by the surgeon(s) and/or the Director of Clinical Governance* ****The Surgical Case form is submitted by the surgeon(s)****
NSW Special Committee Investigating Death under Anaesthesia (SCIDUA)	• A medical practitioner administered an anaesthesia or sedation during a procedure, within 24 hours of death (except posthumous organ donation) *PD2014_036: Clinical Procedure Safety* *IB2015_019: Clinical Procedure Safety PD2014_036 - Revised Commencement Date* *Referral/notification can be made by the anaesthetist(s) and/or the Director of Clinical Governance.* ****The state form report (SMR010.511) is submitted by the administering health practitioner(s)****
NSW Maternal & Perinatal Committee	• Pregnancy, labour or within 365 days of pregnancy • Perinatal death *PD2005_219: Reporting of Maternal Deaths to the NSW Department of Health* *PD2011_076: Deaths - Review and Reporting of Perinatal Deaths* *PD2015_025: NSW Perinatal Data Collection (PDC) Reporting and Submission Requirements from 1 January 2016*
IIMS notification arising from death screen	• Document the IIMS notification number and date of any IIMS lodged as a result of the death screening process
Reportable Incident Brief (RIB)	• IIMS notification scored as SAC 1 • Clinical and corporate criteria as described in policy *PD2014_004: Incident Management Policy*
Root Case Analysis (RCA) Investigation	• IIMS notification scored as SAC 1 *PD2014_004: Incident Management Policy*
NSW Health Mental Health/Drug and Alcohol Office	• If an incident involves the death of a mental health patient complete a Client Death Report form *PD2014_004: Incident Management Policy*
Clinical Governance/Patient Safety for further investigation	• In accordance with internal facility policy
Other	• Includes referral to clinical stream managers • Record the reason and mechanism for Other Review
Death screen completed within 45 days of patient's death?	• Performance measure of death review.