Facility: Clinical Excellence Commission

ADMITTED PATIENT DEATH SCREENING TOOL
Version 4.0

Date of Death: ___ / ___ / ______ Time of Death: ___ : ___ Age at Death: ___ years

Aboriginality: □ Aboriginal, not Torres Strait Islander □ Aboriginal and Torres Strait Islander
□ Torres Strait Islander, not Aboriginal □ Neither Aboriginal nor Torres Strait Islander
□ Not stated □ Declined to respond

Admission Details

Date of Admission: ___ / ___ / ______ Admission Status: □ Emergency □ Elective

Admitted From: □ Home □ Nursing Home □ Hostel
□ Other Hospital ____________ □ Other ____________

Admitting Specialty: __________________________ Discharge Specialty: __________________

Admitting Reason: ________________________________

Cause of Death

Coroner’s case: □ Death determined as unascertainable by Coroner: □

Copy of Coroner’s report attached: □ Coroner’s report date: ___ / ___ / ______

Cause of Death (as recorded on the Medical Certificate of Cause of Death)

a) __________________________ Duration: __________________________
b) __________________________ Duration: __________________________
c) __________________________ Duration: __________________________
d) __________________________ Duration: __________________________

Other Significant Conditions

______________________________ Duration: __________________________
______________________________ Duration: __________________________
______________________________ Duration: __________________________
______________________________ Duration: __________________________

End of Life Management Plan

1. Was there an advance care directive available prior to patient’s death?
   1a. Date of directive
   □ No □ Yes
   Date: ___ / ___ / ______ Time: ___ :

2. Was there an advance care plan available prior to patient’s death?
   2a. Date and time of plan
   □ No □ Yes
   Date: ___ / ___ / ______ Time: ___ : ___
End of Life Management Plan Cont:

3. Was there a resuscitation plan and/or Not for CPR order documented prior to patient’s death?
   3a. Date and time of plan/order
   If YES, □ Resuscitation plan
   □ Not for CPR order
   □ No  □ Yes
   Date: ___ / ___ / ______ Time: ___ : ___

4. Was the patient (with capacity) involved in the decision making process related to treatment plans and goals of care (including but not limited to discussion regarding CPR)?
   4a. If NO, was the substitute decision maker, family or carer involved in the decision making process related to treatment plans and goals of care?
   □ No  □ Yes  □ N/A
   □ No  □ Yes  □ N/A

5. Was the patient seen by the Specialist Palliative Care Team during this admission?
   □ No  □ Yes

End of Life Care In Last 24-48 Hours

1. Did the patient have any YELLOW Zone observations or additional criteria in the 24 hours prior to death?
   1a. If YES, when was a Clinical Review or other CERS call documented?
   □ No  □ Yes  □ N/A
   Date: ___ / ___ / ______ Time: ___ : ___

2. Did the patient have any RED Zone observations or additional criteria in the 24 hours prior to death?
   2a. If YES, when was a Rapid Response call documented?
   □ No  □ Yes  □ N/A
   Date: ___ / ___ / ______ Time: ___ : ___

3. Date and time of last recorded observations taken prior to death
   Date: ___ / ___ / ______ Time: ___ : ___

4. Were any symptoms of patient discomfort or distress documented in the medical record in the 48 hours before death?
   4a. If YES, were these symptoms managed by the treating team?
   □ No  □ Yes
   □ No  □ Yes

5. Was a formal medication management plan/guide used to manage the patient’s pain/symptoms in the last 24-72 hours?
   □ No  □ Yes  □ N/A

6. Was a standardised framework/guideline/plan used to guide care in the last days of life?
   6a. Date and time of framework/guideline/plan
   □ No  □ Yes
   Date: ___ / ___ / ______ Time: ___ : ___
   □ No  □ Yes  □ N/A
   6b. If NO, was there documentary evidence that the patient’s symptoms and comfort were regularly assessed and appropriately managed/escalated?
   □ No  □ Yes  □ N/A
### Screening Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Tick if Yes</th>
<th>Rationale/Comments/Description</th>
</tr>
</thead>
</table>
| Readmission within 28 days from previous hospitalisation                 |             | If YES,  
|                                                                         |             |   - A new problem  
|                                                                         |             |   - Same problem (avoidable)  
|                                                                         |             |   - Same problem (unavoidable)                                                     |
| Unplanned transfer to ICU during admission                                |             | Last Date of Surgical Care = Date of Death  
|                                                                         |             | Surgeon: _______________________________  
|                                                                         |             | Specialty: _______________________________  
|                                                                         |             | Surgeon: _______________________________  
|                                                                         |             | Specialty: _______________________________  |
| Under the care of a surgeon at the time of death                          |             | Last Date of Surgical Care __ / __ / ______  
|                                                                         |             | Surgeon: _______________________________  
|                                                                         |             | Specialty: _______________________________  
|                                                                         |             | Was a procedure performed? YES  
|                                                                         |             | Date of Procedure: __ / __ / ______  
|                                                                         |             | Facility: _______________________________  
|                                                                         |             | If facility is not where death occurred:  
|                                                                         |             | MRN/AUID: _______________________________  
|                                                                         |             | If the operation is in a different admission to death:  
|                                                                         |             | Date of Admission: __ / __ / ______  
|                                                                         |             | Date of Discharge: __ / __ / ______  
|                                                                         |             | Procedure: _______________________________  
|                                                                         |             | Surgeon: _______________________________  
|                                                                         |             | Specialty: _______________________________  
|                                                                         |             | Was a procedure performed? YES  
|                                                                         |             | Date of Procedure: __ / __ / ______  
|                                                                         |             | Facility: _______________________________  
|                                                                         |             | If facility is not where death occurred:  
|                                                                         |             | MRN/AUID: _______________________________  
|                                                                         |             | If the operation is in a different admission to death:  
|                                                                         |             | Date of Admission: __ / __ / ______  
|                                                                         |             | Date of Discharge: __ / __ / ______  
|                                                                         |             | Procedure: _______________________________  |

Repeat collection of dataset to record ALL principal operative procedures performed in the 30 days prior to death.
## Screening Criteria Cont:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Tick if Yes</th>
<th>Rationale/Comments/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned return to theatre</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
| Anaesthesia/sedation in the 24 hours prior to death                      | ☐           | Date: __/__/____  
Start Time: ___ : ___  
Finish Time: ___ : ___  
Name: __________________________  
Facility: _______________________  
If facility is not where death occurred:  
MRN/AUID: _______________________
If the operation is in a different admission to death:  
Date of Admission: ___ / ___ / ______  
Date of Discharge: ___ / ___ / ______  
Procedure: ______________________ |
| Healthcare associated infection *(note type)*                            | ☐           |                                                                                               |
| Technical procedure                                                      | ☐           |                                                                                               |
| Possible missed diagnosis                                                | ☐           |                                                                                               |
| Possible delay in diagnosis                                              | ☐           |                                                                                               |
| Possible delay in treatment                                              | ☐           |                                                                                               |
| Possible clinical management error                                       | ☐           |                                                                                               |
| Transfer to higher level of care not activated                           | ☐           |                                                                                               |
| Retrieval problems                                                       | ☐           |                                                                                               |
| Fall                                                                    | ☐           |                                                                                               |
| Venous thromboembolism (VTE)                                             | ☐           |                                                                                               |
| Adverse drug event                                                       | ☐           |                                                                                               |
| Transfusion reaction                                                     | ☐           |                                                                                               |
| Pregnancy, labour or within 365 days of pregnancy                       | ☐           |                                                                                               |
| Perinatal                                                               | ☐           |                                                                                               |
| IIMS completed                                                          | ☐           |                                                                                               |
| Under mental health care                                                 | ☐           |                                                                                               |
| Suspected suicide                                                       | ☐           |                                                                                               |
| Other                                                                  | ☐           |                                                                                               |
**Facility:**

Clinical Excellence Commission

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### Outcome of Screening

Adapted from Wilson R et al, Quality in Aust Health Care Study, Med J Aust 1995

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Tick if YES (one only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Death may have resulted from medical intervention</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Death is unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(If yes to 1 or 2, the case must be entered into IIMS and be referred to the appropriate department M&amp;M meeting)</em></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Unexpected death not reasonably preventable with clinical intervention</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Unexpected death despite known preventive measures taken in an adequate and timely fashion</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Death following cardiac or respiratory arrest which occurred before patient’s arrival at hospital</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Anticipated death due to disease progression</td>
<td></td>
</tr>
</tbody>
</table>

Open disclosure occurred?  

[ ] Yes  [ ] No  [ ] N/A

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### Referral Following Screening

<table>
<thead>
<tr>
<th>Referral Destination</th>
<th>Tick if YES</th>
<th>Comments/Explanation</th>
<th>Referral Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMS/Facility Executive</td>
<td>[ ]</td>
<td></td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Clinician Review/Morbidity &amp; Mortality Group</td>
<td>[ ]</td>
<td></td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Coroner referral arising from death screen</td>
<td>[ ]</td>
<td></td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Collaborating Hospitals' Audit of Surgical Mortality in NSW (CHASM)</td>
<td>[ ]</td>
<td></td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)</td>
<td>[ ]</td>
<td></td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>NSW Maternal &amp; Perinatal Committee</td>
<td>[ ]</td>
<td></td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
</tbody>
</table>
## Referral Following Screening Cont:

<table>
<thead>
<tr>
<th>Category</th>
<th>Marked</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIMS notification arising from death screen</td>
<td>☐</td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Reportable Incident Brief (RIB)</td>
<td>☐</td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Root Cause Analysis (RCA) Investigation</td>
<td>☐</td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>NSW Health Mental Health/Drug and Alcohol Office</td>
<td>☐</td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Clinical Governance/Patient Safety for further investigation</td>
<td>☐</td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Other (describe)</td>
<td>☐</td>
<td><em><strong>/</strong></em>/_____</td>
</tr>
</tbody>
</table>

## Comments/Case Summary

**Death screen completed within 45 days of patient’s death?**

- ☐ Yes
- ☐ No

**Completed by:**

- [ ]

**Position:**

- [ ]

**Date Screen Completed:**

- ___/___/_____