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Facility:

Clinical Excellence Commission

# ADMITTED PATIENT DEATH SCREENING TOOL

Version 4.0

| | |
|---|---|
| FAMILY NAME | MRN |
| GIVEN NAME | ☐ MALE ☐ FEMALE |
| D.O.B. ____/____/____ | M.O. |
| ADDRESS | |
| | |
| LOCATION / WARD | |
| COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE | |

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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: _____

DO NOT INSERT THIS DOCUMENT INTO THE MEDICAL RECORD

## End of Life Management Plan

| | |
|---|---|
| 1. Was there an advance care directive available prior to patient's death? | ☐ No ☐ Yes |
| 1a. Date of directive | Date: ___ / ___ / _____ Time: ___ : ___ |
| 2. Was there an advance care plan available prior to patient's death? | ☐ No ☐ Yes |
| 2a. Date and time of plan | Date: ___ / ___ / _____ Time: ___ : ___ |

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## End of Life Management Plan Cont:

| | |
|---|---|
| 3. Was there a resuscitation plan and/or Not for CPR order documented prior to patient's death?<br>3a. Date and time of plan/order<br>If **YES**, ☐ Resuscitation plan<br>☐ Not for CPR order | ☐ No ☐ Yes<br><br>Date: ___ / ___ / _____ Time: ___ : ___<br>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)?<br>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<br><br>☐ 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?<br>1a. If **YES**, when was a Clinical Review or other CERS call documented? | ☐ No ☐ Yes ☐ N/A<br><br>Date: ___ / ___ / _____ Time: ___ : ___ |
| 2. Did the patient have any RED Zone observations or additional criteria in the 24 hours prior to death?<br>2a. If **YES**, when was a Rapid Response call documented? | ☐ No ☐ Yes ☐ N/A<br><br>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?<br>4a. If **YES**, were these symptoms managed by the treating team? | ☐ No ☐ Yes<br><br>☐ 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?<br>6a. Date and time of framework/guideline/plan<br>6b. If **NO**, was there documentary evidence that the patient's symptoms and comfort were regularly assessed and appropriately managed/escalated? | ☐ No ☐ Yes<br><br>Date: ___ / ___ / _____ Time: ___ : ___<br>☐ No ☐ Yes ☐ N/A |

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## Screening Criteria

| Criteria | Tick if Yes | Rationale/Comments/Description |
|---|---|---|
| Readmission within 28 days from previous hospitalisation<br>If **YES**, ☐ A new problem<br>☐ Same problem (avoidable)<br>☐ Same problem (unavoidable) | ☐ | |
| Unplanned transfer to ICU during admission | ☐ | |
| Under the care of a surgeon at the time of death | ☐ | Last Date of Surgical Care = Date of Death<br>Surgeon: _____<br>Specialty: _____<br>Surgeon: _____<br>Specialty: _____ |
| Operative procedure in the 30 days prior to death<br><br>*Repeat collection of dataset to record ALL principal operative procedures performed in the 30 days prior to death.* | ☐ | Last Date of Surgical Care __ / __ / _____<br>Surgeon: _____<br>Specialty: _____<br>Was a procedure performed? YES<br>Date of Procedure: ___ / ___ / _____<br>Facility: _____<br>*If facility is not where death occurred:*<br>MRN/AUID: _____<br>*If the operation is in a different admission to death:*<br>Date of Admission: ___ / ___ / _____<br>Date of Discharge: ___ / ___ / _____<br>Procedure: _____<br>Surgeon: _____<br>Specialty: _____<br>Was a procedure performed? YES<br>Date of Procedure: ___ / ___ / _____<br>Facility: _____<br>*If facility is not where death occurred:*<br>MRN/AUID: _____<br>*If the operation is in a different admission to death:*<br>Date of Admission: ___ / ___ / _____<br>Date of Discharge: ___ / ___ / _____<br>Procedure: _____ |

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## Screening Criteria Cont:

| Criteria | Tick if Yes | Rationale/Comments/Description |
|---|---|---|
| Unplanned return to theatre | ☐ | |
| Anaesthesia/sedation in the 24 hours prior to death | ☐ | Date: ___ / ___ / _____<br>Start Time: ___ : ___ Finish Time: ___ : ___<br>Name: _____<br>Facility: _____<br>*If facility is not where death occurred:*<br>MRN/AUID: _____<br>*If the operation is in a different admission to death:*<br>Date of Admission: ___ / ___ / _____<br>Date of Discharge: ___ / ___ / _____<br>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 | ☐ | |

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## Outcome of Screening

| *Adapted from Wilson R et al, Quality in Aust Health Care Study, Med L Aust 1995* | **Tick if YES (one only)** |
|---|---|
| 1. Death may have resulted from medical intervention | ☐ |
| 2. Death is unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management<br>*(If yes to 1 or 2, the case must be entered into IIMS and be referred to the appropriate department M&M meeting)* | ☐ |
| 3. Unexpected death not reasonably preventable with clinical intervention | ☐ |
| 4. Unexpected death despite known preventive measures taken in an adequate and timely fashion | ☐ |
| 5. Death following cardiac or respiratory arrest which occurred before patient's arrival at hospital | ☐ |
| 6. Anticipated death due to disease progression | ☐ |
| Open disclosure occurred? | ☐ Yes ☐ No ☐ N/A |

## Referral Following Screening

| **Referral Destination** | **Tick if YES** | **Comments/Explanation** | **Referral Date** |
|---|---|---|---|
| DMS/Facility Executive | ☐ | | ___ / ___ / _____ |
| Clinician Review/Morbidity & Mortality Group | ☐ | | ___ / ___ / _____ |
| Coroner referral arising from death screen | ☐ | | ___ / ___ / _____ |
| Collaborating Hospitals' Audit of Surgical Mortality in NSW (CHASM) | ☐ | | ___ / ___ / _____ |
| NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) | ☐ | | ___ / ___ / _____ |
| NSW Maternal & Perinatal Committee | ☐ | | ___ / ___ / _____ |

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## Referral Following Screening Cont:

| | | | |
|---|---|---|---|
| IIMS notification arising from death screen | ☐ | | ___ / ___ / _____ |
| Reportable Incident Brief (RIB) | ☐ | | ___ / ___ / _____ |
| Root Cause Analysis (RCA) Investigation | ☐ | | ___ / ___ / _____ |
| NSW Health Mental Health/Drug and Alcohol Office | ☐ | | ___ / ___ / _____ |
| Clinical Governance/Patient Safety for further investigation | ☐ | | ___ / ___ / _____ |
| Other (describe) | ☐ | | ___ / ___ / _____ |

## Comments/Case Summary

| | | |
|---|---|---|
| Death screen completed within 45 days of patient's death? | | ☐ Yes ☐ No |
| Completed by: | Position: | Date Screen Completed: ___ / ___ / _____ |