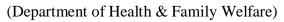


Government of Karnataka SUVARNA AROGYA SURAKSHA TRUST





Death Summary (A brief note)

Hospital Name	:	
Patient ID	:	
Scheme	: ARK/AB-ARK/JSS	
Patient Characteristics	:	
Name	: Age: Sex:	
Source of Admission	: Emergency or Elective	
Length of Admission in days	: Date of Admission: / / Date of	f Death: / /
Clinical Diagnosis (es) on	:	
Admission		
Clinical diagnosis(es) on Dea	th :	
Progress of the patient durin hospitalisation	ıg :	
Abnormal Investigations	:	
Haematology		
Biochemistry		
Radiology		
Microbiology		
Others		
What was the treatment prov	vided?	

Were there any clinical errors, omissions, process problems that hindered the process of giving good quality care?				
Were there identifiable clinical risks/incidents?				
Were there any of the clinical risks/incidents due to:				
Delay in diagnosis :				
Delay in treatment :				
Medical clinical errors :				
Nursing clinical errors :				
Medication errors :				
Process errors :				
Please give further details below:				
Were all standard protocols followed?				
What according to the treating doctor is the cause of death and contributing factors?				
Any other remarks :				

^{*} This form to be filled and sent at the time of beneficiaries death (within 48 hrs) intimation to Arogya Karnataka

MORTALITY AUDIT REPORT

Mortality Audit Committee

The committee comprises of individuals from the hospital that represent the key departments – including management, treating doctors and support departments.

Aims and guidelines for conducting mortality audits

Effectively run clinical audit and peer review processes, incorporating analysis of mortality and morbidity (M&M), contribute to improved patient safety. These guidelines aim to provide practical advice to hospitals on establishing and running M&M/clinical review meetings.

The aim is to ascertain the proportion of patients who died because of 'problems in care', defined as patient harm resulting from healthcare processes including acts of omission (inactions), such as failure to diagnose and treat, or from acts of commission (affirmative actions) such as incorrect treatment or management. The focus should be on the systems and processes of care and not on individual performance.

Recommendations arising from individual cases should focus on measures that can prevent similar outcomes or adverse incidents, or that will improve the processes of care provided to hospital patients. These recommendations should not blame individuals but aim at improving the systems.

Areas to be identified for each case

An area of CONCERN is where the clinician believes that areas of care SHOULD have been better.

An ADVERSE EVENT is an unintended injury caused by medical management rather than by disease process, which is sufficiently serious to lead to prolonged hospitalization or to temporary or permanent impairment or disability of the patient at the time of discharge, or which contributes to or causes death

DEATH AUDIT REPORT

Section A: General Information:

Patient details					
Name					
Age		Sex		Pre-auth No.	
DOA		Date of Surgery		DOD	
Diagnosis					
Treatment given	Surgery / Pr	rocedure / Radioth	nerapy / Chemo	otherapy / Oth	ers (specify)
hospital name					
Name of Treating Doctor					
Section B: Case summary: Please provide a summary of the Case in the form of narrative – including complaints at the time of admission, chronology of events up to death of the patient					

Section C: Case Assessment

Were there any areas of CONCERN or ADVERSE EVENTS in	n Yes	No			
the management of this patient?					
a. A. Was surgery performed?	Yes	No			
b. Were there any Areas of Concern, or Adverse Events in a		wing areas			
if an operation/procedure was performed or treatment		1 27/1			
Discussion points	Yes/No	N/A			
Pre anestheticcheckup/fitness for surgery/treatment					
Choice of operation					
Timing of operation (too late, too soon, wrong time of day)					
Intra-operative process					
Problems in functioning of OT					
Grade/experience of surgeon deciding					
Grade/experience of surgeon operating					
Post-operative period					
c. Was this patient treated in a critical care unit (ICU or HDU) during this admission?	Yes	No			
d. If no, should this patient have been provided critical care	e Yes	No			
in ICU/HDU?					
Opinion of the Audit committee regarding overall risk of death	1				
Minimal					
If there any areas of CONCERN or ADVERSE EVENTS in the patient:					
1. Describe the significant event/s during the course of treatme	nt in the hospit	tal:			
Note any areas of:					
Concern					
Adverse Event					
Note if these areas caused any of the following:					
Made no difference to outcome					
May have contributed to death					
Caused death of patient who would otherwise be expected to survive					

Was th	Was the death preventable?					
				- a · -	<u> </u>	
	ely Pro	babl	Probablyt	Defini v not	l_h't	
know						
Section D. Investigations done and their reports						
Sl. No.	Inves	tigation	Report	Rem	Remarks	
1						
2						
	Section D: Record of cause of death hospital mortality audit committee review findings:					
Primar	y cause of death					
ICD co	ode					
Second	lary cause of					
death						
ICD Co	ode					
	dent cause of					
death	A.					
ICD co		<u> </u> MENDATI(ONS (if any) OF THE	MORTALITY AUD	DIT	
			COMMITTEE			
1						
2						
3						
Attestation by the Mortality Audit Committee members:						
	N	lame	Designat	ion Signa	ature	
1						
2						
3						
Date:	- 1		,	l		
