

The following screen captures from BWH Mortality Review were aquired 3/21/2012

Section One

BRIGHAM AND WOMEN'S HOSPITAL

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Patient Demographics

MRN	21917240	Patient Name	Test, Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team

Section 1: Infections

To the best of your knowledge, were there any of the following healthcare associated infections present?

If yes, please complete the following table. No Yes

Infection (check all that apply)	Acquired Before Admission (Regardless of When Diagnosed)	Acquired This Hospitalization	Contributed to or Caused Death?
Central Venous Catheter Associated Blood Stream Infection	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Surgical Site Infection (SSI)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Ventilator Associated Pneumonia (VAP)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Systemic Fungal Infection or Fungal Pneumonia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
C-Difficile	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Catheter Associated Urinary Tract Infection	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Sepsis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
MRSA Infection (not colonization)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
VRE Bacteremia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Extended Spectrum Beta – Lactamase (ESBL) Producing Bacteria	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Other healthcare acquired infection	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
List uired Infection	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown

Please provide any relevant details (optional) Other relevant details that are optional

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Section Two

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Patient Demographics

MRN	21917240	Patient Name	Test, Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team.

Section 2: Selected Complications

To the best of your knowledge, were any of the following complications present?

If Yes, please complete the following table. No Yes

Complications (check all that apply)	Acquired Before Hospitalization (regardless of when diagnosed)	Occurred this Hospitalization	Contributed to or Caused Death?
Adverse Drug Event Select Drug Class: <input type="text" value="Anticoagulant"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Venous Thromboembolism (VTE) (e.g., DVT, PE)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Fall resulting in injury (e.g., fracture)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Technical surgical complication (e.g., wound healing problem, bleeding, infection, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Technical surgical complication (e.g., blood transfusion reaction, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Anesthesia-related complication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Interventional Radiology (IR) procedure related complication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Non-surgical procedure related complication (e.g., cardiac catheterization, bronchoscopy, EGD)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Bedside procedure related complication (e.g., lumbar puncture, central line placement)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Equipment or Device Malfunction	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Equipment or Device Misuse (Human Error)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Pressure Ulcers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Other complications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown

Please provide any relevant details (optional) Other Optional Relevant Details

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Section Two

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Patient Demographics

MRN	21917240	Patient Name	Test, Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team

Section 2: Selected Complications

To the best of your knowledge, were any of the following complications present? No Yes

If Yes, please complete the following table.

Complications (check all that apply)	Acquired Before Hospitalization (regardless of when diagnosed)	Occurred this Hospitalization	Contributed to or Caused Death?
Adverse Drug Event Select Drug Class: <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Venous Thromboembolism (VTE)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Fall resulting in injury (e.g., change in LOC, intracerebral bleed, fracture)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Technical surgical complication List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Technical surgical complication that required reoperation and/or blood transfusion List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Anesthesia-related complication List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Interventional Radiology (IR) procedure related complication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Non-surgical procedure related complication (e.g., cardiac catheterization, bronchoscopy, EGD) List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Bedside procedure related complication (e.g., lumbar puncture, central line placement) List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Equipment or Device Malfunction List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Equipment or Device Misuse (Human Error)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Pressure Ulcers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Other complications List <input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Please provide any relevant details (optional)	Other Optional Relevant Details		

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Section Three

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Patient Demographics

MRN	21917240	Patient Name	Test, Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team.

Section 3: Timeliness of Interventions

To the best of your knowledge, could any of the following interventions have been more timely?

If Yes, please complete the following table. No Yes


Interventions or Responses (check all that apply)	Occurred this Hospitalization	Contributed to or Caused Death?
Surgical procedure/operating room (e.g., major surgery)	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
All other procedures (e.g., IR, cardiac cath, central catheter placement) List the procedure: Procedure	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Medication administration	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Obtaining imaging (e.g., radiology exam/CT/MRI) List the exam: Exam	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Obtaining blood work and/or results	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
ICU bed transfer	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Availability or response time of consult service	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Clinical response (e.g., to a change in patient status or exam results)	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Please provide any relevant details (optional)	Optional Relevant Details	

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Section Four



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Patient Demographics

MRN	21917240	Patient Name	Test, Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team.

Section 4: Teamwork and Communication

To the best of your knowledge, would improved communication have resulted in better care for this patient?

If Yes, please complete the table in this section. No Yes

Types of Communication (check all that apply)	Yes	Contributed to or Caused Death?
Communication between the:		
ED to Floor or ICU	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
ICU to Floor	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Floor to ICU	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Primary team and consult service	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
House officer to house officer	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Procedure area to ICU or Floor	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Primary nurse and covering team	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Outside hospital to BWH during transfer process	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Other communication issue <input style="width: 80%;" type="text" value="Communication issue"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Supervision		
Do you feel that greater supervision might have improved the care for this patient? Please note that your responses will not be shared with your supervisor or trainee.	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
Please provide any relevant details (optional) <input style="width: 90%;" type="text" value="Other Optional Relevant Details"/>		

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Section Five

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Patient Demographics

MRN	21917240	Patient Name	Test, Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team.

Section 5: End-Of-Life Related Information

1. Just prior to admission, was the patient enrolled in an outpatient hospice program? No Yes

2. DNR/DNI status – at what point did the patient become DNR/DNI? Never, patient remained a full code Before Admission During stay


3. Was this patient placed on comfort measures only (and if so when)? No Before Admission During stay

4. Was the patient in restraints 24 hours before death? (i.e., posey vests or any limb restraints) No Yes Do Not Know

5. Had this patient ever received an organ transplant? No Yes Do Not Know

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Section Six



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Patient Demographics

MRN	21917240	Patient Name	Test,Ck-in	Age	55
Sex	F	Race			
Admit Date	11/17/2011 11:23 AM, Thu	Discharge Date	11/17/2011 11:23 AM, Thu		
Admitting Service		Discharge Service			
Admit Pod		Discharge Pod	NBA	No	
Admit Source		Admit Type			

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Reminder: You are not required to conduct a chart review to complete the following questions. Please answer them to the best of your knowledge. Your responses may be shared with qualified quality and safety staff, but not with any other members of your care team

Section 6: Summary

1. Please provide a brief clinical summary and the circumstances surrounding this patient's death: (If possible, please limit your response to 5-6 sentences).

Brief clinical Summary

Based on your review:

2. Please rate the preventability (1 being least preventable, 5 being most preventable) of the patient's death with respect to the care the patient received at BWH:

1 - Not preventable death, due to terminal illness or condition upon arrival to this hospital
 2 - Not preventable death, and occurred despite the health team taking preventative measures
 3 - Not preventable death, but medical error or system issue was present
 4 - Possibly preventable death resulting from medical error or system issue
 5 - Likely preventable death resulting from medical error or system issue

3. Please provide any other suggestions for quality improvement you may have or thoughts on how this form can be improved.

Suggestions for Quality Improvement

4. Would you like someone from the Center for Professionalism and Peer Support to contact you?
We recognize that an adverse event can be extremely stressful for everyone involved. BWH has a Center for Professionalism and Peer Support that can provide a broad range of guidance. Peer support is private and confidential. [More information about the Center.](#)

No Yes

5. Is there anything that you would like specific follow up on or that you would prefer to discuss instead of reporting here? *Someone from BWH Quality and Safety will be in touch with you.*

No Yes How would you prefer to be contacted?
 E-mail Pager Telephone

6. **To be answered by MICU attendings:**

1. Was patient death expected?

2. Were there any issues or sentinel events requiring further discussion? If so, please describe.

MICU Attending comments

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Summary

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Admitting Service		Discharge Service					
Admit Pod		Discharge Pod	NBA	No			
Admit Source		Admit Type					

The following is a general summary of your responses. To change any of your selections please use the button below marked "Back" to find the appropriate page. Once you have amended your review, return to this summary screen by clicking the "Save and Review" buttons located on each page. When you are finished reviewing your responses, please click "Submit Review".

Section 1: Infections

To the best of your knowledge, were there any of the following healthcare associated infections present?

Infection	Acquired Before Admission (Regardless of When Diagnosed)	Acquired This Hospitalization	Contributed to or Caused Death?	Yes
Central Venous Catheter Associated Blood Stream Infection		X	Unknown	
Surgical Site Infection (SSI)		X	Unknown	
Ventilator Associated Pneumonia (VAP)		X	Unknown	
Systemic Fungal Infection or Fungal Pneumonia		X	Unknown	
C-Difficile		X	Unknown	
Catheter Associated Urinary Tract Infection		X	Unknown	
Sepsis		X	Unknown	
MRSA Infection (not colonization)		X	Unknown	
VRE Bacteremia		X	Unknown	
Extended Spectrum Beta - Lactamase (ESBL) Producing Bacteria		X	Unknown	
Other healthcare acquired infection		X	Unknown	
List Other Healthcare Acquired Infection		X	Unknown	
Please provide any relevant details (optional)	Other relevant details that are optional			

Section 2: Selected Complications

To the best of your knowledge, were there any of the following complications present?

Complications	Acquired Before Admission (Regardless of When Diagnosed)	Acquired This Hospitalization	Contributed to or Caused Death?	Yes
Adverse Drug Event		X	Unknown	
Name of Medication:		X	Unknown	
Venous Thromboembolism (VTE)		X	Unknown	
Fall resulting in injury (e.g., change in LOC, intracerebral bleed, fracture)		X	Unknown	
Technical surgical complication		X	Unknown	
List LIST		X	Unknown	
Technical surgical complication that required reoperation and/or blood transfusion		X	Unknown	
List LIST		X	Unknown	
Anesthesia-related complication		X	Unknown	
List LIST		X	Unknown	
Interventional Radiology (IR) procedure related complication		X	Unknown	
Non-surgical procedure related complication (e.g., cardiac catheterization, bronchoscopy, EGD)		X	Unknown	
List LIST		X	Unknown	
Bedside procedure related complication (e.g., lumbar puncture, central line placement)		X	Unknown	
List LIST		X	Unknown	
Bedside procedure related complication (e.g., lumbar puncture, central line placement)		X	Unknown	
List LIST		X	Unknown	
Equipment or Device Misuse (Human Error)		X	Unknown	
Pressure Ulcers		X	Unknown	
Other complications		X	Unknown	
List LIST		X	Unknown	
Please provide any relevant details (optional)	Optional Relevant Details			

Section 3: Timeliness of Interventions

To the best of your knowledge, were there any of the following interventions have been more timely?

		No
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Section 4: Teamwork and Communication

To the best of your knowledge, would improved communication have resulted in better care for this patient?

Types of Communication	Occurred this Hospitalization	Contributed to or Caused Death?	Yes
Communication between the:			
ED to Floor or ICU	X	Unknown	
ICU to Floor	X	Unknown	
Floor to ICU	X	Unknown	
Primary team and consult service	X	Unknown	
House officer to house officer Communication	X	Unknown	
Procedure area to ICU or Floor	X	Unknown	
Primary nurse and covering team	X	Unknown	
Outside hospital to BWH during transfer process	X	Unknown	
Other communication issue Communication issue	X	Unknown	
Supervision			
Do you feel that greater supervision might have improved the care for this patient?	X	Unknown	
Please note that your responses will not be shared with your supervisor or trainee.			
Please provide any relevant details (optional)	Other Optional Relevant Details		

Section 5: End-Of-Life Related Information

1. Just prior to admission, was the patient enrolled in an outpatient hospice program?	No
2. DNR/DNI status - at what point did the patient become DNR/DNI?	Never, patient remained a full code
3. Was this patient placed on comfort measures only (and if so when)?	
4. Was the patient in restraints 24 hours before death? (i.e., posey vests or any limb restraints)	Yes
5. Had this patient ever received an organ transplant?	Do Not Know

Section 6: Summary

1. Please provide a brief clinical summary and the circumstances surrounding this patient's death.	Brief clinical Summary
Based on your review:	
2. Please rate the preventability (1 being least preventable, 5 being most preventable) of the patient's death with respect to the care the patient received at BWH:	3 - Not preventable death, but medical error or system issue was present
3. Please provide any other suggestions for quality improvement you may have or thoughts on how this form can be improved.	Suggestions for Quality Improvement
4. Would you like someone from the Center for Professionalism and Peer Support to contact you?	No
5. Is there anything that you would like specific follow up on or that you would prefer to discuss instead of reporting here?	Email: email@partners.org
6. To be answered by MICU attendings:	MICU Attending comments
1. Was patient death expected?	
2. Were there any issues or sentinel events requiring further discussion? If so, please describe.	