Sample AMI Death Review Form

Reviewer Role: ☐QA/RN ☐ QA/MD ☐ RN ☐ MD ☐ OTHER _____

MRN:_____ **Name:** First _____MI___Last_____ **Gender: M F, Age:**_____ **LOS:**_____

Admission:
Date**:** ____**/**____**/**_____ Time**:**___**:**___ Day of week: Mo Tu We Th Fr Sa Su
Admitting Service: _____ Adm. Provider : _____
Chief Complaint: ____Drop Down_____
Adm. Source: ☐MD; ☐Clinic; ☐ED; ☐SNF transfer; ☐Acute care hosp transfer; ☐CAH; ☐Other Facility of Transfer: _____

Admitting DX: ☐STEMI ☐NSTEMI ☐OTHER_____

TIMI Risk Scores (circle all that apply and add scores)

STEMI	pts	NSTEMI	pts
Age ≥ 75	3	Age ≥65	1
Age 65-74	2	≥3 CAD frisk factors	1
DM or HTN or angina	1	Known coronary stenosis ≥50%	1
SBP < 100 mmHg	3	Aspirin use in past 7 days	1
HR > 100 bpm	2	2 angina episodes in prior 24 hrs	1
Killip Class II-IV	2	Positive cardiac biomarker	1
Weight <67 Kg (150 lbs)	1	ST deviation ≥0.5 mm on admission ECG	1
Anterior ST elevation or LBBB	1		
Time to reperfusion Tx > 4 hrs	1		
Total		**Total**	

Were there other potential explanations for positive troponin? (mark all that apply)

☐Congestive Heart Failure ☐Pulmonary Embolus ☐Renal failure ☐Cardiac contusion/trauma ☐Defib/ICD/cardioversion shock ☐Myocarditis ☐Stress induced cardiomyopathy ☐Vasospasm ☐Aortic dissection ☐Post PCI ☐None of the listed

Hospitalization:

Rapid Response Team activation: Y N N/A If yes, how many times?____ Date: ___/___/_____ Date: ___/___/_____
Initial CODE Status: ☐DNR ☐Full Code ☐Modified Code
Initial CMO Status: Y N N/A
Was CODE Status changed? Y N N/A If yes Date: ___/___/_____, To what? ☐DNR ☐Full Code ☐Modified Code
Was patient made CMO? Y N N/A If yes Date: ___/___/_____

Attending Provider: _____ Consulting Service: _____
Days spent in each: ICU: _____ PACU: _____ Holding: _____ ED: _____ Inpatient Unit: _____

Surgeries & Special Procedures (require conscious sedation or higher e.g. endoscopy, IR, cath & EP lab procedures):

- Pre- AMI (1 week) ☐No Surgery ☐ GI ☐GU ☐ Orthopedic ☐Neuro ☐Cardiothoracic ☐Vascular ☐Other
- Post- AMI ☐No Surgery ☐ GI ☐GU ☐ Orthopedic ☐Neuro ☐Cardiothoracic ☐Vascular ☐Other

Death: Date: ___ /____/_____ Cause of death: _____
Disch. Service_____ Disch. Provider: _____

Autopsy: ☐Requested/Performed ☐Requested/Family refused ☐ME Case ☐Not Requested/Not Performed

Death within 48 hours of admission Yes No
Death occurred during a readmission that was within 30 days of a previous hospitalization Yes No

Diagnoses (circle all that apply)

Was treatment required for:

Atrial fibrillation	Yes
Ventricular tachycardia	Yes
Cardiac arrest	Yes
Shock or hypotension	Yes
Heart failure	Yes
Stroke	Yes
Recurrent Ischemia	Yes
Acute stent thrombosis	Yes
Hemorrhagic complication of cath	Yes
GI bleeding	Yes

Procedures (circle all that apply)

Were any of the following performed:

Cath	Yes
PCI	Yes
Balloon pump or Impella	Yes
Cardiac surgery	Yes
Pacemaker	Yes
Defibrillator	Yes
Endoscopy	Yes
Dialysis	Yes

Was there significant delay? Yes No
(in recognition of the clinical situation **or** in making the diagnosis **or** *wrong* or *missed* diagnosis)
Contributed to or Caused Death? **Yes Possible No**

Circle all that apply:

1. Cardiac (ischemia, rupture, valvular, electrophysiologic) Y N
2. Exsanguination Y N
3. Gastroenterology (NOT ischemia) Y N
4. Neurologic (intracranial or spinal) Y N
5. Pulmonary (including OSA) Y N
6. Pulmonary embolus Y N
7. Radiologic finding (fractures, bleeds, infections) Y N
8. Renal/electrolyte Y N
9. Sepsis Y N
10. Vascular (peripheral, mesenteric, etc.) Y N
11. HERT Team Activation Y N
12. Other diagnosis issue Y N

Was there failure in documentation or communication? (circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

1. Closing the loop (e.g. after consult) Y N
2. Event documentation Y N
3. Hand-off(s) Y N
4. Pre-hospital/direct admission communication Y N
5. Resuscitation status Y N
6. Attending provider signing within 24 hrs. of admission Y N
7. Other documentation/communication issue Y N

Was there an Iatrogenic infection? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**
DH Acquired? **Yes No**

1. Aspiration pneumonia Y N
2. Catheter-associated blood stream infection Y N
3. Catheter-associated urinary tract infection Y N
4. Clostridium difficile disease Y N
5. Healthcare associated pneumonia Y N
6. Surgical site infection Y N
7. Ventilator associated pneumonia Y N
8. Other infection issue Y N

Were there medication errors? Yes No
(administered inappropriately **or** missed altogether **or** administered in a substandard way)
Contributed to or Caused Death? **Yes Possible No**

Circle all that apply:

1. Antibiotic Y N
2. Anticoagulation Y N
3. Chemotherapy Y N
4. Insulin, oral hyperglycemic agent Y N
5. Medication reconciliation Y N
6. Pain, anxiolytic, sleep, or other sedating medication Y N
7. Pro-arrhythmic Y N
8. Other medication issue Y N

Were there any falls or other misadventures? Yes No Other
Contributed to or Caused Death? **Yes Possible No**
DH Acquired? **Yes No**

Were there issues with appropriate palliation? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

- Appropriate therapies to ease the dying process are not managed in an appropriate or timely manner? Y N
- Lack of clarity or confusion about the prognosis & expectations of care resulting in the patient's wishes not being met? Y N

Were there Procedural Issues or Complications? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

1. Anesthesia Y N
2. Appliances/minor procedures *(ETT, central venous catheter placement, thoracentesis, chest tube)* Y N
3. Dialysis Y N
4. Indication Y N
5. Interventional cardiology Y N
6. Interventional gastroenterology Y N
7. Interventional pulmonary Y N
8. Interventional radiology Y N
9. Surgically related Y N
10. Other procedure issues Y N

Was there failure to institute routine prophylactic measures? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

1. Aspiration Y N
2. Peptic Ulcer Y N
3. Pneumocystis pneumonia Y N
4. Venous thromboembolism Y N
5. Other prophylaxis issues Y N

Were there issues involving a resuscitation? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

1. Intervention Intensity Y N Y N
2. Recognition of patient condition
3. Team activation Y N

Was there evidence of inadequate supervision? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

1. Advanced Allied Health Professional Y N
2. Nursing Y N
3. Resident/Fellow Y N
4. Other Allied Health Provider Y N

Were there Triage effectiveness issues? (Circle all that apply) **Yes No**
Contributed to or Caused Death? **Yes Possible No**

1. Direct admission Y N
2. Discharge Y N
3. Transfers Y N
4. Other Triage issues Y N

Death was:

- ☐ **Preventable** (An event or complication that is an expected or unexpected sequela of a procedure, disease, illness or injury that could have been prevented or substantially ameliorated) **(further review required)**
- ☐ **Potentially preventable** (An event or complication that is a sequela of a procedure, disease, illness or injury that has the potential to be prevented or substantially ameliorated) **(further review required)**
- ☐ **Non-preventable** (An event or complication that is a sequela of a procedure, disease, illness or injury for which reasonable and appropriate preventable steps have been taken)

Supporting Comments (required): _____

_____

_____

Recommended Disposition of Case:

- ☐ No indication of clinical, quality of care or system issues, therefore, no further review necessary
- ☐ Further review required:
  - ☐ Departmental review, specify department(s) _____
  - ☐ Peer review, specify _____
  - ☐ Quality assurance review
  - ☐ Other, specify _____

Remediation recommendation (e.g., counseling, monitoring, education, restriction of privileges):

_____

_____

Reviewer:_____ Date:_____

Reviewer:_____ Date:_____