

Disability Resource Hub Disclaimer

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Client Death Notification Form (CDN)

Office use only

ADHC TRIM NO: _____

Text references e.g.¹ refer to notes in *Guidelines for Completion* (p 5-6)

Person's details

Family name: _____ Given name(s): _____ Date of birth: _____

Gender: Male Female Transgender
 Aboriginal or Torres Strait Islander¹: Yes No Don't know

Country of birth: _____ First language²: English Other (specify): _____

How did the person communicate?³ Verbal language Adjusted verbal language Sign language
 Other signing/gestures Pictures Electronic Other (specify): _____

Details of death

Please provide copies of relevant Critical Incident Reports and/or Incident Briefing Notes

Date and time

Date of death: _____

Time of death: _____

Place of death

At the residence At hospital (specify) _____

Other (specify) _____

Unexpected death

Expected death (attach end-of-life, palliative care or treatment plan)

Provide details of the person's terminal illness/ reason why death was expected: _____

Brief description of the key events leading up to the person's death⁴

Accommodation

Name of service provider⁵ _____

Postal address: _____

Postcode: _____

Contact person: _____

Title: _____

Telephone: _____

Place of residence⁶: _____

District (ADHC) operated service

- Group home (< 7 people)
 Small residential (7-20 people)
 Large residential (>20 people)
 Respite - group home
 Respite - large residential

Funded⁷ service

- Group home (< 7 people)
 Small residential (7-20 people)
 Large residential (>20 people)
 Respite - group home
 Respite - large residential

Assisted boarding house

Other (specify): _____

Person's length of time at this residence: _____

Length of time in accommodation services during lifetime: _____

Number of residents living at this address: _____

Names of other residents who died at service outlet⁸ in last 12 months

Respite stays

Overnight respite stays in previous 12 months: No Yes _____

Disability

Intellectual Borderline Mild Moderate Severe Profound Unknown level

Syndrome Down syndrome Fragile X Rett syndrome Other (specify):

Neurological Dementia Multiple sclerosis Muscular dystrophy Other (specify):

Mental illness Schizophrenia Depression Bipolar disorder Anxiety Other (specify):

Sensory impairment Vision (specify): Hearing (specify):

Physical Cerebral Palsy (including spastic quadriplegia) Spinal cord injury Other (specify):

Other disability Autism spectrum disorder Acquired brain injury Other (specify):

Swallowing, breathing and choking risks

Asthma Recurrent respiratory infections Chronic obstructive pulmonary disease (COPD)/ emphysema

Gastroesophageal reflux (&/or oesophagitis) Swallowing difficulties⁸

Help with meals¹⁰ Tube feeding¹¹ (specify): Was the person nil by mouth?¹² Yes No

Previous choking incidents (specify date/s):

Did the person have: All their teeth Some teeth No teeth Dental aid¹³

Smoking, obesity and other lifestyle risks

Diabetes High blood pressure

Last recorded weight before death: (kg) Date: Weight 3 months before that:

Last recorded height before death: (cm) Date: (kg) Date:

Smoking

Occasional Up to 10/day 11-20/day >20/day No Ex smoker

Mobility

Limited mobility¹⁴ No Wheelchair Walking frame Walking stick Other (specify):

Other health issues

Cancer Epilepsy Osteoporosis Constipation Urinary incontinence¹⁵ Faecal incontinence¹⁶

Other (specify):

Immunisation	Yes	No	Date immunised	Don't know	Immunisation	Yes	No	Date immunised	Don't know
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other (specify) <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

Medication and consent

List all medications the person was prescribed at the time of death. Indicate dosage, and regular¹⁷ or PRN¹⁸:

Item	Dosage	Regular	PRN	Item	Dosage	Regular	PRN
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other medications prescribed for the person in the last 12 months ¹⁹							
■	■	<input type="checkbox"/>	<input type="checkbox"/>	■	■	<input type="checkbox"/>	<input type="checkbox"/>
■	■	<input type="checkbox"/>	<input type="checkbox"/>	■	■	<input type="checkbox"/>	<input type="checkbox"/>
■	■	<input type="checkbox"/>	<input type="checkbox"/>	■	■	<input type="checkbox"/>	<input type="checkbox"/>

Were there any medication incidents²⁰ in the last 12 months?
 No Yes (specify): ■

Responsible for consent²¹ Person themselves Family member Friend Public Guardian
 Private Guardian Other (specify): ■

Health providers

General Practitioners	Date of last visit	Date last comprehensive annual review
■	■	■
■	■	■

	Practitioner/profession	Date last visit	Provider's name
Hearing	■	■	■
Vision	■	■	■
Allied health	Speech pathologist	■	■
	Dietician	■	■
	Occupational therapist	■	■
	Physiotherapist	■	■
	Dentist	■	■
	Psychologist	■	■
	Other (specify) ■	■	■
Medical specialist	Neurologist	■	■
	Cardiologist	■	■
	Psychiatrist	■	■
	Gastroenterologist	■	■
	Other (specify) ■	■	■
Multidisciplinary teams	Palliative care	■	■
	Dysphagia clinic	■	■
	Other (specify) ■	■	■

In the 12 months before the person's death

Behaviour Did the person display behaviours of concern:²² No Self injury²³ Absconding²⁴
 Eating non-food items (Pica) Assault of other clients Assault of others
 Other behaviours of concern (specify): ■

Were restrictive practices²⁵ used: No Yes (specify): ■

Illnesses Did the person have any illness that required treatment by a doctor? (e.g. chest infection)
 No Yes (specify below)

Date	Brief details
■	■
■	■

Hospital admissions Was the person admitted to hospital?²⁶ No Yes (specify below)

Date	Hospital	Reason/s for admission
■	■	■
■	■	■

Injuries Did the person have any serious injuries?
 No Fracture Deep cuts Extensive bruising Concussion Burns Other

Date	Brief details (please provide any incident reports)
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

Falls Did the person experience any falls? No Yes (specify below)²⁷

Date	Brief details
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

Please provide any other relevant information about the person not provided above [REDACTED]

Documents required with the Client Death Notification form

With this form, please provide any current risk assessments and relevant support plans,²⁸ including:

- health care plan²⁹
- client risk plan
- assessment/s of nutrition, swallowing and/or choking risks
- specific health support plans, including any relating to eating and drinking; epilepsy management; asthma/respiratory illness; diabetes management; bowel care; palliative care, etc
- behaviour support plan and/or incident prevention and response plan

Notification to Police³⁰

Date: [REDACTED] Notifying person: [REDACTED] Police Station: [REDACTED]
 Name and rank of police officer: [REDACTED] COPS Event No (if known): [REDACTED]

Checklist for Completion (see Guidelines)

I have completed the following (please tick):

Signed and dated CDN Emailed CDN to: CrossCluster.PerformanceImprovement@facs.nsw.gov.au, Performance Improvement, FACS *within 48 hours of person's death*

Posted the following documents to Performance Improvement, FACS, Locked Bag 10, Strawberry Hills NSW 2012:

CDN form copies of Critical Incident Reports³¹ / Incident Briefing Notes³² about the death

copies of relevant risk assessments and support plans (see previous section)

Form completed by (please print name): [REDACTED] Date: [REDACTED]

Signature Position title: [REDACTED] Telephone: [REDACTED]

ADHC Line Manager: [REDACTED] Senior Manager: [REDACTED]
 Operations Executive Director, Disability Operations: [REDACTED]

Guidelines for Completion of Client Death Notification Form

The service provider fills out the Client Death Notification (CDN) form and submits it to Performance Improvement, Department of Family and Community Services NSW, no later than 48 hours after the person's death. At this time, or as soon as possible, the service provider also sends the associated documents (health care plans, briefing notes etc) to Performance Improvement, who will send all these documents to the NSW Ombudsman's Office.

Ref	CDN question	Guidelines for completion
Person's Details		
1.	Aboriginal or Torres Strait Islander	Tick 'Yes' if this is recorded on the person's file.
2.	First language	Indicate which language the person preferred. If the person was largely non-verbal, indicate which language their family used to communicate with them.
3.	Support for communication	This may have been necessary if the person had limited expressive and/or receptive communication skills. Support examples include use of gestures, adjusted verbal language, signing, pictures and electronic devices, hearing aid.
Details of Death		
4.	Brief description of key events	Provide a brief summary of what happened in the lead-up to the person's death (particularly the last 24 hours).
Accommodation		
5.	Name of service provider	Write full details of the service provider's head office, if applicable.
6.	Person's place of residence	Write full details of the specific service outlet including the Unit name/number at which the person resided.
7.	Funded service	Includes services funded by FACS and those funded under the National Disability Insurance Scheme (NDIS) – including services that are solely funded under the NDIS.
8.	Service outlet	The service outlet refers to the group home or other disability accommodation the person resided in. In the case of a residential centre, the service outlet is the unit they lived in.
Swallowing, breathing and choking risks		
9.	Swallowing difficulties	Tick if person had been identified as having dysphagia (swallowing problems), or if the person required foods and fluids of different texture e.g. minced/ pureed food, or thickened fluids. Do not tick if this only occurred during a final hospital admission before death.
10.	Help with meals	Tick if the person needed help to chop food up (or mince or blend) and/or help to use utensils to eat. Do not tick if the person needed help with cooking.
11.	Tube feeding	Tick if the person received food/ fluid via a tube. Specify which type, eg: nasogastric, PEG (percutaneous endoscopic gastrostomy), or jejunostomy.
12.	Nil by mouth	Tick if the person did not take any food and/ or fluid via their mouth, and they received all food and fluid via a tube. Do not tick if this only occurred during a final hospital admission before death.
13.	Dental aid	A dental aid refers to items such as dentures. Some people may have some of their own teeth and a partial denture.
Smoking, obesity and other lifestyle risks		
14.	Limited mobility	This refers to decreased ability to move freely without assistance or without risk of falling. Other aids may include a hoist or assistance from a carer.

Other health issues		
15.	Urinary incontinence	Tick if the person had decreased ability to control their passing of urine.
16.	Faecal incontinence	Tick if the person had decreased ability to control the emptying of their bowel.
Medication and consent		
17.	Regular medication	Medication taken on a regular basis.
18.	PRN medication	Medication taken as needed.
19.	Other medications in last 12 months	List any medications prescribed for the person in the last 12 months that were ceased before their death.
20.	Medication incidents	Any incident where medication was not given as required. For example, the wrong medications were given, medications were missed or were given at the wrong time, or the wrong dose was given.
21.	Responsible for consent	Indicate who was responsible for providing consent to medical and dental treatment on the person's behalf.
In the 12 months before the person's death		
22.	Behaviours of concern	Behaviour that is of such intensity, frequency or duration that the quality of life and/or physical safety of the person or others is put at risk.
23.	Self injury	Examples are self-hitting, banging head, biting, cutting, scratching or picking skin, burning and eye-poking.
24.	Absconding	The person left a place without the agreement of those responsible for their care.
25.	Restrictive practices	Restrictive practices refer to methods that involve some intrusion on the person's freedom in order to curtail a particular behaviour. May include physical or chemical restraint and seclusion or containment.
26.	Hospital admissions	This refers to a full admission to hospital or a short-term presentation to an Accident and Emergency department.
27.	Falls	Include any falls experienced by the person in the last 12 months, regardless of their cause.
Documents required with the Client Death Notification form		
28.	Current risk assessments and relevant support plans	Please provide any assessments and/or support plans that relate to the health issues, risks and support needs for the person you have identified in the CDN.
29.	Health care plan	Any document that provides a comprehensive overview of the person's health needs and outlines the actions required to meet those needs.
Notification to Police		
30.	Notification to Police	Under the <i>Coroners Act 2009</i> , service providers are required to report the person's death to a police officer, coroner, or assistant coroner as soon as possible after the death.
Checklist for Completion		
31.	Critical incident reports	A staff member's report of a significant incident or event that represented potential danger to the person or other people.
32.	Briefing notes	A short, written outline provided to management about the death.