

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

## Person's details

Family name:	Given name(s):	Date of birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Aboriginal or Torres Strait Islander <sup>1</sup> : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Country of birth:	First language <sup>2</sup> : <input type="checkbox"/> English <input type="checkbox"/> Other (specify):	
How did the person communicate? <sup>3</sup> <input type="checkbox"/> Verbal language <input type="checkbox"/> Adjusted verbal language <input type="checkbox"/> Sign language		
<input type="checkbox"/> Other signing/gestures <input type="checkbox"/> Pictures <input type="checkbox"/> Electronic <input type="checkbox"/> 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 death<sup>4</sup>**

## Accommodation

**Name of service provider<sup>5</sup>**

Postal address:

Postcode:

Contact person:

Position Title:

Telephone:

**Place of residence<sup>6</sup>:**

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 outlet<sup>7</sup> 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 difficulties<sup>7</sup>

Help with meals<sup>8</sup>  Tube feeding<sup>9</sup> (specify): Was the person nil by mouth?<sup>10</sup>  Yes  No

Previous choking incidents (specify date/s):

Did the person have:  All their teeth  Some teeth  No teeth  Dental aid<sup>11</sup>

## 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 mobility<sup>12</sup>  No  Wheelchair  Walking frame  Walking stick  Other (specify):

## Other health issues

Cancer  Epilepsy  Osteoporosis  Constipation  Urinary incontinence<sup>13</sup>  Faecal incontinence<sup>14</sup>

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="checkbox"/>	Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

## Medication and consent

List all medications the person was prescribed at the time of death. Indicate dosage, and regular<sup>15</sup> or PRN<sup>16</sup>:

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

**Any other medications prescribed for the person in the last 12 months<sup>17</sup>**

		<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 incidents<sup>18</sup> in the last 12 months?

No  Yes (specify):

**Responsible for consent<sup>19</sup>**  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
<b>Hearing</b>			
<b>Vision</b>			
<b>Allied health</b>	Speech pathologist		
	Dietician		
	Occupational therapist		
	Physiotherapist		
	Dentist		
	Psychologist		
	Other (specify)		
<b>Medical specialist</b>	Neurologist		
	Cardiologist		
	Psychiatrist		
	Gastroenterologist		
	Other (specify)		
<b>Multidisciplinary teams</b>	Palliative care		
	Dysphagia clinic		
	Other (specify)		

**In the 12 months before the person's death**

**Behaviour** Did the person display behaviours of concern:<sup>20</sup>  No  Self injury<sup>21</sup>  Absconding<sup>22</sup>

Eating non-food items (Pica)  Assault of other clients  Assault of others

Other behaviours of concern (specify):

Were restrictive practices<sup>23</sup> 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?<sup>26</sup>  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)

**Falls** Did the person experience any falls?  No  Yes (specify below)<sup>25</sup>

Date	Brief details

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

## Documents required with the Client Death Notification Form

With this form, please provide any current risk assessments and relevant support plans,<sup>26</sup> including:

- health care plan<sup>27</sup>
- 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 Police<sup>28</sup>

Date: \_\_\_\_\_ Notifying person: \_\_\_\_\_ Police Station: \_\_\_\_\_

Name and rank of police officer: \_\_\_\_\_ COPS Event No (if known): \_\_\_\_\_

## Checklist for Completion (see Guidelines)

Assisted boarding houses

I have completed the following (please tick):

- Signed and dated CDN  Emailed CDN to: [boarding.houses@facs.nsw.gov.au](mailto:boarding.houses@facs.nsw.gov.au), within 48 hours of person's death
- Posted the following documents to Boarding Houses Team, FACS, Locked Bag 10, Strawberry Hills NSW
- 2012: CDN form  copies of Critical Incident Reports<sup>29</sup> / Incident Briefing Notes about the death<sup>30</sup>
- copies of relevant risk assessments and support plans (see previous section) and Boarding House Screening Tool

Form completed by (please print name): \_\_\_\_\_

Date: \_\_\_\_\_

Signature ..... Position title: \_\_\_\_\_

Telephone: \_\_\_\_\_

*FACS Operations*

Manager, Boarding Houses Team

## Guidelines for Completion of Client Death Notification Form

The service provider fills out the Client Death Notification (CDN) form and submits it to Boarding House Team 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 the Boarding house Team, who will send all these documents to the NSW Ombudsman's office.

Ref	CDN question	Guidelines for completion
<b>Person's Details</b>		
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.
<b>Details of Death</b>		
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).
<b>Accommodation</b>		
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.
<b>Swallowing, breathing and choking risks</b>		
7.	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.
8.	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.
9.	Tube feeding	Tick if the person received food/ fluid via a tube. Specify which type, eg: nasogastric, PEG (percutaneous endoscopic gastrostomy), or jejunostomy.
10.	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.
11.	Dental aid	A dental aid refers to items such as dentures. Some people may have some of their own teeth and a partial denture.
<b>Smoking, obesity and other lifestyle risks</b>		
12.	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.

<b>Other health issues</b>		
13.	Urinary incontinence	Tick if the person had decreased ability to control their passing of urine.
14.	Faecal incontinence	Tick if the person had decreased ability to control the emptying of their bowel.
<b>Medication and consent</b>		
15.	Regular medication	Medication taken on a regular basis.
16.	PRN medication	Medication taken as needed.
17.	Other medications in last 12 months	List any medications prescribed for the person in the last 12 months that were ceased before their death.
18.	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.
19.	Responsible for consent	Indicate who was responsible for providing consent to medical and dental treatment on the person's behalf.
<b>In the 12 months before the person's death</b>		
20.	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.
21.	Self injury	Examples are self-hitting, banging head, biting, cutting, scratching or picking skin, burning and eye-poking.
22.	Absconding	The person left a place without the agreement of those responsible for their care.
23.	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.
24.	Hospital admissions	This refers to a full admission to hospital or a short-term presentation to an Accident and Emergency department.
25.	Falls	Include any falls experienced by the person in the last 12 months, regardless of their cause.
<b>Documents required with the Client Death Notification form</b>		
26.	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.
27.	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.
<b>Notification to Police</b>		
28.	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.
<b>Checklist for Completion</b>		
29.	Critical incident reports	A staff member's report of a significant incident or event that represented potential danger to the person or other people.
30.	Briefing notes	A short, written outline provided to management about the death.