# Mortality Review

# (Updated March 2023)

He-M 1001.06 Health and Safety. (g) Each area agency shall assess the relationship of any individual’s unanticipated death to service provision and the natural course of any illness or underlying condition.

1. **Name of deceased:**
2. **Date of Death:**
3. **Cause of Death:**
4. Describe the health status of the individual in the three month period prior to death:

1. Describe any health consults in the three-month period prior to death:

1. What actions were taken by the home provider and agency to advocate for the individual’s optimal health, especially as it relates to the individual’s cause of death?

1. Had the individual been ill or hospitalized in the one year prior to death? Yes **[ ]**  No **[ ]**

*If yes, please describe illness and/or state date(s) and reason(s) for hospitalization(s):*

1. History or presence of swallowing difficulties? Yes **[ ]** No **[ ]**

*If yes, what actions were taken to address this?*

1. History of bronchitis, pneumonia, or aspiration pneumonia? Yes **[ ]**  No **[ ]**

*If yes, what actions were taken to address this?*

1. History of cardiac issues? Yes  **[ ]**  No **[ ]**

*If yes, what actions were taken to address this?*

1. Bladder elimination:  Bowel elimination:
2. History of constipation? Yes  **[ ]** No **[ ]**

*If yes, what actions were taken to address this?*

1. History of urinary tract infection? Yes **[ ]**  No **[ ]**

*If yes, what actions were taken to address this?*

1. Presence of functional decline within past year? Yes **[ ]** No **[ ]**

*If yes, describe functional issues and state what actions were taken to address this:*

1. Increased seizure activity with past three month prior to death? Yes **[ ]**  No **[ ]**

*If yes, what actions were taken to address this?*

1. Did the individual receive 24-hour supervision? Yes **[ ]**  No **[ ]**

*If no, how much?*

1. Was the person receiving respite services within 7 days of death? Yes  **[ ]** No  **[ ]**

*If yes, please describe:*

1. Did the individual have Advance Directives? Yes **[ ]**  No **[ ]**

 *If yes, were the directives followed?* Yes **[ ]**  No **[ ]**

 *If no, why not?*

1. Average hours per week of nursing oversight?
2. Please obtain and mail copies of:
	1. The most recent physical exam Yes **[ ]**  No **[ ]**
	2. Pertinent health practitioner consultations. Yes **[ ]**  No **[ ]**
	3. Ambulance/EMS report Yes **[ ]**  No **[ ]**  N/A **[ ]**
	4. Emergency Room report Yes **[ ]**  No **[ ]** N/A **[ ]**
	5. Latest Hospital Admission History and Physical Yes **[ ]**  No **[ ]** N/A  **[ ]**

### 21. Signature and title of person completing this report:

Email address:

 Date:

**Thank you for your time and for providing this important information.**