Data Extraction Form

ID number	
Age	
Gender	
Admitting specialty	
Date of admission	
Date of death	
Co-morbidities (from past medical history admission clerking)	
History of presenting admission	
Cause of death (1a)	
Bottom line cause of death (1b or 1c)	
Functional status	
Potentially avoidable EOLC admission?	
Failed EOLC discharge (from evidence in notes)?	
Referred to coroner	
EOLC pathway used (which and date commenced)?	
Was CPR attempted (date)?	
Presence of DNACPR (date, signed by, reasons for)?	
Is there reference to an advanced care plan?	

Date	Time	Event leading to decision/ discussion (including details surrounding event)	Who recognised/responded to (or led the) event	Speciality (of individual who recognised/responded to event)	Action	Detail about action	Outcome (escalation)	Additional detail around escalation outcome	Outcome (de-escalation)	Additional detail around de-escalation outcome	Involvement of patient and family	Were preferences of patient known in advance?	Detail of discussion with patient/family, including how preferences of others (patient, family, professionals) were taken into account	Details of ward move	Comments
Line break denotes new episode of deterioration															