

Manual for The Deceased Client Profile Database Entry

The Deceased Patient Profile (DCP) is completed for every client death to provide DMH with information about the deceased. This booklet will provide instructions on how to enter the DCP data. Any issues or questions that are not covered in this manual, please feel free to contact the DCP data manager, Kristen Roy-Bujnowski at (508) 856-8723 or email queries to: Kristen.Roy@umassmed.edu.

This database was created in Microsoft Access, version 1997. If the system being utilized for the DCP data entry has a different version (i.e. 2000 or XP), contact the DCP database manager ASAP. Converting the database to one system's capabilities will block those systems with a previous version ability to log in. The appropriate version of Access will be posted.

Upon opening the database, a blue title screen will display the following options: Sign in Sheet and Data Entry Form. Go to the Sign-In Sheet first by clicking on the appropriate button.

Sign-In Sheet

Before any data is entered into the database, this form needs to be filled out!

It is a simple way to track when database is in use. The required fields are as follows:

Name: The person entering the data is to type his/her name in the provided space.

Date: Type in using the date format as described on page.

Time: Enter the time using the format described on page .

Work Being Done: *Check off all that applies:* Adding new patients, Updating current patient information, Printing facility report.

Data Entry -General rules:

The data collection form is designed to allow data to be gathered in a systematic way. This section will begin with a few general rules, followed by specific instructions for each item. *Please adhere to these rules as much as possible!* If there is a specific recording issue that needs to be addressed, *please contact the DCP Data Manager!*. Revisions will be made if deemed necessary.

Dates: All dates are coded in MM/DD/YY format. For example, September 1, 1996, should be recorded as 09/01/96. If done incorrectly, an error message will appear.

Time: Time is recorded in the medium format: For example: 5:15 pm; 8:18 am.

Missing Data rules:

It is important that *every* item has an item, even if something, which is different from the categories listed on the form is entered. Inevitably missing or incomplete information will occur. When encounter, they should be coded as follows:

“Drop Down” Boxes: All boxes should have the options “7777” and “9999” listed. Please select “7777” if the information is unknown and “9999” for when the paper form lacks an answer for the item.

Unknown information is defined as information not being available at the time when the paper form was being completed. The DCP should be updated as new information is made available.

If an item has been left blank on the *paper* form, it is the responsibility of the person in charge of the DCP collection to go back to the paper files to obtain the missing information. “Truly” Missing information is defined as when the item is not found in the medical record.

Dates: When an entire date is missing, code 09/09/99.

Question by Question Specifications

Data Form

The Data Entry Form is in a “Page Tab” format numbered 1 through 8, with the 9th page labeled as, “Agency Information”. These tabs correspond with the actual DCP form. The form has a light blue background. At the bottom of each page is a button that will advance to the next tab or page.

There are two buttons in the Header Section: A “Main Page” button, and “Add a New Record” Button. After you have completed entering a form, click on the “Add a New Record” button and the program will automatically save the addition before presenting a blank form. Once data entry has been completed, click on the “Main Page” button to return to the Main menu.

Page 1

Client’s First Name: Enter the client’s first name.

Client’s Last Name: Enter the client’s last name.

Age : Enter client’s age at time of death.

Date of Birth: Enter the date as indicated by the date format on page

Gender : Choose one of the following options from the “drop down” box:

- 1 “Male”
- 2 “Female”
- 99 “Missing”

Race: Choose one of the following options from the “drop down” box:

- 1 “Caucasian/white”
- 2 “Hispanic”
- 3 “African-American”
- 4 “Asian”
- 5 “Native Hawaiian/Pacific Islander”
- 6 “Other”
- 77 “Unknown”
- 99 “Missing”

Identify as Latino/Hispanic?: Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

Housing: from the “drop down” box which best identifies the client dwelling at time of death:

- 1 “DMH Residence”
- 2 “Hospital”
- 3 “Supported Housing”
- 4 “Housing with family”
- 5 “Housing with others”
- 6 “Lived alone”
- 7 “Other”
- 77 “Unknown”
- 99 “Missing”

If selected “other”, specify type of residence in the space provided.

DSM Diagnosis – Please enter the person’s diagnosis(es) in the space provided. The DSM code not needed.

Axis 1

Axis 2

Section A: Circumstances of Death (*Page 1 continued*)

1. Date of Death: Enter date according to format as indicated on page .
2. Presumed manner of death: Select one of the following options from the “drop down” box”

- 1 “Natural causes”
- 2 “Accident”
- 3 “Suicide”
- 4 “Homicide”
- 77 “Unknown”
- 99 “Missing”

3. Was this death expected?: Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

4. Is an autopsy being conducted? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If yes, enter by whom (a medical examiner or a hospital) in the provided space. If applicable, enter name of the name of the facility.

5. Location of death: Select the option that best describes the location from the “drop down” box.

- 1 “Hospital”
- 2 “Nursing home”
- 3 “Group home”
- 4 “Supported housing”
- 5 “Apartment/Home”
- 6 “Other”
- 77 “Unknown”
- 99 “Missing”

If selected “other” please specify in the provided space.

Page 2

6. At time of death, the client was: Please select option which best describes with whom the client was with at the time of death.

- 1 “With staff”
- 2 “Alone”
- 3 “With family”
- 4 “With friend”
- 5 “Other”
- 77 “Unknown”
- 99 “Missing”

If selected “other”, specify in the space provided.

7. Narrative: Please describe the circumstances around the client’s death in your own words

8. Major Category Cause of Death Choose one of the following options from the “drop down” box:

“Alzheimer’s Disease”	G30.8
“Anemia”	D64.9
“Atherosclerosis”	I25.1
“Cancer –colon, rectum, anus”	C18
“Mesothelioma”	C45
“Cancer – trachea, bronchus, lung”	C34
“Cancer – breast”	C50.9
“Cancer – Prostrate”	C61
“Cancer- other”	C80
“Cerebrovascular disease-stroke”	I67.8
“Chronic liver disease/cirrhosis”	K70.3
“Chronic lower respiratory disease- COPD, asthma, bronchitis, emphysema”	J44
“Diabetes”	E10
“Heart disease – heart attack”	I22.8
“Other heart disease”	I24
“HIV/AIDS”	B23.8
“Influenza & pneumonia”	J11.0
“Kidney disease – chronic renal failure”	N18
“Meningitis – infection of brain and/ or spinal cord”	A39.0
“Other”	888
“Accident- motor vehicle injuries”	V80.5
“Accident – other”	X39
“Suicide – firearm”	X74
“Suicide – hanging”	X70
“Suicide – jumping”	X80
“Suicide – overdose”	X83
“Homicide – injury by firearms”	X95
“Homicide – other”	X89

“Unknown”	7777
“Missing”	9999

8a. If category is not known, but presumed, check here: Check the box if this statement is true.

9. If specific cause of death is known, please write it here: If cause of death is known, please use the provided space to provide specific information regarding the client’s cause of death.

Page 4

Deceased’s Health Status

1. Smoking

a. Did patient smoke within six months prior to death? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If choose, “Yes”, enter the approximate number of packs a day and the approximate number of years that the person smoked into the designated spaces.

b. Did patient have a known history of ever smoking (i.e. ex-smoker)? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If choose, “Yes”, enter the approximate number of years that the person smoked in the designated space.

2. Substance Abuse

a. Did the patient abuse alcohol with the six months prior to death? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 3 “No”
- 77 “Unknown”
- 99 “Missing”

If choose, “Yes”, enter the approximate number of years that the person used the medication/substance in the designated space.

b. Did the patient ever have a known history of alcohol abuse? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 4 “No”
- 77 “Unknown”
- 99 “Missing”

If choose, “Yes”, enter the approximate number of years that the person used the medication/substance in the designated space.

c. Did the patient abuse illicit substances and/or prescription medications in the six months prior to his/her death? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 5 “No”
- 77 “Unknown”
- 99 “Missing”

If choose, “Yes”, fill in the chart. Enter one item per line, entering the name of substance in the first box, followed by the approximate number of months the substance was used, and check off all applicable routes:

- IV
- Oral
- Snort
- Inhale
- Smoke

Other.

If choose, "Other", specify method in the space provided. Click the "Add a New Record" for each additional item.

Page 5

d. Did the patient ever have a known history of medication or substance abuse? Choose one of the following options from the "drop down" box:

- 1 "Yes"
- 2 "No"
- 77 "Unknown"
- 99 "Missing"

If choose, "Yes", fill in the chart below. Enter one item per line, entering the name of substance in the first box, followed by the approximate number of months the substance was used, and check off all applicable routes:

- IV
- Oral
- Snort
- Inhale
- Smoke
- Other.

If choose, "Other", specify method in the space provided. Click the "Add a New Record" for each additional item.

3. Obesity

If recorded in the chart, please note the most recent:

height _____ft _____inches and **weight** _____lbs., and the date _____

Otherwise, please **estimate** the patient's **height** _____ft _____inches and **weight** _____lbs.

Please note the patient's BMI _____ *See attached table to record BMI (after last page of DCP)*

Enter the height in the form of feet and inches, and the weight in pounds. The BMI chart is located at the end of the DCP Form. Enter the person's BMI in the provided space.

4. Activity

For the two questions below, picture the client as he/she functioned in his/her daily routine. Please answer to the best of your knowledge.

a. Did the client's health limit him/her in moderate activities such as moving a table, pushing a vacuum cleaner, or other regular daily activities

Check the appropriate answer:

- 1 "Yes, limited a lot"
- 2 "Yes, limited a little"
- 3 "No, not at all"
- 77 "Unknown"
- 99 "Missing"

b. Did the client's health limit him/her in climbing several flights of stairs?

Check the appropriate answer:

- 1 "Yes, limited a lot"
- 2 "Yes, limited a little"
- 3 "No, not at all"
- 77 "Unknown"
- 99 "Missing"

5. Nutrition:

Please answer to the best of your knowledge.

a. Was the client's diet well balanced and include regular fruits and vegetables? Choose one of the following options from the "drop down" box:

- 1 "Yes"
- 2 "No"
- 77 "Unknown"
- 99 "Missing"

b. Did the client drink 4-8 glasses of water daily? Choose one of the following options

from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

c. Was the client’s diet characterized by high fat, or high carbohydrate foods? Choose one

of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

Page 6

D. Medications

List all medications at the time of client’s death in the chart, entering one item per a line. In the first box indicate the name of the medication and the dosage in the second. Click the “Add a New Record” for each additional item.

E. Routine Medical Health Care Services

1. Did client comply with annual physicals? Choose one of the following options from

the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If choose, “Yes”, enter the date of the last known physical in the space provided.

2. Did client have a chronic medical condition? Choose one of the following options from

the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, answer questions 3 through 9 as they apply. If “No”, go to Section F (Page 7).

3. Cardiovascular (hypertension, heart condition, as examples) Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, answer items 3a and 3b. If “No”, go to next item.

a. Was the client’s condition evaluated by a stress test? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

b. Was it evaluated by an “ECHO” Echocardiogram? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

4. Pulmonary (COPD, emphysema, asthma, as examples) Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If answer, “Yes”, go to 4a. If “No”, go to next item.

4a. Did the client have pulmonary function testing? (PFT’s) Choose one of the following options from the “drop down” box:

- 1 “Yes”

- 2 “No”
- 77 “Unknown”
- 99 “Missing”

5. Sleep apnea :

a. Was the client evaluated for sleep apnea? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If answer, “Yes”, check all applicable evaluation types:

- Screening
- Questions,
- Sleep studies

Then continue to 5b. If “No”, go to next section.

5b. Did the evaluation result in a diagnosis of sleep apnea? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, check off the appropriate treatment recommendation:

- Lose weight
- CPAP
- Other.

If choose, “Other” specify recommendation in the provided space.

6. Diabetes: Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, check off the appropriate item as it relates to the treatment recommendation:

Diet & Exercise, Oral Medications, Insulin. If “No”, continue to next section.

7. Gastrointestinal (cirrhosis, for example) Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

8. Infectious (AIDS, Hepatitis as examples) Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

9. Did client see a medical specialist (other than primary care physician) for a chronic condition(s) listed above? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

Page 7

F. Recent Acute Medical Health Care Services

1. In the last 3 months, was the client physically sick? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, describe the illness in the space provided. If “No”, go to item 2.

2. Were any medications discontinued in the last 3 months? Choose one of the following options from the “drop down” box:

- 1 "Yes"
- 2 "No"
- 77 "Unknown"
- 99 "Missing"

If "Yes", enter the medication(s) and the date(s) of discontinuation if known in the provided space. If "No", continue onto next item.

3. Did the client receive any new medical treatments (not medication) in the last 3 months? Choose one of the following options from the "drop down" box:

- 1 "Yes"
- 2 "No"
- 77 "Unknown"
- 99 "Missing"

If "Yes", enter the treatments into the space provided. If "No", continue onto next item.

4. To the best of your knowledge, did the client accept new medical recommendations (medications and/or treatments)? Choose one of the following options from the "drop down" box:

- 1 "Yes"
- 2 "No"
- 77 "Unknown"
- 99 "Missing"

G. Overall Compliance Issues

1 In general, did the client have a medical condition or exhibit physical symptoms that needed medical care? Choose one of the following options from the "drop down" box:

- 1 "Yes"
- 2 "No"
- 77 "Unknown"
- 99 "Missing"

2. Did the client follow these medical recommendations (medications and/or treatments)? Choose one of the following options from the "drop down" box:

- 4 "Mostly"
- 3 "Sometimes"
- 2 "Rarely"
- 1 "Not at all"
- 77 "Unknown"

3. Indicate any issues that might have affected the client’s utilization of medical services.
Check all that apply:

- Fear/denial of illness
- Poor organizational skills (e.g. keeping appointments, managing medications)
- Psychiatric symptoms (e.g. paranoid delusions or auditory hallucinations)
- Poor communication skills (difficulty communicating medical problems)
- Communication problems with providers (client complained that medical providers were disrespectful, uninterested, poor communicators)
- Other

If choose “Other” enter reason into the space provided.

H. Psychiatric

1. Approximately, how many times per year did client see psychiatrist? Enter the number of times in the provided space.

Enter the date of the last visit in the format as indicated on page

I. Overall Competency Issues

Presumed Competent: Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

1. Guardianship Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, check off appropriate box:

- Guardianship of Person (Usual & customary medical care)
- Rogers (Substituted judgment for medications)

2. Did client have a Health Care Proxy selected at the time of death? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”

- 77 “Unknown/NA”
- 99 “Missing”

2a. If yes, was Health Care Proxy involved in client’s health care choices? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown/NA”
- 99 “Missing”

2b. Did client receive hospice or other end of life care services? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

J. Death Certificate Available? Choose one of the following options from the “drop down” box:

- 1 “Yes”
- 2 “No”
- 77 “Unknown”
- 99 “Missing”

If “Yes”, enter causes into the provided space.

Agency Information or “Page 9”

This last section asks for the following information:

Name of Person Completing Review: This is the person who filled out the DCP paper form.

Date: Enter the date of which the DCP paper form was completed. Enter in the format as indicated on page

Title: Position of the person who completed the DCP paper form

Phone: Number at which that person can be reached.

Name of Person Entering Form: Name of the data entry person

Date: Date of data entry

Comments: Enter in provided space.

Your Supervisor's Name: The name of the supervisor of the person who completed the DCP paper form.

Phone: The phone number of the supervisor.