Scottish Renal Association
Scottish Mortality Audit in Renal Replacement Therapy (SMARRT)
Confidential Summary and Data Collection Sheet

The Scottish Renal Association is undertaking an audit of deaths in patients receiving RRT and we would be grateful if you could complete this form for every patient receiving RRT for established renal failure who dies in your unit (including satellite units) from 1 January 2008. An expanded instruction sheet has been sent to each renal unit. A copy can be viewed on the SRR Website. Further copies of this document and the instruction sheet are available on the SRR website http://www.show.scot.nhs.uk/SRR or you can photocopy a blank form.

1. Patient ID

Patient Name : Surname Forename	Hospital Patient ID Label would be ideal here
Date of Birth (dd/mm/yyyy)	_____/_____/_____
CHI Number	

2. Unit Information

Name of Parent Renal Unit eg GRI	
Location Patient attended if different from parent unit eg Falkirk	

3. Details of Death

Date of Death	_____/_____/_____
Place of Death	
Cause of Death (EDTA Code)	
Was a Post Mortem performed?	Yes ☐ No ☐
If yes did this influence coded cause of death?	Yes ☐ No ☐

4. RRT

Date referred to Renal Unit	_____/_____/_____
Duration of renal F/U prior to RRT	
Mode 1st RRT	
Date 1st RRT	_____/_____/_____
Mode of RRT at time of death	
Date commenced this treatment	_____/_____/_____
Did patient have a functioning Tx at time of death?	***Yes*** ☐ ***No*** ☐ ***N/A*** ☐

5. Vascular Access

Vascular Access for HD Patient at time of death	
Date access created	_____/_____/_____
Has this patient ever had HD through a fistula?	Yes ☐ No ☐
Previous grafts or fistulae used?	Yes ☐ No ☐

6. Final Illness

If died in hospital, duration of final admission (No of days)	☐☐☐
Was the patient admitted to ICU in the last 30 days?	Yes ☐ No ☐
Number of in-patient episodes in last 90 days?	☐☐

Patient Name	Where possible use
DOB	Patient ID label
CHI Number	

7. Comorbidity

ERA-EDTA Primary Renal Disease Please use ERA-EDTA Code No eg 00	☐☐

Ischaemic Heart Disease	Proven ischaemic event	Yes ☐ No ☐
	Angiographically proven coronary artery disease	Yes ☐ No ☐
Valvular Heart Disease	Clinical valve disease	Yes ☐ No ☐
Heart Failure	CCF	Yes ☐ No ☐
Peripheral Vascular Disease	Clinical Ischaemia/amputation/revascularisation	Yes ☐ No ☐
Cerebro Vascular Disease		Yes ☐ No ☐
COPD	Clinically significant lung disease	Yes ☐ No ☐
Diabetes	Diabetes mellitus	Yes ☐ No ☐
Malignancy		Yes ☐ No ☐
Clinically significant Liver Disease		Yes ☐ No ☐
Other	Ever smoked	Yes ☐ No ☐ Unknown ☐
	Most recent weight Date ___/___/_____	☐☐☐.☐ kg
	height Date ___/___/_____	☐☐☐.☐ cm

8. Laboratory Results (Last routine bloods Pre Dialysis)

Last Haemoglobin	Date _____/_____/_____	☐☐.☐
Last URR	Date _____/_____/_____	☐☐☐
Last Adjusted Calcium	Date _____/_____/_____	☐.☐☐
Last Phosphate	Date _____/_____/_____	☐.☐☐
Last PTH	Date _____/_____/_____	☐☐☐.☐
Last Creatinine	Date _____/_____/_____	☐☐☐☐

9. Was death at least in part attributed to:

Withdrawal of treatment?	Yes ☐ No ☐	Peritoneal infection?	Yes ☐ No ☐
Access failure/infection?	Yes ☐ No ☐	Transplant complications?	Yes ☐ No ☐
Dialysis complications?	Yes ☐ No ☐	Hospital acquired infection?	Yes ☐ No ☐
Non compliance?	Yes ☐ No ☐	Malignancy	Yes ☐ No ☐
H1N1 infection?	Yes ☐ No ☐	Was death Unexpected?	Yes ☐ No ☐

10. Which statement best describes the management of this case? (Tick ONE box)

There were no areas of concern or for consideration in the management of this patient	☐
There were areas for consideration but they made no difference to the eventual outcome	☐
There were areas of concern but they made no difference to the eventual outcome	☐
There were areas of concern which may have contributed to this patient's death	☐
There were areas of concern which CAUSED the death of this patient who would have been expected to survive	☐

11. Please give details of any factors contributing to death not already stated on this form. Please ensure this contains the patient's name, DOB and CHI number.

12. Completed by: …….. Date: ……