Assessing the quality of death certificates: Rapid tool

This tool is designed to assess the quality of death certification practices by checking for common errors in death certificates. This can be used to assess the quality of death certification as part of routine assessment, or to assess the training needs of physicians in designing cause of death certification training. This tool can also be used to evaluate the effectiveness of death certification training.

This tool should be used in conjunction with *Assessing the quality of death certificates: Guidance for the rapid tool*, available to download at: crvsgateway.info/file/7573/62

General instructions

Country	The country where the death was certified.
Date of certification	Write the date the certificate was completed (DD/MM/YYYY). Insert 'not recorded' if unknown or blank.
Hospital/Health area	Name of hospital (or health facility) where the certificate was completed.
Place of death	For example, hospital, other health facility, home or other. Insert 'not recorded' if unknown.
Certifier	For example, hospital or community doctor or other. Insert 'not recorded' if unknown.
Age at death	Age of the deceased at death. Remember to include units (hours, days, months, years). Insert 'not recorded' if unknown.
Sex of deceased	Male or female. Insert 'not recorded' if unknown.
Error types	Detailed instructions on how to assess the quality of the death certificate against each error type are provided in the document *Assessing the quality of death certificates: Guidance for the rapid tool.*

The assessment tool

General details about the deceased

Age at death:	
Sex of deceased:	

Death certificate details

Country:	
Date of certification:	
Hospital/ Health area:	
Place of death:	
Certifier:	

A correctly filled-in death certificate has none of the following errors.
Did the certificate have:

Error type	Yes	No	Unsure because of illegible handwriting
1. Documenting multiple causes of death per line			
2. Missing time interval from disease onset to death			
3. Incorrect or clinically improbable sequence of events leading to death			
4. Ill-defined or poorly-specified conditions entered as the underlying cause of death			
■ If yes, was the condition:			
– Impossible underlying cause (ie signs and symptoms)			
– Intermediate cause			
– Mode of dying (ie respiratory arrest)			
– Unspecified causes within a larger death category (ie unspecified accident)			
– Other – **specify:**			
5. Abbreviations used in certifying the cause of death			
6. Illegible hand writing			
7. Were there additional errors on the certificate?			
■ If yes, select all those that apply:			
– For deaths from external causes, additional details were missing			
– For deaths as a result of neoplasms, additional details were missing			
– Changes/alterations made by any means other than drawing a line through the original text (ie using correction fluid)			
– No units specified for the age			
– Sex of deceased not specified			
– Blank lines within the sequence of events leading to death			
– Other – **specify:**			
8. Overall, was the medical certificate of cause of death correctly filled-in?			

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