SECOND-LINE ASSESSMENT FORM

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GUIDELINES FOR SECOND-LINE ASSESSMENT

INTRODUCTION
VASM has two stages of peer-review assessment:
1) First-Line Assessment
2) Second-Line Assessment

STAGE 2: SECOND-LINE ASSESSMENT
A case note review involves a second-line assessor reviewing the case notes (medical records - last admission only) and writing a one-page report. The review is carried out in the spirit of sympathetic enquiry and provides sufficient details for a clear view of events. The report is written in a detached manner and any opinions expressed are objective and reasonable.

Note: The surgeon responsible for patient care is always informed of the findings of the First-Line Assessment and/or Second-Line Assessment in writing.

COMPLETION INSTRUCTIONS
* To maintain subject confidentiality, never write any patient or consultant identifying information on a Second Line Assessment Form.
* Always answer all questions.
* Use only black ink from a ballpoint pen.
* Print clearly, legibly and accurately within the boxes using block CAPITAL LETTERS.
* For any descriptive fields, avoid abbreviations.
* Use date format (DD/MM/YYYY) eg 4th June 2002 is written as 04/06/2002.
* Use a 24-hour clock when indicating time.
* Do not leave blank fields. Cross through the field and write ‘NA’ if not applicable, ‘NK’ if not known and ‘ND’ if not done.
* Never use correction fluid or erase mistakes. Place a single horizontal line through the error. Write correct information beside error. All corrections must be initialled and dated.
* Any change or correction to a CRF must not obscure the original entry.

By submitting this form to the Mortality Audit, I agree that Australian and New Zealand Audit of Surgical Mortality (ANZASM) may inform the Professional Standards Department of my involvement with the surgical mortality audits, to confirm my compliance with Continuing Professional Development (CPD) requirements.
Second Line Surgical Assessor's Form

1. First line assessor's comments/questions to be addressed by second line assessor in case report

2. Record keeping

<table>
<thead>
<tr>
<th>Medical admission notes</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical follow up notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case summary letter to GP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. If NO OPERATION was performed:

Should an operation have been performed?  
If YES, what operation and why?

4. Assessor's view (before any surgery) of overall risk of death

- Minimal
- Small
- Moderate
- Considerable
- Expected

5. Was this patient treated in a critical care unit during this admission?

Should this patient have been provided critical care in:

- Intensive Care Unit (ICU)
- High Dependency Unit (HDU)

6. Was the decision on the use of DVT prophylaxis appropriate?

7. Was fluid balance an issue in this case?

GUIDELINES FOR COMPLETION OF VASM SECOND LINE ASSESSMENT FORM

Thank you for participating in Victorian Audit of Surgical Mortality. The ‘Second-Line Assessment’ (SLA) form is a standard format used across all Australian states.

Please:
- Answer all questions. It should be noted that if the information provided was not sufficient to reach a conclusion on adequacy of management, a second-line assessment may be recommended to clarify the situation.
- Use not applicable (NA) or 'Don't know' options where appropriate.
- When using abbreviations use standard abbreviations.
- Questions that require a text response should be concise and legible.

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### If an OPERATION WAS PERFORMED:

Were there any Areas for Consideration, Concern or Adverse Events in any of the following areas:

<table>
<thead>
<tr>
<th>Area of Consideration</th>
<th>Concern</th>
<th>Adverse Event</th>
<th>Made no difference to outcome</th>
<th>May have contributed to death</th>
<th>Caused death of patient who would otherwise be expected to survive</th>
<th>Was it preventable?</th>
<th>Associated with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-operative management/preparation</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Decision to operate at all</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Choice of operation</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Timing of operation</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
</tr>
</tbody>
</table>

An area for CONSIDERATION is where the clinician believes areas of care COULD have been IMPROVED or DIFFERENT, but recognises that it may be an area of debate.

An area of CONCERN is where the clinician believes that areas of care SHOULD have been better.

An ADVERSE EVENT is an unintended injury caused by medical management rather than by disease process, which is sufficiently serious to lead to prolonged hospitalisation or to temporary or permanent impairment or disability of the patient at the time of discharge, or which contributes to or causes death.

### Important: please describe the 3 most significant events and list any other events

1. **(please describe most significant event)**

<table>
<thead>
<tr>
<th>Area of:</th>
<th>Which:</th>
<th>Was it preventable?</th>
<th>Associated with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration</td>
<td>Made no difference to outcome</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Concern</td>
<td>May have contributed to death</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adverse Event</td>
<td>Caused death of patient who would otherwise be expected to survive</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

2. **(please describe the second most significant event)**

<table>
<thead>
<tr>
<th>Area of:</th>
<th>Which:</th>
<th>Was it preventable?</th>
<th>Associated with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration</td>
<td>Made no difference to outcome</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Concern</td>
<td>May have contributed to death</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adverse Event</td>
<td>Caused death of patient who would otherwise be expected to survive</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

3. **(please describe the third most significant event)**

<table>
<thead>
<tr>
<th>Area of:</th>
<th>Which:</th>
<th>Was it preventable?</th>
<th>Associated with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration</td>
<td>Made no difference to outcome</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Concern</td>
<td>May have contributed to death</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Adverse Event</td>
<td>Caused death of patient who would otherwise be expected to survive</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### VSCC Case Classification

**Preventability of Outcome**

In the view of the First line assessment, was the outcome in this case potentially preventable? Please select and circle relevant fields. Multiple fields can be selected.

<table>
<thead>
<tr>
<th>A - Yes, in my view the outcome was potentially preventable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>V Failure of communication</td>
<td></td>
</tr>
<tr>
<td>W Lack of timely involvement of experienced staff</td>
<td></td>
</tr>
<tr>
<td>X Inadequate resources</td>
<td></td>
</tr>
<tr>
<td>Y Protocol breach</td>
<td></td>
</tr>
<tr>
<td>Z Other (must be specified)</td>
<td></td>
</tr>
</tbody>
</table>

1 **Preoperative**

1.1 Inadequate preoperative specific condition investigation  
1.2 Inadequate preoperative general investigations  
1.3 Incorrect or untimely diagnosis  
1.4 Inappropriate preoperative preparation  
1.5 Inappropriate treatment delay  
1.6 Other (must be specified)  

2 **Intraoperative**

2.1 Personnel issue  
2.2 Facility / equipment issue  
2.3 Other (must be specified)  

3 **Postoperative**

3.1 Deficient postoperative care  
3.2 Failure of problem recognition  
3.3 Other (must be specified)  

<table>
<thead>
<tr>
<th>B - No, in my view the outcome was not preventable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1 Expected</td>
<td></td>
</tr>
<tr>
<td>B.2 Unexpected</td>
<td></td>
</tr>
</tbody>
</table>

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The College of Surgeons in Australia and New Zealand

**VASM thanks you for your participation in this important quality improvement initiative.**
VASM audit process

VASM receives notification of death

Case record form sent to surgeon for completion

Completed case record form returned to VASM and de-identified

Case record form sent to assessor for first-line assessment

Is second-line assessment required?

Yes

Case record form and medical records sent to another assessor for second-line assessment

Feedback sent to surgeon

Has surgeon appealed the assessment?

Yes

Re-assessment conducted by another assessor

Feedback sent to surgeon

No

No

Feedback sent to surgeon

Case closed

Dissemination of results via publications