VASM audit process

1. VASM receives notification of death
2. Case record form sent to surgeon for completion
3. Completed case record form returned to VASM and de-identified
4. Case record form sent to assessor for first-line assessment
5. Is second-line assessment required?
   - Yes: Case record form and medical records sent to another assessor for second-line assessment
   - No: Feedback sent to surgeon

   a. Has surgeon appealed the assessment?
      - Yes: Re-assessment conducted by another assessor
      - No: Feedback sent to surgeon

6. Case closed

   a. Dissemination of results via publications
GUIDELINES FOR COMPLETION OF VASM CASE RECORD FORM

Thank you for participating in Victorian Audit of Surgical Mortality. The ‘Case Record Form’ (CRF) is a standard format used across all Australian states except NSW.

The ‘treating surgeon’ is responsible for the completion of the Case Record Form. If any part of the form has been completed by junior medical staff, the accuracy of the information they have provided should be confirmed by the consultant responsible for that patient’s care.

Privacy Legislation in Victoria does not allow us to use the actual name of the deceased we are seeking to audit. We do provide the gender, date of birth and dates relevant to the inpatient stay. The name of the treating surgeon and the hospital in which the death occurred are provided by the hospital. If any of this information is incorrect please change as appropriate. While responding to the questions in this form please avoid directly identifying the hospital, the patient or any persons involved in the care of the patient.

Please note:
- Answer all questions. It should be noted that if 1st line assessors feel the information provided was not sufficient to reach a conclusion on adequacy of management, they will recommend a 2nd line assessment to clarify the situation.
- Use not applicable (N/A) options where appropriate.
- When using abbreviations use standard abbreviations.
- Questions that require a text response should be concise and legible. This is particularly relevant to questions 3, 9 and 12.
- Where times are required please use 24 hour clock.

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.

Step 1
Was terminal care planned for this patient prior to or on admission?
- YES (go to step 2 below and specify reason)
- NO (go to page 2 and complete ALL questions on this form)

Step 2
If YES, was an operation performed on this terminal patient?
- YES (go to page 2 and complete ALL questions on this form)
- NO (this patient is EXCLUDED from the audit; do NOT complete this form and return it to the audit office)

Please return this form to the audit office.
### Status of surgeon completing form
- Consultant
- Fellow
- International Medical Graduate
- SET Trainee
- Service Registrar
- GP Surgeon

### Specialty of consultant surgeon in charge of patient
- General
- Ophthalmology
- Vascular
- Paediatrics
- Urology
- Obstetrics & Gynaecology
- Neurosurgery
- Plastic
- Orthopaedics
- Oral/Maxillofacial
- Otolaryngology Head & Neck
- Cardiothoracic
- Other (specify)

### Patient age

### Patient gender
- Male
- Female

### Hospital Status
- Private
- Public
- Co-location

### Aboriginal/Torres Strait Islander descent?
- Yes
- No

### Admission Type
- Elective
- Emergency

### Patient Status
- Private
- Public
- Veteran

### Admitted by surgeon
- Yes
- No

### Main surgical diagnosis on admission (as suspected by clinicians after initial assessment)

### Confirmed main surgical diagnosis (taking into account test results, operations, postmortem etc)

### Final cause of death (taking all information into account, including postmortem)

### Were there significant co-existing factors increasing risk of death? Yes [ ] (tick all that apply) No [ ]
- Cardiovascular
- Advanced malignancy
- Hepatic
- Respiratory
- Diabetes
- Neurological
- Renal
- Obesity
- Age
- Other (specify)
5 ASA Grade
ASA 1 - A normal healthy patient
ASA 2 - A patient with mild systemic disease
ASA 3 - A patient with severe systemic disease which limits activity, but is not incapacitating
ASA 4 - A patient with an incapacitating systemic disease that is a constant threat to life
ASA 5 - A moribund patient who is not expected to survive 24 hrs, with or without an operation
ASA 6 - A brain-dead patient for organ donation

6 Was the patient transferred pre-op?  
Yes  
No (go to Q7)

   Transferred from hospital

   Transferred to hospital

   Distance (km)

   Was there a delay in transfer?  
   Yes  
   No

   Was the transfer appropriate?  
   Yes  
   No

   Was level of care during transport appropriate?  
   Yes  
   No

   Was there sufficient clinical information?  
   Yes  
   No

7 Was there a pre-op delay in confirmation of main surgical diagnosis?  
Yes  
No (go to Q8a)

   Was the delay associated with:
   GP  
   Medical Unit  
   Surgical Unit  
   Other (specify)

   Was this due to: (tick all that apply)
   Failure to do correct test  
   Results not seen  
   Misinterpretation of results  
   Inexperience of staff  
   Unavoidable factors  
   Other (specify)

8a Was this patient treated in a critical care unit (ICU or HDU) during this admission?  
Yes (go to Q8b)  
No (continue)

   Should this patient have been provided critical care in
   Intensive Care Unit (ICU)?  
   Yes (continue)  
   No (go to Q9)
   High Dependency Unit (HDU)?  
   Yes (continue)  
   No (go to Q9)

   Why did this patient not receive critical care? (tick all that apply)
   No ICU/HDU bed available  
   Admission refused by critical care staff  
   No critical care unit in the hospital  
   Active decision not to refer to critical care unit  
   Not applicable

8b Was the surgical team satisfied with the critical care unit (ICU or HDU) management of this patient?  
If NO, specify reason below
Yes (go to Q9)  
No
Please describe the course to death (or attach report) (use back of form if required)

Please do not provide any identifiable information

Is there a report attached?  Yes ☐  No ☐
### Question 10
**Was an operation performed during the last admission?**
*If YES, go to Q11. If NO, tick as necessary below*
- Yes [ ]
- No [ ]

- It was not a surgical problem [ ]
- Active decision not to treat/operate [ ]
- Patient/family refused operation [ ]
- Rapid death [ ]

**Was this a consultant's decision?**
- Yes [ ]
- No [ ]

*If NO operation was performed, please go to Q18*

### Question 11
**Surgeon's view (before any surgery) of overall risk of death**
- Minimal [ ]
- Small [ ]
- Moderate [ ]
- Considerable [ ]
- Expected [ ]

### Question 12
**Description of operation(s) (including relevant radiological or endoscopic procedures)**

#### Operation (1)

- Date [ ] / [ ] / [ ]
- Start time (24hr clock): [ ]: [ ]
- Estimated length of operation: [ ]

#### Operation (2)

- Date [ ] / [ ] / [ ]
- Start time (24hr clock): [ ]: [ ]
- Estimated length of operation: [ ]

#### Operation (3)

- Date [ ] / [ ] / [ ]
- Start time (24hr clock): [ ]: [ ]
- Estimated length of operation: [ ]

#### Operation (4)

- Date [ ] / [ ] / [ ]
- Start time (24hr clock): [ ]: [ ]
- Estimated length of operation: [ ]

#### Operation (5)

- Date [ ] / [ ] / [ ]
- Start time (24hr clock): [ ]: [ ]
- Estimated length of operation: [ ]
Timing of Operation?

<table>
<thead>
<tr>
<th></th>
<th>1st Op</th>
<th>2nd Op</th>
<th>3rd Op</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate (&lt;2 hours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency (&lt;24 hours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled emergency (&gt;24 hours after admission)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Was there a consultant anaesthetist present at the operation?

<table>
<thead>
<tr>
<th></th>
<th>1st Op</th>
<th>2nd Op</th>
<th>3rd Op</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
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</tr>
</tbody>
</table>

Was the operation abandoned on finding a terminal situation?

<table>
<thead>
<tr>
<th></th>
<th>1st Op</th>
<th>2nd Op</th>
<th>3rd Op</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Grades of surgeon(s) making decisions, operating, assisting and present in theatre

<table>
<thead>
<tr>
<th></th>
<th>1st Op</th>
<th>2nd Op</th>
<th>3rd Op</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>Decide</td>
<td>Operate</td>
<td>Assist</td>
</tr>
<tr>
<td>Fellow</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International Medical Graduate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SET Trainee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Registrar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was there a definable post-operative complication?

Yes ☐ No ☐ (go to Q17)

Surgical complications relating to present admission (tick all that apply)

Anastomotic leak (specify) ☐ site Oesophageal ☐ Small bowel ☐
Procedure related sepsis ☐ Gastric ☐ Colorectal ☐
Significant post-op bleeding ☐ Pancreas/biliary ☐
Endoscopic perforation ☐
Tissue ischaemia ☐
Vascular graft occlusion ☐
Other (specify) ☐

Was there a delay in recognising post-operative complications?

Yes ☐ No ☐

Was there an anaesthetic component to this death?

Yes ☐ No ☐ Possibly ☐

Was death within 48 hours of last anaesthetic?

Yes ☐ No ☐ Don't know ☐
### 18 Was a post-mortem examination performed?
- Yes - Hospital
- Yes - Coroner
- No
- Refused
- Unknown

### 19 Was DVT prophylaxis used during this admission?
- Yes
- No (go to Q20)

(If YES, tick all that apply)
- Heparin (any form)
- Sequential compression device
- Aspirin
- Warfarin
- TED Stocking
- Other (specify)

If NO, state reasons
- Not appropriate
- Active decision to withhold
- Not considered

and please comment on why NOT used

### 20 Was there an unplanned return to theatre?
- Yes
- No
- Don’t know

Was there an unplanned admission to a critical care unit?
- Yes
- No
- Don’t know

Was there an unplanned readmission within 30 days of surgery?
- Yes
- No
- Don’t know

Was fluid balance an issue in this case?
- Yes
- No
- Don’t know

Was there an issue with communication at any stage?
- Yes
- No
- Don’t know

### 21a Did this patient die with a clinically-significant infection?
- Yes (continue)
- No (go to Q22)

Was this infection acquired
- Before this admission (go to Q21b)
- During this admission

If acquired during this admission, was the infection
- Acquired pre-operatively
- Acquired post-operatively
- A surgical site infection
- Other invasive-site infection

### 21b Was the infection
- Pneumonia
- Septicaemia
- Intra-abdominal sepsis
- Other

Was the infective organism identified?
- Yes (continue)
- No (go to Q22)

What was the organism?

Was there a delay in treatment of the infection?
- Yes
- No

### 22 Was the antibiotic regimen appropriate?
- Yes
- No
- Don’t know
- N/A
### 23. Do you consider management could have been improved in the following areas?

<table>
<thead>
<tr>
<th>Area of Management</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-operative management/preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision to operate at all</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice of operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timing of operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(too late, too soon, wrong time of day)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intra-operative/technical management of surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade/experience of surgeon deciding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade/experience of surgeon operating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-operative care</td>
<td></td>
<td></td>
<td></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.

### 24a. Were there any areas for **CONSIDERATION**, **CONCERN** or **ADVERSE EVENTS** in the management of this patient?  
Yes [ ] (describe below)  
No [ ] (go to Q24)

### 24b. Important: please describe the 3 most significant events and list any other events

**1. (Please describe the most significant event)**

<table>
<thead>
<tr>
<th>Area of:</th>
<th>Consideration</th>
<th>Concern</th>
<th>Adverse Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which:</td>
<td></td>
<td>Made no difference to outcome</td>
<td>Made no difference to outcome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May have contributed to death</td>
<td>May have contributed to death</td>
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<tr>
<td></td>
<td></td>
<td>Caused death of patient who would otherwise be expected to survive</td>
<td>Caused death of patient who would otherwise be expected to survive</td>
</tr>
<tr>
<td>Was it preventable?</td>
<td>Definitely</td>
<td>Probably</td>
<td>Probably not</td>
</tr>
<tr>
<td>Associated with?</td>
<td>Audited surgical team</td>
<td>Another clinical team</td>
<td>Hospital</td>
</tr>
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</table>

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

<table>
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</thead>
<tbody>
<tr>
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**3. (Please describe the third most significant event)**

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List other events

**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.
### 24 In retrospect, would you have done anything differently?

**Yes** [ ]  **No** [ ]

*If YES, please specify*

Please do not provide any identifiable information

### 25 Was trauma involved?

#### (a) Was trauma the result of a fall?

**Yes** [ ] *(continue)*  **No** [ ] *(go to b)*

If yes, please indicate:
- Fall at home [ ]
- Fall in a care facility [ ]
- Fall in hospital [ ]
- Unknown [ ]
- Other (specify) [ ]
  *(e.g. sport/recreation/farm/work)*

#### (b) Was trauma the result of a road traffic accident?

**Yes** [ ] *(continue)*  **No** [ ] *(go to c)*

If yes, please indicate:
- Motor vehicle accident [ ]
- Motor bike accident [ ]
- Bicycle accident [ ]
- Pedestrian accident [ ]
- Unknown [ ]
- Other (specify) [ ]

#### (c) Was trauma the result of violence?

**Yes** [ ] *(continue)*  **No** [ ]

If yes, please indicate:
- Domestic violence [ ]
- Public violence [ ]
- Self-inflicted violence [ ]
- Unknown [ ]
- Other (specify) [ ]
Additional comments:

Please do not provide any identifiable information
VSCC Case Classification Proforma

Preventability of Outcome
In the view of the surgeon, was the outcome in this case potentially preventable?
Please select relevant fields. Multiple fields can be selected.

A - Yes, in my view the outcome was potentially preventable

V  Failure of communication
W  Lack of timely involvement of experienced staff
X  Inadequate resources
Y  Protocol breach
Z  Other *must be specified*

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*

B - No, in my view the outcome was not preventable

B.1  Expected
B.2  Unexpected

The College of Surgeons in Australia and New Zealand
VASM thanks you for your participation in this important quality improvement initiative.