Closing the quality improvement loop

The journey to Target Zero – tools to address critical areas that require improvement
Date: 14 February 2018
Surgery is safe

VASM data through to June 2017 n = 5348

Overall surgical mortality 3/1000

17% clinical management may have contributed to death

4% clinical management probably contributed to death
Surgery is safe

VASM data through to June 2017 n = 5348

Overall surgical mortality 3/1000

17% clinical management may have contributed to death

4% clinical management probably contributed to death

12/100,000 procedures
Avoidable surgical deaths?

65 year old male - leaking abdominal aortic aneurysm operated on by resident assisted by medical student

91 year old female - died 13 days post pinning fractured NOF – no consultant involvement throughout admission

46 year old female - total pancreatectomy for benign pancreatitis. No pre-op histology

45 year old obese female - difficult appendicectomy performed by registrar, died 48 hours post-op with massive PE. No heparin given.

53 year old male – died 2.5 hours after bilateral burr holes for head injury performed by general surgical registrar with no consultant involvement
The Report of a Confidential Enquiry into Perioperative Deaths

Prepared by N. Buck, H. B. Devlin, and J. N. Lunn

The Nuffield Provincial Hospitals Trust
The King’s Fund

Royal Australasian College of Surgeons
The Report of a Confidential Enquiry into Perioperative Deaths

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1987
Report recommendations

Supervision of trainees

Guidelines to ensure appropriate care of all patients, particularly when responsibility is transferred

Resuscitation, assessment & management of medical disease

Patients who are terminally ill or moribund should not have operations

Clinicians should assess themselves regularly – needs time
Victorian Audit of Surgical Mortality (VASM)

Case Note Review Booklet

Tenth Edition - February 2018

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
Report recommendations

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Improved leadership in patient care

Improved awareness of surgical emergencies, transfers & shared care

Improved perioperative management

Futile surgery and end of life care

Improved communication
The audit loop

1. Identify problem or issue
2. Set criteria & standards
3. Observe practice / data collection
4. Compare performance with criteria & standards
5. Implementing change
Ground zero – VASM review

“VASM ….. highly credible and can provide conclusive evidence of preventable harm”

“VASM has by far the most success in developing a system for reducing avoidable harm”

“The educational process seems to be producing results …..there has been a decline in the number of ‘areas of concern’ detected by the auditing surgeon”

“VASM is a ‘well-oiled machine’ that has secure processes in place for managing information and reporting”
Ground zero – achievements to date

- Decrease in surgical mortality over time
- Assessors identified more clinical issues than the surgeon
- Decrease in some clinical management issues e.g. delay in treatment and operation inappropriate
- Data request from surgeons for in-depth specialty review
- Individual feedback to surgeons
- Aggregate feedback and performance to hospital
- Annual public reports
- Annual case note review booklets
- Annual educational seminars
- Peer reviewed publications
Target zero future goals- reporting gap reduction

Verification of audit numbers and outcomes by:

- Comparison of the Victorian Admitted Episodes Dataset versus the Victorian Audit of Surgical Mortality
- Comparison of the Australian Institute of Health and Welfare (AIHW) dataset versus the ANZ Audit of Surgical Mortality
- Comparison of the National Death Index (NDI) dataset versus the ANZ Audit of Surgical Mortality
- Comparison of the National Coronial Information System (NCIS) inquest versus the ANZ Audit of Surgical Mortality SLA inquests
- Mandate audit across all procedural specialties and include IMGs
- Reach 100% surgical compliance for all specialties
Target zero future goals - Data management

RACS vision and principles “The first digital College”

- Use SNOMED where possible
- Develop RACS products where necessary
- SNOMED Reference set of Diagnoses, Findings, Cause of death and Procedures by generating reference sets
- Develop a (bespoke) Clinical Management Issue (CMI) term set
- As pseudo-READ mimicked codes in SNOMED
- Some content to be added to official SNOMED
Target zero future goals - M&M implementation

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<tr>
<th>Format</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
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<tr>
<td>Structured case identification</td>
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<td>Consistent, structured meeting format</td>
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<td>Regular meeting occurrence and duration</td>
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<td>Written terms of reference</td>
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<td>Prior dissemination of meeting agenda and cases to be presented</td>
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<td>Inter-profession and multidisciplinary involvement</td>
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<td>Appointment of specific M&amp;M meeting personnel to manage administration and completeness of data</td>
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<tr>
<td>Self-nomination of cases</td>
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<th>Conduct</th>
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<td>Consistent, structured case presentation</td>
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<tr>
<td>Safe, blame-free environment</td>
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<td>Systems-focus</td>
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<td>Review of close-calls as well as formal M&amp;M cases</td>
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<td>Assigning a timeline (where necessary) to recommendations for improvement</td>
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<tr>
<td>Assigning an individual/group to carry out recommendations for improvement</td>
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<td>Detailed record keeping</td>
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<td>Audit of M&amp;M meeting procedures</td>
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<td>Follow-up on implementation of recommendations for improvement</td>
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<td>Ensuring recommendations for individual/systems improvement are made for each case</td>
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Target zero future goals - review QP declaration

- Share identified information to the Victorian Surgical Consultative Council (part of the Safe Care Victoria)
- VSCC multidisciplinary panel to review cases where assessor identified that death was considered potentially preventable
- Replace Commonwealth QP with Victoria Division 2 of Part 4 of the Public Health and Wellbeing Act 2008

Public Health and Wellbeing Act 2008
No. 46 of 2008
Target zero future goals- specialty report

Benefit:
The Surgical Specialty Performance Summary Report would reflect trends in potentially preventable mortalities where the assessment has deemed that the final outcome and/or clinical management issues were preventable.

Limitations:
- Denominator data not available
- Breach of qualified privilege requirements
- Punitive versus educational approach
Target zero future goals- surgeon report

Benefit:
This Surgical Individual Surgeon Performance Summary Report would reflect trends in potentially preventable mortalities by individual in a relevant specialty where the assessment has deemed that the final outcome and/or clinical management issues were preventable.

Limitations:
- Denominator data not available
- Breach of qualified privilege requirements
- Punitive versus educational approach
Target zero future goals- Global perspective

- Supporting the development of RACS position statements, new DHHS policies, new hospital guidelines and revised protocols
- Building and learning from national and international partnerships aimed at promoting patient safety
- Continuous research activities and bringing out original audit outcomes from ANZASM
Target zero future goals - summary

• Review Qualified Privilege (QP) declaration
• Close reporting gap and focus on all procedural deaths
• Improve data management and analysis
• Reduce further mortality rates
• Reduce further preventable clinical management issues
• Collaboration with the VSCC/SCV for a multidisciplinary panel to review preventable outcomes
• Development of specialty and surgeon performance report
• Supporting surgeons and hospitals with accreditation requirements
• Generation of improved hospital reports
• National and international collaboration
• Seek stakeholder feedback
• Develop further educational tools for hospitals and surgeons
Primary focus - Safe patient surgical journey

...trust me
I'm a doctor

...God I trust, everyone else provides data!