



**Royal Australasian College of Surgeons  
Australian Capital Territory Audit  
of Surgical Mortality (ACTASM)**

# REPORT 2015



ROYAL AUSTRALASIAN  
COLLEGE OF SURGEONS



The Royal Australian  
and New Zealand  
College of  
Obstetricians  
and Gynaecologists



**ACT**  
Government  
Health



**ANZCA**  
AUSTRALIAN AND NEW ZEALAND  
COLLEGE OF ANAESTHETISTS





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The information contained in this annual report has been prepared under the auspices of the Royal Australasian College of Surgeons, Australian Capital Territory Audit of Surgical Mortality Management Committee, which is a declared quality assurance committee under the *Health Act 1997*.

The information contained in this annual report has been prepared by the Royal Australasian College of Surgeons, Australian Capital Territory Audit of Surgical Mortality Management Committee. The Australian and New Zealand Audit of Surgical Mortality, including the Australian Capital Territory Audit of Surgical Mortality, has protection under the Commonwealth Qualified Privilege Scheme under Part VC of the *Health Insurance Act 1973* (Gazetted 10 July 2016).



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# CHAIRMAN'S REPORT

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I am pleased to present the fifth report for the Australian Capital Territory Audit of Surgical Mortality (ACTASM). This year we have changed the format of the report. As the audit has grown within the Australian Capital Territory (ACT), and throughout Australia, reporting mechanisms have changed, with more targeted information now being provided in the areas in which it can be used most effectively to improve patient outcomes.

While the audit continues to provide individual feedback on each case to the surgeon involved, new feedback processes have been implemented. For example, educational processes, including local and national seminars, local and national case note review booklets, an online app of all published second-line assessment cases, and recommendations on best practice are now available to surgical staff at all levels, as well as other ACT clinicians. Participating hospitals will also receive more de-identified information, with hospitals associated with more than five cases receiving an annual clinical governance report. This report provides themed data for the hospital, benchmarked against national data from similar-sized hospitals. Hospitals also receive national and local annual reports, which include trends in national and local systems issues and patient outcomes.

It is encouraging to note that a reduction in surgical deaths has been demonstrated in regions where the audit has been running for 5 years or more, with Western Australia demonstrating a 30% reduction in surgical deaths.<sup>(1)</sup> A 4-year retrospective analysis of the audit in relation to Australian Institute of Health and Welfare data demonstrated a 15.4% reduction in perioperative mortality rates.<sup>(2)</sup>

In our local region the third case note review booklet is about to be released. Following the success of the first ACTASM seminar in 2015, we are planning the next seminar, to be held on 5 November 2016, with the theme of using audits and evidence to improve practice. As well, all seminars held by regional audits around Australia will now be available as webinars via the Royal Australasian College of Surgeons (RACS) National Case Note Review App. This will enable Fellows to access workshops relevant to their practice at any time, as many of these topics are relevant in all regions.

Following implementation of IT upgrades, ACTASM will now focus on moving towards 100% utilisation of the Fellows Interface. One of the major triggers for second-line assessment is a lack of information – the first-line reviewer may well suspect that nothing of consideration or concern has occurred, but cannot be certain because the relevant information is missing. The prompts within the online system will hopefully reduce this particular source of inefficiency.

Finally, I would like to thank the ACT Department of Health and RACS for their support of ACTASM, as the audit would not be possible without this assistance. I would also like to extend my gratitude to all of my colleagues who have assisted ACTASM by promptly submitting case forms for their cases, assessing cases, serving on the Management Committee, or by contributing to the workshops. It can only thrive if we continue to enjoy this high level of support from all of you.

In July 2016 Ms Veronica Walker, ACTASM Project Manager, left to move back to a clinical role. On behalf of all ACT surgeons I would like to acknowledge her considerable input over four years and wish her well into the future.

**Dr John Tharion**  
Clinical Director

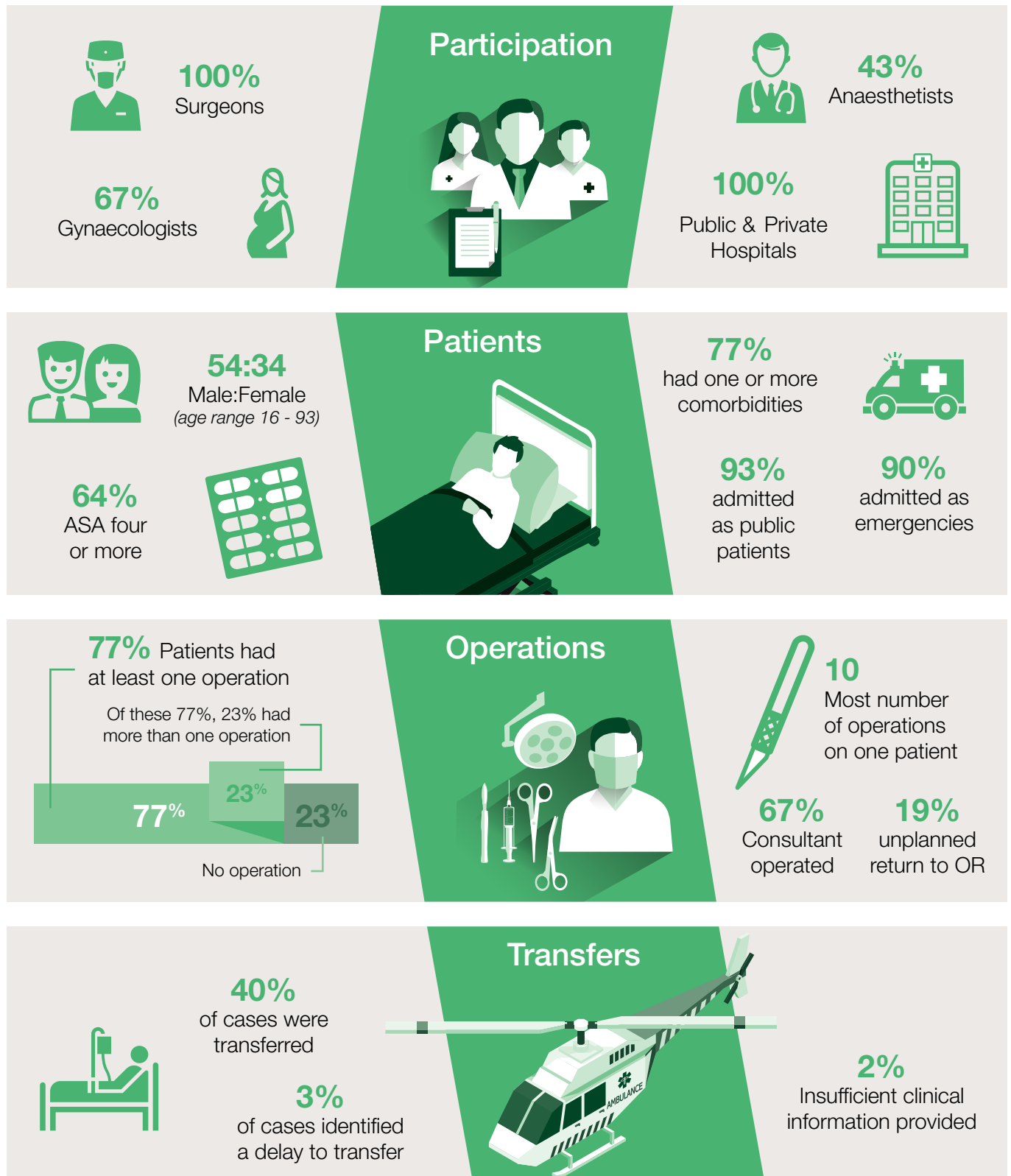
## SHORTENED FORMS

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ACT	Australian Capital Territory
ACTASM	Australian Capital Territory Audit of Surgical Mortality
ANZASM	Australian and New Zealand Audit of Surgical Mortality
ANZCA	Australian and New Zealand College of Anaesthetists
ASA	American Society of Anesthesiologists
DVT	deep vein thrombosis
NSQHS	National Safety and Quality Health Service
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SCF	surgical case form

# EXECUTIVE SUMMARY – ACTASM 2015

The Australian Capital Territory Audit of Surgical Mortality (ACTASM) is an audit process that provides an independent, external peer review of all surgically-related deaths within the Australian Capital Territory (ACT). It is systematic, objective and confidential, and its purpose is to inform and improve surgical practice, with the ultimate goal of improving the quality of patient care.

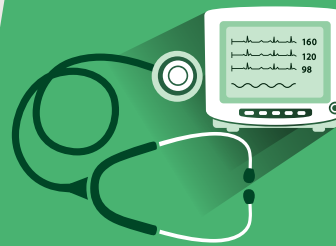




**73%**  
patients received care  
in a Critical Care Unit

**85%**  
DVT prophylaxis used in case

## Risk management



**6%**  
Fluid Balance  
Issues identified

## Infections were

**18%**  
Pneumonia

**8%**  
Intra-  
abdominal  
sepsis

**5%**  
Septicaemia

## Infection



**32%**  
of patients died  
with a clinically  
significant infection



**91%**  
of cases had minor  
or no issues identified

**9%**  
of cases had serious  
issues identified

## Peer review outcomes



**1%**  
of issues  
considered to  
be definitely  
preventable

**88**

cases had individual  
surgeon feedback  
provided



**2**  
hospitals had  
Clinical Governance  
Reports provided

**100%**

positive feedback  
from ACT Seminar  
(48 attended)



## Feedback



**200**  
CNR Booklets  
circulated

# 1. ACTASM RECOMMENDATIONS

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These Australian Capital Territory Audit of Surgical Mortality (ACTASM) recommendations were developed following analysis of data collected through the audit. Although these recommendations were developed for the Australian Capital Territory (ACT) they strongly reflect the issues arising around the country, as seen through the Australian and New Zealand Audits of Surgical Mortality (ANZASM). The recommendations also link strongly with the National Safety and Quality Health Service (NSQHS) Standards developed by the Australian Commission on Safety and Quality in Health Care as the basis for hospital accreditation in Australia.

## Recommendation 1:

Clear plans are required when multiple clinical teams are responsible for the overall care of a patient.

*Links with NSQHS Standard 6: Clinical Handover*

## Recommendation 2:

In terminal care cases, the treatment team should start working collaboratively with the family early to develop a palliative treatment plan that meets the patient's best interests. This may mean not operating in patients where there is no hope of survival.

*Links with NSQHS Standard 2: Partnering with Consumers*

# 2. AIMS FOR 2016

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1. Increase utilisation of Fellows Interface to 80% by the end of 2016. This will assist eliminating transcription errors, decrease data entry time and improve completeness of data.
2. Contribute to the next Anaesthetic Triennial Report 2015-2017.
3. Review all cases identified as 'excluded for terminal care' to ensure they meet exclusion criteria.



## 3. PERFORMANCE REVIEW

This year the ACTASM report has a different format. As the audit has grown within the territory, and throughout Australia, reporting mechanisms have changed. More targeted information is now being provided in the areas in which it can be used most effectively to improve patient outcomes. This report covers the period 1 January 2015 to 31 December 2015, with the census date being 2 May 2016.

Clinical governance reports are now provided to individual hospital quality and safety departments, with specific themed data on their own results. Surgeons can download individual surgeon reports outlining their own activity and outcomes. Themed local and national case note review booklets around focussed outcomes have been implemented. This has led to the 2015 Report returning to the original intention of the annual reports, that is, an outline of the audit's activity over the previous year.

The following are achievements relating to the aims from the 2014 ACTASM Report.

1. Increase utilisation of Fellows Interface to eliminate potential transcription errors, decrease data entry time and improve data completeness.

This will be achieved through:

- Upgrades to the ANZASM database and reporting system, scheduled for during the course of 2016, enabling self-generation of notifications of death and surgical case form (SCF) delegation.
- Once these upgrades are implemented, work towards 100% utilisation of Fellows Interface.

### Progress:

The following upgrades have been implemented to the ANZASM database.

- SCFs can now be delegated electronically to a third party, such as a Trainee or registrar (please refer to the [\*Third party delegation of cases – Fellows user guide\*](#)).
- Passwords can be reset from the Fellows Interface homepage.
- Notifications of death can be self-reported (please refer to the [\*Self-generate Notification of Death user guide\*](#)).
- The Royal Australasian College of Surgeons (RACS) Portfolio Single Sign On User ID and password, to login into Fellows Interface is now available.

Communication with ACT Fellows regarding the move to 100% use of the Fellows Interface has commenced through circulation of a regional newsletter. Individual emails have also been sent to surgeons as cases are received.

2. Continue to develop feedback processes for audit findings, including:

- Conduct seminars to provide feedback on audit findings to Fellows, other clinicians and health directorate personnel.
- Develop the second ACT Case Note Review Booklet.
- Provide individualised hospital feedback via a clinical governance report to all hospitals with greater than five reported cases in an audit year.
- Contribute to the ongoing input and development of the ANZASM App, to include uploading relevant feedback video presentations and publications from the ACT.

**Progress:**

- The first ACTASM seminar, *Closing the Audit Loop*, was held on 12 August 2015 with 48 participants. Evaluation forms were received from 69% of participants (33), and all respondents indicated that the program was informative and of value to their practice. A second seminar is planned for 5 November 2016.
- The second ACT Case Note Review Booklet was developed in collaboration with the Victorian Audit of Surgical Mortality and circulated in July 2015. The third ACT Case Note Review Booklet will be a themed booklet, with a focus on ‘clinical leadership’ in response to a Department of Health request and will be circulated in the latter half of 2016.
- A clinical governance report was provided to the two ACT hospitals with enough cases to ensure that Qualified Privilege was maintained.

3. An upgrade of anaesthetic audit forms in relation to feedback provided by ANZCA (Australian and New Zealand College of Anaesthetists) participants will be undertaken in conjunction with the project managers of the Tasmanian Audit of Surgical Mortality and the South Australian Audit of Perioperative Mortality.

**Progress:**

Anaesthetic audit forms are in the process of being revised and updated nationally. As other jurisdictions commence participation in the review of anaesthesia-related surgical mortality report, changes may be made to the final version.

## 4. BACKGROUND

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The ACTASM is the ACT regional component of the ANZASM, a nation-wide independent peer-review audit that seeks to identify deficiencies of care leading to surgical mortality. It identifies system or process errors and trends in deficiency of care, and helps develop strategies to reduce deaths in the surgical arena, both locally and across Australia. The process involves self-reporting by surgeons and peer review by first- and second-line assessors.

The ACTASM is managed by RACS, with funding and support provided by ACT Health. The ACTASM Management Committee meets quarterly and oversees the project. The project has been gazetted as a Quality Assurance activity under the Commonwealth Qualified Privilege Scheme under Part VC of the Health Insurance Act 1973 (gazetted 23 August 2011). This was updated in 2013 to include ANZCA Fellows, and an application for renewal was accepted in July 2016.

Participation in the ANZASM is a mandatory requirement that forms part of the RACS's CPD Program. Participating surgeons and assessors gain points in category one of the continuing professional development program 'Clinical governance and evaluation of patient care'.

## 5. AUDIT PROCESS

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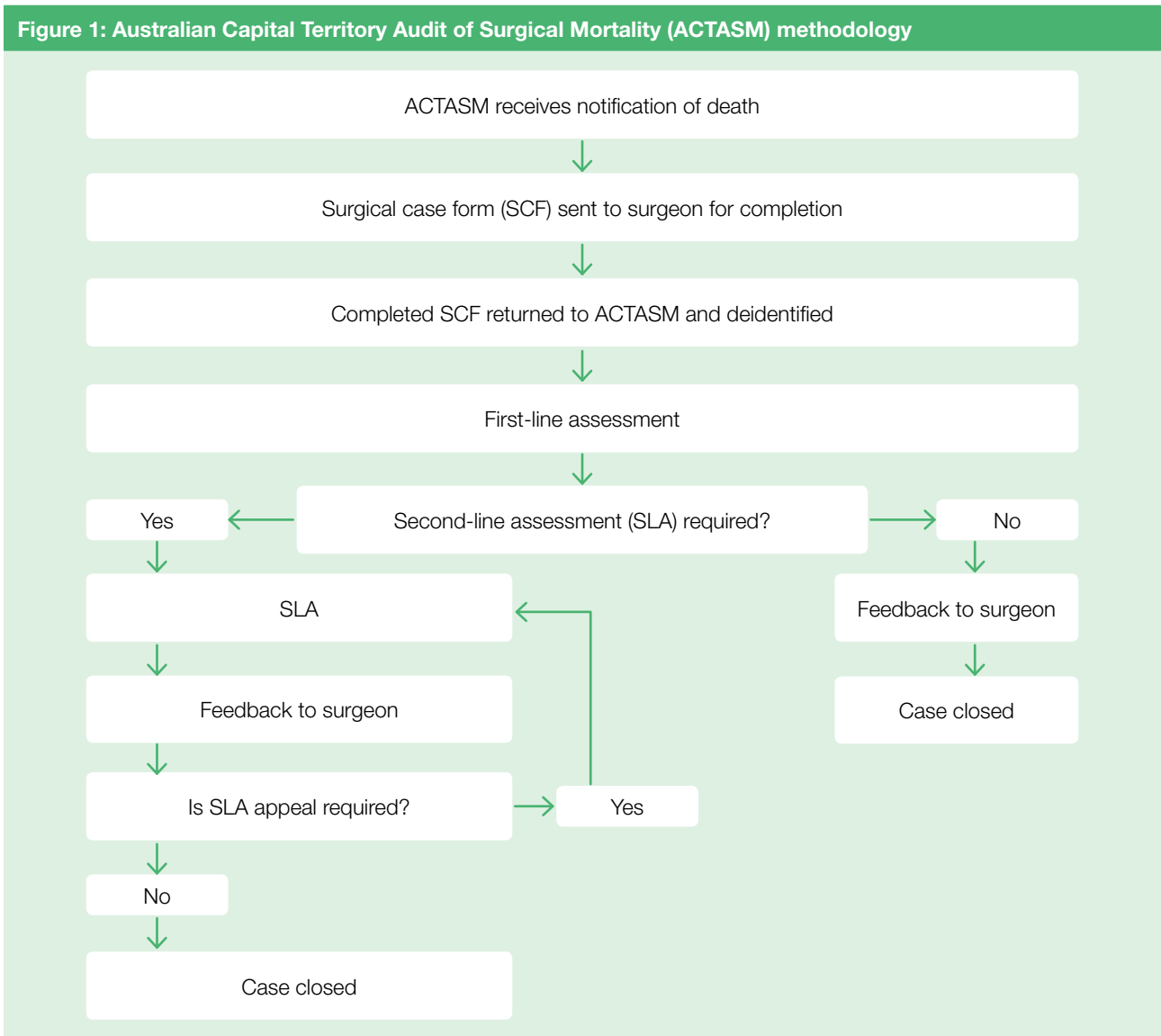
The ACTASM audits public and private hospital deaths that occurred during an episode of surgical care, whether or not the patient underwent a surgical procedure. This can include cases where a surgeon was involved in the management of a patient admitted by another team, or cases transferred to the surgeon's care during the admission. Note any missing data have been excluded from the analysis meaning there may be a change in the denominator in data presented in this report.

The process is outlined below:

1. The ACTASM is notified of a death by the medical records department of a participating hospital.
2. An SCF is sent to the consultant surgeon for completion. This provides an opportunity for self-reflection on the case.
3. The completed SCF is de-identified and sent to a different surgeon of the same specialty for peer review. This is referred to as first-line assessment. The first-line assessor may find no clinical incidents, or may find clinical incidents that do not need further assessment, and can choose to close the case at this stage. If they are unable to come to a decision based on the information available to them, the case is then referred for a case note review. This is referred to as second-line assessment.
4. All ACT second-line assessments are sent interstate to ensure objectivity. The second-line assessor reviews the case notes, identifies any clinical incidents, and provides feedback for the surgeon. Incidents are rated in relation to seriousness, preventability and outcome (see section 5 for full explanation). The case notes and feedback are returned to the ACTASM.
5. Once the assessment is complete and any clinical issues are identified, the case is coded for territory and national reporting, and individualised feedback is provided to the surgeon.
6. The audit is intended to be educational not punitive. At all times the surgeon has the right of reply. Any feedback received is reviewed by the clinical director and, where appropriate, a surgeon may appeal the outcome of the assessment and a further second case note review may be performed.

The process is represented schematically in Figure 1.

**Figure 1: Australian Capital Territory Audit of Surgical Mortality (ACTASM) methodology**





## 6. ASSESSMENT RATING CRITERIA

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Surgeons and assessors are asked to review the case and to determine whether there were any clinical incidents where care could have been improved. These are then classified in relation to whether the death was a direct result of the disease process alone, or if aspects of management of the patient might have contributed to that outcome. If there was a perception that the clinical management may have contributed to death, the clinical incidents were reported against the following criteria.

- **Area for consideration:** the assessor believed an area of care could have been improved or different, but recognises that there may be debate about this.
- **Area of concern:** the assessor believed that an area of care should have been better.
- **Adverse event:** an unintended injury or event is caused by medical management rather than by the disease process. The injury or event is sufficiently serious to lead to prolonged hospitalisation; temporary or permanent impairment or disability of the patient at the time of discharge; or contribute to or cause death.

Once the clinical incidents have been classified the clinician is asked to give their opinion on the following.

- Was the incident preventable, under the categories:
  - definitely
  - probably
  - probably not
  - definitely not.

In this report the categories 'definitely' and 'probably' are considered preventable.

- Who the incident was associated with, categorising this information as:
  - audited surgical team
  - another clinical team
  - hospital
  - other.
- The impact of the incident on the outcome, that is, whether the event:
  - made no difference to the outcome
  - may have contributed to death
  - caused the death of a patient who would otherwise have been expected to survive.

## 7. FEEDBACK

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The ACTASM provides feedback in a variety of different ways, as outlined below.

- Surgeons receive written feedback from first- and second-line assessors (de-identified) on their ACTASM cases.
- Clinical governance reports are provided annually to hospitals with more than five cases reported for that period. These reports indicate the number of cases received and reviewed, and specific clinical management issues relevant to that hospital.
- Feedback seminars are now held in all regional areas. The ACTASM held its first feedback seminar in 2015, *Closing the Audit Loop*, on topics identified by the audit as relevant to the region. Local seminars will now be an annual event, with the next scheduled for 5 November 2016.
- The free ANZASM app is available from the Apple Store and Google Play and includes information on selected published cases from the case note review booklets around Australia. It has been upgraded in 2015 to include information about future events, such as seminars, as well as a video library of previous events.
- All ANZASM regional seminars will now be recorded as webinars, broadening the accessibility of these events for Fellows, other clinical staff, and quality departments within hospitals and area health departments. The webinars will be available via the ANZASM app.
- Annual local and national reports are available to the surgical community on the ACTASM website at [www.surgeons.org/actasm](http://www.surgeons.org/actasm).
- Local and national case note review booklets are provided to all Fellows within the ACT, and are available on the ACTASM website at [www.surgeons.org/actasm](http://www.surgeons.org/actasm).
- The ACTASM has contributed de-identified data for publication in national and international journals. These include a 4-year retrospective analysis published in 2016, which demonstrated a 15.4% reduction in perioperative mortality rates following the introduction of the audits<sup>(2)</sup>.

## 8. AUDIT PARTICIPATION

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All public and private hospitals in the ACT participate in ACTASM. In the period 1 January 2015 to 31 December 2015 there were three hospitals that reported deaths. The other participating hospitals had no notifications during the audit period.

Participation in ACTASM by consultant surgeons in the ACT is 100% (81/81). In the period 1 January 2015 to 31 December 2015, 75% of surgeons also participated as assessors.

Participation in ACTASM by ACT Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Fellows is 67% (18/27). In the period 1 January 2015 to 31 December 2015, 48% (13/27) of the participating Fellows also acted as assessors. Participation is not mandatory for RANZCOG Fellows.

Participation by ANZCA Fellows is 43% (29/67). In the period 1 January 2015 to 31 December 2015, 34% (23/67) of the participating Fellows also acted as assessors. Participation is not mandatory for ANZCA Fellows.

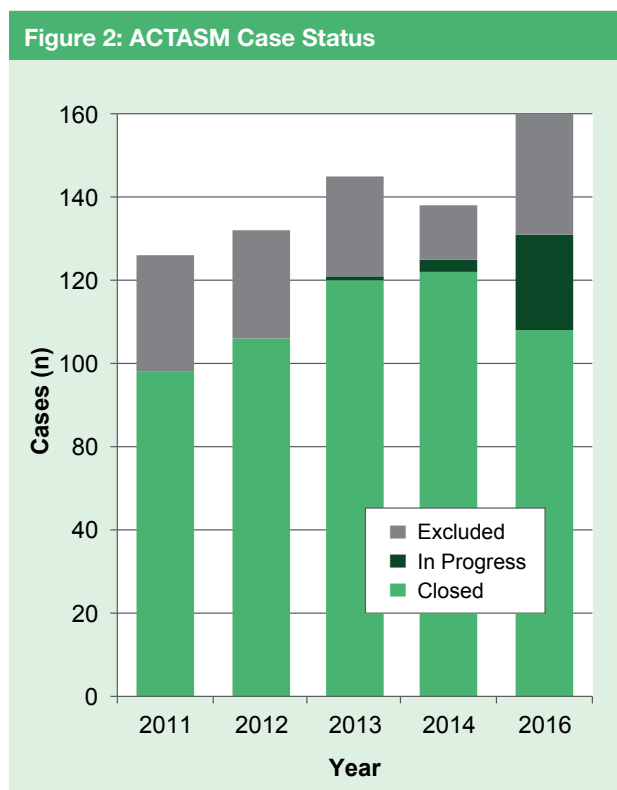
## 9. ACTIVITY

This report covers the period 1 January 2015 to 31 December 2015, with census date being 2 May 2016. During that period 140 cases were reported to ACTASM from three hospitals. This is a 26% increase from 2014. This may be due to increased reporting from two hospitals that have previously had low reporting numbers, or it may be due to the inadvertent reporting of cases which do not fit the audit criteria. The ACTASM case status is shown in Figure 2. Of the 140 cases:

- 63% (88) of cases completed the full audit process and were closed prior to census date. These are the cases that form the basis of the analyses in this report.
- 16% (23) of cases were still in progress at the census date. Some cases take longer to progress through the process due to the nature of the audit. Delays can include cases awaiting coroner's reports or second-line assessments currently undergoing review.
- 21% (29) of cases were excluded. This is a significant increase from previous years, with only 11% excluded in 2014. This may be related to the increased number of cases reported which did not fit the inclusion criteria leading to a higher than usual exclusion rate. The ACTASM is investigating the reasons for the increased number of excluded cases, and reviewing excluded cases for the appropriateness of that decision.

As shown in Figure 2, the number of cases reported to the ACTASM has been increasing over the 5-year period.

In 2015, 17% (15/88) of cases were sent for second-line assessment. This is an increase on previous years, as 10% (9/88) of cases underwent second-line assessment in both 2013 and 2014. This increase may be due to assessors becoming more familiar with the process, and interested in obtaining more in depth feedback on cases, or in some cases it may be due to inadequate completion of the SCF.



## 10. PATIENT PROFILE

Of the 88 patients whose case had completed the audit process:

- 61% (54) were male, with an average age of 69 years (range, 16-93).
- 39% (34) were female, with an average age of 74 years (range, 26-93).

Risk status:

- 77% (68/88) of patients had at least one comorbidity, with 50% (44/88) having three or more.
- 64% (51/80) of patients had an American Society of Anesthesiologists (ASA) grade of 4 or more, indicating the presence of severe systemic disease.
- Assessors considered the patient's risk of death prior to any surgery to be considerable or expected in 61% (43/71) of cases. Note: this analysis only includes patients who had surgery.

## 11. HOSPITAL CARE

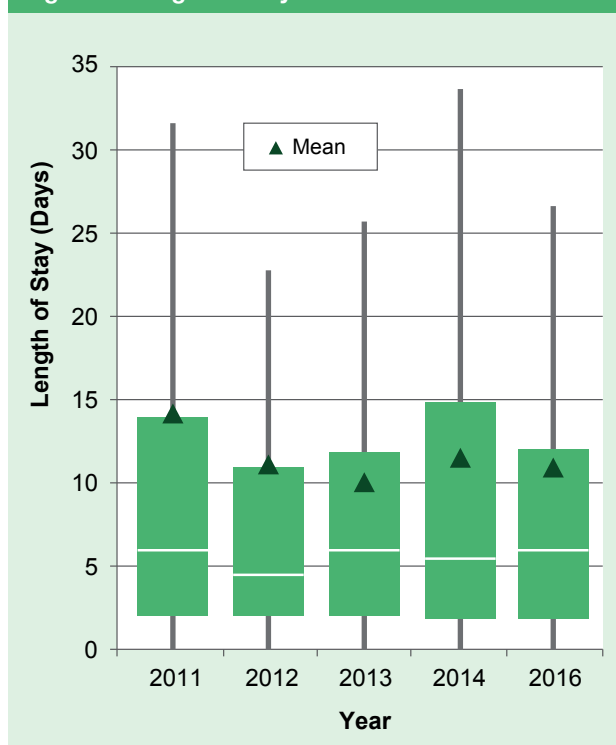
### 11.1 Hospital Admission

In terms of hospital admission cases:

- 93% (76/82; no information provided for 6 cases) were admitted as public patients.
- 90% (78/87; no information provided for 1 case) of patients were admitted as emergencies.

The average length of stay was 13 days, with a median of 6 days. (see Figure 3).

Figure 3: Length of stay



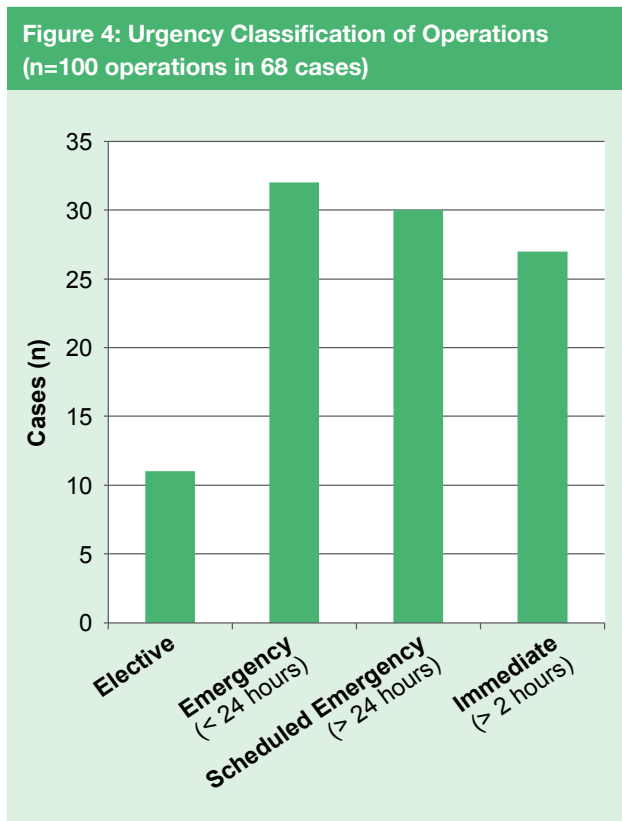
Note: excludes extreme values



## 11.2 Operations

For operations:

- 77% (68/88) of patients had at least one operation. A total of 100 operations were performed.
- 23% (20/88) of patients had more than one operation. The highest number of operations performed on an individual patient was 10.



The consultant completing the SCF was asked to record the seniority of the surgeon who made the clinical decision to operate as well as the seniority of the surgeon who performed the surgery.

- Consultants operated in 67% (67/100) of all operations and 75% (24/32) of second and subsequent operations.
- For each surgical episode there may have been more than one grade of surgeon operating. In this reporting period, Fellows operated in 18% (18/100) of operations; Surgical Education and Training Trainees operated in 23% (23/100) of operations; registrars operated in 3% (3/100) of operations. An International Medical Graduate operated in 1% (1/100) of operations.

Issues:

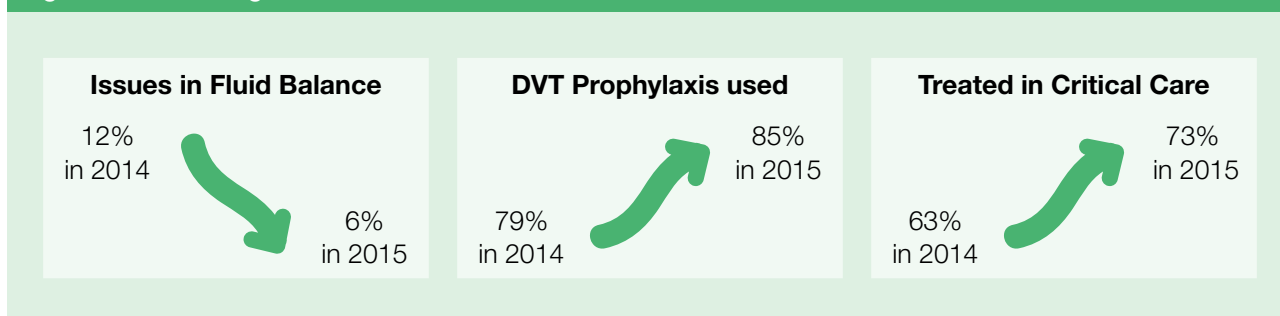
- There was an unplanned return to theatre in 19% (17/88) of cases.
- The operation was abandoned due to finding a terminal situation in 4% (4/100) of operations.
- Surgeons identified that there was an anaesthetic component to the patient's death in 3% (2/68) of operative cases, and that there was possibly an anaesthetic component in 4% (3/68) of operative cases. Since February 2014, all cases in which the surgeon identifies an anaesthetic component are sent for an anaesthetic review.

### 11.3 Risk Management

The treating surgeon was asked to record whether deep vein thrombosis (DVT) prophylaxis was given, and also whether or not a patient received critical care support in an intensive care or high dependency unit before or after surgery. In the ACT:

- 85% (73/86) of patients received some form of DVT prophylaxis. Of the 13 cases involving patients that did not, surgeons indicated that DVT prophylaxis was not appropriate in 10 cases, and in 2 cases it was an active decision to withhold. For the remaining case, no information was provided.
- 72% (63/88) of patients were treated in a critical care unit, an increase from 63% in 2014.
- In 1% (1/88) of cases the assessor considered that the patient would have benefitted from care in either an intensive care unit or high dependency unit. In 3% (3/88) of cases the assessor considered that the patient would have benefitted from care in a high dependency unit.
- Surgeons considered fluid balance to have been an issue in 6% (5/88) of cases, which decreased from 12% in 2014 (see Figure 5).

Figure 5: Risk management issues



### 11.4 Inter-hospital transfers

The treating surgeon was asked to record any issues associated with the transfer of a patient between hospitals. In the ACT:

- 40% (34/84) of patients were transferred during their admission.
- Surgeons indicated that in 4% (3/84) of cases there was a delay in transfer. In 2% (2/84) of cases the surgeon indicated that the transfer was not appropriate (2/84), and in 4% (3/84) of cases there was insufficient information provided by the transferring hospital.

## 12. OUTCOMES

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### 12.1 Infections

In 2012, the ANZASM started collecting data on infection in patients undergoing surgery. The ANZASM and the ACTASM are keen to monitor trends in infection, primarily to ensure that strategies are implemented to prevent and minimise infections contracted both prior to and during surgery. In the ACT:

- 32% (28/88) of patients died with a clinically significant infection. This is a decrease from 35% in 2014.
- 8% (7/88) of infections were acquired before admission while 24% (21/88) were acquired during the admission. Patients who acquired an infection during their admission had a mean age of 76 years, 5 years older than that of the total audited group (71 years).
- Surgeons indicated that the types of infections were pneumonia (18%; 16/88), intra-abdominal sepsis (8%; 7/88), septicaemia (5%; 4/88) and another source (1%; 1/88).
- In cases where there was a clinically significant infection, surgeons considered the antibiotic regime to be appropriate in 89% (25/28) of cases. The appropriateness was unknown in two cases and for the remaining case no response was provided. It is possible the surgeon may have answered 'unknown' for cases in which the organism had not yet been identified.
- The average length of stay for patients with infections was 28 days, compared with 13 days for the total audited group.

### 12.2 Complications

The treating surgeon was asked to record any complications that occurred following a surgical procedure. In the ACT:

- Complications occurred in 20% (18/88) of cases. A total of 23 complications were recorded for the 18 cases with complications.
- Of the 23 identified complications, respiratory- or pneumonia-related issues and cardiac issues were reported most commonly, at 8% (7/88) and 6% (5/88) cases respectively.

### 12.3 Causes of Death

The cause of death recorded by the treating surgeon is based on the clinical course of the patient and any relevant supporting evidence from investigations. Where doubt exists around the circumstances leading to death, the case may be referred to the coroner. In other instances, where the cause of death is not clear, a postmortem examination may be requested. In the ACT:

- 106 causes of death were reported in 88 patients, with surgeons reporting more than one cause of death in 15 patients.
- The most commonly reported causes were neurological causes (22%; 23/106), respiratory/pneumonia (16%; 17/106), multiple organ failure (15%; 16/106), cardiac causes (9%; 10/106) and sepsis (6%; 6/106).

## 13. CLINICAL MANAGEMENT ISSUES

Assessors are asked to identify whether there were any areas for consideration, *areas of concern* or *adverse events* in the management of the patient. It is important to note that these are issues in management, which may or may not have affected the patient's outcome.

Assessors identified 22 clinical management issues in 20% (18/88) of cases. Clinical management issues have remained static, with 20% of cases in 2014 also identified as having clinical management issues.

Ten of the clinical management issues were identified as areas of consideration.

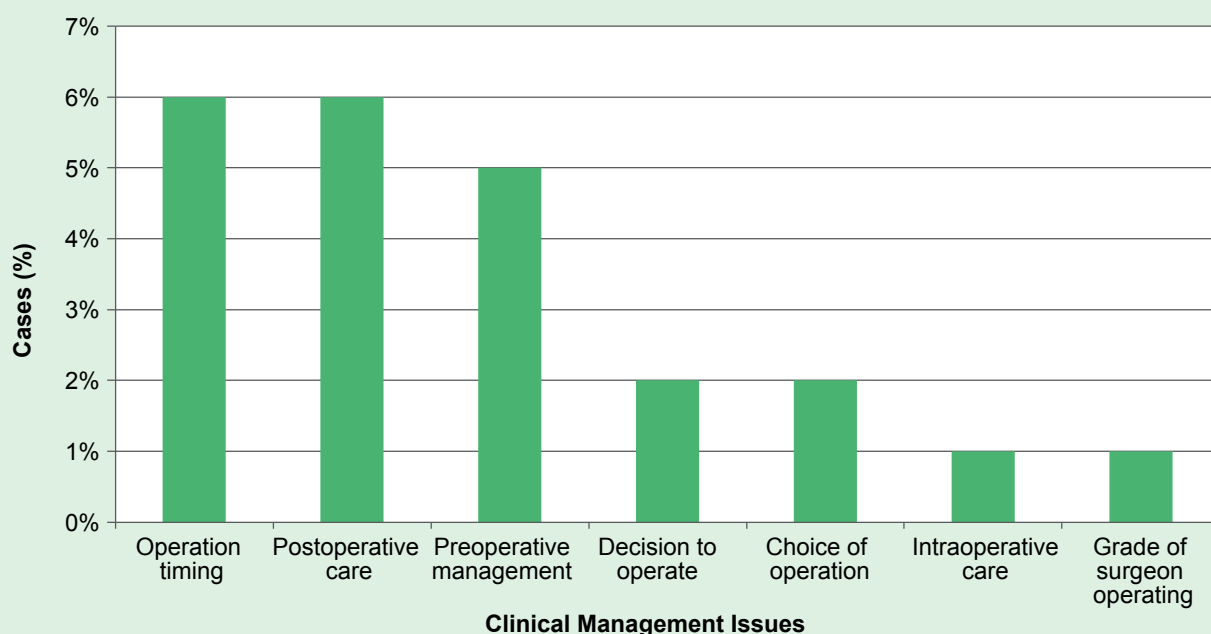
Clinical management issues that were considered an area of concern or adverse event were identified in 10% of cases (9/88). This number is comparable to the 2014 national figure of 12%.<sup>(3)</sup>

In terms of preventability:

- 1% (1/88) of issues were considered definitely preventable, while 3% (3/88) were considered probably preventable.
- The three issues identified by assessors as probably preventable were all related to the underlying disease process and the management of complex cases.
- 3% (3/88) were associated with the audited surgical team, 1% (1/88) with another clinical team, and 5% (5/88) with other issues, such as the underlying disease process.

All surgeons received individualised feedback on their cases. System-wide feedback is incorporated in the clinical governance reporting.

Figure 6: Areas identified by assessors for management improvement (n=88)





As shown in Figure 6, the areas of care most frequently identified by assessors as requiring improvement were operation timing, 6% (5/88); postoperative care, 6% (5/88); and preoperative management, 5% (4/88). Overall, the assessors were happy with the grade of surgeon operating and the intraoperative care received by patients, with only one case where the assessor indicated there could have been an improvement in these areas (1%; 1/88).

One of the most positive aspects of the audit is that it provides the opportunity for surgeon self-reflection and review. In cases in which the registrars provided the majority of care, the surgeon can review the case themselves, or delegate the completion of the form to the registrar before reviewing the form together prior to submission. The ACTASM has found that in 14% (12/88) of cases the surgeon would change some aspect of patient care if presented with the same situation again. The insights generated by this process will inform and improve future patient care.

## 14. FINAL SUMMARY

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This is the fifth full year of reporting for the ACTASM, and the project is now well embedded in the ACT. Increased numbers of reported cases, has led to enabling ACTASM to provide a clearer territory-wide picture of surgical deaths, and increased levels of individualised feedback to surgeons and facilities who may not otherwise have been included.

This year, one of the priority areas for the audit has been providing more usable and better targeted information. While it is essential to ensure that Qualified Privilege is maintained at all times, feedback in a variety of formats has now been made available, from individual surgeon reports to hospital specific clinical governance reports. Efforts at improving feedback to stakeholders are ongoing.

A move to 100% utilisation of online forms will be the key focus for the next 12 months. Online completion of SCFs greatly reduces the time taken on inputting and coding forms, as well as reducing transcription errors. The system upgrades to the Fellows Interface have been implemented and tested, and a targeted promotion of the use of Fellows Interface will occur during the course of 2016.

## 15. ACKNOWLEDGMENTS

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- all second-line assessors
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- the RACS Division of Research, Audit & Academic Surgery staff, particularly:

Professor Guy Maddern	Chair, ANZASM Steering Committee
A/Professor Wendy Babidge	Director, Research, Audit & Academic Surgery Division (RAAS)
Mr Gordon Guy	ANZASM Manager
Ms Veronica Walker	Project Manager, ACTASM
Ursula Hendricks, Anje Scarfe and Tamsin Garrod	RAAS Editorial review team

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A/Professor Deborah Browne	ACT Government, Health Directorate Representative

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