PRIVATE
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VICTORIAN AUDIT OF SURGICAL MORTALITY

FIRST-LINE ASSESSMENT FORM

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Victorian Audit of Surgical Mortality (VASM)

Guidelines for First-Line Assessment

Introduction

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

Stage 1: First-Line Assessment

A First-Line Assessment is conducted for all surgical cases.

Information on the enclosed Surgical Case Form is the only material available for review in this case in the First-Line Assessment process.

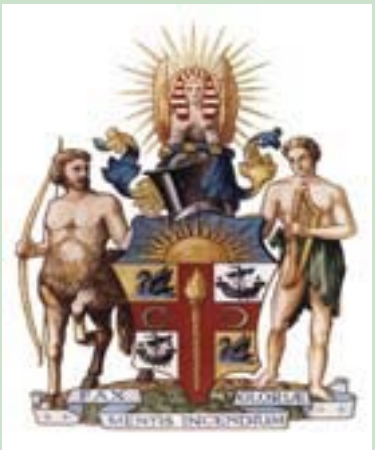
First-Line Assessment is conducted with the intent of making one of two possible findings:

1) Case closed. Death was a direct result of the disease processes involved and no issues of patient management are perceived.
2) A first-line assessor indicates an area of consideration, concern or adverse event occurred but second-line assessment is not necessary.
3) A second-line assessment (case note review) is required either because the information provided by the treating surgeon on the surgical case form was inadequate to reach any conclusion or it is perceived that there may have been significant problems with the surgical case. A case note review would better elucidate any issues.

Completion Instructions

* To maintain subject confidentiality, never write any patient or consultant identifying information on a First 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.



ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

22958

Study Number

Office Use

First Line Surgical Assessor's Form

1 **Was there enough information to come to a conclusion?** ☐ Yes ☐ No

If **NO**, what information was lacking?

2 **Should this case progress for case note review?** ☐ Yes ☐ No

If **YES**, which aspects of the case should be looked at in more detail?

3 **If NO OPERATION was performed:**

Should an operation have been performed? ☐ Yes ☐ No ☐ N/A

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?** ☐ Yes *(go to **Q6**)* ☐ No *(continue)*

Should this patient have been provided critical care in:

Intensive Care Unit (ICU) ☐ Yes ☐ No

High Dependency Unit (HDU) ☐ Yes ☐ No

6 **Was the decision on the use of DVT prophylaxis appropriate?** ☐ Yes ☐ No ☐ Don't know

7 **Was fluid balance an issue in this case?** ☐ Yes ☐ No ☐ Don't know

GUIDELINES FOR COMPLETION OF VASM FIRST LINE ASSESSMENT FORM

Thank you for participating in Victorian Audit of Surgical Mortality. The 'First-Line Assessment' (FLA) form is a standard format used across all Australian states.

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 confidential and cannot be released.

Please note:

- **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 (N/A) or 'Don't know' options where appropriate.
- When using abbreviations use standard abbreviations.
- Questions that require a text response should be concise and legible.

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.

8 **Do you consider management could have been improved in the following areas?**

	Yes	No	N/A		Yes	No	N/A
Pre-operative management/preparation	☐	☐	☐	Intra-operative/technical management of surgery	☐	☐	☐
Decision to operate at all	☐	☐	☐	Grade/experience of surgeon deciding	☐	☐	☐
Choice of operation	☐	☐	☐	Grade/experience of surgeon operating	☐	☐	☐
Timing of operation *(too late, too soon, wrong time of day)*	☐	☐	☐	Post-operative care	☐	☐	☐

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.

9a **Were there any areas for CONSIDERATION, CONCERN or ADVERSE EVENTS in the management of this patient?** ☐ Yes *(describe below)* ☐ No

9b ***Important:*** *please describe the 3 most significant events and list any other events*

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

Area of: ☐ Consideration ☐ Concern ☐ Adverse Event

Which: ☐ Made no difference to outcome ☐ May have contributed to death ☐ Caused death of patient who would otherwise be expected to survive

Was it preventable? ☐ Definitely ☐ Probably ☐ Probably not ☐ Definitely not

Associated with? ☐ Audited surgical team ☐ Another clinical team ☐ Hospital ☐ Other *(specify)*

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

Area of: ☐ Consideration ☐ Concern ☐ Adverse Event

Which: ☐ Made no difference to outcome ☐ May have contributed to death ☐ Caused death of patient who would otherwise be expected to survive

Was it preventable? ☐ Definitely ☐ Probably ☐ Probably not ☐ Definitely not

Associated with? ☐ Audited surgical team ☐ Another clinical team ☐ Hospital ☐ Other *(specify)*

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

Area of: ☐ Consideration ☐ Concern ☐ Adverse Event

Which: ☐ Made no difference to outcome ☐ May have contributed to death ☐ Caused death of patient who would otherwise be expected to survive

Was it preventable? ☐ Definitely ☐ Probably ☐ Probably not ☐ Definitely not

Associated with? ☐ Audited surgical team ☐ Another clinical team ☐ Hospital ☐ Other *(specify)*

VSCC Case Classific

Preventability of Outcome
In the view of the First line assessment, 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.

Additional Comments/Feedback:

VASM audit process