COLLABORATING HOSPITALS' AUDIT OF SURGICAL MORTALITY IN NEW SOUTH WALES

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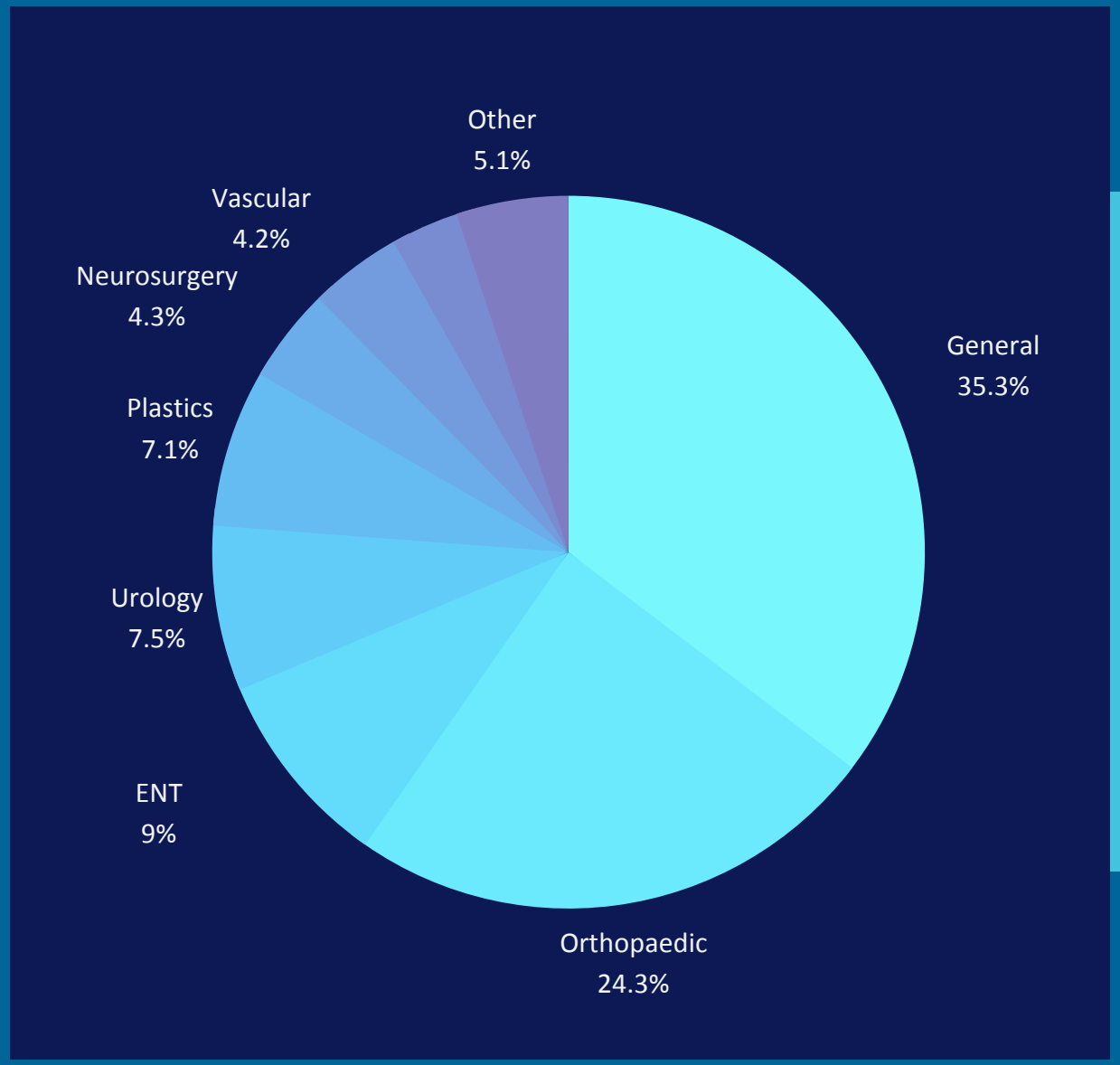
Chairman CHASM
Surgical Oncology Synergy, October 2019



STATE SNAPSHOT
REGISTERED SURGEONS

AHPRA reported the total number of registered surgeons as 1,907 in March 2019.

New South Wales has 674 General Surgeons and 464 Orthopaedic Surgeons.

50 new Admissions to Fellowship

New South Wales

First intake for 2019.

NEUROSURGERY, PLASTIC & RECONSTRUCTIVE AND VASCULAR

Respectively: 2; 3 and; 4 new Surgical Fellows.

UROLOGY

6 new Surgical Fellows.

OTOLARYNGOLOGY

7 new Surgical Fellows.

ORTHOPAEDIC

8 new Surgical Fellows.

GENERAL SURGERY

20 new Surgical Fellows.

Jurisdiction over Private Hospitals

Private Health Facilities Regulation 2017 – Section 18

Private Health Facilities Act 2007 – Section 45(d)

Disclosure of information (acquired by members of an RCA team)

A person who is or was a member of a **root cause analysis** team may make a record of or divulge or communicate, to any of the following committees in connection with any research or investigation the committee is authorised to conduct under section 23 (1) of the Health Administration Act 1982:

(a) the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

(b) the Collaborating Hospitals' Audit of Surgical Mortality Committee (CHASM)

A person who is or was a member of a root cause analysis team must not make a record of, or divulge or communicate to any person, any information acquired by the person as such a member, except: (d) in accordance with the regulations.

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Constituted criteria for CHASM

Health Administration Act 1982 – Section 20(4)

The CHASM Committee is to review deaths that occur:

- within 30 days after an operation or
- during the last hospital admission under the care of a surgeon, irrespective of whether an operation has been performed or not

The Committee's function is to review deaths associated with surgical care, identifying potentially preventable factors associated with these cases, and to provide confidential feedback to the surgeons involved in the case. Further, it is to contribute surgical expertise to the review of clinical incidents involving surgical care and make recommendations for system improvement.

CHASM Terms of Reference

Reporting and Feedback for effective, timely care

To provide information on, or relevant to, the outcome of reviews:

- **Through feedback to individual surgeons involved in the care of the deceased patient**
- **Through provision of reports of de-identified aggregate data**
  - **To Public Health Organisations and Private Health Facilities to assist in improving effective and timely care**
  - **To the Royal Australasian College of Surgeons for the purpose of maintenance of standards (including benchmarking) and education**

Collaborative Opportunities

As a Statutory Health Corporation, the Clinical Excellence Commission is considered a Public Health Organisation. This means the sharing of CHASM specially privileged information as de-identified aggregated data is permitted for the purpose of improving patient safety and timely patient care.

However, the utmost care is taken to ensure the preservation of anonymity of the specially privileged information collected as part of the CHASM Program. As such, it may be necessary to obtain approval from the Secretary, NSW Health or the Minister for Health before dissemination or publication.

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Questions that influence care

CHASM Surgical Case Form (SCF)

Question 8a and 8b identify aspects of communication, access and decision making that may influence outcomes.

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 and then go to Q9)

- 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 management of this patient? Yes ☐ (go to Q9) No ☐ (specify reasons below)

Specify.....

Question 16 centres on post-operative complications and feeds into the collection of data at a national level It also highlights the issue of whether there was a delay in recognising a Hospital Acquired Complication/s.

16 Was there a definable **post-operative** complication? Yes ☐ No ☐ *If NO*, go to Q17

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

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

Was there a **delay in recognising** post-operative complications? Yes ☐ No ☐

Question 21a and 21 b feed into the national data collection for Hospital Acquired Infections.

20

- Was there an **unplanned return** to theatre? Yes ☐ No ☐ Unknown ☐
- Was there an **unplanned admission** to a critical care unit? Yes ☐ No ☐ Unknown ☐
- Was there an **unplanned readmission** within 30 days of surgery? Yes ☐ No ☐ Unknown ☐
- Was **fluid balance** an issue in this case? Yes ☐ No ☐ Unknown ☐
- Would it be beneficial for this case to undergo Root Cause Analysis Yes ☐ No ☐ Unknown ☐
- Was fatigue an issue in this case? Yes ☐ No ☐ Unknown ☐
- Was there an issue with **communication** at any stage? Yes ☐ No ☐ Unknown ☐

If there was an issue with communication, please provide details: .....

21a Did this patient die with a **clinically-significant infection**? Yes ☐ (continue) No ☐ (go to Q23)

Did infection contribute to or cause death? Yes ☐ No ☐

Was this infection acquired: before this admission ☐ (go to Q21b) or during this admission ☐ (continue)

If acquired **during** this admission, was the infection: acquired pre-operatively ☐ or a surgical-site infection ☐ or acquired post-operatively ☐ or other invasive-site infection ☐

21b Was the **infection**: Pneumonia ☐ Intra-abdominal sepsis ☐ Septicaemia ☐ Other source ☐

Was the infective organism identified? Yes ☐ No ☐ (go to Q23)

If ***YES***, *what was the organism?*.....

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

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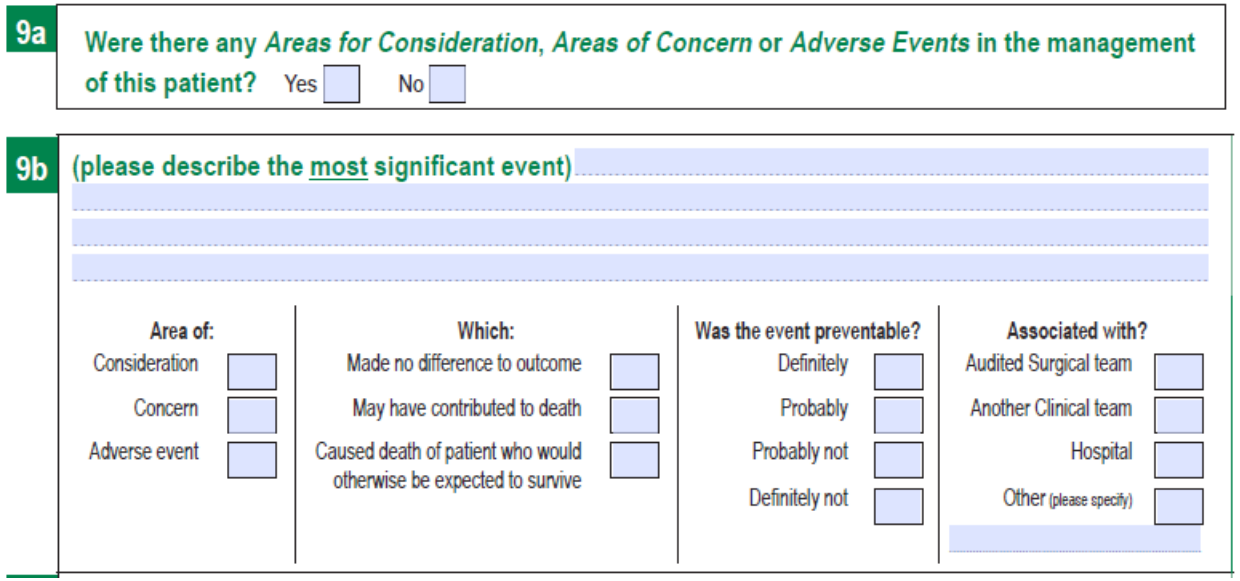
First Line Assessment (FLA)

Determining if the nature of the adverse event is clear

Following the submission of the Surgical Case Form, the information is reviewed for identifiable factors and coded.

An independent assessor is selected from the database who is required to determine if there are ACONs or whether:

- significant errors are thought to have been made in the management of the patient
- a case note review could usefully draw attention to lessons to be learned for the clinicians involved in the case
- there has been an unexpected death (eg in theatre, elective surgery for benign disease, day case surgery, young patients)



9a Were there any *Areas for Consideration*, *Areas of Concern* or *Adverse Events* in the management of this patient? Yes ☐ No ☐

9b (please describe the most significant event)

Area of:		Which:		Was the event preventable?		Associated with?	
Consideration	☐	Made no difference to outcome	☐	Definitely	☐	Audited Surgical team	☐
Concern	☐	May have contributed to death	☐	Probably	☐	Another Clinical team	☐
Adverse event	☐	Caused death of patient who would otherwise be expected to survive	☐	Probably not	☐	Hospital	☐
				Definitely not	☐	Other (please specify)	☐

Definitions: 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.

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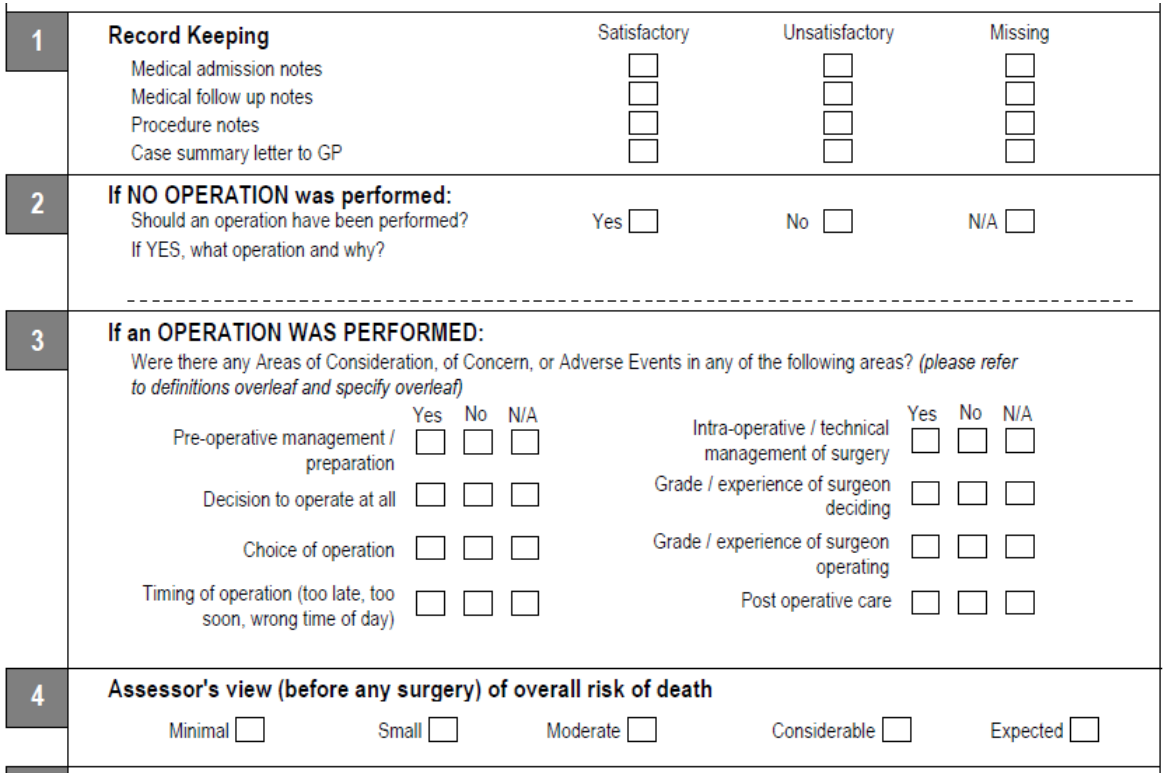
Second Line Assessment (SLA)

Independent Medical Case Note Review

It is recommended that Second Line Assessors attempt to review these key areas in their assessment of the case:

- Appropriate and timely diagnostic and therapeutic measures
- Correct indication and timing of
  - Operations
  - Interventions
  - Intensive care
  - Resuscitation orders
  - Palliative care treatment orders
- Consideration and adherence to guidelines
- Monitoring of the treatment process
- Effective interdisciplinary co-operation
- Accurate documentation of patient management and patient records
- Correct assessment of working diagnosis and treatment effects



1 Record Keeping

	Satisfactory	Unsatisfactory	Missing
Medical admission notes	☐	☐	☐
Medical follow up notes	☐	☐	☐
Procedure notes	☐	☐	☐
Case summary letter to GP	☐	☐	☐

2 If NO OPERATION was performed:

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

If YES, what operation and why?

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3 If an OPERATION WAS PERFORMED:

Were there any Areas of Consideration, of Concern, or Adverse Events in any of the following areas? *(please refer to definitions overleaf and specify overleaf)*

	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	☐	☐	☐

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

Minimal ☐ Small ☐ Moderate ☐ Considerable ☐ Expected ☐

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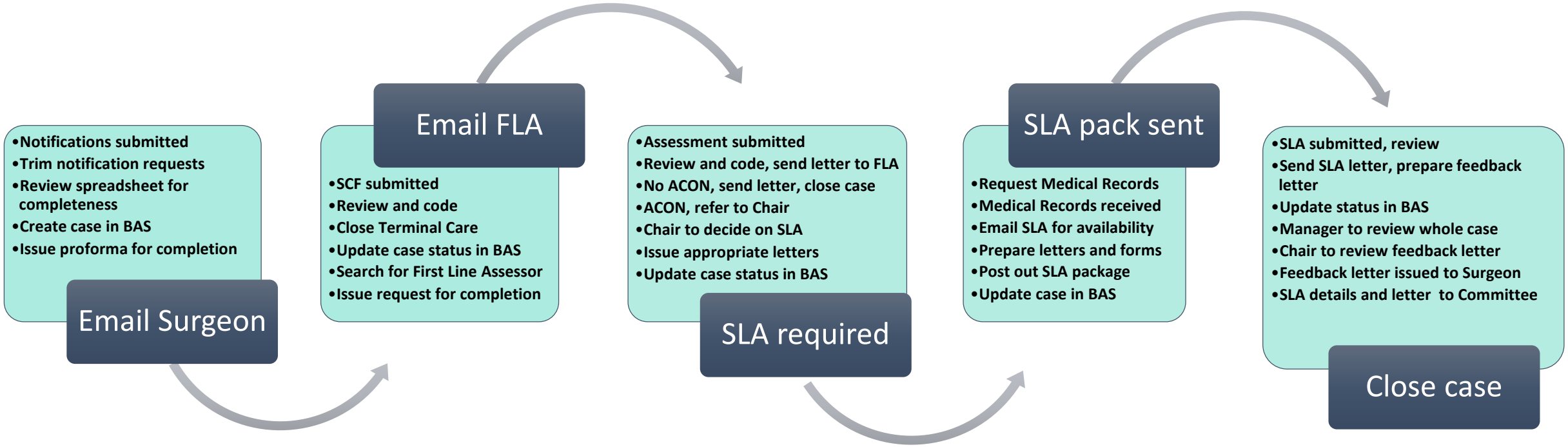
Audit Workflow

Business process for CHASM

CHASM receives almost 2,500 notifications per year with approximately 2,250 sent out to surgeons requesting the completion of surgical case form. The current return rate from surgeons is almost 70%



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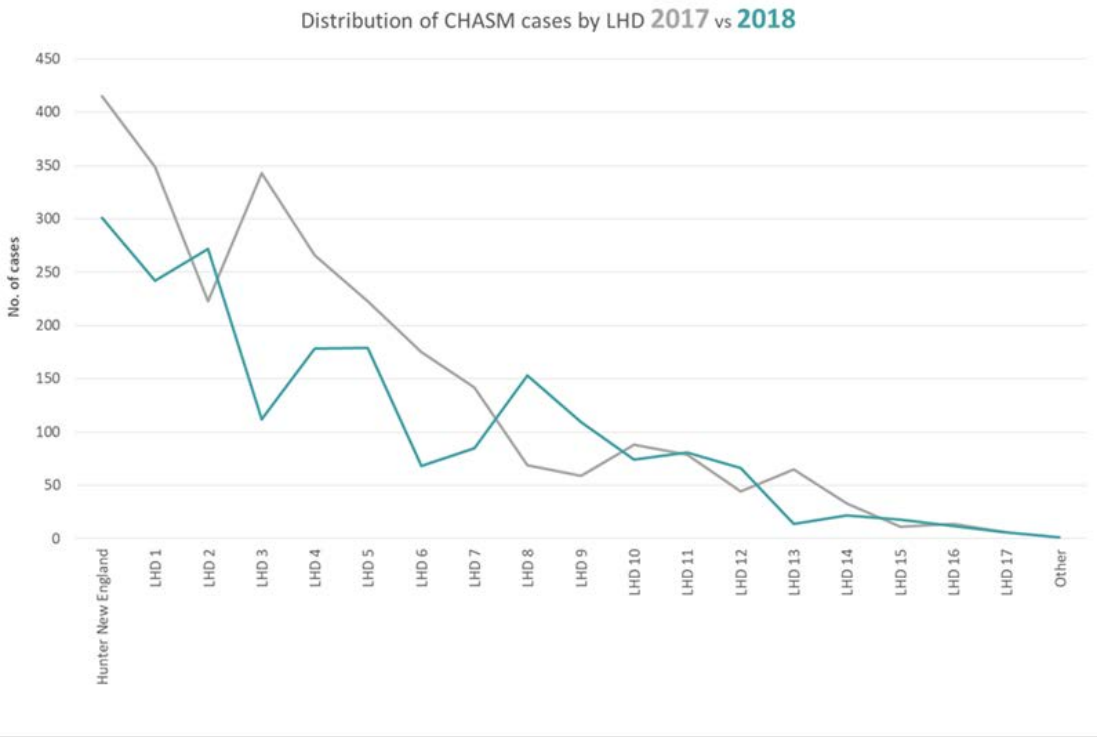
CHASM Notifications and Assessments

Distribution of cases in NSW Health



The CHASM Committee reviews approximately 150 closed second-line peer reviews each year.

Notifications are received regularly (monthly) from 15 LHDs, 2 SHNs and 6 private hospitals. There are also a number of private hospitals that report by exception.

On average, each of the 17 public entities, have 8 cases that receive an independent second line assessment (case note review) in a calendar year.

A culture of over-reporting for LHDs is encouraged by the Committee to ensure any cases without reported incidents (IIMS, RCAs) are reviewed.

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