VASM

Victorian Audit of Surgical Mortality

Royal Australasian College of Surgeons

A Guide for Victorian Hospitals

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

About the Victorian Audit of Surgical Mortality (VASM)

Aims:

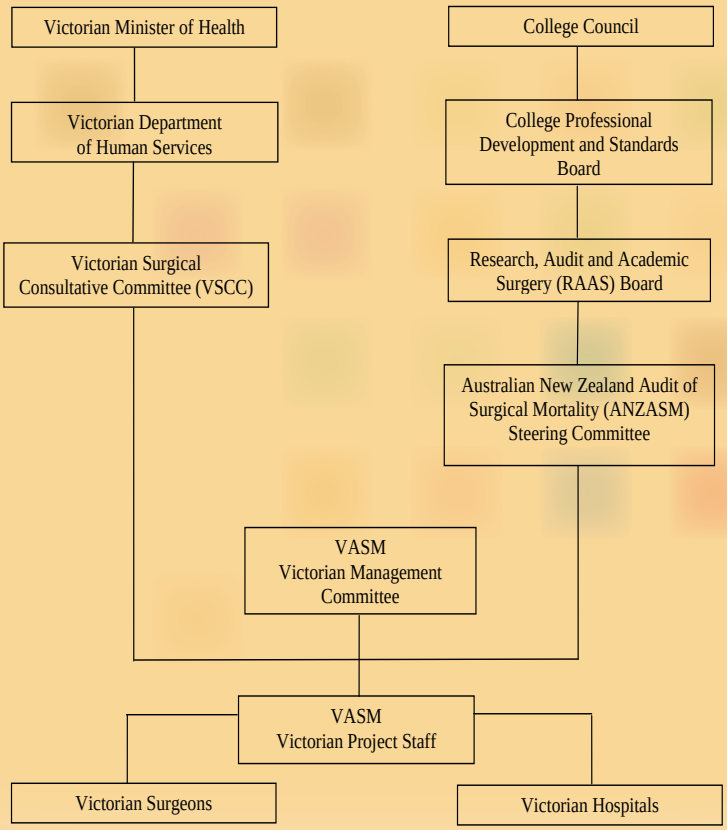
The Victorian Audit of Surgical Mortality is part of the Australian and New Zealand Audit of Surgical Mortality (ANZASM), a bi-national network of regionally-based audits of surgical mortality. It is managed by the Research, Audit and Academic Surgery (RAAS) Division of the Royal Australasian College of Surgeons and is supported and funded by state governments. The audit process is designed to highlight system and process errors. It is intended as an educational rather than a punitive exercise.

Participation in a peer-reviewed surgical audit is an annual requirement of the College's Continuing Professional Development Program. Participation in VASM provides credits towards satisfying the criteria for recertification under this program.

The College

The College is a Fellowship organisation with nine craft groups, represented by thirteen independent specialty organisations across Australia and New Zealand. It is a leading advocate for the use of audit to improve surgical practice. It fully supports and encourages the audit program to be owned by the surgeons with the understanding for the need to have partnerships with governments and other bodies. It promotes voluntary surgeon participation in a confidential and peer-reviewed audit with community participation.

Project Governance Structure



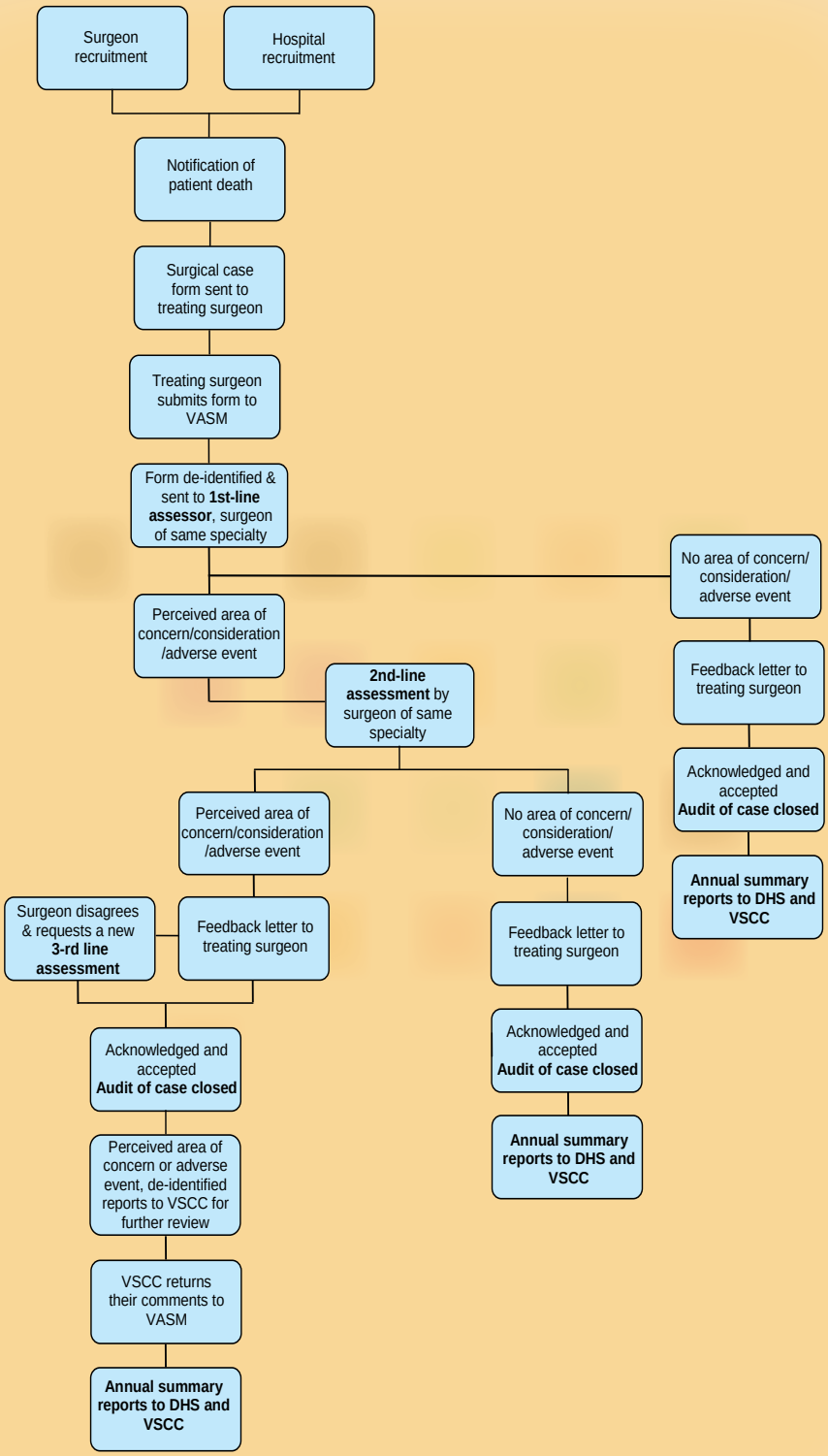
Background

In Victoria, VASM works closely with the Victorian Surgical Consultative Council (VSCC). The VSCC was established by the state government in 2001 to review causes of avoidable mortality and morbidity associated with surgery and to provide feedback to the medical profession on any systemic issues identified. The VSCC has reviewed issues associated with the Coroner's cases, "Sentinel Events" reported to the Victorian Department of Human Services (DHS) and cases voluntarily reported directly to VSCC by surgeons.

The commonality of goals has encouraged a close working relationship between VASM and the VSCC. This has led to the appointment of the Chairman of the VSCC to the management committee of VASM and the Clinical Director of VASM being co-opted to the VSCC. The VSCC has indicated it will cease reviewing reports of surgical mortality sent directly to it after 1 January 2008 and urges Fellows to direct such reports to VASM for review. This will minimise any duplication of reporting. The VASM audit staff will inform the VSCC of trends in surgical mortality and assist with the development of processes to enable the surgical community and healthcare providers to address any system issues. The VSCC will be forwarded de-identified individual reports and annual aggregated reports from VASM which summarise all cases reviewed.

VSCC will inform the surgical community about important issues arising out of the collection and analysis of mortality and morbidity data. Along with the VSCC, VASM aims to support further improvements in patient care in Victoria.

VASM Audit Process



Qualified Privilege

VASM is covered by "Qualified Privilege" under the Commonwealth Qualified Privilege Scheme and the Commonwealth Health Insurance Act (1973). It is classified as a quality assurance activity.

All Fellows are invited to participate, and participation is currently voluntary.

Deliberations of the review process are protected under the Commonwealth Qualified Privilege Scheme and the Commonwealth of Australia Health Insurance Act 1973, under the section 124X/QAA NO. 3/2006.

As a quality assurance activity, VASM protects persons involved in the activity from civil liability as well as protects identifying information from disclosure. This is in the public interest prescribed in regulation 23C to 23G of the Health Insurance Regulations 1975.

The objective of the audit is

"peer review of *all surgical deaths* including":

- all deaths that occur in hospital following a surgical procedure
- deaths that occur in hospital whilst under the care of a surgeon, even though no procedure was performed.

Where we can obtain information on deaths that occur following discharge from a hospital but within 30 days of a procedure or inpatient stay under a surgical unit, these will also be reviewed.

All deaths will be peer reviewed by at least one independent Fellow (first-line assessor), within the relevant specialty, who is unaware of the identity of the surgeon responsible for the care of the patient, the hospital at which the death occurred or the name of the deceased. There is a structured format for all reviews.

There are two possible outcomes following the "first-line assessment":

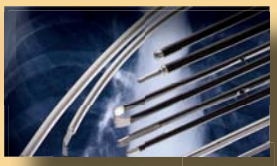
1. The information provided by the surgical team was adequate to conclude that no further review is necessary. VASM will provide this feedback to the treating surgeon.

2. A more extensive review (second-line assessment) is felt to be warranted. This would be recommended if it were felt the information provided was inadequate to reach any conclusion or there were issues of patient management that may require more detailed review of all available medical documentation such as the patient's medical case notes.

   The second-line assessment is conducted, as before, by another independent Fellow trained as an assessor. Again surgeon, hospital and deceased will be de-identified to the reviewer. Where there is perceived to be an area of consideration (see page 8) this in itself, does not require a second-line assessment.

The second line assessment has a number of defined outcomes:

- No issues of patient management were identified.
- Issues of patient management that may have contributed to the death are identified. These are classified as an "area of consideration" (where a clinician believes an area of care could have been improved but acknowledges opinions may differ), "an area of concern" (where a clinician believes an area of care should have been better) and "adverse event" (an unintended injury was caused by the medical management rather than the disease process).



These outcomes will again be fed back to the surgeon responsible for patient care. If the surgeon responsible for the care of the deceased patient is unhappy with the outcome of the second-line assessment, he or she can request another assessment to be undertaken. All second-line assessments where an area of concern or adverse event are perceived will be de-identified and forwarded to the VSCC for further review.

Through all of these mechanisms of review, the VSCC and VASM will continue the most important role of the audit, which is to inform the surgical community in this state of important issues arising out of the collection and analysis of mortality data.

VASM - Outcomes Reporting

Our qualified privilege status dictates the level of detail provided in our annual report to hospitals and to the Victorian Department of Human Services. This is also congruent with our desire for an educative process that attracts participation from a majority of surgeons. On an annual basis we will provide a report with aggregated, de-identified data on outcomes of mortality review to all collaborators. Hospitals will be advised how to identify their own figures from within these reports. Over time, trends in mortality and any systemic issues involved will become evident and be highlighted in reports. The Western Australian Audit of Surgical Mortality (WAASM) has been running since 2001 and has detected some trends and potential steps that might address these.

The audit process might occasionally detect surgeons perceived to be responsible for persistent adverse outcomes or areas of concern. The College has a responsibility to review the basis of such perceptions and decide if such a surgeon could be considered to be an "outlier." These cases will be discussed with the VASM Clinical Director.

Identification of such "outliers" to individual employers/hospitals is not possible under our current Commonwealth Qualified Privilege.

It is important to reiterate that the aim of the project is to educate and to improve patient safety and to avoid a "naming and shaming," punitive approach.

Informing VASM of Mortality

To perform audit on surgical deaths we need to know a death arising from a surgical admission has occurred. Currently, notification of mortality associated with surgery is only available to us from two sources - notification directly from surgeons (self reporting) or by regular reports on mortality supplied by health services or individual hospitals. These methods are complementary.

Notification of a death will trigger a request from VASM to the surgeon responsible for the care of the deceased, to participate in the audit by completing the structured surgical case form. Surgeon participation is entirely voluntary.

Health services and hospitals who wish to participate in VASM will need to assist in the audit process through:

- providing VASM with regular notification of all mortality that has occurred during a surgical admission in their health service or hospital. Actual data requirements are described in a separate document.
- in the case of a second-line assessment being required, making the case record of the deceased patient available to VASM, to de-identify and send to the second line assessor.

VASM

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Collaborators

State Government Victoria Department of Human Services

The Victorian Surgical Consultative Council