The Western Australian Audit of Surgical Mortality (WAASM)

2018 REPORT

Royal Australasian College of Surgeons

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

WAASM Western Australian Audit of Surgical Mortality

ANZASM Australian and New Zealand Audit of Surgical Mortality

EXECUTIVE SUMMARY

Background

The WAASM is an external, independent, peer-reviewed audit of the process of care associated with surgically-related deaths in Western Australia. The WAASM was established in 2001, is funded by the WA Department of Health and has protection under federal legislation.

Reporting Period

The data analysed for this report covers cases reported to the WAASM from **1 January 2013 to 31 December 2017**. Please note that the denominator may sometimes change in this report. This is mainly due to questions left unanswered by surgeons hence resulting in missing data.

Participation

100% Surgeons

100% Hospitals

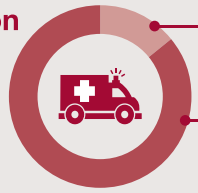
Analysis & Audit Numbers

2,884 Reported cases meeting WAASM criteria

82.1% Completed cases (2,368/2,884)

10.5% Excluded terminal care cases (303/2,884)

Admission type



14.2% Elective (346/2,435)

85.8% Emergency (2,089/2,435)

Hospital status

82.7% Public (2,006/2,427)

11.9% Private (290/2,427)

5.4% Co-location (131/2,427)

Risk Profile

Ages

Overall median age 77 (range 1 day to 103 years)

56:44

Male (1,617/2,884)

Female (1,267/2,884)

88.2% Comorbidities (2,101/2,382)

5.2% Fluid balance issues (120/2,325)

79.4% DVT prophylaxis use (1,872/2,359)

61.8% CCU use (1,471/2,380)

Patient Transfers

28.8% Patients transferred (667/2,313)

8.8% Delay in transfer (54/617)

4.5% Inappropriate transfer (28/621)

2.9% Inappropriate level of care (17/595)

5.9% Insufficient clinical information (35/589)

Operations

67.1% Patients that had surgery (1,656/2,468)

15.5% Unplanned returns to theatre (249/1,611)

5.3% Operations abandoned on finding a terminal situation (110/2,082)

87.7% Consultant Surgeons who made the decision to operate (2,011/2,293)

63.4% Consultant surgeons who performed surgery (1,454/2,293)

Infection

31.7% Patients with clinically significant infection (736/2,320)

Most common infections

40.2% Pneumonia (295/734)

25.6% Septicaemia (188/734)

19.8% Intra-abdominal sepsis (145/734)

Peer Review Outcomes

17.4% Cases with one or more clinical management issues (411/2,368)

26.9% Number of clinical management issues (636/2,368)

11.6% Adverse events (74/636)

28.3% Definitely preventable adverse events that caused death (13/46)

63.0% Adverse events that caused death (46/73)