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Abstract	The Methodology Model of the Victorian Audit of Surgical Mortality (VASM)

Objective:

The Victorian Department of Human Services has contracted with the Royal Australian College of Surgeons to provide The Victorian Audit of Surgical Mortality (VASM). The College, through VASM, works closely with the Victorian Surgical Consultative Council (VSCC) to monitor, analyse and report trends associated with potentially preventable surgical mortality. Therefore, VASM aims to review deaths that have occurred during an inpatient stay under the care of a surgeon. VASM is designed as a longitudinal educational and quality control tool to advise the surgical community and health care providers on system issues identified in trend analysis of surgical mortality. VASM is also intended as a collegial method of encouraging surgeons to participate in mortality audit.

Methods:

Hospitals participating in the audit will notify VASM of all deaths perceived to be associated with surgery. The surgeons responsible for the care of the reported patients will be contacted directly by VASM to request their (voluntary) participation in the audit process. Surgeons who agree to participate will complete the structured audit form and submit it to VASM for peer review by members of the College who have volunteered for the task. The review process is described in a separate communication to health services and surgeons.

Peer review of reported deaths is performed by surgeons in the appropriate sub-specialty who have volunteered to be first or second line assessors. These assessors will be chosen at random from a different hospital to that in which the death occurred.

Participation in the audit is voluntary. When taking part in the audit, the participants are protected under the Commonwealth Qualified Privilege Scheme. All data and reports are de-identified and securely stored in the VASM office.

The Audit Process

1. Notification of death
The VASM office receives notification of a death from a variety of sources, such as the medical records department of a hospital, the surgeon involved, the Coroner's office or relevant state health record data sources.
2. Surgical Case Form
The surgical case form is posted to the surgeon responsible for the patient's inpatient care. If the surgeon agrees to participate, he/she will complete the case proforma and return it to the VASM office.
3. First Line Assessment
All deaths are peer reviewed, this is called 'first line assessment.' A first line assessor will be chosen from the list of regional surgeons who have agreed to act in this role. The surgeon will be of the same specialty, but working at a different hospital to the surgeon responsible. The first line assessor will review the case record proforma and compile a report.

First line assessment will result in one of two recommendations:

Recommendation 1: The surgical case proforma information is complete and indicates that there were no perceived problems. After providing this feedback to the treating surgeon the case is closed.

Recommendation 2: There is deemed to be insufficient information on the surgical case proforma alone or there are perceived problems with surgical care that warrant further investigation and a patient case note review (second line assessment).

4. Second Line Assessment

A second line assessor will be chosen from the list of regional surgeons who have agreed to act in this role, from the same specialty but a different hospital. The second line assessor will compile a report based on the case record proforma, the patient's medical records and the first line assessment feedback. The report will again be fed back to the treating surgeon. If the treating surgeon disagrees with the report a further review can be requested.

5. VSCC Assessment

A referral to VSCC (Victorian Surgical Consultative Council) will be made of all de-identified reports from VASM cases that have been reviewed by first and second line assessors and classified as requiring further review by a cross-section of surgeons.

Conclusion:

VASM ought to demonstrate that it is possible to gain a large amount of reliable information via minimal intervention as a retrospective observational study with a great impact on hospital system and process errors that may affect the delivery of safe and effective surgical care.

The audit can show that such brief surveys are acceptable and feasible for a surgical consultant to complete in the limited time of "Surgeon-Patient encounters".

VASM is capable of self-regulation, promotes the highest standards of surgical practice and facilitates education and research activities. The audit assures the patients receive the highest possible standard of treatment in Victorian public hospitals.