
Surgical safety remains a priority

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While the rate of surgical deaths has remained stable, preventable patient harm has fallen, according to the latest annual Victorian Audit of Surgical Mortality (VASM).

In 2017–18, 891 clinical reviews were conducted for cases where patients died while under the care of a surgeon.

The audit findings are similar to the national figures:

- The majority of surgical deaths in this audited series occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life-threatening condition often requiring surgery
- The actual cause of death was often non-preventable and linked to their pre-existing health status in that the cause of death frequently mirrored the pre-existing illness
- From more than 703,530 surgical procedures there were 1,777 deaths reported to VASM, representing 0.25 per cent
- Elective surgeries were performed as planned and 82.4 per cent of deaths were emergency surgeries
- Unplanned return to the operating theatre increased. This was associated with an increased risk of death and was often due to a complication of the initial procedure
- There was a reduction in transfer delays to and between hospitals
- There was a reduction in clinically significant surgical infections
- There was a reduction in adverse events and areas of concern that were preventable.

Clinical Director of VASM Associate Professor Philip McCahy said “The audit monitors surgical safety, addresses process errors and identifies any significant trends in surgical care. VASM aims to focus on its educational role in disseminating ‘lessons learned’ to clinical teams and using the hospital governance reports to develop further improvements”.

“Feedback on patient management is formally directed to the treating surgeons and is also disseminated for their ongoing education through workshops, seminars, and scientific publications.”

In the VASM 2018-19 report nine key recommendations had been made that reflect the National Safety and Quality Health Service Standards to improve the quality and safety of surgical care in Victoria. Hospital performance results have been prepared for the state’s lead agency on quality and safety, Safer Care Victoria.

The report also contains clinical information on 10,132 deaths over the past six years. Of these deaths, 8,582 have gone through the full audit process. The remaining cases are still under review and will be included in next year’s annual report.

All Victorian public and private hospitals providing surgical services are part of the audit process. VASM is managed by the Royal Australasian College of Surgeons and supported by Safer Care Victoria, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Australian Orthopaedic Association.

[View the full report.](#)

About the Royal Australasian College of Surgeons (RACS). RACS is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. The College is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates. RACS also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. There are nine surgical specialties in Australasia being: Cardiothoracic surgery, General surgery, Neurosurgery, Orthopaedic surgery, Otolaryngology Head-and-Neck surgery, Paediatric surgery, Plastic and Reconstructive surgery, Urology and Vascular surgery.
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