



Surgical Case Form



ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

Important

1. Please do not destroy this form
2. Please do not copy this form
3. **Please return this form to the audit office
(in reply paid envelope provided)**

By submitting this form to the Mortality Audit, I agree that Australian and New Zealand Audit of Surgical Mortality (ANZASM) may inform the Professional Standards Department of my involvement with the surgical mortality audit, to confirm my compliance with Continuing Professional Development (CPD) requirements.

Surgical Case Form

Exclusion for terminal patients

Please complete this section for all patients

Was terminal care planned for this patient **prior** to **or on** admission?

YES

If **YES** please describe the terminal condition:

.....
.....

NO (Go to page 2 and complete ALL questions on this form)

If **YES**, was an operation performed on this terminal care patient?

YES - Go to page 2 and complete ALL questions on this form

NO (this patient is EXCLUDED from the audit; do NOT complete this form)

Return this form to the audit office.

All identifiers will be removed by the Audit office on receipt of this completed form

Study ID:
Gender:
DOB:
Admission Date:
Date of Death:
Specialty:
Hospital ID:

Patient name:
UMRN:
Hospital:
Consultant surgeon:

Name of any Surgeon(s)/Trainee(s) to whom individual feedback should be sent:

Anaesthetist(s) – please name:

Surgical Case Form

Study Number

1

Status of surgeon completing form:

- Consultant
 Fellow
 International Medical Graduate
 SET trainee
 Service Registrar
 GP surgeon
 Consultant confirms they have agreed to contents of the form } YES

Specialty of consultant surgeon in charge of patient:

- General Paediatrics
 Vascular Obstetrics and Gynaecology
 Urology Plastic
 Neurosurgery Oral/Maxillofacial
 Orthopaedics Cardiothoracic
 Otolaryngology Head and Neck Other (specify)
 Ophthalmology

2

Patient Age.....

Patient Sex: Male Female Hospital Status: Private Public Co-Located

Aboriginal/ Torres Strait Islander descent? Yes No

Admission Type: Elective Emergency Patient Status: Private Public Veteran

Patient admitted by a surgeon? Yes No

3

Main surgical diagnosis on admission (*as suspected by clinicians after initial assessment*)

.....

Confirmed main surgical diagnosis (*taking into account test results, operations, post mortem etc*)

.....

Final cause of death (*taking all information into account, including post mortem*)

.....

4

Were there significant co-existing factors increasing risk of death? Yes No (*Tick all that apply*)

- Cardiovascular Hepatic Diabetes Age
 Respiratory Neurological Obesity Advanced malignancy
 Renal Other (specify)

Surgical Case Form

5

ASA 1 - A normal healthy patient <input type="checkbox"/>	ASA 4 - A patient with an incapacitating systemic disease that is a constant threat to life <input type="checkbox"/>
ASA 2 - A patient with mild systemic disease <input type="checkbox"/>	ASA 5 - A moribund patient who is not expected to survive 24 hrs, with or without an operation <input type="checkbox"/>
ASA 3 - A patient with severe systemic disease which limits activity, but is not incapacitating <input type="checkbox"/>	ASA 6 - A brain-dead patient for organ donation <input type="checkbox"/>

6 Was the patient **transferred pre-op**? Yes No If **NO**, go to Q7

Transferred from hospital

Transferred to hospital..... Distance (km).....

Was there a delay in transfer? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was the level of care appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/>
Was the transfer appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was there sufficient clinical information? Yes <input type="checkbox"/> No <input type="checkbox"/>

7 Was there a **pre-op delay** in confirmation of main surgical diagnosis? Yes No

If **NO**, go to Q8a

Was the delay associated with: GP Medical Unit Surgical Unit Other (specify)

Was this due to: *(tick all that apply)*

Inexperience of staff <input type="checkbox"/>	Misinterpretation of results <input type="checkbox"/>	Unavoidable factors <input type="checkbox"/>
Failure to do correct test <input type="checkbox"/>	Results not seen <input type="checkbox"/>	Other (specify) <input type="checkbox"/>

.....

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 <input type="checkbox"/> (continue)	No <input type="checkbox"/> (go to Q9)
High Dependency Unit (HDU)?	Yes <input type="checkbox"/> (continue)	No <input type="checkbox"/> (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 <input type="checkbox"/>	Active decision not to refer to critical care unit <input type="checkbox"/>
Admission refused by critical care staff <input type="checkbox"/>	Not applicable <input type="checkbox"/>
No critical care unit in the hospital <input type="checkbox"/>	

8b Was the surgical team satisfied with the critical care unit management of this patient? Yes (go to Q9) No (specify reasons below)

Specify.....

.....

.....

Surgical Case Form

14

		1st Op	2nd Op	3rd Op
Was there a consultant anaesthetist present at the operation?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the operation abandoned on finding a terminal situation?	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15 Grades of surgeons making decisions, operating, assisting and present in theatre

	1st Op				2nd Op				3rd Op			
	Decide	Operate	Assist	In Theatre	Decide	Operate	Assist	In Theatre	Decide	Operate	Assist	In Theatre
Consultant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fellow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
International Medical Graduate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SET trainee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Service Registrar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP surgeon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/>	site →	Oesophageal <input type="checkbox"/>	Pancreas/biliary <input type="checkbox"/>	Colorectal <input type="checkbox"/>
		Gastric <input type="checkbox"/>	Small Bowel <input type="checkbox"/>	
Procedure related sepsis <input type="checkbox"/>		Tissue ischaemia <input type="checkbox"/>		
Significant post-op bleeding <input type="checkbox"/>		Vascular graft occlusion <input type="checkbox"/>	
Endoscopic perforation <input type="checkbox"/>		Other (specify) <input type="checkbox"/>	
			

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

17 Was there an anaesthetic component to this death? Yes No Possibly

Was death within 48 hours of last anaesthetic? Yes No Don't know

18 Was a post-mortem examination performed?

Yes – hospital Yes – coroner No Refused Unknown

Surgical Case Form

19 Was DVT prophylaxis used during this admission? Yes No

If YES (tick all that apply)

Heparin (any form)

Aspirin

TED Stockings

Warfarin

Sequential compression device

Other (specify)

If NO, state reasons: Not appropriate Active decision to withhold Not considered

and please comment on why NOT used

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

Was there an issue with **communication** at any stage? Yes No Unknown

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

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

If yes, what was the organism?

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

22 Was the **antibiotic regimen** appropriate? Yes No Unknown Not applicable

Surgical Case Form

23 Do you consider **management** could have been **improved** in the following areas?

Pre-operative management/preparation Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Decision to operate at all Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Choice of operation Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Timing of operation (<i>too late, too soon, wrong time of day</i>) Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Intra-operative/technical management of surgery Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Grade/experience of surgeon deciding Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Grade/experience of surgeon operating Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Post operative care Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
---	---

24a 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.

Were there any issues in the management of this patient? Yes (please describe below) No (please go to Q25)

24b *Important: please describe the 3 most significant events and list any other events.*

i). (please describe most significant event)

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

ii). (please describe the second most significant event)

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

iii). (please describe the third most significant event)

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

Surgical Case Form

24c

List other events.....

25

In retrospect, would you have done anything differently? Yes No

If YES, please specify.....

26

Was **trauma** involved? Yes (continue) No unknown

(a) Was the trauma the result of a **fall**?

Yes (continue)

No (go to (b))

If yes, please indicate:

fall at home

fall in a care facility

fall in hospital

unknown

other* (sport/recreation/farm/work)

specify*

.....

.....

(b) Was the trauma the result of a **road traffic accident**?

Yes (continue)

No (go to (c))

If yes, please indicate:

motor vehicle accident

motor bike accident

bicycle accident

pedestrian accident

unknown

other*

specify*

.....

.....

(c) Was the trauma the result of **violence**?

Yes (continue)

No

If yes, please indicate:

domestic violence

public violence

self-inflicted violence

unknown

other*

specify*

.....

.....

