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The Victorian Audit of Surgical Mortality: Improving surgical care

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The 2011 report of the Victorian Audit of Surgical Mortality (VASM), a quality assurance programme aimed at the ongoing improvement of surgical care, was released today.

Funded by the Victorian Department of Health and managed by the Royal Australasian College of surgeons, VASM involves the clinical review of all cases where patients have died while under the care of a surgeon. Cases notified to VASM are reviewed by at least one surgeon, practicing in the same specialty. These 'first line assessors' are unaware of the identity of the treating surgeon, the hospital in which the death occurred or the name of the patient. Where there is insufficient information for the assessor to reach a conclusion or if a more searching review of the case is felt to be necessary, a detailed case note review by another independent surgeon is done.

All but a very few Victorian hospitals providing surgical services have been recruited into the audit process. In 2010, the Royal Australasian College of Surgeons determined that participation in audits of surgical mortality should be a required component of recertification in its Continuing Professional Development (CPD) Program. As a result, 87% of Victorian Fellows are now actively participating in the audit.

In the last financial year, 277,422 patients underwent surgical procedures in Victoria. The number of deaths reported to VASM over the same period was 1,471. This indicates that only 0.5% of patients undergoing a surgical procedure have died following surgery.

The 2011 annual report contains clinical information on 4,177 deaths reported over the last four years. Of these 4,177 deaths, 2,013 have completed the audit process. The remaining cases are still under review and will be included in next year's annual report. The annual report is sent to all surgeons and hospitals, and is available to the community on the College's website.

Among the findings in the 2011 annual report:

- 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 linked to their pre-existing health status in that the cause of death frequently mirrored the pre-existing illness;
- Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved, and not the surgical treatment provided;

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- A detailed case note review, or second-line assessment, required to further elucidate details of the clinical management was only deemed necessary in 10% of audited cases. This is similar to the rate recorded in other Australian states;
- Unplanned return to the operating theatre, often necessitated by a complication of the initial procedure, is associated with increased risk of death. Consultant involvement in such complex cases is important and has increased significantly with time;
- Since the inception of VASM, there has been a significant decrease in the frequency with which assessors are identifying issues of clinical management. In 85% (1,713) of audited deaths no or only minor issues of patient care were suggested. Sixty nine per cent of these clinical management issues were attributed to the surgical team. Only 5% of these management issues were felt to have contributed to the death of the patient;
- In 6% of the 2,013 cases, the clinical management issues were serious enough to be classified as adverse events by reviewers; and
- Assessors identified more clinical management issues than the treating surgeons. This is not unexpected and underlines the value of independent peer review.

“The audit process is designed to monitor the surgical system, address process errors and identify significant trends in surgical care,” the Clinical Director of VASM, Associate Professor Colin Russell said. “The audit enables surgeons and their employing hospitals to address areas of concern and to further refine and develop practices which are proving effective.”

“This is vital to improving the quality of healthcare in Victoria, and the Victorian Government is to be commended for providing the funding for this audit. VASM will continue to work closely with the Victorian Surgical Consultative Council, which reports to the state’s Health Minister, on issues of surgical care.”

Associate Professor Russell noted the concerted effort to recruit the private health sector into the audit in the latter half of 2011. “This was very successful and we are happy to report that already some 80 % of Victoria’s private hospitals are participating in the audit.”

All criticisms of patient management have been formally directed to the treating surgeons for their consideration. This feedback is essential to the audit’s overarching purpose – the provision of ongoing education to surgeons and the improvement of surgical care. VASM, like all audits of surgical mortality conducted by the Royal Australasian College of Surgeons, demonstrates an ongoing commitment to excellence on the part of its Fellows.

**The VASM Annual Report is available on the College’s website: www.surgeons.org/VASM
Go to Research and Audit and click on Audits of Surgical Mortality (Victoria), Reports and Publications.**

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