

Having Surgery in Victoria

Australia has a good and safe healthcare system.

The Victorian Audit of Surgical Mortality (VASM) works to ensure that a high standard of surgical care is maintained in Victoria and that you, as a patient, receive the best care possible.

ABOUT VASM

Established in 2007, VASM is a program funded by the Victorian Department of Health and Human Services' (DHHS) Safer Care Victoria (SCV) branch.



The VASM program independently reviews all surgically-related deaths in Victoria and identifies areas for improvement in care delivered by Victorian surgeons and health services. The findings of the audit are used to improve the quality and safety of surgery.

The VASM program collaborates with other organisations such as;

- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists,
- The Australian Orthopaedic Association,
- The Royal Australian and New Zealand College of Ophthalmologists,
- The Royal Australasian College of Dental Surgeons, and
- Safer Care Victoria.

The VASM not only investigates the deaths of patients who had surgery; it also investigates the deaths of patients who didn't have surgery but were admitted under the care of a surgeon.

Surgeons are asked to review the surgical deaths of patients who were under the care of their fellow surgeons. They are asked to highlight any lessons that can be learnt to improve surgical care. The findings are communicated to other surgeons, non-surgical clinicians and hospitals, as well as used in educational publications and seminars.

SURGERY IS SAFE IN VICTORIA

The number of surgical deaths with identified preventable issues is continuing to drop and the number of annual surgical deaths has halved since 2007.

Most 'surgical deaths' do not occur on the operating table. Such deaths are very rare events.



The majority of surgical deaths have happened in very elderly patients, often with underlying health problems and admitted as emergency patients with life-threatening conditions. The actual cause of death was due to their pre-existing health issues, rather than the surgery itself.

Any surgery has its own level of risk

As a patient, you are entitled to be aware of the risks involved with your care. The operation should be clearly explained by your surgeon. If you do not understand the risks, it is important that you ask questions. The decision to proceed with surgery is up to you or your power of attorney.



VICTORIAN SURGICAL STATISTICS FOR 2018



Hospital Participation

All Victorian public and private hospitals participate.

In 2018, the population of Victoria was approximately 6.4 million.

There were 703,530 hospital admissions involving surgical procedures; approximately 1,777 of which resulted in surgical deaths (0.25%).



Victorian population: 6.4 million

Surgical procedures: 703,530

Auditable mortalities: 1,777

Mortality rate: 0.25%

Elective surgeries: 18%

Emergency surgeries: 82%



Male: 55%

Female: 45%

Mean age: 72

Median age: 77

MOST COMMON COMORBID FACTORS LEADING TO SURGICAL COMPLICATIONS



Cardiovascular

(e.g. heart problems, high blood pressure)



Advanced age

(due to frailty delaying recovery)



Renal

(e.g. diabetes, high blood pressure, kidney disease)



Respiratory

(e.g. asthma, pulmonary disease, smoking)



Neurological

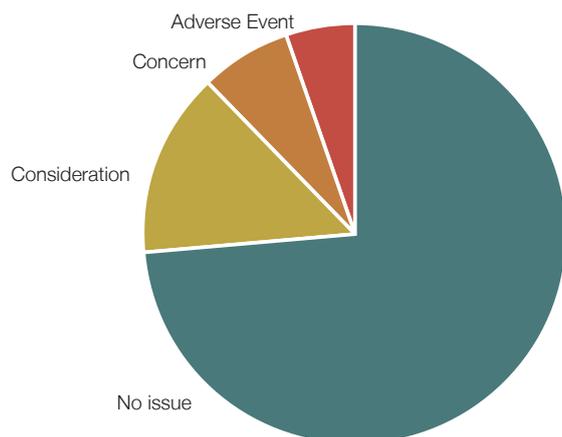
(e.g. structural or biochemical abnormalities in the brain)



Malignancy

(e.g. the presence of a malignant tumour; cancer)

AUDIT OUTCOMES



From the 1,777 surgical deaths, in 891 cases that were audited in 2018, findings showed that:

- **73.7%** (654) of cases had safe and appropriate surgical care provided,
- **14.1%** (125) of cases where alternative treatment may have been an option,
- **7.1%** (63) of cases where improvements could possibly have been made, and
- **5.1%** (45) of cases where improvements were required.

VICTORIAN AUDIT OF SURGICAL MORTALITY

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The Victorian
Surgical Consultative Council



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Excellence in Women's Health