The SAASM is an external, independent, peer-reviewed audit of the process of care associated with surgically-related deaths in South Australia.

**Participation**
- 97% Surgeons
- 100% Public Hospitals
- 100% Private Hospitals

**Analysis & Audit Numbers**
- Return of surgical case forms (1141 of 1182)
- Surgical deaths* (non-terminal care)
  - 2013: 583
  - 2014: 510
  - 2015: 495
  - 2016: 481

**Risk Profile**
- 87% of audited deaths occurred in patients admitted as emergencies with acute life threatening conditions
- 91% of patients had one or more significant coexisting illness

**Ages**
- Mean age of 80, ranged from 3 months to 101 years

**Male: Female**
- 52%:48%
73% of patients underwent a surgical procedure

18% of the surgery patients had an unplanned return to the operating theatre because of complications

72% of operations the consultant was present in theatre

32% of operative patients had postoperative complications, Most commonly: 1. postoperative bleeding 2. anastomotic leak 3. tissue ischaemia

73% of patients underwent a surgical procedure

18% of the surgery patients had an unplanned return to the operating theatre because of complications

72% of operations the consultant was present in theatre

32% of operative patients had postoperative complications, Most commonly: 1. postoperative bleeding 2. anastomotic leak 3. tissue ischaemia

The most common criticisms made by assessors:
1. decision to operate
2. delay to surgery
3. inadequate assessment and/or diagnosis

Assessment

Clinical indicators

Operations

DVT prophylaxis

Patient Transfers

Diagnosis

Critical care units

Cases referred for second line assessment (SLA)

Cases with adverse event (most serious category)

Cases with clinically significant infections

Cases with serious clinical management issues

2015 2016

2015 (36/484) 2016 (49/442)

2015 (36/484) 2016 (49/442)

40% 35%

66% of patients were admitted to a CCU

9% of the non-CCU patients would have benefited from CCU (according to assessors)

14% of transfers had issues of concern, most commonly: delays inappropriate transfers insufficient clinical information

27% of patients were transferred between hospitals

6% of cases had a delay in diagnosis

1% DVT use or non-use considered inappropriate (by assessors)

2015 2016

2015 (49/482) 2016 (30/432)

71% of clinical management issues identified by assessors were attributed (solely or partially) to the surgical team

4

26

7% 11%

2015 2016

2015 (36/484) 2016 (49/442)
Recommendations to surgeons and hospitals....

Patient care

- Surgeons should be expected to undertake comprehensive clinical assessments preoperatively, including clear documentation of risks and patient preference.
- Surgeons and other clinicians should carefully consider whether patients would benefit from admission to a critical care unit.
- The most common postoperative complication identified was ‘significant postoperative bleeding’. This requires increased vigilance in the postoperative period to ensure early detection of this complication.
- The high risk of infection among comorbid surgical patients is an ongoing issue. Adherence to protocols and guidelines for best practice is essential, e.g. the Australian Guidelines for the Prevention and Control of Infection in Healthcare.

Improved leadership and communication

- Communication failures have been identified in association with clinical handover and interhospital transfers and between junior and senior clinicians. There should be a continued focus on standardisation and systematisation of communication processes to minimise errors.
- Consultation with senior surgeons is essential when dealing with important decisions and unexpected complications.
- Surgeons are encouraged to share valuable assessor feedback and audit findings and recommendations with surgical colleagues. The findings and recommendations should be discussed at relevant meetings.

Recent and upcoming reports / activities ....

- Nov. 2016: 10th National Case Note Review Booklet from the ANZASM Theme: Clinical leadership
- May 2017: RACS Annual Scientific Congress in Adelaide
- May 2017: SAASM contribution to the Quality & Safety Section and presentation of research
- July 2017: 11th National Case Note Review Booklet from the ANZASM Theme: Trauma
- April 2018: Individual Surgeons Reports to all participating SA surgeons

Seminar: Nobody told me: Poor communication kills

THANK YOU to all participants & supporters