SURGICAL SAFETY “HOW TO ENGAGE WHOLLY” FOR SUCCESS

Evaluating the audit’s performance

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Trends in clinical quality improvement
Selected milestones in Victoria

Features:
- Clinical unit discussion of selected cases (e.g., Morbidity & Mortality review)
- Coronial investigations
- Limited or ad-hoc monitoring & analysis of clinical incidents & adverse events

Features:
- System-level data collections established
- Monitoring of patient diagnoses & procedures
- Encouragement of voluntary case reporting
- Peer-based case review by independent Councils
- Early development of clinical registries

Features:
- No-blame culture
- Clinical governance & quality systems focus
- Root cause, cluster & system data analyses
- Increased clinician reporting of incidents
- Clinician-led practice improvements to reduce variations in care

Features:
- Increased health system stewardship (oversight)
- Increased transparency, integration & sharing of information
- Investment in approaches & partnerships that lead to practice change
- More timely use of data to improve outcomes

Features:
- Real-time detection & response to clinical risks
- Team-based evaluations & system improvements
- Focus on care pathways
- Integration of services
- Monitoring & payment by patient outcomes
- Public information to promote consumer choice

Pre-existing systems
- Obst & Paed Mortality & Morbidity Council (1962)
- Victorian Anesthetic Consultative Council (1976)
- Victorian Case mix Funding commenced (1993)
- Victorian Surgical Consultative Council (2001)
- Victorian Quality Council (2001-2012)
- Victorian Audit of Surgical Mortality (2007)
- Victorian Clinical Networks Program (2007)
- Review of Hospital Safety & Quality (2016)
- Safer Care Victoria (2017)
- Vic. Agency for Health Information (2017)
- Victorian Clinical Council (2017)
- Future

1960s 1990s 2000s 2010s 2020s
OBJECTIVES OF THE 2018 REVIEW

To evaluate:

- Ongoing ‘authorising’ environment and funding arrangements
  - Alignment and integration with other jurisdictions (ANZASM)
  - Alignment and integration with the Victorian health system

- The perceived value of audit activities to stakeholders:
  - Successful systems for audit
  - Level of ongoing participation
  - Dissemination of findings to a range of stakeholders
  - Use of audit findings to promote improved outcomes for patients

- Ongoing operational arrangements (RACS, DHHS, other)
EVALUATION ACTIVITIES

1. Overview of VASM performance
2. Survey of participating surgeons
3. Discussion and options paper
4. Stakeholder consultations
5. Key findings and recommendations
6. Presentation, draft and final report
AUDIT COVERAGE & POTENTIAL INFLUENCE

Percent of mortalities captured by VASM (2013-17)

Crude rate of procedural mortality in Victoria (2013-17)

Rate of preventable events influencing outcome (2013-17)
SURGEON PERCEPTIONS OF IMPACT

Around one in three surgeons considered that the case studies published by VASM had influenced the way they document and evaluate cases in their clinical unit.

Around one in four surgeons indicated that the case studies had influenced the way they discuss patients, made decisions to operate and provide pre-operative care.

“It is very important to have systems like this in place and evolve and build on them.”

“The audit is one contributing factor, so it’s hard to prove the quantum of contribution - but it is a contributing factor in changing surgeon behaviour.”
#### Area for evaluation

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RECOMMENDATIONS

Maximise patient outcomes

Recognise partnerships

Maximise early detection & review

Improve systems of care

Maintain confidential disclosure

Expand audit objectives

Promote more timely case preparation

Identify ‘significant’ cases

Priority pathways for serious events

Peri-operative review

Ask about clinical management changes

Hospital rates of PPEs and preventable deaths calculated and reported annually (against Victorian average)

Case studies of improvements in care/outcomes resulting from ‘lessons learned’ through VASM with SCV

Victorian annual reports with SCV (incl. trend analysis of delay dx, pre-op, op, post-op & hospitals)

Reports re-structured for individual, hospital, & specialty (pending n). Tech suppl for other info

Include analysis of care pathways (detail pre-op, op & post-op care)

Ask about clinical management changes resulting from each case (team-based)

Expand audit objectives (mortality, no-blame culture, case detection, improving systems of care)

Promote more timely case preparation (incentives, remove de-identification)

Identify ‘significant’ cases (triage) and case clusters (key criteria required)

Priority pathways for serious events (SLA direct, ± peri-operative council review)

Incl. trend analysis of delay dx, pre-op, op, post-op & hospitals

Victorian annual reports with SCV (incl. trend analysis of delay dx, pre-op, op, post-op & hospitals)

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Maximise early detection & review

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Maintain confidential disclosure (enhance exchange: Vic Legislation - consider NSW, VIC, SA)

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