ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

MEDIA RELEASE

First national audit of surgical mortality released

Monday 20 December, 2010

Ongoing improvements in surgical care will be facilitated by today's release of the first National Report of the Australian and New Zealand Audit of Surgical Mortality (ANZASM). The report, based on activities and outcomes during 2009, was released by the Chair of ANZASM, Professor Guy Maddern.

"Since the inception of the first audit of surgical mortality, in Western Australia over seven years ago, there has been considerable support for a national audit," Professor Maddern said. "With audits now in place in every state and territory in Australia, this has become possible."

Each regional audit is overseen by a Clinical Director who interacts with surgeons, hospitals and the respective Department of Health to ensure that regional reports are accurate, relevant and meet local needs.

"The primary objective of the audit is peer review of all deaths Australia wide associated with surgical care, enabling us to highlight system and process errors, and trends associated with surgical mortality. It is first and foremost an initiative to improve the quality and safety of surgery," Professor Maddern said.

"The national audit has maintained a constant dataset across Australia, making it possible to provide national figures. Now that all the regions are contributing, it will result in a very large and powerful dataset. It is anticipated that there will be comparisons of trends over time, as more information becomes available."

Professor Maddern said the audit arrangements needed further refinement. "One of the important challenges remaining is incorporating all private hospitals into the audit system. This has not been embraced by all regions and certainly leaves an important segment of the care of surgical patients unrecorded. I am hoping that the involvement of the private sector in this important process will increase over time."

"The Royal Australasian College of Surgeons can be rightly proud of this important initiative, done in collaboration with the jurisdictions. Aggregated information will be made available to surgeons in order to ensure ongoing improvements in surgical care into the future.

"Surgeons' involvement in the audit process is now a requirement under the College's continuing professional development program, such is the importance we place upon it. The health departments in the States and Territories, which fund the regional audits, are to be commended for supporting this important public health initiative," Professor Maddern said.

Key findings from the report include:

Audit numbers

From 1 January to 31 December 2009 a total of 5777 deaths were reported to the regional ASMs. Of the 5777 case record forms sent to treating surgeons, 3642 (63%) had been completed and returned by the census date (1/2/2010). A total of 2347 (41%) cases had been fully assessed and thus completed the full audit (peer review) process by the census date.

Peer review outcomes

Cases may be referred for a second-line assessment if:

- areas of concern or adverse events are thought to have occurred during the clinical care of the patient that warrants further investigation
- a report could usefully draw attention to lessons to be learned, either for clinicians involved in the case or as part of a collated assessment (case note review book) for wider distribution.

Second-line assessment was requested in 8% of cases. Lack of adequate clinical information was the trigger in a quarter of these. The most common criticism made by assessors was delay in delivering definitive treatment to the patient. Half of these delays were attributed to the surgical team, however. Possible causes of delay were failure to establish and reach a diagnosis or being able to detect adverse clinical trends.

Effective and ongoing external review is fundamental to understanding and documenting any deficiencies.

Profile of operative intervention

Of the audited cases 72% of patients underwent a surgical procedure. The majority of operative procedures (69%) were performed by a consultant surgeon. This is appropriate when the risk profile of the patient is considered.

10% of operative cases had an unplanned return to the operating theatre for complications.

Recommendations

- Recruitment of all surgeons into the ANZASM audit program; and
- Recruitment of all Australian hospitals into the audit (with a view to recruiting any place that performs a surgical procedure – e.g. day surgery clinics).

ANZASM is based on regional audits of surgical mortality funded by State and Territory health departments.

A limited number of printed copies of this report will be available from local regional audit offices. Alternatively an online version can be downloaded from the College's website: www.surgeons.org

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