Victorian Surgical Consultative Council chairperson's triennial report **2015–2017**

VICTORIA State Government | Health and Human Services

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A letter from the chair

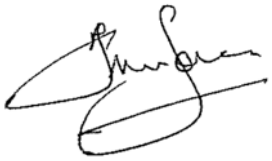
The Victorian Surgical Consultative Council ('the Council') provides advice to the Minister for Health, Safer Care Victoria (SCV), the Department of Health and Human Services ('the department'), hospital chief executives, directors of surgery and surgeons about the quality and safety of surgical practice in Victoria, informing the strategy for improving surgical care for patients. The Council also works closely with the Victorian Audit of Surgical Mortality (VASM), hosting joint seminars every year to educate and provide lessons learnt to surgical fellows and trainees. As the only collector of surgical mortality data in Victoria, the VASM provides regular progress reports to the Council on trend data and also publishes annual reports with recommendations for the sector, which the Council considers and provides feedback on prior to public release.

A new council was selected and appointed by the Minister on 1 July 2015 for a three-year term. We were fortunate to attract an excellent range of expertise including, for the first time, the appointment of two consumer representatives to the Council. All new members contribute to the functioning of the Council in a very constructive manner.

In 2015 the Minister for Health commissioned a review, led by Dr Stephen Duckett, into quality and safety of Victorian public hospitals, including the functioning of the Consultative Councils. The findings and recommendations were released in October 2016 in *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*. These have resulted in a wide-ranging reorganisation of the department to ensure a more robust management of quality and safety issues, in particular mortality and morbidity issues. Part of this reorganisation involved creating SCV and the Victorian Agency for Health Information (VAHI). SCV is the peak state authority for leading quality and safety improvement in health care in Victoria. SCV oversees and supports health services to provide safe, high-quality care and works to eliminate avoidable harm. VAHI analyses and shares information across the Victorian public healthcare system to ensure that everyone has an accurate picture of hospital and healthcare performance.

The most relevant aspect of Dr Duckett's review concerning the Council is a recommendation that it works more closely with VASM. At the time of writing this report SCV continues to work with Council, with VASM and with health services to determine how Council may best contribute to the safer and more effective provision of surgical care. Despite this uncertain time for the Council, we are continuing with new collaborations and projects, in addition to our core functions.

Finally, I would like to express my gratitude for the guidance of the Consultative Council Unit team at SCV over the current Council term. Ms Vickie Veitch continued in the role of manager and Dr Shirin Anil as the acting manager. Ms Christina Gya, Ms Hayley Hellinger and Ms Carla Donnery have been excellent project officers. Their support is greatly appreciated.



Trevor Jones
Chair, Victorian Surgical Consultative Council

Council activities in 2015–2017

Approximately 170,000 Victorians have elective surgery in the public health system each year and surgery safety outcomes in Victoria are among the best in the world. The Council aims to maintain and improve on these high standards by providing advice and recommendations on ways to continuously improve the performance of surgical services.

In its current term the Council:

- provided strategic advice to health services to improve the quality and safety of surgical services in Victoria, which included a review of sentinel events
- disseminated information to support and promote clinical and system-wide performance improvement in health services via yearly seminars and the Council's website
- considered the findings and recommendations of the Victorian Audit of Surgical Mortality (VASM).

Topics considered by the Council as being critical in patient care were:

- improved leadership in patient care
- improved communication, including documentation
- early recognition of deteriorating patients
- surgery in the elderly.

Highlights during this period included a joint presentation with VASM at the annual Medical Students' Conference on the functions of VASM and the Council. The conference discussed reporting on surgical deaths analyses and sentinel events, and defining the concept of patient-informed consent.

In 2015 it was decided that the frequency of the Council meetings would be reduced from monthly to quarterly to align with meetings of the other Consultative Councils and VASM. The Council's past meeting dates are listed below in Table 1.

Table 1: Council meeting dates 2015-2017

2015	2016	2017
27 August	25 February	23 February
26 November	26 May	25 May
	25 August	24 August
	24 November	23 November

Frequent meetings were also held with VASM throughout the current term regarding the lessons learnt through the VASM process, and the Council continued to review sentinel events submitted by the department and Safer Care Victoria.

Council collaboration with VASM

The work of the Council and VASM intersects on a number of levels.

The Council was established in 2001 to continuously improve the safety and quality of surgery. Its terms of reference are:

1. To monitor, analyse and report on key areas of potentially preventable surgical mortality and morbidity within the Victorian hospital system.
2. To liaise with other Consultative Councils on issues of common interest.
3. To improve surgical practice by publication and dissemination of relevant information and practical strategies identified during deliberations of the Council.
4. To regularly report to the Minister for Health.
5. To respond to specific matters referred to the Council by the Minister for investigation and reporting, as required. The Council is convened under the *Public Health and Wellbeing Act 2008*.

The VASM was established in 2007 to collect and report on surgical mortalities. It is managed by the Royal Australasian College of Surgeons (RACS) and funded by Safer Care Victoria (SCV).

To help this close association, the chair of the Council sits on the VASM Management Committee, and the chair of VASM is an *ex officio* member of the Council. Since the introduction of VASM, the Council no longer receives direct reports of incidents of surgical mortality. Previously, the Council reviewed and analysed reported deaths, however this function has evolved to become the responsibility of VASM, with the Council being referred particular cases to be reviewed in greater depth by its multidisciplinary panel. The Council therefore strongly encourages all surgeons in Victoria to participate in the VASM audit.

All surgery carries some risk, and deaths that occur as a result of surgery are classified as either inevitable or avoidable. The majority of these deaths are inevitable, however those that are considered avoidable deaths may have an area of consideration (where management may have been improved) or an area of concern (where the management *should* have been better) in the opinion of the assessors.

The Council provides feedback to VASM on annual report recommendations, hospital clinical governance reports and hospital summary reports. Additionally, the Council receives regular progress reports on VASM mortality data which the Council reviews and provides advice on.

Recent discussions between the Council, VASM and SCV have centred on referring second-line assessments from VASM to the Council for review purposes. The Council intends to establish a multidisciplinary case review subcommittee to accommodate these reviews. This encouraging development will be explored further in 2018.

Sentinel events

Sentinel events are unanticipated events that result in death or serious harm to a patient while in the care of a health service. These events must be reported to Safer Care Victoria by the health services. Safer Care Victoria then share those that relate to surgery with the Council for clinical comment. Between 2015 and 2017, the Council reviewed 20 de-identified sentinel events. The Council carefully considered each event, alongside a Root Cause Analysis (RCA) provided by the hospital concerned. The number and category of surgical sentinel events between 2011 and 2017 are listed in Table 2.

Table 2: Surgical sentinel events, Victoria, 2011–2017

Year	Category of surgical sentinel event	Number	Total
2011	Incorrect operations – patient/site/side	1	
	Retained materials – packs/instruments/drain tubes	6	
	Other catastrophic – bleeding/fire	2	9
2012	Incorrect operations – patient/site/side	0	
	Retained materials – packs/instruments/drain tubes	6	
	Other catastrophic – laparoscopic haemorrhage	2	8
2013	Incorrect operations – patient/site/side	0	
	Retained materials – packs/instruments/drain tubes	6	
	Other catastrophic	0	6
2014	Incorrect operations – patient/site/side	0	
	Retained materials – packs/instruments/drain tubes	2	
	Other catastrophic	0	2
2015	Incorrect operations – patient/site/side	0	
	Retained materials – packs/instruments/drain tubes	1	
	Other catastrophic	0	1
2016	Incorrect operations – patient/site/side	0	
	Retained materials – packs/instruments/drain tubes	6	
	Other catastrophic – delay in transfer to theatre/delay in recognition of cause of harm	2	8
2017	Incorrect operations – patient/site/side	0	
	Retained materials – packs/instruments/drain tubes	7	
	Other catastrophic	4	11

Themes emerging from the Council's review of sentinel events

A summary of the four main themes that emerged from the events reviewed by the Council between 2015 and 2017 is included below.

Retained objects

Retained objects are any foreign bodies left inside a patient after an operation. While retained objects in surgery are rare, they are dangerous and are an issue in all surgical specialties.

The following retained objects were reported in cases reviewed by the Council between 2015 and 2017:

- temporary aneurysm clip
- microvascular clamp
- nut from a valve replacement deployment device
- central line guide wire
- broken pin from a knee prosthesis
- surgical swab
- drain tube
- vacuum assisted closure foam
- broken tip of a surgical sheath
- wound cavity packing
- suture needle
- broken orthopaedic pin.

Council recommendation 1

Retained objects in surgery are an undesirable and entirely preventable cause of morbidity and mortality. Often retained instruments are not identified until after the surgery has been completed and further surgery is usually necessary to remove them.

The Council recommends increased vigilance amongst theatre personnel to surgical count procedures to eliminate this risk in future. More robust processes regarding surgical counts should be implemented, and an educational program that reinforces appropriate count responsibilities and behaviours should be developed. This program should be incorporated into the training of all surgical and nursing staff, similar to the hand hygiene module.

Patient re-presentation and subsequent delay in transfer to theatre

The Council reviewed a case where a fasting patient was accidentally fed and a recommended gastroscopy could not be performed. The patient was discharged with a plan to return for the procedure as an outpatient at a later date. The patient re-presented at the health service two weeks later with symptoms of pain, haematemesis, dizziness, vomiting and faecal incontinence. The patient was transferred for an urgent gastroscopy three hours later. Unfortunately, the patient died during the procedure.

Council recommendation 2

Patient treatment requires co-ordination and collaboration amongst multi-professional teams within a health service. Patients who are 'nil by mouth' need to be prepared for the period of fasting, and all health service staff should have a good understanding of current fasting guidelines. Communication between staff is essential to avoid situations where patients are inadvertently fed and good leadership is required to maintain accountability and clear lines of responsibility in cases that cross specialities.

The Council recommends that an enhanced focus on clinical management and communication, with clear planning, assessment and time allowed for complete and appropriate handover is necessary to avoid delays in treatment.

Delayed recognition of cause of harm

The Council reviewed a complex spinal surgery case where there was a delay in recognising that screws were encroaching on the patient's spinal canal. Motor function was not recovered in the patient's lower extremities following additional surgery to remove these screws.

Council recommendation 3

The timely recognition of the cause of harm is crucial in surgery. While in this particular case it was noted that alternative actions may not have changed the outcome for the patient, the monitoring in the operating theatre was considered complex, leading to a delay in identification of the concern. The health service also had no documented minimum staffing requirement for complex spinal surgery lists. The Council recommends that:

- Surgical scheduling should be performed according to the skill set available. If the skill set is not available, the surgery should be cancelled.
- The effect of theatre waiting lists on surgical decision making should be reviewed. Pressures to manage lists may affect when patients are placed on lists.
- Intraoperative CT scanning for all complex scoliosis cases should be made available.

Artery puncture

Two cases of accidental artery puncture were reviewed by the Council. The first case involved a cardiac surgery where the subclavian artery was punctured, requiring surgical repair with a removal of a portion of the patient's clavicle. The second case involved the puncture of a cerebral artery during a complex neurosurgery, caused by an accidental bump to the neurosurgeon's hand. Each surgery required emergency action to stop the patient bleeding and minimise harm.

Council recommendation 4

Both operations were noted to be extremely technical, and both arteries were successfully repaired. However, both patients experienced life changing consequences. These technical errors are often the most difficult errors to prevent as there are few systemic defence mechanisms that can prevent such injuries.

In order to respond to accidental vascular injuries the Council recommends that all surgery units performing complex operations have action plans in place.

Council seminar: 'Perioperative Care. How can we do better?'

This seminar was presented jointly by the Council, VASM, the Department of Health and Human Services and the Victorian Managed Insurance Authority (VMIA) on 18 February 2015 at the Royal Australasian College of Surgeons in East Melbourne. The aim of this seminar was to focus on improvements in perioperative care of surgical patients. The seminar was made available as a webinar to online users and fellows and other health professionals in regional Victoria and interstate. Continuing Professional Development (CPD) points were awarded to those who attended.

Seven distinguished presenters discussed themes including:

- the meaning of perioperative mortality rate
- lessons learnt from time-critical emergencies with respect to vascular surgery and general surgery
- enhanced recovery after surgery and how it has improved postoperative recovery
- lessons on safer anaesthesia, including continuation of training, peer review and CPD, improvements in organisation and systems management, and ongoing research into better, safer drugs and techniques
- models of care for orthogeriatric patients with respect to hip fractures
- achieving optimal outcomes in preoperative care in private practice.

The seminar was attended by 126 registrants from a range of disciplines including: surgeons; anaesthetists; nurses and nurse educators; clinical health professionals; quality and safety professionals; and healthcare managers and directors, which ensured a rich discussion throughout. Feedback was sought from the registrants after the seminar, which indicated 90–100 per cent satisfaction with the program overall.

Council seminar: 'Transparency, confidentiality and the public interest'

This seminar was presented jointly by the Council and Safer Care Victoria, and was held at the Royal Australasian College of Surgeons in East Melbourne on Friday 8 December 2017. The aim of this seminar was to discuss the challenges of providing transparent information in healthcare, including the balance between privacy and public health, public health surveillance systems, the consumer perspective, and qualified privilege in healthcare quality assurance activities.

Distinguished speakers included:

Professor Wendy Brown, Deputy Chair, Victorian Surgical Consultative Council

Ms Rebekah Kaberry, consumer representative, Victorian Surgical Consultative Council

Professor Sue McDonald of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Professor Guy Maddern, RP Jepson Professor of Surgery, University of Adelaide

Dr Robert Herkes, Clinical Director, Australian Commission on Safety and Quality in Health Care

Dr William Blake, Australian Medical Association Victoria

Ms Anita Rivera, National Director of Communications, Australian Health Practitioner Regulation Agency.

Topics discussed included:

- how data from clinical quality registries can be used to ensure quality improvement
- consumer expectations on how health information and data is used
- case review processes
- qualified privilege in surgery in Australia
- health IT, transparency in health professional's qualifications and credentialing, and
- balancing transparency with the need for privacy.

The seminar was attended by 60 registrants from a range of disciplines including researchers, surgeons, risk managers, healthcare consumers, medical students, data managers, customer relationship managers, policy officers and healthcare quality coordinators. Attendee feedback was overwhelmingly positive, with registrants expressing enthusiasm to attend similar events held by the Council and Safer Care Victoria in future.

Looking ahead to 2018

Mandatory reporting to VASM by RACS fellows has increased identification of in-hospital mortality and associated concerns. In-hospital morbidity data is also recognised as an important factor for improving surgical care and, in 2017, SCV and VAHI made significant progress in this area. Data is currently collected and disseminated on in-hospital sentinel events, hospital-acquired complications and unplanned readmissions for hip and knee replacements. However there remains work to be done, and the Council is committed to working with the department, VAHI and SCV on future initiatives to collect more accurate, meaningful in-hospital morbidity data to improve surgical care.

In 2018 the Council will continue to work with VASM to strengthen the surgical mortality case review process particularly around improvements in perioperative care and system improvements. The Council also looks forward to further increasing and strengthening collaboration with the Consultative Council on Paediatric and Obstetric Morbidity and Mortality and the Victorian Consultative Council on Anaesthetic Mortality and Morbidity in 2018.

Appendix 1: Council membership, 2015–2018

A/Prof. Trevor Jones, General Surgeon, Western Health (Council chair)

A/Prof. David Allen, Chief Medical Officer, Mercy Health

Dr Yeliena Baber, Forensic Pathologist, Victorian Institute of Forensic Medicine

Mr Barry Beiles, Clinical Director, Victorian Audit of Surgical Mortality

Ms Jo Bourke, Director Safety Quality and Innovation, Barwon Health

Dr Grant Brace, Anaesthetist, private practice

Prof. Wendy Brown, Alfred Health (deputy chair)

Mr Stephen Clifforth, Director of Surgery, Western District Health Service

Ms Melissa Evans, General Manager Surgical Services, St Vincent's Hospital

Ms Glenda Gorrie, Director, Stewardship and Support, Safer Care Victoria

Dr Eugene Goh, Nillumbik Medical Centre

A/Prof. Rodney Judson, Director Trauma Services, Melbourne Health

Ms Rebekah Kaberry, consumer representative

Mr Peter Mortensen, Consultant Urologist, Goulburn Valley Health

Ms Louise O'Connor, Executive Director, Epworth Eastern

A/Prof. Marinis Pirpiris, Consultant Orthopaedic Surgeon, Melbourne Health

A/Prof. Graeme Thompson, Quality and Safety Officer, Western Health

Ms Liat Watson, consumer representative