APPENDIX 8:

SURGICAL MORTALITY AND MORBIDITY CLINICAL GOVERNANCE

Perioperative morbidity and mortality

This document describes what perioperative outcomes and events that are significant for surgical audit/peer review, anaesthesia mortality and morbidity (M&M) and what information should be shared for clinical governance at the health service or state level.

The table is designed to show the types of events that should be discussed at surgical M&M (Columns 1 and 2). Significant events – and those that require multidisciplinary review and offer opportunities to improve the system – should also be reported to health service/ hospital clinical governance (Column 3). Column 4 summarises how statewide clinical governance addresses the event, what needs to be reported and to which body. For example, VASM receives all notifications of mortality under the bed card of a surgeon, sentinel events and the ensuing RCA are reported to SCV and reviewed by VPCC from a quality improvement perspective. This process of collating lessons from significant events can help improve the system of care.

VAHI monitors health service KPIs such as mortality rates for fractured neck of femur, unplanned readmission rates (joint replacements and tonsillectomy) and hospital acquired complications (unplanned return to theatre is ACSQHC HAC no 4).

Protection and confidentiality of reports

The VASM process is protected by Commonwealth QP; VPCC and its subcommittees operate under the *Public Health and Wellbeing Act 2008* (Part 4 – Consultative Councils). Case reviews undertaken by VPCC and assessments under VASM are protected.

VPCC will also continue to provide Victorian anaesthesia-related mortality data for ANZCA's triennial Safety of Anaesthesia reports. In addition, VPCC greatly appreciates reports regarding anaesthesia-related morbidity to enhance its ability to identify emerging perioperative safety issues.

Principles of mortality and morbidity conduct

- Clinician engagement for the unit/service being audited or subject of M&M.
- Peer review by colleagues not involved in the care of the patient or managing the event.
- Report other craft group/specialty/ procedural outcomes for particular procedures (e.g. visual acuity after cataract surgery) in addition to the major M&M or near miss events listed.
- Meeting minutes that include attendance and de-identified summary of peer review discussion.
- List of issues arising from audit/M&M reported to hospital/health service clinical governance.
- Documentation of actions/recommendations by whom and when.
- Follow-up plan for how any changes are to be implemented and monitoring for effectiveness.
- Reporting and two-way Information flow between health service clinical governance and M&M (avoid one way reporting as lack of feedback is unhelpful and disengaging).
- Encourage notification of significant issues/ cases/events to VPCC/SCV/VASM that are relevant to those bodies, e.g. individual mortalities to VASM, summary reports of perioperative cardiovascular events and unplanned returns to theatre to VPCC, and anaesthesia-related morbidity and mortality reports to VPCC for review by the anaesthesia subcommittee.

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EXAMPLES OF SIGNIFICANT EVENTS, THEIR INCLUSION IN SURGICAL OR ANAESTHESIA M&M, AND WHAT SHOULD BE REPORTED FOR CLINICAL GOVERNANCE INFORMATION OR REVIEW AT HEALTH SERVICE AND STATE LEVEL

EVENT	SURGICAL AUDIT/ PEER REVIEW/ M&M MEETINGS	CLINICAL GOVERNANCE IN HOSPITALS	VPCC/VASM/ SCV/VAHI STATEWIDE HEALTH SYSTEM
Deaths	Deaths following surgery or under bedcard of a surgeon during hospital admission or within 30 days	Multidisciplinary mortality case review of each death, with focused discussion on avoidable deaths and cases where care could be improved	All deaths peer reviewed by VASM, Anaesthesia related deaths reviewed by VPCC anaesthesia subcommittee; VPCC review of any cases with multidisciplinary issues
Unplanned return to theatre	Unplanned return to theatre within 30 days (whether before or after discharge and regardless of whether same hospital or not)	Aggregate report Individual review of issues raised by surgical peer review Correlated with failure to rescue rate	Aggregate report from health services of HAC no 4 following VPCC classification
Unplanned ICU stay	Unplanned ICU/ HDU admission/ readmission	Aggregate report, case reviews for issues	Awareness of process of review within health services
Significant near misses	Significant near misses	Significant near misses reported where multidisciplinary issues	Near misses can inform health system of opportunities to improve
Unplanned readmissions	Unplanned readmissions/ admissions to other health services within 30 days of discharge	Aggregate rates with interval review of causes and opportunities to reduce/correlated with LOS data	Unplanned readmission rates for specific conditions (VAHI)

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EVENT	SURGICAL AUDIT/ PEER REVIEW/ M&M MEETINGS	CLINICAL GOVERNANCE IN HOSPITALS	VPCC/VASM/ SCV/VAHI STATEWIDE HEALTH SYSTEM
Interhospital transfers for increased care	Transfers out and in requiring higher level management	Case review of transfers where events occur	VPCC will review transfers from private to public requiring surgery or ICU VASM reviews transfer as a potential issue
Other significant complications	Other significant surgical complications (Clavien-Dindo[3,4])	Morbidity reporting, including Aggregate tables for common events and specific case reviews where there are improvement opportunities to identified within recommendations	Notification of significant events to VPCC
Perioperative cardiovascular events	Perioperative cardiovascular events (MI, CVA, PE)	Aggregate annual rates, learning from individual events through case reviews/reports	VPCC developing health service reports for local review
Surgical site infection	Surgical site infection	Aggregate reports of infection rates for monitored procedures	VICNISS review
Neurological complication	Neurological complications related to procedure or positioning	Detailed case review of event	Notification to VPCC
Extended length of stay	Patients staying more than twice expected length of stay for procedure	Health service oversight of long-staying patients and rehabilitation/HITH support	Awareness of local process taking place
Sentinel events	Wrong patient, site, side Retained materials, others Other adverse events (Cat 11)	RCA	Report to SCV and VPCC will be notified