



Anaesthetic Pro Forma - 2007

2007/

Study number

Please return this form to –

Scottish Audit of Surgical Mortality

2nd Floor

Cirrus

Marchburn Drive

Abbotsinch

Paisley

PA3 2SJ

Date form received by Anaesthetist
or Anaesthetic Department

Tel: 0141 282 2280

Fax: 0141 282 2007

Email: sasm@isd.csa.scot.nhs.uk

D	D	M	M	Y	Y
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Scottish Audit of Surgical Mortality

If this form cannot be completed due to the non-availability of case notes by the 31st July 2008, please have it co-signed here by the Medical Records Officer and the Medical Director (or their deputies), and return it to the SASM office.

Medical Records Officer:

Signature:

Name: (PLEASE PRINT)

Medical Director:

Signature:

Name: (PLEASE PRINT)

WWW.SASM.ORG.UK

Supported by the Medical Royal Colleges and Surgical and Anaesthetic Associations
within Scotland

1

ALL IDENTIFIERS WILL BE REMOVED BEFORE 'FIRST LINE' ASSESSMENT

PLEASE COMPLETE THIS SECTION IN BLACK INK FOR ALL PATIENTS

Name of patient _____

Hospital _____

Hospital unit number _____

CHI number _____

Date of birth/age _____

Consultant surgeon _____

Email Address _____

Anaesthetists(s)
[Please provide name(s)] _____

Name of consultant anaesthetist responsible for care of this patient
[Please provide name] _____

Name of any additional anaesthetist(s) **particularly trainees** to whom feedback should be sent
(Feedback for trainees will be sent to the responsible consultant for forwarding to the trainee).

Feedback will be sent automatically to the above named if any areas of concern or for consideration are identified on peer review. Please tick here if you wish feedback even if no areas of concern or for consideration are identified.

2

Date of admission

D	D	M	M	Y	Y
---	---	---	---	---	---

Date of 1st operation

D	D	M	M	Y	Y
---	---	---	---	---	---

Date of last operation

D	D	M	M	Y	Y
---	---	---	---	---	---

Date of death

D	D	M	M	Y	Y
---	---	---	---	---	---

3 Status of anaesthetist completing form

Consultant 1 SpR 2 SHO 3 Associate Specialist 6 Staff grade 4
 Other (*specify*) 19 _____

 Did you anaesthetise the patient Yes 1 No 2

 If no, in what capacity are you filling in the form _____

 Has the responsible consultant anaesthetist seen this completed form Yes 1 No 2 NA 3 Unknown 9

4 Significant co-existing factors increasing risk of death (*please tick appropriate boxes*)

None 2 or

Cardiovascular	<input type="checkbox"/> 1	Respiratory	<input type="checkbox"/> 1	Renal	<input type="checkbox"/> 1
Hepatic	<input type="checkbox"/> 1	Neurological/psychiatric	<input type="checkbox"/> 1	Advanced malignancy	<input type="checkbox"/> 1
Obstructive jaundice	<input type="checkbox"/> 1	Obesity	<input type="checkbox"/> 1	Diabetes	<input type="checkbox"/> 1
Other (<i>specify</i>)	<input type="checkbox"/> 19 _____				

5 Were there any failures or omissions in pre-operative patient assessment

Yes 1 No 2

If yes, specify _____

Were there any failures or omissions in pre-operative patient preparation

Yes 1 No 2

If yes, specify _____

6 Description of most significant operation(s)

1st operation _____ (Office use only)
 Code:

2nd operation _____ (Office use only)
 Code:

Date

D	D	M	M	Y	Y
---	---	---	---	---	---

Date

D	D	M	M	Y	Y
---	---	---	---	---	---

7 ASA grades (*Please consider carefully. For definitions, see back page*)

	1st operation		2nd operation
ASA1	<input type="checkbox"/> 1		<input type="checkbox"/> 1
ASA2	<input type="checkbox"/> 1		<input type="checkbox"/> 1
ASA3	<input type="checkbox"/> 1		<input type="checkbox"/> 1
ASA4	<input type="checkbox"/> 1		<input type="checkbox"/> 1
ASA5	<input type="checkbox"/> 1		<input type="checkbox"/> 1

8 Anaesthetist's view (before surgery) of overall risk of death

Minimal 1 Small 2 Moderate 3 Considerable 4 Expected 5

9

Time into anaesthetic room (24 hour clock)

1st operation

:

2nd operation

:

Duration of anaesthetic (hours)

:

:

10 Type of anaesthetic (may be combined eg local anaesthesia + sedation)

1st operation

2nd operation

- General anaesthesia 1
- Regional anaesthesia alone 2
- General + regional anaesthesia 3
- Local anaesthesia 4
- Sedation 5

- 1
- 2
- 3
- 4
- 5

11 Anaesthetist(s) at operation

(Please ensure that the responsible consultant is named on the inside front cover of this form)

1st operation

2nd operation

- Consultant 1
- SpR 2
- SHO 3
- Associate Specialist 6
- Staff grade 4
- Other (including e.g. Specialist Trainees) 5

- 1
- 2
- 3
- 6
- 4
- 5

If the anaesthetist was not a consultant, how many years has he/she been in present grade

Was the lead anaesthetist a locum

1st operation

2nd operation

Yes 1 No 2

Yes 1 No 2

If a consultant, do you have a routine list in this specialty

Yes 1 No 2

Yes 1 No 2

If a trainee alone, was he/she appropriately trained for this level of responsibility

Yes 1 No 2

Yes 1 No 2

If a trainee alone, did he/she discuss the case with a consultant pre-operatively

Yes 1 No 2

Yes 1 No 2

12 Monitoring

Were the following monitored

1st operation

2nd operation

Yes (1) No (2)

Yes(1) No (2)

- SpO2/ECG/NIBP
- Capnograph
- Vapour analyser
- Body temperature
- Nerve stimulator
- Urine output
- CVP
- Intra-arterial pressure
- Cardiac output measurement

Specify _____

Were there any clinically significant adverse effects as a result of invasive monitoring

Yes 1 No 2

Yes 1 No 2

If yes, specify (please use back page if more space is required)

Did a lack of monitoring affect the outcome

Yes 1 No 2

Yes 1 No 2

13 Anaesthetic technique

Using tick boxes and free text please give a description of the anaesthetic, sufficient to help the assessor's review. If you wish, you may attach an anonymised version of the anaesthetic chart

	1 st operation			2 nd operation	
	Yes (1)	No (2)		Yes(1)	No (2)
Mask/LMA	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
ET tube	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Spont vent	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
IPPV	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Regional/LA	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Please give details of drugs, agents and technique used

14 Were there any problems with any of the following

Breathing system	Yes (1)	No (2)
Disconnections	<input type="checkbox"/>	<input type="checkbox"/>
Misconnections	<input type="checkbox"/>	<input type="checkbox"/>
Leaks	<input type="checkbox"/>	<input type="checkbox"/>
Administration of drugs	Yes (1)	No (2)
Overdosage	<input type="checkbox"/>	<input type="checkbox"/>
Underdosage	<input type="checkbox"/>	<input type="checkbox"/>
Wrong drug	<input type="checkbox"/>	<input type="checkbox"/>
Intubation and control of airway	Yes (1)	No (2)
Failed intubation	<input type="checkbox"/>	<input type="checkbox"/>
Oesophageal intubation	<input type="checkbox"/>	<input type="checkbox"/>
Endobronchial intubation	<input type="checkbox"/>	<input type="checkbox"/>
Accidental or premature extubation	<input type="checkbox"/>	<input type="checkbox"/>
Aspiration	<input type="checkbox"/>	<input type="checkbox"/>
Failure of equipment	Yes (1)	No (2)
Laryngoscopes	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous infusion devices	<input type="checkbox"/>	<input type="checkbox"/>
Breathing system valves	<input type="checkbox"/>	<input type="checkbox"/>
Monitoring devices	<input type="checkbox"/>	<input type="checkbox"/>

15 Untoward events

	Were there any untoward events				If so, did they influence outcome			
	1 st operation		2 nd operation		1 st operation		2 nd operation	
	Yes (1)	No (2)	Yes(1)	No (2)	Yes (1)	No (2)	Yes(1)	No (2)
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant hypoxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant hypotension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothermia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify	_____				_____			

16

Were recovery facilities adequate for this patient

1st operation
Yes 1 No 2

2nd operation
Yes 1 No 2

If no, specify _____

17

Were there any other areas of concern in the patient's care in the first 24 hours post-op

1st operation
Yes 1 No 2

2nd operation
Yes 1 No 2

If yes, specify _____

Did these areas of concern contribute to or cause death

1st operation
Yes 1 No 2

2nd operation
Yes 1 No 2

If yes, specify _____

18

Renal Failure Audit (in collaboration with the Renal Association and NCEPOD)

Black skin Yes 1 No 2 (to calculate eGFR if not available)

Lowest serum creatinine and eGFR within 6 months prior to admission, if available

serum creatinine Value Date

D	D	M	M	Y	Y
D	D	M	M	Y	Y

eGFR Value Date

D	D	M	M	Y	Y
D	D	M	M	Y	Y

Serum creatinine on admission

Value Date

D	D	M	M	Y	Y
D	D	M	M	Y	Y

Highest post-operative serum creatinine

Value Date

D	D	M	M	Y	Y
D	D	M	M	Y	Y

If serum creatinine rose significantly post-operatively, which of the following were likely to be contributory:

	Yes (1)	No (2)
Sepsis	<input type="checkbox"/>	<input type="checkbox"/>
Haemodynamic imbalance	<input type="checkbox"/>	<input type="checkbox"/>
Nephrotoxic drugs	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Specify _____		

Initiation of renal replacement therapy post surgery Yes 1 No 2

If acute renal failure occurred was this avoidable

Definitely 1 Probably 2 Possibly 3 Unavoidable 4

19

Anaesthetist's view (after surgery) of overall risk of death

Minimal 1 Small 2 Moderate 3 Considerable 4 Expected 5

20

Use of ITU/HDU resources (for definitions please see back page)

Did this patient **receive** ITU care during this admission

Yes 1 No 2

If no, did this patient need ITU care during this admission

Yes 1 No 2

Did this patient **receive** HDU care during this admission

Yes 1 No 2

If no, did this patient need HDU care during this admission

Yes 1 No 2

Was critical care available at time of need

ITU

Yes 1

No 2

Not Applicable 3

HDU

Yes 1

No 2

Not Applicable 3

If **no** why not None in hospital 1 Unit full 2 Other (specify) 3 _____

Were there any concerns in the ITU/HDU management of this patient Yes 1 No 2

Specify _____

21 **Could post-op care have been improved**

1st operation

Yes 1 No 2

2nd operation

Yes 1 No 2

If yes, specify

Please give details of any problems in the post-op period

22

Which statement best describes the *management* of this case? (for definitions please see back page)

There were no areas of concern or for consideration in the management of this patient

3

There were areas for consideration but they made no difference to the eventual outcome

4

There were areas of concern but they made no difference to the eventual outcome

5

There were areas of concern which may have contributed to this patient's death

1

There were areas of concern which CAUSED the death of this patient who would have been expected to survive

2

Please comment (Please use back page)

23

In retrospect, could anything have been done differently Yes 1 No 2

If 'Yes', please specify (Please use back page)

24

Has this case been through a local clinical governance process (e.g. Morbidity & Mortality meeting) Yes 1 No 2

If yes, what conclusions were reached and what changes will be/have been instituted

Additional comments:**Definitions:**

An **ITU** is an area to which patients are admitted for treatment of actual or impending organ failure that may require technological support (including mechanical ventilation of the lungs and/or invasive monitoring).

An **HDU** is an area for patients who require more intensive observation and/or nursing than would be expected in a general ward. Patients who require mechanical ventilation or other organ support would not be admitted to this area.

ASA grades

- ASA1** The patient has no organic, physiological, biochemical or psychiatric disturbance. The pathological process for which operation is to be performed is localised and does not entail a systemic disturbance.
- ASA2** Mild to moderate systemic disturbance caused by either the condition to be treated surgically or by other pathophysiological processes.
- ASA3** Severe systemic disturbance of disease from whatever cause, even though it may not be possible to define the degree of disability with finality.
- ASA4** Severe systemic disorders that are already life threatening, not always correctable by operation.
- ASA5** The moribund patient who has little chance of survival but is submitted to operation in desperation.

An **area of concern** is where the assessor believes that areas of care should have been better.

An **area for consideration** is where the assessor wishes to draw the clinician's attention to areas of care that he/she believes could have been improved, but recognises that it may be an area of debate.