



# Neurosurgical Pro Forma - 2010

2010/

Study number

Please return this form to –

Scottish Audit of Surgical Mortality

2nd Floor

Cirrus

Marchburn Drive

Abbotsinch

Paisley

PA3 2SJ

**ON COMPLETION OF THE SURGICAL FORM  
PLEASE FORWARD THE CASE NOTES TO THE  
ANAESTHETIC DEPARTMENT IF THIS PATIENT  
HAD AN OPERATION**

Tel: 0141 282 2280

Fax: 0141 282 2007

E-mail: NSS.isdSASM@nhs.net

For office use only:

Specialty: \_\_\_\_\_

Anaesthetic form required	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Interventional Radiology form required	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ICU form required	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Coded       Entered       Anonymised

## Scottish Audit of Surgical Mortality

If this form cannot be completed due to the non-availability of case notes by the 30th June 2011, 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](http://WWW.SASM.ORG.UK)

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

THE SMALL NUMBERS AT THE BOXES ARE FOR OFFICE USE AND SHOULD BE IGNORED  
SECTIONS 1-4 MUST BE COMPLETED

**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(s) \_\_\_\_\_

@nhs.net

Email Address \_\_\_\_\_

Responsible consultant anaesthetist (if applicable)

*(please provide name)* \_\_\_\_\_

Responsible consultant Interventional Radiologist (if applicable)

*(please provide name)* \_\_\_\_\_

Names of all consultants/trainees with whom care was shared, e.g. surgeons referring from other hospitals/physicians/Hospital At Night (HAN) team. (Those named will also receive a copy of the feedback, addressed to your hospital, unless otherwise informed).

(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.*

**FOR OPERATIVE CASES, PLEASE FORWARD THE ANAESTHETIC FORM  
(ALONG WITH THE CASE NOTES IF POSSIBLE) TO THE RELEVANT ANAESTHETIST.**

2

Male  1 Female  2 Age  years Study number

3

**Admission details**

Time of admission 08.00 - 17.00  1  
17.00 - 22.00  2  
22.00 - 08.00  3

Date of admission   
Date of death   
Date of referral to surgical team

**If elective, time from out-patient to admission**

Months  Days

Was admission Delayed Yes (1)  No (2)   
Cancelled

**Was this patient transferred from another hospital**

Yes  1 No  2 Not applicable  3

**Was this patient transferred from another clinical team in the same hospital**

Yes  1 No  2

*If yes, please provide details of consultants involved on facing sheet.*

**Type of admission to hospital**

Elective  1  
Urgent  3  
Emergency  2

4

**Main surgical diagnosis on admission**

(as suspected by clinicians after initial assessment) \_\_\_\_\_ Code: (Office use only)

**Confirmed main surgical diagnosis**

(taking into account test results, operations, PM etc) \_\_\_\_\_

**Cause of death** (taking all information into account, including PM)

I a) \_\_\_\_\_   
I b) \_\_\_\_\_   
I c) \_\_\_\_\_   
II \_\_\_\_\_

**Was death discussed with Procurator Fiscal**

Yes  1 No  2

5

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

None  2 or

Cardiovascular  1 Respiratory  1 Renal  1  
Hepatic  1 Neurological/psychiatric  1 Advanced malignancy  1  
Obstructive jaundice  1 Obesity  1 Diabetes  1  
Other (specify)  19 \_\_\_\_\_

6

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

Did this patient **receive** ICU care during this admission Yes  1 No  2

If no, did this patient need ICU 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 **ICU** 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 ICU/HDU management of this patient Yes  1 No  2

Specify \_\_\_\_\_

**7 Was an operation performed during the patient's last admission** Yes  1 No  2

**If no, why was no operation/procedure performed** (Tick as many boxes as necessary)

Patient was inappropriately placed in a surgical specialty  1 No operational / procedural option  1

**Operation/procedure possible, but:**

Rapid death  1 Patient refused surgery  1 Surgery would not have affected outcome  1

**If decision was made that surgery would not have affected outcome, was this a consultant decision** Yes  1 No  2

**Would this patient's care have been more appropriately delivered by another specialty** Yes  1 No  2

**8 GCS**

	Best pre-op/ no operation	Immediately pre-operation	Best post-operation
eye opening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
motor response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
verbal response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pupils reacting</b>			
both pupils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
one pupil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
both unreactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**9 Operation(s) carried out**

**1st Operation** \_\_\_\_\_ **2nd Operation** \_\_\_\_\_

\_\_\_\_\_

Date  (Office use only) Code:

Date  (Office use only) Code:

**10 Grade(s) of anaesthetist(s) present** (Tick as many boxes as necessary)

	1 <sup>st</sup> operation		2 <sup>nd</sup> operation	
None	<input type="checkbox"/> 9	Locum <input type="checkbox"/> 1	<input type="checkbox"/> 9	Locum <input type="checkbox"/> 1
Consultant	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Specialist trainee	<input type="checkbox"/> 7	<input type="checkbox"/> 1	<input type="checkbox"/> 7	<input type="checkbox"/> 1
Associate Specialist	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1
Staff grade	<input type="checkbox"/> 4	<input type="checkbox"/> 1	<input type="checkbox"/> 4	<input type="checkbox"/> 1
Other (specify)	<input type="checkbox"/> 19	<input type="checkbox"/> 1	<input type="checkbox"/> 19	<input type="checkbox"/> 1

**11 Grade(s) of surgeon(s) making decision, operating, assisting and immediately available**

	1 <sup>st</sup> operation				2 <sup>nd</sup> operation			
	Deciding	Operating	Assisting	Immediately Available	Deciding	Operating	Assisting	Immediately Available
Consultant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1
Specialist trainee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 7
Associate Specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 6
Staff grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 4
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 19

**Was the lead surgeon a locum consultant**

**If consultant not present :**

1) Was the consultant aware of the operation Yes  1 No  2

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

3) Was the non-consultant operator competent to perform procedure Yes  1 No  2

To be completed by consultant chairing the meeting

12

Clinical Summary of Case

13

Issues of concern discussed at meeting

1

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2

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3

14 Conclusions reached and action taken on above issues

1

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2

---

3

15

Did the patient have an interventional radiological procedure?

Yes  1

No  2

If yes, please write the name of the consultant radiologist responsible on the inside front cover of this form.

16

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

Minimal  1

Small  2

Moderate  3

Considerable  4

Expected  5

17

Was this a death within 24 hours of surgery

Yes  1

No  2

18

Hospital infection

Yes (1)

No (2)

Was this patient transferred to your care with a hospital acquired infection

Did this patient develop a hospital acquired infection after transfer to your care

Was this a surgical site infection

Was hospital acquired infection MRSA+

Was hospital acquired infection Clostridium difficile

Did infection contribute to death

Did infection cause death

19

Was a decision made to limit treatment

At outset

Yes  1

No  2

Subsequently

Yes  1

No  2

20

Was a Post Mortem performed

Yes - hospital  1

Yes - Fiscal  2

No  3

Refused  4

If yes, did the PM contribute additional information which, if known, may have changed management

Yes  1

No  2

If yes, please specify

\_\_\_\_\_

## 21 Secondary factors probably contributing to death

### Outwith NSU

	Yes (1)	No (2)
Delayed referral to or from primary hospital	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate resuscitation/inappropriate treatment prior to transfer	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate referral to NSU	<input type="checkbox"/>	<input type="checkbox"/>
Other (If yes, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

### Within NSU

Delay in evacuation of a mass lesion	<input type="checkbox"/>	<input type="checkbox"/>
Other delay in management	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate management	<input type="checkbox"/>	<input type="checkbox"/>
Post traumatic meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Other (If yes, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
SAH, re-bleed	<input type="checkbox"/>	<input type="checkbox"/>
SAH, delayed ischaemia, not operated	<input type="checkbox"/>	<input type="checkbox"/>
SAH, hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>
Other (If yes, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate grade of surgeon doing operation	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate level of supervision of operation	<input type="checkbox"/>	<input type="checkbox"/>
Non availability of ITU	<input type="checkbox"/>	<input type="checkbox"/>
Non availability of HDU	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate documentation	<input type="checkbox"/>	<input type="checkbox"/>
Inter-staff communication failure	<input type="checkbox"/>	<input type="checkbox"/>
Other (If yes, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Delay in the delivery of appropriate imaging pre-operatively	<input type="checkbox"/>	<input type="checkbox"/>
Did this delay have an impact on outcome	<input type="checkbox"/>	<input type="checkbox"/>
Delay in the delivery of appropriate imaging post-operatively	<input type="checkbox"/>	<input type="checkbox"/>
Did this delay have an impact on outcome	<input type="checkbox"/>	<input type="checkbox"/>

### Peri-operative intracranial complication:-

Infection	<input type="checkbox"/>	<input type="checkbox"/>
Operative/post-operative haematoma	<input type="checkbox"/>	<input type="checkbox"/>
Ischaemia/infarction	<input type="checkbox"/>	<input type="checkbox"/>
Other (If yes, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

### Peri-operative extracranial complication:-

Infection	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>
Other (If yes, please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other unspecified factors	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Chairman of Meeting \_\_\_\_\_