



Orthopaedic Pro Forma - 2007

Study number

2007 /

Please return this form to –

Scottish Audit of Surgical Mortality

2nd Floor

Cirrus

Marchburn Drive

Abbotsinch

Paisley

PA3 2SJ

Tel: 0141 282 2280

Fax: 0141 282 2007

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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

THE SMALL NUMBERS AT THE BOXES ARE FOR OFFICE USE AND SHOULD BE IGNORED
SECTIONS 1-7 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 _____

Email Address _____

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)

Anaesthetists(s) _____

[Please provide name(s)]

Responsible consultant anaesthetist _____

[Please provide name]

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 THE ANAESTHETIC FORM
(ALONG WITH THE CASE NOTES IF POSSIBLE) TO THE RELEVANT ANAESTHETIST.**

2

Male 1 Female 2Age yearsStudy number

3 Status of surgeon completing form

Consultant 1
 *SpR 2
 *SHO 3
 *Associate Specialist 6
 *Staff grade 4
 *Other (specify) 5

* Has the responsible Consultant Surgeon seen this completed form

Yes 1 No 2

4 Do you believe this patient was appropriately placed in orthopaedics:

On admission Yes 1 No 2
 At time of death Yes 1 No 2

5

Degree of patient's mobility:

Independently mobile 1 Walking with 2 sticks 4
 Mobile with frame 2 In a wheelchair 5
 Walking with 1 stick 3 Bedridden 6

6 Admission details

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

Type of admission

Elective 1
 Urgent 3
 Emergency 2

Admitted from

Home (independent) 1
 Home (with extensive social support) 2
 Nursing home 3
 Residential home 4
 Hospital transfer 5

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

If Hospital transfer, please provide details of consultants involved on facing sheet.

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 this death discussed with the Procurator Fiscal

Yes 1 No 2

8

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 Other (specify) 19 _____

COMPLETE THIS PAGE ONLY IF AN OPERATION/PROCEDURE WAS EITHER PERFORMED LESS THAN 30 DAYS PRIOR TO DEATH OR DURING THE PATIENT'S LAST ADMISSION

13 Description of most significant operation(s) (including relevant radiological, endoscopic or thrombolytic interventions)

1st operation _____

Date

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

 (Office use only)
Code:

Was this operation part of your area of usual practice

Yes 1 No 2

If no, were you comfortable performing this procedure

Yes 1 No 2

Complexity of operation

Minor 1
Intermediate 2
Major 3
Complex 4

Timing of operation

Elective 1
Scheduled emergency 4
Same day emergency 3
Immediate within 2 hrs 2

Type of list

Elective 1
Urgent bookable 2
Emergency theatre 3

Was this procedure delayed by your or other clinicians' elective or non-emergency activity

Yes 1 No 2

2nd operation _____

Date

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

 (Office use only)
Code:

Was this operation part of your area of usual practice

Yes 1 No 2

If no, were you comfortable performing this procedure

Yes 1 No 2

Complexity of operation

Minor 1
Intermediate 2
Major 3
Complex 4

Timing of operation

Elective 1
Scheduled emergency 4
Same day emergency 3
Immediate within 2 hrs 2

Type of list

Elective 1
Urgent bookable 2
Emergency theatre 3

Was this procedure delayed by your or other clinicians' elective or non-emergency activity

Yes 1 No 2

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

1st operation

None	<input type="checkbox"/>	9	Locum	<input type="checkbox"/>
Consultant	<input type="checkbox"/>	1		<input type="checkbox"/>
SpR	<input type="checkbox"/>	2		<input type="checkbox"/>
SHO	<input type="checkbox"/>	3		<input type="checkbox"/>
Associate Specialist	<input type="checkbox"/>	6		<input type="checkbox"/>
Staff grade	<input type="checkbox"/>	4		<input type="checkbox"/>
Other (including e.g. Specialist Trainees)	<input type="checkbox"/>	5		<input type="checkbox"/>

2nd operation

None	<input type="checkbox"/>	9	Locum	<input type="checkbox"/>
Consultant	<input type="checkbox"/>	1		<input type="checkbox"/>
SpR	<input type="checkbox"/>	2		<input type="checkbox"/>
SHO	<input type="checkbox"/>	3		<input type="checkbox"/>
Associate Specialist	<input type="checkbox"/>	6		<input type="checkbox"/>
Staff grade	<input type="checkbox"/>	4		<input type="checkbox"/>
Other (including Specialist Trainees)	<input type="checkbox"/>	5		<input type="checkbox"/>

15 Grade(s) of surgeon(s) making decision, operating, assisting and present in theatre

1st operation

	Deciding	Operating	Assisting	In theatre	
Consultant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
SpR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
SHO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Associate Specialist	<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
Other (including e.g. Specialist Trainees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5

2nd operation

	Deciding	Operating	Assisting	In theatre	
	<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"/>	2
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
	<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"/>	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5

Was the lead surgeon a locum

If consultant not present :

- 1) Was the consultant aware of the operation
- 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 suitably trained for this procedure

1st operation
Yes 1 No 2

Yes 1 No 2

Yes 1 No 2

2nd operation
Yes 1 No 2

Yes 1 No 2

Yes 1 No 2

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 Was there a definable post-operative complication

Yes 1 No 2

If yes: Surgical complications related to present admission (more than one may be ticked)

Details:	Yes (1)	No (2)		Yes (1)	No (2)
Anastomotic leak (specify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Procedure related sepsis	<input type="checkbox"/>	<input type="checkbox"/>	Tissue ischaemia	<input type="checkbox"/>	<input type="checkbox"/>
Significant post-operative bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Vascular graft occlusion	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopic perforation	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

Medical complications significantly affecting outcome (more than one may be ticked)

Details:	Yes (1)	No (2)		Yes (1)	No (2)
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>
			Cardiac failure	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
			Pulmonary sepsis	<input type="checkbox"/>	<input type="checkbox"/>
DVT	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>
Renal failure	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatic failure	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____		

Was there a delay in recognising complications

Yes 1 No 2

19 Hospital infection

Yes (1) No (2)

Was this patient transferred to your care with a hospital acquired infection	<input type="checkbox"/>	<input type="checkbox"/>
Did this patient develop a hospital acquired infection after transfer to your care	<input type="checkbox"/>	<input type="checkbox"/>
Was this a surgical site infection	<input type="checkbox"/>	<input type="checkbox"/>
Was hospital acquired infection MRSA+	<input type="checkbox"/>	<input type="checkbox"/>
Was hospital acquired infection Clostridium Difficile	<input type="checkbox"/>	<input type="checkbox"/>
Did infection contribute to or cause death	<input type="checkbox"/>	<input type="checkbox"/>

20 Fluid balance

Were there any problems with fluid management Yes 1 No 2

If yes, what impact did these problems have:

No impact 1

Contributed to death 2

Caused death 3

Did these problems originate in the first 24 hours post-operatively Yes 1 No 2

Could fluid balance have been better managed Yes 1 No 2

21 Was a decision made to limit treatment

At outset Yes 1 No 2 Subsequently Yes 1 No 2

22 Palliative/terminal care (for definitions please see back page)

Did this patient have **general** palliative/terminal care needs Yes 1 No 2
 If so, in your view were these needs met Yes 1 No 2
 Did this patient receive **specialist** palliative/terminal care needs Yes 1 No 2
 If so, in your view were these needs met Yes 1 No 2
 Was the advice of a specialist palliative care professional/team sought for this patient Yes 1 No 2
 In your view, was palliative care provided in the optimal location for this patient Yes 1 No 2
If not, what in your view would have been the optimal location _____
 Was this patient **admitted** for palliative care Yes 1 No 2

23 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 _____

24

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)

25 Were there any areas of concern or for consideration in any of the following areas?

	Yes (1)	No (2)	Not applicable (3)
Care of the non-operative patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grade/experience of surgeon deciding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decision to operate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-operative management/ preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choice of operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timing of operation (too soon, too late, wrong time of day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intra-operative/technical management of surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grade/experience of surgeon operating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grade/experience of anaesthetic staff involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-operative care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication/continuity of care (including transfer between teams)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital At Night (HAN) team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment (Please use back page)

26

In retrospect, would you have done anything differently Yes 1 No 2

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

27

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

Four horizontal lines for text entry.

28

Date anaesthetic form passed to Anaesthetist

DDMMYY date input boxes

29

Additional comments:

30

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.

Palliative care aims to control physical symptoms (e.g. pain, breathlessness) and to address psychological, social and spiritual issues in patients whose disease, whether malignant or non-malignant, is not responsive to curative treatment. For most patients, general palliative care can be provided by their usual health professionals in any care setting. Where more complex needs are identified, specialist palliative care advice/referral may be sought.

Terminal care is an admission which is not specifically for palliative care, but the disease was not responsive to curative treatment.

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.

Many thanks for your help