



Paediatric 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 No

Interventional Radiology form required Yes No

ICU form required Yes No

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

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 1-6 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) _____

Email Address _____ @nhs.net

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 Months Days Study number 2010/

3 Status of surgeon completing form
 Consultant 1 *Specialist trainee 7 *Associate Specialist 6
 *Staff grade 4 *Other (specify) 19
 * Has the responsible Consultant Surgeon seen this completed form Yes 1 No 2 NA 3

4a Specialty - Consultant in charge (more than one may be ticked)
 General C11 Vascular C12 Urology CB Thoracic C42 ENT C5
 Ophthal. C7 Paediatrics CA Gynaecology F2 Plastic C9 Maxillo-facial C13
 Spinal C81 Gynae.oncology F21 Other (specify) C99

4b Specialty - Case (more than one may be ticked)
 General C11 Vascular C12 Urology CB Thoracic C42 ENT C5
 Ophthal. C7 Paediatrics CA Gynaecology F2 Plastic C9 Maxillo-facial C13
 Spinal C81 Gynae.oncology F21 Other (specify) C99

5 Admission details Type of admission to hospital Was this patient transferred from another hospital
 Time of admission 08.00 - 17.00 1 Elective 1 Yes 1 No 2 OR
 17.00 - 22.00 2 Urgent 3 Was this patient transferred from another clinical
 22.00 - 08.00 3 Emergency 2 team in the same hospital
 Date of hospital admission Yes 1 No 2
 Date of death If yes, please provide details of consultants involved on
 Date of referral to this surgical team facing sheet.
 Was this a death within 24 hours of surgery
 Yes 1 No 2 NA 3

6 Main surgical diagnosis on admission Code: (Office use only)
 (as suspected by clinicians after initial assessment)
 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

7 Was a malignancy present, even if not the main diagnosis Yes 1 No 2
 If yes, was it Primary only 1 With nodal metastases 2 With distant metastases 3
 Did malignancy contribute to death 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
 Prematurity 1 Specific gestation in weeks _____ Obesity 1
 Obstructive jaundice 1 Diabetes 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 endoscopic 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

Complexity of operation Yes 1 No 2

Minor 1
Intermediate 2
Major 3
Complex 4

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

Type of list 1
Elective 2
Urgent bookable 3
Emergency theatre

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

Complexity of operation Yes 1 No 2

Minor 1
Intermediate 2
Major 3
Complex 4

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

Type of list 1
Elective 2
Urgent bookable 3
Emergency theatre

Was this procedure delayed by your or other clinicians' elective or non-emergency activity Yes 1 No 2

Additional space on back page or attach an anonymised copy of the operation notes

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

	1 st operation			
	Deciding	Operating	Assisting	Immediately Available
Consultant	<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
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 (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 19

	2 nd operation			
	Deciding	Operating	Assisting	Immediately Available
Consultant	<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
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 (specify)	<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
- 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 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

Complete this page only if an operation/procedure was **either** performed less than 30 days prior to death **or** during the patients last admission

15

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

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

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

Minimal 1 Small 2 Moderate 3 Considerable 4 Expected 5

17

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"/>	Tissue ischaemia	<input type="checkbox"/>	<input type="checkbox"/>
Procedure related sepsis	<input type="checkbox"/>	<input type="checkbox"/>	Vascular graft occlusion	<input type="checkbox"/>	<input type="checkbox"/>
Significant post-operative bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopic perforation	<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"/>	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

18 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"/>

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 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	<input type="checkbox"/>	3
There were areas for consideration but they made no difference to the eventual outcome	<input type="checkbox"/>	4
There were areas of concern but they made no difference to the eventual outcome	<input type="checkbox"/>	5
There were areas of concern which may have contributed to this patient's death	<input type="checkbox"/>	1
There were areas of concern which CAUSED the death of this patient who would have been expected to survive	<input type="checkbox"/>	2

Please comment (Please use back page)

22 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)

23 In retrospect, could anything have been done differently Yes 1 No 2
 If 'Yes', please specify (Please use back page)

24

Does your hospital have a multidisciplinary M & M Meeting? Yes 1 No 2
If so, has this case been discussed? Yes 1 No 2 It will be in the future 3
If yes, what conclusions were reached and what changes will be/have been instituted

Does your local department have an M & M Meeting? Yes 1 No 2
If so, has this case been discussed? Yes 1 No 2 It will be in the future 3

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

25

Additional comments:

26

Definitions:

An **ICU** 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.

An **area of concern** is where it is believed that areas of care should have been better.

An **area for consideration** is where it is believed that areas of care could have been improved whilst recognising that there may be issues for debate.

Many thanks for your help