



# Paediatric Pro Forma - 2007

Study number

2007/

Please return this form to –

Scottish Audit of Surgical Mortality

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Cirrus

Marchburn Drive

Abbotsinch

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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](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 1-6 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 \_\_\_\_\_

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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.**

Male  1 Female  2 Age  years  months  days

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

4a Specialty - Consultant in charge (more than one may be ticked)

General  1 Vascular  2 GI  3 Urology  4 Thoracic  7  
ENT  8 Ophthal.  9 Paediatrics  10 Gynaecology  11 Plastic  12  
Maxillo-facial  13 Spinal  14 Gynae.oncology  15 Other (specify)  19 \_\_\_\_\_

4b Specialty - Case (more than one may be ticked)

General  1 Vascular  2 GI  3 Urology  4 Thoracic  7  
ENT  8 Ophthal.  9 Paediatrics  10 Gynaecology  11 Plastic  12  
Maxillo-facial  13 Spinal  14 Gynae.oncology  15 Other (specify)  19 \_\_\_\_\_

5 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

Type of admission to hospital

Elective  1  
Urgent  3  
Emergency  2

Date of referral to surgical team

Was this patient transferred from another hospital

Yes  1 No  2 Not applicable  3

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

6

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

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 Specify 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

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

1st operation \_\_\_\_\_

2nd operation \_\_\_\_\_

Date 

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

 (Office use only)  
Code:

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

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

If no, were you comfortable performing this procedure  
Complexity of operation Yes  1 No  2

Minor  1  
Intermediate  2  
Major  3  
Complex  4

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

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

Was this procedure delayed by your or other clinicians' elective or non-emergency activity  
Type of list  
Elective  1  
Urgent bookable  2  
Emergency theatre  3  
Yes  1 No  2

Was this procedure delayed by your or other clinicians' elective or non-emergency activity  
Type of list  
Elective  1  
Urgent bookable  2  
Emergency theatre  3  
Yes  1 No  2

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

1<sup>st</sup> operation

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

2<sup>nd</sup> operation

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

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

1<sup>st</sup> 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"/>	3
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

2<sup>nd</sup> 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

1<sup>st</sup> operation  
Yes  1 No  2

Yes  1 No  2

Yes  1 No  2

2<sup>nd</sup> 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

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

Minimal  1      Small  2      Moderate  3      Considerable  4      Expected  5

**15 Was this a death within 24 hours of surgery**      Yes  1      No  2

**16 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

**17 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"/>

**18 Fluid balance**

Were there any problems with fluid management	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
If yes, what impact did these problems have:		
No impact	<input type="checkbox"/> 1	
Contributed to death	<input type="checkbox"/> 2	
Caused death	<input type="checkbox"/> 3	
Did these problems originate in the first 24 hours post-operatively	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
Could fluid balance have been better managed	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2

PLEASE COMPLETE THE REMAINDER OF THIS FORM FOR ALL PATIENTS (I.E. WHETHER OR NOT AN OPERATION/PROCEDURE WAS PERFORMED)

**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  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)

**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

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

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25

Date anaesthetic form passed to Anaesthetist

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

26

Additional comments:

27

**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.

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**