



Surgical 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

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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 **1-6** 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.

2 Male 1 Female 2 Age years Study 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 NA 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 Type of admission to hospital Elective 1 Was this patient transferred from another hospital Yes 1 No 2 Not applicable 3
 17.00 - 22.00 2 Urgent 3
 22.00 - 08.00 3 Emergency 2
 Date of hospital admission Date of referral to surgical team
 Date of death If yes, please provide details of consultants involved on facing sheet.

6 Code: (Office use only)
 Main surgical diagnosis on admission (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
 Obstructive jaundice 1 Obesity 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 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"/>	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

2nd 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

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"/>	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

2nd 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

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)
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- 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 or cause death

20 Fluid balance

Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
<input type="checkbox"/> 1	
<input type="checkbox"/> 2	
<input type="checkbox"/> 3	
Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2

- Were there any problems with fluid management
- If yes, what impact did these problems have:
 - No impact
 - Contributed to death
 - Caused death
- Did these problems originate in the first 24 hours post-operatively
- Could fluid balance have been better managed

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, could anything have been done 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

28

Date anaesthetic form passed to Anaesthetist

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

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