CEC eChartbook Portal Extract

CHASM

Collaborating Hospitals' Audit of Surgical Mortality

Suggested citation: Clinical Excellence Commission [access date]. eChartbook Portal: Safety and Quality of Healthcare in New South Wales. Sydney: Clinical Excellence Commission. Available at: http://www.cec.health.nsw.gov.au/echartbook/cec-indicators-intro-chartbook/cec-indicators-chasm Accessed (insert date of access).

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This publication is part of the CEC's Information Management Series. A complete list of CEC publications is available from the Director, Corporate Services (address above) or via the CEC's web site www.cec.health.nsw.gov.au

PDF file created: Monday, 9 November 2015

CHASM PROGRAM

Collaborating Hospitals' Audit of Surgical Mortality

Why is this important? The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) is a systematic peer-review audit of deaths of patients who were under the care of a surgeon at some time during their hospital stay in NSW, regardless of whether an operation was performed. It is overseen by a statutory committee established under s20 of the *Health Administration Act 1982* (NSW), with members appointed by the Secretary, NSW Health under the delegation of the Minister for Health.

Mortality reporting is a long-recognised method of monitoring the quality of health care, and is undertaken worldwide. CHASM is designed to improve the health outcomes of surgical patients by identifying system and process errors, for ongoing improvement and educational purposes. Its audit methodology is based on the Scottish Audit of Surgical Mortality (SASM) [1], developed in 1994 and similar to the other surgical mortality audits being implemented in Australia, under the Australian and New Zealand Audit of Surgical Mortality (ANZASM) framework.

CHASM is a partner of ANZASM, which is a bi-national framework of regionally-based audits of surgical mortality established by the Royal Australasian College of Surgeons (RACS). The RACS is advocating regular reporting of surgically-related mortality in all Australian States and Territories, and has made participation in ANZASM a requirement of its Continuing Professional Development Program under category one: surgical audit.

Surgeon participation in CHASM ensures that deaths reported are reviewed by an independent peer surgeon, in a way that meets the professional standards and expectations of the RACS.

Findings: Chart CM01 presents the data on surgeon participation in CHASM, i.e. percentage of recorded deaths with completed surgical case forms (SCFs) by local health district (LHD), between 2010 and 2014. During this period, the percentage of completed SCFs returned steadily increased - from 67 to 80 per cent. The rate of SCFs returned varied widely across LHDs. The total numbers of reported deaths in NSW were around 2,000 annually, indicating an established system of notifying deaths to CHASM at most LHDs.

Chart CM02 presents the data on potentially preventable deficiency of care, i.e. percentage of audited deaths identified with potentially preventable deficiency of care. Due to the small numbers on this data at LHDs, seven years of data (2008-2014) was combined. For NSW, yearly data was presented. Over the years, the percentage of audited deaths identified with potentially preventable deficiency of care has declined – from 15 to 10 per cent. The seven-year NSW average is 13 per cent.

Implications: Each participating surgeon receives confidential feedback on the audited death that was under his or her care. In addition, CHASM produces the following publications based on the audit findings:

- an annual casebook which identifies surgical learning and opportunities for practice and system improvement
- an annual individual report for each participating surgeon. This consists of the summary data of reported deaths for the surgeon during the reporting period, compared against the surgeon's peer group and against all participating surgeons in NSW
- an annual individual program report for each participating local health district and the St Vincent Health Network, with the data compared to the NSW data against 13 clinical indicators
- a program report which presents the NSW data by admission type against 13 clinical indicators.

What we don't know:

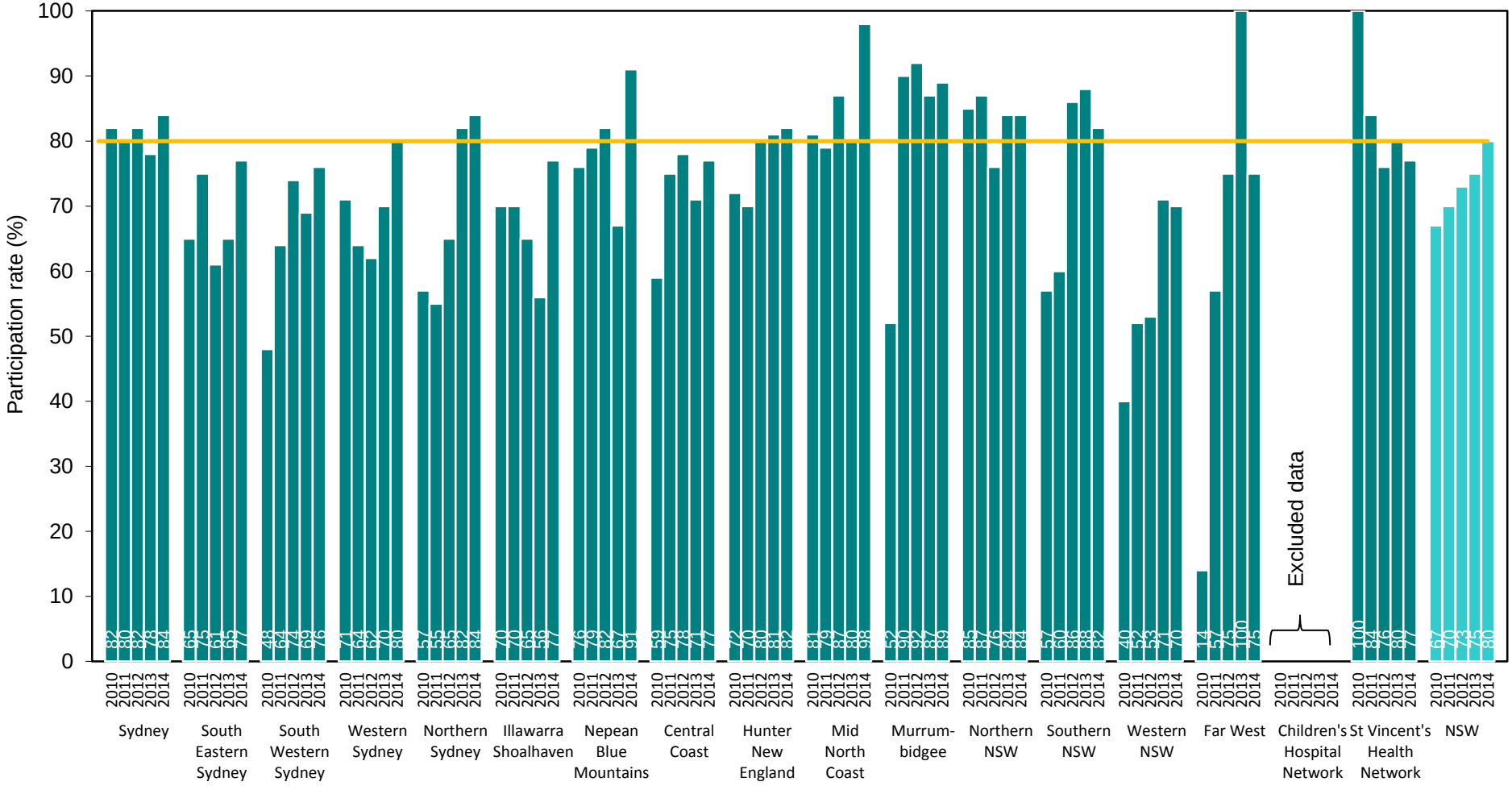
While CHASM has the largest number of reported deaths, when compared to other similar surgical mortality audits in Australia, we do not know how complete the notification data is. CHASM is exploring options to identify the number of surgical admissions/separations for reporting surgical mortality rate in NSW.

References:

[1] Scottish Audit of Surgical Mortality Annual Report 2010: Reporting on 2009 data. Accessed September 2013 http://www.sasm.org.uk/Publications/SASM_Annual_Report_2010.pdf.

Chart CM01 – CHASM participation

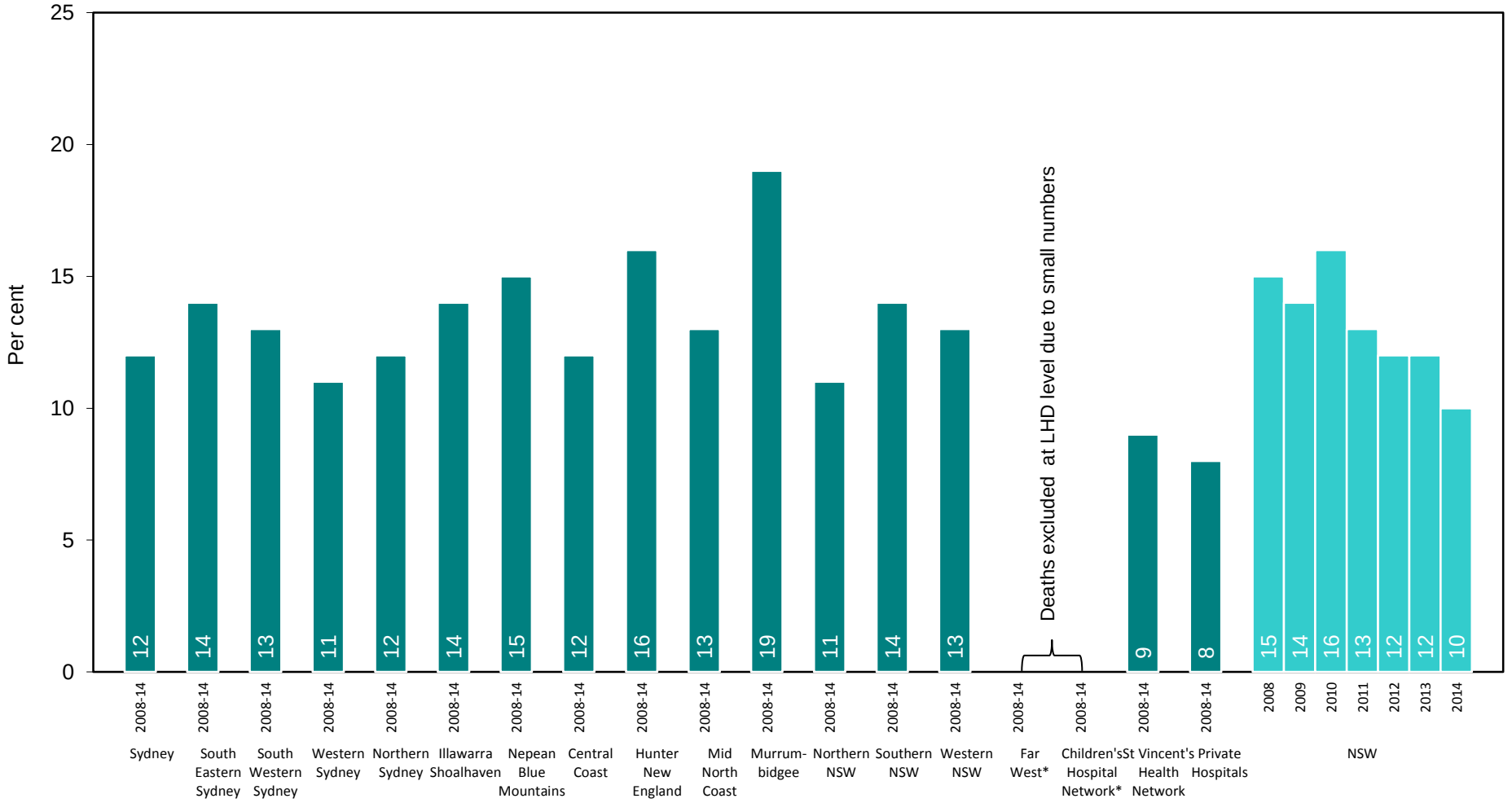
Deaths with completed surgical case forms (%), by LHD/SN and year of notification (2010-2014)



Source: CHASM Team, Clinical Excellence Commission.

Chart CM02 – Deaths with potentially preventable deficiency of care

Percentage of audited deaths with potentially preventable deficiency of care (ACONs*) by LHD/SN and year of death (2008-2014)



Notes: ACON refers to clinical management issues (Area of consideration, Area of concern and Adverse event).

Source: CHASM team, Clinical Excellence Commission.

Data Definitions

Chart:	CM01
Admin Status:	Current, December 2014
Indicator Name:	Surgeon Participation
Description:	Recorded deaths with completed surgical case forms (%) by LHD/SN, 2010-2014
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Number of notified eligible surgical deaths by LHD/SN
Data Exclusions:	Number of non-surgical deaths
Numerator:	Total number of returned surgical case forms (SCF)
Denominator:	Total number of notified eligible surgical deaths
Standardisation:	None
Data Source:	Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Program, Clinical Excellence Commission
Comments:	Not applicable

Chart:	CM02
Admin Status:	Current, December 2014
Indicator Name:	Deaths with potentially preventable deficiency of care
Description:	Deaths with potentially preventable deficiency of care (%) by LHD/SN, 2010-2014
Dimension:	Patient safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Number of notified surgical deaths that have completed the CHASM peer review by LHD/SN
Data Exclusions:	Number of non-surgical deaths, number of notified surgical deaths related to terminal care and number of notified surgical deaths which are undergoing the CHASM peer review
Numerator:	Total number of notified deaths with potentially preventable deficiency of care identified by peer assessors
Denominator:	Total number of notified surgical deaths that have completed the CHASM peer review
Standardisation:	None
Data Source:	Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Program, Clinical Excellence Commission
Comments:	Not applicable