How participation in surgical mortality audits impacts surgical practice

Initiative Type

Audit

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Close

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Summary

Surgical mortality audit is an important tool for quality assurance and professional development but little is known about the impact of such activity on professional practice at the individual surgeon level. This paper reports on the findings of a survey conducted with a self-selected cohort of

surgeons in Queensland, Australia, on their experience of participating in the audit and its impact on their professional practice, as well as implications for hospital systems.

Key dates

Oct 2015

Jul 2017

Implementation sites

There are 38 public hospitals and 37 private hospitals currently participating in QASM.

Partnerships

Queensland Audit of Surgical Mortality (QASM)

Key Contacts

Dr. John North

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paul.blee.hiu

(Clinical Director QASM – Senior Visiting Medical Officer (Orthopaedics) Princess Alexandra Hospital)

Metro South Hospital and Health Service

(07) 3249 2771

johnbnorth@bigpond.com

Aim

To provide evidence that surgical mortality audit is an effective strategy for continuous professional development and for improving patient safety initiatives.

Benefits

- careful review of surgical mortality audit data is an effective learning process for surgeons.
- comprehensive review improves patient safety.
- qualitative data assessment can demonstrate the importance of effective communication and clear documentation in the audit process.

Background

Australia is one of the few places in the world to attempt a nationwide audit of surgical deaths and this shows that surgeons regard patient safety as paramount. What the latest international research tells us is that when there is an adverse event, it is rarely as a result of one person. It is usually a team failure. Queensland Audit of Surgical Mortality (QASM) started in 2007 and is funded by Queensland Health.

Solutions Implemented

The study used a descriptive cross-sectional survey design. All surgeons registered in Queensland in 2015 (n=919) were invited to complete an anonymous online questionnaire between September and October 2015. 184 surgeons completed and returned the questionnaire at a response rate of 20%.

Evaluation and Results

Thirty-nine percent of the participants reported involvement in the audit process affected their clinical practice. This was particularly the case for surgeons whose participation included being an assessor. Thirteen percent of participants had perceived improvement to hospital practices or advancement in patient care and safety as a result of the audit recommendations. Analysis of the open-ended responses suggested the audit experience in action and with increased confidence in best practice and recognise the importance of effective communication and clear documentation.

Lessons Learnt

This is the first study to examine the impact of participation in a mortality audit process on the professional practice of surgeons. The findings offer evidence for surgical mortality audits as an effective strategy for continuous professional development and for improving patient safety initiatives.

Further Reading

Royal Australasian College Of Surgeons: Queensland Audit of Surgical Mortality Biomed Central News: How participation in surgical mortality audit impacts surgical practice