

## References

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## QA10

### ADVOCACY FOR GLOBAL PERIOPERATIVE MORTALITY RATE REPORTING – UNIVERSAL ACCESS TO SAFE SURGERY AND ANAESTHESIA WHEN NEEDED

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**Background:** Surgical conditions are responsible for at least 11% of the global burden of disease. The recent global burden of disease study has shown that worldwide non-communicable diseases (55%) and injuries (11%) account for a greater proportion than communicable diseases for the first time (34%). Much of the world's population living in low and middle income countries (LMIC) do not have access to safe surgery and anaesthesia. Health systems have failed to focus on the care of surgical conditions, many of which are primary health care problems.

**Methods:** Following the 2012 International Symposium on the Global Burden of Surgical Disease, a consensus meeting of surgeons, anaesthetists and public health physicians with an interest in global health and/or mortality was held in March 2013. After reviewing the evidence on indicators the findings were shared with International Colleges of Surgeons and Anaesthetists, and related global health Societies.

**Results:** The WHO metrics of death on the day of surgery (or within 24h), and death before discharge from hospital (or within 30 days whichever is sooner) were agreed as the most appropriate and practical for global implementation of a POMR. The denominator is the number of procedures and numerator the number of deaths. Clinical interpretation can be achieved using simple measures of risk stratification such as age, urgency (emergency or elective), procedure group or condition, and ASA score. The number of procedures per population can be a measure of access.

**Conclusion:** POMR is a credible indicator of access to safe surgery and anaesthesia. Other measures of access may need to be developed.

## QA11P

### A PRE-PRINTED MEDICATION CHART IN THE ICU FOR PATIENTS ADMITTED AFTER CORONARY ARTERY BYPASS GRAFT SURGERY IMPROVES PRESCRIBING OF SECONDARY PREVENTION AT HOSPITAL DISCHARGE

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**Objective:** To determine whether the introduction of a pre-printed Intensive Care Unit (ICU) drug chart after coronary artery bypass graft surgery (CABG) surgery was associated with an improvement in the rates of prescription of secondary prevention medicines at hospital discharge.

**Design:** Prospective cohort study.

**Setting:** Tertiary cardiothoracic referral hospital in Wellington, New Zealand.

**Participants:** 746 CABG surgery patients. 371 from the year before and 357 from the year after the introduction of the pre-printed ICU cardiac drug chart.

**Interventions:** A pre-printed ICU medication chart including aspirin, metoprolol, and atorvastatin used on all patients admitted to the ICU following CABG surgery.

**Main Outcome Measures:** The primary outcome variable was the proportion of patients prescribed appropriate secondary prevention at hospital discharge. Secondary outcome variables included the proportion of patients receiving each of: aspirin, a beta-blocker, or a statin individually.

**Results:** Prescribing of appropriate secondary prevention increased from 81.1% to 92.7% following the introduction of the chart, adjusted OR 2.63 (1.53 to 4.50),  $P < 0.001$ . The association between year of prescription and

overall prescribing was mainly due to an increase in the prescription of beta-blockers.

**Conclusions:** Introduction of a pre-printed ICU cardiac drug chart was associated with an increase in the rates of prescribing of secondary prevention on hospital discharge post-CABG surgery.

## QA12P

### AUDITING THE AUDIT: CAN WE DO BETTER?

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**Purpose:** Surgical audit and peer review are important strategies in maintaining standards of care in surgery and are a requirement for continuing professional development for all Fellows of The Royal Australasian College of Surgeons. We aim to determine if the current process of determining and reporting complications within our unit was accurate.

**Methodology:** A systematic review of the medical records for all admissions from 1/1/13 to 31/3/2013 was performed. Results were then compared with those which had been presented at monthly audit meetings. Complications were graded according to the College guidelines.

**Results:** During the three month period there was a total of 973 admissions, comprising 399 operations performed, 367 endoscopic procedures, and 207 non-operative admissions. Reported complications totalled 17 with 2 grade one, 3 grade two, 7 grade three, and 5 grade four (mortality). Of the 5 mortalities 3 had died of traumatic injuries soon after presentation without operative intervention. Actual complications totalled 70 with 21 grade one, 24 grade two, 20 grade three, and 5 grade four. Also identified were two complications of surgery performed at another facility then transferred for step down care.

**Conclusion:** In our audit of the audit we found that only 24% of complications were reported using our current process. Within our unit a clinical pathway has been introduced to each patients' medical record with a check box system for recording complications. Further review will be required to assess the effectiveness of this intervention. This study highlights how auditing processes need ongoing review and hope it can act as a prompt for other units to ensure accuracy in their auditing process.

## QA13P

### CLINICAL HANDOVER OF PATIENTS TO THE OPERATING ROOM: THE EVIDENCE BASIS FOR MULTIDISCIPLINARY COMMUNICATION

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**Purpose:** The purpose of the study was to: systematically review research pertaining to multidisciplinary information requirements during transfer of the patient to the surgical environment and contribute to the efficiency and quality of patient transfer information, thereby improving patient safety.

**Methodology:** This research utilized a quantitative design using a prospective observational audit.

**Results:** 71 criteria required verification by the clinician conducting handover. 5 criteria (temperature, pulse, respiration rate, blood pressure and oxygen saturation) were recorded for 100% of handover episodes. Patient identification and consent criteria were verified in 85–98% of episodes. 22 criteria were completed in 80% or more of handover episodes and 13 criteria were completed between 60–79% of episodes including verification of patient medical record (67%). 36 criteria were completed for less than 60% of handover episodes including pressure injury score (41%), haematology documentation (40%) and operative site prepared (40%).

**Conclusions:** The functional design of clinical handover documentation may influence exchange, delivery or omission of information during the handover process. Associated communication techniques may be adopted in relation to the format of the documentation. The positive impact on error rate of a standard principle of visualisation and verification of patient documentation requires further investigation. Repetitive conduct of checklist was not an indicator of thoroughness of handover processes. Multidisciplinary collaboration in design of handover documents may contribute to continuity of care and patient safety along the surgical pathway, ensuring appropriate information is accessible to the relevant clinician.