

A THE PATIENT

1. Month and year of birth

m m

y y y y

2. Gender

 Male

 Female

B REFERRAL AND ADMISSION PROCESS

3. a. Did an anaesthetist assess the patient prior to surgery?

 Yes

 No

 Unknown

b. If yes, what was the grade (or nearest equivalent) of the assessing anaesthetist?

 Consultant

 SpR Year (if known)

 Staff Grade

 Associate Specialist

 Unknown

c. What was the date of the assessment?

d d

m m

y y y y

C SCHEDULING OF OPERATIONS

4. a. Start time of anaesthetic induction

(24 hour clock)

b. Time left operating theatre

(24 hour clock)

D MEDICAL OR INTERVENTIONAL MANAGEMENT

5. Please state which medication the patient was on prior to surgery, whether the medication was stopped pre-operatively, and stop dates, where applicable. (answers may be multiple)

	Before surgery	Stopped	Date stopped (dd mm yy)
Beta Blockers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ACE Inhibitors/Angiotensin receptor II antagonist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Potassium Channel Blockers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Calcium Antagonist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clopidogrel	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Warfarin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Low molecular weight heparin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/>
Other please state	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/>

E COMORBIDITIES

6. Did the patient have any of the following comorbidities, and were they reasonably managed pre-operatively?

		Reasonably managed?
Diabetes management	<input type="checkbox"/> 0 (<i>Not diabetic</i>) <input type="checkbox"/> 1 (<i>Diet controlled diabetes</i>) <input type="checkbox"/> 2 (<i>Oral therapy controlled diabetes</i>) <input type="checkbox"/> 3 (<i>Insulin</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hypertension	<input type="checkbox"/> 0 (<i>No hypertension</i>) <input type="checkbox"/> 1 (<i>Treated or BP >140/90 mmHg on >1 occasion prior to admission</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal disease	<input type="checkbox"/> 0 (<i>No renal disease</i>) <input type="checkbox"/> 1 (<i>Functioning transplant</i>) <input type="checkbox"/> 2 (<i>Creatinine >200µmol/l</i>) <input type="checkbox"/> 3 (<i>Dialysis: Acute renal failure; onset within 6 weeks of cardiac surgery</i>) <input type="checkbox"/> 4 (<i>Dialysis: Chronic renal failure; more than 6 weeks prior to cardiac surgery</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
State creatinine closest to surgery	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> µmol l ⁻¹	
State urea closest to surgery	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> • <input type="text"/> mmol l ⁻¹	
Ejection fraction value	<input type="checkbox"/> 1 (<i>Good – LVEF>50%</i>) <input type="checkbox"/> 2 (<i>Fair – LVEF 30-50%</i>) <input type="checkbox"/> 3 (<i>Poor – LVEF <30%</i>)	

Respiratory disease <i>(If yes, please complete the following questions)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was the patient regularly taking bronchodilators?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Was the patient regularly taking oral steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Please state Forced Vital Capacity	<input type="text"/> <input type="text"/> Litres	
Please state Forced Expiratory Volume (FEV1) closest to surgery	<input type="text"/> <input type="text"/> Litres	
Current smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Please state other comorbidities		
Other <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

F THE ANAESTHETIC

7. What was the grade *(or nearest equivalent)* of the most senior anaesthetist present at induction?

Number of years grade held?

- Consultant
- SpR
- Staff Grade/Associate Specialist
- SHO
- Unknown

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

8. What was the grade *(or nearest equivalent)* of the person assisting with the anaesthetic? *(answers may be multiple)*

Number of years grade held?

- Consultant
- SpR
- Staff Grade/Associate Specialist
- SHO
- Operating Department Practitioner
- Nurse
- Unknown

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

9. How many clinical sessions/programmed activities, dedicated to cardiothoracic anaesthesia, does the senior anaesthetist involved in this case work in each week?

10. Is the most senior anaesthetist responsible for the anaesthetic in this case a member of the Association of Cardiothoracic Anaesthetists? Yes No Unknown

G PERI-OPERATIVE MANAGEMENT

11. a. Did any critical incidents^(def) occur during the per- and postoperative period? Yes No Unknown

b. If yes, please describe:

c. If yes, was an incident report compiled? Yes No Unknown

12. a. Did the patient develop any postoperative complications? Yes No Unknown

b. If yes, please tick all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Chest infection |
| <input type="checkbox"/> Renal impairment | <input type="checkbox"/> Tamponade | <input type="checkbox"/> Generalised sepsis |
| <input type="checkbox"/> Wound infection | <input type="checkbox"/> Mediastinitis | <input type="checkbox"/> Pulmonary embolus |
| <input type="checkbox"/> Multi-organ failure | <input type="checkbox"/> Hepatic failure | <input type="checkbox"/> Other (<i>please specify</i>) |
| <input type="checkbox"/> Ventricular arrhythmia requiring treatment | <input type="checkbox"/> Pericardial effusion requiring intervention | <input type="checkbox"/> Haemorrhage requiring re-operation |

c. If yes, was there a delay in detecting any of these complications? Yes No Unknown

d. If yes, please give details for all complications:

e. If yes, in your opinion was the management of any per- and post operative complications adequate? Yes No Unknown

H POSTOPERATIVE CARE

13. a. Immediately following surgery, what level of care^(def) did the patient receive? 0 1 2 3

b. What was the level of care required? 0 1 2 3

c. If level of care was not as required, please state why:

14. a. Was the patient transferred to a lower level of care earlier than they should have been due to reasons other than clinical need? Yes No Unknown

b. If yes, please state why:

I COMMUNICATION AND CONTINUITY OF CARE

15. Were the possible anaesthetic complications described to the patient during the consent process? Yes No Unknown

16. Was a separate written consent obtained for the anaesthetic? Yes No Unknown

17. a. Did you feel there was 'stability' within the theatre team for this case? Yes No Unknown

b. Did you feel 'at ease' within the theatre team for this case? Yes No Unknown

c. If no, please give details:

J MULTIDISCIPLINARY REVIEW AND AUDIT

18. As the anaesthetist involved in this case, were you involved in multidisciplinary team (MDT)^(def) review following surgery? Yes No Unknown

STRUCTURED COMMENTARY

On these next two pages we would ask that you provide any additional comments you wish to report about the management of this patient. We have tried to aid this by highlighting some of the areas that you might want to consider. If you find these areas not to be relevant please complete the not applicable box.

The advisors find a summary of the salient features from the perspective of the clinician involved of immense assistance in assessing the case.

Please consider the following areas, with respect to patient outcome, when you fill in this section.

Delays in the admission process. Not applicable

Deterioration of the patient during transfer. Not applicable

Delays, absence of, or unclear investigations; if so please give examples. Not applicable

STRUCTURED COMMENTARY (CONTINUED)

Placing the patient in an inappropriate area.

Not applicable

Cancelled from the operation list.

Not applicable

The management of comorbidities.

Not applicable

The occurrence and management of critical incidents during the per- and postoperative period.

Not applicable

The appropriateness of the management of any postoperative complications.

Not applicable

Any hindrance of full monitoring of the patient throughout the procedure.

Not applicable

Inappropriateness of the location of the patient immediately after surgery.

Not applicable

STRUCTURED COMMENTARY (CONTINUED)

With the benefit of hindsight is there anything you would have done differently during the operation?

Not applicable

Poor continuity of care during inpatient stay.

Not applicable

Involvement with the multidisciplinary team.

Not applicable

Any additional comments:

DEFINITIONS

Critical incident	<p>Any incident or event which has caused or could have caused an adverse outcome for the patient.</p> <p><i>(CRIME-base Brighton, 2000. www.eee.bham.ac.uk/crime)</i></p>
Levels of care	<p>Level 0: Patients whose needs can be met through normal ward care in an acute hospital.</p> <p>Level 1: Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from critical care teams.</p> <p>Level 2: Patients requiring more detailed observation or intervention including support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.</p> <p>Level 3: Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.</p> <p><i>(Department of Health, 2000)</i></p>
Multidisciplinary team (MDT)	<p>All healthcare professionals involved in the care of the patient.</p>

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