SCIDUA Glossary of Terms – Case Classification

A Deaths Attributable to Anaesthesia

Category 1	Where it is reasonably certain that death was caused by the anaesthesia or other factors under the control of the anaesthetist.
Category 2	Where there is some doubt whether death was entirely attributable to the anaesthesia or other factors under the control of the anaesthetist.
Category 3	Where death was caused by both surgical and anaesthesia factors.

Explanatory Notes:

- *The intention of the classification is not to apportion blame in individual cases but to establish the contribution of the anaesthesia factors to the death.*
- *The above classification is applied regardless of the patient's condition before the procedure. However if it is considered that the medical condition makes a substantial contribution to the anaesthesia-related death subcategory H should also be applied.*
- *If no factor under the control of the anaesthetist is identified which could or should have been done better subcategory G should also be applied.*

B Deaths In Which Anaesthesia Played No Part

Category 4	Surgical death where the administration of the anaesthesia is not contributory and surgical or other factors are implicated.
Category 5	Inevitable death which would have occurred irrespective of anaesthesia or surgical procedure.
Category 6	Incidental death which could not reasonably be expected to have been foreseen by those looking after the patient, was not related to the indication for surgery and was not due to factors under the control of anaesthetist or surgeon.

C Unassessable Deaths

Category 7	Those that cannot be assessed despite considerable data but where the information is conflicting or key data is missing.
Category 8	Cases which cannot be assessed because of inadequate data

CAUSAL OR CONTRIBUTORY FACTORS IN CATEGORY A DEATHS

Note that this is common for more than one factor to be identified in the case of anaesthesia attributable death.

SUB-CATEGORIES

A. Pre-operative

(i) Assessment	This may involve failure to take an adequate history or perform an adequate examination or to undertake appropriate investigation or consultation or make adequate assessment of the volume status of the patient in an emergency. Where this is also a surgical responsibility the case may be classified in Category 3 above.
(ii) Management	This may involve failure to administer appropriate therapy or resuscitation. Urgency and the responsibility of the surgeon may also modify this classification.

B. Anaesthesia Technique

(i) Choice or application	There is inappropriate choice of technique in circumstances where it is contra-indicated or by the incorrect application of a technique which was correctly chosen.
(ii) Airway maintenance including pulmonary aspiration	There is inappropriate choice of artificial airway or failure to maintain or provide adequate protection of the airway or to recognise misplacement or occlusion of an artificial airway.
(iii) Ventilation	Death is caused by failure of ventilation of the lungs for any reason. This would include inadequate ventilator settings and failure to reinstitute proper respiratory support after deliberate hypoventilation (e.g. bypass)
(iv) Circulatory support	Failure to provide adequate support where there is haemodynamic instability, in particular in relation to techniques involving sympathetic blockade.

C. Anaesthesia Drugs

(i) Selection	Administration of a wrong drug or one which is contra-indicated or inappropriate. This would include 'syringe swap' errors.
(ii) Dosage	This may be due to incorrect dosage, absolute or relative to the patient's size, age and condition and practice is usually an overdose.
(iii) Adverse drug reaction	This includes all fatal drug reactions both acute such as anaphylaxis and the delayed effects of anaesthesia agents such as the volatile agents.
(iv) Inadequate reversal	This would include relaxant, narcotic, and tranquilising agents where reversal is indicated.
(v) Incomplete recovery	E.g. prolonged coma.

D. Anaesthesia Management

(i) Crisis management	Inadequate management of unexpected occurrences during anaesthesia or in other situations which, if uncorrected, could lead to death.
(ii) Inadequate monitoring	Failure to observe minimum standards as enunciated in the ANZCA Professional Documents or to undertake additional monitoring when indicated e.g. use of a pulmonary artery catheter in left ventricular failure.
(iii) Equipment failure	Death as a result of failure to check equipment or due to failure of an item of anaesthesia equipment.
(iv) Inadequate resuscitation	Failure to provide adequate resuscitation in an emergency situation.
(v) Hypothermia	Failure to maintain adequate body temperature within recognised limits.

E. Post-operative

(i) Management	Death as a result of inappropriate intervention or omission of active intervention by the anaesthetist or a person under their direction (eg. Recovery or pain management nurse) in some matter related to the patient's anaesthesia, pain management or resuscitation.
(ii) Supervision	Death due to inadequate supervision or monitoring. The anaesthetist has ongoing responsibility but the surgical role must also be assessed.
(iii) Inadequate resuscitation	Death due to inadequate management of hypovolaemia or hypoxaemia or where there has been a failure to perform proper cardiopulmonary resuscitation.

F. Organisational

(i) Inadequate supervision, inexperience or assistance	These factors apply whether the anaesthetist is a trainee, a non-specialist or a specialist undertaking an unfamiliar procedure. The criterion of inadequacy of supervision of a trainee is based on the ANZCA Professional Document on supervision of trainees.
(ii) Poor organisation of the service	Inappropriate delegation, poor rostering and fatigue contributing to a fatality.
(iii) Failure of interdisciplinary planning	Poor communication in peri-operative management and failure to anticipate need for high dependency care.

G. No Correctable Factor Identified

Where the death was due to anaesthesia factors but no better technique could be suggested.

H. Medical Condition of the Patient

Where it is considered that the medical condition was a significant factor in the anaesthesia related death.

Suffixes

Suffix Code	Suffix Description
c	Where bone cement is implicated
f	Where surgery is performed in circumstances in which it is clear before commencement of surgery that the chance of a successful outcome is negligible or non-existent.
t	Critical event at transfer.
01	Patient died as a result of surgical bleeding

Urgency of cases

Emergency

Immediate surgery for life-threatening condition (less than 30 minutes), e.g., ruptured AAA, extra-dural haematoma, prolapsed umbilical cord.

Urgent

At the earliest available time to prevent physiological deterioration (30 minutes – 4 hours), e.g., ruptured viscus, appendicitis, open wound, blocked VP shunt.

Urgent non-emergency

The patient has a condition that requires emergency surgery, but there is time to allow medical optimisation and appropriate organisation of operating time and surgeons or surgical teams (4 hours to days), e.g., fractured neck of femur, pacemaker insertion, laparotomy for bowel obstruction.

Scheduled

Where the patient presents for elective surgery.

Hospital Level

The nomenclature is a numerical system based on (but not identical with) the NSW Guide to Role Delineation of Hospitals.

It is proposed that our new system will classify hospitals as follows:

Level 6: A multi-disciplinary hospital which provides facilities for most or all surgical sub-specialties and the Intensive Care environment to support them. Specialist and sub-specialist anaesthetic staff are on-site during the day and anaesthetic registrar cover is on-site 24 hours a day. This classification also applies to where a hospital is designated as a Trauma Centre.

Level 5: A hospital which is multi-disciplinary, but only provides some sub-specialty surgery and anaesthesia with an appropriate post-operative environment. Specialist and sub-specialist anaesthetic staff are on-site during the day and anaesthetic registrar cover is on-site 24 hours a day or available within 10 minutes.

Level 4: A multi-disciplinary hospital which does not cater for all surgical specialities, but accepts some trauma, and provides a lower level of intensive care, referring any patients in need of specialised life support to a higher level facility. Specialist anaesthetic staff are on-site during the day and provide an on-call service after hours.

Level 3: A hospital or day centre which undertakes a limited range of procedures but does not have the capability to care for high-risk patients or surgery which necessitates high level post-operative care. Specialist anaesthetic staff are on-site during the day.

Level 2: A facility at which anaesthesia or sedation is provided to enable a single procedure to be undertaken on good risk patients (as stand alone ECT or Dentistry).

Level 1: Any other location at which anaesthesia or sedation is administered, such as a dental office.

If the above institution or facility is in regional NSW, the suffix R is added, and for private hospitals, the suffix P.