**NELA Patient Audit Dataset**

**Data field request form (Form B)**

***To improve your chances of success, please request the minimum dataset required to address the purpose of your application***

**Version Control**



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| **Version** | **Date** | **Changes** |
| 2.0 | 24/11/2014 | Changes made to dataset for 2nd year. |
| 2.1.1 | 02/04/2015 | Still in hospital at 60 days answer option added to question 7.7 |
| 2.1.2 | 02/07/2015 | Wording edited for question 2.9 |
| 3.1 | 01/12/2015 | Changes made to dataset for 3rdyear. |
| 3.1.1 | 21/03/2016 | Q1.9 wording edited |
| 4.1 | 01/12/2016 | Changes made to dataset for 4th year. |
| 4.1.1 | 21/12/2016 | Question 1.10b modified to includehospital transfers |
| 5.1 | 01/12/17 | Changes made to dataset for 5th year. |
| 6.1 | 01/12/18 | Changes made to dataset for 6th year. |
| 6.1.1 | 01/04/19 | Possum Calculation removed; Q3.2, 3.25, 6.2, 6.23,Q3.1, 6.1 Updated options |
| 7.1.1 | 01/12/19 | Changes made to dataset for 7th year. |
| 8.1 | 01/12/2020 | Changes made to dataset for 8th year:* Remove Q1.13a,b, Q7.11, Q7.12
* Update Q2.7(new Q’s), Q2.12, Q7.3, Q7.10
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| 9.1 | 01/12/2021 | Changes made to dataset for 9th year: * Re-inclusion of Q1.10b, Q1.11 (with addition of gynaecology as an option), Q2.1
* Addition of Q1.10c, Q2.7a1, Q2.9a, Q2.9b,
* Update to Q2.11 (additional sub-questions for sepsis/intra-abdominal infection), Q5.1 (new answer option for gynae-onc) , Q5.2 (addition of gastric outlet obstruction), Q5.3b (addition of splenectomy), Q7.3, Q7.10
* Removal of Q6.17a (tranexamic acid)
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**NELA Audit Years**

Year 1 – December 2013 to November 2014

Year 2 – December 2014 to November 2015

Year 3 – December 2015 to November 2016

Year 4 – December 2016 to November 2017

Year 5 – December 2017 to November 2018

Year 6 – December 2018 to November 2019

Year 7 – December 2019 to November 2020

Year 8 – December 2020 to November 2021

Year 9 – December 2021 to November 2022

The NELA ***Clinical Audit Export key*** which maps questions to the data fields can be found in [NELA - Support](https://data.nela.org.uk/Support.aspx)

For queries, please contact info@nela.org.uk

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| **1.** | **Demographics and Admission** | **Notes** | **Years collected****(1-9 unless otherwise specified)** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **1.1** | NHS Number |  |  | NOT AVAILABLE |  |  |
| **1.2** | Pseudo-anonymisation | Computer generated |  |  |  |  |
| **1.3** | Local patient id/hospital number |  |  | NOT AVAILABLE |  |  |
| **1.4** | Date of birth |  |  | NOT AVAILABLE |  |  |
|  | Age on arrival | *Age will automatically be calculated on web tool* |  |  |  |  |
| **1.5** | Sex | ⭘Male / ⭘Female |  |  |  |  |
| **1.6** | Forename |  |  | NOT AVAILABLE |  |  |
| **1.7** | Surname |  |  | NOT AVAILABLE |  |  |
| **1.8** | Postcode |  |  | NOT AVAILABLE |  |  |
| **1.9** | Date and time the patient first arrived at the hospital/Emergency department  | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)Time\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | IDENTIFIABLE |  | Specify interval requested  |
| **1.10** | What was the nature of this admission? | ⭘Elective / ⭘Non-elective |  |  |  |  |
| **1.10b** | If non-elective, what was the initial route of admission/assessment? | ⭘ Assessed initially in Emergency Department⭘ Assessed initially in “front of house” acute surgical assessment unit⭘ Direct referral to ward by GP⭘ In-patient referral from another specialty **(from Dec 2021 Yr9)**⭘ Direct admission from Clinic **(Removed from Dec 2019 Yr7)**⭘ Hospital transfer **(Removed from Dec 2019 Yr7)** | Removed between Dec 2019 and Nov 2021 (Yr7 & Yr8)**(see notes)** |  |  |  |
| **1.10c** | If non-elective, following presentation at ED, surgical assessment unit or ward, what was the date and time the patient was first reviewed by medical staff or advanced clinical practitioners? | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known⭘ Not applicable | From Dec 2021 Yr9 | IDENTIFIABLE |  | Specify interval requested  |
| **1.11** | Which specialty was this patient first admitted under?***Do not*** *use “other” if the patient spent a period of observation under Emergency Medicine*  | ⭘ General surgery⭘ Gynaecology (including Gynae-oncology) **From Dec 2021 Yr9**⭘ General medicine⭘ Gastroenterology⭘ Elderly Care⭘ Other | Removed between Dec 2019 and Nov 2021 (Yr7 & Yr8)**(see notes)** |  |  |  |
| **1.12** | Residence before this hospital admission (No longer required) | ⭘ Own home/sheltered housing⭘ Residential care⭘ Nursing care⭘ Unknown | From Dec 2016 Yr4.Removed in Dec 2019 Yr7 |  |  |  |
| **1.13a** | Is this patient known to have a Learning Disability?(No longer required) | ⭘ Yes⭘ No⭘ Unknown | From Dec 2017 Yr5.Removed in Dec 2019 Yr7 |  |  |  |
| **1.13b** | Is this patient known to have an Autistic Spectrum Disorder? (No longer required) | ⭘ Yes⭘ No⭘ Unknown | From Dec 2017 Yr5.Removed in Dec 2019 Yr7 |  |  |  |

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| **2** | **Pre-op****If the patient is returning to theatre as an emergency following previous elective surgery, all answers should relate to the emergency laparotomy, not the previous elective surgery.** | **Years collected****(1-9 unless otherwise specified)** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **2.1** | Date and time first seen by consultant surgeon following admission with acute abdomen. If under care of a non-surgical specialty, this should be the time 1st seen after referral to general surgeons. | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known⭘ Not Seen | Removed between Dec 2019 and Nov 2021 (Yr7 & Yr8) | IDENTIFIABLE |  | Specify interval requested  |
| **2.2** | Date and time that the decision was made to operate*If this is unavailable please enter date and time that this patient was first booked for theatre for emergency laparotomy* | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known |  | IDENTIFIABLE |  | Specify interval requested  |
| **2.3** | Consultant responsible for surgical care at the time the decision was made to operate (this may be different to the operating consultant)(No longer required) |  | Removed from Dec 2019 Yr7 | NOT AVAILABLE |  |  |
| **2.4** | Was there consultant surgeon input into the decision to operate? \*can refer to situations where eg decision is made on consultant ward round pending CT results, which then confirms need for surgery#refers to situations where consultant has not seen patient but has been discussed with consultant (No longer required) | ⭘ Yes **(Removed from Dec 2016 Yr4)**⭘ No **(Removed from Dec 2016 Yr4)**⭘ Yes, consultant reviewed patient at time of decision⭘ Yes, following discussion with junior team member⭘ Decision made by junior team member without consultant input⭘ Unknown | Removed from Dec 2019 Yr7 |  |  |  |
| **2.5** | Did this clinician personally review the patient at the time of this decision? (No longer required) | ⭘ Yes⭘ No⭘ Unknown | Removed in Dec 2015 Yr3 |  |  |  |
| **2.6** | What was the date and time that the patient was first booked for theatre? (No longer required) | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known | Removed in Dec 2014 Yr2 | IDENTIFIABLE |  | Specify interval requested  |
| **2.7** | Was an abdominal CT scan performed in the pre- operative period as part of the diagnostic work-up? If performed, how was this CT reported pre- operatively?(If CT is reported by a registrar and validated by a consultant **before** surgery, select “in-house consultant”. If **not validated** by consultant before surgery, select“registrar”) | ⭘ Yes – reported by in-house consultant⭘ Yes – reported by in-house registrar⭘ Yes – reported by outsourced service⭘ Yes but not reported⭘ No CT performed ⭘ Unknown | Changed in Dec 2019 Yr7 |  |  |  |
| **2.7a1** | What was the date and time of CT scan request? | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known | From Dec 2021 Yr9 | IDENTIFIABLE |  | Specify interval requested  |
| **2.7a** | If performed, how was this CT reported pre-operatively? (If CT is reported by a registrar and validated by a consultant before surgery, select “in-house consultant”. If not validated by consultant before surgery, select “registrar”)(No longer required) | ⭘ In-house consultant⭘ In-house registrar⭘ Outsourced service⭘ Not reported pre-operatively⭘ Unknown | Removed from Dec 2019 Yr7 |  |  |  |
| **2.7b** | Was there a preoperative discussion between the radiologist and the requesting team about the CT findings? (No longer required) | ⭘ Yes⭘ No⭘ Unknown | Removed from Dec 2019 Yr7 |  |  |  |
| **2.7c** | Was there a discrepancy between the CT report and surgical findings that altered or delayed either the diagnosis or surgical management? (No longer required) | ⭘ Yes⭘ No⭘ Unknown | Removed from Dec 2020 Yr8 |  |  |  |
| **2.7d** | What was the Date and Time of CT Scan? | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known | From Dec 2020 Yr8 | IDENTIFIABLE |  | Specify interval requested  |
| **2.7e** | What was the Date and Time the CT Scan was reported electronically? | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known | From Dec 2020 Yr8 | IDENTIFIABLE |  | Specify interval requested  |
| **2.7f** | Was there an addendum added to the initial CT report which altered the patient pathway or the decision to proceed with surgery? |  Yes, consultant addendum to SPR report Yes, in-house radiologist addendum to outsourced report Yes, sub-specialist GI radiologist addendum to non-GI consultant report  No Unknown | From Dec 2020 Yr8 |  |  |  |
| **2.8** | If performed, was this CT reported pre-operatively by a consultant radiologist? (No longer required) | ⭘ Yes⭘ No⭘ Unknown | Removed from Dec 2016 Yr4 |  |  |  |
| **2.8a** | Consultant Anaesthetist involvement in planning perioperative care. *This can include preoperative assessment, discussion about decisions for & risk/benefits of surgery, or need for critical care* (No longer required) | ⭘ Yes – seen by consultant anaesthetist in person⭘ Yes – discussion between consultant anaesthetist & other team member (of any specialty)⭘ No consultant anaesthetist input before surgery⭘ Unknown | Removed from Dec 2019 Yr7 |  |  |  |
| **2.8b** | Intensive care involvement in planning perioperative care. *This can include preoperative assessment, discussion about decisions for & risk/benefits of surgery, or need for critical care*  (No longer required) | ⭘ Yes – seen by consultant intensivist in person⭘ Yes – discussion between consultant intensivist & other team member (of any specialty)⭘ Seen by or discussion with junior ITU team member only⭘ No intensive care input before surgery⭘ Unknown | Removed from Dec 2019 Yr7 |  |  |  |
| **2.9** | Date and time first seen by consultant anaesthetist prior to surgery (No longer required) | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known⭘ Not Seen  | Removed from Dec 2016 Yr4 | IDENTIFIABLE |  | Specify interval requested  |
| **2.9a** | Non-operative management. Prior to a decision to operate, was there a documented consultant decision to initiate a deliberate period or trial of active, non-operative (conservative) management? | ⭘Yes⭘No ⭘Unknown | From Dec 2021 Yr9 |  |  |  |
| **2.9b** | If yes, what was the date and time of the decision? | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known | From Dec 2021 Yr9 | IDENTIFIABLE |  | Specify interval requested  |
| **2.10** | What was the date and time of the first dose of antibiotics following presentation to hospital? *(only relevant for non-elective admissions)* | ⭘ In theatre, orDate \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)⭘ Date not knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known⭘ Not Administered |  | IDENTIFIABLE |  | Specify interval requested  |
| **2.11a** | Was sepsis, with a NEWS2 >=5 or >=3 in any one variable suspected on arrival at hospital? | ⭘Yes⭘No ⭘Unknown | From Dec 2016 Yr4. Changed in Dec 2017 Yr5, Dec 2018 Yr6 and Dec 2021 Yr9 |  |  |  |
| **2.11b** | Was sepsis, with a NEWS2 >=5 or >=3 in any one variable suspected at the time the decision for surgery was made? | ⭘Yes⭘No ⭘Unknown | From Dec 2016 Yr4. Changed in Dec 2017 Yr5, Dec 2018 Yr6 and Dec 2021 Yr9 |  |  |  |
| **2.11c** | Was intra-abdominal infection requiring urgent antibiotics e.g. peritonitis / perforation, suspected on arrival at hospital? | ⭘Yes⭘No ⭘Unknown | From Dec 2021 Yr9 |  |  |  |
| **2.11d** | Was intra-abdominal infection requiring urgent antibiotics e.g. peritonitis / perforation, suspected at the time the decision for surgery was made? | ⭘Yes⭘No ⭘Unknown | From Dec 2021 Yr9 |  |  |  |
| **2.12a** | Was an assessment of frailty performed in the pre-operative period (This can be by any person, it does not have to be elderly medicine)? (No longer required) | ⭘ 'Yes - Electronic Frailty Index' ⭘ 'Yes - Rockwood score' ⭘ 'Yes - Edmonton frail scale' ⭘ 'Yes - Other objective scoring system' ⭘ 'Yes - Subjective assessment' ⭘ 'No' | Removed from Dec 2018 Yr6 |  |  |  |
| **2.12b** | Did the frailty assessment identify the patient as frail? (No longer required) | ⭘Yes⭘No ⭘Unknown | Removed from Dec 2018 Yr6 |  |  |  |
| **2.12** | On admission to hospital and using the Clinical Frailty Score, what was the patient’s pre-admission frailty status assessed as being? (see help box for full pictorial explanation of each grading) | ⭘ (1-3) - not frail⭘ 4 - vulnerable⭘ 5 - mildly frail⭘ 6 - moderately frail⭘ 7 - severely frail - completely dependent for personal care⭘ 8 - very severely frail⭘ 9 - Terminally ill⭘ Not Recorded | From Dec 2018 Yr6 |  |  |  |

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| **3** | **Pre-op Risk stratification** |  | **Years collected****(1-9 unless otherwise specified))** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **3.1** | Prior to surgery, what was the risk of death for the patient that was entered into medical record?*For info, wording of relevant standard “An assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the**medical record.”* | ⭘ Lower (<5%)⭘ High (>=5%)⭘ Not documented  | Changed in Dec 2018 Yr6 |  |  |  |
| **3.1a** | If documented, how was risk assessed? | ⭘ Objective clinical score⭘ Clinical judgement | From Dec 2019 Yr7 |  |  |  |
| **3.1b** | If patient assessed to be high risk, which **consultants** were involved immediately preoperatively in the assessment, decision making process and care of this patient? This may be either direct or indirect care. Please mark all that apply. | ⭘ Consultant Surgeon⭘ Consultant Anaesthetist⭘ Consultant Intensivist⭘ None | Changed in Dec 2019 Yr7 |  |  |  |
| **3.2** | If documented, how was this assessment of risk made? (Please select all that apply)(No longer required) | ⭘ Risk prediction tool (e.g. P-POSSUM)⭘ Clinical Judgement ⭘ Surgical APGAR ⭘ Physiological criteria ⭘ Other e.g. hospital policy | Removed from Dec 2019 Yr7 |  |  |  |
| **3.3** | What was the **ASA** score? | ⭘ 1: No systemic disease⭘ 2: Mild systemic disease ⭘ 3: Severe systemic disease, not life-  threatening⭘ 4: Severe, life-threatening ⭘ 5: Moribund patient  |  |  |  |  |
| **3.4** | What was the most recent pre-operative value for serum Creatinine (micromol/l) |  ⭘Not performed |  |  |  |  |
| **3.5** | What was the most recent pre-operative value for blood lactate – may be arterial or venous (mmol/l) |  ⭘ Not performed |  |  |  |  |
| **3.5i** | What was the most recent pre-operative value for CRP (mg/l)? (No longer required) |  ⭘ Not performed | Removed from Dec 2019 Yr7 |  |  |  |
| **3.5ii** | What was the lowest albumin in pre- operative period (g/l)?  |  ⭘ Not performed |  |  |  |  |
|  | **NELA Risk calculation** |  |  |  |  |  |
|  | **For questions 3.6 to 3.22 please enter values closest to time of booking for theatre in order to calculate NELA Risk score. Answers should reflect chronic *and* acute pathophysiology**. |  |  |  |  |
| **3.6** | Serum Sodium concentration (mmol/l) |  |  |  |  |  |
| **3.7** | Serum Potassium concentration (mmol/l) |  |  |  |  |  |
| **3.8** | Serum Urea concentration (mmol/l) |  |  |  |  |  |
| **3.9** | Serum Haemoglobin concentration (g/dl) |  |  |  |  |  |
| **3.10** | Serum White cell count (x10∧9 / l) |  |  |  |  |  |
| **3.11** | Pulse rate(bpm) |  |  |  |  |  |
| **3.12** | Systolic blood pressure (mmHg) |  |  |  |  |  |
| **3.13** | Glasgow coma scale |  |  |  |  |  |
| **3.14** | Select an option that best describes this patient’s **ECG** | ⭘ No abnormalities ⭘ AF rate 60-90⭘ AF rate >90/ any other abnormal rhythm/paced rhythm/ >5VE/min/  |  |  |  |  |
| **3.15** | Select an option that best describes this patient’s **cardiac signs** and chest xray appearance | ⭘ No failure⭘ Diuretic, digoxin, antianginal or  antihypertensive therapy⭘ Peripheral oedema, warfarin  Therapy or CXR: borderline  cardiomegaly⭘ Raised jugular venous pressure or CXR: cardiomegaly |  |  |  |  |
| **3.16** | Select an option that best describes this patient’s **respiratory history** and chest xray appearance | ⭘ No dyspnoea⭘ Dyspnoea on exertion or CXR: mild  COAD⭘ Dyspnoea limiting exertion to < 1  Flight or CXR: moderate COAD⭘ Dyspnoea at rest/rate > 30 at rest or CXR: fibrosis or consolidation |  |  |  |  |
| **3.16a** | Patient was ventilated prior to emergency laparotomy(No longer required) | ⭘Yes⭘No  | Removed from Dec 2017 Yr5 |  |  |  |
|  | *Online web tool will automatically calculate Physiology severity score* |  |  |  |  |  |
| **3.17** | Select the **operative severity** of the intended surgical intervention (see help box for examples) | ⭘ Major⭘ Major+ |  |  |  |  |
| **3.18** | Including this operation, how many operations has the patient had in the 30 day period prior to this procedure? | ⭘ 1⭘ 2⭘ >2 |  |  |  |  |
| **3.19** | Based on your clinical experience of the intended surgery, please estimate the likely ***intra*operative blood loss** (ml) | ⭘ <100⭘101-500⭘ 501-999⭘ >=1000 |  |  |  |  |
| **3.20** | Please select a value that best describes the likely degree of **peritoneal soiling**  | ⭘ None⭘ Serous fluid⭘ Localised pus⭘ Free bowel content, pus or blood |  |  |  |  |
| **3.21** | What severity of malignancy is anticipated to be present? | ⭘ None⭘ Primary only⭘ Nodal metastases⭘ Distant metastases |  |  |  |  |
| **3.22** | What was the global impression of the urgency of surgery at the time of booking the case? (see help notes for additional information) | ⭘ 3. Expedited (>18 hours)⭘ 2B. Urgent (6-18 hours)⭘ 2A. Urgent (2-6 hours)⭘ 1. Immediate (<2 hours) |  |  |  |  |
|  | *Online web tool will automatically calculate Operative severity score* |  |  |  |  |  |
| **3.23** | Pre-op P-POSSUM predicted mortality*CAUTION: P-POSSUM can over predict mortality (up to two-fold) at risk levels above 15%. See 3.26 for NELA risk model estimate.*(No longer required) | Calculated  | Removed from Dec 2018 Yr6 |  |  |  |
| **3.24** | Pre-op POSSUM predicted morbidity(No longer required) | Calculated  | Removed from Dec 2018 Yr6 |  |  |  |
| **3.25** | Not all investigations available for calculation of NELA Risk | ⭘ |  |  |  |  |
| **3.26** | Estimated mortality using NELA risk adjustment model *(Figure only provided if all data available)* | Calculated |  |  |  |  |

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| **4** | **Intra-op**  |  | **Years collected****(1-9 unless otherwise specified)** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **4.1** | Date and time of entry into operating theatre/anaesthetic room (not theatre suite) | Date \_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY)Time\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM) Time not known |  | IDENTIFIABLE |  | Interval may be requested. Please specify |
| **4.2** | Senior surgeon grade*(this can include surgeon supervising in theatre but not necessarily scrubbed)* | ⭘ Consultant⭘ Post-CCT fellow⭘ SAS grade⭘ Research Fellow / Clinical Fellow⭘ Specialty trainee / registrar⭘ Other |  |  |  |  |
| **4.2a** | Consultant present/supervising: Name/GMC/specialty of operating or supervising consultant *(If consultant not present, enter name of supervising consultant)* | (Please select consultant - Online) |  | NOT AVAILABLE |  |  |
| **4.3** | Senior anaesthetist present in theatre | ⭘ Consultant⭘ Post-CCT fellow⭘ SAS grade⭘ Research Fellow / Clinical Fellow⭘ Specialty trainee / registrar⭘ Other |  |  |  |  |
| **4.3a** | Consultant present (or supervising) : Name/GMC of anaesthetist*(If consultant not present, enter name of supervising consultant)* | (Please select consultant - Online) |  | NOT AVAILABLE |  |  |
| **4.4** | How did you provide goal directed fluid therapy? | ⭘ Patient recruited to FLO-ELA trial \*⭘ Not provided⭘ Dynamic index e.g. Stroke volume, PPV, SVV⭘ Static index e.g. CVP⭘ Other, eg bioimpedence |  |  |  |  |

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| **5** | **Procedure**  |  | **Years collected****(1-9 unless otherwise specified)** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **5.1** | Is this the first surgical procedure of this admission? | ⭘ Yes- First surgical procedure after admission⭘ No - Surgery for complication of previous elective general surgical procedure within the same admission⭘ No – Surgery for complication of previous elective gynae-oncology surgical procedure within the same admission **(from Dec 2021 Yr9)**⭘ No – Previous 'non-abdominal/non-general surgical' procedure within same admission (eg previous hip replacement)⭘ Unknown | **(see notes)** |  |  |  |
| **5.2** | What is the indication for surgery? *(Please select all that apply)* | ⭘ Peritonitis⭘ Perforation⭘ Abdominal abscess⭘ Anastomotic leak⭘ Intestinal fistula⭘ Phlegmon **(from Dec 2015 Yr3)**⭘ Pneumoperitoneum **(from Dec 2015 Yr3)**⭘ Necrosis **(from Dec 2015 Yr3)**⭘ Sepsis⭘ Small bowel obstruction **(from Dec 2015 Yr3)**⭘ Gastric Outlet obstruction **(from Dec 2021 Yr9)** ⭘ Large bowel obstruction **(from Dec 2015 Yr3)**⭘ Volvulus **(from Dec 2015 Yr3)**⭘ Internal hernia **(from Dec 2015 Yr3)**⭘ Pseudo-obstruction **(from Dec 2015 Yr3)**⭘ Intussusception **(from Dec 2015 Yr3)**⭘ Incarcerated hernia **(from Dec 2015 Yr3)**⭘ Obstructing incisional hernia **(from Dec 2015 Yr3)**⭘ Haemorrhage⭘ Ischaemia⭘ Colitis ⭘ Abdominal wound dehiscence ⭘ Abdominal compartment syndrome⭘ Acidosis **(from Dec 2015 Yr3)**⭘ Iatrogenic injury **(from Dec 2015 Yr3)**⭘ Foreign body **(from Dec 2015 Yr3)**⭘ Planned relook⭘ Hiatus Hernia/para-oesophageal hernia⭘ Other **(Dec 2013 Yr1, Dec 2014 Yr2 and from Dec 2021 Yr9)**  | **(see notes)** |  |  |  |
| **5.3.a** | Main procedure  | ⭘ Peptic ulcer – suture or repair of perforation⭘ Peptic ulcer – oversew of bleed⭘ Gastric surgery - other⭘ Gastrectomy: partial or total **(from Dec 2015 Yr3)**⭘ Small bowel resection⭘ Resection of Meckel’s diverticulum **(from Dec 2015 Yr3)**⭘ Repair of para-oesophageal hernia; ⭘ Removal of gastric band⭘ Colectomy: left (including sigmoid colectomy and anterior resection)⭘ Colectomy: right (including ileocaecal resection)⭘ Colectomy: subtotal or panproctocolectomy⭘ Hartmann’s procedure⭘ Colorectal resection - other⭘ Abdominal wall closure following dehiscience⭘ Abdominal wall reconstruction **(from Dec 2015 Yr3)**⭘ Adhesiolysis ⭘ Drainage of abscess/collection⭘ Evacuation of haematoma **(from Dec 2015 Yr3)**⭘ Debridement **(from Dec 2015 Yr3)**⭘ Exploratory/relook laparotomy only⭘ Haemostasis⭘ Intestinal bypass ⭘ Laparostomy formation ⭘ Repair of intestinal perforation⭘ Repair or revision of anastomosis **(from Dec 2015 Yr3)**⭘ Repair of intestinal fistula **(from Dec 2015 Yr3)**⭘ Resection of other intra-abdominal tumour(s)⭘ Defunctioning stoma via midline laparotomy **(from Dec 2015 Yr3)**⭘ Revision of stoma via midline laparotomy **(from Dec 2015 Yr3)**⭘ Washout only⭘ Reduction of volvulus **(from Dec 2015 Yr3)**⭘ Enterotomy **(from Dec 2015 Yr3)**⭘ Stricturoplasty **(from Dec 2015 Yr3)**⭘ Removal of foreign body⭘ Large incisional hernia repair with bowel resection **(from Dec 2016 Yr4)**⭘ Large incisional hernia repair with division of adhesions **(from Dec 2016 Yr4)**⭘ Not amenable to surgery ⭘ Other **(Dec 2013 Yr1, Dec 2014 Yr2 and from Dec 2021 Yr9)** | **(see notes)** |  |  |  |
| **5.3.b** | Second procedure (at same laparotomy) | ⭘ Peptic ulcer – suture or repair of perforation⭘ Peptic ulcer – oversew of bleed⭘ Gastric surgery - other⭘ Gastrectomy: partial or total⭘ Small bowel resection⭘ Resection of Meckel’s diverticulum⭘ Repair of para-oesophageal hernia⭘ Removal of gastric ban⭘ Colectomy: left (including sigmoid colectomy and anterior resection)⭘ Colectomy: right (including ileocaecal resection)⭘ Colectomy: subtotal or panproctocolectomy⭘ Hartmann’s procedure⭘ Colorectal resection - other⭘ Splenectomy **(from Dec 2021 Yr9)**⭘ Abdominal wall closure following dehiscience⭘ Abdominal wall reconstruction⭘ Abdominal hernia repair⭘ Adhesiolysis⭘ Drainage of abscess/collection⭘ Evacuation of haematoma⭘ Debridement⭘ Haemostasis⭘ Intestinal bypass⭘ Laparostomy formation⭘ Repair of intestinal perforation⭘ Repair or revision of anastomosis⭘ Repair of intestinal fistula⭘ Resection of other intra-abdominal tumour(s)⭘ Defunctioning stoma via midline laparotomy⭘ Revision of stoma via midline laparotomy⭘ Reduction of volvulus⭘ Enterotomy⭘ Stricturoplasty⭘ Removal of foreign body⭘ Other **(Dec 2013 Yr1, Dec 2014 Yr2 and from Dec 2021 Yr9)** |  |  |  |  |
| **5.3e** | Was a stoma formed (by any means)? | ⭘ Yes⭘ No | From Dec 2019 Yr7 |  |  |  |
| **5.4** | Procedure approach | ⭘ Open⭘ Laparoscopic⭘ Laparoscopic assisted⭘ Laparoscopic converted to open |  |  |  |  |
| **5.5** | Operative findings:*(Please select all that apply)**If unsure whether this patient is eligible for NELA please refer to help box* | ⭘ Abscess⭘ Adhesions ⭘ Anastomotic leak⭘ Ulcerative colitis **(from Dec 2015 Yr3)**⭘ Other colitis **(from Dec 2015 Yr3)**⭘ Crohn's disease ⭘ Abdominal compartment syndrome⭘ Diverticulitis⭘ Intestinal fistula **(from Dec 2015 Yr3)**⭘ Haemorrhage – peptic ulcer⭘ Haemorrhage – intestinal⭘ Haemorrhage – postoperative⭘ Incarcerated hernia⭘ Internal hernia **(from Dec 2015 Yr3)**⭘ Intussusception **(from Dec 2015 Yr3)**⭘ Stricture **(from Dec 2015 Yr3)**⭘ Pseudo-obstruction **(from Dec 2015 Yr3)**⭘ Gallstone ileus **(from Dec 2015 Yr3)**⭘ Meckel’s diverticulum **(from Dec 2015 Yr3)**⭘ Intestinal ischaemia⭘ Necrotising fasciitis **(from Dec 2015 Yr3)**⭘ Foreign body **(from Dec 2015 Yr3)**⭘ Stoma complications **(from Dec 2015 Yr3)**⭘ Abdominal wound dehiscence **(from Dec 2015 Yr3)**⭘ Malignancy – localised⭘ Malignancy – disseminated⭘ Colorectal cancer **(from Dec 2015 Yr3)**⭘ Gastric cancer **(from Dec 2015 Yr3)**⭘ Perforation – peptic ulcer⭘ Perforation – small bowel/colonic⭘ Volvulus⭘ Normal intra-abdominal findings⭘ Other **(Dec 2013 Yr1, Dec 2014 Yr2 and from Dec 2021 Yr9)** | **(see notes)** |  |  |  |
| **5.6** | Please describe the peritoneal contamination present *(select all that apply)* | ⭘ None or reactive serous fluid only⭘ Free gas from perforation +/- minimal contamination⭘ Pus⭘ Bile⭘ Gastro-duodenal contents⭘ Small bowel contents⭘ Faeculent fluid⭘ Faeces⭘ Blood/haematoma |  |  |  |  |
| **5.7** | Please indicate if the contamination was; | ⭘ Localised to a single quadrant of the abdomen⭘ More extensive / generalised |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **6** | **Post-op Risk stratification** |  | **Years collected****(1-9 unless otherwise specified)** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **6.1** | At the end of surgery, what was the risk of death for the patient that was entered into medical record? | ⭘ Lower (<5%)⭘ High (>=5%)⭘ Not documented  | Changed in Dec 2018 Yr6 |  |  |  |
| **6.1a** | If documented, how was risk assessed? | ⭘ Objective clinical score⭘ Clinical judgement | From Dec 2019 Yr7 |  |  |  |
| **6.2** | How was this assessment of risk made? (Please select all that apply)(No longer required) | ⭘ Risk prediction tool (e.g. P-POSSUM)⭘ Clinical Judgement ⭘ Surgical APGAR ⭘ Physiological criteria ⭘ Other e.g. hospital policy | Removed from Dec 2019 Yr7 |  |  |  |
| **6.3** | Blood lactate – may be arterial or venous (mmol/l) |   Not performed |  |  |  |  |
|  | **Post-operative NELA Risk calculation**Q 6.4 – 6.14 No Longer Required |  |  |  |  |  |
|  | Physiology severity score: |  |  |  |  |  |
| **6.15** | What was the operative severity? (see help box for examples) | ⭘ Major⭘ Major+ |  |  |  |  |
| **6.16** | Including this operation, how many operations has the patient had in the 30 day period prior to this procedure? | ⭘ 1⭘ 2⭘ >2 |  |  |  |  |
| **6.17** | Please select this patient’s measured/estimated intraoperative blood loss (ml) | ⭘ <100⭘ 101-500⭘ 501-1000⭘ >1000 |  |  |  |  |
| **6.18** | Please select the option that best describes this patient’s degree of peritoneal soiling | ⭘ None⭘ Serous fluid⭘ Local pus⭘ Free bowel content, pus or blood |  |  |  |  |
| **6.19** | What was the level of malignancy based on surgical findings | ⭘ None⭘ Primary only⭘ Nodal metastases⭘ Distant metastases |  |  |  |  |
| **6.20** | What was the NCEPOD urgency?*(see help notes for additional information)* | ⭘ 3. Expedited (>18 hours)⭘ 2B. Urgent (6-18 hours)⭘ 2A. Urgent (2-6 hours)⭘ 1. Immediate (<2 hours) |  |  |  |  |
|  | *Online web tool will automatically calculate Operative severity score* |  |  |  |  |  |
| **6.21** | Post-op P-POSSUM predicted **mortality**:(No longer required) | Calculated  | Removed from Dec 2018 Yr6 |  |  |  |
| **6.22** | Post-op POSSUM predicted **morbidity**:(No longer required) | Calculated  | Removed from Dec 2018 Yr6 |  |  |  |
| **6.23** | Not all investigations available for calculation of NELA | ⭘  |  |  |  |  |
| **6.24** | Where did the patient go for continued post-operative care following surgery? | ⭘ Ward⭘ Critical Care (includes Level 2 HDU or Level 3 ICU) ⭘ Extended recovery area within theatres (eg PACU or OIR) **(From Dec 2019 Yr7)**⭘ Enhanced care area on a normal ward **(from Dec 2019 Yr7)**⭘ Other enhanced care area (eg PACU) **(removed in Dec 2019 Yr7)**⭘ Died prior to discharge from theatre complex |  |  |  |  |
| **6.24a** | At the end of surgery, was the decision made to place the patient on an end of life pathway? | ⭘ Yes⭘ No | From Dec 2015 Yr 3 |  |  |  |
| **6.25** | Is the patient on a vasopressor/ inotrope?(No longer required) | ⭘Yes⭘No  | Removed from Dec 2016 Yr 4 |  |  |  |
| **6.26** | Estimated mortality using NELA risk adjustment model *(Figure only provided if all data available)* | Calculated  | From Dec 2016 Yr 4 |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **7** | **Post-op – *Some fields will need to be completed on discharge or death*** |  | **Years collected****(1-9 unless otherwise specified)** | **Do you require this field?****Y/N** | **Justification for request** | ***Restrictions****(to be completed by NELA)* |
| **7.1** | Total length of post-operative critical care stay (rounded up to whole days). *Includes both ICU and HDU stay -see help box for additional information. Do not include LOS in PACU/other enhanced recovery area* | Number required | (Yrs 1-3, ICU & HDU asked as separate questions) |  |  |  |
| **7.2** | Total length of post-operative HDU stay (days) see help box for additional information(No longer required) | Number required | Removed from Dec 2016 Yr 4 |  |  |  |
| **7.3** | For patients aged 80 or older, or 65+ and frail (CFS≥5), was the patient assessed by a member of the geriatrician-led multidisciplinary team during any part of the perioperative period? | ⭘ Yes⭘ No⭘ Unknown | Changed in Dec 2018 Yr6, Dec 2019 Yr7, Dec 2020 Yr8 and Dec 2021 Yr9 |  |  |  |
| **7.4** | Within this admission, did the patient have an unplanned or planned return to theatre in the postoperative period following their initial emergency laparotomy? | ⭘ Yes; unplanned return⭘ Yes; planned return⭘ Yes; unplanned AND planned return⭘ No ⭘ Unknown | In Dec 2016 Yr4 “unplanned” added |  |  |  |
| **7.4a** | What was the main indication for the return to theatre?*(Only one option to be chosen)*  | ⭘Anastomotic leak⭘Abscess⭘Bleeding or Haematoma⭘Decompression of abdominal compartment syndrome⭘Bowel obstruction ⭘Abdominal wall dehiscence⭘Accidental damage to bowel or other organ⭘Stoma viability or retraction⭘Ischaemia/non-viable bowel⭘Sepsis/inadequate source control⭘Deteriorating patient⭘Missed pathology at first laparotomy⭘Other⭘Unknown | From Dec 2016 Yr4 |  |  |  |
| **7.4b** | What was the main indication for the **planned** return to theatre?*(Select most significant)*(No longer required) | ⭘ Removal of packs / ensure haemostasis / washout⭘ Closure of laparostomy⭘ Removal of bogota bag / formation of formal laparostomy with mesh / vac dressing insertion⭘ Definitive procedure following “damage control surgery” +/- stoma formation, +/- restoration of intestinal continuity⭘ Assess viability of GI tract, +/- stoma formation, +/- restoration of intestinal continuity⭘ Other⭘ Unknown | Removed from Dec 2019 Yr7 |  |  |  |
| **7.5** | Did the patient have an unplanned move **from the ward** to a higher level of care within 7 days of surgery? (do not include moves from HDU to ITU, or escalation from other enhanced area/PACU) | ⭘ Yes⭘ No⭘ Unknown |  |  |  |  |
| **7.6** | Histology(No longer required) | ⭘ Crohn's disease⭘ Diverticulitis⭘ Ischaemia⭘ Malignancy⭘ Peptic ulcer disease⭘ Ulcerative colitis⭘ Not applicable/Not available at time of discharge⭘ Other | Removed from Dec 2016 Yr 4 |  |  |  |
| **7.7** | Status at discharge | ⭘ Dead ⭘ Alive ⭘ Still in hospital at 60 days **(from Dec 2014 Yr 2)**  | **(see notes)** |  |  |  |
| **7.8** | Date discharged from hospital | (DD/MM/YYYY) Date required |  | IDENTIFIABLE |  | Specify interval requested  |
| **7.9** | Discharge destination(No longer required) | ⭘ Own home/sheltered housing  ⭘ Residential care ⭘ Nursing care⭘ Hospital transfer for medical reasons⭘ unknown | From Dec 2016 Yr4.Removed in Dec 2019 Yr7 |  |  |  |
|  | **COVID-19 Questions** |  |  |  |  |  |
| **7.10** | Please indicate the patient's SARS-CoV-2/COVID-19 infection status | O COVID symptoms and COVID-19 test positive (eg lateral flow, POCT, PCR) – confirmed pre-operativelyO No COVID symptoms but COVID-19 test positive (eg lateral flow, POCT, PCR) – confirmed pre-operativelyO COVID symptoms and COVID-19 test positive (eg lateral flow, POCT, PCR)– confirmed post-operativelyO No COVID symptoms but COVID-19 test positive (eg lateral flow, POCT, PCR) – confirmed post-operativelyO COVID negative testing throughout in-patient stayO Not tested/status unknown | Introduced in March 2020 Yr7. Changed in Dec 2010 Yr 8 & Dec 2021 Yr 9 ) |  |  |  |
| **7.11** | Regardless of actual COVID status, was the patient managed as infected with COVID whilst in the theatre suite for their initial emergency laparotomy (this does not mean, was enhanced PPE used only for the AGPs)(No longer required) | YesNoUnable to answer | Introduced in March 2020 Yr7. Removed in Dec 2020 Yr8  |  |  |  |
| **7.12** | Please indicate the patient's SARS-CoV-2 antibody status(No longer required) | PositiveNegativeNot testedUnable to answer | Introduced in March 2020 Yr7. Removed in Dec 2020 Yr8 |  |  |  |