



NATIONAL EMERGENCY LAPAROTOMY AUDIT TOP TIPS – Updated November 2018

These 'top tips' were derived from current NELA audit participants and how they are making the audit work at their hospital site.

If you have any 'top tips' you would like to share please send them into - info@nela.org.uk

HOW TO ENSURE COMPLETING PRE-OP RISK ASSESSMENT

I would like to share an example of a simple yet effective strategy that we have employed in our Trust for preop risk assessment. Our analysis of previous years showed that preoperative risk assessment was not being consistently completed or recorded for NELA patients and that we were lagging behind the national average.

So at the beginning of this year, we introduced a pink coloured emergency laparotomy booking form – it is called the 'PINK FORM' because it is pink paper. It is easily recognised by all the staff that it is a booking form for emergency laparotomy and thus immediately raises everyone's awareness that a laparotomy is on the horizon.

We also introduced additional data inputs on the booking form – see details with the red box in the attached booking form (pdf).

1. NELA SCORE
2. Has ITU been informed if the risk is $\geq 5\%$?

If any of the above two data is lacking, the laparotomy CANNOT be booked in theatre. This ensured that every patient had to have a risk assessment completed and ITU to be made aware in all relevant cases. After some teething issues, this is now well established in practice and has meant improvement.

I hope you will be able to share and highlight this through your newsletters and NELA website as an example of simple yet effective strategy for compliance with regard to an extremely vital component of NELA practice.

(Mr S Subramonia – South Tyneside District Hospital)

HOW TO RAISE AWARENESS OF NELA

- Arrange multidisciplinary meetings with NELA surgery lead, ICU consultants, nursing managers etc.
 - Fortnightly meetings between clinical audit manager and lead surgeon.
- (Michael Spry – Countess of Chester Hospital)***
- Carry out presentations to:
 - Surgeons/Anaesthetists in their audit meetings to give background of NELA. These should be ongoing throughout the process to help spread the message. Try and arrange a joint Surgical and Anaesthetic Audit meeting to discuss NELA.
 - Trust Board governance committee for scheduled care about NELA



(Kathryn Aspinwall – North Devon District Hospital)

- Monthly meetings of Acute Care Group
 - The whole hospital to inform them of this ongoing audit
- Provide a short report to Chief exec about the work carried out so far on this front- especially current NELA activity.
 - Talk to the Communications Manager for the Trust for the intranet:
 - Put NELA on Trust main page to inform everyone.
 - Print and distribute fliers all over the hospital. Use the posters and information you can download on the NELA website. Update these regularly as you get more results as it is read by all the staff.
 - Send out regular updates to surgeons and anaesthetists on NELA progress and what needs doing.

(Abhi Arnold – Watford General Hospital)

DATA ENTRY

Below are some suggestions and ideas that are being tried out at different hospital sites to assist in the completion of the NELA audit.

Some of these may work at your hospital and hopefully provide you with ideas on what can be done.

- We have a checklist on A4 yellow paper in place for booking patients needing an emergency laparotomy. We have added the NELA questions to this checklist to be completed by clinical staff. We have also added an extra table to ensure NELA data is being entered:

Action	By Whom	When	Name of person completing	Entered onto NELA database (Y/N)
Section 1	Surgeon	Pre Op		

(Top tip from Pauline McKinney – Northumbria NHS Trust)

- We have laminated the inclusion/exclusion criteria and attached it to the Anaesthetic machine in Emergency Theatres.
- We use our hospital system ‘ORMIS’ to check potential NELA patients that have gone through emergency theatre and then see if they are on the NELA database.
- I have arranged with IT to receive a weekly report of all patients admitted & discharged during the previous 8 weeks. The data includes admission date, discharge date or date of death. I cross check each uncompleted case with this, which enables me to complete discharge or death dates.

(Nick Harper – Blackpool Victoria Hospital)

- Retrospectively, we ask the anaesthetists to complete their section and then send it on the surgeon, I think the fact that people do find this a lot more tiresome than temporal completion has made temporal completion more attractive, and improved compliance. We also post the incomplete patients’ names by surgeon at our monthly quality and safety

meetings, as a reminder, after which we do see a flurry of activity. Compliance is also improving with familiarity.

- I check the theatre book regularly to catch the missed cases as I noted you are not obtaining the equivalent of HES data from Wales, so all our cases are eventually entered.
- We have placed paper forms in the reception area of the operating theatres and keep alongside it a notebook with a record of all patients being recruited. Once these are complete they are ticked off.
- I go through the CEPOD list to pick up any relevant cases that are not already entered.

(Abhi Arnold – Watford General Hospital)

- We have put in place this system:
 - Make forms available in Surgical admissions Unit and Emergency Theatres
 - These are filled out by operating surgeon and anaesthetists and in left in a tray in the emergency theatre.
 - Forms are picked up and checked by research nurses and checked for omissions
 - Omissions are followed up by email to surgeon and/or anaesthetists

(Neil Flint – Leicester Royal infirmary)

- Have explained to surgical teams and theatre staff that any potential case must have NELA form filled out in order to be booked into theatre.
- Adding an aide memoir to the checklist to ensure all patients are captured.

(Phillip Dodd – Hampshire hospitals Trust)

- The theatre clerk copies for me the daily emergency lists so that I can access patient notes to firstly see if they are to be included in the audit.
- I have devised a simple chart which indicates patient details, where I am up to with data collection, what I am waiting for to complete (e.g. histology/discharge date).

(Christine Hughes – Macclesfield District General Hospital)

- We are integrating the NELA dataset within our own Emergency Laparotomy Pathway. So we are now more specific about the extra information we collect routinely on anaesthetic charts and surgical notes.
- We have a research nurse that has taken responsibility for coordinating data entry.
- We have a theatre booking system that flags emergency laparotomies, with a requirement to consider POSSUM scores.
- Having a designated NELA employee to take on the role of audit coordinator makes it more efficient overall.

(Guy Titley – The Royal Bournemouth Hospital)

- NELA paper proforma kept in theatre and then use an excel tracker sheet to track cases. This tracker is sent out weekly to surgical teams.

(Michael Spry – Countess of Chester Hospital)

- For any cases that are not complete, we review the casenotes. If there is a large bit of data missing, we will ask the operating clinician or anaesthetics to complete the form with the casenotes.

(Natalie Draper – Leicester Royal infirmary)



- We placed 50 copies of the audit tool (which incorporates our hospital's local instructions) in Day-Glo folders in the relevant theatres. We then placed a Day-Glo folder in the theatre recovery room for completed forms (we had to sellotape this to the desk to avoid it leaving the room).

(Sue Marshall – Airedale General Hospital)

- Discussion between Surgeons and Anaesthetists on how best to complete the form and when each section will be complete.
 - For example the first 3 sections could be filled in before booking the case to theatre as far as possible to allow discussion of P-POSSUM predicted mortality and level of cover required
 - Sections 4 to 6 could be done in theatre jointly by surgeons and anaesthetists. Anaesthetic trainee have to get hold of operating surgeon to complete this before they leave theatre
 - Section 7 could be filled in by Surgical team at the time of discharge (when they dictate discharge letter)

(Seema Charters - Warrington Hospital)

- Section 7 – We have decided that it is the Audit department role to complete this section. Once a week we will go to theatres and collect the completed yellow sheets. When one comes back incomplete I send the form back to the surgeon/anaesthetist for completion where I highlight what is still missing, along with a self-addressed envelope back to my department to make it easier for them.

(Pauline McKinney – Northumbria NHS Trust)

- As a way to remind colleagues to enter data use a NELA sticker to be printed on patient ID label paper. This can be stuck on the patient notes and could help as a prompt to complete data

(Seema Charters - Warrington Hospital)

- Contact individual consultants to remind them to enter or complete data entering
- Periodic check of emergency theatre register to make sure that all eligible cases are in the database. Email trainees and consultants' reminders if some of the data are not filled in.

(Babu Muthuswamy – Aneurin Bevan Health Board)