Royal College of Anaesthetists | Centre for Research and Improvement | Royal College of Surgeons of England | HQIP Healthcare Quality Improvement Partnership

NoLap Question Proforma

1.	Decision for NoLAP	
1.1	Does the patient have a diagnosis of bowel perforation or suspected bowel ischaemia, where surgery is indicated?	○ Yes ○ No
1.2	Is surgery planned for this patient?	○ Yes (please proceed to fill out the NELA database) ○ No (please proceed to question 1.3)
1.3	Will this patient be considered for surgery or interventional radiology procedures if condition deteriorates?	○ Yes (please proceed to fill out the appropriate database once a definitive decision is made) ○ No (this is a patient for NoLAP database. Please proceed to fill in the remaining questions)

2.	Demographics and Admission	
2.1	NHS number	
2.2	Local patient ID/ hospital number	
2.3	Date of birth	
	Age on arrival	Age will automatically be calculated on the web tool
2.4	Sex	Male/ Female
2.5	Forename	
2.6	Surname	
2.7	Postcode	
2.8	Date and time the patient first arrived at the hospital/ emergency department	Date (DD/MM/YYYY) Date not known Time (HH:MM) Time not known
2.9	What is the nature of this admission?	○ Elective ○ Non-elective
	If non-elective, what is 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
	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 known Time (HH:MM) Time not known
2.10	Which specialty was this patient first admitted under?	○ General surgery ○ General medicine ○ Gastroenterology ○ Elderly care ○ Oncology ○ Gynaecology (including gynae-oncology) ○ Other

3.	Review and Decision Making	

3.1	Date and time first seen by non-consultant (ST3+ or equivalent) surgeon following first presentation with acute abdomen. If under the care of a non-surgical specialty, this should be time first seen after referral to general surgeons.	Date (DD/MM/YYYY) Date not known Time (HH:MM) Time not known
3.2	Date and time first seen by consultant surgeon following presentation with acute abdomen. If under the care of a non-surgical specialty, this should be time first seen after referral to general surgeons.	Date (DD/MM/YYYY) Date not known Time (HH:MM) Time not known Seen by consultant from other specialties
3.3	What was the date and time when the decision to NOT operate was made?	Date (DD/MM/YYYY) Time (HH:MM)
3.4	Who or what specialty(s) were involved in the decision to NOT proceed with surgery? *Tick all that apply*	☐ Patient ☐ Patient via a pre-defined advance care plan ☐ Next of kin or LPA ☐ General Surgery ☐ Anaesthetics ☐ Critical care ☐ Perioperative team with expertise in comprehensive geriatric assessment ☐ Emergency medicine ☐ Palliative medicine ☐ Other: (Please specify)
3.5	What is (are) the documented reason(s) for NO surgery? (please select all that apply)	☐ Patient declined surgery prior to any formal risk assessment/discussion (including the use of pre-defined advance care plan) ☐ High NELA risk score ☐ Pre-existing multi-morbidity ☐ Frailty (CFS≥5) ☐ Advanced malignancy ☐ Inoperable pathology ☐ Unsuitability for level 2/3 interventions ☐ Clinical condition at time of assessment – too unwell for surgery ☐ Other
3.6	After decision not to operate, which of the following teams were involved in the patient's care, during hospital admission? Involvement includes telephone consultation or in-person review. (please select all that apply)	☐ Palliative care team ☐ Perioperative team with expertise in comprehensive geriatric assessment ☐ Oncology ☐ Other (please specify) ☐ None of the above

4.	**CT scanning and antibiotics administration**	
4.1	Was an abdominal CT scan performed as part of diagnostic work-up? If performed, how was this CT reported?	○ Yes- reported by in-house subspecialist GI consultant ○ Yes- reported by in-house non-GI consultant ○ Yes- reported by inhouse ST3+ (non-consultant) ○ Yes- reported by outsourced service ○ Yes- CT performed but NOT reported ○ Yes- CT performed before admission (info not required on who reported)

		○ No CT performed ○ No CT performed because of sickness severity or advance decision making ○ Unknown
4.2	What was the date and time of CT scan request?	Date (DD/MM/YYYY) Date not known Time (HH:MM) Time not known
4.3	What was the date and time of the CT scan performed?	Date (DD/MM/YYYY) Date not known Time (HH:MM) Time not known
4.4	What was the date and time the CT scan was reported electronically?	Date (DD/MM/YYYY) Date not known Time (HH:MM) Time not known
4.5	In addition to any written report, was there direct communication between a senior radiologist (ST3 or above) and senior surgeon (ST3 or above) to discuss the CT findings?	○ Yes, via phone ○ Yes, in person ○ No ○ Unknown

5.	**Advance care plan/ Treatment escalation plan**	
5.1	Was a pre-existing DNA-CPR order in place on patient's arrival to hospital? In order to select 'unable to determine', there must be some documentation that an attempt has been made to establish the presence of a DNA-CPR order.	○ Yes ○ No ○ Unable to determine, eg family not present ○ Unknown
5.2	Was any other type of pre-determined advance care plan(s) available in patient's medical records on arrival to hospital? In order to select 'unable to determine', there must be some documentation that an attempt has been made to establish the presence of an advance care plan.	○ Yes ○ No ○ Unable to determine, eg family not present ○ Unknown
5.3	If yes to 5.2, what is (are) the advance care plan(s) in place? *Tick all that apply*	○ Advance statement of wishes, preferences, and priorities ○ Advance decision to refuse treatment (ADRT) ○ ReSPECT form ○ Trust treatment escalation plan ○ Nomination of a lasting power of attorney ○ Other (please specify):
5.4	If yes to 5.2, To which aspects of care did the documented advance care plan refer specifically? *Tick all that apply*	○ Avoidance of hospital admission ○ Avoidance of surgery ○ Avoidance of transfer to critical care ○ Avoidance of other specific medical interventions ○ Other ○ Unknown

6	**Risk assessment**	
6.1	What was the risk of death for the patient that was entered into the medical record?	○ Lower (<5%) ○ Higher (>=5%)

		○ Not documented
	If documented, how was the risk assessed?	○ Objective clinical score ○ Clinical judgement, including e.g frailty assessment
6.2	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
For the following questions, please enter most recent values prior to the decision to NOT OPERATE being made.		
6.3	Serum creatinine (micromol/l)	
6.4	Blood lactate- may be arterial or venous (mmol/l)	
6.5	Serum albumin (g/l)	
6.6	Serum urea concentration (mmol/l)	
6.7	Serum white cell count (x10^9/l)	
6.8	Pulse rate (bpm)	
6.9	Systolic blood pressure (mmHg)	
6.10	Glasgow coma scale	
6.11	Select an option that best describes this patient's respiratory history and chest x-ray appearance	○ No dyspnoea ○ Dyspnoea on exertion or CXR chows mild COAD ○ Dyspnoea limiting exertion to <1 flight or CXR shows moderate COAD ○ Dyspnoea at rest/ rate>30 at rest or CXR shows fibrosis or consolidation
6.12	Please select a value that best describes the likely degree of peritoneal soiling	○ None ○ Serous fluid ○ Localised pus ○ Free bowel content, pus or blood
6.13	What severity of malignancy is anticipated to be present?	○ None ○ Primary only ○ Nodal metastases ○ Distant metastases
6.14	Had the patient been eligible for surgery, what would the global impression of the urgency of theatre access have been?	○ 3. Expedited (>18 hours) ○ 2B. Urgent (6-18 hours) ○ 2A. Urgent (2-6 hours) ○ 1. Immediate (2 hours)
6.15	Abdominal pathology *(Please select all that apply)*	**Bleeding** ○ Haemorrhage **Other** ○ Abdominal wound dehiscence ○ Abdominal compartment syndrome ○ Planned relook ○ Other **Obstruction** ○ Tender small bowel obstruction ○ Non-tender small bowel obstruction ○ Tender large bowel obstruction ○ Non-tender large bowel obstruction

		O Gastric outlet obstruction O Incarcerated/ strangulated hernia O Hiatus hernia/ para-oesophageal hernia O Volvulus O Internal hernia O Obstructing incisional hernia O Intussusception O Pseudo-obstruction O Foreign body **Sepsis** O Phlegmon O Pneumoperitoneum O Sepsis O Iatrogenic injury O Anastomotic leak O Peritonitis O GI perforation O Abdominal abscess O Intestinal fistula **Ischaemia** O Necrosis O Ischaemia/ infarction O Colitis O Acidosis
6.16	Estimated mortality using NELA Parsimonious Risk Score *(Figure only provided if all data available)*	
6.17	On admission to hospital and using the Clinical Frailty Score (Rockwood), what was the patient's pre-admission frailty status?	O 1-3 (not frail) O 4 (vulnerable) O 5 (mildly frail) O 6 (moderately frail) O 7 (severely frail – completely dependent for personal care) O 8 (very severely frail) O 9 (terminally ill) O Not recorded or not done

7.	**Recognition and care for the dying patient**	
7.1	During this admission, was it recognised that the patient was dying??	O Yes O No O Unknown
7.2	If yes to 7.1, was there an individualised end-of-life care plan documented? (in either the medical or nursing records)	O Yes O No O Unknown

8.	**Patient's outcome**	
8.1	Status at discharge	O Dead O Alive O Still in hospital at 60 days
	Date of death (If applicable)	
8.2	Date discharged from hospital (if applicable)	

8.3	Was a DNA-CPR order in place at time of hospital discharge?	○ Yes ○ No ○ Unknown
8.4	Was a formal advance care plan in place at the time of hospital discharge?	○ Yes ○ No ○ NA – patient died in hospital ○ Unknown
8.5	If yes to Q8.4, what advance care plan was in place at time of hospital discharge?	○ Advance statement of wishes, preferences, and priorities ○ Advance decision to refuse treatment (ADRT) ○ ReSPECT form ○ Trust treatment escalation plan ○ Nomination of a lasting power of attorney ○ Other