NELA Patient Audit Dataset

Version Control

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 3rd year.
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 include hospital 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
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)

10.1	01/04/23	Changes for Year 10 data collection, including: ○ Addition of Q2.0, 2.7g, 2.11a, 2.11b, 211.bi, 211c, 2.11d, 2.11di, 2.11e, 2.11ei, 5.8 ○ Updates to Q2.7, 2.12, 3.1a, 3.22, 5.5, 6.1a, 6.20, 6.24a, 7.3 ○ Removal of Q2.7f, 3.1b, 3.6, 3.7, 3.9, 3.14, 3.15, 3.17, 3.18, 3.19, 6.15, 6.16, 7.10 ○ Move indication for surgery from section 5 to section 3 (Q3.24) ○ Reinstate Q6.17a
11.1	22/01/24	Changes for Year 11 data collection, including: • Addition of Q2.13, 3.2.1, 3.2.2, 7.2.1

This is the NELA proforma. All data entry will be carried out through an online data collection web tool. The web tool will be accessible via pc, tablets and mobiles

This audit is a continuous prospective audit with real time data collection. It is expected that clinical teams enter the data real time rather than retrospectively.

On the NELA Webtool by default Quality Improvement (QI) questions are enabled. If you do not wish to collect data for one or more QI questions, the questions can be disabled. This is done on the NELA webtool.

For queries, please contact info@nela.org.uk
Web tool for data entry: https://data.nela.org.uk/

This for is for information purposes only.

1.	Demographics and Admission	
1.1	NHS Number	
1.2	Pseudo-anonymisation	Computer generated
1.3	Local patient id/hospital number	
1.4	Date of birth	
	Age on arrival	*Age will automatically be calculated on web tool*
1.5	Sex	○ Male / ○ Female
1.6	Forename	
1.7	Surname	
1.8	Postcode	
1.9	Date and time the patient first arrived at the hospital/Emergency department	
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
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 known Time_____(HH:MM) ○ Time not known ○ Not applicable
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) ○ General medicine ○ Gastroenterology ○ Elderly Care ○ Other
1.12	No Longer Required	
1.13a	No Longer Required	
1.13b	No Longer Required	

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.**	
2.0	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 ○ Not Seen
2.1	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

		○ Not Seen
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 known Time_____(HH:MM) ○ Time not known
2.3	No Longer Required	
2.4	No Longer Required	
2.5	No Longer Required	
2.6	No Longer Required	
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 subspecialist GI consultant ○ Yes – reported by in-house non-GI consultant ○ Yes – reported by in-house 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) [skip to Q2.9a] ○ No CT performed [skip to Q2.9a] ○ Unknown [skip to Q2.9a]
2.7a	No Longer Required	
2.7a1	What was the date and time of CT scan request?	Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known
2.7b	No Longer Required	
2.7c	No Longer Required	
2.7d	What was the Date and Time of CT Scan?	Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known
2.7e	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
2.7g	In addition to any written report, was there direct communication preoperatively 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
2.8a	No Longer Required	
2.8b	No Longer Required	
2.9	No Longer required	
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
2.9b	If yes, what was the date and time of the decision?	Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known

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, or Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known ○ Not Administered
2.11a	Was intra-abdominal **infection** requiring urgent antibiotics e.g. peritonitis / perforation, suspected after arrival in hospital but before surgery (NEWS2 1-4)?	○ Yes ○ No [skip to Q2.11c] ○ Unknown [skip to Q2.11c]
2.11b	What was the earliest time point that intra-abdominal **infection** requiring urgent antibiotics e.g. peritonitis / perforation (NEWS2 1-4) was first suspected?	○ On arrival at hospital [skip to Q2.11c] ○ At decision to operate [skip to Q2.11c] ○ Other
2.11bi	When was the date/time of first NEWS2 score 1-4 in the presence of suspected **infection**?	Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known
2.11c	Was **sepsis**, with a NEWS2 >=5 or >=3 in any one variable, suspected after arrival in hospital but before surgery?	○ Yes ○ No [skip to Q2.11e] ○ Unknown [skip to Q2.11e]
2.11d	What was the earliest time point that **sepsis**, with a NEWS2 >=5 or >=3 in any one variable in the presence of suspected intra-abdominal infection, was first suspected?	○ On arrival at hospital [skip to Q2.11e] ○ At decision to operate [skip to Q2.11e] ○ Other
2.11di	When was the date/time of first NEWS2 score >=5 or >=3 in any one variable in the presence of suspected intra-abdominal infection?	Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known
2.11e	Was **septic shock** suspected at any time since arrival but before surgery (as revealed by an elevated lactate [above 2mmol/l] and a NEWS2 of >=5 with a requirement for vasopressor to maintain a mean arterial pressure of 65mmHg)	○ Yes ○ No [skip to Q2.12] ○ Unknown [skip to Q2.12]
2.11e.i	When was the date/time of first NEWS2 score 5+, or >=3 in any one variable, in the presence of an elevated lactate and a requirement for vasopressor to maintain a mean arterial pressure of 65mmHg, such that **septic shock** was suspected?	Date_____(DD/MM/YYYY) ○ Date not known Time_____(HH:MM) ○ Time not known
2.12	What was the patient's clinical frailty score recorded in the notes preoperatively? (see help box for full pictorial explanation of each grading)	○ Not Recorded ○ (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

2.13	What was the patient's preoperative delirium score using the 4AT tool?	○ Not performed ○ 0 ○ 1 – 3 ○ 4

3	**Pre-op Risk stratification**	
3.1	Prior to surgery, what was the risk of death for the patient that was entered into the 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
3.1a	If documented, how was risk assessed?	○ Objective clinical score ○ Clinical judgement (including eg frailty assessment)
3.2	No Longer Required	
3.2.1	Is the patient known to have diabetes?	○ No ○ Yes, type 1 diabetes ○ Yes, diet-controlled type 2 diabetes ○ Yes, tablet-controlled type 2 diabetes ○ Yes, insulin-treated type 2 diabetes ○ Yes, gestational diabetes ○ Yes, other form of diabetes ○ Unknown
3.2.2	What was the most recent blood glucose (Mmol/L) (venous, arterial or capillary (BM)?	☐ ○ Not performed
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	No Longer Required	
3.5ii	What was the most recent pre-operative value for albumin (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	No Longer Required	
3.7	No Longer Required	
3.8	Serum Urea concentration (mmol/l)	
3.9	No Longer Required	
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	No Longer Required	
3.15	No Longer Required	
3.16	Select an option that best describes this patient's **respiratory history** and chest xray appearance	○ No dyspnoea ○ Dyspnoea on exertion or CXR shows 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
3.16a	No Longer Required	
3.17	No Longer Required	
3.18	No Longer Required	
3.19	No Longer Required	
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 global impression of the urgency of theatre access for 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)
3.23	No Longer Required	
3.24	What is the indication for surgery? *(Please select all that apply)*	**Bleeding** ○ Haemorrhage **Other** ○ Abdominal wound dehiscence ○ Abdominal compartment syndrome ○ Planned relook ○ Other **Obstruction** ○ Tender Small bowel obstruction ○ Tender Large bowel obstruction ○ Non-Tender Small bowel obstruction ○ Non-Tender Large bowel obstruction ○ Gastric outlet obstruction ○ Incarcerated/strangulated hernia ○ Hiatus Hernia/para-oesophageal hernia ○ Volvulus ○ Internal hernia ○ Pseudo-obstruction ○ Intussusception ○ Obstructing incisional hernia ○ Foreign body **Sepsis** ○ Phlegmon ○ Pneumoperitoneum

		○ Sepsis ○ Iatrogenic injury ○ Anastomotic leak ○ Peritonitis ○ GI Perforation ○ Abdominal abscess ○ Intestinal fistula **Ischaemia** ○ Necrosis ○ Ischaemia/infarction ○ Colitis ○ Acidosis
3.25	Not all investigations available for calculation of NELA Risk	○
3.26	Estimated mortality using NELA Parsimonious Risk Score *(Figure only provided if all data available)*	Calculated ☐

4	**Intra-op**	
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
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 ○ 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)
4.3	Senior anaesthetist present in theatre	○ Consultant ○ Post-CCT fellow ○ SAS grade ○ Research Fellow / Clinical Fellow ○ Specialty trainee ○ Other

4.3a	Consultant present/supervising : Name/GMC of anaesthetist *(If consultant not present, enter name of supervising consultant)*	(Please select consultant - Online)
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

5	**Procedure**	
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 ○ No – Previous 'non-abdominal/non-general surgical' procedure within same admission (eg previous hip replacement) ○ Unknown
5.2	No Longer Required	

5.3.a	Main procedure	○ Abdominal wall closure following dehiscience ○ Abdominal wall reconstruction ○ Adhesiolysis ○ Colectomy: left (including sigmoid colectomy and anterior resection) ○ Colectomy: right (including ileocaecal resection) ○ Colectomy: subtotal or panproctocolectomy ○ Colorectal resection - other ○ Debridement ○ Defunctioning stoma via midline laparotomy ○ Drainage of abscess/collection ○ Enterotomy ○ Evacuation of haematoma ○ Exploratory/relook laparotomy only ○ Gastrectomy: partial or total ○ Gastric surgery - other ○ Haemostasis ○ Hartmann's procedure ○ Intestinal bypass ○ Laparostomy formation ○ Large incisional hernia repair with bowel resection ○ Large incisional hernia repair with division of adhesions ○ Peptic ulcer – oversew of bleed ○ Peptic ulcer – suture or repair of perforation ○ Reduction of volvulus ○ Removal of foreign body ○ Removal of gastric band ○ Repair of intestinal fistula ○ Repair of intestinal perforation ○ Repair of para-oesophageal hernia ○ Repair or revision of anastomosis ○ Resection of Meckel's diverticulum ○ Resection of other intra-abdominal tumour(s) ○ Revision of stoma via midline laparotomy ○ Small bowel resection ○ Stricturoplasty ○ Washout only ○ Not amenable to surgery ○Other
5.3.b	Second procedure (at same laparotomy)	○ Abdominal wall closure following dehiscience ○ Abdominal wall reconstruction ○ Adhesiolysis ○ Colectomy: left (including sigmoid colectomy and anterior resection) ○ Colectomy: right (including ileocaecal resection) ○ Colectomy: subtotal or panproctocolectomy ○ Colorectal resection - other ○ Debridement ○ Defunctioning stoma via midline laparotomy ○ Drainage of abscess/collection ○ Enterotomy ○ Evacuation of haematoma ○ Exploratory/relook laparotomy only ○ Gastrectomy: partial or total ○ Gastric surgery - other ○ Haemostasis ○ Hartmann's procedure ○ Intestinal bypass ○ Laparostomy formation ○ Large incisional hernia repair with bowel

		resection ○ Large incisional hernia repair with division of adhesions ○ Peptic ulcer – oversew of bleed ○ Peptic ulcer – suture or repair of perforation ○ Reduction of volvulus ○ Removal of foreign body ○ Removal of gastric band ○ Repair of intestinal fistula ○ Repair of intestinal perforation ○ Repair of para-oesophageal hernia ○ Repair or revision of anastomosis ○ Resection of Meckel's diverticulum ○ Resection of other intra-abdominal tumour(s) ○ Revision of stoma via midline laparotomy ○ Small bowel resection ○ Splenectomy ○ Stricturoplasty ○ Washout only ○ Not amenable to surgery ○ Other
5.3e	Was a stoma formed (by any means)?	○ Yes ○ No
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 ○ Anastomotic leak ○ Perforation – peptic ulcer ○ Perforation – small bowel ○ Perforation – colonic ○ Diverticulitis ○ Intestinal fistula ○ Adhesions ○ Incarcerated hernia ○ Volvulus ○ Internal hernia ○ Intussusception ○ Stricture ○ Pseudo-obstruction ○ Gallstone ileus ○ Meckel's diverticulum ○ Malignancy – localised ○ Malignancy – disseminated ○ Colorectal cancer ○ Gastric cancer ○ Haemorrhage – peptic ulcer ○ Haemorrhage – intestinal ○ Haemorrhage – postoperative ○ Ulcerative colitis ○ Other colitis ○ Crohn's disease ○ Abdominal compartment syndrome ○ Intestinal ischaemia ○ Necrotising fasciitis ○ Foreign body ○ Stoma complications ○ Abdominal wound dehiscence ○ Normal intra-abdominal findings ○ Other

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
5.8	Was there a delay in accessing theatre, beyond the original intended urgency of the case?	○ Yes ○ No ○ Unknown

6	**Post-op Risk stratification**	
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

6.1a	If documented, how was risk assessed?	○ Objective clinical score ○ Clinical judgement (including eg frailty assessment)
6.2	No Longer Required	
6.3	Blood lactate – may be arterial or venous (mmol/l)	☐ ○ Not performed
	Post-operative NELA Risk calculation Q 6.4 – 6.16 No Longer Required	
6.15	No Longer Required	
6.16	No Longer Required	
6.17	Please select this patient's measured/estimated intraoperative blood loss (ml)	○ <100 [skip to Q6.18] ○ 101-500 [skip to Q6.18] ○ 501-1000 ○ >1000
6.17a	If the patient's blood loss was estimated to be over 500 mls, was tranexamic acid given?	○ Yes ○ No ○ Unknown
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	Should the surgical urgency have been different to that identified at the time of decision to operate? If so, please update here? *(see help notes for additional information)*	○ 3. Expedited (>18 hours) ○ 2B. Urgent (6-18 hours) ○ 2A. Urgent (2-6 hours) ○ 1. Immediate (<2 hours)
6.21	No Longer Required	
6.22	No Longer Required	
6.23	Not all investigations available for calculation of NELA Parsimonious Risk Score	○
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 overnight in recovery) ○ Enhanced care area on a normal ward ○ 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 ○ Unknown
6.25	No Longer Required	
6.26	Estimated mortality using NELA Parsimonious Risk Score *(Figure only provided if all data available)*	Calculated

7	**Post-op – Some fields will need to be completed on discharge or death**	

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
7.2	No Longer Required	
7.2.1	What was the patient's postoperative delirium score using the 4AT tool within 72 hours of transfer to a general surgical ward?	○ Not performed ○ 0 ○ 1 – 3 ○ 4
7.3	For patients aged 80 and older, or aged 65+ and frail (CFS≥5), did the patient receive postoperative input from a member of a perioperative frailty team? Perioperative frailty teams have expertise in comprehensive geriatric assessment (CGA) and provide clinical care through the patient pathway including: • Preoperative assessment and optimisation of frailty, cognitive disorders and multimorbidity • Prognostication and shared decision making • Assessment and management of postoperative complications, hospital acquired deconditioning, postoperative cognitive disorders • Rehabilitation, goal setting and discharge planning with onward referral to community services • Treatment escalation and advance care planning • Effective communication with patients and carers throughout the perioperative pathway • Streamlined care working with other disciplines and specialties	○ Yes, by geriatrician-led service ○ Yes, by perioperative medicine-led team with established referral pathways to geriatrics ○ No, intensivist and/or anaesthetic review whilst on critical care/PACU/outreach service ○ No input ○ Unknown
7.4	Within this admission, did the patient have an **unplanned or planned** return to theatre in the post-operative period following their initial emergency laparotomy?	○ Yes; unplanned return ○ Yes; planned return ○ Yes; unplanned AND planned return ○ No ○ Unknown
7.4a	What was the main indication for the **unplanned** return to theatre? *(Select most significant reason)*	○ 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

7.4b	No Longer Required	
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	No Longer Required	
7.7	Status at discharge	○ Dead ○ Alive ○ Still in hospital at 60 days
7.8	Date discharged from hospital	(DD/MM/YYYY) Date required
7.9	No Longer Required	
7.10	No Longer Required	
7.11	No Longer Required	
7.12	No Longer Required	