**Version Control**

**NELA Patient Audit Dataset**

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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
 |
| 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)
 |

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 form 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 ACP? | 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 surgeryGynaecology (including gynae-oncology)General medicineGastroenterologyElderly CareOther |
| **1.12** |  No Longer Required |  |
| **1.13a** |  No Longer Required |  |
| **1.13b** |  No Longer Required |  |

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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.** |
| **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 knownTime\_\_\_\_\_\_\_\_\_\_\_\_\_ (HH:MM)⭘ Time not known⭘ Not Seen |
| **2.2** | Date and time that the decision was made to operate | Date (DD/MM/YYYY)* Date not known

Time (HH:MM)* Time not known
 |
|  | *If this is unavailable please enter date and time that this* |
|  | *patient was first booked for theatre for emergency* |
|  | *laparotomy* |
|  |  |  |
| **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 consultant
* Yes – reported by in-house registrar
* Yes – reported by outsourced service
* Yes but NOT reported
* No CT performed
* Unknown
 |
| **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
 |
| **2.7f** | 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
 |
| **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
 |
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| **2.11a** | Was sepsis, with a NEWS2 >=5 or >=3 in any one variable suspected on arrival at hospital? | * Yes
* No
* Unknown
 |
| **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
 |
| **2.11c** | Was intra-abdominal infection requiring urgent antibiotics e.g. peritonitis / perforation, suspected on arrival at hospital? | * Yes
* No
* Unknown
 |
| **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
 |
| **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
 |

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| **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
 |
| **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
 |
| **3.2** | No Longer Required |  |
| **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 forserum 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**. |

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| **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/ Q, ST or T wave abnormalities
 |
| **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 | No Longer Required |  |
|  | *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 thisprocedure? | * 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
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| **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** | No Longer Required |  |
| **3.24** | No Longer Required |  |
| **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** |  |
| **4.1** | Date and time of entry in to 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
 |

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| **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** | What is the indication for surgery?*(Please select all that apply)* | * Peritonitis
* Perforation
* Abdominal abscess
* Anastomotic leak
* Intestinal fistula
* Phlegmon
* Pneumoperitoneum
* Necrosis
* Sepsis
* Small bowel obstruction
* Large bowel obstruction
* Gastric outlet obstruction
* Volvulus
* Internal hernia
* Pseudo-obstruction
* Intussusception
* Incarcerated hernia
* Obstructing incisional hernia
* Haemorrhage
* Hiatus Hernia/para-oesophageal hernia
* Ischaemia
* Colitis
* Abdominal wound dehiscence
* Abdominal compartment syndrome
* Acidosis
* Iatrogenic injury
* Foreign body
* Planned relook
* Other
 |

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| **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 |

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| **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/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
 |

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| **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** |  |
| **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
 |
| **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 – 6.14 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* |  |

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| **6.21** | No Longer Required |  |
| **6.22** | No Longer Required |  |
| **6.23** | Not all investigations available for calculation of NELA Risk |  |
| **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)
* 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 placethe patient on an end of life pathway? | * Yes
* No
 |
| **6.25** | No Longer Required |  |
| **6.26** | Estimated mortality using NELA risk adjustment model*(Figure only provided if all data available)* | Calculated |

|  |  |  |
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| **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 |  |
| **7.3** | 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
 |
| **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
 |

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| **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 escalationfrom 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 |  |
|  | **COVID-19 Questions** |  |
| **7.10** | Please indicate the patient's SARS-CoV-2/COVID-19 infection status | * COVID symptoms and COVID-19 test positive (eg lateral flow, POCT, PCR) – confirmed pre-operatively
* No COVID symptoms but COVID-19 test positive (eg lateral flow, POCT, PCR) – confirmed pre-operatively
* COVID symptoms and COVID-19 test positive (eg lateral flow, POCT, PCR)– confirmed post-operatively
* No COVID symptoms but COVID-19 test positive (eg lateral flow, POCT, PCR) – confirmed post-operatively
* COVID negative testing throughout in-patient stay
* Not tested/status unknown
 |
| **7.11** | No Longer Required |  |
| **7.12** | No Longer Required |  |