ANZELA-QI DATASET & HELPFILE v13.0

Australia and New Zealand Emergency Laparotomy Audit - Quality Improvement

Notes to assist data entry

Data capture and recording

It is the universal experience that the best time to record a large part of the data is in theatre. Most information will be readily available and easily recallable. If the data is collected retrospectively, even a day or so later, much will not be easily located, nor accurately remembered. It is also much more time consuming. A case will not be included in any analysis until closed so the discharge data needs to be recorded timeously.

In almost all cases patients will only need one form completed for each admission. Additional operations after the initial Emergency Laparotomy (EL) will be a planned or unplanned operation. In these cases the original form should be updated to include data about the planned or unplanned return to theatre. A new form only needs to be created if the patient is transferred after one EL and then has a second EL in a second hospital.

Prospective/retrospective data collection

Do not record retrospectively obtained or calculated data as if it was available prospectively. The aim of Quality Improvement (QI) processes is to document data prospectively so it can then be used to change individual patient care. If the data was not available at the time of decision making it cannot have been used to assist in the decision and should not be retrospectively entered as if it was prospectively available. For example, if the CT scan report was not available pre-operatively, but later became available, do not record it as being prospectively available. In particular if the NELA risk assessment was calculated after the Emergency Laparotomy the risk should be recorded as being calculated retrospectively.

Transfers

It is anticipated that the number and proportion of patients transferred in ANZELA-QI (estimated 15% to 30%) will be much greater than in NELA. This will be an important difference to document. However, the reasons and timing of the transfers will be many and varied and difficult to record in detail in the audit. The following notes are provided to ensure consistency of data entry:

1. The fundamental requirement is that the hospital where the EL was undertaken should complete the ANZELA-QI data form. Each ANZELA-QI case records one patient, per hospital, per admission, per EL. Second operation should be recorded as planned and/or unplanned operations and not a new/second Emergency Laparotomy. Any subsequent admissions and subsequent ELs for that patient require a separate new ANZELA-QI record.
2. ***If the patient does not have an EL in hospital A but is transferred to hospital B for the purposes of undergoing an EL***, then receiving hospital B should complete the ANZELA-QI data form. The mode of admission into hospital B should be recorded as a transfer. As there was no EL in hospital A no data is required from them.
3. ***If the patient undergoes an EL in hospital A and is then transferred to hospital B*** (for any reason) then hospital A where the EL was undertaken should complete the ANZELA-QI data form. The mode of discharge should be recorded as a transfer. If there is no further surgery in hospital B then it does not have to record any data.
4. Some patients will undergo an EL in hospital A, be transferred to hospital B and then undergo a second operation. The documentation required in receiving hospital B will depend on the individual patient treatment circumstances:
    a. ***If a transferred patient undergoes a second planned operation in*** hospital B (e.g. removal of packs, planned washout *etc*) then hospital B does not have to record any data. The discharge question in the ANZELA-QI form completed by hospital A will record the patient was transferred.
    b. ***If a transferred patient undergoes a second, unplanned operation hospital B that is a complication of the first EL*** in hospital A (e.g. anastomotic leak) hospital B will not need to complete a second ANZELA-QI form. The discharge question in the ANZELA-QI form completed by hospital A will record the patient was transferred, as will the admission question in hospital B.

c. ***If a transferred patient undergoes a second unplanned EL (not a planned or unplanned operation as above) in hospital B that is for a new event not directly connected to the original EL*** then receiving hospital B will need to complete a second ANZELA-QI form. The discharge question in the ANZELA-QI form completed by hospital A will record the patient was transferred, as will the admission ANZELA-QI question in hospital B. ANZELA-QI will link the forms.

ANZELA-QI would welcome feedback on difficulties related to data capture of the transferred patient as there is likely to be variation in experiences at different hospitals.

Clinician seniority

For the purposes of this program the standard of care for determining seniority is a consultant. In some hospitals there will be senior staff who in many ways act as a consultant in all but name. However, unless appointed as a consultant they should not be entered as such. See the guides below. ANZELA-QI would welcome feedback as there is likely to be variation

Data completeness

Do not leave questions unanswered i.e. blank. If a field is left blank interpretation is difficult and it greatly degrades the data quality. If the answer is not known enter 'unknown'.

Case ascertainment

Every EL needs to be documented so the true denominator is known. Missing cases will degrade the analysis. It is likely to be the best method is for the PI at each hospital to check the theatre register weekly. Post-operative rounds and hand over meetings are an ideal time to ensure full case ascertainment and to also check data completeness.

Patients with an acute abdomen who do not have an Emergency Laparotomy

There are patients who present with an acute abdomen and who satisfy the ANELA-QI inclusion, but do not undergo surgery. The reasons for this may include age, fragility, advanced malignancy, medical co-morbidities, care capped to not include surgery, patient wishes *etc*. These patients have not been included in other EL audits and is recognised as an important gap in their data. These patients are by definition high-risk and while it may be entirely appropriate for them not to undergo an EL, their exclusion may substantially and favourably bias any analysis. ANZELA-QI wishes to collect data on these patients. A reduced number of fields need to be completed for these patients. These patients will be referred from variable sources and many will not be admitted to a surgical ward (for example, terminal malignant small bowel obstruction in an oncology ward, or an aged, frail patient on a geriatric ward). They will be lost unless registered on the ANZELA-QI database immediately. ANZELA-QI would welcome feedback around any difficulties with recognising and recording non-operative cases.

NELA Patient Audit Dataset

NELA Participant Manual

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
Numbered for ease of reference	*The field in the NELA participation manual. Numbers in parentheses are based on NELA but not identical.*	*Section of the dataset grouped by purpose e.g. 'patient demographics'*	*On-screen field name*	*Values able to be selected/entered (including lookup number where relevant)*	*General guidance on how to answer the question*	*Guidance on how to answer for NZ cases only*

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
DM1	[1.1]	Demographics	NHI (New Zealand)	[AAANNNN]		
DM1	[1.1]	Demographics	Medicare number (Australia)	[N(11)]		Not applicable
DM2	1.3	Demographics	Hospital Record Number	[free text]		Not applicable
DM2a		Demographics	Hospital Identifier	[free text		
DM3	1.7	Demographics	Surname	[free text]		
DM4	1.5	Demographics	Sex	1 – Male 2 – Female 3 – Intersex or indeterminate 4 – Not stated/inadequately described		
DM5	1.4	Demographics	Date of Birth	[DD/MM/YYYY]		
DM6		Demographics	Ethnicity [multi-pick]	1 – Aboriginal 2 – Torres Strait Islander 3 – Maori 4 – Pacific Peoples 5 – Any other ethnicity 6 – Unknown		As recorded in Patient Information Management System (PIMS/IPMS)
DM7	1.4	Demographics	[auto-calculated] Age on admission]	[NNN]	Automatically calculated	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
PR1		Admission Data for All Patients	Did the patient meet the inclusion/exclusion criteria for surgery and have an EL?	1 – Yes 2 – No: medical **co-morbidity** reasons: risk of surgery too great 3 – No: **Pathology** too advanced (e.g. disseminated malignancy) 4 – No: **rapid death** during work-up 5 – No: **patient/family wishes** to limit care including Advanced Health Care Directive 6 – Unknown	If 'yes' is chosen the remainder of the form should be completed. The No-Lap are important, but the initial question was badly framed. If No, then we do not need to record any data other than field below. However, complete NELA score, ASA score, Goals of Care field and the last page (discharge). So, if alive the discharge date and location and if died date of death	
PR2	1.9	Admission Data for All Patients	Date and time the patient first arrived at this Hospital/emergency department	[DD/MM/YYYY] Date not known [HH:MM] Time not known	Arrival time is 1st presentation to hospital where the EL was undertaken. It is intended to reflect the time at which the patient's care became the responsibility of the hospital where the EL is undertaken.	
PR3	1.10	Admission Data for All Patients	The nature of this admission	1 – Elective 2 – Emergency 3 – Unknown	This refers to the admission to the hospital where the EL is undertaken. If the patient was an inter-hospital transfer and the EL undertaken before the patient was transferred then the referring hospital should enter the data. If the patient was transferred and then had the EL, the receiving hospital should enter the data.	
PR4		Admission Data for All Patients	[conditional field: PR2 = Emergency] Was this a readmission within 30 days for a previous EL?	1 – Yes 2 – No 3 – Unknown		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
PR5	[1.10b]	Admission Data for All Patients	Where did the patient first present at the hospital?	1 – Emergency Dept 2 – ASU/Ward 3 – Room/clinic 4 – Other 5 – Unknown [free text field for comments]	This is to record the place where the patient first arrived at the hospital where the EL is undertaken	Single point of entry (ED) should be recorded for New Zealand. There is a separate question re: route of admission that is collected in NZ only.
PR6	[1.12]		Residence before hospital admission	1 – Own Home 2 – Sheltered living 3 – Residential Care 4 – Nursing Home 5 – Rehabilitation facility 6 – Other		
PR3a		Admission Data for All Patients	Was this admission a transfer from another hospital?	1 – Yes 2 – No 3 – Unknown	This question records whether the patient was transferred into the hospital where the EL was undertaken	
PR3b		Admission Data for All Patients	[conditional field: PR3a = Yes] Which hospital was the patient transferred from?	[free text field for comments]		
PR3c		Admission Data for All Patients	If transferred, data and time of arrival in referring (original) hospital	[DD/MM/YYYY] Date not known [HH:MM] Time not known	Include a comment that the data and time will normally be in the copy of the referring hospital notes	
PR6	[1.11]	Admission Data for All Patients	Specialty of initial admission	1 – General Surgery 2 – General Medicine 3 – Gastroenterology (if separate from GenMed) 4 – Older People's Health 5 – Obstetrics and Gynaecology 6 – Orthopaedics 7 – Other [free text]		
PR8	[2.1]	Admission Data for All Patients	Date and time first seen by surgeon in this hospital in relation to the initial assessment of acute abdomen	[DD/MM/YYYY] Date not known [HH:MM] Time not known Not seen	This refers to the admission into the hospital where the EL is undertaken. 'Surgical team' refers to any member of the surgical team,	Taken as the time stamp of first completion of the Electronic Assessment Form (EAF).

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					recognising a junior member of the team is a proxy for the consultant. For acute general surgical admissions, detail the first surgical review following admission. For in-patients referred to the surgical team by different specialties, please detail the first surgical review following referral. For patients having emergency surgery as a complication of previous surgery, use the time that the decision was made that they needed a re-operation.	
PR7		Admission Data for All Patients	Sub-specialty of admitting consultant surgeon	1 – Colorectal 2 – Upper Gastrointestinal (GI) 3 – Hepato-pancreato-biliary (HPB) +/- transplant 4 – Breast and/or endocrine 5 – Rural 6 – Trauma 7 – General Surgeon with no special interest 8 – Other (please specify) [free text]		
PR9	2.7	Admission Data for All Patients	Was an abdominal CT scan performed in the preoperative period as part of the diagnostic work-up?	1 – Yes 2 – No 3 – Unknown		
PR9a	2.7a1	Admission Data for All Patients	If Yes, where was the abdominal CT scan done?	1 – In this hospital 2 – Before arrival in this hospital 3 – Unknown	Rephased for transfers	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
PR10	2.7b	Admission Data for All Patients	[conditional field: PR12 = Yes] Date and time of CT scan	[DD/MM/YYYY] Date not known [HH:MM] Time not known		
PR11	[2.7a]	Admission Data for All Patients	[conditional field: PR12 = Yes] Date and time of CT report by consultant	[DD/MM/YYYY] Date not known [HH:MM] Time not known	Report can be verbal or written. Problem is that if transferred, the new hospital will not know	
SE1	[2.11a]	Sepsis	Was sepsis suspected **at time of initial admission into this hospital**?	1 – Yes 2 – No 3 – Other diagnosis suspected requiring antibiotics 4 – Unknown	The assessment of sepsis can be by any means and by any team. For example, patients will be admitted via ED and sepsis suspected on the basis of an EWS, specific blood tests (e.g. lactate), clinical impression undertaken by ED staff. Do not retrospectively enter 'yes'.	Not applicable. qSOFA score will be used for this.
SE2	2.11	Sepsis	If sepsis suspected at time of initial hospital admission, by what criteria?	1 – Clinical assessment only 2 – EWS (any score) 3 – Lactate 4 – Other [free text]	Remove qSOFA as not used and now known not to be reliable in ED	Drop down that only appears if PR15 is Yes.
SE3		Sepsis	Date and time of sepsis assessment	[DD/MM/YYYY] Date not known [HH:MM] Time not known Not done		Drop down that only appears if PR13 is Yes
SE4	2.10	Sepsis	What was the date and time of the first dose of IV antibiotics following presentation to this hospital?	[DD/MM/YYYY] Date not known [HH:MM] Time not known Not administered	Many patients will be admitted via ED and the antibiotics may have been administered before surgical review. If the patient was not originally admitted under surgery, please use date and time of antibiotic	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
					administration following referral to the surgeon. If the surgery is a complication of a previous procedure within the same admission, use date/time of 1st dose since the first procedure.	
SE5		Sepsis	Was the lactate level available to the surgeon at the time of surgical referral?	1 – Yes 2 – No 3 – Unknown		"Yes" = where Time stamp of lactate level pre-dating time stamp of first EAF completion. "No" = where there is no Lactate or the time stamp is post EAF
SE6	3.5	Sepsis	What was the most recent pre-operative value for blood lactate – may be arterial or venous (mmol/l)?	[Mmol/L]		
PR12		Admission Data For All Patients	Were goals of care documented in the notes?	1 – Yes 2 – No 3 – Unknown	Only include if recorded pre-operatively AND documented in the notes. The aim of documenting GoC is that they are available to others, for example during a review out of hours.	Not applicable
PR13	[2.2]	Admission Data For All Patients	[conditional on PR1 = Yes] Date and time the decision to operate was made.	[DD/MM/YYYY] Date not known [HH:MM] Time not known Unknown		= Time stamp when form is entered into PIMS/IPMS (or Theatre Administration System, TAS, where a separate one exists)
SE7	[2.11d]	Sepsis	[conditional on PR1 = Yes] Was sepsis suspected **at the time the decision for surgery was made**?	1 – Yes 2 – No 3 – Unknown		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
SE8		Sepsis	If sepsis suspected **at the time the decision for surgery was made** by what criteria?	1 – Clinical assessment only 2 – EWS (any score) 3 – Lactate 4 – Other		Drop down that only appears if PR12 is Yes. I have kept qSOFA for consistence, but it could be removed
RS1	[3.1 & 3.2]	Operative risk stratification	Prior to surgery, was the risk of death for the patient entered into the medical record preoperatively?	1 – Yes, **calculated** pre-operatively 2 – No, **calculated** and entered into the medical record post-operatively 3 – No, calculated but not entered into medical record 4 – No 5 – Unknown	Australia: use the NELA score, not P-POSSUM, SORT, NSQUIP or another score. New Zealand: use P-POSSUM	New Zealand: use P-POSSUM
RS2	3.1	Operative risk stratification	[conditional on RS1 = 1 or 2] [Australia only] What was the NELA mortality score (%)?	[free text field]	Please enter the exact percentage score. This will give flexibility to 'group' scores in different ways. For example, ≥50 or ≥60 etc	
RS3	3.1	Operative risk stratification	[conditional on RS1 = 1 or 2] [New Zealand only] What was the P-POSSUM score (%)?	[free text field]		
RS4		Operative risk stratification	What was the patient's ASA grade on admission?	1 – A normal healthy patient 2 – A patient with mild systemic disease 3 – A patient with severe systemic disease which limits activity, but is not incapacitating 4 – A patient with an incapacitating systemic disease that is not a constant threat to life 5 – A moribund patient who is not expected to survive 24 hours, with or without an operation 6 – A brain-dead patient for organ donation 7 – Unknown		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
RS5	[2.12a]	Operative risk stratification	[conditional field: DM9 >65] For patients over 65 years, was a pre-operative frailty assessment completed?	1 – Yes 2 – No 3 – No, frailty assessment completed post-operatively 4 – Unknown		
RS6	[2.12a]	Operative risk stratification	For patients over 65 years, what was the pre-operative frailty index?	1 – Very Fit 2 – Well- no active disease symptoms 3 – Managing Well - medical problems well controlled 4 – Vulnerable - symptoms limit activities 5 – Mildly Frail - evident slowing 6 – Moderately Frail - need lifestyle help 7 – Severely Frail - completely dependent for personal care 8 – Very Severely Frail - approaching end of life 9 – Terminally Ill - life expectancy < 6 months 10 – Unknown	Use the Rockwood score. See attached figure	
RS7	[3.22]	Operative risk stratification	[conditional on PR1 = Yes] According to the surgical urgency **WITHIN HOW MANY MAXIMUM HOURS** was the procedure intended to occur?	[free text integer] [free text comments box]	This is the urgency as determined by the surgeon at the time the decision is made. There is at present no consistent emergency surgery 'urgency categorisation' across Australia or New Zealand with at least five versions available. There is current work to create a uniform categorisation. Therefore, at present you are required to enter a whole integer. This can later be grouped for the relevant state and may aid	Where the category is a range of hours, enter the maximum number of hours in the category: e.g. "Within 2-6 hours" on surgical booking form = "6" for ANZELA-QI

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
					the discussion around a uniform urgency categorisation. For some patients this may be after a period of time in hospital. For example, SBO that does not settle. In these cases, the overall time to surgery will be calculated from the time of admission to time of first surgeon review, or time of operation.	
OP1	5.1	Operative	[conditional on PR1 = Yes] Is this the first surgical procedure of this admission?	1 – Yes 2 – No 3 – Other [free text comments]	If the patient had an operation was discharged and then admitted to the same or another hospital and undergoes an EL that is the first operation of this admission.	
OP2	5.2	Operative	[conditional on PR1 = Yes] Pre-operative indication for surgery as on the **surgical booking form**. [multi-select] 'Select all options that apply'	Abdominal abscess Anastomotic leak Abdominal wound dehiscence Abdominal compartment syndrome Acidosis Bile leak Chyle leak Colitis Foreign body Gastric band complication Haemobilia Haemorrhage Hernia - hiatus Hernia - incarcerated Hernia - incisional Hernia - internal	More than one option can be selected. Note that this relates to the pre-operative indication for surgery and may differ from the operative findings Options below are recorded in NELA but not in ANZELA-QI. Now added, Gastric outlet obstruction Lap Bad removal Other	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				Iatrogenic injury Intestinal fistula Intussusception Ischaemia Necrosis Obstruction - Small bowel Obstruction - Large bowel Perforation Peritonitis Phlegmon/inflammatory mass Planned relook Pneumoperitoneum Pseudo-obstruction Sepsis Volvulus Other		
OP2a	5.4	Operative	Procedure approach/ operative technique	Laparoscopically throughout Laparoscopic converted to open Open throughout Unknown	Included in NELA and we should add to make it clear that laparoscopy is included	
OP3	2.2	Operative	[conditional on PR1 = Yes] Date and time of theatre booking	[DD/MM/YYYY] Date not known [HH:MM] Time not known Unknown		Time stamp when form is first entered into PIMS/IPMS/TAS
OP4	[4.1]	Operative	[conditional on PR1 = Yes] Date and time of procedure	1 – Knife to skin 2 – Wheels in then [DD/MM/YYYY] [HH:MM] Time not known	The preferred time is knife to skin (KTS) and will be recordable when data is collected timeously. For data collected retrospectively KTS may be not be so easy to identify. 'Wheels in' is when the patient enters the operating theatre itself, not theatre complex or anaesthetic room.	Time stamp of Knife to Skin from PIMS/IPMS/TAS

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
OP5		Pre-operative	Sub-specialty of operating consultant surgeon	1 – Colorectal 2 – Upper Gastrointestinal (GI) 3 – Hepato-pancreato-biliary (HPB)+/- transplant 4 – Breast and/or endocrine 5 – Rural 6 – Trauma 7 – General Surgeon with no special interest		
OP6	4.2	Operative	[conditional on PR1 = Yes] Most senior surgeon in theatre	1 – Consultant 2 – Staff grade, other non-consultant grade responsible surgeon or MOSS (NZ Only) 3 – Fellow 4 – SET Training Registrar 5 – Service Registrar or equivalent 6 – Other	Consultant supervision is when the consultant is in theatre (but not necessarily scrubbed) AND free of other commitments. A consultant elsewhere in the theatre complex or hospital is NOT supervising. For ANZELA-QI purposes the definition of a Fellow is a surgeon who holds the FRACS, or, in the case of an overseas surgeon, in a post that would otherwise be held by a person with the FRACS. Surgeons who have a Fellowship but are not appointed as consultants should select option 3.	
OP7	4.3	Operative	[conditional on PR1 = Yes] Most senior anesthetist in theatre	1 – Consultant 2 – Staff grade, other non-consultant grade responsible anaesthetist or MOSS (NZ Only) 3 – Fellow 4 - Advanced trainee (post-final exam)	Consultant supervision is when the consultant is in theatre AND free of other commitments. A consultant elsewhere in the theatre complex or hospital is not supervising.	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				5 – Advanced trainee (pre-final exam) 6 – Basic trainee 7 – Other	For ANZELA-QI purposes the definition of a Fellow is an anaesthetist who is in an ANZCA Provisional Fellowship Training post or overseas equivalent. Anesthetists who have a FANZCA diploma but are not appointed as consultants should select option 3 also.	
OP8	5.5	Operative	[conditional on PR1 = Yes] Main operative findings 'Select all options that apply'	Abscess Abdominal Compartment Syndrome Abdominal wall dehiscence Adhesions Anastomotic leak Bile leak Chyle leak Cancer – localised Cancer – disseminated Cancer - gastric Cancer - colorectal Colitis - ulcerative colitis Colitis – Crohn's Disease Colitis - other Diverticulitis Foreign Body Gallstone Ileus Gastric band complication Haemorrhage – peptic ulcer Haemorrhage – intestinal Haemorrhage – post-operative Hernia - incarcerated Hernia - Internal Intestinal fistula Intestinal ischaemia Intussusception Meckel's diverticulum Necrotising fasciitis Pseudo-obstruction	The main operative findings are those that the surgeon, taking all into account, believes are the most clinically relevant. There may be instances where the operative findings are such that, had these findings been known prior to surgery, the patient would not have been included in the audit. However, since they have now had a laparotomy, they are still included. This is why there appear to be some findings/procedures that are under the exclusion criteria. Option below are recorded in NELA but not in ANZELA-QI. Now added - Gastric band complication	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				Perforation – peptic ulcer Perforation – small bowel/colonic Stricture Stoma Complications Volvulus Normal abdomen Other		
OP9	5.6		[conditional on PR1 = Yes] Describe the peritoneal contamination present	1 – None, or reactive serous fluid only 2 – Free gas from perforation +/- minimal contamination 3 – Pus 4 – Bile 5 – Gastro-duodenal contents 6 – Small bowel contents 7 – Faeculant fluid 8 – Faeces 9 – Blood/haematoma		
			What was the relationship between the known pre-operative CT diagnosis and the finding at surgery?	1 – No pre-op CT scan 2 – Good relationship 3 – Poor but acceptable relationship 4 – No relationship 5 – Unknown		
OP10	5.3.a	Operative	[conditional on PR1 = Yes] Primary surgical procedure	Abscess – drainage of abscess/collection Abdominal wall closure following dehiscence Abdominal wall reconstruction Adhesiolysis Anastomosis - repair or revision of Appendicectomy as incidental Biliary reconstruction Cholecystectomy as incidental Colectomy - left (including sigmoid colectomy and anterior resection)	**Option below are recorded in NELA but not in ANZELA-QI. Now added - Gastric band complication**	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				Colectomy - right (including ileocaecal resection) Colectomy - subtotal or panproctocolectomy Colectomy - Hartmann's procedure Colectomy - other colorectal resection Debridement Enterotomy Foreign body - removal Gastrectomy - partial or total Gastric band removal/adjustment Gastric surgery - other Haematoma – evacuation Haemostasis Hiatus hernia repair Intestinal bypass Intestinal fistula – repair of Incisional hernia repair – large with bowel resection Incisional hernia repair – large with division of adhesions Laparotomy - Exploratory/relook only Laparostomy formation Meckel's diverticulum - resection Perforation - repair of intestinal perforation Peptic ulcer – suture or repair of perforation Peptic ulcer – oversew of bleed Tumour - resection of other intra-abdominal tumour(s) Small bowel resection Stricturoplasty Stoma - Defunctioning stoma via midline laparotomy Stoma - Revision of stoma via midline laparotomy Volvulus - reduction Washout only Other Not amendable to surgery		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
OP11	5.3.b	Operative	[conditional on PR1 = Yes] Secondary surgical procedure	Abscess – drainage of abscess/collection Abdominal wall closure following dehiscence Abdominal wall reconstruction Adhesiolysis Anastomosis - repair or revision of Appendicectomy as incidental Biliary reconstruction Cholecystectomy as incidental Colectomy - left (including sigmoid colectomy and anterior resection) Colectomy - right (including ileocaecal resection) Colectomy - subtotal or panproctocolectomy Colectomy - Hartmann’s procedure Colectomy - other colorectal resection Debridement Enterotomy Foreign body - removal Gastrectomy - partial or total Gastric band removal/adjustment Gastric surgery - other Haematoma – evacuation Haemostasis Hiatus hernia repair Intestinal bypass Intestinal fistula – repair of Incisional hernia repair – large with bowel resection Incisional hernia repair – large with division of adhesions Laparotomy - Exploratory/relook only Laparostomy formation Meckel’s diverticulum - resection Perforation - repair of intestinal perforation Peptic ulcer – suture or repair of perforation Peptic ulcer – oversew of bleed Tumour - resection of other intra-abdominal tumour(s) Small bowel resection Stricturoplasty Stoma - Defunctioning stoma via midline		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				laparotomy Stoma - Revision of stoma via midline laparotomy Volvulus - reduction Washout only Other Not amendable to surgery		
OP12	5.3.c	Operative	[conditional on PR1 = Yes] Third/tertiary surgical procedure	Abscess – drainage of abscess/collection Abdominal wall closure following dehiscence Abdominal wall reconstruction Adhesiolysis Anastomosis - repair or revision of Appendicectomy as incidental Biliary reconstruction Cholecystectomy as incidental Colectomy - left (including sigmoid colectomy and anterior resection) Colectomy - right (including ileocaecal resection) Colectomy - subtotal or panproctocolectomy Colectomy - Hartmann's procedure Colectomy - other colorectal resection Debridement Enterotomy Foreign body - removal Gastrectomy - partial or total Gastric band removal/adjustment Gastric surgery - other Haematoma – evacuation Haemostasis Hiatus hernia repair Intestinal bypass Intestinal fistula – repair of Incisional hernia repair – large with bowel resection Incisional hernia repair – large with division of adhesions Laparotomy - Exploratory/relook only Laparostomy formation Meckel's diverticulum - resection		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				Perforation - repair of intestinal perforation Peptic ulcer – suture or repair of perforation Peptic ulcer – oversew of bleed Tumour - resection of other intra-abdominal tumour(s) Small bowel resection Stricturoplasty Stoma - Defunctioning stoma via midline laparotomy Stoma - Revision of stoma via midline laparotomy Volvulus - reduction Washout only Other Not amendable to surgery		
PO1	6.24	Post-operative	[conditional on PR1 = Yes] Where did the patient go for **immediate** continued post-operative care following Emergency Laparotomy?	1 – Ward 2 – ICU/HDU 3 – Died prior to discharge from theatre complex 4 – Other	An ICU must be accredited as such and has facilities for complex care such as ventilation, dialysis etc. An HDU has monitored beds, respiratory support short of invasive ventilation, a higher nurse ratio than a normal ward Recovery beds are neither HDU nor ICU. A bed in a ward that is used to monitor higher risk patients is neither HDU nor ICU.	
PO2	7.5	Post-operative	[conditional on PR1 = Yes] Did the patient move **from the ward** to a higher level of care within 7 days of surgery?	1 – Yes 2 – No 3 – Unknown	This refers to within 7 days of the EL. This does not include escalation from an HDU to an ICU, or increased organ support within a combined critical care unit.	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
PO3	[7.3]	Post-operative	[conditional on DM7 >65 years of age] Was an assessment by Elderly Medicine team completed?	1 – Yes 2 – No 3 – Unknown 4 – Assessed by General Physician		
PO4		Post-operative	[conditional on PR1 = Yes] Clavien Dindo complication grade score at any point during admission	1 – Grade I 2 – Grade II 3 – Grade IIIa 4 – Grade IIIb 5 – Grade IVa 6 – Grade IVb 7 – Grade V 8 – No complications		Not applicable
PO5		Discharge	Within this admission did the patient have either an UNPLANNED or PLANNED return to theatre related their **initial Emergency Laparotomy**	1 – No 2 – Yes; unplanned return 3 – Yes; planned return 4 – Yes; planned and unplanned return 5 – Unknown		This field only applies if the planned/unplanned operation was after a previous EL. If the previous surgery was an elective operation then this was the EL.
PO6		Discharge	Was the patient's initial Emergency Laparotomy performed at this hospital?	1 – Yes 2 – No 3 – Unknown		To drop down is the DS1A above 'Yes'.
PO7	7.4a		[conditional on PR1 = Yes] For an UNPLANNED return to theatre, what was the most significant reason for return?	1 – Anastomotic leak 2 – Abscess 3 – Bleeding or haematoma 4 – Decompression of abdominal compartment syndrome 5 – Bowel obstruction 6 – Abdominal wall dehiscence 7 – Accidental damage to bowel or another organ 8 – Stoma viability or retraction 9 – Other 10 – Unknown 11 – Not applicable	If the original EL was in another hospital, that hospital should have entered the EL data. If this was an EL for a complication of an EL in another hospital then a second form should be completed.	Field has been moved for flow. Drop down depending on answer to DS1A

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
PO8			For a PLANNED return to theatre, what was the most significant reason for return?	1 – Removal of packs 2 – Planned washout 3 – Closure of laparostomy 4 – Definitive surgery following for damage limitation EL 5 – Assess first operation (e.g. assess bowel viability) 6 – Other 7 – Unknown		Drop down depending on answer to DS1A
DS2	7.4	Discharge	[Conditional field. If DS1 = Alive then:] Date of discharge from hospital	[DD/MM/YYYY]		Taken from PIMS/IPMS
DS2a		Discharge	[Conditional field. If DS1 = Dead then:] Date of death	[DD/MM/YYYY]		Taken from PIMS/IPMS
DS2b			[Conditional field. If DS1 = Alive then:] Did the patient return to their pre-hospital residence?	1 – No 2 – Yes 3 – Unknown		
DS3	7.9	Discharge	[Conditional on DS2b= no] Discharge destination, if not returned to pre-hospital residence:	1 – Residential care 2 – Nursing home 3 – Rehabilitation facility (any) 4 – Other Public hospital for ongoing acute care 5 – Private hospital for ongoing acute care 6 – New destination 7 – Unknown		
DS4		Discharge	[Conditional on DS7 = new destination] If Place of discharge 'New destination' - specify	[free text]		