ANZELA-QI DATASET & HELPFILE v7.11

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 very much more time consuming. A case will not be included in any analysis until closed so the discharge data needs to be recorded timeously.

Prospective/retrospective data collection

Do not record retrospectively obtained or calculated data as if it was available prospectively. The aim of 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.

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 an overall pilot audit. The following notes are provided to ensure consistency of data entry:

1. The fundamental requirement is that the hospital where the Emergency Laparotomy (EL) was undertaken should complete the ANZELA-QI data form. Each ANZELA-QI case records one patient, per hospital, per admission, per EL. 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.
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 the patient undergoes a second planned 'non-qualifying' EL* 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 EL in hospital B that is a complication of the first EL* in hospital A (e.g. anastomotic leak), then 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 question in hospital B. ANZELA-QI will link the forms.
   c. *If a transferred patient undergoes a second unplanned EL in hospital B that is for a new event not direct 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.

Clinician seniority

For the purposes of this pilot 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 case 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 have clinical indications for an EL, but do not undergo surgery. The reasons for this futility may include age, fragility, advanced malignancy, medical co-morbidities, care capped to not include surgery, patient wishes etc. These patients were not included in NELA which recognises this is 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 this.

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*
DM1	[1.1]	Demographics	NHI (New Zealand)	[AAANNNN]		
DM2	[1.1]	Demographics	Medicare number (Australia)	[N(11)]		Not applicable
DM3	1.3	Demographics	Hospital Record Number	[free text]		Not applicable
DM4		Demographics	Hospital Identifier	[free text		
DM5	1.7	Demographics	Surname	[free text]		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
DM6	1.5	Demographics	Sex	1 - Male 2 - Female 3 - Intersex or indeterminate 4 - Not stated/inadequately described		
DM7	1.4	Demographics	Date of Birth	[DD/MM/YYYY]		
DM8		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)
PR1		Pre-operative	Did the patient 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: **care capped to non-intervention** treatment (e.g. radiological drainage) or medical care (e.g. no ventilation, no dialysis, no readmit to ICU) only 6 – No: **patient/family wishes** to limit care including Advanced Health Care Directive	If 'yes' is chosen the remainder of the form should be completed. All other options include patients who would normally undergo an EL but who did not for one of the reasons stated. This may include patients who are not under a surgeon, but who they are asked to review (for example malignant SBO). If one of the 'no' options is selected please complete the smaller number of conditional fields.	
PR2	1.9	Pre-operative	Date and time the patient first arrived at the hospital	[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.	
DM9	1.4	Demographics	[auto-calculated] Age on admission	[NNN]		

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PR3	1.10	Pre-operative	The nature of this admission	1 - Elective 2 – Emergency	This refers to the admission to the hospital were 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			Was this a readmission within 30 days for a previous EL?	1 – Yes 2 - No		
PR5	[1.10b]	Pre-operative	Where did the patient first present at the hospital?	1 - Emergency Dept 2 - ASU/Ward 3 – Room/clinic 4 – Other [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		
PR7		Pre-operative	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	
PR8	[1.11]	Pre-operative	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		

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				6. Orthopaedics 7. Other [free text]		
PR9	[2.1]	Pre-operative	Date and time first seen by any member of the surgical team in this hospital	[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, 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.	Taken as the time stamp of first completion of the Electronic Assessment Form (EAF).
PR10	2.7	Pre-operative	Was an abdominal CT scan performed in the preoperative period as part of the diagnostic work-up?	1 - Yes 2 - No 3 – Unknown		
PR11		Pre-operative	[conditional field: PR10 = Yes] Date and time of CT scan	[DD/MM/YYYY] Date not known [HH:MM] Time not known		

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PR12	[2.7a]	Pre-operative	[conditional field: PR10 = 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.	
PR13	[2.11a]		Was sepsis suspected **at time of initial hospital** admission?	1 - Yes 2 - No 3 – 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.
PR14		Pre-operative	Was a qSOFA score done?	1 – Yes **pre**-operatively 2 – Yes **post**-operatively 3 – Yes but timing uncertain 4 - No 5 – Unknown		Taken as timing of first completion of the EAF (where qSOFA is embedded) relative to the timing of Theatre Booking
PR15		Pre-operative	[conditional on PR14 = 1/2/3] What was the qSOFA score	[numeral]		
PR16		Pre-operative	[conditional on PR14 = 1/2/3] Date and time of qSOFA score	[DD/MM/YYYY] Date not known [HH:MM] Time not known		
PR17	2.10	Pre-operative	What was the date and time of the first dose of IV antibiotics following presentation to 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	

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					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.	
PR18		Pre-operative	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
PR19	3.5	Pre-operative	What was the most recent pre-operative value for blood lactate – may be arterial or venous (mmol/l)	[Mmol/L]		
PR20		Pre-operative	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
PR21	[2.2]		[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)
PR22	[2.11b]		[conditional on PR1 = Yes] Was sepsis suspected at the time the decision for surgery was made?	1 - Yes 2 - No 3 – Unknown		

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RS1	[3.1 & 3.2]	Pre-operative risk stratification	Was the risk of death for the patient calculated and **entered into medical record**?	1 - Yes pre-operatively 2 - Yes post-operatively 3 - No 4 - 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	Pre-operative risk stratification	[conditional on RS1 = 1 or 2] [Australia only] What was the NELA mortality score (%)		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	Pre-operative risk stratification	[conditional on RS1 = 1 or 2] [New Zealand only] What was the P-POSSUM score (%)			
RS4	[2.12a]	Pre-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 11- Not done	Use the Rockwood score. See attached figure	
RS5	[3.22]	Pre-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	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

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					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 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.	= "6" for ANZELA-QI
OP1	5.1	Operative	[conditional on PR1 = Yes] Is this the first surgical procedure of this admission?	1 – Yes 2 – No 3 - Other [freetext 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.	

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OP2	7.4a		[conditional on PR1 = Yes] FOR UNPLANNED RETURN TO THEATRE CASES ONLY, 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. If the second EL was not for a complication of the first EL (e.g. remove packs, undertake a washout) no data is required.	
OP3	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 Haemobilia Haemorrhage Hernia - hiatus Hernia - incarcerated Hernia - incisional Hernia - internal Iatrogenic injury Intestinal fistula Intussusception Ischaemia Necrosis Obstruction - Small bowel Obstruction - Large bowel Perforation Peritonitis Phlegmon/inflammatory mass Planned relook	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	

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				Pneumoperitoneum Pseudo-obstruction Sepsis Volvulus		
OP4	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
OP5	[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	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
					anaesthetic room.	
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) 5 – Advanced trainee (pre-final exam) 6 - Basic trainee 7 – Other	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. 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	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
					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 Haemorrhage – peptic ulcer Haemorrhage – intestinal Haemorrhage – post-operative Hernia - incarcerated Hernia - Internal Intestinal fistula Intestinal ischaemia Intussusception Meckel's diverticulum Necrotising fasciitis Pseudo-obstruction Perforation – peptic ulcer Perforation – small bowel/colonic Stricture Stoma Complications Volvulus Normal abdomen	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.	

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
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		
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) 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 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		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				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		
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 surgery - other Haematoma – evacuation Haemostasis Hiatus hernia repair		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				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		
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		

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
				Foreign body - removal Gastrectomy - partial or total 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		
PO1	6.24	Post-operative	[conditional on PR1 = Yes] Where did the patient go for **immediate** continued post-operative care following surgery?	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	

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					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.	
PO3	[7.3]	Post-operative	Assessment by Elderly Medicine team if age >65 years	1 - Yes 2 - No 3 – Unknown		
PO4		Post-operative	[conditional on PR1 = Yes] Clavien Dindo complication grade score if 3 or more at any point during admission	1 - Grade IIIa 2 - Grade IIIb 3 - Grade IVa 4 - Grade IVb 5 - Grade V		Not applicable
DS1	7.7	Discharge	Status at discharge from hospital	1 - Alive 2 - Dead 3 – Still in hospital at 60 days after admission		Alive = date of death is null or is later than the date of discharge Dead = date of death is equal to or predates date of discharge
DS2	7.8	Discharge	[Conditional field. If DS1 = Alive then:] Date of discharge from hospital	[DD/MM/YYYY]		Taken from PIMS/IPMS
DS3		Discharge	[Conditional field. If DS1 = Dead then:] Date of death	[DD/MM/YYYY]		Taken from PIMS/IPMS

ANZELA Ref.	NELA Ref.	Data Group	Field name	Data Domain	General help for data entry	Notes for NZ only
DS4			[Conditional field. If DS1 = Alive then:] Did the patient return to their pre-hospital residence?	1 - No 2 - Yes 3 – Unknown		
DS5	7.9	Discharge	[Conditional on DS4= 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		
DS6		Discharge	[Conditional on DS5 = new destination] If Place of discharge 'New destination' - specify	[freetext]		