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| **Standard Operating Procedures****for ERAS+ sites**  |

**Version Control**

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| **Version** | **Date** | **Changes** |
| 2.1 | 11/02/20 | Changes made to dataset. Some question numbers may have changed.New/altered questions: 1.8; 2.4a; 2.4b; 2.34; 2.35; 3.2; 3.13; 6.18; 6.19; 7.2.Questions removed: 3.1; 3.2. |
| 2.0 | 06/03/19 | Changes made to dataset. Some question numbers may have changed. Question numbers may not increment sequentially as some questions may not be applicable to your hospital. New or modified questions highlighted. Question on smoking cessation removed (formerly Q2.31). |

**Introduction**

The Perioperative Quality Improvement Programme (PQIP) was set up in 2016 by the Health Services Research Centre at the Royal College of Anaesthetists. It is an NIHR portfolio adopted research study supported by UCL (the sponsor), and the Royal College of Anaesthetists, UCL NIHR Surgical Outcomes Research Centre and Health Foundation (funders).

Our aim is to improve the outcomes of patients undergoing major non-cardiac surgery. PQIP measures complications, risk-adjusted mortality and patient reported outcomes on a random sample of five cases per week so we can try to reduce complication rates, improve patient experience and quality of life after surgery.

We have constructed a dataset which we would like you to complete for each patient participating in this study. As there can be many interpretations of questions we have provided this document, a standard operating procedure (SOP) for the PQIP dataset, to provide guidance on correct completion of the form.

Please note that this SOP refers only to the questions that are to be completed by the clinicians or researchers and not by patients themselves.

As you complete the questions in the web-tool, the menu bar will change colour to highlight your progress: blue for empty or unsaved sections; red for sections with errors; orange for incomplete sections requiring further data entry; green for fully completed sections.

If you have any questions please contact the PQIP team at pqip@rcoa.ac.uk

Thank you for your support.

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| **Patient demographics** |
| 1.1 | Enter the patient’s **local hospital ID number**. |
| 1.2 | Enter the patient’s **surname**. |
| 1.3 | Enter the patient’s **first name** as registered on the hospital system. |
| 1.4 | Enter the patient’s **date of birth** in the format ‘DD/MM/YYYY’. |
| 1.5 | Select the patient’s current **gender**. |
| **Address details** |
| 1.6 | Enter the patient’s **current postcode** – enter the outward code (1st part) in the first box and the inward code (2nd part) in the second box. |
| 1.7 | Select **one** of the two options that best describes the patient’s usual residence:* **Own home** – private residence either owned or rented. This would include sheltered accommodation.
* **Care home** – residential or nursing home where assisted living is provided.
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| 1.8 | Enter the **date that patient consent was obtained** in the format ‘DD/MM/YYYY’. |
| **Surgical admission** |
| 1.9 | Enter the patient’s **date of admission** to hospital for this procedure in the format ‘DD/MM/YYYY’. |
| 1.10 | Enter the patient’s **date of surgery** in the format ‘DD/MM/YYYY’. |
| 1.11 | Patient’s age on data of surgery is automatically calculated in years and months. |
| **ID numbers** |
| 1.12-1.13 | For **Scottish hospitals**, enter the patient’s **CHI (Community Health Index) number**. For hospitals in **Northern Ireland**, enter the patient’s **Health and Care (H&C) number**. For hospitals in the rest of the UK enter the patient’s **NHS (National Health Service) number**. All numbers contain 10 digits. |
| 1.14 | Enter the patient’s **height** in centimetres (cm). |
| 1.15 | Enter the patient’s **weight** in kilograms (kg). |
| 1.16-1.18 | The patient’s **body surface area (BSA)**, **body mass index (BMI)** and **ideal body weight (IBW)** will be automatically calculated by the web-tool. |
| **Linked data** |
| 1.19-1.20 | Linked data on mortality and unplanned hospital re-admission will be automatically filled in by the web tool as these data become available. |
| **Patient follow-up** |
| 1.21 | Indicate how the patient would prefer to be **contacted in 6 and 12 months’** time to complete the follow-up questionnaires. This should be indicated on the completed consent form. Patients can also opt in or out to receive e-mail updates from the PQIP study team, approximately once per year. If the patient has chosen to be contacted by e-mail, the webtool will automatically record if reminders have been sent to the patient. |
| 1.22 | Indicate if the patient is enrolled in any other studies. If yes, please note the study. |
| **Pre-operative data** |
| Several of these questions form part of the P-POSSUM risk scoring tool which assigns increasing weight as you descend the tick box options or as a numeric value changes. Some questions have pre-defined wording and criteria which cannot be adjusted. Where this occurs, we have provided further explanation below in an attempt to remove any ambiguity. Please note the acceptable value ranges for questions 2.7-2.16. In the case of extreme values outside this range please double check. If you believe it to be correct then please round to the nearest acceptable value. |
| 2.1-2.2a | Select the **surgical specialty** and **planned procedure** from the lists provided. The **eligible** specialties and procedures are listed on the Procedure List available from the PQIP web site.The magnitude of surgery will be automatically generated from the choices made in questions 2.1–2.2. Surgical magnitude is determined using the AXA-PPP schedule of procedures and is the same as that used in the Surgical Outcome Risk Tool (SORT) (www.sortsurgery.com). |
| 2.2b | Select the mode(s) of surgery that apply to this operation: open; laparoscopic; robotic; thoracoscopic. |
| 2.2c | Indicate if this surgery is part of a **planned multistage procedure**. If so, enter the date of the **final stage** in the format ‘DD/MM/YYY’. This may result in the record not being locked until the final stage has occurred. This will allow us to contact the patient to complete their questionnaires at 6 and 12 months after the final procedure. We would suggest that you record the first stage procedure within the PQIP webtool. |
| 2.3 | PQIP is currently only collecting data on patients having planned surgery. Choose from the following:* **Expedited** – Patient requiring early treatment where the condition is not an immediate threat to life, limb or organ survival. Normally within days of decision to operate. This might include urgent cancer surgery for example.
* **Elective** – Intervention planned or booked in advance of routine admission to hospital. Timing to suit patient, hospital and staff.
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| 2.4 | State whether the indication for surgery is a **cancer diagnosis**. |
| 2.4a | If this is cancer surgery, indicate the pre-operative staging using the **TNM classification**. |
| 2.4b | If this is cancer surgery, indicate whether **neoadjuvant chemotherapy** was received pre-operatively. |
| 2.5 | Indicate if the patient is on an **enhanced recovery pathway**. This includes any protocolised pathway aimed at improving patient outcome and reducing length of stay. |
| 2.6 | Select one or more options from the list which best describe the form of **preoperative assessment** undertaken **prior to hospital admission**. Free text available if ‘other’ chosen. For the purposes of PQIP, assessment on the morning of surgery or an admission clerking would **not** be considered pre-admission pre-operative assessment. |
| 2.7 | Enter the patient’s most recent serum **sodium** prior to surgery in mmol/L [range 105-165]. |
| 2.8 | Enter the patient’s most recent serum **potassium** prior to surgery in mmol/L (to one decimal place) [range 2.5-7.5]. |
| 2.9 | Enter the patient’s most recent serum **urea** prior to surgery in mmol/L (to one decimal place) [range 1.5-30; if outside this range please round to the nearest acceptable value]. |
| 2.10 | Enter the patient’s most recent serum **creatinine** prior to surgery in μmol/L [any value up to 999 acceptable]. |
| 2.11 + | Enter the patient’s most recent serum **troponin** prior to surgery in ng/L.  |
| 2.12 | Enter the patient’s most recent serum **albumin** prior to surgery in g/L [range [10-60]. |
| 2.13 | Enter the patient’s most recent **white cell count** prior to surgery in x109/L (to one decimal place) [range 0-30; if outside this range please round to the nearest acceptable value]. |
| 2.14 | Enter the patient’s most recent **haemoglobin** prior to surgery in g/dL (to one decimal place) [range 5-22]. |
| 2.15 | Enter the patient’s **pulse rate** in beats per minute (bpm) [range 30-199]. |
| 2.16 | Enter the patient’s **systolic blood pressure** in mmHg [range 55-250]. |
| 2.17 | Enter the patient’s **Glasgow Coma Scale** total, ranging from 3–15 (**see p15**). PQIP is recruiting patients who can provide informed consent so we anticipate patients will have a GCS of 15. |
| 2.18 | Enter the patient’s **oxygen saturations (%)** measured in the supine position and after resting for one minute. If the patient is on supplemental oxygen please remove for 10 minutes and then measure oxygen saturations at rest. |
| 2.19 | Select **one** option that best describes the patient’s **pre-operative ECG**. |
| 2.20 | Select **one** option that best describes the patient’s current **cardiac history/findings**. This question enquires about the presence and severity of **cardiac failure**.  The answers can be based on patient history, examination or chest x-ray findings.  The criteria in the second and third tick boxes apply only if the patient is being treated for cardiac failure.  Anti-anginals for ischaemic heart disease or antihypertensives without a diagnosis of cardiac failure would not be scored here. Cardiac failure is not always clearly documented and if there is ambiguity it may require a review of documented examination findings and echocardiogram reports. If multiple options apply, choose the option further down the list (higher score). |
| 2.21 | Select **one** option that best describes the patient’s current **heart failure status** according to the **New York Heart Association (NYHA)** Functional Classification:* **I - No limitation of physical activity.** Ordinary physical activity does not cause undue fatigue, palpitation, dyspnoea.
* **II - Slight limitation of physical activity.** Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnoea.
* **III - Marked limitation of physical activity.** Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnoea.
* **IV - Unable to carry on any physical activity without discomfort**. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

Whereas the P-POSSUM (2.20) uses the presence of medications and clinical signs (oedema, cardiomegaly), the NYHA Functional Classification is a tool for scoring severity of cardiac failure based on **clinical symptoms** and the degree to which a patient is **limited during physical exertion**.  |
| 2.22 | Select one option that best describes the patient’s **current respiratory history/findings.** |
| 2.23 | Select if the patient has had an acute upper or lower **respiratory tract** **infection** in the month prior to surgery. |
| 2.24 | Select one option provided as to the patient’s history of **cerebrovascular disease**:* **No**.
* **Yes – without hemiplegia**: history of TIA or stroke with no or minor sequelae.
* **Yes – with hemiplegia**: stroke with hemiplegia.
 |
| 2.25 | Select one or more of the **cancer diagnosis** options that are current or have been in remission for less than five years:* **No**.
* **Yes – solid tumour: local only** (exclude if > 5 years from diagnosis).
* **Yes – solid tumour**: metastatic disease (including lymph node).
* **Yes – Lymphoma** (NHL, Hodgkin's, Waldenström, multiple myeloma).
* **Yes – Leukaemia** (acute or chronic).
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| 2.26 | Select if the patient has a diagnosis of **chronic cognitive deficit** or **dementia**. |
| 2.27 | Select if the patient has **diabetes mellitus**. If on oral medication and insulin- enter as on insulin. End organ damage includes retinopathy, neuropathy and nephropathy. If the patient is type 2 diabetic please select the option of how the diabetes is controlled. |
| 2.28 | If it was measured, enter the patient’s most recent **HbA1c** prior to surgery as a **%** (to one decimal place) if they are being treated for diabetes mellitus. A conversion calculator from mmol/mol or mmol/L can be accessed through the web tool. |
| 2.29 | Select **one** of the options if the patient has **liver disease**. Cirrhosis can either be diagnosed radiologically, histologically or grossly. * **No**
* **Yes** – cirrhosis or Hep B/C **WITHOUT portal hypertension**
* **Yes** – cirrhosis or Hep B/C **WITH portal hypertension**

If yes, indicate the type of liver disease (Hep B, Hep C, Alcohol-related, Non-alcoholic steatosis) and the severity of liver disease as grade by the Child-Pugh score (A-C; **see p15**). Select **unknown** if not all of the data is available to allow you to calculate this score. |
| 2.30 | Grade the patient’s risk according to the American Society of Anesthesiologists physical status (ASA-PS) classification (**see p16**). |
| 2.31 | If the patient had preoperative **cardiopulmonary exercise testing** enter the required results if available.* VO2 Peak Indexed (ml/kg/min)
* Anaerobic Threshold (AT) Indexed (ml/kg/min)
* VE/VCO2 at AT
* Max work rate (Watt)
* Max heart rate (bpm)
* Max oxygen pulse (ml/beat)
* FEV1/FVC (%)
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| 2.32 | Select **one** option which best describes the patient’s **smoking history**. Smoking includes all forms of inhaled tobacco (but not electronic cigarettes or other nicotine delivery systems, e.g. chewing gum). |
| 2.33 | Select **one** option which best describes the patient’s **current daily alcohol consumption**. One alcohol unit equals 10ml or 8g of pure alcohol which equals one 25ml single measure of whiskey (ABV 40%), or a third of a pint of beer (ABV 5-6%), or half a standard (175ml) glass of red wine (ABV12%). |
| 2.34 | Select the type of **perioperative** **risk assessment**, if any, that was recorded in the notes or consent form. This should convey risk of mortality or morbidity arising from the surgery, **individualised** to the patient. This does not include population risks of anaesthesia-related procedures. All forms of risk stratification accepted: Qualitative (e.g. low / medium / high); Qualitative (e.g. percentage risk of death or complications, e.g. using P-POSSUM/SORT). |
| 2.35 | Select the patient’s **planned post-operative destination**. * **Level 0 (ward)** – Patients whose needs can be met through normal ward care in an acute hospital.
* **Level 1** – Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.
* **Enhanced care (Level 1+)** – An intermediate level of care where a higher level of observation, monitoring and interventions can be provided than on a general ward, but patients not requiring high dependency care/organ support. For example, a patient requiring vasopressor support whilst receiving an epidural for postoperative pain relief is different to an acutely unwell patient requiring vasopressor support due to postoperative sepsis. Enhanced advice and support from the critical care team can be accessed.
* **Level 2** – Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care, and those stepping down from higher levels of care. When basic respiratory and basic cardiovascular support are provided at the same time during the same critical care spell, and no other organ support is required, the care is considered to be level 2 care.
* **Level 3** – Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure. Basic respiratory and basic cardiovascular care do not count as two organs if they occur simultaneously, but will count as level 3 if another organ is supported at the same time.
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| **Surgical admission** |
| 2.36 | Select if the patient received oral mechanical **bowel preparation**. If yes, please specify the type of bowel preparation: antibiotic and/or mechanical. |
| 2.37 | Select if the patient received a clear **carbohydrate drink** approximately 2 hours prior to surgery. |
| **Chest physio instruction** |
| 2.38 + | Indicate if the patient received specific instruction on **chest training and exercise** **+/- incentive spirometer** prior to surgery, and who delivered this. |
| **Surgery school** |
| 2.39 + | Indicate if the patient attended **surgery school** and **how this was delivered**. |
| **App downloaded for surgery** |
| 2.40 + | Indicate if the patient downloaded an application onto an electronic device to help preparation for surgery. |
| **Type of activity** |
| 2.41 + | Indicate **all** the **types of physical activity** that the patient undertook prior to surgery. Multiple options can be selected. If ‘Other’ selected, please indicate the additional activities in the free-text box. |
| **Anaemia treatment** |
| 2.42 | Indicate which **Anaemia treatment** the patient received in the **last 3 months** prior tosurgery. Multiple options can be selected. |
| **Frailty score** |
| 2.43 | Complete the **Rockwood Clinical Frailty Score** to determine the patient’s degree of frailty (**see p17**). |
| **Operative data** |
| 3.1 | Select if **appropriate prophylactic antibiotics** were given within 60 minutes of skin incision. “Appropriate antibiotic prophylaxis” is compliance with local protocols. If no antibiotics are required according to local protocols and none were given, this constitutes appropriate antibiotic prophylaxis. |
| 3.2 | Select all of the **anaesthetic techniques** that the patient received, including the **form(s) of perioperative analgesia** they received. If the patient received a general anaesthetic, indicate the **type(s) of inhalational or intravenous agent** used. Intravenous analgesia remains an option, but if you select this option please be more specific by ticking the other options which apply:   IV paracetamol; IV NSAID; IV opioids; IV ketamine; IV dexmedetomidine; IV lignocaine. |
| 3.3 | Select any **additional intraoperative monitoring** that the patient had in addition to the standard AAGBI monitoring for all operations.Standard AAGBI monitoring includes: pulse oximeter, non-invasive blood pressure, electrocardiograph, airway pressure and airway gases (oxygen, carbon dioxide, anaesthetic agent).Cardiac output monitoring includes any device that was inserted or used to assess the fluid responsiveness of the patient during the surgical procedure. It includes Oesophageal Doppler, Pleth Variability Index (PVI), echocardiogram, arterial pulse contour analysis, pulmonary artery catheter, partial non-rebreathing systems, thoracic bio impedance, endotracheal cardiac output monitor. |
| 3.3a+ | If the patient received **mechanical ventilation** intra-operatively, provide the **average tidal volume** (ml) for the case. |
| 3.4 | Indicate the type(s) of **intraoperative** **warming** **device**, if any, used for this patient. Multiple options can be selected. |
| **Operative findings** |
| 3.5 | Including the present procedure, indicate the **number of operations** the patient has had in the previous **30 days**. |
| 3.6-3.8 | Select if the **actual procedure** was the same as the overall planned procedure. If different, select the actual procedure performed from the lists available, including the **actual mode of surgery**. More than one mode may be selected if the mode change intraoperatively (e.g. change from laparoscopic to open approach). Refer to the answers in sections 2.1–2.2. Also select any **secondary procedure** that was performed. |
| 3.9 | Indicate which **surgical incision** was performed. If more than one incision, **choose the higher ranking incision**: Thoracic > upper abdominal > lower abdominal > other/laparoscopic/thoracoscopic. |
| 3.10 | Select the range of estimated total **blood loss** for the procedure. **If greater than 1000ml indicate the actual amount** in ml. |
| 3.11 | In cases where the abdominal or thoracic cavities were entered, select the option which best describes the **intra-abdominal or intra-thoracic findings**. |
| 3.12 | Select the **length** **of time** that the patient was under general anaesthesia for the procedure. |
| 3.13 | Indicate if the patient received **any additional treatments**, including: tranexamic acid; a bolus dose of vasopressor or inotrope; an infusion (of any duration) of vasopressor or inotrope. |
| **Postoperative destination** |
| 3.14 | Select the patient’s **actual postoperative destination**. For definitions, refer to the notes above for question 2.35. |
| 3.15 | If the actual destination is **different** from that planned (see answer to question 2.35) please indicate the **reason why**. Choose from the options listed or type in the free text box. |

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| **Recovery care** |
| If the patient is transferred directly to a higher-level care facility postoperatively then the “recovery period” should be regarded as the immediate three hours postoperatively. |
| 4.1 | Select yes if the **first core temperature** taken in recovery is greater than or equal to 36°C. |
| 4.2 | Select yes if an **abdominal drain** is present on arrival from theatre. |
| 4.3 | Select yes if a **nasogastric tube** is present on arrival from theatre. |
| 4.4 | Select the patient’s **highest recorded pain** score during their stay in recovery.We would suggest converting numerical pain scales as follows:

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| **0-3 scale:** 0 = None1 = Mild2 = Moderate3 = Severe | **0-10 scale:** 0 = None1-3 = Mild4-6 = Moderate7-10 = Severe |

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| **Postoperative visit on day 2 or day 3** |
| Answer these questions with regard to the patient’s status on post-operative day 1 (within 24 hours from completion of surgery). These assess achievement of the enhanced recovery objectives of the CHEERS-DREAM campaign. |
| 5.1 | Select yes if **IV maintenance fluids** were **discontinued** within 24 hours of surgery ending. |
| 5.2 | Select yes if the patient was tolerating **free fluids** within 24 hours after completion of surgery. No minimum volume currently specified. See web tool for links to recent guidelines. |
| 5.3 | Select yes if the patient **restarted oral diet** (at least soft diet e.g. yoghurt, porridge, fruit) within 24 hours of completion of surgery and tolerated it. This does not have to be full normal diet. If no, indicate if the patient received **supplementary nutrition** within 24hr of surgery ending. If they did receive supplementary nutrition, indicate the **type.** |
| 5.4 | Select yes if the patient **mobilised from bed to chair** with maximum assistance of one person within 24 hours of completion of surgery.  |
| 5.5 + | Indicate the frequency that the patient used the **incentive spirometer in the first 24 hours** after surgery. |
| 5.6 + | Indicate the frequency that the patient **brushed their teeth in the first 24 hours** after surgery. |
| 5.7 + | Indicate the frequency that the patient used **mouthwash in the first 24 hours** after surgery. |
| 5.8 + | Select the **highest level of respiratory support** the patient received **in the first 24 hours** after surgery. Select **one** option only. If applicable, indicate the fraction of inspired oxygen (FiO2) as a percentage. |
| **Day 7 postoperatively** |
| 6.1-6.2 | Select yes if the patient is **currently in hospital** on day 7. If yes, select the patient’s **current location** from the options listed. For definitions, refer to the notes above for question 2.35. Select ‘Level 2/3 care’ for a combined critical care unit. If the patient is no longer in hospital, proceed to answer Q6.18. |
| **Post-Operative Morbidity** |
| The following questions form the Post-Operative Morbidity Survey (POMS), an 18-item survey addressing nine domains of postoperative morbidity. In answering them you should consider the patient’s status on **day 7 post-operatively**. |
| 6.3 | **Pulmonary** – select all options that apply.If the patient has been receiving long-term oxygen therapy and has recovered back to their original level of oxygen requirement prior to surgery, please select **None of the above**. If the patient is receiving any advanced respiratory (including non-invasive ventilation or high flow nasal cannula) support that was not present before surgery, please select **New requirement for ventilator**.  |
| 6.4 | **Infection** – select all options that apply. * Select if the patient is on **IV antibiotics** – this does not include oral antibiotics.
* Select if the patient has had a **temperature of 38°C** or greater during the 24 hours preceding the time point at which the day 7 data is being collected.
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| 6.5 | **Gastrointestinal** – Select all options that apply.* Select **Unable to tolerate enteral nutrition** if: receiving TPN; nil by mouth; clear fluids only; free fluids only; soft diet only; NG tube on free drainage or high NG aspirates; NG fed but not tolerating full prescribed amount and therefore needs to remain in hospital.
* Select **Nausea, vomiting or abdominal distention** if the patient is unable to return to their previous normal diet for the above reasons, this includes paralytic ileus and patients who are requiring anti-emetics.
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| 6.6 | **Renal** – Select all options that apply. * Select **Oliguria** if the urine output was **less than 500ml** during the 24 hours preceding the time point at which the day 7 data is being collected. Do not select this option if the urine output is greater than or equal to 500ml in the preceding 24 hours, if the urine output is not recorded or the fluid balance is inexact.
* Select **Creatinine 30% greater than pre-operative level** if the serum creatinine during the 24 hours preceding the time-point at which the day 7 data is being collected is 30% greater than the pre-operative value. This should not be selected if less than 30% increase or if not measured in the preceding 24 hours. Use the pre-operative creatinine value closest to the date of surgery as the baseline value.
* Select **Urinary catheter in-situ** if the patient has a urethral or supra-pubic catheter in-situ that was not present prior to surgery.
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| 6.7 | **Cardiovascular** – Select all options that apply.* Select **Hypotension** if, during the 24 hours preceding the time point at which the day 7 data is being collected, the patient has required >200ml of fluid resuscitation or has required a mini-jet or infusion of adrenaline or noradrenaline. This does not include GTN infusion for pulmonary oedema.
* Select **New myocardial infarction or ischaemia** if, during the 24 hours preceding the time point at which the day 7 data is being collected, the patient has had a serum troponin sample taken, an ECG, echocardiogram, thrombolysis, a stent, PCI or if they require GTN spray or infusion for chest pain or ischaemic changes. This does not include routine post-operative ECGs.
* Select T**hrombotic event requiring anticoagulation** if, at present or during the 24 hours preceding the time point at which the day 7 data is being collected, the patient required warfarin, heparin, treatment-dose low molecular weight heparin, or other anticoagulation. This does not include prophylactic anticoagulation, return to treatment dose anticoagulation if the patient was on anticoagulation prior to hospital admission, clopidogrel or aspirin.
* Select **Arrhythmias** if, during the 24 hours preceding the time point at which the day 7 data is being collected, the ECG shows any dysrhythmia or if the patient had a non-routine ECG (unless this is for diagnosis of MI in which case “New myocardial infarction or ischemia” should be selected).
* Select **Cardiogenic pulmonary oedema** if at present or during the 24 hrs preceding the time point at which the 7 day data is being collected, the patient has been started on GTN or furosemide for pulmonary oedema.
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| 6.8 | **Neurological** – Select all options that apply.* Select **New neurological deficit** if, at present or during the 24 hours preceding the time point at which the day 7 data is being collected, the patient has a new focal neurological deficit that was not present pre-operatively.
* Select **Delirium or confusion** if, at present or during the 24 hours preceding the time point at which the day 7 data is being collected, the patient’s family or nursing staff report the patient’s behavior is not normal (new confusion or delirium that was not present pre-operatively, or if the patient has pre-existing confusion or delirium that is worse compared to their preoperative state).
* Select **Sedative-induced coma** if the patient is in a sedative-induced coma.
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| 6.9 | **Wound** – Select all options that apply. Select if the patient has required surgical exploration of a dehisced surgical wound, drainage of pus from the operation wound, oozing from the surgical wound, if a swab is sent to a laboratory or if a VAC drain is in situ. |
| 6.10 | **Haematological** – Select all options that apply.* Select **Red cell transfusion** if the patient has received a red blood cell transfusion during the 24 hours preceding the time point at which the day 7 data is being collected.
* Select **Fresh frozen plasma/cryoprecipitate/platelets** if any were given at any point during the 24 hours preceding the time point at which the day 7 data is being collected.
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| 6.11 | **Pain** – Select all options that apply.Select if the patient has received parenteral opioids or regional anaesthesia during the 24 hours preceding the time point at which the day 7 data is being collected. This includes PCA, epidural, IV or IM pain relief. This does not include oral analgesia or using transdermal patches. |
| 6.12 | Select yes if the patient has returned to their **baseline level of mobility** during the 24 hours preceding the time point at which the day 7 data is being collected. |
| 6.13 | Select all the reasons that explain why the patient **still requires admission on day 7** post-operatively. |
| 6.14 + | Select yes if the patient **received antibiotic treatment for longer than 24 hours** in the first 7 days post-operatively. This does not include antibiotics as part of surgical site infection prophylaxis. If yes, indicate the **infection source**. |
| 6.15 + | Indicate the level of **unplanned respiratory support** the patient received between 24 hours and 7 days post-operatively. * **None**: Planned use of supplemental oxygen <0.4 FiO2 or mechanical respiratory support as part of routine patient care (includes patient on normal CPAP), but not in response to a complication or deteriorating physiology.
* **Mild**: Supplemental oxygen <0.6 FiO2.
* **Moderate:** Supplemental oxygen = 0.6 FiO2 and/or requirement for high-flow nasal/facial oxygen.
* **Severe:** Unplanned non-invasive mechanical ventilation, Continuous Positive Airways Pressure (CPAP), or invasive mechanical ventilation requiring endotracheal intubation.
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| 6.16 + | Excluding their regular preoperative medications, indicate if the patient received any **new/additional pharmacological treatment for their breathing**. If not listed please specify in the free-text box. |
| 6.17 + | Indicate if the patient had a **troponin measured in the first 7 days post-operatively**. If measured, please record the highest measured result (ng/L) and the corresponding serum creatinine level (µmol/L). |
| 6.18a | If the patient does not have chronic renal failure with renal replacement therapy (RRT), record the **highest creatinine value** (µmol/L) recorded in the first 7 days post-operatively.  |
| 6.18b | **Excluding patients on long term renal replacement therapy** (RRT) preoperatively, select yes if the patient received **new renal replacement therapy** in the first 7 days post-operatively.  |
| 6.19 | **Oesophagectomies only**. Indicate whether a Gastrografin swallow (or similar radiological contrast study) was undertaken, and if so, enter the date of the test. |

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| **Death, discharge or withdrawal** |
| 7.1 | Select the **discharge destination** or if patient has died prior to discharge or withdrawal from study. |
| 7.1a-c | Enter the **date of discharge, death** **or withdrawal** as applicable in the format ‘DD/MM/YYYY’. |
| 7.1a i | Select the option which best describes the patient’s **opioid status on discharge**. For this question we consider Tramadol to be an opioid. The definition for opioid naïve patients varies but can generally be regarded as those who have not received opioids in the 30 days prior to surgery. |
| **Clavien-Dindo grade of complication** |
| 7.2 | Select the **grade of complication** experienced by the patient during their primary admission for surgery. If the patient experienced multiple complications please list each relevant level of complication. If the patient experienced multiple complications, please **list each grade experienced**.* The treatments allowed for Grade I include: analgesic, antipyretic, antiemetic, and antidiarrheal drugs or drugs required for lower urinary tract infection.
* Radiological interventions can be taken to mean radiologically-guided procedures rather than radiological investigations.
* Grade II includes TPN, blood transfusion and any other drugs not included in Grade I.
 |
| 7.2a | **If Grade II or above**, indicate whether the patient was treated for a **suspected postoperative infection**. |
| 7.2b | **If Grade II or above**, select from the list any **complications experienced**. |

**Glasgow Coma Scale**

|  |  |  |
| --- | --- | --- |
| **Eye opening** | **Best verbal response** | **Best motor response** |
|  Spontaneous To soundTo pressureNone  | 4321 |  OrientatedConfusedWordsSoundsNone | 54321 | Obeys commandsLocalises painNormal flexion to painAbnormal flexion to painExtension to painNone | 654321 |

**Child-Pugh score**

|  |  |
| --- | --- |
| **Parameter** | **Numerical Score** |
| **1** | **2** | **3** |
| Ascites | None | Slight | Moderate to severe |
| Encephalopathy | None | Slight to moderate | Moderate to severe |
| Bilirubin (µmol/L) | <34 | 34-50 | >50 |
| Albumin (g/L) | >35 | 28-35 | <28 |
| Prothrombin time (prolonged over control)*or* INR | <4 sec<1.7 | 4-6 sec1.7-2.30 | >6 sec>2.30 |
| Child-Pugh Class A = 5-6 points; Child-Pugh Class B = 7-9 points; Child-Pugh Class C = 10-15 points. |

**ASA-PS Score**

|  |  |  |
| --- | --- | --- |
| **ASA grade** |  **Definition**  | **Further explanation** |
| **ASA I** | A normal healthy patient | Healthy, non-smoking, no or minimal alcohol use |
| **ASA II** | A patient with mild systemic disease | Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease |
| **ASA III** | A patient with severe systemic disease | Substantive functional limitations: one or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents. |
| **ASA IV** | A patient with severe systemic disease that is a constant threat to life | Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis |
| **ASA V** | A moribund patient who is not expected to survive without the operation | Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction |
| **ASA VI** | A declared brain-dead patient whose organs are being removed for donor purposes |  |

**Rockwood Clinical Frailty Scale**

