



ACUTE BOWEL OBSTRUCTION STUDY

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

CLINICAL QUESTIONNAIRE

CONFIDENTIAL

DETAILS OF THE CLINICIAN COMPLETING THIS QUESTIONNAIRE:

Grade: _____

Specialty _____

What is this study about?

The aim of this study is to identify remedial factors in process of care of patients with both large and small intestinal obstruction.

Inclusions:

Data will be collected on patients aged 16 and over admitted to hospital with an obstructed bowel over a four week period, (Monday 16th April - Sunday 13th May 2018).

Eligible cases were identified from the hospital central record system (using ICD10 codes). Up to 10 cases per hospital have been selected for review.

Who should complete this questionnaire?

For completion by the consultant who was responsible for the patient at the time of hospital admission.

CPD accreditation:

Consultants who complete NCEPOD questionnaires make a valuable contribution to the investigation of patient care. Completion of questionnaires also provides an opportunity for consultants to review their clinical management and undertake a period of personal reflection. These activities have a continuing medical and professional development value for individual consultants. Consequently, NCEPOD recommends that consultants who complete NCEPOD questionnaires keep a record of this activity which can be included as evidence of internal/self directed Continuous Professional Development in their appraisal portfolio.

If you would like email confirmation of the completion of this questionnaire and a certificate at the end of the study, please clearly supply your name, job title and email address below.

I agree to NCEPOD holding my details for the purposes of the study and until the end of the study

Name: _____ Job title: _____

Email address: _____

How to complete the form:

Information will be collected using two methods; box cross and free text, where your opinion will be requested.

This form will be electronically scanned. Please use a black or blue pen. Please complete all questions with block capitals/clear writing that others can easily read or a bold cross inside the boxes provided e.g.

Was the patient given adequate analgesia?

Yes No

If you make a mistake, please "black-out" the incorrect box and re-enter the correct information, e.g.

Yes No

Questions or help?

A list of definitions is provided on page 2 of the questionnaire.

If you have any queries about this study or this questionnaire, please contact:

abo@ncepod.org.uk or telephone 020 7251 9060

Thank you for taking the time to complete this questionnaire. The findings of the study will be published in late 2019.

NCEPOD number:



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DEFINITIONS

Acute Kidney Injury	Stage	Criteria		
	1	Creatinine rise of 26 micromol or more within 48 hours OR Creatinine rise of 50–99% from baseline within 7 days* (1.50–1.99 x baseline) OR Urine output** < 0.5 mL/kg/h for more than 6 hours		
	2	100–199% creatinine rise from baseline within 7 days* (2.00–2.99 x baseline) OR Urine output** < 0.5 mL/kg/hour for more than 12 hours		
	3	200% or more creatinine rise from baseline within 7 days* (3.00 or more x baseline) OR Creatinine rise to 354 micromol/L or more with acute rise of 26 micromol/L or more within 48 hours or 50% or more rise within 7 days OR Urine output** < 0.3 mL/kg/hour for 24 hours or anuria for 12 hours https://cks.nice.org.uk/acute-kidney-injury#!scenario		
Acute Kidney Injury	Stage	eGFR (ml/min/1.73 m²)	Description	Qualifier
	1	≥ 90	Kidney damage, normal or increased GFR	Kidney damage (presence of structural abnormalities and/or persistent haematuria, proteinuria or microalbuminuria) for ≥ 3 months
	2	60-89	Kidney damage, mildly reduced GFR	
	3A	45-59	Moderately reduced GFR ± other evidence of kidney damage	
	3B	30-44		
	4	15-29	Severely reduced GFR ± other evidence of kidney damage	
	5	<15	Kidney damage, mildly reduced GFR	
	https://www.nice.org.uk/guidance/cg169/chapter/Terms-used-in-this-guideline			
Rockwood clinical frailty score	1 VERY FIT - people who are robust, active, energetic, and motivated. These people commonly exercise regularly. They are among the fittest for their age.			
	2 WELL - people who have no active disease symptoms but are less than fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.			
	3 MANAGING WELL - people whose medical problems are well controlled, but are not regularly active beyond routine walking.			
	4 VULNERABLE - while not dependent on others for daily help, often symptoms limit activities. A common complaint it being 'slowed up', and/or being tired during the day.			
	5 MILDLY FRAIL - these people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.			
	6 MODERATELY FRAIL - people need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.			
	7 SEVERELY FRAIL - completely dependent for personal care from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within 6 months of life).			
	8 VERY SEVERELY FRAIL - completely dependent, approaching the end of life. Typically they could not recover even from a minor illness.			
	9 TERMINALLY ILL - approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.			
	http://camapcanada.ca/Frailtyscale.pdf			



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DEFINITIONS

Levels of care (adults)	Level 0/1	Normal ward care in an acute hospital
	Level 2	High Dependency Unit for 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 e.g. ICU
	Level 3	For patient requiring advanced respiratory support alone or monitoring and support for two or more organ systems. Includes all complex support for multi-organ failure e.g. Intensive Care Unit

CODES FOR SPECIALTY

SURGICAL SPECIALTIES

100 = General surgery	101 = Urology	103 = Breast surgery
110 = Trauma & orthopaedics	120 = Ear, nose and throat (ENT)	130 = Ophthalmology
140 = Oral surgery	145 = Oral and maxillo facial surgery	150 = Neurosurgery
160 = Plastic surgery	170 = Cardiothoracic Surgery	180 = Accident & Emergency
190 = Anaesthetics	192 = Critical care medicine	

MEDICAL SPECIALTIES

300 = General medicine	301 = Gastroenterology	302 = Endocrinology
303 = Clinical haematology	314 = Rehabilitation	315 = Palliative medicine
320 = Cardiology	321 = Acute internal medicine	330 = Dermatology
340 = Respiratory medicine	350 = Infectious diseases	360 = Genito-urinary medicine
361 = Nephrology	370 = Medical oncology	400 = Neurology
500 = Obstetrics & gynaecology	501 = Obstetrics	502 = Gynaecology
600 = General medical practice	700 = Learning disability	800 = Clinical oncology
823 = Haematology	900 = Community medicine	000 = Other

CODES FOR GRADE

01 – Consultant	02 – Staff grade/associate specialist
03 – Trainee with CCT	04 – Senior specialist trainee (ST3+ or equivalent)
05 – Junior specialist trainee (ST1&ST2 or CT equivalent)	06 – Basic grade (HO/FY1 or SHO/FY2 or equivalent)
07 - Specialist nurse (nurse consultant, nurse practitioner, clinical nurse specialist)	08 - Senior staff nurse, enrolled nurse (EN) etc)
09 - 1st Level nurse, staff nurse (RGN)	10 - Allied Health Professional (Physiotherapy/ Speech & language therapy/Occupational therapy)
11 - Non-registered staff (HCA etc.)	



STRUCTURED COMMENTARY

Please use the box below to provide a brief summary of this case, adding any additional comments or information you feel relevant. You should be assured that this information is confidential. Please write clearly for the benefit of case reviewers. You may also continue on the back of the form or on additional pages if need be.

NCEPOD attaches great importance to this summary. Please give as much information as possible about the care of this patient.



A. PATIENT DETAILS

1. Age at the time of admission: Years Unknown
2. Sex Male Female
3. Please indicate the location of the obstruction:
 Large bowel Small bowel Both large and small Unknown

B. ARRIVAL IN HOSPITAL

- 1a. What was the date of arrival in hospital? Unknown
d d m m y y y y
- 1a. What was the time of arrival in hospital? (24 hour clock) Unknown
h h m m
- 2a. What was the mode of arrival?
 Emergency Department GP direct to ward Unplanned admission
 Transferred from another hospital Unknown
 Other (please specify)
- 2b. If the patient was TRANSFERRED, what was the reason for the transfer? (Please tick all that apply)
 Stenting Critical care admission Unknown
 Other medical specialty input Other surgical specialty input
 Other (please specify)
- 3a. Did the patient have any communication difficulties? (Please tick all that apply)
 Yes - language Yes - hearing difficulties Yes - learning disability
 Yes - dementia None Unknown
 Other (please specify)
- 3b. Did the patient have the capacity to consent to treatment? Yes No Unknown
- 4a. Did the patient see the GP for this condition prior to admission? Yes No Unknown
- 4b. Did a GP refer the patient for THIS hospital admission? Yes No Unknown
 NA - did not see GP
- 4c. If YES to 4a, was there a delay in referral by the GP? Yes No Unknown
- 5a. Please indicate the number of previous ATTENDANCES to the Emergency Department (ED) with gastrointestinal symptoms in the 1 year period prior to admission (if none please put 0): Number Unknown





5b. Please indicate the number of previous HOSPITAL ADMISSIONS with gastrointestinal symptoms in the 1 year period prior to admission (if none please put 0): Number Unknown

6a. Had the patient undergone previous abdominal surgery related to this condition in the 1 year period prior to admission? Yes No Unknown

6b. If YES, the patient had undergone previous abdominal surgery, please give further details:

C. INITIAL ASSESSMENT

1. What was the presenting complaint on arrival?

2a. Where was the location of the initial assessment on arrival?

Emergency Department Medical assessment unit Surgical assessment unit

Medical ward Surgical ward Level 3 care

Level 2 care Unknown

Other (please specify)

2b. If MEDICAL WARD, please specify the specialty: Specialty Unknown

2c. If SURGICAL WARD, please specify the specialty: Specialty Unknown

3a. Please indicate the date of the first assessment on arrival: Unknown
d d m m y y y y

3b. Please indicate the time of the first assessment on arrival: (24 hour clock) Unknown
h h m m

3c. Please indicate the grade of the clinician responsible for undertaking the first assessment on arrival: Grade Unknown

3d. Please indicate the specialty of the clinician responsible for undertaking the first assessment on arrival: Specialty Unknown

4a. Please describe the clinical presentation of the patient at initial assessment : (Please tick all that apply)

Abdominal pain - colicky Abdominal pain - non-colicky Right Iliac fossa pain

Vomiting - bilious Vomiting - faeculent Weight loss

Constipation (i.e. overflow diarrhoea/absolute constipation) Abdominal distention

Abdominal tenderness Peritonism Unknown

Other (please specify)





4b. For each of the above (where present), please indicate the duration of the symptoms

Abdominal pain - colicky	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown	Abdominal pain - non-colicky	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown
Right Iliac fossa pain	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown	Vomiting - bilious	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown
Vomiting - faeculent	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown	Weight loss	<input type="text"/> <input type="text"/> days	<input type="checkbox"/> Unknown
Constipation (i.e. overflow diarrhoea/absolute constipation)				<input type="text"/> <input type="text"/> days	<input type="checkbox"/> Unknown
Abdominal tenderness	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown	Abdominal distention	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown
Peritonism	<input type="text"/> <input type="text"/> hours	<input type="checkbox"/> Unknown			

5. Which of the following were recorded at the time of the initial assessment? (Answers may be multiple)

<input type="checkbox"/> Pulse	<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Respiratory rate	<input type="checkbox"/> Temperature
<input type="checkbox"/> Oxygen saturation	<input type="checkbox"/> Weight	<input type="checkbox"/> Hydration status	<input type="checkbox"/> BMI
<input type="checkbox"/> Pain score	<input type="checkbox"/> GCS	<input type="checkbox"/> None	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other (please specify)	<input type="text"/>		

6a. Was there an escalation of care of the patient during the initial assessment and prior to admission?

<input type="checkbox"/> Yes – Following use of early warning score	<input type="checkbox"/> Yes – No use of early warning score
<input type="checkbox"/> No	<input type="checkbox"/> Unknown

6b. If YES, please give details:

7a. Which of the following investigations were undertaken as a result of the initial assessment? (Please tick all that apply)

<input type="checkbox"/> Abdominal x-ray	<input type="checkbox"/> CT scan	<input type="checkbox"/> Abdominal ultrasound	<input type="checkbox"/> MRI
<input type="checkbox"/> Gastrografin follow through (WSCS)	<input type="checkbox"/> Arterial blood gas	<input type="checkbox"/> Lactate	
<input type="checkbox"/> C-reactive protein	<input type="checkbox"/> Full blood count	<input type="checkbox"/> Urea & electrolytes	<input type="checkbox"/> None
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (please specify)	<input type="text"/>	

7b. Were you able to access all necessary investigations during the initial assessment? Yes No Unknown

7c. If NO, please specify which investigations could not be accessed: (Please tick all that apply)

<input type="checkbox"/> Abdominal x-ray	<input type="checkbox"/> CT scan	<input type="checkbox"/> Abdominal ultrasound	<input type="checkbox"/> MRI
<input type="checkbox"/> Gastrografin follow through (WSCS)	<input type="checkbox"/> Arterial blood gas	<input type="checkbox"/> Lactate	
<input type="checkbox"/> C-reactive protein	<input type="checkbox"/> Full blood count	<input type="checkbox"/> Urea & electrolytes	
<input type="checkbox"/> Other (please specify)	<input type="text"/>		





7c. If NO, please specify which investigations could not be accessed: (Please tick all that apply)

- Abdominal x-ray CT scan Abdominal ultrasound MRI
 Gastrografen follow through (WSCS) Arterial blood gas Lactate
 C-reactive protein Full blood count Urea & electrolytes
 Other (please specify)

8. Was there any evidence of Acute Kidney Injury (AKI) on arrival? ^{def} Yes No Unknown

9a. Was the patient commenced on a dedicated pathway for bowel obstruction? Yes No Unknown

NA - no dedicated pathway

9b. If YES, was this a dedicated pathway for:

- Small bowel obstruction Large bowel obstruction Unknown

D. ADMISSION TO WARD

1a. Please indicate the date of admission to the ward: Unknown
d d m m y y y y

1b. Please indicate the time of admission to the ward: (24 hour clock) Unknown
h h m m

2a. Where was the patient admitted to?

- Medical assessment unit Surgical assessment unit Medical ward
 Surgical ward Level 3 care Level 2 care Unknown
 Other (please specify)

2b. If MEDICAL WARD, please specify the specialty: Specialty Unknown

2c. If SURGICAL WARD, please specify the specialty: Specialty Unknown

3. Please indicate the specialty the patient was admitted under: Specialty Unknown

4. What was the diagnosis on admission? (Please specify)

1st review on admission

5a. What was the date of the first review following admission? Unknown
d d m m y y y y

5b. What was the time of the first review following admission? (24 hour clock) Unknown
h h m m

5c. What was the grade of the clinician responsible for undertaking the first review following admission? Grade Unknown





- 5d. What was the specialty of the clinician responsible for undertaking the first review following admission? Specialty Unknown
- 5e. Was the patient seen by a CT3+ level clinician within 4 hours of admission? Yes No Unknown

1st consultant review

- 6a. What was the date of the first CONSULTANT review following admission? Unknown
d d m m y y y y
- 6b. What was the time of the first CONSULTANT review following admission? (24 hour clock) Unknown
h h m m
- 6c. What was the specialty of the clinician responsible for undertaking the first CONSULTANT review following admission? Specialty Unknown

1st surgical review

7. Was the patient reviewed by a surgical team/surgeon following admission? Yes No Unknown

If NO, please go to question 10

- 8a. If YES, what was the date of the first SURGICAL review following admission? Unknown
d d m m y y y y
- 8b. If YES, what was the time of the first SURGICAL review following admission? (24 hour clock) Unknown
h h m m
- 8c. What was the grade of the clinician responsible for undertaking the first SURGICAL TEAM review following admission? Grade Unknown
- 8d. What was the specialty of the clinician responsible for undertaking the first SURGICAL TEAM review following admission? Specialty Unknown

1st surgical consultant review

- 9a. What was the date of the first SURGICAL CONSULTANT review following admission? Unknown
d d m m y y y y
- 9b. What was the time of the first SURGICAL CONSULTANT review following admission? (24 hour clock) Unknown
h h m m
- 9c. What was the sub-specialty of the clinician responsible for undertaking the first SURGICAL CONSULTANT review following admission? Specialty Unknown
- 10a. Were there any delays that were outside of your control during the admission process? Yes No Unknown

10b. If YES, please give details:

- 11a. Were there any concerns with communication/the handover of the patient during the admission process? Yes No Unknown

11b. If YES, please give details:



E. EARLY MANAGEMENT ON THE WARD

Within 24 hours of admission to the ward:

1a. Following admission, was the patient treated with: (Please tick all that apply)

- Oxygen IV Fluids Urinary catheterisation Antibiotics
 Nasogastric tube drainage None Unknown
 Other (please specify)

1b. Were there any factors out of your control which led to the inadequate optimisation of the patient during admission? Yes No Unknown

2a. Were the following recorded on admission? (Please tick all that apply)

- Lactate Blood pressure Urine output Fluid balance
 Antibiotic administration None Unknown
 Other (please specify)

2b. If any of the above were not recorded, should they have been? Yes No Unknown

2c. If YES, please specify:

3. If the patient had AKI, was this normalised within 24 hours of recognition? Yes No Unknown

4a. Was a Malnutrition Universal Screening Tool (MUST) or equivalent score recorded? Yes No Unknown

4b. If YES, by whom was this undertaken? (Please tick all that apply)

- Dietitian Nurse Nutrition team Other Unknown

5a. Following admission, was a nutritional assessment undertaken? Yes No Unknown

5b. If YES, by whom was this undertaken? (Please tick all that apply)

- Dietitian Nurse Nutrition team Doctor Unknown
 Other (please specify)

5c. If YES, following assessment what treatment was advised? (Please specify)

6. Was this patient identified as being frail on admission? Yes No Unknown

7a. What was the functional status of the patient prior to the onset of bowel obstruction? ^{def}

1. Very fit 2. Well 3. Managing well 4. Vulnerable
 5. Mildly frail 6. Moderately frail 7. Severely frail 8. Very severely frail
 9. Terminally ill Unknown





7b. What was the functional status of the patient at the time of admission? ^{def}

1. Very fit
 2. Well
 3. Managing well
 4. Vulnerable
 5. Mildly frail
 6. Moderately frail
 7. Severely frail
 8. Very severely frail
 9. Terminally ill
 Unknown

8. Was the patient's pain score measured on admission? Yes No Unknown

9a. Did the patient receive analgesia during this admission? Yes No Unknown

9b. If YES, how long after admission did the patient first receive analgesia? Hours Unknown

9c. Were there any issues in managing pain control in this patient during this admission? Yes No Unknown

9d. If YES, please give further details

10. Was the patient seen by an acute pain team prior to the delivery of their definitive treatment? Yes No Unknown

11a. Did the patient have an NG tube in situ?

- Yes – on arrival to hospital
 Yes – on admission to the ward
 Unknown
 Yes – following ward admission
 No – should have been in situ
 No – not necessary

11b. Did the patient have an urinary catheter in situ?

- Yes – on arrival to hospital
 Yes – on admission to the ward
 Unknown
 Yes – following ward admission
 No – should have been in situ
 No – not necessary

11c. Did the patient have an intravenous cannula in situ? Yes No Unknown

11d. If YES, what type? (Please tick all that apply)

- Peripheral cannula
 Peripherally inserted central catheter
 Central line
 Unknown

11e. If NO to 11c, should there have been? Yes No Unknown

F. IMAGING

1. Following admission, what diagnostic imaging did the patient have? (Please tick all that apply)

- Abdominal x-ray
 CT scan with IV contrast
 CT scan without IV contrast
 MRI scan
 Gastrografin follow through (WSCS)
 Unknown
 Other (please specify) None



Thinking about the imaging undertaken, please answer the following questions:

ABDOMINAL X-RAY

2. Where was the imaging organised?

- ED MAU SAU Medical ward Surgical ward
 Level 3 care Level 2 care Other (specify) Unknown

3a. Please indicate the date requested:

Unknown
d d m m y y y y

3b. Please indicate the time requested:

(24 hour clock) Unknown
h h m m

3c. Please indicate the date reported:

Unknown
d d m m y y y y

3d. Please indicate the time reported:

(24 hour clock) Unknown
h h m m

3e. Please indicate the grade of reporter:

Grade Unknown

4a. Did the results influence decision making?

Yes No Unknown

4b. Was the scan adequate to identify the cause of the bowel obstruction?

Yes No Unknown

5. Was there any delay in undertaking the abdominal x-ray? (Please tick all that apply)

- Yes - delay in referral Yes - delay in request Yes - delay in reporting
 Yes - decision making Yes - deferred to allow treatment of AKI
 Yes - access No delay Unknown

Other (please specify)

CT SCAN WITH IV CONTRAST

6. Where was the imaging organised?

- ED MAU SAU Medical ward Surgical ward
 Level 3 care Level 2 care Other (specify) Unknown

7a. Please indicate the date requested:

Unknown
d d m m y y y y

7b. Please indicate the time requested:

(24 hour clock) Unknown
h h m m

7c. Please indicate the date reported:

Unknown
d d m m y y y y

7d. Please indicate the time reported:

(24 hour clock) Unknown
h h m m





- 7e. Please indicate the grade of reporter: Grade Unknown
- 8a. Did the results influence decision making? Yes No Unknown
- 8b. Was the scan was adequate to identify the cause of the bowel obstruction? Yes No Unknown
9. Was there any delay in undertaking the CT scan with IV contrast? (Please tick all that apply)
- Yes - delay in referral Yes - delay in request Yes - delay in reporting
- Yes - decision making Yes - deferred to allow treatment of AKI
- Yes - access to CT scanning No delay Unknown
- Other (please specify)

CT SCAN WITHOUT IV CONTRAST

10. Where was the imaging organised?
- ED MAU SAU Medical ward Surgical ward
- Level 3 care Level 2 care Other (specify) Unknown
- 11a. Please indicate the date requested: Unknown
d d m m y y y y
- 11b. Please indicate the time requested: (24 hour clock) Unknown
h h m m
- 11c. Please indicate the date reported: Unknown
d d m m y y y y
- 11d. Please indicate the time reported: (24 hour clock) Unknown
h h m m
- 11e. Please indicate the grade of reporter: Grade Unknown
- 12a. Did the results influence decision making? Yes No Unknown
- 12b. Was the scan was adequate to identify the cause of the bowel obstruction? Yes No Unknown
13. Was there any delay in undertaking the CT scan without IV contrast? (Please tick all that apply)
- Yes - delay in referral Yes - delay in request Yes - delay in reporting
- Yes - decision making Yes - deferred to allow treatment of AKI
- Yes - access to CT scanning No delay Unknown
- Other (please specify)

14. Why was the scan undertaken without contrast?





MRI SCAN

15. Where was the imaging organised?

- ED MAU SAU Medical ward Surgical ward
- Level 3 care Level 2 care Other (specify) Unknown

16a. Please indicate the date requested:

Unknown

d d m m y y y y

16b. Please indicate the time requested:

(24 hour clock) Unknown

h h m m

16c. Please indicate the date reported:

Unknown

d d m m y y y y

16d. Please indicate the time reported:

(24 hour clock) Unknown

h h m m

16e. Please indicate the grade of reporter:

Grade Unknown

17a. Did the results influence decision making?

Yes No Unknown

17b. Was the scan was adequate to identify the cause of the bowel obstruction?

Yes No Unknown

18. Was there any delay in undertaking the MRI scan? (Please tick all that apply)

- Yes - delay in referral Yes - delay in request Yes - delay in reporting
- Yes - decision making Yes - deferred to allow treatment of AKI
- Yes - access to MRI No delay Unknown
- Other (please specify)

GASTROGRAFIN FOLLOW THROUGH (WSCS)

19. Where was the imaging organised?

- ED MAU SAU Medical ward Surgical ward
- Level 3 care Level 2 care Other (specify) Unknown

20a. Please indicate the date requested:

Unknown

d d m m y y y y

20b. Please indicate the time requested:

(24 hour clock) Unknown

h h m m

20c. Please indicate the date reported:

Unknown

d d m m y y y y

20d. Please indicate the time reported:

(24 hour clock) Unknown

h h m m

20e. Please indicate the grade of reporter:

Grade Unknown





21a. Did the results influence decision making? Yes No Unknown

21b. Was the scan was adequate to identify the cause of the bowel obstruction? Yes No Unknown

22. Was there any delay in undertaking the gastrografin follow through (WSCS)? (Please tick all that apply)

Yes - delay in referral Yes - delay in request Yes - delay in reporting

Yes - decision making Yes - deferred to allow treatment of AKI

Yes - access No delay Unknown

Other (please specify)

23a. Was all appropriate imaging undertaken? Yes No Unknown

23b. If NO, what should have been undertaken? (Please tick all that apply)

Abdominal x-ray CT scan with IV contrast CT scan without IV contrast

MRI scan Gastrografin follow through (WSCS) Unknown

Other (please specify)

24a. Was any unnecessary imaging undertaken? Yes No Unknown

24b. If YES, what should not have been undertaken? (Please tick all that apply)

Abdominal x-ray CT scan with IV contrast CT scan without IV contrast

MRI scan Gastrografin follow through (WSCS)

Other (please specify)

G. DIAGNOSIS

1a. What was the date of diagnosis? Unknown
d d m m y y y y

1b. What was the time of diagnosis? (24 hour clock) Unknown
h h m m

1c. What was the grade of the clinician who made the diagnosis of acute bowel obstruction? Grade Unknown

1d. What was the speciality of the clinician who made the diagnosis of acute bowel obstruction? Specialty Unknown

2a. Where was the patient cared for when the diagnosis of acute bowel obstruction was made?

Emergency Department Medical assessment unit Surgical assessment unit

Medical ward Surgical ward Level 3 care

Level 2 care Unknown

Other (please specify)

2b. If MEDICAL WARD, please specify the specialty: Specialty Unknown



- 2c. If SURGICAL WARD, please specify the specialty: Specialty Unknown
- 3a. Was there a delay in diagnosis that was outside of your control? Yes No Unknown
- 3b. If YES, how long was the delay? Hours Unknown
- 3c. If YES to 3a, could this have been avoided? Yes No Unknown
- 3d. If YES to 3a, did this affect the outcome? Yes No Unknown

H. TREATMENT PLAN

- 1a. Was a treatment plan recorded in the notes? Yes No Unknown
- 1b. If YES, did this include: (Please tick all that apply)
- Correction of organ failure Imaging Initial management strategy
- Time bound plan for intervention Nutrition plan Frailty/comorbidity plan
- Other (please specify) Unknown
- 1c. If NO to 1a, should there have been? Yes No Unknown
2. Was there Care of the Elderly input pre-operatively/pre-treatment? Yes No Unknown
- Not applicable
3. Prior to treatment, how many different consultant surgeons reviewed the patient? Number Unknown
4. Was there adequate consultant input?
- Yes No - too little No - too much Unknown
- 5a. Was there a delay in making the decision about the best treatment for the patient? Yes No Unknown
- 5b. If YES, how long was the delay? Hours Unknown
- 5c. If YES, did this impact on outcome? Yes No Unknown
- 5d. What was the impact of the delay? (Please tick all that apply)
- Sepsis Bowel perforation Bowel ischaemia
- Acute kidney injury Increased risk of malnutrition No impact
- Peritonitis Pain Unknown
- Other organ failure (please specify)
- Other (please specify)





- 6a.** Was a risk assessment undertaken to aid decision making? Yes No Unknown
- 6b.** If YES, which tool was used? (Please tick all that apply)
- POSSUM score (or equivalent) ASA classification system ACS risk calculator
- NELA risk calculator Surgical outcome risk tool (SORT) Unknown
- Clinical judgement Other (please specify)
- 6c.** If YES, did this influence management? Yes No Unknown
- 7a.** Was an anaesthetic opinion sought to aid decision making about the appropriateness of surgery? Yes No Unknown
- 7b.** If YES, did this influence management? Yes No Unknown
- 7c.** If YES, please specify how:
- Decision to palliate Not fit for surgery Optimisation
- Changed priority for surgery Unknown
- Other (please specify)
- 7d.** If NO to 67a, should anaesthetic opinion have been sought? Yes No Unknown
- 8a.** Was a critical care opinion sought to aid decision making? Yes No Unknown
- 8b.** If YES, did this influence management? Yes No Unknown
- 8c.** If YES, please specify how:
- Decision to palliate Not fit for surgery Optimisation Unknown
- Changed priority for surgery Admitted to critical care pre-operatively
- Decision made patient was for post op critical care admission Ceiling in place for treatment
- Not appropriate for critical care Other (please specify)
- 8d.** If NO to 8a, was there any barrier to seeking a critical care opinion? Yes No Unknown
- 8e.** If YES, please give details:
- 9a.** Were the treatment plan options discussed with the patient? Yes No Unknown
- Not applicable
- 9b.** Were the treatment plan options discussed with the family? Yes No Unknown





10a. Was there any room for improvement in shared decision making? Yes No Unknown

10b. If YES, please give details:

I. NON-SURGICAL THERAPY FOR ALL PATIENTS

1a. For how long was the patient starved pre hospital? Days Unknown

1b. Did the patient undergo an operation? Yes No Unknown

1c. If NO to 1b, how long was the patient starved in hospital? Days Unknown

1d. If YES to 1b, for how long was the patient starved pre-surgery? Days Unknown

1d. If YES to 1b, for how long was the patient starved post surgery? Days Unknown

2a. How long was it until normal* nutrition was re-introduced (*normal amount to meet requirements)? Days Unknown

2b. Were there any barriers to reinstating normal nutrition? Yes No Unknown

2c. If YES, please give details:

3a. During treatment, did the patient have any of the following supplementary feeding methods? (Please tick all that apply)

- Nasogastric feeding tube Peripheral parenteral nutrition via cannula None
 Total parenteral nutrition via peripherally inserted central catheter line Unknown
 Total parenteral nutrition via central line

3b. If NONE, should they have done? Yes No Unknown

3c. If YES to 3b, please give further details:

3d. If YES to any of 3a, was there any delay in insertion Yes No Unknown

3e. If YES to 3d, please give further details:

4. Was pain assessment ongoing throughout the admission? Yes No Unknown



J. SMALL BOWEL OBSTRUCTION

1. Did the patient have a small bowel obstruction? Yes No Unknown
2. Was the cause of the bowel obstruction:
 Adhesional Non-adhesional Unknown
 Other (please specify)
- 3a. Was Gastrografin given? Yes No Unknown Not applicable
- 3b. If YES, was this given: (Please tick all that apply)
 Diagnostically Therapeutically Unknown
- 3c. If YES, please specify the date given: Unknown
d d m m y y y y
- 3d. If YES, please specify the time given: (24 hour clock) Unknown
h h m m
- 3e. Was imaging subsequently undertaken? Yes No Unknown
- 3f. If YES, please specify the date of imaging: Unknown
d d m m y y y y
- 3g. If YES, please specify the time of imaging: (24 hour clock) Unknown
h h m m
- 3h. Were there any delays in gastrografin being given? Yes No Unknown
4. If YES, please specify:

K. LARGE BOWEL OBSTRUCTION

1. Did the patient have a large bowel obstruction? Yes No Unknown
2. What was the cause of the bowel obstruction?
 Cancer Volvulus Benign stricture Unknown
 Other (please specify)

Stenting

- 3a. Was stenting considered?
 Yes No - should have been No - should not have been
 NA - Volvulus (go to volvulus, Q6) Unknown
- 3b. If YES, did the patient subsequently have a stent inserted? Yes No Unknown
- If NO, go to Q6





If YES:

3c. If YES, please specify date of the stent insertion: Unknown
d d m m y y y y

3d. If YES, please specify time of the stent insertion: (24 hour clock) Unknown
h h m m

3e. Please specify the grade of the clinician responsible for undertaking the procedure? Grade Unknown

3f. Please specify the specialty of the clinician responsible for undertaking the procedure? Specialty Unknown

3g. Where was this undertaken?
 X-ray department Endoscopy department Another hospital
 Other (please specify) Unknown

4. Were the options (i.e. stent vs. operation) discussed with the patient and the family prior to surgery?
 Yes – patient Yes – family Yes – both patient & family
 No Unknown Not applicable

5a. Was the stent insertion successful? Yes No Unknown

5b. If NOT, why not? (Please tick all that apply)
 Failed stent Stent migration Stoma
 Stent perforation leading to surgery Unknown
 Other (please specify)

Volvulus
(if there was no record of volvulus please go to L.SURGERY)

6a. Is there a record of endoscopic intervention during the admission? Yes No Unknown

If YES

6b. If YES, please specify date of the last endoscopy: Unknown
d d m m y y y y

6c. If YES, please specify the time of the last endoscopy: (24 hour clock) Unknown
h h m m

7. What type of endoscopy was undertaken?
 Rigid sigmoidoscopy Rigid sigmoidoscopy and flatus tube
 Flexible sigmoidoscopy Colonoscopy Unknown
 Other (please specify)





8a. Were there any barriers to undertaking a timely endoscopy? Yes No Unknown

8b. If YES, please give further details:

9. Was a percutaneous endoscopic colostomy inserted? Yes No Unknown

L. SURGERY

1. Was an operation undertaken? Yes No Unknown

If NO, go to M. ESCALATION OF CARE

If YES

2a. Was a consent form completed? Yes No Unknown

2b. What was the grade of the clinician taking consent? Grade Unknown

2c. What was the specialty of the clinician taking consent? Specialty Unknown

3a. Were the benefits and risks of the procedure stated on the consent form? Yes No Unknown

3b. If YES, did this include risk of death? Yes No Unknown

4. What operation was undertaken? (free text)

5a. Please state the date of the decision to operate: Unknown
d d m m y y y y

5b. Please state the time of the decision to operate: (24 hour clock) Unknown
h h m m

5c. What was the grade of the clinician who made the decision to operate? Grade Unknown

5d. What was the specialty of the clinician who made the decision to operate? Specialty Unknown

6a. Please state the date the operation was undertaken: Unknown
d d m m y y y y

6b. Please state the time the operation was undertaken: (24 hour clock) Unknown
h h m m

7. Was there a delay between the decision to operate and the operation? Yes No Unknown





8. Please specify the category of urgency:

- IMMEDIATE: Immediate life or limb saving surgery. Resuscitation simultaneous with surgical treatment.
- URGENT: Acute onset or deterioration of conditions that threaten life, limb or organ survival; fixation of fractures; relief of distressing symptoms including acute surgical admissions not requiring an operation.
- EXPEDITED: Stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival.
- ELECTIVE: Surgical procedure planned or booked in advance of routine admission to hospital.

9a. Were there any delays in undertaking the surgery? Yes No Unknown

9b. If YES, how long was the delay? Hours Unknown

9c. If YES, what was the reason for the delay? (Please tick all that apply)

- Non-availability of surgeon Non availability of anaesthetist
- Non availability of critical care Non availability of theatre
- Non availability of theatre staff Unknown
- Patient requiring additional pre-operative treatment/optimisation/resuscitation
- Other (please specify)

9d. What was the impact of the delay? (Please tick all that apply)

- Sepsis Bowel perforation Bowel ischaemia
- Acute kidney injury Increased risk of malnutrition No impact
- Peritonitis Pain Unknown
- Other organ failure(please specify)
- Other (please specify)
- No impact Unknown

10a. What was the grade of the clinician who undertook the operation? Grade Unknown

10b. What was the specialty of the clinician who undertook the operation Specialty Unknown

10c. If not performing the operation, was consultant surgeon supervising? Yes No Unknown
 Not applicable

10d. Where was this supervision based?
 At home In hospital Unknown

Other (please specify)

11. What was the grade of the anaesthetist? Grade Unknown





12a. In hindsight, was the most appropriate operation undertaken? Yes No Unknown

12b. If NO, please give further details:

13a. Did the surgical findings correlate with the pre-operative imaging? Yes No Unknown

NA - No pre-operative imaging

13b. If NO, what were the differences? (Please specify)

14a. Where was the patient admitted immediately post operatively?

- Level 3 care Level 2 care Post-operative enhanced recovery
 Medical ward Surgical ward Died in theatre Unknown
 Other (please specify)

14b. If MEDICAL WARD, please specify the specialty: Specialty Unknown

14c. If SURGICAL WARD, please specify the specialty: Specialty Unknown

14d. Was the post-operative location appropriate? Yes No Unknown

M. ESCALATION OF CARE AND CRITICAL CARE

1a. Was an escalation of care required during the admission?
 Yes – Level 3 Yes – Level 2 Yes - Other No Unknown

1b. If an escalation of care was required, was this achieved? Yes No Unknown

If not admitted to level 3, please go to question 6a

If YES, the patient was admitted to level 3:

2. Was this admission: Planned Unplanned Unknown

3a. Was the patient ventilated? Yes No Unknown

3b. If YES, was this: Invasive Non-invasive Unknown

4. What was the duration of the critical care admission? Days Unknown

5a. Following discharge from critical care, was the patient readmitted to critical care during this admission? Yes No Unknown

5b. If YES, could this have been avoided? Yes No Unknown





5c. If YES, please give details :

6a. If the patient was NOT ADMITTED to critical care, was this appropriate?

Yes No Unknown

6b. If NO, why not?

N. COORDINATION OF CARE DURING THE WHOLE ADMISSION

1a. Were there any delays in the care of this patient that were outside your control?

Yes No Unknown

1b. What was the cause of the delay? (Please tick all that apply)

- Multiple handovers of care
 Infrequent consultant review
 Lack of clinical review
 Too many clinical reviews
 Review by inexperienced medical staff
 Unknown
 Other (please specify)

1c. What was impact of the delay? (Please tick all that apply)

- Sepsis
 Bowel perforation
 Bowel ischaemia
 Acute kidney injury
 Increased risk of malnutrition
 No impact
 Peritonitis
 Pain
 Unknown
 Other organ failure(please specify)
 Other (please specify)

1d. Could any of these delays have been avoided?

Yes No Unknown

1e. If YES, please give details :

2a. Were there adequate handover arrangements of this patient's care?

Yes No Unknown

2b. If NO, how could this have been improved? (Please specify)





3. Did formal consultant to consultant transfers occur for each transfer of care? Yes No Unknown
 Not applicable
4. Was post-operative/post treatment pain well managed? Yes No Unknown
5. Was an acute pain team involved in the care of the patient post-operatively/post treatment? Yes No Unknown
- 6a. Was there Care Of the Elderly input post operatively/post-treatment? Yes No Unknown
 Not applicable
- 6b. If NO, should there have been? Yes No Unknown
- 7a. Were SOCIAL CARE involved in the care of this patient during this admission? Yes No Unknown
- 7b. If NO, should they have been? Yes No Unknown
- 7c. Were PHYSIOTHERAPY involved in the care of this patient during this admission? Yes No Unknown
- 7d. If NO, should they have been? Yes No Unknown
- 7e. Were OCCUPATIONAL THERAPY involved in the care of this patient during this admission? Yes No Unknown
- 7f. If NO, should they have been? Yes No Unknown
- 7g. Were DIETETICS involved in the care of this patient during this admission? Yes No Unknown
- 7h. If NO, should they have been? Yes No Unknown
- 7i. Was a NUTRITION TEAM involved in the care of this patient during this admission? Yes No Unknown
- 7j. If NO, should they have been? Yes No Unknown
- 7k. Were ANY OTHER RELEVANT TEAMS involved in the care of this patient during this admission? Yes No Unknown
- 7l. If NO, should they have been? Yes No Unknown

Complications

- 8a. Did the patient suffer any MEDICAL complications? Yes No Unknown
- 8b. If YES, which medical complications? (Please tick all that apply)
- | | |
|--|--|
| <input type="checkbox"/> Acute kidney injury | <input type="checkbox"/> Hospital acquired infection requiring antibiotics |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Intestinal perforation |
| <input type="checkbox"/> Chest infection | <input type="checkbox"/> Malnutrition/weight loss |
| <input type="checkbox"/> Other (please specify) | <input type="checkbox"/> Vascular thrombotic events |
| | <input type="checkbox"/> Death <input type="checkbox"/> Unknown |
-





8c. Were the medical complications managed appropriately? Yes No Unknown

8d. If NO, please expand on your answer:

8e. Were any of the medical complications avoidable? Yes No Unknown

8f. If YES, please expand on your answer:

8g. Did any of the medical complications occur as a result of a delay? Yes No Unknown

8h. If YES, please expand on your answer:

8i. Did any of the medical complications result in a return to theatre? Yes No Unknown

8j. If YES, please expand on your answer:

9a. Did the patient suffer any SURGICAL complications? Yes No Unknown

9b. If YES, which surgical complications? (Please tick all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Haemorrhage | <input type="checkbox"/> Anastomotic leak | <input type="checkbox"/> Surgical site infection |
| <input type="checkbox"/> Abdominal wall dehiscence | <input type="checkbox"/> Stoma-related complications | <input type="checkbox"/> Mesenteric ischaemia |
| <input type="checkbox"/> Enterotomy requiring re-operation | <input type="checkbox"/> Death | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (please specify) | <input type="text"/> | |

9c. Were the surgical complications managed appropriately? Yes No Unknown

9d. If NO, please expand on your answer:

9e. Were any of the surgical complications avoidable? Yes No Unknown

9f. If YES, please expand on your answer:





9g. Did any of the surgical complications occur as a result of a delay? Yes No Unknown

9h. If YES, please expand on your answer:

9i. Did any of the surgical complications result in a return to theatre? Yes No Unknown

9j. If YES, please expand on your answer:

O. DISCHARGE/FOLLOW-UP

1. What was the outcome of this admission?

Patient discharged Patient died Unknown

2a. Please indicate the date of discharge/death:

Unknown
 [][] [][] [][][][]
 d d m m y y y y

2b. Please indicate the time of discharge/death:

Unknown
 [][] [][] (24 hour clock)
 h h m m

If the patient was DISCHARGED:

3. What was the discharge destination of the patient?

Home Other hospital Hospice Nursing home Unknown
 Other (please specify) []

4. What was the functional status of the patient at the time of discharge? ^{def}

1. Very fit 2. Well 3. Managing well 4. Vulnerable
 5. Mildly frail 6. Moderately frail 7. Severely frail 8. Very severely frail
 9. Terminally ill Unknown

5a. Was a frailty assessment undertaken at discharge? Yes No Unknown

5b. If YES, was there a change in score between admission and discharge? Yes No Unknown

5c. If YES to 5b, please specify:

Patient less frail Same level of frailty Patient more frail Unknown

6a. Were there any barriers to effective discharge planning? Yes No Unknown

6b. At discharge, was the patient given advice on nutrition? Yes No Unknown

6c. At discharge, was the patient given advice on new medications? Yes No Unknown
 Not applicable





7a. Was the patient readmitted to this Trust/Health Board within 30 days? Yes No Unknown

7b. If YES, was this related to the original admission under review? Yes No Unknown

7c. If YES to 7a, what was reason for readmission? (Please tick all that apply)

Recurrent small bowel obstruction Recurrent volvulus Missed diagnosis

Post-operative complication Unknown

Other (please specify)

7d. If POST-OPERATIVE COMPLICATION, please give details:

8a. Was the outcome of this patient discussed at a multidisciplinary review/audit/mortality meeting? Yes No Unknown

8b. If YES, were remediable factors in the care of this patient identified? Yes No Unknown

8c. If YES to 8b, what action was taken?

If the patient DIED prior to discharge:

9a. Was the death expected? Yes No Unknown

9b. Did the patient die from: (Please tick all that apply)

The underlying disease Non-operation/not operated on

A delay in operative intervention Complications Unknown

Other (please specify)

P. END OF LIFE CARE

1a. Was the patient put on a End Of Life care pathway?

Yes – appropriately Yes – inappropriately No – appropriately

No - inappropriately Unknown

1b. Was there any advanced care planning discussed within the last year? Yes No Unknown

If the patient was placed on a EOL care pathway:

2a. Was a palliative care team involved? Yes No Unknown





2b. Please indicate which clinicians were members of this team? (Please tick all that apply)

- Palliative care physician
 GP
 Specialist nurse
 Unknown
 Other (please specify)

3. Why was the patient put on to this pathway? (Please tick all that apply)

- Malignancy
 Moribund state
 Sudden post-operative deterioration
 Other (please specify)
 Unknown

4a. Please indicate the date of the decision to put the patient on a palliative care pathway:

Unknown
 d d m m y y y y

4b. Please indicate the date of the first assessment by palliative care team:

Unknown
 d d m m y y y y

For patients who were discharged alive from the hospital admission and who subsequently died

4c. Please indicate the date of death:

Unknown
 d d m m y y y y

5. Where was end of life care delivered? (Please tick all that apply)

- Hospital
 Home
 Hospice
 Care home
 Unknown
 Other (please specify)

Thank you for taking the time to complete this questionnaire



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