

Appendix: Data Dictionary

| Pre-operative Data Fields | Required data (definition / comment) | Suggested source(s) |
|---|---|---|
| 1. Patient age | Years (whole years at the time of operation) | – Clinical notes |
| 2. Patient gender | Male / Female | |
| 3. Cultural identity | European/Aboriginal/Torres Straights Islander/Maori/Pacific Peoples/Asian/Middle Eastern/Latin American/African/Other | – Clinical notes |
| 4. Patient height | Meters (record to two decimal places) | – Drug charts |
| 5. Patient weight | Kilograms (record to one decimal places) | – Clinical notes |
| 6. Patient ASA grade | Grade I-V (Full ASA classification available at: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system). | – Anaesthetic notes |
| 7. History of cardiac disease | Yes (myocardial infarction, angina, congestive cardiac failure within 30d prior to surgery, hypertension on Rx) / No | – Admission clerking – Anaesthetic notes – Outpatient letters |
| 8. Clinical Frailty Score | 1 – 9 | |
| 9. History of chronic respiratory disease | Yes (asthma, chronic obstructive pulmonary disease or pneumonia, bronchiectasis, pulmonary fibrosis, lung cancer, obstructive sleep apnoea, other) / No | |
| 10. History of Diabetes | Diabetes (diet controlled, tablet controlled, insulin controlled) | |
| 11. History of neurological disease / stroke | Yes / No | |
| 12. History of liver disease | Yes / No | |
| 13. Smoking status | Current (includes those who stopped smoking within 6 weeks), Ex-smoker, Never. | |
| 14. Anticoagulant/Antiplatelet | Yes / No | |
| 15. Pre-operative blood test values | Haemoglobin (grams / litre) / Creatinine / estimated Glomerular Filtration Rate (ml / min) / Ferritin (if done) | – Pathology systems |
| 16. Pre-operative anaemia management | Oral or intravenous iron clinic Yes / No Number of days prior to operation patient received treatment | – |
| Abbreviations: ASA = American Society of Anaesthesiologists; Hb = Haemoglobin; PACS = Picture Archiving and Communication. | | |

| Intra-operative Data Fields | Required data (definition / comment) | Suggested source(s) |
|---|--|---|
| 1. Operative urgency (NCEPOD Classification of Intervention) | <p>Immediate (Immediate life, limb or organ-saving intervention – resuscitation simultaneous with intervention. Normally within <u>minutes of decision</u> to operate).</p> <p>Urgent (Intervention for acute onset or clinical deterioration of potentially life-threatening conditions, for those conditions that may threaten the survival of limb or organ, for fixation of many fractures and for relief of pain or other distressing symptoms. Normally within <u>hours of decision</u> to operate)</p> <p>Expedited (requiring early treatment where the condition is not an immediate threat to life, limb or organ survival. Normally within <u>days of decision</u> to operate).</p> <p>Elective (Intervention planned in advance of routine admission to hospital).</p> | <ul style="list-style-type: none"> – Operative note – Admissions clerking – Clinical notes |
| 2. Operative procedure | <p>Select main procedure (closest option from the drop-down list or enter as free text by selecting “other”).</p> <ul style="list-style-type: none"> (1) Upper gastrointestinal tract surgery (2) Colorectal surgery (3) Hepato-pancreato-biliary (HPB) surgery (4) Vascular surgery (5) Urology (6) Gynaecology | |
| 3. Operative contamination | <p>Clean (Gastrointestinal (GI) and genitourinary (GU) tract not entered).</p> <p>Clean-Contaminated (GI or GU tracts entered but no gross contamination).</p> <p>Contaminated (GI or GU tracts entered with gross spillage or major break in sterile technique).</p> <p>Dirty (There is already contamination prior to operation, e.g. faeces or bile).</p> | <ul style="list-style-type: none"> – Operative note – Clinical notes – Theatre records |
| 4. Tranexamic acid use | Yes / No | |
| 5. Intraoperative blood transfusion | 0 / 1 / 2 / 3 / 4 / >4 | |
| 6. Hb at transfusion | Yes / No | |
| 7. Duration of procedure | <p>Minutes</p> <ul style="list-style-type: none"> – Total duration including anaesthetic time – Duration from skin incision to completion of skin closure | |
| | | |
| | | |
| Abbreviations: NCEPOD: National Confidential Enquiry into Patient Outcome and Death. WHO = World Health Organisation | | |

| Post-operative Data Fields | Required data (definition / comment) | Suggested sources |
|---|--|---------------------|
| 1. Critical care admission | Date of admission | – Clinical notes |
| 2. Critical care bed days (if yes) | Date of discharge | |
| 3. Highest inpatient complications | None / Clavien-Dindo Grade I-V (see appendix for the Clavien-Dindo scale). | |
| 4. Reoperation | Yes/No Date List operation performed & date | |
| 5. Post-operative length of stay (hospital) | Date of Discharge | |
| 6. Iron Therapy in post-operative period | Iron Oral / IV / none | – Discharge letter |
| 7. Blood Transfusion in post-operative period | None/Units 1/2/3/4/>4 Hb immediately prior to transfusion Subsequent transfusions in remainder of post op period Y/N | – Pathology systems |
| 8. Discharge Destination | Home / rehabilitation / nursing or supported care | – Discharge letter |
| 9. Haemoglobin level | Admission to HDU / ICU / extended recovery | – Pathology systems |
| | Discharge from HDU / ICU / extended recovery | |
| | Lowest Hb in first 3 days postoperatively | |
| | Last recorded before discharge from hospital | |

| 30-day Data Fields | Required data (definition / comment) | Suggested sources |
|--------------------------------------|---|---|
| 1. RE – admission | Yes / No If yes complete readmission form | <ul style="list-style-type: none"> - Telephone follow-up - Follow up clinic - Clinical notes |
| 2. Hb level | 4-6 weeks | |
| 3. Location | Home/rehabilitation/nursing or supported care | |
| 4. 30-day Infection | Was there post-operative infection Yes/ No Respiratory / urinary / wound / other | |
| 5. Highest 30-day complication grade | None / Clavien-Dindo Grade I-V (see appendix for the Clavien-Dindo scale). | |
| 6. Clinical Frailty score | 1-9 | - Clinical Notes |

| Readmission Data Fields | Required data (definition / comment) | Suggested sources |
|--------------------------------------|--|--|
| 1. Reason for Readmission | Planned Y reason free text Unplanned Y see appendix Scored as per CD scale | - Clinical notes |
| 2. Haemoglobin level | On admission | - Pathology systems |
| | Lowest Hb day 1-3 | |
| | Last recorded before discharge from hospital | |
| 3. Blood transfusion | 0 / 1 / 2 / 3 / 4 | |
| 4. Readmission to HDU / ICU | Date of admission | |
| 5. Discharge from HDU / ICU (if yes) | Date of discharge | |
| 6. Reoperation | Yes / No date List operation performed & date repeat intraoperative and post-operative data | - Discharge letter - Clinical notes |
| 7. Length of stay (hospital) | Number (days from the <u>first re-admission day</u> to <u>day of discharge</u> . If the patient has not been discharged prior to the end of 30-day re-admission, enter '31'). | |
| 8. Discharge Destination | Home / rehabilitation / nursing or supported care | |