

Crohn's Disease

Admission / Mortality

You will need to complete the first page 'Admission/mortality' prior to commencing subsequent pages of the audit

Patient demographics/diagnosis

- 1.0. Is this case being re-entered for reliability testing purposes (i.e. second entry of same case)?
 Yes No
- a. Case id of the original case (generated by web tool)
- 1.1. Given name
- 1.2. Surname
- 1.3. What is the patients' date of birth? DD/MM/YYYY
- a. Admission age (calculated)
- 1.4. What is the patient's UR (hospital record) number?
- 1.5. Gender Male Female Other

Admission

- 1.6. What was the date of admission? DD/MM/YYYY
- 1.7. What was the primary reason for admission?
- New diagnosis of Crohn's disease
 - Emergency admission for active Crohn's disease
 - Planned admission for Crohn's disease (known case)
 - Elective admission for surgery
 - Transfer from another site - for IBD care
 - Not IBD-Related
 - Other
- a. If 'Other' please specify
- 1.8. What was the source of admission? (select all that apply)
- ED admission
 - Referred by GP
 - Advised to attend via IBD nurse helpline
 - Referred in from Hospital OPD
 - Referred in from GE specialist rooms
 - Referred in from surgical specialist rooms

- Transfer from another site
- Other

a. If 'Other' please specify

1.9. Has the patient had previous overnight admissions with CD in the two years prior to this admission at this hospital? Yes No

a. If yes, how many times in the two years prior to this admission?

b. Has there been a CD-related admission within the last 30 days? Yes No

c. Has this patient already been included in this audit (other than for reliability testing)?
 Yes No

i. If yes, what is the patient audit number for the last audited admission? (generated by the web tool)

Discharge/Mortality

1.10. The patient was:

- Discharged home
- Discharged at own risk
- Discharged to nursing home or rehabilitation centre
- Transferred to another centre for surgery
- Transferred to another centre for medical management
- Deceased

a. What was the date of discharge? DD/MM/YYYY

b. What was the date of death? DD/MM/YYYY

c. Was the death CD-related? Yes No Not applicable (N/A)

d. Please enter further details of death with specific reference to post-operative complications, infections, adverse events related to medications, thromboembolic disease, malignancy and other causes:

Extent and Severity of CD

Initial assessment during the first full day following admission

- 2.1. Was duration of disease stated in admission notes? Yes No
- 2.2. What was the month/year of diagnosis? MM/YYYY Month not known
- 2.3. Was the extent of Crohn's disease at the most recent assessment recorded in the admission notes? (Select all that apply) Yes No
- Terminal ileum (L1)
 - Colonic (L2)
 - Ileo-colonic (L3)
 - Perianal
 - Upper GI (L4)
 - Unknown
- 2.4. Were the following items documented in the clinical record?
- a. Number of liquid stools per day Yes No N/A Patient had stoma
 - b. The presence of blood in the stools Yes No N/A
 - c. General wellbeing Yes No N/A
 - d. Perineal examination Yes No N/A
- 2.5. Did the notes record the current presence of any of the following?
- a. Fevers Yes No Not documented
 - b. Active perineal disease Yes No Not documented
 - c. Abdominal mass Yes No Not documented
 - d. Abdominal pain Yes No Not documented
 - e. Mouth ulcers Yes No Not documented
 - f. Oro-facial granulomatosis Yes No Not documented (Paediatric Only)
 - g. Arthralgia Yes No Not documented
 - h. Arthritis Yes No Not documented
 - i. Ankylosing spondylitis Yes No Not documented
 - j. Erythema nodosum Yes No Not documented
 - k. Pyoderma gangrenosum Yes No Not documented

- l. Iritis Yes No Not documented
- m. Anal fissure Yes No Not documented
- n. Fistula Yes No Not documented
- o. Abscess Yes No Not documented
- p. Malnutrition Yes No Not documented

2.6. Was a paediatric Crohn's disease activity index (PCDAI) score recorded? (paediatric Only)

Comorbidity

2.7. Were any significant comorbid diseases/conditions documented? (select all that apply)

- Yes None recorded Statement that patient had no relevant comorbidities

a. Which comorbidities were documented?

- Cardiovascular
- Respiratory
- Renal
- Diabetes
- Liver disease
- Active cancer
- Psychological condition
- Other

i. Specify details of comorbid diseases

Medication on admission

2.8. Was the patient taking treatment for Crohn's disease on admission? (select all that apply)

- Yes No Not stated

a. What treatments was the patient taking? (select all that apply)

- Sulfasalazine
- Oral 5-ASA
- Topical 5-ASA
- Oral corticosteroids
- Topical corticosteroids
- Mercaptopurine
- Azathioprine
- Methotrexate
- Antibiotics
- Exclusive Enteral Nutrition (Paediatric Only)
- Other Dietary therapy

- Allopurinol (Paediatric Only)
- Anti-TNF agent
- Other (e.g. trial medication or complementary medicine)

i. If 'Other' please specify

b. Was there an estimate of compliance recorded? Yes No

Smoking status

2.9. What was the smoking status of the patient?

- Current smoker
- Not currently smoking
- Not documented

Other assessment during admission

Prolonged steroid use

2.10. In the 12 months prior to admission was the patient taking oral steroids for CD (at any time) for >3 months? Yes No Unknown

a. Was an appropriate dose reduction planned? Yes No Unknown

b. Was bone protection used? Yes No Unknown

c. Had a DEXA scan been done within 5 years? Yes No Unknown

d. If yes (>3 m steroids), what steroid sparing strategies were tried? (Select all that apply)

- Thiopurine
- Methotrexate
- Anti-TNF agent
- None
- Other

i. If 'Other' please specify

e. What was the outcome of the steroid-sparing strategy?

- Ongoing steroid-sparing therapy
- Stopped due to intolerance
- Stopped due to lack of clinical benefit
- Successful steroid cessation
- Other

i. If 'Other' please specify

Weight assessment and dietetic support during admission

- 2.11. Was a dietetic assessment recorded? Yes No
- 2.12. Was a formal nutritional risk assessment documented in the patient record? (e.g. MUST, MST) (e.g. STAMP, STRONGkids or PYMS (Paediatric Only)) Yes No
- a. By whom? Nurse Doctor Dietitian Nutrition assistant Unclear
- 2.13. Was the patient's weight recorded within two days of admission? Yes No
- a. Was the patient's height recorded? Yes No (Paediatric Only)
- 2.14. Was the patient's weight recorded within two days of discharge? Yes No
- 2.15. Was BMI recorded? Yes No
- 2.16. Was it documented that a dietitian saw the patient? Yes No N/A (thought to be well nourished/not needed)
- 2.17. Was dietary treatment recommended? Yes No Not recorded

Investigations

- 2.18. What were the admission results (within 24 hours) for the following tests
- a. CRP (mg/L) Not documented
- b. Hb (g/dL) Not documented
- c. Albumin (g/L) Not documented
- d. Faecal calprotectin ($\mu\text{g/g}$) Not documented
- e. Haematocrit (%) Not documented (Paediatric Only)
- f. Esr (mm/hr) Not documented (Paediatric Only)
- 2.19. Was a stool sample sent for stool culture/PCR within 48 hours of admission? Yes No N/A
- a. Was it positive? Yes No
- 2.20. Was a stool sample sent for *Clostridium difficile* toxin within 48 hours of admission? Yes No N/A
- a. Was it positive? Yes No
- 2.21. What imaging was used during the admission? (select all that apply)
- No imaging performed
- AXR
- Abdominal ultrasound (not small bowel specific)

- Specific small bowel ultrasound
- Abdominal CT scan
- MR Enterography
- Other

i. If 'Other' please specify

Care Team

IBD team/ward (who looked after them)

3.1. Which specialty was responsible for the patient's care 24 hours after admission?

- Acute or general medicine
- General surgery
- Gastroenterology
- Colorectal surgery
- Other

a. Please specify

3.2. Was a gastroenterology consultant or registrar consulted?

- Yes No Not required Not documented

3.3. Was a colorectal surgical consultant or registrar consulted?

- Yes No Not required Not documented (Adult Only)

3.3. Was a paediatric surgeon, paediatric colorectal surgeon, colorectal surgeon or respective registrars consulted?

- Yes No Not required Not documented (Paediatric Only)

3.4. Is there documentation that an IBD nurse specialist saw the patient during admission?

- Yes No

3.5. Was the patient cared for on a specialist gastroenterology ward? Yes No

a. Which type of ward?

- Medical
- Joint medical/surgical
- Surgical

3.6. While admitted, did the patient receive any short term psychological support? Yes No

a. Who provided the short term psychological support? ?

- Psychologist
- Psychiatrist
- Social worker

- Pastoral care
- Other

i. Please specify

3.7. While on ward, did the patient receive short-term psychotropic medication (e.g., anxiolytic) to help with adjustment issues (e.g., sleeping difficulties, anxiety)? Yes No NA

Medical Intervention

If the patient was admitted electively for surgery, ignore the medical intervention section other than 4.1

Use of anti-thrombotic therapy

4.1. Was the patient given DVT/PE prophylaxis? Yes No Contraindicated

a. If 'contraindicated', why?

4.2. Did the patient have a thrombotic episode during this admission? Yes No

a. What type of episode was it? DVT PE Other

i. If 'Other' please specify

Steroid therapy

4.3. Were corticosteroids initiated during this admission? Yes No

a. If 'yes', what was the route of administration?

- IV corticosteroids
- Oral corticosteroids
- Topical corticosteroids

4.4. Which other therapies were started during the admission? (select all that apply)

- None
- 5-Aminosalicylates
- Thiopurine therapy
- Methotrexate
- Anti-TNF
- Exclusive enteral nutrition (EEN)
- Other

i. If 'Other' please specify

4.5. Is there documentation of the patient having been discussed at a multidisciplinary team meeting? Yes No

Surgical Intervention

Surgical therapy

- 5.1. Did the patient have surgery on this admission? Yes No
- a. What was the date of surgery? DD/MM/YYYY
- b. Was there a delay of more than 48 hours between decision to operate and surgery?
 Yes No Unclear
- i. What was the reason for the delay?
- Improvement in severity of CD
 - Cancelled due to lack of theatre time or resource related reasons
 - Cancelled for clinical reasons (e.g to correct hyperkalaemia)
 - Patient declined surgery or needed time to consider
 - Unclear
 - Other
- i. If 'Other' please specify
- 5.2. Was the ASA status recorded on an anaesthetic chart? Yes No
- a. What was the status? 1 2 3 4 5 N/A
- 5.3. What were the indications for this surgery? (Select all that apply)
- Obstruction
 - Perforation
 - Abscess
 - Formation of ileostomy
 - Closure of stoma
 - Failure of medical therapy
 - Bleeding
 - Completion proctectomy
 - Dysplasia
 - Cancer
 - Fistula (Paediatric Only)
 - Other indication
- i. If 'Other' please specify
- 5.4. Type of intervention (select all that apply)
- Ileocolonic resection
 - Ileal/jejunal resection
 - Strictureplasty

- Segmental/extended colectomy
- Subtotal colectomy
- Proctocolectomy
- Resection of Intra-abdominal fistula
- Completion proctectomy
- Drainage of abscess
- Formation of ileostomy or colostomy
- Revision of stoma
- Closure of stoma
- Perineal procedure
- Division of adhesions
- Seton Insertion (paediatric Only)**
- Other intervention

i. If 'Other' please specify

5.5. Was the surgery done laparoscopically or laparoscopically assisted? Yes No Unclear

5.6. Was the patient seen by a stoma nurse during this admission? Yes No Unclear

5.7. Was the patient seen by a stoma nurse prior to surgery? Yes No Unclear

Surgical complications

5.8. Did the patient develop postoperative complications? (Select all that apply) Yes No

- Wound infection
- Rectal stump complications
- Intra-abdominal bleeding
- Intra-abdominal abscess
- Anastomotic leakage
- Stoma complications
- Deep vein thrombosis (DVT)
- Pulmonary embolus (PE)
- Small bowel obstruction
- Ileus
- Total parenteral nutrition (TPN)
- Cardiac
- Respiratory
- Clostridium difficile*-associated diarrhoea (CDAD)
- Malnutrition
- Reoperation (for any reason)

i. Please specify reoperation reason

- Other

ii. Please specify 'other' complication details

Prevention of post-operative recurrence

5.9. Was the patient newly prescribed any of the following drugs on discharge, i.e. additional to those on presentation? (select all that apply) Yes No

- Azathioprine
- Mercaptopurine
- Metronidazole
- 5-ASA
- Methotrexate
- Infliximab
- Adalimumab
- Other

i. If 'Other' please specify

Anaemia

5.10. Was the patient anaemic on admission? Yes No Not recorded

a. Was the anaemia noted or commented on by the treating team? Yes No Not recorded

5.11. Was anaemia (at presentation or during hospitalization) due to iron deficiency?

- Yes No Other cause or uncertain Not recorded

a. What treatment was administered? (select all that apply)

- Oral iron
- IV iron
- Blood transfusion
- Nutritional advice
- Not recorded

Discharge Arrangements

This section is only required if you answered that the patient was 'discharged home' or 'at own risk' earlier in the survey

- 6.1. Was the patient taking oral steroids on discharge? Yes No N/A
- a. Was a steroid reduction program stated on discharge? Yes No N/A
- 6.2. Were bone protection agents prescribed? Yes No N/A
- 6.3. Was ongoing nutritional supplementation recommended on discharge?
 Yes No N/A
- 6.4. Were arrangements made for follow-up by a dietitian? Yes No N/A
- 6.5. Was the patient on immunosuppressives on discharge? Yes No N/A
- a. Was a plan for safety monitoring implemented? Yes No N/A
- 6.6. Was there a plan for maintenance anti-TNF on discharge? Yes No N/A
- a. Was a plan for safety monitoring implemented? Yes No N/A
- 6.7. Were psychological/behavioural factors identified to contribute to poor disease management (e.g., significant anxiety/depression leading to non-adherence)
 Yes No N/A
- a. If yes, was an outpatient plan put in place to help the patient address this?
 Yes No N/A
- 6.8. Was the plan for follow-up documented in the discharge summary? Yes No
- 6.9. Was the discharge summary sent/faxed/emailed to the patient's general practitioner?
 Yes No N/A

Outpatient Care Prior to Admission

- 7.1. Did the patient have previous outpatient visits or private practice consultation for IBD?
 Yes No Unknown
- a. How many times was the patient seen in the 12 months prior to the start date of this admission? Unknown
- b. Was disease active at last OPD appointment or private practice review?
 Yes No Unknown