Clinician Perceptions Participation Information Sheet

The 2nd Sprint National Anaesthesia Project (SNAP-2): Epidemiology of Critical Care provision after Surgery (EpiCCS)

The Sprint National Anaesthesia Projects (SNAPs) are 'snapshot' evaluation studies of clinical activity and patient-centred outcomes that are important and relevant to both patients and anaesthetists. SNAP-1 was a two-day evaluation of patient reported outcomes after anaesthesia conducted in May 2014 and over 95% of NHS hospitals in all 4 devolved UK nations participated in that study.

We are now conducting the second SNAP research study (SNAP-2: EpiCCS), a prospective observational cohort study looking at postoperative Critical Care in hospitals throughout the UK, and would like to invite you to take part. Please take time to read the following information carefully. If there is anything that is not clear or if you would like more information, please contact the Local Lead Investigators (details can be found at the bottom of this information sheet).

What is the purpose of the study?

Postoperative complications, such as post-operative nausea and vomiting, infections and death, can vary in their incidence and severity. It has been suggested that one way to reduce complications is to admit patients to Critical Care postoperatively, for more intensive nursing support, or advanced interventions, etc. However, despite national guidelines and recommendations, we know that that there is variation in which patients are cared for in Critical Care in different institutions and countries. We are conducting this study to try and uncover some of the reasons for these findings. We also hope to find out whether Critical Care after surgery shows a beneficial effect on morbidity and mortality after surgery. This is particularly important as the thresholds for critical care admission are not clear from the evidence, and opinions are not consistent between clinicians or hospitals.

Why have I been invited?

Part of our study is looking at reasons why some high-risk patients might not be admitted to a Critical Care bed immediately following surgery. We are therefore interested in seeing how clinicians (anaesthetists, surgeons and intensivists) decide where patients should go for postoperative care.

Do I have to take part?

Completing the questionnaire is entirely voluntary and it is up to you to decide whether you do so. You are free to withdraw at any time. If you choose not to take part or to withdraw your participation, we ask that you provide a reason why, so that we can better account for participant withdrawal during data analysis.

What will I have to do?

We will ask you to complete the short questionnaire on page 3. You will only have to complete this questionnaire once during the SNAP-2 study week. By completing this questionnaire, you are giving permission for us to keep the information you provide and analyse it for our study.

What are the possible disadvantages and risks of taking part?

There are no major disadvantages or risks of taking part. Filling in the questionnaires should be straightforward and does not take up much time. We would like to reassure you that your responses will be used in confidence, without risk of litigation or reprisal. All data will be anonymised so there is no risk of you being identified.

What are the possible benefits of taking part?

We cannot promise the study will help you directly in caring for your patients but we hope that the information you provide will help improve the quality of clinical care delivered in the future. You will be able to get feedback on the findings of the study via the SNAP-2 website (see details below).

Will my taking part in the study be kept confidential?

Yes. The study will abide by strict information governance and confidentiality procedures. The information you provide will be anonymised for analysis.

What will happen to the answers provided in the questionnaires?

The Local Lead Investigator will transfer your responses from the paper questionnaires onto a computer database. Data analysis will be performed by researchers based at the Health Services Research Centre and University College Hospital in London. Your information will be kept securely for 10 years in order for long-term outcomes to be accurately studied.

What will happen to the results of the study?

The results from the study will be published in scientific manuscripts and on the SNAP-2 website. No references will be made that could link you personally to the study.

Who is organising and funding the study?

The study is being funded by the National Institute of Academic Anaesthesia (NIAA), the Association of Anaesthetists of Great Britain & Ireland, the NIAA Health Services Research Centre (HSRC) & the Royal College of Anaesthetists. It is being led by the NIAA HSRC.

Who has reviewed the study?

This study has been reviewed and approved by the South Central - Berkshire B Research Ethics Committee (REC reference: 16/SC/0349) on behalf of the Health Research Authority.

Further information and contact details

Website: http://www.niaa.org.uk/SNAPs

Study email address: snap2@rcoa.ac.uk

Local lead name and contact details:

Clinician Perceptions to risk stratification and postoperative care

We are surveying anaesthetists, surgeons and intensivists to explore their approaches to risk stratification and decision-making surrounding postoperative care.

This should only be completed once by each clinician during the week of the study.

About You

1.1. What is your specialty? (tick all that apply) ☐Anaesthetist ☐Surgeon ☐Intensivist

1.1a. If you are a surgeon or anaesthetist, which of the following best describes your primary workload (you may select more than one)?

☐Cardiothoracic surgery ☐General surgery (including GI surgery and breast surgery)

☐Neurosurgery ☐Oral and maxillofacial surgery

☐Otolaryngology ☐Plastic or reconstructive surgery

☐Trauma and Orthopaedics ☐Urology

☐Vascular surgery

1.2. What is your grade? ☐ Consultant ☐ Staff & Associate specialist

☐ ST3-7 trainee or Trust grade equivalent

☐ Core/Foundation trainee or Trust grade equivalent

1.3. Date of completion of questionnaire: ___/___/_____

1.4. How many years have you been qualified as a doctor? _____

About your views on risk prediction and Critical Care

2.1. What predicted risk of 30-day mortality would you set as a minimum threshold for admitting patients to critical care immediately after surgery? (i.e. if the predicted risk was above this level you would seek a planned critical care admission)

☐<1% ☐1-2.5% ☐2.6-5% ☐5.1-10% ☐10.1-50% ☐>50%

2.2. What risk of 30-day mortality would you consider to be "high-risk" for a patient undergoing surgery?

Please indicate a value between 0 and 100%: _____

2.3. In general, do you feel that there is enough critical care bed capacity at your institution for postoperative patients that need it?

☐Y ☐N ☐Not sure

Commented [A1]: We are also encouraging Interventional Radiologists, Endoscopists and Cardiologists to participate, please ask them to select "Surgeon".

Commented [A2]: If you do not find a specialty that describes your primary workload, please write down a free-text response. We will include the option for "Other" and space for free-text on the online webtool.

Commented [A3]: We understand that this question may seem very subjective. That is the intention. We want to find out what the clinicians' "gut" feelings are about how risky a case might need to be before they would consider sending a patient to Critical Care.

Please elaborate if you would like to contribute a free text response to this question:

2.4. Do you think that high-risk patients admitted for critical care postoperatively generally have better outcomes than if they were admitted onto a general surgical ward?

☐Y ☐N ☐Not sure

Please elaborate if you would like to contribute a free text response to this question:

2.5. Would you proceed with surgery for a high-risk patient if you knew there was no critical care capacity on the day of surgery?

☐Y ☐N ☐Depends

Please elaborate if you would like to contribute a free text response to this question:

2.6. Do pathways exist within your institution for certain operations mandating that patients be admitted to critical care postoperatively?

Commented [A4]: An example of this might be: all cardiopulmonary bypass patients are admitted to critical care postoperatively as a matter of routine.

☐Y ☐N ☐Not sure

2.7. Are there specific types of surgery where you feel critical care admission should be a standard of care (e.g. elective vs. emergency surgery, open laparotomy vs laparoscopic surgery)? Please respond with free text:

2.8. What do you feel is the benefit of critical care in postoperative surgical care**? Rank** the following from **1** (most important) to **6** (least important), if there is no response for "other" please answer that as **6** (least important):

☐Increased monitoring ☐Higher nurse:patient ratio

☐Ability to deliver complex therapies ☐Higher doctor:patient ratio

☐Consultant Intensivist input ☐Other: _____

Risk stratification

How frequently do you use the following risk stratification tools in your perioperative practice?

(Please circle **0** to **4**, where: **0** = Never, **1** = Occasionally, **2** = Usually and **3** = Always)

1. American Society of Anaesthesiologists Physical Status (ASA-PS)	Never 0 1 2 3 always
2. Charlson Comorbidity Index	Never 0 1 2 3 always
3. Revised Cardiac Risk Index (RCRI)	Never 0 1 2 3 always
4. Surgical Risk Scale (SRS)	Never 0 1 2 3 always
5. POSSUM and/or associated derivatives[1]	Never 0 1 2 3 always
6. Surgical Outcome Risk Tool (SORT)	Never 0 1 2 3 always
7. Cardiopulmonary exercise testing (CPET)	Never 0 1 2 3 always
8. EuroSCORE	Never 0 1 2 3 always
9. Duke Activity Status Index or other Metabolic Equivalents (MET) Scoring system	Never 0 1 2 3 always
10. New York Heart Association Functional Classification	Never 0 1 2 3 always
11. Acute Physiology & Chronic Health Evaluation II (APACHE-II)	Never 0 1 2 3 always
12. Sequential Organ Failure Assessment (SOFA)	Never 0 1 2 3 always

[1] Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity, including p-POSSUM, v-POSSUM, etc.