



PICANet Dataset Definitions Version 3 (November 2007)

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Overview of PICANet (Paediatric Intensive Care Audit Network):

The importance of clinical audit is widely acknowledged. The National Service Framework for Children clearly identifies that national audit programs give the public powerful comparative information on performance in complex areas such as paediatric intensive care.¹ Units providing paediatric intensive care are expected to collect information on case mix (including illness severity, method, type and source of admission, median length of stay, interventions, and outcome). The risk adjustment tool used should allow inter-unit and regional comparisons.^{2, 3}

PICANet was established to develop and maintain a secure and confidential high quality clinical database of paediatric intensive care activity, case mix, structure and utilisation, with the following objectives:

- Identification of best practice
- Monitoring of supply and demand
- Monitoring and review of outcomes of treatment episodes
- Strategic planning and resource requirements
- Study of the epidemiology of critical illness in children

The aim was to set up a systematically collected and validated core data set of demographic and clinical data on all admissions to PICUs, allowing comparison of PICU activity at a local level with national benchmarks. Paediatric Intensive Care continues to come under pressure and standardised national information about activity and outcomes in this area is vital. Only by collecting standardised data will it be possible to ensure the comparison of 'like with like' at a national level.

- 1 Department of Health. Getting the right start: National Service Framework for Children, Standards for hospital services. London, DOH, April 2003.
- 2 Paediatric Intensive Care "A Framework for the Future", Report from the National Co-ordinating Group on Paediatric Intensive Care to the Chief Executive of the NHS Executive. London, NHSE, 1997.
- 3 Paediatric Intensive Care Society Standards Document 2001.

The Dataset:

Following input from paediatric intensive care units, the PICANet dataset was agreed by the PICANet Clinical Advisory Group, the PICANet Steering Group and the Department of Health:

Admission Information Identifier, socio-demographic and source information from the time period prior to admission to your unit and at admission to your unit.

Diagnoses and Procedures Reason(s) for admission to your unit plus any co-morbidity.

PIM / PIM2

Medical history Specific acute or chronic conditions documented either prior to admission to your unit and/or at admission to your unit.

Reason for admission Specific conditions relating to the main reason for admission to your unit.

Physiology Physiology data collected from the time of 1st contact with your unit doctor to one hour after admission to your unit.

Intervention record A record of interventions received by the patient during their stay on your unit.

Discharge Outcome data at discharge from your unit.

Follow-up Follow-up information (30 days post unit discharge).

Additional information Additional information relevant to the admission.

Data Collection:

Data are collected for all admissions to your unit regardless of severity of illness, reason for admission, length of stay etc. Data are collected for the same time periods for all admissions. There are no exclusions and no exceptions.

Readmissions:

Data are collected as for a new admission.

Data:

Data that are measured and/or recorded in any part of the permanent written or electronic patient record are acceptable, for example, data from charts, case notes or any medium that comprises the permanent patient record. This excludes trends recorded on monitors that will not become part of the permanent patient record. This is based on the assumption that clinically important information is documented.

Do not enter guesses or fabricated data.

In specifying and defining the dataset, judgements have had to be made. It is recognised that such decisions will not comply with all opinions. However, it should be emphasised that, for the purposes of PICANet, data should be collected as defined and specified in this dataset.

Where appropriate, improbable checks and impossible limits are incorporated in the software. Improbable values should be checked whereas impossible limits are absolute and data entry will not be permitted.

Confidentiality

The Patient Information Advisory Group (PIAG) has granted PICANet exemption from gaining signed patient / parental consent under Section 60 of the Health and Social Care Act 2001. This class support enables PICANet to collect and process patient identifiable information for the purpose of auditing, monitoring and analysing patient treatments to ensure that adequate and appropriate services are available for all children. Should any parents/guardians/children NOT wish their personal details to be sent to PICANet, their record can be anonymised (see page 65).

1. ADMISSION

1.1. PICANet ID

- Definition:** Unique identifying number supplied to each admission to your unit.
- Reason:** PICANet ID provides an identifier for each admission to your unit, particularly useful if coupled with your Site ID.
- Format:** The number is automatically generated and incorporated into each admission record as each admission record is created.
-

Field Name:	<i>PICANETID</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Integer</i>
Example of Format:	<i>11</i>
Comment:	<i>Automatically generated and incorporated into each admission record as each admission record is created.</i>
Value expected?:	<i>N/A</i>
Validation:	<i>None required – generated by software.</i>

- Definition:** Unique identifying number supplied to each unit participating in PICANet. The unit participating is your unit, and not another unit in your hospital that may be participating, nor a unit in another hospital.
- Reason:** Site ID number provides a unique identifier for each unit participating in PICANet and thus allows identification of one unit's data from another.
- Format:** The number is 'hardwired' into the software on installation and incorporated into each admission record.
-

Site ID: technical specification

Field Name:	<i>SITEID</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Integer</i>
Example of Format:	<i>7</i>
Comment:	<i>Automatically incorporated into each admission record.</i>
Value expected?:	<i>N/A</i>
Validation:	<i>None required after installation. PIN code required on installation to ensure correct site is identified.</i>

1.3. Admission number

Definition: Unique identifier assigned to each consecutive admission to your unit.

As recorded in your unit admission book.

Admission to your unit is defined as the physical admission and recording of that admission to a bed or cot in your unit.

Reason: Admission number provides a unique identifier for each admission to each unit participating in PICANet and thus allows identification of one set of admission data from another.

Format: Free text (e.g. 01/389).

Admission number: technical specification

Field Name: ADNO
Field Type: Character, size 10
Domain: Free text
Example of Format: 01/389
Comment: -
Value expected?: Yes
Validation: -

Definition:	Unique identifying number enabling tracing of a patient through the NHS system.
Reason:	NHS number gives a unique, identifiable variable that will allow other identifiable data items to be removed from the database. Can identify individuals who may have had multiple admissions to one or more PICUs.
Format:	Free text (e.g. 1463788990).

NHS number: technical specification

Field Name:	NHSNO
Field Type:	Character, size 10
Domain:	All valid NHS numbers
Example of Format:	1463788990
Comment:	<i>The NHS number should have 10 digits but text has been allowed to enter 'old style' numbers in the rare event that these have been used.</i>
Value expected?:	Yes
Validation:	<i>Modulus-11 check on tenth digit will confirm if valid NHS number (see http://www.nhsia.nhs.uk/nsts/pages/digit_calc.asp for an explanation of how this works).</i>

1.5. Case note number

Definition: Unique identifying number for an individual's hospital records.

Allocated on first admission to hospital.

Reason: Case note number provides a unique identifier that can aid patient tracking throughout the hospital.

Format: Free text (e.g. AB145C).

Case note number: technical specification

Field Name: CASENO
Field Type: Character, size 10
Domain: Free text
Example of Format: AB145C
Comment: -
Value expected?: Yes
Validation: -

1.6. Family name

Definition: The last or surname given to the child as it would appear on the child's birth certificate or other appropriate document.

Reason: Family name provides an additional identifier that can aid patient tracking throughout the hospital.

Can help identify individuals who may have had multiple admissions to one or more PICUs.

Format: Free text (e.g. Brown).

If no family name available record as UNKNOWN and indicate why not available in the comments section.

Family name: technical specification

Field Name: FAMILYNAME
Field Type: Character, size 35
Domain: Free text
Example of Format: Brown
Comment: -
Value expected?: Yes
Validation: -

1.7. Second family name

Definition:	A second family name by which the child might be known.
Reason:	Second family name provides an additional identifier that can aid patient tracking throughout the hospital. Can help identify individuals who may have had multiple admissions to one or more PICUs.
Format:	Free text (e.g. Smith).

Second family name: technical specification

Field Name: FAMILYNAME2
Field Type: Character, size 35
Domain: Free text
Example of Format: Smith
Comment: -
Value expected?: No
Validation: -

1.8. First name

Definition: The first name given to the child as it would appear on the child's birth certificate or other appropriate document.

Reason: First name provides an additional identifier that can aid patient tracking throughout the hospital.

Can help identify individuals who may have had multiple admissions to one or more PICUs.

Format: Free text (e.g. John).

If no first name available record as UNKNOWN and indicate why not available in the comments section.

First name: technical specification

Field Name:	<i>FIRSTNAME</i>
Field Type:	<i>Character, size 35</i>
Domain:	<i>Free text</i>
Example of Format:	<i>John</i>
Comment:	<i>-</i>
Value expected?:	<i>Yes</i>
Validation:	<i>-</i>

Definition:	The normal place of residence for the child.
Reason:	<p>Address provides an additional identifier that can aid patient tracking throughout the hospital.</p> <p>Can help identify individuals who may have had multiple admissions to one or more PICUs.</p> <p>A full residential address is required to enable geographic and demographic information to be linked to the patient for epidemiological analysis and assessment of health services delivery.</p> <p>A full residential address will allow validation of postcode.</p>
Format:	<p>5 free text fields, e.g.</p> <p>ADDRESS1: 83 Green Street ADDRESS2: Brownley ADDRESS3: Sheffield ADDRESS4: South Yorkshire ADDRESS5:</p> <p>At least part of the address should be entered in ADDRESS1. If no information is available, please state UNKNOWN and indicate reason in the comments section.</p> <p>Note that not all fields need to be completed for short addresses, and very long addresses may require sub-districts and town to be combined.</p>

Address (1-5): technical specification

Field Names: ADDRESS1
ADDRESS2
ADDRESS3
ADDRESS4
ADDRESS5

Field Type: Character, size 50

Domain: Free text

Example of Format: 83 Green Street
Brownsley
Sheffield
South Yorkshire

Comment: *The five address fields are identical with the exception of their variable/field names and have been combined here for brevity. Data is required in the first field only as some patients may have flown in from abroad/be in the care of social services etc., and full details may not be available.*

Value expected?: ADDRESS1 Yes
ADDRESS2 No
ADDRESS3 No
ADDRESS4 No
ADDRESS5 No

Validation: -

Definition:	The postcode for the child's normal place of residence.
Reason:	<p>Postcode provides an additional identifier that can aid patient tracking throughout the hospital.</p> <p>Can help identify individuals who may have had multiple admissions to one or more PICUs.</p> <p>Postcode provides a means of linkage to geographic and demographic information for epidemiological analysis and assessment of health services delivery.</p>
Format:	<p>Text (e.g. S10 8NN).</p> <p>Foreign postcodes will be accepted by the software, although a warning will be generated in the case of non UK standard postcodes to ensure that the user checks the data.</p> <p>If postcode is unobtainable, record as UNKNOWN.</p>

Postcode: technical specification

Field Name:	POSTCODE
Field Type:	Character, size 7
Domain:	Text
Example of Format:	S10 8NN
Comment:	-
Value expected?:	Yes
Validation:	<i>The postcode entered should comply with the standard UK postcode format.</i>

1.11. *Date of birth*

Definition: The child's date of birth as recorded on the child's birth certificate or other appropriate document.

Reason: Date of birth and Date of admission are used to calculate age at admission to your unit.

Format: Date; dd/mm/yyyy.

Date of birth should be between 01/01/1980 and Date of admission.

If the child's date of birth is unobtainable, but the child is still on your unit, use your judgement to estimate year of birth and record as 1 January of estimated year (e.g. 01/01/YYYY).

If information is being extracted from notes and the child's date of birth is not recorded, or recorded as unavailable, leave the field blank and enter NK ('9') in the Date of birth estimated/missing field.

If it is necessary for Date of birth to be partly anonymised, enter the correct month and year and record 1 for the day (e.g. 01/MM/YYYY). Then enter Partly anonymised ('2') in the Date of birth estimated/missing field.

Date of birth: technical specification

Field Name: DOB

Field Type: Date/Time

Domain: Date; dd/mm/yyyy

Example of Format: 06/12/2000

Comment: -

Value expected?: Yes

Validation: Valid date check.

Date of birth (DOB) should be between 01/01/1980 and 31/12/2099.

Date of birth (DOB) should be earlier than Date of admission to your unit (ADDATE).

If Date of birth (DOB) is not completed, Date of birth estimated/missing (DOBEST) should be NK ('9').

1.12. Date of birth estimated/missing

Definition: Specifies whether the date of birth is estimated, missing (and cannot be estimated) or partly anonymised.

Reason: Date of birth and Date of admission to your unit are used to calculate age at admission to your unit.

Format: Choose from one of the following:

Estimated
Partly anonymised
NK (and cannot be estimated)

(Not estimated is the default option).

Date of birth estimated/missing: technical specification

Field Name: DOBEST
Field Type: Numeric
Domain: Codes: 0 Not estimated (default)
1 Estimated
2 Partly anonymised
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: Valid date check.

If Date of birth estimated/missing (DOBEST) equals Estimated ('1'), then the date of birth day (dd) and month (mm) should both equal 01.

If Date of birth estimated/missing (DOBEST) equals NK ('9'), then Date of birth (DOB) should be blank.

If Date of birth estimated/missing (DOBEST) equals Partly anonymised ('2'), then Date of birth day (dd) should equal 01.

1.13. Gestational age at delivery

Definition: Gestational age at delivery in completed weeks if aged less than 2 years at admission to your unit.

Reason: For young infants, there is evidence that gestational age can act as an important prognostic factor.

Format: Enter between 20 – 44 weeks.

Enter 99 if unknown.

Gestational age at delivery: technical specification

Field Name:	<i>GEST</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Units: Weeks</i>
Units:	<i>Weeks</i>
Example of Format:	<i>29</i>
Comment:	<i>Only applicable to infants of less than two years of age.</i>
Value expected?:	<i>Yes, if infant less than 2 years old.</i>
Validation:	<i>Gestational age at delivery (GEST) should be in the range 20 - 44 or 99.</i>

1.14. Multiple birth

Definition: Identifies whether the child was a singleton, twin, triplet, etc.

If medical notes are available and there is no mention of multiple birth, assume the child is a singleton.

Reason: Multiple birth information provides an additional identifier that can aid patient tracking throughout the hospital.

Format: Enter 1 for singleton, 2 for twin, 3 for triplet and so on.

Enter 9 if unknown.

Multiple birth: technical specification

Field Name:	MULT
Field Type:	Numeric
Domain:	Ordinal (e.g. 1=singleton, 2 = twin, 3=triplet, etc.; 9=NK)
Example of Format:	1
Comment:	Multiple births of more than 8 are unlikely.
Value expected?:	Yes
Validation:	-

1.15. Delivery order

Definition: Identifies the order in which the child was delivered if a multiple birth.

Reason: In the case of multiple birth, delivery order provides an additional identifier that can aid patient tracking throughout the hospital.

Format: Enter 1 for first born, 2 for second born and so on.
Enter 9 if unknown.

Delivery order: technical specification

Field Name:	<i>DELORDER</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Ordinal (e.g. 1=first born, 2=second born, etc.; 9=NK)</i>
Example of Format:	<i>1</i>
Comment:	<i>-</i>
Value expected?:	<i>Yes, if Multiple birth (MULT) is anything other than 1 or 9.</i>
Validation:	<i>Delivery order (DELORDER) should be less than or equal to Multiple birth (MULT).</i>

Definition: Identifies the genotypical sex of the child at admission to your unit.

Reason: Sex is important for reporting demographic statistics for admissions to your unit.

Sex provides an additional identifier that can aid patient tracking throughout the hospital.

Format: Choose from one of the following:

Male
Female
Ambiguous
NK

Sex: technical specification

Field Name *SEX*

Field Type: *Numeric*

Domain: *Codes: 1 Male*
 2 Female
 3 Ambiguous
 9 NK

Example of Format: *2*

Comment: *-*

Value expected?: *Yes*

Validation: *-*

1.17. Ethnic category/code

Definition: Identifies the child's ethnic origin, according to standard NHS ethnic categories and codes.

Reason: Required for epidemiological analysis and assessment of health services delivery.

Potentially of value in clinical audit in conjunction with other clinical data.

Format: Use free text to record the child's ethnic category and then enter the appropriate code (note: only the ethnic code is entered on the software).

(e.g. White Irish would have a category of White and a code of B – White Irish).

(e.g. 2. Mixed Mediterranean would have a category of Mixed and a code of G – Mixed other).

For codes C, G, L, P or S specify the child's exact ethnic origin (if known) in the 'Other' box available on the software.

Table showing the standard NHS ethnic categories & codes:

Ethnic Categories		Codes
a. White	British	A
	Irish	B
	Any other White background	C
b. Mixed	White and Black Caribbean	D
	White and Black African	E
	White and Asian	F
	Any other mixed background	G
c. Asian or Asian British	Indian	H
	Pakistani	J
	Bangladeshi	K
	Any other Asian background	L
d. Black or Black British	Caribbean	M
	African	N
	Any other Black background	P
e. Other ethnic Groups	Chinese	R
	Any other ethnic group	S
f. Not Stated	Not stated	Z

Ethnic category/code: technical specification

Field Name: ETHNIC

Field Type: Character, size 1

Domain: Codes:

Ethnic Categories		Codes
a. White	British	A
	Irish	B
	Any other White background	C
b. Mixed	White and Black Caribbean	D
	White and Black African	E
	White and Asian	F
	Any other mixed background	G
c. Asian or Asian British	Indian	H
	Pakistani	J
	Bangladeshi	K
	Any other Asian background	L
d. Black or Black British	Caribbean	M
	African	N
	Any other Black background	P
e. Other ethnic Groups	Chinese	R
	Any other ethnic group	S
f. Not Stated	Not stated	Z

Example of Format: B - White Irish.

Comment: -

Value expected?: Yes

Validation: -

1.18. Other ethnic origin

Definition:	<p>The child's exact ethnic origin (if known), if not specified in the table containing standard NHS ethnic categories and codes.</p> <p>If codes C, G, L, P or S are chosen for Ethnic category/code, Other ethnic origin will give a further option to specify the child's <u>exact</u> ethnic origin, if known.</p>
Reason:	<p>Required for epidemiological analysis and assessment of health services delivery.</p> <p>Potentially of value in clinical audit in conjunction with other clinical data.</p>
Format:	<p>Free text (e.g. Mediterranean).</p> <p>In this case G – Mixed other may have been recorded for Ethnic category/code, but the notes may have specifically stated that the child was Mediterranean.</p>

Other ethnic origin: technical specification

Field Name:	<i>ETHNICOTHER</i>
Field Type:	<i>Character, size 35</i>
Domain:	<i>Free text</i>
Example of Format:	<i>Mediterranean</i>
Comment:	<i>-</i>
Value expected?:	<i>Yes, if Ethnic category/code (ETHNIC) equals C, G, L, P or S.</i>
Validation:	<i>-</i>

1.19. Date of admission to your unit

Definition:	<p>The actual date that the child was physically admitted to a bed or cot within your unit.</p> <p>This is not the date of first contact as this may be in another department or hospital.</p> <p>24 hour period, starting from 00:00.</p> <p>23:59 is the end of one day and 00:00 is the start of the next day.</p>
Reason:	<p>Date of admission to your unit, Time of admission to your unit, Date of discharge from your unit and Time of discharge from your unit (or Date of death and Time of death) are used to calculate total length of stay on your unit.</p>
Format:	<p>Date; dd/mm/yyyy.</p>

Date of admission to your unit: technical specification

Field Name: ADDATE

Field Type: Date/Time

Domain: Date; dd/mm/yyyy

Example of Format: 26/08/2002

Comment: -

Value expected?: Yes

Validation: Valid date check.

Date of admission to your unit (ADDATE) should be on or after Date of birth (DOB).

Date of admission to your unit (ADDATE) should be earlier or equal to the Date of discharge from your unit (UNITDISDATE).

1.20. Time of admission to your unit

Definition: The actual time that the child was physically admitted to a bed or cot within your unit (this may be the time first charted if not documented as earlier in the admission case notes).

It is not the time of first contact as this may be in another department or hospital.

Reason: Date of admission to your unit, Time of admission to your unit, Date of discharge from your unit and Time of discharge from your unit (or Date of death and Time of death) are used to calculate total length of stay on your unit.

Format: Time (24 hour clock); hh:mm.

Time of admission to your unit: technical specification

Field Name: ADTIME
Field Type: Date/Time
Domain: Time (24 hour clock); hh:mm
Example of Format: 22:58
Comment: -
Value expected?: Yes
Validation: Valid time check.

Time of admission to your unit (ADTIME) should be earlier than Time of discharge from your unit (UNITDISTIME) if Date of admission to your unit (ADDATE) equals Date of discharge from your unit (UNITDISDATE).

Definition: Identifies type of admission to your unit.

A **planned admission** following surgery is an admission that your unit is aware of before the surgery begins, or one that could have been delayed for more than 24 hours without risk (e.g. spinal surgery).

An **unplanned admission** following surgery is an admission that your unit was not aware of before surgery began (e.g. bleeding tonsillectomy).

Surgery is defined as undergoing all or part of a procedure or anaesthesia for a procedure in an operating theatre or anaesthetic room. Please note: Do not include patients admitted from the operating theatre where surgery is not the main reason for admission (e.g. a patient with a head injury who is admitted from theatre after insertion of an ICP monitor; in this patient the main reason for admission is head injury and thus the admission type would be unplanned - other).

A **planned, other admission** is any other planned admission that is not an emergency (e.g. liver biopsy).

An **unplanned admission** is an admission that your unit was not expecting and is therefore an emergency admission to your unit (e.g. status epilepticus).

Reason: Planned admissions are weighted in PIM/PIM2.

Required for epidemiological analysis and assessment of health services provision.

Format: Choose from one of the following

- Planned admission (following surgery)
 - Unplanned admission (following surgery)
 - Planned admission (other)
 - Unplanned admission
-

Admission type: technical specification

Field Name: ADTYPE

Field Type: Numeric

Domain: Codes: 1 *Planned - following surgery*
2 *Unplanned - following surgery*
3 *Planned – other*
4 *Unplanned*
9 *NK*

Example of Format: 2

Comment: -

Value expected?: Yes

Validation: -

1.22. Previous ICU admission

Definition: Specifies whether the child has had a previous admission to an intensive care environment such as ICU, PICU or NICU before admission to your unit during the current hospital stay.

The ICU/PICU/NICU can be in the same hospital as the one housing your unit, or another hospital, as long as the admission was during the current hospital stay.

If the admission has been previously admitted to more than one ICU/PICU/NICU during the current hospital stay, record the location of the most recent admission.

Current hospital stay is defined as the period from admission to hospital until the time the child is discharged home or dies.

Reason: Important for assessing re-admission rates.

Important for allowing the accurate tracking of children from one admission to another.

Required for epidemiological analysis and assessment of health services provision.

Format: Choose from one of the following:

ICU
PICU
NICU
None
NK

Previous ICU admission: technical specification

Field Name: PREVICUAD

Field Type: Numeric

Domain: Codes: 1 ICU admission
2 PICU admission
3 NICU admission
4 None
9 NK

Example of Format: 3

Comment: -

Value expected?: Yes

Validation: *If Previous ICU admission (PREVICUAD) equals ICU admission ('1'), PICU admission ('2') or NICU admission ('3'), Source of admission should not equal Home ('4').*

1.23. Source of admission

Definition:	<p>The location from where the child was directly admitted to your unit.</p> <p>Same hospital is defined as the same hospital housing your unit.</p> <p>Other hospital is another hospital that does not house your unit.</p> <p>Clinic is defined as an outpatient clinic.</p> <p>Home is defined as the normal place of residence for the child.</p>
Reason:	<p>Required for epidemiological analysis and assessment of health services provision.</p> <p>Acts as a filter field for further data entry.</p>
Format:	<p>Choose from one of the following:</p> <ul style="list-style-type: none">Same hospitalOther hospitalClinicHome

Source of admission: technical specification

Field Name: SOURCEAD

Field Type: Numeric

Domain: Codes: 1 Same hospital
2 Other hospital
3 Clinic
4 Home
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: *If Source of admission equals Home ('4') then Previous ICU admission (PREVICUAD) should not equal ICU admission ('1'), PICU admission ('2') or NICU admission ('3').*

Definition: Specifies whether the child was transferred to your unit by a retrieval team.

If your own retrieval team go to a ward within your own hospital to help the ward staff to stabilise and then transfer a critically ill child into your own unit, this does not count as a retrieval.

A retrieval is any child admitted to your unit from outside of your hospital regardless of who brought the child to your unit.

Reason: Required for epidemiological analysis and assessment of health services provision.

Format: Choose from one of the following:

Yes
No
NK

Retrieval: technical specification

Field Name: RETRIEVAL

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

Definition:	<p>Specifies which retrieval team transported the child to your unit.</p> <p>Own team identifies that your own retrieval team collected the child from the referring hospital.</p> <p>Other PICU specialist team identifies that another PICU retrieval team transferred the child to your unit.</p> <p>Other specialist team identifies that another transport team, not a PICU team (e.g. A&E, theatres or neonatal teams), transported the child to your unit.</p> <p>Non-specialist team identifies that a non-PICU, non-specialist team transported the child to your unit. This could be ward staff transferring the child to your unit.</p>
Reason:	<p>Required for epidemiological analysis and assessment of health services provision.</p>
Format:	<p>Choose from one of the following:</p> <ul style="list-style-type: none">Own teamOther specialist team (PICU)Other specialist team (non-PICU)Non-specialist teamNK

Field Name: RETRIEVALBY

Field Type: Numeric

Domain: Codes: 1 Own team
2 Other specialist team (PICU)
3 Other specialist team (non-PICU)
4 Non-specialist team
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes, if Retrieval (RETRIEVAL) equals Yes.

Validation: -

1.26. Care area admitted from

Definition:	<p>The care area that the child came from immediately before admission to your unit.</p> <p>X-ray, endoscopy, CT scanner or similar area identifies that the child came from an area where diagnostic procedures may have been carried out.</p> <p>Recovery only means the child was cared for in the recovery area prior to admission to your unit.</p> <p>Theatre and recovery means the child has undergone all or part of a surgical procedure or has received an anaesthetic for a procedure within the theatre and recovery area.</p> <p>HDU (step up/step down area) means the child received care in a high dependency area prior to admission to your unit.</p> <p>Other intermediate care area is an area where the level of care is greater than that of the normal wards, but not an ICU/PICU/NICU or HDU.</p> <p>ICU/PICU/NICU means the child received care within one or more of these areas prior to admission to your unit.</p> <p>Ward means the child was admitted directly from a ward to your unit.</p> <p>A&E means the child was admitted to your unit directly from an A&E department.</p>
Reason:	Required for epidemiological analysis and assessment of health services provision.
Format:	Choose from one of the following: X-ray, endoscopy, CT scanner or similar Recovery only HDU (step up/step down unit) Other intermediate care area (not ICU/PICU/NICU) ICU/PICU/NICU Ward Theatre and recovery A&E

Care area admitted from: technical specification

Field Name: CAREAREAAD

Field Type: Numeric

Domain: Codes: 1 X-ray, endoscopy, CT scanner or similar
2 Recovery only
3 HDU (step up/step down unit)
4 Other intermediate care area (not ICU/PICU/NICU)
5 ICU/PICU/NICU
6 Ward
7 Theatre and recovery
8 A&E
9 NK

Example of Format: 6

Comment: -

Value expected?: Yes, if Source of admission to your unit (SOURCEAD) equals hospital.

Validation: Care area admitted from should only equal ICU/PICU/NICU ('5') if Previous ICU admission (PREVICUAD) equals ICU admission ('1'), PICU admission ('2') or NICU admission ('3').

1.27. Export this episode anonymised

Definition:	<p>The patient record can be exported anonymised.</p> <p>If the anonymised option is selected, patient identifiers (such as name, address, NHS number and case note number) will not be exported.</p> <p>Date of birth will be partly anonymised by defaulting the day to 01. This will still allow an age to be calculated.</p>
Reason:	<p>Parent(s)/guardian(s)/children may express a wish for their personal information not to be provided to PICANet.</p>
Format:	<p>Only tick if there is a need to anonymise a particular record.</p>

Export this episode anonymised: technical specification

Field Name: EXPORTANONYMISED

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: .-

Value expected?: N/A – default is No

Validation: -

1.28. GP practice code

Definition: The unique code assigned by the National Administrative Codes Service to the practice that the child's GP is part of.

Reason: Included at the request of commissioners to enable assessment of service delivery at local PCT level. Please consult your service level agreement to determine whether you are required to collect this data by your commissioning body.

Format: One letter followed by five numbers.

GP practice code: technical specification

Field Name: GPPRACTICECODE
Field Type: Character, size 6
Domain: NACS GP Practice code
Example of Format: B86069 (Burley Park Medical Centre, Leeds)
Comment: -
Value expected?: No
Validation: -

Definition: The weight of the child in kilograms.

Reason: Included at the request of those wishing to conduct studies which involve this parameter.

Format: Numerical value (e.g. 4.9).

Units: kg

Weight: technical specification

Field Name: *WEIGHT*

Field Type: *Numeric*

Domain: *Units: kg*

Example of Format: *4.9*

Comment: *-*

Value expected?: *No*

Validation: *-*

Definition: The height of the child in centimetres.

Reason: Included at the request of those wishing to conduct studies which involve this parameter.

Format: Numerical value (e.g. 75.6).

Units: cm

Height: technical specification

Field Name: HEIGHT
Field Type: Numeric
Domain: Units: cm
Example of Format: 75.6
Comment: -
Value expected?: No
Validation: -

1.31. Abdominal circumference

Definition: The abdominal circumference of the child in centimetres.

Reason: Included at the request of those wishing to conduct studies which involve this parameter.

Format: Numerical value (e.g. 53.2).

Units: cm

Abdominal circumference: technical specification

Field Name: ABDOCIRC

Field Type: Numeric

Domain: Units: cm

Example of Format: 53.2

Comment: -

Value expected?: No

Validation: -

2. DIAGNOSES AND PROCEDURES

2.1. Primary diagnosis for this admission - as recorded in notes

Definition: The primary diagnosis for this admission of the child to your unit as assessed and recorded in the child's notes.

The primary diagnosis may only be confirmed during the child's stay on your unit. It may not be obvious at admission. For example a child might be admitted with apnoeas, the diagnosis for this admission is later confirmed as Bronchiolitis. In this case Bronchiolitis should be recorded as the Primary diagnosis for this admission.

Where there are multiple diagnoses, select just one as a primary diagnosis and code the others as 'Other reasons for admission to your unit'.

Do not code the primary diagnosis for this admission to your unit as a procedure or a cause – code the underlying condition that required that procedure.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Free text (optional) description of primary diagnosis for admission given in notes.

Primary diagnosis for this admission - as recorded in the notes: technical specification

Field Name:	<i>PRIMDIAGNOTES</i>
Field Type:	<i>Character, size 255</i>
Domain:	<i>Free text</i>
Example of Format:	<i>Bronchiolitis</i>
Comment:	<i>-</i>
Value expected?:	<i>Optional</i>
Validation:	<i>-</i>

2.2. Primary diagnosis for this admission - clinical code

Definition: The clinical code for the primary diagnosis for this admission of the child to your unit as assessed and recorded in the child's notes.

The primary diagnosis may only be confirmed during the child's stay on your unit. It may not be obvious at admission. For example a child might be admitted with apnoeas, the diagnosis for this admission is later confirmed as Bronchiolitis. In this case Bronchiolitis should be recorded and coded for as the Primary diagnosis for this admission.

Where there are multiple diagnoses, select just one as a primary diagnosis and code the others as 'Other reasons for admission to your unit'.

Do not code the primary diagnosis for this admission to your unit as a procedure or a cause – code the underlying condition that required that procedure.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Clinical code selected from lookup table - see section on revised PICANet clinical coding method

Primary diagnosis for this admission – clinical code: technical specification

Field Name: PRIMDIAG
Field Type: Character, size 5
Domain: Codes: PICANet clinical coding method
Example of Format: X100C
Comment: -
Value expected?: Yes
Validation: -

2.3. Other reason for admission to your unit - as recorded in notes

Definition: Other reasons for the admission of the child to your unit as assessed and recorded at admission.

Other reasons for admission may include additional diagnoses or procedures that may or may not necessitate intensive care.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Free text (optional) description of other reasons for admission given in notes.

Other reason for admission to your unit - as recorded in the notes: technical specification

Field Name: OTHDIAGNOTES
Field Type: Character, size 255
Domain: Free text
Example of Format: Partially obstructed airway
Comment: -
Value expected?: No
Validation: N/A

2.4. Other reasons for admission to your unit - clinical code

Definition: The clinical code(s) for the other reasons for the admission of the child to your unit as assessed and recorded at admission.

Other reasons for admission may include additional diagnoses or procedures that may or may not necessitate intensive care.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Clinical code selected from lookup table - see section on revised PICANet clinical coding method

Other reasons for admission to your unit - clinical code: technical specification

Field Name:	OTHDIAG
Field Type:	Character, size 5
Domain:	Codes: PICANet clinical coding method
Example of Format:	X76bB
Comment:	Clinical code selected from lookup table - see section on revised PICANet clinical coding method
Value expected?:	No, unless Other reasons for admission to your unit - as recorded in the notes (OTHDIAGNOTES) contains text.
Validation:	-

2.5. Operations and / or procedures performed during this admission - as recorded in notes

Definition: Any operations and / or procedures performed during this admission

e.g. An inguinal hernia repair performed for an inguinal hernia.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Free text (optional) description of operations and / or procedures given in notes.

Operations and / or procedures performed during this admission - as recorded in notes: technical specification

Field Name: *OPPROCNOTES*

Field Type: *Character, size 255*

Domain: *Free text*

Example of Format: *Inguinal hernia repair*

Comment: *-*

Value expected?: *No*

Validation: *N/A*

2.6. *Operation and / or procedures performed during this admission - clinical code*

Definition: The clinical code for any operations and or procedures performed during this admission of the child to your unit as assessed and recorded in the child's notes.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Clinical code selected from lookup table - see section on revised PICANet clinical coding method.

*Operations and or procedures performed during this admission - clinical code:
technical specification*

Field Name: OPPROC

Field Type: Character, size 5

Domain: Codes: PICANet clinical coding method

Example of Format: **X010o**

Comment: -

Value expected?: No, unless Operations and / or procedures performed during this admission - as recorded in notes (OPPROCNOTES) contains text.

Validation: -

2.7. Co-morbidity - as recorded in notes

Definition: Co-morbidity recorded on admission of the child to your unit.

Identifies other problems the child had prior to admission to your unit, which may not be related to the reason for admission. Co-morbidity relates to any underlying condition recorded in the notes.

Reason: Required for clinical audit, epidemiological analysis and assessment of health services delivery.

Format: Free text (optional) description of co-morbidity given in notes.

Co-morbidity - as recorded in notes: technical specification

Field Name: COMNOTES
Field Type: Character, size 255
Domain: Free text
Example of Format: Cystic fibrosis
Comment: -
Value expected?: No
Validation: N/A

2.8. Co-morbidity - clinical code

- Definition:** The clinical code(s) for other syndromes, diseases or abnormalities that the child might have on admission to your unit.
- Reason:** Required for clinical audit, epidemiological analysis and assessment of health services delivery.
- Format:** Select text from choices presented: clinical code returned to database **OR** add new code from NHS Clinical Terms Browser - see section on the PICANet clinical coding method.
-

Co-morbidity - clinical code: technical specification

Field Name:	COMDIAG
Field Type:	Character, size 5
Domain:	Codes: PICANet clinical coding method
Example of Format:	C370.
Comment:	Selected from the 'picklist' of available codes or selected from the NHS Clinical Terms Browser and input using the new code facility provided.
Value expected?:	No, unless Co-morbidity - as recorded in the notes (COMNOTES) contains text.
Validation:	-

3. PIM / PIM2 – MEDICAL HISTORY

3.1. Evidence available to assess past medical history

Definition: Identifies whether or not evidence was available around the time of admission to assess medical history.

Evidence may be obtained from in or out-patient hospital notes, GP notes, or information from the child (if able), child's family/friends/relatives or any other responsible adult.

Reason: Important data to confirm whether evidence is available to assess medical history.

Acts as a filter for further data entry.

Format: Choose from one of the following:

Yes
No
NK

Evidence available to assess medical history: technical specification

Field Name: MEDHISTEVID

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: *If No or NK are entered the medical history options that follow will not be displayed.*

Value expected?: Yes

Validation: -

3.2. Cardiac arrest preceding ICU admission

Definition: Identifies whether the child has had a cardiac arrest before admission to intensive care.

Include both in-hospital and out-of-hospital arrests.

Requires either documented absent pulse or the requirement for external cardiac compression.

Do not include past history of cardiac arrest

Reason: Cardiac arrest preceding admission to intensive care is weighted in PIM/PIM2.

Format: Tick if child has a cardiac arrest preceding admission to intensive care.

Cardiac arrest preceding ICU admission: technical specification

Field Name: PRECEDCPR
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.3. Cardiac arrest OUT of hospital

Definition:	Identifies whether the child has had a cardiac arrest before admission to hospital. Only relates to out-of-hospital cardiac arrests. Requires either documented absent pulse or the requirement for external cardiac compression. Do not include past history of cardiac arrest
Reason:	Cardiac arrest preceding admission to hospital is weighted in PIM/PIM2.
Format:	Tick if child has a cardiac arrest prior to hospital admission.

Cardiac arrest OUT of hospital: technical specification

Field Name: PRECEHOSPCARDARR

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: N/A – default is No

Validation: N/A

3.4. Cardiomyopathy or myocarditis

Definition: Cardiomyopathy or myocarditis refers to a documented diagnosis of cardiomyopathy or myocarditis relevant to the period one month before or at first contact with your unit doctor.

First contact with your unit doctor refers to face-to-face contact and may occur at admission to your unit or prior to admission (e.g. on a ward in your hospital or in another hospital, when the decision to start intensive care is made).

If cardiomyopathy or myocarditis only develop subsequently following admission to your unit and are not present at admission then answer **NO**.

Impaired cardiac function associated with sepsis or surgery should **NOT** be recorded as cardiomyopathy.

Descriptions of poor ventricular function alone, whether based upon haemodynamic or invasive pressure measurement, or during real time imaging are **NOT** sufficient evidence of cardiomyopathy.

Echocardiographic appearances of endocardial fibroelastosis in addition to evidence of poor ventricular function (echocardiographic or otherwise) are sufficient evidence of cardiomyopathy.

Reason: Cardiomyopathy and myocarditis are weighted in PIM/PIM2.

Format: Tick if present.

Cardiomyopathy or myocarditis: technical specification

Field Name: CARDIOMYOCARDITIS

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: N/A – default is No

Validation: N/A

3.5. Admitted following cardiac bypass

Definition: Identifies whether the child has been admitted after having undergone cardiac bypass immediately prior to their admission to your unit.

Reason: Cardiac bypass is weighted in PIM/PIM2.

Format: Tick if child has had cardiac bypass prior to this admission.

Admitted following cardiac bypass: technical specification

Field Name: CARDIACBYP
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.6. Severe combined immune deficiency syndrome (SCIDS)

Definition: Identifies whether the child has a diagnosis of severe combined immune deficiency syndrome documented in the case notes prior to or at admission to your unit.

Patients who have severe combined immune deficiency syndrome, who have had a successful bone marrow transplant following which they have been discharged home, are still regarded as having severe combined immune deficiency syndrome.

Reason: Severe combined immune deficiency syndrome is weighted in PIM/PIM2.

Format: Tick if present.

Severe combined immune deficiency syndrome: technical specification

Field Name: SEVCOMBIMMUNE
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.7. Spontaneous cerebral haemorrhage

Definition: Identifies whether the child has a spontaneous cerebral haemorrhage from an aneurysm or AV malformation documented in the case notes prior to or at admission to your unit.

Cerebral haemorrhage should be the cause of or be associated with the intensive care admission, which would normally mean it had occurred within 48 hours prior to the intensive care admission.

A cerebral haemorrhage associated with intracranial bleeding as a result of trauma should not be recorded as spontaneous cerebral haemorrhage.

Reason: Spontaneous cerebral haemorrhage from aneurysm or AV malformation is weighted in PIM/PIM2.

Format: Tick if present.

Spontaneous cerebral haemorrhage: technical specification

Field Name: SPONTCEREBHAEM

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: N/A – default is No

Validation: N/A

3.8. Hypoplastic left heart syndrome

Definition: Identifies whether the child has hypoplastic left heart syndrome documented in the case notes prior to or at admission to your unit.

Patients who have previously survived to discharge home after surgical repair of hypoplastic left heart syndrome are still included.

Patients with similar diagnosis who are not documented as having hypoplastic left heart syndrome are excluded. This includes critical aortic stenosis, mitral atresia, Schones complex and coarctation.

Hypoplastic left ventricle is not synonymous with hypoplastic left heart syndrome unless there is also documented ventriculo-arterial concordance.

Reason: Hypoplastic left heart syndrome is weighted in PIM/PIM2.

Format: Tick if present.

Hypoplastic left heart syndrome: technical specification

Field Name: HYPOPLAS
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.9. Neurodegenerative disorder

Definition: Identifies whether the child has a neurodegenerative disorder documented in the case notes prior to or at admission to your unit.

A neurodegenerative disorder is a disease that leads to a progressive deterioration of neurological function with loss of speech, vision, hearing or locomotion. It is often associated with seizures, feeding difficulties and impairment of intellect.

A static disability should **NOT** be recorded as a neurodegenerative disorder (even if it is severe) unless there is progressive ongoing loss of milestones.

Reason: A neurodegenerative disorder is weighted in PIM/PIM2.

Format: Tick if present.

Neurodegenerative disorder: technical specification

Field Name: NEUROGENDIS
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.10. Leukaemia or lymphoma after completion of 1st induction

Definition: Identifies whether the child has leukaemia or lymphoma for which induction has been received irrespective of current presumed state of immunity or remission.

Reason: Leukaemia or lymphoma after completion of 1st induction is weighted in PIM/PIM2.

Format: Tick if present.

Leukaemia or lymphoma after completion of 1st induction: technical specification

Field Name: LEUKLYMPH1ST

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: N/A – default is No

Validation: N/A

3.11. Severe developmental delay

Definition: Identifies whether the child has severe developmental delay documented in the case notes prior to or at admission to your unit.

Severe developmental delay must be sufficient to suggest that the IQ would, if it were or could be tested, be less than 35. Normally Down's Syndrome children achieve above this level.

Severe developmental delay is a non-progressive impediment to normal behavioural, neurological or educational development.

Reason: Severe developmental delay is weighted in PIM/PIM2.

Format: Tick if present.

Severe developmental delay: technical specification

Field Name: SEVDEVDELAY
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.12. *Liver failure as primary reason for admission*

Definition:	Identifies whether the child has acute or chronic liver failure as the primary reason for admission to your unit. Include patients admitted for recovery following liver transplantation for acute or chronic liver failure.
Reason:	Liver failure as the primary reason for admission to your unit is weighted in PIM/PIM2.
Format:	Tick if child is admitted with acute or chronic liver failure as the primary reason for their admission.

Liver failure as primary reason for admission: technical specification

Field Name: LIVERFAIL
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

3.13. *Human immunodeficiency virus (HIV)*

Definition: Identifies whether the child is HIV antigen positive as documented in the case notes prior to or at admission to your unit.

Reason: The presence of HIV infection is weighted in PIM/PIM2.

Format: Tick if present.

Human immunodeficiency virus (HIV): technical specification

Field Name: HIV

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: N/A – default is No

Validation: N/A

4. PIM / PIM2 – REASON FOR ADMISSION

4.1. Elective admission

Definition: Identifies whether the child is an elective admission to your unit.

Elective admission includes after elective surgery, or an admission for an elective procedure (e.g. insertion of a central line), or elective monitoring or review of home ventilation.

An admission to PICU is considered elective if it could be postponed for more than 6 hours without adverse effects (note: this definition is taken from PIM2 and is less stringent than the PICANet definition of a planned admission (section 1.21) where an admission is only regarded as planned if it could be delayed for more than 24 hours).

Reason: Elective admissions are weighted in PIM/PIM2.

Format: Tick if child is an elective admission.

Elective admission: technical specification

Field Name: ELECTIVEAD
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

4.2. Main reason for this PICU admission

- Definition:** Identifies whether the child has been admitted to your unit with either: Asthma, Bronchiolitis, Croup, Obstructive sleep apnoea, Diabetic ketoacidosis or Recovery from surgery as the main reason for admission to your unit.
- Reason:** These diagnoses are weighted in PIM/ PIM2 if they are the main reason for the admission
- Format:** Choose from one of the following:
- None of the conditions below
 - Asthma
 - Bronchiolitis
 - Croup
 - Obstructive sleep apnoea
 - Diabetic Ketoacidosis
 - Recovery from surgery
 - NK
-

Main reason for this PICU admission: technical specification

Field Name: PRIMREASON

Field Type: Numeric

Domain: Codes: 0 None of the conditions below (default)
1 Asthma
2 Bronchiolitis
3 Croup
4 Obstructive sleep apnoea
5 Diabetic ketoacidosis
6 Recovery from surgery
9 NK

Example of Format: 1

Comment: -

Value expected?: N/A – default is No

Validation: N/A

5. PIM / PIM2 – PHYSIOLOGY

5.1. Systolic blood pressure

Definition: The **first** systolic blood pressure measured and recorded within the period from the time of first contact with your unit doctor to one hour after admission to your unit.

First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).

Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.

Systolic blood pressure values are included irrespective of the measurement method used or the site.

Where systolic blood pressure was measured, but was unrecordable, enter the value 0.

Reason: Systolic blood pressure at first contact with your unit doctor is weighted in PIM/PIM2.

Format: Numerical value (e.g. 130).

Units: mmHg.

Expected range: 20 – 180; validation check if range exceeds 200.

Systolic blood pressure: technical specification

Field Name:	<i>BPSYS</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Units: mmHg</i>
Units:	<i>mmHg</i>
Example of Format:	<i>130</i>
Comment:	<i>Values less than 30 (other than 0) and over 200 mmHg would be queried once received centrally.</i>
Value expected?:	<i>Yes</i>
Validation:	<i>Systolic blood pressure (BPSYS) should be less than or equal to 200 mmHg.</i>

5.2. Blood gas in 1st hour

Definition: Confirmation that results from a blood gas taken and analysed within the first hour of contact with an intensive care doctor or up to one hour post-admission are available.

Reason: Acts as a filter for further data entry.

Blood gas results are weighted in PIM/PIM2.

Format: Choose from one of the following

Yes

No

NK

Blood gas in 1st hour: technical specification

Field Name: GASFIRSTHR

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: *If No is entered, those fields dependent on a blood gas (PaO₂ (PAO2KPA) / (PAO2HG), FiO₂ (FIO2) and Base excess (BASEEXCESS)) will not be displayed.*

Value expected?: Yes

Validation: N/A

5.3. PaO₂: Oxygen pressure (kPa)

Definition: The **first** PaO₂ measured and recorded within the period from the time of first contact with your unit doctor to one hour after admission to your unit.

First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).

Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.

Only arterial blood gas measurements are acceptable.

Reason: PaO₂ (and associated FiO₂) at first contact with your unit doctor is weighted in PIM/PIM2 if oxygen is delivered via an ET tube or a head box.

Format: Numerical value (e.g. 9).

Units: kPa.

Expected range: 3 – 60; validation check if range falls outside 1 – 70.

PaO₂: Oxygen pressure (kPa): technical specification

Field Name:	<i>PAO2KPA</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Units: kPa</i>
Units:	<i>kPa</i>
Example of Format:	<i>9</i>
Comment:	<i>-</i>
Value expected?:	<i>Yes, if PaO₂: Oxygen pressure (mmHg) (PAO2HG) is null.</i>
Validation:	<i>PaO₂: Oxygen pressure (kPa) (PAO2KPA) should be between 1 - 70 kPa.</i>

5.4. PaO₂: Oxygen pressure (mmHg)

Definition:	<p>The first PaO₂ measured and recorded within the period from the time of first contact with your unit doctor to one hour after admission to your unit.</p> <p>First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).</p> <p>Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.</p> <p>Only arterial blood gas measurements are acceptable.</p>
Reason:	<p>PaO₂ (and associated FiO₂) at first contact with your unit doctor is weighted in PIM/PIM2 if oxygen is delivered via an ET tube or a head box.</p>
Format:	<p>Numerical value (e.g. 67.5).</p> <p>Units: mmHg.</p>
Expected range:	<p>22 – 450; validation check if range falls outside 7.5 – 525.</p>

PaO₂: Oxygen pressure (mmHg): technical specification

Field Name:	PAO2HG
Field Type:	Numeric
Domain:	Units: mmHg
Units:	mmHg
Example of Format:	67.5
Comment:	-
Value expected?:	Yes, if PaO ₂ : Oxygen pressure (kPa) (PAO2KPA) is null.
Validation:	PaO ₂ : Oxygen pressure (mmHg) (PAO2HG) should be between 7.5 - 525 mmHg.

5.5. FiO_2 at time of PaO_2 sample (oxygen inspired)

Definition: The FiO_2 associated with the **first** PaO_2 measured and recorded within the period from the time of first contact with your unit doctor to one hour after admission to your unit.

First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).

Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.

PaO_2 and FiO_2 should be recorded from the same arterial blood gas.

Only arterial blood gas measurements are acceptable.

Reason: PaO_2 and associated FiO_2 at first contact with your unit doctor are weighted in PIM/PIM2 if oxygen is delivered via an ET tube or a head box.

Format: Numerical value (e.g. 0.4).

Units: Fraction (decimal).

Expected range: 0.18 – 1; validation check if value less than 0.1.

FiO₂ at time of PaO₂ sample (oxygen inspired): technical specification

Field Name: FIO2

Field Type: Numeric

Domain: Units: Fraction (decimal)

Units: Fraction (decimal)

Example of Format: 0.18

Comment: -

Value expected?: Yes

Validation: *FiO₂ at time of PaO₂ sample (oxygen inspired) (FIO2) should be greater than or equal to 0.1.*

5.6. Associated intubation

Definition: Record whether or not the child was intubated at the time of the **first** PaO₂ and associated FiO₂ (measured and recorded within the period from the time of first contact with your unit doctor to one hour after admission to your unit).

First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).

Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.

Intubated is defined as an endotracheal tube, laryngeal mask or tracheostomy in situ.

Reason: PaO₂ and associated FiO₂ at first contact with your unit doctor are weighted in PIM/PIM2 if oxygen is delivered via an ET tube or a head box.

Format: Choose from one of the following:

Yes
No
NK

Associated intubation: technical specification

Field Name: INTUBATION

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: If Yes is entered, then Use of headbox (HEADBOX) will not be displayed.

Value expected?: Yes

Validation: -

5.7. Use of head box

Definition: Record whether or not the child was receiving oxygen via a head box at the time of the **first** PaO₂ and associated FiO₂ (measured and recorded within the period from the time of first contact with your unit doctor to one hour after admission to your unit).

First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).

Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.

Reason: PaO₂ and associated FiO₂ at first contact with your unit doctor are weighted in PIM/PIM2 if oxygen is delivered via an ET tube or a head box.

Format: Choose from one of the following:

Yes
No
NK

Use of head box: technical specification

Field Name: HEADBOX

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: *If Yes is entered, then Associated intubation (INTUBATION) will not be displayed.*

Value expected?: Yes

Validation: -

5.8. Base excess in arterial or capillary blood

Definition:	<p>The first base excess value measured and recorded from the arterial or capillary blood gas within the period from the time of first face-to-face contact with your unit doctor to one hour after admission to your unit.</p> <p>First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).</p> <p>Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.</p> <p>Manually calculated in vitro or in vivo base excess values are not accepted.</p>
Reason:	Base excess at first contact with your unit doctor is weighted in PIM/PIM2.
Format:	<p>Numerical value (e.g. 6).</p> <p>Indicate + or -.</p> <p>Units: mmol per litre.</p>
Expected range:	-30 to +20; validation check if range outside -40 to +30.

Base excess in arterial or capillary blood: technical specification

Field Name:	BASEEXCESS
Field Type:	Numeric
Domain:	Units: mmol per litre
Units:	mmol per litre
Example of Format:	6
Comment:	-
Value expected?:	Yes
Validation:	Base excess in arterial or capillary blood (BASEEXCESS) should be between -40 and $+30$ mmol l^{-1} .

5.9. Pupillary reaction

Definition: The **first** observed pupillary reaction measured and recorded within the period from the time of first face-to-face contact with your unit doctor to one hour after admission to your unit.

First contact with your unit doctor refers to first face-to-face contact and may occur at admission to your unit or prior to admission (e.g. within your hospital on a ward or in another hospital on retrieval).

Data that are available to your unit doctor at first contact that are current at that time are acceptable. In cases of doubt record the earliest measurement that was current at time of first contact.

Only record as Both fixed and dilated if both pupils are greater than 3mm and both are fixed.

Pupil reactions are used as an index of brain function. Do not record a pupil reaction as being fixed if it is due to toxins, drugs, a local injury to the eye or chronically altered from a previous disease.

Pupil reaction must be assessed by exposure to strong direct light.

Reason: Pupil reaction at first contact with your unit doctor is weighted in PIM/PIM2.

Format: Choose from one of the following:

Both fixed and dilated
Other reaction
NK

Pupillary reaction: technical specification

Field Name: PUPREACT

Field Type: Numeric

Domain: Codes: 1 Both fixed and dilated
2 Other reaction
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

5.10. Mechanical ventilation during 1st hour on your unit

Definition: Specifies whether mechanical ventilation was administered at any time during the first hour of admission to your unit.

Ventilation is defined as where all or some of the breaths, or a portion of the breaths (pressure support) are delivered by a mechanical device. Ventilation can simply be defined as a treatment where some or all of the energy required to increase lung volume during inspiration is supplied by a mechanical device.

High frequency, jet ventilators, negative pressure ventilators and BiPAP are all considered as mechanical ventilation.

CPAP, ECMO and IVOX are **not** considered as mechanical ventilation, however most patients on ECMO and IVOX are usually also being ventilated.

Reason: Mechanical ventilation during the first hour of admission to your unit is weighted in PIM/PIM2.

Format: Choose from one of the following:

Yes
No
NK

Mechanical ventilation during 1st hour on your unit: technical specification

Field Name: MECHVENT
Field Type: Numeric
Domain: Codes: 1 Yes
 2 No
 9 NK
Example of Format: 1
Comment: -
Value expected?: Yes
Validation: -

5.11. CPAP during 1st hour on your unit

Definition: Identifies whether the child receives CPAP during the first hour on your unit.

CPAP may be given by via an endotracheal tube, tracheostomy, facial CPAP mask or nasal CPAP mask / prongs.

Reason: CPAP given during the first hour on your unit is weighted in PIM/PIM2.

Format: Tick if child receives CPAP during the first hour on your unit.

CPAP during the 1st hour on your unit: technical specification

Field Name: CPAPFIRSTHR
Field Type: Numeric
Domain: Codes: 0 No (default)
1 Yes
Example of Format: 1
Comment: -
Value expected?: N/A – default is No
Validation: N/A

6. INTERVENTION RECORD

Clarification on interaction between variables in this section and variables in the Daily Interventions section

If the Paediatric Critical Care Minimum Dataset (PCCMDS) is being collected and entered, then the following summary variables in this section are calculated:

Invasive ventilation
Invasive ventilation: days
Non-invasive ventilation
Non-invasive ventilation: days
Extra corporeal membrane oxygenation (ECMO)
IV vasoactive drug therapy
Left ventricular assist device (LVAD)
Intracranial pressure device
Intracranial pressure device (ventricular drain)
Intracranial pressure device (ICP bolt)
Renal support
Renal support: haemofiltration
Renal support: haemodialysis
Renal support: plasmafiltration
Renal support: plasma exchange
Renal support: peritoneal dialysis

If you enter or import any of the above variables and subsequently enter any daily interventions data in the same category, the summary variable will be overwritten with the calculated value, e.g. if you enter **Haemofiltration** for three days in the daily interventions section then the variable **Renal support: haemofiltration** will be overwritten with 3.

The following variables are not affected:

Tracheostomy
Clinical trial
Clinical trial name

Note: we refer in the intervention record to a tracheostomy performed during this admission to PICU and this will be recorded in addition to a (potentially) pre-existing tracheostomy cared for by nursing staff in the daily interventions section.

6.1. Invasive ventilation

Definition:	<p>Specifies whether the admission received invasive ventilatory support at any time during their stay on your unit.</p> <p>Invasive ventilatory support is defined as any method of ventilation delivered via an endotracheal tube, laryngeal mask or tracheostomy. Examples include SIMV, BiPAP, CPAP, HFOV (oscillation), Jet ventilation and IPPV.</p>
Reason:	<p>Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.</p>
Format:	<p>Choose from one of the following:</p> <ul style="list-style-type: none">YesNoNK

Invasive ventilation: technical specification

Field Name: INVVENT
Field Type: Numeric
Domain: Codes: 1 Yes
 2 No
 9 NK
Example of Format: 1
Comment: -
Value expected?: Yes
Validation: -

6.2. Invasive ventilation: days

Definition: Specifies the total number of days the admission received invasive ventilation during their stay on your unit.

Invasive ventilatory support is defined as **any method of ventilation delivered via an endotracheal tube, laryngeal mask or tracheostomy**. Examples include SIMV, BiPAP, CPAP, HFOV (oscillation), Jet ventilation and IPPV.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Numerical value (e.g. 3).

Units: Day(s).

Any part of period from midnight – midnight counts as 1 day.

Worked example:

Admitted 01.10.02 @ 23.00 (receiving invasive ventilation)
Invasive ventilation stopped 03.10.02 @ 02.00

Total number of days would be 3.

Invasive ventilation: days: technical specification

Field Name: INVVENTDAY

Field Type: Numeric

Domain: Units: day

Units: Day

Example of Format: 3

Comment: -

Value expected?: Yes, if Invasive ventilation (INVVENT) equals Yes.

Validation: -

6.3. Non-invasive ventilation

Definition: Specifies whether the admission received non-invasive ventilatory support at any time during their stay on your unit.

Non-invasive ventilatory support is defined as any method of ventilation NOT given via an endotracheal tube, laryngeal mask or tracheostomy. Non invasive ventilation would include nasal prong or nasal / facial mask CPAP, nasal or facial BiPAP or negative pressure ventilation.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Choose from one of the following:

Yes
No
NK

Non-invasive ventilation: technical specification

Field Name: NONINVVENT

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

6.4. Non-invasive ventilation: days

Definition: Specifies the total number of days the admission received non-invasive ventilation during their stay on your unit.

Non-invasive ventilatory support is defined as any method of ventilation NOT given via an endotracheal tube, laryngeal mask or tracheostomy. Non invasive ventilation would include nasal prong or nasal / facial mask CPAP, nasal or facial BiPAP or negative pressure ventilation.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Numerical value (e.g. 3).

Units: Day(s).

Any part of period from midnight – midnight counts as 1 day.

Worked example:

Admitted 01.10.02 @ 23.00 (receiving non-invasive ventilation)

Non-invasive ventilation stopped 03.10.02 @ 02.00

Total number of days would be 3.

Non-invasive ventilation: days: technical specification

Field Name: NONINVVENTDAY
Field Type: Numeric
Domain: Units: day
Units: Day
Example of Format: 3
Comment: -
Value expected?: Yes, if Non-invasive ventilation (NONINVVENT) equals Yes.
Validation: -

6.5. Tracheostomy

Definition: Specifies whether the child had a tracheostomy performed during their admission to your unit.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Choose from one of the following:

Yes
No
NK

Tracheostomy: technical specification

Field Name: INTRACHEOSTOMY

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

6.6. Extra corporeal membrane oxygenation (ECMO)

Definition: Specifies whether the admission received ECMO therapy at any time during their admission to your unit.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Choose from one of the following:

Yes
No
NK

Extra corporeal membrane oxygenation (ECMO): technical specification

Field Name: ECMO

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

6.7. IV vasoactive drug therapy

Definition: Specifies whether the admission received IV vasoactive drug therapy at any time during their admission to your unit.

IV vasoactive drugs could include Dobutamine, Dopamine, Adrenaline, Noradrenaline, Vasopressin and Milrinone (this list is not exhaustive: please ask a doctor or nurse if you are unsure whether the child has received IV vasoactive drug therapy).

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Choose from one of the following:

Yes
No
NK

IV vasoactive drug therapy: technical specification

Field Name: VASOACTIVE
Field Type: *Numeric*
Domain: Codes: 1 Yes
2 No
9 NK
Example of Format: 1
Comment: -
Value expected?: Yes
Validation: -

6.8. Left ventricular assist device (LVAD)

Definition: Specifies whether the admission received LVAD therapy at any time during their admission to your unit.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Choose from one of the following:

Yes
No
NK

Left ventricular assist device (LVAD): technical specification.

Field Name: LVAD
Field Type: Numeric
Domain: Codes: 1 Yes
2 No
9 NK
Example of Format: 1
Comment: -
Value expected?: Yes
Validation: -

6.9. Intracranial pressure device

Definition: Indicates whether an ICP device was used.

Reason: Logical filter for ventricular drain or ICP bolt.

Format: Choose from one of the following:

Yes

No

NK

Intracranial pressure device: technical specification

Field Name: ICPDEVICE
Field Type: Numeric
Domain: Codes: 1 Yes
2 No
9 NK
Example of Format: 1
Comment: -
Value expected?: Yes
Validation: N/A

6.10. Intracranial pressure device (ventricular drain)

- Definition:** Specifies whether the child had a ventricular drain inserted at any time during their admission to your unit.
- Reason:** Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
- Format:** Tick if child has a ventricular drain inserted.
-

Intracranial pressure device (ventricular drain): technical specification

Field Name: ICPVD

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Intracranial pressure device (ICPDEVICE) equals Yes and Intracranial pressure device (ICP bolt) (ICPBOLT) equals No.

Validation: -

6.11. Intracranial pressure device (ICP bolt)

Definition:	Specifies whether the child had an ICP bolt inserted at any time during their admission to your unit.
Reason:	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Format:	Tick if child has an ICP bolt inserted.

Intracranial pressure device (ICP bolt): technical specification

Field Name: ICPBOLT

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Intracranial pressure device (ICPDEVICE) equals Yes and Intracranial pressure device (ventricular drain) (ICPVD) equals No.

Validation: -

6.12. Renal support

Definition: Indicates whether renal support was provided.

Reason: Logical filter for renal support variables.

Format: Choose from one of the following:

Yes
No
NK

Renal support: technical specification

Field Name: RENALSUPPORT

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: N/A

6.13. Renal support: haemofiltration

Definition: Specifies whether the admission received renal therapy support **in terms of haemofiltration** at any time during their admission to your unit.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Tick if child is receiving haemofiltration.

Renal support: haemofiltration: technical specification

Field Name: RENALHAEMFIL

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Renal support (RENALSUPPORT) equals Yes and all other renal options (RENALHAEMDIA, RENALPLASFILT, RENALPLASEXCH & RENALPERIDIA) equal No.

Validation: -

6.14. Renal support: haemodialysis

- Definition:** Specifies whether the admission received renal therapy support **in terms of haemodialysis** at any time during their admission to your unit.
- Reason:** Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
- Format:** Tick if child is receiving haemodialysis.
-

Renal support: haemodialysis: technical specification

Field Name: RENALHAEMDIA

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Renal support (RENALSUPPORT) equals Yes and all other renal options (RENALHAEMFIL, RENALPLASFILT, RENALPLASEXCH & RENALPERIDIA) equal No.

Validation: -

6.15. Renal support: plasmafiltration

- Definition:** Specifies whether the admission received renal therapy support **in terms of plasmafiltration** at any time during their admission to your unit.
- Reason:** Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
- Format:** Tick if child is receiving plasmafiltration
-

Renal support: plasmafiltration: technical specification

Field Name: RENALPLASFILT

Field Type: Numeric

Domain: Code: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Renal support (RENALSUPPORT) equals Yes and all other renal options (RENALHAEMDIA, RENALHAEMFIL, RENALPLASEXCH & RENALPERIDIA) equal No.

Validation: -

6.16. Renal support: plasma exchange

Definition: Specifies whether the admission received renal therapy support **in terms of plasma exchange** at any time during their admission to your unit.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Tick if child has plasma exchange.

Renal support: plasma exchange: technical specification

Field Name: RENALPLASEXCH

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Renal support (RENALSUPPORT) equals Yes and all other renal options (RENALHAEMDIA, RENALHAEMFIL, RENALPLASFILT & RENALPERIDIA) equal No.

Validation: -

6.17. Renal support: peritoneal dialysis

Definition: Specifies whether the admission received renal therapy support **in terms of peritoneal dialysis** at any time during their admission to your unit.

Reason: Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.

Format: Tick if child has peritoneal dialysis performed.

Renal support: peritoneal dialysis: technical specification

Field Name: RENALPERIDIA

Field Type: Numeric

Domain: Codes: 0 No (default)
1 Yes

Example of Format: 1

Comment: -

Value expected?: Yes expected if Renal support (RENALSUPPORT) equals Yes and all other renal options (RENALHAEMDIA, RENALHAEMFIL, RENALPLASFILT & RENALPLASEXCH) equal No.

Validation: -

Definition:	Specifies whether the child is part of a clinical trial.
Reason:	Prior inclusion on a clinical trial may influence subsequent outcome. Required for epidemiological analysis and assessment of health services delivery.
Format:	Choose from one of the following: Yes No NK

Clinical trial: technical specification

Field Name: CLINTRIAL

Field Type: Numeric

Domain: Codes: 1 Yes
2 No
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

6.19. Clinical trial name

Definition:	The name of the clinical trial the child is participating in.
Reason:	Prior inclusion on a clinical trial may influence subsequent outcome. Required for epidemiological analysis and assessment of health services delivery.
Format:	Free text name of clinical trial.

Clinical trial name: technical specification

Field Name: CLINTRIALNAME

Field Type: Character, size 255

Domain: Free text

Example of Format: CHIP

Comment: -

Value expected?: Yes expected if Clinical trial (CLINTRIAL) equals Yes.

Validation: -

7. DISCHARGE

7.1. Status at discharge from your unit

Definition: Identifies the status (alive or dead) of the child on discharge from your unit.

Dead includes admissions who leave your unit to become heart beating organ donors.

Reason: Identified as one of the principal outcomes of paediatric intensive care.

Required for epidemiological analysis and assessment of health services delivery.

Format: Choose from one of the following:

Alive
Dead

Status at discharge from your unit: technical specification

Field Name: UNITDISSTATUS

Field Type: Numeric

Format: Codes: 1 Alive
2 Dead

Example of Format: 1

Comment: -

Value expected?: Yes

Validation: -

7.2. Discharged for palliative care

Definition: Identifies if the child was discharged from your unit to a palliative care area.

Discharge for palliative care is defined as withdrawal of care at the current level from which it is deemed that the admission can no longer benefit.

Reason: Important information to supplement status at discharge from your unit.

Format: Choose from one of the following:

Yes
No
NK

Discharged for palliative care: technical specification

Field Name: DISPALCARE

Field Type: Numeric

Domain: Codes: 1 Yes
2 No (default if discharged alive)
9 NK

Example of Format: 2

Comment: If Status at discharge from your unit (UNITDISSTATUS) is recorded as Alive, then Discharged for palliative care (DISPALCARE) is set to No, although the user has the ability to change this.

Value expected?: Yes, if Status at discharge from your unit (UNITDISSTATUS) equals Alive.

Validation: -

7.3. Date of discharge from your unit

Definition:	Identifies the date the child was discharged from your unit. Discharge from your unit is defined as the physical discharge and recording of that discharge from a bed or cot in your unit. Discharge does not include temporary transfer from your unit (e.g. surgery) in the expectation of a return to your unit.
Reason:	Date of admission to your unit, Time of admission to your unit, Date of discharge from your unit and Time of discharge from your unit (or Date of death and Time of death) are used to calculate total length of stay on your unit.
Format:	Date; dd/mm/yyyy.

Date of discharge from your unit: technical specification

Field Name: UNITDISDATE

Field Type: Date/Time

Domain: Date; dd/mm/yyyy

Example of Format: 28/08/2002

Comment: -

Value expected?: Yes

Validation: Valid date check.

Date of discharge from your unit (UNITDISDATE) should be later than or equal to the Date of admission to your unit (ADDATE).

Date of discharge from your unit (UNITDISDATE) should be later than or equal to the Date of birth (DOB).

7.4. Time of discharge from your unit

Definition:	Identifies the time that the child was discharged from your unit. Discharge from your unit is defined as the physical discharge and recording of that discharge from a bed or cot in your unit. Discharge does not include temporary transfer from your unit (e.g. surgery) in the expectation of a return to your unit.
Reason:	Date of admission to your unit, Time of admission to your unit, Date of discharge from your unit and Time of discharge from your unit (or Date of death and Time of death) are used to calculate total length of stay on your unit.
Format:	Time (24 hour clock); hh:mm.

Time of discharge from your unit: technical specification

Field Name: UNITDISTIME

Field Type: *Date/Time*

Domain: *Time (24 hour clock); hh:mm*

Example of Format: 02:45

Comment: -

Value expected?: Yes

Validation: *Valid time check.*

Time of discharge from your unit (UNITDISTIME) should be later than Time of admission to your unit (ADTIME) if Date of discharge from your unit (UNITDISDATE) equals Date of admission to your unit (ADDATE).

7.5. Date of death

Definition:	<p>Identifies the date of death if this occurs whilst the child is resident on your unit OR if the date of death is identified at 30 day follow-up.</p> <p>Includes admissions who died whilst physically outside your unit but before being discharged from your unit (e.g. in theatre).</p> <p>For admissions declared brainstem dead, the date of death is the date on which the first test indicates brainstem death (even though death is not pronounced until the second test has been completed).</p> <p>Please note that it is possible in special circumstances for a patient to have a date/time of death before admission.</p>
Reason:	<p>Date of admission to your unit, Time of admission to your unit, Date of discharge from your unit and Time of discharge from your unit (or Date of death and Time of death) are used to calculate total length of stay on your unit.</p> <p>Identified as one of the principal outcomes of paediatric intensive care.</p> <p>Required for epidemiological analysis and assessment of health services delivery.</p>
Format:	<p>Date; dd/mm/yyyy.</p>

Date of death: technical specification

Field Name: DOD

Field Type: *Date/Time*

Domain: *Date; dd/mm/yyyy*

Example of Format: *30/08/2002*

Comment: *If the patient has died on the unit or if they die during the 30 days post discharge, the date will be recorded in a different place on the data collection form but will only appear in one location on the database.*

Please note that it is possible in special circumstances for a patient to have a date/time of death before admission.

Value expected?: *Yes, if Status at discharge from your unit (UNITDISSTATUS) equals Dead, or Status at 30 days post discharge from your unit (FU30DISSTATUS) equals Dead.*

Validation: *Valid time check.*

Date of death (DOD) should be after or equal to Date of birth (DOB) and Date of admission to your unit (ADDATE).

7.6. Time of death

Definition:	<p>Identifies the time of death if this occurs whilst the child is resident on your unit.</p> <p>Includes admissions who died whilst physically outside your unit but before being discharged from your unit (e.g. in theatre).</p> <p>For admissions declared brainstem dead, the time of death is the time when the first test indicates brainstem death (even though death is not pronounced until the second test has been completed).</p> <p>Please note that it is possible in special circumstances for a patient to have a date/time of death before admission.</p>
Reason:	<p>Date of admission to your unit, Time of admission to your unit, Date of discharge from your unit and Time of discharge from your unit (or Date of death and Time of death) are used to calculate total length of stay on your unit.</p> <p>Identified as one of the principal outcomes of paediatric intensive care.</p> <p>Required for clinical audit, epidemiological analysis and assessment of health services delivery.</p>
Format:	<p>Time (24 hour clock); hh:mm.</p>

Time of death: technical specification

Field Name:	TIMEDTH
Field Type:	<i>Date/Time</i>
Domain:	<i>Time (24 hour clock); hh:mm</i>
Example of Format:	10:30
Comment:	<p><i>If the patient has died on the unit or if they die during the 30 days post discharge, the date will be recorded in a different place on the data collection form but will only appear in one location on the database.</i></p> <p><i>Please note that it is possible in special circumstances for a patient to have a date/time of death before admission.</i></p>
Value expected?:	<p><i>Yes, if Status at discharge from your unit (UNITDISSTATUS) equals Dead.</i></p> <p><i>A value is still expected if Status at 30 days post discharge from your unit (FU30DISSTATUS) equals Dead, but it is appreciated that in this case the time of death may not always be available</i></p>
Validation:	<p><i>Valid time check.</i></p> <p><i>Time of death (TIMEDTH) should be later than Time of admission to your unit (ADTIME) if Date of death (DOD) is equal to Date of admission to your unit (ADDATE).</i></p>

7.7. Destination following discharge from your unit

Definition:	Identifies the destination the child was directly discharged to from your unit.
Reason:	Required for epidemiological analysis and assessment of health services delivery.
Format:	Choose from one of the following: Normal residence Hospice Same hospital Other hospital NK

Destination following discharge from your unit: technical specification

Field Name: UNITDISDEST

Field Type: Numeric

Domain: Codes: 1 Normal residence
2 Hospice
3 Same hospital
4 Other hospital
9 NK

Example of Format: 3

Comment: -

Value expected?: Yes, if Status at discharge from your unit (UNITDISSTATUS) equals Alive.

Validation: -

7.8. Destination following discharge from your unit: hospital area

Definition: Identifies the exact destination within either your hospital or another hospital that the child was directly discharged to from your unit.

Reason: Required for epidemiological analysis and assessment of health services delivery.

Format: Choose from one of the following:

ICU
PICU
NICU
HDU
SCBU
Ward
Other
NK

Destination following discharge from your unit: hospital area: technical specification

Field Name: UNITDISDESTHOSP

Field Type: Numeric

Domain: Codes: 1 ICU
2 PICU
3 NICU
4 HDU
5 SCBU
6 Ward
7 Other
9 NK

Example of Format: 3

Comment: The data collection form has separate option boxes for Same hospital or Other hospital but there is only one variable for destination in the database.

Value expected?: Yes, if Destination following discharge from your unit (UNITDISDEST) equals Same hospital or Other hospital.

Validation: -

8. FOLLOW-UP

Follow-up at 30 days post discharge from your unit

Guidance:

It is not necessary to complete this section if Destination following discharge from your unit is Normal residence.

Post discharge follow-up information should only be chased for the 30-day period. For any information not known after this time, the relevant NK boxes can be ticked.

Possible ways of obtaining follow-up information are listed below. We do understand that obtaining this information is not easy, and can be very time consuming, so the list simply offers suggestions.

- Contacting ward staff, either within your hospital or another hospital. This could be done via telephone, e-mail or letter.
- Contacting the medical records department, either within your hospital or another hospital.
- Contacting the child's GP surgery, either by 'phone or in writing.

We do not suggest that you contact the child's family directly.

8.1. Status at 30 days post discharge from your unit

Definition: Identifies the status (alive or dead) of the child 30 days post discharge from your unit.

Reason: Identified as one of the principal outcomes of paediatric intensive care.

Required for epidemiological analysis and assessment of health services delivery. See the guidance notes at the beginning of this section.

Format: Choose from one of the following:

Alive
Dead
NK

Status at 30 days post discharge from your unit: technical specification

Field Name: FU30DISSTATUS

Field Type: Numeric

Format: Codes: 1 Alive
2 Dead
9 NK

Example of Format: 1

Comment: -

Value expected?: Yes, if Status at discharge from your unit (UNITDISSTATUS) equals Alive and if Destination following discharge from your unit (UNITDISDEST) does not equal Normal residence.

Validation: -

8.2. Location at 30 days following discharge from your unit

Definition: Identifies the location of the child 30 days post discharge from your unit.

Reason: Identified as one of the principal outcomes of paediatric intensive care.

Required for epidemiological analysis and assessment of health services delivery.

Format: Choose from one of the following:

Normal residence
Hospice
Same hospital
Other hospital
NK

Location at 30 days following discharge from your unit: technical specification

Field Name: FU30LOCATION

Field Type: Numeric

Domain: Codes: 1 Normal residence
2 Hospice
3 Same hospital
4 Other hospital
9 NK

Example of Format: 3

Comment: -

Value expected?: Yes, if Status at discharge from your unit (UNITDISSTATUS) equal Alive and if Destination following discharge from your unit (UNITDISDEST) does not equal Normal residence.

Validation: -

8.3. Location at 30 days following discharge from your unit: hospital area

Definition:	Identifies the exact destination of the child 30 days post discharge from your unit if they are within your hospital or another hospital.
Reason:	Required for epidemiological analysis and assessment of health services delivery.
Format:	Choose from one of the following: ICU PICU NICU HDU SCBU Ward Other NK

Location at 30 days following discharge from your unit: hospital area: technical specification

Field Name: FU30LOCHOSP

Field Type: Numeric

Domain: Codes: 1 ICU
2 PICU
3 NICU
4 HDU
5 SCBU
6 Ward
7 Other
9 NK

Example of Format: 3

Comment: -

Value expected?: Yes, if Location at 30 days following discharge from your unit (FU30LOCATION) equals Same hospital or Other hospital.

Validation: -

9. ADDITIONAL INFORMATION

Definition: Any additional information considered relevant to the admission.

Text entered in this field may provide extra information about data entered elsewhere in a specific field in the dataset or may provide extra information on the admission, which is not collected as part of the dataset.

No identifiers (patient, nurse, doctor, ICU, hospital) should be included in text data entered into this field.

As there is limited space in this field all text data should be kept to a minimum and be as concise as possible. Text data must not contain any punctuation except a period (full-stop) at the end of each data point.

Reason: No dataset specification covers all eventualities: to deal with this a text field has been included for comments/additional information.

Format: Free text.

Comments: technical specification

Field Name:	<i>Comments</i>
Field Type:	<i>Character, size 255</i>
Domain:	<i>Free text</i>
Example of Format:	<i>Two sisters with same co-morbidity.</i>
Comment:	<i>-</i>
Value expected?:	<i>No</i>
Validation:	<i>-</i>

10. DAILY INTERVENTIONS

Clarification on interaction between variables in this section and variables in the Intervention Record section

If the Paediatric Critical Care Minimum Dataset (PCCMDS) is being collected and entered, then the following summary variables in the Intervention Record section are calculated:

Invasive ventilation
Invasive ventilation: days
Non-invasive ventilation
Non-invasive ventilation: days
Extra corporeal membrane oxygenation (ECMO)
IV vasoactive drug therapy
Left ventricular assist device (LVAD)
Intracranial pressure device
Intracranial pressure device (ventricular drain)
Intracranial pressure device (ICP bolt)
Renal support
Renal support: haemofiltration
Renal support: haemodialysis
Renal support: plasmfiltration
Renal support: plasma exchange
Renal support: peritoneal dialysis

If you enter or import any of the above variables and subsequently enter any daily interventions data in the same category, the summary variable will be overwritten with the calculated value, e.g. if you enter **Haemofiltration** for three days in the daily activity section then the variable **Renal support: haemofiltration** will be overwritten with 3.

The following variables are not affected:

Tracheostomy
Clinical trial
Clinical trial name

Note: we refer in the intervention record to a tracheostomy performed during this admission to PICU and this will be recorded in addition to a (potentially) pre-existing tracheostomy cared for by nursing staff in the daily interventions section.

10.1. Date of critical care activity

Definition:	The date the critical care activity was performed on.
Reason:	Part of the Paediatric Critical Care Minimum Dataset.
Format:	Date; dd/mm/yyyy.

Date of critical care activity: technical specification

Field Name: ACTIVITYDATE

Field Type: Date/Time

Domain: Date; dd/mm/yyyy

Example of Format: 01/10/2007

Comment: -

Value expected?: Yes

Validation: Valid date check.

Activity date (ACTIVITYDATE) should be on or after Date of admission to your unit (ADDATE).

Activity date (ACTIVITYDATE) should be earlier or equal to the Date of discharge from your unit (UNITDISDATE).

10.2. No defined critical care activity

Definition: True if there was no defined critical care activity received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 99)

Format: Tick if true

No defined critical care activity: technical specification

Field Name: NOCRIT

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no other activity should be specified as True for the same Activity date (ACTIVITYDATE).

10.3. Continuous ECG monitoring

Definition: True if continuous ECG monitoring was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 50)

Format: Tick if true

Continuous ECG monitoring: technical specification

Field Name:	ECG
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.4. Continuous pulse oximetry

Definition: True if continuous pulse oximetry was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 73)

Format: Tick if true

Continuous pulse oximetry: technical specification

Field Name:	CPOX
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.5. Invasive ventilation via endotracheal tube

Definition: True if invasive ventilation via endotracheal tube was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 51)

Format: Tick if true

Invasive ventilation via endotracheal tube: technical specification

Field Name: INVVENTET

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.6. Invasive ventilation via tracheostomy tube

Definition: True if invasive ventilation via tracheostomy tube was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 52)

Format: Tick if true

Invasive ventilation via tracheostomy tube: technical specification

Field Name: INVVENTTT

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.7. Non-invasive ventilatory support

Definition: True if non-invasive ventilatory support was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 53)

Format: Tick if true

Non-invasive ventilatory support: technical specification

Field Name:	NIV
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.8. Advanced ventilatory support (jet ventilation)

Definition: True if advanced ventilatory support (jet ventilation) was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 56)

Format: Tick if true

Advanced ventilatory support (jet ventilation): technical specification

Field Name:	AVSJET
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.9. Advanced ventilatory support (oscillatory ventilation)

Definition: True if advanced ventilatory support (oscillatory ventilation) was Tick if activity received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 56)

Format: Tick if true

Advanced ventilatory support (oscillatory ventilation): technical specification

Field Name:	AVSOSC
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p>Date of critical care activity (ACTIVITYDATE) must be specified.</p> <p>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</p>

10.10. Nasopharyngeal airway

Definition: True if a nasopharyngeal airway was in place that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 55)

Format: Tick if true

Nasopharyngeal airway: technical specification

Field Name:	NASO
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.11. Tracheostomy cared for by nursing staff

Definition: True if a tracheostomy was cared for by nursing staff that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 13)

Format: Tick if true

Tracheostomy cared for by nursing staff: technical specification

Field Name:	TRACH
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.12. Supplemental oxygen therapy (irrespective of ventilatory state)

Definition: True if supplemental oxygen therapy (irrespective of ventilatory state) was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 09)

Format: Tick if true

Supplemental oxygen therapy (irrespective of ventilatory state): technical specification

Field Name:	OXTHERAPY
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.13. Upper airway obstruction requiring nebulised epinephrine / adrenaline

Definition:	True if there was an upper airway obstruction requiring nebulised epinephrine / adrenaline that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 57)
Format:	Tick if true

Upper airway obstruction requiring nebulised epinephrine / adrenaline: technical specification

Field Name:	OBSAIR
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.14. Apnoea requiring intervention

Definition: True if there was an apnoea requiring intervention that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 58)

Format: Tick if true

Apnoea requiring intervention: technical specification

Field Name: APNOEA

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.15. Acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser

Definition: True if there was acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 59)

Format: Tick if true

Acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser: technical specification

Field Name: ASTHMAIVBEPH

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.16. Arterial line monitoring

Definition: True if arterial line monitoring was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 60)

Format: Tick if true

Arterial line monitoring: technical specification

Field Name:	ARTLINE
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.17. External pacing

Definition:	True if external pacing was received that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 61)
Format:	Tick if true

External pacing: technical specification

Field Name:	EXTPACE
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.18. Central venous pressure monitoring

Definition: True if central venous pressure monitoring was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 62)

Format: Tick if true

Central venous pressure monitoring: technical specification

Field Name:	CVPMON
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.19. Continuous infusion of inotrope, vasodilator or prostaglandin

Definition: True if there was a continuous infusion of inotrope, vasodilator or prostaglandin that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 06)

Format: Tick if true

Continuous infusion of inotrope, vasodilator or prostaglandin: technical specification

Field Name: *INFINOTROPE*

Field Type: *Numeric*

Domain: *Codes: 0 False (default)
-1 True*

Example of Format: *-1*

Comment: *-*

Value expected?: *Yes*

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.20. Bolus IV fluids (>80 ml/kg/day) in addition to maintenance IV fluids

Definition: True if there were bolus IV fluids (>80 ml/kg/day) in addition to maintenance IV fluids that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 63)

Format: Tick if true

Bolus IV fluids (>80 ml/kg/day) in addition to maintenance IV fluids: technical specification

Field Name:	BOLUS
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.21. Cardio-pulmonary resuscitation

Definition: True if cardio-pulmonary resuscitation was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 64)

Format: Tick if true

Cardio-pulmonary resuscitation: technical specification

Field Name:	CPR
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.22. Extracorporeal membrane oxygenation (ECMO)

Definition: True if extracorporeal membrane oxygenation (ECMO) was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 65)

Format: Tick if true

Extracorporeal membrane oxygenation (ECMO): technical specification

Field Name:	ECMO
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p>Date of critical care activity (ACTIVITYDATE) must be specified.</p> <p>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</p>

10.23. Ventricular assist device (VAD)

Definition: True if a ventricular assist device (VAD) was in place that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 65)

Format: Tick if true

Ventricular assist device (VAD): technical specification

Field Name:	VAD
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.24. Aortic balloon pump

Definition: True if an aortic balloon pump was in place that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 65)

Format: Tick if true

Aortic balloon pump: technical specification

Field Name:	ABPUMP
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.25. Peritoneal dialysis

Definition:	True if peritoneal dialysis was received that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 05)
Format:	Tick if true

Peritoneal dialysis: technical specification

Field Name: PERIDIA

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.26. Haemofiltration

Definition:	True if haemofiltration was received that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 16)
Format:	Tick if true

Haemofiltration: technical specification

Field Name:	HAEMOFILT
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.27. Haemodialysis

Definition:	True if haemodialysis was received that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 66)
Format:	Tick if true

Haemodialysis: technical specification

Field Name:	HAEMODIA
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.28. Plasma filtration

Definition:	True if plasma filtration was received that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 67)
Format:	Tick if true

Plasma filtration: technical specification

Field Name:	PLASMAFILT
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified.</i> <i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.29. Plasma exchange

Definition:	True if plasma exchange was received that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 67)
Format:	Tick if true

Plasma exchange: technical specification

Field Name: PLASMAEXCH

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.30. ICP-intracranial pressure monitoring

Definition: True if intracranial pressure monitoring (ICP) was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 68)

Format: Tick if true

Field Name: ICPMON

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.31. Intraventricular catheter or external ventricular drain

Definition: True if an intraventricular catheter or external ventricular drain was in place that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 69)

Format: Tick if true

Intraventricular catheter or external ventricular drain: technical specification

Field Name: INTCATHEVD

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.32. Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin

Definition: True if diabetic ketoacidosis (DKA) requiring continuous infusion of insulin was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 70)

Format: Tick if true

Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin: technical specification

Field Name:	DKA
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p>

10.33. Exchange transfusion

Definition: True if exchange transfusion was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 04)

Format: Tick if true

Exchange transfusion: technical specification

Field Name: EXTRANS

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.34. Intravenous thrombolysis

Definition: True if intravenous thrombolysis was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 71)

Format: Tick if true

Intravenous thrombolysis: technical specification

Field Name:	<i>INTHROM</i>
Field Type:	<i>Numeric</i>
Domain:	<i>Codes: 0 False (default) -1 True</i>
Example of Format:	<i>-1</i>
Comment:	<i>-</i>
Value expected?:	<i>Yes</i>
Validation:	<i>Date of critical care activity (ACTIVITYDATE) must be specified. If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i>

10.35. Extracorporeal liver support using molecular absorbent recirculating system (MARS)

Definition: True if extracorporeal liver support using molecular absorbent recirculating system (MARS) was received that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 72)

Format: Tick if true

Extracorporeal liver support using molecular absorbent recirculating system (MARS): technical specification

Field Name:	MARS
Field Type:	Numeric
Domain:	Codes: 0 False (default) -1 True
Example of Format:	-1
Comment:	-
Value expected?:	Yes
Validation:	<p>Date of critical care activity (ACTIVITYDATE) must be specified.</p> <p>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</p>

10.36. Patient nursed in single occupancy cubicle

Definition: True if patient was nursed in a single occupancy cubicle that day.

Reason: Part of the Paediatric Critical Care Minimum Dataset (Activity Code 74)

Format: Tick if true

Patient nursed in single occupancy cubicle: technical specification

Field Name: CUBICLE

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

Isolation reason (ISOLREASON) must not be blank for

10.37. Reason for isolation

Definition:	Reason the patient was in isolation for that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (relates to Activity Code 74)
Format:	Choose from ICD10 codes in the following categories (see Appendix G for allowed codes): Infectious causes - to protect others Immunosuppressed host - to protect the patient

Reason for isolation: technical specification

Field Name:	ISOLREASON
Field Type:	Character, size 3-9
Domain:	ICD10 Codes: See Appendix G for allowed codes
Example of Format:	0
Comment:	-
Value expected?:	Yes
Validation:	<p><i>Date of critical care activity (ACTIVITYDATE) must be specified.</i></p> <p><i>If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).</i></p> <p><i>Patient nursed in single occupancy cubicle (CUBICLE)</i></p>

10.38. Medical gases band 1 - nitric oxide

Definition:	True if nitric oxide was administered that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code X84.1)
Format:	Tick if true

Medical gases band 1 - nitric oxide: technical specification

Field Name: NOX

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

10.39. Surfactant

Definition:	True if surfactant was administered that day.
Reason:	Part of the Paediatric Critical Care Minimum Dataset (Activity Code X84.2)
Format:	Tick if true

Surfactant: technical specification

Field Name: SURFACTANT

Field Type: Numeric

Domain: Codes: 0 False (default)
-1 True

Example of Format: -1

Comment: -

Value expected?: Yes

Validation: *Date of critical care activity (ACTIVITYDATE) must be specified.*

If True, no defined critical care activity (NOCRIT) should be specified as False (default) for the same Activity date (ACTIVITYDATE).

Appendix A: PICANet clinical coding method

Introduction

The PICANet data set includes information on primary diagnosis for the admission, other diagnoses, operations and procedures and co-morbidity.

The Department of Health has specified that PICANet should use Clinical Terms 3 (The Read Codes) (referred to as CT3) for clinical coding. CT3 are the precursor to SNOMED Clinical Terms, the NHS preferred clinical terminology¹: CT3 codes will be wholly incorporated into SNOMED Clinical Terms when they are introduced without any recoding necessary.

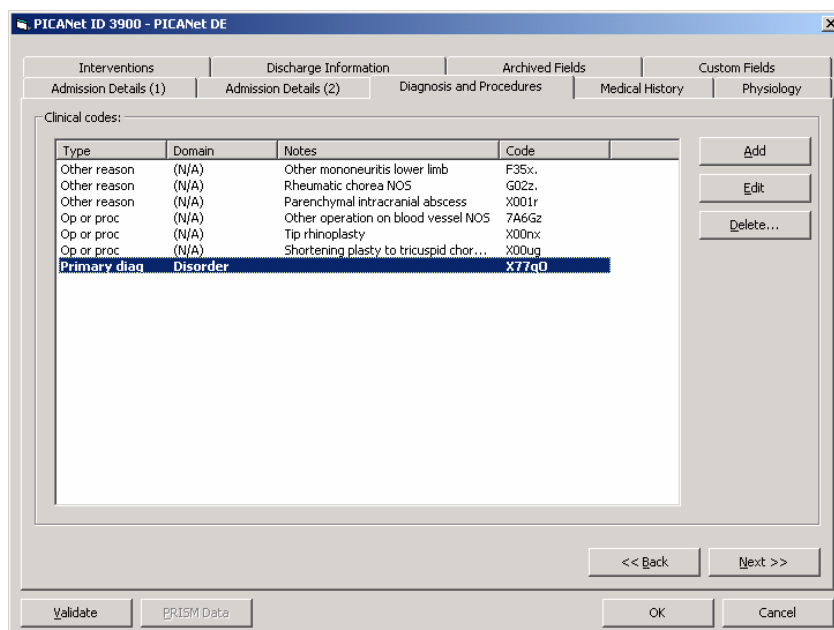
CT3 uses a hierarchical system for classification of disorders and procedures causes, observations, 'context-dependent' diagnoses (and much, much more). The complexity of CT3 allows very accurate coding but makes the coding process difficult in practice. In view of this, the PICANet Steering Group initially proposed that a core set of common disorders and procedures should be assembled and presented in the form of a 'picklist' of CT3 codes and descriptions within the PICANet software. It was hoped that the option to 'add in' codes using the NHS Clinical Terms Browser and the subsequent incorporation of those codes into the PICANet 'picklist' would be sufficient for all coding needs. This has not proved the case and the latest version of the software now includes the whole of the CT3 database of codes.

The instructions on coding given below are also included in the PICANet software manual distributed with the new software version 1.6.

Clinical coding window The CT3 codes are 'hard-wired' into the PICANet data entry software and have all the additional parameters used by PICANet associated with them. The Diagnosis and procedures tab displays the clinical coding window: this lists all the clinical codes entered for this episode and has four elements:

- Type – whether Primary diagnosis, procedure, other reason for admission or co-morbidity
- Domain – whether this is a Disorder, Procedure, Observation or Cause (see the PICANet Data Definition Manual section on clinical coding)
- Notes – what has been written in the clinical notes
- Code – the alpha-numeric Read code

Note that the domain is given as '(N/A)' for 6 of the codes shown below. This is because the data has been imported from an external database. The primary diagnosis has been entered using the software and shows the correct domain for this code.



Adding/editing a clinical code

To add a Clinical Code click the **Add...** button. The Clinical Code window will appear.

To edit a code previously entered, either click the **Edit** button or double click with the mouse. .

Clinical Code window The Clinical Code window is subtly different to the earlier software: all the functions can be carried out from this one window and the search facility has been improved.

You must first select the clinical code Type (Primary diagnosis, Other reason, Operation or Procedure or Co-morbidity). It is no longer necessary to select a 'Concept domain' if you are coding a diagnosis, operation or procedure or co-morbidity as this is automatically indicated. If you select 'Other reason' the Concept domain can be specified as a Cause, Disorder, History and Observation or 'Not specified'. Note that if you use 'Not specified' you can code for drugs, food occupations and all manner of other things.

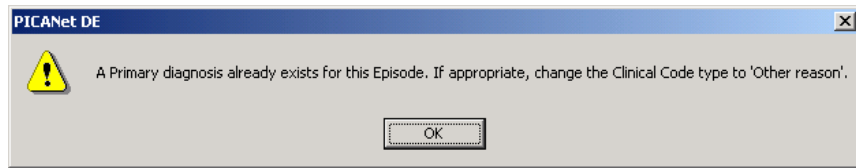
The screenshot shows the 'Clinical Code' window. The 'Type' is set to 'Primary diagnosis'. The 'Notes' field is empty. The 'Clinical code' is '(None)'. In the 'PICANet Clinical Coder' section, the 'Concept domain' is 'Disorder'. The 'Search for text' field is empty. The 'Containing' options are 'all of the words', 'the exact phrase', and 'at least one of the words'. The 'Filter' is '(All)'. The 'Search' button is visible. The 'Search results' table is empty with '(0 rows)'. The 'OK' and 'Cancel' buttons are at the bottom right.

If you type details from the notes into the Notes section you are able to copy this into the search window. You can then set the search criteria as indicated by the radio buttons. Note that you should select the words you search on carefully to increase search efficiency.

Filtered search

One means of improving search efficiency is to use the filter that allows searches to be carried out within distinct diagnostic groups: searching for 'tetralogy of fallot' when the filter is set to '(All)' returns seven results in 19.5 seconds; using the 'Cardiovascular' filter reduces the search time to 3.2 seconds.

Note that you are now unable to add more than one primary diagnosis:



There is no facility to add in additional Read Codes as all the codes are available. This will hopefully save time looking up codes in the NHS Clinical Terms Browser and copying them into the PICANet data entry program.

Appendix B: Variables no longer collected

Manual Ref No V1	Section V1	Variable name	Description
2.1	DIAGNOSES AND PROCEDURES	PDIAGNOTES	Primary reason for admission to your unit – as recorded in notes
2.2	DIAGNOSES AND PROCEDURES	PDOMAIN	Primary reason for admission to your unit – concept domain
2.3	DIAGNOSES AND PROCEDURES	PSYSTEM	Primary reason for admission to your unit – system
2.4	DIAGNOSES AND PROCEDURES	PPROCESS	Primary reason for admission to your unit – process
2.5	DIAGNOSES AND PROCEDURES	PDIAG	Primary reason for admission to your unit – clinical code
2.7	DIAGNOSES AND PROCEDURES	OTHDOMAIN	Other reason for admission to your unit – concept domain
2.8	DIAGNOSES AND PROCEDURES	OTHSYSTEM	Other reason for admission to your unit – system
2.9	DIAGNOSES AND PROCEDURES	OTHPROCESS	Other reason for admission to your unit – process
2.12	DIAGNOSES AND PROCEDURES	COMDOMAIN	Co-morbidity – concept domain
2.13	DIAGNOSES AND PROCEDURES	COMSYSTEM	Co-morbidity – system
2.14	DIAGNOSES AND PROCEDURES	COMPROCESS	Co-morbidity – process
3.2	MEDICAL HISTORY	CPROUTHOSP	Cardiopulmonary resuscitation outside hospital prior to admission to your unit
3.3	MEDICAL HISTORY	CPRINHOSP	Cardiopulmonary resuscitation in hospital prior to admission to your unit
3.10	MEDICAL HISTORY	MALIGNANCY	Malignancy
3.11	MEDICAL HISTORY	MALIGCOMP1ST	Malignancy after completion of first induction
4.10	PHYSIOLOGY	O2MLKGMIN	O2 flow (ml/kg/min)
4.11	PHYSIOLOGY	O2LMIN	O2 flow (l/min)
4.12	PHYSIOLOGY	METHADMIN	Method of administration
5.1	INTERVENTION RECORD	INTUBEVER	Intubation
5.2	INTERVENTION RECORD	INTUBDAYS	Number of days intubated
6.1	DISCHARGE	DDIAGNOTES	Primary diagnosis at discharge from your unit – as recorded in notes
6.2	DISCHARGE	DDOMAIN	Primary diagnosis at discharge from your unit – concept domain
6.3	DISCHARGE	DSYSTEM	Primary diagnosis at discharge from your unit – system
6.4	DISCHARGE	DPROCESS	Primary diagnosis at discharge from your unit – process
6.5	DISCHARGE	DDIAG	Primary diagnosis at discharge from your unit – clinical code
6.6	DISCHARGE	DOTHNOTES	Other diagnosis at discharge from your unit – as recorded in notes
6.7	DISCHARGE	DOTHDOMAIN	Other diagnosis at discharge from your unit – concept domain
6.8	DISCHARGE	DOTHSYSTEM	Other diagnosis at discharge from your unit – system
6.9	DISCHARGE	DOTHPROCESS	Other diagnosis at discharge from your unit – process
6.10	DISCHARGE	DOTHDIAG	Other diagnosis at discharge from your unit – clinical code

Appendix C: Information leaflets

Appendix D: Data collection form

Appendix E: Contacts and support

An e-mail sent to the following address will reach all members of the PICANet team:

picanet@leeds.ac.uk

Individual contact details are given below:

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Appendix F: Acknowledgements

PICANet would like to thank the following people for their contribution:

Past and present members of the Clinical Advisory Group

Past and present members of the Steering Group

All staff working in the participating PICU's.

Appendix G: PCCMDS Isolation Categories

Appendix H: Missing Data Values

Note: missing refers to data missing as in mislaid or missing as in not/never recorded.

The information in the table below refers only to the core dataset:

Manual Section:	Field Description:	If missing, record:
Admission	Gestational age at delivery	99
	Multiple birth	9
	Delivery order	9
PIM Physiology	Systolic blood pressure	999
	Base excess (art or cap)	999
	PaO ₂ (kPa or mmHg)	999
	FiO ₂ at time of PaO ₂	999
Intervention Record	Number of invasive days	9999
	Number of non-invasive days	9999

For all other missing data values please leave blank, unless the manual gives specific instructions to record unknown. These will show as missing data following a validation check, but you will not be prevented from continuing, and the records will be transmitted. Please complete as soon as possible.

Appendix I: Clarification of Methods of Ventilation

Invasive ventilation is any method of ventilation given by means of an endotracheal tube (ET tube), laryngeal mask or tracheostomy tube.

Examples being:

SIMV Synchronised Intermittent Mandatory Ventilation

Provides preset breathes at a preset volume, but is synchronised with the child's own initiation of breathing in. The child can take additional breaths as needed.

BIPAP Biphasic Positive Airway Pressure

Provides high and low positive pressures of gas to the child's airway alternatively at slow rates while the child breathes spontaneously throughout. Initially designed to reduce peak airway pressure.

CPAP Continuous Positive Airway Pressure

Provides a continuous positive pressure of gas to the child's airway during both breathing in and out. The child has no assistance from the machine to breath in or out.

PICANet regards a nasal or facial mask or prongs providing CPAP as non-invasive ventilation.

HFOV High Frequency Oscillation Ventilation

A method of providing continuous gas flow in the child's airways to prevent a build up of carbon dioxide and provide oxygenation by maintaining a continuous mean airway pressure. Breaths are around 600 per minute.

Jet ventilation

A method of delivering gas via a small bore cannula that extends into the ET or tracheostomy tube, allowing large tidal volumes of gas to be delivered at low pressure. Rates are normally around 300 – 600 breaths per minute.

IPPV Intermittent Positive Pressure Ventilation

Provides time-triggered breaths that are dependent upon chest compliance and resistance for volume of gas delivered.

Non-Invasive ventilation is any method of ventilation NOT given by means of an endotracheal tube (ET tube), laryngeal mask or tracheostomy tube.

Examples being:

Nasal prong or mask CPAP

Provides a continuous positive pressure of gas to the child's airway during both breathing in and out by means of a nasal prong or mask fitting over both nostrils. The child has no assistance from the machine to breath in or out. The pressure delivered helps to prevent the child's airways collapsing down after each breath is taken. This may be given for a few hours or days.

PICANet regards an ET tube providing CPAP (regardless of length of tube) as invasive ventilation.

Nasal or facial mask BIPAP

Provides high and low positive pressures of gas to the child's airway alternatively at slow rates by means of a nasal or facial mask. The child breathes spontaneously throughout. The pressure delivered helps to prevent the child's airways collapsing down after each breath is taken. This may be given for a few hours or days.

PICANet regards an ET tube providing BIPAP (regardless of length of tube) as invasive ventilation.

Negative Pressure Ventilation

Provides intermittent negative pressure to the child's chest using a tank or jacket (cuirass). The child does not need to have any mask or prongs in situ to receive this method of ventilation.

If you are unsure of whether a method of ventilation is INVASIVE or NON-INVASIVE please ask the staff on your unit first before contacting PICANet.