How to complete the PICANet Admission data collection form

Record **family name**, **first name**, full **address** and **postcode**. If not known, record *UNKNOWN* and state reason why in comments section

Select the appropriate **ethnic category**. For other (e.g. *White other*), complete text box **Other ethnic category**. Usually found on PAS or ask parents. These categories were defined in the 2001 Census and used by the NHS as a national mandatory standard for the collection and analysis of ethnicity

Precise **date and time of admission**—not time of first contact with unit doctor

Admission number—as recorded in unit admission record

- **Planned following surgery**—unit aware of admission before surgery begun or surgery that could be delayed by >24hrs. Surgery is defined as undergoing all or part of a procedure or anaesthesia for a procedure in theatre or anaesthetic room
- **Unplanned following surgery**—not aware prior to surgery starting but do not include admissions from theatre where surgery is not the primary reason for admission e.g. ICP monitor insertion where head injury is the reason for admission
- **Planned other**—not an emergency e.g. post liver biopsy
- **Unplanned other**—an unexpected/emergency admission

Previous ICU admission—during current hospital stay i.e. from admission to hospital until discharge or death. Can be this hospital or other hospital, not been home in-between. If multiple PICU admissions, choose most recent

PICA Net **Paediatric Intensive Care Audit Network · Data Collection Form** **Admission**

Patient details *(or hospital label)*

Family name

First name

Address

Postcode

NHS/CHI/H&C number ☐ Tick if patient is not eligible for number

Case note number

Date of birth *(dd/mm/yyyy)* __ / __ / ____

Indicate if date of birth is ☐ Estimated ☐ Anonymised ☐ Unknown

Sex ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown

Ethnic category
☐ White British
☐ White Irish
☐ White other *(specify below)*
☐ Mixed White and Black Caribbean
☐ Mixed White and Black African
☐ Mixed White and Asian
☐ Mixed other *(specify below)*
☐ Asian Indian
☐ Asian Pakistani
☐ Asian Bangladeshi
☐ Asian other *(specify below)*
☐ Black Caribbean
☐ Black African
☐ Black other *(specify below)*
☐ Chinese
☐ Other *(specify below)*
☐ Not stated (declined)
☐ Unknown

Other ethnic category

Gestational age at delivery *(if patient is under 2 years old)* __ weeks

Birth order __ of __ Multiplicity

GP practice code

Admission details

Date and time of admission to unit *(dd/mm/yyyy)* __ / __ / 2 0 __ __ : __

Admission number

Type of admission to unit
☐ Planned – following surgery
☐ Unplanned – following surgery
☐ Planned – other
☐ Unplanned – other

Previous ICU admission *(during current hospital stay)*
☐ ICU
☐ PICU
☐ NICU
☐ None
☐ Unknown

Source of admission ☐ Same hospital ☐ Clinic ☐ Other hospital ☐ Home

Care area admitted from *(includes transfers in)*
☐ X-ray / endoscopy / CT scanner
☐ Recovery only
☐ HDU (step up/step down unit)
☐ Other intermediate care area
☐ ICU / PICU / NICU
☐ Ward
☐ Theatre and recovery
☐ A & E

Retrieval / transfer? ☐ Yes ☐ No

Type of transport team
☐ PICU
☐ Centralised transport service (PIC)
☐ Transport team from neonates
☐ Other specialist team
☐ Non-specialist team
☐ Unknown

Transport team

Collection unit

Contact us · picanet@leeds.ac.uk · 0113 343 8125

For more contact details, go to **www.picanet.org.uk/contact-us**

For dataset manuals and guidance, go to **www.picanet.org.uk/Documentation/Guidance/**

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NHS number (England and Wales), **CHI number** (Scotland), **H&C number** (Northern Ireland)—patient **not eligible** if overseas national who does not have an allocated number

Local hospital **case note number**

- **Estimated**—if DOB unknown, estimate year by looking at child (so age can be calculated) and enter *01/01* for dd/mm
- **Anonymised**—tick if anonymising. Enter *01* for dd along with correct month and year
- **Unknown**—only tick if data being extracted retrospectively from notes and DOB not recorded

Record **gestational age at delivery** if patient <2 years only as can be prognostic factor. Obtain from notes or ask parents. If term, record *40*. If truly unknown, record *99*

Birth order/Multiplicity—record *1 of 1* for singleton; *1* or *2 of 2* for twin; *1* or *2* or *3 of 3* for triplet etc. Ask parents or search notes. If not documented in notes, assume singleton. If no information, record *9 of 9*. Do not leave blank

GP practice code—format in England and Wales: letter followed by 5 digits; format in Scotland: 5-digit code

Where child was immediately prior to PICU admission

- **Recovery only**—child cared for in recovery but not been in theatre for procedure
- **Other immediate care area**—care level greater than normal ward but not HDU, PICU, ICU
- **Theatre and recovery**—had part or all of surgery or received anaesthesia for procedure within theatre or recovery are

Any patient **retrieved from/transferred to** another hospital regardless of who brought the child. Do not include unit doctor going to ward within same hospital to stabilise and transfer patients

- **PICU**—a specialised PICU transport team
- **Centralised transport service (PIC)**—team from a centralised PIC transport service
- **Transport team from neonates**—specialist neonatal transport service
- **Other specialist team**—i.e. A&E or theatre staff
- **Non-specialist team**—i.e. DGH ward staff

Record specific name of **transport team**

Name of hospital or location at time of **collection** by transport team

Elective admission i.e. after elective surgery/procedure or for monitoring. Consider elective if could be postponed for >6hrs without adverse effects. Note: Elective admission for PIM purposes differs from a planned admission following surgery, which is defined as the unit being aware of the admission prior to surgery or that the surgery could have been delayed for >24hrs

Main reason for PICU admission—evidence available at the time of the admission event from notes, GP or family. Not including new diagnosis during this PICU admission event. If **recovery from surgery**, select type of procedure

• **Cardiac arrest before ICU admission**—documented absence of pulse or requirement for external cardiac compression before this admission to paediatric intensive care service. Not past history of cardiac arrest • **Cardiomyopathy or myocarditis**—documented diagnosis during 1 month period before or at contact with unit doctor. Not if develops after admission. Not including children with impaired cardiac function due to sepsis or surgery. ECHO findings of endocardial fibroelastosis plus poor ventricular function are sufficient not just poor function • **Severe combined immune deficiency**—documented at or prior to admission. Tick even if had successful bone marrow transplant • **Hypoplastic left heart syndrome**—including those with previous successful surgical repair. Not hypoplastic left ventricle unless documented ventriculo-arterial concordance • **Leukaemia/lymphoma after first induction**—irrespective of state of immunity or remission • **Liver failure** includes patients recovering from liver transplant for acute or chronic liver failure • **Acute NEC** prior to or at first contact with PIC service • **Spontaneous cerebral haemorrhage** e.g. aneurysm, associated with need for admission. Not intracranial bleeds as a result of trauma • **Neurodegenerative disorder**—progressive deterioration with loss of speech, vision, hearing, locomotion. Not static disability even if severe, unless progressive loss of milestones • **HIV** antigen positive • **Bone marrow transplant recipient** during this hospital admission

Tracheostomy performed during this admission—do not include those done prior to this admission where tracheostomy insertion is the reason for admission. Complete at discharge

PIM

*This applies to observations recorded between the first face-to-face contact with ICU doctor **until one hour after admission**. Always use the first recorded measurement during this time period.*

Elective admission

☐ Tick if this is an elective admission

Main reason for PICU admission

☐ Asthma
☐ Bronchiolitis
☐ Croup
☐ Obstructive sleep apnoea
☐ Recovery from surgery → ☐ Bypass cardiac procedure ☐ Non-bypass cardiac procedure ☐ Elective liver transplant ☐ Other procedure
☐ Diabetic ketoacidosis
☐ Seizure disorder
☐ Other (none of the above)

Is evidence available to assess past medical history?

☐ Yes ☐ No

If yes, tick all that apply

☐ Cardiac arrest before ICU admission
→ ☐ Cardiac arrest OUT of hospital
☐ Cardiomyopathy or myocarditis
☐ Severe combined immune deficiency
☐ Hypoplastic left heart syndrome
☐ Leukaemia or lymphoma after first induction
☐ Liver failure main reason for ICU admission
☐ Acute NEC main reason for ICU admission
☐ Spontaneous cerebral haemorrhage
☐ Neurodegenerative disorder
☐ Human Immunodeficiency Virus (HIV)
☐ Bone marrow transplant recipient

Systolic blood pressure

☐☐☐ mmHg

SpO_2 *(via pulse oximetry)* ☐☐☐ % → **FiO_2** *(at the time SpO_2 measured)* ☐.☐☐

Blood gas measured?

☐ Yes ☐ No

Arterial PaO_2 ☐☐.☐☐ kPa OR **Arterial PaO_2** ☐☐☐ mmHg

FiO_2 ☐.☐☐

Intubation?

☐ Yes ☐ No

Headbox?

☐ Yes ☐ No

At the time of arterial PaO_2 sample

Base excess *(specify source)* ☐☐☐.☐ mmol/l → ☐ Arterial ☐ Capillary ☐ Venous

Lactate *(specify source)* ☐☐.☐☐ mmol/l → ☐ Arterial ☐ Capillary ☐ Venous

Mechanical ventilation?

☐ Yes ☐ No

CPAP?

☐ Yes ☐ No

Pupil reaction

☐ Both fixed and dilated
☐ Other reaction
☐ Unknown

Diagnoses and procedures

Primary diagnosis for this admission

Other reasons for this admission

Operations and procedures performed during and prior to this admission

Co-morbidity

Was a tracheostomy performed during this admission?

☐ Yes ☐ No

First **systolic blood pressure** recorded within defined time period. Record *0* if patient in cardiac arrest, or *30* if patient shocked and BP is measured but not recordable. If not measured, enter *999*

Record the first **SpO_2** and corresponding **FiO_2** measured following first face-to-face contact between the patient and a PIC doctor

Tick if **blood gas** samples (arterial, capillary or venous) were taken and recorded within the defined time period

First **arterial PaO_2** measured and recorded at first contact between the patient and a specialist PIC doctor. Do not document if venous or capillary gases. If missing, record *999*

FiO_2 recorded at time of first arterial gas. If arterial gas not recorded write *999*

Tick if **intubated** at time of arterial gas. Includes endotracheal tube, LMA and tracheostomy

First **base excess** from arterial, capillary or venous gas within defined time period. If not or never recorded, write *999*. Indicate –ve or +ve and specify sample type

First blood **lactate** from arterial, capillary or venous gas within defined time period. Specify sample type

Mechanical ventilation—where all or some of the breaths, or portion of the breaths (pressure support) are delivered by a **mechanical device**. Includes high frequency, jet ventilators, negative pressure ventilators, BIPAP & CPAP

CPAP includes via ET, mask, nasal prongs or negative pressure. Do not include high flow nasal cannula therapy

First **pupillary reaction** measured AND recorded within defined time period • Both fixed and dilated if both >3mm and both unreactive to light

• **Primary diagnosis for this admission**—can only choose one diagnosis and must be a disorder/condition • May confirm at end of admission • Not a procedure e.g. hernia repair or cause e.g. apnoea must be the underlying condition • **Other reasons for this admission**—includes additional diagnoses or procedures that may or may not have required intensive care e.g. partially obstructed airway • **Operations or procedures performed during and prior to this admission** e.g. scoliosis repair, lung biopsy. Where type of admission is planned or unplanned following surgery, at least one operation or procedure is required • **Co-morbidity**—diagnoses child has prior to admission that may not be related to reason for this admission. Any underlying conditions e.g. syndromes

Daily interventions—record **admission date** and insert *X* in box for each intervention given at any time in each 24-hour period from midnight to midnight. If no interventions given choose **No defined critical care activity** (i.e. no other interventions recorded) to signify daily intervention record completed for identified day of stay

High flow nasal cannula therapy (HFNCT)—record maximum flow in L/min that day

Record the number of **unplanned extubations** that day, defined as the dislodgement of the ETT from the trachea without the intention to extubate immediately and without the presence of airway competent clinical staff in the bedspace appropriately prepared for the procedure

Patient nursed in single occupancy cubicle—record *X* in box and state **reason for isolation** in text box below

Daily interventions

Please record all interventions given on each day of admission using a cross ☒ *unless otherwise specified.*
If no interventions given, select **No defined critical care activity**.

Admission date: ....

		Day	0	1	2	3	4	5	6	7	8	9	10	11	12	13
Basic	No defined critical care activity	Code 99														
	Continuous ECG monitoring	50														
	Continuous pulse oximetry	73														
Airway and ventilatory	Invasive ventilation via endotracheal tube	51														
	Invasive ventilation via tracheostomy tube	52														
	Non-invasive ventilatory support	53														
	Advanced ventilatory support (jet ventilation)	56														
	Advanced ventilatory support (oscillatory ventilation)	56														
	Nasopharyngeal airway	55														
	Tracheostomy cared for by nursing staff	13														
	Supplemental oxygen therapy (irrespective of ventilatory state)	09														
	High flow nasal cannula therapy *(record maximum daily flow in l/min)*	88														
	Upper airway obstruction requiring nebulised adrenaline (epinephrine)	57														
	Apnoea requiring intervention (>3 in 24 hours or need for bag-mask ventilation)	58														
	Acute severe asthma requiring IV bronchodilator therapy or continuous nebuliser	59														
	Unplanned extubation *(record number of unplanned extubations)*	90														
Cardio-vascular	Arterial line monitoring	60														
	External pacing	61														
	Central venous pressure monitoring	62														
	Continuous infusion of inotrope, vasodilator or prostaglandin	06														
	Bolus IV fluids (>80 ml/kg/day) in addition to maintenance IV fluids	63														
	Cardio-pulmonary resuscitation	64														
	Extracorporeal membrane oxygenation (ECMO)	65														
	Ventricular assist device (VAD)	65														
	Aortic balloon pump	65														
	Arrhythmia requiring intravenous anti-arrhythmic therapy	94														
Renal	Peritoneal dialysis	05														
	Haemofiltration	16														
	Haemodialysis	66														
	Plasma filtration	67														
	Plasma exchange	67														
Neuro-logical	ICP-intracranial pressure monitoring	68														
	Intraventricular catheter or external ventricular drain	69														
	Status epilepticus requiring treatment with continuous infusion of anti-epileptic drugs	97														
	Reduced conscious level (GCS ≤ 12) AND hourly (or more frequent) GCS monitoring	95														
Analgesia/sedation	Epidural catheter in situ	85														
	Continuous intravenous infusion of a sedative agent	96														
Metabolic	Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin	70														
Other	Exchange transfusion	04														
	Intravenous thrombolysis	71														
	Extracorporeal liver support using molecular absorbent recirculating system (MARS)	72														
	Patient nursed in single occupancy cubicle *(state reason for isolation below)*	74														
High cost drugs	Medical gases Band 1 - nitric oxide	X841														
	Surfactant	X842														

Reason for isolation *(if patient nursed in single occupancy cubicle)*

....

Is the patient on a clinical trial—check the hospital notes or ask the parents, as if on a trial this could affect prognosis. Includes clinical trials outside PICU

Completion of **weight** is now mandatory as part of the core admission dataset. Record weight in kilograms measured at or as soon as possible after admission to the unit. If this is not possible then a weight measured immediately prior to transfer to PICU or provided by parent/carer may be recorded

Discharge—as recorded in unit admission book. Physical discharge and recording of discharge from bed or cot. Discharge does not include temporary transfer (e.g. to theatre for surgery) when there is expectation of a return to your unit

Discharged for palliative care—signifies withdrawal of care at the current level from which it is deemed the admission can no longer benefit

Date and time of death—if death occurs while on unit and/or prior to discharge, even if patient not physically present on the unit at the time e.g. in theatre. Include those who leave the unit to become beating heart donors. If **time of death** is prior to admission, add note in comments box and inform PICANet by separate email

• **Treatment withdrawn**—death follows the withdrawal of ongoing organ support • **Treatment limitation**—death follows a decision to limit on-going organ support and may include limitation of support and/or the patient is not for active resuscitation • **Brain stem death**—death confirmed using brain stem death criteria • **Failed cardiopulmonary resuscitation**—death immediately follows an unsuccessful attempt at CPR

Identifies whether the deceased patient was a **transplant donor** and whether solid organs and/or tissues were removed for transplant. **Organs** may include heart, pancreas, liver, kidneys, or intestines. **Tissues** may include skin, tendons, bone, heart valves and cornea

Clinical trial *(if required by your unit)*

Is the patient on a clinical trial?
☐ Yes *(specify name of trial)* ☐ No

Name of trial

Growth measurements *(if required by your unit)*

Height ☐☐☐ . ☐ cm

Weight ☐☐☐ . ☐☐☐ kg

Abdominal circumference ☐☐☐ . ☐ cm

Discharge information

Status at discharge from your unit
☐ Alive ☐ Dead

Date and time of discharge *(dd/mm/yyyy hh:mm)*
☐☐ / ☐☐ / 2 0 ☐☐ ☐☐ : ☐☐

If alive at discharge

Discharged for palliative care?
☐ Yes ☐ No

Destination following discharge from your unit
☐ Normal residence
☐ Hospice
☐ Same hospital
☐ Other hospital
→ ☐ ICU ☐ PICU ☐ NICU ☐ HDU ☐ SCBU ☐ Ward ☐ Other

If dead at discharge

Date and time of death *(dd/mm/yyyy hh:mm)*
☐☐ / ☐☐ / 2 0 ☐☐ ☐☐ : ☐☐

Mode of death
☐ Treatment withdrawn
☐ Treatment limitation
☐ Brain stem death
☐ Failed cardiopulmonary resuscitation

Transplant donor?
☐ No
☐ Yes – solid organs only
☐ Yes – tissues only
☐ Yes – both solid organs and tissues

Follow-up 30 days post-discharge from your unit

Status
☐ Alive ☐ Dead ☐ Unknown

Date of death *(dd/mm/yyyy)*
☐☐ / ☐☐ / 2 0 ☐☐

Location
☐ Normal residence
☐ Hospice
☐ Same hospital
☐ Other hospital
→ ☐ ICU ☐ PICU ☐ NICU ☐ HDU ☐ SCBU ☐ Ward ☐ Other

Comments

Customised data collection *(for local use)*

Form completed by

Status at 30 days post-discharge—complete for all PICU discharges. If cannot find out, record *Unknown*

Location at 30 days post-discharge—information found by using hospital record systems, contacting ward, GP, medical records, NOT directly calling family

For additional information, see the **PICANet admission dataset manual**, available at www.picanet.org.uk