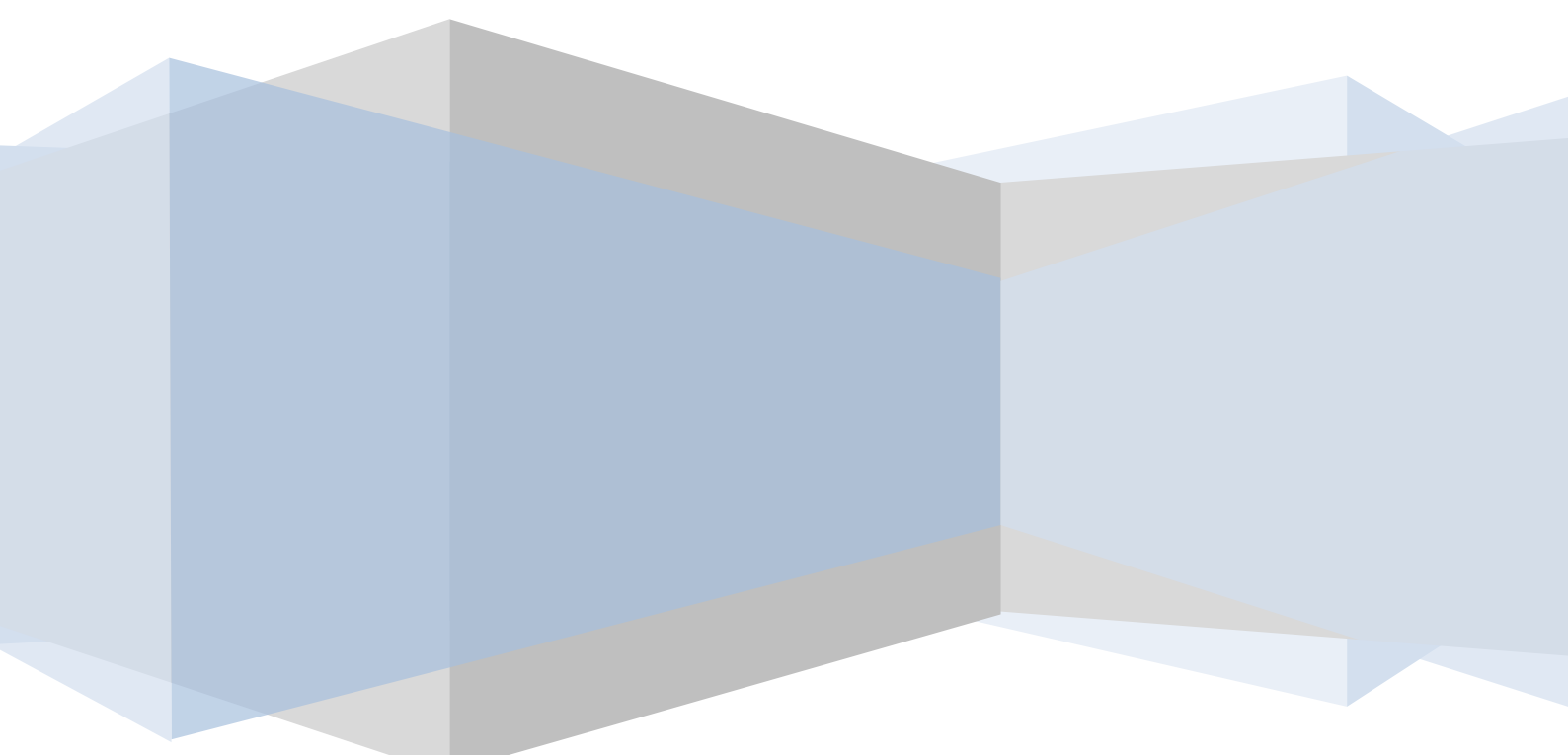


# PICANet Admission Dataset Definitions Manual

Version 5.9 March 2024



**UNIVERSITY OF  
LEICESTER**



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# Contents

<b>ADMISSION DATASET .....</b>	<b>7</b>
<b>PATIENT DETAILS .....</b>	<b>7</b>
Family name.....	7
First name .....	7
Address .....	8
Postcode .....	8
Ethnic category.....	9
Other ethnic category.....	9
NHS, CHI or H&C number.....	10
NHS, CHI or H&C number eligibility.....	10
Case note number .....	11
Date of birth.....	11
Indicate if date of birth is not estimated, estimated or anonymised.....	12
Sex .....	12
Gestational age at delivery .....	13
Birth order (all admissions).....	13
Multiplicity .....	13
<b>ADMISSION DETAILS .....</b>	<b>14</b>
Date and time of admission to unit.....	14
Admission number .....	14
Type of admission to unit .....	15
Previous ICU admission .....	16
Source of admission .....	16
Care area admitted from .....	17
Retrieval/ transfer .....	18
Type of transport team.....	18
Transport team.....	19
Collection unit .....	19
<b>PIM .....</b>	<b>20</b>
Elective admission .....	20
Main reason for PICU admission .....	21
Is evidence available to assess past medical history .....	22
Cardiac arrest before ICU admission .....	22
Cardiac arrest OUT of hospital .....	23

Cardiomyopathy or myocarditis.....	23
Severe combined immune deficiency (SCIDS) .....	24
Hypoplastic left heart syndrome.....	24
Leukaemia or lymphoma after completion of first induction.....	25
Liver failure main reason for ICU admission .....	25
Acute Necrotising Enterocolitis (NEC) main reason for ICU admission .....	25
Spontaneous cerebral haemorrhage.....	26
Neurodegenerative disorder.....	26
Human Immunodeficiency Virus (HIV) .....	26
Bone marrow transplant recipient .....	27
Systolic blood pressure.....	27
SpO <sub>2</sub> – Oxygen Saturation % (via pulse oximetry).....	28
FiO <sub>2</sub> (at the time SpO <sub>2</sub> measured) .....	28
Blood gas measured?.....	29
Arterial PaO <sub>2</sub> : Oxygen pressure (kPa) .....	29
Arterial PaO <sub>2</sub> : Oxygen pressure (mmHg) .....	30
FiO <sub>2</sub> (at the time Arterial PaO <sub>2</sub> measured).....	30
Intubation .....	31
Headbox.....	31
Base excess .....	32
Lactate .....	33
Mechanical ventilation .....	34
CPAP .....	35
Pupil reaction .....	36
<b>DIAGNOSES AND PROCEDURES .....</b>	<b>37</b>
Primary diagnosis for this admission.....	37
Other reasons for this admission .....	37
Operations and procedures performed during and prior to this admission .....	38
Co-morbidity .....	38
Was a tracheostomy performed during this admission?.....	38
<b>DAILY INTERVENTIONS .....</b>	<b>39</b>
Admission Date .....	39
No defined critical care activity.....	39
Continuous ECG monitoring.....	39
Continuous pulse oximetry .....	40
Invasive ventilation via endotracheal tube.....	40
Invasive ventilation via tracheostomy tube.....	40

Non-invasive ventilatory support .....	40
Advanced ventilatory support (jet ventilation) .....	41
Advanced ventilatory support (oscillatory ventilation) .....	41
Nasopharyngeal airway .....	41
Tracheostomy cared for by nursing staff .....	41
Supplemental oxygen therapy (irrespective of ventilatory state) .....	42
High flow nasal cannula therapy .....	42
Upper airway obstruction requiring nebulised adrenaline (epinephrine).....	42
Apnoea requiring intervention (>3 in 24 hours or requiring bag and mask ventilation) .....	42
Acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser .....	43
Unplanned extubation.....	43
Arterial line monitoring .....	43
External pacing.....	44
Central venous catheter in situ .....	44
Central venous pressure monitoring.....	44
Continuous infusion of inotrope, vasodilator or prostaglandin.....	44
Bolus IV fluids (>80 ml/kg/day) in addition to maintenance IV fluids .....	45
Cardio-pulmonary resuscitation.....	45
Extracorporeal membrane oxygenation (ECMO) .....	45
Ventricular assist device (VAD) .....	45
Aortic balloon pump .....	46
Arrhythmia requiring intravenous anti-arrhythmic therapy.....	46
Urine catheter in situ.....	46
Peritoneal dialysis.....	47
Haemofiltration.....	47
Haemodialysis .....	47
Plasma filtration .....	47
Plasma exchange .....	48
ICP-intracranial pressure monitoring .....	48
Intraventricular catheter or external ventricular drain .....	48
Status epilepticus requiring treatment with continuous infusion of anti-epileptic drugs .....	48
Reduced consciousness level (GCS $\leq$ 12 AND hourly (or more frequent) GCS monitoring .....	49
Delirium screening result.....	49
Epidural catheter in situ.....	50
Continuous intravenous infusion of a sedative agent .....	50
Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin.....	52
Exchange transfusion.....	52
Intravenous thrombolysis .....	52

Extracorporeal liver support using molecular absorbent recirculating system (MARS).....	53
Patient nursed in single occupancy cubicle .....	53
Medical gases band 1 - nitric oxide .....	53
Surfactant.....	54
Reason for isolation.....	54
<b>Additional information .....</b>	<b>55</b>
Is the patient on a clinical trial? .....	55
Name of trial .....	55
<b>GROWTH MEASUREMENTS .....</b>	<b>56</b>
Height .....	56
Weight .....	56
Abdominal circumference.....	56
<b>HEALTHCARE ASSOCIATED INFECTIONS (HCAI) .....</b>	<b>57</b>
Number of episodes of PICU-acquired central line associated bloodstream infection (CLABSI).....	57
Number of episodes of PICU-acquired catheter associated urinary tract infection (CAUTI).....	58
<b>DISCHARGE INFORMATION .....</b>	<b>59</b>
Status at discharge from your unit.....	59
Date and time of discharge .....	59
Discharged for palliative care.....	59
Destination following discharge from your unit .....	60
Date and time of death.....	61
Mode of Death .....	61
Transplant Donor?.....	62
<b>FOLLOW UP 30 DAYS POST DISCHARGE FROM YOUR UNIT .....</b>	<b>63</b>
Status .....	63
Date of death post-discharge from your unit .....	63
Location at 30 days following discharge from your unit: hospital area .....	63
<b>COMMENTS .....</b>	<b>64</b>
<b>FORM COMPLETED BY .....</b>	<b>64</b>

# Admission dataset

## PATIENT DETAILS

### Family name

---

<b>Description</b>	The last or family name or surname given to the child as it would appear on the child's birth certificate or other appropriate document
<b>Reason</b>	Family name provides an additional identifier that can aid patient tracking throughout the hospital and PICANet Web.  Can help identify individuals who may have had multiple referrals, transport and/or admission events to one or more PICUs
<b>Format</b>	Free text (e.g. Brown)  If no family name available record as UNKNOWN and indicate why not available in the comments section

### First name

---

<b>Description</b>	The first name given to the child as it would appear on the child's birth certificate or other appropriate document
<b>Reason</b>	First name provides an additional identifier that can aid patient tracking throughout the hospital and PICANet Web  Can help identify individuals who may have had multiple referrals, transport and/or admission events to one or more PICUs
<b>Format</b>	Free text (e.g. John)  If no first name available record as UNKNOWN and indicate why not available in the comments section

## Address

---

<b>Description</b>	The normal place of residence for the child
<b>Reason</b>	<p>Address provides an additional identifier that can aid patient tracking throughout the paediatric intensive care service and PICANet Web</p> <p>Can help identify individuals who may have had multiple referrals, transport and/or admission events 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 effective audit and assessment of health services delivery</p> <p>A full residential address will allow validation of postcode</p>
<b>Format</b>	<p>5 free text fields, e.g. ADDRESS1: 83 Green Street</p> <p>ADDRESS2: Brownley</p> <p>ADDRESS3: Sheffield</p> <p>ADDRESS4: South Yorkshire</p> <p>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> <p>A list of postcodes for overseas countries is available on request from PICANet</p>

## Postcode

---

<b>Description</b>	The postcode for the child's normal place of residence
<b>Reason</b>	<p>Postcode provides an additional identifier that can aid patient tracking throughout the paediatric intensive care service and PICANet Web</p> <p>Can help identify individuals who may have had multiple referrals, transport and/or admission events to one or more PICUs</p> <p>Postcode provides a means of linkage to geographic and demographic information for effective audit and assessment of health services delivery</p>
<b>Format</b>	<p>Text (e.g. S10 8NN)</p> <p>Foreign postcodes will be accepted by PICANet Web</p> <p>If postcode is unobtainable, record as UNOBTAINABLE</p> <p>A list of postcodes for overseas countries is available on request from PICANet</p>



## Ethnic category

---

<b>Description</b>	Identifies the child's ethnic origin according to standard NHS ethnic categories and codes and Ethnic Category 2021 categories
<b>Reason</b>	Required for epidemiological analysis and assessment of health services delivery Potentially of value in clinical audit and research in conjunction with other clinical data
<b>Format</b>	Refer to the listed ethnic categories and use free text to record the child's ethnic category. Then select the appropriate ethnic category from the drop down list on the PICANet Web record e.g. White British

## Other ethnic category

---

<b>Description</b>	The child's exact ethnic origin (if known), if not specified in the table containing standard NHS ethnic categories and codes and the three additional ethnic categories from the Ethnic Category 2021  If codes including 'other' e.g. 'Mixed other' are chosen for Ethnic category, 'Other' ethnic category will give a further option to specify the child's exact ethnic origin
<b>Reason</b>	Required for epidemiological analysis and assessment of health services delivery Of value in clinical audit in conjunction with other clinical data
<b>Format</b>	Free text (e.g. Mediterranean)  In this case Mixed other may have been recorded for Ethnic category, but the notes may have specifically stated that the child was Mediterranean

## NHS, CHI or H&C number

---

<b>Description</b>	Unique identifying number enabling tracing of a patient through the NHS system in the United Kingdom. For English and Welsh patients the NHS number, for Scottish patients the CHI number and for Northern Ireland the H&C number is used as a unique numeric identifier
<b>Reason</b>	<p>NHS, CHI or H&amp;C number gives a unique, identifiable variable that will allow other identifiable data items to be removed from the database</p> <p>Can help identify individuals who may have had multiple referrals, transport and/or admission events to one or more PICUs</p>
<b>Format</b>	<p>Free text (e.g.1463788990)</p> <p>Validation check that NHS, CHI or H&amp;C number is a valid number</p>

## NHS, CHI or H&C number eligibility

---

<b>Description</b>	The patient is not eligible for NHS, CHI or H&C number, he or she is an overseas national who is not ordinarily a resident in the UK and therefore does not have an allocated NHS, CHI or H&C number
<b>Reason</b>	To enable effective audit of availability of NHS, CHI or H&C number and assessment of health services delivery
<b>Format</b>	Tick box if patient is not eligible for an NHS, CHI or H&C number

## Case note number

---

<b>Description</b>	Unique identifying number for an individual's hospital records at the treating unit. Allocated on first admission to hospital
<b>Reason</b>	Case note number provides a unique identifier that can aid patient tracking throughout the hospital
<b>Format</b>	Free text (e.g. AB145C)

## Date of birth

---

<b>Description</b>	The child's date of birth as recorded on the child's birth certificate or other appropriate document
<b>Reason</b>	Date of birth and Date of admission are used to calculate age at admission to this paediatric intensive care service  Date of birth provides an additional identifier that can aid patient tracking throughout the paediatric intensive care service, hospital and PICANet Web  Can help identify individuals who may have had multiple referrals and/or admissions to one or more PICUs
<b>Format</b>	Date; dd/mm/yyyy  Date of birth should be on or prior to the 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). Then tick 'Estimated' in the section 'Indicate if date of birth is' Estimated/Anonymised/Unknown section below  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 in the 'Indicate if date of birth is' field below tick 'Unknown'  If it is necessary for Date of birth to be partly anonymised, enter the correct month and year and record 01 for the day (e.g. 01/MM/YYYY) then tick 'Anonymised' below  Validation check: if patient is aged 18 years or older at admission

## Indicate if date of birth is not estimated, estimated or anonymised

---

**Description** Specifies whether the date of birth is estimated, anonymised or unknown (and cannot be estimated)

**Reason** Date of birth and Date of admission to your unit are used to calculate age at admission to this paediatric intensive care service

**Format** Choose from one of the following:

- Not estimated
- Estimated
- Anonymised
- DOB not known

## Sex

---

**Description** Identifies the genotypical sex of the child at admission to this paediatric intensive care service

**Reason** Sex is important for reporting demographic statistics for admissions to your unit or transport service. Sex provides an additional identifier that can aid patient tracking throughout the paediatric intensive care service and PICANet Web

**Format** Choose from one of the following:

- Male
- Female
- Ambiguous

## Gestational age at delivery

---

<b>Description</b>	Gestational age at delivery in completed weeks if aged less than 2 years at admission to your unit  If gestational age is reported as term record 40 weeks
<b>Reason</b>	For young infants, there is evidence that gestational age can act as an important prognostic factor. Also assists with data matching
<b>Format</b>	Enter between 20-44 weeks  Enter 99 if unknown  Validation check: if range outside 24 to 42.

## Birth order (all admissions)

---

<b>Description</b>	Identifies the order in which the child was delivered if a multiple birth
<b>Reason</b>	In the case of multiple births, delivery order provides an additional identifier that can aid patient matching
<b>Format</b>	Enter 1 for singleton or first born, 2 for second born and so on. Enter 9 if unknown

## Multiplicity

---

<b>Description</b>	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
<b>Reason</b>	Multiple birth information provides an additional identifier that can aid patient matching
<b>Format</b>	Enter 1 for singleton, 2 for twins, 3 for triplets and so on  Enter 9 if unknown

## ADMISSION DETAILS

### Date and time of admission to unit

---

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

### Admission number

---

<b>Description</b>	<p>Unique identifier assigned to each consecutive admission to your unit</p> <p>As recorded in your unit admission book or clinical information system</p> <p>Admission to your unit is defined as the physical admission and recording of that admission to a bed or cot in your unit</p>
<b>Reason</b>	<p>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</p>
<b>Format</b>	<p>Free text (e.g. 01/389)</p>

## Type of admission to unit

---

<b>Description</b>	<p>Identifies type of admission to your unit</p> <p><b>A planned admission following surgery</b> 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)</p> <p><b>An unplanned admission following surgery</b> is an admission that your unit was not aware of before surgery began (e.g. bleeding tonsillectomy)</p> <p>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)</p> <p>A <b>planned - other</b> admission is any other planned admission that is not an emergency (e.g. liver biopsy)</p> <p>An <b>unplanned – other</b> admission is an admission that your unit was not expecting and is therefore an emergency admission to your unit (e.g. status epilepticus)</p>
<b>Reason</b>	<p>Planned admissions are weighted in PIM. Required for epidemiological analysis and assessment of health services provision</p>
<b>Format</b>	<p>Choose from one of the following:</p> <ul style="list-style-type: none"><li>▪ Planned - (following surgery)</li><li>▪ Unplanned - (following surgery)</li><li>▪ Planned - (other)</li><li>▪ Unplanned - (other)</li></ul>

## Previous ICU admission

---

<b>Description</b>	<p>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</p> <p>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. ICU includes adult and general intensive care units</p> <p>If the child has been previously admitted to more than one ICU/PICU/NICU during the current hospital stay, record the location of the most recent admission</p> <p>Current hospital stay is defined as the period from admission to hospital until the time the child is discharged home or dies</p>
<b>Reason</b>	<p>Important for assessing re-admission rates</p> <p>Important for allowing the accurate matching of children from one admission to another</p>
<b>Format</b>	<p>Choose from one of the following:</p> <ul style="list-style-type: none"><li>▪ ICU</li><li>▪ PICU</li><li>▪ NICU</li><li>▪ None</li><li>▪ Unknown</li></ul>

## Source of admission

---

<b>Description</b>	<p>The location from where the child was directly admitted to your unit</p> <p><b>Same hospital</b> is defined as the same hospital housing your intensive care unit</p> <p><b>Other hospital</b> is another hospital which does not house your unit</p> <p><b>Clinic</b> is defined as an outpatient clinic</p> <p><b>Home</b> is defined as the normal place of residence for the child</p>
<b>Reason</b>	<p>Important for allowing the accurate matching of children from one admission to another including retrieval / transfer from another PICU in the original admitting hospital</p> <p>Acts as a filter field for further data entry</p>
<b>Format</b>	<p>Choose from one of the following:</p> <ul style="list-style-type: none"><li>▪ Same hospital</li><li>▪ Other hospital</li><li>▪ Clinic</li></ul>



- Home

## Care area admitted from

---

<b>Description</b>	<p>The care area that the child came from immediately before admission to your unit</p> <p><b>X-ray, endoscopy, CT scanner</b> or similar area identifies that the child came from an area where diagnostic procedures may have been carried out</p> <p><b>Recovery only</b> means the child was cared for in the recovery area prior to admission to your unit</p> <p><b>HDU (step up/step down unit)</b> means the child received care in a high dependency area prior to admission to your unit</p> <p><b>Other intermediate care area</b> 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><b>ICU/PICU/NICU</b> means the child received care within one or more of these areas prior to admission to your unit</p> <p><b>Ward</b> means the child was admitted directly from a ward to your unit</p> <p><b>Theatre and recovery</b> 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. Includes a child admitted directly to your unit following an interventional cardiology procedure in the catheter laboratory</p> <p><b>A&amp;E</b> means the child was admitted to your unit directly from an A&amp;E department</p>
<b>Reason</b>	Required for epidemiological analysis and assessment of health services provision
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>▪ X-ray, endoscopy, CT scanner or similar</li><li>▪ Recovery only</li><li>▪ HDU (step up/step down unit)</li><li>▪ Other intermediate care area (not ICU/PICU/NICU or HDU)</li><li>▪ ICU/PICU/NICU</li><li>▪ Ward</li><li>▪ Theatre and recovery</li><li>▪ A&amp;E</li></ul>

## Retrieval/ transfer

---

<b>Description</b>	<p>Specifies whether the child was transferred to your unit from the original admitting hospital by a transport team</p> <p>If your own PIC 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/transfer</p> <p>A retrieval/transfer is any child admitted to your unit from outside of your hospital regardless of who brought the child to your unit</p>
<b>Reason</b>	Required for epidemiological analysis and assessment of health services provision
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>▪ Yes</li><li>▪ No</li></ul>

## Type of transport team

---

<b>Description</b>	<p>Specifies the type of transport team and identifies whether the team is a specialist PIC team or not</p> <p><b>PICU</b> identifies that a specialised PICU team transferred the child</p> <p><b>Centralised transport service (PIC)</b> identifies that a transport team from a centralised transport service (PIC) transferred the child</p> <p><b>Transport team from neonates</b> identifies that a specialist neonatal transport team transferred the child</p> <p><b>Other specialist team</b> identifies that another specialist team (not a CTS PIC or neonatal transport team), transported the child to your unit. E.g. a trauma transport team transferring the child</p> <p><b>Non-specialist team</b> identifies that a non-specialist team transported the child to your unit</p> <p><b>Unknown</b></p>
<b>Reason</b>	Required for epidemiological analysis and assessment of health services provision
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>▪ PICU</li><li>▪ Centralised transport service (PIC)</li><li>▪ Transport team from neonates</li><li>▪ Other specialist team</li><li>▪ Non-specialist team</li><li>▪ Unknown</li></ul>

## Transport team

---

**Description** The unique name of the centralised transport service (PIC), PICU own team, other specialist team or non-specialist team (DGH) undertaking this episode of transport

**Reason** Required to assist with matching transport events and for epidemiological analysis

**Format** Free text

Record the full name or recognised abbreviation of the transport team i.e. CATS or KIDS in the text box

At data entry to PICANet Web select the organisation type - PICU, CTS or DGH from the organisation coder

Search for the name of the organisation, if this is not available in the given list, but known select 'Other organisation' and enter the name in the 'Other' box, using free text

If the name of the organisation is not known select 'Unknown organisation'

## Collection unit

---

**Description** Identifies the unique name of the hospital or the place such as an airport, where the patient is located at the time of collection by the transport team

**Reason** Required for effective audit and assessment of geographical distribution of referring population to individual units/transport services. To enable effective audit and assessment of health services delivery

**Format** Name of hospital and specialist unit or the DGH

Select the name of the PICU or DGH from the organisation coder

If the name is not available in the given list, but known select 'Other organisation' and enter the name in the 'Other' box, using free text

If the name of the organisation is not known select 'Unknown organisation'

# PIM

*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

---

<b>Description</b>	<p>Identifies whether the child is an elective admission to the paediatric intensive care service</p> <p>Include admission (planned or foreseeable) after elective surgery or admission for an elective procedure (e.g. insertion of a central catheter), or elective monitoring, or review of home ventilation. Unexpected admissions (i.e. not planned and that could not have been foreseen) after elective surgery are not classed as Elective</p> <p>An admission to PICU is considered elective if it could be postponed for more than 6 hours without adverse effects</p> <p>Note: this definition is taken from PIM and is more stringent than the PICANet definition of a planned admission, where an admission is regarded as planned if it could be delayed for more than 24 hours</p>
<b>Reason</b>	Elective admissions are weighted in PIM
<b>Format</b>	Tick if Yes

## Main reason for PICU admission

---

**Description** Identifies whether the child has been admitted to the intensive care service with any of the following as the main reason for admission to your unit:

**Asthma**

**Bronchiolitis** – include children who present either with respiratory distress or central apnoea where the clinical diagnosis is bronchiolitis

**Croup**

**Obstructive sleep apnoea** – record if main reason for admission is obstructive sleep apnoea. If the patient has been admitted following adenoidectomy and/or tonsillectomy, record the type of admission as planned/unplanned following surgery and also complete the operation and procedure code for adenoidectomy and/or tonsillectomy in the diagnoses and procedures section.

**Recovery from surgery or a procedure** - (include a radiological procedure or cardiac catheter). Do not include patients admitted from the operating theatre where recovery from surgery is not the main reason for admission to the paediatric intensive care service e.g. a patient with a head injury who goes to theatre for insertion of an ICP monitor; in this patient the main reason for admission is the head injury.

**Yes** – recovery from a **bypass cardiac procedure** or surgery

**Yes** – recovery from a **non-bypass cardiac procedure** or surgery

**Yes** – recovery from an **elective liver transplant** for acute or chronic liver failure.

**Yes** – recovery from **other procedure** or surgery

**Diabetic ketoacidosis**

**Seizure disorder** - Include a patient who requires admission primarily due to status epilepticus, epilepsy, febrile convulsion, or other epileptic syndrome; where admission is required either to control seizures or to recover from the effects of seizures or treatment.

**Other** (none of the above)

**Reason** These diagnoses are weighted in PIM if they are the main reason for this admission.

**Format**

Choose from the following:

- Asthma
- Bronchiolitis
- Croup
- Obstructive sleep apnoea
- Recovery from surgery .....
- Diabetic ketoacidosis
- Seizure disorder
- Other (none of the above)

.....If recovery from surgery is the main reason for PICU admission, select one from the following:

- Bypass cardiac procedure
- Non-bypass cardiac procedure
- Elective liver transplant
- Other procedure

## Is evidence available to assess past medical history

---

<b>Description</b>	Identifies whether or not evidence was available at the time of the admission event to assess past medical history  Evidence may be obtained from in or out-patient hospital notes, GP notes, or information from the child (if able), the child's family or any other responsible adult
<b>Reason</b>	Important data to confirm whether evidence is available to assess medical history. Acts as a filter for further data entry
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>▪ Yes</li><li>▪ No</li></ul>

## Cardiac arrest before ICU admission

---

<b>Description</b>	Identifies whether the child has had a cardiac arrest before admission to the paediatric intensive care service, including the specialised paediatric intensive care transport service  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.
<b>Reason</b>	Cardiac arrest preceding admission to the paediatric intensive care service is weighted in PIM
<b>Format</b>	Tick if child has a cardiac arrest preceding admission to the paediatric intensive care service

## Cardiac arrest OUT of hospital

---

<b>Description</b>	Identifies whether the child has a cardiac arrest before this admission to hospital. Only relates to out-of-hospital cardiac arrests Requires documented absent pulse or the requirement for external cardiac massage (do not include past history of cardiac arrest)
<b>Reason</b>	Cardiac arrest preceding admission to hospital is required for analysis and research
<b>Format</b>	Tick if child has cardiac arrest out of hospital prior to this hospital admission

## Cardiomyopathy or myocarditis

---

<b>Description</b>	Cardiomyopathy or myocarditis refers to a documented diagnosis of cardiomyopathy or myocarditis relevant to the period one month before or at first contact with the paediatric intensive care service  First contact with the specialist paediatric intensive care 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 first contact then do <b>not</b> record  Impaired cardiac function associated with sepsis or surgery should <b>NOT</b> be recorded as cardiomyopathy  Descriptions of poor ventricular function alone, whether based upon haemodynamic or invasive pressure measurement or during real time imaging are <b>NOT</b> 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
<b>Reason</b>	Cardiomyopathy and myocarditis are weighted in PIM
<b>Format</b>	Tick if true

## Severe combined immune deficiency (SCIDS)

---

**Description** Identifies whether the child has a diagnosis of severe combined immune deficiency syndrome (SCIDS) documented in the case notes prior to or at first contact with the paediatric intensive care service.

Patients who have SCIDS and who have had a successful bone marrow transplant following which they have been discharged home, are still regarded as having SCIDS

**Reason** Severe combined immune deficiency syndrome is weighted in PIM

**Format** Tick if true

## Hypoplastic left heart syndrome

---

**Description** Identifies whether the child has hypoplastic left heart syndrome documented in the case notes prior to or at first contact with the paediatric intensive care service

Include patients of any age but only those cases where a Norwood procedure or equivalent is or was required in the neonatal period to sustain life

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 e.g. 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

**Format** Tick if true



## Leukaemia or lymphoma after completion of first induction

---

<b>Description</b>	<p>Include only cases where admission is related to leukaemia or lymphoma or the therapy for these</p> <p>Identifies whether the child has leukaemia or lymphoma for which first induction has been received and completed irrespective of current presumed state of immunity or remission; prior to or at first contact with the paediatric intensive care service</p>
<b>Reason</b>	Leukaemia or lymphoma after completion of 1st induction is weighted in PIM
<b>Format</b>	Tick if true

## Liver failure main reason for ICU admission

---

<b>Description</b>	<p>Identifies whether the child has acute or chronic liver failure as the main reason for this admission to the paediatric intensive care service</p> <p>Include patients admitted for recovery following liver transplantation for acute or chronic liver failure</p> <p>Include patients where the primary reason for admission is liver failure (of the graft)</p>
<b>Reason</b>	Liver failure as the main reason for admission to the paediatric intensive care service is weighted in PIM.
<b>Format</b>	Tick if true.

## Acute Necrotising Enterocolitis (NEC) main reason for ICU admission

---

<b>Description</b>	<p>Acute necrotising enterocolitis (NEC) refers to a documented diagnosis of an acute episode of NEC prior to or at first contact with the paediatric intensive care service</p> <p>If NEC only develops subsequently following admission to your unit and is not present at first contact then do not record</p>
<b>Reason</b>	NEC at first contact with the paediatric intensive care service is weighted in PIM3
<b>Format</b>	Tick if true

## Spontaneous cerebral haemorrhage

---

<b>Description</b>	<p>Identifies whether the child has a spontaneous cerebral haemorrhage (e.g. from an aneurysm or AV malformation) documented in the case notes prior to or at first contact with the paediatric intensive care service</p> <p>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</p> <p>Do not include traumatic cerebral haemorrhage or intracranial haemorrhage that is not intracerebral (e.g. subdural haemorrhage)</p>
<b>Reason</b>	Spontaneous cerebral haemorrhage from an aneurysm or AV malformation is weighted in PIM
<b>Format</b>	Tick if true

## Neurodegenerative disorder

---

<b>Description</b>	<p>Identifies whether the child has a neurodegenerative disorder documented in the case notes prior to or at admission to the paediatric intensive care service</p> <p>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. Requires a progressive loss of milestones or a diagnosis where this will inevitably occur</p> <p>A static disability should <b>NOT</b> be recorded as a neurodegenerative disorder (even if it is severe)</p>
<b>Reason</b>	A neurodegenerative disorder is weighted in PIM
<b>Format</b>	Tick if true

## Human Immunodeficiency Virus (HIV)

---

<b>Description</b>	Identifies whether the child is HIV antigen positive as documented in the case notes prior to or at admission to the paediatric intensive care service
<b>Reason</b>	The presence of HIV infection is weighted in PIM
<b>Format</b>	Tick if true

## Bone marrow transplant recipient

---

<b>Description</b>	Identifies whether the child has received a bone marrow transplant during this hospital admission
<b>Reason</b>	Bone marrow transplantation during current hospital admission is weighted in PIM3
<b>Format</b>	Tick if true

## Systolic blood pressure

---

<b>Description</b>	<p>The first systolic blood pressure measured and recorded within the period following first face to face (not telephone) contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit</p> <p>First contact may occur in your own hospital (on your ICU, emergency department or ward) or in another hospital on retrieval</p> <p>Data that are available to the specialist paediatric intensive care doctor at first contact and that are current at that time are acceptable. In cases of doubt record the first value of each variable measured after the time of first contact</p> <p>Systolic blood pressure values are included irrespective of the measurement method used or the site</p> <p>Record 0 if the patient is in cardiac arrest. (Only when the BP is truly unrecordable e.g. cardiac arrest should a value of 0 be collected)</p> <p>Record 30 if the patient is shocked and the blood pressure is so low it is unrecordable</p>
<b>Reason</b>	Systolic blood pressure at first contact with the paediatric intensive care service is weighted in PIM
<b>Format</b>	<p>Numerical value (e.g. 130)</p> <p>Units: mmHg. 20 – 180; validation check if range exceeds 200</p>

## SpO<sub>2</sub> – Oxygen Saturation % (via pulse oximetry)

---

<b>Description</b>	<p>The patient's oxygen saturation (SpO<sub>2</sub>), expressed as a percentage</p> <p>Record the first SpO<sub>2</sub> (pulse oximetry) that has a corresponding FiO<sub>2</sub> measured and recorded following first face to face contact between the patient and a specialist paediatric intensive care doctor until one hour after admission to your unit</p> <p>First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval</p> <p>If there is more than one SpO<sub>2</sub> recorded within the specified time period, use the first available SpO<sub>2</sub> that has a corresponding measured and recorded FiO<sub>2</sub>, even if recorded later than an SpO<sub>2</sub> with no corresponding FiO<sub>2</sub></p>
<b>Reason</b>	To allow calculation of SpO <sub>2</sub> /FiO <sub>2</sub> ratio
<b>Format</b>	<p>Numerical value e.g. 096</p> <p>Acceptable range 0-100; validation check if range exceeds 50-100</p>

## FiO<sub>2</sub> (at the time SpO<sub>2</sub> measured)

---

<b>Description</b>	<p>The patient's fraction of inspired oxygen (FiO<sub>2</sub>), expressed as a fraction</p> <p>The FiO<sub>2</sub> at the time of the first SpO<sub>2</sub> measured and recorded following face to face contact between the patient and a specialist paediatric intensive care doctor until one hour after admission to your unit</p> <p>First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval</p> <p>Record the fraction of inspired oxygen being delivered via endotracheal tube (ETT), non-invasive ventilation (NIV), HFNCT or headbox at the same time that the first SpO<sub>2</sub> is measured. This means the FiO<sub>2</sub> and SpO<sub>2</sub> recorded must relate to the same time</p> <p>If SpO<sub>2</sub> is unknown or missing [999], then FiO<sub>2</sub> will also be unknown or missing: record 999</p> <p>If room air only record 0.21 (21%)</p>
<b>Reason</b>	To allow calculation of SpO <sub>2</sub> /FiO <sub>2</sub> ratio
<b>Format</b>	<p>Numerical value e.g. 0.40</p> <p>Units: Fraction (decimal) 0.1-1.00; validation - expecting a value between 0.21 and 1.0</p>

## Blood gas measured?

---

<b>Description</b>	<p>Confirmation that results from a blood gas taken and analysed within the period following first face to face contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit are available</p> <p>First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval</p> <p>Data that are available to the specialist paediatric intensive care 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>The blood gas taken and analysed may be arterial, capillary or venous</p>
<b>Reason</b>	Acts as a filter for further data entry. Blood gas results are weighted in PIM
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>▪ Yes</li><li>▪ No</li><li>▪ Unknown</li></ul>

## Arterial PaO<sub>2</sub>: Oxygen pressure (kPa)

---

<b>Description</b>	<p>The <b>first</b> arterial PaO<sub>2</sub> measured and recorded within the period following first contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit</p> <p>First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval</p> <p>Data that are available to the specialist paediatric intensive care doctor at first contact that are current at that time are acceptable</p> <p>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>
<b>Reason</b>	Arterial PaO <sub>2</sub> (and associated FiO <sub>2</sub> ) at first contact with a specialist paediatric intensive care doctor is weighted in PIM
<b>Format</b>	Numerical value (e.g. 9)  Units: kPa.3-60; validation check if range falls outside 1-70

## Arterial PaO<sub>2</sub>: Oxygen pressure (mmHg)

---

<b>Description</b>	<p>The <b>first</b> arterial PaO<sub>2</sub> measured and recorded within the period following first contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit</p> <p>First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval</p> <p>Data that are available to the specialist paediatric intensive care 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>
<b>Reason</b>	Arterial PaO <sub>2</sub> (and associated FiO <sub>2</sub> ) at first contact with a specialist paediatric intensive care doctor is weighted in PIM
<b>Format</b>	<p>Numerical value (e.g. 67.5)</p> <p>Units: mmHg. 22 – 450; validation check if range falls outside 7.5 – 525</p>

## FiO<sub>2</sub> (at the time Arterial PaO<sub>2</sub> measured)

---

<b>Description</b>	<p>Record the FiO<sub>2</sub> being given at the same time that the <b>first</b> arterial PaO<sub>2</sub> is measured and recorded following first contact between the patient and a specialist paediatric intensive care doctor</p> <p>First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval</p> <p>Data that are available to the specialist paediatric intensive care 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 record in association with arterial blood gas measurements</p> <p>Record 0.21 if patient in air</p> <p>Record 999 if FiO<sub>2</sub> is missing</p>
<b>Reason</b>	Arterial PaO <sub>2</sub> and associated FiO <sub>2</sub> at first contact with a specialist paediatric intensive care doctor are weighted in PIM if oxygen is delivered via an ET tube or a head box
<b>Format</b>	<p>Numerical value (e.g. 0.4)</p> <p>Units: Fraction (decimal)</p>

## Intubation

---

**Description** Record whether or not the child was intubated at the time of the **first** arterial PaO<sub>2</sub> and associated FiO<sub>2</sub> (measured and recorded) following first contact between the patient and a specialist paediatric intensive care doctor

First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval

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

**Reason** PaO<sub>2</sub> and associated FiO<sub>2</sub> at first contact with a specialist paediatric intensive care doctor are weighted in PIM

**Format** Choose from one of the following:

- Yes
- No

## Headbox

---

**Description** Record whether or not the child was receiving oxygen via a head box at the time of the **first** arterial PaO<sub>2</sub> and associated FiO<sub>2</sub> (measured and recorded) following first contact between the patient and a specialist paediatric intensive care doctor

First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval

**Reason** Arterial PaO<sub>2</sub> and associated FiO<sub>2</sub> at first contact with a specialist paediatric intensive care doctor are weighted in PIM if oxygen is delivered via an ET tube or a head box

**Format** Choose from one of the following:

- Yes
- No

## Base excess

---

**Description** The **first** base excess value measured and recorded from the arterial, capillary or venous blood gas within the period following first contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit

First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval

Data that are available to the specialist paediatric intensive care 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

Manually calculated in vitro or in vivo base excess values are **not** accepted

**Specify** source of result: arterial, capillary **or** venous blood gas measurement

**Reason** Base excess at first contact with a specialist paediatric intensive care doctor is weighted in PIM

**Format** Numerical value (e.g. 6.0)

Units: mmol per litre

Expected range -30 to +20 mmol per litre

Validation check if range outside -40 to +30

Select from one of the following:

- Arterial
- Capillary
- Venous



## Lactate

---

**Description** The **first** blood lactate value measured and recorded from the arterial, capillary or venous blood gas within the period following first contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit

First contact with a specialist paediatric intensive care doctor refers to first face-to-face (not telephone) contact in your own hospital (on your ICU, emergency department or ward) or another hospital/unit on retrieval

Data that are available to the specialist paediatric intensive care 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

**Specify** source of result: arterial, capillary **or** venous blood gas measurement

**Reason** Blood lactate at first contact may predict outcome and be valuable alongside PIM

**Format** Numerical value, to 1 decimal place (e.g. 3.1)

Units: mmol per litre

Expected range 0.2 – 15.0: mmol per litre

Validation check if range outside 0.2 to 15.0

Select from one of the following:

- Arterial
- Capillary
- Venous

## Mechanical ventilation

---

**Description** Specifies whether mechanical ventilation was administered at any time within the period following first face to face contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit

First contact with a specialist paediatric intensive care doctor refers to first face-to-face contact in your own hospital (on your ICU, emergency department or ward), or another hospital/unit on retrieval

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

Mechanical ventilation refers to both invasive (ETT or tracheostomy), and non-invasive (nasopharyngeal airway, mask or nasal prongs). High frequency, jet ventilators, negative pressure ventilators, BiPAP and CPAP are all considered as mechanical ventilation. ECMO and IVOX are not considered as mechanical ventilation, however most patients on ECMO and IVOX are usually also being ventilated

**DO NOT** include use of a device to deliver high flow nasal cannula therapy

**Reason** Mechanical ventilation during the first hour of first face to face contact with the paediatric intensive care service is weighted in PIM

**Format** Choose from one of the following:

- Yes
- No
- Unknown

## CPAP

---

**Description** Identifies whether the child receives CPAP at any time within the period following first face to face contact between the patient and a specialist paediatric intensive care doctor to one hour after admission to your unit

First contact with a specialist paediatric intensive care doctor refers to first face-to-face contact in your own hospital (on your ICU, emergency department or ward), or another hospital/unit on retrieval

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

**DO NOT** include use of a device to deliver high flow nasal cannula therapy

**Reason** CPAP given during the first hour of first face to face contact with the paediatric intensive care service is weighted in PIM

**Format** Choose from one of the following:

- Yes
- No
- Unknown

## Pupil reaction

---

<b>Description</b>	<p>The first observed pupil 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</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 record as BOTH fixed and dilated if both pupils are greater than 3mm and both are fixed</p> <p>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, local injury to the eye or chronically altered from a previous disease</p> <p>Pupil reaction must be assessed by exposure to strong direct light</p>
<b>Reason</b>	<p>Pupillary reactions are used as an index of brain function. Reaction to bright light at first contact with your unit doctor is weighted in PIM</p>
<b>Format</b>	<p>Choose from one of the following:</p> <ul style="list-style-type: none"><li>▪ Both fixed and dilated</li><li>▪ Other reaction</li><li>▪ Unknown</li></ul>

## DIAGNOSES AND PROCEDURES

### Primary diagnosis for this admission

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**Description** 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, and epidemiological analysis

**Format** Free text description of primary diagnosis for admission given in clinical notes and / or discharge documentation

### Other reasons for this admission

---

**Description** 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 description of other reasons for admission given in clinical notes and / or discharge documentation

## Operations and procedures performed during and prior to this admission

---

<b>Description</b>	Any operations and / or procedures performed during this admission to PIC or during the current hospital spell and relating to this admission to PIC  Where type of admission to the unit is Planned – following surgery or Unplanned – following surgery at least one operation or procedure is required for this admission event
<b>Reason</b>	Required for clinical audit, epidemiological analysis and assessment of health services delivery
<b>Format</b>	Free text description of other reasons for admission given in clinical notes and / or discharge documentation

## Co-morbidity

---

<b>Description</b>	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 this admission. Co-morbidity relates to any underlying condition recorded in the notes e.g. Trisomy 21
<b>Reason</b>	Required for clinical audit, epidemiological analysis and assessment of health services delivery
<b>Format</b>	Free text description of other reasons for admission given in clinical notes and / or discharge documentation

## Was a tracheostomy performed during this admission?

---

<b>Description</b>	Specifies whether the child had a tracheostomy performed during this admission to your unit
<b>Reason</b>	Required for measurement of main therapeutic interventions and analysis
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>• Yes</li><li>• No</li><li>• Unknown</li></ul>

# DAILY INTERVENTIONS

## Admission Date

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<b>Description</b>	The actual date that the child was physically admitted to a bed or cot within your unit
<b>Reason</b>	Date of admission to your unit is used to identify the date on which the recording of the daily interventions commences  24 hour period, starting from 00hr00mins, 23.59 is the end of one day and 00.00 is the start of the next day
<b>Format</b>	Date: dd/mm/yyyy

## Basic

### No defined critical care activity

---

<b>Description</b>	True if there was no defined critical care activity received that day
<b>Reason</b>	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 99)
<b>Format</b>	Insert an X if true

### Continuous ECG monitoring

---

<b>Description</b>	True if continuous ECG monitoring was received that day
<b>Reason</b>	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 50)
<b>Format</b>	Insert an X if true

## Continuous pulse oximetry

---

**Description** True if continuous pulse oximetry was received that day

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

**Format** Insert an X if true

## Airway and ventilatory

### Invasive ventilation via endotracheal tube

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**Description** True if invasive ventilation via endotracheal tube was received that day

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

**Format** Insert an X if true

### Invasive ventilation via tracheostomy tube

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**Description** True if invasive ventilation via tracheostomy tube was received that day

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

**Format** Insert an X if true

### Non-invasive ventilatory support

---

**Description** True if non-invasive ventilatory support was received that day.

**Do NOT** include use of a device to deliver high flow nasal cannula therapy

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

**Format** Insert an X if true



## Advanced ventilatory support (jet ventilation)

---

**Description** True if advanced ventilatory support (jet ventilation) was received that day

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

**Format** Insert an X if true

## Advanced ventilatory support (oscillatory ventilation)

---

**Description** True if advanced ventilatory support (oscillatory ventilation) was received that day

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

**Format** Insert an X if true

## Nasopharyngeal airway

---

**Description** True if a nasopharyngeal airway was in place that day

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

**Format** Insert an X if true

## Tracheostomy cared for by nursing staff

---

**Description** True if a tracheostomy was cared for by nursing staff that day; including responsibility for and supervision of an external carer (e.g. parent)

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

**Format** Insert an X if true

## Supplemental oxygen therapy (irrespective of ventilatory state)

---

**Description** 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** Insert an X if true

## High flow nasal cannula therapy

---

**Description** If high flow nasal cannula therapy (HFNCT) was received that day, record the maximum flow in l/min that day

**Reason** To enable the audit of delivery of this therapy (Activity code 88)

**Format** Numerical value (e.g. 28)

Units: L/min

Validation check if range outside 04-40

## Upper airway obstruction requiring nebulised adrenaline (epinephrine)

---

**Description** True if there was an upper airway obstruction requiring nebulised adrenalin / epinephrine that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 57)

**Format** Insert an X if true

## Apnoea requiring intervention (>3 in 24 hours or requiring bag and mask ventilation)

---

**Description** True if there was an apnoea >3 in 24 hours or requiring bag and mask ventilation that day

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

**Format**      Insert an X if true

## **Acute severe asthma requiring intravenous bronchodilator therapy or continuous nebuliser**

---

**Description**      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**            Insert an X if true

## **Unplanned extubation**

---

**Description**      True if there was dislodgement of the ETT from the trachea, without the intention to extubate immediately and without the presence of airway competent clinical staff in the bed space, appropriately prepared for the procedure

Record the number of unplanned extubations that day

**Reason**            To audit PICS Standard and CRG reporting requirements (Activity code 90)

**Format**            Numerical values (e.g. 01) if true

Validation check if number greater than 5

## **Cardiovascular**

### **Arterial line monitoring**

---

**Description**      True if arterial line monitoring was received that day.

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

**Format**            Insert an X if true

## External pacing

---

**Description** True if external cardiac pacing, via an external box (pacing wires, external pads or oesophageal pacing) was received that day.

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 61)

**Format** Insert an X if true

## Central venous catheter in situ

---

**Description** True if a central venous catheter is in situ that day, regardless of the number of lumens and the nature of the CVC.

This includes any venous vascular catheter that ends close to or in the great vessels (femoral, subclavian, jugular etc.), chest or within abdominal cavity. This includes peripherally inserted central catheters. CVCs may be short or long term. Common names are PICC, CVC, Portacath, Hickman, Broviac, Leaderflex, UVC etc.

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

**Format** Insert an X if true

## Central venous pressure monitoring

---

**Description** True if central venous pressure monitoring was received that day

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

**Format** Insert an X if true

## Continuous infusion of inotrope, vasodilator or prostaglandin

---

**Description** 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** Insert an X if true

## **Bolus IV fluids (>80 ml/kg/day) in addition to maintenance IV fluids**

---

**Description** 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** Insert an X if true

## **Cardio-pulmonary resuscitation**

---

**Description** True if cardio-pulmonary resuscitation was received that day

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

**Format** Insert an X if true

## **Extracorporeal membrane oxygenation (ECMO)**

---

**Description** True if extracorporeal membrane oxygenation (ECMO) was received that day. Include use of an interventional lung assist device (iLA)

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

**Format** Insert an X if true

## **Ventricular assist device (VAD)**

---

**Description** 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**      Insert an X if true

## **Aortic balloon pump**

---

**Description**      True if an aortic balloon pump was in place that day

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

**Format**            Insert an X if true

## **Arrhythmia requiring intravenous anti-arrhythmic therapy**

---

**Description**      True if an intravenous anti-arrhythmic drug is administered to a patient with a cardiac arrhythmia at any point in that calendar day.

Examples would include, but not be confined to, adenosine, amiodarone, propranolol, flecanide, isoprenaline.

**Reason**            Part of the Paediatric Critical Care Minimum Dataset (Activity Code 94)

**Format**            Insert an X if true

## **Renal**

### **Urine catheter in situ**

---

**Description**      True if urinary catheter is in situ that day. This relates to any urethral or suprapubic catheter that is inserted into the bladder, connected to a closed drainage system, and left in-situ.

This category does NOT include intermittent catheterisation or non-invasive drainage systems such as condom catheter.

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

**Format**            Insert an X if true.

## Peritoneal dialysis

---

**Description** True if peritoneal dialysis was received that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 05)

**Format** Insert an X if true

## Haemofiltration

---

**Description** True if haemofiltration was received that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 16)

**Format** Insert an X if true

## Haemodialysis

---

**Description** True if haemodialysis was received that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 66)

**Format** Insert an X if true

## Plasma filtration

---

**Description** True if plasma filtration was received that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 67)

**Format** Insert an X if true

## Plasma exchange

---

**Description** True if plasma exchange was received that day.

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 67)

**Format** Insert an X if true

## Neurological

### ICP-intracranial pressure monitoring

---

**Description** True if intracranial pressure monitoring (ICP) was received that day

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

**Format** Insert an X if true

### Intraventricular catheter or external ventricular drain

---

**Description** 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** Insert an X if true

### Status epilepticus requiring treatment with continuous infusion of anti-epileptic drugs

---

**Description** True if a patient has status epilepticus at any point in that calendar day AND is receiving a continuous intravenous infusion of an anti-epileptic drug for a period of at least 4 hours in that calendar day

Examples would include, but not be confined to, midazolam (or another benzodiazepine), thiopentone, propofol

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 97)



**Format**      Insert an X if true

## Reduced consciousness level (GCS ≤ 12 AND hourly (or more frequent) GCS monitoring)

---

**Description**      True if a patient has a recorded Glasgow Coma Scale (GCS) score of 12 or below at any point in that calendar day AND is having hourly (or more frequent) assessment and recording of GCS

Note that the patient must be having GCS monitoring for a period of at least 4 hours in that calendar day. AVPU assessment should not be considered as equivalent to GCS

**Reason**            Part of the Paediatric Critical Care Minimum Dataset (Activity Code 95)

**Format**            Insert an X if true

## Delirium screening result

---

**Description**      Identifies whether the child has any positive threshold score on a validated screening tool for delirium within each 24-hour period.

Delirium screening is conducted at least once per 12-hour nursing shift. If the screen is positive on any occasion, enter 'positive'.

**Positive** threshold scores are as follows:

1. Cornell Assessment of Pediatric Delirium (CAPD)
  - a. **positive if the score is 9 or above**
  
2. Sophia Observation withdrawal Score-Paediatric Delirium (SOS-PD)
  - a. **positive if the score is 4 or above**
  - b. **or 4 AND child is hallucinating**
  - c. **OR a parent or carer states behaviour is different to usual or is unrecognisable**
  
3. Pediatric Confusion Assessment Method for the Intensive Care Unit (pCAM-ICU)
  - a. **positive if features 1 (change or fluctuation in mental status), 2 (inattention), and 3 (altered level of consciousness) are present**
  
4. PreSchool Confusion Assessment Method for the Intensive Care Unit (psCAM-ICU)
  - a. **positive if features 1 (change or fluctuation in mental status), 2 (inattention), and 3 (altered level of consciousness) are present**
  - b. **Or positive if features 1 (change or fluctuation in mental status), 2 (inattention), and 4 (disorganised brain) are present**

**Negative:** identifies that the child did not screen positive on the validated delirium screening tool used in the unit (i.e. did not reach the threshold indicating delirium)

**Unable to assess:** identifies that the child was exempt from delirium screening due to any of the following reasons:

- being unarousable [comatose]
- deeply sedated
- receiving continuous neuromuscular blocking agents
- is a pre-term baby <37 weeks gestation
- admitted within the four hours prior to midnight or discharged within four hours from midnight

**Did not assess:** identifies that the child was not exempt from delirium screening but was not assessed for any other reason than those specified in 'Unable to assess'.

**Reason** Required to record prevalence and burden of delirium occurrence for epidemiological analysis

**Format** Choose from one of the following:

- Positive
- Negative
- Unable to access
- Did not assess

## Analgesia/sedation

### Epidural catheter in situ

---

**Description** True if epidural catheter is in situ for the purpose of delivery of epidural analgesia at any point in that calendar day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 85)

**Format** Insert an X if true

### Continuous intravenous infusion of a sedative agent

---

**Description** True if a patient is receiving a continuous intravenous infusion of a sedative agent for at least 4 hours in that calendar day

Examples would include, but not be confined to, midazolam (or another benzodiazepine), clonidine, thiopentone, propofol, morphine, fentanyl, remifentanyl and oxycodone

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code 96)

**Format**

Insert an X if true

## Metabolic

### Diabetic ketoacidosis (DKA) requiring continuous infusion of insulin

---

**Description** 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** Insert an X if true

## Other

### Exchange transfusion

---

**Description** True if exchange transfusion was received that day

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

**Format** Insert an X if true

### Intravenous thrombolysis

---

**Description** True if intravenous thrombolysis was received that day

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

**Format** Insert an X if true

## Extracorporeal liver support using molecular absorbent recirculating system (MARS)

---

**Description** 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** Insert an X if true

## Patient nursed in single occupancy cubicle

---

**Description** True if patient was nursed in a single occupancy cubicle that day.

**Specify** the reason for isolation in the text box provided

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

**Format** Insert an X if true and state reason for isolation in text box below

## High cost drugs

### Medical gases band 1 - nitric oxide

---

**Description** True if nitric oxide was administered that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code X84.1)

**Format** Insert an X if true

## Surfactant

---

**Description** True if surfactant was administered that day

**Reason** Part of the Paediatric Critical Care Minimum Dataset (Activity Code X84.2)

**Format** Insert an X if true

## Reason for isolation

---

**Description** If patient nursed in single occupancy cubicle, state reason for isolation

**Reason** Part of the Paediatric Critical Care Minimum Dataset

**Format** Free text

At data entry to PICANet Web, choose from one of the list provided or select 'Other reason'.  
If not known select 'Unknown'.

## Additional information

### Is the patient on a clinical trial?

---

**Description** Specifies whether the child is part of a clinical trial

**Reason** Prior inclusion on a clinical trial may influence subsequent outcome

**Format** Choose from one of the following:

- Yes
- No
- Unknown

### Name of trial

---

**Description** The name of the clinical trial in which the child is participating

**Reason** Prior inclusion on a clinical trial may influence subsequent outcome

**Format** Free text name of clinical trial.

## GROWTH MEASUREMENTS

### Height

---

<b>Description</b>	Height of child in centimetres
<b>Reason</b>	Included at the request of those wishing to conduct studies which involve this parameter.
<b>Format</b>	Numerical value to 1 decimal place (e.g. 74.9) Units: cm; validation check if range outside 46 to 180.

### Weight

---

<b>Description</b>	Weight of child in kilograms measured at or as soon as possible after admission to the unit  If weight is not measured at the specified time; a weight recorded on another ward or department immediately prior to transfer to your unit, or a recent weight provided by a parent or carer may be recorded.
<b>Reason</b>	To enable the audit of the weight of children admitted to intensive care and epidemiological analysis
<b>Format</b>	Numerical value to 3 decimal places (e.g. 7.940) Units: kg; validation check if range <1.000 to >80.000kg

### Abdominal circumference

---

<b>Description</b>	The abdominal circumference of the child in centimetres
<b>Reason</b>	Included at the request of those wishing to conduct studies which involve this parameter
<b>Format</b>	Numerical value (e.g. 74.9) Units: cm; validation check if range outside 40 to 100



## HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

### Number of episodes of PICU-acquired central line associated bloodstream infection (CLABSI)

---

**Description** Document the number of episodes of PICU-acquired central line associated blood stream infection (CLABSI) ensuring that the child meets all four of the criteria of A, B, C and D:

**A:** Criteria for blood stream infection as defined by PICU HCAI group\*

**AND**

**B:** The presence of at least one central venous catheter (CVC) at the time of the positive blood culture or a CVC that was removed within 48 hours before the positive blood culture

**AND**

**C:** The signs and symptoms and the positive laboratory result, including the pathogen cultured from the blood, are not primarily related to infection at another site

**AND**

**D:** The child has been admitted to PICU for >48 hours (i.e. not admitted to PICU for or with a CLABSI), or is within 48 hours of a PICU discharge at the time of blood culture sampling

\*See the [HCAI expanded dataset definitions and FAQ](#) document for the full BSI criteria, definitions and frequently asked questions in relation to CLABSI.

**Reason** For the purposes of clinical audit, epidemiological analysis and assessment of health services delivery

**Format** Numerical value (e.g. 3)  
Expecting a value between 0 and 9  
If unknown enter 999

## Number of episodes of PICU-acquired catheter associated urinary tract infection (CAUTI)

---

**Description** Document the number of episodes of PICU-acquired catheter associated urinary tract infections (CAUTI), ensuring that the child meets all three of the criteria for A, B and C:

**A:** An indwelling urethral or suprapubic catheter that has been in situ for at least 48 hours or where the urine sample has been obtained within 48 hours of removal of the catheter

**AND**

**B:** UTI criteria: meets either one of the two below:

1. A child of any age with a positive urine culture with  $>10^3$  colony forming units/mL with no more than two species of microorganisms AND at least 1 of the following signs or symptoms:
  - Fever  $> 38^{\circ}\text{C}$
  - Suprapubic tenderness
  - Costovertebral angle pain
  - Costovertebral angle tenderness

**OR**

2. A patient  $<1$  year with a positive urine culture with  $>10^3$  colony forming units/mL with no more than two species of microorganisms AND at least 1 of the following signs or symptoms:
  - Fever  $>38^{\circ}\text{C}$  or hypothermia  $<36^{\circ}\text{C}$
  - Apnoea
  - Bradycardia
  - Lethargy
  - Vomiting

**AND**

**C:** The child has been admitted to PICU for  $>48$  hours (i.e. not admitted to PICU for or with a CAUTI) or is within 48 hours of a PICU discharge at the time of urine culture

See the [HCAI expanded dataset definitions and FAQ](#) document for frequently asked questions in relation to CAUTI.

**Reason** For clinical audit, epidemiological analysis and assessment of health service delivery

**Format** Numerical value (e.g. 3)  
Expecting a value between 0 and 9  
If unknown enter 999

## DISCHARGE INFORMATION

### Status at discharge from your unit

---

**Description** Identifies the status (alive or dead) of the child on discharge from your unit. Dead includes admissions transferred out of your unit to become heart beating organ donors.

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

**Format** Choose from one of the following:

- Alive
- Dead

### Date and time of discharge

---

**Description** Identifies the date and time 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 is used to calculate total length of stay on your unit

**Format** Date: dd/mm/yyyy

Time: (24 hour clock); hh:mm

### Discharged for palliative care

---

**Description** 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

## Destination following discharge from your unit

---

**Description** 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
- Unknown

If same hospital or other hospital, choose from one of the following:

- ICU
- PICU
- NICU
- HDU
- SCBU
- Ward
- Other
- Unknown

## Date and time of death

---

<b>Description</b>	<p>Identifies the date and time of death if this occurs whilst the child is resident on your unit. 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 prior to the data and time of admission</p>
<b>Reason</b>	Date of death and Time of death are identified as one of the principal outcomes of paediatric intensive care. Required for epidemiological analysis and assessment of health services delivery
<b>Format</b>	Date: dd/mm/yyyy <span style="float: right;">Time</span> Time: (24 hour clock); hh:mm

## Mode of Death

---

<b>Description</b>	<p>Specifies the mode of death for the deceased patient</p> <p><b>Treatment withdrawn:</b> death follows the withdrawal of ongoing organ support For example – an infant admitted with Group B septicaemia is extremely unstable, head CT scan shows complete loss of grey-white differentiation; as the infant deteriorates further decisions are made to stop treatment and extubate</p> <p><b>Treatment limitation:</b> death follows a decision to limit on-going organ support and may include a limitation of on-going organ support and/or a decision that the patient is not for active resuscitation For example – a child with an underlying congenital condition, which includes immune deficiency is admitted with pneumonia requiring inotropic support but continues to deteriorate. The family agree their child should not be resuscitated; the child arrests and dies</p> <p><b>Brain stem death:</b> death is confirmed using brain stem death criteria/testing For example: a child with a severe head injury is admitted following a road traffic collision. The child develops fixed dilated pupils and brain stem testing confirms death</p> <p><b>Failed cardiopulmonary resuscitation:</b> death immediately follows an unsuccessful attempt at cardiopulmonary resuscitation For example: a child with a known renal condition on long-term dialysis develops sepsis and deteriorates despite maximum inotropic support. Cardiac arrest occurs but is unsuccessful</p>
<b>Reason</b>	Required for epidemiological analysis and assessment of health services delivery

**Format** Choose from one of the following:

- Treatment withdrawn
- Treatment limitation
- Brain stem death
- Failed CPR

## Transplant Donor?

---

**Description** Identifies whether the deceased patient was a transplant donor, and whether solid organs and/or tissues were removed for transplantation to the body of the recipient

- **Organs:** may include heart, pancreas, liver, kidneys, lungs or intestines
- **Tissues:** may include skin, tendons, bone, heart valves and cornea

**Reason** Enables review of variance in donor rates. Required for clinical audit, epidemiological analysis and assessment of health services delivery. Acts as a filter for further data entry

**Format** Choose from one of the following:

- No
- Yes – solid organs only
- Yes – tissues only
- Yes – both solid organs and tissues

# FOLLOW UP 30 DAYS POST DISCHARGE FROM YOUR UNIT

## Status

---

**Description** Identifies the status (alive or dead) of the child on 30 days post discharge from your unit

**Format** Choose from one of the following:

- Alive
- Dead
- Unknown

## Date of death post-discharge from your unit

---

**Description** Identifies the date of death if this occurs post-discharge from your unit and is identified at 30 day follow-up

**Reason** Date of death and Time of death are identified as one of the principal outcomes of paediatric intensive care. Required for epidemiological analysis and assessment of health services delivery

**Format** Date; dd/mm/yyyy

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

---

**Description** 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
- Unknown

## COMMENTS

<b>Description</b>	<p>Any additional information considered relevant to the admission</p> <p>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</p> <p>No identifiers (patient, nurse, doctor, ICU, hospital) should be included in text data entered into this field</p> <p>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</p>
<b>Reason</b>	<p>No dataset specification covers all eventualities: to deal with this a text field has been included for comments/additional information</p>
<b>Format</b>	<p>Free text</p>

## FORM COMPLETED BY

<b>Description</b>	<p>Name of person completing the form</p>
<b>Reason</b>	<p>For local use only to assist with following up queries relating to completion of this form</p>