How to complete the Admission (Level 2) form

PICANet

Patient details - Record family name, first name, full address and postcode. If not known, record unknown and state reason why in comments section.

NHS – England an Wales,
CHI – Scotland,
H&C - Northern Ireland,
Patient not eligible if overseas national who does not have an allocated NHS,CHI or H&C number.

Case note number - Local hospital case note number if applicable

Date of birth – As recorded on the child's birth certificate or other appropriate document.
Not estimated
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/correct month/correct year.

Sex – Identifies genotypical sex of child at commencement of critical care.

PICANet **Paediatric Intensive Care Audit Network · Data collection form** **Admission (Level 2)**

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)* __ / __ / ____
☐ Not estimated
☐ Estimated
☐ Anonymised

Sex
☐ Male
☐ Female
☐ Ambiguous

Ethnic group
White
☐ English, Welsh, Scottish, Northern Irish or British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Roma
☐ Any other White background *(specify)*
Mixed or multiple ethnic groups
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed or multiple ethnic background *(specify)*
Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background *(specify)*
Black, Black British, Caribbean or African
☐ Caribbean
☐ African
☐ Any other Black, Black British or Caribbean background *(specify)*
Other ethnic group
☐ Chinese
☐ Arab
☐ Any other ethnic group *(specify)*
☐ Not stated (declined)

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

Birth order of **Multiplicity**

Admission details

Date and time of admission to unit
__ / __ / 2 0 __ __ : __

Admission number

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

Previous critical care admission *(during current hospital stay)*
☐ PICU
☐ NICU
☐ ICU (adult)
☐ Level 2 unit (HDU)
☐ None
☐ Unknown

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

Care area admitted from *(includes transfers in)*
☐ X-ray / endoscopy / CT scanner
☐ Recovery only
☐ PICU
☐ NICU
☐ ICU (adult)
☐ Level 2 unit (HDU)
☐ Ward
☐ Theatre and recovery
☐ Emergency department (A&E)
☐ Other intermediate care area *(specify)*

Retrieval / transfer?
☐ Yes ☐ No

If yes
Type of transport team
☐ PICU
☐ Specialised paediatric transport service
☐ Transport team from neonates
☐ Other specialist team
☐ Non-specialist team
☐ Unknown

Transport team

Collection unit

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

Form completed by

For forms, dataset manuals and guidance, go to **picanet.org.uk**

Ethnic group - Identifies the child's ethnic origin, according to 2021 Census categories.

Other ethnic group - The child's exact ethnic origin (if known), if not specified in the table containing 2021 Census categories.

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

Birth order – Identifies the order in which the child was delivered if a multiple birth.
Multiplicity - Identifies whether the child was a singleton, twin, triplet, etc.

Date and time of admission to unit - The actual date and time that the child was physically admitted to a bed or cot within your unit.

Admission number - Unique identifier assigned to each consecutive admission to your unit, as recorded in your unit admission book or clinical information system.

Type of admission to unit
Planned admission following surgery – an admission where clinicians were aware before the surgery begins or if it could have been delayed by >24 hours without risk.
Unplanned admission following surgery – an admission where clinicians were not aware before the surgery began.
Planned (other) – an admission that is not an emergency.
Unplanned (other)- an admission your unit was not expecting; an emergency admission.

Previous critical care admission – Specifies whether the child has had a previous admission to a critical care environment such as PICU, NICU, ICU (Adult) or a Level 2 unit (HDU) before admission to your unit, during their current hospital stay.

Source of admission – The location from where the child was directly admitted to your unit.

PICA Net **Paediatric Intensive Care Audit Network · Data collection form** **Admission (Level 2)**

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)* __ / __ / ____ → ☐ Not estimated ☐ Estimated ☐ Anonymised

Sex
☐ Male
☐ Female
☐ Ambiguous

Ethnic group
White
☐ English, Welsh, Scottish, Northern Irish or British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Roma
☐ Any other White background *(specify)*
Mixed or multiple ethnic groups
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed or multiple ethnic background *(specify)*
Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background *(specify)*
Black, Black British, Caribbean or African
☐ Caribbean
☐ African
☐ Any other Black, Black British or Caribbean background *(specify)*
Other ethnic group
☐ Chinese
☐ Arab
☐ Any other ethnic group *(specify)*
☐ Not stated (declined)

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

Birth order __ of Multiplicity __

Admission details

Date and time of admission to unit __ / __ / 20__ __:__

Admission number

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

Previous critical care admission *(during current hospital stay)*
☐ PICU
☐ NICU
☐ ICU (adult)
☐ Level 2 unit (HDU)
☐ None
☐ Unknown

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

Care area admitted from *(includes transfers in)*
☐ X-ray / endoscopy / CT scanner
☐ Recovery only
☐ PICU
☐ NICU
☐ ICU (adult)
☐ Level 2 unit (HDU)
☐ Ward
☐ Theatre and recovery
☐ Emergency department (A&E)
☐ Other intermediate care area *(specify)*

Retrieval / transfer?
☐ Yes ☐ No

If yes
Type of transport team
☐ PICU
☐ Specialised paediatric transport service
☐ Transport team from neonates
☐ Other specialist team
☐ Non-specialist team
☐ Unknown

Transport team

Collection unit

Contact us · picanet@leeds.ac.uk · 0113 343 8125 **Form completed by**

For forms, dataset manuals and guidance, go to **picanet.org.uk**

Care area admitted from -
X-ray, endoscopy, CT scanner or similar - identifies that the child came from an area where diagnostic procedures may have been carried out.
Recovery only - means the child was cared for in the theatre recovery area prior to admission to your unit (e.g. for intubation).
Level 2 Unit (HDU) - child was receiving care in a Level 2 critical care unit/high dependency area.
PICU - child was receiving care within an adult or other specialist PICU.
NICU - child was receiving care within an adult or other specialist NICU.
ICU (Adult) - child was receiving care within an adult or other specialist ICU.
Ward - child was receiving care in a ward.
Theatre and recovery - child has undergone all or part of a surgical procedure or has received an anaesthetic for a procedure and was receiving care within the theatre and recovery area.
Emergency department (A&E) - child was receiving care within an Accident and Emergency Department.
Other intermediate care area (please specify) - is an area where the level of care is greater than that of the normal Unit (wards, but not an ICU (adult)/PICU/NICU or Level 2 Unit (HDU).

Retrieval/Transfer- Specifies whether the child was transferred to your unit from the original admitting hospital by a transport team.

Type of transport team
PICU - specialised PICU team transferred the child.
Specialised paediatric transport service (SPTS) - transport team from a specialised paediatric transport service (SPTS) transferred the child.
Transport team from neonates - specialist neonatal transport team transferred the child.
Other specialist team - another specialist team (not a centralised transport service (PIC) or neonatal transport team), transported the child. This could be a trauma transport team transferring the child.
Non-specialist team - non-specialist team transported the child.

Transport team - The name of the transport service/team undertaking this episode of transport.

Collection Unit - Identifies the unique name of the PICU, DGH or the place such as an airport, where the patient is located at the time of collection by the transport team.

PIM Eligibility- Identifies whether the observations recorded meet the criteria for the calculation of a PIM 3 score.
PIM 3 applies to observations recorded between the first face-to-face contact with ICU doctor until one hour after admission. measurement during this time period.

Elective admission - An admission is considered elective if it could be postponed for more than 6 hours without adverse effects. Answer yes/no

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

Cardiac arrest before admission – include documented absence of pulse or requirement for external cardiac compression before this admission to Level 2 paediatric critical care service.
<u>**Do not**</u> include past history of cardiac arrest.

Past medical history
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.
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.
Other (none of the above) – Identifies that none of the above apply to the patient.

Severity of illness on admission *(always use the first recorded measurement)*

To assess severity of illness record the first documented observations taken within the first hour of admission

PIM eligibility
Were observations recorded between first face-to-face contact with ICU doctor and up to 1 hour of admission?
☐ Yes ☐ No

Elective admission?
☐ Yes ☐ No

Main reason for admission
☐ Asthma
☐ Bronchiolitis
☐ Croup
☐ Obstructive sleep apnoea
☐ Recovery from surgery → ☐ Bypass cardiac proc. ☐ Non-bypass cardiac proc. ☐ Elective liver transpl't ☐ 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 admission
☐ Cardiac arrest OUT of hospital
☐ Cardiomyopathy or myocarditis
☐ Severe combined immune deficiency
☐ Hypoplastic left heart syndrome
☐ Leukaemia/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
☐ Other (none of the above)

CARDIOVASCULAR

Heart rate
☐☐☐ beats per minute

Capillary refill time
☐☐ seconds

Systolic blood pressure
☐☐☐ mmHg

RESPIRATORY

Spontaneous respiratory rate
☐☐☐ breaths per minute

Respiratory distress
☐ None
☐ Mild
☐ Moderate
☐ Severe
☐ Unknown

SpO_2 *(via pulse oximetry)*
☐☐☐ %

Oxygen *(at time SpO_2 measured)*
FiO_2 ☐ . ☐☐ or **Flow** ☐☐ L/minute

INTERVENTIONS

Mechanical ventilation?
☐ Yes ☐ No

CPAP? *(include via tracheostomy, mask, nasal)*
☐ Yes ☐ No

HHHFT?
☐ Yes ☐ No

Facemask?
☐ Yes ☐ No

BIPAP? *(include via tracheostomy, mask, nasal)*
☐ Yes ☐ No

Tracheostomy ventilation?
☐ Yes ☐ No

Endotracheal intubation?
☐ Yes ☐ No

NEUROLOGICAL

Conscious level
☐ A – alert
☐ V – responds to voice
☐ P – responds to pain
☐ U – unresponsive

Pupil reaction *(if unresponsive)*
☐ Both fixed and dilated
☐ Other
☐ Unknown

Temperature
☐☐ . ☐ °C

BLOOD RESULTS

Blood glucose
☐☐ . ☐☐ mmol/L

Blood gas measured?
☐ Yes ☐ No

Blood gas source
☐ Arterial
☐ Capillary
☐ Venous

If arterial blood gas
Arterial PaO_2 ☐☐ . ☐☐ kPa or **Arterial PaO_2** ☐☐☐ mmHg
FiO_2 *(at time of arterial PaO_2 sample)*
☐ . ☐☐

Base excess
☐☐☐ . ☐ mmol/L

Lactate
☐☐ . ☐☐ mmol/L

Additional information

Was the patient on home oxygen or long-term ventilation immediately prior to this admission?
☐ Yes ☐ No

If yes, specify type (record highest level of intervention)
☐ BIPAP via tracheostomy
☐ CPAP via tracheostomy
☐ BIPAP via facemask
☐ CPAP via facemask
☐ NCPAP
☐ HHHFT
☐ Home oxygen
☐ Other *(specify)*

Weight
☐☐☐ . ☐☐☐ kg

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

Name of trial

Heart rate – The first value measured and recorded within the first hour following admission to your unit.

Capillary refill time – The first capillary refill time measured within the first hour following admission to your unit.

Systolic blood pressure – First systolic blood pressure measured and recorded in the first hour following admission to your unit.
Record *0* if patient in cardiac arrest, *30* if patient shocked and BP is measured but not recordable. Enter 999 if unknown.

Spontaneous respiratory Rate - The first respiratory rate measured and recorded within the first hour following admission to your unit.

Respiratory Distress - The first recorded assessment of respiratory distress recorded within the first hour following admission to your unit.

Sp02 – Record the first SpO2 (pulse oximetry) that has a corresponding FiO2 measured and recorded within the first hour following admission to your unit.
The patient's oxygen saturation (SpO2), expressed as a percentage.

Fi02 at the time of Sp02 – The FiO2 at the time of the first SpO2 measured and recorded following admission to your unit.
The patient's fraction of inspired oxygen (FiO2), expressed as a fraction.
Flow at the time of Sp02 - The Oxygen flow at the time of the first SpO2 measured and recorded in the first hour following admission to your unit.
The flow of oxygen administered to the patient, expressed in Litres per minute.

Identifies whether the child received the following interventions within the first hour following admission to your unit

Mechanical ventilation? - 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.

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

HHHFT?- Identifies whether the child receives heated humidified high flow therapy at any time within the first hour following admission to your unit .

Facemask?- Identifies whether the child receives a facemask at any time within the first hour following admission to your unit

BIPAP?- BIPAP may be given via an endotracheal tube, tracheostomy, facial BIPAP mask or nasal BIPAP mask/prongs.

Tracheostomy ventilation?- Specifies whether mechanical ventilation (other than HFNCT, CPAP or BIPAP) was given via a tracheostomy within the first hour following admission to your unit.

Endotracheal intubation?- Endotracheal intubation is defined as the insertion of an endotracheal tube into the child's airway.

Home 02 and long term ventilation - Specifies whether the child was on home oxygen or long-term ventilation immediately prior to this admission to hospital.
If yes selected – Specify they type of on home oxygen or long-term ventilation the child was on immediately prior to this admission to hospital.

Weight – Weight of child in kilograms measured at or as soon as possible after admission to the unit.

Is the patient on a clinical trial? – Specifies whether the child is part of a clinical trial and the name of the clinical trial in which the child is participating.

Severity of illness on admission *(always use the first recorded measurement)*

To assess severity of illness record the first documented observations taken within the first hour of admission

PIM eligibility
Were observations recorded between first face-to-face contact with ICU doctor and up to 1 hour of admission?
☐ Yes ☐ No

Elective admission?
☐ Yes ☐ No

Main reason for admission
☐ Asthma
☐ Bronchiolitis
☐ Croup
☐ Obstructive sleep apnoea
☐ Recovery from surgery ▶ ☐ Bypass cardiac proc. ☐ Non-bypass cardiac proc. ☐ Elective liver transpl't ☐ 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 admission
▶ ☐ Cardiac arrest OUT of hospital
☐ Cardiomyopathy or myocarditis
☐ Severe combined immune deficiency
☐ Hypoplastic left heart syndrome
☐ Leukaemia/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
☐ Other (none of the above)

CARDIOVASCULAR

Heart rate ☐☐☐ beats per minute

Capillary refill time ☐☐ seconds

Systolic blood pressure ☐☐☐ mmHg

RESPIRATORY

Spontaneous respiratory rate ☐☐☐ breaths per minute

Respiratory distress
☐ None
☐ Mild
☐ Moderate
☐ Severe
☐ Unknown

SpO_2 *(via pulse oximetry)* ☐☐☐ %

Oxygen *(at time SpO_2 measured)*
FiO_2 ☐ . ☐☐ or **Flow** ☐☐ L/minute

INTERVENTIONS

Mechanical ventilation? ☐ Yes ☐ No

CPAP? *(include via tracheostomy, mask, nasal)* ☐ Yes ☐ No

HHHFT? ☐ Yes ☐ No

Facemask? ☐ Yes ☐ No

BIPAP? *(include via tracheostomy, mask, nasal)* ☐ Yes ☐ No

Tracheostomy ventilation? ☐ Yes ☐ No

Endotracheal intubation? ☐ Yes ☐ No

NEUROLOGICAL

Conscious level
☐ A – alert
☐ V – responds to voice
☐ P – responds to pain
☐ U – unresponsive

Pupil reaction *(if unresponsive)*
☐ Both fixed and dilated
☐ Other
☐ Unknown

Temperature ☐☐ . ☐ °C

BLOOD RESULTS

Blood glucose ☐☐ . ☐☐ mmol/L

Blood gas measured? ☐ Yes ☐ No

Blood gas source
☐ Arterial
☐ Capillary
☐ Venous

If arterial blood gas
Arterial PaO_2 ☐☐ . ☐☐ kPa or **Arterial PaO_2** ☐☐☐ mmHg
FiO_2 *(at time of arterial PaO_2 sample)* ☐ . ☐☐

Base excess ☐☐☐ . ☐ mmol/L

Lactate ☐☐ . ☐☐ mmol/L

Additional information

Was the patient on home oxygen or long-term ventilation immediately prior to this admission?
☐ Yes ☐ No

If yes, specify type (record highest level of intervention)
☐ BIPAP via tracheostomy
☐ CPAP via tracheostomy
☐ BIPAP via facemask
☐ CPAP via facemask
☐ NCPAP
☐ HHHFT
☐ Home oxygen
☐ Other *(specify)*

Weight ☐☐☐ . ☐☐☐ kg

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

Name of trial

PICANet Admission (Level 2) data collection form · Version 2.0 · January 2025 · Copyright © 2025 University of Leeds and University of Leicester

The first value measured and recorded within the first hour following admission to your unit

Conscious Level – Measured using the AVPU Scale - Alert/Voice/Pain/Unresponsive.

Pupil Reaction – If 'Conscious level' is 'Unresponsive' or 'Unknown' you must record a measurement of 'Pupil reaction'
Only record as BOTH fixed and dilated if both pupils are greater than 3mm and both are fixed.

Temperature – The first core temperature measured and recorded within the first hour following admission to your unit.
Measurement of tympanic, oesophageal or rectal temperature only.

Blood glucose – The first blood glucose value measured and recorded

Blood gas measured? – Confirmation that results from a blood gas taken and analysed within the first hour following admission to your unit.
Note: Blood gas analysis is not ALWAYS clinically indicated in Level 2 Critical care settings. Select yes if blood gas analysed within first hour following admission to your unit.
Blood Gas Source - Confirmation of the source of the blood gas measurements taken and analysed within the first hour following admission to your unit.

Arterial Pa02 – The first arterial PaO2 measured and recorded within the first hour following admission to your unit.
Recorded in either kPa or mmHg.
Fi02 at time of Pa02 – Record the FiO2 being given at the same time that the first arterial PaO2 is measured and recorded within the first hour following admission to your unit.
Record 0.21 if patient in air.

Base excess – The first base excess value measured and recorded from the arterial, capillary or venous blood gas within the first hour following admission to your unit.
Manually calculated in vitro or in vivo base excess values are not accepted.

Lactate – The first blood lactate value measured and recorded from the arterial, capillary or venous blood gas within the first hour following admission to your unit.

'How-to' PICANet Admission (Level 2) Data Collection Form · Version 2.0 · January 2025 · Copyright © 2025 Universities of Leeds and Leicester

Daily interventions - record admission date and insert '**X**' in the box for each intervention given at any time in each 24-hour period from midnight to midnight.
An item should be recorded in the PCCMDS when the critical care activity applies for a period of greater than 4 hours.
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

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

Maximal oxygen concentrate (%) - If supplemental oxygen therapy was given that day (irrespective of ventilatory state), record the maximum concentration (%) that day.

Heated Humidified High Flow Therapy (HHHFT) - enter X if true, this does not require l/min value (as retired PCCMDS item HFNCT – 88)

Patient nursed in single occupancy cubicle - True if patient was nursed in a single occupancy cubicle that day. Specify the reason for isolation in the text box provided.

Daily interventions

For each day of admission, record (using an X unless otherwise specified) all applicable interventions and observations, sustained for a period of 4 or more hours, from the list below. If none apply, select ***No defined critical care activity***

Admission date: ____________

		Code	Day 0	1	2	3	4	5	6	7	8	9	10	11	12	13
Basic	No defined critical care activity	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														
	Maximal oxygen concentration *(record maximum concentration as %)*	–														
	Heated humidified high flow therapy (HHHFT)	80														
	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														
	Unplanned tracheostomy removal or change *(record number of unplanned events)*	–														
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)*

____

Unplanned extubation - 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.

Unplanned tracheostomy removal - True if there was dislodgement of the tracheostomy from the trachea, or the tracheostomy had to be removed due to malfunction or suspected blockage.
Record the number of unplanned events that day.

Primary diagnosis for this admission - 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 apnoea(s), the diagnosis for this admission is later confirmed as Bronchiolitis. In this case Bronchiolitis should be recorded as the Primary diagnosis for this admission.

Other reasons for this admission - 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 critical care.

Operations and procedures performed during this admission - Any operations and/or procedures performed during this admission to critical care or during the current hospital stay and relating to this admission to critical care. 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.

Diagnoses and procedures

Primary diagnosis for this admission

Other reasons for this admission

Operations and procedures performed prior to and during this admission

Comorbidities

Was a tracheostomy performed during this admission?
☐ Yes ☐ No

Discharge information

Date and time of discharge
☐☐/☐☐/20☐☐ ☐☐:☐☐

Status at discharge from your unit
☐ Alive ☐ Dead

If alive at discharge
Discharged for palliative care?
☐ Yes ☐ No

Was the patient discharged with home oxygen or long-term ventilation?
☐ Yes ☐ No

If yes, specify type (record highest level of intervention)
☐ BIPAP via tracheostomy
☐ CPAP via tracheostomy
☐ BIPAP via facemask
☐ CPAP via facemask
☐ NCPAP
☐ HHHFT
☐ Home oxygen
☐ Other *(specify)*

If alive at discharge
Destination following discharge from your unit
☐ Normal residence
☐ Hospice
☐ Same hospital
☐ Other hospital
→ ☐ PICU ☐ NICU ☐ ICU (adult) ☐ Level 2 (HDU) ☐ SCBU ☐ Ward ☐ Theatre ☐ Other

If dead at discharge
Date and time of death
☐☐/☐☐/20☐☐ ☐☐:☐☐

Mode of death
☐ Treatment withdrawn
☐ Treatment limitation
☐ Death by neurological criteria
☐ Failed cardiopulmonary resuscitation

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

30 days post-discharge from unit

Complete if information available
Status at 30 days post-discharge
☐ Alive ☐ Dead ☐ Unknown

Date of death
☐☐/☐☐/20☐☐

Comments

Comorbidities – 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.

Was a tracheostomy performed during this admission – Specifies whether the child had a tracheostomy performed during this admission to your unit.

Date and time of discharge - 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.

Status at discharge from your unit - 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.

Discharged for palliative care - 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.

Home 02 and long-term ventilation - Specifies whether the child was on home oxygen or long-term ventilation at the point of discharge from your unit.
If yes selected – Specify they type of on home oxygen or long-term ventilation the child was on at the point of discharge from your unit.

Destination following discharge from your unit - Identifies the destination the child was directly discharged to from your unit.
If destination following discharge is the same hospital or another hospital, then identify the hospital area discharged to.

Transplant donor?– 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.

Diagnoses and procedures

Primary diagnosis for this admission

Other reasons for this admission

Operations and procedures performed prior to and during this admission

Comorbidities

Was a tracheostomy performed during this admission?
☐ Yes ☐ No

Discharge information

Date and time of discharge
☐☐/☐☐/2 0☐☐ ☐☐:☐☐

Status at discharge from your unit
☐ Alive ☐ Dead

If alive at discharge
Discharged for palliative care?
☐ Yes ☐ No

Was the patient discharged with home oxygen or long-term ventilation?
☐ Yes ☐ No

If yes, specify type (record highest level of intervention)
☐ BIPAP via tracheostomy
☐ CPAP via tracheostomy
☐ BIPAP via facemask
☐ CPAP via facemask
☐ NCPAP
☐ HHHFT
☐ Home oxygen
☐ Other *(specify)*

If alive at discharge
Destination following discharge from your unit
☐ Normal residence
☐ Hospice
☐ Same hospital
☐ Other hospital
→ ☐ PICU ☐ NICU ☐ ICU (adult) ☐ Level 2 (HDU) ☐ SCBU ☐ Ward ☐ Theatre ☐ Other

If dead at discharge
Date and time of death
☐☐/☐☐/2 0☐☐ ☐☐:☐☐

Mode of death
☐ Treatment withdrawn
☐ Treatment limitation
☐ Death by neurological criteria
☐ Failed cardiopulmonary resuscitation

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

30 days post-discharge from unit

Complete if information available
Status at 30 days post-discharge
☐ Alive ☐ Dead ☐ Unknown

Date of death
☐☐/☐☐/2 0☐☐

Comments

PICANet Admission (Level 2) data collection form · Version 2.0 · January 2025 · Copyright © 2025 University of Leeds and University of Leicester Page 4 of 4

Date and time of death – 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).

Mode of death – Specifies the mode of death for the deceased patient.
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 a limitation of on-going organ support and/or a decision that the patient is not for active resuscitation.
Death by neurological criteria - death is confirmed using brain stem death criteria/testing.
Failed cardiopulmonary resuscitation (CPR) - death immediately follows an unsuccessful attempt at cardiopulmonary resuscitation.

***Status at 30 days post discharge to be completed if information available**

Status at 30 days post discharge – Identifies the status (alive or dead) of the child on 30 days post discharge from your unit.

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