

# PICANet Admission (Level 2) Dataset Definitions Manual

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**UNIVERSITY OF  
LEICESTER**



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## DEMOGRAPHIC DETAILS

Demographic information is collected to uniquely identify a patient and track their treatment and journey across all Paediatric Critical care services. Demographic details are used in the calculation of the PICANet variable "Patient ID" which uniquely identifies an individual in the database based on the data provided.

Demographic data is collected for all event types to enable tracking of a patient across multiple events.

### Family name

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**Description** 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.

**Reason** 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 critical care areas.

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

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

### First name

---

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

**Reason** First name provides an additional identifier that can aid patient tracking throughout the hospital and PICANet Web.

Can help identify individuals who may have had multiple referrals, transport and/or admission events to one or more critical care area.

**Format** 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 Critical Care Service and PICANet Web.</p> <p>Can help identify individuals who may have multiple events in one or more critical care area.</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>4 free text fields, e.g. ADDRESS1: 83 Green Street</p> <p>ADDRESS2: Brownley</p> <p>ADDRESS3: Sheffield</p> <p>ADDRESS4: South Yorkshire</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

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<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 Critical 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 critical care areas (PICU or HDU).</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 item as UNOBTAINABLE on the paper form or leave blank. On PICANet Web this will generate a validation alert to clarify this information is unobtainable.</p> <p>A list of postcodes for overseas countries is available on request from PICANet.</p>

## NHS, CHI or H&C number

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<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>	NHS, CHI or H&C number gives a unique, identifiable variable that will allow other identifiable data items to be removed from the database.  Can help identify individuals who may have had multiple referrals, transport and/or admission events to one or more critical care areas (PICU or HDU).
<b>Format</b>	Free text (e.g.1463788990).  Validation check that NHS, CHI or H&C number is a valid number.

## NHS, CHI or H&C number eligibility

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<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>	<p>Date of birth and date of admission are used to calculate the child's age at admission to this Paediatric Critical Care Service.</p> <p>Date of birth provides an additional identifier that can aid patient tracking throughout the paediatric critical care service, hospital and PICANet Web.</p> <p>Can help identify individuals who may have had multiple referrals and/or admissions to one or more critical care area (PICU or HDU).</p>
<b>Format</b>	<p>Date; dd/mm/yyyy</p> <p>Date of birth should be on or prior to the date of admission.</p> <p>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<sup>st</sup> January of estimated year (e.g. 01/01/YYYY). Then in the 'Indicate if date of birth is' field below tick 'Estimated'.</p> <p>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.</p> <p>Validation check: if patient is aged 18 years or older at admission.</p>

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

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<b>Description</b>	Specifies whether the date of birth is estimated, anonymised or unknown (and cannot be estimated).
<b>Reason</b>	Date of birth and Date of admission to your unit are used to calculate the child's age at admission to this Paediatric Critical Care Service.
<b>Format</b>	<p>Choose from one of the following:</p> <ul style="list-style-type: none"><li>▪ Not Estimated</li><li>▪ Estimated</li><li>▪ Anonymised</li><li>▪ DOB not known</li></ul>

## Sex

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<b>Description</b>	Identifies the genotypical sex of the child at commencement of critical care.
<b>Reason</b>	Sex is important for reporting demographic statistics for admissions to your unit. Sex provides an additional identifier that can aid patient tracking throughout the paediatric critical care service and PICANet Web.
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>▪ Male</li><li>▪ Female</li><li>▪ Ambiguous</li></ul>

## Ethnic category

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<b>Description</b>	Identifies the child's ethnic origin, according to 2021 Census 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. <ul style="list-style-type: none"><li>• White - English, Welsh, Scottish, Northern Irish or British</li><li>• White - Irish</li><li>• White - Gypsy or Irish Traveller</li><li>• White - Roma</li><li>• Any other White background (<i>specify</i>)</li><li>• Mixed - White and Black Caribbean</li><li>• Mixed - White and Black African</li><li>• Mixed - White and Asian</li><li>• Any other mixed or multiple ethnic background (<i>specify</i>)</li><li>• Asian - Indian</li><li>• Asian - Pakistani</li><li>• Asian - Bangladeshi</li><li>• Any other Asian or Asian British Background (<i>specify</i>)</li><li>• Black - Caribbean</li><li>• Black - African</li><li>• Any other Black, Black British or Caribbean background (<i>specify</i>)</li><li>• Chinese</li><li>• Arab</li><li>• Any other ethnic group (<i>specify</i>)</li><li>• Unknown or Not stated (declined)</li></ul>

## Other ethnic category

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<b>Description</b>	<p>The child's exact ethnic origin (if known), if not specified in the table containing standard NHS ethnic categories and codes.</p> <p>If codes 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.</p>
<b>Reason</b>	<p>Required for epidemiological analysis and assessment of health services delivery.</p> <p>Potentially of value in clinical audit and research in conjunction with other clinical data.</p>
<b>Format</b>	<p>Free text (e.g. Mediterranean)</p> <p>In this case Mixed other may have been recorded for Ethnic category, but the notes may have specifically stated that the child was Mediterranean.</p>

## Gestational age at delivery

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

## Birth order (all admissions)

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<b>Description</b>	<p>Identifies the order in which the child was delivered if a multiple birth.</p>
<b>Reason</b>	<p>In the case of multiple births, delivery order provides an additional identifier that can aid patient matching.</p>
<b>Format</b>	<p>Enter 1 for singleton/first born, 2 for second born, 3 for third born and so on</p> <p>Enter 9 if unknown</p>

## Multiplicity

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<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 and evidence unavailable

# ADMISSION DETAILS

## Date and Time of admission to unit

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<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 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>If an admission number is not allocated in your unit this field can be left blank.</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, and/or an admission following surgery 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><b>A planned - other</b> is any other planned admission that is not an emergency (e.g. liver biopsy).</p> <p><b>An 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, deterioration on ward, shortness of breath, asthma attack).</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 critical care admission

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**Description** 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 the current hospital stay.

The PICU/NICU/ICU (Adult)/Level 2 unit (HDU) 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.

If the child has been previously admitted to more than one PICU/NICU/ICU (Adult)/Level 2 unit (HDU) during the current hospital stay, record the location of the most recent admission.

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

**Reason** Important for assessing re-admission rates.

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

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

- PICU
- NICU
- ICU (Adult)
- Level 2 unit (HDU)
- None
- Unknown

## 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 critical 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 critical care area 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><li>▪ Home</li><li>▪ Unknown</li></ul>

## 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 theatre recovery area prior to admission to your unit (e.g. for intubation).</p> <p><b>PICU</b> means the child was receiving care in a PICU prior to admission to your unit.</p> <p><b>NICU</b> means the child was receiving care in a NICU prior to admission to your unit.</p> <p><b>ICU (Adult)</b> means the child was receiving care in an adult ICU prior to admission to your unit.</p> <p><b>Level 2 unit (HDU)</b> means the child was receiving care in a designated Level 2 critical care unit 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>Emergency department (A&amp;E)</b> means the child was admitted to your unit directly from an A&amp;E department.</p> <p><b>Other intermediate care area (please specify)</b> is an area where the level of care is greater than that of the normal wards, but not an ICU/PICU/NICU/Level 2 unit (HDU).</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>• PICU</li><li>• NICU</li><li>• ICU (Adult)</li><li>• Level 2 unit (HDU)</li><li>• Ward</li><li>• Theatre and recovery (Including catheter suite)</li><li>• Emergency department (A&amp;E)</li><li>• Other intermediate care area – not a Level 2 Unit (HDU)/ICU/PICU/NICU (Please specify)</li><li>• Unknown</li></ul>

## Retrieval/ transfer

---

**Description** Specifies whether the child was transferred to your unit from an original admitting hospital by a transport team.

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.

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

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

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

- Yes
- No
- Unknown

## Type of transport team

---

<b>Description</b>	<p>Specifies the type of transport team and identifies whether the team is a Specialist Paediatric Transport Service (SPTS) or not.</p> <p><b>PICU</b> identifies that a specialist PICU team transferred the child.</p> <p><b>Specialised Paediatric Transport Service (SPTS)</b> identifies that a transport team from a Specialised Paediatric Transport Service (SPTS) 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 an SPTS 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>• Specialised Paediatric Transport Service (SPTS)</li><li>• Transport team from neonates</li><li>• Other specialist team</li><li>• Non-specialist team</li><li>• Unknown</li></ul>

## Transport team

---

<b>Description</b>	The unique name of the Specialised Paediatric Transport Service (SPTS), PICU own team, other specialist team or non-specialist team (DGH) undertaking this episode of transport.
<b>Reason</b>	Required to assist with matching transport events and for epidemiological analysis.
<b>Format</b>	<p>Free text</p> <p>Record the full name or recognised abbreviation of the transport team i.e. CATS or KIDS in the text box.</p> <p>At data entry to PICANet Web select the organisation type - PICU, CTS or DGH from the organisation coder.</p> <p>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.</p> <p>If the name of the organisation is not known select 'Unknown organisation'.</p>

## Collection unit

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**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'.

# SEVERITY OF ILLNESS ON ADMISSION

Severity of illness on admission is an important explanatory variable when examining differences in outcomes both between units and within a particular unit over time. A unit that admits more severely ill children is likely to have worse outcomes than one that admits children who are less ill, regardless of the quality of the care provided. It is important therefore that data on severity of illness is collected as part of this project.

For Level 3 care, there is a validated severity of illness score (the PIM Score) that has been used by PICANet for many years.

## *Paediatric Index of Mortality (PIM)*

PIM 3 applies to observations recorded between the first face-to-face contact with ICU doctor **until one hour after admission**. Therefore, this may occur in another area or during transport. Always use the first recorded measurement during this time period.

'PIM Eligibility' requires you to confirm if this timescale applies because it is essential for the PIM 3 calculation.

Unfortunately, there is currently no such validated score for Level 2 care, and it is out of the scope of this project to develop a new severity of illness score for Level 2 care.

However, there are a number of surrogate data items that might indicate greater severity of illness on admission; including cardiac arrest prior to admission, Paediatric Early Warning Score (PEWS), and others. Our intention is to collect such data.

## *Paediatric Early Warning Score*

PEWS is used in this dataset as a surrogate for severity of illness on admission. As far as possible the variables collected will reflect those required for the 'new national PEWS' (<https://adc.bmj.com/content/archdischild/106/7/648.full.pdf>)

PEWS variables are the first observation of each type recorded within the first hour following admission to your unit. Always use the first recorded measurement during this time period.

PIM/PEWS will be calculated by PICANet from the data entered on the form. Units are not required to enter their own score.

Our intention is to collect data from both PIM score where applicable (where observations were recorded between first face-to-face contact with ICU doctor and up to 1 hour after admission, *and also* the PEWS Score variables

## PIM Eligibility

---

**Description** 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**. Therefore, this may occur in another area or during transport. Always use the first recorded measurement during this time period.

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.

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.

**Reason** To identify whether a PIM score can be calculated from the data provided. PIM is a severity of illness score validated for Level 3 care.

**Format** Yes/No

## Elective admission

---

**Description** Identifies whether the child is an elective admission to the paediatric critical care service.

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.

An admission is considered elective if it could be postponed for more than 6 hours without adverse effects.

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.

**Reason** Elective admissions are weighted in PIM.

**Format** Select from the following

- Yes
- No
- Unknown



## Main reason for admission

---

**Description** Identifies whether the child has been admitted to the Level 2 paediatric critical 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><li>▪ Unknown</li></ul>

## Cardiac arrest before admission

---

<b>Description</b>	Identifies whether the child has had a cardiac arrest before this admission to the paediatric critical 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 critical care service is weighted in PIM and can be used to measure severity of illness on admission.
<b>Format</b>	Tick if child has a cardiac arrest preceding admission to the paediatric critical 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.

[Type here]

## Cardiomyopathy or myocarditis

---

**Description** 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 critical 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 **not** record.

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

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

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

**Reason** Cardiomyopathy and myocarditis are weighted in PIM.

**Format** 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 critical 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 critical 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

---

**Description** Include only cases where admission is related to leukaemia or lymphoma or the therapy for these.

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 critical care service..

**Reason** Leukaemia or lymphoma after completion of 1st induction is weighted in PIM.

**Format** Tick if true

## Liver failure main reason for critical care admission

---

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

## Acute Necrotising Enterocolitis (NEC) main reason for critical care admission

---

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

## Spontaneous cerebral haemorrhage

---

<b>Description</b>	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 critical care service.  Cerebral haemorrhage should be the cause of or be associated with the critical care admission, which would normally mean it had occurred within 48 hours prior to the critical care admission.  Do not include traumatic cerebral haemorrhage or intracranial haemorrhage that is not intracerebral (e.g. subdural haemorrhage).
<b>Reason</b>	Spontaneous cerebral haemorrhage from an aneurysm or AV malformation is weighted in PIM.
<b>Format</b>	Tick if true

[Type here]

## Neurodegenerative disorder

---

**Description** Identifies whether the child has a neurodegenerative disorder documented in the case notes prior to or at admission to the paediatric critical care service.

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.

A static disability should **NOT** be recorded as a neurodegenerative disorder (even if it is severe).

**Reason** A neurodegenerative disorder is weighted in PIM.

**Format** Tick if true

## Human Immunodeficiency Virus (HIV)

---

**Description** Identifies whether the child is HIV antigen positive as documented in the case notes prior to or at admission to the paediatric critical care service.

**Reason** The presence of HIV infection is weighted in PIM.

**Format** Tick if true

## Bone marrow transplant recipient

---

**Description** Identifies whether the child has received a bone marrow transplant during this hospital admission.

**Reason** Bone marrow transplantation during current hospital admission is weighted in PIM.

**Format** Tick if true

## Other (none of the above)

---

<b>Description</b>	Identifies that none of the above apply to the patient on admission to paediatric critical care.
<b>Reason</b>	To differentiate between none of the above being applicable and missing data.
<b>Format</b>	Tick if true

## Heart Rate

---

<b>Description</b>	<p>The first value measured and recorded within the first hour following admission to your unit.</p> <p>Heart rate values are included irrespective of the measurement method used or the site.</p> <p>Record 0 if the patient is in cardiac arrest.</p>
<b>Reason</b>	To assess severity of illness on admission.
<b>Format</b>	<p>Numerical value or 999 if unknown</p> <p>Units : bpm 1- 300</p> <p>Validation check if range exceeds 301</p>

## Capillary Refill Time

---

<b>Description</b>	<p>The first capillary refill time measured within the first hour following admission to your unit.</p> <p>Central Capillary refill time measured following 5 seconds occlusion over sternum.</p> <p>The value 99 can be submitted to indicate that this value is unknown.</p>
<b>Reason</b>	To assess severity of illness on admission.
<b>Format</b>	<p>Numerical value or 99 if unknown</p> <p>Units : seconds 1 – 20</p> <p>Validation check if range exceeds 21</p>

[Type here]

## Systolic blood pressure

---

<b>Description</b>	<p>The first systolic blood pressure measured and recorded within the first hour following admission to your unit.</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>	<p>Systolic blood pressure at first contact with the paediatric critical care service is weighted in PIM.</p> <p>To assess severity of illness on admission.</p>
<b>Format</b>	<p>Numerical value (e.g. 130)</p> <p>Units: mmHg. 20 – 180;</p> <p>Validation check if range exceeds 200</p>

## Spontaneous Respiratory Rate

---

<b>Description</b>	<p>The first respiratory rate measured and recorded within the first hour following admission to your unit.</p>
<b>Reason</b>	<p>To assess severity of illness on admission.</p> <p>Do not include spontaneous respiratory rate if mechanically ventilated.</p>
<b>Format</b>	<p>Range : bpm 1-100,</p> <p>Validation check if over 101,</p> <p>Numerical value or 999 if unknown</p> <p>Enter 0 if no spontaneous Respiratory Rate</p>

## Respiratory Distress

---

**Description** The first recorded assessment of respiratory distress recorded within the first hour following admission to your unit.

**Reason** To assess severity of illness on admission.

**Format**

- None
- Mild (Recession)
- Moderate (moderate recession +/- accessory muscle use)
- Severe (Severe recession, accessory muscle use +/- head bobbing, gasping)
- Unknown

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

---

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

The patient's oxygen saturation (SpO<sub>2</sub>), expressed as a percentage.

Record the first SpO<sub>2</sub> (pulse oximetry) and corresponding FiO<sub>2</sub> measured and recorded within the first hour following admission to your unit.

To be included only if recorded.

**Reason** To allow calculation of SpO<sub>2</sub>/FiO<sub>2</sub> ratio.

To assess severity of illness on admission.

**Format** Numerical value e.g. 096 %

Acceptable range 0-100;

Validation check if range falls outside of 50-100

Record 999 if unknown

## Oxygen Therapy – Amount (FiO2 at the time SpO2 measured)

---

<b>Description</b>	<p>The first value measured and recorded within the first hour following admission to your unit.</p> <p>The patient's fraction of inspired oxygen (FiO2), expressed as a fraction.</p> <p>The FiO2 at the time of the first SpO2 measured and recorded following admission to your unit.</p> <p>Record the fraction of inspired oxygen being delivered via endotracheal tube (ETT), non-invasive ventilation (NIV), HHHFT or headbox at the same time that the first SpO2 is measured. This means the FiO2 and SpO2 recorded must relate to the same time.</p> <p>If SpO2 is unknown or missing [999], then FiO2 will also be unknown or missing: Record 9.99</p> <p>If room air only record 0.21 (21%).</p> <p>To be included only if recorded.</p>
<b>Reason</b>	<p>To allow calculation of SpO2/FiO2 ratio.</p> <p>To assess severity of illness on admission.</p>
<b>Format</b>	<p>Numerical value e.g. 0.40</p> <p>Units: Fraction (decimal) 0.21-1.00;</p> <p>Validation check: expecting a value between 0.21 and 1.0</p>

## Oxygen Therapy – Amount (Flow at the time SpO2 measured)

---

<b>Description</b>	<p>The first value measured and recorded within the first hour following admission to your unit.</p> <p>The flow of oxygen administered to the patient, expressed in Litres per minute.</p> <p>The Oxygen flow at the time of the first SpO2 measured and recorded in the first hour following admission to your unit.</p> <p>Record the oxygen flow being delivered via facemask, nasal cannulae, or HHHFT at the same time that the first SpO2 is measured. This means the Flow and SpO2 recorded must relate to the same time.</p> <p>Note patients receiving HHHFT (for example, Airvo or Vapotherm) need both a flow and FiO2.</p> <p>If SpO2 is unknown or missing [999], then flow will also be unknown or missing: record 99.</p> <p>If not receiving supplemental oxygen above room air, record FiO2 as 0.21 (eg, If HHHFT in air record FiO2 as 0.21)</p> <p>To be included only if recorded.</p>
<b>Reason</b>	<p>To allow calculation of SpO2/FiO2 ratio.</p> <p>To assess severity of illness on admission.</p>
<b>Format</b>	<p>Numerical value (e.g. 4)</p> <p>Expecting a range of 0 – 30</p> <p>Validation check if over 31</p>

## Mechanical ventilation?

---

**Description** Specifies whether mechanical ventilation was administered in the first hour following admission to your unit.

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

Mechanical ventilation refers to both invasive (ETT and 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.

Mechanical ventilation during the first hour following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## CPAP?

---

**Description** Identifies whether the child receives CPAP at any time in the first hour following admission to your unit.

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 heated humidified high flow therapy.

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

CPAP during the first hour following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## HHHFT?

---

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

**Reason** HHHFT given during the first hour following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## Facemask?

---

**Description** Identifies whether the child receives facemask oxygen at any time within the first hour following admission to your unit.

Facemask oxygen includes the use of any sort of facemask or low flow nasal cannula.

DO NOT include use of a device to deliver high flow nasal cannula therapy, facemasks used for CPAP/BIPAP, during bag/valve/mask resuscitation or the intermittent use of nebulisers.

**Reason** Facemask given during the first hour following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## BIPAP?

---

**Description** Identifies whether the child receives BIPAP at any time within the first hour following admission to your unit. BIPAP may be given via an endotracheal tube, tracheostomy, facial BIPAP mask or nasal BIPAP mask/prongs.

**DO NOT** include use of a device to deliver heated humidified high flow therapy.

**Reason** BIPAP given during the first hour following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## Tracheostomy ventilation?

---

**Description** Specifies whether mechanical ventilation (other than HHHFT, CPAP or BIPAP) was given via a tracheostomy within the first hour following admission to your unit.

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

Tracheostomy ventilation refers to mechanical ventilation delivered via a tracheostomy. High frequency, jet ventilators, and negative pressure ventilators 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 heated humidified high flow therapy, BIPAP or CPAP as these are included elsewhere.

**Reason** Tracheostomy ventilation during the first hour following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## Endotracheal intubation?

---

**Description** Specifies whether endotracheal intubation was performed at any time within the first hour following admission to your unit.

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

DO NOT include use of a device to deliver heated humidified high flow therapy, BIPAP or CPAP, or mechanical ventilation delivered via a tracheostomy tube, as these are included elsewhere.

**Reason** Endotracheal intubation during the first four hours following admission may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## Conscious level

---

**Description** Measured within the first hour following admission to your unit by the AVPU Scale - Alert/Voice/Pain/Unresponsive.

Record the first measure recorded following admission to your unit.

**Reason** To assess severity of illness on admission.

**Format**

- A - Alert
- V - Responds to Voice
- P - Responds to Pain
- U - Unresponsive
- Unknown

## Pupil reaction

---

**Description** The first observed pupil reaction measured and recorded within the first hour following admission to your unit.

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

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

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

Pupil reaction is only required when 'Conscious level' is 'Unresponsive' or 'Unknown'.

**Reason** 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.

To assess severity of illness on admission.

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

- Both fixed and dilated
- Other reaction
- Unknown

## Temperature

---

**Description** The first core temperature measured and recorded within the first hour following admission to your unit.

Measurement of axilla, tympanic or rectal.

**Reason** To assess severity of illness on admission.

**Format** Numerical value (e.g. 36.8)

Units; degrees Celsius

Validation check if outside of 30-45

## Blood Glucose

---

**Description** The first blood glucose value measured and recorded from the arterial, capillary or venous blood gas within the first hour following admission to your unit.

**Reason** Blood glucose at first contact or in the time following admission to your unit may be an indicator of severity of illness, 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 – 15.0mmol per litre

Validation check if range falls outside 0.2 to 15.0

If unknown enter 999

## Blood gas measured?

---

**Description** Confirmation that results from a blood gas taken and analysed within the first hour following admission to your unit.

The blood gas taken and analysed may be arterial, capillary or venous.

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.

**Reason** Acts as a filter for further data entry.

Blood gas results taken in the time between face-to-face contact with ICU doctor and 1 hour after admission are weighted in PIM.

Blood gas results taken in the hour following admission to your unit may be an indicator of severity of illness.

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

- Yes
- No
- Unknown

## Blood gas source

---

<b>Description</b>	<p>Confirmation of the source of the blood gas measurements taken and analysed within the first hour following admission to your unit.</p> <p>The blood gas taken and analysed may be arterial, capillary or venous.</p> <p>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.</p>
<b>Reason</b>	<p>Acts as a filter for further data entry.</p> <p>Blood gas results taken in the time between face-to-face contact with ICU doctor and 1 hour after admission are weighted in PIM.</p> <p>Blood gas results taken in the hour following admission to your unit may be an indicator of severity of illness.</p>
<b>Format</b>	<p>Choose from one of the following:</p> <ul style="list-style-type: none"><li>▪ Arterial</li><li>▪ Capillary</li><li>▪ Venous</li><li>▪ Unknown</li></ul>

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

---

<b>Description</b>	<p>The first arterial PaO<sub>2</sub> measured and recorded within the first hour following admission to your unit.</p> <p>Only arterial blood gas measurements are acceptable.</p> <p>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.</p>
<b>Reason</b>	<p>Arterial PaO<sub>2</sub> (and associated FiO<sub>2</sub>) taken in the time between face-to-face contact with ICU doctor and 1 hour after admission are weighted in PIM.</p> <p>Arterial PaO<sub>2</sub> (and associated FiO<sub>2</sub>) following admission to your unit may be an indicator of severity of illness.</p>
<b>Format</b>	<p>Numerical value (e.g. 9.6)</p> <p>Units: kPa 3-60;</p> <p>Validation check if outside of range 1 – 70</p> <p>If unknown enter 999</p>

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

---

<b>Description</b>	<p>The first arterial PaO<sub>2</sub> measured and recorded within the first hour following admission to your unit.</p> <p>Only arterial blood gas measurements are acceptable.</p> <p>Note the arterial Oxygen pressure in either kPa or mmHg is required, not both.</p> <p>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.</p>
<b>Reason</b>	<p>Arterial PaO<sub>2</sub> (and associated FiO<sub>2</sub>) taken in the time between face-to-face contact with ICU doctor and 1 hour after admission are weighted in PIM.</p> <p>Arterial PaO<sub>2</sub> (and associated FiO<sub>2</sub>) following admission to your unit may be an indicator of severity of illness.</p>
<b>Format</b>	<p>Numerical value (e.g. 67.5)</p> <p>Units: mmHg. 22 – 450;</p> <p>Validation check if outside range 7.5-525</p> <p>If unknown record 999</p>

## FiO2 (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 first arterial PaO<sub>2</sub> is measured and recorded within the first hour following admission to your unit.</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> <p>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.</p>
<b>Reason</b>	<p>Arterial PaO<sub>2</sub> (and associated FiO<sub>2</sub>) taken in the time between face-to-face contact with ICU doctor and 1 hour after admission are weighted in PIM.</p> <p>Arterial PaO<sub>2</sub> (and associated FiO<sub>2</sub>) following admission to your unit may be an indicator of severity of illness.</p>
<b>Format</b>	<p>Numerical value (e.g. 0.40)</p> <p>Units: Fraction (decimal)</p> <p>Validation check if Range falls outside of 0.21 – 1.00</p> <p>Record 999 if unknown</p>

## Base excess

---

<b>Description</b>	<p>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.</p> <p>Manually calculated in vitro or in vivo base excess values are <b>not</b> accepted.</p>
<b>Reason</b>	<p>Base excess in the time between face-to-face contact with ICU doctor and 1 hour after admission are weighted in PIM.</p> <p>Base excess in the time following admission to your unit may be an indicator of severity of illness.</p>
<b>Format</b>	<p>Numerical value (e.g. 6.0)</p> <p>Units: mmol per litre</p> <p>Expected range -30.0 to +20.0 mmol per litre</p> <p>Validation check if range outside -40.0 to +30.0</p> <p>If unknown enter 999</p>

## Lactate

---

<b>Description</b>	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.
<b>Reason</b>	Blood lactate at first contact or in the time following admission to your unit may be an indicator of severity of illness, predict outcome and be valuable alongside PIM.
<b>Format</b>	Numerical value, to 1 decimal place (e.g. 3.1) Units: mmol per litre Expected range: -2.0 – 15.0mmol per litre Validation check if range falls outside 0.2 to 15.0 If unknown enter 999

## ADDITIONAL INFORMATION

### Was the patient on home oxygen or long-term ventilation immediately prior to this admission?

---

**Description** Specifies whether the child was on home oxygen or long-term ventilation immediately prior to this admission to your unit.

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

**Format**

- Yes
- No
- Unknown

### Type of home oxygen/long-term ventilation immediately prior to this admission

---

**Description** If yes selected:

Specifies the type of home oxygen or long-term ventilation the child was on immediately prior to this admission to your unit. Record highest level of intervention.

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

**Format**

- BIPAP via tracheostomy
- CPAP via tracheostomy
- BIPAP via Facemask (oral or nasal)
- CPAP via Facemask (oral or nasal)
- NCPAP
- HHHFT
- Home Oxygen
- Other (specify)
- Unknown

If 'Other (specify)' selected please use free text description to identify other type of home oxygen or long-term ventilation.

[Type here]

## Weight

---

**Description** 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.

**Reason** To enable the audit of the weight of children admitted to critical care and epidemiological analysis.

**Format** Numerical value to 2 decimal places (e.g. 7.94)

Units: kg

Validation check if outside of range 2.6 to 80kg

If unknown enter 999

## 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

## Clinical trial name

---

**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.

# DAILY INTERVENTIONS

For each calendar day a child is admitted to critical care unit information on the interventions required by that child are completed. These interventions include all those collected as part of the Paediatric Critical Care Minimum Dataset (PCCMDS) plus additional interventions of interest for clinical audit and health service delivery reasons. An item should be recorded in the PCCMDS (daily interventions) when the critical care activity applies for a period of greater than 4 hours.

## Admission Date

---

<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 (Day 0 on PCCMDS).  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.  Continuous refers to more than a single reading of the ECG.
<b>Reason</b>	Part of the Paediatric Critical Care Minimum Dataset (Activity Code 50).
<b>Format</b>	Insert an X if true.

[Type here]

## Continuous pulse oximetry

---

**Description** True if continuous pulse oximetry was received that day.  
Continuous refers to more than a single reading of the oxygen saturation.

**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

---

**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

---

**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.

[Type here]

## Advanced ventilatory support (jet ventilation)

---

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

## Maximal Oxygen Concentration (%)

---

**Description** If supplemental oxygen therapy was administered that day (irrespective of ventilatory state), record the maximum concentration (%) that day.

**Reason** To enable the audit of delivery of this therapy.

**Format** Numerical value (e.g. 60)

Units: %

Validation check if range outside 21-100

## Heated humidified high flow therapy (HHHFT)

---

**Description** Tick if heated humidified high flow therapy (HHHFT) was received that day

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

**Format** Insert an X if true

## Upper airway obstruction requiring nebulised adrenaline (epinephrine)

---

**Description** True if there was an upper airway obstruction requiring nebulised adrenaline/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

## Unplanned Tracheostomy removal or change

---

**Description** 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.

**Reason** To audit the occurrence of these events.

**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 undertaken that day.

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

**Format** Insert an X if true.

## External cardiac 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 pressure monitoring

---

**Description** True if central venous pressure monitoring was in place and used for venous pressure monitoring 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 undertaken 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 that 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

### 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.

[Type here]

## 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.

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. 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.

## 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) and 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.

For example, Alteplase.

**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'.

# DIAGNOSES AND PROCEDURES

For each patient information is collected on diagnoses and procedures for this admission; a primary diagnoses is required for each admission which can be accompanied by several 'other' diagnoses if recorded.

Other information on surgery and procedures performed is also included in this section. For all patients a primary diagnosis must be recorded and if a patient is admitted following surgery a surgical procedure must be provided. This information is required for audit, epidemiological analysis and assessment of health services delivery.

## Primary diagnosis for this admission

---

**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, epidemiological analysis and assessment of health services delivery.

**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 critical 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>	<p>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.</p> <p>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.</p>
<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.

## Comorbidities

---

<b>Description</b>	<p>Co-morbidity recorded on admission of the child to your unit.</p> <p>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.</p>
<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>

# DISCHARGE INFORMATION

## Date and time of discharge

---

<b>Description</b>	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
<b>Reason</b>	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.
<b>Format</b>	Date: dd/mm/yyyy Time: (24 hour clock); hh:mm

## Status at discharge from your unit

---

<b>Description</b>	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.
<b>Reason</b>	Identified as one of the principal outcomes of paediatric critical care.
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>• Alive</li><li>• Dead</li><li>• Unknown</li></ul>

## 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
- Unknown

## Was the patient discharged with home oxygen or long-term ventilation?

---

**Description** Specifies whether the child was on home oxygen or long-term ventilation at the point of discharge from your unit.

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

**Format**

- Yes
- No
- Unknown

## Type of home oxygen/long-term ventilation at discharge

---

**Description** If yes selected:

Specifies the type of home oxygen or long-term ventilation the child was at the point of discharge from your unit. Record highest level of intervention.

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

**Format**

- BIPAP via tracheostomy
- CPAP via tracheostomy
- BIPAP via Facemask (oral or nasal)
- CPAP via Facemask (oral or nasal)
- NCPAP
- HHHFT
- Home Oxygen
- Other (specify)
- Unknown

## 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

## Destination following discharge from your unit: Hospital area

---

**Definition**      If destination following discharge is the same hospital or another hospital, then identify the hospital area discharged to.

**Reason**            Required for epidemiological analysis and assessment of health services delivery.  
  
Potentially of value in clinical audit and research in conjunction with other clinical data.

**Format**

- PICU
- NICU
- ICU (Adult)
- Level 2 (HDU)
- SCBU
- Ward
- Theatre (if not coming back to unit post-operatively)
- Other
- Unknown

## Date and time of death

---

**Description** 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).

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).

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.

**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

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>Death by neurological criteria:</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 (CPR):</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 resuscitation is unsuccessful.</p>
<b>Reason</b>	Required for epidemiological analysis and assessment of health services delivery.
<b>Format</b>	Choose from one of the following: <ul style="list-style-type: none"><li>• Treatment withdrawn</li><li>• Treatment limitation</li><li>• Death by neurological criteria</li><li>• Failed CPR</li></ul>

## 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 at 30 days post discharge to be completed if information available to your unit

## Status at 30 days post discharge

---

**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

# COMMENTS

## Comments

---

**Description** Any additional information considered relevant to the admission.

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

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

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

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

**Format** Free text

## FORM COMPLETED BY

**Description** Name of person completing the form.

**Reason** For local use only to assist with following up queries relating to completion of this form.