

Paediatric High Dependency Core Data Index

Data Item, Basis, Explanation, Values and Origin

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REFERENCE DATASETS

BNDS	Birth Notification Data Set
CAR	WM Congenital Anomalies Register
CCICIC	Standards for the Care of Critically III & Critically Injured Children in the West
	Midlands
CDS	Commissioning Data Set
CEMACH	Confidential Enquiry into Maternal and Child Health
CMDS	Commissioning Minimum Data Set
HES	Hospital Episode Statistics
NSC	National Screening Committee
ONS	Office for National Statistics
SS	SureStart

REFERENCE MATERIAL

High Dependency Care for Children Report of an expert advisory group for Department of Health 2001

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010058&chk=GcyIXt

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A. DEMOGRAPHIC DETAILS

DATA ITEM	NHS Number of patient
BASIS	Unique person identifier
EXPLANATION	Unique identifier for use at local level and for record linkage in patients receiving
	care in more than one unit and for subsequent outcome data
INPUT OPTIONS	3-3-4 numerical format
DATA ORIGIN	BNDS, CDS, CEMACH, HES
DATA ITEM	Postcode of patient at time of care episode
BASIS	Identification of residence at time of admission
EXPLANATION	To derive geographical distribution of patients
	Link to district code to compare with ONS data
	To derive deprivation score
INPUT OPTIONS	Alphanumerical format (Post Office Preferred Format)
DATA ORIGIN	CAR, CDS, CEMACH, HES, SS
DATA ITEM	Date of birth
BASIS	Date of birth
EXPLANATION	Required to derive age for analysis by age at death
INPUT OPTIONS	DD/MM/YYYY
DATA ORIGIN	BNDS, CDS, CEMACH, HES
DATA ITEM	Gender
BASIS	Phenotypic classification of appearance of sex of patient at admission
EXPLANATION	Required to analyse outcome by sex
INPUT OPTIONS	Mutually exclusive
	Male
	Female
	Not specified
	Not known
DATA ORIGIN	BNDS, CDS, CEMACH, HES
DATA ITEM	GP code
BASIS	Unique GP identifier
EXPLANATION	Requirement for commissioning
INPUT OPTIONS	Linked to National GP database
DATA ORIGIN	BNDS, CDS, HES
DATA ITEM	Practice code
BASIS	Practice location identifier
EXPLANATION	Requirement for commissioning
INPUT OPTIONS	Linked to National GP database
DATA ORIGIN	BNDS, CDS

B. COMMENCEMENT OF HD CARE DATA

INPUT OPTIONS DD/MM/YYYY	DATA ITEM	Commencement date of HD care
Required to analyse patient age at admission and discharge, length of Assists in record linkage in patients transferred between units INPUT OPTIONS	BASIS	Date at which an inpatient episode of care commences
INPUT OPTIONS DD/MM/YYYY	EXPLANATION	Used in the calculation of number of care days given.
INPUT OPTIONS DD/MM/YYYY		Required to analyse patient age at admission and discharge, length of stay
		Assists in record linkage in patients transferred between units
	INPUT OPTIONS	DD/MM/YYYY
DATA ORIGIN HES	DATA ORIGIN	HES

DATA ITEM	Source of referral
BASIS	Each separate care episode of the patient on the paediatric high dependency area
EXPLANATION	Required to analyse outcome differences between patients.
	Describes movement of a high risk patients
INPUT OPTIONS	Mutually exclusive
	Home
	This hospital – same ward
	This hospital – other ward (free text)
	Other hospital (free text)
	Hospital at home
DATA ORIGIN	HES

C. MONITORING AND SUPPORT DATA

DATA ITEM BASIS EXPLANATION INPUT OPTIONS	Advanced Respiratory Support A record of need for advanced respiratory support Identifies whether patient required paediatric high dependency care <i>Non-mutually exclusive</i> Care of intubated patient (ETT only) Postoperative Tracheostomy during the first 24 hours Other artificial airway Mechanical ventilation including CPAP, CNEP, PEEP and CPAP via face mask
DATA ORIGIN	CCICIC Standards
DATA ITEM	Basic respiratory monitoring and support
BASIS	A record of need for basic respiratory monitoring and support
EXPLANATION	Identifies whether patient required paediatric high dependency care
INPUT OPTIONS	Non-mutually exclusive
	Care of long term tracheostomy
	Other artificial airway (e.g. guedel airway, nasopharyngeal airway)
	Oxygen 60% or more at any time
	Oxygen 40% or more at any time in neonate less than 28 days
	Nebulised medication >1 per hour for >6 hours (e.g. salbutomol, adrenaline)
	Four apnoeic episodes within 12 hours requiring stimulation
	Care of chest drains for the first 24 hours
	Monitoring (combined ECG and oxygen saturations)
	Postoperative tonsillar and adenoidal bleeds
DATA ORIGIN	CCICIC Standards
DATA ITEM	Circulatory Support
BASIS	A record of need for circulatory support
EXPLANATION	Identifies whether patient required paediatric high dependency care
INPUT OPTIONS	Non-mutually exclusive
	Cardio Pulmonary Resuscitation in the last 24 hours
	Intravenous fluid bolus – greater than 20mls/Kg on any occasion
	Arterial line monitoring
	Central Venous Pressure monitoring
	Inotropic support (e.g. dobutamine, dopamine, adrenaline)
	External cardiac pacing – using a pacing box
	Hourly urine output

DATA ORIGIN

Hourly blood pressure recordings or close visual observation

Bleeding (e.g. concern over volume of blood loss)

CCICIC Standards

DATA ITEM	Neurological Monitoring and Support
DATATIEM	
BASIS	A record of need for neurological monitoring and support
EXPLANATION	Identifies whether patient required paediatric high dependency care
INPUT OPTIONS	Non-mutually exclusive
	Continuous neuro-observations
	Continuous seizures for >1 hour
	Intra cranial pressure bolt monitoring
	Intraventricular catheter insitu – for drainage/monitoring
	Patient receiving Patient Controlled Analgesia (concern over sedatory effects)
DATA ORIGIN	CCICIC Standards
DATA ITEM	Renal Support / Fluid Balance
BASIS	A record of need for renal support and fluid balance monitoring
EXPLANATION	Identifies whether patient required paediatric high dependency care

 EXPLANATION
 Identifies whether patient required paediatric high dependency care

 INPUT OPTIONS
 Non-mutually exclusive

 Peritoneal dialysis
 Nultiple infusions

 Fluid replacement (e.g. naso gastric losses, drain losses, insensible losses)
 Nultiple blood products

 DATA ORIGIN
 CCICIC Standards

D. HD Outcome

	Status at conclusion of HD care
BASIS	Record of patient status at conclusion of HD care
EXPLANATION	An important outcome indicator
INPUT OPTIONS	Mutually exclusive
	Alive
	Dead
DATA ORIGIN	СЕМАСН
DATA ITEM	Date of death
BASIS	A record of the date of death of the patient
EXPLANATION	Used to calculate duration of survival. An important outcome indicator which has
	resource implications
INPUT OPTIONS	DD/MM/YYYY
DATA ORIGIN	CEMACH
DATA ITEM	Time of death
BASIS	A record of the time of death of the patient
EXPLANATION	Used to calculate duration of survival. An important outcome indicator which has
	resource implications
INPUT OPTIONS	HH:MM (24 hour clock)
DATA ORIGIN	CEMACH
DATA ITEM	Cause of death
BASIS	
	A description of cause of death of a patient
	An important outcome indicator
	As per Medical certificate of cause of death ONS
DATA ORIGIN	CEMACH, ONS
DATA ITEM	Post Mortem examination
BASIS	A record of whether post mortem performed
EXPLANATION	Used to determine post mortem rate and refusal rate
INPUT OPTIONS	Mutually exclusive
	No
	No – consent declined
	No – consent declined Yes
DATA ORIGIN	

DATA ITEM	Discharge destination
BASIS	Record of disposition of patient on completion of episode of care on paediatric high
	dependency area
EXPLANATION	Allows analysis of movement of patients within hospital and within region or
	Network.
	Assists record linkage of patients who move within a hospital and between
	hospitals.
INPUT OPTIONS	Mutually exclusive
	Home
	This hospital – other ward (free text)
	This hospital – adult ICU
	This hospital - PICU
	Other hospital – PICU (free text)
	Other hospital – ward (free text)
	Hospital at home
DATA ORIGIN	HES
DATA ITEM	Conclusion date of HD care
BASIS	Date on which inpatient completes an episode of care either because of discharge
	or death
EXPLANATION	Used in the calculation of number of care days given.
	Required to derive length of stay and to assist in record linkage
INPUT OPTIONS	DD/MM/YYYY
DATA ORIGIN	CDS, HES