TRANSPORT TEAM DOCUMENT
Intensive Care

KIDSNTS No.		
BCH No.		
PAGE 1 / 12		

REFERRAL DATE / TIME	D	D	M	M	Y	Y	Y	Y	HH	MM	PREFERRED DESTINATION	

REFERRER DETAILS		PATIENT LOCATION & CONTACT DETAILS				
REFERRER		HOSPITAL				
GRADE /SPECIALITY		WARD/DEPT				
CONTACT NUMBER		CONTACT NUMBER				
HOSPITAL		REFERRAL TYPE	☐ Neonatal uplift	☐ Neonatal repatriation	☐ Capacity	☐ Elective/ outpatients
WARD/DEPT			☐ Neonatal Cardiac	☐ Neonatal Surgical	☐ Neuro / Cooling	☐ ECLS
RESPONSIBLE REFERRING NEONATAL/PAEDIATRIC CONSULTANT						
KIDSNTS CO-ORDINATION CONSULTANT ON DUTY						

PATIENT DETAILS

FIRST NAME		FAMILY NAME											
DATE OF BIRTH	D	D	M	M	Y	Y	Y	Y		HH	MM	AGE	
GENDER	M	F	NOT KNOWN	GEST AGE (<2 YRS)								CORRECTED GEST AGE	
DELIVERY TYPE	☐ NVD	☐ LSCS	BIRTH WEIGHT		kg	CURRENT WEIGHT		kg					
PROVISIONAL DIAGNOSIS													
INFECTION RISK													

TIME CRITICAL	NEONATAL EXTRA TIME CRITICAL
☐ NEUROSURGICAL	☐ GASTROSCHISIS
☐ INTESTINAL PERFORATION /ACUTE ABDOMEN NEEDING URGENT SURGICAL REVIEW	☐ VENTILATED TRACHEO-OESOPHAGEAL FISTULA
☐ DUCT DEPENDENT LESION NOT RESPONDING TO PROSTIN /INTACT ATRIAL SEPTUM	☐ UNSTABLE & NOT RESPONDING TO APPROPRIATE MANAGEMENT
☐ METABOLIC PATIENT NOT RESPONDING TO MEDICAL THERAPY	
☐ ISCHAEMIC LIMB	
☐ PATIENT ACCEPTED FOR ECLS	
☐ OTHER	

CLINICAL TEAM

TEAM LEADER	NURSING STAFF	AMBULANCE TECHNICIAN	OBSERVER

NAME	BCH NUMBER	KIDSNTS NUMBER	STATUS AT REFERRAL PAGE 2 / 12

DATE	D	D	M	M	Y	Y	TIME	HH	MM

AIRWAY

☐ CLEAR	ETT/TT DETAILS	
☐ INTUBATED	SIZE	
☐ BEING INTUBATED	ROUTE	
☐ ASSISTED	LENGTH	

BREATHING

☐ SV	PIP/△P		INSP TIME	
☐ VENTILATED	PEEP		EXP TIME	
☐ CPAP	FiO_2		SpO_2	
☐ BIPAP	MAP		$ETCO_2$	
☐ HFOV	RR/Hz		O_2 INDEX	
COMMENTS			NITRIC ppm	

CIRCULATION

VITAL SIGNS		FLUID BOLUSES (mLs/kg)	
HR		CRYSTALLOID	
NiBP		COLLOID	
ABP (MEAN)		BLOOD	
CRT		FFP / CRYO / PLATLETS (circle)	

ACCESS		
☐ PERIPHERAL	☐ CENTRAL	☐ IO

INOTROPES	DOSE (micro-, or nanogram/kg/min)
☐ DOPAMINE	
☐ DOBUTAMINE	
☐ ADRENALINE	
☐ NORADRENALINE	
☐ PROSTIN	
☐ OTHER	

NEUROLOGY

SEIZURE ACTIVITY	Y ☐	N ☐
☐ SEDATED		
☐ MUSCLE RELAXED		
☐ ACTIVE COOLING	TIME COMMENCED:	TIME TARGET TEMP ACHIEVED:

INFECTION

TEMP °C	
ANTIMICROBIALS	
CULTURE RESULTS	
COLONISATIONS	

RADIOLOGY

CXR / AXR	
CT SCAN	
CUSS	

BLOOD GASES

SAMPLE TYPE	☐ A ☐ V ☐ C	☐ A ☐ V ☐ C	☐ A ☐ V ☐ C	☐ A ☐ V ☐ C
DATE/TIME				
pH				
pCO_2				
pO_2				
HCO_3				
BE				
LACTATE				
GLUCOSE				

BLOOD RESULTS

DATE / TIME				**DATE / TIME**			
Hb				POTASSIUM			
WCC				SODIUM			
NEUTROPHILS				CALCIUM			
PLATELETS				CHLORIDE			
APTT				UREA			
INR/PT				CREATININE			
FIBRINOGEN				AMMONIA			
CRP				BILLIRUBIN			

NAME	BCH NUMBER	KIDSNTS NUMBER			PRE-DEPARTURE CHECKS, REFERRING TEAM & PARENTAL CONTACTS & SAFEGUARDING DETAILS PAGE 3 / 12

PRE-DEPARTURE CHECKS IN AMBULANCE & EQUIPMENT TRACKING

☐ TROLLEY / NUMBER	☐ INCUBATOR / NUMBER	☐ ELECTRICAL SYSTEM	☐ BABYPOD / NUMBER .....
☐ DRUGS BAG / NUMBER.....	☐ KETAMINE	☐ PORTABLE BLOOD GAS ANALYSER NUMBER	☐ PORTABLE BLOOD GAS ANALYSER CARTRIDGES (MIN X 4)
☐ HAMILTON / NUMBER	☐ BABYPAC / NUMBER	☐ VENTIPAC / NUMBER	☐ VENTILATOR TUBING
☐ TRANSWARMERS	☐ TECHOTHERM	☐ DEFIB	☐ ACR
☐ EQUIPMENT BAG / NUMBER.....	☐ SONOSITE / NUMBER.....	☐ THERMAL INJURY BAG ☐ NOT REQUIRED	☐ DOCUMENT FOLDER
☐ GAS CYLINDERS	☐ SPANNER		

☐ INFUSION PUMPS	Number	Number	Number	Number	Number	Number	Number	Number

Ambulance Registration Number			IS THE DRIVER AWARE OF THE CATEGORY AND DESTINATION?				
	☐ AMB WX66 EWY ☐ AMB WX66 EWV ☐ AMB WX66 EWU ☐ AMB WX66 EWW ☐ OTHER.....	☐ Mobile phone ☐ Admin team aware of phones in use? ☐ Referrer asked to discuss parent travel plans?	☐ YES	☐ NO			☐ Team Brief ☐ Referrer aware of ETA **COMPLETE EN ROUTE**
			CATEGORY?	1	2	3	4

REFERRING TEAM & CONTACT DETAILS

	NAME	CONTACT DETAILS
NEONATAL /PAED CONSULTANT		
ANAESTHETIC CONSULTANT		
DOCTOR 1		
DOCTOR 2		
NURSE 1		
NURSE 2		

COMMENTS

SAFEGUARDING CONCERNS?

☐ **No**	☐ **Yes . Please fill in form in Appendix**

CARER INFORMATION & COMMUNICATION

Who Has Parental Responsibility			
Contact Number			
Carer Offered To Travel in Ambulance	☐ Yes ☐ No Comments:	Consent to transfer	☐ Yes ☐ No
Carer's Mode Of Transport			
Parent Signature for consent to transfer	Parent signature		
Known to Social Care? ☐ **Yes** ☐ **No**	Contact Name:	Contact Number:	
	Address:		

NAME	BCH NUMBER	KIDSNTS NUMBER			INITIAL CLINICAL ASSESSMENT PAGE 4 / 12

REFERRING TEAM HANDOVER & ASSESSMENT ON ARRIVAL

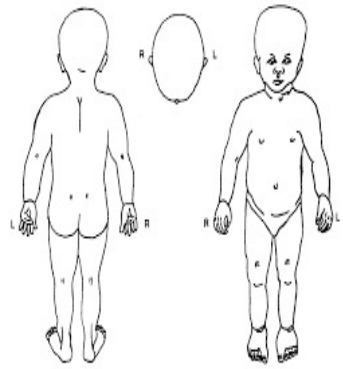
DATE		**TIME**		**CARE AREA**		**CONFIRM PT WEIGHT**	kg
CARE HANDED OVER BY	**Name**		**Sign**			**Designation**	

AIRWAY	☐ CLEAR	☐ COMPROMISED	**TUBE SIZE**	..... mm	**POSITION ON CXR**
	☐ INTUBATED	☐ TRACHEOSTOMY	**TUBE LENGTH**	.....cm @Lips/Nares	**NG / OG** Size.....Fr Length.....cm
C-SPINE	☐ CLEAR	☐ IMMOBILISATION IN SITU	**TUBE TYPE**	☐ Uncuffed	☐ Cuffed Cuff Pressure.....cmH_2O
BREATHING	☐ SPONTANEOUS	☐ FMO_2 FLOW =	☐ HFNC FLOW =	FiO_2 =	☐ HANDBAGGED
	☐ VENTILATED	☐ CPAP ☐ BiPAP ☐ HOME VENTILATOR			

CIRCULATION	HR =	Rhythm =			

ACCESS	**Date**
☐ Peripheral Venous Line 1.	
☐ Peripheral Venous Line 2.	
☐ Peripheral Venous Line 3.	
☐ Peripheral Arterial	
☐ Umbilical Venous	
☐ Umbilical Arterial	
☐ IO	
☐ Other / Comments	

MARK ANY WOUNDS ON BODY MAP



NEUROLOGY			☐ SEIZURES		
	☐ CFAM	☐ NORMAL ☐ ABNORMAL COMMENTS :	☐ ANTI-CONVULSANTS		
			☐ ACTIVE COOLING ☐ CORE/AXILLA TEMP.		
			FONTANELLE ☐ NORMAL ☐ ABNORMAL		
			☐ CUSS DATE :	COMMENTS :	
			LAST BLOOD GLUCOSE = mmol/L		
			FEED TYPE =		

ABDOMEN	**YES**	**NO**
DISTENDED		
TENSE		
TENDER		
DISCOLOURED		
PALPABLE MASSES		
BOWELS OPEN		
NBM		

SEPSIS

ANTIMICROBIAL	**Dose**	**Date / Time last given**	**Day of treat-ment**	**Last level**

RADIOGRAPHY	
CXR	
AXR incl. lines	
CT SCAN	
USS	

OTHER	**ALLERGIES KNOWN**? ☐ NO ☐ YES DETAILS :	**Comments**
	SAFEGUARDING CONCERNS ? ☐ NO ☐ YES = SEE PAGE 3	

NAME	BCH NUMBER	KIDSNTS NUMBER			VITAL SIGNS PAGE 5 / 12

DATE		TIME														
HEART RATE X (Black) BLOOD PRESSURE NIBP (Green) ABP (RED) RESPIRATORY RATE • (BLUE)	220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10															
S_pO2 – Preductal																
S_pO2 – Postductal																
$ETCO_2$																
Core Temperature ºC																
Peripheral Temperature ºC																
Incubator Set Temperature ºC																
Incubator Temperature ºC																
Techotherm Temperature ºC																
Capillary Refill Time																
Lines Checked																
VENTILATION																
MODE																
FiO_2																
RATE / ΔP																
PIP / MAP																
PEEP / Frequency Hz																
I Time																
Tidal volume																
NO (ppm)																
BLOOD GASES VEN / CAP / ART																
pH / H^+																
pCO_2																
pO_2																
SaO_2																
HCO_3^-																
BE																
Glucose																
Na^+																
K^+																
Ca^{++}																
Lactate																
NEUROLOGY																
AVPU / GCS																
Seizures																
Pupil Reaction (Size / + or -) R																
(Size / + or -) L																
E&P SCORE IV																
E&P SCORE ARTERIAL																
INFUSIONS																
Infusion 1 Rate																
Dose																
Infusion 2 Rate																
Dose																
Infusion 3 Rate																
Dose																
Infusion 4 Rate																
Dose																
Infusion 5 Rate																
Dose																
Infusion 6 Rate																
Dose																
Infusion 7 Rate																
Dose																
Infusion 8 Rate																
Dose																

Telephone call to destination unit when 20 minutes away ☐

NAME	BCH NUMBER	KIDSNTS NUMBER			Weight kg	IV DRUG INFUSIONS PAGE 6 / 12

Prescriber Name (Print)		Prescriber Sign:		GMC / NMC Number	

IV Maintenance Fluids		Prescriber Sign:		Nurse Sign:			
Fluid Type		Infusion Rate		Date		Time	

Drug and Fluid Boluses

Date & Time	Drug & Route	Dose	Prescriber Sign	Nurse Sign

Drug and Fluid Boluses

Date & Time	Drug & Route	Dose	Prescriber Sign	Nurse Sign

ANTIMICROBIAL TREATMENT

Date & Time	Antimicrobial Name	Dose	Route	Indication	When to review	Prescriber Sign	Nurse Sign

Infusion Rate Changes

Date & Time	Infusion	Current mL/hr	New mL/hr	Prescriber Sign	Nurse Sign

NAME	BCH NUMBER	KIDSNTS NUMBER			Weight kg	IV DRUG INFUSIONS PAGE 7/ 12

Prescriber Name (Print)		Prescriber Sign:		GMC / NMC Number	

Drug	Dosage	Made up in (Circle Appropriate)	Dose Range	Date / Time	Run at (mL/hr)	Prescriber Sign	Nurse Sign
Morphine 1 mg/kg in 50 mL	..... mg in 50 mL	D5 / D10 / NS	**10 – 40 micrograms/kg/hr** (1 mL/hr = 20 micrograms/kg/hr)				
Fentanyl **Undiluted**	.....micrograms in .....mL	UNDILUTED 50 micrograms/mL	**1 – 5 micrograms/kg/hr**				
Midazolam 3 mg/kg in 50 mL	..... mg in 50 mL	D5 / D10 / NS	**0.5 – 4 micrograms/kg/min** (1 mL/hr = 1 microgram/kg/min)				
Ketamine – for sedation 30 mg/kg in 50 mL	.....mg in 50 mL	D5 / D10 / NS	**10 – 40 micrograms/kg/min** (1 mL/hr = 10 micrograms/kg/min)				
Rocuronium **Undiluted**	..... mg in 50 mL	UNDILUTED 10 mg/mL	**0.6 – 1 mg/kg/hr**				
Dopamine **Peripheral** <5 kg – 15 mg/kg in 50 mL >5 kg – 6 mg/kg in 50 mL	..... mg in 50 mL **(Max. conc. 1.6 mg/mL !)**	D5 / D10 / NS	**1 – 20 micrograms/kg/min**				
Dopamine **Central** 15 mg/kg in 50 mL	..... mg in 50 mL	D5 / D10 / NS	**3 – 20 micrograms/kg/min** (1 mL/h = 5 micrograms/kg/min)				
Dobutamine 15 mg/kg in 50 mL **(Max peripheral strength = 5 mg/mL)**	..... mg in 50 mL	D5 / D10 / NS	**3 – 20 micrograms/kg/min** (1 mL/h = 5 micrograms/kg/min)				
Adrenaline **Central** < 25kg: 0.3 mg/kg in 50 mL	..... mg in 50 mL **(Max. conc. 8 mg/50 mL !)**	D5 / D10 / NS	**0.02 – 1 micrograms/kg/min** < 25 kg: 1 mL/hr = 0.1 micrograms/kg/min > 25 kg: manual calculation				
Adrenaline **Peripheral**	1 mg in 50 mL (if weigtht < 3 kg, use central strength)	D5 / D10 / NS	**0.05 – 0.2 micrograms/kg/min** (0.3 mL/hr/kg = 0.1 micrograms/kg/min) If > 0.2				
Noradrenaline **Central** < 25kg: 0.3 mg/kg in 50 mL	..... mg in 50 mL **(Max. conc. 8 mg/50 mL !)**	D5 / NS	**0.02 – 1 micrograms/kg/min** < 25 kg: 1 mL/hr = 0.1 micrograms/kg/min > 25 kg: manual calculation				
Vasopressin (20 units/mL)	10 units in 50 mL	D5 / NS	**0.0001 – 0.002 units/kg/min** **or** **0.1 – 2 milliunits/kg/min**				
Milrinone	10 mg in 50 mL	D5 / NS	**0.3 – 0.7 micrograms/kg/min**				
Prostaglandin E2 (Dinoprostone)	50 micrograms in 50 mL	D5 / D10 / NS	**5 – 100 nanograms/kg/min**				
Salbutamol (5 mg/mL)	10 mg in 50 mL	D5 / D10 / NS	**1 – 5 micrograms/kg/min**				
Aminophylline 25 mg/kg in 50 mL	..... mg in 50 mL	D5 / D10 / NS	**0.5 – 1 mg/kg/hr** (1mL/h = 0.5 mg/kg/hr)				
Magnesium 50% (500 mg/mL) **(Max peripheral strength = 20 mg/mL)**	..... mg in ..... mL **FOR ASTHMA/PULMONARY HYPERTENSION**	D5 / D10 / NS (Dilute 10 x for central , 25 x for peripheral)	**40 mg/kg** (Give over 20 minutes)				
Insulin 2.5 units/kg (max 50 units / 50mLs)	..... units in ..... mL **FOR HYPERGLYCAEMIA**	D5 / D10 / NS	**Up to 20 kg - 0.1 units/kg/hr** (1 mL/hr = 0.05 units/kg/hr) **REFER TO INSULIN PROTOCOL**				
Heparin Flush For Arterial Line	500 units of Heparin in 500 mL	NS	**1-3 mLs/hr**				

Diluent Key: **D5 = 5% Dextrose** **D10 = 10% Glucose** **NS = 0.9% Sodium Chloride**

NAME	BCH NUMBER	KIDSNTS NUMBER			KIDSNTS TEAM NOTES PAGE 8 / 12

DATE & SIGN ALL ENTRIES	FOR TIME CRITICAL TRANSFERS, NOTES CAN BE WRITTEN IN RETROSPECT

NAME	BCH NUMBER	KIDSNTS NUMBER			KIDSNTS TEAM NOTES PAGE 9 / 12

DATE & SIGN ALL ENTRIES	FOR TIME CRITICAL TRANSFERS, NOTES CAN BE WRITTEN IN RETROSPECT

NAME	BCH NUMBER	KIDSNTS NUMBER			KIDSNTS TEAM NOTES PAGE 10 / 12

DATE & SIGN ALL ENTRIES	FOR TIME CRITICAL TRANSFERS, NOTES CAN BE WRITTEN IN RETROSPECT

Appendix booklet filled in?		
☐ YES	SAFEGUARDING	☐
	BLOOD PRODUCT TRANSFUSION including Human Albumin Solution	☐
	URETHRAL CATHETER INSERTION	☐
	INTUBATION RECORD	☐
	INTER-TEAM HANDOVER	☐
	BOOKLET ATTACHED?	☐
☐ NO		

NAME	BCH NUMBER	KIDSNTS NUMBER			TRANSFER & RECEIVING UNIT HANDOVER PAGE 11 / 12

PRE-DEPARTURE CHECKS PRIOR TO LEAVING REFERRAL HOSPITAL

AIRWAY	☐ ETT POSITION	☐ SECURELY FIXED	☐ REBREATH BAG	☐ AMBUBAG & MASK	☐ EMERGENCY AIRWAY BAG	☐ $ETCO_2$	☐CXR CHECKED ☐ NGT ☐ CVL
VENTILATION	☐ BLOOD GAS CHECKED	☐ FILTER/S	☐ HUMIDIFICATION	☐ STETHOSCOPE			
CIRCULATION	☐ SECURE ADEQUATE WORKING VASCULAR ACCESS		☐ MAINTENANCE FLUIDS		☐ INOTROPES	☐ EMERGENCY DRUGS & FLUIDS	
NEUROLOGICAL	☐ SEDATION, ANALGESIA & PARALYSIS		☐ TEMPERATURE NORMAL (DISCUSSED WITH CONSULTANT IF NOT)				
GI	☐ NPSA NG/OG TUBE	☐ FREE DRAINAGE	☐ BLOOD SUGAR SATISFACTORY				
SAFETY	☐ SATISFACTORY RESTRAINT	☐ INFUSION RATES CHECKED	☐ 2 NAME BANDS (IF PARENTS NOT PRESENT)	☐ MATERNAL BLOOD (if applicable)	☐ 1st BLOOD SPOT ☐ D5 BLOOD SPOT		
EQUIPMENT	☐ SUFFICIENT O_2/AIR	☐NITRIC ☐ IN USE	☐ POWER	☐ EQUIPMENT BAGS	☐ ISTAT	☐ SONOSITE	
COMMUNICATION	☐ PATIENT INFORMATION	☐ REFERRING TEAM QUESTIONNAIRE	☐ CO-ORD CONSULTANT INFORMED & PLAN AGREED		☐ RECEIVING UNIT NURSE IN CHARGE NOTIFIED ☐ RECEIVING UNIT CONSULTANT INFORMED		
DOCUMENTATION	☐ NOTES PHOTOCOPIED ☐ DRUG CHART	☐ REFRERAL/TRANSFER LETTER ☐ BADGER ☐ X-RAYS/SCANS	☐ TRANSFER CONSENT		☐DGH CONTACTS	☐ APPENDIX USED? PLEASE ATTACH	

IN AMBULANCE AIR AND OXYGEN HOSES ATTACHED TO AMBULANCE GAS SUPPLY ☐ BAGGING CIRCUIT CONNECTED TO AMBULANCE OXYGEN ☐ INVERTER ON ☐ ALL LOOSE ITEMS AWAY ☐

DATE, TIME & SIGN	TRANSFER NOTES

RECEIVING TEAM HANDOVER

SITUATION	☐ NAME		☐ AGE			☐ WEIGHT	
BACKGROUND	☐ ADMISSION DATE		☐ ADMISSION REASON		☐ MEDICAL HISTORY	☐ TREATMENT TO DATE	
ASSESSMENT ***AIRWAY***	☐ ETT SIZE	☐ ETT LENGTH	☐ SECRETIONS	☐	☐	☐	☐
VENTILATION	☐MODE	☐ RATE	☐ PRESSURES	☐ FiO_2	☐ SpO_2	☐ $ETCO_2$	☐ GASES
CIRCULATION	☐ HR/RHYTHM	☐ BP	☐ CRT	☐ TEMP	☐ VOLUME	☐ INOTROPES	☐ACCESS
FLUIDS	☐ ALLOWANCE	☐ BM	☐ ENTERAL TUBE	☐ URINE OUT	☐	☐	☐
NEUROLOGY	☐ GCS	☐ PUPILS	☐ SEIZURES	☐ INFUSIONS	☐	☐	☐
OTHER	☐ FAMILY	☐ DRUGS	☐ ALLERGIES	☐ INFECTION	☐ WOUNDS	☐ CHILD PROTECTION	
RECOMMENDATION	☐ CHANGES TO TREATMENT		☐ TESTS REQUIRED		☐ SPECIALISTS TO BE INFORMED OF ADMISSION		

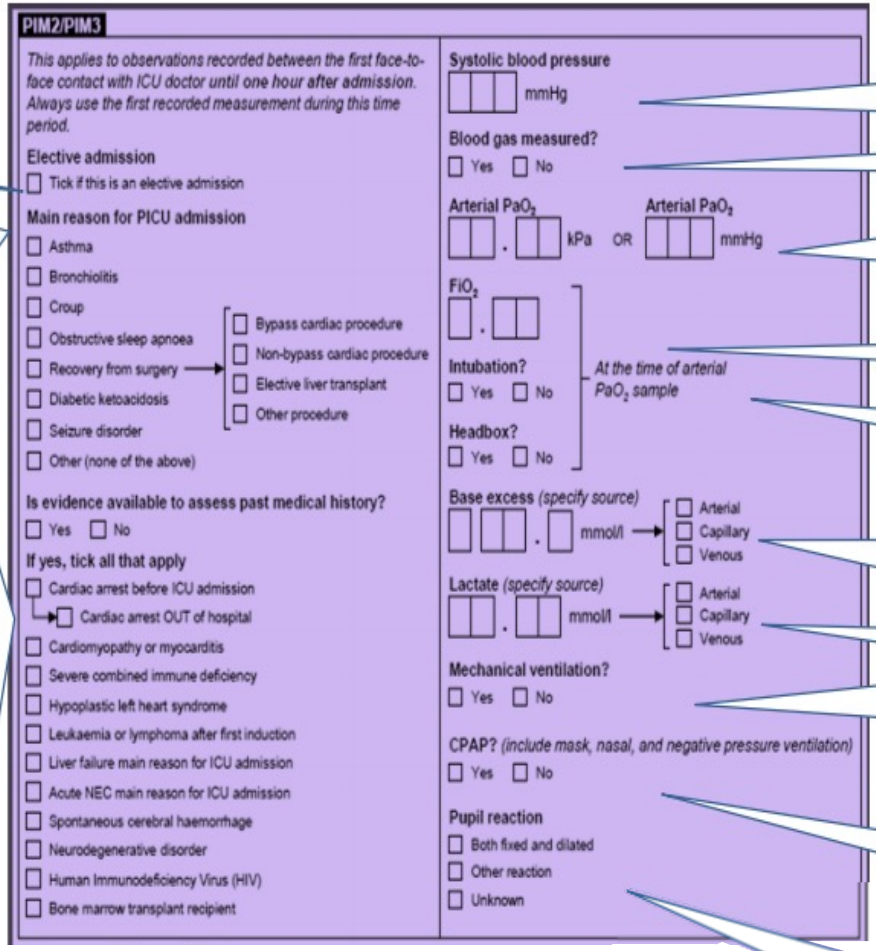
DATE		**TIME**		**NAME**	**SIGN**
DOCTOR / ANP RECEIVING HANDOVER & ACCOUNTABILITY					
DOCTOR / ANP GIVING HANDOVER & TRANSFERRING ACCOUNTABILITY					
NURSE RECEIVING HANDOVER & ACCOUNTABILITY					
NURSE GIVING HANDOVER TRANSFERRING ACCOUNTABILITY					
DRUG INFUSIONS HANDED OVER	☐ YES ☐ NO	**HANDED OVER TO**		**HANDED OVER BY**	
DRUG INFUSIONS DISPOSED OF	☐ YES ☐ NO				

DRUG	VOLUME REMAINING mLs	DISPOSED BY (Sign)
DRUG	VOLUME REMAINING mLs	DISPOSED BY (Sign)
DRUG	VOLUME REMAINING mLs	DISPOSED BY (Sign)
DRUG	VOLUME REMAINING mLs	DISPOSED BY (Sign)
DRUG	VOLUME REMAINING mLs	DISPOSED BY (Sign)
	Teddy bear given ☐	**Feedback card given/comments noted ☐**

Tick if this is an elective admission i.e. after elective surgery/procedure or for monitoring • Considered elective if could be postponed for >6hrs without adverse effects (NB: differs from definition of planned surgery which is >24hrs)

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

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



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

Tick if arterial, capillary or venous gas samples taken and recorded within defined time period.

First arterial Pa02 even if second actual gas patient had taken because first was venous/cap • Do not document if venous or capillary gases. Record '999' if missing

Fi02 recorded at time of first arterial gas
If arterial gas not recorded write '999'

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

First **base excess** from arterial, capillary or venous gas within defined time period • If not/never recorded write '999'• Do not forget to record negative or positive value. • Specify sample type

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

Where all or some of the breaths, or portion of the breaths (pressure support) are delivered by a mechanical device • Includes high frequency, jet ventilators, negative pressure ventilators & BIPAP.

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

First pupillary reaction measured AND recorded within defined time period • Both fixed and dilated if both >3mm and both unreactive to light. Used as evidence of brain function so do not record if due to toxins, drugs, acute local injury to eye, or chronically altered from previous disease

Paediatric Intensive Care Audit Network · Data Collection Form

Transport

Patient details *(or hospital label)*

Family name

First name

Address

Postcode

NHS/CHI/H&C number

☐ Tick if patient is not eligible for number

Case note number *(destination PICU)*

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

Indicate if date of birth is

☐ Estimated ☐ Anonymised ☐ Unknown

Sex

☐ Male ☐ Female ☐ Ambiguous ☐ Unknown

Transport details

Date and time accepted for transport

/ / 20 :

Transport number

Type of transport team

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

Transport team

Grade of clinical team leader

- ☐ Consultant/Associate Specialist/Staff Grade
- ☐ ST 4 – 8
- ☐ ST 1 – 3
- ☐ Nurse practitioner

Speciality of clinical team leader

Grade of most senior nurse

☐ 5 ☐ 6 ☐ 7 ☐ 8

☐ Nurse not present

Collection area

- ☐ X-ray/endoscopy/CT scanner
- ☐ Recovery only
- ☐ HDU (step up/step down unit)
- ☐ Other intermediate care area
- ☐ Theatre and recovery
- ☐ Other transport service
- ☐ ICU
- ☐ PICU
- ☐ NICU
- ☐ Ward
- ☐ A & E

Collection unit *(or location)*

Most senior member of medical staff present at collection unit

- ☐ Consultant/Associate Specialist/Staff Grade
- ☐ ST 4 – 8
- ☐ ST 1 – 3
- ☐ None

Did a medical technician accompany the patient?

☐ Yes ☐ No

Did a parent accompany the patient?

- ☐ Yes
- ☐ No – parent not present
- ☐ No – parent declined to accompany
- ☐ No – parent not permitted to accompany

Transport classification

- ☐ Planned
- ☐ Unplanned

Outcome of this transport event

- ☐ Patient transported
- ☐ Not transported – condition improved
- ☐ Not transported – condition deteriorated
- ☐ Not transported – other reason
- ☐ Patient died before transport team arrived
- ☐ Patient died while transport team present
- ☐ Patient died during transit

Destination type

- ☐ PICU
- ☐ NICU
- ☐ ICU
- ☐ HDU
- ☐ Ward
- ☐ Theatre
- ☐ Other transport service
- ☐ Normal residence
- ☐ Hospice

Destination unit *(or location)*

Critical incidents

Identify all critical incidents while transport team in attendance *(tick all that apply)*

- ☐ No critical incidents
- ☐ Accidental extubation
- ☐ Required intubation in transit
- ☐ Complete ventilator failure
- ☐ Loss of medical gas supply
- ☐ Loss of all IV access
- ☐ Cardiac arrest
- ☐ Medication administration error
- ☐ Equipment failure or incompatibility impacting on patient care
- ☐ Other critical incident *(specify)*

Comments

Form completed by

Contact us · picanet@leeds.ac.uk

General enquiries
0113 343 8125

Data collection queries
0116 252 5414

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

Transport times

BASE TO COLLECTION UNIT

☐ Tick if this section of the trip is not applicable

Mode of transport *(tick all that apply)*

☐ Dedicated ambulance ☐ RRV ☐ Taxi
☐ Other ambulance ☐ Air ✈ ☐ Other

Depart base *(dd/mm/yyyy hh:mm)*

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Arrive base airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Aircraft type

☐ Unpressurised fixed-wing ☐ Dedicated helicopter
☐ Pressurised fixed-wing ☐ Other helicopter

✈ Takeoff base airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Land collection airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Depart collection airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

Arrive collection unit *(or location)*

☐☐/☐☐/20☐☐ ☐☐:☐☐

Blue light or siren used or requested

☐ Yes ☐ No

Organisational delay

☐ None ☐ Team out ☐ Staffing ☐ Vehicle

Vehicle incident

☐ None ☐ Vehicle accident ☐ Vehicle breakdown

PATIENT JOURNEY

☐ Tick if this section of the trip is not applicable

Mode of transport *(tick all that apply)*

☐ Dedicated ambulance ☐ RRV ☐ Taxi
☐ Other ambulance ☐ Air ✈ ☐ Other

Depart collection unit *(or location)*

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Arrive collection airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Aircraft type

☐ Unpressurised fixed-wing ☐ Dedicated helicopter
☐ Pressurised fixed-wing ☐ Other helicopter

✈ Takeoff collection airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Land destination airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Depart destination airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

Arrive destination unit *(or location)*

☐☐/☐☐/20☐☐ ☐☐:☐☐

Blue light or siren used or requested

☐ Yes ☐ No

Organisational delay

☐ None ☐ Team out ☐ Staffing ☐ Vehicle

Vehicle incident

☐ None ☐ Vehicle accident ☐ Vehicle breakdown

DESTINATION UNIT TO BASE

☐ Tick if this section of the trip is not applicable

Mode of transport *(tick all that apply)*

☐ Dedicated ambulance ☐ RRV ☐ Taxi
☐ Other ambulance ☐ Air ✈ ☐ Other

Depart destination unit *(or location)*

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Arrive destination airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Aircraft type

☐ Unpressurised fixed-wing ☐ Dedicated helicopter
☐ Pressurised fixed-wing ☐ Other helicopter

✈ Takeoff destination airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Land base airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

✈ Depart base airport

☐☐/☐☐/20☐☐ ☐☐:☐☐

Arrive base

☐☐/☐☐/20☐☐ ☐☐:☐☐

Blue light or siren used or requested

☐ Yes ☐ No

Organisational delay

☐ None ☐ Team busy ☐ Staffing ☐ Vehicle

Vehicle incident

☐ None ☐ Vehicle accident ☐ Vehicle breakdown

Interventions *(retrievals only)*

Interventions by local team prior to arrival of transport team *(tick all that apply)*

☐ Primary intubation
☐ Re-intubation
☐ Other airway
☐ Non-invasive ventilation
☐ High flow nasal cannula therapy
☐ Primary central venous access
☐ Additional central venous access
☐ Arterial access
☐ Inotrope or vasopressor infusion
☐ Prostaglandin infusion
☐ Primary intraosseus access
☐ Additional intraosseus access
☐ Chest drain insertion
☐ ICP monitoring
☐ ECMO

Interventions while transport team in attendance *(tick all that apply)*

☐ Primary intubation
☐ Re-intubation
☐ Other airway
☐ Non-invasive ventilation
☐ High flow nasal cannula therapy
☐ Primary central venous access
☐ Additional central venous access
☐ Arterial access
☐ Inotrope or vasopressor infusion
☐ Prostaglandin infusion
☐ Primary intraosseus access
☐ Additional intraosseus access
☐ Chest drain insertion
☐ ICP monitoring
☐ ECMO

PIM2/PIM3 *(retrievals only)*

This applies to observations recorded in the first hour after first face-to-face contact with transport team doctor

Elective admission

☐ Tick if this is an elective admission

Main reason for admission

☐ Asthma
☐ Bronchiolitis
☐ Croup
☐ Obstructive sleep apnoea
☐ Recovery from surgery → ☐ Bypass cardiac proc. ☐ Non-bypass cardiac proc. ☐ Elective liver transpl't ☐ Other procedure
☐ Diabetic ketoacidosis
☐ Seizure disorder
☐ Other (none of the above)

Is evidence available to assess past medical history?

☐ Yes ☐ No

If yes, tick all that apply

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

Systolic blood pressure

☐☐☐ mmHg

Blood gas measured

☐ Yes ☐ No

Arterial PaO_2 ☐☐.☐☐ kPa or **Arterial PaO_2** ☐☐☐ mmHg

FiO_2 ☐.☐☐

Intubation

☐ Yes ☐ No

Headbox

☐ Yes ☐ No

At the time of PaO_2 sample

Base excess

☐☐.☐ mmol/l → ☐ Arterial ☐ Capillary ☐ Venous

Lactate

☐☐.☐☐ mmol/l → ☐ Arterial ☐ Capillary ☐ Venous

Mechanical ventilation

☐ Yes ☐ No

CPAP

☐ Yes ☐ No

Pupil reaction

☐ Both fixed and dilated
☐ Other reaction
☐ Unknown

INFECTION CONTROL COMPLIANCE

Date:-…… KIDS Number:-……

VAP Compliance

Bed Tilt 30° **YES / NO**	**If No please give reason:-**
Vent tubing position downwards **YES / NO**	NG Length documented **YES / NO**
Condensate **Minimal/None** ☐ **Visible pooling** ☐	Pooling of secretions **YES / NO**
If cuffed tube, has pressure been checked **YES / NO**	**Pressure**
ET suction by **Nurse / Medic** **Planned / Emergency**	
NG/OG tube **Aspiration 4 hourly**	ANTT **YES / NO**
Hand Hygiene **Before / After / Both**	Disconnection **Correct disposal of condensate** ☐

PVC Insertion: Bundle Compliance

Medic / Nurse Hand Hygiene **Before / After / Both**	Gloves **Worn** ☐ **Attempted** ☐ **Not Worn** ☐	Correct skin prep **YES / NO**	Left to dry **YES / NO**
Documented **YES / NO**		Documented by **Nurse / Doctor**	
Sterile transparent dressing **YES / NO**			

IV Line Access

Hand Hygiene **Before / After / Both**	Circle Line Type **PVC** **Short term CVC** **Femoral CVC** **New Long Term CVC** **Existing Long Term CVC**	
Staff Group Accessing **Nurse / Medic**		
Access cleaned & allowed to dry **YES / NO**	ANTT **YES / NO**	New Sterile Bung **YES / NO / NA**

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CVC Insertion

CVC Insertion **YES / NO**	
Eye protection **YES / NO / Not Indicated**	**Elective** ☐ **Urgent** ☐ **Emergency** ☐
Hand Hygiene **YES / NO**	Asepsis **YES / NO**
Safe sharp disposal **YES / NO**	**Elective** ☐ **Urgent** ☐ **Emergency** ☐
Correct skin prep **YES / NO**	Left to dry **YES / NO**
Drapes ☐ **Gown** ☐ **Gloves** ☐	Operator **Hat / Mask / Both** — **Transparent dressing** ☐ **Bio patch** ☐
Site …… **Documented by;-** **Nurse / Doctor**	

HAND HYGIENE AUDIT

Staff Group Nurse, Medic, AHP or Other	Activity 1) Before Patient Contact. 2) Before Aseptic Technique. 3) After body fluid exposure task. 4) After patient contact. 5) After contact with patient environment. (Choose one)	Were hands decontaminated? YES / NO	If hands were decontaminated, what was used? 1) Soap and Water? 2) Alcohol Hand Gel? 3) Both 1 and 2	Stoned Rings worn? YES / NO	Wrist watch worn? YES / NO	Long Sleeves? YES / NO