Notes on Filling in the Register

1. **Unit number** - First January admission is No.1, then in sequence
2. **Initials of Admitting Nurse**
3. **Return Made**
4. **Name** - Forename(s) followed by surname in capitals
5. **Address**
6. **Postcode**
7. **HAA** - Hospital Activity Analysis county of origin code in UK and Eire, EEC, Other Codes will be found on the Code Card
8. **Telephone**
9. **Next of Kin**
10. **Address**
11. **Date of Birth** - Date, Month, Year (xx,xx,xx)
12. **Age** - Years , except in neonatal/paediatric
13. **Sex** - M or F
14. **Marital Status** - M, S ,W ,D or C (Common law relationship)
15. **Religion**
16. **Hospital Number**
17. **Other Hospital number/GP's name** - either case number or GP's name for transferred patients
18. **Re-admission?** - Previous admission during last six months and date, if known
19. **ICU Admission date (ACPSTAR)** - The *calendar* date at which the ACP starts
20. **ICU Admission time** - 24 hour time (xxxx)
21. **Source of patient** - e.g. ward, theatre
22. **Source of patient** - ACP source code (this is the location of the patient immediately prior to the start of the ACP) see code card
23. **Referring Consultant** - Initials
24. **Speciality Function Code (ACPSPEF)** - this is the main specialty of the consultant clinically managing the ACP
25. **Speciality Code** - from HAA System WEF 1-1-82, see Code Card
26. **ACP end date** - The calendar date at which the ACP ends
27. **Discharge date** - Time, Date, Month, Year + 24 hour time
28. **Length of stay** - Days, to nearest day
29. **Disposal (ACPDISP)** - The destination of a patient following a ACP
30. **Outcome** - This item indicates whether or not the patient survived the ACP, if they did not whether they donated organs (heart, lung, liver, kidney and other solid organs - not corneas and heart valves)
31. **Summary** -

31a **A Intensive Care level days (INTDAYS)** - The number of *calendar* days (i.e. not 24 hour periods) during which a patient receives intensive care within an ACP

31b. **High Dependency Care Level Days (DEPDAYS)** - The number of *calendar* days a patient receives high dependency care within a ACP

31c. **Number of organ systems supported (ORGSUP)** intensive care level only - The *maximum* number of organ systems supported during an ACP *at any one time*

32. **The Augmented Care Planned Indicator (ACPPLAN)** - This indicates whether any part of the ACP was planned in advance of the admission to the ACP location e.g. for a patient requiring care after elective major surgery

33. **Admission Diagnosis** and **Complications in ICU**. To utilise the APACHE score system it is necessary to note whether it is a post operative admission or not and if yes whether emergency, elective and whether there was any complication.

Some of the conditions that are frequently encountered have been preselected and this data can be recorded by circling the appropriate condition as can the existence of severe chronic insufficiency of various systems.

Admission diagnosis refer to conditions existing before admission to the Unit and should be Coded D in following columns.

The first diagnosis should be the name of the primary condition from which the patient is suffering, e.g. Aortic aneurysm, Renal failure, Thoracic trauma.

The second diagnosis can be more specific, possibly arising from the first e.g. Aortic graft, Renal transplant, Fractured ribs.

Alternatively, it may describe another important condition the patient is suffering from, e.g. COAD, Leukaemia, Diabetes.

The third diagnosis may in turn arise from the second (e.g. wound infection, haemorrhage) or may describe another coincidental condition.

In general it will be found unhelpful to enter, at any rate as a first or sole diagnosis, a term such as (Wound infection) or the name of an operation or any other major form of treatment (e.g. Radiotherapy); such entries make it difficult to know what was originally wrong with the patient, so further analysis becomes almost impossible.

Complications refer to things which happen after admission to the unit; they are essentially diagnoses and are entered in the same way. These should be coded C in the following columns.

Planned Admissions
Within the ACP Return it is necessary to record whether this was a planned or unplanned episode.

Codes

Coding is an aid to analysis particularly when using a computer.

34. **Codes D or C** - for Diagnosis or Complication should be entered in the first of these columns as mentioned previously.
35. **Daily Care Level** -Intensive Care or High Dependency Care - see definitions on code card.
36. **Maximum Organ Support** - The maximum number of organs supported in any one day.

Scores

These are potentially extremely useful for categorising patients, but as the systems employed are still in the infancy we have only included broad categories, these can be found at the top of each left hand page. The worst scores during the first 24 hours of admission are recorded

37. **Admission Severity** - This is a simple system based on the likelihood of survival, as judged by the Unit staff. It is, of course, subjective, but is easy to apply. Linked to an objective system, it could become more meaningful. The codes are as follows: 1- Expected to die; 2 - Likely to die; 3 - Even chance of survival; 4 - Likely to live; 5 - Expected to live.
38. **Dependency** - This is a measure of nursing dependency, in fact it is the nurse/patient ratio. It can be used to express the highest ratio (i.e. the greatest number of nurses) needed during the first 24 hours of admission apart from the period immediately following the actual process of admission. The system is fully described at the end of this book.

Treatment Record

The majority of these columns can either be coded simply by ticking, or else where further detail is desirable descriptions or a code can be used.
To accommodate ACP requirements, all columns have been sub-divided to allow for daily record keeping where required.
Examples of suitable codes are given. The column headings have been compiled from the techniques practised most frequently on many units and to comply with ACP dataset requirements. However, if you feel that a particular section is not appropriate to your unit you should have no problem in substituting techniques more commonly used.

Circulation

39. **No of peripheral lines** - This number gives some indication of intensity of therapy and hence of workload.
40. **Central Venous line**
41. **Arterial line**
42. **Pulmonary artery (Swan-Ganz)**
43. **Intra Aortic Balloon Pumping**
44. **Defib/CPR** - Defibrillation/Cardio Pulmonary Resuscitation, an indication of treatment for cardiac arrest.
45. **Blood transfusion** - This records the use of blood products, the number of units may be entered.

VasoDrugs

46. - 48. **Please tick appropriate boxes or enter drug code or name if preferred**. Inotropes, Vasodilators, Rhythm Drugs.

Respiratory

49. **Controlled ventilation No. of hours** - Fully controlled ventilation. Box 36 must be ticked too, unless prolonged hand ventilation via a mask is employed. Please enter the number of hours that a patient is ventilated.

50. **IMV/Assisted ventilation** - This is intended to cover all other patterns of ventilation.
51. **PEEP/CPAP** - Use of positive airway pressure, etc. for alveolar recruitment.
52. **Fixed performance mask** - delivering over 50% oxygen.
53. **ET Tube/Tracheotomy** - This usually implies controlled O_2, humidification, etc.
54. **2 hourly physiotherapy secretion clearance.**
55. **Recently extubated.**
56. **Chest drained** - Implies indwelling drain with non-return mechanism.
57. **Respiratory Observations**

Neuro

58. **Neuro Observations** - Includes pupil size and reactions, level of consciousness, coma scale.
59. **ICP/Cerebal Function Monitoring** - Continues monitoring of intracranial pressure or by cerebal.
60. **EEG/CT Scan** - Implies full EEG record or Cranial computerised tomography.
61. **Brainstem Death** - Fully certified brainstem death in a patient fulfilling essential preconditions, whether or not the ventilator is turned off as a result. The column can also be used to indicate a patient who became an organ donor.

Renal

62. **Peritoneal Dialysis**
63. **Haemodialysis** - Including ultrafiltration
64. **Haemofiltration**
65. **Haemoperfusion** - Charcoal column or other

Drugs & Other

66. **Sedatives**
67. **Opiate**
68. **Relaxants**
69. **Antibiotics**
70. **Regional block.** - Includes epidurals, intercostal blocks, etc.
71. **Parenteral/Enteral Feeding** - Enter IV for parenteral feeding and E for enteral feeding which implies use of nasogastric tube or gastrostomy.
72. **Endoscopy** - Includes laryngoscopy, oesophagoscopy, gastroscopy, bronchoscopy, sigmoidoscopy, etc.
73. **Ex-Unit procedure** - Any procedure which requires patient to be moved out of the Unit, e.g. surgical operation, CT scan, angiography, etc.

Further Copies
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