WardWatcher (2014 version)

Help pages
Definitions for all mandatory pages/fields (Minimum Data Set)
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Section 1: Admission screen

1.1 General

Data are to be collected for all admissions, regardless of age, severity of illness, reason for admission, length of stay etc. Data entered into WardWatcher should be measured and/or recorded in any part of the permanent/electronic records.

1.2 Admission and identity data

**Key:** Every new admission will automatically be allocated a key number. This is useful when data needs to be anonymous. If the same patient is readmitted or transferred to another Critical Care Unit they will have another key number allocated.

**Hospital number:** This is the hospital number/case record number given to the patient by your hospital.

**Date of birth:** If the date of birth is unobtainable use judgement to estimate the year of birth and record as the 1st January of estimated year. Indicate in notes that the DOB has been an estimate.

**Unit admit date:** this is the date on which the patient was admitted to your unit. Admission to your unit is defined as physical admission and recording of that admission to a bed in your unit.

**Time:** This is the time at which the patient was admitted to your unit. Accuracy of time is important as occupancy is calculated minute by minute.
CHI number: Ten-digit number given to all patients who are registered with a GP in Scotland. The first six digits are the same as the patient's date of birth. If a patient does not have a CHI number enter ten zeros.

Admit this hospital: This is the date on which the patient was admitted to THIS hospital.

Referring Consultant: The name of the consultant who has referred the patient to the critical care area.

Unit Consultant: Consultant linked to this unit who has overall responsibility for this patient.

Admitted from (name): This is the local name of the area from which the patient was directly admitted to your unit and does not use the generic labels/categories used by SICSAG. Information in this field is used purely for local analysis and does not form part of the SICSAG minimum data set.

Admitted from (type): This is the source from which the patient was directly admitted to your unit. The source is described generically using one of the 11 mutually exclusive options.

- Emergency Department: patient admitted directly from the Emergency Department
- Recovery/theatre (post operation) the patient has undergone all or part of surgical procedure or anaesthesia for a surgical procedure
- Recovery only (no operation): Patient has been managed in recovery area until a bed has become available in this unit. Patient did not undergo any surgery or procedure requiring anaesthesia.
- Ward
- ICU
- HDU
- Other intermediate area: this could be a CCU or other area where the level of care is greater than the normal ward but is not an ICU or HDU.
- Obstetric area
- Imaging Department: patient underwent interventional radiology, endoscopy or a procedure requiring general, local or regional anaesthesia
- Clinic: patient admitted directly from outpatients or clinic
- Home or normal residence: an admission directly from the community without being admitted to any other part of the hospital.

Housed within: Hospital site the patient is directly admitted from. Options are:

- This hospital
- Other hospital/same health board
- Other hospital/other health board (any NHS hospital within the UK)
- Non-NHS facility (private hospital within the UK or non UK hospital)

Previously located: If a patient has been admitted from a transient area, you will be asked where the patient was located prior to that area. Transient areas are: Emergency department, Theatre/recovery, Imaging department and clinic.

Nature of Surgery: options are emergency/urgent OR scheduled/elective. Surgery is defined as undergoing all or part of a surgical procedure or anaesthesia for a surgical procedure in an operating theatre or an anaesthetic room.

Emergency/Urgent
- Immediate surgery, where resuscitation (stabilisation and physiological optimisation) is simultaneous with surgical treatment OR surgery as soon as possible after resuscitation (stabilisation or physiological optimisation). 

Scheduled/Elective
- Early surgery but not immediately life threatening OR surgery at a time to suit both patient and surgeon.
Section 2: History screen

Figure 2

2.1 General

The history screen records data on the circumstances which led to the patient’s admission to the unit and information on co-morbidity (PMH).

2.2 Circumstances of admission

Admit speciality: Indicate the primary speciality under whose care the patient was admitted. The choice is fixed to a list determined by SICSAG and is not locally modifiable.

CPR in 24 hours prior to admission to unit: Specifically refers to cardiopulmonary resuscitation in the 24 hours prior to admission to your unit. It does NOT include cardiopulmonary resuscitation received AFTER admission to your unit. Cardiopulmonary resuscitation must include either internal or external cardiac massage. Pre-cordial thumps or defibrillation without cardiac massage are excluded.

Readmission to this unit during this hospital stay: Enter Yes (Y) if the patient is being admitted for a second or subsequent time to this unit during this hospital stay (i.e. the patient has remained an in-patient in this hospital between now and the last admission to this unit).
2.3 Past Medical History

All of the sections explained below are no longer required in HDU

**Very severe cardiovascular disease:** specifies whether the patient has fatigue, claudication, dyspnoea or angina at REST. Where any activity increases symptoms, symptoms must be due to myocardial or peripheral vascular disease. Functionally, this patient cannot stand alone, walk slowly or dress without symptoms. Definition equals the New York Heart Association, Class IV. Very severe cardiovascular disease must be documented prior to or at admission to your unit.

**Severe respiratory disease:** specifies whether the patient has permanent shortness of breath WITH LIGHT ACTIVITY, due to pulmonary disease. Functionally, this patient is unable to work and has shortness of breath performing most normal activities of daily living (e.g. walking 20 metres on level ground, walking slowly in the house, climbing one flight of stairs; or dressing or standing). Severe respiratory disease must be documented prior to or at admission to your unit.

**Biopsy proven cirrhosis:** Biopsy proven cirrhosis must be documented prior to or at admission to your unit.

**Imaging proven cirrhosis:** Imaging proven cirrhosis must be documented prior to or at admission to your unit.

**Portal Hypertension:** Evidence of portal hypertension is the presence of oesophageal or gastric varices demonstrated by surgery, imaging or endoscopy; or the demonstration of retrograde splenic-venous flow by ultrasound. DO NOT include GI bleeding without the evidence of portal hypertension. Portal hypertension must be documented prior to or at admission to your unit.

**Hepatic encephalopathy:** episode of hepatic encephalopathy grade 1 or greater (see below). The episodes of encephalopathy must have occurred IN THE SIX MONTHS prior to admission to your unit, and must be documented prior to or at admission to your unit. Grading of hepatic encephalopathy:

- Grade 1: no abnormality detected
- Grade 2: slowness of cerebration, intermittent mild confusion and euphoria
- Grade 3: confused most of the time, increasing drowsiness
- Grade 4: severe confusion, rousable, responds to simple commands
- Grade 5: unconscious, responds to painful stimulus

**Acute Leukaemia:** the patient has acute mylogenous leukaemia, acute lymphocytic leukaemia or multiple myeloma. The presence of such conditions must have been evident in the SIX MONTHS PRIOR to admission to your unit and must be documented prior to or at admission to your unit.

**Chronic Leukaemia:** the patient has chronic myelogenous leukaemia or chronic lymphocytic leukaemia. The presence of such conditions must have been evident in the SIX MONTHS PRIOR to admission to your unit and must be documented prior to or at admission to your unit.

**Metastatic disease:** the patient has distant (Not regional lymph node) metastases, documented by surgery, imaging or biopsy. The presence of metastases must have been evident in the SIX MONTHS PRIOR to admission to your unit and must be documented prior to or at admission to your unit.

**Lymphoma:** the patient has active lymphoma documented by surgery, imaging or biopsy. The presence of lymphoma must have been evident in the SIX MONTHS PRIOR to admission to your unit and must be documented prior to or at admission to your unit.

**AIDS:** the patient has a definitive diagnosis of AIDS according to current WHO definition. The patient is HIV positive with clinical complications. Clinical complications include pneumocystis carinii, Kaposi’s sarcoma, lymphoma, TB, and toxoplasma infection. DO NOT include AIDS-related complex or HIV positivity alone. AIDS must be documented prior to or at admission to your unit.

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**Immunosuppression:** the patient has received 0.3mg per kg or more of prednisolone or an equivalent dosage of another corticosteroid, DAILY FOR THE SIX MONTHS PRIOR to admission to your unit. Where the body weight of an adult is unknown, you should answer Y (yes) if the patient has received 20mg or more per day of prednisolone or an equivalent dosage of another corticosteroid, DAILY FOR THE SIX MONTHS PRIOR to admission to your unit.

**Chronic renal replacement:** the patient currently requires chronic renal replacement therapy (chronic haemodialysis, haemofiltration or peritoneal dialysis) for irreversible renal disease.

### 2.4 Pregnancy

The patient is not pregnant, pregnant, or recently pregnant.

### Section 3: Diagnosis screen

#### Figure 3

![Diagnosis Screen](image)

3.1 General

The diagnosis screen requires an APACHE diagnosis (reason for admission to your unit), SICS diagnosis (diagnosis requiring admission to hospital AND unit*), operation performed (if applicable) and reason for unit admission.

*Reason for admission to this unit is optional in HDU

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3.2 APACHE Diagnosis

The APACHE classification to categorise patients according to the primary diagnosis precipitating admission to the unit.

The APACHE diagnosis is mapped to a co-efficient, which is used as a component in the calculation of a mortality probability.

According to APACHE methodology patients are surgical or medical according to their source of admission. Surgical patients are those admitted directly from theatre/recovery following an operation. All other patients are defined as medical.

In some circumstances patients may be admitted to the unit for medical reasons following surgery (e.g. dysrhythmias during routine surgery). In this case the APACHE methodology still states that the diagnostic classification is made according to the surgery, which the patient underwent.

In other circumstances, patients may be admitted to the unit from a ward within hours of undergoing surgery. In this case the APACHE methodology still states that the diagnostic classification is made according to the medical condition, which precipitated admission.

Please remember that while these rules may appear unsatisfactory it is better to comply with the rules and definitions, which you deem to be incorrect rather than to substitute personal rules and/or definitions.

See Discharge page for information on exclusions from APACHE scoring.

3.3 SICS diagnostic coding

The APACHE diagnosis caters for only a single primary diagnosis. It is a broad classification designed to divide patients into groups whose reason for admission has a similar impact or mortality probability. In addition the choice of diagnostic grouping is small and cannot be modified.

The SICS diagnostic coding is an attempt by the Scottish Intensive Care Society to group patients into categories, which are more useful descriptors of the types of patients being admitted to Scottish units. In addition, the coding is not limited to a single primary diagnosis but allows reason for hospital admission as well as multiple reasons for unit admission to be entered.

The SICS diagnostic coding includes obstetric, cardiothoracic and transplant diagnoses.

Copy button: If reason for admission to unit is exactly the same as reason for admission to hospital this allows ‘copying’ of diagnosis entered for reason for admission to hospital to reason for admission to unit.
Section 4: Severity of Illness Screen

4.1 General

Physiology data form part of the APACHE methodology. Physiology data derive from the time period during the first 24 hours in the unit. For patients admitted for pre-surgical preparation the first 24 hours in your unit commences at the time of admission to your unit. Time spent outside your unit during the first 24 hours (e.g. in theatre) is counted when determining the first 24 hours in your unit. Pre-unit physiology data are disregarded (except for pre-sedation GCS). Only physiology data recorded on the patient chart or record during the first 24 hours following admission to your unit are considered valid data.

**Data collected by:** enter the name or the initials of the person who collected or entered the data.

4.2 Observations

Only charted or recorded data in the first 24 hours of admission should be used. Observations should not be recorded for any admission during periods of iatrogenic disturbance (e.g. physiotherapy, turning, crying etc). If an admission stays less than 24 hours then enter the lowest and highest rates while in your unit. If only one measurement is taken it should be entered as the lowest and highest measurement.

**Blood Pressure:** enter the highest systolic BP value PLUS the paired diastolic BP from the SAME measurement. Enter the lowest diastolic BP value PLUS the paired systolic BP from the SAME measurement.

**Central temperature:** Tympanic membrane thermometers are generally set to record central temperature but if unsure please check with your medical physics department.
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Respiratory rate: for patients who are ventilated the respiratory rate should account for both ventilated and spontaneous breaths in a minute.

4.3 Urine Output

Urine output able to measure: answer yes if the urine output was accurately measured and recorded. Answer no if unable to measure urine (e.g. due to incontinence).

Urine output total: if an admission stays less than 24 hours enter total urine output measured and recorded while in your unit.

4.4 Neurological Function

Able to assess GCS in first 24 hours in unit: This is a clinical decision that should be made by clinical staff responsible for the patient in the first 24 hours. If the patient has received sedation (iatrogenic), affecting their GCS for all of the period (first 24 hours) then an accurate GCS will not be available.

If patient has had sedation and your clinical decision is that it is no longer affecting GCS (within first 24 hours) then enter yes and enter lowest recorded GCS in first 24 hours. If no sedation has been given then enter yes and enter lowest recorded GCS in first 24 hours.

If patient is intubated, the verbal section of the GCS will change to:
Clearly orientated (5 points)
Responsive but orientation in doubt (3 points)
Clearly unresponsive (1 point)
This is to encourage an appropriate assessment of the patient’s neurological function and not an assessment of the patient’s ability to speak, which is prevented by intubation.

Pre-sedation GCS: If an accurate GCS is NOT available in the first 24 hours you will be asked if a pre-sedation GCS is available. Pre-sedation GCS should be a GCS recorded prior to patient being sedated (iatrogenic) in another unit e.g. on arrival to Emergency Department prior to intubation. This must be recorded in the notes. An option to record total GCS or elements (eyes, motor, verbal) is available. If the eyes/motor and verbal score is documented in case notes please record this. It is acceptable to assume that documentation of a patient being alert and orientated = GCS 15.

4.5 Arterial blood gases

Any gas: all four values from the SAME arterial blood gas with the LOWEST PaO2, regardless of intubation status.

Intubated only: all four values from the SAME INTUBATED arterial blood gas with the HIGHEST FiO2. Values are those measured and recorded in the first 24 hours in your unit. Inspired oxygen concentration is expressed as a percentage within WardWatcher.

4.6 Blood tests

Lowest and highest values measured and recorded in the first 24 hours in your unit.
If a patient stays less than 24 hours, then enter values measured and recorded during period in your unit.
Only LABORATORY RESULTS should be used. If only one value was recorded and measured, then enter this value as both the lowest and highest value.

All available data entered: enter yes when all the available data have been entered. If you do not enter yes, then WardWatcher will assume that there is missing data and will alert the user of this fact when an attempt is made to discharge the patient. All sections of the severity of illness page are mandatory except ABGs and Blood tests as it is accepted that in some cases these will not have been performed. WardWatcher will presume these tests are normal if they are not entered.
Section 5: ACP Screen

5.1 General

Augmented Care Period (ACP) and Therapeutic Intervention Scoring System (TISS) data are used to assess the resources used in treating acutely ill patients and in an attempt to stratify them into different levels of care. TISS is no longer mandatory and should only be collected if data valuable locally.

5.2 Augmented Care Period (ACP)

Data is collected for each calendar day for a 24-hour period (midnight to midnight) except for the day of admission and discharge when the period may be less than 24 hours. The highest level of care for that period should be recorded (e.g. if a patient has been ventilated via ETT and then extubated and receiving oxygen via a facemask, connected to a ventilator via ETT should be chosen).

WardWatcher will calculate the level of care daily based on the support of five organ systems, see Calculation of level of care below for more information.

Click on New day at the bottom of the ACP section (figure 5a) to enter ACP details (figure 5b). To view other dates, click on desired date to highlight and then click on View highlighted.
5.2.1 Respiratory Support

**Patient on a ventilator in this unit today?** Answer **yes** if mechanical ventilation has occurred in your unit from midnight to midnight on the specified date. If a patient is connected to a ventilator for **ANY** length of time in this time period, the level of care recorded in their ACP should reflect this (BIPAP machines should also be included). Selecting ‘yes’ will then provide a further 3 options: ETT, Trache and Mask/Hood – select one option.

**Patient on a ventilator in this unit today?** Answer **no** if mechanical ventilation has not occurred from midnight to midnight on the specified date. Please then select the highest level of respiratory support the patient has received in that 24 hr period. Please note that short term increases in FIO\textsubscript{2} for transfers/suctioning/physiotherapy etc should not be included.

**Intubation/reintubation considered at some point today?** Answer **yes** if the patient has had a **formal** medical review/assessment for intubation/reintubation. Answer **no** if no formal medical review/assessment has taken place.

**NB:** Non-invasive ventilation (NIV)/BIPAP should be recorded as connected to a ventilator by mask or hood.

5.2.2 Cardiovascular Support

**Multiple IV vasoactive drugs and/or antiarrhythmics?** Answer **yes** if patient receiving multiple intravenous vasoactive and/or rhythm controlling drugs simultaneously to support or control arterial blood pressure, cardiac output or organ perfusion (e.g. Noradrenaline and Amiodarone)
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**Single IV vasoactive drug and/or antiarrhythmic?**  Answer *yes* if patient receiving a single intravenous vasoactive or rhythm controlling drug to support or control arterial blood pressure, cardiac output or organ perfusion.

**Cardiac output monitoring?**  Answer *yes* if patient’s cardiac *output* has been measured continuously (in the specified time period) via pulmonary artery catheter, pulse contour analysis, oesophageal doppler or other method.  Please note that ECG monitoring should *not* be included in this category.

**Type of cardiac output monitoring?**  If you have answered *yes* to the above, please select the type of cardiac output monitoring from the drop down menu – PA catheter, oesophageal doppler, pulse contour analysis or other.

**Circulatory instability due to hypovolaemia?**  Answer *yes* if patient receives treatment of circulatory instability due to hypovolaemia from any cause.

**Central venous catheter (including haemofiltration/dialysis catheter)?**  Answer *yes* if a patient has the use of a central line for monitoring/fluids/drugs/IV access and/or vascular access for renal support (haemofiltration/dialysis) – does *not* include AV fistula or AV graft.

**Arterial line?**  Answer *yes* if the patient has an arterial line for continuous monitoring of the arterial pressure and/or sampling of arterial blood.

**5.2.3 Renal Support**

**Acute renal replacement therapy (haemofiltration/haemodialysis)?**  Answer *yes* if the patient has received acute renal replacement therapy in the specified time period.

**5.2.4 Neurological Support**

**Invasive neuro monitoring (e.g. ICP, jugular bulb)?**  Answer *yes* if neuro monitoring is invasive.  Does not include EEG/Bispectral Index (BIS) monitoring etc.

**Severely agitated or epileptic needing constant nursing attention and/or sedation** – answer *yes* if the patient requires continuous IV medication to control seizures and/or cerebral monitoring.  

**Agitation** – answer *yes* if the patient requires *constant* care/supervision due to their level of agitation.  This does not include patients that are slightly confused/disorientated that require occasional re-orientation to time, place or person.

**CNS depression enough to prejudice airway (not due to sedation)?**  Answer *yes* if there is sufficient central nervous system depression sufficient to prejudice airway and protective reflexes e.g. CVA, overdose, severe hypoglycaemia etc.

**5.2.5 Gastrointestinal Support**

**Parenteral Nutrition?**  Answer *yes* if the patient is receiving Total Parenteral Nutrition (TPN).

**Enteral nutrition?**  Answer *yes* if the patient is receiving enteral nutrition via Nasogastric tube/PEG tube/naso-jejunal tube.

**5.2.6 Dermatological Support**

**Major skin rashes/exfoliation or burns?**  Answer *yes* if greater than 30% of total body surface area is affected.

**Use of multiple trauma dressings?**  Answer *yes* if there is the use of multiple trauma dressings e.g. multiple limb or limb and head dressings.

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Complex dressings (e.g. open abdomen, large skin areas)? Answer yes for the use of complex dressings e.g. open abdomen, or large skin area greater than 30% of total body surface area, vacuum dressings, or large trauma dressings.

5.2.7 Other Support

Epidural infusion? Answer yes if the patient has had an epidural infusion in the specified time period.

5.2.8 Other Monitoring

Needs more monitoring than available on a general ward? Answer yes unless the patient is ward fit and ready to be discharged.

5.3 Calculating Levels of Care

WardWatcher will score levels of care based on support of five different organ systems: respiratory, cardiovascular, renal, neurological and dermatological. The GI section is not included.

**Level 3**
- Advanced respiratory support (connected to a ventilator via ETT or tracheostomy)
- Two or more organ systems are being supported (except basic respiratory and basic cardiac)
- One organ system is being supported and a different system is in chronic failure*

**Level 2**
- One organ supported

**Level 1**
- Epidural or/and
- General observations requiring more monitoring than can be provided on a general ward

**Level 0**
- A patient is assessed as level 0 if not assessed as level 1, 2 or 3 (e.g. no organ support and adequate monitoring could be provided on a general ward)

* Chronic failure is collected from the PMH section of the history page in WardWatcher. If a patient has a chronic health condition ticked on the History screen, it will be highlighted on the ACP page (see below).
Section 6: Unit Discharge Screen

6.1 Unit Discharge Details

Unit outcome: status of the patient at discharge from your unit. Died includes admissions who leave your unit to become heart beating organ donors.

Ready for discharge: Enter date and time that a MEDICAL DECISION is made to discharge the patient to another unit. This will usually be when unit level of Critical Care is no longer required or a higher or specialist level of care is required (e.g. a patient being transferred from HDU to ITU or general ITU to Neuro ITU). In some circumstances transfer may not be in the best interest of the patient but due to pressure on beds or staffing issues. In this circumstance the patient is NOT ready for discharge and no should be entered. No should be entered if a patient self discharges against medical advice.

Actually discharged: date and time of discharge from your unit is the latest documented date of the patient being physically in your unit.

Gap between ready and actual discharge: WardWatcher will calculate time (hours/minutes) between patient being ready for discharge and actually discharged.
Gap considered
If there is a gap between ready for discharge and actual discharge then you will be asked to consider gap as normal or abnormal. Normal would be the time taken by unit staff to get patient ready for discharge and assemble all documents required for transfer. NB Local areas should decide what is acceptable as a ‘normal delay’.

Destination (name): the actual name of the destination to which the patient was transferred. This information is for local use only.

Destination (type): the generic destination to which the patient was DIRECTLY transferred following discharge from your unit. Options are:
- A: Ward
- B: Intensive care unit
- C: High dependency unit
- D: Other intermediate area
- E: Recovery (NOT for operation)
- F: Home or normal residence

Housed within: Hospital site patient discharged to, options are:
- This hospital
- Other hospital/same health board
- Other hospital/other health board: any NHS hospital within the UK
- Non-NHS facility: private hospital within the UK or non UK hospital

Reason discharged: options are:
- Fully ready for non-unit care: planned discharge for an admission no longer requiring the current level of care
- Early (shortage of unit beds)
- Early (shortage of unit staff)
- Specialist care: discharge to another unit where a higher level of care and/or specialist care is provided
- Repatriation to unit nearest home
- Psychiatric care
- Palliative care
- Self discharge

Expected hospital outcome: indicate the consensus view, at the time of Critical Care discharge, of the medical/nursing team responsible for the care of the patient.

In case of deterioration: Indicate the consensus view, at a time of unit discharge, of the medical/nursing team responsible for the care of the patient.

Died on: date and time of death in your unit. If the patient is declared brain stem dead, then the date and time sought is on the completion of the second set of tests confirming brain stem death.

Brain stem death tests performed: Brain stem death tests performed as per local protocol and documented in notes.

Brain stem death tests confirmed: enter yes if the patient was declared brain stem dead.

Organ donation requested: enter yes if organ donation was requested by medical staff or organ transplant coordinator to the next of kin.

Organs donated: enter yes if the patient went to surgery for organ harvesting as a heart-beating organ donor or non-beating heart donor.
Avoid severity of illness scoring: If severity of illness data are not completed you will be given two options of why this is not collected in order to be able to discharge your patient. Options are:

- Missing core physiology data or
- Unit decision not to score this patient (unit currently not collecting severity of illness data on all or any patients)

Most HDUs do not currently collect severity of illness data so an automatic default to ‘unit decision not to score this patient’ has been set up.

Patients who are not validated for APACHE II methodology will not have an APACHE score calculated and will be automatically omitted from the Standardised Mortality Ratio (SMR). These patients can be discharged from WardWatcher without severity of illness scoring or this question being answered.

Patients who are omitted from APACHE II methodology are:

- under 16 years
- unit stay less than 8 hours
- readmission to same unit during the same hospital stay
- diagnosis of burns, liver transplant or CABG.

SICSAG ADVISES UNITS TO COLLECT SEVERITY OF ILLNESS DATA ON ALL PATIENTS ADMITTED TO ICU or Combined ICU/HDUs as different case-mix adjustment tools will be used in the future that may have no omissions.

New Feature: screen ‘lock’ once patient discharged from unit

After a patient is discharged from a unit, changes to data will only be possible with administrator access on all pages except hospital discharge.
Section 7: Hospital Discharge Screen

7.1 General

This page is only activated when unit discharge is complete. Hospital and ultimate hospital discharge information is required to collect hospital and ultimate hospital outcome and calculate length of stay. It is essential for calculation of the Standardised Mortality Ratio (SMR) data.

7.2 Discharge from this hospital

**Date:** enter date discharged from your hospital.

**Outcome:** status of the patient at discharge from your hospital.

**Sent to (type):** the generic destination type to which the patient was discharged.

**Sent to (name):** the actual name of the destination to which the patient was discharged.

7.3 Early end to acute episode in this hospital

APACHE II requires a discharge date from the original hospital as well as the ultimate ‘acute’ hospital. In some circumstances ‘non-acute’ care (psychiatric care and rehabilitation) will be delivered at another hospital thus ending the acute episode but in some circumstances these services are available on site. This will create an unfair bias to these hospitals by increasing the patients length of stay.

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stay and sometimes increasing their mortality. By answering this section, SICSAG will be able to account for these differences.

**Date ended**: enter date patient was transferred to a rehabilitation or psychiatric ward within your hospital, if applicable.

**Reason ended**: enter reason for early end to acute episode (rehabilitation or psychiatric care)

### 7.4 Ultimate hospital discharge

If a patient is discharged to ‘another acute hospital’ this section will need to be completed.

**Date**: enter date discharged from final ‘acute’ hospital.

**Outcome**: status of the patient at discharge from that hospital.

**Sent to (type)**: the generic destination type to which the patient was discharged.

**Sent to (name)**: the actual name of the destination to which the patient was discharged.

### 7.5 Early end to acute episode in final hospital

**Date ended**: enter date patient was transferred to a rehabilitation or psychiatric ward within final ‘acute’ hospital, if applicable.

**Reason ended**: enter reason for early end to acute episode (rehabilitation or psychiatric care)