

# Indian ICU Case mix And Practice patterns Study (INDICAPS)

## FORM 2

### INDIVIDUAL PATIENT FORM (One form for each patient in the ICU on the study day)

ISCCM Center No. \_\_\_

Patient No. \_\_\_

Date of data collection \_\_/\_\_/2010

Date of ICU admission \_\_/\_\_/2010 Date of hospital admission \_\_/\_\_/2010

Age \_\_ yrs Sex: Male  Female  Weight: \_\_\_ Kg Height \_\_\_ cm

Type of admission:  Medical  Surgical (Directly from OT/Recovery)

Elective  Emergency Site / type of surgery \_\_\_\_\_  Trauma

Is this patient  self paying  payment by employer  private health insurance

Admission source:  Home  Ward of same hospital  Casualty / Emergency Department

Ward of other hospital  ICU of other hospital

Another ICU of same hospital  Others, please specify \_\_\_\_\_

From same city/ town  From other city /town

If from other town, distance from your ICU \_\_\_ \_\_\_ kms

Reason for ICU admission (Tick all that apply)

Basic & observational  Cardiovascular  Digestive  Hematological  Hepatic  Metabolic

Neurological  Poisoning  Renal  Respiratory  Trauma  Other

Did this patient have a cardiac arrest before he was admitted to the ICU?  Yes  NO

Diagnostic code (Use SINGE best diagnostic code from APPENDIX 1) \_\_\_\_\_

Comorbidities

COPD  Cancer Therapy  Metastatic cancer  Hematologic cancer

Insulin dependent diabetes mellitus  Heart failure (NYHA III)  Heart failure (NYHA IV)  Chronic renal failure  HIV infection  Cirrhosis  AIDS

Immunosuppression  Steroid therapy

Was the patient admitted to ICU with suspected / confirmed infection?  Yes  NO

If infection suspected / confirmed, was it (tick all that apply)

Malaria  Leptospirosis  Dengue fever  Scrub typhus

- Bacterial     H1N1     Other Viral     Fungal     Pulmonary TB  
 Other TB     Other

Does the patient have suspected / confirmed infection **today**?  Yes  NO

- Malaria     Leptospirosis     Dengue fever     Scrub typhus  
 Bacterial     H1N1     Other Viral     Fungal     Pulmonary TB  
 Other TB     Other

Did the infection develop in ICU?  Yes  NO

Was any sample sent to microbiology for culture / sensitivity during this ICU admission:  Yes  NO

If infection was confirmed (Enter microorganism codes as per **APPENDIX 2**)

Microorganism    1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

What antibiotics is the patient receiving today (Enter antibiotic code as per **APPENDIX 3**)

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

Is the patient receiving anti-malarials today ?  Yes     No.

If yes, is he getting  Quinine     artesunate     chloroquin

At any time during ICU stay did the patient have

- Severe Sepsis  Yes  NO    Septic Shock  Yes  NO    Low dose steroids (for septic shock)  Yes  NO  
 Activated Protein C  Yes  NO

**Did this patient come to the ICU after poisoning?**  Yes  NO, If yes

- Organophosphorus poisoning     Organochlorine poisoning     Aluminium phosphide poisoning  
 Rat poisoning     Sedative overdose     Tricyclic antidepressant overdose  
 Heroin / Cocaine or recreational drug overdose     Corrosive Poisoning  
 Unknown     Other, please specify \_\_\_\_\_

**Fluids for Resuscitation: In these 24 hours (0800 am today to 0800 am next day)**

**Has this patient received**

- Normal Saline or Ringer lactate at rate equal to or greater than 500 mL/Hr  
 Hemaccel     Gelofusine     Any starch solutions (e.g. Voluven, Hestar, Haes-steril, etc)  
 Whole Blood / packed cells     Fresh Frozen Plasma     Platelets  
 Albumin

**Hemodynamic Monitoring : In these 24 hours (0800 am today to 0800 am next day), did this patient have**

Hourly urine output monitoring (measured every hour)  Yes  NO

Invasive Arterial blood Pressure  Yes  NO    If yes Site Code (as per **APPENDIX 4**) \_\_\_

Central Venous Pressure     Yes  NO    If yes Site Code (as per **APPENDIX 4**) \_\_\_

Cardiac output monitoring     Yes  NO    If yes Monitor type Code (as per **APPENDIX 4**) \_\_\_

Intraaortic Balloon Pump

Yes  NO

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ISCCM Center No. \_\_\_

Patient No. \_\_\_

Fill in the following details for this patient today (only fill if done on that day)

**Cardiovascular system**

Was lactate measured?  Yes  No

Lactate (max) \_ . \_ mmol/L

Was Central Venous Oxygen Saturation measured?  Yes  No If yes, (min) \_ % (max) \_ %

Was Stroke Volume Variation measured?  Yes  No If yes (min) \_ % (max) \_ %

Noradrenaline  Yes  No if yes, dose (max) \_ . \_  $\mu\text{g}/\text{kg}/\text{min}$

Dopamine  Yes  No if yes, dose (max) \_ . \_  $\mu\text{g}/\text{kg}/\text{min}$

Adrenaline  Yes  No if yes, dose (max) \_ . \_  $\mu\text{g}/\text{kg}/\text{min}$

Dobutamine  Yes  No if yes, dose (max) \_ . \_  $\mu\text{g}/\text{kg}/\text{min}$

Other inotropes / vasopressors \_\_\_\_\_ dose \_\_\_\_\_  $\mu\text{g}/\text{kg}/\text{min}$

**Physiological Parameters and Investigations**

Heart rate (min) \_\_\_ (max) \_\_\_ bpm Core body temperature (min) \_ . \_ (max) \_ . \_ ° C

Systolic blood pressure (min) \_\_\_ (max) \_\_\_ mmHg Mean arterial pressure (min) \_\_\_ mmHg

Diastolic blood pressure (min) \_\_\_ (max) \_\_\_ mmHg Respiratory Rate (min) \_\_\_ (max) \_\_\_ bpm

Glasgow Coma Score (worst) Eye opening \_ (1-4) Verbal Response \_ (1-5) Motor Response \_ (1-6)

Total \_\_\_\_\_

Does the patient have acute renal failure ?  Yes  No

Blood urea (max) \_ . \_ mg/dL Sr. creatinine (max) \_ . \_ mg/dL

Urine output \_\_\_ mL/24hours Hemodialysis  Yes  No CRRT  Yes  No

Hemoglobin \_\_\_ gm/dL INR (worst) \_ . \_ PT (worst) \_ \_ secs

Leukocytes (min) \_\_\_ (max) \_\_\_  $10^3/\text{mm}^3$  Platelets (min) \_\_\_  $10^3/\text{mm}^3$

Serum potassium (min) \_ . \_ (max) \_ . \_ mmol/L Serum sodium (min) \_\_\_ (max) \_\_\_ mmol/L

Total bilirubin (max) \_ . \_ mg/dL Serum bicarbonate (min) \_\_\_ mmol/L

Blood glucose (min) --- mg/dL (max) --- mg/dL

pH \_ . \_ PaO<sub>2</sub> (min) \_\_\_ mmHg (max) \_\_\_ mmHg FiO<sub>2</sub> (min) \_\_\_ mmHg (max) \_\_\_ mmHg

PaCO<sub>2</sub> (min) \_\_\_ mmHg (max) \_\_\_ mmHg

**Respiratory system**

Mechanical ventilation  Yes  No Non-Invasive Ventilation  Yes  No

**If the patient is ventilated, reason for ventilation is**

- OP poisoning       Snake bite       GB syndrome or other neuromuscular disease  
 Major Trauma or surgery  COPD       Pneumonia       ARDS       Cardiac failure  
 Severe sepsis  Other , Please specify \_\_\_\_\_  
Endotracheal intubation  Yes  No      If yes, Route  Oral  Nasal  
Tracheostomy  Yes  No      If Yes,  Surgical  Percutaneous

**At 1200 noon, what were the ventilator settings?**

- Mode of MV being used  Pressure control  Volume control       CMV  Assist control  SIMV   
SIMV + Pressure Support  Pressure Support  PRVC  Other, please specify \_\_\_\_\_  
Tidal Volume \_\_\_ mL      PEEP \_\_ cmH<sub>2</sub>O      Plateau Pressure \_\_ cmH<sub>2</sub>O  
Peak Pressure (min) \_\_ (max) \_\_ cmH<sub>2</sub>O      Respiratory rate \_\_ /min  
Patient position  Flat  Head low  Semirecumbent

**At any time in these 24 hours (0800 am today to 0800 am next day), did the patient have**

- Prone position  Yes  No  
Methylprednisolone or other steroid  Yes  No      If yes, Dose \_\_\_ mg      Day no. \_\_\_

**Sedation**

Did this patient receive intravenous sedation today?  Yes  No

If yes,

- Continuous infusion       Intermittent boluses only

What drugs were used for sedation? (tick all that apply)

- Midazolam      Diazepam      Morphine      Fentanyl  
Tramadaol      Pentazocine      Buprenorphine      Propofol      Others

Did this patient receive muscle relaxants today?    Yes    No

Did this patient have physical restraints today?     Yes  No

**Feeding**

Is the patient Nil by Mouth?       Yes  No

Oral Feeding       Yes  No

Enteral tube feeding  Yes  No      If yes, Route code (as per APPENDIX 5) \_\_\_

**What is being fed to the patient?**

Cooked food  Blenderised food  Prepared from commercial powders

If the patient is being fed via tube, is he receiving

Continuous feed  Intermittent bolus feeds

Is the patient receiving Prokinetics? Yes  No

Is the patient receiving Parenteral Nutrition  Yes  No

**Central Nervous system**

**ICP monitoring**  Yes  No

**Miscellaneous**

Stress ulcer prophylaxis  Yes  No

If yes,

H<sub>2</sub> blocker  Proton Pump Inhibitor  Sucralfate

Is the patient receiving Therapeutic anticoagulation?  Yes  No

DVT prophylaxis  Yes  No

If yes

TEDS stockings  Intermittent sequential compression pump or other mechanical device

Low molecular weight heparin  unfractionated heparin  Fondaparinux  Other \_\_\_\_\_

**Was this patient transported (e.g. for CT scan, surgery, etc) out of the ICU today?**  Yes  No

If yes  Within the same hospital  Outside the hospital

