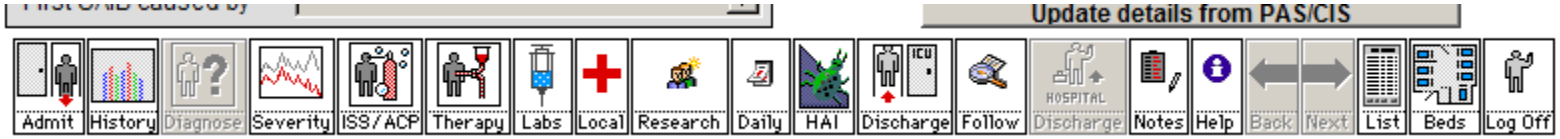
Quick Guide to Entering Diagnosis into Ward Watcher (for ICNARC Purposes)

The Four Data Entry Fields

- Primary Reason for Admission to Unit;
- Secondary Reason (if applicable);
- Other condition in past medical history;
- Ultimate primary reason (if different)

Practical Stuff

- When new doctors start, they send me (matthew.moore@stgeorges.nhs.uk) their SGH e-mail address. I will send them a Ward Watcher Log In/password;
- Diagnosis data is entered using the tab:



- When Doctors leave, inform me and I'll remove their Ward Watcher log in.

Primary Reason for Admission to Unit

Definition for collection:

- the primary reason for admission to your unit as assessed and recorded at admission to and during the first 24 hours in your unit
- the primary reason for admission to your unit is deemed to be the most important underlying condition or reason for admission to your unit and should describe what is happening, or could possibly happen, to this admission that precluded management on the hospital ward
- if the admission to your unit has had surgery for the condition you are coding, then a surgical code is selected, if not, then a non-surgical code is selected
- if an admission to your unit is directly admitted from theatre and recovery following surgery (same or other acute hospital), then the primary or secondary reason for admission must be a surgical code (APACHE II rules). However, where an admission has been in theatre directly before admission to your unit and has not had surgery, or the induction of

  anaesthesia, record a non-surgical reason for admission but enter the reason for being in theatre in the text box (e.g. intubated in theatre)
- if an admission to your unit is directly admitted from theatre and recovery and has had the induction of anaesthesia but has had no surgery (due to complications), record the complication as the primary reason for admission and the proposed surgery as the secondary reason for admission
- there is no point describing a syndrome that is characterised by a series of physiological changes as this will be apparent, so septic shock, septicaemia etc. should be secondary to an underlying condition coded as primary
- where the condition required to be coded is not available, code the condition as far as you can and then enter the name of the condition in the text field (periodically, these text data are used to update and improve the ICNARC Coding Method)

Secondary Reason (if applicable)

Definition for collection:

- the secondary reason for admission to your unit as assessed and recorded at admission to and during the first 24 hours in your unit
- the secondary reason for admission to your unit should describe, in addition to the primary reason for admission to your unit, what is happening, or could possibly happen, to this admission that precluded management on the hospital ward
- if the admission to your unit has had surgery for the condition you are coding, then a surgical code is selected, if not, then a non-surgical code is selected
- if an admission to your unit is directly admitted from theatre and recovery following surgery (same or other acute hospital), then the primary or secondary reason for admission must be a surgical code (APACHE II rules). However, where an admission has been in theatre directly before admission to your unit and has not had surgery or the induction of anaesthesia, record a non-surgical reason for admission but enter the reason for being in theatre in the text box (e.g. intubated in theatre)
- if an admission to your unit is directly admitted from theatre and recovery and has had the induction of anaesthesia but has had no surgery (due to complications), record the complication as the primary reason for admission and the proposed surgery as the secondary reason for admission
- where the condition required to be coded is not available, code the condition as far as you can and then enter the name of the condition in the text field (periodically, these text data are used to update and improve the ICNARC Coding Method)

Other condition in past medical history

Definition for collection:

- other chronic condition in the past medical history relevant to this admission assessed and recorded either prior to admission or at admission
- data on other condition in the past medical history may be important specifically when conditions in the past medical history are either not severe enough to fulfill the definitions for the listed conditions or are not included
- acute conditions should not be recorded as other condition in past medical history
- other condition should not duplicate either those entered in the primary/secondary reason for admission section or in the listed conditions in the past medical history
- the code generated may describe a condition requiring surgery (a surgical code) or a condition not requiring surgery (a non-surgical code)
- codes are generated by the ICNARC Coding Method
- where the condition required to be coded is not available, code the condition as far as you can and then enter the name of the condition in the text field periodically, these text data are used to update and improve the ICNARC Coding Method)

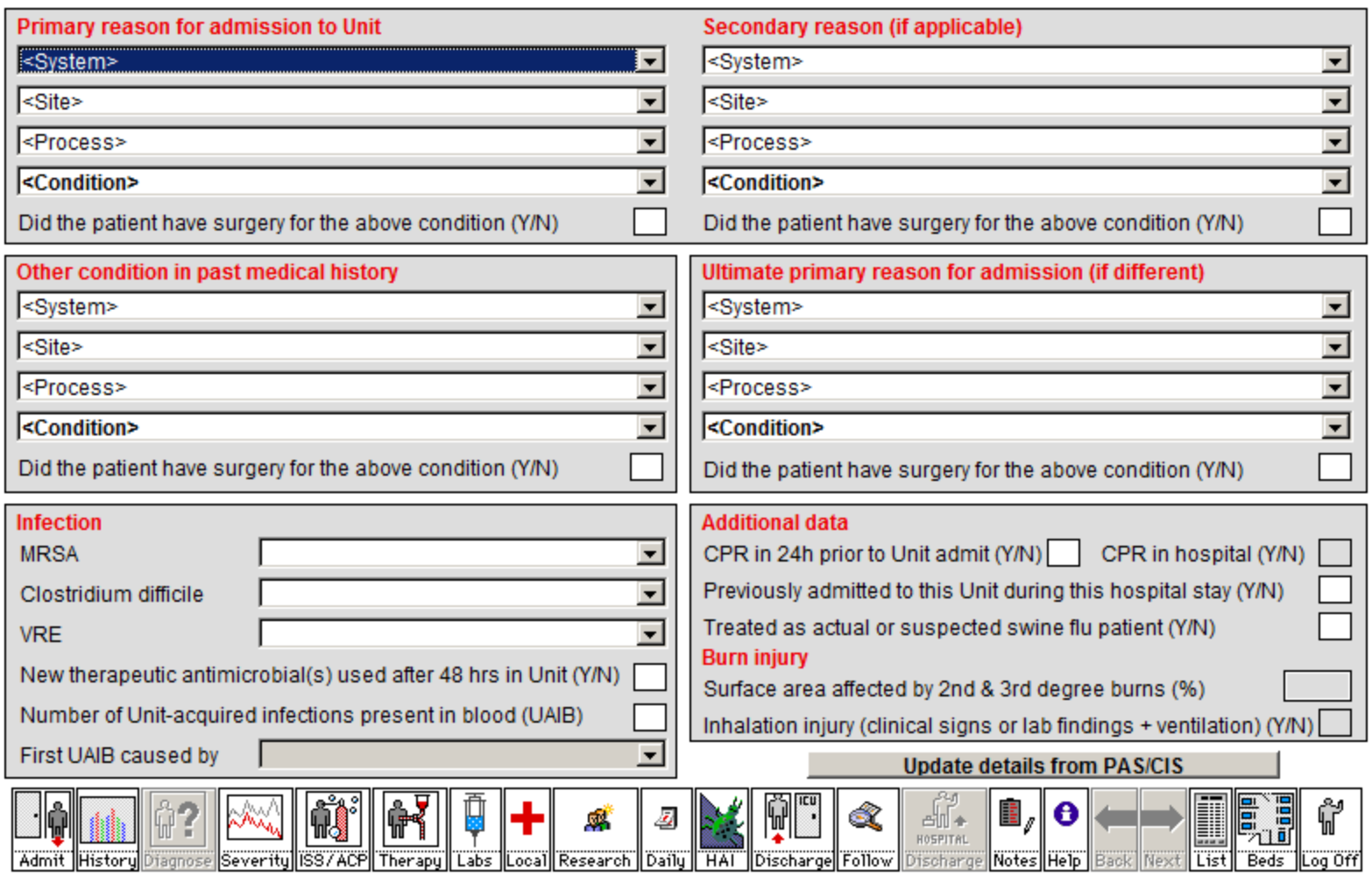
Ultimate primary reason (if different)

Definition for collection:

- the Ultimate primary reason for admission to your unit should describe the precise reason for admission if, after the first 24 hours in your unit, further information has become available from investigations or at autopsy and the Primary reason for admission to your unit recorded is no longer the most appropriate or can be made more explicit
- the Ultimate primary reason for admission to your unit should only be entered if different from the Primary reason for admission to your unit
- if the admission to your unit has had surgery for the condition you are coding, then a surgical code is selected, if not, then a non-surgical code is selected
- codes are generated by the ICNARC Coding Method

Notes on all the above

- □ where the condition required to be coded is not available, code the condition as far as you can and then enter the name of the condition in the text field (periodically, these text data are used to update and improve the ICNARC Coding Method)


Primary reason for admission to Unit
<System>
<Site>
<Process>
<Condition>
Did the patient have surgery for the above condition (Y/N)
Secondary reason (if applicable)
<System>
<Site>
<Process>
<Condition>
Did the patient have surgery for the above condition (Y/N)
Other condition in past medical history
<System>
<Site>
<Process>
<Condition>
Did the patient have surgery for the above condition (Y/N)
Ultimate primary reason for admission (if different)
<System>
<Site>
<Process>
<Condition>
Did the patient have surgery for the above condition (Y/N)
Infection
MRSA
Clostridium difficile
VRE
New therapeutic antimicrobial(s) used after 48 hrs in Unit (Y/N)
Number of Unit-acquired infections present in blood (UAIB)
First UAIB caused by
Additional data
CPR in 24h prior to Unit admit (Y/N)
CPR in hospital (Y/N)
Previously admitted to this Unit during this hospital stay (Y/N)
Treated as actual or suspected swine flu patient (Y/N)
Burn injury
Surface area affected by 2nd & 3rd degree burns (%)
Inhalation injury (clinical signs or lab findings + ventilation) (Y/N)
Update details from PAS/CIS
Admit
History
Diagnose
Severity
ISS/ACP
Therapy
Labs
Local
Research
Daily
HAI
Discharge
Follow
Discharge
Notes
Help
Back
Next
List
Beds
Log Off