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Standard Operating Procedure (SOP) 007

Guidance for completion of Case Report Forms

Scope

To describe the process for completing the paper Case Report Forms (CRFs).

How to collect data

Guidance on the data points to be collected is provided on some of the CRFs and within this SOP.

The completion of the paper CRFs before entering the data on to Macro is optional (apart from the Serious Adverse Event Reporting Form, when applicable). The paper CRFs reflect what data is being collected on Macro, therefore they might be useful to use prior to uploading the data. Section 8: Case Report Forms, of the ISF lists all CRFs to be used.

Who completes the CRFs?

Site research staff authorised to complete and sign off the paper CRFs as per the PICnIC Delegation Log (Section 12: Site Staff Information, of the ISF).

Instructions for completion of CRFs

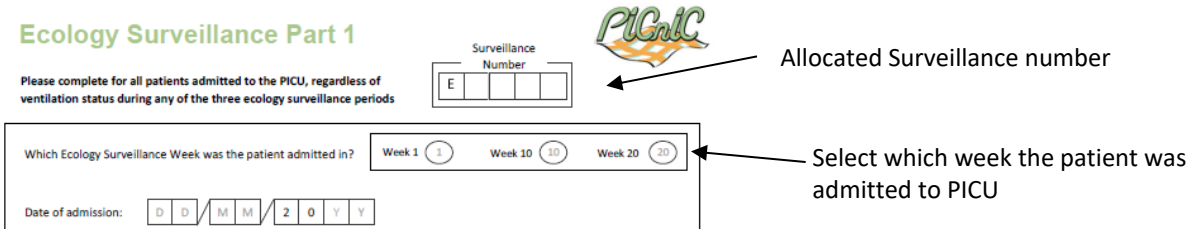
- CRFs should be completed in a timely manner, following the data collection time points.
- Permanent ink (blue or black) should be used to complete the CRF. Pencil should **not** be used.
- Fields should not be left blank. If the data are not available, please write '*not recorded*' (NR) or '*unknown*' (UK). Use the comments section if you wish to provide more information.
- Check that the data entered corresponds with what has been recorded in the source data (e.g. medical records, lab results).
- If a correction needs to be made, **do not use correction fluid**. Put a single line through the entry, enter the correct value and **initial and date the correction.**

Ecology Surveillance CRFs

These CRFs should be used for the Ecology Surveillance Periods at all sites on week 1, 10 and 20. They are for all patients admitted to the PICU during these time periods only, regardless of ventilation status.

Surveillance Number

The Surveillance Number should be taken from the 'PICnIC Ecology Surveillance Number List' in Section 6: Screening and Enrolment, of the ISF and should be written on each CRF page to help ensure the correct details are being recorded for the correct patient. (See SOP 003: Patient screening and enrolment for further details).



Samples

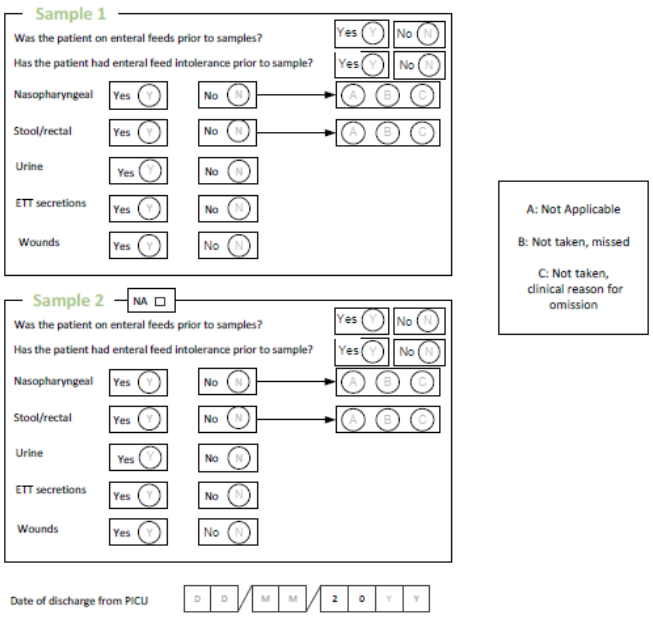
The question about enteral feed intolerance is referring to feeds reduced in volume or withheld due to clinical concerns about feed tolerance or gastric motility.

The samples to be taken and data recorded on are:

- Nasopharyngeal
- Stool/rectal swabs
- Urine (if clinically indicated)
- Sputum/secretions from the endotracheal tube (if clinically indicated)
- Wound swabs, if present (if clinically indicated)

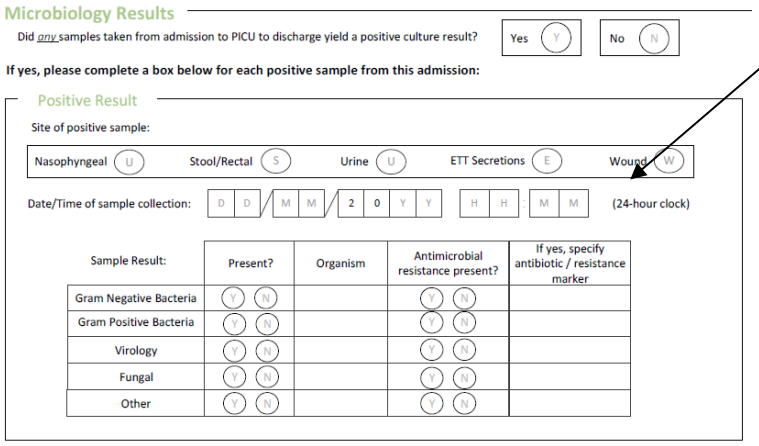
If 2nd sample is not required (due to timing in PICU or refused consent) record N/A on the CRF.

See SOP 012: PICnIC Samples for details of sampling procedures.



Microbiology results

If any samples gave a positive result they should be recorded on the 'Outcomes' page. If there are further positive microbiology results, these can be recorded on additional pages.



If the same sample result on a specific date has more than one organism, this can be noted on the CRF.

(Further drop options on Macro will allow collection of this)

If yes, please specify all antibiotic/resistance markers here, which may include the below:

Gram positive: vancomycin, penicillin, flucloxacillin, gentamicin, linezolid

Gram negative: o-amoxiclav, piperacillin-tazobactam, Ceftriaxone, ceftazidime, gentamicin, amikacin, ciprofloxacin, ertapenem, meropenem

Three markers if applicable: ESBL, AmpC and carbapenemases

Fungal: fluconazole, amphotericin B, echinocandin

(On Macro, if yes is selected for 'antimicrobial resistance present', you will be able to select what antibiotic the resistance is to, and the markers if applicable. Radio button options will be provided for the above options, as well as space to write your own if not mentioned).

Usual Care CRFs

These CRFs should be used at all sites during Period One Usual Care (weeks 2-9) and Period Two Usual Care (weeks 11-19). Period Two Usual Care CRFs will include additional safety monitoring pages (please see Safety CRFs section below).

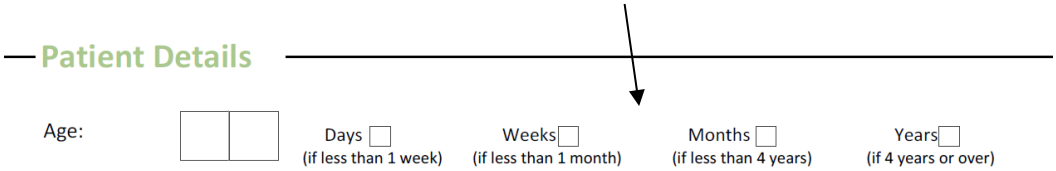
Study Number

The Study Number should be taken from the 'PICnIC Study Number List' in Section 6: Screening and Enrolment, of the ISF and should be written on each CRF page to help ensure the correct details are being recorded for the correct patient. (See SOP 003: Patient screening and enrolment for further details).

Admission

Patient details should be completed at the top of the CRF and then information confirming their eligibility and enrolment based on the inclusion criteria.

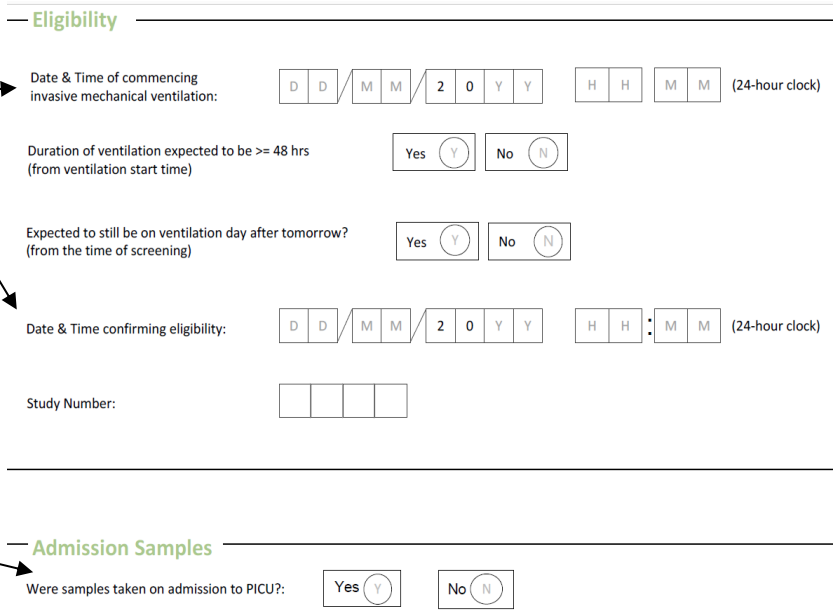
Age should be determined in days (if less than 1 week), in weeks (if less than 1 month) or months (if between 1 month – 47 months) and then in years (if 4 or over).



Date confirming eligibility should be after date commencing invasive ventilation and date of admission.

Time of invasive mechanical ventilation should be actual intubation time, e.g. time of intubation from local hospital

Admission samples should be taken as part of routine care and therefore do not require consent. They should ideally be taken within 6 hours of confirming eligibility.



Weekly Surveillance

The question asking about enteral feed intolerance is referring to feeds reduced in volume or withheld due to clinical concerns about feed tolerance or gastric motility.

The samples to be taken and data recorded on are:

- Nasopharyngeal
- Stool/rectal swabs
- Urine (if clinically indicated)
- Sputum/secretions from the endotracheal tube (if clinically indicated)
- Wound swabs, if present (if clinically indicated)

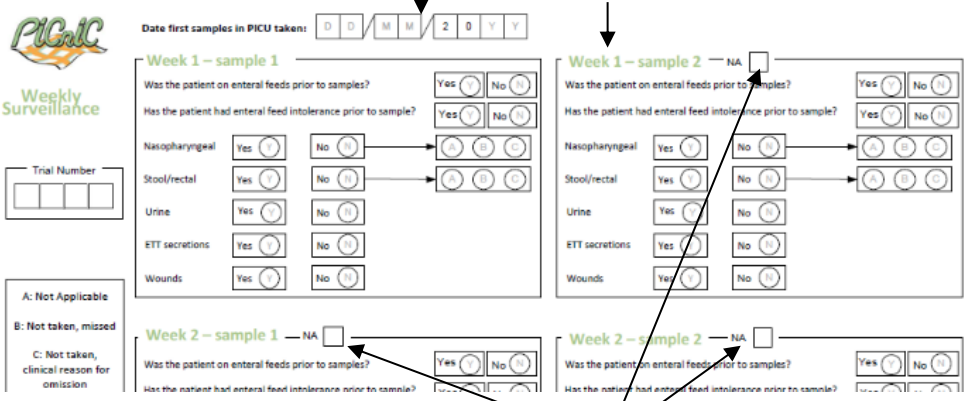
See SOP 012: PICnIC Samples for details of sampling procedures.

Additional pages are available for those that stay over two weeks, with a space to write the week number beside it, e.g. week 3 sample 1, week 3 sample 2, week 4 sample 1, week 4 sample 2.

The date of the first sample in PICU should be at admission. This is expected for all patients

Update week number if using additional pages

Completing the study number will help ensure the correct details are being recorded for the correct patient

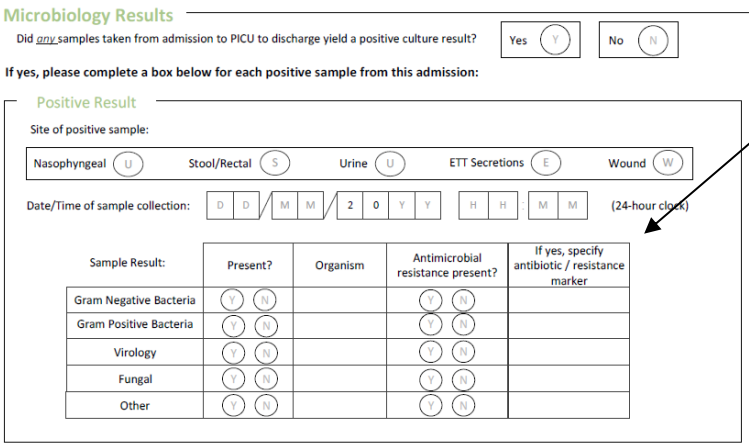


Further samples which are not part of routine care should only be taken if consent has been provided. If consent has been refused, N/A should be selected.

Outcomes

Any healthcare associated infections should be recorded at the top of this page during the patient's stay, detailing whether it was presumed or confirmed (they would only be presumed if clinically suspected without microbiology). They should be for cultures taken after 48 hours from PICU admission.

If any samples taken on admission or twice weekly gave a positive result they should be recorded under 'Microbiology Results'. If there are further microbiology positive results to document, please complete them on the 'Outcomes (additional pages)'.



If yes, please specify all antibiotic/resistance markers here, which may include the below:

Gram positive: vancomycin, penicillin, flucloxacillin, gentamicin, linezolid

Gram negative: o-amoxiclav, piperacillin-tazobactam, Ceftriaxone, ceftazidime, gentamicin, amikacin, ciprofloxacin, ertapenem, meropenem

Three markers if applicable: ESBL, AmpC and carbapenemases

Fungal: fluconazole, amphotericin B, echinocandin

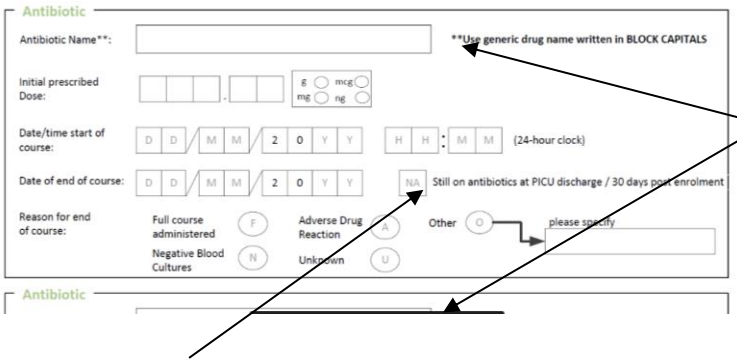
If the same sample result on a specific date has more than one organism, this can be noted on the CRF.

(Further drop options on Macro will allow collection of this).

(On Macro, if yes is selected for 'antimicrobial resistance present', you will be able to select what antibiotic the resistance is to, and the markers if applicable. Radio button options will be provided for the above options, as well as space to write your own if not mentioned).

Antibiotic Use

Antibiotic use should be recorded from index admission up to 30 days. If patients started antibiotics prior to admission and continue to be on them, these can also be recorded. Patients should have noted the generic drug name, dosage, start and end dates. If further antibiotics need to be recorded, additional antibiotic use pages can be used.



Each new antibiotic administered during PICU admission should be recorded in a new box, including if the route changes (e.g. if IV to oral they would count as separate courses).

If the patient is still on antibiotics at PICU discharge or 30 days post enrolment, you do not need to complete the course end date or the reason for end of course.

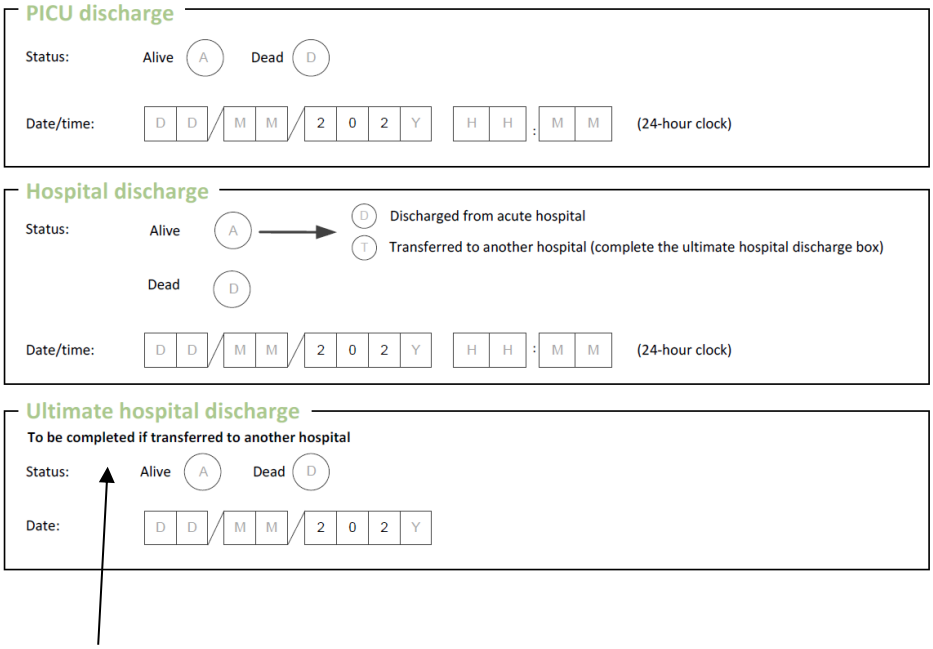
Discharge

The date of the first successful extubation should be recorded. This is defined as the patient being extubated for at least 48 hours without having to be reintubated.

What was the patient status when they were discharged from your PICU?

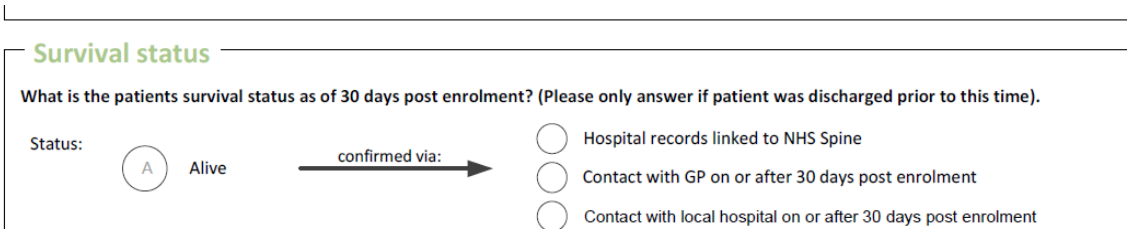
What was the patient status when they were discharged from your hospital? This date/time should be after PICU discharge.

If alive, they would be discharged from your acute hospital (potentially to their usual residence) or transferred to another hospital. (If transferred to another hospital the 'ultimate hospital discharge' box should be completed).



The ultimate hospital discharge details are following the transfer of the patient to another hospital. If required, these can be obtained using NHS Spine or by contacting the receiving hospital.

For example, when the patient returns to their usual residence, after they have been transferred to another hospital (this will be later than the PICU discharge and hospital discharge date).



Data on survival status should only be provided if the patient was discharged prior to 30 days post enrolment into PICnIC.

These CRFs should be used at sites randomised to receive SDD intervention during Period Two (weeks 11-19).

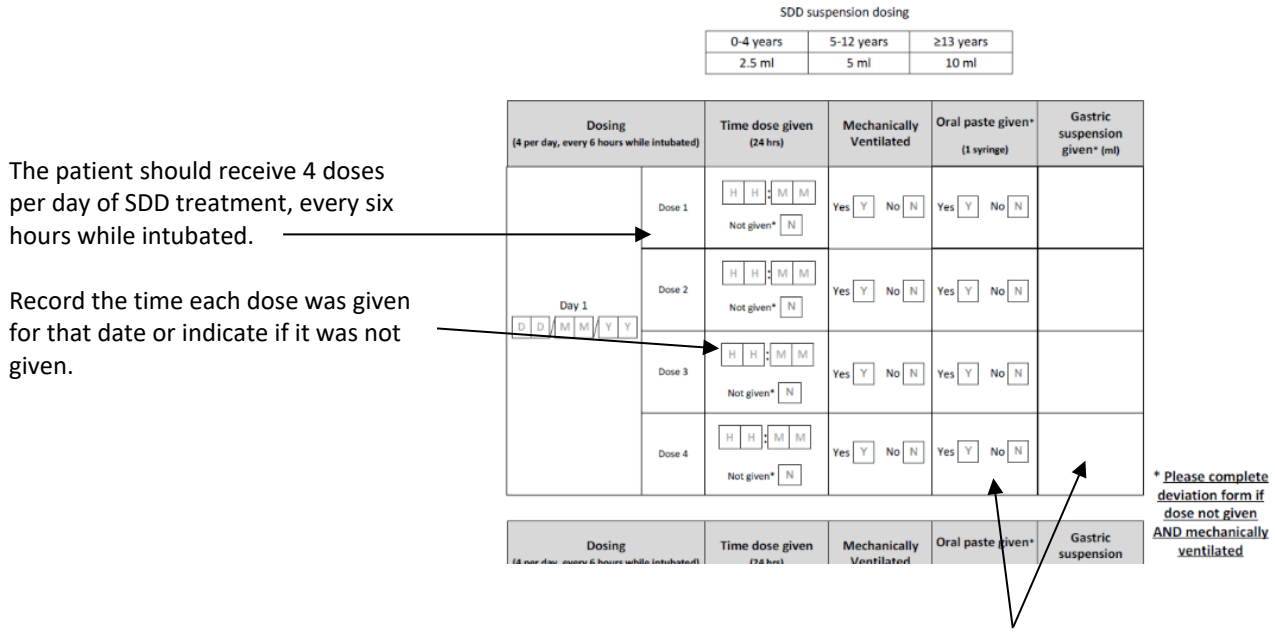
Trial Number
The Study Number should be taken from the 'PICnIC Study Number List' in Section 6: Screening and Enrolment, of the ISF and should be written on each CRF page to help ensure the correct details are being recorded for the correct patient. (See SOP 003: Patient screening and enrolment for further details).

Admission
Same as above

Weekly Surveillance
Same as above

Outcomes
Same as above

SDD Administration
SDD treatment should start within six hours of being identified as eligible and continue for a maximum of 30 days (treatment period) or until the patient is extubated / no longer mechanically ventilated. If a patient is subsequently re-intubated (either during this PICU admission or readmission from another inpatient area) during the treatment period, SDD should be restarted and administration data recorded. All treatments provided should be recorded on the 'SDD administration' page and additional pages can be used.

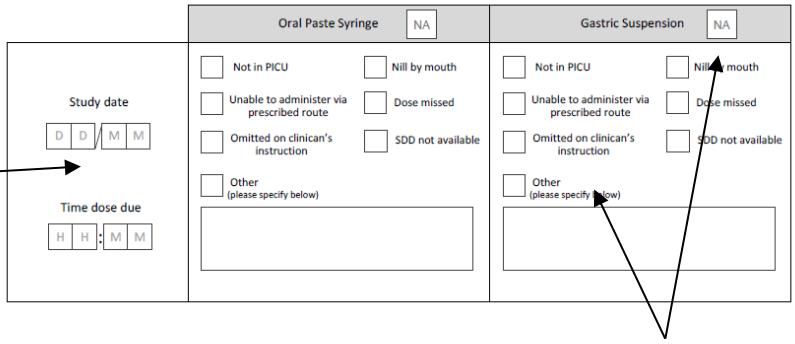


If one or both SDD treatments were not given AND the patient **was** mechanically ventilated, then please complete the 'SDD Administration Deviation' CRF.

SDD Administration Deviation

This page should only be completed if one or both SDD treatments were not given AND the patient **was** mechanically ventilated on the 'SDD Administration' page.

Ensure the study date and time match up with what has been specified on the 'SDD Administration' page where the deviation occurred.



Please specify the reason the SDD treatment was not given. Ensure to select NA if the deviation did not occur for that particular route.

Antibiotic Use

Same as above

Discharge

Same as above.

Safety CRFs

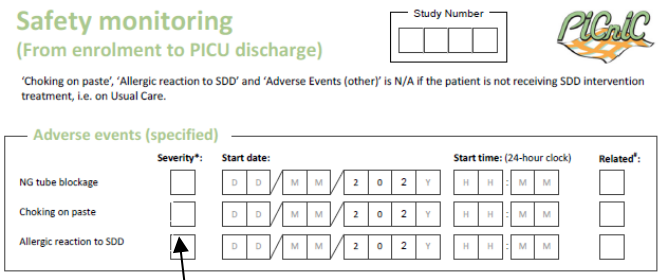
These CRFs should be completed for patients enrolled during Period Two until PICU discharge. Please ensure safety data is recorded for all readmitted intervention patients on SDD. Please see 'SOP 009: Safety Monitoring' for further details on safety reporting processes.

Safety Monitoring

This page should be completed for all patients indicating if they have had the event or not. For those on Usual Care, only NG tube blockage will be required to be completed.

If the specified and expected Adverse Event occurred multiple times, you can make a note of this on the CRF.

(Macro will allow you to put multiple dates and times of the event if required)

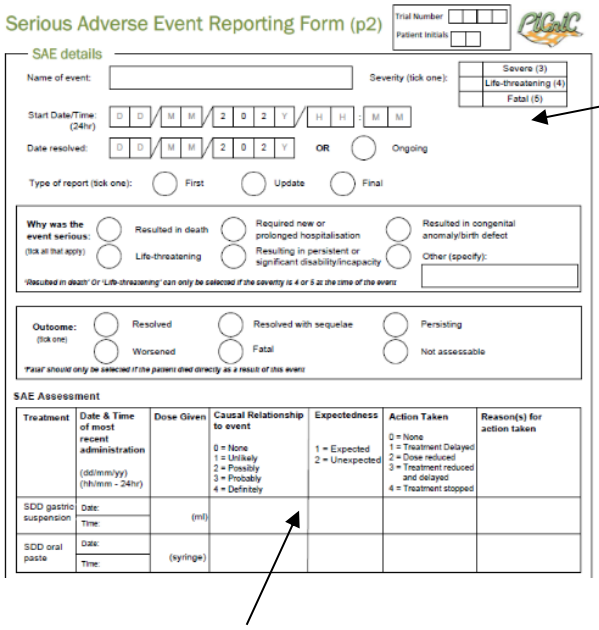


If the specified and expected Adverse Event did not occur, record severity as '0'

Any Adverse Events that occurred but are not specified should be recorded under 'Adverse events (other)', completing the severity dates/times and relatedness.

Serious Adverse Event Reporting Form

A separate Serious Adverse Event Reporting Form should be completed for each event that meets the criteria of severity: 3 = Severe, 4 = Life-threatening or 5 = Fatal. It is important to complete all sections of the Serious Adverse Event Reporting Form, especially the below essential criteria in the first instance:



- Event name
- Date and time of onset
- Severity

- Causal relationship of the event to the study
- Expected (specified) or Unexpected (other)

SAE assessment to only be completed if patient received SDD intervention. The details of the 'dose given' for the SDD treatment should correspond to the single dose given to the patient before the event occurred.

Please update all follow up details as soon as possible.

Where to store completed CRFs

Any completed paper CRFs should be filed securely with a File Note in ISF Section 8: Case Report Forms, detailing the exact location of storage.