Ohio Trauma Registry
2019
Trauma Acute Care Registry
Data Dictionary

Version 2019.0
This edition is effective for all trauma patients presenting for treatment on or after January 1, 2019.
Acknowledgements

The Ohio State Board of Emergency Medical, Fire and Transportation Services and the EMS Division of the Ohio Department of Public Safety would like to thank the myriad of people – too numerous to list here – who have worked tirelessly to create, expand and transform the Ohio Trauma Registry from its inception and embryonic beginnings in the late 1990s into the powerful research and policymaking tool it is today. This growth and development would not have been possible without the strength of their combined knowledge, wisdom and hard work.

TACR is a component of the Ohio Trauma Registry (OTR) and is maintained by the Ohio Department of Public Safety, 1970 W. Broad St., Columbus, Ohio 43218. For more information about the TACR, OTR and/or the State of Ohio’s Trauma System, contact the Ohio Department of Public Safety’s EMS Office of Research and Analysis, at (800)233-0785, EMSdata@dps.ohio.gov or visit http://ems.ohio.gov.
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TACR INCLUSION/EXCLUSION CRITERIA – ICD-10

TRAUMA PATIENT DEFINITION
In order to ensure consistent data collection across the State of Ohio and to follow the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the patient inclusion criteria described below.

PATIENT INCLUSION CRITERIA
To be included in the Trauma Acute Care Registry (TACR),

1. The patient must have incurred, no more than 30 days prior to presentation for initial treatment, at least one of the injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):
   - J70.5 with character modifier of A ONLY (Respiratory conditions due to smoke inhalation – initial encounter)
   - S00-S99 with 7th character modifier of A, B or C ONLY (Injuries to specific body parts – initial encounter):
     - T07 (Unspecified multiple injuries);
     - T14 (Injury of unspecified body region);
     - T20-T28 with 7th character modifier of A ONLY (Burns by specified body parts – initial encounter);
     - T30-T32 with character modifier of A ONLY (Burn by TBSA percentage);
     - T33 with character modifier of A ONLY (Superficial frostbite – initial encounter)
     - T34 with character modifier of A ONLY (Frostbite with tissue necrosis – initial encounter)
     - T67 with character modifier of A ONLY (Effects of heat and light – initial encounter)
     - T68 with character modifier of A ONLY (Hypothermia – initial encounter)
     - T69 with character modifier of A ONLY (Other effects of reduced temperature – initial encounter)
     - T70.4 with character modifier of A ONLY (Effects of high-pressure fluids – initial encounter)
     - T70.8 with character modifier of A ONLY (Other effects of air pressure and water pressure – initial encounter)
     - T70.9 with character modifier of A ONLY (Effect of air pressure and water pressure, unspecified – initial encounter)
     - T71 with character modifier of A ONLY (Asphyxiation – initial encounter)
     - T74.1 with character modifier of A ONLY (Physical abuse, confirmed – initial encounter)
     - T74.4 with character modifier of A ONLY (Shaken infant syndrome – initial encounter)
     - T75.0 with character modifier of A ONLY (Effects of lightning – initial encounter)
     - T75.1 with character modifier of A ONLY (Unspecified effects of drowning and nonfatal submersion – initial encounter)
     - T75.4 with character modifier of A ONLY (Electrocution – initial encounter)
   - T72.00-T72.14, fracture of head/neck of femur ONLY IF age >70 AND it resulted from slipping, tripping, stumbling or a same level fall (W01.0, W18.30, W18.31, W18.39);
   - S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Abrasion or Contusion injuries. Patients with abrasion or contusion injuries that were transferred in/out for treatment of injuries or died because of injuries would be included in the registry)
   - 7th character modifiers of D through S (Late effects)

2. The patient MUST ALSO
   - On initial presentation for treatment of an injury, be admitted to a hospital or hospital observation unit, as defined by a physician order regardless of the length of stay; AND/OR
   - Be transferred via EMS transport (including air ambulance) from one hospital (or free standing emergency department) to another hospital regardless of the patient’s length of stay or admission status; AND/OR
   - Have an outcome of death resulting from the traumatic injury (independent of hospital admission or hospital transfer status).

PATIENT EXCLUSION CRITERIA
Patients with the following isolated ICD-10-CM codes are EXCLUDED from the TACR:

- S72.00-S72.14, fracture of head/neck of femur ONLY IF age >70 AND it resulted from slipping, tripping, stumbling or a same level fall (W01.0, W18.30, W18.31, W18.39);
- S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Abrasion or Contusion injuries. Patients with abrasion or contusion injuries that were transferred in/out for treatment of injuries or died because of injuries would be included in the registry)
- 7th character modifiers of D through S (Late effects)
OTR TACR Inclusion/Exclusion Decision Tree – ICD-10

1. Patient with injury less than 30 days ago in the following ICD-10-CM ranges?
   - J70.5 (A 7th dig.), S00-S99 (A/B/C 7th dig.), T07, T14, T20-T28 (A 7th dig.), T30-32, T33-34 (A 7th dig.), T67-69 (A 7th dig.), T70.4, .8, .9 (A 7th dig.)
   - T71 (A 7th dig.), T74.1, .4 (A 7th dig.), T75.0, .1, .4 (A 7th dig.), T79.A1-T79.A9 (A 7th dig.)
   - If the patient’s ONLY injury is in the ICD-10-CM range of S72.00-S72.14 (fracture of head/neck of femur) and the cause of injury is slipping/tripping/stumbling or same level fall, is the patient ≥70 years old?

2. Was this the initial treatment episode for the patient?

   - YES
   - NO

3. Were the patient’s injuries late effects as indicated by ICD-10-CM 7th character modifiers of D through S?

   - YES
   - NO

4. Did the injury result in death?

   - YES
   - NO

5. Did the patient’s ONLY injury ICD-10-CM start with S00, S10, S20, S30, S40, S50, S60, S70, S80, S90?

   - YES and patient was not transferred in/out
   - NO OR YES but transferred in/out

6. If the patient’s ONLY injury is in the ICD-10-CM range of S72.00-S72.14 (fracture of head/neck of femur) and the cause of injury is slipping/tripping/stumbling or same level fall, is the patient ≥70 years old?

   - YES
   - NO

7. Do ANY of the following apply to the patient?

   - The patient was admitted to your facility (as indicated by a physician order for admit/observation)
   - The patient was transferred out of your facility, including from the ED, by ground or air ambulance
   - The patient was transferred into your facility, including direct admit, by ground or air ambulance

   - YES
   - NO

INCLUDE in OTR

EXCLUDE from OTR
COMMON NULL VALUES

Definition

Common Null Values are terms to be used with OTR TACR Data Elements as described in this document for specifically-defined data fields when an answer cannot be provided.

Field Values

NA= Not Applicable
ND= Not Known/Not Recorded/Not Documented

Additional Information

- Although not written out on the following pages, these Common Null Values are included in the TACR dataset for every allowable data field. To ascertain their allowability by data field, see the “Accepts Null Value” notation on every data field descriptor page.

- Not Applicable (Field Value NA): This null value code applies if, at any time of patient care documentation, the information requested was “Not Applicable” (NA) to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be NA if a patient self-transports to the hospital.

- Not Known/Not Recorded/Not Documented (Field Value ND): This null value applies if, at the time of patient care documentation, information was “Not Known” (to the patient, family, healthcare provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as “Unknown”. Another example, Not Known/Not Recorded/Not Documented should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the TACR are to be electronically stored in a database or moved from one database to another, the indicated null values should be applied.

References to Other Databases

- Compare with NTDS 2019
HOSPITAL CODE

Definition

*Hospital Code* is a four-digit (4) hospital code assigned by the Ohio Department of Public Safety.

Field Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Stored as a four digit code (xxxx)

Data Source Hierarchy Guide

1. Ohio Department of Public Safety Hospital (Facility) Code List
UNIQUE ADMISSION NUMBER

Definition

*Unique Admission Number* is a number assigned to the trauma patient at your facility. A patient encounter number or account number can be used.

Field Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Use an identifiable number specific to your facility, e.g. patient encounter or account number
TRAUMA TRACKING NUMBER

Definition

*Trauma Tracking Number* is a number automatically generated by the trauma registry system.

Field Values

- Relevant value for data element

Common Null Values

- Not Accepted
PATIENT’S HOME CITY

Definition

Patient’s Home City is the patient’s city, township, or village of residence.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- Only reported when ZIP/Postal code is “Not Known/Not Recorded” and country is US.
- The null value "Not Applicable" is reported if Patient’s Home ZIP/Postal Code is documented.
- The null value “Not Applicable” is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2019
PATIENT’S HOME STATE

Definition
Patient’s Home State is the state, territory, or province (or the District of Columbia) of the patient’s residence.

Field Values
• Relevant value for data element (two digit FIPS code)

Common Null Values
• Accepted

Additional Information
• Used to calculate FIPS code
• Only reported when ZIP/Postal code is “Not Known/Not Recorded” and country is US.
• The null value "Not Applicable" is reported if Patient’s Home ZIP/Postal Code is documented.
• The null value “Not Applicable” is reported for non-US hospitals.

Data Source Hierarchy Guide
1  Face Sheet
2  Billing Sheet
3  Admission Form

References to Other Databases
• NTDS 2019
PATIENT'S HOME COUNTY

Definition

*Patient’s Home County* is the patient’s county (or parish) of residence.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- Only reported when ZIP/Postal code is “Not Known/Not Recorded” and country is US.
- The null value "Not Applicable" is reported if Patient’s Home ZIP/Postal Code is documented.
- The null value “Not Applicable” is reported for non-US hospitals.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

References to Other Databases

- NTDS 2019
PATIENT’S HOME ZIP CODE

Definition

*Patient’s Home Zip Code* is the zip code of the patient’s primary residence.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- If ZIP/Postal code is "Not Applicable," report variable: Alternate Home Residence.
- If ZIP/Postal code is "Not Known/Not Recorded," report variables: Patient's Home Country, Patient's Home State (US only), Patient's Home County (US only) and Patient's Home City (US only).
- If ZIP/Postal code is documented, must also report Patient's Home Country.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

References to Other Databases

- NTDS 2019
PATIENT’S HOME COUNTRY

Definition

*Patient's Home Country* is the country where the patient resides.

Field Values

- Relevant value for data element (two digit alpha country code)

Common Null Values

- Accepted

Additional Information

- Values are two character fields representing a country (e.g. U.S.)
- If Patient's Home Country is not US, then the null value "Not Applicable" is reported for: Patient's Home State, Patient's Home County, and Patient's Home City.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

References to Other Databases

- NTDS 2019
ALTERNATE HOME RESIDENCE

Definition

*Alternate Home Residence* is documentation of the residential status of a patient who has no home zip code.

Field Values

1. Homeless
2. Undocumented Resident
3. Migrant Worker

Common Null Values

- Accepted

Additional Information

- Only used when Zip Code is “Not Applicable”
- *Homeless* is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters
- *Undocumented Citizen* is defined as a national of another country who has entered or stayed in another country without permission
- *Migrant Worker* is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is documented

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

References to Other Databases

- NTDS 2019
DATE OF BIRTH

Definition

Date of Birth is the patient’s date of birth at time of injury.

Field Values

• Relevant value for data element

Common Null Values

• Accepted

Additional Information

• Collected as YYYY-MM-DD
• If Date of Birth is “Not Known/Not Recorded,” report variables: Age and Age Units.
• If Date of Birth equals Injury Date, then the Age and Age Units variables must be reported.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage / Trauma Flow Sheet
5 EMS Run Report

References to Other Databases

• NTDS 2019
AGE

**Definition**

*Age* is the patient’s age (or best approximation) at the time of injury.

**Field Values**

- Relevant value for data element

**Common Null Values**

- Accepted

**Additional Information**

- If Date of Birth is “Not Known/Not Recorded,” report variables: Age and Age Units.
- If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported.
- Must also report variable: Age Units.
- The null value “Not Applicable” is reported if Date of Birth is documented.

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage / Trauma Flow Sheet
5. EMS Run Report

**References to Other Databases**

- NTDS 2019
AGE UNITS

Definition

Age Units are the units used to document the patient’s age (hours, days, months, years, minutes, weeks).

Field Values

1  Hours
2  Days
3  Months
4  Years
5  Minutes
6  Weeks

Common Null Values

•  Accepted

Additional Information

•  If Date of Birth is “Not Known/Not Recorded,” report variables: Age and Age Units.
•  If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported.
•  Must also report variable: Age.
•  The null value “Not Applicable” is reported if Date of Birth is reported.

Data Source Hierarchy Guide

1  Face Sheet
2  Billing Sheet
3  Admission Form
4  Triage / Trauma Flow Sheet
5  EMS Run Report

References to Other Databases

•  NTDS 2019
SEX

Definition
The patient’s sex.

Field Values
1  Male
2  Female

Common Null Values
•  Not Accepted

Additional Information
•  Patients who have undergone a surgical and/or hormonal sex change should be coded according to what sex they state they are. If they are unable to state their sex, they should be coded according to what sex they appear to be.

Data Source Hierarchy Guide
1  Face Sheet
2  Billing Sheet
3  Admission Form
4  Triage/Trauma Flow Sheet
5  EMS Run report
6  History & Physical

References to Other Databases
•  NTDS 2019
RACE

Definition

Race is the patient’s race.

Field Values

1. Asian
2. Native Hawaiian or Other Pacific Islander
3. Other Race
4. American Indian
5. Black or African American
6. White

Common Null Values

- Accepted

Additional Information

- Patient race should be based upon self-report or identified by a family member
- Based on the 2010 US Census Bureau
- Select all that apply

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run report
6. History & Physical

References to Other Databases

- NTDS 2019
**ETHNICITY**

**Definition**

*Ethnicity* is the patient’s ethnicity in terms of Hispanic heritage.

**Field Values**

1. Hispanic or Latino
2. Not Hispanic or Latino

**Common Null Values**

- Accepted

**Additional Information**

- Patient ethnicity should be based upon self-report or identified by a family member
- The maximum number of ethnicities that may be reported for an individual patient is 1
- Based on the 2010 US Census Bureau

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. History & Physical
6. EMS Run Report

**References to Other Databases**

- NTDS 2019
PRIMARY ICD-10 EXTERNAL CAUSE CODE

Definition
Primary External Cause Code is a designation used to describe the mechanism (or external factor) that caused the injury event.

Field Values
- Relevant ICD-10-CM code value for injury event

Common Null Values
- Not Accepted

Additional Information
- The Primary External Cause Code should describe the main reason a patient is admitted to the hospital
- External codes can be used to auto-generate the trauma type (blunt, penetrating, burn) and intentionality based upon the CDC matrix
- ICD-10-CM codes are accepted for this data element. Activity codes are not collected under the NTDS and should not be reported in this field.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  o External cause codes for child and adult abuse take priority over all other external cause codes.
  o External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  o External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse.
  o External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  o The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide
1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

References to Other Databases
- NTDS 2019
ADDITIONAL ICD-10 EXTERNAL CAUSE CODE

Definition

*Additional External Cause Code* is used in conjunction with the Primary External Cause Code if multiple external cause codes are required to describe the injury event.

Field Values

- Relevant ICD-10-CM code value for injury event

Common Null Values

- Accepted

Additional Information

- The null value “Not Applicable” is used if no additional external cause codes are used
- Activity codes should not be reported in this field
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
  - External cause codes for transport accident take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Nursing Notes/ Flow Sheet
4. History & Physical
5. Progress Notes

References to Other Databases

- NTDS 2019
ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Definition

*ICD-10 Place of Occurrence external cause code* is a Y92.x code used to describe the place, site or location of the injury event.

Field Values

- Relevant ICD-10-CM code value for injury event

Common Null Values

- Not Accepted

Additional Information

- Only ICD-10-CM codes will be accepted for ICD-10 Place of Occurrence External Cause Code.

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

References to Other Databases

- NTDS 2019
WORK-RELATED

Definition

Work-related is whether the injury occurred during paid employment.

Field Values

1  Yes
2  No

Common Null Values

- Accepted

Additional Information

- If work-related, two additional data fields must be completed, Patient’s Occupational Industry and Patient’s Occupation

Data Source Hierarchy Guide

1  EMS Run Report
2  Triage/Trauma Flow Sheet
3  History & Physical
4  Face Sheet
5  Billing Sheet

References to Other Databases

- NTDS 2019
PATIENT’S OCCUPATIONAL INDUSTRY

Definition

*Patient’s Occupational Industry* is the occupational industry associated with the patient’s work environment.

Field Values

<table>
<thead>
<tr>
<th>Field Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Finance, Insurance, Real Estate</td>
</tr>
<tr>
<td>2</td>
<td>Manufacturing</td>
</tr>
<tr>
<td>3</td>
<td>Retail Trade</td>
</tr>
<tr>
<td>4</td>
<td>Transportation, Public Utilities</td>
</tr>
<tr>
<td>5</td>
<td>Agriculture, Forestry, Fishing</td>
</tr>
<tr>
<td>6</td>
<td>Professional, Business Services</td>
</tr>
<tr>
<td>7</td>
<td>Education, Health Services</td>
</tr>
<tr>
<td>8</td>
<td>Construction</td>
</tr>
<tr>
<td>9</td>
<td>Government</td>
</tr>
<tr>
<td>10</td>
<td>Natural Resources, Mining</td>
</tr>
<tr>
<td>11</td>
<td>Information Services</td>
</tr>
<tr>
<td>12</td>
<td>Wholesale Trade</td>
</tr>
<tr>
<td>13</td>
<td>Leisure, Hospitality</td>
</tr>
<tr>
<td>14</td>
<td>Other Services</td>
</tr>
</tbody>
</table>

Common Null Values

- Accepted

Additional Information

- Code as *NA* if injury is not work-related
- If work related, also report *Patient’s Occupation*
- Based upon US Bureau of Labor Statistics Industry Classification

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

References to Other Databases

- NTDS 2019
PATIENT’S OCCUPATION

Definition

*Patient’s Occupation* is the occupation of the patient.

Field Values

2. Architecture, Engineering Occupations
3. Community, Social Services Occupations
4. Education, Training, Library Occupations
5. Healthcare Practitioners, Technical Occupations
6. Protective Service Occupations
7. Building, Grounds Cleaning & Maintenance
8. Sales & Related Occupations
9. Farming, Fishing, Forestry Occupations
10. Installation, Maintenance, Repair Occupations
11. Transportation, Material Moving Occupations
12. Management Occupations
13. Computer, Mathematical Occupations
14. Life, Physical, Social Science Occupations
15. Legal Occupations
16. Arts, Design, Entertainment, Sports, Media
17. Healthcare Support Occupations
18. Food Preparation, Serving Related
19. Personal Care, Service Occupations
20. Office, Administrative Support Occupations
21. Construction, Extraction Occupations
22. Production Occupations
23. Military Specific Occupations

Common Null Values

- Accepted

Additional Information

- Only completed if injury is work-related, otherwise document “NA”
- If work related, also report *Patient’s Occupational Industry*
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC)

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INJURY INCIDENT DATE

Definition

Injury Incident Date is the date that the injury occurred.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- Estimates of the date of injury should be based upon report by patient, witness, family or health care provider. Other proxy measures (e.g. 911 call-time) should NOT be used

Data Source Hierarchy Guide

1. EMS Run report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

References to Other Databases

- NTDS 2019
INJURY INCIDENT TIME

Definition

_Injury Incident Time_ is the time of day that the injury occurred.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HH:MM military time
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g. 911 call-time) should NOT be used

Data Source Hierarchy Guide

1. EMS Run report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

References to Other Databases

- NTDS 2019
INCIDENT CITY

Definition

*Incident City* is the city, township or village in which the injury occurred or to which the EMS unit responded for the patient.

Field Values

- Relevant value for data element (five digit FIPS code)

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US.
- If incident location resides outside of formal city boundaries, report nearest city/town.
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is documented.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2019
INCIDENT STATE

Definition

Incident State is the state, territory or province (or best approximation) in which the patient was injured or to which the EMS unit responded for the patient.

Field Values

- Relevant value for data element (two digit numeric FIPS code)

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US.
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is documented.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2019
INCIDENT COUNTY

Definition

*Incident County* is the county or parish (or best approximation) where the patient was found or to which the EMS unit responded to the patient.

Field Values

- Relevant value for data element (three digit FIPS code)

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US.
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is documented.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2019
INCIDENT LOCATION ZIP CODE

Definition

*Incident Location Zip Code* is the zip code of the location where the patient was injured.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Stored as a five digit code (XXXXX)
- May require adherence to HIPAA regulations
- If "Not Known/Not Recorded," report variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- If ZIP/Postal code is documented, then must report Incident Country.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2019
INCIDENT COUNTRY

Definition

*Incident Country* is the country (or best approximation) in which the patient was injured or to which the EMS unit responded to the patient.

Field Values

- Relevant value for data element (two digit alpha country code)

Common Null Values

- Accepted

Additional Information

- Values are two character FIPS codes representing a country (e.g. US)
- If Incident Country is not US, then the null value "Not Applicable" is reported for: Incident State, Incident County, and Incident Home City

Data Source Hierarchy Guide

1. EMS Run report
2. Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2019
PROTECTIVE DEVICES

Definition

*Protective Devices* is the safety equipment in use or worn by the patient at the time of the injury.

Field Values

1. None Used
2. Lap Belt
3. Personal Floatation Device
4. Protective Non-Clothing Gear (e.g. shin guard)
5. Eye Protection
6. Child Restraint (booster seat, child car seat)
7. Helmet (e.g., bicycle, skiing, motorcycle)
8. Airbag Present
9. Protective Clothing (e.g. padded leather pants)
10. Shoulder Belt
11. Other

Common Null Values

- Accepted
- Field cannot be “Not Applicable”

Additional Information

- Report all that apply
- If “Child Restraint” is present, report variable *Child Specific Restraint*
- If “Airbag” is present, report variable *Airbag Deployment*
- Evidence of the use of safety equipment may be reported or observed
- “Lap belt” should be reported to include those patients that are restrained, but not further specified
- If chart indicates "3-point-restraint," report Field Values “2. Lap Belt” and “10. Shoulder Belt.”
- If documented that a “Child Restraint (booster seat or child care seat)” was used or worn, but not properly fastened, either on the child or in the car, report Field Value “1. None.”

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma Flow Sheet
3. Nursing Notes / Flow Sheet
4. History & Physical

References to Other Databases

- NTDS 2019
CHILD SPECIFIC RESTRAINT

Definition

*Child Specific Restraint* indicates protective child restraint devices used by the pediatric patient at the time of injury.

Field Values

1. Child Car Seat
2. Infant Car Seat
3. Child Booster Seat

Common Null Values

- Accepted

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only reported when *Protective Devices* include "6. Child Restraint (booster seat or child car seat)."
- The null value "Not Applicable" is reported if Field Value 6. "Child Restraint" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma Flow Sheet
3. Nursing Notes / Flow Sheet
4. History & Physical

References to Other Databases

- NTDS 2019
AIRBAG DEPLOYMENT

Definition

Airbag Deployment indicates whether an airbag deployed during a motor vehicle crash.

Field Values

1  Airbag Not Deployed
2  Airbag Deployed Front
3  Airbag Deployed Side
4  Airbag Deployed Other (knee, airbelt, curtain, etc.)

Common Null Values

• Accepted

Additional Information

• Report all that apply.
• Evidence of the use of airbag deployment may be reported or observed.
• Only report when Protective Devices include "8. Airbag Present."
• Airbag Deployed Front should be reported for patients with documented airbag deployments, but are not further specified.
• The null value "Not Applicable" is reported if Field Value 8. "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

1  EMS Run Sheet
2  Triage/Trauma Flow Sheet
3  Nursing Notes / Flow Sheet
4  History & Physical

References to Other Databases

• NTDS 2019
TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL

Definition

*Transport Mode for Arrival at Your Hospital* is the manner of transport delivering the patient to your hospital.

Field Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private or Public Vehicle or Walk-in
5. Police Transport
6. Other Transport Mode

Common Null Values

- Accepted

Additional Information

- Example of “Other Transport Mode” include boat
- Examples of “Public or Private or Walk-in” include: bus or bicycle
- If a patient was a visitor/in-house patient at your facility and experienced an event to require admission to the ED select patient’s mode of arrival as “4/Private or Public Vehicle or Walk-In”.

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2019
TRANSPORT AGENCY

Definition

Transport Agency is the EMS agency or air ambulance that delivered the patient to your hospital.

Field Values

- Relevant value for data element (ODPS-assigned EMS Agency ID)

Common Null Values

- Accepted

Additional Information

- “Non-applicable” (NA) is used to indicate that a patient arrived via “Private or Public Vehicle or Walk-in,” “Police Transport,” or “Other Transport Mode”

Data Source Hierarchy Guide

1. EMS Run Report
2. ED Record

References to Other Databases

- Not an NTDS Field
OTHER TRANSPORT MODES

Definition

*Other Transport Modes* documents all other types of transport used during patient care prior to the patient arriving at your hospital, except the transport mode delivering the patient to your hospital. An example is an ambulance transporting the patient to the helicopter landing zone.

Field Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private or Public Vehicle or Walk-in
5. Police Transport
6. Other Transport Mode

Common Null Values

- Accepted

Additional Information

- For patients with an unspecified mode of transport, select 6, *Other*
- “Non-applicable” (NA) is used to indicate that a patient had a single mode of transport and therefore this field does not apply to the patient

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2019
EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY

Definition
The date the unit *transporting to your hospital* was notified by dispatch.

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as YYYY-MM-DD
- For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- Used to auto-generate an additional calculated field, *Total EMS Time* (which is the elapsed time from EMS dispatch to hospital arrival)
- The null value "Not Applicable" is reported for patients who were not transported by EMS

Data Source Hierarchy Guide
1. EMS Run Report

References to Other Databases
- NTDS 2019
EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY

Definition
The time the unit transporting to your hospital was notified by dispatch.

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as HH:MM military time
- For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- Used to auto-generate an additional calculated field, Total EMS Time (which is the elapsed time from EMS dispatch to hospital arrival)
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide
1  EMS Run Report

References to Other Databases
- NTDS 2019
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition
The date the unit transporting to your hospital arrived on the scene/transferring facility (the time the vehicle stopped moving).

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as YYYY-MM-DD
- For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- Used to auto-generate additional calculated fields, Total EMS Response Time (which is the elapsed time from EMS dispatch to scene arrival) & Total EMS Scene Time (which is the elapsed time from EMS scene arrival to scene departure)
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide
1 EMS Run Report

References to Other Databases
- NTDS 2019
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Definition
The time the unit *transporting to your hospital* arrived on the scene (the time the vehicle stopped moving).

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as HH:MM military time
- For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- Used to auto-generate additional calculated fields, *Total EMS Response Time* (which is the elapsed time from EMS dispatch to scene arrival) & *Total EMS Scene Time* (which is the elapsed time from EMS scene arrival to scene departure)
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide
1. EMS Run Report

References to Other Databases
- NTDS 2019
 EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition
The date the unit transporting to your hospital left the scene (the time the vehicle started moving).

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as YYYY-MM-DD
- For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).
- Used to auto-generate an additional calculated field, Total EMS Scene Time (which is the elapsed time from EMS scene arrival to scene departure)
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide
1 EMS Run Report

References to Other Databases
- NTDS 2019
EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition
The time the unit transporting to your hospital left the scene (the time the vehicle started moving).

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as HH:MM military time
- For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).
- Used to auto-generate an additional calculated field Total EMS Scene Time (which is the elapsed time from EMS scene arrival to scene departure)
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide
1 EMS Run Report

References to Other Databases
- NTDS 2019
 INITIAL FIELD SYSTOLIC BLOOD PRESSURE

**Definition**

Initial Field *Systolic Blood Pressure* is the first recorded systolic blood pressure measured.

**Field Values**

- Relevant value for data element

**Common Null Values**

- Accepted

**Additional Information**

- Used to auto-generate an additional calculated field, *Revised Trauma Score---EMS* (adult & pediatric)
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field systolic blood pressure was NOT measured

**Data Source Hierarchy Guide**

1. EMS Run Report

**References to Other Databases**

- NTDS 2019
INITIAL FIELD PULSE RATE

Definition

Initial Field Pulse Rate is the first recorded pulse measured (palpated or auscultated), expressed as a number per minute.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as Not Known/Not Recorded/Not Documented
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field pulse rate was NOT measured

Data Source Hierarchy Guide

1  EMS Run Report

References to Other Databases

- NTDS 2019
INITIAL FIELD RESPIRATORY RATE

Definition

*Initial Field Respiratory Rate* is the first recorded respiratory rate measured (expressed as a number per minute).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Revised Trauma Score---EMS* (adult & pediatric)
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field respiratory rate was NOT measured

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2019
INITIAL FIELD OXYGEN SATURATION

Definition

*Initial Field Oxygen Saturation* is the first recorded oxygen saturation measured (expressed as a percentage).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- Value should be based upon assessment before administration of supplemental oxygen
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field oxygen saturation was NOT measured

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2019
INITIAL FIELD GCS - EYE

Definition

*Initial Field GCS Eye Opening* is the first recorded Glasgow Coma Score eye assessment done.

Field Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Common Null Values
- Accepted

Additional Information
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient’s pupils are PERRL,” an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/ Walk-in
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS-Eye was NOT measured

Data Source Hierarchy Guide

1. EMS Run Record

References to Other Databases
- NTDS 2019
INITIAL FIELD GCS - VERBAL

Definition

Initial Field GCS Verbal Response is the first recorded Glasgow Coma Score verbal assessment done.

Field Values

- **Pediatric** (<= 2 years of age)
  1. No vocal response
  2. Inconsolable, agitated
  3. Inconsistently consolable, moaning
  4. Cries but is consolable, inappropriate interactions
  5. Smiles, oriented to sounds, follows objects, interacts

- **Adult**
  1. No verbal response
  2. Incomprehensible sounds
  3. Inappropriate words
  4. Confused
  5. Oriented

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as Not Known/Not Recorded/Not Documented
- If patient is intubated, then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/ Walk-in
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Verbal was NOT measured

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2019
INITIAL FIELD GCS - MOTOR

Definition

*Initial Field GCS Motor Response* is the first recorded Glasgow Coma Score motor assessment done.

Field Values

- **Pediatric (<= 2 years of age)**
  1. No motor response
  2. Extension to pain
  3. Flexion to pain
  4. Withdrawal from pain
  5. Localizing pain
  6. Appropriate response to stimulation

- **Adult**
  1. No motor response
  2. Extension to pain
  3. Flexion to pain
  4. Withdrawal from pain
  5. Localizing pain
  6. Obeys commands

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Motor was NOT measured

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2019
INITIAL FIELD GCS - TOTAL

Definition

Initial Field Scene GCS Total Score is the first recorded total Glasgow Coma Score done.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, Revised Trauma Score---EMS (adult & pediatric)
- If the patient is transferred to your facility with no EMS run sheet from the scene of injury, record as Not Known/Not Recorded/Not Documented
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Total was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- NTDS 2019
INITIAL FIELD GCS QUALIFIER

Definition

Initial Field GCS Qualifier documents circumstances related to the patient when or near the time that the INITIAL Field Scene GCS Total Score was obtained.

Field Values

1. Patient is chemically sedated or paralyzed
2. Obstruction to the patient’s eye(s) prevents accurate eye assessment
3. Patient is intubated
4. GCS is valid meaning that the patient is not sedated, not intubated and without eye obstruction

Common Null Values

- Accepted

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- Select NA if the patient was not transported to your hospital by EMS

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- Not an NTDS Field
SCENE INTERVENTIONS

Definition

*Scene Interventions* indicates whether a critical procedure was performed by EMS at the scene or en route to your hospital, and if so, the procedure that was performed.

Field Values

1. CPR
2. Needle Thoracostomy or Chest Tube
3. Nasal Endotracheal Tube
4. Oral Endotracheal Tube
5. Surgical Airway (i.e. surgical, needle or percutaneous cricothyrotomy, tracheostomy)
6. Other Non-Surgical Airway (Supraglottic Airway (e.g., Laryngeal Mask Airway, King, Combitube))

Common Null Values

- Accepted

Additional Information

- Select NA If the patient was not treated at the scene by EMS

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- Not an NTDS Field
PREHOSPITAL CARDIAC ARREST

Definition

*Prehospital Cardiac Arrest* is indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.

Field Values

1. Yes
2. No

Common Null Values

- Accepted

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation
- The event must have occurred outside of the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring institution
- Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider who is trained to perform basic and/or advanced cardiac life support

Data Source Hierarchy Guide

1. EMS Run Report
2. Nursing Notes/Flow Sheet
3. History & Physical
4. Transfer Notes

References to Other Databases

- NTDS 2019
INTER-FACILITY TRANSFER

Definition

*Inter-facility Transfer* is whether the patient was transferred to your facility from another hospital.

Field Values

1. Yes
2. No

Common Null Values

- Accepted

Additional Information

- A patient transferred from a private doctor’s office, stand-alone ambulatory surgery center, and urgent care clinic or delivered to your hospital by a non-EMS transport is NOT considered an inter-facility transfer.
- Outlying facilities (i.e. hospitals and free-standing emergency departments) that provide emergency care services to assess and/or stabilize a patient are considered to be acute care facilities.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow sheet
3. History & Physical

References to Other Databases

- NTDS 2019
TRANSFERRING HOSPITAL CODE

Definition

*Transferring Hospital Code* documents the Ohio Department of Public Safety (ODPS) assigned-number for the acute care facility which transferred a trauma patient to your hospital.

Field Values

- Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Data Source Hierarchy Guide

1. ED Record
2. History & Physical

References to Other Databases

- Not an NTDS Field
ED/HOSPITAL ARRIVAL DATE

Definition

*ED/Hospital Arrival Date* is the date that the patient arrived at your ED/hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

References to Other Databases

- NTDS 2019
ED/HOSPITAL ARRIVAL TIME

Definition

*ED/Hospital Arrival Time* is the time of day that the patient arrived to your ED/hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient was brought to your hospital ED, enter the time patient arrived at the ED. If the patient was a directly admit to your hospital and bypassed the ED, enter that time that the patient was admitted to your hospital.
- Collected as HH:MM military time
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

References to Other Databases

- NTDS 2019
TRAUMA ACTIVATION LEVEL

Definition

Trauma Activation Level is the highest level of trauma activation called for the patient when at your hospital.

Field Values

1  Highest Level of Activation
2  Other Level of Activation
3  No Trauma Activation

Common Null Values

•  Accepted

Additional Information

•  Select 3 if your facility does not have a Trauma Service

Data Source Hierarchy Guide

1  Triage/Trauma Flow Sheet
2  ED Record

References to Other Databases

•  Not an NTDS Field
INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition

*ED/Hospital Initial Systolic Blood Pressure* is the patient’s first recorded systolic blood pressure within 30 minutes or less of ED/hospital arrival.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes
4. History & Physical

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL PULSE RATE

Definition

*ED/Hospital Initial Pulse Rate* is the patient’s first recorded pulse rate within 30 minutes or less of ED/hospital arrival (palpated or auscultated), expressed as a number per minute.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL RESPIRATORY RATE

Definition

ED/Hospital Initial Respiratory Rate is the patient’s first recorded respiratory rate within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Field Values

• Relevant value for data element

Common Null Values

• Accepted

Additional Information

• If documented, report additional field Initial ED/Hospital Respiratory Assistance
• Please note that first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Respiratory Therapy Notes/Flow Sheet

References to Other Databases

• NTDS 2019
INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition

ED/Hospital Initial Respiratory Assistance documents whether the patient was receiving respiratory assistance within 30 minutes or less of ED/hospital arrival.

Field Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate

Common Null Values

- Accepted

Additional Information

- Only reported if Initial ED/Hospital Respiratory Rate is documented
- Respiratory Assistance is defined as mechanical and/or external support of respiration
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value “Not Applicable” is reported if “Initial ED/Hospital Respiratory Rate” is “Not Known/Not Recorded”

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL OXYGEN SATURATION

**Definition**

*ED/Hospital Initial Oxygen Saturation* is the patient’s first recorded oxygen saturation within 30 minutes or less of ED/hospital arrival, expressed as a percentage.

**Field Values**

- Relevant value for data element

**Common Null Values**

- Accepted

**Additional Information**

- If documented, report additional field *Initial ED/Hospital Supplemental Oxygen*
- Please note that first recorded hospital vitals do not need to be from the same assessment

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

**References to Other Databases**

- NTDS 2019
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition

*ED/Hospital Supplemental Oxygen* is whether supplemental oxygen was provided to the patient during the assessment of *ED/Hospital Initial Oxygen Saturation Level* within 30 minutes or less of ED/hospital arrival.

Field Values

1. No Supplemental Oxygen
2. Supplemental Oxygen

Common Null Values

- Accepted

Additional Information

- The null value “Not Applicable” is reported if the *Initial ED/Hospital Oxygen Saturation* is “Not Known/Not Recorded”
- Please note that first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL TEMPERATURE

Definition

*Initial ED/Hospital Temperature* is the patient’s first recorded temperature within 30 minutes or less of ED/hospital arrival, documented in degrees Fahrenheit.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL GCS - EYE

Definition

*Initial ED/Hospital GCS Eye Opening* is the patient’s first recorded Glasgow Coma Score (GCS) eye assessment documented within 30 minutes or less of ED/hospital arrival in your ED/hospital.

Field Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Common Null Values

- Accepted

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient’s pupils are PERRL,” an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Eye was not measured within 30 minutes or less of ED/hospital arrival

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL GCS - VERBAL

Definition

*ED/Hospital Initial GCS Verbal Response* is the patient’s first recorded Glasgow Coma Score verbal assessment documented within 30 minutes or less of ED/hospital arrival.

Field Values

- **Pediatric** ($\leq 2$ years of age)
  1. No vocal response
  2. Inconsolable, agitated
  3. Inconsistently consolable, moaning
  4. Cries but is consolable, inappropriate interactions
  5. Smiles, oriented to sounds, follows objects, interacts

- **Adult**
  1. No verbal response
  2. Incomprehensible sounds
  3. Inappropriate words
  4. Confused
  5. Oriented

Common Null Values

- Accepted

Additional Information

- If patient is intubated then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient is oriented to person place and time,” a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/hospital arrival

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL GCS - MOTOR

Definition

*ED/Hospital Initial GCS Motor Response* is the patient’s first recorded Glasgow Coma Score motor assessment documented within 30 minutes or less of ED/hospital arrival.

Field Values

- **Pediatric** (≤ 2 years of age)
  - 1  No motor response
  - 2  Extension to pain
  - 3  Flexion to pain
  - 4  Withdrawal from pain
  - 5  Localizing pain
  - 6  Appropriate response to stimulation

- **Adult**
  - 1  No motor response
  - 2  Extension to pain
  - 3  Flexion to pain
  - 4  Withdrawal from pain
  - 5  Localizing pain
  - 6  Obeys commands

Common Null Values

- Accepted

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/hospital arrival

Data Source Hierarchy Guide

1  Triage/Trauma/ Hospital Flow Sheet
2  Nurses Notes/Flow Sheet
3  Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL GCS - TOTAL

Definition

*ED/Hospital Initial GCS Total Score* is the patient’s first recorded Glasgow Coma Score documented within 30 minutes or less of ED/hospital arrival in your ED/hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Eye, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal were not measured within 30 minutes or less of ED/Hospital arrival

Data Source Hierarchy Guide

1. Triage/Trauma/ Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2019
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Definition

*ED/Hospital Initial GCS Qualifiers* are factors that potentially affected the patient’s first Glasgow Coma Score assessment within 30 minutes or less of ED/hospital arrival.

Field Values

1. Patient Chemically Sedated
2. Obstruction to the Patient’s Eye
3. Patient Intubated
4. Valid GCS: Patient not sedated, not intubated and without eye obstruction

Common Null Values

- Accepted

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis) atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine’s effects last for only 5-10 minutes
- Please note that first recorded hospital vitals do not need to be from the same assessment
- Report all that apply
- The null value “Not Known/Not Recorded” is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival

Data Source Hierarchy Guide

1. Triage/Trauma/ Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2019
HEIGHT

Definition

*Height* is the patient’s height in centimeters.

Field Values

- Height in centimeters

Common Null Values

- Accepted

Additional Information

- Recorded in centimeters
- May be based on family or self-report
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Height was not measured within 24 hours or less of ED/hospital arrival

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

References to Other Databases

- NTDS 2019
WEIGHT

**Definition**

*Weight* is the patient's weight in kilograms.

**Field Values**

- Weight in kilograms

**Common Null Values**

- Accepted

**Additional Information**

- Recorded in kilograms
- May be based on family or self-report
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Weight was not measured within 24 hours or less of ED/hospital arrival

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

**References to Other Databases**

- NTDS 2019
ED DISCHARGE ORDER WRITTEN DATE

Definition

*ED Discharge Order Written Date* is the date that the order was written for the patient to be discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate additional calculated field, *Total ED Time* (elapsed time from ED admit to ED discharge)
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physicians’ Progress Notes

References to Other Databases

- Not an NTDS field
ED DISCHARGE ORDER WRITTEN TIME

Definition

*ED Discharge Order Written Time* is the time that the order was written for the patient to be discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate additional calculated field, *Total ED Time* (elapsed time from ED admit to ED discharge)
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Time is the time of death as indicated on the patient’s death certificate
- Collected as HH:MM military time

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physicians’ Progress Notes

References to Other Databases

- Not an NTDS field
ED DISCHARGE DATE*  

Definition*  
*ED Discharge Date* is the date that the patient was discharged from your ED.

Field Values  
- Relevant value for data element

Common Null Values  
- Accepted

Additional Information  
- Used to auto-generate additional calculated field, *Total ED Time* (elapsed time from ED admit to ED discharge)  
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.  
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate  
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide  
1. Physician Order  
2. ED Record  
3. Triage/Trauma/Hospital Flow Sheet  
4. Nursing Notes/Flow Sheet  
5. Discharge Summary  
6. Billing Sheet  
7. Progress Notes

References to Other Databases  
- NTDS 2019 (field name only)

*ED Discharge Date* field name matches NTDS 2019. Definition is different.
ED DISCHARGE TIME*

Definition*

*ED Discharge Time* is the time that the patient was discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate additional calculated field, *Total ED Time* (elapsed time from ED admit to ED discharge)
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Time is the time of death as indicated on the patient’s death certificate
- Collected as HH:MM military time

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

References to Other Databases

- NTDS 2019

*ED Discharge Time* field name matches NTDS 2019. Definition is different.
ED DISCHARGE DISPOSITION

Definition

*ED Discharge Disposition* is a general location of where the patient goes at the time of discharge from your ED.

Field Values

1. Floor bed (general admission, non-specialty unit bed)
2. Observation unit
3. Telemetry/step-down unit (less acuity than ICU)
4. Home with services
5. Deceased/Expired
6. Other (jail, institutional care, mental health, etc.)
7. Operating Room
8. Intensive Care Unit (ICU)
9. Home without services
10. Left against medical advice
11. Transferred to another hospital

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11 the Hospital Discharge Date, Time, Disposition and Inpatient Transfer to Hospital should be “Not Applicable”

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Summary
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. ED Record
6. History & Physical

References to Other Databases

- NTDS 2019
ED TRANSFER TO HOSPITAL

Definition

*ED Transfer to Hospital* is a subsequent hospital destination of the patient upon discharge from your ED.

Field Values

- Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11 the Hospital Discharge date, Time, Disposition and Inpatient Transfer to Hospital should be “Not Applicable”

Data Source Hierarchy Guide

1. ED Record
2. History & Physical

References to Other Databases

- Not an NTDS Field
SIGN OF LIFE

Definition

*Signs of Life are whether the patient arrived for treatment in the ED/Hospital with signs of life.*

Field Values

1. Arrived with no signs of life
2. Arrived with signs of life

Common Null Values

- Accepted

Additional Information

- A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Progress Notes
3. Nursing Notes/Flow Sheet
4. EMS Run Report
5. History & Physical

References to Other Databases

- NTDS 2019
ALCOHOL SCREEN

Definition

Alcohol Screen is a blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter.

Field Values

1 Yes
2 No

Common Null Values

- Not Accepted

Additional Information

- Alcohol screen may be administered at any facility, unit or setting treating this patient event

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2019
ALCOHOL SCREEN RESULTS

Definition

*Alcohol Screen Results* is the first recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collect as X.XX grams per deciliter (g/dl)
- Record BAC results within 24 hours after first hospital encounter at either your facility or the transferring facility
- The null value “Not Applicable” is used for those patients who were not tested

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

References to Other Databases

- NTDS 2019
**DRUG SCREEN**

**Definition**

*Drug Screen* is the first recorded positive drug screen within 24 hours after first hospital encounter (select all that apply).

**Field Values**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>AMP (Amphetamine)</td>
</tr>
<tr>
<td>2.</td>
<td>BAR (Barbiturate)</td>
</tr>
<tr>
<td>3.</td>
<td>BZO (Benzodiazepines)</td>
</tr>
<tr>
<td>4.</td>
<td>COC (Cocaine)</td>
</tr>
<tr>
<td>5.</td>
<td>mAMP (Methamphetamine)</td>
</tr>
<tr>
<td>6.</td>
<td>MDMA (Ecstasy)</td>
</tr>
<tr>
<td>7.</td>
<td>MTD (Methadone)</td>
</tr>
<tr>
<td>8.</td>
<td>OPI (Opioid)</td>
</tr>
<tr>
<td>9.</td>
<td>OXY (Oxycodone)</td>
</tr>
<tr>
<td>10.</td>
<td>PCP (Phencyclidine)</td>
</tr>
<tr>
<td>11.</td>
<td>TCA (Tricyclic Antidepressant)</td>
</tr>
<tr>
<td>12.</td>
<td>THC (Cannabinoid)</td>
</tr>
<tr>
<td>13.</td>
<td>Other</td>
</tr>
<tr>
<td>14.</td>
<td>None</td>
</tr>
<tr>
<td>15.</td>
<td>Not Tested</td>
</tr>
</tbody>
</table>

**Common Null Values**

- Not Accepted

**Additional Information**

- Report positive drug screen results within 24 hours after first hospital encounter, at either your facility or transferring facility
- “None” is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients who were tested and had no positive results
- If multiple drugs are detected, only report drugs that were not administered at any facility (or setting) treating this patient event

**Data Source Hierarchy Guide**

1. Lab Results
2. Transferring Facility Records

**References to Other Databases**

- NTDS 2019
ICD-10 HOSPITAL PROCEDURES

Definition

Hospital Procedures are all operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to the OTR.

Field Values

- Major and minor procedure ICD-10 PCS procedure codes
- The maximum number of procedures that may be reported for a patient is 200

Common Null Values

- Accepted

Additional Information

- The null value “Not Applicable” is reported if the patient did not have procedures
- Include only procedures performed at your institution
- Report all procedure performed in the operating room
- Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries or their complications
- Procedures with an asterisk have the potential to be performed multiple times during one episode event even if there is more than one
- Note that the hospital may capture additional procedures

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

References to Other Databases

- NTDS 2019
PROCEDURE LIST FOR HOSPITAL PROCEDURES DATA FIELD

**DIAGNOSTIC & THERAPEUTIC IMAGING**
- Computerized tomographic studies* (Head, Chest, Abdomen, Pelvis, C-Spine, T-Spine, L-Spine)
- Diagnostic ultrasound (includes FAST)*
- Doppler ultrasound of extremities*
- Angiography
- Angioembolization
- REBOA
- Inferior vena cava (IVC) filter

**GENITOURINARY**
- Ureteric catheterization (i.e. ureteric stent)
- Suprapubic cystostomy

**MUSCULOSKELETAL**
- Soft tissue/bony debridement*
- Closed reduction fractures
- Skeletal (and halo) traction
- Fasciotomy

**CARDIOVASCULAR**
- Open cardiac massage
- Cardiopulmonary Resuscitation (CPR)

**CENTRAL NERVOUS SYSTEM**
- Insertion of ICP monitor*
- Ventriculostomy*
- Cerebral oxygen monitoring*

**RESPIRATORY**
- Insertion of endotracheal tube* (Exclude intubations performed in the OR)
- Continuous invasive mechanical ventilation*
- Chest tube*
- Bronchoscopy*
- Tracheostomy

**GASTROINTESTINAL**
- Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
- Gastrostomy/jejunostomy (percutaneous/or endoscopic)
- Percutaneous (endoscopic) gastrojejunostomy

**TRANSFUSION**
- The following blood products should be captured over first 24 hours after hospital arrival:
  - Transfusion of red cells *
  - Transfusion of platelets *
  - Transfusion of plasma *

*May be performed multiple times during hospitalization*
PROCEDURE EPISODE

Definition

Procedure Episode documents the frequency of operative visits. Each trip to the operating room should be identified in sequential order (regardless of number of procedures completed at that time).

Field Values

1  First Operative Episode
2  Second Operative Episode
3  Third Operative Episode
4  Fourth Operative Episode
5  Fifth Operative Episode
6  Sixth Operative Episode
7  Seventh Operative Episode
8  Eighth Operative Episode
9  Ninth Operative Episode
10  Tenth or More Operative Episode

Common Null Values

- Accepted

Additional Information

- Include only those operative procedures performed at your hospital
- This field is linked to the Hospital Procedures Field
- Leave field blank if procedure was not performed in the Operating Room
- All of the procedures done in the first OR visit would be Episode 1, all in visit 2 would be Episode 2, and so forth.

Data Source Hierarchy Guide

1  Operative Reports

References to Other Databases

- Not an NTDS Field
HOSPITAL PROCEDURE START DATE

Definition

The date operative and selected non-operative procedures were performed.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This field is linked to the Hospital Procedures Field
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Report
7. Discharge Summary

References to Other Databases

- NTDS 2019
HOSPITAL PROCEDURE START TIME

Definition

The time operative and selected non-operative procedures were performed.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Procedure start time is defined as the time that the incision was made or that the procedure started
- If distinct procedures with the same procedure code are performed, their start time must be different.
- This field is linked to the Hospital Procedures Field
- Collected as HH:MM military time

Data Source Hierarchy Guide

1. Operative Reports
2. Anesthesia Record
3. Procedure Notes
4. Trauma Flow Sheet
5. ED Record
6. Nursing Notes/Flow Sheet
7. Radiology Reports
8. Discharge Summary

References to Other Databases

- NTDS 2019
ADVANCE DIRECTIVE LIMITING CARE

Definition
The patient had a written request limiting life sustaining therapy, or similar advanced directive.

Field Values
1. Yes
2. No

Common Null Values
- Accepted

Additional Information
- Present prior to arrival at your center.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

References to Other Databases
- NTDS 2019
ALCOHOL USE DISORDER

Definition
Diagnosis of alcohol use disorder documented in the patient medical record.

Field Values
1 Yes
2 No

Common Null Values
• Accepted

Additional Information
• Present prior to injury.
• Consistent with American Psychiatric Association (APA) DSM 5, 2013.
• A diagnosis of Alcohol Use Disorder must be documented in the patient's medical record.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
• NTDS 2019
ANGINA PECTORIS

Definition
Chest pain or discomfort due to coronary heart disease. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men.

Field Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of Angina or Chest Pain must be documented in the patient's medical record.
- Consistent with American Heart Association (AHA), May 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
ANTICOAGULANT THERAPY

Definition
Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting.

<table>
<thead>
<tr>
<th>ANTICOAGULANTS</th>
<th>ANTIPLATELET AGENTS</th>
<th>THROMBIN INHIBITORS</th>
<th>THROMBOLYTIC AGENTS</th>
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<tbody>
<tr>
<td>Fondaparinux</td>
<td>Tirofiban</td>
<td>Bevalirudin</td>
<td>Alteplase</td>
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<td>Dipyridamole</td>
<td>Argatroban</td>
<td>Reteplose</td>
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<td>Lepirudin, Hirudin</td>
<td>Tenacteplase</td>
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<td>Drotrecogin alpha</td>
<td>Kabikinase</td>
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<td>Dipyridamole</td>
<td>Dabigatran</td>
<td>tPA</td>
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<td>APC</td>
<td>Clopidogrel</td>
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<td></td>
</tr>
<tr>
<td>Ximelagatran</td>
<td>Cilostazol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pentoxifylline</td>
<td>Abciximab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rivaroxaban</td>
<td>Ticlopidine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apixaban</td>
<td>Prasugrel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heparin</td>
<td>Ticagrelor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Exclude patients whose only anticoagulant therapy is chronic Aspirin.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician’s Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

Definition
A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Field Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  Present prior to ED/Hospital arrival.
•  A diagnosis of ADD/ADHD must be documented in the patient's medical record.
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
•  NTDS 2019
BLEEDING DISORDER

Definition
A group of conditions that result when the blood cannot clot properly.

Field Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden).
- Consistent with American Society of Hematology, 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
CEREBRAL VASCULAR ACCIDENT (CVA)

**Definition**
A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

**Field Values**
1. Yes
2. No

**Common Null Values**
- Accepted

**Additional Information**
- Present prior to injury.
- A diagnosis of CVA must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

**Data Source Hierarchy Guide**
1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**References to Other Databases**
- NTDS 2019
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Definition
Lung ailment that is characterized by a persistent blockage of airflow from the lungs. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:
- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- Do not include patients whose only pulmonary disease is acute asthma.
- Do not include patients with diffuse interstitial fibrosis or sarcoidosis.
- Consistent with World Health Organization (WHO), 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
CHRONIC RENAL FAILURE

Definition
Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Field Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  Present prior to injury.
•  A diagnosis of Chronic Renal Failure must be documented in the patient's medical record.
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
•  NTDS 2019
CIRRHOSIS

Definition
Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease.

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
CONGENITAL ANOMALIES

Definition
Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly.

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
CONGESTIVE HEART FAILURE (CHF)

Definition
The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure.

Field Values
1 Yes
2 No

Common Null Values
• Accepted

Additional Information
• Present prior to injury.
• A diagnosis of CHF must be documented in the patient's medical record.
• To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
• Common manifestations are:
  o Abnormal limitation in exercise tolerance due to dyspnea or fatigue
  o Orthopnea (dyspnea or lying supine)
  o Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
  o Increased jugular venous pressure
  o Pulmonary rales on physical examination
  o Cardiomegaly
  o Pulmonary vascular engorgement
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
• NTDS 2019
CURRENT SMOKER

Definition
A patient who reports smoking cigarettes every day or some days within the last 12 months.

Field Values
1 Yes
2 No

Common Null Values
• Accepted

Additional Information
• Present prior to injury.
• Exclude patients who report smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
• NTDS 2019
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Definition
A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.

Field Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  Present prior to injury.
•  Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
•  NTDS 2019
DEMENTIA

Definition
Documentation in the patient’s medical record of dementia including senile or vascular dementia (e.g., Alzheimer’s).

Field Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  Present prior to injury.
•  A diagnosis of Dementia must be documented in the patient’s medical record.
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician’s Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
•  NTDS 2019
DIABETES MELLITUS

Definition
Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
DISSEMINATED CANCER

Definition
Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Other terms describing disseminated cancer include: "diffuse", "widely metastatic", "widespread", or "carcinomatosis."
- Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone).
- A diagnosis of Cancer that has spread to one or more sites must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
FUNCTIONALLY DEPENDENT HEALTH STATUS

Definition
Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL).

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician’s Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
HYPERTENSION

Definition
History of persistent elevated blood pressure requiring medical therapy.

Field Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  Present prior to injury.
•  A diagnosis of Hypertension must be documented in the patient's medical record.
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician’s Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
•  NTDS 2019
MENTAL/PERSOALITY DISORDERS

Definition
Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder.

Field Values
1  Yes
2  No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
MYOCARDIAL INFARCTION (MI)

Definition
History of a MI in the six months prior to injury.

Field Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  Present prior to injury.
•  A diagnosis of MI must be documented in the patient's medical record.
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
•  NTDS 2019
OSTEOPOROSIS

Definition
Thinning of bone tissue and loss of bone density over time.

Field Values
1    Yes
2    No

Common Null Values
• Accepted

Additional Information
• Most common in post-menopausal women.

Data Source Hierarchy Guide
1    History & Physical
2    Physician's Notes
3    Progress Notes
4    Case Management/Social Services
5    Nursing Notes/Flow Sheet
6    Triage/Trauma Flow Sheet
7    Discharge Summary

References to Other Databases
• Not an NTDS field
PERIPHERAL ARTERIAL DISEASE (PAD)

Definition
The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms.

Field Values
1  Yes
2  No

Common Null Values
• Accepted

Additional Information
• Present prior to injury.
• Consistent with Centers for Disease Control, 2014 Fact Sheet.
• A diagnosis of PAD must be documented in the patient's medical record.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1  History & Physical
2  Physician’s Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
• NTDS 2019
PREMATURITY

Definition
Babies born before 37 weeks of pregnancy are completed.

Field Values
1 Yes
2 No

Common Null Values
• Accepted

Additional Information
• Present prior to injury.
• A diagnosis of Prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
• NTDS 2019
STEROID USE

Definition
Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

Field Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are: prednisone and dexamethasone.
- Examples of chronic medical conditions are: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
Definition
Documentation of substance abuse disorder in the patient medical record.

Field Values
1   Yes
2   No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.
- A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- EXCLUDE: Tobacco Use Disorder and Alcohol Use Disorder

Data Source Hierarchy Guide
1   History & Physical
2   Physician’s Notes
3   Progress Notes
4   Case Management/Social Services
5   Nursing Notes/Flow Sheet
6   Triage/Trauma Flow Sheet
7   Discharge Summary

References to Other Databases
- NTDS 2019
DNR STATUS

Definition

*DNR Status* documents the presence of a physician’s order to withhold select resuscitative efforts from the patient, and whether the order was issued prior to or during the patient’s stay at your ED/hospital.

Field Values

- 0  Not a DNR patient (patient is to receive all resuscitative efforts if needed)
- 1  DNR status ordered prior to patient’s arrival at your hospital
- 2  DNR status ordered after patient’s arrival to your hospital

Common Null Values

- Not Accepted

Additional Information

- This field is completed for each patient
- DNR status is typically ordered for a patient who does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing) near the end of life.
- A DNR status includes both *DNR-CC* (comfort care) and *DNR-CCA* (comfort care arrest) orders.
- DNR may also be referred to as *Allow Natural Death (AND)*
- Until DNR status is documented, the patient is considered to be “not a DNR patient”

Data Source Hierarchy Guide

1  Do Not Resuscitate Document
2  History and Physical
3  Discharge Sheet
4  Billing Sheet

References to Other Databases

- Not an NTDS field
ICD-10 INJURY DIAGNOSES

Definition

*Injury Diagnoses* are the patient’s diagnoses for all injuries identified at your ED/hospital for this injury event. Diagnoses must be confirmed by a physician at your facility.

Field Values

- Injury diagnoses are defined by ICD-10-CM codes; refer to inclusion criteria
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Common Null Values

- Not Accepted

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician’s Notes
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

References to Other Databases

- NTDS 2019
AIS PRE-DOT CODE

Definition

*AIS Pre-dot Code* is a component of the Abbreviated Injury Scale (AIS) code that reflects the patient’s injuries diagnosed at your ED/hospital.

Field Values

- The pre-dot code is the 6 digits preceding the decimal point in an associated AIS code

Common Null Values

- Accepted

Additional Information

- Can be utilized to generate Abbreviated Injury Score and Injury Severity Score

Data Source Hierarchy Guide

1. AIS Coding Manual

References to Other Databases

- NTDS 2019
AIS SEVERITY

Definition
AIS Severity is the Abbreviated Injury Scale (AIS) severity codes that reflect the patient’s injuries diagnosed at your ED/hospital.

Field Values
1  Minor Injury
2  Moderate Injury
3  Serious Injury
4  Severe Injury
5  Critical Injury
6  Maximum Injury, Virtually Non-survivable
9  Not Possible to Assign an AIS

Common Null Values
•  Accepted

Additional Information
•  Field value #9, Not Possible to Assign an AIS, is chosen if the severity of an injury is not known

Data Source Hierarchy Guide
1  AIS Coding Manual

References to Other Databases
•  NTDS 2019
AIS VERSION

Definition

AIS version is the software version used to calculate Abbreviated Injury Scale (AIS) severity codes for the patient’s current injury event.

Field Values

6  AIS 05, Updated 08
7  AIS 2015

Common Null Values

- Accepted

Data Source Hierarchy Guide

1  AIS Coding Manual

References to Other Databases

- NTDS 2019
INJURY SEVERITY SCORE

Definition

Injury Severity Score (ISS) is a nationally-accepted scoring system that reflects the patient's injuries for this injury event.

Field Values

- Relevant ISS value for the constellation of injuries

Common Null Values

- Accepted

Data Source Hierarchy Guide

1  AIS Coding Manual

References to Other Databases

- Not an NTDS Field
TOTAL ICU LENGTH OF STAY

Definition

Total ICU Length of Stay documents the total number of days that the patient spent in any intensive care unit (ICU) (including all episodes) while in your hospital.

Field Values

- Relevant numeric value

Common Null Values

- Accepted

Additional Information

- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient’s chart.
- If any dates are missing then a LOS cannot be calculated.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS.
- If the patient had no ICU days according to the above definition, code as ‘Not applicable.’
- See Appendix E for examples of ICU LOS calculations

Data Source Hierarchy Guide

1. ICU Flow Sheet
2. Nursing Notes/Flow Sheet

References to Other Databases

- NTDS 2019
TOTAL VENTILATOR DAYS

Definition

Total Ventilator Days documents the total number of days that the patient spent on mechanical ventilation (excluding time in the OR) while in your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient’s chart.
- If any dates are missing then a Total Vent Days cannot be calculated.
- At no time should the Total Vent Days exceed the Hospital LOS.
- If the patient was not on the ventilator according to the above definition, code as ‘Not applicable.’
- See Appendix E for examples of Total Ventilator Days calculations

Data Source Hierarchy Guide

1 Respiratory Therapy Notes/Flow Sheet
2 ICU Flow Sheet
3 Progress Notes

References to Other Databases

- NTDS 2019
HOSPITAL DISCHARGE ORDER WRITTEN DATE

Definition
Hospital Discharge Order Written Date is the date that the order was written for the patient to be discharged from your hospital.

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Used to auto generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to Hospital Discharge)
- Collected as YYYY-MM-DD
- The null value “Not Applicable” is reported if ED Discharge Disposition is 5. Deceased/Expired
- The null value “Not Applicable” is reported if ED Discharge Disposition = 4, 6, 9, 10, or 11
- If Hospital Discharge Disposition is “5. Deceased/Expired,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate

Data Source Hierarchy Guide
1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

References to Other Databases
- Not an NTDS Field
Definition

*Hospital Discharge Order Written Time* is the time that the order was written for the patient to be discharged from your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto generate an additional calculated field: *Total Length of Hospital Stay* (elapsed time from ED/Hospital Arrival to Hospital Discharge)
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 (Deceased/ expired).
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is “5. Deceased/Expired,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate
- Collected as HH:MM military time

Data Source Hierarchy Guide

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

References to Other Databases

- Not an NTDS Field
HOSPITAL DISCHARGE DATE*

Definition*

* Hospital Discharge Date is the date that the patient was discharged from your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to Hospital Discharge)
- Collected as YYYY-MM-DD
- The null value “Not Applicable” is reported if ED Discharge Disposition is 5. Deceased/Expired
- The null value “Not Applicable” is reported if ED Discharge Disposition = 4, 6, 9, 10, or 11
- If Hospital Discharge Disposition is “5. Deceased/Expired,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

References to Other Databases

- NTDS 2019

* Hospital Discharge Date field name matches NTDS 2019. Definition is different.
HOSPITAL DISCHARGE TIME*

Definition*

*Hospital Discharge Time* is the time of day that the patient was discharged from your hospital.

Field Values
- Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Used to auto generate an additional calculated field: *Total Length of Hospital Stay* (elapsed time from ED/Hospital Arrival to Hospital Discharge)
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 (Deceased/ expired).
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is “5. Deceased/Expired,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate
- Collected as HH:MM military time

Data Source Hierarchy Guide
1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

References to Other Databases
- NTDS 2019

* *Hospital Discharge Time* field name matches NTDS 2019. Definition is different.
HOSPITAL DISCHARGE DISPOSITION

Definition

Hospital Discharge Disposition documents in general terms where the patient went after discharge from your hospital.

Field Values

1. Discharged/Transferred to another hospital for ongoing acute inpatient care
2. Discharged to an intermediate care facility (ICF)/long term care facility (LTCF)
3. Discharged/Transferred to home under the care of an organized home health service
4. Left against medical advice (AMA) or discontinued care
5. Died
6. Discharged home or self-care (routine discharge)
7. Discharged to a skilled nursing facility (SNF)
8. Discharged to hospice care
9. [Value 9 not used]
10. Discharged to court/law enforcement/jail
11. Discharged to another type of inpatient rehabilitation facility (IRF)
12. Discharged to a long term acute care hospital (LTACH)
13. Discharged/transferred to psychiatric hospital/psychiatric unit
14. Discharged/transferred to other type of institution not listed here

Common Null Values

- Accepted

Additional Information

- Field value "6. Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).
- Field values based upon UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be coded as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition is “5, Deceased/Expired.”
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Field Values above, which is why there are numbering gaps.
- Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

References to Other Databases

- NTDS 2019
INPATIENT TRANSFER TO HOSPITAL

Definition

_Inpatient Transfer to Hospital_ documents a subsequent hospital destination for the patient after inpatient admission at your hospital. This includes transfers to inpatient rehabilitation facilities.

Field Values

- Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Data Source Hierarchy Guide

1. Discharge Summary
2. Progress Notes
3. Billing/Registration Sheet

References to Other Databases

- Not an NTDS Field
DISCHARGE STATUS

Definition

_Discharge Status_ is whether the patient left your hospital alive or dead.

Field Values

1. Alive
2. Dead

Common Null Values

- Not Accepted

Data Source Hierarchy Guide

1. Discharge Summary
2. Progress Notes
3. Billing Sheet

References to Other Databases

- Not an NTDS Field
DATE OF DEATH

Definition

*Date of Death* is the date that the patient was pronounced dead or time of declaration of brain death.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Only complete field when *Discharge Status* is completed as *Dead*
- This may differ from the date of discharge
- *Date of Death* must be ≤ *Hospital Discharge Date*
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

References to Other Databases

- Not an NTDS Field
TIME OF DEATH

Definition

*Time of Death* is the time of day that the patient was pronounced dead or time of declaration of brain death.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Only complete field when *Discharge Status* is completed as *Dead*
- This may differ from the time of discharge
- *Time of Death* must be ≤ *Hospital Discharge Time*
- Collected as HH:MM military time

Data Source Hierarchy Guide

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

References to Other Databases

- Not an NTDS Field
PRIMARY METHOD OF PAYMENT
Data Format is single-choice.

Definition
*Primary Method of Payment* is the patient’s foremost source of payment for care while in your hospital.

Field Values
1  Medicaid
2  Not Billed (for any reason)
3  Self-Pay
4  Private/Commercial Insurance
6  Medicare
7  Other Government Payer Source
8  Workers Compensation
10 Other

Common Null Values
- Accepted

Additional Information
- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as “4. Private/Commercial Insurance”.
- Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Field Values. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments.
- Examples of “Other Government Payer Source”: Veterans Affairs (VA), TRICARE, CHAMPVA
- Charity or HCAP should be coded under “Not Billed”

Data Source Hierarchy Guide
1  Billing Sheet
2  Admission Form
3  Face Sheet

References to Other Databases
- NTDS 2019
AUTOPSY PERFORMED
Data Format is single-choice.

Definition

*Autopsy Performed* documents whether an internal organ exam was performed on the patient by a trained pathologist.

Field Values

1. Yes, an autopsy was performed
2. No, an autopsy was not performed

Common Null Values

- Accepted

Additional Information

- Select *NA* if the patient is alive
- If only an external or visual-type exam was done and no internal organs were surgically explored, field value #2, *No, an autopsy was not performed*, should be selected.

Data Source Hierarchy Guide

1. Autopsy Report
2. Discharge Summary

References to Other Databases

- Not an NTDS Field
ACUTE KIDNEY INJURY (AKI)

Definition
Acute kidney injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient’s stay at your hospital.

KDIGO (Stage 3) Table:
(SCr) 3 times baseline

OR
Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

OR
Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m²

OR
Urine output <0.3 ml/kg/h for ≥ 24 hours

OR
Anuria for ≥ 12 hours

Field Values
1  Yes
2  No

Additional Information
• Must have occurred during the patient’s initial stay at your hospital.
• A diagnosis of AKI must be documented in the patient's medical record.
• If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
• EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.
• Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

Data Source Hierarchy Guide
1  History and Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
• NTDS 2019
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

**Definition**

**Timing:** Within 1 week of known clinical insult or new or worsening respiratory symptoms.

**Chest imaging:** Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules

**Origin of edema:** Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.

**Oxygenation:**

- **Mild**  
  \[200 \text{ mm Hg} < \text{PaO}_2/\text{FI}_2 < 300 \text{ mm Hg}\]  
  With PEEP or CPAP \(\geq 5 \text{ cm H}_2\text{O}\)

- **Moderate**  
  \[100 \text{ mm Hg} < \text{PaO}_2/\text{FI}_2 < 200 \text{ mm Hg}\]  
  With PEEP >5 cm H2O

- **Severe**  
  \[\text{PaO}_2/\text{FI}_2 < 100 \text{ mm Hg}\]  
  With PEEP or CPAP >5 cm H2O

**Field Values**

1. Yes
2. No

**Additional Information**

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**References to Other Databases**

- NTDS 2019
ALCOHOL WITHDRAWAL SYNDROME

Definition
Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption and, when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens).

Field Values
1 Yes
2 No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

Data Source Hierarchy Guide
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
CARDIAC ARREST WITH CPR

Definition
Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

Field Values
1 Yes
2 No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- Cardiac Arrest must be documented in the patient's medical record.
- EXCLUDE patients who are receiving CPR on arrival to your hospital.
- INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

Data Source Hierarchy Guide
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Definition
A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of the event, with day of device placement being day 1,

AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of the event for the UTI must be day of discontinuation or the next day for the UTI to be catheter-associated.

January 2016 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, and 3 below:

1. Patient had an indwelling catheter in place for the entire day on the date of event and such catheter had been in place for calendar days, on the that date (day of device placement = Day 1) AND was either:
   - Present for any portion of the calendar day on the date of event, OR
   - Removed the day before the date of event

2. Patient has at least one of the following signs or symptoms:
   - Fever (≥ 38⁰ C)
   - Suprapubic tenderness with no other recognized cause
   - Costovertebral angle pain or tenderness with no other recognized cause

3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria > 10⁵ CFU/ml.

January 2016 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2, and 3 below:

1. Patient is ≤ 1 year of age

2. Patient has at least one of the following signs or symptoms:
   - Fever (> 38.0°C)
   - Hypothermia (<36.0°C)
   - Apnea with no other recognized cause
   - Bradycardia with no other recognized cause
   - Lethargy with no other recognized cause
   - Vomiting with no other recognized cause
   - Suprapubic tenderness with no other recognized cause

3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥ 10⁵ CFU/ml.
Field Values
1  Yes
2  No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CAUTI.

Data Source Hierarchy Guide
1  History and Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Definition
A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

**AND**
The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then remove, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient’s central line, day of first access in an inpatient location is considered Day. “Access” is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule). Note that the “de-access” of a port does not result in the patient’s removal from CLABSI surveillance.

**January 2016 CDC Criterion LCBI 1:**
Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).

**AND**
Organism(s) identified in blood is not related to an infection at another site.

**OR**

**January 2016 CDC Criterion LCBI 2:**
Patient has at least one of the following signs or symptoms:
- Fever (>38°C)
- Chills
- Hypotension

**AND**
Organism(s) identified from blood is not related to an infection at another site

**AND**
The same common commensal (i.e., diphtheroids [Corynebacterium spp. Not C. diphtheria], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

**OR**

**January 2016 CDC Criterion LCBI 3:**
Patient ≤ 1 year of age has at least one of the following signs or symptoms:

- Fever (>38°C)
- Hypothermia (<36°C)
- Apnea
- Bradycardia

AND

Organism(s) identified from blood is not related to an infection at another state

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. Not C. diphtheria], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

Field Values

1  Yes
2  No

Additional Information

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of CLABSI must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC defined CLABSI.

Data Source Hierarchy Guide

1  History and Physical
2  Physician’s Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases

- NTDS 2019
DEEP SURGICAL SITE INFECTION

**Definition**
Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) According to list in Table 2

**AND**

Patient has at least one of the following:

- Purulent drainage from the deep incision
- A deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ACS/AST) or culture or non-culture based microbiologic test method is not performed

**AND**

Patient has at least one of the following signs or symptoms:

- Fever (>38°C)
- Localized pain or tenderness
- A culture or non-culture based test that has a negative finding does not meet this criterion
- An abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

**COMMENTS:** There are two specific types of deep incisional SSIs:

- Deep Incisional Primary (DIP): a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
- Deep Incisional Secondary (DIS): a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB.)

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories.  Day 1 = the date of the procedure.

<table>
<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
<th>Code</th>
<th>Operative Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Abdominal Aortic Aneurysm repair</td>
<td>LAM</td>
<td>Laminectomy</td>
</tr>
<tr>
<td>AMP</td>
<td>Limb Amputation</td>
<td>LTP</td>
<td>Liver transplant</td>
</tr>
<tr>
<td>APPY</td>
<td>Appendix Surgery</td>
<td>NECK</td>
<td>Neck surgery</td>
</tr>
<tr>
<td>AVSD</td>
<td>Shunt for dialysis</td>
<td>NEPH</td>
<td>Kidney surgery</td>
</tr>
<tr>
<td>BIBL</td>
<td>Bile duct, liver or pancreatic surgery</td>
<td>OVRY</td>
<td>Ovarian surgery</td>
</tr>
<tr>
<td>CEA</td>
<td>Carotid endarterectomy</td>
<td>PRST</td>
<td>Prostate surgery</td>
</tr>
<tr>
<td>CHOL</td>
<td>Gallbladder Surgery</td>
<td>REC</td>
<td>Rectal surgery</td>
</tr>
<tr>
<td>COLO</td>
<td>Colon Surgery</td>
<td>SB</td>
<td>Small bowel surgery</td>
</tr>
<tr>
<td>CSEC</td>
<td>Cesarean Section</td>
<td>SPLE</td>
<td>Spleen surgery</td>
</tr>
<tr>
<td>Code</td>
<td>Operative Procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAST</td>
<td>Gastric surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THOR</td>
<td>Thoracic surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTP</td>
<td>Heart transplant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THUR</td>
<td>Thyroid and/or parathyroid surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYST</td>
<td>Abdominal hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VHYS</td>
<td>Vaginal hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KTP</td>
<td>Kidney transplant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X LAP</td>
<td>Exploratory Laparotomy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**90- day Surveillance**

<table>
<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRST</td>
<td>Breast surgery</td>
</tr>
<tr>
<td>CARD</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>CBGB</td>
<td>Coronary artery bypass graft with both chest and donor site incisions</td>
</tr>
<tr>
<td>CBGC</td>
<td>Coronary artery bypass graft with check incision only</td>
</tr>
<tr>
<td>CRAN</td>
<td>Craniotomy</td>
</tr>
<tr>
<td>FUSN</td>
<td>Spinal fusion</td>
</tr>
<tr>
<td>FX</td>
<td>Open reduction of fracture</td>
</tr>
<tr>
<td>HER</td>
<td>Herniorrhaphy</td>
</tr>
<tr>
<td>HPRO</td>
<td>Hip prosthesis</td>
</tr>
<tr>
<td>KPRO</td>
<td>Knee prosthesis</td>
</tr>
<tr>
<td>PACE</td>
<td>Pacemaker surgery</td>
</tr>
<tr>
<td>PVBY</td>
<td>Peripheral vascular bypass surgery</td>
</tr>
<tr>
<td>VSHN</td>
<td>Ventricular shunt</td>
</tr>
</tbody>
</table>

**Field Values**

1. Yes
2. No

**Additional Information**

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**References to Other Databases**

- NTDS 2019
DEEP VEIN THROMBOSIS (DVT)

Definition
The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

Field Values
1 Yes
2 No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

Data Source Hierarchy Guide
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
EXTREMITY COMPARTMENT SYNDROME

Definition
A condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder.

Field Values
1 Yes
2 No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.
- A diagnosis of extremity compartment syndrome must be documented in the patient's medical record.

Data Source Hierarchy Guide
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
MYOCARDIAL INFARCTION (MI)

Definition
An acute myocardial infarction must be noted with documentation of any of the following:

Documentation of ECG changes indicative of acute MI (one or more of the following three):

1. ST elevation >1 mm in two or more contiguous leads
2. New left bundle branch block
3. New q-wave in two or more contiguous leads

OR

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

OR

Physician diagnosis of myocardial infarction

Field Values
1. Yes
2. No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of MI must be documented in the patient's medical record.

Data Source Hierarchy Guide
1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

References to Other Databases
- NTDS 2019
ORGAN/SPACE SURGICAL SITE INFECTION

Definition
Must meet the following criteria:
Infection that occurs within 30 or 90 days after the NHS operative procedure (where da 1 = the procedure date) according to the list in Table 2

AND
Infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND
Patient has at least one of the following:

a) Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)

b) Organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment) e.g., not Active Surveillance Culture/Testing (ASC/AST).

c) An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND
Meets at least one criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

<table>
<thead>
<tr>
<th>30- day Surveillance</th>
<th>90- day Surveillance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Operative Procedure</td>
</tr>
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<tr>
<td>HTP</td>
<td>Heart transplant</td>
</tr>
<tr>
<td>HYST</td>
<td>Abdominal hysterectomy</td>
</tr>
<tr>
<td>KTP</td>
<td>Kidney transplant</td>
</tr>
<tr>
<td>CODE</td>
<td>Operative Procedure</td>
</tr>
<tr>
<td>BRST</td>
<td>Breast surgery</td>
</tr>
<tr>
<td>CARD</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>Code</td>
<td>Site</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>CBGB</td>
<td>Coronary artery bypass graft with both chest and donor site incisions</td>
</tr>
<tr>
<td>CRAN</td>
<td>Craniotomy</td>
</tr>
<tr>
<td>FX</td>
<td>Open reduction of fracture</td>
</tr>
<tr>
<td>HP</td>
<td>Hip prosthesis</td>
</tr>
<tr>
<td>PACE</td>
<td>Pacemaker surgery</td>
</tr>
<tr>
<td>VSHN</td>
<td>Ventricular shunt</td>
</tr>
</tbody>
</table>

Table 3. Specific Sites of an Organ/Space SSI

<table>
<thead>
<tr>
<th>Code</th>
<th>Site</th>
<th>Code</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>BONE</td>
<td>Osteomyelitis</td>
<td>LUNG</td>
<td>Other infections of respiratory tract</td>
</tr>
<tr>
<td>BRST</td>
<td>Breast abscess mastitis</td>
<td>MED</td>
<td>Mediastinitis</td>
</tr>
<tr>
<td>CARD</td>
<td>Myocarditis or Pericarditis</td>
<td>MEN</td>
<td>Meningitis or ventriculitis</td>
</tr>
<tr>
<td>DISC</td>
<td>Disc space</td>
<td>ORAL</td>
<td>Oral cavity (mouth, tongue, or gums)</td>
</tr>
<tr>
<td>EAR</td>
<td>Ear, Mastoid</td>
<td>OREP</td>
<td>Other infections of the male or female reproductive tract</td>
</tr>
<tr>
<td>EMET</td>
<td>Endometritis</td>
<td>PJI</td>
<td>Periprosthetic Joint Infection</td>
</tr>
<tr>
<td>ENDO</td>
<td>Endocarditis</td>
<td>SA</td>
<td>Spinal abscess without meningitis</td>
</tr>
<tr>
<td>EYE</td>
<td>Eye, other than conjunctivitis</td>
<td>SINU</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>GIT</td>
<td>GI Tract</td>
<td>UR</td>
<td>Upper respiratory tract</td>
</tr>
<tr>
<td>HEP</td>
<td>Hepatitis</td>
<td>USI</td>
<td>Urinary System Infection</td>
</tr>
<tr>
<td>IAB</td>
<td>Intraabdominal, not specified</td>
<td>VASC</td>
<td>Arterial or venous infection</td>
</tr>
<tr>
<td>IC</td>
<td>Intracranial, brain abscess or dura</td>
<td>VCUF</td>
<td>Vaginal cuff</td>
</tr>
<tr>
<td>JNT</td>
<td>Joint or bursa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Field Values

1 Yes
2 No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2019
OSTEOMYELITIS

Definition
Osteomyelitis must meet at least one of the following criteria:
1. Patient has organisms identified by culture or non-cultured based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/ASST)).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic examination.
3. Patient has at least two of the following localized signs or symptoms:
   - Fever (>38° C)
   - Swelling*
   - Pain or Tenderness*
   - Heat*
   - Drainage*

AND at least one of the following:
   a) Organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]) which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis)
   b) Imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.,]), which is equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis)

*With no other recognized cause

Field Values
1. Yes
2. No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2016 CDC definition of Bone and Joint infection.

Data Source Hierarchy Guide
1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

References to Other Databases
- NTDS 2019
PULMONARY EMBOLISM (PE)

Definition
A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system.

Field Values
1  Yes
2  No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient’s medical record.
- Exclude sub segmental PE’s.

Data Source Hierarchy Guide
1  History and Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
PRESSURE ULCER

Definition
A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury.

Field Values
1 Yes
2 No

Additional Information
• Must have occurred during the patient's initial stay at your hospital.
• Pressure Ulcer documentation must be in the patient's medical record.
• Consistent with the NPUAP 2014.

Data Source Hierarchy Guide
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
• NTDS 2019
SEVERE SEPSIS

Definition

Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.

Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

Field Values

1 Yes
2 No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of Sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

Data Source Hierarchy Guide

1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2019
STROKE/CVA

Definition
A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

**AND:**
- Duration of neurological deficit ≥ 24 h

**OR:**
- Duration of deficit < 24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

**AND:**
- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

**AND:**
- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography,) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission.)

Field Values
1  Yes
2  No

Additional Information
- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

Data Source Hierarchy Guide
1  History and Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2019
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition
Must meet the following criteria:
Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

Involves only skin or subcutaneous tissue of the incision

AND

Patient has at least one of the following:
  a. Purulent drainage from the superficial incision.
  b. Organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
  c. Superficial incision is deliberately opened by the surgeon, attending physician** or other designee and culture or non-culture based testing is not performed

AND

Patient has at least one of the following signs or symptoms:
  • Pain or tenderness
  • Localized swelling
  • Erythema
  • Heat
  • A culture or non-culture based test that has a negative finding does not meet this criterion

d. Diagnosis of Superficial incisional SSI by the surgeon or attending physician** or other designee.

COMMENTS: There are two specific types of superficial incisional SSIs:

  1. Superficial Incisional Primary (SIP)- a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
  2. Superficial Incisional Secondary (SIS)- a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

Field Values
  1  Yes
  2  No

Additional Information
  • Must have occurred during the patient's initial stay at your hospital.
  • A diagnosis of SSI must be documented in the patient's medical record.
  • Consistent with the January 2016 CDC defined SSI.
Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

References to Other Databases

- NTDS 2019
UNPLANNED ADMISSION TO ICU

Definition
Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

Field Values
1  Yes
2  No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure.

Data Source Hierarchy Guide
1  History and Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
UNPLANNED INTUBATION

Definition
  Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

Field Values
  1  Yes
  2  No

Additional Information
  • Must have occurred during the patient’s initial stay at your hospital.
  • In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

Data Source Hierarchy Guide
  1  History and Physical
  2  Physician's Notes
  3  Progress Notes
  4  Case Management/Social Services
  5  Nursing Notes/Flow Sheet
  6  Triage/Trauma Flow Sheet
  7  Discharge Summary

References to Other Databases
  • NTDS 2019
UNPLANNED RETURN TO THE OPERATING ROOM

**Definition**
Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

**Field Values**
1. Yes
2. No

**Additional Information**
- Must have occurred during the patient's initial stay at your hospital.
- The null value "Not Applicable" is reported for patients who were never in the OR during their initial stay at your hospital.

**Data Source Hierarchy Guide**
1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**References to Other Databases**
- NTDS 2019
VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Definition
A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

AND
The ventilator was in place on the date of event or the day before.

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>At least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>- New or progressive and persistent infiltrate</td>
<td>- Fever (&lt;38°C or &lt;100.4°F)</td>
<td>- Organism identified from blood</td>
</tr>
<tr>
<td>- Consolidation</td>
<td>- Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>- Organism identified from pleural fluid</td>
</tr>
<tr>
<td>- Cavitation</td>
<td>- For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>- Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)</td>
</tr>
<tr>
<td>- Pneumatoceles, in infants ≤1 year old</td>
<td>AND at least two of the following:</td>
<td>- ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram’s stain)</td>
</tr>
<tr>
<td>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</td>
<td>- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td>- Positive quantitative culture of lung tissue</td>
</tr>
<tr>
<td></td>
<td>- New onset or worsening cough, or dyspnea, or tachypnea</td>
<td>- Histopathologic exam shows at least one of the following evidences of pneumonia:</td>
</tr>
<tr>
<td></td>
<td>- Rales or bronchial breath sounds</td>
<td>o Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</td>
</tr>
<tr>
<td></td>
<td>- Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand)</td>
<td>o Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</td>
</tr>
</tbody>
</table>
**VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):**

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>At least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>• New or progressive and persistent infiltrate</td>
<td>• Fever (&gt;38°C or &gt;100.4°F)</td>
<td>• Virus, <em>Bordetella, Legionella, Chlamydia</em> or <em>Mycoplasma</em> identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).)</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>• Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>• Fourfold rise in <em>L. pneumophila</em> serogroup 1 antibody titer to ≥1:128 in pared acute and convalescent sera by indirect IFA.</td>
</tr>
<tr>
<td>• Pneumatoceles, in infants ≤1 year old</td>
<td>AND at least two of the following:</td>
<td>• Detection of <em>L. pneumophila</em> serogroup 1 antigens in urine by RIA or EIA</td>
</tr>
<tr>
<td></td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New onset or worsening cough, or dyspnea, or tachypnea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rales or bronchial breath sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand)</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.
**VAP Algorithm (PNU3 Immunocompromised Patients):**

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest radiographs with at least one of the following:</td>
<td>Patient who is immunocompromised has at least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• New or progressive and persistent infiltrate</td>
<td>• Fever (&gt;38°C or &gt;100.4°F)</td>
<td></td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td></td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td></td>
</tr>
<tr>
<td>• Pneumatoceles, in infants ≤1 year old</td>
<td>• New onset or worsening cough, or dyspnea, or tachypnea</td>
<td></td>
</tr>
<tr>
<td>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable</td>
<td>• Rales or bronchial breath sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### VAP Algorithm ALTERNATE CRITERIA (PNU1), for infants ≤1 year old:

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
</table>
| Two or more serial chest imaging test results with at least one of the following:  
  - New or progressive and persistent infiltrate  
  - Consolidation  
  - Cavitation  
  - Pneumatoceles, in infants ≤1 year old  
| Worsening gas exchange (e.g., O₂ desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)  
AND at least three of the following:  
  - Temperature instability  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms)  
  - New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
  - Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting  
  - Wheezing, rales, or rhonchi  
  - Cough  
  - Bradycardia (<100 beats/min) or tachycardia (>170 beats/min) |

### VAP Algorithm ALTERNATE CRITERIA (PNU1), for children >1 year old or ≤12 years old:

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
</table>
| Two or more serial chest imaging test results with at least one of the following:  
  - New or progressive and persistent infiltrate  
  - Consolidation  
  - Cavitation  
  - Pneumatoceles, in infants ≤1 year old  
| At least three of the following:  
  - Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F)  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³)  
  - New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
  - New onset or worsening cough, or dyspnea, apnea, or tachypnea  
  - Rales or bronchial breath sounds  
  - Worsening gas exchange (e.g., O₂ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)  
|
Field Values
1  Yes
2  No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined VAP.

Data Source Hierarchy Guide
1  History and Physical
2  Physician's Notes
3  Progress Notes
4  Case Management/Social Services
5  Nursing Notes/Flow Sheet
6  Triage/Trauma Flow Sheet
7  Discharge Summary

References to Other Databases
- NTDS 2019
## Appendix A
### Discharge Disposition

<table>
<thead>
<tr>
<th>Field Value</th>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Intermediate Care Facility (ICF)</td>
<td>A nursing home providing long-term care less than a skilled level, usually custodial care only.</td>
</tr>
<tr>
<td>7</td>
<td>Skilled Nursing Facility (SNF)</td>
<td>A nursing home or unit which provides skilled nursing or rehabilitation care, less than the level of an inpatient rehabilitation facility.</td>
</tr>
<tr>
<td>8</td>
<td>Hospice</td>
<td>A special way of caring for persons who are terminally ill. Hospice services can be provided in the home or at a nursing facility.</td>
</tr>
<tr>
<td>9</td>
<td>Inpatient Rehabilitation Facility (IRF)</td>
<td>A hospital or part of a hospital which provides intensive (3 hours per day) of rehabilitation therapies to persons with disability from recent injury or illness.</td>
</tr>
<tr>
<td>10</td>
<td>Long Term Acute Care Hospital (LTACH)</td>
<td>A special hospital or part of a hospital that provides treatment for patients who stay, on average, more than 25 days for extended acute care. Most patients are transferred from an intensive or critical care unit.</td>
</tr>
</tbody>
</table>
Appendix B
Calculating ICU Length of Stay and Ventilator Days

<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (2 episodes within one calendar day)</td>
</tr>
<tr>
<td>C.</td>
<td>01/01/11</td>
<td>16:00</td>
<td>01/01/11</td>
<td>18:00</td>
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## Appendix C
### Glossary of Abbreviations

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<td>ACE</td>
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<td>ACS</td>
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<td>ADL</td>
<td>Activities of daily living</td>
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<td>AIS</td>
<td>Abbreviated Injury Scale</td>
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<td>Acute respiratory distress syndrome</td>
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<td>ARF</td>
<td>Acute Renal Failure</td>
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<td>BMI</td>
<td>Body mass index</td>
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<td>BP</td>
<td>Blood pressure</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CHF</td>
<td>Congestive heart failure</td>
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<td>CPAP/BIPAP</td>
<td>Continuous positive airway pressure/variable bi-level positive airway pressure</td>
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<td>Computerized topography</td>
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<td>CVA</td>
<td>Cerebral vascular accident</td>
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<td>DNR</td>
<td>Do not resuscitate</td>
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<tr>
<td>DNR-CC</td>
<td>Do not resuscitate; comfort care only</td>
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<tr>
<td>DNR-CCA</td>
<td>Do not resuscitate; comfort care arrest</td>
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<td>EOA</td>
<td>Esophageal Obturator Airway</td>
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<td>ED</td>
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<td>FAST</td>
<td>Focused assessment with sonography for trauma</td>
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<td>Myocardial infarction</td>
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<td>OPO</td>
<td>Organ Procurement Organization</td>
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<td>PVD</td>
<td>Peripheral vascular disease</td>
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<td>SaO2</td>
<td>Saturation of oxygen in arterial blood</td>
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