

# 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),

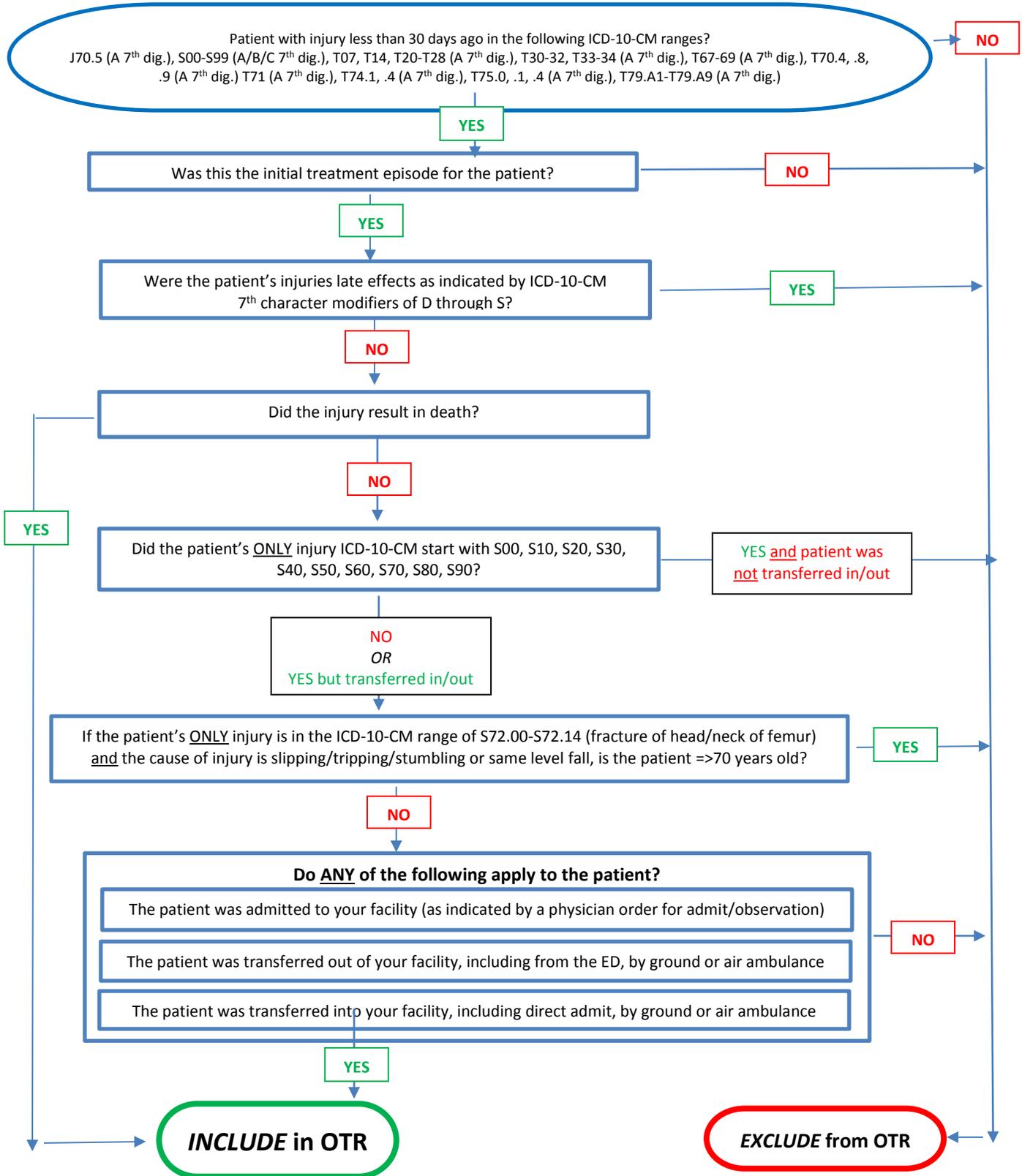
1. The patient must have incurred, no more than 30 days prior to presentation for initial treatment, at least one of the injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):
  - **J70.5 with character modifier of A ONLY** (Respiratory conditions due to smoke inhalation – initial encounter)
  - **S00-S99 with 7<sup>th</sup> 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 7<sup>th</sup> character modifier of A ONLY** (Burns by specified body parts – initial encounter);
  - **T30-T32** (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)
  - **T79.A1-T79.A9 with 7<sup>th</sup> character modifier of A ONLY** (Traumatic compartment syndrome – initial encounter)
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)
- **7<sup>th</sup> character modifiers of D through S** (Late effects)

### OTR TACR Inclusion/Exclusion Decision Tree – ICD-10



## 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-transport 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:
  - 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 accidents 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

## 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

- |   |                                  |    |                           |
|---|----------------------------------|----|---------------------------|
| 1 | Finance, Insurance, Real Estate  | 8  | Construction              |
| 2 | Manufacturing                    | 9  | Government                |
| 3 | Retail Trade                     | 10 | Natural Resources, Mining |
| 4 | Transportation, Public Utilities | 11 | Information Services      |
| 5 | Agriculture, Forestry, Fishing   | 12 | Wholesale Trade           |
| 6 | Professional, Business Services  | 13 | Leisure, Hospitality      |
| 7 | Education, Health Services       | 14 | Other Services            |

### 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

- |   |   |
|---|---|
| 1 Business, Financial Operations Occupations      | 13 Computer, Mathematical Occupations         |
| 2 Architecture, Engineering Occupations           | 14 Life, Physical, Social Science Occupations |
| 3 Community, Social Services Occupations          | 15 Legal Occupations                          |
| 4 Education, Training, Library Occupations        | 16 Arts, Design, Entertainment, Sports, Media |
| 5 Healthcare Practitioners, Technical Occupations | 17 Healthcare Support Occupations             |
| 6 Protective Service Occupations                  | 18 Food Preparation, Serving Related          |
| 7 Building, Grounds Cleaning & Maintenance        | 19 Personal Care, Service Occupations         |
| 8 Sales & Related Occupations                     | 20 Office, Administrative Support Occupations |
| 9 Farming, Fishing, Forestry Occupations          | 21 Construction, Extraction Occupations       |
| 10 Installation, Maintenance, Repair Occupations  | 22 Production Occupations                     |
| 11 Transportation, Material Moving Occupations    | 23 Military Specific Occupations              |
| 12 Management 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                                      | 7 Helmet (e.g., bicycle, skiing, motorcycle)      |
| 2 Lap Belt                                       | 8 Airbag Present                                  |
| 3 Personal Floatation Device                     | 9 Protective Clothing (e.g. padded leather pants) |
| 4 Protective Non-Clothing Gear (e.g. shin guard) | 10 Shoulder Belt                                  |
| 5 Eye Protection                                 | 11 Other  |
| 6 Child Restraint (booster seat, child car seat) |   |

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

### 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

## SIGNS 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

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

### 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 procures 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

### **CARDIOVASCULAR**

Open cardiac massage  
Cardiopulmonary Resuscitation (CPR)

### **CENTRAL NERVOUS SYSTEM**

Insertion of ICP monitor\*  
Ventriculostomy\*  
Cerebral oxygen monitoring\*

### **GASTROINTESTINAL**

Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)  
Gastrostomy/jejunostomy (percutaneous/or endoscopic)  
Percutaneous (endoscopic) gastrojejunoscopy

### **GENITOURINARY**

Ureteric catheterization (i.e. ureteric stent)  
Suprapubic cystostomy

### **MUSCULOSKELETAL**

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

### **RESPIRATORY**

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

### **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.

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Retepase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenecteplase
Lovenox	Eptifibatide	Drotrecogin alpha	kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

### 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:
  - Abnormal limitation in exercise tolerance due to dyspnea or fatigue
  - Orthopnea (dyspnea or lying supine)
  - Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
  - Increased jugular venous pressure
  - Pulmonary rales on physical examination
  - Cardiomegaly
  - 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/PERSONALITY 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

## SUBSTANCE ABUSE DISORDER

---

### 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

## HOSPITAL DISCHARGE ORDER WRITTEN TIME

---

### 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  $\leq$  *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  $\leq$  *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  $\geq 4.0$  mg/dl ( $\geq 353.6$   $\mu\text{mol/l}$ )

**OR**

Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m<sup>2</sup>

**OR**

Urine output <0.3 ml/kg/h for  $\geq 24$  hours

**OR**

Anuria for  $\geq 12$  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 collapse, or nodules
Origin of edema:	Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation:	
Mild	200 mm Hg < PaO <sub>2</sub> /FIO <sub>2</sub> < 300 mm Hg With PEEP or CPAP ≥ 5 cm H <sub>2</sub> O
Moderate	100 mm Hg < PaO <sub>2</sub> /FIO <sub>2</sub> < 200 mm Hg With PEEP >5 cm H <sub>2</sub> O
Severe	PaO <sub>2</sub> /FIO <sub>2</sub> < 100 mm Hg With PEEP or CPAP >5 cm H <sub>2</sub> O

### 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 U TI 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 ( $\geq 38^{\circ}$  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  $> 10^5$  CFU/ml.

### **January 2016 CDC CAUTI Criterion SUTI 2:**

Patient must meet 1, 2, **and** 3 below:

1. Patient is  $\leq 1$  year of age
2. Patient has at least one of the following signs or symptoms:
  - Fever ( $> 38.0^{\circ}$ C)
  - Hypothermia ( $<36.0^{\circ}$ 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  $\geq 10^5$  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 removed, 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  $\leq$  1 year of age has at least one of the following signs or symptoms:

- Fever ( $>38^{\circ}\text{C}$ )
- Hypothermia ( $<36^{\circ}\text{C}$ )
- 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.**

30- day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal Aortic Aneurysm repair	LAM	Laminectomy
AMP	Limb Amputation	LTP	Liver transplant
APPY	Appendix Surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BIBL	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder Surgery	REC	Rectal surgery
COLO	Colon Surgery	SB	Small bowel surgery
CSEC	Cesarean Section	SPLE	Spleen surgery

GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
<b>90- day Surveillance</b>			
<b>Code</b>	<b>Operative Procedure</b>		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with check incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

**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:

- 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)
- 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).
- 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.**

30- day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal Aortic Aneurysm repair	LAM	Laminectomy
AMP	Limb Amputation	LTP	Liver transplant
APPY	Appendix Surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BIBL	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder Surgery	REC	Rectal surgery
COLO	Colon Surgery	SB	Small bowel surgery
CSEC	Cesarean Section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90- day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		

CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with check incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

**Table 3. Specific Sites of an Organ/Space SSI**

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

**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

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## 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
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- 7 Discharge Summary

## References to Other Databases

- NTDS 2019

## PULMONARY EMBOLISM (PE)

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### 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

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### 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

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### 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  $\geq$  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

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### 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
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- 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

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### 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):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul> <p>NOTE: In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest imaging test result is acceptable.</p>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li> <li>• Leukopenia (<math>&lt;4000</math> WBC/<math>\text{mm}^3</math>) or leukocytosis (<math>\geq 12,000</math> WBC/<math>\text{mm}^3</math>)</li> <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> </ul> <p><b>AND at least two of the following:</b></p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., <math>\text{O}_2</math> desaturations (e.g., <math>\text{PaO}_2/\text{FiO}_2 \leq 240</math>), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Organism identified from blood</li> <li>• Organism identified from pleural fluid</li> <li>• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)</li> <li>• <math>\geq 5\%</math> BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)</li> <li>• Positive quantitative culture of lung tissue</li> <li>• Histopathologic exam shows at least <b>one</b> of the following evidences of pneumonia: <ul style="list-style-type: none"> <li>○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</li> <li>○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</li> </ul> </li> </ul>

**VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul> <p>NOTE: In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest imaging test result is acceptable</p>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li> <li>• Leukopenia (<math>&lt;4000</math> WBC/<math>\text{mm}^3</math>) or leukocytosis (<math>\geq 12,000</math> WBC/<math>\text{mm}^3</math>)</li> <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> </ul> <p><b>AND at least two of the following:</b></p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., <math>\text{O}_2</math> desaturations (e.g., <math>\text{PaO}_2/\text{FiO}_2 \leq 240</math>), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Virus, <i>Bordetella</i>, <i>Legionella</i>, <i>Chlamydia</i> or <i>Mycoplasma</i> 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).</li> <li>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</li> <li>• Fourfold rise in Legionella pneumophila serogroup 1 antibody titer to <math>\geq 1:128</math> in paired acute and convalescent sera by indirect IFA.</li> <li>• Detection of <i>L. pneumophila</i> serogroup 1 antigens in urine by RIA or EIA</li> </ul>

**VAP Algorithm (PNU3 Immunocompromised Patients):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest radiographs with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul> <p>NOTE: In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest imaging test result is acceptable</p>	<p>Patient who is immunocompromised has at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li> <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., <math>\text{O}_2</math> desaturations (e.g., <math>\text{PaO}_2/\text{FiO}_2 \leq 240</math>), increased oxygen requirements, or increased ventilator demand)</li> <li>• Hemoptysis</li> <li>• Pleuritic chest pain</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Identification of matching <i>Candida</i> spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.<sup>11,12,13</sup></li> <li>• Evidence of fungi from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: <ul style="list-style-type: none"> <li>○ Direct microscopic exam</li> <li>○ Positive culture of fungi</li> <li>○ Non-culture diagnostic laboratory test</li> </ul> </li> </ul> <p>Any of the following from:  <b>LABORATORY CRITERIA DEFINED UNDER PNU2</b></p>

**VAP Algorithm ALTERNATE CRITERIA (PNU1), for infants ≤1 year old:**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> imaging test result is acceptable.</p>	<p>Worsening gas exchange (e.g., O<sub>2</sub> desaturation [e.g. pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</p> <p><b>AND</b> at least <b>three</b> of the following:</p> <ul style="list-style-type: none"> <li>• Temperature instability</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) <b>or</b> leukocytosis (≥15,000 WBC/mm<sup>3</sup>) and left shift (≥10% band forms)</li> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting</li> <li>• Wheezing, rales, or rhonchi</li> <li>• Cough</li> <li>• Bradycardia (&lt;100 beats/min) or tachycardia (&gt;170 beats/min)</li> </ul>

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest radiograph is acceptable</p>	<p>At least <b>three</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38.0°C or &gt;100.4°F) or hypothermia (&lt;36.0°C or &lt;96.8°F)</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) <b>or</b> leukocytosis (≥15,000 WBC/mm<sup>3</sup>)</li> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, apnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations [e.g., pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</li> </ul>

**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
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- 7 Discharge Summary

**References to Other Databases**

- NTDS 2019

## Appendix A

### Discharge Disposition

Field Value	Variable	Definition
2	Intermediate Care Facility (ICF)	A nursing home providing long-term care less than a skilled level, usually custodial care only.
7	Skilled Nursing Facility (SNF)	A nursing home or unit which provides skilled nursing or rehabilitation care, less than the level of an inpatient rehabilitation facility.
8	Hospice	A special way of caring for persons who are terminally ill. Hospice services can be provided in the home or at a nursing facility.
9	Inpatient Rehabilitation Facility (IRF)	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.
10	Long Term Acute Care Hospital (LTACH)	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.

## Appendix B

### Calculating ICU Length of Stay and Ventilator Days

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was in ICU on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in ICU on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

## Appendix C

### Glossary of Abbreviations

ACE	Angiotensin Converting Enzyme
ACS	Abdominal compartment syndrome; American College of Surgeons
ADL	Activities of daily living
AIS	Abbreviated Injury Scale
ARDS	Acute respiratory distress syndrome
ARF	Acute Renal Failure
BMI	Body mass index
BP	Blood pressure
CDC	Centers for Disease Control and Prevention
CHF	Congestive heart failure
CPAP/BIPAP	Continuous positive airway pressure/variable bi-level positive airway pressure
CT	Computerized topography
CVA	Cerebral vascular accident
DNR	Do not resuscitate
DNR-CC	Do not resuscitate; comfort care only
DNR-CCA	Do not resuscitate; comfort care arrest
DVT	Deep vein thrombosis
EOA	Esophageal Obturator Airway
ED	Emergency department
EMS	Emergency medical services
FAST	Focused assessment with sonography for trauma
FIPS	Federal Information Processing Standard codes
GCS	Glasgow Coma Score
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IgG	Immunoglobulin G
ISS	Injury Severity Score
LMA	Laryngeal Mask Airway
MI	Myocardial infarction
MRI	Magnetic resonance imaging
NTDS	National Trauma Data Standard
OPO	Organ Procurement Organization
OR	Operating Room
OTR	Ohio Trauma Registry
PT	Prothrombin time
PTT	Partial thromboplastin time
PVD	Peripheral vascular disease
SaO <sub>2</sub>	Saturation of oxygen in arterial blood
TACR	Trauma Acute Care Registry
UB-04	Uniform Billing Form-04
XSD	XML (Extensible Markup Language) Schema definition

## CHANGE LOG

September, 2018

Field Name	Change Location	Change Text
INCLUSION CRITERIA	Inclusion Criteria	Removed: O45.8x1-O45.93 (Other and unspecified premature separation of placenta)
PATIENT'S HOME ZIP/POSTAL CODE	Additional Information	Changed: 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.
PATIENT'S HOME STATE	Additional Information	Added: The null value "Not Applicable" is reported for non-US hospitals
PATIENT'S HOME COUNTY	Additional Information	Added: The null value "Not Applicable" is reported for non-US hospitals
PATIENT'S HOME CITY	Additional Information	Added: The null value "Not Applicable" is reported for non-US hospitals
DATE OF BIRTH	Additional Information	Removed: Used to calculate patient age in minutes, hours, day, months, or years
DATE OF BIRTH	Additional Information	Removed: If age is known, but the date of birth is not, enter 01/01/YYYY (YYYY appropriate to patient's known age)
DATE OF BIRTH	Additional Information	Added: Collected as YYYY-MM-DD.
AGE	Additional Information	Removed: Used to calculate patient age in minutes, hours, day, months, or years
AGE	Additional Information	Added: The null value "Not Applicable" is reported if Date of Birth is documented
AGE UNITS	Field Values	Added: 6. Weeks
AGE UNITS	Additional Information	Removed: Used to calculate patient age in minutes, hours, day, months, or years
AGE UNITS	Additional Information	Added: The null value "Not Applicable" is reported if Date of Birth is reported
INJURY INCIDENT DATE	Additional Information	Added: Collected as YYYY-MM-DD.
INJURY INCIDENT TIME	Additional Information	Added: Collected as HH:MM military time
ICD-10 PRIMARY EXTERNAL CAUSE CODE	Additional Information	Changed: 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.
ICD-10 PRIMARY EXTERNAL CAUSE CODE	Additional Information	Added: Multiple Cause Coding Hierarchy
ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE	Additional Information	Removed: Multiple Cause Coding Hierarchy
ICD-10 ADDITIONAL EXTERNAL CAUSE CODE	Additional Information	Removed: External cause codes are used to auto-generate two calculated fields:

		Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based on CDC matrix)
PROTECTIVE DEVICES	Additional Information	Added: 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."
EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY	Additional Information	Added: Collected as YYYY-MM-DD.
EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY	Additional Information	Added: Collected as HH:MM military time
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY	Additional Information	Added: Collected as YYYY-MM-DD.
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY	Additional Information	Added: Collected as HH:MM military time
EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY	Additional Information	Added: Collected as YYYY-MM-DD.
EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY	Additional Information	Added: Collected as HH:MM military time
INITIAL FIELD SYSTOLIC BLOOD PRESSURE	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field systolic blood pressure was NOT measured
INITIAL FIELD PULSE RATE	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured
INITIAL FIELD RESPIRATORY RATE	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field respiratory rate was NOT measured
INITIAL FIELD OXYGEN SATURATION	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field oxygen saturation was NOT measured
INITIAL FIELD GCS - EYE	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Eye was NOT measured
INITIAL FIELD GCS - EYE	Additional Information	Removed: Used to calculate overall GCS - EMS Score

INITIAL FIELD GCS - VERBAL	Additional Information	Removed: Used to calculate overall GCS - EMS Score
INITIAL FIELD GCS - VERBAL	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Verbal was NOT measured
INITIAL FIELD GCS - MOTOR	Additional Information	Removed: Used to calculate overall GCS - EMS Score
INITIAL FIELD GCS - MOTOR	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Motor was NOT measured
INITIAL FIELD GCS - TOTAL	Additional Information	Added: The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Total was NOT measured
ED/HOSPITAL ARRIVAL DATE	Additional Information	Added: Collected as YYYY-MM-DD.
ED/HOSPITAL ARRIVAL TIME	Additional Information	Added: Collected as HH:MM military time
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN	Additional Information	Removed: Only complete if a value is reported for Initial ED/Hospital Oxygen Saturation, otherwise report as "Not Applicable".
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN	Additional Information	Added: The null value "Not Applicable" is reported if the Initial ED/Hospital Oxygen Saturation is "Not Known/Not Recorded"
INITIAL ED/HOSPITAL GCS - EYE	Additional Information	Removed: Used to calculate Overall GCS - ED Score
INITIAL ED/HOSPITAL GCS - EYE	Additional Information	Added: 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.
INITIAL ED/HOSPITAL GCS - VERBAL	Additional Information	Removed: Used to calculate Overall GCS - ED Score
INITIAL ED/HOSPITAL GCS - VERBAL	Additional Information	Added: 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.

INITIAL ED/HOSPITAL GCS - MOTOR	Additional Information	Removed: Used to calculate Overall GCS - ED Score
INITIAL ED/HOSPITAL GCS - MOTOR	Additional Information	Added: 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.
INITIAL ED/HOSPITAL GCS - TOTAL	Additional Information	Added: 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.
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS	Additional Information	Added: 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.
INITIAL ED/HOSPITAL HEIGHT	Additional Information	Added: 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.
INITIAL ED/HOSPITAL WEIGHT	Additional Information	Added: 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.
ED DISCHARGE ORDER WRITTEN DATE	Additional Information	Added: Collected as YYYY-MM-DD.
ED DISCHARGE ORDER WRITTEN TIME	Additional Information	Added: Collected as HH:MM military time
ED DISCHARGE DATE	Additional Information	Added: Collected as YYYY-MM-DD.
ED DISCHARGE TIME	Additional Information	Added: Collected as HH:MM military time
ALCOHOL SCREEN RESULTS	Additional Information	Changed: Collect as X.XX grams per deciliter (g/dl)
ICD-10 HOSPITAL PROCEDURES	Field Values	Changed: Major and minor procedure ICD-10 PCS procedure codes
HOSPITAL PROCEDURE START DATE	Additional Information	Added: Collected as YYYY-MM-DD.

HOSPITAL PROCEDURE START TIME	Additional Information	Added: Collected as HH:MM military time
CO-MORBID CONDITIONS	Data Field	Retired
ADVANCED DIRECTIVE LIMITING CARE	Data Field	NEW
ALCOHOL USE DISORDER	Data Field	NEW
ANGINA PECTORIS	Data Field	NEW
ANTICOAGULANT THERAPY	Data Field	NEW
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)	Data Field	NEW
BLEEDING DISORDER	Data Field	NEW
CEREBRAL VASCULAR ACCIDENT (CVA)	Data Field	NEW
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Data Field	NEW
CHRONIC RENAL FAILURE	Data Field	NEW
CIRRHOSIS	Data Field	NEW
CONGENITAL ANOMALIES	Data Field	NEW
CONGESTIVE HEART FAILURE (CHF)	Data Field	NEW
CURRENT SMOKER	Data Field	NEW
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER	Data Field	NEW
DEMENTIA	Data Field	NEW

DIABETES MELLITUS	Data Field	NEW
DISSEMINATED CANCER	Data Field	NEW
FUNCTIONALLY DEPENDENT HEALTH STATUS	Data Field	NEW
HYPERTENSION	Data Field	NEW
MENTAL/PERSONALITY DISORDERS	Data Field	NEW
MYOCARDIAL INFARCTION (MI)	Data Field	NEW
PERIPHERAL ARTERIAL DISEASE (PAD)	Data Field	NEW
PREMATURITY	Definition	Updated
PREMATURITY	Data Field	NEW
STEROID USE	Data Field	NEW
SUBSTANCE ABUSE DISORDER	Definition	Updated
SUBSTANCE ABUSE DISORDER	Data Field	NEW
ICD-10 INJURY DIAGNOSES	Additional Information	Removed: Used to auto generate additional calculated fields: Abbreviated Injury Scale (six body regions) and Injury Severity
AIS VERSION	Field Values	Added: 7. AIS 2015
AIS VERSION	Field Values	Changed: 6. AIS 05, Updated 08
HOSPITAL COMPLICATIONS	Data Field	Retired
ACUTE KIDNEY INJURY	Data Field	NEW

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)	Data Field	NEW
ALCOHOL WITHDRAWAL SYNDROME	Data Field	NEW
CARDIAC ARREST WITH CPR	Data Field	NEW
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)	Data Field	NEW
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)	Data Field	NEW
DEEP SURGICAL SITE INFECTION	Data Field	NEW
DEEP VEIN THROMBOSIS (DVT)	Data Field	NEW
EXTREMITY COMPARTMENT SYNDROME	Data Field	NEW
MYOCARDIAL INFARCTION (MI)	Data Field	NEW
ORGAN/SPACE SURGICAL SITE INFECTION	Data Field	NEW
OSTEOMYELITIS	Data Field	NEW
PULMONARY EMBOLISM	Definition	Updated to exclude sub segmental PE's.
PULMONARY EMBOLISM	Data Field	NEW
PRESSURE ULCER	Data Field	NEW
SEVERE SEPSIS	Data Field	NEW
STROKE/CVA	Data Field	NEW
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION	Data Field	NEW

UNPLANNED ADMISSION TO ICU	Data Field	NEW
UNPLANNED INTUBATION	Definition	Updated to remove cardiac failure
UNPLANNED INTUBATION	Data Field	NEW
UNPLANNED RETURN TO THE OPERATING ROOM	Data Field	NEW
VENTILATOR-ASSOCIATED PNEUMONIA (VAP)	Data Field	NEW
HOSPITAL DISCHARGE ORDER WRITTEN DATE	Additional Information	Added: Collected as YYYY-MM-DD.
HOSPITAL DISCHARGE ORDER WRITTEN TIME	Additional Information	Added: Collected as HH:MM military time
HOSPITAL DISCHARGE DATE	Additional Information	Added: Collected as YYYY-MM-DD.
HOSPITAL DISCHARGE TIME	Additional Information	Added: Collected as HH:MM military time
DATE OF DEATH	Additional Information	Added: Collected as YYYY-MM-DD.
Appendix B	Appendix B Procedure List	Removed. Contents of list are now contained in ICD-10 Hospital Procedures definition
Appendix C	Appendix C	Removed. Contents of list are now individual fields
Appendix D	Appendix D	Removed. Contents of list are now individual fields
Appendix E	Appendix E	Changed: Appendix E is now Appendix B
Appendix F	Appendix F	Changed: Appendix F is now Appendix C
MULTIPLE	Additional Information	Changed to match NTDS where applicable
MULTIPLE	Data Source Hierarchy Guide	Changed to match NTDS where applicable

MULTIPLE	References to Other Databases	Changed: NTDS 2019
MULTIPLE	Throughout Entire Document	Made minor spelling, grammar, and formatting corrections