

Ohio Trauma Registry 2021

Trauma Acute Care Registry Data Dictionary

Version 2021.0

*This edition is effective for all trauma patients
presenting for treatment on or after January 1, 2021.*



Department of
Public Safety



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.

Trauma Acute Care Registry (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 43223. For more information about the TACR, OTR and/or the State of Ohio's Trauma System, contact the Ohio Department of Public Safety, Division of EMS, Research and Analysis Section, at (800)233-0785, EMSdata@dps.ohio.gov or visit www.ems.ohio.gov.

Table of Contents

ACKNOWLEDGEMENTS.....	2
STATEMENT ABOUT ITDX / TECHNICAL STANDARDS VS. CLINICAL STANDARDS	9
NATIONAL ELEMENTS THAT WILL NOT BE COLLECTED IN THE OHIO TRAUMA ACUTE CARE REGISTRY.....	10
OHIO SPECIFIC ELEMENTS.....	11
DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS).....	12
TACR INCLUSION/EXCLUSION CRITERIA – ICD-10.....	15
OTR TACR INCLUSION/EXCLUSION DECISION TREE – ICD-10	17
COMMON NULL VALUES.....	18
HOSPITAL CODE	19
UNIQUE ADMISSION NUMBER.....	20
TRAUMA TRACKING NUMBER	21
FACILITY TYPE.....	22
PATIENT’S HOME CITY.....	23
PATIENT’S HOME STATE.....	24
PATIENT’S HOME COUNTY.....	25
PATIENT’S HOME ZIP CODE.....	26
PATIENT’S HOME COUNTRY.....	27
ALTERNATE HOME RESIDENCE	28
DATE OF BIRTH.....	29
AGE.....	30
AGE UNITS.....	31
SEX.....	32
RACE.....	33
ETHNICITY.....	34
PRIMARY ICD-10 EXTERNAL CAUSE CODE	35
ADDITIONAL ICD-10 EXTERNAL CAUSE CODE	36
ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE.....	37
WORK-RELATED	38
PATIENT’S OCCUPATIONAL INDUSTRY.....	39
PATIENT’S OCCUPATION	40
INJURY INCIDENT DATE	41

INJURY INCIDENT TIME	42
INCIDENT CITY	43
INCIDENT STATE	44
INCIDENT COUNTY	45
INCIDENT LOCATION ZIP CODE	46
INCIDENT COUNTRY	47
PROTECTIVE DEVICES	48
CHILD SPECIFIC RESTRAINT	49
AIRBAG DEPLOYMENT.....	50
TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL	51
TRANSPORT AGENCY.....	52
OTHER TRANSPORT MODES.....	53
EMS PATIENT CARE REPORT UNIQUE IDENTIFIER (UUID)	54
EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY	55
EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY	56
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY	57
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY	58
EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY	59
EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY	60
INITIAL FIELD SYSTOLIC BLOOD PRESSURE	61
INITIAL FIELD PULSE RATE	62
INITIAL FIELD RESPIRATORY RATE	63
INITIAL FIELD OXYGEN SATURATION	64
INITIAL FIELD GCS - EYE	65
INITIAL FIELD GCS - VERBAL	66
INITIAL FIELD GCS - MOTOR	67
INITIAL FIELD GCS - TOTAL	68
INITIAL FIELD GCS QUALIFIER.....	69
SCENE INTERVENTIONS.....	70
PREHOSPITAL CARDIAC ARREST	71
INTER-FACILITY TRANSFER	72
TRANSFERRING HOSPITAL CODE.....	73

ED/HOSPITAL ARRIVAL DATE	74
ED/HOSPITAL ARRIVAL TIME.....	75
HIGHEST ACTIVATION	76
TRAUMA SURGEON ARRIVAL DATE	77
TRAUMA SURGEON ARRIVAL TIME.....	78
INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	79
INITIAL ED/HOSPITAL PULSE RATE	80
INITIAL ED/HOSPITAL RESPIRATORY RATE	81
INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE.....	82
INITIAL ED/HOSPITAL OXYGEN SATURATION	83
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN.....	84
INITIAL ED/HOSPITAL TEMPERATURE	85
INITIAL ED/HOSPITAL GCS - EYE	86
INITIAL ED/HOSPITAL GCS - VERBAL	87
INITIAL ED/HOSPITAL GCS - MOTOR	88
INITIAL ED/HOSPITAL GCS - TOTAL	89
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS.....	90
HEIGHT	91
WEIGHT	92
ED DISCHARGE ORDER WRITTEN DATE.....	93
ED DISCHARGE ORDER WRITTEN TIME.....	94
ED DISCHARGE DATE.....	95
ED DISCHARGE TIME	96
ED DISCHARGE DISPOSITION	97
ED TRANSFER TO HOSPITAL	98
ALCOHOL SCREEN	99
ALCOHOL SCREEN RESULTS.....	100
DRUG SCREEN	101
ICD-10 HOSPITAL PROCEDURES	102
PROCEDURE EPISODE.....	104
HOSPITAL PROCEDURE START DATE.....	105
HOSPITAL PROCEDURE START TIME	106

ADVANCE DIRECTIVE LIMITING CARE	107
ALCOHOL USE DISORDER	108
ANGINA PECTORIS.....	109
ANTICOAGULANT THERAPY	110
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD).....	111
BLEEDING DISORDER.....	112
CEREBRAL VASCULAR ACCIDENT (CVA)	113
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD).....	114
CHRONIC RENAL FAILURE	115
CIRRHOSIS	116
CONGENITAL ANOMALIES.....	117
CONGESTIVE HEART FAILURE (CHF).....	118
CURRENT SMOKER	119
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER	120
DEMENTIA.....	121
DIABETES MELLITUS.....	122
DISSEMINATED CANCER.....	123
FUNCTIONALLY DEPENDENT HEALTH STATUS.....	124
HYPERTENSION	125
MENTAL/PERSONALITY DISORDERS.....	126
MYOCARDIAL INFARCTION (MI).....	127
PERIPHERAL ARTERIAL DISEASE (PAD).....	128
PREGNANCY	129
PREMATURITY	130
STEROID USE	131
SUBSTANCE USE DISORDER	132
DNR STATUS.....	133
ICD-10 INJURY DIAGNOSES	134
AIS CODE	135
AIS VERSION	136
INJURY SEVERITY SCORE	137
TOTAL ICU LENGTH OF STAY.....	138

TOTAL VENTILATOR DAYS	139
HOSPITAL DISCHARGE ORDER WRITTEN DATE	140
HOSPITAL DISCHARGE ORDER WRITTEN TIME	141
HOSPITAL DISCHARGE DATE	142
HOSPITAL DISCHARGE TIME.....	143
HOSPITAL DISCHARGE DISPOSITION	144
INPATIENT TRANSFER TO HOSPITAL	145
DISCHARGE STATUS	146
DATE OF DEATH	147
PRIMARY METHOD OF PAYMENT	148
AUTOPSY PERFORMED.....	149
ACUTE KIDNEY INJURY (AKI).....	150
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS).....	151
ALCOHOL WITHDRAWAL SYNDROME.....	152
CARDIAC ARREST WITH CPR.....	153
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)	154
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI).....	156
DEEP SURGICAL SITE INFECTION	158
DEEP VEIN THROMBOSIS (DVT)	160
DELIRIUM	161
EXTREMITY COMPARTMENT SYNDROME	162
MYOCARDIAL INFARCTION (MI).....	163
ORGAN/SPACE SURGICAL SITE INFECTION	164
OSTEOMYELITIS.....	166
PULMONARY EMBOLISM (PE).....	167
PRESSURE ULCER.....	168
SEVERE SEPSIS.....	169
STROKE/CVA.....	170
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION	172
UNPLANNED ADMISSION TO ICU	174
UNPLANNED INTUBATION	175
UNPLANNED VISIT TO THE OPERATING ROOM	176

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)..... 177

Appendix A - Discharge Disposition Definitions..... 182

Appendix B - Calculating ICU Length of Stay and Ventilator Days 183

Appendix C - Glossary of Abbreviations..... 184

CHANGE LOG..... 185

STATEMENT ABOUT ITDX / TECHNICAL STANDARDS VS. CLINICAL STANDARDS

The State of Ohio recognizes the ITDX as the transmission standard for 2021. The Ohio Trauma Acute Care Registry Data Dictionary reflects the American College of Surgeons (ACS) reporting requirements adopted by the State of Ohio for 2021. The manner of end-point collection is left to the trauma vendor(s) provided that these vendors are able to meet both State and ACS reporting requirements.

NATIONAL ELEMENTS THAT WILL NOT BE COLLECTED IN THE OHIO TRAUMA ACUTE CARE REGISTRY

The following elements will not be collected and should be defaulted to Not Applicable.

- Initial ED/Hospital GCS 40 – Eye
- Initial ED/Hospital GCS 40 – Verbal
- Initial ED/Hospital GCS 40 – Motor

OHIO SPECIFIC ELEMENTS

- Hospital Code
- Unique Admission Number
- Trauma Tracking Number
- Facility Type
- Transport Agency
- EMS Dispatch Date
- EMS Dispatch Time
- EMS Unit Arrival Date at Scene or Transferring Facility
- EMS Unit Arrival Time at Scene or Transferring Facility
- EMS Unit Departure Date From Scene or Transferring Facility
- EMS Unit Departure Time From Scene or Transferring Facility
- Initial Field Systolic Blood Pressure
- Initial Field Pulse Rate
- Initial Field Respiratory Rate
- Initial Field Oxygen Saturation
- Initial Field GCS Eye
- Initial Field GCS Verbal
- Initial Field GCS Motor
- Initial Field GCS Total
- Initial Field GCS Qualifier
- Scene Interventions
- Transferring Hospital Code
- ED Discharge Order Written Date
- ED Discharge Order Written Time
- ED Transfer to Hospital
- Procedure Episode
- DNR Status
- Injury Severity Score
- Hospital Discharge Order Written Date
- Hospital Discharge Order Written Time
- Inpatient Transfer To Hospital
- Discharge Status
- Date of Death
- Autopsy Performed

DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)

Inclusion Criteria Differences

- Ohio follows NTDS Inclusion Criteria with exceptions:
 - Ohio INCLUDES: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in/out or died.)
 - Note that these codes are excluded when patients with these isolated injuries were **NOT** transferred in/out or died, per NTDS.
 - Ohio INCLUDES:
 - J70.5
 - T20-28
 - T30-32
 - T33
 - T34
 - T67
 - T68
 - T69
 - T70.4
 - T70.8
 - T70.9
 - T71
 - T74.1
 - T74.4
 - T75
 - T75.1
 - T75.4

OH Definition Is Different Than NTDS

- Height
 - OH does not include “within 24 hours or less of ED/Hospital arrival” in definition
- Weight
 - OH does not include “within 24 hours or less of ED/Hospital arrival” in definition

OH Additional Information Is Different Than NTDS

- Patient Home City
 - OH does not include “Only reported when patients home zip postal code is not known not recorded and country is US.”
 - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
- Patient Home State
 - OH does not include “Only reported when patient home zip / postal code is not known / not recorded and country is US.”
 - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
- Patient Home County
 - OH does not include “Only reported when patient home zip / postal code is not known not recorded and country is US.”
 - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”

- Patient Home Zip Code
 - OH does not include “May require adherence to HIPAA regulations.”
- Age
 - OH does not include the “Null value not applicable is reported if date of birth is reported.”
- Age Units
 - OH does not include the “Null value not applicable is reported if date of birth is reported.”
- Incident City
 - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
 - OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
- Incident State
 - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
 - OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
- Incident County
 - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
 - OH does not include the “Null value not applicable is reported if incident location zip postal code is reported.”
- Incident Zip Code
 - NTDS says “Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or CA and can be stored in the postal code format of the applicable country.”
 - Ohio says “Stored as a five-digit code (XXXXX)”
- Transport mode for arrival at your hospital
 - OH added examples
- Other Transport Modes
 - OH added examples
- Height
 - OH does not include “...within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
- Weight
 - OH does not include “...within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
- Hospital Procedure Start Date
 - OH added “Linked to hospital procedures element”
- Hospital Procedure Start Time
 - OH added “Linked to hospital procedures element”
 - OH added “If distinct procedures with the same procedure code are performed, their start time must be different”

Other Element Name and Definition Differences

- ED Discharge Order Written Date
- ED Discharge Order Written Time
 - These are Ohio specific elements. However, they match in definition to NTDS ED Discharge Date and ED Discharge Time

- ED Discharge Date
- ED Discharge Time
 - These are NTDS elements, however the Ohio definition is different

- Hospital Discharge Order Written Date
- Hospital Discharge Order Written Time
 - These are Ohio specific elements. However, they match in definition to NTDS Hospital Discharge Date and Hospital Discharge Time

- Hospital Discharge Date
- Hospital Discharge Time
 - These are NTDS elements, however the Ohio definition is different

Element Value Differences

- ED Discharge Disposition
 - Ohio added “12 Interventional Radiology (IR)”
- Primary Method of Payment
 - Ohio added “8 Workers Compensation”

Edit Check Differences

- For element Hospital Procedure Start Date, the following edit check should not be present:
 - 6607 Hospital Procedure Start Date is later than Hospital Discharge Order Written Date. (Note: NTDS refers to this field as Hospital Discharge Date – Ohio has a different definition for this field.)
- For element Hospital Procedure Start Time, the following edit check should not be present:
 - 6707 Hospital Procedure Start Time is later than Hospital Discharge Order Written Time. (Note: NTDS refers to this field as Hospital Discharge Time – Ohio has a different definition for this field.)

NOTE: Reference to this section is included on each individual element page that is affected by the differences listed.

TACR INCLUSION/EXCLUSION CRITERIA – ICD-10

TRAUMA PATIENT DEFINITION

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 within 14 days of initial hospital encounter and meeting the following:

PATIENT INCLUSION CRITERIA

To be included in the Trauma Acute Care Registry (TACR):

The patient must have incurred at least one of the injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):

- **J70.5 with character modifier of A ONLY** (Respiratory conditions due to smoke inhalation – initial encounter)
- **S00-S99 with 7th character modifier of A, B or C ONLY** (Injuries to specific body parts – initial encounter):
- **T07** (Unspecified multiple injuries);
- **T14** (Injury of unspecified body region);
- **T20-T28 with 7th character modifier of A ONLY** (Burns by specified body parts – initial encounter);
- **T30-T32** (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 7th character modifier of A ONLY** (Traumatic compartment syndrome – initial encounter)
- **S00, S10, S20, S30, S40, S50, S60, S70, S80, S90** (Patients with these isolated injuries that were transferred in/out or died.)

PATIENT EXCLUSION CRITERIA

Patients with the following isolated ICD-10-CM codes are **EXCLUDED** from the TACR:

- **S00, S10, S20, S30, S40, S50, S60, S70, S80, S90** (Patients with these isolated injuries that were **not** transferred in/out or died would be excluded.);
- **7th character modifiers of D through S** (Late effects)

THE PATIENT MUST ALSO IN ADDITION TO THE ABOVE INCLUSION CRITERIA

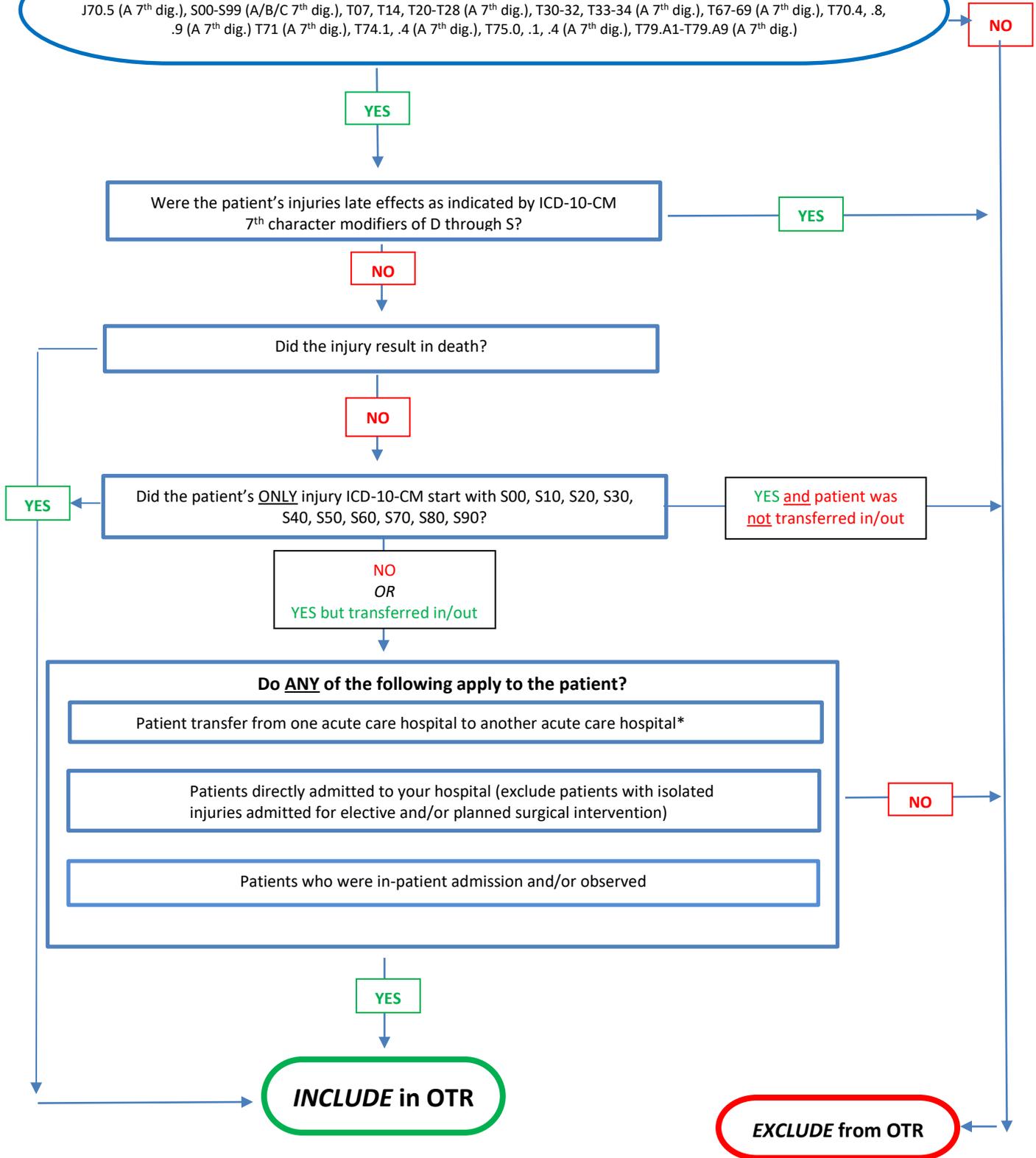
- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status);
OR
- Patient transfer from one acute care hospital* to another acute care hospital;
OR
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention);
OR
- Patients who were an in-patient admission and/or observed.

*Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for short-term illness or condition). “CMS Data Navigator Glossary of Terms” https://www.cms.gov/Research-Statistics-Data-and-systems/Research/ResearchGeninfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed January 15, 2019).

NOTE: INCLUSION / EXCLUSION CRITERIA differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

OTR TACR INCLUSION/EXCLUSION DECISION TREE – ICD-10

Patient sustaining a traumatic injury within 14 days of initial hospital encounter in the following ICD-10-CM ranges?
 J70.5 (A 7th dig.), S00-S99 (A/B/C 7th dig.), T07, T14, T20-T28 (A 7th dig.), T30-32, T33-34 (A 7th dig.), T67-69 (A 7th dig.), T70.4, .8,
 .9 (A 7th dig.) T71 (A 7th dig.), T74.1, .4 (A 7th dig.), T75.0, .1, .4 (A 7th dig.), T79.A1-T79.A9 (A 7th dig.)



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.

Element 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 element. To ascertain their allowability by data field, see the “Accepts Null Value” notation on every data element descriptor page.
- *Not Applicable (Element 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 (Element 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

- NTDS 2021

HOSPITAL CODE

Definition

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

Element 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

References to Other Databases

- Not an NTDS element

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.

Element 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

References to Other Databases

- Not an NTDS Element

TRAUMA TRACKING NUMBER

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

References to Other Databases

- Not an NTDS Element

FACILITY TYPE

Definition

Facility Type is the type of facility at time of admission, transfer in or transfer out for each patient.

Element Values

- 1 Free Standing Emergency Department
- 2 Acute Care Hospital
- 3 Adult Trauma 1
- 4 Adult Trauma 2
- 5 Adult Trauma 3
- 6 Pediatric Trauma 1
- 7 Pediatric Trauma 2

Common Null Values

- Not Accepted

References to Other Databases

- Not an NTDS Element

PATIENT'S HOME CITY

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- 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 2021

NOTE: PATIENT HOME CITY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- 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 2021

NOTE: PATIENT HOME STATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME COUNTY

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- 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 2021

NOTE: PATIENT HOME COUNTY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME ZIP CODE

Definition

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

Element 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 2021

NOTE: PATIENT HOME ZIP CODE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME COUNTRY

Definition

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character FIPS codes representing the 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 2021

ALTERNATE HOME RESIDENCE

Definition

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

Element 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
- Report all that apply

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

DATE OF BIRTH

Definition

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

Element 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 2021

AGE

Definition

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

Element 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.

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 2021

NOTE: AGE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

AGE UNITS

Definition

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

Element 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.

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 2021

NOTE: AGE UNITS differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

SEX

Definition

The patient's sex.

Element Values

- 1 Male
- 2 Female
- 3 Non-binary

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 2021

RACE

Definition

Race is the patient's race.

Element 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 2021

ETHNICITY

Definition

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

Element 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 2021

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.

Element 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
- ICD-10-CM codes are accepted for this data element. Activity codes should not be reported for this data element.
- 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 2021

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.

Element 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 for this data element
- Report all that apply (maximum 2)
- 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 2021

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.

Element 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 2021

WORK-RELATED

Definition

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

Element Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- If work-related, two additional data elements 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 2021

PATIENT'S OCCUPATIONAL INDUSTRY

Definition

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

Element 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 2021

PATIENT'S OCCUPATION

Definition

Patient's Occupation is the occupation of the patient.

Element 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 2021

INJURY INCIDENT DATE

Definition

Injury Incident Date is the date that the injury occurred.

Element 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 2021

INJURY INCIDENT TIME

Definition

Injury Incident Time is the time of day that the injury occurred.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM 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 2021

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.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town.
- 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 2021

NOTE: INCIDENT CITY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- 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 2021

NOTE: INCIDENT STATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- 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 2021

NOTE: INCIDENT COUNTY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

INCIDENT LOCATION ZIP CODE

Definition

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

Element 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 2021

NOTE: INCIDENT LOCATION ZIP CODE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element 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 2021

PROTECTIVE DEVICES

Definition

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

Element 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
- Element 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 element value “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 Element 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 2021

CHILD SPECIFIC RESTRAINT

Definition

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

Element 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 Element 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 2021

AIRBAG DEPLOYMENT

Definition

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

Element 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 Element 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 2021

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.

Element 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, bicycle or personal vehicle
- 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 2021

NOTE: TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

TRANSPORT AGENCY

Definition

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

Element 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 element

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.

Element 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*
- The null value “Not Applicable” is reported to indicate that a patient had a single mode of transport.
- Report all that apply with a maximum of 5.
- An example is an ambulance transporting the patient to the helicopter landing zone.

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2021

NOTE: OTHER TRANSPORT MODES differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

EMS PATIENT CARE REPORT UNIQUE IDENTIFIER (UUID)

Definition

The patient's universally unique identifier (UUID) as assigned by the emergency medical service (EMS) agency transporting the patient directly from the scene of injury to your hospital.

Element Values

- Relevant value for data element
- Must be represented in canonical form, matching the following regular expression:
[a-fA-F0-9]{8}-[a-fA-F0-9]{4}-[1-5][a-fA-F0-9]{3}-[89abAB][a-fA-F0-9]{3}-[afA-F0-9]{12}

Additional Information

- A sample UUID is: e48cd734-01cc-4da4-ae6a-915b0b1290f6
- Assigned by the transporting EMS agency in accordance with the IETF RFC 4122 standard
- The null value "Not Applicable" must be reported for all patients where **Inter-facility Transfer** is *Element Value* "1. Yes".
- The null value "Not Known/Not Recorded" should be reported if the UUID is not documented on the EMS Run Report or if the EMS provider is not NEMESIS v3.5.0 compliant.
- The null value "Not Applicable" must be reported for all patients where **Transport Mode** is *Element Values* "4. Private/Public Vehicle/Walk-in", "5. Police", "6. Other" or if patient is not transported from the scene of

Data Source Hierarchy Guide

- 1 EMS Run Report

References to Other Databases

- NTDS 2021

EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY

Definition

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

Element 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.
- 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

- Not an NTDS element

EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM 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.
- 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

- Not an NTDS element

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).

Element 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).
- 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

- Not an NTDS element

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).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM 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).
- 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

- Not an NTDS element

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).

Element 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).
- 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

- Not an NTDS element

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).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM 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).
- 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

- Not an NTDS element

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Definition

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

Element 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 systolic blood pressure was NOT measured

Data Source Hierarchy Guide

- 1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD PULSE RATE

Definition

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

Element 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

- Not an NTDS element

INITIAL FIELD RESPIRATORY RATE

Definition

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

Element 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*
- 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

- Not an NTDS element

INITIAL FIELD OXYGEN SATURATION

Definition

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

Element 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

- Not an NTDS element

INITIAL FIELD GCS - EYE

Definition

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

Element 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

- Not an NTDS element

INITIAL FIELD GCS - VERBAL

Definition

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

Element 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

- Not an NTDS element

INITIAL FIELD GCS - MOTOR

Definition

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

Element 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

- Not an NTDS element

INITIAL FIELD GCS - TOTAL

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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

- Not an NTDS element

INITIAL FIELD GCS QUALIFIER

Definition

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

Element 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 element 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 element

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.

Element 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 element

PREHOSPITAL CARDIAC ARREST

Definition

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

Element 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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

INTER-FACILITY TRANSFER

Definition

Was the patient transferred to your facility from another acute care facility?

Element Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- Patients transferred from a private doctor's office or stand-alone ambulatory surgery centers are NOT considered inter-facility transfers.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

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.

Element 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 element

ED/HOSPITAL ARRIVAL DATE

Definition

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

Element 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
- 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 2021

ED/HOSPITAL ARRIVAL TIME

Definition

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

Element 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 HHMM military time

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 2021

HIGHEST ACTIVATION

Definition

Patient received the highest level of trauma activation at your hospital.

Element Values

- 1 Yes
- 2 No

Additional Information

- Highest level of activation is defined by your hospital's criteria.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were downgraded after arrival to your center.
- INCLUDE: patients who received a lower level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were upgraded to the highest level of trauma activation.
- EXCLUDE: patients who received the highest level of trauma activation after emergency department (ED) discharge.

Data Source Hierarchy Guide

- 1 Triage/Trauma Flow Sheet
- 2 ED Record
- 3 History & Physical
- 4 Physician Notes
- 5 Discharge Summary

References to Other Databases

- NTDS 2021

TRAUMA SURGEON ARRIVAL DATE

Definition

The date the first trauma surgeon arrived at the patient's bedside.

Element Values

Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD.
- Limit reporting to the 24 hours after ED/Hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- The null value "Not Applicable" is reported if the data element *Highest Activation* is reported as *Element Value* "2. No."

Data Source Hierarchy Guide

- 1 Triage/Trauma Flow Sheet
- 2 History & Physical
- 3 Physician Notes
- 4 Nursing Notes

References to Other Databases

- NTDS 2021

TRAUMA SURGEON ARRIVAL TIME

Definition

The time the first trauma surgeon arrived at the patient's bedside.

Element Values

Relevant value for data element

Additional Information

- Collected as HHMM military time.
- Limit reporting to the 24 hours after ED/Hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- The null value "Not Applicable" is reported if the data element *Highest Activation* is reported as *Element Value* "2. No."

Data Source Hierarchy Guide

- 1 Triage/Trauma Flow Sheet
- 2 History & Physical
- 3 Physician Notes
- 4 Nursing Notes

References to Other Databases

- NTDS 2021

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.

Element 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 2021

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.

Element 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 2021

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).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If documented, report additional element *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 2021

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.

Element 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 2021

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.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If documented, report additional element *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 2021

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.

Element 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 2021

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.

Element 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 2021

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.

Element 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 2021

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.

Element 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 2021

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.

Element 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 2021

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.

Element 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 2021

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.

Element 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 element 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 2021

HEIGHT

Definition

Height is the patient's height in centimeters.

Element 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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

NOTE: HEIGHT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

WEIGHT

Definition

Weight is the patient's weight in kilograms.

Element 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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

NOTE: WEIGHT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element Values

- Relevant value for data element

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 "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 element

NOTE: ED DISCHARGE ORDER WRITTEN DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element Values

- Relevant value for data element

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 "5. Deceased/Expired," then ED Discharge Time is the time of death as indicated on the patient's death certificate
- Collected as HHMM 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 element

NOTE: ED DISCHARGE ORDER WRITTEN TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE DATE

Definition

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

Element Values

- Relevant value for data element

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 "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 2021 (element name only)

NOTE: ED DISCHARGE DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE TIME

Definition

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

Element Values

- Relevant value for data element

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 "5. Deceased/Expired," then ED Discharge Time is the time of death as indicated on the patient's death certificate
- Collected as HHMM 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 2021 (element name only)

NOTE: ED DISCHARGE TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE DISPOSITION

Definition

The disposition unit the order was written for the patient to be discharged from the ED.

Element 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.) | 12 Interventional Radiology |

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"
- If multiple orders were written, report the final disposition order

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 2021

NOTE: ED DISCHARGE DISPOSITION differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED TRANSFER TO HOSPITAL

Definition

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

Element 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 element

ALCOHOL SCREEN

Definition

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

Element 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 2021

ALCOHOL SCREEN RESULTS

Definition

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

Element 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 2021

DRUG SCREEN

Definition

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

Element 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 2021

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.

Element 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 of hospitalization. In this case, report only the first event. If there is no asterisk, report each 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 2021

PROCEDURE LIST FOR *HOSPITAL PROCEDURES* ELEMENT

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).

Element 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 element is linked to the *Hospital Procedures* element
- Leave element 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 element

HOSPITAL PROCEDURE START DATE

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This element is linked to the Hospital Procedures element
- 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 2021

NOTE: HOSPITAL PROCEDURE START DATE differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

HOSPITAL PROCEDURE START TIME

Definition

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

Element 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 the procedure started).
- If distinct procedures with the same procedure code are performed, their start time must be different.
- This element is linked to the Hospital Procedures element
- Collected as HHMM 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 2021

NOTE: HOSPITAL PROCEDURE START TIME differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ADVANCE DIRECTIVE LIMITING CARE

Definition

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

Element 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 2021

ALCOHOL USE DISORDER

Definition

Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient's medical record.

Element Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- 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 2021

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.

Element 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 2021

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
Pentasaccharide	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

Element 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.
- Anticoagulant must be part of the patient's active medication.

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 2021

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

Definition

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

Element 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 2021

BLEEDING DISORDER

Definition

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

Element 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 2021

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).

Element 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 2021

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Definition

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used but are now included within the COPD diagnosis.

Element 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), 2019.
- 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 2021

CHRONIC RENAL FAILURE

Definition

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

Element 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 2021

CIRRHOSIS

Definition

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

Element 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 2021

CONGENITAL ANOMALIES

Definition

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

Element 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 2021

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.

Element 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 2021

CURRENT SMOKER

Definition

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

Element 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 2021

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Definition

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

Element 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 2021

DEMENTIA

Definition

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

Element 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 2021

DIABETES MELLITUS

Definition

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

Element 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 2021

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.

Element 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 2021

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).

Element 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 2021

HYPERTENSION

Definition

History of persistent elevated blood pressure requiring medical therapy.

Element 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 2021

MENTAL/PERSONALITY DISORDERS

Definition

History of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record:

- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Social Anxiety Disorder
- Post-traumatic Stress Disorder
- Antisocial Personality Disorder

Element Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- 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 2021

MYOCARDIAL INFARCTION (MI)

Definition

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

Element 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 2021

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.

Element 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 2021

PREGNANCY

Definition

Pregnancy confirmed by lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient's medical record.

Element Values

- 1 Yes
- 2 No

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 2021

PREMATURITY

Definition

Babies born before 37 weeks of pregnancy are completed.

Element 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 2021

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.

Element 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 2021

SUBSTANCE USE DISORDER

Definition

Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient's medical record:

- Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
- Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder; Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder
- Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
- Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
- Stimulant Use Disorder; Other Stimulant-Induced Disorder; Other Stimulant-Related Disorder

Element Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- Present prior to arrival at your center
- Consistent with the 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 2021

DNR STATUS

Definition

DNR Status documents the presence of signed DNR paperwork 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.

Element 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 element 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"
- DNR Status is to be collected at time of discharge if patient has multiple status changes during stay
- Refer to Ohio Department of Health for additional details: <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/do-not-resuscitate-comfort-care>

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 element

ICD-10 INJURY DIAGNOSES

Definition

Injury Diagnoses related to all identified injuries.

Element 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 element

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 2021

AIS CODE

Definition

The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.

Element Values

- The code is the 8-digit AIS code

Additional Information

Data Source Hierarchy Guide

- 1 AIS Coding Manual

References to Other Databases

- NTDS 2021

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.

Element 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 2021

INJURY SEVERITY SCORE

Definition

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

Element 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 element

TOTAL ICU LENGTH OF STAY

Definition

The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.

Element Values

- Relevant value for data element

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.
- The null value "Not Known / Not Recorded" is reported if any dates are missing.
- 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.
- The null value "Not applicable" is reported if the patient had no ICU days according to the above definition.
- See Appendix B for examples of ICU LOS calculations

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

TOTAL VENTILATOR DAYS

Definition

The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.

Element 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.
- The null value "Not known / Not Recorded" is reported if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.
- See Appendix B 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 2021

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.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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 element

NOTE: HOSPITAL DISCHARGE ORDER WRITTEN DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

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.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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 HHMM 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 element

NOTE: HOSPITAL DISCHARGE ORDER WRITTEN TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE DATE

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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 2021 (element name only)

NOTE: HOSPITAL DISCHARGE DATE differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

HOSPITAL DISCHARGE TIME

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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 HHMM 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 2021 (element name only)

NOTE: HOSPITAL DISCHARGE TIME differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

HOSPITAL DISCHARGE DISPOSITION

Definition

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

Element 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

- Element value "6. Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).
- Element 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 Element Values above, which is why there are numbering gaps.
- Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- If multiple orders were written, report the final disposition order.

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 2021

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.

Element 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 element

DISCHARGE STATUS

Definition

Discharge Status is whether the patient left your hospital alive or dead.

Element 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 element

DATE OF DEATH

Definition

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Only complete element 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 element

PRIMARY METHOD OF PAYMENT

Definition

Primary Method of Payment is the primary source of payment for hospital care.

Element 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 Element 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 2021

NOTE: PRIMARY METHOD OF PAYMENT differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

AUTOPSY PERFORMED

Definition

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

Element 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, element 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 element

ACUTE KIDNEY INJURY (AKI)

Definition

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

KDIGO (Stage 3) Table:

(SCr) 3 times baseline

OR

Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 $\mu\text{mol/l}$)

OR

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

OR

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

OR

Anuria for ≥ 12 hours

Element 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 2021

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	$200 \text{ mm Hg} < \text{PaO}_2/\text{FIO}_2 < 300 \text{ mm Hg}$ With PEEP or CPAP $\geq 5 \text{ cm H}_2\text{O}$
Moderate	$100 \text{ mm Hg} < \text{PaO}_2/\text{FIO}_2 < 200 \text{ mm Hg}$ With PEEP $> 5 \text{ cm H}_2\text{O}$
Severe	$\text{PaO}_2/\text{FIO}_2 < 100 \text{ mm Hg}$ With PEEP or CPAP $> 5 \text{ cm H}_2\text{O}$

Element 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 2021

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).

Element 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 2019 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 2021

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.

Element 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 whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.
- INCLUDE patients who, after arrival at your hospital, 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 2021

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 more than 2 consecutive days in an inpatient location and then removed, the date of the event for the U TI must be day of device discontinuation or the next day for the UTI to be catheter-associated.

January 2019 CDC CAUTI Criterion SUTI 1a:

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

1. Patient had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of the event 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): Reminder: to use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE.
 - Suprapubic tenderness with no other recognized cause
 - Costovertebral angle pain or tenderness
 - Urinary urgency
 - Urinary frequency
 - dysuria
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 2019 CDC CAUTI Criterion SUTI 2:

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

1. Patient is ≤ 1 year of age
2. Patient has at least one of the following signs or symptoms:
 - Fever ($> 38.0^{\circ}$ C)
 - Hypothermia ($<36.0^{\circ}$ C)
 - Apnea
 - Bradycardia
 - Lethargy
 - Vomiting
 - Suprapubic tenderness

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.

Element 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 2019 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 2021

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.

Element 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 2021

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 purposed 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	OVRV	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		

Element 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 2019 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 2021

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.

Element 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 2021

DELIRIUM

Definition

Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

OR

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM or the Intensive Care Delirium Screening Checklist (ICDSC).

OR

A diagnosis of delirium documented in the patient's medical record.

Element Values

- 1 Yes
- 2 No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patient's whose delirium is due to alcohol withdrawal.

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 Discharge Summary

References to Other Databases

- NTDS 2021

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.

Element 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 2021

MYOCARDIAL INFARCTION (MI)

Definition

An acute myocardial infarction must be noted with documentation of ECG changes indicative of acute MI

AND

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

AND

Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center

Element Values

- 1 Yes
- 2 No

Additional Information

- Must have occurred during the patient's 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 2021

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	OVRV	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		

Element 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 2019 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 2021

OSTEOMYELITIS

Definition

Osteomyelitis must meet at least one of the following criteria:

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

AND at least one of the following:

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

*With no other recognized cause

Element Values

- 1 Yes
- 2 No

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

PULMONARY EMBOLISM (PE)

Definition

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

Element 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 2021

PRESSURE ULCER

Definition

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

Element 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 2021

SEVERE SEPSIS

Definition

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

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

Element 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 2021

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.)

Element 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 2021

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition

Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

Involves only skin or subcutaneous tissue of the incision

AND

Patient has at least **one** of the following:

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

AND

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

- Pain or tenderness
 - Localized swelling
 - Erythema
 - Heat
 - A culture or non-culture based test that has a negative finding does not meet this criterion
- d. Diagnosis of Superficial incisional SSI by the surgeon or attending physician** or other designee.

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

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

Element 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 2019 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 2021

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.

Element 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 2021

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.

Element 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 2021

UNPLANNED VISIT TO THE OPERATING ROOM

Definition

Patients with an unplanned operative procedure OR patients returned to the operating room after initial operation management of a related previous procedure.

Element Values

- 1 Yes
- 2 No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Pre-planned, staged and/or procedures for incidental findings.
- EXCLUDE: Operative management related to a procedure that was initially performed prior to arrival at your center.

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 2021

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 one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤ 1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</p>	<p>At least one of the following:</p> <ul style="list-style-type: none"> • Fever ($>38^{\circ}\text{C}$ or $>100.4^{\circ}\text{F}$) • Leukopenia (<4000 WBC/mm^3) or leukocytosis ($\geq 12,000$ WBC/mm^3) • For adults ≥ 70 years old, altered mental status with no other recognized cause <p>AND at least two of the following:</p> <ul style="list-style-type: none"> • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations (e.g., $\text{PaO}_2/\text{FiO}_2 \leq 240$), increased oxygen requirements, or increased ventilator demand) 	<p>At least one of the following:</p> <ul style="list-style-type: none"> • Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) • $\geq 5\%$ BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least one of the following evidences of pneumonia: <ul style="list-style-type: none"> ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

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 one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤ 1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable</p>	<p>At least one of the following:</p> <ul style="list-style-type: none"> • Fever ($>38^{\circ}\text{C}$ or $>100.4^{\circ}\text{F}$) • Leukopenia (<4000 WBC/mm^3) or leukocytosis ($\geq 12,000$ WBC/mm^3) • For adults ≥ 70 years old, altered mental status with no other recognized cause <p>AND at least two of the following:</p> <ul style="list-style-type: none"> • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations (e.g., $\text{PaO}_2/\text{FiO}_2 \leq 240$), increased oxygen requirements, or increased ventilator demand) 	<p>At least one of the following:</p> <ul style="list-style-type: none"> • 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). • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia) • Fourfold rise in Legionella pneumophila serogroup 1 antibody titer to $\geq 1:128$ in paired acute and convalescent sera by indirect IFA. • Detection of <i>L. pneumophila</i> serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm (PNU3 Immunocompromised Patients):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest radiographs with at least one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤ 1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable</p>	<p>Patient who is immunocompromised has at least one of the following:</p> <ul style="list-style-type: none"> • Fever ($>38^{\circ}\text{C}$ or $>100.4^{\circ}\text{F}$) • For adults ≥ 70 years old, altered mental status with no other recognized cause • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations (e.g., $\text{PaO}_2/\text{FiO}_2 \leq 240$), increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain 	<p>At least one of the following:</p> <ul style="list-style-type: none"> • Identification of matching <i>Candida</i> spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.^{11,12,13} • 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"> ○ Direct microscopic exam ○ Positive culture of fungi ○ Non-culture diagnostic laboratory test <p>Any of the following from: LABORATORY CRITERIA DEFINED UNDER PNU2</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 one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable.</p>	<p>Worsening gas exchange (e.g., O₂ desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)</p> <p>AND at least three of the following:</p> <ul style="list-style-type: none"> • Temperature instability • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable</p>	<p>At least three of the following:</p> <ul style="list-style-type: none"> • Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O₂ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Element 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 2019 CDC defined VAP.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2021

Appendix A - Discharge Disposition Definitions

Element 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 ₂	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, 2020

Field Name	Change Location	Change Text
STATEMENT ABOUT ITDX		CHANGED TO: The State of Ohio recognizes the ITDX as the transmission standard for 2021. The Ohio Trauma Acute Care Registry Data Dictionary reflects the American College of Surgeons (ACS) reporting requirements adopted by the State of Ohio for 2021. The manner of end-point collection is left to the trauma vendor(s), provided that these vendors are able to meet both State and ACS reporting requirements.
NATIONAL ELEMENTS THAT WILL NOT BE COLLECTED IN THE OHIO TRAUMA ACUTE CARE REGISTRY ELEMENTS		REMOVED: <ul style="list-style-type: none"> • Initial Field GCS 40 – Eye • Initial Field GCS 40 – Verbal • Initial Field GCS 40 – Motor
OHIO SPECIFIC ELEMENTS		NEW
DIFFERENCES BETWEEN OHIO AND NTDS		NEW
SEX	ELEMENT VALUE	ADDED: "3. Non-binary
EMS PATIENT CARE REPORT UNIQUE IDENTIFIER (UUID)	ELEMENT	NEW
EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element, Total EMS Time (which is the elapsed time from EMS dispatch to hospital arrival)

EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element, Total EMS Time (which is the elapsed time from EMS dispatch to hospital arrival)
EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate additional calculated elements, 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)
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY	ADDITIONAL INFORMATION	REMOVED: 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)
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element, Total EMS Scene Time (which is the elapsed time from EMS scene arrival to scene departure)
EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element Total EMS Scene Time (which is the elapsed time from EMS scene arrival to scene departure)
EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD SYSTOLIC BLOOD PRESSURE	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element, Revised Trauma Score---EMS (adult & pediatric)
INITIAL FIELD SYSTOLIC BLOOD PRESSURE	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD PULSE RATE	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD RESPIRATORY RATE	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element, Revised Trauma Score---EMS (adult & pediatric)
INITIAL FIELD RESPIRATORY RATE	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD OXYGEN SATURATION	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD GCS - EYE	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD GCS - VERBAL	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD GCS - MOTOR	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
INITIAL FIELD GCS - TOTAL	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate an additional calculated element, Revised Trauma Score---EMS (adult & pediatric)

INITIAL FIELD GCS - TOTAL	REFERENCES TO OTHER DATABASES	CHANGED TO: Not an NTDS Element
ED/HOSPITAL ARRIVAL DATE	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate two additional calculated elements: 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).
ED/HOSPITAL ARRIVAL TIME	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate two additional calculated elements: 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).
TRAUMA ACTIVATION LEVEL	ELEMENT	RETIRED
HIGHEST ACTIVATION	ELEMENT	NEW
TRAUMA SURGEON ARRIVAL DATE	ELEMENT	NEW
TRAUMA SURGEON ARRIVAL TIME	ELEMENT	NEW
ED DISCHARGE ORDER WRITTEN DATE	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate additional calculated element, Total ED Time (elapsed time from ED admit to ED discharge)
ED DISCHARGE ORDER WRITTEN TIME	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate additional calculated element, Total ED Time (elapsed time from ED admit to ED discharge)
ED DISCHARGE DATE	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate additional calculated element, Total ED Time (elapsed time from ED admit to ED discharge)
ED DISCHARGE TIME	ADDITIONAL INFORMATION	REMOVED: Used to auto-generate additional calculated element, Total ED Time (elapsed time from ED admit to ED discharge)
ED DISCHARGE DISPOSITION	ELEMENT VALUE	ADDED: 12 Interventional Radiology (IR)
ANTICOAGULANT THERAPY	ADDITIONAL INFORMATION	ADDED: Anticoagulant must be part of the patient's active medication.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	DEFINITION	CHANGED TO: Chronic Obstructive Pulmonary Disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE	ADDITIONAL INFORMATION	CHANGED TO: Consistent with the World Health Organization (WHO), 2019.
HOSPITAL DISCHARGE ORDER WRITTEN DATE	ADDITIONAL INFORMATION	REMOVED: Used to auto generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to Hospital Discharge)
HOSPITAL DISCHARGE ORDER WRITTEN TIME	ADDITIONAL INFORMATION	REMOVED: Used to auto generate an additional calculated element: Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to Hospital Discharge)
HOSPITAL DISCHARGE DATE	ADDITIONAL INFORMATION	REMOVED: Used to auto generate an additional calculated element: Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to Hospital Discharge)
HOSPITAL DISCHARGE TIME	ADDITIONAL INFORMATION	REMOVED: Used to auto generate an additional calculated element: Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to Hospital Discharge)
ALCOHOL WITHDRAWAL SYNDROME	ADDITIONAL INFORMATION	CHANGED TO: Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)	ADDITIONAL INFORMATION	CHANGED TO: 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 more than 2 consecutive days in an inpatient location and then removed, the date of the event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated.
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)	ADDITIONAL INFORMATION	CHANGED TO: Consistent with the January 2019 CDC defined CAUTI.
DEEP SURGICAL SITE INFECTION	ADDITIONAL INFORMATION	CHANGED TO: Consistent with the January 2019 CDC defined SSI.
ORGAN / SPACE SURGICAL SITE INFECTION	ADDITIONAL INFORMATION	CHANGED TO: Consistent with the January 2019 CDC defined SSI.

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION	ADDITIONAL INFOMRATION	CHANGED TO: Consistent with the January 2019 CDC defined SSI.
VENTILATOR- ASSOCIATED PNEUMONIA (VAP)	ADDITIONAL INFOMRATION	CHANGED TO: Consistent with the January 2019 CDC defined VAP.
MULTIPLE	REFERENCES TO OTHER DATABASES	CHANGED TO: NTDS 2021
MULTIPLE	THROUGHOUT ENTIRE DOCUMENT	CHANGED: "Variable" to "Element" where applicable.
MULTIPLE	THROUGHOUT ENTIRE DOCUMENT	CHANGED: "Field" to "Element" where applicable.
MULTIPLE	THROUGHOUT ENTIRE DOCUMENT	ADDED: NOTE: <ELEMENT NAME> differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.