ACKNOWLEDGEMENTS

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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.
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STATEMENT ABOUT ITDX / TECHNICAL STANDARDS VS. CLINICAL STANDARDS

The State of Ohio recognizes the ITDX as the transmission standard. The Ohio Trauma Acute Care Registry Data Dictionary reflects the American College of Surgeons (ACS) reporting requirements adopted by the State of Ohio for 2022. 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:
  o 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.
  o 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
  o OH does not include “within 24 hours or less of ED/Hospital arrival” in definition
• Weight
  o 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
  o OH does not include “Only reported when patients home zip postal code is not known not recorded and country is US.”
  o OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
• Patient Home State
  o OH does not include “Only reported when patient home zip / postal code is not known / not recorded and country is US.”
  o OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
• Patient Home County
  o OH does not include “Only reported when patient home zip / postal code is not known not recorded and country is US.”
  o OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
• Patient Home Zip Code
  o OH does not include “May require adherence to HIPAA regulations.”
• Age
  o OH does not include the “Null value not applicable is reported if date of birth is reported.”
• Age Units
  o OH does not include the “Null value not applicable is reported if date of birth is reported.”
• Incident City
  o OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
  o OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
• Incident State
  o OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
  o OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
• Incident County
  o OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
  o OH does not include the “Null value not applicable is reported if incident location zip postal code is reported.”
• Incident Zip Code
  o 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.”
  o Ohio says “Stored as a five-digit code (XXXXX)”
• Transport mode for arrival at your hospital
  o OH added examples
• Other Transport Modes
  o OH added examples
• Height
  o OH does not include “…within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
• Weight
  o OH does not include “…within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
• Hospital Procedure Start Date
  o OH added “Linked to hospital procedures element”
• Hospital Procedure Start Time
  o OH added “Linked to hospital procedures element”
  o 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.
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 criteria:

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.

*In-house traumatic injuries sustained after initial ED/Hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.


**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.)

YES

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

NO

Did the injury result in death?

NO

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

YES

-or-

YES but transferred in/out

YES and patient was not transferred in/out

DO ANY of the following apply to the patient?

- Patient transfer from one acute care hospital to another acute care hospital*

- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention)

- Patients who were in-patient admission and/or observed

NO

INCLUDE in OTR

EXCLUDE from OTR
COMMON NULL VALUES

Definition

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

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 2022
HOSPITAL CODE

Description

*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

Description

*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

Description
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

Description
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

Description

*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 2022

**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

Description

*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 2022

**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

Description

*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 2022

**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

Description

*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 2022

**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

Description

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 2022
ALTERNATE HOME RESIDENCE

Description

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 Patient’s Home ZIP/Postal 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 2022
DATE OF BIRTH

Description

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 2022
AGE

Description

*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 2022

**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

Description
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 2022

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

**Description**

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 2022
RACE

Description
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 2022
ETHNICITY

Description

*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 2022
PRIMARY ICD-10 EXTERNAL CAUSE CODE

Description

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.
- 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, and terrorism.
  - External cause codes for cataclysmic events 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 2022
ADDITIONAL ICD-10 EXTERNAL CAUSE CODE

Description

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 2022
ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Description

*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 or ICD-10-CA code value for injury event

Common Null Values

- Not Accepted

Additional Information

- Only ICD-10-CM or ICD-10-CA 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 2022
**WORK-RELATED**

**Description**

*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 2022
PATIENT’S OCCUPATIONAL INDUSTRY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- If work related, also report *Patient’s Occupation*
- Based upon US Bureau of Labor Statistics Industry Classification
- Code as NA if injury is not work-related AND Work-Related value is coded is given a value of “2. No”.

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 2022
PATIENT’S OCCUPATION

Description

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

Element Values

<table>
<thead>
<tr>
<th>1</th>
<th>Business, Financial Operations Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Architecture, Engineering Occupations</td>
</tr>
<tr>
<td>3</td>
<td>Community, Social Services Occupations</td>
</tr>
<tr>
<td>4</td>
<td>Education, Training, Library Occupations</td>
</tr>
<tr>
<td>5</td>
<td>Healthcare Practitioners, Technical Occupations</td>
</tr>
<tr>
<td>6</td>
<td>Protective Service Occupations</td>
</tr>
<tr>
<td>7</td>
<td>Building, Grounds Cleaning &amp; Maintenance</td>
</tr>
<tr>
<td>8</td>
<td>Sales &amp; Related Occupations</td>
</tr>
<tr>
<td>9</td>
<td>Farming, Fishing, Forestry Occupations</td>
</tr>
<tr>
<td>10</td>
<td>Installation, Maintenance, Repair Occupations</td>
</tr>
<tr>
<td>11</td>
<td>Transportation, Material Moving Occupations</td>
</tr>
<tr>
<td>12</td>
<td>Management Occupations</td>
</tr>
<tr>
<td>13</td>
<td>Computer, Mathematical Occupations</td>
</tr>
<tr>
<td>14</td>
<td>Life, Physical, Social Science Occupations</td>
</tr>
<tr>
<td>15</td>
<td>Legal Occupations</td>
</tr>
<tr>
<td>16</td>
<td>Arts, Design, Entertainment, Sports, Media</td>
</tr>
<tr>
<td>17</td>
<td>Healthcare Support Occupations</td>
</tr>
<tr>
<td>18</td>
<td>Food Preparation, Serving Related</td>
</tr>
<tr>
<td>19</td>
<td>Personal Care, Service Occupations</td>
</tr>
<tr>
<td>20</td>
<td>Office, Administrative Support Occupations</td>
</tr>
<tr>
<td>21</td>
<td>Construction, Extraction Occupations</td>
</tr>
<tr>
<td>22</td>
<td>Production Occupations</td>
</tr>
<tr>
<td>23</td>
<td>Military Specific Occupations</td>
</tr>
</tbody>
</table>

Common Null Values

- Accepted

Additional Information

- Only report if injury is work related.
- If work related, also report *Patient’s Occupational Industry*.
- Code as NA if injury is not work-related AND Work-Related value is coded is given a value of “2. No”.

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 2022
INJURY INCIDENT DATE

Description

*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 2022
INJURY INCIDENT TIME

Description

*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 2022
INCIDENT CITY

Description

*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 2022

**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

Description

*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 2022

**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

Description

*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 2022

**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

Description

_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).
- If "Not Known/Not Recorded," report variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- 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 2022

**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

Description

*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 2022


PROTECTIVE DEVICES

Description

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

Element Values

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

Common Null Values

- Accepted
- 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 2022
CHILD SPECIFIC RESTRAINT

Description
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 2022
AIRBAG DEPLOYMENT

Description

*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 2022
TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL

Description

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 2022

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

Description

*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

Description

*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 2022

**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)

Description
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 Interfacility 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 NEMSIS 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" or "6. Other".
- If Transport Mode is Element Value "1. Ground Ambulance", "2. Helicopter Ambulance" or "3. Fixed Wing Ambulance" but the patient was not transported from the scene of injury, report the null value "Not Known/Not Recorded."

Data Source Hierarchy Guide
1 EMS Run Report

References to Other Databases
- NTDS 2022
EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY

**Description**
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 interfacility 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

Description
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 interfacility 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

Description
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 interfacility 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

Description
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 interfacility 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
Description
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 interfacility 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

Description
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 interfacility 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

Description
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

Description

*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

Description

*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

Description

*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

Description

*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

Description

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

Description

*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

Description

*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

Description

*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

Description

*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

Description

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

Element Values

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

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 2022
INTERFACILITY TRANSFER

Description
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 interfacility 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 2022
Description

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

Description

*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 2022
ED/HOSPITAL ARRIVAL TIME

Description

*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 2022
HIGHEST ACTIVATION

Description
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 2022
TRAUMA SURGEON ARRIVAL DATE

Description
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 2022
TRAUMA SURGEON ARRIVAL TIME

Description
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 2022
INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Description

*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 2022
INITIAL ED/HOSPITAL PULSE RATE

Description

*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 2022
INITIAL ED/HOSPITAL RESPIRATORY RATE

Description

*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 2022
INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Description

*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 2022
INITIAL ED/HOSPITAL OXYGEN SATURATION

Description

*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 2022
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Description

*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 2022
INITIAL ED/HOSPITAL TEMPERATURE

Description

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 2022
INITIAL ED/HOSPITAL GCS - EYE

Description

*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 2022
INITIAL ED/HOSPITAL GCS - VERBAL

Description

**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 2022
INITIAL ED/HOSPITAL GCS - MOTOR

Description

*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 2022
INITIAL ED/HOSPITAL GCS - TOTAL

Description

*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 2022
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Description

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 2022
HEIGHT

Description

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 2022

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

Description

*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 2022

**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

Description

*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

Description

*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

Description

*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

- Collected as YYYY-MM-DD
- 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.

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 2022 (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

Description

*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

- Collected as HHMM military time
- 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.

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 2022 (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

Description
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 2022

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

Description

*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

Description

*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 2022
ALCOHOL SCREEN RESULTS

Description

*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 2022
DRUG SCREEN

Description

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

Element Values

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

Common Null Values

- Not Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2022
ICD-10 HOSPITAL PROCEDURES

Description

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 procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries or their complications
- Procedures with an asterisk have the potential to be performed multiple times during one episode 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.
- Plain radiography of whole body, Plain radiography of whole skeleton, and Plain radiography of infant whole body to the Diagnostic and Therapeutic Imaging.
- 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 2022
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
Diagnostic imaging interventions on the total body
Plain radiography of whole body
Plain radiography of whole skeleton
Plain radiography of infant whole body

**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 *

**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

*May be performed multiple times during hospitalization
PROCEDURE EPISODE

Description

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

Description

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 2022

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

Description

The time 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 HHMM military time
- 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.

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 2022

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

Description
The patient had a written request to limit life-sustaining treatment that restricted the care for the patient during this patient care event.

Element Values
1  Yes
2  No

Common Null Values
•  Accepted

Additional Information
•  The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center
•  Report Element Value "2. No" for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.
•  Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive cranietomy, operation for hemorrhage control, angiography)
•  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 2022
ALCOHOL USE DISORDER

Description
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 2022
ANGINA PECTORIS

Description
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 including microvascular angina, Prinzmetal's angina, stable angina, unstable angina and variant angina, 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 2022
ANTICOAGULANT THERAPY

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

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

Element Values
1 Yes
2 No

Common Null Values
• Accepted

Additional Information
• Present prior to injury.
• Anticoagulant must be part of the patient’s active medication.
• Exclude patients whose only anticoagulant therapy is chronic Aspirin.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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

References to Other Databases
• NTDS 2022
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

Description
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 2022
BLEEDING DISORDER

Description
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 2022
CEREBRAL VASCULAR ACCIDENT (CVA)

Description
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 2022
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Description
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 2022
CHRONIC RENAL FAILURE

**Description**
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 2022
CIRRHOSIS

Description
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 2022
CONGENITAL ANOMALIES

Description
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.
- Only report on patients ≤18 years-of-age.
- 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.
- The null value "Not Applicable" must be reported for patients > 18-years-of-age.

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 2022
CONGESTIVE HEART FAILURE (CHF)

Description
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:
  o  Abnormal limitation in exercise tolerance due to dyspnea or fatigue
  o  Orthopnea (dyspnea or lying supine)
  o  Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
  o  Increased jugular venous pressure
  o  Pulmonary rales on physical examination
  o  Cardiomegaly
  o  Pulmonary vascular engorgement
•  The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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

References to Other Databases
•  NTDS 2022
CURRENT SMOKER

Description
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 2022
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Description
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 2022
DEMENTIA

Description
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 2022
DIABETES MELLITUS

Description
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 2022
DISSEMINATED CANCER

Description
Cancer that has spread to one or more sites in addition to the primary site AND in 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.
- Another term describing disseminated cancer is "metastatic cancer."
- 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 2022
FUNCTIONALLY DEPENDENT HEALTH STATUS

Description
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 2022
HYPERTENSION

Description
History of persistent elevated blood pressure requiring antihypertensive medication.

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.
•  Report Element Value ‘1. Yes’ for patients who were non-compliant with their prescribed antihypertensive 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 2022
MENTAL/PERSONALITY DISORDERS

Description
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 2022
MYOCARDIAL INFARCTION (MI)

Description
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 2022
PERIPHERAL ARTERIAL DISEASE (PAD)

Description
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 Peripheral Arterial Disease (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 2022
PREGNANCY

Description
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 2022
PREMATURITY

Description
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.
• Only report on patients ≤18 years-of-age.
• 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.
• The null value "Not Applicable" must be reported for patients > 18 years-of-age.

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 2022
STEROID USE

Description
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 2022
SUBSTANCE USE DISORDER

Description
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 2022
DNR STATUS

Description
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

Description

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 2022
AIS CODE

Description
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
None

Data Source Hierarchy Guide
1 AIS Coding Manual

References to Other Databases
- NTDS 2022
AIS VERSION

Description

*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
- 16  AIS 2015

Additional Information

None

Common Null Values

- Accepted

Data Source Hierarchy Guide

1  AIS  Coding Manual

References to Other Databases

- NTDS 2022
INJURY SEVERITY SCORE

Description
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

Additional Information
None

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

Description
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.
- A ‘0’ (zero) in this field is not an acceptable value.
- 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 2022
TOTAL VENTILATOR DAYS

Description
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.
- A ‘0’ (zero) in this field is not an acceptable value.
- 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 2022
HOSPITAL DISCHARGE ORDER WRITTEN DATE

Description

*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 = 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
- The null value “Not Applicable” is reported if ED Discharge Disposition is 5. Deceased/Expired

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

Description

*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

- Collected as HHMM military time
- 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
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 (Deceased/ expired).

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.
Description

*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 = 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
- The null value “Not Applicable” is reported if ED Discharge Disposition is 5. Deceased/Expired

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 2022 (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

Description

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

- Collected as HHMM military time
- 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
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 (Deceased/ expired).

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 2022 (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

Description
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 = 4, 6, 9, 10, or 11.
- The null value “Not Applicable” is reported if ED Discharge Disposition is “5, Deceased/Expired.”
- 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 2022
INPATIENT TRANSFER TO HOSPITAL

Description

*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

Additional Information

None

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element
DISCHARGE STATUS

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

Element Values
1  Alive
2  Dead

Common Null Values
•  Not Accepted

Additional Information
None

Data Source Hierarchy Guide
1  Discharge Summary
2  Progress Notes
3  Billing Sheet

References to Other Databases
•  Not an NTDS element
DATE OF DEATH

Description

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

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

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

Description

*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
5. Medicare
6. Other Government Payer Source
7. Workers Compensation
8. 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 2022

**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

Description
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)

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

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

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

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

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

OR
Anuria for ≥ 12 hours

Element Values
1 Yes
2 No

Additional Information
- Onset of symptoms began after arrival to your ED/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 2022
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Description
Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules
Origin of edema: Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.

Oxygenation:
Mild: 200 mm Hg < PaO2/FIO2 < 300 mm Hg With PEEP or CPAP >= 5 cm H2Oc
Moderate: 100 mm Hg < PaO2/FIO2 < 200 mm Hg With PEEP >5 cm H2O
Severe: PaO2/FIO2 < 100 mm Hg With PEEP or CPAP >5 cm H2O

Element Values
1 Yes
2 No

Additional Information
- Onset of symptoms began after arrival to your ED/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 2022
ALCOHOL WITHDRAWAL SYNDROME

Description
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
- Onset of symptoms began after arrival to your ED/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 2022
CARDIAC ARREST WITH CPR

Description
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
- Onset of symptoms began after arrival to your ED/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 2022
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Description
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 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 (≥ 38⁰ 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 > 10⁵ 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°C)
   • Hypothermia (<36.0°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**
- Onset of symptoms began after arrival to your ED/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 2022
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

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

AND

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

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

AND

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

OR

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

AND

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

AND

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

OR
January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms:

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

AND

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

AND

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

Element Values

1  Yes
2  No

Additional Information

- Onset of symptoms began after arrival to your ED/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 2022
DEEP SURGICAL SITE INFECTION

Description
Must meet the following criteria:

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

AND

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

AND

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

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

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

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

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

**90-day Surveillance**

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

**Element Values**

1. Yes
2. No

**Additional Information**

- Onset of symptoms began after arrival to your ED/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 2022
DEEP VEIN THROMBOSIS (DVT)

Description
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
- Onset of symptoms began after arrival to your ED/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 2022
DELIRIUM

Description
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
- Onset of symptoms began after arrival to your ED/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 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases
- NTDS 2022
MYOCARDIAL INFARCTION (MI)

Description
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
• Onset of symptoms began after arrival to your ED/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 2022
ORGAN/SPACE SURGICAL SITE INFECTION

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

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

AND
Patient has at least one of the following:

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

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

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

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

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</table>

Table 3. Specific Sites of an Organ/Space SSI

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

Element Values
1. Yes
2. No

Additional Information
- Onset of symptoms began after arrival to your ED/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 2022
OSTEOMYELITIS

Description
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/AST)).
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, for example, not Active Surveillance Culture/Testing (ASC/AST) AND Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

b. Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

*With no other recognized cause

Element Values
1. Yes
2. No

Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of osteomyelitis must be documented in the patient’s medical record.
- Consistent with the January 2020 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 2022
PULMONARY EMBOLISM (PE)

Description
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
- Onset of symptoms began after arrival to your ED/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 2022
PRESSURE ULCER

Description
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
- Onset of symptoms began after arrival to your ED/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 2022
SEVERE SEPSIS

Description
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
• Onset of symptoms began after arrival to your ED/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 2022
STROKE/CVA

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

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

AND

- Duration of neurological deficit ≥ 24 h

OR

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

AND

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

AND

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

Element Values
1 Yes
2 No

Additional Information
- Onset of symptoms began after arrival to your ED/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 2022
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Description
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
• Onset of symptoms began after arrival to your ED/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 2022
UNPLANNED ADMISSION TO ICU

Description
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 with a planned post-operative ICU stay.
- INCLUDE: patients who required ICU care due to an event that occurred during surgery or in the PACU.

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 2022
UNPLANNED INTUBATION

Description
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 2022
UNPLANNED VISIT TO THE OPERATING ROOM

Description
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: Non-urgent trachoeostomy and percutaneous endoscopic gastrostomy.
- 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 2022
VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

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

AND

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

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

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


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

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>At least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>• New or progressive and persistent infiltrate</td>
<td>• Fever (&gt;38°C or &gt;100.4°F)</td>
<td>• Virus, <em>Bordetella, Legionella, Chlamydia or Mycoplasma</em> identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>• Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>• Fourfold rise in <em>Legionella. pneumophila</em> serogroup 1 antibody titer to ≥1:128 in pared acute and convalescent sera by indirect IFA.</td>
</tr>
<tr>
<td>• Pneumatoceles, in infants ≤1 year old</td>
<td>AND at least two of the following:</td>
<td>• Detection of <em>L. pneumophila</em> serogroup 1 antigens in urine by RIA or EIA</td>
</tr>
<tr>
<td>NOTE: In patients <strong>without</strong> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable</td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New onset or worsening cough, or dyspnea, or tachypnea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rales or bronchial breath sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### VAP Algorithm (PNU3 Immunocompromised Patients):

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest radiographs with at least <strong>one</strong> of the following:</td>
<td>Patient who is immunocompromised has at least <strong>one</strong> of the following:</td>
<td>At least <strong>one</strong> of the following:</td>
</tr>
<tr>
<td>• New or progressive <strong>and</strong> persistent infiltrate</td>
<td>• Fever (&gt;38°C or &gt;100.4°F)</td>
<td>• Identification of matching <em>Candida</em> spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>• Evidence of fungi from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td>• Direct microscopic exam</td>
</tr>
<tr>
<td>• Pneumatoceles, in infants ≤1 year old</td>
<td>• New onset or worsening cough, or dyspnea, or tachypnea</td>
<td>• Positive culture of fungi</td>
</tr>
<tr>
<td></td>
<td>• Rales or bronchial breath sounds</td>
<td>• Non-culture diagnostic laboratory test</td>
</tr>
<tr>
<td></td>
<td>• Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand)</td>
<td>Any of the following from:</td>
</tr>
<tr>
<td></td>
<td>• Hemoptysis</td>
<td>LABORATORY CRITERIA DEFINED UNDER PNU2</td>
</tr>
<tr>
<td></td>
<td>• Pleuritic chest pain</td>
<td>Any of the following:</td>
</tr>
</tbody>
</table>

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.
VAP Algorithm ALTERNATE CRITERIA (PNU1), for infants ≤1 year old:

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

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.

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

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
</table>
| Two or more serial chest imaging test results with at least one of the following:  
  - New or progressive and persistent infiltrate  
  - Consolidation  
  - Cavitation  
  - Pneumatoceles, in infants ≤1 year old | At least three of the following:  
  - Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F)  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³)  
  - New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
  - New onset or worsening cough, or dyspnea, apnea, or tachypnea  
  - Rales or bronchial breath sounds  
  - Worsening gas exchange (e.g., O₂ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) |

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.
Element Values
1  Yes
2  No

Additional Information
- Onset of symptoms began after arrival to your ED/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 2022
### Appendix A - Discharge Disposition Definitions

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

<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (2 episodes within one calendar day)</td>
</tr>
<tr>
<td></td>
<td>01/01/11</td>
<td>16:00</td>
<td>01/01/11</td>
<td>18:00</td>
<td>1 day (2 episodes within one calendar day)</td>
</tr>
<tr>
<td>C.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td></td>
<td>01/02/11</td>
<td>09:00</td>
<td>01/02/11</td>
<td>18:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>D.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>16:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>E.</td>
<td>01/02/11</td>
<td>09:00</td>
<td>01/02/11</td>
<td>21:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>F.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/01/11</td>
<td>16:00</td>
<td>1 day (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>G.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>H.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>I.</td>
<td>01/02/11</td>
<td>18:00</td>
<td>01/02/11</td>
<td>Unknown</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>J.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>K.</td>
<td>Unknown</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>3 days (patient was in ICU on 3 separate calendar days)</td>
</tr>
<tr>
<td>L.</td>
<td>01/03/11</td>
<td>18:00</td>
<td>01/03/11</td>
<td>20:00</td>
<td>3 days (patient was in ICU on 3 separate calendar days)</td>
</tr>
<tr>
<td>M.</td>
<td>Unknown</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>Unknown (can't compute total)</td>
</tr>
</tbody>
</table>
## Appendix C - Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE</td>
<td>Angiotensin Converting Enzyme</td>
</tr>
<tr>
<td>ACS</td>
<td>Abdominal compartment syndrome; American College of Surgeons</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>AIS</td>
<td>Abbreviated Injury Scale</td>
</tr>
<tr>
<td>ARDS</td>
<td>Acute respiratory distress syndrome</td>
</tr>
<tr>
<td>ARF</td>
<td>Acute Renal Failure</td>
</tr>
<tr>
<td>BMI</td>
<td>Body mass index</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>CPAP/BIPAP</td>
<td>Continuous positive airway pressure/variable bi-level positive airway pressure</td>
</tr>
<tr>
<td>CT</td>
<td>Computerized topography</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebral vascular accident</td>
</tr>
<tr>
<td>DNR</td>
<td>Do not resuscitate</td>
</tr>
<tr>
<td>DNR-CC</td>
<td>Do not resuscitate; comfort care only</td>
</tr>
<tr>
<td>DNR-CCA</td>
<td>Do not resuscitate; comfort care arrest</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep vein thrombosis</td>
</tr>
<tr>
<td>EOA</td>
<td>Esophageal Obturator Airway</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency medical services</td>
</tr>
<tr>
<td>FAST</td>
<td>Focused assessment with sonography for trauma</td>
</tr>
<tr>
<td>FIPS</td>
<td>Federal Information Processing Standard codes</td>
</tr>
<tr>
<td>GCS</td>
<td>Glasgow Coma Score</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, Ninth Revision, Clinical Modification</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>International Classification of Diseases, Tenth Revision, Clinical Modification</td>
</tr>
<tr>
<td>IgG</td>
<td>Immunoglobulin G</td>
</tr>
<tr>
<td>ISS</td>
<td>Injury Severity Score</td>
</tr>
<tr>
<td>LMA</td>
<td>Laryngeal Mask Airway</td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td>NTDS</td>
<td>National Trauma Data Standard</td>
</tr>
<tr>
<td>OPO</td>
<td>Organ Procurement Organization</td>
</tr>
<tr>
<td>OR</td>
<td>Operating Room</td>
</tr>
<tr>
<td>OTR</td>
<td>Ohio Trauma Registry</td>
</tr>
<tr>
<td>PT</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>PTT</td>
<td>Partial thromboplastin time</td>
</tr>
<tr>
<td>PVD</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>SaO2</td>
<td>Saturation of oxygen in arterial blood</td>
</tr>
<tr>
<td>TACR</td>
<td>Trauma Acute Care Registry</td>
</tr>
<tr>
<td>UB-04</td>
<td>Uniform Billing Form-04</td>
</tr>
<tr>
<td>XSD</td>
<td>XML (Extensible Markup Language) Schema definition</td>
</tr>
</tbody>
</table>
Appendix D – Ohio Regional Trauma System Data Dictionary

Ohio contains several regional trauma systems. These are organized, coordinated efforts in a defined geographic area that deliver the full range of care to all injured patients and work together with emergency services and disaster preparedness making efficient use of health care resources to improve patient outcomes in the state of Ohio. Membership in a regional trauma system is voluntary and not generally restricted by a facility’s location.

This “Ohio Regional Data Dictionary” is an effort to collapse individual regional dictionaries into a single unified regional dictionary to improve state, regional and vendor responsiveness during the annual reconciliation with the changes issued by the American College of Surgeons (ACS).

It has been included as a reference in the State of Ohio Trauma Acute Care Registry’s data dictionary and intended as a shared reference and data set common to all regional trauma systems. Specific questions about its contents should be directed to the regional trauma system to which you are a member.

If you are not a member of a regional trauma system then you are not required to collect the items in this appendices. These items are for regional trauma system use only and should not be submitted to the state unless otherwise directed by the Division of EMS.
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**CAUSE CODE**

**Description**

*Cause Code* is the code for the cause or mechanism of injury.

**Element Values**

<table>
<thead>
<tr>
<th>ANIMAL</th>
<th>Animal injury (includes Bite, fall from, and struck by)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSAULT</td>
<td>Assault by person (blunt mechanism)</td>
</tr>
<tr>
<td>BIKE</td>
<td>Bicycle</td>
</tr>
<tr>
<td>BITING</td>
<td>Biting (human)</td>
</tr>
<tr>
<td>BURN</td>
<td>Burns (Chemical, Thermal, Electrical)</td>
</tr>
<tr>
<td>CRUSH</td>
<td>Crush Injury</td>
</tr>
<tr>
<td>CUT</td>
<td>Cut (Unintentional)</td>
</tr>
<tr>
<td>DROWN</td>
<td>Drowning/Submersion</td>
</tr>
<tr>
<td>FALL.SL</td>
<td>Fall same Level</td>
</tr>
<tr>
<td>FALL.MINOR</td>
<td>Fall &lt; 10 feet (not same level fall)</td>
</tr>
<tr>
<td>FALL.MAJOR</td>
<td>Fall &gt; 10 feet</td>
</tr>
<tr>
<td>FALL.NFS</td>
<td>Fall NFS (unwitnessed fall)</td>
</tr>
<tr>
<td>GSW.I</td>
<td>Gun Shot Wound/Firearm – Intentional</td>
</tr>
<tr>
<td>GSW.U</td>
<td>Gun Shot Wound/Firearm – Unintentional</td>
</tr>
<tr>
<td>GSW.S</td>
<td>Gun Shot Wound/Firearm – Self-Inflicted</td>
</tr>
<tr>
<td>GSW.NK</td>
<td>Gun Shot Wound/Firearm – of unknown intent</td>
</tr>
<tr>
<td>INHAL</td>
<td>Inhalation</td>
</tr>
<tr>
<td>MACHINE</td>
<td>Machine</td>
</tr>
<tr>
<td>MCC</td>
<td>Motorcycle Crash</td>
</tr>
<tr>
<td>MVC</td>
<td>Motor Vehicle Crash</td>
</tr>
<tr>
<td>OV</td>
<td>Other Vehicle/Off road (ATV, Golf Cart)</td>
</tr>
<tr>
<td>PED</td>
<td>Pediatric</td>
</tr>
<tr>
<td>SPORT</td>
<td>Sport Injury</td>
</tr>
<tr>
<td>STAB.I</td>
<td>Stabbing/Cut/Pierce – Intentional</td>
</tr>
<tr>
<td>STAB.U</td>
<td>Stabbing/Pierce - Unintentional</td>
</tr>
<tr>
<td>STAB.S</td>
<td>Stabbing/Cut/Pierce – Self-Inflicted</td>
</tr>
<tr>
<td>STAB.NK</td>
<td>Stabbing/Cut/Pierce – of unknown intent</td>
</tr>
<tr>
<td>STRUCK</td>
<td>Struck by or against</td>
</tr>
<tr>
<td>SUFF</td>
<td>Suffocation/Hanging/Asphyxiation</td>
</tr>
<tr>
<td>WATERCRAFT</td>
<td>Watercraft</td>
</tr>
<tr>
<td>UNK</td>
<td>Unknown (Found down)</td>
</tr>
</tbody>
</table>

**Common Null Values**

- Not Accepted

**Additional Information**

- The Primary E-Code assigned should correlate with the patient’s cause code.
- See Appendix E for additional clarifications

**Data Source Hierarchy Guide**

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Documentation
INJURY DETAILS

Description

*Injury Details* is a free text description that describes the circumstances of how the patient was injured.

Element Values

- Relevant value for data element

Additional Information

- Include as many details as possible
- Recommended examples:
  - 23-year old male, restrained driver, was T-boned by a tractor-trailer on the driver’s side of the car, positive LOC, from Scene
  - 56-year old female fell down a flight of basement stairs and struck her head on the concrete floor, denies LOC, transfer by EMS from OSH

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Documentation
SCENE DELAY

Description

*Scene Delay* is if there was a delay on the scene by EMS due to the patient being entrapped and requiring extrication (i.e. vehicle, building, trench, etc.) or due to scene circumstances delaying care being provided to the patient.

Element Values

1. Yes
2. No

Common Null Values

- Accepted

Additional Information

- Examples of Scene Delay are:
  - The “Jaws of Life” was used to extricate a patient from a vehicle, building or other confined structure
  - Debris was moved off the patient
  - Patient was placed in a safety basket and air lifted out of a flooded stream or deep trench
  - Access to building where EMS has to wait to be taken to patient, or due to unsafe environment such as active shooter or hoarder house.
- “Not-applicable” (NA) is used to indicate that a patient was not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Documentation
4. Medical Records
TRAUMA TYPE

Description

Trauma Type is injury to human tissues or organs resulting from the transfer of energy from the environment to the human body, in which the human body lacks resilience to resist the energy transference. Trauma refers to critical injury that threatens life or permanent loss of function of a body part. There are five classifications of trauma, also referred to as trauma type. Trauma Type is the classification of the trauma.

Element Values

A  Asphyxia
B  Blunt Trauma
P  Penetrating Trauma
TH Thermal
OTHER Other

Common Null Values

- Not Accepted

Additional Information

- Enter the trauma type which causes the highest injury severity
- Penetrating Trauma: Injury resulting from a projectile or thrust foreign object with perforation of tissues and underlying structures.
- Blunt Trauma: Injury secondary to a violent diffuse force that displaces tissues and or underlying structures. It also or the absence of oxygen as in asphyxiation from smoke or drowning.
- Thermal: Injury as a result of exposure to extreme temperatures of heat or cold, including chemical and electrical burns
- Asphyxia: Injury as a result of inhalation or carbon monoxide intoxication, drowning, asphyxiation, hanging, strangulation, or suffocation.
- Other: Injury as a result of none of the above choices, such as overexertion resulting in injury
- Enter the injury type that causes the most serious injury as determined by the attending physician.

Data Source Hierarchy Guide

1  EMS Run Sheet
2  Triage Form/Trauma Flow Sheet
3  ED Documentation
4  E-Code Matrix
5  Discharge Summary
TRAUMA ACTIVATION LEVEL*

Description

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

Element Values

1. Highest Level of Activation
2. Intermediate Level of Activation
3. Lowest Level of Activation (includes consults)
4. No Trauma Activation

Common Null Value

- Accepted

Additional Information

- Enter a common null value of “Not Applicable” if your facility does not have a trauma service and is NOT a verified trauma center.
- 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 2022
- Ohio Trauma Registry, Trauma Acute Care Registry 2022

*Element Values different than NTDS and OTR
ADMITTING SPECIALTY

Description

*Admitting Specialty* is the medical specialty of the attending physician who admits the patient to your hospital.

Element Values

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Admitted (Died in your ED, transferred to another facility or discharged home)</td>
</tr>
<tr>
<td>1</td>
<td>General Adult Surgery</td>
</tr>
<tr>
<td>2</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>3</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>4</td>
<td>General Pediatric Surgery</td>
</tr>
<tr>
<td>5</td>
<td>Burn Service</td>
</tr>
<tr>
<td>6</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>7</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>8</td>
<td>All Other Surgical Services</td>
</tr>
<tr>
<td>9</td>
<td>All Other Non-Surgical Services</td>
</tr>
<tr>
<td>10</td>
<td>Cardio Thoracic Surgery</td>
</tr>
<tr>
<td>11</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>12</td>
<td>Hand Surgery</td>
</tr>
<tr>
<td>13</td>
<td>Microvascular Surgery</td>
</tr>
<tr>
<td>14</td>
<td>OBGYN Surgery</td>
</tr>
<tr>
<td>15</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>16</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>17</td>
<td>Urology</td>
</tr>
<tr>
<td>18</td>
<td>Intensivist/ Critical Care</td>
</tr>
<tr>
<td>19</td>
<td>Geriatrics</td>
</tr>
<tr>
<td>20</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>21</td>
<td>Trauma - Pediatric</td>
</tr>
<tr>
<td>22</td>
<td>Trauma – Adult</td>
</tr>
<tr>
<td>23</td>
<td>Oral-Maxillofacial Surgery</td>
</tr>
<tr>
<td>24</td>
<td>Pediatrics</td>
</tr>
</tbody>
</table>

Additional Information

- This is not necessarily the service to which the patient is designated upon admission to the hospital, but the medical specialty of the patient’s attending physician

Common Null Value

- Accepted

Data Source Hierarchy Guide

1. ED Record
2. Trauma Flow Sheet
3. Billing/Registration Sheet
4. History & Physical
PROCEDURE LOCATION

Description
Procedure Location documents the location of the procedures performed while the patient was in your hospital.

Element Values
1 Emergency Department
2 Operating Room
3 ICU
4 Floor
5 Radiology
6 Other Specialty Area
7 Interventional radiology (IR)
8 Stepdown/Telemetry Unit
9 Observation Unit
10 Post Anesthesia Care Unit

Additional Information
- Include only those procedures performed at your hospital.
- This field is linked to the Hospital Procedures Field
- Other Specialty Area includes: Endo, cardiac cath lab, dialysis, etc.

Common Null Value
- Accepted

Data Source Hierarchy Guide
1 Operative Reports
2 Procedure Notes
3 ED and ICU Records
4 Trauma Flow Sheet
5 Nursing Notes
6 Radiology Reports
7 Anesthesia Record
8 Billing Sheet/Medical Records Coding Summary Sheet
9 Hospital Discharge Summary
# HOSPITAL PROCEDURE CODE

**Description**

*Hospital Procedure Code* is all operative or essential procedures conducted on the patient during his/her stay at your hospital.

**Element Values**

- All values for data element

<table>
<thead>
<tr>
<th>At minimum:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGRAM</td>
</tr>
<tr>
<td>BBOARD</td>
</tr>
<tr>
<td>PRBC</td>
</tr>
<tr>
<td>FFP</td>
</tr>
<tr>
<td>CELL</td>
</tr>
<tr>
<td>CRYO</td>
</tr>
<tr>
<td>MASS</td>
</tr>
<tr>
<td>PLAT</td>
</tr>
<tr>
<td>CCOLLAR</td>
</tr>
<tr>
<td>CENTLINE</td>
</tr>
<tr>
<td>CRANI</td>
</tr>
<tr>
<td>CHEST</td>
</tr>
<tr>
<td>CLRDF</td>
</tr>
<tr>
<td>CPR</td>
</tr>
<tr>
<td>CT</td>
</tr>
<tr>
<td>CTA</td>
</tr>
<tr>
<td>CTABD</td>
</tr>
<tr>
<td>CTCHEST</td>
</tr>
<tr>
<td>CTFACE</td>
</tr>
<tr>
<td>CTHEAD</td>
</tr>
<tr>
<td>CTPELVIS</td>
</tr>
<tr>
<td>CTSPINE</td>
</tr>
<tr>
<td>CTA</td>
</tr>
<tr>
<td>CTABD</td>
</tr>
<tr>
<td>CTCHEST</td>
</tr>
<tr>
<td>CTFACE</td>
</tr>
<tr>
<td>CTHEAD</td>
</tr>
<tr>
<td>CTPELVIS</td>
</tr>
<tr>
<td>CTSPINE</td>
</tr>
</tbody>
</table>
Additional Information

- Operative and/or essential procedures are defined as procedures performed in the Operating Room, Emergency Department, and/or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient’s specific injuries or their complications at your hospital.
- Include only procedures performed at your hospital.
- At a minimum, the procedures listed should be captured. The hospital may choose to capture additional procedures for internal use. Procedures included in the Procedures List that are designated with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- FAST is defined as a rapid bedside ultrasound examination 'Focused Assessment with Sonography for Trauma'

Data Source Hierarchy Guide

1 Operative Reports
2 ED and ICU Records
3 Trauma Flow Sheet
4 Anesthesia Record
5 Billing Sheet/Medical Records Coding Summary Sheet
6 Hospital Discharge Summary
INJURY DIAGNOSES DESCRIPTION

Description

_Injury Diagnoses Description_ is a free text element of the patient’s description for all injuries identified at your ED/hospital for this injury event that match the corresponding ICD-10 assigned. Diagnoses must be confirmed by a physician at your facility.

Element Values

- Relevant Value for Data Element

Additional Information

- Provide detailed information of injury
  - Example: Right femur fx, comminuted and displaced
  - Scalp laceration, 7 cm
- Can be utilized to generate Abbreviated Injury Score and Injury Severity Score
- The maximum number of diagnoses that may be reported for an individual patient is 50

Common Null Values

- Accepted

Data Source Hierarchy Guide

1. Autopsy Report
2. Operative Report
3. Discharge Summary
4. Trauma Flow Sheet
5. Radiology Results
6. Billing Sheet/Medical Records Coding Summary Sheet
7. ED and ICU Records
ISS BODY REGION

Description

*ISS Body Region* is the Injury Severity Score assigned by body region codes that reflects the patient’s injury(ies) diagnosed at your ED/hospital for this injury event.

Element Values

1. Head or Neck
2. Face
3. Chest
4. Abdominal or Pelvic Contents
5. Extremities or Pelvic Girdle
6. External

Additional Information

- Field value #1, *Head or Neck*, includes injury to the brain, skull, cervical spine and/or cervical spine fractures
- Field value #2, *Face*, includes those areas involving the mouth, ears, nose and/or facial bones
- Field value #3, *Chest*, includes all lesions to internal organs within the chest, diaphragm, rib cage and/or thoracic spine
- Field value #4, *Abdominal or Pelvic Contents*, includes all lesions to internal organs within the abdomen and lumbar spine
- Field value #5, *Extremities or Pelvic Girdle*, includes sprains, dislocations, fractures and amputations *except for the spinal column, skull and rib cage*
- Field value #6, *External*, includes injuries such as lacerations, contusions, abrasions and burns independent of their location on the body surface

Common Null Values

- Accepted

Data Source Hierarchy Guide

1. Autopsy Report
2. Operative Report
3. Discharge Summary
4. Trauma Flow Sheet
5. Radiology Results
6. Billing Sheet/Medical Records Coding Summary Sheet
7. ED and ICU Records
LENGTH OF STAY

Description

*Length of Stay documents* the total number of days that the patient occupied a bed while in your hospital.

Element Values

- Relevant value for data element

Additional Information

- This field is calculated from data in the “Hospital Arrival Date” and “Discharge Date” fields, automatically.
- Recorded in full day increments with any partial calendar day counted as a full calendar day.

Data Source Hierarchy Guide

1. Registration Form
2. Discharge Form
SCENE EMS RUN REPORT PRESENT

Description

*Scene EMS Run Report Present* documents whether the run report generated by EMS at the injury scene is found in the patient’s medical record.

- For patients transported from the scene of injury to your hospital, this is the run report transporting the patient to your facility from the scene.

Element Values

0  Yes, EMS scene run sheet is present in hospital medical record after registrar intervention (Trauma Registrar had to contact agency to obtain the EMS scene run sheet)
1  Yes, EMS run sheet is present in hospital medical record (Trauma Registrar did not have to contact agency to obtain EMS scene run sheet)
2  No, EMS run sheet is not present in hospital medical record

Additional Information

- If the patient arrives by any means other than ground or air EMS (i.e. private vehicle, walk-in, law enforcement, etc.) then enter the appropriate code for NA
- “Non-applicable” (NA) is used to indicate that a patient was not transported by EMS.

Common Null Value

- Accepted

Data Source Hierarchy Guide

1  EMS Run Sheet
INJURY DIAGNOSES KNOWN

Description
_Injury Diagnoses Known_ is the location in which the diagnoses were captured by the trauma registrar.

Element Values
- **T** Transfer In/ Referring
- **O** Own Facility Documentation
- **A** Autopsy
- **AO** Autopsy Only – Only found in autopsy – No other methods

Additional Information
- **T** Example - if a diagnosis was captured from a CT completed at the referring facility ONLY then option T - transfer in/ Referring would be reported.

- **O** Example - if a diagnosis was identified/ documented at your facility then option O – Own facility Documentation would be reported. In the scenario when your facility confirms a diagnosis initially identified by T - the transfer in/ referring facility report it as own facility

- **A** Example –
  - If diagnosis was identified by facility in which patient expired and was confirmed on Autopsy, without changing AIS code, change your diagnosis known from O - Own facility documentation to A – Autopsy
  - If diagnosis was identified by facility in which patient expired and autopsy findings change the initially assigned ICD-10/ AIS code, change your diagnosis known from O - Own facility documentation to A – Autopsy

- **AO** – Example –
  - If a diagnosis was identified/ documented during the autopsy findings that were NOT identified at O- your own facility, enter AO – Autopsy Only.

Common Null Values
- Not Accepted
<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANIMAL</td>
<td>Animal Injury (Including but not limited to, bite, fall from and struck by)</td>
</tr>
<tr>
<td>ASSAULT</td>
<td>Assault by person (blunt mechanism only)</td>
</tr>
<tr>
<td>BICYCLE</td>
<td>Any accident involving a bicyclist</td>
</tr>
<tr>
<td>BITING</td>
<td>Human bite only</td>
</tr>
<tr>
<td>BURN</td>
<td>Burn – Chemical, Thermal, Electrical, or Other</td>
</tr>
<tr>
<td>CRUSH</td>
<td>Crushing mechanism</td>
</tr>
<tr>
<td>CUT</td>
<td>Cut – UNINTENTIONAL only</td>
</tr>
<tr>
<td>DROWN</td>
<td>Drowning/ Submersion</td>
</tr>
<tr>
<td>FALL.SL</td>
<td>Any fall from standing (feet on ground), may include subsequent strike against object</td>
</tr>
<tr>
<td>FALL.MINOR</td>
<td>Any fall &lt;10 feet that is not a same level fall</td>
</tr>
<tr>
<td>FALL.MAJOR</td>
<td>Any fall &gt;/= 10 feet</td>
</tr>
<tr>
<td>FALL.NFS</td>
<td>Use only if no details stated about the fall, unwitnessed fall</td>
</tr>
<tr>
<td>GSW.I</td>
<td>Gunshot wound/ firearm injury – intentional (not self-inflicted)</td>
</tr>
<tr>
<td>GSW.U</td>
<td>Gunshot wound/ firearm injury – unintentional</td>
</tr>
<tr>
<td>GSW.S</td>
<td>Gunshot wound/ firearm injury – intentionally self-inflicted</td>
</tr>
<tr>
<td>GSW.NK</td>
<td>Gunshot wound/ firearm injury of unknown/ unspecified intent</td>
</tr>
<tr>
<td>INHAL</td>
<td>Smoke or chemical inhalation type injuries</td>
</tr>
<tr>
<td>MACHINE</td>
<td>Injury caused by machinery</td>
</tr>
<tr>
<td>MCC</td>
<td>Motorcycle related injuries</td>
</tr>
<tr>
<td>MVC</td>
<td>Cars, trucks, vans, SUV’s on roads or parking lots etc.</td>
</tr>
<tr>
<td>OV</td>
<td>All off road and other vehicles not included elsewhere.</td>
</tr>
<tr>
<td></td>
<td>(ATVs, snowmobiles, riding lawnmowers, 4-wheelers, golf carts, etc.)</td>
</tr>
<tr>
<td>PED</td>
<td>Person walking (or using their typical mode of mobility) struck by motor vehicle.</td>
</tr>
<tr>
<td></td>
<td>(If a person uses a wheelchair, scooter, or other such conveyance to get around, they are still considered a pedestrian though they are not walking)</td>
</tr>
<tr>
<td>SPORT</td>
<td>Injury sustained while person is involved in playing a sport (recreational or organized). Also includes fall from skateboard, skis, snowboard etc.</td>
</tr>
<tr>
<td>STAB.I</td>
<td>Stabbing/ Cut/ Pierce – intentional (not self-inflicted)</td>
</tr>
<tr>
<td>STAB.U</td>
<td>Stabbing/ Pierce – unintentional</td>
</tr>
<tr>
<td>STAB.S</td>
<td>Stabbing/ Cut/ Pierce – intentionally self-inflicted</td>
</tr>
<tr>
<td>STAB.NK</td>
<td>Stabbing/ Cut/ Pierce injury of unknown/ unspecified intent</td>
</tr>
<tr>
<td>STRUCK</td>
<td>Struck by or against a person or object (not intentionally by someone)</td>
</tr>
<tr>
<td>SUFF</td>
<td>Suffocation, Hanging, or Asphyxiation</td>
</tr>
<tr>
<td>WATERCRAFT</td>
<td>Injury involving any boat (including jet skis), to include anything pulled behind watercraft (water skis, inner tubes, etc.)</td>
</tr>
<tr>
<td>UNK</td>
<td>Unknown (Found Down)</td>
</tr>
</tbody>
</table>
# CHANGE LOG

## January, 2022

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Change Location</th>
<th>Change Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Various</td>
<td>CHANGED: Corrected multiple spelling variations to “interfacility” throughout document.</td>
</tr>
<tr>
<td>Ohio Regional Data Dictionary (ORDD)</td>
<td>Appendix D</td>
<td>ADDED: The final 2022 regional data dictionary contents.</td>
</tr>
<tr>
<td>ORDD Reference Item</td>
<td>Appendix E</td>
<td>ADDED: INJURY MECHANISM DEFINITION (Ohio Regional Data Dictionary) Reference appendix item.</td>
</tr>
<tr>
<td>STATEMENT ABOUT ITDX</td>
<td></td>
<td>CHANGED TO: The State of Ohio recognizes the ITDX as the transmission standard. The Ohio Trauma Acute Care Registry Data Dictionary reflects the American College of Surgeons (ACS) reporting requirements adopted by the State of Ohio for 2022. 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.</td>
</tr>
<tr>
<td>TACR to EXCLUSION CRITERIA – ICD-10</td>
<td></td>
<td>ADDED: *In-house traumatic injuries sustained after initial ED/Hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.</td>
</tr>
<tr>
<td>EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)</td>
<td>Additional Information</td>
<td>ADDED: If Transport Mode is Element Value &quot;1. Ground Ambulance&quot;, &quot;2. Helicopter Ambulance&quot; or &quot;3. Fixed Wing Ambulance&quot; but the patient was not transported from the scene of injury, report the null value &quot;Not Known/Not Recorded.&quot;</td>
</tr>
<tr>
<td>EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)</td>
<td>Additional Information</td>
<td>CHANGED: The null value &quot;Not Applicable&quot; must be reported for all patients where Transport Mode is Element Values &quot;4. Private/Public Vehicle/Walk-in&quot;, &quot;5, Police&quot; or &quot;6. Other&quot;.</td>
</tr>
<tr>
<td>ICD-10 HOSPITAL PROCEDURES</td>
<td>Additional Information</td>
<td>ADDED: Plain radiography of whole body, Plain radiography of whole skeleton, and Plain radiography of infant whole body to the Diagnostic and Therapeutic Imaging.</td>
</tr>
<tr>
<td>ADVANCED DIRECTIVE LIMITING CARE (Pre-Existing Condition)</td>
<td>Additional Information</td>
<td>ADDED: Report Element Value &quot;2. No&quot; for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.</td>
</tr>
<tr>
<td>ADVANCED DIRECTIVE LIMITING CARE (Pre-Existing Condition)</td>
<td>Additional Information</td>
<td>ADDED: The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center</td>
</tr>
<tr>
<td>Condition Type</td>
<td>Status</td>
<td>Additional Information</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>ADVANCED DIRECTIVE LIMITING CARE (Pre-Existing Condition)</strong></td>
<td><strong>ADDED</strong></td>
<td><strong>ADDED:</strong> Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography).</td>
</tr>
<tr>
<td><strong>ANGINA PECTORIS (Pre-Existing Condition)</strong></td>
<td><strong>CHANGED TO:</strong></td>
<td><strong>CHANGED TO:</strong> A diagnosis of angina including microvascular angina, Prinzmetal’s angina, stable angina, unstable angina and variant angina, must be documented in the patient's medical record.</td>
</tr>
<tr>
<td><strong>CONGENITAL ANOMALIES (Pre-Existing Condition)</strong></td>
<td><strong>Only report on patients ≤18 years-of-age.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CONGENITAL ANOMALIES (Pre-Existing Condition)</strong></td>
<td><strong>The null value &quot;Not Applicable&quot; must be reported for patients &gt; 18 years-of-age.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DISSEMINATED CANCER (Pre-existing Condition)</strong></td>
<td><strong>CHANGED TO:</strong></td>
<td><strong>CHANGED TO:</strong> &quot;Another term describing disseminated cancer is &quot;metastatic cancer.&quot;&quot;</td>
</tr>
<tr>
<td><strong>HYPERTENSION (Pre-Existing Condition)</strong></td>
<td><strong>ADDED:</strong></td>
<td><strong>ADDED:</strong> Report Element Value ‘1. Yes’ for patients who were non-compliant with their prescribed antihypertensive medication.</td>
</tr>
<tr>
<td><strong>PREMATURITY (Pre-existing Condition)</strong></td>
<td><strong>Only report on patients ≤18 years-of-age.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PREMATURITY (Pre-existing Condition)</strong></td>
<td><strong>The null value &quot;Not Applicable&quot; must be reported for patients &gt; 18 years-of-age.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ACUTE KIDNEY INJURY (Hospital Event)</strong></td>
<td><strong>REMOVED:</strong></td>
<td><strong>REMOVED:</strong> Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td><strong>ACUTE KIDNEY INJURY (Hospital Event)</strong></td>
<td><strong>ADDED:</strong></td>
<td><strong>ADDED:</strong> Onset of symptoms began after arrival to your ED/hospital.</td>
</tr>
<tr>
<td><strong>ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS) (Hospital Event)</strong></td>
<td><strong>REMOVED:</strong></td>
<td><strong>REMOVED:</strong> Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td><strong>ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS) (Hospital Event)</strong></td>
<td><strong>ADDED:</strong></td>
<td><strong>ADDED:</strong> Onset of symptoms began after arrival to your ED/hospital.</td>
</tr>
<tr>
<td><strong>ALCOHOL WITHDRAWAL SYNDROME (Hospital Event)</strong></td>
<td><strong>REMOVED:</strong></td>
<td><strong>REMOVED:</strong> Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td><strong>ALCOHOL WITHDRAWAL SYNDROME (Hospital Event)</strong></td>
<td><strong>ADDED:</strong></td>
<td><strong>ADDED:</strong> Onset of symptoms began after arrival to your ED/hospital.</td>
</tr>
<tr>
<td><strong>CARDIAC ARREST WITH CPR (Hospital Event)</strong></td>
<td><strong>REMOVED:</strong></td>
<td><strong>REMOVED:</strong> Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>Condition</td>
<td>Event Description</td>
<td>Additional Information</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>CARDIAC ARREST WITH CPR (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI) (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI) (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI) (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI) (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>DEEP SURGICAL SITE INFECTION (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>DEEP SURGICAL SITE INFECTION (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>DEEP VEIN THROMBOSIS (DVT) (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>DEEP VEIN THROMBOSIS (DVT) (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>DELIRIUM (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>DELIRIUM (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>MYOCARDIAL INFARCTION (MI) (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>MYOCARDIAL INFARCTION (MI) (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>ORGAN/SPACE SURGICAL SITE INFECTION (Hospital Event)</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
<td></td>
</tr>
<tr>
<td>Hospital Event</td>
<td>Additional Information</td>
<td>Change</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>ORGAN/SPACE SURGICAL SITE INFECTION (Hospital Event)</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
<td></td>
</tr>
<tr>
<td>OSTEOMYELITIS (Hospital Event)</td>
<td>Additional Information</td>
<td>UPDATED: To be consistent with the January 2020 CDC definition of Bone and Joint Infection.</td>
</tr>
<tr>
<td>OSTEOMYELITIS (Hospital Event)</td>
<td>Additional Information</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>OSTEOMYELITIS (Hospital Event)</td>
<td>Additional Information</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
</tr>
<tr>
<td>PULMONARY EMBOLISM (Hospital Event)</td>
<td>Additional Information</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>PULMONARY EMBOLISM (Hospital Event)</td>
<td>Additional Information</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
</tr>
<tr>
<td>PRESSURE ULCER (Hospital Event)</td>
<td>Additional Information</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>PRESSURE ULCER (Hospital Event)</td>
<td>Additional Information</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
</tr>
<tr>
<td>SEVERE SEPSIS (Hospital Event)</td>
<td>Additional Information</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>SEVERE SEPSIS (Hospital Event)</td>
<td>Additional Information</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
</tr>
<tr>
<td>STROKE/CVA (Hospital Event)</td>
<td>Additional Information</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>STROKE/CVA (Hospital Event)</td>
<td>Additional Information</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
</tr>
<tr>
<td>SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION (Hospital Event)</td>
<td>Additional Information</td>
<td>REMOVED: Must have occurred during the patient's initial stay at your hospital.</td>
</tr>
<tr>
<td>SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION (Hospital Event)</td>
<td>Additional Information</td>
<td>ADDED: Onset of symptoms began after arrival to your ED/hospital</td>
</tr>
</tbody>
</table>
| UNPLANNED ADMISSION TO ICU (Hospital Event) | Additional Information | ADDED: "EXCLUDE: Patients with a planned ICU stay post-operative. INCLUDE: patients who required ICU care due to an event that occurred during surgery or in the PACU."
<p>| UNPLANNED VISIT TO THE OPERATING ROOM (Hospital Event) | Additional Information | EXCLUDE: Non-urgent trachoeostomy and percutaneous endoscopic gastrostomy |</p>
<table>
<thead>
<tr>
<th><strong>VENTILATOR-ASSOCIATED PNEUMONIA (VAP) (Hospital Event)</strong></th>
<th><strong>Additional Information</strong></th>
<th><strong>REMOVED:</strong> Must have occurred during the patient's initial stay at your hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VENTILATOR-ASSOCIATED PNEUMONIA (VAP) (Hospital Event)</strong></td>
<td><strong>Additional Information</strong></td>
<td><strong>ADDED:</strong> Onset of symptoms began after arrival to your ED/hospital.</td>
</tr>
<tr>
<td><strong>NATIONAL PROVIDER IDENTIFIER (NPI)</strong></td>
<td><strong>Data Source Hierarchy Guide</strong></td>
<td><strong>ADDED:</strong> Medical record</td>
</tr>
<tr>
<td><strong>ALL ELEMENTS</strong></td>
<td><strong>Definition</strong></td>
<td><strong>CHANGED TO:</strong> Description</td>
</tr>
<tr>
<td><strong>ADVANCED DIRECTIVE LIMITING CARE (Pre-Existing Condition)</strong></td>
<td><strong>Description</strong></td>
<td><strong>CHANGED TO:</strong> The patient had a written request to limit life-sustaining treatment that restricted the care for the patient during this patient care event.</td>
</tr>
<tr>
<td><strong>DISSEMINATED CANCER (Pre-existing Condition)</strong></td>
<td><strong>Description</strong></td>
<td><strong>CHANGED TO:</strong> &quot;Cancer that has spread to one or more sites in addition to the primary site AND in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.&quot;</td>
</tr>
<tr>
<td><strong>HYPERTENSION (Pre-Existing Condition)</strong></td>
<td><strong>Description</strong></td>
<td><strong>CHANGED TO:</strong> History of persistent elevated blood pressure requiring antihypertensive medication.</td>
</tr>
<tr>
<td><strong>STEROID USE (Pre-existing Condition)</strong></td>
<td><strong>Description</strong></td>
<td><strong>CHANGED TO:</strong> &quot;Regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.&quot;</td>
</tr>
<tr>
<td><strong>AIS Version</strong></td>
<td><strong>Element Value</strong></td>
<td><strong>CHANGED:</strong> Element value “7 AIS 2015” TO “16 AIS 2015” to align with NTDS dictionary.</td>
</tr>
<tr>
<td><strong>EXTREMITY COMPARTMENT SYNDROME (Hospital Event)</strong></td>
<td><strong>ELEMENT</strong></td>
<td><strong>RETIRED</strong></td>
</tr>
<tr>
<td><strong>MULTIPLE REFERENCES TO OTHER DATABASES</strong></td>
<td><strong>REFERENCES TO OTHER DATABASES</strong></td>
<td><strong>CHANGED TO:</strong> NTDS 2022</td>
</tr>
<tr>
<td><strong>MULTIPLE</strong></td>
<td><strong>THROUGHOUT ENTIRE DOCUMENT</strong></td>
<td><strong>CHANGED:</strong> “Definition” to “Description” where applicable.</td>
</tr>
</tbody>
</table>