

ILLINOIS TRAUMA
DATA DICTIONARY

2020

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**Section: Demographic/Record
Info/Patient/Relative-Guardian**

1. The trauma number will auto-populate when the chart is created.
2. Record Tab: The “Record Created By” will auto-populate to user logged in and creating the chart.
3. Record Tab: The facility name and number will auto-populate
4. Patient tab: The name of the patient will transfer over from the Record Info Tab.
5. Patient Tab: City FIPS, state, county and country are auto-populated after entering the zip code.

****MANDATORY NTDS definition fields denoted with BLUE FONT****

Additional clarification from NTDS:

COMMON NULL VALUES

Definition

These values are to be used with each of the National Trauma Data Standard Data Elements described in this document which have been defined to accept the Null Values.

Field Values

1 Not Applicable

2 Not Known/Not Recorded

Additional Information

- 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 National Trauma Data Standard are to be electronically stored in a database or moved from one database to another using XML, the indicated null values should be applied.
- *Not Applicable (NA)*: This null value code applies if, at the time of patient care documentation, the information requested was "Not Applicable" to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be "Not Applicable" if a patient self- transports to the hospital.
- *Not Known/Not Recorded (NK/NR)*: This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, health care 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 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).

References to Other Databases

- Compare with NHTSA V.2.10 - E00

The screenshot shows the 'Trauma Data Editor' application. On the left, a dropdown menu for 'Initial Location' is open, listing 13 options. An orange arrow points to this menu. The main window has tabs for 'Demographic', 'Injury', 'Prehospital', 'Referring Facility', 'ED/Floor', 'Patient Tracking', 'Providers', 'Procedures', 'Diagnoses', 'Outcome', 'QA Tracking', 'Notes', and 'Custom'. The 'Record Info' tab is active, showing fields for 'Record Created', 'Record Created By', 'Facility', and 'Initial Location'. Below this are 'Identities' fields for 'Triage R', 'Medical Record R', 'Patient Arrival', 'Account R', 'Patient Name: Last', 'Patient Origin', 'First', and 'Inclusion Source'. There is also an 'Inclusion Information' section with a checkbox for 'Advocate'.

Initial Location

Definition

Where the patient was initially treated when they arrived to the facility.

Element Values: DI Dropdown Menu

- | | | |
|-------------------------|---------------------|------------------------------------|
| 1. Resuscitation room | 5. Step-Down Unit | 10. This number missing an element |
| 2. Emergency Department | 6. Floor | 11. Post Anesthesia Care Unit |
| 3. Operating Room | 7. Telemetry Unit | 12. Special Procedure Unit |
| 4. Intensive Care Unit | 8. Observation Unit | 13. Labor and Delivery |
| | 9. Burn Unit | ?. Unknown |

Data Source Hierarchy Guide

1. ADT Events
2. Encounter Report (EMR)
3. Nursing Notes
4. Triage – Arrival information
5. H&P

The screenshot shows the 'Trauma Data Editor' application window. The 'Identifiers' section contains the following fields:

- Trauma #: 20153426
- Patient Arrival: 10/09/2019 (highlighted in blue)
- Medical Record #: [Empty]
- Account #: [Empty]
- Patient Name: Last: [Empty]
- First: Karen
- MI: [Empty]
- Patient Origin: [Empty]
- Inclusion Source: [Empty]

The 'Inclusion Information' section has the following options:

- NTDB
- Advocate

The status bar at the bottom of the window displays: 'Arrive: 10/9/2019', 'Trauma Number: 20153426', and 'MFRN: [Empty]'.

Patient Arrival Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Definition

The date that the patient arrived to your facility.

Element Values

1. Relevant value for data element

Data source Hierarchy Guide

1. ADT Events
2. Triage – Arrival information
3. Face Sheet
4. EMS Run Sheet
5. ED Patient Care Timeline
6. H&P
7. Billing sheet

Additional Information

- If the patient was brought to the ED, report date patient arrived at ED. If patient was directly admitted to the hospital, report date patient was admitted to the hospital.
- Reported as YYYY-MM-DD.

Associated Edit Checks

Rule ID	Level	Message
4501	1	Date is not valid
4502	1	Date out of range
4503	2	Element cannot be blank
4505	2	Element cannot be "Not Known/Not Recorded"
4506	3	ED/Hospital Arrival Date is earlier than EMS Dispatch Date
4507	3	ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date
4508	3	ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date
4509	2	ED/Hospital Arrival Date is later than ED Discharge Date
4510	2	ED/Hospital Arrival Date is later than Hospital Discharge Date
4511	2	ED/Hospital Arrival Date is earlier than Date of Birth
4513	3	ED/Hospital Arrival Date minus Injury Incident Date is more than 14 days
4515	2	Element cannot be "Not Applicable"
4540	1	Single Entry Max exceeded

The screenshot shows the 'Trauma Data Editor' application window. The 'Identifiers' section is highlighted, showing the 'Patient Arrival' field with a blue background and the text '@ :'. An orange arrow points to this field. The 'Trauma #' is 20153426, and the 'Patient Name: Last' is Karen. The 'Inclusion Information' section shows 'NTDB' checked and 'Advocate' unchecked. The status bar at the bottom indicates the patient's name is Karen, arrival date is 10/9/2019, trauma number is 20153426, and MRN is blank.

Patient Arrival Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Definition

The time that the patient arrived to your facility.

NOTE: If the patient was brought to the ED, report time patient arrived at ED. If patient was directly admitted to the hospital, report time patient was admitted to the hospital.

Element Values

1. Relevant value for data element

Data Source Hierarchy Guide

1. ADT Events
2. Triage – Arrival Information
3. Face Sheet
4. ED Patient Care Timeline
5. EMS Run Sheet
6. H&P

Associated Edit Checks

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time out of range
4603	2	Element cannot be blank
4604	3	ED/Hospital Arrival Time is earlier than EMS Dispatch Time
4605	3	ED/Hospital Arrival Time is earlier than EMS Unit Arrival on Scene Time
4606	3	ED/Hospital Arrival Time is earlier than EMS Unit Scene Departure Time
4607	3	ED/Hospital Arrival Time is later than ED Discharge Time
4608	2	ED/Hospital Arrival Time is later than Hospital Discharge Time
4609	2	Element cannot be "Not Applicable"
4640	1	Single Entry Max exceeded

Medical Record Number

Definition

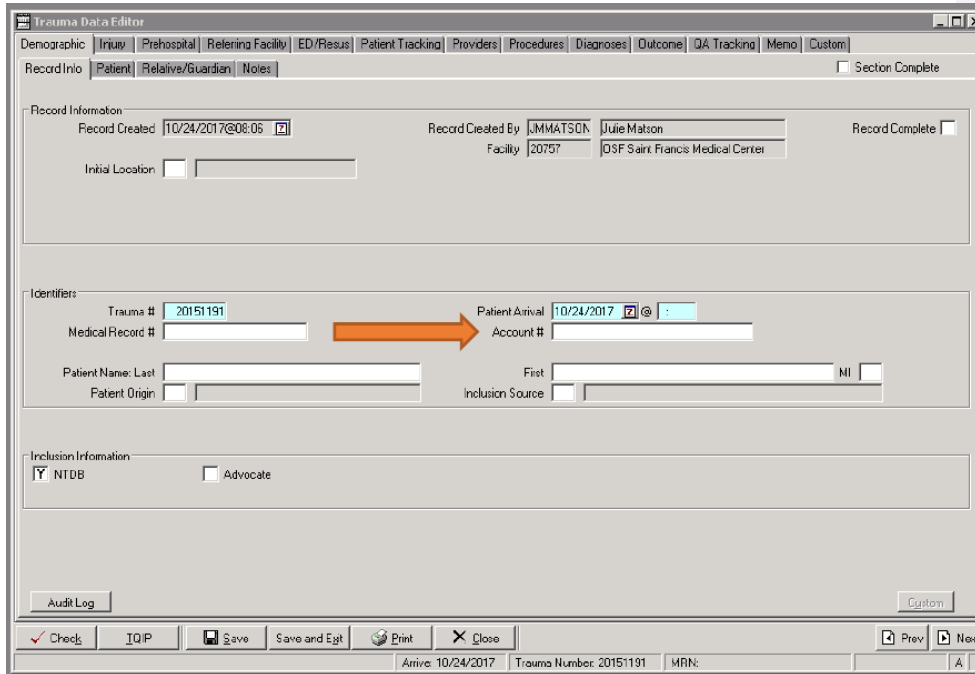
Number assigned to patient (MRN): Every patient's number is unique to them and is the same for every visit.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide:

1. Face Sheet
2. EMR Banner



Account Number

Definition

Patient number assigned for that specific encounter; primarily used for billing and coding.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Face Sheet

Patient Name**Definition**

Patient's legal name.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

- Face Sheet
- Snapshot – Demographics
- EMR Patient Banner

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Record Info | Patient | Relative/Guardian | Notes

Record Information

Record Created: [10/24/2017@08:06] Record Created By: JMMATSON Julie Matson Record Complete:

Facility: [20757] OSF Saint Francis Medical Center

Initial Location: []

Identifiers

Trauma #: [20151191] Patient Arrival: [10/24/2017] @ []

Medical Record #: [] Account #: []

Patient Name: Last [] First [] MI []

Patient Origin: [] Inclusion Source: []

Inclusion Information

NTDB Advocate

Audit Log [] Custom []

Check [] IQIP [] Save [] Save and Edit [] Print [] Close [] Prev [] Next []

Arrive: 10/24/2017 Trauma Number: 20151191 MRN: []

Patient Origin**Definition**

Where the patient came from prior to being transported to your facility

Element Values- DI dropdown screen

1. Scene
2. Referring Hospital
3. Physician's Office/Urgent Care
4. Extended Care Facility
- ?. Unknown

Data Source Hierarchy Guide

1. H&P
2. Nursing notes
3. Media tab
4. Scanned documents
5. EMS Run Sheet
6. Referring hospital information

Inclusion Source:

Definition

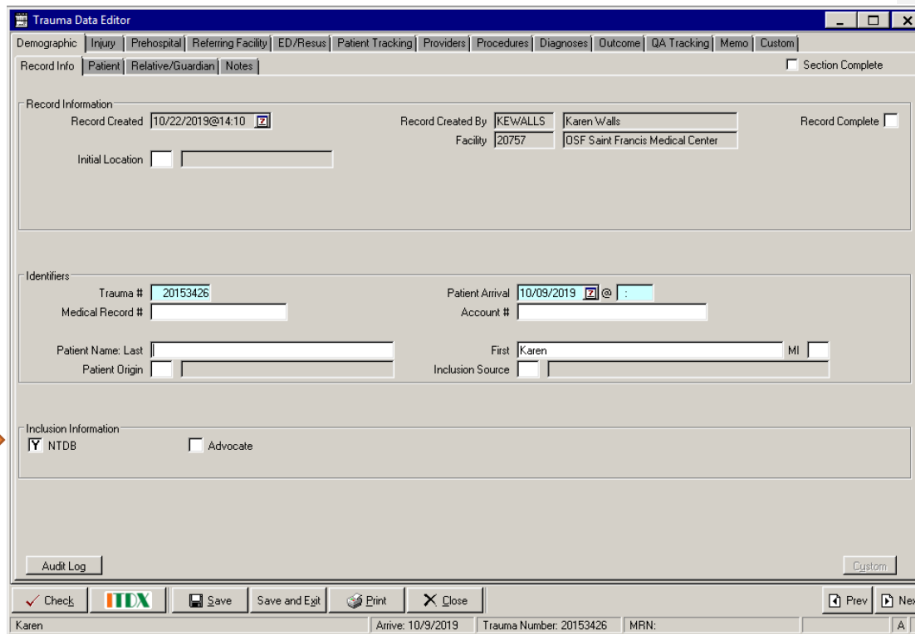
Reason why the patient was included in the trauma registry: where or how it was determined that the patient should be included in the organization's trauma registry. These may be based off the NTDS Patient Inclusion Criteria or organizational registry criteria.

Element Values: DI dropdown screen

- | | |
|---------------------------------|-------------------------|
| 1. Dead on scene | 5. Service Transfer |
| 2. Prehospital | 6. Retrospective Review |
| 3. Emergency Department | /. Not Applicable |
| 4. Acute Care Facility Transfer | ? Unknown |

Data Source Hierarchy Guide

- Hierarchy of Evidence depends on the type of patient. Some examples are:
 - Dead on Scene – Prehospital/coroner report
 - Prehospital – Prehospital Run Report
 - Emergency Department – ED physician note, ED nurses note
 - Acute Care Facility Transfer – H&P, Nurses note, Media tab
 - Service Transfer – Progress note and Hospital Injury
 - Retrospective Review – Audit filters



The screenshot shows the 'Trauma Data Editor' window with the following data:

- Record Information:** Record Created: 10/22/2019@14:10; Record Created By: KEWALLS Karen Walls; Facility: 20757 OSF Saint Francis Medical Center; Record Complete:
- Identifiers:** Trauma #: 20153426; Patient Arrival: 10/09/2019; Medical Record #: [blank]; Account #: [blank]; Patient Name: Last [blank], First: Karen, MI: [blank]; Patient Origin: [blank]; Inclusion Source: [blank]
- Inclusion Information:** NTDS; Advocate

The status bar at the bottom displays: Karen, Arrive: 10/9/2019, Trauma Number: 20153426, MRN: [blank]

Inclusion Information

Definition

Patient meets inclusion criteria for the **box checked: NTDS** and is eligible to be submitted to the NTDS and/or Illinois Trauma Registry. (As of 2019 and forward, the Illinois box is auto-populated and inclusion criteria are identical and follow below.)

Element Values

- Yes
- No

Data Source Hierarchy Guide

1. National Trauma Data Standard Patient Inclusion Criteria for that admission year.

2020 NTDS Patient Inclusion Criteria:**NATIONAL TRAUMA DATA STANDARD (NTDS) PATIENT INCLUSION CRITERIA**

Definition: To ensure consistent data collection across States into 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:

At least one of the following injury diagnostic codes defined as follows:

International Classification of Diseases, Tenth Revision (ICD-10-CM):

- S00-S99 with 7th character modifiers 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 specific body parts – initial encounter*)
- T30-T32 (*burn by TBSA percentages*)
- T79.A1-T79.A9 with 7th character modifier of A ONLY (*Traumatic Compartment Syndrome – initial encounter*)

EXCLUDING the following isolated injuries:

ICD-10-CM:

- S00 (*Superficial injuries of the head*)
- S10 (*Superficial injuries of the neck*)
- S20 (*Superficial injuries of the thorax*)
- S30 (*Superficial injuries of the abdomen, pelvis, lower back and external genitals*)
- S40 (*Superficial injuries of shoulder and upper arm*)
- S50 (*Superficial injuries of elbow and forearm*)
- S60 (*Superficial injuries of wrist, hand and fingers*)
- S70 (*Superficial injuries of hip and thigh*)
- S80 (*Superficial injuries of knee and lower leg*)
- S90 (*Superficial injuries of ankle, foot and toes*)

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO

(ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9) :

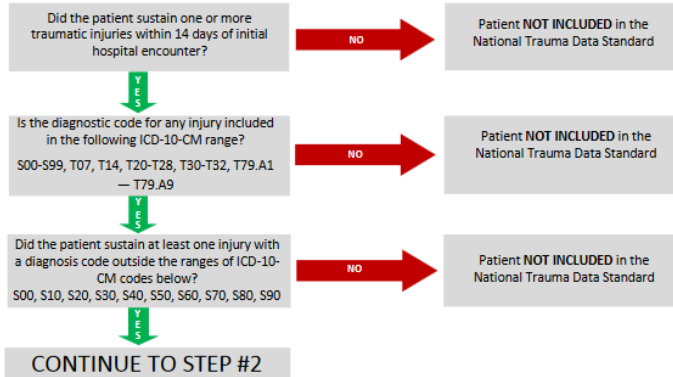
- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status);
- OR
- Patient transfer from one acute care hospital* to another acute care hospital;
- OR
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective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

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

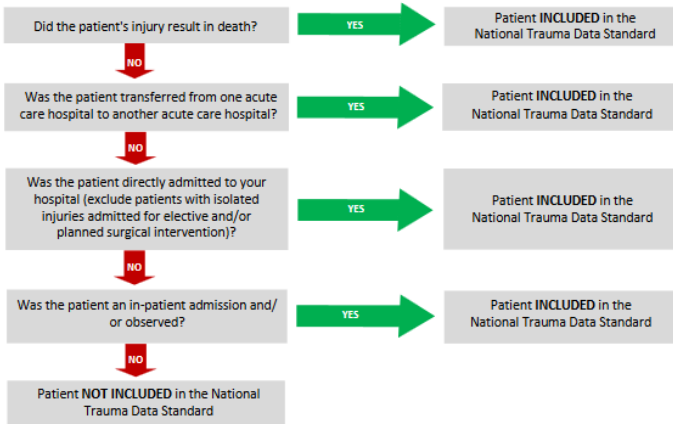
2020 NTDS Inclusion Criteria Algorithm

NTDS PATIENT INCLUSION CRITERIA

STEP #1:



STEP #2:



The screenshot displays the 'Trauma Data Editor' application window. The 'Patient Information' section is highlighted, and an orange arrow points to the 'Alias: Last' field. The form includes various input fields for patient details, a status bar at the bottom, and a 'Custom' button.

Alias

Definition

- Known alternate names that the patient uses when seeking medical care.
- May also be alternate name given by hospital if patient's identity/name unknown at time of arrival and patient is registered initially under an alternate name. Example: Trauma 12 Male.

Element Values

- Relevant Value for data element

Data Source Hierarchy Guide

1. Demographics
2. Insurance section

Date of Birth: BLUE FIELD; NTDS Definition rules follow.

Definition

The patient's date of birth.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- If Date of Birth is "Not Known/Not Recorded", report data elements: Age and Age Units
- If Date of Birth is the same as the Injury Incident Date, then the Age and Age Units data elements 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

Associated Edit Checks

Rule ID	Level	Message
0601	1	Invalid value
0602	1	Date out of range
0603	2	Element cannot be blank
0609	2	Date of Birth is later than Injury Incident Date
0610	2	Date of Birth is later than ED Discharge Date
0611	2	Date of Birth is later than Hospital Discharge Date
0612	2	Date of Birth + 120 years must be less than Injury Incident Date
0613	2	Element cannot be "Not Applicable"
0640	1	Single Entry Max exceeded

NOTE: Age will auto-fill based on Date of Birth entered.

AGE**Definition**

The patient's age at the time of injury (best approximation).

Element Values

- Relevant value for data element

Additional Information

- If Date of Birth is "Not Known/Not Recorded," report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: Age Units.
- The null value "Not Applicable" is reported if Date of Birth is reported.

Data Source Hierarchy Guide

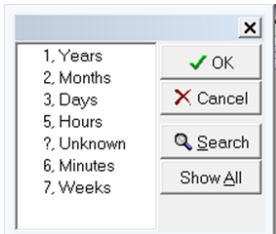
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
0701	1	Age is outside the valid range of 0 - 120
0703	2	Element cannot be blank
0705	3	Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.
0708	2	Element must be "Not Known/Not Recorded" when Age Units is "Not Known/Not Recorded"
0709	2	Element must be "Not Applicable" if Date of Birth is reported
0740	1	Single Entry Max exceeded

NOTE: Age Units will auto-fill based on Date of Birth

DI dropdown screen:



AGE UNITS

Definition

The units used to report the patient's age (Minutes, Hours, Days, Months, Years, Weeks).

Element Values

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

Additional Information

- If Date of Birth is "Not Known/Not Recorded," report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: Age.
- The null value "Not Applicable" is reported if Date of Birth is reported.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
0801	1	Value is not a valid menu option
0803	2	Element cannot be blank
0806	2	Element must be "Not Known/Not Recorded" when Age is "Not Known/Not Recorded"
0809	2	Element must be "Not Applicable" when Date of Birth is reported
0840	1	Single Entry Max exceeded

Gender: BLUE FIELD; NTDS Definition rules follow.

The screenshot shows the 'Trauma Data Editor' window with the 'Patient Information' tab selected. The 'Gender' field is highlighted with a blue arrow. The form includes fields for Name (Last, First, MI), SSN, Date of Birth, Age, Race, and Ethnicity.

DI dropdown screen element values:

The dropdown menu is open, showing three options: '1. Male', '2. Female', and '?. Unknown'. There are buttons for 'OK', 'Cancel', 'Search', and 'Show All'.

SEX

Definition

The patient's sex.

Element Values

- 1. Male
- 2. Female

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be reported using their current assignment.

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

Associated Edit Checks

Rule ID	Level	Message
1101	1	Value is not a valid menu option
1102	2	Element cannot be blank
1103	2	Element cannot be "Not Applicable"
1140	1	Single Entry Max exceeded

Race: BLUE FIELD; NTDS Definition rules follow.

DI dropdown screen element values:

Race (Choose up to 6)

<input type="checkbox"/> American Indian	<input type="checkbox"/> White
<input type="checkbox"/> Asian	<input type="checkbox"/> Other Race
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Unknown
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	

RACE

Definition

The patient's race.

Element Values

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

Additional Information

- Patient race should be based upon self-report or identified by a family member.
- Based on the 2010 US Census Bureau.
- Report 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

Associated Edit Checks

Rule ID	Level	Message
0901	1	Value is not a valid menu option
0902	2	Element cannot be blank
0903	2	Element cannot be "Not Applicable" (excluding CA hospitals)
0905	2	If any Element Value is reported, neither "Not Applicable" or "Not Known/Not Recorded" can also be reported
0950	1	Multiple Entry Max exceeded

Ethnicity: MANDATORY BLUE FIELD; NTDS Definition rules follow.

The screenshot shows the 'Trauma Data Editor' interface. The 'Patient Information' section contains several input fields: Name (Last, First), Alias (Last, First), SSN, Date of Birth, Gender, Age, Race, and Ethnicity. An orange arrow points to the Ethnicity dropdown menu.

DI dropdown screen element values:

The dropdown menu displays the following values:

- 2. Not Hispanic or Latino
- 3. Mexican
- 4. Puerto Rican
- 5. Cuban
- 6. Central or South American
- 7. Other Hispanic or Latino
- ?. Unknown

Buttons: OK, Cancel, Search, Show All

ETHNICITY**Definition**

The patient's ethnicity.

Element Values

1. Hispanic or Latino
2. Not Hispanic or Latino

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

Associated Edit Checks

Rule ID	Level	Message
1001	1	Value is not a valid menu option
1002	2	Element cannot be blank
1003	2	Element cannot be "Not Applicable" (excluding CA hospitals)
1040	1	Single Entry Max exceeded

Patient's Home Zip / Postal Code: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Patient Address Information

The screenshot shows a form for 'Patient Address Information'. An orange arrow points to the 'ZIP' field, which is highlighted in blue. The 'Postal Code' field is also highlighted in blue. Other fields include 'Street 1', 'Street 2', 'City', 'City FIPS', 'State', 'County', and 'Country'. There are also checkboxes for 'Homeless', 'Alternate Residence', and 'Telephone'.

PATIENT'S HOME ZIP/POSTAL CODE**Definition**

The patient's home ZIP/Postal code of primary residence.

Element Values

- Relevant value for data element

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is "Not Applicable," report data element: Alternate Home Residence.
- If ZIP/Postal code is "Not Known/Not Recorded," report data elements: 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 reported, must also report Patient's Home Country.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
0001	1	Invalid value
0002	2	Element cannot be blank
0040	1	Single Entry Max exceeded

Patient Address Information

ZIP	<input type="text"/>	Postal Code	<input type="text"/>	Homeless	<input type="checkbox"/>
Street 1	<input type="text"/>				
Street 2	<input type="text"/>				
City	<input type="text"/>				
City FIPS	<input type="text"/>	<input type="text"/>			
State	<input type="text"/>	<input type="text"/>			
County	<input type="text"/>	<input type="text"/>	Alternate Residence	<input type="checkbox"/>	
Country	<input type="text"/>	<input type="text"/>	Telephone	<input type="text"/>	<input type="text"/>

Patient Address - Street 1, Street 2**Definition**

Address where the patient currently resides. Street 2 is used for apartment numbers and PO Boxes

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Face Sheet
2. Snapshot – Demographic information
3. EMS Run Sheet

Alternate Home Residence: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Patent Address Information

ZIP	Postal Code	N/A	Homeless	<input type="checkbox"/>
Street 1				
Street 2				
City				
City FIPS				
State				
County			Alternate Residence	<input type="checkbox"/>
Country			Telephone	<input type="text"/>

DI dropdown screen data elements:

Homeless dropdown:

<ol style="list-style-type: none"> 1. Undocumented Citizen 2. Migrant Worker 3. Foreign Visitor /. Not Applicable ? Unknown 	<ol style="list-style-type: none"> 1. Yes 2. No ? Unknown N/A Not Applicable
--	--

ALTERNATE HOME RESIDENCE

Definition

Documentation of the type of patient without a home ZIP/Postal Code.

Element Values

- | | |
|-------------------------|-------------------|
| 1. Homeless | 3. Migrant Worker |
| 2. Undocumented Citizen | |

Additional Information

- Only reported when 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 reported.
- Report all that apply

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
0501	1	Value is not a valid menu option
0502	2	Element cannot be blank
0503	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
0540	1	Multiple Entry Max exceeded

NOTE: Alternate Residence and the Homeless option will only open if you N/A for both the Zip and Postal Code.

Patient's Home State: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Patient Address Information

ZIP Postal Code Homeless

Street 1

Street 2

City

City FIPS

State

County

County

Alternate Residence

Telephone

DI dropdown screen:

AL, Alabama	<input type="checkbox"/>
AK, Alaska	<input type="checkbox"/>
AZ, Arizona	<input type="checkbox"/>
AR, Arkansas	<input type="checkbox"/>
CA, California	<input type="checkbox"/>
CO, Colorado	<input type="checkbox"/>
CT, Connecticut	<input type="checkbox"/>
DE, Delaware	<input type="checkbox"/>
DC, District of Columbia	<input type="checkbox"/>
FL, Florida	<input type="checkbox"/>
GA, Georgia	<input type="checkbox"/>
HI, Hawaii	<input type="checkbox"/>
ID, Idaho	<input type="checkbox"/>
IL, Illinois	<input type="checkbox"/>
IN, Indiana	<input type="checkbox"/>
IA, Iowa	<input type="checkbox"/>
KS, Kansas	<input type="checkbox"/>
KY, Kentucky	<input type="checkbox"/>
LA, Louisiana	<input type="checkbox"/>
ME, Maine	<input type="checkbox"/>
MD, Maryland	<input type="checkbox"/>
MA, Massachusetts	<input type="checkbox"/>
MI, Michigan	<input type="checkbox"/>
MN, Minnesota	<input type="checkbox"/>
MS, Mississippi	<input type="checkbox"/>
MO, Missouri	<input type="checkbox"/>
MT, Montana	<input type="checkbox"/>
NE, Nebraska	<input type="checkbox"/>
NV, Nevada	<input type="checkbox"/>
NH, New Hampshire	<input type="checkbox"/>
NJ, New Jersey	<input type="checkbox"/>
NM, New Mexico	<input type="checkbox"/>
NY, New York	<input type="checkbox"/>
NC, North Carolina	<input type="checkbox"/>
ND, North Dakota	<input type="checkbox"/>

PATIENT'S HOME STATE

Definition

The state (territory, province, or District of Columbia) where the patient resides.

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

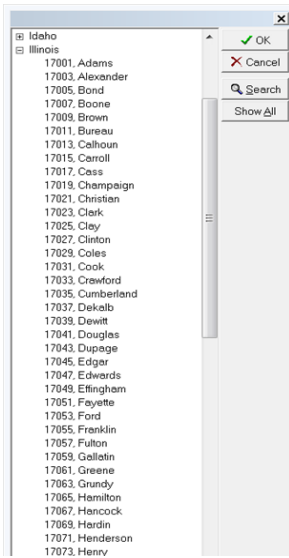
1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0201	1	Invalid value
0202	2	Element cannot be blank
0204	2	Element must be "Not Applicable" (Non-US hospitals only)
0205	2	Element must be "Not Applicable" when Patient's Home Zip/Postal code is reported
0240	1	Single Entry Max exceeded

Patient's Home County and Country: MANDATORY BLUE FIELD; NTDS Definition rules follow.

DI dropdown screen:



PATIENT'S HOME COUNTY

Definition

The patient's county (or parish) of residence.

Element Values

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

Additional Information

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

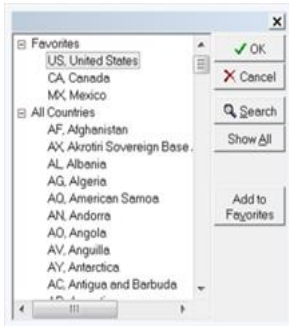
Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
0301	1	Invalid value
0302	2	Element cannot be blank
0304	2	Element must be "Not Applicable" (Non-US hospitals only)
0305	2	Element must be "Not Applicable" when Patient's Home Zip/Postal Code is reported
0340	1	Single Entry Max exceeded

DI dropdown screen:



PATIENT'S HOME COUNTRY

Definition

The country where the patient resides.

Element Values

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

Additional Information

- Values are two-character FIPS codes representing the country (e.g., US).
- 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

Associated Edit Checks

Rule ID	Level	Message
0101	1	Invalid value
0102	2	Element cannot be blank
0104	2	Element cannot be "Not Applicable"
0105	2	Element cannot be "Not Known/Not Recorded" when Home ZIP/Postal Code is not "Not Applicable" or "Not Known/Not Recorded"
0140	1	Single Entry Max exceeded

Relative/Guardian Information

Definition

Either a relative, guardian or emergency contact's address and phone number

Element Values – Relationship to Patient - DI dropdown screen:

1. Spouse	8. Foster Parent
2. Child	9. Sibling
3. Parent	10. Other Family Member
4. Grandparent	11. Unrelated Caregiver
5. Grandchild	/. Not Applicable
6. Aunt or Uncle	? Unknown
7. Step Parent	

Element Values – Guardian - DI dropdown screen:

- Yes
- No
- ? Unknown
- N/A Not Applicable

Element Values – All Other Fields

- Relevant value for data element

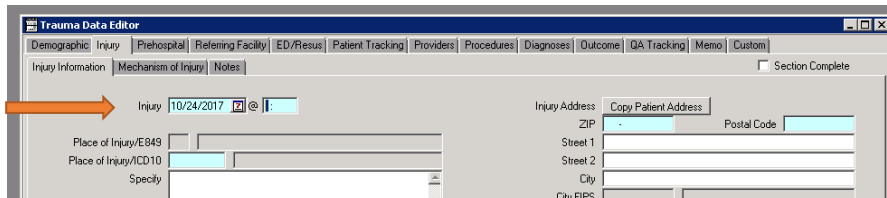
Data Source Hierarchy Guide

1. Face Sheet
2. Demographics
3. Scanned documents for legal papers

Injury Information

- The City, City FIPS, State, County, and Country will auto-populate based on the injury zip code that is entered.
- Injury Type, blunt or penetrating, is auto-populated when the Primary ICD-10 injury code is entered.
- Much of the Injury information can be garnered from the EMS Run Report. Please note that EMS agencies use different run reports and the information may be in different spots for different agencies. These images are just used as a reference, please follow the data source hierarchy guide to find the correct information.

INJURY INCIDENT DATE: MANDATORY BLUE FIELD; NTDS Definition rules follow.



INJURY INCIDENT DATE

Definition

The date the injury occurred.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) should not be reported.

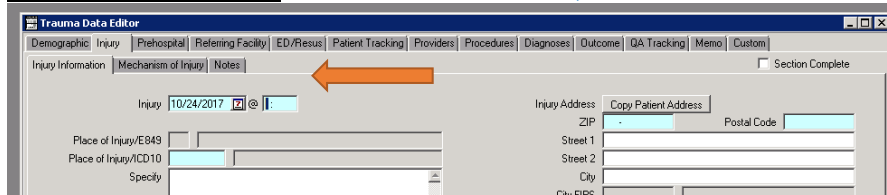
Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
1201	1	Date is not valid
1202	1	Date out of range
1203	2	Element cannot be blank
1204	2	Injury Incident Date is earlier than Date of Birth
1205	3	Injury Incident Date is later than EMS Dispatch Date
1206	3	Injury Incident Date is later than EMS Unit Arrival on Scene Date
1207	3	Injury Incident Date is later than EMS Unit Scene Departure Date
1208	3	Injury Incident Date is later than ED/Hospital Arrival Date
1209	3	Injury Incident Date is later than ED Discharge Date
1210	2	Injury Incident Date is later than Hospital Discharge Date
1211	2	Element cannot be "Not Applicable"
1212	3	Injury Incident Date is greater than 14 days earlier than ED/Hospital Arrival Date
1240	1	Single Entry Max exceeded

INJURY INCIDENT TIME: MANDATORY BLUE FIELD; NTDS Definition rules follow.



INJURY INCIDENT TIME

Definition

The time the injury occurred.

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
1301	1	Time is not valid
1302	1	Time out of range
1303	2	Element cannot be blank
1304	3	Injury Incident Time is later than EMS Dispatch Time
1305	3	Injury Incident Time is later than EMS Unit Arrival on Scene Time
1306	3	Injury Incident Time is later than EMS Unit Scene Departure Time
1307	3	Injury Incident Time is later than ED/Hospital Arrival Time
1308	3	Injury Incident Time is later than ED Discharge Time
1309	2	Injury Incident Time is later than Hospital Discharge Time
1310	2	Element cannot be "Not Applicable"
1340	1	Single Entry Max exceeded

ICD-10 Place of Occurrence / E Code: MANDATORY BLUE FIELD; NTDS Definition rules follow.

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.X).

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
9001	1	Invalid value (ICD-10-CM only)
9002	2	Element cannot be blank
9003	3	Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I,O] or 0-9) (ICD-10-CM only)
9004	1	Invalid value (ICD-10-CA only)
9005	3	Place of Injury code should be U98X (where X is 0-9) (ICD-10-CA only)
9006	2	Element cannot be "Not Applicable"
9040	1	Single Entry Max exceeded

PROTECTIVE DEVICES: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Restrains, Airbags, and Equipment in DI correspond to Protective Devices, Child Specific Restraint, and Airbag Deployment for the NTDS. The following are the Element Values for DI for each category. The pages following that will be the NTDS definitions and then EPIC Screen shots.

Restrains

- | | | |
|-------------------------------|----------------------------|-----------------------|
| • None | • Seatbelt – Shoulder Only | • Infant Car Seat |
| • Seatbelt – Lap and Shoulder | • Seatbelt – NFS | • Truck Bed Restraint |
| • Seatbelt – Lap Only | • Child Booster Seat | / . Not Applicable |
| | • Child Car Seat | ? Unknown |

Airbags

- | | | |
|---------------------------|--|------------------------|
| 1. No Airbags in Vehicle | 4. Side (Deployed) | 6. Airbag Type Unknown |
| 2. Airbags Did Not Deploy | 5. Airbag Deployed Other (Knee, Air Belt, Curtain, etc.) | (Deployed) |
| 3. Front (Deployed) | | / . Not Applicable |
| | | ? Unknown |

Equipment

- | | | |
|------------------------|--|--------------------|
| 1. None | 5. Protective Non-Clothing Gear (e.g. Shin Guard, Padding) | 8. Window Bars |
| 2. Helmet | 6. Hard Hat | 9. Other |
| 3. Eye Protection | 7. Personal Flotation Device | / . Not Applicable |
| 4. Protective Clothing | | ? Unknown |

Data Source Hierarchy Guide

- EMS Run Report
- ED Trauma Summary
- History and Physical
- Nursing Notes

PROTECTIVE DEVICES**Definition**

Protective devices (safety equipment) in use or worn by the patient at the time of the injury.

Element Values

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

Additional Information

- Report all that apply.
- If "Child Restraint" is present, must report data element Child Specific Restraint.
- If "Airbag" is present, must report data element 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 Values "2. Lap Belt" and "10. Shoulder Belt."
- If documented that a "Child Restraint (booster seat or child care seat)" was used or worn, but not properly fastened, either on the child or in the car, report Element Value "1. None."

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Element cannot be blank
2507	2	Element cannot be "Not Applicable"
2508	2	Element cannot be "Not Known/Not Recorded" along with any other valid value
2550	1	Multiple Entry Max exceeded

CHILD SPECIFIC RESTRAINT**Definition**

Protective child restraint devices used by patient at the time of injury.

Element Values

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

Additional Information

- Evidence of the use of a 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" must be reported if Element Value "6. Child Restraint" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
2601	1	Value is not a valid menu option
2603	2	Element cannot be blank
2604	2	Element cannot be "Not Applicable" when Protective Device is "6. Child Restraint"
2640	1	Single Entry Max exceeded

AIRBAG DEPLOYMENT**Definition**

Indication of airbag deployment during a motor vehicle crash.

Element Values

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

Additional Information

- Report all that apply.
- Evidence 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" must be reported if Element Value 8. "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
2701	1	Value is not a valid menu option
2703	2	Element cannot be blank
2704	2	Element cannot be "Not Applicable" when Protective Device is "8 Airbag Present"
2705	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
2750	1	Multiple Entry Max exceeded



Incident Location Zip / Postal Code: MANDATORY BLUE FIELD; NTDS Definition rules follow.

The screenshot shows the 'Trauma Data Editor' application. The 'Injury Information' tab is selected. An orange arrow points to the 'Injury Address' section, specifically the 'ZIP' field. The interface includes various input fields for injury details, protective devices, and work-related information.

INCIDENT LOCATION ZIP/POSTAL CODE

Definition

The ZIP/Postal code of the incident location.

Element Values

- Relevant value for data element

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 "Not Known/Not Recorded," report data elements: 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 reported, then must report Incident Country.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
2001	1	Invalid value
2002	2	Element cannot be blank
2006	2	Element cannot be "Not Applicable"
2040	1	Single Entry Max exceeded

Injury: Street 1, Street 2

Definition

Address where the injury occurred. Street 2 is used for apartment numbers and PO boxes.

Element Values

1. Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Sheet
2. ED Trauma Narrator Event Log

Work Related Injury: MANDATORY BLUE FIELD; NTDS Definition rules follow.

WORK-RELATED

Definition

Indication of whether the injury occurred during paid employment.

Element Values

- 1. Yes
- 2. No

Additional Information

- If work-related, two additional data elements must be reported: 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

Associated Edit Checks

Rule ID	Level	Message
1401	1	Value is not a valid menu option
1402	2	Element cannot be blank
1407	2	Element cannot be "Not Applicable"
1440	1	Single Entry Max exceeded

Additional DI Element Values

/. Not Applicable

?. Unknown

Injury Address: Where the patient was injured

Occupation: MANDATORY BLUE FIELD; NTDS Definition rules follow. Opens if Work-Related.

The screenshot shows the 'Trauma Data Editor' interface. The 'Injury Information' tab is active. The 'Injury' date is 10/03/2019. The 'Work Related' checkbox is checked. An orange arrow points to the 'Occupation' field, which is currently blank. Other fields include 'Place of Injury/EB49', 'Place of Injury/ICD10', 'Protective Devices', 'Airbags', 'Equipment', 'Injury Address', 'ZIP', 'Street 1', 'Street 2', 'City', 'City FIPS', 'State', 'County', 'Country', 'Occupational Industry', 'Domestic Violence', 'Report of Physical Abuse', and 'Investigation of Physical Abuse'.

PATIENT'S OCCUPATION

Definition

The occupation of the patient.

Element Values

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

Additional Information

- Only reported if injury is work-related.
- If work-related, must also report Patient's Occupational Industry.
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- The null value "Not Applicable" is reported if Work-Related is "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

Associated Edit Checks

Rule ID	Level	Message
1601	1	Value is not a valid menu option
1604	2	Element cannot be blank
1605	2	If Work-Related is "1. Yes", Patient's Occupation cannot be "Not Applicable"
1606	2	"Not Applicable" must be reported if Work-Related is "2. No"
1640	1	Single Entry Max exceeded

Patient's Occupational Industry: MANDATORY BLUE FIELD; NTDS Definition rules follow.

PATIENT'S OCCUPATIONAL INDUSTRY

Definition

The occupational industry associated with the patient's work environment.

Element Values

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

Additional Information

- If work-related, must also report Patient's Occupation.
- Based upon US Bureau of Labor Statistics Industry Classification.
- The null value "Not Applicable" is reported if Work-Related is "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

Associated Edit Checks

Rule ID	Level	Message
1501	1	Value is not a valid menu option
1504	2	Element cannot be blank
1505	2	If Work-Related is "1. Yes", Patient's Occupational Industry cannot be "Not Applicable"
1506	2	"Not Applicable" must be reported if Work-Related is "2. No"
1540	1	Single Entry Max exceeded

Injury Information

44

patient

Address: City, State, and Zip: Phone: None Marital Status: Religion: Primary Care Provider:	DOB: 1/31/1900 (119 yrs) Sex: Male Race: Language: Place of Worship: PCP Phone: None
---	---

Patient Employment Info

Employer: No address on file.	Occupation: Employment Status:
----------------------------------	-----------------------------------

Guarantor

NOTE: Found in Print Forms – Face Sheet

Will only generate if you click yes to “Work Related.”

Domestic Violence

Definition

Domestic violence includes behaviors that physically harm, arouse fear, prevent a partner from doing what they wish or force them to behave in ways they do not want. It includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation.

Element Values

- | | |
|--------|-------------------------|
| 2. Yes | 4. N/A – Not Applicable |
| 3. No | 5. ? - Unknown |

Data Source Hierarchy Guide

- History and Physical
- ED Nursing Note
- Case Management/Social Work Note
- EMS Run Sheet

Report of Physical Abuse

Definition

A report of physical abuse made to the correct authorities.

Element Values

- | | |
|--------|-------------------------|
| 1. Yes | 3. N/A – Not Applicable |
| 2. No | 4. ? - Unknown |

Data Source Hierarchy Guide

- | | |
|-------------------------------------|---------------------------|
| 1. Physician Progress Note | 4. Child Abuse Specialist |
| 2. ED Nursing Note | 5. EMS Run Report |
| 3. Case Management/Social Work Note | |

Investigation of Physical Abuse

Definition

An investigation of physical abuse was conducted by the correct authorities.

Element Values

- | | |
|--------|-------------------------|
| 5. Yes | 7. N/A – Not Applicable |
| 6. No | 8. ? - Unknown |

Data Source Hierarchy Guide

1. Physician Progress Note
2. ED Nursing Note
3. Case Management/Social Work Note
4. Child Abuse Specialist
5. EMS Run Report

ICD-10 Primary & Addtl E-Code: MANDATORY BLUE FIELD; NTDS Definition rules follow.

The screenshot shows the 'Trauma Data Editor' window with the 'Injury Information' tab selected. The 'Mechanism' section contains fields for 'Primary Mechanism', 'Secondary Mechanism', and 'Cause of Injury'. The 'Motor Vehicle Crash' section contains fields for 'Position in Vehicle' and 'Impact Location'. A blue arrow points to the 'ICD10' field in the Mechanism section.

ICD-10 PRIMARY EXTERNAL CAUSE CODE**Definition**

External cause code used to describe the mechanism (or external factor) that caused the injury event.

Element Values

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

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 are not reported under the NTDS and 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 reported for each cause. The first-listed external cause code will be selected in the following order:
 - External cause codes for child and adult abuse take priority over all other external cause codes.
 - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
 - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
 - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
 - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
8901	1	E-Code is not a valid ICD-10-CM code (ICD-10-CM only)
8902	2	Element cannot be blank
8904	2	Should not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD-10-CM only)
8905	3	ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)
8906	1	E-Code is not a valid ICD-10-CA code (ICD-10-CA only)
8907	2	Element cannot be "Not Applicable"
8940	1	Single Entry Max exceeded

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Definition

Additional external cause code 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

Additional Information

- Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code.
- Activity codes are not reported under the NTDS and should not be reported for this data element.
- The null value "Not Applicable" is reported if no additional external cause codes are reported.
- 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 cause code will be selected in the following order:
 - External cause codes for child and adult abuse take priority over all other external cause codes.
 - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
 - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
 - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
 - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
9101	1	E-Code is not a valid ICD-10-CM code (ICD-10-CM only)
9102	3	Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10
9103	2	Element cannot be blank
9104	1	E-Code is not a valid ICD-10-CA code (ICD-10-CA only)
9105	2	ICD-10-CM T74 and T76 codes cannot be submitted as Additional External Cause Codes
9140	1	Multiple Entry Max exceeded

The screenshot shows the 'Trauma Data Editor' window with the 'Injury Information' tab selected. The interface includes several input fields and sections:

- Mechanism:** Primary Mechanism, Secondary Mechanism, Cause of Injury (text area), Injury Type (checkbox).
- Motor Vehicle Crash:** Position in Vehicle, Impact Location.
- Activity Code - ICD10:** Specify (text field).
- Alcohol Involvement - ICD10:** (text field).
- Injury Mechanism:** (checkbox).
- Police Report Number:** (text field).
- Disaster Casualty:** 1 (checkbox), Not Multiple or Mass (checkbox).
- Casualty Event:** (text field).

An orange arrow points to the 'Specify' field under 'Activity Code - ICD10'. The status bar at the bottom shows 'Arrive: 10/3/2013', 'Trauma Number: 20153426', and 'MRN:'. Navigation buttons like 'Check', 'Save', 'Print', and 'Close' are visible.

Activity Code

Definition

What the patient was doing while the injury occurred.

Element Values

- Relevant ICD-10 code value for activity.

Data Source Hierarchy Guide

- EMS Run Report
- H&P
- Trauma Flowsheet
- ED Nursing Note
- Progress Notes

Alcohol Involvement

Definition

Patient blood alcohol level at the time of injury

Element Values

- Relevant ICD-10 code for blood alcohol level

Data Source Hierarchy Guide

1. Lab Values
2. Lab Values from transferring facility

The screenshot shows the 'Trauma Data Editor' window with the 'Injury Information' tab selected. The interface includes a menu bar at the top with options like 'Demographic', 'Injury', 'Prehospital', etc. Below the menu, there are tabs for 'Injury Information', 'Mechanism of Injury', and 'Notes'. The main area contains several input fields: 'Primary Mechanism', 'Secondary Mechanism', 'Cause of Injury' (a text area), 'Injury Type', 'Activity Code - ICD10', 'Specify', 'Alcohol Involvement - ICD10', 'Injury Mechanism', 'Motor Vehicle Crash' (with sub-fields for 'Position in Vehicle' and 'Impact Location'), 'Police Report Number', 'Disaster Casualty' (with a dropdown menu showing '1 Not Multiple or Mass'), and 'Casualty Event'. At the bottom, there is a toolbar with icons for 'Check', 'Save', 'Save and Exit', 'Print', and 'Close', along with 'Prev' and 'Next' navigation buttons. The status bar at the very bottom shows 'Arrive: 10/3/2019', 'Trauma Number: 20153426', and 'MRN:'. An orange arrow points to the 'Injury Mechanism' field.

Injury Mechanism

Definition

Description of the mechanism (external event) that caused the injury.

Element Values

- | | | |
|--|---------------------------|---------------------------------|
| 1. MVC (see ANSI definition below) | 5. Fall – NFS | 17. Other Penetrating Mechanism |
| 2. Fall Under 1m (3.3 ft) (Use this response for Standing Height Falls regardless of pt's physical height and actual drop from head to surface). | 6. Assault | 18. Chemical Burn |
| 3. Fall 1m – 6m (3.3 – 19.7 ft) | 7. Motorcycle | 19. Inhalation Burn |
| 4. Fall over 6m (19.7 ft) | 8. Pedestrian | 20. Thermal Burn |
| | 9. Bicycle | 21. Electrical Burn |
| | 10. Other Blunt Mechanism | 22. Other Burn Mechanism |
| | 11. Knife | /. Not Applicable |
| | 12. Handgun | ? Unknown |
| | 13. Shotgun | |
| | 14. Other gun | |
| | 15. Glass | |
| | 16. Biting | |

According to ANSI D16-2017, a motor vehicle is defined as the following:

1. Automobile (See 2.2.12)
 - Van, passenger or cargo (See 2.2.14.1-2)

- Van-based motorhome (See 2.2.14.3)
- Other automobile
 - Utility vehicle (See 2.2.11)
- Bus (See 2.2.10)
 - School (See 2.8)
 - Van-based (See 2.2.14.4)
 - Other
- Motorcycle (has its own response (#7) in the Registry)
 - Moped (See 2.2.9.4)
 - Autocycle (See 2.2.9.7)
- Single Unit Truck (See 2.2.19)
 - Truck tractor (See 2.2.20)
- Truck combination (See 2.2.21)
 - Single unit truck and full trailer
 - Single unit truck and semitrailer
 - Truck tractor and semitrailer
 - Truck tractor, semitrailer and full trailer(s) (double or triple)
- Other Motor Vehicle
 - ATV
 - Low speed vehicle (ex, riding lawnmower)
 - Golf cart
 - Snowmobile

Data Source Hierarchy Guide

1. EMS Run Report
2. H&P
3. Trauma Flowsheet
4. ED Nursing Note

The screenshot shows the 'Trauma Data Editor' window with the 'Injury Information' tab selected. The 'Mechanism' section includes 'Primary Mechanism' and 'Secondary Mechanism' text boxes, and a 'Cause of Injury' text area. An orange arrow points from the 'Primary Mechanism' field to the 'Motor Vehicle Crash' section. The 'Motor Vehicle Crash' section contains 'Position in Vehicle' and 'Impact Location' text boxes. Below this are 'Injury Type', 'Activity Code - ICD10', 'Specify', 'Alcohol Involvement - ICD10', and 'Injury Mechanism' fields. To the right, there are 'Police Report Number', 'Disaster Casualty' (with a dropdown showing '1 Not Multiple or Mass'), and 'Casualty Event' fields. The bottom status bar displays 'Arrive: 10/9/2019 | Trauma Number: 20153426 | MRN:'.

Position in Vehicle

Definition

Where the patient was located in the vehicle during the motor vehicle crash. Will auto populate “driver” if driver is used for the ICD-10 Primary Mechanism.

NOTE: Data does not need to be a precise match. It can be taken from narrative notes (EMS Run Sheet, ED Notes, or Inpt Notes when clarity is ultimately determined that may not be possible in the Resuscitation Phase of care.)

Element Values

- | | | |
|-------------------------|------------------------|--------------------|
| 1. Driver | 7. Third Row Left | 13. Bus Passenger |
| 2. Front Seat Middle | 8. Third Row Middle | 14. Passenger NFS |
| 3. Front Seat Passenger | 9. Third Row Right | / . Not Applicable |
| 4. Second Row Left | 10. Station Wagon Rear | ? Unknown |
| 5. Second Row Middle | 11. Truck/Van Rear | |
| 6. Second Row Right | 12. Truck Bed | |

Data Source Hierarchy Guide

- | | |
|---------------------|---|
| 1. EMS Run Report | 4. IDOT Mandated Elements: Point of Impact and Seat Position: |
| 2. H&P | 5. ED Nursing Note |
| 3. Trauma Flowsheet | |

6. Progress Notes

Impact Location

Definition

The side of the vehicle that impacted with another object.

NOTE: Data does not need to be a precise match. It can be taken from narrative notes (EMS Run Sheet, ED Notes, or Inpt Notes when clarity is ultimately determined that may not be possible in the Resuscitation Phase of care.)

Element Values

- | | | |
|-------------|--------------|--------------------|
| 1. Frontal | 5. Rear | 9. Other |
| 2. Nearside | 6. Rollover | / . Not Applicable |
| 3. Far side | 7. Roof | ? . Unknown |
| 4. Side NOS | 8. Broadside | |

Data Source Hierarchy Guide

- | | |
|-------------------|--------|
| 1. EMS Run Report | 2. H&P |
|-------------------|--------|

3. Trauma Flowsheet
4. ED Nursing Note

5. Progress Notes

Police Report Number

Definition

The number assigned to the report taken by a police officer.

Data Element

1. Relevant value for data element

Data Source Hierarchy Guide

1. ED Nursing Note
2. Media Scan

Casualty Event

Definition

Name of the Mass Casualty or Disaster event.

Element Values

- Relevant values for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Incident Action Plan
3. History & Physical
4. ED Nursing Note
5. Progress Notes

Prehospital Information

- Disclaimer: Prehospital agencies all have different charting systems that are used to document prehospital care. The data may be found in different places for different agencies.
- The inclusion source at the top of the page is auto-populated based on the selection in the demographics section
- You may add multiple agencies if there were several on scene. For example a fire department that does not transport and a different transporting EMS agency. Make sure to delineate which one is the transporting agency when entering that data.
- Scene time and transport time will auto-populate based on the data entered regarding the scene arrival, departure, and arrival at destination information.
- When entering vitals, procedures, and medications the agencies that you have entered on the first tab will auto-populate at the top of the box. If you have multiple agencies please make sure to click the one that performed the intervention. If you only have one agency it will automatically populate in the top three boxes.
- Within the vitals section, the RTS and Triage RTS will auto-populate once the systolic blood pressure, pulse rate, unassisted respiratory rate and GCS are entered.
- The pediatric trauma score will only open if the patient is under the age of 18. The PTS total will auto-populate once all 6 boxes of the PTS are filled out.

The screenshot shows the 'Trauma Data Editor' application window. The 'Prehospital Information' section is expanded, displaying several input fields. An orange arrow points to the 'Extrication' field, which contains a dropdown menu with the option 'Was Patient Extricated?'. Other fields include 'Fluid Amount', 'Inclusion Source', and 'Time Required/Minutes'. Below the main form is a table for 'Scene/Transport Providers' with columns for ID, Agency, Unit, Mode, Arrived Destination Date, and Time. The bottom of the window features a toolbar with buttons for 'Check', 'Save', 'Save and Exit', 'Print', 'Close', 'Prev', and 'Next', along with a status bar showing 'Arrive: 10/3/2019', 'Trauma Number: 20153426', and 'MRN:'.

Extrication

Definition

A period of time spent removing a patient from where they were injured.

Data Elements

Was Patient Extricated?

- Yes
- No
- N/A – Not Applicable
- ? – Unknown

Time Required/Minutes

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

The screenshot shows the 'Trauma Data Editor' application window. The 'Prehospital Information' section is expanded, containing several input fields: 'Fluid Amount' (highlighted with an orange arrow), 'Inclusion Source', 'Extrication', 'Was Patient Extricated?', and 'Time Required/Minutes'. Below this is a table for 'Scene/Transport Providers' with columns for ID, Agency, Unit, Mode, Arrived Destination Date, and Time. At the bottom, there is a 'Prehospital Triage Rationale' section with a grid of input fields. The status bar at the bottom indicates 'Arrive: 10/3/2019', 'Trauma Number: 20153426', and 'MRN:'.

Fluid Amount

Definition

The amount of fluid given prehospital before arriving to your facility

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

Trauma Alert Called in by EMS

Definition

The date and time that EMS called into their medical control or your facility if you are not the resource hospital to activate a trauma.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Triage Rationale: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Content for this NTDS field, based on national guidelines, follows on the next two pages.

NOTE: NTDS Data Dictionary requires a precise data match with the EMS Run Sheet. However, NTDB/ TQIP review approved using the truncated version of the triage criteria listed on the IL EMS Run Sheets given the confidence from our IL EMS Data Coordinator that they are accurately mapped to the NEMSIS 3.4 criteria by our IL EMS database vendors. (8/25/2020)

TRAUMA TRIAGE CRITERIA (Steps 1 and 2)**Definition**

Physiologic and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

Element Values

- | | |
|--|---|
| 1. Glasgow Coma Score \leq 13 | 7. Crushed, degloved, mangled, or pulseless extremity |
| 2. Systolic blood pressure $<$ 90 mmHg | 8. Amputation proximal to wrist or ankle |
| 3. Respiratory rate $<$ 10 or $>$ 29 breaths per minute ($<$ 20 in infants aged $<$ 1 year) or need for ventilatory support | 9. Pelvic fracture |
| 4. All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee | 10. Open or depressed skull fracture |
| 5. Chest wall instability or deformity (e.g., flail chest) | 11. Paralysis |
| 6. Two or more proximal long-bone fractures | |

Additional Information

- The null value "Not Applicable" should be reported to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if EMS Run Report indicates patient did not meet any Trauma Triage Criteria.
- The null value "Not Known/Not Recorded" should be reported if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital
- Report all that apply.
- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
9501	1	Value is not a valid menu option
9502	2	Element cannot be blank
9506	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
9550	1	Multiple Entry Max exceeded

TRAUMA TRIAGE CRITERIA (Steps 3 and 4)**Definition**

EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

Element Values

- | | |
|---|---|
| 1. Fall adults: > 20 ft. (one story is equal to 10 ft.) | 8. Motorcycle crash > 20 mph |
| 2. Fall children: > 10 ft. or 2-3 times the height of the child | 9. For adults > 65; SBP < 110 |
| 3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site | 10. Patients on anticoagulants and bleeding disorders |
| 4. Crash ejection (partial or complete) from automobile | 11. Pregnancy > 20 weeks |
| 5. Crash death in same passenger compartment | 12. EMS provider judgment |
| 6. Crash vehicle telemetry data (AACN) consistent with high risk injury | 13. Burns |
| 7. Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact | 14. Burns with Trauma |

Additional Information

- The null value "Not Applicable" should be reported to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if EMS Run Report indicates patient did not meet any Trauma Triage Criteria.
- The null value "Not Known/Not Recorded" should be reported if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital
- Report all that apply.
- Consistent with NEMESIS v3.

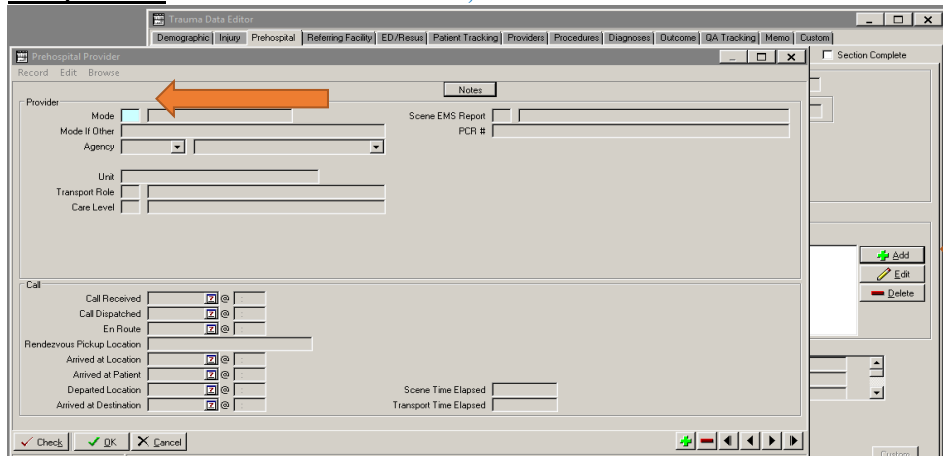
Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
9601	1	Value is not a valid menu option
9602	2	Element cannot be blank
9607	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
9650	1	Multiple Entry Max exceeded

Transport Mode: MANDATORY BLUE FIELD; NTDS Definition rules follow.



TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Element Values

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

Additional Information

Data Source Hierarchy Guide

- EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be "Not Applicable"
3440	1	Single Entry Max exceeded

NOTE: (#8 in DI) should be entered if the patient was not directly transported to your facility from the scene of injury. Entering that will open the 'Mode if Other' dialogue boxes to enter details of the scene to initial hospital transport. The details of that inter-agency transport will then be collected in the Referring Facility tab.

DI Element Values

- | | | |
|-------------------------|-------------------------------|-------------------|
| 1. Ground Ambulance | 4. Private Vehicle or Walk-in | 8. Other |
| 2. Helicopter Ambulance | 5. Police | /. Not Applicable |
| 3. Fixed-Wing Ambulance | 6. Public Safety | ? Unknown |
| | 7. Water Ambulance | |

Agency**Definition**

The prehospital agency that is responsible for some or all aspects of the patient's care prior to arrival at the hospital. There may be multiple agencies added based on who has responded to the scene.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Provider

Record Edit Browse

Notes

Provider

Mode 1 Ground Ambulance

Mode If Other

Agency

Unit

Transport Role

Care Level

Scene EMS Report

PCR #

Call

Call Received

Call Dispatched

En Route

Rendezvous Pickup Location

Arrived at Location

Arrived at Patient

Departed Location

Arrived at Destination

Scene Time Elapsed

Transport Time Elapsed

Check OK Cancel

1 of 1

Unit

Definition

Call sign used by the specific unit responding to the scene.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

The screenshot shows a software window titled "Prehospital Provider" with a menu bar (Record, Edit, Browse) and a "Notes" tab. The main form area contains several input fields:

- Mode:** A dropdown menu with "1" selected and "Ground Ambulance" displayed.
- Mode If Other:** A text input field.
- Agency:** A dropdown menu.
- Unit:** A text input field.
- Transport Role:** A dropdown menu with an orange arrow pointing to it from the right.
- Care Level:** A dropdown menu.
- Scene EMS Report:** A checkbox.
- PCR #:** A text input field.

NOTE: If the patient is transported to the hospital per this agency then Transport Role corresponds to Transport Mode in the NTDS data dictionary. All others involved in the transport correspond to the NTDS data dictionary's "Other Transport Mode." If the agency does not transport the patient, please mark the agency as non-transport.

OTHER TRANSPORT MODE

Definition

All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital.

Element Values

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

Additional Information

- Include in "Other" unspecified modes of transport.
- 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.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3550	1	Multiple Entry Max exceeded

DI Data Elements

- | | |
|--|--------------------------------------|
| 1. Non-Transport | 5. Transport to Other |
| 2. Transport from Scene to Facility | 6. Transport from Non-Scene Location |
| 3. Transport from Scene to Rendezvous | /. Not Applicable |
| 4. Transport from Rendezvous to Facility | ? Unknown |

Care Level**Definition**

The level of care the agency is able to provide to the patient based on Illinois State EMS regulations.

Element Values

1. Advanced Life Support
2. Basic Life Support
- /. Not Applicable
- ? Unknown

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Provider

Record Edit Browse

Notes

Provider

Mode 1 Ground Ambulance

Mode If Other

Agency

Unit

Transport Role

Care Level

Scene EMS Report

PCR #

Call

Call Received

Call Dispatched

En Route

Rendezvous Pickup Location

Arrived at Location

Arrived at Patient

Departed Location

Arrived at Destination

Scene Time Elapsed

Transport Time Elapsed

Check OK Cancel

1 of 1

Call Received Date and Time

Definition

The date and time that the call was received by the dispatcher

Data Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

EMS Dispatch Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

EMS DISPATCH DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
2801	1	Date is not valid
2802	1	Date out of range
2803	3	EMS Dispatch Date is earlier than Date of Birth
2804	3	EMS Dispatch Date is later than EMS Unit Arrival on Scene Date
2805	3	EMS Dispatch Date is later than EMS Unit Scene Departure Date
2806	3	EMS Dispatch Date is later than ED/Hospital Arrival Date
2807	3	EMS Dispatch Date is later than ED Discharge Date
2808	3	EMS Dispatch Date is later than Hospital Discharge Date
2809	2	Element cannot be blank
2840	1	Single Entry Max exceeded

EMS Dispatch Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.

EMS DISPATCH TIME

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
2901	1	Time is not valid
2902	1	Time out of range
2903	3	EMS Dispatch Time is later than EMS Unit Arrival on Scene Time
2904	3	EMS Dispatch Time is later than EMS Unit Scene Departure Time
2905	3	EMS Dispatch Time is later than ED/Hospital Arrival Time
2906	3	EMS Dispatch Time is later than ED Discharge Time
2907	3	EMS Dispatch Time is later than Hospital Discharge Time
2908	2	Element cannot be blank
2940	1	Single Entry Max exceeded

En-Route Date and Time

Definition

The date and time that unit was en-route to the scene.

Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Provider

Record Edit Browse

Notes

Provider

Mode 1 Ground Ambulance

Mode If Other

Agency

Unit

Transport Role

Care Level

Scene EMS Report

PCR #

Call

Call Received

Call Dispatched

En Route

Rendezvous Pickup Location

Arrived at Location

Arrived at Patient

Departed Location

Arrived at Destination

Scene Time Elapsed

Transport Time Elapsed

Rendezvous Pickup Location

Definition

Will only populate if the pt. was transported to a rendezvous point to be transported by a different agency. The location where the transporting agency intercepted the patient.

Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

The date the unit transporting to your hospital arrived on the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	EMS Unit Arrival on Scene Date is earlier than Date of Birth
3004	3	EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date
3005	3	EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date
3006	3	EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date
3007	3	EMS Unit Arrival on Scene Date is later than ED Discharge Date
3008	3	EMS Unit Arrival on Scene Date is later than Hospital Discharge Date
3009	3	EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days
3010	2	Element cannot be blank
3040	1	Single Entry Max exceeded

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Definition

The time the unit transporting to your hospital arrived on the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3101	1	Time is not valid
3102	1	Time out of range
3103	3	EMS Unit Arrival on Scene Time is earlier than EMS Dispatch Time
3104	3	EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time
3105	3	EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time
3106	3	EMS Unit Arrival on Scene Time is later than ED Discharge Time
3107	3	EMS Unit Arrival on Scene Time is later than Hospital Discharge Time
3108	2	Element cannot be blank
3140	1	Single Entry Max exceeded

The screenshot shows the 'Prehospital Provider' software interface. The window title is 'Prehospital Provider' and it has a menu bar with 'Record', 'Edit', and 'Browse'. A 'Notes' tab is active. The 'Provider' section contains fields for Mode (1 Ground Ambulance), Mode If Other, Agency, Unit, Transport Role, and Care Level. The 'Call' section contains time-stamped fields for Call Received, Call Dispatched, En Route, Rendezvous Pickup Location, Arrived at Location, Arrived at Patient, Departed Location, and Arrived at Destination. There are also fields for Scene Time Elapsed and Transport Time Elapsed. An orange arrow points to the 'Arrived at Patient' field.

Arrived at Patient Date and Time

Definition

The date and time that the prehospital personnel made contact with the patient.

Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

The date the unit transporting to your hospital left the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3201	1	Date is not valid
3202	1	Date out of range
3203	3	EMS Unit Scene Departure Date is earlier than Date of Birth
3204	3	EMS Unit Scene Departure Date is earlier than EMS Dispatch Date
3205	3	EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date
3206	3	EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date
3207	3	EMS Unit Scene Departure Date is later than ED Discharge Date
3208	3	EMS Unit Scene Departure Date is later than Hospital Discharge Date
3209	3	EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date is greater than 7 days
3210	2	Element cannot be blank
3240	1	Single Entry Max exceeded

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

The time the unit transporting to your hospital left the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3301	1	Time is not valid
3302	1	Time out of range
3303	3	EMS Unit Scene Departure Time is earlier than EMS Dispatch Time
3304	3	EMS Unit Scene Departure Time is earlier than EMS Unit Arrival on Scene Time
3305	3	EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time
3306	3	EMS Unit Scene Departure Time is later than the ED Discharge Time
3307	3	EMS Unit Scene Departure Time is later than Hospital Discharge Time
3308	2	Element cannot be blank
3340	1	Single Entry Max exceeded

Arrived at Destination Date and Time

Definition

The date and time that the transporting unit arrived to the hospital.

Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

Scene EMS Report

Definition

The prehospital report and its level of completion/hospital’s access to the report.

Element Values

- | | | |
|---------------|----|----------------|
| 1. Complete | /. | Not Applicable |
| 2. Incomplete | ? | Unknown |
| 3. Missing | | |
| 4. Unreadable | | |

Data Source Hierarchy Guide

1. EMS Run Report
2. Media or Scanned Documents

PCR Number**Definition**

The unique number assigned to the patient and the EMS call by the EMS agency.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Vitals Date and Time Recorded

Definition

The date and time that the prehospital vitals were obtained.

Element Values

- Relevant Values for data element

Data Source Hierarchy Guide

1. EMS Run Report

Paralytic Agents

Definition

Patient was given paralytic agents prior to vitals being obtained and within their duration of effect.

Element Values

- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report

Sedated

Definition

Patient was given sedative agents prior to vitals being obtained and within their duration of effect.

Element Values

- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report

The screenshot shows the 'Prehospital Vitals' form in a software application. The form is organized into several sections:

- Scene/Transport:** Recorded [] @ [] : []
- Prehospital Vitals:**
 - Provider: []
 - Agency: []
 - Unit: []
 - At Time Vitals Taken:
 - Paralytic Agents?
 - Sedated?
 - Eye Obstruction?
 - Intubated?
 - Respiration Assisted?
 - If Yes, Method: []
 - If Yes, Type: []
 - Vitals:
 - SBP/DBP: [] / []
 - Pulse Rate: []
 - Unassisted Resp Rate: []
 - Assisted Resp Rate: []
 - O2 Saturation: []
 - Supplemental O2:
 - GCS: Eye [], Verbal [], Motor [], Total [], RTS [], Triage RTS [], GCS 40
- Prehospital Medications:** ID [], Agen []
- Prehospital Physical Exam:** ID [], Agen []
- PTS:** Weight [], Airway [], Skeletal [], Cutaneous [], CNS [], Pulse Palp [], PTS Total []

At the bottom, there are buttons for 'Check', 'OK', 'Cancel', and navigation arrows. The status bar at the very bottom shows 'Arrive: 10/9/2019', 'Trauma Number: 20153426', and 'MRN: []'.

Eye Obstruction

Definition

Injury or other condition that causes the patient to be unable to open their eyes or obstructs their vision at the time the vitals were taken.

Element Values

- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report

The screenshot shows a software window titled "Prehospital Vitals" with a menu bar (Demographic, Injur, Record, Edit, Browse). The form is divided into several sections:

- At Time Vitals Taken:** Includes checkboxes for "Paralytic Agents?", "Sedated?", "Eye Obstruction?", "Intubated?", "Inspiration Assisted?", and "If Yes, Method". An orange arrow points to the "Intubated?" checkbox, which is checked.
- Vitals:** Includes checkboxes for "SBP/DBP", "Pulse Rate", "Unassisted Resp Rate", "Assisted Resp Rate", "O2 Saturation", "Supplemental O2", "GCS: Eye", "Verbal", "Motor", "Total", "RTS", and "Triage RTS". The "GCS 40" checkbox is checked.
- PTS:** Includes checkboxes for "Weight", "Airway", "Skeletal", "Cutaneous", "CNS", "Pulse Palp", and "PTS Total".

At the bottom, there are navigation buttons (Check, OK, Cancel) and a status bar showing "Arrive: 10/9/2019", "Trauma Number: 20153426", and "MRN:".

Intubated

Definition

Patient had an airway device in place when the vitals were taken.

Element Values

Intubated

- Yes
- No
- ? Unknown
- N/A Not Applicable

If Yes, Method:

1. Combitube
2. Cricothyrotomy
3. Cricothyrotomy – Needle
4. Endotracheal Tube – Nasal
5. Endotracheal Tube – Oral
6. Endotracheal Tube – Route NFS
7. Esophageal Obturator Airway
8. Laryngeal Mask Airway
9. LT Blind Insertion Airway Device
10. Tracheostomy
- ? Unknown

Data Source Hierarchy Guide

1. EMS Run Report

Respiration Assisted

Definition

Patient's respirations were being assisted by an external device while vitals were taken.

Element Values

Respiration Assisted

- Yes
- No

- ? Unknown
- N/A Not Applicable

If Yes, Type

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Bag Valve Mask 2. Nasal Airway 3. Oral Airway | <ol style="list-style-type: none"> 4. Ventilator ?. Unknown |
|--|---|

Data Source Hierarchy Guide

1. EMS Run Report

Initial Field Systolic BP: MANDATORY BLUE FIELD; NTDS Definition rules follow.

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Definition

First recorded systolic blood pressure measured at the scene of injury.

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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.
- 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 at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3601	1	Invalid value
3602	2	Element cannot be blank
3603	3	The value is above 220
3606	2	The value submitted falls outside the valid range of 0-380
3607	3	The value is below 30
3640	1	Single Entry Max exceeded

NOTE: First recorded diastolic blood pressure *measured at the scene of injury*

Diastolic Blood Pressure

Definition

The first recorded diastolic blood pressure recorded at the scene of injury

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

Initial Field Pulse Rate: MANDATORY BLUE FIELD; NTDS Definition rules follow.

INITIAL FIELD PULSE RATE

Definition

First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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.
- 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 at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3701	1	Invalid value
3702	2	Element cannot be blank
3703	3	The value submitted is above 220
3706	2	The value submitted falls outside the valid range of 0-300
3707	3	The value submitted is below 30
3740	1	Single Entry Max exceeded

Initial Field Resp Rate: MANDATORY BLUE FIELD; NTDS Definition rules follow.

INITIAL FIELD RESPIRATORY RATE

Definition

First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).

Element Values

- Relevant value for data element.

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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 at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3801	1	Invalid value
3802	2	Element cannot be blank
3806	2	The value submitted falls outside the valid range of 0-100
3807	3	The value is below 5
3808	3	The value is above 75
3840	1	Single Entry Max exceeded

NOTE: Unassisted Resp. Rate should be used if patient is breathing on their own. Assisted Resp. Rate should be used if patient's respirations are being supported by an external device.

Initial Field O2 Saturation: MANDATORY BLUE FIELD; NTDS Definition rules follow.

INITIAL FIELD OXYGEN SATURATION

Definition

First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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 at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3901	1	Invalid value
3902	2	Element cannot be blank
3906	2	The value submitted falls outside the valid range 0-100
3907	3	The value is below 40
3940	1	Single Entry Max exceeded

Supplemental O2

Definition

Patient was being administered oxygen at the time that vitals were taken. Note – Initial Field Oxygen Saturation must be entered prior to oxygen administration.

Element Values

- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS - EYE

Definition

First recorded Glasgow Coma Score (Eye) measured at the scene of injury.

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

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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 reported. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be reported, 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 - Eye was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 – Eye is reported.

Data Source Hierarchy Guide

- 1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4001	1	Value is not a valid menu option
4003	2	Element cannot be blank
4006	2	Element must be "Not Known/Not Recorded" when Initial Field GCS 40 – Eye is reported.
4040	1	Single Entry Max exceeded

Unit | _____

At Time Vitals Taken


Paralytic Agents? Intubated? If Yes, Method _____

Sedated? Respiration Assisted? If Yes, Type _____

Eye Obstruction?

Vitals

SBP/DBP / GCS: Eye _____

Pulse Rate  Verbal _____

Unassisted Resp Rate Motor _____

Assisted Resp Rate Total _____

O2 Saturation 95% RTS _____

Supplemental O2 Triage RTS _____

GCS 40

BTC

INITIAL FIELD GCS - VERBAL

Definition

First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.

Element Values

Pediatric (≤ 2 years):

- | | |
|---------------------------------------|---|
| 1. No vocal response | 4. Cries but is consolable, inappropriate interactions |
| 2. Inconsolable, agitated | 5. Smiles, oriented to sounds, follows objects, interacts |
| 3. Inconsistently consolable, moaning | |

Adult

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

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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 reported. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, 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 - Verbal was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 - Verbal is reported.

Data Source Hierarchy Guide

- EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4101	1	Value is not a valid menu option
4103	2	Element cannot be blank
4106	2	Element must be "Not Known/Not Recorded" when Initial Field GCS 40 - Verbal is reported.
4140	1	Single Entry Max exceeded

Unit |

At Time Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation 95

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

GCS 40

PTC

INITIAL FIELD GCS - MOTOR

Definition

First recorded Glasgow Coma Score (Motor) measured at the scene of injury.

Element Values

Pediatric (≤ 2 years):

- | | |
|----------------------|--|
| 1. No motor response | 4. Withdrawal from pain |
| 2. Extension to pain | 5. Localizing pain |
| 3. Flexion to pain | 6. Appropriate response to stimulation |

Adult

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

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- 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 reported. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, 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 at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 - Motor is reported.

Data Source Hierarchy Guide

- EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4201	1	Value is not a valid menu option
4203	2	Element cannot be blank
4206	2	Element must be "Not Known/Not Recorded" when Initial Field GCS 40 – Motor is reported.
4240	1	Single Entry Max exceeded

Pediatric Trauma Score: Weight

Definition

The weight of the patient at the time of injury. Will only populate if patient is under the age of 18.

Element Values

- | | |
|-------------------------------------|-------------------|
| 2. Greater than 20kg (44 lbs.) | /. Not Applicable |
| 1. Between 10 and 20kg (22-44 lbs.) | ? Unknown |
| -1. Less than 10kg (22 lbs.) | |

Data Source Hierarchy Guide

1. EMS Run Report

Pediatric Trauma Score: Airway

Definition

The status of the patient’s airway upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values

- | | | |
|--------------------------------|----|----------------|
| 1. Normal | /. | Not Applicable |
| 2. Maintainable | | |
| 3. Unmaintainable or Intubated | ? | Unknown |

Data Source Hierarchy Guide

1. EMS Run Report

Pediatric Trauma Score: Skeletal

Definition

The presence or absence of known fractures on EMS assessment will only populate if patient is under the age of 18.

Element Values

- | | | |
|-------------------------------|----|----------------|
| 1. None | /. | Not Applicable |
| 2. Closed Fracture | ? | Unknown |
| 3. Open or Multiple Fractures | | |

Data Source Hierarchy Guide

1. EMS Run Report

Pediatric Trauma Score: Cutaneous

Definition

The presence or absence of open wounds on EMS assessment. Will only populate if patient is under the age of 18.

Element Values

- | | | |
|--------------------------------------|----|----------------|
| 2. No Open Wounds | /. | Not Applicable |
| 1. Minor Open Wounds | ? | Unknown |
| -1. Major or Penetrating Open Wounds | | |

Data Source Hierarchy Guide

1. EMS Run Report

Pediatric Trauma Score: CNS

Definition

The mental status of the patient upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values

- | | | |
|--------------------------------------|----|----------------|
| 2. Awake | /. | Not Applicable |
| 1. Altered Mental Status or Obtunded | ? | Unknown |
| -1. Coma or Abnormal Flexion | | |

Data Source Hierarchy Guide

1. EMS Run Report

Pediatric Trauma Score: Pulse Palp

Definition

The presence or absence of pulses in different anatomical areas upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values

- | | |
|---|---|
| <ul style="list-style-type: none"> 2. Pulse Palpable at Wrist (SBP over 90 mmHg) 1. Pulse Palpable at Groin (SBP Btwn 50 and 90 mmHg) | <ul style="list-style-type: none"> -1. Pulse Not Palpable (SBP under 50 mmHg) /. Not Applicable ?. Unknown |
|---|---|

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Procedure

Definition

Medical interventions performed by EMS or first responders either on scene or en-route to the initial treatment facility

NOTE: Illinois consensus is to enter only those invasive prehospital procedures essential to the diagnosis, stabilization, or treatment of the patient's specific injuries. Facilities may choose to enter more, but entering ALL interventions is no longer encouraged as the EMS database is a robust resource to gather that information now.

DI Element Values

- | | | |
|------------------------------|---|--------------------------------|
| 0. None | 16. Cricothyrotomy-Needle | 28. Intravenous Fluids |
| 1. Airway-Nasal | 17. Decontamination | 29. Laryngeal Mask Airway |
| 2. Airway Opened or Cleared | 18. Defibrillation-Automated | 30. LT Blind Insertion Device |
| 3. Airway-Oral | 19. Defibrillation-Manual | 31. MAST |
| 4. Arterial Line Maintenance | 20. Defibrillation-NFS | 32. Nasogastric Tube |
| 5. Assisted Ventilation | 21. Endotracheal Tube-Nasal | 33. Pericardiocentesis |
| 6. Bag Valve Mask | 22. Endotracheal Tube-Oral | 34. Pharmacological Restraints |
| 7. Blood Draw | 23. Endotracheal Tube Route Note Recorded | 35. Physical Restraints |
| 8. Blood Glucose Analysis | 24. Esophageal Obturator Airway | 36. Rapid Sequence Intubation |
| 9. Cardiac Monitor | 25. Extrication | 37. Rescue |
| 10. Chest Tube | 26. Intra-Aortic Balloon Pump | 38. Spinal Immobilization |
| 11. Child Birth | 27. Intraosseous Access or Infusion | 39. Splinting |
| 12. CNS Catheter | | 40. Thoracostomy-Needle |
| 13. Combitube | | |
| 14. CPR | | |
| 15. Cricothyrotomy | | |

Prehospital Information

106

- | | | |
|-----------------------------|--------------------------|---------------------|
| 41. Tracheostomy | 46. Wound Care | / . Not Application |
| 42. Traction | 47. Other | ? . Unknown |
| 43. Urinary Catheterization | 48. C-Collar Application | |
| 44. Venous Access | 49. Hemorrhage Control | |
| 45. Ventilator | 50. Tourniquet | |

Data Source Hierarchy Guide

1. EMS Run Report

Referring Facility Information

- Disclaimer: Referring facilities may have different electronic health records and therefore paperwork and modes of transfer of information may be different. Due to this there is not pictures of where to find the information because the documentation can be so vastly different.
- For example if a patient is in the same hospital system, the chart can be accessed from our electronic health record.
- Some facilities have the same electronic health record and the information maybe be viewed through the care everywhere button.
- Other facilities may not be compatible with our system and may send their paperwork with the patient which will be scanned into the system and found under the media tab.
- Referring facility length of stay will be calculated once the arrival and departure time are documented.
- Referring facilities vitals, medications, procedures, and inter-facility transport will auto-populate the name of the referring facility at the top of the box. Please note if there are more than one referring facility then you need to choose which intervention was done at which facility.
- In the inter-facility transport section, the transport time will auto-populate based on departure date and time from the referring facility and arrival to the receiving facility date and time.

Inter-Facility Transfer: MANDATORY BLUE FIELD; NTDS Definition rules follow.

The screenshot shows a software window titled 'Referring Facility Information' with several tabs: 'Referral History', 'Assessments', 'Vitals/Medication', 'Procedures', 'Inter-Facility Transport', and 'Notes'. The 'Inter-Facility Transport' tab is active. Below the tabs, there are two sub-sections: 'Immediate Referring Facility' and 'Additional Referring Facilities'. An orange arrow points to the 'Transfer In?' checkbox, which is checked. Below this, there are fields for 'Referring Facility' (with a dropdown menu), 'If Other' (with a text input), 'Arrival' (with a date and time picker), 'Departure' (with a date and time picker), and 'Length of Stay' (with a text input). There is also a 'Late Referral' section with a dropdown menu set to 'Not Applicable'. At the bottom, there is a 'Transfer Rationale' dropdown menu set to '2 Level of Care' and a 'Trans Fac Notified' checkbox which is checked. A 'Custom' button is located at the bottom right of the form area.

INTER-FACILITY TRANSFER

Definition

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

Element Values

- 1. Yes
- 2. No

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
4401	2	Element cannot be blank
4402	1	Value is not a valid menu option
4405	2	Element cannot be "Not Applicable"
4440	1	Single Entry Max exceeded

Referral History | Assessments | Vitals/Medication | Procedures | Inter-Facility Transport | Notes | Section Complete

Immediate Referring Facility | Additional Referring Facilities

Transfer In

Immediate Referring Facility

Referring Facility Arrival @ :

If Other Departure @ :

Length of Stay

Late Referral / Not Applicable

Transfer Rationale 2 | Level of Care

Trans Fac Notified @ :

Custom

Referring Facility

Definition

The name and ID number of the facility that redereced emergency are for the patient priot to being transported to your facility

Element Values

1. Relavant Value for Data Element

Element values can be found in numbers or names. A name will auto-populate the numer and the number will auto-populate the name.

Data Source Hierarchy


- a. Access Center Triage Note (Trauma Triage flowsheet)
- b. Referring Facility Record
- c. EMS Run Record

Referral History | Assessments | Vitals/Medication | Procedures | Inter-Facility Transport | Notes Section Complete

Immediate Referring Facility | Additional Referring Facilities

Transfer In

Immediate Referring Facility

Referring Facility 

If Other

Arrival @ :

Departure @ :

Length of Stay

Late Referral / Not Applicable

Transfer Rationale 2 | Level of Care

Trans Fac Notified @ :

Referring Facility: Departure Date and Time

Definition

The time and date the patient left the facility that rendered emergency care for the patient prior to being transported to your facility.

Element Values

2. Relevant Value for Data Element.

Data Source Hierarchy

1. Referring Facility Record
2. EMS Run Record

Facility Level

Defintion

The state designation of the facility that rendered emergency care for the patient prior to being transported to your facility.

Element Values

- | | |
|-------------------|--------------------|
| 1. Non-Designated | 9. Other Specialty |
| 2. Level I | / . Not Applicable |
| 3. Level II | ? . Unknown |
| 4. Level III | |
| 5. Level IV | |
| 6. Level V | |

Data Source Hierarchy Guide

4. Referring Facility Paperwork

Late Referral

Definition

The reason why transport from the referring facility to your facility was delayed.

Element Values

- Over 6 hours in ED or Resus
- Surgery Performed
- Admissions
- ICU
- Radiology
- Referring Physician Decisions
- 7. Weather or Natural Forces
- 8. Mass Casualty Incident
- 9. EMS Transfer Issues
- 10. Destination Facility Issues
- /. Not Applicable
- ? Unknown

Data Source Hierarchy Guide

- 0. Referring Facility Paperwork

Transfer Rationale

Definition

The reason why the patient needed to be transferred to your facility.

Element Values

- | | | |
|--------------------|----|----------------|
| 1. Economic | /. | Not Applicable |
| 2. Level of Care | ? | Unknown |
| 3. Personal | | |
| 4. System Protocol | | |
| 5. Other | | |

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Transfer Rationale By

Definition

The individual at the referring facility that made the decision to transfer the patient to you facility.

Element Values

- | | | |
|--------------|----|----------------|
| 1. Physician | /. | Not Applicable |
| 2. Patient | ? | Unknown |
| 3. Payor | | |

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Additional Referring Facility Information

Record Edit Browse

Referring Facility Information

Referring Facility

If Other

Arrival @ :

Departure @ :

Length of Stay

Late Referral / Not Applicable

Transfer Rationale 2 Level of Care

Trans Fac Notified @ :

Check OK Cancel

1 of 1

Additional Referring Facilities

Defintion

Was the patient transported to an additional facility, other than the referring facility that transported the patient to your facility?

Element Values

3. Relevant Value for Data Element.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
2. Trauma/ Triage flowsheet

Additional Referring Facility

Definition

The name and ID number of the facility that rendered emergency care for the patient prior to being transported to the hospital that referred the patient to your facility.

Element Values

4. Relevant Value for Data Element
5. Element Values can be found in numbers or names. A name will auto-populate the number and the number will auto-populate the name.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
2. EMS Run Sheet

Additional Referring Facility Information

Record Edit Browse

Referring Facility Information

Referring Facility [dropdown] [dropdown]

If Other [text field]

Referring Physician [text field]

Facility Level [checkbox] [text field]

Transfer Rationale [checkbox] [text field] By [checkbox] [text field]

Arrival [date and time field]

Departure [date and time field]

Length of Stay [text field]

Late Referral [checkbox] [text field]

[checkbox] [text field]

[checkbox] [text field]

Check OK Cancel

1 of 1

Additional Referring Facility Arrival Date and Time

Definition

The time and date the patient arrived at the facility that rendered emergency care for the patient, prior to being transported to the hospital that referred the patient to your facility.

Element Values

6. Relevant Value for Data Element.

Data Sourced Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

Additional Referring Facility Information

Record Edit Browse

Referring Facility Information

Referring Facility [dropdown] [dropdown]

If Other [text field]

Referring Physician [text field]

Facility Level [checkbox] [text field]

Transfer Rationale [checkbox] [text field] By [checkbox] [text field]

Arrival [date/time picker]

Departure [date/time picker]

Length of Stay [text field]

Late Referral [checkbox] [text field]

[checkbox] [text field]

[checkbox] [text field]

Check OK Cancel

1 of 1

Additional Referring Facility Departure Date and Time

Definition

The time and date the patient left the facility that rendered emergency care for the patient, prior to being transported to the hospital that referred the patient to your facility.

Element Values

1. Relevant Value for Data Element

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

Additional Referring Facility: Facility Level

Defintion

The state designation of the facility that rendered emergency care for the patient prior to being transported to the hospital that referred the patient to your facility

Element Values

- Non-Designated
- Level I
- Level II
- Level III
- Level IV
- Level V
- 9. Other Specialty
- /. Not Applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Additional Referring Facility
2. Referring Facility Paperwork

Additional Referring Facility: Late Referral

Definition

The reason why transport from the referring facility to the hospital that transferred the patient to your facility is delayed.

Element Values

- | | |
|----------------------------------|---------------------------------|
| 0. Over 6 hours in ED or Resus | 7. Weather or Natural Forces |
| 1. Surgery Performed | 8. Mass Casualty Incident |
| 2. Admissions | 9. EMS Transfer Issues |
| 3. ICU | 10. Destination Facility Issues |
| 4. Radiology | / . Not Applicable |
| 5. Referring Physician Decisions | ? . Unknown |

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

Additional Referring Facility Information

Record Edit Browse

Referring Facility Information

Referring Facility

Other

Arrival @ :

Departure @ :

Length of Stay

Late Referral Not Applicable

Transfer Rationale 2 Level of Care

Trans Fac Notified @ :

✓ Check OK ✗ Cancel

1 of 1

Additional Referring Facility: Transfer Rationale

Definition

The reason why the patient needed to be transferred to the hospital that transferred the patient to your facility.

Element Values

- | | |
|--------------------|-------------------|
| 1. Economic | 5. Other |
| 2. Level of Care | /. Not Applicable |
| 3. Personal | ? . Unknown |
| 4. System Protocol | |

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

Additional Referring Facility: Transfer Rational By

Definition

The individual at the referring facility that made the decision to transfer the patient to your facility, or the individual that referred the patient to your facility.

Element Values

- | | | |
|--------------|----|----------------|
| 1. Physician | /. | Not Applicable |
| 2. Patient | ? | Unknown |
| 3. Payor | | |

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork



Referral History | Assessments | **Vitals/Medication** | Procedures | Inter-Facility Transport | Notes Section Complete

Immediate Referring Facility

Initial Vitals
 Recorded @ Temperature/Unit/Route

At Time Vitals Taken
 Paralytic Agents? % Intubated? % If Yes, Method
 Sedated? % Respiration Assisted? % If Yes, Type
 Eye Obstruction? %

Vitals
 SBP/DBP / GCS: Eye
 Pulse Rate Verbal
 Unassisted Resp Rate Motor
 Assisted Resp Rate Total
 Pulse Oximetry Weighted RTS Triage RTS
 Supplemental O2 PTS PTS Total
 GCS 40

Toxicology
 Alcohol Use Indicator ETOH/BAC Level mg/dl
 Drug Use Indicators
 Drug Screen Drug Specify Clinician Administered
 If Other

Referring Facility: Initial Vitals Recorded Date and Time

Definition

The date and time that the first set of vitals were recorded at the referring facility

Element Values

- 2. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. Referring Facility

The screenshot shows a software interface for 'Referring Facility Information'. It includes tabs for 'Referral History', 'Assessments', 'Vitals/Medication', 'Procedures', 'Inter-Facility Transport', and 'Notes'. A 'Section Complete' checkbox is in the top right. The main form is titled 'Immediate Referring Facility' and contains several sections:

- Initial Vitals:** A 'Recorded' field with a question mark icon and an orange arrow pointing to a 'Temperature/Unit/Route' field.
- At Time Vitals Taken:** Fields for 'Paralytic Agents?' (Yes/No), 'Sedated?' (Yes/No), 'Eye Obstruction?' (Yes/No), 'Intubated?' (Yes/No), 'Respiration Assisted?' (Yes/No), 'If Yes, Method', and 'If Yes, Type'.
- Vitals:** Fields for 'SBP/DBP', 'Pulse Rate', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'Pulse Oximetry', 'Supplemental O2', 'GCS: Eye', 'Verbal', 'Motor', 'Total', 'Weighted RTS', 'Triage RTS', 'PTS', 'GCS 40', and 'PTS Total'.
- Toxicology:** Fields for 'Alcohol Use Indicator', 'ETOH/BAC Level' (mg/dl), and 'Drug Use Indicators'. A 'Drug Screen' table has columns for 'Drug Screen', 'Drug Specify', and 'Clinician Administered'. An 'If Other' field is at the bottom.

Referring Facility: Initial Temperature/Unit/Route

Definition

The first temperature recorded upon arrival within 30 minutes to the referring facility. Recorded as the degree, unit and route the temperature was taken.

Element values

- 3. Relevant Value for Data Element

Unit-

- F. Fahrenheit
- C. Celsius

Route-

- 1. Oral
- 2. Rectal
- 3. Rectal
- 4. Axillary
- 5. Core
- 6. Other
- 7. Temporal
- ? Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

The screenshot shows a medical form with several sections. An orange arrow points to the 'At Time Vitals Taken' section. The form includes tabs for 'Referral History', 'Assessments', 'Vitals/Medication', 'Procedures', 'Inter-Facility Transport', and 'Notes'. The 'Vitals/Medication' tab is active. The form contains various input fields for patient information, including 'Recorded' time, 'Temperature/Unit/Route', and 'At Time Vitals Taken' questions like 'Paralytic Agents? %', 'Sedated? %', and 'Eye Obstruction? %'. There are also sections for 'Vitals' (SBP/DBP, Pulse Rate, etc.), 'GCS' (Eye, Verbal, Motor), 'Triage RTS', and 'Toxicology' (Alcohol Use Indicator, Drug Use Indicators, ETOH/BAC Level, Drug Screen, etc.).

Referring Facility: Paralytic Agents

Definition

Were paralytic agents affecting the patient at the time the vitals were taken?

Element Values

- Y. Yes
- N. No
- /. Not applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility: Sedated

Definition

Were sedative agents affecting the patient at the time the vitals were taken?

Element Values

- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals/Medication' tab selected. An orange arrow points to the 'Eye Obstruction?' checkbox under the 'At Time Vitals Taken' section. The interface includes various input fields for patient data, such as 'Recorded' time, 'Temperature/Unit/Route', and 'Vitals' (SBP/DBP, Pulse Rate, etc.). There are also checkboxes for 'Paralytic Agents?', 'Sedated?', 'Intubated?', 'Respiration Assisted?', and 'Eye Obstruction?'. The 'Toxicology' section includes fields for 'Alcohol Use Indicator', 'ETOH/BAC Level', and 'Drug Use Indicators'.

Referring Facility: Eye Obstruction

Definition

Was there an eye obstruction affecting the patient at the time the vitals were taken?

Element Values

- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility: Intubated

Definition

Was the Patient intubated at the time the vitals were taken?

Element Values

- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility: Intubation Method

Definition

The device or method used to intubate the patient.

NOTE: Will only populate if you answer yes to the referring facility intubated questions.

Element Values

- | | |
|--------------------------------|--------------------------------|
| 1. Combitube | 7. Esophageal Obturator Airway |
| 2. Cricothyrotomy | 8. Laryngeal Mask Airway |
| 3. Cricothyrotomy-Needle | 9. LT Blind Insertion Device |
| 4. Endotracheal Tube-Needle | 10. Tracheostomy |
| 5. Endotracheal Tube-Oral | ? Unknown |
| 6. Endotracheal Tube-Route NFS | |

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility: Respiration Assisted

Definition

Did the patient require assisted respirations at the time the vitals were taken?

Element Values

- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility: Respiration Assisted Type

Definition

The Device used to assist the patient’s respirations.

NOTE: Will only populate if you answer **YES** to the referring facility respiration assisted question.

Element Values

- 1. Bag Valve mask
- 2. Nasal Airway
- 3. Oral Airway
- 4. Ventilator
- ?. Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

The screenshot shows a medical software interface with the following sections:

- Initial Vitals:** Recorded [] @ [] : Temperature/Unit/Route [] [] [] [] [] []
- At Time Vitals Taken:**
 - Paralytic Agents?
 - Sedated?
 - Eye Obstruction?
 - Intubated?
 - Respiration Assisted?
 - If Yes, Method [] []
 - If Yes, Type [] []
- Vitals:**
 - SBP/DBP [] / []
 - Pulse Rate [] []
 - Unassisted Resp Rate [] []
 - Assisted Resp Rate [] []
 - O2 Saturation [] []
 - Supplemental O2
 - GCS: Eye [] []
 - Verbal [] []
 - Motor [] []
 - Total [] []
 - RTS [] []
 - PTS [] []
 - GCS 40 [] []
 - Triage RTS
 - PTS Total [] []
- Toxicology:**
 - Alcohol Use Indicator [] []
 - Drug Use Indicators [] []
 - ETOH/BAC Level [] mg/dl
 - Drug Screen [] [] [] []
 - Drug Specify [] [] [] []
 - Clinician Administered [] [] [] []
 - If Other [] [] [] []

Referring Facility: Initial Systolic and Diastolic Blood Pressure

Definition

The first recorded systolic and diastolic blood pressure at the referring facility within 30 minutes or less of the patients arrival at ED/Hospital.

Element Values

- 4. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assesment. 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. Referring Facility Paperwork

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals/Medication' tab selected. An orange arrow points to the 'Pulse Rate' field in the 'Vitals' section. The interface includes various input fields for patient vitals, medication, and toxicology data.

Referring Facility: Initial Pulse Rate

Definition

The first recorded pulse in the ED/Hospital (palpated or auscultated) within 30 minutes or less of ED/Hospital arrival (expressed as number per minute).

Element Values

- 5. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assesment. Measurement reported must be without the assistance of CPR or an type of mechanical chest compressions; report the value obtained while compressions are paused.

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

Referring Facility: Unassisted Respiratory Rate

Definition

The first recorded unassisted respiratory rate in the ED/Hospital within 30 minutes or less of ED/Hospital arrival (expressed as a number per minute).

Element Value

- 6. Relevant Data for data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment. The box will only auto-populate if you check YES to the respiration assisted questions.

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

The screenshot shows a software interface with a menu bar at the top containing: Demographic, Injury, Prehospital, Referring Facility, ED/Resus, Patient Tracking, Providers, Procedures, Diagnoses, Outcome, QA Tracking, Memo, Custom. Below the menu bar are tabs: Referral History, Assessments, Vitals/Medication, Procedures, Inter-Facility Transport, Notes. A 'Section Complete' checkbox is on the right.

The main form area is titled 'Immediate Referring Facility'. It contains several sections:

- Initial Vitals:** Recorded [] @ [] : [] Temperature/Urinal/Route [] [] [] []
- All Time Vitals Taken:** Paralytic Agents? [], Sedated? [], Eye Obstruction? [], Intubated? [], Respiration Assisted? [], If Yes, Method [], If Yes, Type []
- Vitals:** SBP/DBP [] / [], Pulse Rate [], Unassisted Resp Rate [], Assisted Resp Rate [], O2 Saturation [], Supplemental O2 [], GCS: Eye [], Verbal [], Motor [], Total [], RTS [], Triage RTS [], PTS [], GCS 40 [], PTS Total []
- Toxicology:** Alcohol Use Indicator [], Drug Use Indicators [], ETOH/BAC Level [] mg/dl, Drug Screen [], Drug Specity [], Clinician Administered [], If Other []

An orange arrow points to the 'O2 Saturation' field. At the bottom, there is a toolbar with 'Check', 'Save', 'Save and Exit', 'Print', 'Close', 'Prev', 'Next' buttons. The status bar at the very bottom shows: Arrive: 1/6/2020, Trauma Number: 20154015, MRN.

Referring Facility: Oxygen Saturation

Definition

The first recorded oxygen saturation in the ED/Hospital within 30 Minutes or less of ED/Hospital arrival (expressed as a percentage).

Element Values

- 7. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assesment. If reported, report **additional data element: Supplemental Oxygen.**

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals/Medication' tab selected. The 'Initial Vitals' section has a 'Recorded' field with a dropdown menu. The 'At Time Vitals Taken' section contains checkboxes for 'Paralytic Agents?', 'Sedated?', and 'Eye Obstruction?'. The 'Vitals' section includes input fields for 'SBP/DBP', 'Pulse Rate', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'O2 Saturation', 'Supplemental O2', 'GCS: Eye', 'Verbal', 'Motor', 'Total', 'RTS', 'Triage RTS', 'PTS', and 'GCS 40'. The 'Toxicology' section has an 'Alcohol Use Indicator' and 'ETOH/BAC Level' field. The 'Drug Screen' section has a 'Drug Screen' checkbox and a table for 'Drug Specify' and 'Clinician Administered'. The bottom toolbar includes 'Check', 'Save', 'Save and Exit', 'Print', 'Close', 'Prev', and 'Next' buttons.

Referring Facility: Supplemental Oxygen

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/Hospital oxygen saturation within 30 minutes or less of ED/Hospital arrival.

Element Values

- 8. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment. The box will only auto-populate if you record an oxygen saturation.

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

Referring Facility: GCS Eye

Definition

The first recorded Glasgow Coma Scale Eye in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values

- 1. No Eye Movement when Assessed / . Not Applicable
- 2. Opens Yes in Response to Painful Stimulation ? . Unknown
- 3. Opens Eyes in Response to Verbal Stimulation
- 4. Opens Eyes Spontaneously

NOTE: 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 number score may be reported.

The null value "Not Known/Not Recorded" is reported if the patient's initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Arrival Hierarchy Guide

- 1. Referring Facility Paperwork

Referring Facility: GCS Verbal

Definition

The first recorded Glasgow Coma Scale Verbal in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values

1. No Verbal Response (Pediatric \leq 2 years: No vocal response)
2. Incomprehensible Sounds (Pediatric \leq 2 years: Inconsolable, Agitated)
3. Inappropriate Words (Pediatric \leq 2 years: Inconsistently Consolable, Moaning)
4. Confused (Pediatric \leq 2 years: Cries but is consolable, Inappropriate Interactions)
5. Oriented Pediatric (Pediatric \leq 2 years: Smiles, Oriented to sounds, Interacts)

/ . Not Applicable

? . Unknown

NOTE: 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 number score may be reported.

The null value "Not Known/Not Recorded" is reported if the patient's initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows the 'Trauma Data Editor' window with the 'Referring Facility' tab selected. The 'Vitals/Medication' sub-tab is active. An orange arrow points to the 'GCS: Motor' field in the 'Vitals' section. The 'GCS: Eye' field is empty, while 'GCS: Verbal' and 'GCS: Motor' have text input fields. The 'GCS: Total' field is also present. Other fields include 'SBP/DBP', 'Pulse Rate', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'O2 Saturation', 'Supplemental O2', 'PTS', 'GCS 40', 'Triage RTS', and 'PTS Total'. The 'Toxicology' section includes 'Alcohol Use Indicator', 'Drug Use Indicators', and 'ETOH/BAC Level'. The 'Drug Screen' section has a table with columns for 'Drug Screen', 'Drug Specificity', and 'Clinician Administered'.

Referring Facility: GCS Motor

Definition

The first recorded Glasgow Coma Motor Verbal in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values

1. No Motor Response
2. Extension to Pain
3. Flexion to Pain
4. Withdrawal from Pain
5. Locating Pain
6. Obeys Commands (Pediatric ≤ 2 years: Appropriate Response to Stimulation).
- /. Not Applicable
- ? Unknown

NOTE: 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 number score may be reported.

The null value "Not Known/Not Recorded" is reported if the patient's initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows a software window titled 'Pediatric Trauma Score' with the following fields and options:

- Initial Vitals:** Recorded [] @ [] : [] Temperature/Unit/Route 98.0 [] [] []
- At Time Vitals Taken:** Paralytic Agents? Intubated? If Yes, Method 1 Combitube
- SpO2:** Respiration Assisted? If Yes, Time [] [] []
- Eye Obs:**
- Vitals Section:** SB [] Puli [] PTS []
- Weight:** [] [] []
- Airway:** [] [] []
- Skeletal:** [] [] []
- Cutaneous:** [] [] []
- CNS:** [] [] []
- Pulse Palp:** [] [] []
- PTS Total:** [] [] []
- Toxicology:** QK
- Alcohol Use Indicator:** [] [] [] ETOH/BAC Level [] mg/dL
- Drug Use Indicators:** [] [] [] [] [] []
- Drug Screen:** [] [] [] [] [] []
- Drug Specify:** [] [] [] [] [] []
- Clinician Administered:** [] [] [] [] [] []
- If Other:** [] [] [] [] [] []

Pediatric Trauma Score: Weight

Definition

The weight of the patient at the time of injury.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

2. Greater Than 20kg (44 lbs.)
1. Between 10 and 20kg (22-44 lbs.)
- 1. Less than 10kg (22 lbs.)
- /. Not applicable
- ? Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot displays a medical software interface with a 'Pediatric Trauma Score' window open. The window has a title bar with 'Pediatric Trauma Score' and a menu bar with 'Record', 'Edit', and 'Navigate'. The main area contains several input fields for patient information, including 'Weight', 'Airway', 'Skeletal', 'Cutaneous', 'CNS', 'Pulse Palp', and 'PTS Total'. An orange arrow points to the 'Airway' field. The background shows other parts of the software interface, including 'Initial Vitals', 'At Time Vitals Taken', and 'Toxicology' sections.

Pediatric Trauma Score: Airway

Definition

The status of the patient's airway upon ED/Hospital initial assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. Normal
- 1. Maintainable
- 1. Unmaintainable or Intubated
- /. Not applicable
- ?. Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

Pediatric Trauma Score: Skeletal

Definition

The presence or absence of known fractures on ED/Hospital known assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. None
- 1. Closed Fractures
- 1. Open or Multiple Fractures
- /. Not applicable
- ? Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Pediatric Trauma Score: Cutaneous

Definition

The presence or absence of open wounds on ED/Hospital initial assessment

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. No open wounds
- 1. Minor open wounds
- 1. Major or penetrating open wounds
- /. Not applicable
- ? Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

The screenshot shows a medical software interface with a 'Pediatric Trauma Score' form overlaid. The background window has tabs for 'Referral History', 'Assessments', 'Vitals/Medication', 'Procedures', 'Inter-Facility Transport', and 'Notes'. The 'Vitals/Medication' tab is active. The form includes fields for 'Initial Vitals', 'At Time Vitals Taken', 'Eye Obs', 'Vitals', 'Toxicology', and 'Drug Use Indicators'. The 'Vitals' section is highlighted with a blue bar and contains a table for recording PTS values. An orange arrow points to the 'CNS' field in the table.

Pediatric Trauma Score: CNS

Definition

The mental status of the patient upon ED/Hospital initial assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

2. Awake
1. Altered mental status or obtunded
- 1. Coma or abnormal flexion
- /. Not applicable
- ? Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows a medical software interface with a 'Pediatric Trauma Score' window open. The window has a title bar and a menu bar with 'Record', 'Edit', and 'Navigate'. The main area contains several input fields for different assessment categories. An orange arrow points to the 'Pulse Palp' field. Below the main form, there are sections for 'Toxicology' and 'Drug Use Indicators'.

Pediatric Trauma Score: Pulse Palp

Definition

The presence or absence of pulses in different anatomical areas upon ED/Hospital initial assesment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. Pulse Palpable at Wrist (SBP over 90 mmHg)
- 1. Pulse Palpable at groin (SBP btwn 50 and 90 mmHg)
- 1. Pulse not palpable (SBP under 50 mmHg)
- /. Not applicable
- ? . Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

Referring Facility ETOH Use: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Referral History | Assessments | Vitals/Medication | Procedures | Inter-Facility Transport | Notes Section Complete

Immediate Referring Facility

Initial Vitals
 Recorded @ : Temperature/Unit/Route

At Time Vitals Taken
 Paralytic Agents? Inubated? If Yes, Method
 Sedated? Respiration Assisted? If Yes, Type

Vitals
 SBP/DBP / GCS: Eye
 Pulse Rate Verbal
 Unassisted Resp Rate Motor
 Assisted Resp Rate Total
 O2 Saturation RTS Triage RTS
 Supplemental O2 PTS PTS Total

Toxicology
 Alcohol Use Indicator ETOH/BAC Level mg/dl
 Drug Use Indicators
 Drug Screen Drug Specity Clinician Administered
 If Other

Referring Facility: Alcohol Use Indicator

Definition

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

Element Values

1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test)
4. Yes (confirmed by test: beyond legal limit)
- /. Not applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows a medical software interface with a menu bar at the top containing options like 'Graphic', 'Injury', 'Intrahospital', 'Referring Facility', 'EM/HESUS', 'Patient Tracking', 'Providers', 'Procedures', 'Diagnoses', 'Outcome', 'QA Tracking', 'Memo', and 'Custom'. Below the menu bar, there are tabs for 'Vitals/Medication', 'Procedures', 'Inter-Facility Transport', and 'Notes'. The main content area is divided into several sections: 'Vital Vitals' with fields for 'Recorded' and 'Temperature/Unit/Route'; 'Time Vitals Taken' with checkboxes for 'Paralytic Agents?', 'Sedated?', 'Eye Obstruction?', 'Intubated?', and 'Respiration Assisted?'; 'Vitals' with fields for 'SBP/DBP', 'Pulse Rate', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'O2 Saturation', 'Supplemental O2', 'GCS: Eye', 'Verbal', 'Motor', 'Total', 'RTS', 'Triage RTS', 'PTS', and 'GCS 40'; and 'Toxicology' with fields for 'Alcohol Use Indicator', 'Drug Use Indicators', 'ETOH/BAC Level', and a table for 'Drug Screen', 'Drug Specify', and 'Clinician Administered'. An orange arrow points to the 'Drug Use Indicators' field in the 'Toxicology' section.

Referring Facility: Drug Use Indicator

Definition

A Drug Test was performed on the patient within 24 hours after the first hospital encounter.

Element Values

1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test: prescription drugs)
4. Yes (confirmed by test: illegal drug use)
- /. Not applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

MANDATORY BLUE FIELD; NTDS Definition rules follow.

Referring Facility: ETOH/BAC Level

Definition

First recorded blood alcohol concentration (BAC) results within 24 hours after first initial hospital encounter.

Elemental Values

9. Relevant value for data element.

NOTE: Reported as grams per deciliter.

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility Drug Screen: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Definition

First recorded positive drug screen results within 24 hours after first hospital encounter (record all that apply).

Element Values

- | | |
|---------------------------|------------------------------------|
| 1. AMP (Amphetamine) | 9. OXY (Oxycodone) |
| 2. BAR (Barbituate) | 10. PCP (Phencyclidine) |
| 3. BZO (Benzodiazepines) | 11. TCA (Tricyclic Antidepressant) |
| 4. COC (Cocaine) | 12. THC (Cannabinoid) |
| 5. mAMP (Methamphetamine) | 13. Other |
| 6. MDMA (Ecstasy) | 15. Not Tested |
| 7. MTD (Methadone) | ?. Unknown |
| 8. OPI (Opioid) | |

NOTE: Drug Screen may be administered at any facility, unit or setting treating the patient event.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referral History | Assessments | **Vitals/Medication** | Procedures | Inter-Facility Transport | Notes | Section Complete

Immediate Referring Facility

Initial Vitals
 Recorded @ Temperature/Unit/Route

At Time Vitals Taken
 Paralytic Agents? Sedated? Eye Obstruction?
 Intubated? Respiration Assisted? If Yes, Method
 If Yes, Type

Vitals
 SBP/DBP / Pulse Rate
 Unassisted Resp Rate Assisted Resp Rate
 O2 Saturation Supplemental O2
 GCS: Eye Verbal
 Motor Total
 PTS GCS 40 Triage RTS PTS Total

Toxicology
 Alcohol Use Indicator Yes [Confirmed by Test [Trace Levels]] ETOH/BAC Level mg/dl
 Drug Use Indicators

Drug Screen	Drug Specify	Clinician Administered
<input checked="" type="checkbox"/>	10 PCP (Phencyclidine)	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="text" value=""/>	<input type="checkbox"/>

 If Other

Custom

Referring Facility: Clinician Administered

MANDATORY BLUE FIELD; NTDS Definition rules follow.

Definition

Was the drug screen positive because that particular medication was administered by a clinician?

Element Values

- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows a software window titled "Referring Facility Vitals". An orange arrow points to the "Referring Facility" dropdown menu. The window is divided into several sections:

- Header:** Includes "Referring Facility" (dropdown), "Assessment Type" (dropdown), and "Recorded" (text field).
- At Time Vitals Taken:** Contains checkboxes for "Paralytic Agents?", "Sedated?", "Eye Obstruction?", "Intubated?", "Respiration Assisted?", and "If Yes, Method/Type" (text fields).
- Vitals:** Includes input fields for "SBP/DBP", "Pulse Rate", "Unassisted Resp Rate", "Assisted Resp Rate", "O2 Saturation", "Supplemental O2", "GCS: Eye", "Verbal", "Motor", "Total", "RTS", and "Triage RTS".
- PTS:** Includes input fields for "Weight", "Airway", "Skeletal", "Cutaneous", "CNS", "Pulse Palp", and "PTS Total".

 The window also features a sidebar on the left with a table for "Referring Facility" and a control panel on the right with "Add", "Edit", and "Delete" buttons. At the bottom, there are standard software controls like "Check", "OK", "Cancel", "Save", "Print", and "Close".

Additional Referring Facility: Vitals

Definition

Any additional vitals recorded at the referring facility prior to transfer to your facility.

Element Values

10. Refer to previous vitals for specific information regarding the documentation of the vital signs.

NOTE: These vitals do not have to be performed within the first 30 minutes of arrival to the ED/Hospital.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Referring Facility: Procedures

Definition

Operative and selective non-operative procedures conducted during the referring facility 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.

Element Values

1. Major and minor procedures ICD-10 codes.

NOTE: Only report procedures performed at the referring facility

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows a data entry form for 'Referring Facility Procedure ICD10'. The form includes the following fields and controls:

- Referring Facility:** A dropdown menu.
- ICD10 Code:** A text input field.
- Start:** A date and time input field with a calendar icon and a time selection icon. An orange arrow points to this field.
- Diagnostic Result:** A text input field.
- Notes:** A multi-line text area.

Navigation and action buttons are located on the right side (Add, Edit, Delete) and at the bottom (Check, OK, Cancel). A status bar at the bottom left indicates '1 of 1' records.

Referring Facility: Procedure – Start Date and Time

Definition

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

Element Values

Relevant value for data element.

NOTE: Procedure start time is defined as the time the incision was made (or the procedure was started).

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The screenshot shows a software window titled "Referring Facility Procedures (All Referring Facilities)". It contains a table with columns for "ID", "Record", "Edit", and "Browse". Below the table, there are several input fields: "Referring Facility" (a dropdown menu), "ICD10 Code" (a text field), "Start" (a date/time field), "Diagnostic Result" (a text field with an orange arrow pointing to it), and "Notes" (a text area). At the bottom of the window, there are buttons for "Check", "OK", and "Cancel", along with navigation arrows and a "Custom" button.

Referring Facility: Procedure – Diagnostic Result

Definition

The operative or selected non-operative procedure had diagnostic capabilities

Element Values

- Positive /. Not Applicable
- Negative ?. Unknown
- Intermediate

NOTE: We do not input this field because we do not have a clear definition on positive or negative results. This is very difficult to determine at times. It would be more beneficial if noted normal or abnormal imaging results

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Transport Mode: MANDATORY BLUE FIELD; NTDS Definition rules follow.

TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Element Values

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

Additional Information

Data Source Hierarchy Guide

- 1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be "Not Applicable"
3440	1	Single Entry Max exceeded

DI Elements

- 1. Ambulance
- 2. Helicopter
- 3. Police
- 4. Public Safety
- 5. Private Vehicle
- 6. Walk In
- 7. Other
- /, Not Applicable
- ?, Unknown
- 8. Fixed-Wing Ambulance

Data Source Hierarchy Guide:

- 1. EMS Run Record

Inter-Facility Transport

Record Edit Browse

Referring Facility [] []

Provider

Mode []

If Other []

Agency [] []

Unit []

Transport Role []

Care Level []

EMS Report []

PCR # []

Call

Call Received [] [] @ []

Call Dispatched [] [] @ []

En Route [] [] @ []

Arrived at Location [] [] @ []

Arrived at Patient [] [] @ []

Departed Location [] [] @ []

Arrived at Destination [] [] @ []

Transport Time Elapsed []

✓ Check [] ✓ OK [] ✗ Cancel []

of 1

Agency**Definition**

The prehospital agency that is responsible for transporting the patient from the referring facility to your facility

Element Value

2. Relevant Value for Date Element

Data Source Hierarchy Guide

1. EMS Run Report

Inter-Facility Transport

Record Edit Browse

Referring Facility [] []

Provider

Mode [] EMS Report []

If Other [] PCR # []

Agency [] [] Dispatch # []

Unit [] ←

Transport Role []

Care Level []

Call

Call Received [] @ []

Call Dispatched [] @ []

En Route [] @ []

Arrived at Location [] @ []

Arrived at Patient [] @ []

Departed Location [] @ []

Arrived at Destination [] @ []

Transport Time Elapsed []

✓ Check ✓ OK ✗ Cancel

of 1

Unit**Definition**

Call sign used by the specific unit who is transferring the patient to your facility.

Element Values

3. Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

If the patient is transported to the hospital per this agency then **Transport Role** corresponds to **Transport Mode** in the NTDS data dictionary. All others involved in the transport correspond to the NTDS data dictionary’s “Other Transport Mode.”

OTHER TRANSPORT MODE

Definition

All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital.

Element Values

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

Additional Information

- Include in "Other" unspecified modes of transport.
- 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.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3550	1	Multiple Entry Max exceeded

DI Data Elements

1. Non-Transport
2. Transport from Scene to Facility
3. Transport from Scene to Rendezvous
4. Transport from Scene to Rendezvous Facility
5. Transport to Other
6. Transport from Non-Scene Location
- /. Not Applicable
- ? Unknown

The screenshot shows a software window titled "Inter-Facility Transport" with a menu bar containing "Record", "Edit", and "Browse". The interface is divided into several sections:

- Referring Facility:** Two dropdown menus.
- Provider:**
 - Mode: (checked)
 - If Other:
 - Agency: Two dropdown menus.
 - Unit:
 - Transport Role:
 - Care Level: (highlighted by an orange arrow)
 - EMS Report:
 - PCR #:
 - Dispatch #:
- Call:**
 - Call Received: [?] @
 - Call Dispatched: [?] @
 - En Route: [?] @
 - Arrived at Location: [?] @
 - Arrived at Patient: [?] @
 - Departed Location: [?] @
 - Arrived at Destination: [?] @
 - Transport Time Elapsed:

At the bottom, there are buttons for "Check", "OK", and "Cancel", along with navigation icons and a status bar showing "of 1".

Care Level**Definition**

The level of care the agency is able to provide to the patient based on Illinois State EMS Regulations.

Element Values

1. Advanced Life Support
2. Basic Life Support
- /. Not Applicable
- ? Unknown

Data Source Hierarchy Guide

1. EMS Run Report

Call Received: Date and Time

Definition

The date and time that the call was received by the dispatcher.

Element Values

- 4. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. EMS Run Report

Inter-facility EMS Dispatch Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

The screenshot shows a software interface for 'Inter-facility Transport'. The form is divided into several sections:

- Referring Facility:** Two dropdown menus.
- Provider:**
 - Mode: []
 - If Other: []
 - Agency: []
 - Unit: []
 - Transport Role: []
 - Care Level: []
 - EMS Report: []
 - PCR #: []
 - Dispatch #: []
- Call:**
 - Call Received: [] @ []
 - Call Dispatched: [] @ []
 - En Route: [] @ []
 - Arrived at Location: [] @ []
 - Arrived at Patient: [] @ []
 - Departed Location: [] @ []
 - Arrived at Destination: [] @ []
 - Transport Time Elapsed: []

EMS DISPATCH DATE**Definition**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Inter-facility EMS Dispatch Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Providers/Vitals | Procedures/Medications

Inter-Facility Transport

cord Edit Browse

Referring Facility [] []

Provider

Mode [] EMS Report []

If Other [] PCR # []

Agency [] [] Dispatch # []

Unit []

Transport Role []

Care Level []

Call

Call Received [] @ []

Call Dispatched [] @ [] ←

En Route [] @ []

Arrived at Location [] @ []

Arrived at Patient [] @ []

Departed Location [] @ []

Arrived at Destination [] @ []

Transport Time Elapsed []

EMS DISPATCH TIME**Definition**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

record edit browse

Referring Facility [] []

Provider

Mode []

If Other []

Agency [] []

Unit []

Transport Rule []

Care Level []

EMS Report []

PCR # []

Dispatch # []

Call

Call Received [] @ []

Call Dispatched [] @ []

En Route [] @ []


Arrived at Location [] @ []

Arrived at Patient [] @ []

Departed Location [] @ []

Arrived at Destination [] @ []

Transport Time Elapsed []



En-Route: Date and Time

Definition

The date and time the unit was en route to the referring facility.

Element Values

5. Relevant value for data element.

Data Source Hierarchy Guide

1. EMS Run Report

Inter-Facility EMS Arrival Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Record Edit Browse

Referring Facility

Provider

Mode

If Other

Agency

Unit

Transport Role

Care Level

EMS Report

PCR #


Dispatch #

Call

Call Received @

Call Dispatched @

En Route @

Arrived at Location @ 

Arrived at Patient @

Departed Location @

Arrived at Destination @

Transport Time Elapsed

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY**Definition**

The date the unit transporting to your hospital arrived on the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

- EMS Run Report

Referring Facility Information Form

Referring Facility: [Dropdown] [Dropdown]

Provider:

Mode: [Field]
If Other: [Field]
Agency: [Dropdown] [Dropdown]

EMS Report: [Field]
PCR #: [Field]
Dispatch #: [Field]

Unit: [Field]
Transport Role: [Field]
Care Level: [Field]

Call:

Call Received: [Field] @ [Field]
Call Dispatched: [Field] @ [Field]
En Route: [Field] @ [Field]

Arrived at Location: [Field] @ [Field]
Arrived at Patient: [Field] @ [Field] ←
Departed Location: [Field] @ [Field]
Arrived at Destination: [Field] @ [Field]

Transport Time Elapsed: [Field]

Arrived at Patient: Date and Time**Definition**

The date and time that the prehospital personnel made contact with the patients.

Element Values

6. Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

Inter-Facility EMS Departure Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Record Edit Browse

Referring Facility [] []

Provider

Mode [] EMS Report []

If Other [] PCR # []

Agency [] [] Dispatch # []

Unit []

Transport Role []

Care Level []

Call

Call Received [] @ []

Call Dispatched [] @ []

En Route [] @ []

Arrived at Location [] @ []

Arrived at Patient [] @ []

Departed Location [] @ []

Arrived at Destination [] @ []

Transport Time Elapsed []

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

The date the unit transporting to your hospital left the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Arrived at Destination: Date and Time

Definition

The date and time that the transporting unit arrived to your hospital.

Element Values

- 7. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. EMS Run Report

The screenshot shows a software interface with the following fields and sections:

- Referring Facility:** Two dropdown menus.
- Provider:**
 - Mode: (highlighted in light blue)
 - If Other:
 - Agency: Two dropdown menus
 - Unit:
 - Transport Role:
 - Care Level:
- Call:**
 - Call Received: [?] @
 - Call Dispatched: [?] @
 - En Route: [?] @
 - Arrived at Location: [?] @
 - Arrived at Patient: [?] @
 - Departed Location: [?] @
 - Arrived at Destination: [?] @
 - Transport Time Elapsed:

An orange arrow points from the 'Mode' field to the 'EMS Report' field.

Scene EMS Report

Definition

The prehospital report and its level of completion or the hospital's access to the report

Element Values

1. Complete
2. Incomplete
3. Missing
4. Unreadable
- / . Not Applicable
- ? Unknown

Data Source Hierarchy Guide

1. EMS Run Report

Record Edit Browse

Referring Facility

Provider

Mode

If Other

Agency

Unit

Transport Role

Care Level

EMS Report

PCR #

Dispatch #

Call

Call Received @

Call Dispatched @

En Route @

Arrived at Location @

Arrived at Patient @

Departed Location @

Arrived at Destination @

Transport Time Elapsed

PCR Number**Definition**

The unique number assigned to the patient and the EMS call by the EMS agency.

Element Values

8. Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

Dispatch Number**Definition**

Number assigned to this transport by the dispatch center, if provided.

Note: Given the elective versus emergent nature of the inter-facility transport, this # will likely be Unavailable.

Element Values:

9. Relevant value for data element

Data Source Hierarchy Guide:

1. EMS Run Sheet

Prehospital Vitals: Date and Time Recorded

Definition

The date and time vitals were taken during the inter-facility transport recorded.

Element Values

- 10. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. EMS Run Report

Paralytic Agents

Definition

Patient was given paralytic agents prior to vitals being obtained and within their duration of effect.

Element Values

- Y. Yes
- N. No
- ? . Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

- 3. EMS Run Report

Inter-Facility Vitals

Record Edit Browse

Provider

Referring Facility [] []

Agency [] []

Initial Vitals

Recorded [] @ []

At Time Initial Vitals Taken

Paralytic Agents? Intubated? If Yes, Method [] []

Sedated? Respiration Assisted? If Yes, Type [] []

Eye Obstruction?

Vitals

SBP/DBP [] / [] GCS: Eye [] []

Pulse Rate [] Verbal [] []

Unassisted Resp Rate [] Motor [] []

Assisted Resp Rate [] Total [] []

Pulse Oximetry [] Weighted RTS [] []

Supplemental O2 Triage RTS []

GCS 40

PTS

Weight [] [] Cutaneous [] []

Airway [] [] CNS [] []

Skeletal [] [] Pulse Palp [] []

PTS Total [] []

✓ Check [] ✓ OK [] ✗ Cancel []

1 of 1

Sedated

Definition

Patient was given sedative agent prior to vitals being obtained and within their duration of effect.

Element Values

- Y. Yes
- N. No
- ? . Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report

Eye Obstruction

Definition

Injury or other condition that causes the patient to be unable to open their eyes, or obstructs their vision at the time the vitals were taken

Element Values

- Y. Yes
- N. No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Record

Referring Facility


Agency

Unit

Initial Vitals

Recorded @

At Time Initial Vitals Taken

Paralytic Agents?  Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

GCS 40

PTS

Intubated

Definition

Patient had an airway device in place when the vitals were taken.

Element Values

- 11. Combitube
- 12. Cricothyrotomy
- 13. Cricothyrotomy – Needle
- 14. Endotracheal Tube – Nasal
- 15. Endotracheal Tube – Oral
- 16. Endotracheal Tube – Route NFS
- 17. Esophageal Obturator Airway
- 18. Laryngeal Mask Airway
- 19. LT Blind Insertion Airway Device
- 20. Tracheostomy
- /. Unknown

Data Source Hierarchy Guide

- 1. EMS Run Record

Record Edit Browse

Provider _____

Referring Facility

Agency

Unit


-Initial Vitals

Recorded: @

-At Time Initial Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction? 

-Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

GCS 40

Respiration Assisted

Definition

Patient’s respirations were being assisted by an external device while vitals were taken.

Element Values

Respiration Assisted:

- i. Yes /. Unknown
- ii. No N/A Not Applicable

If yes, Type:

- 5. Bag Valve Mask
- 6. Nasal Airway
- 7. Oral Airway
- 8. Ventilator
- ?. Unknown

Data Source Hierarchy Guide

- 1. Ems Run Report

Referring Facility	<input type="text"/>	<input type="text"/>
Agency	<input type="text"/>	<input type="text"/>
Unit	<input type="text"/>	
Initial Vitals		
Recorded	<input type="text"/>	@ <input type="text"/> :
At Time Initial Vitals Taken		
Paralytic Agents?	<input type="checkbox"/>	Intubated? <input type="checkbox"/>
Sedated?	<input type="checkbox"/>	Respiration Assisted? <input type="checkbox"/>
Eye Obstruction?	<input type="checkbox"/>	If Yes, Method <input type="text"/>
		If Yes, Type <input type="text"/>
Vitals		
SBP/DBP	<input type="text"/> / <input type="text"/>	<input type="text"/>
Pulse Rate	<input type="text"/>	Verbal <input type="text"/>
Unassisted Resp Rate	<input type="text"/>	Motor <input type="text"/>
Assisted Resp Rate	<input type="text"/>	Total <input type="text"/>
O2 Saturation	<input type="text"/>	RTS <input type="text"/>
Supplemental O2	<input type="text"/>	Triage RTS <input type="text"/>
	GCS 40	<input type="checkbox"/>
PTS		
Weight	<input type="text"/>	Cutaneous <input type="text"/>
Airway	<input type="text"/>	CNS <input type="text"/>
Skeletal	<input type="text"/>	Pulse Palp <input type="text"/>
		PTS Total <input type="text"/>

Systolic Blood Pressure/Diastolic Blood Pressure

Definition

Systolic and diastolic blood pressure measurements recorded during transport to your facility.

Element Values

- 11. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. EMS Run Report

Pulse Rate

Definition

Pulse rate recorder during transport to your facility

Element Values

- 12. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. EMS Run Report

Unassisted/Assisted Respiratory Rate

Definition

Unassisted or Assisted Respiratory rates recorded during transport to your facility.

Element Values

13. Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

Provider

Referring Facility

Agency

Unit

Initial Vitals

Recorded @ :

At Time Initial Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye


Verbal

Motor

Total

Triage RTS

GCS 40



Oxygen Saturation

Definition

The oxygen saturation measurements of the patient during transport to your facility.

Element Values

- 14. Relevant Value for Data Element

Data Source Hierarchy Guide

- 1. EMS Run Report

Referring Facility

Agency

Unit

-Initial Vitals

Recorded @

-At Time Initial Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

-Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal


Motor

Total

RTS

Triage RTS

GCS 40



Inter-Facility Transport: Supplemental O2

Definition

Patient was being administered oxygen at the time that vitals were taken.

Element Values

- 15. Yes ?. Unknown
- 16. No N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report

-Provider-

Referring Facility

Agency

Unit

-Initial Vitals-

Recorded @ :


-At Time Initial Vitals Taken-

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

-Vitals-

SBP/DBP /  GCS: Eye

Pulse Rate Verbal

Unassisted Resp Rate Motor

Assisted Resp Rate Total

O2 Saturation RTS

Supplemental O2 Triage RTS

GCS 40

Inter-Facility Transport: GCS - Eye

Definition

The patients recorded Glasgow Coma Score Eye at the time that the vitals were taken during transport to your facility.

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
- / . Not Applicable
- ? Unknown

NOTE: 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 number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

GCS 40

DTC

Inter-Facility Transport: GCS - Verbal

Definition

The patients recorded Glasgow Coma Score Verbal at the time that the vitals were taken during transport to your facility.

Element Values

1. No verbal Response (Pediatrics \leq 2 years: No Vocal Response)
2. Incomprehensible Sounds (Pediatrics \leq 2 years: Inconsolable, Agitated)
3. Inappropriate Words (Pediatrics \leq 2 years: Inconsistently Consolable, Moaning)
4. Confused (Pediatrics \leq 2 years: Cries but is Consolable, Inappropriate Interactions)
5. Oriented (Pediatrics \leq 2 years: Smiles, Oreinted to Sounds, Interacts)
- /. Not Applicable
- ? Unknown

NOTE: 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 number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record

Unit |

-At Time Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

-Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation 95

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

GCS 40

DTC

Inter-Facility Transport: GCS - Motor

Definition

The patients recorded Glasgow Coma Score Motor at the time that the vitals were taken during transport to your facility.

Element Values

1. No Motor Resonse
2. Extension to Pain
3. Flexion to Pain
4. Withdrawal from Pain
5. Localizing Pain
6. Obeys Commands (Pediatric \leq 2 years: Appropriate Response to Stimulation)
- / . Not Applicable
- ? Unknown

NOTE: 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 number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record

PTS		<input type="checkbox"/> Weight <input type="text"/>		<input type="checkbox"/> Cutaneous <input type="text"/>	
<input type="checkbox"/> Airway <input type="text"/>		<input type="checkbox"/> CNS <input type="text"/>		<input type="checkbox"/> Pulse Palp <input type="text"/>	
<input type="checkbox"/> Skeletal <input type="text"/>		<input type="checkbox"/> PTS Total <input type="text"/>			

Pediatric Trauma Score: Weight

Definition

The weight of the patient at the time of injury.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

3. Greater Than 20kg (44 lbs.)
2. Between 10 and 20kg (22-44 lbs.)
- 1. Less than 10kg (22 lbs.)
- / . Not applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

PTS		<input type="checkbox"/> Weight <input type="text"/>		<input type="checkbox"/> Cutaneous <input type="text"/>	
<input type="checkbox"/> Airway <input type="text"/>		<input type="checkbox"/> CNS <input type="text"/>		<input type="checkbox"/> Pulse Palp <input type="text"/>	
<input type="checkbox"/> Skeletal <input type="text"/>		<input type="checkbox"/> PTS Total <input type="text"/>			

Pediatric Trauma Score: Airway

Definition

The status of the patient's airway upon ED/Hospital initial assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

2. Normal
1. Maintainable
- 1. Unmaintainable or Intubated
- / . Not applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

The image shows a screenshot of the Pediatric Trauma Score (PTS) form. On the left side, under the heading 'PTS', there are three input fields: 'Weight', 'Airway', and 'Skeletal'. An orange arrow points to the 'Skeletal' field. On the right side, there are four input fields: 'Cutaneous', 'CNS', 'Pulse Palp', and 'PTS Total'.

Pediatric Trauma Score: Skeletal

Definition

The presence or absence of known fractures on ED/Hospital known assesment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. None
- 1. Closed Fractures
- 1. Open or Multiple Fractures
- /. Not applicable
- ? Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

The image shows a screenshot of the Pediatric Trauma Score (PTS) form. On the left side, under the heading 'PTS', there are three input fields: 'Weight', 'Airway', and 'Skeletal'. On the right side, there are four input fields: 'Cutaneous', 'CNS', 'Pulse Palp', and 'PTS Total'. An orange arrow points to the 'Cutaneous' field.

Pediatric Trauma Score: Cutaneous

Definition

The presence or absence of open wounds on ED/Hospital initial assesment

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. No open wounds
- 1. Minor open wounds
- 1. Major or penetrating open wounds
- /. Not applicable
- ? Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

PTS		Weight	<input type="text"/>	Cutaneous	<input type="text"/>
	Airway	<input type="text"/>		CNS	<input type="text"/>
	Skeletal	<input type="text"/>		Pulse Palp	<input type="text"/>
				PTS Total	<input type="text"/>

Pediatric Trauma Score: CNS**Definiton**

The mental status of the patient upon ED/Hospital initial assesment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. Awake
- 1. Altered mental status or obtunded
- 1. Coma or abnormal flexion
- / . Not applicable
- ? . Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork

PTS		Weight	<input type="text"/>	Cutaneous	<input type="text"/>
	Airway	<input type="text"/>		CNS	<input type="text"/>
	Skeletal	<input type="text"/>		Pulse Palp	<input type="text"/>
				PTS Total	<input type="text"/>

Pediatric Trauma Score: Pulse Palp**Definiton**

The presence or absence of pulses in different anatomical areas upon ED/Hopsigal initial assesment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

- 2. Pulse Palpable at Wrist (SBP over 90 mmHg)
- 1. Pulse Palpable at groin (SBP btwn 50 and 90 mmHg)
- 1. Pulse not palpable (SBP under 50 mmHg)
- / . Not applicable
- ? . Unknown

Data Source Hierarchy Guide

- 1. Referring Facility Paperwork:

The screenshot shows a software window titled "Referring Facility Information". It contains three rows of input fields: "Referring Facility", "Agency", and "Unit". Each row has a dropdown menu on the left and a text input field on the right. Below these fields is a section labeled "Procedure" with an orange arrow icon pointing to the right, followed by a checkbox and a text input field. At the bottom of the window is a control bar with buttons for "Check" (with a checkmark), "OK" (with a green checkmark), and "Cancel" (with an X). To the right of these buttons are several navigation icons: a green plus sign, a red minus sign, and four arrow keys (left, right, left, right). The bottom-left corner of the window displays "1 of 1".

Inter-facility: Transport Procedure

Definition

Medical Intervention performed by EMS or first responder's en-route to transfer facility.

NOTE: DI has a multiple procedures list that can be picked.

Data Source Hierarchy Guide

1. EMS Run record

Provider

Referring Facility

Agency

Unit

Medication

✓ Check ✓ OK ✕ Cancel + - ◀ ▶

1 of 1

Inter-facility Transport: Medication Administration

Definition

Medications that were given to the patient en-route to referring facility.

NOTE: DI has multiple medication lists that can be picked.

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Procedures

Record Edit Browse

Provider

Agency [dropdown] [dropdown]

Unit [text box]

Procedure [checkbox] [text box]

Start [date/time picker]

Check OK Cancel [navigation buttons]

1 of 1

Prehospital Procedure Start Date and Time

Definition

The date and time that medical interventions were performed by EMS or first responders either on scene or en-route to the initial treatment facility.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Medications

Record Edit Browse

Provider

Agency [dropdown] [text box]

Unit [text box]

Medication [arrow icon] [text box]

✓ Check ✓ OK ✗ Cancel + - < >

1 of 1

Prehospital: Medication Administration**Definition**

Medications that were given to the patient either on scene or en-route to the initial treatment facility

Element Values

- Relevant Value for Data Element
- Multiple Values in DI

Data Source Hierarchy Guide

1. EMS Run Report

ED Arrival/Resuscitation

- The ED/Hospital Arrival date will auto-populate based on the demographics
- The mode of arrival will auto-populate based on information placed in the prehospital section.
- The elapsed time for response activation and revised response activation will generate based on arrival and activation date and time.
- Please note the box at the top to denote if it is a direct admit or not.

****MANDATORY NTDS definition fields denoted with BLUE FONT****

ED Arrival =ED or Hospital Arrival Date (see below)

Definition

The date the patient arrived in the Emergency Department ...OR... was admitted to your hospital. The patient may not enter your facility via ED, e.g., Direct Admission to the floor or ICU.

ED/HOSPITAL ARRIVAL DATE**Definition**

The date the patient arrived to the ED/hospital.

Element Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, report date patient arrived at ED. If patient was directly admitted to the hospital, report date patient was admitted to the hospital.
- Reported 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

Associated Edit Checks

Rule ID	Level	Message
4501	1	Date is not valid
4502	1	Date out of range
4503	2	Element cannot be blank
4505	2	Element cannot be "Not Known/Not Recorded"
4506	3	ED/Hospital Arrival Date is earlier than EMS Dispatch Date
4507	3	ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date
4508	3	ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date
4509	2	ED/Hospital Arrival Date is later than ED Discharge Date
4510	2	ED/Hospital Arrival Date is later than Hospital Discharge Date
4511	2	ED/Hospital Arrival Date is earlier than Date of Birth
4513	2	ED/Hospital Arrival Date minus Injury Incident Date is more than 14 days
4515	2	Element cannot be "Not Applicable"
4540	1	Single Entry Max exceeded

****MANDATORY NTDS definition fields denoted with BLUE FONT****

ED Arrival Time

Definition

The time the *patient arrived in the Emergency Department or into your Facility*. The patient may not enter your facility via ED, e.g., Direct Admission to the floor, ICU. Enter the time the patient entered into the facility.

ED/HOSPITAL ARRIVAL TIME**Definition**

The time the patient arrived to the ED/hospital.

Element Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, report time patient arrived at ED. If patient was directly admitted to the hospital, report time patient was admitted to the hospital.
- Reported as HH:MM military time.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time out of range
4603	2	Element cannot be blank
4604	3	ED/Hospital Arrival Time is earlier than EMS Dispatch Time
4605	3	ED/Hospital Arrival Time is earlier than EMS Unit Arrival on Scene Time
4606	3	ED/Hospital Arrival Time is earlier than EMS Unit Scene Departure Time
4607	3	ED/Hospital Arrival Time is later than ED Discharge Time
4608	2	ED/Hospital Arrival Time is later than Hospital Discharge Time
4609	2	Element cannot be "Not Applicable"
4640	1	Single Entry Max exceeded

ED Departure Order: MANDATORY BLUE FIELD; NTDS Definition rules follow.

****MANDATORY NTDS definition fields denoted with BLUE FONT****

ED Discharge Date = ED Departure Order

ED DISCHARGE DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the patient was 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

Associated Edit Checks

Rule ID	Level	Message
6301	1	Date is not valid
6302	1	Date out of range
6303	2	Element cannot be blank
6304	3	ED Discharge Date is earlier than EMS Dispatch Date
6305	3	ED Discharge Date is earlier than EMS Unit Arrival on Scene Date
6306	3	ED Discharge Date is earlier than EMS Unit Scene Departure Date
6307	2	ED Discharge Date is earlier than ED/Hospital Arrival Date
6308	2	ED Discharge Date is later than Hospital Discharge Date
6309	3	ED Discharge Date is earlier than Date of Birth
6310	3	ED Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
6340	1	Single Entry Max exceeded

NOTE: if no ED DC Order written: First Choice= Date Admit Orders entered; Second Choice = Date of ED discharge

Arrival/Admission | Initial Assessment | Vitals | Notes | Section Complete

N Direct Admit

ED Arrival [] @ :
ED Departure/Admitted [] @ :
ED Departure Order [] @ : ←
Time in ED []

Signs of Life 2 Arrived with Signs of Life

Trauma Activation by EMS [] @ :
Response Activation [] @ : Elapsed []
Revised Response Activation [] @ : Elapsed []

Mode of Arrival []
Response Level []
Revised Response Level []

ED Departure Order Time = BLUE FIELD; NTDS Definition rules.

ED DISCHARGE TIME**Definition**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the patient was 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

Associated Edit Checks

Rule ID	Level	Message
6401	1	Time is not valid
6402	1	Time out of range
6403	2	Element cannot be blank
6404	3	ED Discharge Time is earlier than EMS Dispatch Time
6405	3	ED Discharge Time is earlier than EMS Unit Arrival on Scene Time
6406	3	ED Discharge Time is earlier than EMS Unit Scene Departure Time
6407	2	ED Discharge Time is earlier than ED/Hospital Arrival Time
6408	2	ED Discharge Time is later than Hospital Discharge Time
6440	1	Single Entry Max exceeded

NOTE: if no ED DC Order written: First Choice= Time Admit Orders entered; Second Choice = Time of ED discharge

ED Departure / Admitted: MANDATORY BLUE FIELD; NTDS Definition rules.

Arrival/Admission | Initial Assessment | Vitals | Notes | Section Complete

Direct Admit

ED Arrival @ :

ED Departure/Admitted @ :

ED Departure Order @ :

Time in ED

Signs of Life Arrived with Signs of Life

Trauma Activation by EMS @ :

Response Activation @ : Elapsed

Revised Response Activation @ : Elapsed

Mode of Arrival

Response Level

Revised Response Level

ED/Resus ED Departure/Admitted**Definition**

The date and time the patient left the Emergency Department either for admission or discharge.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Physician admission/discharge orders
2. Progress Notes
3. Trauma Flowsheet

Signs of Life: MANDATORY BLUE FIELD; NTDS Definition rules.
Signs of Life**Definition**

Indication of whether the patient arrived at the ED/Hospital with signs of life. **(NOTE: It is no longer required with the 2020 Admission NTDS data dictionary).** The patient will have none of the following if they arrived with no signs of life: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This generally means the patient was brought in with CPR in progress.

Element Values

- | | | |
|----------------------------------|----|----------------|
| 1. Arrived with No Signs of Life | /. | Not Applicable |
| 2. Arrived with Signs of Life | ? | Unknown |

Data Source Hierarchy Guide

1. History and Physical
2. Progress Note
3. Flowsheet
4. EMS Run Report

Response Level

Definition

The level of trauma activation for the patient arriving to your facility.

- **Full:** Inhouse Team Activation Criteria met for full team response (highest level activation)
- **Partial:** Inhouse Team Activation Criteria met for partial team response.
- **Consult:** Inhouse Team Activation Criteria NOT met. Trauma Surgeon activated for consultation. May or may not result in Trauma Service admission.
- **No Trauma Activation:** IL Trauma Registry Inclusion Criteria met. No Trauma Surgeon involvement. Admitted to Service other than Trauma Service.
- **N/A:** IL Trauma Registry Inclusion Criteria NOT met. Trauma Surgeon may / may not have been involved. Often will be used for Facility – specific cohort tracking identifier

Element Values

- | | |
|------------|-------------------------|
| 1. Full | 4. No Trauma Activation |
| 2. Partial | /. Not Applicable |
| 3. Consult | ? Unknown |

Data Source Hierarchy Guide

1. Progress notes
2. History and Physical
3. EMS run sheet
4. Trauma Flowsheet

Response Activation Date and Time

Definition

The date (MONTH/DATE/YEAR) and time that the trauma was activated at your facility.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. History and Physical
2. Progress Notes
3. EMS Run Sheet
4. Trauma Flowsheet

Revised Response Activation Date and Time

Definition

The date (MONTH/DATE/YEAR) and time that the trauma was re-categorized after being evaluated or consulting with a physician en-route at your facility.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical
3. Progress Notes
4. EMS Run Sheet

****MANDATORY NTDS definition fields denoted with BLUE FONT****

ED DISCHARGE DISPOSITION

Definition

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

Element Values

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

Additional Information

- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition 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

Associated Edit Checks

Rule ID	Level	Message
6101	1	Value is not a valid menu option
6102	2	Element cannot be blank
6104	2	Element cannot be "Not Known/Not Recorded"
6106	2	Element cannot not be "Not Applicable" when Hospital Discharge Date is "Not Applicable"
6107	2	Element cannot not be "Not Applicable" when Hospital Discharge Date is "Not Known/Not Recorded"
6108	2	Element cannot not be "Not Applicable" when Hospital Discharge Disposition is "Not Applicable"
6109	2	Element cannot not be "Not Applicable" when Hospital Discharge Disposition is "Not Known/Not Recorded"
6140	1	Single Entry Max exceeded

Entry Title Changed to POST ED DISPOSITION**DI Element Values**

3. Operating Room	41. Home with Services	75. Hospice
4. Intensive Care Unit	42. Left AMA	76. Mental Health/ Psychiatric Hospital (Inpatient)
5. Step-Down Unit	43. Correctional Facility/Court/Law Enforcement	77. Nursing Home
6. Floor	44. Morgue	78. Other (Out of Hospital)
7. Telemetry Unit	45. Child Protective Agency	79. Another Type of Inpatient Facility Not Defined Elsewhere
8. Observation Unit	70. Acute Care Facility	88. Burn Center
9. Burn Unit	71. Intermediate Care Facility	/ . Not Applicable
13. Labor and Delivery	72. Skilled Nursing Facility	? . Unknown
14. Neonatal/Pediatric Care Unit	73. Rehab (Inpatient)	
15. Other (In Hospital)	74. Long-Term Care	
40. Home		

Admitting Service

Definition

The provider service that admitted the patient.

Element Values:

- | | | |
|--------------------|---------------------------|--------------------|
| 1. Trauma | 5. Pediatric Surgery | 9. Pediatrics |
| 2. Neurosurgery | 6. Cardiothoracic Surgery | 23. Hospitalist |
| 3. Orthopedics | 7. Burn Services | 65. Intensivist |
| 4. General Surgery | 8. Emergency Medicine | 98. Other Surgical |

Data Source Hierarchy Guide:

1. Physician Order
2. History and Physical
3. Consult Note
4. Billing Sheets

Admitting Physician

Definition

The provider that is admitting the patient to the hospital

Element Values

- Relevant Value for Data Set

Data Source Hierarchy Guide

1. Physician Order
2. History and Physical
3. Progress Notes
4. Billing Sheets

Surgeon**Definition**

Denotes whether or not the admitting physician is a surgeon.

NOTE: Data entry of Admitting Physician turns the Surgeon box white to indicate if the admitting physician is a surgeon.

Element Values

- | | |
|----------------------|--------------------|
| 1. Yes, Surgeon | / . Not Applicable |
| 2. No, Not a Surgeon | ? . Unknown |

Data Source Hierarchy Guide

1. Progress Notes
2. Billing Sheets

Post OR Disposition

Definition

If the patient went from the emergency department to the operating room, this designates where the person went post-operatively.

Element Values

4. Intensive Care Unit	9. Burn Unit	44. Morgue
5. Step-Down Unit	11. Post Anesthesia Care Unit	/. Not Applicable
6. Floor	14. Neonatal/Pediatric Care Unit	? Unknown
7. Telemetry Unit	42. Left AMA	
8. Observation Unit		

Data Source Hierarchy Guide

1. Operative Note
2. Progress Note

The screenshot shows the 'Trauma Data Editor' application with the 'Vitals' tab active. An orange arrow points to the 'Recorded Date/Time' field, which is set to '01/06/2020'. The interface is divided into several sections: 'Vitals' (SBP/DBP, Pulse Rate, Unassisted/Assisted Resp Rate, O2 Saturation, Supplemental O2, GCS: Eye, Verbal, Motor, Total, PT6, GCS 40, Triage RTS, PTS Total), 'Labs' (ABGs Drawn, Hematocrit, INR, pH, PaO2, PaCO2, Base Deficit/Excess), and 'Toxicology' (Alcohol Use Indicator, Drug Use Indicators, ETOH/BAC Level, Drug Screen, Drug Specify, Clinician Administered). The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

ED/Resus Initial Vitals Recorded Date and Time

Definition

The date and time that the first set of vitals was recorded within your facility.

NOTE: The initial values must be recorded within 30 minutes of patient arrival.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Trauma Flowsheet
2. Flowsheets
3. History and Physical
4. Progress Notes

Initial ED / Hospital Patient Weight: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' window with the 'Arrival/Admission' tab selected. An orange arrow points to the 'Weight/Units' field. The interface includes several sections: 'Recorded Date/Time' (01/06/2020), 'Weight/Units' (with a 'Timely' checkbox), 'Height/Units' (with a 'Timely' checkbox), 'Temperature/Unit/Route', and 'BMI'. Below these are 'At Time Vitals Taken' checkboxes for Paralytic Agents, Sedated, and Eye Obstruction. There are also checkboxes for Intubated, Respiration Assisted, and If Yes, Method/Type. A 'Labs' section includes checkboxes for ABGs Drawn, Hemelocrit, INR, pH, PaO2, PaCO2, and Base Deficit/Excess. A 'Vitals' section contains input fields for SBP/DBP, Pulse Rate, Unassisted Resp Rate, Assisted Resp Rate, O2 Saturation, Supplemental O2, GCS: Eye, Verbal, Motor, Total, RTS, Triage RTS, and PTS Total. There are also checkboxes for PT6 and GCS 40.

INITIAL ED/HOSPITAL WEIGHT**Definition**

First recorded weight within 24 hours or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
8601	1	Invalid value
8602	2	Element cannot be blank
8603	3	The value is above 200
8604	2	Element cannot be "Not Applicable"
8605	2	The value submitted falls outside the valid range 1-650
8606	3	The value is below 3
8640	1	Single Entry Max exceeded

NOTE: Once weight is entered, you will be asked for pounds or kilograms. Then you will be asked if it was timely. Timely refers to weight being available within the 24 hour timeframe put forth by the NTDS.

Initial ED / Hospital Patient Weight: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals' tab selected. The 'Weight/Units' field is highlighted with an orange arrow. The form includes sections for 'At Time Vitals Taken', 'Vitals', and 'Labs'. The 'Weight/Units' field is a blue field, indicating it is mandatory. Other fields include 'Height/Units', 'BMI', 'Temperature/Unit/Route', 'SBP/DBP', 'Pulse Rate', 'GCS: Eye', 'GCS: Verbal', 'GCS: Motor', 'GCS: Total', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'O2 Saturation', 'Supplemental O2', 'RTS', 'Triage RTS', 'PTS', 'PTS Total', 'GCS 40', 'ABGs Drawn', 'Hematocrit', 'INR', 'pH', 'PaO2', 'PaCO2', and 'Base Deficit/Excess'.

INITIAL ED/HOSPITAL HEIGHT**Definition**

First recorded height within 24 hours or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
8501	1	Invalid value
8502	2	Element cannot be blank
8503	3	The value is above 215
8504	2	Element cannot be "Not Applicable"
8505	2	The value submitted falls outside the valid range of 30-275
8506	3	The value is below 50
8540	1	Single Entry Max exceeded

NOTE: Once entered, it will ask for centimeters or inches, and will then ask if it was timely. If it doesn't meet the criteria of less than 24 hours after arrival, it is not timely.

Initial ED / Hospital Temperature: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals' tab selected. The 'Recorded Date/Time' is set to 01/06/2020. The 'Temperature/Unit/Route' field is highlighted with a blue border and an orange arrow pointing to it. Other fields include Weight/Units, Height/Units, BMI, and various vital signs like SBP/DBP, Pulse Rate, and GCS. There are also checkboxes for 'At Time Vitals Taken' and 'Labs'.

INITIAL ED/HOSPITAL TEMPERATURE**Definition**

First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

- Relevant value for data element

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

Associated Edit Checks

Rule ID	Level	Message
4901	1	Invalid value
4902	2	Element cannot be blank
4903	3	The value is above 42.0
4904	2	Element cannot be "Not Applicable"
4905	2	The value submitted falls outside the valid range of 10.0-45.0
4906	3	The value is below 20.0
4940	1	Single Entry Max exceeded

NOTE: Once entered it will ask for cc (centigrade) or ff (Fahrenheit).

It also will open "source" – 1. Oral; 2. Tympanic; 3. Rectal; 4. Axillary; 5. Core; 6. Other; 7. Temporal; ?.Unknown

ED Resus Paralytic Agents: MANDATORY BLUE FIELD; NTDS Definition rules.

ED/Resus Paralytic Agents

Definition

Were paralytic agents affecting the patient at the time the initial set of vitals were taken?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide:

1. Medication Administration Record
2. Trauma Flowsheet / Nurse's Notes
3. ED Timeline
4. History and Physical
5. Progress Notes

ED Resus Sedated: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals' tab selected. The interface includes several sections:

- Recorded Date/Time:** A date and time input field.
- Weight/Units:** A numeric input field with a unit dropdown.
- Height/Units:** A numeric input field with a unit dropdown.
- Temperature/Unit/Route:** A numeric input field with unit and route dropdowns.
- BMI:** A numeric input field.
- At Time Vitals Taken:** A section containing checkboxes for 'Paralytic Agents?', 'Sedated?' (highlighted with an orange arrow), and 'Obstruction?'. It also includes fields for 'Intubated?' and 'Respiration Assisted?' with associated method and type dropdowns.
- Labs:** A section with checkboxes for 'ABGs Drawn', 'Hematocrit', and 'INR', along with input fields for 'pH', 'PaO2', 'PaCO2', and 'Base Deficit/Excess'.
- Vitals:** A section with input fields for 'SBP/DBP', 'Pulse Rate', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'O2 Saturation', 'Supplemental O2', 'GCS: Eye', 'Verbal', 'Motor', 'Total', 'RTS', and 'PTS'. There are also checkboxes for 'GCS 40' and 'Triage RTS'.
- Toxicology:** A section with checkboxes for 'Alcohol Use Indicator' and 'Drug Use Indicators', a field for 'ETOH/BAC Level' in mg/dl, and a table for 'Drug Screen' with columns for 'Drug Screen', 'Drug Specity', and 'Clinician Administered'. There is also an 'If Other' field.

ED/Resus Sedated**Definition**

Were sedative agents affecting the patient at the time the initial set of vitals were taken?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Medication Administration Record
2. Trauma Flowsheet / Nurse's Notes
3. ED Timeline
4. History and Physical
5. Progress Notes

Eye Obstruction: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals' tab active. An orange arrow points to the 'Eye Obstruction?' checkbox, which is currently unchecked. Other fields in the 'Vitals' section include SBP/DBP, Pulse Rate, Unassisted Resp Rate, Assisted Resp Rate, O2 Saturation, Supplemental O2, GCS: Eye (Verbal, Motor, Total), and PTS. The 'Labs' section includes ABGs Drawn, Hematocrit, INR, pH, PaO2, PaCO2, and Base Deficit/Excess. The 'Toxicology' section includes Alcohol Use Indicator, Drug Use Indicators, ETOH/BAC Level, Drug Screen, Drug Specity, and Clinician Administered.

ED/Resus Eye Obstruction**Definition**

Was there an eye obstruction affecting the patient at the time the initial set of vitals were taken?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Medication Administration Record
2. Trauma Flowsheet / Nurse's Notes
3. ED Timeline
4. History and Physical
5. Progress Notes

ED / Resus Intubation: MANDATORY BLUE FIELD; NTDS Definition rules.

ED/Resus Intubated

Definition

Was the patient intubated at the time the initial set of vitals were taken?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. History and Physical / Procedure Notes
2. Progress Notes
3. Flowsheets

ED/Resus Intubation Method

Definition

The device or method used to intubate the patient.

NOTE: Will only populate if you answer yes to the referring facility intubated question.

Element Values

- | | | |
|----------------------------|---------------------------------|------------------------------|
| 1. Combitube | 5. Endotracheal Tube-Oral | 9. LT Blind Insertion Device |
| 2. Cricothyrotomy | 6. Endotracheal Tube- Route NFS | 10. Tracheostomy |
| 3. Cricothyrotomy-Needle | 7. Esophageal Obturator Airway | ? Unknown |
| 4. Endotracheal Tube-Nasal | 8. Laryngeal Mask Airway | |

Data Source Hierarchy Guide

1. History and Physical / Procedure Notes
2. Flowsheets
3. Progress Notes

ED Resus Respiration Assisted: MANDATORY BLUE FIELD; NTDS Definition rules.

ED/Resus Respiration Assisted

Definition

Did the patient required assisted respirations at the time the initial set of vitals were taken?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. History and Physical
2. Flowsheets
3. Progress Notes

ED/Resus Respiration Assisted Type

Definition

The device used to assist the patient's respirations.

NOTE: Will only populate if you answer yes.

Element Values

- | | |
|-------------------|---------------|
| 1. Bag Value Mask | 4. Ventilator |
| 2. Nasal Airway | ?. Unknown |
| 3. Oral Airway | |

Data Source Hierarchy Guide

1. History and Physical
2. Flowsheets
3. Progress Notes

Initial ED / Hospital Systolic BP: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' application with the 'Vitals' tab active. An orange arrow points to the 'SBP/DBP' field. The interface includes sections for 'Recorded Date/Time', 'Temperature/Unit/Route', 'Weight/Units', 'Height/Units', 'BMI', 'At Time Vitals Taken', 'Intubated?', 'Respiration Assisted?', 'Paralytic Agents?', 'Sedated?', 'Eye Obstruction?', 'GCS: Eye', 'Verbal', 'Motor', 'Total', 'RTS', 'Triage RTS', 'PTS', 'GCS 40', 'Labs', 'ABGs Drawn', 'Hematocrit', 'INR', 'pH', 'PaO2', 'PaCO2', and 'Base Deficit/Excess'.

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE**Definition**

First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

- Relevant value for data element

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

Associated Edit Checks

Rule ID	Level	Message
4701	1	Invalid value
4702	2	Element cannot be blank
4704	3	The value is above 220
4705	2	Element cannot be "Not Applicable"
4706	2	The value submitted falls outside the valid range of 0-380
4707	3	The value is below 30
4740	1	Single Entry Max exceeded

Initial ED / Hospital Diastolic BP: MANDATORY BLUE FIELD; NTDS Definition rules.

The screenshot shows the 'Trauma Data Editor' window with the 'Vitals' tab selected. The interface includes various input fields and checkboxes for patient assessment. An orange arrow points to the 'Respiration Assisted?' checkbox, which is highlighted in the original image.

Initial ED/Hospital Diastolic Blood Pressure**Definition**

First recorded diastolic blood pressure in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values

- Relevant value for data element

NOTE: Please note that the 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. Flowsheets
2. ED Trauma Summary
3. History and Physical
4. Progress Notes

INITIAL ED/HOSPITAL PULSE RATE

Definition

First recorded pulse in the ED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

- Relevant value for data element

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

Associated Edit Checks

Rule ID	Level	Message
4801	1	Invalid value
4802	2	Element cannot be blank
4804	3	The value is above 220
4805	2	Element cannot be "Not Applicable"
4806	2	The value submitted falls outside the valid range of 0-300
4807	3	The value is below 30
4840	1	Single Entry Max exceeded



INITIAL ED/HOSPITAL RESPIRATORY RATE

Definition

First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

- Relevant value for data element

Additional Information

- If reported, report additional data 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

Associated Edit Checks

Rule ID	Level	Message
5001	1	Invalid value.
5002	2	Element cannot be blank
5005	3	The value submitted falls outside the valid range of 0-100
5006	2	Element cannot be "Not Applicable"
5007	3	The value is below 5
5008	3	The value is above 75
5040	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition

Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.

Element Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate

Additional Information

- Only reported if Initial ED/Hospital Respiratory Rate is reported.
- 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

Associated Edit Checks

Rule ID	Level	Message
5101	1	Value is not a valid menu option
5102	2	Element cannot be blank
5103	2	Element must be "Not Applicable" when Initial ED/Hospital Respiratory Rate is "Not Known/Not Recorded"
5140	1	Single Entry Max exceeded

NOTE: Only opens if auto-populated by entering data into the Respiratory Assisted element.

Initial ED / Hospital O2 Saturation: MANDATORY BLUE FIELD; NTDS Definition rules.

INITIAL ED/HOSPITAL OXYGEN SATURATION

Definition

First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage).

Element Values

- Relevant value for data element

Additional Information

- If reported, report additional data 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

Associated Edit Checks

Rule ID	Level	Message
5201	1	Invalid value
5202	2	Element cannot be blank
5205	2	Element cannot be "Not Applicable"
5206	2	The value submitted falls outside the valid range of 0-100
5207	3	The value is below 40
5240	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival.

Element Values

1. No Supplemental Oxygen
2. Supplemental Oxygen

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

Associated Edit Checks

Rule ID	Level	Message
5301	1	Value is not a valid menu option
5303	2	Element cannot be blank
5304	2	Element must be "Not Applicable" when Initial ED/Hospital Oxygen Saturation is "Not Known/Not Recorded"
5340	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - EYE

Definition

First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

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

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 reported. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be reported, 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 40 – Eye is documented.
- 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

Associated Edit Checks

Rule ID	Level	Message
5401	1	Value is not a valid menu option
5403	2	Element cannot be blank
5404	2	Element cannot be "Not Applicable"
5405	2	Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS 40 – Eye is reported.
5440	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - VERBAL

Definition

First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival.

Element Values

Pediatric (≤ 2 years):

- 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

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 reported. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, 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 40 - Verbal is reported.
- 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

Associated Edit Checks

Rule ID	Level	Message
5501	1	Value is not a valid menu option
5503	2	Element cannot be blank
5504	2	Element cannot be "Not Applicable"
5505	2	Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS 40 - Verbal is reported.
5540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - MOTOR

Definition

First recorded Glasgow Coma Score (Motor) within 30 minutes or less of ED/hospital arrival.

Element Values

Pediatric (≤ 2 years):

- 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

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 reported. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, 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 40 – Motor is reported.
- 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

Associated Edit Checks

Rule ID	Level	Message
5601	1	Value is not a valid menu option
5603	2	Element cannot be blank
5604	2	Element cannot be "Not Applicable"
5605	2	Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS 40 – Motor is reported
5640	1	Single Entry Max exceeded

The screenshot shows a medical software interface with a 'Pediatric Trauma Score' window open. The window has a title bar with 'Record', 'Edit', and 'Navigate' buttons. Inside, there are several input fields for patient data. An orange arrow points to the 'Weight' field under the 'PTS' section. Other fields include 'Airway', 'Skeletal', 'Cutaneous', 'CNS', 'Pulse Palp', and 'PTS Total'. The background interface shows tabs for 'Referral History', 'Assessments', 'Vitals/Medication', 'Procedures', 'Inter-Facility Transport', and 'Notes'. A 'Section Complete' checkbox is visible in the top right corner.

Pediatric Trauma Score: Weight

Definition

The weight of the patient at the time of injury. Will only populate if patient is under the age of 18.

Element Values

- | | |
|-------------------------------------|--------------------|
| 2. Greater than 20kg (44 lbs.) | / . Not Applicable |
| 1. between 10 and 20kg (22-44 lbs.) | ? . Unknown |
| -1. Less than 10kg (22 lbs.) | |

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical

Referral History | Assessments | Vitals/Medication | Procedures | Inter-Facility Transport | Notes Section Complete

Immediate Referring Facility

Initial Vitals
Recorded @ : Temperature/Unit/Route 98.0

At Time Vitals Taken
Paralytic Agents? Intubated? If Yes, Method 1 Combitube
Sedated? Resuscitation Assistant? If Yes, Time

Eye Obstat

Vitals

SB
Pul
Unassisted Res
Assist
O2 Sa
Supplem

PTS
Weight
Airway
Skeletal

Cutaneous
CNS
Pulse Palp
PTS Total

Toxicology OK

Alcohol Use Indicator ETOH/BAC Level mg/dL

Drug Use Indicators

Drug Screen Drug Specify Clinician Administered

If Other

Custom

Pediatric Trauma Score: Airway**Definition**

The status of the patient's airway upon ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

Element Values

- | | |
|---------------------------------|-------------------|
| 2. Normal | /. Not Applicable |
| 1. Maintainable | ? Unknown |
| -1. Unmaintainable or Intubated | |

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical
3. Progress Notes

The screenshot shows a medical software interface with a 'Pediatric Trauma Score' window. The window has a blue title bar and a 'Record' button. The form includes fields for 'Recorded', 'Temperature/Unit/Route', 'Paralytic Agents?', 'Intubated?', 'Syringed?', 'Resuscitation Assistant?', 'Eye Obat', 'SB', 'Pul', 'Unassisted Res', 'Assisted Res', 'O2 vs Supplement', 'Toxicology', 'Alcohol Use Indicator', 'Drug Use Indicators', 'Drug Screen', 'Drug Specify', and 'Clinician Administered'. An orange arrow points to the 'Skeletal' field in the 'PTS' section.

Pediatric Trauma Score: Skeletal

Definition

The presence or absence of known fractures on ED/Hospital known assessment. Will only populate if patient is under the age of 18.

Element Values

- | | |
|--------------------------------|-------------------|
| 2. None | /. Not Applicable |
| 1. Closed Fracture | ? Unknown |
| -1. Open or Multiple Fractures | |

Data Source Hierarchy Guide

1. Flowsheets
2. Radiology Reports
3. History and Physical
4. Progress Notes

Referral History | Assessments | Vitals/Medication | Procedures | Inter-Facility Transport | Notes Section Complete

Immediate Referring Facility

Recorded @ : Temperature/Unit/Route 98.0

At Time Vitals Taken

Paralytic Agents? Intubated? If Yes, Method 1 Combilube

Sprinkled? Resuscitation Assistant? If Yes, Time

Eye Obat

Vitals

SB

Puls


Unassisted Res

Assisted Res

O2 Sa

Supplem

PTS

Weight  Cutaneous

Airway CNS

Skeletal Pulse Palp

PTS Total

Toxicology

OK

Alcohol Use Indicator ETOH/BAC Level mg/dl

Drug Use Indicators

Drug Screen

Drug Specify

Clinician Administered

If Other

Custom

Pediatric Trauma Score: Cutaneous

Definition

The presence or absence of open wounds on ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

Element Values

- | | | |
|--------------------------------------|----|----------------|
| 2. No Open Wounds | /. | Not Applicable |
| 1. Minor Open Wounds | ? | Unknown |
| -1. Major or Penetrating Open Wounds | | |

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical
3. Progress Notes

Pediatric Trauma Score: CNS

Definition

The mental status of the patient upon ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

Element Values

- | | | |
|--------------------------------------|----|----------------|
| 2. Awake | /. | Not Applicable |
| 1. Altered Mental Status or Obtunded | ? | Unknown |
| -1. Coma or Abnormal Flexion | | |

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical
3. Progress Notes

The screenshot shows a medical software interface with a 'Pediatric Trauma Score' window open. The window has a title bar with 'Record', 'Edit', and 'Navigate' buttons. The form contains several input fields: 'Weight', 'Airway', 'Skeletal', 'Cutaneous', 'CNS', 'Pulse Palp', and 'PTS Total'. An orange arrow points from the 'Pulse Palp' field to the 'PTS Total' field. The background shows other parts of the software interface, including 'Initial Vitals', 'At Time Vitals Taken', and 'Toxicology' sections.

Pediatric Trauma Score: Pulse Palp

Definition

The presence or absence of pulses in different anatomical areas upon ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

Element Values

2. Pulse Palpable at Wrist (SBP over 90 mmHg)
1. Pulse Palpable at Groin (SBP Btwn 50 and 90 mmHg)

-1. Pulse Not Palpable (SBP under 50 mmHg)
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical
3. Progress Notes

The screenshot shows the 'Trauma Data Editor' application window. The 'Toxicology' section is highlighted with an orange arrow. It includes the following fields and options:

- Alcohol Use Indicator: [Text Field]
- Drug Use Indicators: [Text Field]
- ETOH/BAC Level: [Text Field] mg/dl
- Drug Screen: [Text Field]
- Drug Specity: [Text Field]
- Clinician Administered: [Text Field]
- If Other: [Text Field]

ALCOHOL SCREEN

Definition

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

Element Values

- 1. Yes
- 2. No

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

Associated Edit Checks

Rule ID	Level	Message
5911	1	Value is not a valid menu option
5912	2	Element cannot be blank
5913	2	Element cannot be "Not Applicable"
5940	1	Single Entry Max exceeded

ALCOHOL SCREEN RESULTS

Definition

First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

Element Values

- Relevant value for data element.

Additional Information

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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

Rule ID	Level	Message
5931	1	Invalid value
5932	2	Element cannot be blank
5933	2	Element cannot be "Not Applicable" when Alcohol Screen is "1. (Yes)"
5935	2	The value submitted falls outside the valid range of 0.0-1.5
5936	3	The value is above 0.4
5934	1	Single Entry Max exceeded

NOTE: A positive alcohol result will activate an opening for entry of ETOH/BAC Level.

ED/Resus: Drug Use Indicator

Definition

A drug test was performed on the patient within 24 hours after the first hospital encounter.

Element Values

- | | |
|---|--|
| 1. No (Not Tested) | 4. Yes (Confirmed by Test: Illegal Drug Use) |
| 2. No (Confirmed by Test) | / . Not Applicable |
| 3. Yes (Confirmed by Test: Prescription Drug) | ? . Unknown |

NOTE: Drug screen may be administered at any facility, unit, or setting treating this patient event.

NOTE: Cannabis is ILLEGAL...regardless of medical Rx or IL legislation. TQIP has ruled on this already.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records
3. Progress Notes



The screenshot shows the 'Trauma Data Editor' application window. The 'Drug Screen' section is highlighted with an orange arrow. The interface includes various input fields for patient data, vital signs, and laboratory results.

DRUG SCREEN

Definition

First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).

Element Values

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

Additional Information

- Report positive drug screen results within 24 hours after first hospital encounter, at either your facility or the 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

Associated Edit Checks

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Element cannot be blank
6013	2	Element cannot be "Not Applicable"
6014	2	Element cannot be "Not Known/Not Recorded" along with any other valid value
6050	1	Multiple Entry Max exceeded

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Arrival/Admission | Initial Assessment | Vitals | Notes Section Complete

Recorded Date/Time : Temperature/Unit/Route

Weight/Units Timely

Height/Units Timely

BMI

At Time Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

Labs

ABGs Drawn

Hematocrit

INR

pH

PaO2

PaCO2

Base Deficit/Excess

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

PTS

PTS Total

GCS 40

Toxicology

Alcohol Use Indicator

Drug Use Indicators

ETOH/BAC Level mg/dl

Drug Screen

Drug Specify

Clinician Administered

If Other

Custom

ED/Resus Drug Specifv**Definition**

What drug was positive within 24 hours after the first hospitalization encounter?

Element Values

- | | |
|-------------------|--------------------|
| 1. Amphetamine | 6. Methamphetamine |
| 2. Barbiturate | 7. Opiates |
| 3. Benzodiazepine | 8. PCP |
| 4. Cannabis | 9. Other |
| 5. Cocaine | ? Unknown |

Data Source Hierarchy Guide

1. 1. Lab Results
2. Transfer Center Records

ED/Resus: Clinician Administered**Definition**

Was the drug screen positive because that particular medication was administered by a clinician?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Medication Administration Record
2. Transferring Facility Paperwork
3. Flowsheets / ED Timeline
4. History and Physical
5. Progress Notes

ED/Resus: ABGs Drawn

Definition

Arterial Blood Gases were drawn on the patient within 24 hours of arrival.

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Lab Results

The screenshot shows the 'Trauma Data Editor' application window. The 'Vitals' section is highlighted with an orange arrow pointing to the 'pH' field in the 'Labs' section. The interface includes various input fields for patient data, including recorded date/time, weight, height, temperature, and vital signs like SBP/DBP, pulse rate, and respiratory rates. There are also checkboxes for 'At Time Vitals Taken' and 'Labs' sections for 'ABGs Drawn', 'Hematocrit', and 'INR'.

ED/Resus: pH

Definition

The measurement of the acidity of arterial blood. Found in the lab results for ABG within the first 24 hours.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

ED/Resus: PaO2**Definition**

The measurement of the oxygen levels of arterial blood. Found in the lab results for ABG within the first 24 hours.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

ED/Resus: PaCO2**Definition**

The measurement of the carbon dioxide levels of arterial blood. Found in the lab results for ABG within the first 24 hours.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

ED/Resus: Base Deficit / Excess

Definition

The measurement of the excess or deficit of base present in arterial blood. Found in the lab results for ABG within the first 24 hours.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

The screenshot shows the 'Trauma Data Editor' application. The 'Vitals' tab is active. In the 'Labs' section, an orange arrow points to the 'Hematocrit' input field. Other fields include 'ABGs Drawn', 'pH', 'PaO2', 'PaCO2', and 'Base Deficit/Excess'. The 'Toxicology' section at the bottom includes 'Alcohol Use Indicator', 'Drug Use Indicators', 'ETOH/BAC Level', and a table for 'Drug Screen', 'Drug Specity', and 'Clinician Administered'.

ED/Resus: Hematocrit

Definition

The proportion, by volume, of the blood that consists of red blood cells. Measured from the first lab test drawn with that particular result.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

ED/Resus: INR**Definition**

A result that helps to evaluate the body's ability to appropriately form blood clots, it is derived from the pro-time results. Results of the first lab test drawn with that particular result.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

The screenshot displays the 'Trauma Data Editor' window with the 'ED/Resus Vitals' tab active. The interface is divided into several sections: 'Assessment Type' at the top, 'At Time Vitals Taken' with checkboxes for 'Paralytic Agents?', 'Sedated?', and 'Eye Obstruction?'; 'Vitals' section with fields for 'SBP/DBP', 'Pulse Rate', 'Unassisted Resp Rate', 'Assisted Resp Rate', 'O2 Saturation', 'Supplemental O2', 'GCS: Eye', 'Verbal', 'Motor', 'Total', 'RTS', and 'Triage RTS'; and 'PTS' section with checkboxes for 'Weight', 'Airway', 'Skeletal', 'Cutaneous', 'CNS', 'Pulse Palp', and 'PTS Total'. A toolbar on the right contains 'Add', 'Edit', and 'Delete' buttons, with two orange arrows pointing to the 'Add' and 'Edit' buttons. The bottom of the window shows a status bar with 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Additional ED/Resus: Vitals

Definition

Portions of the Initial Assessment will populate to the Vitals tab. Any additional vitals recorded during the patient's initial ED stay or during the resuscitation phase.

NOTE: You can also EDIT and DELETE the information if needed.

Element Values

- Refer to previous vitals for specific information regarding the documentation of the vital signs
 - NOTE:** These vitals do not have to be performed within the first 30 minutes of arrival to the ED/Hospital.
 - The American College of Surgeons suggests checking the vitals at least every hour.

Data Source Hierarchy Guide

1. Flowsheets
2. OR Records
3. Progress Notes

The screenshot displays the 'Trauma Data Editor' application. The main window is titled 'ED/Resus Vitals' and contains a table with columns for 'Assessment Type', 'Date', 'Time', 'Paralytic Agents', 'Sedated', 'Intubated', 'Resp Asst', 'SBP', 'DBP', 'Pulse Rate', 'Unasst Resp Rate', 'O2 Sat', and 'GC'. To the right of the table are 'Add', 'Edit', and 'Delete' buttons. A 'Medications' dialog box is overlaid on the main window, featuring a 'Code Medication' field with an orange arrow pointing to it, a 'Medication' input field, and buttons for 'Check', 'OK', 'Cancel', and navigation. The main window also includes a 'Warming Measures' field and a 'Mass Blood Protocol' section with 'Date' and 'Mass Blood Protocol Administered' fields. The bottom status bar indicates 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

ED/Resus: Medications

Definition

Medications that were given during the initial ED stay or during the resuscitation phase. Note these can all be edited or deleted formally by the box to the right.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Medication Administration Record
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. OR / Anesthesia Records
4. History and Physical
5. Progress Notes
6. Nursing Notes

ED/Resus: Warming Measures

Definition

The presence or absence of warming measures taken to maintain a patient's temperature during the resuscitation phase.

Element Values

- | | | |
|-----------------------------|----|----------------|
| 0. No Warming Measures | /. | Not Applicable |
| 1. Warming Measures Applied | ? | Unknown |

Data Source Hierarchy Guide

1. Trauma Flowsheet
2. OR Records
3. History and Physical
4. Progress Notes

ED/Resus: Mass Blood Protocol**Definition**

Was a massive blood transfusion protocol activated for the patient?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes

ED/Resus: Mass Blood Protocol Time and Date Ordered

Definition

The time and date that the massive transfusion protocol was ordered

Element Values

- Relevant Values for Data Element

Data Source Hierarchy Guide

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes

ED/Resus: Mass Blood Protocol Time and Date Ordered

Definition

The date and time that the massive transfusion protocol was initiated.

Element Values

- Relevant Values for Data Element

Data Source Hierarchy Guide

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes

Location/Service/Blood/Ventilator Tracking

- The elapsed time for each location will auto-populate based on the date and times that are placed. ICU and Step-Down days will automatically calculate based on the location option that you select.
- Service Tracking elapsed time will auto-populate after the date and times are entered for each service.
- Ventilator tracking will calculate the amount of days that the patient is on a ventilator automatically based on the dates and times that are entered.
- IL Consensus to enter blood components as UNITS statewide vs using the other quantity options.

Location Tracking: Location Code

Definition

The different units and procedural areas where the patient was admitted throughout their inpatient hospital stay.

Element Values

- | | |
|------------------------------|--|
| 1. Resuscitation Room | 9. Burn Unit |
| 2. Emergency Department | 10. Radiology |
| 3. Operating Room | 11. Post Anesthesia Care Unit |
| 4. Intensive Care Unit | 12. Special Procedure Unit |
| 5. Step-Down Unit (Adv Care) | 13. Labor and Delivery |
| 6. Floor | 14. Neonatal/Pediatric Care Unit |
| 7. Telemetry Unit | (FYI: if used for Peds ICU, it will not auto-calculate ICU days) |
| 8. Observation Unit | ? Unknown |
| | / Not Applicable |

Data Source Hierarchy Guide

- ADT Events
- Encounter Report (EPIC)
- Nursing Notes
- Progress Notes

NOTE: Can enter the Peds ICU days as “4 “Intensive Care Unit. Then after entering arrival & departure dates / times and allowing it to auto calculate, return and edit that row entering “14” and the total times will remain.

The screenshot displays the 'Trauma Data Editor' interface. At the top, there are tabs for 'Demographic', 'Injury', 'Prehospital', 'Referring Facility', 'ED/Resus', 'Patient Tracking', 'Providers', 'Procedures', 'Diagnoses', 'Outcome', 'QA Tracking', 'Memo', and 'Custom'. The main window is titled 'Location/Service Ventilator/Blood Notes' and includes a 'Section Complete' checkbox. Below this, there are two main sections: 'Location Tracking' and 'Service Tracking'. The 'Location Tracking' section contains a table with the following columns: Code, Location, Arrival Date, Time, Departure D... / Time, Elapsed Time, and Detail. To the right of this table are buttons for '+ Add', 'Edit', and '- Delete'. A 'Location Tracking' dialog box is open in the center, with an orange arrow pointing from the table to it. The dialog box has a title bar with 'Record Edit Browse' and contains fields for 'Location Code', 'Arrival', 'Departure', 'Elapsed Time', and 'Detail'. At the bottom of the dialog box are buttons for 'Check', 'OK', 'Cancel', and navigation arrows. The status bar at the bottom of the main window shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'. There are also buttons for 'Check', 'ITX', 'Save', 'Save and Exit', 'Print', and 'Close'.

Location Tracking: Arrival Date and Time

Definition

The date and time that a patient arrived to a particular unit or procedural area.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes

Location Tracking: Departure Date and Time

Definition

The date and time that a patient departed a particular unit or procedural area.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes

IL UAT Web Registry and C/S

Patient Name: Cruz, Paul Facility: Carle Foundation Hospital Arrival: 2019-07-26 Trauma #: 96000003 MRN: 2210778 Status: Active

Demographic Injury Prehospital Referring Facility ED/Resus Patient Tracking Providers Procedures Diagnosis Outcome QA Tracking HSWI Memo

Trauma Category Level	Location	Start Date	Stop Date	Name	Add

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IL Trauma Patient Categorization: Mandatory Illinois Element, if applicable

Definition

The trauma acuity Category assigned to the patient based on the criteria specified in the IL Trauma Rules & Regulations.

Categorization Rules can be found in Section 515, Appendices C and F. (Screen shots follow on next 3 pages)

Patient can meet State Categorization anytime the Criteria is met *prior to or within 10minutes of hospital arrival*. (For example: Prehospital Sustained SBP ≤ 90 on 2 consecutive measurements at least 5 minutes apart = Category I; ED first 10minutes with confirmed SBP ≤ 90 = Category I; ICU or OR SBP ≤ 90 or ED Drop in SBP after evaluation has begun and the 10min clock has passed = sick patient, but no state categorization.)

Element Values for Illinois:

1. Category I
2. Category II

NOTE: Field Element Values in the DI Software are based on CDC Field and IL In-house criteria. Currently use only those IL approved elements as highlighted below:

This field is **NOT MULTI-SELECT**. You will need to **ADD** a new row for each new element.

INHOUSE ACTIVATION CRITERIA; TAC Approved 2015 but not yet in RULES

1. Cat I – Amputation Proximal to Wrist or Arm
2. Cat I – Blood infusing to Maintain Vital Signs
3. Cat I – Chest Wall Instability or Deformity (e.g., Flail chest)
4. Cat I – Confirmed SBP <90 in Adults; <80 in Peds (this would be Field Surgeon Activation)
5. Cat I – Crushed, De-gloved, Mangled or Pulseless Extremity
6. Cat I – Emergency Physician Discretion
7. Cat I – GCS \leq 10
8. Cat I – Inability to Intubate with Anticipation of Surgical Airway
9. Cat I – Open or Depressed Skull Fracture
10. Cat I – Other (Facility Specific Criteria for Full Team Activation)

FIELD ACTIVATION CRITERIA: TAC Approved in 2012 but not yet in RULES

11. Cat I – Paralysis proximal to the Wrist or Ankle
12. Cat I – Pelvis Fractures (Unstable)
13. Cat I – Penetrating Injuries Excluding Distal Extremities (Head, Neck, Torso, Groin)
14. Cat I – Respiratory Rate <10 or >29 or requiring ventilator support
15. Cat I – Systolic BP <90mmHg (<80mmHg in Peds)
16. Cat I – Two or more Proximal Long Bone Fractures
17. Cat 2 – Auto Crash Death in Same Passenger Compartment
18. Cat 2 – Auto Crash Ejection
19. Cat 2 - Auto Crash Intrusion >18in (>12in for Occupant Site)
20. Cat 2 – Auto Crash Telemetry Data Indication
21. Cat 2 – Auto vs Cyclist Thrown, Run Over or >20mph Impact
22. Cat 2 – Auto vs Pedestrian Thrown, Run Over or >20mph Impact
23. Cat 2 – Fall; Adults >20ft (One Story = 10ft)
24. Cat 2 – Fall Children >10ft or 2-3 Times Height of Child
25. Cat 2 – GCS 11-13 with Mechanism Attributed to Trauma
26. Cat 2 – Motorcycle crash >20mph (also recreational vehicles)
27. Cat 2 – Other (Facility Specific Criteria for Partial Team Activation)

MISSING FROM DI ELEMENT CHOICES BUT APPROVED IN IDPH SET

XX Cat I – Combination Trauma with \geq 20% TBSA Burns

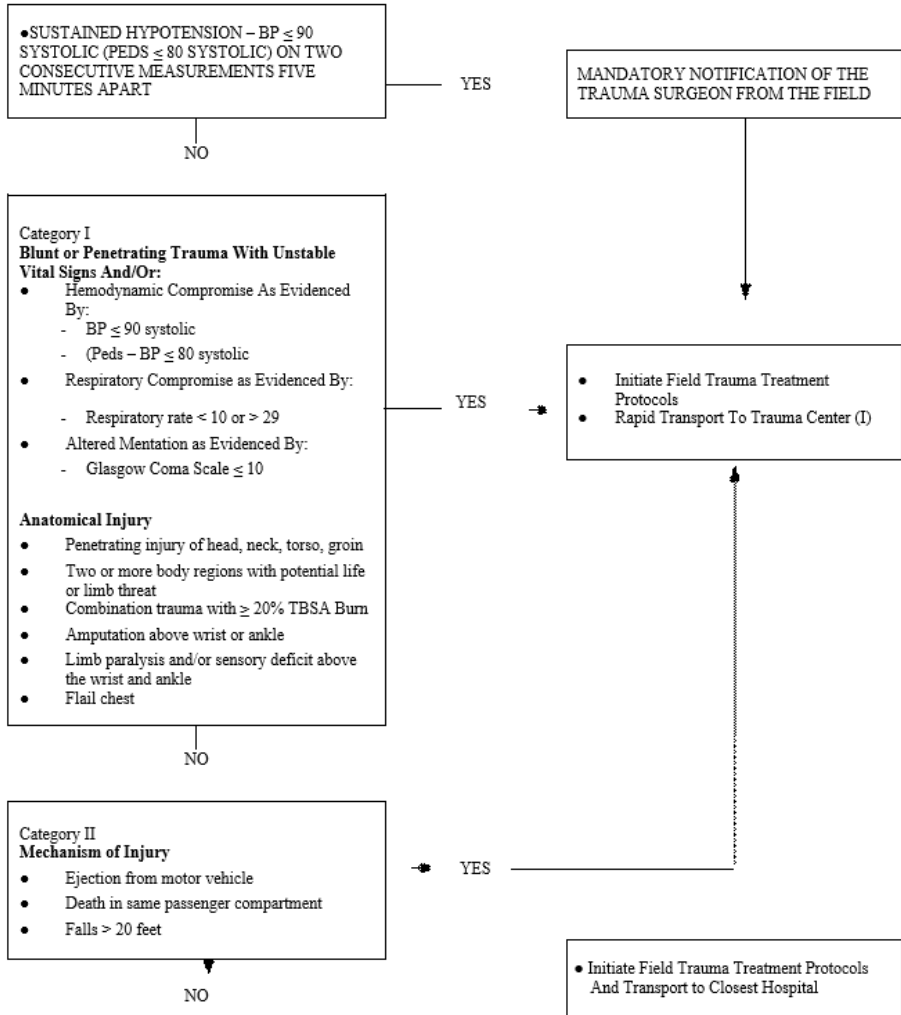
XX Cat I – Two or more body regions with potential life or limb threat

XX Cat I - SUSTAINED Hypotension- BP \leq 90 Systolic (Peds \leq 80 Systolic) on 2 consecutive measurements 5min apart (USING Element #4 “Confirmed SBP <90...”)

Data Source Hierarchy Guide

1. Trauma Flowsheet / Navigator
2. EMS Run Sheet
3. EMS Radio Report Sheet
4. Nursing Notes
5. Progress Notes

Section 515.APPENDIX C Minimum Trauma Field Triage Criteria



Section 515.APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

- a) Patient Evaluation
 - 1) Any EMS System transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center if less than 25 minutes from the trauma center; otherwise, follow Section 515.Appendix C. Mandatory field notification of a trauma surgeon will occur in cases of:
 - A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 80 Hg for a pediatric patient on two consecutive measures five minutes apart); or
 - B) Cavity penetration of the torso or neck.
 - 2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED's attending emergency physician or designee immediately upon arrival. (Section 515.2060(a))
 - 3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515.2060(b))
 - 4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.
 - 5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.
 - 6) Once the patient has been assigned a Category I or II status that patient cannot be downgraded until the patient is evaluated by the trauma surgeon or appropriate subspecialist.
- b) Category I
The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician's discretion.

Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery and cardiovascular surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery or cardiovascular surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and shall be completed within two hours. An isolated injury refers to transfer of energy to a single anatomic body region with no potential for multisystem involvement.

c) Category II

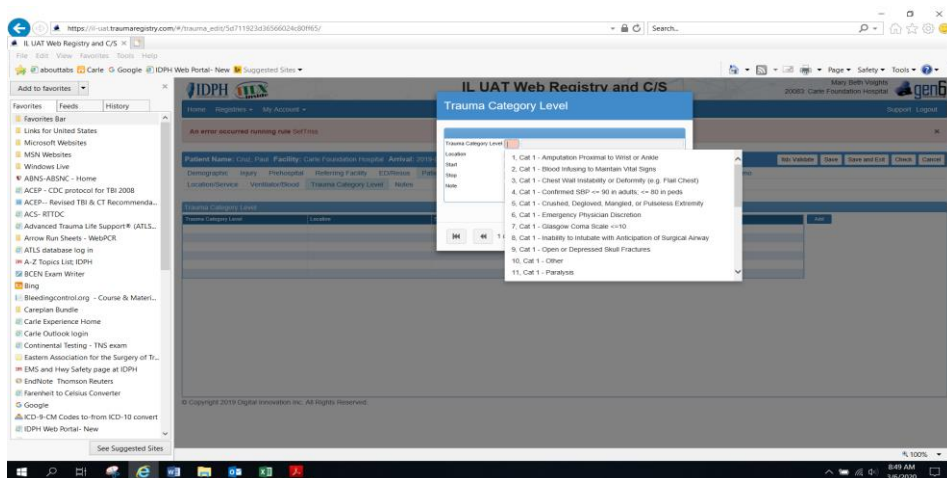
Any other patient who is admitted for traumatic injury requires notification/consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level I) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515.Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515.Appendix C).

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)



Definition

The actual trauma acuity Category criteria met by the patient as specified in the IL Trauma Rules & Regulations.

NOTE: Categorization Rules can be found in Section 515, Appendices C and F. (Screen shots on prior 3 pages).

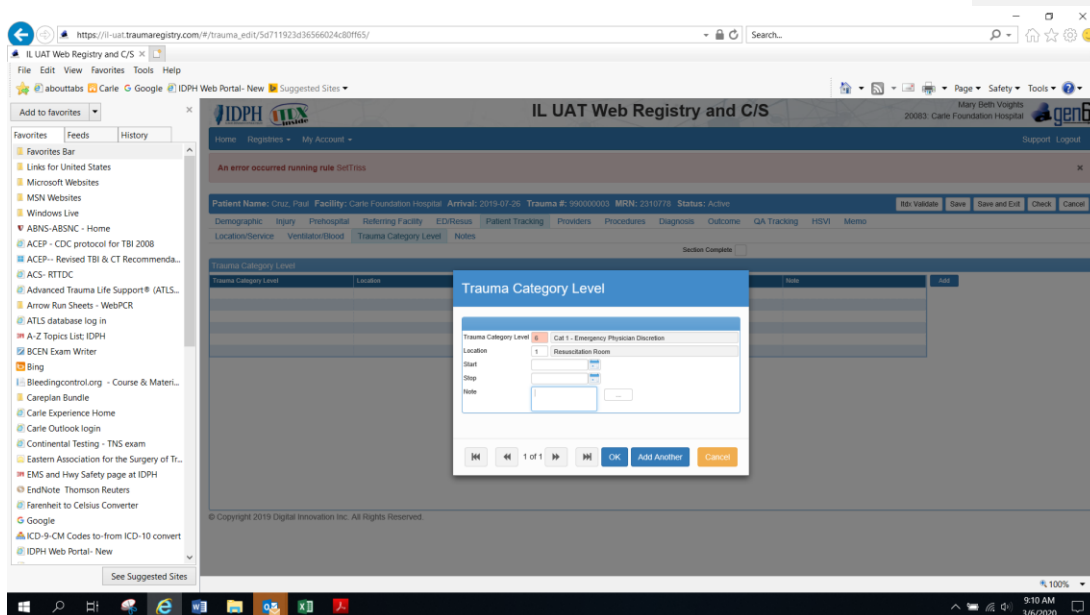
Patient can meet State Categorization anytime the Criteria is met prior to or within 10minutes of hospital arrival.

Element Values

- | | |
|---|---|
| <p>CATEGORY I</p> <ol style="list-style-type: none"> 1. Sustained SBP ≤ 90 (≤80 Peds) 2. RR <10 or >29 3. GCS ≤ 10 <p>CATEGORY II</p> <ol style="list-style-type: none"> 4. Penetrating head, torso, groin 5. 2 or more body regions life/limb threat 6. Combo trauma / Burns ≥20% TBSA 7. Amputation above wrist or ankle 8. Limb deficit above wrist or ankle 9. Flail chest | <ol style="list-style-type: none"> 1. Motor vehicle ejection 2. Death same compartment 3. Falls >20ft |
|---|---|

Data Source Hierarchy Guide

1. Trauma Flowsheet / Navigator
2. EMS Run Sheet
3. EMS Radio Report Sheet
4. Nursing Notes
5. Progress Notes



Location Tracking: Trauma Category Location

Definition

The location of the patient when IDPH Trauma Patient Categorization Criteria was/were identified.

NOTE: Prehospital is not an option in the DI List for this element. Please use () _____ when the categorization criteria were met in the Prehospital setting. (IDPH to supply the missing clarity.)

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes

The screenshot displays a web browser window with the URL https://il-uat.traumaregistry.com/#/trauma_edit/5d711923d36566024c8d9165/. The page title is "IL UAT Web Registry and C/S". A modal dialog box titled "Trauma Category Level" is open, showing a form with the following fields:

- Trauma Category Level:
- Location:
- Start:
- Stop:
- Note:

Buttons at the bottom of the dialog include "OK", "Add Another", and "Cancel". The background interface shows a patient record for "Carl Foundation Hospital" with various tabs and a table for "Trauma Category Level".

Location Tracking: Trauma Category Time / Date

Definition

The date when IDPH Trauma Patient Categorization Criteria was/were identified.

Stop Date can be entered as NA (/).

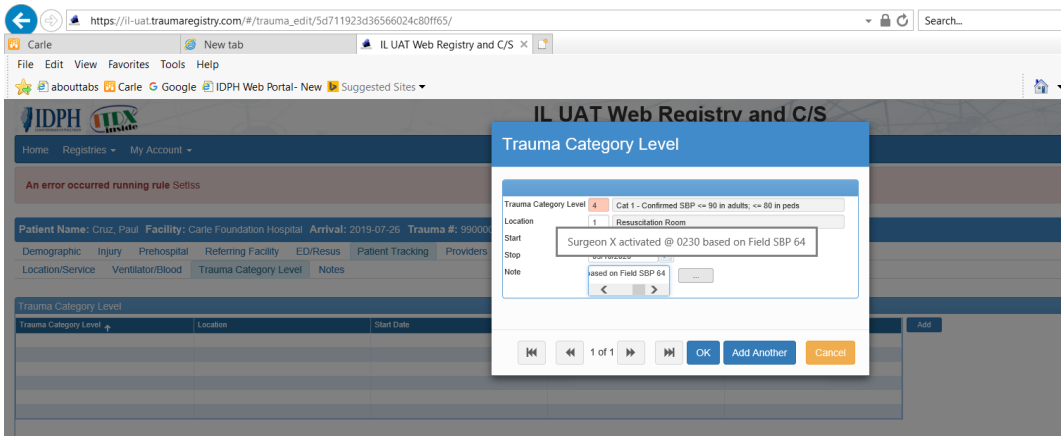
NOTE: There is no need to identify or track a STOP time for this element.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes



Location Tracking: Trauma Category Notes

Definition

Free text opportunity to add notes pertinent to the IDPH Trauma Patient Categorization process.

Examples

- Specifying time that activation occurred and/or why.
- Specifying the Facility-specific criteria utilized if not present in the approved / highlighted lists.
- Specifying Prehospital as the location of criteria being met since not a dropdown item

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide:

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes

ICU Days – See next page for NTDS definitions. **MANDATORY BLUE FIELD: NTDS Definition rules.**

NOTE: ICU days will auto-populate based on location tracking
 Use of location #14, Neonatal / Pediatric Care Unit, will not auto-populate ICU days. You CAN however, enter ICU location # 4 initially for the software to calculate the days and then switch location to #14 Neonatal / Pediatric Care Unit and the calculated days will remain in the reporting blue field.
 Stepdown/IMC Days – These will also auto-populate based on location tracking.

TOTAL ICU LENGTH OF STAY**Definition**

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

Element Values

- Relevant value for data element

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.

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7501	1	Invalid value
7502	2	Element cannot be blank
7503	2	Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7504	3	The value is above 60
7505	2	The value submitted falls outside the valid range of 1-575
7540	1	Single Entry Max exceeded

The screenshot shows the 'Trauma Data Editor' interface. The 'Location Tracking' window displays a table with columns: Date, Location, Arrival Date, Time, Discharge D., Time, Elapsed Time, and Detail. A record is shown for 'Step Down Unit' on 07/10/2020 at 19:00, with a discharge date of 07/10/2020 at 10:45, and an elapsed time of 3 Days 12:45. An orange arrow points to the 'Service Tracking' dialog box, which has fields for Service Code, Start, Stop, and Elapsed Time. The 'Service Tracking' dialog also has 'Check', 'OK', and 'Cancel' buttons. The main window has a menu bar with options like Demographic, Injury, Prehospital, Referring Facility, ED/Resus, Patient Tracking, Providers, Procedures, Diagnosis, Outcome, QA Tracking, Memo, and Custom. The status bar at the bottom shows 'Amre: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Service Tracking: Service Code

Definition

The physician specialty service(s) caring for the patient. Up to 8 services can be added. **NOTE:** Enter the Primary Service first if you enter multiples.

Useful to track service handoffs / assumption of care (such as Trauma Service handing isolated injury case to Orthopedics, who added Hospitalists, etc.).

Facility can determine if tracking only Primary Service, specific Service Lines, or every service involved with the patient.

Element Values

- Relevant values for Data Element (Specialty Provider Groups)

Data Source Hierarchy Guide

1. History and Physical
2. Consult Notes
3. Progress Notes
4. Treatment Team entries if doing concurrent abstraction

The screenshot shows a dropdown menu with a list of medical specialties. The list includes: 1. Trauma, 2. Neurosurgery, 3. Orthopedics, 4. General Surgery, 5. Pediatric Surgery, 6. Cardiothoracic Surgery, 7. Burn Services, 8. Emergency Medicine, 9. Pediatrics, 11. Cardiology, 14. Critical Care, 19. ENT, 20. Family Medicine, 21. GI, 23. Hospitalist, 24. Infectious Disease, 25. Internal Medicine, 27. Nephrology, 28. Neurology, 32. Ob-Gyn, 34. Oncology, 35. Ophthalmology, 36. Oral Surgery, 37. Oromaxillo Facial Service, 38. Ortho-Spine, 43. Plastic Surgery, 45. Pulmonary, 52. Thoracic Surgery, 55. Urology, 56. Vascular Surgery, 98. Other Surgical, 99. Other Non-Surgical, and ?. Unknown. The menu has 'OK', 'Cancel', 'Search', and 'Show All' buttons.

The screenshot displays the Trauma Data Editor interface. At the top, there are tabs for Demographic, Injury, Prehospital, Referring Facility, ED/Resus, Patient Tracking, Providers, Procedures, Diagnoses, Outcome, QA Tracking, Memo, and Custom. The main window is divided into sections: Location/Service, Ventilator/Blood, and Notes. The Location Tracking section contains a table with the following data:

Code	Location	Arrival Date	Time	Departure D...	Time	Elapsed Time	Detail
5	Step-Down Unit	01/06/2020	19:00	01/10/2020	07:45	3 Days 12:45	

An orange arrow points from the 'Start' field in the Service Tracking dialog box to the 'Time' column of the Location Tracking table. The Service Tracking dialog box has the following fields:

- Service Code: []
- Start: [] @ []
- Stop: [] @ []
- Elapsed Time: []
- Detail: []

At the bottom of the dialog box, there are buttons for Check, OK, and Cancel, along with navigation arrows. The main window also has buttons for Add, Edit, and Delete on the right side. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN: []'.

Service Tracking: Start Date and Time

Definition

The date and time that a physician subspecialty group begins to primarily care for a patient.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. History and Physical
2. Consult Notes
3. Progress Notes
4. Treatment Team entries if concurrent abstraction

The screenshot displays the 'Trauma Data Editor' application. The main window is titled 'Location/Service' and contains a 'Location Tracking' table. The table has the following columns: Code, Location, Arrival Date, Time, Departure Date, Time, Elapsed Time, and Detail. A single row is visible with the following data: Code: 5, Location: Step-Down Unit, Arrival Date: 01/06/2020, Time: 19:00, Departure Date: 01/10/2020, Time: 07:45, Elapsed Time: 3 Days 12:45, and Detail. An orange arrow points from the 'Service Tracking' dialog box to the 'Service Code' field. The dialog box is titled 'Service Tracking' and contains fields for Service Code, Start, Stop, and Elapsed Time, along with a Detail field and buttons for Check, OK, and Cancel. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Service Tracking: Stop Date and Time

Definition

The date and time that a physician subspecialty group stops primarily caring for a patient.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. History and Physical
2. Progress Notes
3. Treatment Team entries if concurrent abstraction

The screenshot displays the 'Trauma Data Editor' application. The main window has tabs for 'Location/Service', 'Ventilator/Blood', and 'Notes'. The 'Ventilator Tracking' section contains a table with columns for 'Start Date', 'Start Time', 'Stop Date', 'Stop Time', and 'Elapsed Time'. Below this table is a 'Total Ventilator Days' field. A modal dialog box titled 'Ventilator Tracking' is open, allowing the user to 'Record', 'Edit', or 'Browse' a record. The dialog has fields for 'Start', 'Stop', and 'Elapsed Time', each with a date and time picker. An orange arrow points from the 'Total Ventilator Days' field to the 'Start' field in the dialog. The 'Blood Tracking' section below has a table with columns for 'Product', 'Volume', and 'Units'. The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Ventilator Tracking: Start Date and Time: MANDATORY BLUE FIELD; follow NTDS Definition rules

Definition:

The date and time that a patient was placed on mechanical ventilation.
See next page for NTDS definitions.

NOTE: Ventilator days will auto-populate based on date/time entered.
Field will accept multiple episodes of ventilation (failed and required reintubation / ventilation).

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. Respiratory Therapy Notes / Flowsheets
2. ICU Flowsheet
3. Progress Notes
4. Procedure Note

TOTAL VENTILATOR DAYS**Definition**

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

Element Values

- Relevant value for data element

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 Ventilator 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.

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	

	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)
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Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range 1-575
7640	1	Single Entry Max exceeded

The screenshot displays the 'Trauma Data Editor' application. The main window has tabs for 'Location/Service', 'Ventilator/Blood', and 'Notes'. The 'Ventilator Tracking' section contains a table with columns for 'Start Date', 'Start Time', 'Stop Date', 'Stop Time', and 'Elapsed Time'. Below this table is a 'Total Ventilator Days' field with a slider. The 'Blood Tracking' section has a table with columns for 'Product', 'Volume', and 'Units'. A modal dialog box titled 'Ventilator Tracking' is open, showing 'Record Edit Browse' options and fields for 'Start', 'Stop', and 'Elapsed Time'. An orange arrow points from the 'Elapsed Time' field in the dialog to the 'Elapsed Time' column in the main table. The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Ventilator Tracking: Stop Date and Time: MANDATORY BLUE FIELD; follow NTDS Definition rules.

Definition

The date and time that a patient was removed from mechanical ventilation

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. Respiratory Therapy Notes / Flowsheets
2. ICU Flowsheet
3. Progress Notes

NOTE: The total ventilator days will auto-populate based on your ventilator tracking information

TOTAL VENTILATOR DAYS

Definition

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

Element Values

- Relevant value for data element

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 Ventilator 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.

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	

	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)
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Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range 1-575
7640	1	Single Entry Max exceeded

Blood Tracking: Blood Product

Definition

The type of blood product given to the patient.

Element Values

- | | |
|---------------------------|---|
| 1. Packed Red Blood Cells | 4. Other Blood Substitute (Cryoprecipitate) |
| 2. Plasma | / . Not Applicable |
| 3. Platelets | ? . Unknown |

NOTE: Whole blood should be an option in the Web Version.

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record

The screenshot displays the 'Trauma Data Editor' application. The main window is titled 'Trauma Data Editor' and has several tabs: Demographic, Injury, Prehospital, Referring Facility, ED/Resus, Patient Tracking, Providers, Procedures, Diagnoses, Outcome, QA Tracking, Memo, and Custom. The 'Ventilator/Blood' tab is active, showing a 'Ventilator Tracking' section with a table for recording ventilator use. An orange arrow points from the 'Blood Product' field to the 'Volume' field in the 'Blood Tracking' sub-window. The sub-window also includes fields for 'Location', 'Time Period', and 'Units'. The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Blood Tracking: Volume

Definition

The volume of a particular blood product given to the patient reflected as # of units for red cells or # of packs for coagulation components

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record

Blood Tracking: Units

Definition

The units used to measure the volume of blood product given.

NOTE: Illinois will use UNITS as the standard measure for data entry.

Element Values

- | | |
|---|-------------------|
| 1. L | /. Not Applicable |
| 2. mL | ? Unknown |
| 3. Units (red cells) or Packs (coag components) | |

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record

Blood Tracking: Location

Definition

Where the patient was located when they received the blood products.

NOTE: Location of the administration of blood can be configured by looking at the time and date it was given and comparing that to the pt.'s ADT events

Element Values

- | | |
|-------------------------|----------------------------------|
| 1. Resuscitation Room | 10. Radiology |
| 2. Emergency Department | 11. Post Anesthesia Care Unit |
| 3. Operating Room | 12. Special Procedure Unit |
| 4. Intensive Care Unit | 13. Labor and Delivery |
| 5. Step-Down Unit | 14. Neonatal/Pediatric Care Unit |
| 6. Floor | 90. Prehospital |
| 7. Telemetry Unit | 91. Referring Facility |
| 8. Observation Unit | / . Not Applicable |
| 9. Burn Unit | ? . Unknown |

Data Source Hierarchy Guide

- | | |
|--|---------------------|
| 1. Flowsheets (I&O, MTP, Blood Tracking, etc.) | 3. Encounter Report |
| 2. ADT Events | 4. Nursing Notes |

Blood Tracking: Time Period

Definition

The time period during the patient's stay when they received the blood

Determined by comparing the Date and Time that the blood was administered to the patient's arrival date and time.

Element Values

- | | |
|--|---|
| 0. Prior to Facility Arrival | 4. Between 24 and 48 Hours after Facility Arrival |
| 2. First 4 Hours after Facility Arrival | 5. More than 48 Hours after Facility Arrival |
| 3. Between 4 and 24 Hours after Facility Arrival | /. Not Applicable |
| | ? Unknown |

Data Source Hierarchy Guide

1. Blood Tracking Flowsheets
2. ADT Events
3. Nursing Notes
4. EMS Run Reports
5. Transferring Facility Documentation

Providers

- The provider elapsed time will auto-populate based on ED/Hospital arrival time and Provider arrived time.
- The Timeliness box is based on state or other certifying body's time expectations for the different providers to arrive.

Resus: Provider

Definition

The providers who were involved with the patient’s initial resuscitation after arriving to your facility.

Include as many choices as necessary to identify physicians participating with the trauma team response. Can include consults generated in the Emergency Department for expectant response IN the emergency department. All other consults are entered in the next tab (in-hospital section).

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Nursing Notes
4. Consult Notes

Resus: Provider Called

Definition

The date and time that the particular provider was called or paged because their specialty was needed for the care of the patient.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Nursing Notes
4. Consult Notes

Resus: Provider Responded

Definition

The date and time that the particular provider responded to the page or call because their specialty was needed for the care of the patient.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. History and Physical
2. Progress Notes
3. Trauma Flowsheet / Nursing Notes
4. Consult Notes

Resus: Provider Arrived

Definition

The date and time that the particular provider arrived to treat the patient, and makes actual verbal or physical contact with the patient.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes / Trauma Flowsheet
5. Consult Notes

Resus Team: Timeliness

Definition

Did the provider arrive within a specific timeframe that is designated by the appropriate governing body or hospital policy?

Element Values

- | | | |
|---------------|----|----------------|
| 1. Timely | /. | Not Applicable |
| 2. Not Timely | ? | Unknown |
| 3. Absent | | |

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
5. Consult Notes

Section 515.APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

a) Patient Evaluation

- 1) Any EMS System transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center if less than 25 minutes from the trauma center; otherwise, follow Section 515.Appendix C. Mandatory field notification of a trauma surgeon will occur in cases of:
 - A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 80 Hg for a pediatric patient on two consecutive measures five minutes apart); or
 - B) Cavity penetration of the torso or neck.
- 2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED's attending emergency physician or designee immediately upon arrival. (Section 515.2060(a))
- 3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515.2060(b))
- 4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.
- 5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.
- 6) Once the patient has been assigned a Category I or II status that patient cannot be downgraded until the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) Category I

The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician's discretion.

Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery and cardiovascular surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery or cardiovascular surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and shall be completed within two hours. An isolated injury refers to transfer of energy to a single anatomic body region with no potential for multisystem involvement.

- c) **Category II**
Any other patient who is admitted for traumatic injury requires notification/consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level D) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515, Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515, Appendix C).

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)

In-House Consults

Definition

The subspecialties consulted after the patient has been admitted to the hospital.

Element Values

1. Relevant Value for Data Element

NOTE: The provider's name should be attached to the consult note

Data Source Hierarchy Guide

1. Consult Notes
2. Progress Notes
3. Nursing Notes

In-House Consult: Provider Called

Definition

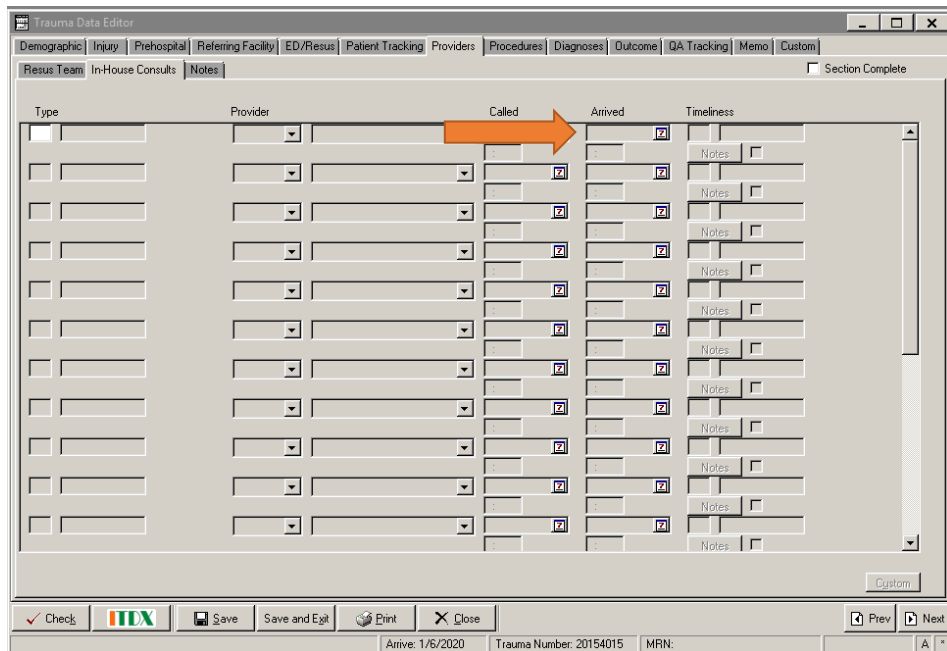
The date and time that the particular provider was called or paged because their specialty was needed for the care of the patient after the patient was admitted.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Consult Notes / Notes
2. Progress Notes
3. Nursing Notes



In-House Consults: Provider Arrived

Definition

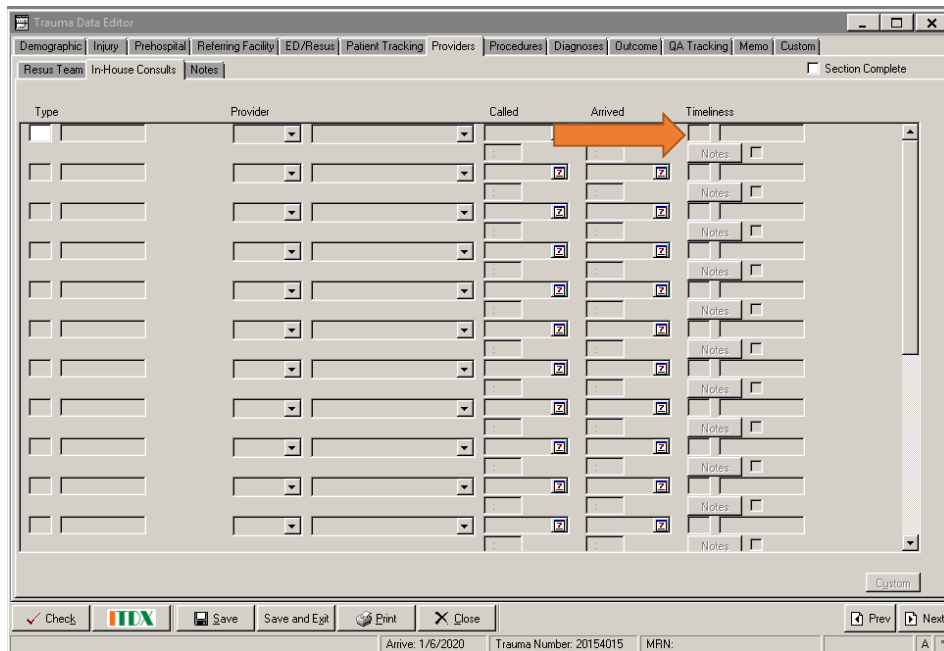
The date and time that the particular provider arrived to treat the patient after the patient has been admitted to the hospital.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Consult Notes
2. Progress Notes
3. Nursing Notes



In House Consults: Timeliness

Definition

Did the provider arrive within a specific timeframe that is designated by the appropriate governing body or hospital policy?

NOTE: Refer to the IL Trauma Center Rules / Regulations in the *Resus Team Consult Tab* to assist in making this determination.

Element Values

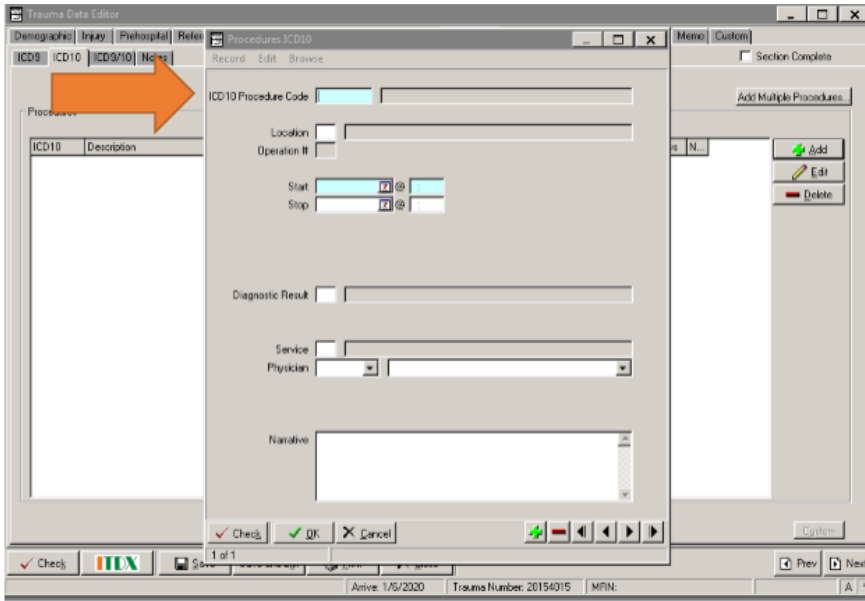
- | | | |
|---------------|----|----------------|
| 1. Timely | /. | Not Applicable |
| 2. Not Timely | ? | Unknown |
| 3. Absent | | |

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes

Procedures Information

- Procedures are entered using the very specific ICD-10 codes
- Procedures, based on the NTDS definition adopted by Illinois, are limited to those essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The NTDS has a recommended list and the IL CQI / Registry Committee has also created a standardized list of codes to assist in making these decisions and standardized entries. They are embedded in this Section.
- (Many of the procedures entered pre-2019 will no longer be needed. Each facility can enter as many as they want, but there is no longer a mandate to capture all of them, allowing you an opportunity to limit some of that historic work).



Hospital Procedures: BLUE FIELD; NTDS Definition rules follow.

ICD-10 HOSPITAL PROCEDURES**Definition**

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 NTDB.

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.

Additional Information

- The null value "Not Applicable" is reported if the patient did not have procedures.
- Only report procedures performed at your institution.
- Report all procedures 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.
- Note that the hospital may report additional procedures.

DIAGNOSTIC AND THERAPEUTIC IMAGING

Computerized tomographic Head *
 Computerized tomographic Chest *
 Computerized tomographic Abdomen *
 Computerized tomographic Pelvis *
 Computerized tomographic C-Spine*
 Computerized tomographic T-Spine*
 Computerized tomographic L-Spine*
 Doppler ultrasound of extremities *
 Diagnostic ultrasound (includes FAST) *
 Angioembolization
 Angiography
 IVC filter
 REBOA

CARDIOVASCULAR

Open cardiac massage
 CPR

CNS

Insertion of ICP monitor *

MUSCULOSKELETAL

Soft tissue/bony debridement *
 Closed reduction of fractures
 Skeletal and halo traction
 Fasciotomy

TRANSFUSION

Transfusion of red cells * (only report first 24 hours after hospital arrival)
 Transfusion of platelets * (only report first 24 hours after hospital arrival)
 Transfusion of plasma * (only report first 24 hours after hospital arrival)

RESPIRATORY

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

Ventriculostomy *	GASTROINTESTINAL
Cerebral oxygen monitoring *	Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
GENITOURINARY	Gastrostomy/jejunostomy (percutaneous or endoscopic)
Ureteric catheterization (i.e. Ureteric stent)	Percutaneous (endoscopic) gastrojejunoscopy
Suprapubic cystostomy	

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

Associated Edit Checks

Rule ID	Level	Message
8801	1	Invalid Value (ICD-10 PCS only)
8803	2	Element cannot be blank
8804	3	Element should not be "Not Applicable" unless patient had no procedures performed
8805	1	Invalid value (ICD-10-CA only)
8850	1	Multiple Entry Max exceeded

NOTE: Please refer to the *Commonly Used ICD-10 Procedure Codes Chart* on the next page for standardization of the common procedures performed during trauma patient evaluation and treatment.

NOTE: Standardized codes for Blood and AntiCoag Administration:

- The blood admin codes for use in Procedures if you also track it there are:
 - PRBC: 30233N1
 - Plasma / FFP: 30233L1
 - Platelets: 30233R1
 - Cryoprecipitate: 30233M1
 - TXA: 30243T1
 - Whole Blood
- There is currently **NO CODE** for Massive Transfusion Protocol; use products
- AntiCoag Reversal
 - PCC (KCentra) - 30283B1

Commonly Used ICD - 10 Procedure Codes

Resuscitation		Diagnostic X-rays		MRI	
2W32X3Z	C-Collar/Aspen Application	BN05ZZZ	XR Panorex	B030ZZZ	MRI Brain
2W1LX7Z	Tourniquet Right Lower Leg	BN00ZZZ	XR Skull	BR30ZZZ	MRI C-Spine
2W1MX7Z	Tourniquet Left Lower Leg	BR00ZZZ	XR C-Spine	BR37ZZZ	MRI T-Spine
2W1BX7Z	Tourniquet Left Upper Arm	BR07ZZZ	XR T-Spine	BR39ZZZ	MRI L-Spine
2W1AX7Z	Tourniquet Right Upper Arm	BR09ZZZ	XR L-Spine	UltraSound	
5A19054	BVM/Ambu Bag	BPOYZZZ	XR Left Ribs	B345ZZZ	Carotid Dopplers
0BH17EZ	Intubation	BPOXZZZ	XR Right Ribs	B246ZZZ	Echocardiogram
0WHQ7YZ	King Airway/Combitube/Igel/LMA	BW03ZZZ	XR Chest	BW41ZZZ	FAST Exam
0WPOXYZ	Extubation	BW00ZZZ	XR Abdomen	B54DZZZ	Bilateral Dopplers
0BH13EZ	Cricothyrotomy	BT04ZZZ	XR KUB	Vascular	
5A1201Z	CPR	BR0CZZZ	XR Pelvis	5A1223Z	Transvenous Pacer
5A1221Z	CPR - Lucas Device	Diagnostic CT scans		03HC3DZ	Left Arterial Line - Arm
5A2204Z	Defibrillation	BW28ZZZ	CT Head	03HB3DZ	Right Arterial Line - Arm
0W993ZZ	Right Needle Decompression	B020ZZZ	CT Brain	04HL3DZ	Left Arterial Line - Femoral
0W983ZZ	Left Needle Decompression	BN25ZZZ	CT Facial Bones	04HK3DZ	Right Arterial Line - Femoral
0W9D3ZZ	Pericardiocentesis	BB24ZZZ	CT Chest (Bilateral Lungs)	06HN33Z	Left Central Line - Femoral
0WJ80ZZ	Left Thoracotomy	BW25ZZZ	CT Chest/Abdomen/Pelvis	06HM33Z	Right Central Line - Femoral
0WJ90ZZ	Right Thoracotomy (Clamshell)	BW24ZZZ	CT Chest/Abdomen	05H633Z	Left Central Line - Chest/Subclavian
02QA0ZZ	Open Cardiac Massage	BW21ZZZ	CT Abdomen/Pelvis	05H533Z	Right Central Line - Chest/Subclavian
3E080GC	Intra Cardiac Epi	BR2CZZZ	CT Pelvis	4A02X4Z	EKG
04V03EZ	REBOA	BR20ZZZ	CT C-Spine	Wound/Ortho Treatment	
3E0V37Z	Intraosseous Access	BR27ZZZ	CT T-Spine	2W33X3Z	TPOD Placement
Respiratory		BR29ZZZ	CT L-Spine	2W35X3Z	TLSO Brace
5A09357	CPAP/BiPAP < 24 hours	Angiography		Genitourinary	
5A09457	CPAP/BiPAP 24-96 hours	B32R1ZZ	CTA Head	0T9B70Z	Foley Catheter
5A09557	CPAP/BiPAP >96 hours	B3251ZZ	CTA Neck	0T2BX0Z	Removal of Foley
5A1935Z	Vent < 24 hours	B32S1ZZ	CT PE	BT1B1ZZ	Cystogram
5A1945Z	Vent 24-96 hours	B3201ZZ	CTA Chest	BT141ZZ	Retrograde Urethrogram
5A1955Z	Vent > 96 hours	BF2C1ZZ	CTA Abdomen/Pelvis	Gastrointestinal	
09HN7BZ	Nasal Airway	BP2T1ZZ	CTA Right Upper Arm	0D9670Z	OG/NG Tube Placement
0CHY7BZ	Oral Airway	BP2U1ZZ	CTA Left Upper Arm	Neuro	
0W9900Z	Right Chest Tube - Open	BP2V1ZZ	CTA Bilateral Upper Extremities	4A003BD	ICP Monitoring
0W9B00Z	Left Chest Tube - Open	B42H1ZZ	CTA Bilateral Lower Extremities	009630Z	EVD Placement - Perc
0W9930Z	Right Chest Tube - Perc	B42G1ZZ	CTA Left Lower Leg	009600Z	EVD Placement - Open
0W9B30Z	Left Chest Tube - Perc	B42F1ZZ	CTA Right Lower Leg	009Y3ZZ	Lumbar Puncture
0BJ08ZZ	Bronchoscopy			4A10X4Z	EEG
0B110Z4	Tracheostomy				

Procedure Location

Definition

The area of the healthcare facility where the procedure was performed.

Element Values

- | | |
|-------------------------|----------------------------------|
| 1. Resuscitation Room | 9. Burn Unit |
| 2. Emergency Department | 10. Radiology |
| 3. Operative Room | 11. Post Anesthesia Care Unit |
| 4. Intensive Care | 12. Special Procedure Unit |
| 5. Step-Down Unit | 13. Labor and Delivery |
| 6. Floor | 14. Neonatal/Pediatric Care Unit |
| 7. Telemetry Unit | / . Not Applicable |
| 8. Observation Unit | ? . Unknown |

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. History and Physical
4. Progress Notes
5. Nursing Notes

Operation Number

Definition

Operations are valued in numerical order. This is the number of the operation where the particular procedure being entered was performed.

Element Values

1. Relevant Data for Element Values

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. History and Physical
4. Progress Notes
5. Nursing Notes
6. ADT Events

Hospital Procedure Start Date: Mandatory BLUE FIELD; NTDS Definition rules follow.

HOSPITAL PROCEDURE START DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported 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 Reports
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6603	3	Hospital Procedure Start Date is earlier than EMS Dispatch Date
6604	3	Hospital Procedure Start Date is earlier than EMS Unit Arrival on Scene Date
6605	3	Hospital Procedure Start Date is earlier than EMS Unit Scene Departure Date
6606	3	Hospital Procedure Start Date is earlier than ED/Hospital Arrival Date
6607	2	Hospital Procedure Start Date is later than Hospital Discharge Date
6609	2	Element cannot be blank
6650	1	Multiple Entry Max exceeded

Procedure Stop Date and Time

Definition

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

NOTE: Illinois recommendation to enter STOP times for *invasive procedures only*.

Element Values

1. Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Anesthesia Notes
4. History and Physical
5. Progress Notes
6. Nursing Notes
7. ADT Events

The screenshot shows the 'Trauma Data Editor' application. The main window is titled 'Procedures ICD10'. On the left, there is a table with columns 'ICD10' and 'Description'. The main form area contains the following fields:

- ICD10 Procedure Code: [Text Field]
- Location: [Text Field]
- Operation #: [Text Field]
- Start: [Time Picker]
- Stop: [Time Picker]
- Diagnostic Result: [Text Field] (highlighted by an orange arrow)
- Service: [Text Field]
- Physician: [Dropdown Menu]
- Narrative: [Text Area]

At the bottom of the window, there are buttons for 'Check', 'OK', and 'Cancel'. The status bar at the very bottom displays 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Diagnostic Result

Definition

Did the procedure result in a diagnosis of a new injury or other medical issue being managed by the Trauma Team?

Element Values

1. Positive (or abnormal / IL definition).
2. Negative (or normal / IL definition).
3. Indeterminate (or equivocal / IL definition).
4. /. Not Applicable
5. /. Unknown

Data Source Hierarchy Guide

- Operative Notes
- Procedure Notes
- Anesthesia Notes
- History and Physical
- Progress Notes
- Nursing Notes

Service

Definition

The subspecialty service that performed or ordered the procedure.

Element Values

2. Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Progress Notes
4. History and Physical
5. Nursing Note
6. Radiology Reports

Physician

Definition

The physician responsible for performing the procedure.

Element Values

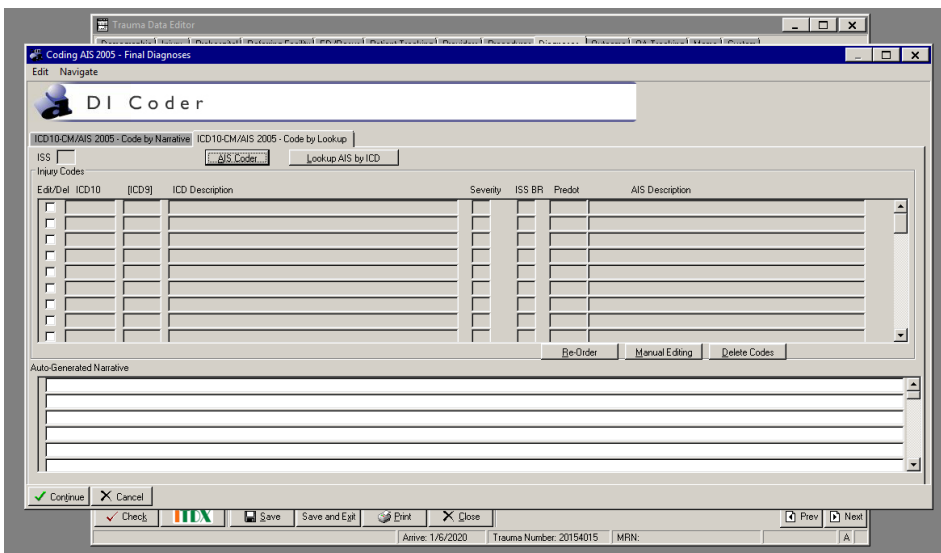
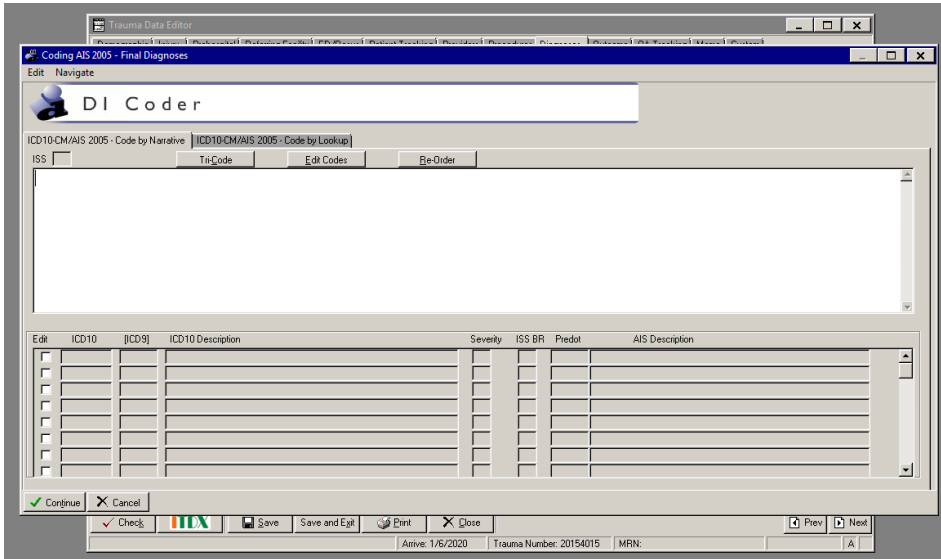
3. Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Progress Notes
4. History and Physical
5. Nursing Note
6. Radiology Reports

Diagnosis Codes

- There are three different ways to code diagnosis codes in the trauma registry.
 - One is the Tri-Code feature where the narrative information is typed into the box and the computer will assign ICD-10 and AIS codes. These codes need to be checked after they populate to ensure that they are accurate and meet the AIS coding rules.
 - The second way is to enter the AIS codes and then have them converted to ICD -10 codes. These codes need to be checked as well because AIS is not as comprehensive as the ICD-10 system.
 - The final way is to enter the ICD-10 codes and convert them to AIS codes. These codes also need to be checked for accuracy.
 - *EDITOR NOTE: Would be nice for DI to enter their 'hierarchy insight' here that they verbalized during training. Well said and would be helpful, but I didn't write it down. MBV*
- Once the diagnosis codes are in, along with the ED initial vitals, GCS, Age, and Mechanism of Injury, the ISS, TRISS, and NISS scores will auto-populate. ISS and NISS will populate just based off the severity of the AIS codes, TRISS scores need more information.



DIAGNOSES: MANDATORY BLUE FIELD; NTDS Definition rules follow.

[NTDS definitions for the mandated ICD-10 and AIS codes are on the next 2 pages.](#)

ICD-10 INJURY DIAGNOSES

Definition

Diagnoses related to all identified injuries.

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28 and T30-T32.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

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

Associated Edit Checks

Rule ID	Level	Message
8701	1	Invalid value (ICD-10-CM only)
8702	2	Element cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CM only)
8705	1	Invalid value (ICD-10-CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CA only)
8750	1	Multiple Entry Max exceeded

Non-Trauma Diagnosis

Definition

All other medical diagnoses that are not related to the injury diagnoses.

No minimum entry requirement for IL Trauma Registry.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Progress Notes
2. Nursing Notes
3. Consult Notes
4. History and Physical
5. Radiology Reports
6. Autopsy Reports
7. Lab Values

Prehospital Cardiac Arrest: MANDATORY BLUE FIELD; NTDS Definition rules follow.

The screenshot shows the 'Trauma Data Editor' application window. The 'Prehospital Cardiac Arrest' checkbox is checked and highlighted with an orange arrow. The main area contains a table for 'Comorbidities' with columns for 'Code', 'Comorbidity', and 'Note'. The table is currently empty. To the right of the table are buttons for 'Add', 'Edit', and 'Delete'. The bottom toolbar includes 'Check', 'Save', 'Save and Exit', 'Print', 'Close', 'Prev', and 'Next' buttons. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'. The 'Prehospital Cardiac Arrest' checkbox is located at the top left of the main data entry area, with an orange arrow pointing to it from the left.

PRE-HOSPITAL CARDIAC ARREST

Definition

Indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.

Element Values

- 1. Yes
- 2. No

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 index hospital. Pre-hospital cardiac arrest could occur at a transferring institution.
- Any component of basic and/or advanced cardiac life support must have been initiated.

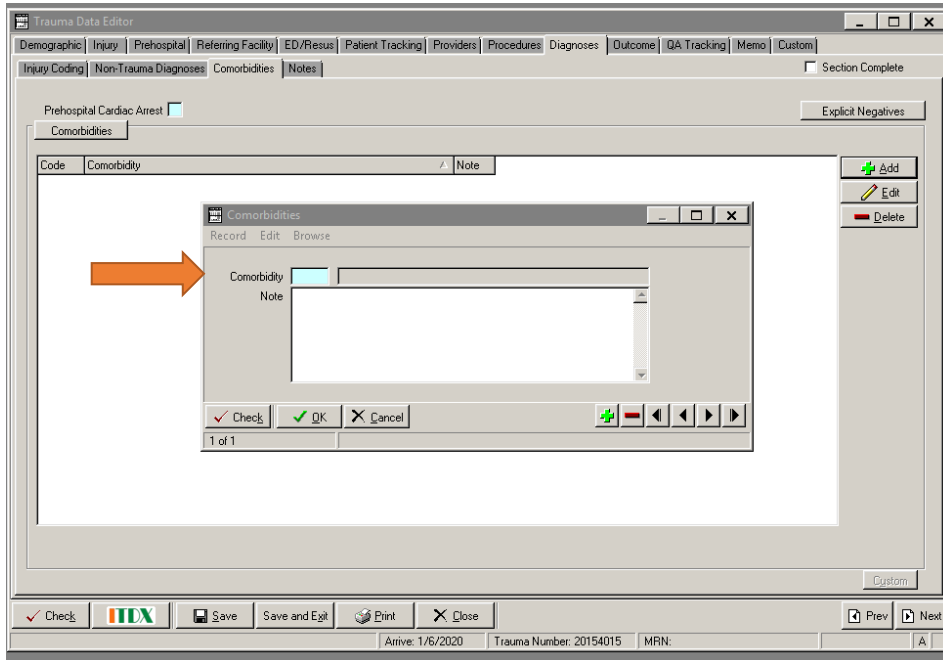
Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
9701	1	Value is not a valid menu option
9702	2	Element cannot be blank
9703	2	Element cannot be "Not Applicable"
9740	1	Single Entry Max exceeded

Pre-Existing Conditions / Co Morbidities: MANDATORY BLUE FIELD; NTDS Definition rules follow.



Pre-Existing Conditions / Comorbidities:

Definition

Medical conditions that existed prior to the patient becoming injured.

NOTE: Please refer to the NTDS Data Dictionary for the specifics regarding pre-existing conditions. (Multiple page reference with very specific definitions).

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. History and Physical
2. Nursing Notes/Triage Flowsheet
3. Progress Notes
4. Consult Notes
5. Previous Patient Encounters

Outcome

- The total ICU, Ventilator, and Hospital days will calculate based on the information that has already been placed in the chart.
- Remember the NTDS Discharge Order date and time signify the end of the patient's stay. Please make sure you are utilizing the final order if multiple orders are placed and cancelled. Anything documented after the discharge order date and time will not be included.
- The Death tab will only be accessible if the discharge status is marked as Dead. The Initial Discharge 2 tab will only be accessible if the discharge status is marked Alive.
- In the Billing Section, the account number will auto-populate from the initial demographics page.
- Total charges collected and last date collected will generate off of the information placed regarding payments and dates in the above section.

The screenshot displays the 'Trauma Data Editor' application window. The 'Outcome' tab is selected, and the 'Initial Discharge Information' section is highlighted with an orange arrow. The form contains various input fields and checkboxes for recording patient discharge details. The status bar at the bottom indicates the patient arrived on 1/6/2020, with Trauma Number 20154015 and MRN.

Discharge Status

Definition

Is the patient alive or deceased at discharge?

Element Values

1. Alive
2. Dead

Data Source Hierarchy Guide

1. Discharge Summary
2. Post-Mortem Flowsheet
3. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge' section is active, and an orange arrow points to the 'Discharge Condition' field. The form includes various input fields for patient information, discharge status, and physician details. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Discharge Condition

Definition

The condition of the patient compared to previous health at discharge

Element Values

- | | |
|--|--------------------------------|
| 1. Discharge with Previous Level of Function | 4. Severe Disability |
| 2. Temporary Disability Expected to Return to Previous Level of Function | 5. Persistent Vegetative State |
| 3. Moderate Disability with Expected Ability for Self-Care | 6. Dead |
| | ?. Unknown |

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Post-Mortem Flowsheet
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Initial Discharge' tab selected. The 'Patient Directive Applied' field is highlighted with a red arrow. The interface includes various input fields for discharge information, physician details, and transfer rationale.

Patient Directive Applied

Definition

Did the patient have an advanced directive that was utilized during their hospital stay?

Element Values

- | | |
|-------------------------------|--------------------|
| 1. Care Directive Applied | |
| 2. Care Directive Not Applied | / . Not Applicable |
| 3. No Care Directive Provided | ? . Unknown |

Data Source Hierarchy Guide

1. Discharge Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
5. Advanced Directives form or scanned document

Discharge / Death Time and Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Discharge/Death Date and Time:**Definition**

The actual time and date that the patient left your facility.

NOTE: Please note this is the actual date and time the patient left the facility or was pronounced.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Discharge Summary
3. Nursing Notes
4. Post – Mortem Flowsheet

Discharge Order Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

HOSPITAL DISCHARGE DATE

Definition

The date the order was written for the patient to be discharged from the hospital.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

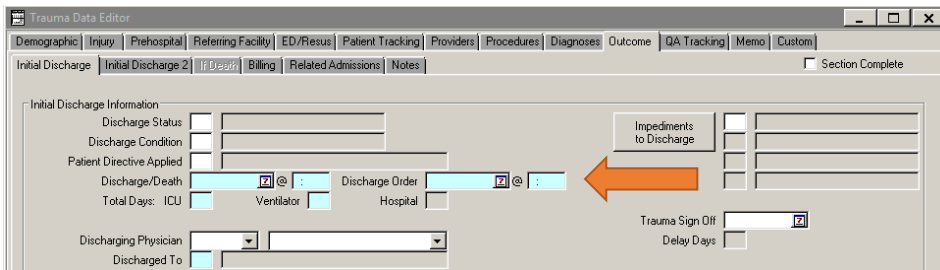
Associated Edit Checks

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Element cannot be blank
7704	3	Hospital Discharge Date is earlier than EMS Dispatch Date
7705	3	Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date
7706	3	Hospital Discharge Date is earlier than EMS Unit Scene Departure Date
7707	2	Hospital Discharge Date is earlier than ED/Hospital Arrival Date
7708	2	Hospital Discharge Date is earlier than ED Discharge Date
7709	2	Hospital Discharge Date is earlier than Date of Birth
7710	3	Hospital Discharge Date minus Injury Incident Date is greater than 365 days
7711	3	Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
7712	2	Element must be "Not Applicable" when ED Discharge Disposition is 4,5, 6, 9,10, or 11
7740	1	Single Entry Max exceeded

Commented [FT1]: Change title to Hospital Discharge Order Date

Commented [M2R1]: This is an NTDS field; No edits allowed ;)

Discharge Order Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.



HOSPITAL DISCHARGE TIME

Definition

The time the order was written for the patient to be discharged from the hospital.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Element cannot be blank
7804	3	Hospital Discharge Time is earlier than EMS Dispatch Time
7805	3	Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time
7806	3	Hospital Discharge Time is earlier than EMS Unit Scene Departure Time
7807	2	Hospital Discharge Time is earlier than ED/Hospital Arrival Time
7808	2	Hospital Discharge Time is earlier than ED Discharge Time
7809	2	Element must be "Not Applicable" when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
7840	1	Single Entry Max exceeded

Commented [FT3]: Change title to Hospital Discharge Order Time

Commented [M4R3]: Same as above. But I believe the definition is pretty clear re: Order vs physically leave the building which is captured in the prior elements.

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Initial Discharge Information

Discharge Status

Discharge Condition

Patient Directive Applied

Discharge/Death [?] @ : Discharge Order [?] @ :

Total Days: ICU Ventilator Hospital

Discharging Physician

Discharged To

Specify

Discharge to Alternate Caregiver

If Transferred, Facility

If Other

Alt. Discharge Facility

Impediments to Discharge

Trauma Sign Off [?]

Delay Days

Transfer Rationale

Transfer Rationale By

Buttons: Burn Custom

Checkmarks: ICDX Save Save and Exit Print Close Prev Next

Arrive: 1/6/2020 Trauma Number: 20154015 MRN: A

NOTE: Total Days: ICU, Ventilator and Hospital will auto-populate from the Patient Tracking tab entries.

If you feel they are inaccurate, you need to return to that tab / screen to edit.

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge Information' section is expanded, and an orange arrow points to the 'Discharging Physician' dropdown menu. The interface includes various input fields for discharge status, condition, and dates, as well as checkboxes for 'Impediments to Discharge' and 'Discharge to Alternate Caregiver'. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Discharging Physician

Definition

The provider that is discharging the patient from your facility.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Discharge Summary
2. Discharge Order
3. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge Information' section is expanded, and an orange arrow points to the 'Discharging Physician' dropdown menu. Other visible fields include 'Discharge Status', 'Discharge Condition', 'Patient Directive Applied', 'Discharge/Death' (with date and time pickers), 'Discharge Order' (with date and time pickers), 'Total Days: ICU', 'Ventilator', 'Hospital', 'Impediments to Discharge', 'Trauma Sign Off', 'Delay Days', and 'Transfer Rationale'.

HOSPITAL DISCHARGE DISPOSITION

Definition

The disposition of the patient when discharged from the hospital.

Element Values

- | | |
|---|--|
| 1. Discharged/Transferred to a short-term general hospital for inpatient care | 8. Discharged/Transferred to hospice care |
| 2. Discharged/Transferred to an Intermediate Care Facility (ICF) | 10. Discharged/Transferred to court/law enforcement. |
| 3. Discharged/Transferred to home under care of organized home health service | 11. Discharged/Transferred to inpatient rehab or designated unit |
| 4. Left against medical advice or discontinued care | 12. Discharged/Transferred to Long Term Care Hospital (LTCH) |
| 5. Deceased/Expired | 13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital |
| 6. Discharged to home or self-care (routine discharge) | 14. Discharged/Transferred to another type of institution not defined elsewhere |
| 7. Discharged/Transferred to Skilled Nursing Facility (SNF) | |

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 reported as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

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

DI Data Element Numbers / Choices

40. Home or Self-Care (Routine Discharge)	72. Skilled Nursing Facility
41. Home with Services (Home Health Care)	73. Rehab (Inpatient)
42. Left AMA	74. Long-Term Care (LTAC Facility/Vent)
43. Correctional Facility/Court/Law Enforcement	75. Hospice
44. Morgue	76. Mental Health/Psychiatric Hospital (Inpatient)
45. Child Protective Agency	77. Nursing Home
70. Acute Care Facility (Hospital for Inpatient Care)	79. Another Type of Inpatient Facility Not Defined Elsewhere
71. Intermediate Care Facility (Step Down Hospital)	80. Burn Center
	? . Unknown

NOTES:

- If the patient returns to the environment from which they came, that disposition is entered as #40 (home).
 - Example: Patient admitted from Skilled Nursing Facility (SNF, ECF) following fall and returns back to the SNF / ECF care setting, NTDS considers this a return HOME. If the patient came from Assisted Living (ALF) and is discharged to Skilled Nursing (SNF, ECF), that would be entered as 72 (Skilled Nursing Facility) since the level of care changed.
- Rehab (#73) references Inpatient, CARF-certified multidisciplinary Rehab Programs. Therapy programs at skilled care facilities do not meet this definition, regardless of facility name.

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge Information' section contains several fields: 'Discharge Status', 'Discharge Condition', 'Patient Directive Applied', 'Discharge/Death' (with a date field), 'Total Days: ICU', 'Ventilator', 'Hospital', 'Discharging Physician', 'Discharged To', 'Specify', 'Discharge to Alternate Caregiver' (highlighted by an orange arrow), 'If Transferred, Facility', 'If Other', 'Alt. Discharge Facility', 'Impediments to Discharge', 'Trauma Sign Off', 'Delay Days', 'Transfer Rationale', and 'Transfer Rationale By'. The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MFRN:'. Navigation buttons like 'Check', 'Save', 'Print', 'Close', 'Prev', and 'Next' are visible at the bottom.

Discharge to Alternate Caregiver

Definition

Was the patient discharged with a different person than the person that primarily cares for them or lives with them?

NOTE: Will only populate if there is a Y (yes) in the report of physical abuse in the Injury Section

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Child Abuse Physician Notes
3. Case Management Notes
4. Child Protective Service Notes
5. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge Information' section is highlighted with an orange arrow. The form includes fields for Discharge Status, Discharge Condition, Patient Directive Applied, Discharge/Death (with checkboxes for ICU, Ventilator, Hospital), Discharging Physician, Discharged To (Acute Care Facility), Discharge to Alternate Caregiver (with checkboxes for If Transferred, Facility, If Other), and Alt. Discharge Facility. There are also sections for Impediments to Discharge, Trauma Sign Off (with Delay Days), Transfer Rationale, and Transfer Rationale By. The bottom of the window shows a toolbar with Check, Save, Save and Exit, Print, Close, Prev, and Next buttons, along with a status bar displaying 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

If Transferred, Facility

Definition

The facility that the patient was transferred to, if the patient was transferred out of your hospital.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge Information' section is expanded, showing fields for Discharge Status, Discharge Condition, Patient Directive Applied, Discharge/Death (with checkboxes for ICU, Ventilator, Hospital), Discharging Physician, Discharged To (Acute Care Facility), Discharge to Alternate Caregiver, If Transferred (Facility, If Other), and Alt. Discharge Facility. An orange arrow points from the 'Alt. Discharge Facility' field to the 'Transfer Rationale' field. Other fields include Impediments to Discharge, Trauma Sign Off, and Delay Days.

Transfer Rationale

Definition

The reason why the patient was transferred out of your facility

Element Values

- | | | |
|--------------------|-------------------------------|------------------------|
| 1. Economic | 9. Cardiothoracic Care | 16. Burn Unit |
| 2. Level of Care | 10. Orthopedic Care | 17. Replantation |
| 3. Personal | 11. Urology | 18. Spinal Cord Injury |
| 4. System Protocol | 12. Ophthalmology | Management |
| 5. Other | 13. Oral/dental care services | 19. Other Specialty |
| 6. Pediatrics/PICU | 14. ENT | / . Not Applicable |
| 7. Neurosurgery | 15. Plastics/maxillofacial | ? . Unknown |
| 8. OB Care | services | |

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Initial Discharge Information' section includes fields for Discharge Status, Discharge Condition, Patient Directive Applied, Discharge/Death (with a date field), Discharge Order (with a date field), Total Days: ICU, Ventilator, Hospital, Discharging Physician, Discharged To (70 Acute Care Facility), Discharge to Alternate Caregiver, If Transferred: Facility, If Other, Alt. Discharge Facility, Impediments to Discharge, Trauma Sign Off, Delay Days, Transfer Rationale, and Transfer Rationale By. An orange arrow points to the 'Transfer Rationale By' field.

Transfer Rationale By

Definition

The person that made the decision to transfer the patient out of the facility.

Element Values

- | | | |
|--------------|----|----------------|
| 1. Physician | /. | Not Applicable |
| 2. Patient | ? | Unknown |
| 3. Payor | | |

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Initial Discharge Information' section contains several fields: 'Discharge Status', 'Discharge Condition', 'Patient Directive Applied', 'Discharge/Death' (with a date field), 'Discharge Order' (with a date field), 'Total Days: ICU', 'Ventilator', and 'Hospital'. Below these are fields for 'Discharging Physician', 'Discharged To' (with a dropdown menu showing '70 Acute Care Facility'), 'Specify', 'Discharge to Alternate Caregiver' (with a checked checkbox), 'If Transferred, Facility', 'If Other', and 'Alt. Discharge Facility'. To the right, there is a section for 'Impediments to Discharge' with a grid of checkboxes. Below that are 'Trauma Sign Off' and 'Delay Days' fields. At the bottom, there are 'Transfer Rationale' and 'Transfer Rationale By' fields. The interface also includes a toolbar with 'Check', 'Save', 'Save and Exit', 'Print', and 'Close' buttons, and a status bar at the very bottom showing 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Impediments to Discharge

Definition

Any issues or contributing factors to the patient's *discharge being delayed*.

Element Values

- | | |
|----------------------------|--|
| 0. None | 5. Non-availability of Transfer Facility |
| 1. Delay in Discharge Plan | 6. Psychiatric |
| 2. Financial | 7. Social |
| 3. Homeless | 8. Other |
| 4. Legal | ? . Unknown |

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Initial Discharge Information' section is populated with data. An orange arrow highlights the 'Trauma Sign Off' field, which is currently empty. The 'Delay Days' field is set to 0. The status bar at the bottom indicates the patient arrived on 1/6/2020, with Trauma Number 20154015 and MRN.

Trauma Sign Off

Definition

The date that trauma services handed over primary care to another service.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Progress Notes
2. Consult Notes

The screenshot shows the 'Trauma Data Editor' application. The 'Disabilities' checkbox is highlighted with an orange arrow. A 'Disabilities' dialog box is open, showing 'Pre-Existing' and 'Discharge' sections with checkboxes for Feeding, Locomotion, Expression, and Total. Another orange arrow points to the 'Pre-Existing' section. The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Disabilities: Pre-Existing Feeding

Definition

Feeding disabilities that are either temporary or permanent that the patient had prior to their injury admission.

Element Values

Box 1

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
- / . Not Applicable
- ? . Unknown

Box 2

1. Permanent
2. Temporary
- / . Not Applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

The screenshot shows the 'Trauma Data Editor' application. The 'Disabilities' checkbox is highlighted with an orange arrow. A 'Disabilities' dialog box is open, showing 'Pre-Existing' and 'Discharge' sections with checkboxes for Feeding, Locomotion, Expression, and Total. Another orange arrow points to the 'Disabilities' dialog box. The bottom status bar shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Disabilities: Pre-Existing Locomotion

Definition

Locomotion disabilities that are either temporary or permanent that the patient had prior to their injury admission

Element Values

Box 1

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
- / . Not Applicable
- ? . Unknown

Box 2

1. Permanent
2. Temporary
- / . Not Applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

Disabilities: Pre-Existing Expression

Definition

Expression disabilities that are either temporary or permanent that the patient had prior to their injury admission

Element Values

Box 1

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
- /. Not Applicable
- ? Unknown

Box 2

1. Permanent
2. Temporary
- /. Not Applicable
- ? Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

The screenshot shows the 'Trauma Data Editor' application. The 'Disabilities' section is highlighted with an orange arrow. Below it, a 'Disabilities' dialog box is open, showing 'Pre-Existing' and 'Discharge' columns for Feeding, Locomotion, Expression, and Total. An orange arrow points from the 'Pre-Existing' column to the 'Discharge' column.

Disabilities: Discharge Feeding

Definition

Feeding disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
- / . Not Applicable
- ? . Unknown

Box 2

1. Permanent
2. Temporary
- / . Not Applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

Disabilities: Discharge Locomotion

Definition

Locomotion disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
- / . Not Applicable
- ? . Unknown

Box 2

1. Permanent
2. Temporary
- / . Not Applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

Disabilities: Discharge Expression

Definition

Expression disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
- / . Not Applicable
- ? . Unknown

Box 2

1. Permanent
2. Temporary
- / . Not Applicable
- ? . Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

Rehabilitation Potential

Definition

The likelihood that with rehabilitation, the patient will be independent with cares or return to their previous level of function.

Element Values

- | | |
|---|---------------------------|
| 1. Discharged with Previous Level of Function | 4. Improbable Improvement |
| 2. Probable Improvement | /. Not Applicable |
| 3. Possible Improvement | ? Unknown |

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

Location

Definition

The place where the patient expired while in the hospital.

Element Values

- | | |
|--------------------------|----------------------------------|
| 1. Resuscitation Room | 9. Burn Unit |
| 2. Emergency Departments | 10. Radiology |
| 3. Operating Room | 11. Post Anesthesia Care Unit |
| 4. Intensive Care Unit | 12. Special Procedure Unit |
| 5. Step-Down Unit | 13. Labor and Delivery |
| 6. Floor | 14. Neonatal/Pediatric Care Unit |
| 7. Telemetry Unit | ?. Unknown |
| 8. Observation Unit | |

Data Source Hierarchy Guide

1. Discharge Summary
2. Post-Mortem Flowsheet
3. Progress Notes
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Manner (Suspected)' field in the 'Death Information' section is highlighted with an orange arrow. The 'Organ Procurement' section contains a table for 'Organs Procured' and several checkboxes for donation requests. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Manner (Suspected)

Definition

The suspected reason behind the patient's death.

Element Values

- | | |
|-------------------|-------------------|
| 1. Accidental | 5. Undetermined |
| 2. Homicide | /. Not Applicable |
| 3. Natural Causes | ? Unknown |
| 4. Suicide | |

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Reports
2. Discharge Summary
3. Progress / Consult Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Death Information' section is highlighted with an orange arrow. It includes fields for 'Location', 'Manner (Suspected)', 'Cause', 'Withdrawal of Care', 'Was autopsy performed?', 'Medical Examiner #', and 'Autopsy #'. The 'Organ Procurement' section includes 'Was organ donation requested?', 'Was request granted?', a table for 'Organs Procured', 'If Other, Specify', 'If None, Reason', 'Donor Status', and 'Date/Time Organs Procured'. The status bar at the bottom indicates 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Manner (Cause)

Definition

The suspected cause of the patient's death.

Element Values

- | | |
|-------------------|-------------------|
| 1. Accidental | 5. Undetermined |
| 2. Homicide | /. Not Applicable |
| 3. Natural Causes | ? Unknown |
| 4. Suicide | |

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Reports
2. Discharge Summary

Withdrawal of Care

Definition

Treatment was withdrawn based on a decision to either remove or withhold further life supporting interventions.

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Progress Notes
3. Palliative Care Notes
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'If Death' sub-tab is active, displaying the 'Death Information' section. An orange arrow points to the 'Was autopsy performed?' checkbox. The 'Organ Procurement' section is also visible, including fields for 'Was organ donation requested?', 'Was request granted?', and a table for 'Organs Procured'.

Was Autopsy Performed?

Definition

Was an autopsy performed after the patient's death?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Death Information' section includes fields for Location, Manner (Suspected), Cause, Withdrawal of Care, Was autopsy performed?, Medical Examiner #, and Autopsy #. An orange arrow points to the 'Autopsy #' field. The 'Organ Procurement' section includes checkboxes for 'Was organ donation requested?' and 'Was request granted?', a table for 'Organs Procured', and fields for 'If Other, Specify', 'If None, Reason', 'Donor Status', and 'Date/Time Organs Procured'. The status bar at the bottom shows 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Autopsy Number

Definition

The autopsy number given to the patient from the medical examiner.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report

The screenshot shows the 'Trauma Data Editor' application window. The 'Outcome' tab is selected. The 'Organ Procurement' section is highlighted with an orange arrow. The 'Organ Procurement' section includes the following fields:

- Was organ donation requested? Y
- Was request granted? Y
- Organs Procured: A table with 10 rows and 2 columns.
- If Other, Specify:
- If None, Reason:
- Donor Status:
- Date/Time Organs Procured:

Was Organ Donation Requested?

Definition

Was the possibility of organ donation requested of the patient's healthcare power of attorney?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Organ Procurement Coordinator Notes
2. Discharge Summary
3. Palliative Care Note
4. Progress Note
5. Nursing Note

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Organ Procurement' section is highlighted with an orange arrow. It contains two dropdown menus: 'Was organ donation requested?' and 'Was request granted?', both with 'Y' selected. Below these are two columns of checkboxes for 'Organs Procured'. Other fields include 'Medical Examiner #', 'Autopsy #', 'Autopsy Memo', 'If Other, Specify', 'If None, Reason', 'Donor Status', and 'Date/Time Organs Procured'.

Was Request Granted?

Definition

Was the request for organ donation granted by the patient's healthcare power of attorney?

Element Values

Y. Yes
N. No

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Organ Procurement Coordinator Notes
2. Discharge Summary
3. Palliative Care Note
4. Progress Note
5. Nursing Note

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab active. The 'Organ Procurement' section is highlighted with an orange arrow. The 'Organs Procured' table is empty. The 'Death Information' section contains several input fields and checkboxes. The 'Organ Procurement' section includes checkboxes for 'Was organ donation requested?' and 'Was request granted?', both of which are checked. Below these are fields for 'If Other, Specify', 'If None, Reason', 'Donor Status', and 'Date/Time Organs Procured'.

Organs Procured

Definition

The organs that were able to be procured for donation.

Element Values

- | | | |
|-------------------|-----------------|----------------|
| 0. None | 8. Heart | 16. Skin |
| 1. Adrenal Glands | 9. Heart Valves | 17. Stomach |
| 2. Bone | 10. Intestine | 18. Tendons |
| 3. Bone Marrow | 11. Kidney | 19. Whole Eyes |
| 4. Cartilage | 12. Liver | 20. Other |
| 5. Corneas | 13. Lungs | ? Unknown |
| 6. Dura Mater | 14. Nerves | |
| 7. Fascialata | 15. Pancreas | |

Data Source Hierarchy Guide

1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data
3. Autopsy/Medical Examiners Report

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Death Information' section contains fields for Location, Manner (Suspected), Cause, Withdrawal of Care (checked), Was autopsy performed? (checked), Medical Examiner #, and Autopsy #. Below this is an 'Autopsy Memo' text area. An orange arrow points from the 'Autopsy Memo' area to the 'Organ Procurement' section. The 'Organ Procurement' section includes checkboxes for 'Was organ donation requested?' (checked) and 'Was request granted?' (checked). It features a table titled 'Organs Procured' with one row containing '11' and 'Kidney'. Below the table are fields for 'If Other, Specify', 'If None, Reason', 'Donor Status', and 'Date/Time Organs Procured'. The bottom of the window shows a toolbar with 'Check', 'Save', 'Save and Exit', 'Print', and 'Close' buttons, and a status bar with 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Donor Status

Definition

The type of organ donor the patient was classified.

Element Values

- | | |
|----------------------|------------|
| 1. Brain Death | ?. Unknown |
| 2. Non-Beating Heart | |

Data Source Hierarchy Guide

1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data
3. Discharge Summary

The screenshot shows the 'Trauma Data Editor' window with the 'Outcome' tab selected. The 'Organ Procurement' section contains the following fields:

- Was organ donation requested?
- Was request granted?
- Organs Procured table:

Quantity	Organ	Procured
11	Kidney	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- If Other, Specify:
- If None, Reason:
- Donor Status:
- Date/Time Organs Procured: @

An orange arrow points to the 'Date/Time Organs Procured' field.

Date and Time Organs were Procured

Definition

The date and time that the organ procurement surgeon began the operative procedure.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Account #

Charges Billed \$

DRG

MS-DRG

ICD-10 DRG

Payor Information

Primary Payor \$

Additional Payors \$

\$

Specify

Total Charges Collected \$

Last Date Collected

Print

Check ITX Save Save and Exit Print Close Prev Next

Arrive: 1/6/2020 Trauma Number: 20154015 MRN:

Charges Billed \$

Definition

The total charges billed to the patient for their hospital stay.

Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Account #

Charges Billed \$

DRG

MS-DRG

ICD-10 DRG

Payor Information

Primary Payor \$

Additional Payors \$

\$

Specify

Total Charges Collected \$

Last Date Collected

Print

Check ITX Save Save and Exit Print Close Prev Next

Arrive: 1/6/2020 Trauma Number: 20154015 MRN:

ICD-10 DRG

Definition

The diagnosis related group which is how hospitalization costs are calculated through Medicare.

Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

Primary Pavor: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Primary Pavor

Definition

The primary payor responsible for paying for the hospitalization costs.

Note: Organ Donor Payor: Per NDTs, Primary Payor = payor source at admission; NOT the organ procurement agency.

Element Value

- | | | |
|---|----------------------------------|---------------------------|
| 1. Self-Pay | 8. Medicare | 15. Other (Violence fund) |
| 2. HMO | 9. Medicaid | 16. Charity Pending |
| 3. PPO | 10. Military (Tricare) | 17. Liability |
| 5. Blue Cross Blue Shield
(including PPO and HMO,
etc.) | 11. Other Commercial | /. Not Applicable |
| 6. Automobile | 12. Other Government | ? Unknown |
| 7. Worker's Compensation | 13. Not Billed for Any
Reason | |
| | 14. Charity | |

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Account #

Charges Billed \$

DRG

MS-DRG

ICD-10 DRG

Payor Information

Primary Payor \$

Additional Payors \$

\$

Specify

Total Charges Collected \$

Last Date Collected

Custom

Check | | Save | Save and Exit | Print | Close | Prev | Next

Arrive: 1/6/2020 | Trauma Number: 20154015 | MRN: | A

Primary Payor Amount \$

Definition

The total amount of payment collected from the Primary Payor.

Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Account #


Charges Billed \$

DRG

MS-DRG

ICD-10 DRG

Payor Information

Primary Payor 

Additional Payors

\$

\$

\$

Specify

Total Charges Collected \$

Last Date Collected

Print

Check Save Save and Exit Print Close Prev Next

Arrive: 1/6/2020 Trauma Number: 20154015 MRN:

Primary Payor Date

Definition

The last date the primary payor made payments for the hospitalization.

Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Account #

Charges Billed \$

DRG

MS-DRG

ICD-10 DRG

Payor Information

Primary Payor \$

Additional Payors

\$

\$

Specify

Total Charges Collected \$

Last Date Collected

Print

Check Save Save and Exit Print Close Prev Next

Arrive: 1/6/2020 Trauma Number: 20154015 MRN:

Additional Payors

Definition

Secondary payors responsible for paying some of the hospital costs after the primary payor.

Element Value

- | | | |
|---------------------------|-------------------------------|---------------------|
| 1. Self-Pay | 9. Medicaid | 15. Other |
| 2. HMO | 10. Military (Tricare) | 16. Charity Pending |
| 3. PPO | 11. Other Commercial | 17. Liability |
| 5. Blue Cross Blue Shield | 12. Other Government | /. Not Applicable |
| 6. Automobile | 13. Not Billed for Any Reason | ? Unknown |
| 7. Worker's Compensation | 14. Charity | |
| 8. Medicare | | |

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

Trauma Data Editor

Demographic | Injury | Prehospital | Referring Facility | ED/Resus | Patient Tracking | Providers | Procedures | Diagnoses | Outcome | QA Tracking | Memo | Custom

Initial Discharge | Initial Discharge 2 | If Death | Billing | Related Admissions | Notes

Section Complete

Account #

Charges Billed \$

DRG

MS-DRG

ICD-10 DRG

Payor Information

Primary Payor \$

Additional Payors \$

\$

\$

Specify

Total Charges Collected \$

Last Date Collected

Print

Check Save Save and Exit Print Close Prev Next

Arrive: 1/6/2020 Trauma Number: 20154015 MRN:

Additional Payor Amount \$

Definition

The total amount of payment collected from the additional payor.

Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

The screenshot displays the 'Trauma Data Editor' interface. The 'Related Admission' tab is active, showing a form with the following fields: Admission Date (with a calendar icon), Admitting Service, Type of Admission, If Unplanned, Reason, Account #, Total Charges, Discharge Date (with a calendar icon), and Discharged To. A large empty text area labeled 'Memo' is located below these fields. At the bottom of the window, a status bar indicates 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'. An orange arrow points to the 'Admission Date' field.

Related Admission: Admission

Definition

The date that the patient was readmitted to the hospital

NOTE: Only collect on admissions within 30 days of original discharge. Only include admissions for an issue related to the original trauma admission. Admissions related to an alternate cause may be tracked here for PI purposes.

Element Values

1. Relevant Value for Data Element

Data Source Hierarchy Guide

1. Patient Encounter Events
2. ADT Events
3. History and Physical
4. Nursing Notes

The screenshot shows the 'Trauma Data Editor' application window. The 'Related Admissions' tab is selected, and the 'Admission Date' field is highlighted with an orange arrow. The form contains the following fields:

- Admission Date (with a calendar icon)
- Admitting Service (dropdown menu)
- Type of Admission (dropdown menu)
- If Unplanned, Reason (dropdown menu)
- Account # (text field)
- Total Charges (text field)
- Discharge Date (with a calendar icon)
- Discharged To (dropdown menu)
- Memo (text area)

At the bottom of the window, there is a status bar with the following information: Arrive: 1/6/2020, Trauma Number: 20154015, MRN: [blank].

Related Admission: Admitting Service

Definition

The service that readmitted the patient to the hospital

NOTE: Only collect on admissions within 30 days of original discharge

Element Values

- | | | |
|----------------------|---------------------------|------------------------|
| 1. Trauma | 6. Cardiothoracic Surgery | 65. Intensivist |
| 2. Neurosurgery | 7. Burn Services | 98. Other Surgical |
| 3. Orthopedics | 8. Emergency Medicine | 99. Other Non-Surgical |
| 4. General Surgery | 9. Pediatrics | |
| 5. Pediatric Surgery | 23. Hospitalist | |

Data Source Hierarchy Guide

1. Physician Order
2. History and Physical
3. Consult Note

The screenshot shows the 'Trauma Data Editor' application window. The 'Related Admissions' tab is selected, and the 'Type of Admission' dropdown menu is highlighted with an orange arrow. The form contains the following fields:

- Admission Date
- Admitting Service
- Type of Admission
- If Unplanned, Reason
- Account #
- Total Charges
- Discharge Date
- Discharged To
- Memo

At the bottom of the window, the status bar displays: Arrive: 1/6/2020 | Trauma Number: 20154015 | MRN: | A

Related Admission: Type of Admission

Definition

Was the admission planned or unplanned

NOTE: Only collect on admissions within 30 days of original discharge

Element Values

- | | | |
|--------------|----|----------------|
| 1. Planned | /. | Not Applicable |
| 2. Unplanned | ? | Unknown |

Data Source Hierarchy Guide

1. History and Physical
2. Consult Note
3. Nursing Note

The screenshot shows the 'Trauma Data Editor' window with the 'Related Admission' form open. The form includes fields for Admission Date, Admitting Service, Type of Admission (set to 2), If Unplanned, Reason (set to Unplanned), Account #, Total Charges, Discharge Date, and Discharged To. A memo field is also present. The bottom of the window shows a status bar with 'Trauma Number: 20154015' and 'MRN:'.

Related Admission: If Unplanned, Reason

Definition

What was the reason the patient was readmitted.

NOTE: Only collect on admissions within 30 days of original discharge

Element Values

1. Infection
2. Missed Diagnosis
3. Pain
4. Progression of Disease
5. Other
- /. Not Applicable
- ? Unknown

Data Source Hierarchy Guide

1. History and Physical
2. Consult Note
3. Nursing Note

The screenshot shows the 'Trauma Data Editor' application window. The 'Related Admission' form is active, displaying various data entry fields. An orange arrow points to the 'Account #' field, which is currently empty. Other fields include 'Admission Date', 'Admitting Service', 'Type of Admission' (set to '2 | Unplanned'), 'If Unplanned, Reason' (set to '1'), 'Total Charges', 'Discharge Date', and 'Discharged To'. A 'Memo' field is also present. The bottom of the window shows a status bar with 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'. Navigation buttons like 'Check', 'OK', 'Cancel', 'Print', and 'Close' are visible at the bottom.

Related Admission: Account Number**Definition**

Patient number assigned for that specific encounter (HAR); primarily used for billing and coding

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide:

1. Face Sheet

The screenshot shows the 'Trauma Data Editor' window with the 'Related Admission' tab selected. The 'Total Charges' field is highlighted by an orange arrow. The interface includes a menu bar with options like 'Demographic', 'Injury', 'Prehospital', etc., and a toolbar with buttons for 'Check', 'OK', 'Cancel', and navigation. The status bar at the bottom displays 'Arrive: 1/6/2020', 'Trauma Number: 20154015', and 'MRN:'.

Related Admission: Total Charges

Definition

The total charges billed for the hospital encounter

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide:

1. Billing/Coding
2. Medical Records

The screenshot shows the 'Trauma Data Editor' application window. The 'Related Admissions' tab is selected, displaying a form with the following fields:

- Admission Date: [Date field]
- Admitting Service: [Text field]
- Type of Admission: [Text field]
- If Unplanned, Reason: [Text field]
- Account #: [Text field]
- Total Charges: [Text field]
- Discharge Date: [Date field] (highlighted by an orange arrow)
- Discharged To: [Text field]

Below the form is a 'Memo' text area. At the bottom of the window, there is a status bar with the text: 'Arrive: 1/6/2020 Trauma Number: 20154015 MRN:'. The interface also includes a menu bar with options like 'Demographic', 'Injury', 'Prehospital', etc., and a toolbar with buttons for 'Check', 'OK', 'Cancel', 'Save', etc.

Related Admission: Discharge Date

Definition

The date that the patient was discharged from their readmission stay.

NOTE: Only collect on admissions within 30 days of original discharge

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Discharge Summary
3. Nursing Notes

Related Admission: Discharged To**Definition**

Where the patient was discharged to after their hospital stay was complete.

NOTE: Only collect on admissions within 30 days of original discharge. If the patient dies during the readmission, place the details on the “If Death” tab.

Element Values / Choices in DI

- 40. Home or Self-Care (Routine Discharge)
- 41. Home with Services
- 42. Left AMA
- 43. Correctional Facility/Court/Law Enforcement
- 44. Morgue
- 45. Child Protective Agency
- 70. Acute Care Facility
- 71. Intermediate Care Facility
- 72. Skilled Nursing Facility
- 73. Rehab (Inpatient)
- 74. Long-Term Care
- 75. Hospice
- 76. Mental Health/Psychiatric Hospital (Inpatient)
- 77. Nursing Home
- 79. Another Type of Inpatient Facility Not Defined Elsewhere
- 80. Burn Center
- ? Unknown

The screenshot shows a software window titled 'Related Admission' with a menu bar containing 'Record', 'Edit', and 'Browse'. The window contains several data entry fields: 'Admission Date', 'Admitting Service', 'Type of Admission', 'If Unplanned, Reason', 'Account #', 'Total Charges', 'Discharge Date', and 'Discharged To'. An orange arrow points to the 'Discharged To' field. The window also has a 'Memo' field at the bottom.

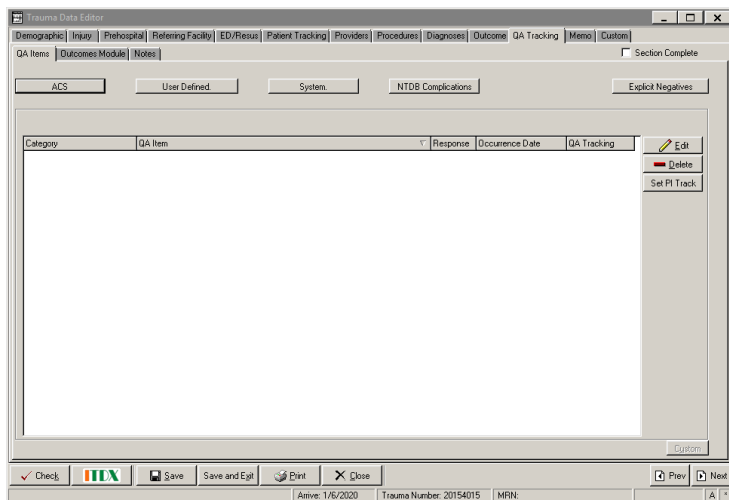
Data Source Hierarchy Guide

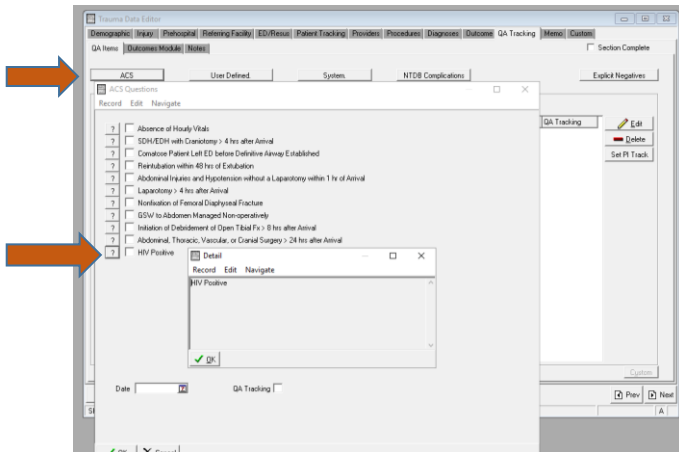
1. ADT Events
2. Discharge Summary
3. Case Management Note
4. Nursing Notes

QA Tracking

QA Items

1. There are multiple different QA items that you can enter into the registry.
2. Much of this work is often done in collaboration with the Trauma Program Manager / Coordinator, Trauma PI Nurse and Registrar(s). Each facility will determine the workflow appropriate for their facility.
3. Detailed definitions for the Mandatory NTDB hospital event (Events and Complications) can be found in your NTDS Data Dictionary. (Note that some NTDS definitions for complications differ from the CDC or other national definitions being used by your facility ID / HIM coders.)
4. The ACS hospital events have question marks that will display the definitions when you click on them.
5. The System QA has several items to choose from and generally look at hospital events from a system breakdown perspective.
6. The IL Trauma Registry has the additional DI Driller capability which is accessible to all IL Trauma Centers and provides both statistical data and graph capability for a variety of data points.





ACS List

Definition

American College of Surgeons’ recommended QI variances.

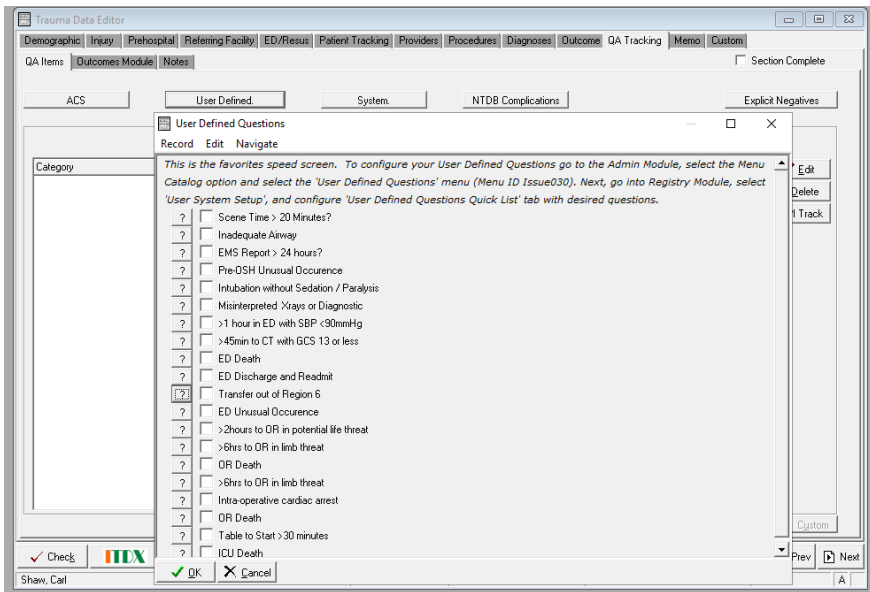
NOTE: The ACS hospital events have question marks that will display the definition of that variable when you click on them.

Element Values:

- 1. Yes
- 2. No
- 3. ? Unknown
- 4. / Non-applicable

Data Source Hierarchy:

- 1. Variable sources based on element being reviewed.



User Defined List

Definition

Institution – defined QI variances being monitored.

(Editor Note: Unsure re: this functionality in the State system, but allows for specific variable monitoring in your system).

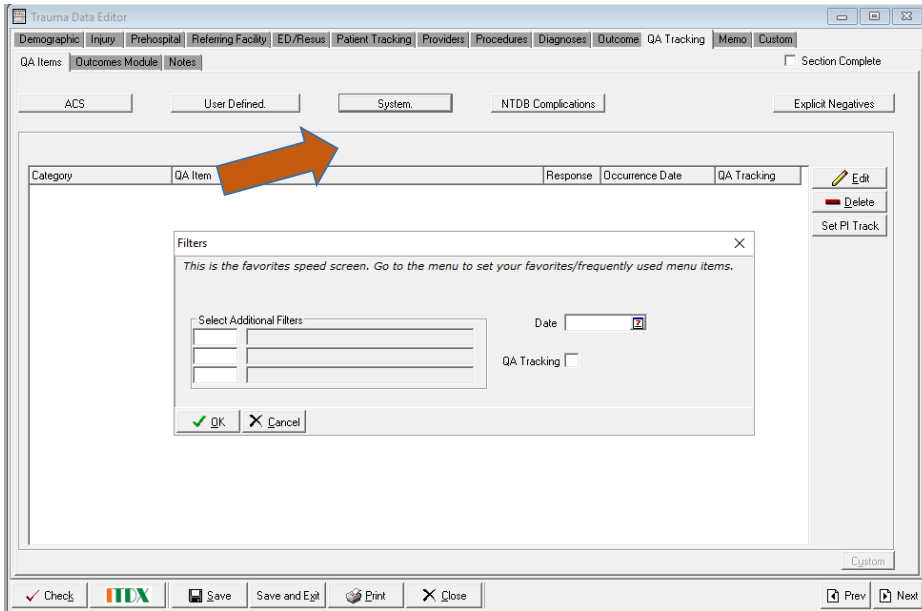
NOTE: The User-defined events also have question marks that will display the definition of that variable when you click on them.

Element Values:

- | | |
|--------|---------------------|
| 1. Yes | 3. ? Unknown |
| 2. No | 4. / Non-applicable |

Data Source Hierarchy:

- Variable sources based on element being reviewed.

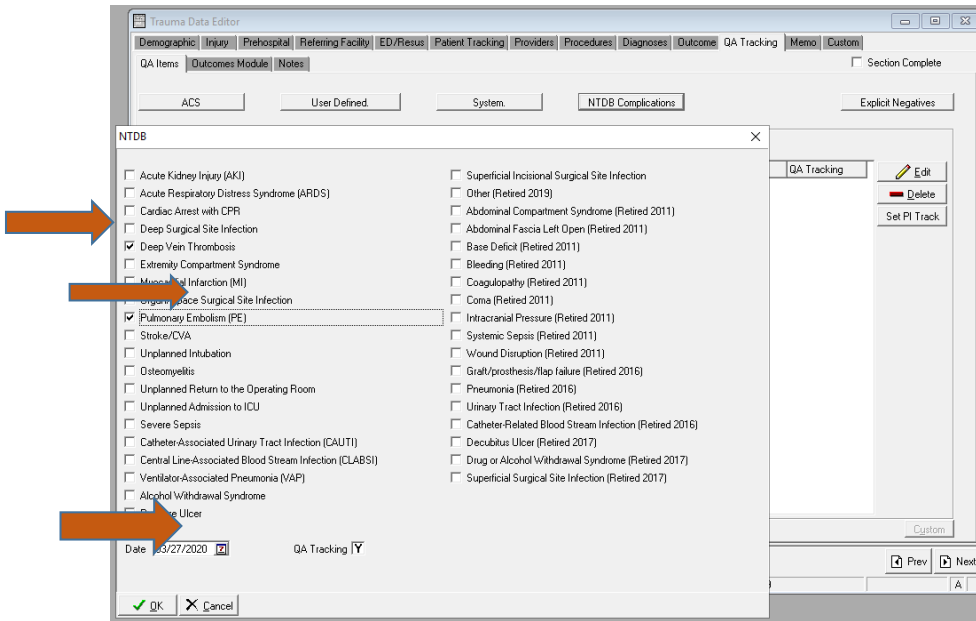


System List

Definition:

Speed access option to address defined system or Facility recommended QI variances.

Editor Note: Don't see this option on the Web-based State version. Server-based facilities already familiar with use).



NTDB Complications and Hospital Events: MANDATORY BLUE FIELD; NTDS Definition rules.

Definition:

NTDB – defined complications. (See Hospital Events Section of the NTDS Data Dictionary for the detailed definitions being used for this item). It is >20 pages long, so not incorporated into our IL Dictionary.)

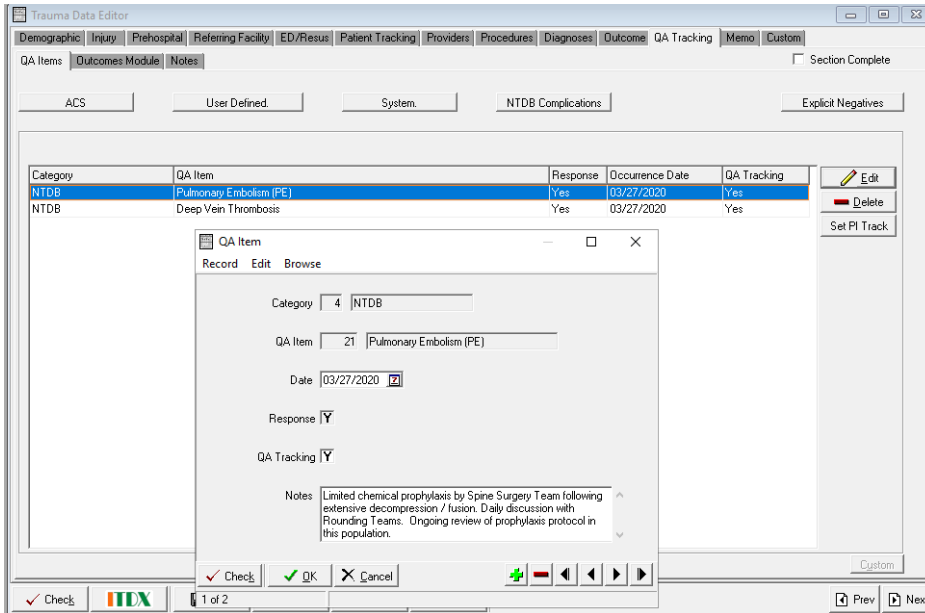
NOTE: Each Complication / Hospital Event is further designated with the date it was identified / diagnosed. This list is multi-select for complications identified / diagnosed on the same date.

Element Values:

- 1. Yes
- 2. No
- 3. ? Unknown
- 4. / Non-applicable

Data Source Hierarchy:

- 1. Variable sources based on element being reviewed.



NTDS Complication Details:

Definition:

Detailed of the occurrence and/or PI actions related to each NTDB – defined complication.

NOTE: The Registry will populate a row for each Complication entered. Selecting that row will allow you to edit / add details of the review and/or actions associated with each complication.

Element Values:

- 1. Yes
- 2. No
- 3. ? Unknown
- 4. / Non-applicable

Data Source Hierarchy:

- 1. Variable sources based on element being reviewed and your Trauma Center PI Plan.

The screenshot shows the 'Trauma Data Editor' application with the 'Explicit Negatives' dialog box open. The dialog box has a title bar 'Explicit Negatives' and buttons for 'Record', 'Edit', and 'Navigate'. Below the title bar is a paragraph of text explaining the purpose of the review. At the bottom of the dialog box, there is a grid of checkboxes for various complications. An orange arrow points to the 'Explicit Negatives Reviewed' checkbox at the top left of the grid.

Explicit Negatives Reviewed

Unplanned Return to the Operating Room Not Known Not Applicable

<input type="checkbox"/> Acute Kidney Injury (AKI)	<input type="checkbox"/> Not Known	<input type="checkbox"/> Organ/Space Surgical Site Infection	<input type="checkbox"/> Not Known
<input type="checkbox"/> Acute Respiratory Distress Syndrome (ARDS)	<input type="checkbox"/> Not Known	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Not Known
<input type="checkbox"/> Alcohol Withdrawal Syndrome	<input type="checkbox"/> Not Known	<input type="checkbox"/> Pulmonary Embolism (PE)	<input type="checkbox"/> Not Known
<input type="checkbox"/> Cardiac Arrest with CPR	<input type="checkbox"/> Not Known	<input type="checkbox"/> Pressure Ulcer	<input type="checkbox"/> Not Known
<input type="checkbox"/> Catheter-Associated Urinary Tract Infection (CAUTI)	<input type="checkbox"/> Not Known	<input type="checkbox"/> Severe Sepsis	<input type="checkbox"/> Not Known
<input type="checkbox"/> Central Line-Associated Bloodstream Infection (CLABSI)	<input type="checkbox"/> Not Known	<input type="checkbox"/> Stroke/CVA	<input type="checkbox"/> Not Known
<input type="checkbox"/> Deep Surgical Site Infection	<input type="checkbox"/> Not Known	<input type="checkbox"/> Superficial Incisional Surgical Site Infection	<input type="checkbox"/> Not Known
<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Not Known	<input type="checkbox"/> Unplanned Admission to ICU	<input type="checkbox"/> Not Known
<input type="checkbox"/> Extremity Compartment Syndrome	<input type="checkbox"/> Not Known	<input type="checkbox"/> Unplanned Intubation	<input type="checkbox"/> Not Known
<input type="checkbox"/> Myocardial Infarction (MI)	<input type="checkbox"/> Not Known	<input type="checkbox"/> Ventilator-Associated Pneumonia (VAP)	<input type="checkbox"/> Not Known

Explicit Negatives

Definition

Verification that each NTDB – defined complication has been evaluated for / captured during the chart review process.

NOTE: The description paragraph on this page details the intent and process. NTDS Data Dictionary Hospital Events (Complications) section is the reference for this work. “NOT KNOWN” should be a RARE response given the detailed chart review that has occurred at this point of data entry.

Data Source Hierarchy

1. Variable sources based on element being reviewed.

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