

Indiana Department of Health

# Trauma Data Dictionary

# 2024

Updated  
10/1/2023



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## Indiana Inclusion/Exclusion Criteria

### Description:

To ensure consistent data collection across the State and with the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

The patient must have incurred, **no more than 14 days prior to presentation for initial treatment**, at least one of the following injury diagnostic codes defined as follows:

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

#### A. 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 An ONLY** (burns by specific body parts – initial encounter)

**T30-T32** (burn by TBSA percentages)

**T79.A1-T79.A9 with 7th character modifier of An ONLY** (Traumatic Compartment Syndrome – initial encounter)

#### B. 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.**

**Starting 2022, exclude in-house traumas**

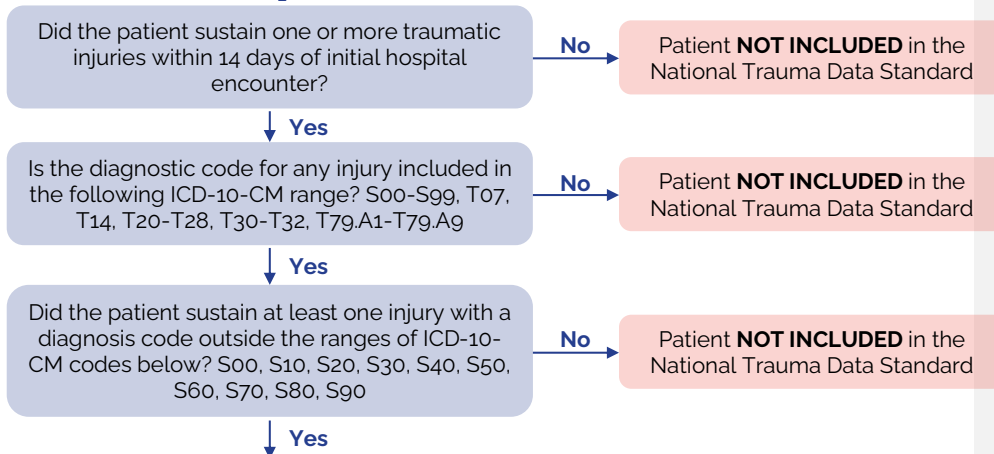
**AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-10- CM S00-S99,**

**T07, T14, and T79.A1-T79.A9):**

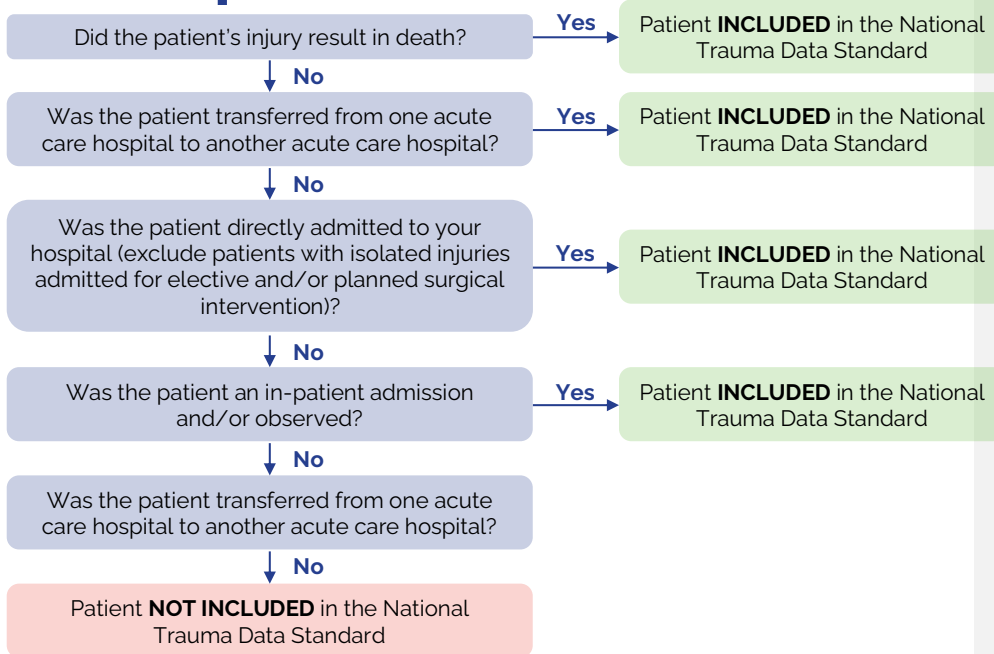
- Death resulting from the traumatic injury (independent of hospital admission or transfer status) **OR:**
- Patient transfer from one acute care\* to another acute care hospital **OR:**
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or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

## Indiana Trauma Registry Inclusion Criteria Map

### Step 1



### Step 2



## COMMON NULL VALUES

---

National & State Element  
**Data Format** [combo] single choice

### Description

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

### Element Values

1. Not Applicable
2. Not Known / Not Recorded

### Additional Information

- For any collection of data to be of value and reliably represents 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 and Indiana 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-transport 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, or health care provider) or no value for the element 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).

## **Demographic Information**

## **MEDICAL RECORD #**

**TR 1.2**

**Data Format** [text]

### **ImageTrend Description**

The hospital's medical record number for the patient.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Auto-generated by the hospital

## **ACCOUNT NUMBER**

---

TR 1.27

**Data Format** [text]

### **ImageTrend Description**

The hospital's encounter number for the patient that is unique to this visit.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Auto-generated by the hospital



## INJURY INCIDENT DATE\*

TR 5.1

National & State Element

**Data Format** [date]

### NTDB/ImageTrend Description

The date the injury occurred.

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>		IncidentDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1,990	<b>Max. Constraint:</b> 2,030	

### Element Values

- Relevant value for data element

### Additional Information

- Reported as MM/DD/YYYY.
- Estimated injury date must be based on patient, witness, family, or healthcare provider report. Other proxy measures (e.g., 911 call times) must not be reported.
- If date of injury is "Not Known/Not Recorded", the null value is unknown.

### Data Source

- EMS Run Report
- Triage Form / Trauma Flow Sheet
- History & Physical
- Face Sheet

### National Element

Page 13 in the 2024 National Trauma Data Standard

## INJURY INCIDENT TIME \*

TR 5.18

National & State Element  
**Data Format** [time]

### NTDB/ImageTrend Description

The time the injury occurred.

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>		IncidentTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59	

### Element Values

- Relevant value for data element

### Additional Information

- Reported as HHMM military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used.
- If time of injury is "Not Known/Not Recorded", the null value is unknown.

### Data Source

- EMS Run Report
- Triage Form / Trauma Flow Sheet
- History & Physical
- Face Sheet

### National Element

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## **PATIENT'S LAST NAME**

---

TR 1.9

**Data Format** [text]

### **ImageTrend Description**

The patient's last name.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

## **PATIENT'S FIRST NAME**

---

**TR 1.8**

**Data Format** [text]

### **ImageTrend Description**

The patient's first name.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

## **PATIENT'S MIDDLE INITIAL**

**TR 1.10**

**Data Format** [text]

### **ImageTrend Description**

The patient's middle initial.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

## **PATIENT'S SOCIAL SECURITY #**

**TR 1.11**

**Data Format** [number]

### **ImageTrend Description**

The patient's social security number.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as ###-##-####

### **Data Source**

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

## DATE OF BIRTH\*

TR 1.7

National & State Element  
Data Format [date]

### NTDB/ImageTrend Description

The patient's date of birth.

XSD Data Type	xs: date	XSD Element / Domain (Complex Type)	DateOfBirth
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes	Min. Constraint: 1,890	Max. Constraint: 2,030

### Element Values

- Relevant value for data element

### Additional Information

- Reported as MM/DD/YYYY.
- If Date of Birth is "Not Known/Not Recorded," report 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

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report

### National Element

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## AGE (at date of incident)\*

TR 1.12

National & State Element

**Data Format** [number]

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	Age
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 120

### Element Values

- Relevant value for data element

### Additional Information

- Auto calculated to patient's age in years when "Date of Birth" is entered.
- Must also report Age Units.
- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed.
- If date of birth is "Not Known/Not Recorded" complete variables: Age and Age Units.
- The null value "Not Applicable" is reported if Date of Birth is reported.

### Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report

### National Element

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## AGE UNITS\*

TR 1.14

National & State Element  
**Data Format** [combo] single-choice

### NTDB Description

The units used to report the patient's age.

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	AgeUnits
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Hours	Years
Days	Minutes
Months	Weeks

### Additional Information

- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed.
- If date of birth is "Not Known/Not Recorded" complete variables: Age and Age Units
- Must also complete variable: Age
- The null value "Not Applicable" is reported if Date of Birth is reported.

### Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form

- Triage Form/Trauma Flow Sheet
- EMS Run Report

**National Element**

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## **OTHER RACE**

---

**TR 1.28**

**Data Format** [text]

### **ImageTrend Description**

The patient's secondary race (if the first race field is insufficient).

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Patient race should be based upon self-report or identified by a family member
- Only completed if Race is "Other Race"

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes

## ETHNICITY\*

TR 1.17

National & State Element  
**Data Format** [combo] single-choice

### ImageTrend Description

The patient's ethnicity.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	Ethnicity
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Hispanic or Latino

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

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- History & Physical
- EMS Run Report

### National Element

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## GENDER\*

TR 1.15

National & State Element  
**Data Format** [combo] single-choice

### NTDB Description

The patient's sex.

### ImageTrend Description

The patient's gender (sex).

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	Sex
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Male

Female

Non-binary (Intersex or Indeterminate)

### Additional Information

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

### Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report
- History & Physical

### National Element

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## HEIGHT\* (in)

TR1.6.1

National & State Element  
**Data Format** [combo] single-choice

### NTDB Description

First recorded height after ED/hospital arrival.

### ImageTrend Description

Indicate the patient's height in centimeters.

<b>XSD Data Type</b>	xs: Decimal	<b>XSD Element / Domain (Complex Type)</b>	Height
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 244 (cm)

### Element Values

- Relevant value for data element

### Additional Information

- Recorded in centimeters.
- May be based on family or self-report.
- Please note that the 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 prior to discharge.

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Pharmacy Record

### National Element

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## **WEIGHT\* (kg)**

**TR1.6.5**

National & State Element  
**Data Format** [combo] single-choice

### **NTDB Description**

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

### **ImageTrend Description**

First recorded, measured, or estimated baseline weight upon ED/hospital arrival.

<b>XSD Data Type</b>	xs: decimal	<b>XSD Element / Domain (Complex Type)</b>	Weight
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 907 (kg)

### **Element Values**

- Relevant value for data element

### **Additional Information**

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

### **Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Pharmacy Record

### **National Element**

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## **PATIENT'S HOME ADDRESS**

---

**TR 1.18**

**Data Format** [text]

### **ImageTrend Description**

The home street address of the patient's primary residence.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes

## ADDRESS LINE 2

TR 1.18.1

**Data Format**[text]

### ImageTrend Description

The continuation of the street address of the patient's primary residence.

### Element Values

- Relevant value for data element

### Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes

## PATIENT'S HOME COUNTRY\*

TR 1.19

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

The country where the patient resides.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HomeCountry
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- When completed with ZIP code, city, county, and state auto-calculate
- Values are two characters FIPS codes representing the country (e.g., US)
- If Patient's Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home State, Patient's Home County and Patient's Home City
- The null value "Not Applicable" is reported for non-US hospitals.

### Data Source

- Face Sheet
- Billing Sheet
- Admission Form

### National Element

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## PATIENT'S HOME ZIP/POSTAL CODE\*

TR 1.20

National & State Element  
**Data Format** [text]

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HomeZip
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- May require adherence to HIPAA regulations.
- 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.
- When completed with Country the city, county, and state auto-calculate
- If ZIP code is "Not Applicable", complete variable: Alternate Home Residence
- If ZIP code is "Not Recorded / Not Known", complete variables: Patient's Home State (US only) ; Patient's Home County (US only); Patient's Home City (US only)
- If ZIP code is reported, must also complete Patient's Home Country

### Data Source

- Face Sheet
- Billing Sheet
- Admission Form

### National Element

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## PATIENT'S HOME CITY\*

TR 1.21

National & State Element  
Data Format [combo] single-choice

### NTDB Description

The patient's city (or township, or village) of residence.

### ImageTrend Description

The patient's home city (or township, or village) of residence.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HomeCity
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

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

### Data Source

- Face Sheet
- Billing Sheet
- Admission Form

### National Element

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## PATIENT'S HOME COUNTY\*

TR 1.22

National & State Element  
Data Format [combo] single-choice

### NTDB Description

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

### ImageTrend Description

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

<b>XSD Data Type</b>	xs:string	<b>XSD Element / Domain (Complex Type)</b>	HomeCounty
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- Auto Calculated if ZIP code and Country are completed.
- Only reported when Patient's Home ZIP/Postal Code is "Not Known/Not Recorded", and the country is the US.
- Used to calculate the 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

- Face Sheet
- Billing Sheet
- Admission Form

### National Element

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## PATIENT'S HOME STATE\*

TR 1.23

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HomeState
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- Auto Calculated if ZIP code and Country are completed.
- Only reported when Patient's Home 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

- Face Sheet
- Billing Sheet
- Admission Form

### National Element

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## PATIENT'S ALTERNATE RESIDENCE\*

TR 1.13

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	HomeResidence
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Homeless  
Undocumented Citizen

Migrant Worker

### Additional Information

- Only complete when Patient's Home ZIP/Postal Codes 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 used if Patient's Home Zip/Postal Code is reported.
- Report all that apply.

### Data Source

- Face Sheet
- Billing Sheet
- Admission Form

### National Element

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## **OTHER BILLING SOURCE**

---

**TR2.13**

**Data Format** [text]

### **ImageTrend Description**

Other billing source that is not specific in the Primary Method of Payment drop-down menu.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Primary Method of Payment is "Other"

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form
- Face Sheet

## **REIMBURSED CHARGES**

---

**TR 2.8**

**Data Format** [number]

### **ImageTrend Description**

The amount the hospital was reimbursed for services.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

## **SECONDARY METHOD OF PAYMENT**

TR 2.7

**Data Format** [combo] single-choice

### **ImageTrend Description**

Any known secondary source of finance expected to assist in payment of medical bills.

### **Element Values**

Medicare Supp	Private / Commercial Insurance
Managed Care	Workers Compensation
No Fault Automobile	Other
Not Billed (for any reason)	Self-Pay
Medicare	Other Government
Medicaid	

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

## **SECONDARY OTHER BILLING SOURCE**

---

TR2.14

**Data Format** [text]

### **ImageTrend Description**

Secondary other billing source that is not specific in the Secondary Method of Payment drop-down menu.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Primary Method of Payment is "Other"

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

## **THIRD METHOD OF PAYMENT**

**TR2.18**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Any known third source of finance expected to assist in payment of medical bills.

### **Element Values**

Medicare Supp	Private / Commercial Insurance
Managed Care	Workers Compensation
No Fault Automobile	Other
Not Billed (for any reason)	Self Pay
Medicare	Other Government
Medicaid	

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

## **THIRD OTHER BILLING SOURCE**

TR2.19

**Data Format** [text]

### **ImageTrend Description**

Third other billing source that is not specific in the Third Method of Payment drop-down menu.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Third Method of Payment is "Other"

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

## **BILLED HOSPITAL CHARGES**

---

**TR 2.9**

**Data Format** [number]

### **ImageTrend Description**

The total amount the hospital charged for the patient's care.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form



## WORK-RELATED\*

TR 2.10

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

Indication of whether the injury occurred during paid employment.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	WorkRelated
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- If work related, two additional data elements must be completed: Patient's Occupational Industry and Patient's Occupation.

### Data Source

- EMS Run Report
- Triage/Trauma Flow Sheet
- History & Physical
- Face Sheet
- Billing Sheet

### National Element

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## PATIENT'S OCCUPATIONAL INDUSTRY\*

TR 2.6

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	PatientsOccupationalIndustry
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- If work related, also complete Patient's Occupation.
- Based upon US Bureau of Labor Statistics Industry Classification.
- The null value "Not Applicable" is used if Work Related is 2. No.

### Data Source

- Billing Sheet
- Face Sheet
- Case Management/Social Services Notes
- EMS Run Report
- Nursing Notes/Flow Sheet

### National Element

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## **PATIENT'S OCCUPATIONAL INDUSTRY DESCRIPTION**

---

**TR2.27**

**Data Format** [text]

### **ImageTrend Description**

A description of the occupational industry associated with the patient's work environment.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if injury is work-related

### **Data Source**

- Triage Form / Trauma Flow Sheet
- EMS Run Report
- ED Nurses' Notes
- Other ED Documentation

## PATIENT'S OCCUPATION\*

TR 2.11

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

The occupation of the patient.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	PatientsOccupation
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- Only completed if injury is work-related.
- If work related, also complete Patient's Occupational Industry
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- The null value "Not Applicable" is used if Work Related is 2. No.

### Data Source

- Billing Sheet
- EMS Run Report
- Face Sheet
- Nursing Notes/Flow Sheet
- Case Management/Social Service Notes

### National Element

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## **PATIENT'S OCCUPATION DESCRIPTION**

TR2.12

**Data Format** [text]

### **ImageTrend Description**

The description of the occupation of the patient.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if injury is work-related

### **Data Source**

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED documentation
- EMS Run Report

## **Injury Information**

## INCIDENT LOCATION ZIP/POSTAL CODE\*

TR 5.6

National & State Element

**Data Format** [text]

### NTDB/ImageTrend Description

The ZIP/Postal code of the incident location.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	InjuryZip
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Stored as a 5 or 9 digit code for US and CA or can be stored in the postal code format of the applicable country
- If "Not Known/Not Recorded," complete variables: Incident Country, Incident State (US ONLY) and Incident City (US ONLY)
- May require adherence to HIPAA regulations
- If ZIP/Postal code is reported, then must complete Incident Country
- When completed with Country, the city, county, and state auto-calculate

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

### National Element

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## INCIDENT COUNTRY\*

TR 5.11

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

The country where the patient was found or to which the unit responded (or best approximation).

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	IncidentCountry
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

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

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

### National Element

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## AGE UNITS

TR 5.10

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

The city or township where the patient was found or to which the unit responded (or best approximation).

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	IncidentCity
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

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

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

### National Element

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## INCIDENT COUNTY\*

TR 5.9

National & State Element  
**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

The county or parish where the patient was found or to which the unit responded (or best approximation).

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	IncidentCounty
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- Only complete when Incident Location Zip/Postal Code is "Not Applicable", or "Not Known/Not Recorded"
- Used to calculate FIPS code
- The null value "Not Applicable" is used if Incident Location Zip/Postal Code is reported
- If Incident Country is not US, report the null value "Not Applicable"
- Auto-Calculated if ZIP code and Country are completed

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

### National Element

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## INCIDENT STATE\*

TR 5.7

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

The state, territory, or province where the patient was found or to which the unit responded (or best approximation).

<b>XSD Data Type</b>	xs:string	<b>XSD Element / Domain (Complex Type)</b>	IncidentState
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Known/Not Recorded" and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is used if Incident Location Zip/Postal Code is reported
- If Incident Country is not US, report the null value "Not Applicable"
- Auto-Calculated if ZIP code and Country are completed

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

### National Element

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## ICD-10 LOCATION CODE\*

TR200.5.1

National & State Element

**Data Format** [number]

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	PlaceOfInjuryCode
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

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

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- History & Physical
- Progress Notes

### National Element

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## **(Complaint) SUPPLEMENTAL CAUSE OF INJURY**

TR 5.8

**Data Format** [combo] single-choice

### **ImageTrend Description**

The event that occurred to cause injury to the patient.

### **Element Values**

---

Accident	Fire	Rollerblading
Aircraft	Fireworks Related	Roller-skating
All-Terrain Vehicle	Frostbite	Scooter
Assault	Gunshot Wound	Skateboarding
Bicycle Crash	Hanging	Skydiving
Boating	Heat Related	Sledding
Burn	Industrial Incident	Snowboarding
Child Abuse	Injured by Animal	Snowmobile
Cut/Pierce	Jet Ski	Sport Related
Dirt Bike	Lightning	Stab Wound
Diving	Motor Pedestrian Crash	Struck By / Against
Domestic Abuse	Motor Vehicle Crash	Tornado
Drowning	Motorcycle Crash	Train
Electrical Injury	Police	Waterskiing
Fall	Rape	
Farm/Heavy Equipment/Machine	Recreational	

### **Data Source**

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

## **INJURY DESCRIPTION**

---

**TR 20.12**

**Data Format** [text]

### **ImageTrend Description**

The description of the injury. This can be any supporting or supplemental data about the injury, other circumstances, etc.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- History & Physical Documentation
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

## ICD-10 PRIMARY EXTERNAL CAUSE CODE\*

TR 200.3

National & State Element

**Data Format** [number]

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>		PrimaryECodeIcd10
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

### Element Values

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

### Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital
- External cause codes are used to auto-generate two calculated elements: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- ICD-10-CM or ICD 10-CA 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

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- History & Physical
- Progress Notes

### National Element

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## ICD-10 ADDITIONAL EXTERNAL CAUSE CODE\*

National & State Element

**Data Format** [number]

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	AdditionalECodeIcd10
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### Additional Information

- Only ICD-10-CM or ICD-10-CA codes will be accepted for ICD-10 Additional External Cause Code.
- Activity codes should not be reported in this element or under the NTDS and should not be reported for this data element.
- The null value "Not Applicable" is used if no additional external cause codes are used
- Report all that apply (maximum 2)
- 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

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- History & Physical
- Progress Notes

### National Element

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## **ICD-10 INTENTIONALITY**

**TR 200.3.2**

**Data Format** [number]

### **ImageTrend Description**

Intentionality.

### **Element Values**

Relevant ICD-10-CM code value for intentionality.

- Assault
- Other
- Self-Inflicted
- Unintentional
- Undetermined

## ICD-10 TRAUMA TYPE

TR 200.3.3

**Data Format** [number]

### ImageTrend Description

Type of Injury.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	TraumaType
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Relevant ICD-10-CM code value for intentionality.

- Blunt
- Penetrating
- Burn
- Other

## **BARRIERS TO PATIENT CARE**

**TR 14.46**

**Data Format [combo]** multiple-choice

### **ImageTrend Description**

Indication of whether or not there were any patient specific barriers to serving the patient at the scene.

### **Element Values**

Developmentally Impaired	Unattended or Unsupervised (including minors)
Physically Impaired	Not Known
Speech Impaired	Language
Not Applicable	Physically Restrained
Hearing Impaired	Unconscious
None	Not Known/Not Recorded

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **Pre-Hospital Information**

## ARRIVED FROM

TR 16.22

**Data Format [combo]** single-choice

### ImageTrend Description

Location the patient arrived from.

### Element Values

Clinic / MD Office	Nursing Home
Home	Referring Hospital
Jail	Scene

### Additional Information

- Used to auto-generate an additional calculated element: Inter-Facility Transfer (patient transferred from another acute care facility to your facility)

### Data Source

- EMS Run Report
- 911 or Dispatch Center
- Other ED Documentation

## TRANSPORTED TO YOUR FACILITY BY (EMS Transport Party) \*

TR 8.8

National & State Element

Data Format [combo] single-choice

### NTDB Description

The mode of transport delivering the patient to your hospital.

### ImageTrend Description

The mode of transport delivering the patient to the hospital.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	TransportMode
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Ground Ambulance	Private/Public Vehicle/Walk-In
Helicopter Ambulance	Police
Fixed-wing Ambulance	Other

### Data Source

- EMS Run Report

### National Element

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## **OTHER TRANSPORT MODE**

**TR 8.9**

National & State Element

**Data Format** [combo] single-choice

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	OtherTransportMode
<b>Multiple Entry Configuration</b>	Yes, max 5	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

Ground Ambulance	Private/Public Vehicle/Walk-In
Helicopter Ambulance	Police
Fixed-wing Ambulance	Other

### **Additional Information**

- Report all that apply (maximum of 5).
- Report Element Value "6. Other" for unspecified modes of transport.
- The null value "Not Applicable" is reported to indicate that the patient had a single mode of transport.

### **Data Source**

- EMS Run Report

### **National Element**

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## INTER-FACILITY TRANSFER\*

TR 25.54

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

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

#### INCLUDE:

- Patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center.

#### EXCLUDE:

- Patients transferred from a private doctor's office or stand-alone ambulatory surgery center.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	InterFacilityTransfer
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes No

### Additional Information

- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.
- 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](https://www.cms.gov/Research-Statistics-Data-and-systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf) (accessed January 15, 2019).

### Data Source

- EMS Run Report
- Triage/Trauma Flow Sheet
- History and Physical

### National Element

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## **MASS CASUALTY INCIDENT**

**TR 14.37**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indicator if this event would be considered a mass casualty incident (overwhelmed existing EMS resources).

### **Element Values**

No      Yes

### **Data Source**

- EMS Run Report
- Trauma Flow Sheet
- 911 or Dispatch Center
- Other ED Documentation

## **PREGNANCY**

**TR 14.38**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication of the possibility that the patient is currently pregnant.

### **Element Values**

No      Yes

### **Data Source**

- EMS Run Report
- 911 or Dispatch Center
- Other ED Documentation

## **ESTIMATED BODY WEIGHT (Initial ED/Hospital Weight)\***

**TR 1.6.5**

National & State Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **ImageTrend Description**

First recorded, measured or estimated baseline weight upon ED/Hospital arrival (in kilograms).

### **Element Values**

- Relevant value for data element

### **Additional Information**

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

### **Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Pharmacy Record

### **National Element**

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## **LAW ENFORCEMENT / CRASH REPORT NUMBER** **TR 14.40**

---

**Data Format** [text]

### **ImageTrend Description**

The unique number associated with the law enforcement or crash report.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation

## VEHICULAR INJURY INDICATORS

TR 14.41

**Data Format** [combo] single-choice

### ImageTrend Description

The kind of risk factor predictors associated with the vehicle involved in the incident.

### Element Values

Dash Deformity	Side Post Deformity
DOA Same Vehicle	Space Intrusion > 1 Foot
Ejection	Steering Wheel Deformity
Fire	Windshield Spider / Star
Rollover / Roof Deformity	

### Data Source

- EMS Run Report
- Other ED Documentation

## **SEAT ROW LOCATION (of Patient in Vehicle)**

---

TR 14.43

**Data Format** [number]

### **ImageTrend Description**

The seat row location of the patient in vehicle at the time of the crash with the front seat numbered as 1.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation

**POSITION OF PATIENT (in the seat of the vehicle) TR 14.44**

---

**Data Format** [combo] single-choice

**ImageTrend Description**

The seat position of the patient in the vehicle at the time of the crash.

**Element Values**

Driver	Middle	Right
Left (Non-driver)	Other	

**Data Source**

- EMS Run Report
- Other ED Documentation

## **HEIGHT OF FALL IN FEET**

**TR 14.45**

**Data Format** [number]

### **ImageTrend Description**

The distance in feet the patient fell, measured from the lowest point to the ground.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation



## TRAUMA TRIAGE CRITERIA (Steps 1 and 2)\*

TR 17.22

State Element

Data Format [combo] single-choice

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element/Domain (Complex Type)</b>	TraumaCenterCriterion
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

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

### 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

- EMS Run Report

## **TRAUMA TRIAGE CRITERIA (Steps 3 and 4)\***

**TR 17.47**

State Element

**Data Format** [combo] single-choice

### **ImageTrend Description**

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**

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

### **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**

- EMS Run Report

## PROTECTIVE DEVICES (Safety Device Used)\*

TR 29.24

National & State Element  
Data Format [combo] single-choice

### NTDB Description

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

### ImageTrend Description

The use (or lack of use) of safety equipment relevant to the injury cause.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	ProtectiveDevice
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

1. None
2. Lap Belt – TR 29.11
3. Personal Floatation Device – TR29.8
4. Protective Non-Clothing Gear (e.g., shin guard) – TR29.12
5. Eye Protection – TR29.6
6. Child Restraint (booster seat or child car seat) – TR29.13
7. Helmet (e.g., bicycle, skiing, motorcycle) – TR29.2
8. Airbag Present – TR29.3
9. Protective Clothing (e.g., padded leather pants) – TR29.7
10. Shoulder Belt – TR29.14
11. Other – TR29.9

### Additional Information

- Report all that apply.
- Evidence of the use of safety equipment may be reported or observed.
- If Element Value "6. Child Restraint" is reported, report Child Specific Restraint.
- If Element Value "8. Airbag" is reported, report Airbag Deployment.
- Lap Belt should be reported to include those patients that are restrained but not further specified.
- If the documentation indicates "3-point-restraint," report Element Values "2. Lap Belt" and "10. Shoulder Belt."
- If documented that a "Child Restraint (booster seat or child/infant car seat)" was used or worn, but not properly fastened, either on the child or in the car, report Element Value "1. None."

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet
- History & Physical

### National Element

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## CHILD SPECIFIC RESTRAINT\*

TR 29.31

National & State Element

Data Format [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	ChildSpecificRestraint
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

1. Not Applicable
2. Child Booster Seat (TR29.17)
3. Child Car Seat (TR29.15)
4. Infant Car Seat (TR29.16)
5. Not Known/Not Recorded

### 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" is reported if Element Value "6. Child Restraint" is NOT reported for Protective Devices.

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet
- History & Physical

### National Element

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## AIRBAG DEPLOYMENT\*

TR 29.32

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

Indication of airbag deployment during a motor vehicle crash.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	AirbagDeployment
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

1. Not Applicable
2. Airbag Deployed Front (TR29.21)
3. Airbag Deployed Other (TR29.22)
4. Airbag Deployed Side (TR29.19)
5. Airbag Not Deployed (TR29.20)
6. Not Known/Not Recorded

### Additional Information

- Only completed when 'Airbag Present' is marked "Yes"
- Evidence of the use of airbag deployment may be reported or observed
- The null value "Not Applicable" is used if no "Airbag Present" is reported under Protective Devices

### Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet
- History & Physical

### National Element

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## **SAFETY (Equipment) DESCRIPTION**

TR 29.10

**Data Format** [text]

### **ImageTrend Description**

Other protective equipment in use or worn by the patient at the time of the injury

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Evidence of the use of safety equipment may be reported or observed
- Only completed if Other is "Yes"

### **Data Source**

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet

## **EMS RUN NUMBER**

---

**TR 7.1**

**Data Format** [text]

### **ImageTrend Description**

The EMS Run number is assigned by the EMS agency that generated the incident. The NEMESIS data section is eResponse.03 (Incident Number).

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **EMS PATIENT CARE REPORT (PCR) NUMBER**

---

TR9.11

**Data Format** [text]

### **ImageTrend Description**

The run number assigned and entered on the run sheet of the primary emergency service, specific to the individual run/patient.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation



## **NAME OF EMS SERVICE**

**TR7.3**

**Data Format** [combo] single-choice

### **ImageTrend Description**

The name of the EMS service that transferred the patient.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation

## EMS DISPATCH DATE

TR 9.1

**Data Format** [date]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	EMSNotifyDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 2030

### Element Values

- Relevant value for data element

### Additional Information

- Collected as MM/DD/YYYY
- 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 used for patients who were not transported by EMS

### Data Source

- EMS Run Report

## EMS DISPATCH TIME

TR 9.10

Data Format [time]

### ImageTrend Description

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

XSD Data Type	xs: time	XSD Element / Domain (Complex Type)	EMSNotifyTime		
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values		
Required in XSD	Yes	Min. Constraint:	00:00	Max. Constraint:	23:59

### Element Values

- Relevant value for data element

### Additional Information

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

### Data Source

- EMS Run Report

## (EMS Unit) ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

TR 9.2

Data Format [time]

### ImageTrend Description

The date the unit transporting to the hospital arrived on the scene (the date the vehicle stopped moving).

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	EMSArrivalDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element
- Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

### Additional Information

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

### Data Source

- EMS Run Report

## (EMS Unit) ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

TR 9.2.1

Data Format [time]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	EMSArrivalTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element
- Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

### Additional Information

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

### Data Source

- EMS Run Report

## (EMS Unit) DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

TR 9.3

Data Format [time]

### ImageTrend Description

The date the unit transporting to the hospital left the scene.

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	EMSLeftDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element

### Additional Information

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

### Data Source

- EMS Run Report

## (EMS Unit) DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

TR 9.3.1

Data Format [time]

### ImageTrend Description

The time the unit transporting to the hospital left the scene.

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	EMSLeftTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element
- Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

### Additional Information

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

### Data Source

- EMS Run Report

## **UNIT ARRIVED HOSPITAL DATE**

---

TR 9.4

**Data Format** [time]

### **ImageTrend Description**

The date the EMS Agency arrived with the patient at the destination of EMS transport.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Reported as YYYY-MM-DD
- Scene may be defined as "initial hospital" for inter-facility transfers

### **Data Source**

- EMS Run Report
- 911 or Dispatch Center



## UNIT ARRIVED HOSPITAL TIME

TR 9.4.1

**Data Format** [time]

### ImageTrend Description

The time the EMS Agency arrived with the patient at the destination of EMS transport.

<b>XSD Data Type</b>	xs: string	<b>Element / Domain (Simple Type)</b>	TimeUnitAtDestination
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Collected as HH:MM
- Scene may be defined as "initial hospital" for inter-facility transfers
- HH:MM should be collected as military time

### Data Source

- EMS Run Report
- 911 or Dispatch Center

## **EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)**

**TR7.7**

---

### **Description**

The universally unique identifier (UUID) of the patient care report (PCR) of each emergency medical service (EMS) unit treating the patient from the time of injury to arrival at your hospital.

### **ELEMENT VALUES**

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

### **ADDITIONAL INFORMATION**

- A sample UUID is: `e48cd734-01cc-4da4-ae6a-915b0b1290f6`
- Assigned by any applicable transporting EMS agency in accordance with the IETF RFC 4122 standard.
- The null value "Not Known/Not Recorded" must be reported if the UUID is not documented on the EMS Run Report. The UUID will not be documented on EMS Run Reports in NEMSIS versions lower than 3.5.0. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 3.5.0 is widely implemented.
- The null value "Not Applicable" must be reported if the patient was never transported via EMS prior to arrival at your hospital.
- Report all that apply (maximum 20).
- Consistent with NEMSIS v3.5.0.

### **DATA SOURCE HIERARCHY GUIDE**

1. EMS Run Report

### **National Element**

Page 31 the 2024 National Trauma Data Standard

## **(Pre-Hospital) DESTINATION DETERMINATION**

TR 15.32

**Data Format** [combo] single-choice

### **ImageTrend Description**

Major reason for transferring the patient to the facility chosen.

### **Element Values**

Closet Facility	On-Line Medical Direction
Diversion	Other
Hospital of Choice	Specialty Resource Center

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **TRIAGE DESTINATION PROTOCOL**

---

**TR 9.13**

**Data Format** [time]

### **ImageTrend Description**

Indicates whether the out of hospital triage destination protocol was used to determine patient needed resources of this trauma care facility.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- 911 or Dispatch Center

## **TRIAGE CRITERIA**

**TR 9.14**

**Data Format** [time]

### **ImageTrend Description**

Indicates criterion (a) used to triage patient criteria that may be selected are those in the adult out of hospital trauma triage criteria decision protocol of the EMS Bureau of the IDPH up to 20 criteria may be chosen (if EMS run sheet unavailable, give best estimate of circumstances of injury).

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- 911 or Dispatch Center

**(Pre-Hospital Thoracentesis) / TUBE THORACOSTOMY** **TR 18.97**  
**Data Format** [combo] single-choice

**ImageTrend Description**

Indication as to if this procedure was performed while under the care of EMS.

**Element Values**

Not Performed                      Performed

**Data Source**

- EMS Run Report
- Other ED Documentation

## **(Pre-Hospital) CPR PERFORMED**

TR 15.39

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if CPR management was conducted while under the care of EMS.

### **Element Values**

Performed      Not Performed

### **Data Source**

- EMS Run Report
- Other ED Documentation

## EMS STATUS

TR 15.38

**Data Format** [combo] single-choice

### ImageTrend Description

Status of the EMS run sheet or Patient Care Report (PCR).

### Element Values

Complete                      Missing

Incomplete                      Pending

### Data Source

- EMS Run Report
- Other ED Documentation



## PRE-HOSPITAL CARDIAC ARREST\*

TR 15.53

**Data Format** [combo] single-choice  
National & State Element

### NTDB Description

Indication of whether the patient experienced cardiac arrest prior to ED/hospital arrival.

### ImageTrend Description

Whether the person suffered a cardiac arrest at any stage prior to arrival at the definitive care hospital.

<b>XSD Data Type</b>	xs:integer	<b>Element/Domain (Simple Type)</b>	cardiac_arrest
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

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 advance cardiac life support must have been initiated.

### Data Source

- EMS Run Report
- Other ED Documentation

### National Element

- Page 33 in the 2024 National Trauma Data Standard

## **(Pre-Hospital) NEEDLE THORACOSTOMY**

**TR 18.96**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if this procedure was performed while under the care of EMS.

### **Element Values**

Not Performed

Performed

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **(Pre-Hospital) AIRWAY MANAGEMENT**

**TR 15.40**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to whether a device or procedure was used to prevent or correct obstructed respiratory passage while under the care of EMS.

### **Element Values**

CPAP	Cricoid	EOA
Nasal Cannula	LMA	Nasal Trumpet
Non-rebreather mask	Nasal ETT	Supplemental Oxygen
Bag & Mask	Oral Airway	King Airway
Combitube	Oral ETT	Airway cleared
	Trach	Alternative Airway Device

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **(Pre-Hospital) FLUIDS**

**TR 15.30**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to the amount of IV fluids that were administered to the patient while under the care of EMS.

### **Element Values**

- Saline lock
- < 500
- 500-2000
- IVF Attempted
- IVF Unknown Amount

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **(Pre-Hospital) MEDICATIONS**

TR 15.31

**Data Format** [combo] multiple-choice

### **ImageTrend Description**

Medications given to the patient while under the care of EMS.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **(Pre-Hospital) VITALS DATE**

**TR18.106**

**Data Format** [date]

### **ImageTrend Description**

Date of first recorded vital signs in the Pre-Hospital setting.

### **Element Values**

- Collected as MM/DD/YYYY

### **Data Source**

- EMS Run Report
- Other ED Documentation

## **(Pre-Hospital) VITALS TIME**

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**TR18.110**

**Data Format** [time]

### **ImageTrend Description**

Time of first recorded vital signs in the Pre-Hospital setting.

### **Element Values**

- Collected as HHMM
- HHMM should be collected as military time

### **Data Source**

- EMS Run Report
- Other ED Documentation

## INITIAL FIELD GCS - EYE\*

TR 18.60

**Data Format** [number]

### ImageTrend Description

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

XSD Data Type	xs: integer	XSD Element / Domain (Simple Type)	EmsGcsEye		
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values		
Required in XSD	Yes	Min. Constraint:	1	Max. Constraint:	4

### Element Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

### Additional Information

- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 - Eye is reported.
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- If patient does not have a numeric GCS Score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patients pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Eye was NOT measured at the scene of injury.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*



## INITIAL FIELD GCS - VERBAL\*

TR 18.61.2 / TR 18.61.0 (ped)

**Data Format** [number]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	EmsGcsVerbal
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 5

### Element Values

#### Pediatric ( $\leq 2$ years):

No vocal response                      Cries but is consolable, inappropriate interactions  
Inconsolable, agitated                Smiles, oriented to sounds, follows objects, interacts  
Inconsistently consolable, moaning

#### Adult:

No vocal response                      Inappropriate words                      Oriented  
Incomprehensible sounds              Confused

### Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- If a patient is intubated, then the GCS Verbal score is equal to 1.
- 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 Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 - Verbal is reported.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## INITIAL FIELD GCS - MOTOR\*

TR 18.62.2 / TR 18.62.0 (ped)

Data Format [number]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	EmsGcsMotor
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 1</b>	<b>Max. Constraint: 6</b>

### Element Values

#### Pediatric (≤ 2 years):

No motor response	Withdrawal from pain
Extension to pain	Localizing pain
Flexion to pain	Appropriate response to stimulation

#### Adult:

No motor response	Flexion to pain	Localizing pain
Extension to pain	Withdrawal from pain	Obeys commands

### Additional Information

- 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 used if the patient is transferred to your facility with no EMS Run Sheet 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 - Motor is reported.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## (Initial Field) GCS QUALIFIER (UP TO 3)

TR 18.63

**Data Format** [combo] multiple-choice

### ImageTrend Description

Documentation of factors potentially affecting the first assessment of GCS before arrival in the ED/hospital.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	EmsGcsQualifier
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Patient chemically sedated or paralyzed
- Obstruction to the Patient's Eye
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

### Additional Information

- To select more than 1, hold down the Shift Key
- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)

### Data Source

- EMS Run Report

## **(Initial Field) SYSTOLIC BLOOD PRESSURE\***

TR 18.67

**Data Format** [number]

### **ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsSbp
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 0</b>	<b>Max. Constraint: 300</b>

### **Element Values**

- Relevant value for data element

### **Additional Information**

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

### **Data Source**

- EMS Run Report

## **(Initial Field) DIASTOLIC BLOOD PRESSURE**

TR 18.68

**Data Format** [number]

### **ImageTrend Description**

First recorded diastolic blood pressure in the pre-hospital setting.

<b>XSD Data Type</b>	xsd:string	<b>Element/Domain (Complex Type)</b>	EMSDbp
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element

### **Additional Information**

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave blank to record as "Not Known / Not Recorded"

### **Data Source**

- EMS Run Report

## (Initial Field) PULSE RATE\*

TR 18.69

**Data Format** [number]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsPulseRate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 300

### Element Values

- Relevant value for data element

### Additional Information

- The null value "Not Known / Not Recorded" is used if the patient is transferred to (Initial ED/Hospital) SP02 (Oxygen Saturation) \*
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured at the scene of injury.

### Data Source

- EMS Run Report

## (Initial Field) RESPIRATORY RATE\*

TR 18.70

**Data Format** [number]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsRespiratoryRate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 100

### Element Values

- Relevant value for data element

### Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field respiratory rate was NOT measured at the scene of injury

### Data Source

- EMS Run Report

## (Initial Field) SP02 (Oxygen Saturation) \*

TR 18.82

**Data Format** [number]

### ImageTrend Description

First recorded oxygen saturation at the scene of injury.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsPulseOximetry
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 0</b>	<b>Max. Constraint: 100</b>

### Element Values

- Relevant value for data element

### Additional Information

- The null value "Not Known/Not Recorded" is used 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 used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field oxygen saturation was NOT measured at the scene of injury

### Data Source

- EMS Run Report



## INITIAL FIELD GCS - TOTAL\*

TR 18.64

**Data Format** [number]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsTotalGcs
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 3	<b>Max. Constraint:</b> 15

### Element Values

- Relevant value for data element

### Additional Information

- The null value "Not Known/Not Recorded" is used 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 recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Total was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is used if Initial Field GCS 40 - Total is reported.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## INITIAL FIELD GCS 40- EYE\*

TR 18.90.2 / TR 18.90.0 (ped)

**Data Format** [number]

### ImageTrend Description

First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsGcs40Eye
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 3	<b>Max. Constraint:</b> 15

### Element Values

#### Adults:

None  
To Pressure  
To Sound  
Spontaneous  
Not Testable

#### Pediatric <5 years:

None  
To Pain  
To Sound  
Spontaneous  
Not Testable

### 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 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in".
- Report Field Value "5. Not Testable" if unable to assess (e.g. swelling to eye(s)).
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS 40 – Eye was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Eye is reported.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## INITIAL FIELD GCS 40- VERBAL\*

TR 18.91.2 / TR 18.91.0 (ped)

Data Format [number]

### Description

First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsGcs40Verbal
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 3</b>	<b>Max. Constraint: 15</b>

### Element Values

#### Adults:

None  
Sounds  
Words  
Confused  
Oriented  
Not Testable

#### Pediatric <5 years:

None  
Cries  
Vocal Sounds  
Words  
Talks Normally  
Not Testable

### 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 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in".
- Report Field Value "6. Not Testable" if unable to assess (e.g. patient is intubated).
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS 40-Verbal was not measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Verbal is reported.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## INITIAL FIELD GCS 40- MOTOR\*

TR 18.92.2 / TR 18.92.0 (ped)

**Data Format** [number]

### Description

First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmsGcs40Motor
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 3</b>	<b>Max. Constraint: 15</b>

### Element Values

#### Adults:

None  
Extension  
Abnormal Flexion  
Normal Flexion  
Localizing  
Obeys Commands  
Not Testable

#### Pediatric <5 years:

None  
Extension to Pain  
Flexion to Pain  
Localizing Pain  
Talks Normally  
Obeys Commands  
Not Testable

### 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 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in".
- Report Field Value "7. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS 40 – motor was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.

### Data Source

- EMS Run Report

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## **(Pre-Hospital Revised Trauma Score) RTS (Total) TR 18.66**

---

**Data Format** [number]

### **ImageTrend Description**

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the pre-hospital setting.

### **Element Values**

- Relevant value for data element

### **Data Source**

- EMS Run Report

## (Pre-Hospital) RESPIRATORY ASSISTANCE

TR 18.80

**Data Format** [combo] single-choice

### ImageTrend Description

The determination of mechanical and/or external support of respiration.

<b>XSD Data Type</b>	xs: integer	<b>Element/Domain (Complex Type)</b>	RespiratoryAssistance
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Unassisted Respiratory Rate

Assisted Respiratory Rate

### Additional Information

- Only completed if a value is provided for Initial ED/Hospital Respiratory Rate
- 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 used if "Initial ED/Hospital Respiratory Rate" is "Not Known/Not Recorded"

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

## **Referring Hospital Information**

## **TRANSPORTED TO REFERRING FACILITY BY**

**TR 33.48**

**Data Format** [combo] single-choice

### **ImageTrend Description**

The mode of transport delivering the patient to the referring hospital

### **Element Values**

- ALS Ground Ambulance
- Charter Fixed-Wing
- Charter Helicopter
- ALS Helicopter
- BLS Ground Ambulance
- BLS Helicopter
- Other
- Police
- Private/Public Vehicle/Walk-In

### **Data Source**

- Referring Hospital Medical Record Information



## **REFERRING HOSPITAL NAME**

**TR 33.1**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Name of the referring hospital.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Referring Hospital Medical Record Information

## **REFERRING HOSPITAL ARRIVAL DATE**

---

TR 33.2

**Data Format** [date]

### **ImageTrend Description**

The date the patient arrived at the referring hospital.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY

### **Data Source**

- Referring Hospital Medical Record Information

## REFERRING HOSPITAL ARRIVAL TIME

TR 33.3

**Data Format** [time]

### ImageTrend Description

The time the patient arrived at the referring hospital

### Element Values

- Relevant value for data element

### Additional Information

- Collected as HHMM
- HHMM should be collected in military time

### Data Source

- Referring Hospital Medical Record Information

## **REFERRING HOSPITAL DISCHARGE DATE**

---

TR 33.30

**Data Format** [date]

### **Description**

The date the patient was discharged from the referring hospital.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY

### **Data Source**

- Referring Hospital Medical Record Information

## REFERRING HOSPITAL DISCHARGE TIME

TR 33.31

**Data Format** [time]

### ImageTrend Description

The time the patient was discharged from the referring hospital.

### Element Values

- Relevant value for data element

### Additional Information

- Collected as HHMM
- HHMM should be collected in military time

### Data Source

- Referring Hospital Medical Record Information

## **REFERRING HOSPITAL PHYSICIAN NAME**

---

TR 33.4

**Data Format** [text]

### **ImageTrend Description**

The name of the patient's referring physician.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Referring Hospital Medical Record Information

## **REFERRING HOSPITAL VITALS DATE**

---

TR 33.54

**Data Format** [number]

### **ImageTrend Description**

The referring hospital vitals date.

### **Element Values**

- Relevant value for data element

## (Referring Hospital) GCS - MOTOR

TR 33.14.2 / TR 33.14.0 (ped)

Data Format [number]

### ImageTrend Description

First recorded Glasgow Coma Score (Motor) at the referring hospital.

### Element Values

#### Pediatric (≤ 2 years):

No motor response	Extension to pain
Withdrawal from pain	Localizing pain
Flexion to pain	Appropriate response to stimulation

#### Adult:

No motor response	Flexion to pain	Localizing pain
Extension to pain	Withdrawal from pain	Obeys commands

#### Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

### Data Source

- Referring Hospital Medical Record Information

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*



## (Referring Hospital) GCS - EYE

TR 33.12

Data Format [number]

### ImageTrend Description

First recorded Glasgow Coma Score (Eye) at the referring hospital.

<b>XSD Data Type</b>	xs: integer		
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 4

### Element Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

### Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

### Data Source

- Referring Hospital Medical Record Information

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## (Referring Hospital) GCS - VERBAL

TR 33.13.2 /TR 33.13.0(ped)

**Data Format** [number]

### ImageTrend Description

First recorded Glasgow Coma Score (Verbal) at the referring hospital

<b>XSD Data Type</b>	xs: integer		
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 5

### Element Values

#### Pediatric ( $\leq 2$ years):

- No vocal response
- Inconsolable, agitated
- Inconsistently consolable, moaning
- Cries but is consolable, inappropriate interactions
- Smiles, oriented to sounds, follows objects, interacts

#### Adult:

- No vocal response
- Inappropriate words
- Oriented
- Incomprehensible sounds
- Confused

### Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

### Data Source

- Referring Hospital Medical Record Information

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## (Referring Hospital) GCS - MOTOR TR 33.14.2 / TR 33.14.0 (ped)

**Data Format** [number]

### ImageTrend Description

First recorded Glasgow Coma Score (Motor) at the referring hospital.

<b>XSD Data Type</b>	xs: string		
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 6

### Element Values

#### Pediatric ( $\leq 2$ years):

No motor response	Withdrawal from pain
Extension to pain	Localizing pain
Flexion to pain	Appropriate response to stimulation

#### Adult:

No motor response	Flexion to pain	Localizing pain
Extension to pain	Withdrawal from pain	Obeys commands

### Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

### Data Source

- Referring Hospital Medical Record Information

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## **(Referring Hospital) GCS ASSESSMENT QUALIFIERS (UP TO 3) TR 33.16**

---

**Data Format** [combo] multiple-choice

### **ImageTrend Description**

Documentation of factors potentially affecting the first assessment of GCS upon arrival to the referring hospital.

### **Element Values**

- Patient chemically sedated
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
- Obstruction to the Patient's Eye

### **Additional Information**

- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- To select more than 1, hold down the Shift Key

### **Data Source**

- Referring Hospital Medical Record Information

## **(Referring Hospital) TEMPERATURE**

---

TR 33.7

**Data Format** [number]

### **ImageTrend Description**

Referring Temp Celsius.

### **Element Values**

- Relevant value for data element
- Used to auto-generate an additional calculated element: Temperature in degrees Fahrenheit

### **Data Source**

- Referring Hospital Medical Record Information

## **(Referring Hospital) SYSTOLIC BLOOD PRESSURE**

**TR 33.5**

---

**Data Format** [number]

### **ImageTrend Description**

Referring Systolic Blood Pressure.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Used to auto-generate an additional calculated element: Revised Trauma Score - Referring Hospital (adult & pediatric)

### **Data Source**

- Referring Hospital Medical Record Information

## **(Referring Hospital) PULSE RATE**

---

**TR 33.6**

**Data Format** [number]

### **ImageTrend Description**

First recorded pulse at the referring hospital (palpated or auscultated), expressed as a number per minute.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Referring Hospital Medical Record Information

## **(Referring Hospital) RESPIRATORY RATE**

---

**TR 33.8**

**Data Format** [number]

### **ImageTrend Description**

First recorded respiratory rate at the referring hospital (expressed as a number per minute).

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Used to auto-generate an additional calculated element: Revised Trauma Score - Referring Hospital (adult & pediatric)

### **Data Source**

- Referring Hospital Medical Record Information



## **(Referring Hospital) SP02 (Oxygen Saturation)**

TR 33.11

---

**Data Format** [number]

### **ImageTrend Description**

Referring Oxygen Saturation.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Referring Hospital Medical Record Information

## (Referring Hospital) MANUAL GCS TOTAL

TR 33.15

**Data Format** [number]

### ImageTrend Description

First recorded Glasgow Coma Score (total) at the referring hospital.

### Element Values

- Relevant value for data element

### Additional Information

- Use only if total score is available without component score
- Used to auto-generate an additional calculated element: Revised Trauma Score - Referring Hospital (adult & pediatric)
- If a patient does not have a numeric GCS score recorded, but with documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15, IF there is no other contradicting documentation
- 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

### Data Source

- Referring Hospital Medical Record Information

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## **(Referring Hospital Revised Trauma Score) MANUAL RTS TR 33.17**

---

**Data Format** [number]

### **ImageTrend Description**

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient at the referring hospital setting.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Use only if total score is available without component score
- Auto-generated if Manual GCS - Total is entered

### **Data Source**

- Referring Hospital Medical Record Information

## (Referring Hospital) Supplemental Oxygen

TR 33.10

---

**Data Format** [combo] single-choice

### ImageTrend Description

Supplemental Oxygen.

### Element Values

No Yes

### Data Source

- Referring Hospital Medical Record Information

## **(Referring) HOSPITAL ICU**

**TR 33.18**

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

Determination of whether or not the patient went to the ICU at the referring hospital.

### **Element Values**

Yes      No

### **Data Source**

- Referring Hospital Medical Record Information
- Other ICU Documentation

## **(Referring) HOSPITAL OR**

**TR 33.19**

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

Referring Operating Room.

### **Element Values**

Yes      No

### **Data Source**

- Referring Hospital Medical Record Information
- Other OR Documentation

## **(Referring) CPR PERFORMED**

**TR 33.20**

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if CPR management was conducted while under the care of the referring hospital.

### **Element Values**

Yes                      No

### **Data Source**

- Referring Hospital Medical Record Information

## (Referring Hospital) CT HEAD (Results)

TR 33.21

---

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

### Element Values

Positive                  Negative                  Not Performed

### Data Source

- Referring Hospital Medical Record Information
- Radiology Report



## (Referring Hospital) CT CERVICAL (Results)

TR 33.33

---

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

### Element Values

Positive

Negative

Not Performed

### Data Source

- Referring Hospital Medical Record Information
- Radiology Report

## **(Referring Hospital) CT ABD/PELVIS (Results)**

TR 33.22

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if this procedure was performed while under the care of the referring hospital.

### **Element Values**

Positive                  Negative                  Not Performed

### **Data Source**

- Referring Hospital Medical Record Information
- Radiology Report

## (Referring Hospital) CT CHEST (Results)

TR 33.23

---

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

### Element Values

Positive          Negative          Not Performed

### Data Source

- Referring Hospital Medical Record Information
- Radiology Report

**(Referring Hospital) ABDOMINAL ULTRASOUND (Results) TR 33.24**

---

**Data Format** [combo] single-choice

**ImageTrend Description**

Indication as to if this procedure was performed while under the care of the referring hospital.

**Element Values**

Positive          Negative          Not Performed

**Data Source**

- Referring Hospital Medical Record Information
- Radiology Report

## (Referring Hospital) AORTOGRAM (Results)

TR 33.25

---

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

### Element Values

Positive          Negative

### Data Source

- Referring Hospital Medical Record Information
- Radiology Report

## (Referring Hospital) AIRWAY MANAGEMENT

TR 33.27

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to whether a device or procedure was used to prevent or correct an obstructed airway passage while under the care of the referring hospital.

### Element Values

Bag & Mask	LMA
CPAP	Nasal ETT
King Airway	Not Performed
Nasal Cannula	Oral Airway
Non-Rebreather Mask	Oral ETT
Combi tube	Supplemental Oxygen
Crico	Trach

### Data Source

- Referring Hospital Medical Record Information

## **(Referring Hospital) DESTINATION DETERMINATION**

TR 33.29

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

The reason the facility transferred this patient to another acute care hospital.

### **Element Values**

- Hospital of Choice
- Specialty Resource Center

### **Data Source**

- Referring Hospital Medical Record Information

## **(Referring Hospital) MEDICATIONS**

TR 33.28

---

**Data Format** [combo] multiple-choice

### **ImageTrend Description**

Indication as to which, if any, medications were administered to the patient while under the care of the referring hospital

### **Element Values**

- Relevant value for data element

### **Data Source**

- Referring Hospital Medical Record Information
- Other ED Documentation



## **ED/Acute Care Information**

## DIRECT ADMIT TO HOSPITAL

TR 17.30

---

**Data Format** [combo] single-choice

### ImageTrend Description

Indicates if the patient was a direct admission.

### Element Values

No

Yes

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Registration
- Hospital Discharge Summary

## DATE ARRIVED IN ED/ACUTE CARE\*

TR 18.55

National & State Element

**Data Format** [date]

### NTDB/ImageTrend Description

The date the patient arrived in the ED/Hospital.

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	HospitalArrivalDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 2030

### Element Values

- Relevant value for data element
- Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge)

### Additional Information

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

### Data Source

- Triage Form/Trauma Flow Sheet
- Other ED Documentation
- ED Record
- Face Sheet
- Billing Sheet
- Discharge Summary

### National Element

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## TIME ARRIVED IN ED/ACUTE CARE\*

TR 18.56

National & State Element  
**Data Format** [time]

### NTDB/ImageTrend Description

The time the patient arrived at the ED/Hospital.

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	HospitalArrivalTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element
- Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

### Additional Information

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

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Record
- Fact Sheet
- Billing Sheet
- Discharge Summary

### National Element

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## TRAUMA TEAM ACTIVATED

TR 17.21

---

**Data Format** [radio]

### ImageTrend Description

Level of Trauma Team activated.

### Element Values

- Not Activated
- Level 1
- Level 2
- Level 3
- Level 4

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## HIGHEST ACTIVATION\*

TR17.21.1

National & State Element

Data Format [combo] single-choice

### NTDB/ImageTrend Description

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

#### INCLUDE:

- Patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- Patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were downgraded after arrival to your center.
- Patients who received a lower level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were upgraded to the highest level of trauma activation.

#### EXCLUDE:

- Patients who received the highest level of trauma activation after emergency department (ED) discharge.

### Element Values

Yes

No

### Additional Information

- Highest level of activation is defined by your hospital's criteria.

### Data Source

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

### National Element

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## DATE TRAUMA TEAM ACTIVATED

TR 17.31

---

**Data Format** [date]

### ImageTrend Description

The date the trauma team was activated.

### Element Values

- Relevant value for data element

### Additional Information

- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## TIME TRAUMA TEAM ACTIVATED

TR 17.34

---

**Data Format** [time]

### **ImageTrend Description**

The time the trauma team was activated.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary



## ADMITTING MD/STAFF

TR 18.98

---

**Data Format** [combo] single-choice

### ImageTrend Description

Physician or staff member's name to which the patient is designated upon admission to the facility.

### Element Values

- Relevant value for data element

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## TEAM MEMBER

TR 17.9

---

**Data Format** [combo] single-choice

### ImageTrend Description

Name of the team member called when trauma team was activated.

### Element Values

- Relevant value for data element

### Additional Information

- Only completed if Trauma Team is activated

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## ADMITTING SERVICE

TR 18.99

**Data Format** [combo] single-choice

### ImageTrend Description

The department within the hospital that admitted the patient after being discharged from the ED.

### Element Values

Cardiology	Medicine
Cardiovascular Surgery	Nephrology
Ears, Nose, Throat (ENT)	Ophthalmology
Family Practice	Orthopedics
Gastrointestinal (GI)	Pediatric Surgery
General Surgery	Plastic Surgery
Hem-Onc	Surgery Subspecialty
Hospitalist	Trauma
Infection Control	
Internal Medicine	

### Additional Information

- Burn, OMFS, Hand, etc. fall under "Surgery Subspecialty"

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## (Trauma Team Member) SERVICE TYPE

TR 17.13

**Data Format** [combo] single-choice

### ImageTrend Description

The specialty of the team member (physician) called for the Trauma Team Activation.

### Element Values

Anesthesia	Internal Medicine	Pediatric Surgery
Crisis RN	Maxillofacial Surgery	Pediatric Hospitalist
CRNA	Nephrologist	Pediatric Intensivist
Dental	Nephrology	Physician Assistant
Emergency Medicine	Neurosurgery	Plastic Surgery
ENT	Nurse Practitioner	Pulmonology
Family Practice	Obstetrics & Gyn	Social Work
Hospitalist	Ophthalmology	Surgery Senior Resident
Infectious Diseases	Organ Retrieval	Surgery/Trauma
Intensive Care Unit	Orthopedic Surgery	Urology
		Vascular Surgery

### Additional Information

- Only completed if Trauma Team is activated

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## **DATE (Trauma Team Member) CALLED**

TR 17.10

---

**Data Format** [date]

### **ImageTrend Description**

The date the team member (physician) was called when the trauma team was activated.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **TIME (Trauma Team Member) CALLED**

TR 17.14

---

**Data Format** [time]

### **ImageTrend Description**

The time the team member (physician) was called when the trauma team was activated.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **DATE (Trauma Team Member) ARRIVED**

TR 17.15

---

**Data Format** [date]

### **ImageTrend Description**

The date the team member (physician) arrived when the trauma team was activated.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **TIME (Trauma Team Member) ARRIVED**

TR 17.11

---

**Data Format** [time]

### **ImageTrend Description**

The time the team member (physician) arrived when the trauma team was activated.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation



## **(Trauma Team) TIMELY ARRIVAL**

**TR 17.12**

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

Was the (ED physician) respond to the call to see the patient in a timely manner?

### **Element Values**

Yes

No

### **Additional Information**

- Only completed if Trauma Team is activated
- Criteria for timely arrival is defined by the facility

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## TRAUMA SURGEON ARRIVAL DATE\*

TR17.15.1

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs:date	<b>XSD Element Name:</b>	TraumaSurgeonHighestActivationArrivalDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>XSD ComplexType:</b>	Date19902030
<b>Minimum Value:</b>	1990-01-01	<b>Maximum Value:</b>	2030-01-01

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source

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

### National Element

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## TRAUMA SURGEON ARRIVAL TIME\*

TR17.15.2

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: time	<b>XSD Element Name:</b>	TraumaSurgeonHighestActivationArrivalTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>XSD Complex Type:</b>	Time

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source

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

### National Element

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## CONSULTING SERVICES

TR 17.29

**Data Format** [combo] single-choice

### ImageTrend Description

The determination that consulting services were provided.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element/Domain (Simple Type)</b>	ConsultingService
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

**(Consulting) SERVICE TYPE**

TR 17.32

**Data Format** [combo] single-choice**ImageTrend Description**

The specialty of any consults made during the patient's time at the hospital.

**Element Values**

Acute Rehabilitation Medicine	Infectious Disease	Pediatric Hospitalist
Anesthesia	Internal Medicine	Pediatric Infectious Disease
Bariatric	Interventional Radiology	Pediatric Intensivist
Burn	Kidney Transplant	Pediatric Nephrology
Cardiology	Liver	Pediatric Neurology
Cardiothoracic Surgery	Neonatal	Pediatric Orthopedic
Chemical Dependency	Nephrology	Pediatric Pulmonary
Colo-Rectal	Neurointensive Care	Pediatric Surgery
Critical Care Medicine	Neurology	Physical Med & Rehab
Critical Care Surgery	Neurosurgery	Plastic Surgeon
Dentistry	Obstetric	Psychiatry
Dermatology	Oculoplastic	Psychology
Electrophysiology	Oncology	Rheumatology
Endocrinology	Ophthalmology	Social Work
Ear Nose Throat	Oral Maxilla Facial Surgery	Trauma Surgeon
Family Medicine	Orthopedic Surgeon	Urology
Gastroenterology	Pain	Vascular Surgery
General Surgery	Pediatric Cardiology	
Geriatric	Pediatric Critical Care Medicine	
Gynecology	Pediatric Dentistry	
Hand Pediatric	Gastroenterology	
Hematology Oncology	Pediatric Hematology Oncology	

**Additional Information**

- Only completed if Consulting Services is "Yes"

**Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## **CONSULTING STAFF**

**TR 17.33**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Name of staff member that consulted on the patient.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Consulting Services is "Yes"

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## **DATE (Consulting Practitioner Requested)**

---

TR 17.7

**Data Format** [date]

### **ImageTrend Description**

The date the consultant was called.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY
- Only completed if Consulting Services is "Yes"

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

## **TIME (Consulting Practitioner Requested)**

TR 17.8

**Data Format** [time]

### **ImageTrend Description**

The time the consultant was called.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Consulting Services is "Yes"

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary



## DATE DISCHARGED FROM ED (ORDERS WRITTEN) \* TR 17.41

National & State Element  
**Data Format** [date]

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	EdDischargeOrdersWrittenDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as MM/DD/YYYY.
- Used to auto-generate an additional calculated element: Total ED Time: (elapsed time from ED admit to ED discharge).
- If multiple orders were written, report the final disposition order date.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Date is the date of death as indicated on the patient's death certificate.

### Data Source

- Physician Order
- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

### National Element

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## **TIME DISCHARGED FROM ED (ORDERS WRITTEN) \* TR 17.42**

National & State Element

**Data Format** [time]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	EdDischargeOrdersWrittenTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Reported as HHMM military time.
- Used to auto-generate an additional calculated element: Total ED Time (elapsed time from ED admit to ED discharge)
- If multiple orders were written, report the final disposition order time.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Decreased/Expired, then ED Discharge Time is the time of death as indicated on the patient's death certificate.

### **Data Source**

- Physician Order
- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

### **National Element**

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## DATE DISCHARGED FROM ED (PHYSICAL EXIT)

TR 17.25

Data Format [date]

### ImageTrend Description

The date the patient physically left the ED.

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	EdDischargePhysicalDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 2030

### Element Values

- Relevant value for data element
- Total ED Time (elapsed time from ED admit to ED discharge)

### Additional Information

- Collected as MM/DD/YYYY
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

### Data Source

- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

## TIME DISCHARGED FROM ED (PHYSICAL EXIT)

TR 17.26

**Data Format** [time]

### ImageTrend Description

The time the patient physically left the ED.

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	EdDischargePhysicalTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element
- Total ED Time (elapsed time from ED admit to ED discharge)

### Additional Information

- Collected as HH:MM military time
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital

### Data Source

- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

## ED DISCHARGE DISPOSITION\*

TR 17.27

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EdDischargeDisposition
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Floor bed (general admission, non-specialty unit bed)
- Observation Unit
- Telemetry / step-down unit (less acuity than ICU)
- Home with Services
- Deceased/Expired
- Other (jail, institutional care, mental health, etc.)
- Operating Room
- Intensive Care Unit (ICU)
- Home without services
- Left against medical advice.
- Transferred to another hospital.

### Additional Information

- The null value "Not Applicable" is used if the patient is 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

- Physician Order
- Discharge Summary
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- ED Record
- History & Physical

### National Element

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## **DISCHARGE TRANSPORT MODE\***

**TR 17.60**

**Data Format** [combo] single-choice

### **ImageTrend Description**

The type of transportation used to transfer the patient. For 2020 per NTDS, patients who are transferred by private vehicle are included in the trauma registry.

### **Element Values**

- Ground Ambulance
- Helicopter Ambulance
- Fixed Wing Ambulance
- Private/Public Vehicle/Walk-In
- Police
- Other

### **Additional Information**

- Include in "Other" unspecified modes of transport.
- The null value "Not Applicable" is used to indicate that a patient had a single mode of transport and therefore this element does not apply to the patient.
- Check all that apply with a maximum of 5.

### **Data Source**

- EMS Run Report

*\*Patients transferred from one acute care hospital to another acute care hospital by private vehicle are to be included in the trauma registry per the 2021 NTDS Data Dictionary. \**

## PRIMARY TRAUMA SERVICE TYPE\*

TR18.205

National & State Element

Data Format [combo] single-choice

### NTDB/ImageTrend Description

The primary service type responsible for the care of this patient.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element/Domain (Complex Type)</b>	PrimaryTraumaServiceType
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Adult

Pediatric

### Additional Information

- The primary service type responsible for trauma evaluation and care of the patient.
- This element will be used to determine which eligible Trauma Quality Programs report [adult or pediatric] the patient will appear; report age criteria will still apply.
- Adult trauma centers that do not have a separate pediatric service must report Element Value "1. Adult."
- Pediatric trauma centers that do not have a separate adult service must report Element Value "2. Pediatric."

### Data Source

- Triage Form / Trauma Flow Sheet
- History and Physical
- Discharge Summary

### National Element

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## **TRANSFER DELAY\***

TR 17.45

*State Element (Only for Non-Trauma Centers)*

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indicate whether or not there was a delay transferring a patient to a hospital.

### **Element Values**

No                      Yes

### **Additional Information**

- Only completed if ED Disposition is "Transferred to another Hospital"

### **Data Source**

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet



## REASON FOR TRANSFER DELAY - Communication Issue

TR 17.44. Communication

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

Communication Issue - Detailed Reason for Transfer Delay.

### Element Values

- Miscommunication between sending and receiving facility
- Nursing delay in calling for/arranging transportation
- Nursing delay in contacting EMS
- Physician response delay

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Delay Issue

TR 17.44. Delay

---

*State Element (Only for Non-Trauma Centers)*

**Data Format** [combo] single-choice

### ImageTrend Description

Delay Issue - Detailed Reason for Transfer Delay.

### Element Values

- Delay in diagnosis
- Delay in Emergency Department disposition decision
- Delay in trauma team activation

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - EMS Issue

TR 17.44. EMS

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

EMS Issue - Detailed Reason for Transfer Delay.

### Element Values

- Air transport ETA greater than ground transport ETA
- Air transport not available due to weather
- ALS transportation delay
- No ALS available
- No hospital staff available to accompany BLS EMS personnel
- Out of county
- Shortage of available ground transportation

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Equipment Issue

TR 17.44. Equipment

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

Equipment Issue - Detailed Reason for Transfer Delay.

### Element Values

Equipment broken

Equipment missing/unavailable

Not Known

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Error Issue

TR 17.44. Error

---

*State Element (Only for Non-Trauma Centers)*

**Data Format** [combo] single-choice

### ImageTrend Description

Error Issue - Detailed Reason for Transfer Delay.

### Element Values

Error in judgement

Error in technique

Error in treatment

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Patient Issue

TR 17.44. Patient

*State Element (Only for Non-Trauma Centers)*

**Data Format** [combo] single-choice

### ImageTrend Description

Family, Legal Guardian, or Patient Issue - Detailed Reason for Transfer Delay.

### Element Values

- Change in patient condition
- Child Protective Services (CPS)
- Family requested transfer
- Patient requested transfer

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Receiving Facility Issue

TR 17.44. Receiving

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

Receiving Facility Issue - Detailed Reason for Transfer Delay.

### Element Values

Bed availability

Difficulty obtaining accepting facility/hospital

New ED staff

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Referring Facility Issue

TR 17.44. Referring

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

Referring Facility Issue - Detailed Reason for Transfer Delay.

### Element Values

Physician decision making

Priority of transfer

Radiology workup delay

Surgeon availability

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet



## REASON FOR TRANSFER DELAY - Transportation Issue

TR 17.44. Transportation

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

Transportation Issue - Detailed Reason for Transfer Delay.

### Element Values

Transportation issue

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## REASON FOR TRANSFER DELAY - Weather or Natural Issue

TR 17.44. Weather

*State Element (Only for Non-Trauma Centers)*

Data Format [combo] single-choice

### ImageTrend Description

Weather or Natural Factors Issue - Detailed Reason for Transfer Delay.

### Element Values

- Flooding
- Rain
- Snow
- Tornado

### Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

### Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## **OTHER REASON FOR TRANSFER DELAY**

TR 17.43

*State Element (Only for Non-Trauma Centers)*

**Data Format** [text]

### **ImageTrend Description**

Reason for delay in transferring the patient.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Reason for Transfer Delay is "Other"

### **Data Source**

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

## **Initial Assessment Information**

## **(Initial ED/Hospital) VITALS DATE**

TR 18.104

**Data Format** [date]

### **ImageTrend Description**

The date of the first recorded vitals in the ED/Hospital setting.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY

### **Data Source**

- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

## **(Initial ED/Hospital) VITALS TIME**

TR 18.110

**Data Format** [time]

### **ImageTrend Description**

The time of the first recorded vitals in the ED/Hospital setting.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM
- HHMM should be collected in military time

### **Data Source**

- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

## **(Initial ED/Hospital) SYSTOLIC BLOOD PRESSURE\* TR 18.11**

National & State Element  
**Data Format** [number]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	<small>xs: integer</small>	<b>XSD Element / Domain (Complex Type)</b>	SBP
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 300

### **Element Values**

- Relevant value for data element

### **Additional Information**

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

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes
- History & Physical

### **National Element**

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## **(Initial ED/Hospital) DIASTOLIC BLOOD PRESSURE TR 18.13**

**Data Format** [number]

### **ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>		DBP
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 0</b>	<b>Max. Constraint: 299</b>	

### **Element Values**

- Relevant value for data element

### **Additional Information**

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

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes



## **(Initial ED/Hospital) PULSE RATE\***

**TR 18.2**

National & State Element  
**Data Format** [number]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>		PulseRate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 300	

### **Element Values**

- Relevant value for data element

### **Additional Information**

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

### **Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet

### **National Element**

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## **(Initial ED/Hospital) TEMPERATURE\***

**TR 18.30**

National & State Element  
**Data Format** [number]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: decimal	<b>XSD Element / Domain (Complex Type)</b>	Temperature
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 45.0°C

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Please note that the first recorded hospital vitals do not need to be from the same assessment
- Used to auto-generate an additional calculated element: Temperature in degrees Fahrenheit

### **Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet

### **National Element**

Page 41 in the 2024 National Trauma Data Standard

## **(Initial ED/Hospital) TEMPERATURE ROUTE**

TR 18.147

**Data Format** [number]

### **ImageTrend Description**

Indicates the initial emergency department/hospital temperature measurement route.

### **Element Values**

Axillary	Rectal
Foley	Temporal Artery
Oral	Tympanic
Other	

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes

## **(Initial ED/Hospital) SP02 (Oxygen Saturation) \* TR 18.31**

National & State Element  
**Data Format** [number]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	PulseOximetry
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 0</b>	<b>Max. Constraint: 100</b>

### **Element Values**

- Relevant value for data element

### **Additional Information**

- If reported, complete additional element: "Initial ED/Hospital Supplemental Oxygen"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

### **Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

### **National Element**

Page 44 in the 2024 National Trauma Data Standard

## **(Initial ED/Hospital) RESPIRATORY RATE\***

**TR 18.7**

National & State Element  
**Data Format** [number]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	RespiratoryRate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 0	<b>Max. Constraint:</b> 120

### **Element Values**

- Relevant value for data element

### **Additional Information**

- If recorded, complete additional element: "Initial ED/Hospital Respiratory Assistance"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

### **Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

### **National Element**

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## (Initial ED/Hospital) SUPPLEMENTAL OXYGEN\*

TR 18.109

National & State Element

**Data Format** [combo] single-choice

### ImageTrend Description

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.

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)	SupplementalOxygen
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

### Element Values

- No Supplemental Oxygen
- 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 the first recorded hospital vitals do not need to be from the same assessment

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet

### National Element

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## **(Initial ED/hospital Revised Trauma Score) RTS (Total) TR 18.28**

---

**Data Format** [number]

### **ImageTrend Description**

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Use only if total score is available without component score
- Auto-generated if Manual GCS - Total is entered

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **(Initial ED/hospital Pediatric Trauma Score) PTS (Total) TR 21.10**

---

**Data Format** [number]

### **ImageTrend Description**

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting for a pediatric patient.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Use only if total score is available without component score

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation



## (Initial ED/Hospital) GCS - EYE\*

TR 18.14

National & State Element

**Data Format** [number]

### NTDB/ImageTrend Description

First recorded Glasgow Coma Scale (GCS) Eyes in the ED/hospital within 30 minutes of ED/hospital arrival.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	GcsEye
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 4

### Element Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

### Additional Information

- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 – Eye is documented.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

### National Element

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*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.\**

## (Initial ED/Hospital) GCS - VERBAL\*

TR18.15.2

National & State Element

Data Format [number]

### NTDB/ImageTrend Description

First recorded Glasgow Coma Scale (GCS) Verbal within 30 minutes of ED/hospital arrival.

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)	GcsVerbal
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes	Min. Constraint: 1	Max. Constraint: 6

### Element Values

#### Pediatric (< 2 years):

- No vocal response
- Inconsolable, agitated
- Inconsistently consolable, moaning
- Cries but is consolable, inappropriate interactions
- Smiles, oriented to sounds, follow objects, interacts

#### Adult:

- No verbal response
- Incomprehensible sounds
- Inappropriate words
- Confused
- Oriented

### Additional Information

- If the patient is intubated, the GCS Verbal is equal to 1.
- If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (e.g. the chart indicates: "patient is oriented to person place and time," a GCS Verbal of 5 may be reported, IF there is no other contradicting documentation).
- 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 of ED/hospital arrival.
- Please note that the first recorded hospital vitals do not need to be from the same assessment.

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

### National Element

Page 47 in the 2024 National Trauma Data Standard

\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.



## (Initial ED/Hospital) MANUAL GCS TOTAL\*

TR 18.19

National & State Element

Data Format [number]

### NTBD/ImageTrend Description

First recorded Glasgow Coma Scale (GCS) Total Score within 30 minutes of ED/hospital arrival.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>		TotalGcs
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint: 1</b>	<b>Max. Constraint: 15</b>	

### Element Values

- Relevant value for data element

### Additional Information

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

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nursing notes
- Physician Notes

### National Element

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*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## **(Initial ED/Hospital) GCS ASSESSMENT QUALIFIERS (UP TO 3)\* TR 18.21**

National & State Element

**Data Format** [combo] multiple-choice

### **NTDB Description**

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes of ED/hospital arrival.

### **ImageTrend Description**

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	GcsQualifier
<b>Multiple Entry Configuration</b>	Yes, max 3	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Patient Chemically Sedated or Paralyzed
- Obstruction to the Patient's Eye
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

### **Additional Information**

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

- Report all that apply

**Data Source**

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

**National Element**

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*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## (Initial ED/Hospital) GCS 40 – EYE\*

TR18.40.2

National & State Element

**Data Format** [number]

### NTDB/ImageTrend Description

First recorded Glasgow Coma Scale 40 (GCS-40) Eyes score in the ED/hospital within 30 minutes of ED/hospital arrival.

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)	Gcs40Eye
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes	Min. Constraint: 1	Max. Constraint: 4

### Element Values

#### Adult:

- None
- To Pressure
- To Sound
- Spontaneous
- Not Testable

#### Pediatric <5 years:

- None
- To Pain
- To Sound
- Spontaneous
- Not Testable

### 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 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "5. Not Testable" if unable to assess (e.g. swelling to eye(s)).
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Eye is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS 40- Eye was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

### National Element

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\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.

## (Initial ED/Hospital) GCS 40 – VERBAL\*

TR18.41.2

National & State Element  
Data Format [number]

### NTDB/ImageTrend Description

First recorded Glasgow Coma Scale 40 (GCS-40) Verbal score within 30 minutes of ED/hospital arrival.

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)	Gcs40Verbal
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes	Min. Constraint: 1	Max. Constraint: 4

### Element Values

#### Adult:

- None
- Sounds
- Words
- Confused
- Oriented
- Not Testable

#### Pediatric <5 years:

- None
- Cries
- Vocal Sound
- Words
- Talks Normally
- Not Testable

### Additional Information

- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "6. Not Testable" if unable to assess (e.g. patient is intubated).
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Verbal is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS 40 - Verbal was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

### National Element

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*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*



## (Initial ED/Hospital) GCS 40 – MOTOR\*

TR18.42.2

National & State Element

Data Format [number]

### NTDB/ImageTrend Description

First recorded Glasgow Coma Scale 40 (GCS-40) Motor within 30 minutes or less of ED/hospital arrival.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	Gcs40Motor
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 4

### Element Values

#### Adult:

- None
- Extension
- Abnormal Flexion
- Normal Flexion
- Localizing
- Obeys Commands
- Not Testable

#### Pediatric <5 years:

- None
- Extension to Pain
- Flexion to Pain
- Localizing Pain
- Talks Normally
- Obeys Commands
- Not Testable

### Additional Information

- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "7. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS 40 - Motor was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

### National Element

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\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.

## (Initial ED/Hospital) RESPIRATORY ASSISTANCE\* TR 18.10

National & State Element  
Data Format [combo] single-choice

### NTDB Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	Respiratory Assistance
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Unassisted Respiratory Rate
- Assisted Respiratory Rate

### Additional Information

- Only completed if a value is provided for "Initial ED/Hospital Respiratory Rate"
- Respiratory assistance is defined as mechanical and/or external support of respiration
- Please note that the first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Applicable" is used if "Initial ED/Hospital Respiratory Rate" is "Not Known/Not Recorded"

### Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

### National Element

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## (Initial ED/Hospital) AIRWAY MANAGEMENT

TR 14.36

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to whether a device or procedure was performed to prevent or correct an obstructed respiratory passage while under the care of the ED/Hospital.

### Element Values

1 Bag & Mask	Oral Airway
BiPAP	Oral ETT
Combitude	Trach
Cricoid	Not Performed
King Airway	Supplemental Oxygen
LMA	Simple Mask
Nasal Cannula	
Non-rebreather mask	
Nasal ETT	

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **(Initial ED / Hospital) CPR PERFORMED**

TR 18.71

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if CPR management was conducted while under the care of the ED/Hospital.

### **Element Values**

CPR in Progress, continued      Not Performed      Performed

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## UNITS OF BLOOD

TR 22.13

---

**Data Format** [number]

### **ImageTrend Description**

Total units of blood Given.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **BLOOD ORDERED DATE**

TR 22.14

---

**Data Format** [date]

### **ImageTrend Description**

Date and time the blood was ordered for the patient in the ED/Hospital

### **Element Values**

- Collected as MM/DD/YYYY

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## CROSSMATCH DATE

TR 22.15

---

**Data Format** [date]

### **ImageTrend Description**

Date and time the blood was crossmatched for the patient in the ED/Hospital.

### **Element Values**

- Collected as MM/DD/YYYY

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **BLOOD ADMINISTERED DATE**

TR 22.16

---

**Data Format** [date]

### **ImageTrend Description**

Date and time the blood was administered to the patient in the ED/Hospital.

### **Element Values**

- Collected as MM/DD/YYYY

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation



## (Initial ED/Hospital) CT HEAD (Results)

TR 18.72

---

**Data Format** [combo] single-choice

### ImageTrend Description

Indication as to if the procedure was performed while under the care of the ED/Hospital.

### Element Values

Positive                  Negative                  Not Performed

### Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

### Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

## **(Initial ED/Hospital) CT ABD/PELVIS (Results)**

TR 18.73

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if the procedure was performed while under the care of the ED/Hospital.

### **Element Values**

Positive                  Negative                  Not Performed

### **Additional Information**

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

## **(Initial ED/Hospital) CT CHEST (Results)**

TR 18.74

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if the procedure was performed while under the care of the ED/Hospital.

### **Element Values**

Positive                  Negative                  Not Performed

### **Additional Information**

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

## **(Initial ED/Hospital) CT CERVICAL (Results)**

TR 18.105

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if the procedure was performed while under the care of the ED/Hospital.

### **Element Values**

Positive                  Negative                  Not Performed

### **Additional Information**

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

## **(Initial ED/Hospital) DATE SENT TO CT**

**TR 18.101**

**Data Format** [date]

### **ImageTrend Description**

The date the patient had a CT performed while under the care of the ED/Hospital.

### **Element Values**

- Collected as MM/DD/YYYY

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **(Initial ED/Hospital) TIME SENT TO CT**

TR 18.111

**Data Format** [time]

### **ImageTrend Description**

The time the patient had a CT performed while under the care of the ED/Hospital.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM
- HHMM should be collected in military time

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

**(Initial ED/Hospital) ABDOMINAL ULTRASOUND DATE TR 18.102**

---

**Data Format** [date]

**ImageTrend Description**

The date and time abdominal ultrasound was performed on the patient while under the care of the ED/Hospital.

**Element Values**

- Collected as MM/DD/YYYY

**Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

## **(Initial ED/Hospital) ABDOMINAL ULTRASOUND TIME TR18.112**

---

**Data Format** [time]

### **ImageTrend Description**

The time the abdominal ultrasound was performed on the patient while under the care of the ED/Hospital.

### **Element Values**

- Collected as HHMM
- HHMM should be collected in military time

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation



## **(Initial ED/Hospital) ARTERIOGRAM (Results)**

TR 18.76

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if the procedure was performed while under the care of the ED/Hospital.

### **Element Values**

Positive

Negative

### **Additional Information**

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

## **(Initial ED/Hospital) AORTOGRAM (Results)**

TR 18.77

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to if the procedure was performed while under the care of the ED/Hospital.

### **Element Values**

Positive

Negative

### **Additional Information**

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

### **Data Source**

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

## ALCOHOL SCREEN\*

TR 18.46

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

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

<b>XSD Data Type</b>	xs:string	<b>XSD Element / Domain (Complex Type)</b>	AlcoholScreen
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

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

### Data Source

- Lab results (facility specific; inter-facility data not valid)
- Transferring Facility Records

### National Element

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## ALCOHOL SCREEN RESULTS (Blood Alcohol Content)\*

TR 18.46

National & State Element

Data Format [combo] single-choice

### NTDB Description

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

<b>XSD Data Type</b>	xs: decimal	<b>XSD Element / Domain (Complex Type)</b>	AlcoholScreenResult
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Collect 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.
- Report the null value "Not Applicable" for those patients who were not tested.

### Data Source

- Lab results (facility specific; inter-facility data not valid)
- Transferring Facility Records

### National Element

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## **(Initial ED / Hospital) BASE DEFICIT**

TR 18.93

**Data Format** [number]

### **ImageTrend Description**

The first recorded base deficit (the arterial blood gas component showing the degree of acid/base imbalance), measured in mEq/L.

### **Element Values**

- Relevant value for data element

### **Data Source**

- Lab results (facility specific; inter-facility data not valid)

## DRUG SCREEN\*

TR 18.45

National & State Element

**Data Format** [combo] multiple-choice

### NTDB Description

First recorded positive drug screen results within 24 hours after first hospital encounter.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	DrugScreen
<b>Multiple Entry Configuration</b>	Yes, max 2	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

AMP (Amphetamine)	OXY (Oxycodone)
BAR (Barbiturate)	PCP (Phencyclidine)
BZO (Benzodiazepines)	TCA (Tricyclic Antidepressant)
COC (Cocaine)	THC (Cannabinoid)
mAMP (Methamphetamine)	Other
MDMA (Ecstasy)	None
MTD (Methadone)	Not Tested
OPI (Opioid)	

### Additional Information

- Record 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

- Lab results (facility specific; inter-facility data not valid)
- Transferring Facility Records

### National Element

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## **Diagnosis Information**

## ICD-10 INJURY DIAGNOSIS\*

TR 200.1

National & State Element  
**Data Format** [combo] multiple-choice

### NTDB Description

Diagnoses related to all identified injuries.

### ImageTrend Description

Diagnoses related to all identified injuries. Injury diagnoses as defined by (ICD-10-CM) codes.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	DiagnosisIcd10
<b>Multiple Entry Configuration</b>	Yes, max 100	<b>Accepts Null Value</b> Yes, common null values	
<b>Required in XSD</b>	Yes		

### Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 OR compatible ICD-10-CA code range
- 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

- Autopsy/Medical Examiner Report
- Operative Reports
- Radiology Reports
- Physician's Notes
- Trauma Flow Sheet
- History & Physical
- Nursing Notes/Flow Sheet
- Progress Notes
- Discharge Summary

### National Element

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## AIS CODE\*

TR 200.14.1

**Data Format** [combo] multiple-choice

### NTDB Description

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

### ImageTrend Description

ICD 10 code view.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>		AISCODE
<b>Multiple Entry Configuration</b>	Yes, max 50	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

### Element Values

- The code is the 8-digit AIS code.

### Data Source

- AIS Coding Manual

### National Element

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## **AIS VERSION\***

**TR 21.25**

**Data Format** [text]

### **NTDB Description**

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.

### **ImageTrend Location**

This information may be found under the ImageTrend Diagnosis tab.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	AisVersion
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- AIS 05, Update 08
- AIS 2015

### **National Element**

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## ISS (Body) REGION

**Data Format** [number]

### Description

The Injury Severity Score (ISS) body region codes that reflects the patient's injuries.

### ImageTrend Location

This information may be found under the ImageTrend Diagnosis tab.

XSD Data Type	xs: integer	XSD Element / Domain (Simple Type)	IssRegion
Multiple Entry Configuration	Yes, max 50	Accepts Null Value	Yes, common null values
Required in XSD	Yes	Min. Constraint:	1
		Max. Constraint:	6

### Element Values

Head or Neck	Abdominal or pelvic contents
Face	Extremities or pelvic girdle
Chest	External

### Additional Information

- Auto-calculated once AIS code is typed in
- This variable is considered optional and is not required as part of the State dataset
- Head or neck injuries include injury to the brain or cervical spine, skull or cervical spine fractures
- Facial injuries include those involving mouth, ears, nose and facial bones
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region
- Injuries to the extremities or to the pelvic or shoulder girdle include sprains, fractures, dislocations, and amputations, except for the spinal column, skull, and rib cage
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface

### Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation / Nurses' Notes
- Other Hospital Documentation

### National Element

National Element IS\_03 from the 2024 National Trauma Data Standard

## **AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS\***

**Data Format** [number]

### **Description**

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

### **ImageTrend Location**

This information may be found in a table under the ImageTrend Diagnosis tab.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>		AisSeverity
<b>Multiple Entry Configuration</b>	Yes, max 50	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 9	

### **Element Values**

Minor Injury                      Severe Injury  
Moderate Injury                  Critical Injury  
Serious Injury6                  Maximum Injury, Virtually Insurvivable  
Not Possible to Assign

### **Additional Information**

- The element value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury

### **Data Source**

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

## MANUAL (Locally Calculated ISS)\*

**Data Format** [number]

### Description

The Injury Severity Score (ISS) that reflects the patient's injuries.

### ImageTrend Location

This information may be found under the ImageTrend Diagnosis tab.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>		IssLocal
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1	<b>Max. Constraint:</b> 75	

### Element Values

- Auto-calculated once AIS scores are typed in
- Relevant ISS value for the constellation of injuries

### Additional Information

- This variable is considered optional and is not required as part of the State dataset

### Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

## **Comorbidity Information**

## ADVANCED DIRECTIVE LIMITING CARE

**(Pre-Existing Conditions – Advance Directive Limiting Care)**

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

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

### Element Values

Yes

No

### Additional Information

- Present prior to arrival at your center.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available
- Report Element Value "2. No" for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.
- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography)

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **ALCOHOL USE DISORDER (Pre-ExistingConditions -AlcoholUseDisorder)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## ANTICOAGULANT THERAPY

(Pre-Existing Conditions - Anticoagulant Therapy)

National & State Optional Element  
Data Format [combo] single-choice

### NTDB Description

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

EXCLUDE:

- Patients whose only anticoagulant therapy is chronic Aspirin.

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

### Element Values

Yes

No

### Additional Information

- Present prior to injury
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Anticoagulant must be part of the patient's active medication

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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

(Pre-Existing Conditions – ADD/ADHD)

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

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

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- A diagnosis of ADD/ADHD must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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**BIPOLAR I/II DISORDER** (Pre-ExistingConditions - BipolarDisorder)

National & State Optional Element  
Data Format [combo] single-choice

**NTDB Description**

A bipolar I/II disorder diagnosis documented in the medical record.

**Element Values**

Yes No

**Additional Information**

- Present prior to injury.
- Only report on patients  $\geq 15$  years-of-age.
- The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## **BLEEDING DISORDER**

**(Pre-ExistingConditions - BleedingDisorder)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **Element Values**

Yes

No

### **Additional Information**

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

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## CEREBRAL VASCULAR ACCIDENT (CVA)

### (Pre-ExistingConditions - CerebralVascularAccident)

National & State Optional Element

**Data Format** [combo] single-choice

#### NTDB Description

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

#### Element Values

Yes

No

#### Additional Information

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

#### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

#### National Element

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## CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

(Pre-Existing Conditions - Chronic Obstructive Pulmonary Disease)

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

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

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing

### EXCLUDE:

- Patients whose only pulmonary disease is acute asthma.
- Patients with diffuse interstitial fibrosis or sarcoidosis.

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- Consistent with World Health Organization (WHO), 2019.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## CHRONIC RENAL FAILURE

(Pre-ExistingConditions - ChronicRenalFailure)

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

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

### Element Values

Yes

No

### Additional Information

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

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **CIRRHOSIS**

**(Pre-Existing Conditions - Cirrhosis)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.

EXCLUDE:

- Patients who no longer have cirrhosis due to a successful liver transplant.

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### **Data Source**

- History & Physical
- Physician's Notes/ Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## CONGENITAL ANOMALIES

### (Pre-ExistingConditions - CongenitalAnomalies)

National & State Optional Element

**Data Format** [combo] single-choice

#### NTDB Description

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

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	ComorbidCondition
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

#### Element Values

Yes

No

#### Additional Information

- Present prior to injury.
- A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients < 15 years-of-age.
- Only report on patients < 15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15-years-of-age.

#### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

#### National Element

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## CONGESTIVE HEART FAILURE (CHF)

(Pre-Existing Conditions - Congestive Heart Failure)

National & State Optional Element

Data Format [combo] single-choice

### NTDB Description

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

### Element Values

Yes

No

### Additional Information

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

### Data Source

- History & Physical
- Physician's Notes / Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **CURRENT SMOKER**

**(Pre-ExistingConditions - CurrentSmoker)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **EXCLUDE:**

- Patients who report smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER**

**(Pre-ExistingConditions - CurrentlyReceivingChemotherapyCancer)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **Element Values**

Yes

No

### **Additional Information**

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

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **DEMENTIA**

**(Pre-Existing Conditions - Dementia)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- A diagnosis of dementia including Alzheimer's Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Consistent with the National Institute on Aging December 2017.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **DIABETES MELLITUS**

**(Pre-Existing Conditions - Dementia)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.
- Report *Element Value* "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **DISSEMINATED CANCER (Pre-Existing Conditions.DisseminatedCancer)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

Cancer that has spread to one or more sites in addition to the primary site and in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

### **Element Values**

Yes

No

### **Additional Information**

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

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## FUNCTIONALLY DEPENDENT HEALTH STATUS

**(Pre-ExistingConditions.FunctionallyDependentHealthStatus)**

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

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

### Element Values

Yes

No

### Additional Information

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

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **HYPERTENSION**

**(Pre-Existing Conditions - Hypertension)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

History of persistent elevated blood pressure requiring antihypertensive medication.

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- A diagnosis of Hypertension must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Report Element Value '1. Yes' for patients who were non-compliant with their prescribed antihypertensive medication.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## MAJOR DEPRESSIVE DISORDER

(Pre-ExistingConditions - MajorDepressiveDisorder)

National & State Optional Element

Data Format [combo] single-choice

### NTDB Description

A major depressive disorder diagnosis documented in the medical record.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Simple Type)</b>	ComorbidCondition
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- Only report on patients  $\geq 15$  years-of-age.
- The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## MYOCARDIAL INFARCTION (MI)

**(Pre-Existing Conditions - Myocardial Infarction)**

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

History of myocardial infarction (MI) in the six months prior to injury.

### Element Values

Yes

No

### Additional Information

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

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## OTHER MENTAL/PERSONALITY DISORDERS

(Pre-Existing Conditions - Other Mental Personality Disorders)

National & State Optional Element

Data Format [combo] single-choice

### NTDB Description

A diagnosis of any of the following documented in the medical record:

- Antisocial personality disorder
- Avoidant personality disorder
- Borderline personality disorder
- Dependent personality disorder
- Generalized anxiety disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Obsessive-compulsive disorder
- Obsessive-compulsive personality disorder
- Panic disorder
- Paranoid personality disorder
- Schizotypal personality disorder

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- Only report on patients  $\geq 15$  years-of-age.
- The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet /Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## PERIPHERAL ARTERIAL DISEASE (PAD)

(Pre-Existing Conditions - Peripheral Arterial Disease)

National & State Optional Element

Data Format [combo] single-choice

### NTDB Description

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

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.
- A diagnosis of PAD must be documented in the patient's medical record.
- Only report on patients  $\geq 15$  years-of-age.
- The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## POST-TRAUMATIC STRESS DISORDER

(Pre-ExistingConditions - PostTraumaticStressDisorder)

National & State Optional Element

**Data Format** [combo] single-choice

### NTDB Description

A post-traumatic stress disorder diagnosis documented in the medical record.

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- Only report on patients  $\geq 15$  years-of-age.
- The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **PREGNANCY**

**(Pre-ExistingConditions - Pregnancy)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

### **Element Values**

Yes

No

### **Additional Information**

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

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **PREMATURITY**

**(Pre-ExistingConditions - Prematurity)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

Babies born before 37 weeks of pregnancy are completed.

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- A diagnosis of Prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
- Only report on patients <15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15 years-of-age.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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**SCHIZOAFFECTIVE DISORDER (Pre-ExistingConditions-Schizoaffective Disorder)**

National & State Optional Element

**Data Format** [combo] single-choice

**NTDB Description**

A schizoaffective disorder diagnosis documented in the medical record.

**Element Values**

Yes

No

**Additional Information**

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## **SCHIZOPHRENIA**

**(Pre-Existing Conditions - Schizophrenia)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

A schizophrenia diagnosis documented in the medical record.

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- Only report on patients  $\geq 15$  years-of-age.
- The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **STEROID USE**

**(Pre-ExistingConditions - SteroidUse)**

National & State Optional Element

**Data Format** [combo] single-choice

### **NTDB Description**

Regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

#### *EXCLUDE:*

- Topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

### **Element Values**

Yes

No

### **Additional Information**

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone.
- Examples of chronic medical conditions are Chronic Obstructive Pulmonary Disease (COPD), asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## SUBSTANCE USE DISORDER

(Pre-ExistingConditions - SubstanceUseDisorder)

National & State Optional Element

Data Format [combo] single-choice

### NTDB Description

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

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

### Element Values

Yes

No

### Additional Information

- Present prior to injury.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.

- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## **CO-MORBID CONDITION NOTES**

TR 21.23

**Data Format** [text]

### **ImageTrend Description**

Additional information about the pre-existing medical conditions.

### **Element Values**

- Relevant value for data element

### **Data Source**

- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

## **Procedures Information**

## ICD-10 HOSPITAL PROCEDURES\*

TR200.2

National & State Element  
Data Format [combo] multiple-choice

### NTDB/ImageTrend Description

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.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalProcedureIcd10
<b>Multiple Entry Configuration</b>	Yes, max 200	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### 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 used if the patient did not have procedures.
- Include only procedures performed at your institution.
- Capture all procedures performed in your operating room.
- Capture all procedures performed 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, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Plain radiography of whole body, Plain radiography of whole skeleton, and Plain radiography of infant whole body to the Diagnostic and Therapeutic Imaging.
- Note that the hospital may capture additional procedures.

<b>Diagnostic &amp; Therapeutic Imaging</b>	<b>Musculoskeletal</b>
Computerized tomographic Head *	Soft tissue / bony debridements *
Computerized tomographic Chest *	Closed reduction of fractures
Computerized tomographic Abdomen *	Skeletal and halo traction
Computerized tomographic Pelvis *	Fasciotomy
Diagnostic ultrasound (includes FAST) *	



Doppler ultrasound of extremities*	<b>Transfusion</b>
Angiography	Transfusion of red cells * (only capture first 24 hours after hospital arrival)
Angioembolization	Transfusion of platelets * (only capture first 24 hours after hospital arrival)
IVC filter	Transfusion of plasma * (only capture first 24 hours after hospital arrival)
<b>Cardiovascular</b>	<b>Respiratory</b>
Open cardiac massage	Insertion of endotracheal tube * (exclude intubations performed in the OR)
CPR	Continuous mechanical ventilation *
<b>CNS</b>	Chest tube *
Insertion of ICP monitor *	Bronchoscopy *
Ventriculostomy *	Tracheostomy
Cerebral oxygen monitoring *	<b>Gastrointestinal</b>
<b>Genitourinary</b>	Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Ureteric catheterization (i.e. Ureteric stent)	Gastrostomy / jejunostomy (percutaneous or endoscopic)
Suprapubic cystostomy	Percutaneous (endoscopic) gastrojejunoscopy

**Data Source**

- Operative Reports
- Nursing Notes/Flow Sheet
- Procedure Notes
- Radiology Reports
- Trauma Flow Sheet
- Discharge Summary
- ED Record

**National Element**

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## **PROCEDURE PERFORMED**

**TR 22.30**

**Data Format** [combo] single-choice

### **Description**

Indicates if the patient had a procedure performed upon them while in your facility.

### **Element Values**

No                      Yes

### **Data Source**

- Operative Reports
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

## **(Procedure Performed) LOCATION**

TR 200.11

**Data Format** [combo] single-choice

### **ImageTrend Description**

The hospital location where the procedure was performed.

### **Element Values**

Minor Surgery Unit	Catherization Lab
Nuclear Medicine	ED
Observation	Floor
Other	GI Lab
Outpatient Clinic	ICU
Recovery	OR
Rehabilitation	Other
Scene	Radiology
Special Procedure Unit	Readmit OR (planned OR)
Step-Down	Tele
Transport from Scene	

### **Data Source**

- Operative Reports
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

**(Hospital Procedure) DATE PERFORMED\***

**TR 200.8**

National & State Element

**Data Format** [date]

**NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	HospitalProcedureStartDate
<b>Multiple Entry Configuration</b>	Yes	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 2030

**Element Values**

- Relevant value for data element

**Additional Information**

- Collected as MM/DD/YYYY

**Data Source**

- Operative Reports
- Procedure Notes
- Trauma Flow Sheet
- ED Record
- Nursing Notes/Flow Sheet
- Radiology Reports
- Discharge Summary

**National Element**

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## **(Hospital Procedure Start) TIME PERFORMED\***

TR 200.9

National & State Element  
**Data Format** [time]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	HospitalProcedureStartTime
<b>Multiple Entry Configuration</b>	Yes	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Reported as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).
- If distinct procedures with the same procedure code are performed, their start times must be different

### **Data Source**

- Operative Reports
- Anesthesia Reports
- Procedure Notes
- Trauma Flow Sheet
- ED Record
- Nursing Notes/Flow Sheet
- Radiology Reports
- Discharge Summary

### **National Element**

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## **(Physician Performing the Procedure) STAFF**

TR 200.10

**Data Format** [combo] single-choice

### **ImageTrend Description**

Physician performing the procedure.

### **Element Values**

- Relevant value for data element

### **Data Source**

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

## **SERVICE TYPE (of the Physician)**

**TR 200.6**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Service type of the physician.

### **Element Values**

Cardiology	Ophthalmology
Critical Care Medicine	Oral Maxillo Facial Surgery
Ear Nose Throat	Orthopedic Surgery
Emergency Medicine	Pediatric Orthopedic
Gastroenterology	Pediatric Surgery
General Surgery	Plastic Surgery
Gynecology	Radiology
Hand Surgery	Thoracic Surgery
Medicine	Trauma Surgery
Neurosurgery	Urology
Obstetrics	Vascular Surgery

### **Data Source**

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

## **(Procedure) COMMENTS**

TR 200.7

**Data Format** [text]

### **ImageTrend Description**

Additional information about the procedure

### **Element Values**

- Relevant value for data element

### **Data Source**

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record



## RESOURCE UTILIZATION

TR 26.59

Data Format [combo] single-choice

### ImageTrend Description

A list of the resources utilized during the treatment and care of the patient.

### Element Values

Adult Protective Service	Peripheral Parenteral Nutrition (PPN)
Bi-Pap	Physical Therapy
Case Management	PICC line
Cerebral Brain Flow Studies	PRISMA (CVVHD)
Child Protective Service	Respiratory Therapy
CRRT	RN accompanied transfer
Dialysis	Specialized Bed
Epidural Catheter	Speech Therapy
Exceeds LOS	TLSO Brace
Factor VIIa (Novoseven)	Total Parenteral Nutrition (TPN)
High dose methylprednisolone	Traction
Hypertonic Saline	Transfusion of FFP
Level-1 Blood/Fluid Warmer	Transfusion of Platelets
LiCox Monitor	Transfusion of PRBC
Massive Blood Transfusion	Tube Feeding
Miama J Collar	Uncrossmatched Blood
MRI	Vaccine Post-Splenectomy
None	Venous Doppler
Nutritionist	Wound Care RN
Occupational Therapy	Wound Vacuum
Pentobarbital Coma	

### Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

**Complications/Performance Improvement  
Information**

**ACUTE KIDNEY INJURY (AKI)\* (HospitalEvents -AcuteKidneyInjury)**

National & State Element

Data Format [combo] single-choice

**NTDB Description**

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

KDIGO (Stage 3) Table:

(SCr) 3 times baseline

or

Increase in SCr to  $\geq 4.0$  mg/dl ( $\geq 353.6$   $\mu$ mol/l)

or

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

or

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

or

Anuria for  $\geq 12$  hours

**EXCLUDE:**

- Patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

**ImageTrend Description**

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

<b>XSD Data Type</b>	xs:string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes

No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.

- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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**ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)\***  
**(HospitalEvents - AcuteRespiratoryDistressSyndrome)**

National & State Element  
**Data Format** [combo] single-choice

**NTDB/ImageTrend Description**

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

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

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

Oxygenation:

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	Hospital Complication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## ALCOHOL WITHDRAWAL SYNDROME\*

(HospitalEvents.AlcoholWithdrawalSyndrome)

National & State Element

Data Format [combo] single-choice

### NTDB Description

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

### ImageTrend Description

Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

### Data Source Hierarchy Guide

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **CARDIAC ARREST WITH CPR\* (HospitalEvents - CardiacArrestCPR)**

National & State Element  
**Data Format** [combo] single-choice

### **NTDB Description**

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

#### **INCLUDE:**

- Patients who, after arrival at your hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

#### **EXCLUDE:**

- Patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.

### **ImageTrend Description**

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

Yes No

### **Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- Cardiac Arrest must be documented in the patient's medical record.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)\*

(HospitalEvents.CathAssociatedUTI)

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National & State Element

Data Format [combo] single-choice

### NTDB/ImageTrend Description

UPDATED TO: A urinary tract infection (UTI) where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

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

### January 2019 CDC CAUTI Criterion SUTI 1a:

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

1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
  - Present for any portion of the calendar day on the date of event, OR
  - Removed the day before the date of event
2. Patient has at least **one** of the following signs or symptoms:
  - Fever (>38°C): Reminder: To use fever in a patient > 65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place or was removed the day before the DOE
  - Suprapubic tenderness with no other recognized cause
  - Costovertebral angle pain or tenderness
  - Urinary urgency
  - Urinary frequency
  - Dysuria
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacterium >10<sup>5</sup> CFU/ml.



January 2019 CDC CAUTI Criterion SUTI 2:

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

1. Patient is  $\leq 1$  year of age
2. Patient has at least **one** of the following signs or symptoms:
  - fever ( $> 38.0^{\circ}\text{C}$ ) hypothermia ( $< 36.0^{\circ}\text{C}$ )
  - apnea with no other recognized cause
  - bradycardia with no other recognized cause
  - lethargy with no other recognized cause
  - vomiting with no other recognized cause
  - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of  $\geq 10^5$  CFU/ml.

XSD Data Type	xs: string	XSD Element / Domain (Complex Type)	HospitalComplication
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

**Element Values**

Yes No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined CAUTI.

**Data Source**

- History & Physical
- Physician's Notes
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)\*

(HospitalEvents - CentralLineAssociatedBSI)

National & State Element

Data Format [combo] single-choice

### NTDB Description

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

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

#### January 2016 CDC Criterion LCBI 1:

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

AND

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

OR

#### January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms: fever (>38°C), chills, or hypotension

AND

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

AND

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

OR

January 2016 CDC Criterion LCBI 3:

Patient  $\leq$  1 year of age has at least one of the following signs or symptoms: fever ( $>38^{\circ}$  C), hypothermia ( $<36^{\circ}$ C), apnea, or bradycardia

AND

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

AND

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

**ImageTrend Description**

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of central line-associated bloodstream infection (CLABSI) must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## DEEP SURGICAL SITE INFECTION\*

### HospitalEvents.DeepSurgicalSiteInfection

National & State Element

Data Format [combo] single-choice

#### NTDB Description

Must meet the following criteria:

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

AND

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

AND

patient has at least one of the following:

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

AND

patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.

- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

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

#### ImageTrend Description

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

AND

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

AND

patient has at least one of the following:

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

AND

patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.

- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## **DEEP VEIN THROMBOSIS (DVT)\*(HospitalEvents-DeepVeinThrombosis)**

National & State Element

**Data Format** [combo] single-choice

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

Yes

No

### **Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## **DELIRIUM\***

## **(HospitalEvents-DeepVeinThrombosis)**

National & State Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

#### **OR**

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

#### **OR**

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

### **ImageTrend Description**

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

#### **EXCLUDE:**

- Patient's whose delirium is due to alcohol withdrawal.

### **Element Values**

Yes

No

### **Additional Information**

- Onset of symptoms began after arrival to your ED/hospital

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## MYOCARDIAL INFARCTION (MI)\*

### (HospitalEvents-MyocardialInfarction)

National & State Element

**Data Format** [combo] single-choice

#### NTDB/ImageTrend Description

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

AND

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

AND

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

#### Element Values

Yes

No

#### Additional Information

- Onset of symptoms began after arrival to your ED/hospital

#### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

#### National Element

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## ORGAN/SPACE SURGICAL SITE INFECTION\*

(HospitalEvents-OrganSpaceSurgicalSiteInfection)

National & State Element

Data Format [combo] single-choice

### NTDB/ImageTrend Description

Must meet the following criteria:

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

AND

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

AND

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

- purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
- an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

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

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	<u>Herniorrhaphy</u>		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

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

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes

No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## OSTEOMYELITIS\*

(HospitalEvents-Osteomyelitis)

National & State Element

Data Format [combo] single-choice

### NTDB/ImageTrend Description

Osteomyelitis must meet at least one of the following criteria:

- 1 Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- 2 Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
- 3 Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling\*, pain or tenderness\*, heat\*, or drainage\*

And at least **one** of the following:

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

\* With no other recognized cause

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- Onset of symptoms began after arrival to your ED/hospital

- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint infection.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## PRESSURE ULCER (PE)\*

(HospitalEvents - PressureUlcer)

National & State Element

Data Format [combo] single-choice

### NTDB Description

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

### ImageTrend Description

A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

XSD Data Type	xs: string	XSD Element / Domain (Complex Type)	HospitalComplication
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

### Element Values

Yes

No

### Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Pressure Ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## **PULMONARY EMBOLISM (PE)\* (HospitalEvents-PulmonaryEmbolism)**

National & State Element

**Data Format** [combo] single-choice

### **NTDB Description**

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

EXCLUDE:

- Subsegmental PE's.

### **ImageTrend Description**

A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

Yes

No

### **Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- Consider the condition present if the patient has a VQ scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.

### **Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### **National Element**

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## SEVERE SEPSIS\*

(HospitalEvents-SevereSepsis)

National & State Element

Data Format [combo] single-choice

### NTDB Description

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

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

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of Sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

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## STROKE/CVA\*

(HospitalEvents-StrokeCva)

National & State Element

Data Format [combo] single-choice

### NTDB Description

A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which is temporary caused by a temporary clot. The patient must have at least one of the following symptoms:

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

AND:

- Duration of neurological deficit  $\geq 24$  h

OR:

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

AND:

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

AND:

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

### ImageTrend Description

A focal or global neurological deficit of rapid onset and NOT present on admission.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes

No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

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## **SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION\***

**(HospitalEvents-SuperficialIncisionSurgicalSiteInfection)**

National & State Element

**Data Format** [combo] single-choice

### **NTDB Description**

Must meet the following criteria:

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

AND

involves only skin and subcutaneous tissue of the incision

AND

patient has at least one of the following:

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

patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture-based test that has a negative finding does not meet this criterion.

- d) diagnosis of a superficial incisional SSI by the surgeon or attending physician\*\* or other designee.

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

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

### **ImageTrend Description**

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes

No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

Page 124 in the 2024 National Trauma Data Standard

## UNPLANNED ADMISSION TO ICU\*

(HospitalEvents-UnplannedAdmissionToICU)

National & State Element

**Data Format** [combo] single-choice

### NTDB/ImageTrend Description

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

#### INCLUDE:

- Patients who required ICU care due to an event that occurred during surgery or in the PACU.

#### EXCLUDE:

- Patients with a planned post-operative ICU stay.

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- Must have occurred during the patient's initial stay at your hospital.

### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

### National Element

Page 126 in the 2024 National Trauma Data Standard

**UNPLANNED INTUBATION\*** (HospitalEvents-UnplannedIntubation)

National & State Element  
**Data Format** [combo] single-choice

**NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs:string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

Yes No

**Additional Information**

- Must have occurred during the patient's initial stay at your hospital.
- In patients who were intubated in the element or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

Page 127 in the 2024 National Trauma Data Standard



## UNPLANNED VISIT TO THE OPERATING ROOM\*

### (HospitalEvents-UnplannedVisitToOR)

National & State Element

**Data Format** [combo] single-choice

#### NTDB/ImageTrend Description

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

#### EXCLUDE:

- Pre-planned, staged and/or procedures for incidental findings.
- Operative management related to a procedure that was initially performed prior to arrival at your center.
- Non-urgent tracheostomy and percutaneous endoscopic gastrostomy

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	HospitalComplication
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

#### Element Values

Yes

No

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital.

#### Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

#### National Element

Page 128 in the 2024 National Trauma Data Standard

**VENTILATOR-ASSOCIATED PNEUMONIA (VAP)\***  
**(HospitalEvents-VentilatorAssociatedPneumonia)**

National & State Element  
**Data Format** [combo] single-choice

**NTDB/ImageTrend Description**

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

AND

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

**VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):**

IMAGING TEST EVIDENCE	SIGNS/SYMPOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• <b>Pneumatoceles</b>, in <b>infants</b> ≤1 year old</li> </ul> <p>NOTE: In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest imaging test result is acceptable.</p>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• Leukopenia (≤4000 WBC/mm<sup>3</sup>) or leukocytosis (≥12,000 WBC/mm<sup>3</sup>)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least one of the following:</p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations (e.g., PaO<sub>2</sub>/FIO<sub>2</sub> ≤240), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Organism identified from blood</li> <li>• Organism identified from pleural fluid</li> <li>• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.)</li> <li>• ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)</li> <li>• Positive quantitative culture of lung tissue</li> <li>• Histopathologic exam shows at least <b>one</b> of the following evidences of pneumonia: <ul style="list-style-type: none"> <li>○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</li> <li>○ Evidence of lung parenchyma invasion by fungal hyphae or <b>pseudohyphae</b></li> </ul> </li> </ul>

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• <u>Pneumatoceles</u>, in <u>infants</u> ≤1 year old</li> </ul> <p>NOTE: In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest imaging test result is acceptable.</p>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• Leukopenia (≤4000 WBC/mm<sup>3</sup>) or leukocytosis (≥12,000 WBC/mm<sup>3</sup>)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations (e.g., PaO<sub>2</sub>/FIO<sub>2</sub> ≤240), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Virus, <u>Bordetella</u>, <u>Legionella</u>, <u>Chlamydia</u> or <u>Mycoplasma</u> identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).</li> <li>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, <u>Chlamydia</u>)</li> <li>• Fourfold rise in <u>Legionella pneumophila</u> serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA.</li> <li>• Detection of L. <u>pneumophila</u> serogroup 1 antigens in urine by RIA or EIA</li> </ul>

### VAP Algorithm (PNU3 Immunocompromised Patients):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• <b>Pneumatoceles</b>, in <b>infants</b> ≤1 year old</li> </ul> <p>NOTE: In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest imaging test result is acceptable.</p>	<p>Patient who is immunocompromised has at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> <li>• New onset of purulent sputum<sup>3</sup>, or change in character of sputum<sup>4</sup>, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea<sup>5</sup></li> <li>• Rales<sup>6</sup> or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations [e.g., PaO<sub>2</sub>/FiO<sub>2</sub> &lt;240]<sup>7</sup>, increased oxygen requirements, or increased ventilator demand)</li> <li>• Hemoptysis</li> <li>• Pleuritic chest pain</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Identification of matching <i>Candida</i> spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.<sup>11,12,13</sup></li> <li>• Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: <ul style="list-style-type: none"> <li>- Direct microscopic exam</li> <li>- Positive culture of fungi</li> <li>- Non-culture diagnostic laboratory test</li> </ul> </li> </ul> <p>Any of the following from:  <b>LABORATORY CRITERIA DEFINED UNDER PNU2</b></p>

**VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1-year-old:**

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

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

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

XSD Data Type	xs: string	XSD Element / Domain (Complex Type)	HospitalComplication
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

**Element Values**

Yes

No

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of pneumonia must be documented in the patient's medical record.

- Consistent with the January 2019 CDC defined VAP.

**Data Source**

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

**National Element**

Page 129 in the 2024 National Trauma Data Standard

## **(Complication) STATUS**

---

TR 23.15

**Data Format** [radio]

### **ImageTrend Description**

The status of the complication.

### **Element Values**

Open

Close

## **(Complication) OCCURRENCE DATE**

---

**Data Format** [date]

### **ImageTrend Description**

The date that the complication was first documented.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY



## **(Complication) OCCURRENCE TIME**

---

TR 23.20

**Data Format** [time]

### **ImageTrend Description**

The time that the complication was first documented.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM

**(Complication) LOCATION OF OCCURRENCE**

TR 23.19

**Data Format** [combo] single-choice

**ImageTrend Description**

The location that the complication occurred.

**Element Values**

Burn Unit	OR
Catherization Lab	Pre-Hospital
ED	PTA (Referring Hospital)
Floor Bed	Radiology
GI Lab	Readmit OR (planned OR)
ICU	Telemetry / Step-Down Unit

## **COMPLICATION STAFF INVOLVED**

---

TR 23.46

**Data Format** [combo] multiple-choice

### **ImageTrend Description**

Staff involved with the complication.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Press and hold "CTRL" key to select multiple values

## **(Complication) PR DATE**

---

TR 23.6

**Data Format** [date]

### **ImageTrend Description**

Complications peer review date.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY

## **(Complication) PR TIME**

---

TR23.18

**Data Format** [time]

### **ImageTrend Description**

Complications peer review time.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM

**(Complication) CORRECTIVE ACTION**

TR 23.9

**Data Format** [combo] single-choice

**ImageTrend Description**

The action taken based on the complication.

**Element Values**

- |                          |                          |
|--------------------------|--------------------------|
| Counseling               | Privilege/Credentialing  |
| Education                | Process Improvement Team |
| Guideline / Protocol     | Resource Enhancement     |
| Not Indicated            | Trend                    |
| Other                    | Unnecessary              |
| Peer Review Presentation |                          |

## **(Complication) OTHER CORRECTIVE ACTION**

---

TR 23.10

**Data Format** [text]

### **ImageTrend Description**

Any other action taken based on the complication.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Correction Action is "Other"

## **(Complication) DETERMINATION**

TR 23.11

**Data Format** [combo] single-choice

### **ImageTrend Description**

Indication as to what was determined to be cause the complication.

### **Element Values**

- Cannot be Determined
- Disease-Related
- Procedure-Related
- Provider-Related
- System-Related



**FURTHER EXPLANATION / ACTION (of Complication) TR 23.8**

---

**Data Format** [text]

**ImageTrend Description**

Further explanation of the complication.

**Element Values**

- Relevant value for data element

## **PREVENTABILITY (of Complication)**

---

TR 23.12

**Data Format** [combo] single-choice

### **ImageTrend Description**

Is the complication preventable?

### **Element Values**

- Cannot Be Determined
- Non-preventable
- Potentially Preventable
- Preventable

## **JUDGMENT (of Complication)**

TR 23.14

**Data Format** [combo] single-choice

### **ImageTrend Description**

Outcome of peer review of a complication.

### **Element Values**

- Acceptable
- Acceptable with Reservations
- Defer Peer Review
- Unacceptable
- Will Never Undergo PR

## **(COMPLICATION CORRESPONDENCE) STAFF**

TR 23.1.14

**Data Format** [combo] single-choice

### **ImageTrend Description**

Staff involved with the complication correspondence.

### **Element Values**

- Relevant value for data element

## **(Complication Correspondence) NOTE**

---

TR 23.1.15

**Data Format** [text]

### **ImageTrend Description**

Complication correspondence note.

### **Element Values**

- Relevant value for data element

## **(Complication Correspondence) SOURCE**

TR 23.1.13

**Data Format** [combo] single-choice

### **ImageTrend Description**

Complication correspondence source.

### **Element Values**

- Autopsy
- Patient/Family Concern/Comment
- Conversation
- PI Comm
- Daily Rounds
- Referrals
- EMS Run Sheet
- Risk Management Variance report
- Hospital Quality Department
- Staff Concern
- Medical Record

## **(Complication Correspondence) TYPE**

TR 23.1.12

**Data Format** [combo] single-choice

### **ImageTrend Description**

Complication correspondence type.

### **Element Values**

- Action Plan
- Process Concern
- Care Concern
- Primary Review
- Secondary Review
- Tertiary Review

## **(Complication Correspondence) GROUP**

TR 23.1.16

**Data Format** [combo] single-choice

### **ImageTrend Description**

Complication correspondence group.

### **Element Values**

- Neuro
- Peds
- Ortho
- Trauma
- Other



## **(Performance Improvement) STATUS**

TR 31.9

**Data Format** [radio]

### **ImageTrend Description**

The status of the QA peer review judgement.

### **Element Values**

Open

Close

**(Performance Improvement) OCCURRENCE DATE** TR 31.7

---

**Data Format** [date]

**ImageTrend Description**

The date that the performance improvement audit occurred.

**Element Values**

- Relevant value for data element

**Additional Information**

- Collected as MM/DD/YYYY

**(Performance Improvement) OCCURRENCE TIME** TR 31.18

---

**Data Format** [time]

**ImageTrend Description**

The time that the performance improvement audit occurred.

**Element Values**

- Relevant value for data element

**Additional Information**

- Collected as HHMM

## **(Performance Improvement) PR DATE**

---

TR 31.8

**Data Format** [date]

### **ImageTrend Description**

The QA indicator peer review date.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY

## **(Performance Improvement) PR TIME**

---

TR 31.19

**Data Format** [time]

### **ImageTrend Description**

The QA indicator peer review time.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as HHMM

## **FURTHER EXPLANATION / ACTION (of PI)**

---

TR 31.10

**Data Format** [text]

### **ImageTrend Description**

Further explanation of the Performance Improvement.

### **Element Values**

- Relevant value for data element

## **(PI CORRESPONDENCE) STAFF**

**TR31.14**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Staff involved with the performance improvement audit correspondence.

<b>XSD Data Type</b>	xs: string	<b>XSD Element/Domain (Simple Type)</b>	Correspondence_Staff
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	No
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element

## **(PI CORRESPONDENCE) NOTE**

---

TR 31.15

**Data Format** [text]

### **ImageTrend Description**

Performance Improvement audit correspondence note.

### **Element Values**

- Relevant value for data element



## **(PI Correspondence) SOURCE**

TR 31.13

Data Format [combo] single-choice

### **ImageTrend Description**

Performance Improvement audit correspondence source.

### **Element Values**

- Autopsy
- PI Comm
- Conversation
- Referrals
- Daily Rounds
- Risk Management Variance
- EMS Run Sheet
- Report
- Hospital Quality Department
- Staff Concern
- Medical Record
- Patient/Family Concern/Comment

## **(PI Correspondence) TYPE**

TR 31.12

**Data Format** [combo] single-choice

### **ImageTrend Description**

Performance Improvement audit correspondence type.

### **Element Values**

- Action Plan
- Process Concern
- Care Concern
- Primary Review
- Secondary Review
- Tertiary Review

## **(PI Correspondence) GROUP**

**TR 31.16**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Performance Improvement audit correspondence group.

### **Element Values**

- Neuro
- Peds
- Ortho
- Trauma
- Other

## **Outcome Information**

## HOSPITAL DISCHARGE SERVICE

TR 25.31

Data Format [combo] single-choice

### ImageTrend Description

The department that discharged the patient from the hospital.

### Element Values

Acute Rehabilitation Medicine	Neurology
Anesthesia	Neurosurgery
Bariatric	Obstetric
Burn	Oculoplastic
Cardiology	Ophthalmology
Cardiothoracic Surgery	Oral Maxillo Facial Surgery
Chemical Dependency	Orthopedic Surgery
Critical Care Medicine	Pain
Critical Care Surgery	Pediatric Cardiology
Dentistry	Pediatric Critical Care Medicine
Dermatology	Pediatric Dentistry
Ear Nose Throat	Pediatric Gastroenterology
Emergency Medicine	Pediatric Hematology Oncology
Endocrinology	Pediatric Hospitalist
Family Medicine	Pediatric Infectious Disease
Gastroenterology	Pediatric Neurology
General Pediatrics	Pediatric Orthopedic
General Surgery	Pediatric Pulmonary
Geriatric	Plastic Surgeon
Hand	Psychiatry
Hematology Oncology	Psychology
Infectious Disease	Pulmonary
Internal Medicine	Rheumatology
Kidney Transplant	Trauma Surgeon
Liver	Urology
Neonatal	Vascular Surgery
Nephrology	

### Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## HOSPITAL ADMISSION DATE

TR 25.33

**Data Format** [date]

### ImageTrend Description

Date patient was discharged from the ED (or arrived at the facility if the patient was a direct admit).

<b>XSD Data Type</b>	xs:string	<b>XSD Element/Domain (Simple Type)</b>	AdmissionDateTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

### Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## HOSPITAL ADMISSION TIME

TR 25.47

**Data Format** [time]

### ImageTrend Description

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

<b>XSD Data Type</b>	xs: string	<b>XSD Element/Domain (Simple Type)</b>	AdmissionTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

### Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **HOSPITAL DISCHARGE DATE (ORDERS WRITTEN) \* TR 25.93**

National & State Element  
**Data Format** [date]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: date	<b>XSD Element/Domain (Complex Type)</b>	HospitalDischargeOrdersWrittenDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element
- Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to hospital discharge)

### **Additional Information**

- Collected as YYYY-MM-DD.
- If multiple orders were written, report the final disposition order date.
- 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**

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

### **National Element**

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## **HOSPITAL DISCHARGE TIME (ORDERS WRITTEN) \* TR 25.94**

National & State Element  
**Data Format** [time]

### **NTDB/ImageTrend Description**

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

<b>XSD Data Type</b>	xs: time	<b>XSD Element/Domain (Complex Type)</b>	HospitalDischargeOrdersWrittentime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element
- Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to hospital discharge)

### **Additional Information**

- Collected as HHMM
- If multiple orders were written, report the final disposition order 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**

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

### **National Element**

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## **HOSPITAL DISCHARGE DATE (PHYSICAL EXIT)**

TR 25.34

**Data Format** [date]

### **ImageTrend Description**

The date the patient physically left the hospital.

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	HospitalPhysicalDischargeDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 1990	<b>Max. Constraint:</b> 2030

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Collected as MM/DD/YYYY
- The null value "Not Applicable" is used if ED Discharge Disposition = 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**

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

## HOSPITAL DISCHARGE TIME (PHYSICAL EXIT)

TR 25.48

Data Format [time]

### ImageTrend Description

The time the patient physically left the hospital.

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	HospitalPhysicalDischargeTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes	<b>Min. Constraint:</b> 00:00	<b>Max. Constraint:</b> 23:59

### Element Values

- Relevant value for data element

### Additional Information

- Collected as HH:MM military time
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge)
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/expired)
- The null value "Not Applicable" is used if ED Discharge Disposition = 4,6,9,10 or 11
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate

### Data Source

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

## TOTAL ICU DAYS\*

TR 26.9

National & State Element

**Data Format** [number]

### NTDB Description

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

### ImageTrend Description

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

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)		TotalIcuLos
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values	
Required in XSD	Yes	Min. Constraint: 1	Max. Constraint: 400	

### Element Values

- Relevant value for data element

### Additional Information

- Recorded in full day increments with any partial day listed 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 used 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 Total ICU LOS exceed the Hospital LOS
- The null value "Not Applicable" is used if the patient had no ICU days according to the above definition.

### Data Source

- ICU Flow Sheet
- Nursing Notes/Flow Sheet

### National Element

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## TOTAL VENTILATOR DAYS\*

TR 26.58

National & State Element

**Data Format** [number]

### NTDB Description

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

### ImageTrend Description

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

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)		TotalVentDays
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values	
Required in XSD	Yes	Min. Constraint: 1	Max. Constraint: 400	

### Element Values

- Relevant value for data element

### Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator hours.
- Recorded in full day increments with any partial calendar day county 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 used if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS
- The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.

### Data Source

- Respiratory Therapy Notes/Flow Sheet
- ICU Flow Sheet
- Progress Notes

### National Element

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## DISABILITY AT DISCHARGE - FEEDING

TR 26.54

Data Format [combo] single-choice

### ImageTrend Description

A score calculated to derive a baseline of trauma patient feeding disability at discharge from an acute care facility.

### Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

### Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Assess as close to discharge as possible. Includes using suitable utensils to bring food to mouth, chewing, and swallowing (once meal is appropriately prepared). Opening containers, cutting meat, buttering bread and pouring liquids are not included as they are often part of meal preparation.
- Dependent-total help required: Either performs less than half of feeding tasks or does not eat or drink full meals by mouth and relies at least in part on other means of alimentation, such as parenteral or gastrostomy feedings.
- Dependent-partial help required: Performs half or more of feeding tasks but requires supervision (e.g., standby, cueing, or coaxing) setup (application of Orthopedics), or other help.
- Independent with device: Uses an adaptive or assisting device such as a straw, spork, or rocking knives, or requires more than a reasonable time to eat.
- Independent: Eats from a dish and drinks from a cup or glass presented in the customary manner on table or tray. Uses ordinary knife, fork, and spoon.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

### Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

## **DISABILITY AT DISCHARGE - LOCOMOTION**

TR 26.55

Data Format [combo] single-choice

### **ImageTrend Description**

A score calculated to derive a baseline of trauma patient locomotion (independence) disability at discharge from an acute care facility.

### **Element Values**

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

### **Additional Information**

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes walking once in a standing position, or using a wheelchair, once in a seated position, indoors
- Dependent - total help required: Performs less than half of locomotion effort to go a minimum of 50 feet or does not walk or wheel a minimum of 50 feet. Requires assistance of one or more persons.
- Dependent - partial help required: If walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet, or walks independently only short distances (a minimum of 50 feet). If not walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet in wheelchair, or operates manual or electric wheelchair independently only short distances (a minimum of 50 feet).
- Independent with Device: Walks a minimum of 150 feet but uses a brace or prosthesis on leg, special adaptive shoes, cane, crutches, or walker; takes more than a reasonable time; or there are safety considerations. If not walking, operates manual or electric wheelchair independently for a minimum of 150 feet; turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; maneuvers on rugs and over doorsills.
- Independent: Walks a minimum of 150 feet without assisting devices. Does not use a wheelchair. Performs safely.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

## **DISABILITY AT DISCHARGE - EXPRESSION (MOTOR) TR 26.56**

---

**Data Format** [combo] single-choice

### **ImageTrend Description**

A score calculated to derive a baseline of trauma patient motor (expression) disability at discharge from an acute care facility.

### **Element Values**

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

### **Additional Information**

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes clear expression of verbal or nonverbal language. This means expressing linguistic information verbally or graphically with appropriate and accurate meaning and grammar
- Dependent - total help required: Expresses basic needs and ideas less than half of the time. Needs prompting more than half the time or does not express basic needs appropriately or consistently despite prompting
- Dependent - partial help required: Expresses basic needs and ideas about everyday situations half (50%) or more than half of the time. Requires some prompting, but requires that prompting less than half (50%) of the time
- Independent with Device: Expresses complex or abstract ideas with mild difficulty. May require an augmentative communication device or system
- Independent: Expresses complex or abstract ideas intelligibly and fluently, verbal or nonverbal, including signing or writing
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form



## HOSPITAL DISCHARGE DISPOSITION\*

TR 25.27

National & State Element  
Data Format [combo] single-choice

### NTDB/ImageTrend Description

The disposition of the patient when discharged from the hospital.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type):</b> HospitalDischargeDisposition	
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

1. Discharged/Transferred to a short-term general hospital for inpatient care.
2. Discharged/Transferred to an Intermediate Care Facility (ICF)
3. Discharged/Transferred to home under care of organized home health service.
4. Left against medical advice (AMA) or discontinued care.
5. Deceased/Expired
6. Discharged to home or self-care (routine discharge)
7. Discharged/Transferred to Skilled Nursing Facility (SNF)
8. Discharged/Transferred to hospice care.
9. Discharged/Transferred to court/law enforcement.
10. Discharged/Transferred to inpatient rehab or designated unit.
11. Discharged/Transferred to Long Term Care Hospital (LTCH)
12. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
13. Discharged/Transferred to another type of institution not defined elsewhere.

### Additional Information

- If multiple orders were written, report the final disposition order.
- 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 must be reported as Element Value "6. Discharged to home or self-care (routine discharge)."
- Disposition to any other medical facility must be reported as Element Value "14. Discharged/ Transferred to another type of institution not defined elsewhere."
- The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Value 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 number gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

**Data Source**

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

**National Element**

Page 138 in from the 2024 National Trauma Data Standard

## **HOSPITAL TRANSFERRED TO**

**TR 25.35**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Name of the receiving facility the patient was transferred to.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Hospital Disposition "Acute Care Hospital", "Burn Care Facility", or "Rehab or long-term facility" is selected.

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **(Other) FACILITY (Transferred to)**

TR 25.39

**Data Format** [text]

### **ImageTrend Description**

Any other identifying facility not found on the available list of options to which the patient was discharged.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Hospital Transferred to "Other" is selected

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **(Other) CITY (Transferred to)**

TR 25.40

**Data Format** [text]

### **ImageTrend Description**

The city in which the transfer facility is located.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Hospital Transferred to "Other" is selected

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **(Other) STATE (Transferred to)**

TR 25.41

**Data Format** [text]

### **ImageTrend Description**

The state in which the transfer facility is located.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Hospital Transferred to "Other" is selected

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **(Discharge) TRANSPORT MODE**

TR 25.43

**Data Format** [combo] single-choice

### **ImageTrend Description**

Hospital discharge transport mode.

### **Element Values**

- Ambulance
- Helicopter
- Fixed Wing
- Police
- Private Vehicle

### **Additional Information**

- Only completed if Hospital Disposition "Acute Care Hospital" is selected

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **DISABILITY AT DISCHARGE - FIM SCORE**

**TR 26.61**

**Data Format** [number]

### **ImageTrend Description**

A score calculated (by adding together the Feeding, Independence, and Motor scores) to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression)

### **Element Values**

- Relevant value for data element
- Auto-calculated by combining Feeding, Locomotion, and Motor scores when entered

### **Data Source**

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form



## **LOCATION OF DEATH**

**TR 25.30**

**Data Format** [combo] single-choice

### **ImageTrend Description**

The location where the patient died.

### **Element Values**

- ICU
- OR
- Floor
- Prior to Arrival
- ER

### **Additional Information**

- Only completed if Hospital Disposition is "Expired"

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## **DATE & TIME OF DEATH**

**TR 25.36**

**Data Format** [Date] [Time]

### **ImageTrend Description**

Date and time the patient died.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Hospital Disposition is "Expired"

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

## DEATH CIRCUMSTANCE

TR 25.32

Data Format [combo] single-choice

### ImageTrend Description

Indicates patient's primary cause of death.

#### Element Values

Brain Injury	Thoracic Aortic Transection
Burn Shock	Trauma Shock
Cardio Failure	Treatment Withheld
Drowning	Brain Death
Electrocution	Sepsis
Heart Laceration	Cardiac Arrest due to
Liver Laceration	Strangulation
Multiple Organ	Cardiac Arrest
Failure/Metabolic	Family D/C Life Support
Other	Medical
Pre-Existing Illness	Multisystem Trauma
Pulmonary Failure	Trauma Wound
Pulmonary Failure/Sepsis	

### Additional Information

- Only completed if Hospital Disposition is "Expired"

### Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Autopsy Report

## **OTHER (Death Circumstance) DESCRIPTION**

TR 25.45

**Data Format** [text]

### **ImageTrend Description**

The circumstance under which the patient died.

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Only completed if Death Circumstance is "Other"

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Autopsy Report

## **ORGAN DONATION**

**TR 25.29**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Were organs/tissue donated? - To make a gift of a differentiated structure (as a heart, kidney, leaf, or stem) consisting of cells and tissues and performing some specific function in an organism.

### **Element Values**

Yes

No

Tissue Donation

### **Additional Information**

- Only completed if Hospital Disposition is "Expired"

### **Data Source**

- Hospital Documentation

## **AUTOPSY PERFORMED**

**TR 25.37**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Was an autopsy performed? - An examination of a body after death to determine the cause of death or the character and extent of changes produced by disease.

### **Element Values**

Yes                      No

### **Additional Information**

- Only completed if Hospital Disposition is "Expired"

### **Data Source**

- Hospital Documentation

## **ADVANCED DIRECTIVE**

**TR 25.28**

**Data Format** [combo] single-choice

### **ImageTrend Description**

Determination whether the patient had an Advanced Directive.

### **Element Values**

Yes                      No

### **Additional Information**

- Only completed if Hospital Disposition is "Expired"

### **Data Source**

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

# TRAUMA QUALITY IMPROVEMENT PROGRAM

## Measures for Processes of Care

The elements in this section should be reported by Level 1 and Level 2 TQIP participating centers **ONLY**. Please contact us at [indianatrauma@isdh.IN.gov](mailto:indianatrauma@isdh.IN.gov) if you have question or at [tqip@facs.org](mailto:tqip@facs.org) for information about joining TQIP



## HIGHEST GCS TOTAL

TR 39.1

Data Format [combo] single-choice

### NTDB Description

Highest total GCS score on calendar day after ED/hospital arrival.

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	TBI: HighestTotalGcs
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

Commented [NT1]: TBI?

### Element Values

- Relevant value for data element

### Additional Information

- Refers to highest total GCS on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival.
- If patient is intubated, then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", report this as GCS of 15 IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day

### Data Source

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

### National Element

Page 142 in the 2024 National Trauma Data Standard.

## HIGHEST GCS MOTOR

TR 39.2

Data Format [combo] single-choice

### NTDB Description

Highest GCS motor on calendar day after ED/hospital arrival.

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)	TBIGcsMotor
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

### Element Values

Pediatric (≤ 2 years):

No motor response	Withdrawal from pain
Extension to pain	Localizing pain
Flexion to pain	Appropriate response to stimulation

Adult

No motor response	Withdrawal from pain
Extension to pain	Localizing pain
Flexion to pain	Obeys commands

### Additional Information

- Refers to highest GCS motor on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- Requires review of all data sources to obtain the highest GCS motor on the calendar day after ED/hospital arrival.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS 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. For example, 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 that do not meet the reporting criterion. The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Motor, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

### Data Source

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

### National Element

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## GCS Assessment (Qualifier Component) of Highest GCS TOTAL

TR 39.3

Data Format [combo] single-choice

### NTDB Description

Documentation of factors potentially affecting the highest GCS on calendar day after ED/hospital arrival.

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

XSD Data Type	xs: integer	XSD Element / Domain (Complex Type)	TB GcsQualifier
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

Commented [NT2]: TBI?

### Element Values

- Patient chemically sedated or paralyzed
- Obstruction to the patient's eye
- Patient intubated
- Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye

### Additional Information

- Refers to highest GCS assessment qualifier score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element does not apply to self-medication the patient may have administered (i.e. ETOH, prescriptions, etc.).
- Must be the assessment qualifier for the Highest GCS Total on calendar day after ED/hospital arrival.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then

the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be reported.

- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Report all that apply.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

#### **Data Source**

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes
- Medication Summary

#### **National Element**

Page 145 in the 2024 National Trauma Data Standard

*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

## HIGHEST GCS 40 - MOTOR

TR 39.40.2

Data Format [combo] single-choice

### NTDB Description

Highest GCS 40 motor on calendar day after ED/hospital arrival.

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	TBI Gcs40Motor
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

Commented [NT3]: TBI?

### Element Values

#### Adult:

None	Normal Flexion
Extension	Localizing
Abnormal Flexion	Obeys commands
	Not Testable

#### Pediatric < 5 years:

None	Localizes Pain
Extension to Pain	Obeys Commands
Flexion to Pain	Not Testable

### Additional Information

- Refers to highest GCS 40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS 40 motor score on the calendar day after ED/hospital arrival.
- If a patient does not have a numeric GCS 40 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 opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be reported, IF there is no other contradicting documentation.)

- Report Element Value “0. Not Testable” if unable to assess (e.g. neuromuscular blockade).
- The null value “Not Known/Not Recorded” is reported if Highest GCS – Motor is reported.
- If reporting Highest GCS 40 – Motor, the null value “Not Applicable” is reported if the patient’s ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

**Data Source**

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

**National Element**

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*\*Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*



## MIDLINE SHIFT

### NTDB Description

>5mm shift of the brain past its center line within 24 hours after time of injury

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	TBIMidlineShift
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes                      Not Imaged (e.g. CT Scan, MRI)                      No

### Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, report element value "1. Yes."
- Radiological and surgical documentation from transferring facilities should be considered for this data element.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the element value "1. Yes" if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the element value "3. Not Imaged (e.g. CT Scan, MRI)."

### Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet
5. Hospital Discharge Summary

### National Element

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## CEREBRAL MONITOR

TR 39.4

Data Format [combo] single-choice

### NTDB Description

Indicate all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), licox monitor, jugular venous bulb.

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

<b>XSD Data Type</b>	xs: integer		<b>XSD Element / Domain (Complex Type)</b>	TBICerebralMonitor
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

### Element Values

- Intraventricular drain/catheter (e.g. ventriculostomy; external ventricular drain)
- Intraparenchymal pressure monitor (e.g. Camino bolt, subarachnoid bolt, intraparenchymal catheter)
- Intraparenchymal oxygen monitor (e.g. Licox)
- Jugular venous bulb
- None

### Additional Information

- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Report all that apply.

### Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

### National Element

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## CEREBRAL MONITOR DATE

TR 39.5

Data Format [combo] single-choice

### NTDB Description

Date of first cerebral monitor placement.

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>	TBI CerebralMonitorDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

Commented [NT4]: TBI

### Element Values

- Relevant value for data element

### Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor date must be the date of insertion at the referring facility.

### Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

### National Element

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## CEREBRAL MONITOR TIME

TR 39.6

Data Format [combo] single-choice

### NTDB Description

Time of first cerebral monitor placement.

\*\* Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). \*\*

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	TBICerebralMonitorTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor time must be the time of insertion at the referring facility.

### Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

### National Element

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**VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE** **TR40.1**

**Data Format** [combo] single-choice

**NTDB Description**

Type of first dose of venous thromboembolism prophylaxis administered to patient at your hospital.

EXCLUDE:

- Sequential compression devices

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>		VteProphylaxisType
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

**Element Values**

Xa Inhibitor (Rivaroxaban, etc.)

None

LMWH (Daktarin, Enoxaparin, etc.)

Other

Direct Thrombin Inhibitor (Dabigatran, etc.)

Unfractionated Heparin (UH)

**Additional Information**

- Element Value "5. None" is reported if the first dose of Venous Thromboembolism Prophylaxis is administered post discharge order date/time.
- Element Value "5. None" is reported for patients who refuse VTE prophylaxis
- Venous Thromboembolism Prophylaxis Types 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 Venous Thromboembolism Prophylaxis Types.
- Element Value "10. Other" is reported if "Coumadin" and/or "aspirin" are given as Venous Thromboembolism Prophylaxis.

**Data Source Hierarchy Guide**

1. Medication Summary
2. Nursing Notes/Flow Sheet
3. Pharmacy Record

**National Element**

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## **VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE TR40.2**

**Data Format** [combo] single-choice

### **NTDB Description**

Date of administration of first dose of VTE prophylaxis administered to patient at your hospital

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>		VteProphylaxisDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Reported as YYYY-MM-DD.
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type element.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

### **Data Source**

1. Medication Summary
2. Nursing Notes/Flow Sheet

### **National Element**

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## **VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME TR40.3**

**Data Format** [combo] single-choice

### **NTDB Description**

Time of administration of first dose of VTE prophylaxis administered to patient at your hospital

\*\* Reporting Criterion: Report all on patients\*\*

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>		VteProphylaxisTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Reported as HH:MM military time.
- Refers to date upon which patient first received the prophylactic agent indicated in Venous Thromboembolism Prophylaxis Type.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

### **Data Source**

1. Medication Summary
2. Nursing Notes/Flow Sheet

### **National Element**

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## PACKED RED BLOOD CELLS

TR22.22

**Data Format** [combo] single-choice

### NTDB Description

Volume of packed red blood cells transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

### EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell saver blood.

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Comple Type)</b>	TransfusionBlood4Hours
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Refers to amount of transfused packed red blood cells (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no packed red blood cells were given, then volume reported must be 0 (zero).

### Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

### National Element

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## WHOLE BLOOD

**Data Format** [combo] single-choice

### NTDB Description

Volume of whole blood transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

### EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell saver blood

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	WholeBlood4Hours
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Refers to amount of transfused whole blood (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no whole blood was given, then volume reported must be 0 (zero).

### Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

### National Element

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## PLASMA

TR40.5

Data Format [combo] single-choice

### NTDB Description

Volume of plasma (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival

#### EXCLUDE:

- Plasma transfusing upon patient arrival.
- Cell saver blood.

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	TransfusionPlasma4Hours
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no plasma was given, then volume reported must be 0 (zero).

### Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

### National Element

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## PLATELETS

TR40.6

Data Format [combo] single-choice

### NTDB Description

Volume of platelets (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival

### EXCLUDE:

- Platelets transfusing upon patient arrival.
- Cell saver blood.

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	TransfusionPlatelets4Hours
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Refers to amount of transfused platelets (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no platelets were given, then volume reported must be 0 (zero).

### Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

### National Element

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## **CRYOPRECIPTIATE (4 Hours)**

**TR 40.7**

**Data Format** [combo] single-choice

### **NTDB Description**

Volume of solution enriched with clotting factors transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

### **EXCLUDE:**

- Cryoprecipitate transfusing upon patient arrival.
- Cell saver blood.

\*\* Reporting Criterion: Report on all patients\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	Cryoprecipitate4Hours
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no cryoprecipitate was given, then volume reported must be 0 (zero).

### **Data Source**

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

### **National Element**

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## ANGIOGRAPHY

TR 40.12

Data Format [combo] single-choice

### NTDB Description

First interventional angiogram for hemorrhage control within first 24 hours of ED/hospital arrival

### EXCLUDE:

- Computerized tomographic angiography (CTA).

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	Angiography
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

None                                      Angiogram with embolization  
Angiogram only                              Angiogram with stenting

### Additional Information

- Limit reporting angiography data to the first 24 hours following ED/hospital arrival.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Only report Element Value "4. Angiogram with stenting" if stenting was performed specifically for hemorrhage control.

### Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

### National Element

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## EMBOLIZATION SITE

TR 40.18

Data Format [combo] single-choice

### NTDB Description

Organ/site of embolization for hemorrhage control.

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	EmbolizationSite
<b>Multiple Entry Configuration</b>	Yes, max 7	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Liver	Retroperitoneum (lumbar, sacral)
Spleen	Peripheral vascular (neck, extremities)
Kidneys	Other
Pelvic (iliac, gluteal, obturator)	

### Additional Information

- Report all that apply.
- The null value "Not Applicable" is reported if Angiography is Element Value "1. None," "2. Angiogram only," or "4. Angiogram with stenting."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Embolization Sites 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 Embolization Sites.

### Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

### National Element

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## ANGIOGRAPHY DATE

TR 40.13

Data Format [combo] single-choice

### NTDB Description

Date the first angiogram with or without embolization was performed.

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

<b>XSD Data Type</b>	xs: date	<b>XSD Element / Domain (Complex Type)</b>		AngiographyDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values	
<b>Required in XSD</b>	Yes			

### Element Values

- Relevant value for data element

### Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Angiography is Element Value "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start date is the date of needle insertion in the groin.

### Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

### National Element

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## ANGIOGRAPHY TIME

TR 40.14

Data Format [combo] single-choice

### NTDB Description

Time the first angiogram with or without embolization was performed.

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	AngiographyTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Angiography is Element Value "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start time is the time of needle insertion in the groin.

### Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

### National Element

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**SURGERY FOR HEMORRHAGE CONTROL TYPE** **TR 40.19**  
**Data Format** [combo] single-choice

**NTDB Description**

First type of surgery for hemorrhaged control within the first 24 hours of ED/hospital arrival.

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

<b>XSD Data Type</b>	xs: integer	<b>XSD Element / Domain (Complex Type)</b>	HemorrhageControlSurgeryType
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

**Element Values**

- None
- Extremity
- Laparotomy
- Neck
- Thoracotomy
- Mangled extremity/traumatic amputation
- Sternotomy
- Other skin/soft tissue (e.g. scalp laceration)
- Extraperitoneal Pelvic Packing

**Additional Information**

- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Element Value "1. None" is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option.

**Data Source**

1. Operative Reports
2. Procedure Notes
3. Progress Notes

**National Element**

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## **SURGERY FOR HEMORRHAGE CONTROL DATE TR 40.20**

**Data Format** [combo] single-choice

### **NTDB Description**

Date of first surgery for hemorrhaged control within the first 24 hours of ED/hospital arrival.

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

<b>XSD Data Type</b>	xs: Date	<b>XSD Element / Domain (Complex Type)</b>	HemorrhageControlSurgeryDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

- Relevant value for data element

### **Additional Information**

- Reported as YYYY-MM-DD.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start date is defined as the date the incision was made (or the procedure started).

### **Data Source**

1. Operative Reports
2. Procedure Notes
3. Progress Notes

### **National Element**

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## SURGERY FOR HEMORRHAGE CONTROL TIME

TR 40.21

Data Format [combo] single-choice

### NTDB Description

Time of first surgery for hemorrhaged control within the first 24 hours of ED/hospital arrival.

\*\* Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival\*\*

XSD Data Type	xs: Time	XSD Element / Domain (Complex Type)	HemorrhageControlSurgeryTime
Multiple Entry Configuration	No	Accepts Null Value	Yes, common null values
Required in XSD	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as HH:MM military time.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start time is defined as the time the incision was made (or the procedure started).

### Data Source

1. Operative Reports
2. Procedure Notes
3. Progress Notes

### National Element

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## **WITHDRAWAL OF LIFE SUPPORTING TREATMENT TR 40.15**

**Data Format** [combo] single-choice

### **NTDB Description**

Treatment was withdrawn based on a decision to either remove or withhold further life supporting intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next to kin.

\*\* Reporting Criterion: Report on all patients \*\*

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	WithdrawalOfLifeSupportingTreatment
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### **Element Values**

Yes

No

### **Additional Information**

- Do-not-resuscitate (DNR) order not a requirement.
- A note to limit escalation of treatment qualifies as a withdrawal of life supporting treatment. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-supporting intervention (e.g. intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of life supporting treatment.
- Element Value "2. No" should be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care.

### **Data Source**

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

### **National Element**

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## WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE      TR 40.16

**Data Format** [combo] single-choice

### NTDB Description

The date treatment was withdrawn

\*\* Reporting Criterion: Report on all patients \*\*

<b>XSD Data Type</b>	xs: Date	<b>XSD Element / Domain (Complex Type)</b>	WithdrawalOfLifeSupportingTreatmentDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the date the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life supporting intervention(s) occurs (e.g. intubation).

### Data Source

1. Physician Order
2. Progress Order
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

### National Element

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## WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME TR 40.17

**Data Format** [combo] single-choice

### NTDB Description

The time treatment was withdrawn

\*\* Reporting Criterion: Report on all patients \*\*

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	WithdrawalOfLifeSupportingTreatmentTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the time the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life supporting intervention(s) occurs (e.g. intubation).

### Data Source

1. Physician Order
2. Progress Order
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

### National Element

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## ANTIBIOTIC THERAPY

TR 18.189

Data Format [combo] single-choice

### NTDB Description

Intravenous antibiotic therapy was administered to the patient within 24 hours after injury.

\*\* Reporting Criterion: Report on all patients with any open fracture(s)\*\*

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	AntibioticTherapy
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

Yes

No

### Additional Information

- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

### Data Source

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

### National Element

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## ANTIBIOTIC THERAPY DATA

TR 18.190

Data Format [combo] single-choice

### NTDB Description

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

\*\* Reporting Criterion: Report on all patients with any open fracture(s)\*\*

<b>XSD Data Type</b>	xs: Date	<b>XSD Element / Domain (Complex Type)</b>	AntibioticTherapyDate
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported as YYYY-MM-DD
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Applicable" is reported if Antibiotic Therapy is Element Value "2. No".
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

### Data Source

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

### National Element

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## ANTIBIOTIC THERAPY TIME

TR 18.190.1

Data Format [combo] single-choice

### NTDB Description

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

\*\* Reporting Criterion: Report on all patients with any open fracture(s)\*\*

<b>XSD Data Type</b>	xs: time	<b>XSD Element / Domain (Complex Type)</b>	AntibioticTherapyTime
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Reported HH:MM military time
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Applicable" is reported if Antibiotic Therapy is Element Value "2. No".
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

### Data Source

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

### National Element

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## **Surgeon Specific Reporting - Optional**

## NATIONAL PROVIDER IDENTIFIER (NPI)

**Data Format** [combo] single-choice

### NTDB Description

The National Provider Identifier (NPI) of the admitting surgeon.

\*\* Reporting Criterion: Report on all patients with any open fracture(s)\*\*

<b>XSD Data Type</b>	xs: string	<b>XSD Element / Domain (Complex Type)</b>	NationalProviderIdentifier
<b>Multiple Entry Configuration</b>	No	<b>Accepts Null Value</b>	Yes, common null values
<b>Required in XSD</b>	Yes		

### Element Values

- Relevant value for data element

### Additional Information

- Must be stored as a 10-digit numeric value.
- This variable is considered optional and is not required as part of the NTDS dataset.
- The null value "Not Applicable" is reported if this optional element is not being reported.

### Data Source

1. Medical Record

### National Element

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## Regarding Injury Severity Score (ISS) and Abbreviated Injury Score (AIS)\*

In ImageTrend, the ISS is calculated from the AIS codes by using the AIS region and severity that is associated with the AIS code. The AIS codes are entered along with a corresponding ICD-10.

When an ICD-10 code is added to a patient, the ImageTrend Patient Registry can show the registrar the AIS code used frequently with the diagnosis. If the registrar agrees with the stated code, they can click the **add** button. When the Diagnosis and AIS are added, the system will automatically update the ISS and Probability of Survival. (Below)

**Diagnosis List**

ICD-9 Code	Diagnosis Name	AIS Code	AIS Description	AIS Version	ISS Region	Order
ICD-9 Code: <input type="text"/>	<input type="button" value="ICD9 Lookup"/>			AIS 05 Code: <input type="text"/>	<input type="button" value="AIS Lookup"/>	
<input type="button" value="Add Diagnosis"/> <input type="button" value="Save Order"/>						

**ICD 10 Diagnosis**

Type keyword(s) or ICD-10 code #, i.e.:S42 initial open humerus

Comments:

Code	Description	AIS	AIS Description	AIS Version	ISS Region
No Records					

**Injury-Related Scores**

AIS Based Injury Severity Scores by Diagnosis

ISS Region	Head	Face	Chest	Abdomen	Extremity	External	ISS
Calculated	0	0	0	0	0	0	0
Manual	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	N/A

Age: RTS:

Probability of Survival: N/A \* Not Calculable

Manual Probability of Survival: N/A \* Not Calculable

New Injury Severity Score: 0

\* NISS is based on the diagnosis list entered above.

The ImageTrend Patient Registry use the AIS 05 with updates from 2008. Also, in addition to calculating the ISS, the New Injury Severity Score (NISS) will also be calculated.

**Appendix 1: Edit Checks for the National Trauma  
Data Standard Data Elements**

The flags described in this Appendix are those that are produced by the Validator when an NTDS XML file is checked. Each rule ID is assigned a flag level 1 – 4. Level 1 and 2 flags must be resolved, or the entire file cannot be submitted to NTDB. Level 3 and 4 flags serve as recommendations to check data elements associated with the flags. However, level 3 and 4 flags do not necessarily indicate that data are incorrect.

The Flag Levels are defined as follows:

- **Level 1: Format / schema\*** – any element that does not conform to the “rules” of the XSD.  
That is, these are errors that arise from XML data that cannot be parsed or would otherwise not be legal XML. Some errors in this Level do not have a Rule ID – for example: illegal tag, commingling of null values and actual data, out of range errors, etc.
- **Level 2: Inclusion criteria and/or critical to analyses\*** – this level affects the elements needed to determine if the record meets the inclusion criteria for NTDB or are required for critical analyses.
- **Level 3: Major logic** – data consistency checks related to variables commonly used for reporting. Examples include Arrival Date, E-code, etc.
- **Level 4: Minor logic** – data consistency checks (e.g. dates) and blank fields that are acceptable to create a “valid” XML record but may cause certain parts of the record to be excluded from analysis.

**Important Notes:**

- Any XML file submitted to NTDB that contains one or more Level 1 or 2 Flags will result in the entire file being rejected. These kinds of flags must be resolved before a submission will be accepted.
- Facility ID, Patient ID and Last Modified Date/Time are not described in the data dictionary and are only required in the XML file as control information for back-end NTDB processing. However, these elements are mandatory to provide in every XML record. Consult your Registry Vendor if one of these flags occurs.

## Demographic Information

### PATIENT'S HOME ZIP/POSTAL CODE

#### Rule ID Level Message

0001 1 Invalid value  
0002 2 Element cannot be blank  
0040 1 Single Entry Max exceeded

### PATIENT'S HOME COUNTRY

#### 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 any response other than "Not Applicable" or "Not Known/Not Recorded"  
0140 1 Single Entry Max exceeded

### PATIENT'S HOME STATE

#### Rule ID Level Message

0201 1 Invalid value (US only)  
0202 2 Element cannot be blank (US only)  
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

#### 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

### PATIENT'S HOME CITY

#### Rule ID Level Message

0401 1 Invalid value (US only)  
0402 2 Element cannot be blank  
0404 2 Element must be Not Applicable (Non-US hospitals only)  
0405 2 Element must be Not Applicable when Patient's Home Zip/Postal Code is reported  
0440 1 Single Entry Max exceeded

### ALTERNATE HOME RESIDENCE

#### 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

#### **DATE OF BIRTH**

##### **Rule ID Level Message**

0601 1 Invalid value  
0602 1 Date out of range  
0603 2 Element cannot be blank  
0612 2 Date of Birth + 120 years must be less than Injury Date  
0613 2 Element cannot be Not Applicable  
0640 1 Single entry exceeded

#### **AGE**

##### **Rule ID Level Message**

0701 1 Age is outside the valid range of 0 - 120  
0703 2 Element cannot be blank  
0705 4 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 Element must be and can only be "Not Applicable" if date of Birth is reported unless Date of Birth is the same as ED/Hospital Arrival Date  
0740 1 Single Entry Max exceeded

#### **AGE UNITS**

##### **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  
0810 2 Element must be and can only be "Not Applicable" if **Age** is "Not Applicable"  
0840 1 Single Entry Max exceeded

#### **RACE**

##### **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 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value  
0950 1 Multiple Entry Max exceeded

## **ETHNICITY**

### **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

## **SEX**

### **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

## **Injury Information**

### **INJURY INCIDENT DATE**

#### **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
- 1211 2 Element cannot be "Not Applicable"
- 1212 3 Injury Incident Date is greater than 14 days earlier than ED/ hospital
- 1240 1 Single Entry Max exceeded

### **INJURY INCIDENT TIME**

#### **Rule ID Level Message**

- 1301 1 Time is not valid
- 1302 1 Time out of range
- 1303 2 Element cannot be blank
- 1310 2 Element cannot be Not Applicable
- 1340 1 Single Entry Max exceeded

### **WORK-RELATED**

#### **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

### **PATIENT'S OCCUPATIONAL INDUSTRY**

#### **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

#### **PATIENT'S OCCUPATION**

##### **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 report if Work-Related is "2. No"  
1640 1 Single Entry Max exceeded

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

##### **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 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE**

##### **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

#### **ICD-10 ADDITIONAL EXTERNAL CAUSE CODE**

##### **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  
9106 2 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any value"  
9140 1 Multiple Entry Max exceeded

## **INCIDENT LOCATION ZIP/POSTAL CODE**

### **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

## **INCIDENT COUNTRY**

### **Rule ID Level Message**

2101 1 Invalid value  
2102 2 Element cannot be blank  
2104 2 Element cannot be Not Applicable  
2105 2 Element cannot be "Not Known/Not Recorded" when Incident Location ZIP/Postal Code is any response other than "Not Known/Not Recorded" Code is not "Not Known/Not Recorded"  
2140 1 Single Entry Max exceeded

## **INCIDENT STATE**

### **Rule ID Level Message**

2201 1 Invalid value  
2203 2 Element cannot be blank  
2204 2 Element must be Not Applicable (Non-US hospitals)  
2205 2 Element must be Not Applicable when Incident Location Zip/Postal Code is documented  
2240 1 Single Entry Max exceeded

## **INCIDENT COUNTRY**

### **Rule ID Level Message**

2301 1 Invalid value (US only)  
2303 2 Element cannot be blank  
2304 2 Element must be Not Applicable (Non-US hospitals)  
2305 2 Element must be Not Applicable when Incident Location Zip/Postal code is reported  
2340 1 Single Entry Max exceeded

## **INCIDENT CITY**

### **Rule ID Level Message**

2401 1 Invalid value  
2403 2 Element cannot be blank  
2404 2 Element must be Not Applicable (Non-US hospitals)  
2405 2 Element must be Not Applicable when Incident Location Zip/Postal Code is reported  
2440 1 Single Entry Max exceeded

## **PROTECTIVE DEVICES**

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" or "1. None" along with element values 2,3,4,5,6,7,8,9,10, and/ or 11  
2550 1 Multiple Entry Max exceeded

#### **CHILD SPECIFIC RESTRAINT**

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**

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

### **Pre-hospital Information**

#### **EMS DISPATCH DATE**

##### **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**

##### **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

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

##### **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**

##### **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

#### **EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY**

##### **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**

##### **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

#### **TRANSPORT MODE**

##### **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

#### **OTHER TRANSPORT MODE**

##### **Rule ID Level Message**

3501 1 Value is not a valid menu option  
3502 2 Element cannot be blank  
3503 2 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value  
3550 1 Multiple Entry Max exceeded

#### **EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)**

##### **Rule ID Level Message**

9940 1 Multiple Entry Max exceeded  
90000 1 Invalid value  
90001 2 Element cannot be blank

90002 2 Rule ID 90002 Element cannot be "Not Known/Not Recorded" along with any other value

#### **INITIAL FIELD SYSTOLIC BLOOD PRESSURE**

##### **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

#### **INITIAL FIELD PULSE RATE**

##### **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 of 0 – 300  
3707 3 The value submitted is below 30  
3740 1 Single Entry Max exceeded

#### **INITIAL FIELD RESPIRATORY RATE**

##### **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

#### **INITIAL FIELD OXYGEN SATURATION**

##### **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

#### **INITIAL FIELD GCS - EYE**

##### **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

#### **INITIAL FIELD GCS - VERBAL**

##### **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

#### **INITIAL FIELD GCS - MOTOR**

##### **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

#### **INITIAL FIELD GCS - TOTAL**

##### **Rule ID Level Message**

4301 1 GCS Total is outside the valid range of 3 – 15  
4303 3 Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS – Motor, unless any of these values are "Not Known/Not Recorded"  
4304 2 Element cannot be blank  
4306 2 Element must be "Not Known/Not Recorded" when Initial Field GCS 40 – Eye, Initial Field GCS 40 – Verbal, or Initial Field GCS 40 – Motor are reported.  
4340 1 Single Entry Max exceeded

#### **INITIAL FIELD GCS 40 - EYE**

##### **Rule ID Level Message**

15001 1 Value is not a valid menu option  
15003 2 Element cannot be blank  
15006 2 Element must be "Not Known/Not Recorded" when Initial Field GCS – Eye is reported  
15040 1 Single Entry Max exceeded

### **INITIAL FIELD GCS 40 – Verbal**

#### **Rule ID Level Message**

15101 1 Value is not a valid menu option

15103 2 Element cannot be blank

15106 2 Element must be "Not Known/Not Recorded" when Initial Field GCS – Verbal is reported

15140 1 Single Entry Max exceeded

### **INITIAL FIELD GCS 40 – Motor**

#### **Rule ID Level Message**

15201 1 Value is not a valid

15203 2 Element cannot be blank

15205 2 Element must be "Not Known/Not Recorded" when Initial Field GCS – Motor is reported

15240 1 Single Entry Max exceeded

### **INTER-FACILITY TRANSFER**

#### **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

### **TRAUMA CENTER CRITERIA (Steps 1 and 2)**

#### **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 CENTER CRITERIA (Steps 3 and 4)**

#### **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

### **PRE-HOSPITAL CARDIAC ARREST**

#### **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

## Emergency Department Information

### ED/HOSPITAL ARRIVAL DATE

#### 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"

4511 3 ED/Hospital Arrival Date is earlier than Date of Birth

4513 2 ED/Hospital Arrival Date minus Injury Incident Date occurs more than 14 days after Injury Incident Date

4515 2 Element cannot be "Not Applicable"

4516 3 *ED/Hospital Arrival Date* is earlier than *Injury Incident Date*

4540 1 Single Entry Max exceeded

### ED/HOSPITAL ARRIVAL TIME

#### Rule ID Level Message

4601 1 Time is not valid

4602 1 Time out of range

4603 2 Element cannot be blank

4609 2 Element cannot be "Not Applicable"

4610 3 *ED/Hospital Arrival Time* is earlier than *Injury Incident Time*

4640 1 Single Entry Max exceeded

### INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

#### 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 PULSE RATE

#### 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 TEMPERATURE**

##### **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

#### **HIGHEST TRAUMA ACTIVATION**

##### **Rule ID Level Message**

14201 1 Value is not a valid menu option  
14202 2 Element cannot be blank  
14240 1 Single Entry Max exceeded

#### **TRAUMA SURGEON ARRIVAL DATE**

##### **Rule ID Level Message**

14301 1 Date is not valid  
14302 1 Date is out of range  
14303 2 Element cannot be blank  
14304 Trauma Surgeon Arrival Date is earlier than Injury Incident Date  
14340 1 Single Entry Max exceeded

#### **TRAUMA SURGEON ARRIVAL TIME**

##### **Rule ID Level Message**

14401 1 Time is not valid  
14402 1 Time is out of range  
14403 2 Element cannot be blank  
14404 Trauma Surgeon Arrival Time is earlier than Injury Incident Time  
14440 1 Single Entry Max exceeded

#### **INITIAL ED/HOSPITAL RESPIRATORY RATE**

##### **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**

##### **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

#### **INITIAL ED/HOSPITAL OXYGEN SATURATION**

##### **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**

##### **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**

##### **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**

#### **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**

#### **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

### **INITIAL ED/HOSPITAL GCS - TOTAL**

#### **Rule ID Level Message**

- 5701 1 GCS Total is outside the valid range of 3 - 15
- 5703 3 Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS Eye, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS – Motor, unless any of these values are "Not Known/Not Recorded"
- 5705 2 Element cannot be blank
- 5706 2 Element cannot be "Not Applicable"
- 5707 2 Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.
- 5740 1 Single Entry Max exceeded

### **INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS**

#### **Rule ID Level Message**

- 5801 1 Value is not a valid menu option
- 5802 2 Element cannot be blank
- 5803 2 Element cannot be "Not Applicable"
- 5804 2 Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.
- 5805 2 Element cannot be "Not Known/Not Recorded" along with any other valid value
- 5850 1 Multiple Entry Max exceeded

#### **INITIAL ED/HOSPITAL GCS 40 - EYE**

##### **Rule ID Level Message**

- 15301 1 Value is not a valid menu option
- 15303 2 Element cannot be blank
- 15304 2 Element cannot be "Not Applicable"
- 15305 2 Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS – Eye is reported.
- 15340 1 Single Entry Max exceeded

#### **INITIAL ED/HOSPITAL GCS 40 - MOTOR**

##### **Rule ID Level Message**

- 15501 1 Value is not a valid menu option
- 15503 2 Element cannot be blank
- 15504 2 Element cannot be "Not Applicable"
- 15505 2 Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS 40 – Motor is reported
- 15506 If patient age is less than 5, element value 6 is not a valid menu option
- 15540 1 Single Entry Max exceeded

#### **INITIAL ED/HOSPITAL HEIGHT**

##### **Rule ID Level Message**

- 8501 1 Invalid value
- 8502 2 Element cannot be blank
- 8503 3 Height exceeds the max of 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

#### **INITIAL ED/HOSPITAL WEIGHT**

##### **Rule ID Level Message**

- 8601 1 Invalid value
- 8602 2 Element cannot be blank
- 8603 3 Weight exceeds the max of 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

## DRUG SCREEN

### 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", or "15. Not Tested" along with element values 1,2,3,4,5,6,7,8,9,10,11,12, and/ or 13
- 6050 1 Multiple Entry Max exceeded

## ALCOHOL SCREEN

### 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

### Rule ID Level Message

- 5931 1 Invalid value
- 5932 2 Element cannot be blank
- 5933 Element must be and can only be "Not Applicable" when Alcohol Screen is Element Value "2. No"
- 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

## ED DISCHARGE DISPOSITION

### 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"
- 6140 1 Single Entry Max exceeded

## ED DISCHARGE DATE

### Rule ID Level Message

- 6301 1 Date is not valid
- 6302 1 Date out of range
- 6303 2 Element cannot be blank
- 6307 2 ED Discharge Date is earlier than ED/Hospital Arrival Date
- 6310 3 ED Discharge Date occurs more than 365 days after ED/Hospital Arrival Date
- 6311 2 Element must be and can only be "Not Applicable" when **ED Discharge Disposition** is "Not Applicable"
- 6312 3 **ED Discharge Date** is earlier than **Injury Incident Date**

6313 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Date* cannot be earlier than *Hospital Procedure Start Date*

6314 3 *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* is earlier than *Cerebral Monitor Date*

6315 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Date* cannot be earlier than *Venous Thromboembolism Prophylaxis Date*

6316 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Date* cannot be earlier than *Angiography Date*

6317 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Date* cannot be earlier than *Surgery For Hemorrhage Control Date*

6318 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Date* cannot be earlier than *Withdrawal of Life Supporting Treatment Date*

6319 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Date* cannot be earlier than *Antibiotic Therapy Date*

6340 1 Single Entry Max exceeded

#### **ED DISCHARGE TIME**

##### **Rule ID Level Message**

6401 1 Time is not valid

6402 1 Time out of range

6403 2 Element cannot be blank

6407 4 ED Discharge Time is earlier than ED/Hospital Arrival Time

6409 2 Element must be and can only be "Not Applicable" when *ED Discharge Date* is "Not Applicable"

6410 3 Element must be "Not Known/Not Recorded" when *ED Discharge Date* is "Not Known/Not Recorded"

6411 3 *ED Discharge Time* is earlier than *Injury Incident Time*

6412 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Hospital Procedure Start Time*

6413 3 *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Time* is earlier than *Cerebral Monitor Time*

6414 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Venous Thromboembolism Prophylaxis Time*

6415 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Angiography Time*

6416 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Surgery For Hemorrhage Control Time*

6417 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Withdrawal of Life Supporting Treatment Time*

6418 2 If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Antibiotic Therapy Time*

6440 1 Single Entry Max exceeded

## Hospital Procedure Information

### ICD-10 HOSPITAL PROCEDURES

#### Rule ID Level Message

8801 1 Invalid Value (ICD-10 PCS only)

8803 2 Element cannot be blank

8804 2 Element must not be "Not Applicable" or "Not Known/Not Recorded" along with any other value

8805 1 Invalid value (ICD-10 CA only)

8850 1 Multiple Entry Max exceeded

### HOSPITAL PROCEDURE START DATE

#### Rule ID Level Message

6601 1 Date is not valid

6602 1 Date out of range

6606 3 Hospital Procedure Start Date is earlier than ED/Hospital Arrival Date

6609 2 Element cannot be blank

6610 2 Element must be and can only be "Not Applicable" when *ICD-10 Hospital*

*Procedures* is "Not Applicable"

6611 2 Element must be "Not Known/Not Recorded" when *ICD-10 Hospital Procedures* is "Not Known/Not Recorded"

6650 1 Multiple Entry Max exceeded

### HOSPITAL PROCEDURE START TIME

#### Rule ID Level Message

6701 1 Time is not valid

6702 1 Time out of range

6706 3 Hospital Procedure Start Time is earlier than ED/Hospital Arrival Time

6708 2 Element cannot be blank

6709 2 Element must be and can only be "Not Applicable" when *Hospital Procedure*

*Start Date* is "Not Applicable"

6710 2 Element must be "Not Known/Not Recorded" when *Hospital Procedure*

*Start Date* is "Not Known/Not Recorded"

6750 1 Multiple Entry Max Exceeded

## Diagnosis Information

### ICD-10 INJURY DIAGNOSES

#### 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)

8704 4 Element should not be Not Known/Not Recorded



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)  
8707 2 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value  
8750 1 Multiple Entry Max exceeded

#### **AIS CODE**

##### **Rule ID Level Message**

21001 1 Invalid value  
21004 2 AIS codes submitted are not valid AIS 05, Update 08, or AIS 2015 codes  
21007 2 Element cannot be blank  
21008 2 Element cannot be Not Applicable  
21009 2 Element cannot be "Not Known/Not Recorded" along with any other value  
21050 1 Multiple Entry Max exceeded

#### **AIS VERSION**

##### **Rule ID Level Message**

7301 1 Value is not a valid menu option  
7302 2 Element cannot be blank  
7303 2 Element cannot be "Not Applicable"  
7340 1 Single Entry Max exceeded

### **Hospitals Events**

#### **ACUTE KIDNEY INJURY (AKI)**

##### **Rule ID Level Message**

18501 1 Value is not a valid menu option  
18503 2 Element cannot be blank  
18504 2 Element cannot be "Not Applicable"  
18540 1 Single Entry Max exceeded

#### **ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)**

##### **Rule ID Level Message**

18601 1 Value is not a valid menu option  
18603 2 Element cannot be blank  
18604 2 Element cannot be "Not Applicable"  
18640 1 Single Entry Max exceeded

#### **ALCOHOL WITHDRAWAL SYNDROME**

##### **Rule ID Level Message**

18701 1 Value is not a valid menu option  
18703 2 Element cannot be blank  
18704 2 Element cannot be "Not Applicable"  
18740 1 Single Entry Max exceeded

#### **CARDIAC ARREST WITH CPR**

##### **Rule ID Level Message**

18801 1 Value is not a valid menu option  
18803 2 Element cannot be blank  
18804 2 Element cannot be "Not Applicable"  
18840 1 Single Entry Max exceeded

#### **CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)**

##### **Rule ID Level Message**

18901 1 Value is not a valid menu option  
18903 2 Element cannot be blank  
18904 2 Element cannot be "Not Applicable"  
18940 1 Single Entry Max exceeded

#### **CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)**

##### **Rule ID Level Message**

19001 1 Value is not a valid menu option  
19003 2 Element cannot be blank  
19004 2 Element cannot be "Not Applicable"  
19040 1 Single Entry Max exceeded

#### **DEEP SURGICAL SITE INFECTION**

##### **Rule ID Level Message**

19101 1 Value is not a valid menu option  
19103 2 Element cannot be blank  
19104 2 Element cannot be "Not Applicable"  
19140 1 Single Entry Max exceeded

#### **DEEP VEIN THROMBOSIS (DVT)**

##### **Rule ID Level Message**

19201 1 Value is not a valid menu option  
19203 2 Element cannot be blank  
19204 2 Element cannot be "Not Applicable"  
19240 1 Single Entry Max exceeded

## **DELIRIUM**

### **Rule ID Level Message**

21601 1 Value is not a valid menu option  
21603 2 Element cannot be blank  
21604 2 Element cannot be "Not Applicable"  
21640 1 Single Entry Max exceeded

## **MYOCARDIAL INFARCTION (MI)**

### **Rule ID Level Message**

19401 1 Value is not a valid menu option  
19403 2 Element cannot be blank  
19404 2 Element cannot be "Not Applicable"  
19440 1 Single Entry Max exceeded

## **ORGAN/SPACE SURGICAL SITE INFECTION**

### **Rule ID Level Message**

19501 1 Value is not a valid menu option  
19503 2 Element cannot be blank  
19504 2 Element cannot be "Not Applicable"  
19540 1 Single Entry Max exceeded

## **OSTEOMYELITIS**

### **Rule ID Level Message**

19601 1 Value is not a valid menu option  
19603 2 Element cannot be blank  
19604 2 Element cannot be "Not Applicable"  
19640 1 Single Entry Max exceeded

## **PULMONARY EMBOLISM (PE)**

### **Rule ID Level Message**

19701 1 Value is not a valid menu option  
19703 2 Element cannot be blank  
19704 2 Element cannot be "Not Applicable"  
19740 1 Single Entry Max exceeded

## **PRESSURE ULCER**

### **Rule ID Level Message**

19801 1 Value is not a valid menu option  
19803 2 Element cannot be blank

19804 2 Element cannot be "Not Applicable"  
19840 1 Single Entry Max exceeded

#### **SEVERE SEPSIS**

##### **Rule ID Level Message**

19901 1 Value is not a valid menu option  
19903 2 Element cannot be blank  
19904 2 Element cannot be "Not Applicable"  
19940 1 Single Entry Max exceeded

#### **Outcome Information**

##### **TOTAL ICU LENGTH OF STAY**

###### **Rule ID Level Message**

7501 1 Total ICU Length of Stay is outside the valid range of 1 - 575  
7502 2 Element cannot be blank  
7503 3 Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date  
7504 3 Value is greater than 365, please verify this is correct

##### **TOTAL VENTILATOR DAYS**

###### **Rule ID Level Message**

7601 1 Total Ventilator Days is outside the valid range of 1 - 575  
7602 2 Element cannot be blank  
7603 4 Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date  
7604 4 Value is greater than 365, please verify this is correct

##### **HOSPITAL DISCHARGE DATE**

###### **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 3 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 = 4, 5, 6, 9, 10, or 11  
7740 1 Single Entry Max exceeded

## **HOSPITAL DISCHARGE TIME**

### **Rule ID Level Message**

7801 1 Time is not valid  
7802 1 Time out of range  
7803 2 Element cannot be blank  
7804 4 Hospital Discharge Time is earlier than EMS Dispatch Time  
7805 4 Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time  
7806 4 Hospital Discharge Time is earlier than EMS Unit Scene Departure Time  
7807 4 Hospital Discharge Time is earlier than ED/Hospital Arrival Time  
7808 4 Hospital Discharge Time is earlier than ED Discharge Time  
7809 2 Element must be Not Applicable when ED Discharge Disposition = 4, 5, 6, 9, 10, or 11  
7840 1 Single Entry Max exceeded

## **HOSPITAL DISCHARGE DISPOSITION**

### **Rule ID Level Message**

7901 1 Value is not a valid menu option  
7902 2 Element cannot be blank  
7903 2 Element must be Not Applicable when ED Discharge Disposition = 5 (Died)  
7907 2 Element must be Not Applicable when ED Discharge Disposition = 4, 6,9,10, or 11  
7908 2 Element cannot be Not Applicable  
7909 2 Element cannot be "Not Known/Not Recorded" when Hospital Arrival Date and Hospital Discharge Date are not "Not Applicable" or "Not Known/Not Recorded"

## **Outcome Information**

## **TOTAL ICU LENGTH OF STAY**

### **Rule ID Level Message**

7501 1 Invalid value  
7502 2 Element cannot be blank  
7503 3 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 Total ICU Length of Stay is outside the valid range of 1 - 575  
7540 1 Single Entry Max exceeded

## **TOTAL VENTILATOR DAYS**

### **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 Total Ventilator Days is outside the valid range of 1 - 575

7640 1 Single Entry Max exceeded

### HOSPITAL DISCHARGE DATE

#### Rule ID Level Message

7701 1 Date is not valid

7702 1 Date out of range

7703 2 Element cannot be blank

7707 2 Hospital Discharge Date cannot be earlier than ED/Hospital Arrival Date

7708 2 Hospital Discharge Date cannot be earlier than ED Discharge Date

7711 3 Hospital Discharge Date occurs more than 365 days after ED/Hospital Arrival Date

7713 2 Element must be Not Applicable when ED Discharge Disposition = 5 (Died)

7713 2 Element must be and can only be "Not Applicable" when **Hospital Discharge Disposition** is "Not Applicable"

7714 3 **Hospital Discharge Date** is earlier than **Injury Incident Date**

7715 2 **Hospital Discharge Date** is earlier than **Hospital Procedure Start Date**

7716 2 **Hospital Discharge Date** is earlier than **Cerebral Monitor Date**

7717 2 **Hospital Discharge Date** is earlier than **Venous Thromboembolism Prophylaxis Date**

7718 2 **Hospital Discharge Date** is earlier than **Angiography Date**

7719 2 **Hospital Discharge Date** is earlier than **Surgery for Hemorrhage Control Date**

7720 2 **Hospital Discharge Date** cannot be earlier than **Withdrawal of Life**

#### Supporting Treatment Date

7721 3 **Hospital Discharge Date** is earlier than **Antibiotic Therapy Date**

### HOSPITAL DISCHARGE TIME

#### Rule ID Level Message

7801 1 Time is not valid

7802 1 Time out of range

7803 2 Element cannot be blank

7807 4 Hospital Discharge Time cannot be earlier than ED/Hospital Arrival Time

7808 4 Hospital Discharge Time cannot be earlier than or equal to ED Discharge Time

7810 2 Element must be Not Applicable when ED Discharge Disposition = 5 (Died)

7810 2 Element must be and can only be "Not Applicable" when **Hospital Discharge Date** is "Not Applicable"

7811 2 Element must be "Not Known/Not Recorded" when **Hospital Discharge Date** is "Not Known/Not Recorded"

7812 3 **Hospital Discharge Time** is earlier than **Injury Incident Time**

7813 2 **Hospital Discharge Time** is earlier than **Hospital Procedure Start Time**

7814 2 **Hospital Discharge Time** is earlier than **Cerebral Monitor Time**

7815 2 **Hospital Discharge Time** is earlier than **Venous Thromboembolism Prophylaxis Time**

7816 2 **Hospital Discharge Time** is earlier than **Angiography Time**

7817 2 **Hospital Discharge Time** is earlier than **Surgery for Hemorrhage Control Time**

7818 2 **Hospital Discharge Time** cannot be earlier than **Withdrawal of Life**

#### Supporting Treatment Time

7819 3 **Hospital Discharge Time** is earlier than **Antibiotic Therapy Time**

## **HOSPITAL DISCHARGE DISPOSITION**

### **Rule ID Level Message**

7901 1 Value is not a valid menu option

7902 2 Element cannot be blank

7907 2 Element must be "Not Applicable" when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11

7908 2 Element cannot be "Not Applicable" if ED Discharge Disposition is not 4, 5, 6, 9, 10, or 11

7909 2 Element cannot be "Not Known/Not Recorded" when Hospital Arrival Date and Hospital Discharge Date are not "Not Applicable" or "Not Known/Not Recorded"

## **Financial Information**

### **PRIMARY METHOD OF PAYMENT**

#### **Rule ID Level Message**

8001 1 Value is not a valid menu option

8002 2 Element cannot be blank

8003 2 Element cannot be Not Applicable

## **Hospital Complications Information**

### **HOSPITAL COMPLICATIONS**

#### **Rule ID Level Message**

8101 1 Value is not a valid menu option

8102 2 Element cannot be blank

8103 3 Hospital Complications include Ventilator Associated Pneumonia although Total Ventilator Days is Not Applicable. Please verify.

## **TQIP Measures for Processes of Care**

### **HIGHEST GCS TOTAL**

#### **Rule ID Level Message**

10001 1 GCS Total is outside the valid range of 3 - 15

10002 2 Element cannot be blank

10003 2 Highest GCS Total is less than GCS Motor Component of Highest GCS Total

10004 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria

10005 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day

10006 2 Element must be "Not Known/Not Recorded" when Highest GCS 40 – Motor is reported.

10007 1 Invalid Value  
10008 2 Element must be "Not Applicable" as the patient was discharged on the same date as **ED/Hospital Arrival Date**  
10040 1 Single Entry Max exceeded

#### **HIGHEST GCS MOTOR**

##### **Rule ID Level Message**

10101 1 Value is not a valid menu option  
10102 2 Element cannot be blank  
10104 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria  
10105 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day  
10106 2 Element must be "Not Known/Not Recorded" when Highest GCS 40 – Motor is reported.  
10107 2 Element must be "Not Applicable" as the patient was discharged on the same date as **ED/Hospital Arrival Date**  
10140 1 Single Entry Max exceeded

#### **GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL**

##### **Rule ID Level Message**

10201 1 Value is not a valid menu option  
10202 2 Element cannot be blank  
10203 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria  
10204 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day  
10206 2 Element must be "Not Known/Not Recorded" when Highest GCS 40 – Motor is reported.  
10207 2 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value  
10208 2 Element must be "Not Applicable" as the patient was discharged on the same date as **ED/Hospital Arrival Date**  
10250 1 Multiple Entry Max exceeded

#### **HIGHEST GCS 40 - MOTOR**

##### **Rule ID Level Message**

20601 1 Value is not a valid menu option  
20602 2 Element cannot be blank  
20604 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria



20605 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day

20606 2 Element must be "Not Known/Not Recorded" when Highest GCS - Motor is reported

20607 2 Element must be "Not Applicable" as the patient was discharged on the same date as **ED/Hospital Arrival Date**

20608 If patient age is less than 5, Element Value 6 is not a valid menu option

20640 1 Single Entry Max exceeded

### **INITIAL ED/HOSPITAL PUPILLARY RESPONSE**

#### **Rule ID Level Message**

13601 1 Value is not a valid menu option

13602 2 Element cannot be blank

13603 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria

13604 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria.

13640 1 Single Entry Max exceeded

### **MIDLINE SHIFT**

#### **Rule ID Level Message**

13701 1 Value is not a valid menu option

13702 2 Element cannot be blank

13703 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria

13704 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria

13740 1 Single Entry Max exceeded

### **CEREBRAL MONITOR**

#### **Rule ID Level Message**

10301 1 Value is not a valid menu option

10302 2 Element cannot be blank

10304 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criteria

10305 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criteria.

10306 2 Element cannot be "Not Applicable" or "Not Known/Not Recorded", or "5. None" along with element values 1, 2, 3, any/ or 4

10350 1 Multiple Entry Max exceeded

### **CEREBRAL MONITOR DATE**

#### **Rule ID Level Message**

10401 1 Date is not valid

10402 2 Element cannot be blank  
10403 1 Date out of range  
10405 3 Element should not be "Not Known/Not Recorded" when Cerebral Monitor is 1, 2, 3, and/or 4  
10407 3 Cerebral Monitor Date should not be earlier than ED/Hospital Arrival Date unless placed at referring facility and used for monitoring  
10409 2 Element must be and can only be "Not Applicable: when Cerebral Monitor is "Not Applicable" or "5 None"  
10410 2 Element must be "Not Known/Not Recorded" when **Cerebral Monitor** is "Not Known/Not Recorded"  
10440 1 Single Entry Max exceeded

#### **CEREBRAL MONITOR TIME**

##### **Rule ID Level Message**

10501 1 Time is not valid  
10502 1 Time out of range  
10503 2 Element cannot be blank  
10505 3 Element should not be "Not Known/Not Recorded" when Cerebral Monitor is 1, 2, 3, and/or 4  
10506 3 Cerebral Monitor Time should not be earlier than ED/Hospital Arrival Time unless placed at referring facility and used for monitoring  
10509 2 Element must be and can only be "Not Applicable" when **Cerebral Monitor Date** is "Not Applicable"  
10510 2 Element must be "Not Known/Not Recorded" when **Cerebral Monitor Date** is "Not Known/Not Recorded"  
10540 1 Single Entry Max exceeded

#### **VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE**

##### **Rule ID Level Message**

10601 1 Value is not a valid menu option  
10602 2 Element cannot be blank  
10603 2 Element cannot be "Not Applicable"  
10640 1 Single Entry Max exceeded

#### **VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE**

##### **Rule ID Level Message**

10701 1 Date is not valid  
10702 1 Date out of range  
10703 2 Element cannot be blank  
10706 2 VTE Prophylaxis Date is earlier than ED/Hospital Arrival Date  
10708 2 Element must be and can only be "Not Applicable" when VTE Prophylaxis Type is "5. None"  
10709 2 Element must be "Not Known/Not Recorded" when **Venous Thromboembolism Prophylaxis Type** is "Not Known/Not Recorded"

10740 1 Single Entry Max exceeded

#### **VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME**

##### **Rule ID Level Message**

10801 1 Time is not valid

10802 1 Time out of range

10803 2 Element cannot be blank

10806 2 VTE Prophylaxis Time is earlier than ED/Hospital Arrival Time

10809 2 Element must be and can only be "Not Applicable" when **Venous**

**Thromboembolism Prophylaxis Date** is "Not Applicable"

10810 2 Element must be "Not Known/Not Recorded" when **Venous Thromboembolism Prophylaxis Date** is "Not Known/Not Recorded"

10840 1 Single Entry Max exceeded

#### **PACKED RED BLOOD CELLS**

##### **Rule ID Level Message**

21801 1 Invalid value

21802 2 Element cannot be blank

21803 2 Element cannot be "Not Applicable"

21804 3 Value exceeds 40,000 for CCs

21840 1 Single Entry Max exceeded

EXCLUDE: Cell Saver blood

#### **WHOLE BLOOD**

##### **Rule ID Level Message**

21101 1 Invalid value

21102 2 Element cannot be blank

21103 2 Element cannot be "Not Applicable"

21104 3 Value exceeds 40,000 for CCs

21140 1 Single Entry Max exceeded

EXCLUDE: Cell Saver blood

#### **PLASMA**

##### **Rule ID Level Message**

21201 1 Invalid value

21202 2 Element cannot be blank

21204 3 Value exceeds 40,000 for CCs

21208 2 Element cannot be "Not Applicable"

21240 1 Single Entry Max exceeded

EXCLUDE: Cell Saver blood

#### **PLATELETS**

##### **Rule ID Level Message**

21301 1 Invalid value

21302 2 Element cannot be blank  
21304 3 Value exceeds 40,000 for CC  
21308 2 Element cannot be "Not Applicable"  
21340 1 Single Entry Max exceeded  
EXCLUDE: Cell Saver blood

#### **CRYOPRECIPITATE**

##### **Rule ID Level Message**

21401 1 Invalid value  
21402 2 Element cannot be blank  
21404 3 Value exceeds 40,000 for CCs  
21408 2 Element cannot be "Not Applicable"  
21440 1 Single Entry Max exceeded  
EXCLUDE: Cell Saver blood

#### **ANGIOGRAPHY**

##### **Rule ID Level Message**

11701 1 Value is not a valid menu option  
11702 2 Element cannot be blank  
11704 2 Element must be and can only be "Not Applicable" when Packed Red Blood Cells and Whole Blood are 0  
11705 2 Element must be "Not Known/Not Recorded" when Packed Red Blood Cells and Whole Blood are "Not Known/Not Recorded"  
11740 1 Single Entry Max exceeded

#### **EMBOLIZATION SITE**

##### **Rule ID Level Message**

11801 1 Value is not a valid menu option  
11802 2 Element cannot be blank  
11804 2 Element must be and can only be "Not Applicable" when Angiography is "1. None", "2. Angiogram only", or "4. Angiogram with stenting"  
11805 2 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value  
11850 1 Multiple Entry Max exceeded

#### **ANGIOGRAPHY DATE**

##### **Rule ID Level Message**

11901 1 Date is not valid  
11902 1 Date out of range  
11903 2 Element cannot be blank  
11905 2 Element must be and can only be "Not Applicable" when Angiography is "Not Applicable" or "1. None"  
11906 2 Angiography Date is earlier than ED/Hospital Arrival Date  
11908 2 Angiography Date occurs more than 24 hours after ED Hospital Arrival Date

11909 2 Element must be "Not Known/Not Recorded" when **Angiography** is "Not Known/Not Recorded"  
11940 1 Single Entry Max exceeded

#### **ANGIOGRAPHY TIME**

##### **Rule ID Level Message**

12001 1 Time is not valid  
12002 1 Time out of range  
12003 2 Element cannot be blank  
12004 2 Element cannot be "Not Applicable" when Angiography is "2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. 'Angiogram with stenting'"  
12005 2 Element must be and can only be "Not Applicable" when Angiography is "Not Applicable" or "1. None"  
12006 2 Angiography Time is earlier than ED/Hospital Arrival Time  
12008 2 Angiography Time occurs more than 24 hours after ED/Hospital Arrival Time  
12009 2 Element must be "Not Known/Not Recorded" when **Angiography Date** is "Not Known/Not Recorded"  
12040 1 Single Entry Max exceeded

#### **SURGERY FOR HEMORRHAGE CONTROL TYPE**

##### **Rule ID Level Message**

12101 1 Value is not a valid menu option  
12102 2 Element cannot be blank  
12104 2 Element must be and can only be "Not Applicable" when Packed Red Blood Cells and Whole Blood are 0  
12105 2 Element must be "Not Known/Not Recorded" when Packed Red Blood Cells and Whole Blood are "Not Known/Not Recorded"  
12140 1 Single Entry Max exceeded

#### **SURGERY FOR HEMORRHAGE CONTROL DATE**

##### **Rule ID Level Message**

12201 1 Date is not valid  
12202 1 Date out of range  
12203 2 Surgery for Hemorrhage Control Date is earlier than ED/Hospital Arrival Date  
12206 2 Element must be and can only be "Not Applicable" when Surgery For Hemorrhage Control Type is "Not Applicable" or "1. None"  
12207 2 Element cannot be blank  
12208 2 Surgery for Hemorrhage Control Date occurs more than 24 hours after ED Hospital Arrival Date  
12209 2 Element must be "Not Known/Not Recorded" when **Surgery For Hemorrhage Control Type** is "Not Known/Not Recorded"  
12240 1 Single Entry Max exceeded

## **SURGERY FOR HEMORRHAGE CONTROL TIME**

### **Rule ID Level Message**

- 12301 1 Time is not valid
- 12302 1 Time out of range
- 12303 2 Surgery for Hemorrhage Control Time is earlier than ED/Hospital Arrival Time
- 12307 2 Element cannot be blank
- 12308 2 Surgery for Hemorrhage Control Time occurs more than 24 hours after ED/Hospital Arrival Time
- 12309 2 Element must be and can only be "Not Applicable" when **Surgery For Hemorrhage Control Date** is "Not Applicable"
- 12310 2 Element must be "Not Known/Not Recorded" when **Surgery For Hemorrhage Control Date** is "Not Known/Not Recorded"
- 12340 1 Single Entry Max exceeded

## **WITHDRAWAL OF LIFE SUPPORTING TREATMENT**

### **Rule ID Level Message**

- 13801 1 Value is not a valid menu option
- 13802 2 Element cannot be blank
- 13803 2 Element cannot be "Not Applicable"
- 13840 1 Single Entry Max exceeded

## **WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE**

### **Rule ID Level Message**

- 13901 1 Date is not valid
- 13902 1 Date out of range
- 13903 2 Withdrawal of Life Supporting Treatment Date is earlier than ED/Hospital Arrival Date
- 13906 2 Element must be and can only be "Not Applicable" when Withdrawal of Life Supporting Treatment is "2. No"
- 13907 2 Element cannot be blank
- 13908 2 Element must be "Not Known/Not Recorded" when **Withdrawal of Life Supporting Treatment** is "Not Known/Not Recorded"
- 13940 1 Single Entry Max exceeded

## **WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME**

### **Rule ID Level Message**

- 14001 1 Time is not valid
- 14002 1 Time out of range
- 14003 2 Withdrawal of Life Supporting Treatment Time is earlier than ED/Hospital Arrival Time
- 14007 2 Element cannot be blank
- 14008 2 Element must be and can only be "Not Applicable" when **Withdrawal of Life Supporting Treatment Date** is "Not Applicable"
- 14009 2 Element must be "Not Known/Not Recorded" when **Withdrawal of Life Supporting Treatment Date** is "Not Known/Not Recorded"
- 14040 1 Single Entry Max exceeded

## ANTIBIOTIC THERAPY

### Rule ID Level Message

20701 2 Value is not a valid menu option

20702 2 Element cannot be Blank

20705 2 Element must be "Not Applicable" as the AIS codes provided do not meet the reporting criterion

20706 2 Element must not be "Not Applicable" as the AIS codes provided meet the reporting criterion

20740 1 Single Entry Max exceeded

## ANTIBIOTIC THERAPY DATE

### Rule ID Level Message

20801 1 Date is not valid

20802 2 Date is out of range

20804 2 Element must be and can only be "Not Applicable" when Antibiotic Therapy is "Not Applicable" or "2. No"

20808 2 Element cannot be blank

20809 2 Element must be "Not Known/Not Recorded" when **Antibiotic Therapy** is "Not Known/Not Recorded"

20840 1 Single Entry Max exceeded

## ANTIBIOTIC THERAPY TIME

### Rule ID Level Message

20901 1 Time is not valid

20902 2 Time is out of range

20908 2 Element cannot be blank

20909 2 Element must be and can only be "Not Applicable" when **Antibiotic Therapy Date** is "Not Applicable"

20910 2 Element must be "Not Known/Not Recorded" when **Antibiotic Therapy Date** is "Not Known/Not Recorded"

20940 1 Single Entry Max exceeded

## Appendix 2: Indiana Hospitals

*See below for a list of Indiana's 123 acute care hospitals with Emergency Departments, as of 2023.*

Zip Code	Facility Name	Trauma Level	District
46733	Adams Memorial Hospital	Non-Trauma Centers	3
46016	Ascension St. Vincent Anderson	Trauma Level III	6
46123	Ascension St. Vincent- Avon (Neighborhood Hospital)	Non-Trauma Centers	5
46250	Ascension St. Vincent- Castleton (Neighborhood Hospital)	Non-Trauma Centers	5
47714	Ascension St. Vincent Evansville	Trauma Levels I & II	10
46260	Ascension St. Vincent Hospital - Indianapolis	Trauma Levels I & II	5
46237	Ascension St. Vincent- Indianapolis South (Neighborhood Hospital)	Non-Trauma Centers	5
46901	Ascension St. Vincent Kokomo	Non-Trauma Centers	6
46036	Ascension St. Vincent Mercy Hospital	Non-Trauma Centers	6
46168	Ascension St. Vincent- Plainfield (Neighborhood Hospital)	Non-Trauma Centers	5
47394	Ascension St. Vincent Randolph	Non-Trauma Centers	6
47167	Ascension St. Vincent Salem Hospital	Non-Trauma Centers	8
47601	Ascension St. Vincent Warrick	Non-Trauma Centers	10
47993	Ascension St. Vincent Williamsport	Non-Trauma Centers	4
46032	Ascension St. Vincent-Carmel	Non-Trauma Centers	5
47834	Ascension St. Vincent-Clay	Non-Trauma Centers	7
46037	Ascension St. Vincent-Fishers	Non-Trauma Centers	5
47265	Ascension St. Vincent-Jennings	Non-Trauma Centers	9
47150	Baptist Health Floyd	Non-Trauma Centers	9
46714	Bluffton Regional Medical Center	Non-Trauma Centers	3
46703	Cameron Memorial Community Hospital	Non-Trauma Centers	3
47130	Clark Memorial Hospital	Non-Trauma Centers	9
47201	Columbus Regional Hospital	Non-Trauma Centers	8
46219	Community EAST Health Network Comm Hosp	Non-Trauma Centers	5



46011	Community Hosp of Anderson and Madison Co	Trauma Level III	6
46321	Community Hospital Munster	Non-Trauma Centers	1
46506	Community Hospital of Bremen	Non-Trauma Centers	2
46902	Community Howard Regional Health	Non-Trauma Centers	6
46256	Community NORTH Health Network Comm Hosp	Non-Trauma Centers	5
46227	Community SOUTH Health Network Comm Hosp	Non-Trauma Centers	5
47501	Daviess Community Hospital	Non-Trauma Centers	10
47630	Deaconess Gateway Hospital	Non-Trauma Centers	10
47670	Deaconess Gibson Hospital	Non-Trauma Centers	10
47747	Deaconess Midtown Hospital	Trauma Levels I & II	10
47240	Decatur County Memorial Hospital	Non-Trauma Centers	9
46970	Dukes Memorial Hospital	Non-Trauma Centers	3
46825	Dupont Hospital	Non-Trauma Centers	3
46514	Elkhart General Hospital	Trauma Level III	2
46202	Eskenazi Health	Trauma Levels I & II	5
47933	Franciscan Health Crawfordsville	Non-Trauma Centers	4
46307	Franciscan Health Crown Point	Trauma Level III	1
46311	Franciscan Health Dyer	Non-Trauma Centers	1
46237	Franciscan Health Indianapolis	Trauma Level III	5
47095	Franciscan Health Lafayette East	Trauma Level III	4
46360	Franciscan Health Michigan City	Non-Trauma Centers	1
46158	Franciscan Health Mooresville	Non-Trauma Centers	5
46321	Franciscan Health Munster	Non-Trauma Centers	1
47978	Franciscan Health Rensselaer	Non-Trauma Centers	1
47591	Good Samaritan Hospital	Trauma Level III	10
46526	Goshen Health	Non-Trauma Centers	2
47441	Greene County General Hospital	Non-Trauma Centers	7
46140	Hancock Health	Non-Trauma Centers	5
47112	Harrison County Hospital	Non-Trauma Centers	9
46122	Hendricks Regional Health	Non-Trauma Centers	5

47362	Henry Community Health	Non-Trauma Centers	6
47905	IU Health Arnett Hospital	Trauma Level III	4
47303	IU Health Ball Memorial Hospital	Trauma Level III	6
47421	IU Health Bedford Hospital	Non-Trauma Centers	8
47403	IU Health Bloomington Hospital	Trauma Level III	8
46041	IU Health Frankfort Hospital	Non-Trauma Centers	4
47371	IU Health Jay	Non-Trauma Centers	6
46202	IU Health Methodist Hospital	Trauma Levels I & II	5
46151	IU Health Morgan Hospital	Non-Trauma Centers	5
46032	IU Health North Hospital	Non-Trauma Centers	5
47454	IU Health Paoli Hospital	Non-Trauma Centers	8
46202	IU Health Riley Hospital for Children	Trauma Levels I & II	5
46037	IU Health Saxony Hospital	Non-Trauma Centers	5
46072	IU Health Tipton Hospital	Non-Trauma Centers	6
46123	IU Health West Hospital	Non-Trauma Centers	5
47960	IU Health White Memorial Hospital	Non-Trauma Centers	4
47371	Jay County Hospital	Non-Trauma Centers	6
46131	Johnson Memorial Hospital	Non-Trauma Centers	5
46802	Lutheran Downtown	Non-Trauma Centers	3
46804	Lutheran Hospital of Indiana	Trauma Levels I & II	3
46580	Lutheran Kosciusko Hospital	Non-Trauma Centers	2
46176	Major Hospital	Non-Trauma Centers	5
47006	Margaret Mary Health	Non-Trauma Centers	9
46952	Marion Health	Non-Trauma Centers	6
47546	Memorial Hospital and Health Care Center	Trauma Level III	10
46947	Memorial Hospital Logansport	Non-Trauma Centers	4
46601	Memorial Hospital of South Bend	Trauma Levels I & II	2
46402	Methodist Hospitals Inc Northlake Campus	Non-Trauma Centers	1
46410	Methodist Hospitals Inc Southlake Campus	Non-Trauma Centers	1
47403	Monroe Hospital	Non-Trauma Centers	8

46350	Northwest Health La Porte	Non-Trauma Centers	1
46368	Northwest Health Portage	Non-Trauma Centers	1
46383	Northwest Health Porter	Non-Trauma Centers	1
46383	Northwest Health Valparaiso Medical Center (VMC)	Non-Trauma Centers	1
47250	Norton King's Daughters' Health	Non-Trauma Centers	9
46706	Parkview DeKalb Hospital	Non-Trauma Centers	3
46750	Parkview Huntington Hospital	Non-Trauma Centers	3
46761	Parkview LaGrange Hospital	Non-Trauma Centers	3
46755	Parkview Noble Hospital	Non-Trauma Centers	3
46805	Parkview Randallia	Non-Trauma Centers	3
46845	Parkview Regional Medical Center	Trauma Levels I & II	3
46992	Parkview Wabash	Non-Trauma Centers	3
	Parkview Warsaw	Non-Trauma Centers	3
46725	Parkview Whitley	Non-Trauma Centers	3
47586	Perry County Memorial Hospital	Non-Trauma Centers	10
46260	Peyton Manning Childrens Hospital at St Vincent	Non-Trauma Centers	5
46996	Pulaski Memorial Hospital	Non-Trauma Centers	2
46135	Putnam County Hospital	Non-Trauma Centers	7
47374	Reid Health	Trauma Level III	6
47331	Reid Health Connersville	Non-Trauma Centers	6
46060	Riverview Health	Non-Trauma Centers	5
46074	Riverview Health Westfield	Non-Trauma Centers	5
46173	Rush Memorial Hospital	Non-Trauma Centers	6
46545	Saint Joseph Regional Medical Center (Mishawaka)	Non-Trauma Centers	2
46563	Saint Joseph Regional Medical Center (Plymouth)	Non-Trauma Centers	2
47274	Schneck Medical Center	Non-Trauma Centers	8
47170	Scott Memorial Health	Non-Trauma Centers	9
46312	St. Catherine Hospital East Chicago	Non-Trauma Centers	1
47025	St. Elizabeth Dearborn	Non-Trauma Centers	9
46342	St. Mary Medical Center (Hobart)	Non-Trauma Centers	1

46534	Starke Hospital	Non-Trauma Centers	2
47882	Sullivan County Community Hospital	Non-Trauma Centers	7
47802	Terre Haute Regional Hospital	Trauma Level III	7
47842	Union Hospital Clinton	Non-Trauma Centers	7
47804	Union Hospital Terre Haute	Trauma Level III	7
46052	Witham Health Services	Non-Trauma Centers	5
46077	Witham Health Services at Anson	Non-Trauma Centers	5
46975	Woodlawn Hospital	Non-Trauma Centers	2

## **Appendix 3: Glossary of Terms**

## Glossary

### CO-MORBID CONDITIONS

**Advanced Directive Limiting Care:** The patient had a written request limiting life sustaining therapy, or similar advanced directive, present prior to arrival at your center.

**Alcohol Use Disorder:** (Consistent with the American Psychiatric Association (APA) DMS 5, 2013.

Always use the most recent definition provided by the APA.) Diagnosis of alcohol use disorder documented in the patient's medical record, present prior to injury.

**Angina Pectoris:** (Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA.) Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of Angina or Chest Pain must be documented in the patient's medical record.

**Anticoagulant Therapy:** Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Exclude patients who are on chronic Aspirin therapy. Some examples are:

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

**Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD):**

A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment, present prior to ED/Hospital arrival. A diagnosis of ADD/ADHD must be documented in the patient's medical record.

**Bleeding Disorder:** (Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology.) A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden.)

**Cerebral Vascular Accident (CVA):** A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g. hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory). A diagnosis of CVA must be documented in the patient's medical record.

**Chronic Obstructive Pulmonary Disease (COPD):** (Consistent with World Health Organization (WHO), 2015. Always use the most recent definition provided by the WHO.) Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease, but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

A diagnosis of COPD must be documented in the patient's medical record. Do not include patients whose only pulmonary disease is acute asthma, and/or diffuse interstitial fibrosis or sarcoidosis.

**Chronic Renal Failure:** Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration, present prior to injury. A diagnosis of Chronic Renal Failure must be documented in the patient's medical record.

**Cirrhosis:** Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease, present prior to injury. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic

encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.

**Congenital Anomalies:** Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly, present prior to injury. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.

**Congestive Heart Failure (CHF):** The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure, present prior to injury. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.

Common manifestations are:

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

**Current Smoker:** A patient who reports smoking cigarettes every day or some days within the last 12 months, prior to injury. Exclude patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

**Currently Receiving Chemotherapy for Cancer:** A patient who is currently receiving any chemotherapy treatment for cancer, prior to injury. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

**Dementia:** Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's) present prior to injury.



**Diabetes Mellitus:** Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent, present prior to injury. A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.

**Disseminated Cancer:** Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal, present prior to injury. Other terms describing disseminated cancer include: "diffuse", "widely metastatic", "widespread", or "carcinomatosis". Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, and/or bone). A diagnosis of Cancer that has spread to one or more sites must be documented in the patient's medical record.

**Functionally Dependent Health Status:** Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL). Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking. Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

**Hypertension:** History of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of Hypertension must be documented in the patient's medical record.

**Mental/Personality Disorder:** (Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.) Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

**Myocardial Infarction:** History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

**Peripheral Arterial Disease (PAD):** (Consistent with Centers for Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC.) The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called

atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PAD must be documented in the patient's medical record.

**Prematurity:** Infants delivered before 37 weeks from the first day of the last menstrual period, and a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. A diagnosis of Prematurity, or delivery before 37 weeks gestation, must be documented in the patient's medical record.

**Steroid Use:** Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition. Examples of oral or parenteral corticosteroid medications are: prednisone and dexamethasone. Examples of chronic medical conditions are: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease. Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

**Substance Abuse Disorder:** (Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.) Documentation of Substance Abuse Disorder documented in the patient medical record, present prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.

### **HOSPITAL COMPLICATIONS**

**Acute Kidney Injury:** (Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline. Always use the most recent definition provided by the KDIGO.) Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient's initial stay at your hospital.

#### **KDIGO (Stage 3) Table:**

(SCr) 3 times baseline

**OR**

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

**OR**

Initiation of renal replacement therapy OR, in patients  $< 18$  years, decrease in eGFR to  $< 35$  ml/min per  $1.73$   $\text{m}^2$

**OR**

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

**OR**

Anuria for > 12 hours

A diagnosis of AKI must be documented in the patient's medical record. If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.

EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

**Acute Respiratory Distress Syndrome (ARDS):** (Consistent with the 2012 New Berlin Definition. Always use the most recent New Berlin definition provided.)

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

Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or Nodules Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.

Oxygenation:  $200 < PaO_2/FiO_2 \leq 300$  (at a minimum) With PEEP or CPAP  $\geq 5$  cmH<sub>2</sub>O

A diagnosis of ARDS must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Alcohol Withdrawal Syndrome:** (Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.)

Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record.

**Cardiac Arrest with CPR:** Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac Arrest must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

EXCLUDE patients who are receiving CPR on arrival to your hospital.

INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

**Catheter-Associated Urinary Tract Infection (CAUTI):** (Consistent with the January 2016 CDC defined

CAUTI. Always use the most recent definition provided by the CDC.) A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1, **AND**

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

#### **January 2016 CDC CAUTI Criterion SUTI 1a:**

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

1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device
  - placement = Day 1) AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least **one** of the following signs or symptoms:
  - Fever (>38<sup>0</sup>C)
  - Suprapubic tenderness with no other recognized cause
  - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10<sup>5</sup> CFU/ml.

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

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

1. Patient is ≤1 year of age
2. Patient has at least **one** of the following signs or symptoms:
  - fever (>38.0<sup>0</sup>C)
  - hypothermia (<36.0<sup>0</sup>C)
  - apnea with no other recognized cause
  - bradycardia with no other recognized cause
  - lethargy with no other recognized cause

- vomiting with no other recognized cause
- suprapubic tenderness with no other recognized cause

Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of  $\geq 10^5$  CFU/ml.

A diagnosis of UTI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Central Line-Associated Bloodstream Infection (CLABSI):** (Consistent with the January 2016 CDC defined CLABSI. Always use the most recent definition provided by the CDC.) A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

**AND**

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

**January 2016 CDC Criterion LCBI 1:**

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

**AND**

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

**OR**

**January 2016 CDC Criterion LCBI 2:**

Patient has at least one of the following signs or symptoms: fever ( $>38^{\circ}\text{C}$ ), chills, or hypotension

**AND**

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

**AND**

The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*],

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

**OR**

**January 2016 CDC Criterion LCBI 3:**

Patient  $\leq$  1 year of age has at least one of the following signs or symptoms: fever ( $>38^{\circ}$  C), hypothermia ( $<36^{\circ}$ C), apnea, or bradycardia

**AND**

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

**AND**

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

A diagnosis of LCBSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Deep Surgical Site Infection:** (Consistent with the January 2016 CDC defined SSI.

Always use the most recent definition provided by the CDC.) Must meet the following criteria:

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

**AND**

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

**AND**

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

- a. purulent drainage from the deep incision.

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

**AND**

patient has at least **one** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.

c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

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

**Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN**

**Operative**

**Procedure Categories. Day 1 = the date of the procedure.**

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Deep Vein Thrombosis (DVT):** The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava. A diagnosis of DVT must be documented in the patient's medical record. This diagnosis may be confirmed by a venogram, ultrasound, or CT, and must have occurred during the patient's initial stay at your hospital.

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



Compartment Syndrome must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital. Only record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

**Myocardial Infarction (MI):** An acute myocardial infarction must be noted with documentation of any of the following:

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

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

**OR**

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

**OR**

Physician diagnosis of myocardial infarction

Must have occurred during the patient's initial stay at your hospital.

**Organ/Space Surgical Site Infection:** (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria:

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

**AND**

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

**AND**

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

- a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

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

**AND**

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

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy

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AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

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

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

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Osteomyelitis:** (Consistent with the January 2016 CDC definition of Bone and Joint infection. Always use the most recent definition provided by the CDC.) Osteomyelitis must meet at least **one** of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling\*, pain or tenderness\*, heat\*, or drainage\*

**And at least one of the following:**

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

\* With no other recognized cause

A diagnosis of Osteomyelitis must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Pulmonary Embolism:** A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record. Must have occurred during the patient's initial stay at your hospital.

**Pressure Ulcer:** (Consistent with the National Pressure Ulcer Advisory Panel (NPUAP) 2014. Always use the most recent definition provided by the NPUAP.) A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Severe Sepsis:** (Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010. Always use the most recent definition provided by the American College of Chest Physicians and the Society of Critical Care Medicine.)

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

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

A diagnosis of Sepsis must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

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

- Change in level of consciousness

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

**AND:**

- Duration of neurological deficit  $\geq 24$  h

**OR:**

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

**AND:**

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

**AND:**

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

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

**Superficial Incisional Surgical Site Infection:** (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria:

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

**AND**

involves only skin and subcutaneous tissue of the incision

**AND**

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

- a. purulent drainage from the superficial incision.

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

**AND**

patient has at least **one** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture-based test that has a negative finding does not meet this criterion.

- d. diagnosis of a superficial incisional SSI by the surgeon or attending physician\*\* or other designer.

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

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

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

**Unplanned Admission to ICU:** Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge. Must have occurred during the patient's initial stay at your hospital. **EXCLUDE:** Patients in which ICU care was required for postoperative care of a planned surgical procedure.

**Unplanned Intubation:** Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the element or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubating. Must have occurred during the patient's initial stay at your hospital.

**Unplanned Return to the Operating Room:** Unplanned return to the operating room after initial operation management for a similar or related previous procedure. Must have occurred during the patient's initial stay at your hospital.

**Ventilator-Associated Pneumonia (VAP):** (Consistent with the January 2016 CDC defined VAP. Always use the most recent definition provided by the CDC.) A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

**AND**

The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.

**VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):**

**VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least one of the following:	At least one of the following:	At least one of the following:

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<ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatocoles, in infants <math>\leq 1</math> year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</p>	<ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li> <li>• Leukopenia (<math>\leq 4000</math> WBC/mm<sup>3</sup>) or leukocytosis (<math>\geq 12,000</math> WBC/mm<sup>3</sup>)</li> <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least two of the following:</p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations (e.g., PaO<sub>2</sub>/FiO<sub>2</sub><math>\leq 240</math>), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<ul style="list-style-type: none"> <li>• Organism identified from blood</li> <li>• Organism identified from pleural fluid</li> <li>• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.)</li> <li>• <math>\geq 5\%</math> BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)</li> <li>• Positive quantitative culture of lung tissue</li> <li>• Histopathologic exam shows at least one of the following evidences of pneumonia:               <ul style="list-style-type: none"> <li>○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</li> <li>○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</li> </ul> </li> </ul>
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**VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least one of the following: <ul style="list-style-type: none"> <li>New or progressive and persistent infiltrate</li> <li>Consolidation</li> <li>Cavitation</li> <li>Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul>	At least one of the following: <ul style="list-style-type: none"> <li>Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li> <li>Leukopenia (<math>\leq 4000</math> WBC/mm<sup>3</sup>) or leukocytosis (<math>\geq 12,000</math> WBC/mm<sup>3</sup>)</li> <li>For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> </ul> AND at least one of the following:	At least one of the following: <ul style="list-style-type: none"> <li>Virus, <i>Bordetella</i>, <i>Legionella</i>, <i>Chlamydia</i> or <i>Mycoplasma</i> identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).</li> <li>Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, <i>Chlamydia</i>)</li> <li>Fourfold rise in <i>Legionella pneumophila</i> serogroup 1 antibody titer to <math>\geq 1:128</math> in paired acute and convalescent sera by indirect IFA.</li> </ul>

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NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	<ul style="list-style-type: none"> <li>New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>New onset or worsening cough, or dyspnea, or tachypnea</li> <li>Rales or bronchial breath sounds</li> <li>Worsening gas exchange (e.g., O<sub>2</sub> desaturations (e.g., PaO<sub>2</sub>/FIO<sub>2</sub><math>\leq 240</math>), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<ul style="list-style-type: none"> <li>Detection of <i>L. pneumophila</i> serogroup 1 antigens in urine by RIA or EIA</li> </ul>
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**VAP Algorithm (PNU3 Immunocompromised Patients):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least one of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease),</p>	<p>Patient who is immunocompromised has at least one of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> <li>• New onset of purulent sputum<sup>3</sup>, or change in character of sputum<sup>4</sup>, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea<sup>5</sup></li> <li>• Rales<sup>6</sup> or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations [e.g., PaO<sub>2</sub>/FiO<sub>2</sub> &lt;240]<sup>7</sup>, increased oxygen requirements, or increased ventilator demand)</li> </ul>	<p>At least one of the following:</p> <ul style="list-style-type: none"> <li>• Identification of matching <i>Candida</i> spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.<sup>11,12,13</sup></li> <li>• Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: <ul style="list-style-type: none"> <li>- Direct microscopic exam</li> <li>- Positive culture of fungi</li> <li>- Non-culture diagnostic laboratory test</li> </ul> </li> </ul> <p>Any of the following from:  <b>LABORATORY CRITERIA DEFINED UNDER PNU2</b></p>

A3.16

one definitive chest imaging test result is acceptable.	<ul style="list-style-type: none"> <li>• Hemoptysis</li> <li>• Pleuritic chest pain</li> </ul>
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**VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:**

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

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

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

A diagnosis of Pneumonia must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Other Terms**

**Patient's Occupational Industry:** The occupational history associated with the patient's work environment.

*Element Value Definitions:*

**Finance and Insurance** - The Finance and Insurance sector comprises establishments

primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:

- Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
- Pooling of risk by underwriting insurance and annuities.
- Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

**Real Estate** - Industries in the Real Estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.

**Manufacturing** - The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling equipment. However, establishments that make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

**Retail Trade** - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:

- Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
- Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

**Transportation and Public Utilities** - The Transportation and warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.

**Agriculture, Forestry, Fishing** - The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. The establishments in this sector are often described as farms, ranches, dairies, greenhouses, nurseries, orchards, or hatcheries.

**Professional and Business Services** - The Professional, Scientific, and Technical

Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. These activities require a high degree of expertise and training. The establishments in this sector specialize according to expertise and provide these services to clients in a variety of industries and, in some cases, to households. Activities performed include legal advice and representation; accounting, bookkeeping, and payroll services; architectural, engineering, and specialized design services; computer services; consulting services; research services; advertising services; photographic services; translation and interpretation services; veterinary services; and other professional, scientific, and technical services.

**Education and Health Services** - The Educational Services sector comprises establishments that provide instruction and training in a wide variety of subjects. This instruction and training is provided by specialized establishments, such as schools, colleges, universities, and training centers. These establishments may be privately owned and operated for profit or not for profit, or they may be publicly owned and operated. They may also offer food and/or accommodation services to their students. The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities.

**Construction** - The construction sector comprises establishments primarily engaged in the construction of buildings or engineering projects (e.g., highways and utility systems). Establishments primarily engaged in the preparation of sites for new construction and establishments primarily engaged in subdividing land for sale as building sites also are included in this sector. Construction work done may include new work, additions, alterations, or maintenance and repairs.

**Government** - Civil service employees, often called civil servants or public employees, work in a variety of elements such as teaching, sanitation, health care, management, and administration for the federal, state, or local government. Legislatures establish basic prerequisites for employment such as compliance with minimal age and educational requirements and residency laws.

**Natural Resources and Mining** - The Mining sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations, beneficiating (e.g., crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity.

**Information Services** - The Information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, and (c) processing data.

**Wholesale Trade** - The Wholesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The merchandise described in this sector includes the outputs of agriculture, mining, manufacturing, and certain information industries, such as publishing.

**Leisure and Hospitality** - The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. This sector comprises (1) establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; (2) establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and (3) establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. The Accommodation and Food Services sector comprises establishments providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment.

**Other Services** - The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grantmaking, advocacy,

**Patient's Occupation:** The occupation of the patient.

*Element Value Definitions:*

**Business and Financial Operations Occupations**

Buyers and Purchasing Agents Accountants and Auditors Claims Adjusters, Appraisers, Examiners, and Investigators Human Resources Workers, Market Research Analysts and Marketing Specialists Business Operations Specialists

**Architecture and Engineering Occupations**

Landscape Architects, Surveyors, Cartographers, and Photogrammetrists  
Agricultural Engineers, Chemical Engineers Civil Engineers, Electrical Engineers

**Community and Social Services Occupations**

Marriage and Family Therapists Substance Abuse and Behavioral Disorder Counselors  
Healthcare Social workers, Probation Officers and Correctional Treatment Specialists  
Clergy

**Education, Training, and Library Occupations**

Engineering and Architecture Teachers, Postsecondary Math and Computer Teachers,  
Postsecondary  
Nursing Instructors and Teachers, Postsecondary

Law, Criminal Justice, and Social Work Teachers, Postsecondary Preschool and Kindergarten Teachers, Librarians

**Healthcare Practitioners and Technical Occupations**

Dentists, All Other Specialists Dietitians and Nutritionists Physicians and Surgeons Nurse Practitioners, Cardiovascular Technologists and Technicians  
Emergency Medical Technicians and Paramedics

**Protective Service Occupations**

Firefighters Police Officers  
Animal Control Workers  
Security Guards Lifeguards, Ski Patrol, and Other Recreational Protective Service

**Building and Grounds Cleaning and Maintenance**

Building Cleaning Workers  
Landscaping and Grounds keeping Workers Pest Control Workers Pesticide Handlers, Sprayers, and Applicators, Vegetation  
Tree Trimmers and Pruners

**Sales and Related Occupations**

Advertising Sales Agents Retail Salespersons Counter and Rental Clerks  
Door-to-Door Sales Workers, News and Street Vendors, and Related Workers Real Estate Brokers

**Farming, Fishing, and Forestry Occupations**

Animal Breeders, Fishers and Related Fishing Workers  
Agricultural Equipment Operators Hunters and Trappers Forest and Conservation Workers, Logging Workers

**Installation, Maintenance, and Repair Occupations**

Electric Motor, Power Tool, and Related Repairers Aircraft Mechanics and Service Technicians Automotive Glass Installers and Repairers Heating, Air Conditioning, and Refrigeration Mechanics and Installers Maintenance Workers, Machinery Industrial Machinery Installation, Repair, and Maintenance Workers

**Transportation and Material Moving Occupations**

Rail Transportation Workers, All Other Subway and Streetcar Operators Packers and Packagers, Hand Refuse and Recyclable Material Collectors Material Moving Workers, All Other Driver/Sales Workers

**Management Occupations**

Public Relations and Fundraising Managers Marketing and Sales Managers Administrative Services Managers Transportation, Storage, and Distribution Managers Transportation, Storage, and Distribution Managers Food Service Managers

**Computer and Mathematical Occupations**

Computer Occupations, All Other Web Developers  
Software Developers and Programmers  
Database Administrators Statisticians

### **Life, Physical, and Social Science Occupations**

Psychologists Economists Foresters Zoologists and Wildlife Biologists Political Scientists  
Agricultural and Food Science Technicians

### **Legal Occupations**

Lawyers and Judicial Law Clerks Paralegals and Legal Assistants Court Reporters  
Administrative Law Judges, Adjudicators, and Hearing Officers  
Arbitrators, Mediators, and Conciliators Title Examiners, Abstractors, and Searchers

### **Arts, Design, Entertainment, Sports, and Media**

Artists and Related Workers, All Other  
Athletes, Coaches, Umpires, and Related Workers  
Dancers and Choreographers Reporters and Correspondents  
Interpreters and Translators Photographers

### **Healthcare Support Occupations**

Nursing, Psychiatric, and Home Health Aides Physical Therapist Assistants and Aides  
Veterinary Assistants and Laboratory Animal Caretakers Healthcare Support Workers, All  
Other Medical Assistants

### **Food Preparation and Serving Related**

Bartenders  
Cooks, Institution and Cafeteria Cooks, Fast Food Dishwashers  
Counter Attendants, Cafeteria, Food Concession, and Coffee Shop Waiters and waitresses

### **Personal Care and Service Occupations**

Animal Trainers  
Amusement and Recreation Attendants  
Barbers, Hairdressers, Hairstylists and Cosmetologists Baggage Porters, Bellhops, and  
Concierges Tour Guides and Escorts Recreation and Fitness Workers

### **Office and Administrative Support Occupations**

Bill and Account Collectors Gaming Cage Workers Payroll and Timekeeping Clerks Tellers  
Court, Municipal, and License Clerks Hotel, Motel, and Resort Desk Clerks

### **Construction and Extraction Occupations**

Brickmasons, Blockmasons, and Stonemasons Carpet, Floor, and Tile Installers and  
Finishers Construction Laborers, Electricians, Pipelayers, Plumbers, Pipefitters, and  
Steamfitters Roofers

### **Production Occupations**

Electrical, Electronics, and Electromechanical Assemblers Engine and Other Machine  
Assemblers  
Structural Metal Fabricators and Fitters Butchers and Meat Cutters  
Machine Tool Cutting Setters, Operators, and Tenders, Metal and Plastic Welding,  
Soldering, and Brazing Workers

### **Military Specific Occupations**

Air Crew Officers, Armored Assault Vehicle Officers Artillery and Missile Officers, Infantry



Officers

Military Officer Special and Tactical Operations Leaders,

All Other and providing dry cleaning and laundry services, personal care services, and death care services, pet care services, photofinishing services, temporary parking services, and dating services.

**Foreign Visitor** is defined as any person visiting a country other than his/her usual place of residence for any reason.

**Intermediate care facility:** A facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board.

**Home Health Service:** A certified service approved to provide care received at home as part-time skilled nursing care, speech therapy, physical or occupational therapy or part-time services of home health aides.

**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.

**Hospice:** An organization which is primarily designed to provide pain relief, symptom management and supportive services for the terminally ill and their families.

**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.

**Operative and/or essential procedures** is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries. Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

**Skilled Nursing Care:** Daily nursing and rehabilitative care that is performed only by or under the supervision of skilled professional or technical personnel. Skilled care includes administering medication, medical diagnosis and minor surgery.

**Undocumented Citizen** is defined as a national of another country who has entered or stayed in another country without permission.

# Appendix 4

## Indiana Statewide Trauma Center and Emergency Department Map

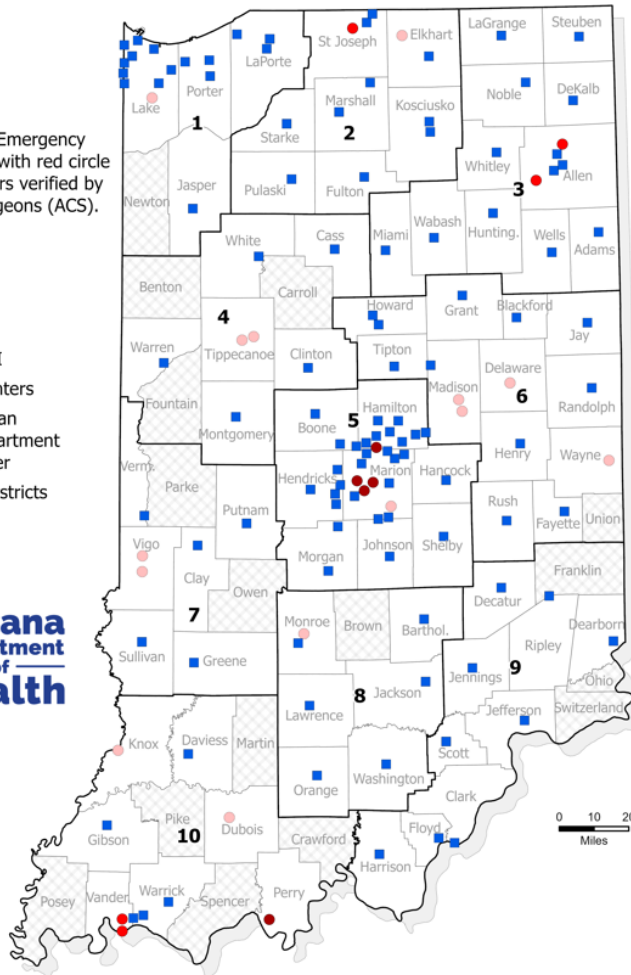
All hospital locations have Emergency Departments (ED). Locations with red circle indicators have trauma centers verified by the American College of Surgeons (ACS).

### Map Legend

- Trauma Level I
- Trauma Level II
- Trauma Level III
- Non-Trauma Centers
- County without an Emergency Department or Trauma Center
- Preparedness Districts



**Indiana  
Department  
of  
Health**



Data Source: IDOH Division of Trauma and Injury Prevention  
 Map Author: IDOH Office of Data Analytics  
 Date: 10/06/2023

## Appendix 5: Acronyms

- AIS: Abbreviated Injury Scale
- CDC: Centers for Disease Control
- CPR: cardiopulmonary resuscitation
- CT: computerized tomography
- ED: emergency department
- EMS: emergency medical service
- GCS: Glasgow Coma Scale
- ICD-10: International Classification of Diseases, Tenth Revision
- ICD-10-CA: International Classification of Diseases, Tenth Revision, Canada
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
- ICD-10-PCS: International Classification of Diseases, Tenth Revision, Procedure Coding System
- ICU: intensive care unit
- LOS: length of stay
- NA: not applicable
- NEMSIS: National Emergency Medical Services Information System
- NK/NR: not known/not recorded
- NTDB: National Trauma Data Bank
- NTDS: National Trauma Data Standard
- OR: operating room
- PACU: post-anesthesia care unit
- TQIP: Trauma Quality Improvement Program
- TQP: Trauma Quality Programs