ATTACHMENT A

ARKANSAS TRAUMA DATA DICTIONARY

Arkansas Department of Health

Arkansas Trauma Registry

Data Dictionary

Required Data Elements

Revision 7.0

Effective January 1, 2019

Contents

Patient Inclusion Criteria xv

DEMOGRAPHIC INFORMATION 1

RECORD INFORMATION 2

FACILITY 3

TRAUMA NUMBER 4

PATIENT ARRIVAL (DATE) 5

PATIENT ARRIVAL (TIME) 6

TRAUMA BAND NUMBER 7

PATIENT NAME: LAST 8

PATIENT NAME: FIRST 9

ARRIVED FROM 10

PATIENT INFORMATION 11

DATE OF BIRTH 12

AGE 13

AGE UNITS 14

SEX 15

ETHNICITY 16

RACE 17

PATIENT'S HOME ZIP/POSTAL CODE 18

PATIENT'S HOMELESS STATUS 19

PATIENT'S HOME CITY 20

PATIENT'S HOME STATE 21

PATIENT'S HOME COUNTY 22

PATIENT'S HOME COUNTRY 23

ALTERNATE HOME RESIDENCE 24
INJURY 25
INJURY INFORMATION 26
INJURY INCIDENT DATE 27
INJURY INCIDENT TIME 28
ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE 29
CHILD SPECIFIC RESTRAINT 30
AIRBAG DEPLOYMENT 31
PROTECTIVE DEVICES 32
INCIDENT LOCATION ZIP/POSTAL CODE 33
INCIDENT CITY 34
INCIDENT STATE 35
INCIDENT COUNTY 36
INCIDENT COUNTRY 37
WORK-RELATED 38
PATIENT'S OCCUPATION 39
PATIENT'S OCCUPATIONAL INDUSTRY 2
REPORT OF PHYSICAL ABUSE 3
INVESTIGATION OF PHYSICAL ABUSE 4
MECHANISM OF INJURY 5
ICD-10 PRIMARY EXTERNAL CAUSE CODE 6
ICD-10 ADDITIONAL EXTERNAL CAUSE CODE 7
PRE-HOSPITAL INFORMATION 8
SCENE/TRANSPORT PROVIDERS 9
TRANSPORT MODE 10

OTHER TRANSPORT MODE 11
TRANSPORT ROLE 12
SCENE EMS REPORT 13
EMS DISPATCH DATE 14
EMS DISPATCH TIME 15
EMS RESPOND DATE 16
EMS RESPOND TIME 17
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY 18
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY 19
EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY 20
EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY 21
EMS UNIT ARRIVED AT DESTINATION DATE 22
EMS UNIT ARRIVED AT DESTINATION TIME 23
TRAUMA CENTER CRITERIA 24
VEHICULAR, PEDESTRIAN, OTHER RISK INJURY 25
TREATMENT 27
INITIAL FIELD RESPIRATORY ASSISTANCE 28
INITIAL FIELD SYSTOLIC BLOOD PRESSURE 29
INITIAL FIELD PULSE RATE 30
INITIAL FIELD RESPIRATORY RATE 31
INITIAL FIELD OXYGEN SATURATION 32
INITIAL FIELD SUPPLEMENTAL OXYGEN 33
INITIAL FIELD GCS - EYE 34
INITIAL FIELD GCS - VERBAL 35
INITIAL FIELD GCS - MOTOR 36

INITIAL FIELD GCS - TOTAL 37
INITIAL FIELD GCS 40 - EYE 38
INITIAL FIELD GCS 40 - VERBAL 39
INITIAL FIELD GCS 40 - MOTOR 40
REFERRING FACILITY 41
REFERRAL HISTORY – IMMEDIATE REFERRING FACILITY 42
INTER-FACILITY TRANSFER 43
REFERRING HOSPITAL 44
REFERRING HOSPITAL ARRIVAL DATE 45
REFERRING HOSPITAL ARRIVAL TIME 46
REFERRING HOSPITAL DISCHARGE DATE 47
REFERRING HOSPITAL DISCHARGE TIME 48
ASSESSMENTS 49
REFERRING HOSPITAL SYSTOLIC BLOOD PRESSURE 50
REFERRING HOSPITAL PULSE RATE 51
REFERRING HOSPITAL UNASSISTED RESPIRATION RATE 52
REFERRING HOSPITAL ASSISTED RESPIRATION RATE 53
REFERRING HOSPITAL GCS - EYE 54
REFERRING HOSPITAL GCS - VERBAL 55
REFERRING HOSPITAL GCS - MOTOR 56
REFERRING HOSPITAL GCS - TOTAL 57
ALCOHOL SCREEN 58
ALCOHOL SCREEN RESULTS 59
DRUG SCREEN 60
INTER-FACILITY TRANSPORT 61

TRANSPORT MODE 62
TRANSPORT ROLE 63
EMS DISPATCH DATE 64
EMS DISPATCH TIME 65
EMS RESPOND DATE 66
EMS RESPOND TIME 67
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY 68
EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY 69
EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY 70
EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY 71
EMS UNIT ARRIVED AT DESTINATION DATE 72
EMS UNIT ARRIVED AT DESTINATION TIME 73
ED / RESUSCITATION 74
ARRIVAL/ADMISSION 75
ED DIRECT ADMIT 76
ED/HOSPITAL ARRIVAL DATE 77
ED/HOSPITAL ARRIVAL TIME 78
ED DISCHARGE DATE 79
ED DISCHARGE TIME 80
ED DEPARTURE DATE 81
ED DEPARTURE TIME 82
SIGNS OF LIFE 83
MODE OF ARRIVAL 84
TRAUMA TEAM ACTIVATION LEVEL 85
TRAUMA TEAM ACTIVATION DATE 86

TRAUMA TEAM ACTIVATION TIME 87
ED DISCHARGE DISPOSITION 88
HOSPITAL ADMITTING SERVICE 89
NATIONAL PROVIDER IDENTIFIER (NPI) 90
OR DISPOSITION 91
ARKANSAS TRAUMA COMMUNICATIONS CENTER (ATCC) UTILIZATION 92
ATCC NOT UTILIZED; PLEASE SPECIFY* 93
ATCC DATE OF CONTACT 94
ATCC TIME OF CONTACT 95
REASON FOR TRANSFER* 96
ANTIBIOTICS THERAPY* 97
ANTIBIOTICS THERAPY - SPECIFY LOCATION* 98
ANTIBIOTICS THERAPY DATE* 99
ANTIBIOTICS THERAPY TIME* 100
ANTICOAGULANTS AT HOME 101
ANTICOAGULANTS AT HOME 102
HEAD CT SCAN 103
INITIAL ASSESSMENT 104
INITIAL ED/HOSPITAL TEMPERATURE 105
INITIAL ED/HOSPITAL TEMPERATURE UNITS 106
INITIAL ED/HOSPITAL TEMPERATURE ROUTE 107
INITIAL ED/HOSPITAL WEIGHT 108
INITIAL ED/HOSPITAL WEIGHT UNITS 109
INITIAL ED/HOSPITAL HEIGHT 110
INITIAL ED/HOSPITAL HEIGHT UNITS 111

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS 112
INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE 114
INITIAL ED/HOSPITAL PULSE RATE 115
INITIAL ED/HOSPITAL RESPIRATORY RATE 116
INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE 117
INITIAL ED/HOSPITAL OXYGEN SATURATION 118
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN 119
INITIAL ED/HOSPITAL GCS – EYE 120
INITIAL ED/HOSPITAL GCS - VERBAL 121
INITIAL ED/HOSPITAL GCS - MOTOR 122
INITIAL ED/HOSPITAL GCS - TOTAL 123
INITIAL ED/HOSPITAL GCS 40 - EYE 124
INITIAL ED/HOSPITAL GCS 40 - VERBAL 125
INITIAL ED/HOSPITAL GCS 40 - MOTOR 126
LABS/TOXICOLOGY 127
PATIENT TRACKING 131
LOCATION/SERVICE 132
TOTAL ICU LENGTH OF STAY 133
VENTILATOR/BLOOD 134
TOTAL VENTILATOR DAYS 135
PROVIDERS 136
RESUSCITATION TEAM 137
SURGEON CALLED DATE 138
SURGEON CALLED TIME 139
SURGEON ARRIVED DATE 140

SURGEON ARRIVED TIME 141
IN-HOUSE CONSULTS 142
CONSULTS 143
PROCEDURES 144
ICD-10 HOSPITAL PROCEDURES 145
HOSPITAL PROCEDURE START DATE 148
HOSPITAL PROCEDURE START TIME 149
DIAGNOSIS 150
INJURY CODING 151
AIS VERSION 152
ISS 153
ICD-10 INJURY DIAGNOSIS 154
AIS PREDOT CODE 155
AIS SEVERITY 156
ISS BODY REGION 157
COMORBIDITIES 158
PRE-HOSPITAL CARDIAC ARREST 159
ADVANCE DIRECTIVE LIMITING CARE 160
ALCOHOL USE DISORDER 161
ANGINA PECTORIS 162
ANTICOAGULANT THERAPY 163
ATTENTION DEFICITY DISORDER/ATTENTION DEFICITY HYPERACTIVITY DISORDER (ADD/ADHD) 164
BLEEDING DISORDER 165
CEREBRAL VASCULAR ACCIDENT (CVA) 166
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) 167

CHRONIC RENAL FAILURE 168
CIRRHOSIS 169
CONGENITAL ANOMALIES 170
CONGESTIVE HEART FAILURE (CHF) 171
CURRENT SMOKER 172
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER 173
DEMENTIA 174
DIABETES MELLITUS 175
DISSEMINATED CANCER 176
FUNCTIONALLY DEPENDENT HEALTH STATUS 177
HYPERTENSION 178
MENTAL/PERSONALITY DISORDERS 179
MYOCARDIAL INFARCTION (MI) 180
PERIPHERAL ARTERIAL DISEASE (PAD) 181
PREMATURITY 182
STEROID USE 183
SUBSTANCE ABUSE DISORDER 184
OUTCOME 185
INITIAL DISCHARGE 186
HOSPITAL DISCHARGE STATUS 187
DISCHARGE/DEATH DATE 188
DISCHARGE/DEATH TIME 189
HOSPITAL DISCHARGE DATE 190
HOSPITAL DISCHARGE TIME 191
TOTAL ICU LENGTH OF STAY 192

TOTAL VENTILATOR DAYS 193
TOTAL HOSPITAL DAYS 194
HOSPITAL DISCHARGE DISPOSITION 195
CAREGIVER AT DISCHARGE 196
DISCHARGE DESTINATION HOSPITAL 197
PATIENT TRANSFER MODE (SENDING FACILITY ONLY) 198
IF DEATH 199
LIFE SUPPORT WITHDRAWN 200
AUTOPSY DONE 201
AUTOPSY NUMBER 202
AUTOPSY RESULTS REQUESTED 203
AUTOPSY RESULTS RECEIVED 204
ORGAN DONATION 205
ORGANS DONATED 206
BILLING 207
QA TRACKING 209
QA ITEMS 210
ACUTE KIDNEY INJURY (AKI) 211
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS) 213
ALCOHOL WITHDRAWAL SYNDROME 214
CARDIAC ARREST WITH CPR 215
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI) 216
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI) 218
DEEP SURGICAL SITE INFECTION 220
DEEP VEIN THROMBOSIS (DVT) 222

EXTREMITY COMPARTMENT SYNDROME 223
MYOCARDIAL INFARCTION (MI) 224
ORGAN/SPACE SURGICAL SITE INFECTION 225
OSTEOMYELITIS 227
PULMONARY EMBOLISM (PE) 228
PRESSURE ULCER 229
SEVERE SEPSIS 230
STROKE/CVA 231
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION 233
UNPLANNED ADMISSION TO ICU 235
UNPLANNED INTUBATION 236
UNPLANNED RETURN TO THE OPERATING ROOM 237
VENTILATOR-ASSOCIATED PNEUMONIA (VAP) 238
MEASURES FOR PROCESSES OF CARE INFORMATION 243
HIGHEST GCS TOTAL 244
HIGHEST GCS MOTOR 245
GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL 246
HIGHEST GCS 40 - MOTOR 248
INITIAL ED/HOSPITAL PUPILLARY RESPONSE 250
MIDLINE SHIFT 251
CEREBRAL MONITOR 252
CEREBRAL MONITOR DATE 253
CEREBRAL MONITOR TIME 254
VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE 255
VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE 256

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME 257
TRANSFUSION BLOOD (4 HOURS) 258
TRANSFUSION BLOOD MEASUREMENT 259
TRANSFUSION BLOOD CONVERSION 260
TRANSFUSION PLASMA (4 HOURS) 261
TRANSFUSION PLASMA MEASUREMENT 262
TRANSFUSION PLASMA CONVERSION 263
TRANSFUSION PLATELETS (4 HOURS) 264
TRANSFUSION PLATLETS MEASUREMENT 265
TRANSFUSION PLATELETS CONVERSION 266
CRYOPRECIPITATE (4 HOURS) 267
CRYOPRECIPITATE MEASUREMENT 268
CRYOPRECIPITATE CONVERSION 269
LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE 270
ANGIOGRAPHY 271
EMBOLIZATION SITE 272
ANGIOGRAPHY DATE 273
ANGIOGRAPHY TIME 274
SURGERY FOR HEMORRHAGE CONTROL TYPE 275
SURGERY FOR HEMORRHAGE CONTROL DATE 276
SURGERY FOR HEMORRHAGE CONTROL TIME 277
WITHDRAWAL OF LIFE SUPPORTING TREATMENT 278
WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE 279
WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME 280
ANTIBIOTIC THERAPY 281

ANTIBIOTIC THERAPY DATE 282

ANTIBIOTIC THERAPY TIME 283

APPENDICES 284

Appendix 1: ATR Change Log 285

Appendix 2: NTDS Change Log 287

Acknowledgements 289

Introduction

The Arkansas Trauma Registry Data Dictionary details the requirements for the mandatory data elements submitted by Arkansas trauma centers.

This Dictionary provides a detailed description of each data point included in the Arkansas Trauma Registry.

For further information, please contact:
Trauma Registry Section
Health Statistics Branch
Center for Public Health Practice
Arkansas Department of Health
4815 W. Markham, Slot 19
Little Rock, Arkansas 72205
Phone: (501) 280-4063
Fax: (501) 661-2240

Patient Inclusion Criteria

Definition: To ensure consistent data collection across the state, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

At least one of the following injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):**S00-S99 (with 7th character modifiers of A,B, or C only), T07, T14, T20-T28 (with 7th character modifier of A only), T30-T32, T59.811A-T59.814A, T59.91XA-T59.94XA (Smoke Inhalation), T63.001A Snakebites (Venomous), T71.111A-T71.114A, T71.121A-T71.124A, T71.131A-T71.134A, T71.141A-T71.144A, T71.151A-T71.154A, T71.161A-T71.164A, T71.191A-T71.194A, T71.20XA-T71.21XA, T71.221A-T71.224A, T71.231A-T71.234A, T71.29XA, T71.9XXA (Asphyxiation and Strangulation includes Hanging), T75.1XXA (Drowning and nonfatal submersion), T75.4XXA Electrocution, T75.00XA-T75.01XA (Lightning), T79.A1-T79.A9 (with 7th character modifier of A only), and E-code W54.0XXA Dog bite.**

The following list is a quick reference for the categories of injury diagnostic codes mentioned above:

- S00-S09 Injuries to the head (*with 7th character modifiers of A,B, or C only)*
- S10-S19 Injuries to the neck (*with 7th character modifiers of A,B, or C only)*
- S20-S29 Injuries to the thorax (*with 7th character modifiers of A,B, or C only)*
- S30-S39 Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
- S40-S49 Injuries to the shoulder and upper arm (*with 7th character modifiers of A,B, or C only)*
- S50-S59 Injuries to the elbow and forearm (*with 7th character modifiers of A,B, or C only)*
- S60-S69 Injuries to the wrist, hand and fingers (*with 7th character modifiers of A,B, or C only)*
- S70-S79 Injuries to the hip and thigh (*with 7th character modifiers of A,B, or C only)*
- S80-S89 Injuries to the knee and lower leg (*with 7th character modifiers of A,B, or C only)*
- S90-S99 Injuries to the ankle and foot (*with 7th character modifiers of A,B, or C only)*
- T07 Injuries involving multiple body regions

- T14 Injury of unspecified body region
- T20-T25 Burns and corrosions of external body surface, specified by site *(with 7th character modifier of A only)*
- T26-T28 Burns and corrosions confined to eye and internal organs
- T30-T32 Burns and corrosions of multiple and unspecified body regions
- T59 Toxic effect of other gases, fumes and vapors (See specific codes above)
- T63.001A Snakebites (Venomous)
- T71 Asphyxiation and Strangulation includes Hanging (See specific codes above)
- T75 Other and unspecified effects of other external causes (lightning, drowning, and nonfatal submersion, electrocution) (See specific codes above)
- T79 Certain early complications of trauma *(T79.A1-T79.A9 with 7th character modifier of A only)*
- W54.0XXA Dog bite

Excluding the following isolated injuries:

Late effects of injury:

- L59.9
- M67.90, M84.369S, M84.376S, M84.40XS, M84.429S, M84.453S, M84.459S, M84.469S, M84.48XS, M84.739S
- S00.90XS, S00.93XS, S01.90XS, S02.0XXS, S02.10XS, S02.110S-S02.113S, S02.118S-S02.119S, S02.19XS, S02.2XXS, S02.3XXS, S02.400S-S02.402S, S02.411S-S02.413S, S02.42XS, S02.5XXS, S02.600S, S02.609S, S02.61XS-S02.67XS, S02.8XXS, S02.91XS-S02-92XS, S03.0XXS, S03.9XXS, S04.9XXS, S06.9X9S, S07.9XXS, S09.0XXS
- S10.90XS, S10.93XS, S11.90XS, S12.9XXS, S13.20XS, S13.9XXS, S14.109S, S14.2XXS, S14.9XXS, S15.9XXS, S17.9XXS
- S20.20XS, S20.90XS, S21.90XS, S22.009S, S22.9XXS, S23.20XS, S23.9XXS, S24.109S, S24.2XXS, S24.9XXS, S25.90XS, S26.99XS, S27.9XXS, S28.0XXS, S29.9XXS
- S30.0XXS, S30.1XXS, S30.201S, S30.202S, S30.91XS, S30.92XS, S30.96XS, S30.97XS, S31.000S, S31.109S, S32.9XXS, S33.30XS, S33.9XXS, S34.109S, S34.139S, S34.21XS, S34.22XS, S34.9XXS, S35.90XS, S36.90XS, S37.90XS,

S38.001S, S38.002S, S38.1XXS, S39.91XS-S39.94XS

- S40.029S, S40.919S, S40.929S, S41.009S, S41.109S, S42.309S, S42.409S, S42.90XS, S43.90XS, S44.90XS, S45.909S, S46.919S, S47.9XXS, S48.306S, S48.919S, S49.90XS

- S50.00XS, S50.10XS, S50.909S, S50.919S, S50.929S, S51.009S, S51.809S, S52.90XS, S53.499S, S54.90XS, S55.909S, S56.919S, S57.00XS, S57.80XS, S57.90XS, S58.922S, S59.909S

- S60.219S, S60.229S, S61.409S, S61.509S, S62.90XS, S63.006S, S63.90XS, S64.90XS, S65.909S, S66.919S, S67.90XS, S68.419S, S69.90XS

- S70.00XS, S70.10XS, S70.919S, S70.929S, S71.009S, S71.109S, S72.009S, S73.006S, S73.109S, S74.90XS, S75.909S, S76.919S, S77.00XS, S77.10XS, S78.019S, S79.009S, S79.919S, S79.929S

- S80.00XS, S80.10XS, S80.919S, S80.929S, S81.009S, S81.809S, S82.009S, S82.90XS, S83.006S, S83.106S, S83.209S, S83.90XS, S84.90XS, S85.909S, S87.00XS, S87.80XS, S88.919S, S89.90XS

- S90.00XS, S90.30XS, S90.919S, S90.929S, S91.009S, S92.909S, S92.919S, S93.06XS, S93.306S, S93.609S, S94.90XS, S95.909S, S96.919S, S97.00XS, S97.80XS, S99.919S, S99.929S

- T09.90XS, T15.90XS, T16.9XXS, T17.1XXS, T17.900S, T18.0XXS, T18.9XXS, T19.9XXS, T20.00XS, T20.40XS, T21.00XS, T21.40XS, T22.00XS, T22.40XS, T23.009S, T23.079S, T23.40S. T23.479S, T24.009S, T24.409S, T28.40XS, T28.90XS, T50.901S, T50.905S, T65.91XS-T65.94XS, T75.89XS, T78.8XXS T79.9XXS, T88.7XXS, or T88.9XXS

- **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.**

- **Superficial injuries, including blisters, contusions, abrasions, and insect bites**: S00.0-S97.97XS, S10.0-S10.97XS, S20.0-S20.97XS, S30.0-S30.98XS, S40.0-S40.929S, S50.0-S50.919S, S60.0-S60.949S, S70.0-S70.929S, S80.0-S80.929S, S90.0-S90.936S

- **Foreign bodies:** T15-T19

- **Same level fall in patients > 65 with isolated hip fracture**: S72.0-S72.2

- **Injuries that are more than 7 days old**

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO ICD-10-CM:

- Hospital admission for injury. Hospital admission is defined as ED disposition other than out of hospital destination (home, jail, back to skilled nursing facility or other institutional care, etc.). Excludes ED disposition to L&D for monitoring. Excludes hospital admission for reasons other than trauma, i.e., diagnostic work-up for chest pain/syncope, medical management of medical conditions (dehydration, diabetes, HTN, etc.), psychiatric related concerns

- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)

EXCLUDES:

- Planned readmits or scheduled admits via the clinic

Other System Inclusion Criteria:

- All trauma team activations involving the trauma surgeon

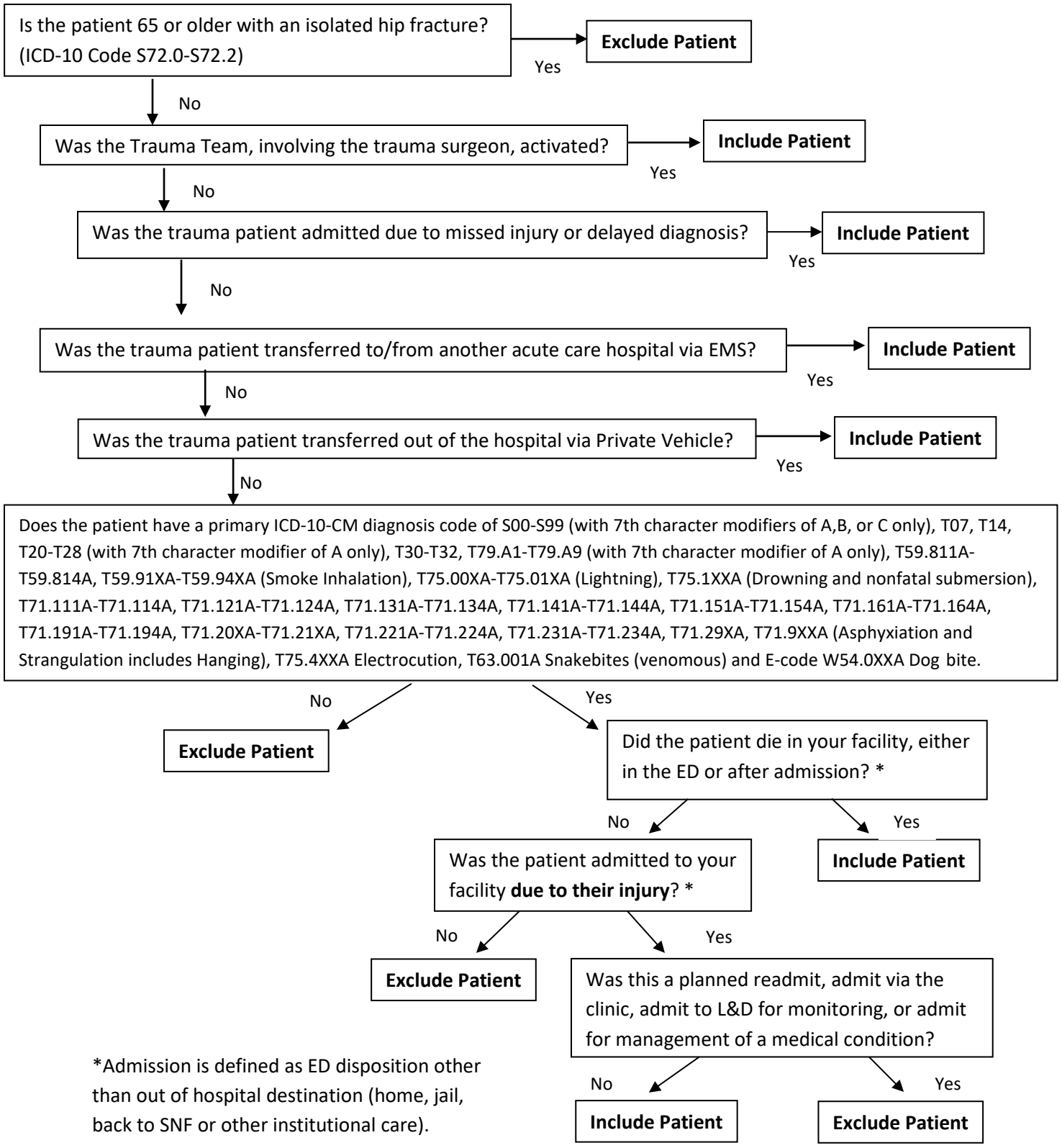
- Any admission post ED/Hospital discharge that occurs as a result of missed injury or delayed diagnosis

- Any acute care hospital to acute care hospital trauma transfer via EMS

- Trauma transfers out via private vehicle

Trauma Registry Inclusion Criteria

*(Follow downward until an **"Include Patient"** or "**Exclude Patient**" is achieved)*



*Admission is defined as ED disposition other than out of hospital destination (home, jail, back to SNF or other institutional care).

DATA DICTIONARY DEFINITION FORMAT

This section contains a description of each data point to be reported to the Arkansas Trauma Registry, organized by section of the data (demographics, diagnoses, etc.). At the end of the Data Dictionary, there is a glossary of all data elements.

COMMON NULL VALUES

Options:

/ = Not applicable

? = Not known/Not recorded

Definitions:

For any collection of information to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the National Trauma Data Standard and Arkansas Trauma Registry Data Dictionary are to be electronically stored in a database or moved from one data base to another using XML, the indicated null values should be applied.

Not Applicable - This null value code applies if, at the time of patient care documentation, the information requested was “Not applicable” to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be “Not applicable” if a patient self-transports to the hospital.

Not Known/Not Recorded - This null value applies if, at the time of patient care documentation, information was “Not known” (to the patient, family, health care provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as “Unknown.” Another example: Not known/Not recorded should also be coded when documentation was expected, but none was provided (e.g., no EMS Run Report in the hospital record for patient transported by EMS).

Note - In certain fields, common null values may be specified that are different from those outlined above. If such values are specified for some variables, those alternatives must be used instead of the common null values.

DEMOGRAPHIC INFORMATION

RECORD INFORMATION

FACILITY

Definition

The number and name of the facility that is entering the patient record.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Facility	**NTDB Element Number** N/A
Local V5 Field Name Facility	**NTDB Data Dictionary Page Number** N/A

Field Values

- Auto-generated

Additional Information

- Automatically assigned by the registry software.
- This information may not be changed.

Data Source Hierarchy Guide

TRAUMA NUMBER

Definition

A unique identifier for a patient and trauma incident within a specific institution, this is a maximum 12-digit number.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Trauma #	**NTDB Element Number** N/A
Local V5 Field Name Trauma #	**NTDB Data Dictionary Page Number** N/A

Field Values

- Auto-generated

Additional Information

- Automatically assigned by the registry software.
- This number may not be changed.

Data Source Hierarchy Guide

PATIENT ARRIVAL (DATE)

Definition

The date the patient arrived at the ED/hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Patient Arrival (Date)	**NTDB Element Number** ED_01
Local V5 Field Name Patient Arrival (Date)	**NTDB Data Dictionary Page Number** 59

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Collected as MM/DD/YYYY.
- Used to auto-generate additional calculated fields:
  ED Arrival/Admit (If entered here and not altered in ED/Resus section), Discharge/Death (If entered here and not altered in Outcome section and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge)

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Hospital Discharge Summary

PATIENT ARRIVAL (TIME)

Definition

The time the patient arrived at the ED/hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Patient Arrival (Time)	**NTDB Element Number** ED_02
Local V5 Field Name Patient Arrival (Time)	**NTDB Data Dictionary Page Number** 60

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as HH:MM
- If the patient was brought to the ED, enter date patient arrived at ED. If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Used to auto-generate two additional calculated fields: Total EMS Time (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Hospital Discharge Summary

TRAUMA BAND NUMBER

Definition

An alpha-numeric ID number printed on a plastic band is used to provide a link between entities (EMS, hospitals) within the State Trauma System. It is typically applied to the patient by the first agency/facility involved, with the number recorded in the Trauma Band Number field.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Trauma Band #	**NTDB Element Number** ED_02
Local V5 Field Name Trauma Band #	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element

Additional Information

- Having an alpha character followed by a six (6) digit number, the letter and all numbers must be entered.
- Trauma bands shall be placed on all trauma patients transported to, or presenting to a trauma center. Once applied to a trauma patient the trauma band number shall be recorded on the patient care record.
- Maximum allowable characters: 7

Data Source Hierarchy Guide

1. EMS Run Sheet
2. ED Admission Form
3. Triage Form/Trauma Flow Sheet
4. ED Nurses Notes
5. Billing Sheet/Medical Records Coding Summary Sheet

PATIENT NAME: LAST

Definition

The patient's last or family name.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Patient Name: Last	**NTDB Element Number** N/A
Local V5 Field Name Patient Name: Last	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Alpha characters

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. EMS Run Report
3. ED Admission Form
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

PATIENT NAME: FIRST

Definition

The patient's first given name.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name First	**NTDB Element Number** N/A
Local V5 Field Name First	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Alpha characters

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Admission Form
3. EMS Run Report
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

ARRIVED FROM

Definition

The location of the patient before their transport to your hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived From	**NTDB Element Number** N/A
Local V5 Field Name Arrived From	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Scene
- 2 - Referring Hospital
- 3 - Home
- 4 - Other
- 5 - Acute Care Hospital
- 6 - Clinic
- Common null values

Additional Information

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

PATIENT INFORMATION

DATE OF BIRTH

Definition

The patient's date of birth.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Date of Birth	**NTDB Element Number** D_07
Local V5 Field Name Date of Birth	**NTDB Data Dictionary Page Number** 8

Field Values

- Relevant value for data element.
- Common null values.

Additional Information

- Collected as MM/DD/YYYY.
- If Date of Birth is "Not Known/Not Recorded," report variables: Age and Age Units.
- If Date of Birth is equal to Injury Date, then the Age and Age Units variables must be reported.
- If Date of Birth is equal to ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.
- If "Not Recorded/Not Known" complete variables: Age and Age Units.

Data Source Hierarchy Guide

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

AGE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Age	**NTDB Element Number** D_08
Local V5 Field Name Age	**NTDB Data Dictionary Page Number** 9

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values.

Additional Information

- If Date of Birth is "Not Known/Not Recorded," report variables: Age and Age Units.
- If Dates of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported.
- Must also report variable: Age Units.
- The null value "Not Applicable" is reported if Date of Birth is documented.
- Only completed when Date of Birth is "Not Recorded/Not Known" or age is less than 24 hours.

Data Source Hierarchy Guide

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

AGE UNITS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name In	**NTDB Element Number** D_09
Local V5 Field Name In	**NTDB Data Dictionary Page Number** 10

Field Values

- 1 – Years
- 2 – Months
- 3 – Days
- 5 – Hours
- 6 – Minutes
- * - Weeks
- Common null values

Additional Information

- If Dates of Birth is "Not Known/Not Recorded", report variables: Age and Age Units
- If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported.
- Must also report variable: Age
- The null value "Not Applicable" is reported is Date of Birth is reported.

Data Source Hierarchy Guide

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

*This value will be added in 2019.

SEX

Definition

The patient's sex.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Gender	**NTDB Element Number** D_12
Local V5 Field Name Gender	**NTDB Data Dictionary Page Number** 13

Field Values

- 1 - Male
- 2 - Female
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

ETHNICITY

Definition

The patient's ethnicity.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Ethnicity	**NTDB Element Number** D_11
Local V5 Field Name Ethnicity	**NTDB Data Dictionary Page Number** 12

Field Values

- 1 - Hispanic or Latino
- 2 - Not Hispanic or Latino
- Common null values

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 one (1).
- Based on the 2010 US Census Bureau.

Data Source Hierarchy Guide

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

RACE

Definition

The patient's race.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Race	**NTDB Element Number** D_10
Local V5 Field Name Race	**NTDB Data Dictionary Page Number** 11

Field Values

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

Additional Information

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

Data Source Hierarchy Guide

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

PATIENT'S HOME ZIP/POSTAL CODE

Definition

The patient's home ZIP code of primary residence.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ZIP/Postal Code	**NTDB Element Number** D_01
Local V5 Field Name ZIP/Postal Code	**NTDB Data Dictionary Page Number** 2

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal Code is "Not Applicable," report variable: Alternate Home Address.
- If ZIP/Postal Code is "Not Known/Not Recorded," report variables: Patient's Home Country, Patient's Home State (US only), Patient's Home County (US only), and Patient's Home City (US only).
- If ZIP/Postal Code is documented, must also report Patient's Home Country.

Data Source Hierarchy Guide

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

PATIENT'S HOMELESS STATUS

Definition

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.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Homeless	**NTDB Element Number** N/A
Local V5 Field Name Homeless	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values.

Additional Information

Data Source Hierarchy Guide

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

PATIENT'S HOME CITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name City	**NTDB Element Number** D_05
Local V5 Field Name City	**NTDB Data Dictionary Page Number** 6

Field Values

- Relevant value for data element (five-digit numeric FIPS code).
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

PATIENT'S HOME STATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name State	**NTDB Element Number** D_03
Local V5 Field Name State	**NTDB Data Dictionary Page Number** 4

Field Values

- Relevant value for data element (two-digit numeric FIPS code).
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

PATIENT'S HOME COUNTY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name County	**NTDB Element Number** D_04
Local V5 Field Name County	**NTDB Data Dictionary Page Number** 5

Field Values

- Relevant value for data element (three-digit numeric FIPS code).
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

PATIENT'S HOME COUNTRY

Definition

The country where the patient resides.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Country	**NTDB Element Number** D_02
Local V5 Field Name Country	**NTDB Data Dictionary Page Number** 3

Field Values

- Relevant value for data element (two-digit alpha country code).
- Common null values

Additional Information

- Values are two-character FIPS codes representing the country (e.g., US).
- If Patient's Home Country is not US, then the null value "Not Applicable" is reported for: Patient's Home State, Patient's Home County, and Patient's Home City.
- Only completed when ZIP code is "Not Recorded/Not Known."
- Will auto populate when valid ZIP code is entered.

Data Source Hierarchy Guide

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

ALTERNATE HOME RESIDENCE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Alternate Residence	**NTDB Element Number** D_06
Local V5 Field Name Alternate Residence	**NTDB Data Dictionary Page Number** 7

Field Values

- 1 - Undocumented Citizen
- 2 - Migrant Worker
- 3 – Retired 2019 - Foreign Visitor
- Common null values

Additional Information

- Only reported when ZIP/Postal Code is “Not Applicable.”
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same country.
- Foreign visitor is any person visiting a country other than his/her usual place of residence for any reason without intending to receive earnings in the visited country. (Retired)
- The null value "Not Applicable" is reported if Patient's Home Zip/Postal Code is documented.

Data Source Hierarchy Guide

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

INJURY

INJURY INFORMATION

INJURY INCIDENT DATE

Definition

The date the injury occurred.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Injury (Date)	**NTDB Element Number** I_01
Local V5 Field Name Injury (Date)	**NTDB Data Dictionary Page Number** 15

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.

Data Source Hierarchy Guide

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

INJURY INCIDENT TIME

Definition

The time the injury occurred.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Injury (Time)	**NTDB Element Number** I_02
Local V5 Field Name Injury (Time)	**NTDB Data Dictionary Page Number** 16

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values.

Additional Information

- Collected as HH:MM (midnight – 12:00 a.m.) through 23:59 (11:59 p.m.), valid military time
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.

Data Source Hierarchy Guide

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

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICD 10 Location Code	**NTDB Element Number** I_07
Local V5 Field Name ICD 10 Location Code	**NTDB Data Dictionary Page Number** 21

Field Values

- Relevant ICD-10-CM code value for injury event.
- Common null values.

Additional Information

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

Data Source Hierarchy Guide

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

CHILD SPECIFIC RESTRAINT

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Restraint	**NTDB Element Number** I_15
Local V5 Field Name Restraint	**NTDB Data Dictionary Page Number** 29

Field Values

- 1 – None
- 2 – Seatbelt – Lap and Shoulder
- 3 – Seatbelt – Lap Only
- 4 – Seatbelt – Shoulder Only
- 5 – Seatbelt – NFS
- 6 – Child Booster Seat
- 7 – Child Car Seat
- 8 – Infant Car Seat
- 9 – Truck Bed Restraint
- Common null values

Additional Information

- Evidence of the use of child restraint may be reported or observed.
- Only reported when Protective Devices include "6. Child booster seat" or "7. Child car seat".
- The null value "Not Applicable" is reported if Field Value "6. Child booster seat" or "7. Child car seat" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

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

AIRBAG DEPLOYMENT

Definition

Indication of airbag deployment during a motor vehicle crash.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Airbags	**NTDB Element Number** I_16
Local V5 Field Name Airbags	**NTDB Data Dictionary Page Number** 30

Field Values

- 1 – No Airbags in Vehicle
- 2 – Airbags Did Not Deploy
- 3 – Front (Deployed)
- 4 – Side (Deployed)
- 5 – Airbag Deployed Other (Knee, Airbelt, Curtain, etc.)
- 6 – Airbags Type Unknown (Deployed)
- Common null values

Additional Information

- Report all that apply.
- Evidence of the use of airbag deployment may be reported or observed.
- Only report when Protective Devices include "Airbag Present."
- Airbag Deployed Front should be reported for patients with documented airbag deployments, but are not further specified.
- The null value "Not Applicable" is reported if "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

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

PROTECTIVE DEVICES

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Equipment	**NTDB Element Number** I_14
Local V5 Field Name Equipment	**NTDB Data Dictionary Page Number** 28

Field Values

- 1 – None
- 2 – Helmet (e.g., bicycle, skiing, motorcycle)
- 3 – Eye Protection
- 4 – Protective Clothing (e.g., padded leather pants)
- 5 – Protective Non-Clothing Gear (e.g., Shin Guard, Padding)
- 6 – Hard Hat
- 7 – Personal Flotation Device
- 8 – Other
- Common null values

Additional Information

- Report all that apply.
- If “Child Restraint” is present, complete variable “Child Specific Restraint.”
- If “Airbag” is present, complete variable “Airbag Deployment.”
- Evidence of the use of safety equipment may be reported or observed.
- Lap Belt should be used to include those patients who are restrained, but not further specified.
- If chart indicates "3-point-restraint," report Field Values “3. Seatbelt - Lap Only” and “4. Seatbelt - Shoulder Only.”
- If documented that a “Child Restraint” (booster seat or child care seat)” was used or worn, but not properly fastened, either on the child or in the car, reported Field Value “1. None.”
- Pick list available.

Data Source Hierarchy Guide

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

INCIDENT LOCATION ZIP/POSTAL CODE

Definition

The ZIP/Postal Code of the incident location.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ZIP/Postal Code	**NTDB Element Number** I_09
Local V5 Field Name ZIP/Postal Code	**NTDB Data Dictionary Page Number** 23

Field Values

- Relevant value for data element.
- Common null values.

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- If "Not Known/Not Recorded," report variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is documented, then must report Incident Country.

Data Source Hierarchy Guide

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

INCIDENT CITY

Definition

The city or township where the patient was found or to which the unit responded.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name City	**NTDB Element Number** I_13
Local V5 Field Name City	**NTDB Data Dictionary Page Number** 27

Field Values

- Relevant value for data element (five-digit numeric FIPS code).
- For V5 portal users, relevant value for data element.
- Common null values.

Additional Information

- Only reported 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 reported if Incident Location ZIP/Postal Code is documented.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

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

INCIDENT STATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name State	**NTDB Element Number** I_11
Local V5 Field Name State	**NTDB Data Dictionary Page Number** 25

Field Values

- Relevant value for data element (two-digit numeric FIPS code).
- For V5 portal users, relevant value for data element (two-character state abbreviation).
- Common null values.

Additional Information

- Only reported when Incident Location 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 Incident Location ZIP/Postal Code is documented.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

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

INCIDENT COUNTY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name County	**NTDB Element Number** I_12
Local V5 Field Name County	**NTDB Data Dictionary Page Number** 26

Field Values

- Relevant value for data element (County Name).
- Common null values.

Additional Information

- Only reported when Incident Location 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 Incident Location ZIP/Postal Code is documented.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

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

INCIDENT COUNTRY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Country	**NTDB Element Number** I_10
Local V5 Field Name Country	**NTDB Data Dictionary Page Number** 24

Field Values

- Relevant value for data element (incident country name).
- Common null values.

Additional Information

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

Data Source Hierarchy Guide

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

WORK-RELATED

Definition

Indication of whether the injury occurred during paid employment.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Work Related	**NTDB Element Number** I_03
Local V5 Field Name Work Related	**NTDB Data Dictionary Page Number** 17

Field Values

- Yes
- No
- Common null values.

Additional Information

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

Data Source Hierarchy Guide

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

PATIENT'S OCCUPATION

Definition

The occupation of the patient.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Occupation	**NTDB Element Number** I_05
Local V5 Field Name Occupation	**NTDB Data Dictionary Page Number** 19

Field Values

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

Additional Information

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

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

PATIENT'S OCCUPATIONAL INDUSTRY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Occupational Industry	**NTDB Element Number** I_04
Local V5 Field Name Occupational Industry	**NTDB Data Dictionary Page Number** 18

Field Values

- 1 - Finance, Insurance, and Real Estate
- 2 - Manufacturing
- 3 - Retail Trade
- 4 - Transportation and Public Utilities
- 5 - Agriculture, Forestry, and 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
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

REPORT OF PHYSICAL ABUSE

Definition

A report of suspected physical abuse was made to law enforcement and/or protective services.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Report of Physical Abuse	**NTDB Element Number** I_17
Local V5 Field Name Report of Physical Abuse	**NTDB Data Dictionary Page Number** 31

Field Values

- Yes
- No
- Common null values

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse as defined by state/local authorities.

Data Source Hierarchy Guide

1. Case Management/Social Service Notes
2. ED Records
3. Progress Notes
4. Discharge Summary
5. History & Physical
6. Nursing Notes/Flow Sheet
7. EMS Run Report

INVESTIGATION OF PHYSICAL ABUSE

Definition

An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Investigation of Physical Abuse	**NTDB Element Number** I_18
Local V5 Field Name Investigation of Physical Abuse	**NTDB Data Dictionary Page Number** 32

Field Values

- Yes
- No
- Common null values

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse as defined by state/local authorities.
- Only report when Report of Physical Abuse is “1. Yes.”
- The null value “Not Applicable” should be reported for patients where Report of Physical abuse is “2. No.”

Data Source Hierarchy Guide

1. Case Management/Social Service Notes
2. ED Records
3. Progress Notes
4. Discharge Summary
5. History & Physical
6. Nursing Notes/Flow Sheet

MECHANISM OF INJURY

ICD-10 PRIMARY EXTERNAL CAUSE CODE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Primary ICD 10 Mechanism	**NTDB Element Number** I_06
Local V5 Field Name Primary ICD 10 Mechanism	**NTDB Data Dictionary Page Number** 20

Field Values

- Relevant ICD-10-CM code value for injury event.
- Common null values.

Additional Information

- The Primary external cause should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM codes are accepted for this data element. Activity codes are not collected under the NTDS and should not be reported in this field.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
    - External cause codes for child and adult abuse take priority over all other external cause codes.
    - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
    - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
    - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
    - The first listed external cause code should correspond to the cause of the most serious diagnosis above due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

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

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Definition

Additional external cause code used in conjunction with the primary external cause code if multiple external cause codes are required to describe the injury event.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Secondary ICD 10 Mechanism	**NTDB Element Number** I_08
Local V5 Field Name Secondary ICD 10 Mechanism	**NTDB Data Dictionary Page Number** 22

Field Values

- Relevant ICD-10-CM code value for injury event.
- Common null values.

Additional Information

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

Data Source Hierarchy Guide

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

PRE-HOSPITAL INFORMATION

SCENE/TRANSPORT PROVIDERS

TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Mode	**NTDB Element Number** P_07
Local V5 Field Name Mode	**NTDB Data Dictionary Page Number** 41

Field Values

- 1 - Ground Ambulance
- 2 - Helicopter Ambulance
- 3 - Fixed Wing Ambulance
- 4 - Private/Public Vehicle/Walk-in
- 5 - Police
- 6 - Other
- Common null values

Additional Information

- When other is selected, make sure that the mode of transport is specified in the appropriate box labeled Mode If Other.

Data Source Hierarchy Guide

1. EMS Run Report

OTHER TRANSPORT MODE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Mode If Other	**NTDB Element Number** P_08
Local V5 Field Name Mode If Other	**NTDB Data Dictionary Page Number** 42

Field Values

- 1 - Ground Ambulance
- 2 - Helicopter Ambulance
- 3 - Fixed Wing Ambulance
- 4 - Private/Public Vehicle/Walk-in
- 5 - Police
- 6 - Other
- Common null values

Additional Information

- Include in "Other" unspecified modes of transport.
- The null value "Not Applicable" is reported to indicate that a patient had a single mode of transport.
- Report all that apply with a maximum of 5.

Data Source Hierarchy Guide

1. EMS Run Report

TRANSPORT ROLE

Definition

The role the EMS provider was performing for the leg of travel being recorded.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Transport Role	**NTDB Element Number** N/A
Local V5 Field Name Transport Role	**NTDB Data Dictionary Page Number** N/A

Field Values

- 3 - Non-Transport
- 4 - Transport from Scene to Facility
- 5 - Transport from Scene to Rendezvous
- 6 - Transport from Rendezvous to Facility
- 7 - Transport to Other
- 8 - Transport from Non-Scene Location
- Common null values

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

SCENE EMS REPORT

Definition

Indicator of availability of the EMS responder's report in the medical record from the EMS responder who transports the patient for each leg of an EMS Agency patient transport.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Scene EMS Report	**NTDB Element Number** N/A
Local V5 Field Name Scene EMS Report	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Complete
- 2 - Incomplete
- 3 - Missing
- 4 - Unreadable
- Common null values

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

EMS DISPATCH DATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Call Dispatched (Date)	**NTDB Element Number** P_01
Local V5 Field Name Call Dispatched (Date)	**NTDB Data Dictionary Page Number** 35

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

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 reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS DISPATCH TIME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Call Dispatched (Time)	**NTDB Element Number** P_02
Local V5 Field Name Call Dispatched (Time)	**NTDB Data Dictionary Page Number** 36

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

EMS RESPOND DATE

Definition

The date on which unit responded to the call

- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility responded to the call.
- 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 responded.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name En Route (Date)	**NTDB Element Number** N/A
Local V5 Field Name En Route (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY
- Times are associated with the agency that transported the patient to the hospital.

Data Source Hierarchy Guide

1. EMS Run Report

EMS RESPOND TIME

Definition

The time the unit responded to the call.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name En Route (Time)	**NTDB Element Number** N/A
Local V5 Field Name En Route (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- For inter-facility transfer patients, this is the time the unit transporting the patient to your facility from the transferring facility responded to the call.
- For patients transported from the scene of injury to your hospital, this is the time the unit transporting the patient to your facility from the scene responded.
- Times are associated with the agency that transported the patient to the hospital.

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Arrived at Location (Date)	**NTDB Element Number** P_03
Local V5 Field Name Arrived at Location (Date)	**NTDB Data Dictionary Page Number** 37

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

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 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 date on which the unit transporting the patient to your facility from the scene arrived at the scene. (Arrival is defined at date/time when the vehicle stopped moving.)
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Arrived at Location (Time)	**NTDB Element Number** P_04
Local V5 Field Name Arrived at Location (Time)	**NTDB Data Dictionary Page Number** 38

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Departed Location (Date)	**NTDB Element Number** P_05
Local V5 Field Name Departed Location (Date)	**NTDB Data Dictionary Page Number** 39

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values
- Times are associated with the agency that transported the patient to the hospital.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Additional Information

- Collected as MM/DD/YYYY
- For inter-facility transfer patients, this is the date 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 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 reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Departed Location (Time)	**NTDB Element Number** P_06
Local V5 Field Name Departed Location (Time)	**NTDB Data Dictionary Page Number** 40

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVED AT DESTINATION DATE

Definition

The date unit arrived at its specific destination.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived at Destination (Date)	**NTDB Element Number** N/A
Local V5 Field Name Arrived at Destination (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values
- Times are associated with the agency that transported the patient to the hospital.

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVED AT DESTINATION TIME

Definition

The time at which unit arrived at its specific destination.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived at Destination (Time)	**NTDB Element Number** N/A
Local V5 Field Name Arrived at Destination (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Times are associated with the agency that transported the patient to the hospital.

Data Source Hierarchy Guide

1. EMS Run Report

TRAUMA CENTER CRITERIA

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Prehospital Triage Rationale	**NTDB Element Number** P_21
Local V5 Field Name Prehospital Triage Rationale	**NTDB Data Dictionary Page Number** 55

Field Values

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

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 Center Criteria.
- The null value “Not Known/Not Recorded” should be reported if this information is not indicated on the EMS Run Report or if the EMS Run Report is not available.
- Field Values must be determined by the EMS provider and must not be assigned by the index hospital.
- Report all that apply.
- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

VEHICULAR, PEDESTRIAN, OTHER RISK INJURY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
V5 Field Name Prehospital Triage Rationale	**NTDB Element Number** P_22
Local V5 Field Name Prehospital Triage Rationale	**NTDB Data Dictionary Page Number** 56

Field Values

- 13 - Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site
- 14 - Crash ejection (partial or complete) from vehicle
- 15 - Crash death in same passenger compartment
- 16 - Crash vehicle telemetry data (AACN) consistent with high risk injury
- 17 - Auto vs. pedestrian/bicyclist thrown, run over, or > 20 MPH impact
- 18 – Auto vs. cyclist thrown, run over or > 20 mph impact
- 19 - Motorcycle crash > 20 MPH
- 20 – Trauma with older child
- 21 – Trauma with child
- 22- Patients on anticoagulants and bleeding disorders
- 23 – Trauma with burns
- 24 - Pregnancy > 20 weeks
- 25 - EMS provider judgment
- 26 - Fall adults: > 20 ft. (one story is equal to 10 ft.)
- 27 - Fall children: > 10 ft. or 2-3 times the height of the child
- 28 - For adult > 65; SBP < 110
- 29 – Burns

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 Vehicle, Pedestrian, or Other Risk Injury 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.
- Field Values must be determined by the EMS provider and must not be assigned by the index hospital.
- Report all that apply.

- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

TREATMENT

INITIAL FIELD RESPIRATORY ASSISTANCE

Definition

The presence of endotracheal intubation, King/Lumen airway, or combitube for respiratory support.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Respiration Assisted?	**NTDB Element Number** N/A
Local V5 Field Name Respiration Assisted?	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Definition

The first recorded systolic blood pressure measured at the scene of injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name SBP	**NTDB Element Number** P_09
Local V5 Field Name SBP	**NTDB Data Dictionary Page Number** 43

Field Values

- Field value range 0-300
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement must be recorded without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value “Not Applicable” is reported for patient who arrive by “4. Private/Public/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field systolic blood pressure was NOT measured at the scene of the injury.

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD PULSE RATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Pulse Rate	**NTDB Element Number** P_10
Local V5 Field Name Pulse Rate	**NTDB Data Dictionary Page Number** 44

Field Values

- Field value range 0-299
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value “Not Applicable” is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD RESPIRATORY RATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Unassisted Resp Rate	**NTDB Element Number** P_11
Local V5 Field Name Unassisted Resp Rate	**NTDB Data Dictionary Page Number** 45

Field Values

- Field value range 0-120
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD OXYGEN SATURATION

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name O2 Saturation	**NTDB Element Number** P_12
Local V5 Field Name O2 Saturation	**NTDB Data Dictionary Page Number** 46

Field Values

- Field value range 0-100
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value “Not Applicable” is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field oxygen saturation was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD SUPPLEMENTAL OXYGEN

Definition

The use of a storage tank of oxygen or a machine which provides an extra supply of oxygen to the patient.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Supplemental O2	**NTDB Element Number** N/A
Local V5 Field Name Supplemental O2	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- Vitals should be associated with those captured at the scene.

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS - EYE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Eye	**NTDB Element Number** P_13
Local V5 Field Name GCS: Eye	**NTDB Data Dictionary Page Number** 47

Field Values

- 1 - No eye movement when assessed
- 2 - Opens eyes in response to painful stimulation
- 3 - Opens eyes in response to verbal stimulation
- 4 - Opens eyes spontaneously
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be 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 reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS – Eye was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported is Initial Field GCS 40 – Eye is reported.

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS - VERBAL

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Verbal	**NTDB Element Number** P_14
Local V5 Field Name GCS: Verbal	**NTDB Data Dictionary Page Number** 48

Field Values

- Pediatric (≤ 2 years old)
  - 1 - No vocal response
  - 2 - Inconsolable, agitated
  - 3 - Inconsistently consolable, moaning
  - 4 - Cries, but is consolable, inappropriate interactions
  - 5 - Smiles, oriented to sounds, follows objects, interacts
- Adult
  - 1 - No verbal response
  - 2 - Incomprehensible sounds
  - 3 - Inappropriate words
  - 4 - Confused
  - 5 - Oriented
  - Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS - MOTOR

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Motor	**NTDB Element Number** P_15
Local V5 Field Name GCS: Motor	**NTDB Data Dictionary Page Number** 49

Field Values

- Pediatric (≤ 2 years old)
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Appropriately responds to stimulation
  - Common null values
- Adult
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Obeys commands
  - Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS - TOTAL

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Total	**NTDB Element Number** P_16
Local V5 Field Name GCS: Total	**NTDB Data Dictionary Page Number** 50

Field Values

- Relevant value for data element, minimum 3, maximum 15
- Common null values

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

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS 40 - EYE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** P_17
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 51

Field Values

Adult:

- 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 “0. 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 Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS 40 - VERBAL

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** P_18
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 52

Field Values

Adult:

- 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 “0. 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 Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS 40 - MOTOR

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** P_19
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 53

Field Values

Adult:

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

Pediatric < 5 years:

- None
- Extension to Pain
- Flexion to Pain
- Localizes Pain
- 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 patients 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 “0. 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 Hierarchy Guide

1. EMS Run Report

REFERRING FACILITY

REFERRAL HISTORY – IMMEDIATE REFERRING FACILITY

INTER-FACILITY TRANSFER

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfer In	**NTDB Element Number** P_20
Local V5 Field Name Inter-facility Transfer	**NTDB Data Dictionary Page Number** 54

Field Values

- Y – Yes, indicates that the patient was transferred to this hospital from another acute care hospital.
- N – No, indicates that the patient was NOT transferred to this hospital from another hospital OR the patient was transferred to this hospital from a doctor's office, clinic, or stand-alone ambulatory surgery center.
- Common null values

Additional Information

- Patients transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport are not considered an inter-facility transfer.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Data Source Hierarchy Guide

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

REFERRING HOSPITAL

Definition

Referring hospital's name.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Referring Facility	**NTDB Element Number** N/A
Local V5 Field Name Referring Facility	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for field

Additional Information

- Complete only if the patient was transferred from another acute care hospital to your hospital.
- Choose from listed facilities.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet
2. EMS Run Report

REFERRING HOSPITAL ARRIVAL DATE

Definition

The date the patient arrived at the referring hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrival (Date)	**NTDB Element Number** N/A
Local V5 Field Name Arrival (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet
2. EMS Run Report

REFERRING HOSPITAL ARRIVAL TIME

Definition

The time the patient arrived at the referring hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrival (Time)	**NTDB Element Number** N/A
Local V5 Field Name Arrival (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet
2. EMS Run Report

REFERRING HOSPITAL DISCHARGE DATE

Definition

The date the patient was discharged from the referring facility.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Departure (Date)	**NTDB Element Number** N/A
Local V5 Field Name Departure (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet
2. EMS Run Report

REFERRING HOSPITAL DISCHARGE TIME

Definition

The time the patient was discharged from the referring facility.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Departure (Time)	**NTDB Element Number** N/A
Local V5 Field Name Departure (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet
2. EMS Run Report

ASSESSMENTS

REFERRING HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition

The first recorded systolic blood pressure measured in the referring hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name SBP	**NTDB Element Number** N/A
Local V5 Field Name SBP	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-300
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value “Not Applicable” is reported for patient who arrive by Private/Public Vehicle/Walk-in.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL PULSE RATE

Definition

First recorded pulse measured in the referring hospital (palpated or auscultated), expressed as number per minute

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Pulse Rate	**NTDB Element Number** N/A
Local V5 Field Name Pulse Rate	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-299
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL UNASSISTED RESPIRATION RATE

Definition

The first respiratory rate recorded at the referring hospital (expressed as number per minute).

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Unassisted Resp Rate	**NTDB Element Number** N/A
Local V5 Field Name Unassisted Resp Rate	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-299
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL ASSISTED RESPIRATION RATE

Definition

The first respiratory rate recorded at the referring hospital (expressed as number per minute).

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Assisted Resp Rate	**NTDB Element Number** N/A
Local V5 Field Name Assisted Resp Rate	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-99
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL GCS - EYE

Definition

The first recorded GCS – Eye measured at the referring hospital ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name GCS: Eye	**NTDB Element Number** N/A
Local V5 Field Name GCS: Eye	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - No eye movement when assessed
- 2 - Opens eyes in response to painful stimulation
- 3 - Opens eyes in response to verbal stimulation
- 4 - Opens eyes spontaneously
- Common null values

Additional Information

- Used to calculate Overall GCS Score.
- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.
- If a patient does not have a numeric GCS score recorded, but there is written documentation closely (or directly) related to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL GCS - VERBAL

Definition

The first recorded GCS – Verbal measured at the referring hospital ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name GCS: Verbal	**NTDB Element Number** N/A
Local V5 Field Name GCS: Verbal	**NTDB Data Dictionary Page Number** N/A

Field Values

- Adult
  - 1 - No verbal response
  - 2 - Incomprehensible sounds
  - 3 - Inappropriate words
  - 4 - Confused
  - 5 - Oriented
  - Common null values
- Pediatric (≤ 2 years old)
  - 1 - No vocal response
  - 2 - Inconsolable, agitated
  - 3 - Inconsistently consolable, moaning
  - 4 - Cries, but is consolable, inappropriate interactions
  - 5 - Smiles, oriented to sounds, follows objects, interacts
  - Common null values

Additional Information

- Used to calculate Overall GCS Score.
- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.
- If a patient does not have a numeric GCS score recorded, but there is written documentation closely (or directly) related to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL GCS - MOTOR

Definition

The first recorded GCS – Motor measured at the referring hospital ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name GCS: Motor	**NTDB Element Number** N/A
Local V5 Field Name GCS: Motor	**NTDB Data Dictionary Page Number** N/A

Field Values

- Adult
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Obeys commands
  - Common null values

- Pediatric (≤ 2 years old)
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Appropriately responds to stimulation
  - Common null values

Additional Information

- Used to calculate Overall GCS Score
- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.
- If a patient does not have a numeric GCS score recorded, but there is written documentation closely (or directly) related to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

REFERRING HOSPITAL GCS - TOTAL

Definition

The first recorded GCS – Motor measured at the referring hospital ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name GCS: Total	**NTDB Element Number** N/A
Local V5 Field Name GCS: Total	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 3; Maximum: 15
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as Not Known/Not Recorded.
- If the three GCS components are completed, the relevant value will be auto-calculated. If the three component values are Not Known/Not Recorded, but a total is provided, it may be entered into the field.

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet

ALCOHOL SCREEN

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Alcohol Use Indicator	**NTDB Element Number** ED_21
Local V5 Field Name Alcohol Use Indicator	**NTDB Data Dictionary Page Number** 79

Field Values

- 1 - No (Not Tested)
- 2 - No (Confirmed by Test)
- 3 - Yes (Confirmed by Test [Trace Levels])
- 4 - Yes (Confirmed by Test [Beyond Legal Limit])
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

ALCOHOL SCREEN RESULTS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ETOH/BAC Level	**NTDB Element Number** ED_22
Local V5 Field Name ETOH/BAC Level	**NTDB Data Dictionary Page Number** 80

Field Values

- Relevant value for data element.

Additional Information

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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

DRUG SCREEN

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Drug Screen	**NTDB Element Number** ED_20
Local V5 Field Name Drug Screen	**NTDB Data Dictionary Page Number** 78

Field Values

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

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 Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

INTER-FACILITY TRANSPORT

TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Mode	**NTDB Element Number** P_07
Local V5 Field Name Mode	**NTDB Data Dictionary Page Number** 41

Field Values

- 1 - Ground Ambulance
- 2 - Helicopter Ambulance
- 3 - Fixed Wing Ambulance
- 4 - Private/Public Vehicle/Walk-in
- 5 - Police
- 6 - Other
- Common null values

Additional Information

- When other is selected, make sure that the mode of transport is specified in the appropriate box labeled Mode If Other.

Data Source Hierarchy Guide

1. EMS Run Report

TRANSPORT ROLE

Definition

The role the EMS provider was performing for the leg of travel being recorded.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Transport Role	**NTDB Element Number** N/A
Local V5 Field Name Transport Role	**NTDB Data Dictionary Page Number** N/A

Field Values

- 3 - Non-Transport
- 4 - Transport from Facility to Your Facility
- 5 - Transport from Facility to Rendezvous
- 6 - Transport from Rendezvous to Your Facility
- 7 - Transport to Other
- Common null values

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

EMS DISPATCH DATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Call Dispatched (Date)	**NTDB Element Number** P_01
Local V5 Field Name Call Dispatched (Date)	**NTDB Data Dictionary Page Number** 35

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

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 reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS DISPATCH TIME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Call Dispatched (Time)	**NTDB Element Number** P_02
Local V5 Field Name Call Dispatched (Time)	**NTDB Data Dictionary Page Number** 36

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

EMS RESPOND DATE

Definition

The date on which unit responded to the call

- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility responded to the call.
- 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 responded.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name En Route (Date)	**NTDB Element Number** N/A
Local V5 Field Name En Route (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- Times are associated with the agency that transported the patient to the hospital.

Data Source Hierarchy Guide

1. EMS Run Report

EMS RESPOND TIME

Definition

The time the unit responded to the call.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name En Route (Time)	**NTDB Element Number** N/A
Local V5 Field Name En Route (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- For inter-facility transfer patients, this is the time the unit transporting the patient to your facility from the transferring facility responded to the call.
- For patients transported from the scene of injury to your hospital, this is the time the unit transporting the patient to your facility from the scene responded.
- Times are associated with the agency that transported the patient to the hospital.

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Arrived at Location (Date)	**NTDB Element Number** P_03
Local V5 Field Name Arrived at Location (Date)	**NTDB Data Dictionary Page Number** 37

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

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 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 date on which the unit transporting the patient to your facility from the scene arrived at the scene. (Arrival is defined at date/time when the vehicle stopped moving.)
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Arrived at Location (Time)	**NTDB Element Number** P_04
Local V5 Field Name Arrived at Location (Time)	**NTDB Data Dictionary Page Number** 38

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Departed Location (Date)	**NTDB Element Number** P_05
Local V5 Field Name Departed Location (Date)	**NTDB Data Dictionary Page Number** 39

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values
- Times are associated with the agency that transported the patient to the hospital.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Additional Information

- Collected as MM/DD/YYYY.
- For inter-facility transfer patients, this is the date 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 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 reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

The time the unit transporting to your hospital departed from the scene/transferring facility (the time the vehicle started moving)

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Departed Location (Time)	**NTDB Element Number** P_06
Local V5 Field Name Departed Location (Time)	**NTDB Data Dictionary Page Number** 40

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVED AT DESTINATION DATE

Definition

The date unit arrived at its specific destination.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived at Destination (Date)	**NTDB Element Number** N/A
Local V5 Field Name Arrived at Destination (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values
- Times are associated with the agency that transported the patient to the hospital

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. EMS Run Report

EMS UNIT ARRIVED AT DESTINATION TIME

Definition

The time at which unit arrived at its specific destination.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived at Destination (Time)	**NTDB Element Number** N/A
Local V5 Field Name Arrived at Destination (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Times are associated with the agency that transported the patient to the hospital.

Data Source Hierarchy Guide

1. EMS Run Report

ED / RESUSCITATION

ARRIVAL/ADMISSION

ED DIRECT ADMIT

Definition

Identifies a patient who was admitted to the hospital without going through the ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Direct Admit	**NTDB Element Number** N/A
Local V5 Field Name Direct Admit	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- Null values are not accepted for this variable.

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

ED/HOSPITAL ARRIVAL DATE

Definition

The date the patient arrived at the ED/hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ED Arrival/Admit (Date)	**NTDB Element Number** ED_01
Local V5 Field Name ED Arrival/Admit (Date)	**NTDB Data Dictionary Page Number** 59

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

ED/HOSPITAL ARRIVAL TIME

Definition

The time the patient arrived at the ED/hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ED Arrival/Admit (Time)	**NTDB Element Number** ED_02
Local V5 Field Name ED Arrival/Admit (Time)	**NTDB Data Dictionary Page Number** 60

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

ED DISCHARGE DATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ED Departure Order (Date)	**NTDB Element Number** ED_25
Local V5 Field Name ED Departure Order (Date)	**NTDB Data Dictionary Page Number** 83

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- The null value “Not Applicable” is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “44, Morgue,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

ED DISCHARGE TIME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ED Departure Order (Time)	**NTDB Element Number** ED_26
Local V5 Field Name ED Discharge Order (Time)	**NTDB Data Dictionary Page Number** 84

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- The null value “Not Applicable” is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “44, Morgue,” then ED Discharge Time is the time of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

ED DEPARTURE DATE

Definition

The time the patient was discharged from the ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ED Departure (Date)	**NTDB Element Number** NA
Local V5 Field Name ED Departure (Date)	**NTDB Data Dictionary Page Number** NA

Field Values

- Minimum constraint: 1990; Maximum constraint: 2030
- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- This field reflects when the patient physically left the emergency department.
- The null value “Not Applicable” is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “44, Morgue,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

ED DEPARTURE TIME

Definition

The time the patient was discharged from the ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ED Departure (Time)	**NTDB Element Number** NA
Local V5 Field Name ED Departure (Time)	**NTDB Data Dictionary Page Number** NA

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Relevant value for data element
- Common null values

Additional Information

- Collected as HH:MM, military time
- This field reflects when the patient physically left the emergency department.
- The null value “Not Applicable” is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “44, Morgue” then ED Discharge Time is the time of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

SIGNS OF LIFE

Definition

Indication of whether patient arrived at ED/Hospital with signs of life.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Signs of Life	**NTDB Element Number** ED_24
Local V5 Field Name Signs of Life	**NTDB Data Dictionary Page Number** 82

Field Values

- 1 - Arrived with NO signs of life
- 2 - Arrived with signs of life
- Common null values

Additional Information

- A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.

Data Source Hierarchy Guide

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

MODE OF ARRIVAL

Definition

Indicator of the mode of transport to the ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Mode of Arrival	**NTDB Element Number** N/A
Local V5 Field Name Mode of Arrival	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Advanced Life Support Ambulance
- 2 - Advanced Life Support Helicopter
- 3 - Ambulance
- 4 - Basic Life Support Ambulance
- 5 - Basic Life Support Helicopter
- 6 - Helicopter
- 7 - Police
- 8 - Private Vehicle
- 9 - Walk-In
- Common null values

Additional Information

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

TRAUMA TEAM ACTIVATION LEVEL

Definition

Indicator that an announcement was made of an incoming trauma patient via pager system to assemble appropriate members of the trauma team in the ED.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Response Level	**NTDB Element Number** N/A
Local V5 Field Name Response Level	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Level 1
- 2 - Level 2
- 3 - Level 3
- 4 - Consult
- Common null values

Additional Information

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

TRAUMA TEAM ACTIVATION DATE

Definition

The date the trauma team was activated

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Response Activation (Date)	**NTDB Element Number** N/A
Local V5 Field Name Response Activation (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for activation level
- Common null values

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

TRAUMA TEAM ACTIVATION TIME

Definition

The time the trauma team was activated.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Response Activation (Time)	**NTDB Element Number** N/A
Local V5 Field Name Response Activation (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for activation level
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

ED DISCHARGE DISPOSITION

Definition

The disposition of the patient at the time of discharge from the ED.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ED Disposition	**NTDB Element Number** ED_23
Local V5 Field Name ED Disposition	**NTDB Data Dictionary Page Number** 81

Field Values

- 3 - Operating Room
- 4 - Intensive Care Unit (ICU)
- 5 - Step-Down Unit
- 6 - Floor
- 7 - Telemetry Unit
- 8 - Observation Unit
- 9 - Burn Unit
- 13 - Labor and Delivery
- 14 - Neonatal/Pediatric Care Unit
- 40 - Home or Self Care (Routine Discharge)
- 41 - Home with Services
- 42 - Left AMA
- 43 - Correctional Facility/Court/Law Enforcement
- 44 - Morgue
- 45 - Child Protective Agency
- 70 - Acute Care Facility
- 71 - Intermediate Care Facility
- 72 - Skilled Nursing Facility
- 73 - Rehab (Inpatient)
- 74 - Long-Term Care
- 75 - Hospice
- 76 - Mental Health/Psychiatric Hospital (Inpatient)
- 77 - Nursing Home
- 79 - Another Type of Inpatient Facility Not Defined Here
- 80 - Burn Center
- Common null values

Additional Information

- The null value “Not Applicable” is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 41 – Home with Services, 44 – Morgue, 43 – Correctional Facility/Court/Law Enforcement, 40 – Home or Self Care (Routine Discharge), 42 – Left AMA, or 70 – Acute Care Facility, then Hospital Discharge Date, Time, and Disposition should be N/A.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Summary
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. ED Record
6. History & Physical

HOSPITAL ADMITTING SERVICE

Definition

Indicator of the section of the hospital to which the patient was sent for care.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Admitting Service	**NTDB Element Number** N/A
Local V5 Field Name Admitting Service	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Trauma
- 2 - Neurosurgery
- 3 - Orthopedics
- 4 - General Surgery
- 5 - Pediatric Surgery
- 6 - Cardiothoracic Surgery
- 7 - Burn Services
- 8 - Emergency Medicine
- 9 - Pediatrics
- 23 - Hospitalist
- 57 - Medicine
- 58 - Intensivist
- 98 - Other Surgical
- 99 - Other Non-Surgical
- Common null values

Additional Information

Data Source Hierarchy Guide

1. ED Discharge/Transfer Sheet
2. Nursing Progress Notes

NATIONAL PROVIDER IDENTIFIER (NPI)

Definition

The National Provider Identifier (NPI) of the admitting surgeon.

Required in ATR No	**Required in NTDB** Optional
Web V5 Field Name Admitting Physician	**NTDB Element Number** SSR_01
Local V5 Field Name Admitting Physician	**NTDB Data Dictionary Page Number** 209

Field Values

- Relevant value for data element

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.
- Must be stored as a 10-digit numeric value.
- The null value “Not Applicable” is reported if this optional field is not being reported.

Data Source Hierarchy Guide

OR DISPOSITION

Definition

The disposition of the patient following post-anesthesia recovery.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Post OR Disposition	**NTDB Element Number** N/A
Local V5 Field Name OR Disposition	**NTDB Data Dictionary Page Number** N/A

Field Values

- 4 - Intensive Care Unit
- 5 - Step-Down Unit
- 6 - Floor
- 7 - Telemetry Unit
- 8 - Observation Unit
- 9 - Burn Unit
- 11 - Post-Anesthesia Care Unit
- 14 - Neonatal/Pediatric Care Unit
- 42 - Left AMA
- 44 - Morgue
- 70 - Acute Care Facility
- Common null values

Additional Information

Data Source Hierarchy Guide

1. OR Nurse's Notes
2. Operative Records

ARKANSAS TRAUMA COMMUNICATIONS CENTER (ATCC) UTILIZATION

Definition

Indicator that the ATCC was contacted to coordinate patient transfer.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was ATCC utilized for the patient transfer?	**NTDB Element Number** N/A
Local V5 Field Name Was ATCC utilized for the patient transfer?	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- This field is required by the sending facility only
- Question will be presented as: “Was ATCC utilized for the patient transfer?”
- Field will become active if ED disposition is “Acute Care Facility” (option 70) or “Burn Center” (option 80).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

ATCC NOT UTILIZED; PLEASE SPECIFY*

Definition

Specification of the reason for not utilizing the ATCC to facilitate patient transfer.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name TBD	**NTDB Element Number** N/A
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - VA transfer
- 2 - Transfer to NP facility
- 3 - In-patient transfer or direct admit
- 4 - Free-text box (only use when other values do not apply)
- Common null values

Additional Information

- Field will become active if ED disposition is “Acute Care Facility” (option 70) or “Burn Center” (option 80).
- Transfers to burn center should be coordinated through ATCC.
- If value is “other” use the free-text box to indication.
- This field is required by the sending facility only.

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

*This is new to the registry and may not available at the time of publication. We will begin collecting this information from the date it becomes available.

ATCC DATE OF CONTACT

Definition

Indicator of the date that the ATCC was contacted to coordinate patient transfer.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ATCC Contacted (Date)	**NTDB Element Number** N/A
Local V5 Field Name ATCC Contacted (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Collected as MM/DD/YYYY
- Common null values

Additional Information

- This field is required by the sending facility only
- Field will become active if ED disposition is “Acute Care Facility” (option 70), or “Burn Center” (option 80).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

ATCC TIME OF CONTACT

Definition

Indicator of the time that the ATCC was contacted in the transfer process

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ATCC Contacted (Time)	**NTDB Element Number** N/A
Local V5 Field Name ATCC Contacted (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Collected as HH:MM, military time
- Minimum constraint: 00:00; Maximum Constraint 23:59
- Field will become active if ED disposition is “Acute Care Facility” (option 70) or “Burn Center” (option 80).
- Common null values

Additional Information

- This field is required by the sending facility only
- Question will be presented as: “Time ATCC was contacted for patient transfer”
- Field will become active if ED disposition is “Acute Care Facility” (option 70) or “Burn Center” (option 80).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

REASON FOR TRANSFER*

Definition

The primary reason for transferring the patient.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name TBD	**NTDB Element Number** N/A
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Neuro (Head/Spine)
- 2 - Ortho (excludes pelvic)
- 3 - Facial or Eye
- 4 - Multi-System
- 5 - Hand Trauma
- 6 - General Surgery/OR
- 7 - Burn (Adult or Pedi)
- 8 - Complex Pelvic
- 9 - Pediatric, non-specific
- 10 - CT/MRI
- 11 - Other (please specify)
- Common null values

Additional Information

- Record the primary service that is not available at the transferring facility and is the reason for transfer.
- Field will become active if ED disposition is “Acute Care Facility” (option 70) or “Burn Center” (option 80).
- This is an Arkansas specific variable and must be answered for all transfers out of the ED/ER.

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

*This is new field to the registry and may not available at the time of publication. We will begin collecting this information from the date it becomes available.

ANTIBIOTICS THERAPY*

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

Intravenous antibiotic therapy was administered to the patient within 24 hours after first hospital encounter.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Were IV antibiotics given for long bone fractures?	**NTDB Element Number** PM_36
Local V5 Field Name Were IV antibiotics given for long bone fractures?	**NTDB Data Dictionary Page Number** 205

Field Values

- Yes
- No
- Common null values

Additional Information

- Question presented as “Were IV antibiotics given for open long bone fractures?”
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report intravenous antibiotic therapy that was administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

*This field has been modified to fit the NTDB definition for open fractures. Updates to the registry platform to reflect this change are in progress.

ANTIBIOTICS THERAPY - SPECIFY LOCATION*

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

The location where the first dose of intravenous antibiotics was given.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name TBD	**NTDB Element Number** N/A
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - This facility
- 2 - Transferring facility
- 3 - Prehospital (EMS)
- Common null values

Additional Information

- Specify the location where the first dose of intravenous antibiotic therapy was administered to the patient within 24 hours.
- The null value “Not Applicable” is reported if the data element value for Antibiotic Therapy is “No.”
- Will only become active if “Yes,” in the Antibiotics data element.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. EMS Patient Care Record
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record
7. Billing Report

*This is a new field to the registry and may not available at the time of publication. We will begin collecting this information from the date it becomes available.

ANTIBIOTICS THERAPY DATE*

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name IV antibiotics given (Date)	**NTDB Element Number** PM_37
Local V5 Field Name IV antibiotics given (Date)	**NTDB Data Dictionary Page Number** 206

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collect as MM/DD/YYYY.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report the date of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility of the transferring facility.
- The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Field Value “2. No”.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

ANTIBIOTICS THERAPY TIME*

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after the first hospital encounter.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name IV antibiotics given (Time)	**NTDB Element Number** PM_38
Local V5 Field Name IV antibiotics given (Time)	**NTDB Data Dictionary Page Number** 207

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collect as HH:MM military time
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report the time of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility of the transferring facility.
- The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Field Value “2. No”.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow sheet
5. Pharmacy Record

ANTICOAGULANTS AT HOME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Did patient home medications list include anticoagulants?	**NTDB Element Number** N/A
Local V5 Field Name Did patient home medications list include anticoagulants?	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- Question presented as “Did patient home medications list include anticoagulants?”

Data Source Hierarchy Guide

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

ANTICOAGULANTS AT HOME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name If Yes, Specify:	**NTDB Element Number** N/A
Local V5 Field Name If Yes, Specify:	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Coumadin (Warfarin)
- 2 - Plavix (Clopidogrel)
- 3 - Xarelto (Rivaroxaban)
- 4 - Pradaxa (Dabigatran)
- 5 - Brillinta (Ticagrelor)
- 6 - Effient (Prasugruel)
- 7 - Eliquis (Apixaban)

*This list of options will be updated and include the medications listed below. Updates to the registry platform to reflect this change are in progress and may not be available at the time of publication.

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

Additional Information

- Check all that apply
- Question presented as “If Yes, Specify”

Data Source Hierarchy Guide

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

HEAD CT SCAN

Definition

The completion of a head CT during the patient's stay in the emergency department at your facility.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was a CT of the head done at your facility?	**NTDB Element Number** N/A
Local V5 Field Name Was a CT of the head done at your facility?	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- Question presented as "Was a CT of the head done at your facility?"
- Answer "Yes" only if the CT was performed at your facility.

Data Source Hierarchy Guide

1. Triage Trauma Flow Sheet
2. Operative Records
3. ER/ICU Records
4. Hospital Discharge Summary
5. Radiology Report
6. Billing Report

INITIAL ASSESSMENT

INITIAL ED/HOSPITAL TEMPERATURE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Temperature	**NTDB Element Number** ED_05
Local V5 Field Name Temperature	**NTDB Data Dictionary Page Number** 63

Field Values

- Minimum constraint: 0.0; Maximum constraint: 45.0
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Nurses Notes/Flow Sheet

INITIAL ED/HOSPITAL TEMPERATURE UNITS

Definition

Indicator of whether the temperature was captured in Fahrenheit or Celsius (centigrade).

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Unit	**NTDB Element Number** N/A
Local V5 Field Name Unit	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 – C (Celsius)
- 2 – F (Fahrenheit)

Additional Information

- Variable is captured only in the V5 registry.

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records

INITIAL ED/HOSPITAL TEMPERATURE ROUTE

Definition

Indicator of the route of patient temperature assessment.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Route	**NTDB Element Number** N/A
Local V5 Field Name Route	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Oral
- 2 - Tympanic
- 3 - Rectal
- 4 - Axillary
- 5 - Core
- 6 - Other
- 7 - Temporal
- Common null values

Additional Information

- Variable is captured only in the V5 registry.

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records

INITIAL ED/HOSPITAL WEIGHT

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Weight	**NTDB Element Number** ED_19
Local V5 Field Name Weight	**NTDB Data Dictionary Page Number** 77

Field Values

- Minimum constraint: 0; Maximum constraint: 907 (kg)
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

INITIAL ED/HOSPITAL WEIGHT UNITS

Definition

Indicator of whether the weight was captured in pounds (lbs.) or kilograms (kg).

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Units	**NTDB Element Number** N/A
Local V5 Field Name Units	**NTDB Data Dictionary Page Number** N/A

Field Values

- lbs.
- kg.
- Common null values

Additional Information

- In V5 Registry, only completed if a value is provided for “Weight.”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records

INITIAL ED/HOSPITAL HEIGHT

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Height	**NTDB Element Number** ED_18
Local V5 Field Name Height	**NTDB Data Dictionary Page Number** 76

Field Values

- Minimum constraint: 0; Maximum constraint: 244
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

INITIAL ED/HOSPITAL HEIGHT UNITS

Definition

Indicator of whether the height was captured in centimeters or inches.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Units	**NTDB Element Number** N/A
Local V5 Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Centimeters
- Inches
- Common null values

Additional Information

- In V5 Registry, only completed if a value is provided for “Height”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name At Time Vitals Taken	**NTDB Element Number** ED_14
Local V5 Field Name At Time Vitals Taken	**NTDB Data Dictionary Page Number** 72

Field Values

- Paralytic Agents
- Patient Intubated
    - If Yes, Method
        - Combitube
        - Cricothyrotomy
        - Cricothyrotomy – Needle
        - Endotracheal Tube – Nasal
        - Endotracheal Tube – Oral
        - Endotracheal Tube – Route NFS
        - Esophageal Obturator Airway
        - Laryngeal Mask Airway
        - LT Blind Insertion Airway Device
        - Tracheostomy
        - Unknown
- Patient Sedated
- Respiration Assisted
    - If Yes, Type
        - Bag Valve Mask
        - Nasal Airway
        - Oral Airway
        - Ventilator
        - Unknown
- Eye Obstruction
- Common null values

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.

- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- Report all that apply.
- The null value “Not Known/Not Recorded” is reported if 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.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician’s Notes/Flow Sheet

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name SBP	**NTDB Element Number** ED_03
Local V5 Field Name SBP	**NTDB Data Dictionary Page Number** 61

Field Values

- Field value range 0-300
- Common null values

Additional Information

- Please note that 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 Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician's Notes
4. History & Physical

INITIAL ED/HOSPITAL PULSE RATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Pulse Rate	**NTDB Element Number** ED_04
Local V5 Field Name Pulse Rate	**NTDB Data Dictionary Page Number** 62

Field Values

- Field value range 0-299
- Common null values

Additional Information

- Please note that 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 Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Nurses Notes/Flow Sheet

INITIAL ED/HOSPITAL RESPIRATORY RATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Unassisted Resp Rate	**NTDB Element Number** ED_06
Local V5 Field Name Unassisted Resp Rate	**NTDB Data Dictionary Page Number** 64

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values

Additional Information

- If documented, report additional field: Initial ED/Hospital Assisted Respiratory Rate
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Assisted Resp Rate	**NTDB Element Number** ED_07
Local V5 Field Name Assisted Resp Rate	**NTDB Data Dictionary Page Number** 65

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

INITIAL ED/HOSPITAL OXYGEN SATURATION

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name O2 Saturation	**NTDB Element Number** ED_08
Local V5 Field Name O2 Saturation	**NTDB Data Dictionary Page Number** 66

Field Values

- Minimum constraint: 0; Maximum constraint: 100
- Common null values

Additional Information

- If documented, report additional field: Initial ED/Hospital Supplemental Oxygen.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Supplemental O2	**NTDB Element Number** ED_09
Local V5 Field Name Supplemental O2	**NTDB Data Dictionary Page Number** 67

Field Values

- No supplemental oxygen
- Supplemental oxygen
- Common null values

Additional Information

- The null value “Not Applicable” is reported if the Initial ED/Hospital Oxygen Saturation is “Not Known/Not Recorded.”
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

INITIAL ED/HOSPITAL GCS – EYE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Eye	**NTDB Element Number** ED_10
Local V5 Field Name GCS: Eye	**NTDB Data Dictionary Page Number** 68

Field Values

- 1 - No eye movement when assessed
- 2 - Opens eyes in response to painful stimulation
- 3 - Opens eyes in response to verbal stimulation
- 4 - Opens eyes spontaneously
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician's Notes/Flow Sheet

INITIAL ED/HOSPITAL GCS - VERBAL

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Verbal	**NTDB Element Number** ED_11
Local V5 Field Name GCS: Verbal	**NTDB Data Dictionary Page Number** 69

Field Values

- **Pediatric (< 2 years)**
  - 1 - No vocal response
  - 2 - Inconsolable, agitated
  - 3 - Inconsistently consolable, moaning
  - 4 - Cries but is consolable, inappropriate interactions
  - 5 - Smiles, oriented to sounds, follows objects, interacts
- **Adult**
  - 1 - No verbal response
  - 2 - Incomprehensible sounds
  - 3 - Inappropriate words
  - 4 - Confused
  - 5 - Oriented
  - Common null values

Additional Information

- If patient is intubated, then the GCS Verbal score is equal to 1 (No vocal response).
- 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 reported if Initial ED/Hospital GCS 40 – Verbal is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician’s Notes/Flow Sheet

INITIAL ED/HOSPITAL GCS - MOTOR

Definition

First recorded Glasgow Coma Score – Motor in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Motor	**NTDB Element Number** ED_12
Local V5 Field Name GCS: Motor	**NTDB Data Dictionary Page Number** 70

Field Values

- **Pediatric (≤ 2 years)**
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Appropriate response to stimulation
  - Common null values
- **Adult**
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Obeys commands
  - Common null values

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., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Motor is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician’s Notes/Flow Sheet

INITIAL ED/HOSPITAL GCS - TOTAL

Definition

First recorded Glasgow Coma Scale – Total in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS: Total	**NTDB Element Number** ED_13
Local V5 Field Name GCS: Total	**NTDB Data Dictionary Page Number** 71

Field Values

- Minimum constraint: 3; Maximum constraint: 15
- Common null values

Additional Information

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as “AAOx3,” “awake alert and oriented,” or “patient with normal mental status,” interpret this as GCS of 15 IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 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 were not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician’s Notes/Flow Sheet

INITIAL ED/HOSPITAL GCS 40 - EYE

Definition

First recorded Glasgow Coma Score 40 (Eye) measured in the ED/hospital within 30 minutes or less of ED/hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** ED_15
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 73

Field 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 "0. Not Testable" if unable to assess (e.g. swelling to eye(s)).
- The null value "Not Known/Not Recorded" is reported if Initial Field ED/Hospital 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 Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

INITIAL ED/HOSPITAL GCS 40 - VERBAL

Definition

First recorded Glasgow Coma Score 40 (Verbal) within 30 minutes or less of Ed/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** ED_16
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 74

Field Values

Adult:

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

Pediatric < 5 years:

- None
- Cries
- Vocal Sounds
- 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 “0. Not Testable” if unable to assess (e.g. patient is intubated).
- The null value “Not Known/Not Recorded” is reported if Initial Field ED/Hospital 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 Hierarchy Guide

1. Triage Form/Trauma/Hospital Flow Sheet
2. Nurse Notes/Flow Sheet
3. Physician Notes/Flow Sheet

INITIAL ED/HOSPITAL GCS 40 - MOTOR

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** ED_17
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 75

Field Values

Adult:

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

Pediatric < 5 years:

- None
- Extension to Pain
- Flexion to Pain
- Localizes Pain
- 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., if the chart indicates “patient opened mouth and stuck out tongue when asked,” for adult patients, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.
- Report Field Value “0. Not Testable” if unable to assess (e.g. neuromuscular blockade).
- The null value “Not Known/Not Recorded” is reported if Initial Field ED/Hospital 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 Hierarchy Guide

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

LABS/TOXICOLOGY

ALCOHOL SCREEN

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Alcohol Use Indicator	**NTDB Element Number** ED_21
Local V5 Field Name Alcohol Use Indicator	**NTDB Data Dictionary Page Number** 79

Field Values

- 1 - No (Not Tested)
- 2 - No (Confirmed by Test)
- 3 - Yes (Confirmed by Test [Trace Levels])
- 4 - Yes (Confirmed by Test [Beyond Legal Limit])
- Common null values

Additional Information

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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

ALCOHOL SCREEN RESULTS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ETOH/BAC Level	**NTDB Element Number** ED_22
Local V5 Field Name Drug Use Indicator	**NTDB Data Dictionary Page Number** 80

Field Values

- Relevant value for data element.

Additional Information

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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

DRUG SCREEN

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Drug Screen	**NTDB Element Number** ED_20
Local V5 Field Name Drug Screen	**NTDB Data Dictionary Page Number** 78

Field Values

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

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 Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

PATIENT TRACKING

LOCATION/SERVICE

TOTAL ICU LENGTH OF STAY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICU Days	**NTDB Element Number** O_01
Local V5 Field Name ICU Days	**NTDB Data Dictionary Page Number** 156-157

Field Values

- Minimum constraint: 1; Maximum constraint: 400
- Relevant value for data element
- Common null values

Additional Information

- Reported in full day increments, with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient had no ICU days according to the above definition.

Data Source Hierarchy Guide

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

References

- For examples, see page 156 of the NTDB 2019 Data Dictionary.

VENTILATOR/BLOOD

TOTAL VENTILATOR DAYS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Total Ventilator Days	**NTDB Element Number** O_02
Local V5 Field Name Total Ventilator Days	**NTDB Data Dictionary Page Number** 158-159

Field Values

- Minimum constraint: 1; Maximum constraint: 400
- Relevant value for data element
- Common null values

Additional Information

- Excludes mechanical ventilation time associated with OR procedures
- Non-invasive means of support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping any ventilator episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- At no time should the Total Vent Days exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.

Data Source Hierarchy Guide

1. Respiratory Therapy Notes/Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

References

- For examples, see page 158 of the NTDB 2019 Data Dictionary

PROVIDERS

RESUSCITATION TEAM

SURGEON CALLED DATE

Definition

The date that the surgeon was called.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Called (Date)	**NTDB Element Number** N/A
Local V5 Field Name Called (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element.

Additional Information

- Collected as MM/DD/YYYY
- Common null values

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

SURGEON CALLED TIME

Definition

The date that the surgeon was called.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Called (Time)	**NTDB Element Number** N/A
Local V5 Field Name Called (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- Common null values

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

SURGEON ARRIVED DATE

Definition

The date that the surgeon arrived.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived (Date)	**NTDB Element Number** N/A
Local V5 Field Name Arrived (Date)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element.

Additional Information

- Collected as MM/DD/YYYY**.**
- Common null values

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

SURGEON ARRIVED TIME

Definition

The date that the surgeon arrived.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Arrived (Time)	**NTDB Element Number** N/A
Local V5 Field Name Arrived (Time)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- Common null values

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

IN-HOUSE CONSULTS

CONSULTS

Definition

Record of other specialties consulted during the emergency room visit.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Type	**NTDB Element Number** N/A
Local V5 Field Name Type	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Trauma
- 2 - Neurosurgery
- 3 - Orthopedics
- 4 - General Surgery
- 5 - Pediatric Surgery
- 6 - Cardiothoracic Surgery
- 7 - Burn Services
- 8 - Emergency Medicine
- 9 - Pediatrics
- 10 - Anesthesiology
- 11 - Cardiology
- 12 - Chaplain
- 13 - Child Protective Team
- 14 - Critical Care
- 15 - Discharge Planner
- 16 - Documentation Recorder
- 17 - Drug/Alcohol Counselor
- 19 - ENT
- 20 - Family Medicine
- 21 - GI
- 22 - Home Health
- 23 - Hospitalist
- 24 - Infectious Disease
- 25 - Internal Medicine
- 26 - Laboratory
- 27 - Nephrology
- 28 - Neurology
- 29 - Nurse Practitioner
- 30 - Nursing
- 31 - Nutrition
- 32 - OB-GYN
- 33 - Occupational Therapy
- 34 - Oncology
- 35 - Ophthalmology
- 36 - Oral Surgery
- 37 - Oromaxillo Facial Service
- 38 - Ortho-Spine
- 39 - Palliative Care
- 40 - Pharmacy
- 41 - Physiatry
- 42 - Physical Therapy
- 43 - Plastic Surgery
- 44 - Psychiatry
- 45 - Pulmonary
- 46 - Radiology
- 47 - Rehab
- 48 - Respiratory Therapist
- 49 - Social Services
- 50 - Social Worker
- 51 - Speech Therapy
- 52 - Thoracic Surgery
- 53 - Trauma Resuscitation Nurse
- 54 - Triage Nurse
- 55 - Urology
- 56 - Vascular Surgery
- 58 - Intensivist
- 98 - Other Surgical
- 99 - Other Non-Surgical
- Common null values

Additional Information

- Consults during an inpatient stay are not required.
- Multiple entries are allowed.

Data Source Hierarchy Guide

1. Nurses' Notes
2. Social Services Notes

PROCEDURES

ICD-10 HOSPITAL PROCEDURES

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB. This list is based on procedures sent to NTDB with a high frequency. Not all hospitals capture all procedures listed below. Please transmit those procedures that you do capture to NTDB.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICD-10 Procedure Code	**NTDB Element Number** HP_01
Local V5 Field Name ICD-10 Procedure Code	**NTDB Data Dictionary Page Number** 86-87

Field Values

- Major and minor procedure ICD 10-PCS procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.
- Common null values

Additional Information

- The null value "Not Applicable" is reported if the patient did not have procedures.
- Include only procedures performed at your institution.
- Report all procedures performed in the operating room.
- Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Note that the hospital may report additional procedures.

Diagnostic and Therapeutic Imaging:
Computerized tomographic Head*
Computerized tomographic Chest*
Computerized tomographic Abdomen*
Computerized tomographic Pelvis*
Computerized tomographic C-Spine*
Computerized tomographic T-Spine*
Computerized tomographic L-Spine*
Doppler ultrasound of extremities*
Diagnostic ultrasound (includes FAST)*
Angioembolization
Angiography
IVC Filter
REBOA

Genitourinary:

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

Transfusion:
The following blood products should be capturedover first 24 hours after hospital arrival:

- Transfusion of red cells *
- Transfusion of platelets *
- Transfusion of plasma *

In addition to coding the individual blood products listed above assign the appropriate procedure code on patients that receive > 10 units of blood products over first 24 hours following hospital arrival
For pediatric patients (age 14 and under), assign the appropriate procedure code on patients that receive 40cc/kg of blood products over first 24 hours following hospital arrival

Cardiovascular:
Open cardiac massage
CPR

Respiratory:
Insertion of endotracheal tube* (exclude intubations performed in the OR)
Continuous mechanical ventilation*
Chest tube*
Bronchoscopy*
Tracheostomy

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

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

Musculoskeletal:
Soft tissue/bony debridements*
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

HOSPITAL PROCEDURE START DATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Start (Date)	**NTDB Element Number** HP_02
Local V5 Field Name Start (Date)	**NTDB Data Dictionary Page Number** 88

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

HOSPITAL PROCEDURE START TIME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Start (Time)	**NTDB Element Number** HP_03
Local V5 Field Name Start (Time)	**NTDB Data Dictionary Page Number** 89

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM (midnight – 12:00 a.m.) through 23:59 (11:59 p.m.), valid military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Data Source Hierarchy Guide

1. Operative Reports
2. Anesthesia Reports
3. Procedure Notes
4. Trauma Flow Sheet
5. ED Record
6. Nursing Notes/Flow Sheet
7. Radiology Reports
8. Discharge Summary

DIAGNOSIS

INJURY CODING

AIS VERSION

Definition

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name AIS Version	**NTDB Element Number** DG_04
Local V5 Field Name AIS Version	**NTDB Data Dictionary Page Number** 120

Field Values

- AIS 05, Update 08
- AIS 2015

Additional Information

Data Source Hierarchy Guide

1. AIS Coding Manual

ISS

Definition

The Injury Severity Score (ISS) that reflects the patient's injuries

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ISS	**NTDB Element Number** N/A
Local V5 Field Name ISS	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 1; Maximum constraint: 75
- Relevant ISS value for the constellation of injuries
- Common null values

Additional Information

- Field is auto-calculated based on AIS Severity and ISS Body Region.

Data Source Hierarchy Guide

ICD-10 INJURY DIAGNOSIS

Definition

Diagnoses related to all identified injuries.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICD-10 Code	**NTDB Element Number** DG_01
Local V5 Field Name ICD-10	**NTDB Data Dictionary Page Number** 117

Field Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28, and T30-T32.
- The maximum number of diagnoses that may be reported for an individual patient is 100.

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in the field.

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician's Notes
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

AIS PREDOT CODE

Definition

The Abbreviated Injury Scale (AIS) pre-dot codes that reflect the patient's injuries.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name PreDot	**NTDB Element Number** DG_02
Local V5 Field Name PreDot	**NTDB Data Dictionary Page Number** 118

Field Values

- The pre-dot code is the 6 digits preceding the decimal point in an associated AIS code.

Additional Information

Data Source Hierarchy Guide

1. AIS Coding Manual

AIS SEVERITY

Definition

The Abbreviated Injury Scale (AIS) severity codes that reflect that patient's injuries.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Severity	**NTDB Element Number** DG_03
Local V5 Field Name Severity	**NTDB Data Dictionary Page Number** 119

Field Values

- 1 – Minor Injury
- 2 – Moderate Injury
- 3 – Serious Injury
- 4 – Severe Injury
- 5 - Critical Injury
- 6 – Maximum Injury, Virtually Unsurvivable
- 9 – Not Possible to Assign
- 0 – Combined with Other Injury

Additional Information

- The field value "9. Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury.

Data Source Hierarchy Guide

1. AIS Coding Manual

ISS BODY REGION

Definition

The Injury Severity Score (ISS) body region codes that reflect the patient's injuries.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ISS Body Region	**NTDB Element Number** N/A
Local V5 Field Name ISS Body Region	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Head or neck
- 2 - Face
- 3 - Chest
- 4 - Abdominal or pelvic contents
- 5 - Extremities or pelvic girdle
- 6 - External
- 9 - Not determined
- Common null values

Additional Information

- This variable is considered optional and is not required as part of the NTDS 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 Hierarchy Guide

COMORBIDITIES

This information was formerly categorized as “Comorbid Conditions” in the previous NDTS Data Dictionary. The new name for this category is “Pre-Existing Conditions” in the 2019 NTDS Data Dictionary.

PRE-HOSPITAL CARDIAC ARREST

Definition

Indication of whether the patient experienced cardia arrest prior to ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Pre-Hospital Cardiac Arrest	**NTDB Element Number** P_23
Local V5 Field Name Pre-Hospital Cardiac Arrest	**NTDB Data Dictionary Page Number** 57

Field Values

- Yes
- No
- Common null values

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation
- The event must have occurred outside of the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring institution.
- Any component of basic and/or advance cardiac life support must have been initiated by a health care provider.

Data Source Hierarchy Guide

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

ADVANCE DIRECTIVE LIMITING CARE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_01
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 91

Field 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 Hierarchy Guide

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

ALCOHOL USE DISORDER

Definition

Diagnosis of alcohol use disorder documented in the patient medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_02
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 92

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- A diagnosis of Alcohol Use Disorder must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

ANGINA PECTORIS

Definition

Chest pain or discomfort due to coronary heart disease. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_03
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 93

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of Angina or Chest Pain must be documented in the patient's medical record.
- Consistent with American Heart Association (AHA), May 2015.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

ANTICOAGULANT THERAPY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_04
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 94

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

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- Exclude patients whose only anticoagulant therapy is chronic Aspirin.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

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

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_05
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 95

Field Values

- Yes
- No

Additional Information

- Present prior to ED/Hospital arrival.
- A diagnosis of ADD/ADHD must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

BLEEDING DISORDER

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_06
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 96

Field 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 Willenbrand Disease, Factor V Leiden).
- Consistent with American Society of Hematology, 2015.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CEREBRAL VASCULAR ACCIDENT (CVA)

Definition

A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_07
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 97

Field 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 Hierarchy Guide

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Definition

Lung ailment that is characterized by a persistent blockage of airflow from the lungs. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms “chronic bronchitis” and “emphysema” are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_08
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 98

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient’s medical record.
- Do not include patients whose only pulmonary disease is acute asthma.
- Do not include patients with diffuse interstitial fibrosis or sarcoidosis.
- Consistent with World Health Organization (WHO), 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CHRONIC RENAL FAILURE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_09
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 99

Field 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 Hierarchy Guide

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

CIRRHOSIS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_10
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 100

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CONGENITAL ANOMALIES

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_11
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 101

Field 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.

Data Source Hierarchy Guide

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

CONGESTIVE HEART FAILURE (CHF)

Definition

The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_12
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 102

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

Data Source Hierarchy Guide

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

CURRENT SMOKER

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_13
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 103

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- Exclude patients who report smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_14
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 104

Field 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 Hierarchy Guide

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

DEMENTIA

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_15
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 105

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of a Dementia must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

DIABETES MELLITUS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_16
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 106

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of a Diabetes Mellitus must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

DISSEMINATED CANCER

Definition

Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_17
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 107

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- Other terms describing disseminated cancer include: “diffuse,” “widely metastatic,” “widespread,” or “carcinomatosis.”
- Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone).
- A diagnosis of Cancer that has spread to one or more sites must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

FUNCTIONALLY DEPENDENT HEALTH STATUS

Definition

Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_18
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 108

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Included patients who prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, were partially dependent or completely depending upon equipment, devices or another person to complete some or all activities of daily living.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

HYPERTENSION

Definition

History of persistent elevated blood pressure requiring medical therapy.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_19
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 109

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of a Hypertension must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

MENTAL/PERSONALITY DISORDERS

Definition

Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_20
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 110

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

MYOCARDIAL INFARCTION (MI)

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_21
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 111

Field 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 Hierarchy Guide

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

PERIPHERAL ARTERIAL DISEASE (PAD)

Definition

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_22
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 112

Field 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.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

PREMATURITY

Definition

Babies born before 37 weeks of pregnancy are completed.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_23
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 113

Field 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.

Data Source Hierarchy Guide

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

STEROID USE

Definition

Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_24
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 114

Field 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: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

SUBSTANCE ABUSE DISORDER

Definition

Documentation of substance abuse disorder in the patient's medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** CC_25
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 115

Field Values

- Yes
- No

Additional Information

- Present prior to injury.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.
- A diagnosis of a Substance Abuse Disorder must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- EXCLUDE: Tobacco Use Disorder and Alcohol Use Disorder

Data Source Hierarchy Guide

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

OUTCOME

INITIAL DISCHARGE

HOSPITAL DISCHARGE STATUS

Definition

The status of the patient upon discharge.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge Status	**NTDB Element Number** N/A
Local V5 Field Name Discharge Status	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Alive
- 2 - Dead

Additional Information

Data Source Hierarchy Guide

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

DISCHARGE/DEATH DATE

Definition

The time the patient was discharged from the hospital or the time of death as indicated on the patient's death certificate.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge/Death (Date)	**NTDB Element Number** NA
Local V5 Field Name Discharge/Death (Date)	**NTDB Data Dictionary Page Number** NA

Field Values

- Minimum constraint: 1990; Maximum constraint: 2030
- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- This field reflects when the patient physically left the facility.
- The null value "Not Applicable" is reported if ED Discharge Disposition is "Morgue."
- The null value "Not Applicable" is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is "44, Morgue," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

DISCHARGE/DEATH TIME

Definition

The time the patient was discharged from the hospital or the time of death as indicated on the patient's death certificate.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge/Death (Time)	**NTDB Element Number** NA
Local V5 Field Name Discharge/Death (Time)	**NTDB Data Dictionary Page Number** NA

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Relevant value for data element
- Common null values

Additional Information

- Collected as HH:MM, military time
- This field reflects when the patient physically left the facility.
- The null value "Not Applicable" is reported if ED Discharge Disposition is "Morgue."
- The null value "Not Applicable" is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is "44, Morgue," then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

HOSPITAL DISCHARGE DATE

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharge Order (Date)	**NTDB Element Number** O_03
Local V5 Field Name Discharge Order (Date)	**NTDB Data Dictionary Page Number** 160

Field Values

- Minimum constraint: 1990; Maximum constraint: 2030
- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- The null value “Not Applicable” is reported if ED Discharge Disposition is “Morgue.”
- The null value “Not Applicable” is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is “44, Morgue,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

HOSPITAL DISCHARGE TIME

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharge Order (Time)	**NTDB Element Number** O_04
Local V5 Field Name Discharge Order (Time)	**NTDB Data Dictionary Page Number** 161

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Relevant value for data element
- Common null values

Additional Information

- Collected as HH:MM, military time.
- The null value “Not Applicable” is reported if ED Discharge Disposition is “Morgue.”
- The null value “Not Applicable” is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is “44, Morgue,” then Hospital Discharge Time is the time of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

TOTAL ICU LENGTH OF STAY

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Total Days: ICU	**NTDB Element Number** O_01
Local V5 Field Name Total Days: ICU	**NTDB Data Dictionary Page Number** 156-157

Field Values

- Minimum constraint: 1; Maximum constraint: 400
- Relevant value for data element
- Common null values

Additional Information

- Recorded in full day increments, with any partial calendar day counted as a full calendar day
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient had no ICU days according to the above definition.

Data Source Hierarchy Guide

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

References

- For examples, see page 156 of the NTDB 2019 Data Dictionary.

TOTAL VENTILATOR DAYS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Ventilator	**NTDB Element Number** O_02
Local V5 Field Name Ventilator	**NTDB Data Dictionary Page Number** 158-159

Field Values

- Minimum constraint: 1; Maximum constraint: 400
- Relevant value for data element
- Common null values

Additional Information

- Excludes mechanical ventilation time associated with OR procedures
- Non-invasive means of support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping any ventilator episode are recorded in the patient's chart.
- The null value "Not Known/Not Reported" is reported if any days are missing.
- At no time should the Total Vent Days exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.

Data Source Hierarchy Guide

1. Respiratory Therapy Notes/Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

References

- For examples, see page 158 of the NTDB 2019 Data Dictionary

TOTAL HOSPITAL DAYS

Definition

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

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Hospital	**NTDB Element Number** N/A
Local V5 Field Name Hospital	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 1; Maximum constraint: 99999
- Relevant value for data element
- Common null values

Additional Information

- Recorded in full day increments, with any partial calendar day counted as a full calendar day
- If any dates are missing, then a LOS cannot be calculated.

Data Source Hierarchy Guide

1. ICU Nursing Flow Sheet
2. Calculate Based on Admission Form and Discharge Sheet
3. Nurses Progress Notes

HOSPITAL DISCHARGE DISPOSITION

Definition

The disposition of the patient when discharged from the hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharged To	**NTDB Element Number** O_05
Local V5 Field Name Discharged To	**NTDB Data Dictionary Page Number** 162-163

Field Values

- 40 – Home or Self Care (Routine Discharge)
- 41 – Home with Services
- 42 – Left AMA
- 43 – Correctional Facility/Court/Law Enforcement
- 44 – Morgue
- 45 – Child Protective Agency
- 70 – Acute Care Facility
- 71 – Intermediate Care Facility
- 72 – Skilled Nursing Facility
- 73 – Rehab (Inpatient)
- 74 – Long-Term Care
- 75 – Hospice
- 76 – Mental Health/Psychiatric Hospital (Inpatient)
- 77 – Nursing Home
- 79 – Another Type of Inpatient Facility Not Defined Elsewhere
- 80 – Burn Center
- Common null values

Additional Information

- Field value = “40. Home” refers to the patient’s current place of residence (e.g., Prison, Child Protective Services, etc.).
- Field values based upon UB-04 disposition coding.
    - **Note: For the convenience of ATR Users, the numbering of field values reported by NTDS has been updated in the data dictionary to match what is in our registry. The registry vendor, Digital Innovations, Inc., ensures all field values are mapped properly when submitting to the National Trauma Data Bank (NTDB) and the Trauma Quality Improvement Program (TQIP).**
- Disposition to any other non-medical facility should be coded as 40.
- Disposition to any other medical facility should be coded as 79.
- The null value “Not Applicable” is reported if ED Discharge Disposition is “44. Morgue.”
- The null value “Not Applicable” is reported if ED Discharge Disposition = 42, 40, 43, or 73.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Field Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

CAREGIVER AT DISCHARGE

Definition

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharge to Alternate Caregiver	**NTDB Element Number** I_19
Local V5 Field Name Discharge to Alternate Caregiver	**NTDB Data Dictionary Page Number** 33

Field Values

- Yes
- No
- Common null values

Additional Information

- Only complete when Report of Physical abuse is Yes.
- Only complete for minors as determined by state/local definition, excluding emancipated minors.
- The null value “Not Applicable” should be reported for patients where Report of Physical abuse is No or where older than the state/local age definition of a minor.
- The null value “Not Applicable” should be reported if the patient expires prior to discharge.

Data Source Hierarchy Guide

1. Case Manager / Social Services’ Notes
2. Physician Discharge Summary
3. Nursing Notes
4. Progress Notes

DISCHARGE DESTINATION HOSPITAL

Definition

The name of the receiving hospital of the patient transferred from the ED to another acute care hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name If Transferred, Facility	**NTDB Element Number** N/A
Local V5 Field Name If Transferred, Facility	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. Trauma Flow Sheet
3. ED Records
4. Billing Sheet/Medical Records Coding Summary Sheet

PATIENT TRANSFER MODE (SENDING FACILITY ONLY)

Definition

Indicator of the mode of transport to the ED

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge Transport Mode	**NTDB Element Number** N/A
Local V5 Field Name Discharge Transport Mode	**NTDB Data Dictionary Page Number** N/A

Field Values

- 1 - Ground Ambulance
- 2 - Helicopter Ambulance
- 3 - Fixed-Wing Ambulance
- 4 - Private/Public Vehicle
- 5 - Police
- 6 - Other
- Common null values

Additional Information

- This field is required by the sending facility only
- Field will become active if Discharged To field is a relevant value (e.g. Acute Care Facility).

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

IF DEATH

LIFE SUPPORT WITHDRAWN

Definition

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 of kin.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Life Support Withdrawn	**NTDB Element Number** N/A
Local V5 Field Name Life Support Withdrawn	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, life support was withdrawn
- No, life support was NOT withdrawn
- Common null values

Additional Information

- DNR 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.
- The field value '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 Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Case Manager/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

AUTOPSY DONE

Definition

Indicator that an autopsy was performed.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was autopsy performed?	**NTDB Element Number** N/A
Local V5 Field Name Was autopsy performed?	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, autopsy done
- No, autopsy not done
- Common null values

Additional Information

- Entry is required when disposition is Death, DOA, or Died.

Data Source Hierarchy Guide

AUTOPSY NUMBER

Definition

Autopsy number.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Autopsy #	**NTDB Element Number** N/A
Local V5 Field Name Autopsy #	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element.

Additional Information

- The field value accepts alpha and numeric characters. Spaces and dashes (-) are not accepted.

Data Source Hierarchy Guide

1. Autopsy Report

AUTOPSY RESULTS REQUESTED

Definition

Indicator that a report of autopsy results was requested.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Autopsy Results Requested	**NTDB Element Number** N/A
Local V5 Field Name Autopsy Results Requested	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, autopsy results requested
- No, autopsy results not requested
- Common null values

Additional Information

Data Source Hierarchy Guide

AUTOPSY RESULTS RECEIVED

Definition

Indicator that a report of the autopsy was received, if an autopsy was requested.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Autopsy Results Received	**NTDB Element Number** N/A
Local V5 Field Name Autopsy Results Received	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, autopsy results received
- No, autopsy results not received
- Common null values

Additional Information

Data Source Hierarchy Guide

ORGAN DONATION

Definition

Indicator that a gift was made, of a differentiated structure (as a heart or kidney) consisting of cells and tissues and performing some specific function in an organism.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was organ donation requested?	**NTDB Element Number** N/A
Local V5 Field Name Was organ donation requested?	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- Entry is required if Hospital Discharge Status is “2 - Dead.”

Data Source Hierarchy Guide

1. Nurses Notes
2. Physician’s Progress Notes

ORGANS DONATED

Definition

Record of organs donated.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was request granted?	**NTDB Element Number** N/A
Local V5 Field Name Was request granted?	**NTDB Data Dictionary Page Number** N/A

Field Values

- 0 - None
- 1 - Adrenal Glands
- 2 – Bone
- 3 – Bone Marrow
- 4 – Cartilage
- 5 – Corneas
- 6 – Dura Mater
- 7 – Fascialata
- 8 – Heart
- 9 – Heart Valves
- 10 – Intestine
- 11 – Kidney
- 12 – Liver
- 13 – Lungs
- 14 – Nerves
- 15 – Pancreas
- 16 – Skin
- 17 – Stomach
- 18 – Tendons
- 19 – Whole Eyes
- 20 – Other
- Common null values

Additional Information

- Entry is required if Hospital Discharge Status is “2 - Dead.”

Data Source Hierarchy Guide

1. Nurses Notes
2. Physician’s Progress Notes

BILLING

PRIMARY METHOD OF PAYMENT

Definition

The primary source of payment for hospital care.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Primary Payer	**NTDB Element Number** F_01
Local V5 Field Name Primary Payer	**NTDB Data Dictionary Page Number** 165

Field Values

- 1 - Medicaid
- 2 - Not billed (for any reason)
- 3 - Self-Pay
- 4 - Private/Commercial Insurance
- 5 - No Fault Automobile
- 6 - Medicare
- 7 - Other government
- 8 - Workers Compensation
- 9 - Blue Cross/Blue Shield
- 10 - Other
- Common null values

Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "4. Private/Commercial Insurance". *Please note for the purposes of answering the PRQ Payer Mix question*.
- Primary methods of payment which were retired greater than 2 years before the current NTDS version are no longer listed under Field Values. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments.

Data Source Hierarchy Guide

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

QA TRACKING

QA ITEMS

These data points can be found on the QA Tracking tab as a menu within the NTDB Complications button. This information is listed as “Hospital Event” in the 2019 NTDS Data Dictionary.

ACUTE KIDNEY INJURY (AKI)

Definition

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 ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

OR

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

OR

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

OR

Anuria for > 12 hours

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_01
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 122

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
- EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.**Data.**

Source Hierarchy

1. History and Physical
2. Physician's Notes

3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Definition

Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.

Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, 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:

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_02
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 124

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.

Data Source Hierarchy Guide

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

ALCOHOL WITHDRAWAL SYNDROME

Definition

Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption and, when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_03
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 125

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

Data Source Hierarchy Guide

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

CARDIAC ARREST WITH CPR

Definition

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_04
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 126

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Cardiac Arrest must be documented in the patient's medical record.
- EXCLUDE patients who are receiving CPR on arrival to your hospital.
- INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

Data Source Hierarchy Guide

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

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Definition

A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of 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^{0}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 bacteria >10^5 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 (>38.0ºC)
   - hypothermia (<36.0ºC)
   - 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 ≥10^5 CFU/ml.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_05
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 127

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CAUTI.

Data Source Hierarchy Guide

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

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Definition

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

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's 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 (>38ºC), 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 ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38º C), hypothermia (<36ºC), 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 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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_06
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 129

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of CLABSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.

Data Source Hierarchy Guide

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

DEEP SURGICAL SITE INFECTION

Definition

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

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_07
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 131

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

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

DEEP VEIN THROMBOSIS (DVT)

Definition

The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_08
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 133

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

Data Source Hierarchy Guide

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

EXTREMITY COMPARTMENT SYNDROME

Definition

A condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_09
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 134

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability. A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.
- A diagnosis of extremity compartment syndrome must be documented in the patient's medical record.

Data Source Hierarchy Guide

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

MYOCARDIAL INFARCTION (MI)

Definition

An acute myocardial infarction must be noted with documentation of any of the following:
Documentation of ECG changes indicative of acute MI (one or more of the following three):

1. ST elevation >1 mm in two or more contiguous leads
2. New left bundle branch block
3. New q-wave in two or more contiguous leads

OR
New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia
OR
Physician diagnosis of myocardial infarction.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_10
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 135

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of MI must be documented in the patient's medical record.

Data Source Hierarchy Guide

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

ORGAN/SPACE SURGICAL SITE INFECTION

Definition

Must meet the following criteria:
Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to 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
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

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
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_11
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 136

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

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

OSTEOMYELITIS

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_12
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 138

Field Values

- Yes
- No

Additional Information

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

Data Source Hierarchy Guide

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

PULMONARY EMBOLISM (PE)

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_13
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 140

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.
- Exclude sub segmental PE's.

Data Source Hierarchy Guide

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

PRESSURE ULCER

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_14
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 141

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Pressure Ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

Data Source Hierarchy Guide

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

SEVERE SEPSIS

Definition

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

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_15
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 142

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of Sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

Data Source Hierarchy Guide

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

STROKE/CVA

Definition

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

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

AND:

- Duration of neurological deficit ≥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).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_16
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 143

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission. With the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

Data Source Hierarchy Guide

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

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition

Must meet the following criteria:
Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin 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 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).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_17
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 145

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet

UNPLANNED ADMISSION TO ICU

Definition

Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_18
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 147

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure.

Data Source Hierarchy Guide

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

UNPLANNED INTUBATION

Definition

Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_19
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 148

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

Data Source Hierarchy Guide

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

UNPLANNED RETURN TO THE OPERATING ROOM

Definition

Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_20
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 149

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- The null value "Not Applicable" is reported for patients who were never in the OR during their initial stay at your hospital.

Data Source Hierarchy Guide

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

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Definition

A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,
AND
The ventilator was in place on the date of event or the day before.

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old 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.	At least **one** of the following: • Fever (>38°C or >100.4°F) • Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least one of the following: • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP Algorithm (PNU2 Viral, Legionnella, 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: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old 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.	At least **one** of the following: • Fever (>38°C or >100.4°F) • Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Virus, *Bordetella*, *Legionella*, *Chlamydia or Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*) • Fourfold rise in *Legionella pneumophila* serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. • Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm (PNU3 Immunocompromised Patients):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old 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.	Patient who is immunocompromised has at least ***one*** of the following: • Fever (>38°C or >100.4°F) • For adults ≥70 years old, altered mental status with no other recognized cause • New onset of purulent sputum3, or change in character ofsputum4, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea5 • Rales6 or bronchial breath sounds • Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240]7, increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	At least **one** of the following: • Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13 • Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: – Direct microscopic exam – Positive culture of fungi – Non-culture diagnostic laboratory test Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old 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.	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old 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.	At least **three** of the following: • Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F) • Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** HE_21
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 150

Field Values

- Yes
- No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined VAP.

Data Source Hierarchy Guide

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

MEASURES FOR PROCESSES OF CARE INFORMATION

The fields in this section should be collected and transmitted by TQIP participating centers only.

HIGHEST GCS TOTAL

Collection Criterion: Collect 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).

Definition

Highest total GCS on calendar day after ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Highest GCS Total	**NTDB Element Number** PM_01
Local V5 Field Name Highest GCS Total	**NTDB Data Dictionary Page Number** 167

Field Values

- Relevant value for data element
- Minimum constraint: 3; Maximum constraint: 15
- Common null values

Additional Information

- Refers to highest total GCS within 24 hours 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,” interpret 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 collection criteria.
- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- The null value “Not Applicable” is reported if the patients ED Discharge Disposition Date or Hospital Discharge Date are prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

HIGHEST GCS MOTOR

Collection Criterion: Collect 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).

Definition

Highest GCS motor on calendar day after ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS Motor	**NTDB Element Number** PM_02
Local V5 Field Name GCS Motor	**NTDB Data Dictionary Page Number** 168-169

Field Values

- Pediatric (≤ 2 years)
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Appropriate response to stimulation
- Adult
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Obeys commands
  - Common null values

Additional Information

- Refers to highest GCS motor score within 24 hours 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 collection criteria.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after Ed/Hospital arrival.
- 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 listed. For example, 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 Known/Not Recorded” is reported if reporting Highest GCS – Motor 40.
- The null value “Not Applicable” is reported if the patient’s ED Discharge Disposition Date or Hospital Discharge Date are prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

Collection Criterion: Collect 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).

Definition

Documentation of factors potentially affecting the highest GCS within 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS Qualifier	**NTDB Element Number** PM_03
Local V5 Field Name GCS Qualifier	**NTDB Data Dictionary Page Number** 170-171

Field Values

- Patient chemically sedated or paralyzed
- Obstruction to the patient's eyes
- Patient intubated
- Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye.
- Common null values

Additional Information

- Refers to highest GCS assessment qualifier score 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 collection criterion.
- Requires review of all data sources to obtain the highest GCS assessment qualifier score, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS, but 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
- 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. The chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of an 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.
- Report all that apply.

- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- The null value “Not Applicable” is reported if the patient’s ED Discharge Disposition Date or Hospital Discharge Date are prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes
5. Medication Summary

HIGHEST GCS 40 - MOTOR

Collection Criterion: Collect 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).

Definition

Highest GCS 40 motor on calendar day after ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name TBD	**NTDB Element Number** PM_04
Local V5 Field Name TBD	**NTDB Data Dictionary Page Number** 172-173

Field Values

- Pediatric (<5 years)
  - 1 - None
  - 2 - Extension to Pain
  - 3 - Flexion to Pain
  - 4 - Localizes Pain
  - 5 - Obeys Commands
  - 7 - Not Testable
- Adult
  - 1 - None
  - 2 - Extension
  - 3 - Abnormal Flexion
  - 4 - Normal Flexion
  - 5 - Localizing
  - 6 - Obeys Commands
  - 7 - Not Testable

Additional Information

- Refers to highest GCS 40 motor score 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 collection criteria.
- Requires review of all data sources to obtain the highest GCS motor 40 score on 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 listed. (E.g., the chart indicates: “patient opened mouth and stuck out tongue when asked” for adult patients, 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 Highest GCS – Motor is reported.
- The null value “Not Applicable” is reported if the patient’s ED Discharge Disposition Date or Hospital Discharge Date are prior to the next calendar day.
- Must be the motor component of Highest GCS 40 Total.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

Collection Criterion: Collect 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).

Definition

Physiological response of the pupil size within 30 minutes or less of ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Pupillary response	**NTDB Element Number** PM_05
Local V5 Field Name Pupillary response	**NTDB Data Dictionary Page Number** 174

Field Values

- 1 – Both reactive
- 2 – One reactive
- 3 – Neither reactive

Additional Information

- Please note that first recorded hospital vitals do no need to be from the same assessment.
- If a patient does not have a listed field value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" submit field value 1. Both reactive IF there is no other contradicting documentation.
- The null value “Not Known/Not Recorded” should be submitted if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- Field value “2 - One reactive” should be reported for patients who have a prosthetic eye.
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.

Data Source Hierarchy Guide

1. ED Nurses' Notes/Trauma Flow Sheet
2. Physician's Progress Notes
3. History & Physical

MIDLINE SHIFT

Collection Criterion: Collect 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).

Definition

>5mm shift of the brain past its center line within 24 hours after time of injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Midline shift	**NTDB Element Number** PM_06
Local V5 Field Name Midline shift	**NTDB Data Dictionary Page Number** 175

Field Values

- Yes
- No
- Not Imaged (e.g. CT Scan, MRI)

Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, submit field value 1. Yes.
- Radiological and surgical documentation from transferring facilities should be considered for this data field.
- The null value "Not Applicable" is reported for patients that do not meet the collection 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 field 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 field value "3. Not Imaged (e.g. CT Scan, MRI)."

Data Source Hierarchy Guide

1. Radiology Report
2. OP Report
3. Physician's Progress Notes
4. Nurse's Notes
5. Hospital Discharge Summary

CEREBRAL MONITOR

Collection Criterion: Collect 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).

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Cerebral Monitor	**NTDB Element Number** PM_07
Local V5 Field Name Cerebral Monitor	**NTDB Data Dictionary Page Number** 176

Field Values

- Intraventricular drain/catheter (e.g., ventriculostomy, external ventricular drain)
- Intraparenchymal pressure monitor (e.g., Camion bolt, subarachnoid bolt, intraparenchymal catheter)
- Intraparenchymal oxygen monitor (e.g., Licox)
- Jugular venous bulb
- Common null values

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 collection criterion.
- Report all that apply.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

CEREBRAL MONITOR DATE

Collection Criterion: Collect 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).

Definition

Date of first cerebral monitor placement.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Date	**NTDB Element Number** PM_08
Local V5 Field Name Date	**NTDB Data Dictionary Page Number** 177

Field Values

- Relevant value for data element
- Minimum constraint: 2010; Maximum constraint: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- The null value “Not Applicable” is reported if the date field Cerebral Monitor is “None.”
- The null value “Not Applicable” is reported for patients that do not meet the collection 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 Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

CEREBRAL MONITOR TIME

Collection Criterion: Collect 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).

Definition

Time of first cerebral monitor placement.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Time	**NTDB Element Number** PM_09
Local V5 Field Name Time	**NTDB Data Dictionary Page Number** 178

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- The null value “Not Applicable” is reported if the data field Cerebral Monitor is “None.”
- The null value “Not Applicable” is reported for patients that do not meet the collection 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 Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Collection Criterion: Collect on all patients.

Definition

Type of first dose of VTE prophylaxis administered to patient at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name VTE Type	**NTDB Element Number** PM_10
Local V5 Field Name VTE Type	**NTDB Data Dictionary Page Number** 179

Field Values

- ~~RETIRED 2019 Heparin~~
- None
- LMWH (Dalteparin, Enoxaparin, etc.)
- Direct Thrombin Inhibitor (Dabigatran, etc.)
- Xa Inhibitor (Rivaroxaban, etc.)
- ~~RETIRED 2019 Coumadin~~
- Other
- Unfractionated Heparin (UH)
- Common null values

Additional Information

- Field Value “None” is reported if the first dose of Venous Thromboembolism Prophylaxis is administered post discharge order date/time.
- Venous Thromboembolism Prophylaxis Types which were retired greater than 2 years before the current NTDS version are no longer listed under Field Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Venous Thromboembolism Prophylaxis Types.
- Exclude sequential compression devices.
- Field Value “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

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

Collection Criterion: Collect on all patients.

Definition

Date of administration to patient of first prophylactic dose of Heparin or other anticoagulants at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name VTE Date	**NTDB Element Number** PM_11
Local V5 Field Name VTE Date	**NTDB Data Dictionary Page Number** 180

Field Values

- Minimum constraint: 2010: Maximum constraint: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type field.
- The null value “Not Applicable” is reported if Venous Thromboembolism Prophylaxis Type = “None”.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Collection Criterion: Collect on all patients.

Definition

Time of administration to patient of first prophylactic dose of Heparin or other anticoagulants at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name VTE Time	**NTDB Element Number** PM_12
Local V5 Field Name VTE Time	**NTDB Data Dictionary Page Number** 181

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- Refers to time at which patient first received the prophylactic agent indicated in VTE Prophylaxis Type field
- The null value “Not Applicable” is reported if Venous Thromboembolism Prophylaxis Type = “None”.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet

TRANSFUSION BLOOD (4 HOURS)

Collection Criterion: Collect on all patients.

Definition

Volume of packed red blood cell transfusion (units) **within first 4 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Blood (4 hrs)	**NTDB Element Number** PM_13
Local V5 Field Name Transfusion Blood (4 hrs)	**NTDB Data Dictionary Page Number** 182

Field Values

- Minimum constraint: 0; Maximum constraint: 80
- Common null values

Additional Information

- Refers to amount of transfused packed red blood cells in units within first 4 hours after arrival to index hospital, where index hospital is the hospital abstracting the data.
- If no blood given, then volume should be 0 (zero).
- If packed red blood cells are transfusing upon patient arrival, report as 1-unit. Or, if reporting CCs, report the amount of CCs transfused at your center.
- Must also report the fields Transfusion Blood Measurement and Transfusion Blood Conversion.
- 1 unit of blood = 350ml

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

TRANSFUSION BLOOD MEASUREMENT

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after Ed/hospital arrival.

Definition

The measurement used to document the patient's blood transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Blood Measurement	**NTDB Element Number** PM_14
Local V5 Field Name Transfusion Blood Measurement	**NTDB Data Dictionary Page Number** 183

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Report if Transfusion Blood (4hours) is valued.
- Must also complete field Transfusion Blood Conversion.
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.
- The null value "Not Applicable" is reported if no packed red blood cells were transfused.

Data Source Hierarchy Guide

1. Blood Bank

TRANSFUSION BLOOD CONVERSION

Collection Criterion: Collect on all patients who transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The quantity of CCs [MLs] constituting a “unit” for blood transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Blood Conversion	**NTDB Element Number** PM_15
Local V5 Field Name Transfusion Blood Conversion	**NTDB Data Dictionary Page Number** 184

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Reported if Transfusion Blood (4hours) is valued.
- Must also complete field Transfusion Blood Measurement.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- The null value “Not Applicable” is reported if reporting transfusion blood measurements in CCs.
- The null value “Not Applicable” is reported if no packed red blood cells were transfused.

Data Source Hierarchy Guide

1. Blood Bank

TRANSFUSION PLASMA (4 HOURS)

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Volume of plasma (units or CCs) transfused within first 4 hours after ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Plasma	**NTDB Element Number** PM_16
Local V5 Field Name Transfusion Plasma	**NTDB Data Dictionary Page Number** 185

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values

Additional Information

- Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (units or CCs) within first 4 hours 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 collection criterion.
- If the patient meets the collection criteria and plasma is transfusing upon patient arrival, report as 1-unit. If reporting CCs, report the amount of CCs transfused at your center.
- Must also report the fields Transfusion Plasma Measurement and Transfusion Plasma Conversion when product is transfused.

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

TRANSFUSION PLASMA MEASUREMENT

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The measurement used to document the patient's plasma transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Plasma Measurement	**NTDB Element Number** PM_17
Local V5 Field Name Transfusion Plasma Measurement	**NTDB Data Dictionary Page Number** 186

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Report if Transfusion Plasma (4hours) is valued.
- Must also complete field Transfusion Plasma Conversion.
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.
- The null value "Not Applicable" is reported if no plasma was transfused.

Data Source Hierarchy Guide

1. Blood Bank

TRANSFUSION PLASMA CONVERSION

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The quantity of CCs [MLs] constituting a “unit” for plasma transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Plasma Conversion	**NTDB Element Number** PM_18
Local V5 Field Name Transfusion Plasma Conversion	**NTDB Data Dictionary Page Number** 187

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Reported if Transfusion Plasma (4hours) is valued.
- Must also complete field Transfusion Plasma Measurement.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- The null value “Not Applicable” is reported if reporting transfusion plasma measurements in CCs.
- The null value “Not Applicable” is reported is no plasma was transfused.

Data Source Hierarchy Guide

1. Blood Bank

TRANSFUSION PLATELETS (4 HOURS)

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Volume of platelets (units or CCs) **within first 4 hours** after ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Platelets (4 hrs)	**NTDB Element Number** PM_19
Local V5 Field Name Transfusion Platelets (4 hrs)	**NTDB Data Dictionary Page Number** 188

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Refers to amount of transfused platelets (units or CCs) within first 4 hours 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 collection criterion.
- If the patient meets the collection criteria and platelets are transfusing upon patient arrival, report as 1-unit. If reporting CCs, report the amount of CCs transfused at your center.
- Must also complete the fields Transfusion Platelets Measurement and Transfusion Platelets Conversion when product is transfused.

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

TRANSFUSION PLATLETS MEASUREMENT

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The measurement used to document the patient's platelets transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Plasma Measurement	**NTDB Element Number** PM_20
Local V5 Field Name Transfusion Plasma Measurement	**NTDB Data Dictionary Page Number** 189

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Reported if Transfusion Platelets (4hours) is valued.
- Must also complete field Transfusion Platelets Conversion.
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.
- The null value "Not Applicable" is reported if no platelets were transfused.

Data Source Hierarchy Guide

1. Blood Bank

TRANSFUSION PLATELETS CONVERSION

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The quantity of CCs [MLs] constituting a “unit” for platelets transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Transfusion Platelets Conversion	**NTDB Element Number** PM_21
Local V5 Field Name Transfusion Platelets Conversion	**NTDB Data Dictionary Page Number** 190

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Reported if Transfusion Platelets (4 Hours) is valued.
- Must also complete field Transfusion Platelets Measurement.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- The null value “Not Applicable” is reported if reporting transfusion platelets measurements in CCs.
- The null value “Not Applicable” is reported if no platelets were transfused.

Data Source Hierarchy Guide

1. Blood Bank

CRYOPRECIPITATE (4 HOURS)

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Volume of solution enriched with clotting factors transfused (units or CCs) within first 4 hours after ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Cryoprecipitate (4 hours)	**NTDB Element Number** PM_22
Local V5 Field Name Cryoprecipitate (4 hours)	**NTDB Data Dictionary Page Number** 191

Field Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused cryoprecipitate in units within first 4 hours 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 collection criterion.
- If the patient meets the collection criteria and cryoprecipitate is transfusing upon patient arrival, count as 1-unit. If reporting CCs, report the amount of CCs transfused at your center.
- Must also complete the fields Cryoprecipitate Measurement and Cryoprecipitate Conversion when product is transfused.

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

CRYOPRECIPITATE MEASUREMENT

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The measurement used to document the patient's cryoprecipitate transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Cryoprecipitate Measurement	**NTDB Element Number** PM_23
Local V5 Field Name Cryoprecipitate Measurement	**NTDB Data Dictionary Page Number** 192

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Reported if Cryoprecipitate (4 Hours) is valued.
- Must also complete field Cryoprecipitate Conversion.
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.
- The null value "Not Applicable" is reported if no cryoprecipitate was transfused.

Data Source Hierarchy Guide

1. Blood Bank

CRYOPRECIPITATE CONVERSION

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

The quantity of CCs [MLs] constituting a “unit” for cryoprecipitate transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Cryoprecipitate Conversion	**NTDB Element Number** PM_24
Local V5 Field Name Cryoprecipitate Conversion	**NTDB Data Dictionary Page Number** 193

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Reported if Cryoprecipitate (4 Hours) is valued.
- Must also complete field Cryoprecipitate Measurement.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- The null value “Not Applicable” is reported if reporting transfusion cryoprecipitate measurements in CCs.
- The null value “Not Applicable” is reported if no cryoprecipitate was transfused.

Data Source Hierarchy Guide

1. Blood Bank

LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Lowest systolic blood pressure measured within the first hour of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Lowest ED SBP	**NTDB Element Number** PM_25
Local V5 Field Name Lowest ED SBP	**NTDB Data Dictionary Page Number** 194

Field Values

- Relevant value for data element
- Minimum constraint: 0; Maximum constraint: 300
- Common null values

Additional Information

- Refers to lowest SBP in the ED of the 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 collection criterion.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Operative Report
3. Nursing Notes/Flow Sheet

ANGIOGRAPHY

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

First interventional angiogram with or without embolization **within first 24 hours** of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Angiography	**NTDB Element Number** PM_26
Local V5 Field Name Angiography	**NTDB Data Dictionary Page Number** 195

Field Values

- None
- Angiogram only
- Angiogram with embolization
- Angiogram with stenting
- Common null values

Additional Information

- Limit collection of angiography data to first 48 hours following ED/hospital arrival.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion
- Excludes computerized tomographic angiography (CTA).
- Only report Field Value “Angiogram with stenting” if stenting was performed specifically for hemorrhage control.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

EMBOLIZATION SITE

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Organ / site of embolization for hemorrhage control.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Embolization Site	**NTDB Element Number** PM_27
Local V5 Field Name Embolization Site	**NTDB Data Dictionary Page Number** 196

Field Values

- Liver
- Spleen
- Kidneys
- Pelvic (iliac, gluteal, obturator)
- Retroperitoneum (lumbar, sacral)
- Peripheral vascular (neck, extremities)
- Aorta (thoracic or abdominal)
- Other
- Common null values

Additional Information

- The null value “Not Applicable” is reported if Angiography is “None” or “Angiogram Only.”
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report all that apply.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

ANGIOGRAPHY DATE

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Date the first angiogram with or without embolization was performed.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Angiography Date	**NTDB Element Number** PM_28
Local V5 Field Name Angiography Date	**NTDB Data Dictionary Page Number** 197

Field Values

- Minimum constraint: 2013; Maximum constraint: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- The null value “Not Applicable” is reported if the data field Angiography is “None.”
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion
- Procedure start date is the date of needle insertion in the groin.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

ANGIOGRAPHY TIME

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Time the first angiogram with or without embolization was performed.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Angiography Time	**NTDB Element Number** PM_29
Local V5 Field Name Angiography Time	**NTDB Data Dictionary Page Number** 198

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- The null value “Not Applicable” is reported if the data field Angiography is “None.”
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion
- Procedure start time is the time of needle insertion in the groin.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TYPE

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

First type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Surgery Hemorrhage Control Type	**NTDB Element Number** PM_30
Local V5 Field Name Surgery Hemorrhage Control Type	**NTDB Data Dictionary Page Number** 199

Field Values

- None
- Laparotomy
- Thoracotomy
- Sternotomy
- Extremity
- Neck
- Mangled extremity/traumatic amputation
- Other skin/soft tissue
- 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 collection criterion.
- Field Value “None” is reported if Surgery for Hemorrhage Control Type is not a listed Field Value option.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL DATE

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Date of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Surgery Hemorrhage Control Date	**NTDB Element Number** PM_31
Local V5 Field Name Surgery Hemorrhage Control Date	**NTDB Data Dictionary Page Number** 200

Field Values

- Minimum constraint: 2010; Maximum constraint: 2030
- Common null values
- Select Not Applicable if no surgery for hemorrhage control

Additional Information

- Collected as MM/DD/YYYY.
- 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 “None.”
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TIME

Collection Criterion: Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.

Definition

Time of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Surgery Hemorrhage Control Time	**NTDB Element Number** PM_32
Local V5 Field Name Surgery Hemorrhage Control Time	**NTDB Data Dictionary Page Number** 201

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected 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 “None.”
- The null value "Not Applicable" is reported for patients that do not meet the collection criterion.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Collection Criterion: Collect on all patients.

Definition

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 of kin.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Withdrawal of Care	**NTDB Element Number** PM_33
Local V5 Field Name Withdrawal of Care	**NTDB Data Dictionary Page Number** 202

Field Values

- Yes
- No
- Common null values

Additional Information

- DNR is not a requirement.
- A note to limit escalation of care qualifies as a withdrawal of care. 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-saving intervention (e.g., intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of care.
- The field value “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 Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Case Manager/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Collection Criterion: Collect on all patients.

Definition

The date treatment was withdrawn.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Withdrawal of Care Date	**NTDB Element Number** PM_34
Local V5 Field Name Withdrawal of Care Date	**NTDB Data Dictionary Page Number** 203

Field Values

- Minimum constraint: 1990; Maximum constraint: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- The null value “Not Applicable” is reported for patients where Withdrawal of Life Supporting Treatment is “No.”
- Record the time the first of any existing life-sustaining 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-saving intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Collection Criterion: Collect on all patients.

Definition

The time treatment was withdrawn.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Withdrawal of Care Time	**NTDB Element Number** PM_35
Local V5 Field Name Withdrawal of Care Time	**NTDB Data Dictionary Page Number** 204

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- The null value “Not Applicable” is reported for patients where Withdrawal of Life Supporting Treatment is “No.”
- Record the time the first of any existing life-sustaining 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-saving intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

ANTIBIOTIC THERAPY

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

Intravenous antibiotic therapy was administered to the patient within 24 hours after first hospital encounter.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Antibiotic Therapy	**NTDB Element Number** PM_36
Local V5 Field Name Antibiotic Therapy	**NTDB Data Dictionary Page Number** 205

Field Values

- Yes
- No
- Common null values

Additional Information

- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report intravenous antibiotic therapy that was administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

ANTIBIOTIC THERAPY DATE

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Antibiotic Therapy: Date	**NTDB Element Number** PM_37
Local V5 Field Name Antibiotic Therapy	**NTDB Data Dictionary Page Number** 206

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collect as MM/DD/YYYY.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report the date of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Field Value “No.”

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet

ANTIBIOTIC THERAPY TIME

Collection Criterion: Collect on all patients with any open fracture(s).

Definition

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Antibiotic Therapy: Time	**NTDB Element Number** PM_38
Local V5 Field Name Antibiotic Therapy	**NTDB Data Dictionary Page Number** 207

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collect as HH:MM, military time.
- The null value “Not Applicable” is reported for patients that do not meet the collection criterion.
- Report the time of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Field Value “No.”

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

APPENDICES

Appendix 1: ATR Change Log

The following changes have been made to the below data fields:

RETIRED DATA FIELDS	
CITY FIPS	V5 FIELD NAME*
PRIMARY E-CODE	NTRACS FIELD NAME*
SECONDARY E-CODE	**pertains to language in the data dictionary*
PLACE OF INJURY/E849	
ED READMISSION	
ED DEATH DETAILS	
NEW DATA FIELDS	
ATCC NOT UTILIZED; PLEASE SPECIFY	WEB V5 FIELD NAME
REASON FOR TRANSFER	LOCAL V5 FIELD NAME*
ANTIBIOTICS THERAPY SPECIFY LOCATION	**pertains to language in the data dictionary*
AUTOPSY NUMBER	
DISCHARGE/DEATH DATE	
DISCHARGE/DEATH TIME	
PATIENT ARRIVAL DATE	
FACILITY	
ED DEPARTURE DATE	
ED DEPARTURE TIME	
NAME CHANGE TO DATA FIELD	
HOSPITAL NUMBER	Changed to FACILITY
TRAUMA REGISTRY NUMBER	Changed to TRAUMA NUMBER
ED ARRIVED FROM	Changed to ARRIVED FROM
EMS ARRIVAL DESTINATION DATE	Changed to EMS Unit Arrived at Destination Date
EMS ARRIVAL DESTINATION TIME	Changed to EMS Unit Arrived at Destination Time

The following changes have been made to the below definitions:

ANTIBIOTICS THERAPY	Updated to align with the NTDS definition
ED DISCHARGE DATE	Changed to record when the order was written
ED DISCHARGE TIME	Changed to record when the order was written
HOSPITAL DISCHARGE DATE	Changed to record when the order was written
HOSPITAL DISCHARGE TIME	Changed to record when the order was written

The following changes have been made to the below field values:

ALTERNATE RESIDENCE*	Retired: Foreign Visitor
CHILD SPECIFIC RESTRAINT (Field Name: Restraint)	Added: • 1 – None • 2 – Seatbelt – Lap and Shoulder • 3 – Seatbelt – Lap Only • 4 – Seatbelt – Shoulder Only • 5 – Seatbelt – NFS • 9 – Truck Bed Restraint
ANTICOAGULANTS AT HOME	Updated to reflect field values available for NTDS data element anticoagulant therapy.
DISCHARGE SERVICE*	Added: Hospitalist **Updates to the registry platform to reflect this change are in progress and may not be available at the time of publication*.

Appendix 2: NTDS Change Log

The following changes have been made to the below data fields:

RETIRED DATA FIELDS	
CO-MORBID CONDITIONS (see page 155 for more details)	TRANSFUSION PLASMA (24 HOURS)
HOSPITAL COMPLICATIONS (see page 208 for more details)	TRANSFUSION PLATELETS (24 HOURS)
TRANSFUSION BLOOD (24 HOURS)	CRYOPRECIPITATE (24 HOURS)
NEW DATA FIELDS	
INITIAL FIELD GCS 40 - EYE	PREMATURITY
INITIAL FIELD GCS 40-VERBAL	STEROID USE
INITIAL FIELD GCS 40 - MOTOR	SUBSTANCE ABUSE DISORDER
INITIAL ED/HOSPITAL GCS 40 - EYE	ACUTE KIDNEY INJURY
INITIAL ED/HOSPITAL GCS 40 - VERBAL	ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)
INITIAL ED/HOSPITAL GCS 40 - MOTOR	ALCOHOL WITHDRAWAL SYNDROME
ADVANCED DIRECTIVE LIMITING CARE	CARDIAC ARREST WITH CPR
ALCOHOL USE DISORDER	CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)
ANGINA PECTORIS	CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)
ANTICOAGULANT THERAPY	DEEP SURGICAL SITE INFECTION
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)	DEEP VEIN THROMBOSIS (DVT)
BLEEDING DISORDER	EXTREMITY COMPARTMENT SYNDROME
CEREBRAL VASCULAR ACCIDENT (CVA)	MYOCARDIAL INFARCTION (MI)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	ORGAN/SPACE SURGICAL SITE INFECTION
CHRONIC RENAL FAILURE	OSTEOMYELITIS
CIRRHOSIS	PULMONARY EMBOLISM
CONGENITAL ANOMALIES	PRESSURE ULCER
CONGESTIVE HEART FAILURE (CHF)	SEVERE SEPSIS
CURRENT SMOKER	STROKE/CVA
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER	SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION
DEMENTIA	UNPLANNED ADMISSION TO ICU
DIABETES MELLITUS	UNPLANNED INTUBATION
DISSEMINATED CANCER	UNPLANNED RETURN TO THE OPERATING ROOM
FUNCTIONALLY DEPENDENT HEALTH STATUS	VENTILATOR-ASSOCIATED PNEUMONIA (VAP)
HYPERTENSION	HIGHEST GCS 40 - MOTOR

MENTAL/PERSONALITY DISORDERS	ANTIBIOTIC THERAPY
PERIPHERAL ARTERIAL DISEASE (PAD)	ANTIBIOTIC THERAPY DATE
	ANTIBIOTIC THERAPY TIME

The following changes have been made to the below definitions:

INITIAL ED/HOSPITAL HEIGHT	Changed: First recorded height within 24 hours or less of ED/hospital arrival
INITIAL ED/HOSPITAL WEIGHT	Changed: First recorded weight within 24 hours or less of ED/hospital arrival.
PREMATURITY	Updated
SUBSTANCE ABUSE DISORDER	Updated
PULMONARY EMBOLISM	Updated to exclude sub segmental PE's .
UNPLANNED INTUBATION	Updated to remove cardiac failure
HIGHEST GCS TOTAL	Changed: Highest total GCS on calendar day after ED/Hospital arrival.
HIGHEST GCS MOTOR	Changed: Highest GCS motor on calendar day after ED/Hospital arrival.
TRANSFUSION PLASMA (4 HOURS)	Changed: Volume of plasma (units or CCs) transfused within first 4 hours after ED/Hospital arrival.
LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Removed: sustained (> 5 min) from the definition

The following changes have been made to the below field values:

AGE UNITS	Added: 6. Weeks
ICD-10 HOSPITAL PROCEDURES	Changed: Major and minor procedure ICD-10 PCS procedure codes
AIS VERSION	Added: 7. AIS 2015
VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE	Retire: 1. Heparin
VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE	Retire: 9. Coumadin
VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE	Added: 11. Unfractionated Heparin (UH)
ANGIOGRAPHY	Added: 4. Angiogram with stenting
SURGERY FOR HEMORRHAGE CONTROL TYPE	Added: 9. Extraperitoneal Pelvic Packing
MULTIPLE ENTRIES	For GCS 40 data elements, Field Value “0” was assigned to all Not Testable options
AIS VERSION	Changed AIS 2015 to Field Value #16

Acknowledgements

ACS Committee on Trauma

All participating board members

NTDS Work Group

Michael Chang, Christopher Hoeft, Tammy Morgan,

Avery Nathens, Melanie Neal, Amy Svestka, & Ben Zarzaur

Arkansas Trauma Registry Staff

Jana Jacobs, Britni Lee, & Amie Lein

Arkansas Trauma Registry Users Group

Nita Baker, Canara Banister, Betty Bohanna,

Scarlett Byers, Jennifer Carger, Andrea Crouch,

Regina Dworshak, Diannia Hall-Clutts, Lori Hickman,

Kirsten Johnston, Monica Kimbrell, Christi Kraft,

Lynda Lehing, Paula Lewis, Rose Ludeke, Faith Lyke

Lew McColgan, Debra Moore, Elaine Mott, Becky Parker

Austin Porter, Deborah Sills, Aundria Webber,

Jonathan Weigt, Casey Whitley, & Kendall Wilson

Special thanks to everyone who participated as a creator, editor, reviewer, producer, and pilot project participant of the NTDS since its inception