ILLINOIS TRAUMA

2020

DATA DICTIONARY

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

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

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

(Addt'l note of awareness added where possible without adding pages)

Additional clarification from NTDS:

COMMON NULL VALUES

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

Field Values
1 Not Applicable

2 Not Known/Not Recorded

Additional Information

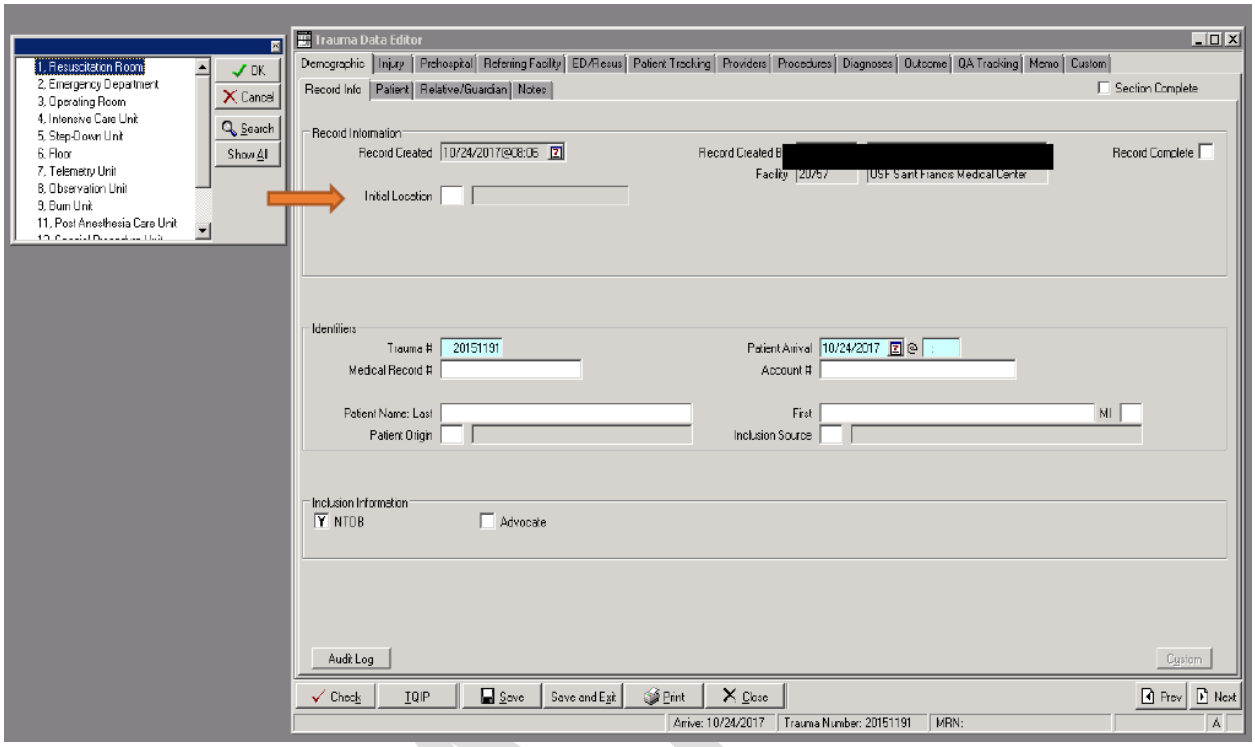
- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the National Trauma Data Standard are to be electronically stored in a database or moved from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

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

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

References to Other Databases

- Compare with NHTSA V.2.10 - E00



Initial Location

Definition:

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

Element Values: DI Dropdown Menu:

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

?. Unknown

Data Source Hierarchy Guide:

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

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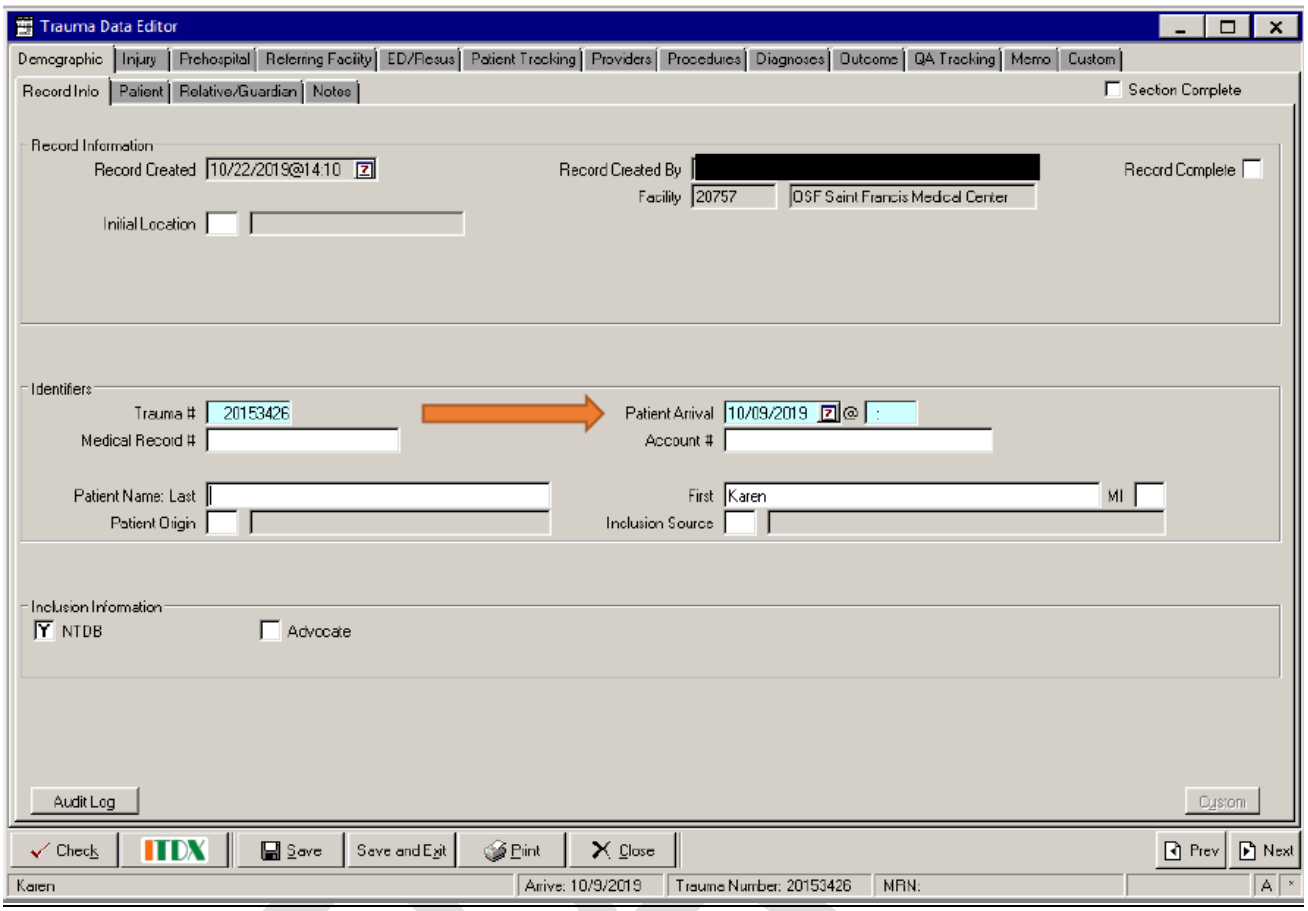

Patient Arrival Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Definition:

The date that the patient arrived to your facility.

Element Values

1. Relevant value for data element

Data source Hierarchy Guide:

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

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Additional Information

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

Associated Edit Checks

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

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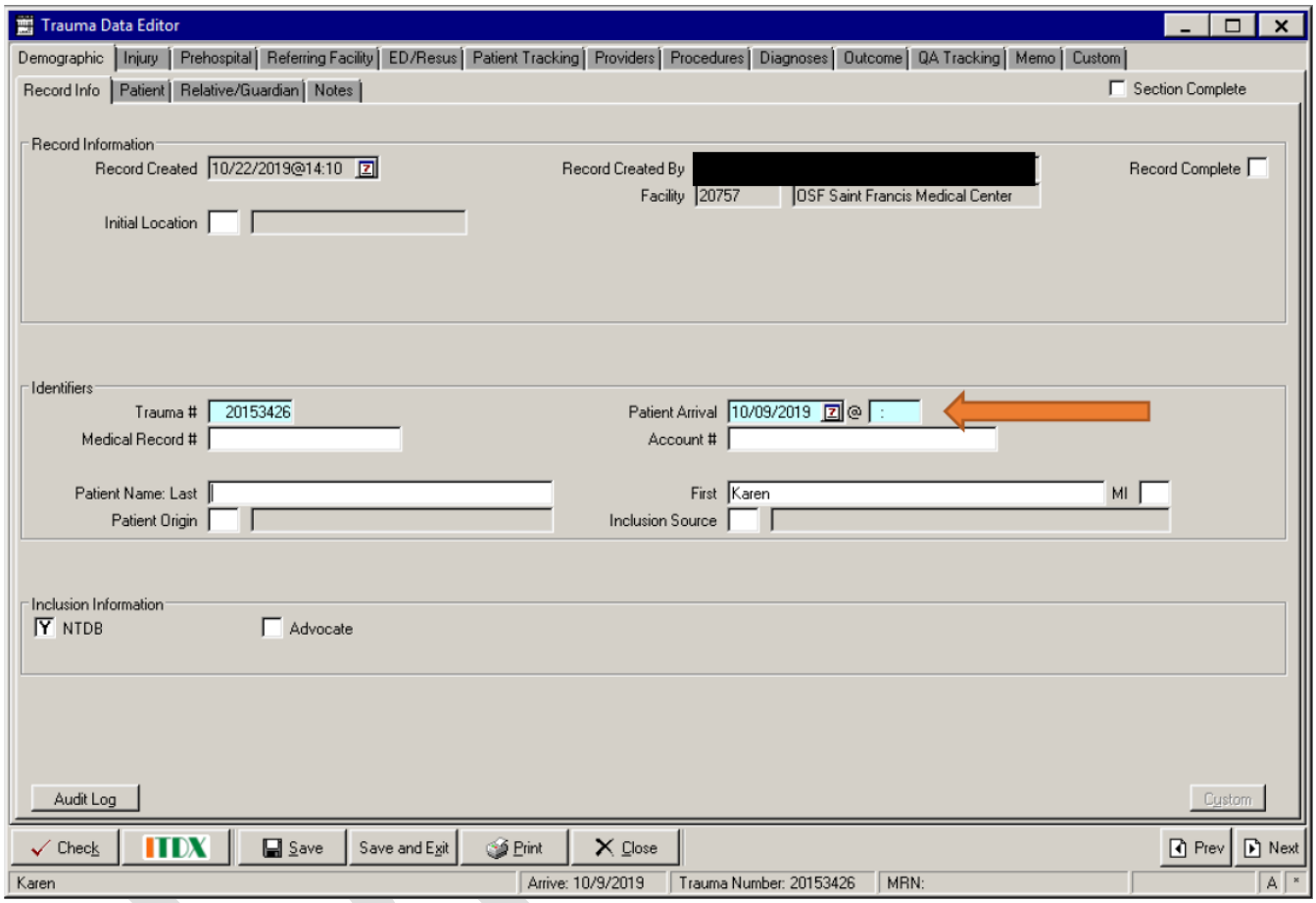

Patient Arrival Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Definition:

The time that the patient arrived to your facility

Element Values

2. Relevant value for data element

Data Source Hierarchy Guide:

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

Additional Information

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

Associated Edit Checks

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

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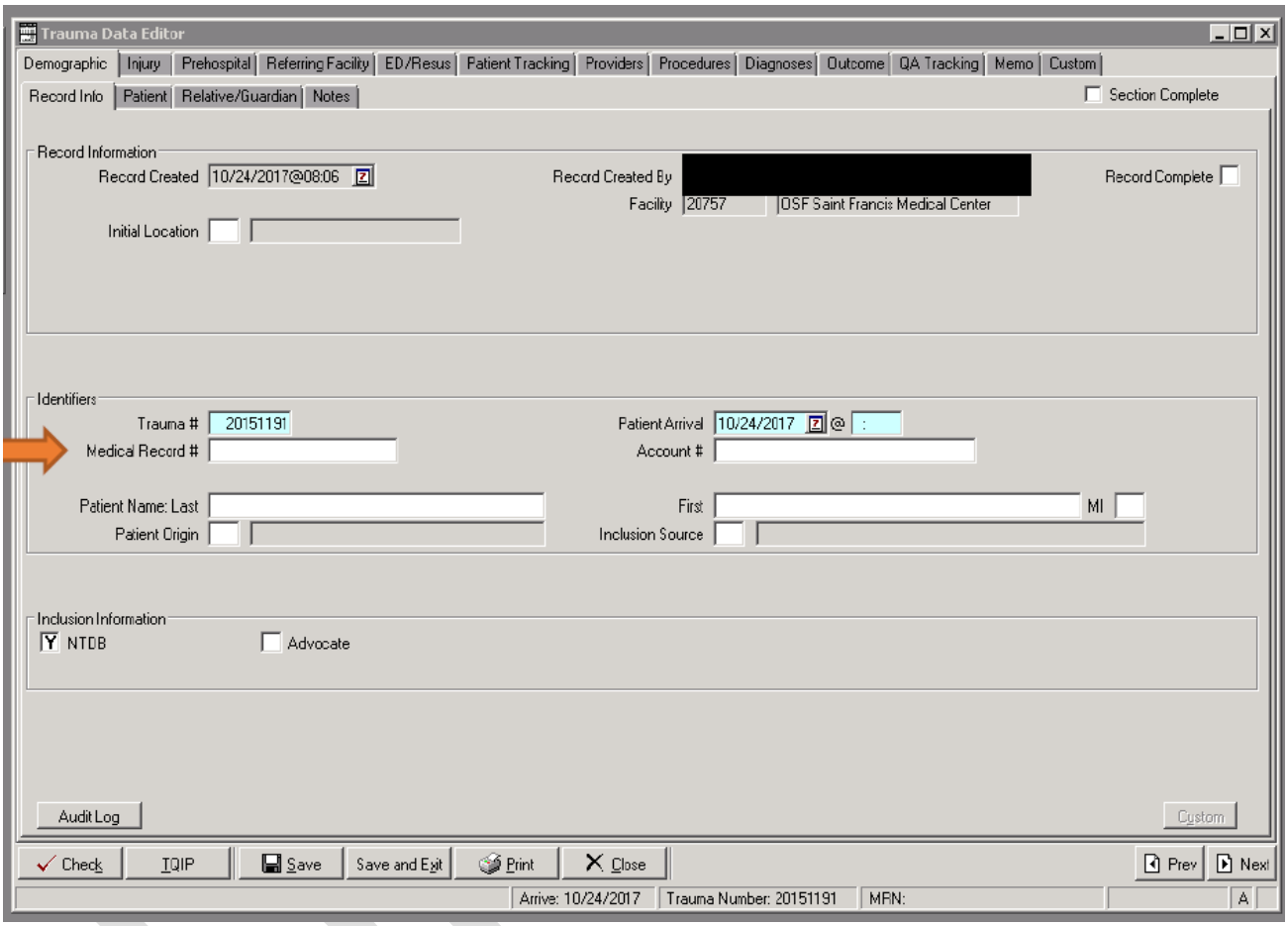


Medical Record Number

Definition:

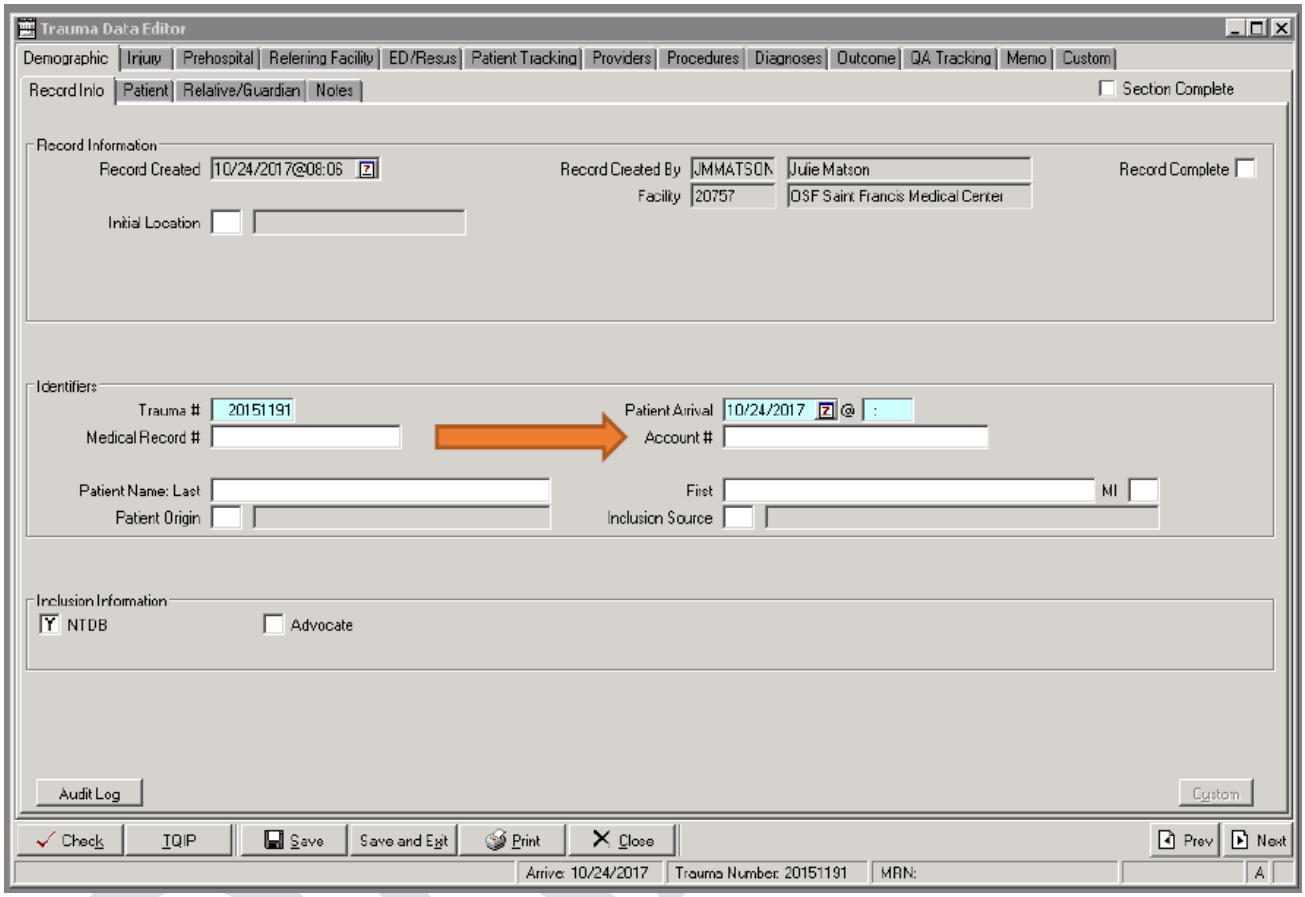
Number assigned to patient (MRN): Every patient's number is unique to them and is the same for every visit.

Element Values:

3. Relevant value for data element

Data Source Hierarchy Guide:

1. Face Sheet
2. EMR Banner



Account Number

Definition

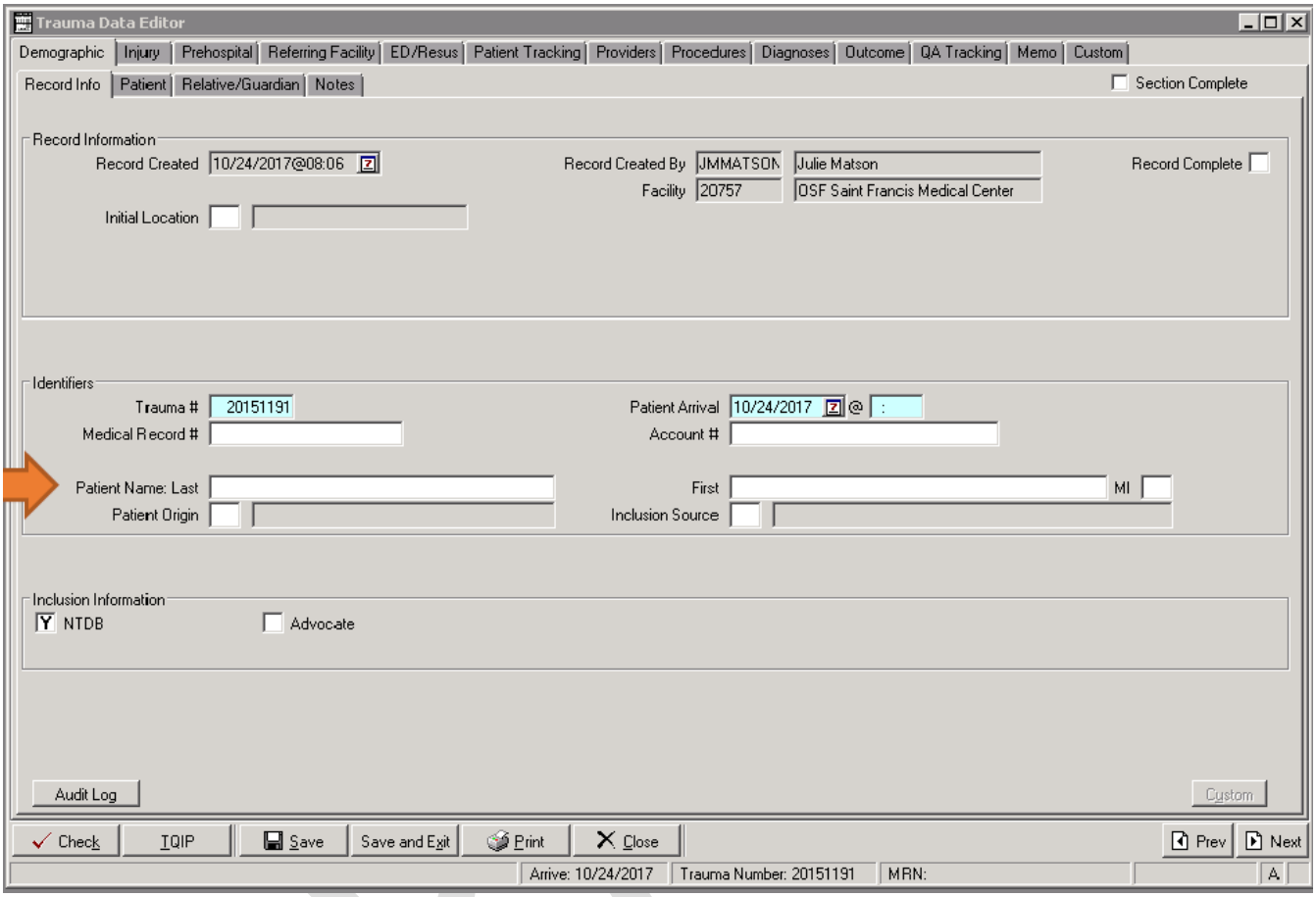
Patient number assigned for that specific encounter: primarily used for billing and coding.

Element Values:

4. Relevant Value for Data Element

Data Source Hierarchy Guide:

1. Face Sheet



Patient Name

Definition:

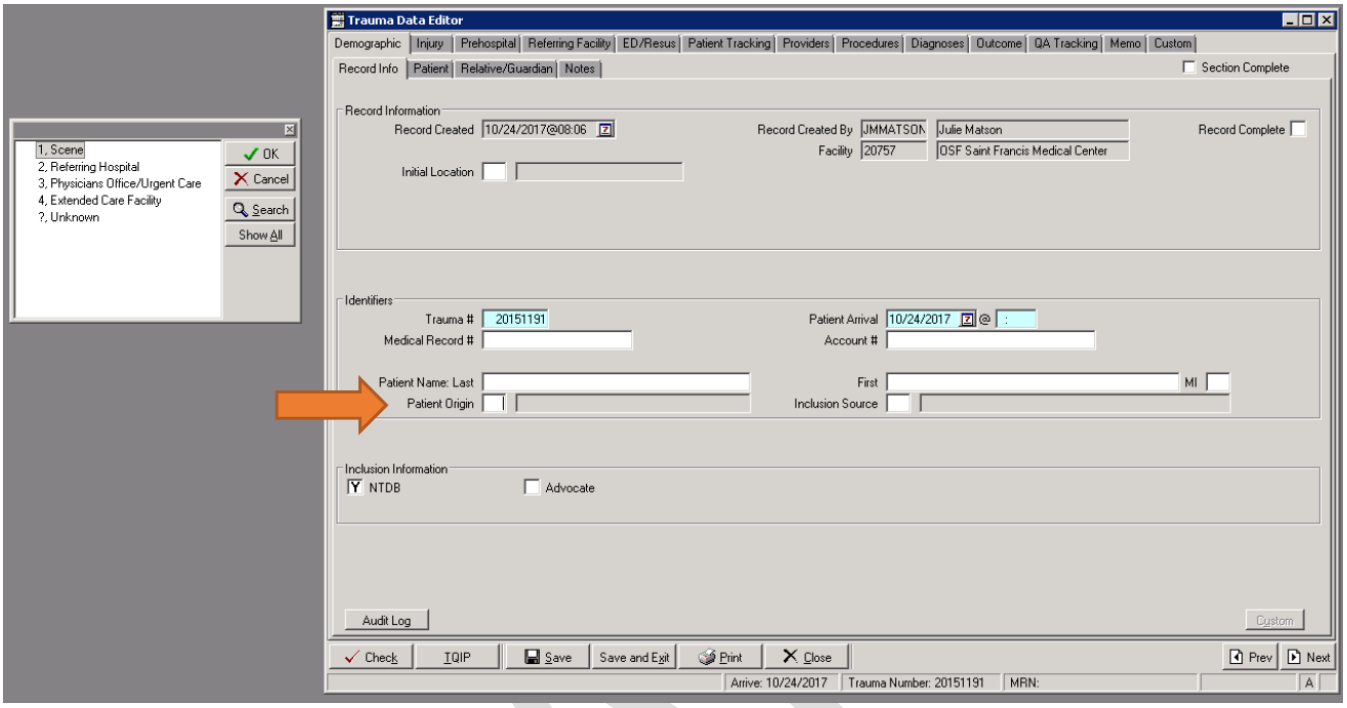
Patient's legal name.

Element Values:

5. Relevant value for data element

Data Source Hierarchy Guide:

2. Face Sheet
3. Snapshot – Demographics
4. EMR Patient Banner



Patient Origin

Definition:

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

Element Values- DI dropdown screen

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

Data Source Hierarchy Guide:

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

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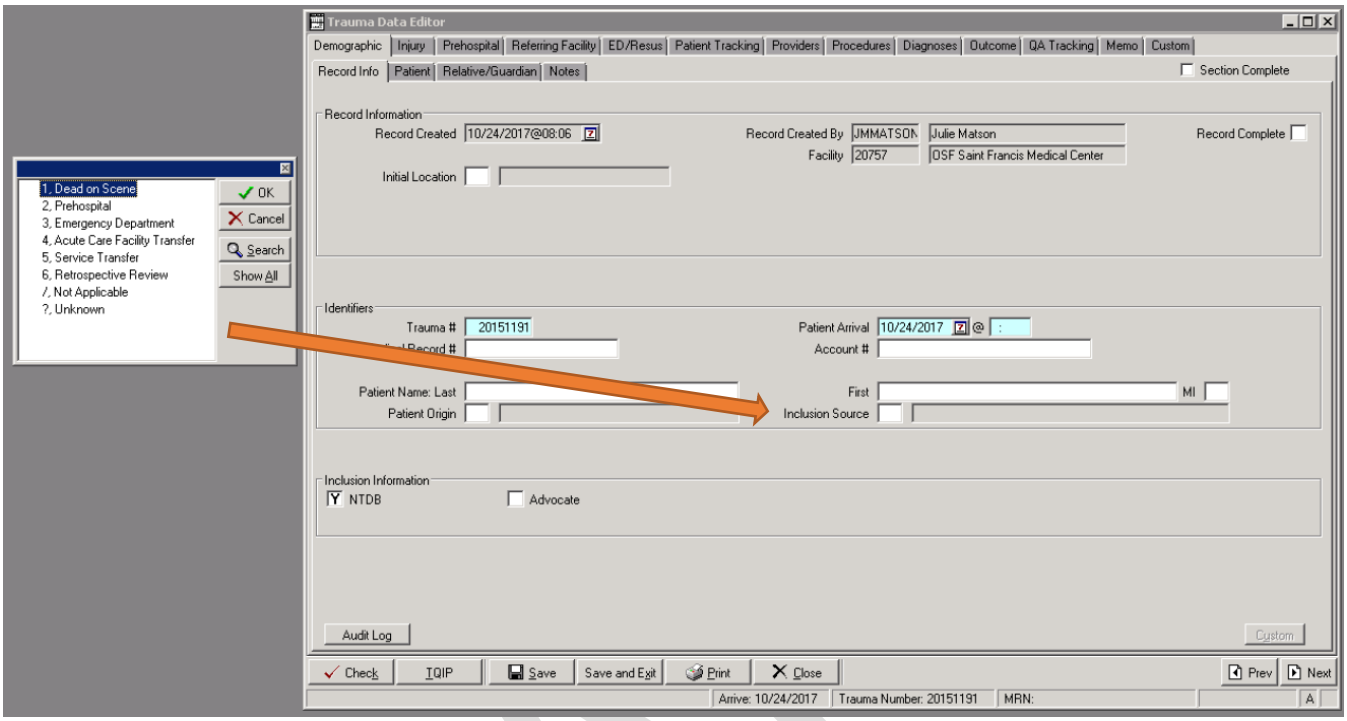

Inclusion Source

Definition:

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

Element Values: DI dropdown screen

1. Dead on scene
2. Prehospital
3. Emergency Department
4. Acute Care Facility Transfer
5. Service Transfer
6. Retrospective Review

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

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

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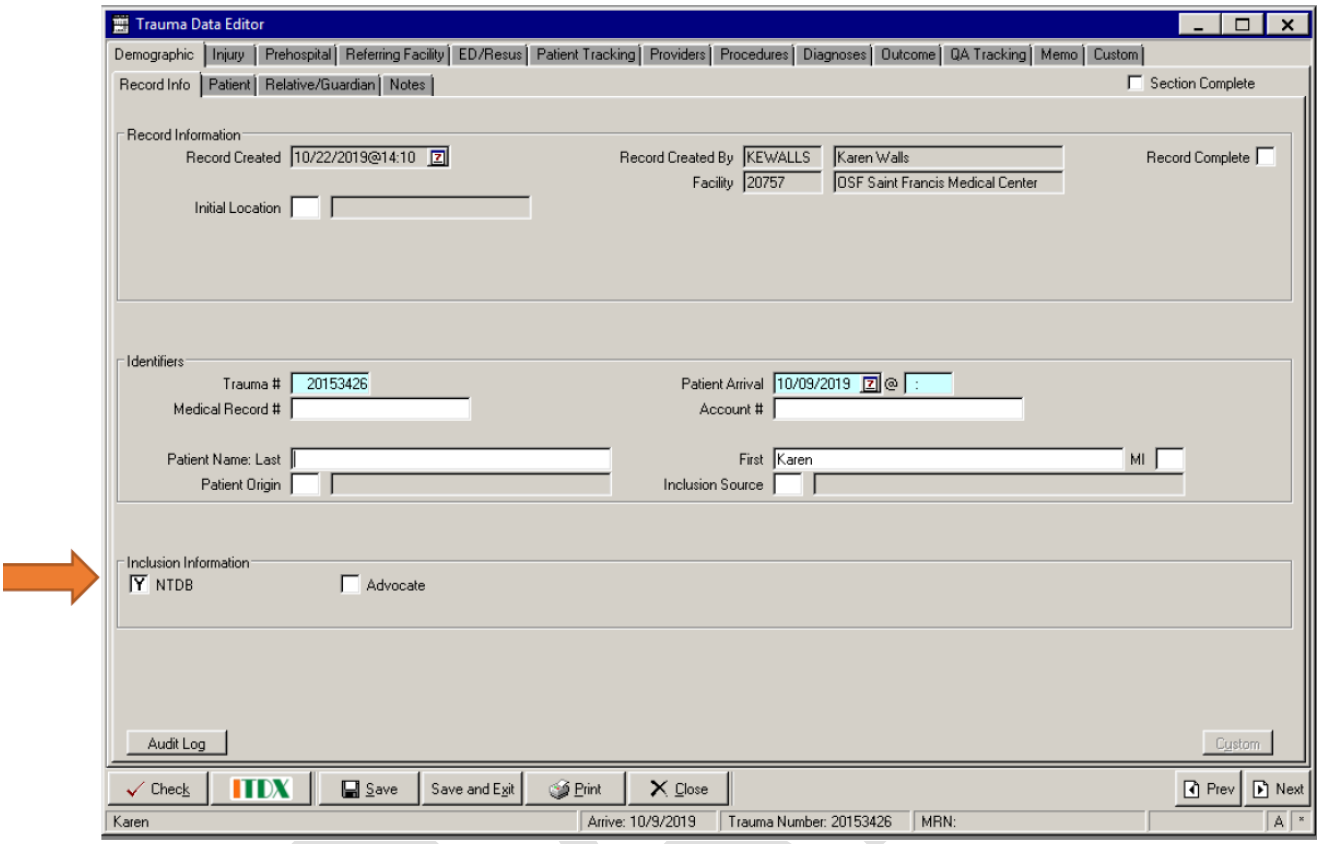


Inclusion Information

Definition:

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

Element Values

- Yes
- No

Data Source Hierarchy Guide

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

2020 NTDS Patient Inclusion Critieria:

NATIONAL TRAUMA DATA STANDARD (NTDS) PATIENT INCLUSION CRITERIA

Definition: To ensure consistent data collection across States into the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria:

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

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

- **S00-S99 with 7th character modifiers of A, B, or C ONLY.** *(Injuries to specific body parts – initial encounter)*
- **T07** *(unspecified multiple injuries)*
- **T14** *(injury of unspecified body region)*
- **T20-T28 with 7th character modifier of A *ONLY*** *(burns by specific body parts – initial encounter)*
- **T30-T32** *(burn by TBSA percentages)*
- **T79.A1-T79.A9 with 7th character modifier of A ONLY** *(Traumatic Compartment Syndrome – initial encounter)*

EXCLUDING the following isolated injuries:

ICD-10-CM:

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

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

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9) :

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

  OR

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

  OR

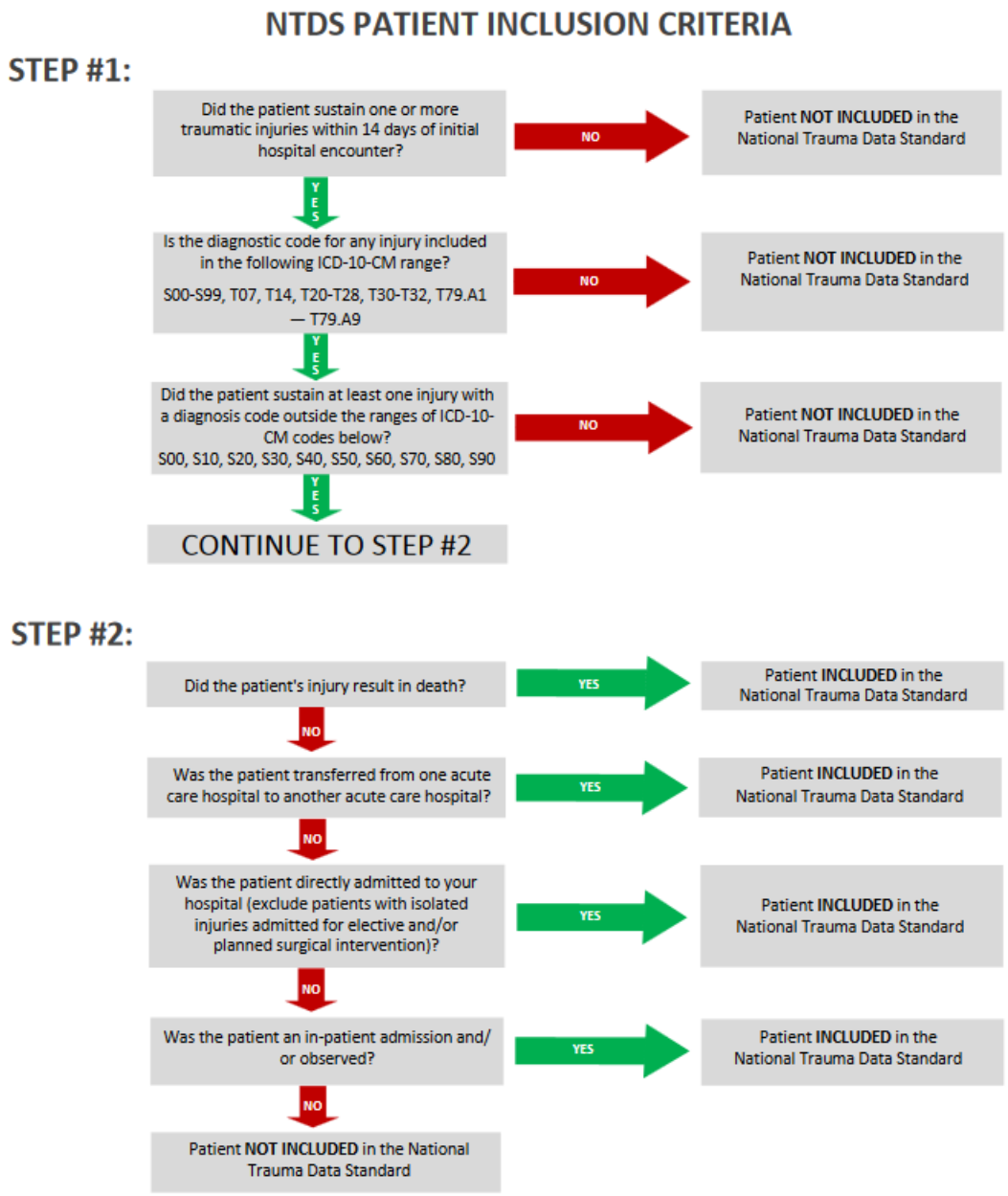
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for electiv and/or planned surgical intervention);

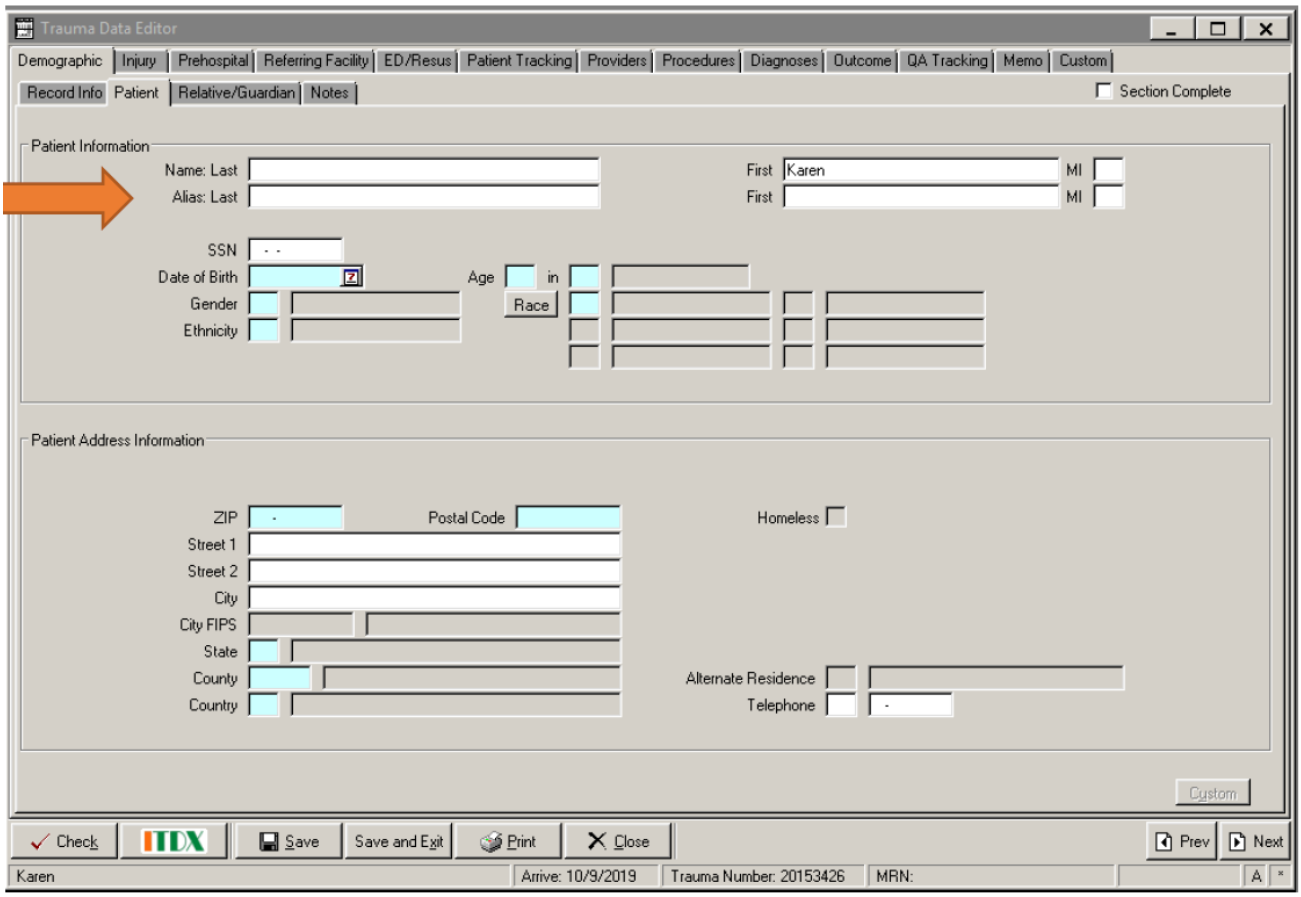
  OR

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

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

2020 NTDS Inclusion Criteria Algorithm





Alias

Definition:

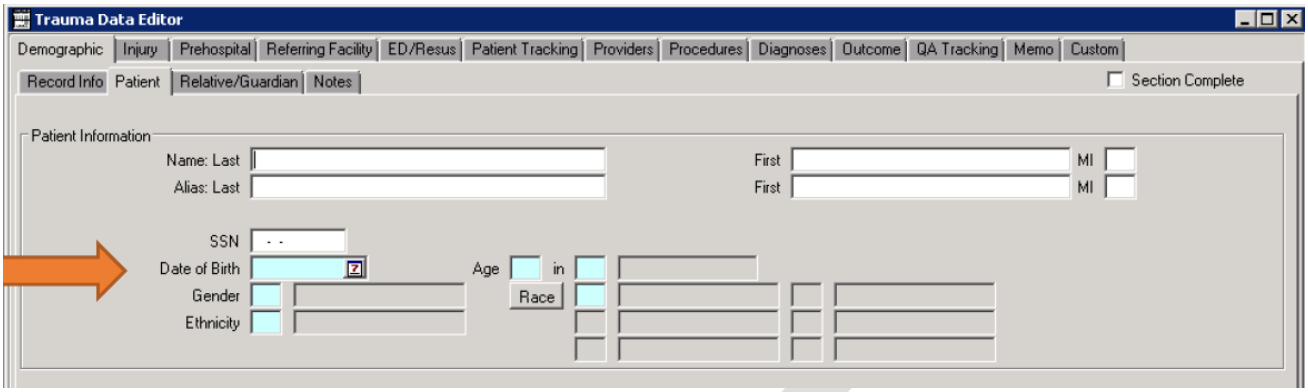
Known alternate names that the patient uses when seeking medical care
May also be alternate name given by hospital if patient's identity/name unknown at time of arrival and patient is registered initially under an alternate name. Example: Trauma 12 Male.

Element Values

- Relevant Value for data element

Data Source Hierarchy Guide

1. Demographics
2. Insurance section



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

Definition:

The patient's date of birth

Element Values:

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

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

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

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AGE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

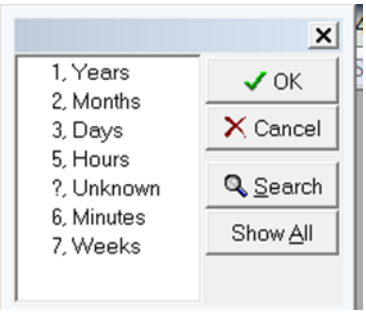
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

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

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

DI dropdown screen:



AGE UNITS

Definition

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

Element Values

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

Additional Information

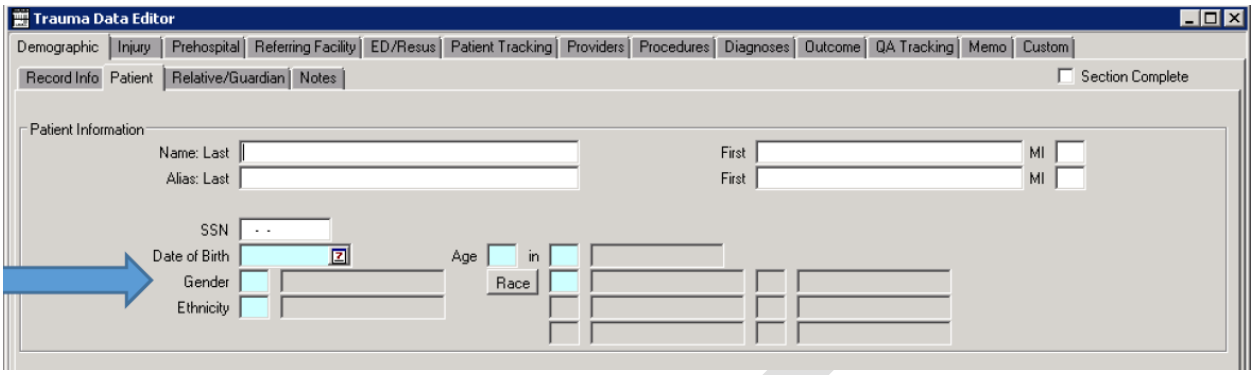
- If Date of Birth is "Not Known/Not Recorded," report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: Age.
- The null value "Not Applicable" is reported if Date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

Data Source Hierarchy Guide

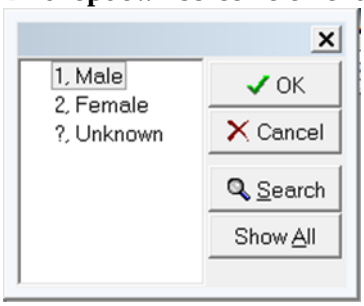
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

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



DI dropdown screen element values:



SEX

Definition

The patient's sex.

Element Values

1. Male
2. Female

Additional Information

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

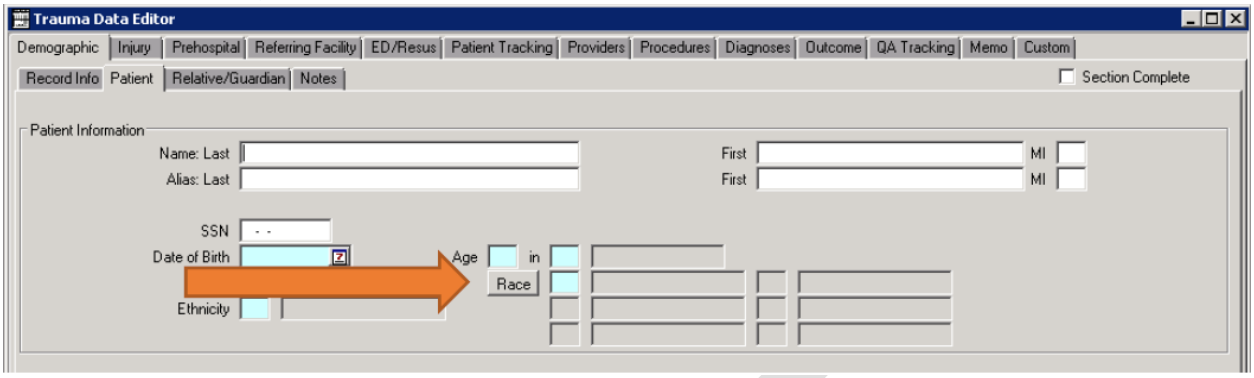
Data Source Hierarchy Guide

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

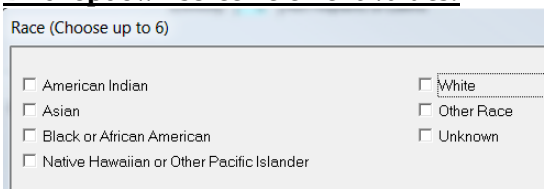
Associated Edit Checks

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

Race: BLUE FIELD; NTDS Definition rules follow.



DI dropdown screen element values:



RACE

Definition

The patient's race.

Element Values

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

Additional Information

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

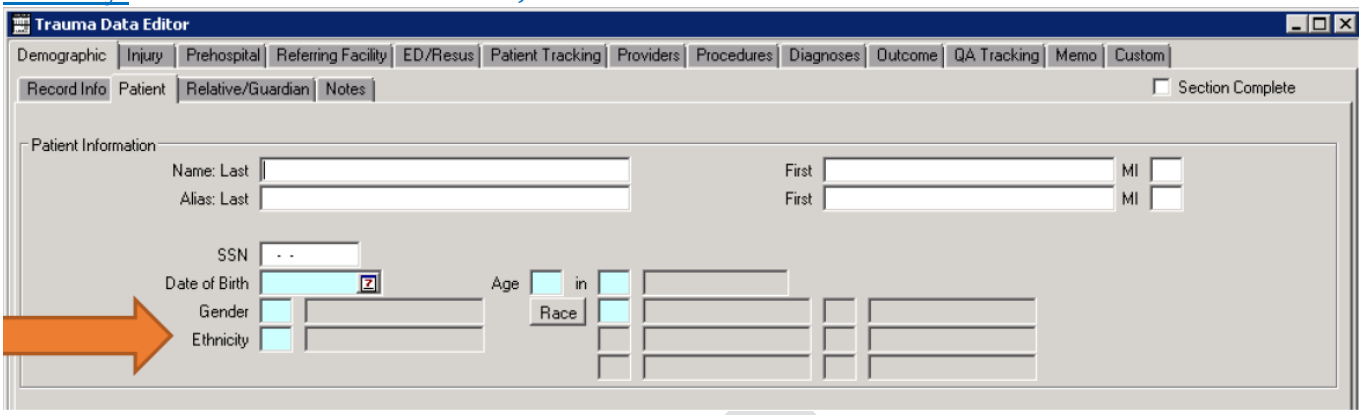
Data Source Hierarchy Guide

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

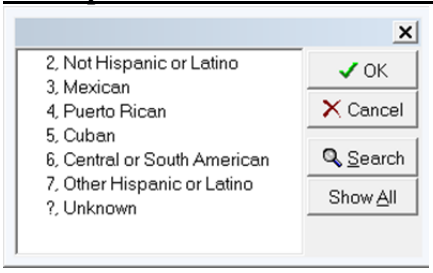
Associated Edit Checks

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

Ethnicity: MANDATORY BLUE FIELD; NTDS Definition rules follow.



DI dropdown screen element values:



ETHNICITY

Definition

The patient's ethnicity.

Element Values

1. Hispanic or Latino
2. Not Hispanic or Latino

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member.
- The maximum number of ethnicities that may be reported for an individual patient is 1.
- Based on the 2010 US Census Bureau.

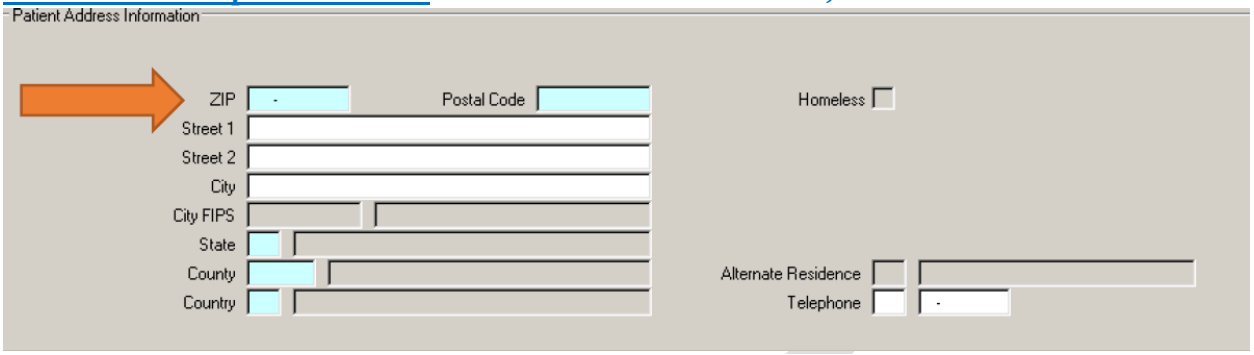
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



PATIENT'S HOME ZIP/POSTAL CODE

Definition

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

Element Values

- Relevant value for data element

Additional Information

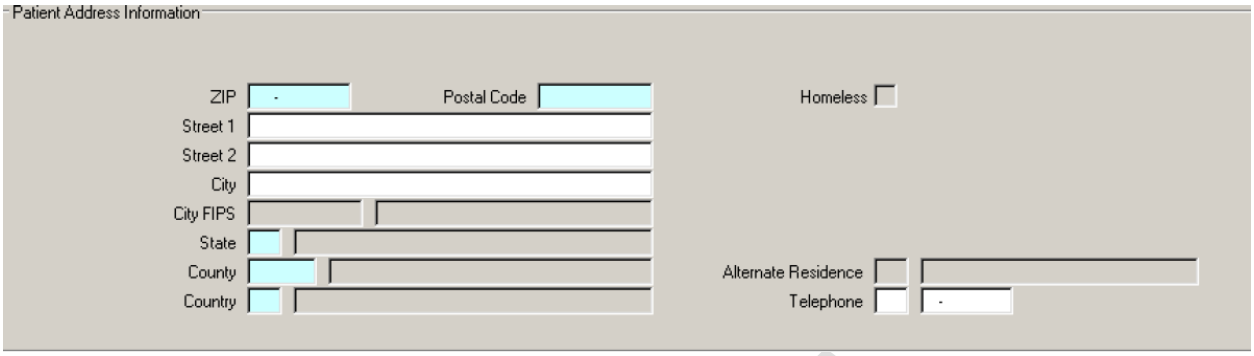
- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is "Not Applicable," report data element: Alternate Home Residence.
- If ZIP/Postal code is "Not Known/Not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

Data Source Hierarchy Guide

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

Associated Edit Checks

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



Patient Address - Street 1, Street 2

Definition:

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

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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

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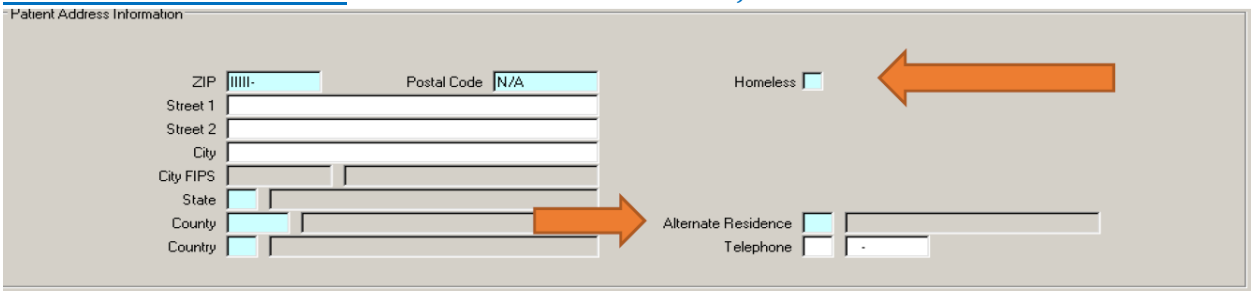
Alternate Home Residence: MANDATORY BLUE FIELD; NTDS Definition rules follow.



DI dropdown screen data elements:	Homeless dropdown:
1. Undocumented Citizen 2. Migrant Worker 3. Foreign Visitor /. Not Applicable ?. Unknown	1. Yes 2. No ?. Unknown N/A Not Applicable

ALTERNATE HOME RESIDENCE

Definition

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

Element Values

1. Homeless
2. Undocumented Citizen
3. Migrant Worker

Additional Information

- Only reported when ZIP/Postal code is "Not Applicable."
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- Report all that apply

Data Source Hierarchy Guide

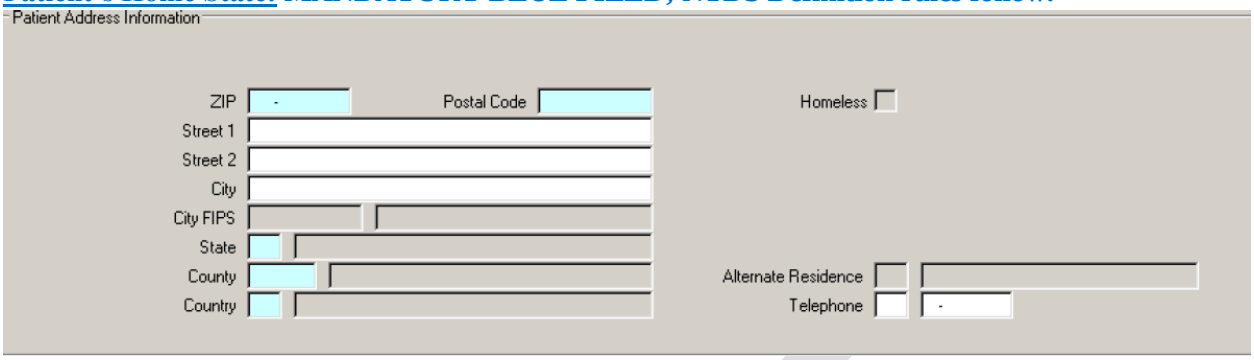
1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

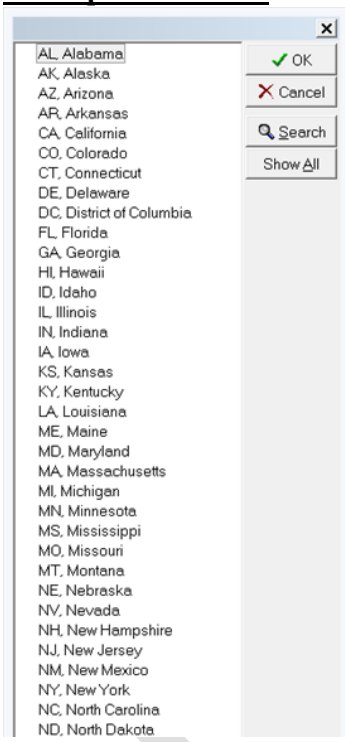
Rule ID	Level	Message
0501	1	Value is not a valid menu option
0502	2	Element cannot be blank
0503	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
0540	1	Multiple Entry Max exceeded

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

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



DI dropdown screen:



PATIENT'S HOME STATE

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

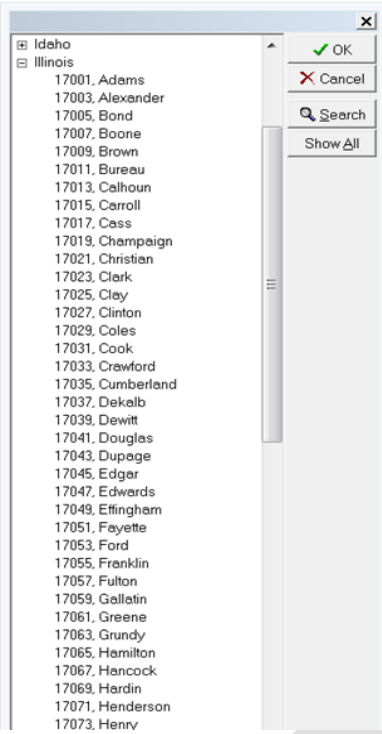
1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

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

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

DI dropdown screen:



PATIENT'S HOME COUNTY

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

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

DI dropdown screen:

PATIENT'S HOME COUNTRY

Definition

The country where the patient resides.

Element Values

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

Additional Information

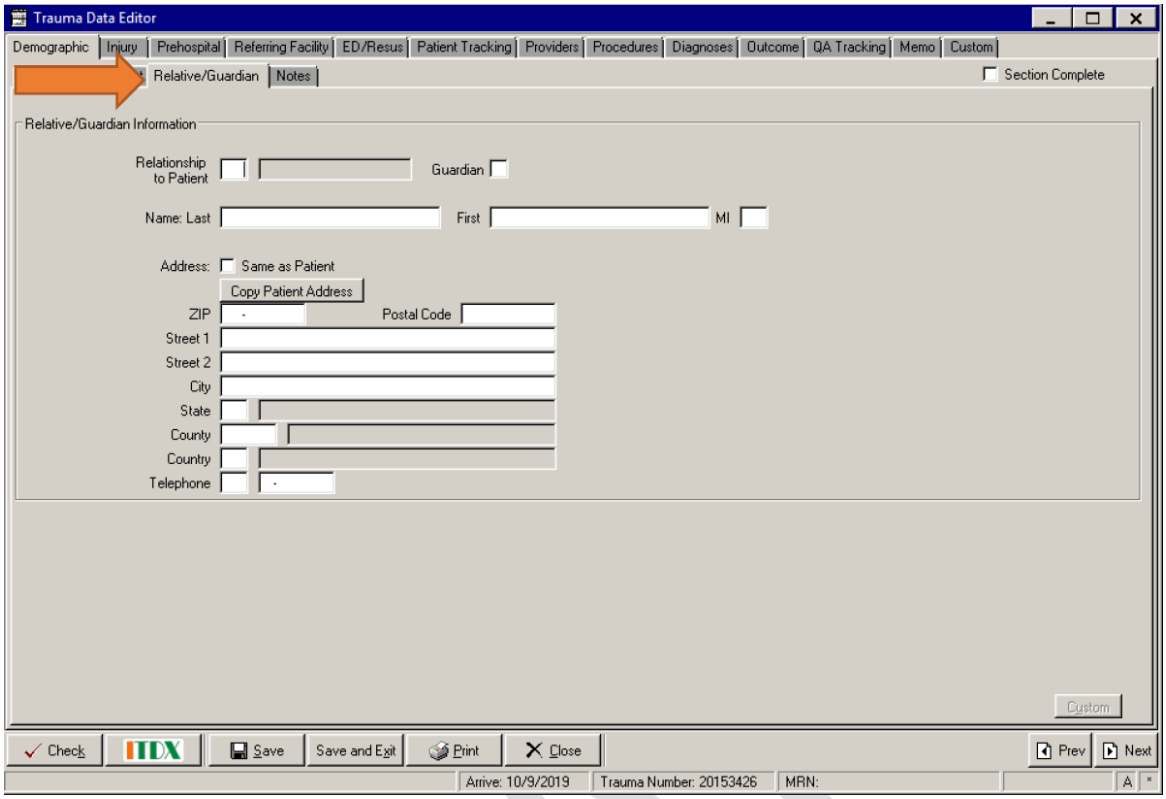
- Values are two-character FIPS codes representing the country (e.g., US).
- If Patient's Home Country is not US, then the null value "Not Applicable" is reported for: Patient's Home State, Patient's Home County, and Patient's Home City.

Data Source Hierarchy Guide

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

Associated Edit Checks

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



Relative/Guardian Information

Definition

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

Element Values – Relationship to Patient - DI dropdown screen:

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

Element Values – Guardian - DI dropdown screen:

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

Element Values – All Other Fields

- Relevant value for data element

Data Source Hierarchy Guide

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

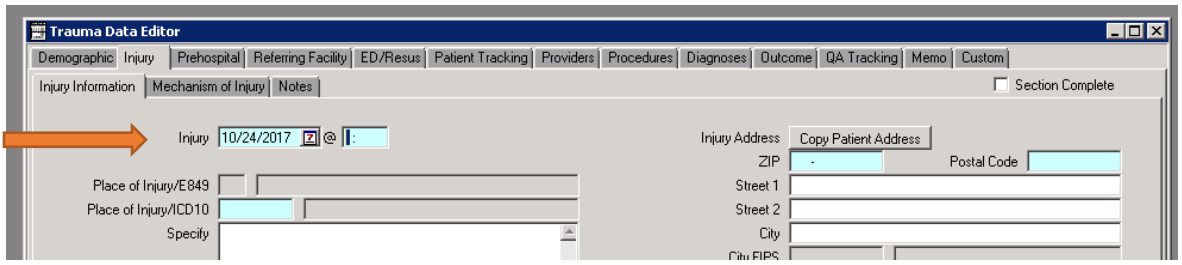
DRAFT

Injury Information

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

DRAFT

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



INJURY INCIDENT DATE

Definition

The date the injury occurred.

Element Values

- Relevant value for data element

Additional Information

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

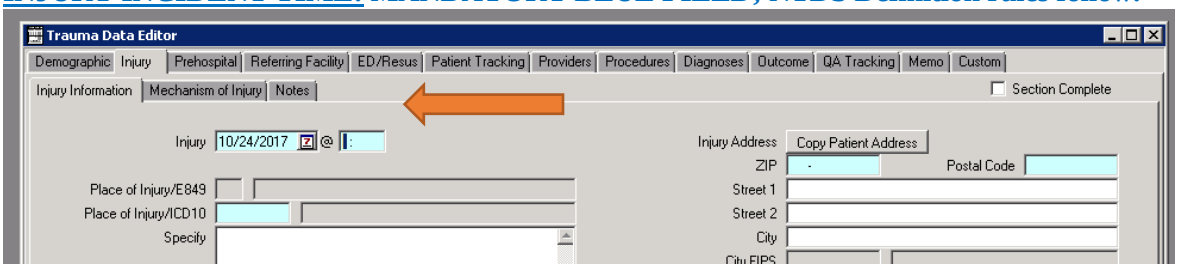
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



INJURY INCIDENT TIME

Definition

The time the injury occurred.

Element Values

- Relevant value for data element

Additional Information

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

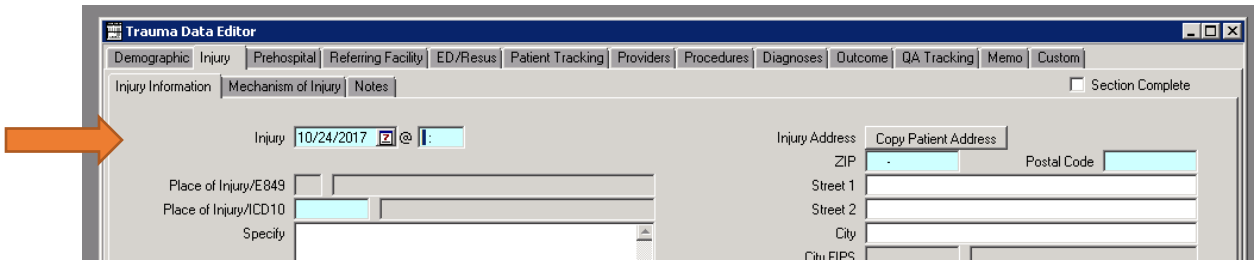
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Definition

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

Element Values

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

Additional Information

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

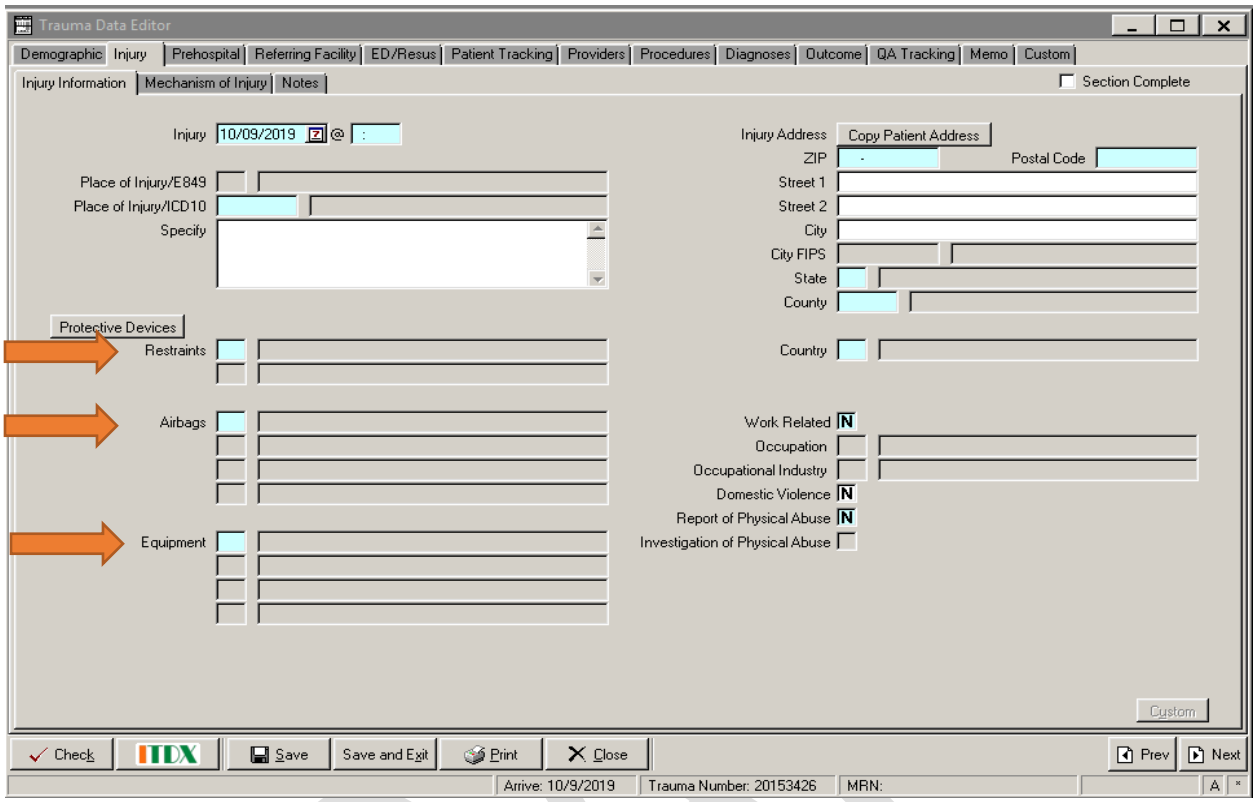
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



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

Restraints

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

/. Not Applicable
?. Unknown

Airbags

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

/. Not Applicable
?. Unknown

Equipment

1. None
2. Helmet
3. Eye Protection
4. Protective Clothing
5. Protective Non-Clothing Gear (e.g. Shin Guard, Padding)
6. Hard Hat
7. Personal Flotation Device
8. Window Bars
9. Other

/. Not Applicable
?. Unknown

DRAFT

Data Source Hierarchy Guide

1. EMS Run Report
2. ED Trauma Summary
3. History and Physical
4. Nursing Notes

PROTECTIVE DEVICES

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

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

CHILD SPECIFIC RESTRAINT

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

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

AIRBAG DEPLOYMENT

Definition

Indication of airbag deployment during a motor vehicle crash.

Element Values

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

Additional Information

- Report all that apply.
- Evidence of airbag deployment may be reported or observed.
- Only report when Protective Devices include "8. Airbag Present."
- Airbag Deployed Front should be reported for patients with documented airbag deployments but are not further specified.
- The null value "Not Applicable" must be reported if Element Value 8. "Airbag Present" is NOT reported for Protective Devices.

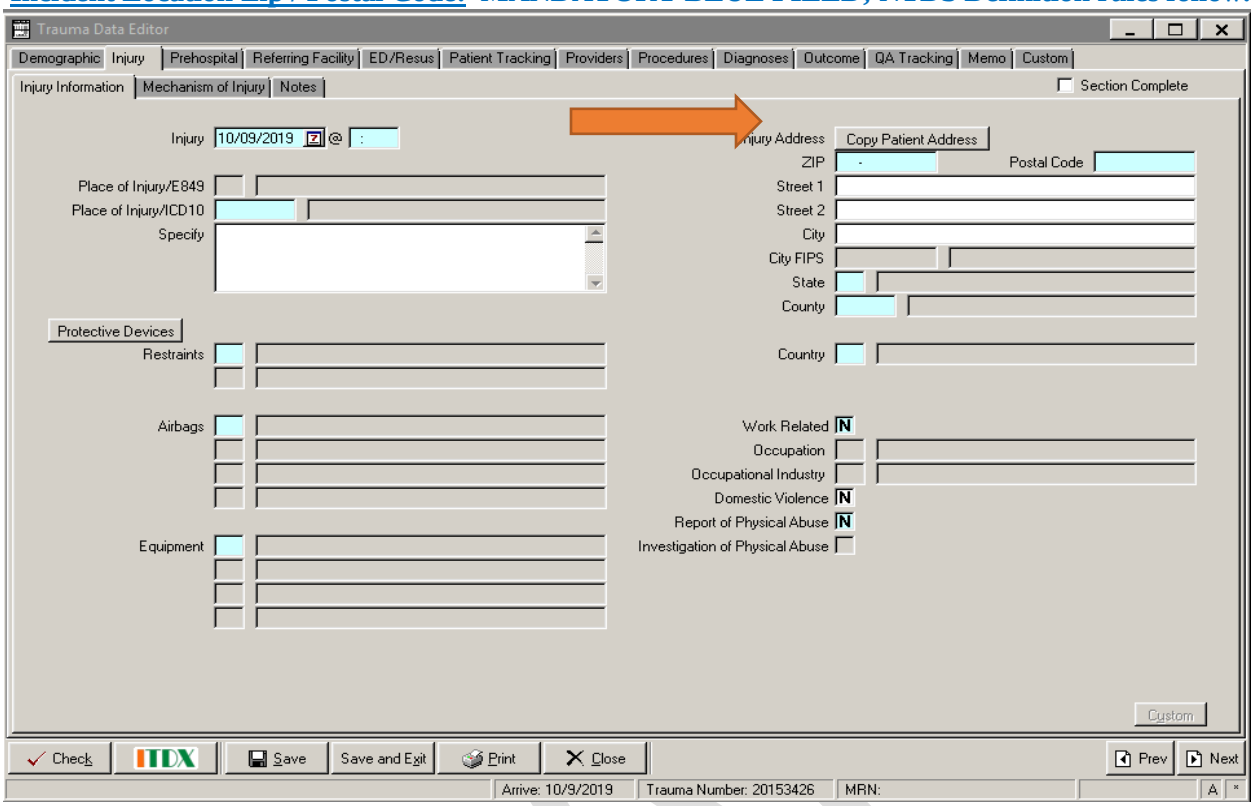
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



INCIDENT LOCATION ZIP/POSTAL CODE

Definition

The ZIP/Postal code of the incident location.

Element Values

- Relevant value for data element

Additional Information

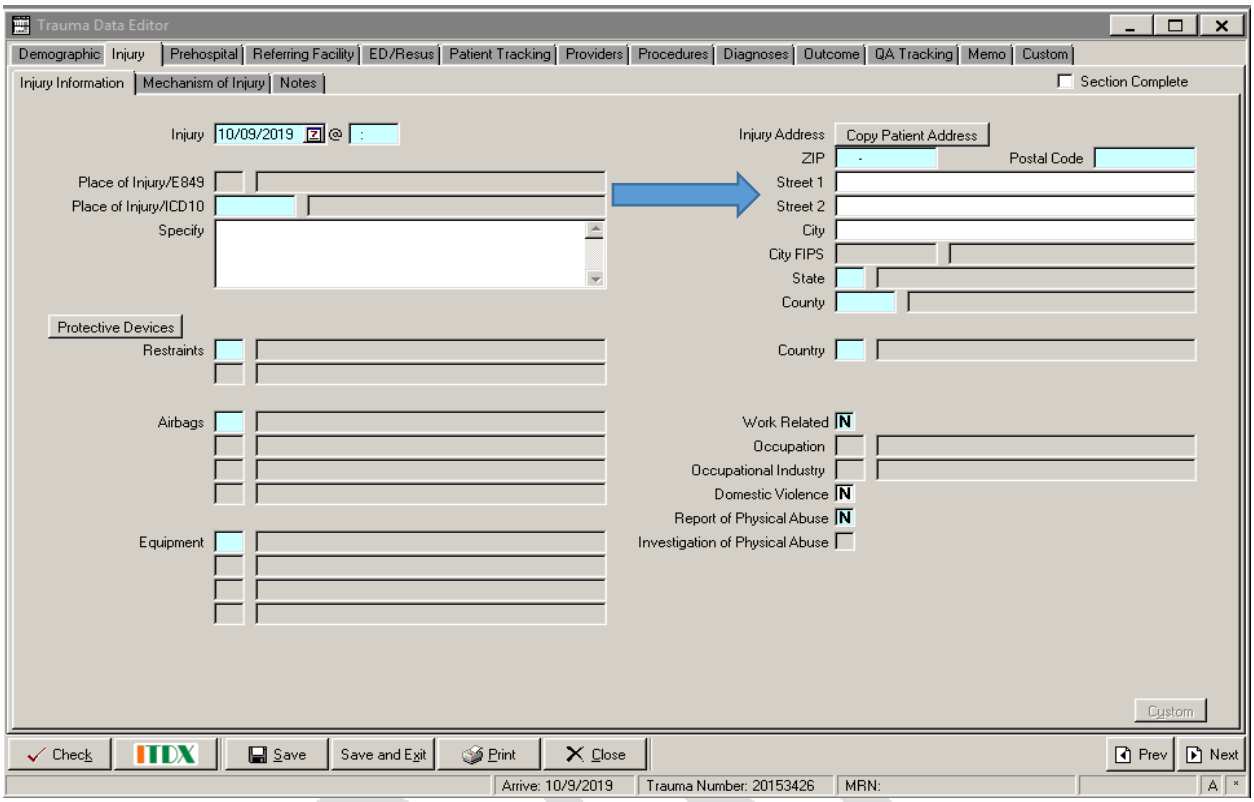
- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- If "Not Known/Not Recorded," report data elements: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require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

Data Source Hierarchy Guide

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

Associated Edit Checks

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



Injury: Street 1, Street 2

Definition

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

Element Values

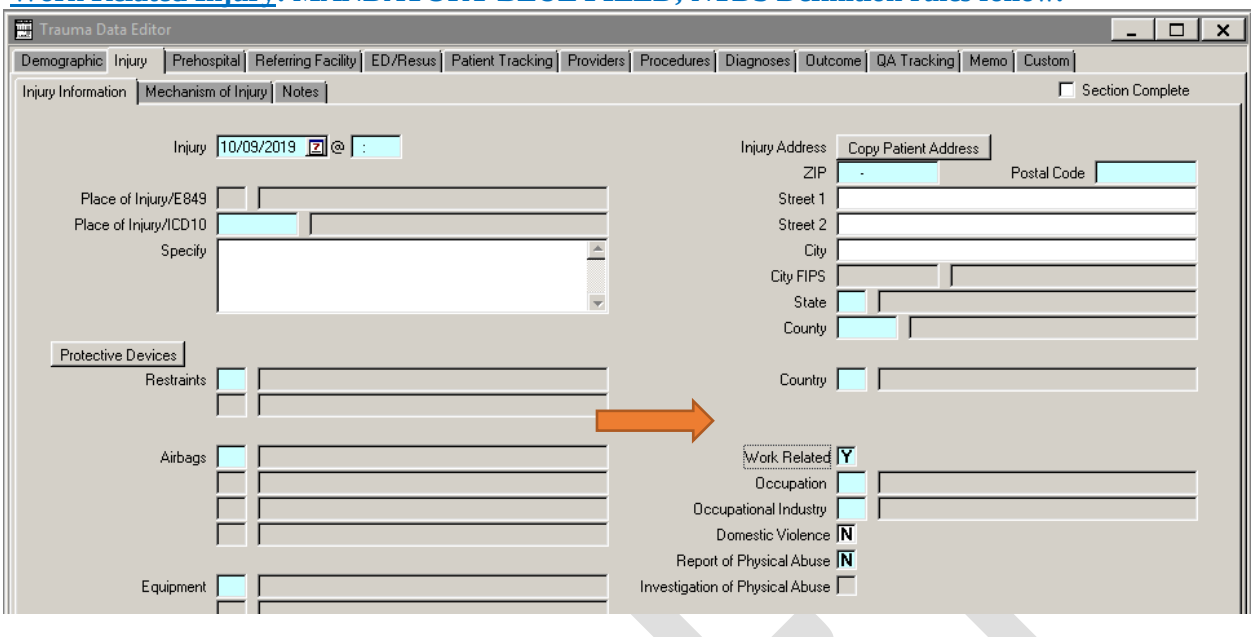
- Relevant value for data element

Data Source Hierarchy Guide

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

DRAFT

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



WORK-RELATED

Definition

Indication of whether the injury occurred during paid employment.

Element Values

1. Yes 2. No

Additional Information

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

Data Source Hierarchy Guide

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

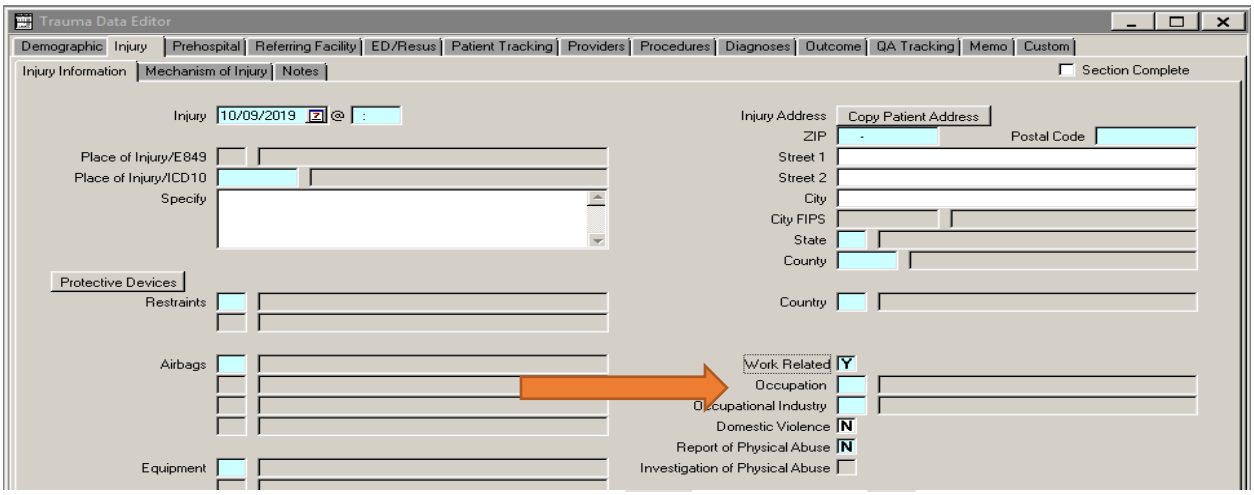
Associated Edit Checks

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

Additional DI Element Values

/. Not Applicable
?. Unknown
Injury Address: Where the patient was injured

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



PATIENT'S OCCUPATION

Definition

The occupation of the patient.

Element Values

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

Additional Information

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

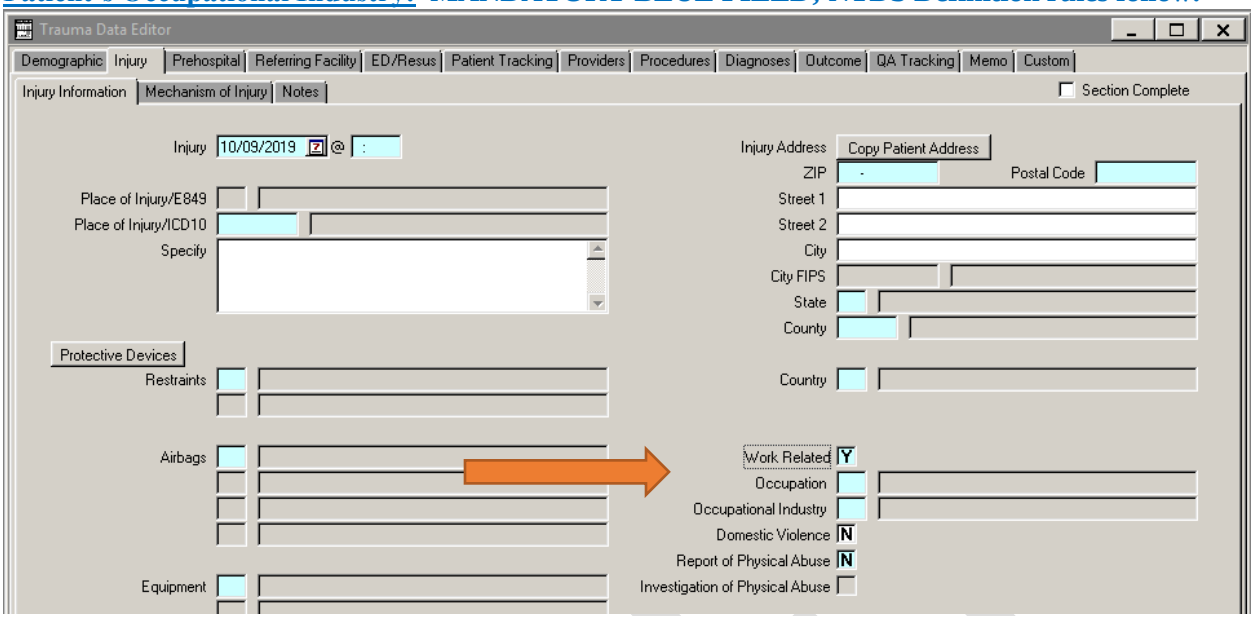
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



PATIENT'S OCCUPATIONAL INDUSTRY

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

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

Patient

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

Patient Employment Info

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

Guarantor

NOTE: Found in Print Forms – Face Sheet

Will only generate if you click yes to "Work Related."

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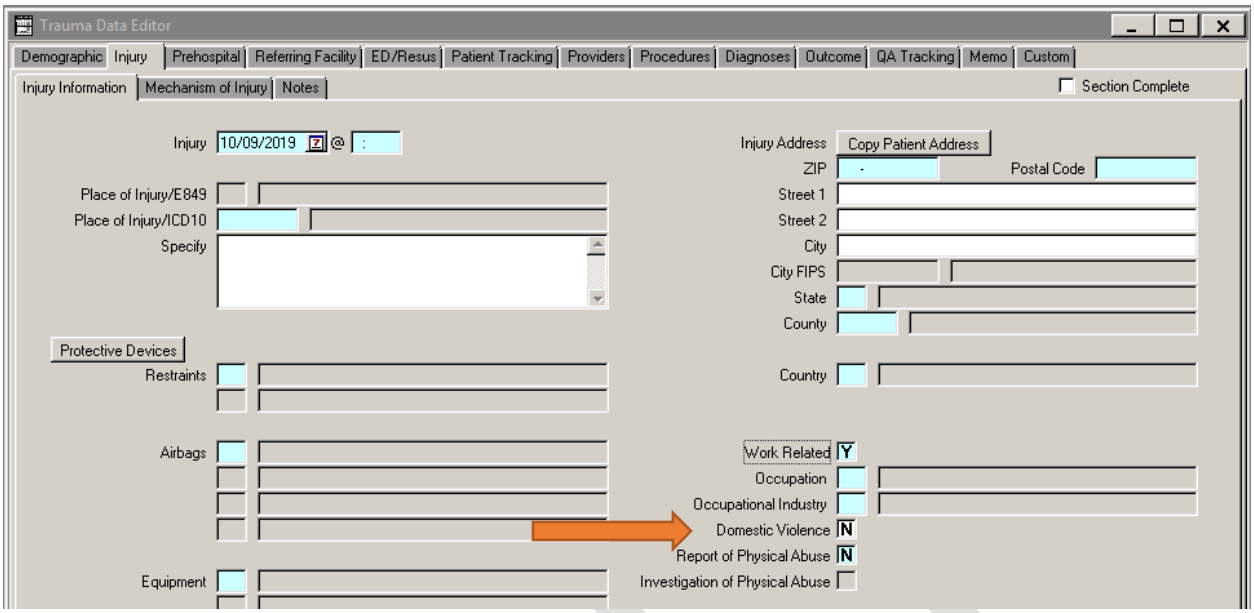


Domestic Violence

Definition

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

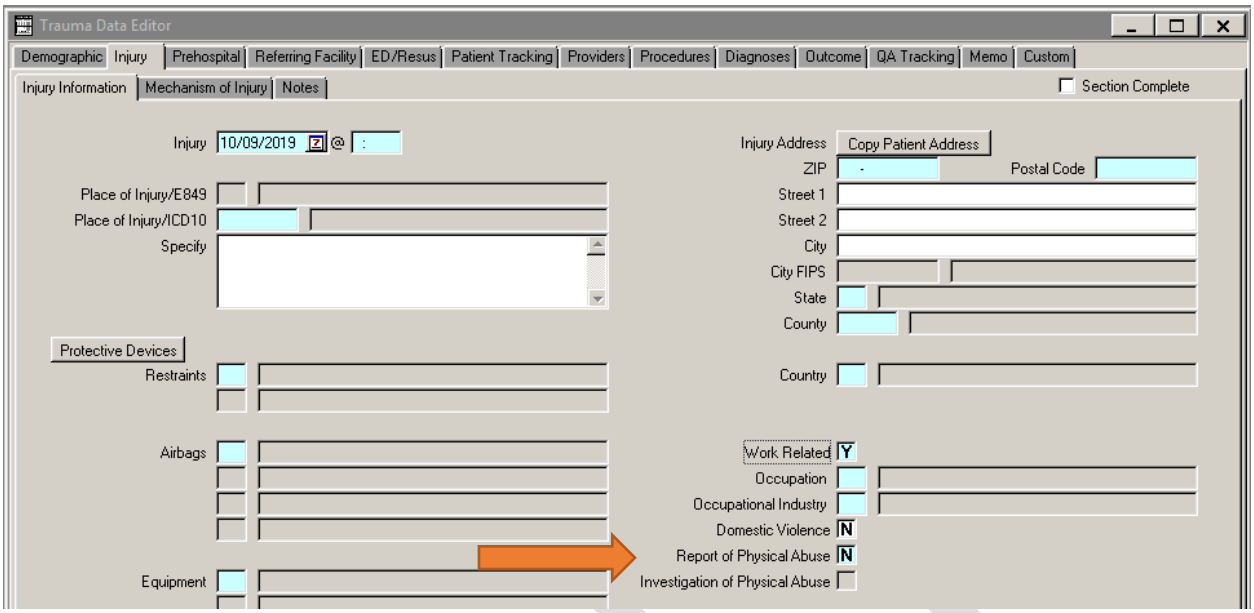
Element Values

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

Data Source Hierarchy Guide

1. History and Physical
2. ED Nursing Note
3. Case Management/Social Work Note
4. EMS Run Sheet

DRAFT



Report of Physical Abuse

Definition

A report of physical abuse made to the correct authorities.

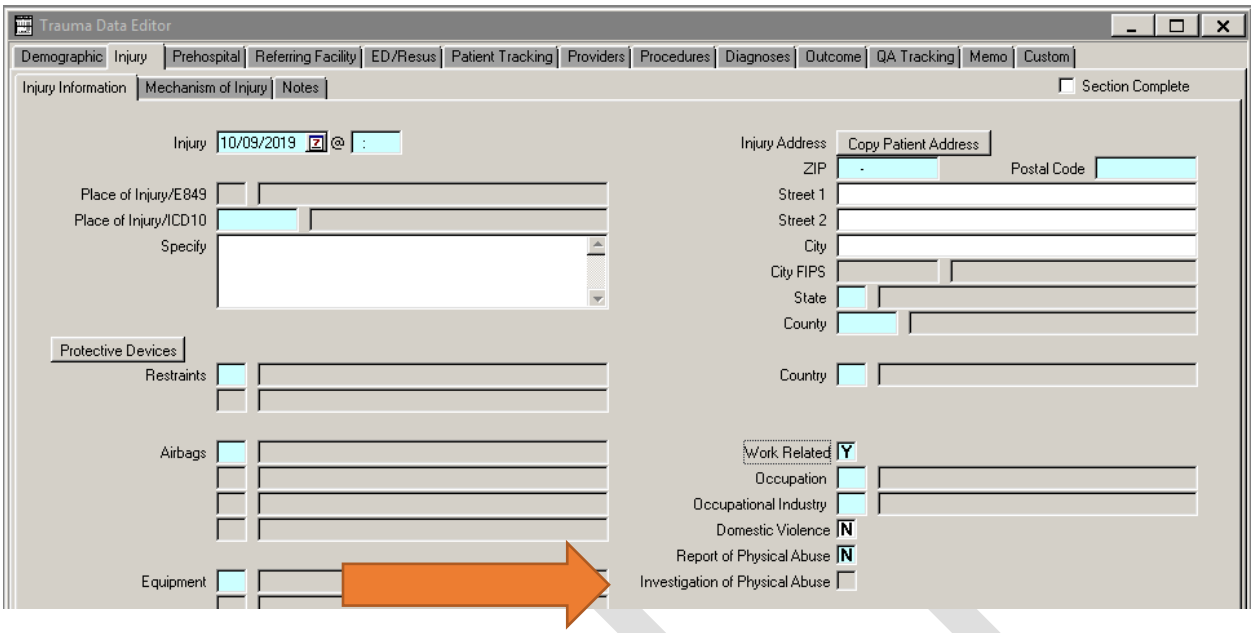
Element Values

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

Data Source Hierarchy Guide

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

DRAFT



Investigation of Physical Abuse

Definition

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

Element Values

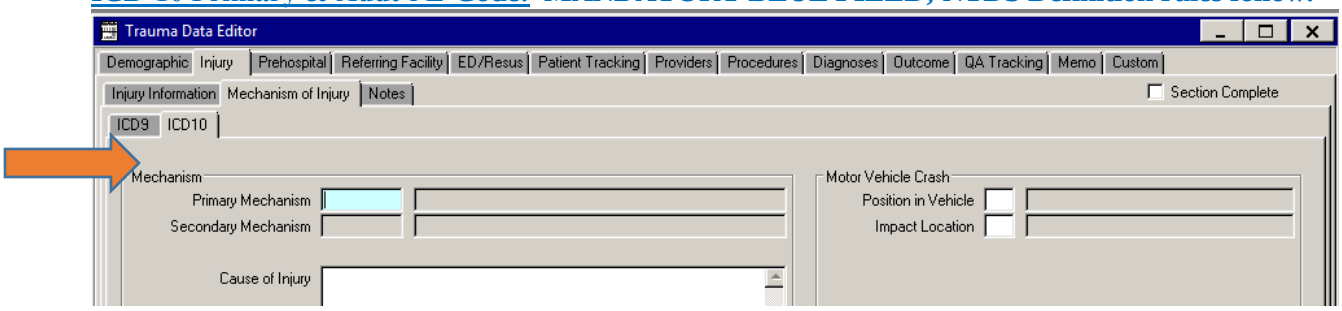
- Yes
- No
- N/A – Not Applicable
- ? - Unknown

Data Source Hierarchy Guide

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

DRAFT

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



ICD-10 PRIMARY EXTERNAL CAUSE CODE

Definition

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

Element Values

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

Additional Information

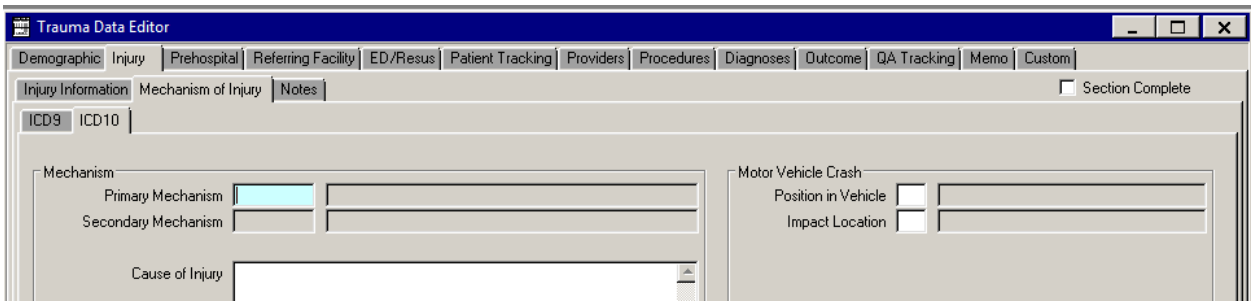
- The primary external cause code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM codes are accepted for this data element. Activity codes are not reported under the NTDS and should not be reported for this data element.
- Multiple Cause Coding Hierarchy: If two or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

Data Source Hierarchy Guide

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

Associated Edit Checks

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



ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Definition

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

Element Values

- Relevant ICD 10-CM code value for injury event

Additional Information

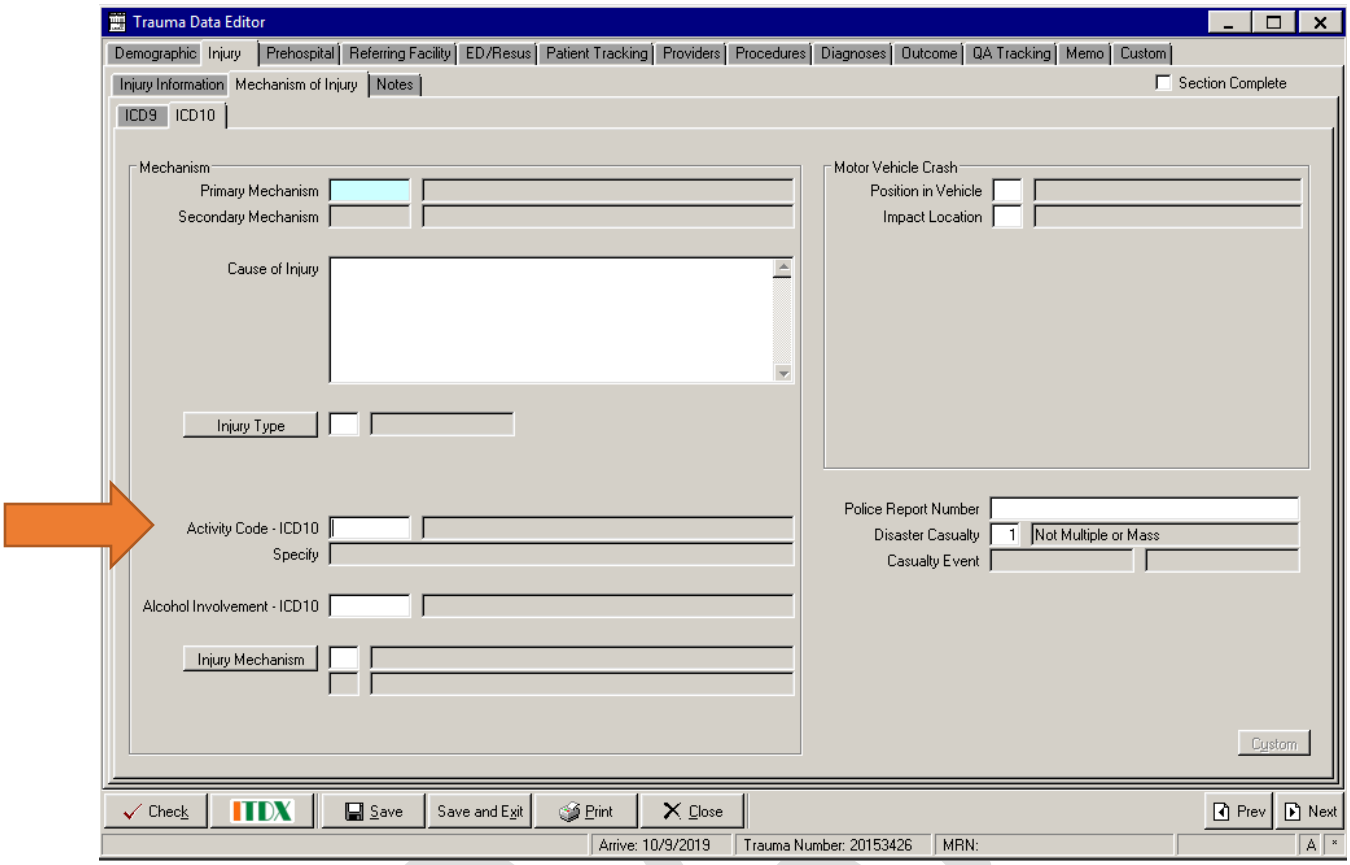
- Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code.
- Activity codes are not reported under the NTDS and should not be reported for this data element.
- The null value "Not Applicable" is reported if no additional external cause codes are reported.
- Report all that apply (maximum 2)
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes.
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

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

Associated Edit Checks

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



Activity Code

Definition

What the patient was doing while the injury occurred.

Element Values

- Relevant ICD-10 code value for activity.

Data Source Hierarchy Guide

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

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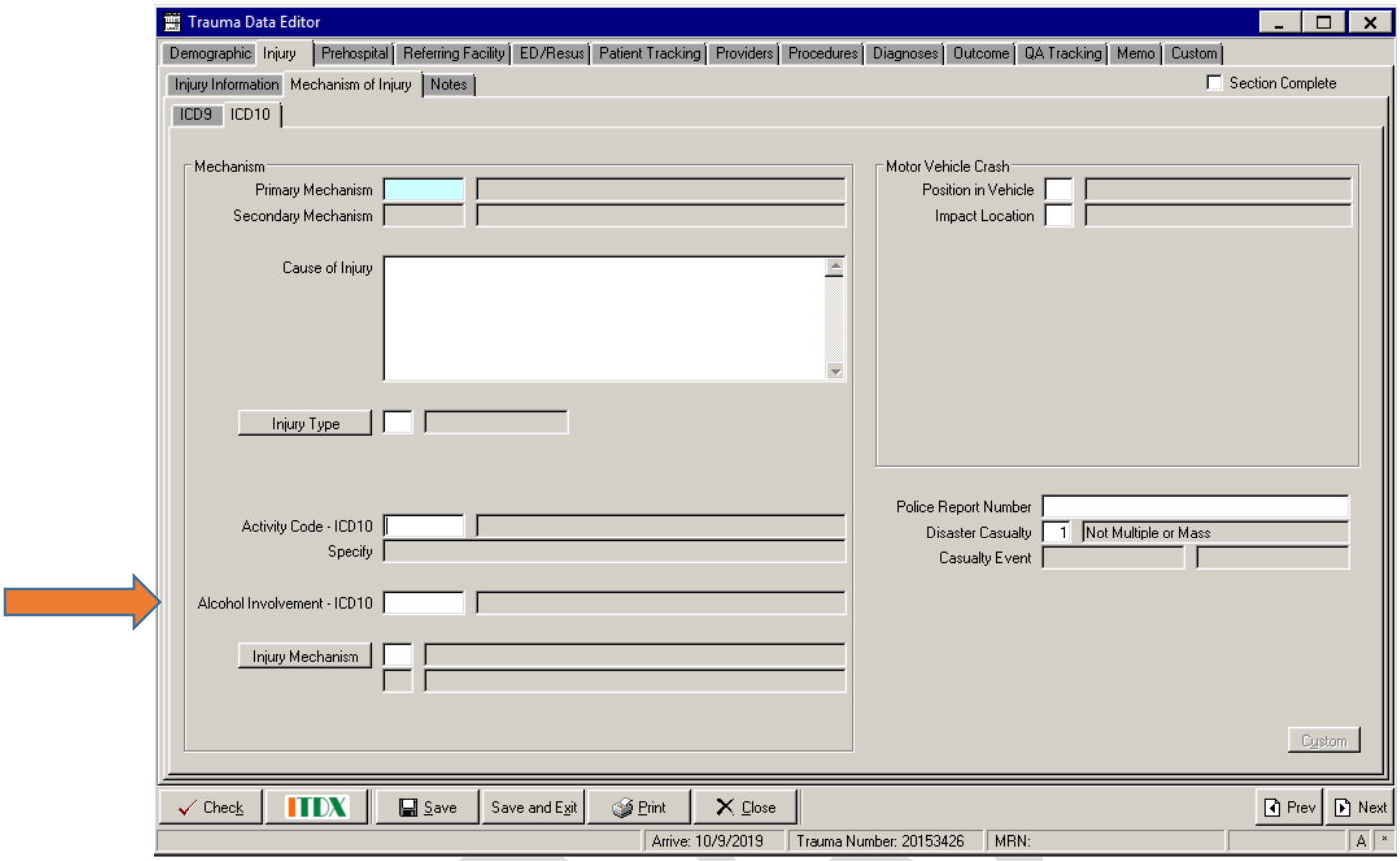


Alcohol Involvement

Definition

Patient blood alcohol level at the time of injury

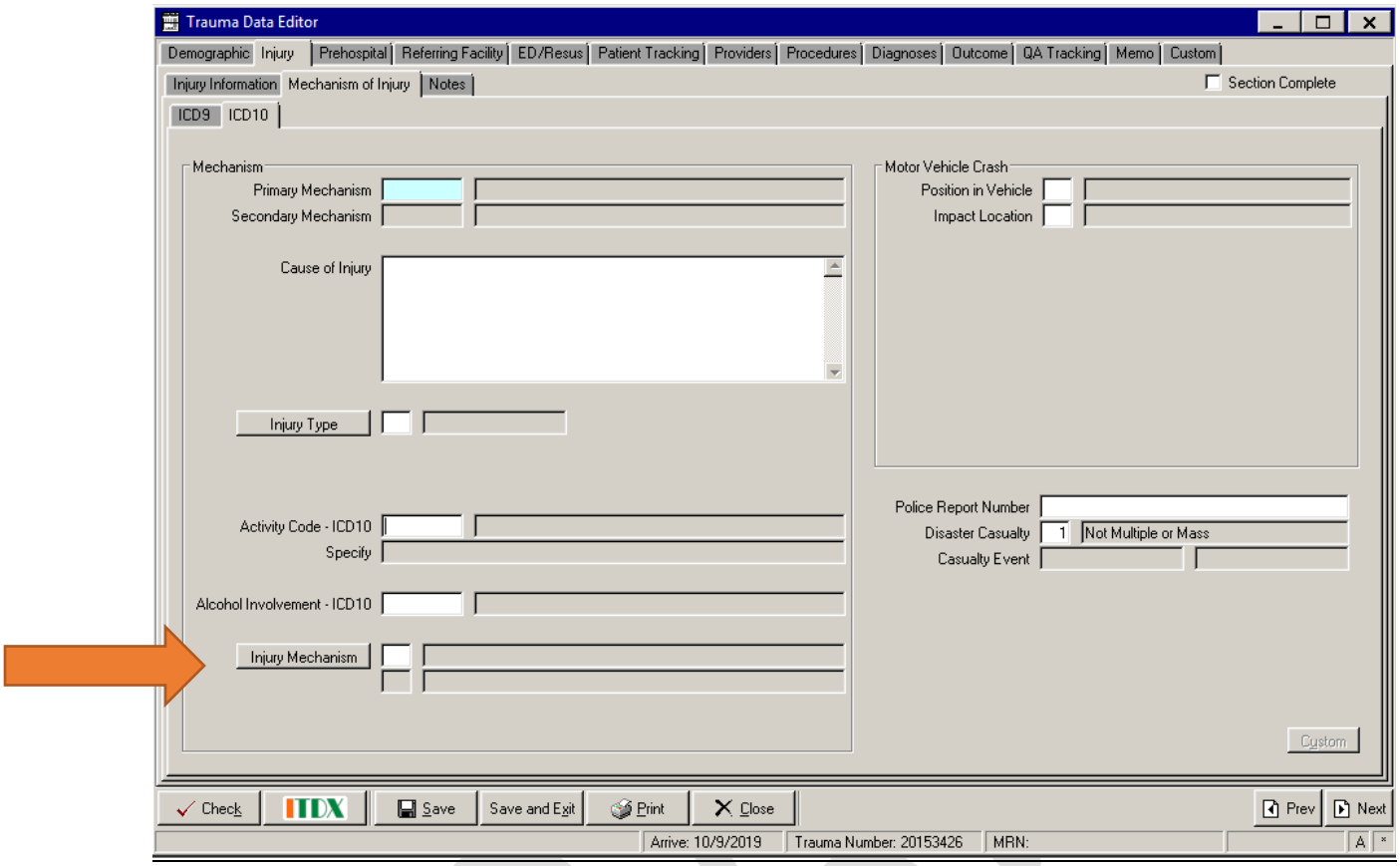
Element Values

- Relevant ICD-10 code for blood alcohol level

Data Source Hierarchy Guide

1. Lab Values
2. Lab Values from transferring facility

DRAFT



Injury Mechanism

Definition

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

Element Values

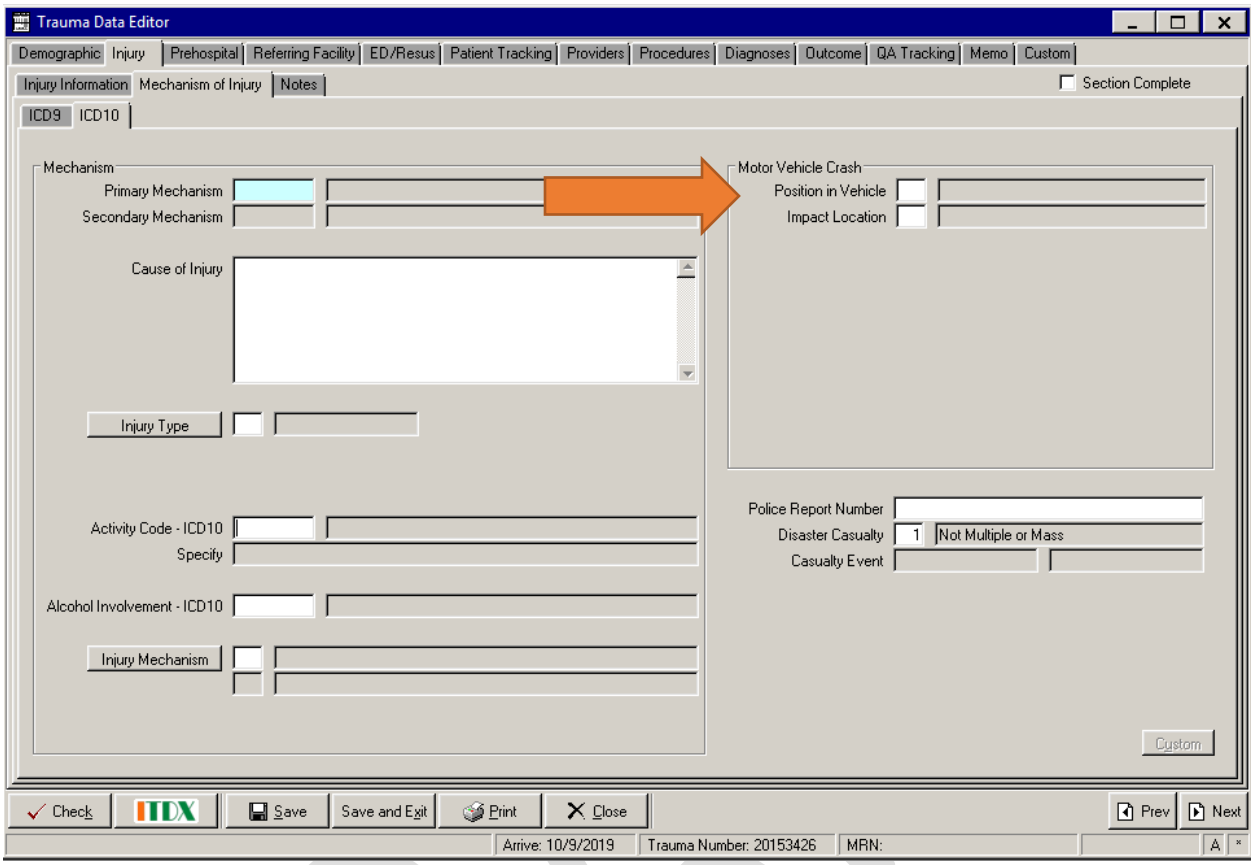
1. MVC
2. Fall Under 1m (3.3 ft)
3. Fall 1m – 6m (3.3 – 19.7 ft)
4. Fall over 6m (19.7 ft)
5. Fall – NFS
6. Assault
7. Motorcycle
8. Pedestrian
9. Bicycle
10. Other Blunt Mechanism
11. Knife
12. Handgun
13. Shotgun
14. Other gun
15. Glass
16. Biting
17. Other Penetrating Mechanism
18. Chemical Burn
19. Inhalation Burn
20. Thermal Burn
21. Electrical Burn
22. Other Burn Mechanism

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

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



Position in Vehicle

Definition

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

Element Values

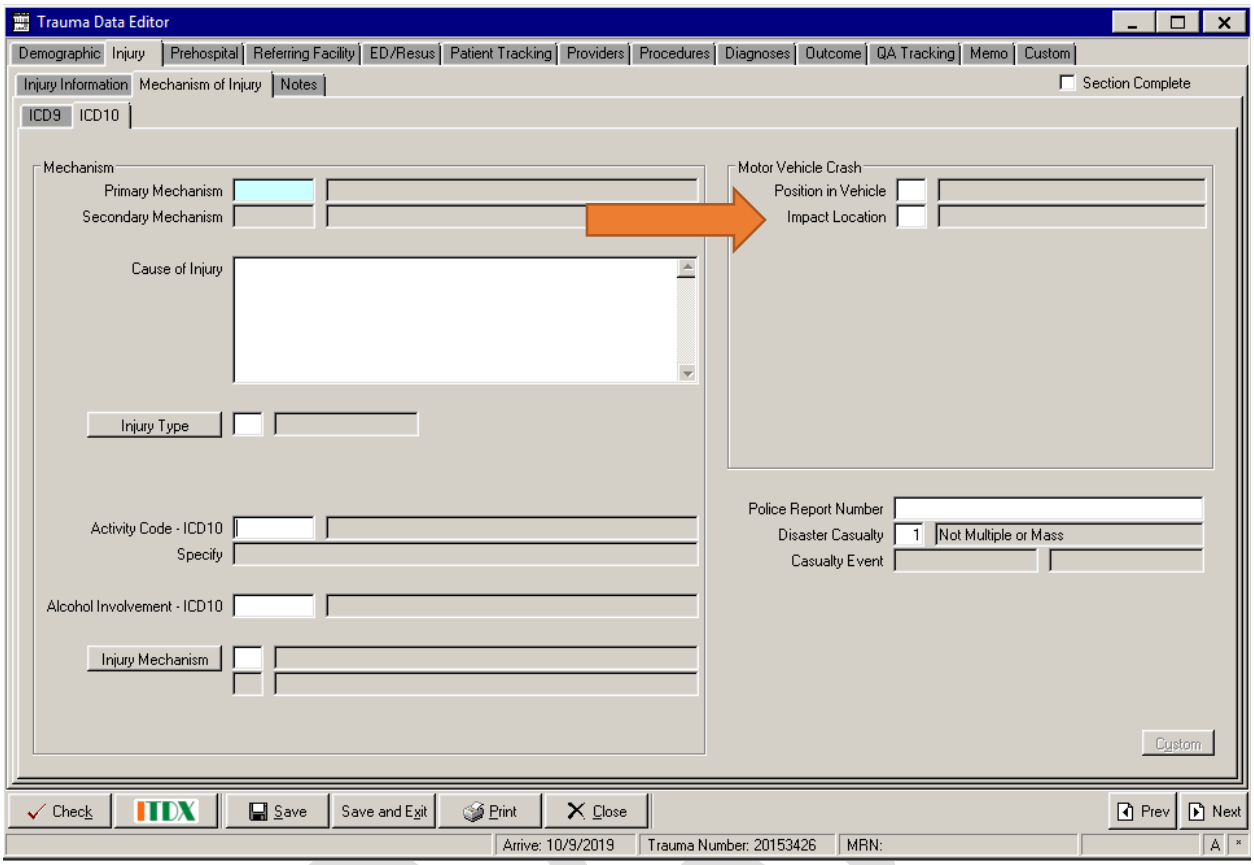
1. Driver
2. Front Seat Middle
3. Front Seat Passenger
4. Second Row Left
5. Second Row Middle
6. Second Row Right
7. Third Row Left
8. Third Row Middle
9. Third Row Right
10. Station Wagon Rear
11. Truck/Van Rear
12. Truck Bed
13. Bus Passenger
14. Passenger NFS

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

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



Impact Location

Definition

The side of the vehicle that impacted with another object.

Element Values

1. Frontal
2. Nearside
3. Far side
4. Side NOS
5. Rear
6. Rollover
7. Roof
8. Broadside
9. Other

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

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

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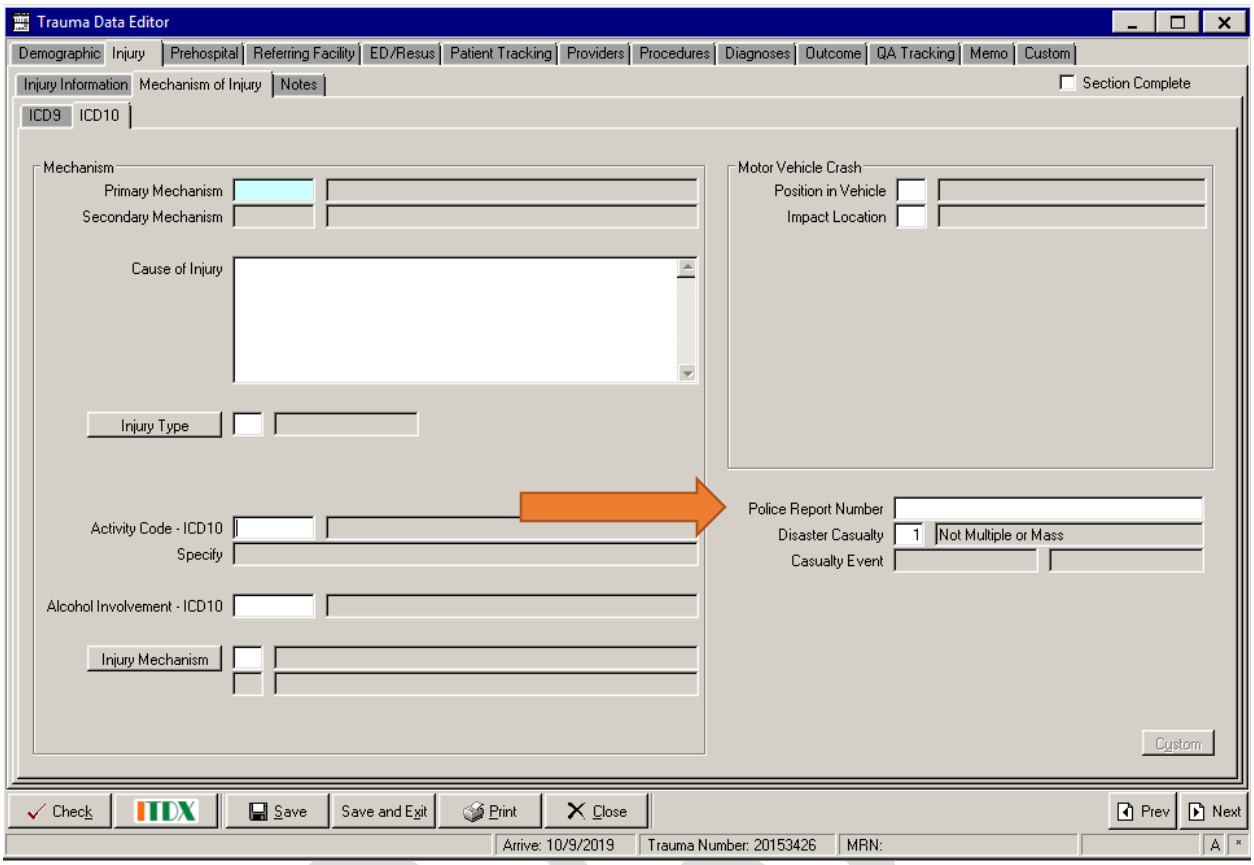

Police Report Number

Definition

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

Data Element

- Relevant value for data element

Data Source Hierarchy Guide

- EMS Run Sheet
- ED Nursing Note
- Media Scan

NOTE: Rarely available to us on; Do not spend significant time looking for it.

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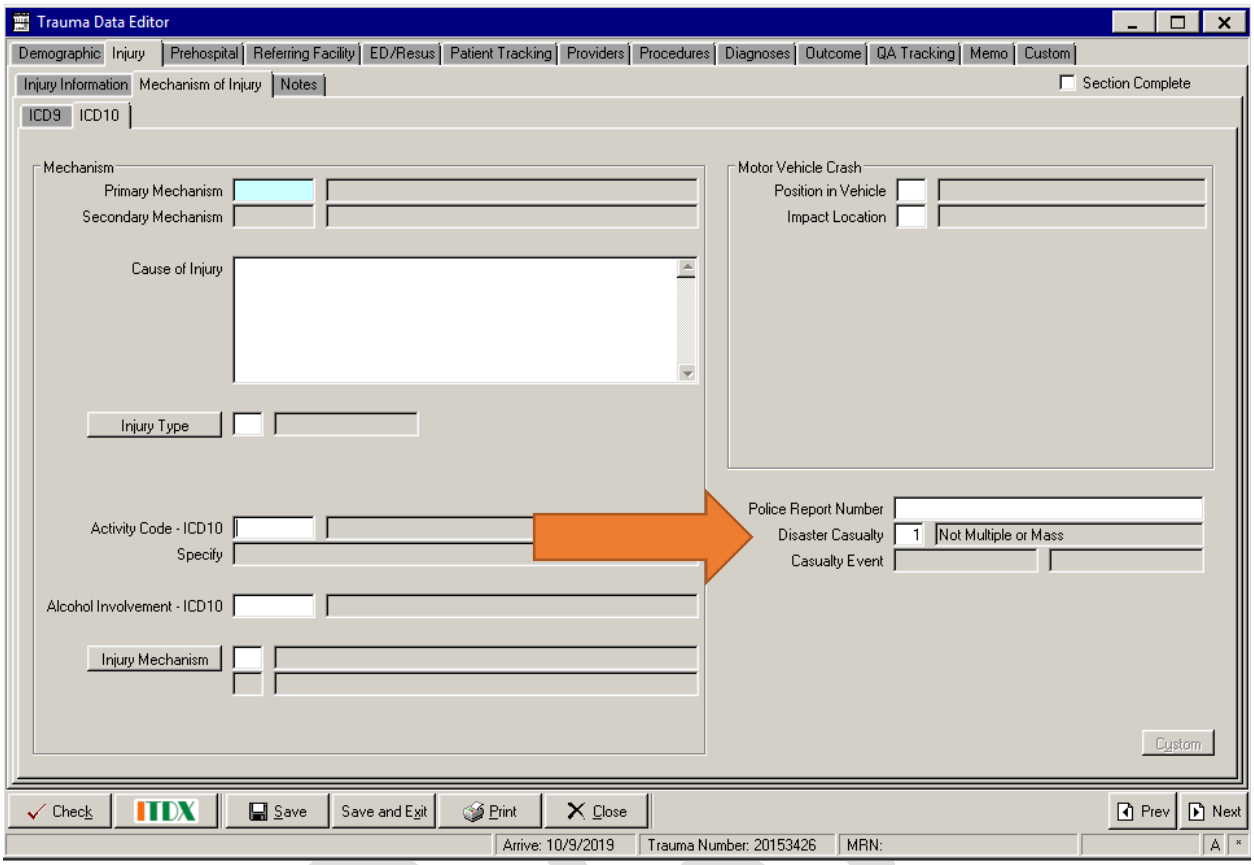

Disaster Casualty

Definition

Denotes if the patient is injured due to a multiple or mass causality event

Element Values

1. Not Multiple or Mass
2. Multiple
3. Mass

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report
2. H&P
3. Triage Flowsheet
4. Trauma Flowsheet
5. ED Nursing Note
6. Progress Notes

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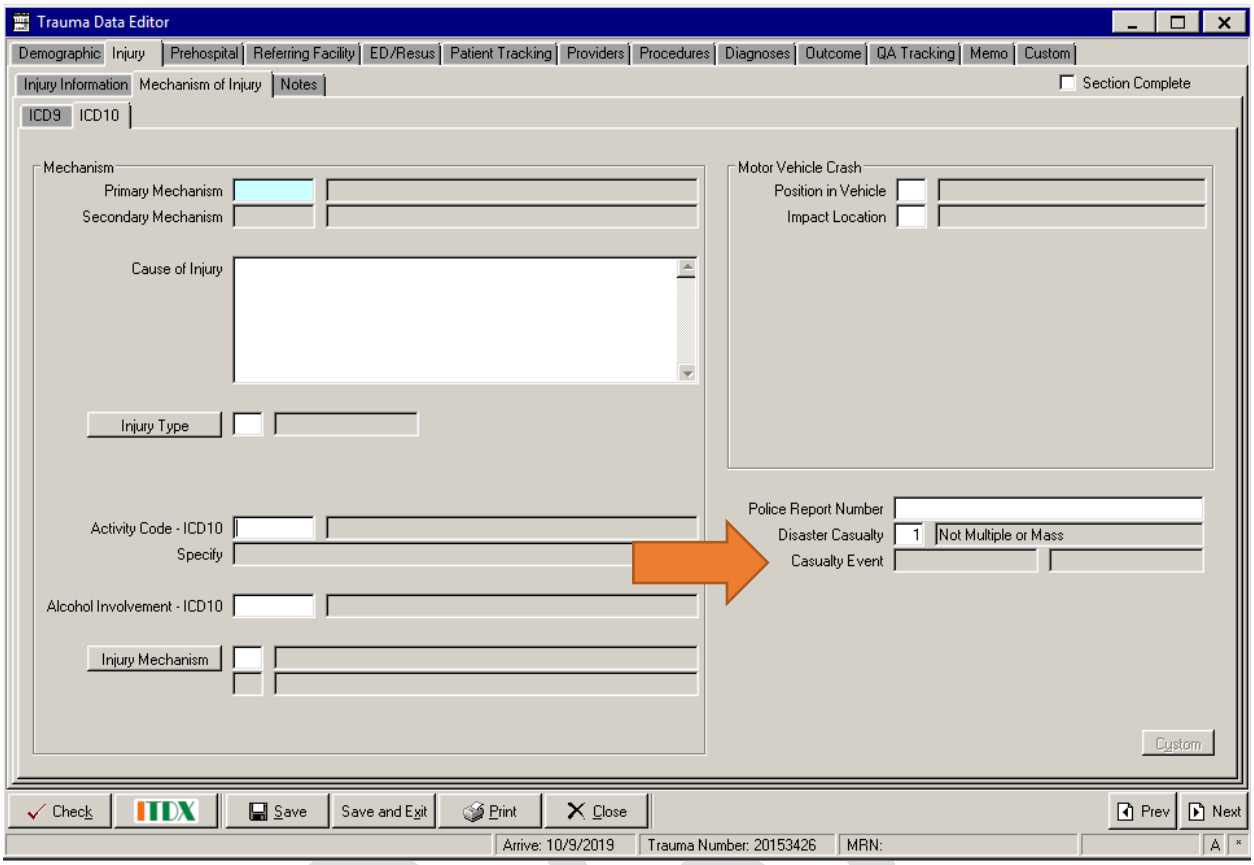

Casualty Event

Definition

Name of the Mass Casualty or Disaster event.

Element Values

- Relevant values for data element

Data Source Hierarchy Guide

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

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Prehospital Information

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

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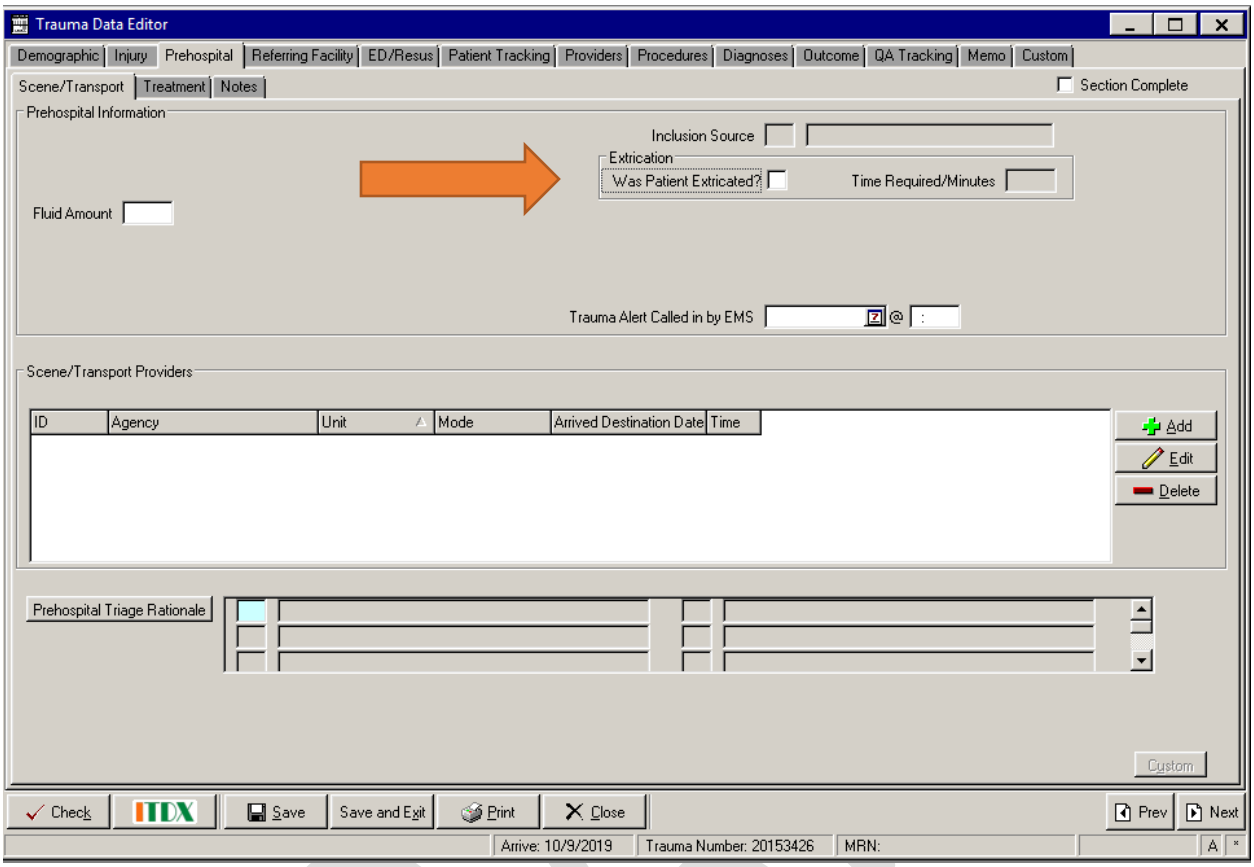


Extrication

Definition

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

Data Elements

Was Patient Extricated?

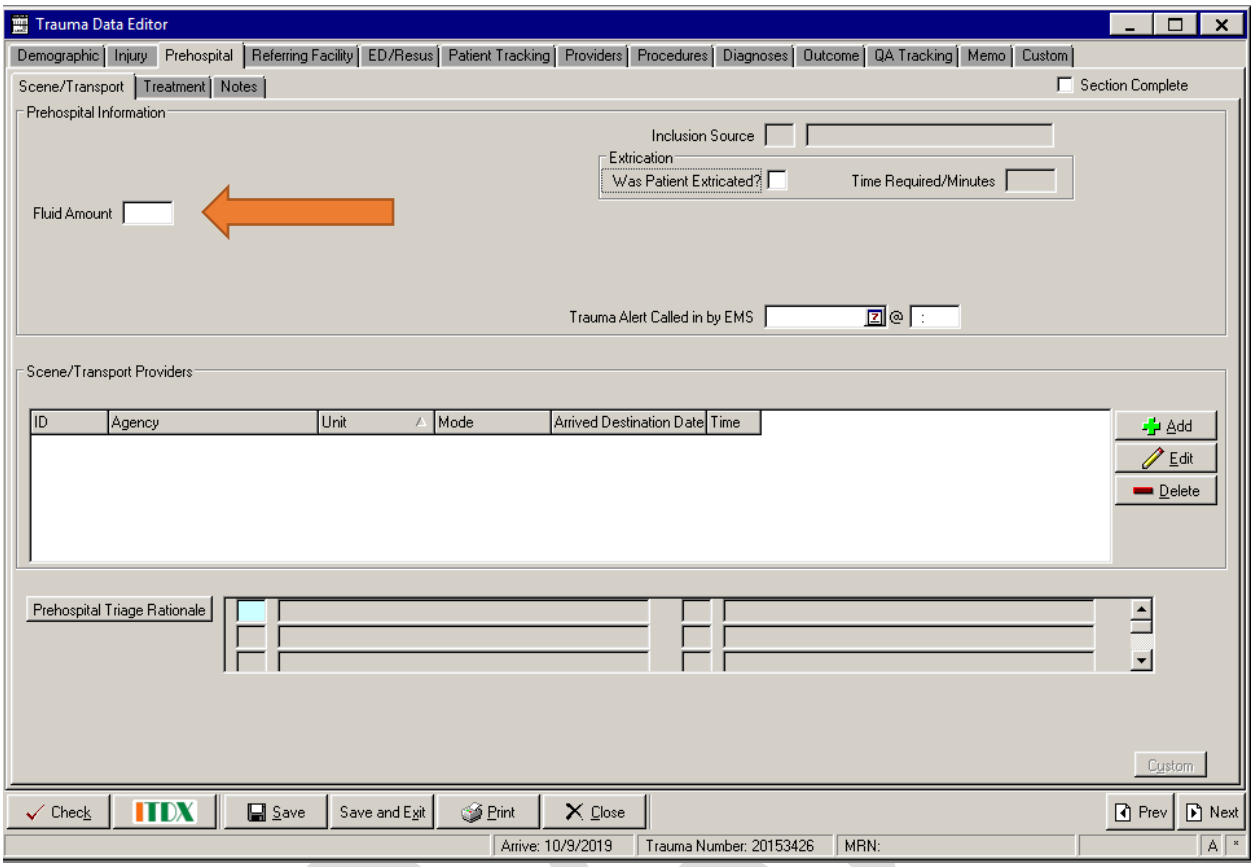
- Yes
- No
- N/A – Not Applicable
- ? – Unknown

Time Required/Minutes

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report



Fluid Amount

Definition

The amount of fluid given prehospital before arriving to your facility

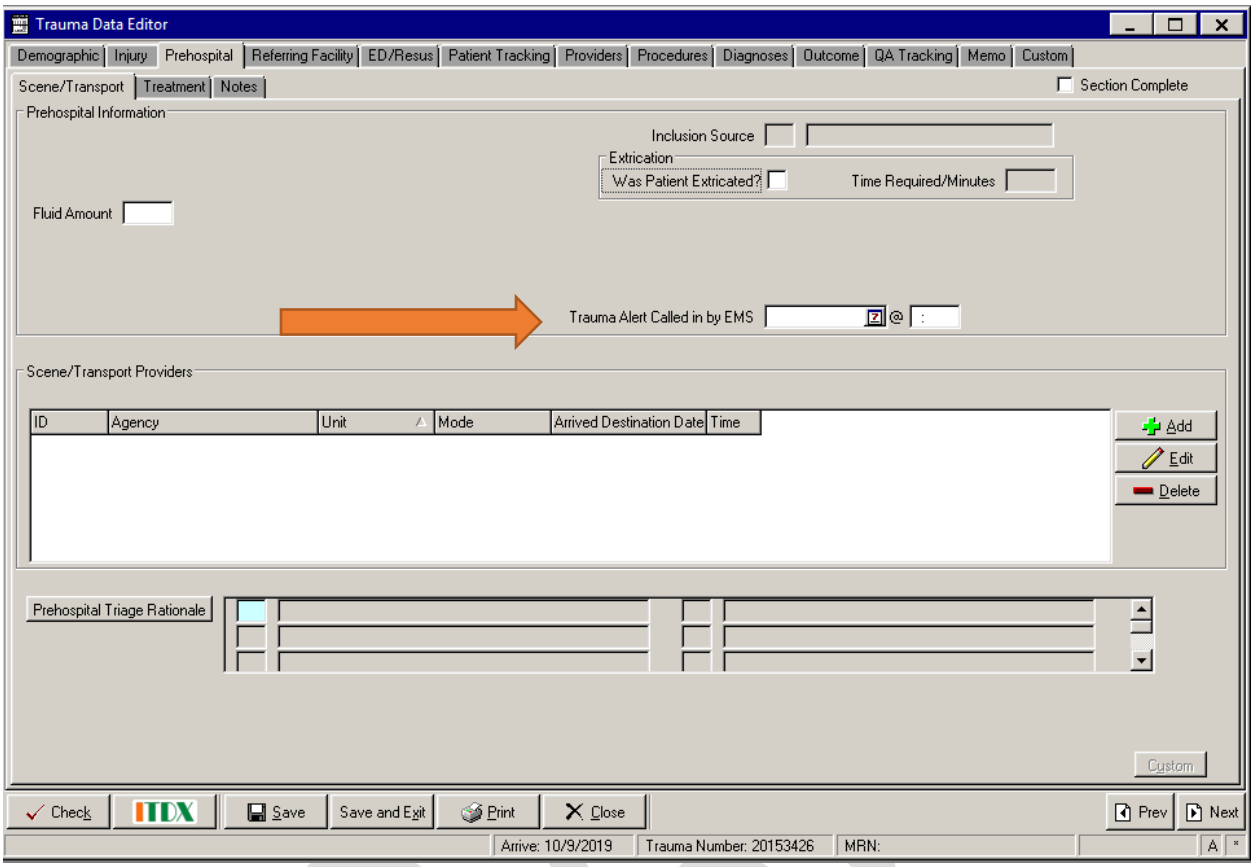
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Trauma Alert Called in by EMS

Definition

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

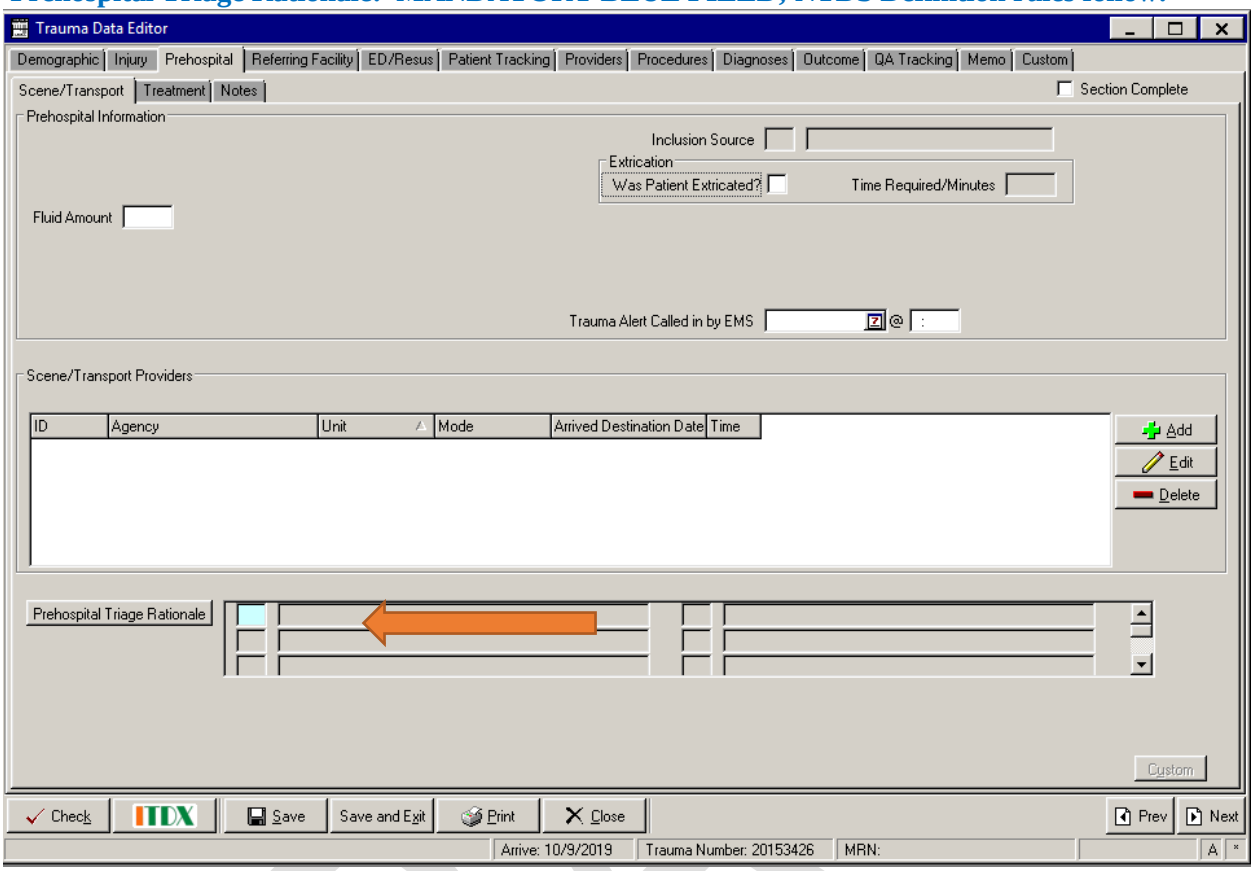
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

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



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

NOTE: MUST BE FOUND ON THE EMS RUN SHEET. Cannot be inferred from other team member reports for the Pre-Hospital section.

TRAUMA TRIAGE CRITERIA (Steps 1 and 2)

Definition

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

Element Values

1. Glasgow Coma Score <= 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 ventilatory 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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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

TRAUMA TRIAGE CRITERIA (Steps 3 and 4)

Definition

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

Element Values

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

Additional Information

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

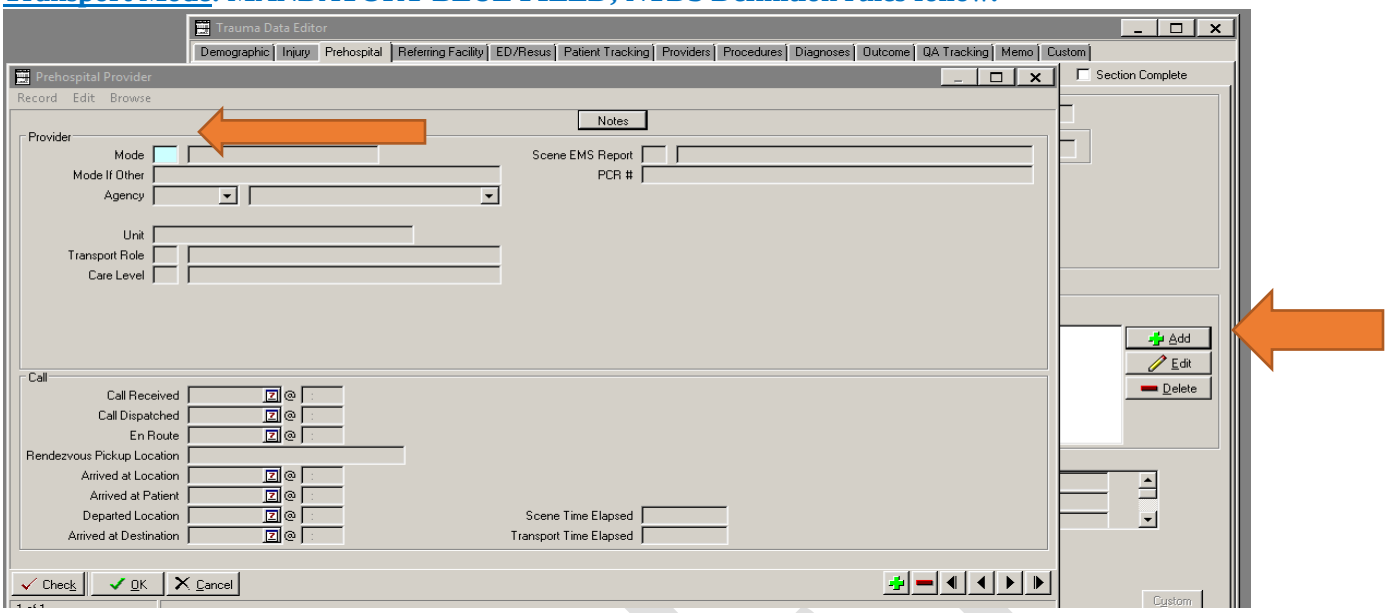
Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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

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



TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Element Values

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

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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

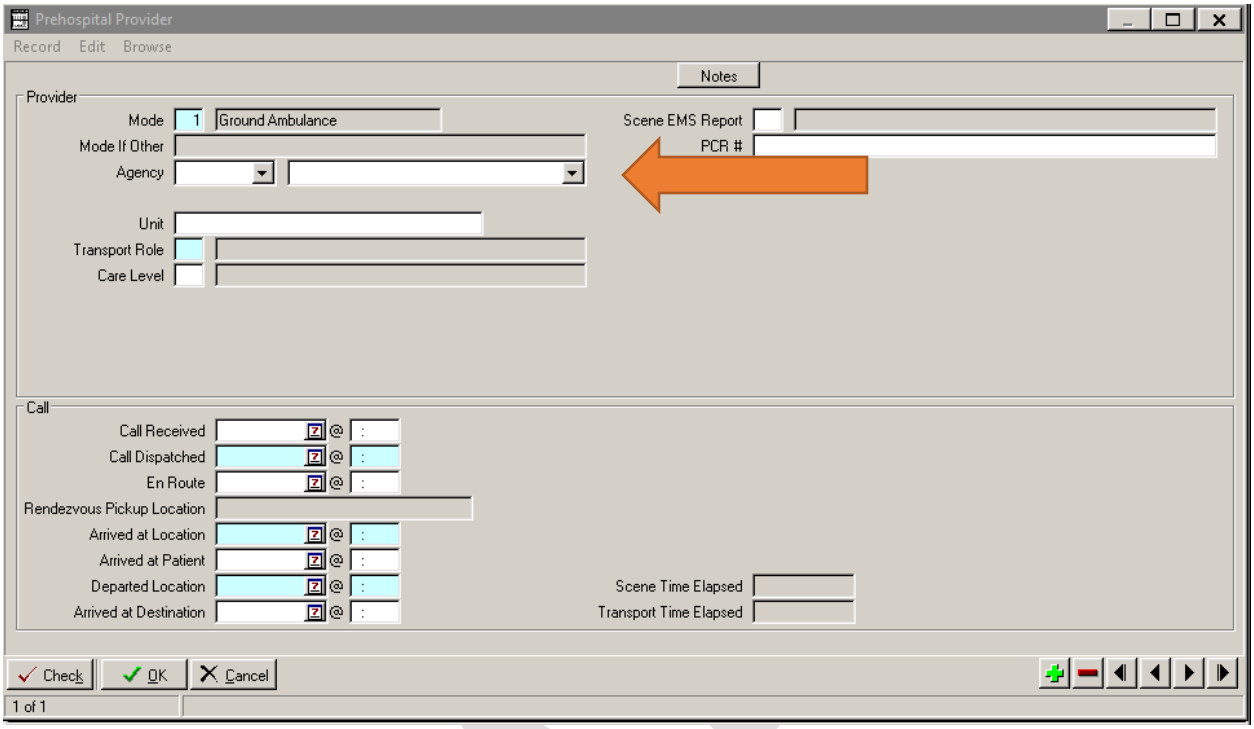
NOTE: (#8 in DI) should be entered if the patient was not directly transported to your facility from the scene of injury. Entering that will open the 'Mode if Other' dialogue boxes to enter details of the scene to initial hospital transport. The details of that inter-agency transport will then be collected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

DI Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing Ambulance
4. Private Vehicle or Walk-in
5. Police
6. Public Safety
7. Water Ambulance
8. Other

/. Not Applicable

?. Unknown



Agency

Definition

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

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

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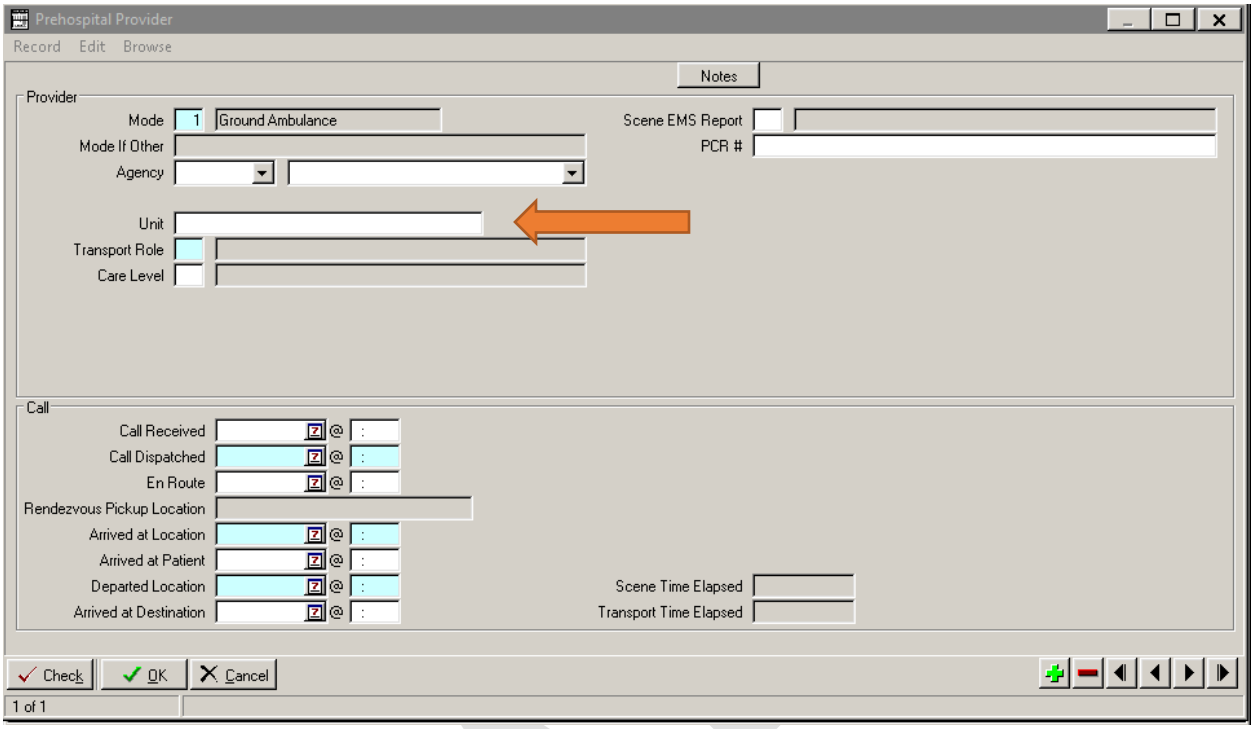


Unit

Definition

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

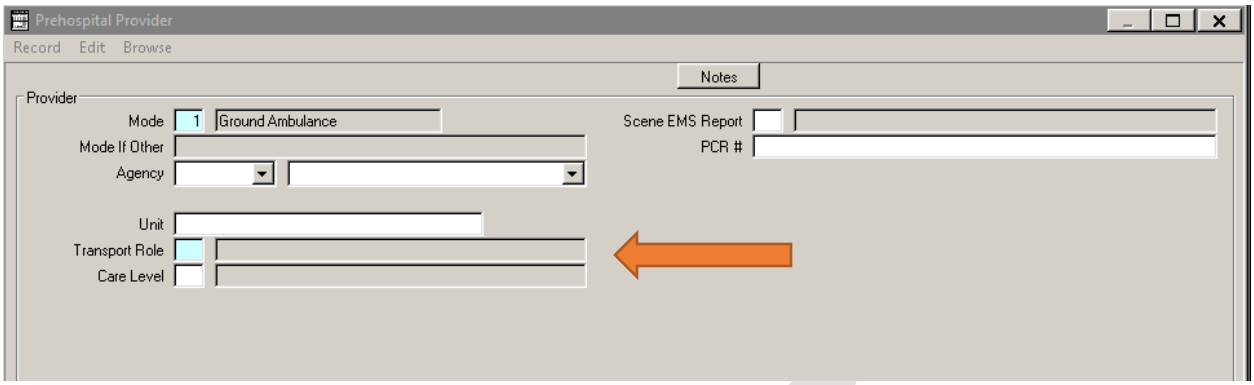
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



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

OTHER TRANSPORT MODE

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

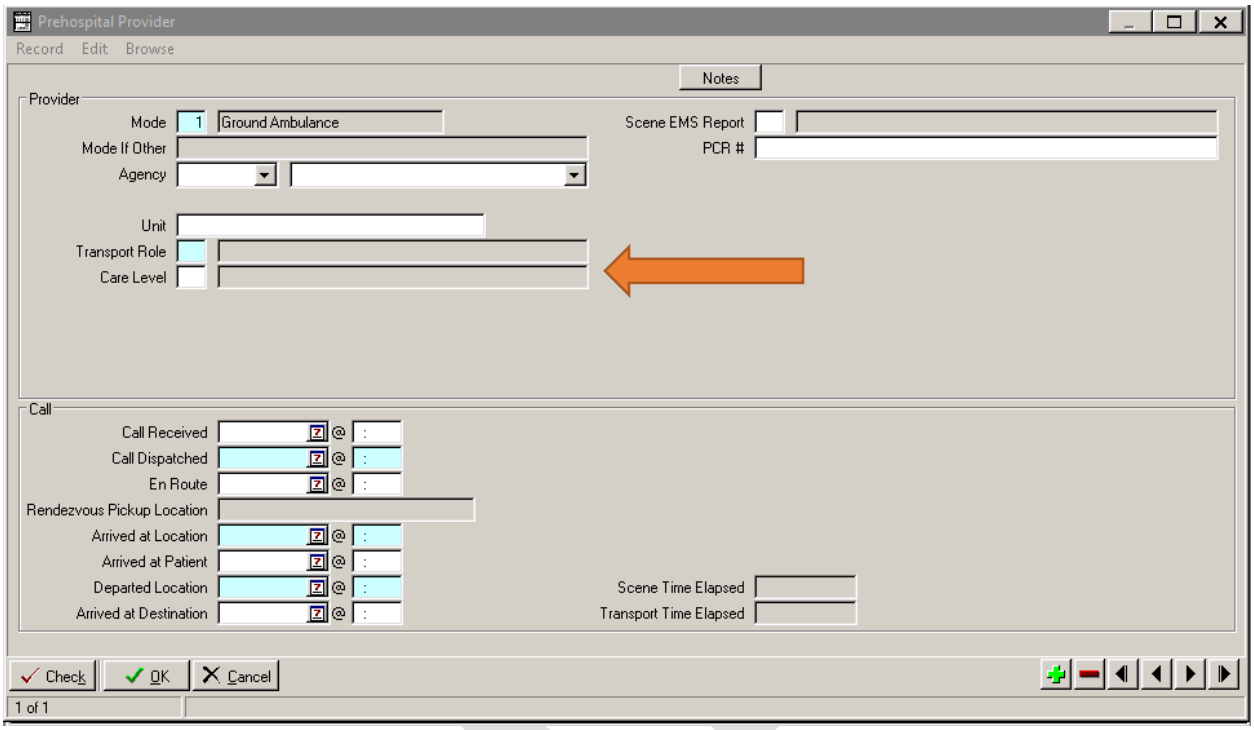
Rule ID	Level	Message
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3550	1	Multiple Entry Max exceeded

DI Data Elements

1. Non-Transport
2. Transport from Scene to Facility
3. Transport from Scene to Rendezvous
4. Transport from Rendezvous to Facility
5. Transport to Other
6. Transport from Non-Scene Location

/. Not Applicable

?. Unknown



Care Level

Definition

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

Element Values

1. Advanced Life Support
2. Basic Life Support

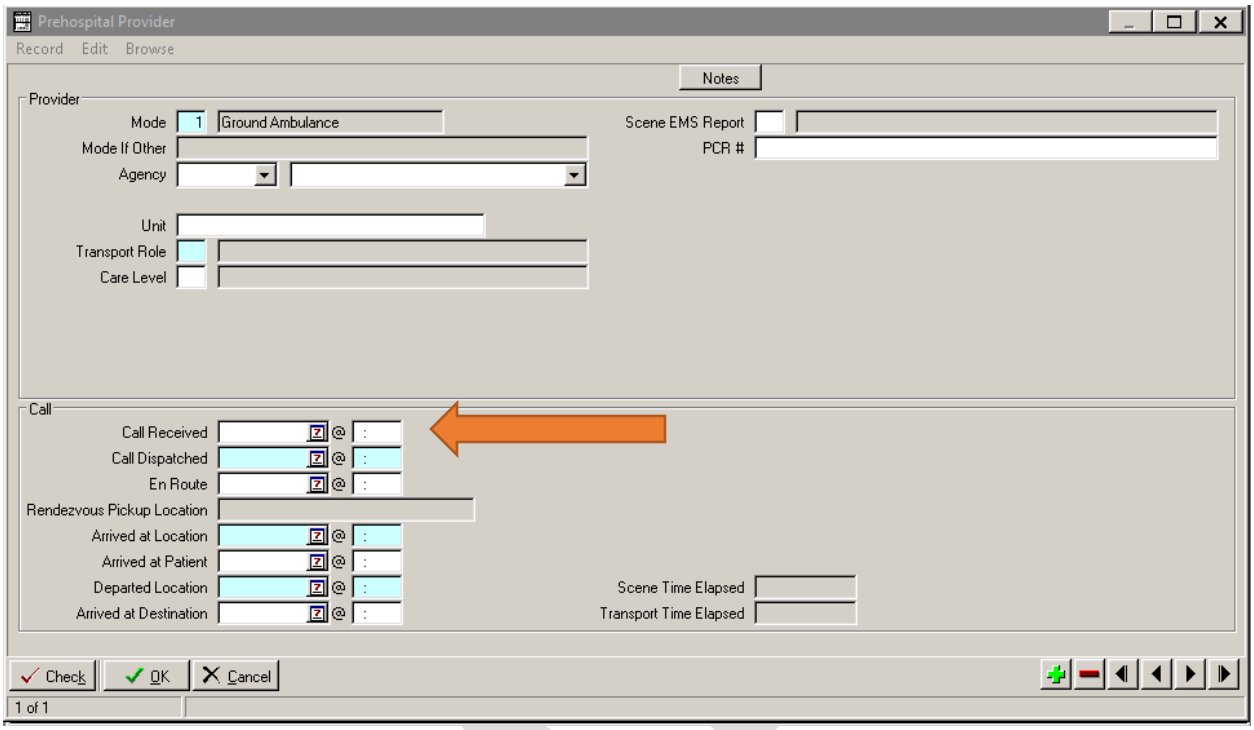
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Call Received Date and Time

Definition

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

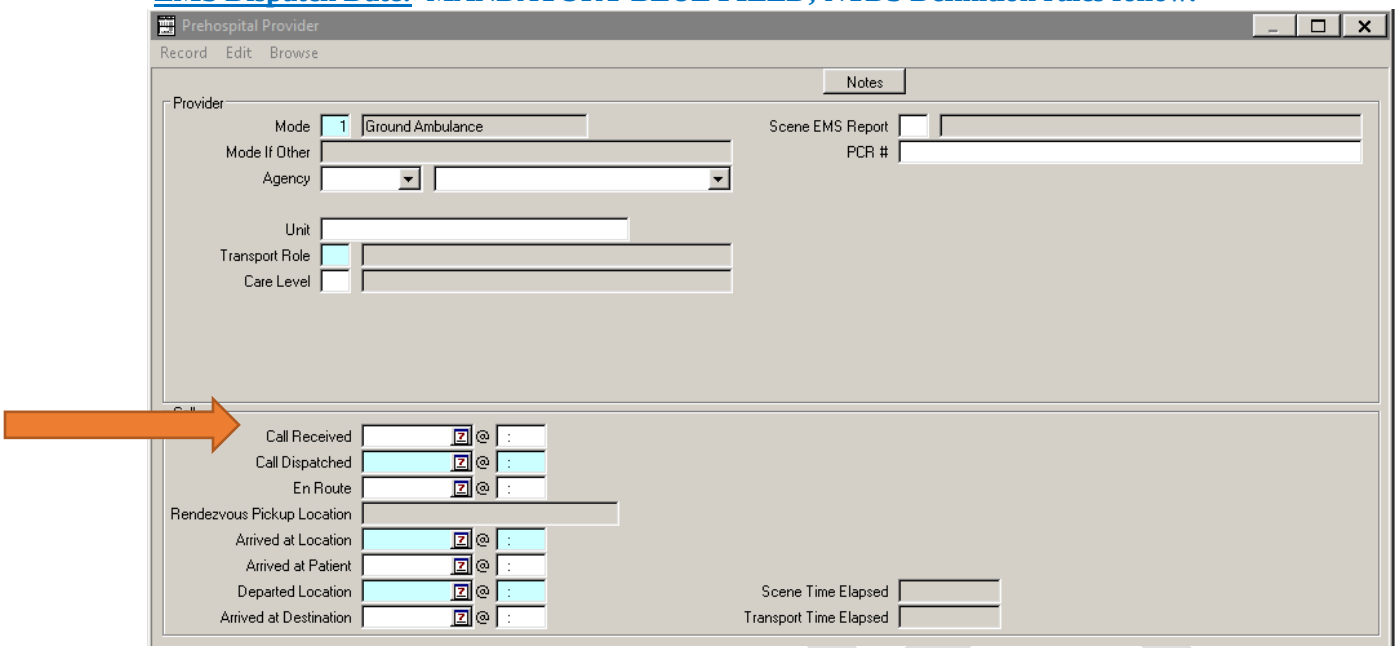
Data Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

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



EMS DISPATCH DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

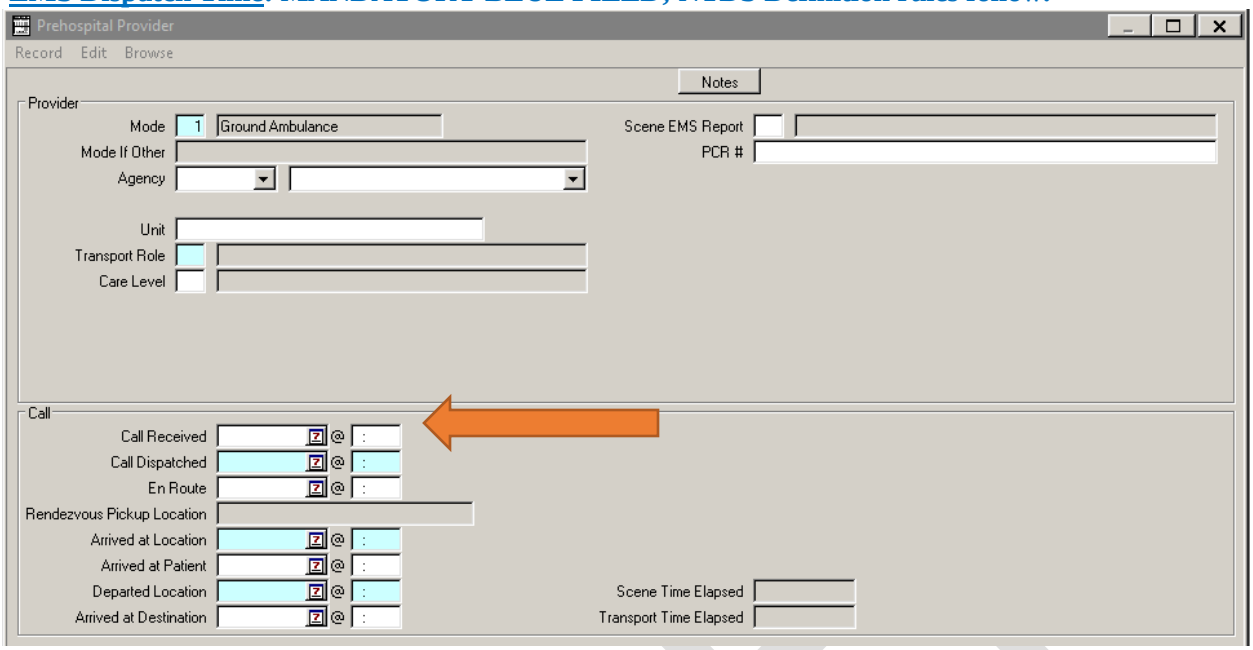
Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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

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



EMS DISPATCH TIME

Definition

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

Element Values

- Relevant value for data element

Additional Information

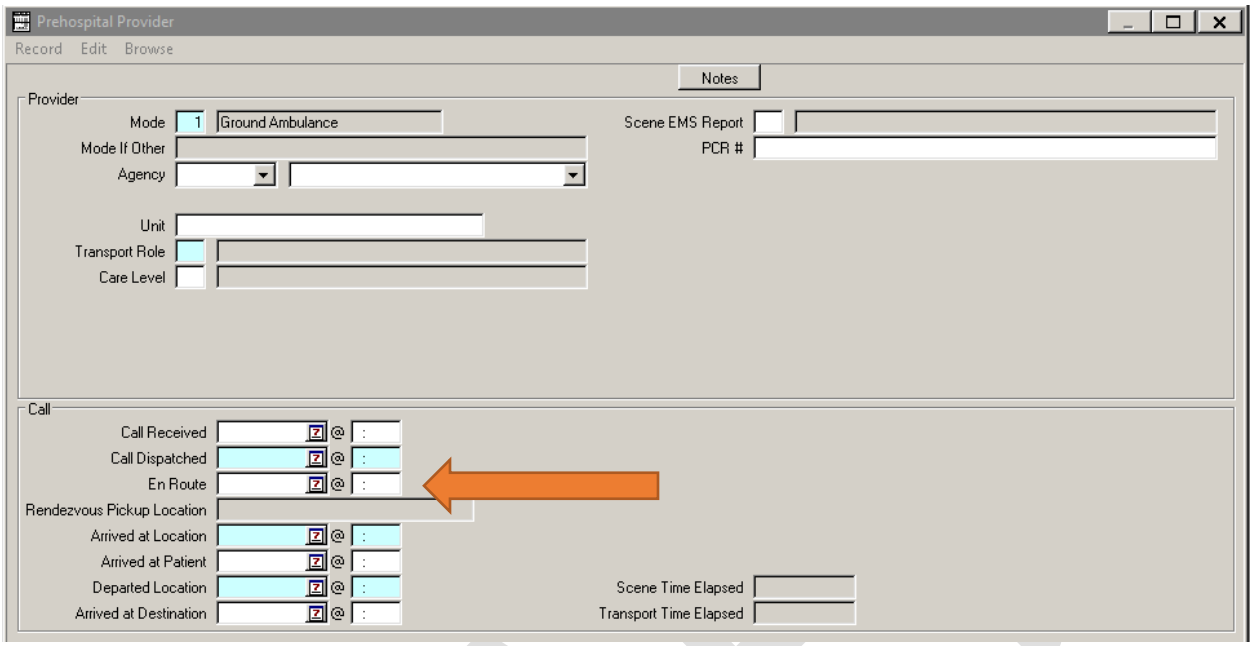
- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



En-Route Date and Time

Definition

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

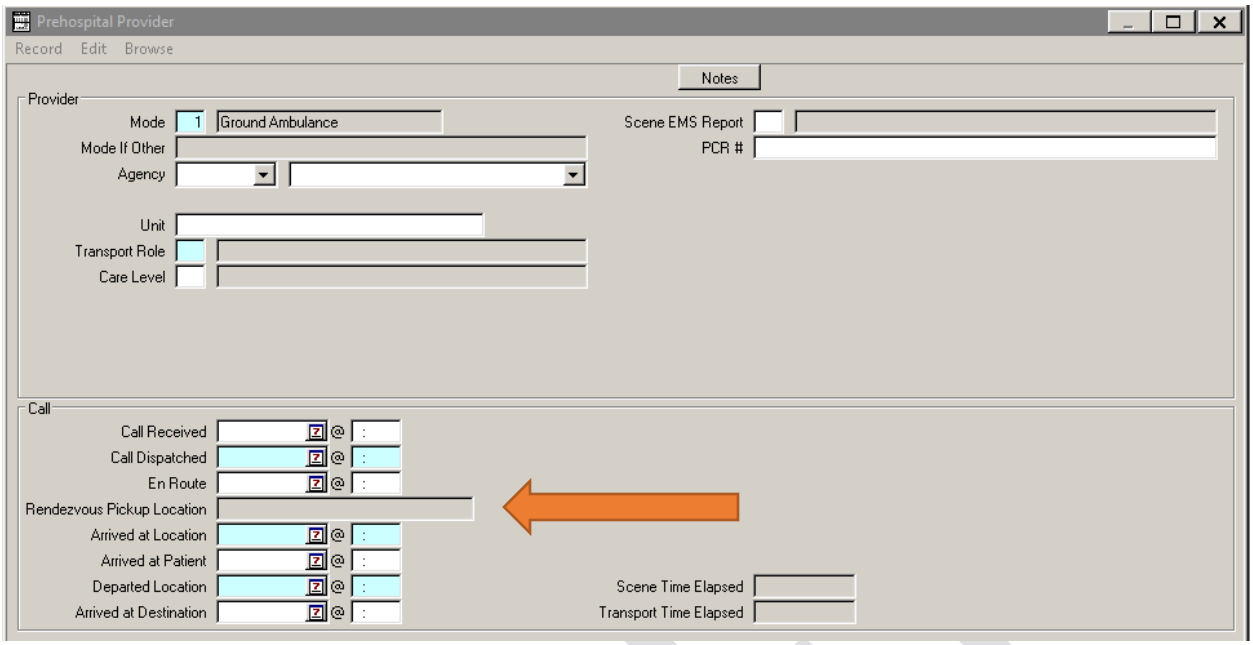
Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Rendezvous Pickup Location

Definition

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

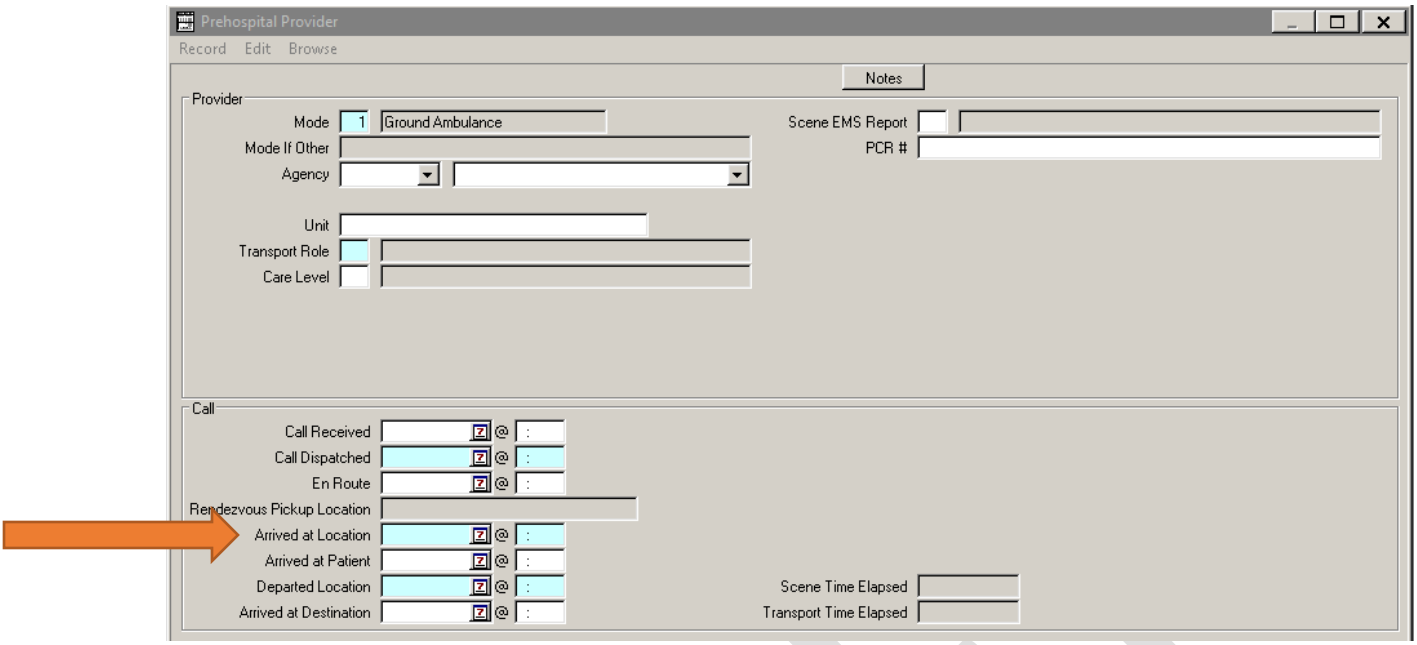
Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

- Relevant value for data element

Additional Information

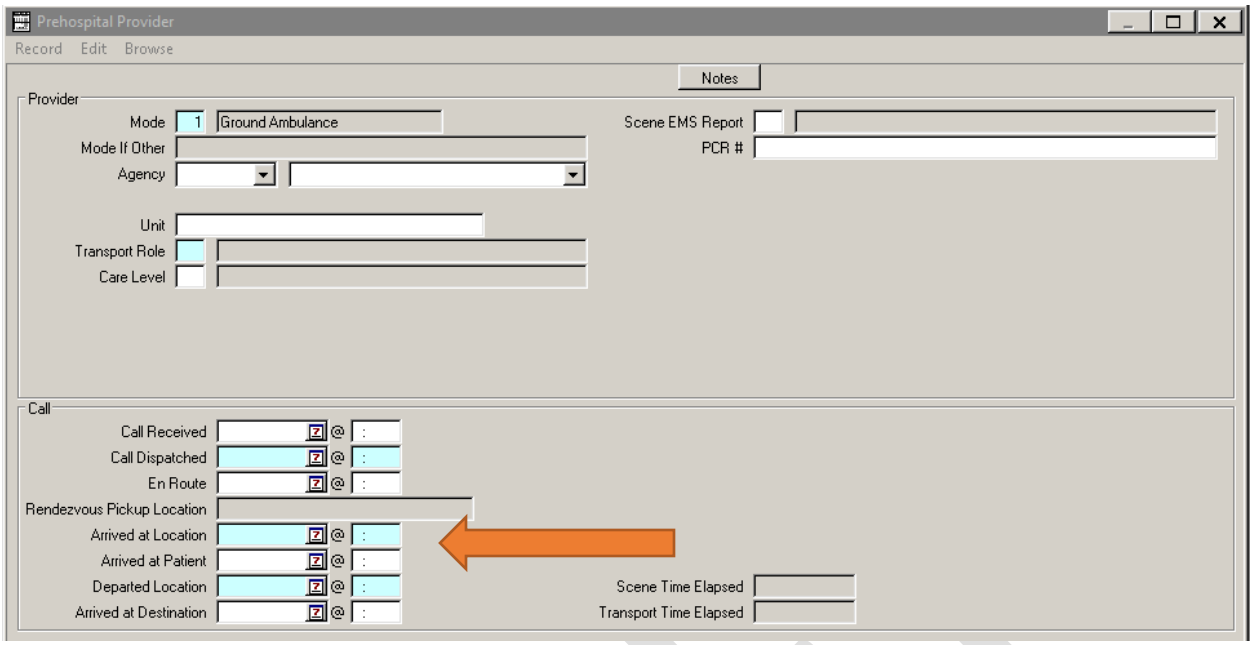
- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

- Relevant value for data element

Additional Information

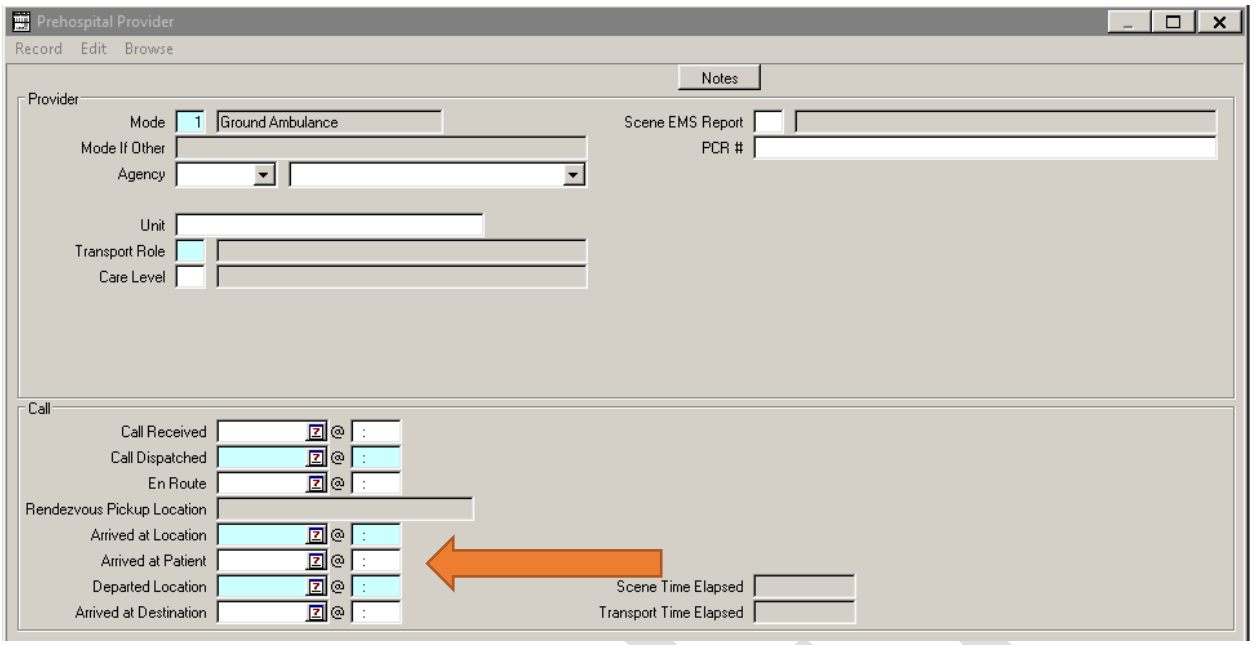
- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



Arrived at Patient Date and Time

Definition

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

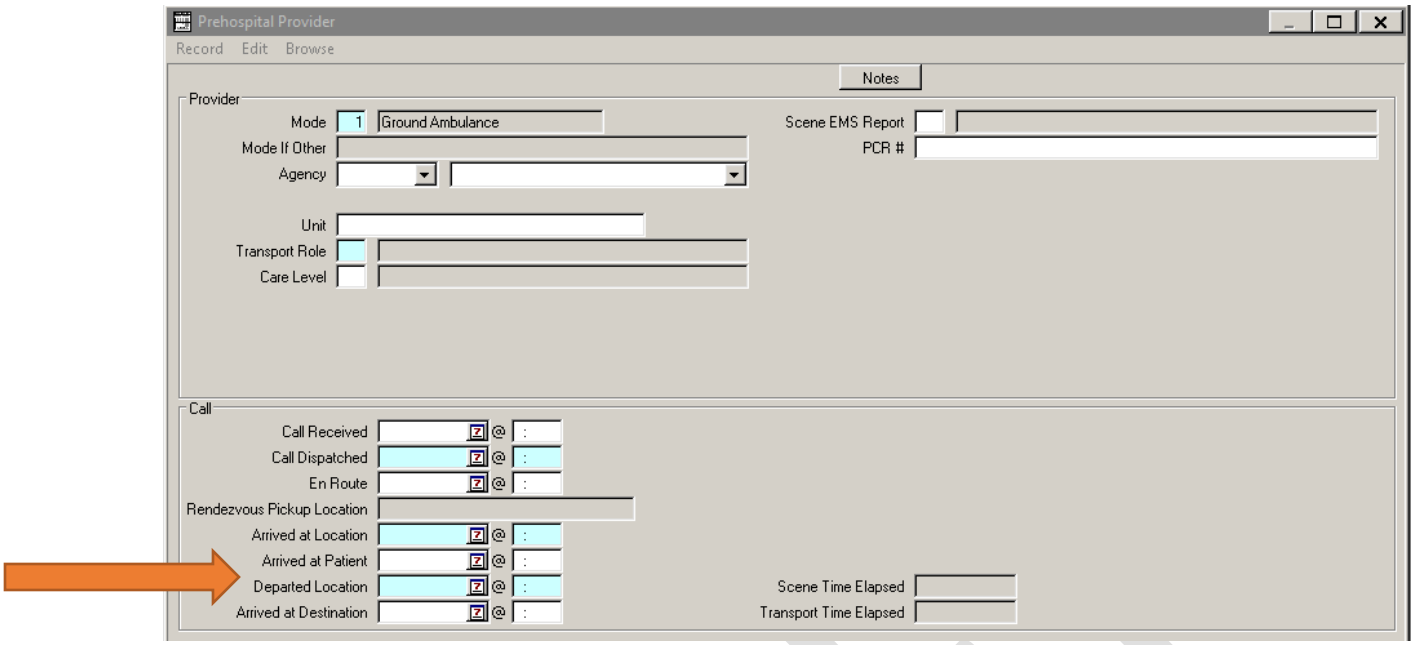
Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

- Relevant value for data element

Additional Information

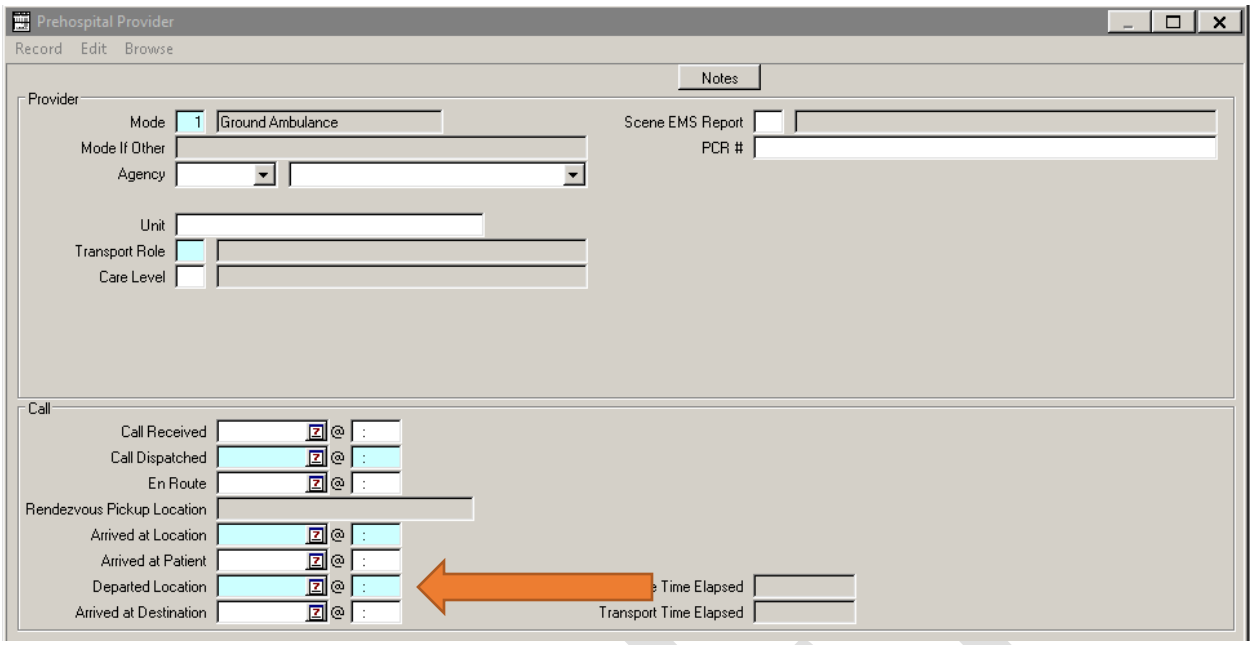
- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

- Relevant value for data element

Additional Information

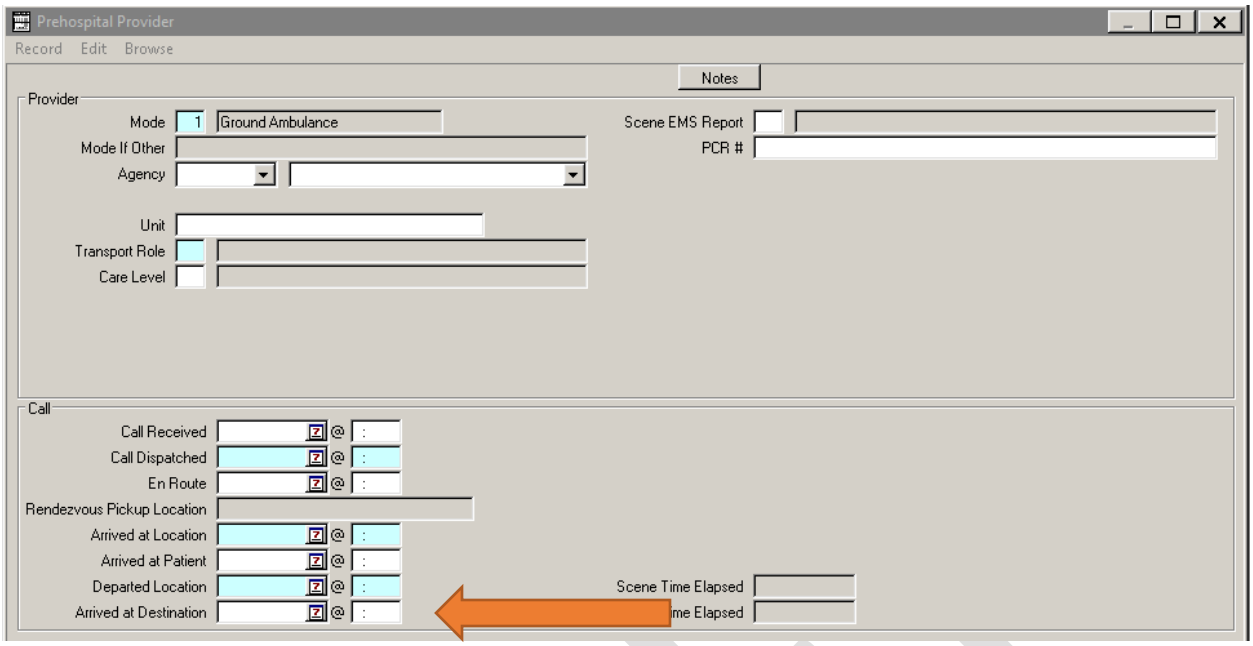
- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



Arrived at Destination Date and Time

Definition

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

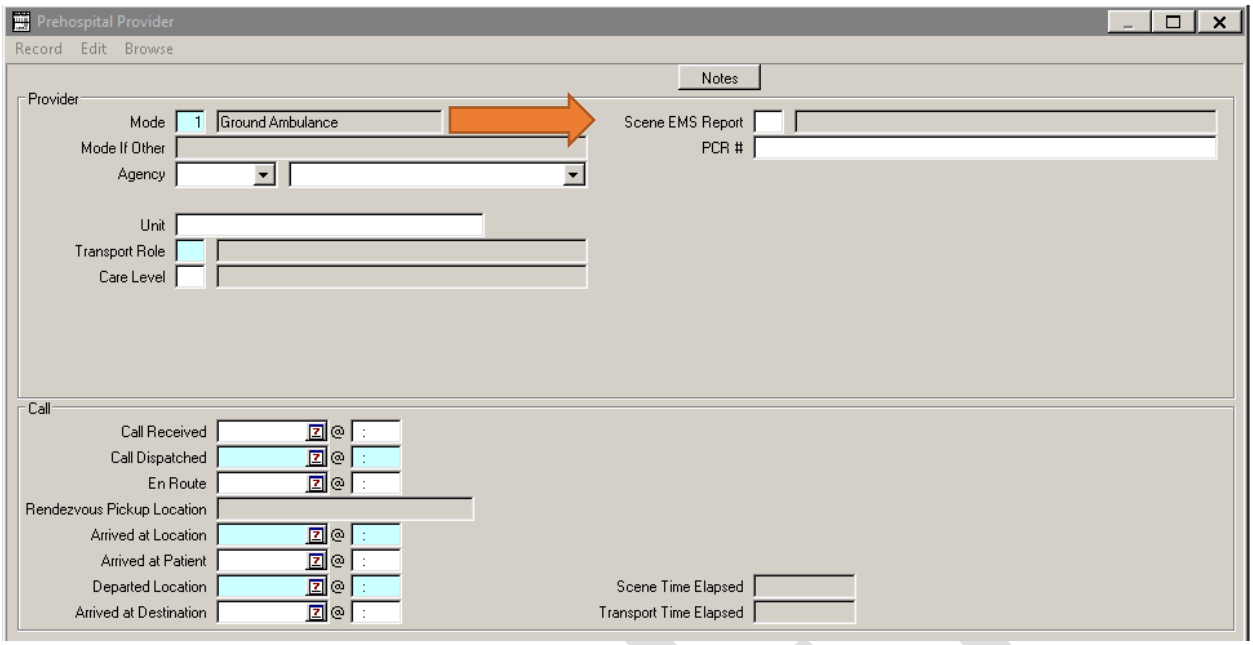
Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Scene EMS Report

Definition

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

Element Values

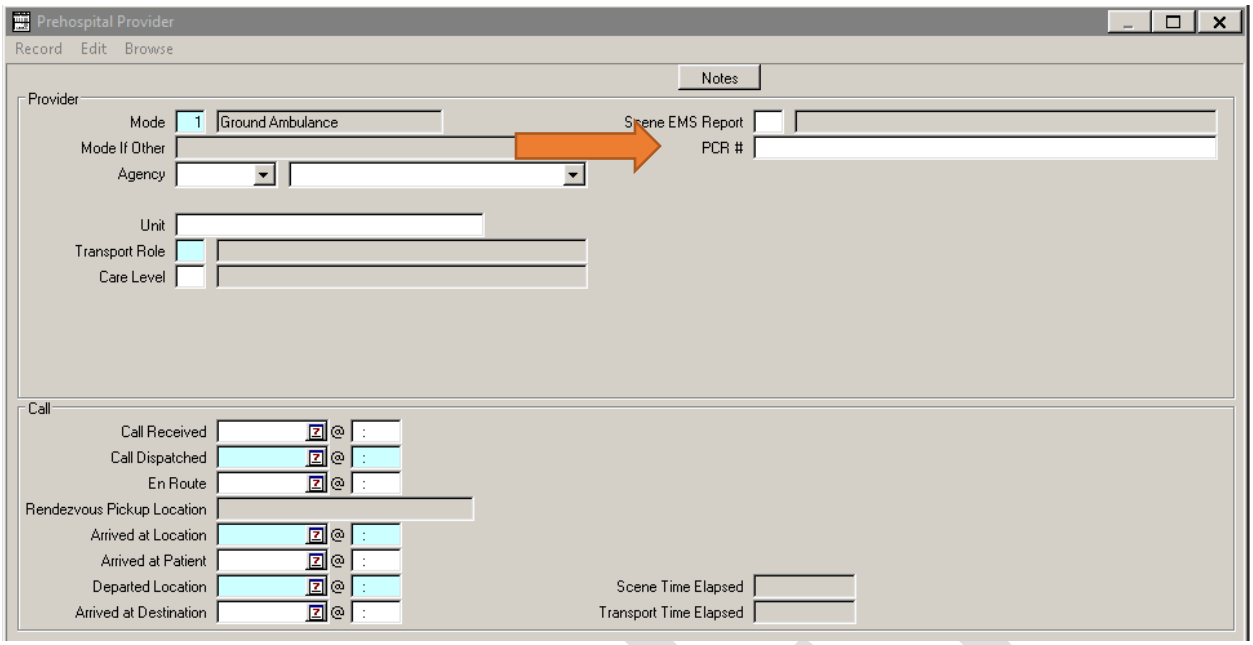
1. Complete
2. Incomplete
3. Missing
4. Unreadable

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report
2. Media or Scanned Documents

DRAFT



PCR Number

Definition

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

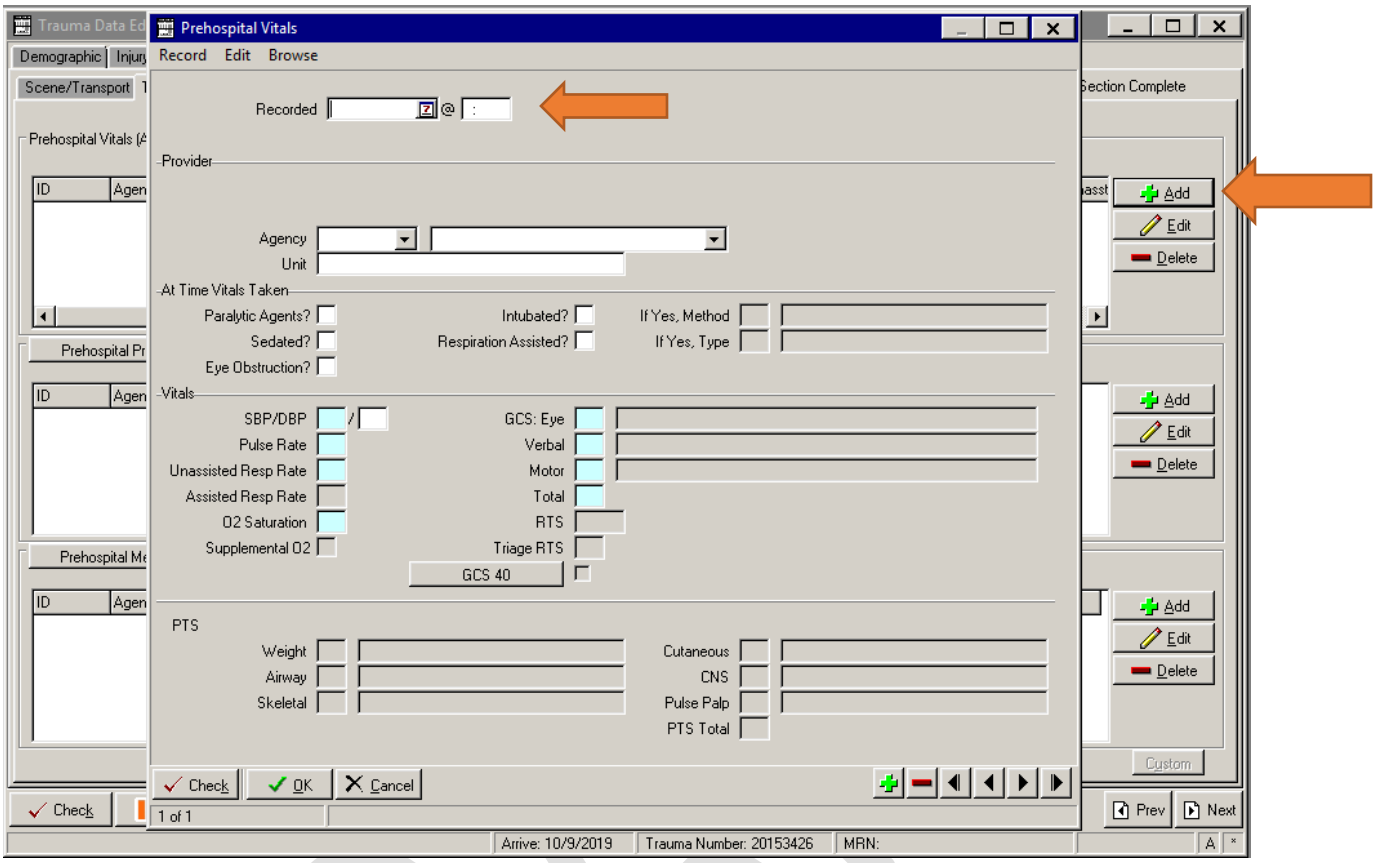
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Prehospital Vitals Date and Time Recorded

Definition

The date and time that the prehospital vitals were obtained.

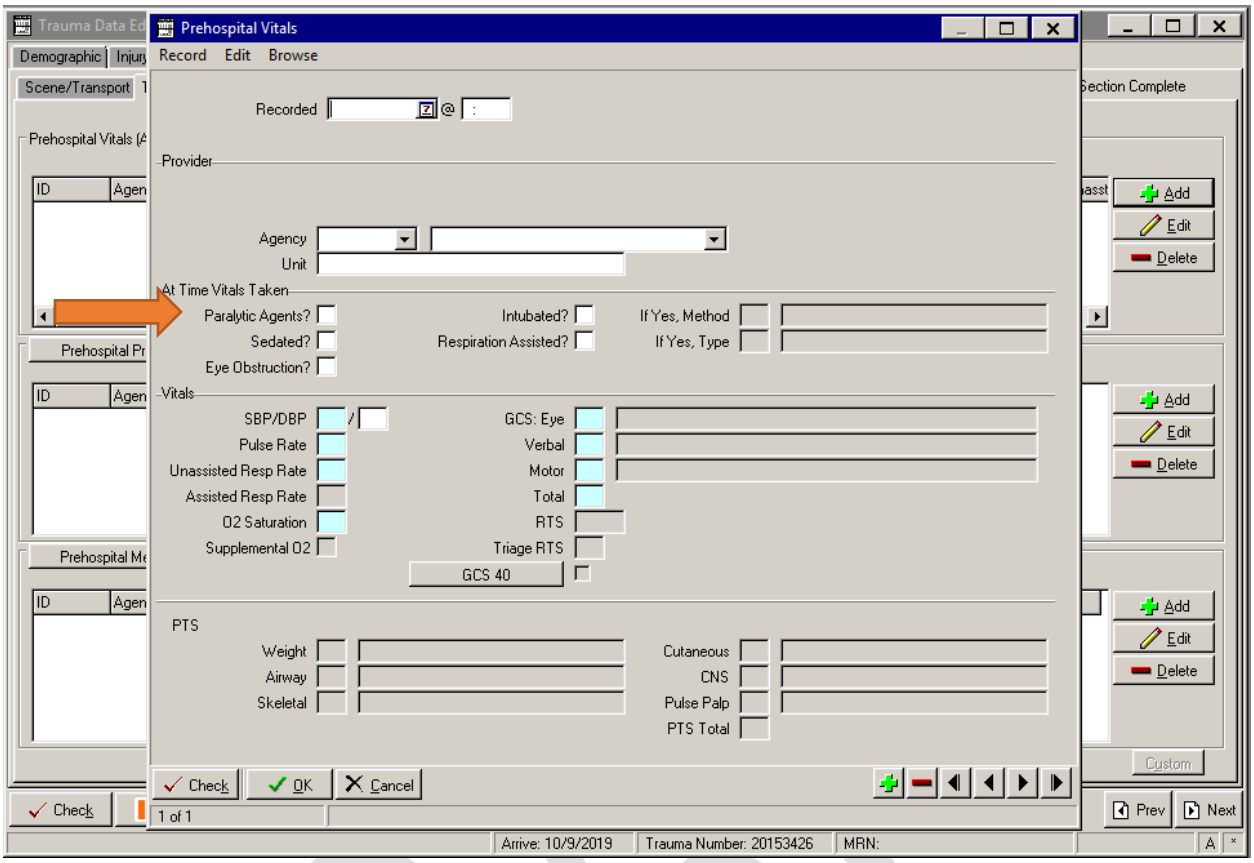
Element Values

- Relevant Values for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Paralytic Agents

Definition

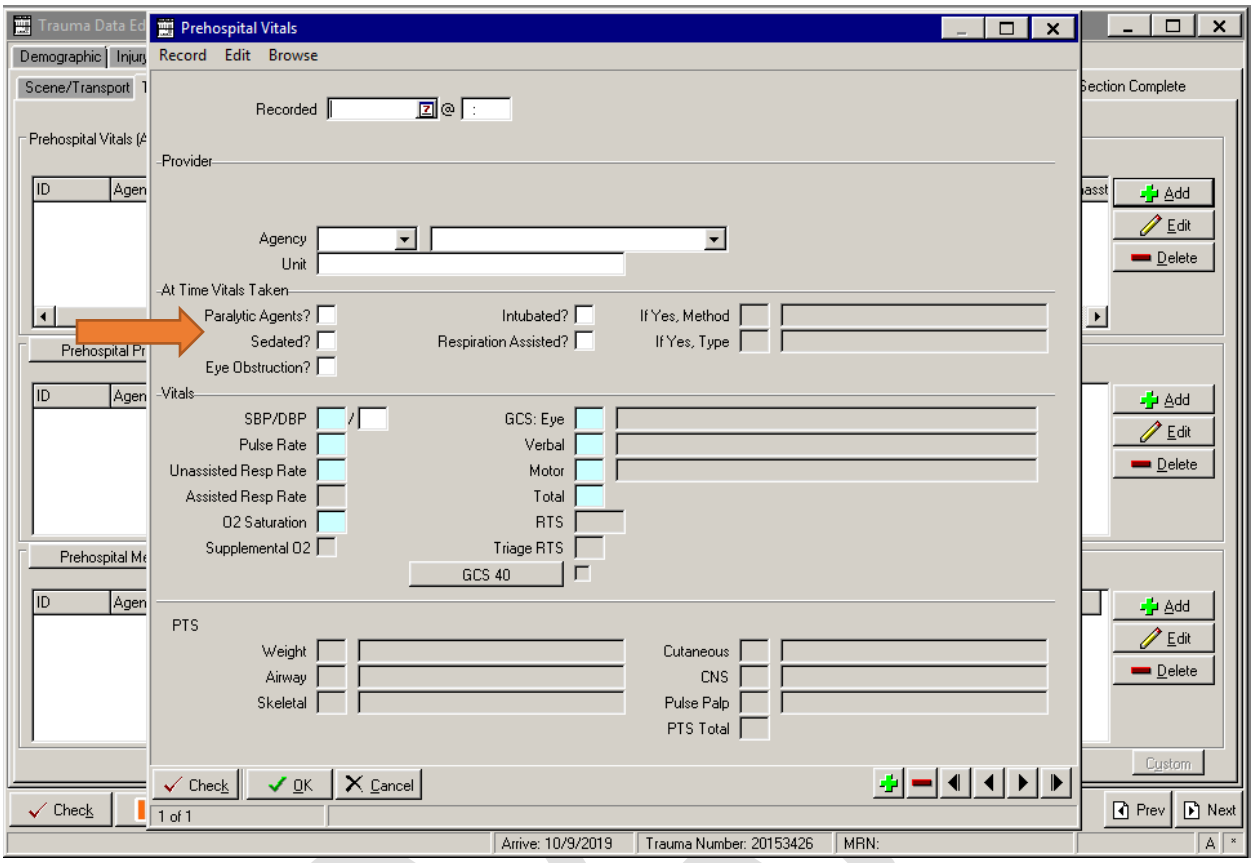
Patient was given paralytic agents prior to vitals being obtained and within their duration of effect.

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Sedated

Definition

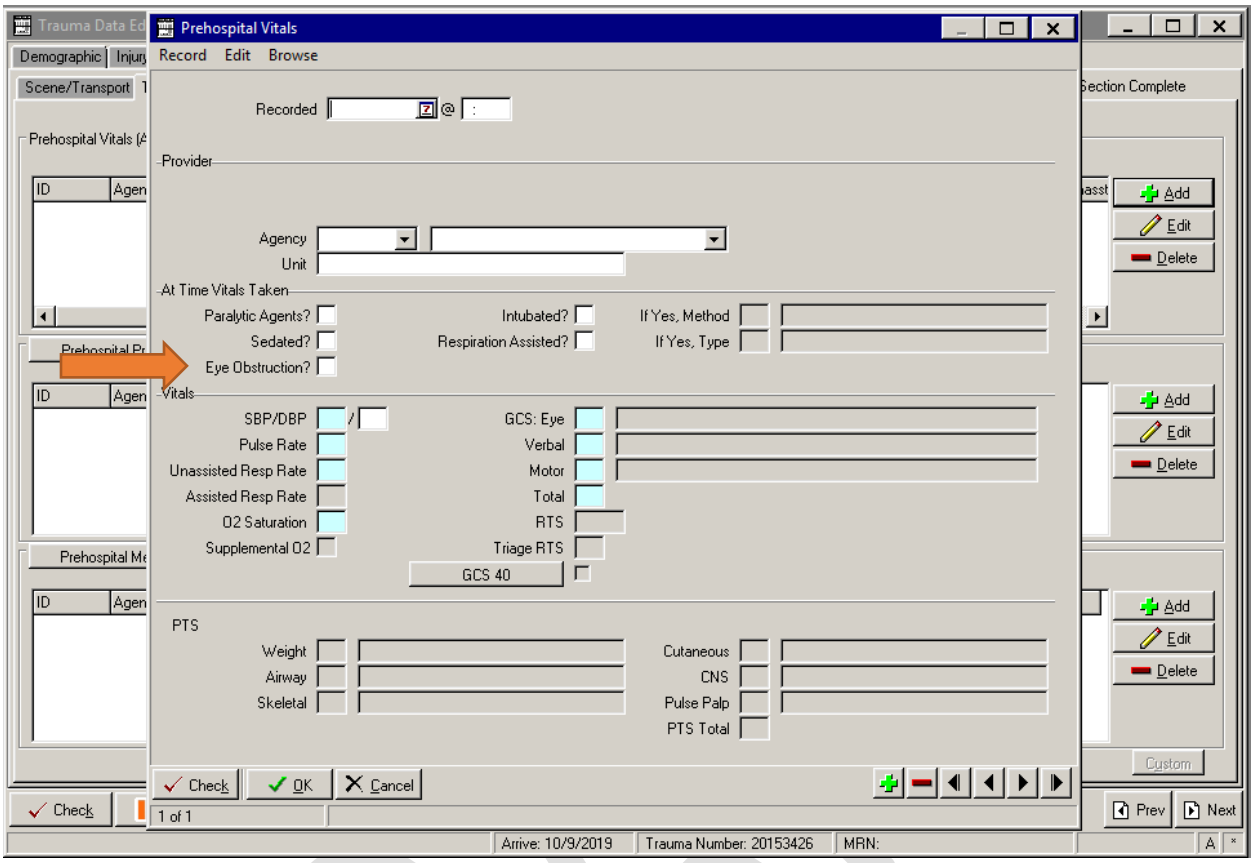
Patient was given sedative agents prior to vitals being obtained and within their duration of effect.

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Eye Obstruction

Definition

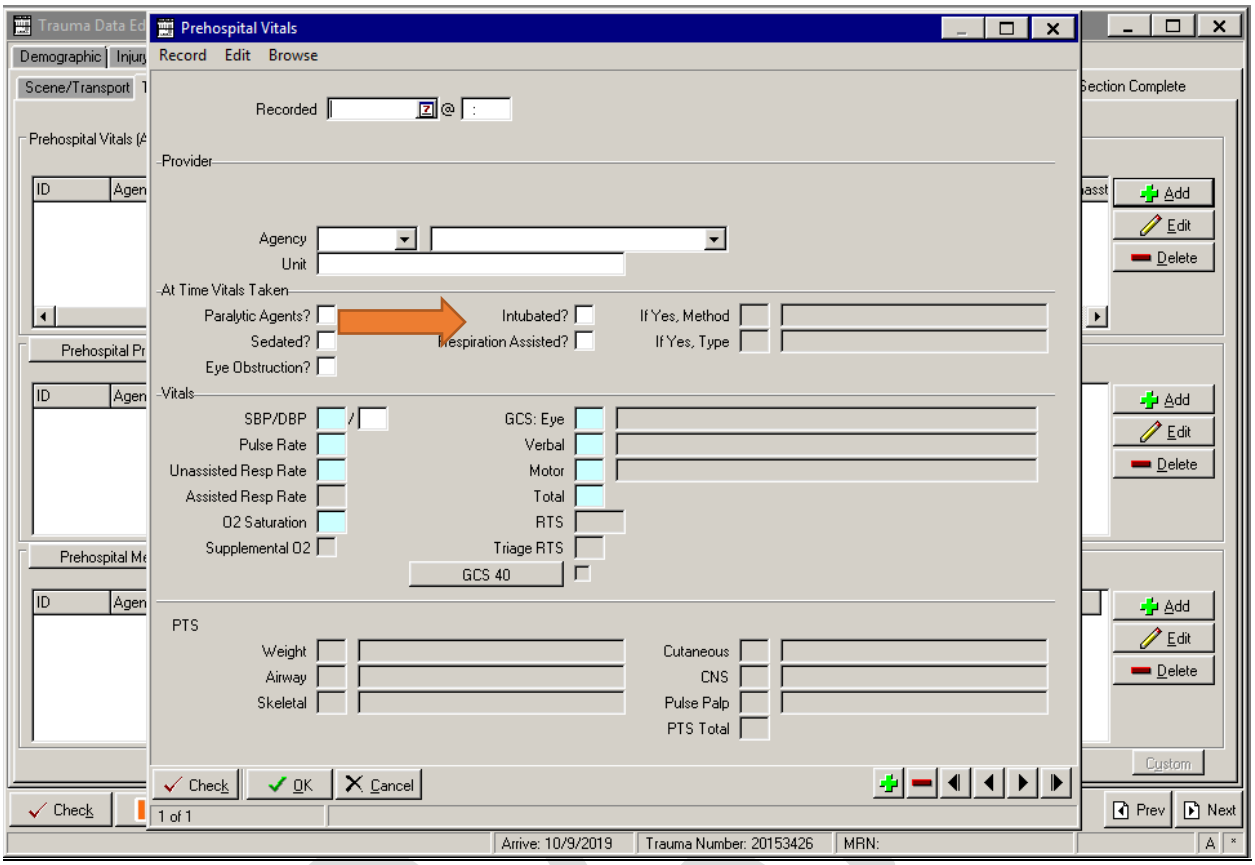
Injury or other condition that causes the patient to be unable to open their eyes or obstructs their vision at the time the vitals were taken.

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Intubated

Definition

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

Element Values

Intubated

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

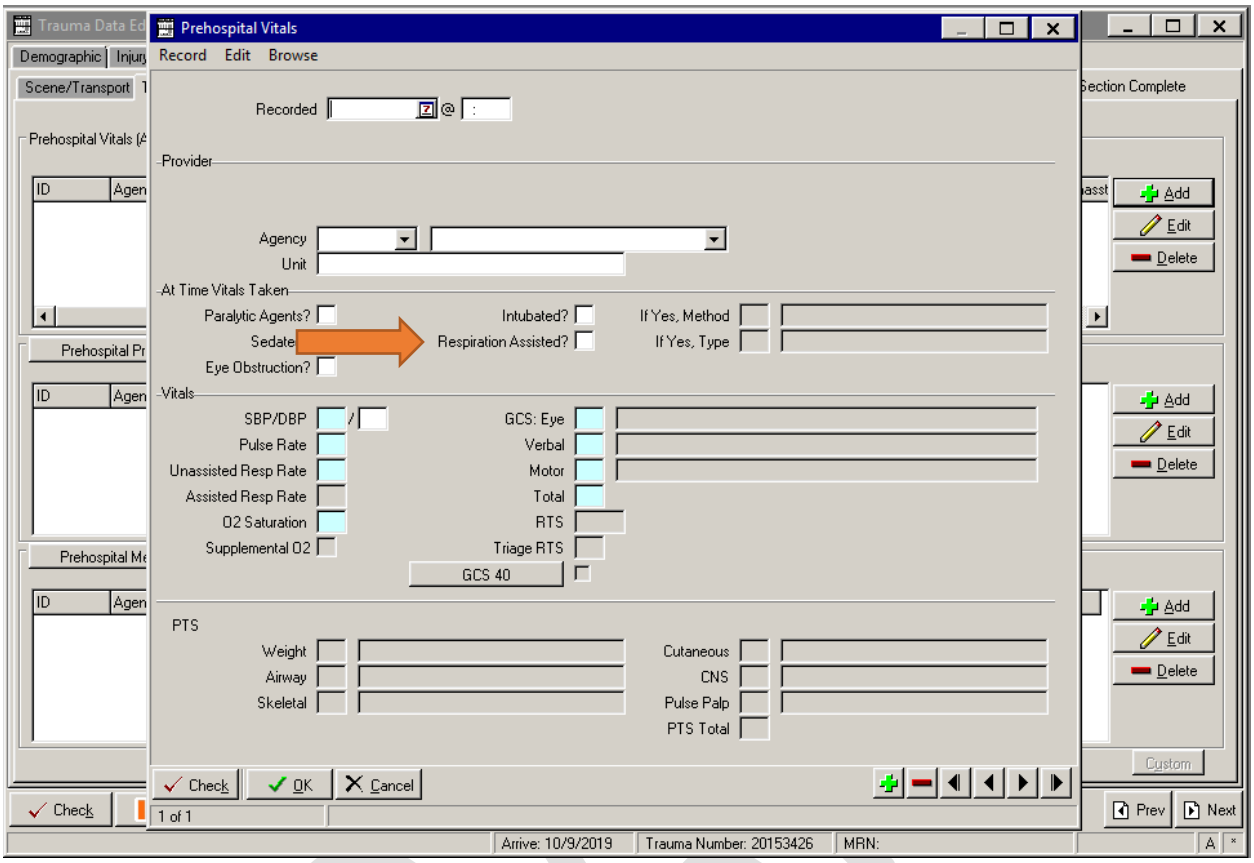
If Yes, Method

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

?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report



Respiration Assisted

Definition

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

Element Values

Respiration Assisted

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

If Yes, Type

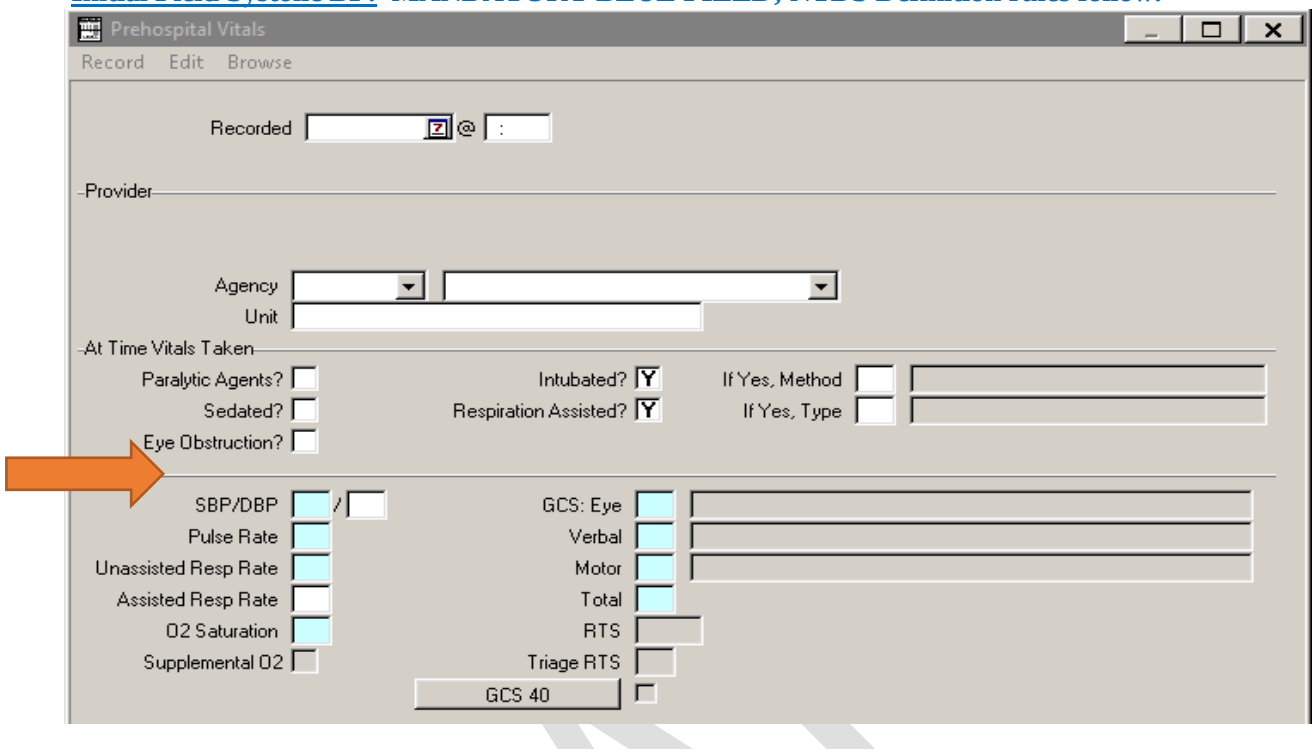
1. Bag Valve Mask
2. Nasal Airway
3. Oral Airway
4. Ventilator

?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report

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



INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

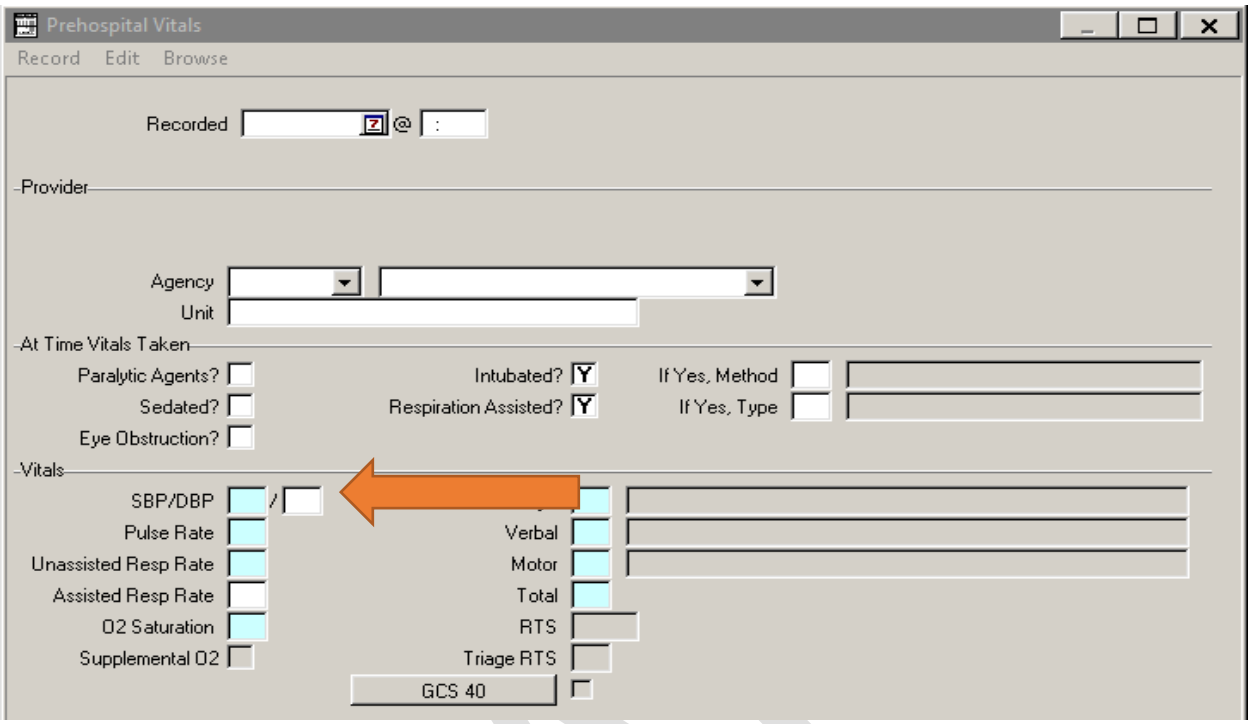
Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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

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



Diastolic Blood Pressure

Definition

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

Element Values

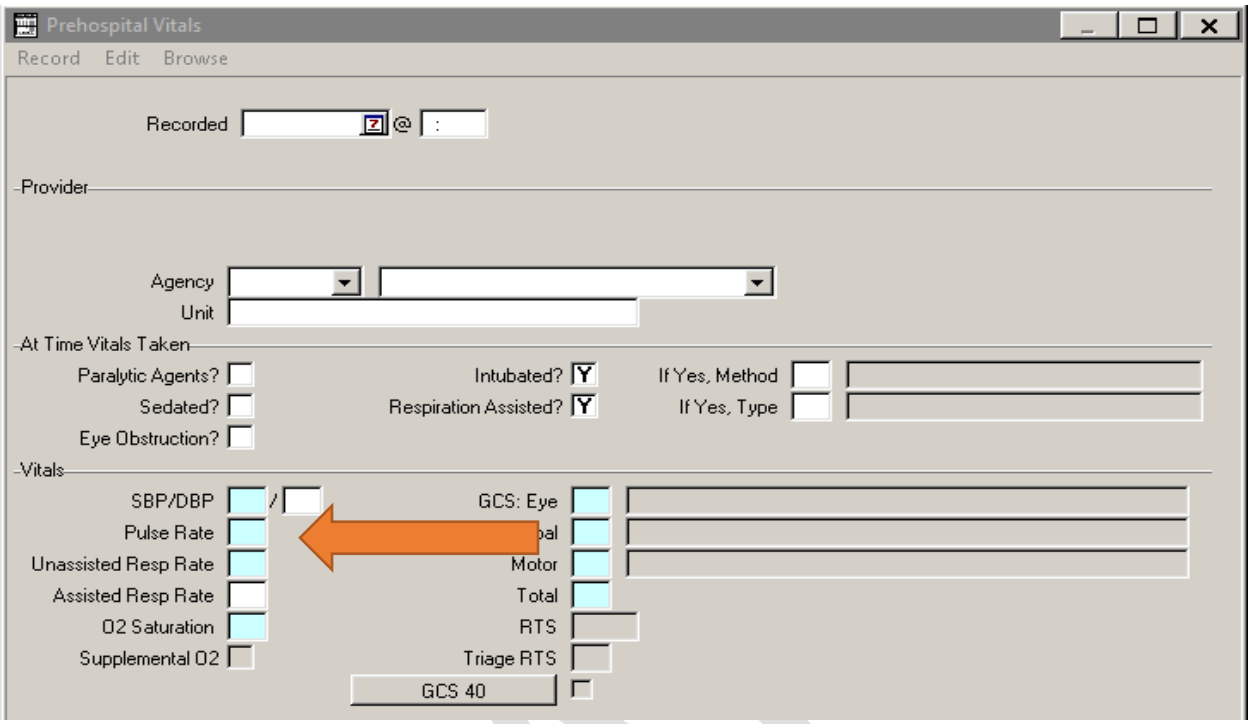
- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT

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



INITIAL FIELD PULSE RATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

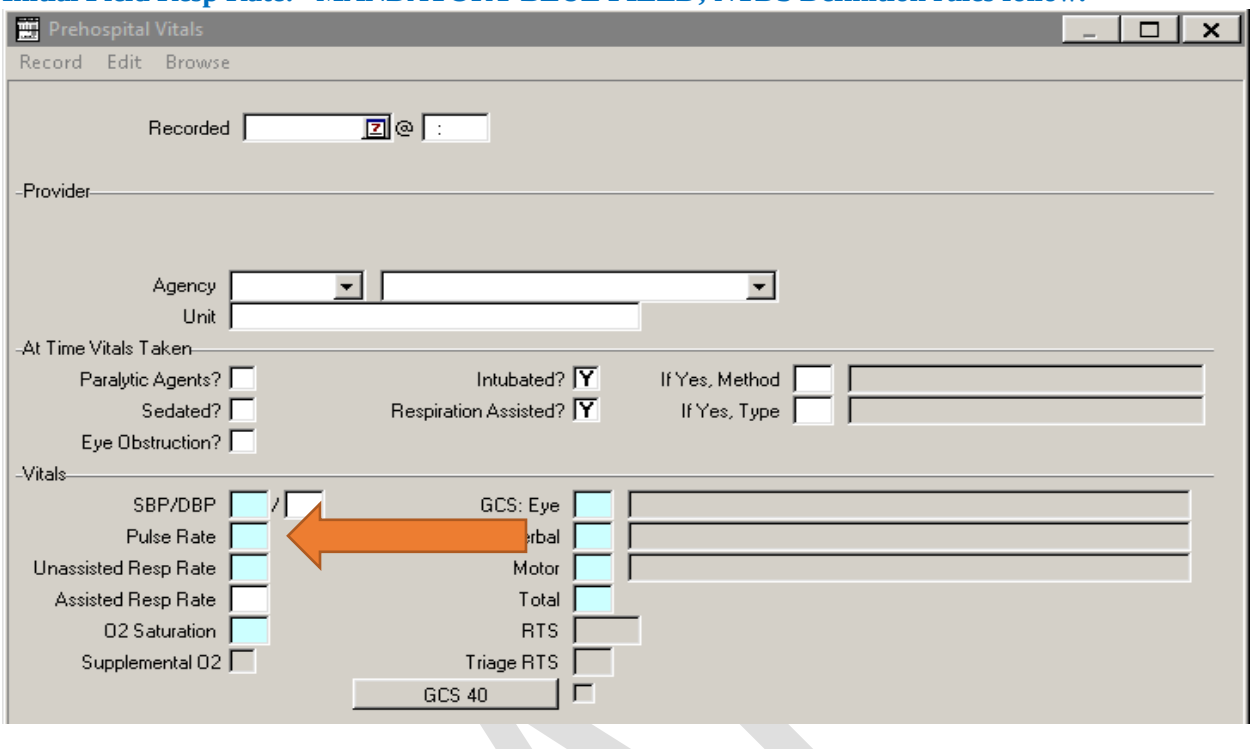
Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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

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



INITIAL FIELD RESPIRATORY RATE

Definition

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

Element Values

- Relevant value for data element.

Additional Information

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

Data Source Hierarchy Guide

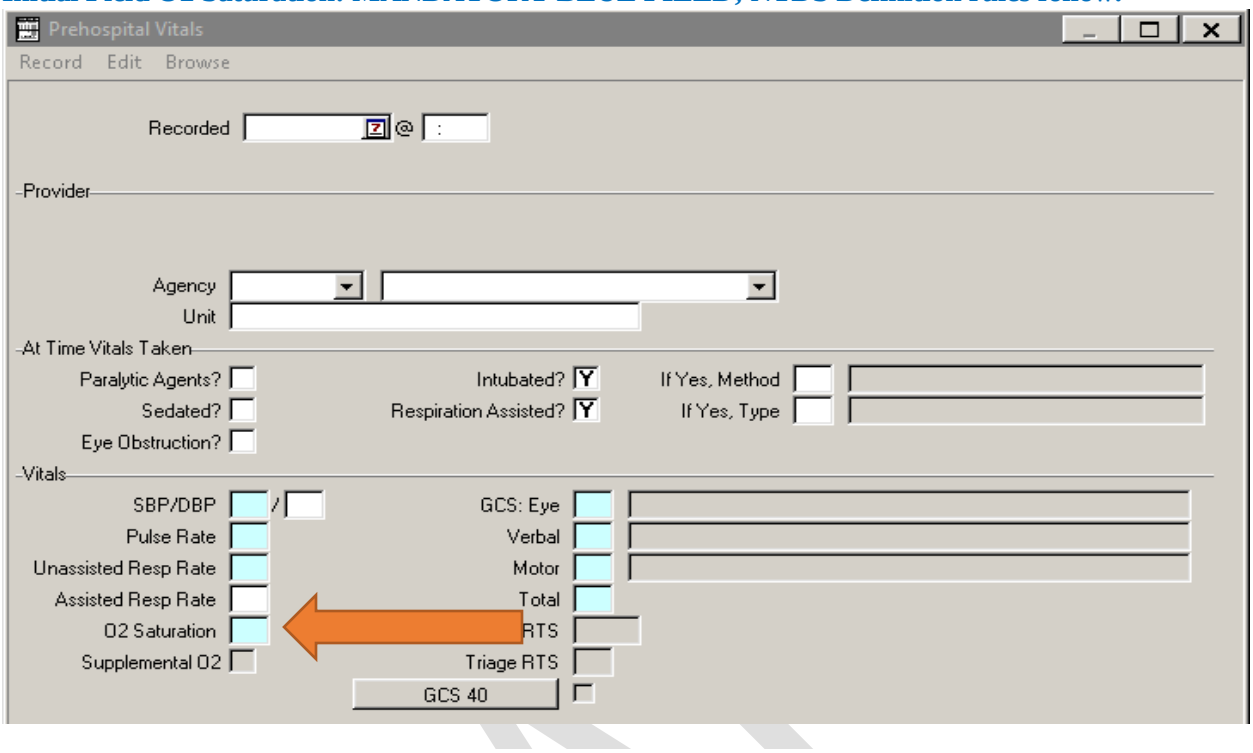
1. EMS Run Report

Associated Edit Checks

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

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

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



INITIAL FIELD OXYGEN SATURATION

Definition

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

Element Values

- Relevant value for data element

Additional Information

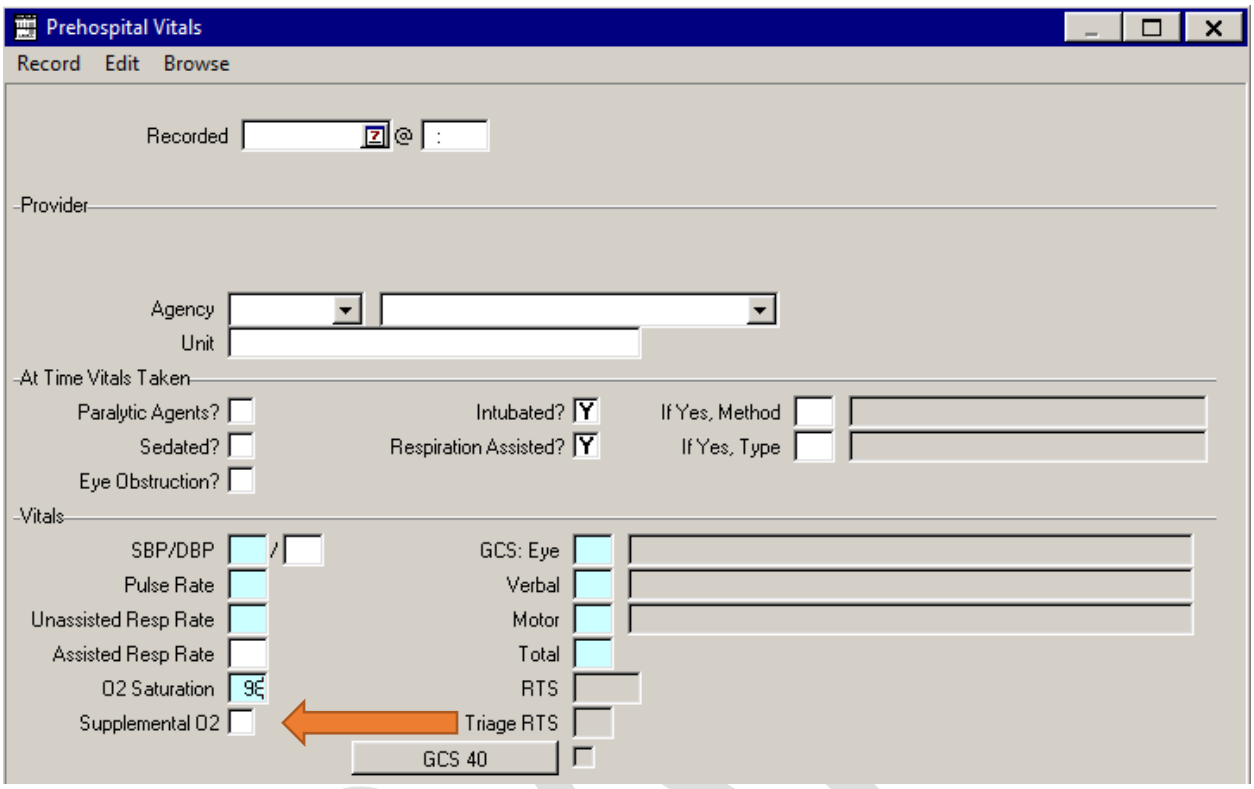
- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value "Not Applicable" is reported for patients who arrive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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



Supplemental O2

Definition

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

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report

Prehospital Vitals

Record Edit Browse

Recorded @ :

Provider

Agency

Unit

At Time Vitals Taken

Paralytic Agents? Intubated? Y If Yes, Method

Sedated? Respiration Assisted? Y If Yes, Type

Eye Obstruction?

Vitals

SBP/DBP / GCS: Eye

Pulse Rate Verbal

Unassisted Resp Rate Motor

Assisted Resp Rate Total

O2 Saturation 98 RTS

Supplemental O2 Triage RTS

GCS 40

INITIAL FIELD GCS - EYE

Definition

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

Element Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Additional Information

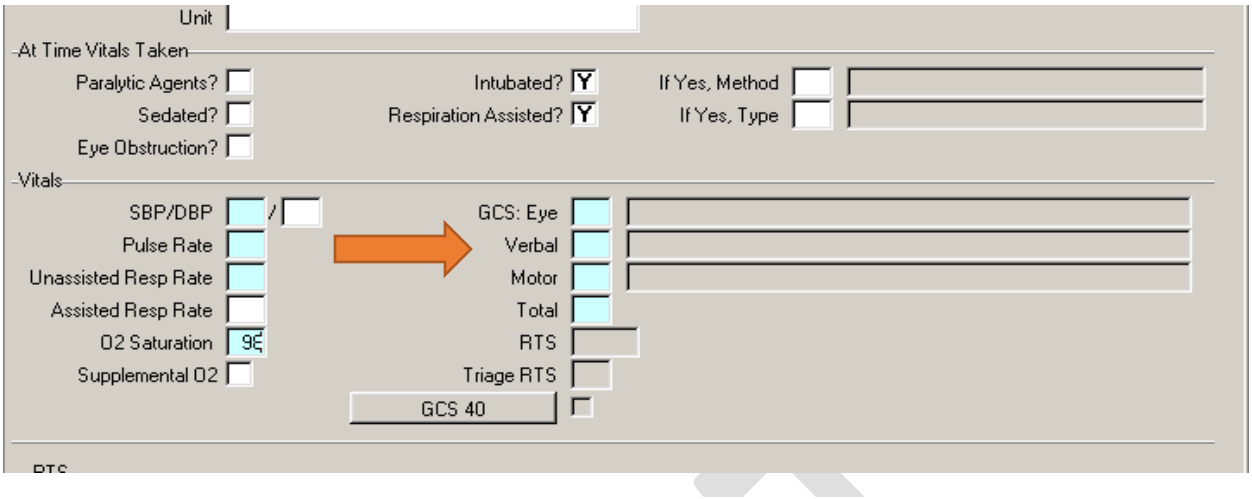
- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



INITIAL FIELD GCS - VERBAL

Definition

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

Element Values

Pediatric (≤ 2 years):

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

Adult

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

Additional Information

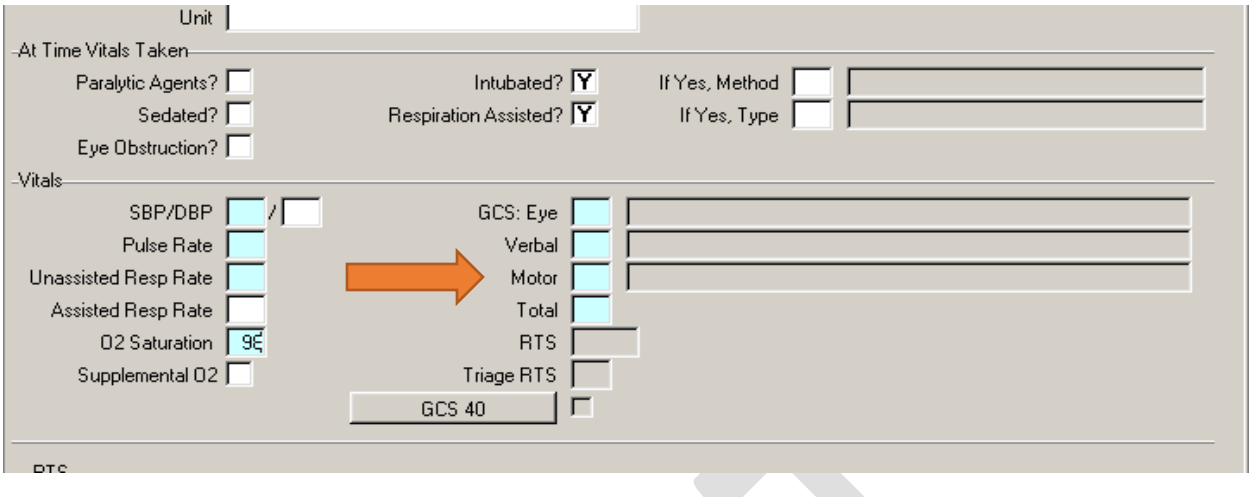
- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If patient is intubated, then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



INITIAL FIELD GCS - MOTOR

Definition

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

Element Values

Pediatric (≤ 2 years):

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

Adult

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

Additional Information

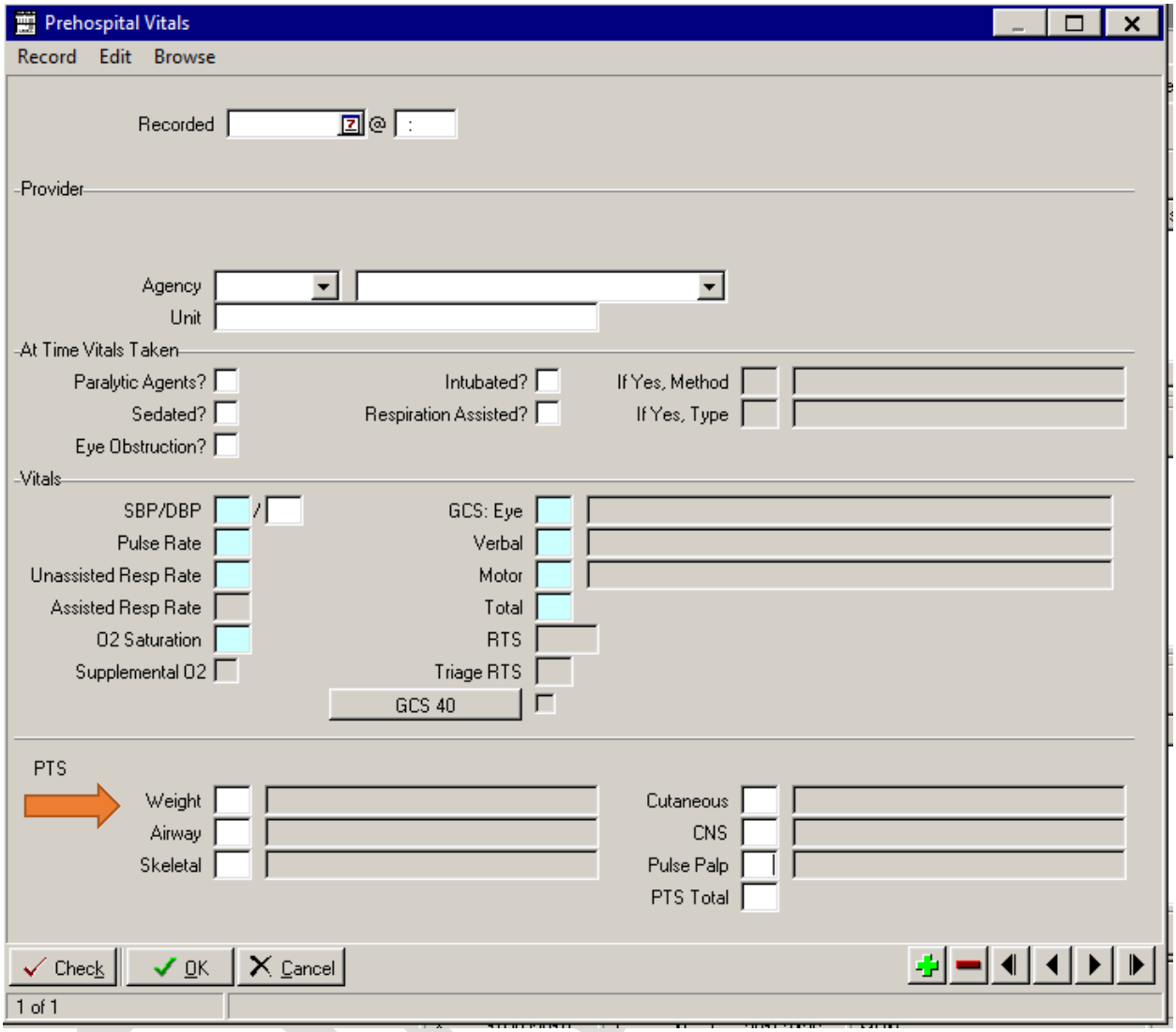
- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level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

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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



Pediatric Trauma Score: Weight

Definition

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

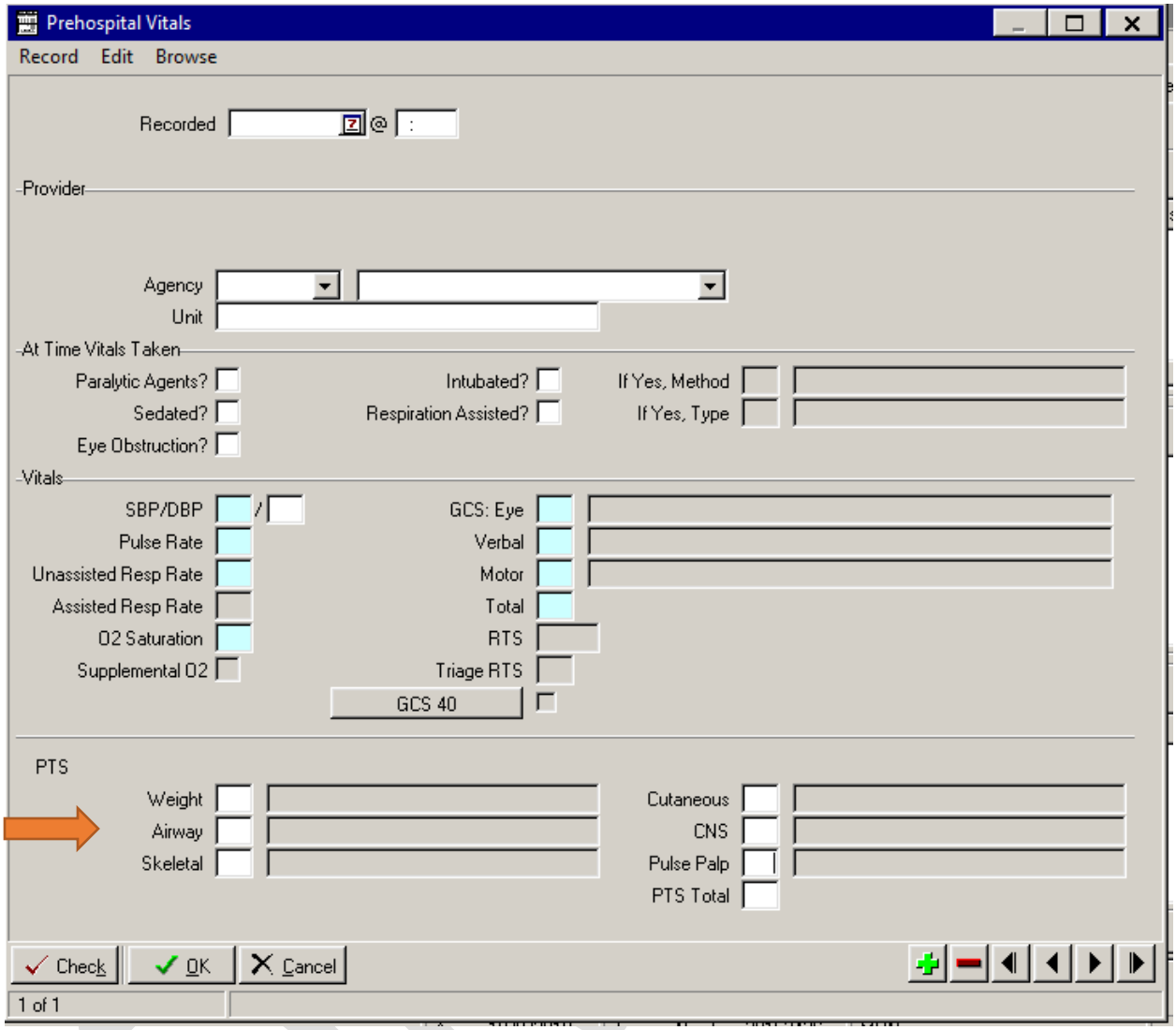
Element Values

2. Greater than 20kg (44 lbs.)
1. Between 10 and 20kg (22-44 lbs.)
-1. Less than 10kg (22 lbs.)

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report



Pediatric Trauma Score: Airway

Definition

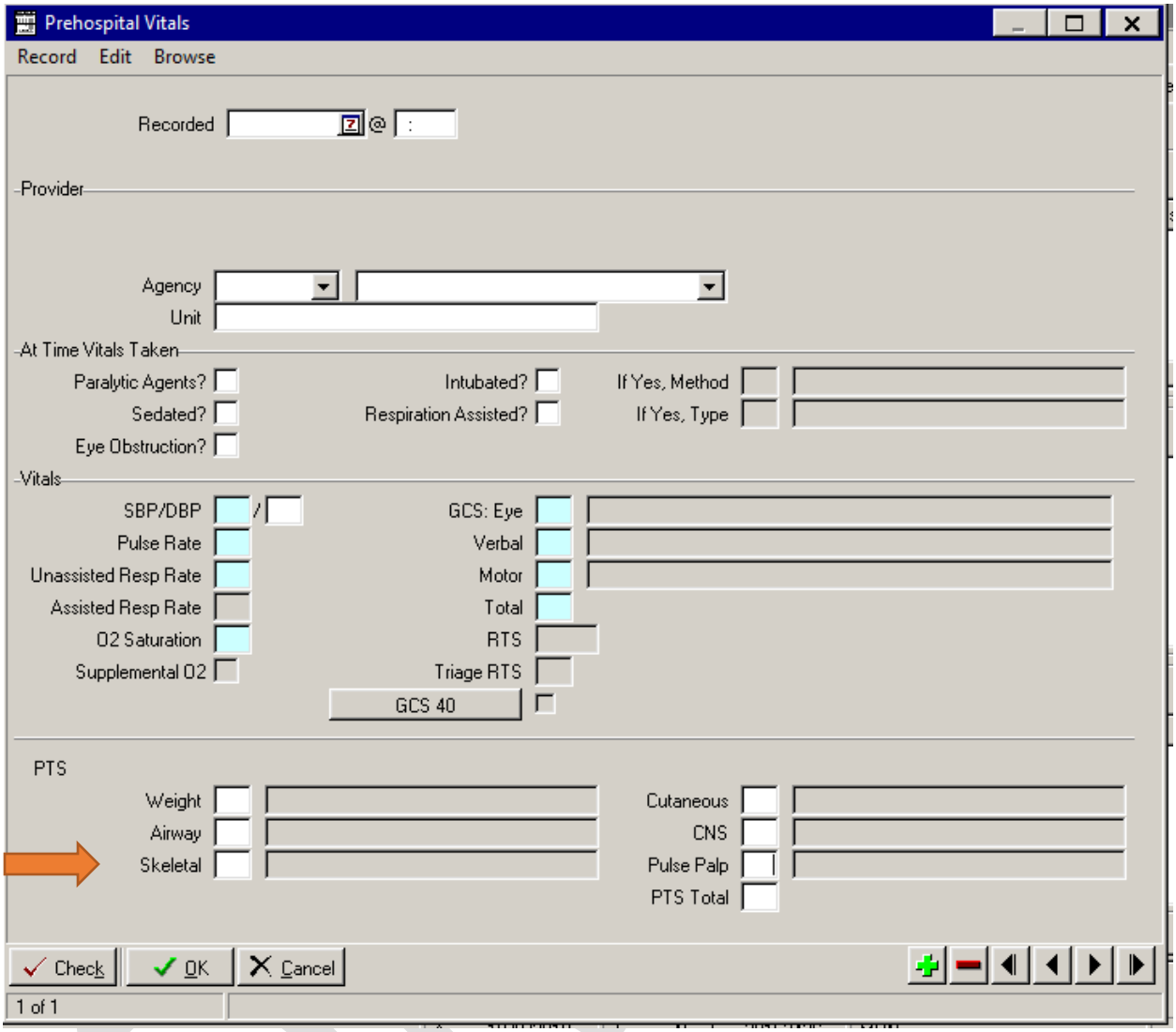
The status of the patient's airway upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Pediatric Trauma Score: Skeletal

Definition

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

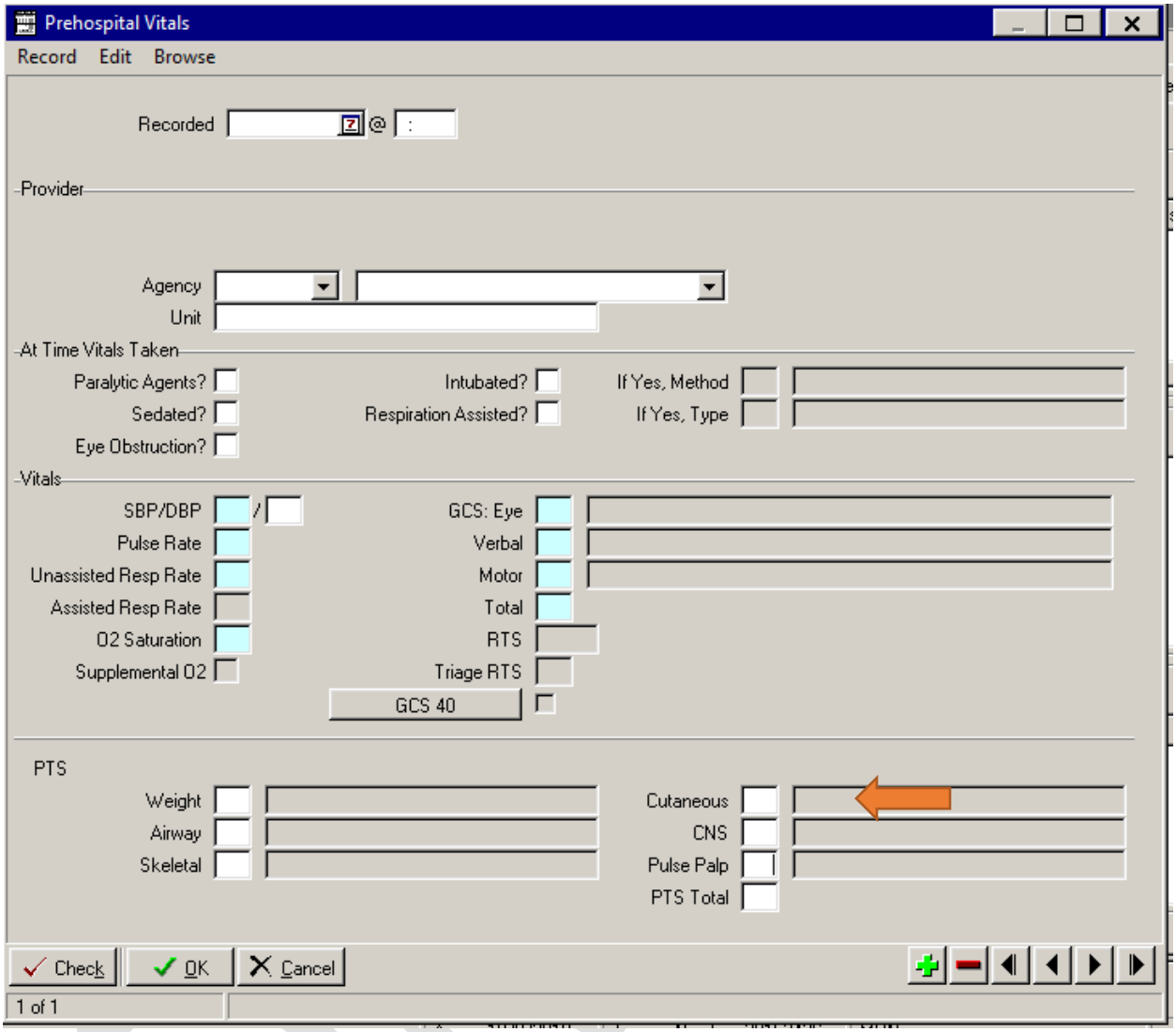
Element Values

1. None
2. Closed Fracture
3. Open or Multiple Fractures

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report



Pediatric Trauma Score: Cutaneous

Definition

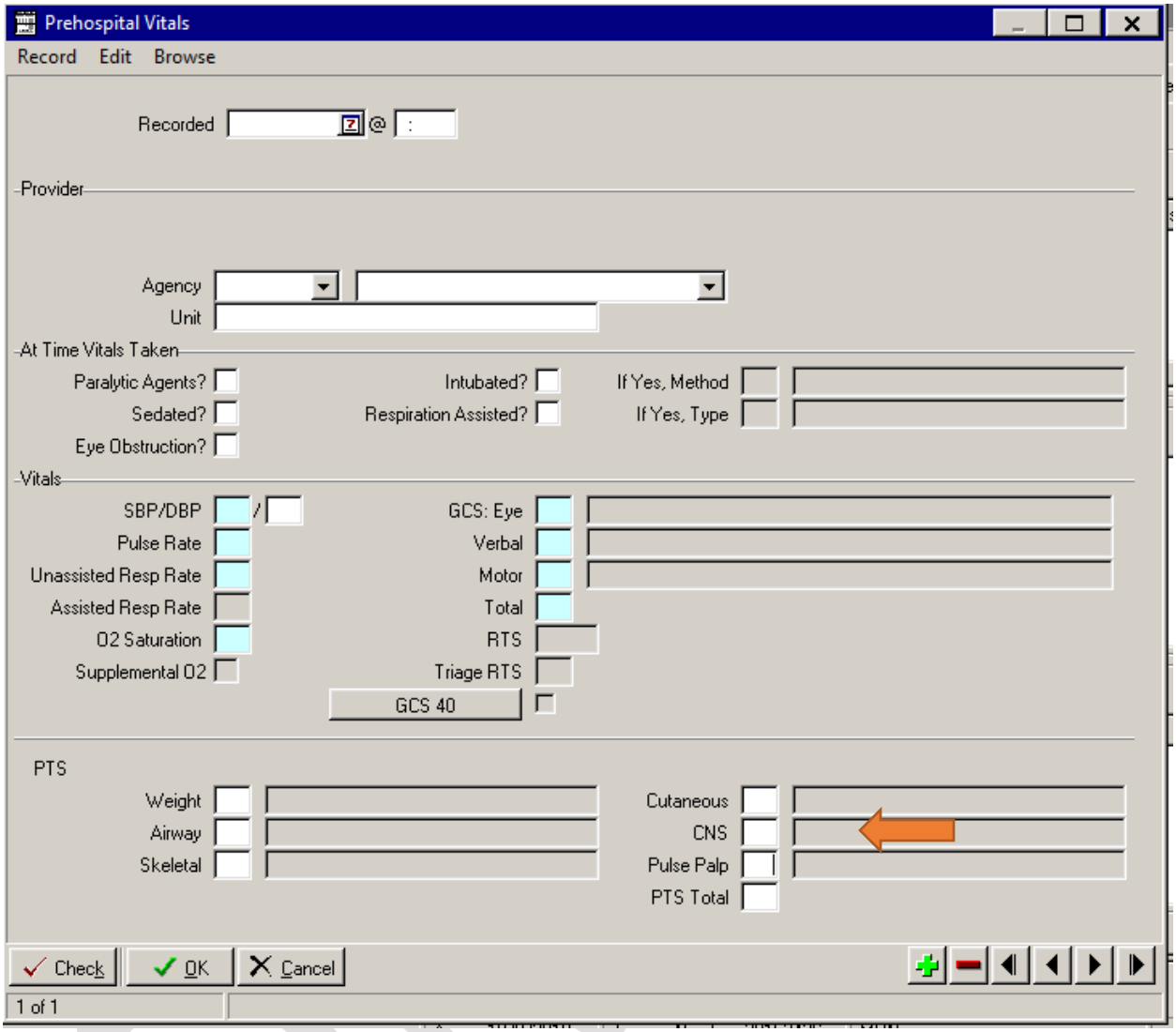
The presence or absence of open wounds on EMS assessment. Will only populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Pediatric Trauma Score: CNS

Definition

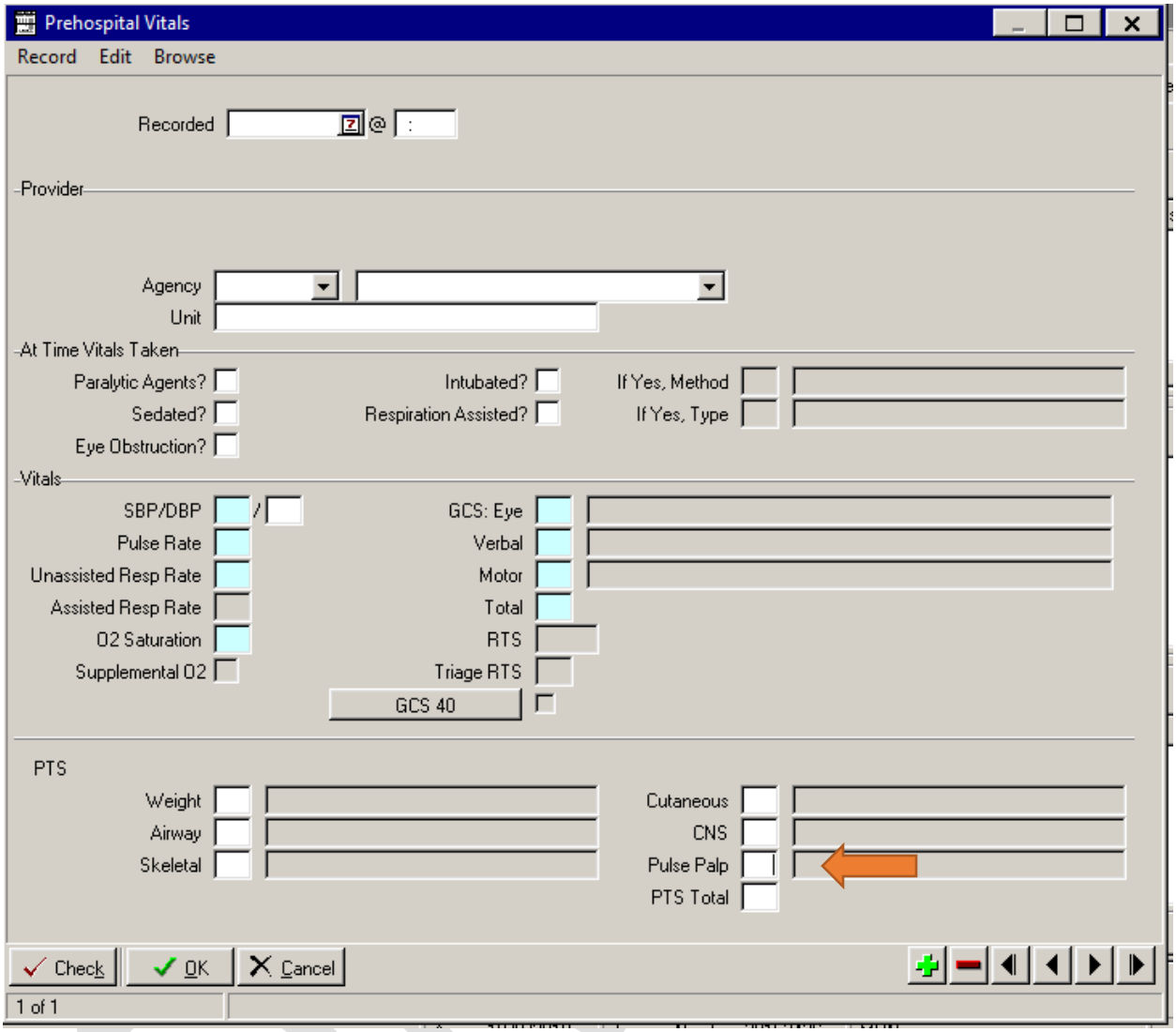
The mental status of the patient upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Pediatric Trauma Score: Pulse Palp

Definition

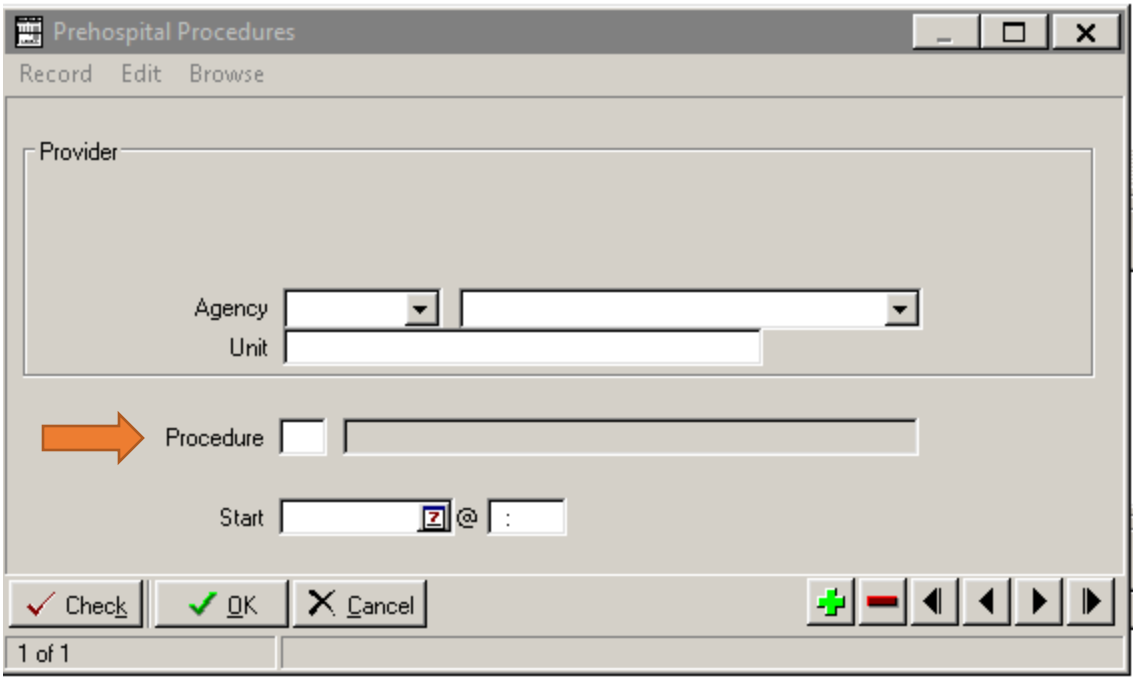
The presence or absence of pulses in different anatomical areas upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values

2. Pulse Palpable at Wrist (SBP over 90 mmHg
1. Pulse Palpable at Groin (SBP Btwn 50 and 90 mmHg)
-1. Pulse Not Palpable (SBP under 50 mmHg)
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report



Prehospital Procedure

Definition

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

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

DI Element Values

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

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41. Tracheostomy
42. Traction
43. Urinary Catheterization
44. Venous Access
45. Ventilator
46. Wound Care
47. Other
48. C-Collar Application
49. Hemorrhage Control
50. Tourniquet

/. Not Application
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT

Referring Facility Information

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

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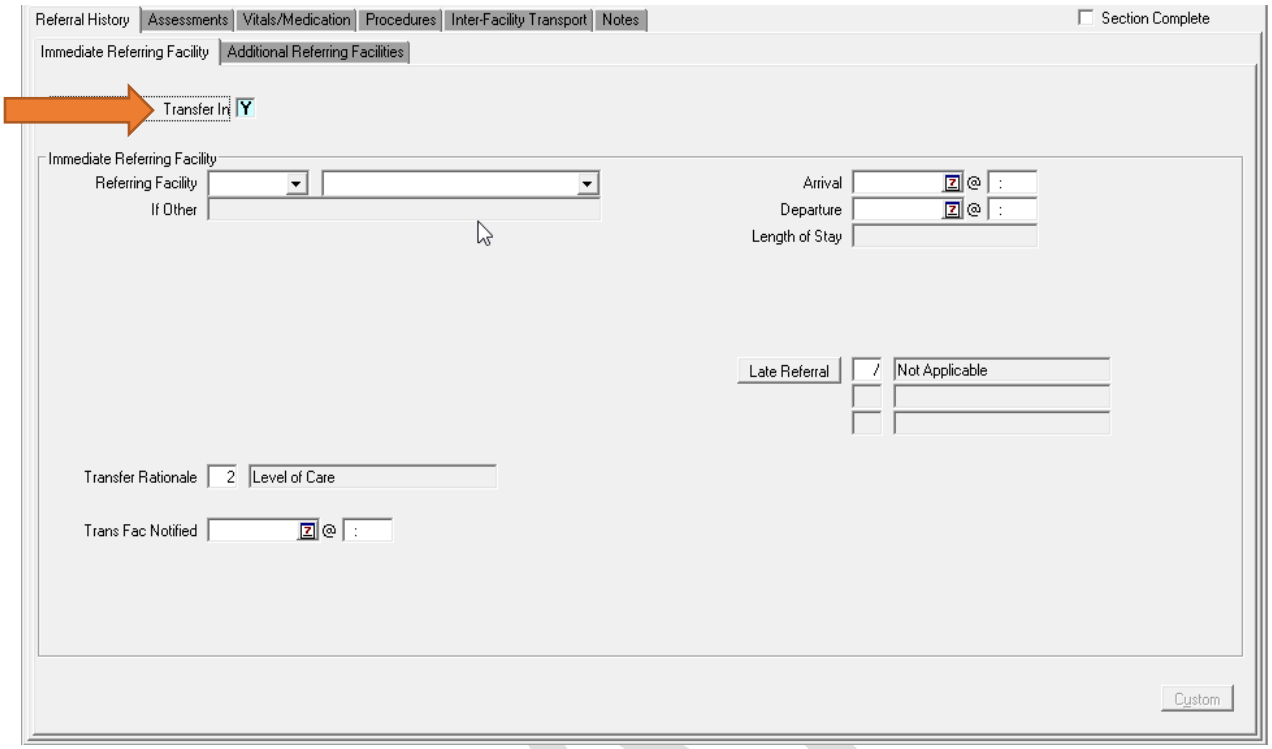
Inter-Facility Transfer: MANDATORY BLUE FIELD; NTDS Definition rules follow.



INTER-FACILITY TRANSFER

Definition

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

Element Values

1. Yes
2. No

Additional Information

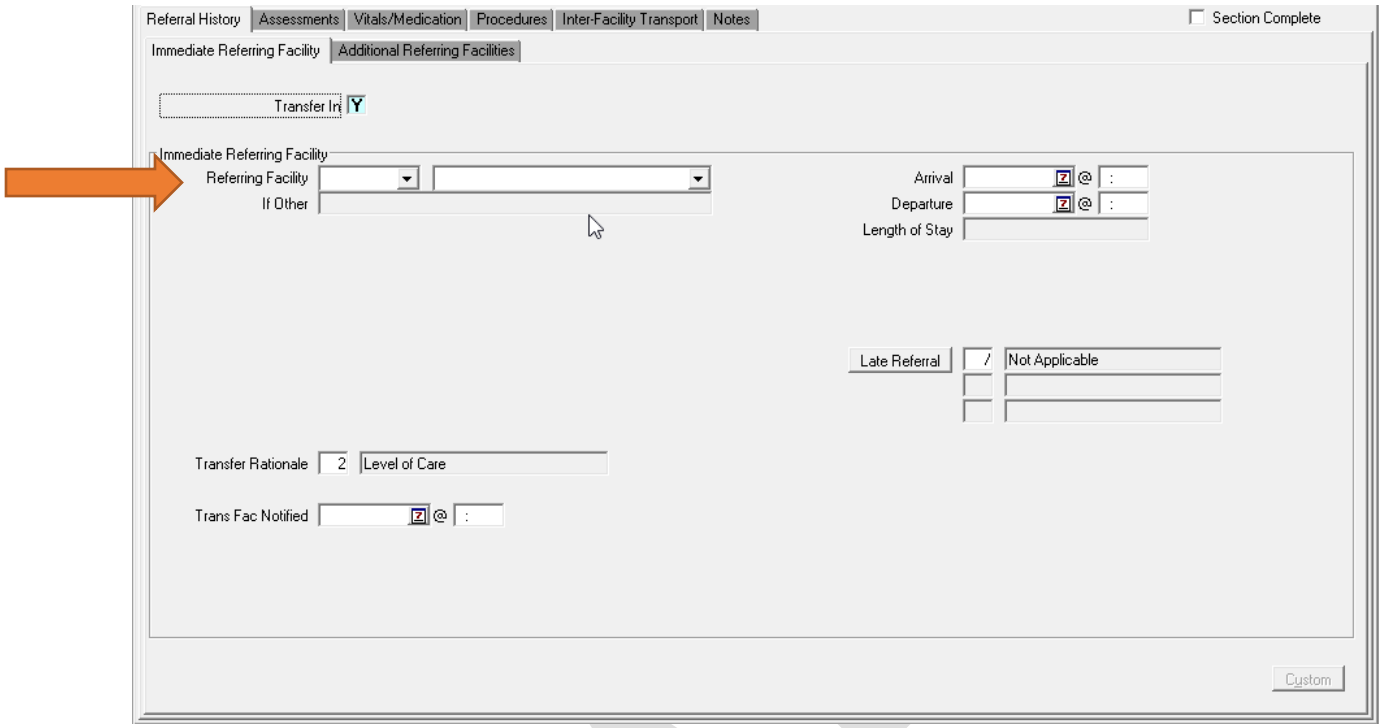
- Patients transferred from a private doctor's office or a stand-alone ambulatory surgery center are not considered inter-facility transfers.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Data Source Hierarchy Guide

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

Associated Edit Checks

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



Referring Facility

Definition

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

Element Values

- Relavant Value for Data Element

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

Data Source Hierarchy

1. Access Center Triage Note (Trauma Triage flowsheet)
2. Referring Facility Record
3. EMS Run Record

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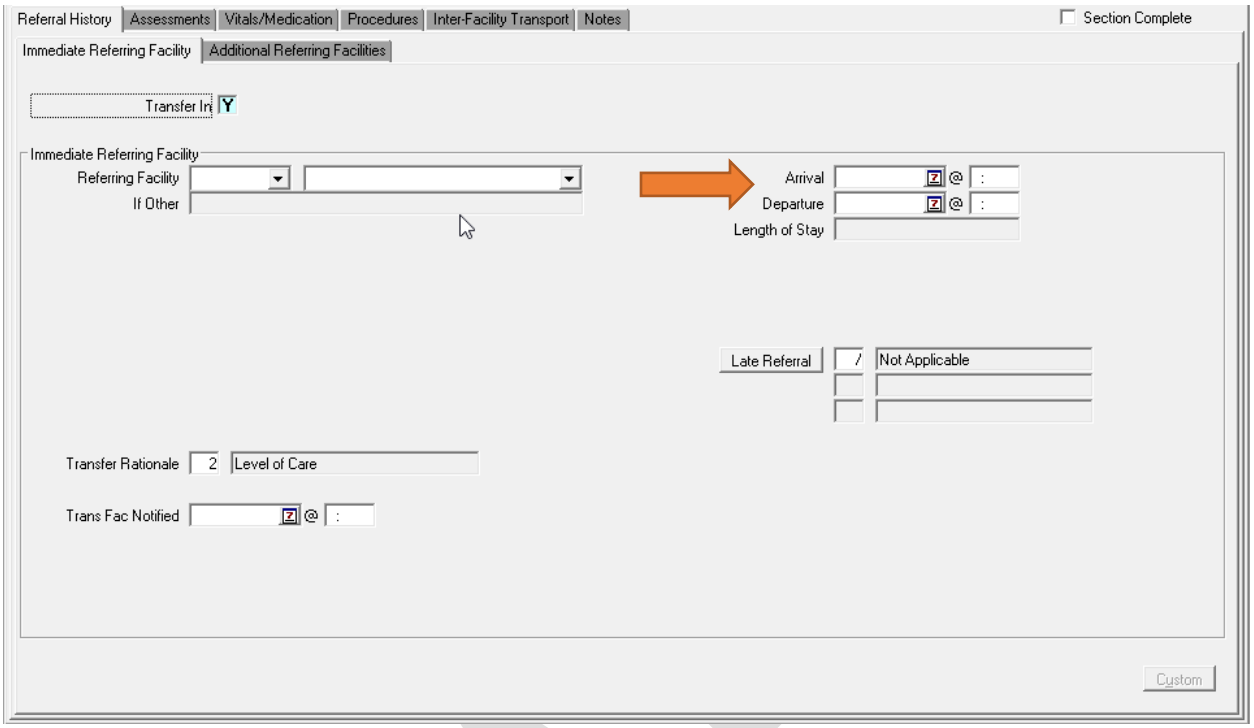


Referring Facility Departure Date and Time

Definition

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

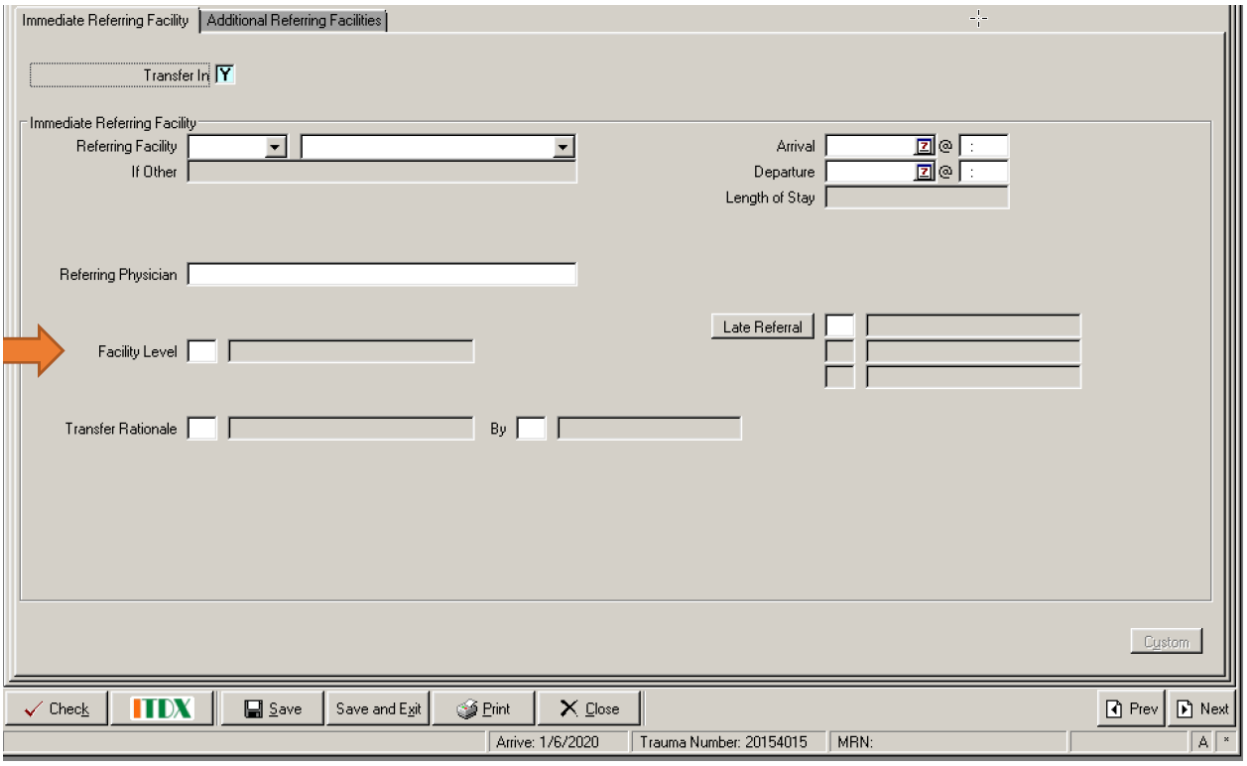
Element Values

- Relevant Value for Data Element.

Data Source Hierarchy

1. Referring Facility Record
2. EMS Run Record

DRAFT



Facility Level

Defintion

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

Element Values

0. Non-Designated
1. Level 1
2. Level II
3. Level III
4. Level IV
5. Level V

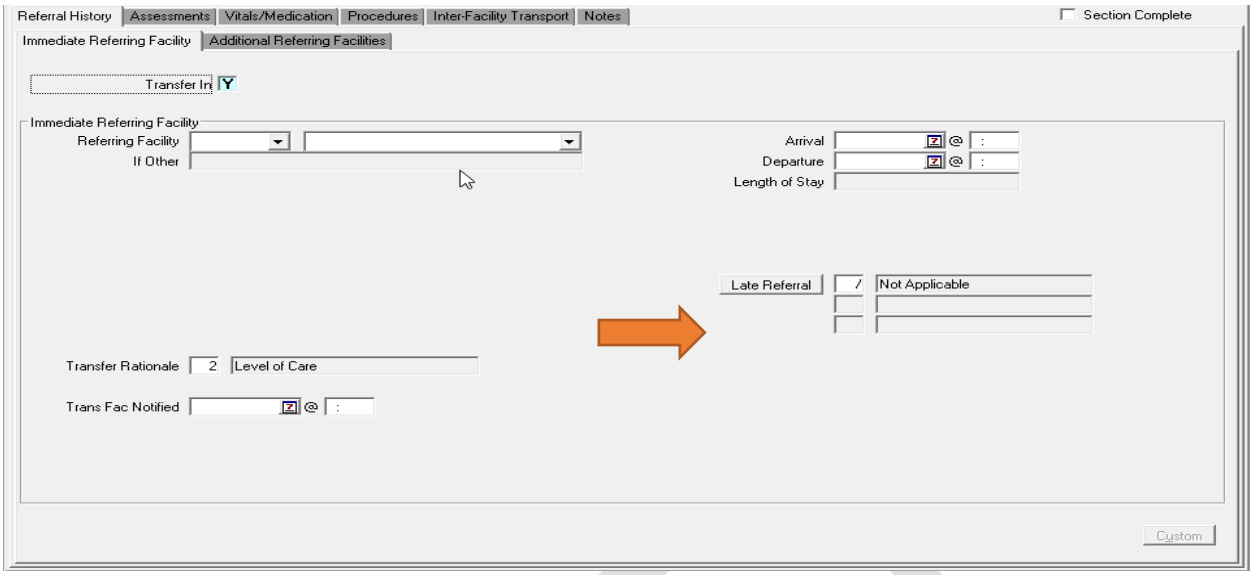
9. Other Specialty

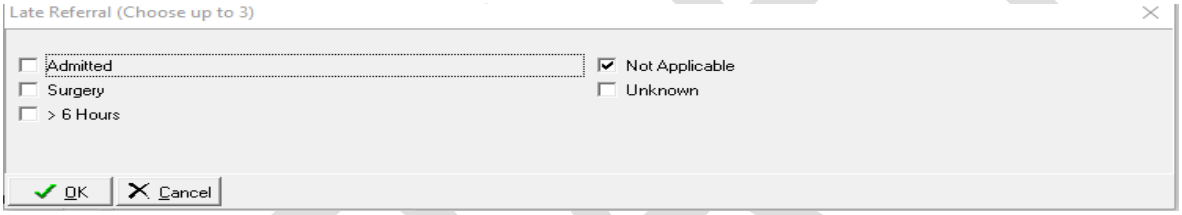
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork





Late Referral

Definition

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

Element Values

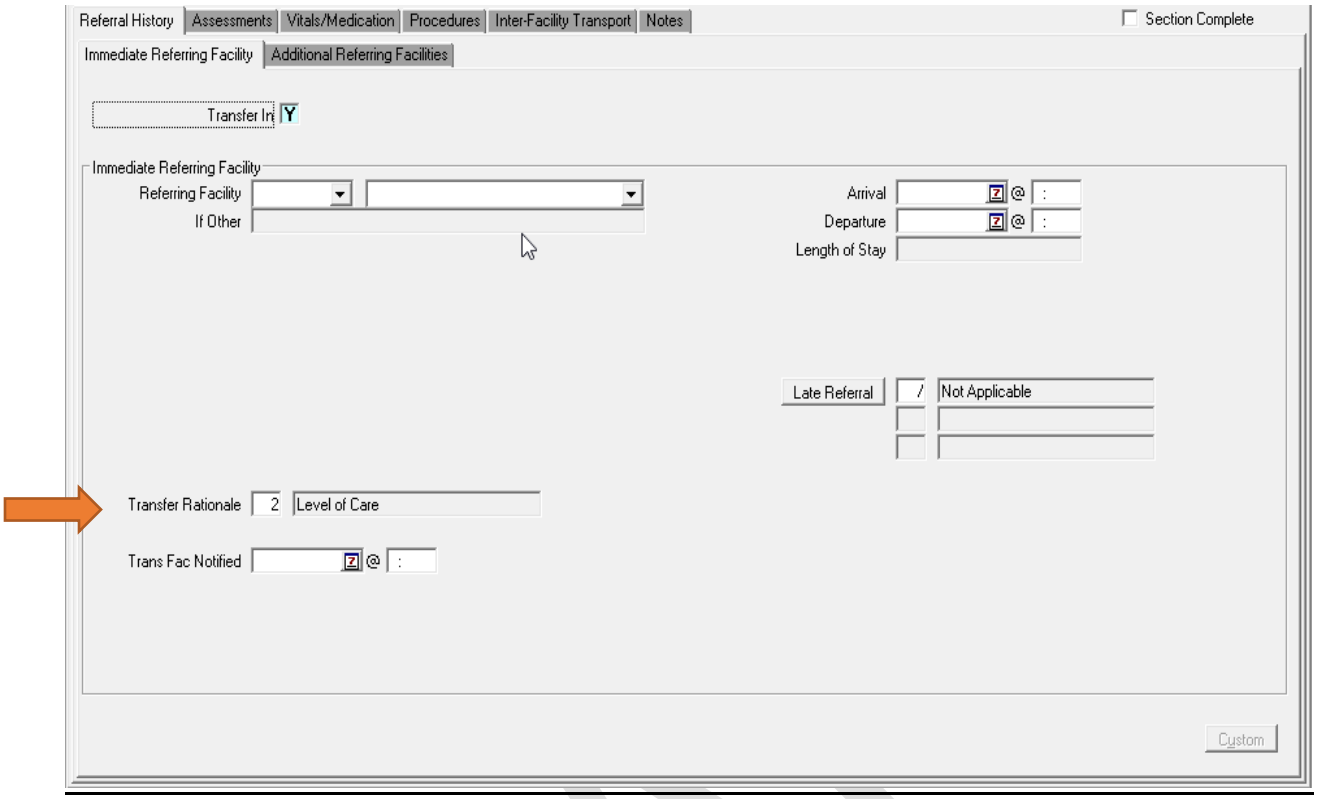
1. Over 6 hours in ED or Resuss
2. Surgery Performed
3. Admissions
4. ICU
5. Radiology
6. Referring Physician Decisions
7. Weather or Natural Forces
8. Mass Casualty Incident
9. EMS Transfer Issues
10. Destination Facility Issues

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Transfer Rationale

Definition

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

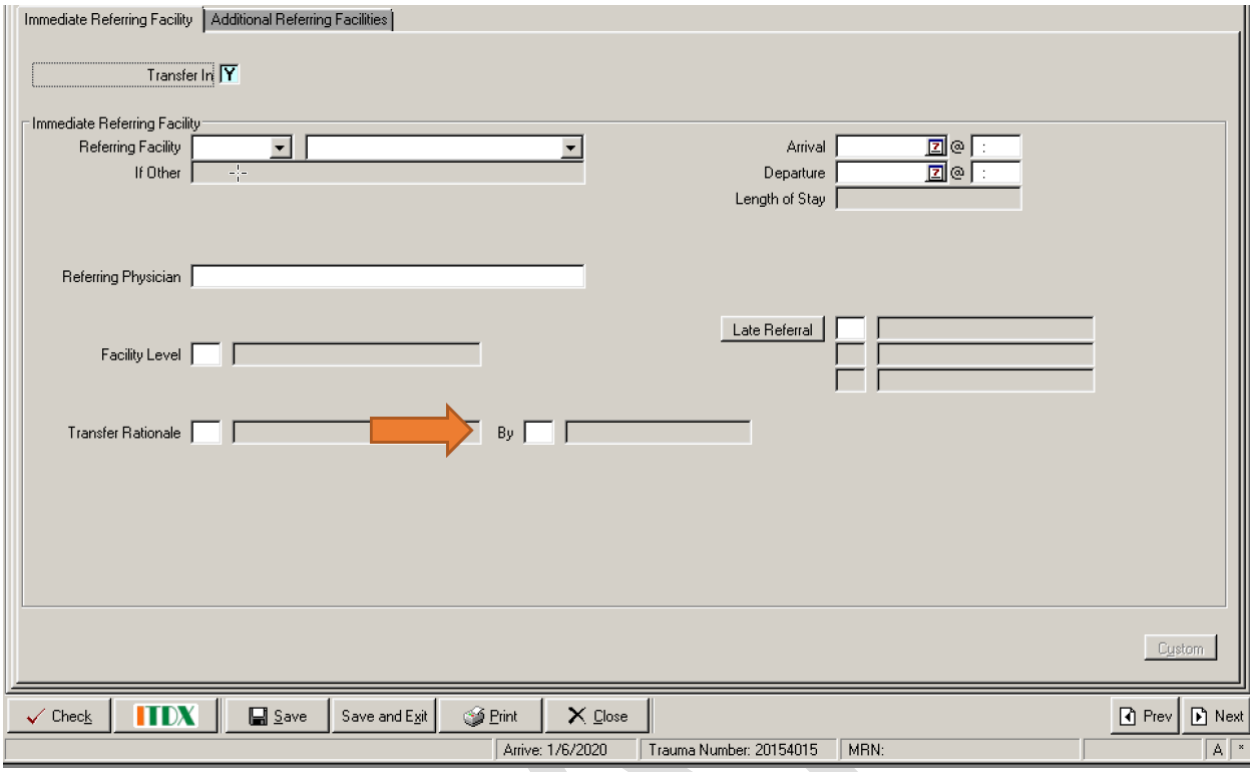
Element Values

1. Economic
2. Level of Care
3. Personal
4. System Protocol
5. Other

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Transfer Rationale By

Definition

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

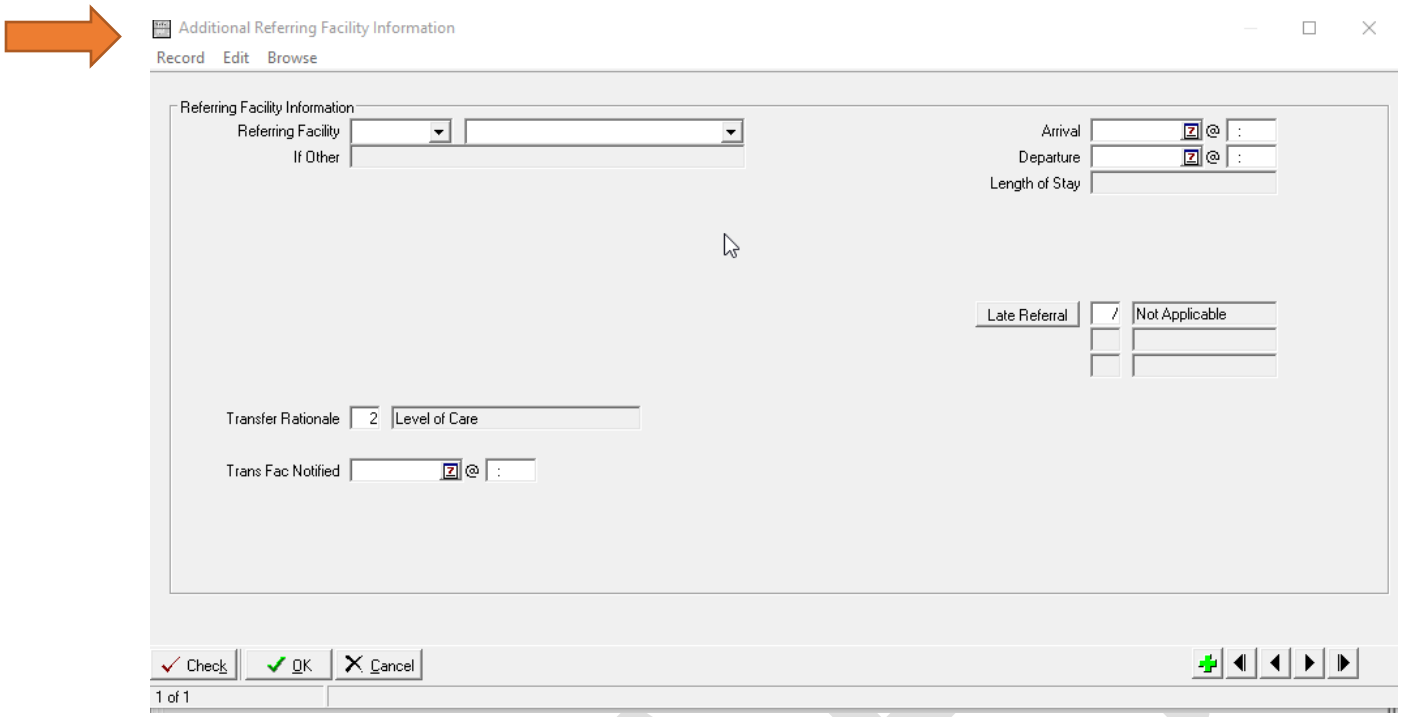
Element Values

1. Physician
2. Patient
3. Payor

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Additional Referring Facilities

Defintion

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork
2. Trauma/ Triage flowsheet

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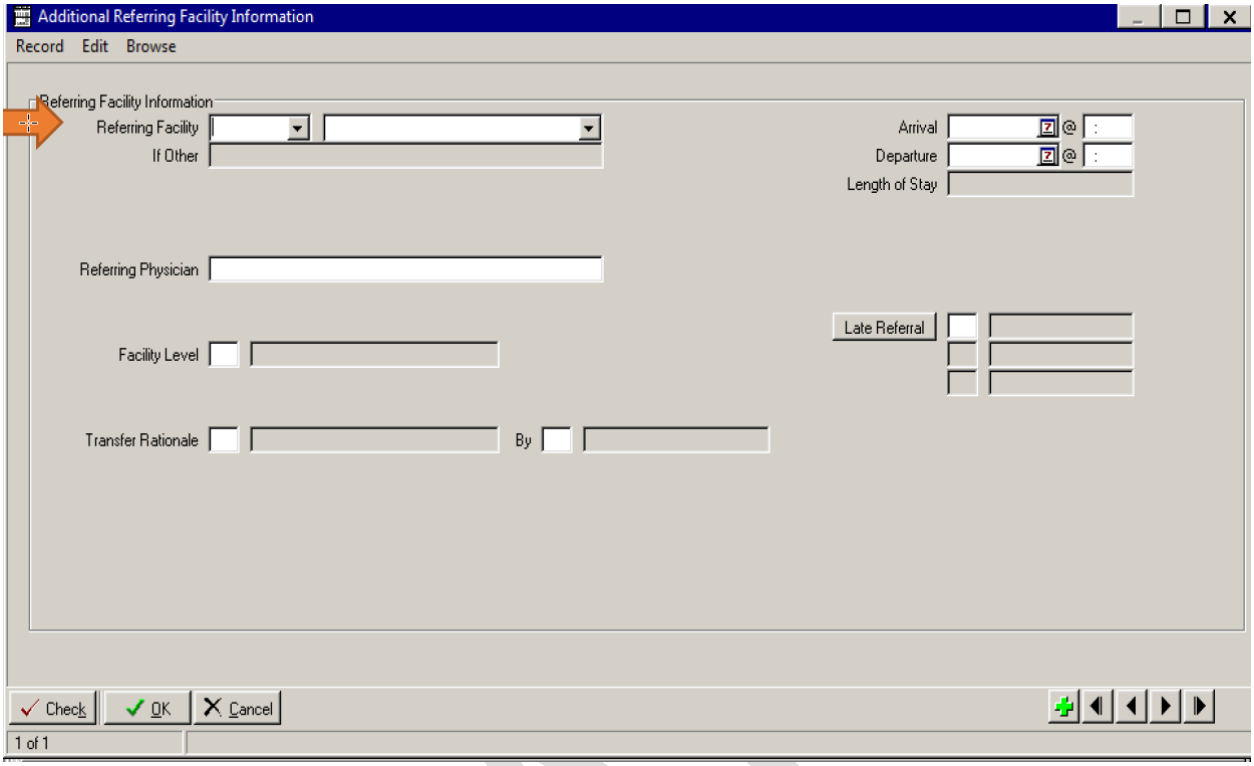


Additional Referring Facility

Defintion

The name and ID number of the facility that rendered emergency care for the patient prir to being trasported to the hosptial that reffered the patient to your facility.

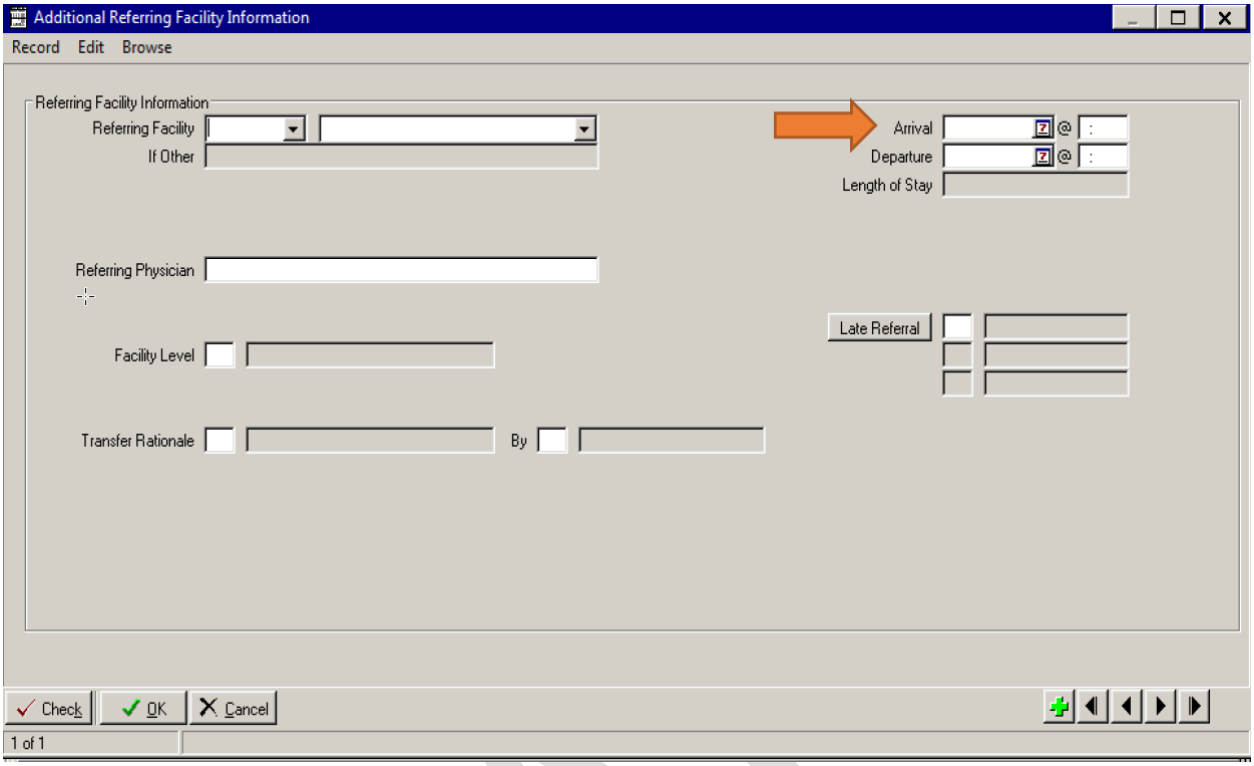
Element Values

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

Data Source Hiearcyh Guide

1. Referring Facility Paperwork
2. EMS Run Sheet

DRAFT



Additional Referring Facility Arrival Date and Time

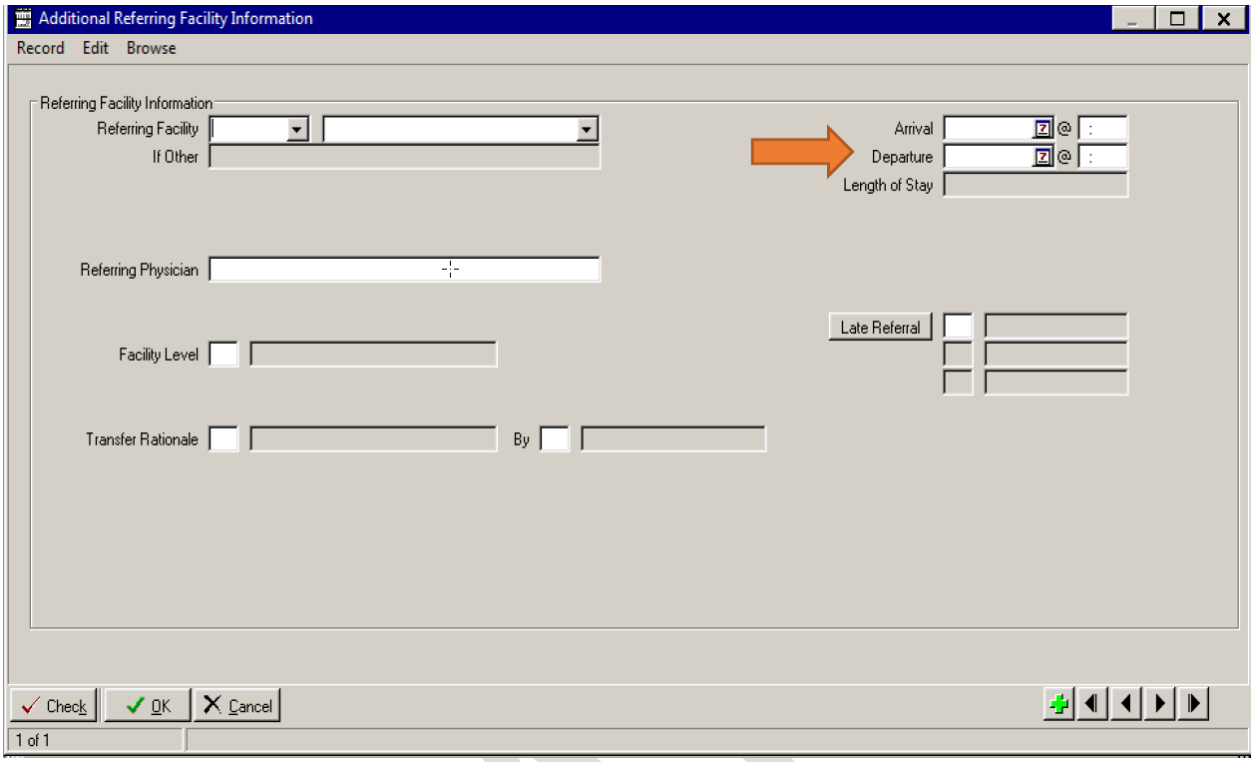
Definition

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

Data Sourced Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

DRAFT



Additional Referring Facility Departure Date and Time

Definitoin

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

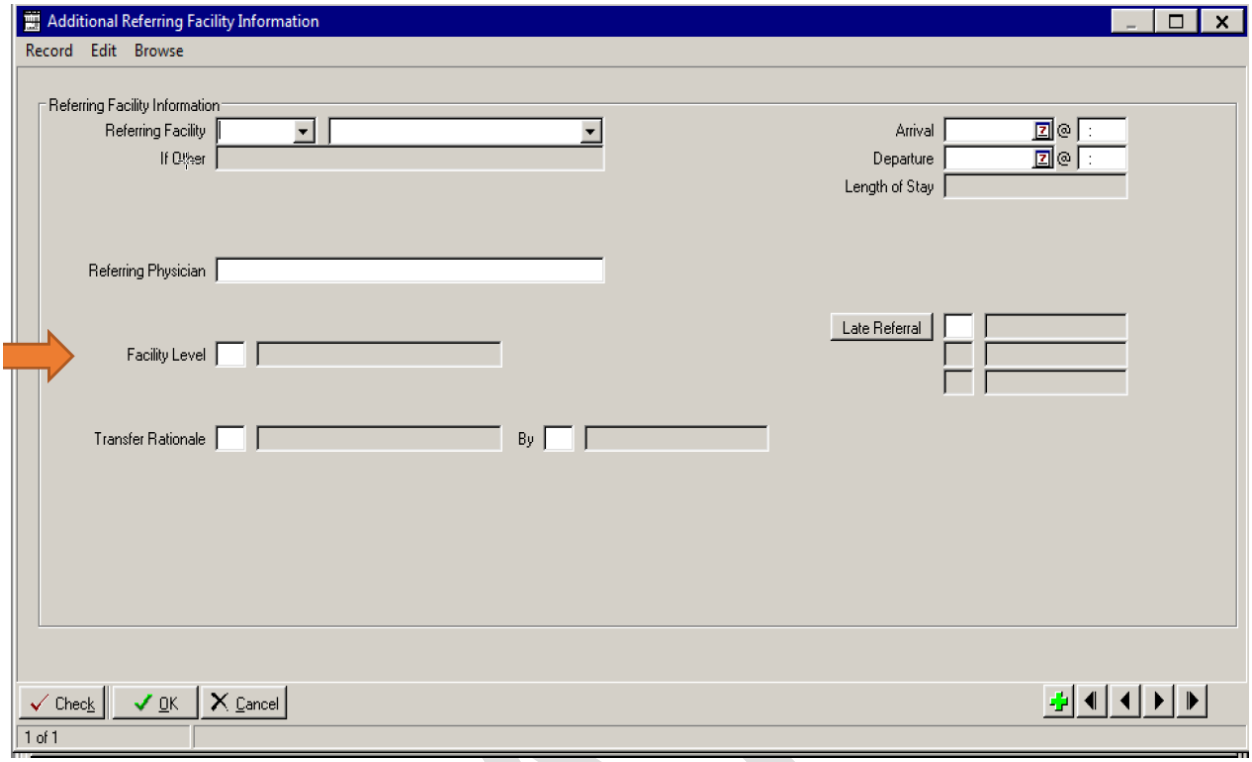
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

DRAFT



Additional Referring Faicilty: Facility Level

Defintion

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

Element Values

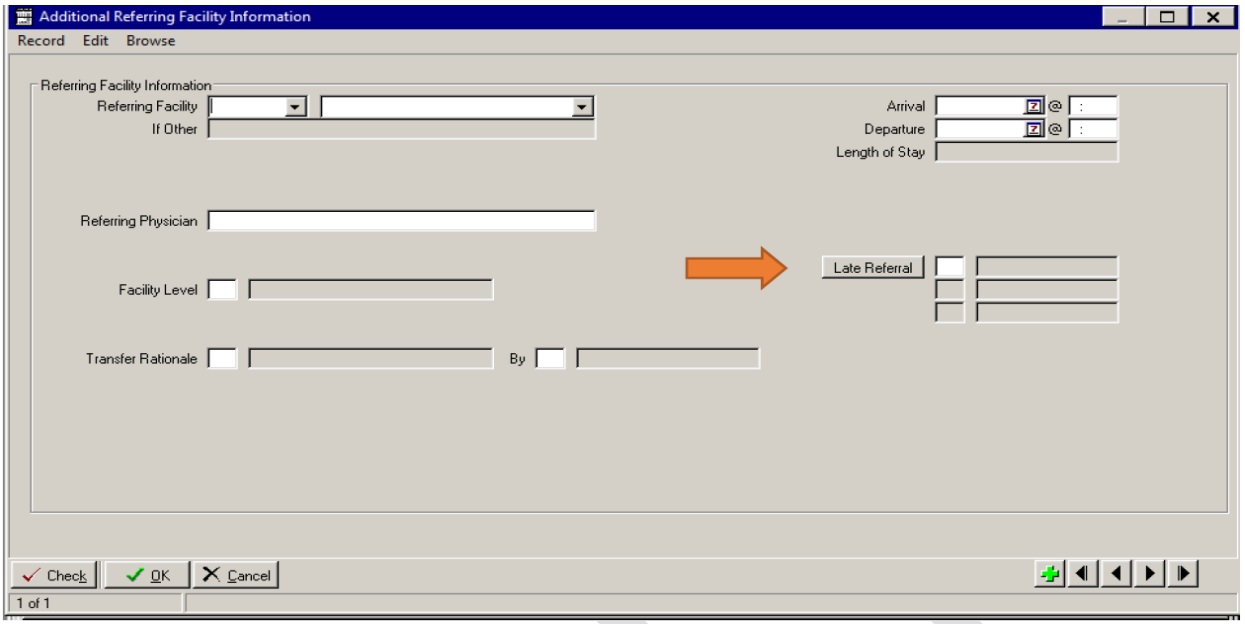
0. Non-Designated
1. Level I
2. Level II
3. Level III
4. Level IV
5. Level V
9. Other Specialty

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Additional Referring Facility
2. Referring Facility Paperwork



Additional Referring Facility: Late Referral

Definition

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

Element Values

1. Over 6 hours in ED or Resuss
2. Surgery Performed
3. Admissions
4. ICU
5. Radiology
6. Referring Physician Decisions
7. Weather or Natural Forces
8. Mass Casualty Incident
9. EMS Transfer Issues
10. Destination Facility Issues

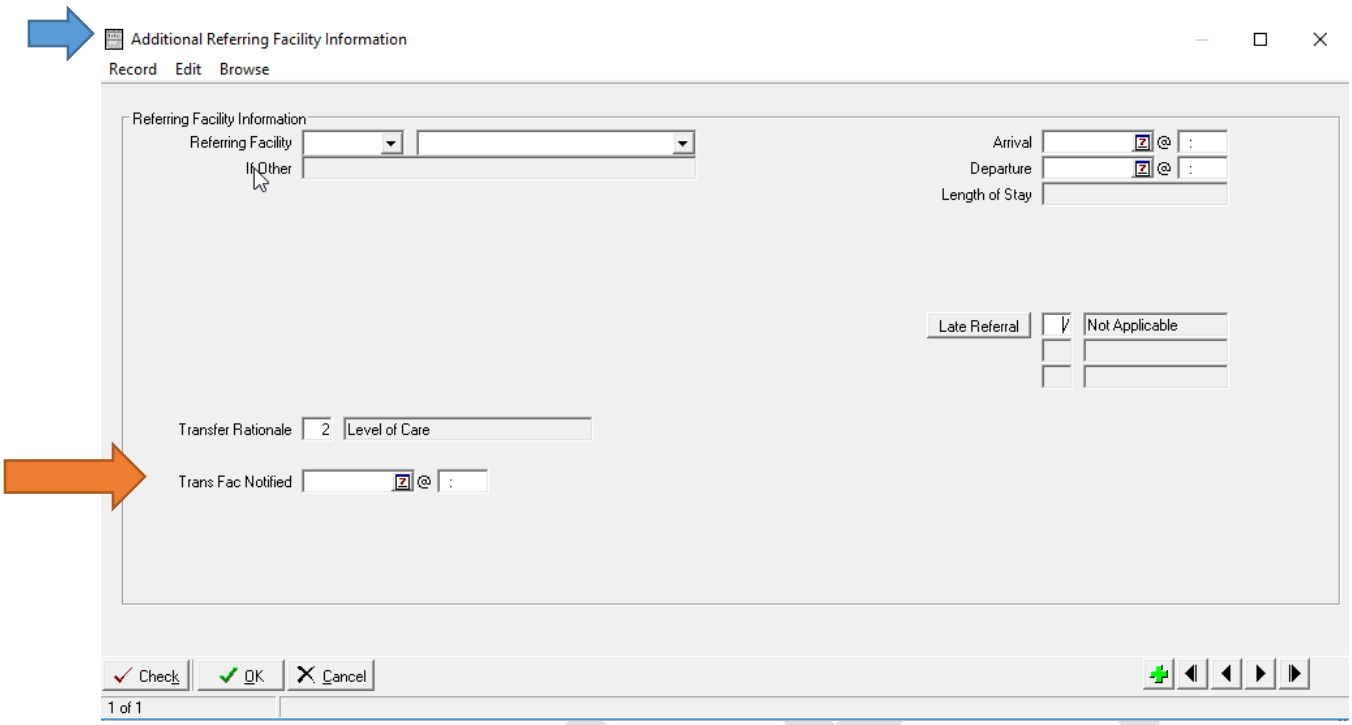
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

DRAFT



Additional Referring Facility: Transfer Rationale

Defintion

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

Element Values

1. Economic
2. Level of Care
3. Personal
4. System Protocol
5. Other

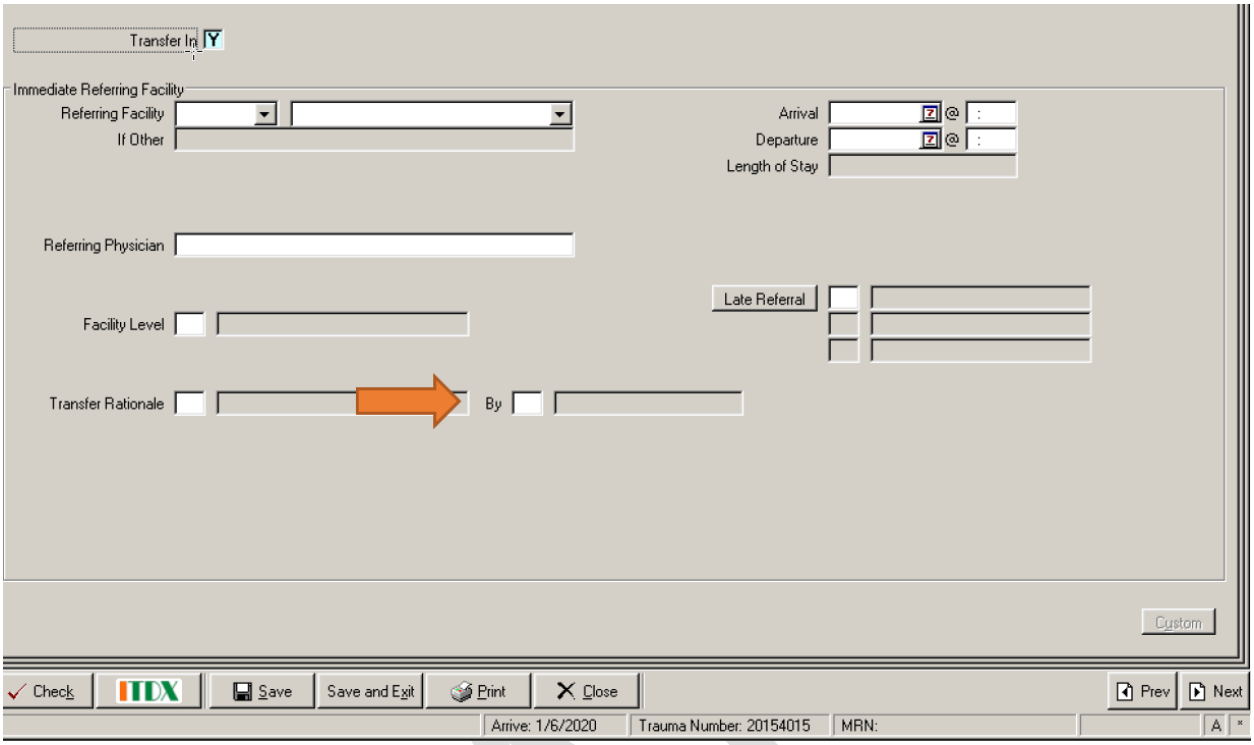
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

DRAFT



Additional Referreing Facility: Transfer Rational By

Defintion

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

Element Values

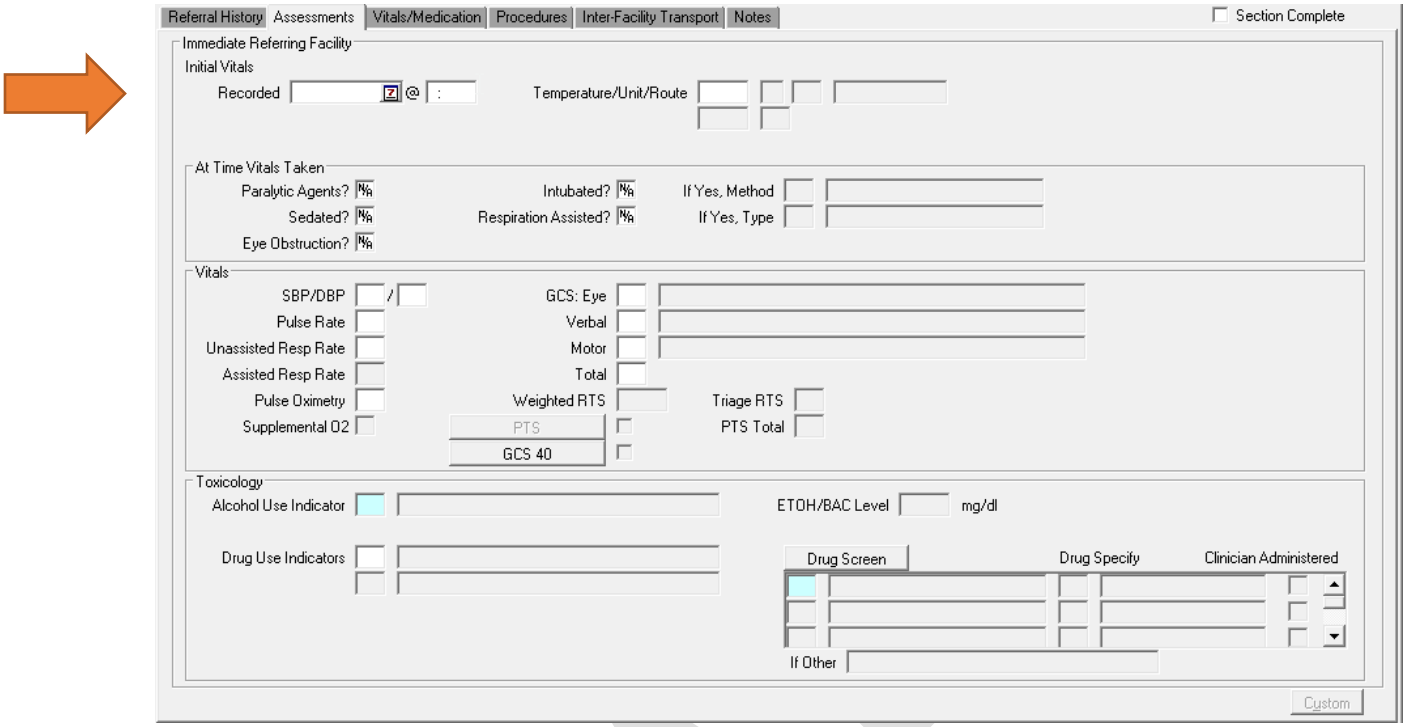
1. Physician
2. Patient
3. Payor

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork

DRAFT



Referring Facility: Initial Vitals Recorded Date and Time

Definition

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

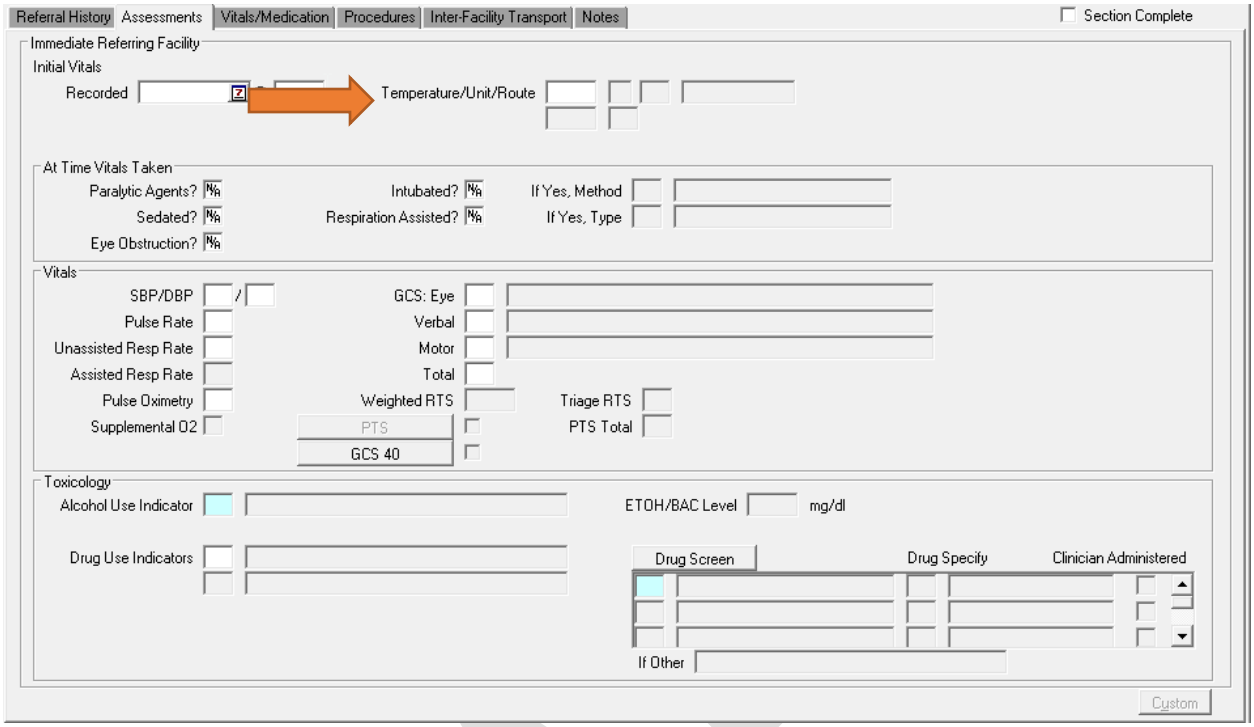
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Referring Facility

DRAFT



Referring Facility: Initial Temperature/Unit/Route

Defintion

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

Element values

- Relevant Value for Data Element

Unit-

F. Fahrenheit
C. Celsius

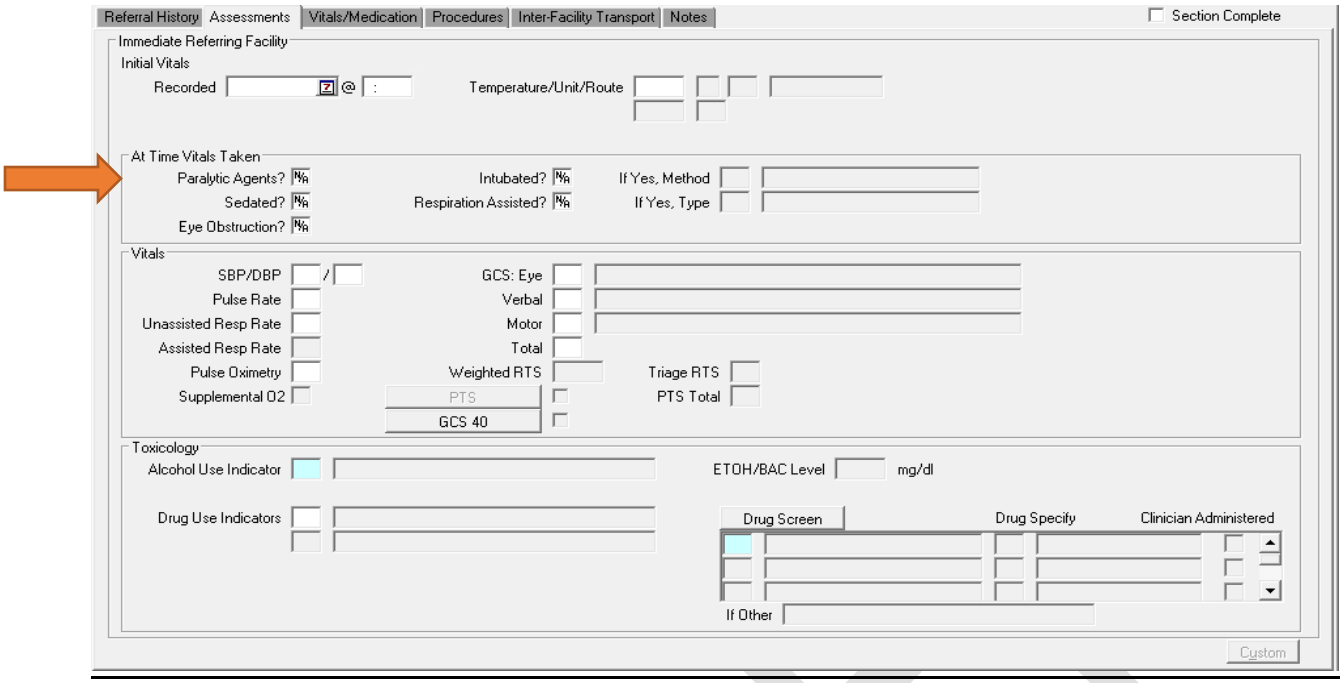
Route-

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

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Paralytic Agents

Defintion

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

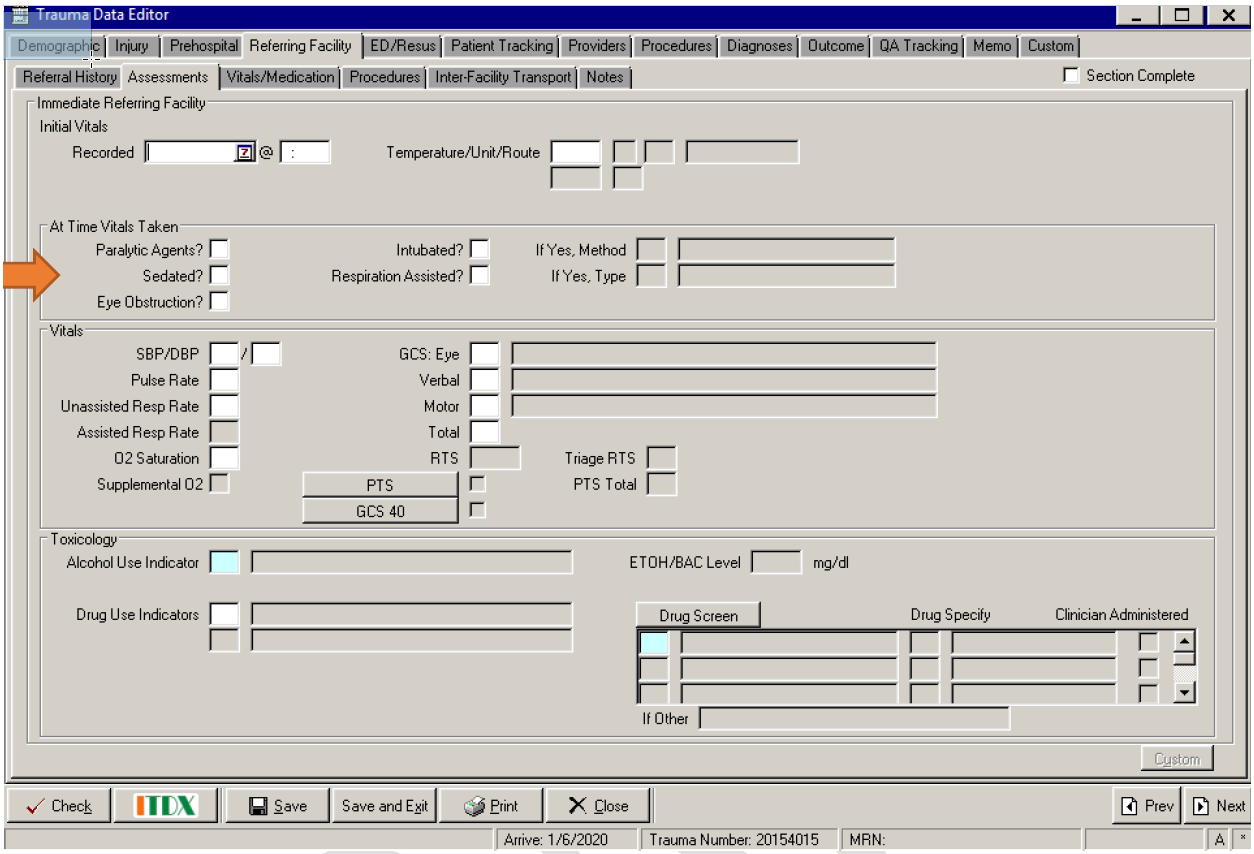
Element Values

Y. Yes	/. Not applicalbe
N. No	?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Sedated

Defintion

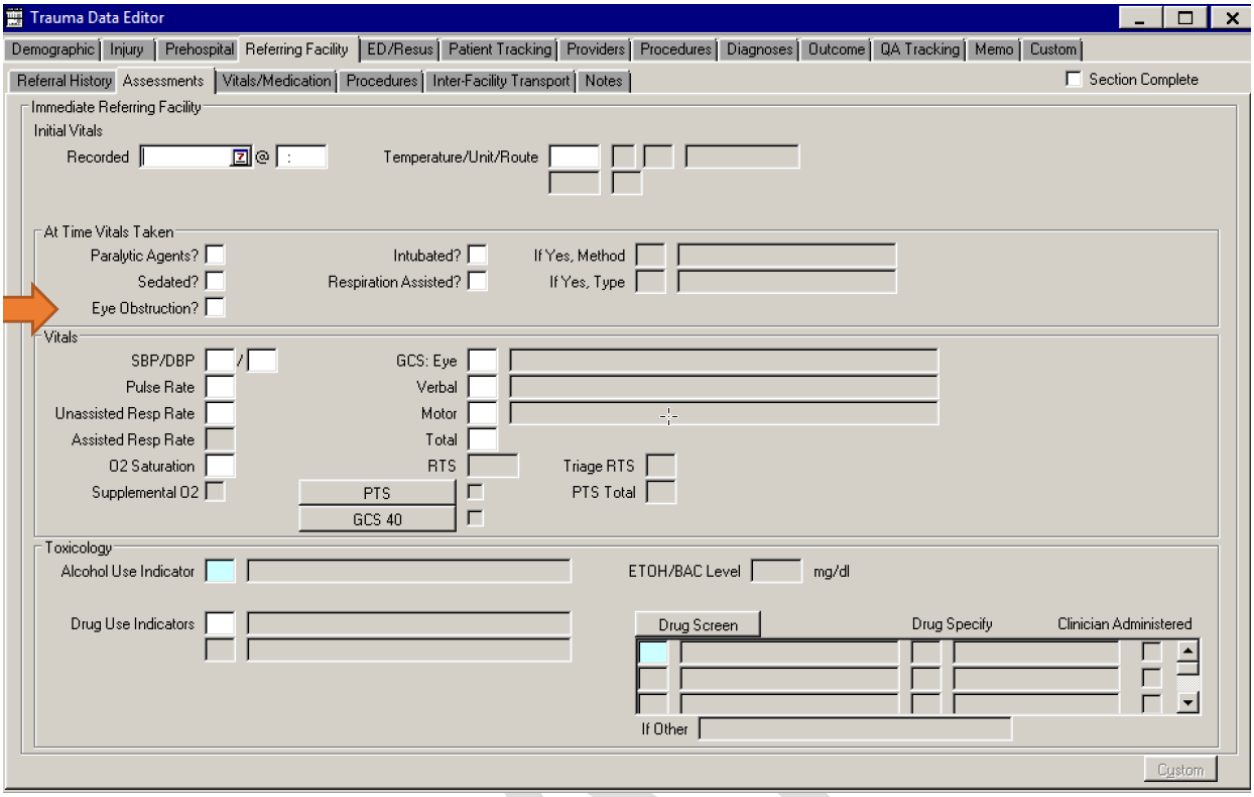
Were sedative agents affecting the patient at the time the vitals were taken?

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Eye Obstruction

Defintion

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

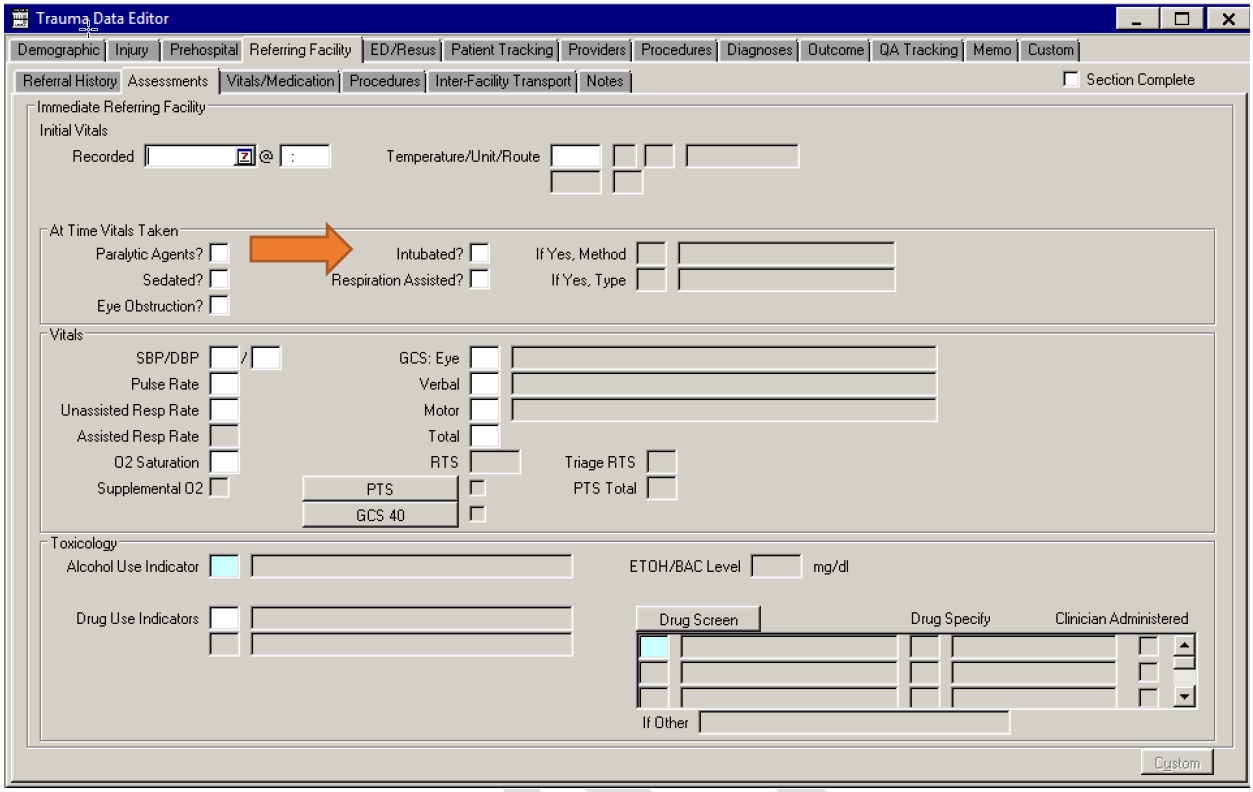
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Intubated

Defintion

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

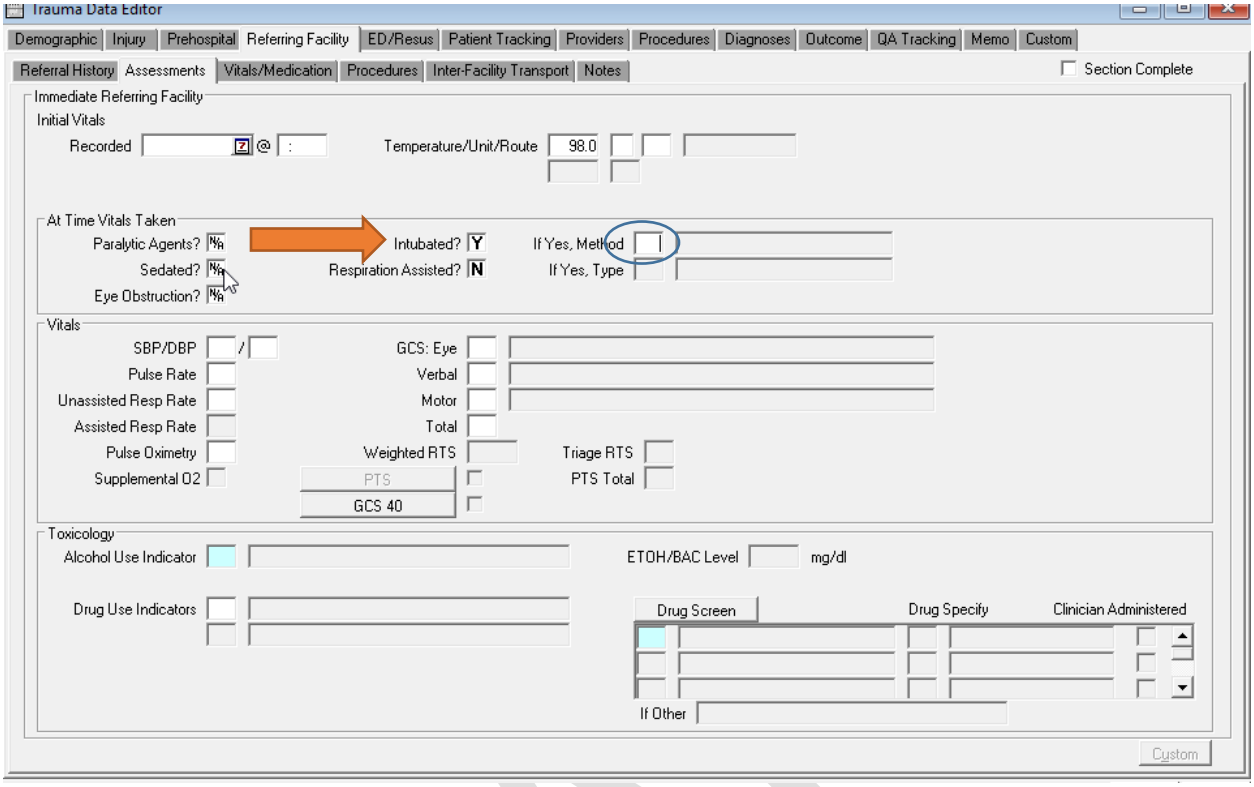
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facilty: Intubation Method

Defintion

The device or method used to intubate the patient.

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

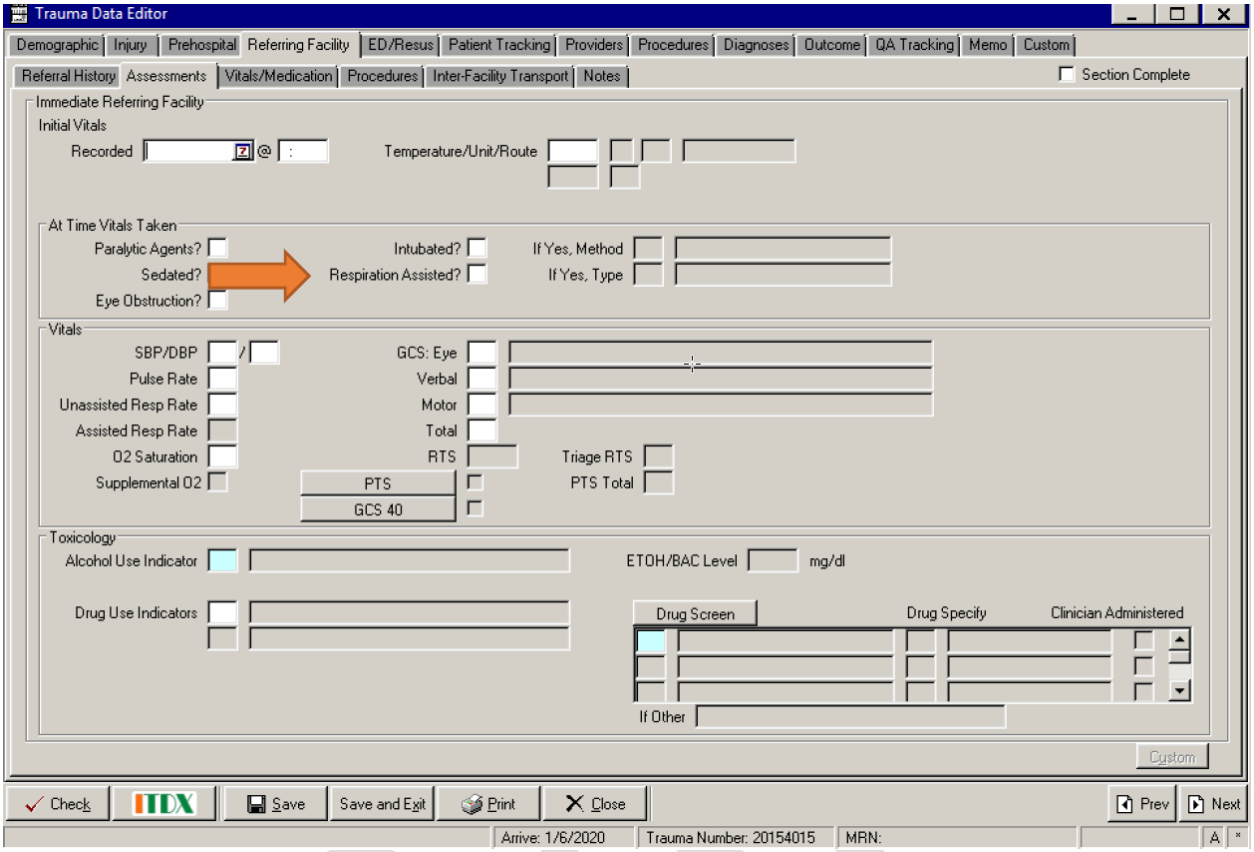
Element Values

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

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Respiration Assisted

Defintion

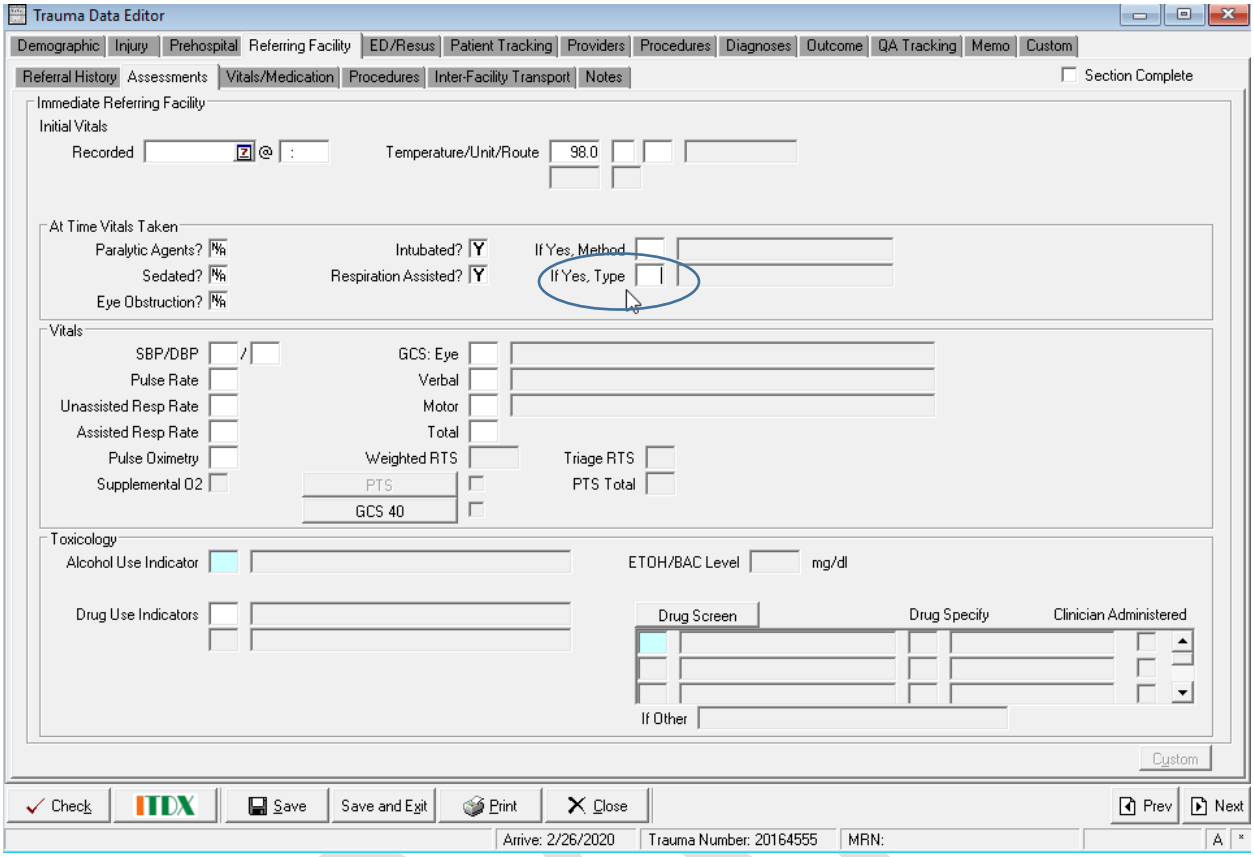
Did the patient require assisted respirations at the time the vitals were taken?

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Respiration Assisted Type

Defintion

The Device used to assist the patient's respirations.

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

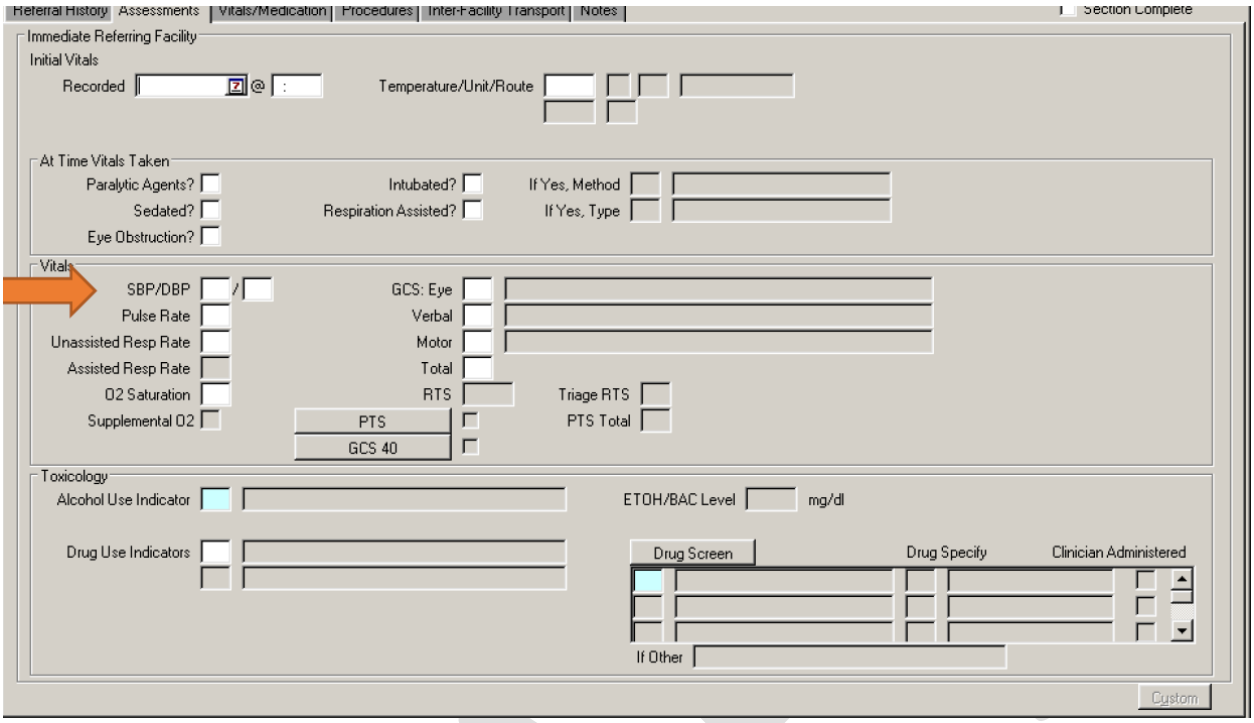
Element Values

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

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Intial Systolic and Diastolic Blood Pressure

Defintion

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

Element Values

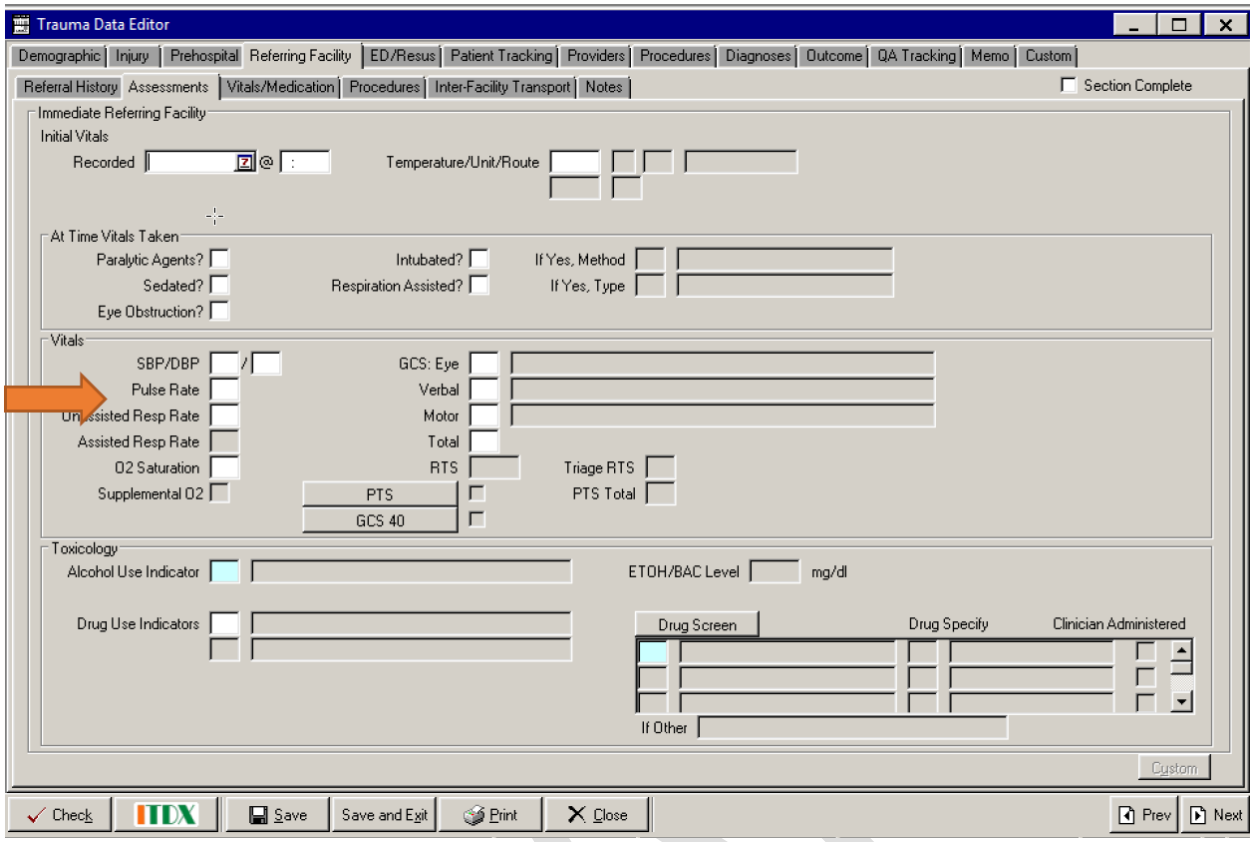
- Relevant Value for Data Element

NOTE: The first recorded referring facility bitals do not need to be from the same assesment. Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, repor the value obtained while compressions are paused.

Date Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Initial Pulse Rate

Definition

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

Element Values

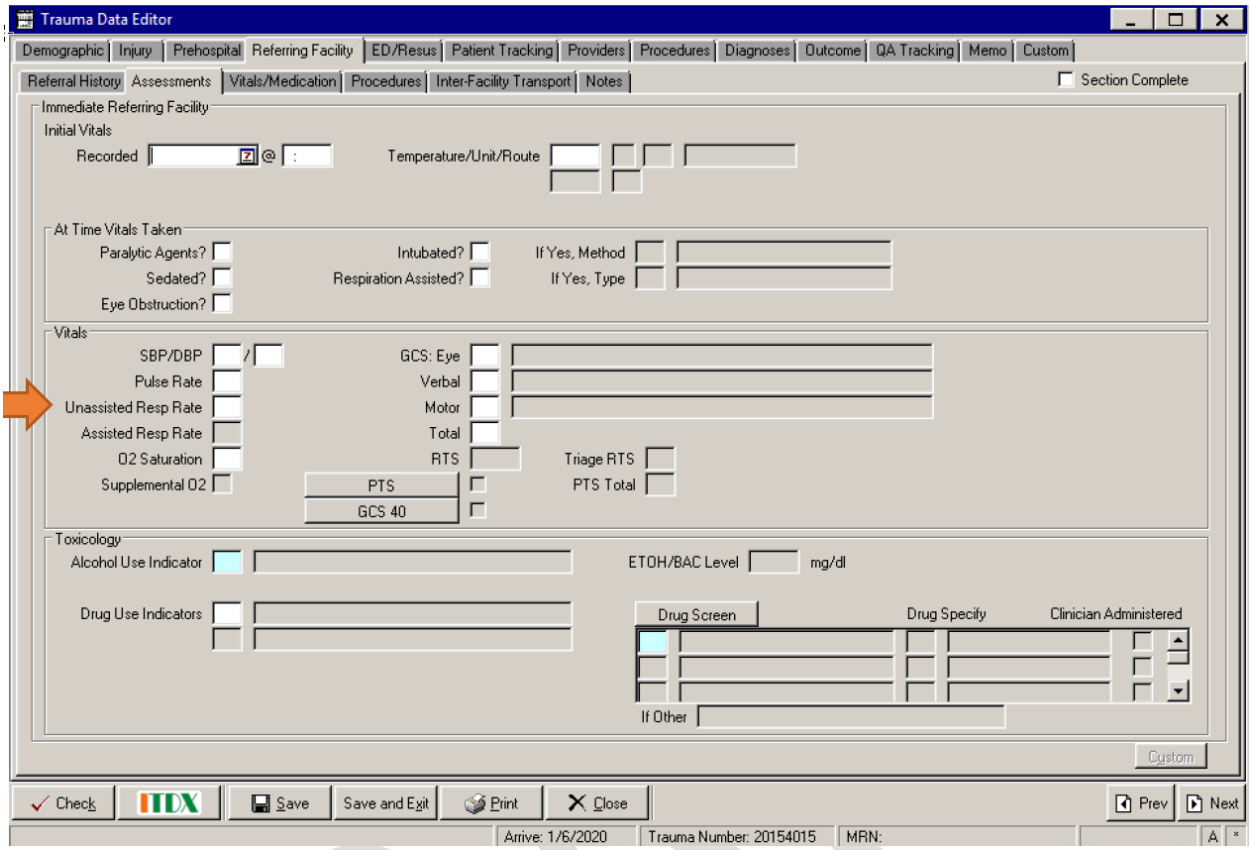
- Relevant Value for Data Element

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

Measurement reported must be without the assistance of CPR or an type of mechanical chest compressions; report the value obtained while compressions are paused.

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Unassisted Respiratory Rate

Defintion

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

Element Value

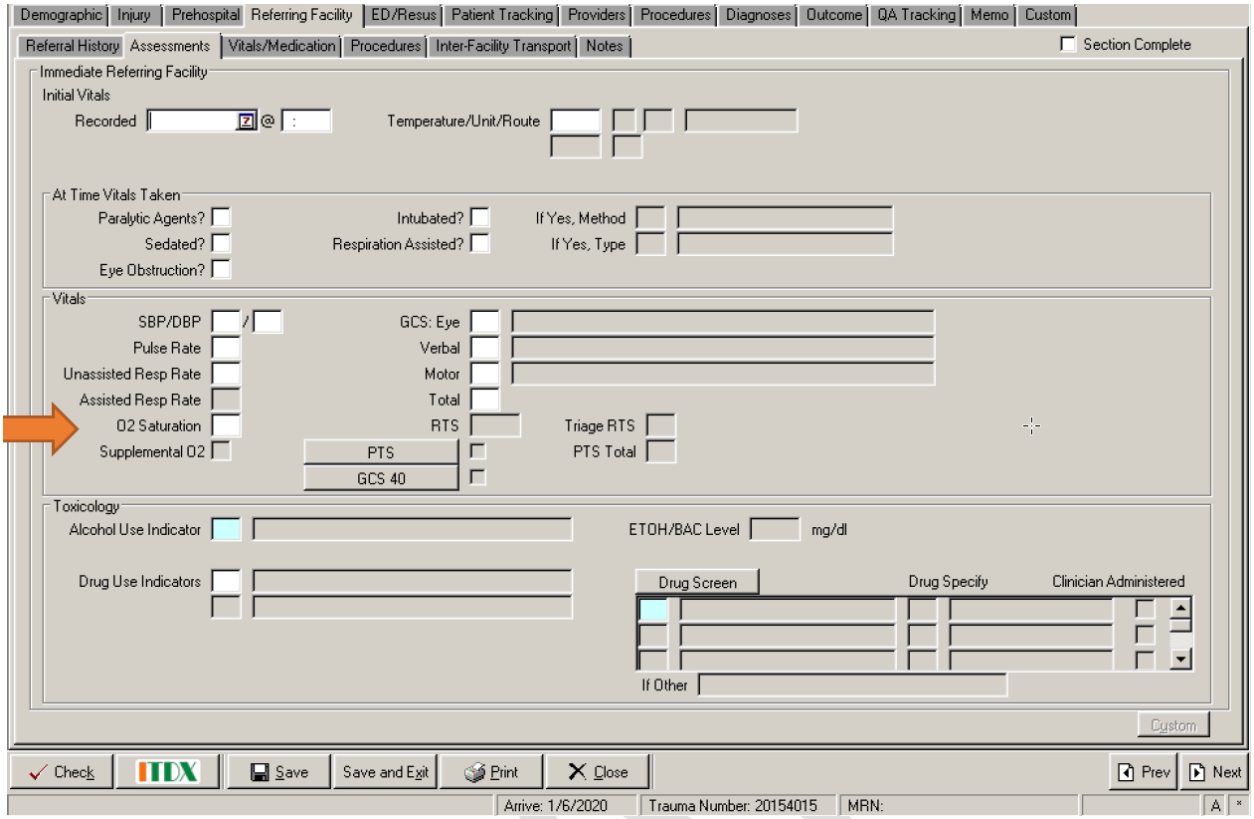
- Relevant Data for data Element

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

Data Source Hiearchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facilty: Oxygen Saturation

Defintion

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

Element Values

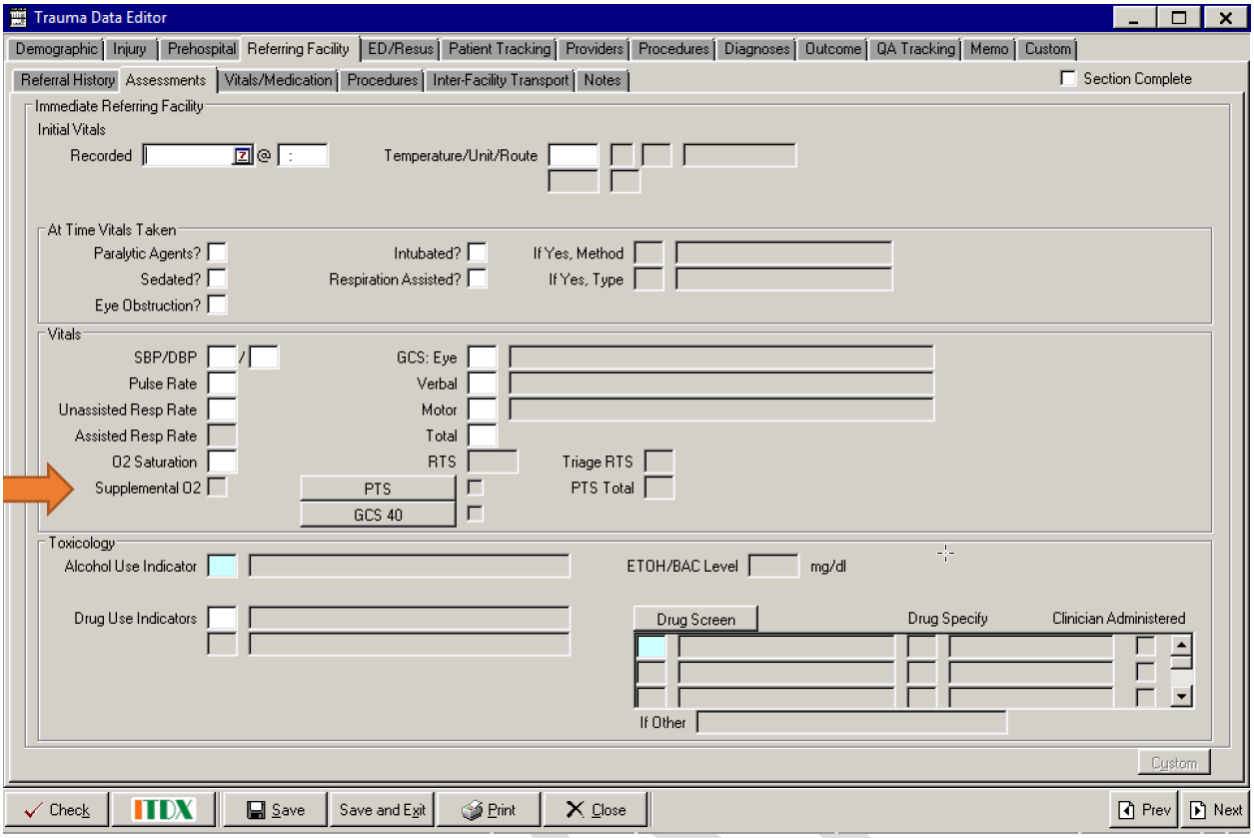
- Relevant Value for Data Element

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Supplemenatl Oxygen

Defintion

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

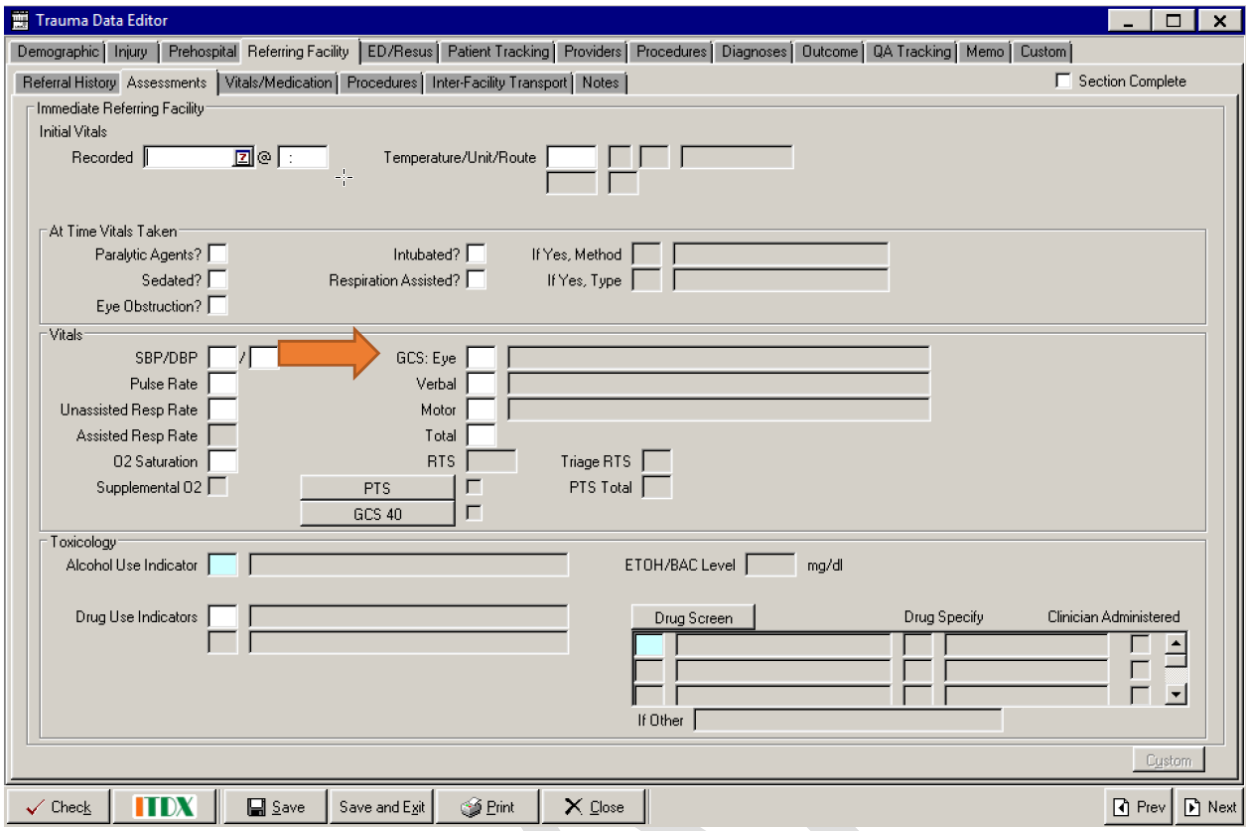
Element Values

- Rleveant Value for Data Element

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Refering Facility: GCS Eye

Defintion

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

Element Values

1. No Eye Movement when Assessed
2. Opens Yes in Response to Painful Stimulation
3. Opens Eyes in Response to Verbal Stimulation
4. Opens Eyes Spontaneously

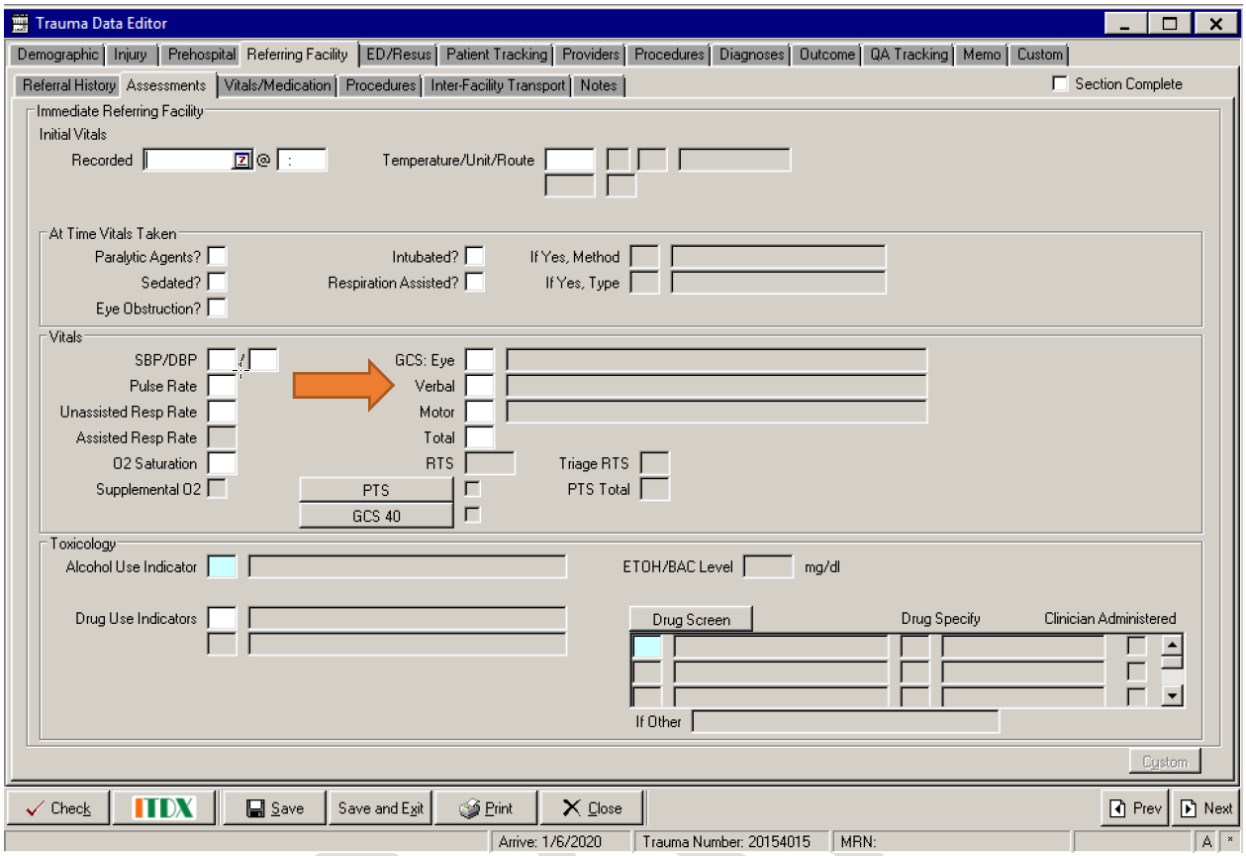
/. Not Applicable

?. Unknown

NOTE: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate number score may be reported.
The null value "Not Known/Not Recorded" is reported if the patient's initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Arrival Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: GCS Verbal

Defintion

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

Element Values

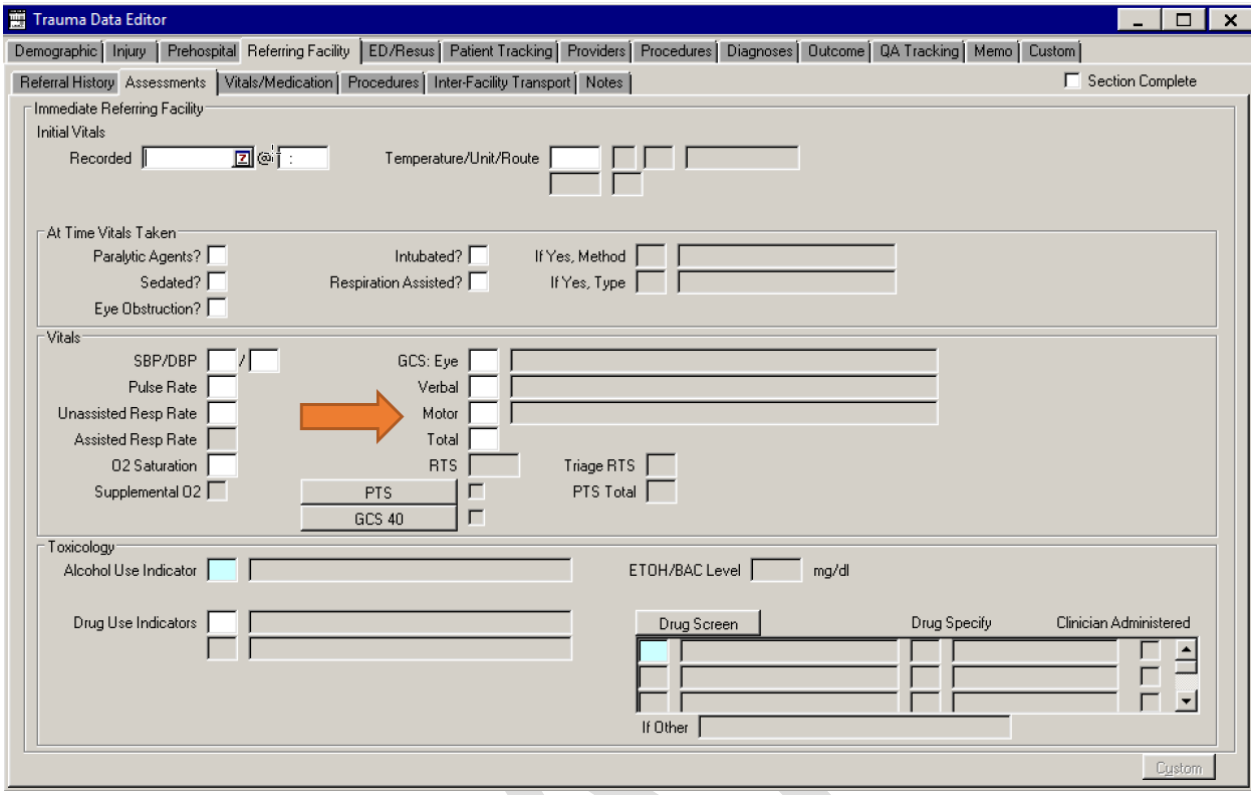
1. No Verbal Response (Pediatric ≤ 2 years: No vocal response)
2. Incomprehensible Sounds (Pediatric ≤ 2 years: Inconsolable, Agitated)
3. Inappropriate Words (Pediatric ≤ 2 years: Inconsistently Consolable, Moaning)
4. Confused (Pediatric ≤ 2 years: Cries but is consolable, Inappropriate Interactions)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

/. Not Applicable
?. Unknown

NOTE: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate number score may be reported.
The null value "Not Known/Not Recorded" is reported if the patient's initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: GCS Motor

Defintion

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

Element Values

1. No Motor Response
2. Extension to Pain
3. Flexion to Pain
4. Withdrawal from Pain
5. Locating Pain
6. Obeys Commands (Pediatric ≤ 2 years: Appropriate Response to Stimulation).

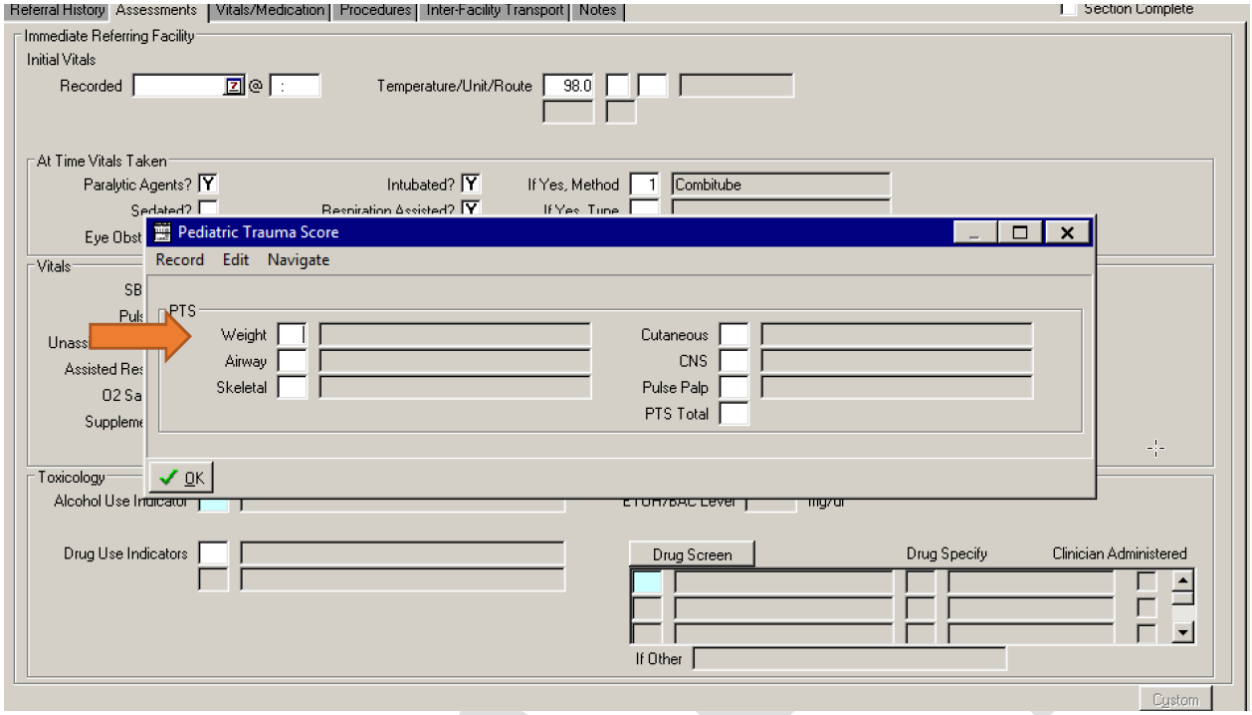
/. Not Applicable

?. Unknown

NOTE: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate number score may be reported.
The null value "Not Known/Not Recorded" is reported if the patient's initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: Weight

Defintion

The weight of the patient at the time of injury.

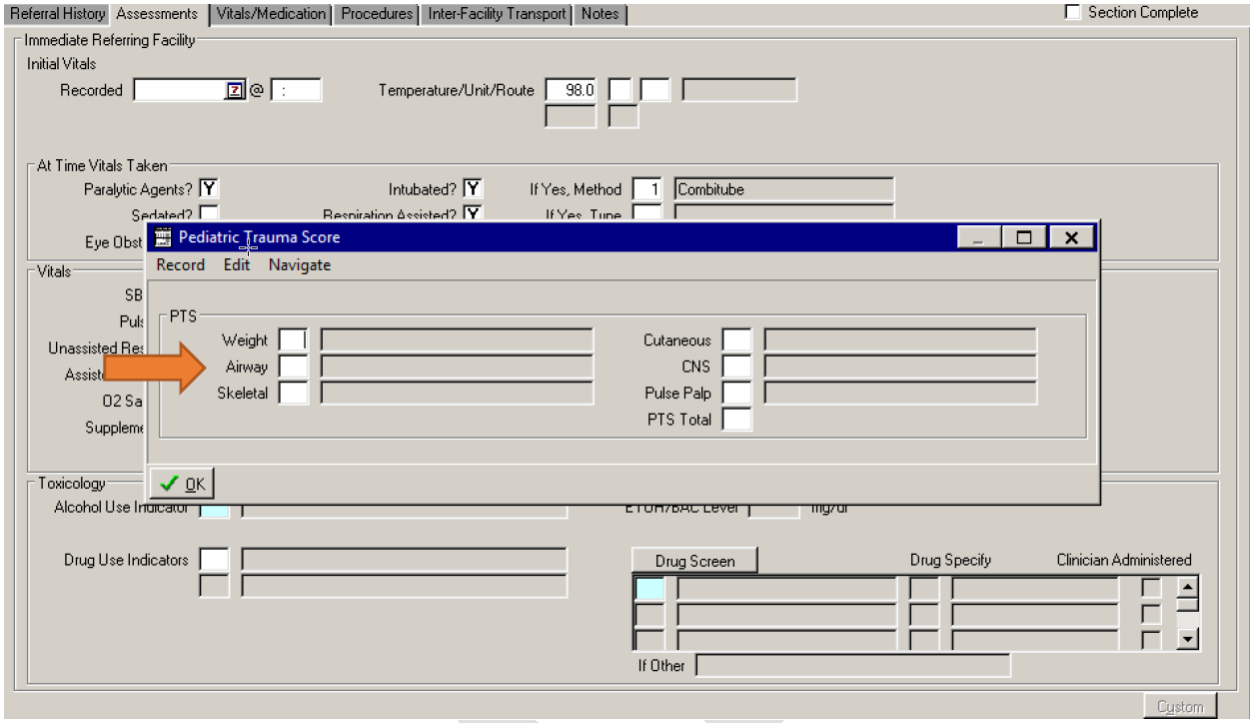
NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: Airway

Defintion

The status of the aptient's airway upon ED/Hospital initial assemesment.

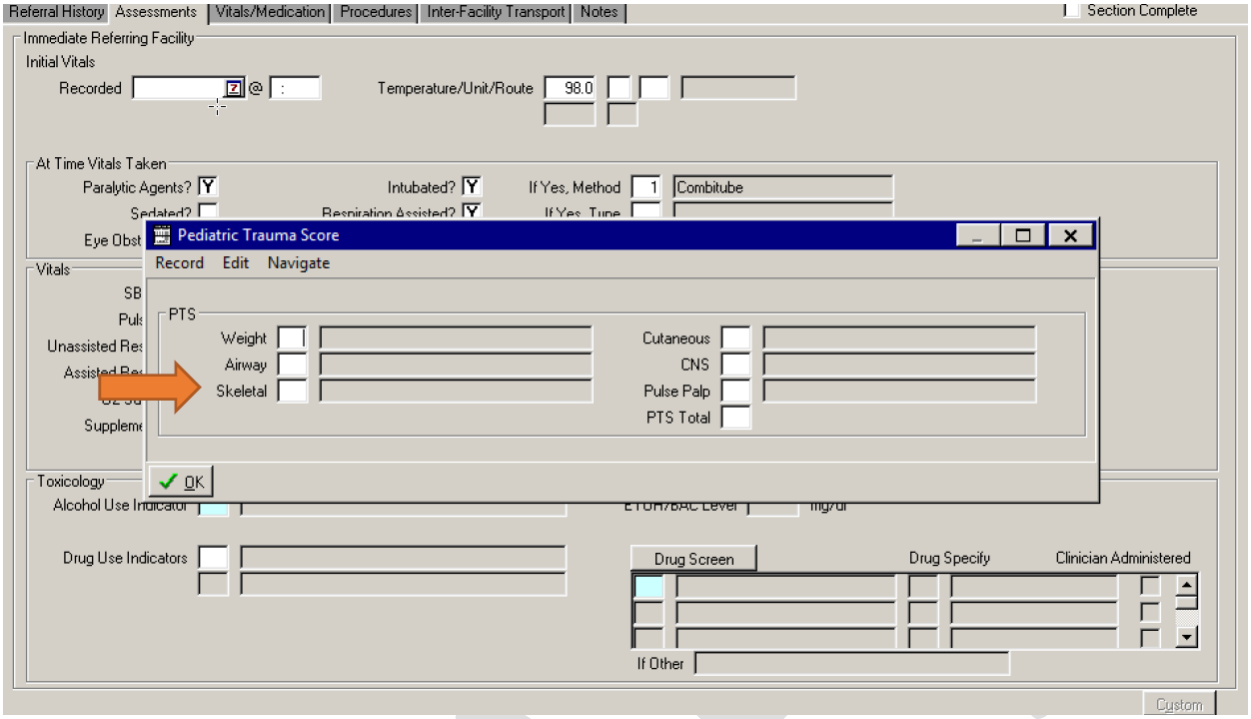
NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: Skeletal

Defintion

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

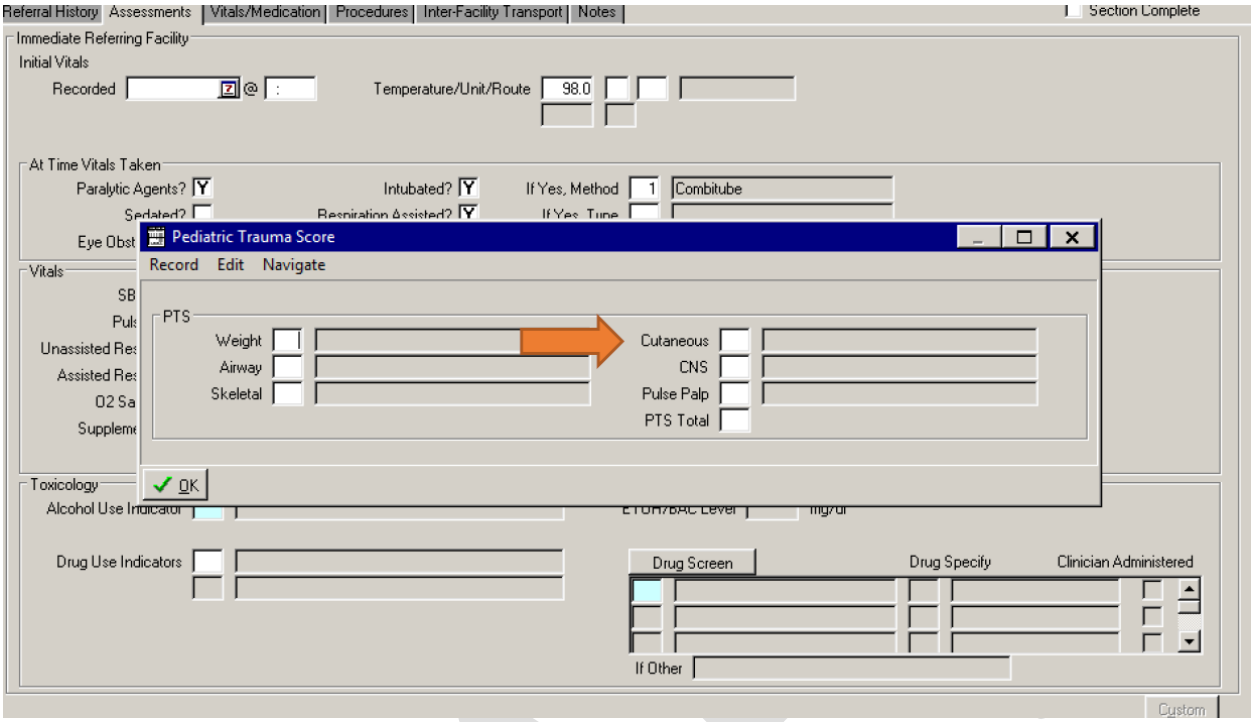
NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: Cutaneous

Defintion

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

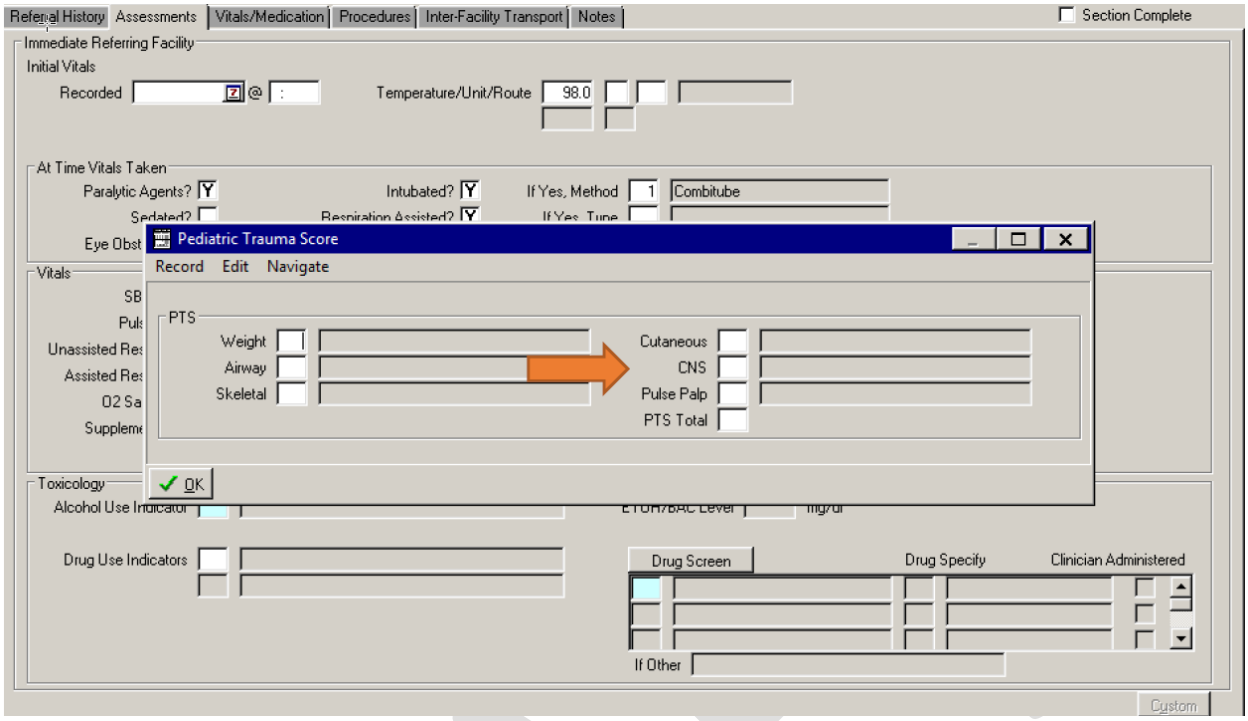
NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: CNS

Definiton

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

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

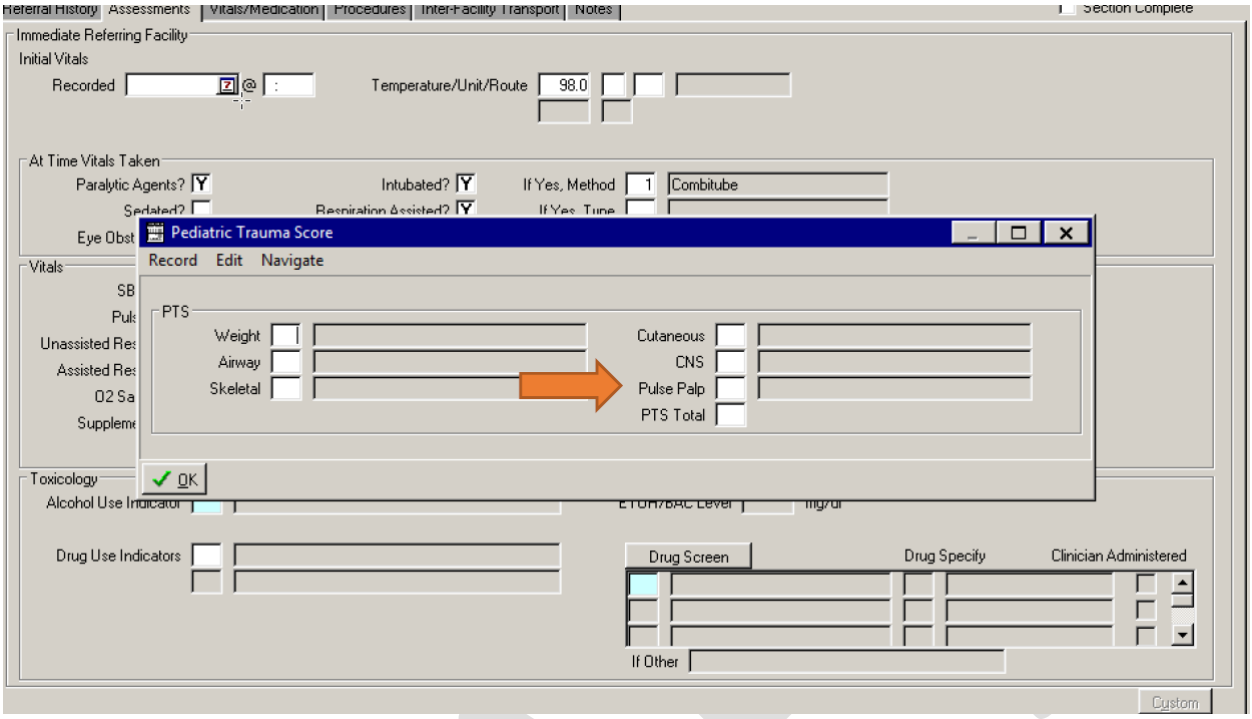
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Pediatric Trauma Score: Pulse Palp

Definiton

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

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

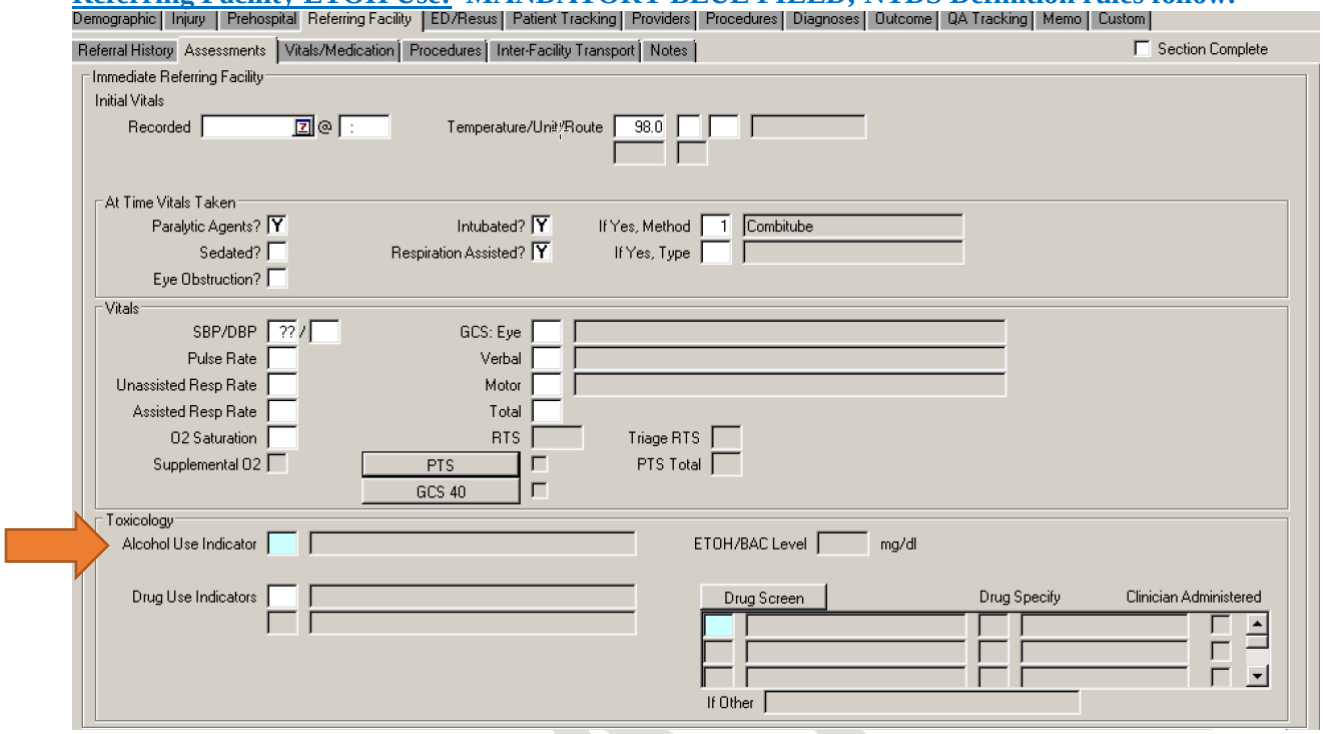
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

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



Referring Facility: Alcohol Use Indicator

Definition

A blood alcholo concetration (BAC) test was peroformed on the patient within 24 hours after the first hospital encounter.

Element Values

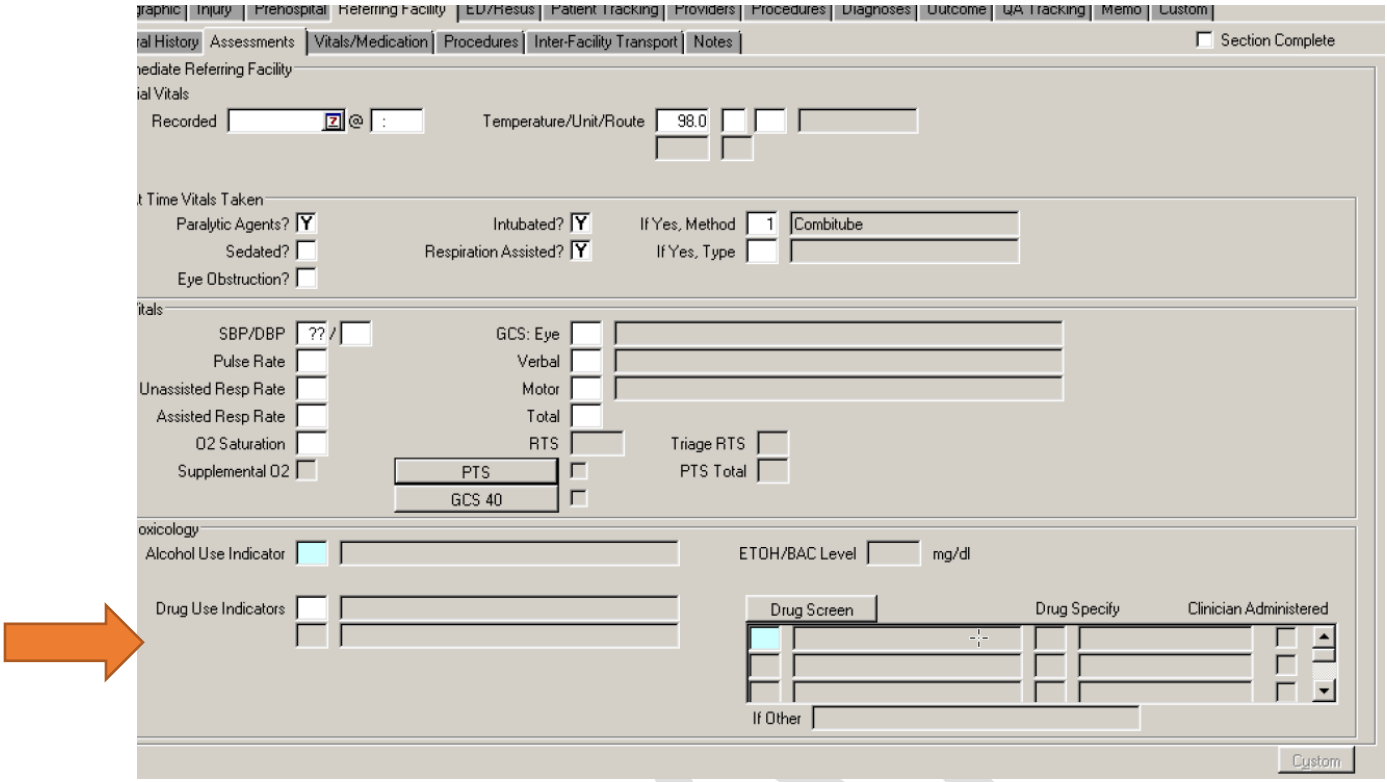
1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test)
4. Yes (confirmed by test: beyond legal limit)

/. Not applicable

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility: Drug Use Indicator

Definition

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

Element Values

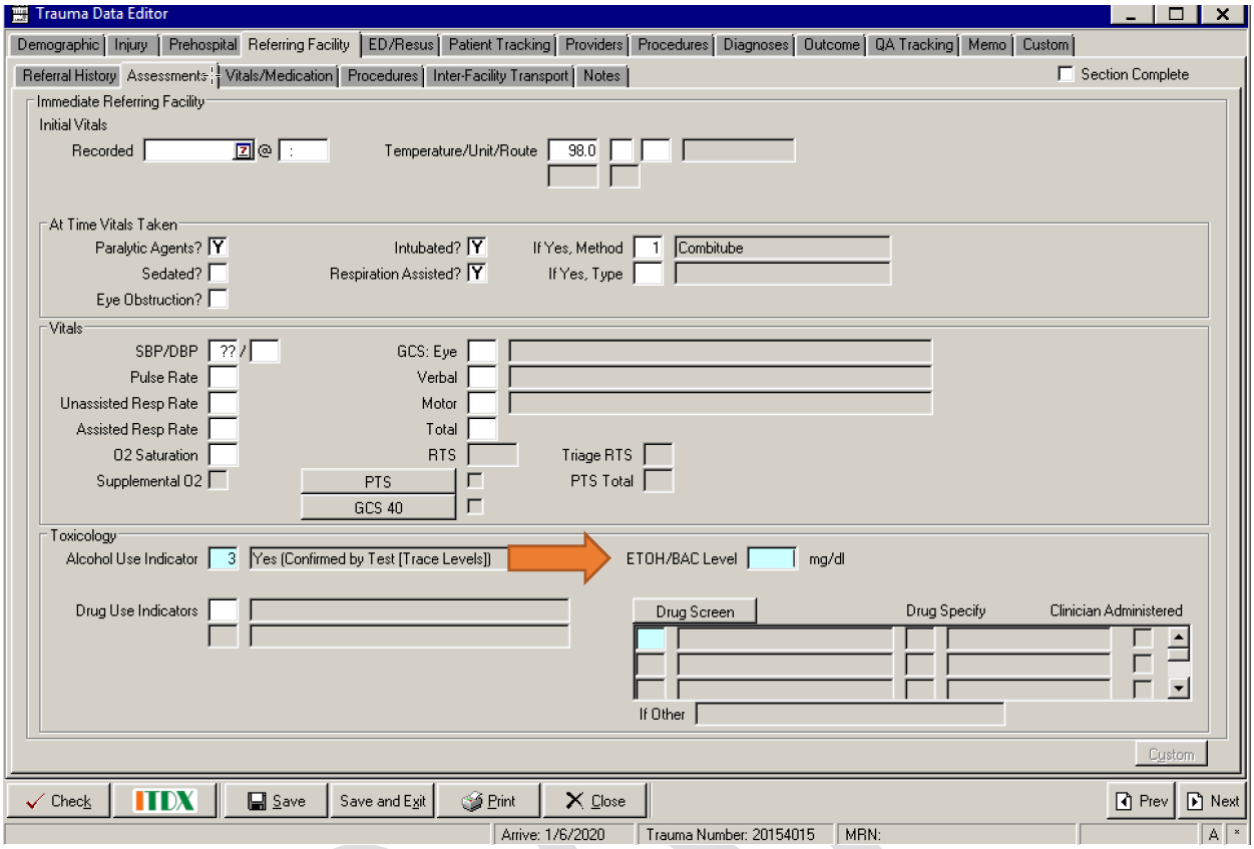
1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test: prescription drugs)
4. Yes (confirmed by test: illegal drug use)

/. Not applicable

?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork



MANDATORY BLUE FIELD; NTDS Definition rules follow.

Referring Facility: ETOH/BAC Level

Definition

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

Elemental Values

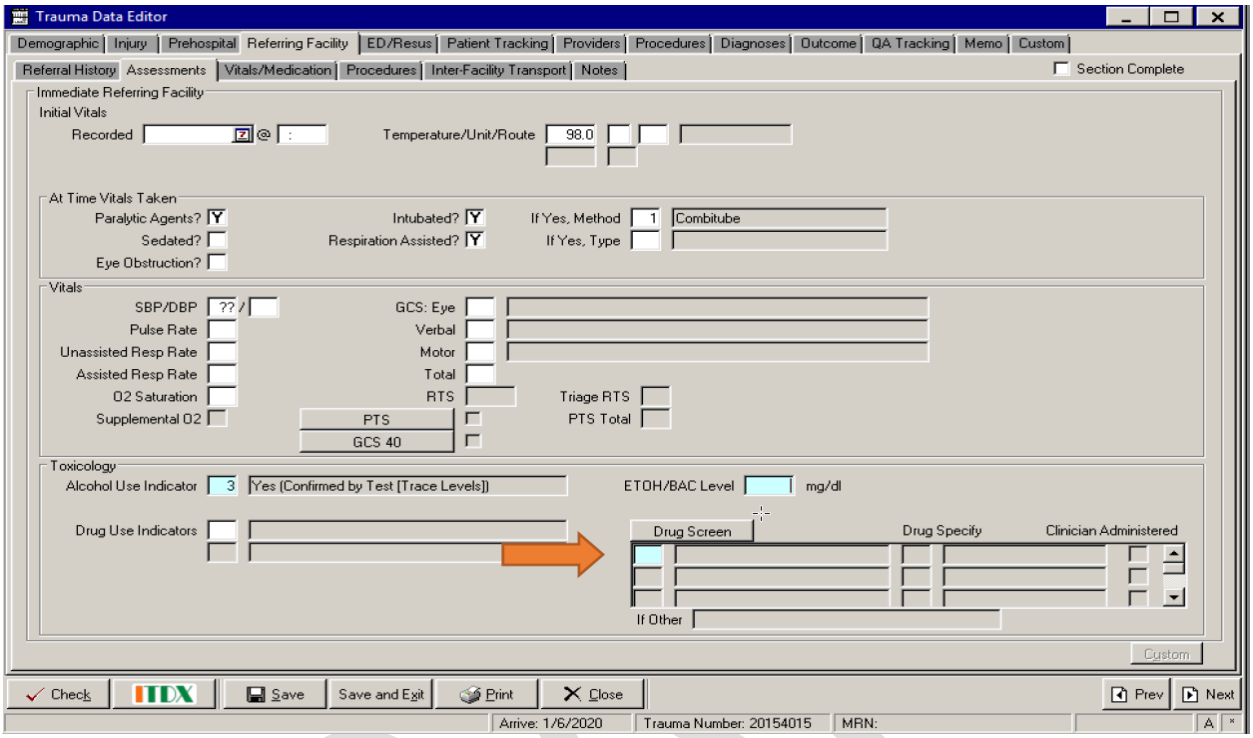
- Relelveant value for data element.

NOTE: Reported at grams per deciliter.
Alchol screen may be administered at any facility, unit or setting treating this patient event.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



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

Referring Facility: Drug Screen

Definition

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

Element Values

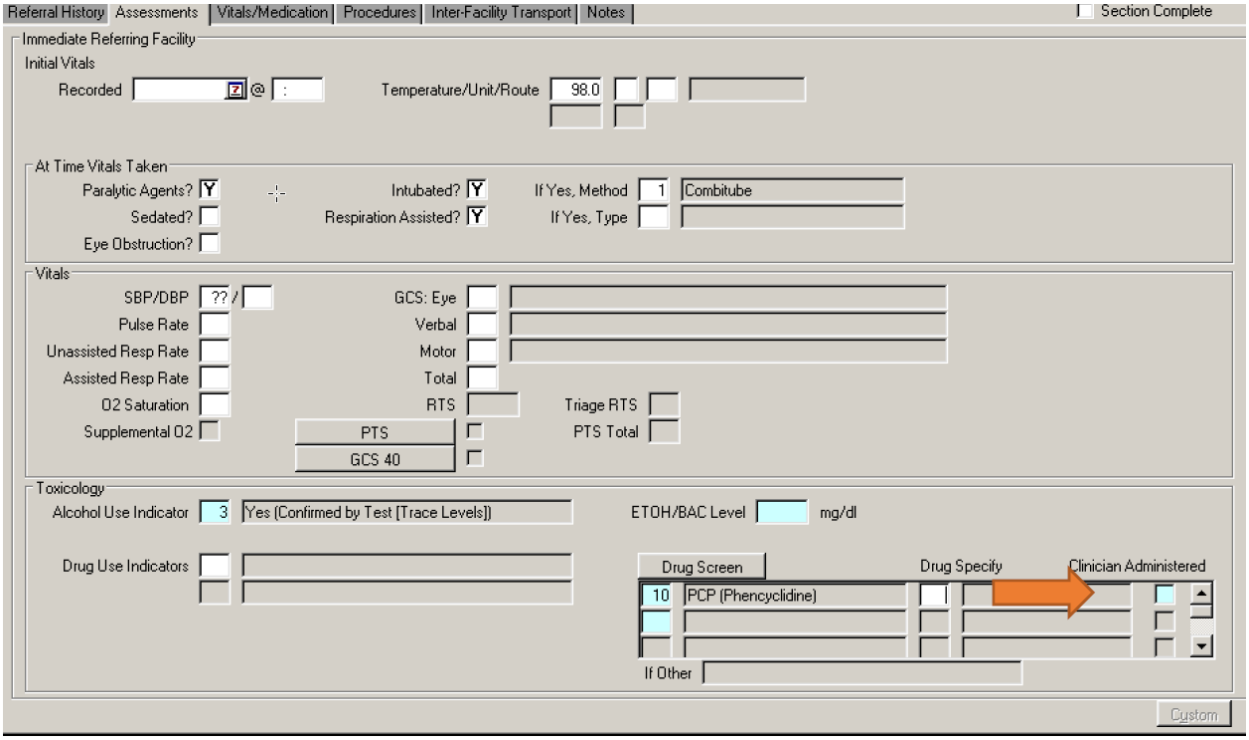
1. AMP (Amphetamine)
2. BAR (Barbituate)
3. BZO (Benzodiazepines)
4. COC (Cocaine
5. mAMP (Methamphetamine)
6. MDMA (Ecstasy)
7. MTD (Methadone)
8. OPI (Opioid)
9. OXY (Oxycodone)
10. PCP (Phencyclidine)
11. TCA (Tricyclic Antidepressant)
12. THC (Cannabinoid)
13. Other
15. Not Tested

?. Unknown

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Referring Facility Clinical Admin: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Referring Facility: Clinician Administered

Definition

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

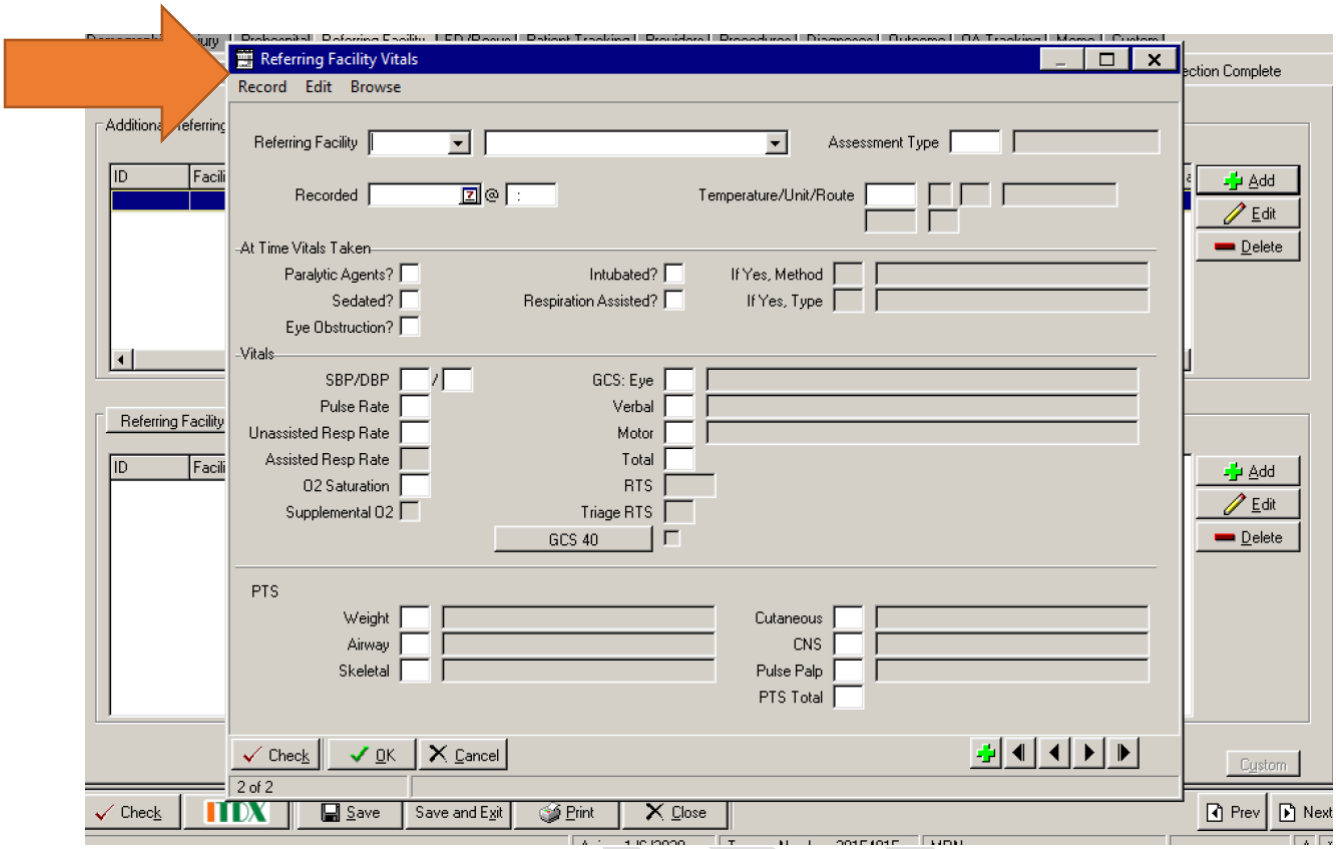
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Additional Referring Facility: Vitals

Definition

Any additional vitals recoreded at the referring facility prior to transer to your facility.

Element Values

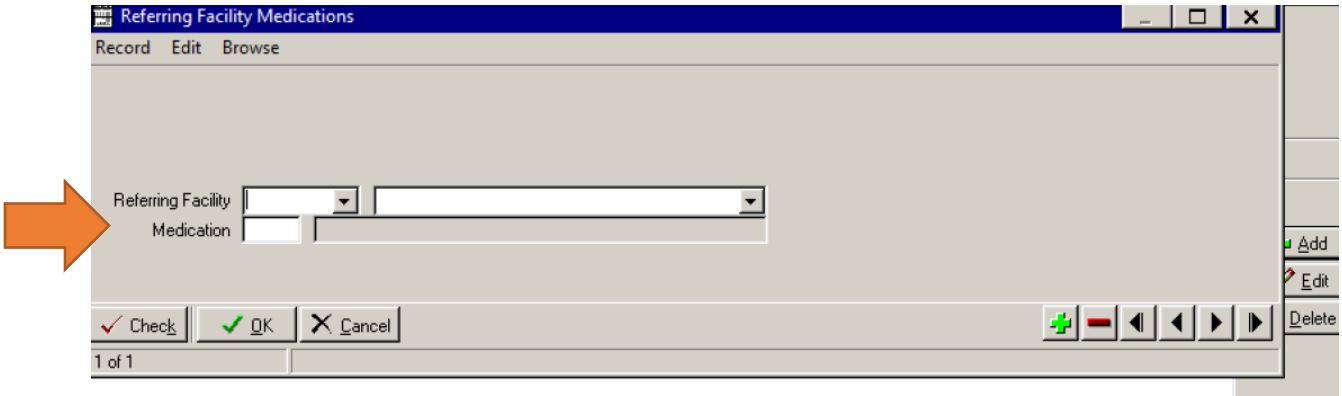
- Refer to previous vitals for specific information regarding the documentation of the vital signs.

NOTE: These vitals do not have to be performed within the first 30 minutes of arrival to the ED/Hospital. Only 1 set of VS at the Referring Facility is required. Additional might be warranted for PI monitoring purposes; Facility determines that.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Medications

Definition

All medications given at the referring facility prior to transfer to your facility.

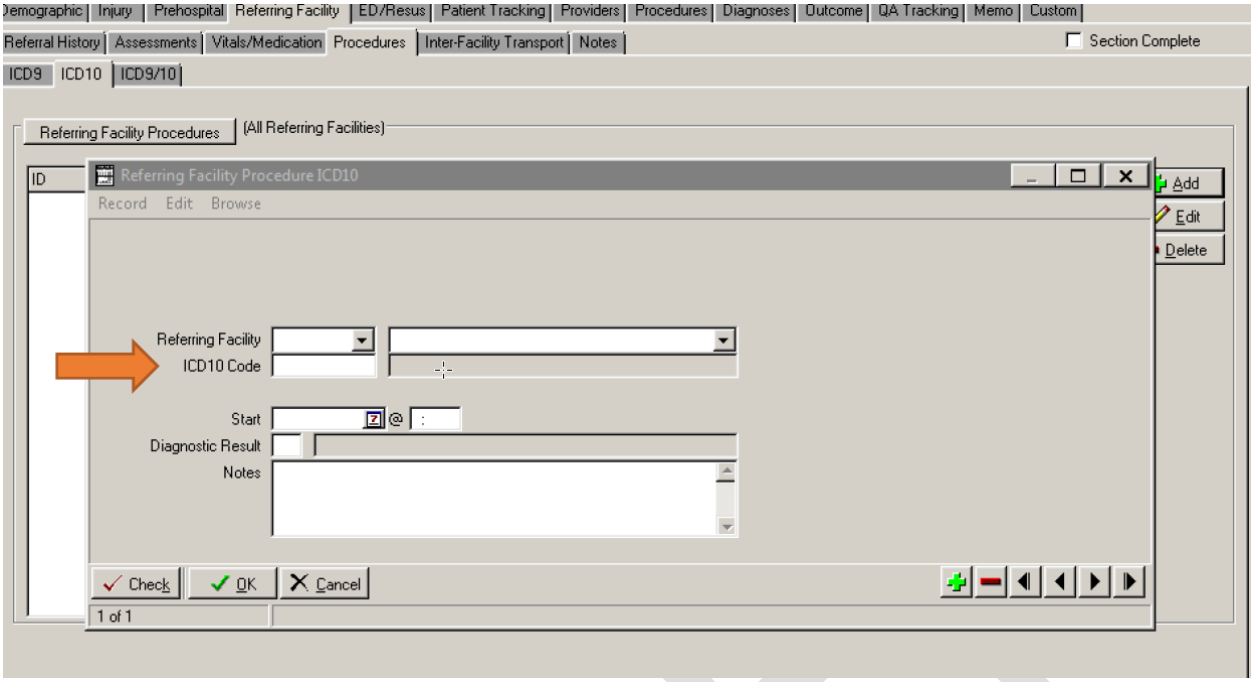
Element Values

- Releavnt Value for data element.
- DI has multiple medications that can be picked.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Procedures

Definition

Operative and selective non-operative procedures conducted during the referring facility stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or compkications.

Element Values

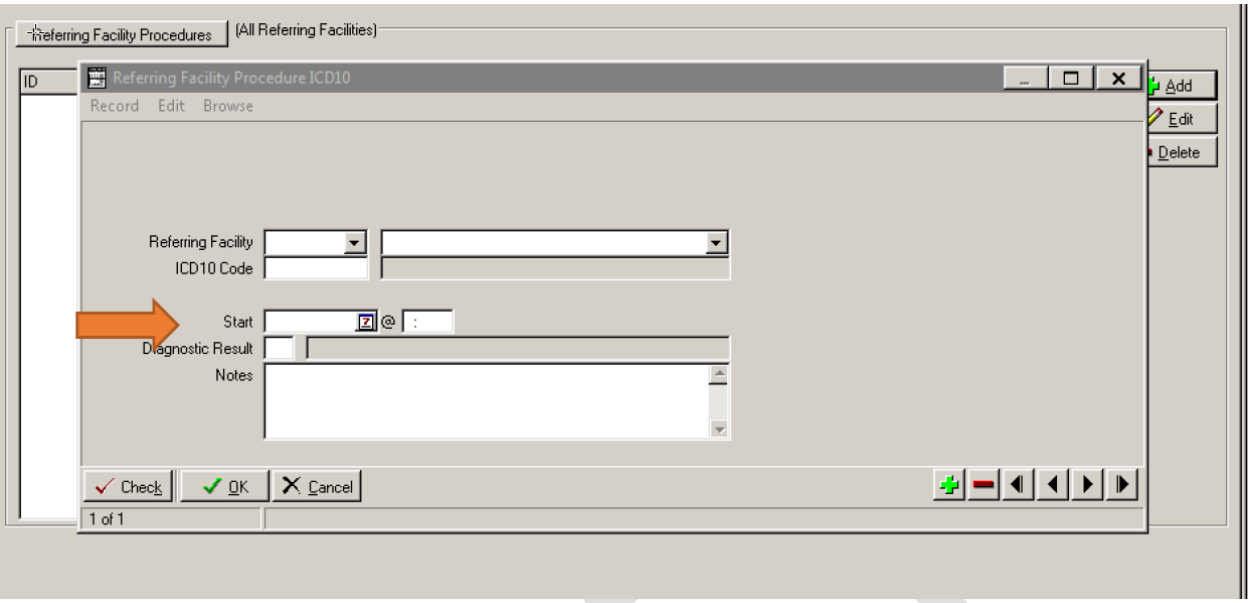
- Major and minor proccedures ICD-10 codes.

NOTE: Only report procedures performed at the referring facility. Same focus on essential vs all procedures for this daata element.

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Procedure – Start Date and Time

Definition

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

Element Values

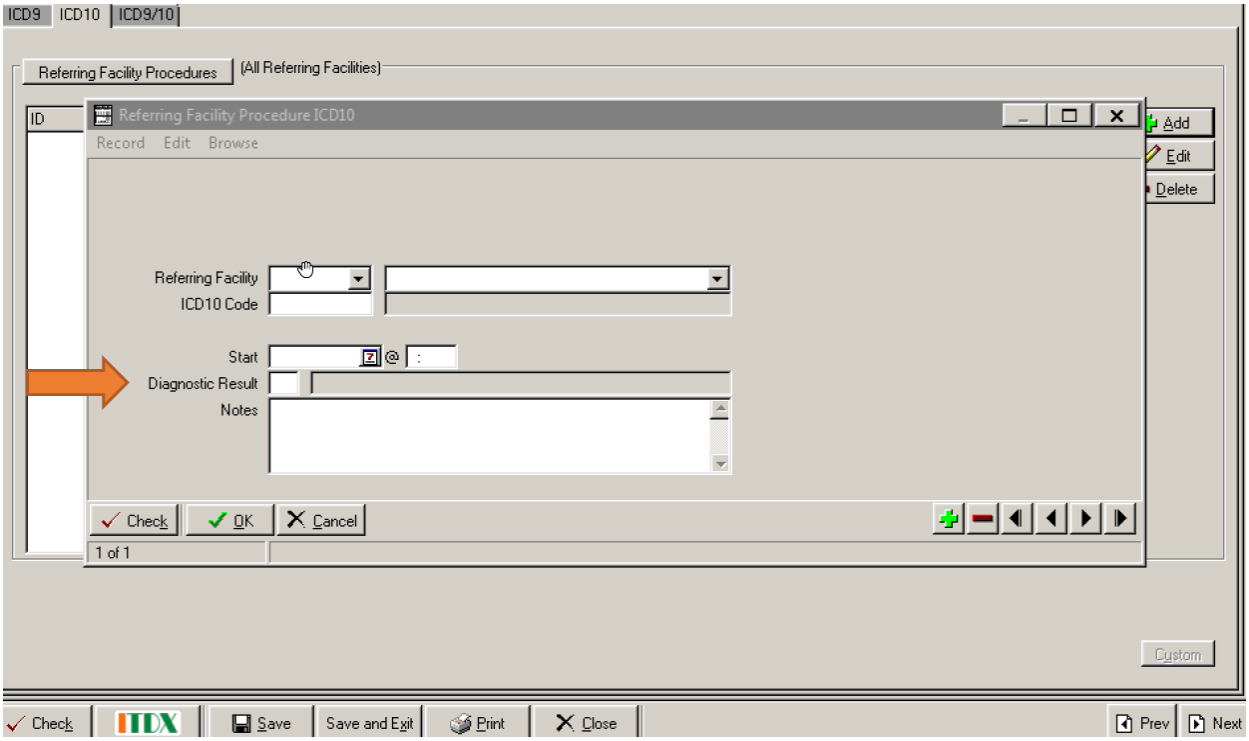
Relevant value for data eleent.

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Referring Facility: Procedure – Diagnostic Result

Definition

The opeartive or selected non-operative procedure had diagnostic capabiities

Element Values

1. Positive
2. Negative
3. Intermediate

/. Not Applicable
?. Unknown

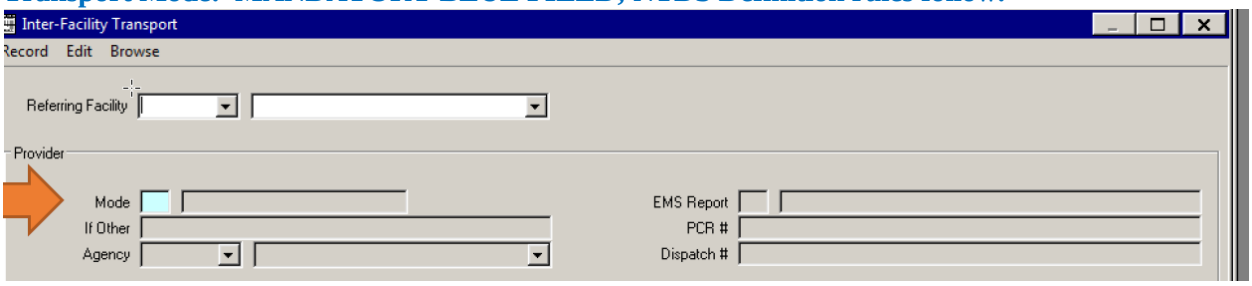
NOTE: We do not input this field because we do not have a clear definition on positive or negative results. This is very difficult to determine at times. It would be more beneficial if noted normal or abnormal imaging results

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT

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



TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Element Values

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

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

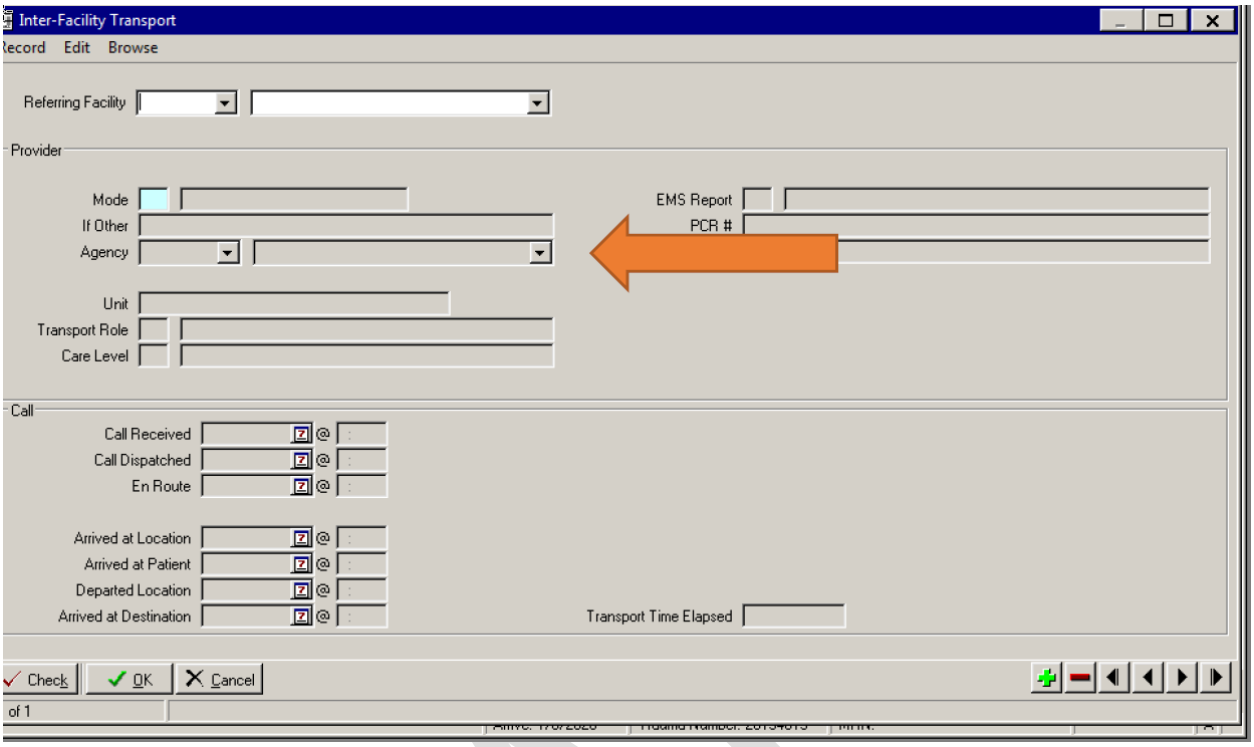
Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be "Not Applicable"
3440	1	Single Entry Max exceeded

DI Elements

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

Data Source Hierarchy Guide:

1. EMS Run Record



Agency

Definition

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

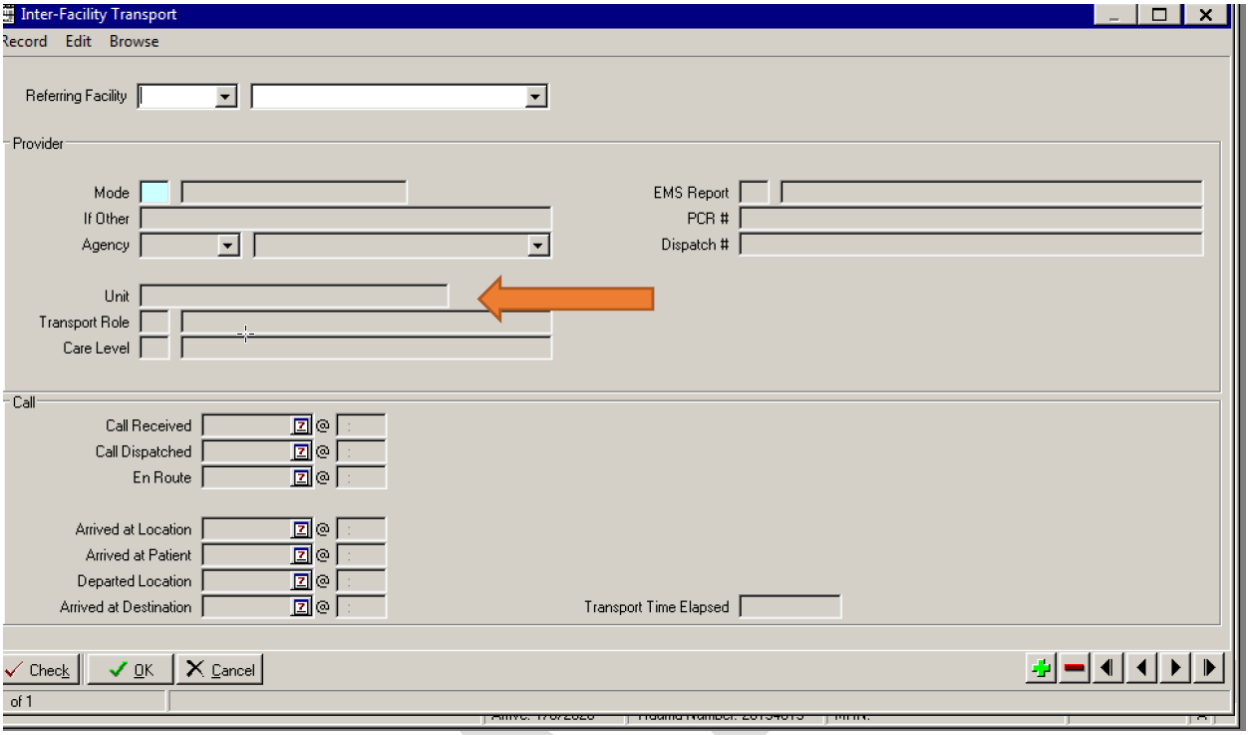
Element Value

- Relevant Value for Date Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Unit

Definition

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

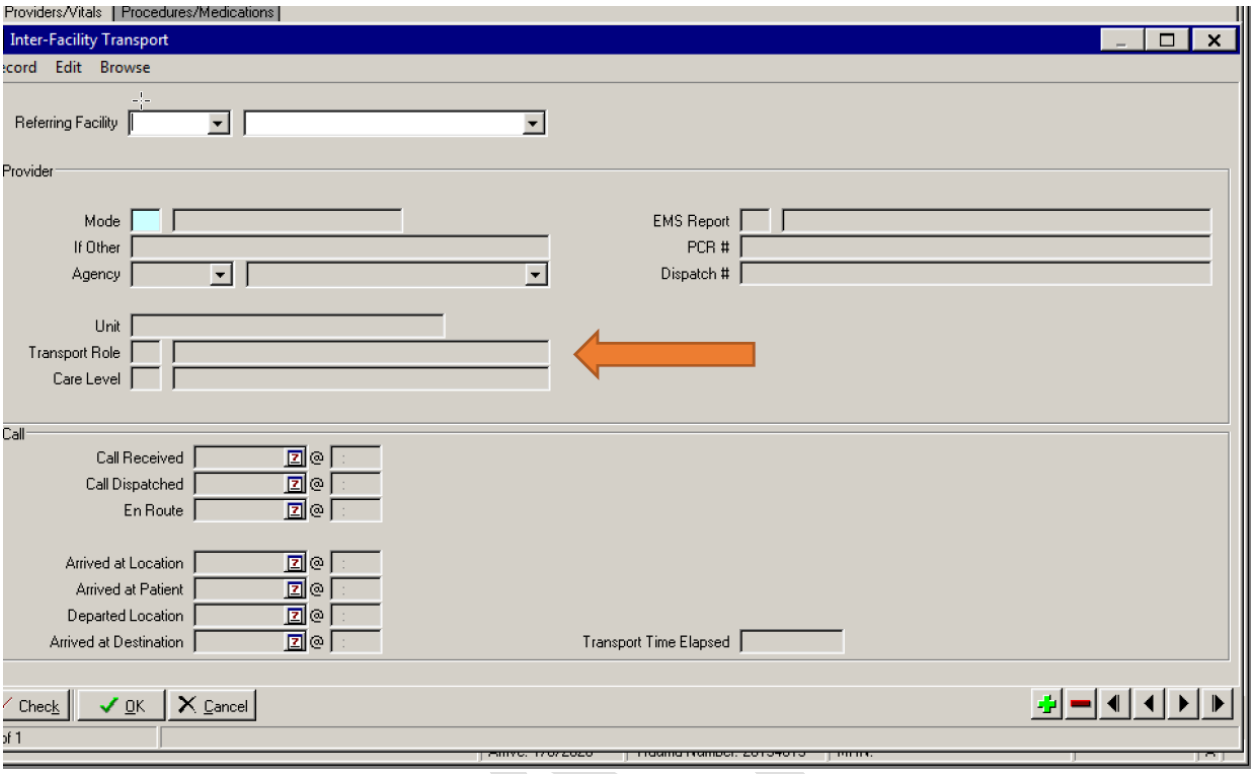
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



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

OTHER TRANSPORT MODE

Definition

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

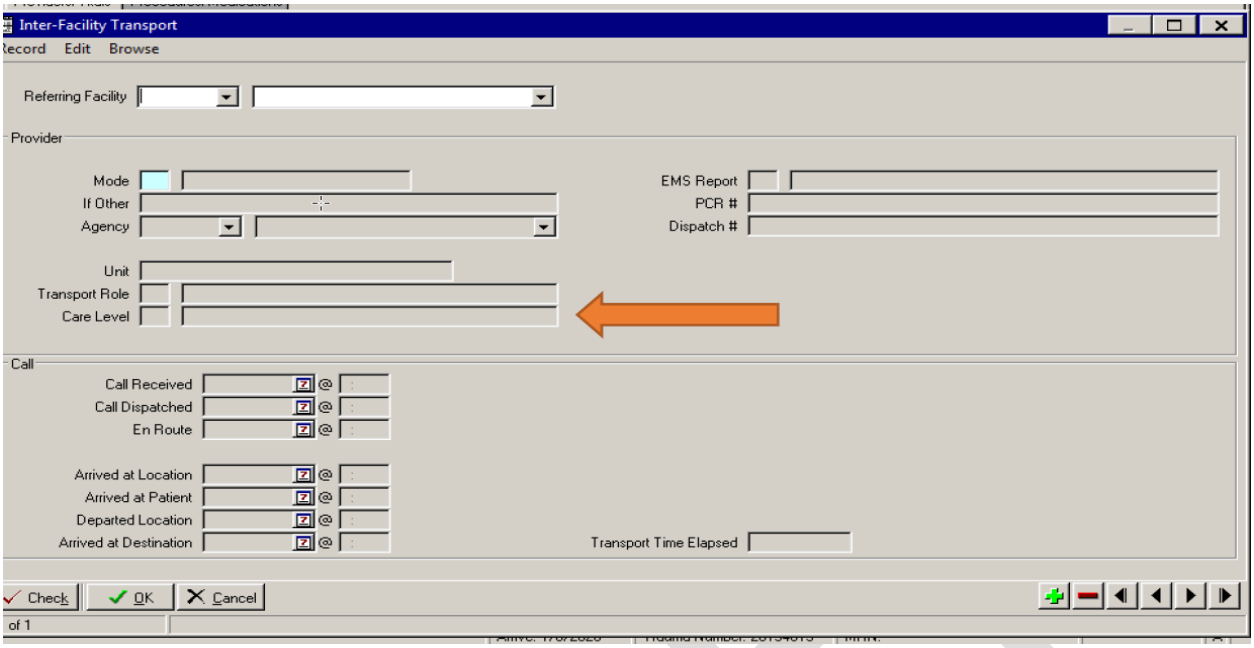
Associated Edit Checks

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

DI[1]Data Elements

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
/. Not Applicable
?. Unknown

DRAFT



Care Level

Definition

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

Element Values

1. Advanced Life Support
2. Basic Life Support

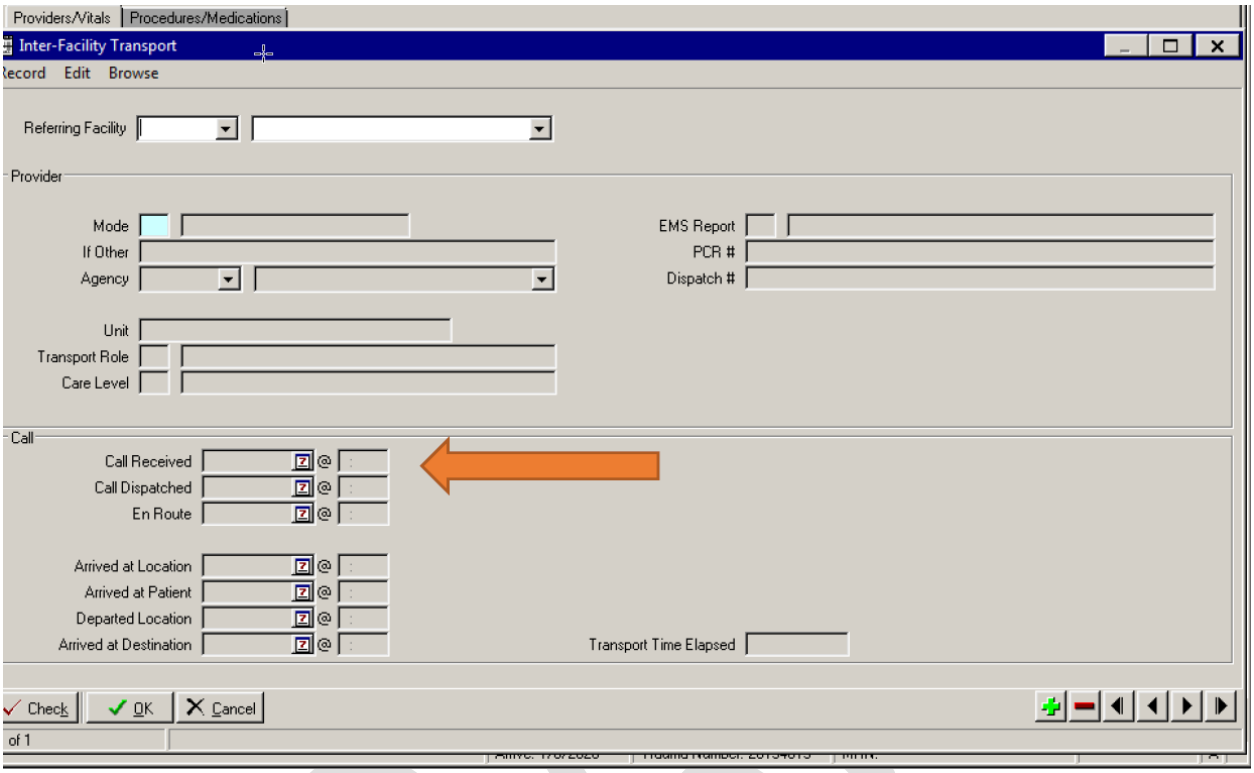
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Call Received: Date and Time

Definition

The date and time tahat the call was received by the distpatcher.

Element Values

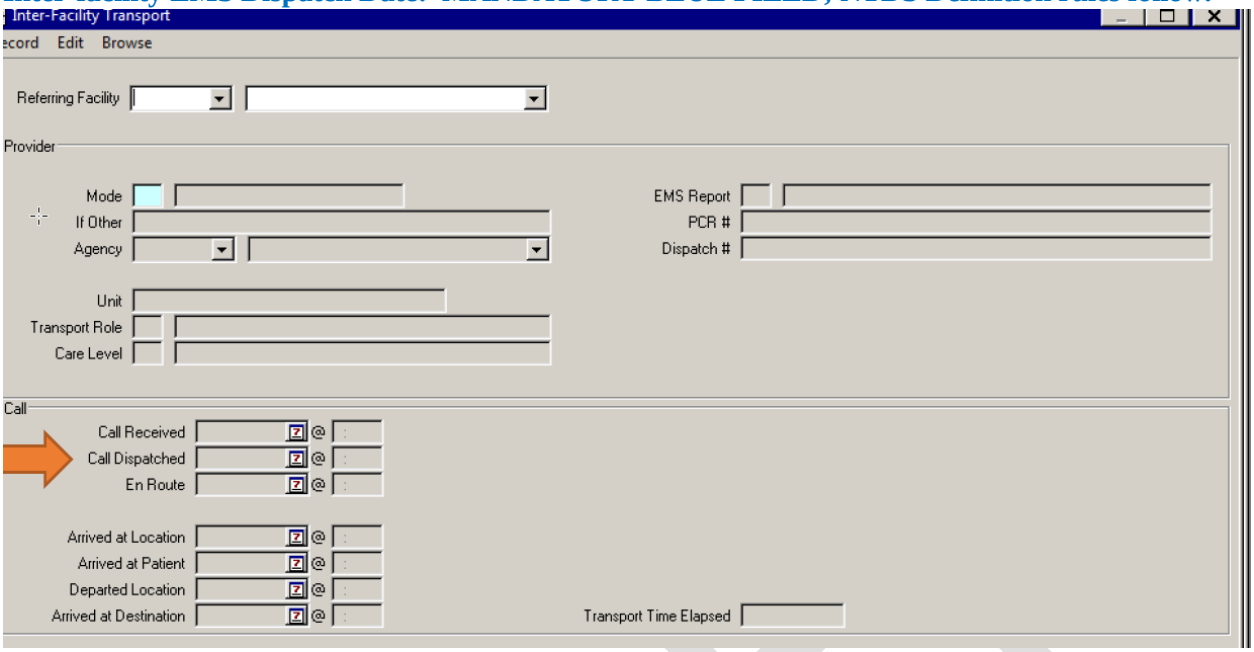
- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT

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



EMS DISPATCH DATE

Definition

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

Element Values

- Relevant value for data element

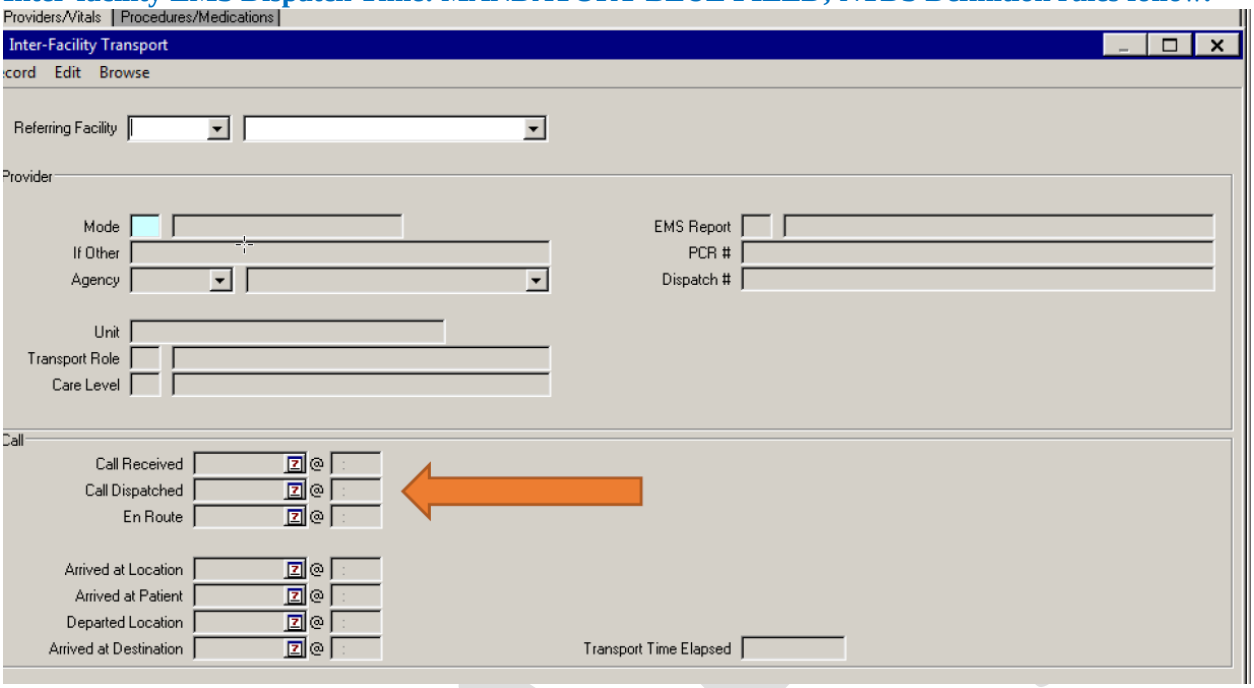
Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

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



EMS DISPATCH TIME

Definition

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

Element Values

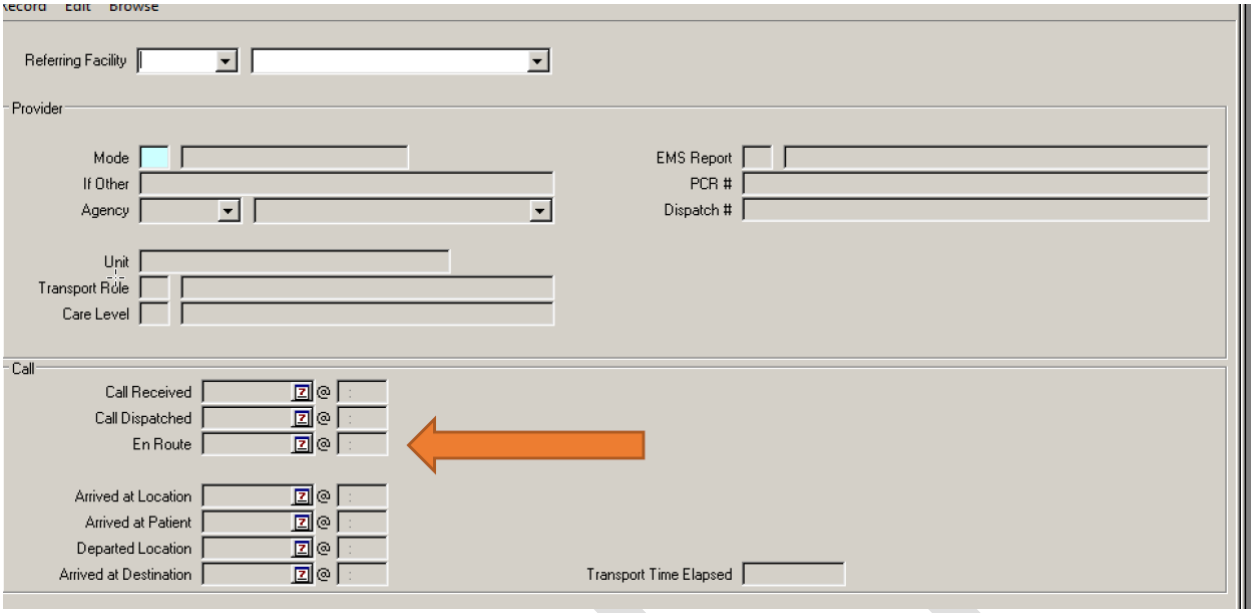
- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report



En-Route: Date and Time

Definition

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

Element Values

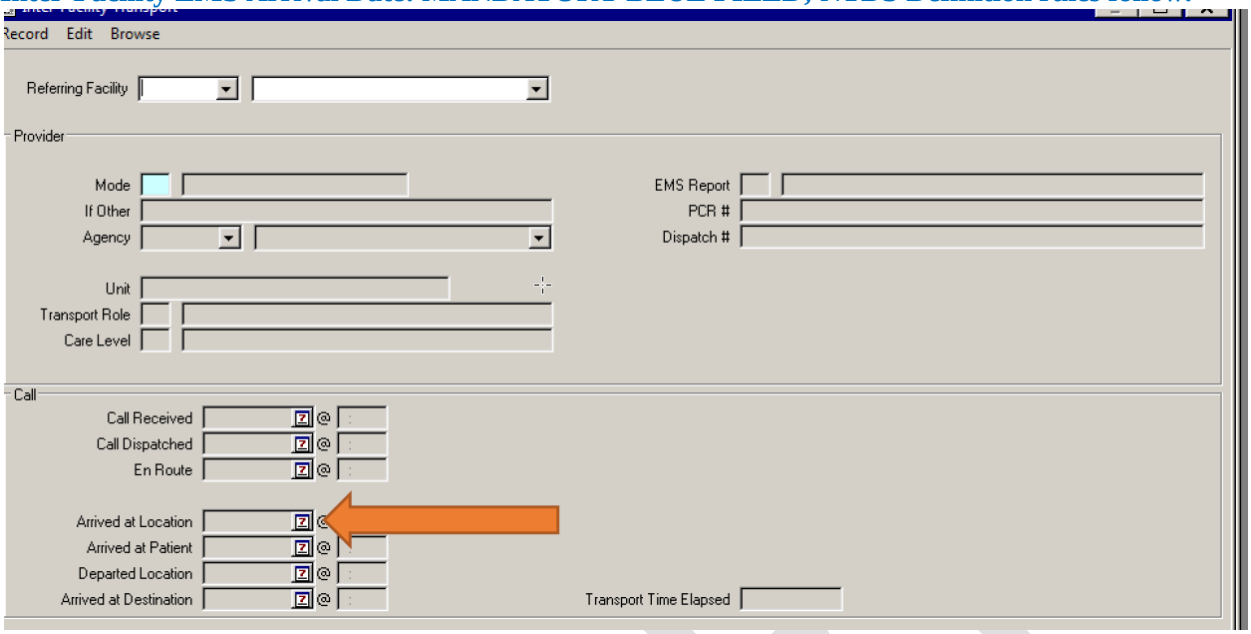
- Relevant value for data element.

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT

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



EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

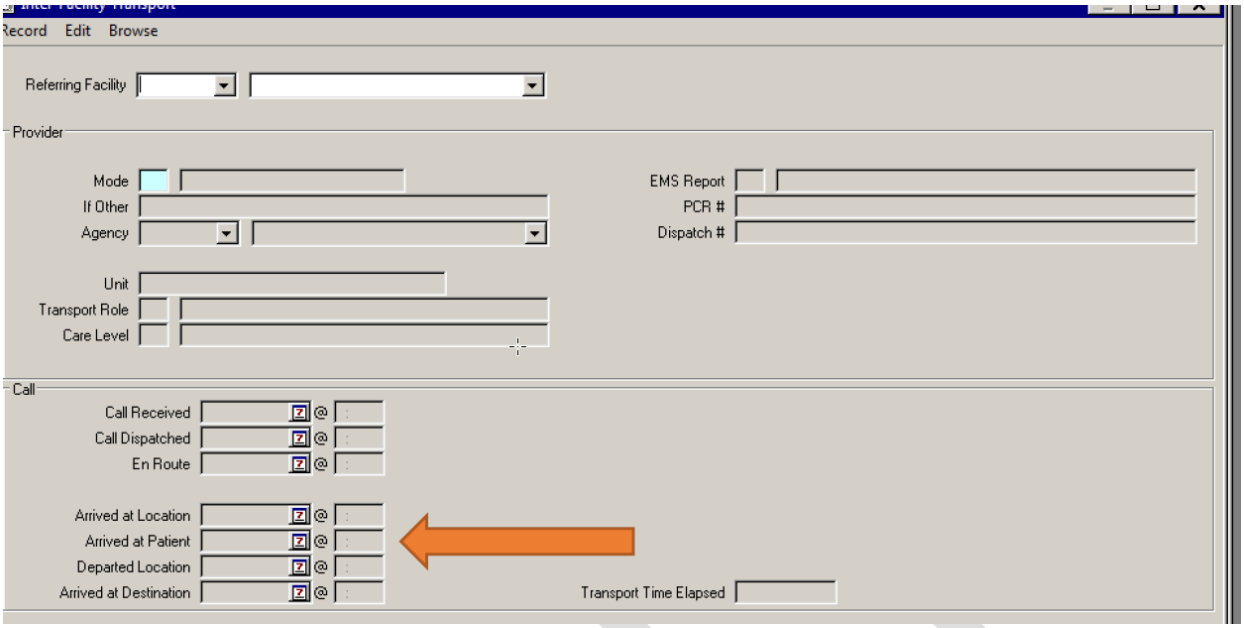
- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report



Arrived at Paitent: Date and Time

Definition

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

Element Values

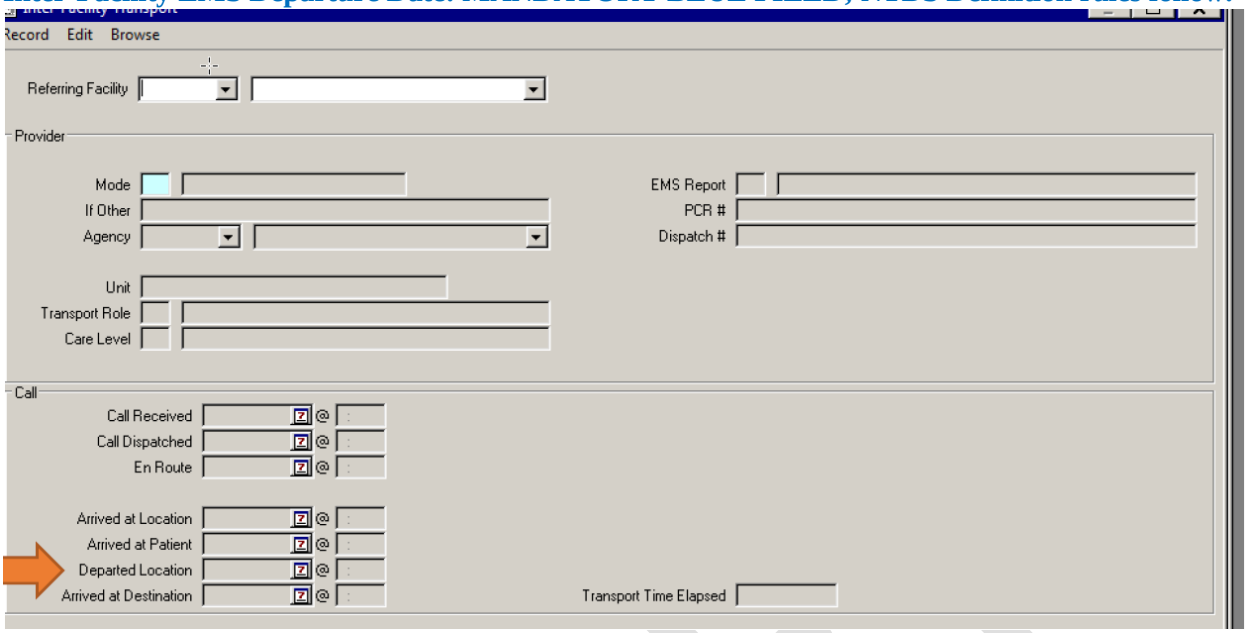
- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT

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



EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

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

Element Values

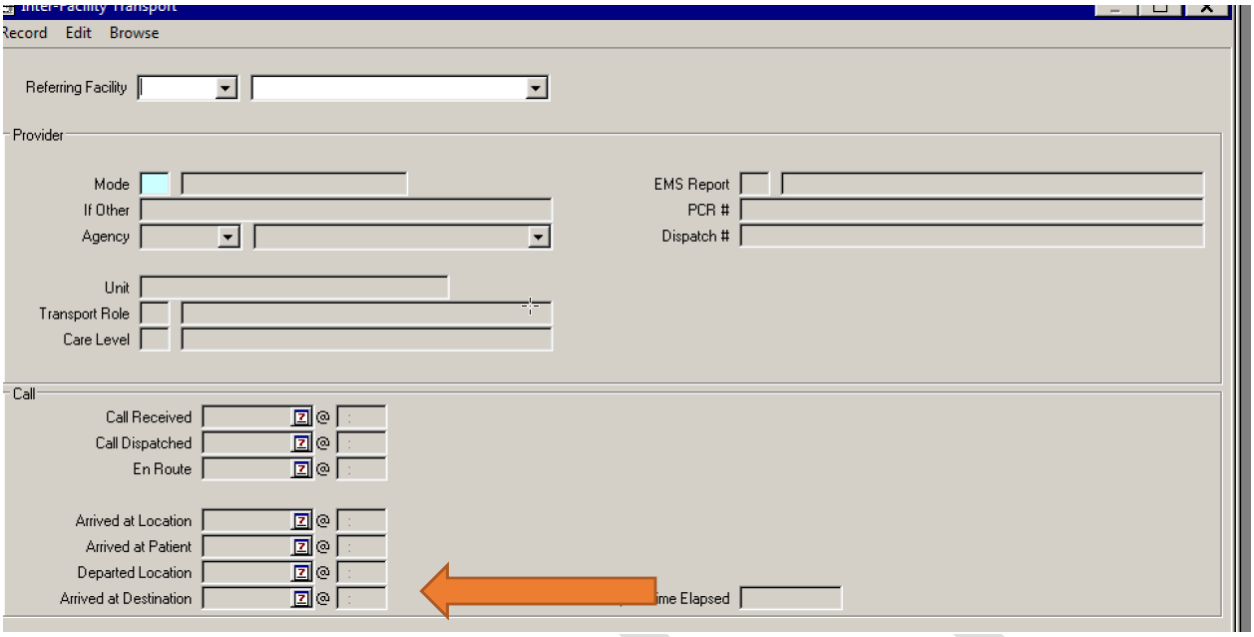
- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report



Arrived at Destination: Date and Time

Definition

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

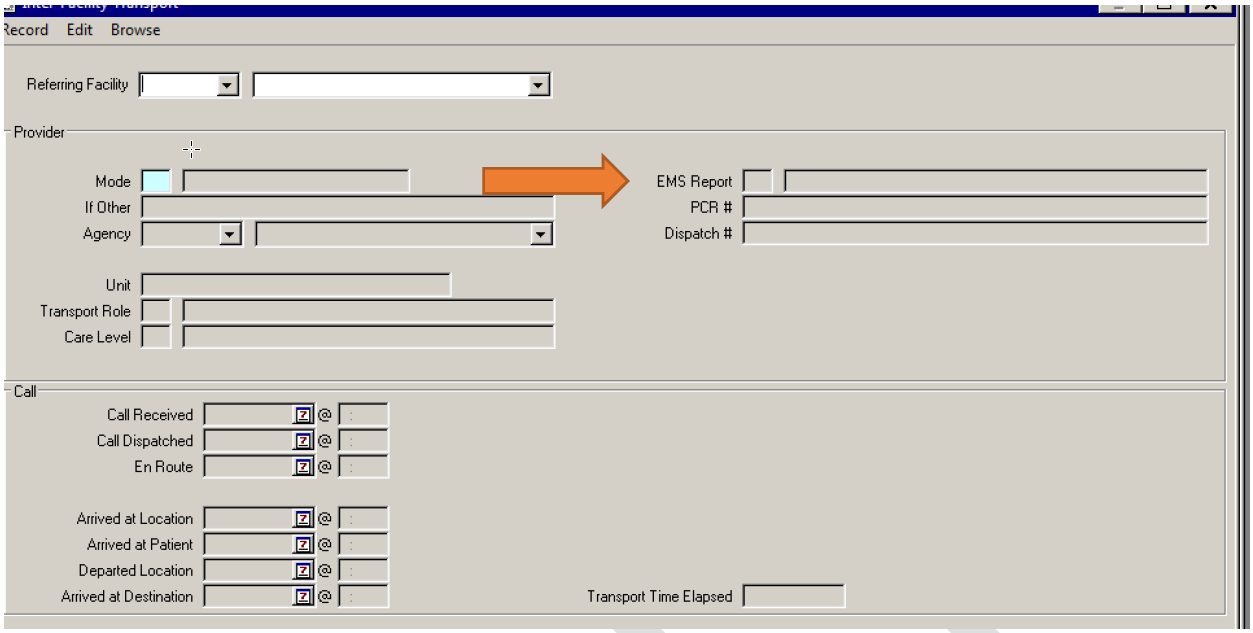
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Scene EMS Report

Definition

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

Element Values

1. Complete
2. Incomplete
3. Missing
4. Unreadable

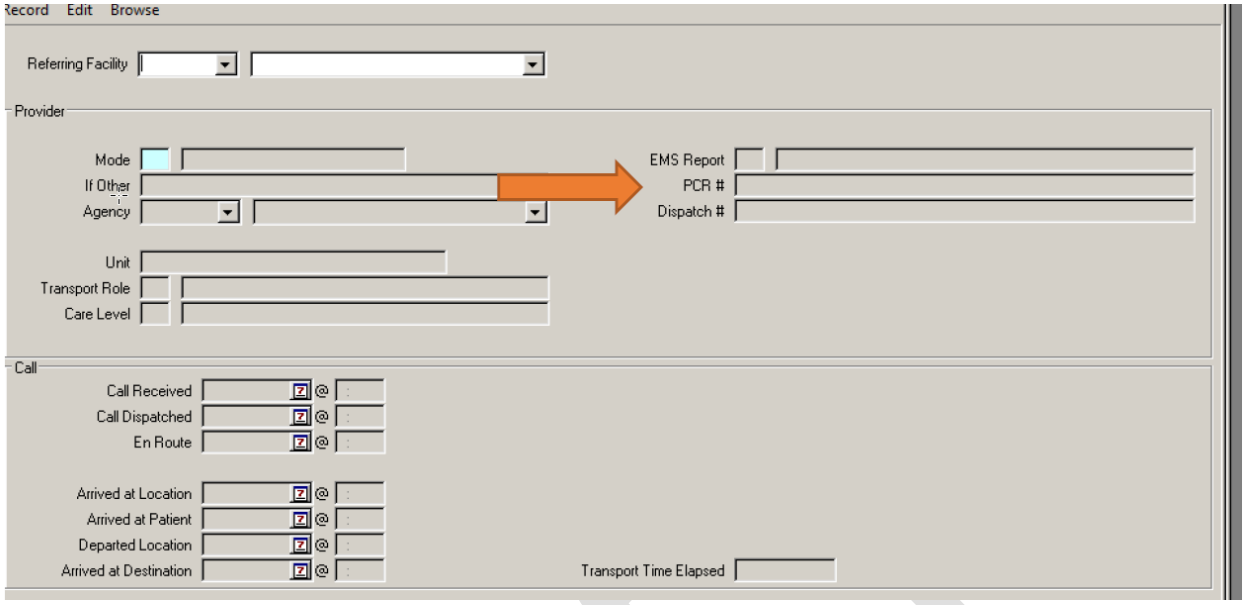
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



PCR Number

Definition

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

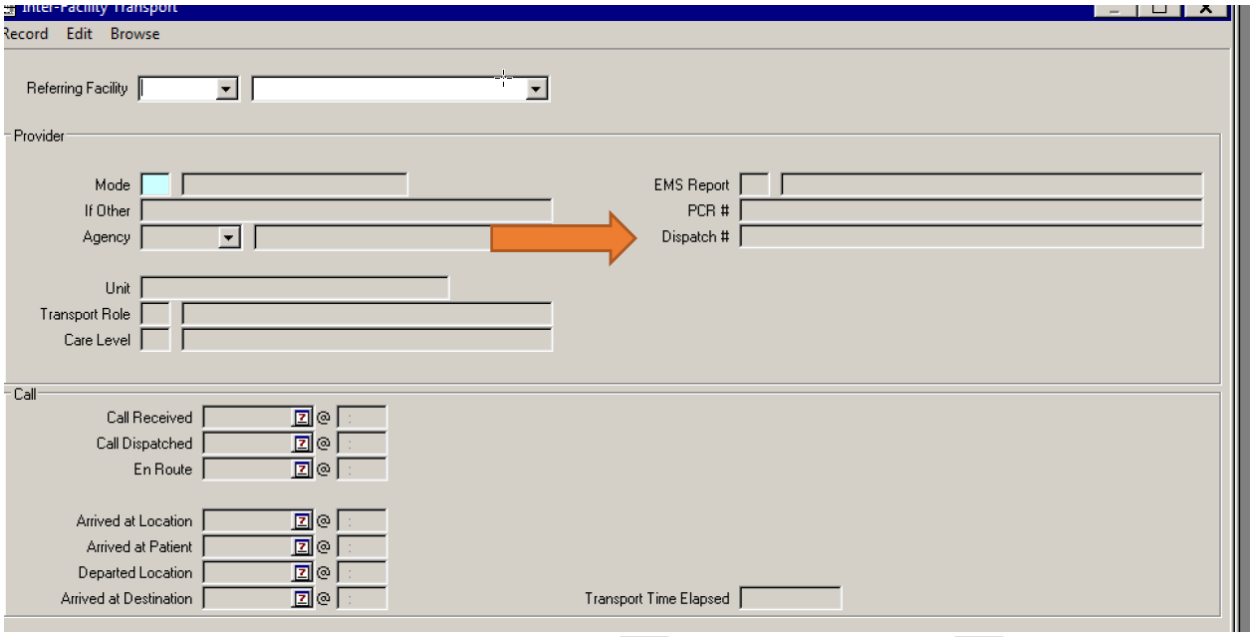
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Dispatch Number

Definition

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

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

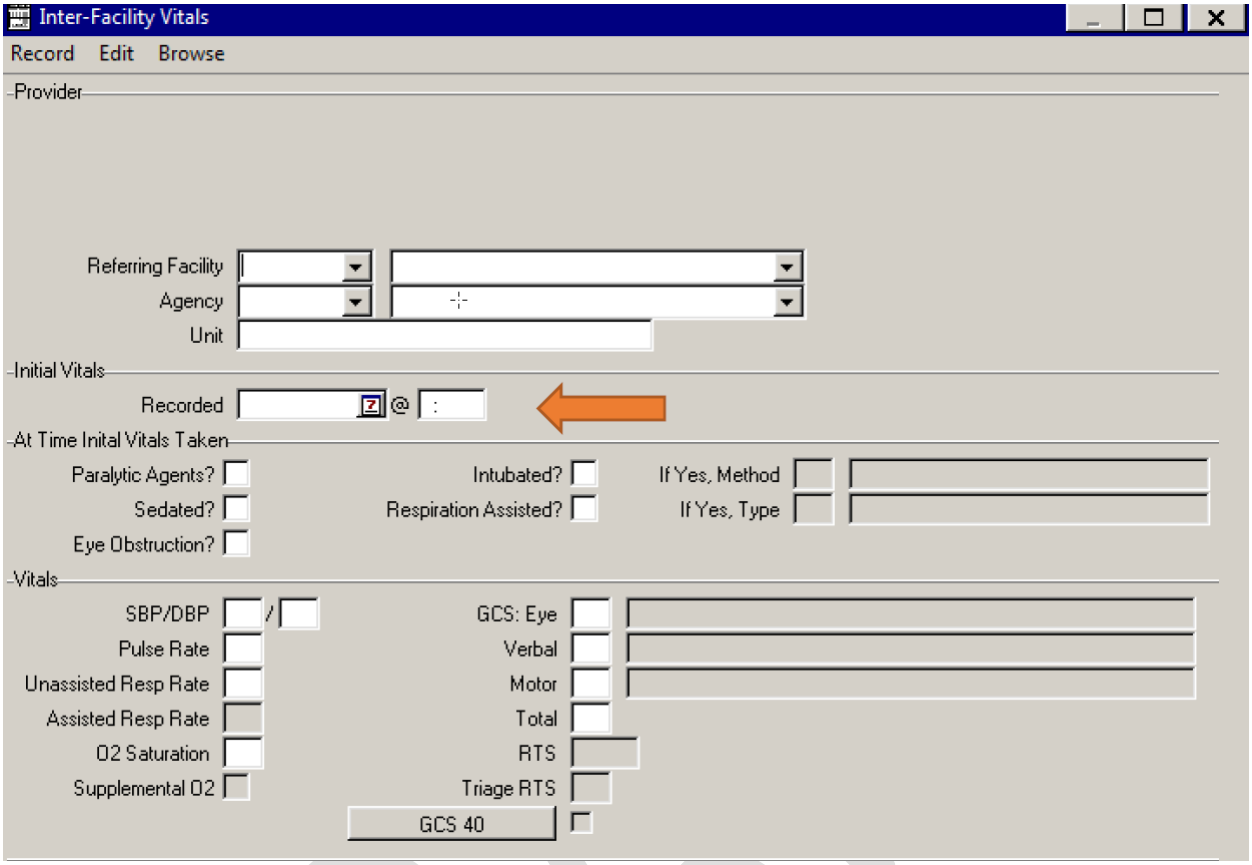
Element Values:

- Relevant value for data element

Data Source Hierarchy Guide:

1. EMS Run Sheet

DRAFT



Prehospital Vitals: Date and Time Recorded

Definition

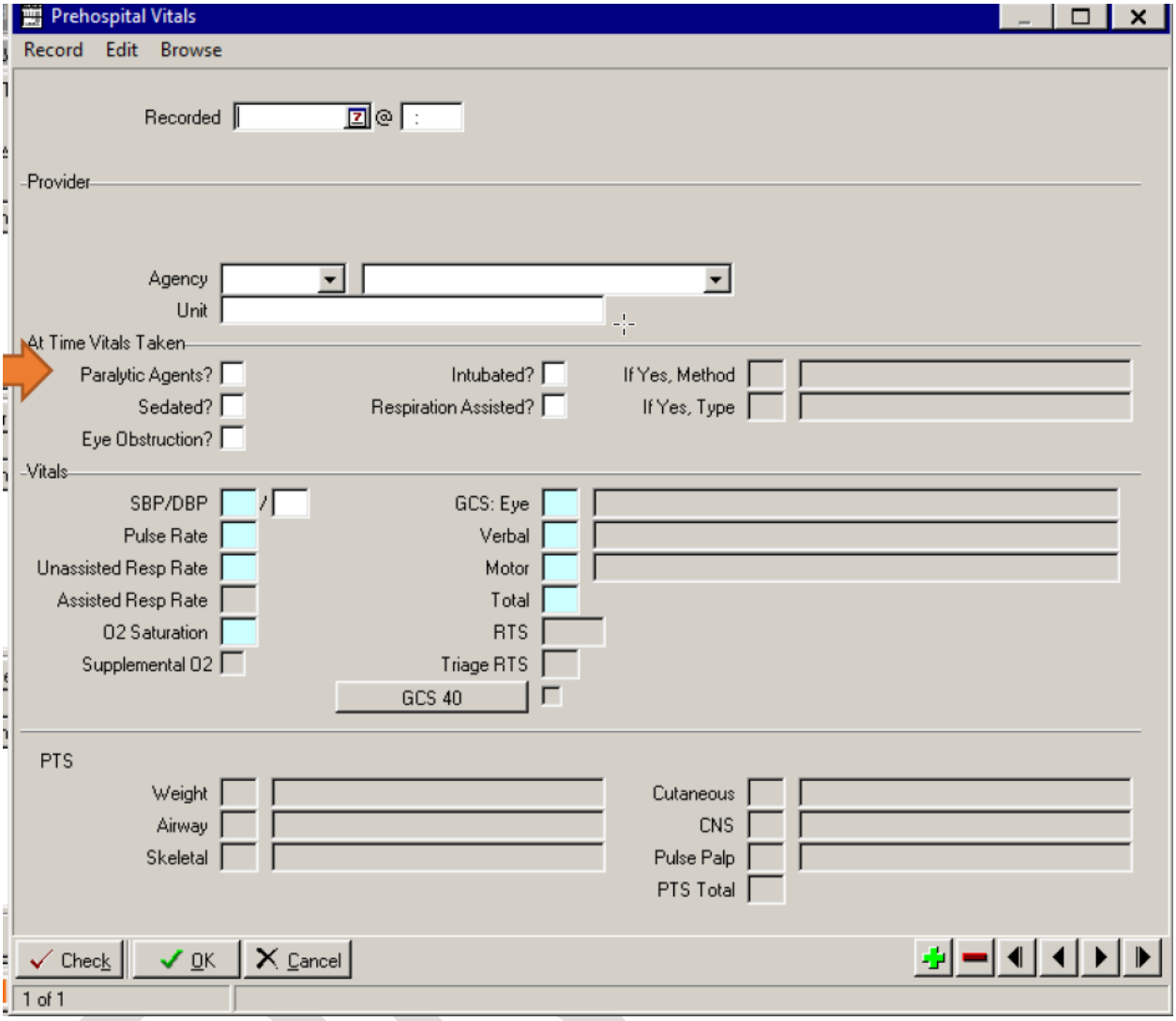
The date and time vitals were taken during the inter-facility transport recorded.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report



Paralytic Agents

Definition

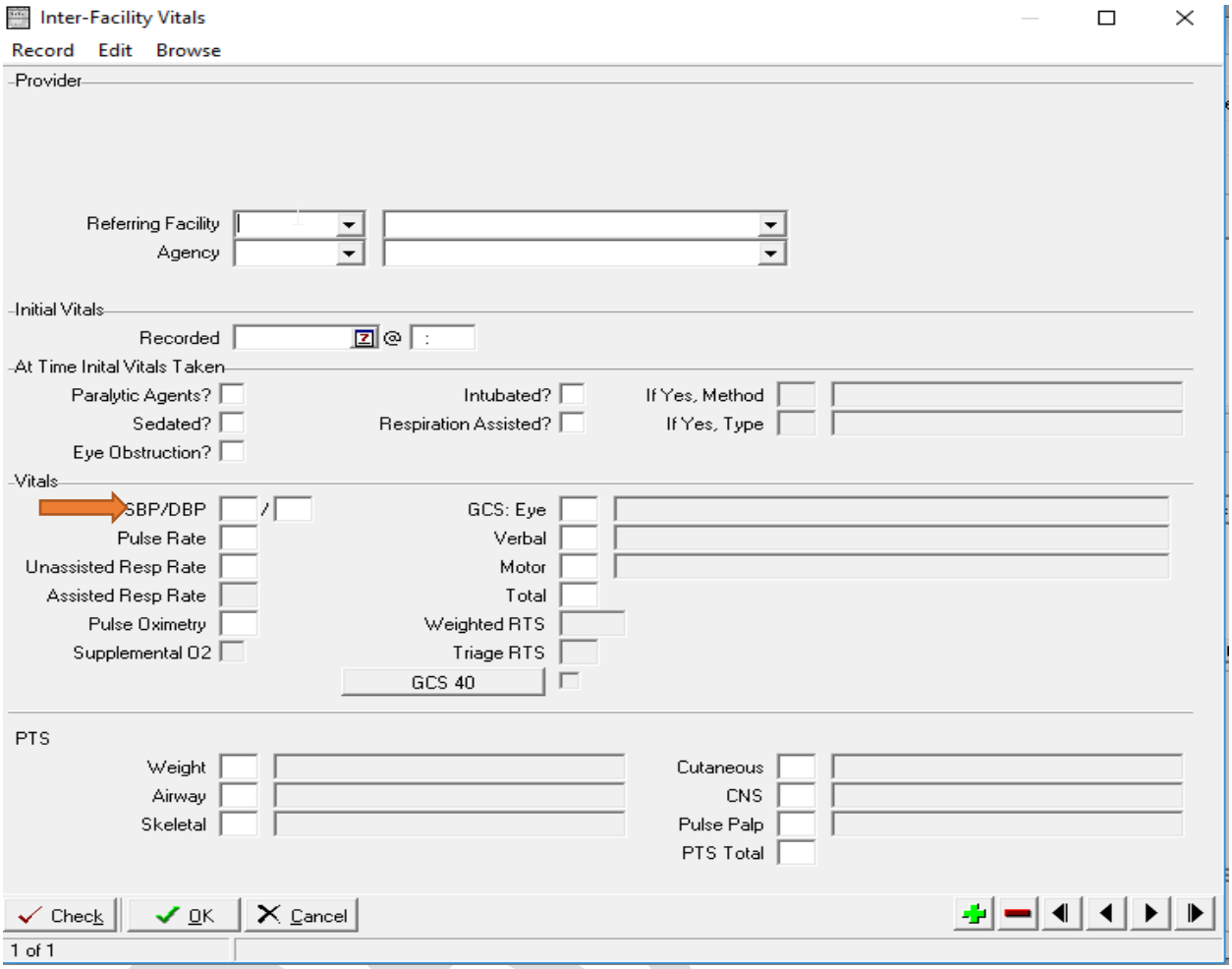
Patient was givedn paralytic agents prior to visitals being obtained and within their duration of effect.

Elemant Values

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

Data Source Hierarchy Guide

2. EMS Run Report



Sedated

Definition

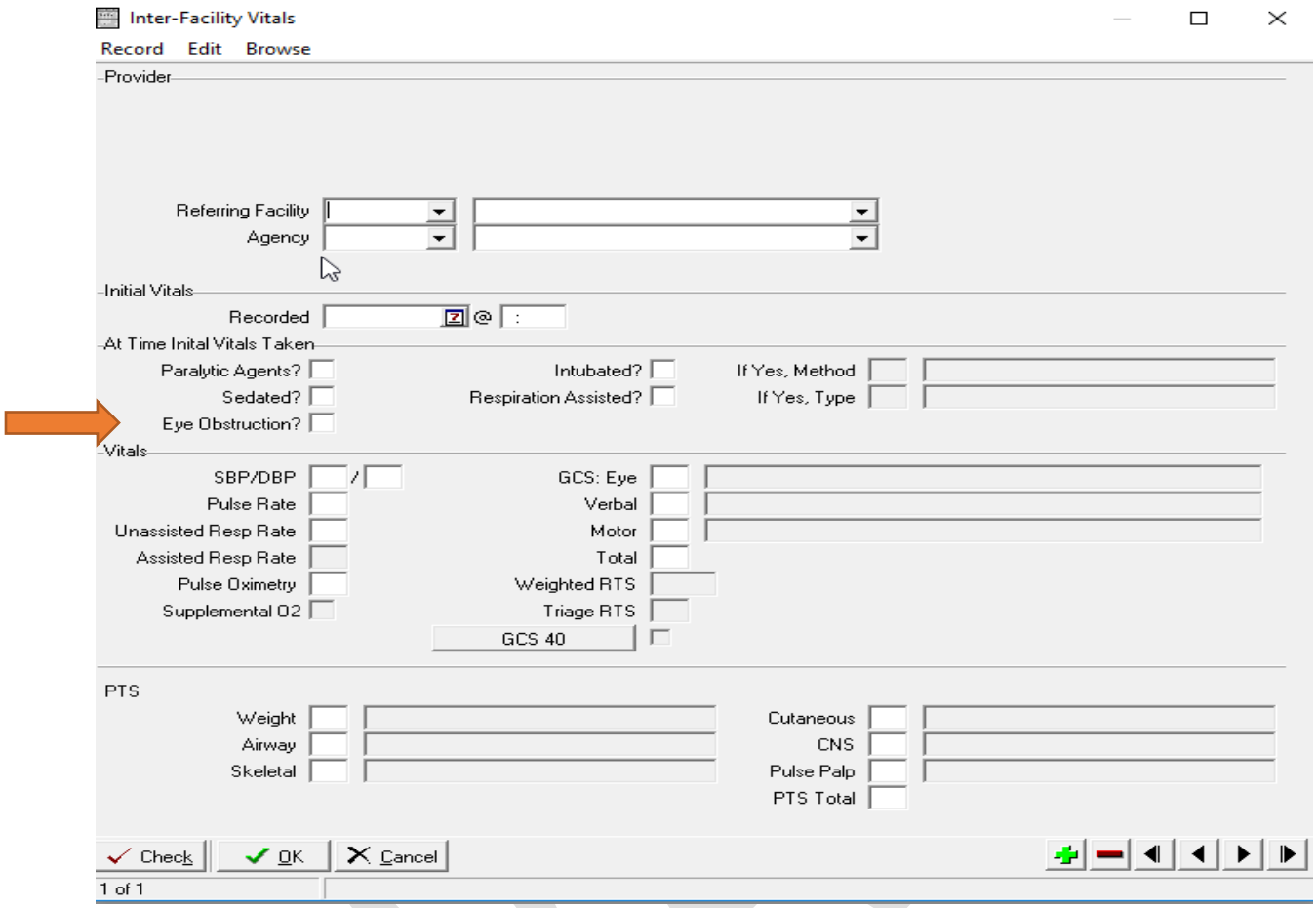
Patient was given sedative agenda prior to vitals being obtained and within their duration of effect.

Elemant Values

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

Data Source Hierarchy Guide

1. EMS Run Report



Eye Obstruction

Definition

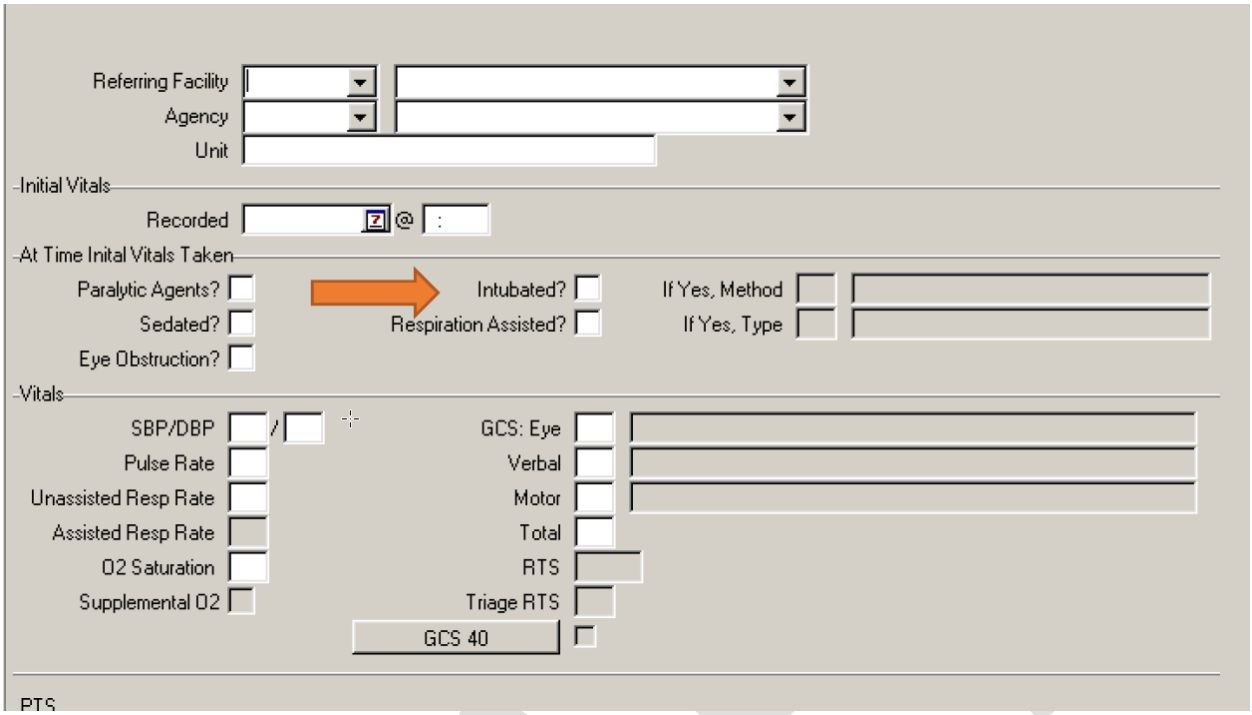
Injury or other condition that causes the patioent to be unable to open their eyes or obstructs their vision at the time the vitals were taken

Elemant Values

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

Data Source Hierarchy Guide

1. EMS Run Record



Intubated

Definition

Patient had an airway device in plae when the bitals were taken.

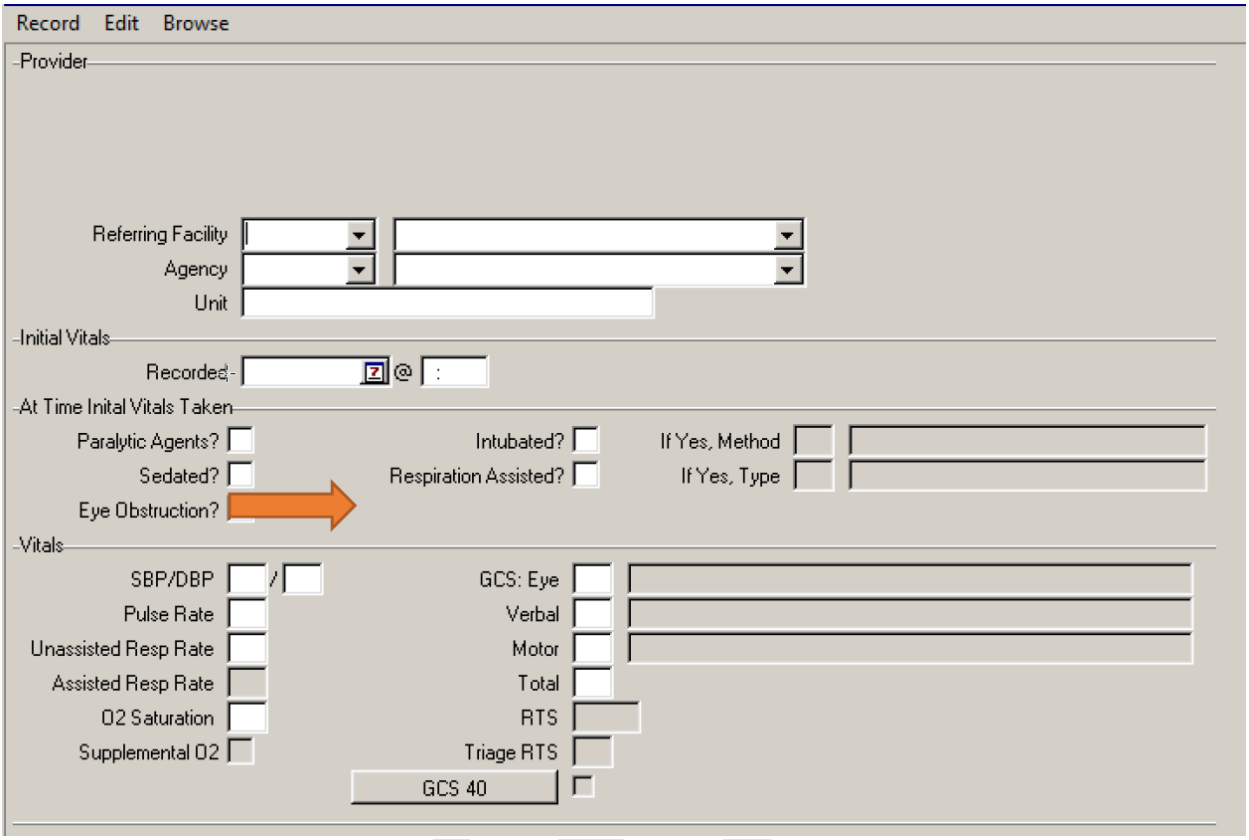
Element Values

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

/. Unknown

Data Source Hierarchy Guide

1. EMS Run Record



Respiration Assisted

Definition

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

Element Values

Respiration Assited:

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

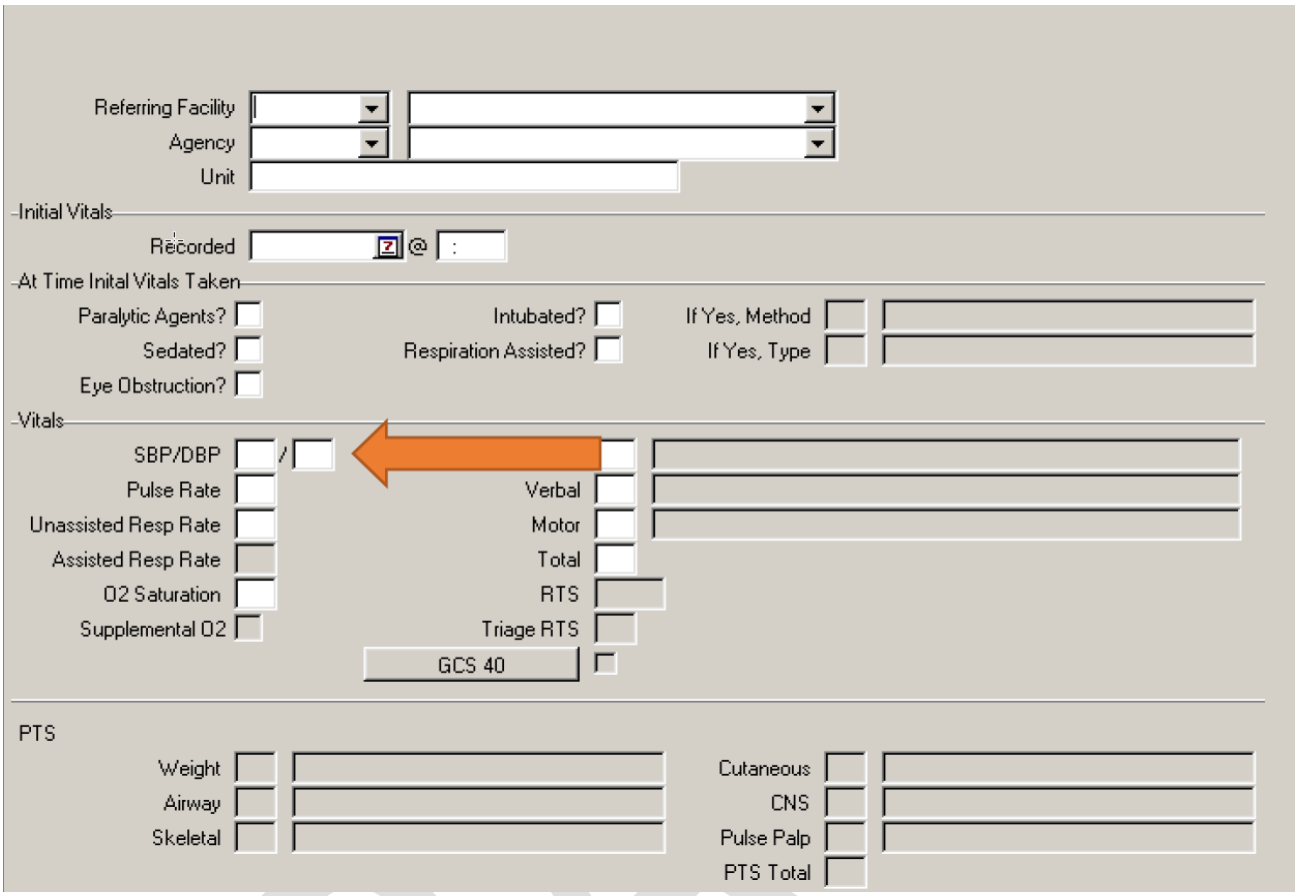
If yes, Type:

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

?. Unknown

Data Source Hierarchy Guide

1. Ems Run Report



Systolic Blood Pressure/Diastolic Blood Pressure

Definition

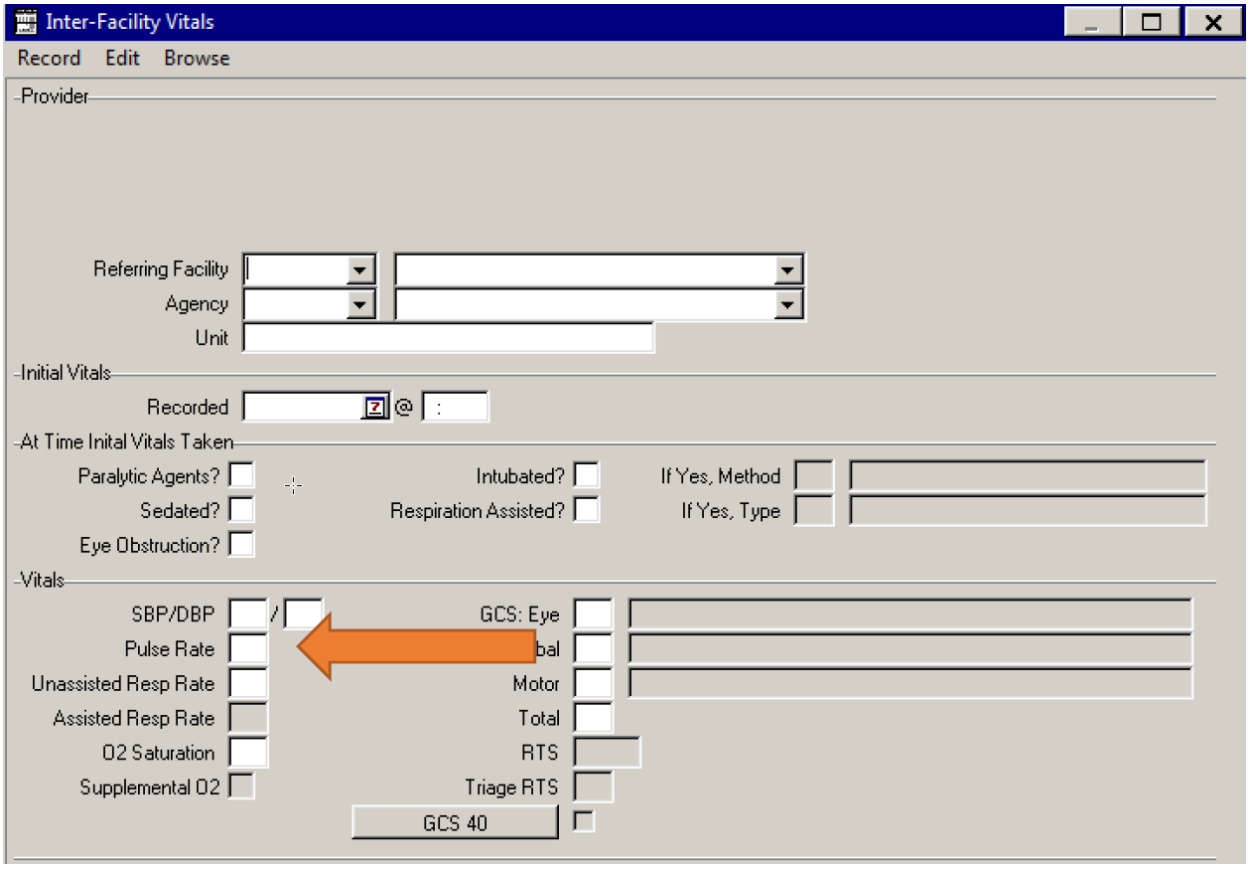
Systolic and diastolic blood pressure measurements recorded during transport to your facility.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report



Pulse Rate

Definition

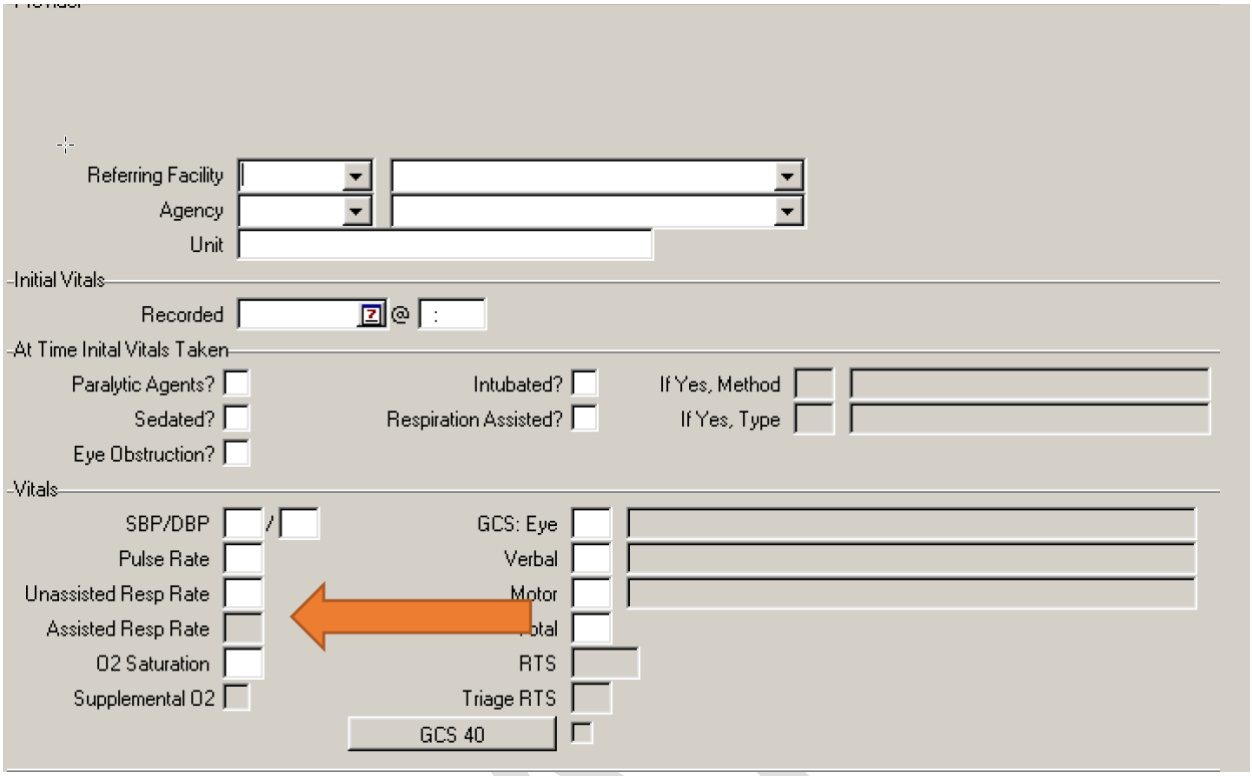
Pulse rate recorder during transport to your facility

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report



Unnassisted/Assisted Respiratory Rate

Definition

Unnassisted or Assisted Respirator rates recorded during transport to your facility.

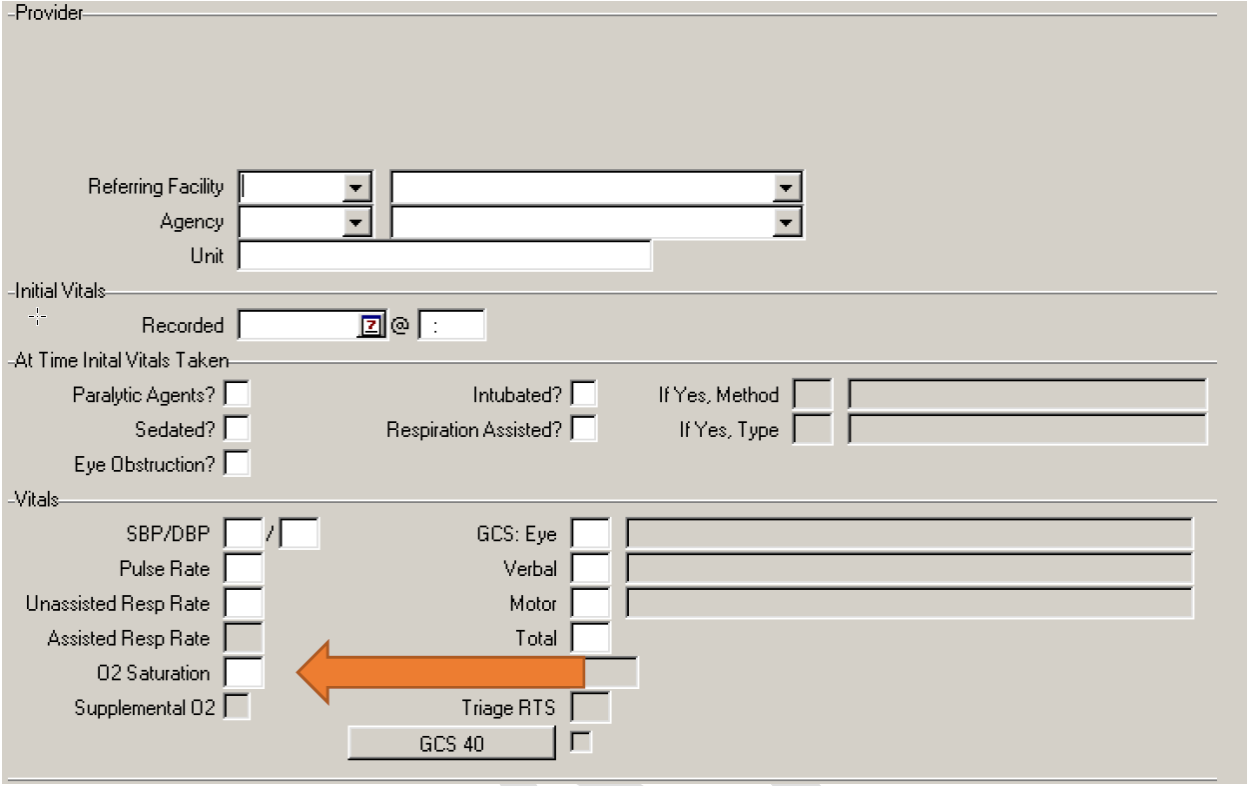
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Oxygen Saturation

Definition

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

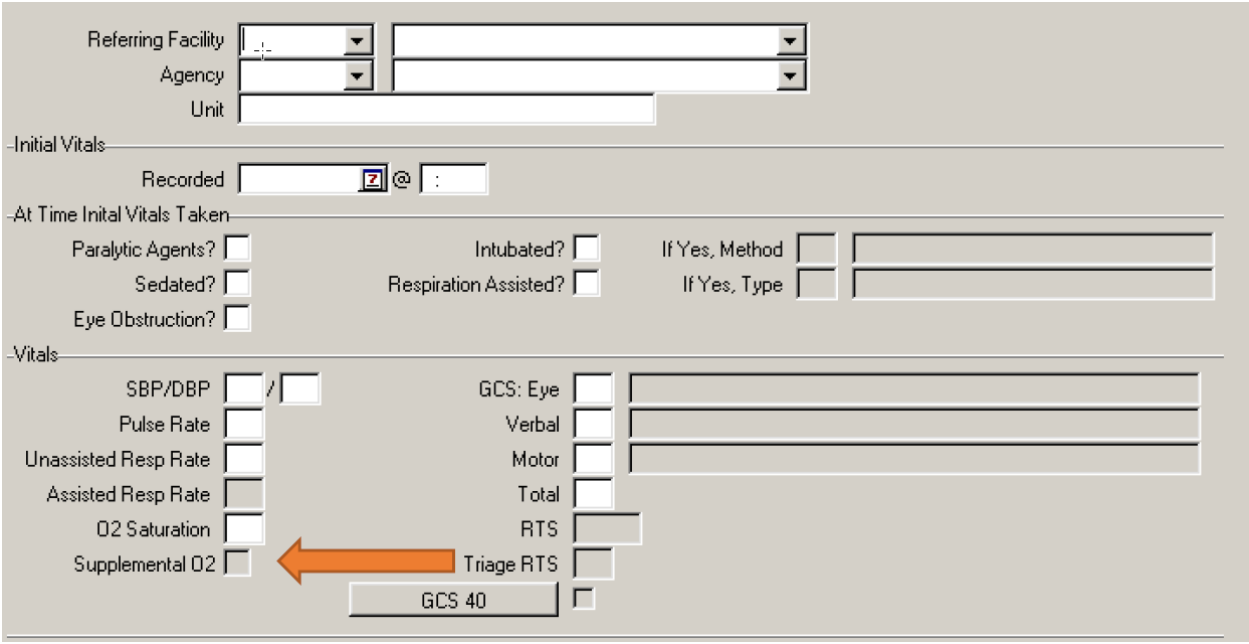
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Inter-Facility Transport: Supplemental O2

Definition

Patient was eing administered oxygen at the time that vitals were taken

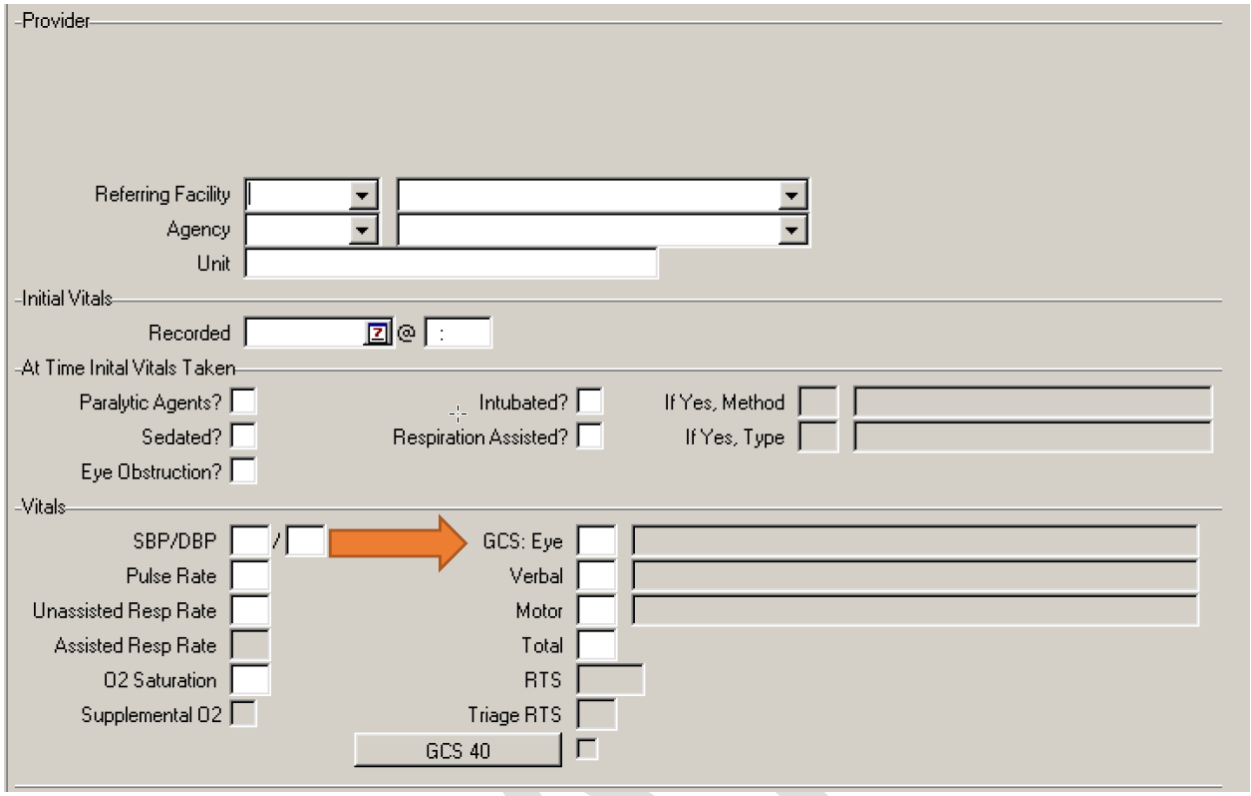
Element Values

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

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Inter-Facility Transport: GCS - Eye

Definition

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

Element Values

1. No Eye Movement When Assessed
2. Opens Eyes in Response to Painful Stimulation
3. Opens Eyes in Response to Verbal Stimulation
4. Opens Eyes Spontaneously

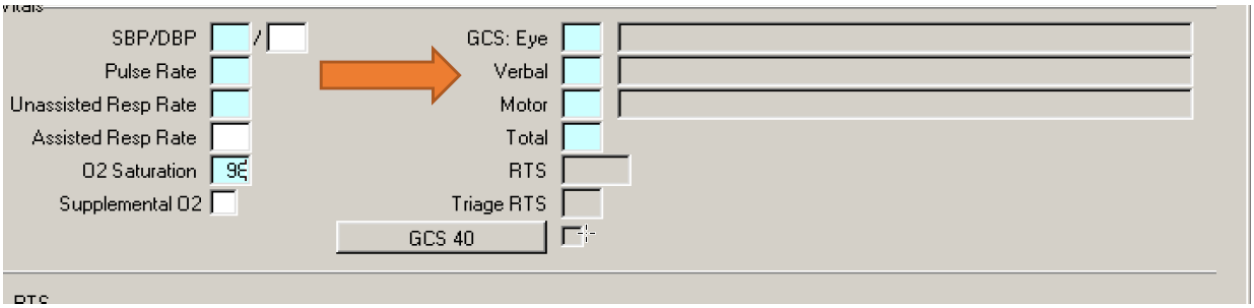
/. Not Applicable

?. Unknown

NOTE: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record



Inter-Facility Transport: GCS - Verbal

Definition

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

Element Values

1. No verbal Response (Pediatrics ≤ 2 years: No Vocal Response)
2. Incomprehensible Sounds (Pediatrics ≤ 2 years: Inconsolable, Agitated)
3. Inappropriate Words (Pediatrics ≤ 2 years: Inconsistently Consolable, Moaning)
4. Confused (Pediatrics ≤ 2 years: Cries but is Consolable, Inappropriate Interactions)
5. Oriented (Pediatrics ≤ 2 years: Smiles, Oreinted to Sounds, Interacts

/. Not Applicable

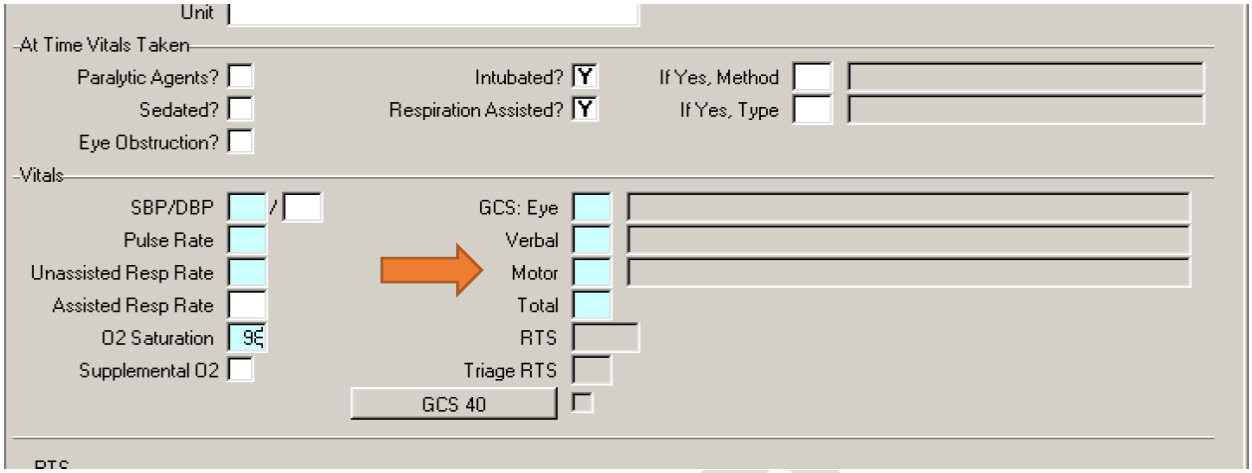
?. Unknown

NOTE: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record

DRAFT



Inter-Facility Transport: GCS - Motor

Definition

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

Element Values

1. No Motor Resonse
2. Extension to Pain
3. Flexion to Pain
4. Withdrawal from Pain
5. Localizing Pain
6. Obeys Commands (Pediatric ≤ 2 years: Appropriate Response to Stimulation)

/. Not Applicable

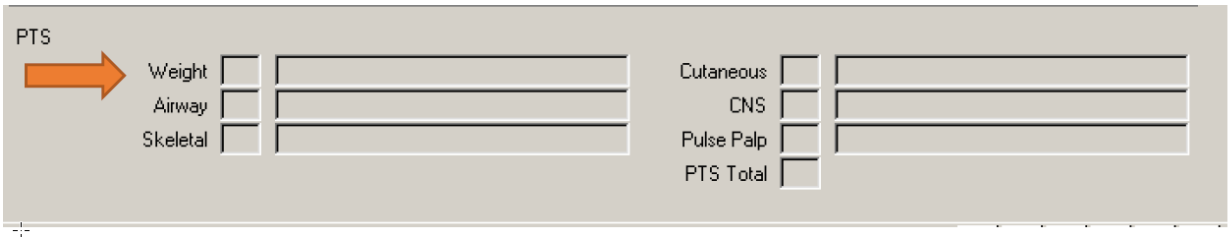
?. Unknown

NOTE: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record

DRAFT



Pediatric Trauma Score: Weight

Defintion

The weight of the patient at the time of injury.

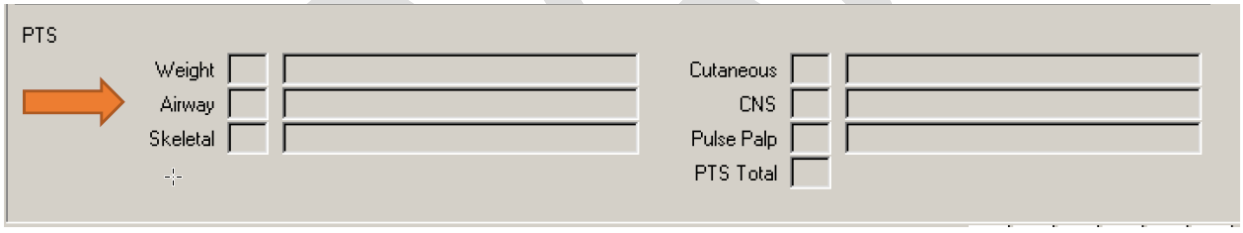
NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: Airway

Defintion

The status of the aptient's airway upon ED/Hospital initial assemesment.

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

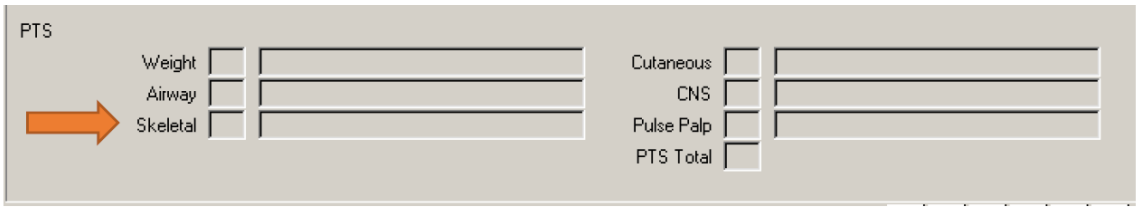
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Pediatric Trauma Score: Skeletal

Defintion

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

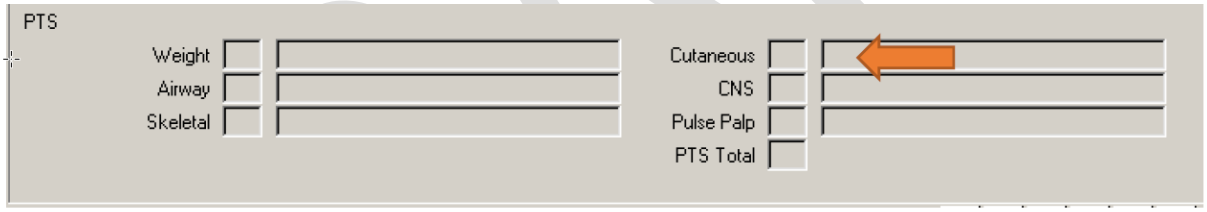
NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork



Pediatric Trauma Score: Cutaneous

Defintion

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

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

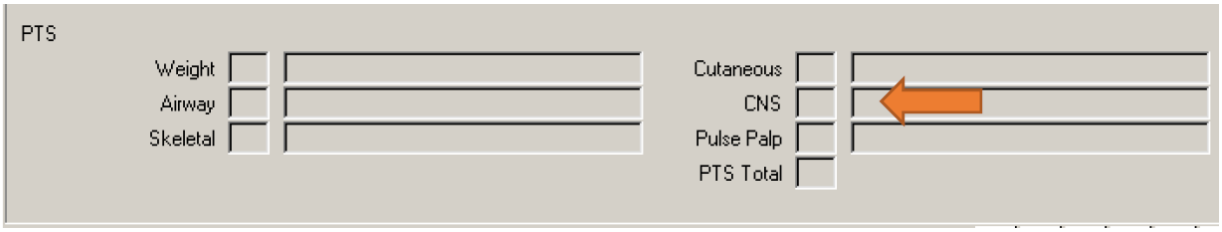
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Pediatric Trauma Score: CNS

Definiton

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

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

Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

Pediatric Trauma Score: Pulse Palp

Definiton

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

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

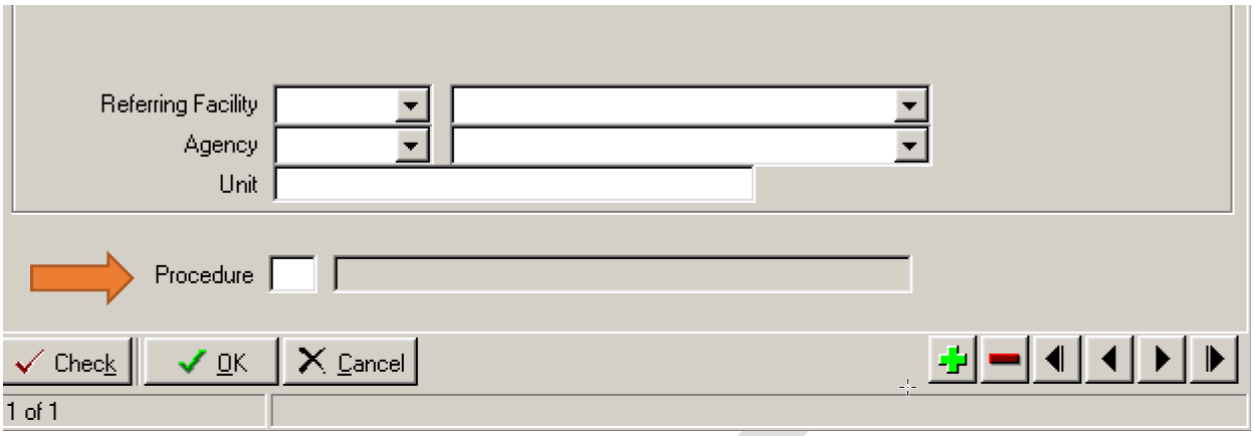
Element Values

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

Data Source Hierarchy Guide

1. Referring Facility Paperwork

DRAFT



Inter-facility Transport Procedure

Definition

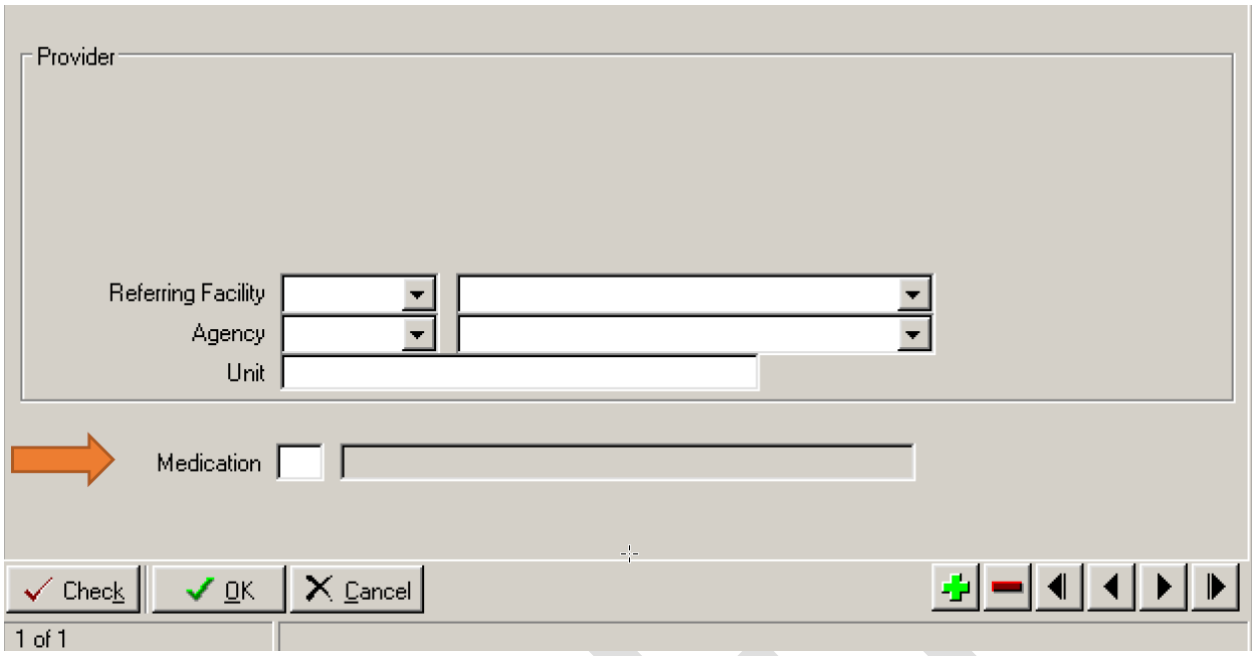
Medical Intervention performed by EMS or first responders en-route to transfer facility.

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

Data Source Hierarchy Guide

1. EMS Run record

DRAFT



Inter-facility Transport: Medical Administration

Definition

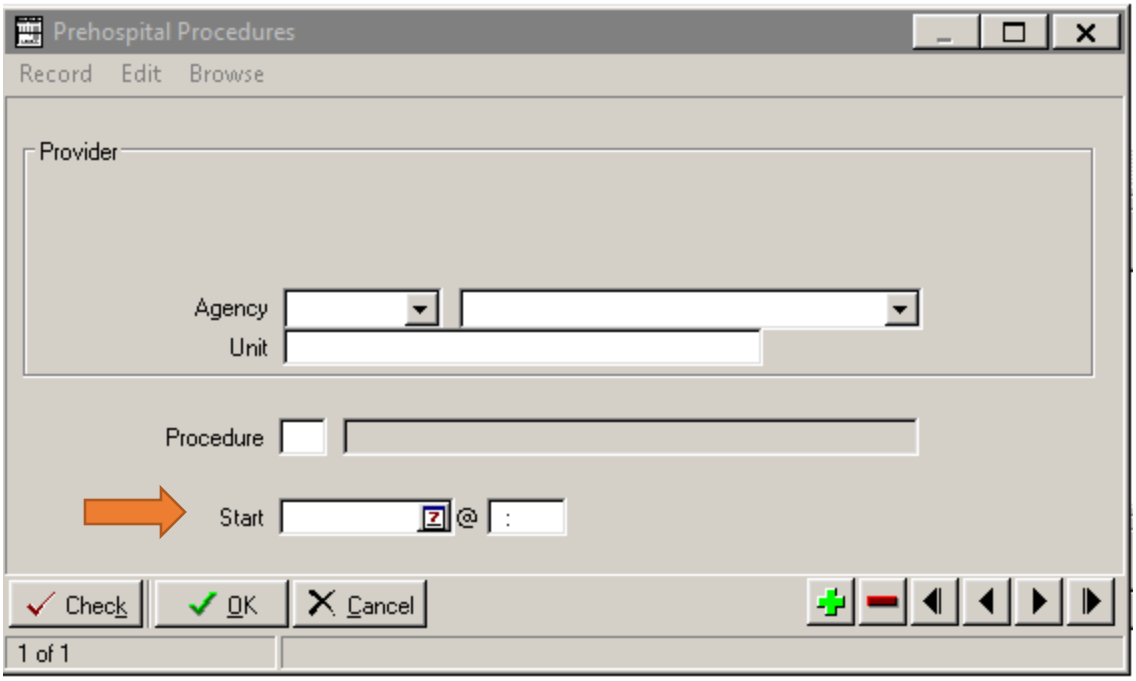
Medications that were given to the patient en-route to referring facility.

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

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Prehospital Procedure Start Date and Time

Definition

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

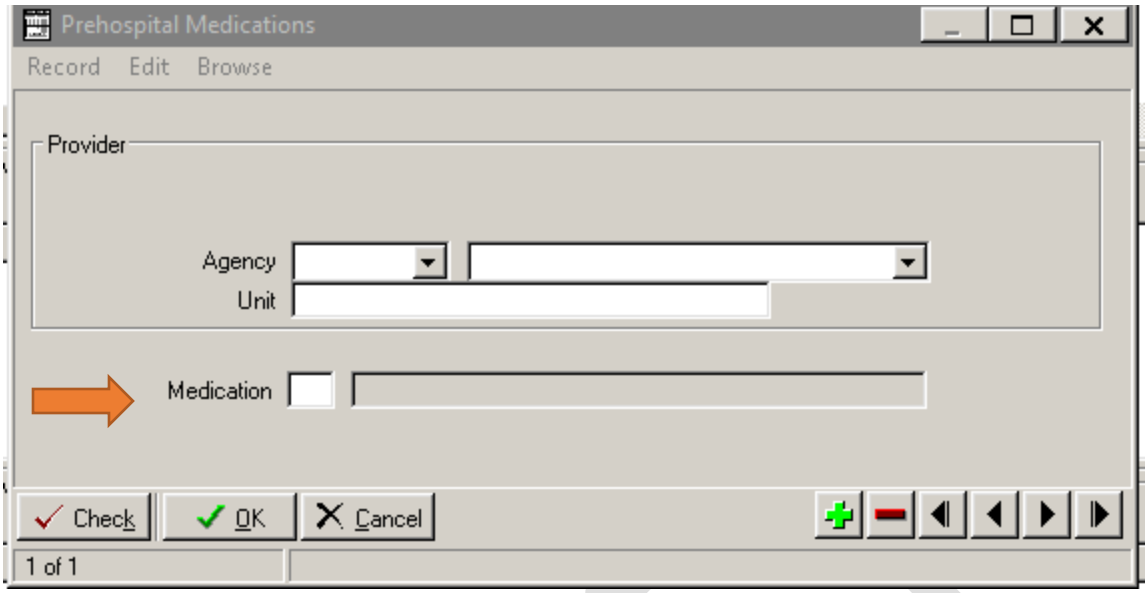
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report

DRAFT



Prehospital: Medication Administration

Definition

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

Element Values

- Relevant Value for Data Element
- Multiple Values in DI

Data Source Hierarchy Guide

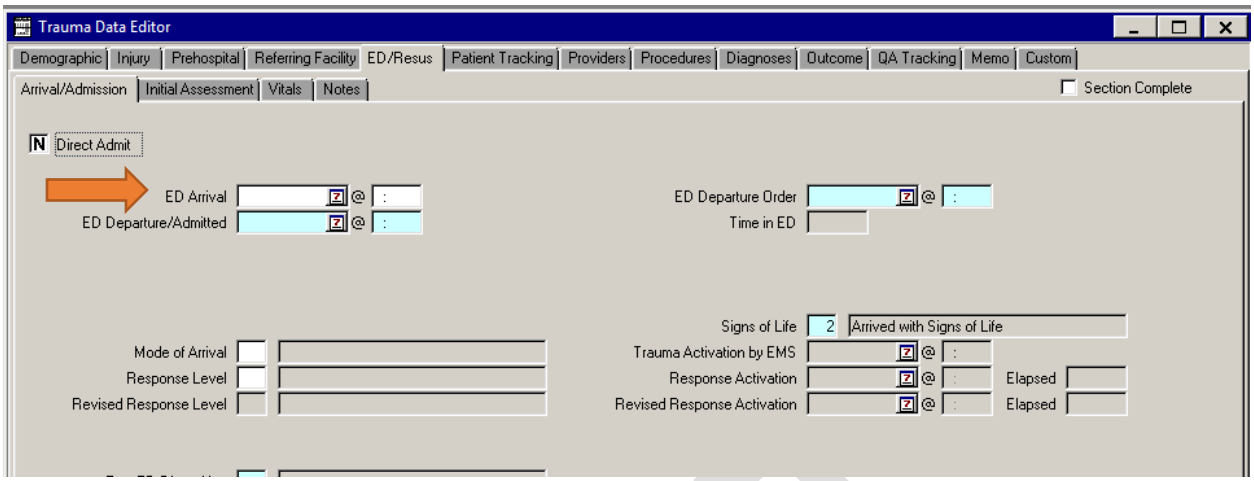
1. EMS Run Report

DRAFT

ED Arrival/Resuscitation

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

DRAFT



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

<u>ED Arrival =ED or Hospital Arrival Date (see below)</u>

<u>Definition</u>

The date the patient arrived in the Emergency Department …OR… was admitted to your hospital. The patient may not enter your facility via ED, e.g., Direct Admission to the floor, ICU, or OR. The date they first arrived into your facility's ED gurney, hospital bed or OR room is the Arrival date.

DRAFT

ED/HOSPITAL ARRIVAL DATE

Definition

The date the patient arrived to the ED/hospital.

Element Values

- Relevant value for data element

Additional Information

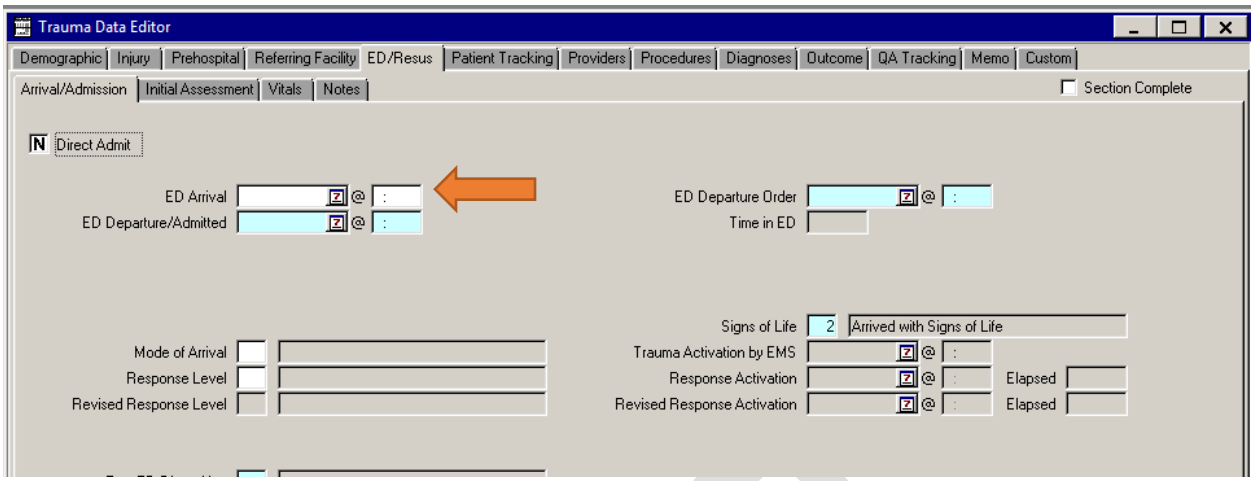
- If the patient was brought to the ED, report date patient arrived at ED. If patient was directly admitted to the hospital, report date patient was admitted to the hospital.
- Reported as YYYY-MM-DD.

Data Source Hierarchy Guide

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

Associated Edit Checks

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



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

ED Arrival Time

Definition

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

DRAFT

ED/HOSPITAL ARRIVAL TIME

Definition

The time the patient arrived to the ED/hospital.

Element Values

- Relevant value for data element

Additional Information

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

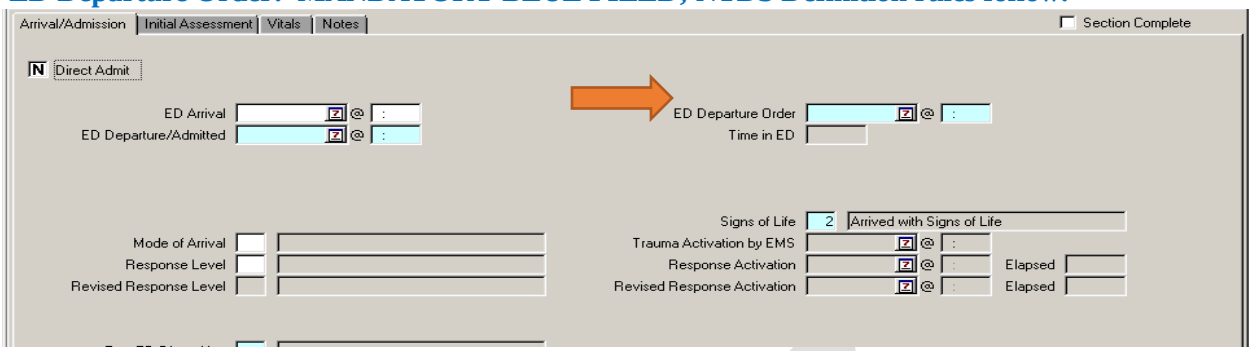
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



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

<u>ED Discharge Date = ED Departure Order</u>

ED DISCHARGE DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is "5. Deceased/Expired," then ED Discharge Date is the date of death as indicated on the patient's death certificate.

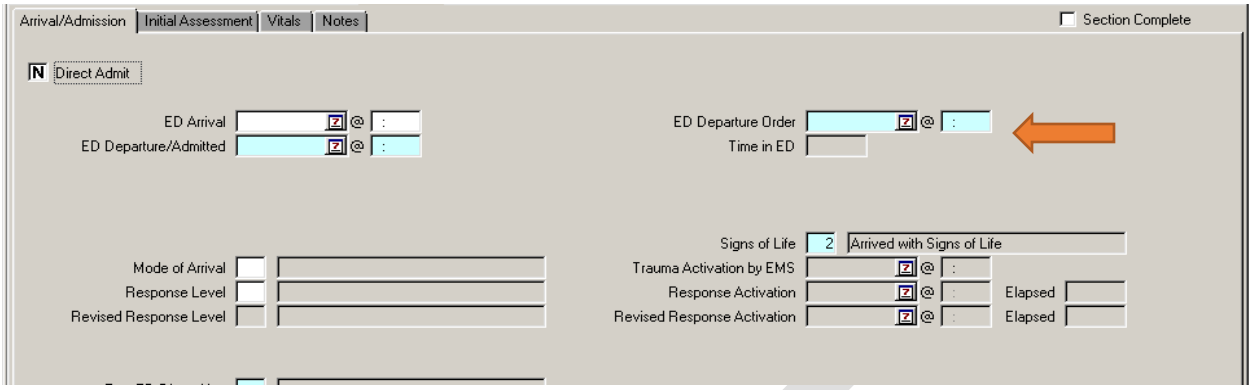
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



<u>ED Departure Order Time</u> = **BLUE FIELD; NTDS Definition rules.**

ED DISCHARGE TIME

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is "5. Deceased/Expired," then ED Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

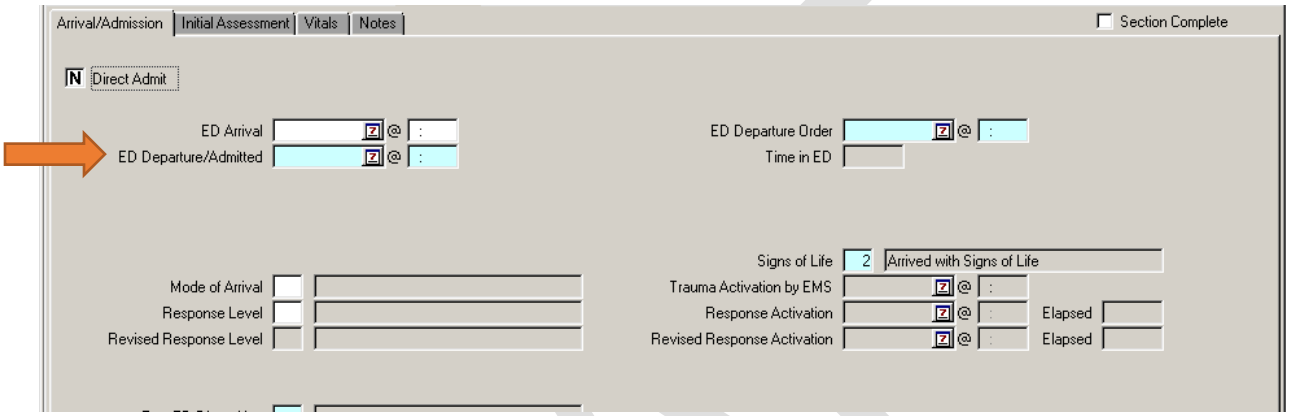
1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

Associated Edit Checks

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

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

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



ED/Resus ED Departure/Admitted

Definition

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

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

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

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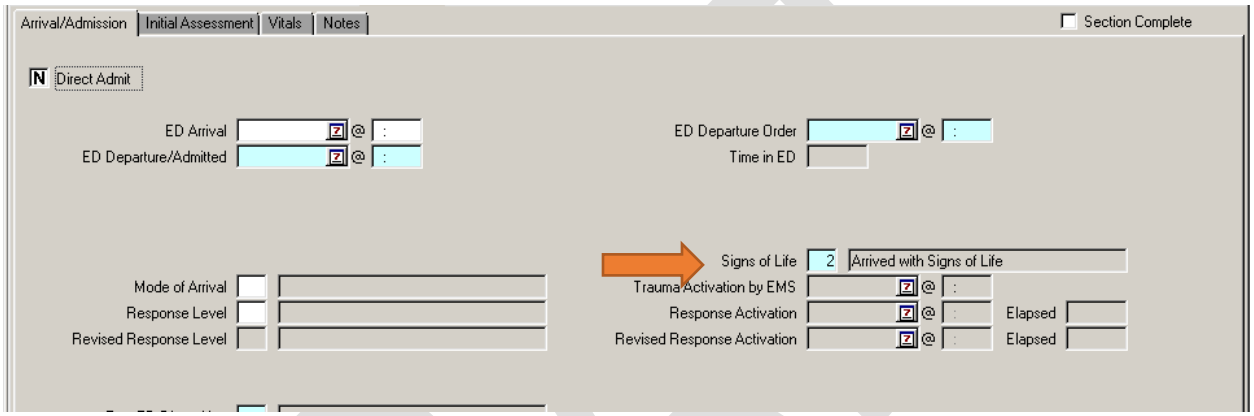
Signs of Life: MANDATORY BLUE FIELD; NTDS Definition rules.



Signs of Life

Definition

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

Element Values

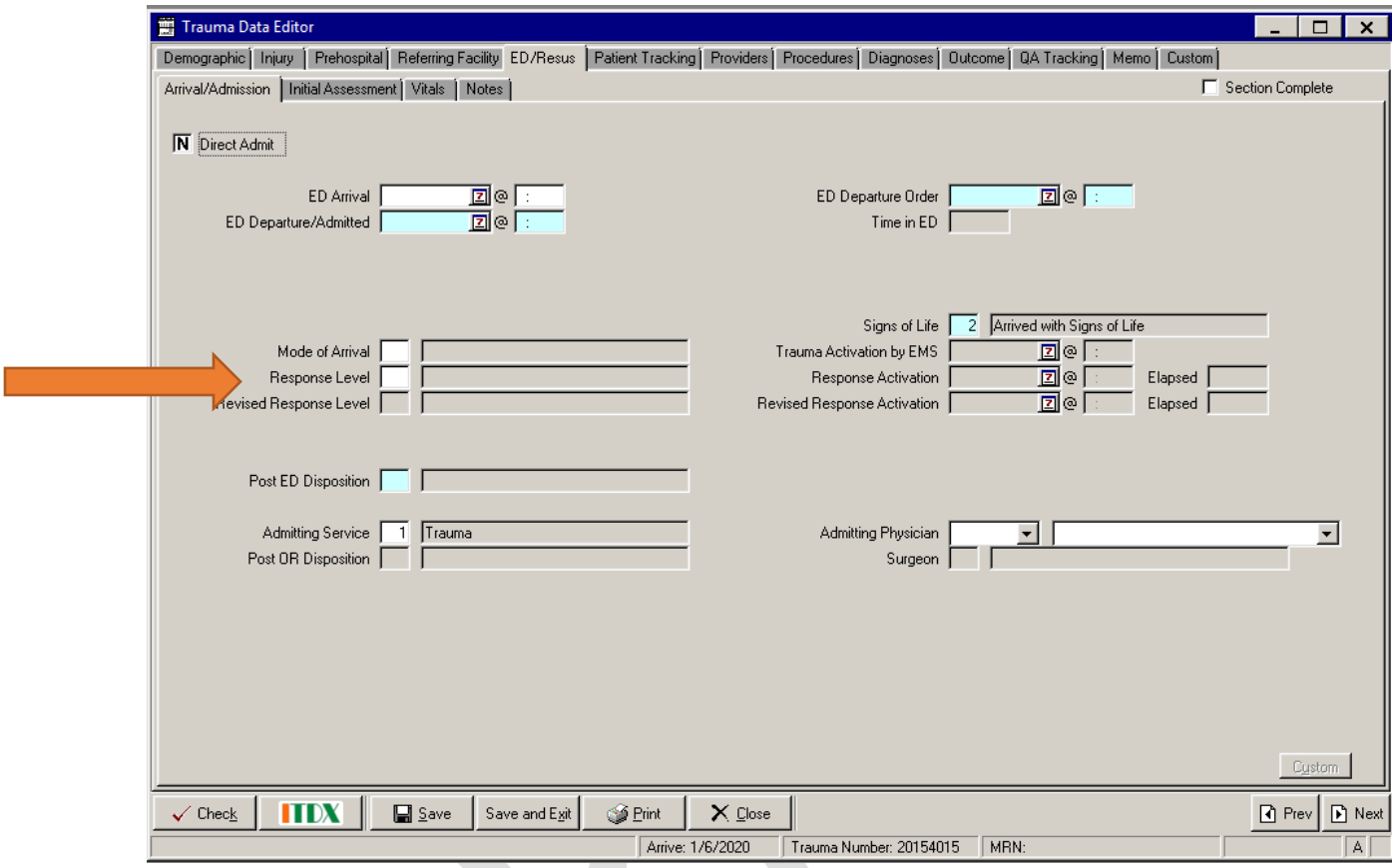
1. Arrived with No Signs of Life
2. Arrived with Signs of Life

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

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



Response Level

Definition

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

Element Values

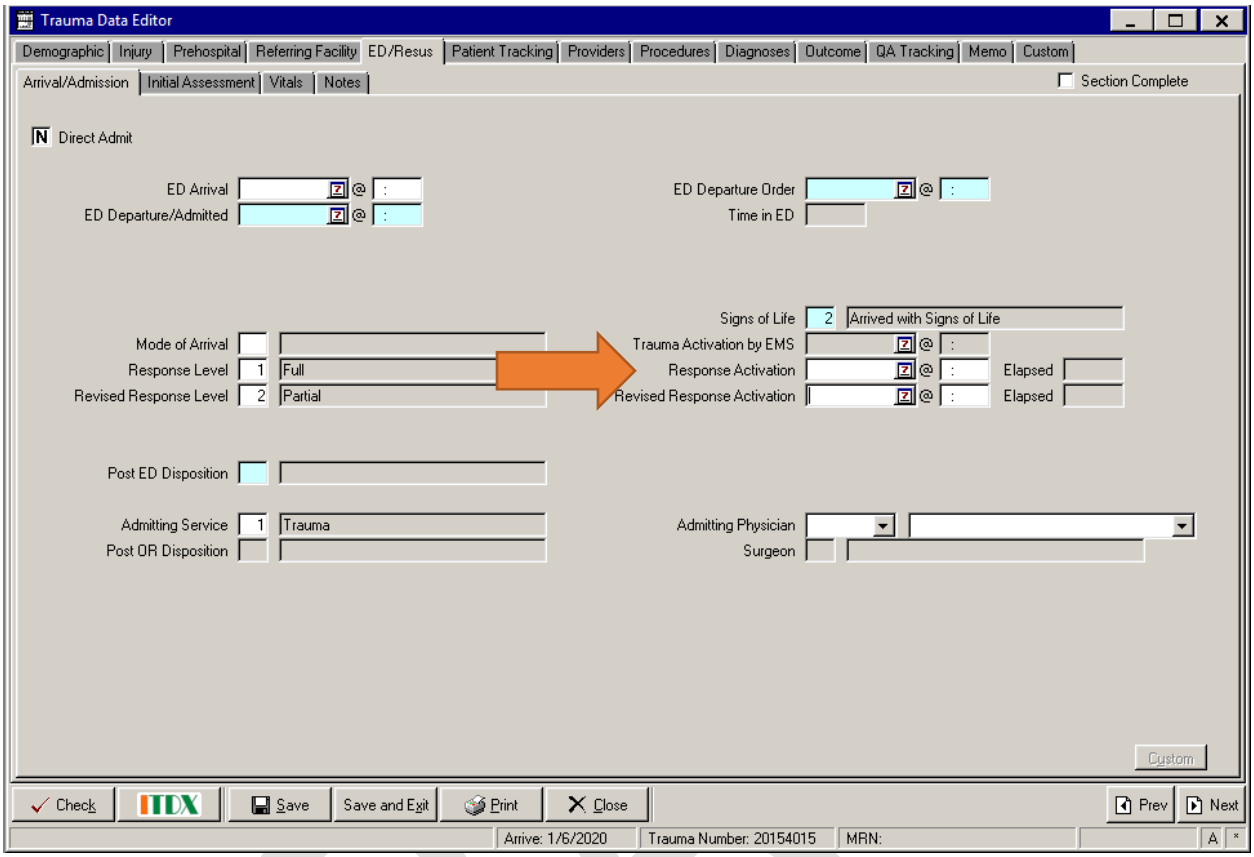
1. Full
2. Partial
3. Consult
4. No Trauma Activation

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

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



Response Activation Date and Time

Definition

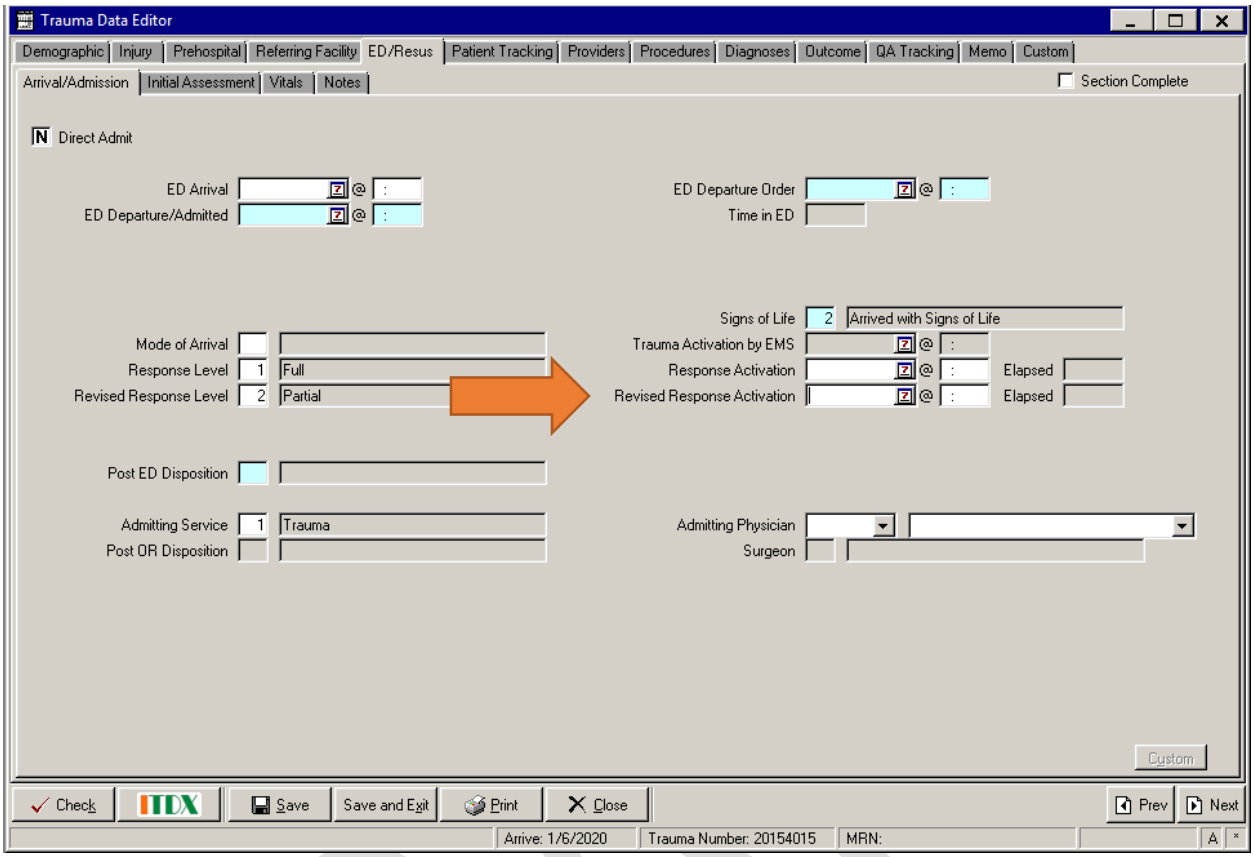
The date (MONTH/DATE/YEAR) and time that the trauma response was activated at your facility.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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



Revised Response Activation Date and Time

Definition

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

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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

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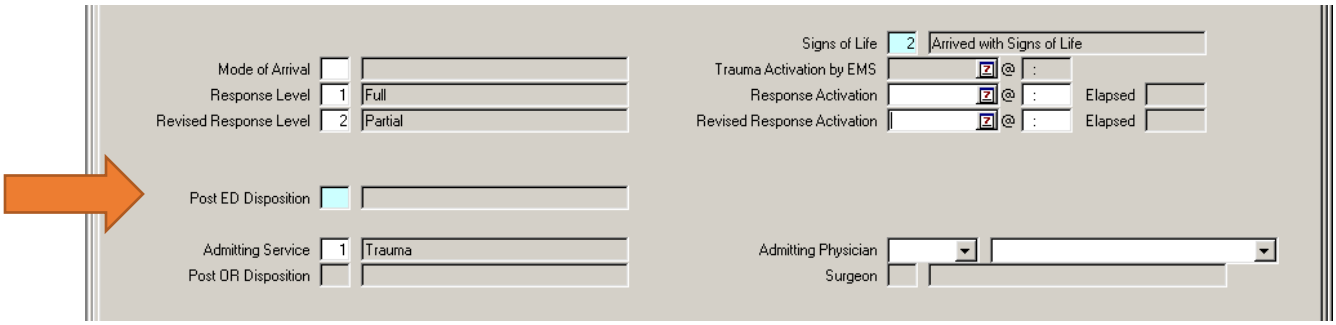


*****MANDATORY NTDS definition fields denoted with BLUE FONT*****

ED DISCHARGE DISPOSITION

Definition

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

Element Values

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

Additional Information

- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be "Not Applicable.".
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

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

Associated Edit Checks

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

Entry Title Changed to POST ED DISPOSITION

DI Element Values

3. Operating Room

4. Intensive Care Unit

5. Step-Down Unit

6. Floor

7. Telemetry Unit

8. Observation Unit

9. Burn Unit

13. Labor and Delivery

14. Neonatal/Pediatric Care Unit

15. Other (In Hospital)

40. Home

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

78. Other (Out of Hospital)

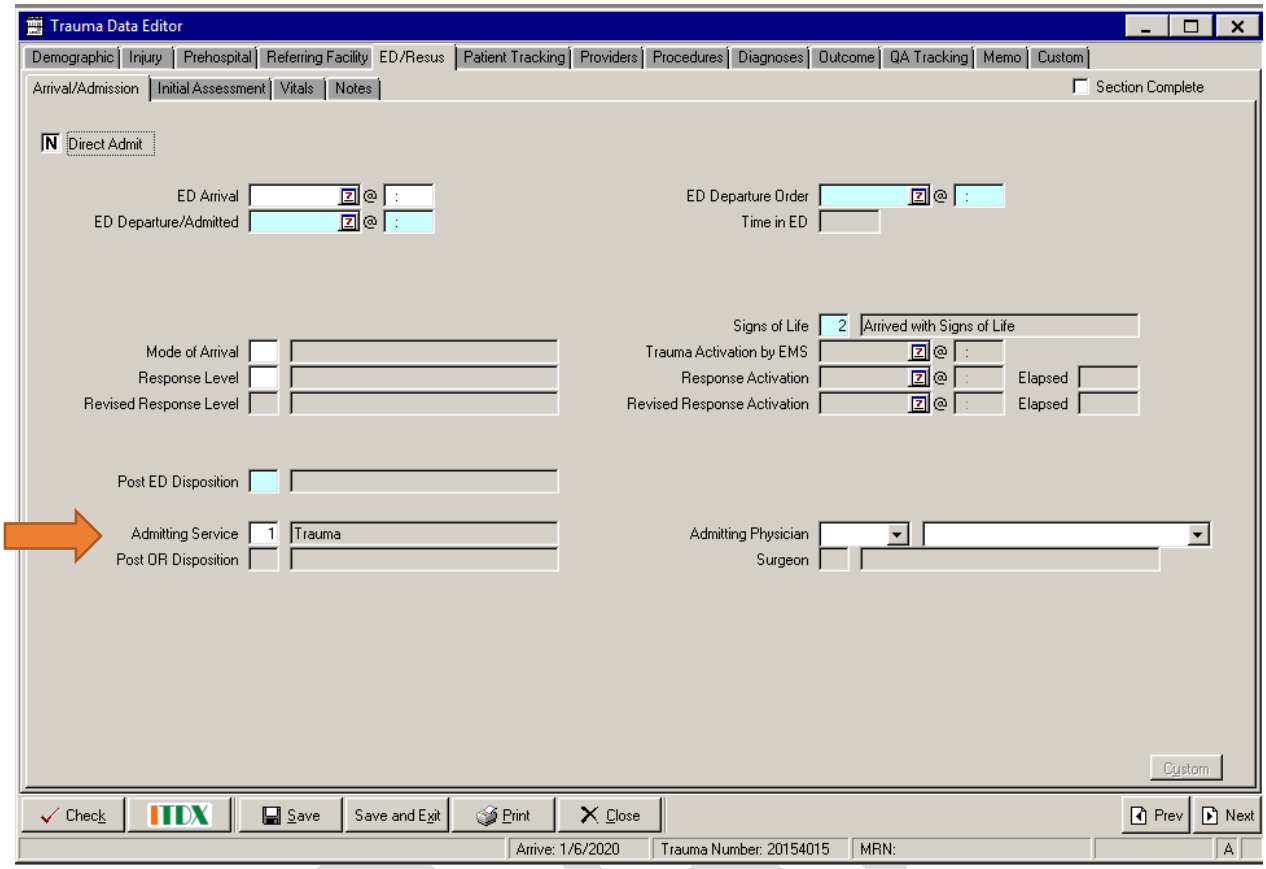
79. Another Type of Inpatient Facility Not Defined Elsewhere

88. Burn Center

/. Not Applicable

?. Unknown

DRAFT



Admitting Service

Definition

The provider service that admitted the patient.

Element 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
65. Intensivist
98. Other Surgical

Data Source Hierarchy Guide:

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

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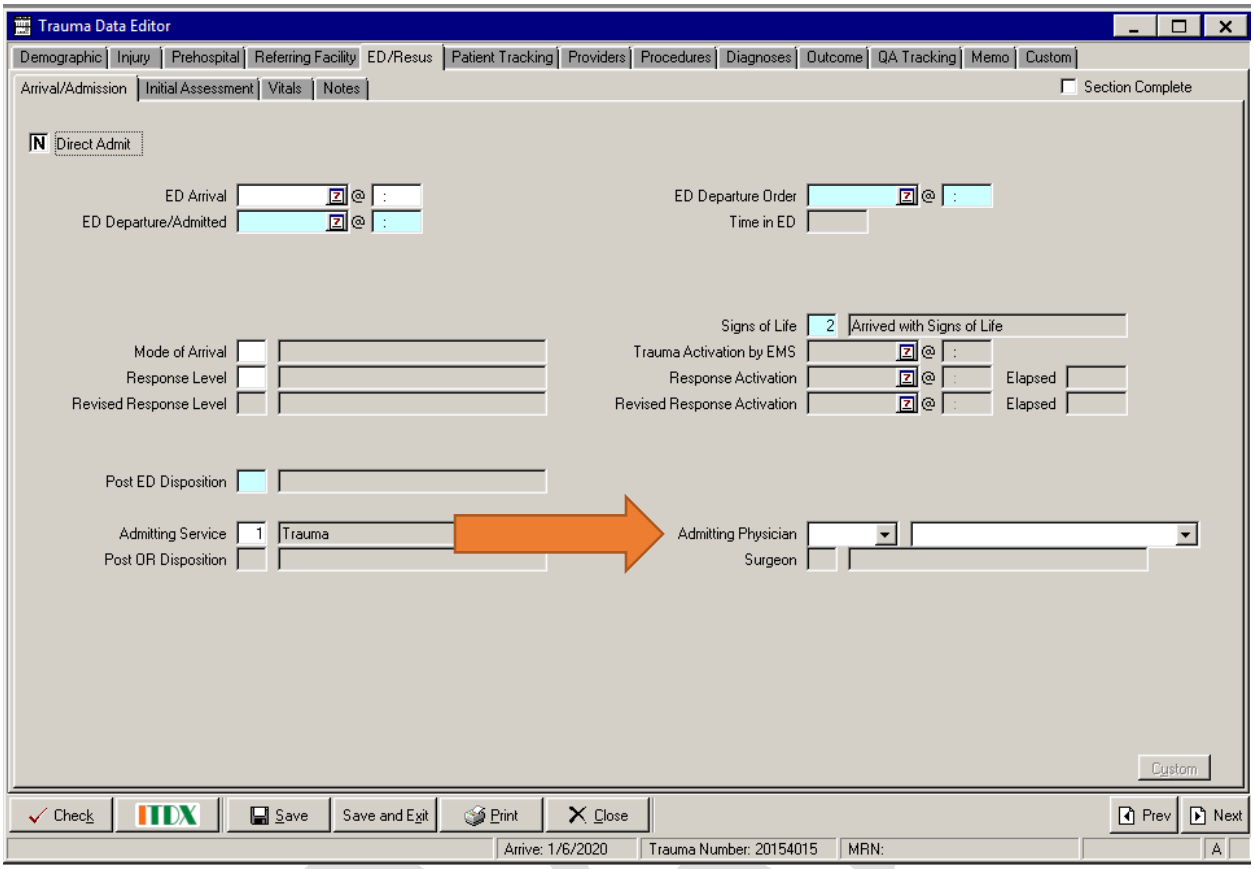


Admitting Physician

Definition

The provider that is admitting the patient to the hospital

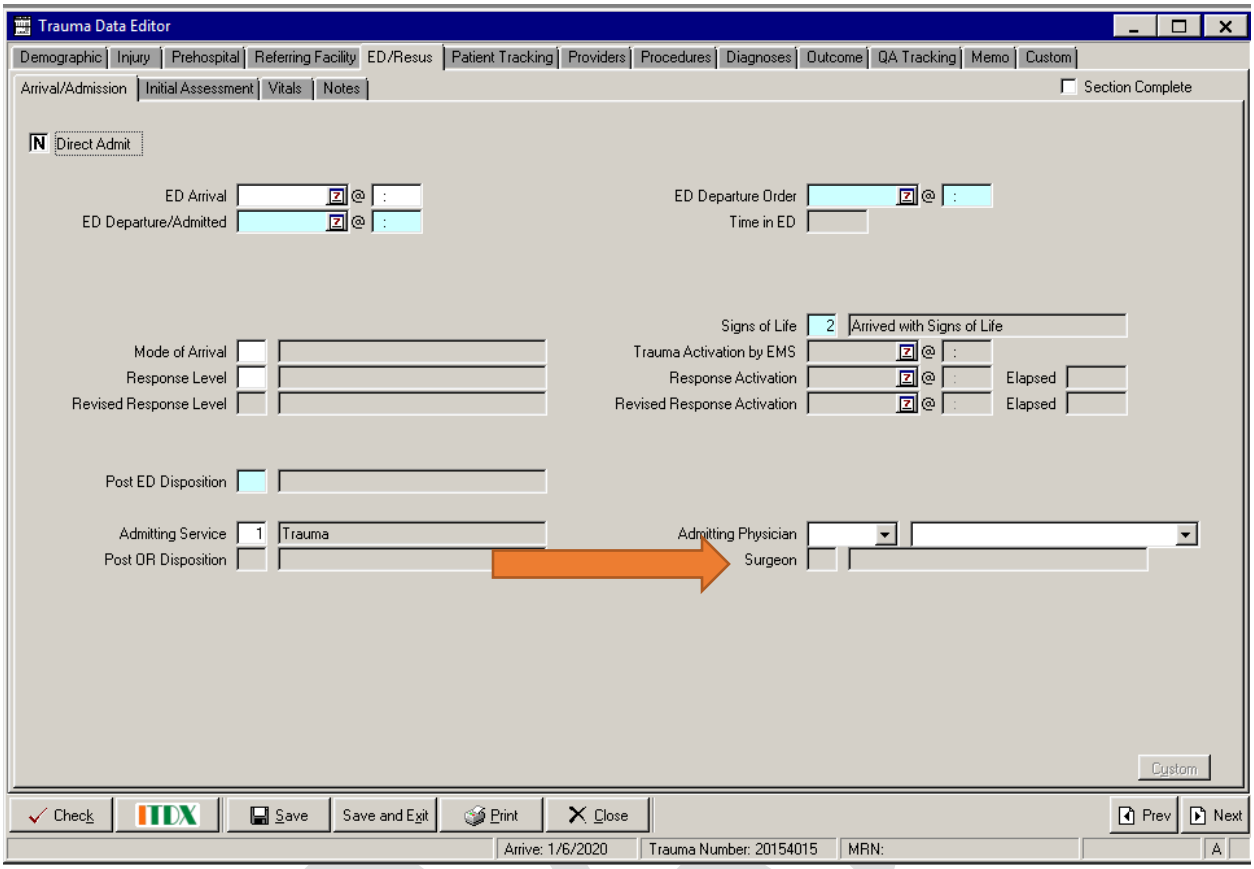
Element Values

- Relevant Value for Data Set

Data Source Hierarchy Guide

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

DRAFT



Surgeon

Definition

Denotes whether or not the admitting physician is a surgeon.

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

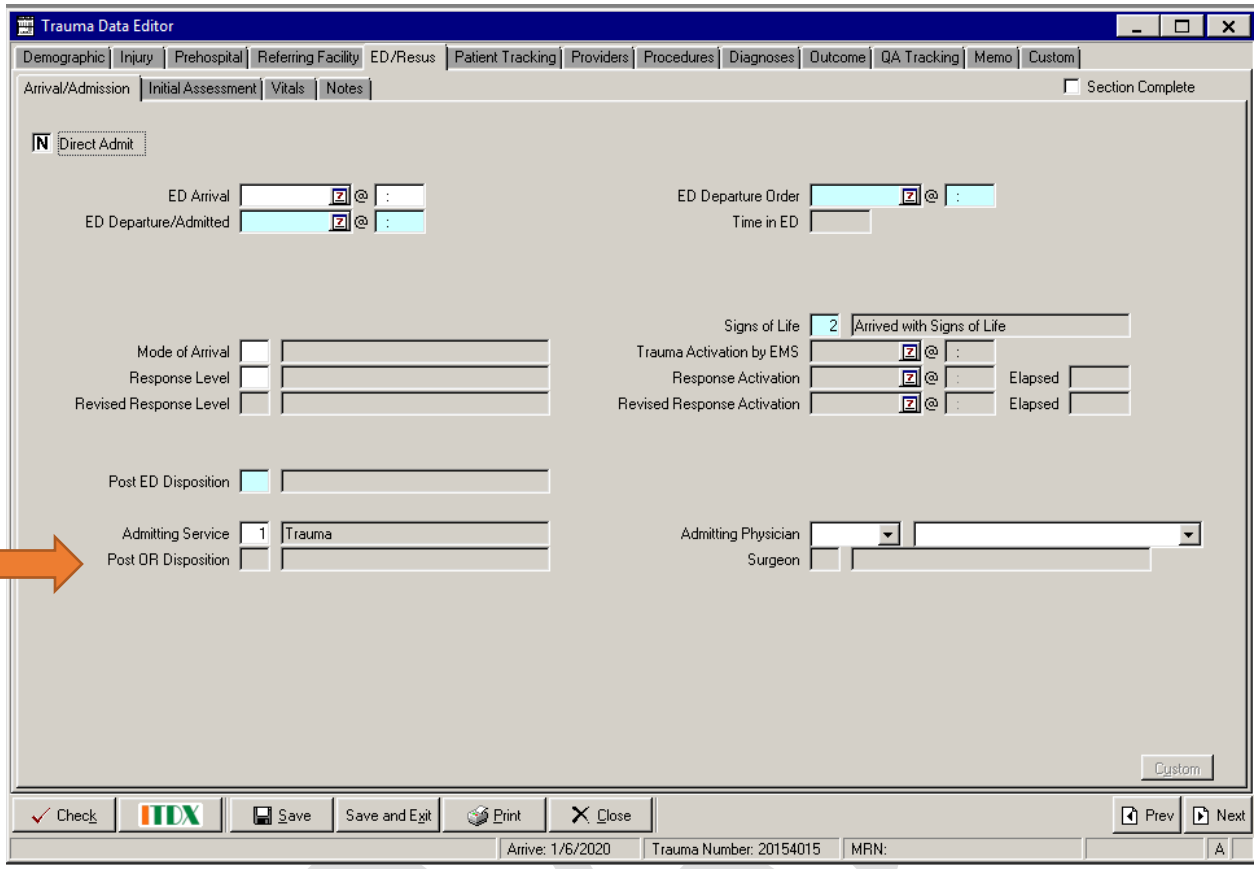
Element Values

1. Yes, Surgeon
2. No, Not a Surgeon

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Progress Notes
2. Billing Sheets



Post OR Disposition

Definition

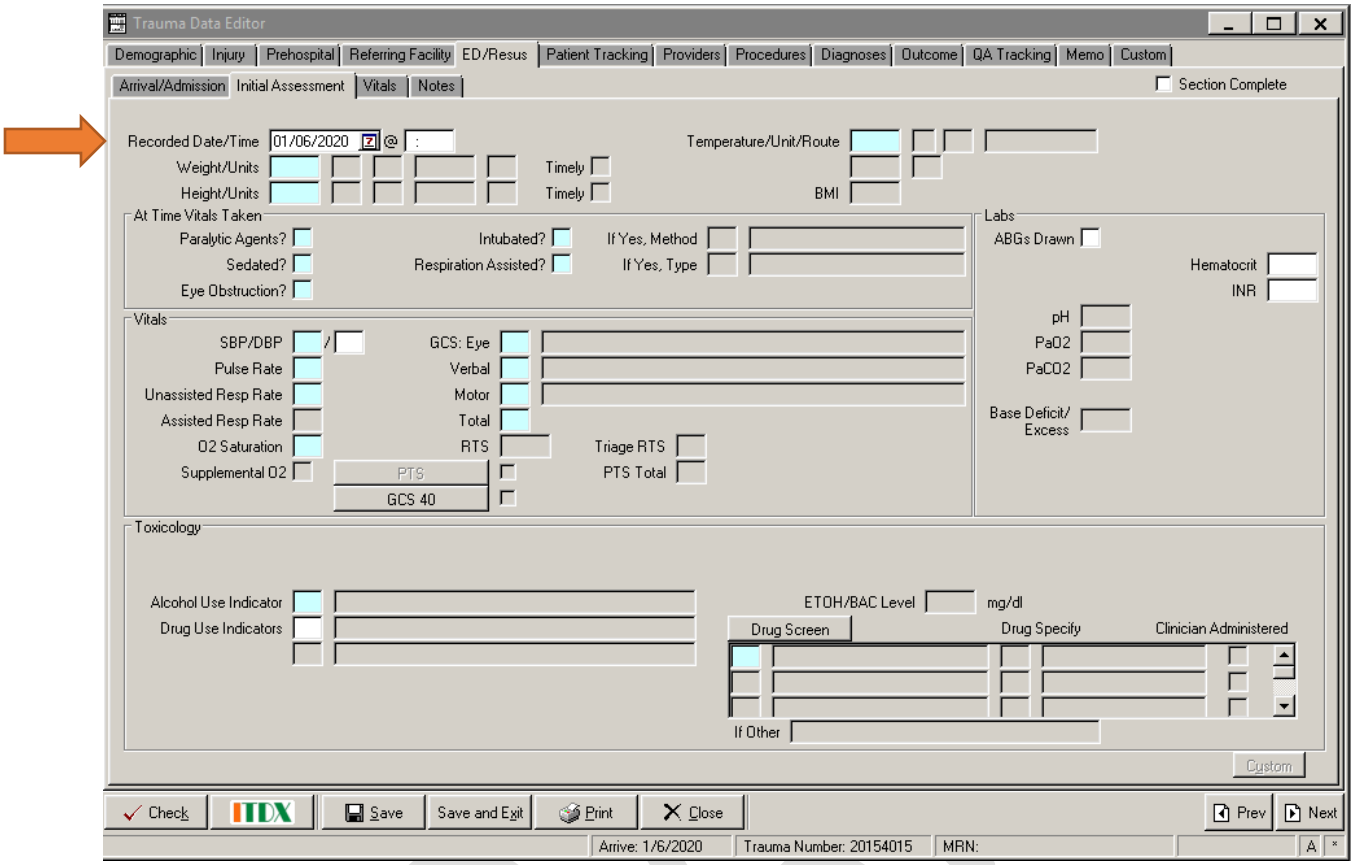
If the patient went from the emergency department to the operating room, this designates where the person went post-operatively.

Element Values

4. Intensive Care Unit
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
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Operative Note
2. Progress Note



ED/Resus Initial Vitals Recorded Date and Time

Definition

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

NOTE: The initial values must be recorded within 30 minutes of patient arrival or they cannot be entered.

Element Values

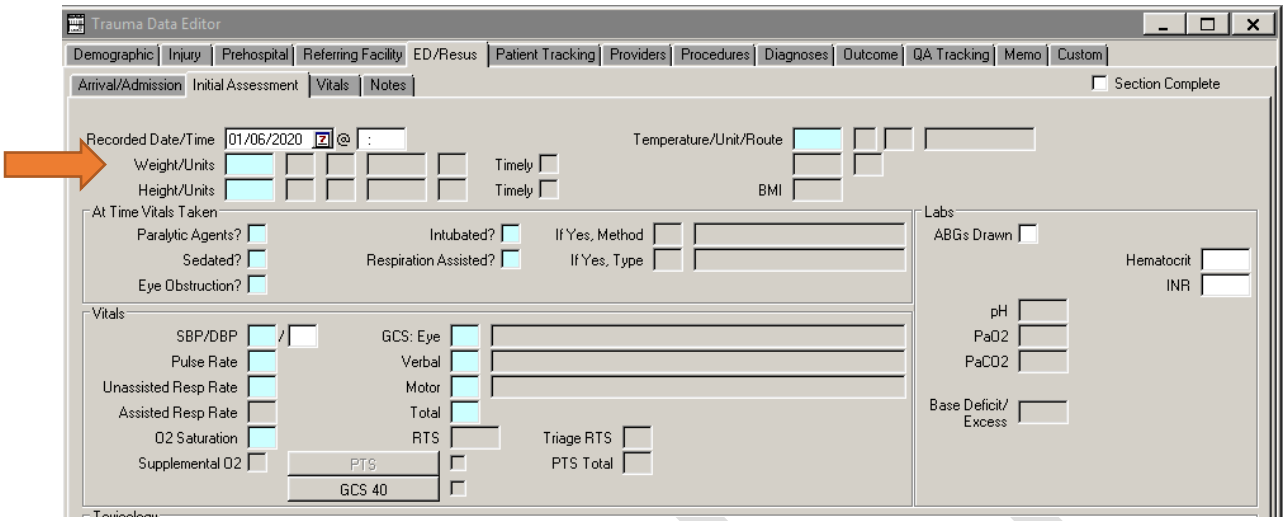
- Relevant Value for Data Element

Data Source Hierarchy Guide

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

DRAFT

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



INITIAL ED/HOSPITAL WEIGHT

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

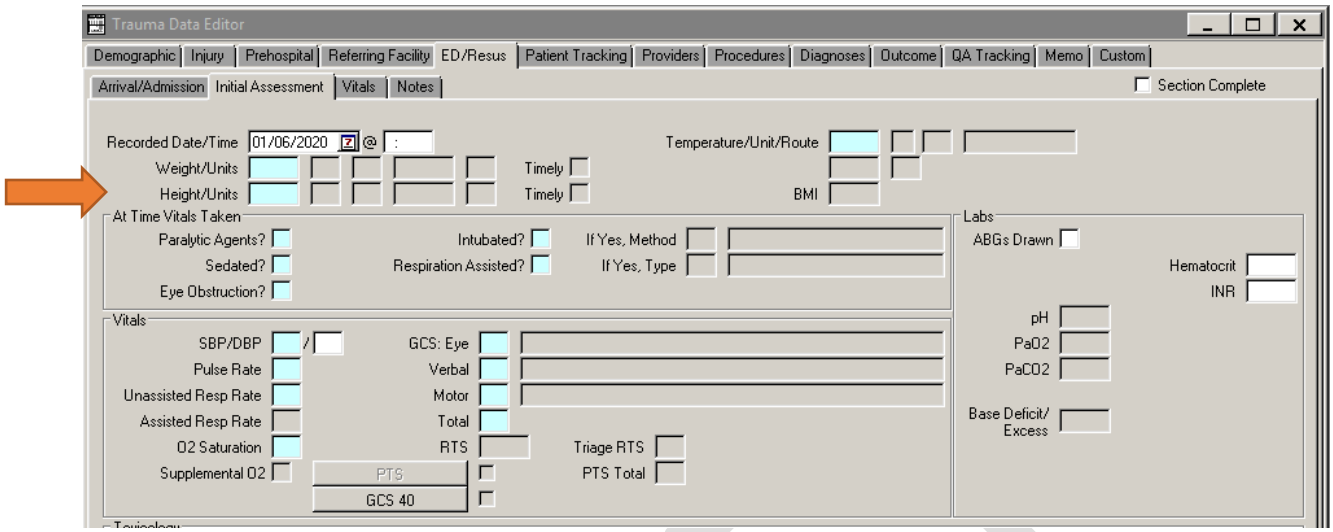
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks

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

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

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



INITIAL ED/HOSPITAL HEIGHT

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

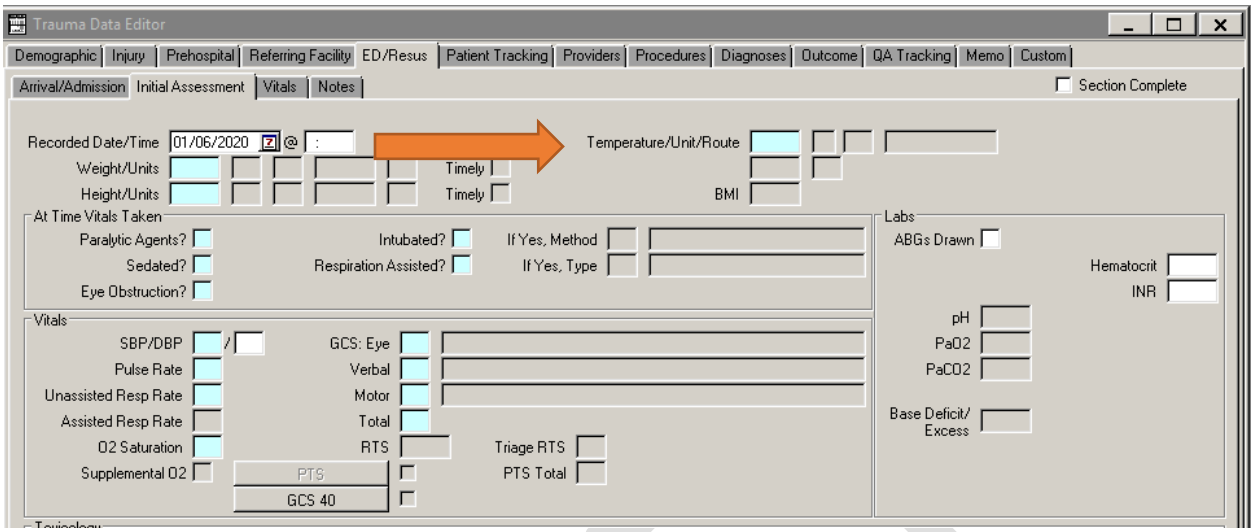
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks

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

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

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



INITIAL ED/HOSPITAL TEMPERATURE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

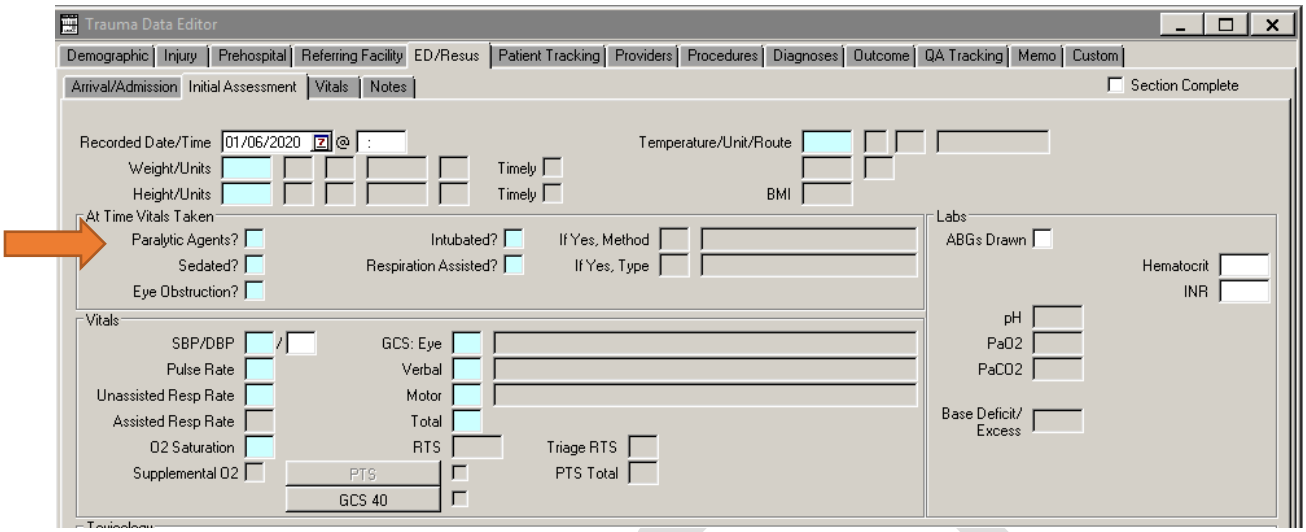
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks

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

NOTE: Once entered it will ask for cc (centigrade) or ff (Fahrenheit).
It also will open "source" – 1. Oral; 2. Tympanic; 3. Rectal; 4. Axillary; 5. Core; 6. Other; 7. Temporal; ?.Unknown

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



ED/Resus Paralytic Agents

Definition

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

Element Values

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

Data Source Hierarchy Guide:

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

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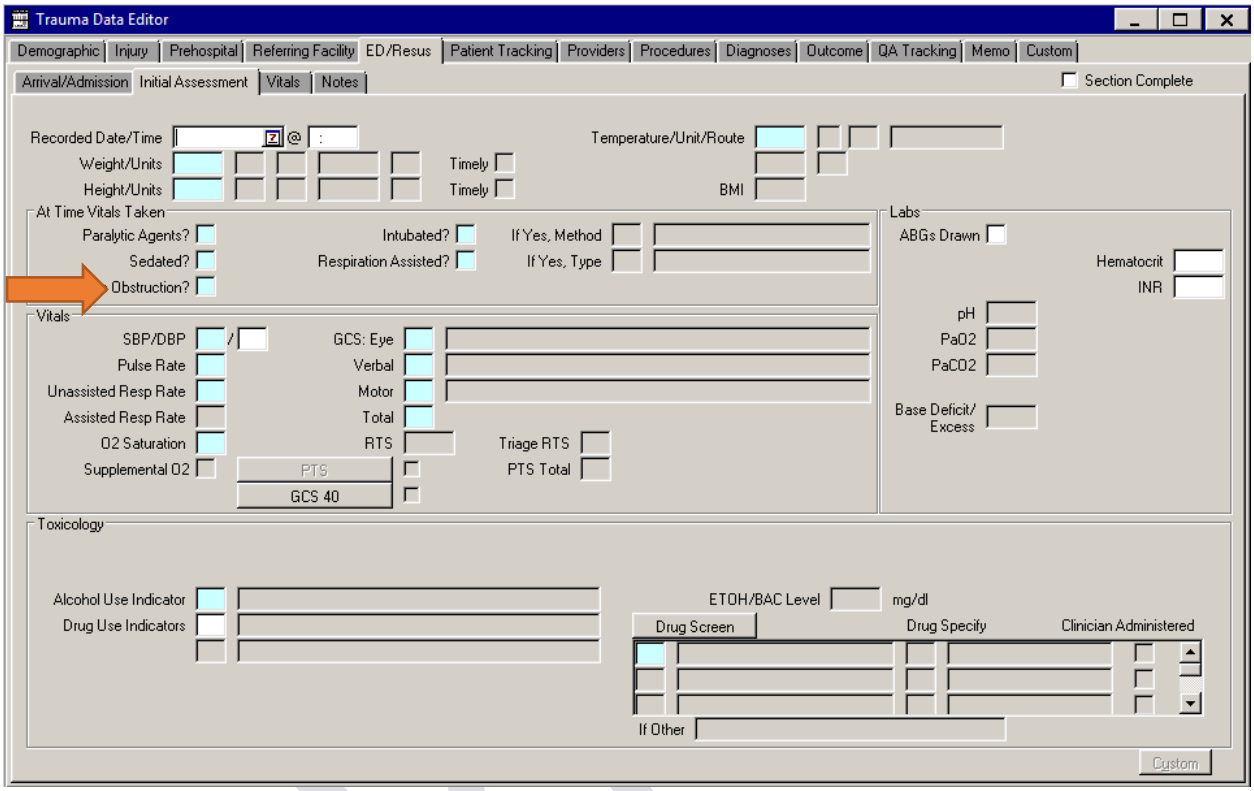
ED Resusc Sedated: MANDATORY BLUE FIELD; NTDS Definition rules.



ED/Resus Sedated

Definition

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

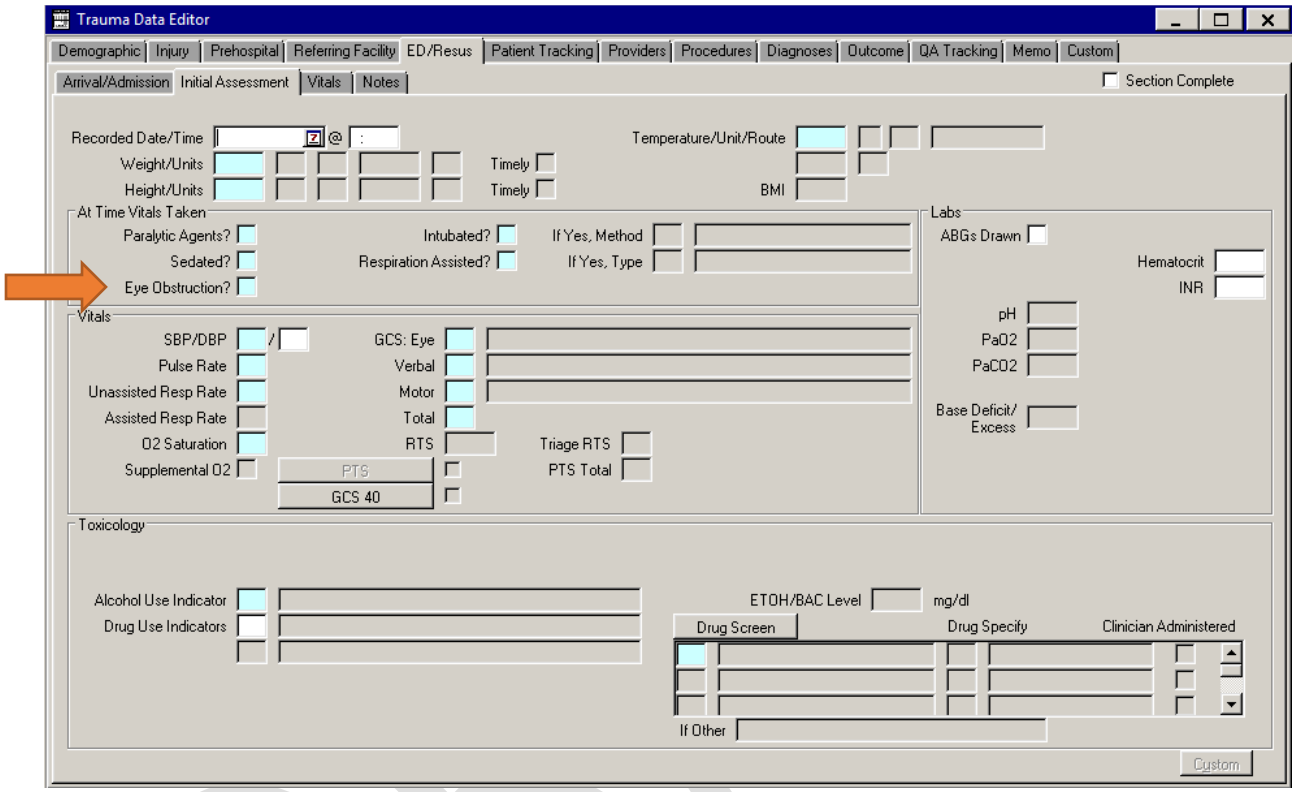
Element Values

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

Data Source Hierarchy Guide

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

Eye Obstruction: MANDATORY BLUE FIELD; NTDS Definition rules.



ED/Resus Eye Obstruction

Definition

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

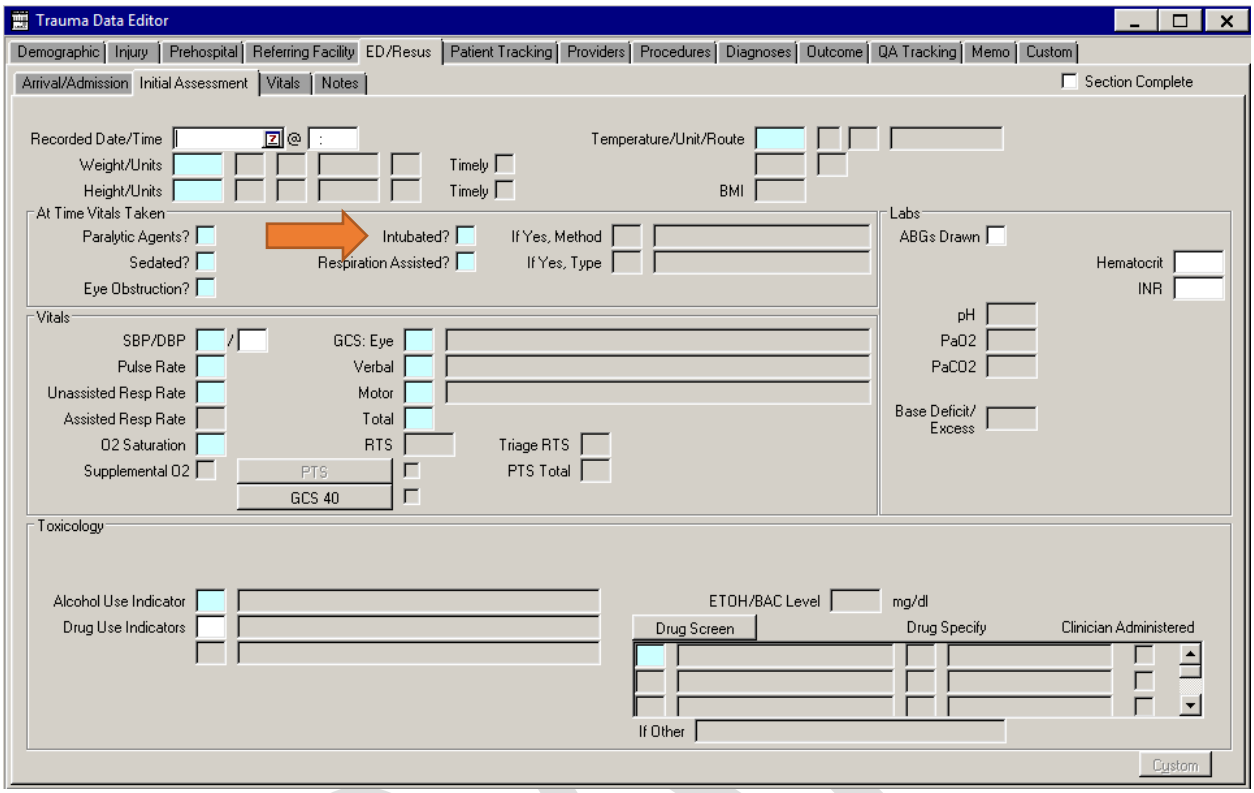
Element Values

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

Data Source Hierarchy Guide

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

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



ED/Resus Intubated

Definition

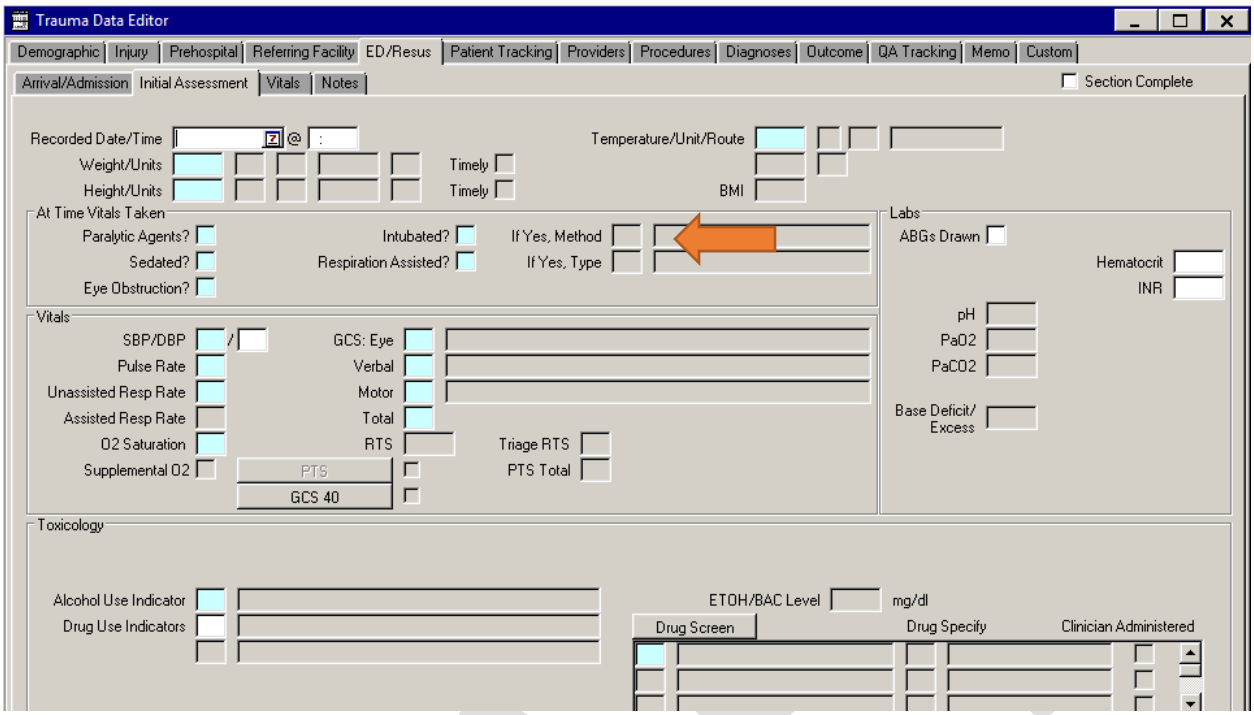
Was the patient intubated at the time the initial set of vitals were taken?

Element Values

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

Data Source Hierarchy Guide

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



ED/Resus Intubation Method

Definition

The device or method used to intubate the patient.

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

Element Values

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

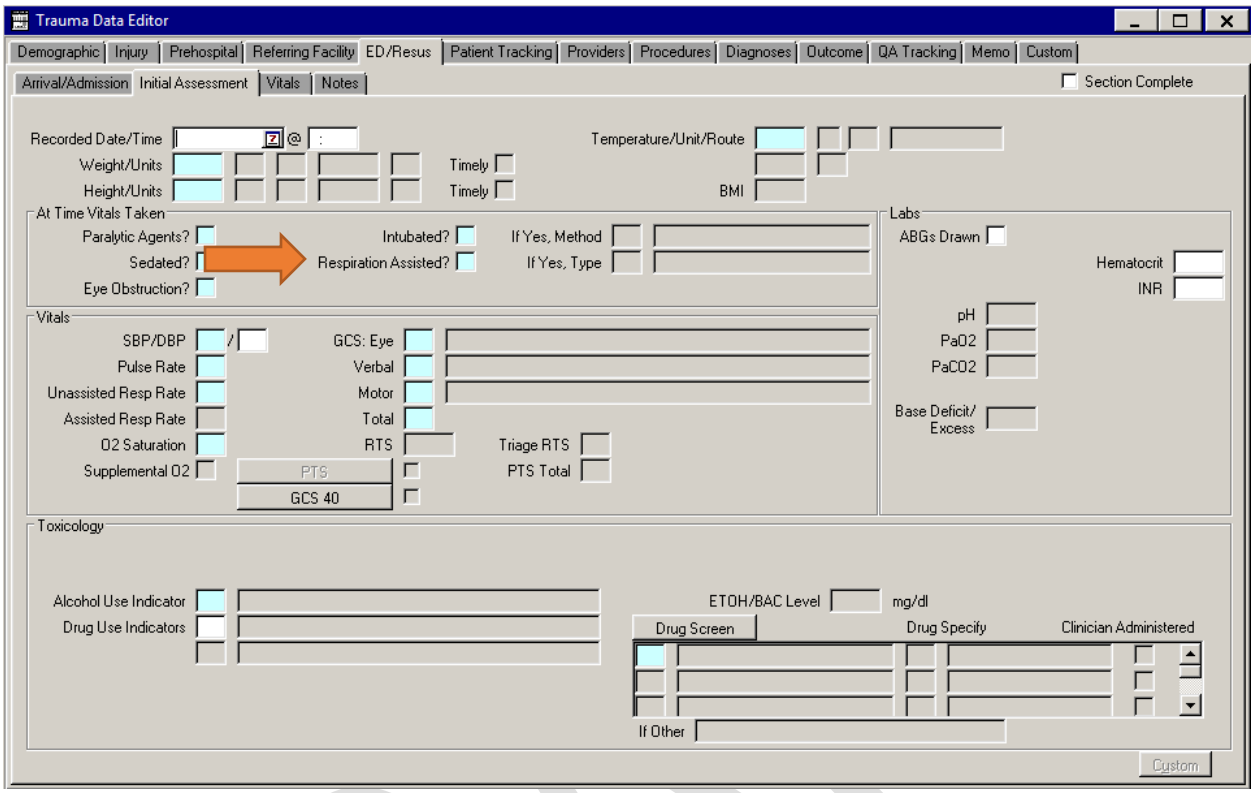
?. Unknown

Data Source Hierarchy Guide

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

DRAFT

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



ED/Resus Respiration Assisted

Definition

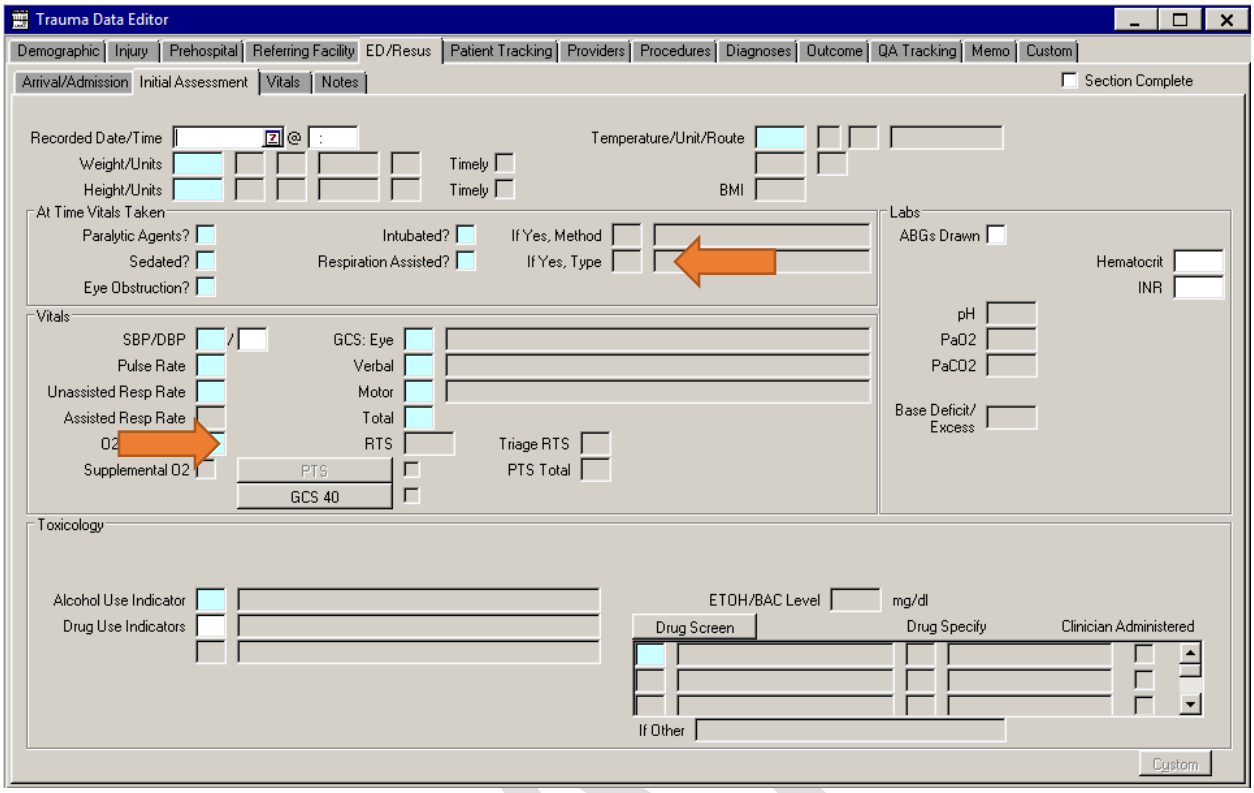
Did the patient required assisted respirations at the time the initial set of vitals were taken?

Element Values

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

Data Source Hierarchy Guide

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



ED/Resus Respiration Assisted Type

Definition

The device used to assist the patient's respirations.

NOTE: Will only populate if you answer yes.

Element Values

1. Bag Value Mask
2. Nasal Airway
3. Oral Airway
4. Ventilator

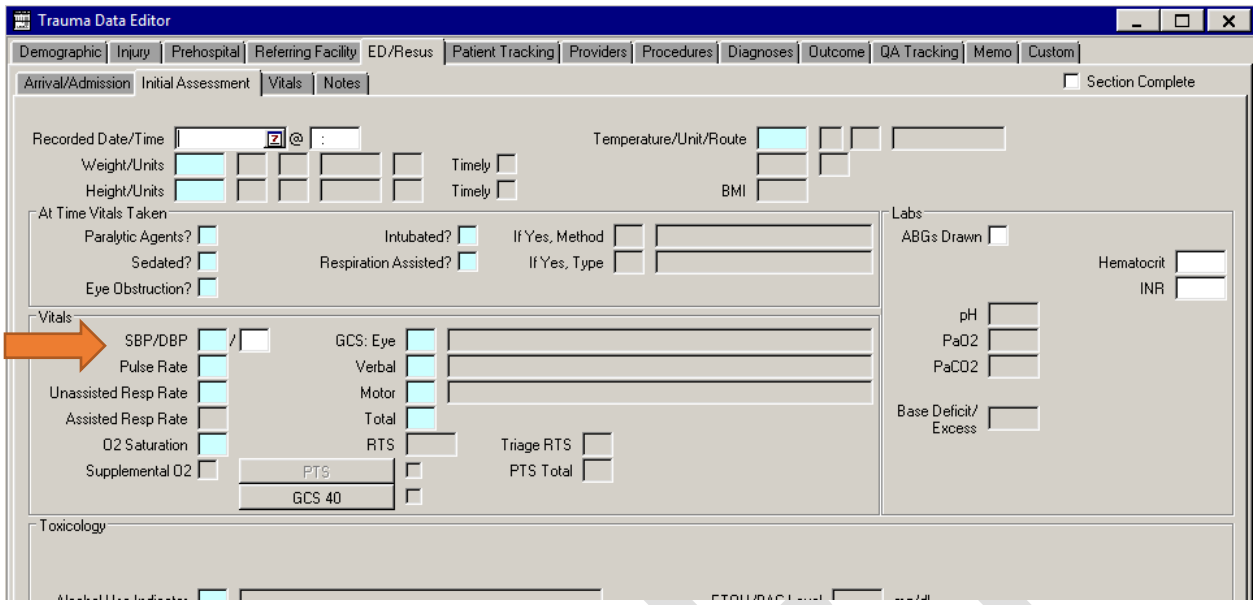
?. Unknown

Data Source Hierarchy Guide

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

DRAFT

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



INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

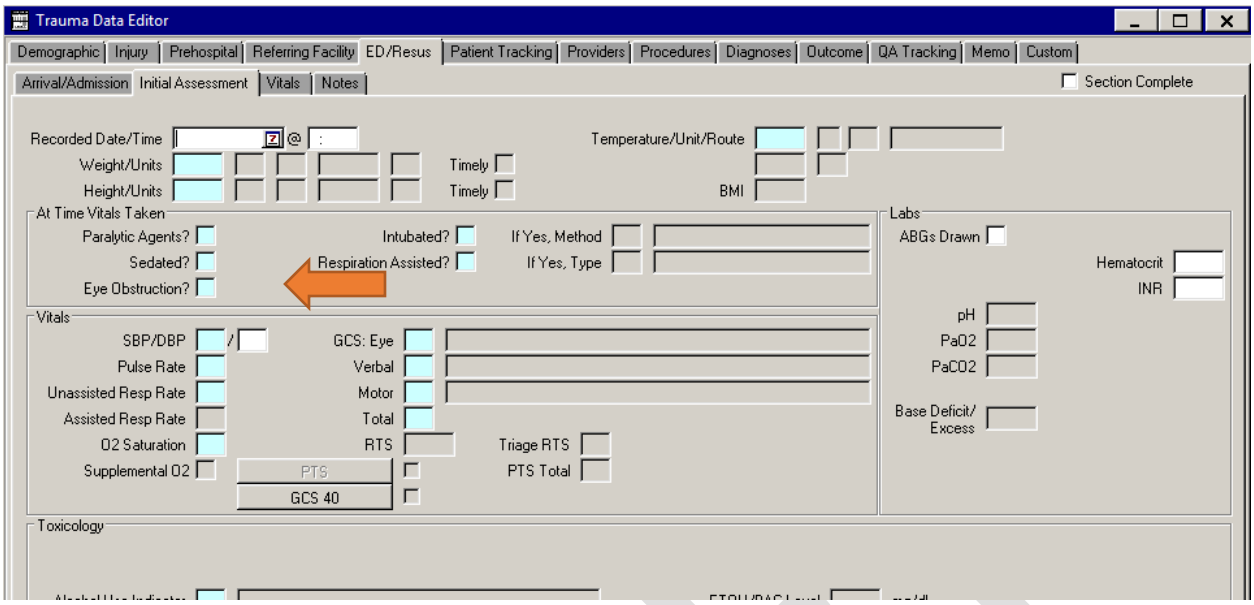
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



Initial ED/Hospital Diastolic Blood Pressure

Definition

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

Element Values

- Relevant value for data element

Additional Information

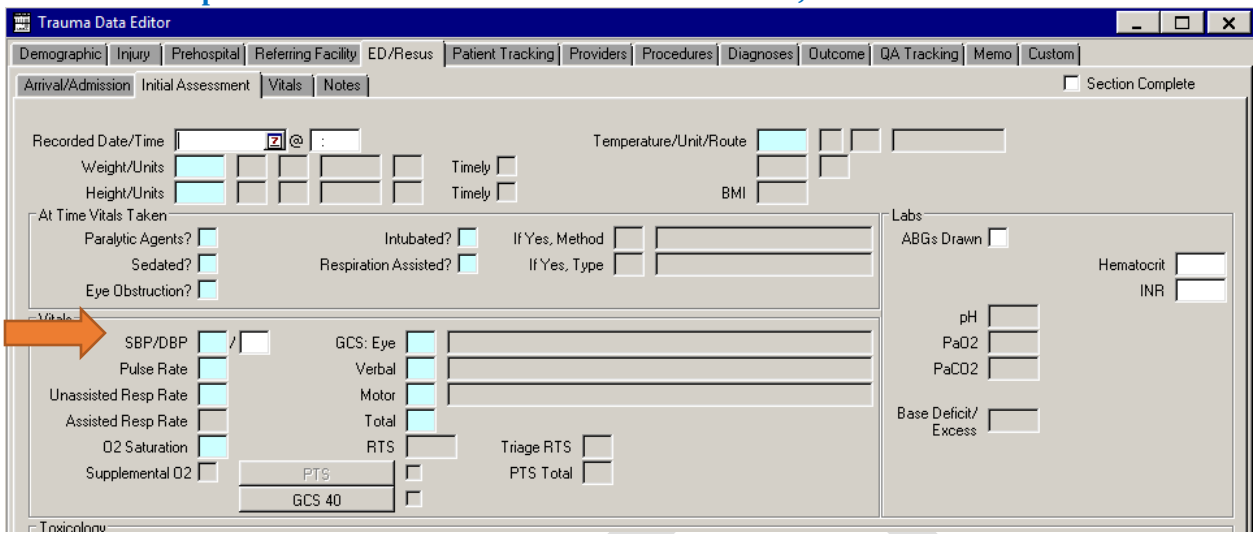
- Please note that the first recorded hospital vitals do not need to be from the same assessment.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report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

Data Source Hierarchy Guide

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

DRAFT

Initial ED / Hospital Pulse Rate: MANDATORY BLUE FIELD; NTDS Definition rules



INITIAL ED/HOSPITAL PULSE RATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

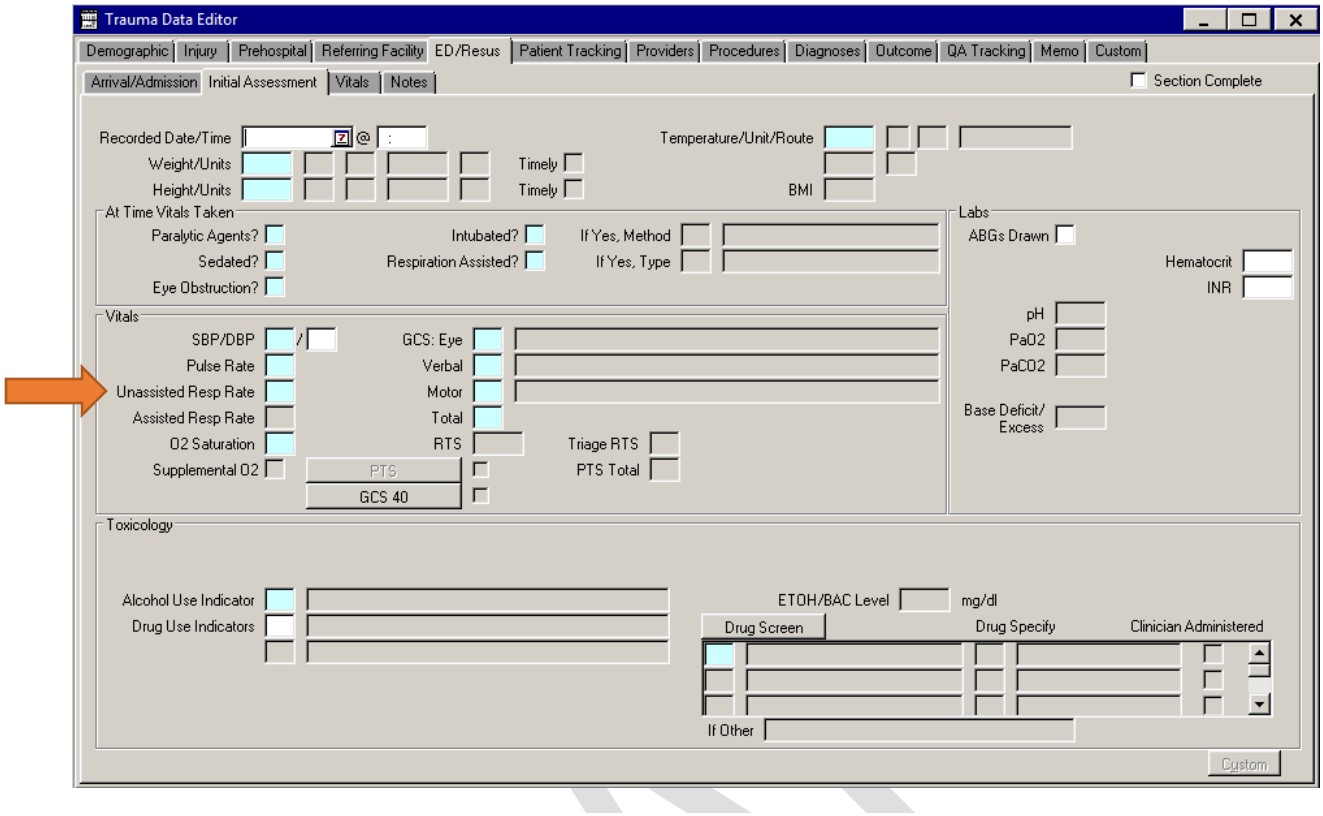
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report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

Data Source Hierarchy Guide

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

Associated Edit Checks

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



INITIAL ED/HOSPITAL RESPIRATORY RATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

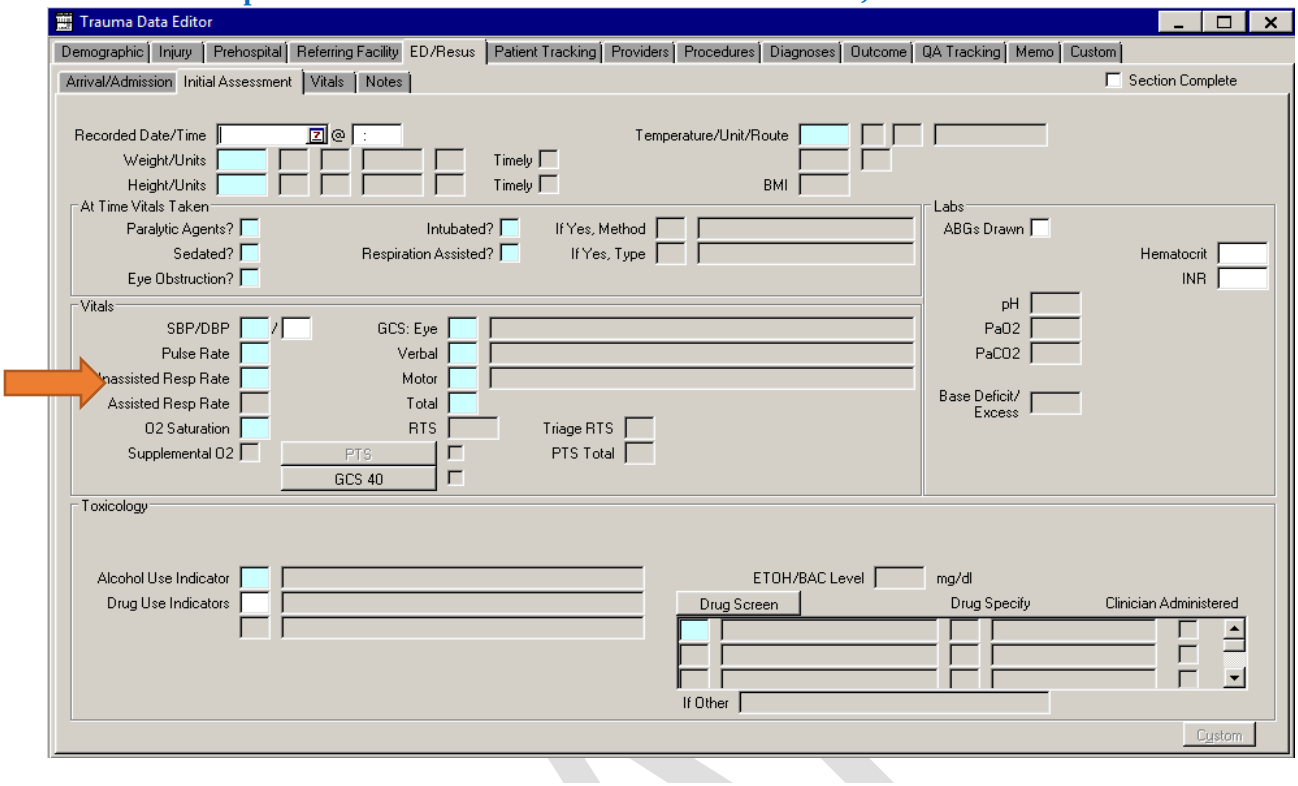
Data Source Hierarchy Guide

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

Associated Edit Checks

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

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



INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition

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

Element Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate

Additional Information

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

Data Source Hierarchy Guide

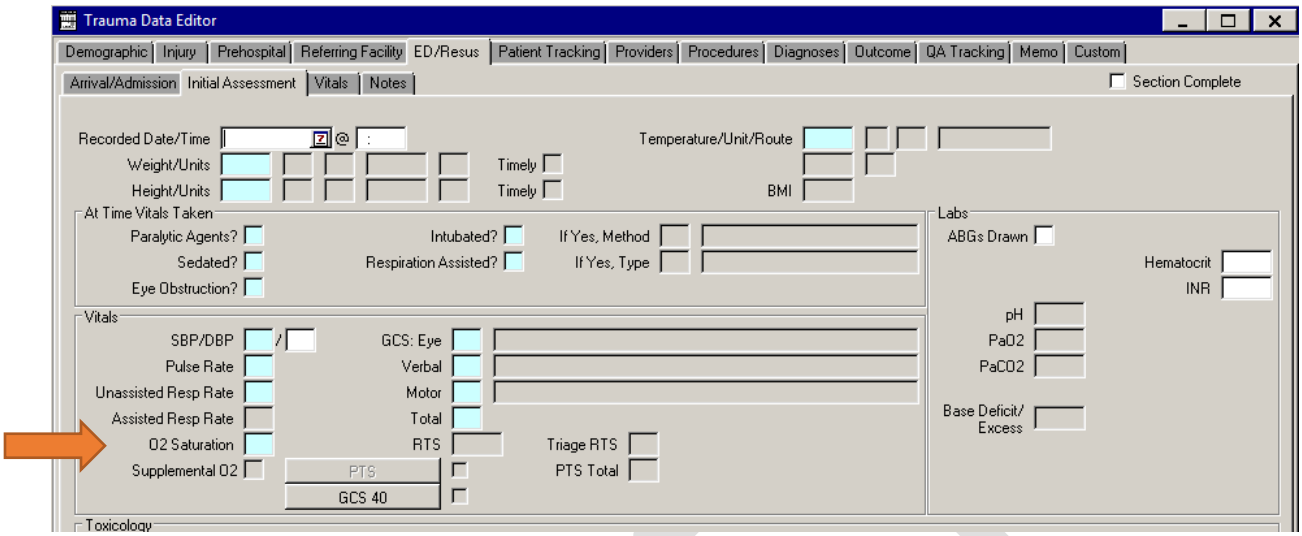
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks

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

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

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



INITIAL ED/HOSPITAL OXYGEN SATURATION

Definition

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

Element Values

- Relevant value for data element

Additional Information

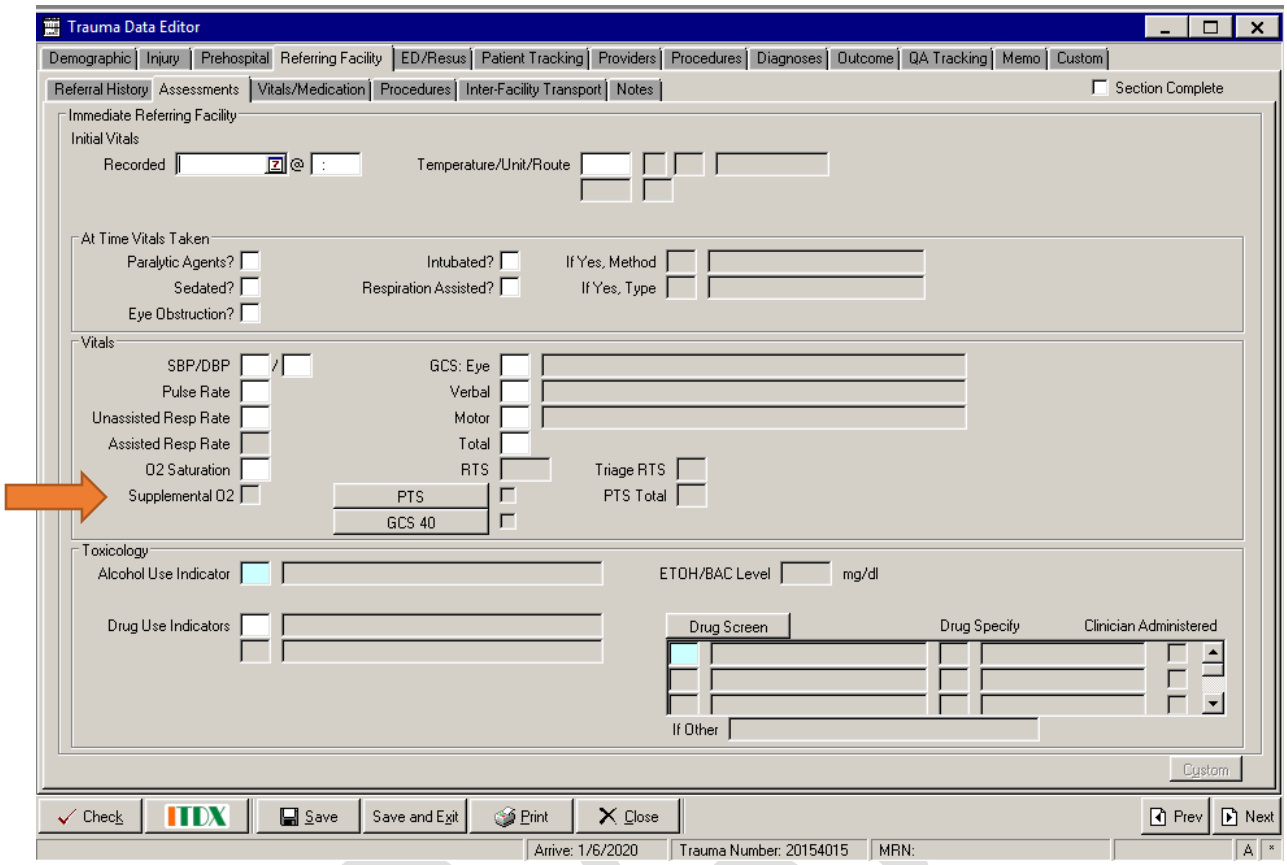
- If reported, report additional data element: Initial ED/Hospital Supplemental Oxygen.
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

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

Associated Edit Checks

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



INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition

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

Element Values

1. No Supplemental Oxygen
2. Supplemental Oxygen

Additional Information

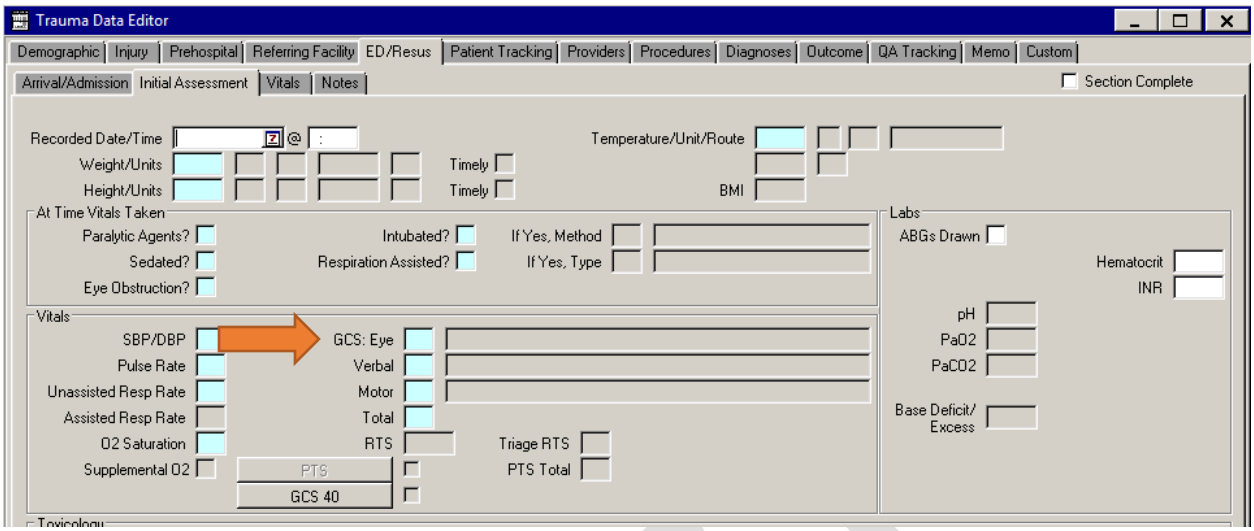
- The null value "Not Applicable" is reported if the Initial ED/Hospital Oxygen Saturation is "Not Known/Not Recorded"
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

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

Associated Edit Checks

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



INITIAL ED/HOSPITAL GCS - EYE

Definition

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

Element Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

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

Trauma Data Editor

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

Arrival/Admission | Initial Assessment | Vitals | Notes

Section Complete

Recorded Date/Time @ :

Weight/Units Timely

Height/Units Timely

Temperature/Unit/Route

BMI

At Time Vitals Taken

Paralytic Agents?

Sedated?

Eye Obstruction?

Intubated?

Respiration Assisted?

If Yes, Method

If Yes, Type

Labs

ABGs Drawn

Hematocrit

INR

pH

PaO2

PaCO2

Base Deficit/ Excess

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

PTS Total

PTS

GCS 40

Toxicology

Alcohol Use Indicator

Drug Use Indicators

ETOH/BAC Level mg/dl

Drug Screen

Drug Specify

Clinician Administered

If Other

Custom

DRAFT

INITIAL ED/HOSPITAL GCS - VERBAL

Definition

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

Element Values

Pediatric (≤ 2 years):

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

Adult

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

Additional Information

- If patient is intubated, then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Verbal is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

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

Associated Edit Checks

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

Trauma Data Editor

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

Arrival/Admission | Initial Assessment | Vitals | Notes

Section Complete

Recorded Date/Time @ :

Weight/Units Timely

Height/Units Timely

Temperature/Unit/Route

BMI

At Time Vitals Taken

Paralytic Agents?

Sedated?

Eye Obstruction?

Intubated?

Respiration Assisted?

If Yes, Method

If Yes, Type

Labs

ABGs Drawn

Hematocrit

INR

pH

PaO2

PaCO2

Base Deficit/ Excess

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

PTS Total

PTS

GCS 40

Toxicology

Alcohol Use Indicator

Drug Use Indicators

ETOH/BAC Level mg/dl

Drug Screen

Drug Specify

Clinician Administered

If Other

Custom

DRAFT

INITIAL ED/HOSPITAL GCS - MOTOR

Definition

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

Element Values

Pediatric (≤ 2 years):

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

Adult

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

Additional Information

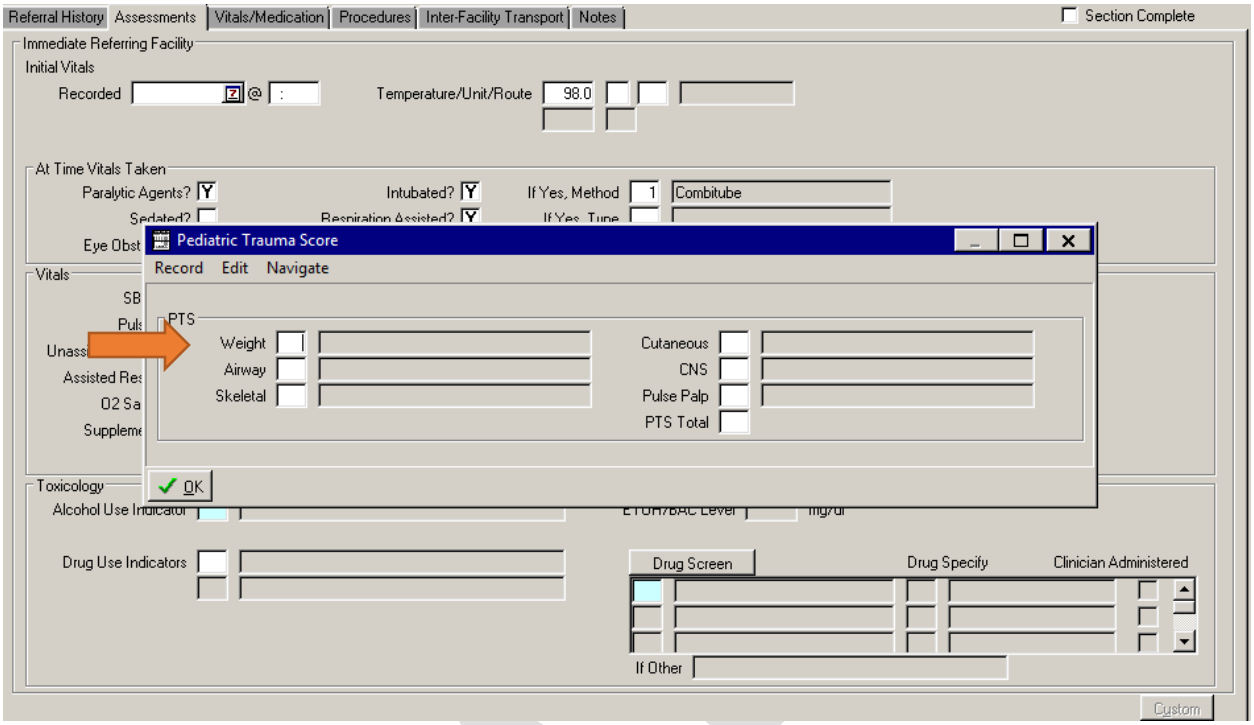
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient withdraws from a painful stimulus,"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

Data Source Hierarchy Guide

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

Associated Edit Checks

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



Pediatric Trauma Score: Weight

Definition

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

Element Values

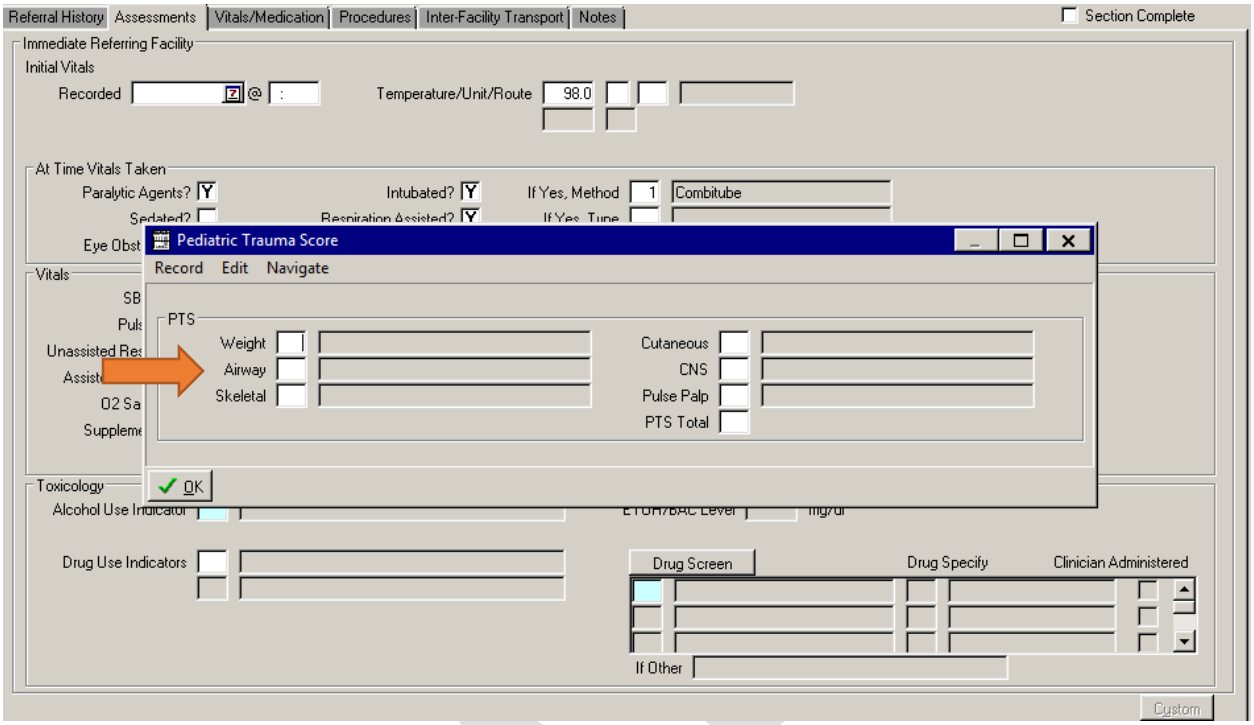
2. Greater than 20kg (44 lbs.)
1. between 10 and 20kg (22-44 lbs.)
-1. Less than 10kg (22 lbs.)

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical

DRAFT



Pediatric Trauma Score: Airway

Definition

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

Element Values

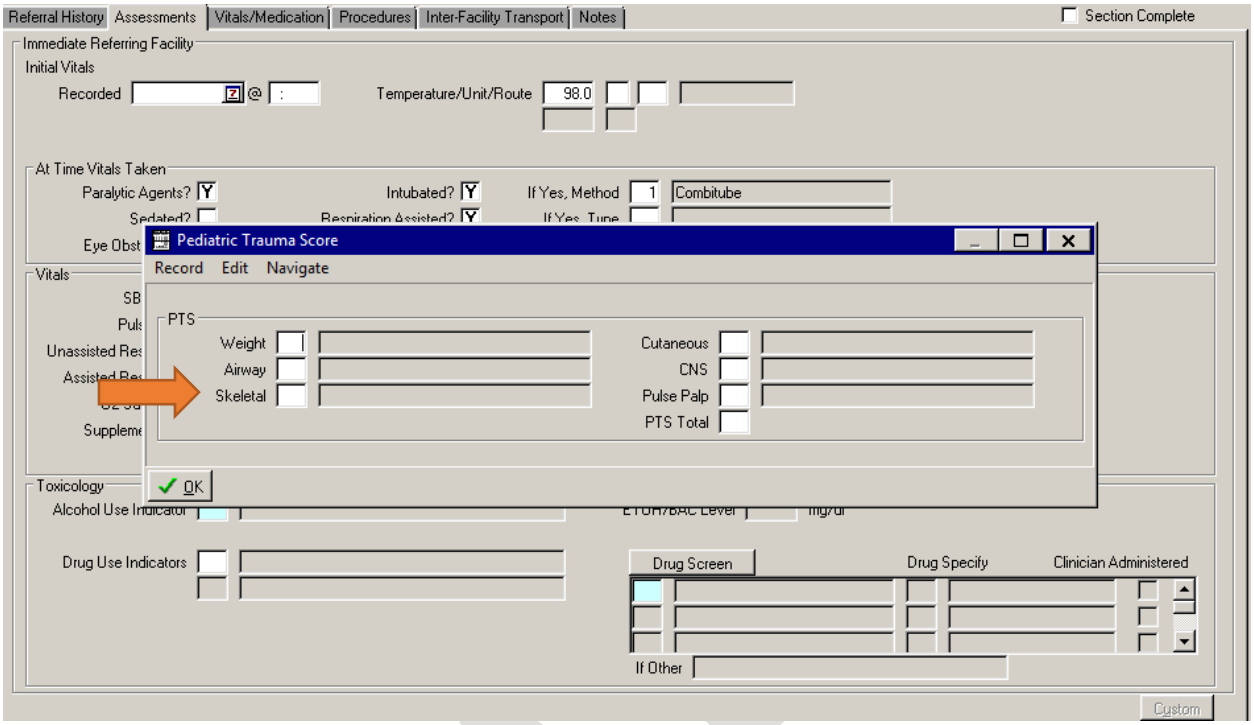
2. Normal
1. Maintainable
-1. Unmaintainable or Intubated

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

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

DRAFT



Pediatric Trauma Score: Skeletal

Definition

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

Element Values

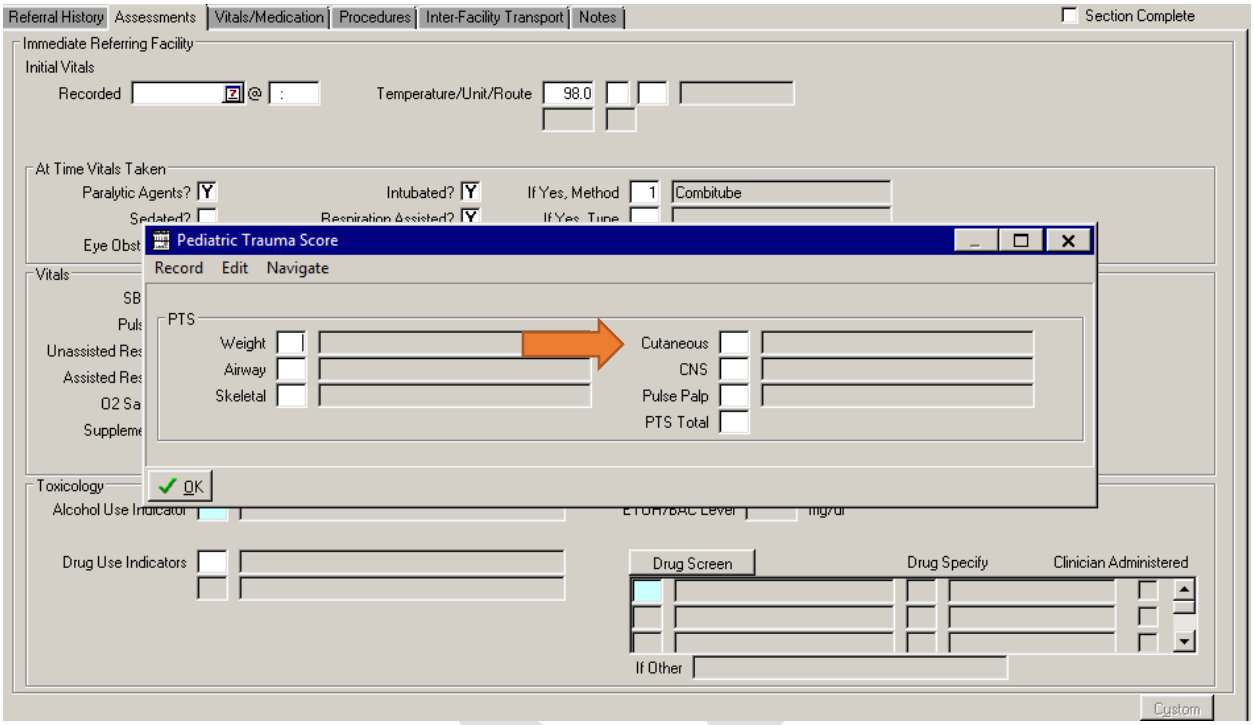
2. None
1. Closed Fracture
-1. Open or Multiple Fractures

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

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

DRAFT



Pediatric Trauma Score: Cutaneous

Definition

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

Element Values

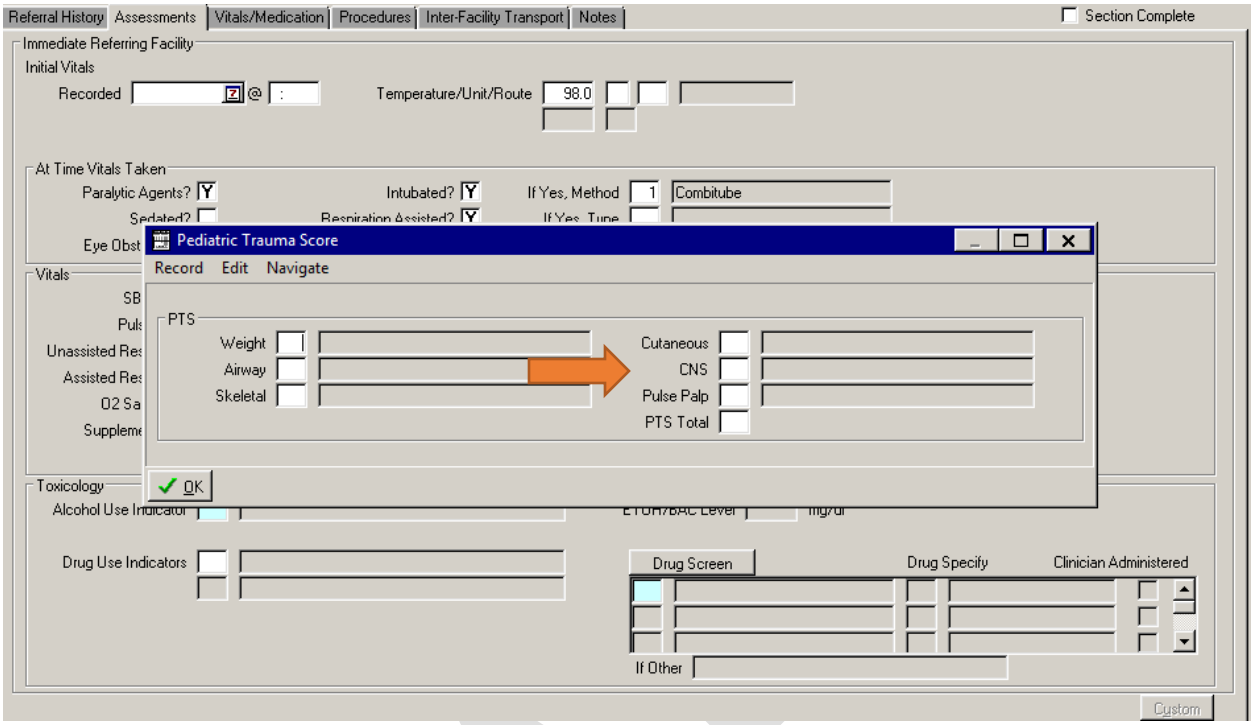
2. No Open Wounds
1. Minor Open Wounds
-1. Major or Penetrating Open Wounds

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

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

DRAFT



Pediatric Trauma Score: CNS

Definition

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

Element Values

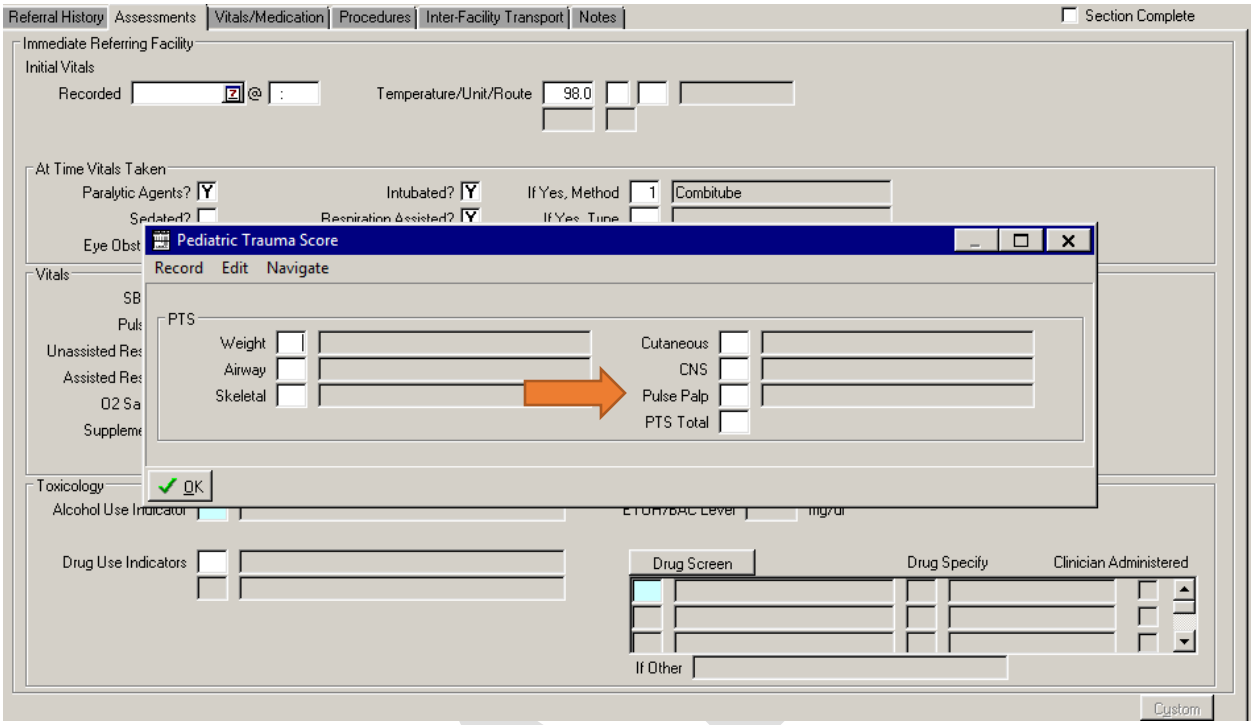
2. Awake
1. Altered Mental Status or Obtunded
-1. Coma or Abnormal Flexion

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

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

DRAFT



Pediatric Trauma Score: Pulse Palp

Definition

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

Element Values

2. Pulse Palpable at Wrist (SBP over 90 mmHg
1. Pulse Palpable at Groin (SBP Btwn 50 and 90 mmHg)
-1. Pulse Not Palpable (SBP under 50 mmHg)
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

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

DRAFT

Trauma Data Editor

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

Arrival/Admission | Initial Assessment | Vitals | Notes

Section Complete

Recorded Date/Time @ :
Weight/Units Timely
Height/Units Timely
Temperature/Unit/Route
BMI

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

Labs
ABGs Drawn
Hematocrit
INR
pH
PaO2
PaCO2
Base Deficit/ Excess

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

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

ALCOHOL SCREEN

Definition

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

Element Values

1. Yes
2. No

Additional Information

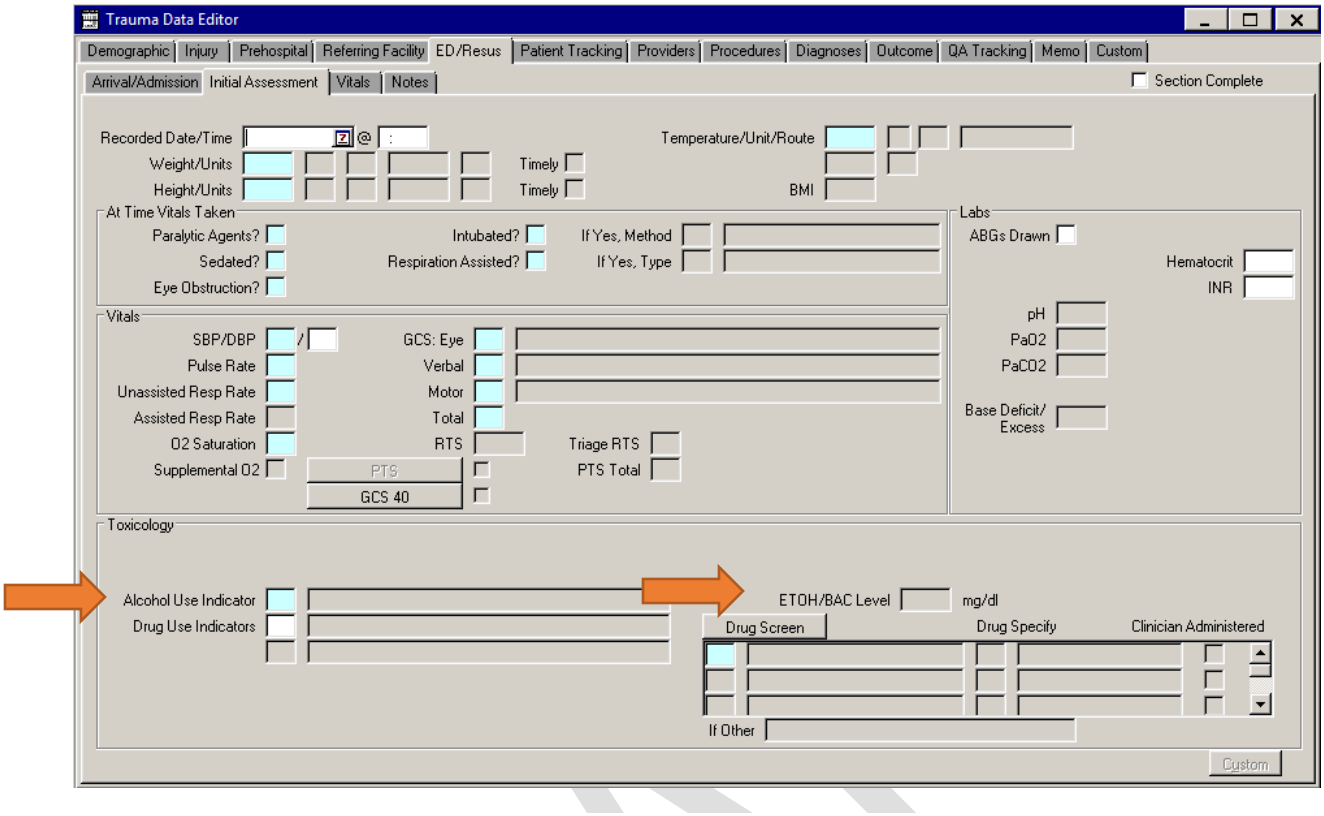
- Alcohol screen may be administered at any facility, unit, or setting treating this patient event.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

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



ALCOHOL SCREEN RESULTS

Definition

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

Element Values

- Relevant value for data element.

Additional Information

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

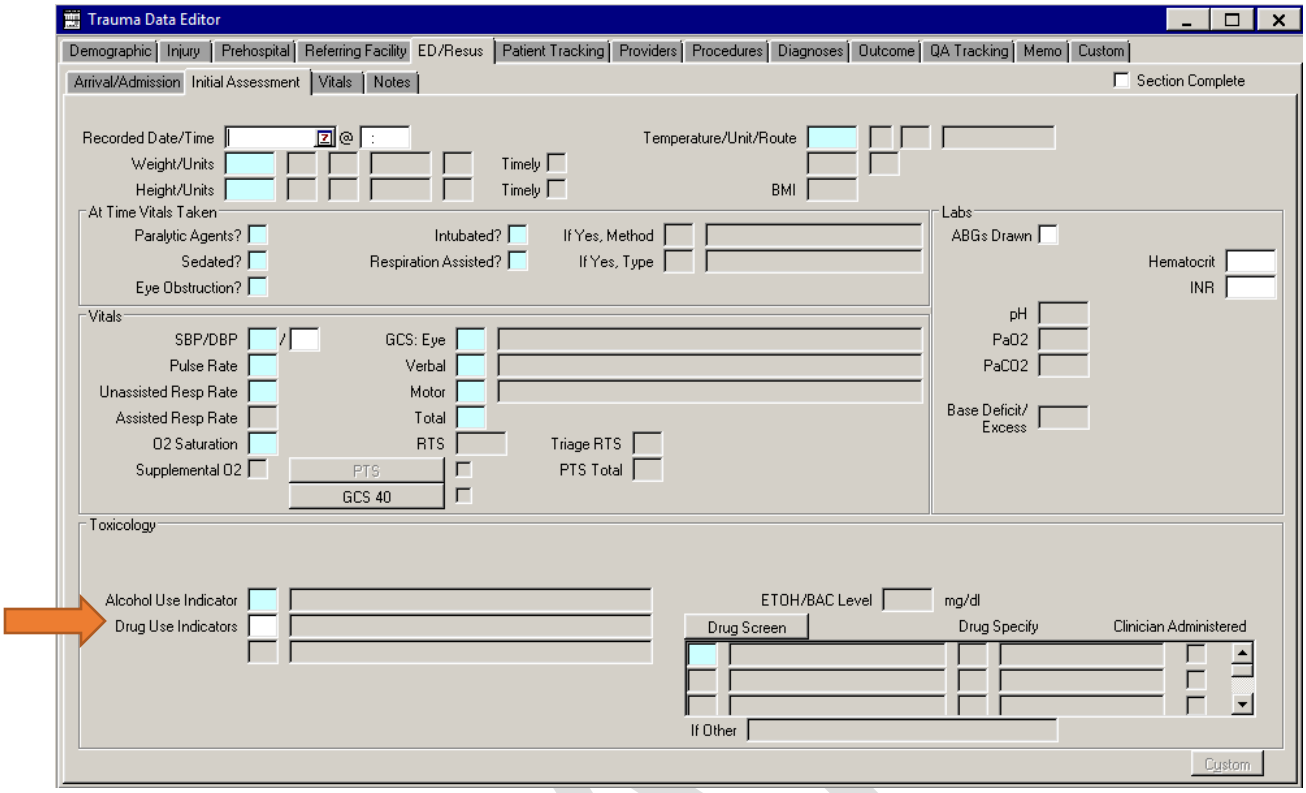
Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

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

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



ED/Resus Drug Use Indicator

Definition

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

Element Values

1. No (Not Tested)
2. No (Confirmed by Test)
3. Yes (Confirmed by Test: Prescription Drug)
4. Yes (Confirmed by Test: Illegal Drug Use)

/. Not Applicable

?. Unknown

NOTE: Drug 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
3. Progress Notes

DRAFT

Trauma Data Editor

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

Arrival/Admission | Initial Assessment | Vitals | Notes

Section Complete

Recorded Date/Time @ :

Temperature/Unit/Route

Weight/Units Timely

Height/Units Timely

BMI

At Time Vitals Taken

Paralytic Agents? Intubated? If Yes, Method

Sedated? Respiration Assisted? If Yes, Type

Eye Obstruction?

Labs

ABGs Drawn

Hematocrit

INR

pH

PaO2

PaCO2

Base Deficit/ Excess

Vitals

SBP/DBP /

Pulse Rate

Unassisted Resp Rate

Assisted Resp Rate

O2 Saturation

Supplemental O2

GCS: Eye

Verbal

Motor

Total

RTS

Triage RTS

PTS Total

PTS

GCS 40

Toxicology

Alcohol Use Indicator

Drug Use Indicators

ETOH/BAC Level mg/dl

Drug Screen | Drug Specify | Clinician Administered

If Other

Custom

DRAFT

DRUG SCREEN

Definition

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

Element Values

1. AMP (Amphetamine)
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

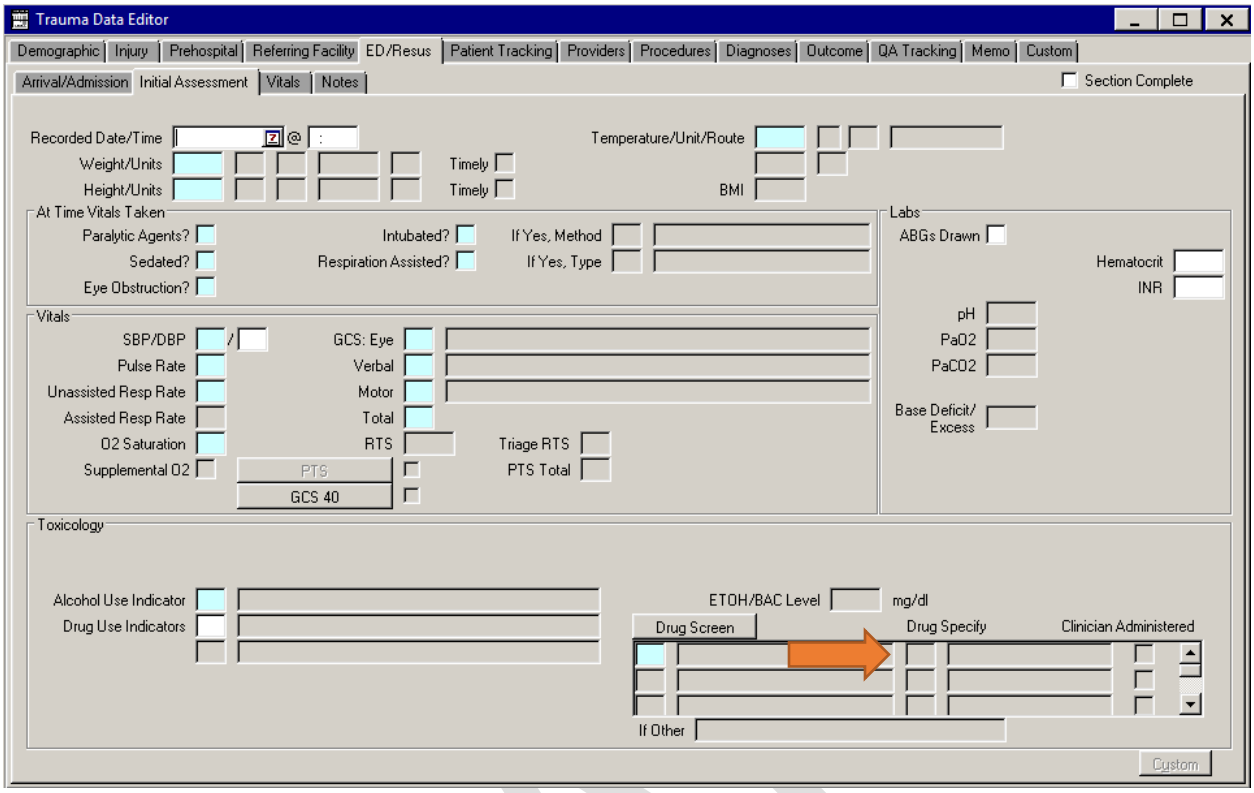
- Report positive drug screen results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- "None" is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

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



ED/Resus Drug Specify

Definition

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

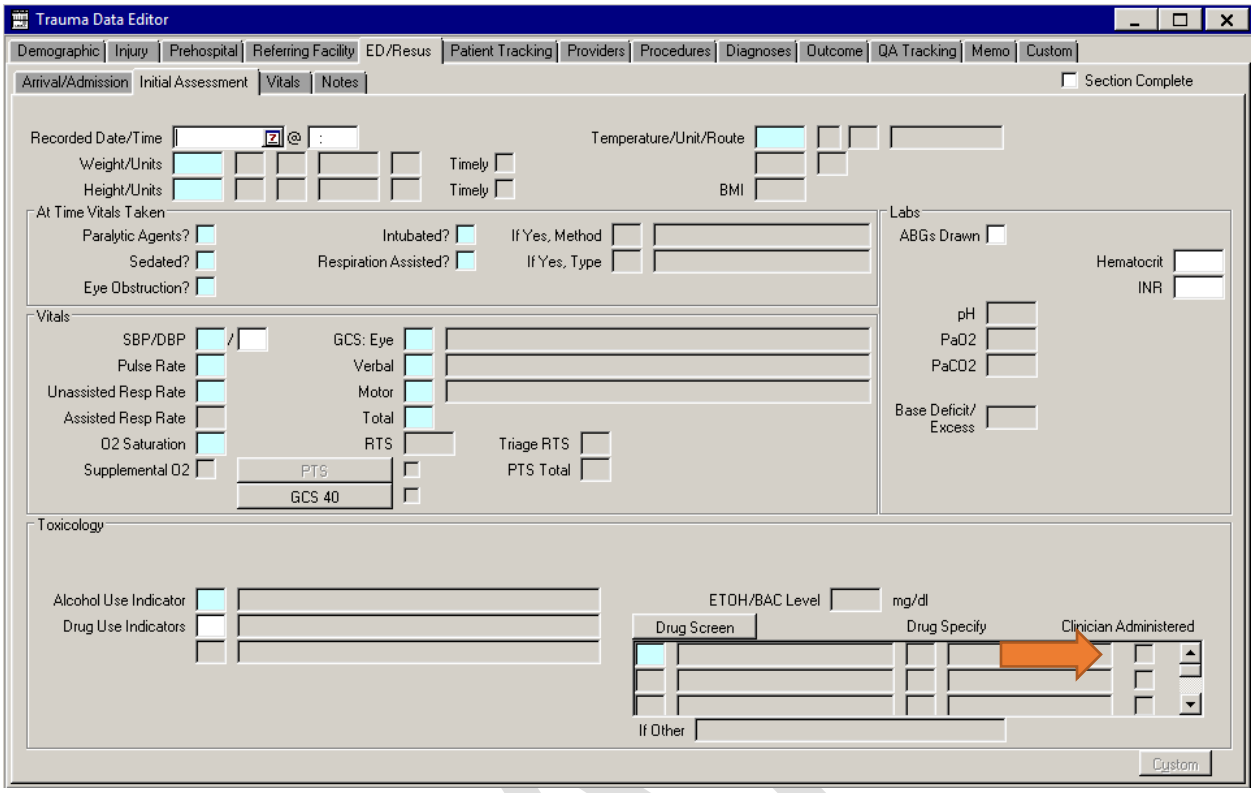
Element Values

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

? Unknown

Data Source Hierarchy Guide

1. 1. Lab Results
2. Transfer Center Records



ED/Resus Clinician Administered

Definition

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

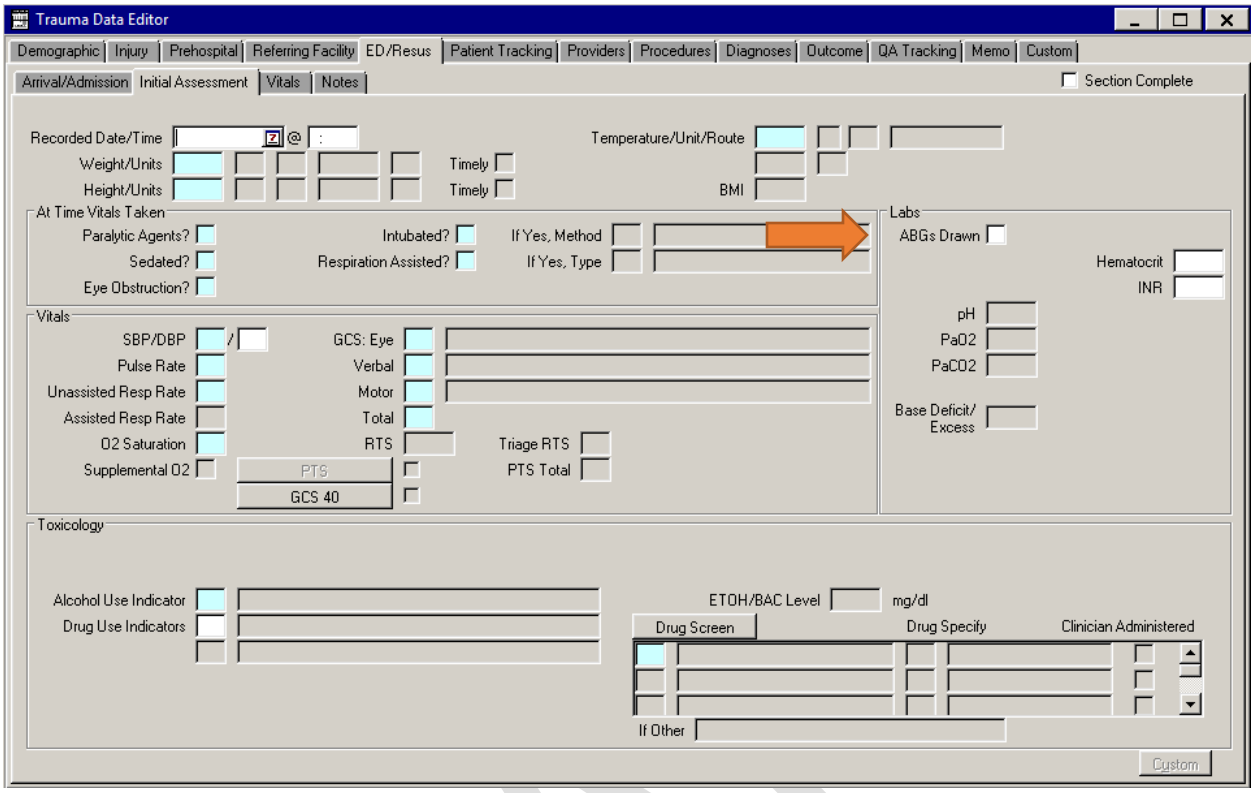
Element Values

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

Data Source Hierarchy Guide

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

DRAFT



ED/Resus ABGs Drawn

Definition

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

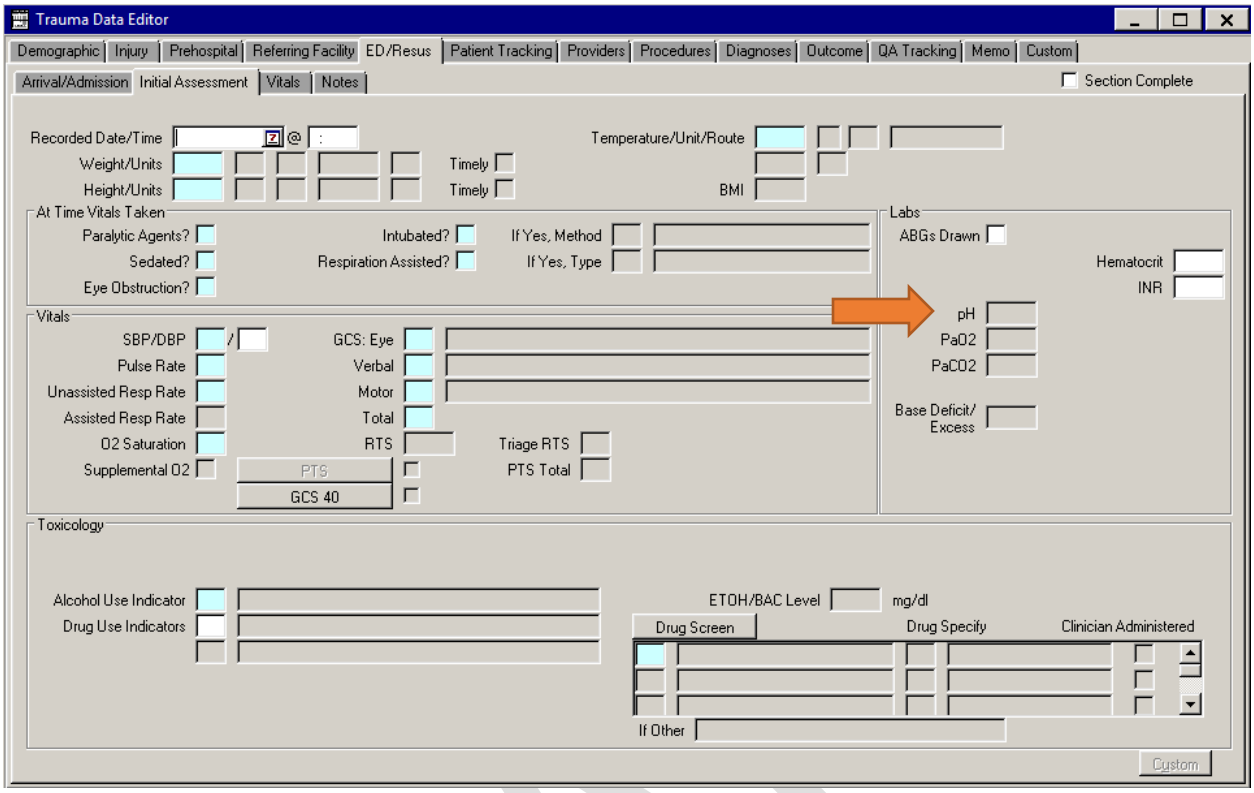
Element Values

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

Data Source Hierarchy Guide

1. Lab Results

DRAFT



ED/Resus pH

Definition

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

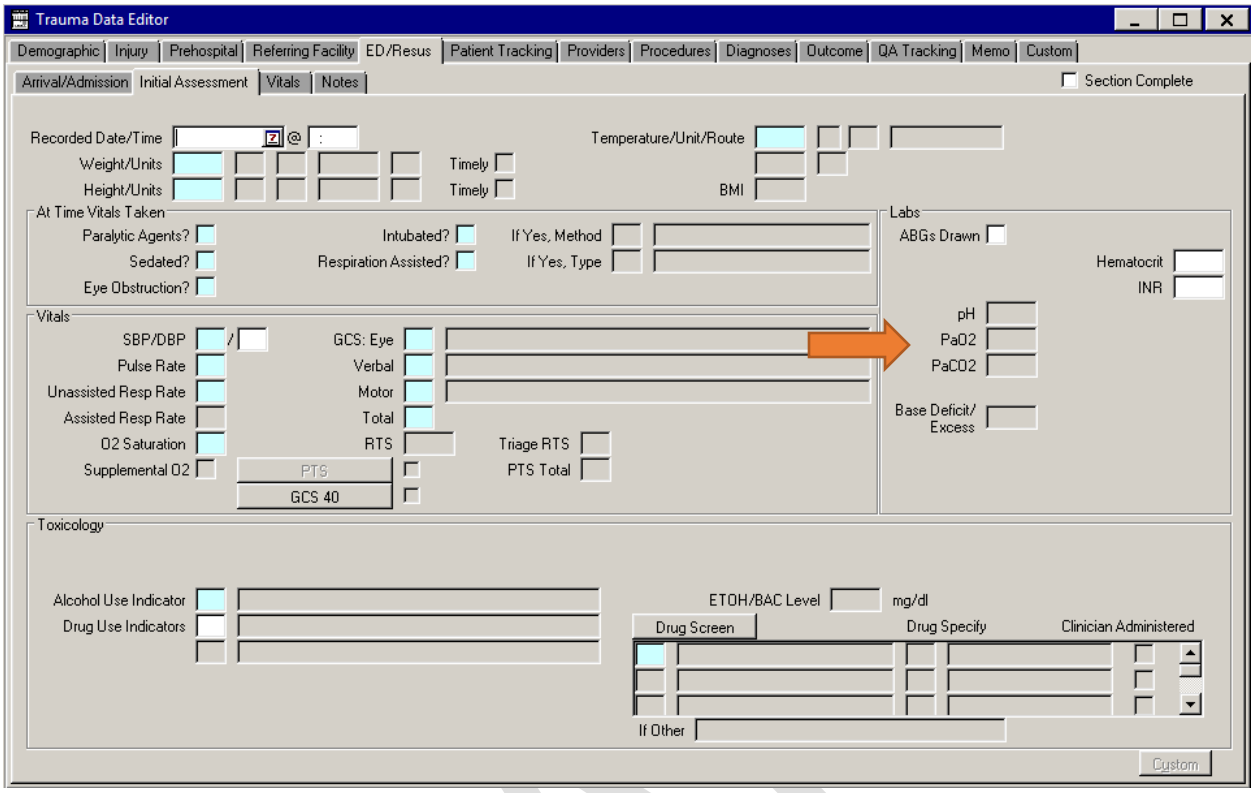
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

DRAFT



ED/Resus PaO2

Definition

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

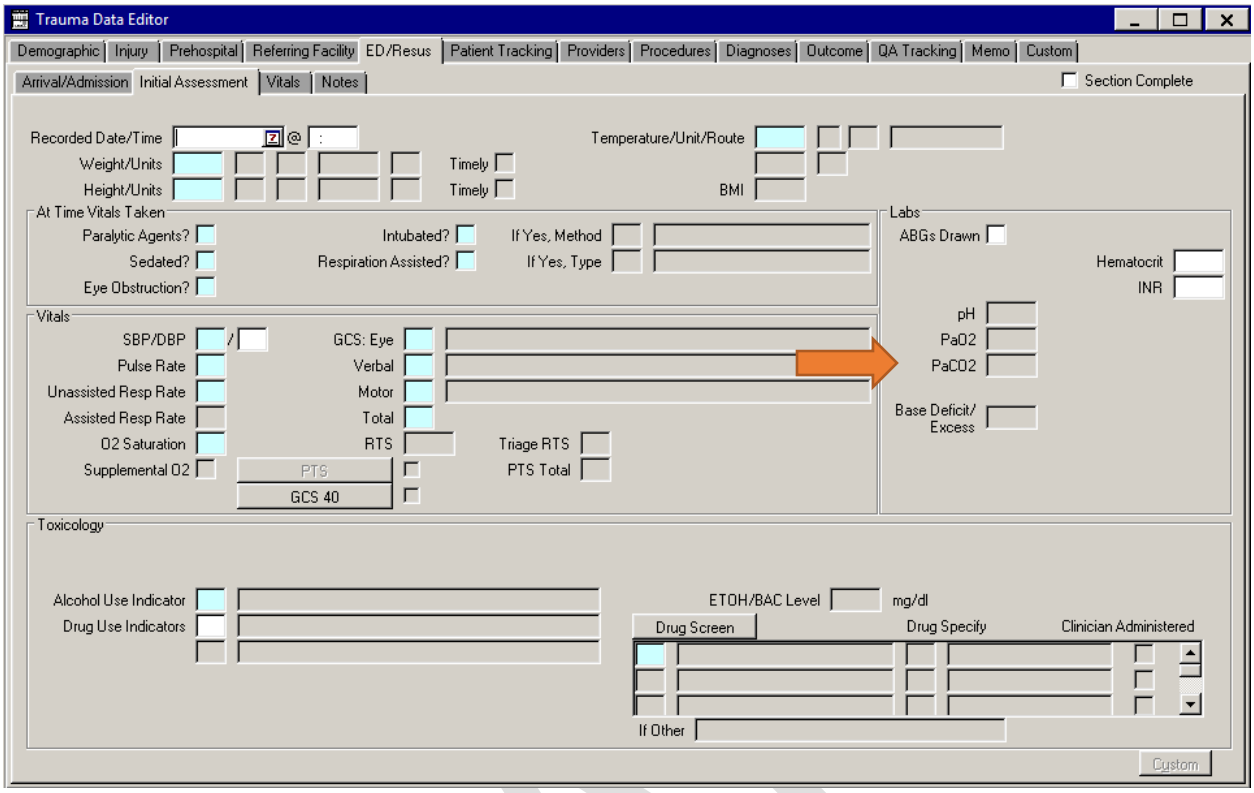
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

DRAFT



ED/Resus PaCO2

Definition

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

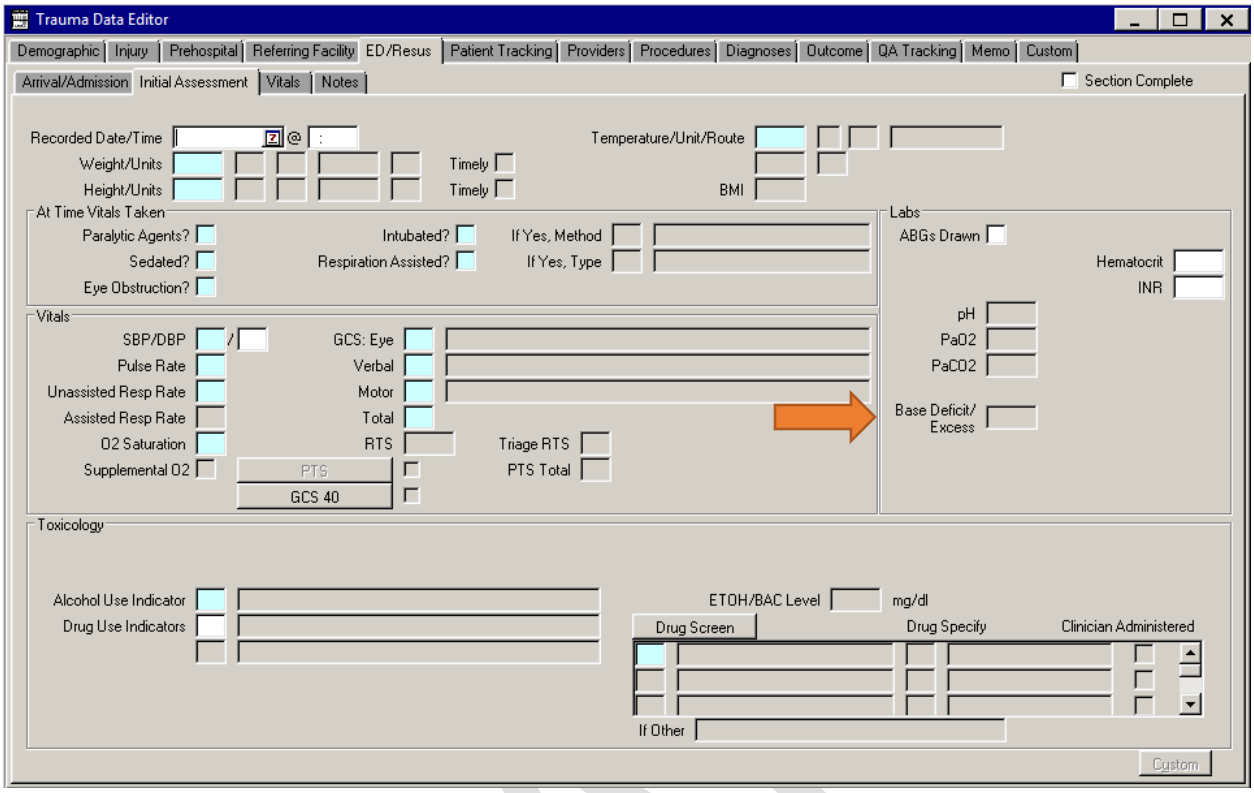
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

DRAFT



ED/Resus Base Deficit / Excess

Definition

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

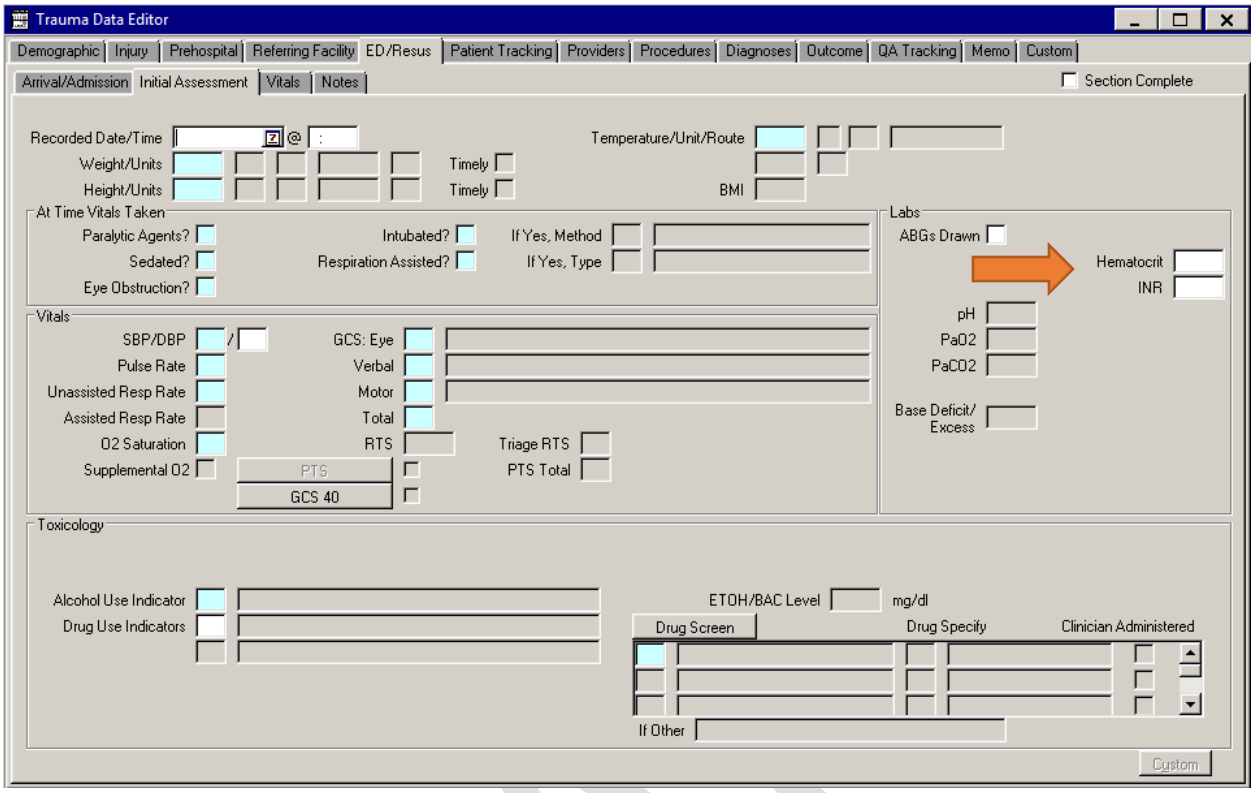
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

DRAFT



ED/Resus Hematocrit

Definition

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

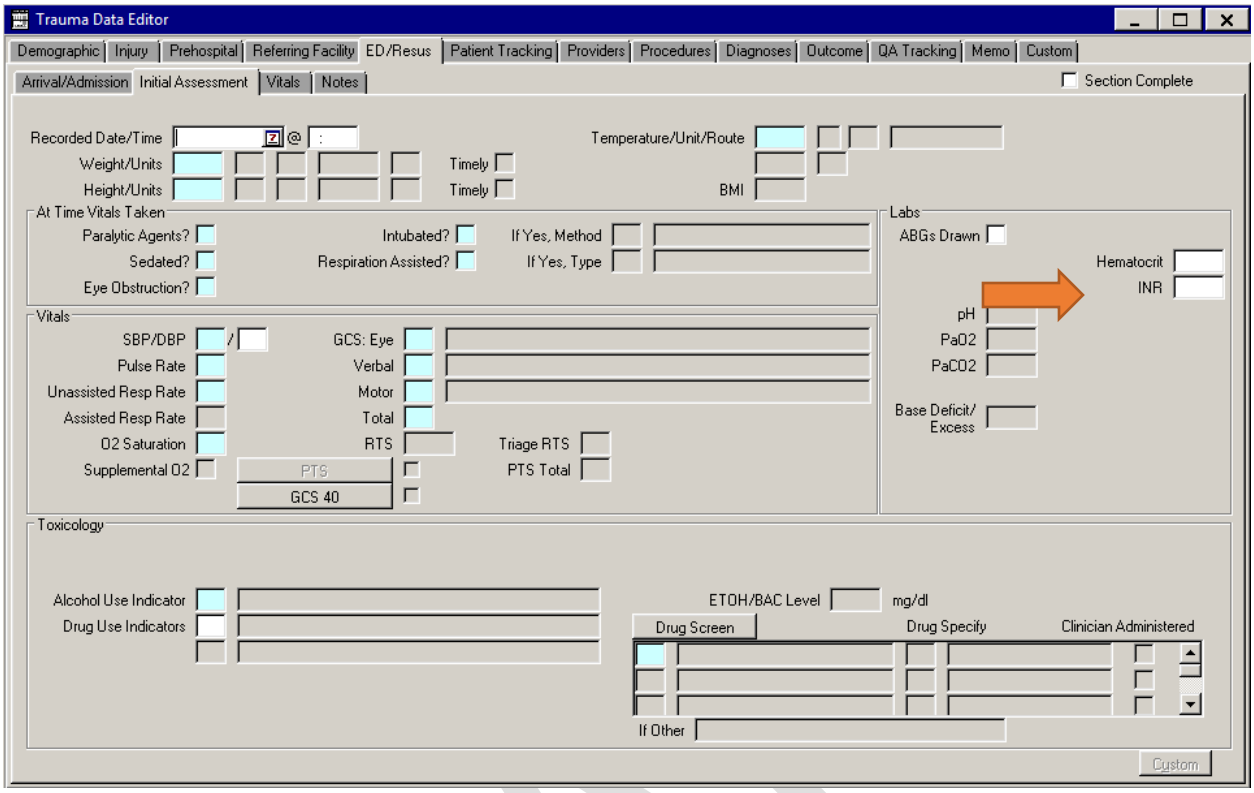
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

DRAFT



ED/Resus INR

Definition

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

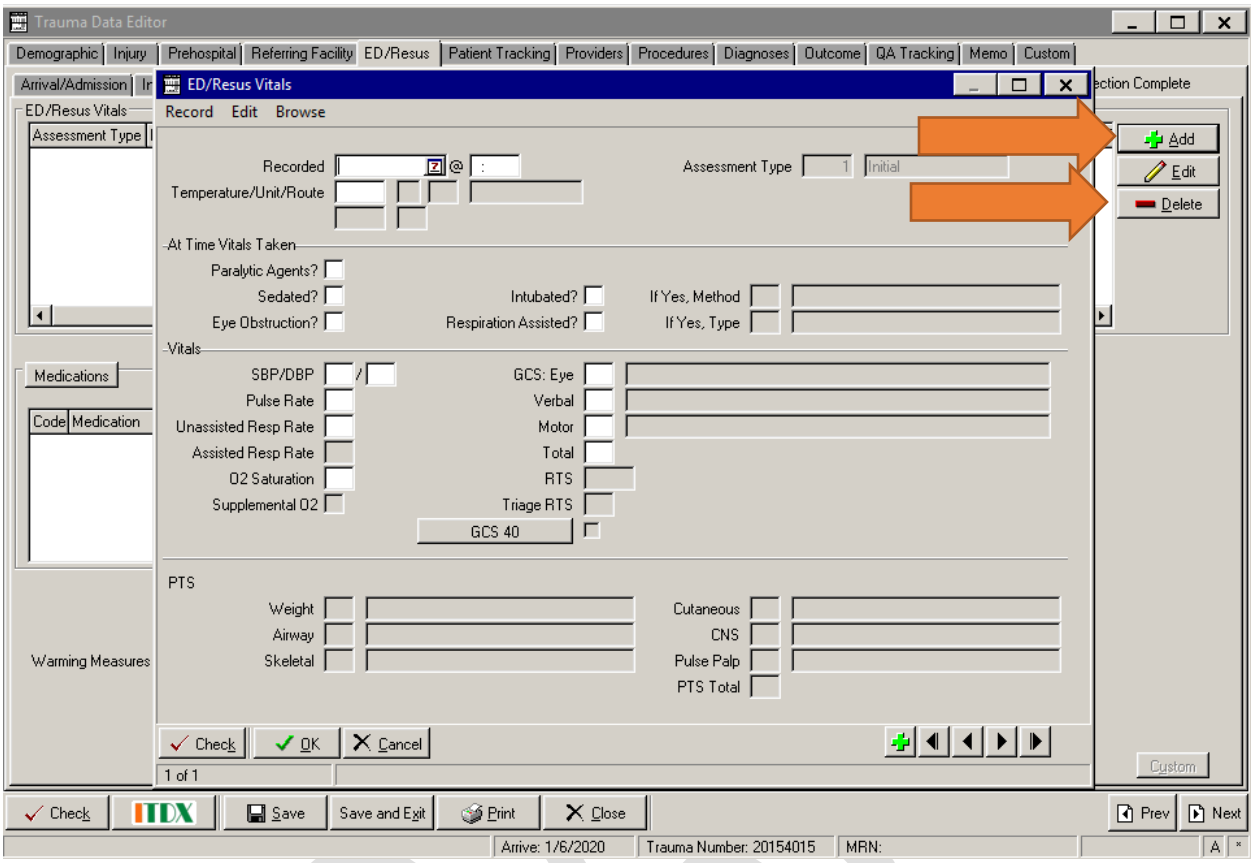
Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab Results

DRAFT



Additional ED/Resus Vitals

Definition

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

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

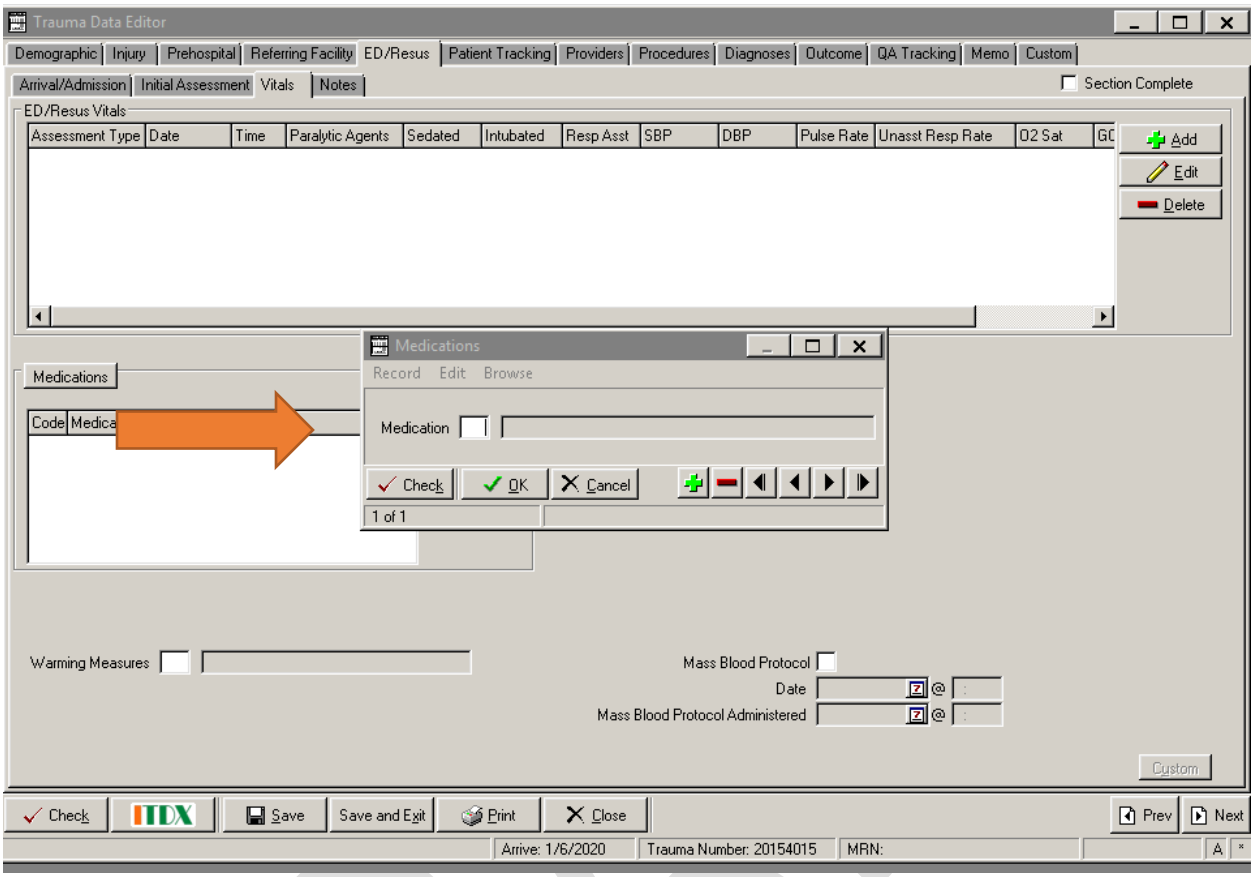
Element Values

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

  NOTE: These vitals do not have to be performed within the first 30 minutes of arrival to the ED/Hospital.
  The American College of Surgeons suggests checking the vitals at least every hour.

Data Source Hierarchy Guide

1. Flowsheets
2. OR Records
3. Progress Notes



ED/Resus Medications

Definition

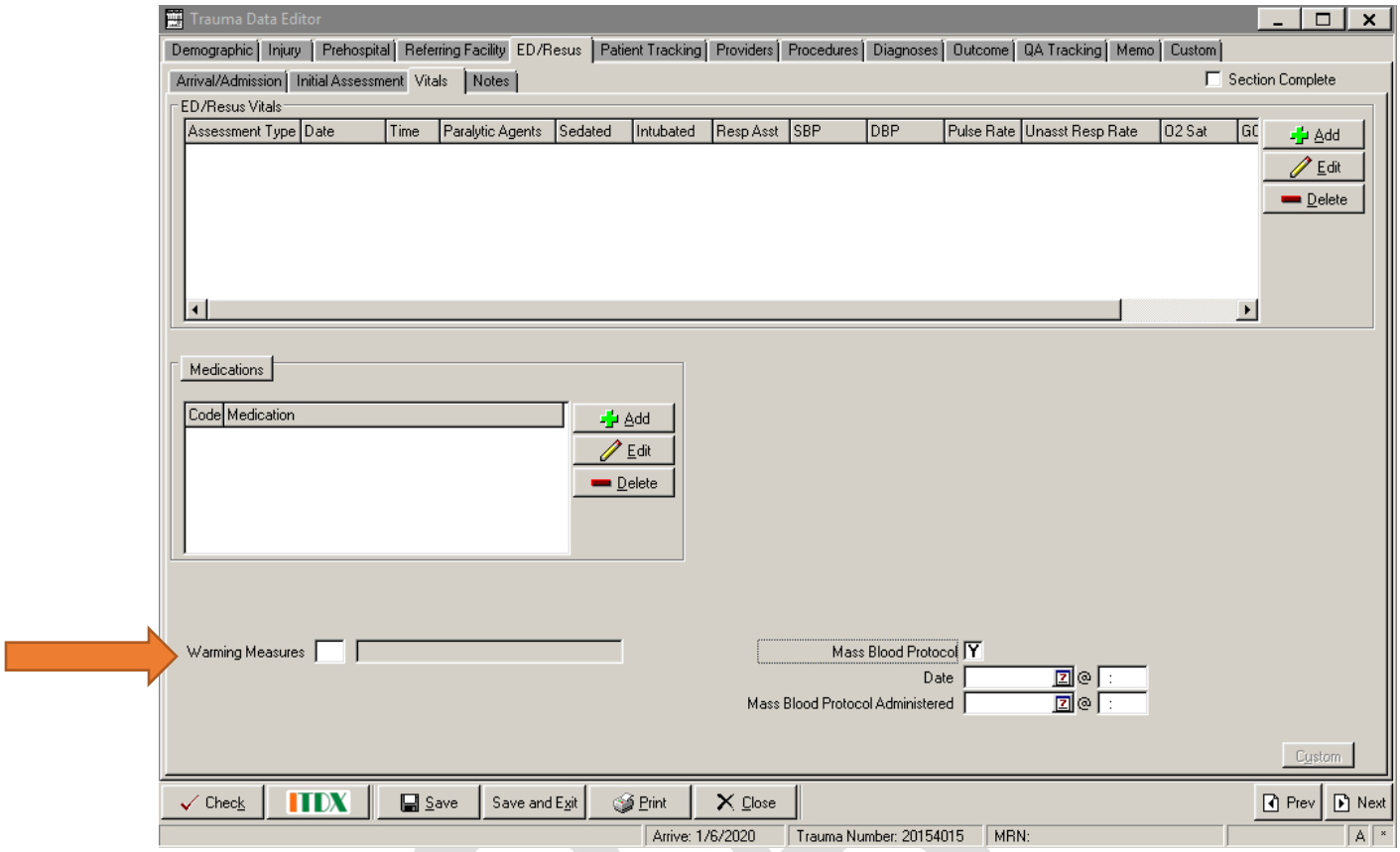
Medications that were given during the initial ED stay or during the resuscitation phase. Note these can all be edited or deleted formally by the box to the right.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

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



ED/Resus Warming Measures

Definition

The presence or absence of warming measures taken to maintain a patient's temperature during the resuscitation phase.

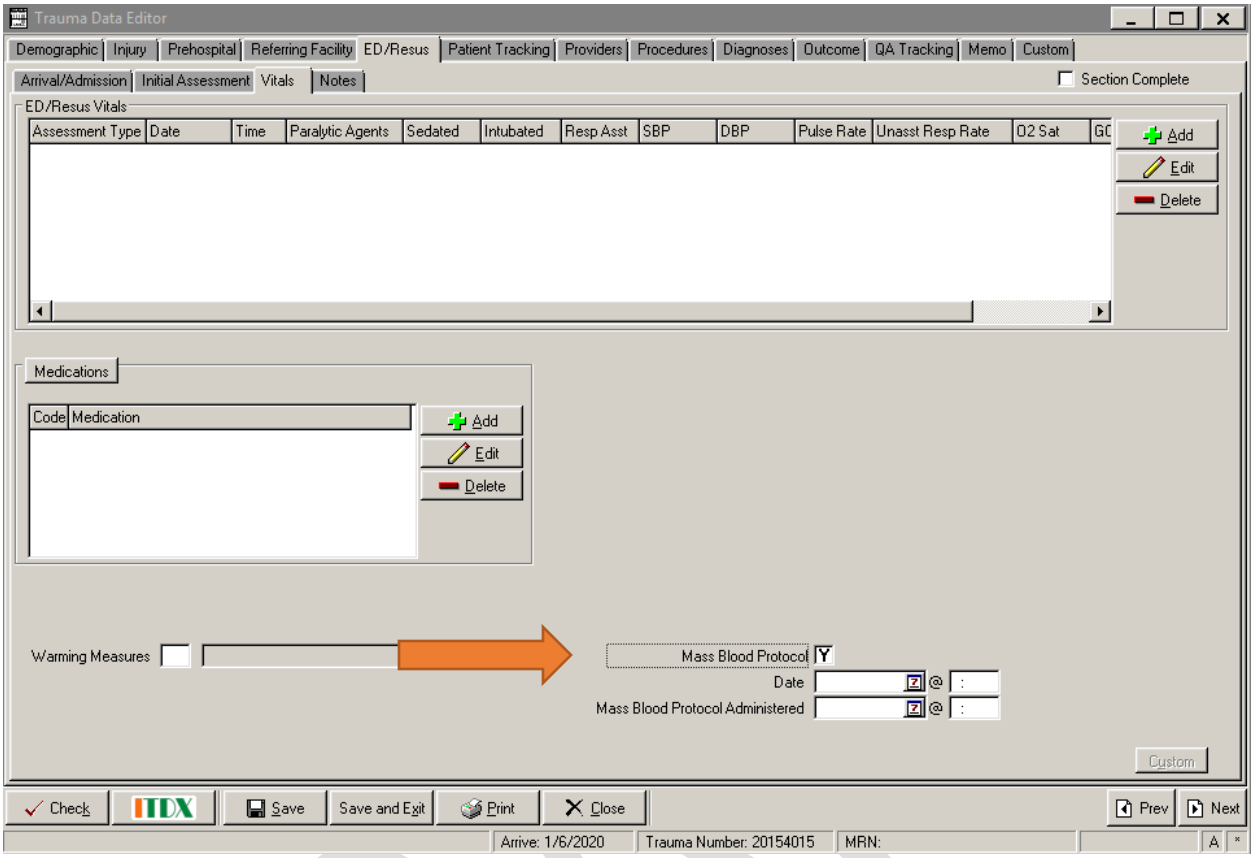
Element Values

0. No Warming Measures
1. Warming Measures Applied

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

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



ED/Resus Mass Blood Protocol

Definition

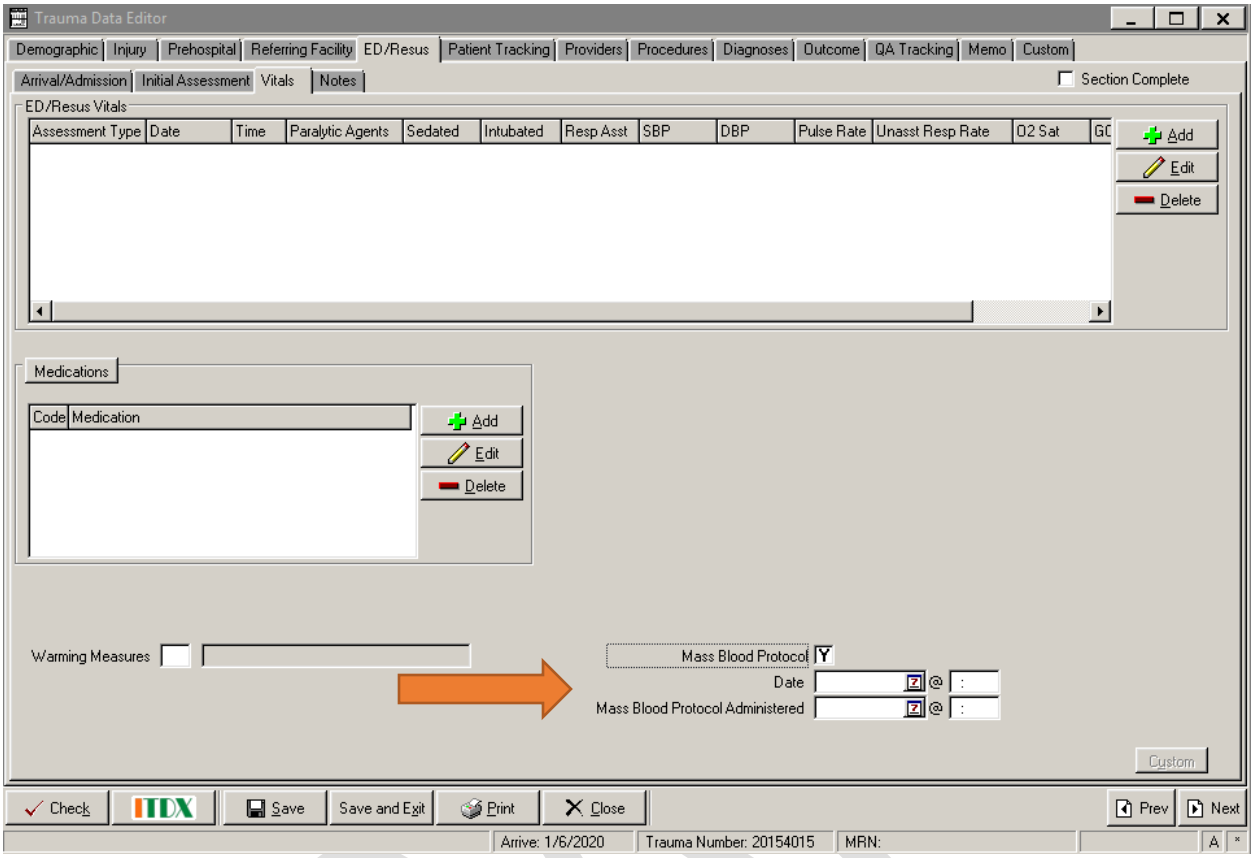
Was a massive blood transfusion protocol activated for the patient?

Element Values

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

Data Source Hierarchy Guide

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes



ED/Resus Mass Blood Protocol Time and Date Ordered

Definition

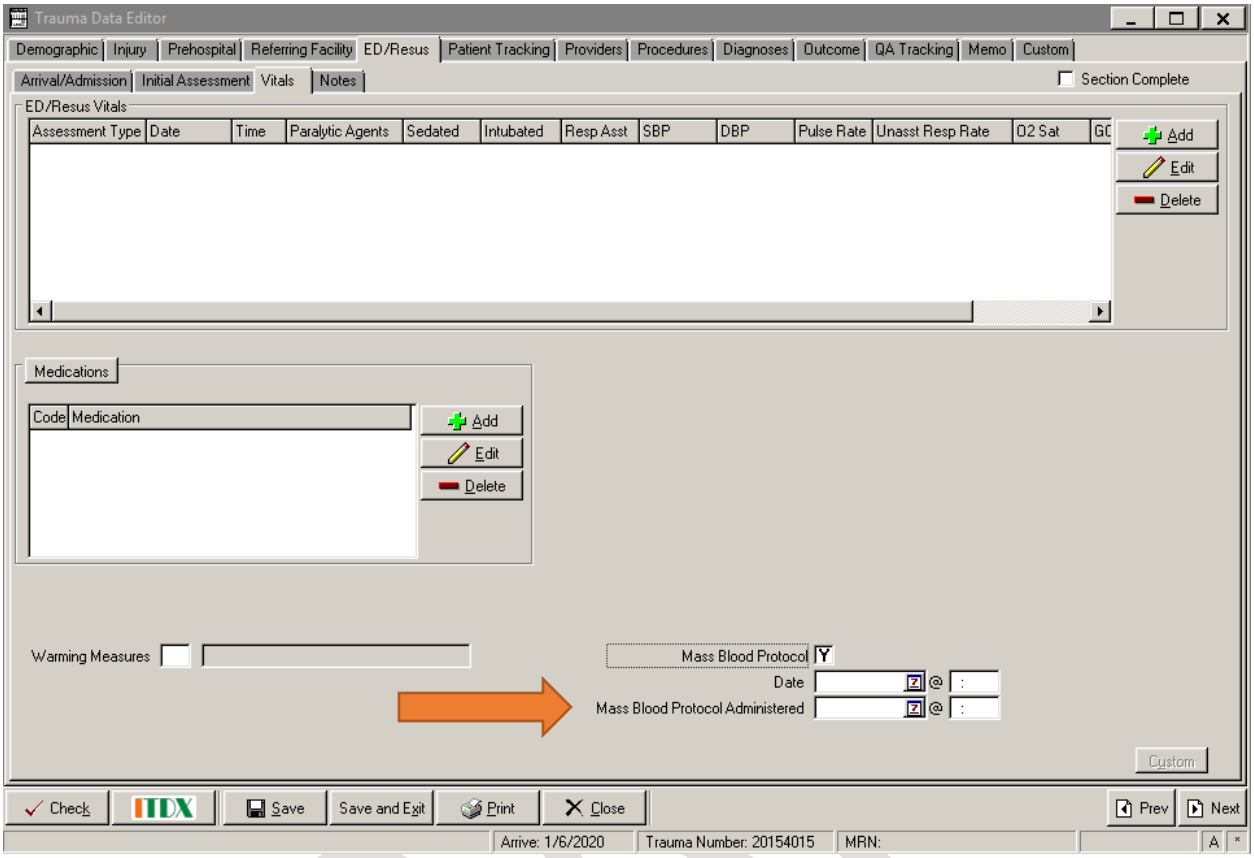
The time and date that the massive transfusion protocol was ordered

Element Values

- Relevant Values for Data Element

Data Source Hierarchy Guide

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes



ED/Resus Mass Blood Protocol Time and Date Ordered

Definition

The date and time that the massive transfusion protocol was initiated.

Element Values

- Relevant Values for Data Element

Data Source Hierarchy Guide

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes

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Location/Service/Blood/Ventilator Tracking

- The elapsed time for each location will auto-populate based on the date and times that are placed. ICU and Step-Down days will automatically calculate based on the location option that you select.
- Service Tracking elapsed time will auto-populate after the date and times are entered for each service.
- Ventilator tracking will calculate the amount of days that the patient is on a ventilator automatically based on the dates and times that are entered.
- IL Consensus to enter blood components as UNITS statewide vs using the other quantity options.

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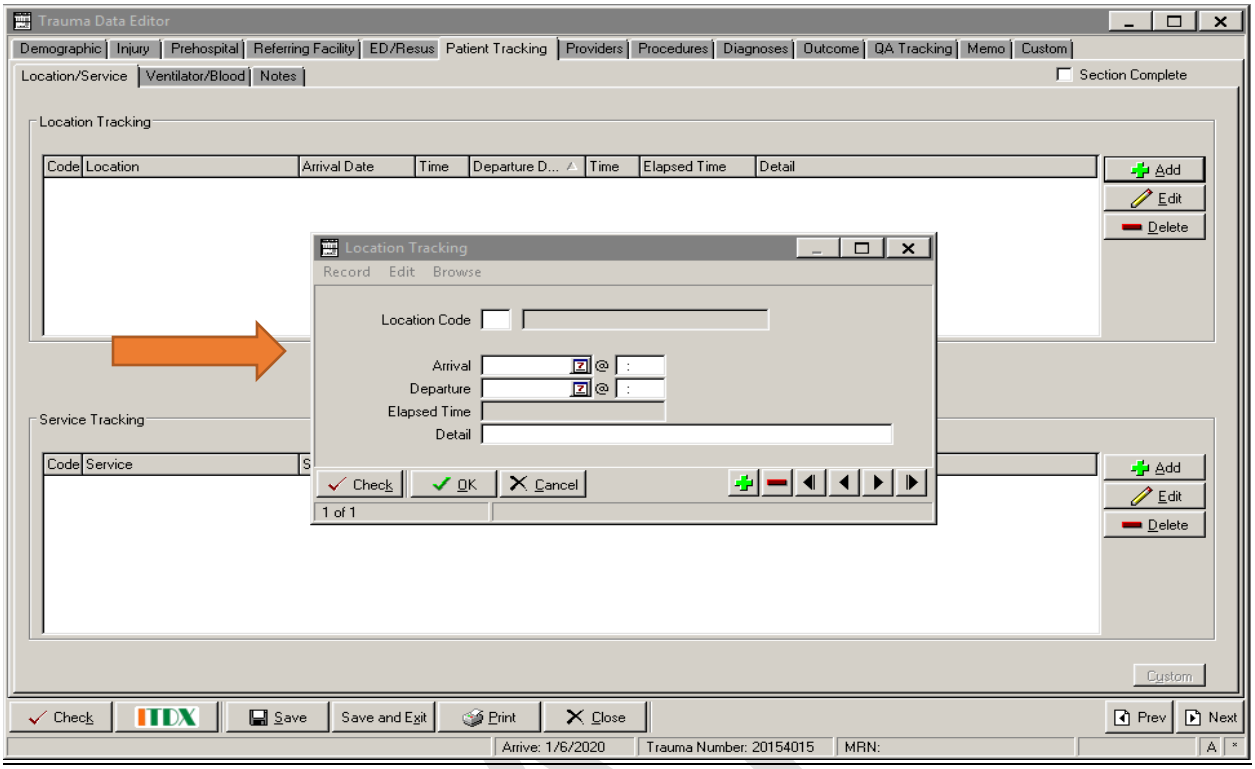


Location Tracking: Location Code

Definition

The different units and procedural areas where the patient was admitted throughout their inpatient hospital stay.

Element Values

1. Resuscitation Room
2. Emergency Department
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit (Adv Care)
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit (FYI: if used for Peds ICU, it will not auto-calculate ICU days)

?. Unknown

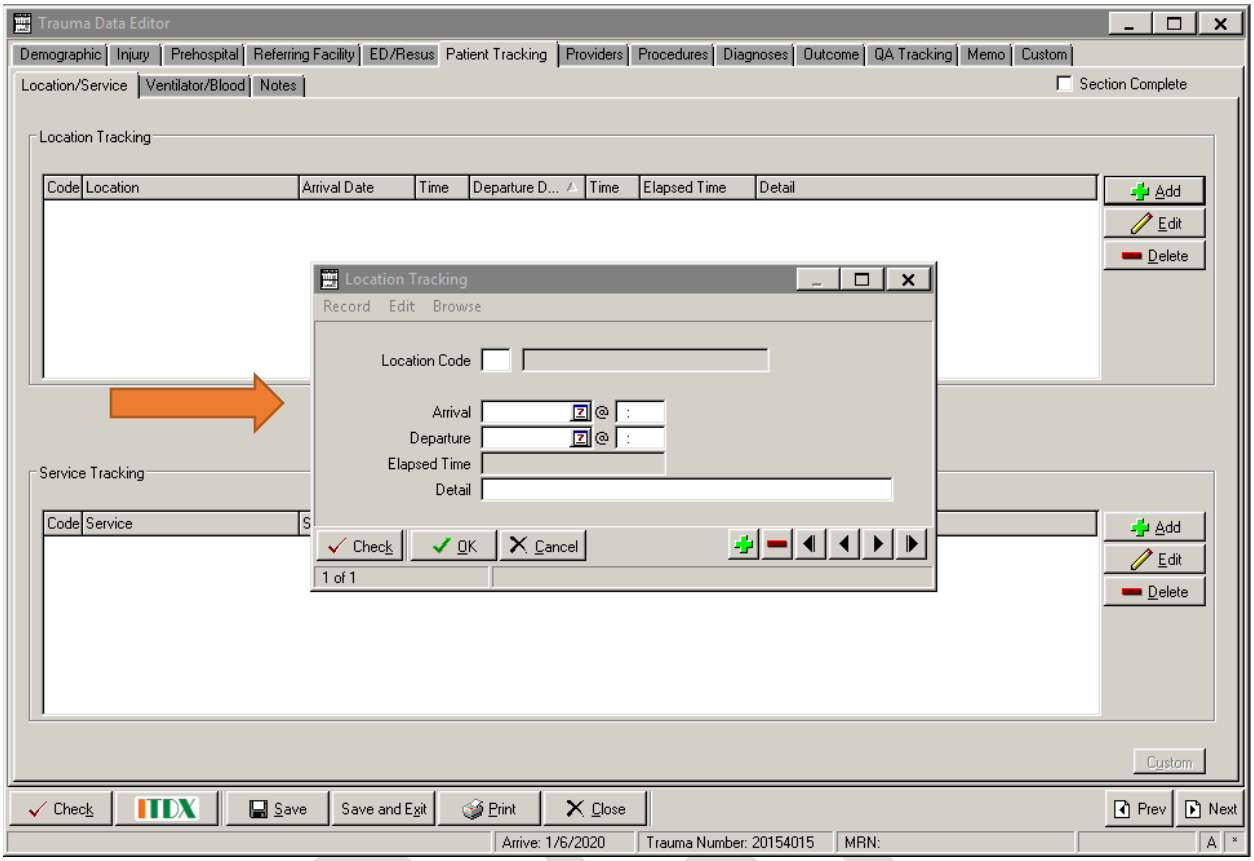
/. Not Applicable

Data Source Hierarchy Guide

1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes

NOTE: Can enter the Peds ICU days as "4 "Intensive Care Unit. Then after entering arrival & departure dates / times and allowing it to auto calculate, return and edit that row entering "14" and the total times will remain.

DRAFT



Location Tracking: Arrival Date and Time

Definition

The date and time that a patient arrived to a particular unit or procedural area.

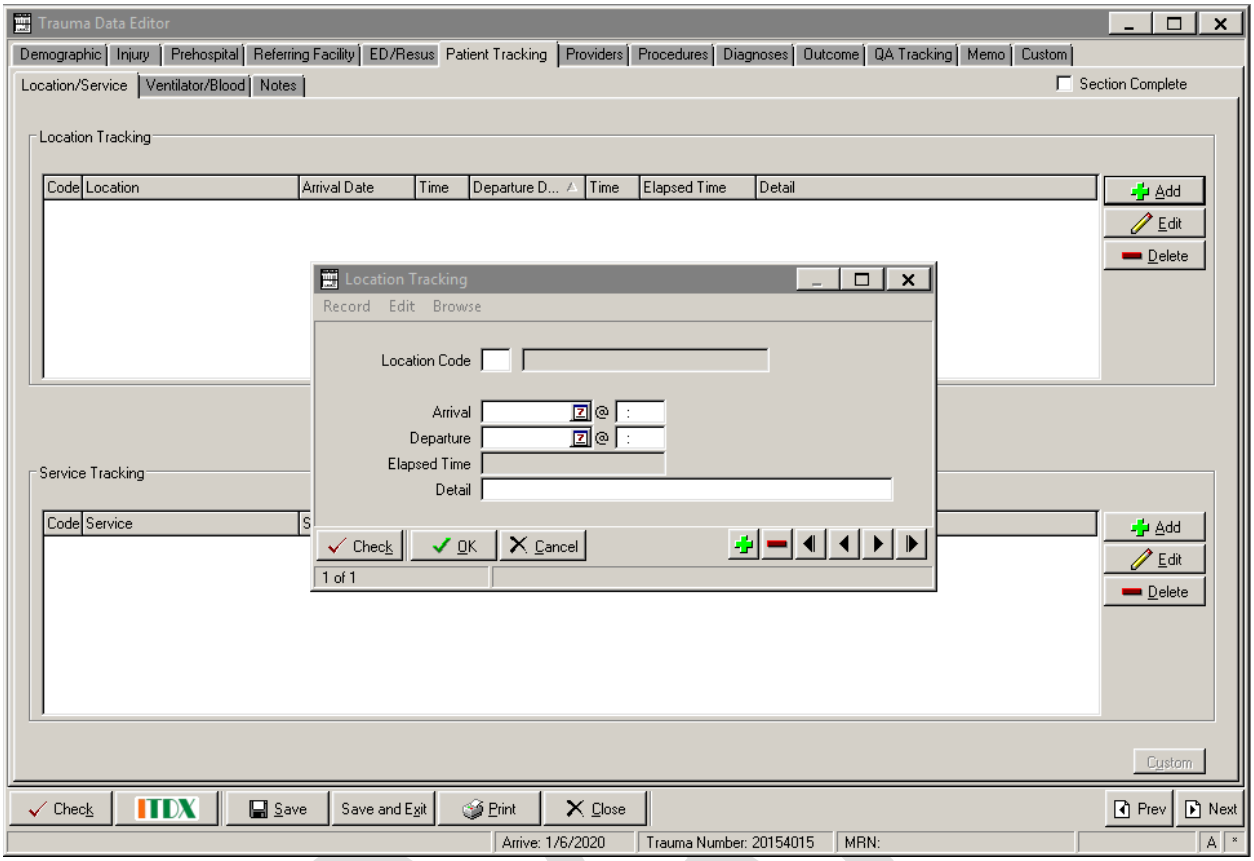
Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes

DRAFT



Location Tracking: Departure Date and Time

Definition

The date and time that a patient departed a particular unit or procedural area.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes

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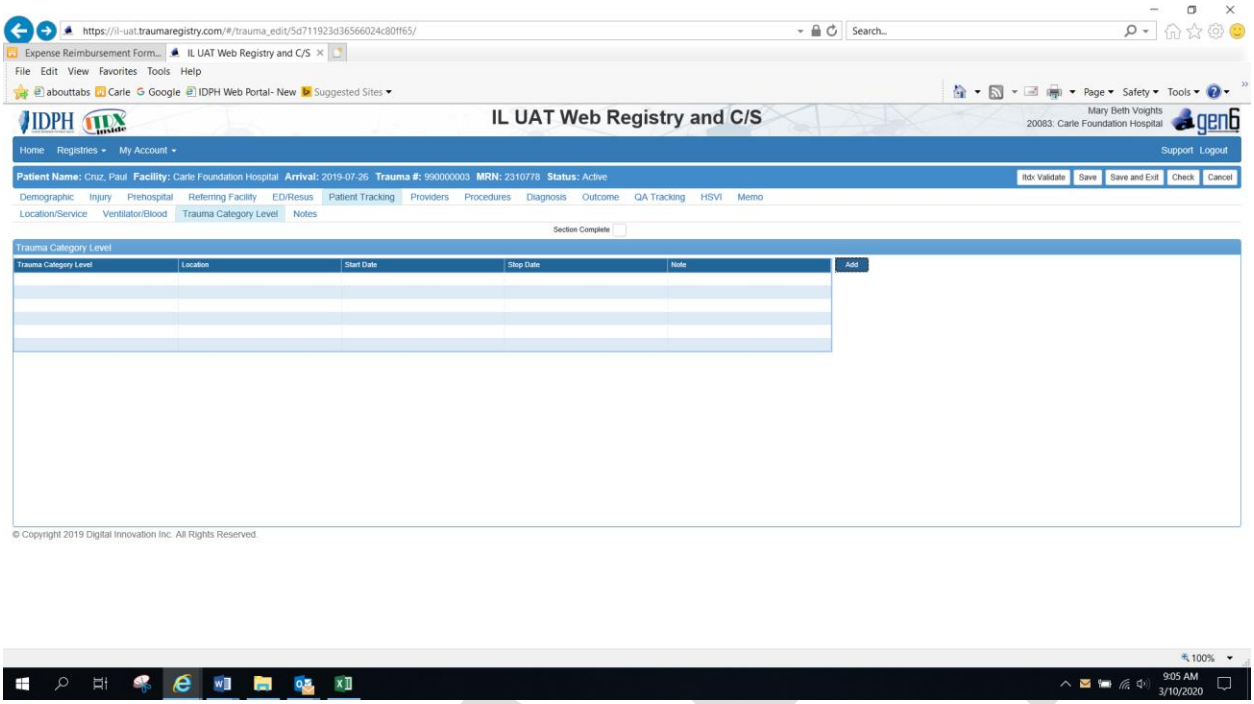

IL Trauma Patient Categorization: Mandatory Illinois Element, if applicable

Definition

The trauma acuity Category assigned to the patient based on the criteria specified in the IL Trauma Rules & Regulations.

Categorization Rules can be found in Section 515, Appendices C and F. (Screen shots follow on next 3 pages)

Patient can meet State Categorization anytime the Criteria is met *prior to or within 10minutes of hospital arrival*. (For example: Prehospital Sustained SBP ≤90 on 2 consecutive measurements at least 5 minutes apart = Category I; ED first 10minutes with confirmed SBP ≤90 = Category I; ICU or OR SBP ≤90 or ED Drop in SBP after evaluation has begun and the 10min clock has passed = sick patient, but no state categorization.)

Element Values for Illinois:

1. Category I
2. Category II

NOTE: Field Element Values in the DI Software are based on CDC Field and IL In-house criteria. Currently use only those IL approved elements from the Rules as highlighted below:

This field is NOT MULTI-SELECT. You will need to ADD a new row for each new element.

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INHOUSE ACTIVATION CRITERIA; TAC Approved 2015 but not yet in RULES

1. Cat I – Amputation Proximal to Wrist or Arm
2. Cat I – Blood infusing to Maintain Vital Signs
3. Cat I – Chest Wall Instability or Deformity (e.g., Flail chest)
4. Cat I – Confirmed SBP <90 in Adults; <80 in Peds (this would be Field Surgeon Activation)
5. Cat I – Crushed, De-gloved, Mangled or Pulseless Extremity
6. Cat I – Emergency Physician Discretion
7. Cat I – GCS ≤ 10
8. Cat I – Inability to Intubate with Anticipation of Surgical Airway
9. Cat I – Open or Depressed Skull Fracture
10. Cat I – Other (Facility Specific Criteria for Full Team Activation)

FIELD ACTIVATION CRITERIA: TAC Approved in 2012 but not yet in RULES

11. Cat I – Paralysis proximal to the Wrist or Ankle
12. Cat I – Pelvis Fractures (Unstable)
13. Cat I – Penetrating Injuries Excluding Distal Extremities (Head, Neck, Torso, Groin)
14. Cat I – Respiratory Rate <10 or >29 or requiring ventilator support
15. Cat I – Systolic BP <90mmHg (<80mmHg in Peds)
16. Cat I – Two or more Proximal Long Bone Fractures
17. Cat 2 – Auto Crash Death in Same Passenger Compartment
18. Cat 2 – Auto Crash Ejection
19. Cat 2 - Auto Crash Intrusion >18in (>12in for Occupant Site)
20. Cat 2 – Auto Crash Telemetry Data Indication
21. Cat 2 – Auto vs Cyclist Thrown, Run Over or >20mph Impact
22. Cat 2 – Auto vs Pedestrian Thrown, Run Over or >20mph Impact
23. Cat 2 – Fall; Adults >20ft (One Story = 10ft)
24. Cat 2 – Fall Children >10ft or 2-3 Times Height of Child
25. Cat 2 – GCS 11-13 with Mechanism Attributed to Trauma
26. Cat 2 – Motorcycle crash >20mph (also recreational vehicles)
27. Cat 2 – Other (Facility Specific Criteria for Partial Team Activation)

MISSING FROM DI ELEMENT CHOICES BUT APPROVED IN IDPH SET

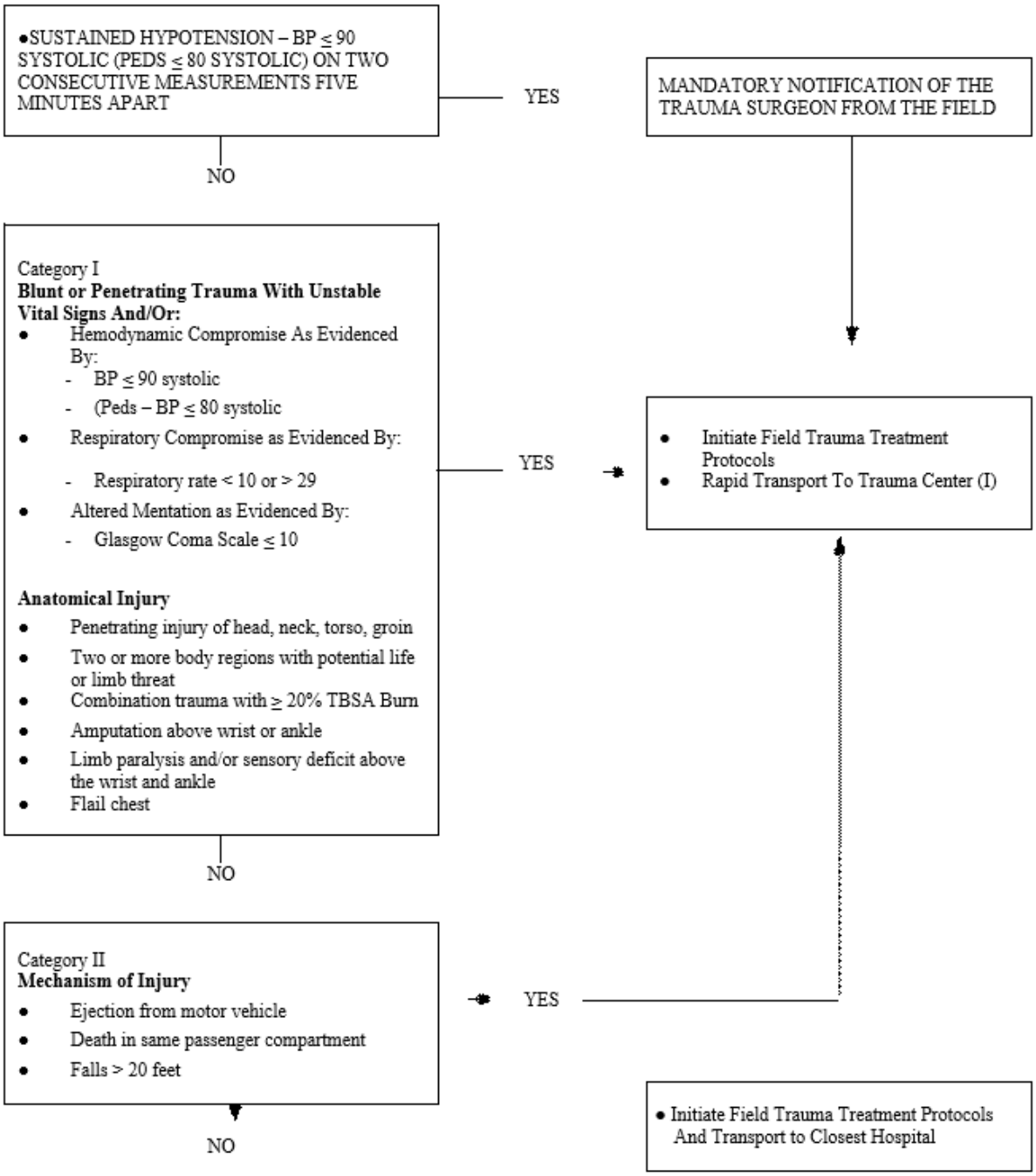
XX Cat I – Combination Trauma with ≥ 20% TBSA Burns
XX Cat I – Two or more body regions with potential life or limb threat
XX Cat I - SUSTAINED Hypotension- BP ≤90 Systolic (Peds ≤80 Systolic) on 2 consecutive measurements 5min apart (USING Element #4 "Confirmed SBP <90…)

Data Source Hierarchy Guide

1. Trauma Flowsheet / Navigator
2. EMS Run Sheet
3. EMS Radio Report Sheet
4. Nursing Notes
5. Progress Notes

DRAFT

Section 515.APPENDIX C Minimum Trauma Field Triage Criteria



Section 515.APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

a) Patient Evaluation

1) Any EMS System transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center if less than 25 minutes from the trauma center; otherwise, follow Section 515.Appendix C. Mandatory field notification of a trauma surgeon will occur in cases of:

A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 80 Hg for a pediatric patient on two consecutive measures five minutes apart); or

B) Cavity penetration of the torso or neck.

2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED's attending emergency physician or designee immediately upon arrival. (Section 515.2060(a))

3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515.2060(b))

4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.

5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.

6) Once the patient has been assigned a Category I or II status that patient cannot be downgraded until the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) Category I

The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician's discretion.

Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery and cardiovascular surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery or cardiovascular surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and shall be completed within two hours. An isolated injury refers to transfer of energy to a single anatomic body region with no potential for multisystem involvement.

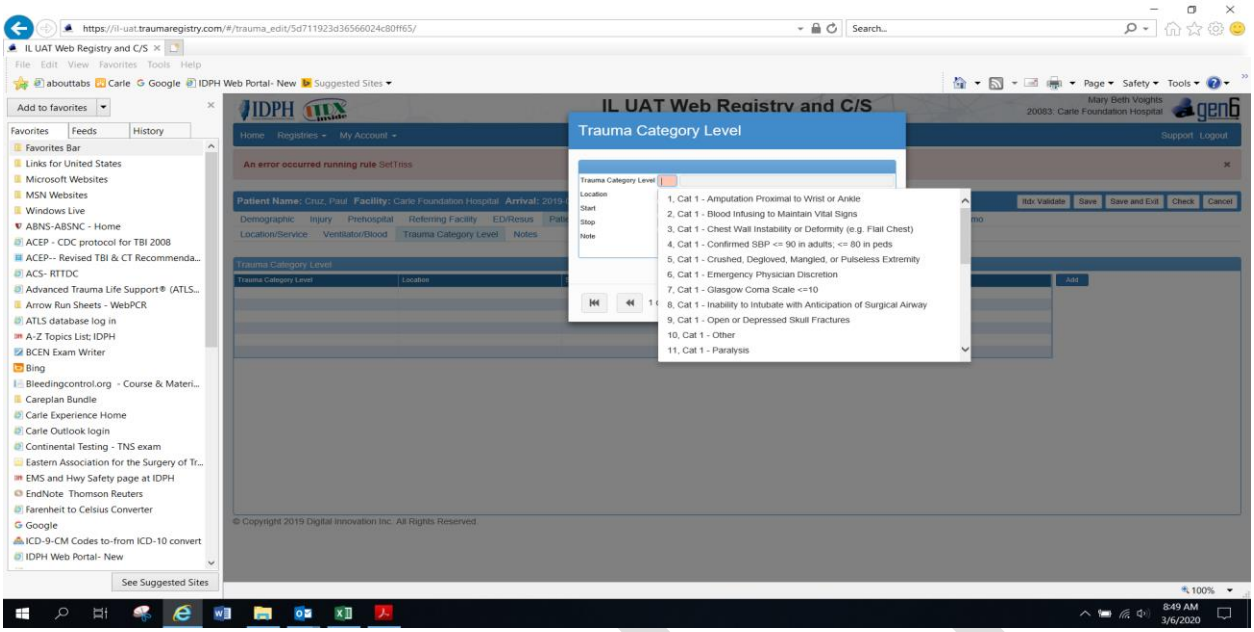
c) Category II
Any other patient who is admitted for traumatic injury requires notification/consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level I) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515.Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515.Appendix C).

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)



Definition

The actual trauma acuity Category criteria met by the patient as specified in the IL Trauma Rules & Regulations.

NOTE: Categorization Rules can be found in Section 515, Appendices C and F. (Screen shots on prior 3 pages).
Patient can meet State Categorization anytime the Criteria is met prior to or within 10minutes of hospital arrival.

Element Values

CATEGORY I

1. Sustained SBP ≤ 90 (≤80 Peds)
2. RR <10 or >29
3. GCS ≤ 10

CATEGORY II

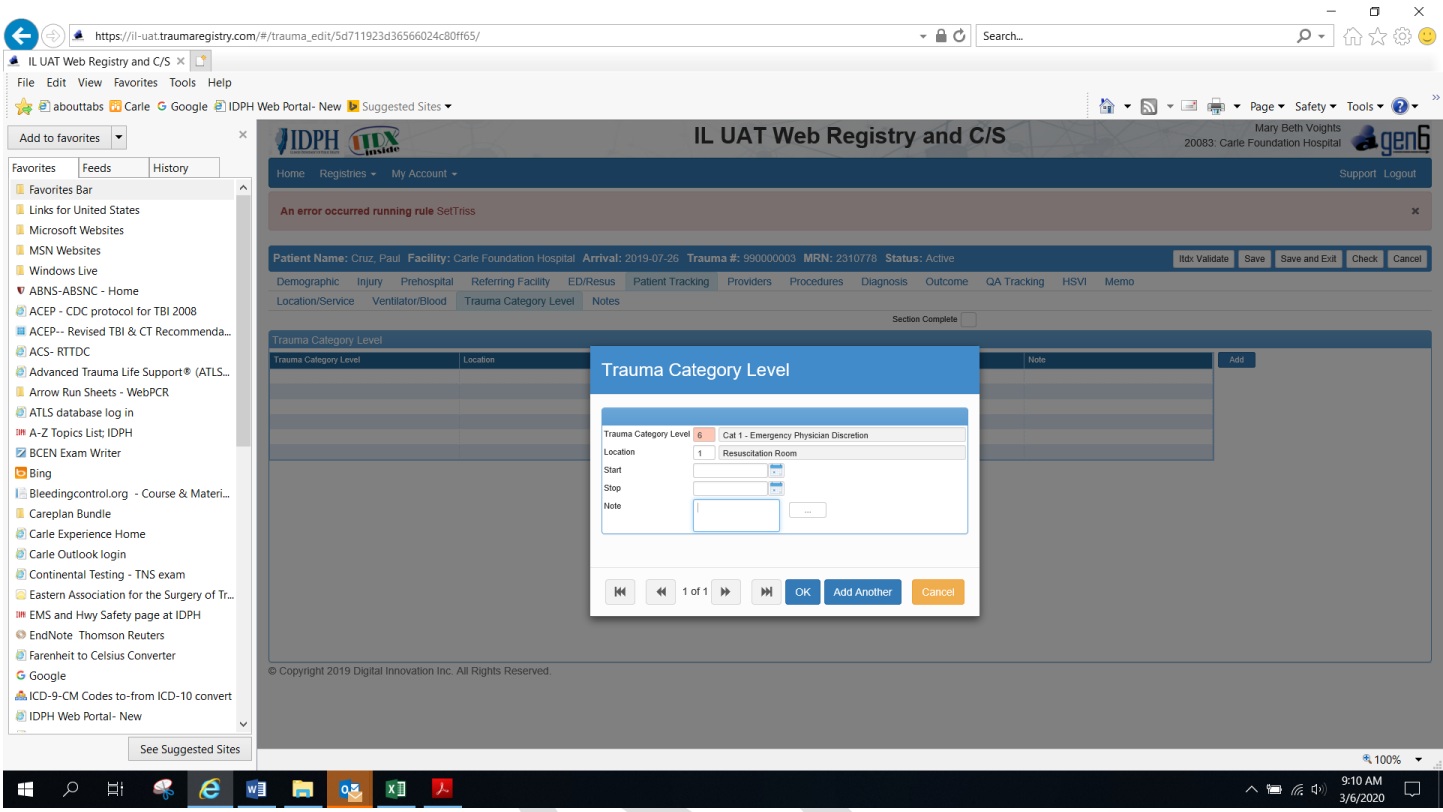
4. Penetrating head, torso, groin
5. 2 or more body regions life/limb threat
6. Combo trauma / Burns ≥20% TBSA
7. Amputation above wrist or ankle
8. Limb deficit above wrist or ankle
9. Flail chest

1. Motor vehicle ejection
2. Death same compartment
3. Falls >20ft

Data Source Hierarchy Guide

1. Trauma Flowsheet / Navigator
2. EMS Run Sheet
3. EMS Radio Report Sheet
4. Nursing Notes
5. Progress Notes

DRAFT



Location Tracking: Trauma Category Location

Definition

The location of the patient when IDPH Trauma Patient Categorization Criteria was/were identified.

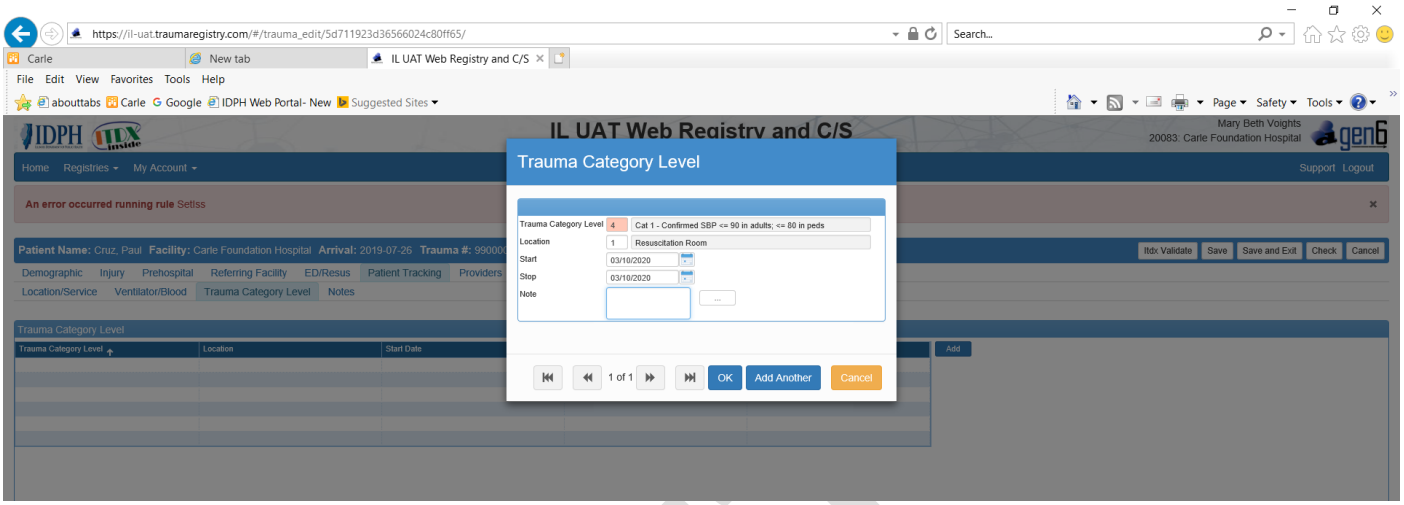
NOTE: Prehospital is not an option in the DI List for this element. Please enter the patient's first location at your facility if the categorization criteria were met in the Prehospital setting. (DI has been asked to build a TIME element which will allow IDPH to capture those PreHospital categorizations by running a report with categorization time preceding arrival time.)

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes



Location Tracking: Trauma Category Time / Date

Definition

The date when IDPH Trauma Patient Categorization Criteria was/were identified.

Stop Date can be entered as NA (/).

NOTE: There is no need to identify or track a STOP time for this element.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes

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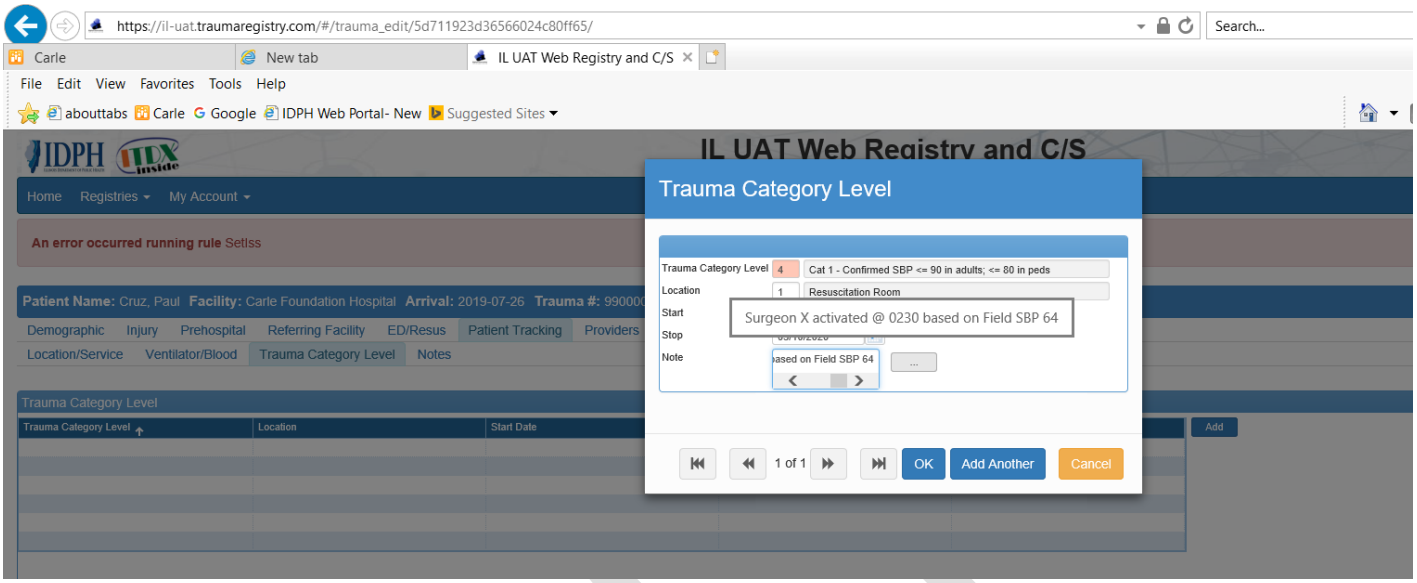

Location Tracking: Trauma Category Notes

Definition

Free text opportunity to add notes pertinent to the IDPH Trauma Patient Categorization process.

Examples

- Specifying time that activation occurred and/or why.
- Specifying the Facility-specific criteria utilized if not present in the approved / highlighted lists.
- Specifying Prehospital as the location of criteria being met since not a dropdown item

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide:

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes

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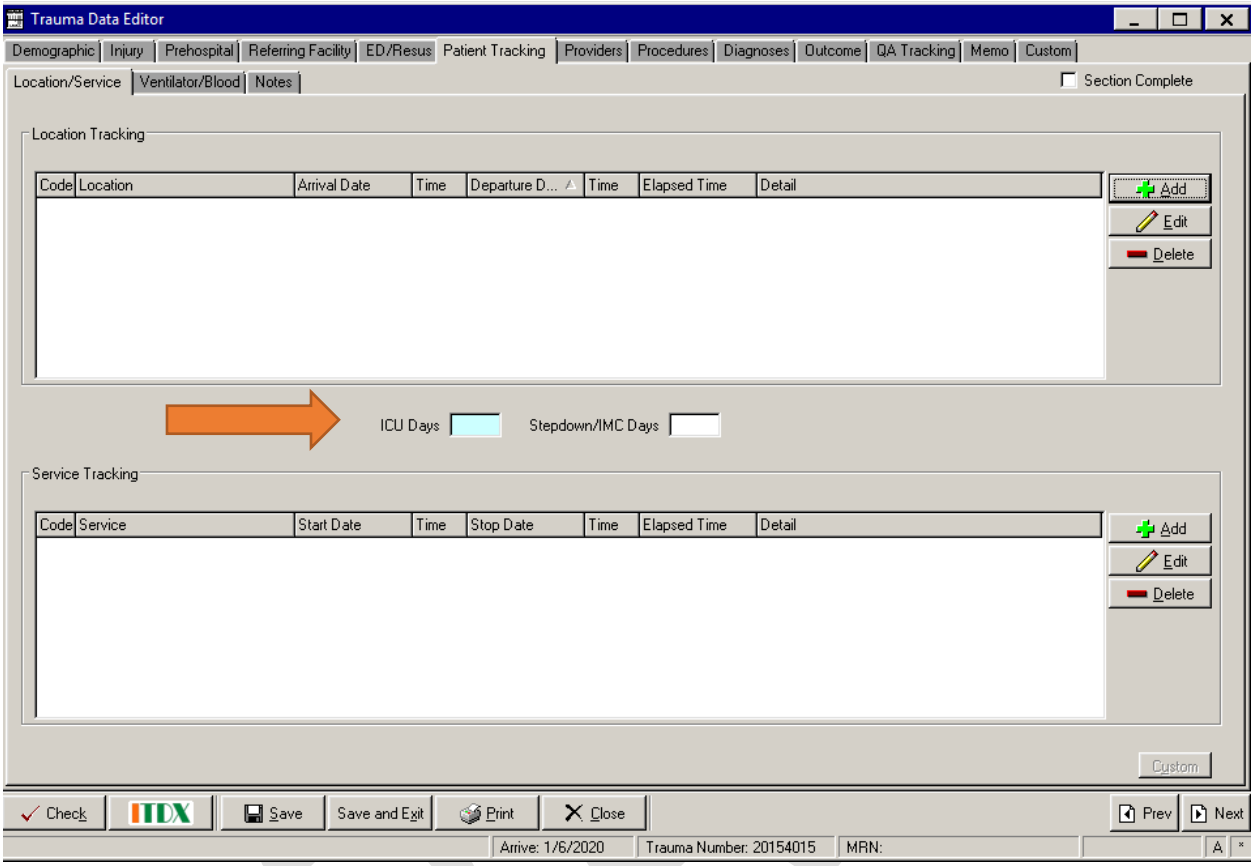


ICU Days – See next page for NTDS definitions. **MANDATORY BLUE FIELD: NTDS Definition rules.**

NOTE: ICU days will auto-populate based on location tracking
Use of location #14, Neonatal / Pediatric Care Unit, will not auto-populate ICU days. You CAN however, enter ICU location # 4 initially for the software to calculate the days and then switch location to #14 Neonatal / Pediatric Care Unit and the calculated days will remain in the reporting blue field.
Stepdown/IMC Days – These will also auto-populate based on location tracking.

TOTAL ICU LENGTH OF STAY

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

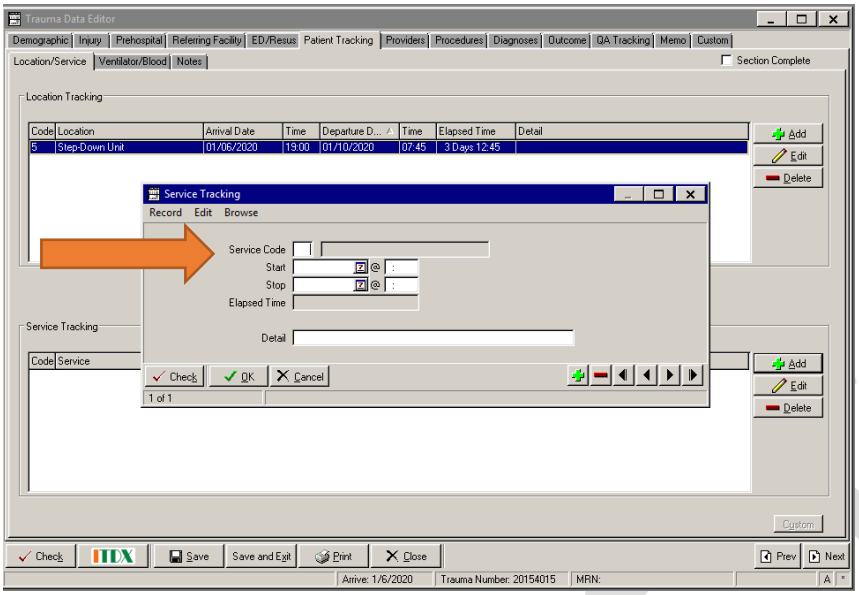
Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was in ICU on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in ICU on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

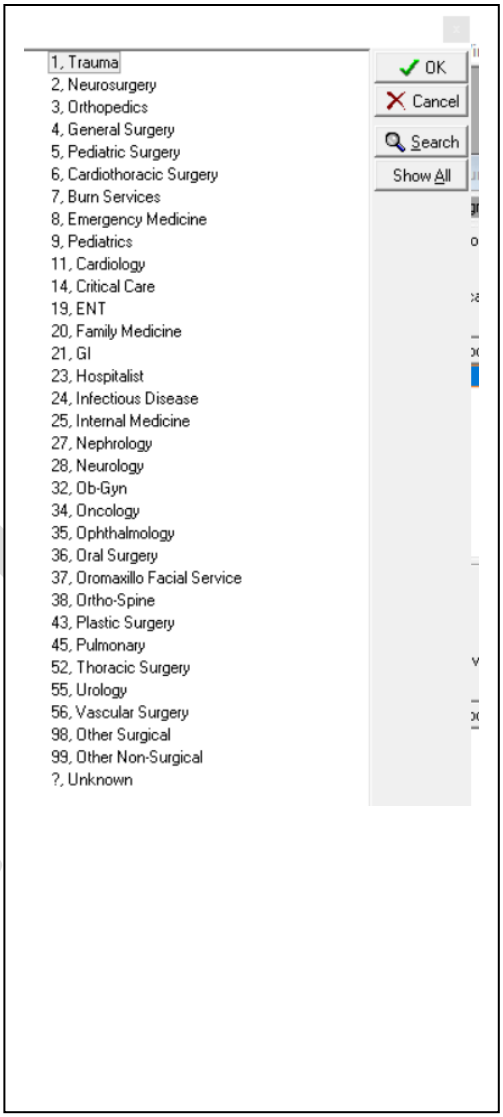
Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7501	1	Invalid value
7502	2	Element cannot be blank
7503	2	Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7504	3	The value is above 60
7505	2	The value submitted falls outside the valid range of 1-575
7540	1	Single Entry Max exceeded





Service Tracking: Service Code

Definition

The physician specialty service(s) caring for the patient. Up to 8 services can be added. **NOTE:** Enter the Primary Service first if you enter multiples.

Useful to track service handoffs / assumption of care (such as Trauma Service handing isolated injury case to Orthopedics, who added Hospitalists, etc.).

Facility can determine if tracking only Primary Service, specific Service Lines, or every service involved with the patient.

Element Values

- Relevant values for Data Element (Specialty Provider Groups)

Data Source Hierarchy Guide

1. History and Physical
2. Consult Notes
3. Progress Notes
4. Treatment Team entries if doing concurrent abstraction

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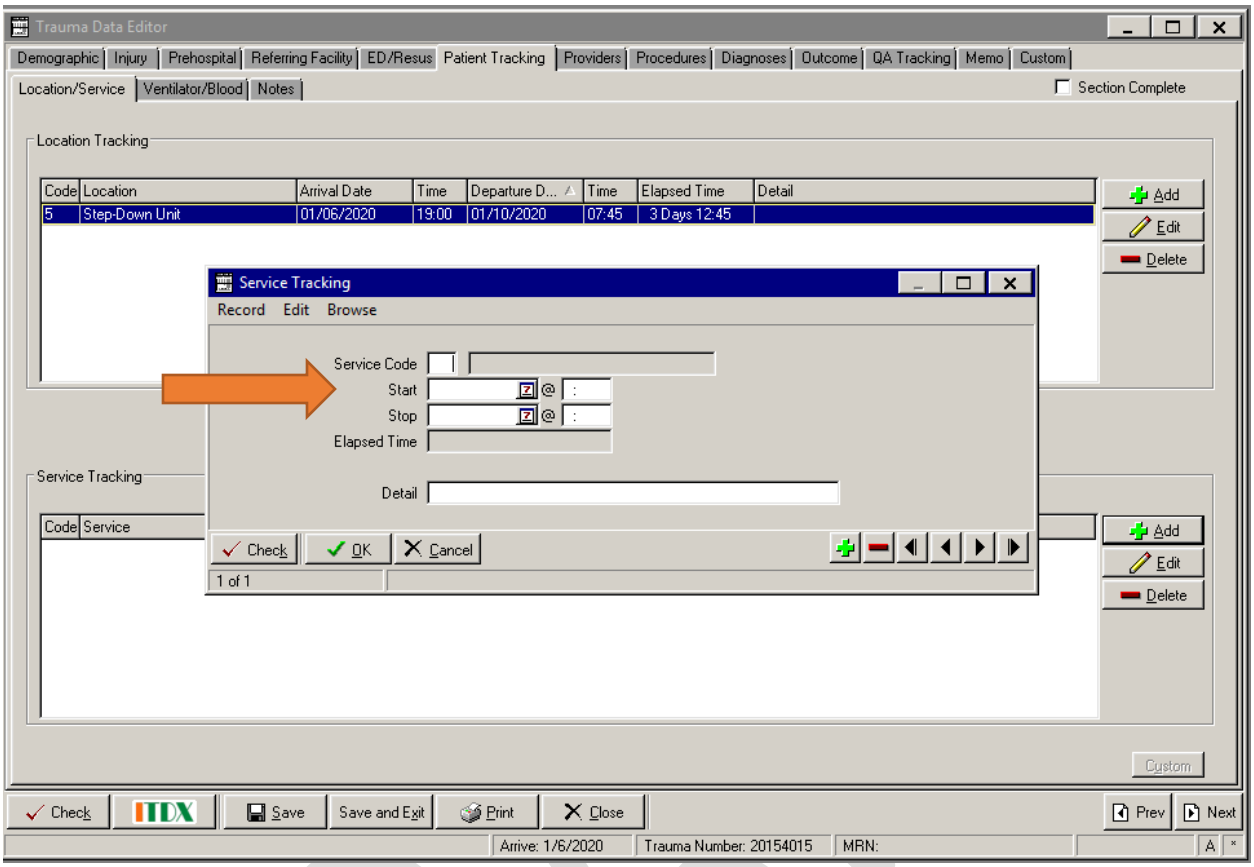


Service Tracking: Start Date and Time

Definition

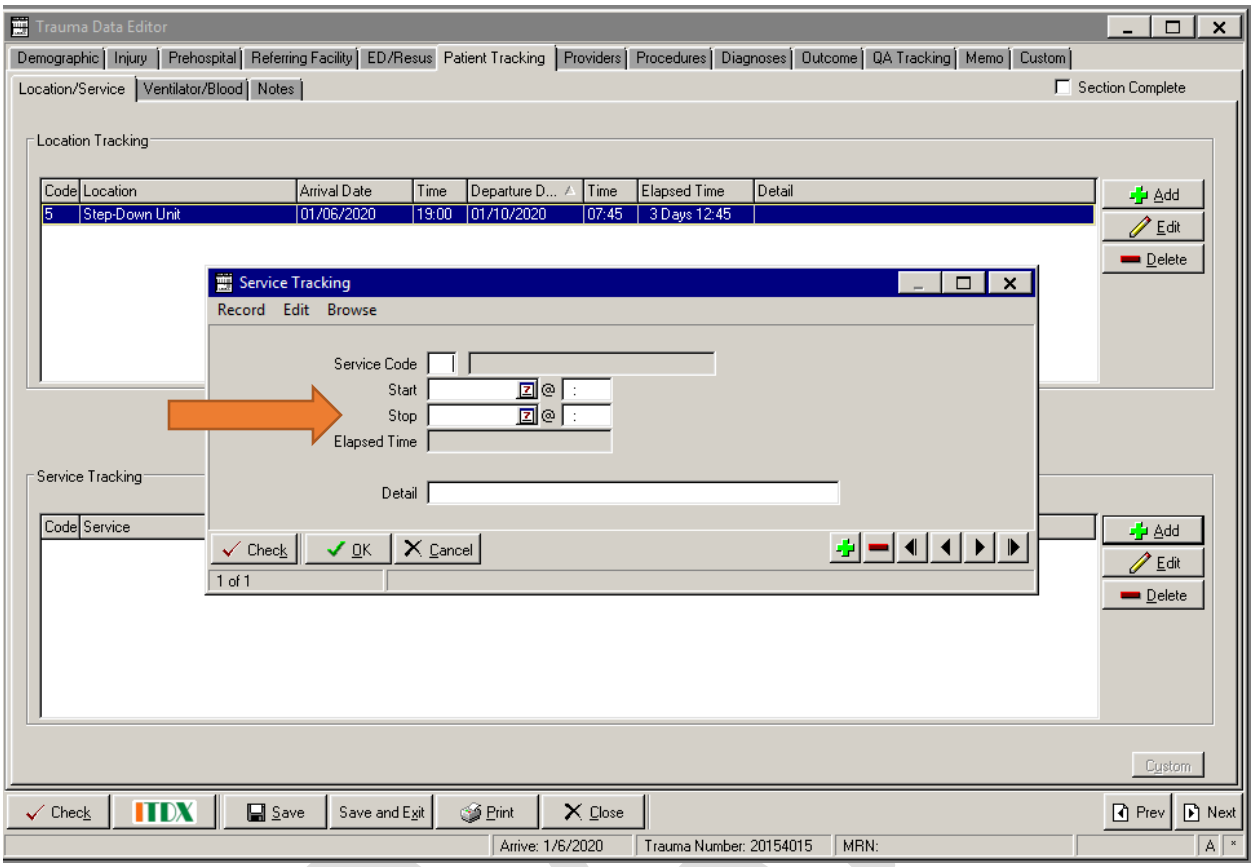
The date and time that a physician subspecialty group begins to primarily care for a patient.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. History and Physical
2. Consult Notes
3. Progress Notes
4. Treatment Team entries if concurrent abstraction



Service Tracking: Stop Date and Time

Definition

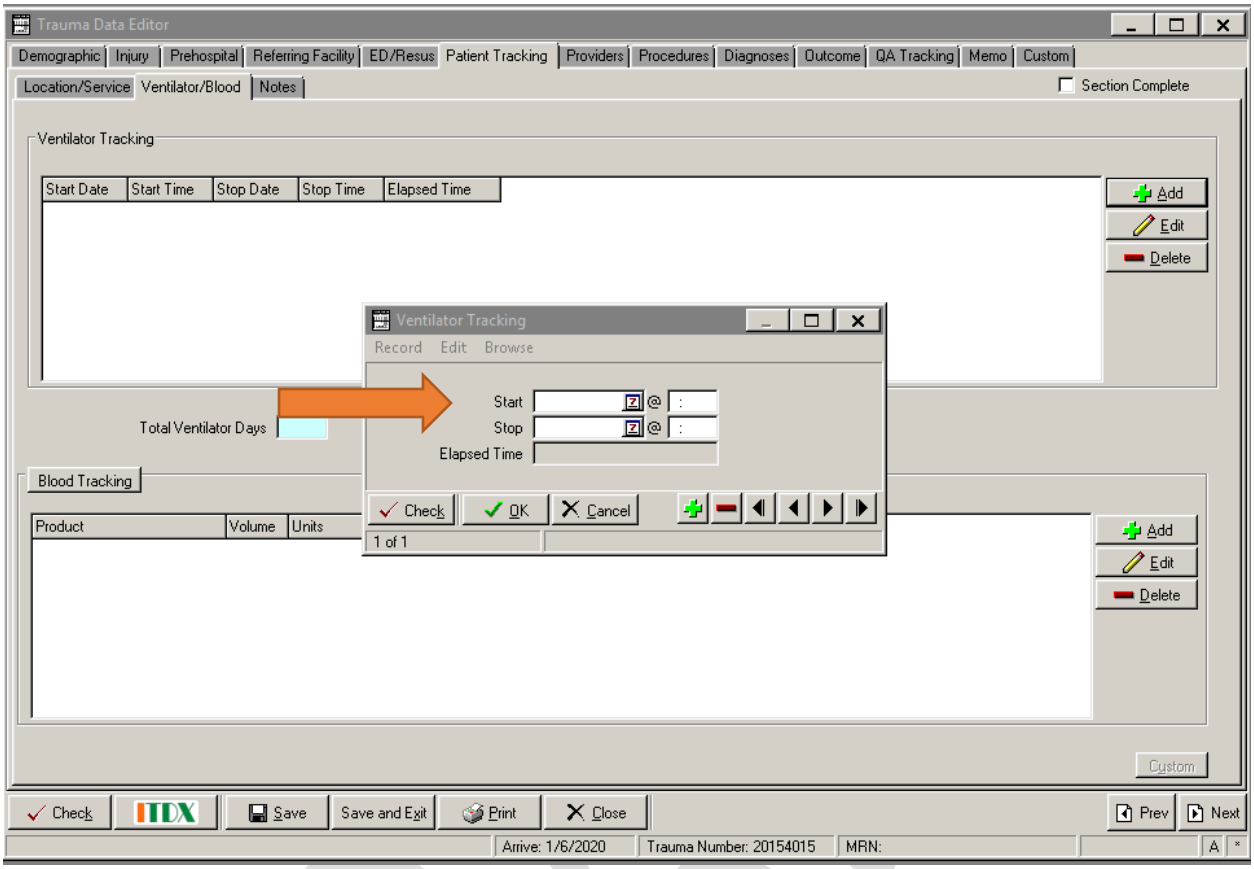
The date and time that a physician subspecialty group stops primarily caring for a patient.

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. History and Physical
2. Progress Notes
3. Treatment Team entries if concurrent abstraction



Ventilator Tracking: Start Date and Time: **MANDATORY BLUE FIELD; follow NTDS Definition rules**

Definition:

The date and time that a patient was placed on mechanical ventilation.
See next page for NTDS definitions.

NOTE: Ventilator days will auto-populate based on date/time entered.
Field will accept multiple episodes of ventilation (failed and required reintubation / ventilation).

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. Respiratory Therapy Notes / Flowsheets
2. ICU Flowsheet
3. Progress Notes
4. Procedure Note

TOTAL VENTILATOR DAYS

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

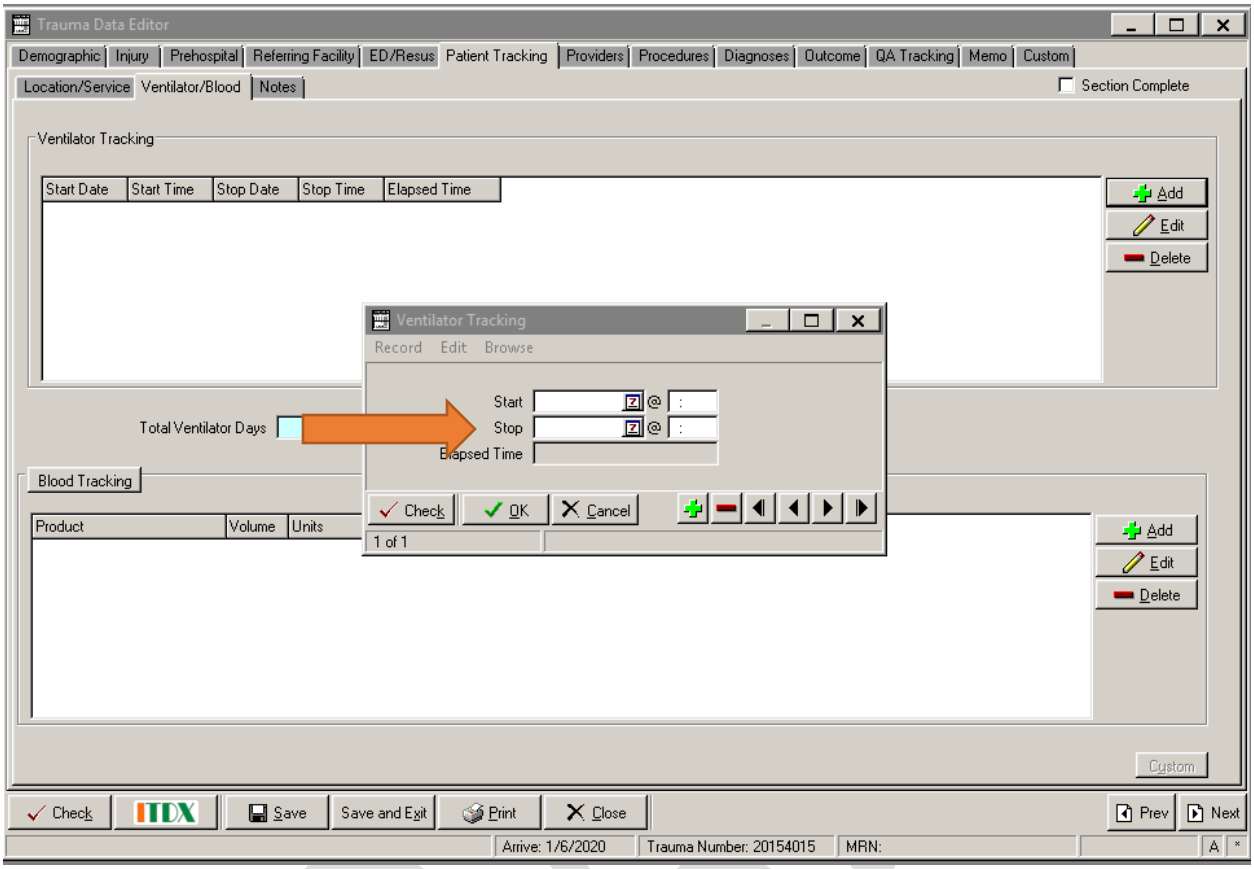
Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range 1-575
7640	1	Single Entry Max exceeded



Ventilator Tracking: Stop Date and Time: **MANDATORY BLUE FIELD; follow NTDS Definition rules.**

Definition

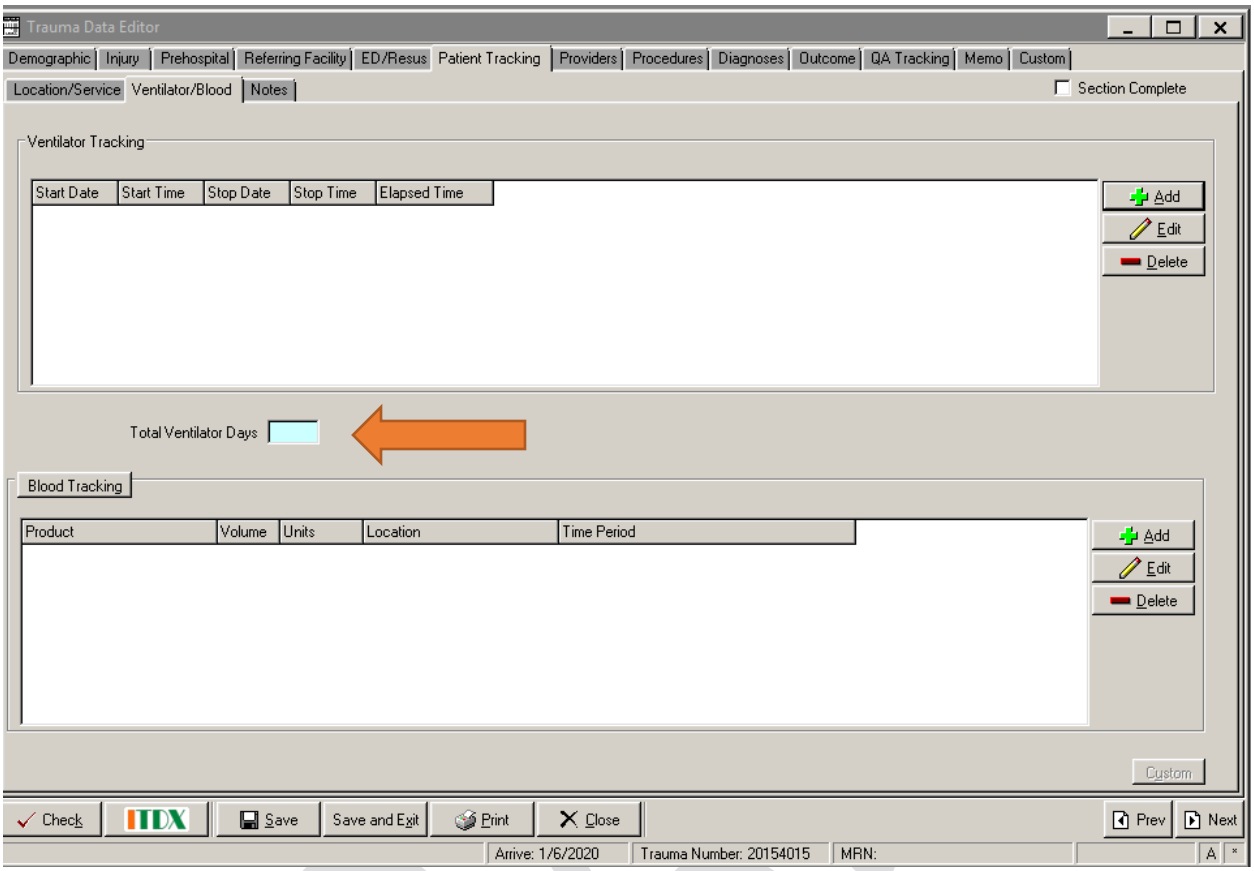
The date and time that a patient was removed from mechanical ventilation

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. Respiratory Therapy Notes / Flowsheets
2. ICU Flowsheet
3. Progress Notes



NOTE: The total ventilator days will auto-populate based on your ventilator tracking information

TOTAL VENTILATOR DAYS

Definition

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

Element Values

- Relevant value for data element

Additional Information

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

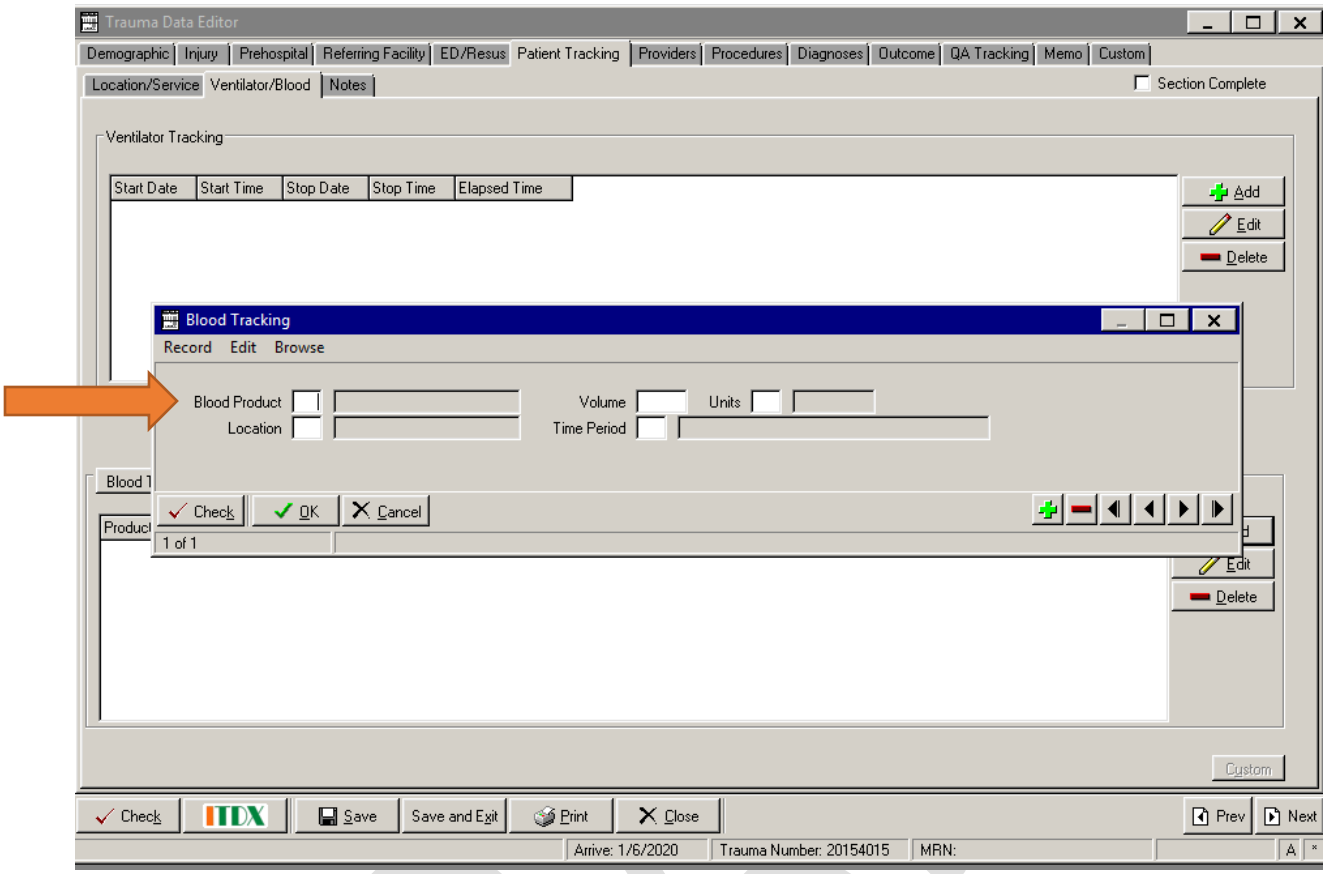
Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range 1-575
7640	1	Single Entry Max exceeded



Blood Tracking: Blood Product

Definition

The type of blood product given to the patient.

Element Values

1. Packed Red Blood Cells
2. Plasma
3. Platelets
4. Other Blood Substitute (Cryoprecipitate)

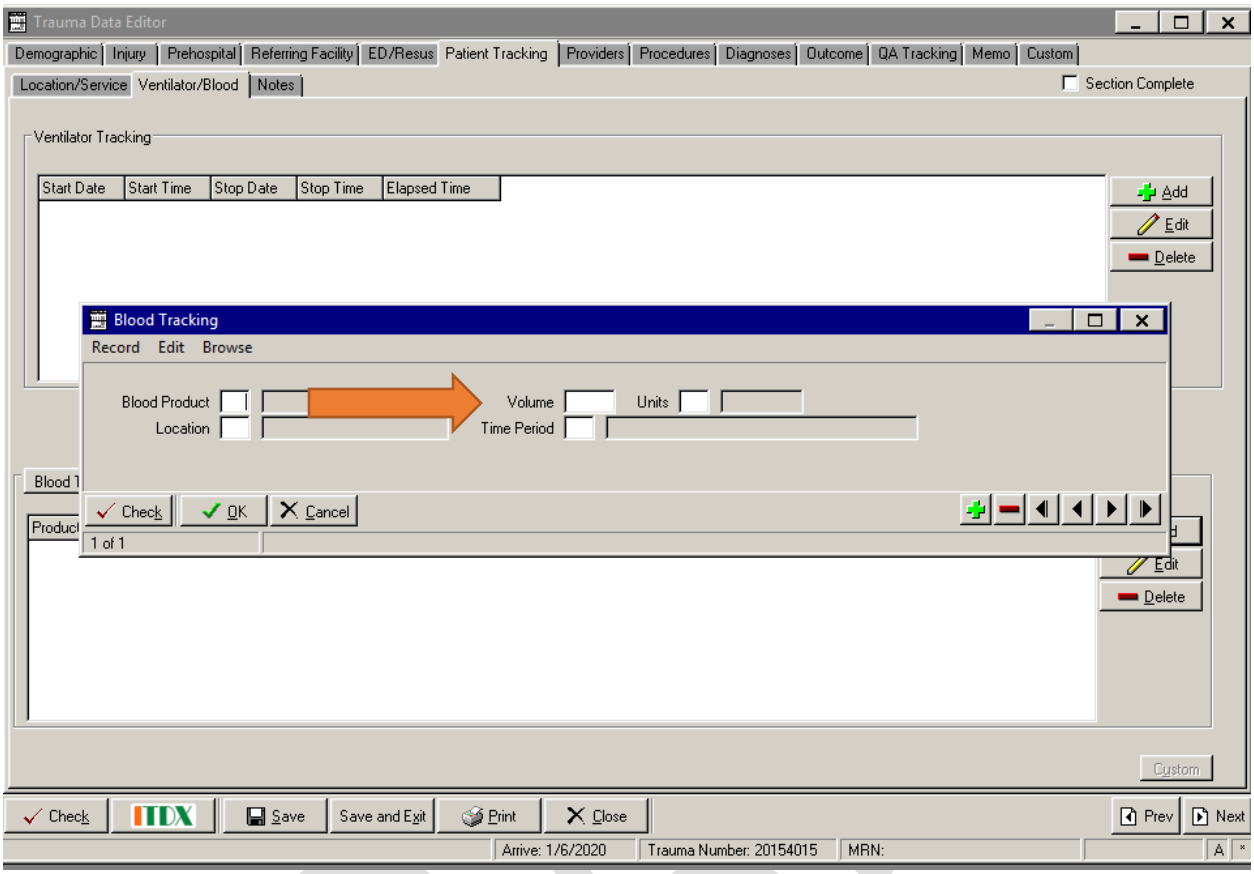
/. Not Applicable

?. Unknown

NOTE: Whole blood should be an option in the Web statewide Version.

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record



Blood Tracking: Volume

Definition

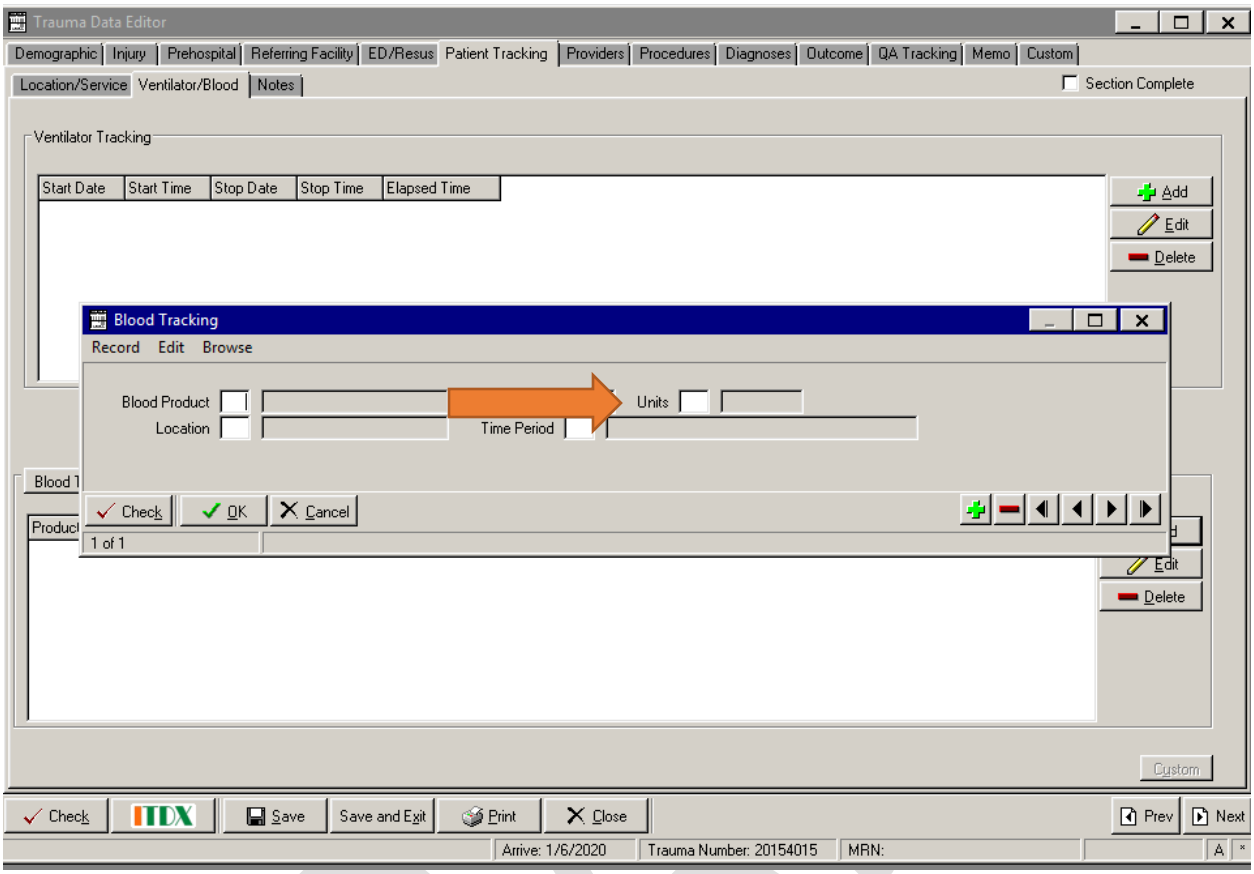
The volume of a particular blood product given to the patient reflected as # of units for red cells or # of packs for coagulation components

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record



Blood Tracking: Units

Definition

The units used to measure the volume of blood product given.

NOTE: Illinois will use UNITS as the standard measure for data entry.

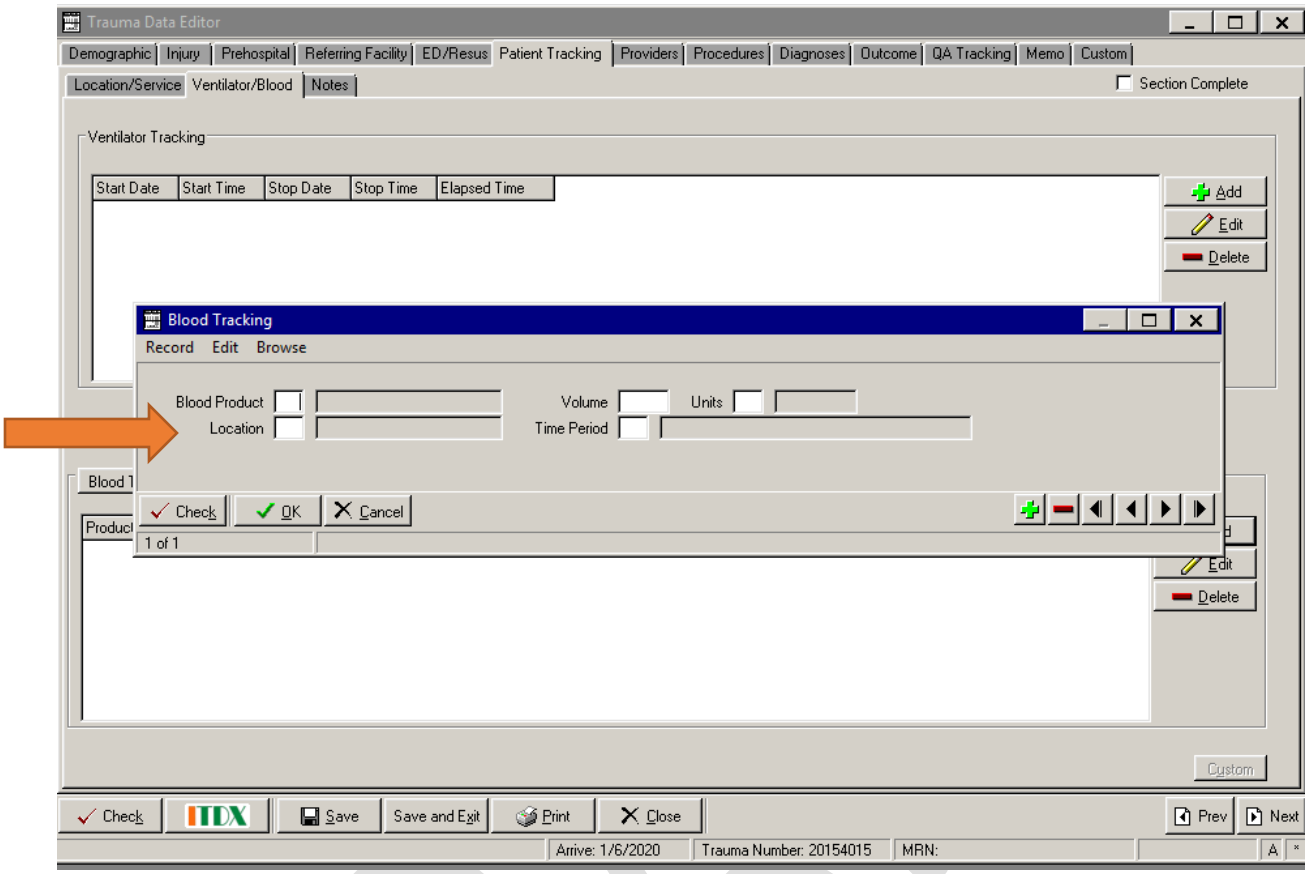
Element Values

1. L
2. mL
3. Units (red cells) or Packs (coag components)

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record



Blood Tracking: Location

Definition

Where the patient was located when they received the blood products.

NOTE: Location of the administration of blood can be configured by looking at the time and date it was given and comparing that to the pt.'s ADT events

Element Values

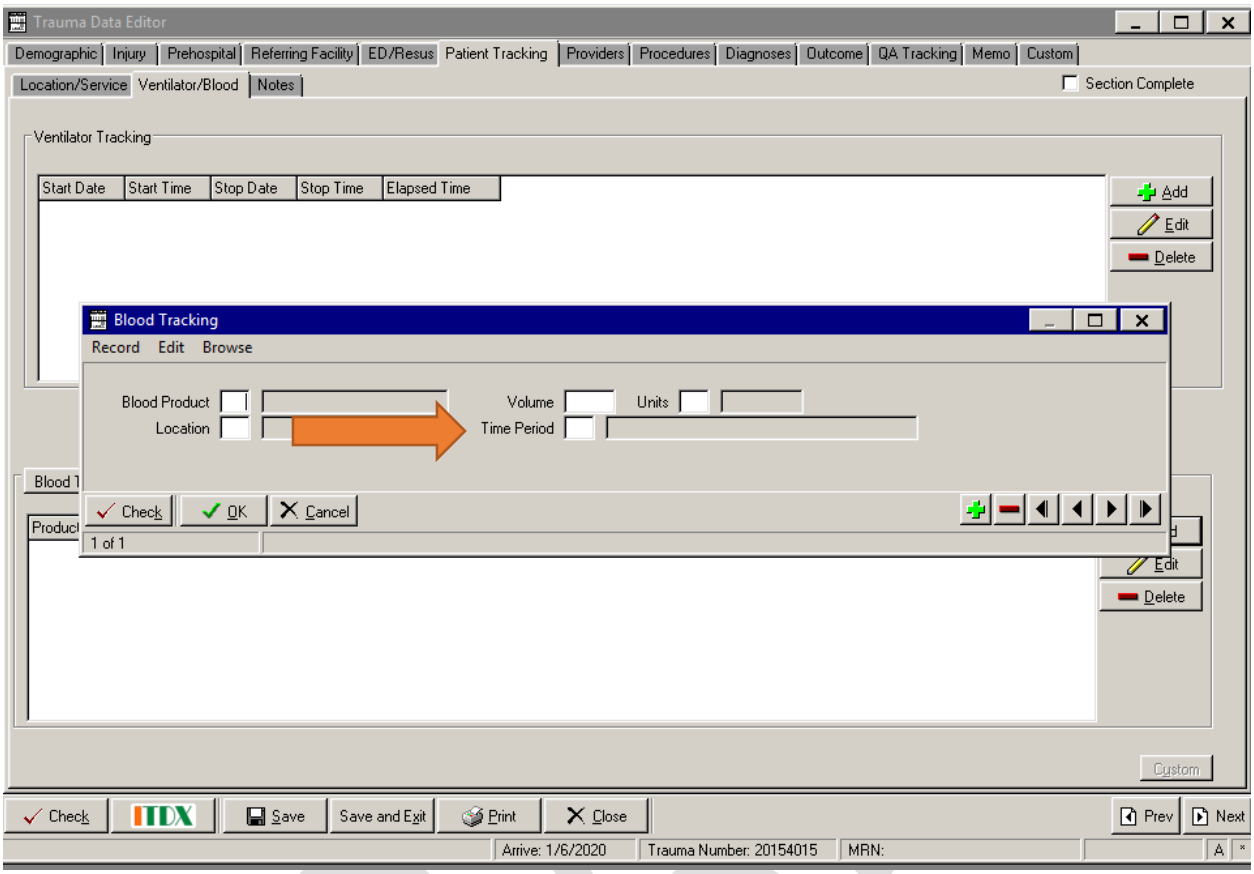
1. Resuscitation Room
2. Emergency Department
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit

90. Prehospital
91. Referring Facility

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. ADT Events
3. Encounter Report
4. Nursing Notes



Blood Tracking: Time Period

Definition

The time period during the patient's stay when they received the blood

Determined by comparing the Date and Time that the blood was administered to the patient's arrival date and time.

Element Values

0. Prior to Facility Arrival
2. First 4 Hours after Facility Arrival
3. Between 4 and 24 Hours after Facility Arrival
4. Between 24 and 48 Hours after Facility Arrival
5. More than 48 Hours after Facility Arrival

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Blood Tracking Flowsheets
2. ADT Events
3. Nursing Notes
4. EMS Run Reports
5. Transferring Facility Documentation

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Providers

- The provider elapsed time will auto-populate based on ED/Hospital arrival time and Provider arrived time.

- The Timeliness box is based on state or other certifying body's time expectations for the different providers to arrive.

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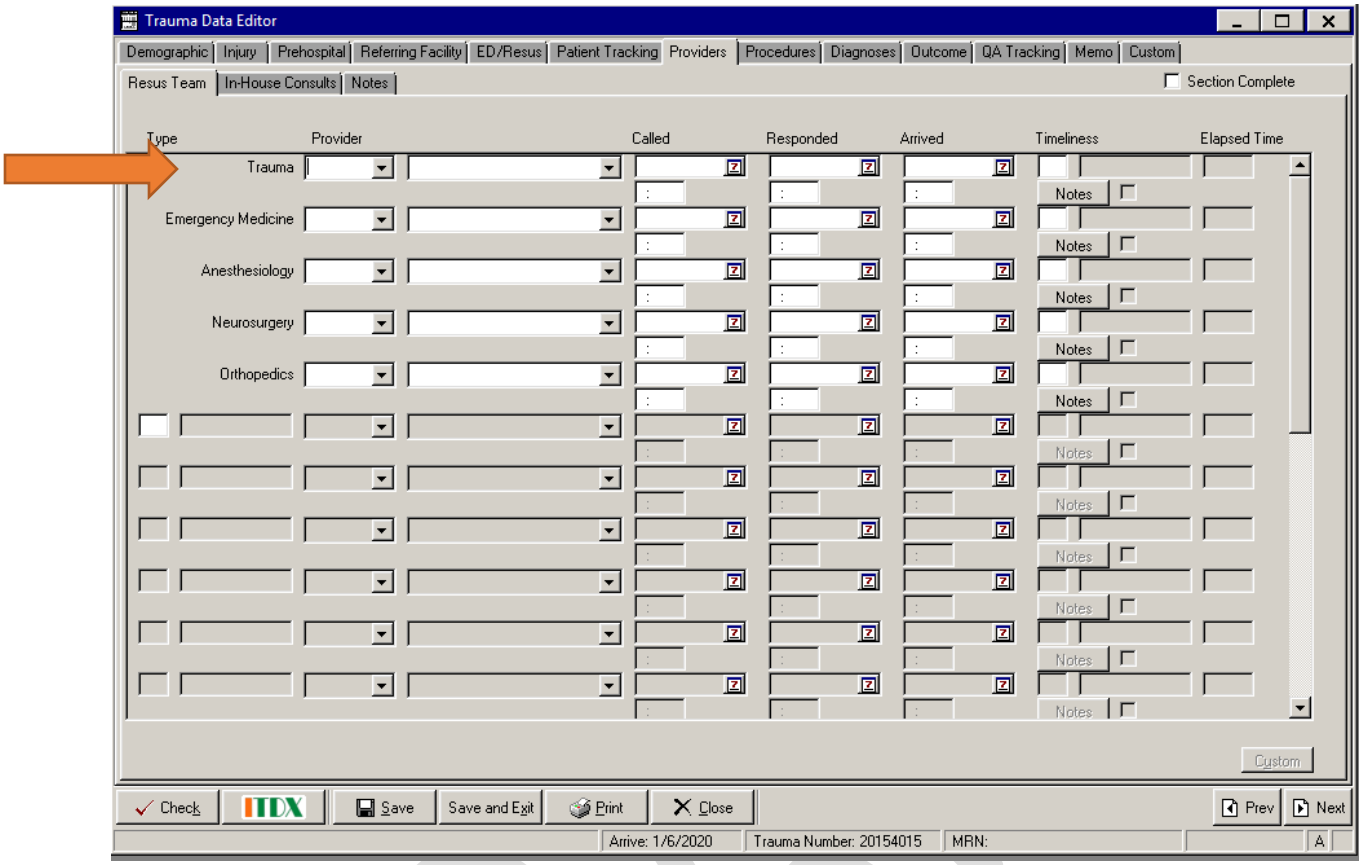

Resus: Provider

Definition

The providers who were involved with the patient's initial resuscitation after arriving to your facility.

Include as many choices as necessary to identify physicians participating with the trauma team response. NOTE: Include consults generated in the Emergency Department for expectant response IN the emergency department. All other consults are entered in the next tab (in-hospital section).

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Nursing Notes
4. Consult Notes

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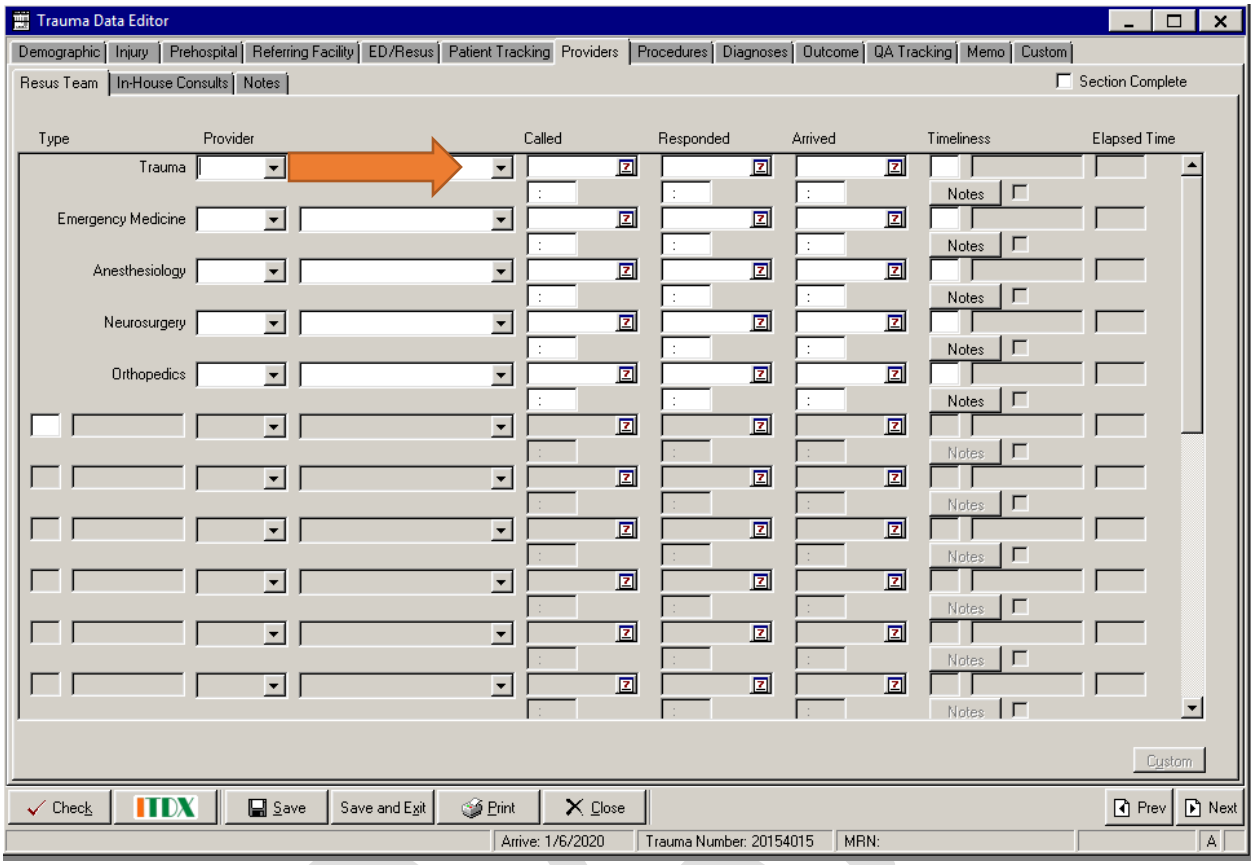

Resus: Provider Called

Definition

The date and time that the particular provider was called or paged because their specialty was needed for the care of the patient.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Nursing Notes
4. Consult Notes

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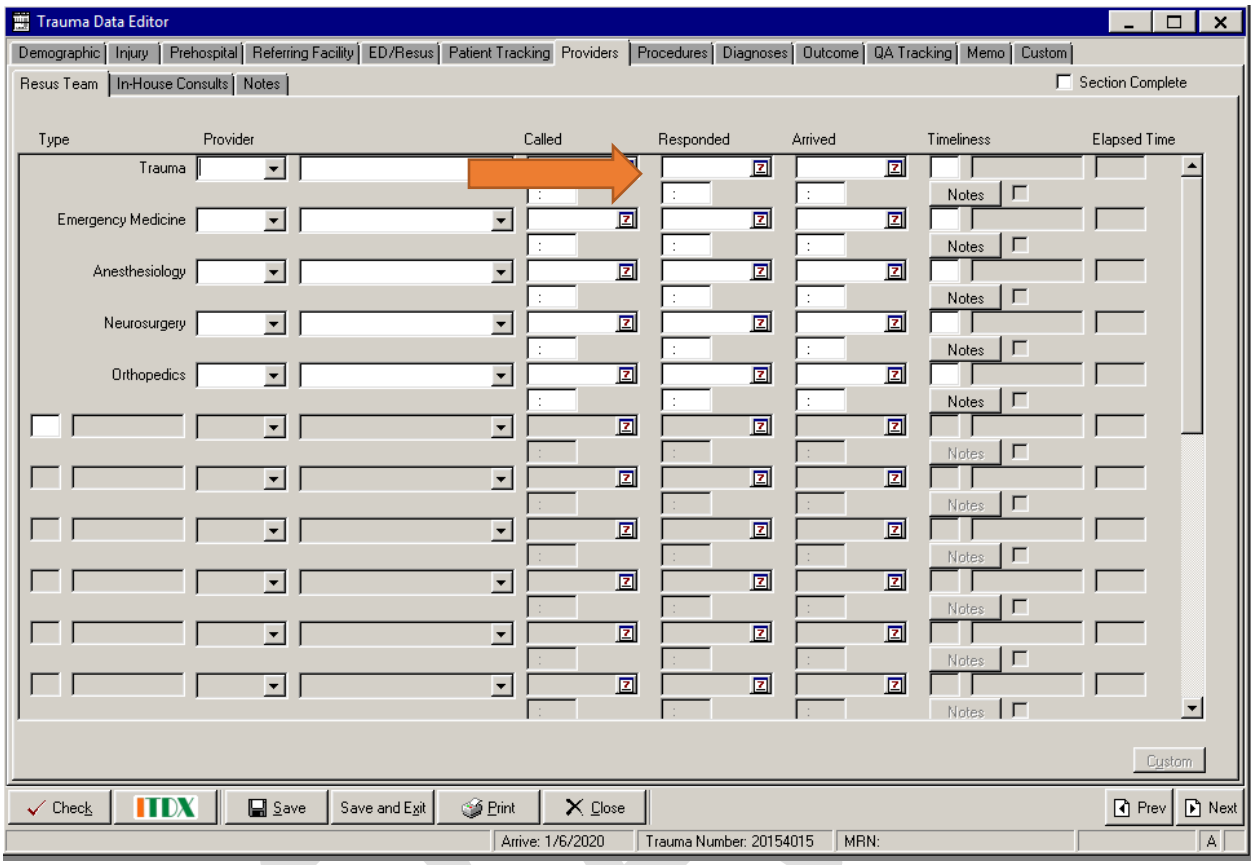


Resus: Provider Responded

Definition

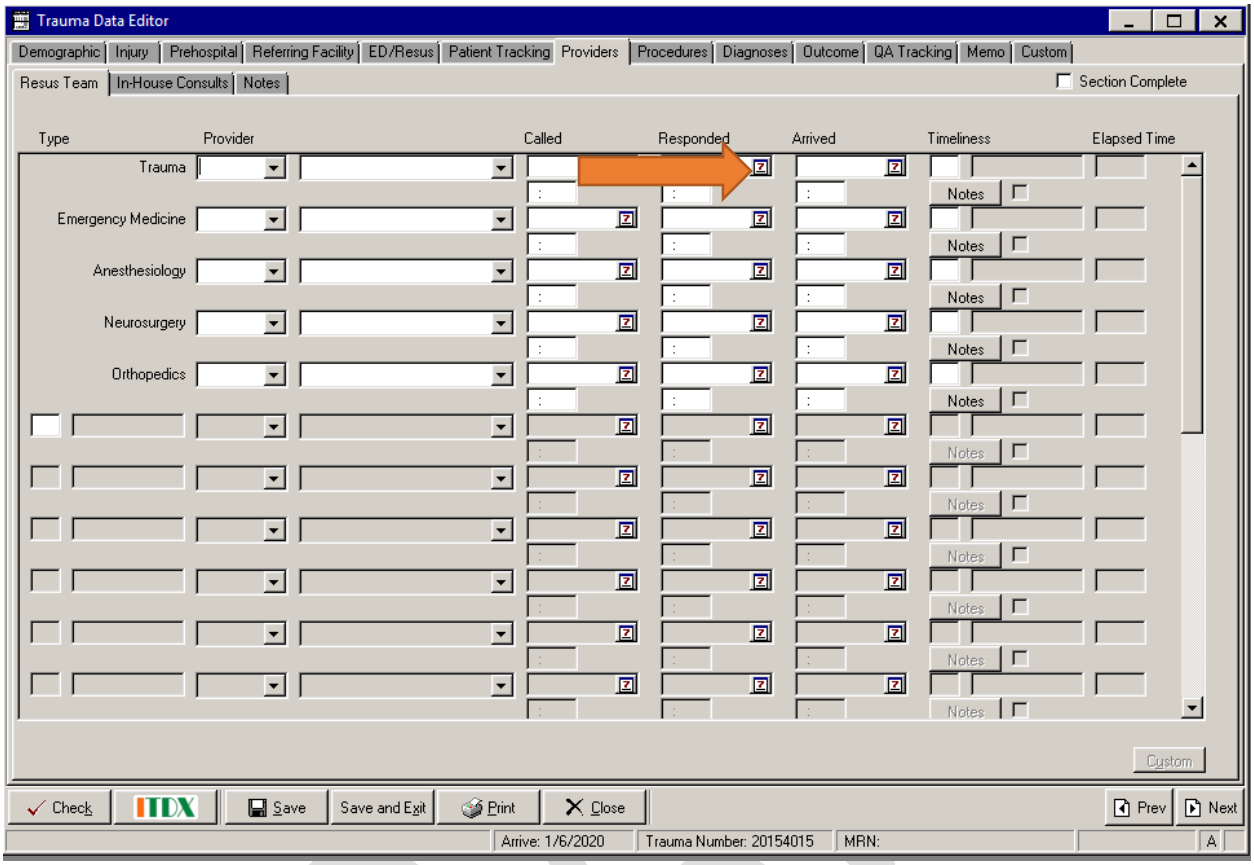
The date and time that the particular provider responded to the page or call because their specialty was needed for the care of the patient.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. History and Physical
2. Progress Notes
3. Trauma Flowsheet / Nursing Notes
4. Consult Notes



Resus: Provider Arrived

Definition

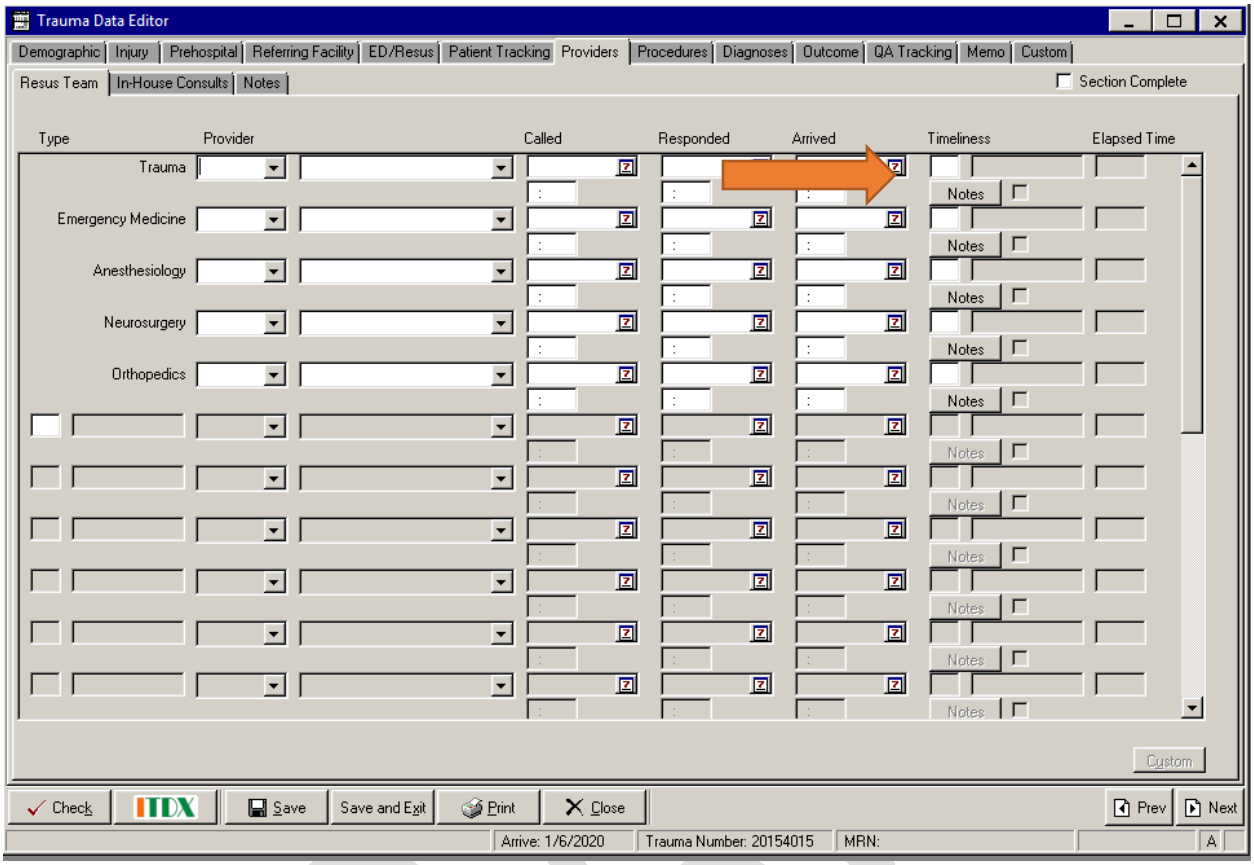
The date and time that the particular provider arrived to treat the patient, and makes actual verbal or physical contact with the patient.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes / Trauma Flowsheet
5. Consult Notes



Resus Team: Timeliness

Definition

Did the provider arrive within a specific timeframe that is designated by the appropriate governing body or hospital policy?

Element Values

1. Timely
2. Not Timely
3. Absent

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
5. Consult Notes

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Section 515.APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

a) Patient Evaluation

1) Any EMS System transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center if less than 25 minutes from the trauma center; otherwise, follow Section 515.Appendix C. Mandatory field notification of a trauma surgeon will occur in cases of:

A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 80 Hg for a pediatric patient on two consecutive measures five minutes apart); or

B) Cavity penetration of the torso or neck.

2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED's attending emergency physician or designee immediately upon arrival. (Section 515.2060(a))

3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515.2060(b))

4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.

5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.

6) Once the patient has been assigned a Category I or II status that patient cannot be downgraded until the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) Category I

The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician's discretion.

Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery and cardiovascular surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery or cardiovascular surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and shall be completed within two hours. An isolated injury refers to transfer of energy to a single anatomic body region with no potential for multisystem involvement.

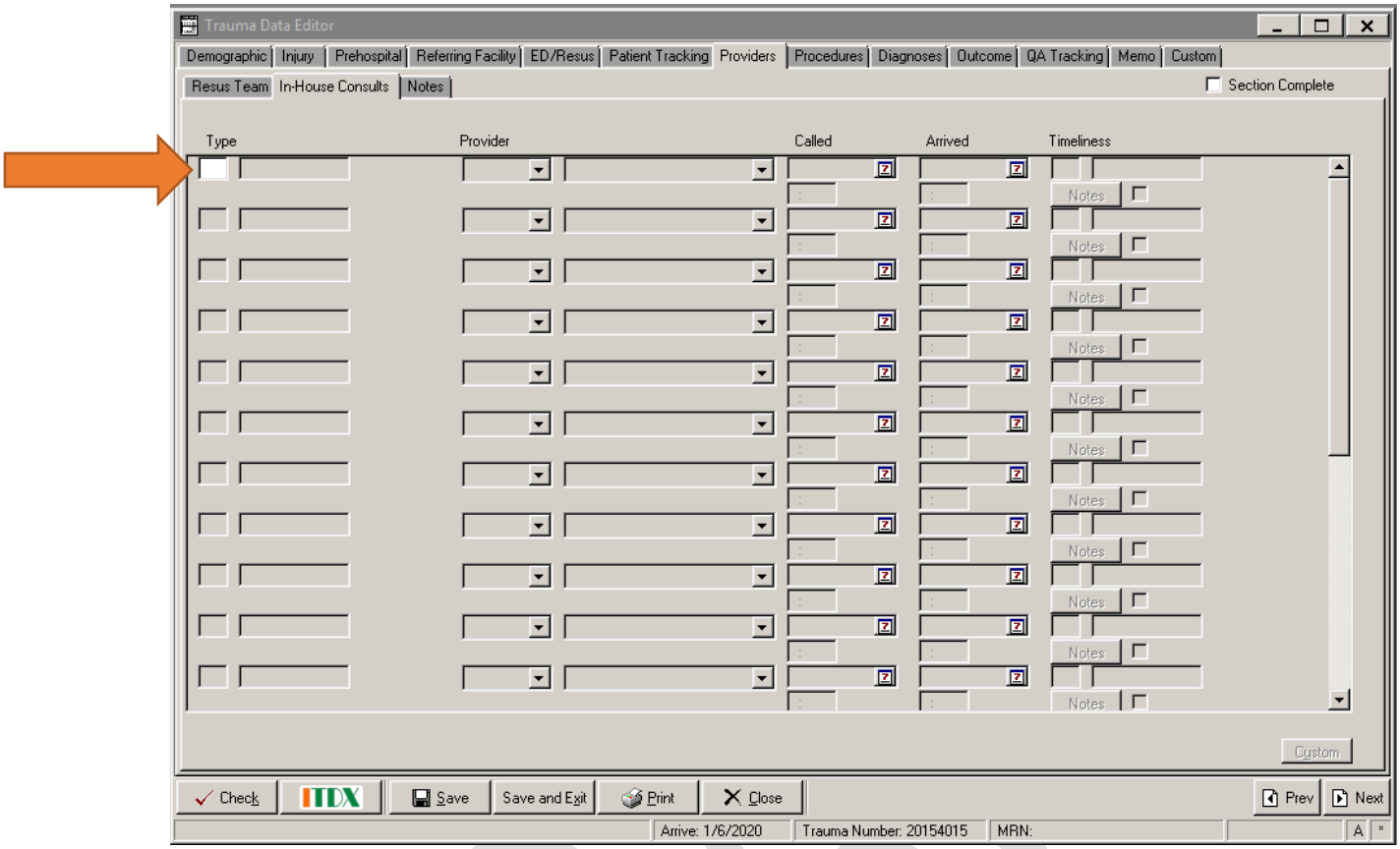
c) Category II
Any other patient who is admitted for traumatic injury requires notification/consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level I) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515.Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515.Appendix C).

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)



In-House Consults

Definition

The subspecialties consulted or expected to respond after the patient has been admitted to the hospital.

Element Values

- Relevant Value for Data Element

NOTE: The provider's name should be attached to the consult note

Data Source Hierarchy Guide

1. Consult Notes
2. Progress Notes
3. Nursing Notes

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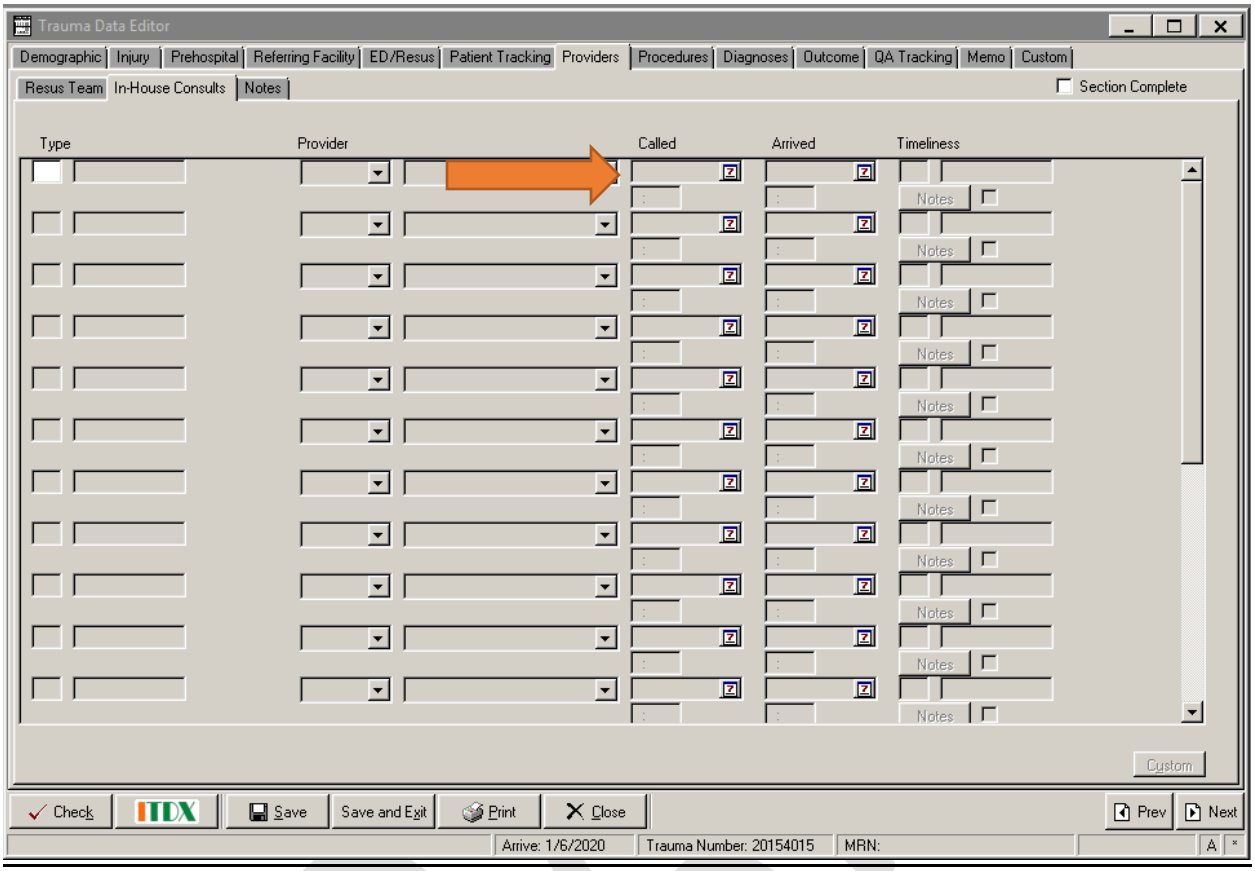

In-House Consult Provider Called

Definition

The date and time that the particular provider was called or paged because their specialty was needed for the care of the patient after the patient was admitted.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Consult Notes / Notes
2. Progress Notes
3. Nursing Notes

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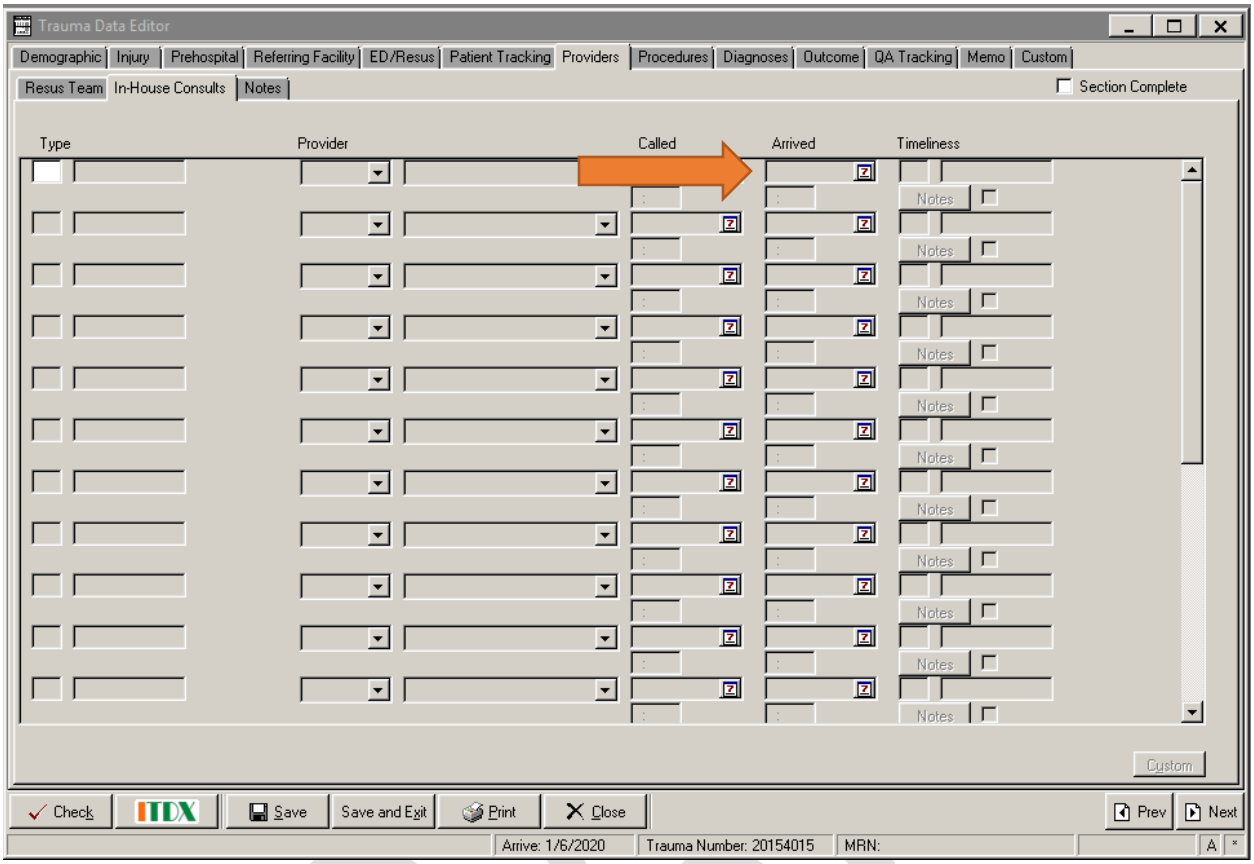


In-House Consults: Provider Arrived

Definition

The date and time that the particular provider arrived to treat the patient after the patient has been admitted to the hospital.

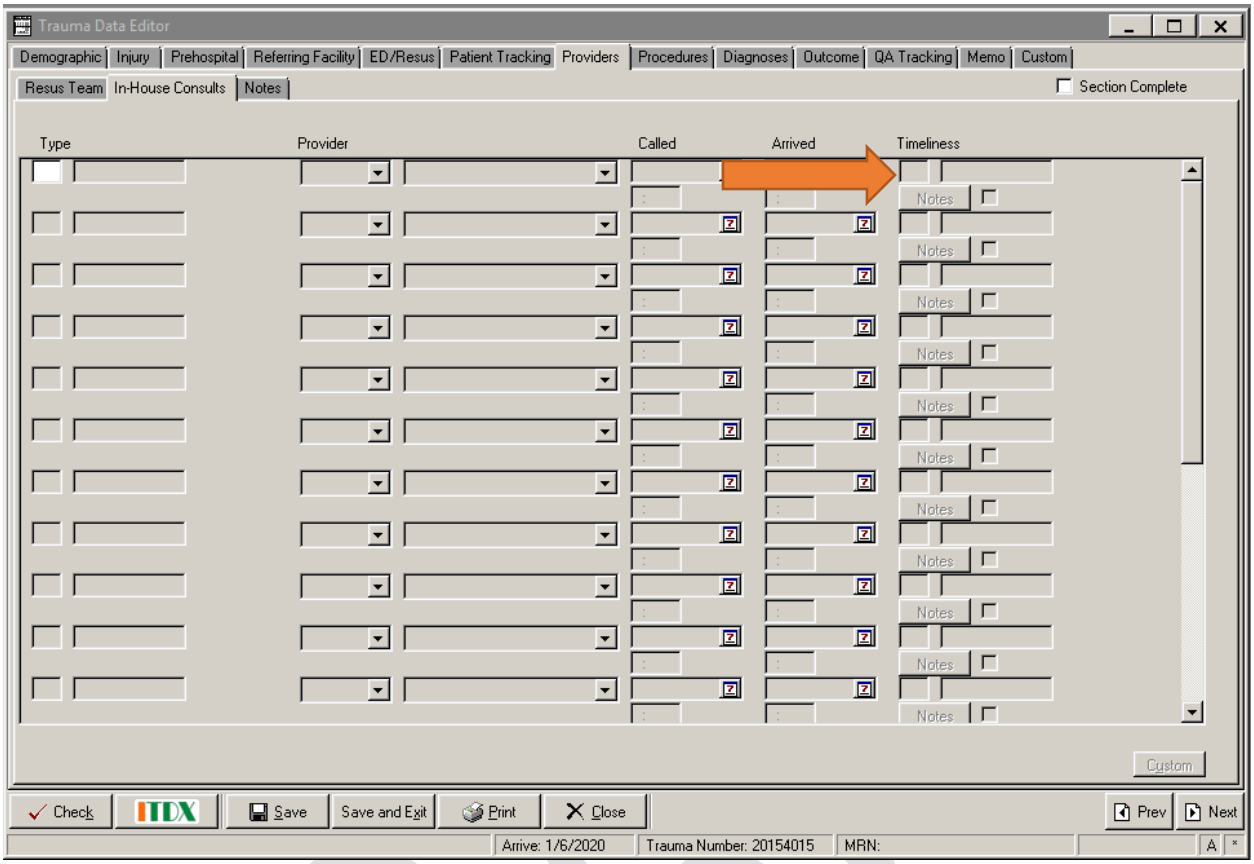
Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Consult Notes
2. Progress Notes
3. Nursing Notes

DRAFT



In House Consults: Timeliness

Definition

Did the provider arrive within a specific timeframe that is designated by the appropriate governing body or hospital policy?

NOTE: Refer to the IL Trauma Center Rules / Regulations, Appendix F, in the ***Resusc Team Consult Tab*** to assist in making this determination.

Element Values

1. Timely
2. Not Timely
3. Absent

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes

DRAFT

Procedures Information

- Procedures are entered using the very specific ICD-10 codes

- Procedures, based on the NTDS definition adopted by Illinois, are limited to those essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The NTDS has a recommended list and the IL CQI / Registry Committee has also created a standardized list of codes to assist in making these decisions and standardized entries. They are embedded in this Section.

- (Many of the procedures entered pre-2019 will no longer be needed. Each facility can enter as many as they want, but there is no longer a mandate to capture all of them, allowing you an opportunity to limit some of that historic work).

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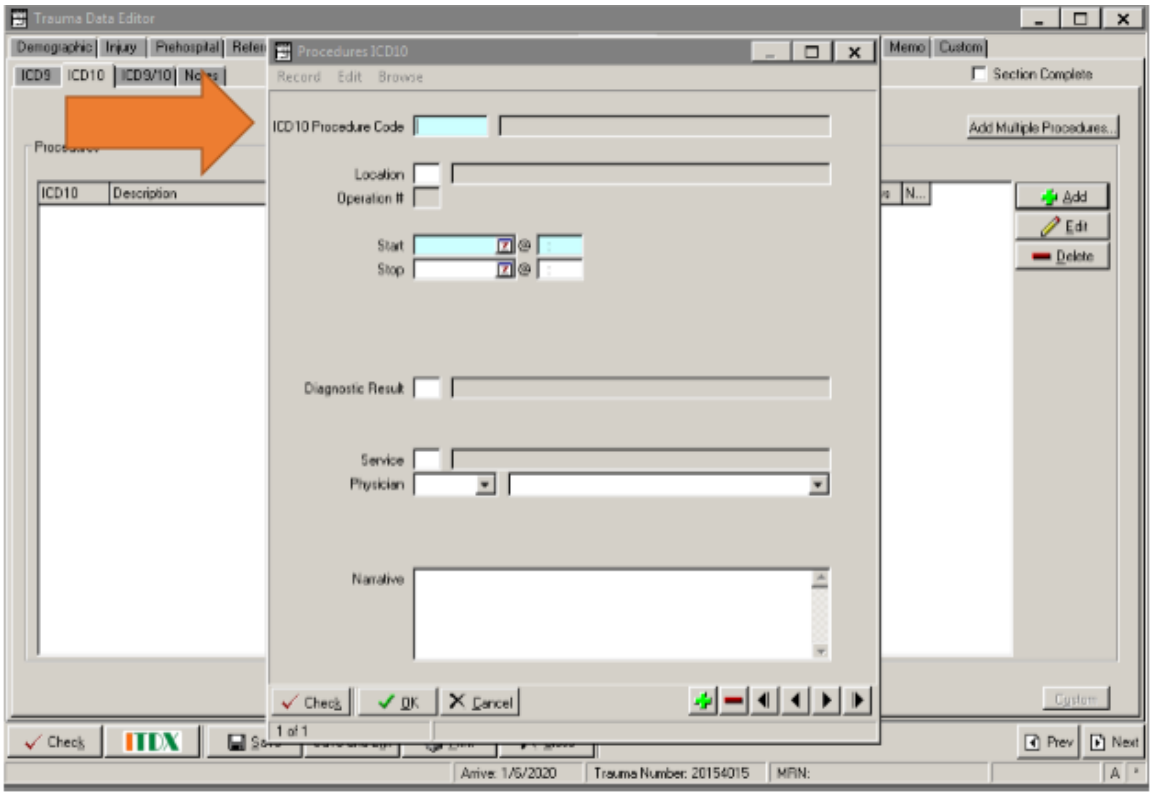


Hospital Procedures: **BLUE FIELD; NTDS Definition rules follow.**

DRAFT

ICD-10 HOSPITAL PROCEDURES

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB.

Element Values

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

Additional Information

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

DIAGNOSTIC AND THERAPEUTIC IMAGING

Computerized tomographic Head *

Computerized tomographic Chest *

Computerized tomographic Abdomen *

Computerized tomographic Pelvis *

Computerized tomographic C-Spine*

Computerized tomographic T-Spine*

Computerized tomographic L-Spine*

Doppler ultrasound of extremities *

Diagnostic ultrasound (includes FAST) *

Angioembolization

Angiography

IVC filter

REBOA

CARDIOVASCULAR

Open cardiac massage

CPR

CNS

Insertion of ICP monitor *

MUSCULOSKELETAL

Soft tissue/bony debridement *

Closed reduction of fractures

Skeletal and halo traction

Fasciotomy

TRANSFUSION

Transfusion of red cells * (only report first 24 hours after hospital arrival)

Transfusion of platelets * (only report first 24 hours after hospital arrival)

Transfusion of plasma * (only report first 24 hours after hospital arrival)

RESPIRATORY

Insertion of endotracheal tube * (exclude intubations performed in the OR)

Continuous mechanical ventilation *

Chest tube *

Bronchoscopy *

Tracheostomy

Ventriculostomy *

Cerebral oxygen monitoring *

GENITOURINARY

Ureteric catheterization (i.e. Ureteric stent)

Suprapubic cystostomy

GASTROINTESTINAL

Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)

Gastrostomy/jejunostomy (percutaneous or endoscopic)

Percutaneous (endoscopic) gastrojejunoscopy

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
8801	1	Invalid Value (ICD-10 PCS only)
8803	2	Element cannot be blank
8804	3	Element should not be "Not Applicable" unless patient had no procedures performed
8805	1	Invalid value (ICD-10-CA only)
8850	1	Multiple Entry Max exceeded

DRAFT

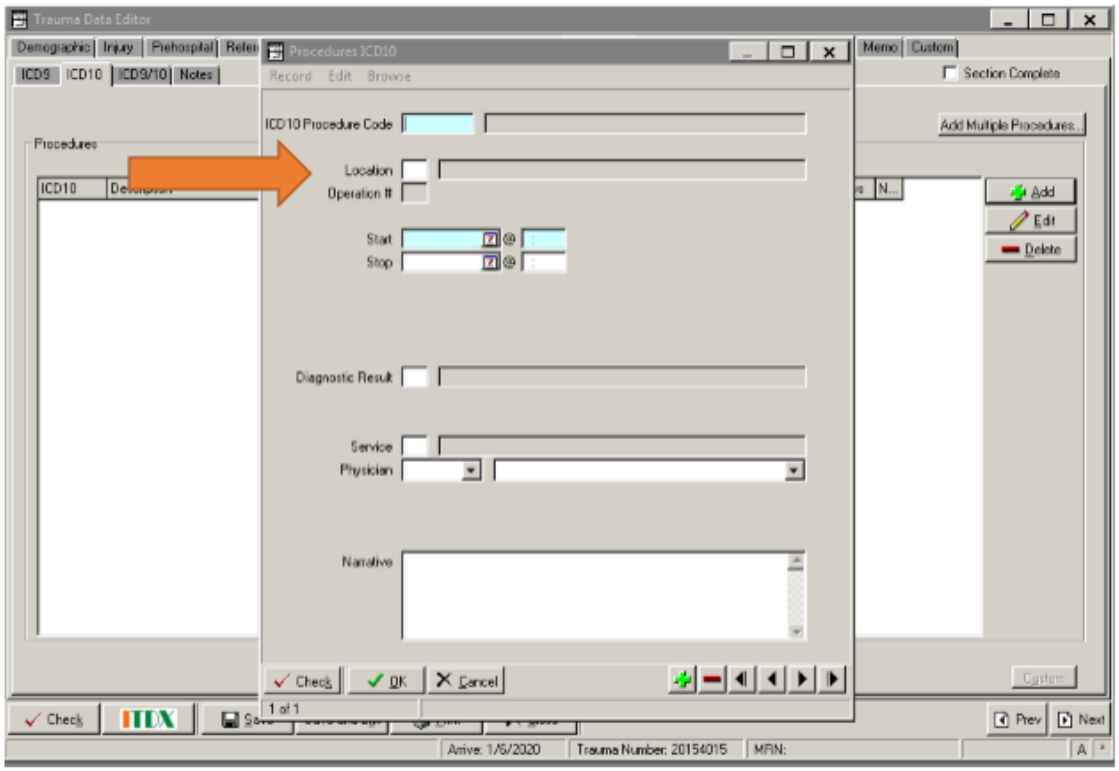
NOTE: Please refer to the ***Commonly Used ICD-10 Procedure Codes Chart*** on the next page for standardization of the common procedures performed during trauma patient evaluation and treatment.

Commonly Used ICD - 10 Procedure Codes

	Resuscitation
2W32X3Z	C-Collar/Aspen Application
2W1LX7Z	Tourniquet Right Lower Leg
2W1MX7Z	Tourniquet Left Lower Leg
2W1BX7Z	Tourniquet Left Upper Arm
2W1AX7Z	Tourniquet Right Upper Arm
5A19054	BVM/Ambu Bag
0BH17EZ	Intubation
0WHQ7YZ	King Airway/Combitube/Igel/LMA
0WP0XYZ	Extubation
0BH13EZ	Cricothyrotomy
5A12012	CPR
5A1221Z	CPR - Lucas Device
5A2204Z	Defibrillation
0W993ZZ	Right Needle Decompression
0W9B3ZZ	Left Needle Decompression
0W9D3ZZ	Pericardiocentisis
0WJB0ZZ	Left Thoracotomy
0WJ90ZZ	Right Thoracotomy (Clamshell)
02QA0ZZ	Open Cardiac Massage
3E080GC	Intra Cardiac Epi
04V03EZ	REBOA
3E0V37Z	Intraosseous Access
	Respiratory
5A09357	CPAP/BiPAP < 24 hours
5A09457	CPAP/BiPAP 24-96 hours
5A09557	CPAP/BiPAP >96 hours
5A1935Z	Vent < 24 hours
5A1945Z	Vent 24-96 hours
5A1955Z	Vent > 96 hours
09HN7BZ	Nasal Airway
0CHY7BZ	Oral Airway
0W9900Z	Right Chest Tube - Open
0W9B00Z	Left Chest Tube- Open
0W9930Z	Right Chest Tube - Perc
0W9B30Z	Left Chest Tube - Perc
0BJ08ZZ	Bronchoscopy
0B110Z4	Tracheostomy

	Dianostic X-rays
BN05ZZZ	XR Panorex
BN00ZZZ	XR Skull
BR00ZZZ	XR C-Spine
BR07ZZZ	XR T-Spine
BR09ZZZ	XR L-Spine
BP0YZZZ	XR Left Ribs
BP0XZZZ	XR Right Ribs
BW03ZZZ	XR Chest
BW00ZZZ	XR Abdomen
BT04ZZZ	XR KUB
BR0CZZZ	XR Pelvis
	Diganostic CT scans
BW28ZZZ	CT Head
B020ZZZ	CT Brain
BN25ZZZ	CT Facial Bones
BB24ZZZ	CT Chest (Bilateral Lungs)
BW25ZZZ	CT Chest/Abdomen/Pelvis
BW24ZZZ	CT Chest/Abdomen
BW21ZZZ	CT Abdomen/Pelvis
BR2CZZZ	CT Pelvis
BR20ZZZ	CT C-Spine
BR27ZZZ	CT T-Spine
BR29ZZZ	CT L-Spine
	Angiography
B32R1ZZ	CTA Head
B3251ZZ	CTA Neck
B32S1ZZ	CT PE
B3201ZZ	CTA Chest
BF2C1ZZ	CTA Abdomen/Pelvis
BP2T1ZZ	CTA Right Upper Arm
BP2U1ZZ	CTA Left Upper Arm
BP2V1ZZ	CTA Bilateral Upper Extremities
B42H1ZZ	CTA Bilateral Lower Extremities
B42G1ZZ	CTA Left Lower Leg
B42F1ZZ	CTA Right Lower Leg

	MRI
B030ZZZ	MRI Brain
BR30ZZZ	MRI C-Spine
BR37ZZZ	MRI T-Spine
BR39ZZZ	MRI L-Spine
	UltraSound
B345ZZZ	Carotid Dopplers
B246ZZZ	Echocardiogram
BW41ZZZ	FAST Exam
B54DZZZ	Bilateral Dopplers
	Vascular
5A1223Z	Transvenous Pacer
03HC3DZ	Left Arterial Line - Arm
03HB3DZ	Right Arterial Line - Arm
04HL3DZ	Left Arterial Line - Femoral
04HK3DZ	Right Arterial Line - Femoral
06HN33Z	Left Central Line - Femoral
06HM33Z	Right Central Line - Femoral
05H633Z	Left Central Line - Chest/Subclavian
05H533Z	Right Central Line - Chest/Subclavian
4A02X4Z	EKG
	Wound/Ortho Treatment
2W33X3Z	TPOD Placement
2W35X3Z	TLSO Brace
	Genitourinary
0T9B70Z	Foley Catheter
0T2BX0Z	Removal of Foley
BT1B1ZZ	Cystogram
BT141ZZ	Retrograde Urethrogram
	Gastrointestional
0D9670Z	OG/NG Tube Placement
	Neuro
4A003BD	ICP Monitoring
009630Z	EVD Placement - Perc
009600Z	EVD Placement - Open
009Y3ZZ	Lumbar Puncture
4A10X4Z	EEG



Procedure Location

Definition

The area of the healthcare facility where the procedure was performed.

Element Values

1. Resuscitation Room
2. Emergency Department
3. Operative Room
4. Intensive Care
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. History and Physical
4. Progress Notes
5. Nursing Notes

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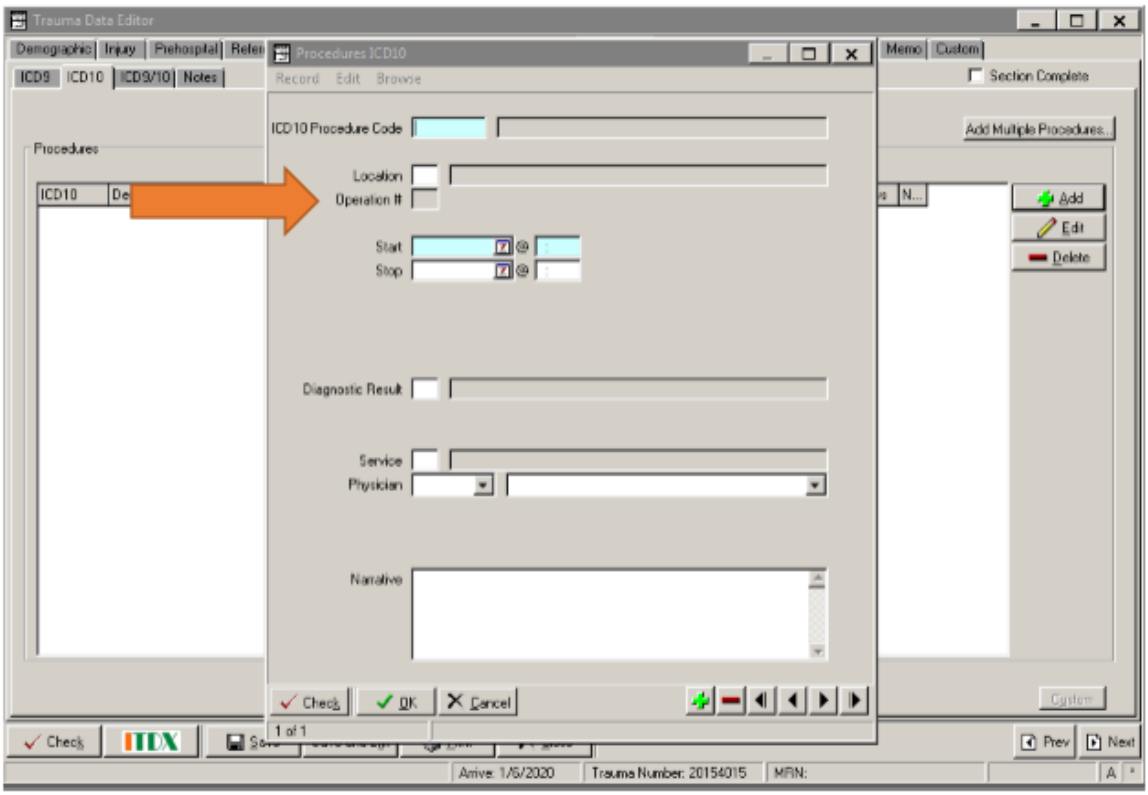


Operation Number

Definition

Operations are valued in numerical order. This is the number of the operation where the particular procedure being entered was performed.

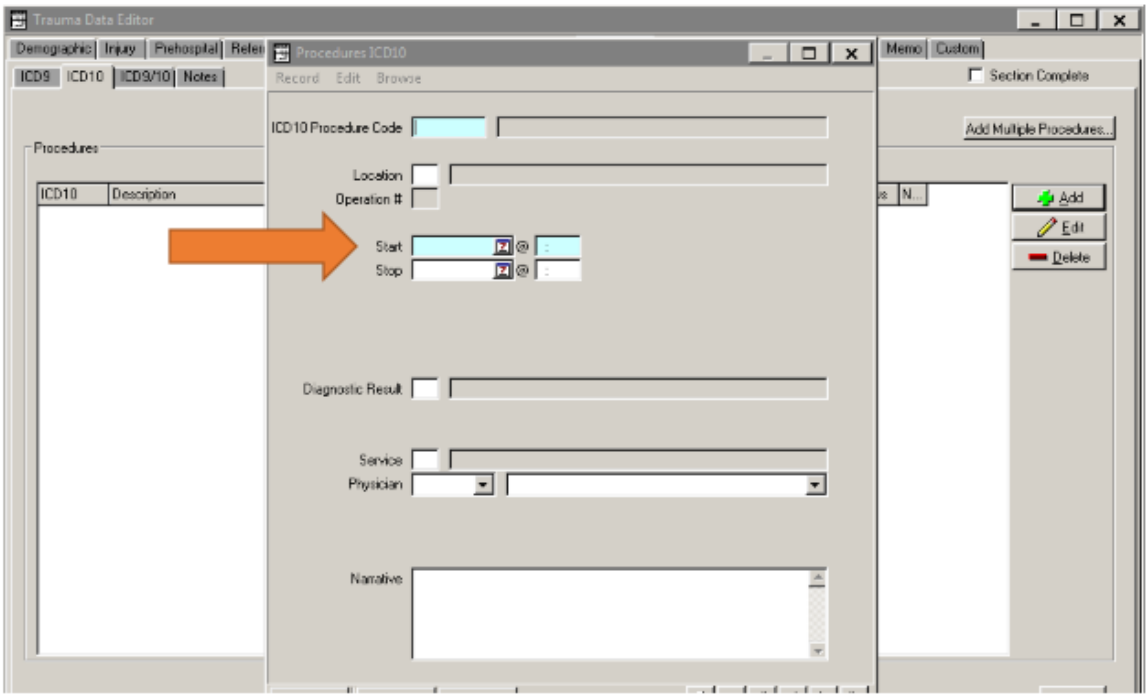
Element Values

- Relevant Data for Element Values

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. History and Physical
4. Progress Notes
5. Nursing Notes
6. ADT Events

Hospital Procedure Start Date: Mandatory BLUE FIELD; NTDS Definition rules follow.



HOSPITAL PROCEDURE START DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

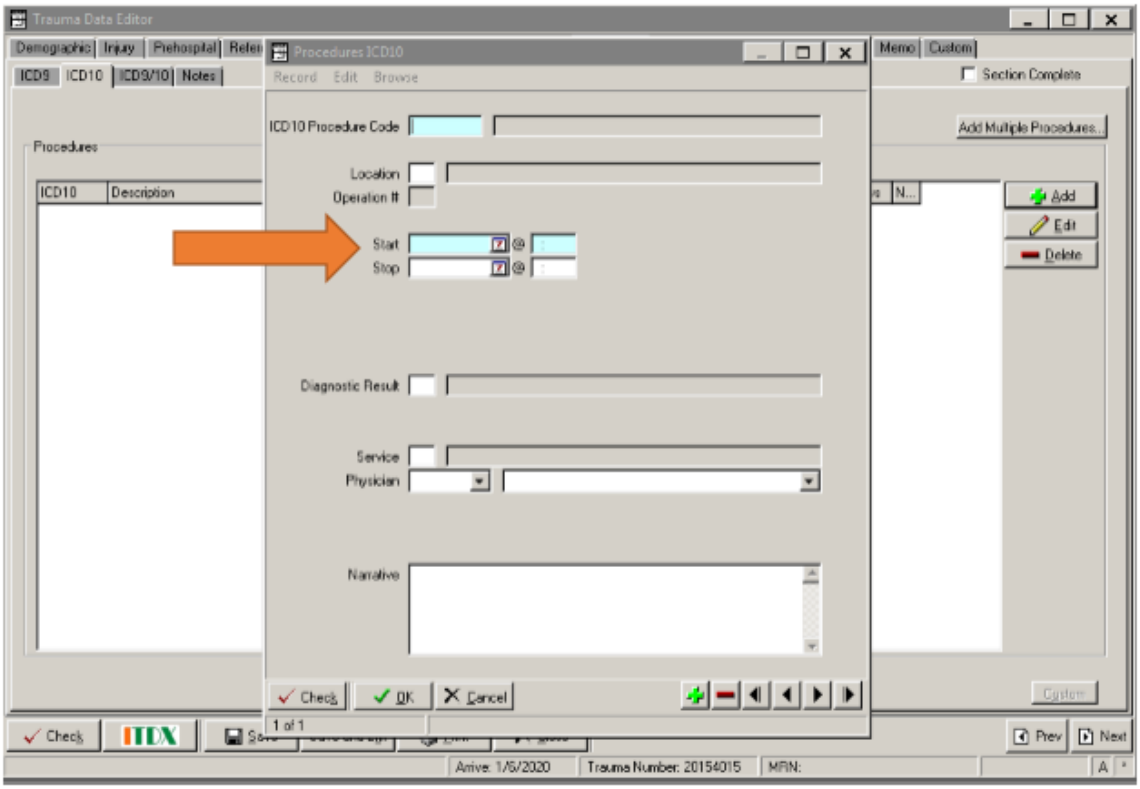
- Reported as YYYY-MM-DD.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6603	3	Hospital Procedure Start Date is earlier than EMS Dispatch Date
6604	3	Hospital Procedure Start Date is earlier than EMS Unit Arrival on Scene Date
6605	3	Hospital Procedure Start Date is earlier than EMS Unit Scene Departure Date
6606	3	Hospital Procedure Start Date is earlier than ED/Hospital Arrival Date
6607	2	Hospital Procedure Start Date is later than Hospital Discharge Date
6609	2	Element cannot be blank
6650	1	Multiple Entry Max exceeded



Procedure Stop Date and Time

Definition

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

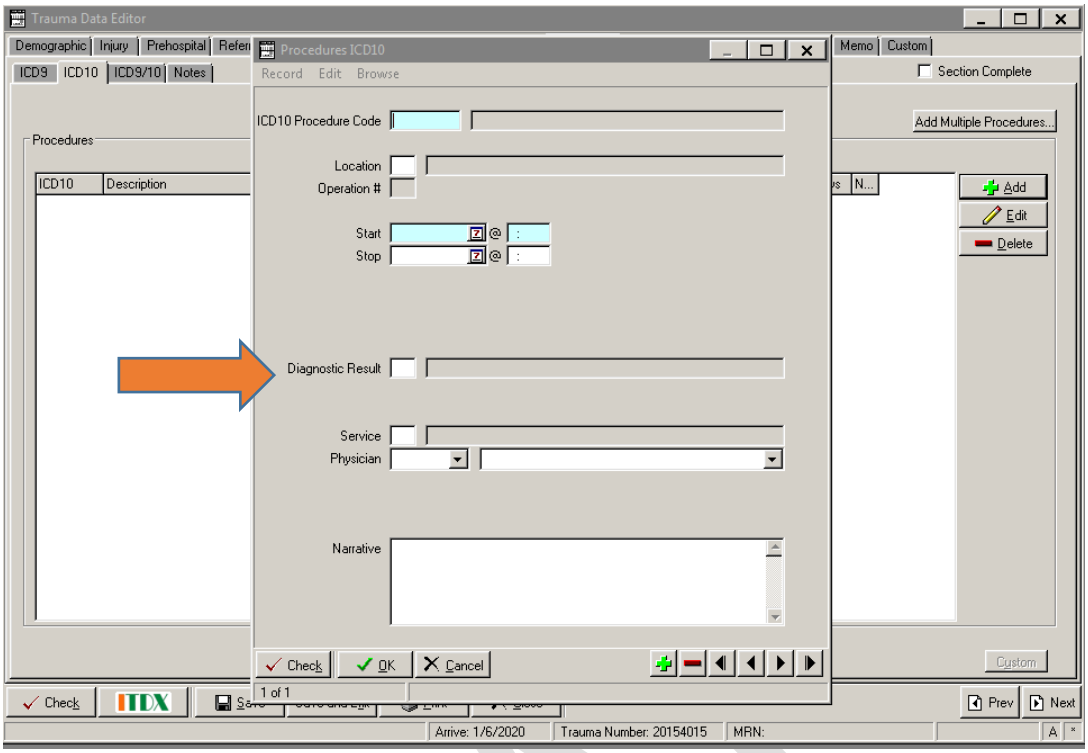
NOTE: Illinois recommendation to enter STOP times for ***invasive procedures only.***

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Anesthesia Notes
4. History and Physical
5. Progress Notes
6. Nursing Notes
7. ADT Events



Diagnostic Result

Definition

Did the procedure result in a diagnosis of a new injury or other medical issue being managed by the Trauma Team?

Element Values

1. Positive (or abnormal / IL definition).
2. Negative (or normal / IL definition).
3. Indeterminate (or equivocal / IL definition).
4. /. Not Applicable
5. /. Unknown

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Anesthesia Notes
4. History and Physical
5. Progress Notes
6. Nursing Notes

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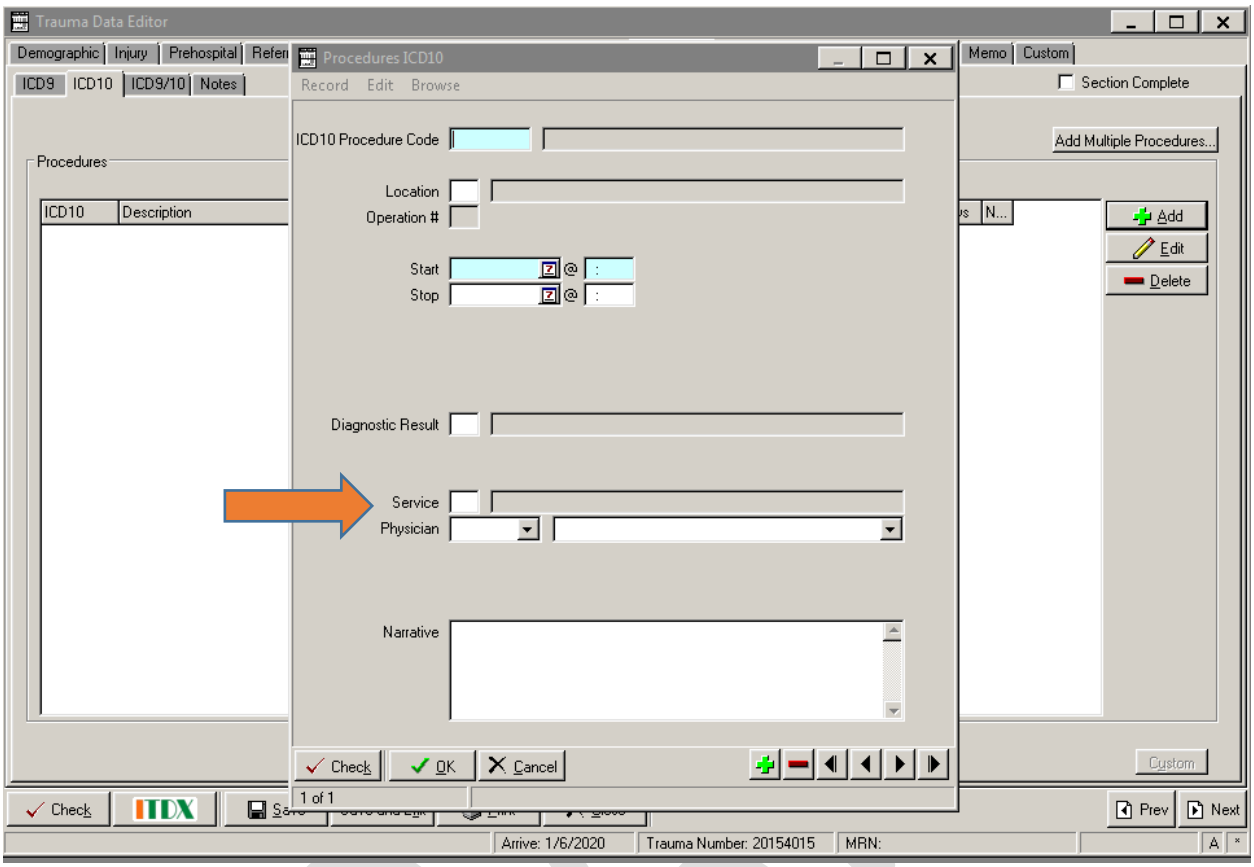

Service

Definition

The subspecialty service that performed or ordered the procedure.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Progress Notes
4. History and Physical
5. Nursing Note
6. Radiology Reports

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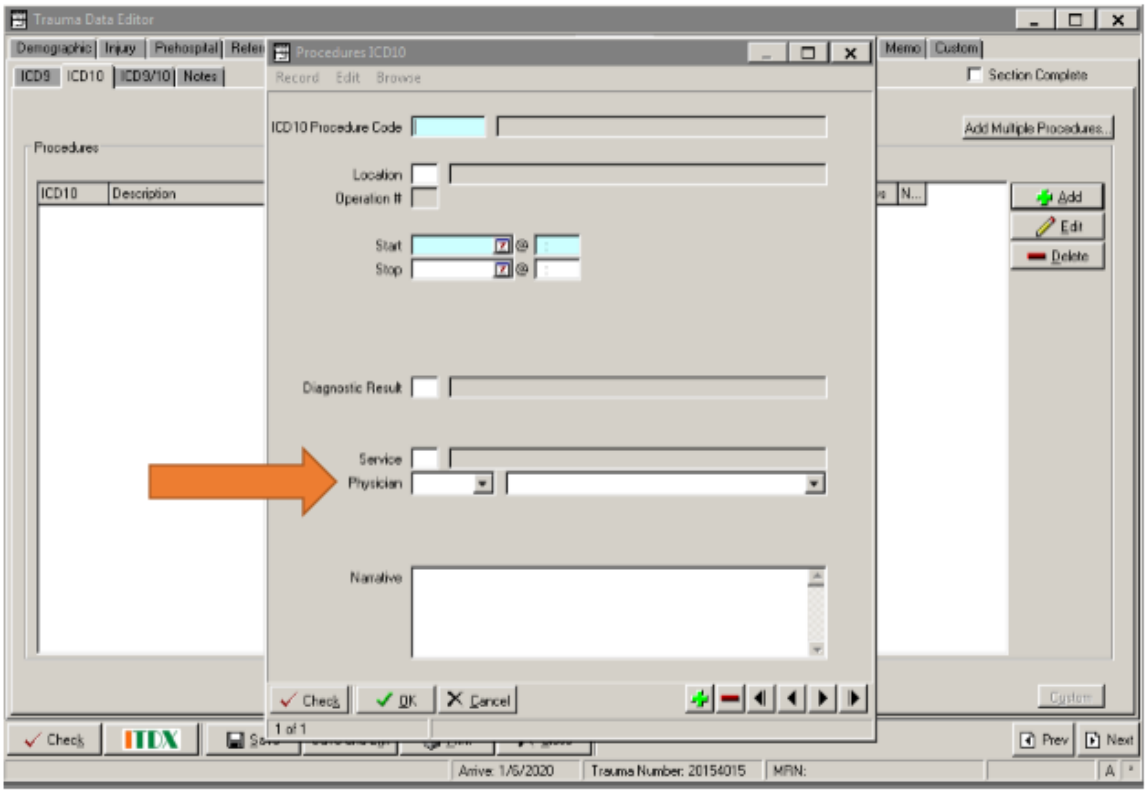

Physician

Definition

The physician responsible for performing the procedure.

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Progress Notes
4. History and Physical
5. Nursing Note
6. Radiology Reports

DRAFT

Diagnosis Codes

- There are three different ways to code diagnosis codes in the trauma registry.
    - One is the Tri-Code feature where the narrative information is typed into the box and the computer will assign ICD-10 and AIS codes. These codes need to be checked after they populate to ensure that they are accurate and meet the AIS coding rules.
    - The second way is to enter the AIS codes and then have them converted to ICD -10 codes. These codes need to be checked as well because AIS is not as comprehensive as the ICD-10 system.
    - The final way is to enter the ICD-10 codes and convert them to AIS codes. These codes also need to be checked for accuracy.
    - *EDITOR NOTE: Would be nice for DI to enter their 'hierarchy insight' here that they verbalized during training. Well said and would be helpful, but I didn't write it down. MBV*
- The most significant injury should be listed first. There is an option to Reorder the List of diagnosis and Edit them to correctly align both AIS and ICD-10 codes.
- Once the diagnosis codes are in, along with the ED initial vitals, GCS, Age, and Mechanism of Injury, the ISS, TRISS, and NISS scores will auto-populate. ISS and NISS will populate just based off the severity of the AIS codes, TRISS scores need more information.

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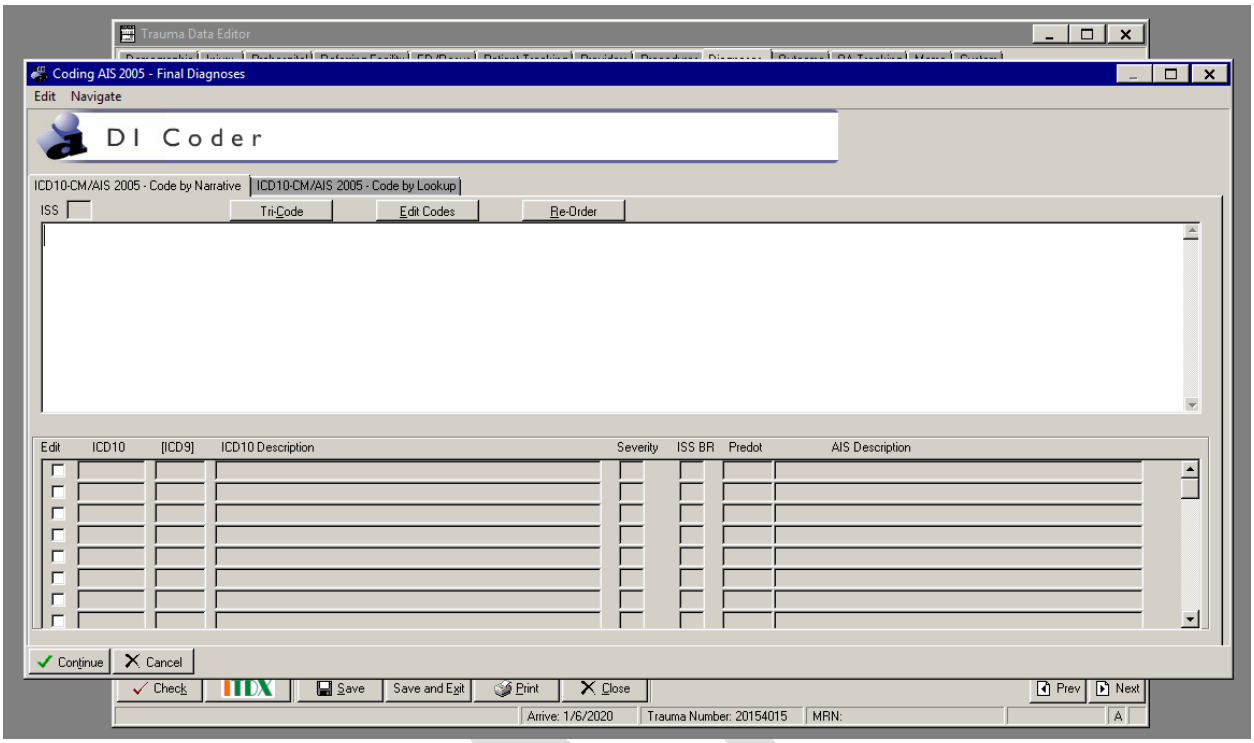
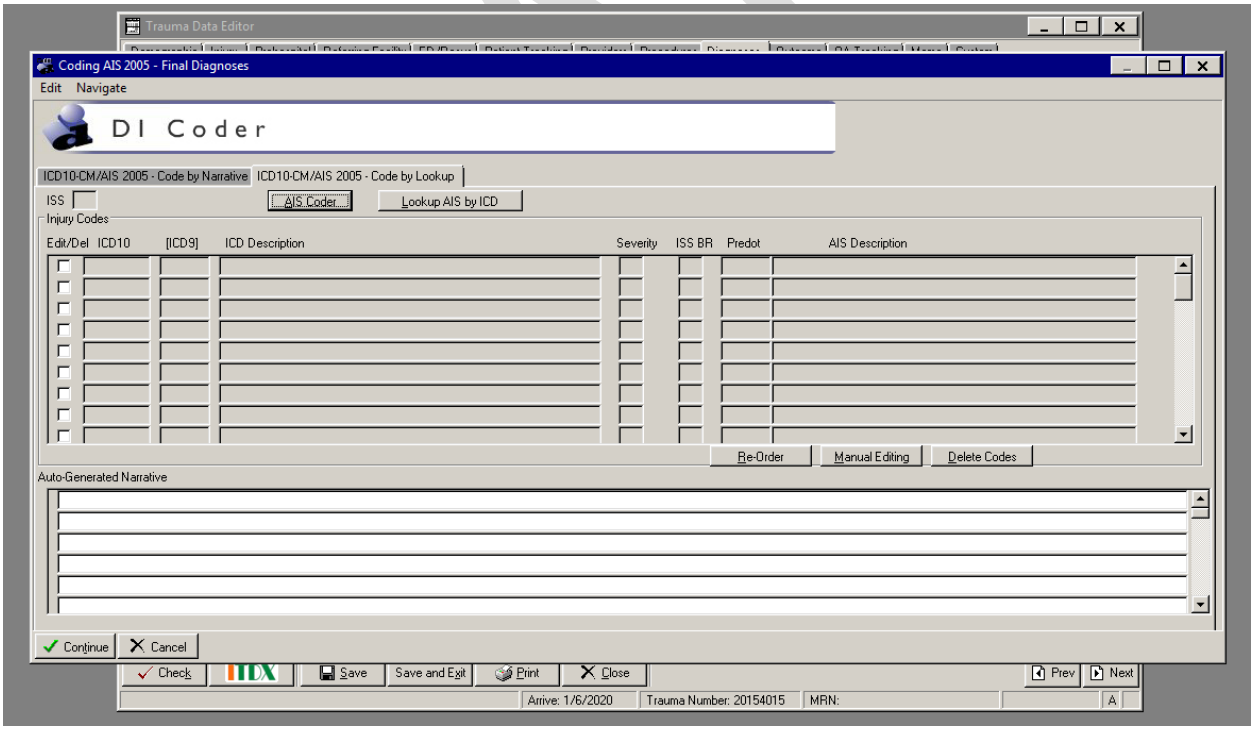




<u>DIAGNOSES</u>: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

NTDS definitions for the mandated ICD-10 and AIS codes are on the next 2 pages.

ICD-10 INJURY DIAGNOSES

Definition

Diagnoses related to all identified injuries.

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28 and T30-T32.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
8701	1	Invalid value (ICD-10-CM only)
8702	2	Element cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CM only)
8705	1	Invalid value (ICD-10-CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CA only)
8750	1	Multiple Entry Max exceeded

AIS CODE

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

Element Values
- The code is the 8 digit AIS code

Additional Information

Data Source Hierarchy Guide
1. AIS Coding Manual

Associated Edit Checks

Rule ID	Level	Message
21001	1	Invalid value
21004	2	AIS codes submitted are not valid AIS 05, Update 08, or AIS 2015 codes
21007	2	Element cannot be blank
21008	2	Element cannot be "Not Applicable"
21050	1	Multiple Entry Max exceeded

AIS VERSION

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

Element Values
6. AIS 05, Update 08

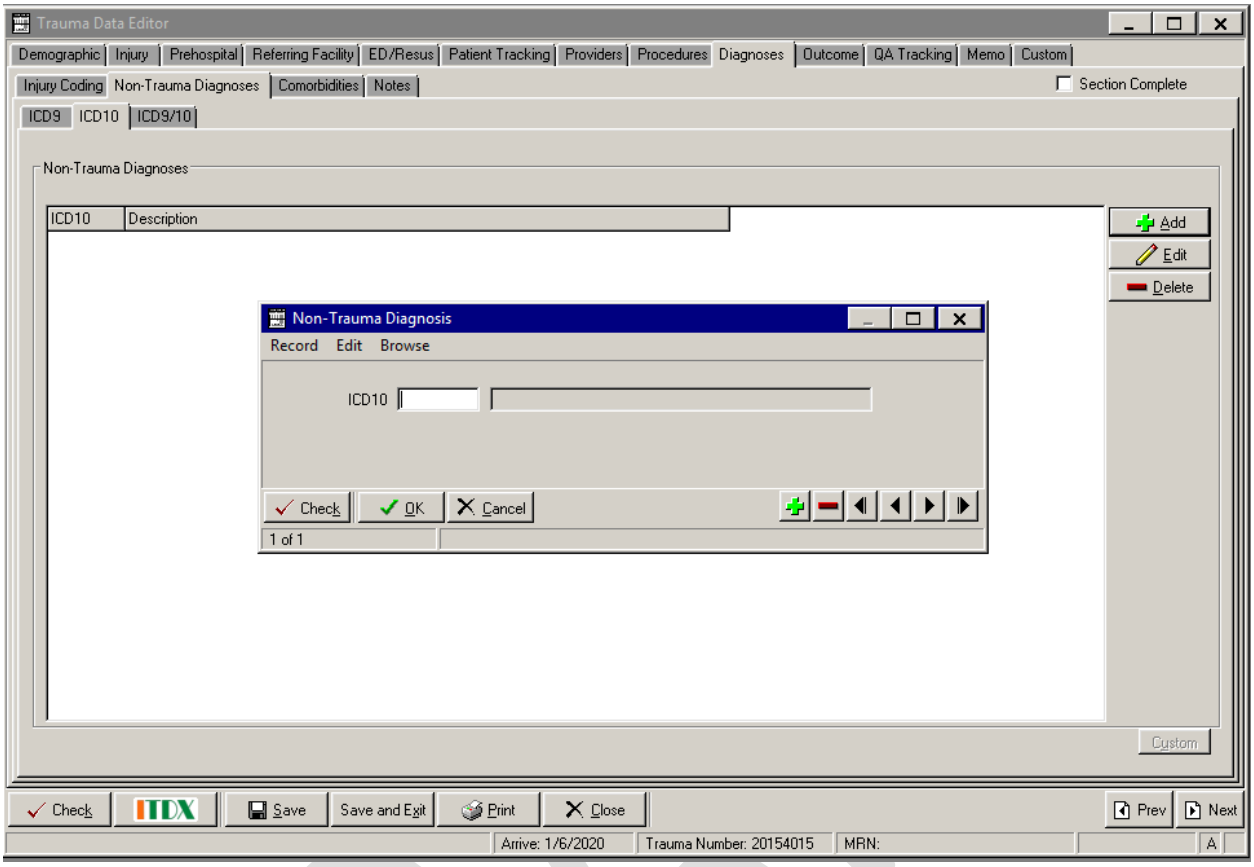
16. AIS 2015

Additional Information

Data Source Hierarchy Guide
1. AIS Coding Manual

Associated Edit Checks

Rule ID	Level	Message
7301	1	Value is not a valid menu option
7302	2	Element cannot be blank
7303	2	Element cannot be "Not Applicable"
7340	1	Single Entry Max exceeded



Non-Trauma Diagnosis

Definition

All other medical diagnoses that are not related to the injury diagnoses.

No minimum entry requirement for IL Trauma Registry.

Element Values

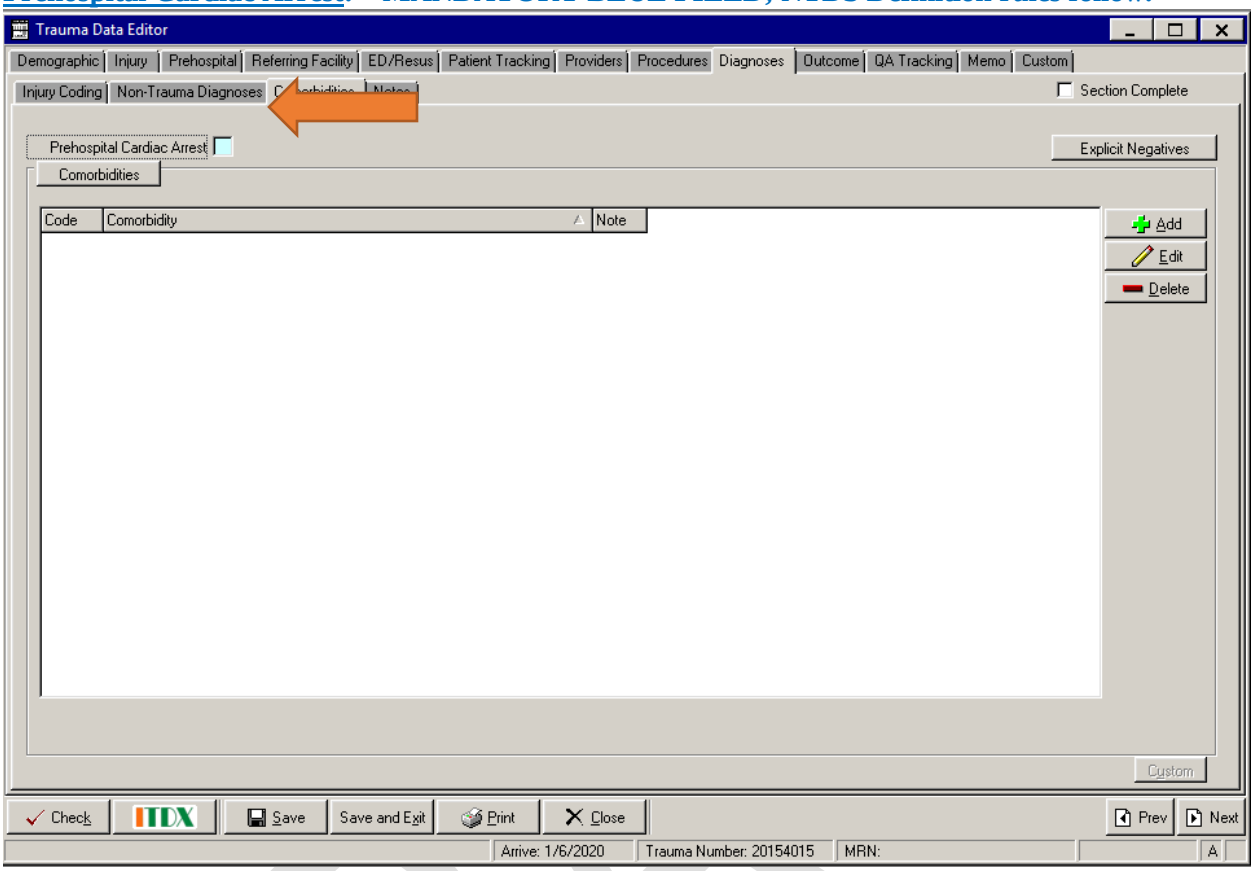
- Relevant Data for Element Value

Data Source Hierarchy Guide

1. Progress Notes
2. Nursing Notes
3. Consult Notes
4. History and Physical
5. Radiology Reports
6. Autopsy Reports
7. Lab Values

DRAFT

Prehospital Cardiac Arrest: MANDATORY BLUE FIELD; NTDS Definition rules follow.



PRE-HOSPITAL CARDIAC ARREST

Definition

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

Element Values

1. Yes
2. No

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the index hospital. Pre-hospital cardiac arrest could occur at a transferring institution.
- Any component of basic and/or advanced cardiac life support must have been initiated.

Data Source Hierarchy Guide

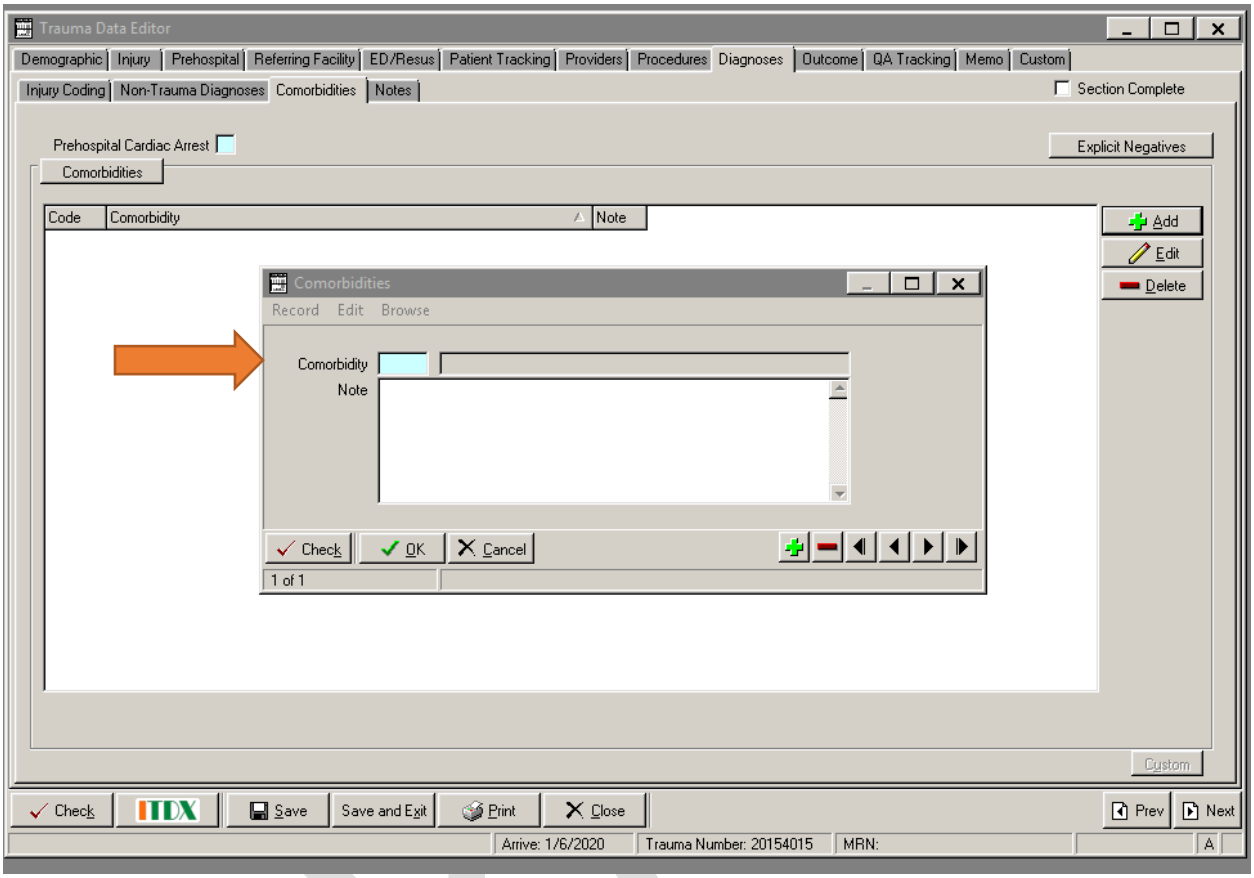
1. EMS Run Report
2. Nursing Notes/Flow Sheet
3. History & Physical
4. Transfer Notes

Associated Edit Checks

Rule ID	Level	Message
9701	1	Value is not a valid menu option
9702	2	Element cannot be blank
9703	2	Element cannot be "Not Applicable"
9740	1	Single Entry Max exceeded

DRA

<u>Pre-Existing Conditions / Co Morbidities</u>: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**



<u>Pre-Existing Conditions / Comorbidities:</u>

<u>Definition</u>

Medical conditions that existed prior to the patient becoming injured.

<u>NOTE</u>: Please refer to the NTDS Data Dictionary for the specifics regarding pre-existing conditions. (Multiple page reference with very specific definitions).

<u>Element Values</u>

- Relevant Data for Element Value

<u>Data Source Hierarchy Guide</u>

1. History and Physical
2. Nursing Notes/Triage Flowsheet
3. Progress Notes
4. Consult Notes
5. Previous Patient Encounters

Outcome

- The total ICU, Ventilator, and Hospital days will calculate based on the information that has already been placed in the chart.
- Remember the NTDS Discharge Order date and time signify the end of the patient's stay. Please make sure you are utilizing the final order if multiple orders are placed and cancelled. Anything documented after the discharge order date and time will not be included.
- The Death tab will only be accessible if the discharge status is marked as Dead. The Initial Discharge 2 tab will only be accessible if the discharge status is marked Alive.
- In the Billing Section, the account number will auto-populate from the initial demographics page.
- Total charges collected and last date collected will generate off of the information placed regarding payments and dates in the above section.

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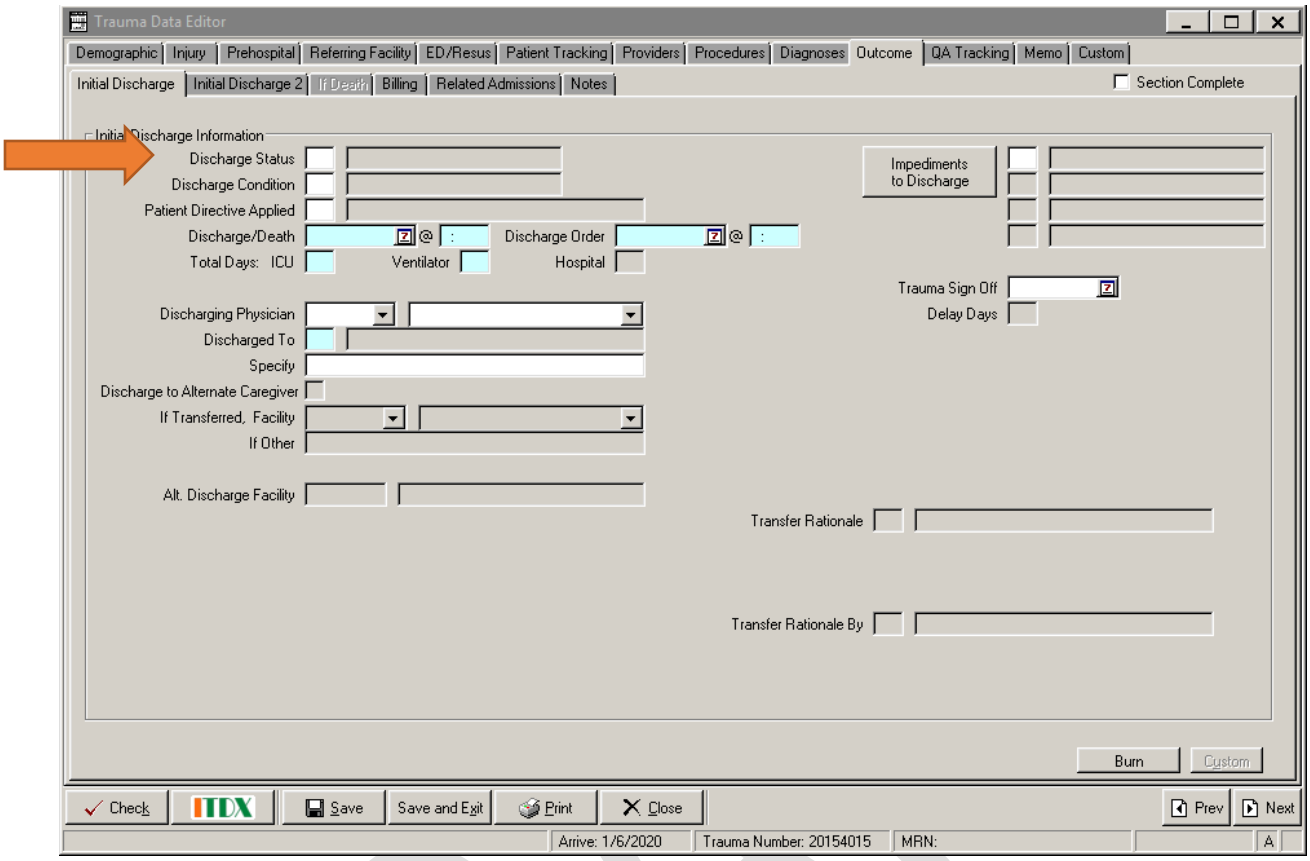

Discharge Status

Definition

Is the patient alive or deceased at discharge?

Element Values

1. Alive
2. Dead

Data Source Hierarchy Guide

1. Discharge Summary
2. Post-Mortem Flowsheet
3. Nursing Notes

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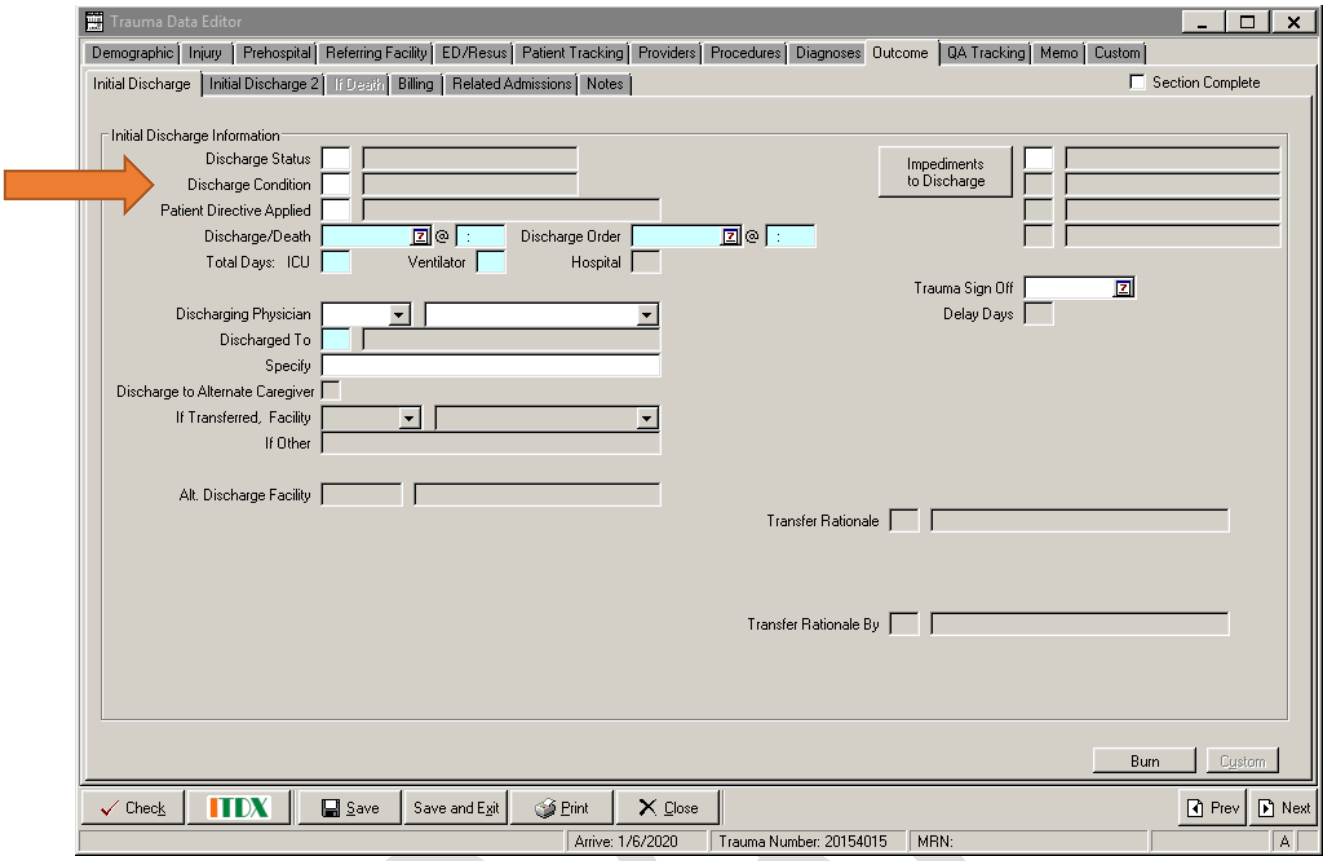


Discharge Condition

Definition

The condition of the patient compared to previous health at discharge

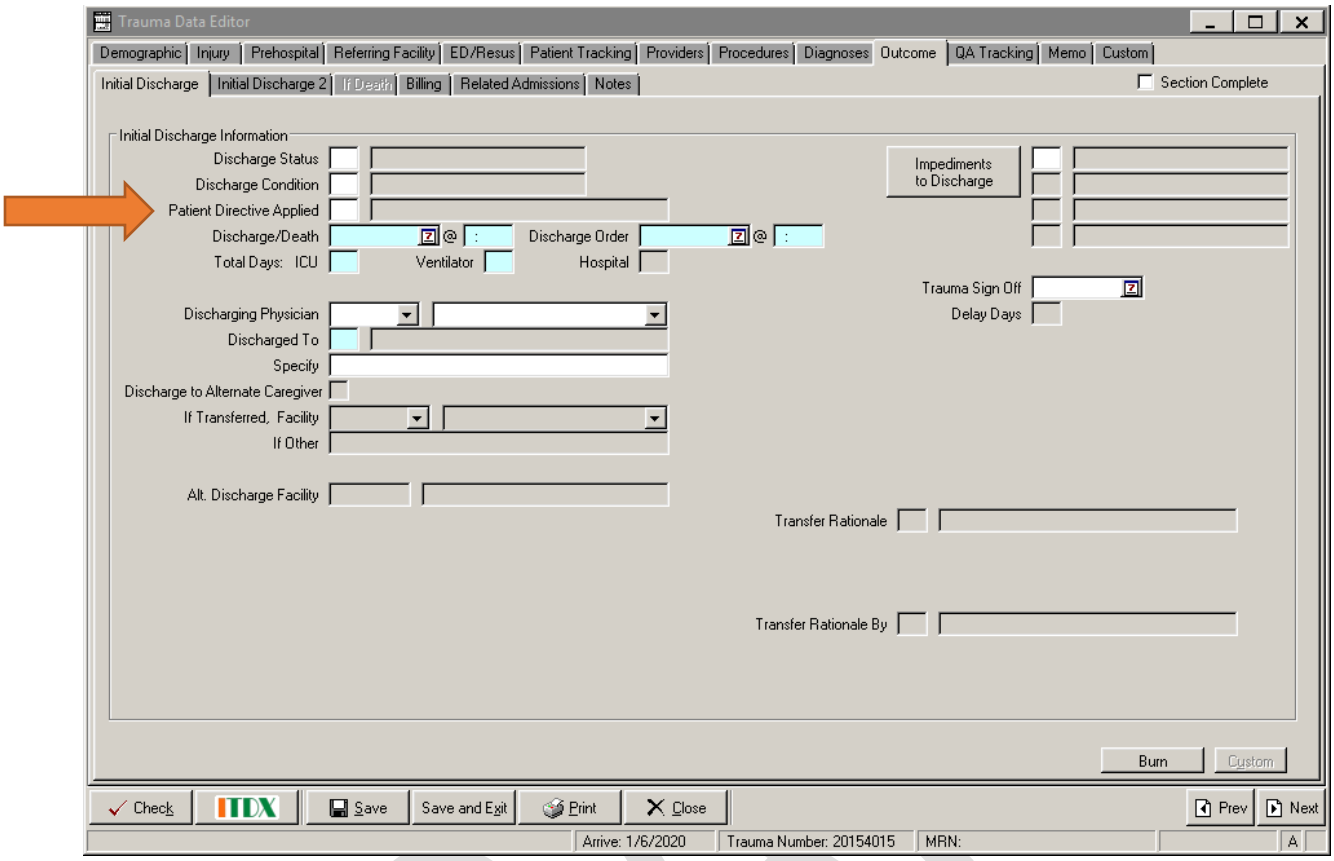
Element Values

1. Discharge with Previous Level of Function
2. Temporary Disability Expected to Return to Previous Level of Function
3. Moderate Disability with Expected Ability for Self-Care
4. Severe Disability
5. Persistent Vegetative State
6. Dead

?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Post-Mortem Flowsheet
4. Nursing Notes



Patient Directive Applied

Definition

Did the patient have an advanced directive that was utilized during their hospital stay?

Element Values

1. Care Directive Applied
2. Care Directive Not Applied
3. No Care Directive Provided

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
5. Advanced Directives form or scanned document

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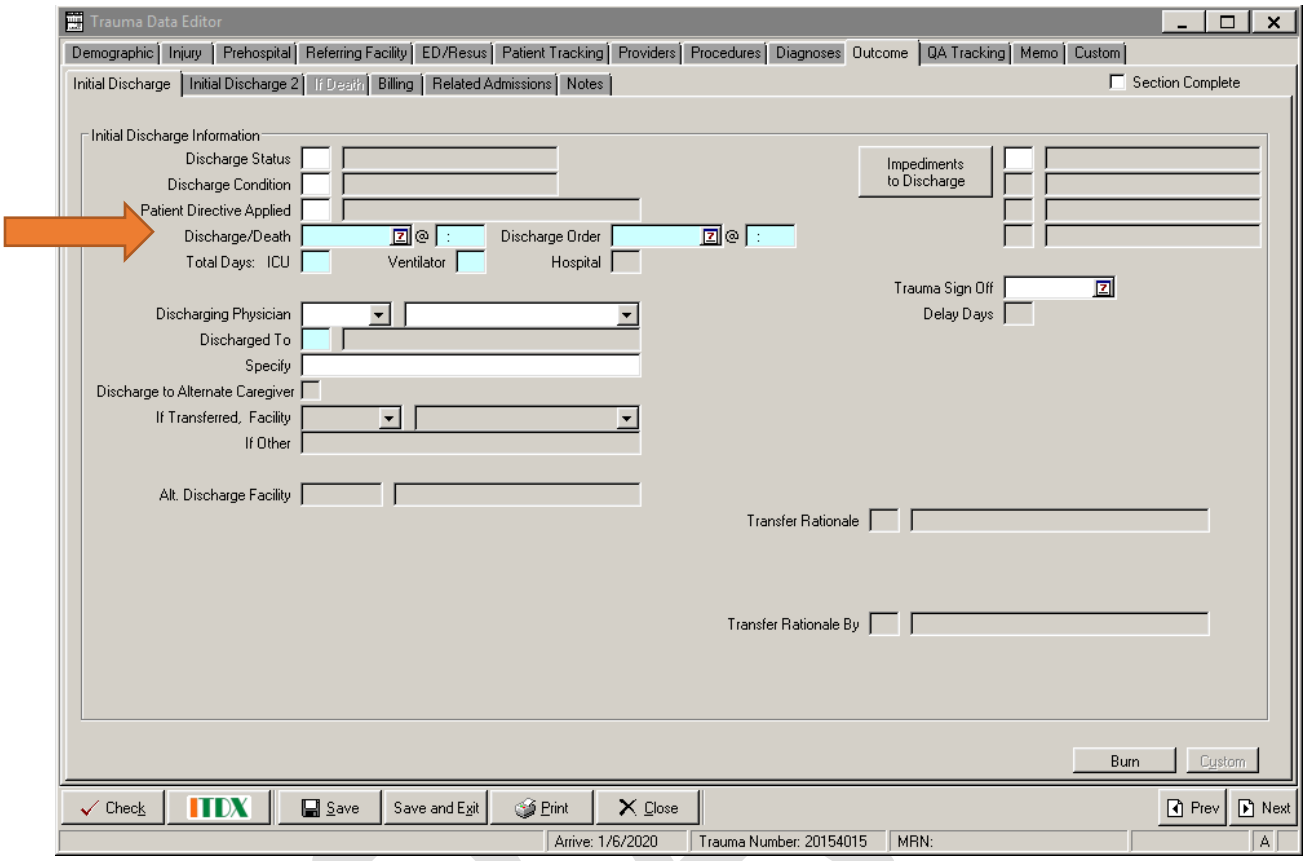
Discharge / Death Time and Date: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**



Discharge/Death Date and Time:

Definition

The actual time and date that the patient left your facility.

NOTE: Please note this is the actual date and time the patient left the facility or was pronounced.

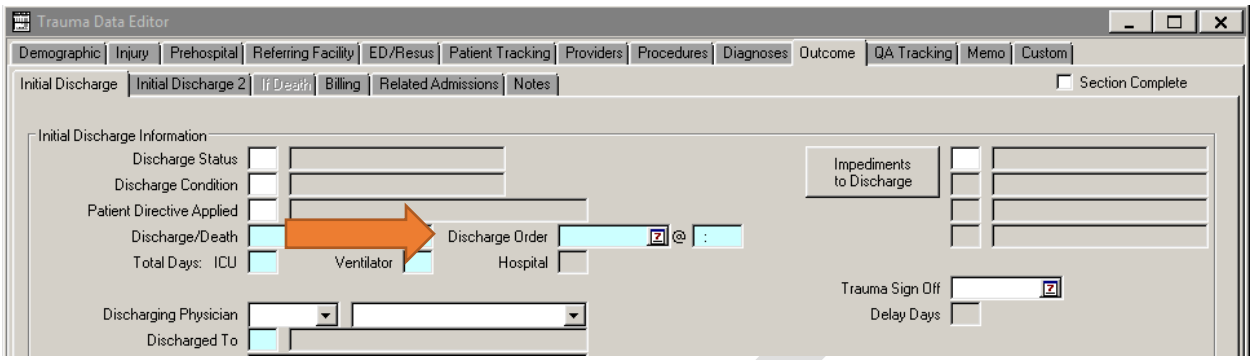
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Discharge Summary
3. Nursing Notes
4. Post – Mortem Flowsheet

Discharge Order Date: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**



HOSPITAL DISCHARGE DATE

Definition

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.

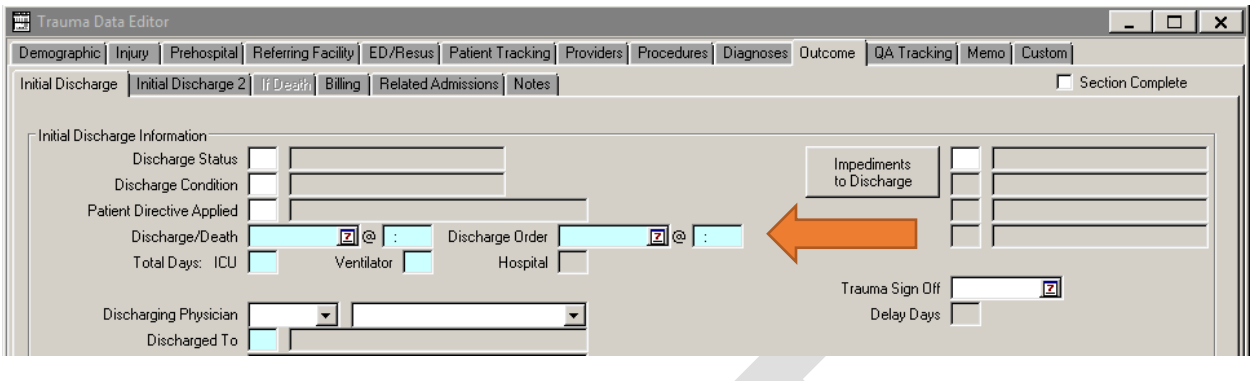
Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Element cannot be blank
7704	3	Hospital Discharge Date is earlier than EMS Dispatch Date
7705	3	Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date
7706	3	Hospital Discharge Date is earlier then EMS Unit Scene Departure Date
7707	2	Hospital Discharge Date is earlier than ED/Hospital Arrival Date
7708	2	Hospital Discharge Date is earlier than ED Discharge Date
7709	2	Hospital Discharge Date is earlier than Date of Birth
7710	3	Hospital Discharge Date minus Injury Incident Date is greater than 365 days
7711	3	Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
7712	2	Element must be "Not Applicable" when ED Discharge Disposition is 4,5, 6, 9,10, or 11
7740	1	Single Entry Max exceeded

Discharge Order Time: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**



HOSPITAL DISCHARGE TIME

Definition

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

Element Values

- Relevant value for data element

Additional Information

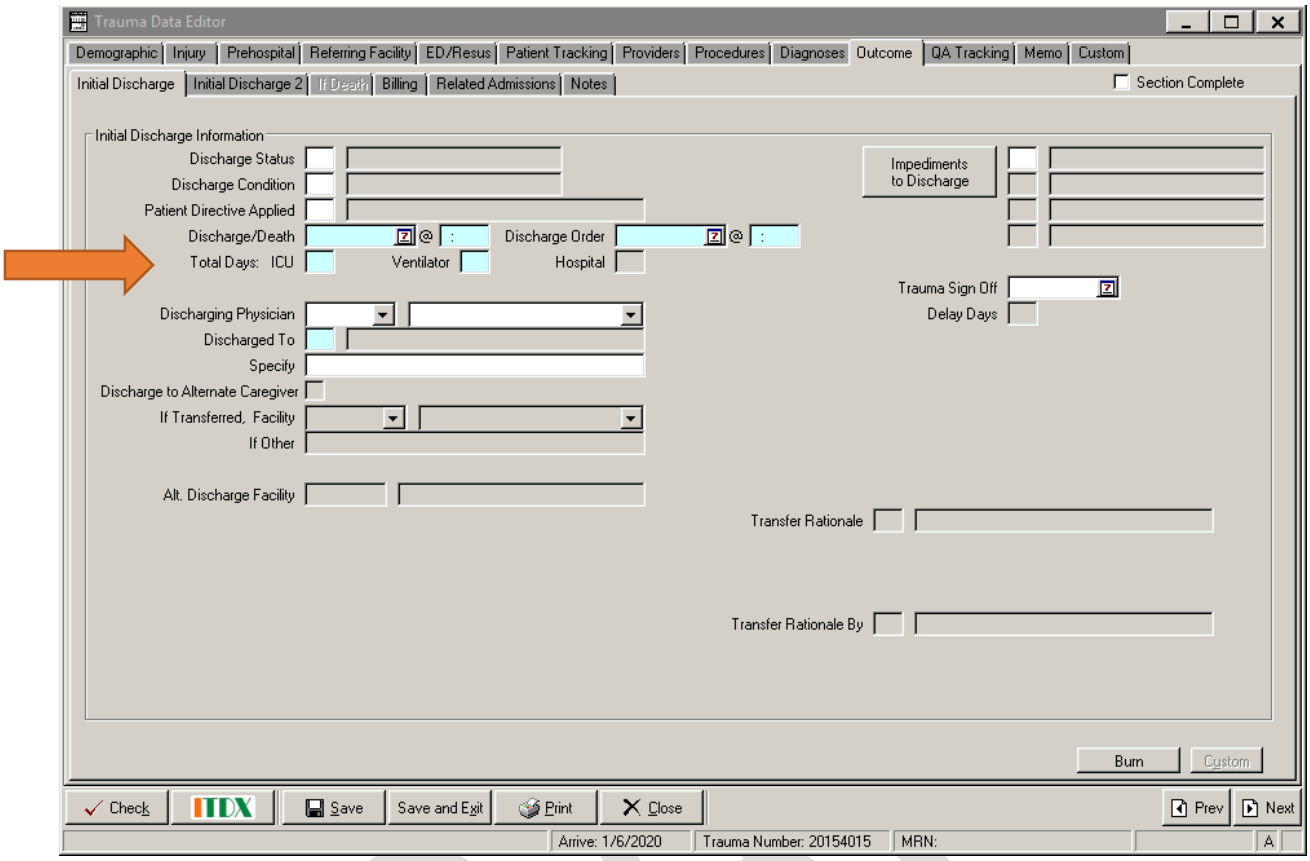
- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Element cannot be blank
7804	3	Hospital Discharge Time is earlier than EMS Dispatch Time
7805	3	Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time
7806	3	Hospital Discharge Time is earlier than EMS Unit Scene Departure Time
7807	2	Hospital Discharge Time is earlier than ED/Hospital Arrival Time
7808	2	Hospital Discharge Time is earlier than ED Discharge Time
7809	2	Element must be "Not Applicable" when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
7840	1	Single Entry Max exceeded



NOTE: Total Days: ICU, Ventilator and Hospital will auto-populate from the Patient Tracking tab entries.
If you feel they are inaccurate, you need to return to that tab / screen to edit.

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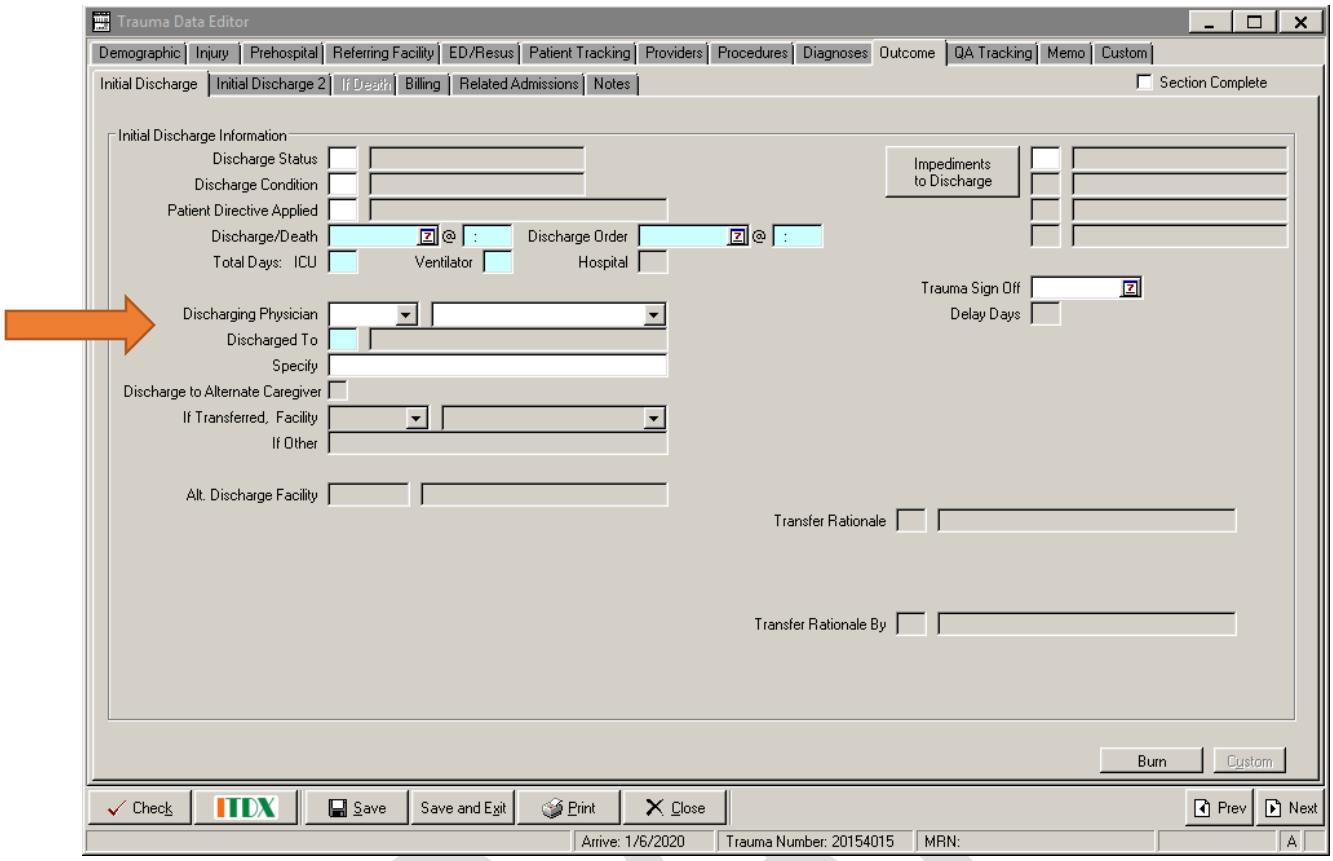


Discharging Physician

Definition

The provider that is discharging the patient from your facility.

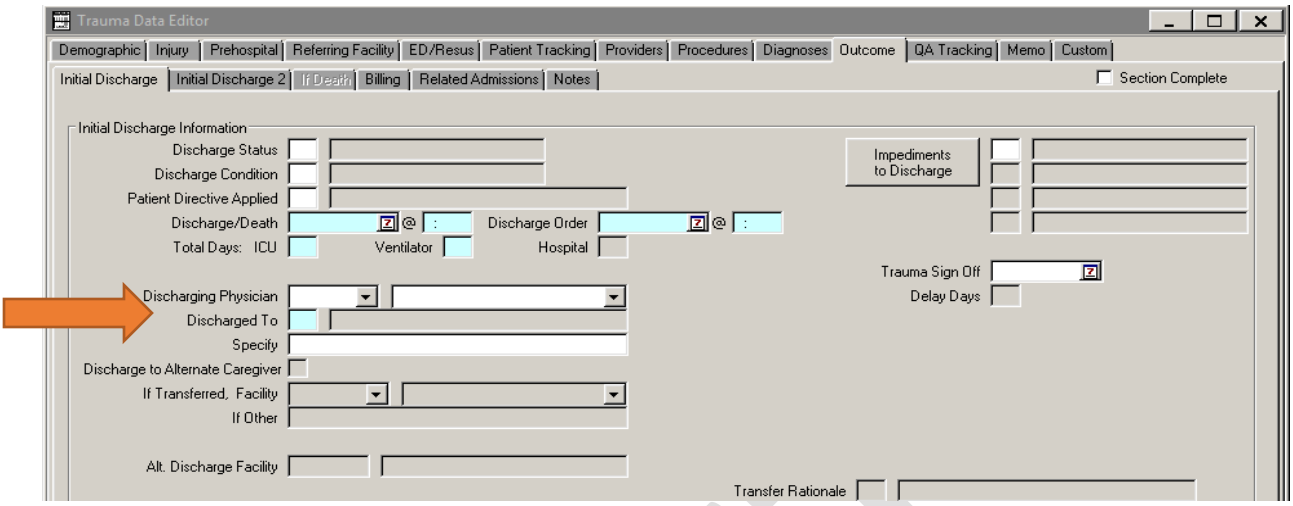
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Discharge Summary
2. Discharge Order
3. Nursing Notes

DRAFT



HOSPITAL DISCHARGE DISPOSITION

Definition

The disposition of the patient when discharged from the hospital.

Element Values

1. Discharged/Transferred to a short-term general hospital for inpatient care
2. Discharged/Transferred to an Intermediate Care Facility (ICF)
3. Discharged/Transferred to home under care of organized home health service
4. Left against medical advice or discontinued care
5. Deceased/Expired
6. Discharged to home or self-care (routine discharge)
7. Discharged/Transferred to Skilled Nursing Facility (SNF)
8. Discharged/Transferred to hospice care
10. Discharged/Transferred to court/law enforcement.
11. Discharged/Transferred to inpatient rehab or designated unit
12. Discharged/Transferred to Long Term Care Hospital (LTCH)
13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
14. Discharged/Transferred to another type of institution not defined elsewhere

Additional Information

- Element value "6. Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).
- Element values based upon UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be reported as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

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

DI Data Element Numbers / Choices

40. Home or Self-Care (Routine Discharge)

41. Home with Services (Home Health Care)

42. Left AMA

43. Correctional Facility/Court/Law Enforcement

44. Morgue

45. Child Protective Agency

70. Acute Care Facility (Hospital for Inpatient Care)

71. Intermediate Care Facility (Step Down Hospital)

72. Skilled Nursing Facility

73. Rehab (Inpatient)

74. Long-Term Care (LTAC Facility/Vent)

75. Hospice

76. Mental Health/Psychiatric Hospital (Inpatient)

77. Nursing Home

79. Another Type of Inpatient Facility Not Defined Elsewhere

80. Burn Center

?. Unknown

NOTES:

- If the patient returns to the environment from which they came, that disposition is entered as #40 (home).
    - Example: Patient admitted from Skilled Nursing Facility (SNF, ECF) following fall and returns back to the SNF / ECF care setting, NTDS considers this a return HOME. If the patient came from Assisted Living (ALF) and is discharged to Skilled Nursing (SNF, ECF), that would be entered as 72 (Skilled Nursing Facility) since the level of care changed.
- Rehab (#73) references Inpatient, CARF-certified multidisciplinary Rehab Programs. Therapy programs at skilled care facilities do not meet this definition, regardless of facility name.

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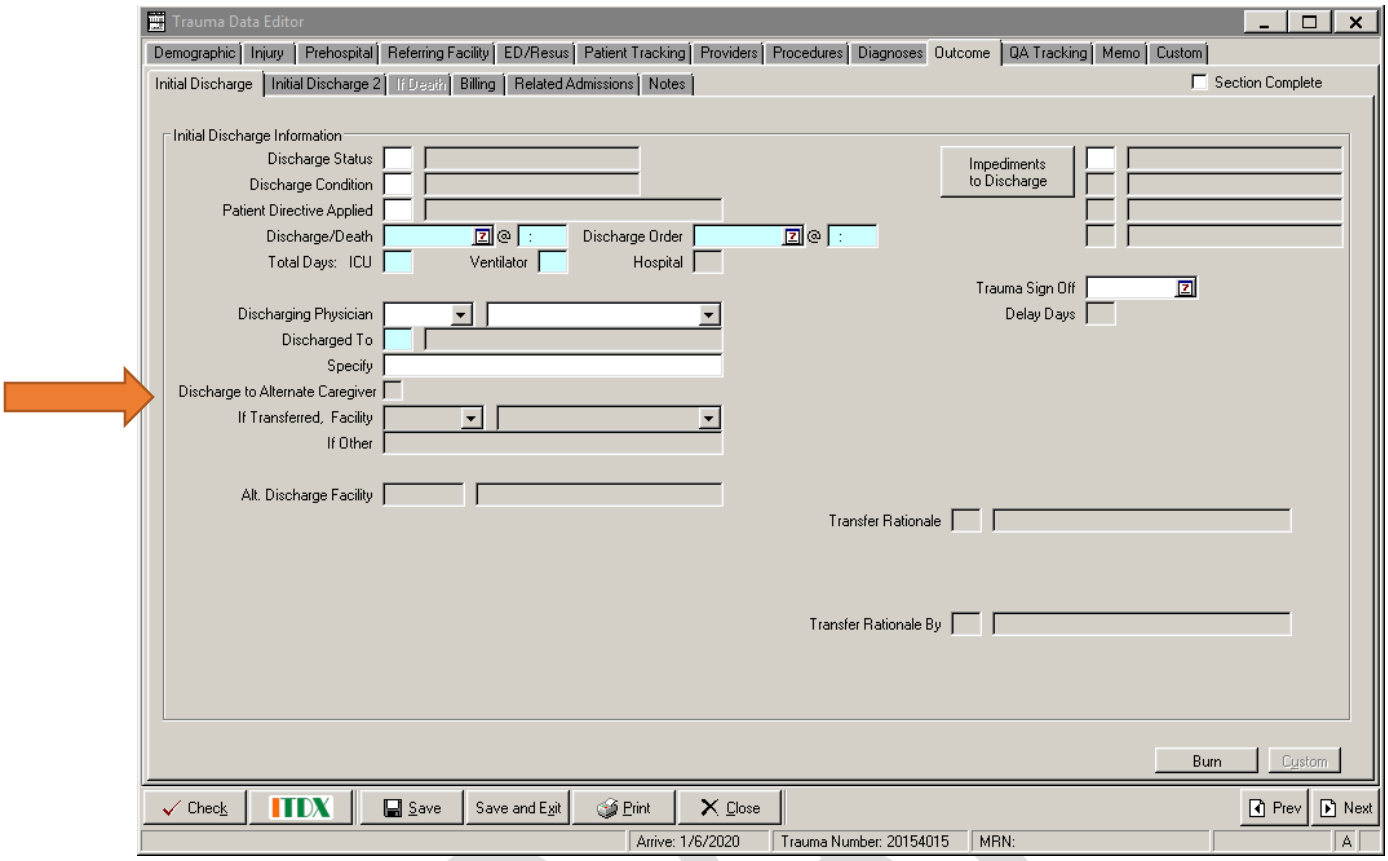

Discharge to Alternate Caregiver

Definition

Was the patient discharged with a different person than the person that primarily cares for them or lives with them?

NOTE: Will only populate if there is a Y (yes) in the report of physical abuse in the Injury Section

Element Values

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

Data Source Hierarchy Guide

1. Discharge Summary
2. Child Abuse Physician Notes
3. Case Management Notes
4. Child Protective Service Notes
5. Nursing Notes

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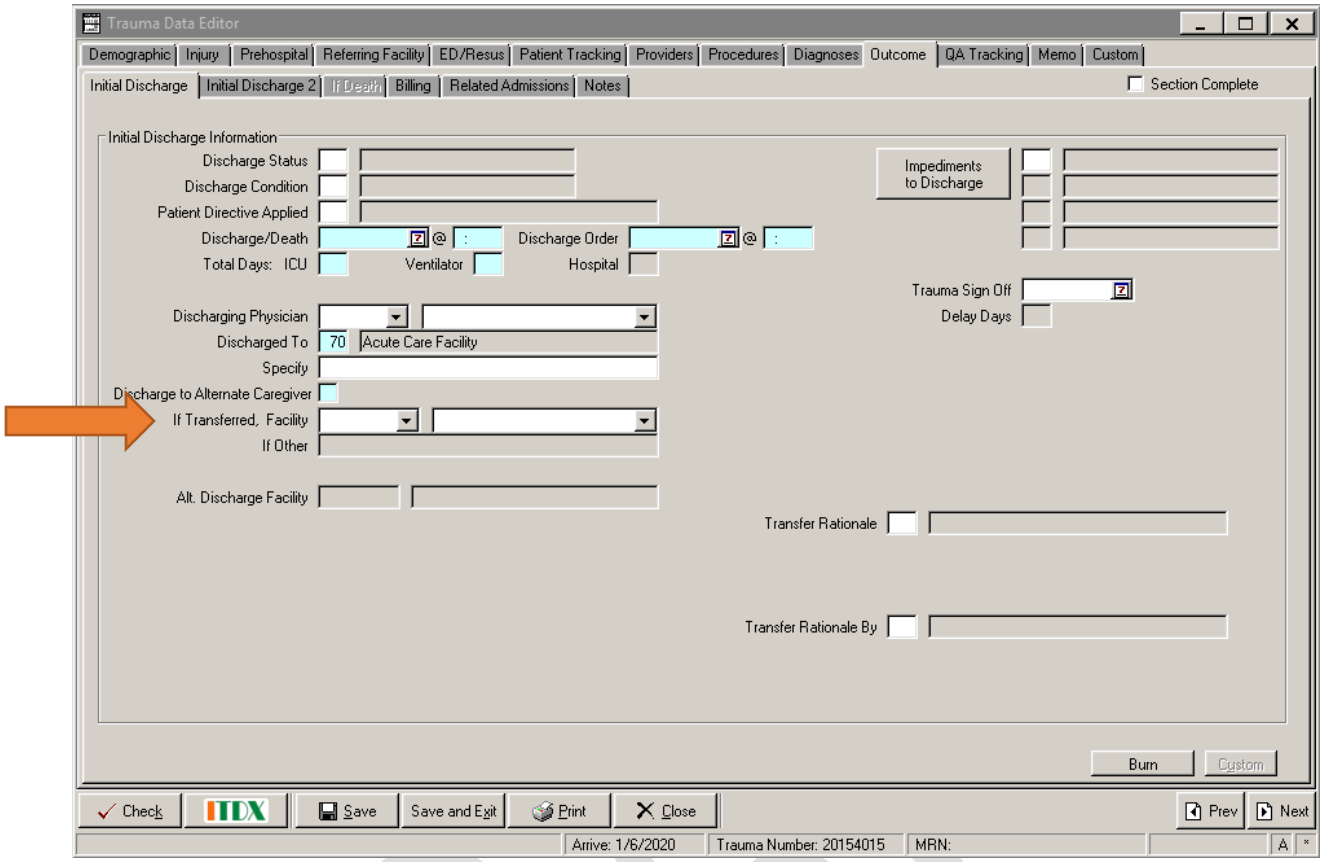

If Transferred, Facility

Definition

The facility that the patient was transferred to, if the patient was transferred out of your hospital.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

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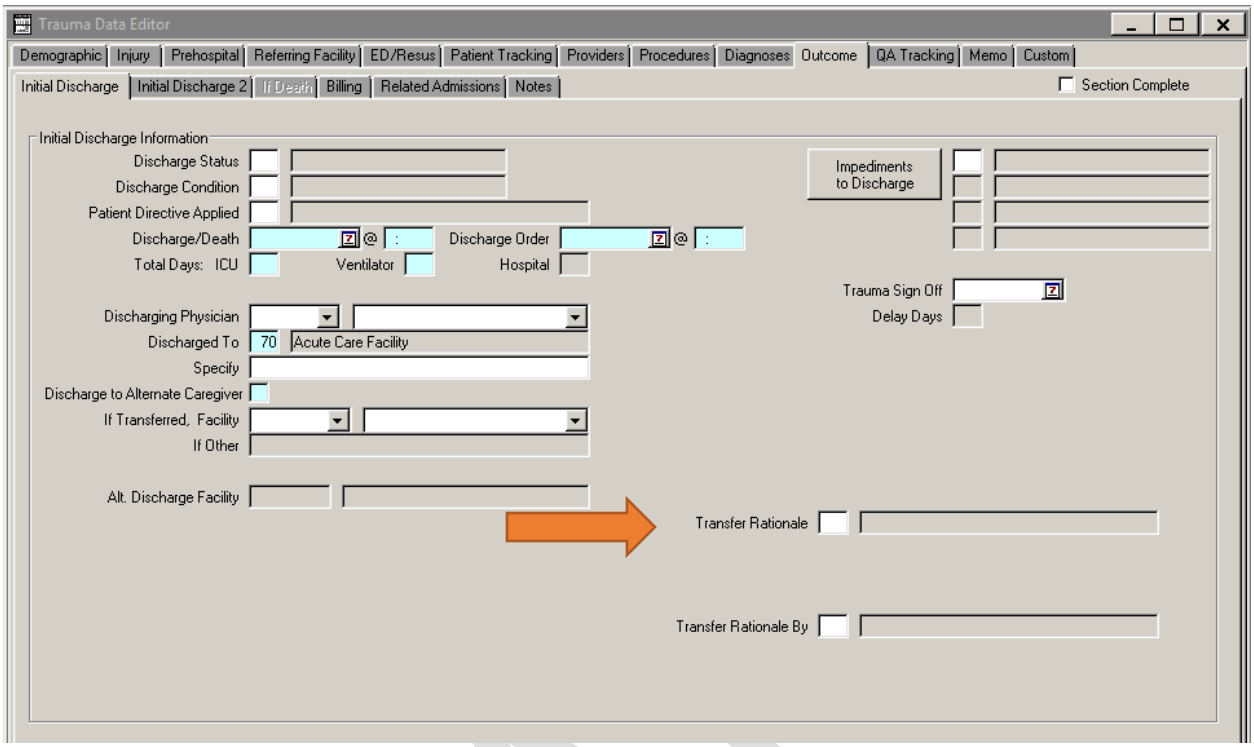

Transfer Rationale

Definition

The reason why the patient was transferred out of your facility

Element Values

1. Economic
2. Level of Care
3. Personal
4. System Protocol
5. Other
6. Pediatrics/PICU
7. Neurosurgery
8. OB Care
9. Cardiothoracic Care
10. Orthopedic Care
11. Urology
12. Ophthalmology
13. Oral/dental care services
14. ENT
15. Plastics/maxillofacial services
16. Burn Unit
17. Replantation
18. Spinal Cord Injury Management
19. Other Specialty

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

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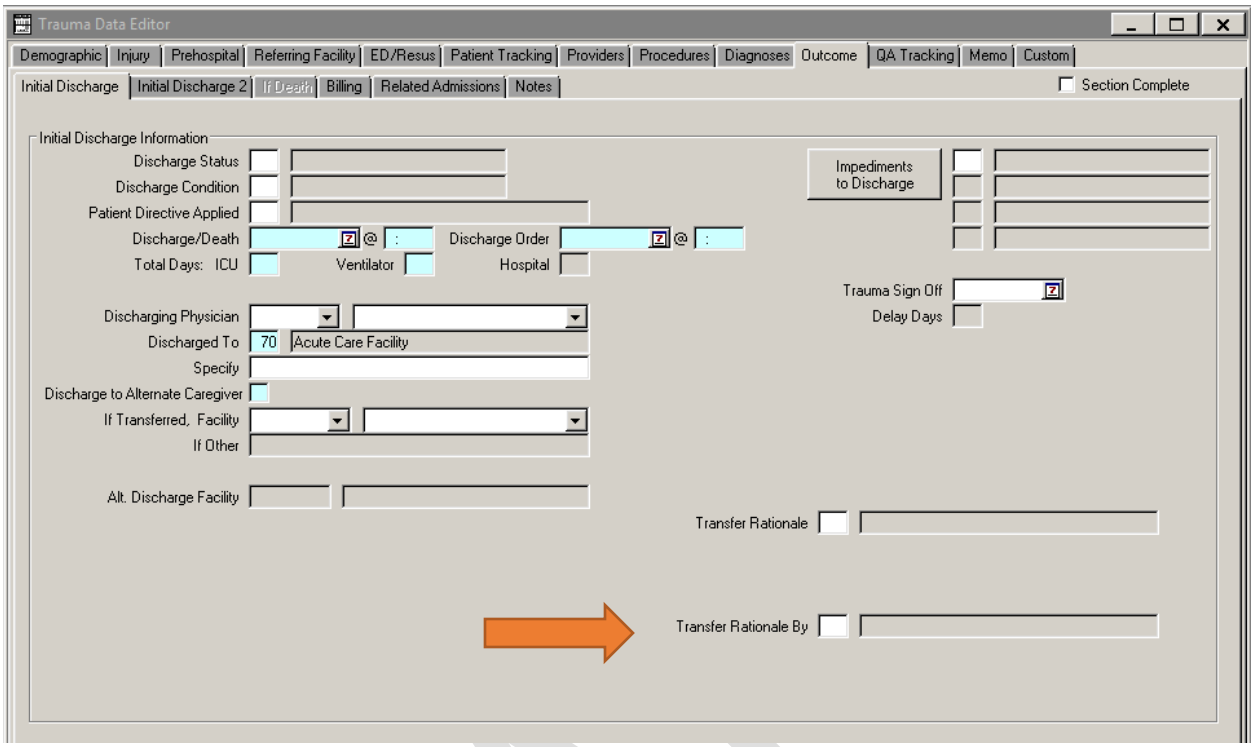

Transfer Rationale By

Definition

The person that made the decision to transfer the patient out of the facility.

Element Values

1. Physician
2. Patient
3. Payor

/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes

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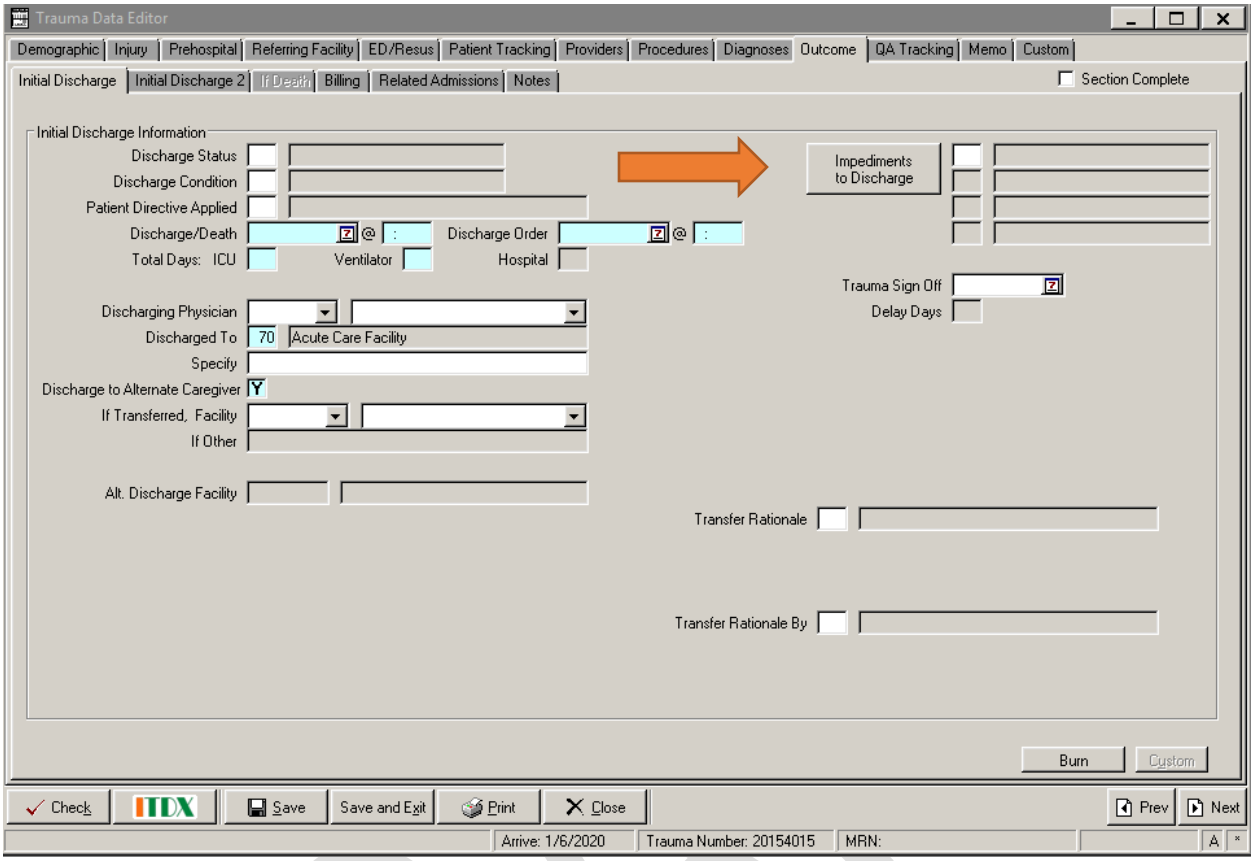


Impediments to Discharge

Definition

Any issues or contributing factors to the patient's ***discharge being delayed.***

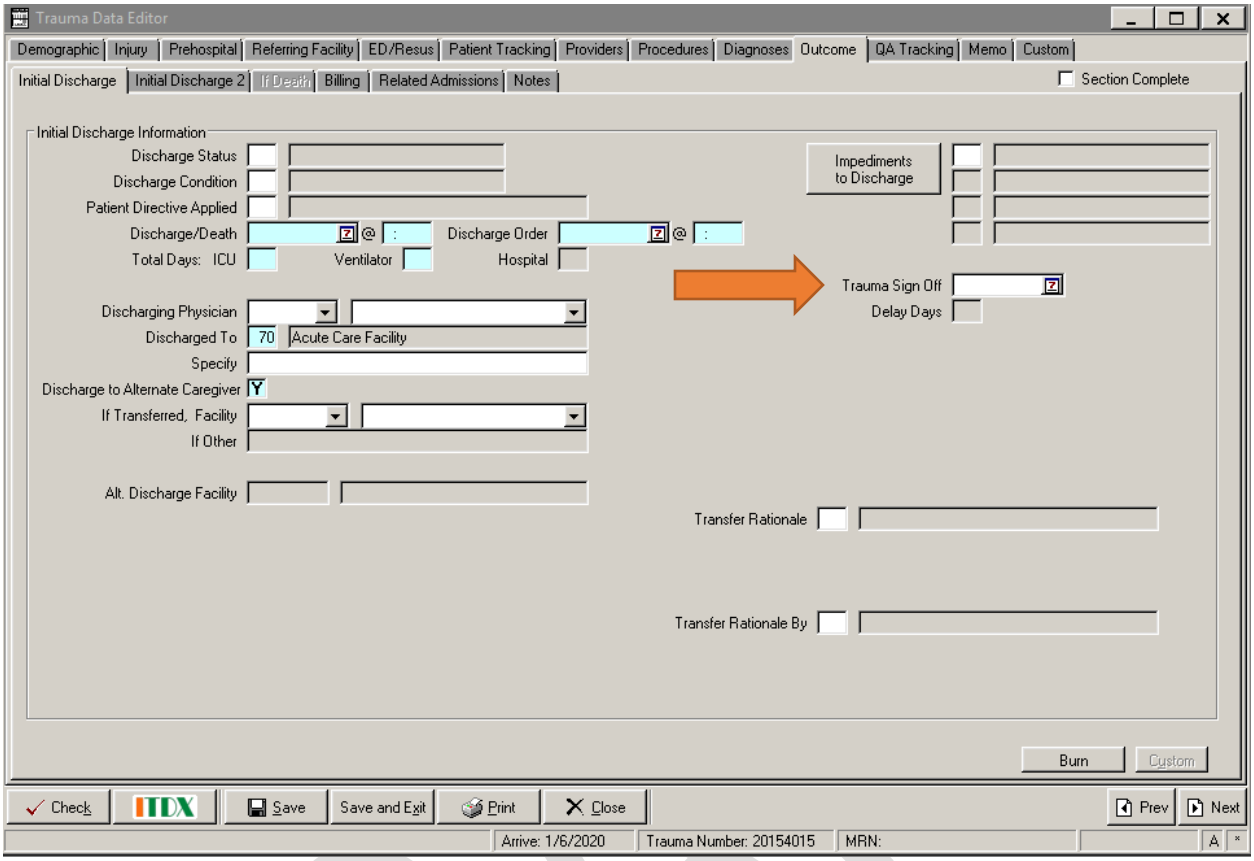
Element Values

0. None
1. Delay in Discharge Plan
2. Financial
3. Homeless
4. Legal
5. Non-availability of Transfer Facility
6. Psychiatric
7. Social
8. Other

?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes



Trauma Sign Off

Definition

The date that trauma services handed over primary care to another service.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Progress Notes
2. Consult Notes

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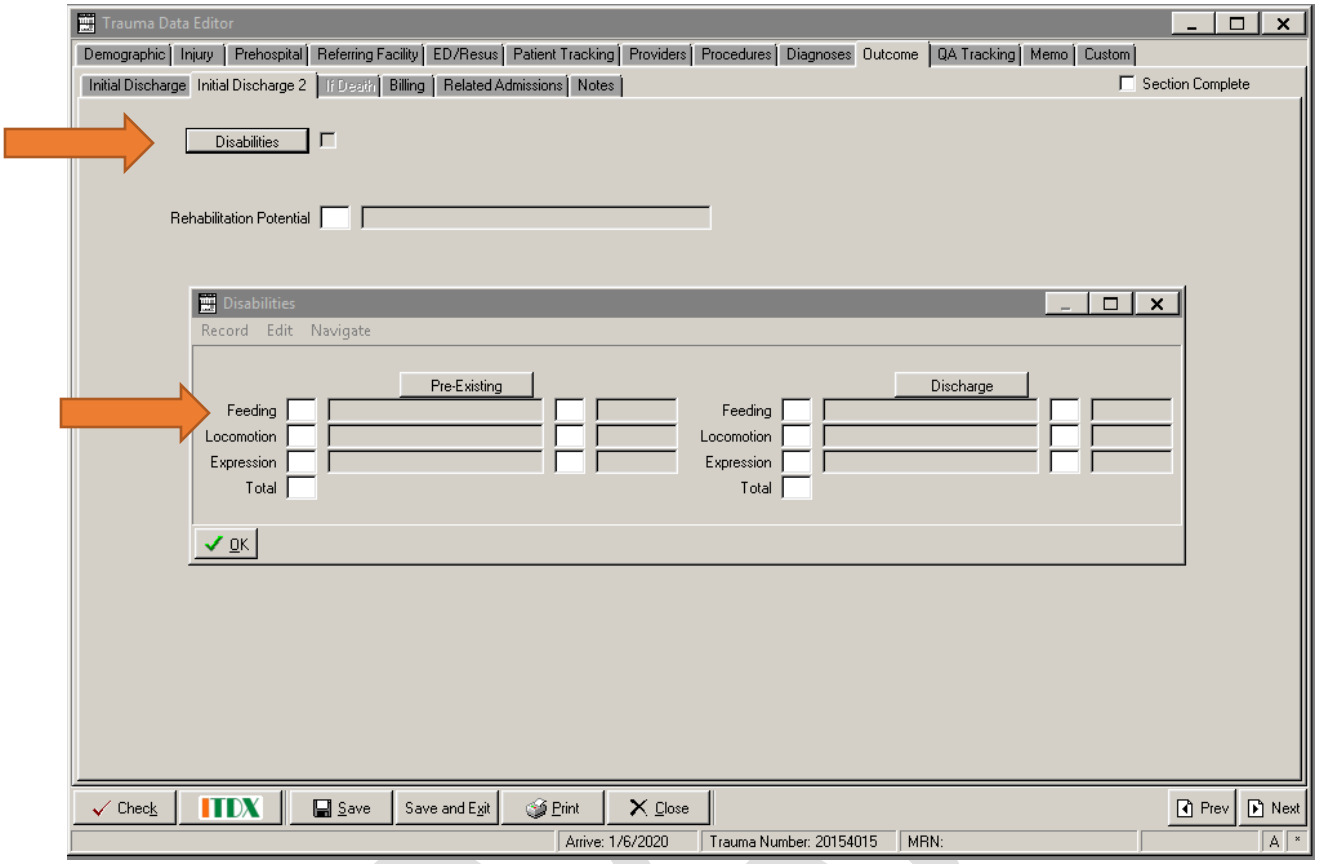

Disabilities: Pre-Existing Feeding

Definition

Feeding disabilities that are either temporary or permanent that the patient had prior to their injury admission.

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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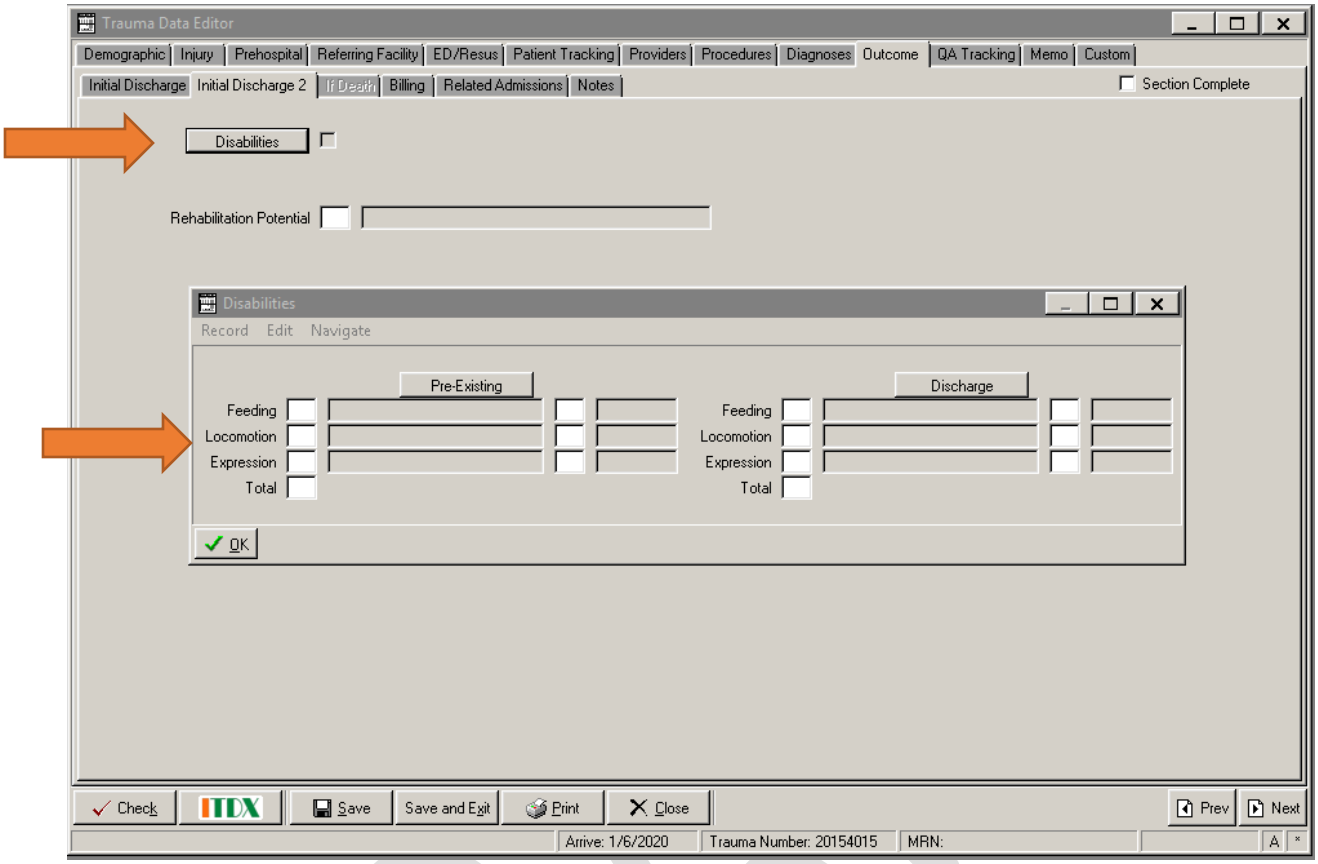

Disabilities: Pre-Existing Locomotion

Definition

Locomotion disabilities that are either temporary or permanent that the patient had prior to their injury admission

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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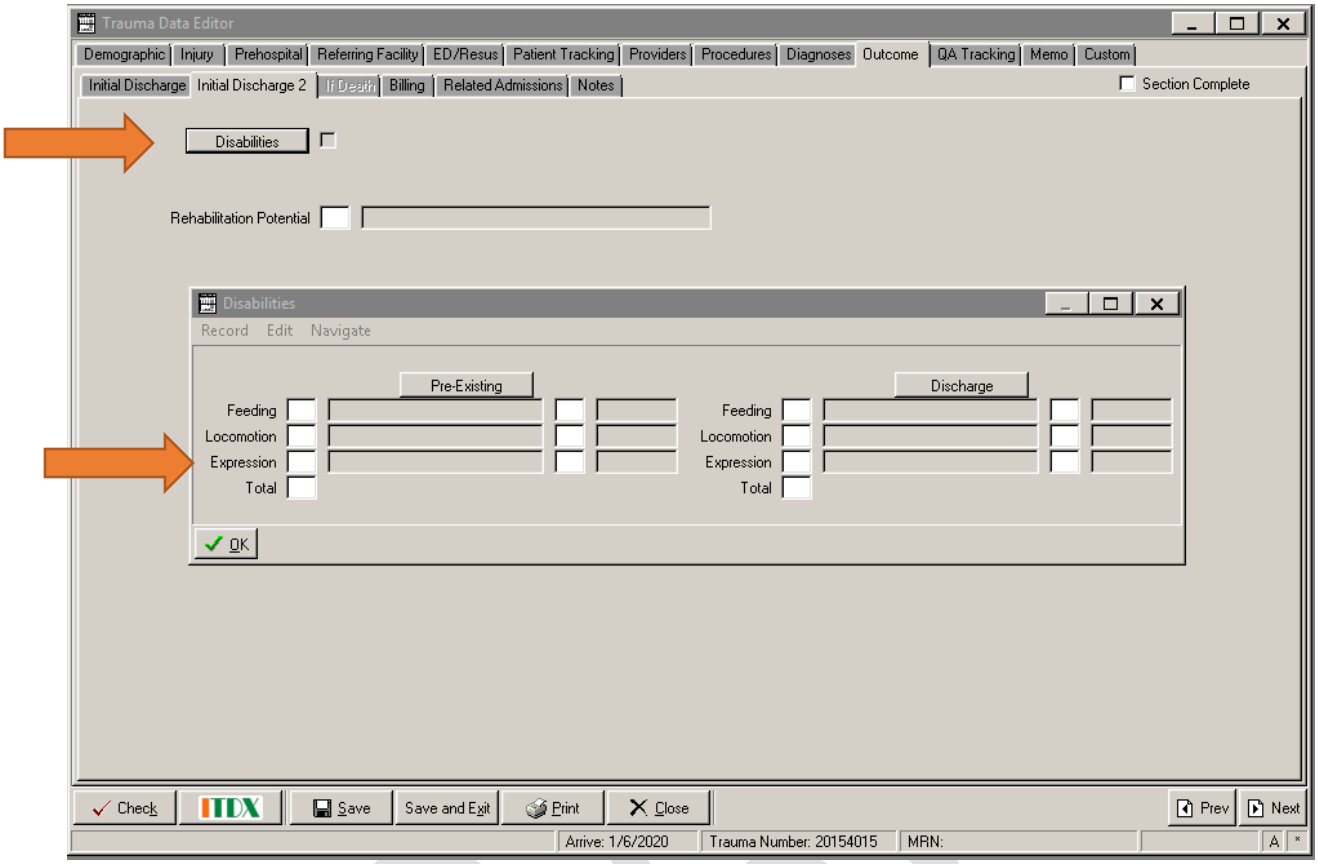

Disabilities: Pre-Existing Expression

Definition

Expression disabilities that are either temporary or permanent that the patient had prior to their injury admission

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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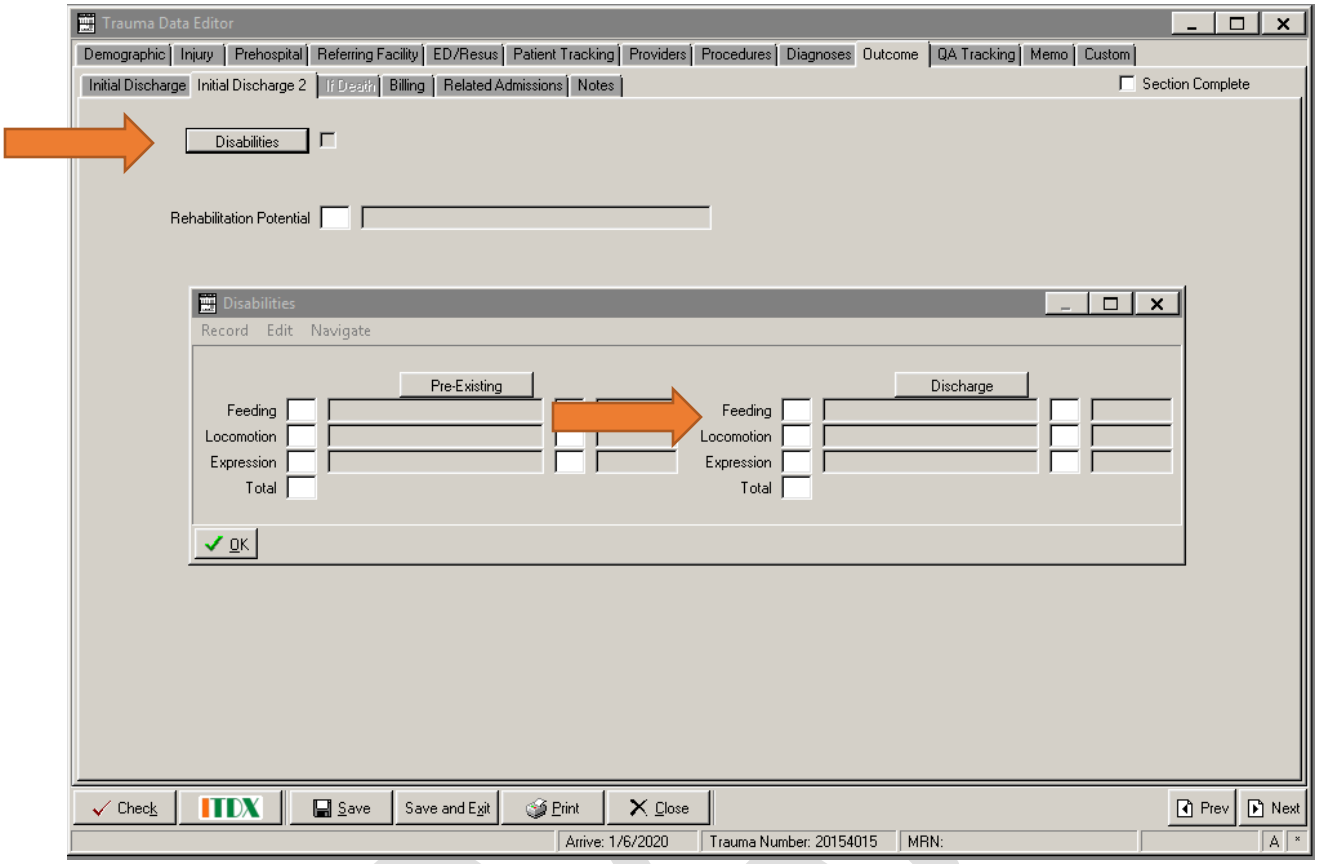

Disabilities: Discharge Feeding

Definition

Feeding disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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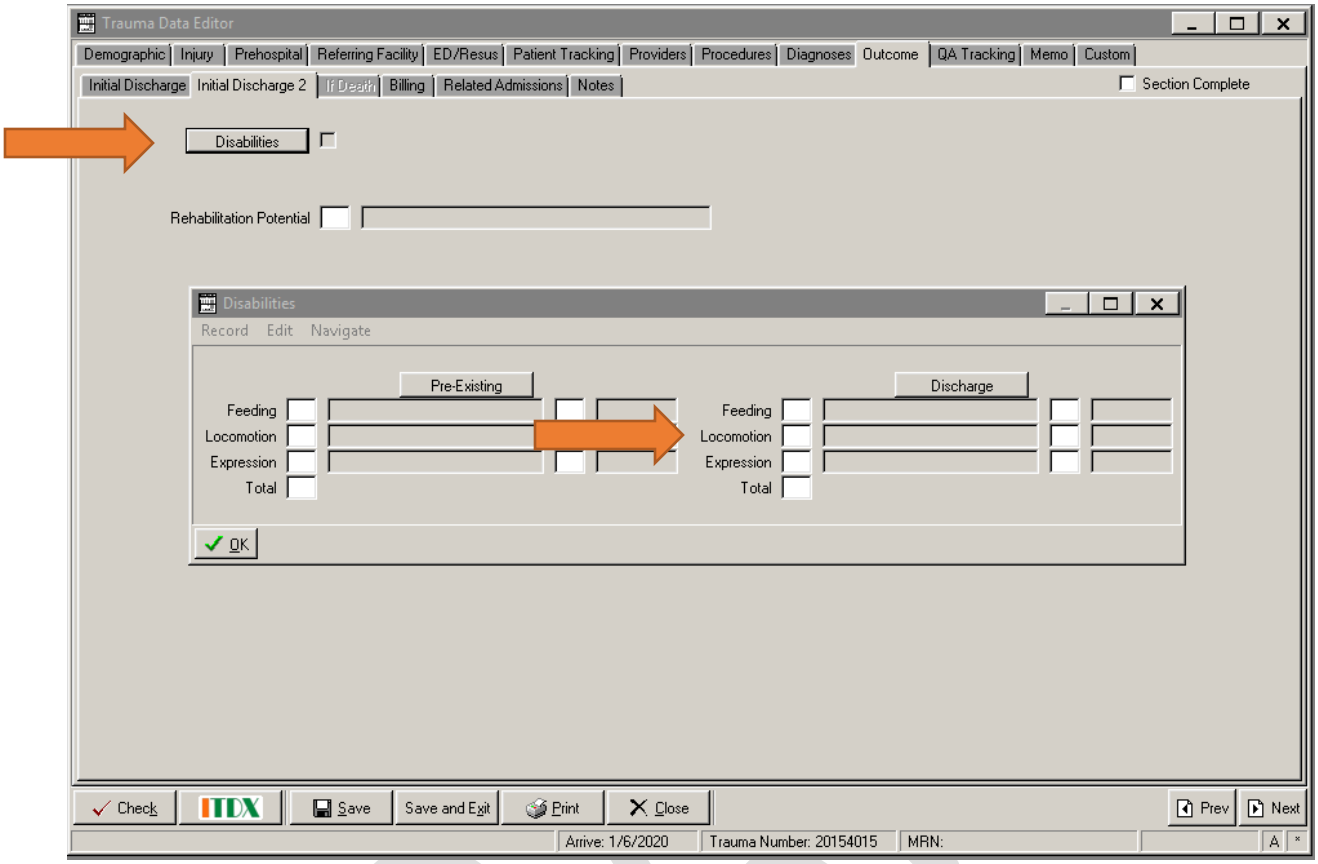

Disabilities: Discharge Locomotion

Definition

Locomotion disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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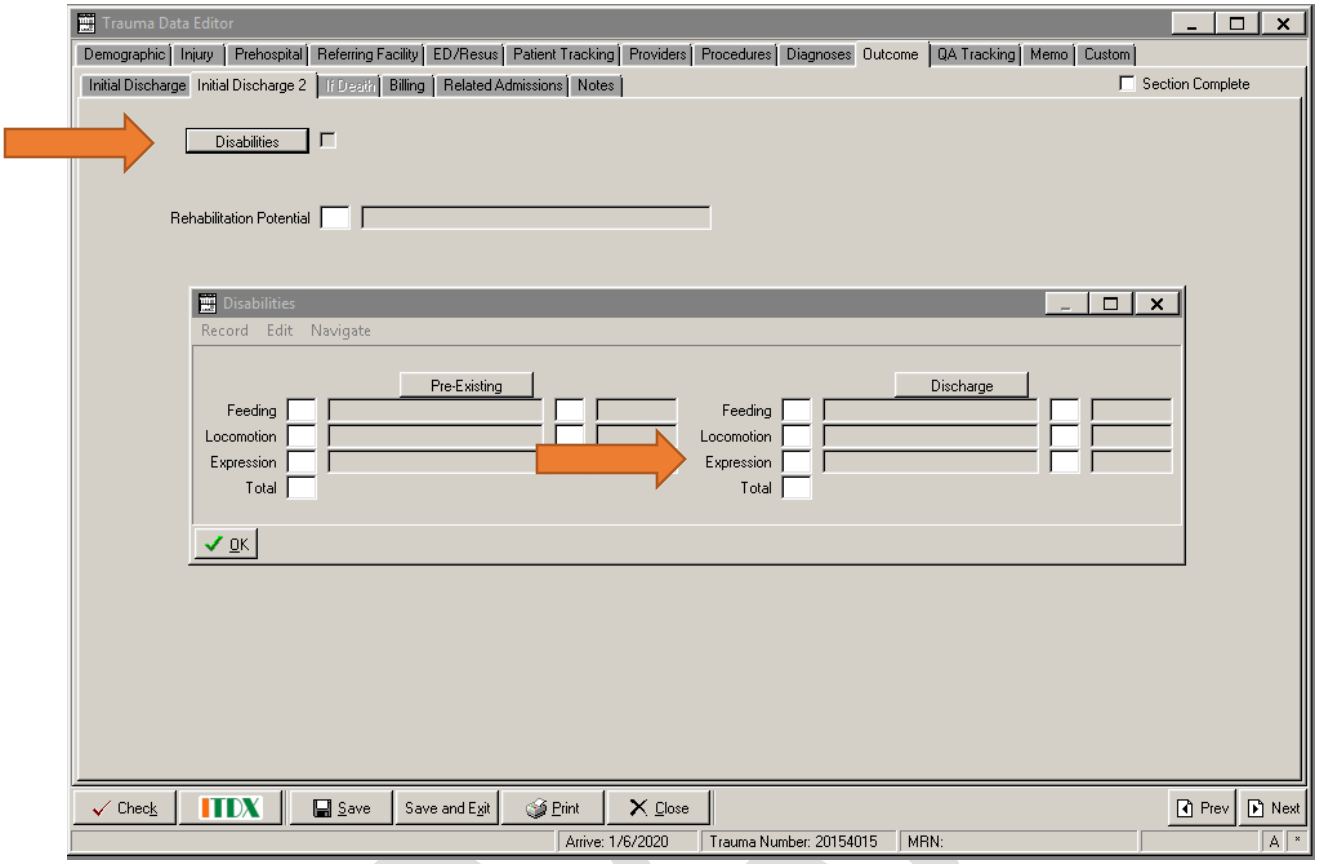

Disabilities: Discharge Expression

Definition

Expression disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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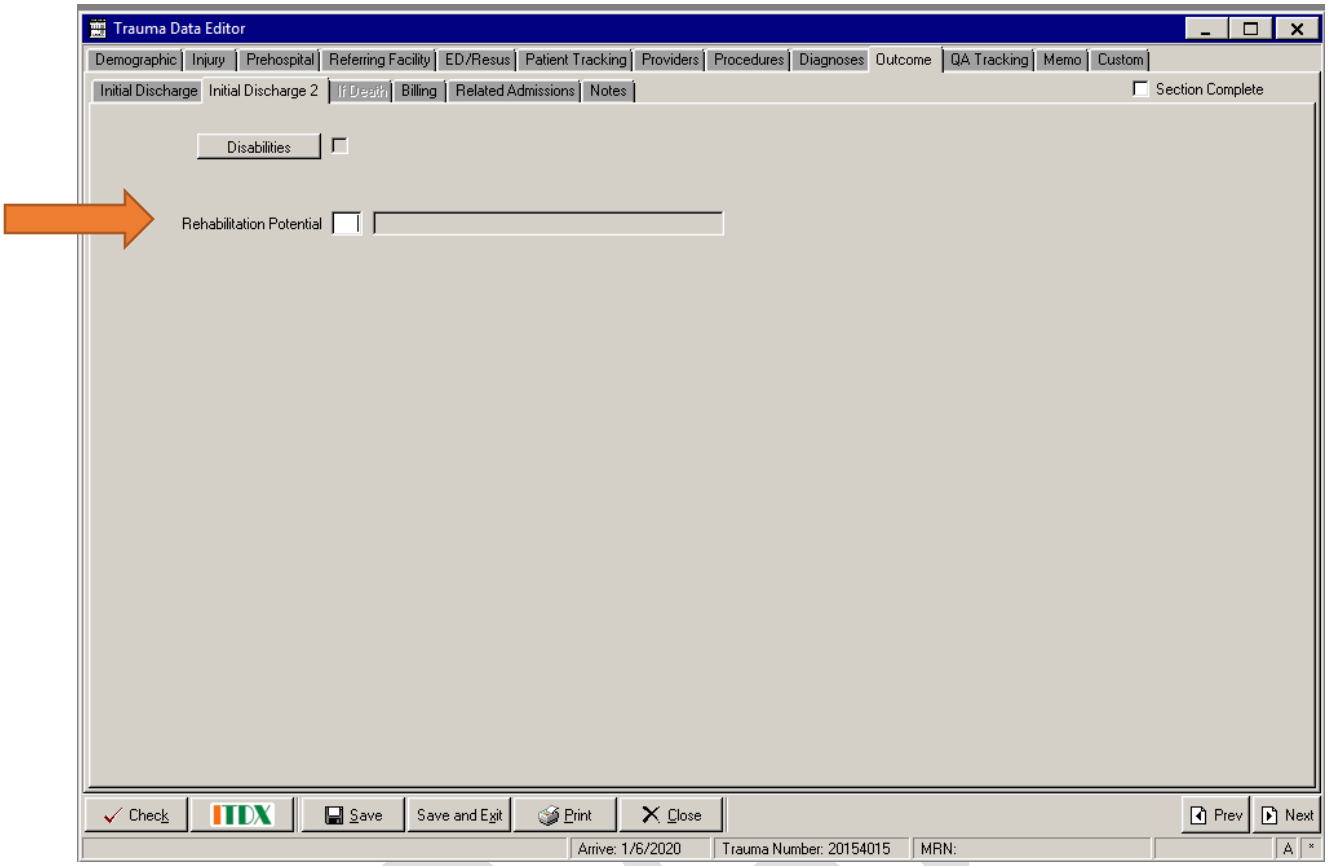

Rehabilitation Potential

Definition

The likelihood that with rehabilitation, the patient will be independent with cares or return to their previous level of function.

Element Values

1. Discharged with Previous Level of Function
2. Probable Improvement
3. Possible Improvement
4. Improbable Improvement

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes

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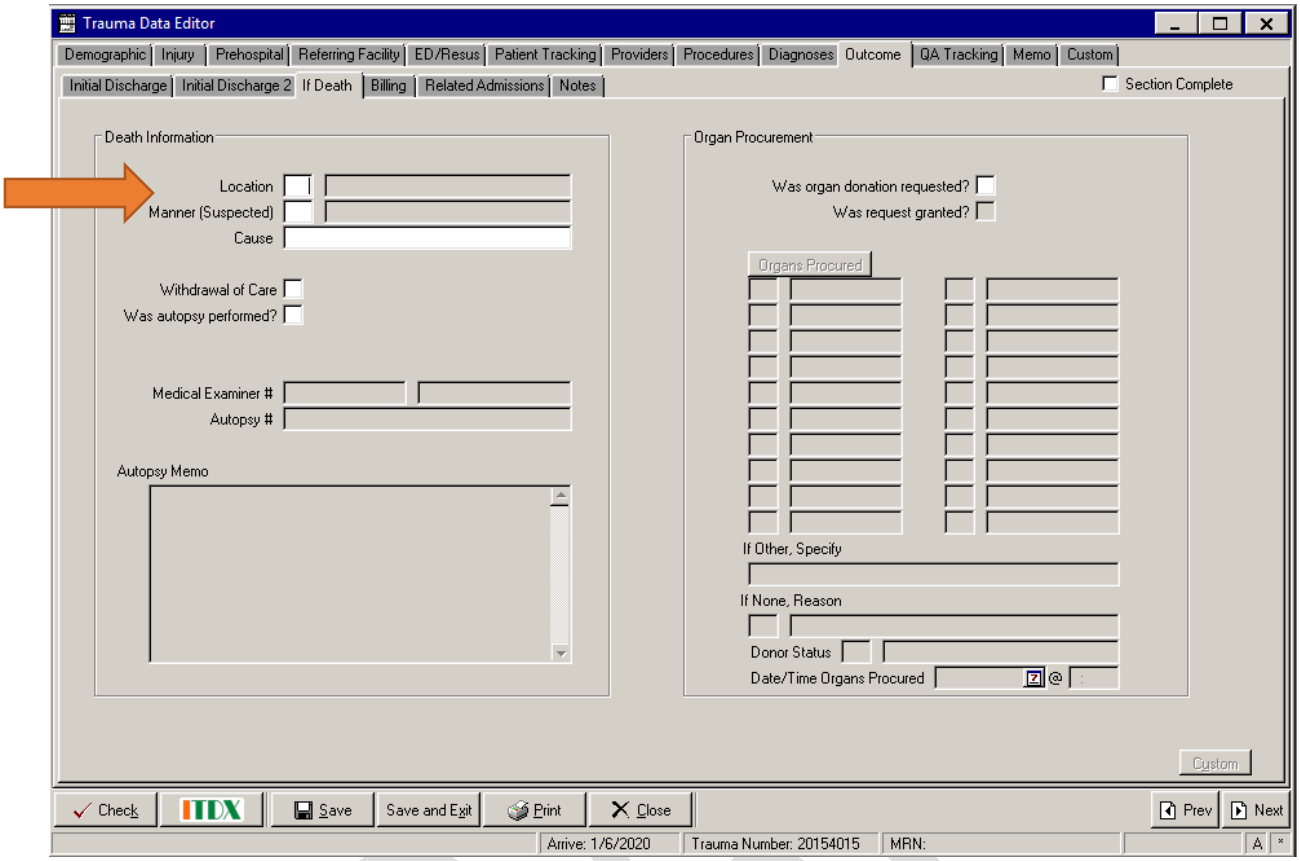


Location

Definition

The place where the patient expired while in the hospital.

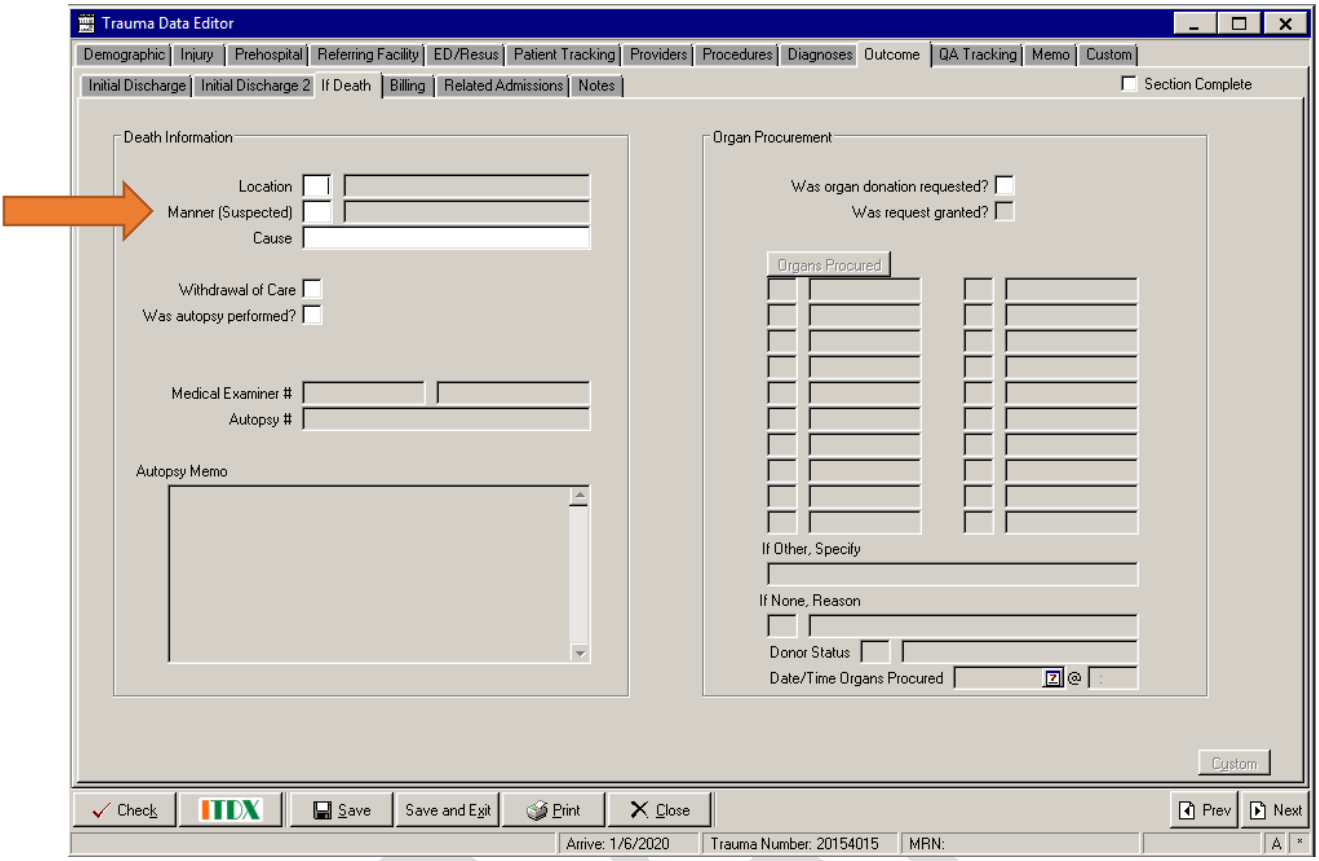
Element Values

1. Resuscitation Room
2. Emergency Departments
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit

?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Post-Mortem Flowsheet
3. Progress Notes
4. Nursing Notes



Manner (Suspected)

Definition

The suspected reason behind the patient's death.

Element Values

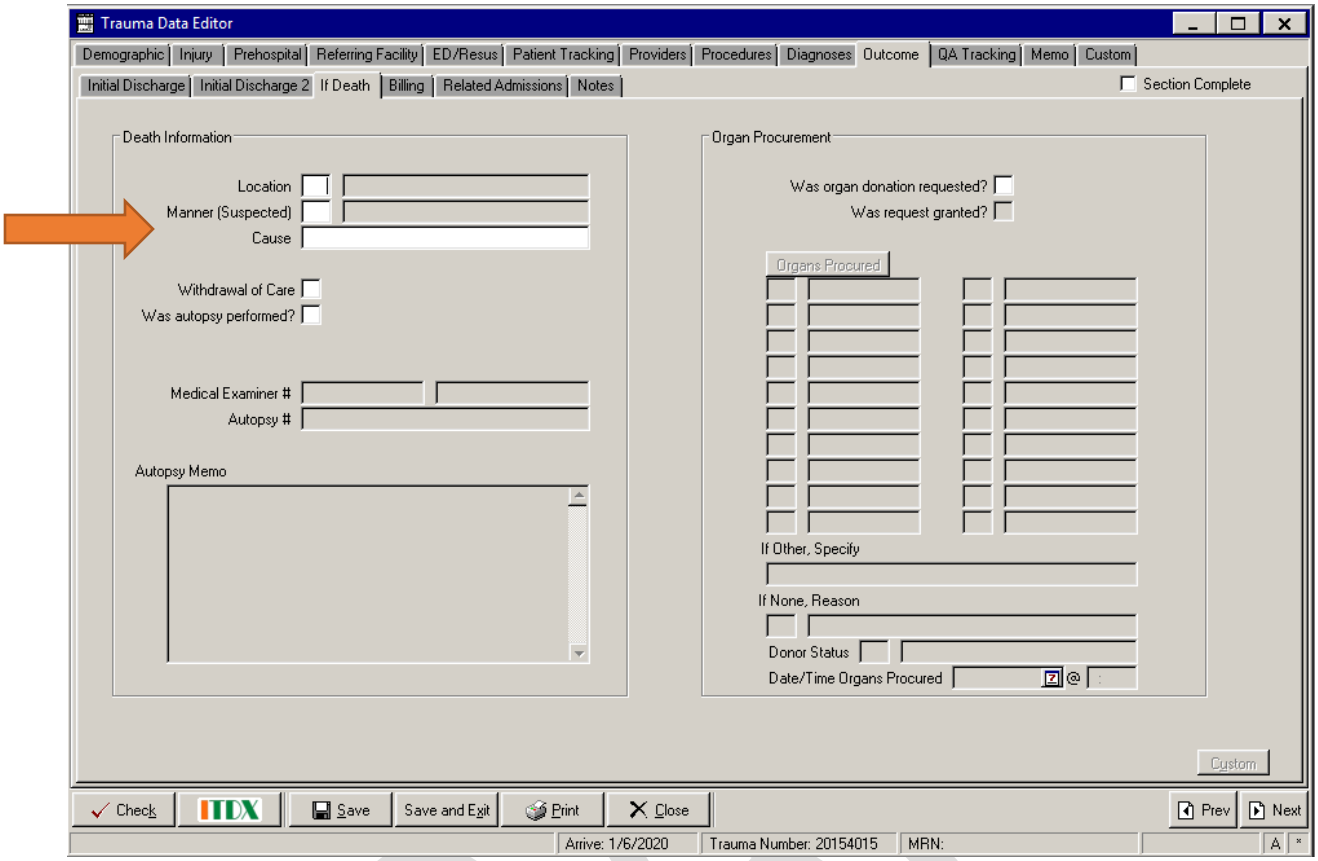
1. Accidental
2. Homicide
3. Natural Causes
4. Suicide
5. Undetermined

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Reports
2. Discharge Summary
3. Progress / Consult Notes



Manner (Cause)

Definition

The suspected cause of the patient's death.

Element Values

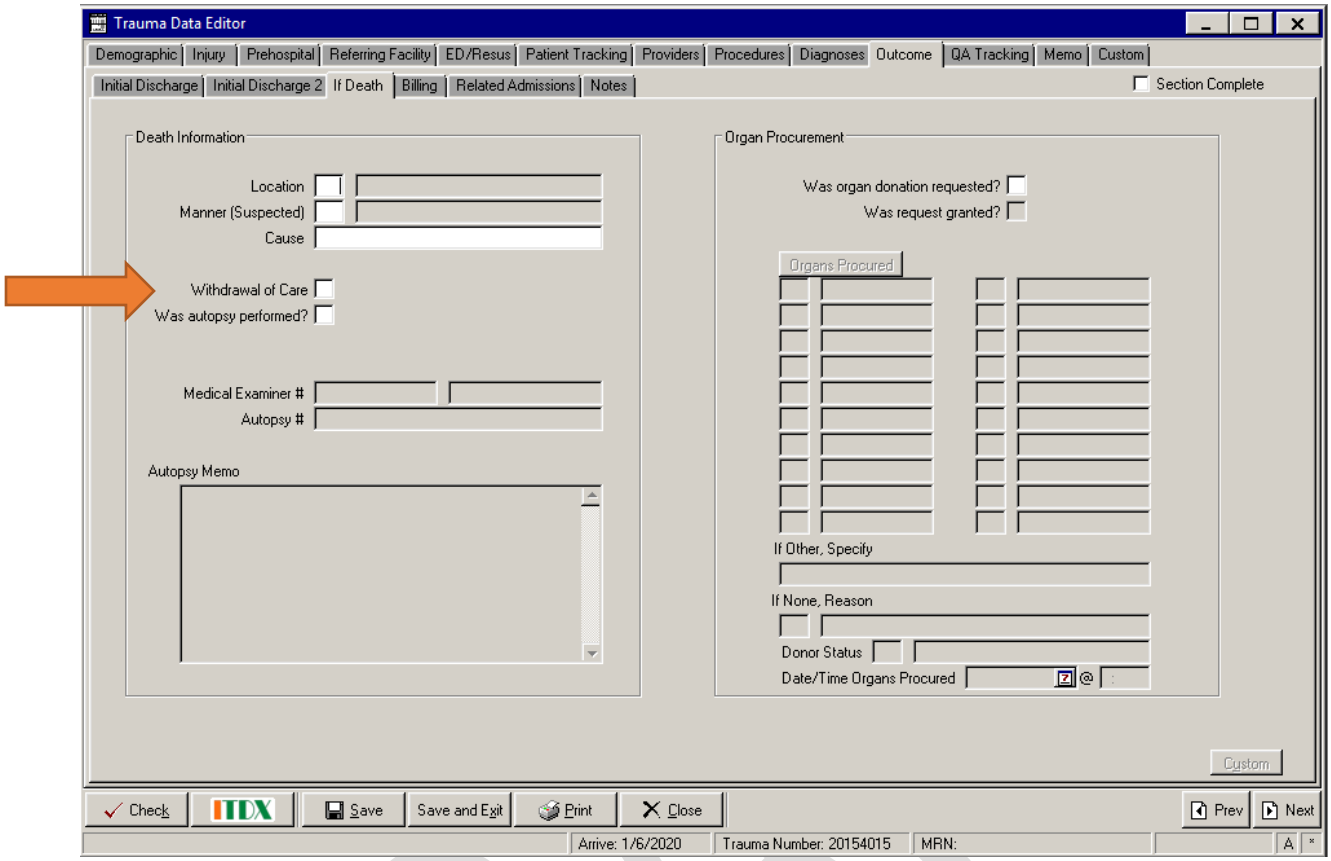
1. Accidental
2. Homicide
3. Natural Causes
4. Suicide
5. Undetermined

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Reports
2. Discharge Summary



Withdrawal of Care

Definition

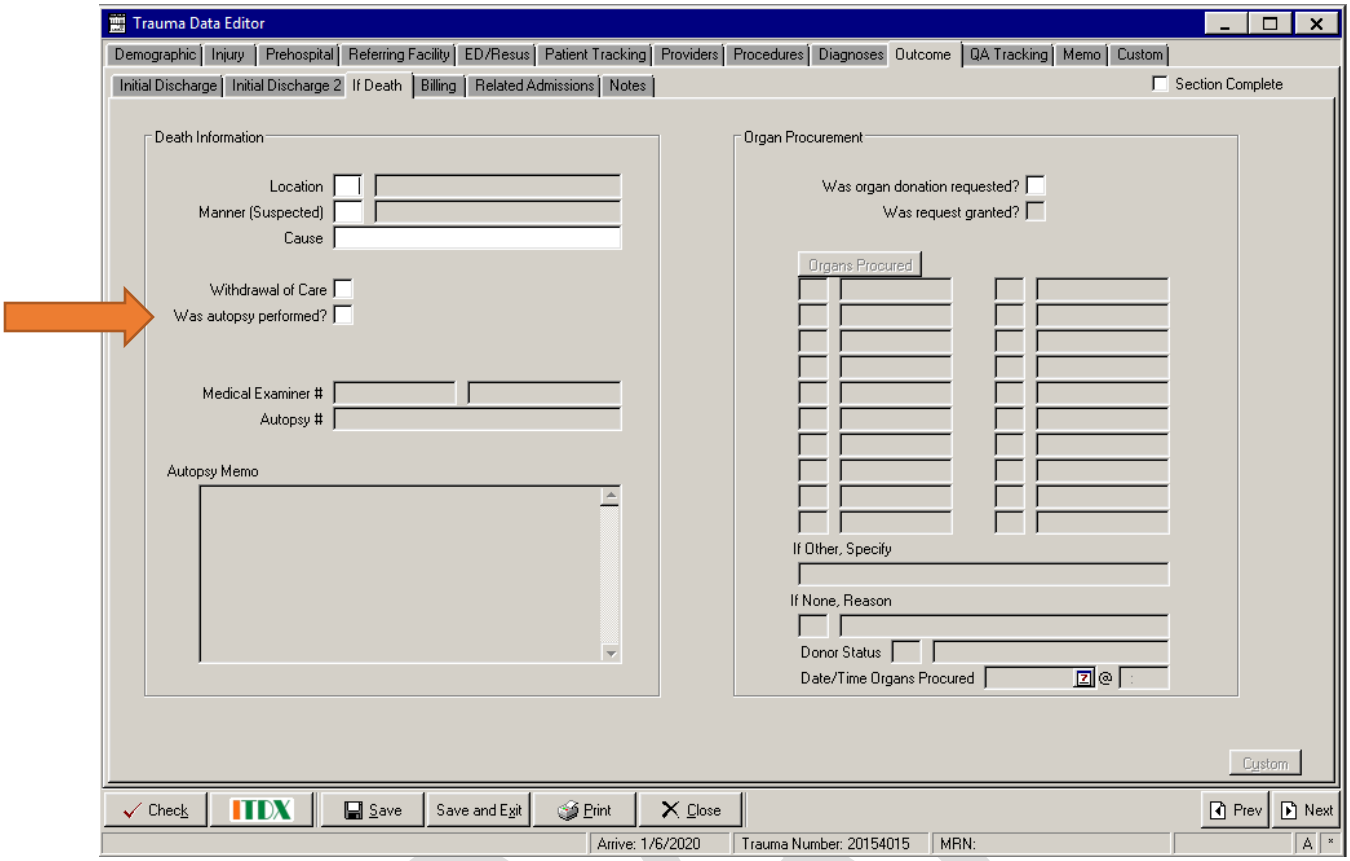
Treatment was withdrawn based on a decision to either remove or withhold further life supporting interventions.

Element Values

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

Data Source Hierarchy Guide

1. Discharge Summary
2. Progress Notes
3. Palliative Care Notes
4. Nursing Notes



Was Autopsy Performed?

Definition

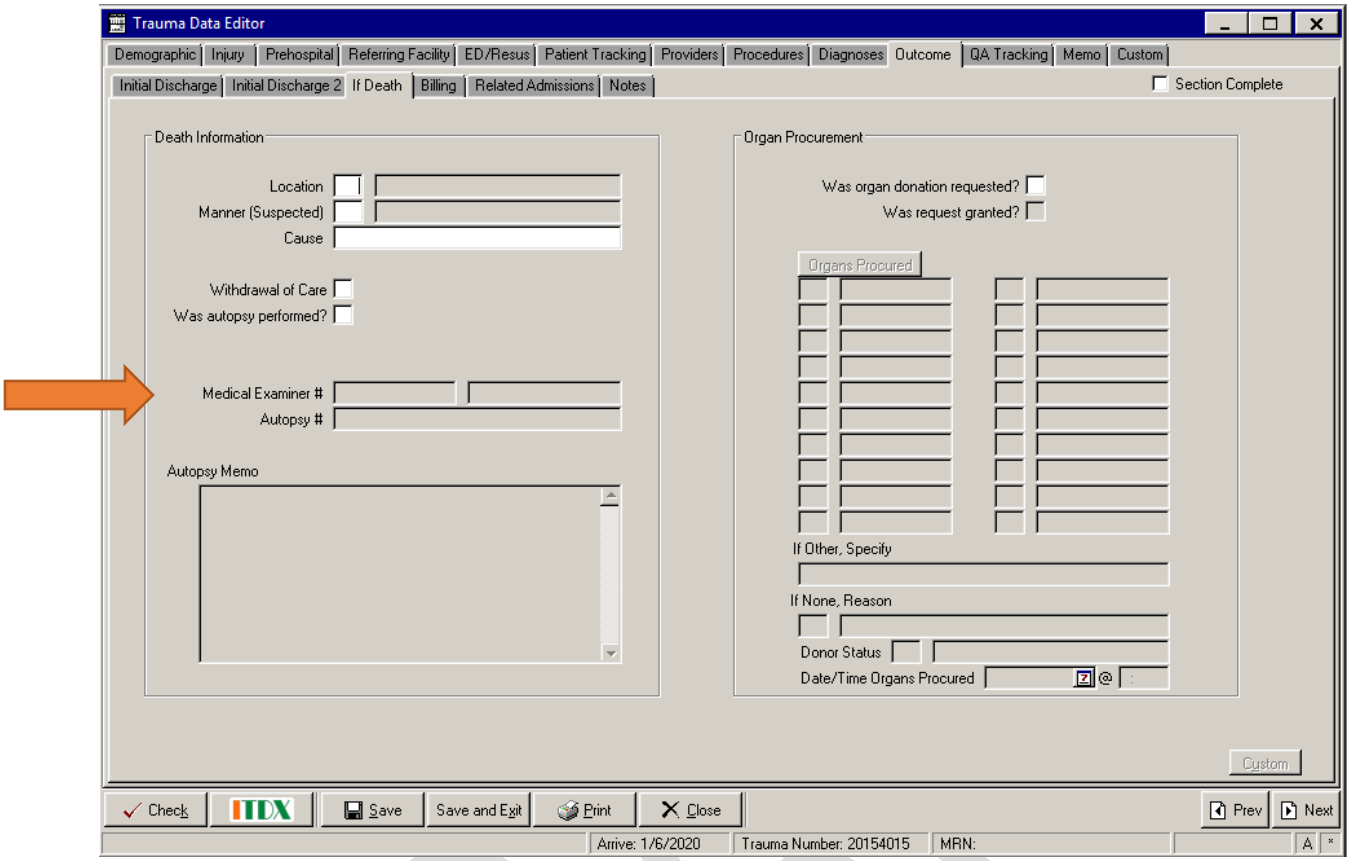
Was an autopsy performed after the patient's death?

Element Values

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

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report



Medical Examiner

Definition

The number provided to the medical examiner within your registry.

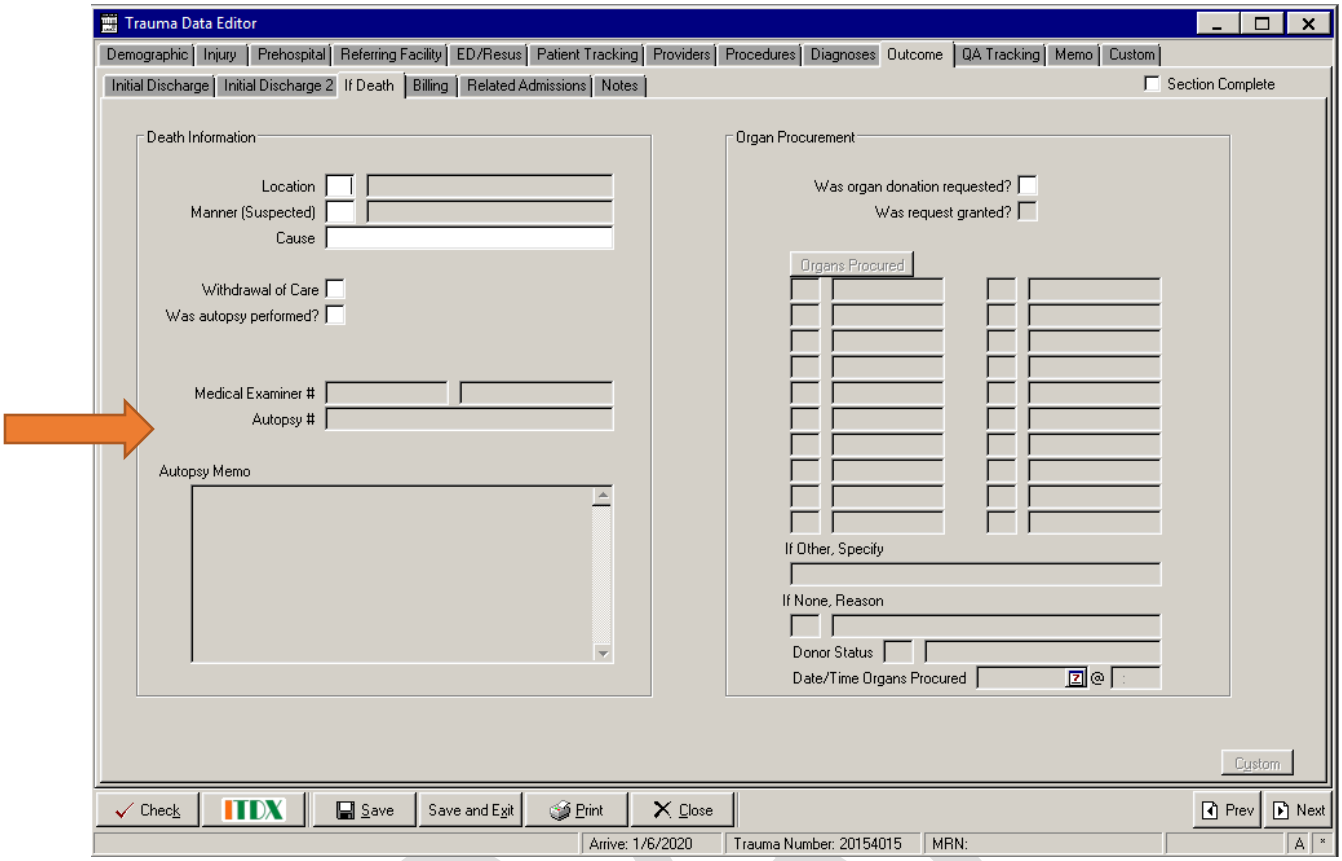
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report

DRAFT



Autopsy Number

Definition

The autopsy number given to the patient from the medical examiner.

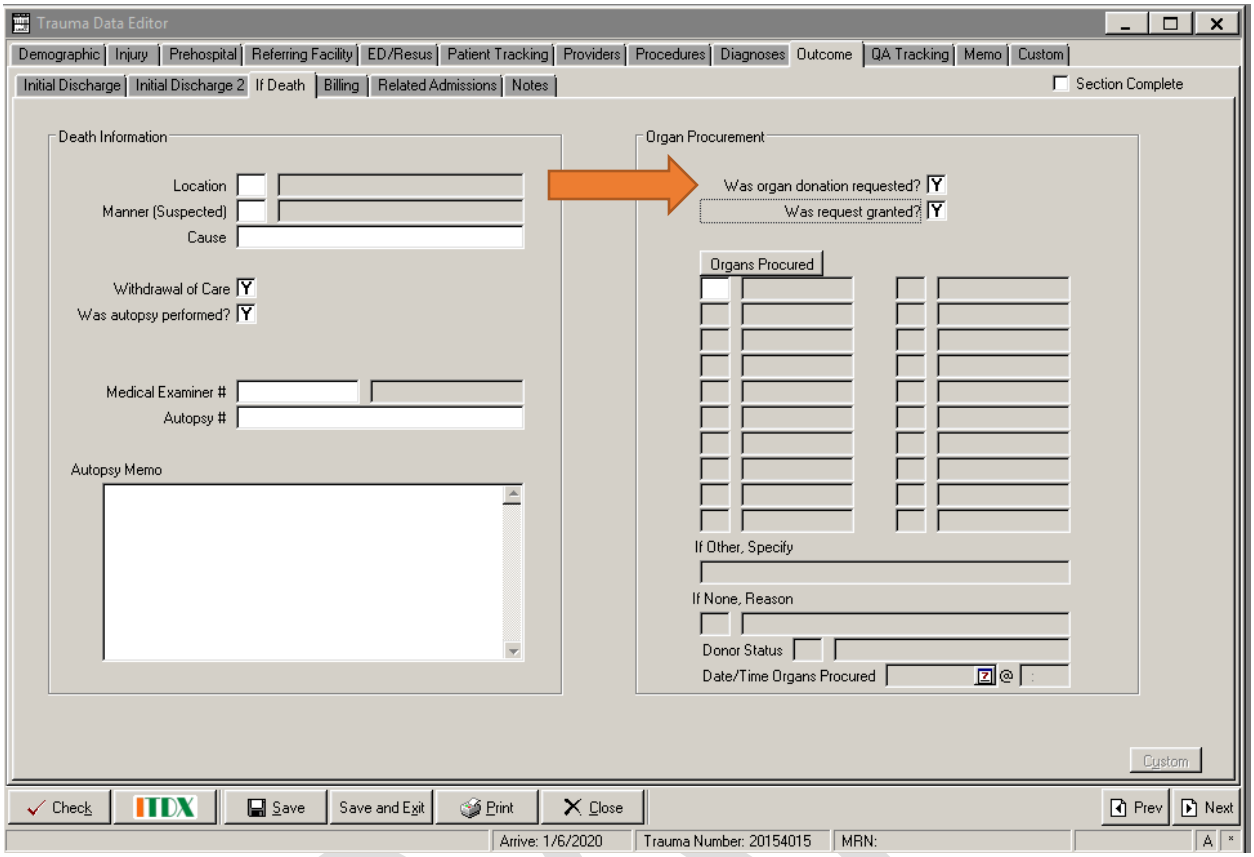
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report

DRAFT



Was Organ Donation Requested?

Definition

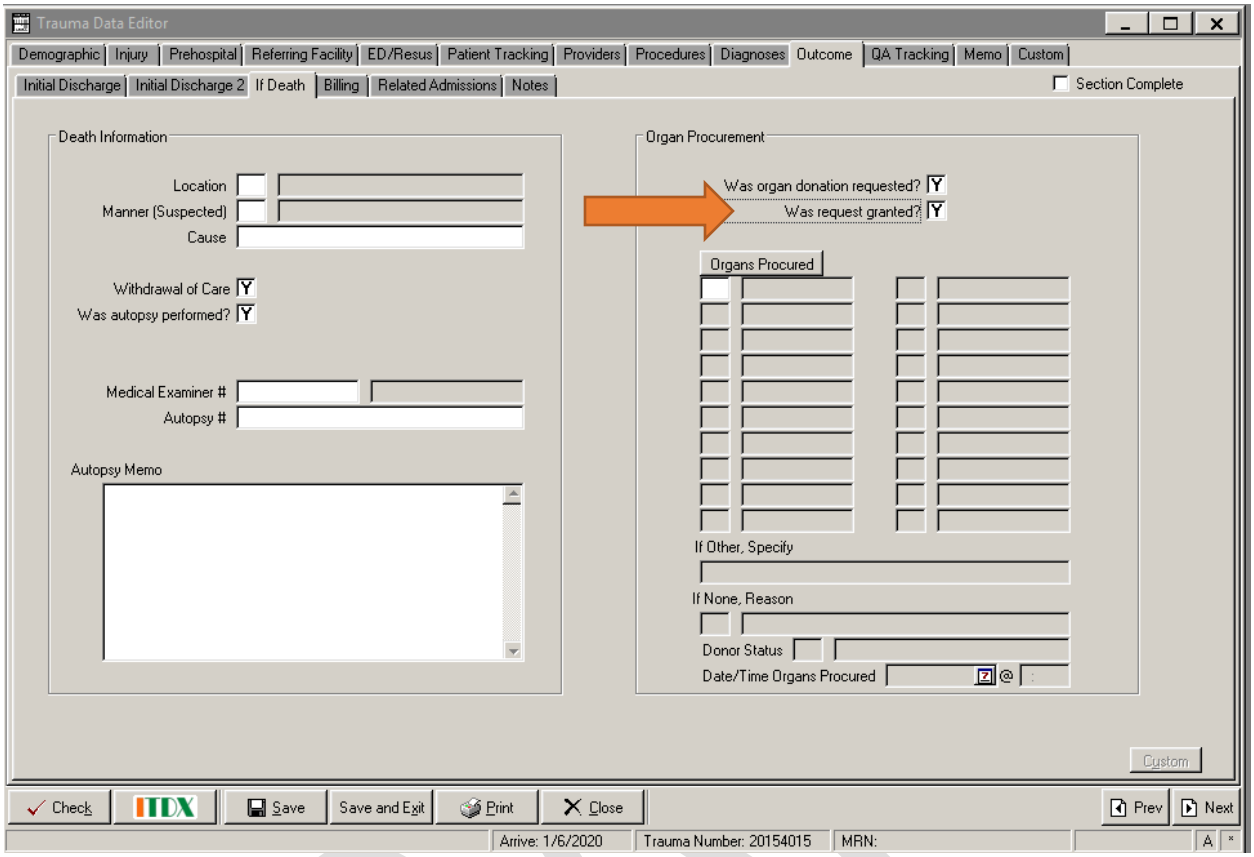
Was the possibility of organ donation requested of the patient's healthcare power of attorney?

Element Values

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

Data Source Hierarchy Guide

1. Organ Procurement Coordinator Notes
2. Discharge Summary
3. Palliative Care Note
4. Progress Note
5. Nursing Note



Was Request Granted?

Definition

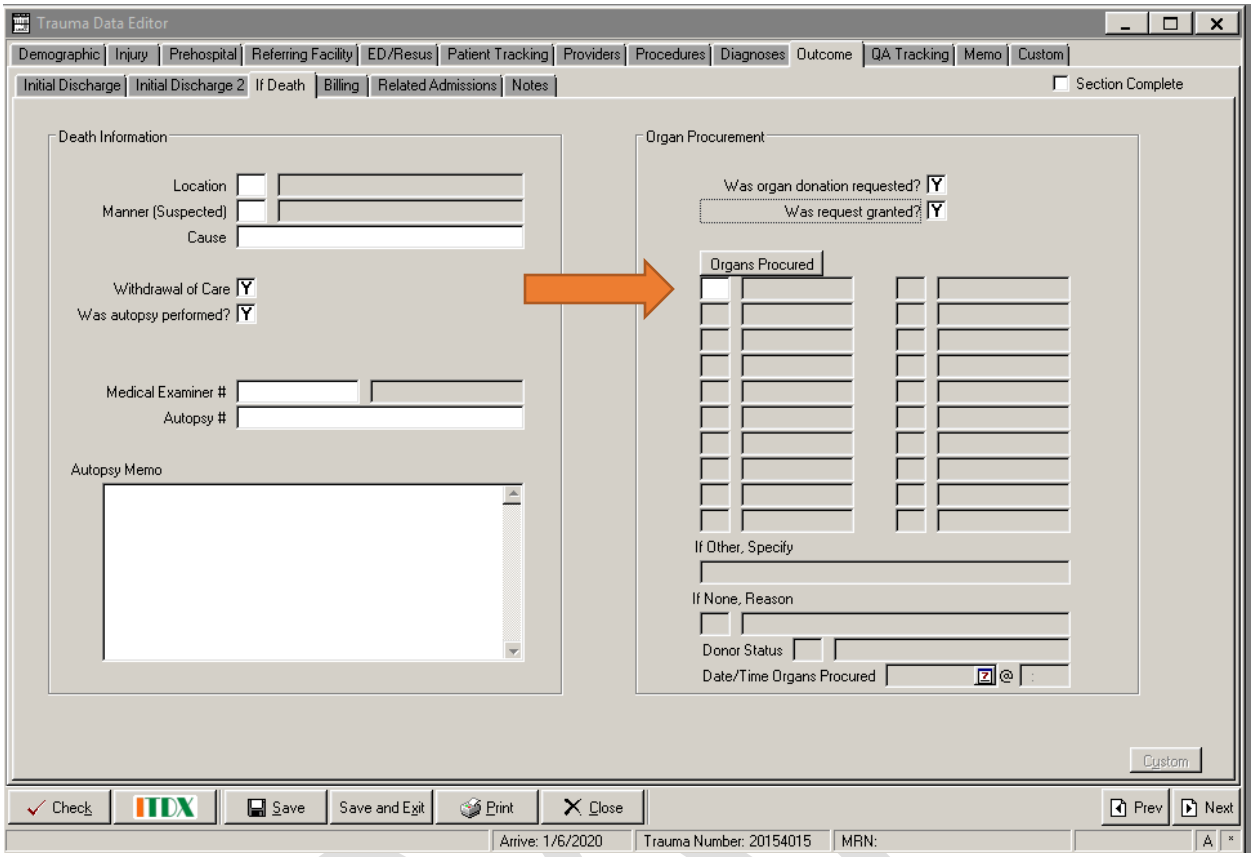
Was the request for organ donation granted by the patient's healthcare power of attorney?

Element Values

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

Data Source Hierarchy Guide

1. Organ Procurement Coordinator Notes
2. Discharge Summary
3. Palliative Care Note
4. Progress Note
5. Nursing Note



Organs Procured

Definition

The organs that were able to be procured for donation.

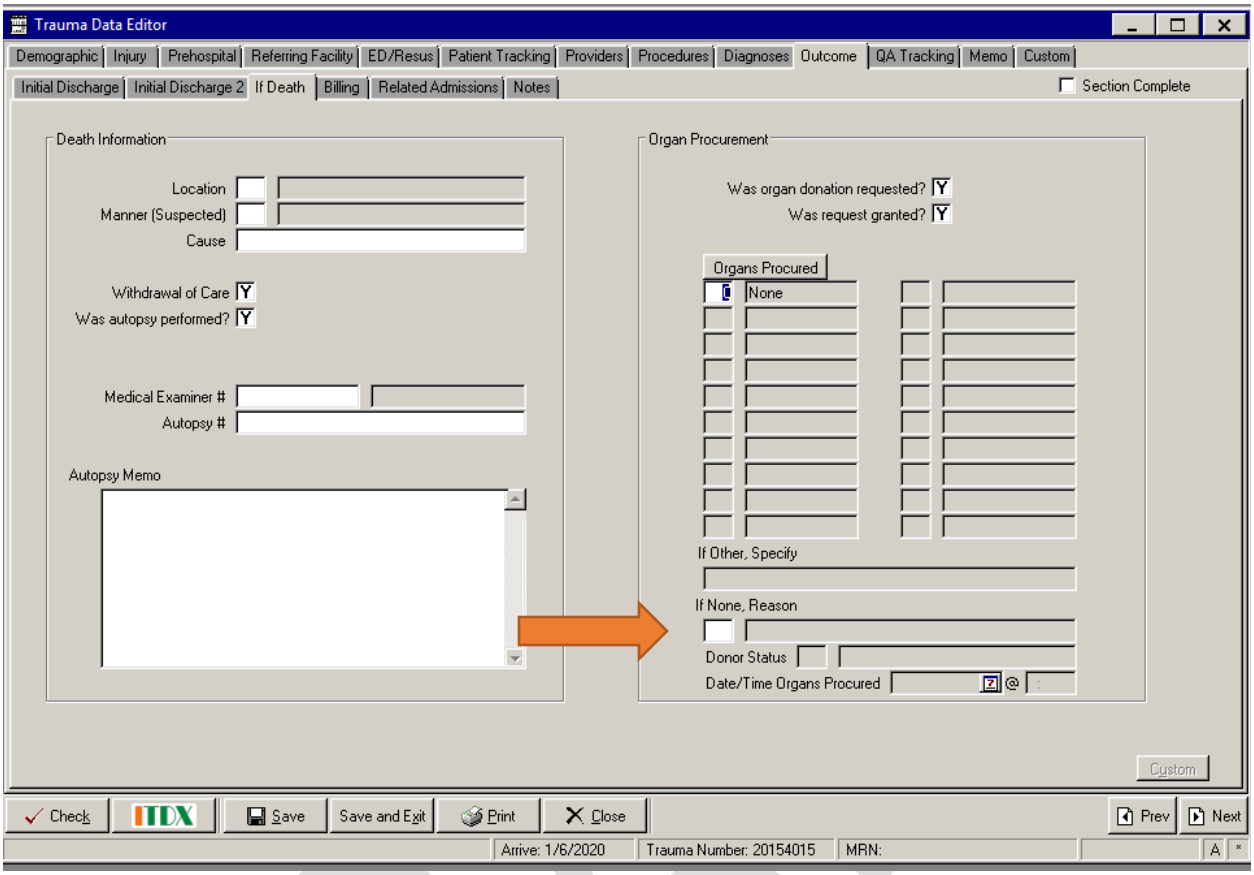
Element Values

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

?. Unknown

Data Source Hierarchy Guide

1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data
3. Autopsy/Medical Examiners Report



If None, Reason

Definition

If organ donation request was granted, but no organs were procured, specify the reason organs were not donated.

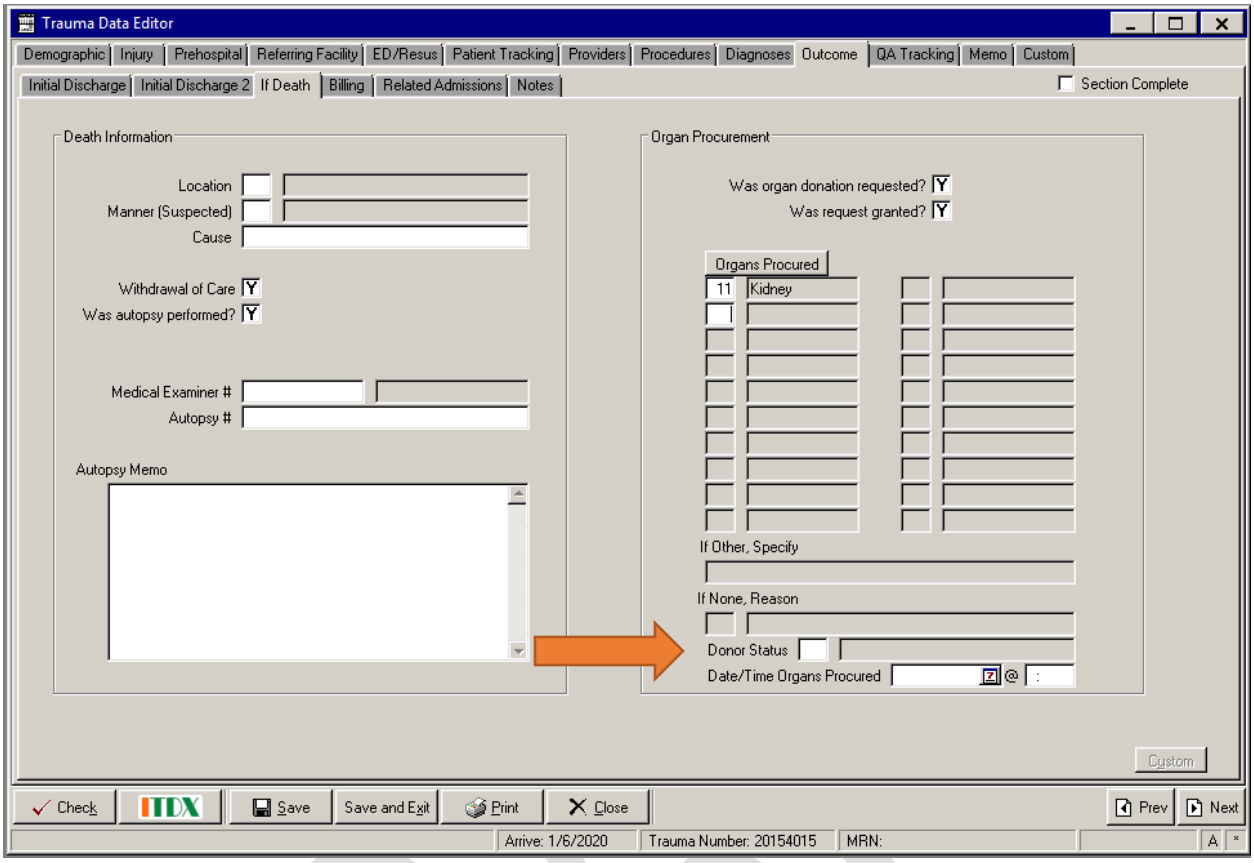
Element Values

1. No Medical Examiner Consent
2. Medically Unsuitable – Clinical Condition
3. Medically Unsuitable – Social History

?. Unknown

Data Source Hierarchy Guide

1. Organ Procurement Coordinator Note



Donor Status

Definition

The type of organ donor the patient was classified.

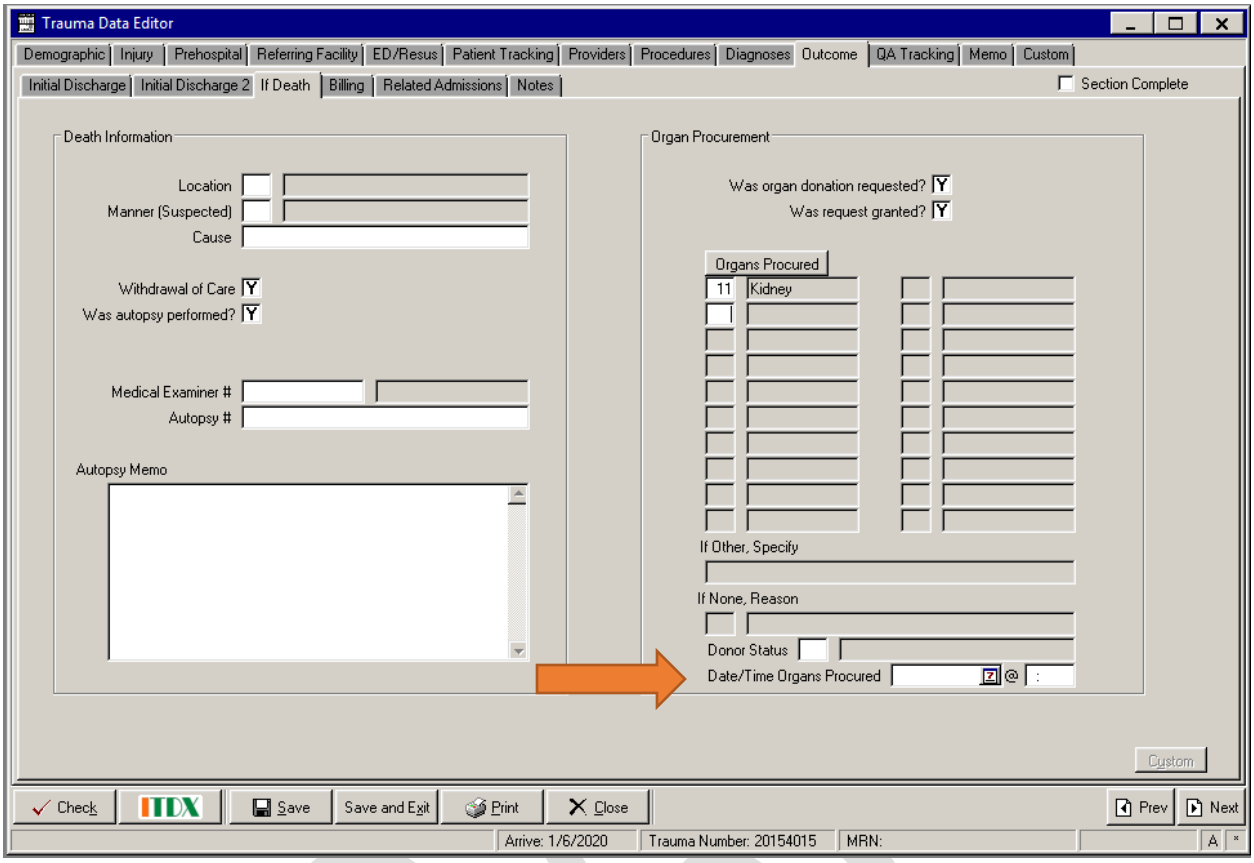
Element Values

1. Brain Death
2. Non-Beating Heart

?. Unknown

Data Source Hierarchy Guide

1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data
3. Discharge Summary



Date and Time Organs were Procured

Definition

The date and time that the organ procurement surgeon began the operative procedure.

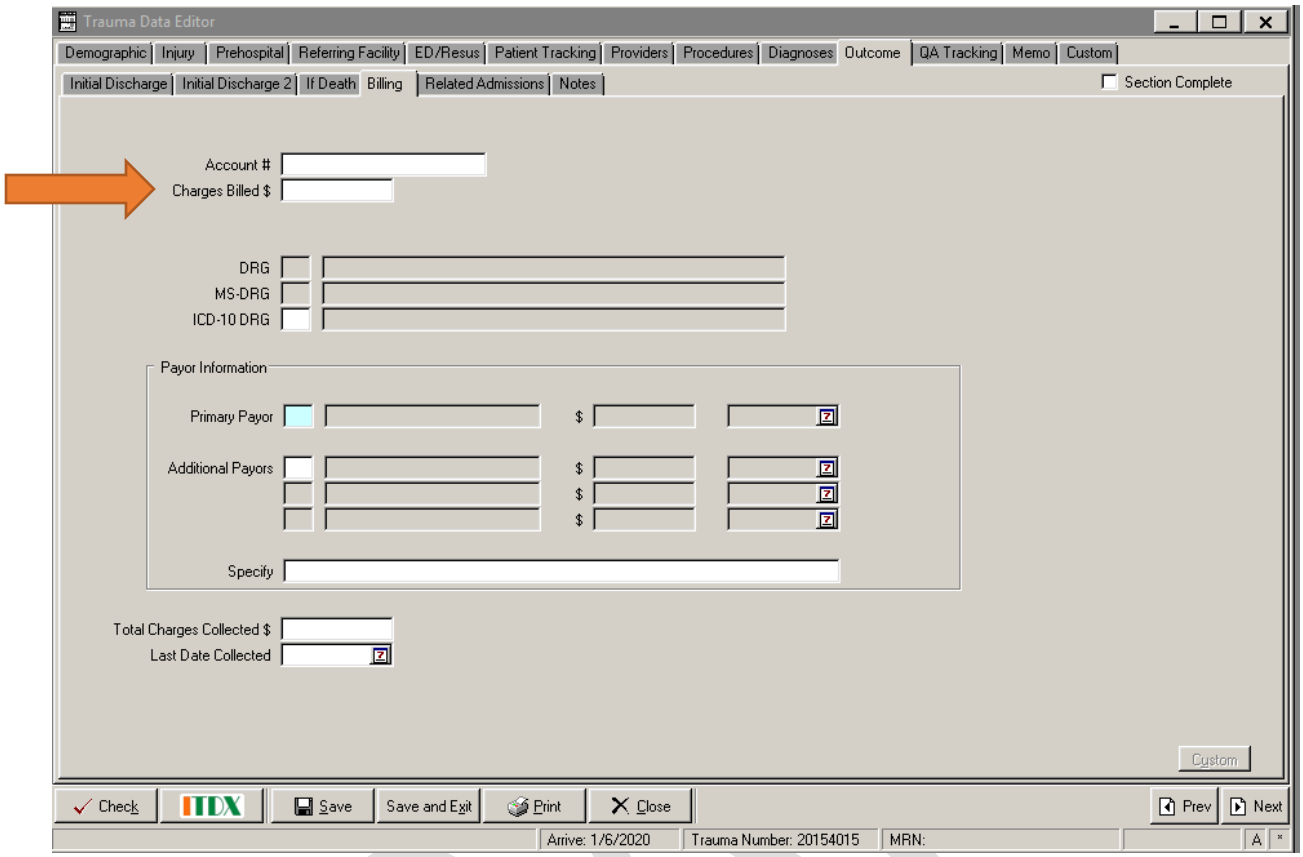
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data

DRAFT



Charges Billed $

Definition

The total charges billed to the patient for their hospital stay.

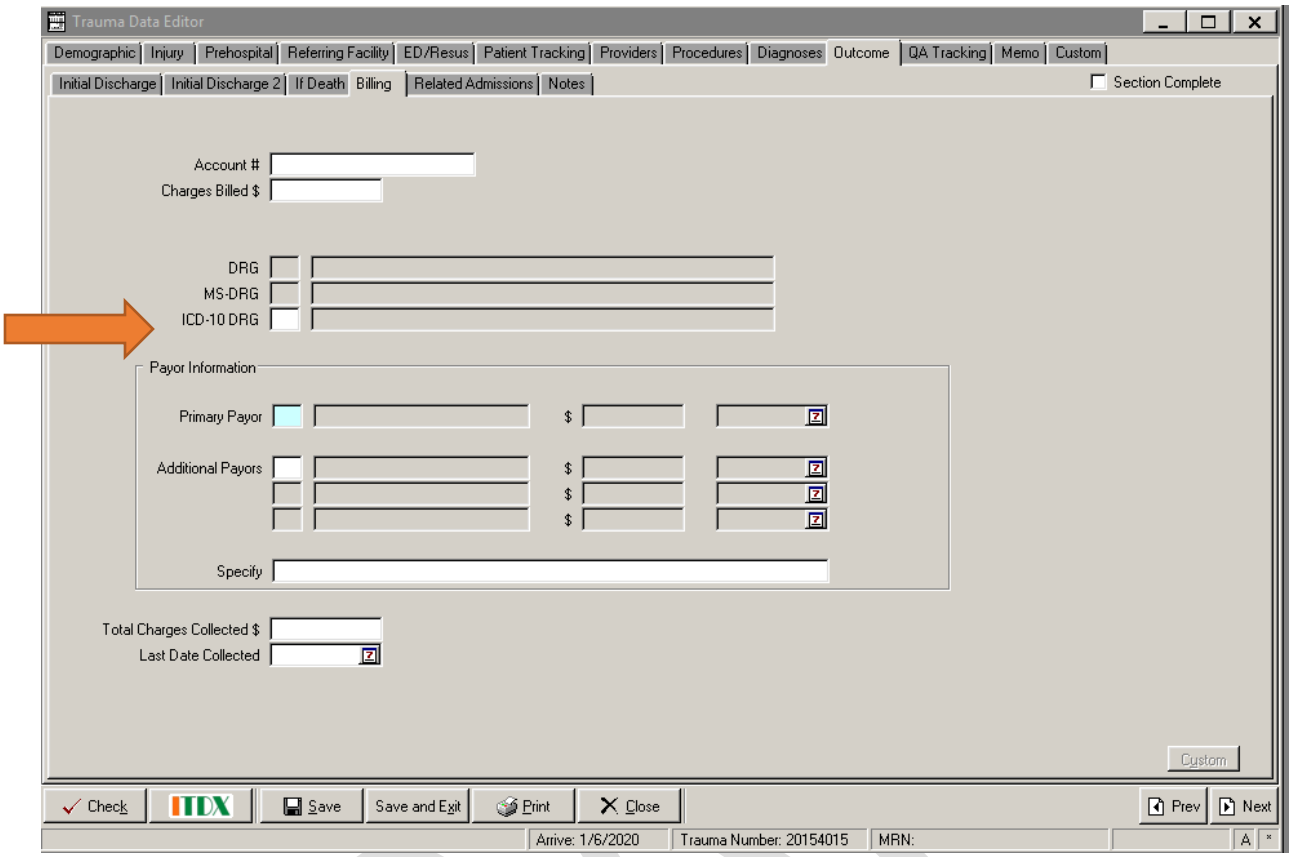
Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

DRAFT



ICD-10 DRG

Definition

The diagnosis related group which is how hospitalization costs are calculated through Medicare.

Element Value

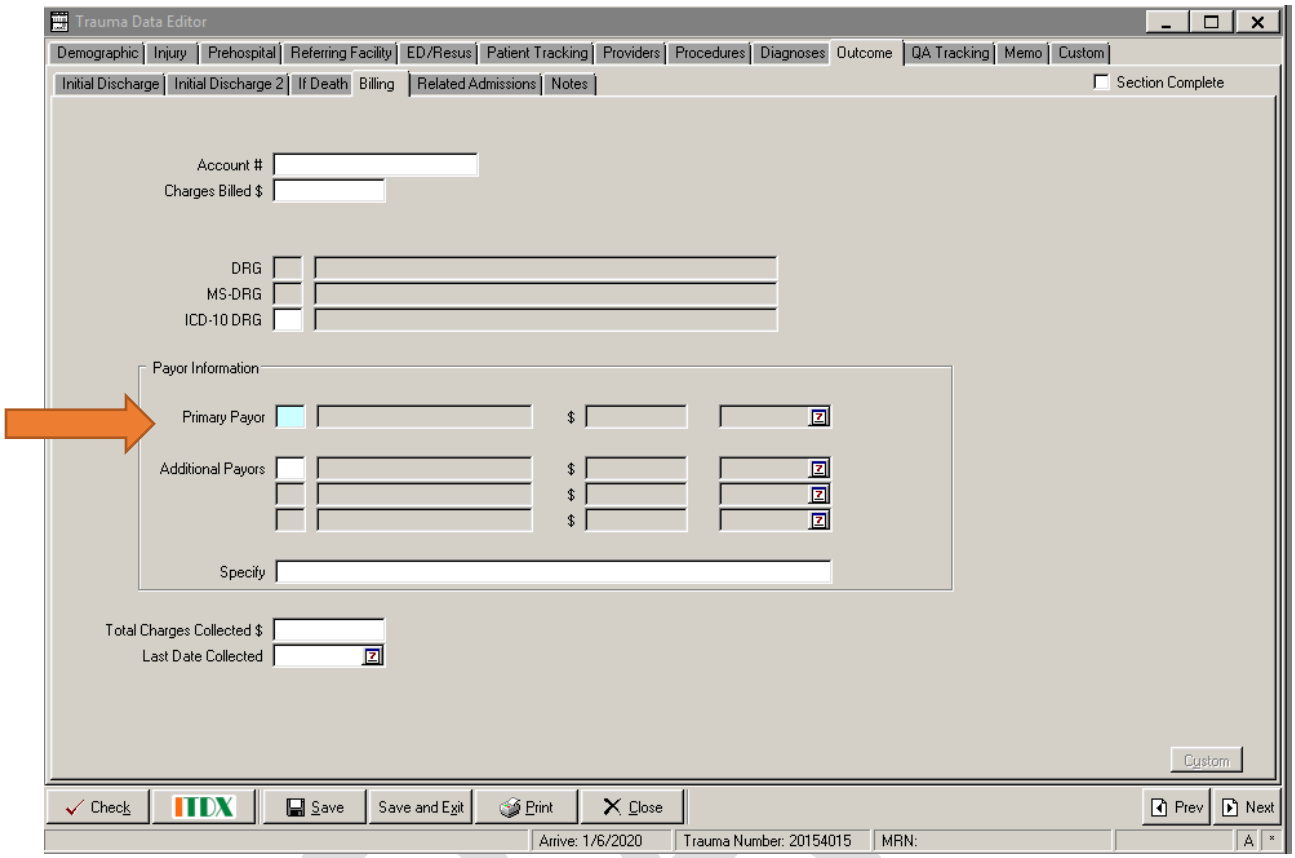
- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

DRAFT

Primary Payor: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**



Primary Payor

Definition

The primary payer responsible for paying for the hospitalization costs.

Element Value

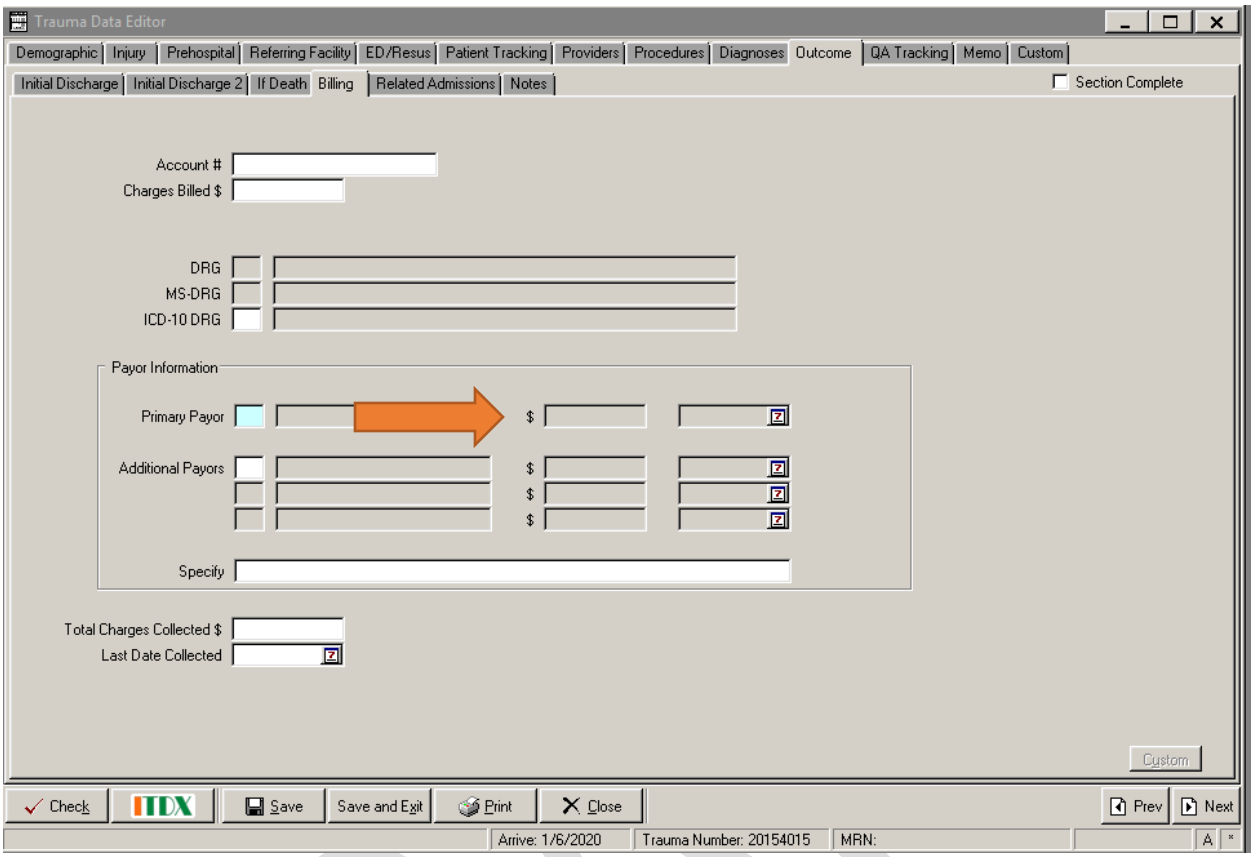
1. Self-Pay
2. HMO
3. PPO
5. Blue Cross Blue Shield (including PPO and HMO, etc.)
6. Automobile
7. Worker's Compensation
8. Medicare
9. Medicaid
10. Military (Tricare)
11. Other Commercial
12. Other Government
13. Not Billed for Any Reason
14. Charity
15. Other (Violence fund)
16. Charity Pending
17. Liability

/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records



Primary Payor $

Definition

The total amount of payment collected from the Primary Payor

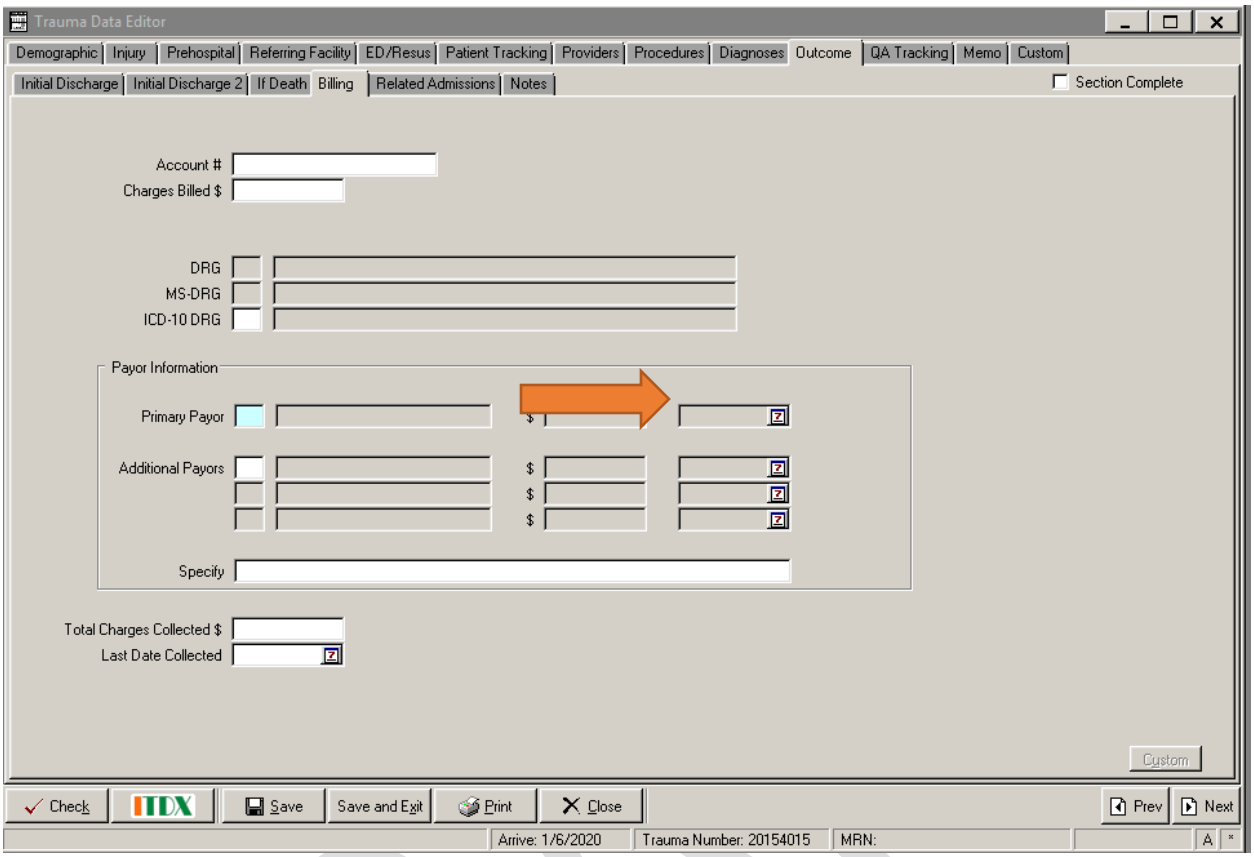
Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

DRAFT



Primary Payor Date

Definition

The last date the primary payor made payments for the hospitalization.

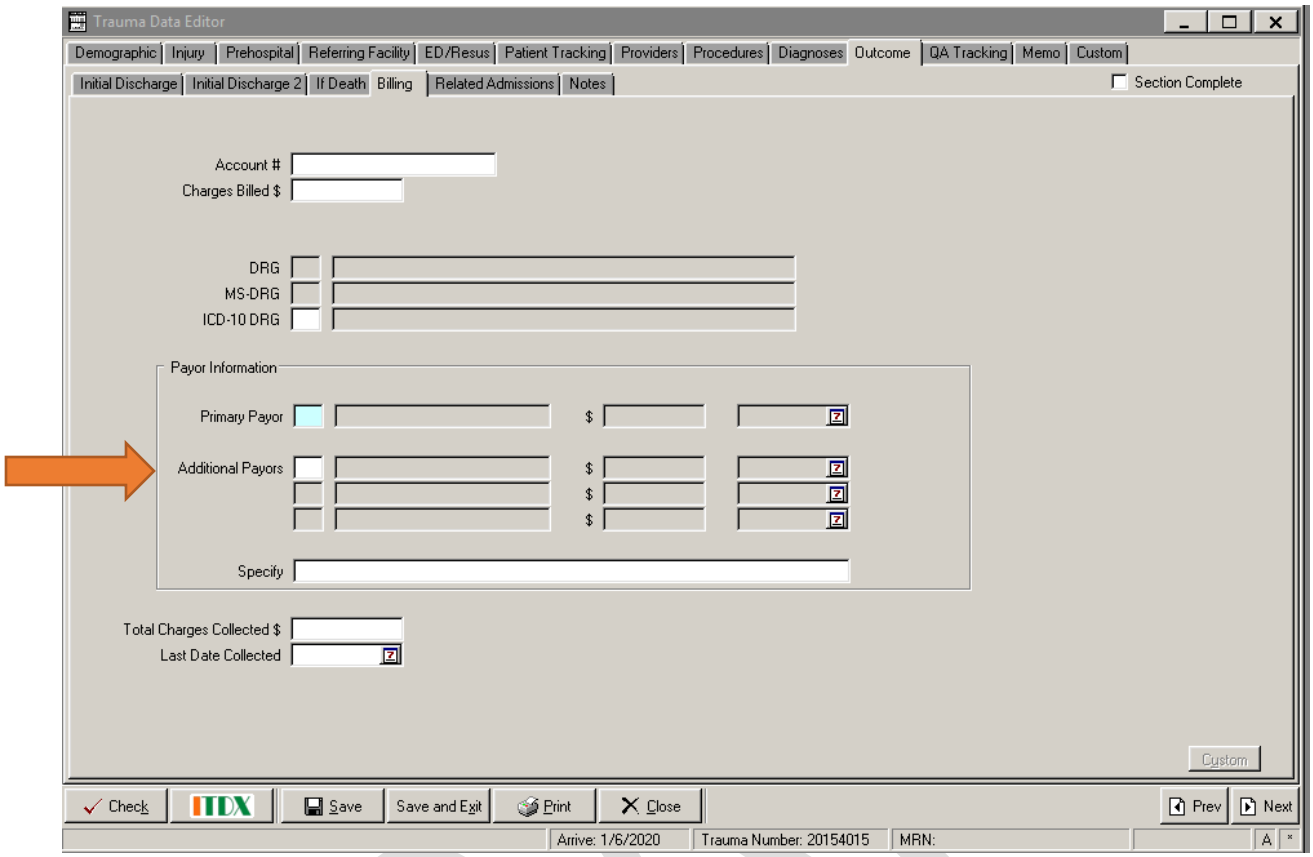
Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

DRAFT



Additional Payors

Definition

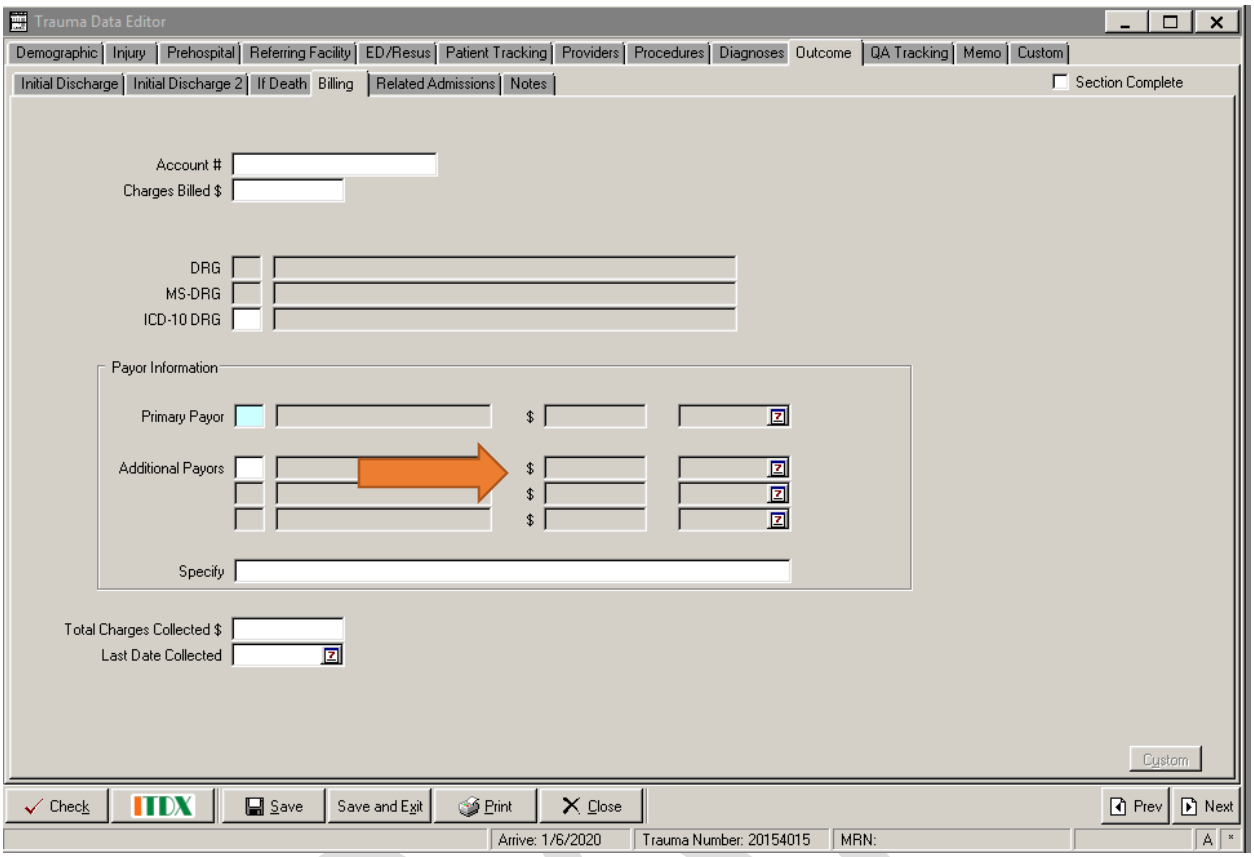
Secondary payors responsible for paying some of the hospital costs after the primary payor.

Element Value

1. Self-Pay
2. HMO
3. PPO
5. Blue Cross Blue Shield
6. Automobile
7. Worker's Compensation
8. Medicare
9. Medicaid
10. Military (Tricare)
11. Other Commercial
12. Other Government
13. Not Billed for Any Reason
14. Charity
15. Other
16. Charity Pending
17. Liability
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records



Additional Payor $

Definition

The total amount of payment collected from the additional payor.

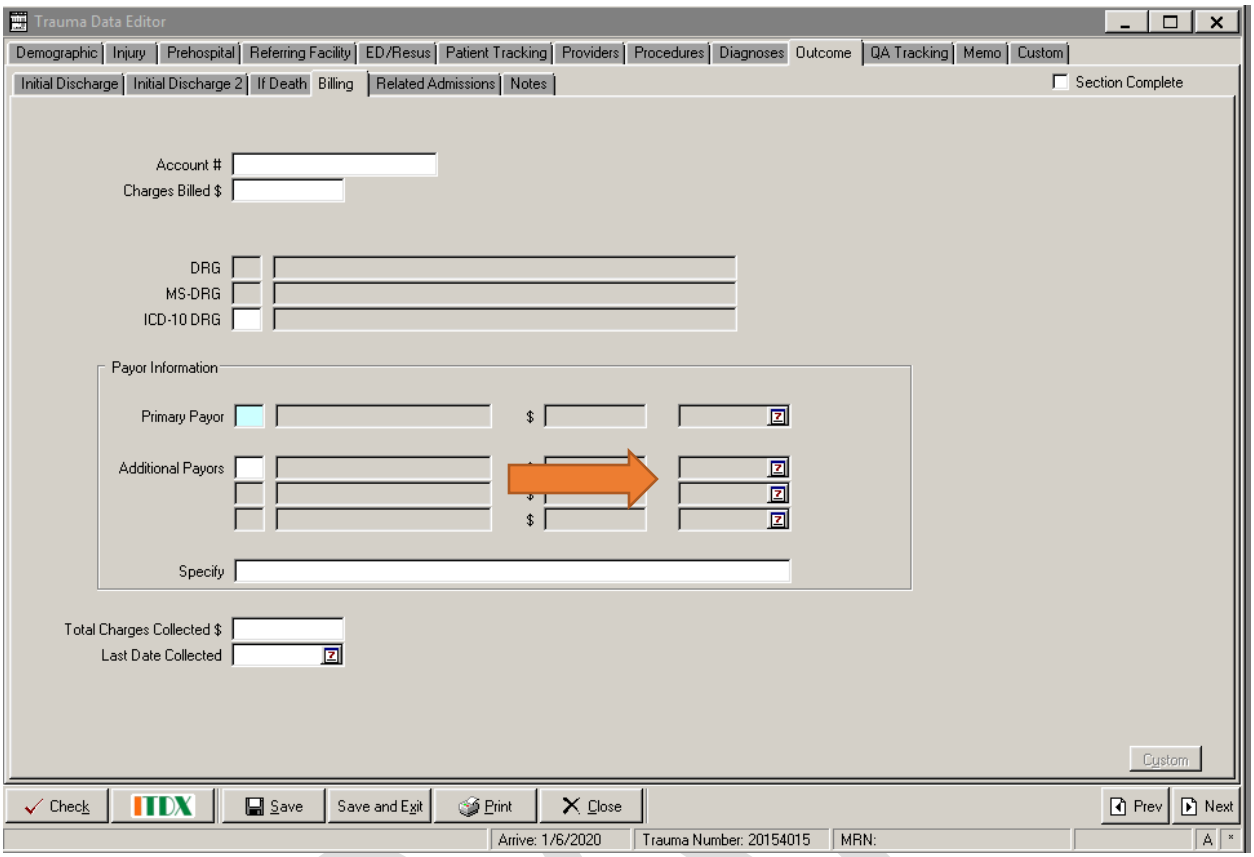
Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

DRAFT



Primary Payor Date

Definition

The last date the additional payor made payments for the hospitalization.

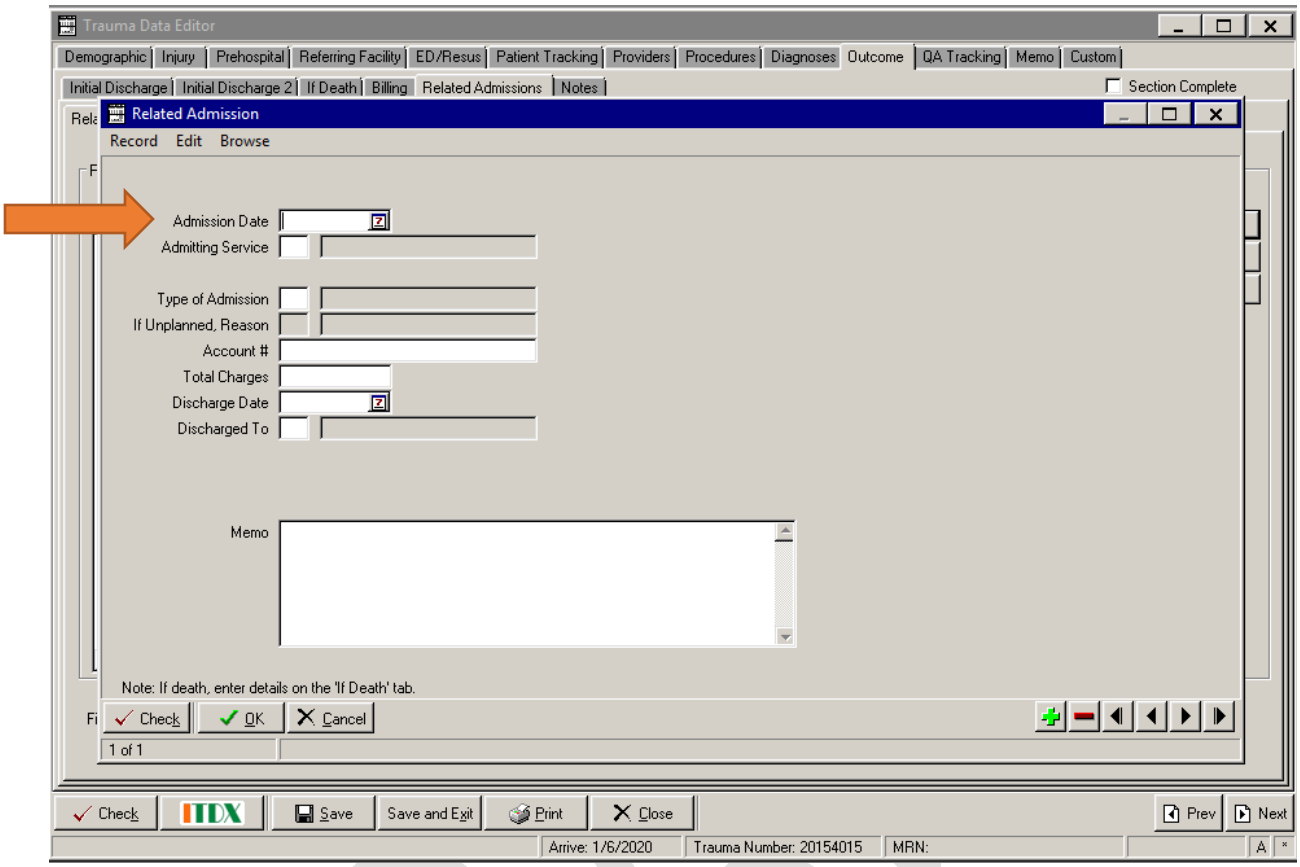
Element Value

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Billing/Coding
2. Medical Records

DRAFT



Related Admission: Admission

Definition

The date that the patient was readmitted to the hospital

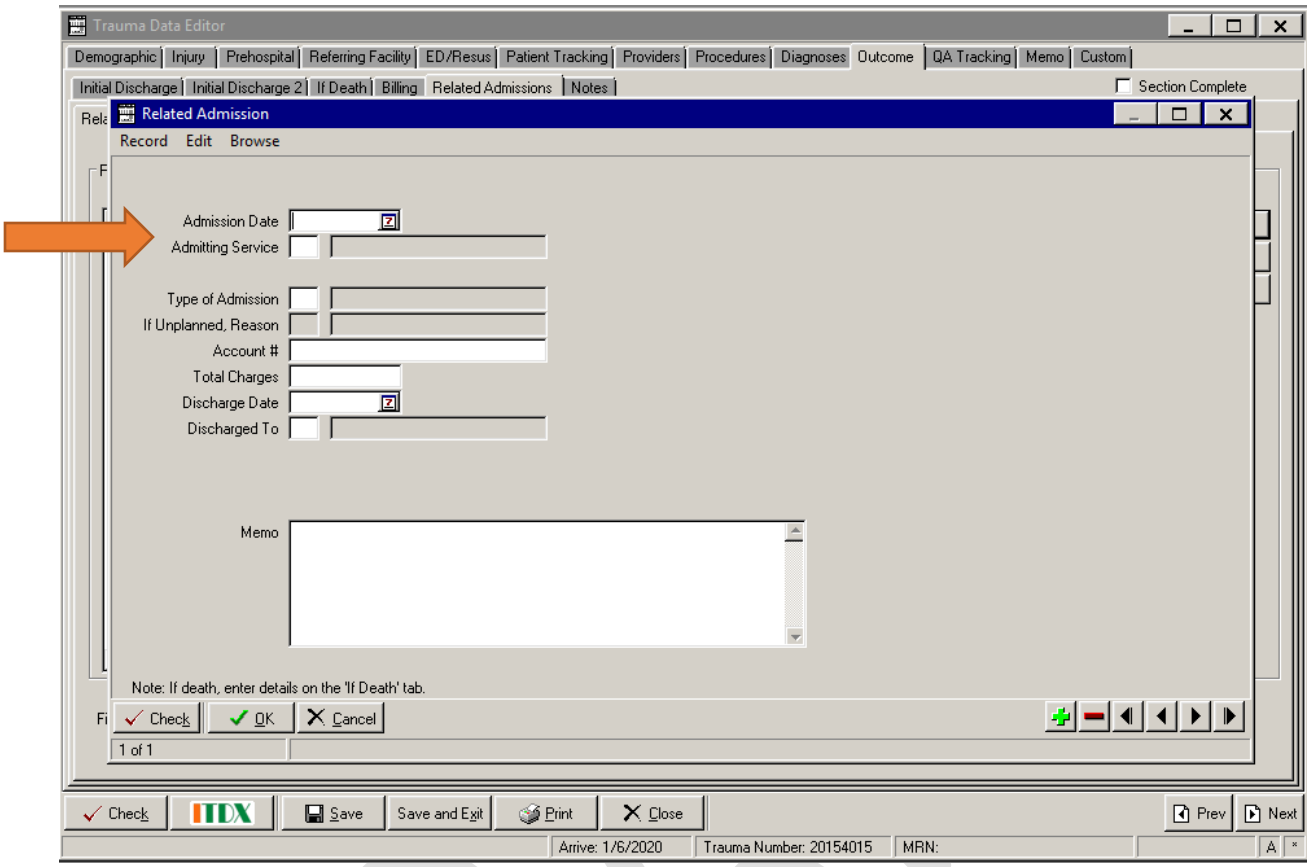
NOTE: Only collect on admissions within 30 days of original discharge. Only include admissions for an issue related to the original trauma admission.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Patient Encounter Events
2. ADT Events
3. History and Physical
4. Nursing Notes



Related Admission: Admitting Service

Definition

The service that readmitted the patient to the hospital

NOTE: Only collect on admissions within 30 days of original discharge

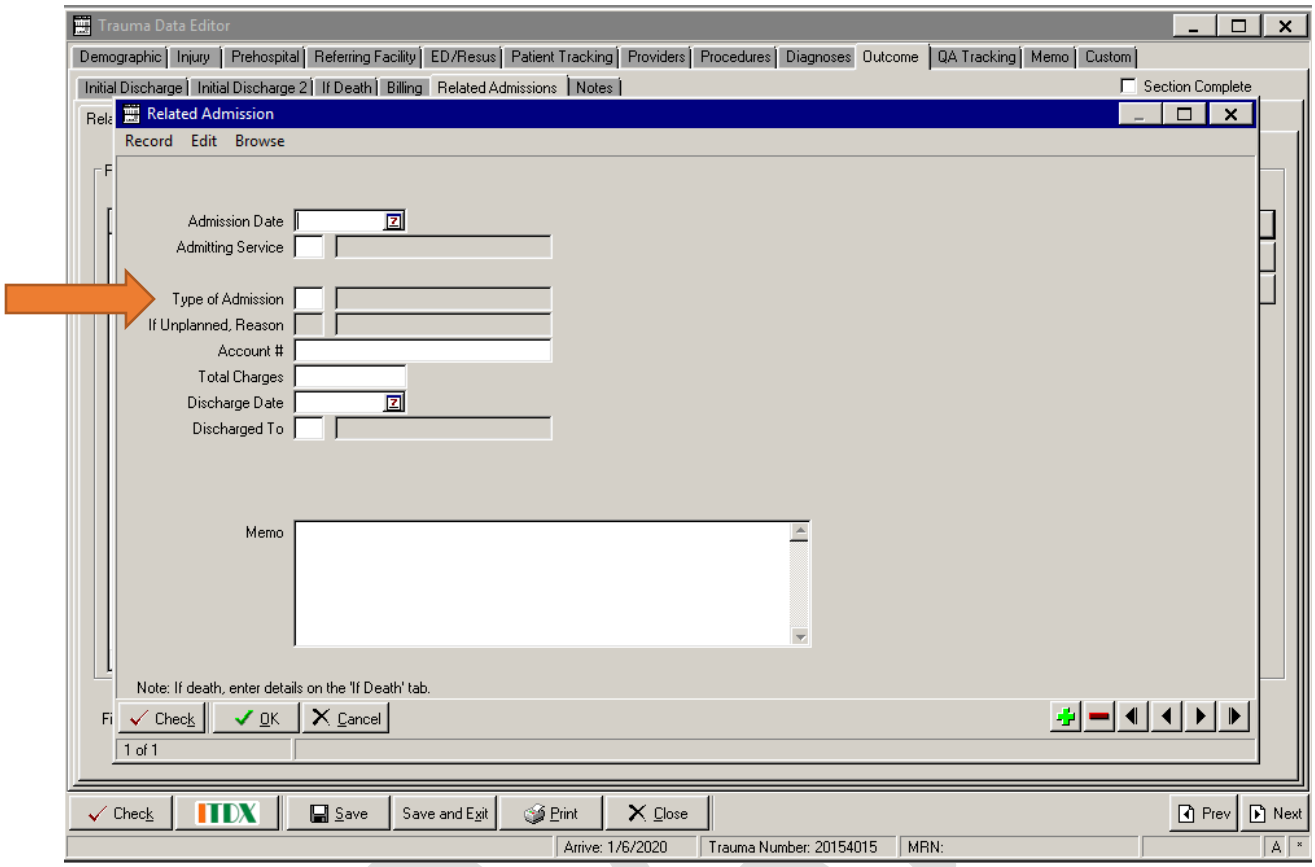
Element Values

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

Data Source Hierarchy Guide

1. Physician Order
2. History and Physical
3. Consult Note

DRAFT



Related Admission: Type of Admission

Definition

Was the admission planned or unplanned

NOTE: Only collect on admissions within 30 days of original discharge

Element Values

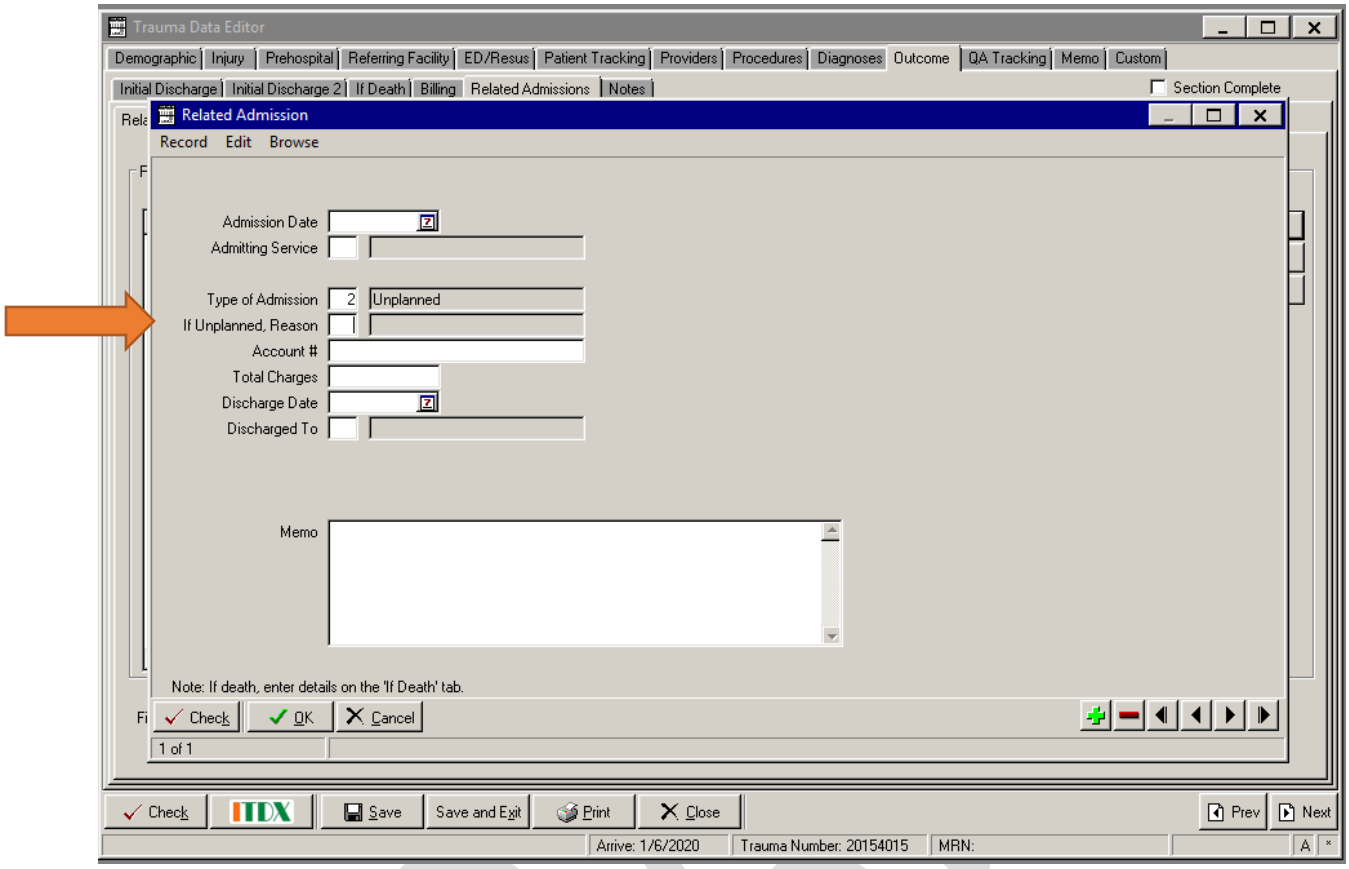
1. Planned
2. Unplanned

/. Not Applicable
? Unknown

Data Source Hierarchy Guide

1. History and Physical
2. Consult Note
3. Nursing Note

DRAFT



Related Admission: If Unplanned, Reason

Definition

What was the reason the patient was readmitted.

NOTE: Only collect on admissions within 30 days of original discharge

Element Values

1. Infection
2. Missed Diagnosis
3. Pain
4. Progression of Disease
5. Other

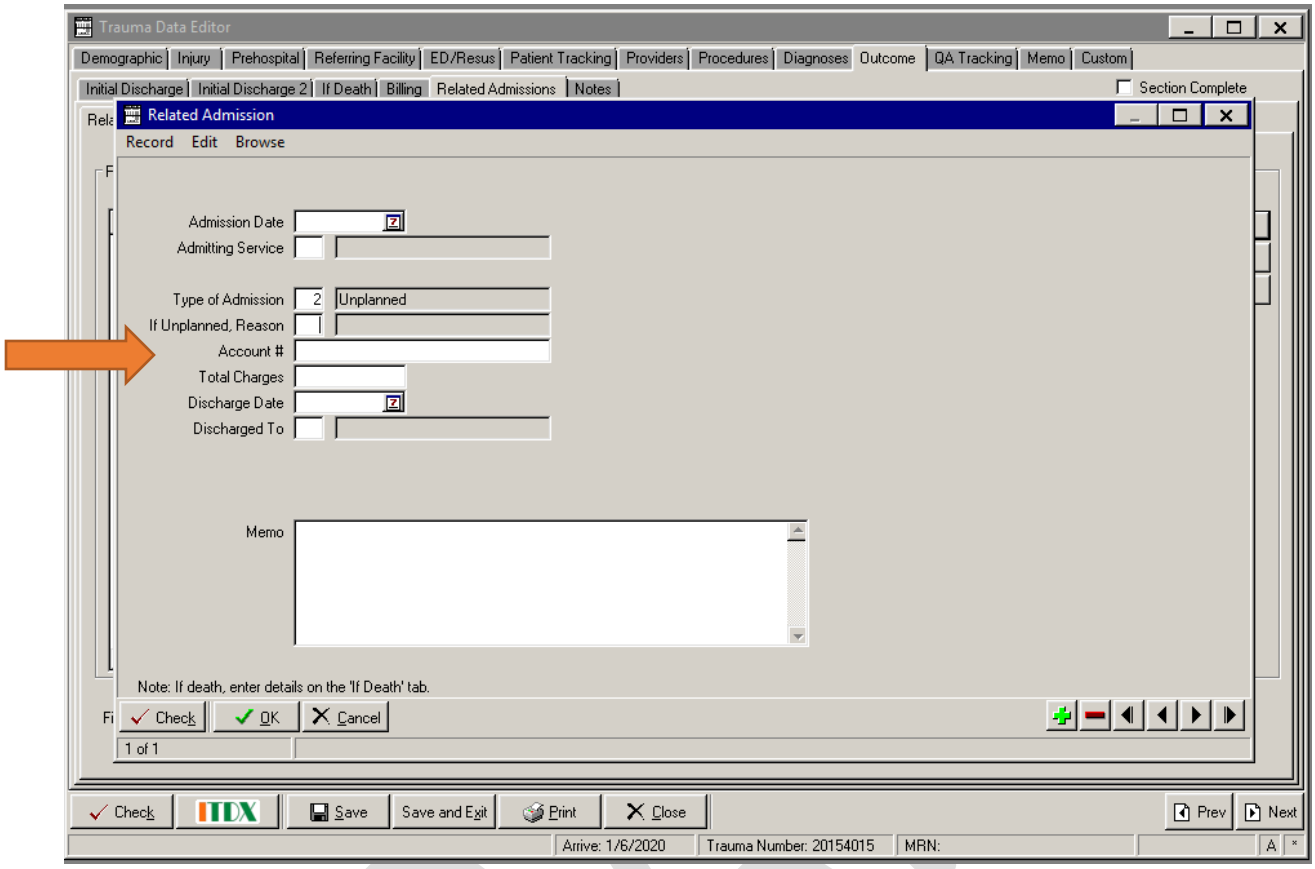
/. Not Applicable

?. Unknown

Data Source Hierarchy Guide

1. History and Physical
2. Consult Note
3. Nursing Note

DRAFT



Related Admission: Account Number

Definition

Patient number assigned for that specific encounter (HAR); primarily used for billing and coding

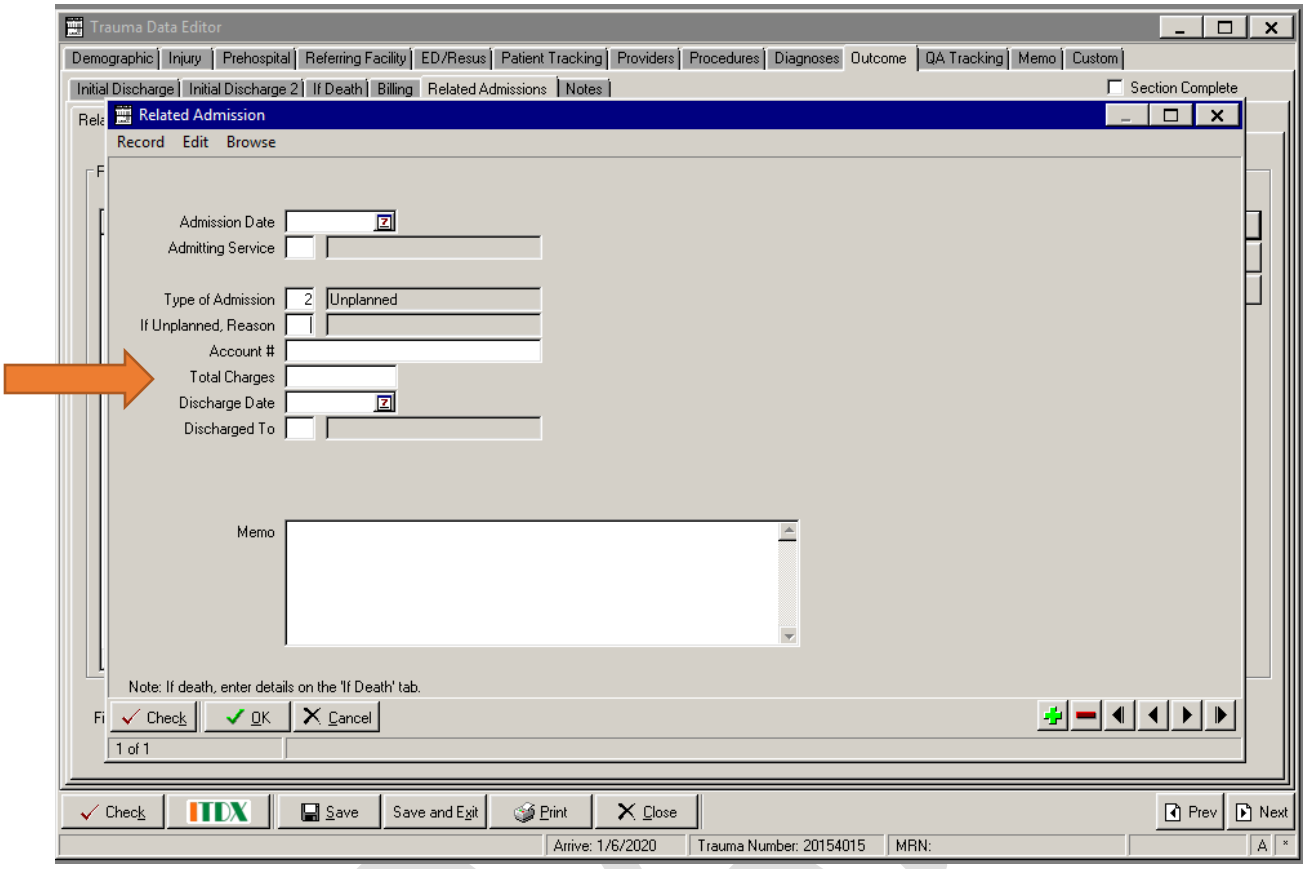
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide:

1. Face Sheet

DRAFT



Related Admission: Total Charges

Definition

The total charges billed for the hospital encounter

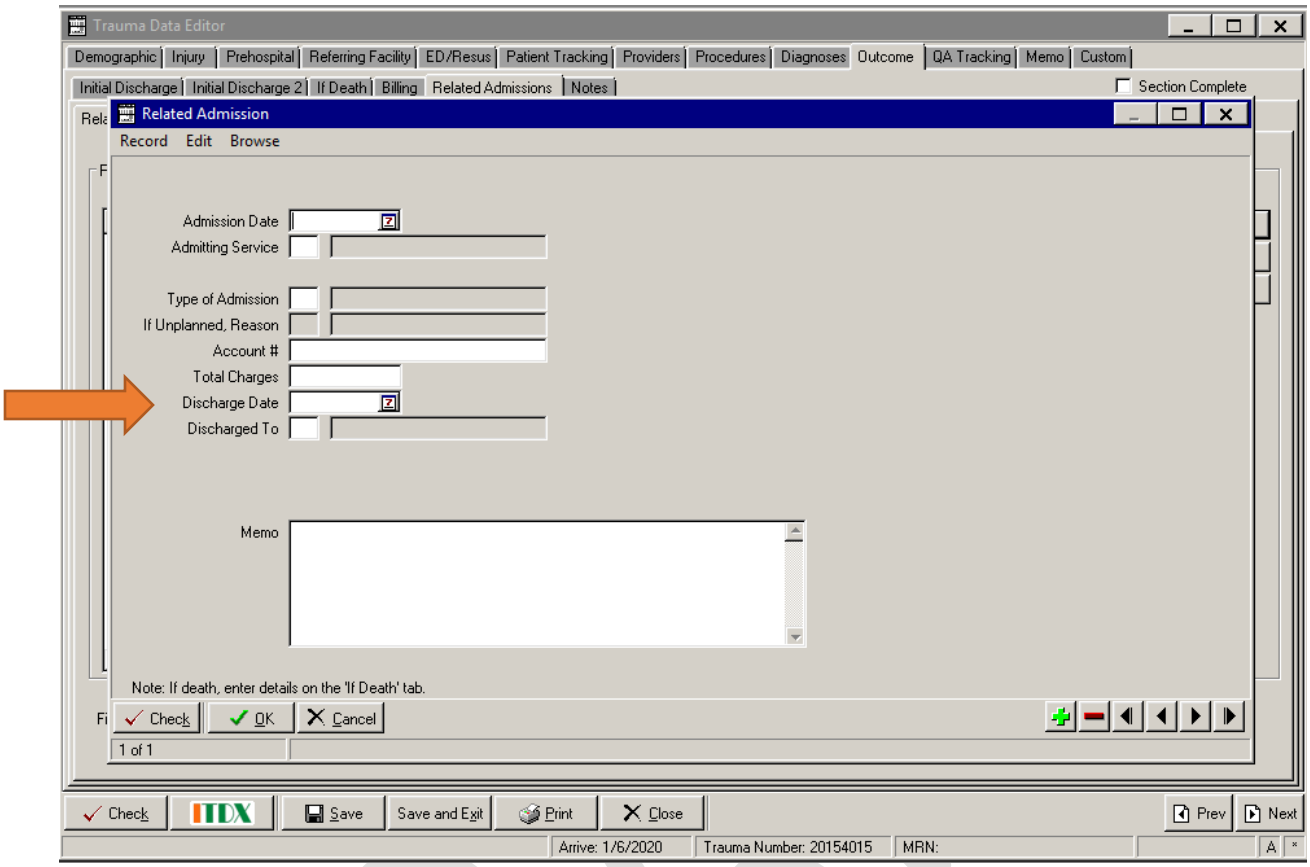
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide:

1. Billing/Coding
2. Medical Records

DRAFT



Related Admission: Discharge Date

Definition

The date that the patient was discharged from their readmission stay.

NOTE: Only collect on admissions within 30 days of original discharge

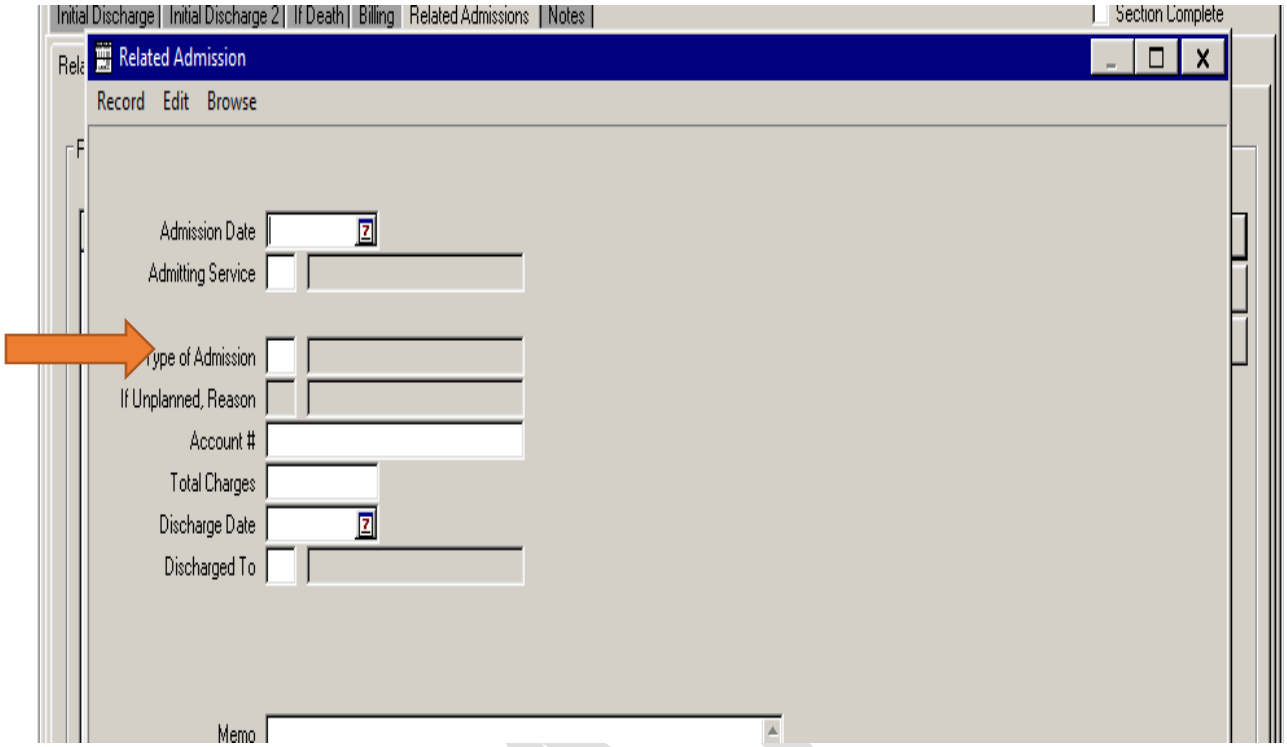
Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. ADT Events
2. Discharge Summary
3. Nursing Notes

DRAFT



Related Admission: Discharged To

Definition

Where the patient was discharged to after their hospital stay was complete.

NOTE: Only collect on admissions within 30 days of original discharge. If the patient dies during the readmission, place the details on the "If Death" tab.

Element Values / Choices in DI

40. Home or Self-Care (Routine Discharge)
41. Home with Services
42. Left AMA
43. Correctional Facility/Court/Law Enforcement
44. Morgue
45. Child Protective Agency
70. Acute Care Facility
71. Intermediate Care Facility
72. Skilled Nursing Facility
73. Rehab (Inpatient)
74. Long-Term Care
75. Hospice
76. Mental Health/Psychiatric Hospital (Inpatient)
77. Nursing Home
79. Another Type of Inpatient Facility Not Defined Elsewhere
80. Burn Center
?. Unknown

DRAFT

Data Source Hierarchy Guide

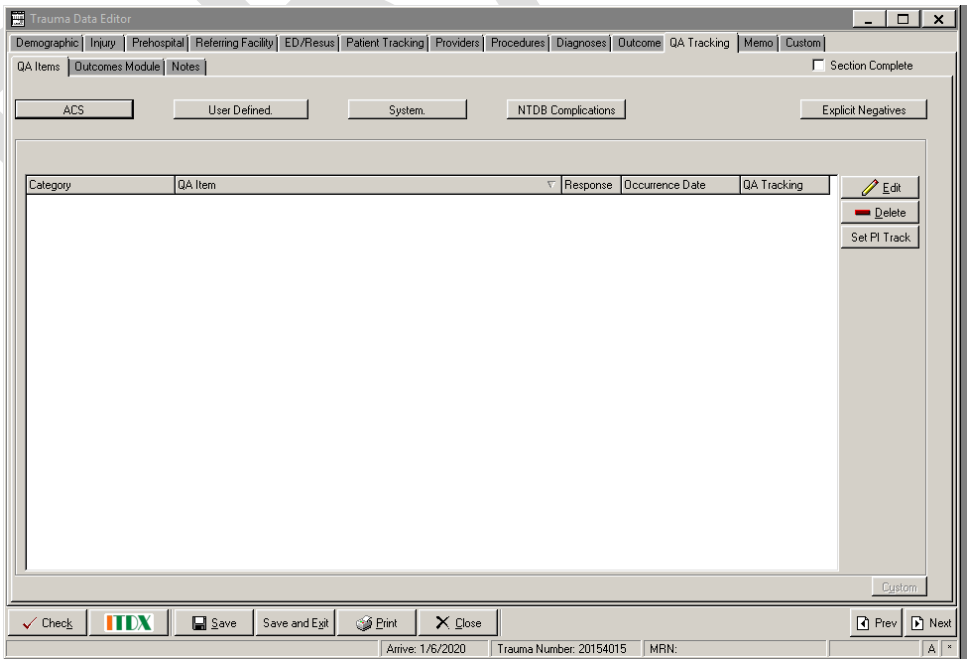
1. ADT Events
2. Discharge Summary
3. Case Management Note
4. Nursing Notes

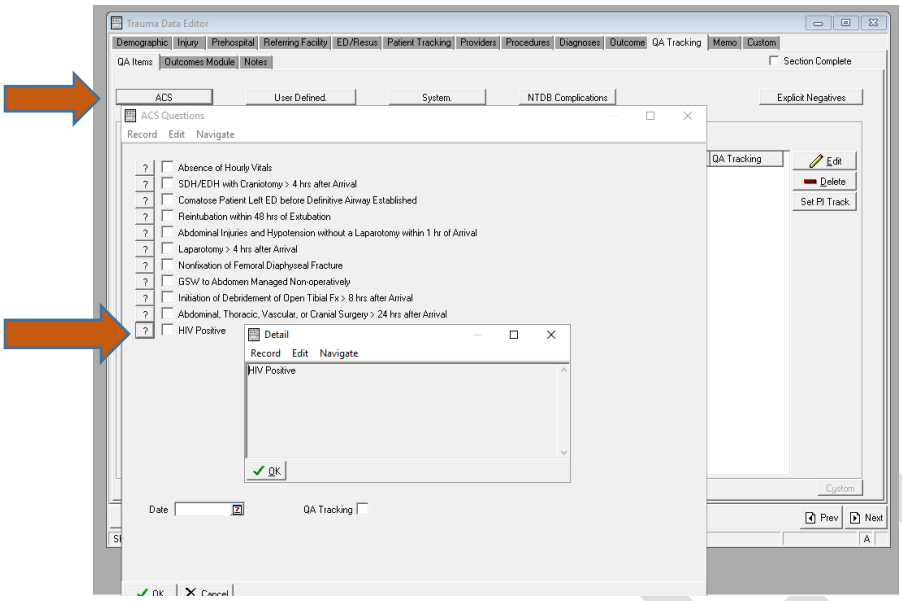
DRAFT

QA Tracking

QA Items

- There are multiple different QA items that you can enter into the registry.
- Much of this work is often done in collaboration with the Trauma Program Manager / Coordinator, Trauma PI Nurse and Registrar(s). Each facility will determine the workflow appropriate for their facility.
- Detailed definitions for the Mandatory NTDB hospital event (Events and Complications) can be found in your NTDS Data Dictionary. (Note that some NTDS definitions for complications differ from the CDC or other national definitions being used by your facility ID / HIM coders.)
- The ACS hospital events have question marks that will display the definitions when you click on them.
- The System QA has several items to choose from and generally look at hospital events from a system breakdown perspective.
- Entries in this Section are not viewable by IDPH; they are for use by you / your facility for PI activity.
- The IL Trauma Registry has the additional DI Driller capability which is accessible to all IL Trauma Centers and provides both statistical data and graph capability for a variety of data points.





ACS List

Definition

American College of Surgeons' recommended QI variances.

NOTE: The ACS hospital events have question marks that will display the definition of that variable when you click on them.

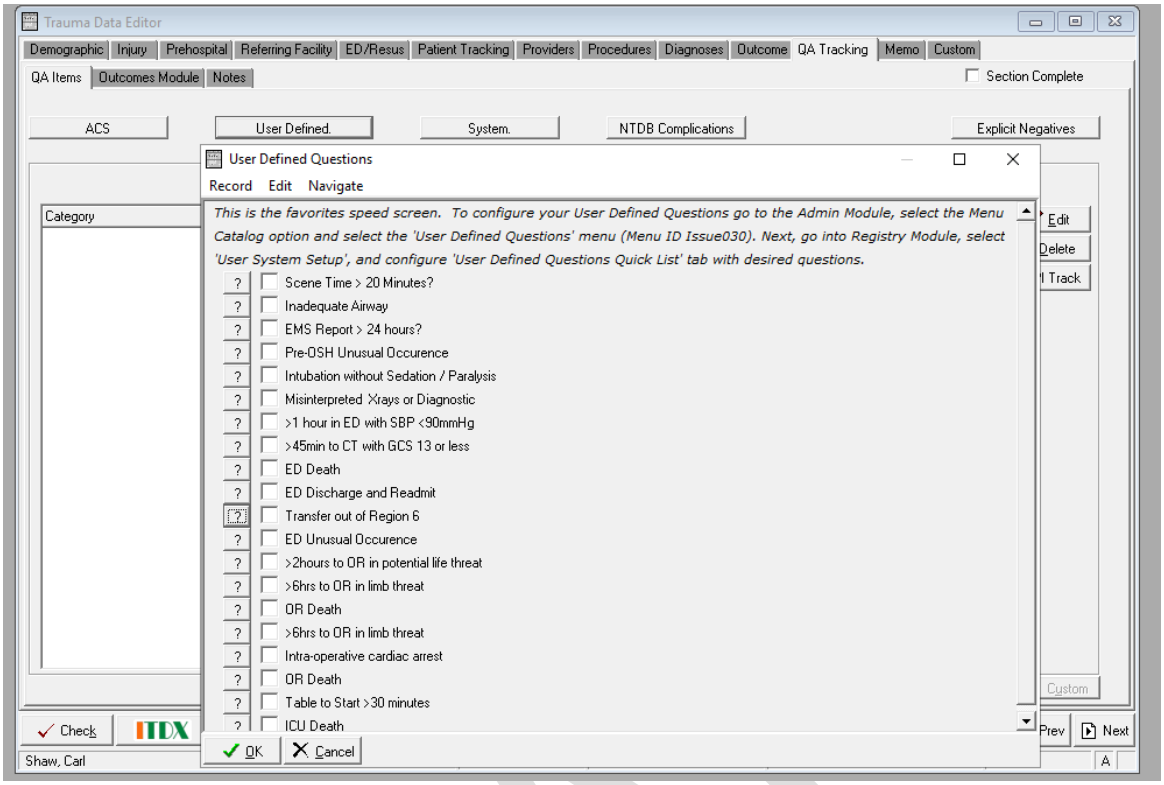
Element Values:

1. Yes
2. No
3. ? Unknown
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed.

DRAFT



User Defined List

Definition

Institution – defined QI variances being monitored.

(**Editor Note**: Unsure re: the exact functionality in the State web-based system, but should allow for specific variable monitoring in your system).

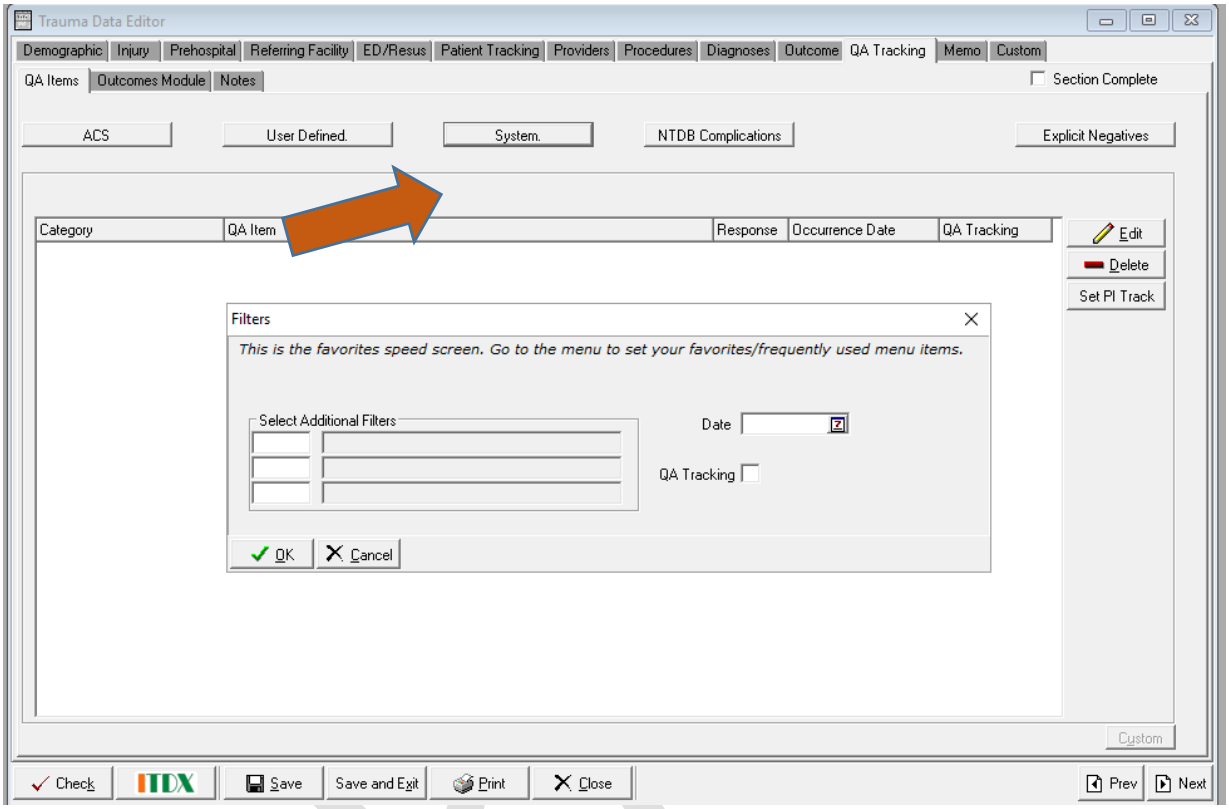
NOTE: The User-defined events also have question marks that will display the definition of that variable when you click on them.

Element Values:

1. Yes
2. No
3. ? Unknown
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed.

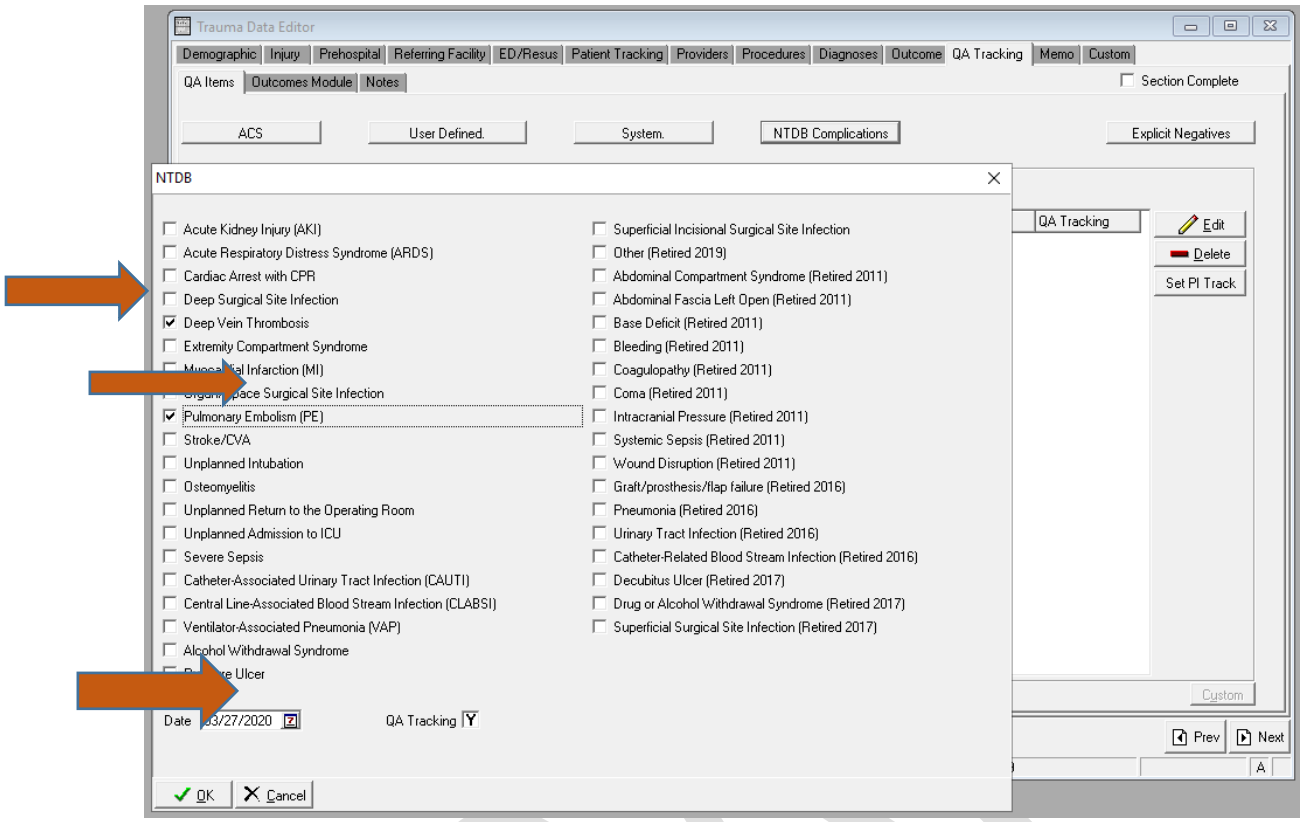


System List

Definition:

Speed access option to address defined system or Facility recommended QI variances.

(**Editor Note**: Don't see this option on the Web-based State version. Server-based facilities already familiar with use).



NTDB Complications and Hospital Events: MANDATORY BLUE FIELD; NTDS Definition rules.

Definition:

NTDB – defined complications. (See Hospital Events Section of the NTDS Data Dictionary for the detailed definitions being used for this item). It is >20 pages long, so not incorporated into our IL Dictionary.)

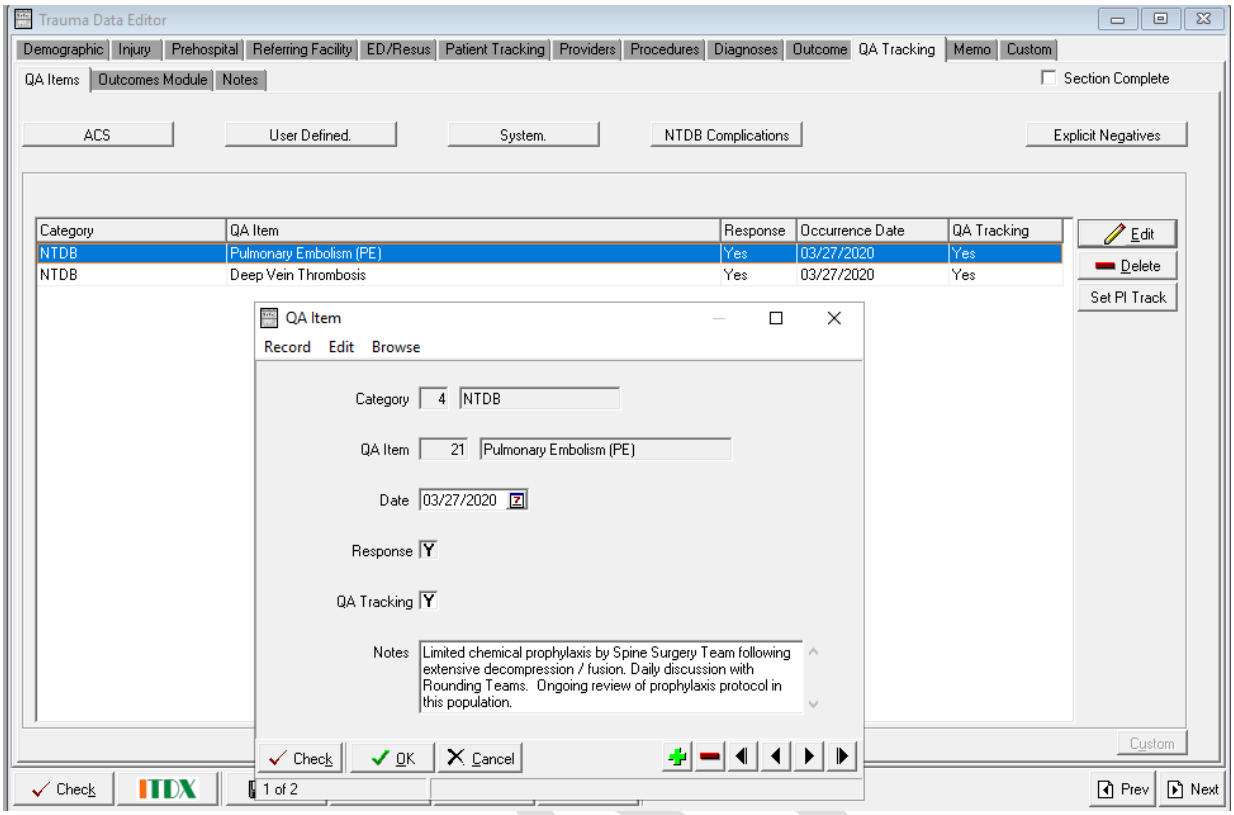
NOTE: Each Complication / Hospital Event is further designated with the date it was identified / diagnosed. This list is multi-select for complications identified / diagnosed on the same date.

Element Values:

1. Yes
2. No
3. ? Unknown
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed.



NTDS Complication Details:

Definition:

Detailed of the occurrence and/or PI actions related to each NTDB – defined complication.

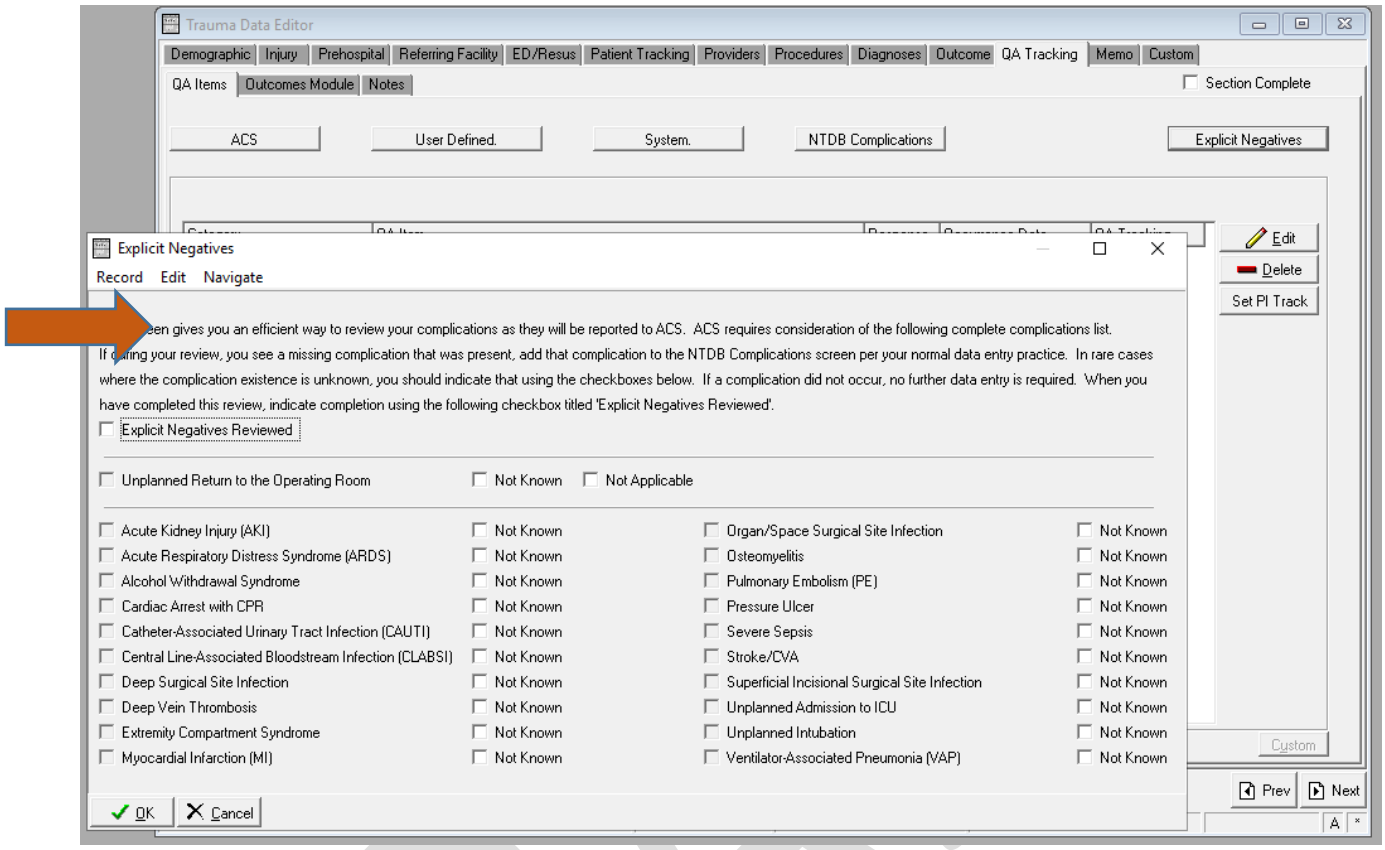
NOTE: The Registry will populate a row for each Complication entered. Selecting that row will allow you to edit / add details of the review and/or actions associated with each complication.

Element Values:

1. Yes
2. No
3. ? Unknown
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed and your Trauma Center PI Plan.



Explicit Negatives

Definition

Verification that each NTDB – defined complication has been evaluated for / captured during the chart review process.

NOTE: The description paragraph on this page details the intent and process. NTDS Data Dictionary Hospital Events (Complications) section is the reference for this work. "NOT KNOWN" should be a RARE response given the detailed chart review that has occurred at this point of data entry.

Data Source Hierarchy

1. Variable sources based on element being reviewed.

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