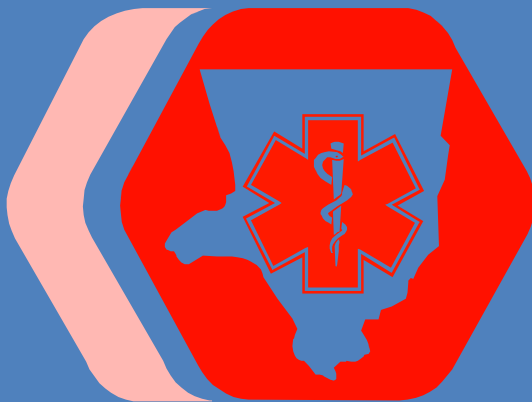


# TRAUMA CENTER DATA DICTIONARY

Los Angeles County  
Emergency Medical Services Agency



Incorporating:  
National Trauma Data Standards (NTDS®) 2022 Admissions  
Trauma Quality Improvement Program (TQIP®)



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## COMMON NULL VALUES

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### Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values.

### Field Values

- **F6:** Not Documented
- **F7:** Not Applicable

### 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.**
- *Not Documented (ND)*: This null value code applies if hospital documentation of an information system has an empty field or nothing is recorded. This null value signifies that the hospital patient care record provides a “placeholder” to document the specific data element, but that no value for that element was recorded for the patient. For example, a hospital patient care record may request date of birth, but the information was “*Not Documented*”.
- *Not Applicable (NA)*: This null value code applies if, at the time of patient care documentation, the information requested was “*Not Applicable*” to the patient, the hospitalization, or the patient care event. For example, variables documenting EMS care would be “*Not Applicable*” if a patient self-transport to the hospital.

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**NATIONAL TRAUMA DATABASE STANDARD (NTDS®) & TRAUMA  
QUALITY IMPROVEMENT PROGRAM (TQIP®)**

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**Definition**

National databases that LA County trauma centers contribute data to.

**Field Values**

- NTDS® values are mapped from the applicable LA County values
- TQIP® fields are identified by field titles in bold blue ink

**Additional Information**

- Additional fields specific to LA County, but not in NTDS® or TQIP®, are collected for system monitoring and evaluation.

## FUNCTION AND HOT KEYS

### Definition

These function and hot keys can be utilized at your discretion.

### Field Values

FUNCTION KEYS		HOT KEYS	
F2	Enter the current date or time.	^C	Copy
F3	Enter last entered date or time.	^E	Close ... (Report, Pathway, Page, etc.)
F4	Restore default value in selected field.	^I	Make new window copy.
F6	Not Documented.	^K	Run cross-checks for all fields in the current window.
F7	Not Applicable.	^L	List open windows.
F8	Calculate selected calculable field.	^M	Open note attached to selected field.
^F8	Calculate all calculable fields in the window.	^N	New ... (Report, Pathway, Page, etc.)
F9	Clear selected field.	^O	Open ... (Report, Pathway, Page, etc.)
F10	Set the current pathway and page to the user's defaults.	^P	Open picklist for selected field.
F11	Move to the next field group defined on the current window/page. Data Entry	^S	Save ... (Report, Pathway, Page, etc.)
F11	Place non-leaf picklist item in selected field. Report/Population	^T	Display descriptive text for the code entered in the selective field. Data Entry
Shift + F11	Move to the previous field group defined on the current window/page. Data Entry	^U	Undo
F12	Return to parent.	^V	Paste
^PgUp	Go to previous page in pathway or in multiple-paged window.	^X	Cut
^PgDn	Go to next page in pathway or in in multiple-paged window.	ALT + Q	Quick exit from the system.

(^ Control Key)

## SCROLLING WINDOWS COMMANDS

### Definition

These commands can be utilized at your discretion.

### Field Values

COMMANDS FOR SCROLLING WINDOWS	
PGUP	Move up a window full of items at a time in scrolling window and picklists.
PGDN	Move down a window full of items at a time in scrolling window and picklists.
^UP ARROW	Move out of scrolling window to previous item.
^DOWN ARROW	Move out of scrolling window to next item.
^A	Add new row to scrolling window.
^I	Insert new row above current row in scrolling window.
^D	Delete selected row in scrolling window.
^C	Copy selected row in scrolling window to the end of the scrolling window.
ALT+F9	Copy selected field value in scrolling window to the same field in successive rows having no values.
ALT+R	Resize scrolling windows and graphic boxes with arrows. (Valid only in Reconfiguration.)
^F	Go to first row in scrolling window.
^B	Go to last row in scrolling window.
SYSTEM-WIDE	
Single Click	Selects object.
Double Click	On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist. On a title bar, minimizes the window.
Right Click	On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist.
ESC	Close open picklist, dialog window, or menu.

(^ Control Key)

# GENERAL INFORMATION

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**DHS PATIENT?**

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**Definition**

Indicates whether the patient meets TEMIS database inclusion criteria (LA Trauma Database Inclusion Criteria).

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- “Yes” indicates that patient meets LA Trauma Database Inclusion Criteria.
- “No” indicates that patient does not meet LA Trauma Database Inclusion Criteria, and will not be included in the LA County Trauma Database.
- Patient’s with ONLY ICD-10-CM or ICD-10-CA codes “NFS”, or unspecified codes resulting in an AIS severity score of 9, and therefore no ISS, should be identified as DHS=No patients.
- DHS=Yes patients based upon inclusion criteria of Hospital Admission (AD), MUST be evaluated by the Trauma Surgeon in the ED.
- DHS=Yes patients based upon inclusion criteria of Transfer Higher Level of Care (TS), MUST be transferred to or from your facility, and admitted by a Trauma Surgeon for care of an injury.
- Null Values are not accepted for this data field.

**Uses**

- Determines which patients should be submitted to the LA County Trauma Database.

**Other Associated Elements**

- LA TRAUMA DATABASE INCLUSION CRITERIA

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**TRAUMA CENTER CODE**


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**Definition**

Three-letter code for the trauma center submitting data.

**Field Values**

<b>AVH</b>	Antelope Valley Hospital	<b>LBM</b>	MemorialCare Long Beach Medical Center
<b>CAL</b>	Dignity Health – California Hospital Medical Center	<b>NRH</b>	Dignity Health – Northridge Hospital Medical Center
<b>CHH</b>	Children’s Hospital Los Angeles	<b>PVC</b>	Pomona Valley Hospital Medical Center
<b>CSM</b>	Cedars-Sinai Medical Center	<b>SFM</b>	St. Francis Medical Center
<b>HCH</b>	Providence Holy Cross Medical Center	<b>SMM</b>	Dignity Health – Saint Mary Medical Center
<b>HGH</b>	LAC Harbor-UCLA Medical Center	<b>UCL</b>	Ronald Reagan UCLA Medical Center
<b>HMH</b>	Huntington Hospital	<b>USC</b>	LAC+USC Medical Center
<b>HMN</b>	Henry Mayo Newhall Hospital		

**Additional Information**

- Auto-populated as a read-only field – no user action necessary.

**Uses**

- Identifies the treating facility.
- System evaluation and monitoring.

---

**LAST NAME**

---

---

**Definition**

Patient's last name.

**Field Values**

- Free text

**Additional Information**

- Null Values are not accepted for this data field.

**Uses**

- Patient identifier.
- Link between other databases.

**Data Source Hierarchy**

- Facesheet
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

**Other Associated Elements**

- FIRST NAME
- MIDDLE INITIAL



---

**FIRST NAME**

---

---

**Definition**

Patient's first name.

**Field Values**

- Free text

**Additional Information**

- Null Values are not accepted for this data field.

**Uses**

- Patient identifier.
- Link between other databases.

**Data Source Hierarchy**

- Facesheet
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

**Other Associated Elements**

- MIDDLE INITIAL
- LAST NAME

---

---

## MIDDLE INITIAL

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**Definition**

Patient's middle initial.

**Field Values**

- Free text

**Uses**

- Patient identifier.
- Link between other databases.

**Data Source Hierarchy**

- Facesheet
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

**Other Associated Elements**

- FIRST NAME
- LAST NAME

---

**ARRIVAL DATE**

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**Definition**

The date the patient arrived in the Emergency Department (ED) or was admitted to the hospital.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- If the patient was brought to the ED, enter the date patient arrived in the ED.
- If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Null Values are not accepted for this data field.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.
- Used to calculate Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

**Data Source Hierarchy**

- ED Record
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- Other Hospital Records
- Hospital Discharge Summary

**Other Associated Elements**

- ARRIVAL TIME
- DISPATCH DATE/TIME
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME

---

## ARRIVAL TIME

---

### Definition

The time of the day the patient arrived to the ED/hospital.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- If the patient was brought to the ED, enter time patient arrived in the ED.
- If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.
- Data entry of this field will auto-populate ED arrival time regardless of entry mode (ED arrival time will be auto-populated even if the patient is a direct admit).
- Field value cannot be *“Not Applicable”*.
- Field value cannot be left blank.

### Uses

- Establishes care intervals and incident timelines.
- Used to calculate Total Length of Hospital Stay.

### Data Source Hierarchy

- ED Records
- EMS Record

### Other Associated Elements

- ARRIVAL DATE
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME

---

**HOME ADDRESS**

---

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**Definition**

The house or building number of the patient's primary residence.

**Field Values**

- Free text

**Additional Information**

- If the only address provided is a P.O. Box, enter in place of the patient's home address.

**Uses**

- Epidemiological statistics.
- Patient identifier.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- HOME STREET/TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

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---

## HOME STREET/TYPE

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**Definition**

The street name and type of the patient's primary residence.

**Field Values**

- Free text

**Uses**

- Epidemiological statistics.
- Patient identifier.

**Data Source Hierarchy**

- Facesheet
- ED records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- HOME ADDRESS
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

---

**HOME APT #**

---

---

**Definition**

The apartment number of the patient's primary residence.

**Field Values**

- Free text

**Uses**

- Allows data to be sorted based upon the geographic location of the patient's home.
- Patient identifier.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- HOME ADDRESS
- HOME STREET/TYPE
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

---

---

## HOME ZIP CODE

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---

### Definition

The zip code of the patient's primary residence.

### Field Values

- Five-digit numeric value

### Additional Information

- Data entry of a valid home zip code will auto-populate home city, home county, home state, and home country.
- Enter the null value of "*Not Documented*" if patient possess an address that cannot be found on any document.
- Enter the null value of "*Not Applicable*" for patients that do not have a home.
- Zip code entered as "*Not Applicable*" will auto-populate all subsequent address related fields with "*Not Applicable*".
- If the only address provided is a P.O. Box, utilize the zip code for the P.O. Box.
- Data element cannot be left blank.

### Uses

- Used to calculate Federal Information Processing Standard (FIPS) code.
- Epidemiological statistics.

### Data Source Hierarchy

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

### Other Associated Elements

- HOME ADDRESS
- HOME STREET/TYPE
- HOME APT #
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY



**ALTERNATE HOME ADDRESS**

**Definition**

Documentation of the type of address the patient has when the home zip code is *“Not Applicable”*.

**Field Values**

LA COUNTY		NTDS	
<b>H</b>	Homeless	1	Homeless
<b>U</b>	Undocumented Citizen	2	Undocumented Citizen
<b>M</b>	Migrant Worker	3	Migrant Worker
<b>F</b>	Foreign Visitor	<i>“Not Applicable”</i>	

**Additional Information**

- Only complete when zip 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 the US without permission.
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country to accept seasonal employment in the same country.
- Foreign Visitor is defined as a national of another country who is visiting in Los Angeles County.
- Data element cannot be left blank.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- History and Physical
- EMS Record

**Other Associated Elements**

- HOME ADDRESS
- HOME STREET/TYPE
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

**HOME CITY**

**Definition**

The city of the patient's primary residence.

**Field Values**

<b>AA</b>	Arleta	<b>DU</b>	Duarte	<b>LM</b>	La Mirada
<b>AC</b>	Acton	<b>DZ</b>	Dominguez	<b>LN</b>	Lawndale
<b>AD</b>	Altadena	<b>EL</b>	East Los Angeles	<b>LO</b>	Lomita
<b>AE</b>	Arlington Heights	<b>EM</b>	El Monte	<b>LP</b>	La Puente
<b>AG</b>	Agua Dulce	<b>EN</b>	Encino	<b>LQ</b>	LAX
<b>AH</b>	Agoura Hills	<b>EO</b>	El Sereno	<b>LR</b>	La Crescenta
<b>AL</b>	Alhambra	<b>EP</b>	Echo Park	<b>LS</b>	Los Nietos
<b>AN</b>	Athens	<b>ER</b>	Eagle Rock	<b>LT</b>	Lancaster
<b>AO</b>	Avocado Heights	<b>ES</b>	El Segundo	<b>LU</b>	Lake Hughes
<b>AR</b>	Arcadia	<b>EV</b>	Elysian Valley	<b>LV</b>	La Verne
<b>AT</b>	Artesia	<b>EZ</b>	East Rancho Dominguez	<b>LW</b>	Lake View Terrace
<b>AV</b>	Avalon	<b>FA</b>	Fairmont	<b>LX</b>	Lennox
<b>AW</b>	Atwater Village	<b>FL</b>	Florence County	<b>LY</b>	Lynwood
<b>AZ</b>	Azusa	<b>FO</b>	Fair Oaks Ranch	<b>LZ</b>	Lake Elizabeth
<b>BA</b>	Bel Air Estates	<b>GA</b>	Gardena	<b>MA</b>	Malibu
<b>BC</b>	Bell Canyon	<b>GF</b>	Griffith Park	<b>MB</b>	Manhattan Beach
<b>BE</b>	Bellflower	<b>GH</b>	Granada Hills	<b>MC</b>	Malibu Beach
<b>BG</b>	Bell Gardens	<b>GK</b>	Glenoaks	<b>MD</b>	Marina Del Rey
<b>BH</b>	Beverly Hills	<b>GL</b>	Glendale	<b>ME</b>	Monte Nido
<b>BK</b>	Bixby Knolls	<b>GO</b>	Gorman	<b>MG</b>	Montecito Heights
<b>BL</b>	Bell	<b>GP</b>	Glassell Park	<b>MH</b>	Mission Hills
<b>BN</b>	Baldwin Hills	<b>GR</b>	Green Valley	<b>MI</b>	Mint Canyon
<b>BO</b>	Bouquet Canyon	<b>GV</b>	Glenview	<b>ML</b>	Malibu Lake
<b>BP</b>	Baldwin Park	<b>GW</b>	Glendora	<b>MM</b>	Miracle Mile
<b>BR</b>	Bradbury	<b>HA</b>	Hawthorne	<b>MN</b>	Montrose
<b>BS</b>	Belmont Shore	<b>HB</b>	Hermosa Beach	<b>MO</b>	Montebello
<b>BT</b>	Bassett	<b>HC</b>	Hacienda Heights	<b>MP</b>	Monterey Park
<b>BU</b>	Burbank	<b>HE</b>	Harvard Heights	<b>MR</b>	Mar Vista
<b>BV</b>	Beverly Glen	<b>HG</b>	Hawaiian Gardens	<b>MS</b>	Mount Wilson
<b>BW</b>	Brentwood	<b>HH</b>	Hidden Hills	<b>MT</b>	Montclair
<b>BX</b>	Box Canyon	<b>HI</b>	Highland Park	<b>MU</b>	Mount Olympus
<b>BY</b>	Boyle Heights	<b>HK</b>	Holly Park	<b>MV</b>	Monrovia
<b>BZ</b>	Byzantine-Latino Quarter	<b>HO</b>	Hollywood	<b>MW</b>	Maywood
<b>CA</b>	Carson	<b>HP</b>	Huntington Park	<b>MY</b>	Metler Valley
<b>CB</b>	Calabasas	<b>HR</b>	Harbor City	<b>NA</b>	Naples
<b>CC</b>	Culver City	<b>HV</b>	Hi Vista	<b>NE</b>	Newhall
<b>CE</b>	Cerritos	<b>HY</b>	Hyde Park	<b>NH</b>	North Hollywood
<b>CH</b>	Chatsworth	<b>IG</b>	Inglewood	<b>NN</b>	Neenach
<b>CI</b>	Chinatown	<b>IN</b>	City of Industry	<b>NO</b>	Norwalk
<b>CK</b>	Charter Oak	<b>IR</b>	Irwindale	<b>NR</b>	Northridge
<b>CL</b>	Claremont	<b>JH</b>	Juniper Hills	<b>NT</b>	North Hills
<b>CM</b>	Compton	<b>JP</b>	Jefferson Park	<b>OP</b>	Ocean Park
<b>CN</b>	Canyon Country	<b>KG</b>	Kagel Canyon	<b>OT</b>	Other
<b>CO</b>	Commerce	<b>KO</b>	Koreatown	<b>PA</b>	Pasadena
<b>CP</b>	Canoga Park	<b>LA</b>	Los Angeles	<b>PB</b>	Pearblossom
<b>CR</b>	Crenshaw	<b>LB</b>	Long Beach	<b>PC</b>	Pacoima
<b>CS</b>	Castaic	<b>LC</b>	La Canada Flintridge	<b>PD</b>	Palmdale
<b>CT</b>	Century City	<b>LD</b>	Ladera Heights	<b>PE</b>	Pacific Palisades
<b>CU</b>	Cudahy	<b>LE</b>	Leona Valley	<b>PH</b>	Pacific Highlands
<b>CV</b>	Covina	<b>LF</b>	Los Feliz	<b>PI</b>	Phillips Ranch
<b>CY</b>	Cypress Park	<b>LH</b>	La Habra Heights	<b>PL</b>	Playa Vista
<b>DB</b>	Diamond Bar	<b>LI</b>	Little Rock	<b>PM</b>	Paramount
<b>DO</b>	Downey	<b>LK</b>	Lakewood	<b>PN</b>	Panorama City
<b>DS</b>	Del Sur	<b>LL</b>	Lake Los Angeles	<b>PO</b>	Pomona

<b>PP</b>	Palos Verdes Peninsula	<b>SK</b>	Sherman Oaks	<b>UP</b>	University Park
<b>PR</b>	Pico Rivera	<b>SL</b>	Sun Valley	<b>VA</b>	Valencia
<b>PS</b>	Palms	<b>SM</b>	Santa Monica	<b>VC</b>	Venice
<b>PT</b>	Porter Ranch	<b>SN</b>	San Marino	<b>VE</b>	Vernon
<b>PV</b>	Palos Verdes Estates	<b>SO</b>	South Gate	<b>VG</b>	Valley Glen
<b>PY</b>	Playa Del Rey	<b>SP</b>	South Pasadena	<b>VI</b>	Valley Village
<b>QH</b>	Quartz Hill	<b>SQ</b>	Sleepy Valley	<b>VL</b>	Valinda
<b>RB</b>	Redondo Beach	<b>SR</b>	San Pedro	<b>VN</b>	Van Nuys
<b>RC</b>	Roosevelt Corner	<b>SS</b>	Santa Fe Springs	<b>VV</b>	Val Verde
<b>RD</b>	Rancho Dominguez	<b>ST</b>	Santa Clarita	<b>VW</b>	View Park
<b>RE</b>	Rolling Hills Estates	<b>SU</b>	Sunland	<b>VY</b>	Valyermo
<b>RH</b>	Rolling Hills	<b>SV</b>	Stevenson Ranch	<b>WA</b>	Walnut
<b>RK</b>	Rancho Park	<b>SW</b>	Sawtelle	<b>WB</b>	Willowbrook
<b>RM</b>	Rosemead	<b>SX</b>	South Central County	<b>WC</b>	West Covina
<b>RO</b>	Rowland Heights	<b>SY</b>	Sylmar	<b>WE</b>	West Hills
<b>RP</b>	Rancho Palos Verdes	<b>SZ</b>	Studio City	<b>WG</b>	Wilsona Gardens
<b>RS</b>	Reseda	<b>TA</b>	Tarzana	<b>WH</b>	West Hollywood
<b>RV</b>	Rampart Village	<b>TC</b>	Temple City	<b>WI</b>	Whittier
<b>RW</b>	Rosewood	<b>TD</b>	Tropico	<b>WK</b>	Winnetka
<b>SA</b>	Saugus	<b>TE</b>	Topanga State Park	<b>WL</b>	Woodland Hills
<b>SB</b>	Sandberg	<b>TH</b>	Thousand Oaks	<b>WM</b>	Wilmington
<b>SC</b>	Santa Clara	<b>TI</b>	Terminal Island	<b>WN</b>	Windsor Hills
<b>SD</b>	San Dimas	<b>TJ</b>	Tujunga	<b>WO</b>	Westlake
<b>SE</b>	South El Monte	<b>TL</b>	Toluca Lake	<b>WP</b>	Walnut Park
<b>SF</b>	San Fernando	<b>TO</b>	Torrance	<b>WR</b>	Westchester
<b>SG</b>	San Gabriel	<b>TP</b>	Topanga	<b>WS</b>	Windsor Square
<b>SH</b>	Signal Hill	<b>TR</b>	Three Points	<b>WT</b>	Watts
<b>SI</b>	Sierra Madre	<b>TT</b>	Toluca Terrace	<b>WV</b>	Westlake Village
<b>SJ</b>	Silver Lake	<b>UC</b>	Universal City	<b>WW</b>	Westwood

**Additional Information**

- Data entry of a valid home zip code will auto-populate the home city.
- Only complete when zip code is "Not Documented" or "Not Known".
- Zip code entered as "Not Applicable" will auto-populate all subsequent address related fields with "Not Applicable".
- If the zip code entered doesn't match the patient's home city provided, manually override the information and enter the correct patient's home city. Follow-up with Lancet by ESO representatives for identification of problem zip codes.
- Data element cannot be left blank.

**Uses**

- Used to calculate FIPS code.
- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- HOME ADDRESS
- HOME STREET/TYPE
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

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**HOME COUNTY**

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**Definition**

The county of the patient's primary residence.

**Field Values**

- **Los Angeles:** Los Angeles
- **Orange:** Orange
- **Riverside:** Riverside
- **San Bernardino:** San Bernardino
- **San Diego:** San Diego
- **Ventura:** Ventura
- **Other:** Other

**Additional Information**

- Data entry of a valid home zip code will auto-populate the home county.
- Only complete when home zip code is *"Not Documented"* or *"Not Known"*.
- Zip code entered as *"Not Applicable"* will auto-populate all subsequent address related fields with *"Not Applicable"*.
- Data element cannot be left blank.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- HOME ADDRESS
- HOME STREET/TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME STATE
- HOME COUNTRY

## HOME STATE

### Definition

The two-letter code for the state (territory, province, or District of Columbia) of the patient’s primary residence.

### Field Values

<b>AK</b>	Alaska	<b>LA</b>	Louisiana	<b>OR</b>	Oregon
<b>AL</b>	Alabama	<b>MA</b>	Massachusetts	<b>PA</b>	Pennsylvania
<b>AR</b>	Arkansas	<b>MD</b>	Maryland	<b>PR</b>	Puerto Rico
<b>AS</b>	American Samoa	<b>ME</b>	Maine	<b>PW</b>	Palau
<b>AZ</b>	Arizona	<b>MH</b>	Marshall Islands	<b>RI</b>	Rhode Island
<b>CA</b>	California	<b>MI</b>	Michigan	<b>SC</b>	South Carolina
<b>CO</b>	Colorado	<b>MN</b>	Minnesota	<b>SD</b>	South Dakota
<b>CT</b>	Connecticut	<b>MO</b>	Missouri	<b>TN</b>	Tennessee
<b>DC</b>	District of Columbia	<b>MP</b>	Northern Mariana Islands	<b>TX</b>	Texas
<b>DE</b>	Delaware	<b>MS</b>	Mississippi	<b>UM</b>	US Minor Outlying Islands
<b>FL</b>	Florida	<b>MT</b>	Montana	<b>UT</b>	Utah
<b>FM</b>	Federated States of Micronesia	<b>NC</b>	North Carolina	<b>VA</b>	Virginia
<b>GA</b>	Georgia	<b>ND</b>	North Dakota	<b>VI</b>	Virgin Islands of the US
<b>GU</b>	Guam	<b>NE</b>	Nebraska	<b>VT</b>	Vermont
<b>HI</b>	Hawaii	<b>NH</b>	New Hampshire	<b>WA</b>	Washington
<b>IA</b>	Iowa	<b>NJ</b>	New Jersey	<b>WI</b>	Wisconsin
<b>ID</b>	Idaho	<b>NM</b>	New Mexico	<b>WV</b>	West Virginia
<b>IL</b>	Illinois	<b>NV</b>	Nevada	<b>WY</b>	Wyoming
<b>IN</b>	Indiana	<b>NY</b>	New York	<b>OT</b>	Other
<b>KS</b>	Kansas	<b>OH</b>	Ohio		
<b>KY</b>	Kentucky	<b>OK</b>	Oklahoma		

### Additional Information

- Data entry of a valid home zip code will auto-populate the home state.
- Only complete when home zip code is "Not Documented" or "Not Known".
- Zip code entered as "Not Applicable" will auto-populate all subsequent address related fields with "Not Applicable".
- Data element cannot be left blank.

### Uses

- Epidemiological statistics.

### Data Source Hierarchy

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME COUNTRY

## HOME COUNTRY

### Definition

The country of the patient's primary residence.

### Field Values

<b>AFG</b>	Afghanistan	<b>EQU</b>	Equatorial Guinea	<b>MAS</b>	Mauritius
<b>ALB</b>	Albania	<b>ETH</b>	Ethiopia	<b>MAT</b>	Malta
<b>ALG</b>	Algeria	<b>FIJ</b>	Fiji	<b>MAU</b>	Mauritania
<b>ANG</b>	Angola	<b>FIN</b>	Finland	<b>MAV</b>	Maldives
<b>ANT</b>	Antigua and Barbuda	<b>FRA</b>	France	<b>MAY</b>	Malaysia
<b>ARG</b>	Argentina	<b>FRE</b>	French Polynesia	<b>MEX</b>	Mexico
<b>ARM</b>	Armenia	<b>GAB</b>	Gabon	<b>MON</b>	Mongolia
<b>AUS</b>	Australia	<b>GAM</b>	Gambia	<b>MOR</b>	Morocco
<b>AUT</b>	Austria	<b>GER</b>	German	<b>MOZ</b>	Mozambique
<b>BAH</b>	Bahamas	<b>GHA</b>	Ghana	<b>MYA</b>	Burma
<b>BAA</b>	Bahrain	<b>GRE</b>	Greece	<b>NAM</b>	Nambia
<b>BAN</b>	Bangladesh	<b>GRN</b>	Grenada	<b>NEH</b>	Netherlands Antilles
<b>BAR</b>	Barbados	<b>GUA</b>	Guadalupe	<b>NEP</b>	Nepal
<b>BEL</b>	Belgium	<b>GUT</b>	Guatemala	<b>NET</b>	Netherlands
<b>BEI</b>	Belize	<b>GUI</b>	Guinea	<b>NEW</b>	New Caledonia
<b>BEN</b>	Benin	<b>GUN</b>	Guinea-Bissau	<b>NEZ</b>	New Zealand
<b>BHU</b>	Bhutan	<b>GUY</b>	Guyana	<b>NIC</b>	Nicaragua
<b>BOL</b>	Bolivia	<b>HAI</b>	Haiti	<b>NIE</b>	Nigeria
<b>BOS</b>	Bosnia	<b>HON</b>	Honduras	<b>NIG</b>	Niger
<b>BOT</b>	Botswana	<b>HOK</b>	Hong Kong	<b>NOR</b>	Norway
<b>BRA</b>	Brazil	<b>HUN</b>	Hungary	<b>OMA</b>	Oman
<b>BRU</b>	Brunei	<b>ICE</b>	Iceland	<b>PAC</b>	Pacific Islands
<b>BUL</b>	Bulgaria	<b>IND</b>	India	<b>PAK</b>	Pakistan
<b>BUR</b>	Burkina Faso	<b>INO</b>	Indonesia	<b>PAN</b>	Panama
<b>BUU</b>	Burundi	<b>IRA</b>	Iran	<b>PAP</b>	Papua New Guinea
<b>CAM</b>	Cambodia	<b>IRQ</b>	Iraq	<b>PAR</b>	Paraguay
<b>CAE</b>	Cameroon	<b>IRE</b>	Ireland	<b>PER</b>	Peru
<b>CAN</b>	Canada	<b>ISR</b>	Israel	<b>PHI</b>	Philippines
<b>CAP</b>	Cape Verde	<b>ITA</b>	Italy	<b>POL</b>	Poland
<b>CEN</b>	Central African Republic	<b>JAM</b>	Jamaica	<b>POR</b>	Portugal
<b>CHA</b>	Chad	<b>JAP</b>	Japan	<b>PUE</b>	Puerto Rico
<b>CHI</b>	Chile	<b>JOR</b>	Jordan	<b>QAT</b>	Qatar
<b>CHN</b>	China	<b>KEN</b>	Kenya	<b>REU</b>	Reunion
<b>COL</b>	Columbia	<b>KOE</b>	South Korea	<b>ROM</b>	Romania
<b>COM</b>	Comoros	<b>KOR</b>	North Korea	<b>RUS</b>	Russia
<b>CON</b>	Congo	<b>KUW</b>	Kuwait	<b>RWA</b>	Rwanda
<b>COS</b>	Costa Rica	<b>LAO</b>	Laos	<b>SAI</b>	Saint Lucia
<b>COT</b>	Cote D'Ivoire	<b>LEB</b>	Lebanon	<b>SAO</b>	Sao Tome and Principe
<b>CUB</b>	Cuba	<b>LES</b>	Lesotho	<b>SAU</b>	Saudi Arabia
<b>CYP</b>	Cyprus	<b>LBR</b>	Liberia	<b>SEN</b>	Senegal
<b>CZE</b>	Czechoslovakia	<b>LBY</b>	Libya	<b>SEY</b>	Seychelles
<b>DEN</b>	Denmark	<b>LUX</b>	Luxembourg	<b>SIE</b>	Sierra Leone
<b>DJI</b>	Djibouti	<b>LVA</b>	Latvia	<b>SIN</b>	Singapore
<b>DOM</b>	Dominica	<b>MAC</b>	Macao	<b>SOL</b>	Solomon Islands
<b>DOI</b>	Dominica Republic	<b>MAD</b>	Madagascar	<b>SOM</b>	Somalia
<b>ECU</b>	Ecuador	<b>MAI</b>	Mali	<b>SOU</b>	South Africa
<b>EGY</b>	Egypt	<b>MAL</b>	Malawi	<b>SPA</b>	Spain
<b>ELS</b>	El Salvador	<b>MAR</b>	Martinique	<b>SRI</b>	Sri Lanka
<b>STK</b>	St. Kitts-Nevis	<b>TON</b>	Tonga	<b>STV</b>	St. Vincent & The Grenadines
<b>SUD</b>	Sudan	<b>TUN</b>	Tunisia	<b>VEN</b>	Venezuela

<b>SUR</b>	Suriname	<b>TUR</b>	Turkey	<b>VIE</b>	Vietnam
<b>SWA</b>	Swaziland	<b>UGA</b>	Uganda	<b>WES</b>	Western Sahara
<b>SYR</b>	Syria	<b>UKR</b>	Ukraine	<b>YMN</b>	Yemen
<b>TAI</b>	Taiwan	<b>UNI</b>	United Arab Emirates	<b>ZAI</b>	Zaire
<b>TAN</b>	Tanzania	<b>UNT</b>	United Kingdom	<b>ZAM</b>	Zambia
<b>THA</b>	Thailand	<b>USA</b>	United States	<b>ZIM</b>	Zimbabwe
<b>TOG</b>	Togo	<b>URU</b>	Uruguay		
<b>TRI</b>	Trinidad and Tobago	<b>VAN</b>	Vanuatu		

**Additional Information**

- Data entry of a valid home zip code will auto-populate the home country.
- Only complete when zip code is "Not Documented" or "Not Known".
- If patient's home country is not US, then the null value "Not Applicable" is reported to NTDS® for: patient's home state, patient's home county, and patient's home city.
- Zip code entered as "Not Applicable" will auto-populate all subsequent address related fields with "Not Applicable".
- Data element cannot be left blank.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- HOME ADDRESS
- HOME STREET/TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE

## GENDER

### Definition

Patient’s gender.

### Field Values

LA COUNTY		NTDS	
<b>M</b>	Male	1	Male
<b>F</b>	Female	2	Female
<b>N</b>	Nonbinary	3	Non-binary

### Additional Information

- Patients who are undergoing, or have undergone, a hormonal and/or surgical sex reassignment should be coded using their stated preference.
- Nonbinary is a gender option for individuals whose gender identity isn’t exclusively male or female.
- Field value cannot be a *null value*.
- Field value cannot be left blank.

### Uses

- Epidemiological statistics.

### Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical
- EMS Record



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**DATE OF BIRTH (DOB)**

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**Definition**

Patient's date of birth.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- If "*Not Documented*", or "*Not Known*" complete variables: age and age units.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- AGE
- AGE UNITS
- PEDIATRIC/ADULT

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**AGE**

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**Definition**

Numeric value for the age (actual or best approximation) of the patient at the time of injury when the date of birth is unavailable.

**Field Values**

- Positive numeric value

**Additional Information**

- If date of birth is entered, the age and age units will be auto-populated.
- Entry required only when the date of birth is less than 24 hours, "*Not Documented*", or "*Not Known*".
- If approximation of the patient's age is utilized, must also complete age unit field.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

**Other Associated Elements**

- DATE OF BIRTH
- AGE UNIT

## AGE UNIT

### Definition

The unit of measurement used to document the best approximation of the patient's age at the time of injury when the date of birth is unavailable.

### Field Values

LA COUNTY		NTDS	
<b>Y</b>	Years	4	Years
<b>M</b>	Months	3	Months
<b>W</b>	Weeks	6	Weeks
<b>D</b>	Days	2	Days
<b>H</b>	Hours	1	Hours
<i>(Not Applicable in LA County)</i>		5	Minutes
<b>YE</b>	Years Estimated	4	Years
<b>ME</b>	Months Estimated	3	Months
<b>WE</b>	Weeks Estimated	6	Weeks
<b>DE</b>	Days Estimated	2	Days
<b>HE</b>	Hours Estimated	1	Hours

### Additional Information

- If date of birth is entered, the age and age unit will be auto-populated.
- Entry required only when the date of birth is less than 24 hours, "Not Documented", or "Not Known".
- If date of birth is unknown, use estimated field values.
- If unit of measurement used to document the best approximation of the patient's age is utilized, must also complete age field.
- For patients 2 years of age or older, use "Y".
- For patients 1 to 23 months of age, use "M".
- For patients whose age is reported in weeks instead of months, use "W".
- For patients 1 to 29 days old, use "D".
- For patients up to 23 hours old, use "H".

### Uses

- Epidemiological statistics.

### Data Source Hierarchy

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

### Other Associated Elements

- DATE OF BIRTH
- AGE

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**PEDIATRIC/ADULT**

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**Definition**

Patient's status, adult versus pediatric, at the time of injury.

**Field Values**

- **A:** Adult
- **P:** Pediatric

**Additional Information**

- Normally calculated from date of birth and auto-populated.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

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

**Other Associated Elements**

- DATE OF BIRTH
- AGE
- AGE UNIT

## RACE/ETHNICITY

### Definition

Patient’s race/ethnicity.

### Field Values

LA COUNTY		NTDS			
Race/Ethnicity		Race		Ethnicity	
<b>A</b>	Asian/Non-Pacific Islander	1	Asian	2	Not Hispanic or Latino
<b>B</b>	Black/African American	5	Black/African American	2	Not Hispanic or Latino
<b>H</b>	Hispanic/Latino	6	White	1	Hispanic or Latino
<b>N</b>	Native American/Alaska Native	4	American Indian	2	Not Hispanic or Latino
<b>P</b>	Pacific Islander/Hawaiian	2	Hawaiian/Pacific Islander	2	Not Hispanic or Latino
<b>U</b>	Unknown	3	Other Race	2	Not Hispanic or Latino
<b>W</b>	White	6	White	2	Not Hispanic or Latino
<b>O</b>	Other	3	Other Race	2	Not Hispanic or Latino

### Additional Information

- Patient race/ethnicity should be based upon self-report or identified by a family member.
- Asian/Non-Pacific Islander is defined as a person with origins in the Far East, southeast Asia, or the Indian subcontinent, e.g. Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black/African American is defined as a person with origins in any of the Black racial groups of Africa (includes Haitians).
- Hispanic/Latino is defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Native American/Alaska Native is defined as a person with origins in North, Central, and South America and maintains tribal affiliation or community attachment.
- Pacific Islander/Native Hawaiian is defined as a person with origins in Hawaii, Guam, Samoa, or other Pacific Islands.
- White is defined as a person with origins in Europe, the Middle East, or North Africa.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

### Uses

- Epidemiological statistics.

### Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical

## ENTRY MODE

### Definition

Mode of transport of the patient to the treating facility.

### Field Values

LA COUNTY	NTDS			
Entry Mode	Transport Mode		Interfacility Transfer	
<b>EMS:</b>				
EMS/Ground	1	Ground	2	No
EMS/Air	2	Helicopter	2	No
<b>NON-EMS:</b>				
Vehicle/Walk-in	4	Vehicle/Walk-in	2	No
Police	5	Police	2	No
Other	6	Other	2	No
<b>TRANSFERRED:</b>				
9-1-1 Re-Triage/Ground	1	Ground	1	Yes
9-1-1 Re-Triage/Air	2	Helicopter	1	Yes
ED to ED/Ground	1	Ground	1	Yes
ED to ED/Air	2	Helicopter	1	Yes
Direct Admit/Ground	1	Ground	1	Yes
Direct Admit/Air	2	Helicopter	1	Yes
<i>(Not applicable in LA County)</i>	3	Fixed Wing	1	Yes

### Additional Information

- If entry mode is “Non-EMS”, “Vehicle”, “Police”, or “Other”, the EMS data fields will be auto-populated with “*Not Applicable*”, e.g. Dispatch Information, Provider, Field Vital Signs, etc.
- “9-1-1 Re-Triage” is indicated when the patient is transferred from the ED of an acute care facility emergently via 9-1-1 to the ED at your facility (Use Default Pathway for data entry).
- “ED to ED” is indicated when the patient is both transferred from the ED of an acute care facility and has an ED phase of care at your facility (Use Default Pathway for data entry).
- “Direct Admit” is indicated when the patient is transferred from an acute care facility to your facility as an inpatient. Excludes patients transferred from a private doctor’s office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport (Use Direct Admit Pathway for data entry).
- Use of the Direct Admit Pathway will auto-populate ED specific data fields with “*Not Applicable*”.
- Field value cannot be “*Not Applicable*”.

### Uses

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME

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## EMS RECORD AVAILABLE?

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### Definition

Indicates whether a copy of the EMS record is available for abstraction.

### Field Values

- **Y:** Yes
- **N:** No

### Additional Information

- The EMS Record is an essential link between the EMS, Base, and Trauma databases – **every effort should be made to obtain the EMS Record.**
- If entry mode is EMS, entering “No” will auto-populate the following EMS fields with “*Not Documented*”:
  - PROVIDER
  - RA/SQ
  - DISPATCH DATE
  - DISPATCH TIME
  - 1st ON SCENE
  - TRANSPORT ARRIVAL DATE
  - TRANSPORT ARRIVAL TIME
  - TRANSPORT LEFT SCENE DATE
  - TRANSPORT LEFT SCENE TIME
  - 1st FIELD GCS
  - FIELD INTUBATION?
  - PREHOSPITAL TOURNIQUET
  - 1st FIELD VS

### Uses

- System evaluation and monitoring

### Data Source Hierarchy

- EMS Record

### Other Associated Elements

- ENTRY MODE

**TRANSFERRED FROM**

**Definition**

EMS Agency’s three-letter code for the hospital from which the patient was transferred to your facility, if applicable.

**Field Values**

LOS ANGELES COUNTY 9-1-1 RECEIVING			
<b>ACH</b>	Alhambra Hospital Medical Center	<b>LBC</b>	Community Hospital Long Beach
<b>AHM</b>	Catalina Island Medical Center	<b>LBM</b>	MemorialCare Long Beach Medical Center
<b>AMH</b>	Methodist Hospital of Southern California	<b>LCH</b>	Palmdale Regional Medical Center
<b>AVH</b>	Antelope Valley Hospital	<b>LCM</b>	Providence Little Co. of Mary M.C. - Torrance
<b>BEV</b>	Beverly Hospital	<b>MCP</b>	Mission Community Hospital
<b>BMC</b>	Southern California Hospital at Culver City	<b>MHG</b>	Memorial Hospital of Gardena
<b>CAL</b>	Dignity Health - California Hospital Medical Center		
<b>CHH</b>	Children’s Hospital Los Angeles	<b>MLK</b>	Martin Luther King Jr. Community Hospital
<b>CHP</b>	Community Hospital of Huntington Park	<b>MPH</b>	Monterey Park Hospital
<b>CNT</b>	Centinela Hospital Medical Center	<b>NOR</b>	Los Angeles Community Hospital at Norwalk
<b>CPM</b>	Coast Plaza Hospital	<b>NRH</b>	Dignity Health - Northridge Hospital Medical Center
<b>CSM</b>	Cedars-Sinai Medical Center	<b>OVM</b>	LAC Olive View-UCLA Medical Center
<b>DCH</b>	PIH Health Hospital - Downey	<b>PAC</b>	Pacifica Hospital of the Valley
<b>DFM</b>	Cedars-Sinai Marina Del Rey Hospital	<b>PIH</b>	PIH Health Hospital - Whittier
<b>DHL</b>	Lakewood Regional Medical Center	<b>PLB</b>	College Medical Center
<b>ELA</b>	East Los Angeles Doctors Hospital	<b>PVC</b>	Pomona Valley Hospital Medical Center
<b>ENH</b>	Encino Hospital Medical Center	<b>QOA</b>	Hollywood Presbyterian Medical Center
<b>FPH</b>	Emanate Health Foothill Presbyterian Hospital	<b>QVH</b>	Emanate Health Queen of the Valley Hospital
<b>GAR</b>	Garfield Medical Center	<b>SDC</b>	San Dimas Community Hospital
<b>GEM</b>	Greater El Monte Community Hospital	<b>SFM</b>	St. Francis Medical Center
<b>GMH</b>	Dignity Health - Glendale Memorial Hospital and Health Center	<b>SGC</b>	San Gabriel Valley Medical Center
<b>GSH</b>	Good Samaritan Hospital	<b>SJH</b>	Providence Saint John’s Health Center
<b>GWT</b>	Adventist Health - Glendale	<b>SJS</b>	Providence Saint Joseph Medical Center
<b>HCH</b>	Providence Holy Cross Medical Center	<b>SMH</b>	Santa Monica-UCLA Medical Center
<b>HGH</b>	LAC Harbor-UCLA Medical Center	<b>SMM</b>	Dignity Health - St. Mary Medical Center
<b>HMH</b>	Huntington Hospital	<b>SOC</b>	Sherman Oaks Hospital
<b>HMN</b>	Henry Mayo Newhall Hospital	<b>SPP</b>	Providence Little Co. of Mary M.C. - San Pedro
<b>HWH</b>	West Hills Hospital and Medical Center	<b>TOR</b>	Torrance Memorial Medical Center
<b>ICH</b>	Emanate Health Inter-Community Hospital	<b>TRM</b>	Providence Cedars-Sinai Tarzana Medical Center
<b>KFA</b>	Kaiser Foundation Hospital – Baldwin Park	<b>UCL</b>	Ronald Reagan UCLA Medical Center
<b>KFB</b>	Kaiser Foundation Hospital – Downey	<b>USC</b>	LAC+USC Medical Center
<b>KFH</b>	Kaiser Foundation Hospital – South Bay	<b>VHH</b>	USC Verdugo Hills Hospital
<b>KFL</b>	Kaiser Foundation Hospital – Sunset (Los Angeles)	<b>VPH</b>	Valley Presbyterian Hospital
<b>KFO</b>	Kaiser Foundation Hospital – Woodland Hills	<b>WHH</b>	Whittier Hospital Medical Center
<b>KFP</b>	Kaiser Foundation Hospital – Panorama City	<b>WMH</b>	Adventist Health - White Memorial
<b>KFW</b>	Kaiser Foundation Hospital – West Los Angeles		



ORANGE COUNTY 9-1-1 RECEIVING			
<b>ANH</b>	Anaheim Regional Medical Center	<b>LPI</b>	La Palma Intercommunity Hospital
<b>CHO</b>	Children’s Hospital of Orange County	<b>PLH</b>	Placentia Linda Hospital
<b>FHP</b>	Fountain Valley Regional Hospital and Medical Center	<b>SJD</b>	St. Jude Medical Center
<b>KHA</b>	Kaiser Foundation Hospital – Anaheim	<b>UCI</b>	UCI Medical Center
<b>KFI</b>	Kaiser Foundation Hospital – Irvine	<b>WMC</b>	Western Medical Center Santa Ana
<b>LAG</b>	Los Alamitos Medical Center		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
<b>ARM</b>	Arrowhead Regional Medical Center	<b>KFN</b>	Kaiser Foundation Hospital - Ontario
<b>CHI</b>	Chino Valley Medical Center	<b>LLU</b>	Loma Linda University Medical Center
<b>DHM</b>	Montclair Hospital Medical Center	<b>SAC</b>	San Antonio Community Hospital
<b>KFF</b>	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
<b>LRR</b>	Los Robles Hospital & Medical Center (Ventura)	<b>SJO</b>	St. John Regional Medical Center (Ventura)
<b>SIM</b>	Adventist Health - Simi Valley Hospital (Ventura)	<b>RCC</b>	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
<b>LBV</b>	Long Beach VA	<b>WVA</b>	Wadsworth VA Medical Center

**Additional Information**

- Excludes non-EMS transports and patients transferred from a private doctor’s office or stand-alone ambulatory surgery center.

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- ENTRY MODE

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**9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE**

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**Definition**

For 9-1-1 Re-triage, enter the date the patient arrived at the facility they are being transferred from.

**Collection Criterion**

**ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.**

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME

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**9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME**

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**Definition**

For 9-1-1 Re-triage, enter the time of day the patient arrived at the facility they are being transferred from.

**Collection Criterion**

**ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.**

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements Other Associated Elements**

- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME

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**9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE**

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**Definition**

For 9-1-1 Re-triage, enter the date the patient exited the facility they are being transferred from.

**Collection Criterion**

**ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.**

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME

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**9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME**

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**Definition**

For 9-1-1 Re-triage, enter the time of day the patient exited the facility they are being transferred from.

**Collection Criterion**

**ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.**

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE

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## SEQUENCE #

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### Definition

Unique, alphanumeric EMS Record number found pre-printed at the top right corner of EMS Record hard copies or electronically assigned to electronic patient care records (ePCRs) by the EMS provider's electronic capture device.

### Field Values

- For EMS patients: consists of two letters and six digits on pre-printed EMS Records; or two-letters, ten digits if an approved ePCR provider.
- For non-EMS patients: consists of the last two digits of the current year, followed by the three-letter trauma center code (of the first treating trauma facility), and the sequential non-EMS patient number.

### Additional Information

- REQUIRED field for all patients.
- Sequence #s on EMS Report Form hard copies follow "Mod-9" formula: 2 letters and 6 numbers that when added together are divisible by 9.
- ePCR sequence #s utilizes the EMS provider's two-letter code, the last 2- digits of the incident year, and an additional 8-digits.
- Non-EMS patients sequence #s (e.g. 20USC001) should only be utilized when 'Entry Mode' is not equal to "EMS" (ground or air).
- DHS=No patients without an existing EMS or Non-EMS # utilize: last two digits of the current year, followed by the two-letter Trauma Log Code "TL", plus the sequential DHS=No patient number, e.g. **18TL001**.
- Sequence #s are the essential link between the EMS, Base and Trauma databases – **every effort should be made to collect this information from any available source**. If not obtainable by any means, a "dummy number" can be requested from the EMS Agency. Supporting documentation of collection efforts must be provided, along with other specified fields that will enable additional search for the patient's sequence number in the Base and/or EMS databases.
- Dummy #s will not be issued for DHS=No patients.
- For transferred patients, or patients with more than one sequence #, use the sequence number from the initial contact whenever possible.
- For patients arriving from outside of LA County, contact the EMS Agency to request an "Out-of-County" sequence #.
- None of the sequence # formats should contain spaces.
- Null Values are not accepted for this data field.

### Uses

- Unique patient identifier.
- Essential link between other EMS databases.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- Fire Station Logs
- EMS Agency

### Other Associated Elements

- MEDICAL RECORD #
- OTHER #

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**MEDICAL RECORD (MR) #**

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**Definition**

Medical record number assigned to the patient by the treating facility.

**Field Values**

- Free text

**Uses**

- Patient identifier.
- Link between the other EMS Agency databases.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

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**OTHER #**

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**Definition**

Other number assigned to the patient by the treating facility.

**Field Values**

- Free text

**Additional Information**

- OPTIONAL FIELD: This field may be used at the discretion of each treating facility.

**Uses**

- Patient identifier.

**Data Source Hierarchy**

- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet



# PREHOSPITAL

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**INJURY DATE**

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**Definition**

The date the injury occurred.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Estimates of injury date should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.
- Field value cannot be *“Not Applicable”*.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
- History and Physical

**Other Associated Elements**

- INJURY TIME

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## INJURY TIME

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### Definition

The time of day the injury occurred.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- Estimates of injury time should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
- History and Physical

### Other Associated Elements

- INJURY DATE

## PROVIDER

### Definition

The two-letter code for the EMS provider primarily responsible for the patient’s prehospital care.

### Field Values

PUBLIC PROVIDERS					
<b>AF</b>	Arcadia Fire	<b>CS</b>	LA County Sheriff	<b>OT</b>	Other Provider
<b>AH</b>	Alhambra Fire	<b>DF</b>	Downey Fire	<b>PF</b>	Pasadena Fire
<b>AV</b>	Avalon Fire	<b>ES</b>	El Segundo Fire	<b>RB</b>	Redondo Beach Fire
<b>BA</b>	Burbank Airport Fire	<b>FS</b>	U.S. Forest Service	<b>SA</b>	San Marino Fire
<b>BF</b>	Burbank Fire	<b>GL</b>	Glendale Fire	<b>SG</b>	San Gabriel Fire
<b>BH</b>	Beverly Hills Fire	<b>LB</b>	Long Beach Fire	<b>SI</b>	Sierra Madre Fire
<b>CB</b>	LA County Beaches	<b>LH</b>	La Habra Heights Fire	<b>SM</b>	Santa Monica Fire
<b>CC</b>	Culver City Fire	<b>LV</b>	La Verne Fire	<b>SP</b>	South Pasadena Fire
<b>CF</b>	LA County Fire	<b>MB</b>	Manhattan Beach Fire	<b>SS</b>	Santa Fe Springs Fire
<b>CG</b>	US Coast Guard	<b>MF</b>	Monrovia Fire	<b>TF</b>	Torrance Fire
<b>CI</b>	LA City Fire	<b>MO</b>	Montebello Fire	<b>VE</b>	Ventura County Fire
<b>CM</b>	Compton Fire	<b>MP</b>	Monterey Park Fire	<b>WC</b>	West Covina Fire
PRIVATE PROVIDERS					
<b>AA</b>	American Professional	<b>FC</b>	First Recue Ambulance	<b>PN</b>	PRN Ambulance
<b>AB</b>	AmbuLife Ambulance	<b>FM</b>	Firstmed Ambulance	<b>RE</b>	REACH Air Medical Service
<b>AN</b>	Antelope Ambulance	<b>GG</b>	Go Green Ambulance	<b>RR</b>	Rescue Services (Medic-1)
<b>AR</b>	American Medical Response	<b>GU</b>	Guardian Ambulance	<b>RY</b>	Royalty Ambulance
<b>AT</b>	All Town Ambulance	<b>JA</b>	Journey Ambulance	<b>SO</b>	Symbiosis (Di Biassi)
<b>AU</b>	AmbuServe/Shoreline Ambu.	<b>LE</b>	Lifeline Ambulance	<b>SY</b>	Symons Ambulance
<b>AW</b>	AMWest Ambulance	<b>LT</b>	Liberty Ambulance	<b>TR</b>	Trinity Ambulance
<b>AZ</b>	Ambulnz Health, Inc.	<b>LY</b>	Lynch EMS Ambulance	<b>VA</b>	Viewpoint Ambulance, Inc.
<b>CA</b>	CARE Ambulance	<b>MI</b>	MedResponse	<b>VI</b>	Vital Care Ambulance
<b>CO</b>	College Costal Care, LLC	<b>MR</b>	MedReach Ambulance	<b>WE</b>	Westcoast Ambulance
<b>CL</b>	CAL-MED Ambulance	<b>MT</b>	MedCoast Ambulance	<b>WM</b>	West Med/McCormick
<b>EA</b>	Emergency Ambulance	<b>MY</b>	Mercy Air		
<b>EX</b>	Explorer 1 Ambulance	<b>PE</b>	Premier Medical Transport		

### Additional Information

- The null value “Not Applicable” is auto-populated for non-EMS patients.

### Uses

- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

### Other Associated Elements

- RA/SQ

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**RA/SQ #**

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**Definition**

The alphanumeric apparatus code of the paramedic unit primarily responsible for the patient's prehospital care.

**Field Values**

- Free text

**Additional Information**

- Non-picklist – manually enter information exactly as it appears on the EMS Record.
- The null value of *“Not Applicable”* is auto-populated for non-EMS patients.

**Uses**

- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Audio records
- ED Records

**Other Associated Elements**

- PROVIDER

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## DISPATCH DATE

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### Definition

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

### Field Values

- Collected as MMDDYYYY

### Additional Information

- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

### Uses

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio records
- ED Records

### Other Associated Elements

- DISPATCH TIME
- 1<sup>st</sup> ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

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## DISPATCH TIME

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### Definition

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

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

### Uses

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record

### Other Associated Elements

- DISPATCH DATE
- 1<sup>st</sup> ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

---

**1<sup>st</sup> ON SCENE**

---

---

**Definition**

The time of day of arrival of the **first** EMS unit (ALS or BLS) arrived on scene.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Indicates time prehospital EMS care began.
- The null value of *“Not Applicable”* is auto-populated for non-EMS patients.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- DISPATCH DATE
- DISPATCH TIME
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME



---

**TRANSPORT UNIT ARRIVAL DATE**

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---

**Definition**

The date the unit *transporting the patient to your hospital* arrived on scene.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Auto-populated based upon the dispatch date. For midnight cross-over, user needs to manually change the date.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- DISPATCH DATE
- DISPATCH TIME
- 1<sup>st</sup> ON SCENE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

---

**TRANSPORT UNIT ARRIVAL TIME**

---

---

**Definition**

The time of day the unit transporting the patient to your hospital arrived on the scene.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- DISPATCH DATE
- DISPATCH TIME
- 1<sup>st</sup> ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

---

**TRANSPORT UNIT LEFT DATE**

---

---

**Definition**

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

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Auto-populated based upon the dispatch date. For midnight cross-over, user needs to manually change the date.
- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- DISPATCH DATE
- DISPATCH TIME
- 1<sup>st</sup> ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT TIME

---

**TRANSPORT UNIT LEFT TIME**

---

---

**Definition**

The time of day the unit transporting the patient to your hospital left the scene.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- DISPATCH DATE
- DISPATCH TIME
- 1<sup>st</sup> ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE

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**BLUNT/PENETRATING/CRITICAL BURN**

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**Definition**

Indicates the **type** of the injury sustained by the patient:

- BLUNT in which the tissues are injured by forces like compression (crushing), shearing (tearing), acceleration, and deceleration;
- PENETRATING in which tissues are penetrated by single or multiple objects; or
- CRITICAL BURN as defined as follows:
  - Patients 15 years of age or older with 2<sup>nd</sup> (partial thickness) and 3<sup>rd</sup> (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA).
  - Patients ≤ 14 years of age with 2<sup>nd</sup> (partial thickness) and 3<sup>rd</sup> (full thickness) degree burns involving equal to or greater than 10% TBSA.

**Field Values**

- **B:** Blunt
- **P:** Penetrating
- **U:** Critical Burn

**Additional Information**

- Injury Type, blunt, penetrating, and critical burn, is primarily utilized to identify a specific patient population. For this reason, only one Injury Type can be entered.
- The type of injury, BLUNT vs PENETRATING, should reflect the **injury force**, Blunt (MVA, Fall, & Auto vs Ped) versus Penetrating (GSW or ST).
- Critical Burn classification, degree and TBSA, should be based upon the medic's assessment.
- If the patient has more than one type of injury, use the type of injury for the most significant injury, the injury most likely to cause prolonged disability or death.
- Blunt force injuries can result in penetration of tissues, but the injury type is still BLUNT, e.g. shrapnel from a bomb blast.

**Uses**

- Assists with determination of treatment and transport.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

**Other Associated Elements**

- INJURY DESCRIPTION
- MECHANISM OF INJURY
- PROTECTIVE DEVICES

## INJURY DESCRIPTION

### Definition

The two-letter complaint code(s) describing the patient's injury.

### Field Values

BLUNT:		PENETRATING:		OTHER:	
<b>BL</b>	Minor Laceration/Contusion	<b>PL</b>	Minor Laceration	<b>NA</b>	No Apparent Injury
<b>BT</b>	Trauma Arrest	<b>PT</b>	Trauma Arrest	<b>CB</b>	Critical Burn
<b>BH</b>	Head	<b>PH</b>	Head	<b>BU</b>	Burns / Electric Shock
<b>14</b>	Blunt Head with GCS ≤14			<b>90</b>	SBP <90, 70 SBP <1yr
<b>BF</b>	Face/Mouth	<b>PF</b>	Facial/Mouth	<b>RR</b>	Respiratory Rate <10/>29, <20 if <1y
<b>BN</b>	Neck	<b>PN</b>	Neck		
<b>BB</b>	Back	<b>PB</b>	Back	<b>SX</b>	Suspected Pelvic Fracture
<b>BC</b>	Chest	<b>PC</b>	Chest	<b>SC</b>	Spinal Cord Injury
<b>FC</b>	Flail Chest			<b>UB</b>	Uncontrolled Bleeding
<b>BP</b>	Tension Pneumothorax	<b>PP</b>	Tension Pneumothorax		
<b>BA</b>	Abdomen	<b>PA</b>	Abdomen		
<b>BD</b>	Diffuse Tenderness				
<b>BG</b>	Genitals	<b>PG</b>	Genitals	<b>Transfer Inpatient:</b>	
<b>BK</b>	Buttocks	<b>PK</b>	Buttocks	<b>IT</b>	Inpatient Trauma (Direct Admit)
<b>BE</b>	Extremity	<b>PE</b>	Extremity ↓ elbow/knee		
<b>BR</b>	Fracture ≥ 2 long bone	<b>PX</b>	Extremity ↑ elbow/knee		
<b>BI</b>	Amputation ↑ wrist/ankle	<b>PI</b>	Amputation ↑ wrist/ankle		
<b>BV</b>	Neuro/Vascular/Mangled	<b>PV</b>	Neuro/Vascular/Mangled		

### Additional Information

- If the patient has multiple injuries, enter the most significant injury first (most likely to be fatal).
- The injury description should reflect the **injury force**, Blunt (MVA, Fall, Auto vs Ped) versus Penetrating (GSW or SW), selected.
- If the patient has an injury that fits multiple field values, e.g., Blunt Chest (BC) and Flail Chest (FC), Blunt Head (BH) and Blunt Head with GCS ≤14 (14), use the most significant injury. Flail Chest is a more significant injury than Blunt Chest, as is Blunt Head with GCS ≤14 more significant than Blunt Head.
- 14, 90, RR should **not** be used instead of/or in addition to PT and BT.
- Field value cannot be left blank.
- Refer to Appendix 3: Glossary of Terms – Injury Description (*Prehospital*) for additional details.

### Uses

- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- Epidemiological statistics.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

### Other Associated Elements

- MECHANISM OF INJURY
- BLUNT/PENETRATING/CRITICAL BURN
- PROTECTIVE DEVICES

## MECHANISM OF INJURY

### Definition

The two-letter code(s) describing the patient’s mechanism of injury (MOI).

### Field Values

<b>EV</b>	Enclosed Vehicle	<b>GS</b>	GSW
<b>EJ</b>	Ejected	<b>AN</b>	Animal Bite
<b>EX</b>	Extricated	<b>CR</b>	Crush
<b>PS</b>	Passenger Space Intrusion (PSI) - Unspecified	<b>TD</b>	Telemetry Data
<b>12</b>	PSI > 12 Inches – Occupied Passenger Space	<b>FA</b>	Fall
<b>18</b>	PSI >18 Inches - Unoccupied Passenger Space	<b>15</b>	Fall >15Ft. Adult / >10Ft. Child
<b>SF</b>	Survived Fatal Accident	<b>SA</b>	Self-Inflicted Accidental
<b>20</b>	Unenclosed Vehicle >20 MPH	<b>SI</b>	Self-Inflicted Intentional
<b>RT</b>	Ped/Bike Thrown / Runover >20 MPH	<b>ES</b>	Electrical Shock
<b>PB</b>	Ped/Bike ≤20 MPH	<b>TB</b>	Thermal Burn
<b>MM</b>	Motorcycle / Moped	<b>HE</b>	Hazmat Exposure
<b>TA</b>	Taser	<b>WR</b>	Work Related
<b>SP</b>	Sports / Recreation	<b>UN</b>	Unknown
<b>AS</b>	Assault	<b>OT</b>	Other
<b>ST</b>	Stabbing		

### Additional Information

- If the patient has more than one MOI use all that apply, e.g. Enclosed Vehicle (EV), Extrication Required (EX), and Passenger Space Intrusion (PS).
- For PSI to meet Trauma Criteria and/or Guidelines per Reference No. 506, the intrusion must be specified as greater than 12 inches into an occupied passenger space, or greater than 18 inches into an unoccupied passenger space.
- Insect bites and bee stings are not considered animal bites, and should be coded as “Other” and do not meet the inclusion criteria for the trauma registry.
- Utilize the field value of Other (OT) for patients who are reported to have “fallen out of a moving vehicle”.
- Field value cannot be left blank.
- Refer to Appendix 3: Glossary of Terms – Mechanism of Injury (*Prehospital*) for additional details.

### Uses

- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

### Other Associated Elements

- INJURY DESCRIPTION
- BLUNT/PENETRATING/CRITICAL BURN
- PROTECTIVE DEVICES

## PROTECTIVE DEVICES

### Definition

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

### Field Values

LA COUNTY		NTDS			
Protective Devices		Protective Devices		Child Specific Restraint	Airbag Deployment
<b>NO</b>	None	1	None		N/A
<b>HE</b>	Helmet	7	Helmet		N/A
<b>PC</b>	Protective Clothing	9	Clothing		N/A
<b>PG</b>	Protective Gear (non-clothing)	4	Non-Clothing Gear		N/A
<b>EP</b>	Eye Protection	5	Eye protection		N/A
<b>PF</b>	Personal Flotation	3	Personal Flotation		N/A
<b>SB</b>	SB Seatbelt - Shoulder Belt	10	Shoulder Belt		N/A
<b>LB</b>	LB Seatbelt - Lap Belt	2	Lap Belt		N/A
<b>OT</b>	OT Other	11	Other		N/A
<b>Airbags</b>					
<b>AN</b>	Airbag Not Deployed	8	Airbag Present		1 Airbag Not Deployed
<b>AF</b>	Airbag Deployed - Front	8	Airbag Present		2 Airbag Deployed Front
<b>AS</b>	Airbag Deployed - Side	8	Airbag Present		3 Airbag Deployed Side
<b>AO</b>	Airbag Deployed - Other	8	Airbag Present		4 Airbag Deployed Other
<b>Child Restraints</b>					
<b>IC</b>	Infant Car Seat (up to 1yr/20lbs)	6	Child Restraint	2	Infant Car Seat N/A
<b>CC</b>	Child Car Seat (>1yr/20-40lbs)	6	Child Restraint	1	Child Car seat N/A
<b>CB</b>	Child Booster (>40lbs/<4'9")	6	Child Restraint	3	Child Booster Seat N/A

### Additional Information

- A value of “None” **MUST** be entered if no protective devices are in use at the time of injury.
- If a child restraint is present, a value for “Child Restraints” must be entered.
- Enter an “Airbags” value for all enclosed vehicle crashes.
- Enter the null value of “Not Documented” if no airbag use is documented under protective devices.
- Presence or use of protective devices may be reported or observed.
- Wheelchairs, walkers, etc. are medical devices and are not considered protective devices.
- Indicate all that apply.
- Field value cannot be left blank.

### Uses

- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Record

### Other Associated Elements

- INJURY DESCRIPTION
- MECHANISM OF INJURY
- BLUNT/PENETRATING/CRITICAL BURN



---

**1<sup>st</sup> FIELD VS: SBP (Systolic Blood Pressure)**

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**Definition**

First recorded systolic blood pressure (*without the assistance of CPR or any type of mechanical chest compressions*) measured at the scene of injury.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- Enter the null value of “*Not Documented*” for references to capillary refill, or if the medics are unable to obtain a blood pressure in the field.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

---

**1<sup>st</sup> FIELD VS: DBP (Diastolic Blood Pressure)**

---

---

**Definition**

First recorded diastolic blood pressure (DBP) measured at the scene of injury.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- Enter the null value of “*Not Documented*” if the diastolic pressure is not measured (i.e., only palpated systolic pressure measured).
- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

---

**1<sup>st</sup> FIELD VS: HR (Heart Rate)**

---

**Definition**

First recorded pulse (Heart Rate) measured at the scene of injury expressed as a number per minute.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- Measurement recorded **must be without the assistance of CPR or any type of mechanical chest compression device**. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value of *“Not Applicable”* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

---

**1<sup>st</sup> FIELD VS: RR (Respiratory Rate)**

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---

**Definition**

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

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

---

**1<sup>st</sup> FIELD VS: O<sub>2</sub> SAT**

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---

**Definition**

First recorded oxygen saturation (O<sub>2</sub> Sat) measured at the scene of injury.

**Field Values**

- Up to three-digit percentage from 0 to 100

**Additional Information**

- Value should be **based upon assessment before the administration of oxygen.**
- The null value of *“Not Applicable”* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

## 1<sup>st</sup> FIELD GCS: EYE

### Definition

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial eye opening response to stimuli.

### Field Values

LA COUNTY	
4	Opens eyes spontaneously
3	Opens eyes in response to verbal stimulation
2	Opens eyes in response to painful stimulation
1	No eye opening

### Additional Information

- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

### Uses

- Element necessary to calculate the overall GCS score.
- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record

### Other Associated Elements

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

**1<sup>st</sup> FIELD GCS: VERBAL****Definition**

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient's initial verbal response to stimuli.

**Field Values**

LA COUNTY	
ADULT	
5	Oriented X 3
4	Confused
3	Inappropriate words
2	Incomprehensible sounds
1	No verbal response
INFANT AND TODDLER	
5	Smiles and tracks objects, speech appropriate for age
4	Cries but consolable, or confused
3	Inconsistently consolable, or random words
2	Moaning, incoherent sounds only
1	No verbal response

**Additional Information**

- If the patient is intubated, then the GCS Verbal score is equal to 1.
- The null value of "Not Applicable" is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Element necessary to calculate the overall GCS score.
- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

---

## 1<sup>st</sup> FIELD GCS: MOTOR

---

**Definition**

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient's initial motor response to stimuli.

**Field Values**

LA COUNTY	
6	Obeys commands
5	Localizes pain
4	Withdraws from pain
3	Flexion (decorticate) to pain
2	Extension (decerebrate) to pain
1	No motor response

**Additional Information**

- The null value of "Not Applicable" is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Element necessary to calculate the overall GCS score.
- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL GCS



---

**1<sup>st</sup> FIELD GCS: TOTAL GCS**

---

---

**Definition**

Sum of the initial three numerical values documented for each element of the Glasgow Coma Scale.

**Field Values**

- One- or two-digit numeric value between 3 and 15

**Additional Information**

- Entering values for each of the GCS component fields will result in an auto-calculated 1<sup>st</sup> FIELD GCS: TOTAL.
- Value may be hand-entered if GCS component fields are not documented, but a GCS total is recorded.
- If a patient does not have a numeric GCS recorded, but documentation related to their level of consciousness exists such as, “awake, alert, and oriented”, this may be interpreted as a GCS of 15, if no other contraindicating information exists.
- The null value of “*Not Applicable*” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**Uses**

- Element necessary to calculate the overall GCS score.
- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record

**Other Associated Elements**

- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O<sub>2</sub> SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR

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## PREHOSPITAL TOURNIQUET?

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### Definition

Checkbox indicating whether the patient had a tourniquet placed in the prehospital setting by EMS personnel.

### Field Values

- **Y:** Yes
- **N:** No

### Additional Information

- Non-commercial tourniquets (e.g. belts, etc.) not applied by EMS personnel should NOT be included.
- A prehospital tourniquet is not applied to most patients; therefore, this field will auto-populate with a value of 'No'. If a prehospital tourniquet is applied, user should change the value from "No" to "Yes".
- Tourniquets applied to patients to control non-traumatic bleeding, e.g. to control bleeding from a fistula, are **not** considered trauma patients and are only required to be transported to a trauma center per Reference No. 506 due to the likely need for immediate surgical intervention. These patients should not be included in the LA County Trauma Database.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

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**FIELD INTUBATION?**

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**Definition**

Indicates whether the patient was intubated in the prehospital setting.

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- Includes endotracheal tube or King LTS-D placement.
- Field intubation does not occur in most patients; therefore, this field will auto-populate with a value of “No”. If the patient is intubated in the field, the user should change the value from “No” to “Yes”.

**Uses**

- Provides documentation of assessment and care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Audio Records
- ED Medical Records

## PREHOSPITAL CARDIAC ARREST?

### Definition

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

### Field Values

LA COUNTY		NTDS	
Y	Yes	1	Yes
N	No	2	No

### Additional Information

- A patient who experienced a sudden cessation of cardiac activity, was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the hospital, prior to arrival at the center in which the registry is maintained. Prehospital cardiac arrest could occur at a transferring facility.
- Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider.
- Prehospital cardiac arrest does not occur in most patients; therefore, this field will auto-populate with a value of 'No'. If the patient experienced cardiac arrest in the field, user should change value from "No" to "Yes".
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.
- The following edit check has been applied to Trauma One®:
  - ✓ PREHOSPITAL CARDIAC ARREST entered as "Yes", but Prehospital Vital Signs other than BP-Systolic 0, HR 0, and RR 0 have been entered.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
- History & Physical
- Transfer Records

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## EXTERNAL CAUSE CODE

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### Definition

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

### Field Values

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

### Additional Information

- The primary external cause of injury code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM or ICD-10-CA codes are accepted for this data element. Activity codes are not reported under the NTDS and should not be reported for this data element.
- If two or more events cause separate injuries, an external cause code should be reported for each cause according to the following hierarchy:
  - ✓ 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 events.
  - ✓ External cause codes for transport accidents take priority over all other external cause codes, except cataclysmic events, child and adult abuse, and terrorism events.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be “*Not Documented*”.
- Field value cannot be left blank.

### Uses

- System evaluation and monitoring.
- NTDS® uses the external cause to determine the trauma type (Blunt, Penetrating, Burn) and intentionality.

### Data Source Hierarchy

- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- ADDITIONAL CAUSE CODE
- PLACE OF OCCURRENCE CODE

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**ADDITIONAL CAUSE CODE**

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**Definition**

Additional External Cause Code used in conjunction with the Primary External Cause Code if multiple external cause codes are required to describe the event.

**Field Values**

- Relevant ICD-10-CM or ICD-10-CA code value for injury event up to six characters

**Additional Information**

- Only ICD-10-CM or ICD-10-CA codes will be accepted for ICD-10 Additional External Cause Code.
- Enter the null value *“Not Applicable”* if no additional external cause codes are used.
- If two or more events cause separate injuries, an external cause code should be reported for each cause according to the following hierarchy:
  - 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.
- Field value cannot be left blank.

**Uses**

- System evaluation and monitoring.
- NTDS® uses the external cause to determine the trauma type (Blunt, Penetrating, Burn) and intentionality.

**Data Source Hierarchy**

- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- EXTERNAL CAUSE CODE
- PLACE OF OCCURRENCE CODE

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**PLACE OF OCCURRENCE CODE**

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**Definition**

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

**Field Values**

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

**Additional Information**

- Only ICD-10-CM or ICD-10-CA codes are accepted for ICD-10 Place of Occurrence External Cause Code.
- Field value cannot be left blank.

**Uses**

- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- EXTERNAL CAUSE CODE
- ADDITIONAL CAUSE CODE

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**INJURY LOCATION ZIP CODE**

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**Definition**

The zip code of the incident location.

**Field Values**

- Five-digit numeric value

**Additional Information**

- Data entry of a valid injury location zip code will auto-populate the injury location city, injury location county, and injury location state.
- If *"Not Documented"*, or *"Not Known"*, must complete variables of injury location city, injury location county, and injury location state.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

**Uses**

- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- INJURY LOCATION CITY
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE



## INJURY LOCATION CITY

### Definition

The city where the injury occurred.

### Field Values

LA COUNTY					
AA	Arleta	DS	Del Sur	LK	Lakewood
AC	Acton	DU	Duarte	LL	Lake Los Angeles
AD	Altadena	DZ	Dominguez	LM	La Mirada
AE	Arlington Heights	EL	East Los Angeles	LN	Lawndale
AG	Agua Dulce	EM	El Monte	LO	Lomita
AH	Agoura Hills	EN	Encino	LP	La Puente
AL	Alhambra	EO	El Sereno	LQ	LAX
AN	Athens	EP	Echo Park	LR	La Crescenta
AO	Avocado Heights	ER	Eagle Rock	LS	Los Nietos
AR	Arcadia	ES	El Segundo	LT	Lancaster
AT	Artesia	EV	Elysian Valley	LU	Lake Hughes
AV	Avalon	EZ	East Rancho Dominguez	LV	La Verne
AW	Atwater Village	FA	Fairmont	LW	Lake View Terrace
AZ	Azusa	FL	Florence County	LX	Lennox
BA	Bel Air Estates	FO	Fair Oaks Ranch	LY	Lynwood
BC	Bell Canyon	GA	Gardena	LZ	Lake Elizabeth
BE	Bellflower	GF	Griffith Park	MA	Malibu
BG	Bell Gardens	GH	Granada Hills	MB	Manhattan Beach
BH	Beverly Hills	GK	Glenoaks	MC	Malibu Beach
BK	Bixby Knolls	GL	Glendale	MD	Marina Del Rey
BL	Bell	GO	Gorman	ME	Monte Nido
BN	Baldwin Hills	GP	Glassell Park	MG	Montecito Heights
BO	Bouquet Canyon	GR	Green Valley	MH	Mission Hills
BP	Baldwin Park	GV	Glenview	MI	Mint Canyon
BR	Bradbury	GW	Glendora	ML	Malibu Lake
BS	Belmont Shore	HA	Hawthorne	MM	Miracle Mile
BT	Bassett	HB	Hermosa Beach	MN	Montrose
BU	Burbank	HC	Hacienda Heights	MO	Montebello
BV	Beverly Glen	HE	Harvard Heights	MP	Monterey Park
BW	Brentwood	HG	Hawaiian Gardens	MR	Mar Vista
BX	Box Canyon	HH	Hidden Hills	MS	Mount Wilson
BY	Boyle Heights	HI	Highland Park	MT	Montclair
BZ	Byzantine-Latino Quarter	HK	Holly Park	MU	Mount Olympus
CA	Carson	HO	Hollywood	MV	Monrovia
CB	Calabasas	HP	Huntington Park	MW	Maywood
CC	Culver City	HR	Harbor City	MY	Metter Valley
CE	Cerritos	HV	Hi Vista	NA	Naples
CH	Chatsworth	HY	Hyde Park	NE	Newhall
CI	Chinatown	IG	Inglewood	NH	North Hollywood
CK	Charter Oak	IN	City of Industry	NN	Neenach
CL	Claremont	IR	Irwindale	NO	Norwalk
CM	Compton	JH	Juniper Hills	NR	Northridge
CN	Canyon Country	JP	Jefferson Park	NT	North Hills
CO	Commerce	KG	Kagel Canyon	OP	Ocean Park
CP	Canoga Park	KO	Koreatown	OT	Other
CR	Crenshaw	LA	Los Angeles	PA	Pasadena
CS	Castaic	LB	Long Beach	PB	Pearblossom
CT	Century City	LC	La Canada Flintridge	PC	Pacoima
CU	Cudahy	LD	Ladera Heights	PD	Palmdale
CV	Covina	LE	Leona Valley	PE	Pacific Palisades
CY	Cypress Park	LF	Los Feliz	PH	Pacific Highlands
DB	Diamond Bar	LH	La Habra Heights	PI	Phillips Ranch
DO	Downey	LI	Little Rock	PL	Playa Vista

<b>PM</b>	Paramount	<b>SI</b>	Sierra Madre	<b>UC</b>	Universal City
<b>PN</b>	Panorama City	<b>SJ</b>	Silver Lake	<b>UP</b>	University Park
<b>PO</b>	Pomona	<b>SK</b>	Sherman Oaks	<b>VA</b>	Valencia
<b>PP</b>	Palos Verdes Peninsula	<b>SL</b>	Sun Valley	<b>VC</b>	Venice
<b>PR</b>	Pico Rivera	<b>SM</b>	Santa Monica	<b>VE</b>	Vernon
<b>PS</b>	Palms	<b>SN</b>	San Marino	<b>VG</b>	Valley Glen
<b>PT</b>	Porter Ranch	<b>SO</b>	South Gate	<b>VI</b>	Valley Village
<b>PV</b>	Palos Verdes Estates	<b>SP</b>	South Pasadena	<b>VL</b>	Valinda
<b>PY</b>	Playa Del Rey	<b>SQ</b>	Sleepy Valley	<b>VN</b>	Van Nuys
<b>QH</b>	Quartz Hill	<b>SR</b>	San Pedro	<b>VV</b>	Val Verde
<b>RB</b>	Redondo Beach	<b>SS</b>	Santa Fe Springs	<b>VW</b>	View Park
<b>RC</b>	Roosevelt Corner	<b>ST</b>	Santa Clarita	<b>VY</b>	Valyermo
<b>RD</b>	Rancho Dominguez	<b>SU</b>	Sunland	<b>WA</b>	Walnut
<b>RE</b>	Rolling Hills Estates	<b>SV</b>	Stevenson Ranch	<b>WB</b>	Willowbrook
<b>RH</b>	Rolling Hills	<b>SW</b>	Sawtelle	<b>WC</b>	West Covina
<b>RK</b>	Rancho Park	<b>SX</b>	South Central County	<b>WE</b>	West Hills
<b>RM</b>	Rosemead	<b>SY</b>	Sylmar	<b>WG</b>	Wilsona Gardens
<b>RO</b>	Rowland Heights	<b>SZ</b>	Studio City	<b>WH</b>	West Hollywood
<b>RP</b>	Rancho Palos Verdes	<b>TA</b>	Tarzana	<b>WI</b>	Whittier
<b>RS</b>	Reseda	<b>TC</b>	Temple City	<b>WK</b>	Winnetka
<b>RV</b>	Rampart Village	<b>TD</b>	Tropico	<b>WL</b>	Woodland Hills
<b>RW</b>	Rosewood	<b>TE</b>	Topanga State Park	<b>WM</b>	Wilmington
<b>SA</b>	Saugus	<b>TH</b>	Thousand Oaks	<b>WN</b>	Windsor Hills
<b>SB</b>	Sandberg	<b>TI</b>	Terminal Island	<b>WO</b>	Westlake
<b>SC</b>	Santa Clara	<b>TJ</b>	Tujunga	<b>WP</b>	Walnut Park
<b>SD</b>	San Dimas	<b>TL</b>	Toluca Lake	<b>WR</b>	Westchester
<b>SE</b>	South El Monte	<b>TO</b>	Torrance	<b>WS</b>	Windsor Square
<b>SF</b>	San Fernando	<b>TP</b>	Topanga	<b>WT</b>	Watts
<b>SG</b>	San Gabriel	<b>TR</b>	Three Points	<b>WV</b>	Westlake Village
<b>SH</b>	Signal Hill	<b>TT</b>	Toluca Terrace	<b>WW</b>	Westwood

**Additional Information**

- Data entry of a valid injury location zip code will auto-populate the injury location city.
- If a valid zip code is not entered, select the city from picklist, or enter a non-picklist city directly.
- Only complete when injury location zip code is "Not Documented" or "Not Known".
- Field value cannot be left blank.

**Uses**

- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- ED Records

**Other Associated Elements**

- INJURY LOCATION ZIP CODE
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE

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**INJURY LOCATION COUNTY**

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**Definition**

The county where the injury occurred.

**Field Values**

- **Kern:** Kern
- **Los Angeles:** Los Angeles
- **Orange:** Orange
- **Riverside:** Riverside
- **San Bernardino:** San Bernardino
- **San Diego:** San Diego
- **Ventura:** Ventura
- **Other:** Other

**Additional Information**

- Data entry of a valid injury location zip code will auto-populate injury location county.
- If a valid zip code is not entered, select the county from picklist, or enter a non-picklist county directly.
- Only complete when injury location zip code is *"Not Documented"* or *"Not Known"*.
- Field value cannot be left blank.

**Uses**

- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records

**Other Associated Elements**

- INJURY LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION STATE

## INJURY LOCATION STATE

### Definition

The two-letter code for the state (territory, province, or District of Columbia) where the injury occurred.

### Field Values

LA COUNTY					
<b>AK</b>	Alaska	<b>LA</b>	Louisiana	<b>OR</b>	Oregon
<b>AL</b>	Alabama	<b>MA</b>	Massachusetts	<b>PA</b>	Pennsylvania
<b>AR</b>	Arkansas	<b>MD</b>	Maryland	<b>PR</b>	Puerto Rico
<b>AS</b>	American Samoa	<b>ME</b>	Maine	<b>PW</b>	Palau
<b>AZ</b>	Arizona	<b>MH</b>	Marshall Islands	<b>RI</b>	Rhode Island
<b>CA</b>	California	<b>MI</b>	Michigan	<b>SC</b>	South Carolina
<b>CO</b>	Colorado	<b>MN</b>	Minnesota	<b>SD</b>	South Dakota
<b>CT</b>	Connecticut	<b>MO</b>	Missouri	<b>TN</b>	Tennessee
<b>DC</b>	District of Columbia	<b>MP</b>	Northern Mariana Islands	<b>TX</b>	Texas
<b>DE</b>	Delaware	<b>MS</b>	Mississippi	<b>UM</b>	US Minor Outlying Islands
<b>FL</b>	Florida	<b>MT</b>	Montana	<b>UT</b>	Utah
<b>FM</b>	Federated States of Micronesia	<b>NC</b>	North Carolina	<b>VA</b>	Virginia
<b>GA</b>	Georgia	<b>ND</b>	North Dakota	<b>VI</b>	Virgin Islands of the US
<b>GU</b>	Guam	<b>NE</b>	Nebraska	<b>VT</b>	Vermont
<b>HI</b>	Hawaii	<b>NH</b>	New Hampshire	<b>WA</b>	Washington
<b>IA</b>	Iowa	<b>NJ</b>	New Jersey	<b>WI</b>	Wisconsin
<b>ID</b>	Idaho	<b>NM</b>	New Mexico	<b>WV</b>	West Virginia
<b>IL</b>	Illinois	<b>NV</b>	Nevada	<b>WY</b>	Wyoming
<b>IN</b>	Indiana	<b>NY</b>	New York	<b>OT</b>	Other
<b>KS</b>	Kansas	<b>OH</b>	Ohio		
<b>KY</b>	Kentucky	<b>OK</b>	Oklahoma		

### Additional Information

- Data entry of a valid injury location zip code will auto-populate the injury location state.
- Only complete when injury location zip code is "Not Documented" or "Not Known".
- Field value cannot be left blank.

### Uses

- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records

### Other Associated Elements

- INJURY LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION COUNTY

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## WORK RELATED?

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**Definition**

Indicates whether the patient's injury occurred during paid employment.

**Field Values**

LA COUNTY		NTDS	
Y	Yes	1	Yes
N	No	2	No

**Additional Information**

- If "Yes", must complete "Occupation" and "Industry".
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

**Uses**

- Incident tracking.
- Epidemiological statistics.

**Data Source Hierarchy**

- ED Records
- EMS Record

**Other Associated Elements**

- INDUSTRY
- OCCUPATION

## OCCUPATION

### Definition

The occupation of the patient, if applicable.

### Field Values

LA COUNTY		NTDS	
ARCH/ENG	Architecture & Engineering	2	Architecture & Engineering
ARTS	Arts, Design, Entertainment, Sports, & Media	16	Arts, Design, Entertainment, Sports, & Media
BUILD/MAINT	Building & Grounds Cleaning & Maintenance	7	Building & Grounds Maintenance
BUS/FIN	Business & Financial Operations	1	Business & Financial Operations
COMM/SOC	Community & Social Services	3	Community & Social Services
COMP/MATH	Computer & Mathematical	13	Computer & Mathematical
CONSTRUCTION	Construction & Extraction	21	Construction & Extraction
ED/TRAINING	Education, Training, & Library	4	Education, Training, & Library
FARMING	Farming, Fishing, & Forestry	9	Farming, Fishing, & Forestry
FOOD	Food Preparation & Serving	18	Food Preparation & Serving
HEALTH PRACT	Healthcare Practitioners	5	Healthcare Practitioners
HEALTH SUPPORT	Healthcare Support	17	Healthcare Support
INST/MAINT	Installation, Maintenance, & Repair	10	Installation, Maintenance, & Repair
LEGAL	Legal	15	Legal
MANAGEMENT	Management	12	Management
MILITARY	Military Specific	23	Military Specific
OFFICE	Office & Administrative Support	20	Office & Administrative Support
PERSONAL	Personal Care & Service	19	Personal Care & Service
PRODUCTION	Production	22	Production
PROTECTIVE	Protective Service	6	Protective Service
SALES	Sales & Related	8	Sales & Related
SCIENCE	Life, Physical, & Social Science	14	Life, Physical, & Social Science
TRANSPORTATION	Transportation & Material Moving	11	Transportation & Material Moving

### Additional Information

- Only complete if injury is work related – must also complete “Industry”.
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- Field value cannot be left blank.

### Uses

- Incident tracking.
- Epidemiological statistics.

### Data Source Hierarchy

- Facesheet
- History & Physical
- ED Records

### Other Associated Elements

- WORK RELATED?
- INDUSTRY

## INDUSTRY

### Definition

The occupational industry associated with the patient’s work environment, if applicable.

### Field Values

LA COUNTY		NTDS	
<b>AGRICULTURAL</b>	Agricultural, Forestry, Fishing	5	Agricultural, Forestry, Fishing
<b>CONSTRUCTION</b>	Construction	8	Construction
<b>ED/HEALTH</b>	Education and Health Services	7	Education and Health Services
<b>INFORMATION</b>	Information Services	11	Information Services
<b>FIN/INS/REAL</b>	Finance, Insurance, and Real Estate	1	Finance, Insurance, and Real Estate
<b>GOVERNMENT</b>	Government	9	Government
<b>LEISURE</b>	Leisure and Hospitality	13	Leisure and Hospitality
<b>MANUFACTURING</b>	Manufacturing	2	Manufacturing
<b>NATURAL</b>	Natural Resources and Mining	10	Natural Resources and Mining
<b>PROFESSIONAL</b>	Professional and Business Services	6	Professional and Business Services
<b>RETAIL</b>	Retail Trade	3	Retail Trade
<b>TRANS/UTIL</b>	Transport and Public Utilities	4	Transport and Public Utilities
<b>WHOLESALE</b>	Wholesale Trade	12	Wholesale Trade
<b>OTHER</b>	Other Services	14	Other Services

### Additional Information

- Only complete if injury is work related – must also complete “Occupation”.
- Field value cannot be left blank.

### Uses

- Incident tracking.
- Epidemiological statistics.

### Data Source Hierarchy

- Facesheet
- History & Physical
- ED Records

### Other Associated Elements

- WORK RELATED?
- OCCUPATION

# **EMERGENCY DEPARTMENT (ED)/HOSPITAL**



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## ED NOTIFIED?

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### Definition

Indicates whether the Emergency Department (ED) received notification prior to the patient's arrival.

### Field Values

- **Y:** Yes
- **N:** No

### Additional Information

- Indicate "Yes" or "No" for all patients.
- Enter the value of "No" for walk-ins.
- Enter the null value of *"Not Applicable"* for Direct Admits.

### Uses

- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

### Other Associated Elements

- ACTIVATION?
- ACTIVATION TIME
- ACTIVATION LEVEL
- MD SERVICE
- MD CODE
- STAT?
- REQ TIME
- ARR TIME

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## **MET CRITERIA?**

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### **Definition**

Indicates whether the patient met trauma criteria per LA County Reference No. 506.

### **Field Values**

- **Y:** Yes
- **N:** No

### **Additional Information**

- Do not include patients that meet trauma guidelines/special considerations.

### **Uses**

- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

### **Data Source Hierarchy**

- EMS Record
- ED Records
- Base Hospital Form
- Audio records

### **Other Associated Elements**

- GUIDELINES/SPECIAL CONSIDERATION MET
- LA TRAUMA DATABASE INCLUSION CRITERIA

**CRITERIA/GUIDELINES/SPECIAL CONSIDERATIONS MET**

**Definition**

Trauma Criteria/Guidelines/Special Considerations met, per LA County Reference No. 506.

**Field Values**

LA COUNTY (ALL Patients)	
Criteria	
14	Blunt Head with GCS <sub>≤</sub> 14
15	Adult fall from heights >15 feet, or
	Pediatrics from heights >10 feet, or >3 times child's height
20	Unenclosed vehicle crash impact >20 mph
70	Blood Pressure <70mmHg Systolic Infant
90	Blood Pressure <90mmHg Systolic Adult
RR	Respiratory Rate <10/>29, <20 if <1yr.
CB	Critical Burn (CB or CB w/ 70, 90, RR, AN, 55, BP, IU & PJ)
	Critical Burn (CB w/ any other code, excluding: 70, 90, RR, AN, 55, BP, IU & PJ)
FC	Flail Chest
SX	Suspected Pelvic Fracture
SC	Spinal Cord Injury with Sensory Deficit
EJ	Ejected
12	Passenger Space Intrusion of >12 inches into an occupied passenger space
RT	Ped/Bicyclist Run over / Thrown / Impact >20 mph
TQ	Tourniquet (Commercial) applied
BD	Blunt Abdomen with Diffuse Abd Tenderness
BI	Blunt Amputation above the Wrist or Ankle
BR	Blunt Fractures of Two or More Long Bones
BV	Blunt Extremity with Neuro / Vascular / Mangled
PA	Penetrating Abdomen
PC	Penetrating Chest
PF	Penetrating Face/Mouth
PG	Penetrating Genitals
PH	Penetrating Head
PI	Penetrating Amputation above the Wrist or Ankle
PK	Penetrating Buttocks
PN	Penetrating Neck
PT	Penetrating Full Arrest
PV	Penetrating Extremity with Neuro / Vascular / Mangled
PX	Penetrating Extremity above the Elbow or Knee
PY	Penetrating Back
Guidelines	
18	Passenger Space Intrusion of >18 inches into an unoccupied passenger space
AN	Anticoagulant Medication (other than aspirin only) or with Bleeding Disorder
EX	Extrication Required
PB	Pedestrians/Bicyclists Impact ≤ 20 mph
SF	Survivor of Fatal Crash (same vehicle), with Complaint of Injury
TD	Telemetry Data
Special Considerations	
BT	Blunt Trauma Full Arrest
55	Age greater than 55 years
BP	Systolic B/P less than 110mmHg for patient greater than 65 years of age
IU	Pregnancy greater than 20 weeks
PJ	Prehospital judgment that transport to Trauma Center is in the patient's best interest

**Additional Information**

- If the patient did not meet trauma criteria, values from the “Criteria” sub-picklist may NOT be selected.
- Guidelines & special considerations are prehospital tools utilized to determine if the patient warrants transportation to a trauma center and are NOT to be utilized by the trauma center as the rationale for trauma registry inclusion.
- For PSI to meet Trauma Criteria and/or Guidelines per Reference No. 506, the intrusion must be specified as greater than 12 inches (Criteria 12) into an occupied passenger space or greater than 18 inches (Guideline 18) into an unoccupied passenger space.
- Refer to Appendix 2: Glossary of Terms – Criteria/Guidelines/Special Considerations (*ED*) for additional details.
- The following edit checks have been applied to Trauma One®:
  - ✓ Mechanism of Injury Criteria (15, 20, EJ, PS, & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (55, BP, IU, & PJ) cannot be selected for non-EMS patients.
  - ✓ Special Considerations (BT, 55, BP, IU, & PJ) cannot be selected if a criteria/guideline exists.

**Uses**

- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**

- EMS Record
- ED Records
- Base Hospital Form
- Audio Records

**Other Associated Elements**

- MET CRITERIA?
- LA TRAUMA DATABASE INCLUSION CRITERIA

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**ED/HOSPITAL ARRIVAL DATE**

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**Definition**

The date the patient arrived to the ED/hospital.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Used to calculate Total Length of Hospital Stay.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- ED Records
- EMS Record

**Other Associated Elements**

- ARRIVAL DATE
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME
- ED/HOSPITAL ARRIVAL TIME

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**ED/HOSPITAL ARRIVAL TIME**

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**Definition**

The time of day the patient arrived to the ED/hospital.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Used to calculate Total Length of Hospital Stay.
- This field auto-populates from the data entered for arrival time from the General Information section.
- Field value cannot be *“Not Applicable”*.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- ED Records
- EMS Record

**Other Associated Elements**

- ARRIVAL DATE
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME
- ED/HOSPITAL ARRIVAL DATE

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**TRAUMA TEAM ACTIVATION?**

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**Definition**

Indicates whether the treating facility's trauma team was activated.

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- The responding team must include the Trauma Surgeon or a post-graduate year four (PGY4) surgical resident (minimum) – regardless of the level of trauma activation.
- **Requests for Trauma Consults are NOT considered Activations.**

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician's Progress Notes

**Other Associated Elements**

- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION TIME
- ACTIVATION LEVEL

---

**ACTIVATION DATE**

---

**Definition**

The date the treating facility's trauma team was activated, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- ED Records
- Physician's Progress Notes

**Other Associated Elements**

- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION?
- ACTIVATION LEVEL
- ACTIVATION TIME



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**ACTIVATION TIME**

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**Definition**

The time of day the treating facility's trauma team was activated, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- ED Records
- Physician's Progress Notes

**Other Associated Elements**

- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION?
- ACTIVATION LEVEL
- ACTIVATION DATE

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## ACTIVATION LEVEL

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### Definition

The level of the trauma team's activation, if applicable.

### Field Values

- Customized list

### Additional Information

- Enter activation level code directly, or create facility-specific picklist.
- If the Trauma Centers' highest level of activation on file with the EMS Agency is indicated, it will be mapped to NTDB's Highest Level of Activation. To ensure continued accuracy, the EMS Agency must be notified if changes are made to the customized list.
- **Requests for Trauma Consults are NOT considered Activations.**

### Uses

- Establishes care intervals and incident timelines.

### Data Source Hierarchy

- ED Records
- Physician's Progress Notes

### Other Associated Elements

- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION?
- ACTIVATION DATE
- ACTIVATION TIME

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**ED DISPOSITION ORDER DATE**

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**Definition**

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

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Enter the null value of *“Not Applicable”* if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- Physician’s Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

**Other Associated Elements**

- ED DISPOSITION ORDER TIME
- ED EXIT DATE
- ED EXIT TIME
- NEXT PHASE AFTER ED

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**ED DISPOSITION ORDER TIME**

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---

**Definition**

The time of day the order was written for the patient to be dispositioned from the ED.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- The null value of *“Not Applicable”* is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- ED Records
- Hospital Record

**Other Associated Elements**

- ED DISPOSITION ORDER DATE
- ED EXIT DATE
- ED EXIT TIME
- NEXT PHASE AFTER ED

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## ED EXIT DATE

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### Definition

The date the patient left the ED.

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Enter the null value of *“Not Applicable”* if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

### Uses

- Establishes care intervals and incident timelines.

### Data Source Hierarchy

- Physician’s Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

### Other Associated Elements

- ED DISPOSITION ORDER DATE
- ED DISPOSITION ORDER TIME
- ED EXIT TIME
- NEXT PHASE AFTER ED

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**ED EXIT TIME**

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---

**Definition**

The time of day the patient left the ED.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- The null value of *“Not Applicable”* is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

**Uses**

- Establishes care intervals and incident timelines.

**Data Source Hierarchy**

- ED Records
- Hospital Record

**Other Associated Elements**

- ED DISPOSITION ORDER DATE
- ED DISPOSITION ORDER TIME
- ED EXIT DATE
- NEXT PHASE AFTER ED

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**HEIGHT**

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**Definition**

Patient's height, or the best approximation, reported within 24 hours of ED/hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- May be self-reported or provided by family.
- Enter a value "*Not Documented*" if the patient's height was not provided within 24 hours of ED/hospital arrival.
- Field value cannot be "*Not Applicable*".
- Field value cannot be left blank.

**Data Source Hierarchy**

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

**Other Associated Elements**

- HEIGHT UNITS

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## HEIGHT UNITS

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**Definition**

Unit of measurement used to report the patient's height, or the best approximation, within 24 hours of ED/hospital arrival.

**Field Values**

- **I:** Inches
- **C:** Centimeters

**Additional Information**

- May be self-reported or provided by family.
- Enter a value "*Not Documented*" if the patient's height was not provided within 24 hours of ED/hospital arrival.

**Data Source Hierarchy**

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

**Other Associated Elements**

- HEIGHT



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**WEIGHT**

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**Definition**

Patient's weight, or the best approximation, reported within 24 hours of ED/hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- May be self-reported or provided by family.
- Enter a value "*Not Documented*" if the patient's weight was not provided within 24 hours of ED/hospital arrival.
- Field value cannot be "*Not Applicable*".
- Field value cannot be left blank.

**Data Source Hierarchy**

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

**Other Associated Elements**

- WEIGHT UNITS

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**WEIGHT UNITS**

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**Definition**

Unit of measurement used to report the patient's weight, or the best approximation, within 24 hours of ED/Hospital arrival.

**Field Values**

- **L:** Pounds
- **K:** Kilograms

**Additional Information**

- May be self-reported or provided by family.
- Enter a value "*Not Documented*" if the patient's weight was not provided within 24 hours of ED/hospital arrival.

**Data Source Hierarchy**

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

**Other Associated Elements**

- WEIGHT

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**1<sup>st</sup> ED/HOSPITAL VS: DATE**

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**Definition**

Date of the first recorded vital signs within 30 minutes of ED/hospital arrival.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- All timed values are tied to a date and time; therefore, the 1<sup>st</sup> set of ED vitals at the ED receiving facility (Trauma Center) must be used, NOT the 1<sup>st</sup> set of documented ED vitals from the ED sending facility. Although this will result in variance in the Revised Trauma Score, vital signs that are timed prior to ED arrival at the trauma center will result in data validation issues.
- Enter the null value of “*Not Documented*” if the first recorded vital signs time is not within 30 minutes of ED/hospital arrival.

**Uses**

- Provides documentation of assessment and/or care.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1<sup>ST</sup> ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: TIME**

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---

**Definition**

Time of day of the first recorded vital signs within 30 minutes of ED/hospital arrival.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- All timed values are tied to a date and time; therefore, the 1<sup>st</sup> set of ED vitals at the ED receiving facility (Trauma Center) must be used, NOT the 1<sup>st</sup> set of documented ED vitals from the ED sending facility. Although this will result in variance in the Revised Trauma Score, vital signs that are timed prior to ED arrival at the trauma center will result in data validation issues.
- Enter the null value of “*Not Documented*” if the first recorded vital signs time is not within 30 minutes of ED/hospital arrival.

**Uses**

- Provides documentation of assessment and/or care.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: BP – SYSTOLIC (SBP)**

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**Definition**

Numeric value of the first recorded systolic blood pressure (SBP) (*without the assistance of CPR or any type of mechanical chest compressions*) within 30 minutes of ED/hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Enter the null value of “*Not Documented*” if the first recorded systolic blood pressure is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Revised Trauma Score - ED (adult & pediatric).

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: BP – DIASTOLIC (DBP)**

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**Definition**

Numeric value of the first recorded diastolic blood pressure (DBP) within 30 minutes of ED/hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- The null value “*Not Documented*” is used if the diastolic pressure is not measured (i.e., only palpated SYSTOLIC pressure measured or if the first recorded diastolic blood pressure is not within 30 minutes of ED/hospital arrival.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: HEART RATE (HR)**

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**Definition**

Numeric value of the first recorded pulse (Heart Rate {HR}) (*palpated or auscultated ONLY – no monitor readings*) within 30 minutes of ED/Hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- First recorded HR should be palpated or auscultated **ONLY**, no monitor readings.
- Measured in beats palpated per minute.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Enter the null value of “*Not Documented*” if the first recorded heart rate is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: RESPIRATORY RATE (RR)**

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**Definition**

Numeric value of the first recorded respiratory rate (RR) within 30 minutes of ED/hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- Enter actual rate only – indicate whether respirations were assisted in the next field: “ASST?”
- Enter the null value of “*Not Documented*” if the first recorded respiratory rate is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Revised Trauma Score - ED (adult & pediatric).

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS



## 1<sup>st</sup> ED/HOSPITAL VS: RESPIRATORY RATE (RR) ASSISTED?

### Definition

Indicates whether there was respiratory assistance associated with the initial respiratory rate within 30 minutes of ED/hospital arrival.

### Field Values

LA COUNTY		NTDS	
Y	Yes	2	Assisted Respiratory Rate
N	No	1	Unassisted Respiratory Rate

### Additional Information

- Only reported if initial 1<sup>st</sup> ED/Hospital VS: Respiratory Rate (RR) is reported.
- Respiratory assistance is defined as mechanical and/or external support of respiration (e.g. BMV, ventilator, etc.).
- The null value of “*Not Applicable*” is reported if the 1<sup>st</sup> ED/Hospital VS: Respiratory Rate (RR) is “*Not Known/Not Recorded*”.
- Field value cannot be left blank.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- Physician’s Progress Notes

### Other Associated Elements

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

---

**1<sup>st</sup> ED/HOSPITAL VS: O<sub>2</sub> SAT**

---

**Definition**

Numeric value of the first recorded oxygen saturation (O<sub>2</sub> sat) within 30 minutes of ED/hospital arrival.

**Field Values**

- Up to three-digit percentage from 0 to 100

**Additional Information**

- Enter the null value of “*Not Documented*” if the first recorded oxygen saturation is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

## 1<sup>st</sup> ED/HOSPITAL VS: ON O<sub>2</sub>?

### Definition

Indicates whether supplemental oxygen was in use during the initial assessment of the O<sub>2</sub> saturation within 30 minutes of ED/hospital arrival.

### Field Values

LA COUNTY		NTDS	
Y	Yes	2	Supplemental Oxygen
N	No	1	No Supplemental Oxygen
U	Unknown	Not Documented	

### Additional Information

- Only complete if a numeric value is reported for 1st ED/hospital VS: O<sub>2</sub> saturation, otherwise enter the null value of “*Not Applicable*”.
- Field value cannot be left blank.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- Physician’s Progress Notes

### Other Associated Elements

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

---

**1<sup>st</sup> ED/HOSPITAL VS: TEMPERATURE (TEMP)**

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---

**Definition**

Numeric value of the first recorded temperature within 30 minutes of ED/hospital arrival.

**Field Values**

- Up to three-digit positive numeric value

**Additional Information**

- Document to the 10<sup>th</sup> of a degree (e.g. 37.2°C)
- Enter the null value of “*Not Documented*” if the first recorded temperature is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

---

**1<sup>st</sup> ED/HOSPITAL VS: TEMP UNITS**

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---

**Definition**

Unit of measurement for first recorded temperature within 30 minutes of ED/hospital arrival.

**Field Values**

- **C:** Celsius
- **F:** Fahrenheit

**Additional Information**

- Only complete if a numeric value is reported for 1st ED/hospital vital signs temperature, otherwise enter the null value of *“Not Applicable”*.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: TEMP TIME**

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---

**Definition**

Time of the first recorded temperature within 30 minutes of ED/hospital arrival.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- If the first recorded temperature time in the ED/hospital is not within 30 minutes of arrival, enter the null value of "*Not Documented*".

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician's Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

## 1<sup>st</sup> ED/HOSPITAL VS: GCS – EYE

### Definition

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial eye opening response to stimuli, recorded within 30 minutes of ED/hospital arrival.

### Field Values

LA COUNTY		NTDS	
4	Opens eyes spontaneously	4	Opens eyes spontaneously
3	Opens eyes in response to verbal stimulation	3	Opens eyes in response to verbal stimulation
2	Opens eyes in response to painful stimulation	2	Opens eyes in response to painful stimulation
1	No eye opening	1	No eye movement when assessed

### Additional Information

- Enter the null value of “*Not Documented*” if the first recorded GCS eye score is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Total GCS.

### Data Source Hierarchy

- ED Records
- Physician’s Progress Notes

### Other Associated Elements

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

## 1<sup>st</sup> ED/HOSPITAL VS: GCS – VERBAL

### Definition

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial verbal response to stimuli, recorded within 30 minutes of ED/hospital arrival.

### Field Values

LA COUNTY		NTDS	
<b>ADULT</b>			
5	Oriented X 3	5	Oriented
4	Confused	4	Confused
3	Inappropriate words	3	Inappropriate words
2	Incomprehensible sounds	2	Incomprehensible sounds
1	No verbal response	1	No verbal response
<b>INFANT</b>			
5	Smiles and tracks objects, speech appropriate for age	5	Smiles, oriented to sounds, follows objects, interacts
4	Cries but consolable, or confused	4	Cries but is consolable, inappropriate interactions
3	Inconsistently consolable, or random words	3	Inconsistently consolable, moaning
2	Moaning, incoherent sounds only	2	Incomprehensible sounds
1	No verbal response	1	No vocal response

### Additional Information

- If the patient is intubated, then the GCS Verbal score is equal to 1.
- Enter the null value of “*Not Documented*” if the first recorded GCS verbal score is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Total GCS.

### Data Source Hierarchy

- ED Records
- Physician’s Progress Notes

### Other Associated Elements

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS



- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

## 1<sup>st</sup> ED/HOSPITAL VS: GCS – MOTOR

### Definition

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial motor response to stimuli, recorded within 30 minutes of ED/hospital arrival.

### Field Values

LA COUNTY		NTDS	
6	Obeys commands	6	Obeys commands/Appropriate response to stimuli
5	Localizes pain	5	Localizes pain
4	Withdraws from pain	4	Withdraws from pain
3	Flexion (decorticate) to pain	3	Flexion (decorticate movement) to pain
2	Extension (decerebrate) to pain	2	Extension (decerebrate movement) to pain
1	No motor response	1	No motor response

### Additional Information

- Enter the null value of “*Not Documented*” if the first recorded GCS motor score is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Total GCS.

### Data Source Hierarchy

- ED Records
- Physician’s Progress Notes

### Other Associated Elements

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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**1<sup>st</sup> ED/HOSPITAL VS: GCS – TOTAL**

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**Definition**

Sum of the initial three numerical values for each element of the Glasgow Coma Scale, recorded within 30 minutes of ED/hospital arrival.

**Field Values**

- One- or two-digit numeric value between 3 and 15

**Additional Information**

- Is auto-calculated if components are entered, or total can be hand-entered if components not available.
- If a patient does not have a numeric GCS recorded, but documentation related to their level of consciousness exists, i.e., AAOx3, awake alert and oriented, interpret this as GCS of 15, IF there is no other contraindicating documentation.
- Field value cannot be “*Not Applicable*”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Revised Trauma Score - EMS (adult & pediatric).

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS MODIFIERS

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## 1<sup>st</sup> ED/HOSPITAL VS: GCS MODIFIERS

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**Definition**

Indicates the presence of factors that could potentially affect the first GCS assessment within 30 minutes of ED/hospital arrival.

**Field Values**

LA COUNTY		NTDS	
<b>S</b>	Sedated	1	Chemically Sedated or Paralyzed
<b>E</b>	Eye Obstruction	2	Obstruction to the Patient's Eye
<b>I</b>	Intubated	3	Intubated
	<i>Not Applicable</i>	4	Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

**Additional Information**

- Refers to identified medical treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.).
- Intubation includes alternate airway devices (e.g. LMA, etc.).
- Enter the null value of *"Not Applicable"* if the patient was not chemically sedated, intubated, and did not have eye obstruction.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician's Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O<sub>2</sub> SAT
- 1st ED/HOSPITAL VS: ON O<sub>2</sub>?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL

## LA TRAUMA DATABASE INCLUSION CRITERIA RATIONALE

### Definition

Indicates the primary rationale for inclusion of the patient in the TEMIS database.

### Field Values

LA COUNTY	
<b>PH</b>	Prehospital care personnel made destination decision to transport to a Trauma Center based on criteria, guidelines, or special considerations – must be documented on EMS Record.
<b>CG</b>	Non-EMS patient met Trauma Triage Physiological &/or Anatomical criteria, per Reference No. 506.1, ( <b>excludes Trauma Triage Mechanism of Injuries, Guidelines, &amp; Special Considerations</b> ).
<b>AD</b>	Admitted for care of an injury after ED evaluation by the Trauma Surgeon.
<b>DI</b>	Died of an injury-related problem.
<b>TS</b>	Transfer Higher Level of Care to or from your facility, and <b>admitted</b> by a Trauma Surgeon for care of an injury.
<b>NO</b>	DHS = No – use for patients not meeting LA Trauma Database Inclusion Criteria inclusion criteria that your facility wishes to capture in your hospital database (e.g., hangings, or patients being followed for special studies).

### Additional Information

- Always use the rationale that occurs *first* in the patient’s course of treatment.
- Mechanism of injuries, guidelines, & special considerations are prehospital tools utilized to determine if the patient warrants transportation to a trauma center, and are NOT to be utilized by the trauma center as the rationale for LA Trauma Database inclusion for non-EMS patients.
- AD is only utilized for patients that do not meet the PH or CG rules and are admitted for care of an injury after ED evaluation by the Trauma Surgeon.
- Inclusion criteria rationale of AD, MUST involve the evaluation by the Trauma Surgeon in the ED.
- Inclusion criteria rationale of TS, MUST be admitted by a Trauma Surgeon for care of an injury.
- Null Values are not accepted for this data field.
- The following edit checks have been applied to Trauma One®:
  - ✓ PH - Mode of Entry MUST be EMS.
  - ✓ CG - Physiological and/or Anatomical Criteria MUST exist (14, 70, 90, CB, FC, BD, BI, BR, BV, PA, PC, PF, PG, PH, PI, PK, PN, PT, PV, PX, PY, RR, SC, & SX).
  - ✓ CG - EXCLUDES all Mechanism of Injury Criteria (12, 15, 20, EJ, & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (55, BP, IU, & PJ).
  - ✓ AD - Mode of Entry cannot be EMS with an existing Criteria/Guideline.

### Uses

- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- DHS PATIENT?
- MET CRITERIA?
- CRITERIA MET
- GUIDELINES/SPECIAL CONSIDERATION MET

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**ADMITTING PHYSICIAN**

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**Definition**

The physician primarily responsible for admitting the patient to the hospital, if applicable.

**Field Values**

- Free text

**Additional Information**

- Can either enter the physician's name or code at discretion of each facility.

**Uses**

- System evaluation and monitoring.

**Data Source Hierarchy**

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

**Other Associated Elements**

- ADMITTING SERVICE

## ADMITTING SERVICE

### Definition

The three-letter code for the physician service primarily responsible for admitting the patient to the hospital, if applicable.

### Field Values

LA COUNTY					
<b>ANE</b>	ANESTHESIOLOGY	<b>NCC</b>	NEURO CRITICAL CARE	<b>PNS</b>	PEDIATRIC NEUROSURGERY
<b>BUR</b>	BURN SPECIALIST	<b>NEO</b>	NEONATOLOGY	<b>POS</b>	PEDIATRIC ORTHOPEDIC SURGERY
<b>CAR</b>	CARDIOLOGY	<b>NEP</b>	NEPHROLOGY	<b>POT</b>	PEDIATRIC OTOLARYNGOLOGY
<b>CTS</b>	CARDIOTHORACIC SURGERY	<b>NEU</b>	NEUROLOGY	<b>PPY</b>	PEDIATRIC PSYCHIATRIST
<b>CCI</b>	CRITICAL CARE INTENSIVIST	<b>NES</b>	NEUROSURGERY	<b>PPS</b>	PEDIATRIC PULMONARY SPECIALIST
<b>DEN</b>	DENTAL	<b>OBS</b>	OBSTETRICS	<b>PES</b>	PEDIATRIC SURGERY
<b>DER</b>	DERMATOLOGY	<b>OPS</b>	OPHTHALMOLOGIC SURGERY	<b>PUR</b>	PEDIATRIC UROLOGY
<b>END</b>	ENDOCRINOLOGY	<b>ORS</b>	ORAL SURGERY	<b>PED</b>	PEDIATRICS
<b>FNM</b>	FAMILY MEDICINE	<b>ORT</b>	ORTHOPEDIC SURGERY	<b>PHY</b>	PHYSIATRY
<b>GAS</b>	GASTROENTEROLOGY	<b>ONL</b>	OTHER NOT LISTED	<b>PLS</b>	PLASTIC SURGERY
<b>GES</b>	GENERAL SURGERY	<b>OTO</b>	OTOLARYNGOLOGY	<b>POD</b>	PODIATRY
<b>GER</b>	GERIATRICS	<b>PAL</b>	PALLIATIVE CARE	<b>PSC</b>	PSYCHOLOGY
<b>GYN</b>	GYNECOLOGY	<b>PEA</b>	PEDIATRIC ALLERGY	<b>PSY</b>	PSYCHIATRY
<b>HAS</b>	HAND SURGEON	<b>PEC</b>	PEDIATRIC CARDIOLOGY	<b>PUL</b>	PULMONARY SPECIALIST
<b>HEM</b>	HEMATOLOGY	<b>PCS</b>	PEDIATRIC CARDIOTHORACIC SURGERY	<b>RHE</b>	RHEUMATOLOGY
<b>HNS</b>	HEAD & NECK SURGERY	<b>PEN</b>	PEDIATRIC ENDOCRINOLOGY	<b>SPI</b>	SPINAL
<b>HBO</b>	HYPERBARIC MEDICINE	<b>PEG</b>	PEDIATRIC GASTROENTEROLOGY	<b>THO</b>	THORACIC SURGERY
<b>INF</b>	INFECTIOUS MEDICINE	<b>PEH</b>	PEDIATRIC HEMATOLOGY	<b>TRS</b>	TRAUMA SURGERY
<b>INN</b>	INTERVENTIONAL NEUROLOGY	<b>PEI</b>	PEDIATRIC INTENSIVIST	<b>URO</b>	UROLOGY
<b>INR</b>	INTERVENTIONAL RADIOLOGY	<b>PMS</b>	PAIN MANAGEMENT SPECIALIST	<b>VAS</b>	VASCULAR SURGERY
<b>INT</b>	INTERNAL MEDICINE	<b>PNP</b>	PEDIATRIC NEPHROLOGY		
<b>MAS</b>	MAXILLOFACIAL SURGERY	<b>PNE</b>	PEDIATRIC NEUROLOGY		

### Uses

- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- ADMITTING PHYSICIAN

## TRAUMA TEAM SERVICE

### Definition

Services activated to evaluate the patient upon arrival to the ED, if applicable.

### Field Values

LA COUNTY					
<b>ANE</b>	ANESTHESIOLOGY	<b>NCC</b>	NEURO CRITICAL CARE	<b>POS</b>	PEDIATRIC ORTHOPEDIC SURGERY
<b>BUR</b>	BURN SPECIALIST	<b>NER</b>	NEURORADIOLOGY	<b>PES</b>	PEDIATRIC SURGERY
<b>CTS</b>	CARDIOTHORACIC SURGERY	<b>NES</b>	NEUROSURGERY	<b>PED</b>	PEDIATRICS
<b>CCI</b>	CRITICAL CARE INTENSIVIST	<b>OBS</b>	OBSTETRICS	<b>PTN</b>	PRIMARY TRAUMA NURSE
<b>EDP</b>	ED PHYSICIAN/ATTENDING	<b>OPS</b>	OPHTHAMOLOGIC SURGERY	<b>PUL</b>	PULMONARY SPECIALIST
<b>EDR</b>	ED RESIDENT	<b>ORS</b>	ORAL SURGERY	<b>RAD</b>	RADIOLOGY
<b>GES</b>	GENERAL SURGERY	<b>ORT</b>	ORTHOPEDIC SURGERY	<b>SPI</b>	SPINAL
<b>HAS</b>	HAND SURGERY	<b>ONL</b>	OTHER NOT LISTED	<b>THO</b>	THORACIC SURGERY
<b>HNS</b>	HEAD & NECK SURGERY	<b>PCS</b>	PEDIATRIC CARDIOTHORACIC SURGEON	<b>TRR</b>	TRAUMA RESIDENT
<b>INN</b>	INTERVENTIONAL NEUROLOGY	<b>PEI</b>	PEDIATRIC INTENSIVIST	<b>TRS</b>	TRAUMA SURGEON/ATTENDING
<b>INR</b>	INTERVENTIONAL RADIOLOGY	<b>PNR</b>	PEDIATRIC NEURORADIOLOGY	<b>VAS</b>	VASCULAR SURGERY
<b>INT</b>	INTERNAL MEDICINE	<b>PNS</b>	PEDIATRIC NEUROSURGERY		

### Additional Information

- Trauma Team composition will vary by facility.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- PHYSICIAN CODE (*Trauma Team*)
- REQUEST DATE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)
- ARRIVAL TIME (*Trauma Team*)



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**PHYSICIAN CODE (*Trauma Team*)**

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**Definition**

Name or code of trauma team (TT) physician activated to evaluate the patient upon arrival to the ED, if applicable.

**Field Values**

- Free text

**Additional Information**

- Enter physician name or code directly, or create facility-specific picklist.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- TRAUMA TEAM SERVICE
- REQUEST DATE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)
- ARRIVAL TIME (*Trauma Team*)

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**REQUEST DATE (*Trauma Team*)**

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**Definition**

Date that trauma team physician was activated to evaluate the patient upon arrival to the ED, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- TRAUMA TEAM SERVICE
- PHYSICIAN SERVICE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)
- ARRIVAL TIME (*Trauma Team*)

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**REQUEST TIME (*Trauma Team*)**

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**Definition**

Time of day that trauma team physician was activated to evaluate the patient upon arrival to the ED, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- TRAUMA TEAM SERVICE
- PHYSICIAN SERVICE (*Trauma Team*)
- REQUEST DATE (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)
- ARRIVAL TIME (*Trauma Team*)

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**STAT? (*Trauma Team*)**

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**Definition**

Indicates whether the trauma team physician was requested to respond immediately (responding without delay when notified) to evaluate the injured patient upon arrival to the ED.

**Field Values**

- Y: Yes
- N: No

**Uses**

- Assists with determination of appropriate treatment.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- TRAUMA TEAM SERVICE
- PHYSICIAN CODE (*Trauma Team*)
- REQUEST DATE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)
- ARRIVAL TIME (*Trauma Team*)

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**ARRIVAL DATE (*Trauma Team*)**

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**Definition**

Date that Trauma Team physician, or services consulted during the ED phase of care, **arrived at the bedside to evaluate the injured patient** in the ED.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Trauma Team member equal to “TRS” will be mapped to NTDS’s “Trauma Surgeon Arrival Date”.
- A “**phone response**” is **NOT to be utilized as an *Arrival Time***. Physical evaluation of the patient is not possible via the phone.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Used in quality management for the evaluation of care.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- TRAUMA TEAM SERVICE
- PHYSICIAN CODE (*Trauma Team*)
- REQUEST DATE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL TIME (*Trauma Team*)

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## ARRIVAL TIME (*Trauma Team*)

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### Definition

Time that Trauma Team physician, or services consulted during the ED phase of care, **arrived at the bedside to evaluate the injured patient** in the ED.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- Trauma Team member equal to “TRS” will be mapped to NTDS’s “Trauma Surgeon Arrival Time”.
- A “**phone response**” is **NOT to be utilized as an *Arrival Time***. Physical evaluation of the patient is not possible via the phone.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

### Uses

- Used in quality management for the evaluation of care.

### Data Source Hierarchy

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- TRAUMA TEAM SERVICE
- PHYSICIAN CODE (*Trauma Team*)
- REQUEST DATE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)

## CONSULTATION SERVICE

### Definition

Services consulted to evaluate the patient during the ED phase of care, if applicable.

### Field Values

LA COUNTY					
<b>ANE</b>	ANESTHESIOLOGY	<b>NCC</b>	NEURO CRITICAL CARE	<b>PNS</b>	PEDIATRIC NEUROSURGERY
<b>BUR</b>	BURN SPECIALIST	<b>NEO</b>	NEONATOLOGY	<b>POS</b>	PEDIATRIC ORTHOPEDIC SURGERY
<b>CAR</b>	CARDIOLOGY	<b>NEP</b>	NEPHROLOGY	<b>POT</b>	PEDIATRIC OTOLARYNGOLOGY
<b>CTS</b>	CARDIOTHORACIC SURGERY	<b>NEU</b>	NEUROLOGY	<b>PPY</b>	PEDIATRIC PSYCHIATRIST
<b>CCI</b>	CRITICAL CARE INTENSIVIST	<b>NES</b>	NEUROSURGERY	<b>PPS</b>	PEDIATRIC PULMONARY SPECIALIST
<b>DEN</b>	DENTAL	<b>OBS</b>	OBSTETRICS	<b>PES</b>	PEDIATRIC SURGERY
<b>DER</b>	DERMATOLOGY	<b>OPS</b>	OPHTHALMOLOGIC SURGERY	<b>PUR</b>	PEDIATRIC UROLOGY
<b>END</b>	ENDOCRINOLOGY	<b>ORS</b>	ORAL SURGERY	<b>PED</b>	PEDIATRICS
<b>FNM</b>	FAMILY MEDICINE	<b>ORT</b>	ORTHOPEDIC SURGERY	<b>PHY</b>	PHYSIATRY
<b>GAS</b>	GASTROENTEROLOGY	<b>ONL</b>	OTHER NOT LISTED	<b>PLS</b>	PLASTIC SURGERY
<b>GES</b>	GENERAL SURGERY	<b>OTO</b>	OTOLARYNGOLOGY	<b>POD</b>	PODIATRY
<b>GER</b>	GERIATRICS	<b>PAL</b>	PALLIATIVE CARE	<b>PSC</b>	PSYCHOLOGY
<b>GYN</b>	GYNECOLOGY	<b>PEA</b>	PEDIATRIC ALLERGY	<b>PSY</b>	PSYCHIATRY
<b>HAS</b>	HAND SURGEON	<b>PEC</b>	PEDIATRIC CARDIOLOGY	<b>PUL</b>	PULMONARY SPECIALIST
<b>HEM</b>	HEMATOLOGY	<b>PCS</b>	PEDIATRIC CARDIOTHORACIC SURGERY	<b>RHE</b>	RHEUMATOLOGY
<b>HNS</b>	HEAD & NECK SURGERY	<b>PEN</b>	PEDIATRIC ENDOCRINOLOGY	<b>SPI</b>	SPINAL
<b>HBO</b>	HYPERBARIC MEDICINE	<b>PEG</b>	PEDIATRIC GASTROENTEROLOGY	<b>THO</b>	THORACIC SURGERY
<b>INF</b>	INFECTIOUS MEDICINE	<b>PEH</b>	PEDIATRIC HEMATOLOGY	<b>TRS</b>	TRAUMA SURGERY
<b>INN</b>	INTERVENTIONAL NEUROLOGY	<b>PEI</b>	PEDIATRIC INTENSIVIST	<b>URO</b>	UROLOGY
<b>INR</b>	INTERVENTIONAL RADIOLOGY	<b>PMS</b>	PAIN MANAGEMENT SPECIALIST	<b>VAS</b>	VASCULAR SURGERY
<b>INT</b>	INTERNAL MEDICINE	<b>PNP</b>	PEDIATRIC NEPHROLOGY		
<b>MAS</b>	MAXILLOFACIAL SURGERY	<b>PNE</b>	PEDIATRIC NEUROLOGY		

### Additional Information

- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- PHYSICIAN CODE (*ED Consult*)
- REQUEST TIME (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)

---

**PHYSICIAN CODE (*ED Consult*)**

---

---

**Definition**

Name or code of physician consulted to evaluate the patient during the ED phase of care, if applicable.

**Field Values**

- Free text

**Additional Information**

- Enter physician name or code directly, or create facility-specific picklist.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- CONSULTATION SERVICES
- REQUEST DATE (*ED Consult*)
- REQUEST TIME (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL DATE (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)



---

**REQUEST DATE (*ED Consult*)**

---

**Definition**

Date that the consult services was requested to evaluate the patient in the ED phase of care, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- CONSULTATION SERVICES
- PHYSICIAN CODE (*ED Consult*)
- REQUEST TIME (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL DATE (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)

---

**REQUEST TIME (*ED Consult*)**

---

---

**Definition**

Time of day that the consult services was requested to evaluate the patient in the ED phase of care, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- CONSULTATION SERVICES
- PHYSICIAN CODE (*ED Consult*)
- REQUEST DATE (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL DATE (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)

---

**STAT? (*ED Consult*)**

---

---

**Definition**

Indicates whether the consulting service physician was requested to respond immediately (responding without delay when notified) to evaluate the patient in the ED phase of care, if applicable.

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Assists with determination of appropriate treatment.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- CONSULTATION SERVICES
- PHYSICIAN CODE (*ED Consult*)
- REQUEST DATE (*ED Consult*)
- REQUEST TIME (*ED Consult*)
- ARRIVAL DATE (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)

---

**ARRIVAL DATE (*ED Consult*)**

---

---

**Definition**

Date that the consulting services **arrived at the bedside to evaluate the injured patient** in the ED phase of care, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- A “**phone response**” is **NOT to be utilized as an *Arrival Date***. Physical evaluation of the patient is not possible via the phone.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- CONSULTATION SERVICES
- PHYSICIAN CODE ED (*Consult*)
- REQUEST TIME (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)

---

**ARRIVAL TIME (ED Consult)**

---

---

**Definition**

Time of day that the consulting services **arrived at the bedside to evaluate the injured patient** in the ED phase of care, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- A **“phone response” is NOT to be utilized as an *Arrival Time***. Physical evaluation of the patient is not possible via the phone.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- CONSULTATION SERVICES
- PHYSICIAN CODE ED (*Consult*)
- REQUEST TIME (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL DATE (*ED Consult*)

---

## 1<sup>ST</sup> ANTIBIOTIC ADMINISTRATION DATE

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---

### Definition

Date of 1<sup>st</sup> antibiotic administration for patients that meet the collection criteria.

### Collection Criterion

- **COLLECT ON ALL TRAUMA PATIENTS THAT MEET THE LA TRAUMA DATABASE INCLUSION CRITERIA WITH ANY OPEN FRACTURE.**

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Open fractures as defined by the codes listed in Association for the Advancement of Automotive Medicine Abbreviated Injury Scale (AIS) Coding Rules and Guidelines.
- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria.

### Uses

- Used in calculating time interval of time of arrival to antibiotic administration.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records

### Other Associated Elements

- 1<sup>st</sup> ANTIBIOTIC ADMINISTRATION TIME
- ARRIVAL DATE
- ARRIVAL TIME

---

## 1<sup>ST</sup> ANTIBIOTIC ADMINISTRATION TIME

---

---

### Definition

Time of day of the 1<sup>st</sup> antibiotic administration for patients that meet the collection criteria.

### Collection Criterion

- **COLLECT ON ALL TRAUMA PATIENTS THAT MEET THE LA TRAUMA DATABASE INCLUSION CRITERIA WITH ANY OPEN FRACTURE.**

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- Open fractures as defined by the codes listed in Association for the Advancement of Automotive Medicine Abbreviated Injury Scale (AIS) Coding Rules and Guidelines.
- The null value of *“Not Applicable”* is used for patients that do not meet the collection criteria.

### Uses

- Used in calculating time interval of time of arrival to antibiotic administration.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records

### Other Associated Elements

- 1<sup>ST</sup> ANTIBIOTIC ADMINISTRATION DATE
- ARRIVAL DATE
- ARRIVAL TIME

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## IV FLUIDS IN ED

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**Definition**

Total amount of all crystalloids and colloids, excluding blood products, received by the patient in the ED.

**Field Values**

- Up to five-digit positive numeric value.

**Additional Information**

- Collected as milliliters – not liters or units.
- Enter the null value of “*Not Documented*” if IV fluids are documented, but the specific amount is not recorded.

**Uses**

- Provides documentation of assessment and/or care.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records



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## SIGNS OF LIFE ON ARRIVAL?

---

### Definition

Indicates whether the patient arrived in the ED/Hospital with signs of life.

### Field Values

- Y: Yes
- N: No

### Additional Information

- A patient with no signs of life is defined as having none of the following:
  - ✓ Organized ECG activity
  - ✓ Pupillary responses
  - ✓ Spontaneous respiratory effort
  - ✓ Unassisted blood pressure
- This usually implies that the patient arrived with CPR in progress.
- Field value cannot be *“Not Applicable”*.
- Field value cannot be left blank.
- The following edit check has been applied to Trauma One®:
  - ✓ ARRIVED WITH SIGNS OF LIFE? entered as “No”, 1<sup>st</sup> ED VS SBP, HR, and RR must be 0.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records

### Other Associated Elements

- DEATH IN ED
- NEXT PHASE AFTER ED
- ED EXIT ED DATE
- ED EXIT TIME
- TRASFERRED/DISCHARGED TO
- PHASE PRIOR TO DISCHARGE

## DEATH IN ED

### Definition

Provides details on patients who are declared Dead on Arrival (DOA) or who died in the ED.

### Field Values

LA COUNTY		
<b>D</b>	DOA	Death declared <b>on arrival</b> no resuscitative efforts initiated in the ED.
<b>F</b>	Failed Resuscitation	Death pronounced in the ED after failure to respond to resuscitative efforts <b>within 15 minutes</b> of ED arrival.
<b>O</b>	Died in ED	Death pronounced in the ED <b>other than Failed Resuscitation.</b>

### Additional Information

- Although CPR is a resuscitative procedure, if that is the **ONLY** procedure performed while determining the patient’s DEATH IN ED status, the patient should be considered DOA.
- Enter the null value of *“Not Applicable”* if the patient did not die in the ED

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring

### Data Source Hierarchy

- ED Records

### Other Associated Elements

- SIGNS OF LIFE ON ARRIVAL?
- NEXT PHASE AFTER ED
- ED EXIT DATE
- ED EXIT TIME
- TRANSFERRED/DISCHARGED TO
- PHASE PRIOR TO DISCHARGE

## NEXT PHASE AFTER ED

### Definition

Phase of care occurring directly after the ED phase (ED disposition).

### Field Values

LA COUNTY		NTDS	
Next Phase After ED		ED Discharge Disposition	
23HR OBS	<24 hour Observation	2	Observation Unit
ICU	Intensive/Critical Care Unit	8	Intensive Care Unit (ICU)
INT RAD	Interventional Radiology	7	Operating Room
OR	Operating Room	7	Operating Room
ORR	Operating Room Recovery	7	Operating Room
PICU	Pediatric ICU	8	Intensive Care Unit (ICU)
PEDSWARD	Pediatric Ward	1	Floor bed (general admission, non-specialty bed)
SPECIAL	Special Procedures	8	Intensive Care Unit (ICU)
STEPDOWN	Stepdown or Telemetry Unit	3	Telemetry/Step-down Unit (less acuity than ICU)
WARD	Ward/Floor	1	Floor bed (general admission, non-specialty bed)
POSTHOSP	<i>Posthospital - (Use LA County "Transferred/Discharged To:"):</i>		

### Additional Information

- Next phase begins when patient is no longer being cared for by the ED or ED personnel, except for Interventional Radiology and/or Special procedures.
- All patients admitted to observation status, regardless of their actual physical location – use 23hr OBS as the next phase after ED.
- ICU Admission is based upon the level of care the patient requires, and not the location of the patient within the hospital. If the patient is admitted to the ICU for a monitored bed only, the patient’s next phase after ED should be documented as Stepdown **NOT** ICU.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records

### Other Associated Elements

- ED EXIT DATE
- ED EXIT TIME
- DEATH IN ED
- TRANSFERRED/DISCHARGED TO

# **RADIOLOGY/LABORATORY**

## RADIOLOGY: Body Part/ICD-10

### Definition

Body region and ICD-10 code of the radiological studies performed that were essential to the diagnosis of the patient's specific injuries, if applicable.

### Field Values

BODY PART	X-Ray	CT	CT w/contrast	BODY PART	X-Ray	CT	CT w/contrast
<b>HEAD</b>				<b>UPPER EXTREMITIES</b>	BW0JZZZ		
Head / Skull	BN00ZZZ	BW28ZZZ	BW281ZZ	Right Upper Extremity	BP0EZZZ	BP2EZZZ	BP2E1ZZ
Brain		B020ZZZ	B0201ZZ	Right hand	BP0NZZZ	BP2NZZZ	BP2N1ZZ
Orbits	BN03ZZZ	BN23ZZZ	BN231ZZ	Right wrist	BP0LZZZ	BP2LZZZ	BP2L1ZZ
Facial	BN05ZZZ	BN25ZZZ	BN251ZZ	Right forearm	BP0JZZZ	BP2JZZZ	BP2J1ZZ
Mandible	BN06ZZZ	BN26ZZZ	BN261ZZ	Right elbow	BP0GZZZ	BP2GZZZ	BP2G1ZZ
				Right humerus	BP0AZZZ	BP2AZZZ	BP2A1ZZ
<b>NECK / SPINE</b>				Right clavicle	BP04ZZZ	BP24ZZZ	BP241ZZ
Neck		BW2FZZZ	BW2F1ZZ	Right shoulder	BP08ZZZ	BP28ZZZ	BP281ZZ
Cervical spine	BR00ZZZ	BR20ZZZ	BR201ZZ	Left Upper Extremity	BP0FZZZ	BP2FZZZ	BP2F1ZZ
Thoracic spine	BR07ZZZ	BR27ZZZ	BR271ZZ	Left hand	BP0PZZZ	BP2PZZZ	BP2P1ZZ
Lumbosacral spine	BR09ZZZ	BR29ZZZ	BR291ZZ	Left wrist	BP0MZZZ	BP2MZZZ	BP2M1ZZ
				Left forearm	BP0KZZZ	BP2KZZZ	BP2K1ZZ
<b>CHEST / ABDOMEN</b>				Left elbow	BP0HZZZ	BP2HZZZ	BP2H1ZZ
Chest	BW03ZZZ	BW24ZZZ	BP241ZZ	Left humerus	BP0BZZZ	BP2BZZZ	BP2B1ZZ
Chest & Abdomen		BW24ZZZ	BP241ZZ	Left clavicle	BP05ZZZ	BP25ZZZ	BP251ZZ
Chest, Abdomen, Pelvis		BW25ZZZ	BW251ZZ	Left shoulder	BP09ZZZ	BP29ZZZ	BP291ZZ
Right Ribs	BP0XZZZ	BP2XZZZ	BP2X1ZZ				
Left Ribs	BP0YZZZ	BP2YZZZ	BP2Y1ZZ	<b>LOWER EXTREMITIES</b>	BW0CZZZ		
Sternum	BR0HZZZ			Right Lower Extremity	BQ0DZZZ	BQ2DZZZ	BQ2D1ZZ
Heart / Lung		B226ZZZ	B2261ZZ	Right ankle	BQ0GZZZ	BQ2GZZZ	BQ2G1ZZ
Abdomen		BW20ZZZ	BW201ZZ	Right foot	BQ0LZZZ	BQ2LZZZ	BQ2L1ZZ
Abdomen / Pelvis	BW00ZZZ	BW21ZZZ	BW211ZZ	Right femur	BQ03ZZZ	BQ23ZZZ	BQ231ZZ
Kidneys (KUB)	BT03ZZZ	BT23ZZZ	BT231ZZ	Right knee	BQ07ZZZ	BQ27ZZZ	BQ271ZZ
Right Kidney	BT01ZZZ	BT21ZZZ	BT211ZZ	Right tibia/fibula		BQ2BZZZ	BQ2B1ZZ
Left Kidney	BT02ZZZ	BT22ZZZ	BT221ZZ	Right hip	BQ00ZZZ	BQ20ZZZ	BQ201ZZ
				Left Lower Extremity	BQ0FZZZ	BQ2FZZZ	BQ2F1ZZ
<b>OTHER</b>				Left ankle	BQ0HZZZ	BQ2HZZZ	BQ2H1ZZ
Right scapula	BP06ZZZ	BP26ZZZ	BP261ZZ	Left foot	BQ0MZZZ	BQ2MZZZ	BQ2M1ZZ
Left scapula	BP07ZZZ	BP27ZZZ	BP271ZZ	Left femur	BQ04ZZZ	BQ24ZZZ	BQ241ZZ
Pelvis	BR0CZZZ	BW2GZZZ	BW2G1ZZ	Left knee	BQ08ZZZ	BQ28ZZZ	BQ281ZZ
Sacrum	BR0FZZZ	BR2FZZZ	BR2F1ZZ	Left tibia/fibula		BQ2CZZZ	BQ2C1ZZ
Skeletal Survey	BW0LZZZ			Left hip	BQ01ZZZ	BQ21ZZZ	BQ211ZZ

### Additional Information

- Head CT results are **NOT** considered abnormal if a facial fracture is the only abnormality identified.
- The codes for CT's **with contrast** are for **Low Osmolar Contrast**.
- For CTs using **Other Contrast**, replace the Approach Code of 1 (5<sup>th</sup> Digit) with Y.
- Code all CTs **individually** by "body part".
- A larger version of the above table can be found in Appendix 2.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Radiology Records
- ED Records

### Other Associated Elements

- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description

## RADIOLOGY: Study

### Definition

Type of radiological study performed during hospital stay that were essential to the diagnosis of patient's specific injuries, if applicable.

### Field Values

LA COUNTY	
CT Scan	Computerized Tomography Scan
FAST	Focused Assessment Sonography for Trauma
MRI	Magnetic Resonance Imaging
PLAIN FILMS	Plain Films
Radionucleotide Scans	Radionucleotide Scans
Ultrasound	Ultrasound
Other	Other Study

### Additional Information

- CTs and MRIs are diagnostic radiology and may or may not include contrast.
- The ONLY difference between a **diagnostic** CT and MRI done with contrast versus “angiography” (CTA or MRA), is the timing of the contrast. To decrease variability and increase interrater reliability, **simply code either procedure as a CT or MRI.**
- Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).
- Record subsequent radiology studies if they identify missed injuries.
- Interventional Angiogram (Catheter Angiogram, Formal Angiogram) involves interventional radiology (IR). IR is considered an invasive procedure; therefore, **IR procedures should not be coded in the radiology section, they belong in the procedure section.** For IR a special catheter is inserted into an artery or vein through a small incision, and is moved directly into the artery being studied. X-ray images can be obtained while contrast is delivered directly into the artery being studied and allows for embolization, coiling, or other treatment if needed.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Radiology Records
- ED Records

### Other Associated Elements

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description

---

**RADIOLOGY: Date**

---

---

**Definition**

Date radiological studies were performed, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description



---

**RADIOLOGY: Time**

---

---

**Definition**

Time of day that radiological studies were performed, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Result
- RADIOLOGY: Description

---

**RADIOLOGY: Result**

---

---

**Definition**

Results of radiological studies, if applicable.

**Field Values**

- **N:** Normal
- **A:** Abnormal

**Additional Information**

- Abnormal results are radiological findings due to the traumatic event. For example, a cervical spine x-ray with degenerative findings, is an abnormality; however, it is not a result of trauma. Therefore, the cervical spine x-ray would be considered normal.
- Head CT results are **NOT** considered abnormal if a facial fracture is the only abnormality identified.
- (Radiology) results are **ONLY** considered abnormal if the abnormality identified corresponds to the ordered body region being imaged, e.g. C-spine should not be identified as abnormal due to rib fractures previously identified on the CXR.
- “Possible”, “Probable”, “Questionable”, etc. radiology findings not substantiated by the discharge diagnosis should not be recorded as abnormal.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Description

---

**RADIOLOGY: Description**

---

---

**Definition**

Comments or additional information pertaining to radiology testing performed.

**Field Values**

- Free text

**Additional Information**

- OPTIONAL FIELD: This field may be used for free text comments at the discretion of each treating facility.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

---

**SOLID ORGAN INJURY?**

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**Definition**

Indicates whether a solid organ injury exists.

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- ORGANS INJURED
- ORGAN GRADE – Liver
- ORGAN GRADE – Spleen
- ORGAN GRADE – Kidney

## ORGANS INJURED

### Definition

Indicates which solid organ(s) were injured.

### Field Values

LA COUNTY	
LIVER	Liver
SPLEEN	Spleen
R KIDNEY	Right kidney
L KIDNEY	Left kidney
PANCREAS	Pancreas

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Radiology Records
- ED Records

### Other Associated Elements

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGAN GRADE – Liver
- ORGAN GRADE – Spleen
- ORGAN GRADE – Kidney

**ORGAN GRADE – Liver**

**Definition**

Results of solid organ grading of the liver, if applicable.

**Field Values**

LA COUNTY		
<b>Grade I</b>	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
<b>Grade II</b>	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <10cm diameter
	Laceration	1-3cm parenchymal depth, <10cm length
<b>Grade III</b>	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >10cm or expanding
	Laceration	>3cm parenchymal depth
<b>Grade IV</b>	Laceration	Parenchymal disruption involving 25-75% of hepatic lobe 1-3 Couinaud's segments in a single lobe
<b>Grade V</b>	Laceration	Parenchymal disruption involving >75% of hepatic lobe >3 Couinaud's segments within a single lobe
	Vascular	Juxtahepatic venous injuries i.e., retrohepatic vena cava/central major hepatic veins
<b>Grade VI</b>	Vascular	Hepatic Avulsion

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Spleen
- ORGAN GRADE – Kidney
- ORGAN GRADE – Pancreas

**ORGAN GRADE – Spleen**

**Definition**

Results of solid organ grading of the spleen, if applicable.

**Field Values**

LA COUNTY		
<b>Grade I</b>	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
<b>Grade II</b>	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <5cm diameter
	Laceration	1-3cm parenchymal depth not involving a parenchymal vessel
<b>Grade III</b>	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >5cm
	Laceration	>3cm parenchymal depth or involving trabecular vessels
<b>Grade IV</b>	Laceration	Laceration of segmental or hilar vessels producing major devascularization (>25% of spleen)
<b>Grade V</b>	Laceration	Completely shattered spleen
	Vascular	Hilar vascular injury which devascularized the spleen

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Liver
- ORGAN GRADE – Kidney
- ORGAN GRADE – Pancreas

**ORGAN GRADE – Kidney**

**Definition**

Results of solid organ grading of one or both kidney(s), if applicable.

**Field Values**

LA COUNTY		
<b>Grade I</b>	Contusion	Microscopic or gross hematuria, urological studies normal
	Hematoma	Subcapsular, nonexpanding without parenchymal laceration
<b>Grade II</b>	Hematoma	Nonexpanding perirenal hematoma confined to renal retroperitoneum
	Laceration	<1cm parenchymal depth of renal cortex without urinary extravasation
<b>Grade III</b>	Laceration	>1cm depth of renal cortex, without collecting system rupture or urinary extravasation
<b>Grade IV</b>	Laceration	Parenchymal laceration extending through the renal cortex, medulla and collecting system
	Vascular	Main renal artery or vein injury with contained hemorrhage
<b>Grade V</b>	Laceration	Completely shattered kidney
	Vascular	Avulsion of renal hilum which devascularizes the kidney

**Additional Information**

- If both kidneys are injured, enter grading for both.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Liver
- ORGAN GRADE – Spleen
- ORGAN GRADE - Pancreas



**ORGAN GRADE – Pancreas**

**Definition**

Results of solid organ grading of the pancreas, if applicable.

**Field Values**

LA COUNTY		
<b>Grade I</b>	Hematoma	Minor contusion without ductal injury
	Laceration	Superficial laceration without ductal injury
<b>Grade II</b>	Hematoma	Major contusion without ductal injury or tissue loss
	Laceration	Major laceration without ductal injury or tissue loss
<b>Grade III</b>	Laceration	Distal transection or pancreatic parenchymal injury with ductal injury
<b>Grade IV</b>	Laceration	Proximal transection or pancreatic parenchymal injury involving the ampulla
<b>Grade V</b>	Laceration	Massive disruption of the pancreatic head

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Records
- ED Records

**Other Associated Elements**

- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Liver
- ORGAN GRADE - Spleen
- ORGAN GRADE – Kidney

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**LABORATORY: Date**

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**Definition**

Date laboratory testing was performed, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Scrolling window fields: enter date, time, group/panel, description and results for each test as applicable.

**Uses**

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Result
- LABORATORY: Description

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**LABORATORY: Time**

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**Definition**

Time of day laboratory testing was performed, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Scrolling window fields: enter time, group/panel, description, and results for each test as applicable.

**Uses**

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- LABORATORY: Date
- LABORATORY: Group/Panel
- LABORATORY: Result
- LABORATORY: Description

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**LABORATORY: Group/Panel**

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**Definition**

Type of laboratory testing performed, if applicable.

**Field Values**

- 24 Hour Urinalysis
- Blood Bank – Type & Cross
- Blood Bank – Type & Hold
- Blood Gas
- Cardiac Enzyme Fractions
- Cerebrospinal Fluid
- Chemistry
- Coagulation Studies
- Cultures
- Electrolytes
- Hemoglobin
- Hematocrit
- Peritoneal Lavage
- Serology Studies
- Special Chemistry
- Urinalysis

**Additional Information**

- Hemoglobin and/or Hematocrit are mandatory values if performed.
- Scrolling window fields: enter time, group/panel, description, and results for each test as applicable.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Result
- LABORATORY: Description

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**LABORATORY: Result**

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**Definition**

Results of laboratory testing performed, if applicable.

**Field Values**

- **N:** Normal
- **A:** Abnormal

**Additional Information**

- Hemoglobin (Hgb) and Hematocrit (Hct) should only be considered abnormal if results fall **below** the normal range.
- Scrolling window fields: enter time, group/panel, description, and results for each test as applicable.
- Detailed laboratory test and value fields can be found by clicking on the "Other Labs" button.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Description

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**LABORATORY: Description**

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**Definition**

Comments or additional information pertaining to laboratory testing performed.

**Field Values**

- Free text

**Additional Information**

- OPTIONAL FIELD: This field may be used for free text comments at the discretion of each treating facility.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Results

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**ETOH/TOXICOLOGY: Date**

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**Definition**

Date ETOH/Toxicology testing occurred, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Scrolling window fields: enter time, specimen source, substance, results, and comments for each test as applicable.
- Must be within 24 hours of ED/hospital arrival.
- Enter the null value of *“Not Applicable”* if ETOH/Toxicology testing was not done.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS

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**ETOH/TOXICOLOGY: Time**

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**Definition**

Time of day ETOH/Toxicology testing occurred, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Scrolling window fields: enter time, specimen source, substance, results, and comments for each test as applicable. Must be within 24 hours of ED/hospital arrival.
- Must be within 24 hours of ED/Hospital arrival.
- Enter the null value of *"Not Applicable"* if ETOH/Toxicology testing was not done.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS



**ETOH/TOXICOLOGY: Substance**

**Definition**

Type of toxicology screening that occurred within the first 24 hours of hospital arrival.

**Field Values**

LA COUNTY	NTDS	
Ethanol (ETOH)	Alcohol Screen	
Toxicology Screen	Drug Screen	
Amphetamines	1	Amphetamines (AMP)
Antidepressants (excluding Tricyclics)	13	Other
Antipsychotics	13	Other
Benzodiazepines	3	Benzodiazepines (BZO)
Barbiturates	2	Barbiturates (BAR)
Cannabinoids	12	Cannabinoids (THC)
Cocaine	4	Cocaine (COC)
MDMA (3,4-methylenedioxy-methamphetamine) Ecstasy	6	Ecstasy (MDMA)
Methadone	7	Methadone (MTD)
Methamphetamines	5	Methamphetamines (mAMP)
Narcotics / Opioids	8	Opioids (OPI)
Oxycodone	9	Oxycodone (OXY)
PCP (Phencyclidine)	10	Phencyclidine (PCP)
Tricyclic Antidepressants	11	Tricyclic Antidepressants (TCA)
Other toxins	13	Other

**Additional Information**

- ETOH and Toxicology Screens are **BOTH** mandatory data fields for **ALL** patients.
- If an ETOH or Toxicology Screen(s) is (are) **NOT PERFORMED**, the results MUST be entered as "NOT TESTED" for the ETOH/Toxicology: Results.
- The choice of "Toxicology Screen" should only be utilized if the screen was **NOT PERFORMED** or was NEGATIVE for **ALL** toxins.
- If a toxin(s) is (are) identified, enter the toxin(s) from the picklist for the ETOH/Toxicology: Substance instead of the picklist value of "Toxicology Screen".
- Must be within 24 hours of ED/hospital arrival.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS

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**ETOH/TOXICOLOGY: Source**

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**Definition**

Specimen type used for ETOH/Toxicology testing, if applicable.

**Field Values**

- **Blood**
- **Urine**

**Additional Information**

- Scrolling window fields: enter time, specimen source, substance, results, and comments for each test as applicable.
- Must be within 24 hours of ED/hospital arrival.
- Enter the null value of *“Not Applicable”* if ETOH/Toxicology testing was not done.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Lab Results
- ED Records

**Other Associated Elements**

- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS

## ETOH/TOXICOLOGY: Result

### Definition

Results of ETOH/toxicology testing, if applicable.

### Field Values

LA COUNTY	NTDS			
ETOH/Toxicology	ETOH		Drug Screen	
<b>FOUND</b> (Positive)	1	YES	1-13	ENTER IDENTIFIED TOXIN(S)
<b>NOT FOUND</b> (Negative/None)	1	YES	14	NONE
<b>NOT TESTED</b>	2	NO	15	NOT TESTED

### Additional Information

- ETOH and Toxicology Screens are **BOTH** mandatory data fields for **ALL** patients.
- If an ETOH or toxicology Screen(s) is (are) **NOT PERFORMED**, the results **MUST** be entered as "NOT TESTED" for the ETOH/Toxicology: Results.
- If a toxin(s) is (are) identified, enter the toxin(s) from the picklist for the ETOH/Toxicology: Substance instead of the picklist value of "Toxicology Screen".
- If an ETOH Screen (Blood Alcohol Concentration [BAC]) was performed, a numeric value **MUST** be entered in the ETOH "Value" field.
- If ETOH Screen BAC results are NOT FOUND (Negative/None), a numeric value of "0" **MUST** be entered for the ETOH "Value" field.
- "Not Found (Negative/None)" is used for patients whose only positive results are due to substances administered during the medical care provided e.g. Morphine for pain control.
- Must be within 24 hour of ED/hospital arrival.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Lab Results
- ED Records

### Other Associated Elements

- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH VALUE
- ETOH UNITS

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## ETOH VALUE

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### Definition

Numeric value for blood alcohol concentration (BAC) results, if applicable.

### Field Values

- Up to three-digit positive numeric value

### Additional Information

- If an ETOH Screen (Blood Alcohol Concentration [BAC]) was performed, a numeric value received from your lab **MUST** be entered.
- If ETOH Screen BAC results are NOT FOUND (Negative/None), a numeric value of "0" **MUST** be entered.
- Must be within 24 hours of ED/hospital arrival.
- Enter the null value of "*Not Applicable*" for patients that were not tested for ETOH.
- Field value cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Lab Results
- ED Records

### Other Associated Elements

- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH UNITS

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## ETOH UNITS

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### Definition

Units used by your facility's laboratory for reporting blood alcohol concentration (BAC), if applicable.

### Field Values

- **g/dl** (grams/deciliter)
- **mg/dl** (milligrams/deciliter)

### Additional Information

- If an ETOH Screen BAC was completed, and a numeric value was entered for the ETOH Value, even a numeric value of "0", enter the ETOH units used by your facility's laboratory for reporting BAC.
- BAC values entered as mg/dl (whole numbers) will be converted to g/dl (decimal numbers) prior to data submission to NTDS<sup>®</sup>/TQIP<sup>®</sup>.
- Enter the null value of "*Not Applicable*" for patients that were not tested for ETOH.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Lab Results
- ED Records

### Other Associated Elements

- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE

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**MASSIVE TRANSFUSION PROTOCOL (MTP) ACTIVATED?**

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**Definition**

Indicates whether the Massive Transfusion Protocol (MTP) was activated within the **first four hours** of ED/hospital arrival

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- Utilize the *Blood Info* button to access all information regarding blood collection.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Trauma Flow Sheet
- ED Records
- Blood Bank Records
- Transfusion Records

**Other Associated Elements**

- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**TQIP® BLOOD INCLUSION?**

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**Definition**

Indicates whether the patient received blood during the **first four hours** of ED/Hospital arrival.

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- Utilize the *Blood Info* button to access all information regarding blood collection.
- Enter a value of "No" if the patient did not receive blood.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Trauma Flow Sheet
- ED Records
- Physician's Progress Notes
- Operative Report
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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## LOWEST SYSTOLIC BLOOD PRESSURE (SBP)

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### Definition

Numeric value of the patient's lowest systolic blood pressure (SBP) **WITHIN THE FIRST HOUR** of ED/hospital arrival.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS OR WHOLE BLOOD WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

- Up to three-digit positive numeric value

### Additional Information

- Utilize the *Blood Info* button to access all information regarding blood collection.
- Enter the null value of "Not Applicable" if the patient did not meet the collection criteria.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Trauma Flow Sheet
- ED Records
- Physician's Progress Notes
- Operative Report
- Other Hospital Records

### Other Associated Elements

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS



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**WHOLE BLOOD (4 HOURS)**

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**Definition**

Total volume of whole blood received by the patient during the **first 4 hours** of care.

**COLLECTION CRITERION**  
**COLLECT ON ALL PATIENTS****Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of whole blood** is equivalent to **500 ccs** if the actual volume of the unit is not documented.
- If whole blood was not given in the first 4 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Record
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**PACKED CELLS (PRBC) (4 HOURS)**

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**Definition**

Total volume of packed red blood cells (PRBCs) received by the patient during the **first four hours** of care.

**COLLECTION CRITERION  
COLLECT ON ALL PATIENTS****Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of PRBCs** is equivalent to **350 ccs** if the actual volume of the unit is not documented.
- If no PRBCs were given in the first 4 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be *"Not Applicable"*.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**PLASMA (FFP) (4 HOURS)**

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**Definition**

Total volume of fresh frozen plasma (FFP) received by the patient during the **first four hours** of care.

**COLLECTION CRITERION  
COLLECT ON ALL PATIENTS****Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of plasma** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- If no plasma was given in the first 4 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be *"Not Applicable"*.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**PLATELETS (4 HOURS)**

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**Definition**

Total volume of platelets received by the patient during the **first four hours** of care.

**COLLECTION CRITERION**  
**COLLECT ON ALL PATIENTS****Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of Platelets** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- For facilities utilizing platelet *Jumbo Packs*, the facility specific unit value equivalent (how many units is a Jumbo Pack equivalent to) must be determine for the data entry of all platelet related data fields, 4 Hours, 24 Hours, and Total.
- If no platelets were given in the first 4 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**CRYOPRECIPITATE (4 HOURS)**

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**Definition**

Total volume of cryoprecipitate received by the patient during the **first four hours** of care.

**COLLECTION CRITERION**  
**COLLECT ON ALL PATIENTS****Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 pack of Cryoprecipitate** is equivalent to **100 ccs** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 4 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be *"Not Applicable"*.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

---

**WHOLE BLOOD (24 HOURS)**

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**Definition**

Total volume of whole blood received by the patient during the **first 24 hours** of care.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of Whole Blood** is equivalent to **500 ccs** if the actual volume of the unit is not documented.
- If no whole blood given in the first 24 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be *"Not Applicable"*.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**PACKED CELLS (PRBC) (24 HOURS)**

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**Definition**

Total volume of PRBCs received by the patient during the **first 24 hours** of care.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of PRBCs** is equivalent to **350 ccs** if the actual volume of the unit is not documented.
- If no packed red blood cells were given in the first 24 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be *"Not Applicable"*.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

---

**PLASMA (FFP) (24 HOURS)**

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**Definition**

Total volume FFP received by the patient during the **first 24 hours** of care.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of plasma** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- If no plasma was given in the first 24 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS



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**PLATELETS (24 HOURS)**

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**Definition**

Total volume of platelets received by the patient during the **first 24 hours** of care.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of Platelets** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- For facilities utilizing platelet *Jumbo Packs*, the facility specific unit value equivalent (how many units is a Jumbo Pack equivalent to) must be determine for the data entry of all platelet related data fields, 4 Hours, 24 Hours, and Total.
- If no platelets were given in the first 24 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**CRYOPRECIPITATE (24 HOURS)**

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**Definition**

Total volume of cryoprecipitate received by the patient during the **first 24 hours** of care.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 pack of Cryoprecipitate** is equivalent to **100 ccs** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 24 hours, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

---

**WHOLE BLOOD (TOTAL)**

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**Definition**

Total volume of whole blood received by the patient **while hospitalized**.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of Whole Blood** is equivalent to **500 ccs** if the actual volume of the unit is not documented.
- If no whole blood was given during the patient's hospital stay, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**PACKED CELLS (PRBC) (TOTAL)**

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**Definition**

Total volume of PRBCs received by the patient **while hospitalized**.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of PRBCs** is equivalent to **350 ccs** if the actual volume of the unit is not documented.
- If no packed red blood cells were given during the patient's hospital stay, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**PLASMA (FFP) (TOTAL)**

---

**Definition**

Total volume of FFP received by the patient **while hospitalized**.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 unit of Plasma** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- If no plasma was given during the patient's hospital stay, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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## PLATELETS (TOTAL)

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### Definition

Total volume of platelets received by the patient **while hospitalized**.

### Field Values

- Up to five-digit positive numeric value

### Additional Information

- Collected in ccs.
- **1 unit of Platelets** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- For facilities utilizing platelet *Jumbo Packs*, the facility specific unit value equivalent (how many units is a Jumbo Pack equivalent to) must be determine for the data entry of all platelet related data fields, 4 Hours, 24 Hours, and Total.
- If no platelets were given during the patient's hospital stay, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

### Data Source Hierarchy

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

### Other Associated Elements

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS

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**CRYOPRECIPITATE (TOTAL)**

---

**Definition**

Total volume of cryoprecipitate received by the patient **while hospitalized**.

**Field Values**

- Up to five-digit positive numeric value

**Additional Information**

- Collected in ccs.
- **1 pack of Cryoprecipitate** is equivalent to **100 ccs** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given during the patient's hospital stay, then enter the volume as zero.
- **EXCLUDE:** Cell Saver Blood
- Volume should never be "*Not Applicable*".

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- TOTAL BLOOD PRODUCTS

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## TOTAL BLOOD PRODUCTS

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### Definition

Total volume of blood products, including whole blood, PRBCs, FFP, platelets, and cryoprecipitate given to the patient **while hospitalized**.

### Field Values

- Up to five-digit positive numeric value

### Additional Information

- Auto-calculated using sum of WHOLE BLOOD (*TOTAL*), PRBC (*TOTAL*), FFP (*TOTAL*), PLATELETS (*TOTAL*), and CRYOPRECIPITATE (*TOTAL*) values.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

### Other Associated Elements

- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (*4 HOURS*)
- PRBC (*4 HOURS*)
- FFP (*4 HOURS*)
- PLATELETS (*4 HOURS*)
- CRYOPRECIPITATE (*4 HOURS*)
- WHOLE BLOOD (*24 HOURS*)
- PRBC (*24 HOURS*)
- FFP (*24 HOURS*)
- PLATELETS (*24 HOURS*)
- CRYOPRECIPITATE (*24 HOURS*)
- WHOLE BLOOD (*TOTAL*)
- PRBC (*TOTAL*)
- FFP (*TOTAL*)
- PLATELETS (*TOTAL*)
- CRYOPRECIPITATE (*TOTAL*)



# **PROCEDURES/OPERATIONS**

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## PHASE BEGUN

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### Definition

Phase of care where operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications were begun, if applicable.

### Field Values

- **23HR OBS:** <24 Hour Observation
- **ED:** Emergency Department
- **ICU:** Intensive/Critical Care Unit
- **INT RAD:** Interventional Radiology
- **OR:** Operating Room
- **PICU:** Pediatric ICU
- **PEDSWARD:** Pediatric Ward
- **READMIT:** Re-Admit
- **SPECIAL:** Special Procedures
- **STEPDOWN:** Stepdown or Telemetry Unit
- **WARD:** Ward/Floor

### Additional Information

- Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).
- Use "Readmit" phase of care for procedures done following readmission.

### Uses

- Assists with determination of appropriate treatment.
- Establishes care intervals and timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- OR Records
- ED Records
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- START DATE
- START TIME
- END TIME
- PROCEDURES (*ICD-10 Codes*)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS

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**START DATE**

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**Definition**

Date when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications were begun, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- OR Records
- ED Records
- Progress Notes
- Other Hospital Records

**Other Associated Elements**

- PHASE BEGUN
- START TIME
- END TIME
- PROCEDURES (*ICD-10 Codes*)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS

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## START TIME

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### Definition

Time of day when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications were begun, if applicable.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Uses

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- OR Records
- ED Records
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- PHASE BEGUN
- START DATE
- END TIME
- PROCEDURES (*ICD-10 Codes*)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS

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## END TIME

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### Definition

Time of day when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications ended, if applicable.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Uses

- Establishes care intervals and incident timelines.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Reports
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- PHASE BEGUN
- START DATE
- START TIME
- PROCEDURES (*ICD-10 Codes*)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS

**PROCEDURES (ICD-10 Codes)**

**Definition**

Operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications, if applicable.

**Field Values**

MANDATORY PROCEDURES	ICD-10 CODES	MANDATORY PROCEDURES	ICD-10 CODES
Central Line Approach: <ul style="list-style-type: none"> <li>Chest, Open</li> <li>Chest, Percutaneous</li> </ul> <b>Special Note:</b> The ICD-10 Code for central lines varies depending on the site and the approach used for placement.	0JH60XZ 0JH63XZ	Inferior Vena Cava (IVC) Filters (temporary or permanent) Approach: <ul style="list-style-type: none"> <li>Open</li> <li>Percutaneous</li> <li>Percutaneous Endoscopic</li> </ul>	06H00DZ 06H03DZ 06H04DZ
Chest Tube (left)	0W9B30Z	Interventional Angiogram (IA) <b>Special Note:</b> The ICD-10 Code for IA varies depending on the site and the approach used.	
Chest Tube (right)	0W9930Z		
Cricothyroidotomy Approach: <ul style="list-style-type: none"> <li>Open</li> <li>Percutaneous</li> <li>Percutaneous Endoscopic</li> </ul>	0B110F4 0B113F4 0B114F4	Intracranial Pressure (ICP) Monitor: <ul style="list-style-type: none"> <li>Percutaneous</li> <li>Via Natural or Artificial Opening</li> </ul>	4A103BD 4A107BD
Diagnostic Peritoneal Aspirate (DPA)	0W9G3ZX	Percutaneous Endoscopic Gastrostomy (PEG) Approach: <ul style="list-style-type: none"> <li>Percutaneous</li> <li>Percutaneous Endoscopic</li> </ul>	0DH63UZ 0DH64UZ
Diagnostic Peritoneal Lavage (DPL)	3E1M38X		
Embolization:  <b>Special Note:</b> The ICD-10 Code for embolization varies depending on the site embolized and the approach used.		Thoracotomy	02JA0ZZ
		Tracheostomy Approach: <ul style="list-style-type: none"> <li>Open</li> <li>Percutaneous</li> <li>Percutaneous Endoscopic</li> </ul>	0B110F4 0B113F4 0B114F4
Endotracheal (ETT) Intubation: <ul style="list-style-type: none"> <li>Via Natural or Artificial Opening</li> <li>Via Natural or Artificial Opening Endoscopic</li> </ul>	0BH17EZ 0BH18EZ	Ventilator: <ul style="list-style-type: none"> <li>Less than 24 Consecutive Hours</li> <li>24-96 Consecutive Hours</li> <li>&gt; 96 Consecutive Hours</li> </ul>	5A1935Z 5A1945Z 5A1955Z

**Additional Information**

- Optional operative or essential major and minor procedures ICD-10-CM codes conducted during hospital stay include the following: Licox, Bronchoscopy, & PICC line.
- All Operative or essential major and minor procedures must be entered.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Operative Reports
- ED Records
- ICU Records
- Billing Sheet/Medical Records
- Other Hospital Records

**Other Associated Elements**

- PHASE BEGUN
- START DATE

- START TIME
- END TIME
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS

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## SURGERY TYPE

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### Definition

Two-digit numerical code for the type of surgical procedure performed, if applicable.

### Field Values

- **00 Surgical Procedures done outside of the operating room**
- **01 Orthopedic**
- **02 Thoracic**
- **03 Abdominal**
- **04 Cardiovascular**
- **05 Plastics**
- **06 Urology**
- **07 Vascular**
- **08 Neurosurgical – Head**
- **09 Neurosurgical – Spine**
- **10 Obstetrics/Gynecology**
- **11 Ophthalmology**
- **99 Other**

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- OR Reports
- Anesthesia Record
- Other Hospital Records

### Other Associated Elements

- PHASE BEGUN
- START DATE
- START TIME
- END TIME
- PROCEDURES (*ICD-10 Codes*)
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS



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## PHYSICIAN CODE

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**Definition**

Name or code of the surgeon that performed the surgical procedure, if applicable.

**Field Values**

- Free text

**Additional Information**

- Non-picklist – free text physician name or code at discretion of each facility.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- OR Records
- Anesthesia Record
- Other Hospital Records

**Other Associated Elements**

- PHASE BEGUN
- START DATE
- START TIME
- END TIME
- PROCEDURES (*ICD-10 Codes*)
- SURGERY TYPE
- TOTAL VENTILATOR DAYS

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## TOTAL VENTILATOR DAYS

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### Definition

The total number of days the patient spent on a mechanical ventilator (include all episodes), if applicable.

### Field Values

- Up to four-digit positive numeric value

### Additional Information

- Recorded in full day increments with any partial day entered as one full day.
- Includes all invasive ventilator support days via endotracheal tube or tracheostomy tube.
- Excludes mechanical ventilation time associated with OR procedures and the immediate recovery period.
- A ventilator required for up to 6 hours post-operatively is considered routine and should not be counted as a ventilator day.
- Enter the null value of *“Not Applicable”* if no ventilator episodes are recorded. Do not enter the numeric value of “0”.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Records
- ICU Records
- Respiratory Therapy Records
- OR Records
- Anesthesia Record
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- PHASE BEGUN
- START DATE
- START TIME
- END TIME
- PROCEDURES (*ICD-10 Codes*)
- SURGERY TYPE
- PHYSICIAN CODE

## 1<sup>st</sup> ANGIOGRAPHY

### Definition

First interventional angiogram performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

LA COUNTY	NTDS	
Angiogram Only	2	Angiogram Only
Angiogram with Embolization	3	Angiogram with Embolization
Angiogram with Stenting	4	Angiogram with Stenting
None	1	None

### Additional Information

- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria and for those who did not undergo an angiography.
- Excludes CTA.
- Only applies to angiograms performed in the IR suite.
- Interventional Angiogram (Catheter Angiogram, Formal Angiogram) involves interventional radiology (IR). For IR a special catheter is inserted into an artery or vein through a small incision, and is moved directly into the artery being studied. X-ray images can be obtained while contrast is delivered directly into the artery being studied and allows for embolization, coiling, or other treatment if needed.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- 1st ANGIOGRAPHY DATE
- 1st ANGIOGRAPHY TIME
- EMBOLIZATION SITES
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)

---

## 1<sup>st</sup> ANGIOGRAPHY DATE

---

### Definition

Date the first interventional angiogram was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Only applies to angiograms performed in the IR suite.
- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria and for those who did not undergo an angiography.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- 1st ANGIOGRAPHY
- 1st ANGIOGRAPHY TIME
- EMBOLIZATION SITES
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)

---

**1<sup>st</sup> ANGIOGRAPHY TIME**

---

**Definition**

Time of day the first interventional angiogram was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

**Collection Criterion**

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Only applies to angiograms performed in the IR suite.
- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria and for those who did not undergo an angiography.

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

**Other Associated Elements**

- 1st ANGIOGRAPHY
- 1st ANGIOGRAPHY DATE
- EMBOLIZATION SITES
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)

## EMBOLIZATION SITES

### Definition

Organ/site of embolization for hemorrhage control, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

LA COUNTY		NTDS
Liver	1	Liver
Spleen	2	Spleen
Kidneys	3	Kidneys
Pelvic (iliac, gluteal, obturator)	4	Pelvic (iliac, gluteal, obturator)
Retroperitoneum (lumbar, sacral)	5	Retroperitoneum (lumbar, sacral)
Peripheral vascular (neck, extremities)	6	Peripheral vascular (neck, extremities)
Other	8	Other

### Additional Information

- Limit collection of angiography data to the first 24 hours following ED/hospital arrival.
- Only applies to angiograms performed in the IR suite.
- The null value of "Not Applicable" is used for patients that do not meet the collection criteria, for those patients who underwent an angiography but without embolization, and for those who did not undergo an angiography.
- Select all applicable sites.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

### Other Associated Elements

- 1st ANGIOGRAPHY
- 1st ANGIOGRAPHY DATE
- 1st ANGIOGRAPHY TIME
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)

## HEMORRHAGE CONTROL TYPE

### Definition

First type of surgery performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

LA COUNTY	NTDS	
None	1	None
Laparotomy	2	Laparotomy
Thoracotomy	3	Thoracotomy
Sternotomy	4	Sternotomy
Extremity	5	Extremity
Neck	6	Neck
Mangled / traumatic amputation	7	Mangled extremity / traumatic amputation
Other skin	8	Other skin / soft tissue
Pelvic Packing	9	Extraperitoneal Pelvic Packing

### Additional Information

- REBOA is a minimally invasive procedure to **temporarily** occlude large vessels (aorta) in support of hemorrhage control. REBOA helps maintain blood flow to critical organs until the hemorrhage control can be definitively controlled via surgery. Therefore, it is not considered a first type of surgery for hemorrhage control.
- If unclear if surgery performed was for hemorrhage control, consult with the Trauma Medical Director or relevant surgeon.
- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria.
- Select all that apply.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Report
- Progress Notes

### Other Associated Elements

- HEMORRHAGE CONTROL DATE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)

---

## HEMORRHAGE CONTROL DATE

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### Definition

Date the first surgery was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Refers to the date the incision was made (or the procedure started) for hemorrhage control.
- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria and for those who did not undergo hemorrhage control surgery.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Report
- Progress Notes

### Other Associated Elements

- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)



---

## HEMORRHAGE CONTROL TIME

---

### Definition

Time of day the first surgery was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- Refers to the time of day the incision was made (or the procedure started) for hemorrhage control.
- The null value of *“Not Applicable”* is used for patients that do not meet the collection criteria and for those who did not undergo hemorrhage control surgery.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Report
- Progress Notes

### Other Associated Elements

- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL DATE
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)

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**NEXT PHASE AFTER OR**

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**Definition**

Phase of care occurring directly following each OR phase, if applicable.

**Field Values**

- **23HR OBS:** <24 Hour Observation
- **ED:** Emergency Department
- **ICU:** Intensive/Critical Care Unit
- **INT RAD:** Interventional Radiology
- **OR:** Operating Room
- **PICU:** Pediatric ICU
- **PEDSWARD:** Pediatric Ward
- **POSTHOSP.:** Posthospital
- **READMIT:** Re-Admit
- **SPECIAL:** Special Procedures
- **STEPDOWN:** Stepdown or Telemetry Unit
- **WARD:** Ward/Floor

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Operative Report
- ICU records
- Progress Notes

**Other Associated Elements**

- DISCHARGE DATE
- DISCHARGE TIME

# **INTENSIVE CARE UNIT (ICU)/ACUTE CARE**

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## ICU ARRIVAL DATE

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### Definition

Date the patient was admitted to the Intensive Care Unit (ICU), if applicable.

### Field Values

- Collected as MMDDYYYY

### Additional Information

- ICU arrival date is the actual date the patient physically arrives in the ICU, regardless of when the order to admit to the ICU is written.
- ICU admission is based upon the level of care the patient requires, and not the location of the patient within the hospital. If the patient is admitted to the ICU for a monitored bed only, the patient's NEXT PHASE AFTER ED should be documented as Stepdown **NOT** ICU.
- Enter the null value of *"Not Applicable"* if the patient was not admitted to the ICU.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate ICU Length of Stay (LOS).

### Data Source Hierarchy

- ICU Records
- ED Records
- Progress Notes

### Other Associated Elements

- ICU EXIT DATE
- ICU LENGTH OF STAY (LOS)

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**ICU EXIT DATE**

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**Definition**

Date patient was discharged or transferred from ICU, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- ICU exit date should be based on when the order for transfer out or discharge from the ICU is written, and ICU resources are no longer being utilized for the care of the patient.

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate ICU Length of Stay (LOS).

**Data Source Hierarchy**

- ICU Records
- Progress Notes

**Other Associated Elements**

- ICU ARRIVAL DATE
- ICU LENGTH OF STAY (LOS)

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**ICU LENGTH OF STAY (LOS)**

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**Definition**

The total number of patient days in any ICU (including all episodes), if applicable.

**Field Values**

- Up to four-digit positive numeric value

**Additional Information**

- ICU LOS should be based on the actual time the patient is physically in the ICU and ICU resources are being utilized for the care of the patient.
- Recorded in full day increments with any partial day listed as a full day.
- Field allows for multiple admission and discharge dates and auto-populates the total ICU LOS.

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ICU Records
- Progress Notes

**Other Associated Elements**

- ICU ARRIVAL DATE
- ICU EXIT DATE

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**CONSULTATION DATE**

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**Definition**

Date during the patient's hospital stay when physician consultation occurred, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress Notes
- Consultation Notes

**Other Associated Elements**

- CONSULTATION SERVICE
- CONSULTATION PHYSICIAN

## CONSULTATION SERVICE

### Definition

Service/specialty of the physician consulted during the patient's hospital stay, if applicable.

### Field Values

LA COUNTY					
<b>ANE</b>	ANESTHESIOLOGY	<b>NCC</b>	NEURO CRITICAL CARE	<b>PNS</b>	PEDIATRIC NEUROSURGERY
<b>BUR</b>	BURN SPECIALIST	<b>NEO</b>	NEONATOLOGY	<b>POS</b>	PEDIATRIC ORTHOPEDIC SURGERY
<b>CAR</b>	CARDIOLOGY	<b>NEP</b>	NEPHROLOGY	<b>POT</b>	PEDIATRIC OTOLARYNGOLOGY
<b>CTS</b>	CARDIOTHORACIC SURGERY	<b>NEU</b>	NEUROLOGY	<b>PPY</b>	PEDIATRIC PSYCHIATRIST
<b>CCI</b>	CRITICAL CARE INTENSIVIST	<b>NES</b>	NEUROSURGERY	<b>PPS</b>	PEDIATRIC PULMONARY SPECIALIST
<b>DEN</b>	DENTAL	<b>OBS</b>	OBSTETRICS	<b>PES</b>	PEDIATRIC SURGERY
<b>DER</b>	DERMATOLOGY	<b>OPS</b>	OPHTHALMOLOGIC SURGERY	<b>PUR</b>	PEDIATRIC UROLOGY
<b>END</b>	ENDOCRINOLOGY	<b>ORS</b>	ORAL SURGERY	<b>PED</b>	PEDIATRICS
<b>FNM</b>	FAMILY MEDICINE	<b>ORT</b>	ORTHOPEDIC SURGERY	<b>PHY</b>	PHYSIATRY
<b>GAS</b>	GASTROENTEROLOGY	<b>ONL</b>	OTHER NOT LISTED	<b>PLS</b>	PLASTIC SURGERY
<b>GES</b>	GENERAL SURGERY	<b>OTO</b>	OTOLARYNGOLOGY	<b>POD</b>	PODIATRY
<b>GER</b>	GERIATRICS	<b>PAL</b>	PALLIATIVE CARE	<b>PSC</b>	PSYCHOLOGY
<b>GYN</b>	GYNECOLOGY	<b>PEA</b>	PEDIATRIC ALLERGY	<b>PSY</b>	PSYCHIATRY
<b>HAS</b>	HAND SURGEON	<b>PEC</b>	PEDIATRIC CARDIOLOGY	<b>PUL</b>	PULMONARY SPECIALIST
<b>HEM</b>	HEMATOLOGY	<b>PCS</b>	PEDIATRIC CARDIOTHORACIC SURGERY	<b>RHE</b>	RHEUMATOLOGY
<b>HNS</b>	HEAD & NECK SURGERY	<b>PEN</b>	PEDIATRIC ENDOCRINOLOGY	<b>SPI</b>	SPINAL
<b>HBO</b>	HYPERBARIC MEDICINE	<b>PEG</b>	PEDIATRIC GASTROENTEROLOGY	<b>THO</b>	THORACIC SURGERY
<b>INF</b>	INFECTIOUS MEDICINE	<b>PEH</b>	PEDIATRIC HEMATOLOGY	<b>TRS</b>	TRAUMA SURGERY
<b>INN</b>	INTERVENTIONAL NEUROLOGY	<b>PEI</b>	PEDIATRIC INTENSIVIST	<b>URO</b>	UROLOGY
<b>INR</b>	INTERVENTIONAL RADIOLOGY	<b>PMS</b>	PAIN MANAGEMENT SPECIALIST	<b>VAS</b>	VASCULAR SURGERY
<b>INT</b>	INTERNAL MEDICINE	<b>PNP</b>	PEDIATRIC NEPHROLOGY		
<b>MAS</b>	MAXILLOFACIAL SURGERY	<b>PNE</b>	PEDIATRIC NEUROLOGY		

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- Progress Notes
- Consultation Notes

### Other Associated Elements

- CONSULTATION DATE
- CONSULTATION PHYSICIAN



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**CONSULTATION PHYSICIAN**

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**Definition**

Name or code of physician consulted during the patient's hospital stay, if applicable.

**Field Values**

- Free text

**Additional Information**

- Enter physician name or code directly, or create facility-specific picklist.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress Notes
- Consultation Notes

**Other Associated Elements**

- CONSULTATION DATE
- CONSULTATION SERVICE

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**TQIP® TBI INCLUSION?**

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**Definition**

Indicates whether the patient meets the Trauma Quality Improvement Program (TQIP®) Traumatic Brain Injury (TBI) inclusion criteria.

**Collection Criterion**

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Radiology Report
- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

**Other Associated Elements**

- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

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## INITIAL PUPILLARY RESPONSE

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**Definition**

Initial physiological pupil response within 30 minutes of ED/hospital arrival.

**Collection Criterion**

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

**Field Values**

LA COUNTY		NTDS	
<b>BOTH</b>	Both Reactive	1	Both Reactive
<b>ONE</b>	One Reactive	2	One Reactive
<b>NEITHER</b>	Neither Reactive	3	Neither Reactive

**Additional Information**

- If a patient does not have a listed field value recorded, but there is documentation related to their pupillary response such as PERRL “Pupils Equal Round Reactive to Light” submit field value for both reactive, IF there is no other contradicting documentation.
- “One” reactive should be reported for patients who have a prosthetic eye.
- Enter the null value of “*Not Known/Not Recorded*” if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- Enter the null value of “*Not Applicable*” for patients that do not meet the collection criteria.
- Field cannot be left blank.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- TQIP® TBI INCLUSION?
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

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## HIGHEST GCS TOTAL

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**Definition**

Highest GCS total **on the first calendar day after** ED/hospital arrival.

**Collection Criterion**

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

**Field Values**

- One- or two-digit numeric value between 3 and 15

**Additional Information**

- Requires review of all data sources to obtain the highest GCS total. In many cases, the highest GCS may occur after the ED phase of care.
- If patient is intubated, then the GCS verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "A&Ox3," "awake, alert, and oriented" interpret this as GCS of 15, if there is no other contradicting documentation.
- Enter the null value of *"Not Applicable"* for patients that do not meet the collection criteria or if the patient is discharged from your hospital prior to the next calendar day.
- Field cannot be left blank.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

**Other Associated Elements**

- TQIP<sup>®</sup> TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

## HIGHEST GCS MOTOR

### Definition

Highest GCS motor **on the first calendar day after** ED/hospital arrival.

### Collection Criterion

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

### Field Values

LA COUNTY		NTDS	
6	Obeys commands	6	Obeys commands / Appropriate response to stimuli
5	Localizes pain	5	Localizes pain
4	Withdraws from pain	4	Withdraws from pain
3	Flexion (decorticate) to pain	3	Flexion (decorticate movement) to pain
2	Extension (decerebrate) to pain	2	Extension (decerebrate movement) to pain
1	No motor response	1	No motor response

### Additional Information

- Requires review of all data sources to obtain the highest GCS motor. In many cases, the highest GCS motor may occur after the ED phase of care.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- Enter the null value of *"Not Applicable"* for patients that do not meet the collection criteria or if the patient is discharged from your hospital prior to the next calendar day.
- Field cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

### Other Associated Elements

- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

## QUALIFIER FOR HIGHEST GCS

### Definition

Documentation of factors potentially affecting the highest GCS total **on first calendar day after** ED/hospital arrival.

### Collection Criterion

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

### Field Values

LA COUNTY		NTDS	
<b>O</b>	Obstruction to Patient's Eye	2	Obstruction to the patient's eye
<b>S</b>	Chemically Sedated/Paralyzed	1	Chemically Sedated Paralyzed
<b>T</b>	Intubated	3	Patient Intubated
<b>TO</b>	Intubated & Obstruction	3	Patient Intubated
		2	Obstruction to the patient's eye
<b>TS</b>	Intubated & Sedated/Paralyzed	3	Patient Intubated
		1	Chemically Sedated/Paralyzed
<b>TSO</b>	Intubated, Sedated/Paralyzed, & Obstruction	3	Patient Intubated
		1	Chemically Sedated/Paralyzed
		2	Obstruction to the patient's eye
<b>SO</b>	Sedated/Paralyzed & Obstruction	1	Chemically Sedated/Paralyzed
		2	Obstruction to the patient's eye
<b>L</b>	Valid GCS: Not sedated, intubated, or obstructed	4	Valid GCS: Not sedated, intubated, or obstructed

### Additional Information

- Applies to medical treatments that may affect the first assessment of GCS. This field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.).
- Requires review of all data sources to obtain the highest GCS motor score which might occur after the ED phase of care.
- Must be the assessment qualifier for the Highest GCS Total.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of agents like Succinylcholine, Mivacurium, Rocuronium, Atracurium, Vecuronium, or Pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, Succinylcholine's effects last for only 5-10 minutes.
- Enter the null value of "Not Applicable" for patients that do not meet the collection criteria or if the patient is discharged from your hospital prior to the next calendar day.
- Field cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- Physician's Progress Notes

**Other Associated Elements**

- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

## MIDLINE SHIFT?

### Definition

Indicates whether a midline shift exists (>5mm shift past its center line) **within 24 hours** after time of injury.

### Collection Criterion

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

### Field Values

LA COUNTY		NTDS	
<b>Y</b>	Yes	1	Yes
<b>N</b>	No	2	No
<b>O</b>	Not Imaged (e.g., CT Scan, MRI	3	Not Imaged

### Additional Information

- If there is documentation of “massive” midline shift in lieu of >5mm shift measurement, enter field value “Yes”.
- Radiological and surgical documentation from transferring facilities should also be considered for this data field.
- Enter the null value “*Not Known/Not Recorded*” if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, enter the field value “Yes”, if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of day of injury, enter the field value “Not Imaged (e.g., CT Scan, MRI)”.
- Enter the null value of “*Not Applicable*” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.

### Data Source Hierarchy

- Radiology Report
- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

### Other Associated Elements

- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL



- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

## CEREBRAL MONITOR TYPE

### Definition

Indicate the type(s) of cerebral monitors that were placed, if applicable.

### Collection Criterion

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

### Field Values

LA COUNTY		NTDS
Intraparenchymal Oxygen Monitor (e.g. Licox)	3	Intraparenchymal Oxygen Monitor (e.g. Licox)
Intraparenchymal Pressure Monitor (e.g. Camino bolt, subarachnoid bolt)	2	Intraparenchymal Pressure Monitor (e.g. Camino bolt, subarachnoid bolt, Intraparenchymal catheter)
Intraventricular Drain/Catheter (e.g. Ventriculostomy, External Ventricular Drain)	1	Intraventricular Drain/Catheter (e.g. Ventriculostomy, External Ventricular Drain)
Jugular Venous Bulb	4	Jugular Venous Bulb
None	5	None

### Additional Information

- Refers to insertion of an ICP monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- Selection of the field value of 'none' for the Cerebral Monitor Type, will result in the autofill of "Not Applicable" for the Cerebral Monitor date and time.
- Enter the null value of "Not Applicable" for patients that do not meet the collection criteria.
- Field cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

### Other Associated Elements

- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL

- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

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## CEREBRAL MONITOR DATE

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### Definition

Date that the first cerebral monitor was placed, if applicable.

### Collection Criterion

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria.
- The field is auto-populated with the null value of *“Not Applicable”* if the cerebral monitor type is “none”.
- Field cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

### Other Associated Elements

- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR TIME

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## CEREBRAL MONITOR TIME

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### Definition

Time of day that the first cerebral monitor was placed, if applicable.

### Collection Criterion

**ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- Enter the null value of *“Not Applicable”* for patients that do not meet the collection criteria.
- The field is auto-populated with the null value of *“Not Applicable”* if the cerebral monitor type is “none”.
- Field cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

### Other Associated Elements

- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE

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**TQIP® VTE PROPHYLAXIS INCLUSION?**

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**Definition**

Indicates whether the patient received Venous Thromboembolism (VTE) prophylaxis at your facility.

**Collection Criterion**

**COLLECT ON ALL PATIENTS**

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- Field value cannot be *“Not Applicable”*.
- Field cannot be left blank.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress Notes
- ICU records
- Hospital Discharge Summary

**Other Associated Elements**

- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

## VTE PROPHYLAXIS TYPE

### Definition

Type of VTE prophylaxis that was first administered to the patient at your facility, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS.**

### Field Values

LA COUNTY	NTDS	
None	5	None
LMWH (Dalteparin, Enoxaparin, etc.)	6	LMWH (Dalteparin, Enoxaparin, etc.)
Direct Thrombin Inhibitor (Dabigatran, etc.)	7	Direct Thrombin Inhibitor (Dabigatran, etc.)
Oral Xa Inhibitor (Rivaroxaban, etc.)	8	Xa Inhibitor (Rivaroxaban, etc.)
Coumadin	10	Other
Other	10	Other
Unfractionated Heparin (UH) (Heparin Drip &/or SQ Heparin)	11	Unfractionated Heparin (UH)

### Additional Information

- If Aspirin is ordered for VTE prophylaxis utilize “other”.
- If patient refuses prophylaxis utilize “None”.
- Null values are not accepted for this data field.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Medication Summary
- Nursing Notes/Flow Sheet
- Pharmacy Record
- Progress Notes
- ICU records

### Other Associated Elements

- TQIP® VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

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## VTE PROPHYLAXIS DATE

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### Definition

Date VTE prophylaxis was first administered to the patient at your facility, if applicable.

### Collection Criterion

**COLLECT ON ALL PATIENTS.**

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Enter the null value of *“Not Applicable”* if VTE Prophylaxis is equal to “none”.
- Field value cannot be left blank.

### Uses

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Medication Summary
- Nursing Notes/Flow Sheet
- Pharmacy Record
- Progress Notes
- ICU records

### Other Associated Elements

- TQIP® VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS TIME



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## VTE PROPHYLAXIS TIME

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**Definition**

Time of day VTE prophylaxis was first administered to the patient at your facility, if applicable.

**Collection Criterion**

**COLLECT ON ALL PATIENTS.**

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Enter the null value of *“Not Applicable”* if VTE Prophylaxis Type is equal to “none”.
- Field value cannot be left blank.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Medication Summary
- Nursing Notes/Flow Sheet
- Pharmacy Record
- Progress Notes
- ICU records

**Other Associated Elements**

- TQIP® VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE

## WITHDRAWAL OF LIFE SUPPORTING TREATMENT?

### Definition

Indicates whether care was withdrawn based on a decision to either remove or withhold further life sustaining intervention.

### Field Values

LA COUNTY		NTDS	
Y	Yes	1	Yes
N	No	2	No

### Additional Information

- DNR is not a requirement and is not the same as withdrawal of care.
- This decision **MUST** be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.
- This decision **MUST** be documented with the date and time. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-saving intervention (e.g. intubation).
- Field value cannot be left blank.

### Uses

- System evaluation and monitoring.
- Provides documentation of care.

### Data Source Hierarchy

- Progress Notes
- ICU Records
- Withdrawal of Care Order
- Hospital Discharge Summary

### Other Associated Elements

- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

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**WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE**

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**Definition**

The date care was withdrawn, if applicable.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Enter the null value of “*Not Applicable*” if care was not withdrawn.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress Notes
- ICU Records
- Withdrawal of Care Order
- Hospital Discharge Summary

**Other Associated Elements**

- WITHDRAWAL OF LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

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**WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME**

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**Definition**

The time of day care was withdrawn, if applicable.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Enter the null value of “*Not Applicable*” if care was not withdrawn.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress Notes
- ICU records
- Withdrawal of Care Order
- Hospital Discharge Summary

**Other Associated Elements**

- WITHDRAWAL OF LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

# POSTHOSPITAL

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**HOSPITAL DISPOSITION ORDER DATE**

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**Definition**

The **date the order was written** for the patient to be transferred or discharged from the hospital, or the date the patient died.

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- Utilize the time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

**Uses**

- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

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**HOSPITAL DISPOSITION ORDER TIME**

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**Definition**

The time of day **the order was written** for the patient to be transferred or discharged from the hospital, or the time of day the patient died.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Utilize The time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

**Uses**

- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- HOSPITAL DISPOSITION ORDER DATE
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

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## DISCHARGE DATE

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### Definition

The date the patient was discharged or transferred from the hospital, or the date the patient died.

### Field Values

- Collected as MMDDYYYY

### Additional Information

- Utilize the time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

### Uses

- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY



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## DISCHARGE TIME

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### Definition

The time of day the patient was discharged or transferred from the hospital, or the time of day the patient died.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- Utilize the time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

### Uses

- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

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## PHASE PRIOR TO DISCHARGE

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### Definition

Phase of care occurring directly prior to hospital discharge of the patient.

### Field Values

- **23HR OBS:** <24 Hour Observation
- **ED:** Emergency Department
- **ICU:** Intensive/Critical Care Unit
- **INT RAD:** Interventional Radiology
- **OR:** Operating Room
- **ORR:** Operating Room Recovery
- **PICU:** Pediatric ICU
- **PEDSWARD:** Pediatric Ward
- **READMIT:** Re-Admit
- **SPECIAL:** Special Procedures
- **STEPDOWN:** Stepdown or Telemetry Unit
- **WARD:** Ward/Floor

### Additional Information

- For patients with phase of care prior to discharge is equal to 23HR OBS:
  - If the patient's LOS does not exceed 23 hours, the phase prior to discharge remains 23HR OBS.
  - If the patient's LOS exceeds 23 hours, use the actual unit the patient was discharged from.

### Uses

- Establishes care intervals and incident times.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

## TRANSFERRED/DISCHARGED TO

### Definition

The disposition of the patient when discharged from the hospital.

### Field Values

LA COUNTY		NTDS	
<b>ACUTE</b>	Acute Care Facility	1	Discharged/Transferred to another acute care hospital for inpatient care
<b>AMA</b>	AMA/Eloped/LWBS	4	Left against medical advice or discontinued care
<b>BURN</b>	Burn Center	1	Discharged/Transferred to another acute care hospital for inpatient care
<b>CLF</b>	Congregate Living Facility	14	Discharged/Transferred to another type of institution not defined elsewhere
<b>HOME WITH</b>	Home W/Home Health Services	3	Discharged/Transferred to home under care of organized home health service
<b>HOME W/O</b>	Home Without Services	6	Discharged home (routine discharge)
<b>HOSPICE</b>	Hospice	8	Discharged/Transferred to hospice care
<b>JAIL</b>	Jail	10	Discharged/Transferred to court/law enforcement
<b>LTCH</b>	Long Term Care Hospital	12	Discharged/Transferred to Long Term Care Hospital (LTCH)
<b>MORGUE</b>	Morgue	5	Deceased/Expired
<b>PSYCH</b>	Psychiatric Hospital or Department of Hospital	13	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
<b>RCF</b>	Recuperative Care Facility	14	Discharged/Transferred to another type of institution not defined elsewhere
<b>REHAB</b>	Rehabilitation Center	11	Discharged/Transferred to inpatient rehab or designated unit
<b>SCJ</b>	Jail Ward at LAC+USC	10	Discharged/Transferred to court/law enforcement
<b>SNF</b>	Skilled Nursing Facility	7	Transferred to Skilled Nursing Facility (SNF)
<b>SUBACUTE</b>	Subacute Care	2	Transferred to an Intermediate Care Facility (ICF)
<b>TRAUMA</b>	Trauma Center	1	Transferred to another acute care hospital for inpatient care
<b>OTHER</b>	Other	14	Discharged/Transferred to another type of institution not defined elsewhere

### Additional Information

- For patients pronounced brain dead and whose care is assumed by an organ procurement agency enter “Morgue”.
- Long-term care hospitals (LTCHs) focus on patients who, on average, stay more than 25 days, and no longer need the level of services that an acute care hospital provides.
- A SNF is an institution that provides skilled nursing care after a patient no longer needs the level of services that an acute care hospital provides.
- “Home” refers to the patient’s current place of residence, e.g., prison, Child Protective Services, etc.
- Patients discharged to Hospice care are considered a death by TQIP® for purposes of risk-adjusted benchmark reporting.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

## FACILITY NAME

### Definition

The three-letter code for the facility to which the patient was transferred to, if applicable.

### Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
<b>ACH</b>	Alhambra Hospital Medical Center	<b>LBC</b>	Community Hospital Long Beach
<b>AHM</b>	Catalina Island Medical Center	<b>LBM</b>	MemorialCare Long Beach Medical Center
<b>AMH</b>	Methodist Hospital of Southern California	<b>LCH</b>	Palmdale Regional Medical Center
<b>AVH</b>	Antelope Valley Hospital	<b>LCM</b>	Providence Little Co. of Mary M.C. - Torrance
<b>BEV</b>	Beverly Hospital	<b>MCP</b>	Mission Community Hospital
<b>BMC</b>	Southern California Hospital at Culver City	<b>MHG</b>	Memorial Hospital of Gardena
<b>CAL</b>	Dignity Health - California Hospital Medical Center		
<b>CHH</b>	Children's Hospital Los Angeles	<b>MLK</b>	Martin Luther King Jr. Community Hospital
<b>CHP</b>	Community Hospital of Huntington Park	<b>MPH</b>	Monterey Park Hospital
<b>CNT</b>	Centinela Hospital Medical Center	<b>NOR</b>	Los Angeles Community Hospital at Norwalk
<b>CPM</b>	Coast Plaza Hospital	<b>NRH</b>	Dignity Health - Northridge Hospital Medical Center
<b>CSM</b>	Cedars-Sinai Medical Center	<b>OVM</b>	LAC Olive View-UCLA Medical Center
<b>DCH</b>	PIH Health Hospital - Downey	<b>PAC</b>	Pacifica Hospital of the Valley
<b>DFM</b>	Cedars-Sinai Marina Del Rey Hospital	<b>PIH</b>	PIH Health Hospital - Whittier
<b>DHL</b>	Lakewood Regional Medical Center	<b>PLB</b>	College Medical Center
<b>ELA</b>	East Los Angeles Doctors Hospital	<b>PVC</b>	Pomona Valley Hospital Medical Center
<b>ENH</b>	Encino Hospital Medical Center	<b>QOA</b>	Hollywood Presbyterian Medical Center
<b>FPH</b>	Emanate Health Foothill Presbyterian Hospital	<b>QVH</b>	Emanate Health Queen of the Valley Hospital
<b>GAR</b>	Garfield Medical Center	<b>SDC</b>	San Dimas Community Hospital
<b>GEM</b>	Greater El Monte Community Hospital	<b>SFM</b>	St. Francis Medical Center
<b>GMH</b>	Dignity Health - Glendale Memorial Hospital and Health Center	<b>SGC</b>	San Gabriel Valley Medical Center
<b>GSH</b>	Good Samaritan Hospital	<b>SJH</b>	Providence Saint John's Health Center
<b>GWT</b>	Adventist Health - Glendale	<b>SJS</b>	Providence Saint Joseph Medical Center
<b>HCH</b>	Providence Holy Cross Medical Center	<b>SMH</b>	Santa Monica-UCLA Medical Center
<b>HGH</b>	LAC Harbor-UCLA Medical Center	<b>SMM</b>	Dignity Health - St. Mary Medical Center
<b>HMH</b>	Huntington Hospital	<b>SOC</b>	Sherman Oaks Hospital
<b>HMN</b>	Henry Mayo Newhall Hospital	<b>SPP</b>	Providence Little Company of Mary Medical Center - San Pedro
<b>HWH</b>	West Hills Hospital and Medical Center	<b>TOR</b>	Torrance Memorial Medical Center
<b>ICH</b>	Emanate Health Inter-Community Hospital	<b>TRM</b>	Providence Cedars-Sinai Tarzana Medical Center
<b>KFA</b>	Kaiser Foundation Hospital – Baldwin Park	<b>UCL</b>	Ronald Reagan UCLA Medical Center
<b>KFB</b>	Kaiser Foundation Hospital – Downey	<b>USC</b>	LAC+USC Medical Center
<b>KFH</b>	Kaiser Foundation Hospital – South Bay	<b>VHH</b>	USC Verdugo Hills Hospital
<b>KFL</b>	Kaiser Foundation Hospital – Sunset (Los Angeles)	<b>VPH</b>	Valley Presbyterian Hospital
<b>KFO</b>	Kaiser Foundation Hospital – Woodland Hills	<b>WHH</b>	Whittier Hospital Medical Center
<b>KFP</b>	Kaiser Foundation Hospital – Panorama City	<b>WMH</b>	Adventist Health - White Memorial
<b>KFW</b>	Kaiser Foundation Hospital – West Los Angeles		

ORANGE COUNTY 9-1-1 RECEIVING			
<b>ANH</b>	Anaheim Regional Medical Center	<b>LPI</b>	La Palma Intercommunity Hospital
<b>CHO</b>	Children's Hospital of Orange County	<b>PLH</b>	Placentia Linda Hospital
<b>FHP</b>	Fountain Valley Regional Hospital and Medical Center	<b>SJD</b>	St. Jude Medical Center
<b>KHA</b>	Kaiser Foundation Hospital – Anaheim	<b>UCI</b>	UCI Medical Center
<b>KFI</b>	Kaiser Foundation Hospital – Irvine	<b>WMC</b>	Western Medical Center Santa Ana
<b>LAG</b>	Los Alamitos Medical Center		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
<b>ARM</b>	Arrowhead Regional Medical Center	<b>KFN</b>	Kaiser Foundation Hospital - Ontario
<b>CHI</b>	Chino Valley Medical Center	<b>LLU</b>	Loma Linda University Medical Center
<b>DHM</b>	Montclair Hospital Medical Center	<b>SAC</b>	San Antonio Community Hospital
<b>KFF</b>	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
<b>LRR</b>	Los Robles Hospital & Medical Center (Ventura)	<b>SJO</b>	St. John Regional Medical Center (Ventura)
<b>SIM</b>	Adventist Health - Simi Valley Hospital (Ventura)	<b>RCC</b>	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
<b>LBV</b>	Long Beach VA	<b>WVA</b>	Wadsworth VA Medical Center

REHABILITATION CENTERS			
<b>AMR</b>	Methodist Hospital of Southern California (Rehab Center)	<b>LBR</b>	MemorialCare Long Beach Medical Center (Rehab Center)
<b>BMR</b>	Southern California Hospital at Culver City (Rehab Center)	<b>LMR</b>	La Mirada Physicians Medical Center (Rehab Center)
<b>CCC</b>	Casa Colina Centers for Rehabilitative Medicine	<b>NRR</b>	Dignity Health-Northridge Hospital Medical Center (Rehab Center)
<b>CHR</b>	Children's Hospital of Los Angeles (Rehab Center)	<b>OTR</b>	Other Rehabilitation Center
<b>CNR</b>	Centinela Hospital Medical Center (Rehab Center)	<b>PIR</b>	PIH Health – Whittier (Rehab Center)
<b>CRI</b>	California Rehabilitation Institution	<b>QOR</b>	Hollywood Presbyterian Medical Center (Rehab)
<b>DFR</b>	Cedars-Sinai Marina Del Rey Hospital (Rehab Center)	<b>QVR</b>	Emanate Health Queen of the Valley Hospital (Rehab Center)
<b>ENR</b>	Encino Hospital Medical Center (Rehab Center)	<b>RLA</b>	LAC/Rancho Los Amigos National Rehabilitation Center
<b>GMR</b>	Dignity Health-Glendale Memorial Hospital & Health Center (Rehab Center)	<b>SMR</b>	Dignity Health-St. Mary Medical Center (Rehab Center)
<b>GRR</b>	Garfield Medical Center (Rehab Center)	<b>SPR</b>	Providence Little Company of Mary Medical Center-San Pedro (Rehab Center)
<b>GSR</b>	Good Samaritan Hospital (Rehab Center)	<b>TMR</b>	Torrance Memorial Medical Center (Rehab Center)
<b>GWR</b>	Adventist Health-Glendale (Rehab Center)	<b>USR</b>	LAC+USC Medical Center (Rehab Center)
<b>HCR</b>	Providence Holy Cross Medical Center (Rehab Center)	<b>VMR</b>	Valley Hospital Medical Center (Rehab Center)
<b>HMR</b>	Huntington Hospital (Rehab Center)	<b>WHR</b>	Adventist Health-White Memorial (Rehab Center)
<b>HNR</b>	Henry Mayo Newhall Memorial Hospital (Rehab Center)		

BURN CENTERS			
<b>USB</b>	LAC/USC Medical Center (Burn Center)	<b>TOB</b>	Torrance Memorial Hospital (Burn Center)
<b>HWB</b>	West Hills Regional Medical Center (Grossman Burn Center)	<b>OTB</b>	Other Burn Center

DISASTER RECEIVING FACILITIES			
<b>BRH</b>	Barlow Respiratory Hospital	<b>NCH</b>	USC Kenneth Norris Jr. Cancer Center
<b>COA</b>	Silver Lake Medical Center	<b>PAM</b>	Pacific Alliance Medical Center
<b>COH</b>	City of Hope National Medical Center	<b>RLA</b>	LAC-Rancho Los Amigos
<b>LAC</b>	Los Angeles Community Hospital – Olympic	<b>TEM</b>	Temple Community Hospital
<b>HOL</b>	Southern California Hospital at Hollywood	<b>USH</b>	Keck Hospital of USC
<b>KMC</b>	Kern Medical Center		

SKILLED NURSING FACILITIES			
<b>ACS</b>	Alhambra Healthcare	<b>LCS</b>	Providence Little Company of Mary Transitional Care Center
<b>CAS</b>	California Post-Acute	<b>LDS</b>	Lanterman Development Center (SNF)
<b>ENS</b>	Encino Hospital Medical Center (SNF)	<b>LES</b>	Las Encinas Hospital
<b>GHS</b>	Granada Hills Convalescent Hospital	<b>MHS</b>	Skyline Healthcare Center
<b>GMS</b>	Glendale Memorial Hospital and Health Center	<b>OTS</b>	Other Skilled Nursing Facility
<b>GSS</b>	Good Samaritan Hospital (SNF)	<b>SFS</b>	St. Francis Medical Center (SNF)
<b>GWS</b>	Glendale Post-Acute Center	<b>SGS</b>	San Gabriel Convalescent Center
<b>HCS</b>	Holy Cross Medical Center (SNF)	<b>SHS</b>	Santa Monica Health Care Center
<b>HMS</b>	Huntington Post-Acute		
<b>LBS</b>	Long Beach Memorial Medical Center		

**Additional Information**

- For patients transferred to non-acute care facilities (e.g., Rehab, SNF, Subacute) use “Other” if no three-letter code exists for the facility.

**Uses**

- Provides documentation of assessment and/or care.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRASFERRED/DISCHARGED TO
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

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**TRANSFERRED OUT VIA**

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**Definition**

Method used for transferring the patient to another facility, if applicable.

**Field Values**

- **G:** Ground
- **A:** Air

**Additional Information**

- This field will automatically be filled with “*Not Applicable*” for patients Discharged To:
  - AMA/Eloped/LWBS (Left Without Being Seen)
  - Home w/Home Health Services
  - Home w/o Services
  - Morgue
  - Jail
  - USC Jail

**Uses**

- Provides documentation of assessment and/or care.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRASFERRED / DISCHARGED TO
- FACILITY NAME
- TRANSFER RATIONALE
- DISCHARGE CAPACITY



## TRANSFER RATIONALE

### Definition

The rationale for transfer of the patient, if applicable.

### Field Values

LA COUNTY		
<b>CU</b>	In Custody	Patient discharged/transferred in custody of law enforcement
<b>EX</b>	Extended Care	Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a long-term care hospital (LTCH), skilled nursing facility (SNF), convalescent home, board-and-care, etc.
<b>FI</b>	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
<b>HO</b>	Hospice	Patient transferred to hospice
<b>HP</b>	Health Plan	Health Plan decision
<b>OT</b>	Other	Transfer rationale other than above ( <b>Includes</b> Psych)
<b>RH</b>	Rehab	Patient required rehabilitation
<b>SH</b>	Specialized/ Higher Level Care	Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, and reimplantation ( <b>Excludes</b> Psych)

### Additional Information

- Enter the null value of *“Not Applicable”* if the patient was not transferred to another facility.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- DISCHARGE CAPACITY

## DISCHARGE CAPACITY

### Definition

Patient’s gross functional capacity upon discharge from the hospital.

### Field Values

LA COUNTY		
<b>H</b>	PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
<b>T</b>	TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
<b>P</b>	PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

### Additional Information

- The value of “P” for Pre-injury capacity should be utilized for all patients discharged home from the ED, eloped, or left AMA (Against Medical Advice).
- Enter the null value of “*Not Applicable*” if the patient expired.
- A splenectomy is NOT considered a permanent handicap.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE

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## LIVED/DIED

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### Definition

Indicates whether the patient died of injuries during the hospital stay.

### Field Values

- **L:** Lived
- **D:** Died

### Additional Information

- Patients discharged to hospice care are considered a death by TQIP® for purposes of risk-adjusted benchmark reporting.

### Uses

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Records
- Hospital Discharge Summary
- Progress Notes

### Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #

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**AUTOPSY UPDATE?**

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**Definition**

Indicates whether an autopsy update was provided/obtained.

**Field Values**

- Y: Yes
- N: No

**Additional Information**

- Enter "Yes" if a Coroner's Report is received.
- To ensure that the data accurately reflects the extent of the patient's injuries, enter any additional injuries identified in the autopsy report in the discharge diagnoses.

**Uses**

- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.

**Data Source Hierarchy**

- Coroner's Report

**Other Associated Elements**

- CORONER #

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**CORONER #**

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**Definition**

Coroner's ID number or code, if applicable.

**Field Values**

- Free text

**Additional Information**

- Non-picklist – free text Coroner ID number or code at discretion of facility.

**Uses**

- Identifies the coroner case number

**Data Source Hierarchy**

- Coroner's Report

**Other Associated Elements**

- AUTOPSY UPDATE?

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**ORGAN REFERRAL?**

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ACS PRQ

**Definition**

Indicates whether the patient was referred for potential solid organ donation.

**Field Values**

- Y: Yes
- N: No

**Uses**

- Allows tracking of organ referrals.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes

**Other Associated Elements**

- ORGAN DONOR?
- ORGANS DONATED

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**ORGAN DONOR?**

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ACS PRQ

**Definition**

Indicates whether the patient's solid organs were donated.

**Field Values**

- Y: Yes
- N: No

**Additional Information**

- Excludes non-solid organ donations such as bone, bone marrow, eyes, skin, etc.

**Uses**

- Allows tracking of organ donation.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- OR Records

**Other Associated Elements**

- ORGAN REFERRAL?
- ORGANS DONATED

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**ORGANS DONATED**

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ACS PRQ

**Definition**

Indicates which specific solid organs were donated.

**Field Values**

- Heart
- Intestine
- Kidney (1)
- Kidneys (2)
- Liver
- Lung (1)
- Lungs (2)
- Pancreas

**Additional Information**

- Excludes non-solid organ donations such as bone, bone marrow, eyes, skin, etc.

**Uses**

- Allows tracking of organ donation.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- OR Records

**Other Associated Elements**

- ORGAN REFERRAL?
- ORGAN DONOR?



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## DISCHARGE DIAGNOSES – ICD-10 CODES

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### Definition

All identified ICD-10 discharge diagnoses related to the patient's injuries.

### Field Values

- ICD-10 codes

### Additional Information

- Injury diagnoses as defined by ICD-10-CM codes are in the range of S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9, or compatible ICD-10-CA code range.
- ICD-10-CM codes are in the range of T20-T28 and T30-T32, or compatible ICD-10-CA code range, have been removed for NTDS's inclusion criteria.
- ICD-10 codes should be listed starting with the most significant injury.
- The primary injury resulting in the hospitalization should be listed first.
- The "significance" of other injuries should be based upon severity and location.
- Patients with ONLY ICD-10 NFS codes or unspecified codes, resulting in an AIS severity score of 9, and no ISS score, should be DHS=No patients.
- Enter the COVID-19 ICD-10 code if the patient arrives with a known positive test or a positive test is acquired while hospitalized.
- Additional injuries identified at the transferring facilities should **not be entered** into the database by the sending facility. This allows for accurate reflection of the extent of the patient's known injuries while being treated at the sending facility. If additional injuries are identified at the receiving facility they will be documented accordingly.
- Patients transferred from the ED are excluded from the TQIP® benchmark reports and thus this will have no effect on the sending facility's benchmarking reports.
- To ensure that the data accurately reflects the extent of the patient's injuries, if a Coroner's report is received enter any additional injuries identified in the autopsy report.

### Uses

- Used to calculate Abbreviated Injury Scale (AIS) and Injury Severity Score (ISS).
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- ER Records
- ICU Records
- OR Records
- Physician Notes
- Coroner's Report

### Other Associated Elements

- DISCHARGE DIAGNOSES – ABBREVIATED INJURY SCALE
- CO-MORBID CONDITIONS
- COMPLICATIONS

## DISCHARGE DIAGNOSES – ABBREVIATED INJURY SCALE

### Definition

The Abbreviated Injury Scale (AIS) is an anatomical-based coding system to classify and describe the severity of injuries. It represents the threat to life associated with the injury rather than the comprehensive assessment of the severity of the injury.

### Field Values

- Up to six-digit positive numeric value

### Additional Information

- The scale describes three aspects of the injury, type, location, and severity using 7 numbers written as 123456.7

THE NUMBERS 123456.7 INDICATE THE FOLLOWING:	EXAMPLE: 851814.3, FEMORAL SHAFT FRACTURE
<b>1 – Body Region</b> 1. Head (Cranium & Brain) 2. Face (including eyes & ears) 3. Neck 4. Thorax 5. Abdomen 6. Spine 7. Upper Extremity 8. Lower Extremity 9. External & Other	<b>8 = Body Region: Lower Extremity</b>
<b>2 – Type of Anatomic Structure</b>	<b>5 = Type of Anatomic Structure: Skeletal</b>
<b>3 &amp; 4 – Specific Anatomic Structure</b>	<b>18 = Specific Anatomic Structure: Femur</b>
<b>5 &amp; 6 – Level of Injury</b>	<b>14 = Level of Injury: Shaft</b>
<b>.7 – AIS: Severity Score</b> (Ranging from 1 {least severe} to 6 {most severe}) 1. Minor 2. Moderate 3. Serious 4. Severe 5. Critical 6. Maximal (currently untreatable) 9. Unable to assign	<b>.3 = AIS: Severity Score: Serious</b>

- To ensure that the data accurately reflects the extent of the patient’s injuries, if a Coroner’s report is received enter any additional injuries identified in the autopsy report.
- Enter AIS: Severity Score of “9” if it is not possible to assign a severity to an injury.
- In Trauma One the AIS is displayed as AIS Severity (postdot), ISS Body Part, and then AIS 6-digit code (predot).
- Field value cannot be “Not Applicable”.
- Field cannot be left blank.

### Uses

- Used to calculate Injury Severity Score.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- AIS Coding Manual (AIS 15)
- Hospital Discharge Summary
- ER Records
- ICU Records
- OR Records
- Coroner's Report

**Other Associated Elements**

- DISCHARGE DIAGNOSES – ICD-10 CODES
- CO-MORBID CONDITIONS
- COMPLICATIONS

**CO-MORBID CONDITIONS**

**Definition**

Pre-existing co-morbid factors present before patient arrival at the ED/Hospital.

**Field Values**

LA COUNTY	NTDS
No NTDS Co-Morbidities	
Co-Morbid ( <i>Pre-existing</i> ) Conditions are Not Known	
Advanced Directive (limiting care) (DNR status)	Advanced Directive (limiting care)
Alcoholism	Alcohol Use Disorder
Angina (Pectoris)	Angina Pectoris
Anticoagulant Therapy	Anticoagulant Therapy
Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)	Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)
Bleeding Disorder	Bleeding Disorder
Cerebral Vascular Accident (CVA) / Residual Neuro Deficit	Cerebral Vascular Accident (CVA)
Chemotherapy (currently receiving)	Currently receiving Chemotherapy for cancer
Chronic Obstructive Pulmonary Disease (COPD)	Chronic Obstructive Pulmonary Disease (COPD)
Cirrhosis	Cirrhosis
Congenital Anomalies	Congenital Anomalies
Congestive Heart Failure (CHF)	Congestive Heart Failure (CHF)
Current Smoker	Current Smoker
Dementia	Dementia
Diabetes Mellitus	Diabetes Mellitus
Dialysis	Chronic Renal Failure
Disseminated Cancer	Disseminated Cancer
Drug (Substance) Abuse or Dependence	Substance Abuse Disorder
Functionally Dependent Health Status	Functionally Dependent Health Status
Hypertension	Hypertension
Mental/Personality Disorder	Mental/Personality Disorder
Myocardial Infarction (MI)	Myocardial Infarction (MI)
Peripheral Arterial Disease (PAD)	Peripheral Arterial Disease (PAD)
Pregnancy	Pregnancy
Prematurity	Prematurity
Seizure Disorder	
Steroid Use	Steroid Use
Other:	

**Additional Information**

- Select the applicable field values from the Co-Morbid Conditions listed above for the patient.
- Enter the field value “No Co-Morbid Conditions” if none of the co-morbid conditions listed above are present for the patient.
- Enter the field value of “Co-Morbid Conditions are Not Known” if the Co-Morbid Conditions listed above are not known for the patient.

- Following data entry, select the “Confirm Co-Morbid Conditions” to populate the appropriate values of “Yes”, for the co-morbid conditions selected, and “No” for those not selected., or “Not Known” for patients with unknown medical history.

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress/Consultation Notes
- Nursing Notes

**Other Associated Elements**

- DISCHARGE DIAGNOSES – ICD-10 CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- COMPLICATIONS

## COMPLICATIONS

### Definition

Any medical (events) complication that occurred during the patient’s stay at your hospital.

### Field Values

LA COUNTY	NTDS
No Listed Hospital Complications Occurred	
Acute Kidney Injury (dialysis)	Acute Kidney Injury (AKI)
Acute Respiratory Distress Syndrome (ARDS)	Acute Respiratory Distress Syndrome (ARDS)
Alcohol Withdrawal	Alcohol Withdrawal Syndrome
Cardiac Arrest with CPR	Cardiac Arrest with CPR
Central Line-Associated Bloodstream Infection (CLABSI)	Central Line-Associated Bloodstream Infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	Stroke/CVA
Decubitus (Pressure) Ulcer	Pressure Ulcer
Deep Vein Thrombosis (DVT) / Thrombophlebitis	Deep Vein Thrombosis (DVT)
Delirium	Delirium
Extremity Compartment Syndrome	Extremity Compartment Syndrome
Myocardial Infarction	Myocardial Infarction (MI)
Osteomyelitis	Osteomyelitis
Pneumonia Ventilator Associated (VAP)	Ventilator-Associated Pneumonia (VAP)
Pulmonary Embolism (PE)	Pulmonary Embolism (PE)
Sepsis and/or Severe Sepsis	Severe Sepsis
Surgical (Incisional) Site Infection (superficial)	Superficial Incisional Surgical Site Infection
Surgical Site Infection (deep)	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	Organ/Space Surgical Site Infection
Unplanned Intubation	Unplanned Intubation
Unplanned Readmission	
Unplanned Return to the ICU	Unplanned Admission to the ICU
Unplanned Visit to the OR	Unplanned Visit to the OR
Urinary Tract Infection Catheter Associated (CAUTI)	Catheter-Associated Urinary Tract Infection (CAUTI)
Other:	

### Additional Information

- Select the applicable field values from the Hospital Complications listed above for the patient.
- Enter the field value “No Listed Hospital Complications Occurred” if none of the hospital complications listed above occurred during the patient’s hospital stay.
- Following data entry, select the “Confirm Hospital Complications” to populate the appropriate values of “Yes” and “No” for each of the Hospital Complications listed.

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Progress/Consultation Notes
- Hospital Nursing Notes

**Other Associated Elements**

- DISCHARGE DIAGNOSES – ICD-10 CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- NTDS CO-MORBID CONDITIONS

# UNPLANNED READMISSION



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## DATE OF READMISSION

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### Definition

The date the patient returned to an inpatient bed for an **unplanned readmission** within 30 days of discharge, elopement, AMA, etc., from a previous inpatient status related to the same event.

### Field Values

- Collected as MMDDYYYY

### Additional Information

- ED visits are NOT considered inpatient status.
- Readmission is based on the same event and must be a “DHS=Yes” patient.
- If the patient is admitted to an inpatient bed from the ED, enter the date the patient returned to the ED. If patient was directly admitted to the hospital, enter the date the patient was re-admitted to the hospital.
- The following edit check has been applied to Trauma One®:
  - ✓ Readmission date must occur within 30 days of ED/Hospital Discharge.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

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## TIME OF READMISSION

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### Definition

The time of day the patient was readmitted to an inpatient bed for an **unplanned readmission** within 30 days of discharge, elopement, AMA, etc., from a previous inpatient status related to the same event.

### Field Values

- Collected as HHMM
- Use 24-hour clock

### Additional Information

- ED visits are NOT considered inpatient status.
- Readmission is based on the same event and must be a “DHS=Yes” patient.

### Uses

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- DATE OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

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**READMISSION COMMENT**

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**Definition**

Comment(s) related to the unplanned readmission of the patient.

**Field Values**

- Free text

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- ED Records
- ICU Records
- Operative Reports
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

**Other Associated Elements**

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

## READMISSION COMPLICATIONS

### Definition

Any medical complication that occurred during the patient's unplanned readmission.

### Field Values

LA COUNTY	NTDS
No Listed Hospital Complications Occurred	
Acute Kidney Injury (dialysis)	Acute Kidney Injury (AKI)
Acute Respiratory Distress Syndrome (ARDS)	Acute Respiratory Distress Syndrome (ARDS)
Alcohol Withdrawal	Alcohol Withdrawal Syndrome
Cardiac Arrest with CPR	Cardiac Arrest with CPR
Central Line-Associated Bloodstream Infection (CLABSI)	Central Line-Associated Bloodstream Infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	Stroke/CVA
Decubitus (Pressure) Ulcer	Pressure Ulcer
Deep Vein Thrombosis (DVT) / Thrombophlebitis	Deep Vein Thrombosis (DVT)
Delirium	Delirium
Extremity Compartment Syndrome	Extremity Compartment Syndrome
Myocardial Infarction (MI)	Myocardial Infarction (MI)
Osteomyelitis	Osteomyelitis
Pneumonia Ventilator Associated (VAP)	Ventilator-Associated Pneumonia (VAP)
Pulmonary Embolism (PE)	Pulmonary Embolism
Sepsis and/or Severe Sepsis	Severe Sepsis
Surgical (Incisional) Site Infection (superficial)	Superficial Incisional Surgical Site Infection
Surgical Site Infection (deep)	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	Organ/Space Surgical Site Infection
Unplanned Intubation	Unplanned Intubation
Unplanned Readmission	
Unplanned Return to the ICU	Unplanned Admission to the ICU
Unplanned Visit to the OR	Unplanned Visit to the OR
Urinary Tract Infection Catheter Associated (CAUTI)	Catheter-Associated Urinary Tract Infection (CAUTI)
Other:	

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- Progress/Consultation Notes
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

### Other Associated Elements

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS

- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

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## READMIT DISCHARGE DATE

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**Definition**

The date the patient was discharged or transferred from the hospital following the unplanned readmission, or the date the patient died following readmission.

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

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**READMIT DISCHARGE TIME**

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**Definition**

The time of day the patient was discharged or transferred from the hospital following the unplanned readmission, or the date the patient died following readmission.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Utilize The time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

**Uses**

- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

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**READMIT PRIOR PHASE**

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**Definition**

Phase of care prior to discharge of the patient following the unplanned readmission.

**Field Values**

- **23HR OBS:** <24 Hour Observation
- **ICU:** Intensive/Critical Care Unit
- **INT RAD:** Interventional Radiology
- **OR:** Operating Room
- **PICU:** Pediatric ICU
- **PEDSWARD:** Pediatric Ward
- **SPECIAL:** Special Procedures
- **STEPDOWN:** Stepdown or Telemetry Unit
- **WARD:** Ward/Floor

**Uses**

- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY



## READMIT TRANSFERRED/DISCHARGED TO

### Definition

The disposition of the patient following the unplanned readmission.

### Field Values

LA COUNTY		NTDS	
ACUTE	Acute Care Facility	1	Discharged/Transferred to another acute care hospital for inpatient care
AMA	AMA/Eloped/LWBS	4	Left against medical advice or discontinued care
BURN	Burn Center	1	Discharged/Transferred to another acute care hospital for inpatient care
CLF	Congregate Living Facility	14	Discharged/Transferred to another type of institution not defined elsewhere
HOME WITH	Home W/Home Health Services	3	Discharged/Transferred to home under care of organized home health service
HOME W/O	Home Without Services	6	Discharged home (routine discharge)
HOSPICE	Hospice	8	Discharged/Transferred to hospice care
JAIL	Jail	10	Discharged/Transferred to court/law enforcement
LTCH	Long Term Care Hospital	12	Discharged/Transferred to Long Term Care Hospital (LTCH)
MORGUE	Morgue	5	Deceased/Expired
PSYCH	Psychiatric Hospital or Department of Hospital	13	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
RCF	Recuperative Care Facility	14	Discharged/Transferred to another type of institution not defined elsewhere
REHAB	Rehabilitation Center	11	Discharged/Transferred to inpatient rehab or designated unit
SCJ	Jail Ward at LAC+USC	10	Discharged/Transferred to court/law enforcement
SNF	Skilled Nursing Facility	7	Transferred to Skilled Nursing Facility (SNF)
SUBACUTE	Subacute Care	2	Transferred to an Intermediate Care Facility (ICF)
TRAUMA	Trauma Center	1	Transferred to another acute care hospital for inpatient care
OTHER	Other	14	Discharged/Transferred to another type of institution not defined elsewhere

### Additional Information

- Enter "Morgue" for patients who are pronounced brain dead and care is assumed by an organ procurement agency.
- Long-term care hospitals (LTCHs) are certified as acute care hospitals, but focus on patients who, on average, stay more than 25 days.
- A SNF is an institution that provides skilled nursing care after a patient no longer needs the level of services that an acute care hospital provides.

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

## READMIT TRANSFER RATIONALE

### Definition

The rationale for transfer following the unplanned readmission, if applicable.

### Field Values

LA COUNTY		
<b>CU</b>	In Custody	Patient discharged/transferred in custody of law enforcement
<b>EX</b>	Extended Care	Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a long-term care hospital (LTCH), skilled nursing facility (SNF), convalescent home, board-and-care, etc.
<b>FI</b>	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
<b>HO</b>	Hospice	Patient transferred to hospice
<b>HP</b>	Health Plan	Health Plan decision
<b>OT</b>	Other	Transfer rationale other than above ( <b>Includes</b> Psych)
<b>RH</b>	Rehabilitation	Patient required rehabilitation
<b>SH</b>	Specialized/ Higher Level Care	Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, and reimplantation ( <b>Excludes</b> Psych)

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY

**READMIT TRANSFER TO**

**Definition**

The three-letter code for the facility to which the patient was transferred following the unplanned readmission, if applicable.

LOS ANGELES COUNTY 9-1-1 RECEIVING			
<b>ACH</b>	Alhambra Hospital Medical Center	<b>LBC</b>	Community Hospital Long Beach
<b>AHM</b>	Catalina Island Medical Center	<b>LBM</b>	MemorialCare Long Beach Medical Center
<b>AMH</b>	Methodist Hospital of Southern California	<b>LCH</b>	Palmdale Regional Medical Center
<b>AVH</b>	Antelope Valley Hospital	<b>LCM</b>	Providence Little Co. of Mary M.C. - Torrance
<b>BEV</b>	Beverly Hospital	<b>MCP</b>	Mission Community Hospital
<b>BMC</b>	Southern California Hospital at Culver City	<b>MHG</b>	Memorial Hospital of Gardena
<b>CAL</b>	Dignity Health - California Hospital Medical Center		
<b>CHH</b>	Children's Hospital Los Angeles	<b>MLK</b>	Martin Luther King Jr. Community Hospital
<b>CHP</b>	Community Hospital of Huntington Park	<b>MPH</b>	Monterey Park Hospital
<b>CNT</b>	Centinela Hospital Medical Center	<b>NOR</b>	Los Angeles Community Hospital at Norwalk
<b>CPM</b>	Coast Plaza Hospital	<b>NRH</b>	Dignity Health - Northridge Hospital Medical Center
<b>CSM</b>	Cedars-Sinai Medical Center	<b>OVM</b>	LAC Olive View-UCLA Medical Center
<b>DCH</b>	PIH Health Hospital - Downey	<b>PAC</b>	Pacifica Hospital of the Valley
<b>DFM</b>	Cedars-Sinai Marina Del Rey Hospital	<b>PIH</b>	PIH Health Hospital - Whittier
<b>DHL</b>	Lakewood Regional Medical Center	<b>PLB</b>	College Medical Center
<b>ELA</b>	East Los Angeles Doctors Hospital	<b>PVC</b>	Pomona Valley Hospital Medical Center
<b>ENH</b>	Encino Hospital Medical Center	<b>QOA</b>	Hollywood Presbyterian Medical Center
<b>FPH</b>	Emanate Health Foothill Presbyterian Hospital	<b>QVH</b>	Emanate Health Queen of the Valley Hospital
<b>GAR</b>	Garfield Medical Center	<b>SDC</b>	San Dimas Community Hospital
<b>GEM</b>	Greater El Monte Community Hospital	<b>SFM</b>	St. Francis Medical Center
<b>GMH</b>	Dignity Health - Glendale Memorial Hospital and Health Center	<b>SGC</b>	San Gabriel Valley Medical Center
<b>GSH</b>	Good Samaritan Hospital	<b>SJH</b>	Providence Saint John's Health Center
<b>GWT</b>	Adventist Health - Glendale	<b>SJS</b>	Providence Saint Joseph Medical Center
<b>HCH</b>	Providence Holy Cross Medical Center	<b>SMH</b>	Santa Monica-UCLA Medical Center
<b>HGH</b>	LAC Harbor-UCLA Medical Center	<b>SMM</b>	Dignity Health - St. Mary Medical Center
<b>HMH</b>	Huntington Hospital	<b>SOC</b>	Sherman Oaks Hospital
<b>HMN</b>	Henry Mayo Newhall Hospital	<b>SPP</b>	Providence Little Co. of Mary M.C. - San Pedro
<b>HWH</b>	West Hills Hospital and Medical Center	<b>TOR</b>	Torrance Memorial Medical Center
<b>ICH</b>	Emanate Health Inter-Community Hospital	<b>TRM</b>	Providence Cedars-Sinai Tarzana Medical Center
<b>KFA</b>	Kaiser Foundation Hospital – Baldwin Park	<b>UCL</b>	Ronald Reagan UCLA Medical Center
<b>KFB</b>	Kaiser Foundation Hospital – Downey	<b>USC</b>	LAC+USC Medical Center
<b>KFH</b>	Kaiser Foundation Hospital – South Bay	<b>VHH</b>	USC Verdugo Hills Hospital
<b>KFL</b>	Kaiser Foundation Hospital – Sunset (Los Angeles)	<b>VPH</b>	Valley Presbyterian Hospital
<b>KFO</b>	Kaiser Foundation Hospital – Woodland Hills	<b>WHH</b>	Whittier Hospital Medical Center
<b>KFP</b>	Kaiser Foundation Hospital – Panorama City	<b>WMH</b>	Adventist Health - White Memorial
<b>KFW</b>	Kaiser Foundation Hospital – West Los Angeles		

<b>ORANGE COUNTY 9-1-1 RECEIVING</b>			
<b>ANH</b>	Anaheim Regional Medical Center	<b>LPI</b>	La Palma Intercommunity Hospital
<b>CHO</b>	Children's Hospital of Orange County	<b>PLH</b>	Placentia Linda Hospital
<b>FHP</b>	Fountain Valley Regional Hospital and Medical Center	<b>SJD</b>	St. Jude Medical Center
<b>KHA</b>	Kaiser Foundation Hospital – Anaheim	<b>UCI</b>	UCI Medical Center
<b>KFI</b>	Kaiser Foundation Hospital – Irvine	<b>WMC</b>	Western Medical Center Santa Ana
<b>LAG</b>	Los Alamitos Medical Center		
<b>SAN BERNARDINO COUNTY 9-1-1 RECEIVING</b>			
<b>ARM</b>	Arrowhead Regional Medical Center	<b>KFN</b>	Kaiser Foundation Hospital - Ontario
<b>CHI</b>	Chino Valley Medical Center	<b>LLU</b>	Loma Linda University Medical Center
<b>DHM</b>	Montclair Hospital Medical Center	<b>SAC</b>	San Antonio Community Hospital
<b>KFF</b>	Kaiser Foundation Hospital - Fontana		
<b>OTHER COUNTY 9-1-1 RECEIVING</b>			
<b>LRR</b>	Los Robles Hospital & Medical Center (Ventura)	<b>SJO</b>	St. John Regional Medical Center (Ventura)
<b>SIM</b>	Adventist Health - Simi Valley Hospital (Ventura)	<b>RCC</b>	Ridgecrest Regional Hospital (Kern)
<b>NON-BASIC HOSPITALS</b>			
<b>LBV</b>	Long Beach VA	<b>WVA</b>	Wadsworth VA Medical Center

**Uses**

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
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- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT DISCHARGE CAPACITY

## READMIT DISCHARGE CAPACITY

### Definition

Patient’s gross functional capacity upon discharge following the unplanned readmission.

### Field Values

LA COUNTY		
<b>H</b>	PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
<b>T</b>	TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
<b>P</b>	PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

### Additional Information

- Enter the null value of “*Not Applicable*” if the patient expired.
- A splenectomy in NOT considered a permanent handicap.

### Uses

- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements

- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO

# FINANCIAL

**PAYOR**

**Definition**

Indicate the primary source of payment for patient’s hospital care.

**Field Values**

LA COUNTY	NTDS	
<b>Private/Commercial:</b>		
HMO	4	Private/Commercial Insurance
Medi-Cal HMO	4	Private/Commercial Insurance
Auto Insurance	4	Private/Commercial Insurance
Worker’s Comp.	4	Private/Commercial Insurance
Organ Donor Subsidy	7	Other Government
Other Private	4	Private/Commercial Insurance
<b>Medicaid:</b>		
Medi-Cal	1	Medicaid
Medi-Cal pending	1	Medicaid
Medicare Part A & B (including Medicare HMO)	6	Medicare
Medicare Part A only	6	Medicare
Medicare Part B only	6	Medicare
<b>Self:</b>		
Cash	3	Self Pay
ATP Liability	3	Self Pay
Pre-pay	3	Self Pay
<b>Not billed:</b>		
Charity	2	Not Billed (for any reason)
ATP without Ability to Pay	2	Not Billed (for any reason)
<b>Government:</b>		
CCS (California Children’s Services)	7	Other Government
County Indigent	7	Other Government
Custody Funds	7	Other Government
Military insurance	7	Other Government
VOC (Victims of Crime)	7	Other Government
Other Government	7	Other Government
<b>Other</b>	10	Other

**Additional Information**

- Field value cannot be “Not Applicable”.

**Uses**

- System evaluation and monitoring.

**Data Source Hierarchy**

- Facesheet
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- TOTAL HOSPITAL CHARGES



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**TOTAL HOSPITAL CHARGES**

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**Definition**

The total amount of all charges for the patient's hospital care.

**Field Values**

- Up to twelve-digit positive numeric value

**Additional Information**

- Field value cannot be *"Not Applicable"*.

**Uses**

- System evaluation and monitoring.

**Data Source Hierarchy**

- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

- PAYOR

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## RECORD COMPLETE?

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### Definition

Indicates whether the patient's record is complete.

### Field Values

- Y: Yes
- N: No

### Additional Information

- Field value defaults to "No", upon completion of the record, user needs to change the 'No' value to "Yes".
- Null Values are not accepted for this data field.
- Only records that indicate "yes", are exported to NTDB® and TQIP®.
- The following edit checks has been applied to the Trauma One®:
  - ✓ Record cannot be marked complete if DHS patient?, Sequence Number, or LA Trauma Database Inclusion Criteria data fields are incomplete.

### Uses

- Identifies if the record is complete for export to NTDB® and TQIP®.
- System evaluation and monitoring.

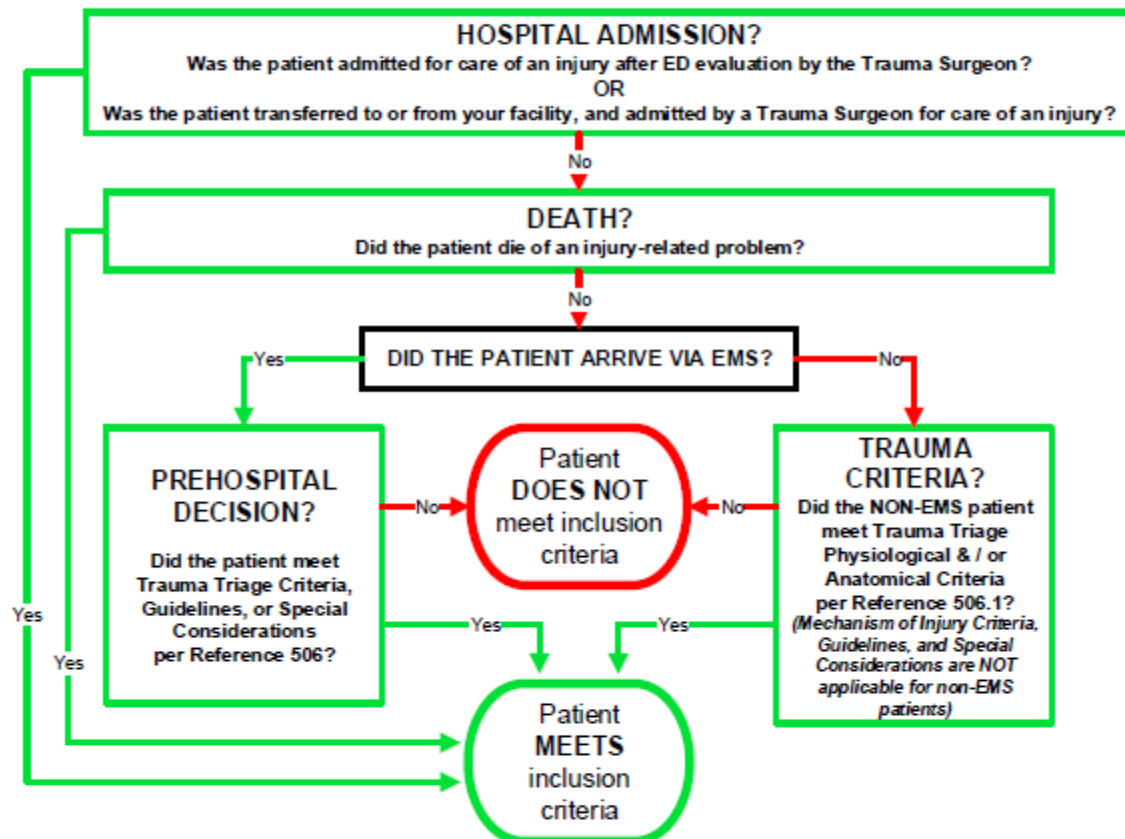
# **APPENDIX 1: Reference Documents**

**LOS ANGELES COUNTY TRAUMA DATABASE INCLUSION CRITERIA**

**TRAUMA CENTER SERVICE AGREEMENT  
PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM**

**EXCLUSIONS:**  
 Patients with the following injuries are to be EXCLUDED from the registry, unless an additional injury that meets criteria/guidelines exists:  
**GROUND LEVEL FALLS:**  
 resulting in isolated closed hip fractures in patients > 50 years of age; or  
 ALL injuries of or distal to the knee or elbow in patients of any age  
 OR  
 drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries (S00, S10, S20, S30, S40, S50, S60, S70, S80, & S90); insect bites; isolated injuries to fingers and/or toes; and injury codes that do not generate an ISS.

**INCLUSIONS:**  
 Does the patient have at least one ICD-10 injury diagnostic code within the range of S00 - S99; T20-T28; T30-T32; & T79.A1 - T79.A9?



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET THE INCLUSION CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

January 1, 2021 (Implemented)  
 Valid until amended by the EMS Agency  
 (Replaces Exhibit C dated January 1, 2020)

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**NATIONAL TRAUMA DATA STANDARD (NTDS®) INCLUSION CRITERIA 2022**

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**NATIONAL TRAUMA DATA STANDARD (NTDS) PATIENT INCLUSION CRITERIA**

**DESCRIPTION:** 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)
- 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, and T79.A1-T79.A9):**

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

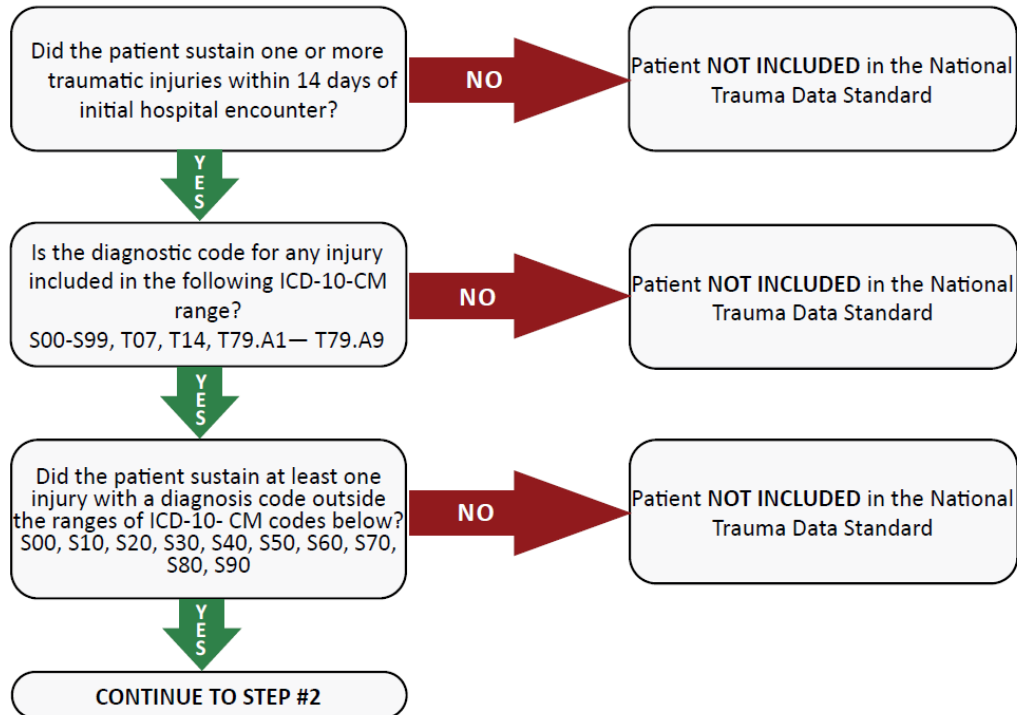
\*In-house traumatic injuries sustained after initial ED/Hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.

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

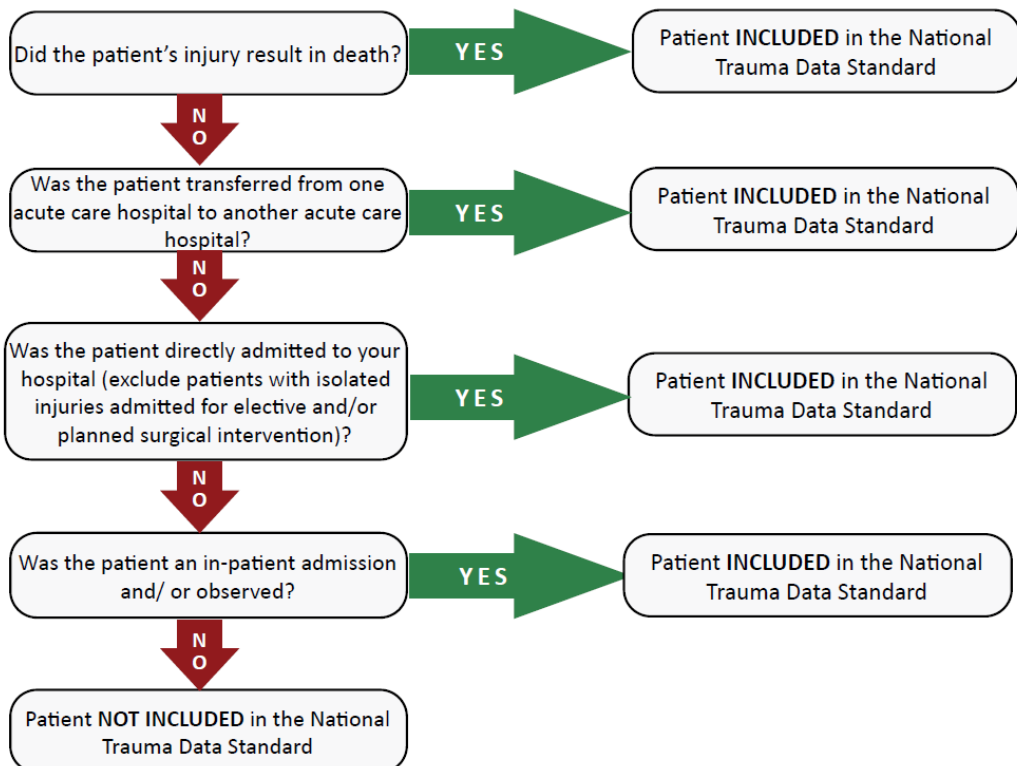
**NTDS® INCLUSION CRITERIA ALGORITHM 2022**

**NTDS PATIENT INCLUSION CRITERIA (ALGORITHM)**

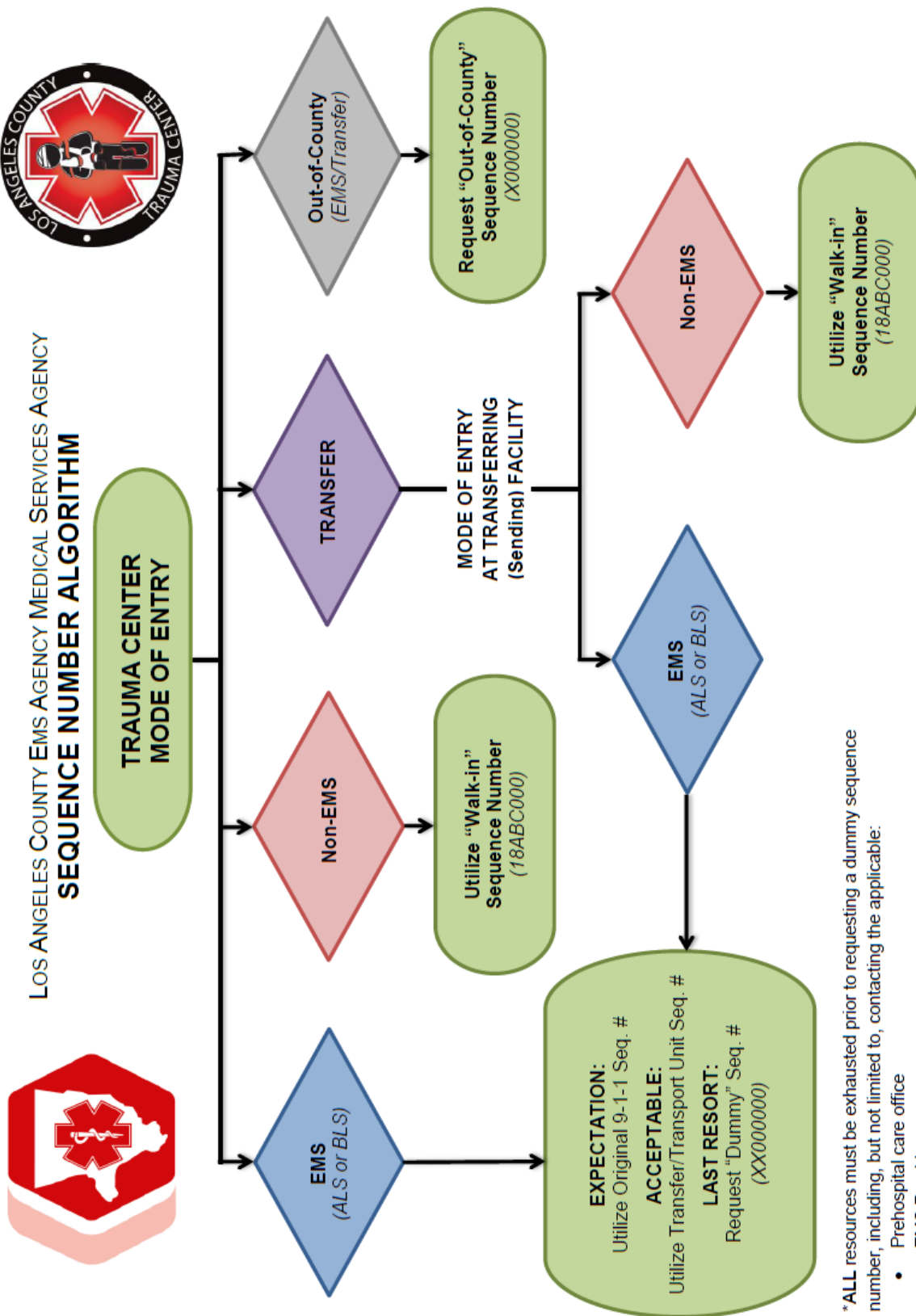
**STEP #1:**



**STEP #2:**



SEQUENCE NUMBER ALGORITHM



09/07/2017

\*ALL resources must be exhausted prior to requesting a dummy sequence number, including, but not limited to, contacting the applicable:

- Prehospital care office
- EMS Provider
- Transferring Facility
- Transporting Unit

*If more than one sequence number exists, utilize the first sequence number unless Base Contact was made with an alternate number.*

**MECHANISM OF INJURY REFERENCE GUIDE**



**Transportation  
Mechanisms of Injuries  
Quick Reference Guide**



If patient is:	AND:	Then applicable MOI choices are:
<b>STRUCK BY a moving transport, and NOT in an enclosed vehicle</b>	Force is greater than 20mph, OR Patient is thrown, or run over by motorized transport	RT (and MM if applicable)
	Force is equal to or less than 20mph	PB SP CR* FA* OT (and MM if applicable)
<b>OPERATING any transport</b>	Transport is unenclosed, and force is GREATER than 20mph	20 (and MM if applicable)
	Transport is unenclosed, and force is EQUAL to or LESS than 20mph	SP MM CR* FA* OT
	Transport is enclosed, regardless of speed	EV EJ EX SP OT

(\*) - Rarely applicable in transport accidents.

ICD-9 defines a transport accident (E800-E848) as any accident involving a device/vehicle designed and used primarily for conveying persons or goods from one place to another. For the purposes of this policy, refer to the following examples.

<b>MOTORIZED</b> transports include, but are not limited to:	<b>UNENCLOSED</b> transports include, but are not limited to:
<ul style="list-style-type: none"> <li>• Cars/Trucks</li> <li>• Vans</li> <li>• Buses</li> <li>• Planes</li> <li>• Trains</li> <li>• Motorcycles</li> <li>• Motorized bicycles (mopeds)</li> <li>• Motorized scooters</li> <li>• Golf carts</li> </ul>	<ul style="list-style-type: none"> <li>• Bicycles</li> <li>• Roller skates/blades</li> <li>• Skateboards</li> <li>• Non-motorized scooters</li> <li>• Non-motorized wheelchairs</li> <li>• Horses</li> <li>• Watercraft</li> <li>• ATVs</li> </ul>





## **APPENDIX 2: Glossary of Terms**

## CO-MORBID (*PRE-EXISTING*) CONDITIONS

**Advanced Directive (limiting care):** The patient had a written request, signed/dated by the patients and/or his/her designee, to limit life-sustaining treatment that restricted the care for the patient during this patient care event prior to arrival at your center.

Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g., decompressive craniectomy, operation for hemorrhage control, angiography).

**Alcohol Use Disorder (Alcoholism):** Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient’s medical record, consistent with American Psychiatric Association (APA) DSM 5, 2013.

**Angina (Pectoris):** Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of angina including microvascular angina, Prinzmetal’s angina, stable angina, unstable angina, and variant angina, consistent with American Heart Association (AHA), May 2015, must be documented in the patient’s medical record.

**Anticoagulant Therapy:** Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Anticoagulant must be part of the patient’s active medication. Exclude patients who are on chronic Aspirin therapy. Some examples are:

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

**Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD):** History of a disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment. A diagnosis of ADD/ADHD must be documented in the patient’s medical record.

**Bleeding Disorder:** A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient’s medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden, Thrombocytopenia), consistent with American Society of Hematology, 2015. Sickle cell anemia is not a clotting disorder; therefore, it is not considered a bleeding disorder.

**Cerebral Vascular Accident (CVA):** A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor, sensory, or cognitive dysfunction (e.g.,

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hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory). A diagnosis of CVA must be documented in the patient's medical record.

**Chemotherapy (currently receiving for cancer):** A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

**Chronic Obstructive Pulmonary Disease (COPD):** Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis. COPD must be documented in the patient's medical record, consistent with World Health Organization (WHO), 2019. Do not include patients whose only pulmonary disease is acute asthma, and patients with diffuse interstitial fibrosis or sarcoidosis.

**Cirrhosis:** Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

**Congenital Anomalies:** Documentation of a cardiac, pulmonary, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record. [Only report on patients ≤ 18 years-of -age.](#)

**Congestive Heart Failure (CHF):** Inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset or increasing symptoms within 30 days prior to injury. Common manifestations are:

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea on lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

**Current Smoker:** A patient who reports smoking cigarettes every day or some days within the last 12 months. Exclude patients who smoke cigars or pipes or use smokeless tobacco (E-cigarettes, vape pens, chewing tobacco or snuff).

**Dementia:** Brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected. Pay particular attention to senile or vascular dementia (e.g., Alzheimer's). A diagnosis of Dementia must be documented in the patient's medical record.

**Diabetes Mellitus:** Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent. Do not include a patient if diabetes is controlled by diet alone. A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.

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**Dialysis (Chronic Renal Failure):** Renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration. A diagnosis of Chronic Renal Failure must be documented in the patient's medical record.

**Disseminated Cancer:** Patients who have cancer that:

- Has spread to one site or more sites in addition to the primary site

**AND**

- In the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Another term describing disseminated cancer is metastatic.

**Drug (Substance) Use Disorder:** Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient's medical record:

- Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
- Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder; Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder
- Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
- Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
- Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder

**Functionally Dependent Health Status:** Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. The patient is considered to have a Functionally Dependent Health Status if prior to injury they were partially dependent or completely dependent upon equipment, devices, or another person to complete some or all activities of daily living.

**Hypertension:** History of persistent elevated blood pressure requiring antihypertensive medication, present prior to injury, even if non-compliant with their prescribed antihypertensive medication. A diagnosis of Hypertension must be documented in the patient's medical record.

**Mental/Personality Disorder:** History of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record: major depressive disorder, bipolar disorder, schizophrenia, antisocial personality disorder, post-traumatic stress disorder, and social anxiety disorder.

**Myocardial Infarction (MI):** History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

**Peripheral Arterial Disease (PAD):** The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD is a type of PVD (Peripheral Vascular Disease) and can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PVD or PAD must be documented in the patient's medical record, consistent with Centers for Disease Control, 2014 Fact Sheet.

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**Pregnancy:** Pregnancy confirmed by lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient's medical record.

**Prematurity:** Defined as documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period, and must be documented in the patient's medical record. Only report on patients  $\leq$  18 years of age.

**Seizure Disorder (history of):** History of a seizure disorder prior to injury that required medication to control.

**Steroid Use:** Regular administration of oral or parenteral corticosteroid medications (e.g., Prednisone, Decadron) in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

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## HOSPITAL (EVENTS) COMPLICATIONS

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**Acute Kidney Injury (dialysis):** Abrupt (within 48 hours) reduction of kidney function as defined as:

- Increase in serum creatinine of more than or equal to 3x baseline
- OR
- Increase in serum creatinine to  $\geq 4\text{mg/dl}$  ( $\geq 353.6\mu\text{mol/l}$ )
- OR
- Patients  $< 18$  years with a decrease in  $eGFR$  to  $< 35$  ml/min per  $1.73\text{m}^2$
- OR
- Reduction in urine output of  $< 0.3$  ml/kg/hr for  $\geq 24$  hours
- OR
- Anuria for  $\geq 12$  hours
- OR
- Requiring renal replacement therapy (e.g., continuous renal replacement therapy (CRRT) or periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration).

A diagnosis of AKI must be documented in the patient's medical record, that is consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline and onset of symptoms began after arrival to your ED/hospital.

**NOTE:** Even if the patient or family refuses treatment (e.g., dialysis) the condition is still considered to be present if a combination of oliguria and creatinine are present.

EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration prior to injury.

### **Acute Respiratory Distress Syndrome (ARDS):**

- |                  |   |
|------------------|---|
| Timing:          | Within 1 week of known clinical insult or new or worsening respiratory symptoms.  |
| Chest imaging:   | Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules.  |
| Origin of edema: | Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factors present.   |
| Oxygenation:     | Mild $200\text{mmHg} < \text{PaO}_2/\text{FIO}_2 < 300\text{mmHg}$ <b>WITH</b> PEEP or CRAP $\geq 5\text{cm H}_2\text{O}$<br>Moderate $100\text{mmHg} < \text{PaO}_2/\text{FIO}_2 < 200\text{mmHg}$ <b>WITH</b> PEEP $> 5\text{cm H}_2\text{O}$<br>Severe $\text{PaO}_2/\text{FIO}_2 < 100\text{mmHg}$ <b>WITH</b> PEEP or CRAP $\geq 5\text{cm H}_2\text{O}$ |

A diagnosis of ARDS must be documented in the patient's medical record, that is consistent with the 2012 New Berlin Definition and onset of symptoms began after arrival to your ED/hospital.

**Alcohol Withdrawal (Syndrome):** Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Onset of symptoms began after arrival to your ED/hospital, and documentation of alcohol withdrawal must be in the patient's medical record, that is consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

**Cardiac Arrest with CPR:** The sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

INCLUDE patients who, after arrival at your ED/hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was in the prehospital setting prior to arrival to your hospital.

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

**AND**

A CL or UC was in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the LCBI criteria must be fully met on the day of discontinuation or the next day. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), and that is the patient's only central line, day of first access as an inpatient is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance. A diagnosis of CLABSI must be documented in the patient's medical record, that is consistent with the January 2016 CDC defined CLABSI and onset of symptoms began after arrival to your ED/hospital.

Criterion 1:

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

**AND**

Organism cultured from blood is not related to an infection at another site

**OR**

Criterion 2:

Patient has at least one of the following signs or symptoms:

- o fever (>38°C)
- o chills
- o hypotension

**AND**

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

**AND**

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

Criterion 3:

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



- fever (>38°C)
- hypothermia
- apnea
- bradycardia

**AND**

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

**AND**

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

**Cerebral Vascular Accident (CVA)/Stroke:** A focal or global neurological deficit of rapid onset and onset of symptoms began after arrival to your ED/hospital. The patient must have at least one of the following symptoms:

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

**AND**

Duration of neurological deficit ≥24 h

**OR**

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

**AND**

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

**AND**

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

Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

**Decubitus (Pressure) Ulcer:** A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient's medical record, consistent with the NPUAP 2014, and onset of symptoms began after arrival to your ED/hospital.

**Deep Vein Thrombosis (DVT)/Thrombophlebitis:** The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. A diagnosis of

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DVT must be documented in the patient's medical record, which may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava. Onset of symptoms began after arrival to your ED/hospital.

**Delirium:** Acute onset of behaviors with an onset after arrival to your ED/hospital characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

**OR**

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).

**OR**

A diagnosis of delirium documented in the patient's medical record.

EXCLUDE patients whose delirium is due to alcohol withdrawal.

**Extremity Compartment Syndrome:** Condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability. A diagnosis of Extremity Compartment Syndrome must be documented in the patient's medical record.

**Myocardial Infarction (MI):** An acute myocardial infarction must be noted with documentation of ECG changes indicative of acute MI with onset of symptoms beginning after arrival to your ED/hospital

**AND**

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

**AND**

Physician diagnosis of myocardial infarction that occurred subsequent to arrival at your facility.

**Osteomyelitis:** Existence of at least one of the following criteria:

- Organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- Evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologic examination.
- At least two of the following signs or symptoms with no other recognized cause:
  - fever (38°C), localized swelling, pain or tenderness, heat, or drainage at suspected site of bone infection

**AND** at least one of the following:

- Organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).
- imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by

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clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis)

A diagnosis of osteomyelitis must be documented in the patient's medical record, that is consistent with the January 2020 CDC definition of Bone and Joint Infection and onset of symptoms began after arrival to your ED/hospital.

**Pulmonary Embolism (PE):** Lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record. Exclude subsegmental PEs. Onset of symptoms began after arrival to your ED/hospital.

**Sepsis/Severe Sepsis:** Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs. Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation. A diagnosis of Sepsis must be documented in the patient's medical record, consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010, and onset of symptoms began after arrival to your ED/hospital.

**Surgical Site Infection (SSI) (superficial):** A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, onset of symptoms began after arrival to your ED/hospital, and meet the following criteria: Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

**AND**

involves only skin and subcutaneous tissue of the incision

**AND**

patient has at least **one** of the following:

- purulent drainage from the superficial incision.
- organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
- superficial incision that is deliberately opened by a surgeon, attending physician\*\* or other designee and culture or non-culture based testing is not performed.

**AND**

- patient has at least **one** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.
- diagnosis of a superficial incisional SSI by the surgeon or attending physician\*\* or other designee.

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

1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C- section incision or chest incision for CBGB)
2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

**Surgical Site Infection (deep):** Must meet the following criteria:

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

**AND**

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

**AND**

patient has at least **one** of the following:

- purulent drainage from the deep incision
- a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician\*\* or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed

**AND**

patient has at least **one** of the following signs or symptoms:

- fever (>38°C); localized pain or tenderness
- a culture or non-culture based test that has a negative finding does not meet this criterion
- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

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

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

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		

FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CSC defined SSI, and onset of symptoms began after arrival to your ED/hospital.

**Surgical Site Infection (organ/space):** Must meet the following criteria:

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

**AND**

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

**AND**

patient has at least **one** of the following:

- purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
- an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

**AND**

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

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair		
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NEC	Neck surgery
AVSD	Shunt for dialysis	NEP	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVR	Ovarian surgery
CEA	Carotid endarterectomy	PRS	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPL	Spleen surgery
GAST	Gastric surgery	THO	Thoracic surgery
HTP	Heart transplant	THU	Thyroid and/or parathyroid
HYST	Abdominal hysterectomy	VHY	Vaginal hysterectomy
KTP	Kidney transplant	XLA	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		

CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

**Table 3. Specific Sites of an Organ/Space SSI.**

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

A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, and onset of symptoms began after arrival to your ED/ hospital.

**Unplanned Intubation:** Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

**Unplanned Readmission:** Unplanned **readmission** to an inpatient bed following discharge, elopement, AMA, etc., from a previous inpatient status.

**Unplanned Return (admission) to the ICU:** Unplanned return to the intensive care unit after initial ICU discharge or admission to the ICU after initial transfer to the floor.

EXCLUDE patients with a planned ICU stay post-operative.

INCLUDE patients who required ICU care due to an event that occurred during surgery or in the PACU.

**Unplanned Visit to the OR:** Unplanned operative procedure or patients returned to the operating room after initial operation management for a similar or related previous procedure.

EXCLUDE **non-urgent tracheostomy and percutaneous endoscopic gastrostomy**; pre-planned, staged and/or procedures for incidental findings; and operative management related to a procedure that was initially performed prior to arrival at your center.

**Urinary Tract Infection Catheter-Associated (CAUTI):** A urinary tract infection (UTI) where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

**AND**

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated. A diagnosis of UTI must be documented in the patient’s medical record that is consistent with the January 2019 CDC defined CAUTI and onset of symptoms began after arrival to your ED/hospital.

*Criterion 1:*

- *Criterion 1:* Patient must meet 1, 2, **and** 3 below:
  1. Patient has an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of event **AND** was either:
    - Present for any portion of the calendar day of the event, **OR**
    - Removed the day before the date of event
  2. Patient has at least **one** of the following signs or symptoms:
    - Fever (>38<sup>0</sup>C): Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place **OR** was removed the day before the DOE
    - Suprapubic tenderness
    - Costovertebral angle pain or tenderness
    - Urinary urgency
    - Urinary frequency
    - dysuria
  3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium >10<sup>5</sup> CFU/ml.

*Criterion 2:* Patient must meet 1, 2 **and** 3 below:

1. Patient is ≤1 year of age
2. Patient has at least **one** of the following signs or symptoms:
  - fever (>38.0<sup>0</sup>C)
  - hypothermia (<36.0<sup>0</sup>C)
  - apnea
  - bradycardia
  - lethargy
  - vomiting
  - suprapubic tenderness
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacterium of ≥10<sup>5</sup> CFU/ml.

Consistent with the January 2019 CDC defined CAUTI.

**Pneumonia Ventilator-Associated (VAP):** A pneumonia where the patient is on mechanical ventilation for >2 calendar days on the date of event, with day of ventilator placement being Day 1

**AND**

The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.

**VAP ALGORITHM (PNU2 BACTERIAL OR FILAMENTOUS FUNGAL PATHOGENS):**

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with	At least <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Fever (&gt;38<sup>0</sup>C or &gt;100.4<sup>0</sup>F)</li> </ul>	At least <b>one</b> of the following:

- at least **one** of the following:
- New or progressive **and** persistent infiltrate
  - Consolidation
  - Cavitation
  - Pneumatoceles, in infants  $\leq 1$  year old

**NOTE:** In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.

- Leukopenia ( $<4000$  WBC/mm<sup>3</sup>) or leukocytosis ( $\geq 12,000$  WBC/mm<sup>3</sup>)
  - For adults  $\geq 70$  years old, altered mental status with no other recognized cause
- AND** at least two of the following:
- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
  - New onset or worsening cough, or dyspnea, or tachypnea
  - Rales or bronchial breath sounds
  - Worsening gas exchange (e.g.,  $O_2$  desaturations (e.g.,  $PaO_2/FiO_2 \leq 240$ ), increased oxygen requirements, or increased ventilator demand)

- Positive growth in blood culture not related to another source of infection
- Positive growth in culture of pleural fluid
- Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)
- $\geq 5\%$  BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)
- Positive quantitative culture of lung tissue
- Histopathologic exam shows at least **one** of the following evidences of pneumonia:
  - Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli
  - Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

**VAP ALGORITHM (PNU2 VIRAL, LEGIONNELLA, AND OTHER BACTERIAL PNEUMONIAS):**

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with at least <b>one</b> of the following: <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul> <p><b>NOTE:</b> In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b></p>	At least <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}C</math> or <math>&gt;100.4^{\circ}F</math>)</li> <li>• Leukopenia (<math>&lt;4000</math> WBC/mm<sup>3</sup>) or leukocytosis (<math>\geq 12,000</math> WBC/mm<sup>3</sup>)</li> <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> </ul> <p><b>AND</b> at least two of the following:</p> <ul style="list-style-type: none"> <li>○ New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>○ New onset or worsening cough, or dyspnea, or tachypnea</li> <li>○ Rales or bronchial breath sounds</li> <li>○ Worsening gas exchange (e.g., <math>O_2</math> desaturations (e.g., <math>PaO_2/FiO_2 \leq 240</math>),</li> </ul>	At least <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Positive culture of virus, Legionella or Chlamydia from respiratory secretions</li> <li>• Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus, Bordetella, Chlamydia, Mycoplasma, Legionella (e.g., EIA &lt; FAMA &lt; shell vial assay, PCR, micro-IF)</li> <li>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</li> <li>• Fourfold rise in L. pneumophila serogroup 1 antibody titer to <math>\geq 1:128</math> in paired acute and</li> </ul>



Radiology	Signs/Symptoms	Laboratory
chest radiograph is acceptable.	increased oxygen requirements, or increased ventilator demand)	convalescent sera by indirect IFA <ul style="list-style-type: none"> <li>Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA</li> </ul>

**VAP ALGORITHM (PNU3 IMMUNOCOMPROMISED PATIENTS):**

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with at least <b>one</b> of the following: <ul style="list-style-type: none"> <li>New or progressive <b>and</b> persistent infiltrate</li> <li>Consolidation</li> <li>Cavitation</li> <li>Pneumatocoles, in infants ≤1 year old</li> </ul> <p><b>NOTE:</b> In patients <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest radiograph is acceptable.</p>	Patient who is immunocompromised has at least <b>one</b> of the following: <ul style="list-style-type: none"> <li>Fever (&gt;38<sup>0</sup>C or &gt;100.4<sup>0</sup>F)</li> <li>For adults ≥70 years old, altered mental status with no other recognized cause</li> <li>New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>New onset or worsening cough, or dyspnea, or tachypnea</li> <li>Rales or bronchial breath sounds</li> <li>Worsening gas exchange (e.g., O<sub>2</sub> desaturations (e.g., PaO<sub>2</sub>/FiO<sub>2</sub> ≤240), increased oxygen requirements, or increased ventilator demand)</li> <li>Hemoptysis</li> <li>Pleuritic chest pain</li> </ul>	At least <b>one</b> of the following: <ul style="list-style-type: none"> <li>Identification of matching Candida spp. From blood and sputum, endotracheal aspirate, BAL, or protected specimen brushing 11, 12, 13</li> <li>Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: <ul style="list-style-type: none"> <li>Direct microscopic exam</li> <li>Positive culture of fungi</li> <li>Non-culture diagnostic laboratory test</li> </ul> </li> </ul> <p>Any of the following:  <b>LABORATORY CRITERIA DEFINED UNDER PNU2</b></p>

**VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR INFANT'S ≤1 YEAR OLD:**

Radiology	Signs/Symptoms
Two or more serial chest radiographs with at least <b>one</b> of the following: <ul style="list-style-type: none"> <li>New or progressive <b>and</b> persistent infiltrate</li> <li>Consolidation</li> <li>Cavitation</li> <li>Pneumatocoles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic</p>	Worsening gas exchange (e.g., O <sub>2</sub> desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) <b>AND</b> at least <b>three</b> of the following: <ul style="list-style-type: none"> <li>Temperature instability</li> <li>Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) <b>or</b> leukocytosis (≥15,000WBC/mm<sup>3</sup>) and left shift (≥10% band forms)</li> <li>New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting</li> <li>Wheezing, rales, or rhonchi</li> </ul>

obstructive pulmonary disease), **one definitive** chest radiograph is acceptable

- Cough
- Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

**VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR CHILDREN >1 YEAR OLD OR ≤12 YEARS OLD:**

Radiology	Signs/Symptoms/Laboratory
<p>Two or more serial chest radiographs with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest radiograph is acceptable</p>	<p>At least <b>three</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38.0<sup>0</sup>C or &gt;100.4<sup>0</sup>F) or hypothermia (&lt;36.0<sup>0</sup>C or &lt;96.8<sup>0</sup>F)</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) <b>or</b> leukocytosis (≥15,000WBC/mm<sup>3</sup>)</li> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, apnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations [e.g., pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand</li> </ul>

A diagnosis of pneumonia must be documented in the patient’s medical record that is consistent with the January 2019 CDC defined VAP and onset of symptoms began after arrival to your ED/hospital.

## INJURY DESCRIPTIONS (*Prehospital*)

INJURY DESCRIPTION	
<b>14</b>	GCS $\leq 14$ : Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits.
<b>90</b>	SBP $< 90$ ( $< 70$ if under 1y): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event.
<b>BA</b>	<b>Blunt Abdomen</b> : Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt force.
<b>BB</b>	<b>Blunt Back</b> : Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt force.
<b>BC</b>	<b>Blunt Chest</b> : Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt force.
<b>BD</b>	<b>Blunt Diffuse Abdominal Tenderness</b> : Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.
<b>BE</b>	<b>Blunt Extremities</b> : Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt force.
<b>BF</b>	<b>Blunt Face/mouth</b> : Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt force.
<b>BG</b>	<b>Blunt Genitals</b> : Injury to the external reproductive structures due to blunt force.
<b>BH</b>	<b>Blunt Head</b> : Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt force. This code can also be applied in association with facial injuries when it is likely that the brain is involved.
<b>BI</b>	<b>Blunt Amputation</b> : Amputation proximal to (above) the wrist or ankle due to blunt force.
<b>BK</b>	<b>Blunt Buttocks</b> : Injury to the buttocks due to blunt force.
<b>BL</b>	<b>Blunt Minor Lacerations</b> : Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt force.
<b>BN</b>	<b>Blunt Neck</b> : Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt force.
<b>BP</b>	<b>Blunt Tension Pneumothorax</b> : Injury resulting in air entering the pleural space due to blunt force, creating pressure on chest organs.
<b>BR</b>	<b>Blunt Fracture of 2 or more long bones</b> : Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).
<b>BT</b>	<b>Blunt Trauma Arrest</b> : Cessation of cardiac output and effective circulation due to blunt force.
<b>BU</b>	<b>Burns/Elec. Shock</b> : Thermal or chemical burn, or electric shock.
<b>BV</b>	<b>Blunt extremity injury with neurological and/or Vascular compromise</b> , or one that is crushed, degloved, or mangled due to blunt force.
<b>CB</b>	<b>Critical Burn</b> : Patients $\geq 15$ years w/ 2 <sup>nd</sup> and 3 <sup>rd</sup> degree burns involving $\geq 20\%$ Total Body Surface Area (TBSA) or Patients $\leq 14$ years of age with 2 <sup>nd</sup> and 3 <sup>rd</sup> degree burns involving $\geq 10\%$ TBSA.

INJURY DESCRIPTION	
FC	<b>Flail Chest:</b> Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations.
IT	<b>Inpatient Trauma:</b> Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers.
NA	<b>No Apparent Injury:</b> No complaint, or signs or symptoms of injury following a traumatic event.
PA	<b>Penetrating Abdomen:</b> Injury to any of the abdominal quadrants, flanks, or pelvis due to penetrating force.
PB	<b>Penetrating Back:</b> Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force.
PC	<b>Penetrating Chest:</b> Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to penetrating force.
PE	<b>Penetrating Extremities:</b> Injury or pain to the shoulders, arms, hands, legs, or feet due to penetrating force.
PF	<b>Penetrating Face/mouth:</b> Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to penetrating force.
PG	<b>Penetrating Genitals:</b> Injury to the external reproductive structures due to penetrating force.
PH	<b>Penetrating Head:</b> Injury to the head or skull in the area from above the eyebrows to behind the ears, due to penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved.
PI	<b>Penetrating Amputatlon:</b> Amputation proximal to (above) the wrist or ankle due to penetrating force.
PK	<b>Penetrating ButtockKs:</b> Injury to the buttocks due to penetrating force.
PL	<b>Penetrating Minor Lacerations (Penetrating):</b> Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to penetrating force.
PN	<b>Penetrating Neck:</b> Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force.
PP	<b>Penetrating Tension Pneumothorax:</b> Injury resulting in air entering the pleural space due to penetrating force, creating pressure on chest organs.
PT	<b>Penetrating Trauma Arrest:</b> Cessation of cardiac output and effective circulation due to penetrating force.
PV	<b>Penetrating extremity injury with neurological and/or Vascular compromise,</b> or one that is crushed, degloved, or mangled due to penetrating force.
PX	<b>Penetrating eXtremity injury proximal to (above) the knee or elbow</b> due to penetrating force.
RR	<b>RR &lt;10/&gt;29 (&lt;20 if &lt;1y):</b> A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event.
SC	<b>Spinal Cord Injury:</b> Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.
SX	<b>Suspected Pelvic Fracture:</b> Suspected pelvic fracture, eXcluding isolated hip fractures from a ground level fall.
UB	<b>Uncontrolled Bleeding:</b> Extremity bleeding requiring use of a tourniquet or hemostatic dressing.

**MECHANISM OF INJURY (Prehospital)**

MECHANISM OF INJURY (MOI)	
12	Intrusion of >12 inches into an occupied passenger space.
15	Fall >15 ft. (>10 ft. Peds): A vertical, <u>uninterrupted</u> fall of >15 feet for an adult or >10 feet or 3 times the height of the child for a pediatric patient. Excludes falling down stairs or rolling down a sloping cliff.
18	Intrusion of >18 inches into an unoccupied passenger space.
20	An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of >20 mph, not involving a moving auto.
AN	<b>AN</b> imal Bite: The teeth of a human, reptile, dog, cat, or other animal inflicted an injury.
AS	<b>AS</b> sault: Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting.
CR	<b>CR</b> ush: Injury sustained as the result of external pressure being placed on body parts between two opposing forces.
EJ	<b>EJ</b> ected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles.
ES	<b>ES</b> Electrical Shock: Passage of an electrical current through the body due to contact with an electrical source.
EV	<b>EV</b> nclosed Vehicle: Patient involved in collision while in an enclosed vehicle, such as an automobile, bus, or other enclosed motorized vehicle.
EX	<b>EX</b> trication: Use of a pneumatic tool was required to remove patient from the vehicle.
FA	<b>FA</b> ll: Any injury resulting from a fall from any height.
GS	<b>GS</b> unShot Wound (GSW): Injury was caused by discharge of a gun (accidental or intentional).
HE	<b>HE</b> zmat <b>EX</b> posure: An injury that occurs as a result of a hazmat exposure.
MM	<b>MM</b> otorcycle/ <b>M</b> oped: The patient was riding on a motorcycle or moped at the time of day of impact; code should be used whenever a motorcycle or moped is involved, other codes may apply (e.g. 20, RT, or PB).
OT	<b>OT</b> her: A cause of injury that does not fall into any of the existing categories.
PB	<b>PB</b> edestrian/ <b>B</b> icyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH.
PS	<b>PS</b> Passenger <b>S</b> pace Intrusion: Unspecified.
RT	Moving auto vs. pedestrian/bicyclist/motorcyclist: <b>R</b> un over, <b>T</b> hrown, or estimated impact of >20 MPH.
SA	<b>SA</b> Self-Inflicted, <b>A</b> ccidental: The injury appears to have been accidentally caused by the patient.
SF	<b>SF</b> Survived <b>F</b> atal crash: An injured patient that survived a collision in which a person in the same vehicle was fatally injured.
SI	<b>SI</b> Self-Inflicted, <b>I</b> ntentional: The injury appears to have been intentionally caused by the patient.
SP	<b>SP</b> orts/ <b>R</b> ecreation: Any injury that occurs during a sporting or recreational athletic activity.
ST	<b>ST</b> abbing: A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) was used to cause an injury which penetrated the skin.
TA	<b>TA</b> ser: Injury due to the deployment of a conducted electrical weapon (CEW), e.g. Taser®.
TB	<b>TB</b> Thermal <b>B</b> urn: Burn caused by heat.
TD	<b>TD</b> Telemetry <b>D</b> ata: Vehicle telemetry data that is consistent with high risk of serious injury.
UN	<b>UN</b> known: The cause or mechanism of injury is unknown.
WR	<b>WR</b> ork-Related: Injury occurred while patient was working.

**CRITERIA/GUIDELINES/SPECIAL CONSIDERATIONS (ED)**

LA COUNTY	
Physiological & Anatomical Criteria	
<b>14</b>	<b>GCS ≤14:</b> Blunt force head injury associated with a G score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits.
<b>70</b>	<b>SBP &lt;70:</b> Systolic blood pressure less than 70mmHg in a patient less than one year of age following a traumatic event.
<b>90</b>	<b>SBP &lt;90:</b> Systolic blood pressure less than 90mmHg in a patient greater than one year of age following a traumatic event.
<b>BD</b>	<b>Blunt Diffuse Abdominal Tenderness:</b> Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.
<b>BI</b>	<b>Blunt Amputatlon:</b> Amputation proximal to (above) the wrist or ankle due to blunt force.
<b>BR</b>	<b>Blunt FRacture of 2 or more long bones:</b> Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).
<b>BV</b>	<b>Blunt extremity injury with neurological and/or Vascular compromise,</b> or one that is crushed, degloved, or mangled due to blunt force.
<b>CB</b>	<b>Critical Burn:</b> Patients ≥15 years w/ 2 <sup>nd</sup> and 3 <sup>rd</sup> degree burns involving ≥20% Total Body Surface Area (TBSA) or Patients ≤14 years of age with 2 <sup>nd</sup> and 3 <sup>rd</sup> degree burns involving ≥10% TBSA.
<b>FC</b>	<b>Flail Chest:</b> Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations.
<b>PA</b>	<b>Penetrating Abdomen:</b> Injury to the abdomen, flanks, or pelvis due to penetrating force.
<b>PC</b>	<b>Penetrating Chest:</b> Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to penetrating force.
<b>PF</b>	<b>Penetrating Face/mouth:</b> Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to penetrating force.
<b>PG</b>	<b>Penetrating Genitals:</b> Injury to the external reproductive structures due to penetrating force.
<b>PH</b>	<b>Penetrating Head:</b> Injury to the head or skull in the area from above the eyebrows to behind the ears, due to penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved.
<b>PI</b>	<b>Penetrating Amputatlon:</b> Amputation proximal to (above) the wrist or ankle due to penetrating force.
<b>PK</b>	<b>Penetrating ButtocKs:</b> Injury to the buttocks due to penetrating force.
<b>PN</b>	<b>Penetrating Neck:</b> Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force.
<b>PT</b>	<b>Penetrating Trauma Arrest:</b> Cessation of cardiac output and effective circulation due to penetrating force.
<b>PV</b>	<b>Penetrating extremity injury with neurological and/or Vascular compromise,</b> or one that is crushed, degloved, or mangled due to penetrating force.
<b>PX</b>	<b>Penetrating eXtremity injury proximal to (above) the knee or elbow</b> due to penetrating force.
<b>PY</b>	<b>Penetrating Back:</b> Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force. WhY, because PB was already used.
<b>RR</b>	<b>RR &lt;10/&gt;29 (&lt;20 if &lt;1y):</b> A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event.
<b>SC</b>	<b>Spinal Cord Injury:</b> Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.
<b>SX</b>	<b>Suspected Pelvic Fracture:</b> Suspected pelvic fracture, eXcluding isolated hip fractures from a ground level fall.

<b>TQ</b>	<b>TourniQuet:</b> Tourniquet (Commercial) was required to control extremity bleeding not controlled by direct pressure.
<b>Mechanism of Injury Criteria</b>	
<b>15</b>	Fall > <b>15</b> ft. (>10 ft. Peds): A vertical, uninterrupted fall of >15 feet for an adult or >10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
<b>20</b>	An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of > <b>20</b> mph, not involving a moving auto.
<b>EJ</b>	<b>EJ</b> ected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles.
<b>12</b>	Intrusion of >12 inches into an occupied passenger space.
<b>RT</b>	Moving auto vs. pedestrian/bicyclist/motorcyclist: <b>R</b> un over, <b>T</b> hrown, or estimated impact of >20 MPH
<b>Guidelines</b>	
<b>18</b>	Intrusion of > <b>18</b> inches into an unoccupied passenger space.
<b>AN</b>	Injured patient on <b>AN</b> ticoagulant Medication (other than aspirin only) or with known bleeding disorder.
<b>EX</b>	<b>EX</b> trication: Use of a pneumatic tool was required to remove patient from the vehicle.
<b>PB</b>	<b>P</b> edestrian/ <b>B</b> icyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH.
<b>SF</b>	<b>S</b> urvived <b>F</b> atal crash: An injured patient that survived a collision in which a person in the same vehicle was fatally injured.
<b>TD</b>	<b>T</b> elemetry <b>D</b> ata: Vehicle telemetry data that is consistent with high risk of serious injury.
<b>Special Considerations</b>	
<b>BT</b>	<b>B</b> lunt <b>T</b> rauma <b>A</b> rrest: Cessation of cardiac output and effective circulation due to blunt force.
<b>55</b>	Injured patient that is greater than <b>55</b> years of age.
<b>BP</b>	Systolic <b>B</b> lood <b>P</b> ressure less than 110mmHg for patient greater than 65 years of age following a traumatic event.
<b>IU</b>	Injured patient with an <b>I</b> ntra <b>U</b> terine pregnancy greater than 20 weeks.
<b>PJ</b>	<b>P</b> rehospital <b>J</b> udgment that transport to Trauma Center is in the patient's best interest.

## **APPENDIX 3: Auto-Calculated Variables**



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## AUTO-CALCULATED VARIABLES

**Injury Severity Score:** The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries.

*Calculation:* Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis) and External). The 3 most severely injured body regions have their AIS score squared and added together to produce the ISS score. Only the highest AIS score in each body region is used. The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (un-survivable injury), the ISS score is automatically assigned to 75.

**Overall GCS - EMS score (adult and pediatric):** A scale calculated in the out-of-hospital setting which evaluates the patient's initial level of awareness, which indirectly indicates the extent of neurologic injury. The score is based upon three categories of patient responses; eye opening, verbal response, and motor response. The lowest score is 3 and is indicative of no response, the highest score is 15, indicates the patient is alert and aware of his or her surroundings.

*Calculation:* Initial Field GCS Eye + Initial Field GCS Verbal + Initial Field GCS Motor

**Overall GCS - ED score (adult and pediatric):** A scale calculated in the emergency department (ED) or hospital setting which evaluates the patient's initial (upon arrival) level of awareness, which indirectly indicates the extent of neurologic injury. The score is based upon three categories of patient responses; eye opening, verbal response, and motor response. The lowest score is 3 and is indicative of no response, the highest score is 15, indicates the patient is alert and aware of his or her surroundings.

*Calculation:* Initial ED/Hospital GCS Eye + Initial ED/Hospital GCS Verbal + Initial ED/Hospital GCS Motor

**Revised Trauma Score - ED (adult and pediatric):** The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting.

*Calculation:*  $RTS = 0.9368$  (Initial ED/Hospital GCS Total) +  $0.7326$  (Initial ED/Hospital Systolic Blood Pressure) +  $0.2908$  (Initial ED/Hospital Respiratory Rate)

**Total Length of Hospital Stay:** The total elapsed time the patient was in the hospital.

*Calculation:* Hospital Discharge Date/Time – ED/Hospital Arrival Date/Time

**Trauma Injury Severity Score (TRISS)/ Probability of Survival (POS):** The Trauma Injury Severity Score (TRISS) determines the **Probability of Survival** of a patient based upon the patient's age, type of injury (blunt versus penetrating), the Injury Severity Score (ISS), and the Revised Trauma Score (RTS).

**Length of Stay (Days) in Readmission:** The total elapsed time the patient was in the hospital for readmission.

*Calculation:* Readmit Discharge Date/Time – Date/Time of Readmission