DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **TRAUMA CENTER DATA DICTIONARY** REFERENCE NO. 646

TRAUMA CENTER DATA DICTIONARY

Los Angeles County

Emergency Medical Services Agency

Incorporating:
National Trauma Data Standards (NTDS®) 2025 Admissions
Trauma Quality Improvement Program (TQIP®)

REVISED: 2024

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COMMON NULL VALUES

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-transports to the hospital.

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

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

DHS PATIENT?

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.
- Field value cannot be left blank.

Uses

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

Other Associated Elements

- LA TRAUMA DATABASE INCLUSION CRITERIA

TRAUMA CENTER CODE

Definition

Three-letter code for the trauma center submitting data.

Field Values

AVH	Antelope Valley Medical Center	**LBM**	MemorialCare Long Beach Medical Center
CAL	Dignity Health – California Hospital Medical Center	**LMC**	Los Angeles General Medical Center
CHH	Children's Hospital Los Angeles	**NRH**	Dignity Health – Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	**PVC**	Pomona Valley Hospital Medical Center
HCH	Providence Holy Cross Medical Center	**SFM**	St. Francis Medical Center
HGH	Harbor-UCLA Medical Center	**SMM**	Dignity Health – Saint Mary Medical Center
HMH	Huntington Hospital	**UCL**	Ronald Reagan UCLA Medical Center
HMN	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

- If the patient's name contains a suffix (Jr., Sr., etc.), include as part of and at the end of the last name.
- Null Values are not accepted for this data field.
- Field value cannot be left blank.

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.
- Field value cannot be left blank.

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

Definition

Patient's middle initial.

Field Values

- Free text

Additional Information

- If no middle name exists, enter *"Not Applicable"*.
- Field value cannot be left blank.

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

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

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 the P.O. Box **number** in place of the patient's home address.
- If the home address includes "1/2", enter "1/2" in addition to the patient's home street in the "Street" field.
- Field value cannot be left blank.

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

HOME STREET/TYPE

Definition

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

Field Values

- Free text

Additional Information

- If the only address provided is a P.O. Box, enter "P.O. Box" in place of "Street".
- If the home address includes "1/2", enter "1/2" in addition to the patient's home street in the "Street" field. (Ex. ½ Elm Dr.).
- Field value cannot be left blank.

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, space, or unit number of the patient's primary residence.

Field Values

- Free text

Additional Information

- If no apartment, space, or unit number exists, enter *"Not Applicable".*
- Field value cannot be left blank.

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

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 home address related fields with *"Not Applicable"*.
- When choosing *"Not Applicable",* must complete "Alternate Home Address" field.
- If the only address provided is a P.O. Box, utilize the zip code for the P.O. Box.
- Field value 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	
H	Homeless	1	Homeless
U	Undocumented Citizen	2	Undocumented Citizen
M	Migrant Worker	3	Migrant Worker
F	Foreign Visitor	*"Not Applicable"*	

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.
- Field value 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

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

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

HOME COUNTY

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"*.
- Field value 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

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

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

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

SEX ASSIGNED AT BIRTH

Definition

The patient's sex assigned at birth.

Field Values

LA COUNTY		NTDS	
M	Male	1	Male
F	Female	2	Female
I	Intersex	3	Intersex

Additional Information

- Intersex is a term for people born with or develop sex characteristics that are not typically male or female. These characteristics can include Chromosomes, Genitalia, Hormone production, Reproductive organs, and Secondary sex traits.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Uses

- Epidemiological statistics.

Data Source Hierarchy

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

GENDER

Definition

Patient's gender identity.

Field Values

LA COUNTY		NTDS	
M	Male	1	Male
F	Female	2	Woman
N	Nonbinary	3	Non-binary, genderqueer, gender nonconforming
D	Non-Disclosed	4	Non-Disclosed

Additional Information

- Patients who are undergoing, or have undergone, a hormonal and/or surgical sex reassignment should be coded using their stated preference.
- Non-binary is a gender option for individuals whose gender identity isn't exclusively male or female and should be reported by the patient or identified by a family member
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Uses

- Epidemiological statistics.

Data Source Hierarchy

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

GENDER-AFFIRMING HORMONE THERAPY

Definition

Indicates weather the patient is currently (i.e., within the past 30 days) taking hormone therapy.

Field Values

LA COUNTY		NTDS	
Y	Yes	1	Yes
N	No	2	No
D	Non-Disclosed	3	Non-Disclosed

Additional Information

- Gender-affirming hormone therapy includes but is not limited to estrogen, antiandrogens, and testosterone.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Uses

- Epidemiological statistics.

Data Source Hierarchy

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

DATE OF BIRTH (DOB)

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.
- Field value cannot be left blank.

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

AGE

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.
- Field value cannot be left blank.

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	
Y	Years	4	Years
M	Months	3	Months
W	Weeks	6	Weeks
D	Days	2	Days
H	Hours	1	Hours
(Not Applicable in LA County)		5	Minutes
YE	Years Estimated	4	Years
ME	Months Estimated	3	Months
WE	Weeks Estimated	6	Weeks
DE	Days Estimated	2	Days
HE	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".
- Field value cannot be left blank.

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

PEDIATRIC/ADULT

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.
- Los Angeles County defines a pediatric patient as ≤ 14 years old.
- Field value cannot be left blank.

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	
A	Asian/Non-Pacific Islander	1	Asian	2	Not Hispanic or Latino
B	Black/African American	5	Black/African American	2	Not Hispanic or Latino
H	Hispanic/Latino	6	White	1	Hispanic or Latino
N	Native American/Alaska Native	4	American Indian	2	Not Hispanic or Latino
P	Pacific Islander/Hawaiian	2	Hawaiian/Pacific Islander	2	Not Hispanic or Latino
U	Unknown	3	Other Race	2	Not Hispanic or Latino
W	White	6	White	2	Not Hispanic or Latino
O	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**	
EMS:				
EMS/Ground	1	Ground	2	No
EMS/Air	2	Helicopter	2	No
NON-EMS:				
Vehicle/Walk-in	4	Vehicle/Walk-in	2	No
Police	5	Police	2	No
Other	6	Other	2	No
TRANSFERRED:				
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
(Not applicable in LA County)	3	Fixed Wing	1	Yes

Additional Information

- If entry mode is “Non-EMS”, “Vehicle”, “Police”, or “Other” (e.g., private ambulance transport), 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”*.
- Field value cannot be left blank.

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

EMS RECORD AVAILABLE?

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
- For non-EMS patient's document null value *"Not Applicable".*
- Field value cannot be left blank.

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

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	AHMC Anaheim Regional Medical Center	**LPI**	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	**PLH**	UCI Health – Placentia Linda
FHP	UCI Health – Fountain Valley	**SJD**	St. Jude Medical Center
KHA	Kaiser Foundation Hospital – Anaheim	**UCI**	University of California, Irvine Medical Center
KFI	Kaiser Foundation Hospital – Irvine	**WMC**	Orange County Global Medical Center
LAG	UCI Health – Los Alamitos		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	**KFN**	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	**LLU**	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	**SAC**	San Antonio Regional Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Regional Medical Center (Ventura)	**SJO**	Saint John's Regional Medical Center (Ventura)
SIM	Adventist Health Simi Valley (Ventura)	**RCC**	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Veteran's Administration Hospital – Long Beach	**WVA**	Veteran's Administration Hospital – West LA/Wadsworth

Additional Information

- Excludes non-EMS transports and patients transferred from a private doctor's office, urgent care or stand-alone ambulatory surgery center.
- For non-EMS patient's document *"Not Applicable".*
- Field value cannot be left blank.

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

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

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

Additional Information

- For non-EMS patient's document *"Not Applicable".*
- Field value cannot be left blank.

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

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

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

Additional Information

- For non-EMS patient's document *"Not Applicable".*
- Field value cannot be left blank.

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

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

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

Additional Information

- For non-EMS patient's document *"Not Applicable".*
- Field value cannot be left blank.

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

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

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

Additional Information

- For non-EMS patient's document *"Not Applicable".*
- Field value cannot be left blank.

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

SEQUENCE

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 sequence #, Non-EMS # (e.g., 20USC001), or "Out-of-County" patients 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 DHS=YES 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 #

MEDICAL RECORD (MR)

Definition

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

Field Values

- Free text

Additional Information

- Field value cannot be *"Not Applicable".*
- Field value cannot be left blank.

Uses

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

Data Source Hierarchy

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

OTHER

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

INJURY DATE

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

INJURY TIME

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					
AF	Arcadia Fire	**ES**	El Segundo Fire	**RB**	Redondo Beach Fire
AH	Alhambra Fire	**FS**	U.S. Forest Service	**SA**	San Marino Fire
AV	Avalon Fire	**GL**	Glendale Fire	**SG**	San Gabriel Fire
BF	Burbank Fire	**LB**	Long Beach Fire	**SI**	Sierra Madre Fire
BH	Beverly Hills Fire	**LH**	La Habra Heights Fire	**SM**	Santa Monica Fire
CC	Culver City Fire	**LV**	La Verne Fire	**SP**	South Pasadena Fire
CF	LA County Fire	**MB**	Manhattan Beach Fire	**SS**	Santa Fe Springs Fire
CG	US Coast Guard	**MF**	Monrovia Fire	**TF**	Torrance Fire
CI	LA City Fire	**MO**	Montebello Fire	**VE**	Ventura County Fire
CM	Compton Fire	**MP**	Monterey Park Fire	**WC**	West Covina Fire
CS	LA County Sheriff	**OT**	Other Provider		
DF	Downey Fire	**PF**	Pasadena Fire		
PRIVATE PROVIDERS					
AA	American Professional Ambulance Corp.	**FM**	Firstmed Ambulance Services, Inc.	**PE**	Premier Medical Transport, Inc. dba Premier Ambulance
AB	AmbuLife Ambulance, Inc.	**GR**	Gentle Ride Ambulance, Inc.	**PN**	PRN Ambulance, Inc.
AN	Antelope Ambulance Service	**GU**	Guardian Ambulance Service	**RE**	REACH Air Medical Service, LLC.
AR	American Medical Response of So. Calif.	**HE**	Heart Ambulance Corporation	**RR**	Rescue Services International, Ltd. Dba Medic-1 Ambulance
AT	All Town Ambulance, LLC	**HN**	Horizon Oc. LLC, dba Horizon OC Ambulance	**RY**	Royalty Ambulance Service, Inc.
AU	AmbuServe, Inc.	**JA**	Journey via Gurney, LLC., dba Journey Ambulance	**SO**	Di Biassi Corporation Symbiosis
AW	AMWest, Inc. dba Amwest Ambulance	**LE**	EastWestProto, Inc. dba Lifeline Ambulance	**SY**	Symons Emergency Specialties, Inc. dba Symbiosis
CA	Falck Mobile Health Corp. dba Care Ambulance	**LY**	Filyn Corporation, dba Lynch	**VA**	Viewpoint Ambulance, Inc.
CL	California Medical Response, Inc. dba Cal-Med Ambulance	**MA**	Mauran Ambulance Service Inc.	**VI**	Vital Care Ambulance
CO	College Costal Care, LLC	**MD**	MedTrans, Inc.	**WE**	Westcoast Ambulance, Inc.
CW	Citywide Ambulance, LCC	**MI**	MedResponse, Inc.	**WM**	Westmed Ambulance, Inc. dba McCormick Ambulance
EA	Emergency Ambulance Service Incorporated	**MR**	MedReach, Inc. dba MedReach Ambulance	**ZM**	Solartricity dba Zoom Medical Transportation
EX	Explorer 1 Ambulance & Medical Services, LLC.	**MU**	Mercury Ambulance Services, LLC		
FC	First Rescue Ambulance Inc.	**MY**	Mercy Air		

Additional Information

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

Uses

- System evaluation and monitoring.

Data Source Hierarchy

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

Other Associated Elements

- RA/SQ

RA/SQ

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.
- The null value *"Not Applicable"* cannot be used for EMS patients.
- Field cannot be left blank.

Uses

- System evaluation and monitoring.

Data Source Hierarchy

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

Other Associated Elements

- PROVIDER

DISPATCH DATE

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.
- The null value *"Not Applicable"* cannot be used for 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
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

DISPATCH TIME

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.
- The null value *"Not Applicable"* cannot be used for 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
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

1st 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.
- The null value *"Not Applicable"* cannot be used for EMS patients.
- Field 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
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME

TRANSPORT UNIT ARRIVAL DATE

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

BLUNT/PENETRATING/CRITICAL BURN

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 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA).
  - Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (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, Taser, & Auto vs Ped) versus Penetrating (GSW, ST, dog bite, impalement, or spearing type trauma).
- 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, firework injury, punched a window, etc.).

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

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

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 >12 Inches (12).
- If the patient has multiple MOIs, enter the most significant MOI first.
- 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", "punched a window", or a cause that does not fall into any of the existing categories.
- Field value cannot be left blank.
- Refer to Appendix 2: 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**	
NO	None	1	None		N/A		N/A
HE	Helmet	7	Helmet		N/A		N/A
PC	Protective Clothing	9	Clothing		N/A		N/A
PG	Protective Gear (non-clothing)	4	Non-Clothing Gear		N/A		N/A
EP	Eye Protection	5	Eye protection		N/A		N/A
PF	Personal Flotation	3	Personal Flotation		N/A		N/A
SB	SB Seatbelt - Shoulder Belt	10	Shoulder Belt		N/A		N/A
LB	LB Seatbelt - Lap Belt	2	Lap Belt		N/A		N/A
OT	OT Other	11	Other		N/A		N/A
Airbags							
AN	Airbag Not Deployed	8	Airbag Present		N/A	1	Airbag Not Deployed
AF	Airbag Deployed - Front	8	Airbag Present		N/A	2	Airbag Deployed Front
AS	Airbag Deployed - Side	8	Airbag Present		N/A	3	Airbag Deployed Side
AO	Airbag Deployed - Other	8	Airbag Present		N/A	4	Airbag Deployed Other
Child Restraints							
IC	Infant Car Seat (up to 1yr/20lbs)	6	Child Restraint	2	Infant Car Seat		N/A
CC	Child Car Seat (>1yr/20-40lbs)	6	Child Restraint	1	Child Car seat		N/A
CB	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.
- Enter the values *"SB Seatbelt – Shoulder Belt"* ***and*** *"LB Seatbelt – Lap Belt"* if the EMS record, base hospital form, audio recording, or ED record state "3-point restraints" or "patient restrained".
- 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

1st FIELD VS: SBP (Systolic Blood Pressure)

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_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

1st FIELD VS: DBP (Diastolic Blood Pressure)

Definition

First recorded diastolic 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*" if the diastolic pressure is not measured (i.e., only palpated systolic pressure measured).
- 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: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

1st FIELD VS: HR (Heart Rate)

Definition

First recorded pulse (Heart Rate) ***(without the assistance of CPR or any type of mechanical chest compressions)*** 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_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

1st FIELD VS: RR (Respiratory Rate)

Definition

First recorded respiratory rate ***(without ventilation assistance)*** 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 ventilation assistance**.
- 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_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

1st FIELD VS: O_2 SAT

Definition

First recorded oxygen saturation (O_2 Sat) ***(without the administration of oxygen)*** 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

1st 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

- If a patient does not have a numeric GCS recorded for "Eye", but there is documentation related to their initial level of stimuli, enter the corresponding numeric value.
- 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_2 SAT
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

1st 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 a patient does not have a numeric GCS recorded for "Verbal", but there is documentation related to their initial level of stimuli, enter the corresponding numeric value.
- 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_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS

1st 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

- If a patient does not have a numeric GCS recorded for "Motor", but there is documentation related to their initial level of stimuli, enter the corresponding numeric value.
- 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_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL GCS

1st 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 1st 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 GSC 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_2 SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR

PREHOSPITAL BLEEDING CONTROL?

Definition

Indicates whether bleeding was controlled in the prehospital setting by EMS personnel.

Field Values

- **T**: Tourniquet
- **H**: Hemostatic Agent
- **B:** Both Tourniquet and Hemostatic Agent
- **X:** Tranexamic Acid (TXA)
- **N:** None

Additional Information

- Non-commercial tourniquets (e.g. belts, etc.) not applied by EMS personnel should NOT be included.
- Tourniquet, Hemostatic Agent, and Tranexamic Acid (TXA) are not utilized on most patients; therefore, this field will auto-populate with a value of 'N: None'.
- 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

PREHOSPITAL BLOOD INITIATION?

Definition

Indicates whether blood was initiated in the prehospital setting by EMS personnel.

Field Values

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

Additional Information

- Prehospital blood initiation by EMS personnel is not common; therefore, this field will auto-populate with a value of “N: No”.
- Patients receiving blood, which was started at the transferring facility, and transported by EMS personnel, report the Field Value as “N: No”.
- Field value cannot be *“Not Applicable”.*
- Field cannot be left blank.

Uses

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

Data Source Hierarchy

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

INTUBATION PRIOR TO ARRIVAL?

Definition

Indicates whether the patient was intubated prior to arriving at the trauma center and what type of airway management device was utilized.

Field Values

LA COUNTY		NTDS	
E	Definitive Airway	1	Yes
I	I-Gel	2	No
N	No	2	No

Additional Information

- Definitive airways placed below the vocal cords include, endotracheal tube (ET), tracheostomy, and cricothyroidotomy.
- Intubation prior to arrival at the trauma center does not occur in most patients; therefore, this field will auto-populate with a value of “No”.
- If Field Value “E:Definitive Airway” is reported, you must report “Intubation Location” as Field Value “P:Prehospital Setting” or “T:Transfering Facility”.
- If Field Value “I:I-Gel” is reported, “Intubation Location?” will auto-populate to “P:Prehospital Setting” and will be reported to NTDS as *“Not Applicable”.*
- For patients with an established airway prior to injury event (e.g., Chronic Ventilator Dependence) report *“Not Applicable”*.
- Field cannot be left blank.

Uses

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

Data Source Hierarchy

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

Other Associated Elements

- INTUBATION LOCATION?

INTUBATION LOCATION?

Definition

The location the patient was intubated at prior to trauma center arrival.

Field Values

LA COUNTY		NTDS	
P	Prehospital Setting	1	Out of Hospital Intubation
T	Transferring Facility	2	Transferring Facility

Additional Information

- If Field Value "E:Definitive Airway" is reported in "Intubation Prior to Arrival?", you must report "Intubation Location" as Field Value "P:Prehospital Setting" or "T:Transfering Facility".
- If Field Value *"Not Applicable"* was reported for "Intubation Prior to Arrival?", the Field Value for "Intubation Location?" will auto-populate to *"Not Applicable".*
- If Field Value "I:I-Gel" is reported for "Intubation Prior to Arrival?", "Intubation Location?" will auto-populate to "P:Prehospital Setting" and will be reported to NTDS as *"Not Applicable".*
- If Field Value "N: No" was reported for "Intubation Prior to Arrival?", the Field Value for "Intubation Location?" will auto-populate to *"Not Applicable".*
- Field cannot be left blank.

Uses

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

Data Source Hierarchy

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

Other Associated Elements

- INTUBATION PRIOR TO ARRIVAL?

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

EXTERNAL CAUSE CODE

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.
  - 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 *"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

ADDITIONAL CAUSE CODE

Definition

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

PLACE OF OCCURRENCE CODE

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 *"Not Applicable".*
- 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

INJURY LOCATION ZIP CODE

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**	Metler 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

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

INJURY LOCATION COUNTY

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

WORK RELATED?

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). Link: https://www.bls.gov/oes/current/oes_stru.htm.
- 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	
AGRICULTURAL	Agricultural, Forestry, Fishing	5	Agricultural, Forestry, Fishing
CONSTRUCTION	Construction	8	Construction
ED/HEALTH	Education and Health Services	7	Education and Health Services
INFORMATION	Information Services	11	Information Services
FIN/INS/REAL	Finance, Insurance, and Real Estate	1	Finance, Insurance, and Real Estate
GOVERNMENT	Government	9	Government
LEISURE	Leisure and Hospitality	13	Leisure and Hospitality
MANUFACTURING	Manufacturing	2	Manufacturing
NATURAL	Natural Resources and Mining	10	Natural Resources and Mining
PROFESSIONAL	Professional and Business Services	6	Professional and Business Services
RETAIL	Retail Trade	3	Retail Trade
TRANS/UTIL	Transport and Public Utilities	4	Transport and Public Utilities
WHOLESALE	Wholesale Trade	12	Wholesale Trade
OTHER	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

ED NOTIFIED?

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.
- Field cannot be left blank.

Uses

- System evaluation and monitoring.

Data Source Hierarchy

- ED Records
- Base hospital form
- Everbridge/Trauma System Activation
- 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

MET CRITERIA?

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 only meet trauma guidelines/special considerations.
- Field cannot be *"Not Applicable".*
- Field 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
- 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≤14
10	Fall 10 Ft. (All patients)
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, BP, IU & PJ)
	Critical Burn (CB w/ any other code, excluding: 70, 90, RR, AN, 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
UB	Uncontrolled Bleeding
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
BP	Systolic B/P less than 110mmHg for patient greater than 65 years of age
HR	Heart rate > systolic blood pressure for > 14 years of age
IU	Pregnancy greater than 20 weeks
PJ	Prehospital judgment that transport to Trauma Center is in the patient's best interest
UN	Child (0-9 yrs. old) unrestrained/unsecured child safety seat

Additional Information

- If the patient did not meet trauma criteria, values from the "Criteria" sub-picklist may NOT be selected.
- 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.
- 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 (10, 20, EJ, & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (BP, HR, IU, & PJ) cannot be selected for non-EMS patients.
  - ✓ Special Considerations (BT, BP, HR, IU, & PJ, UN) 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

PRIMARY MEDICAL EVENT

Definition

The patient experienced a documented primary medical event (e.g., seizure, cerebral vascular accident, myocardial infarction, arrythmia, syncope, stroke, hypoglycemia) that immediately preceded the traumatic injury.

Field Values

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

Additional Information

- Enter the null value *"Not Documented"* if it is unknown that a primary medical event immediately preceded the traumatic injury.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

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

ED/HOSPITAL ARRIVAL DATE

Definition

The date the patient arrived at 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

ED/HOSPITAL ARRIVAL TIME

Definition

The time of day the patient arrived at 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

TRAUMA TEAM ACTIVATION?

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 and should be entered as field value *"N: No".***
- Field value cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field cannot be left blank.

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

Additional Information

- Field cannot be left blank.

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

ACTIVATION TIME

Definition

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

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Field cannot be left blank.

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

ACTIVATION LEVEL

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.**
- Field value cannot be left blank.

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

ED DISPOSITION ORDER DATE

Definition

The date the final order was written for the patient to be dispositioned from the ED, or the date the patient eloped, left AMA, or died in the ED.

Field Values

- Collected as MMDDYYYY

Additional Information

- Enter the date the order was written for the patient to be discharged from the ED, not the date the patient exited the ED.
- 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

ED DISPOSITION ORDER TIME

Definition

The time of day the final order was written for the patient to be dispositioned from the ED, or the time the patient eloped, left AMA from, or died in the ED.

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Enter the time the order was written for the patient to be discharged from the ED, not the time the patient exited the ED.
- 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

ED EXIT DATE

Definition

The date the patient left the ED, or the date the patient eloped, left AMA, or died in 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

ED EXIT TIME

Definition

The time of day the patient left the ED, or the time the patient eloped, left AMA, or died in 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

PRIMARY TRAUMA SERVICE TYPE

Definition

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

Field Values

LA COUNTY		NTDS	
A	Adult	1	Adult
P	Pediatric	2	Pediatric

Additional Information

- The primary service type responsible for trauma evaluation and care of the patient.
- Adult trauma centers that do not have a separate pediatric service must report *Element Value* "1. Adult."
- Pediatric trauma centers that do not have a separate adult service must report *Element Value* "2. Pediatric."
- Field value cannot be left blank.

Uses

- This element will be used to determine which eligible Trauma Quality Programs report [adult or pediatric] the patient will appear; report age criteria will still apply.

Data Source Hierarchy

- ED Record
- Hospital Record
- Discharge Summary

Other Associated Elements

- TRAUMA TEAM ACTIVATION

HEIGHT

Definition

Patient's height, or the best approximation, after ED/hospital arrival.

Field Values

- Up to three-digit positive numeric value

Additional Information

- Enter the null value *"Not Documented"* if the patient's height was not recorded prior to discharge.
- May be self-reported or provided by family.
- 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

HEIGHT UNITS

Definition

Unit of measurement used to report the patient's height, after ED/hospital arrival.

Field Values

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

Additional Information

- May be self-reported or provided by family.
- Only complete if a numeric value is reported for the height, otherwise, enter the null value *"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

WEIGHT

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

WEIGHT UNITS

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.
- Only complete if a numeric value is reported for the weight, otherwise, enter the null value *"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

1st ED/HOSPITAL VS: DATE

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 1st set of ED vitals at the ED receiving facility (Trauma Center) must be used, NOT the 1st 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.
- Field value cannot be *"Not Applicable".*

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: 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: TIME

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 1st set of ED vitals at the ED receiving facility (Trauma Center) must be used, NOT the 1st 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: BP – SYSTOLIC (SBP)

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.
- If the patient arrives in traumatic arrest (pulseless on arrival), enter zero "0" for the 1st ED vital signs.
- 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: BP – DIASTOLIC (DBP)

Definition

Numeric value of the first recorded diastolic blood pressure (DBP) ***(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.
- If the patient arrives in traumatic arrest (pulseless on arrival), enter zero "0" for the 1st ED vital signs.
- 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.
- 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: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: HEART RATE (HR)

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.
- If the patient arrives in traumatic arrest (pulseless on arrival), enter zero "0" for the 1st ED vital signs.
- 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: RESPIRATORY RATE (RR)

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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st 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 1st ED/Hospital VS: Respiratory Rate (RR) is reported.
- Respiratory assistance is defined as mechanical and/or external support of respiration (e.g. BVM, ventilator, etc.).
- The null value of *"Not Applicable"* is reported if the 1st 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: O_2 SAT

Definition

Numeric value of the first recorded oxygen saturation (O_2 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_2?
- 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

1st ED/HOSPITAL VS: ON O_2?

Definition

Indicates whether supplemental oxygen was in use during the initial assessment of the O_2 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_2 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_2 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

1st ED/HOSPITAL VS: TEMPERATURE (TEMP)

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 10th 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: TEMP UNITS

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"*.
- 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: TEMP TIME

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"*.
- 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st 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	
ADULT			
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
INFANT			
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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: GCS – TOTAL

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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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

1st ED/HOSPITAL VS: GCS MODIFIERS

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	
S	Sedated	1	Chemically Sedated or Paralyzed
E	Eye Obstruction	2	Obstruction to the Patient's Eye
I	Intubated	3	Intubated
	Not Applicable	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. i-gel
- 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_2 SAT
- 1st ED/HOSPITAL VS: ON O_2?
- 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	
PH	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.
CG	Non-EMS patient met Trauma Triage Physiological &/or Anatomical criteria, per Reference No. 506.1, (**excludes Trauma Triage Mechanism of Injuries, Guidelines, & Special Considerations**).
AD	Admitted for care of an injury after ED evaluation by the Trauma Surgeon.
DI	Died of an injury-related problem.
TS	Transfer Higher Level of Care to or from your facility and evaluated by the Trauma Surgeon in the ED and/or **admitted** by a Trauma Surgeon for care of an injury.
NO	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 (CG)**.
- 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.
- 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, 10, 20, EJ, & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (BP, IU, & PJ).
  - ✓ AD - Mode of Entry cannot be EMS with an existing Criteria/Guideline.
- Null Values are not accepted for this data field.
- Field value cannot be left blank.

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

ADMITTING PHYSICIAN

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.
- Enter the null value *"Not Applicable"* if the patient was discharged or transferred from the ED, patient eloped, left AMA, or died in the ED.
- Field value cannot be left blank.

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

Additional Information

- Enter the null value *"Not Applicable"* if the patient was discharged or transferred from the ED, patient eloped, left AMA, or died in the ED.
- Field value cannot be left blank.

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

Additional Information

- Trauma Team composition will vary by facility.
- The Trauma Surgeon **must** evaluate the patient in the ED (refer to Los Angeles County Trauma Database Inclusion Criteria).
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank.

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)*

PHYSICIAN CODE *(Trauma Team)*

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.
- The Trauma Surgeon **must** evaluate the patient in the ED (refer to Los Angeles County Trauma Database Inclusion Criteria).
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank.

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)*

REQUEST DATE *(Trauma Team)*

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

- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank.

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)*

REQUEST TIME *(Trauma Team)*

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

- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank

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)*

STAT? *(Trauma Team)*

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

Additional Information

- Highest level activations should be entered as "Yes" as the trauma surgeon must be at the bedside within 15 minutes (Level I or II trauma centers).
- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank

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)*

ARRIVAL DATE *(Trauma Team)*

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.
- The Trauma Surgeon **must** evaluate the patient in the ED (refer to Los Angeles County Trauma Database Inclusion Criteria).
- Enter the null value *"Not Documented"* if the Trauma Surgeon (TRS) did not arrive at the bedside to evaluate the injured patient in the ED.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank.

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)*

ARRIVAL TIME *(Trauma Team)*

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.
- The Trauma Surgeon **must** evaluate the patient in the ED (refer to Los Angeles County Trauma Database Inclusion Criteria).
- Enter the null value *"Not Documented"* if the Trauma Surgeon (TRS) did not arrive at the bedside to evaluate the injured patient in the ED.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- Field cannot be *"Not Applicable",* unless the patient is a direct admit.
- Field value cannot be left blank.

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

Additional Information

- Telemedicine consults for NES, Psych, and Tele Stroke, requested in the ED and the patient is evaluated in the ED, may be entered under ED Consults.
- Field value cannot be left blank.

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.

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

- Telemedicine consults for NES, Psych, or Tele Stroke are acceptable. Enter the date the consult was requested, if ordered in the ED.

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

- Telemedicine consults for NES, Psych, or Tele Stroke are acceptable. Enter the time the consult was requested, if ordered in the ED.

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

- Telemedicine consults for NES, Psych, or Tele Stroke, if done in the ED, document the date of the consult.
- **A "phone response" is NOT to be utilized as an *Arrival Date*.** Physical evaluation of the patient is not possible via the phone.
- For patients transferred or admitted (e.g., floor/unit, OR, IR, etc.) enter the null value *"Not Documented"* if the consult was requested in the ED, but the specialist **did not** arrive at the bedside to evaluate the injured patient **in the ED**.
- Services requested as an ED Consult that do NOT physically evaluate the patient while in the ED, document Arrival Date, Arrival Time, Consultation Service, and Consultation Physician 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.
- For patients transferred or admitted (e.g., floor/unit, OR, IR, etc.) enter the null value *"Not Documented"* if the consult was requested in the ED, but the specialist **did not** arrive at the bedside to evaluate the injured patient **in the ED**.
- Services requested as an ED Consult that do NOT physically evaluate the patient while in the ED, document Arrival Date, Arrival Time, Consultation Service, and Consultation Physician in the **ICU/Acute Care** section.
- .
- Telemedicine consults for NES, Psych, or Tele Stroke, if done in the ED, document the time of the consult.

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)*

1ST ANTIBIOTIC ADMINISTRATION DATE

Definition

Date of 1st 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 Association of Advancement of Automotive Medicine Abbreviated Injury Scale (AIS) Coding Rules and Guidelines and includes all AIS code descriptors that contain “open” and all AIS extremity/limb code descriptors that contain “amputation.”.
- For antibiotics administered at a transferring facility, enter the date of 1st antibiotic administration at that facility.
- 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

- 1st ANTIBIOTIC ADMINISTRATION TIME
- ARRIVAL DATE
- ARRIVAL TIME

1ST ANTIBIOTIC ADMINISTRATION TIME

Definition

Time of day of the 1st 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 Association of Advancement of Automotive Medicine Abbreviated Injury Scale (AIS) Coding Rules and Guidelines and includes all AIS code descriptors that contain “open” and all AIS extremity/limb code descriptors that contain “amputation”.
- For antibiotics administered at a transferring facility, enter the time of 1st antibiotic administration at that facility.
- 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

- 1st ANTIBIOTIC ADMINISTRATION DATE
- ARRIVAL DATE
- ARRIVAL TIME

IV FLUIDS IN ED

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.
- If no IV fluids are given enter the value zero (0).
- Field value cannot be left blank.

Uses

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

Data Source Hierarchy

- ED Records

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", 1st ED VS SBP, HR, and RR must be zero (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		
D	DOA	Death declared **on arrival** no resuscitative efforts initiated in the ED.
F	Failed Resuscitation	Death pronounced in the ED after failure to respond to resuscitative efforts **within 15 minutes** of ED arrival.
O	Died in ED	Death pronounced in the ED **other than Failed Resuscitation**.

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
- Field cannot be left blank.

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
- TRASFERRED/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**	12	Interventional Radiology Suite
OR	**Operating Room/Hybrid OR**	7	Operating Room/Hybrid OR
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/Telemetry Unit**	3	Telemetry/Step-down Unit (less acuity than ICU)
WARD	**Ward/Floor**	1	Floor bed (general admission, non-specialty bed)
POSTHOSP	***Posthospital - (Use LA County "Transferred/Discharged To:"):***		

Additional Information

- If the patient was boarded in the ED, the disposition must be the location the patient was ordered to go when their ED workup was completed.
- 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.
- Examples of Special Procedures include Cath. Lab and GI Lab.
- The null value *"Not Applicable"* is auto-populated for direct admit patients.
- Field value cannot be left blank.

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
HEAD				**UPPER EXTREMITIES**	BW0JZZZ		
Head / Skull	BN00ZZZ	BW28ZZZ	BW281ZZ	Right Upper Extremity	BP0EZZZ	BP2EZZZ	BP2E1ZZ
Temporal Bone		BN2FZZZ	BN2F1ZZ	Right Finger(s)	BP0RZZZ	BP2RZZZ	BP2R1ZZ
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
NECK / SPINE				Right clavicle	BP04ZZZ	BP24ZZZ	BP241ZZ
Neck		BW2FZZZ	BW2F1ZZ	Right shoulder	BP08ZZZ	BP28ZZZ	BP281ZZ
Cervical spine	BR00ZZZ	BR20ZZZ	BR201ZZ	Right Scapula	BP06ZZZ	BP26ZZZ	BP261ZZ
Thoracic spine	BR07ZZZ	BR27ZZZ	BR271ZZ	Left Upper Extremity	BP0FZZZ	BP2FZZZ	BP2F1ZZ
Lumbosacral spine	BR09ZZZ	BR29ZZZ	BR291ZZ	Left Finger(s)	BP0SZZZ	BP2SZZZ	BP2S1ZZ
				Left hand	BP0PZZZ	BP2PZZZ	BP2P1ZZ
CHEST / ABDOMEN				Left wrist	BP0MZZZ	BP2MZZZ	BP2M1ZZ
Chest/Thoracic	BW03ZZZ	BW24ZZZ	BW241ZZ	Left forearm	BP0KZZZ	BP2KZZZ	BP2K1ZZ
Chest & Abdomen		BW24ZZZ	BW241ZZ	Left elbow	BP0HZZZ	BP2HZZZ	BP2H1ZZ
Right Ribs	BP0XZZZ	BP2XZZZ	BP2X1ZZ	Left humerus	BP0BZZZ	BP2BZZZ	BP2B1ZZ
Left Ribs	BP0YZZZ	BP2YZZZ	BP2Y1ZZ	Left clavicle	BP05ZZZ	BP25ZZZ	BP251ZZ
Sternum	BR0HZZZ			Left shoulder	BP09ZZZ	BP29ZZZ	BP291ZZ
Heart/Pericardium		B226ZZZ	B2261ZZ	Left scapula	BP07ZZZ	BP27ZZZ	BP271ZZ
Lung/Pleura		BB24ZZZ	BB241ZZZ				
Abdomen		BW20ZZZ	BW201ZZ	**LOWER EXTREMITIES**	BW0CZZZ		
Abdomen / Pelvis	BW00ZZZ	BW21ZZZ	BW211ZZ	Right Lower Extremity	BQ0DZZZ	BQ2DZZZ	BQ2D1ZZ
KUB/Cystogram	BT04ZZZ			Right ankle	BQ0GZZZ	BQ2GZZZ	BQ2G1ZZ
Kidneys - Bilateral	BT03ZZZ	BT23ZZZ	BT231ZZ	Right foot	BQ0LZZZ	BQ2LZZZ	BQ2L1ZZ
Right Kidney	BT01ZZZ	BT21ZZZ	BT211ZZ	Right toe(s)	BQ0PZZZ	BQ2PZZZ	BQ2P1ZZ
Left Kidney	BT02ZZZ	BT22ZZZ	BT221ZZ	Right femur	BQ03ZZZ	BQ23ZZZ	BQ231ZZ
				Right knee	BQ07ZZZ	BQ27ZZZ	BQ271ZZ
OTHER				Right tibia/fibula		BQ2BZZZ	BQ2B1ZZ
Pelvis	BR0CZZZ	BW2GZZZ	BW2G1ZZ	Right hip	BQ00ZZZ	BQ20ZZZ	BQ201ZZ
Sacrum	BR0FZZZ	BR2FZZZ	BR2F1ZZ	Left Lower Extremity	BQ0FZZZ	BQ2FZZZ	BQ2F1ZZ
Whole Skeleton	BW0LZZZ			Left ankle	BQ0HZZZ	BQ2HZZZ	BQ2H1ZZ
Whole Body	BW0KZZZ			Left foot	BQ0MZZZ	BQ2MZZZ	BQ2M1ZZ
				Left toe(s)	BQ0QZZZ	BQ2QZZZ	BQ2Q1ZZ
				Left femur	BQ04ZZZ	BQ24ZZZ	BQ241ZZ
				Left knee	BQ08ZZZ	BQ28ZZZ	BQ281ZZ
				Left tibia/fibula		BQ2CZZZ	BQ2C1ZZ
				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** (5th Digit) with **Y**.
- Code all CTs **individually** by "body part".
- Field value must be *"Not Applicable"* if no radiological studies were performed.
- 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

- 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.
- Field value must be *"Not Applicable"* if no radiological studies were performed.
- 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

- 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

Additional Information

- Field value must be *"Not Applicable"* if no radiological studies were performed.
- Field value cannot be left blank.

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

Additional Information

- Field value must be *"Not Applicable"* if no radiological studies were performed.
- Field value cannot be left blank.

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.
- Field value must be *"Not Applicable"* if no radiological studies were performed.
- 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

- 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.
- Field value must be *"Not Applicable"* if no radiological studies were performed. 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

- Radiology Records
- ED Records

Other Associated Elements

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

SOLID ORGAN INJURY?

Definition

Indicates whether a solid organ injury exists.

Field Values

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

Additional Information

- Field 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

- 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

Additional Information

- Refer to the American Association for the Surgery of Trauma (AAST) Injury Scoring Scale: https://www.aast.org/resources-detail/injury-scoring-scale.
- 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

- Radiology Records
- OR Records
- ED Records
- Progress Notes
- Other Hospital Records
- Autopsy Report

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		
Grade I	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
Grade II	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <10cm diameter
	Laceration	1-3cm parenchymal depth, <10cm length
Grade III	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >10cm or expanding
	Laceration	>3cm parenchymal depth
Grade IV	Laceration	Parenchymal disruption involving 25-75% of hepatic lobe 1-3 Couinaud's segments in a single lobe
Grade V	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
Grade VI	Vascular	Hepatic Avulsion

Additional Information

- 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

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

Autopsy Report

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

Additional Information

- 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

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

Autopsy Report

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

Additional Information

- Field value cannot be left blank

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

Autopsy Report

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

Additional Information

- 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

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

Autopsy Report

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

LABORATORY: Date

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.
- Field value must be *"Not Applicable"* if no laboratory studies were performed.
- Field value cannot be left blank.

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

LABORATORY: Time

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.
- Field value must be *"Not Applicable"* if no laboratory studies were performed.
- Field value cannot be left blank.

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

LABORATORY: Group/Panel

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.
- Field value must be *"Not Applicable"* if no laboratory studies were performed.
- 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

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

LABORATORY: Result

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.
- Field value must be *“Not Applicable”* if no laboratory studies were performed.
- 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

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

LABORATORY: Description

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.
- Field value must be *"Not Applicable"* if no laboratory studies were performed.
- 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

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

ETOH/TOXICOLOGY: Date

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

ETOH/TOXICOLOGY: Time

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.
- 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: 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)
Fentanyl	8	Opioids (OPI)
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

ETOH/TOXICOLOGY: Source

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.
- 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: 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**	
FOUND (Positive)	1	YES	1-13	ENTER IDENTIFIED TOXIN(S)
NOT FOUND (Negative/None)	1	YES	14	NONE
NOT TESTED	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, Fentanyl) 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

ETOH VALUE

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

ETOH UNITS

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®/TQIP®.
- 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

MASSIVE TRANSFUSION PROTOCOL (MTP) ACTIVATED?

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

- 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

BLOOD INCLUSION?

Definition

Indicates whether the patient received any blood products 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 any blood products during the first four hours of ED/Hospital arrival.
- By choosing Y: Yes, the following additional fields will need to be addressed: Lowest Systolic Blood Pressure (SBP), Whole Blood, Packed Cells (PRBC), Plasma (FFP), Platelets, Cryoprecipitate, First Angiography, Hemorrhage Control Type.
- 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

- 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

LOWEST SYSTOLIC BLOOD PRESSURE (SBP)

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.
- 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

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

Other Associated Elements

- MTP ACTIVATED?
- 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

WHOLE BLOOD *(4 HOURS)*

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 **550 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?
- 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

PACKED CELLS (PRBC) *(4 HOURS)*

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 **325 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?
- 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

PLASMA (FFP) *(4 HOURS)*

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 **250 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?
- 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

PLATELETS *(4 HOURS)*

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 **200 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?
- 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

CRYOPRECIPITATE *(4 HOURS)*

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?
- 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)*

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 **550 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?
- 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

PACKED CELLS (PRBC) *(24 HOURS)*

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 **325 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?
- 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)*

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 **250 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?
- 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

PLATELETS *(24 HOURS)*

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 **200 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?
- 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

CRYOPRECIPITATE *(24 HOURS)*

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?
- 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)*

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 **550 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?
- 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

PACKED CELLS (PRBC) *(TOTAL)*

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 **325 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?
- 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

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 **250 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?
- 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

PLATELETS *(TOTAL)*

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 **200 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?
- 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

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?
- 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

TOTAL BLOOD PRODUCTS

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?
- 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

PHASE BEGUN

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
- **SPECIAL**: Special Procedures (e.g., Cath Lab, GI Lab)
- **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.
- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

START DATE

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

Additional Information

- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

START TIME

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

Additional Information

- The start time is the "incision time", "cut time", or "puncture time", not the time the patient arrived in the OR, IR, or Special Procedures unit.
- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

END TIME

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

Additional Information

- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

<table>
<tr><th>MANDATORY PROCEDURES</th><th>ICD-10 CODES</th><th>MANDATORY PROCEDURES</th><th>ICD-10 CODES</th></tr>
<tr><td>Central Line Approach:
• Chest, Open
• Chest, Percutaneous
Special Note: The ICD-10 Code for central lines varies depending on the site and the approach used for placement.</td><td>0JH60XZ
0JH63XZ</td><td>Inferior Vena Cava (IVC) Filters (temporary or permanent) Approach:
• Open
• Percutaneous
• Percutaneous Endoscopic</td><td>06H00DZ
06H03DZ
06H04DZ</td></tr>
<tr><td>Chest Tube (left)</td><td>0W9B30Z</td><td colspan="2" rowspan="2">Interventional Angiogram (IA)
Special Note: The ICD-10 Code for IA varies depending on the site and the approach used.</td></tr>
<tr><td>Chest Tube (right)</td><td>0W9930Z</td></tr>
<tr><td>Cricothyroidotomy Approach:
• Open
• Percutaneous
• Percutaneous Endoscopic</td><td>0B110F4
0B113F4
0B114F4</td><td>Intracranial Pressure (ICP) Monitor:
• Percutaneous
• Via Natural or Artificial Opening</td><td>4A103BD
4A107BD</td></tr>
<tr><td>Diagnostic Peritoneal Aspirate (DPA)</td><td>0W9G3ZX</td><td rowspan="2">Percutaneous Endoscopic Gastrostomy (PEG) Approach:
• Percutaneous
• Percutaneous Endoscopic</td><td rowspan="2">0DH63UZ
0DH64UZ</td></tr>
<tr><td>Diagnostic Peritoneal Lavage (DPL)</td><td>3E1M38X</td></tr>
<tr><td colspan="2" rowspan="2">Embolization:

Special Note: The ICD-10 Code for embolization varies depending on the site embolized and the approach used.</td><td>Thoracotomy</td><td>02JA0ZZ</td></tr>
<tr><td>Tracheostomy Approach:
• Open
• Percutaneous
• Percutaneous Endoscopic</td><td>0B110F4
0B113F4
0B114F4</td></tr>
<tr><td>Endotracheal (ETT) Intubation:
• Via Natural or Artificial Opening
• Via Natural or Artificial Opening Endoscopic</td><td>0BH17EZ
0BH18EZ</td><td>Ventilator:
• Less than 24 Consecutive Hours
• 24-96 Consecutive Hours
• > 96 Consecutive Hours</td><td>5A1935Z
5A1945Z
5A1955Z</td></tr>
<tr><td colspan="2"></td><td colspan="2"><u>Special Note:</u> The ICD-10-PCS ventilator code is based on <u>hours</u> on the ventilator; therefore, the code may be different than the Total Number of Ventilator <u>Days</u>.</td></tr>
</table>

Additional Information

- Optional operative or essential major and minor procedures ICD-10-CM codes conducted during hospital stay include, but are not limited to, the following: Licox, Bronchoscopy, & PICC line.
- All Operative or essential major and minor procedures must be entered.
- Field value must be *"Not Applicable",* if no procedure was performed.
- 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

- 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

SURGERY TYPE

Definition

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

Field Values

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

Additional Information

- Field value must be *"Not Applicable",* if no procedure was performed.
- 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

- 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

PHYSICIAN CODE

Definition

Name or MD code of the surgeon that performed the major or minor surgical procedure, if applicable.

Field Values

- Free text

Additional Information

- Major or minor surgical procedures can occur during any phase of care (e.g., ED, ICU, Special Procedures), not specifically in the OR or IR.
- Non-picklist – free text physician name or code at discretion of each facility.
- Field value must be *"Not Applicable"* if no procedure was performed.
- 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

- 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

TOTAL VENTILATOR DAYS

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.
- At no time can the **Total Ventilator Days** exceed the hospital LOS.
- Field value cannot be left blank.

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

1st 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?
- BLOOD INCLUSION?
- WHOLE BLOOD *(4 HOURS)*
- PACKED CELLS *(4 HOURS)*

1st 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?
- BLOOD INCLUSION?
- WHOLE BLOOD *(4 HOURS)*
- PACKED CELLS *(4 HOURS)*

1st 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?
- 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?
- 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.
- First surgery performed for hemorrhage control does not have to be performed in the OR (e.g., Thoracotomy performed in the ED).
- 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

- Operative Report
- Progress Notes

Other Associated Elements

- HEMORRHAGE CONTROL DATE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- BLOOD INCLUSION?
- WHOLE BLOOD *(4 HOURS)*
- PACKED CELLS *(4 HOURS)*

HEMORRHAGE CONTROL DATE

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?
- 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?
- BLOOD INCLUSION?
- WHOLE BLOOD *(4 HOURS)*
- PACKED CELLS *(4 HOURS)*

NEXT PHASE AFTER OR

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 (e.g., Cath Lab, GI Lab)
- **STEPDOWN**: Stepdown or Telemetry Unit
- **WARD**: Ward/Floor

Additional Information

- Can be based on Next Phase After IR, or Next Phase After Special Procedures.
- Field value cannot be left blank.

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

ICU ARRIVAL DATE

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 and the ICU Arrival Date should be *"Not Applicable".*
- Enter the null value of *"Not Applicable"* if the patient was not admitted to the ICU.
- Field value cannot be left blank.

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)

ICU EXIT DATE

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.
- Enter the null value of *"Not Applicable"* if the patient was not admitted to the ICU.
- Field value cannot be left blank.

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)

ICU LENGTH OF STAY (LOS)

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 (e.g., neuro checks, advanced respiratory support, etc.).
- 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

CONSULTATION DATE

Definition

Date during the patient's hospital stay when physician consultation occurred, if applicable.

Field Values

- Collected as MMDDYYYY

Additional Information

- Services requested in the ED that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- **A "phone response" is NOT to be utilized as an *Arrival Date*.** Physical evaluation of the patient is not possible via the phone.
- For Telemedicine consults (NES, Psych, and Tele Stroke) that do NOT evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- Enter the null value of *"Not Applicable"* if there were no hospital consultations.
- Field value cannot be left blank.

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 TIME

Definition

Time during the patient's hospital stay when physician consultation occurred, if applicable.

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Services requested in the ED that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- **A "phone response" is NOT to be utilized as an *Arrival Time*.** Physical evaluation of the patient is not possible via the phone.
- For Telemedicine consults (NES, Psych, and Tele Stroke) that do NOT evaluate the patient while in the ED should be listed in the **ICU/Acute Care** section.
- Enter the null value of *"Not Applicable"* if there were no hospital consultations.
- Field value cannot be left blank.

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

Additional Information

- Enter the null value of *"Not Applicable"* if there were no hospital consultations.
- Field value cannot be left blank.

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

CONSULTATION PHYSICIAN

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.
- Enter the null value of *"Not Applicable"* if there were no hospital consultations.
- 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

- Progress Notes
- Consultation Notes

Other Associated Elements

- CONSULTATION DATE
- CONSULTATION SERVICE

TQIP® TBI INCLUSION?

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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

Field Values

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

Additional Information

- Enter field value “N: No” for patients that do not meet the collection criteria, this will auto-populate *“Not Applicable”* to remaining TBI data fields.
- 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

- 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

INITIAL PUPILLARY RESPONSE

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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

Field Values

LA COUNTY		NTDS	
BOTH	Both Reactive	1	Both Reactive
ONE	One Reactive	2	One Reactive
NEITHER	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

HIGHEST GCS TOTAL

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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

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® 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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

Field Values

LA COUNTY		NTDS	
O	Obstruction to Patient's Eye	2	Obstruction to the patient's eye
S	Chemically Sedated/Paralyzed	1	Chemically Sedated Paralyzed
T	Intubated	3	Patient Intubated
TO	Intubated & Obstruction	3	Patient Intubated
		2	Obstruction to the patient's eye
TS	Intubated & Sedated/Paralyzed	3	Patient Intubated
		1	Chemically Sedated/Paralyzed
TSO	Intubated, Sedated/Paralyzed, & Obstruction	3	Patient Intubated
		1	Chemically Sedated/Paralyzed
		2	Obstruction to the patient's eye
SO	Sedated/Paralyzed & Obstruction	1	Chemically Sedated/Paralyzed
		2	Obstruction to the patient's eye
L	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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

Field Values

LA COUNTY		NTDS	
Y	Yes	1	Yes
N	No	2	No
O	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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

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 is acceptable if such a monitor was used by receiving facility to monitor and manage the patient with severe TBI.
- 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

CEREBRAL MONITOR DATE

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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

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

CEREBRAL MONITOR TIME

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. Exclude patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s) as those injuries are assigned to the External body region for calculating an ISS.

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

TQIP® VTE PROPHYLAXIS INCLUSION?

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

- If field value is *"N: No",* the **VTE Prophylaxis Type** will auto-populate to "None" and the **VTE Prophylaxis Date** and **Time** will auto-populate to *"Not Applicable".*
- 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”.
- Excludes: Sequential compression devices.
- If the first dose of VTE prophylaxis is administered post **Hospital Discharge Order Date/Time**, utilize “None”.
- 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

VTE PROPHYLAXIS DATE

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

VTE PROPHYLAXIS TIME

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).
- Excludes the discontinuation of CPR.
- Field value cannot be *"Not Applicable".*
- 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

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Definition

The date care was withdrawn, if applicable.

Field Values

- Collected as MMDDYYYY

Additional Information

- Report the date the **first** of an existing life-supporting intervention(s) is withdrawn (e.g., extubation). If no intervention(s) is in place, record the date the decision not to proceed with life-supporting intervention(s) occurred (e.g., intubation).
- 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

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Definition

The time of day care was withdrawn, if applicable.

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Report the time the **first** of an existing life-supporting intervention(s) is withdrawn (e.g., extubation). If no intervention(s) is in place, record the time the decision not to proceed with life-supporting intervention(s) occurred (e.g., intubation).
- 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

HOSPITAL DISPOSITION ORDER DATE

Definition

The **date the final order was written** for the patient to be transferred or discharged from the hospital, or the date the patient eloped, left AMA, or died in the hospital.

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
- TRASFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

HOSPITAL DISPOSITION ORDER TIME

Definition

The time of day **the final order was written** for the patient to be transferred or discharged from the hospital, or the time of day the patient eloped, left AMA, or died in the hospital.

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
- TRASFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

DISCHARGE DATE

Definition

The date the patient was discharged or transferred from the hospital, or the date the patient eloped, left AMA or died in the hospital.

Field Values

- Collected as MMDDYYYY

Additional Information

- If multiple orders were written, report the final disposition order.
- 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
- TRASFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

DISCHARGE TIME

Definition

The time of day the patient was discharged or transferred from the hospital, or the time of day the patient eloped, left AMA or died in the hospital.

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- If multiple orders were written, report the final disposition order time.
- 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
- TRASFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

PHASE PRIOR TO DISCHARGE

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 (e.g., Cath Lab, GI Lab)
- **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
- TRASFERRED/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	
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	13	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 Los Angeles General Medical Center	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

- 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.
- For patients that report their current place of residence as “homeless”, but are discharged to an existing residence, e.g., family member’s residence, enter “Home With” or “Home W/O”.
- 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			
ACH	Alhambra Hospital Medical Center	**KFW**	Kaiser Foundation Hospital – West LA
AHM	Catalina Island Medical Center	**LBM**	MemorialCare Long Beach Medical Center
AMH	USC Arcadia Hospital	**LCH**	Palmdale Regional Medical Center
AVH	Antelope Valley Medical Center	**LCM**	Providence Little Company of Mary Medical Center Torrance
BEV	Adventist Health White Memorial Montebello	**LMC**	Los Angeles General Medical Center
BMC	Southern California Hospital at Culver City	**MCP**	Mission Community Hospital
CAL	Dignity Health - California Hospital Medical Center	**MHG**	Memorial Hospital of Gardena
CHH	Children's Hospital Los Angeles	**MLK**	Martin Luther King Jr. Community Hospital
CHP	Community Hospital of Huntington Park	**MPH**	Monterey Park Hospital
CNT	Centinela Hospital Medical Center	**NOR**	Norwalk Community Hospital
CPM	Coast Plaza Hospital	**NRH**	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	**OVM**	Olive View-UCLA Medical Center
DCH	PIH Health Downey Hospital	**PAC**	Pacifica Hospital of the Valley
DFM	Cedars-Sinai Marina Del Rey Hospital	**PIH**	PIH Health Whittier Hospital
DHL	UCI Health - Lakewood	**PLB**	College Medical Center
ELA	East Los Angeles Doctors Hospital	**PVC**	Pomona Valley Hospital Medical Center
ENH	Encino Hospital Medical Center	**QOA**	Hollywood Presbyterian Medical Center
FPH	Emanate Health Foothill Presbyterian Hospital	**QVH**	Emanate Health Queen of the Valley Hospital
GAR	Garfield Medical Center	**SDC**	San Dimas Community Hospital
GEM	Greater El Monte Community Hospital	**SFM**	St. Francis Medical Center
GMH	Dignity Health - Glendale Memorial Hospital and Health Center	**SGC**	San Gabriel Valley Medical Center
GSH	PIH Health Good Samaritan Hospital	**SJH**	Providence Saint John's Health Center
GWT	Adventist Health Glendale	**SJS**	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	**SMH**	Santa Monica-UCLA Medical Center and Orthopaedic Hospital
HGH	Harbor-UCLA Medical Center	**SMM**	Dignity Health - St. Mary Medical Center
HMH	Huntington Hospital	**SOC**	Sherman Oaks Hospital
HMN	Henry Mayo Newhall Hospital	**SPP**	Providence Little Company of Mary Medical Center San Pedro
HWH	UCLA West Valley Medical Center	**TOR**	Torrance Memorial Medical Center
ICH	Emanate Health Inter-Community Hospital	**TRM**	Providence Cedars-Sinai Tarzana Medical Center
KFA	Kaiser Foundation Hospital – Baldwin Park	**UCL**	Ronald Reagan UCLA Medical Center
KFB	Kaiser Foundation Hospital – Downey	**VHH**	USC Verdugo Hills Hospital
KFH	Kaiser Foundation Hospital – South Bay	**VPH**	Valley Presbyterian Hospital
KFL	Kaiser Foundation Hospital – Los Angeles	**WHH**	Whittier Hospital Medical Center
KFO	Kaiser Foundation Hospital – Woodland Hills	**WMH**	Adventist Health White Memorial
KFP	Kaiser Foundation Hospital – Panorama City		

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	AHMC Anaheim Regional Medical Center	**LPI**	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	**PLH**	UCI Health - Placentia-Linda
FHP	UCI Health – Fountatin Valley	**SJD**	St. Jude Medical Center
KHA	Kaiser Foundation Hospital – Anaheim	**UCI**	University of California, Irvine Medical Center
KFI	Kaiser Foundation Hospital – Irvine	**WMC**	Orange County Global Medical Center
LAG	UCI Health - Los Alamitos		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	**KFN**	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	**LLU**	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	**SAC**	San Antonio Regional Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Regional Medical Center (Ventura)	**SJO**	Saint John's Regional Medical Center (Ventura)
SIM	Adventist Health Simi Valley (Ventura)	**RCC**	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Veteran's Administration Hospital – Long Beach	**WVA**	Veteran's Administration Hospital – West LA/Wadsworth

REHABILITATION CENTERS			
AMR	Methodist Hospital of Southern California (Rehab Center)	**LBR**	MemorialCare Long Beach Medical Center (Rehab Center)
BMR	Southern California Hospital at Culver City (Rehab Center)	**LMR**	La Mirada Physicians Medical Center (Rehab Center)
CCC	Casa Colina Centers for Rehabilitative Medicine	**NRR**	Dignity Health-Northridge Hospital Medical Center (Rehab Center)
CHR	Children's Hospital of Los Angeles (Rehab Center)	**OTR**	Other Rehabilitation Center
CNR	Centinela Hospital Medical Center (Rehab Center)	**PIR**	PIH Health – Whittier (Rehab Center)
CRI	California Rehabilitation Institution	**QOR**	Hollywood Presbyterian Medical Center (Rehab)
DFR	Cedars-Sinai Marina Del Rey Hospital (Rehab Center)	**QVR**	Emanate Health Queen of the Valley Hospital (Rehab Center)
ENR	Encino Hospital Medical Center (Rehab Center)	**RLA**	LAC/Rancho Los Amigos National Rehabilitation Center
GMR	Dignity Health-Glendale Memorial Hospital & Health Center (Rehab Center)	**SMR**	Dignity Health-St. Mary Medical Center (Rehab Center)
GRR	Garfield Medical Center (Rehab Center)	**SPR**	Providence Little Company of Mary Medical Center-San Pedro (Rehab Center)
GSR	Good Samaritan Hospital (Rehab Center)	**TMR**	Torrance Memorial Medical Center (Rehab Center)
GWR	Adventist Health-Glendale (Rehab Center)	**USR**	LAC+USC Medical Center (Rehab Center)
HCR	Providence Holy Cross Medical Center (Rehab Center)	**VMR**	Valley Hospital Medical Center (Rehab Center)
HMR	Huntington Hospital (Rehab Center)	**WHR**	Adventist Health-White Memorial (Rehab Center)
HNR	Henry Mayo Newhall Memorial Hospital (Rehab Center)		

BURN CENTERS			
HWB	West Hills Regional Medical Center (Grossman Burn Center)	**USB**	Los Angeles General Medical Center (Burn Center)
TOB	Torrance Memorial Hospital (Burn Center)	**OTB**	Other Burn Center
UCB	UCI Medical Center (Burn Center)		

DISASTER RECEIVING FACILITIES			
BRH	Barlow Respiratory Hospital	**NCH**	USC Kenneth Norris Jr. Cancer Center
COA	L.A. Downtown Medical Center	**PAM**	Pacific Alliance Medical Center
COH	City of Hope National Medical Center	**RLA**	LAC-Rancho Los Amigos
LAC	Los Angeles Community Hospital – Olympic	**TEM**	Temple Community Hospital
HOL	Southern California Hospital at Hollywood	**USH**	Keck Hospital of USC
KMC	Kern Medical Center		

SKILLED NURSING FACILITIES			
ACS	Alhambra Healthcare	**LCS**	Providence Little Company of Mary Transitional Care Center
CAS	California Post-Acute	**LDS**	Lanterman Development Center (SNF)
ENS	Encino Hospital Medical Center (SNF)	**LES**	Las Encinas Hospital
GHS	Granada Hills Convalescent Hospital	**MHS**	Skyline Healthcare Center
GMS	Glendale Memorial Hospital and Health Center	**OTS**	Other Skilled Nursing Facility
GSS	Good Samaritan Hospital (SNF)	**SFS**	St. Francis Medical Center (SNF)
GWS	Glendale Post-Acute Center	**SGS**	San Gabriel Convalescent Center
HCS	Holy Cross Medical Center (SNF)	**SHS**	Santa Monica Health Care Center
HMS	Huntington Post-Acute		
LBS	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

TRANSFERRED OUT VIA

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		
CU	In Custody	Patient discharged/transferred in custody of law enforcement
EX	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.
FI	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
HO	Hospice	Patient transferred to hospice
HP	Health Plan	Health Plan decision
OT	Other	Transfer rationale other than above (**Includes** Psych, Repatriation, Patient and/or Family Request)
RH	Rehab	Patient required rehabilitation
SH	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 (**Excludes** 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
- TRASFERRED/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		
H	PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
T	TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
P	PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

Additional Information

- The value of "T" for Temporary Handicap may be utilized for patients transferred to another acute care hospital for higher level of trauma care.
- 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 in 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
- TRASFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE

LIVED/DIED

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, however, they are entered in the database as **"L: Lived".**
- Field value cannot be left blank.

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
- TRASFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #

AUTOPSY UPDATE?

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 #

CORONER

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?

ORGAN REFERRAL?

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

ORGAN DONOR?

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

ORGANS DONATED

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?

DISCHARGE DIAGNOSES – ICD-10 CODES

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
1 – Body Region 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	**8** = Body Region: **Lower Extremity**
2 – Type of Anatomic Structure	**5** = Type of Anatomic Structure: **Skeletal**
3 & 4 – Specific Anatomic Structure	**18** = Specific Anatomic Structure: **Femur**
5 & 6 – Level of Injury	**14** = Level of Injury: **Shaft**
.7 – AIS: Severity Score (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	**.3** = AIS: Severity Score: **Serious**

- 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 *(Pre-existing)* 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)
Autism Spectrum Disorder	Autism Spectrum Disorder
Bipolar I/II Disorder	Bipolar I/II Disorder
Bleeding Disorder	Bleeding Disorder
Bronchopulmonary Dysplasia/Chronic Lung Disease	Bronchopulmonary Dysplasia/Chronic Lung Disease
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
Major Depressive Disorder	Major Depressive Disorder
Myocardial Infarction (MI)	Myocardial Infarction (MI)
Other Mental/Personality Disorders	Other Mental/Personality Disorders
Peripheral Arterial Disease (PAD)	Peripheral Arterial Disease (PAD)
Post-Traumatic Stress Disorder	Post-Traumatic Stress Disorder
Pregnancy	Pregnancy
Prematurity	Prematurity
Schizoaffective Disorder	Schizoaffective Disorder
Schizophrenia	Schizophrenia
Seizure Disorder	
Steroid Use	Steroid Use
Ventilator Dependance	Ventilator Dependance

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

DATE OF READMISSION

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

TIME OF READMISSION

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.
- If the patient is admitted to an inpatient bed from the ED, enter the time the patient returned to the ED. If patient was directly admitted to the hospital, enter the time the patient was re-admitted to the hospital.

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

READMISSION COMMENT

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, trauma, or NTDS 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

READMISSION PROCEDURE/OR PHASE BEGUN

Definition
Phase of care where operative or essential major and minor procedures conducted during readmission 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
- **SPECIAL**: Special Procedures (e.g., Cath Lab, GI Lab)
- **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.
- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

READMISSION PROCEDURE/OR START DATE

Definition

Date when operative or essential major and minor procedures conducted during readmission 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

Additional Information

- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

READMISSION PROCEDURE/OR START TIME

Definition

Time of day when operative or essential major and minor procedures conducted during readmission 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

Additional Information

- The start time is the "incision time", "cut time", or "puncture time", not the time the patient arrived in the OR, IR, or Special Procedures unit.
- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

READMISSION PROCEDURE/OR END TIME

Definition

Time of day when operative or essential major and minor procedures conducted during readmission 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

Additional Information

- Field value must be *"Not Applicable",* if no procedure was performed.
- Field value cannot be left blank.

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

READMISSION PROCEDURES *(ICD-10 Codes)*

Definition

Operative or essential major and minor procedures conducted during readmission 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: • Chest, Open • Chest, Percutaneous **Special Note:** 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: • Open • Percutaneous • Percutaneous Endoscopic	06H00DZ 06H03DZ 06H04DZ
Chest Tube (left)	0W9B30Z	Interventional Angiogram (IA) **Special Note:** The ICD-10 Code for IA varies depending on the site and the approach used.	
Chest Tube (right)	0W9930Z		
Cricothyroidotomy Approach: • Open • Percutaneous • Percutaneous Endoscopic	0B110F4 0B113F4 0B114F4	Intracranial Pressure (ICP) Monitor: • Percutaneous • Via Natural or Artificial Opening	4A103BD 4A107BD
Diagnostic Peritoneal Aspirate (DPA)	0W9G3ZX	Percutaneous Endoscopic Gastrostomy (PEG) Approach: • Percutaneous • Percutaneous Endoscopic	0DH63UZ 0DH64UZ
Diagnostic Peritoneal Lavage (DPL)	3E1M38X		
Embolization: **Special Note:** The ICD-10 Code for embolization varies depending on the site embolized and the approach used.		Thoracotomy	02JA0ZZ
		Tracheostomy Approach: • Open • Percutaneous • Percutaneous Endoscopic	0B110F4 0B113F4 0B114F4
Endotracheal (ETT) Intubation: • Via Natural or Artificial Opening • Via Natural or Artificial Opening Endoscopic	0BH17EZ 0BH18EZ	Ventilator: • Less than 24 Consecutive Hours • 24-96 Consecutive Hours • > 96 Consecutive Hours	5A1935Z 5A1945Z 5A1955Z
		Special Note: The ICD-10-PCS ventilator code is based on hours on the ventilator; therefore, the code may be different than the Total Number of Ventilator Days.	

Additional Information

- Optional operative or essential major and minor procedures ICD-10-CM codes conducted during hospital stay include, but are not limited to, the following: Licox, Bronchoscopy, & PICC line.
- All Operative or essential major and minor procedures must be entered.
- Field value must be *"Not Applicable",* if no procedure was performed.
- 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

- 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

SURGERY TYPE

Definition

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

Field Values

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

Additional Information

- Field value must be *"Not Applicable",* if no procedure was performed.
- 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

- 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

PHYSICIAN CODE

Definition

Name or MD code of the surgeon that performed the major or minor surgical procedure, if applicable.

Field Values

- Free text

Additional Information

- Major or minor surgical procedures can occur during any phase of care (e.g., ED, ICU, Special Procedures), not specifically in the OR or IR.
- Non-picklist – free text physician name or code at discretion of each facility.
- Field value must be *"Not Applicable"* if no procedure was performed.
- 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

- 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

READMISSION DISCHARGE DATE

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

READMISSION DISCHARGE TIME

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

READMISSION PRIOR PHASE

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 (e.g., Cath Lab, GI Lab)
- **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

READMISSION 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 Los Angeles General Medical Center	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

- 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.
- For patients that report their current place of residence as “homeless”, but are discharged to an existing residence, e.g., family member’s residence, enter “Home With” or “Home W/O”.
- Patients discharged to Hospice care are considered a death by TQIP® for purposes of risk-adjusted benchmark reporting.

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

READMISSION TRANSFER RATIONALE

Definition

The rationale for transfer following the unplanned readmission, if applicable.

Field Values

LA COUNTY		
CU	In Custody	Patient discharged/transferred in custody of law enforcement
EX	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.
FI	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
HO	Hospice	Patient transferred to hospice
HP	Health Plan	Health Plan decision
OT	Other	Transfer rationale other than above (**Includes** Psych, Repatriation, Patient and/or Family Request)
RH	Rehabilitation	Patient required rehabilitation
SH	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 (**Excludes** Psych)

Additional Information

- Enter the null value of *"Not Applicable"* if the patient was not transferred to another facility.

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

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

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	AHMC Anaheim Regional Medical Center	**LPI**	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	**PLH**	UCI Health - Placentia-Linda l
FHP	UCI Health - Fountain Valley	**SJD**	St. Jude Medical Center
KHA	Kaiser Foundation Hospital – Anaheim	**UCI**	University of California, Irvine Medical Center
KFI	Kaiser Foundation Hospital – Irvine	**WMC**	Orange County Global Medical Center
LAG	UCI Health - Los Alamitos		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	**KFN**	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	**LLU**	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	**SAC**	San Antonio Regional Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Regional Medical Center (Ventura)	**SJO**	Saint John's Regional Medical Center (Ventura)
SIM	Adventist Health - Simi Valley (Ventura)	**RCC**	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Veteran's Administration Hospital – Long Beach	**WVA**	Veteran's Administration Hospital – West LA/Wadsworth

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 DISCHARGE CAPACITY

READMISSION DISCHARGE CAPACITY

Definition

Patient's gross functional capacity upon discharge following the unplanned readmission.

Field Values

LA COUNTY		
H	PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
T	TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained

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	
Private/Commercial:		
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
Medicaid:		
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
Self:		
Cash	3	Self Pay
ATP Liability	3	Self Pay
Pre-pay	3	Self Pay
Not billed:		
Charity	2	Not Billed (for any reason)
ATP without Ability to Pay	2	Not Billed (for any reason)
Government:		
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
Other	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

TOTAL HOSPITAL CHARGES

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

RECORD COMPLETE?

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

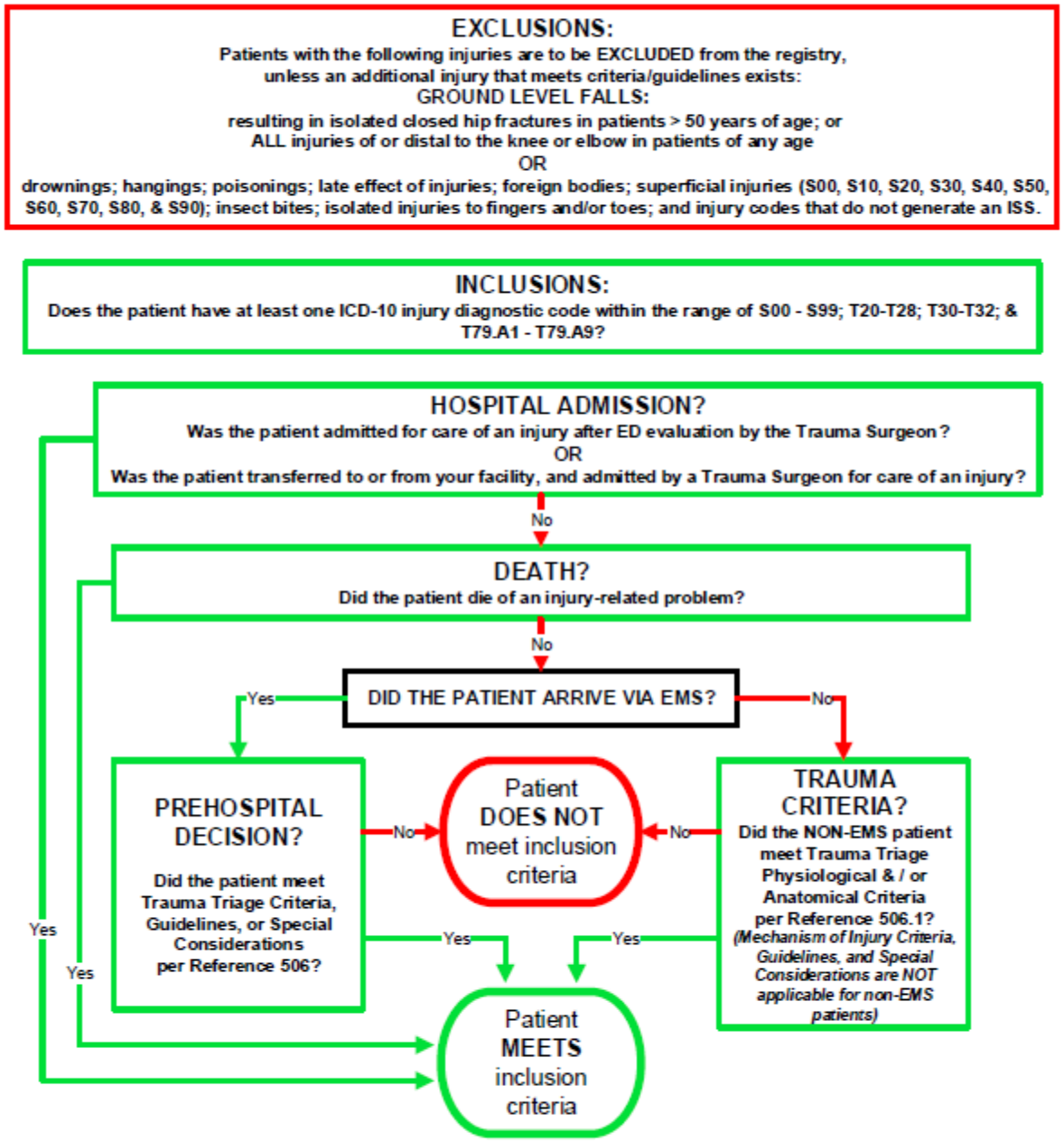
- Identifies if the record is complete for export to NTDB® and TQIP®.
- System evaluation and monitoring.

APPENDIX 1: Reference Documents

LOS ANGELES COUNTY TRAUMA DATABASE INCLUSION CRITERIA

TRAUMA CENTER SERVICE AGREEMENT

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM



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)

NATIONAL TRAUMA DATA STANDARD (NTDS®) INCLUSION CRITERIA 2025

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

- Patients transferred from one acute care hospital** to another acute care hospital;

OR

- Patients transferred/discharged to hospice (e.g., hospice facility, hospice unit, home hospice);

OR

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

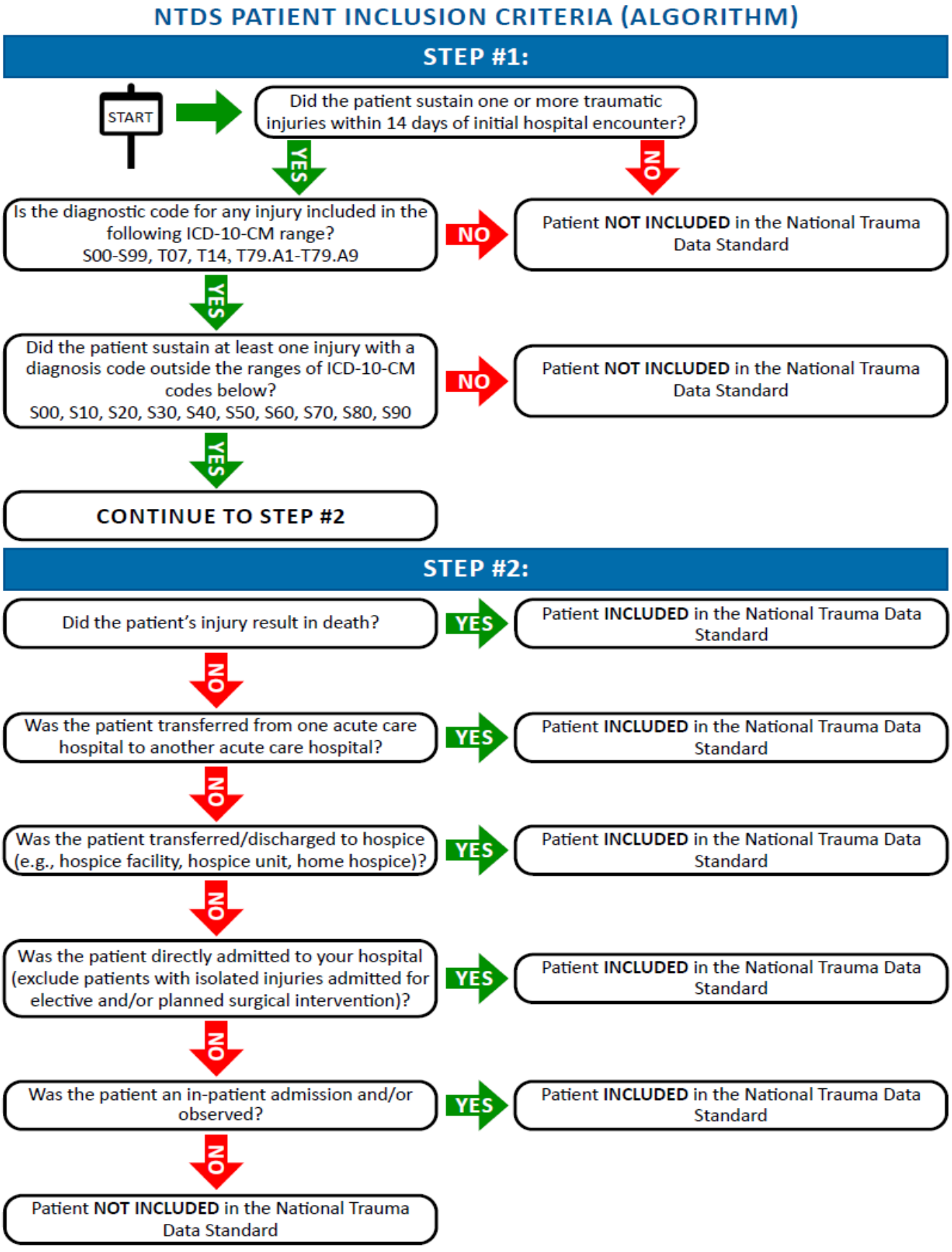
OR

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

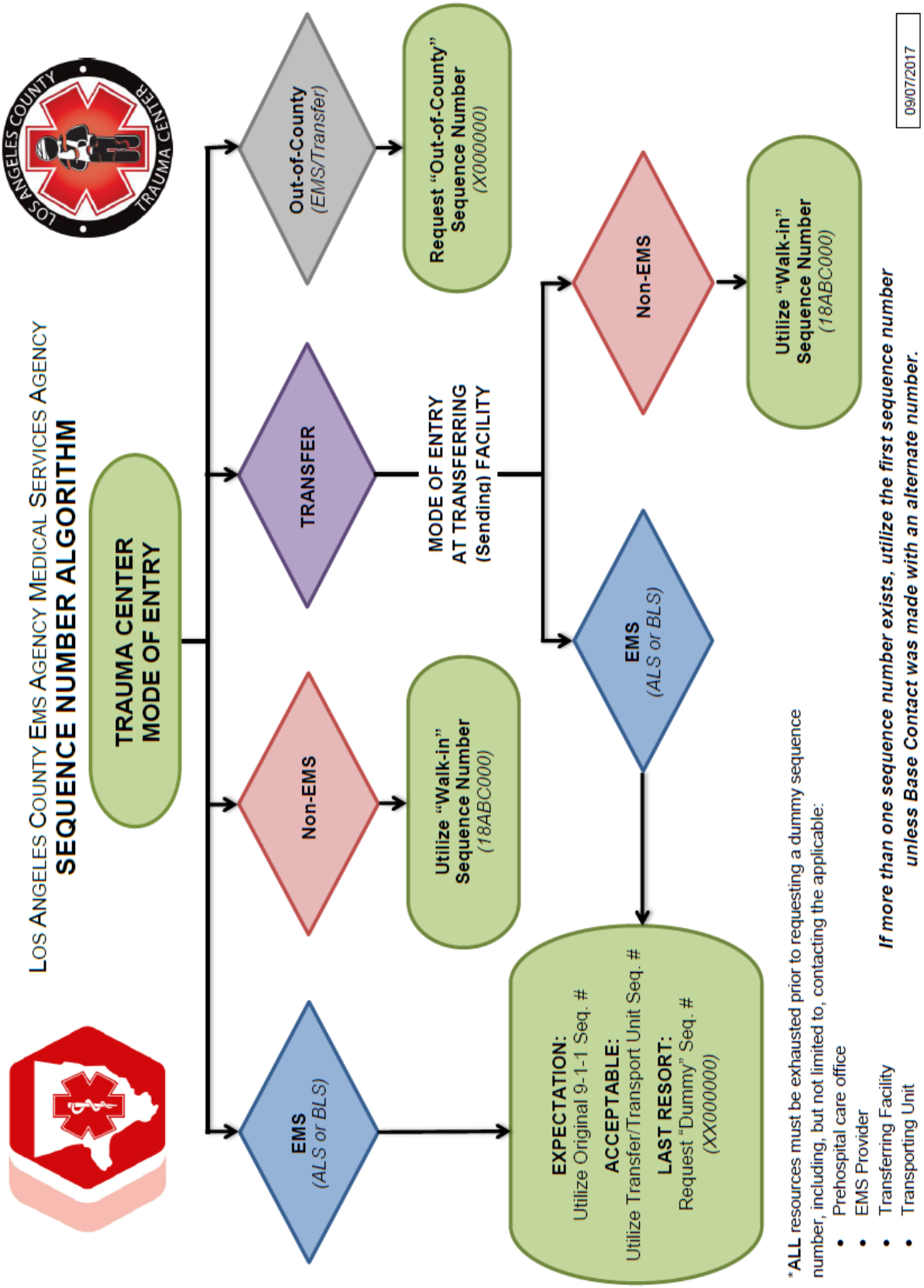
*In-house traumatic injuries sustained after initial ED/hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.

**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 (accessed January 15, 2019).

NTDS® INCLUSION CRITERIA ALGORITHM 2025



SEQUENCE NUMBER ALGORITHM



MECHANISM OF INJURY REFERENCE GUIDE

Transportation Mechanisms of Injuries Quick Reference Guide

If patient is:	AND:	Then applicable MOI choices are:
STRUCK BY a moving transport, and NOT in an enclosed vehicle	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)***
OPERATING any transport	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-10 defines a transport accident (V00-V099) as any accident involving a device designed primarily for, or used at the time primarily for, conveying persons or goods from one place to another.

ENCLOSED transports include, but are not limited to:	**UNENCLOSED** transports include, but are not limited to:	
• Cars/Trucks • Vans • Buses • Planes • Trains	• Bicycles • Roller skates/blades • Skateboards • Scooters • Wheelchairs • Horses • Watercraft	• ATVs • Motorcycles • Motorized bicycles (mopeds) • Motorized scooters • Golf carts

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. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

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	Tenacteplase
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

Autism Spectrum Disorder (ASD): A disorder involving problems with social communication and interaction, and restricted or repetitive behaviors or interests as well as different ways of learning, moving, or paying attention, disorder is present prior to injury. A diagnosis of ASD must be documented in the patient's medical record (e.g., autism, autism spectrum disorder, or Asperger's syndrome/disorder).

Bipolar I/II Disorder: A bipolar I/II disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age, based on the patient's age the day of arrival at the hospital.

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.

Bronchopulmonary Dysplasia/Chronic Lung Disease: Disorders which constitute Chronic Lung Disease (CLD) generally have a slow tempo of progression over may months or even years. The most common causes of CLD in children are Cystic Fibrosis (CF), and other causes of bronchiectasis (such as immunodeficiency, and in the third world, post-infective bronchiectasis (e.g., measles), Bronchopulmonary Dysplasia (BPD), or lung disease of prematurity), disorder is present prior to injury. Only report on patients ≤14 years-of age.

Cerebral Vascular Accident (CVA): A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor, sensory, or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory). A diagnosis of CVA must be documented in the patient's medical record.

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. A diagnosis of COPD must be documented in the patient's medical record, present prior to injury, 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. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

Cirrhosis: Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver disease. A diagnosis of cirrhosis or end-stage liver disease by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record. Documentation in the medical record may include CHILD and MELD scores that support evidence of cirrhosis.
Exclude: Patients who no longer have cirrhosis due to a successful liver transplant

Congenital Anomalies: Documentation of a cardiac, pulmonary, airway, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly, present prior to injury. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record. Only report on patients <15 years-of -age, based on the patient's age on the day of arrival at the hospital.

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, present prior to injury. A diagnosis of Dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) or vascular 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.

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 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 cancer".

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

Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

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.

Major Depressive Disorder: A major depressive disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

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.

Other Mental/Personality Disorders: A diagnosis of any of the following documented in the medical record:

- Antisocial personality disorder
- Avoidant personality disorder
- Borderline personality disorder
- Dependent personality disorder
- Generalized anxiety disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Obsessive-compulsive disorder
- Obsessive-compulsive personality disorder
- Panic disorder
- Paranoid personality disorder
- Schizotypal personality disorder

The diagnosis must be present prior to injury. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

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. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

Post-Traumatic Stress Disorder: A post-traumatic stress disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

Pregnancy: Pregnancy confirmed by lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient's medical record.

Prematurity: Babies born before 37 weeks of pregnancy are completed. A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record. Only report on patients <15 years-of-age, based on the patient's age on the day of arrival at the hospital.

Schizoaffective Disorder: A schizoaffective disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

Schizophrenia: A schizophrenia diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age, based on the patient's age on the day of arrival at the hospital.

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.

Ventilator Dependence: Patients who are ventilator dependent with a tracheostomy prior to injury.

HOSPITAL *(EVENTS)* COMPLICATIONS

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 ≥4mg/dl (≥353.6µmol/l)

OR

- Patients <18 years with a decrease in $_{e}$GFR to <35 ml/min per 1.73m^2

OR

- Reduction in urine output of <0.3 ml/kg/hr for ≥24 hours

OR

- Anuria for ≥12 hours

OR

- Requiring renal replacement therapy (e.g., continuous renal replacement therapy (CRRT) or periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration).

Onset of AKI Stage 3 began after arrival to your ED/hospital.

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.

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 collage, 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 200mmHg<PaO_2/FIO_2<300mmHg **WITH** PEEP or CRAP≥5cm H_2Oc
	Moderate 100mmHg<PaO_2/FIO_2<200mmHg **WITH** PEEP>5cm H_2O
	Severe PaO_2/FIO_2<100mmHg **WITH** PEEP or CRAP≥5cm H_2O

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:
- fever (>38^{0}C)
- chills
- 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^{0}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 (NPUAP Stage II) 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 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 if 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 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 sub segmental 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^{0}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 >10^5 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^{0}C)
    - hypothermia (<36.0^{0}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 ≥10^5 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 **one** of the following: • New or progressive **and**	At least **one** of the following: • Fever (>38^{0}C or >100.4^{0}F) • Leukopenia (<4000 WBC/mm^3)or leukocytosis (≥12,000WBC/mm^3) • For adults ≥70 years old,	At least **one** of the following: • Positive growth in blood culture not related to another source of infection • Positive growth in culture of pleural fluid

persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old **NOTE:** In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.	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.,0_2 desaturations (e.g., PaO_2/FiO_2≤240), increased oxygen requirements, or increased ventilator demand)	• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP ALGORITHM (PNU2 VIRAL, LEGIONNELLA, AND OTHER BACTERIAL PNEUMONIAS):

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old **NOTE:** In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.	At least **one** of the following: • Fever (>38^{0}C or >100.4^{0}F) • Leukopenia (<4000 WBC/mm^3) or leukocytosis (≥12,000WBC/mm^3) • For adults ≥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.,0_2 desaturations (e.g.,PaO_2/FiO_2≤240), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Positive culture of virus, Legionella or Chlamydia from respiratory secretions • Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus,Bordetella, Chylamydia, Mycoplasma, Legionella (e.g., EIA<FAMA< shell vial assay, PCR,micro-IF) • Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia) • Fourfold rise in L. pneumophila serogroup 1 antibody titer to ≥1:128in pared acute and convalescent sera by indirect IFA • Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP ALGORITHM (PNU3 IMMUNOCOMPROMISED PATIENTS):

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old **NOTE:** In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.	Patient who is immunocompromised has at least **one** of the following: • Fever (>38^{0}C or >100.4^{0}F) • For adults ≥70 years old, altered mental status with no other recognized cause • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g.,0_2 desaturations (e.g.,PaO_2/FiO_2≤240), increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	At least **one** of the following: • Identification of matching Candida spp. From blood and sputum, endotracheal aspirate, BAL, or protected specimen brushing 11, 12, 13 • Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: ○ Direct microscopic exam ○ Positive culture of fungi ○ Non-culture diagnostic laboratory test Any of the following: **LABORATORY CRITERIA DEFINED UNDER PNU2**

VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR INFANT'S ≤1 YEAR OLD:

Radiology	Signs/Symptoms
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1year 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	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (<4000 WBC/mm^3) **or** leukocytosis (≥15,000WBC/mm^3) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR CHILDREN >1 YEAR OLD OR ≤12 YEARS OLD:

Radiology	Signs/Symptoms/Laboratory

Two or more serial chest radiographs with at least **one** of the following:

- New or progressive **and** persistent infiltrate
- Consolidation
- Cavitation
- Pneumatoceles, in infants ≤1year 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

At least **three** of the following:

- Fever (>38.0^{0}C or >100.4^{0}F) or hypothermia (<36.0^{0}C or <96.8^{0}F)
- Leukopenia (<4000 WBC/mm^3) **or** leukocytosis (≥15,000WBC/mm^3)
- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- New onset or worsening cough, or dyspnea, apnea, or tachypnea
- Rales or bronchial breath sounds
- Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand

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
14	GCS ≤**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.
90	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.
BA	**B**lunt **A**bdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt force.
BB	**B**lunt **B**ack: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt force.
BC	**B**lunt **C**hest: 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.
BD	**B**lunt **D**iffuse Abdominal Tenderness: Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.
BE	**B**lunt **E**xtremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt force.
BF	**B**lunt **F**ace/mouth: 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.
BG	**B**lunt **G**enitals: Injury to the external reproductive structures due to blunt force.
BH	**B**lunt **H**ead: 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.
BI	**B**lunt Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to blunt force.
BK	**B**lunt Buttoc**K**s: Injury to the buttocks due to blunt force.
BL	**B**lunt Minor **L**acerations: Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt force.
BN	**B**lunt **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt force.
BP	**B**lunt Tension **P**neumothorax: Injury resulting in air entering the pleural space due to blunt force, creating pressure on chest organs.
BR	**B**lunt F**R**acture of 2 or more long bones: Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).
BT	**B**lunt **T**rauma Arrest: Cessation of cardiac output and effective circulation due to blunt force.
BU	**BU**rns/Elec. Shock: Thermal or chemical burn, or electric shock.
BV	**B**lunt extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to blunt force.
CB	**C**ritical **B**urn: Patients ≥15 years w/ 2nd and 3rd degree burns involving ≥20% Total Body Surface Area (TBSA) or Patients ≤14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA.

INJURY DESCRIPTION	
FC	**F**lail **C**hest: Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations.
IT	**I**npatient **T**rauma: Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers.
NA	**N**o **A**pparent Injury: No complaint, or signs or symptoms of injury following a traumatic event.
PA	**P**enetrating **A**bdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to penetrating force.
PB	**P**enetrating **B**ack: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force.
PC	**P**enetrating **C**hest: 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	**P**enetrating **E**xtremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to penetrating force.
PF	**P**enetrating **F**ace/mouth: 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	**P**enetrating **G**enitals: Injury to the external reproductive structures due to penetrating force.
PH	**P**enetrating **H**ead: 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	**P**enetrating Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to penetrating force.
PK	**P**enetrating Buttoc**K**s: Injury to the buttocks due to penetrating force.
PL	**P**enetrating Minor **L**acerations (Penetrating): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to penetrating force.
PN	**P**enetrating **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force.
PP	**P**enetrating Tension **P**neumothorax: Injury resulting in air entering the pleural space due to penetrating force, creating pressure on chest organs.
PT	**P**enetrating **T**rauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force.
PV	**P**enetrating extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to penetrating force.
PX	**P**enetrating e**X**tremity injury proximal to (above) the knee or elbow due to penetrating force.
RR	**RR** <10/>29 (<20 if <1y): 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	**S**pinal **C**ord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.
SX	**S**uspected Pelvic Fracture: Suspected pelvic fracture, e**X**cluding isolated hip fractures from a ground level fall.
UB	**U**ncontrolled **B**leeding: 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.
10	Fall 10 ft. (All patients): A vertical, uninterrupted fall of 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	**AN**imal Bite: The teeth of a human, reptile, dog, cat, or other animal inflicted an injury.
AS	**AS**sault: Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting.
CR	**CR**ush: Injury sustained as the result of external pressure being placed on body parts between two opposing forces.
EJ	**EJ**ected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles.
ES	**E**lectrical **S**hock: Passage of an electrical current through the body due to contact with an electrical source.
EV	**E**nclosed **V**ehicle: Patient involved in collision while in an enclosed vehicle, such as an automobile, bus, or other enclosed motorized vehicle.
EX	**EX**trication: Use of a pneumatic tool was required to remove patient from the vehicle.
FA	**FA**ll: Any injury resulting from a fall from any height.
GS	**G**un**S**hot Wound (GSW): Injury was caused by discharge of a gun (accidental or intentional).
HE	**H**azmat **Ex**posure: An injury that occurs as a result of a hazmat exposure.
MM	**M**otorcycle/**M**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	**OT**her: A cause of injury that does not fall into any of the existing categories.
PB	**P**edestrian/**B**icyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH.
RT	Moving auto vs. pedestrian/bicyclist/motorcyclist: **R**un over, **T**hrown, or estimated impact of >20 MPH.
SA	**S**elf-Inflicted, **A**ccidental: The injury appears to have been accidentally caused by the patient.
SF	**S**urvived **F**atal crash: An injured patient that survived a collision in which a person in the same vehicle was fatally injured.
SI	**S**elf-Inflicted, **I**ntentional: The injury appears to have been intentionally caused by the patient.
SP	**SP**orts/Recreation: Any injury that occurs during a sporting or recreational athletic activity.
ST	**ST**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	**TA**ser: Injury due to the deployment of a conducted electrical weapon (CEW), e.g. Taser®.
TB	**T**hermal **B**urn: Burn caused by heat.
TD	**T**elemetry **D**ata: Vehicle telemetry data that is consistent with high risk of serious injury.
UN	**UN**known: The cause or mechanism of injury is unknown.
WR	**W**ork-**R**elated: Injury occurred while patient was working.

CRITERIA/GUIDELINES/SPECIAL CONSIDERATIONS *(ED)*

LA COUNTY	
Physiological & Anatomical Criteria	
14	GCS ≤**14**: 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.
70	SBP <**70**: Systolic blood pressure less than 70mmHg in a patient less than one year of age following a traumatic event.
90	SBP <**90**: Systolic blood pressure less than 90mmHg in a patient greater than one year of age following a traumatic event.
BD	**B**lunt **D**iffuse Abdominal Tenderness: Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.
BI	**B**lunt Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to blunt force.
BR	**B**lunt F**R**acture of 2 or more long bones: Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).
BV	**B**lunt extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to blunt force.
CB	**C**ritical **B**urn: Patients ≥15 years w/ 2nd and 3rd degree burns involving ≥20% Total Body Surface Area (TBSA) or Patients ≤14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA.
FC	**F**lail **C**hest: Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations.
PA	**P**enetrating **A**bdomen: Injury to the abdomen, flanks, or pelvis due to penetrating force.
PC	**P**enetrating **C**hest: 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.
PF	**P**enetrating **F**ace/mouth: 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	**P**enetrating **G**enitals: Injury to the external reproductive structures due to penetrating force.
PH	**P**enetrating **H**ead: 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	**P**enetrating Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to penetrating force.
PK	**P**enetrating Buttoc**K**s: Injury to the buttocks due to penetrating force.
PN	**P**enetrating **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force.
PT	**P**enetrating **T**rauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force.
PV	**P**enetrating extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to penetrating force.
PX	**P**enetrating e**X**tremity injury proximal to (above) the knee or elbow due to penetrating force.
PY	**P**enetrating Back: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force. Wh**Y**, because PB was already used.
RR	**RR** <10/>29 (<20 if <1y): 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	**S**pinal **C**ord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.
SX	**S**uspected Pelvic Fracture: Suspected pelvic fracture, e**X**cluding isolated hip fractures from a ground level fall.

Mechanism of Injury Criteria	
10	Fall 10 ft. all patients: A vertical, uninterrupted fall of 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.
20	An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of >**20** mph, not involving a moving auto.
EJ	**EJ**ected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles.
12	Intrusion of >12 inches into an occupied passenger space.
RT	Moving auto vs. pedestrian/bicyclist/motorcyclist: **R**un over, **T**hrown, or estimated impact of >20 MPH
Guidelines	
18	Intrusion of >**18** inches into an unoccupied passenger space.
AN	Injured patient on **AN**ticoagulant Medication (other than aspirin only) or with known bleeding disorder.
EX	**EX**trication: Use of a pneumatic tool was required to remove patient from the vehicle.
PB	**P**edestrian/**B**icyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH.
SF	**S**urvived **F**atal crash: An injured patient that survived a collision in which a person in the same vehicle was fatally injured.
TD	**T**elemetry **D**ata: Vehicle telemetry data that is consistent with high risk of serious injury.
Special Considerations	
BT	**B**lunt **T**rauma Arrest: Cessation of cardiac output and effective circulation due to blunt force.
BP	Systolic **B**lood **P**ressure less than 110mmHg for patient greater than 65 years of age following a traumatic event.
IU	Injured patient with an **I**ntra**U**terine pregnancy greater than 20 weeks.
PJ	**P**rehospital **J**udgment that transport to Trauma Center is in the patient's best interest.

APPENDIX 3: Auto-Calculated Variables

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