Pediatric Data Dictionary

Los Angeles County

Emergency Medical Services Agency

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Contents

INCLUSION CRITERIA

IS THE PATIENT LESS THAN OR EQUAL TO 14 YEARS OF AGE?

Definition

Checkbox indicating whether the patient is less than or equal to 14 years old

Field Values

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

Uses

- Identify patients for inclusion into database
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- EMS Report Form
- Base Hospital Form
- ED Records

GENERAL INFORMATION TAB

MODE OF ARRIVAL

Definition

Checkbox indicating whether the patient was transported to your facility by EMS via the 9-1-1 system ALS or walk into emergency department

Field Values

- **Walk In**
- **EMS ALS**

Uses

- Identify patients for inclusion into database
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- EMS Patient Care Record
- Notification Form
- Notification Log
- Base Hospital Form

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the EMS provider. Found pre-printed at the top right corner of EMS report form hard copies, or electronically assigned to electronic patient care records (ePCRs) from approved providers

Additional Information

- Data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider
- If sequence number is missing or incorrectly documented, every effort must be taken to obtain it – by reviewing the patient's medical record, or by contacting either the Prehospital Care Coordinator of the applicable base hospital or the EMS provider that transported the patient

Uses

- Unique patient identifier

Data Source Hierarchy

- ED Records
- EMS Patient Care Record
- Notification Form
- Notification Log
- Base Hospital Form

VISITOR IDENTIFICATION NUMBER

Definition

Unique, numeric record numbers.

Additional Information

- Data entry cannot begin without this number
- Consists of digits.

Uses

- Unique patient identifier

PROVIDER

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	MB	Manhattan Beach Fire
AH	Alhambra Fire	MF	Monrovia Fire
AV	Avalon Fire	MO	Montebello Fire
BA	Burbank Airport Fire	MP	Monterey Park Fire
BF	Burbank Fire	ND	Not Documented
BH	Beverly Hills Fire	OT	Other Provider
CB	LA County Beaches	PF	Pasadena Fire
CC	Culver City Fire	RB	Redondo Beach Fire
CF	LA County Fire	SA	San Marino Fire
CG	US Coast Guard	SG	San Gabriel Fire
CI	LA City Fire	SI	Sierra Madre Fire
CM	Compton Fire	SM	Santa Monica Fire
CS	LA County Sheriff	SP	South Pasadena Fire
DF	Downey Fire	SS	Santa Fe Springs Fire
ES	El Segundo Fire	TF	Torrance Fire
FS	U.S. Forest Service	UF	Upland Fire
GL	Glendale Fire	VE	Ventura County Fire
LB	Long Beach Fire	VF	Vernon Fire
LH	La Habra Heights Fire	WC	West Covina Fire
LV	La Verne Fire		

- **ND:** Not Documented
- **NA:** Not Applicable

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Patient Care Record
- Notification Log
- Notification Form
- ED Records
- Base Hospital Form

PH-DISPATCH DATE

Definition

Date the provider was notified by dispatch of the incident

Field Values

- Collected as **MMDDYYYY**

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- EMS Patient Care Record

PH-DISPATCH TIME

Definition

Time of day the provider was notified by dispatch of the incident

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- EMS Patient Care Record

ED ARRIVAL DATE

Definition

The date the patient arrived at your facility

Field Values

- Collected as **MMDDYYYY**
- **ND:** Not documented

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical

ED ARRIVAL TIME

Definition

The time of day that the patient arrived at your facility

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical

AGE

Definition
Numeric value for the age (actual or best approximation) of the patient

Field Values
- **Up to two-digit positive numeric value**

Additional Information
- Enter the numeric age value Additional Information
- Required field for all notification calls
- Must also indicate unit of age Uses
- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy
- Facesheet
- ED Records
- History and Physical

AGE UNITS

Definition
Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Years** – used for patients 2 years old or older
- **Months** – used for patients 1 month to 23 months old
- **Weeks** – used for patients whose age is reported in weeks instead of months
- **Days** – used for patients 1 to 29 days old
- **Hours** – used for patients who are newborn and up to 23 hours old
- **ND:** Not Documented
- **NA:** Not applicable

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical

PATIENT WEIGHT IN THE ED

Definition:
The patient's body weight measured and documented in the Emergency Department during the encounter.

Field Value:
- Numeric

Unit of Measure: Kilograms (kg)

Notes: Record the actual measured weight obtained in the ED. For medication dosing and quality reporting purposes, weight should be documented in kilograms only.

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

Data Source Hierarchy
- ED Records
- History and Physical
- Other Hospital Records

PATIENT WEIGHT UNITS

Definition
Unit of measurement used to report weight

Field Value
- **Kg**: Kilograms
- **Lbs:** Pounds
- **ND**: Not Documented
- **NA**: Not applicable

Additional Information
- Required for all pediatric base hospital contacts

Uses
- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy
- ED Records
- History and Physical
- Other Hospital Records

GENDER

Definition
Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female
- **N**: Nonbinary
- **ND:** Not documented
- **NA:** Not Applicable

Additional Information

- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Nonbinary is a gender option within the State of California for individuals whose gender identity is not exclusively male or female

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical

LENGTH BASED TAPE- Location (Optional Entry)

Definition
Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape Field

Field Values
- **PH:** Prehospital
- **ED:** Emergency Department
- **ND:** Not documented
- **NA:** Not Applicable

Additional Information
- Required field for all pediatric base contacts
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the “Too Short” or “Too Tall” checkbox.

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

Data Source Hierarchy
- ED Records
- EMS Patient Care Record
- Notification Form
- Notification Log
- Base Hospital Form

LENGTH BASED TAPE MEASURE-Colors (Optional Entry)

Definition
Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values
- **Grey**: 3, 4, or 5 kg (newborn infants)
- **Pink**: 6-7 kg (~3 -6 mos)
- **Red:** 8-9 kg (~7-10 mos)
- **Purple**: 10-11 kg (~12-18 mos)
- **Yellow**: 12-14 kg (~19-35 mos)
- **White:** 15-18 kg (~3-4 yrs)
- **Blue**: 19-22 kg (~5-6 yrs)
- **Orange:** 24-28 kg (~7-9 yrs)
- **Green:** 30-36 kg, or about 80 lbs (~10-12 yrs)
- **Too Tall:** Patient is longer than tape
- **Too Short**: patient is shorter than tape
- **ND**: Not Documented
- **NA**: Not Applicable

Additional Information
- Field for all pediatric base contacts
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the “Too Short” or “Too Tall” checkbox, and estimate the patient’s weight in kilograms

Uses
- Assists with determination of appropriate treatment
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- EMS Patient Care Record
- Notification Form
- Notification Log
- Base Hospital Form

WEIGHT BASED ON LENGTH TAPE (Optional Entry)

Definition
Number that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values

- **Grey**: 3, 4, or 5 kg (newborn infants)
- **Pink**: 6-7 kg (~3 -6 mos)
- **Red:** 8-9 kg (~7-10 mos)
- **Purple**: 10-11 kg (~12-18 mos)
- **Yellow**: 12-14 kg (~19-35 mos)
- **White:** 15-18 kg (~3-4 yrs)
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- **Orange:** 24-28 kg (~7-9 yrs)
- **Green:** 30-36 kg, or about 80 lbs (~10-12 yrs)
- **Too Tall:** Patient is longer than tape
- **Too Short**: patient is shorter than tape
- **ND**: Not Documented
- **NA**: Not Applicable

Data Source Hierarchy

- ED Records
- EMS Patient Care Record
- Notification Form
- Notification Log
- Base Hospital Form

DATE OF FIRST SET OF VITAL SIGNS IN THE ED

Definition: The documented date at which the first complete set of vital signs was obtained during the encounter.

Field Values

- Collected as **MMDDYYYY**

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical
- Other Hospital Records

TIME OF FIRST SET OF VITAL SIGNS in the ED

Definition: The documented clock time at which the first complete set of vital signs was obtained during the encounter.

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical
- Other Hospital Records

HEAD TO TOE ASSESSMENT DOCUMEMTED BY RN OR FOCUSED ASSESSMENT

Definition:
Indicates whether a complete head-to-toe assessment or a focused assessment relevant to the patient's condition was performed and documented by a Registered Nurse (RN) during the encounter.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Notes: "Yes" reflects documented evidence of either a full systematic assessment of all body systems or a targeted assessment addressing specific patient complaints or clinical concerns. "ND" indicates no assessment documented by the RN.

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical
- Progress Notes

BLOOD PRESSURE DOCUMENTED

Definition
Numeric values of the patient's systolic and/or diastolic blood pressure documented during the encounter.

*Blood pressure (for patients < 3 years, documentation of capillary refill)

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not Documented
- **NA:** Not Applicable

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

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records

RESPIRATORY RATE DOCUMENTED

Definition
Numeric values of the patient's initial, unassisted respiratory rate documented during the encounter.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not Documented
- **NA:** Not Applicable

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

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records

HEART RATE DOCUMENTED

Definition
Documentation of patient's pulse rate documented during the encounter.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not Documented
- **NA:** Not Applicable

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

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records

TEMPERATURE

Definition: Indicates whether the patient's body temperature was measured and documented during the encounter.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Notes: "Yes" reflects that a temperature value (regardless of route of measurement) was recorded in the medical record. "ND" indicates insufficient documentation to confirm that temperature was assessed.

Uses

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

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

PROVIDER IMPRESSION

Definition

Four-letter code(s) representing the provider's impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bronchospasm
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distress/Other
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distress/Pulmonary Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Active
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Postictal
BPNT	Body Pain – Non-Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhalation
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venomous Bites
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/TIA
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/Drowning
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

Additional Information

- First copy of Provider Impression cannot be a null value
- Do not enter more than one copy of the same Provider Impression code

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- ED Records
- EMS Patient Care Record
- Notification Form

- Notification Log
- EMS Report Form
- Base Hospital Form

NORMAL PEDIATRIC VITAL SIGNS

Age Group	Heart Rate (awake)	Respiratory Rate	Systolic BP (minimum)*
Neonate (0–28 days)	100–205 bpm	30–60/min	60 mmHg
Infant (1–12 months)	100–190 bpm	30–53/min	70 mmHg
Toddler (1–2 yrs)	98–140 bpm	22–37/min	70 + (2 × age)
Preschool (3–5 yrs)	80–120 bpm	20–28/min	70 + (2 × age)
School Age (6–12 yrs)	75–118 bpm	18–25/min	70 + (2 × age)
Adolescent (13–18 yrs)	60–100 bpm	12–20/min	90 mmHg

Additional Information

- **Hypotension definition (1–10 yrs):**
  Systolic BP < **70 + (2 × age in years)**
- Hypotension is a **late sign of shock in pediatrics**
- **Always interpret vitals in clinical context (fever, crying, pain increase HR/RR)**

Normal Pediatric Vital Signs (Neonate → Adolescent)

Age Group	Heart Rate (Awake)	Heart Rate (Asleep)	Respiratory Rate (Awake)	Respiratory Rate (Asleep)	Systolic BP (Minimum)*	SpO_2 (Room Air)
Neonate (0–28 days)	100–205	90–160	30–60	30–60	60 mmHg	≥95%
Infant (1–12 mo)	100–190	90–160	30–53	24–40	70 mmHg	≥95%
Toddler (1–2 yr)	98–140	80–120	22–37	20–30	70 + (2 × age)	≥95%
Preschool (3–5 yr)	80–120	65–100	20–28	18–25	70 + (2 × age)	≥95%
School Age (6–12 yr)	75–118	58–90	18–25	14–20	70 + (2 × age)	≥95%
Adolescent (13–18 yr)	60–100	50–90	12–20	10–16	90 mmHg	≥95%

VITAL SIGNS NORMAL FOR AGE?

Definition
Indicate whether vital signs were normal for age**.** Reference MCG NO. 1309

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Additional Information
Circumstances should also be considered when assessing for and determining cause for concern regarding abnormal vital signs, ex. crying, sleeping

Data Source Hierarchy
- ED Records
- History and Physical
- Other Hospital Records

IF NO, WAS PROVIDER NOTIFIED?

Definition
Indicate whether provider was notified of abnormal vital signs

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

DATE PROVIDER WAS NOTIFIED

Definition
Date provider was notified of abnormal vital sign

Field Values
- Collected as **MMDDYYYY**

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

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

TIME PROVIDER WAS NOTIFIED

Definition
Time provider was notified of abnormal vital sign

Field Values
- Collected as **HHMM**
- Use 24-hour clock

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

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

PAIN SCORE DOCUMENTED

Definition
Indicate whether a pain score was documented

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

PAIN SCALE USED

Definition
Type of pain scale used appropriate for age

Field Values

- **Numeric pain:** Pain assessed using a numeric rating scale, typically from 0 (no pain) to 10 (worst possible pain).
- **FACES:** Pain assessed using the Wong-Baker FACES® Pain Rating Scale**,** in which the patient selects the face that best represents their pain level.
- **FLACC:** Face, Legs, Activity, Cry, Consolability : Behavioral pain assessment tool commonly used for infants, young children, or patients unable to self-report pain.
- **Other:** Pain assessed using a method not listed above. Additional details should be documented when applicable.
- **ND:** Not Documented
- **NA**: Not Applicable

Uses

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

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

PAIN LEVEL

Definition:
Categorizes the patient's self-reported or clinically assessed pain intensity using a standardized numeric pain scale during the encounter.

Field Type

- **None** (0)
- **Mild** (1–3)
- **Moderate** (4–6)
- **Severe** (7–10)
- **ND** Not Documented
- **NA:** Not Applicable

Notes: Pain level should be based on the documented numeric rating scale (0–10) at the time of assessment. Select the corresponding category that aligns with the recorded score. "ND" indicates no documented pain assessment in the medical record.

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical
- Progress Notes

SEVERE PAIN, WAS PAIN ADDRESSED?

Definition
Indicate whether pain was addressed

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

TYPE OF PAIN INTERVENTION

Definition:
Determine whether intervention was pharmacological/non-pharm

Field Values

- **Pharmacological**
- **Nonpharmacological**
- **ND:** Not documented
- **NA:** Not Applicable

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical
- Progress Notes

DATE OF PAIN INTERVENTION

Definition:
Date of pain intervention

Field Values
- Collected as **MMDDYYYY**

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

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

TIME OF PAIN INTERVENTION

Definition:
The time pain intervention

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Uses

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

Data Source Hierarchy

- ED Records
- History and Physical
- Progress Notes

PAIN REASSESSMENT

Definition:
Indicate whether pain was reassessed after the intervention

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical
- Progress Notes

DATE PAIN WAS REASSESSED

Definition:
The time pain was reassessed after an intervention

Field Values
- Collected as **MMDDYYYY**

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

Data Source Hierarchy
- ED Records
- History and Physical
- Progress Notes

TIME PAIN WAS REASSESSED

Definition:
The time pain was reassessed after an intervention

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Uses

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

Data Source Hierarchy

- ED Records
- History and Physical
- Progress Notes

ED DIAGNOSIS

Definition

Emergency department diagnosis as documented by a physician, advanced practice provider

Field Values

- ICD-10 codes
- **OT:** Other

Uses

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

Data Source Hierarchy

- ED Records
- Other Hospital Records
- Progress Notes

DISCHARGE DATE

Definition

Date the patient was discharged from the emergency department

Field Values

- Collected as **MMDDYYYY**

Additional Information

- Applicable when the patient:
  - Expires
  - Is discharged
  - Leaves against medical advice (AMA)
  - Leaves without being seen (LWBS) or elopes
  - Is transferred to a rehabilitation, skilled nursing, or hospice unit (at your facility or another facility)
  - Is transferred to an acute inpatient unit at another facility

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet

DISCHARGE TIME

Definition

Time the patient was discharged from the emergency department

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Additional Information

- Applicable when the patient:
  - Expires
  - Is discharged
  - Leaves against medical advice (AMA)
  - Leaves without being seen (LWBS) or elopes
  - Is transferred to a rehabilitation, skilled nursing, or hospice unit (at your facility or another facility)
  - Is transferred to an acute inpatient unit at another facility

Uses

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

Data Source Hierarchy

- ED Records
- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet

ED DISPOSITION

Definition

Checkbox indicating the patient's next phase of care after the Emergency Department (ED)

Field Values

- **DC**: Discharged
- **P:** Pediatric Ward: Patient was admitted to a Pediatric Ward unit from the ED
- **I:** Pediatric: ICU Patient was admitted to the PICU from the ED
- **OR:** Patient went to the OR from the ED
- **DE:** Patient died in the ED
- **TX:** Transferred to another Acute Care Facility
- **O:** Other
- **ND:** Not Documented
- **NA:** Not Applicable

Additional Information

- If "Post Hosp" is checked, "Hosp. Disposition" field is required

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- Billing sheet / Medical records coding summary sheet
- Other hospital records
- Hospital discharge summary

HOSPITAL DISPOSITION

Definition

Checkbox indicating the patient's destination upon discharge from the acute care unit at your facility

Field Values

- **Died in Hospital**
- **Discharged Alive**
- **Patient Made DNR**
- **Transferred to Another Acute Care Facility**
- **ND:** Not documented
- **NA:** Not Applicable

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- ED records
- Billing sheet / Medical records coding summary sheet
- Other hospital records
- Hospital discharge summary

IF TRANSFERRED SELECT HOSPITAL

Definition

Code indicating to which acute care facility the patient was transferred to

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS			
ACH	Alhambra Hospital Medical Center	KFW	Kaiser Foundation Hospital - West Los Angeles
AHM	Catalina Island Medical Center	LBM	Long Beach Memorial Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary Medical Center - Torrance
BEV	Beverly Hospital	MCP	Mission Community Hospital
BMC	Southern California Hospital at Culver City	MHG	Memorial Hospital of Gardena
CAL	Dignity Health - California Hospital Medical Center	MID	Olympia Medical Center
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	LA Community Hospital at Norwalk
CPM	Coast Plaza Doctors Hospital	NRH	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	OVM	LAC Olive View - UCLA Medical Center
DCH	PIH Health Hospital - Downey	PAC	Pacifica Hospital of the Valley
DFM	Marina Del Rey Hospital	PIH	PIH Health Hospital- Whittier
DHL	Lakewood Regional Medical Center	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	Foothill Presbyterian Hospital	QVH	Citrus Valley M.C. - Queen of the Valley Campus
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	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
HEV	Glendora Community Hospital	SMM	Dignity Health - St. Mary Medical Center
HGH	LAC Harbor-UCLA Medical Center	SOC	Sherman Oaks Hospital
HMH	Huntington Hospital	SPP	Providence Little Co. of Mary Medical Center - San Pedro
HMN	Henry Mayo Newhall Hospital	SVH	St. Vincent Medical Center
HWH	West Hills Hospital & Medical Center	TOR	Torrance Memorial Medical Center
ICH	Citrus Valley M.C. - Intercommunity Campus	TRM	Providence Tarzana Medical Center
KFA	Kaiser Foundation Hospital - Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Foundation Hospital - Downey	USC	LAC+USC Medical Center
KFH	Kaiser Foundation Hospital - South Bay	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Foundation Hospital - Sunset (LA)	VPH	Valley Presbyterian Hospital
KFO	Kaiser Foundation Hospital - Woodland Hills	WHH	Whittier Hospital Medical Center
KFP	Kaiser Foundation Hospital - Panorama City	WMH	Adventist Health - White Memorial

ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS			
ANH	Anaheim Regional Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
FHP	Fountain Valley Regional Hospital & Medical Center	SJD	St. Jude Medical Center
KHA	Kaiser Foundation Hospital - Anaheim	UCI	University of California - Irvine Medical Center
KFI	Kaiser Foundation Hospital - Irvine	WMC	Western Medical Center Santa Ana
LAG	Los Alamitos Medical Center		
SAN BERNADINO COUNTY 9-1-1 RECEIVING HOSPITALS			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Hospital- Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Hospital
DHM	Montclair Hospital Medical Ctr.	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital- Fontana		
OTHER COUNTY 9-1-1 RECEIVING HOSPITALS			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SIM	Adventist Health - Simi Valley (Ventura)
RCC	Ridgecrest Regional Hospital (Kern)	SJO	St. John Regional Medical Center (Ventura)

- **ND:** Not documented
- **NA:** Not Applicable

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
- Transfer Records

PRIMARY REASON PATIENT WAS TRANSFERRED -Transfer Rationale

Definition
Checkbox indicating the rationale for transfer of the patient, if applicable

Field Values

Age	Extended Care/Skilled Nursing Facility (SNF)/Long term Care
Special Situation	Transfer required due to a unique clinical, social, legal, or operational circumstance not otherwise categorized.
Emergency Specialty	Decision based on financial status (i.e., cash or self-pay, uninsured)
Mental Health	Patient required higher level of care not available at transferring facility
Trauma	Patient transferred to a designated trauma center for definitive trauma care.
Health Plan	Health Plan decision
Other	Transfer rationale other than above

- **ND:** Not documented
- **NA:** Not Applicable

Additional Information

- If a patient is discharged home with hospice care, enter “Home”
- If a patient was residing in an Extended/Skilled Nursing Facility prior to hospital arrival and is discharged back to the same Extended/Skilled Nursing Facility, enter “Home”

Uses

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

Data Source Hierarchy

- ED records
- Billing sheet / Medical records coding summary sheet
- Other hospital records
- Hospital discharge summary
- Transfer Records

VS TAKE PRIOR TO TRANSFER

Definition:
Indicates whether the patient's vital signs (e.g., heart rate, respiratory rate, blood pressure, temperature, oxygen saturation) were measured and documented within 30 minutes prior to transfer to another unit or facility.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Notes: "Yes" reflects that at least one complete set of vital signs was recorded within the 30-minute window before transfer. "ND" indicates no documentation of vital signs within this timeframe.

Uses

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

Data Source Hierarchy

- ED records
- Billing sheet / Medical records coding summary sheet
- Other hospital records
- Hospital discharge summary
- Transfer Records

TRANSFER FORM COMPLETED

Definition
Indicates whether a transfer form was completed or if the physician documented the clinical necessity for patient transfer to another facility.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Notes: “Yes” reflects either completion of the formal transfer paperwork or explicit physician documentation supporting the need for transfer. “ND” indicates insufficient documentation to verify either.

Data Source Hierarchy
- ED records
- Billing sheet / Medical records coding summary sheet
- Other hospital records
- Hospital discharge summary
- Transfer Records

SELECT ALL THAT APPLY

Definition

Select all categories that apply to the patient encounter. Multiple selections may be made if the patient meets the criteria for more than one category. Select **None of the Above** only if none of the listed categories apply.

Variable	Definition
SOBB	**Shortness of Breath/Bronchospasm:** A patient presenting with shortness of breath, wheezing, bronchospasm, asthma exacerbation, reactive airway disease, or other lower airway obstruction resulting in respiratory distress or requiring treatment for bronchospasm.
48HR RETURN	**48-Hour Return Visit:** A patient who returns to the emergency department within 48 hours of a previous ED discharge for the same, related, or worsening condition.
CHILD MALTREATMENT	**Child Maltreatment:** Any case involving suspected or confirmed physical abuse, sexual abuse, emotional abuse, neglect, exploitation, or other forms of harm to a child, regardless of whether a formal report has been made.
CARDIAC ARREST	**Cardiac Arrest:** A patient who experiences cessation of effective cardiac mechanical activity, resulting in the absence of a detectable pulse and requiring resuscitative interventions such as CPR and/or advanced life support measures.
NONE OF THE ABOVE	**None of the Above:** Indicates that the patient encounter does not meet the criteria for any of the listed categories (Shortness of Breath/Bronchospasm, 48-Hour Return Visit, Child Maltreatment, or Cardiac Arrest).

SOBB TAB

CHIEF COMPLAINT

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Variable	Definition
APNEIC EPISODES	**Apneic Episodes:** A patient presenting with one or more episodes of cessation of breathing, either witnessed or reported, requiring medical evaluation. Includes brief resolved unexplained events (BRUE) and other episodes of apnea.
ASTHMA	**Asthma:** A patient presenting with an acute asthma exacerbation characterized by airway inflammation, bronchoconstriction, wheezing, coughing, chest tightness, or respiratory distress requiring evaluation and/or treatment.
CHOKING	**Choking:** A patient presenting with actual or suspected airway obstruction caused by a foreign object, food, liquid, or other material resulting in respiratory symptoms or distress.
CROUP	**Croup:** A patient presenting with symptoms consistent with viral laryngotracheobronchitis, including a characteristic barking cough, inspiratory stridor, hoarseness, or upper airway obstruction.
FEVER	**Fever:** A patient presenting with an elevated body temperature, either measured or reported by the caregiver, requiring medical evaluation.
FOREIGN BODY	**Foreign Body:** A patient presenting with actual or suspected ingestion, aspiration, insertion, or retention of a foreign object requiring evaluation or intervention.
NEAR DROWNING	**Near Drowning:** A patient presenting after a submersion or immersion event resulting in respiratory impairment, regardless of symptom severity or outcome.
OTHER	**Other:** A patient encounter involving a respiratory, airway, or related condition that does not meet the criteria for any of the specified categories.
OVERDOSE	**Overdose:** A patient presenting with actual or suspected ingestion, inhalation, injection, or exposure to a medication, drug, toxin, or other substance in an amount that may cause harm.
RESPIRATORY ARREST	**Respiratory Arrest:** A patient who experiences complete cessation of effective respirations requiring immediate resuscitative intervention, assisted ventilation, or advanced airway management.
RESPIRATORY DISTRESS	**Respiratory Distress:** A patient presenting with signs of increased work of breathing, including but not limited to tachypnea, retractions, nasal flaring, grunting, or use of accessory muscles.
SHORTNESS OF BREATH	**Shortness of Breath:** A patient presenting with subjective difficulty breathing or dyspnea, with or without objective signs of respiratory compromise.

Variable	Definition
WHEEZING	**Wheezing:** A patient presenting with audible or auscultated wheezing suggestive of lower airway obstruction or bronchospasm, regardless of the underlying diagnosis.
NOT DOCUMENTED	**Not Documented:** Insufficient information is available in the medical record to determine whether the condition or presentation was present.
NOT APPLICABLE	**Not Applicable:** The data element does not apply to the patient encounter or is not relevant to the clinical presentation being evaluated.

Additional Information

- If the patient has multiple complaints, enter in order of significance
- Do not enter more than one copy of the same chief complaint code

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- ED Record
- EMS Patient Care Record
- Base Hospital Form
- Base Hospital Log
- Other hospital records

OXYGEN DOCUMENTED IN TRIAGE

Definition
Indicate whether O2 saturation documented by triage nurse

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

DATE PROVIDER AT BEDSIDE

Definition
The date and time when a licensed healthcare provider (e.g., physician, nurse practitioner, or physician assistant) first arrives at the patient's bedside to perform an in-person clinical evaluation and assessment.

Field Values
- Collected as **MMDDYYYY**

Uses
- Measures timeliness of provider evaluation.
- Assesses compliance with emergency department and pediatric readiness performance metrics.
- Supports quality improvement initiatives related to patient flow and throughput.
- Evaluates response times for high-risk or time-sensitive pediatric presentations.
- Identifies potential delays in care and opportunities for process improvement.
- Assists in calculating key performance indicators such as arrival-to-provider time and provider response time.

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

TIME PROVIDER AT BEDSIDE

Definition
The time the provider was at the bedside for evaluation

Field Values
- Collected as **HHMM**
- Use 24-hour clock

Uses
- Measures timeliness of provider evaluation.
- Assesses compliance with emergency department and pediatric readiness performance metrics.
- Supports quality improvement initiatives related to patient flow and throughput.
- Evaluates response times for high-risk or time-sensitive pediatric presentations.
- Identifies potential delays in care and opportunities for process improvement.
- Assists in calculating key performance indicators such as arrival-to-provider time and provider response time.

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

BREATH SOUNDS DOCUMENTED

Definition:
Indicates whether the patient's work of breathing was documented during the encounter.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital record

WHO DOCUMENTED BREATH SOUNDS

Definition: Identifies the clinician discipline(s) who assessed and documented the patient's breath sounds during the encounter.

Field Values: Can select multiple

- **RN:** Registered Nurse
- **RT**: Respiratory Therapist
- **OT:** Other
- **ND**: Not Documented
- **NA**: Not Applicable

Notes: Multiple selections are permitted if more than one clinician documented breath sounds. Selection reflects the discipline of the clinician who performed and documented the reassessment (Respiratory Therapist [RT] or Registered Nurse [RN]).

"OT" should be selected if documentation was completed by a discipline not listed and specified in a corresponding free-text field, if available. "ND" indicates no documented breath sound assessment in the medical record.

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital record

OXYGEN SATURATION MONITORED DURING CARE OF THE PATIENT

Definition
Was oxygen saturation monitored during the encounter.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

WAS OXYGEN ADMINISTERED

Definition
Was oxygen administered to the patient during the encounter.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

OXYGEN ROUTE

Definition:
Checkboxes indicating the type of device used to deliver oxygen to the patient

Field Values

- **BiPAP:** Bilevel Positive Airway Pressure: Noninvasive ventilation providing two levels of positive airway pressure during inhalation and exhalation.
- **Blow-By:** Oxygen delivered by directing a flow of oxygen toward the patient's face without a sealed interface.
- **BMV** Bag-Mask Ventilation: Manual ventilation using a self-inflating bag and face mask.
- **CPAP** Continuous Positive Airway Pressure: Noninvasive ventilation providing continuous positive airway pressure throughout the respiratory cycle.
- **ETT** Endotracheal Tube: Airway secured with a tube placed into the trachea for ventilation and oxygenation.
- **High-Flow**: Oxygen delivered at high flow rates, typically using a heated, humidified high-flow nasal cannula system**.**
- **NC:** Nasal Cannula: Oxygen delivered through prongs placed in the nostrils.
- **NRB:** Non-Rebreather Mask: Face mask with a reservoir bag used to deliver high concentrations of oxygen.
- **Trach** Oxygenation or ventilation provided through an existing tracheostomy tube.
- **SGA** Supraglottic Airway: Airway device placed above the vocal cords to maintain a patent airway and facilitate ventilation.

Uses

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

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

WORK OF BREATHING ASSESSED

Definition
Indicates whether the patient's work of breathing was evaluated and documented during the encounter.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Notes: "Assessment of work of breathing" includes documentation of clinical indicators such as use of accessory muscles, retractions, nasal flaring, grunting, or overall respiratory effort. "ND" indicates no clear documentation in the medical record.

Uses
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

TYPE OF MEDICATION GIVEN

Definition: Identifies the specific medication administered to the patient during the encounter.

Field Values:

- **Albuterol**
- **Albuterol + Atrovent**
- **Prednisone**
- **Prednisolone**
- **Dexamethasone**
- **Methylprednisolone**
- **Magnesium Sulfate**
- **OT (Other)**
- **Pulmicort**
- **Racemic Epinephrine**
- **ND (Not Documented)**
- **NA: Not Applicable**

Notes: Select the primary medication administered for the documented treatment event. “OT” should be selected if the medication given is not listed, if available. “ND” indicates insufficient documentation in the medical record.

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

3 DOSES OF CORRECTLY DOSED BETA-2 AGONIST GIVEN IN FIRST HOUR

Definition:
Indicates whether the patient received three appropriately weight- and age-based dosed beta-2 agonist treatments within the first hour of presentation or treatment initiation.

Field Values:

- **Yes**
- **No**
- **Documentation patient clear <3 doses**
- **ND** (Not Documented)
- **Not Applicable**

Notes: “Yes” reflects that three separate doses were administered within 60 minutes and were dosed according to established clinical guidelines. “ND” indicates insufficient documentation to verify the number of doses, timing, or dosing accuracy.

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

DATE OF BETA- 2 AGONIST GIVEN

Definition:
The documented date at which a beta 2 agonist medication was administered to the patient during the encounter.

Field Values

- Collected as **MMDDYYYY**

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

TIME OF BETA- 2 AGONIST GIVEN

Definition
The documented clock time at which a beta 2 agonist medication was administered to the patient during the encounter.

Field Values
- Collected as **HHMM**
- Use 24-hour clock

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

CORTICOSTERIODS GIVEN BEFORE, DURING OR JUST AFTER SECOND BETA-2 AGONIST TREATMENT

Definition:
Indicates whether a corticosteroid was administered before, during, or immediately after the second beta-2 agonist treatment during the encounter.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- NA: Not Applicable

Notes: “Yes” reflects that corticosteroid administration occurred at any point prior to, concurrently with, or shortly following completion of the second beta-2 agonist treatment, as documented in the medical record. “ND” indicates insufficient documentation to determine timing.

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

DATE OF CORTICOSTEROID GIVEN

Definition:
The documented date at which a corticosteroid medication was administered to the patient during the encounter.

Field Values

- Collected as **MMDDYYYY**

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

TIME OF CORTICOSTEROID GIVEN

Definition
The documented clock time at which a corticosteroid medication was administered to the patient during the encounter.

Field Values
- Collected as **HHMM**
- Use 24-hour clock

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

BREATHING EFFORT AND RATE REASSESSED AFTER MEDICATION ADMINISTRATION

Definition:
Indicates whether the patient's breathing effort and respiratory rate were reassessed following medication administration.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

PATIENT UNDERWENT X-RAY IN ED

Definition:
Indicates whether the patient underwent diagnostic radiographic imaging (X-ray) during the encounter.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Notes: “Yes” reflects that at least one plain radiograph study was completed during the visit, regardless of body site or number of views.

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

X-RAY RESULT

Definition:
Documents the final interpreted result of the patient's radiographic (X-ray) study as reported by a qualified radiologist or authorized provider.

Field Values

- **Normal** Findings documented as normal with no abnormalities identified.
- **PNA** Pneumonia: Findings consistent with or indicative of pneumonia.
- **OT** Other: Findings not represented by the listed options. Additionally details should be documented when applicable.
- **ND** Not Documented: The assessment or finding was not documented in the medical record.
- **NA** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

UNSCHEDULED 48 HOUR RETURN TAB

PROVIDED WITH RESOURCES AT DISCHARGE-1st VISIT

Definition:
Indicates whether standardized educational materials were incorporated into the patient's emergency department (ED) discharge paperwork at the time of discharge.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

EDUCATIONAL MATERIALS BUILT IN THE EMERGENCY DEPARTMENT'S DISCHARGE PAPERWORK

Definition:
Indicates whether standardized educational materials were incorporated into the patient's emergency department (ED) discharge paperwork at the time of discharge.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented
- **NA:** Not Applicable

Notes: "Yes" reflects that condition-specific or diagnosis-related educational materials were automatically generated or manually included in the discharge instructions provided to the patient and/or caregiver.

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

PATIENT ADMITTED OR TRANSFERRED AT RETURN VISIT

Definition:
Indicates whether the patient was admitted to the hospital or transferred to another facility during a return visit.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

CHILD MALTREATMENT TAB

HOSPITAL SOCIAL WORKER NOTIFIED

Definition
Indicates whether a social worker was notified to provide support and assistance during a suspected child maltreatment case.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

LAW ENFORCEMENT AGENCY NOTIFIED

Definition
Indicates whether a law enforcement agency was notified to provide support and assistance during a suspected child maltreatment case.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

DCFS/CPS NOTIFIED

Definition
Checkbox indicating Department Child and Family Services called for suspected child maltreatment case.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

DOCUMENTED IN CHART: SUSPECTED CHILD ABUSE FORM (SCAR, etc.) REPORT SUBMITTED VIA PHONE/ONLINE/FAX/MAIL

Definition
Indicates whether a Suspected Child Abuse Report (e.g., SCAR) was documented in the patient chart as submitted to the appropriate authority via phone, online portal, fax, or mail.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Additional Information
Includes any formally documented report submission method (phone, online, fax, or mail).

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

DOCUMENTED IN CHART MANDATED REPORTER NUMBER

Definition
Indicates whether a Mandated Reporter Number has been documented in the patient chart.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

SART PATIENT

Definition
Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

NEED SPECIALTY FORENSIC CARE (SART)?

Definition

Indicates whether the patient requires specialized forensic medical services provided by a Sexual Assault Response Team (SART), including evidence collection, forensic examination, and coordinated care following a reported or suspected sexual assault.

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

IF YES, DID THEY GET APPROPRIATE REFERRAL TO SART CENTER

Definition
Indicates whether the patient received an appropriate referral to a Sexual Assault Response Team (SART) center when indicated.

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Data Source Hierarchy
- ED Records
- History and Physical
- Other hospital records

CARDIAC ARREST TAB

CARDIAC ARREST

Definition
A non-traumatic out-of-hospital cardiac arrest where resuscitation is attempted by a 911 Responder (CPR and/or defibrillation). This also includes patients that receive an AED shock by a bystander prior to the arrival of 911 Responders

INIT. CARDIAC ARREST DATE

Definition
Date of the initial cardiac arrest

Field Values

- Collected as **MMDDYYYY**

Uses

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

Data Source Hierarchy

- EMS Patient Care Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST TIME

Definition
Time of the initial cardiac arrest

Field Values

- Collected as **HHMM**
- Use 24-hour clock

Uses

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

Data Source Hierarchy

- EMS Patient Care Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

SOCIAL WORKER NOTIFIED

Definition
Was Social Worker Notified

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses
- System evaluation and monitoring

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records

LAW ENFORCEMENT AGENCY NOTIFIED

Definition
Was law enforcement notified

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

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

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records

FAMILY PRESENCE DURING CODE/ PRONOUCEMENT DOCUMENTED

Definition
Was family present during code/pronouncement

Field Values
- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

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

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records

ONE LEGACY NOTIFIED AND DOCUMENTED IN CHART

Definition
Was one legacy notified and documented in chart

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA:** Not Applicable

Uses

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

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

CORONER NOTIFIED AND DOCUMENTED IN CHART

Definition
Coroner Notified of death and documented in chart

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not documented
- **NA**: Not Applicable

Uses

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

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

CARES

Cardiac Arrest Registry to Enhance Survival

WAS HYPOTHERMIA CARE, ALSO KNOWN AS TARGETED TEMPERATIRE MANAGEMENT (TTM), INITIATED OR CONTINUED IN THE HOSPITAL

Definition

Hypothermia care is provided in the hospital if measures were taken to reduce the patient's body temperature by either non-invasive means (i.e. administration of cold intravenous saline, external cold pack application to armpits and groin, use of a cooling blanket, torso vest or leg wrap devices) or by invasive means (i.e. use of a cooling catheter inserted in the femoral vein).

o NOTE: Maintaining "normothermia" is considered TTM if the hospital is actively managing the patient with a TTM protocol

Field Values

- **Yes**
- **No**
- **ND:** Not Documented
- **Not Applicable**

Additional Information

Was Hypothermia Care Initiated/ Continued in the Hospital Definition
Yes Measures were taken to reduce the patient's body temperature by either non-invasive or invasive means in the hospital.
No Measures were not taken to reduce the patient's body temperature in the hospital.

Uses

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

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

NEUROLOGICAL OUTCOME AT DISCHARGE FROM HOSPITAL

Definition/Description:
• The neurological outcome of the patient at the time of hospital discharge, defined by the simple and validated Cerebral Performance Categories (CPC) scale.
• Survival without higher neurological function is suboptimal; therefore, it is important to attempt to assess neurological outcome at time of discharge.

Fields
Pediatric/Neonate Cerebral Performance Categories Scale CARES Coding

- **PCPC 1 (Normal) -** Age-appropriate level of functioning; preschool child developmentally appropriate; school-age child attends regular classes.
  - Neonate – No obvious neurological abnormalities. Good Cerebral Performance (CPC 1)
- **PCPC 2 (Mild cerebral disability) –** Able to interact at an age-appropriate level; minor neurological disease that is controlled and does not interfere with daily functioning (i.e. seizure disorder that is well controlled with medication); preschool child may have minor developmental delays, but more than 75% of all daily living milestones are above the 10th percentile; school-age child attends regular school, but grade is not appropriate for age, or child is failing appropriate grade because of cognitive difficulties.
  - Neonate – Minor neurological abnormality; neurological disease that is controlled and does not interfere with daily functioning. Moderate Cerebral Disability (CPC 2)
- **PCPC 3 (Moderate cerebral disability)** – Below age-appropriate functioning; neurological disease that is not controlled and severely limits activities; most activities of preschool child's daily living developmental milestones are below the 10th percentile; school-age child can perform activities of daily living but attends special classes because of cognitive difficulties and/or has a learning deficit.
  - Neonate – Neurological disease that is not controlled (i.e. breakthrough seizures despite medications which affect responsiveness to environment). Moderate Cerebral Disability (CPC 2)
- **PCPC 4 (Severe cerebral disability)** – Preschool child's activities or daily living milestones are below the 10th percentile, and child is excessively dependent on others for provision of activities of daily living; school-age child may be so impaired as to be unable to attend school and is dependent on others for provision of activities of daily living; abnormal motor movements for both preschool and school-age child may include non-purposeful, decorticate, or decerebrate responses to pain. Severe Cerebral Disability (CPC 3)
  - Neonate – Obvious severe neurological disorder. Abnormal motor movements may include non-purposeful, decorticate, or decerebrate response to pain.
- **PCPC 5 (Coma or vegetative state) -** Any degree of coma. Unaware, even if awake in appearance, without clear or consistent interaction with environment. Unresponsive with no evidence of cortical function (not aroused by verbal stimuli). Possibility of some reflexive response, spontaneous eye-opening, and sleep-wake cycles. Coma, vegetative state (CPC 4)

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

WHY WAS HYPOTHERMIA CARE/TTM NOT INITIATED OR CONTINUED IN THE HOSPITAL

Definition:
Indicates the reason that hypothermia care was not initiated or continued in the hospital setting. Instructions for Coding:

• Select the primary reason that hypothermia care was not initiated or continued, according to the medical record.

Fields

- **Awake:** Patient is awake and responsive to medical staff upon initial presentation to hospital.
- **Following commands:** Patient is alert and responsive to medical staff upon initial presentation to hospital.
- **DNR/Family:** request Patient has a valid Do Not Resuscitate (DNR) order in place, or family requests that hypothermia care not be provided. Unwitnessed cardiac arrest
- **Unwitnessed cardiac arrest: Patient** has a cardiac arrest that is neither seen nor heard.
- **Unshockable rhythm:** First monitored cardiac rhythm upon application of manual monitor/defibrillator or AED was asystole, idioventricular/PEA, or unknown unshockable.
- **No TH program in place** Destination hospital does not have therapeutic hypothermia program in place.
- **Other:** Reason for not initiating/continuing hypothermia care does not fall into one of the defined categories.
- **Unknown:** Information not available in medical record
- **Not Documented**
- **Not Applicable**

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- Discharge Summary

WAS THE FINAL DIAGNOSIS ACUTE MYOCARDIAL INFARCTION

Definition:
Diagnoses of acute myocardial infarction (MI) via electrocardiogram (ECG), cardiac markers, angiography, or autopsy.

Fields:

- **Yes:** There was a final diagnosis of an acute myocardial infarction.
- **No:** There was no final diagnosis of an acute myocardial infarction.
- **Not Documented**
- **Not Applicable**

Additional Information

- This diagnosis refers to the index cardiac arrest event only. Instructions for Coding:
- If the final diagnosis was acute MI, code as “Yes.”
  - NOTE: STEMI and NSTEMI are included in a final diagnosis of acute MI.
- If the final diagnosis was not acute MI, code as “No.”
- In the case of transfer patients, this field should be completed by the final hospital of care.

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- Discharge Summary

CORONARY ANGIOGRAPHY PERFORMED

Definition:
Coronary angiography is a therapeutic procedure that uses contrast dye, usually containing iodine, and x-ray to detect blockages in the coronary arteries.

Fields:

- **Yes:** Coronary angiography procedure was performed on the patient. Provide date and time (initial groin puncture of the femoral artery) of the procedure.
- **No:** Coronary angiography procedure was not performed on the patient.
- **Not Documented**
- **Not Applicable**

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- Discharge Summary

WAS A CARDIAC STENT PLACED

Definition:
A cardiac stent is a small mesh, expandable tube that is used to treat narrowed or blocked arteries. A stent is placed during a percutaneous coronary intervention (PCI) procedure to keep a coronary artery open.

Fields:
- **Yes:** A cardiac stent was placed.
- **No:** A cardiac stent was not placed.
- **Not Documented**
- **Not Applicable**

Additional Information
- If a cardiac stent was placed during this angiography (does not apply to previously placed stents), code as “Yes.”
- If a cardiac stent was not placed during this angiography, code as “No.” Was A Cardiac Stent Placed Definition

Data Source Hierarchy
- ED Records
- Progress Notes
- Other Hospital Records
- Discharge Summary

CABG PERFORMED

Definition:
Coronary artery bypass grafting (CABG) is a surgical procedure to restore normal blood flow to an obstructed coronary artery.

Fields: Indicate whether CABG was performed during this hospitalization.

- **Yes:** If CABG was performed, code as
- **No:** If CABG was not performed, code as
- **Not Documented**
- **Not Applicable**

Additional Information

- Yes Coronary artery bypass grafting (CABG) was performed.
- No Coronary artery bypass grafting (CABG) was not performed.
- Unknown Information not available in medical record.

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- Discharge Summary