CCSO

Critical Care
Services Ontario

Ontario Trauma Registry (OTR) Data Dictionary

August 2025

Version Control

Ontario Trauma Registry (OTR) Data Dictionary	
Version 1.0	Initial Draft (May 10, 2024)
Version 2.0	Release Version (December 12, 2024)
Version 3.0	2025 NTDS Release and OTR Immediate Fixes (August 25, 2025)
For more information contact	Critical Care Services Ontario (CCSO) Email: info@ccso.ca

Information for Hospital and System Stakeholders

About Critical Care Services Ontario

Established in 2005, Critical Care Services Ontario (CCSO) led the implementation of Ontario's first Critical Care Strategy and now centrally coordinates and develops integrated system solutions for critical care (Adult, Paediatric and Neonatal) and specialty programs aligned with critical care (Neurosurgery, Trauma and Burns, and the Life or Limb Policy). CCSO's work is the result of an ongoing collaboration between critical care providers, hospital administrators, partners from the Ministry of Health, Ontario Health, and other health system leaders.

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Introduction

1.1. Ontario Trauma System

An effective, well–coordinated, and inclusive trauma system is critical in caring for injured patients. Patients with traumatic injuries receiving care within an inclusive system have improved survival rates, quality of life, and functional outcomes, as well as cost–effective delivery of care. The Ontario Trauma System continues to strive towards the aim of an integrated, accessible, inclusive, and sustainable provincial trauma system that delivers the 'right care' at the 'right time' in the 'right setting' by the 'right healthcare provider' to achieve the best possible health outcomes for injured patients.

The Ontario Trauma System comprises several components that are needed to reduce the burden of injury and includes 11 Lead Trauma Hospitals over 14 sites, 8 Regional Trauma Networks, 6 identified Level III Trauma Centres (since 2022), and other referring hospitals.

1.2. Ontario Trauma Registry

The Ontario Trauma Registry (OTR) houses data entered by hospitals identified as trauma centres on the care of trauma patients. Many injured Ontarians benefit from improved access, quality, and trauma survival rates made possible through insights generated from the OTR data.

This information is used to inform where system resources may be needed to support accessible, quality care and improved outcomes of injured patients. Local and regional system planners, including the trauma programs at identified trauma centres, can access and analyze the data to inform patterns of injury and injury surveillance, the development and impact of injury prevention strategies, planning for mass casualty and emergency responses, the development of clinical practice standards, reporting on trauma centre performance and the subsequent development of performance improvement strategies. The OTR data also plays an important role in supporting local, provincial, and national research initiatives that impact efficiency and quality of care for injured patients and informs innovation of care delivery with the ultimate goal of improved outcomes for patients.

The OTR has been in place since the 1990's and underwent a comprehensive review of data elements in 2023 with an upgrade of the registry to a web–based platform. This data dictionary was updated in 2024 to reflect the changes made to the data elements as part of the registry upgrade.

There are over 250 required data elements in the OTR that are categorized into the following sections:

- Demographic information
- Injury information
- Prehospital information
- Referring facility
- ED/Resuscitation
- Providers
- Procedures
- Diagnoses
- Outcome
- QA tracking
- Trauma Data Program (TDP)/Process measures

1.2.1. Data Dictionary Label

The data elements are grouped according to the type of data they cover. Each data element will have the following specifications:

Data Element Label	
Description	The OTR description of the data element.
Element Values	The actual value that is required for the data element.
Additional Information	Any additional directives for entering data into the data element will be written in this box. It also contains any other information that would be useful for someone who is either documenting the data or analyzing the information.
OTR Required	Indicates whether the data element is OTR Required i.e. mandatory or optional.
NTDB* Required	Indicates whether the data element is NTDB Required i.e. mandatory or optional.
Data Source Hierarchy	Source hierarchy for finding data elements in the patient's chart.
Data History	Historical changes to the data elements, with effective dates of changes.
Data Attributes	Field Name: The actual name of the element in the database. Field Type: The type of data that can be entered into the field (i.e. string). Field Length: The number of characters required for the data element.

*National Trauma Data Bank.

OTR Inclusion Criteria

Step 1

| Did the patient experience a traumatic event within 14 days of initial hospital encounter? **AND** Does the patient's ICD-10 external cause of injury meet the definition of trauma? (Appendix C in OTR Data Dictionary 2024) | **NO** → | Patient **NOT INCLUDED** in OTR |

YES ↓

| Continue to Step 2 |

Step 2

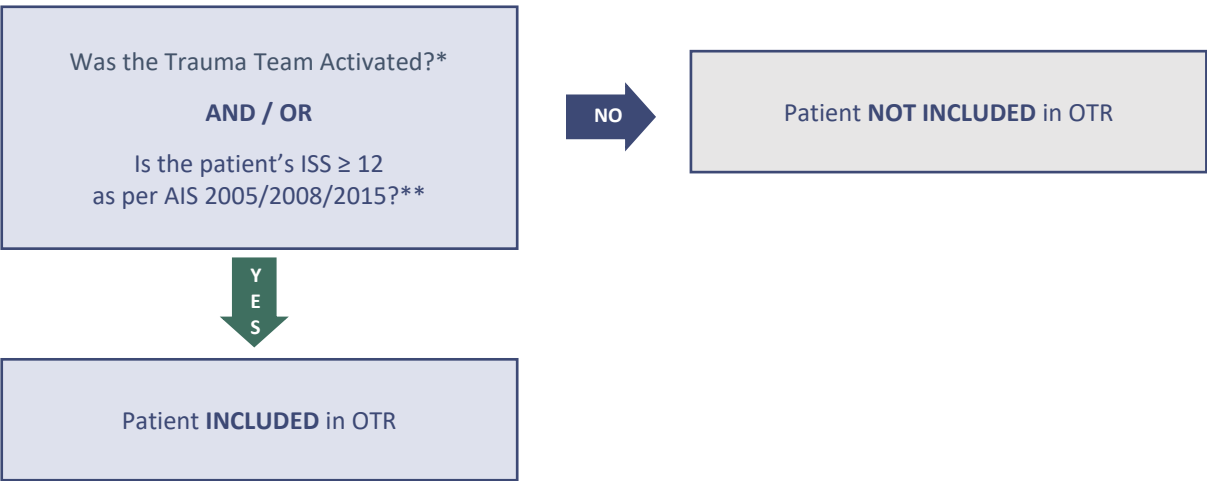| Was the Trauma Team Activated?* **AND / OR** Is the patient's ISS ≥ 12 as per AIS 2005/2008/2015?** | **NO** → | Patient **NOT INCLUDED** in OTR |

YES ↓

| Patient **INCLUDED** in OTR |

Additional Notes
* Trauma team activation criteria must be clearly defined in all trauma facilities. Facilities can refer to the American College of Surgeons (ACS) suggested criteria for the highest level of activation.
** Facilities can capture data on patients with ISS <12 for internal tracking purposes. However, only cases that meet the inclusion criteria will be included in the Ministry of Health's provincial data set. Cases that do not meet the OTR inclusion criteria should be marked as 'N' in the inclusion checkbox when entering data.
• Include patients admitted to a participating facility, or treated in emergency but not admitted, or bypassed the emergency department and directly admitted to a service, or died in the emergency department after treatment was initiated, provided they meet the inclusion criteria.
• Include transfers from a Level III Trauma Centre to a Lead Trauma Hospital provided they meet the inclusion criteria.
• Exclude all isolated hip fractures unless trauma team was activated.
• Consult the Abbreviated Injury Scale (AIS) coding manual for additional clarification regarding AIS coding rules.
• Refer to Appendix C of the OTR Data Dictionary for definition of Trauma, External Cause of Injury Codes – Inclusions and Exclusions.
• Refer to the next page, which illustrates different scenarios related to repatriation and readmission.

OTR Inclusion Criteria Cont'd

These scenarios are provided to support data entry as a provincial guideline and to promote standardized practices. However, please note that hospitals may collect this information at their discretion.

Example A:

A patient first presented to Hospital A and received initial treatment, was then escalated to Hospital B, and later returned to Hospital A for follow-up care.

→ **Include only the initial episode at Hospital A.** Do **not** include the second visit to Hospital A, as it is considered **repatriation.**

Example B:

A patient received trauma care at Hospital A, and then went to Hospital B as a *direct admit* where further active trauma care was provided.

→ **Include the patient in both Hospital A and Hospital B.**

Example C:

A patient received trauma are at Hospital A, and then went to Hospital B as a *direct admit* for non-active trauma care (e.g., waiting for rehab or long-term care) without receiving additional trauma care.

→ **Do not include the patient in Hospital B's report.**

Example D:

A patient arrived at the ED of Hospital A, then went to Hospital B but not admitted or treated there, and was then sent back to the Hospital A.

→ **Treat both ED visits as a single case and report only once.**

Example E:

A Trauma Team Activation (TTA) occurred at Hospital A, but the patient was not admitted and was sent to Hospital B.

→ **Include the patient in both Hospital A (since a TTA was activated) and Hospital B.**

1.3. General Coding Guidelines

1. OTR Required data elements: All OTR required data elements are specified in the respective data element tables. It is mandatory to input values for any required data elements. However, in cases where the information is genuinely not applicable or unknown, null values may be reported as 'Not Applicable (/)' or 'Unknown (?)' as necessary. OTR required data elements must not be left blank and edit checks for all mandatory data elements will be conducted through Gen6's built–in checks.

2. OTR Optional data elements: OTR Gen6 software contains additional data elements beyond those required for the OTR. Completion of these data elements is left to the discretion of the individual hospital. In the case of non–mandatory data elements, edit checks will be allowed for null values.

3. Custom data elements: Custom data elements are specific to Ontario and are created by facilities to enhance monitoring and reporting processes. The OTR includes provincial custom data elements that are not facility–specific.

4. Default Setting: Data elements can be set to a default menu option by individual hospitals whenever appropriate. Built–in checks within the software will remain dormant for these designated data elements.

5. Not Applicable (/) and 'Unknown (?) may be used as necessary and are included as options on some menus. Not Applicable should be used in cases where the information would not be meaningful or appropriate for a specific case. An example is the primary hospital number for patients who are transported directly to the lead/trauma hospital from the scene. Unknown should be used in cases where the information is not documented. Unknown should also be used if there are two conflicting sources of information that cannot be verified or for data elements where the information was expected to be made available but has not been made available at the time the record is closed. In cases where there are conflicting sources of information, the Medical Director should be consulted.

6. Skips: Skips are incorporated into the Gen6 platform to facilitate the data entry. In many cases, data elements that are inappropriate based on a particular response to an earlier data element are skipped. These skips have been documented in the data dictionary. An example is for data elements relevant to the Operating Room, which can be skipped if a patient did not go to the Operating Room.

7. Dates and times should be documented whenever they are known. A best guess should not be used to maintain the integrity of the data. Data checks have been built in to alert the user to times that are not

sequential. For example, the time the ambulance call is received and the time the ambulance is dispatched must be sequential. If these times are documented as the same on the Ambulance Call Report, the second time should be documented as one minute later. Unknown may be entered in a portion of date and time data elements if specific details are not known or if information is vague.

8. Facilities should exercise caution when entering data into free–text fields and ensure compliance with privacy regulations to protect sensitive information. Free–text fields have a high character limit. For example –Free text Notes sections can accommodate approximately 4000 characters, while single free text fields to collect additional information or specify other can hold up to 100 characters which could result in PHI being entered for which there is no specific reason, use or requirement.

9. Old injuries (outside 14 days of initial hospital encounter) should not be included. Only injuries within 14 days of initial hospital encounter that are related to the cause of admission should be documented.

10. When patients are readmitted to a lead/trauma hospital with a missed injury, the missed injury should be added to the original list of injuries in the initial admission. No new record should be created for this missed injury. If the patient is admitted for the first time to the lead/trauma hospital with a missed injury, all injuries relating to the ISS≥12 incident should be documented.

1.4. **Submitting Sites**

LEAD TRAUMA HOSPITALS (LTHs)			
Regional Trauma Network	Location	Facility Name	Facility (Master) Number
Erie St. Clair	Windsor	Windsor Regional Hospital	4773
South West	London	London Health Sciences Centre Children's Hospital, LHSC	4359 4359
Central South	Hamilton	Hamilton Health Sciences McMaster Children's Hospital	1982 1994
South Central (GTA)	Toronto	St. Michael's Hospital – Unity Health Toronto	4865
South Central (GTA)	Toronto	Sunnybrook Health Sciences Centre	3936
South Central (GTA)	Toronto	The Hospital for Sick Children	1406
South East	Kingston	Kingston Health Sciences Centre	4831
Champlain	Ottawa	The Ottawa Hospital Children's Hospital of Eastern Ontario	4046 1657
North East	Sudbury	Health Sciences North	4059
North West	Thunder Bay	Thunder Bay Regional Health Sciences Centre	3853

LEVEL III TRAUMA CENTRES (L3TCs)			
Regional Trauma Network	Location	Facility Name	Facility (Master) Number
Central South	Guelph	Guelph General Hospital	1946
South Central (GTA)	Oshawa	Lakeridge Health	3932
South Central (GTA)	Peterborough	Peterborough Regional Health Centre	1768
South Central (GTA)	Barrie	Royal Victoria Regional Health Centre	1825
South Central (GTA)	Newmarket	Southlake Regional Health Centre	2038
Champlain	Cornwall	Cornwall Community Hospital	4451

Demographic Information

Facility	
Description	The facility ID and description of the hospital that created the record
Element Values	4–digit master number assigned to each hospital by the Ministry of Health.
Additional Information	- Automatically populated with assigned facility number and name of facility for user who is logged in. - This should be the facility number of the patient record that you are entering. If you enter for more than one hospital, please make sure you log in using the correct facility number. - If a patient dies in the emergency room, inpatient code for the lead/trauma hospital should be used. - The following is a link to the 2023 Ministry of Health and Long–Term Care Master Numbering System. https://www.ontario.ca/page/ministry–reports–master–numbering–system
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	Ministry of Health Master Numbering System
Data History	NA
Data Attributes	Field Name: FACILITY_LNK Field Type: Integer Field Length: 4

Trauma Number	
Description	Unique patient identification number auto–assigned in consecutive sequence by the registry software.
Element Values	Up to 9–digit trauma patient identifying number.
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	The formatting varies across centres.
Data Attributes	Field Name: TRAUMA_NUM Field Type: Integer Field Length: 9

Patient Arrival Date	
Description	The date the patient arrived to the ED/hospital.
Element Values	MM DD YYYY
Additional Information	• Can be different from Date of Admission. • Field cannot be NA or blank. • This is the date on which the patient was first triaged/registered at the Level 1/Level 3 trauma centre after arriving from the scene. Please use the earliest date/time recorded from the patient's chart. • For inpatients who sustain a trauma injury of ISS≥12 while being treated for conditions unrelated to trauma, admission date will be the same as date of injury.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: PAT_A_DATE Field Type: Date Field Length: 2, 2, 4

Patient Arrival Time	
Description	The time the patient arrived to the ED/hospital.
Element Values	HH MM in 24–hour clock
Additional Information	• If the patient was brought to the ED, report the time the patient arrived at the ED. If the patient was directly admitted to the hospital, report the time the patient was admitted to the hospital. • Field cannot be NA or blank. • For inpatients who sustain a trauma injury while being treated for conditions unrelated to trauma, admission time will be the same as time of injury.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: PAT_A_TIME Field Type: Time Field Length: 2, 2

Provincial Health Card Number	
Description	Patient's Ontario health number including the 2–character version code.
Element Values	10–digit health care number with an additional 1– or 2– character alpha code. No spaces.
Additional Information	- Custom Field ?–Unknown /–Not Applicable - If the health number is unknown, enter "?". For example, this may apply to a patient who dies in the ED or an Ontario patient with an unknown health card number. - If the patient is not eligible for an Ontario health number, enter "/". For example, this may apply to a patient from out of province. - Not Applicable should be documented if the patient does not have a health number due to religious reasons. Unknown should be documented if the patient has newly arrived in Ontario and is eligible for but has not yet received a health number.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Demographics tab in EMR 2. Face Sheet
Data History	NA
Data Attributes	Field Name: PAT_ACCOUNT Field Type: String Field Length: 12

Date of Birth	
Description	The patient's birth date.
Element Values	MM DD YYYY
Additional Information	?—Unknown.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Face sheet 2. ED physician record 3. ED nursing record
Data History	NA
Data Attributes	Field Name: DOB_DATE Field Type: Date Field Length: 2, 2, 4

Age	
Description	The patient's age at the time of injury (best approximation).
Element Values	Relevant value for data element
Additional Information	• Auto–calculated using 1) Date of birth AND 2) Date of Admission (when patient is not admitted use Patient Arrival Date) • For paediatric patients less than 1 year of age enter the age in months, selecting months from the AGE_UNIT data field.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Data History	NA
Data Attributes	Field Name: AGE_VALUE Field Type: Integer Field Length: 3

in (Age Units)	
Description	The units used to document the patient's age (minutes, hours, days, months, years, weeks).
Element Values	1 Years (≥ 12 months of age) 2 Months (< 12 months) 3 Days (< 1 month) 5 Hours 6 Minutes 7 Weeks ? Unknown
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED physician record 2. ED nursing record 3. Face sheet
Data History	NA
Data Attributes	Field Name: AGE_UNIT Field Type: Integer Field Length: 1

Sex	
Description	The patient's sex.
Element Values	1 Male 2 Female 3 Intersex ? Unknown
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form 4. Triage/Trauma Flow Sheet 5. EMS Run Report 6. History and Physical
Data History	NA
Data Attributes	Field Name: PAT_GENDER Field Type: Integer Field Length: 1

Gender Identity	
Description	Each person's internal and individual experience of gender.
Element Values	1 Transgender–Female (The patient identifies as Transgender Male–to–Female) 2 Transgender–Male (The patient identifies as Transgender Female–to–Male) 3 Non–Binary, Genderqueer, Gender Non–Confirming 4 Male (The patient identifies as Male) 5 Female (The patient identifies as Female) 6 Other (Other Gender Identity) 7 Non–Disclosed (The patient does not wish to disclose Gender Identity) / Not Applicable ? Unknown
Additional Information	• The default setting can be configured to 'Not Applicable' for Ontario non–TQIP sites, allowing sites to input values of 'Not Applicable'. • TQIP sites may use 'Unknown', as 'Not Applicable' is not an available option • Patient gender should be based upon self–report or identified by a family member.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: PAT_GENDER_ID Field Type: Integer Field Length: 1

Gender–Affirming Hormone Therapy	
Description	Has the patient been using hormone therapy within the past month (30 days)?
Element Values	1 Yes 2 No 3 Non–Disclosed / Not Applicable ? Unknown
Additional Information	• This is a new data element introduced in the NTDB 2025 update. • The default setting can be configured to 'Not Applicable' for Ontario non–TQIP sites, allowing sites to input values of 'Not Applicable. • TQIP sites may use 'No' unless there is a documentation that the patient is currently taking hormone therapy.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: PAT_GENDER_ID Field Type: Integer Field Length: 1

Race	
Description	The patient's race.
Element Values	1 American Indian 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White 6 Other Race ? Unknown
Additional Information	• Report all that apply (up to 6 selections). • Patient race should be based upon self–report or identified by a family member. • The default setting can be configured to 'Not Applicable' for Ontario non–TQIP sites, allowing sites to input values of 'Not Applicable.'
OTR Required	No
NTDB Required	Yes (TQIP 'Unknown')
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form 4. Triage/Trauma Flow Sheet 5. EMS Run Report 6. History and Physical
Data History	NA
Data Attributes	Field Name: PAT_RACE01 / PAT_RACE02 / PAT_RACE03 / PAT_RACE04 / PAT_RACE05 / PAT_RACE06 Field Type: Integer Field Length: 1

Ethnicity	
Description	The patient's ethnicity.
Element Values	1 Hispanic or Latino 2 Not Hispanic or Latino ? Unknown
Additional Information	• Patient ethnicity should be based upon self–report or identified by a family member. • The maximum number of ethnicities that may be reported for an individual patient is 1. • The default setting can be configured to 'Not Applicable' for Ontario non–TQIP sites, allowing sites to input values ranging from 'Not Applicable.'
OTR Required	Yes
NTDB Required	Yes (TQIP 'Unknown')
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form 4. Triage/Trauma Flow Sheet 5. History and Physical 6. EMS Run Report
Data History	NA
Data Attributes	Field Name: PAT_ETHNIC Field Type: Integer Field Length: 1

Patient Address – ZIP Code	
Description	The patient's home ZIP code of primary residence.
Element Values	NNNNN
Additional Information	- The default setting can be configured to 'Not Applicable' for Ontario sites, but a user can indicate *Postal Code (see the following data element).* - Enter the patient's primary residential ZIP Code (in NNNNN format) with no space. ZIP Code must be entered in numerical values only.
OTR Required	No
NTDB Required	Yes (TQIP 'Unknown')
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_ZIP Field Type: Integer Field Length: 5

Patient Address – Postal Code	
Description	The patient's home Postal code of primary residence.
Element Values	ANANAN
Additional Information	• Enter the patient's primary residential postal code (in ANANAN format) with no space. • If Ontario primary residence postal code is unknown, enter "? Unknown". • A primary residential address is not a PO Box but the physical location of their home. • If a patient does not have a primary residence enter '/ Not Applicable'. • The default setting can be configured to 'Not Applicable' for Ontario non–TQIP sites, allowing sites to input values ranging from 'Not Applicable.'
OTR Required	Yes
NTDB Required	Yes (TQIP 'Unknown')
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_POST Field Type: String Field Length: 6

Patient Address – Homeless	
Description	Indicator to specify if the patient is homeless.
Element Values	Y/N
Additional Information	• Only reported when 'Patient's Home Postal Code' and/or 'ZIP Code' is not applicable. • Homeless is defined as a person who lacks stable housing. • Includes persons living unsheltered, emergency sheltered, or provisionally accommodated (in transitional housing or a supervised public or private facility providing temporary living quarters).
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Face Sheet 2. Physician Record 3. Nursing Record
Data History	NA
Data Attributes	Field Name: PAT_HOMLS_YN Field Type: Character (Y/N) Field Length: 1

Patient Address – Province/Territory	
Description	The province or territory where the patient resides.
Element Values	AB Alberta BC British Columbia MB Manitoba NL Newfoundland and Labrador NB New Brunswick NT Northwest Territories NS Nova Scotia ON Ontario PE Prince Edward Island PQ Quebec SK Saskatchewan NU Territory of Nunavut YT Yukon / Not Applicable ? Unknown
Additional Information	
OTR Required	Yes (This may appear as optional in Gen6 but is required for entry.)
NTDB Required	Yes (TQIP 'Not Applicable')
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_ST / PAT_ADR_FST Field Type: Character Field Length: 2

Patient Address – City	
Description	The city where the patient resides.
Element Values	Relevant value for data element.
Additional Information	Enter the patient's city (or town/village/hamlet) of residence.
OTR Required	Yes
NTDB Required	Yes (TQIP 'Not Applicable')
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_CI / PAT_ADR_FCI Field Type: Character Field Length: 50

Patient Address – State	
Description	The state where the patient resides.
Element Values	Relevant value for data element.
Additional Information	The default setting can be configured to 'Not Applicable' for Ontario facilities.
OTR Required	Yes
NTDB Required	Yes (TQIP 'Not Applicable')
Data Source Hierarchy	4. Face Sheet 5. Billing Sheet 6. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_CI / PAT_ADR_FCI Field Type: Character Field Length: 50

Patient Address – Country	
Description	The country where the patient resides.
Element Values	Refer to Appendix B.
Additional Information	• Enter the patient's country of residence from the drop–down menu. Canada is at the top of the list. • If the patient spends the majority of time in one country, enter that country as country of residence. The full country menu drop–down list is in alphabetical order and can be viewed in the OTR. • Unknown is at the bottom of the list. • Field cannot be '/' or blank. • This data will be sent to NTDB as the only patient residential information we send.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_CY_S Field Type: Character Field Length: 2

Patient Resident Code	
Description	Patient's residence code from the Ministry of Health and Long–Term Care Residence Coding Manual.
Element Values	4–digit code assigned by the Ontario Ministry of Health
Additional Information	• Custom Field. • Valid data: 0000–9999 • The element is required when 'Patient – Postal Code' is entered. • The Residence Codes manual is available by registering on the MOHLTC website: https://www.ontario.ca/page/ministry–reports–master–numbering–system • The first two digits represent the county, district or regional municipality in which the place is located. Digits three and four identify municipalities within the county, or areas of the county if the area is not municipally organized, or Indian Reserves and Settlements.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: PAT_ADR_RES Field Type: Integer Field Length: 4

Alternate Residence	
Description	Documentation of the type of patient without a home ZIP/Postal code.
Element Values	1 Undocumented Citizen 2 Migrant Worker 3 Foreign Visitor / Not Applicable ? Unknown
Additional Information	• Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission. • Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country to accept seasonal employment in the same or different country. • Foreign visitor is defined as any person legally visiting another country other than his/her usual place of residence for any reason. 2016 NTDS categorizes this as retired but please still fill out for OTR information (will not be sent to NTDB).
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Face Sheet 2. Billing Sheet 3. Admission Form
Data History	NA
Data Attributes	Field Name: PAT_ADR_ALT / PAT_ADR_ALT02 / PAT_ADR_ALT03 Field Type: Integer Field Length: 1

Injury Information

Injury Date	
Description	The date the injury occurred.
Element Values	MM DD YYYY
Additional Information	• Field cannot be blank. "?" should be entered for unknown. • Estimated injury date must be based on patient, witness, family, or healthcare provider report. Other proxy measures (e.g., 911 call times) must not be reported. • In the case of a baby that suffers injury before birth in a motor vehicle collision and subsequently requires delivery by C–Section the following day, the date of injury should be entered as the day before birth. • For patients who sustain a trauma injury of ISS≥12 while being treated for conditions unrelated to trauma, admission date will be the same as date of injury.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. History and Physical 4. Face Sheet 5. ED Physician Note
Data History	NA
Data Attributes	Field Name: INJ_DATE Field Type: Date Field Length: 2, 2, 4

Injury Time	
Description	The time the injury occurred.
Element Values	HH MM in 24–hour clock
Additional Information	• Field cannot be NA or blank. "?" should be entered for unknown. • Estimated injury time must be based on patient, witness, family, or healthcare provider report. Other proxy measures (e.g., 911 call times) must not be reported. • Incident time should be taken from the Ambulance Call Report, Police Crash Report, or from the history notes on the hospital chart. It is important to document an incident time when possible because calculations for elapsed times are based on this data element. • For patients who sustain a trauma injury while being treated for conditions unrelated to trauma, admission time will be the same as time of injury.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. History and Physical 4. Face Sheet 5. ED Physician Note
Data History	NA
Data Attributes	Field Name: INJ_TIME Field Type: Integer Field Length: 2, 2

ICD–10 Location Code	
Description	Place of occurrence external cause code used to describe the place/site/location of the injury event (U98.x).
Element Values	Relevant value for data element.
Additional Information	Only ICD–10–CM or ICD–10–CA codes are accepted.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
Data History	NA
Data Attributes	Field Name: INJ_PLC_ICD10 Field Type: String Field Length: 5

Protective Devices – Restraint	
Description	Protective devices in use or worn by the patient at the time of the injury. Includes protective child restraint devices used by the patient at the time of injury.
Element Values	1 None 2 Seatbelt – Lap and Shoulder 3 Seatbelt – Lap Only 4 Seatbelt – Shoulder Only 5 Seatbelt – NFS 6 Child Booster Seat 7 Child Car Seat 8 Infant Car Seat 9 Truck Bed Restraint / Not Applicable ? Unknown
Additional Information	• Allows up to 2 selections. • Evidence of the use of protective device may be reported or observed. • Protective devices in use or worn (or not used/worn) by the patient at the time of the injury. Collect for all mechanisms of injury. Enter '/' for Car/Pedestrian incident where the pedestrian was injured.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. Nursing Notes/Flow Sheet 4. History and Physical
Data History	NA
Data Attributes	Field Name: INJ_RESTR / INJ_RESTR2 Field Type: Integer Field Length: 1

Protective Devices – Airbag	
Description	Indication of airbag deployment during a motor vehicle crash.
Element Values	1 No Airbags in Vehicle 2 Airbags Did Not Deploy 3 Front (Deployed) 4 Side (Deployed) 5 Airbag Deployed Other (Knee, Airbelt, Curtain, etc.) 6 Airbag Type Unknown (Deployed) / Not Applicable ? Unknown
Additional Information	• Allows up to 4 selections. • Evidence of airbag deployment may be reported or observed. • Report "3 Front (Deployed)" for patients with documented airbag deployments but are not further specified.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. Nursing Notes/Flow Sheet 4. History and Physical
Data History	NA
Data Attributes	Field Name: AIRBAG01, AIRBAG02, AIRBAG03, AIRBAG04 Field Type: Integer Field Length: 1

Protective Devices – Equipment	
Description	Protective devices (safety equipment) in use or worn by the patient at the time of the injury.
Element Values	1 None 2 Helmet 3 Eye Protection 4 Protective Clothing 5 Protective Non–Clothing Gear (e.g., Shin Guard, Padding) 6 Hard Hat 7 Personal Floatation Device 8 Other / Not Applicable ? Unknown
Additional Information	• Allows up to 4 selections. • If safety equipment is available and there is no safety equipment worn then it should be marked as "None". If there is no safety equipment available and none is worn then it should be marked as "Not Applicable". For example, if a child is hurt riding an ATV and the child is not wearing a helmet, this should be marked as "None" not "NA". • "2 Helmet" should be reported if a helmet was worn but flew off.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. Nursing Notes/Flow Sheet 4. History and Physical
Data History	NA
Data Attributes	Field Name: INJ_PDEV01 / INJ_PDEV02 / INJ_PDEV03 / INJ_PDEV04 Field Type: Integer Field Length: 1

Injury Address – ZIP Code	
Description	The ZIP code of the incident location.
Element Values	NNNNN
Additional Information	• The default setting can be configured to 'Not Applicable' for Ontario sites, but a user can indicate *Postal Code (see the following data element).* • Enter the patient's primary residential ZIP Code (in NNNNN format) with no space. ZIP Code must be entered in numerical values only.
OTR Required	No
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: INJ_ADR_ZIP Field Type: Integer Field Length: 6

Injury Address – Postal Code	
Description	The Postal code of the incident location.
Element Values	ANANAN
Additional Information	• Enter the incident location's postal code (in ANANAN format) with no space. ZIP Code must be entered in upper case. • The default setting can be configured to 'Not Applicable' for Ontario non–TQIP sites, allowing sites to input values ranging from 'Not Applicable.'
OTR Required	Yes
NTDB Required	Yes (TQIP 'Unknown')
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: INJ_ADR_POST Field Type: String Field Length: 6

Injury Address – City	
Description	The city or township where the patient was found or to which the unit responded.
Element Values	Relevant value for data element.
Additional Information	Fill in city closest to where injury occurred.
OTR Required	Yes
NTDB Required	Yes (TQIP 'Not Applicable')
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: INJ_ADR_CI, INJ_ADR_FCI Field Type: Character Field Length: 50

Injury Address – Province/Territory	
Description	The province or territory where the patient was found or to which the unit responded (or best approximation).
Element Values	AB Alberta BC British Columbia MB Manitoba NL Newfoundland and Labrador NB New Brunswick NT Northwest Territories NS Nova Scotia ON Ontario PE Prince Edward Island PQ Quebec SK Saskatchewan NU Territory of Nunavut YT Yukon / Not Applicable ? Unknown
Additional Information	
OTR Required	Yes
NTDB Required	Yes (TQIP 'Not Applicable')
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: INJ_ADR_ST, INJ_ADR_FST Field Type: Character Field Length: 2

Injury Address – Country	
Description	The country where the patient was found or to which the unit responded (or best approximation).
Element Values	Refer to Appendix B.
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report Triage/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: INJ_ADR_CY_S Field Type: Character Field Length: 2

UTM Code	
Description	Seven–digit numeric classification code to document the location of the injury incident for all patients who arrive by ambulance.
Element Values	Seven–digit numeric classification code
Additional Information	• Custom Field • ?—Unknown: Includes patients for whom the geocode is not available in the documentation or cannot be obtained through reasonable effort. • /—Not Applicable: Includes injuries occurring outside of Ontario or arriving by private vehicle. • If the patient was transferred by a self–dispatched area which does not document geocodes, enter an "S" before the 5– or 7–digit code from the self–dispatched area. • In cases where the geocode received from the ambulance dispatch service is identified by OTR edit checks as incorrect, hospitals may enter the geocode found in the Metro geocode book rather than documenting unknown. • For those individuals obtaining geocode information from UTM maps please note that the first three digits of a geocode represent the three most significant of the Easting and the last four digits of the geocode represent the four most significant digits of the Northing. • Geocodes are based on UTMs (Universal Transverse Mercator) which is a mapping projection like latitude and longitude. However, a map is required to determine geocodes and may not be available to ambulance dispatch staff for some areas.
OTR Required	Yes (This may appear as optional in Gen6 but is required for entry)
NTDB Required	No
Data Source Hierarchy	Ambulance Call Report and may be recorded as the UTM on the pre–hospital D form or F8 form.
Data History	NA
Data Attributes	Field Name: PHP_PCR_NUMS_L Field Type: Integer Field Length: 7

Work Related	
Description	Indication of whether the injury occurred during paid employment.
Element Values	Y/N

Additional Information	• If work-related, *Occupation* and *Occupational Industry* must be reported.
	• Self–employed work such as farming or ranching are considered work–related injuries.
	• Work–related injuries include only those injuries that occur while the patient is being paid for services. Tradespeople who are injured while voluntarily working at their trade at their own home or at a friend's home or as a hobby are not considered as work–related injury.
	• Work–related injuries include:
	  ○ Injuries resulting from an event in the work environment where people are present as a condition of their employment including:
	  ○ Employer's premises
	  ○ Other locations where employees are engaged in work–related activities or are present as a condition of their employment
	  ○ Not only the primary facility, but also areas such as company storage facilities
	  ○ Equipment or materials used in the course of an employee's work
	  ○ Incidents that occur while people work at home if the incident occurs while conducting business tasks
	  ○ Injuries to full or part time employees
	  ○ Injuries that occur outside normal working hours
	  ○ Injuries that occur during travel for company business (all the time spent in the interest of the company including, but not limited to, travel to and from customer contacts, and entertaining or being entertained for the purpose of transacting, discussing or promoting business etc.)
	• Work–related injuries exclude:
	  ○ Travel to and from work
	  ○ Incidents that occur in company parking lots on the way to and from work.

OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. History and Physical 4. Face Sheet 5. Billing Sheet
Data History	NA
Data Attributes	Field Name: INJ_WORK_YN Field Type: Character (Y/N) Field Length: 1

Occupation	
Description	The occupation of the patient.
Element Values	The table below lists patient's occupation.
Additional Information	• Only reported if the injury is work–related. • The null value "Not Applicable" is reported if Work Related is "N".
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. EMS Run Sheet 3. ED Nurses' Notes
Data History	NA
Data Attributes	Field Name: PAT_JOB, PAT_JOB_S Field Type: Integer Field Length: 2

Patient's Occupation	
1	Business and Financial Operations Occupations
2	Architecture and Engineering Occupations
3	Community and Social Services Occupations
4	Education, Training, and Library Occupations
5	Healthcare Practitioners and Technical Occupations
6	Protective Service Occupations
7	Building and Grounds Cleaning and Maintenance Occupations
8	Sales and Related Occupations
9	Farming, Fishing, and Forestry Occupations
10	Installation, Maintenance, and Repair Occupations
11	Transportation and Material Moving Occupations
12	Management Occupations
13	Computer and Mathematical Occupations
14	Life, Physical, and Social Science Occupations
15	Legal Occupations
16	Arts, Design, Entertainment, Sports, and Media Occupations
17	Healthcare Support Occupations
18	Food Preparation and Serving Related Occupations
19	Personal Care and Service Occupations
20	Office and Administrative Support Occupations
21	Construction and Extraction Occupations
22	Production Occupations
23	Military Specific Occupations
/	Not Applicable
?	Unknown

Occupational Industry	
Description	The occupational industry associated with the patient's work environment.
Element Values	1 Finance, Insurance, and Real Estate 2 Manufacturing 3 Retail Trade 4 Transportation and Public Utilities 5 Agriculture, Forestry, Fishing 6 Professional and Business Services 7 Education and Health Services 8 Construction 9 Government 10 Natural Resources and Mining 11 Information Services 12 Wholesale Trade 13 Leisure and Hospitality 14 Other Services / Not Applicable ? Unknown
Additional Information	• Only reported if the injury is work-related. • The null value "Not Applicable" is reported if *Work Related* is "N".
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. EMS Run Sheet 3. ED Nurses' Notes
Data History	NA
Data Attributes	Field Name: PAT_JOB_TYPE, PAT_JOB_TYPE_S Field Type: Integer Field Length: 2

Report of Physical Abuse	
Description	A report of suspected physical abuse was made to law enforcement and/or protective services.
Element Values	Y/N
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Nurses' Notes 2. Social Work 3. Physician Notes
Data History	NA
Data Attributes	Field Name: INJ_ABUSE_RP_YN Field Type: Character (Y/N) Field Length: 1

Investigation of Physical Abuse	
Description	Investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.
Element Values	Y/N
Additional Information	The element is required when 'Report of Physical Abuse' is entered.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Nurses' Notes 2. Social Work 3. Physician Notes
Data History	NA
Data Attributes	Field Name: INJ_ABUSE_INVST_YN Field Type: Character (Y/N) Field Length: 1

ICD–10 Primary External Cause Code	
Description	External cause code used to describe the mechanism (or external factor) that caused the injury event.
Element Values	Relevant ICD–10–CA code value for injury event.
Additional Information	- The primary external cause code should describe the main reason a patient is admitted to the hospital. - V01–Y98 is a classification within the ICD–10 that describes the nature of injury. Refer to Appendix C for a list of ICD–10–CA inclusion and exclusion external cause codes. - This field cannot be NA or blank. - Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code must be reported for each cause. The first–listed external cause code will be selected in the following order: - External cause codes for child and adult abuse take priority over all other external cause codes. - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse. - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism. - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism. - The first listed external cause code must correspond to the cause of the most serious diagnosis due to an assault, accident or self–harm, following the order of hierarchy listed above.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Referring hospital nots 3. Triage/Trauma Flow Sheet 4. Nursing Notes/Flow Sheet 5. History and Physical 6. Progress Notes
Data History	NA
Data Attributes	Field Name: INJ_ECODE_ICD10_01 Field Type: String Field Length: 7

ICD–10 Secondary External Cause Code	
Description	Additional external cause code used in conjunction with the primary external cause code if multiple external cause codes are required to describe the injury event.
Element Values	Relevant ICD–10–CA code value for injury event.

Additional Information	• V01–Y98 is a classification within the ICD–10 that describes the nature of injury. Refer to Appendix C for an extensive list of ICD–10–CA inclusion and exclusion external cause codes.
	• The null value "Not Applicable" is reported if no additional external cause codes are reported.
	• Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code must be assigned for each cause. The first–listed external cause code will be selected in the following order:
	   o External cause codes for child and adult abuse take priority over all other external cause codes.
	   o External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
	   o External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
	   o External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
	   o The first listed external cause code must correspond to the cause of the most serious diagnosis due to an assault, accident or self–harm, following the order of hierarchy listed above.

OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Referring hospital nots 3. Triage/Trauma Flow Sheet 4. Nursing Notes/Flow Sheet 5. History and Physical 6. Progress Notes
Data History	NA
Data Attributes	Field Name: INJ_ECODE_ICD10_02 Field Type: String Field Length: 7

ICD–10 Tertiary External Cause Code	
Description	Additional external cause code used in conjunction with the primary/secondary external cause code if multiple external cause codes are required to describe the injury event.
Element Values	Relevant ICD–10–CA code value for injury event.

Additional Information	• V01–Y98 is a classification within the ICD–10 that describes the nature of injury. Refer to Appendix C for an extensive list of ICD–10–CA inclusion and exclusion external cause codes.
	• The null value "Not Applicable" is reported if no additional external cause codes are reported.
	• Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code must be assigned for each cause. The first–listed external cause code will be selected in the following order:
	   o External cause codes for child and adult abuse take priority over all other external cause codes.
	   o External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
	   o External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
	   o External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
	   o The first listed external cause code must correspond to the cause of the most serious diagnosis due to an assault, accident or self–harm, following the order of hierarchy listed above.

OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Referring hospital notes 3. Triage/Trauma Flow Sheet 4. Nursing Notes/Flow Sheet 5. History and Physical 6. Progress Notes
Data History	NA
Data Attributes	Field Name: INJ_ECODE_ICD10_03 Field Type: String Field Length: 7

Specify – Cause of Injury	
Description	Free text with additional details about cause of injury.
Element Values	Relevant value for data element.
Additional Information	• Describe in more detail the cause of the injury. • Use standardized language for data analysis purposes.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS Run Sheet 2. Referring hospital notes 3. Triage Form / Trauma Flow Sheet 4. ED Nurses' Notes 5. History and Physical 6. Progress Notes
Data History	NA
Data Attributes	Field Name: INJ_CAU_SS, INJ_CAU_S01, INJ_CAU_S02, INJ_CAU_S03 Field Type: String Field Length: 200

Injury Type	
Description	The primary source of the trauma injury sustained by the patient.
Element Values	1 Blunt 2 Penetrating 3 Burn 4 Other / Not Applicable ? Unknown

Additional Information	• Consider only the cause of injury. For example, a patient struck by a motor vehicle is documented as a blunt injury even if his injuries include deep lacerations. For patients with more than one type of injury (i.e., blunt and penetrating) consider the most severe injury to determine the injury type. If there are concerns, consult your medical director or the physician responsible for the patient's care.
	• In an assault where injuries are the result of both stabbing and beating:
	  ○ If the injuries include a head injury and a stab to the arm, the injury type would be documented as blunt because the more severe head injury.
	  ○ If the injuries include a laceration to an organ as a result of the stabbing and minimal injury from the assault, the injury type would be penetrating.
	• Strangulation and hanging injuries are reported as "1 Blunt".
	• Blast injures are reported as "1 Blunt".
	• Penetrating is only if a missile (bullets, knives, and items such as pieces of sharp glass or metal) enters the body.
	• Electrocution injuries are reported as "3 Burn". For isolated burns but if accompanying injury with AIS>1 should be reported as "1 Blunt" or "2 Penetrating "depending on the other injury.
	• Drowning injuries are reported as "4 Other".

OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS run sheet 2. ED physician record 3. ED nursing record 4. Trauma nurse flow sheet 5. Trauma Physician
Data History	NA
Data Attributes	Field Name: INJ_TYPES, INJ_TYPE01, INJ_TYPE02, INJ_TYPE03 Field Type: integer Field Length: 1

Position in Vehicle	
Description	For motor vehicle crash, the position of the patient in the vehicle prior to the crash.
Element Values	1 Driver 2 Front Seat Middle 3 Front Seat Passenger 4 Second Row Left 5 Second Row Middle 6 Second Row Right 7 Third Row Left 8 Third Row Middle 9 Third Row Right 10 Station Wagon Rear 11 Truck/Van Rear 12 Truck Bed 13 Bus Passenger 14 Passenger NFS 15 Hanger On 16 Ejected / Not Applicable ? Unknown
Additional Information	• Position in Vehicle is a numbering system designed by the Ministry of Transportation to indicate the position of the patient when injured in, on, or by a vehicle. • All occupants of the third bench in a minivan or SUV should be coded as "7 Third Row Left", "8 Third Row Middle", or "9 Third Row Right". • Riders in a box of a pickup truck should be coded as "12 Truck Bed". Riders in the rear of an enclosed truck or van (e.g. cargo van with no seats in back) should be coded as "11 Truck/Van Rear". • If a patient is boarding and alighting or jumping from a vehicle, then this field should be coded as "Not Applicable".
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Ambulance Report 2. Documentation of verbal report from police received in ED
Data History	NA
Data Attributes	Field Name: INJ_VEH_POS Field Type: Integer Field Length: 2

Impact Location	
Description	For motor vehicle crash, the location on the vehicle of impact.
Element Values	1 Frontal 2 Nearside 3 Farside 4 Side NOS 5 Rear 6 Rollover 7 Roof 8 Broadside 9 Other / Not Applicable ? Unknown
Additional Information	• Impact Location is a description as defined by the Ministry of Transportation for the vehicle in which the patient was travelling in or on. This information is found on the MVAR (Appendix D). • Enter the type of impact for the primary vehicle. The primary vehicle for the purposes of the OTR is the one that the patient is travelling in or on. • The null value "Not Applicable" is reported if a patient is an animal rider.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Ambulance Report 2. Documentation of verbal report from police received in ED
Data History	NA
Data Attributes	Field Name: INJ_IMP_LOC Field Type: Integer Field Length: 1

Prehospital Information

POV/Walk In	
Description	The patient arrived at your hospital in a privately–owned vehicle or walked in. (Private or Public Vehicle)
Element Values	Y/N
Additional Information	Cases where patients did not arrive by EMS will indicate 'Yes' for a POV/Walk In.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS run report
Data History	NA
Data Attributes	Field Name: PH_POV_YN Field Type: Character (Y/N) Field Length:1

Was Patient Extricated?	
Description	Was the patient removed/released from the vehicle by emergency response team?
Element Values	Y/N
Additional Information	Extrication is documented if the patient was trapped and required release from the scene of the incident. Examples include extrication from motor vehicles, dwellings on fire and falls where extrication is required. For some cases, extrication is not a consideration, i.e. fall from highchair. Use Inappropriate if this is the case.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS Run Report 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. Billing Sheet / Medical Records Coding Summary Sheet
Data History	NA
Data Attributes	Field Name: PH_EXT_YN Field Type: Character (Y/N) Field Length: 1

Extrication Time Required/Minutes	
Description	If the patient was extricated, the time in minutes to complete the extrication.
Element Values	MMM
Additional Information	Enter the time of extrication in minutes. Extrication time is from the time of arrival of the rescue team to the time of successful extrication. Extrication time can be found on the Ambulance Call Report. This field will be skipped if "no" was entered in the previous field.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS Run Report 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. Billing Sheet / Medical Records Coding Summary Sheet
Data History	NA
Data Attributes	Field Name: PH_EXT_MINS Field Type: Integer Field Length: 3

Prehospital Provider – Mode

Description	The mode of transport delivering the patient to your hospital.
Element Values	1 Ground Ambulance 2 Helicopter Ambulance 3 Fixed–Wing Ambulance 4 Private Vehicle or Walk–In 5 Police 6 Public Safety 7 Water Ambulance 8 Other / Not Applicable ? Unknown
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_MODES Field Type: Integer Field Length: 1

Prehospital Provider – Agency	
Description	The agency transporting the patient to your facility.
Element Values	Three–digit ambulance service number from ACR for land ambulances only.
Additional Information	A list of ambulance service number is available in the Report Pickup.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHP_AGNCLNKS Field Type: Integer Field Length: 3

Prehospital Provider – Unit	
Description	The unit of the Agency transporting the patient to your facility.
Element Values	Relevant value for data element
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: PHP_UNITS Field Type: Character Field Length:50

Prehospital Provider – Care Level	
Description	The care level the patient received by the transport provider that brought the patient to your facility.
Element Values	1 Advanced Life Support (Retired) 2 Basic Life Support (Retired) 3 PCP (Primary Care Paramedic) 4 ACP (Advanced Care Paramedic) 5 CCP (Critical Care Paramedic) / Not Applicable ? Unknown
Additional Information	• Please select from menu options 3–5, 'Not Applicable', or 'Unknown'. • "3 PCP" is equivalent to "2 Basic Life Support". • "4 ACP" is equivalent to "1 Advanced Life Support".
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_CARES Field Type: Integer Field Length: 1

Prehospital Provider – Scene EMS Report	
Description	Quality of report provided by EMS from the scene.
Element Values	1 Complete 2 Incomplete 3 Missing 4 Unreadable / Not Applicable ? Unknown
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_RP_DETAILS Field Type: Integer Field Length: 1

Prehospital Provider – PCR UUID	
Description	The patient's universally unique identifier (UUID) as assigned by the emergency medical service (EMS) agency (Call Number),
Element Values	Relevant value for data element
Additional Information	Canada does not use PRC UUID. Will be defaulted to N/A.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_PCR_UUIDS Field Type: String Field Length: 12

Prehospital Provider – Call Received Date	
Description	The date the call was received by the EMS dispatch centre.
Element Values	MM DD YYYY
Additional Information	- For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed. - If dates are unknown, "?—Unknown" should be documented in all or a portion of the date data elements.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_C_DATES Field Type: Date Field Length: 2, 2, 4

Prehospital Provider – Call Received Time	
Description	The time the call was received by the EMS dispatch centre.
Element Values	HH MM in 24–hour clock
Additional Information	The time the ambulance arrived at the scene using the 24–hour clock.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_C_TIMES Field Type: Integer Field Length: 2, 2

Prehospital Provider – Call Dispatched Date	
Description	The date the unit transporting to your hospital was notified by dispatch.
Element Values	MM DD YYYY
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_D_DATES Field Type: Date Field Length: 2, 2, 4

Prehospital Provider – Call Dispatched Time	
Description	The time the unit transporting to your hospital was notified by dispatch.
Element Values	HH MM in 24–hour clock
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_E_TIMES Field Type: Time Field Length: 2,2

Prehospital Provider – Arrived at Location Date	
Description	The date the unit transporting to your hospital arrived on the scene/transferring facility.
Element Values	MM DD YYYY
Additional Information	For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_A_DATES Field Type: Date Field Length: 2, 2, 4

Prehospital Provider – Arrived at Location Time	
Description	The time the unit transporting to your hospital arrived on the scene/transferring facility.
Element Values	HH MM in 24–hour clock
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_A_TIMES Field Type: Time Field Length: 2, 2

Prehospital Provider – Arrived at Patient Date	
Description	The date the unit arrived to the patient.
Element Values	MM DD YYYY
Additional Information	• For all ambulance dates, the default is the date of the incident. Enter a different date if necessary or press Enter to accept the dates displayed. • If dates are unknown, "/" should be documented in all or a portion of the date data elements.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_P_DATES Field Type: Date Field Length: 2, 2, 4

Prehospital Provider – Arrived at Patient Time	
Description	The time the unit arrived to the patient
Element Values	HH MM in 24–hour clock
Additional Information	EMS Arrival Time to Patient
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_P_TIMES Field Type: Time Field Length: 2, 2

Prehospital Provider – Departed Location Date	
Description	The date EMS left the scene/transferring facility transporting to your facility
Element Values	MM DD YYYY
Additional Information	• Date Departed from Scene/Transferring Facility. • Enter the date the ambulance departed from the scene if different from the date of the incident. • For patients transported from the scene of injury, this is the date on which the unit transporting the patient from the scene departed from the scene (departure is defined at date/time when the vehicle started moving). • It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene enter in chronological order with the transport taking patient to hospital last.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_L_DATES Field Type: Date Field Length: 2, 2, 4

Prehospital Provider – Departed Location Time (Scene/ Transferring Facility)	
Description	The time the unit transporting to your hospital left the scene/transferring facility.
Element Values	HH MM in 24–hour clock
Additional Information	• Enter the time the ambulance departed from the scene using the 24–hour clock. • For patients transported from the scene of injury, this is the time at which the unit transporting the patient from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_L_TIME Field Type: Time Field Length: 2, 2

Prehospital Provider – Scene Time Elapsed	
Description	The elapsed amount of time from when the unit arrived at the location to when they departed the scene.
Element Values	HH MM in 24–hour clock
Additional Information	• Total scene time is a calculated field based on the time ambulance arrived at the scene location/rendezvous point (required data element) to the time the ambulance departed the scene (required data element). Scene time will be displayed on the screen in hours and minutes when all times on this screen have been entered. • Arrival and departure dates should be documented from a patient care perspective. The arrival time of the first care transport should be documented even if the majority of care is given by another transport. The departure time of the transport responsible for the transport of the patient should be documented. • It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene, it may be necessary to combine the dates, times and the on–scene procedures from both call reports.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHP_ELAPSED, PHP_ELAPSED_MINS Field Type: Time Field Length: 2, 2

Prehospital Triage Rationale	
Description	Physiologic and anatomic EMS trauma triage criteria and mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons–Committee on Trauma.
Element Values	Relevant value for data element
Additional Information	Use standardized language for data analysis purposes.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PH_TRIAGES_AS_TEXT, PH_TRIAGE01–18 Field Type: Integer Field Length: 2

National Field Triage	
Description	ACS COT 2022 revised National Guideline for the Field Triage of Injured Patients.
Element Values	Relevant value for data element
Additional Information	National Guideline for Field Triage of Injured Patients. https://www.facs.org/quality–programs/trauma/systems/field–triage–guidelines/
OTR Required	No
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: NAT_FLD_TRIAGE01–37 Field Type: Integer Field Length:2

Prehospital Vitals – Paralytic Agents?	
Description	Were paralytic agents/sedatives in place for the patient at the time the GCS was calculated by EMS?
Element Values	Y/N
Additional Information	- For land transport, within the context of ACP/PCP, sedatives such as ketamine or midazolam may be administered during the prehospital stage. - For air transport, Critical Care Paramedic (CPP) crews may carry paralytics and/or sedatives for use at the scene or during a transfer. Similarly, for land transfers, CCP crews on board may administer paralytic agents. - Use standardized language for data analysis purposes.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHAS_PAR_YNS_AS_TEXT Field Type: Character (Y/N) Field Length: 1

Prehospital Vitals – Intubated?	
Description	Was the patient intubated at the time of the GCS at the scene was calculated?
Element Values	Y/N
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS Run Report 2. Triage Form/Trauma Flow Sheet 3. ED Record 4. Nurses Notes
Data History	NA
Data Attributes	Field Name: PHAS_INTUB_YNS Field Type: Character (Y/N) Field Length: 1

Prehospital Vitals – SBP	
Description	First recorded systolic blood pressure measured at the scene of injury.
Element Values	Relevant value for data element.
Additional Information	• Defined as the patient's first recorded SBP upon arrival of EMS personnel at the scene. If the SBP is not taken or not documented, document as unknown. • If the patient is documented as VSA before assistance is initiated, enter "0" zero. • 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 patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'NA' for NTDB submission.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHAS_SBPS Field Type: Integer Field Length:3

Prehospital Vitals – DBP	
Description	Recorded diastolic blood pressure measured at the scene of injury.
Element Values	Relevant value for data element.
Additional Information	• Defined as the patient's first recorded DBP upon arrival of EMS personnel at the scene. If the DBP is not taken or not documented (or EMS PCR is not available) document as 'Unknown'. • If the patient is documented as VSA before assistance is initiated, enter "0" zero. • 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 patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'NA' for NTDB submission.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHAS_DBPS Field Type: Integer Field Length:3

Prehospital Vitals – Pulse Rate	
Description	First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.
Element Values	Relevant value for data element.
Additional Information	• Defined as the patients first recorded pulse rate (#/min) (palpated or auscultated) upon arrival of EMS personnel at the scene. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the PR is not documented (or EMS PCR is not available) document as '?' unknown. • 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 patients arrive by POV/walk in the treatment section will become inactive and this data field will map to 'NA' for NTDB submission.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHAS_PULSES Field Type: Integer Field Length:3

Prehospital Vitals – Unassisted Respiratory Rate (URR)	
Description	First recorded unassisted respiratory rate measured at the scene of injury (expressed as a number per minute).
Element Values	Relevant value for data element.
Additional Information	• Defined as the patient's first recorded unassisted RR upon arrival of EMS personnel at the scene (# per min). Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the RR is not documented (or EMS PCR is not available) document as '?' unknown. Enter '/' (not applicable) if patient respirations are assisted. • Respiratory assistance is defined as mechanical and/or external support of respiration.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHAS_URRS Field Type: Integer Field Length:3

Prehospital Vitals – O2 Saturation	
Description	First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).
Element Values	Relevant value for data element.
Additional Information	• Defined as the patient's first recorded O2 saturation taken upon arrival of EMS personnel at the scene (as a %). Values recorded can be between 0–100. This value should be based upon assessment before administration of supplemental oxygen if O2 saturation of patient was assessed before O2 was given. This may be documented as R/A (room air) breathing without O2 given. If the O2 saturation is not documented or was not taken before supplemental O2 was given, or EMS PCR is not available document as '?' unknown. • If patients arrive by private vehicle/walk-in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Report
Data History	NA
Data Attributes	Field Name: PHAS_SAO2S Field Type: Integer Field Length: 2

Prehospital Vitals – GCS: Eye	
Description:	First recorded Glasgow Coma Score (Eye) measured at the scene of injury.
Element Values	1. No Eye movement when assessed 2. Opens Eyes in Response to Painful Stimulation 3. Opens Eyes in Response to Verbal Stimulation 4. Opens Eyes Spontaneously ⁄ Not Applicable ? Unknown

Additional Information	• Defined as the patient's first eye–opening response for the GCS documented upon arrival of EMS personnel. If the eye–opening response is not documented or if the patient's eyes are swollen shut, or if the PCR is not available, enter '?'
	• If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "Patient's pupils are PERRL," an Eye GCS of 4 may be recorded, If there is no other contradicting documentation.
	• If patients arrive by private vehicle/walk-in the treatment section will become inactive and this data field will map to 'Not Applicable' for NTDB submission.
	• Paediatric value descriptors (child/infant). Infant response underlined.
	  ○ Verbal
	    1. Paediatric (≤2 years):
	    2. No vocal response
	    3. Inconsolable, agitated (moans/grunts)
	    4. Inconsistently consolable, moaning (inconsolable cry)
	    5. Cries but is consolable, inappropriate
	    6. interactions (consolable cry)
	    7. Smiles, oriented to sounds, follow objects, interacts (coos/babbles)
	  ○ Motor
	    1. Paediatric (≤2 years):
	    2. No motor response
	    3. Extension to pain
	    4. Flexion to pain
	    5. Withdrawal from pain
	    6. Localizing pain (withdrawal to touch)
	    7. Appropriate response to stimulation (normal movement)

OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_GCS_EOS Field Type: Integer Field Length: 1

Prehospital Vitals – GCS: Verbal	
Description	First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.
Element Values	1. No Verbal Response (Ped: No Vocal Response) 2. Incomprehensible Sounds (Ped: Inconsolable, Agitated) 3. Inappropriate Words (Ped: Inconsistently Consolable, Moaning) 4. Confused (Ped: Cries but is Consolable, Inappropriate Interactions) 5. Oriented (Ped: Smiles, Oriented to Sounds, Follows Objects, Interacts) / Not Applicable ? Unknown
Additional Information	• Defined as the patient's first verbal response for the GCS documented upon arrival of EMS personnel at the scene. Please use appropriate Adult or Paediatric scale. If the verbal response is not documented or if the PCR is not available, enter '?' unknown. If the patient is intubated then the GCS Verbal score is '1'. • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient is oriented to person, place and time" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation. • If patients arrive by private vehicle/walk-in the treatment section will become inactive and this data field will map to 'Not Applicable' for NTDB submission. • **Please refer to "*Prehospital Vitals – GCS: Eye"* for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_GCS_VRS Field Type: Integer Field Length: 1

Prehospital Vitals – GCS: Motor	
Description	First recorded Glasgow Coma Score (Motor) measured at the scene of injury.
Element Values	1. No Motor Response 2. Extension to Pain 3. Flexion to Pain 4. Withdrawal from Pain 5. Localizing Pain 6. Obeys Commands (Ped: Appropriate Response to Stimulation) / Not Applicable ? Unknown
Additional Information	• Defined as the patient's first motor response for the GCS documented upon arrival of EMS personnel at the scene. Please use appropriate Adult or Paediatric scale. If the motor response is not documented or if the PCR is not available, enter '?' unknown. If the patient is under paralytics then the GCS motor score will be '1'. Intubation alone does not indicate a GCS motor score of 1 since motor response can still be assessed. • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. • If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'Not Applicable' for NTDB submission. • **Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_GCS_MRS Field Type: Integer Field Length: 1

Prehospital Vitals – GCS: Total	
Description	First recorded Glasgow Coma Score (Total) measured at the scene of injury.
Element Values	Relevant value for data element.
Additional Information	- Defined as the total GCS first documented upon arrival of EMS personnel at the scene. If the GCS is not documented or there is no EMS PCR available, enter '?'Unknown Total GCS is calculated automatically if all 3 GCS components are entered. Total GCS values must be between 3–15, please do not enter n/a. - If any of these fields are not valued, GCS is not calculated and will be displayed as "I" on the screen. Press Enter to move to the next field if "I" is displayed. - Do not anticipate what the expected GCS component score would be if the patient were not intubated, paralytic agents were not in effect or their eyes were not swollen shut. - If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented (AAOx3), the total GCS may be assumed to be 15, IF there is no other contradicting documentation. - Component definitions and menu selections for GCS can be found on the 3 previous pages. - If patients arrive by private vehicle/walk–in in the treatment section will become inactive and this data field will map to 'Not Applicable' for NTDB submission. - Although there is value in documenting the component scores when they are available, hospitals may document only the total GCS in cases where only the total score is documented. (Working Group 03/96) **Please refer to "*Prehospital Vitals – GCS: Eye"* for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_RTS_WSC Field Type: Decimal Field Length: 4, 3

Prehospital Vitals – RTS	
Description	The Revised Trauma Score based on vitals measured at the scene of injury. Consists of Glasgow Coma Scale, Systolic Blood Pressure and Respiratory Rate.
Element Values	Relevant value for data element.
Additional Information	Revised Trauma Score at the scene is an auto–calculated field based on Glasgow Coma Scale, systolic blood pressure and respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will not be calculated and "/" should be entered.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: PHAS_RTS_WSC Field Type: Integer Field Length: 2

Prehospital Vitals – GCS 40: Eye	
Description	First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury.
Element Values	0 Not Testable 1 None 2 To Pressure (Paediatric (<5 years) to Pain) 3 To Sound 4 Spontaneous ? Unknown / Not Applicable
Additional Information	• **GCS 40 data elements can be set "Not Applicable" as Ontario currently does not collect any information.** • Defined as first recorded Glasgow Coma Scale (Eye) measured at the scene of injury. • Please enter Unknown or Not Applicable as per 2019 NTDB guidelines.
OTR Required	Yes
NTDB Required	Yes.
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_GCS40_EOS Field Type: Integer Field Length: 2

Prehospital Vitals – GCS 40: Verbal	
Description	First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury.
Element Values	0 Not Testable 1 None 2 Sounds (Paediatric (<5 years) Cries) 3 Words (Paediatric (<5 years) Vocal Sounds) 4 Confused (Paediatric (<5 years) Words) 5 Oriented (Paediatric (<5 years) Talks Normally) ? Unknown / Not Applicable
Additional Information	• **GCS 40 data elements can be set "Not Applicable" as Ontario currently does not collect any information.** • Defined as first recorded Glasgow Coma Scale (Verbal) measured at the scene of injury.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_GCS40_VRS Field Type: Integer Field Length: 2

Prehospital Vitals – GCS 40: Motor	
Description	First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury.
Element Values	0 Not Testable 1 None 2 Extension (Paediatric (<5 years) Extension to Pain) 3 Abnormal Flexion (Paediatric (<5 years) Flexion to Pain) 4 Normal Flexion (Paediatric (<5 years) Localizes Pain) 5 Localizing (Paediatric (<5 years) Obeys Commands) 6 Obeys Commands ? Unknown / Not Applicable
Additional Information	• Defined as first recorded Glasgow Coma Scale (Motor) measured at the scene of injury. • **GCS 40 data elements can be set "Not Applicable" as Ontario currently does not collect any information.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: PHAS_GCS40_MRS Field Type: Integer Field Length: 2

Prehospital Vitals – PTS Total	
Description	The total Paediatric Trauma Score measured at the scene of injury.
Element Values	Relevant value for data element
Additional Information	Please refer to "ED/Resus – Initial Assessment – *Initial Vitals – Paediatric Trauma Score – Total*" for the Paediatric Trauma score calculations.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED physician record 2. ED nursing record 3. Medical progress notes 4. Radiology reports 5. Operative reports
Data History	NA
Data Attributes	Field Name: PHAS_PTSSC Field Type: Integer Field Length: 2

Prehospital Procedures – Procedure	
Description	The procedures performed on the patient at the scene of injury or en route to the first hospital. This element repeats 5 times.
Element Values	Refer to Appendix E
Additional Information	Please note bagging should be considered as ventilation whether it occurs in emergency or at the scene and whether it is manual or mechanical. (Working Group 08/00)
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Ambulance Report 2. Emergency Notes
Data History	NA
Data Attributes	Field Name: NONOP_S_01, NONOP_S_02, NONOP_S_03, NONOP_S_04, NONOP_S_05 Field Type: Integer Field Length: 2

Prehospital Procedures – If Other	
Description	Free text to specify additional procedures performed at the scene of injury. Description of prehospital procedures if "other" was entered.
Element Values	Free Text description
Additional Information	• Use standardized language for data analysis purposes. • This field will be skipped unless "other" was selected from the previous menu. This field is available to identify other non–operative procedures performed at the scene (not included in the previous list of values) that the Lead Trauma Hospitals is interested in capturing.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Ambulance Report 2. Emergency Note
Data History	NA
Data Attributes	Field Name: PH_INTS Field Type: String Field Length: 15

Referring Facility

[Referral History] Immediate Referring Facility – Transfer In	
Description	Was the patient transferred to your facility from another acute care facility?
Element Values	Y/N
Additional Information	• Was the patient transferred to your trauma centre from another acute care or ambulatory facility? (Rural hospital, other trauma centre, reserve/northern nursing station, military base, anywhere with ambulatory (ED) care facilities). Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities. • Primary physician offices (family docs) stand–alone ambulatory surgery centres (day surgeries) are not considered inter–facility transfers. If a patient goes from the scene to family doctor and then is transported to your hospital the patient is considered as coming from 'other' site with appropriate transport entered (EMS or private vehicle in the pre–hospital section as applicable).
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Report 2. Triage/Trauma Flow Sheet 3. History and Physical
Data History	NA
Data Attributes	Field Name: IT_XFR_YN Field Type: Character (Y/N) Field Length: 1

[Referral History] Immediate Referring Facility – Referring Facility	
Description	The Facility ID and Description of the hospital from which the patient was referred.
Element Values	Master Numbering System
Additional Information	A referring hospital is defined as the hospital that transfers the patient directly to the district/tertiary trauma hospital. Hospitals in which the patient is seen and released home with or without treatment before the patient is seen at a district/tertiary trauma hospital are not considered to be referring institutions. Ministry reports: Master Numbering System https://www.ontario.ca/page/ministry–reports–master–numbering–system#section–1
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	
Data History	NA
Data Attributes	Field Name: RFS_FACLNK Field Type: Integer Field Length: 4

[Referral History] Immediate Referring Facility – Arrival Date	
Description	The date the patient arrived at the immediate referring facility.
Element Values	MM DD YYYY
Additional Information	For inter–facility transfer patients, this is the date on which the patient was first triaged/registered at the immediate referring facility after arriving from the scene. Please use the earliest date/time recorded from the patient's chart.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record 2. Triage Form / Trauma Flow Sheet 3. Nursing Notes 4. In–hospital patient database
Data History	NA
Data Attributes	Field Name: RFS_A_DATE Field Type: Date Field Length: 2, 2, 4

[Referral History] Immediate Referring Facility – Arrival Time	
Description	The time the patient arrived at the immediate referring facility.
Element Values	HH MM in 24–hour clock
Additional Information	For inter–facility transfer patients, this is the time at which the patient was first triaged/registered at the immediate referring facility after arriving from the scene. Please use the earliest date/time recorded from the patient's chart.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record 2. Triage Form / Trauma Flow Sheet 3. Nursing Notes 4. In–hospital patient database
Data History	NA
Data Attributes	Field Name: RFS_A_TIME Field Type: Time Field Length: 2, 2

[Referral History] Immediate Referring Facility – Departure Date	
Description	The date the patient departed the immediate referring facility.
Element Values	MM DD YYYY
Additional Information	For inter–facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS Run Sheet 2. ED record 3. Nursing notes
Data History	NA
Data Attributes	Field Name: RFS_DIS_DATE Field Type: Date Field Length: 2, 2, 4

[Referral History] Immediate Referring Facility – Departure Time	
Description	The time the patient departed the immediate referring facility.
Element Values	HH MM in 24–hour clock
Additional Information	For inter–facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. EMS Run Sheet 2. ED record 3. Nursing notes
Data History	NA
Data Attributes	Field Name: RFS_DIS_TIME Field Type: Time Field Length: 2, 2

[Referral History] Additional Referring Facility	
Description	The Facility ID and Description of the hospital from which the patient was referred.
Element Values	Master Numbering System
Additional Information	Ministry reports: Master Numbering System https://www.ontario.ca/page/ministry–reports–master–numbering–system#section–1
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: RFS_FACLNKS Field Type: Integer Field Length: 4

[Assessments] Immediate Referring Facility – Temperature Value	
Description	Recorded temperature by referring facility.
Element Values	25–50
Additional Information	• ? –unknown. If temperature is not documented or not taken within first 30 minutes enter "?". • You will need to choose if you are entering temperature in Celsius (c) or Fahrenheit (F) from the units drop–down list. The other measure will be converted automatically.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_TEMP Field Type: Decimal Field Length: 4, 1

[Assessments] Immediate Referring Facility – Paralytic Agents?	
Description	Were paralytic agents in effect when the GCS was calculated at the referring facility?
Element Values	Y/N
Additional Information	• Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range. • Common paralytic agents include rocuronium (Zemuron), vecuronium, cisatracurium (Nimbex), succinylcholine, pancuronium (Pavulon) and atracurium. • Succinylcholine/Anectine produces complete skeletal muscle relaxation and is used in trauma patients prior to intubation or induction of anesthesia. • Morphine, Demerol, Ativan/lorazepam and Thiopental/Pentothal have pain killing and sedating actions, which are used in combination with a paralyzing agent. • The intent of collecting whether or not paralytic agents were administered is to evaluate the number of times that the GCS cannot be completed due to paralytic agents rather than the number of paralytic agents administered.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician note 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_PAR_YN Field Type: Character (Y/N) Field Length: 1

[Assessments] Immediate Referring Facility – Intubated?	
Description	Was the patient intubated at the time the GCS at the immediate referring facility was calculated?
Element Values	Y/N
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_INTUB_YN Field Type: Character (Y/N) Field Length: 1

[Assessments] Immediate Referring Facility – SBP	
Description	Recorded systolic blood pressure measured at the referring facility.
Element Values	Y/N
Additional Information	• Defined as the patient's first recorded SBP upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. • Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If vitals are not taken in first 30 minutes, or if SBP was not taken or is undocumented, enter SBP as '? Unknown'.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_SBP Field Type: Character (Y/N) Field Length: 1

[Assessments] Immediate Referring Facility – Pulse Rate	
Description	Recorded pulse measured at the referring facility (palpated or auscultated), expressed as a number per minute.
Element Values	Relevant value for data element
Additional Information	• Defined as the patient's first recorded pulse rate (or heart rate) upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document '?' (Unknown). • Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the PR is not documented, enter '? Unknown'.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_PULSE Field Type: Integer Field Length: 3

[Assessments] Immediate Referring Facility – Unassisted Respiration Rate (URR)	
Description	Recorded respiratory rate measured at the referring facility (expressed as a number per minute).
Element Values	Relevant value for data element.

Additional Information	• Defined as the patient's first recorded unassisted RR upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document as '?'.
	• Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated.
	• If the URR is not documented, enter '?'.
	• Enter '/' if patient respirations are assisted, that is, patient is intubated, combitubes or being bagged.
	• Assisted ventilation is defined as:
	  o If there is something placed in the patient's airway to assist them in breathing such as ETT, King or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King or LMA the patient still had assisted ventilation.
	  o If the patient is being bagged (bag–valve–mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated.
	  o OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but by themselves are not assisted ventilation. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation.
	• If a patient chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.

OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_URR Field Type: Integer Field Length: 3

[Assessments] Immediate Referring Facility – GCS: Eye	
Description	Recorded Glasgow Coma Score (Eye) measured at the referring facility.
Element Values	1 No Eye movement when assessed 2 Opens Eyes in Response to Painful Stimulation 3 Opens Eyes in Response to Verbal Stimulation 4 Opens Eyes Spontaneously / Not Applicable ? Unknown
Additional Information	• Defined as the patient's first eye–opening response for the GCS documented upon arrival at the referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If eye response is not taken in first 30 minutes, or if the eye–opening response is not documented, document '?'. • If a patient does not have a numeric GCS documented, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (e.g. the chart indicates "patient's pupils are PERRL," a GCS Eyes of 4 may be reported, IF there is no other contradicting documentation). • The null value "?" is reported if the patient's Immediate *Referring Facility GCS – Eye* was not measured within 30 minutes of ED/hospital arrival. • Please note that the first recorded hospital vitals do not need to be from the same assessment. • **Please refer to "*Prehospital Vitals – GCS: Eye"* for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_GCS_EO Field Type: Integer Field Length: 1

[Assessments] Immediate Referring Facility – GCS: Verbal	
Description	Recorded Glasgow Coma Score (Verbal) measured at the referring facility.
Element Values	1 No Verbal Response (Ped: No Vocal Response) 2 Incomprehensible Sounds (Ped: Inconsolable, Agitated) 3 Inappropriate Words (Ped: Inconsistently Consolable, Moaning) 4 Confused (Ped: Cries but is Consolable, Inappropriate Interactions) 5 Oriented (Ped: Smiles, Oriented to Sounds, Follows Objects, Interacts) / Not Applicable ? Unknown
Additional Information	• If the patient is intubated, the GCS Verbal is equal to 1. • If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (e.g. the chart indicates: "patient is oriented to person place and time," a GCS Verbal of 5 may be reported, IF there is no other contradicting documentation). • The null value "?" is reported if the patient's Immediate *Referring Facility GCS – Verbal* was not measured within 30 minutes of ED/hospital arrival. • Please note that the first recorded hospital vitals do not need to be from the same assessment. • **Please refer to "*Prehospital Vitals – GCS: Eye"* for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_GCS_VR Field Type: Integer Field Length: 1

[Assessments] Immediate Referring Facility – GCS: Motor	
Description	Recorded Glasgow Coma Score (Motor) measured at the referring facility.
Element Values	1 No Motor Response 2 Extension to Pain 3 Flexion to Pain 4 Withdrawal from Pain 5 Localizing Pain 6 Obeys Commands (Ped: Appropriate Response to Stimulation) / Not Applicable ? Unknown
Additional Information	• If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (e.g. the chart indicates: "patient withdraws from a painful stimulus," a GCS Motor of 4 may be reported, IF there is no other contradicting documentation). • The null value "Not Known/Not Recorded" is reported if the patient's *Immediate Referring Facility – GCS: Motor* was not measured within 30 minutes of ED/hospital arrival. • Please note that the first recorded hospital vitals do not need to be from the same assessment. • **Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_GCS_MR Field Type: Integer Field Length: 1

[Assessments] Immediate Referring Facility – GCS: Total	
Description	Recorded Glasgow Coma Score (Total) measured at the referring (primary) facility.
Element Values	Relevant value for data element.
Additional Information	• If a patient does not have a numeric GCS score recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," report this as GCS score of 15 IF there is no other contradicting documentation. • The null value "Not Known/Not Recorded" is reported if Immediate Referring Facility GCS – Eyes, Immediate Referring Facility GCS – Motor, Immediate Referring Facility GCS – Verbal were not measured within 30 minutes of Immediate referring facility arrival. • Please note that the first record Immediate Referring Facility – GCS: Total does not need to be from the same assessment. • **Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.**
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flowsheet 2. ED nursing notes 3. Inpatient nursing flow sheet 4. ED physician notes 5. Trauma resuscitation record
Data History	NA
Data Attributes	Field Name: RFAS_GCS Field Type: Integer Field Length: 2

[Assessments] Immediate Referring Facility – RTS	
Description	The Revised Trauma Score based on vitals measured at the referring facility. Consists of Glasgow Coma Scale, Systolic Blood Pressure and Respiratory Rate.
Element Values	Relevant value for data element.
Additional Information	• Not direct a data entry element. • Revised Trauma Score at the primary hospital is a calculated field based on Glasgow Coma Scale (all components), systolic blood pressure and unassisted respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will be displayed as '/ Not Applicable' on the screen.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: RFAS_RTS_W Field Type: Decimal Field Length: 4, 3

[Assessments] Immediate Referring Facility – Paediatric Trauma Score – Total	
Description	Paediatric Trauma Score at the primary hospital for patients <16 years of age.
Element Values	Relevant value for data element.
Additional Information	Please refer to "*[ED/Resuscitation] Initial Assessment – Initial Vitals: Paediatric Trauma Score – Total*" for the Paediatric Trauma score calculations.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: RFAS_PTS Field Type: Integer Field Length: 2

[Assessments] Immediate Referring Facility – ETOH/BAC Level (mmol/L)	
Description	Recorded blood alcohol concentration (BAC) results at referring facility.
Element Values	Relevant value for data element.
Additional Information	• Enter the patient's blood alcohol concentration in SI units (mmol/L) at the trauma center within 24 hours after first hospital arrival. Enter '?' if the results are not available. If the lab results state < 2 or trace document as '0'. • The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyzer test) while 17 mmol/L is equivalent to the criminal 0.08 limit.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Lab Results 2. Triage Form/Trauma Flow Sheet 3. ED Record 4. Nurses' Notes
Data History	• At the March 21, 1995 TRAC meeting, it was recommended that BAC should be routinely collected at lead/trauma hospitals on all trauma patients >10 years of age. • At the January 31, the BAC recommendation was updated to the following: BAC should be routinely collected at lead/trauma hospitals on all trauma patients >10 years of age with an ISS >12 when the patient is admitted within 12 hours of the incident. • The legal alcohol limit is 17 mmol/L. • The ISS component of the January 31 subcommittee recommendation should be removed given that the staff in the emergency department do not know the ISS at the time of treatment. • To comply with the NTR the age <10 years has been removed.
Data Attributes	Field Name: RFS_ETOH_BAC_LVL Field Type: Decimal Field Length: 6, 3

[Procedures] CCI Code	
Description	The procedures performed on the patient at the referring facility.
Element Values	Canadian Classification of Health Interventions (CCI). Refer to Appendix J for a list of non–operative procedures.
Additional Information	• Please enter all operative and non–operative procedures done at the referring facilities. • For Non–TQIP sites, the requirement is to report non–operative procedures carried out in the emergency department. While a list of such procedures is provided in Appendix J, facilities may report additional procedures at their discretion. • TQIP sites should consult the NTDB data dictionary for reporting guidelines.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Operative Reports 2. Anesthesia Reports 3. Procedure Notes 4. Trauma Flow Sheet 5. ED Record 6. Nursing Notes/Flow Sheet 7. Radiology Reports 8. Hospital Discharge Summary
Data History	NA
Data Attributes	Field Name: RFPR_ICD10_S Field Type: String Field Length: 9

[Inter–Facility Transport: Providers/Vitals] Mode	
Description	The mode of transport delivering patient to the referred facility.
Element Values	1 Ground Ambulance 2 Helicopter Ambulance 3 Fixed–Wing Ambulance 4 Private Vehicle or Walk–In 5 Police 6 Public Safety 7 Water Ambulance 8 Other / Not Applicable ? Unknown
Additional Information	• Enter the mode of transport from the referring facility. Enter the transport mode by main mode of transport first, other methods in sequential order after that starting with the immediate referring facility and then in reverse order of referring facility transferred from. Clarification: Enter the main mode of transport that was used to deliver the patient to the facility. (e.g. ORNGE first, ground ambulance second). • Mode of transport refers to the vehicle/provider used during patient transport from the scene to hospital and between hospitals. • Military helicopter ambulances should be coded as helicopter ambulances. • Infinite modes of transport (land or air vehicles) can be documented for each run. A run is a prehospital transfer, which may be from the scene to a hospital or between hospitals. • If mode is other please enter mode of transport in text box provided.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_MODES Field Type: Integer Field Length: 1

[Inter–Facility Transport: Providers/Vitals] Agency	
Description	The three–digit ambulance service number from the ACR for land ambulances only.
Element Values	Relevant value for data element.
Additional Information	Enter '/ Not Applicable' for Air Transport.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_AGNCLNKS, ITP_AGNCLNKS_L, ITP_AGNCLNKS_L_AS_TEXT Field Type: Integer Field Length: 3

[Inter–Facility Transport: Providers/Vitals] Unit	
Description	The unit of the Agency transporting the patient to the referred facility.
Element Values	Relevant value for data element.
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_UNITS Field Type: String Field Length: 50

[Inter–Facility Transport: Providers/Vitals] EMS Report	
Description	Quality of report provided by EMS to the referred facility.
Element Values	1. Complete 2. Incomplete 3. Missing 4. Unreadable ∕ Not Applicable ? Unknown
Additional Information	New collection of data element.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_RP_DETAILS Field Type: Integer Field Length: 1

[Inter–Facility Transport: Providers/Vitals] Call Dispatched Date	
Description	The date the unit transporting to your hospital was notified by dispatch.
Element Values	MM DD YYYY
Additional Information	• Enter the date the ambulance call was received. You can also choose the date from the calendar icon on the right. There is no default date (i.e. date of injury). • If date is unknown, '? Unknown' should be documented in the date and time data elements
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_C_DATES Field Type: Date Field Length: 2, 2, 4

[Inter–Facility Transport: Providers/Vitals] Call Dispatched Time	
Description	The time the unit transporting to your hospital was notified by dispatch.
Element Values	HH MM in 24–hour clock
Additional Information	• For EMS this is noted as time unit notified and for ORNGE it is called dispatch time. • If time is unknown, '? Unknown' should be documented in the date and time data elements.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_C_TIMES Field Type: Time Field Length: 2, 2

[Inter–Facility Transport: Providers/Vitals] Arrived at Location Date	
Description	The date the unit transporting arrived at the referred facility.
Element Values	MM DD YYYY
Additional Information	• Enter the date the ambulance arrived at the transfer facility. You can also choose the date from the calendar icon on the right. Arrival is defined at date/time when the vehicle stopped moving. • If date is unknown, '? Unknown' should be documented in the date and time data elements.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_A_DATES Field Type: Date Field Length: 2, 2, 4

[Inter–Facility Transport: Providers/Vitals] Arrived at Location Time	
Description	The time the unit transporting arrived at the referred facility.
Element Values	HH MM in 24–hour clock
Additional Information	• This is recorded as the time EMS arrives at transfer facility NOT the time EMS arrives at the patient's side. • If time is unknown, "? Unknown" should be documented in the date and time data elements.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_A_TIMES Field Type: Time Field Length: 2, 2

[Inter–Facility Transport: Providers/Vitals] Departed Location Date

Description	The date the unit transporting to your hospital left the transferring facility.
Element Values	MM DD YYYY
Additional Information	- For patients transported from a referral facility, this is the date on which the unit transporting the patient from the facility departed from that referring facility (departure is defined at date/time when the vehicle started moving). - Arrival and departure dates should be documented from a patient care perspective. The arrival time of the first care transport should be documented even if the majority of care is given by another transport. The departure time of the transport responsible for the transport of the patient should be documented. - It is important to capture the date and time of inter–facility transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene, it may be necessary to combine the dates, times and the on–scene procedures from both call reports. - If date is unknown, '? Unknown' should be documented in the date and time data elements.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_L_DATES Field Type: Date Field Length:2, 2, 4

[Inter–Facility Transport: Providers/Vitals] Departed Location Time	
Description	The time the unit transporting to your hospital left the transferring facility.
Element Values	HH MM in 24–hour clock.
Additional Information	• For patients transported from a referring facility, this is the time at which the unit transporting the patient from the facility departed from that referring facility (departure is defined at date/time when the vehicle started moving). • If time is unknown, '? Unknown' should be documented in the date and time data elements.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	EMS Run Sheet
Data History	NA
Data Attributes	Field Name: ITP_L_TIMES Field Type: Time Field Length: 2, 2

ED/Resuscitation

[Arrival/Admission] Direct Admit	
Description	Patient transferred from another acute care facility and taken to the operating room or interventional suite prior to hospital admission, or admitted directly to intensive care or other unit of the hospital.
Element Values	Y/N
Additional Information	• Was the patient admitted directly to a service (ICU, OR, ward bed etc.) bypassing the emergency department? • If checked "Y", all ED data will automatically be bypassed (i.e. patients who sustained a trauma injury of ISS≥12 while being treated for conditions unrelated to trauma).
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ED_BYPASS_YN Field Type: Character (Y/N) Field Length: 1

[Arrival/Admission] ED Arrival Date	
Description	The date the patient arrived to the ED/hospital.
Element Values	MM DD YYYY
Additional Information	• Enter the date of arrival at the trauma hospital emergency department. This date must be entered for all cases including ED deaths and transfers, to ensure accurate reporting. • Arrival is defined as the date the patient was first triaged/registered at the trauma centre. Please use the earliest date/time recorded on the patient's chart. • If patient is admitted to ED (i.e. Direct Admit is checked "N") this section will automatically populate from the Demographics arrival date/time data elements. If Direct Admit is checked as "Y" this data field will be inactive.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: EDA_DATE Field Type: Date Field Length: 2, 2, 4

[Arrival/Admission] ED Arrival Time	
Description	The time the patient arrived to the ED/hospital.
Element Values	HH MM in 24–hour clock
Additional Information	• Arrival time is defined as the time the patient was first triaged/registered at the trauma centre. Please use the earliest date/time recorded on the patient's chart. • If patient is admitted to ED (i.e. *Direct Admit* is checked "N") this section will automatically populate from the Demographics arrival date/time data elements.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: EDA_TIME Field Type: Time Field Length: 2, 2

[Arrival/Admission] ED Departure/Admitted Date	
Description	The date the patient was physically discharged from the ED.
Element Values	MM DD YYYY
Additional Information	The date the patient physically left the ED to account for time spent in the ED waiting on a hospital bed.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: EDD_DATE Field Type: Date Field Length: 2, 2, 4

[Arrival/Admission] ED Departure/Admitted Time	
Description	The time the patient was physically discharged from the ED.
Element Values	HH MM in 24–hour clock
Additional Information	The time the patient physically left the ED to account for time spent in the ED waiting on a hospital bed.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: EDD_TIME Field Type: Time Field Length: 2, 2

[Arrival/Admission] ED Departure Order Date

Description	The date the order was written for the patient to be discharged from the ED.
Element Values	MM DD YYYY
Additional Information	• The date the order was written for the patient to be discharged from the trauma centre emergency department. The date when the patient stopped receiving ED level of care. • Will be inactive if the patient is directly admitted to hospital (will be mapped to n/a for NTDB submission). • If patient dies in ED (or is DOA) this will be the same date as ED Departure Date and Death Date. • If time is unknown (not recorded) please enter "?". • Field cannot be blank.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: EDD_O_DATE Field Type: Date Field Length: 2, 2, 4

[Arrival/Admission] ED Departure Order Time	
Description	The time the order was written for the patient to be discharged from the ED.
Element Values	HH MM in 24–hour clock
Additional Information	• The time in 24–hour clock the order was written for the patient to be discharged from the trauma centre emergency department. The time when the patient stopped receiving ED level of care. • Will be inactive if the patient is directly admitted to hospital (will be mapped to n/a for NTDB submission). • If patient dies in ED (or is DOA) this will be the same time as ED Departure Date and Death time. • If time is unknown (not recorded) please enter "?". • Field cannot be blank.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Physician Note 2. ED Nursing Note 3. EMS Run Sheet 4. Inpatient Unit Nursing Notes 5. Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: EDD_O_TIME Field Type: Time Field Length: 2, 2

[Arrival/Admission] Response Level	
Description	The initial trauma team activation level prior to the patient's arrival or on arrival to your ED.
Element Values	1 Full 2 Partial 3 Consult 4 No Trauma Activation / Not Applicable ? Unknown
Additional Information	• Each hospital may use its own unique definition of the trauma team activation level (i.e. some facilities may not have partial activation). • Unknown should be used if you cannot find the information but please check with your trauma coordinators first to see if they can find the information in their own records. If you check "?" you will not be able to fill out the activation date and time.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. TTA form 2. Trauma Coordinator records 3. ED Record 4. Triage Form/Trauma Flow Sheet 5. Nursing Notes
Data History	NA
Data Attributes	Field Name: ED_TTA_TYPE01 Field Type: Integer Field Length: 1

[Arrival/Admission] Post ED Disposition	
Description	The disposition of the patient at the time of discharge from the ED.
Element Values	The table below lists Post ED Disposition.
Additional Information	• If multiple orders were written, report the final disposition order. • The null value "Not Applicable" is reported if the patient was directly admitted to the hospital. • If ED Discharge Disposition is 4, 5, 6, 9, 10, or 11, then Hospital Discharge Date, Hospital Discharge Time, and Hospital Discharge Disposition must be "Not Applicable." • Paediatric and Neonatal Care Units are not ICUs. For paediatric/neonatal patients transferred to ICU, select "4 ICU".
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. History & Physical
Data History	NA
Data Attributes	Field Name: ED_DSP Field Type: Integer Field Length: 2

Post ED Disposition	
3	Operating Room
4	Intensive Care Unit
5	Step–Down Unit
6	Floor
7	Telemetry Unit
8	Observation Unit
9	Burn Unit
13	Labor and Delivery
16	Interventional Radiology
19	Neonatal Care Unit
20	Paediatric Care Unit
22	Hybrid OR
40	Home or Self Care (Routine Discharge)
41	Home with Services
42	Left Against Medical Advice (AMA)
44	Morgue
45	Child Protective Agency
70	Acute Care Facility
71	Intermediate Care Facility
72	Skilled Nursing Facility
73	Rehab (Inpatient)
74	Long–Term Care
75	Hospice
76	Mental Health/Psychiatric Hospital (Inpatient)
77	Nursing Home
79	Another Type of Inpatient Facility Not Defined Elsewhere
80	Burn Centre
/	Not Applicable
?	Unknown

[Arrival/Admission] Post ED Disposition Specify	
Description	The disposition of the patient at the time of discharge from the ED, if not listed in the Post ED Disposition menu.
Element Values	Free text
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ED_DSP_S Field Type: String Field Length: 50

[Arrival/Admission] Admitting Service	
Description	The provider service admitting the patient.
Element Values	Refer to Appendix F
Additional Information	• For patients who die in ED or are discharged directly from the ED, "Not Applicable" should be entered. • For patients admitted to a SCU, the recommendation for using the critical care doctor service is to follow the individual institution's admitting pattern, i.e. if a patient is admitted to ICU under neurosurgery, the admission service should be neurosurgery, if the patient is admitted to ICU under the critical care specialist, the admission service should be critical care specialist. (Working Group 08/00)
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: ADM_SVC Field Type: Integer Field Length: 3

[Arrival/Admission] Post OR Disposition	
Description	The disposition of the patient from the OR.
Element Values	The table below lists Post OR Disposition.
Additional Information	Post OR destination is the destination of the patient after leaving the operating room following discharge from the emergency department. If a patient is returned to the ED it should be coded as other.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. OR record 2. Nursing Notes
Data History	NA
Data Attributes	Field Name: OR_DISP Field Type: Integer Field Length: 2

Code	Description
4	Intensive Care Unit
5	Step–Down Unit
6	Floor
7	Telemetry Unit
8	Observation Unit
9	Burn Unit
11	Post Anesthesia Care Unit
19	Neonatal Care Unit
20	Paediatric Care Unit
40	Home or Self Care (Routine Discharge)
41	Home with Services
42	Left AMA
44	Morgue
/	Not Applicable
?	Unknown

[Arrival/Admission] Admitting Surgeon NPI	
Description	The National Provider Identification number of the admitting surgeon.
Element Values	Relevant value for data element.
Additional Information	"/" should be reported if this data element is not being reported.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	Medical Record
Data History	NA
Data Attributes	Field Name: ADMP_NPI Field Type: Integer Field Length: 10

[Arrival/Admission] Primary Medical Event	
Description	The patient suffered a documented major medical incident (such as seizure, heart attack, arrhythmia, syncope, or hypoglycaemia) immediately before the traumatic injury occurred.
Element Values	1 Yes 2 No / Not Applicable ? Unknown
Additional Information	
OTR Required	No
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: Field Type: Integer Field Length: 1

[Arrival/Admission] Intubation Prior To Arrival	
Description	The patient was intubated with a definitive airway (below the vocal cords) after sustaining traumatic injury prior to arrival at your hospital.
Element Values	1 Yes 2 No / Not Applicable ? Unknown
Additional Information	
OTR Required	No
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: Field Type: Integer Field Length: 1

[Arrival/Admission] Intubation Location	
Description	The physical location patient intubation occurred prior to your hospital arrival.
Element Values	1 Out of Hospital Intubation 2 Transferring Facility / Not Applicable ? Unknown
Additional Information	
OTR Required	No
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: Field Type: Integer Field Length: 1

[Arrival/Admission] Signs of Life	
Description	Indication of whether the patient arrived at ED/hospital with signs of life.
Element Values	1 Arrived with No Signs of Life 2 Arrived with Signs of Life / Not Applicable ? Unknown
Additional Information	A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage/Trauma/Hospital Flow Sheet 2. Progress Notes 3. Nursing Notes 4. EMS Report 5. History & Physical
Data History	NA
Data Attributes	Field Name: LIFE_SIGNS Field Type: Integer Field Length: 1

[Arrival/Admission] Primary Trauma Service Type	
Description	The primary service responsible for the care of the patient.
Element Values	Adult/Paediatric
Additional Information	• The primary service type responsible for trauma evaluation and care of the patient. • Adult trauma centres that do not have a separate paediatric service must report "Adult". • Paediatric trauma centres that do not have a separate adult service must report "Paediatric". • A paediatric patient is defined as anyone under 18 years old.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage/Trauma Flow Sheet 2. History and Physical 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: PRIM_TRAUMA_SVC_TYPE Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – Temperature Value	
Description	First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	25–50
Additional Information	Please note the first recorded hospital vitals do not need to be from the same assessment.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage/Trauma/Hospital Flow Sheet 2. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: EDAS_TEMP Field Type: Decimal Field Length: 4, 1

[Initial Assessment] Initial Vitals – Weight	
Description	First recorded, measured or estimated baseline weight within 24 hours or less of ED/hospital arrival.
Element Values	Relevant value for data element.
Additional Information	• Only 3 digits can be entered before the decimal place and 2 digits after. You do not have to enter the digits after the decimal place (the calculation will still work). • Please choose whether you are entering in lbs. or kgs from the drop–down list to the right. The registry will automatically calculate the weight in the other unit. Weight in kg gets submitted to NTDB. • Weight may be based on family or self–report. • Please note that first recorded/hospital vitals do not need to be from the same assessment. • Field cannot be blank or Not Applicable.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses' notes 5. Self–report 6. Family report
Data History	NA
Data Attributes	Field Name: EDAS_WGT Field Type: Decimal Field Length: 5, 2

[Initial Assessment] Initial Vitals – Weight Unit	
Description	The units used to document the patient's weight (kilograms or pounds).
Element Values	1 kg 2 lbs
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses' notes 5. Self–report 6. Family report
Data History	NA
Data Attributes	Field Name: EDAS_WGT_U Field Type: Decimal Field Length: 5, 2

[Initial Assessment] Initial Vitals – Height	
Description	First recorded height anytime during admission
Element Values	Relevant value for data element.
Additional Information	• Enter the patient's first recorded height in centimeters or inches within 24 hours of arrival to the hospital. Only 3 digits can be entered before the decimal place and 2 digits after. You do not have to enter the digits after the decimal place (the calculation will still work). • Please choose whether you are entering in cm or inches from the drop–down list to the right. The registry will automatically calculate the height in the other unit. Height in cm gets submitted to NTDB. If you enter a value that does not make sense (for example you meant to enter 400 cm but put inches, the second calculation will outline in red to indicate that the value is outside the normal range). • Height may be based on family or self–report. • Please note that first recorded/hospital vitals do not need to be from the same assessment. • Field cannot be blank or Not Applicable.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses' notes 5. Self–report 6. Family report
Data History	NA
Data Attributes	Field Name: EDAS_HGT Field Type: Decimal Field Length: 5, 2

[Initial Assessment] Initial Vitals – Height Unit	
Description	The units used to document the patient's height (centimeters or inches).
Element Values	1 cm 2 in
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses' notes 5. Self–report 6. Family report
Data History	NA
Data Attributes	Field Name: EDAS_HGT_U Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – Paralytic Agents?	
Description	Determination of paralytic agents potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Used as a Hospital GCS Assessment Qualifier for NTDB.
Element Values	Y/N
Additional Information	• Was the patient chemically paralyzed when the first assessment of GCS was calculated? • Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range. • Common paralytic agents include rocuronium (Zemuron), vecuronium, cisatracurium (Nimbex), succinylcholine, pancuronium (Pavulon) and atracurium. • Succinylcholine/Anectine produces complete skeletal muscle relaxation and is used in trauma patients prior to intubation or induction of anesthesia. • Morphine, Demerol, Ativan/lorazepam and Thiopental/Pentothal have pain killing and sedating actions, which are used in combination with a paralyzing agent. • The intent of collecting whether or not paralytic agents were administered is to evaluate the number of times that the GCS cannot be completed due to paralytic agents rather than the number of paralytic agents administered. (Working Group 3/99) • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_PAR_YN Field Type: Character (Y/N) Field Length: 1

[Initial Assessment] Initial Vitals – Sedated?	
Description	Determination of sedation potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Used as a Hospital GCS Assessment Qualifier.
Element Values	Y/N
Additional Information	• Was the patient chemically sedated when the first assessment of the GCS was calculated? • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_SED_YN Field Type: Character (Y/N) Field Length: 1

[Initial Assessment] Initial Vitals – Eye Obstruction?	
Description	Determination of obstruction to the eye potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Used as a Hospital GCS Assessment Qualifier for NTDB.
Element Values	Y/N
Additional Information	? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 1. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_E_OB_YN Field Type: Character (Y/N) Field Length: 1

[Initial Assessment] Initial Vitals – Intubated?	
Description	Determination of intubation potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Used as a Hospital GCS Assessment Qualifier for NTDB.
Element Values	Y/N
Additional Information	• Was the patient intubated at the time the first assessment of the GCS at the trauma centre was calculated? • Intubation refers to oral/nasal intubation, Tracheostomy, or Cricothyroidotomy, King LT, Combitubes and LMA. • If patient arrived with assisted ventilation then enter "?" in the "assisted ventilation" data field because "/" gives an error. • LMA, King, Combitubes are airway adjuncts and included as intubation as per requirement of NTDB and data subcommittee Jan 10 2019. • OPAs and NPAs are not considered intubation or airway management. • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 1. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_INTUB_YN Field Type: Character (Y/N) Field Length: 1

[Initial Assessment] Initial Vitals – SBP	
Description	First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	Relevant value for data element.
Additional Information	• Vital signs must be within 30 minutes of arrival to hospital whether recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP, the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital signs just to report the patient's first recorded vital signs in the ED/hospital within 30 minutes or less ED/hospital arrival • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. PCR/Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_SBP Field Type: Integer Field Length: 3

[Initial Assessment] Initial Vitals – DBP	
Description	First recorded diastolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	Relevant value for data element.
Additional Information	• Vital signs must be within 30 minutes of arrival to hospital whether recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP, the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital signs just to report the patient's first recorded vital signs in the ED/hospital within 30 minutes or less ED/hospital arrival • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. PCR/Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_DBP Field Type: Integer Field Length: 3

[Initial Assessment] Initial Vitals – Pulse Rate

Description	First recorded pulse in the ED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).
Element Values	Relevant value for data element.
Additional Information	• Defined as the patient's first recorded pulse rate/heart rate upon arrival at the trauma centre (ED or inpatient unit if ED bypass), within 30 minutes of arrival (expressed as a number per minute). • Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated • If vitals are not taken in first 30 minutes, or if PR was not taken or not documented, enter as '?'. • Please note that the first recorded/hospital vitals do not need to be from the same assessment. • New 2016 NTDS: 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. • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. PCR/Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes 4. Trauma Resuscitation Record
Data History	NA
Data Attributes	Field Name: EDAS_PULSE Field Type: Integer Field Length: 3

[Initial Assessment] Initial Vitals – Unassisted Respiratory Rate	
Description	First recorded unassisted respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).
Element Values	Relevant value for data element.
Additional Information	- Please refer to "*Initial Vitals – Assisted Respiratory Rate?*" ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes, please see the definition in the current NTDB data dictionary
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_URR Field Type: Integer Field Length: 2

[Initial Assessment] Initial Vitals – Respiration Assisted?	
Description	Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.
Element Values	Y/N

Additional Information	• Assisted ventilation is defined as:
	   o If there is something placed in the patient's airway to assist them in breathing such as ETT, King or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King or LMA the patient still had assisted ventilation.
	   o If the patient is being bagged (bag–valve–mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated.
	   o OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but by themselves are not assisted ventilation. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation.
	• If a patient chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.
	• ? Unknown or N/A Not Applicable can be entered.

OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_ARR_YN Field Type: Character (Y/N) Field Length: 1

[Initial Assessment] Initial Vitals – Assisted Respiratory Rate	
Description	First recorded assisted respiratory rate measured in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as number per minute).
Element Values	Relevant value for data element.
Additional Information	- Assisted Ventilation is defined as: - If there is something placed in the patient's airway to assist them in breathing such as ETT, King, Combitube or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King, Combitube or LMA the patient still had assisted ventilation. - If the patient is being bagged (bag–valve–mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated. - OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but by themselves are not assisted ventilation. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation. ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_ARR Field Type: Integer Field Length:3

[Initial Assessment] Initial Vitals – O2 Saturation	
Description	First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage).
Element Values	Relevant value for data element.
Additional Information	• Defined as the patient's first recorded O2 saturation taken upon arrival at the trauma centre (ED or inpatient unit if ED bypass), within 30 minutes of arrival (expressed as a %). If vitals are not taken in first 30 minutes, or O2 saturation is not documented, enter as '?' unknown. • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_SAO2 Field Type: Integer Field Length: 3

[Initial Assessment] Initial Vitals – Supplemental O2	
Description	Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival.
Element Values	Y/N
Additional Information	• Was the patient being given supplemental oxygen at the time the assessment of initial trauma centre O2 saturation level was being measured (within first 30 minutes of ED arrival or ED hospital bypass admission)? Refers to recorded O2 saturation data field above. • ? Unknown or N/A Not Applicable can be entered.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_SO2_YN Field Type: Character (Y/N) Field Length: 1

[Initial Assessment] Initial Vitals – GCS: Eye	
Description	First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	1 No Eye movement when assessed 2 Opens Eyes in Response to Painful Stimulation 3 Opens Eyes in Response to Verbal Stimulation 4 Opens Eyes Spontaneously / Not Applicable ? Unknown
Additional Information	• Defined as the patient's first eye–opening response for the GCS documented upon arrival at the trauma centre (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If eye response is not taken in first 30 minutes, or if the eye–opening response is not documented enter '?' unknown. • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation. • Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS_EO Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – GCS: Verbal	
Description	First recorded Glasgow Coma Score (Verbal) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	1 No Verbal Response (Ped: No Vocal Response) 2 Incomprehensible Sounds (Ped: Inconsolable, Agitated) 3 Inappropriate Words (Ped: Inconsistently Consolable, Moaning) 4 Confused (Ped: Cries but is Consolable, Inappropriate Interactions) 5 Oriented (Ped: Smiles, Oriented to Sounds, Follows Objects, Interacts) / Not Applicable ? Unknown
Additional Information	• Defined as the patient's first verbal response for the GCS documented upon arrival at the trauma centre (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If verbal response is not taken in first 30 minutes, or verbal response is not documented, enter '?'. If the patient is intubated within the first 30 minutes before GCS is assessed document as "1". • Please use the appropriate Adult or Paediatric GCS scale as applicable. • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person, place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation. • Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS_VR Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – GCS: Motor	
Description	First recorded Glasgow Coma Score (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	1 No Motor Response 2 Extension to Pain 3 Flexion to Pain 4 Withdrawal from Pain 5 Localizing Pain 6 Obeys Commands (Ped: Appropriate Response to Stimulation) / Not Applicable ? Unknown
Additional Information	• Defined as the patient's first motor response for the GCS documented upon arrival at the trauma centre (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If motor response is not taken in first 30 minutes, or motor response is not documented, enter '?'. If the patient is under paralytics then the GCS motor score will be '1'. Intubation alone does not indicate a GCS motor score of not applicable since motor response can still be assessed. • Please use the appropriate Adult or Paediatric GCS scale as applicable. • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. • Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS_MR Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – GCS: Total	
Description	First recorded Glasgow Coma Score (Total) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	Relevant value for data element.
Additional Information	• Defined as the total GCS documented upon arrival at the trauma centre (ED or inpatient unit if direct admission) within 30 minutes of arrival. If the total GCS (or any component of the GCS) is not documented enter '?'. • If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented (AAOx3) the total GCS may be assumed to be 15 IF there is no other contradicting documentation. Total GCS value must be 3 – 15 • Please refer to "*Prehospital Vitals – GCS: Eye"* for paediatric GCS value descriptors.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS Field Type: Integer Field Length: 2

[Initial Assessment] Initial Vitals – RTS	
Description	The Revised Trauma Score based on vitals measured at the scene of injury. Consists of Glasgow Coma Scale, Systolic Blood Pressure and Respiratory Rate.
Element Values	Relevant value for data element.
Additional Information	- Revised Trauma Score at the primary hospital is a calculated field based on Glasgow Coma Scale (all components), systolic blood pressure and unassisted respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will be displayed as '/' on the screen. - Not a direct data entry element. - Please refer to "*Prehospital Vitals – GCS: Eye*" for paediatric GCS value descriptors.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_RTS_W Field Type: Decimal Field Length: 4, 2

[Initial Assessment] Initial Vitals – GCS 40: Eye	
Description	First recorded Glasgow Coma Score 40 (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	0 Not Testable 1 None 2 To Pressure (Paediatric (<5 years) to Pain) 3 To Sound 4 Spontaneous ? Unknown / Not Applicable
Additional Information	**GCS 40 data elements can be set "Not Applicable" as Ontario currently does not collect any information.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS40_EO Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – GCS 40: Verbal

Description	First recorded Glasgow Coma Score 40 (Verbal) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	0 Not Testable 1 None 2 Sounds (Paediatric (<5 years) Cries) 3 Words (Paediatric (<5 years) Vocal Sounds) 4 Confused (Paediatric (<5 years) Words) 5 Oriented (Paediatric (<5 years) Talks Normally) ? Unknown / Not Applicable
Additional Information	**GCS 40 data elements can be set "Not Applicable" as Ontario currently does not collect any information.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS40_VR Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – GCS 40: Motor	
Description	First recorded Glasgow Coma Score 40 (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values	0 Not Testable 1 None 2 Extension (Paediatric (<5 years) Extension to Pain) 3 Abnormal Flexion (Paediatric (<5 years) Flexion to Pain) 4 Normal Flexion (Paediatric (<5 years) Localizes Pain) 5 Localizing (Paediatric (<5 years) Obeys Commands) 6 Obeys Commands ? Unknown / Not Applicable
Additional Information	**GCS 40 data elements can be set "Not Applicable" as Ontario currently does not collect any information.**
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_GCS40_MR Field Type: Integer Field Length: 1

[Initial Assessment] Initial Vitals – Paediatric Trauma Score – Total	
Description	The total Paediatric Trauma Score measured on arrival.
Element Values	Relevant value for data element. – See additional information
Additional Information	Patient's Paediatric Trauma Score at the scene for patients <16 years of age. Unknown or Not Applicable can be entered. Paediatric Trauma Score can range from 6 - 12. Paediatric Trauma Score should be calculated by the lead/trauma hospital if the components are documented. The weight at the lead/trauma hospital may be used. If any components are missing, enter unknown. Although a negative sign can be entered when necessary, a positive sign cannot be entered.

Component	Score		
	+2	+1	−1
Size	>20kg	10–20 kg	<10 kg
Airway	Normal	Maintainable (oral or nasal)	Unmaintainable (intubated)
Systolic BP	>90 mm Hg	90–50 mm Hg	<50 mm Hg
CNS	Awake	Obtunded/LOC	Coma ecerebrate
Open Wound	None	Minor	Major/penetrating
Skeletal	None	Closed fracture open	Multiple fractures
Sum (PTS) range is 6 - 12			

OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: EDAS_PTS Field Type: Integer Field Length: 2

[Labs/Toxicology] SBIRT	
Description	Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.
Element Values	Y/N
Additional Information	• Custom Field. • Only includes alcohol intervention.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: SCRN_YN01 Field Type: Character (Y/N) Field Length: 1

[Labs/Toxicology] SBIRT Date	
Description	Date SBIRT performed
Element Values	MM DD YYYY
Additional Information	Custom Field
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: SCRN_DATE01 Field Type: Date Field Length: 2, 2, 4

[Labs/Toxicology] Alcohol Use Indicator	
Description	Use of alcohol by the patient. A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter.
Element Values	1 No (Not Tested) 2 No (Confirmed by Test) 3 Yes (Confirmed by Test [Trace Levels]) 4 Yes (Confirmed by Test [Beyond Legal Limit]) / Not Applicable ? Unknown
Additional Information	• The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyzer test) while 17 mmol/L is equivalent to the 0.08 limit. • Choice 1 will be mapped to 'No' for NTDB submission, while choices 2–4 will be mapped to 'Yes'. Submission will look at both referring and definitive centres answers for BAC tested so please answer for all sites where BAC may have been taken. • Field cannot be blank or Not Applicable.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Lab Results 2. Triage Form/Trauma Flow Sheet 3. ED Record 4. Nurses' notes
Data History	NA
Data Attributes	Field Name: ED_IND_ALC Field Type: Integer Field Length: 1

[Labs/Toxicology] ETOH/BAC Level (mmol/L)	
Description	First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter. Equivalent to Alcohol Screen Results.
Element Values	Relevant value for data element.
Additional Information	• Enter the patient's blood alcohol concentration in SI units (mmol/L) at the trauma centre within 24 hours after first hospital arrival. Enter '?' if the results are not available. If previous field was '/' (for patients ≤ 9 years of age) or checked 'No' this section will be inactive and will be mapped to 0 for NTDB submission. If the lab results state < 2 or trace document as '0'. • The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyzer test) while 17 mmol/L is equivalent to the criminal 0.08 limit. • Cannot be 'Not Applicable' if *Alcohol Use Indicator* was 'Yes'.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form/Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: ETOH_BAC_LVL Field Type: Decimal Field Length: 6, 3

[Labs/Toxicology] Drug Screen	
Description	First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).
Element Values	1. AMP (Amphetamine) 2. BAR (Barbiturate) 3. BZO (Benzodiazepines) 4. COC (Cocaine) 5. mAMP (Methamphetamine) 6. MDMA (Ecstasy) 7. MTD (Methadone) 8. OPI (Opioid) 9. OXY (Oxycodone) 10. PCP (Phencyclidine) 11. TCA (Tricyclic Antidepressant) 12. THC (Cannabinoid) 13. Other 14. None ? Unknown
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage Form/Trauma Flow Sheet 2. ED Record 3. Nurses' notes
Data History	NA
Data Attributes	Field Name: RFS_RF_DRG01–13 Field Type: Integer Field Length: 2

Patient Tracking

[Location/Service] Location Code	
Description	Location of a patient as they move through a medical facility.
Element Values	1 Resuscitation Room 2 Emergency Department 3 Operating Room 4 Intensive Care Unit 5 Step–Down Unit 6 Floor 7 Telemetry Unit 8 Observation Unit 9 Burn Unit 10 Radiology 11 Post Anesthesia Care Unit 12 Special Procedure Unit 13 Labor and Delivery 16 Interventional Radiology 18 Emergency Dept–Hold 19 Neonatal Care Unit 20 Paediatric Care Unit 22 Hybrid OR ? Unknown
Additional Information	• Enter a location/unit that the patient was admitted to. • ICU is a unit with the ability to ventilate patients. • Paediatric and Neonatal Care Unit are not ICU/critical care or step–down, but instead ward level care. • For paediatric ICU, select 4. ICU; for paediatric step–down unit, select 5. Step–Down Unit
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: LT_CODES_AS_TEXT Field Type: Integer Field Length: 2

[Location/Service] Arrival Date	
Description	The date the patient arrived at the location.
Element Values	MM DD YYYY
Additional Information	This is the arrival date of patient to a specific location in the trauma centre.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: LT_A_DATES Field Type: Date Field Length: 2, 2, 4

[Location/Service] Departure Date	
Description	The date the patient departed the location.
Element Values	MM DD YYYY
Additional Information	This is the discharge/departure date of patient from a specific location in the trauma centre.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: LT_DIS_DATES Field Type: Date Field Length: 2, 2, 4

[Location/Service] ICU Days	
Description	Intensive care unit (ICU) length of stay
Element Values	Relevant value for data element
Additional Information	• Reported in full–day increments with any partial calendar day counted as a full calendar day. Refer to the NTDB Data Dictionary for the detailed descriptions. • The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart. • At no time should the ICU LOS exceed the hospital LOS. • The null value "?" is reported if any dates are missing. • If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day. • The null value "/" is reported if the patient had no ICU days according to the • above description.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ICU Flow Sheet 2. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: ICU_DAYS Field Type: Integer Field Length: 3

[Location/Service] Service Code	
Description	Service of a patient as they move through a medical facility.
Element Values	Refer to Appendix F
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet
Data History	NA
Data Attributes	Field Name: ST_CODES Field Type: Integer Field Length: 3

[Location/Service] Start Date	
Description	The date the patient was admitted to the service.
Element Values	MM DD YYYY
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ST_MD_A_DATES Field Type: Date Field Length: 2, 2, 4

[Location/Service] Start Time	
Description	The time the patient was admitted to the service.
Element Values	HH MM in 24–hour clock
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ST_MD_A_TIMES Field Type: Time Field Length: 2,2

[Location/Service] Stop Date	
Description	The date the patient was transferred from the service.
Element Values	MM DD YYYY
Additional Information	For the only or final service in which the patient was admitted, this stop date will be the same as the discharge date.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ST_DIS_DATES Field Type: Date Field Length: 2, 2, 4

[Location/Service] Stop Time	
Description	The time the patient was transferred from the service.
Element Values	HH MM in 24–hour clock
Additional Information	For the only or final service in which the patient was admitted, this stop time will be the same as the discharge time.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ST_DIS_TIMES Field Type: Time Field Length: 2,2

[Location/Service] Elapsed Time	
Description	Elapsed Time from patient tracking service start to stop.
Element Values	__days, HH MM
Additional Information	This is a calculated variable based on patient location arrival date/time and patient location departure date/time at trauma centre. If time of arrival and departure is not being entered this data element cannot be calculated.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ST_ELAPSEDS Field Type: String Field Length: 12

[Ventilator/Blood] Total Ventilator Days	
Description	Length of time on ventilator.
Element Values	Relevant value for data element
Additional Information	• Excludes mechanical ventilation time associated with OR procedures. • Non–invasive means of ventilatory support (CPAP or BiPAP) should not be considered in the calculation of ventilator days. • Reported in full–day increments with any partial calendar day counted as a full calendar day. Refer to the NTDB Data Dictionary for the detailed descriptions. • The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient's chart. • At no time should the *Total Ventilator Days* exceed the hospital LOS. • The null value "?" is reported if any dates are missing. • The null value "/" is reported if the patient was not on the ventilator according to the above description.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ICU Respiratory Therapy Flowsheet 2. ICU Nursing Flow Sheet 3. Physician's Daily Progress Notes 4. Calculate based on Admission Form and Discharge Sheet
Data History	NA
Data Attributes	Field Name: VENT_DAYS Field Type: Integer Field Length: 3

Providers

[Resuscitation Team] Trauma Provider	
Description	Resus Team Trauma Provider/Trauma Team Leader
Element Values	Refer to Appendix G
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Records 2. Trauma Flow Sheet 3. Nurses' Notes
Data History	NA
Data Attributes	Field Name: EDP_TYPE01, EDP_MD_LNK01 Field Type: Integer Field Length: 3

[Resuscitation Team] Arrived Date	
Description	The date the Trauma Provider/Trauma Team Leader (TTL) arrived at the patient's bedside.
Element Values	MM DD YYYY
Additional Information	• The trauma surgeon/TTL leads the trauma team and is responsible for the overall care of the trauma patient, including coordinating care with other specialties and maintaining continuity of care. • The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon/TTL within 24 hours of ED/hospital arrival.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage/Trauma Flow Sheet 2. History and Physical 3. Physician Notes/Flow Sheet 4. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: EDP_A_DATE01 Field Type: Date Field Length: 2, 2, 4

[Resuscitation Team] Arrived Time	
Description	The time the Trauma Provider/TTL arrived at the patient's bedside.
Element Values	HH MM
Additional Information	• The trauma surgeon/TTL leads the trauma team and is responsible for the overall care of the trauma patient, including coordinating care with other specialties and maintaining continuity of care. • The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon/TTL within 24 hours of ED/hospital arrival.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage/Trauma Flow Sheet 2. History and Physical 3. Physician Notes/Flow Sheet 4. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: EDP_A_TIME01 Field Type: Time Field Length: 2, 2

Procedures

ICD–10 Procedure Code	
Description	Operative and selected non–operative procedures conducted during hospital stay. Operative and selected non–operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications.
Element Values	Canadian Classification of Health Interventions (CCI) codes. Refer to Appendix K for a list of non–operative procedures.
Additional Information	- The maximum number of procedures that may be reported for a patient is 200. - Only report procedures performed at your institution. - Report all procedures performed in the operating room. - For Non–TQIP sites, the requirement is to report non–operative procedures carried out in the emergency department. While a list of such procedures is provided in Appendix K, facilities may report additional procedures at their discretion. - TQIP sites should consult the NTDB data dictionary for reporting guidelines. - Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications. - Note that the hospital may report additional procedures. - Report the null value "Not Applicable" if the patient did not have procedures.
OTR Required	Yes
NTDB Required	Yes (please see the definition in the current NTDB data dictionary)
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Trauma Flow Sheet 4. ED Record 5. Nursing Notes/Flow Sheet 6. Radiology Reports 7. Discharge Summary
Data History	NA
Data Attributes	Field Name: PR_ICD10_S Field Type: String Field Length: 9

CCI Attributes	
Description	CCI intervention attribute designed to allow users to identify additional circumstances or conditions which may impact on the resources required to perform the intervention or the outcome expected (field repeats 10 times).
Element Values	The Canadian Classification of Health Intervention Codes
Additional Information	• Custom Field • Status: Describes the state or condition of the intervention (i.e. partial or complete). • Location: Refers to the anatomical site or specific location where the intervention is performed. • Extent: Indicates the range or scope of the intervention (i.e. radical or partial). • Mode: Retired.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Trauma Flow Sheet 4. ED Record 5. Nursing Notes/Flow Sheet 6. Radiology Reports 7. Discharge Summary
Data History	NA
Data Attributes	Field Name: RFPR_PR_STAT_ATTRS / RFPR_PR_LOC_ATTRS / RFPR_PR_EXTENT_ATTRS Field Type: String Field Length: 2

Start Date	
Description	The date the operative and selected non–operative procedures were performed
Element Values	MM DD YYYY
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Trauma Flow Sheet 4. ED Record 5. Nursing Notes/Flow Sheet 6. Radiology Reports 7. Discharge Summary
Data History	NA
Data Attributes	Field Name: PR_STR_DATES Field Type: Date Field Length: 2, 2, 4

Start Time	
Description	The time the operative and selected non–operative procedures were performed. Procedure start time is defined as the time the incision was made (or the procedure started).
Element Values	HH MM in 24–hour clock
Additional Information	
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Operative Reports 2. Anesthesia Record 3. Procedure Notes 4. Trauma Flow Sheet 5. ED Record 6. Nursing Notes/Flow Sheet 7. Radiology Reports 8. Discharge Summary
Data History	NA
Data Attributes	Field Name: PR_STR_TIMES Field Type: Time Field Length: 2, 2

Stop Time	
Description	The time the operative and selected non–operative procedures were completed. For procedures in the OR, the OTR defines this as "the time the patient left the operating theatre".
Element Values	HH MM in 24–hour clock
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Operative Reports 2. Anesthesia Record 3. Procedure Notes 4. Trauma Flow Sheet 5. ED Record 6. Nursing Notes/Flow Sheet 7. Radiology Reports 8. 8. Discharge Summary
Data History	NA
Data Attributes	Field Name: PR_STP_DATES Field Type: Time Field Length: 2, 2

Diagnoses

[Injury Coding] AIS version	
Description	The software version used to calculate the Abbreviated Injury Scale (AIS) severity codes.
Element Values	TRUE AIS 85 (Retired) TRUE AIS 90 (Retired) TRUE AIS 2005 (Retired) TRUE AIS 2015 (Mandatory as of Jan 1, 2025)
Additional Information	• This field is auto–generated by the software to reflect the e–version of AIS associated with the accompanying codes. • AIS is an anatomically based consensus–driven, global severity scoring system that classifies each injury by body region according to its relative importance on a 6 point ordinal scale. AIS of 1 is considered minor while an AIS of 6 is the maximum and is currently considered untreatable. • Source: Association for the Advancement of Automotive Medicine (AAAM), AIS 2015
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: AIS_VER Field Type: String Field Length: 7

[Injury Coding] ISS	
Description	The Injury Severity Score (ISS) is the sum of the squares of highest AIS in each of the three most severely injured AIS body regions. ISS is used to predict a patient's mortality and morbidity.
Element Values	Relevant value for data element.
Additional Information	- ISS is an anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an AIS score, allocated to one of six body regions: - Head/ neck (including c–spine) - Face - Chest (including T–spine) - Abdomen (including pelvic contents and L–spine) - Extremities (including pelvic skeleton) - External - The ISS is a calculated field based on the injury descriptions entered in the Narrative (Injury Text). The ISS is the sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. ISS ranges from 1 to 75 with 1 being minor and 75 being incompatible with life. - For trauma inpatients who sustain additional trauma injuries, the injuries should not be considered in the calculation of ISS at initial presentation.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	Calculated by program
Data History	Previous AIS Version 90 used from 1995 to 2014.
Data Attributes	Field Name: ISS Field Type: Integer Field Length: 2

[Injury Coding] TRISS	
Description	TRISS is a calculated field based on the first recorded set of vital signs at Lead/Trauma Hospital.
Element Values	Relevant value for data element
Additional Information	- The TRISS model is derived from Major Trauma Outcome Study (MTOS) data done in 1986. It uses logistical regression to predict patient survival probability. It is calculated for blunt and penetrating trauma only (not for burns). - Because of the nature of this calculation in ATR, if TRISS cannot be calculated due to missing data the data element will appear blank on the screen. - TRISS combines both physiologic and anatomic indices to characterize severity of injury and estimate patient survival probability (Ps). The physiologic index is the RTS as assessed at emergency department admission. The RTS is a weighted sum of coded values (0–4) of the Glasgow Coma Scale (GCS), systolic blood pressure (SBP) and respiratory rate (RR). Because TRISS requires the RTS, it does not calculate probability of survival for patients who are intubated at the time ED department GCS is calculated. - TRISS combines these physiologic and anatomic measures to estimate survival probability as follows: PS=1/(1+e to the minus b) where b=b0 + b1(RTS) + b2(ISS) + b3(age) Age=0 for age <55 years and age=1 for age >=55 years. The "b" are regression weights that differ for blunt and penetrating injury. - Reference: www.trauma.org
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	Software–generated
Data History	NA
Data Attributes	Field Name: TRISS Field Type: Decimal Field Length: 5, 4

[Injury Coding] Narrative	
Description	Used to record injury text for processing using the Tri–Code Narrative Interpreter tool.
Element Values	Free text field (Refer to AIS manual or Tri–Code Training for correct ways to enter injury text)
Additional Information	• This is the "easiest" way to enter your injury coding; simply type in detailed descriptions of all injuries the patient sustained as a result of the traumatic event. Please type in order from head first, down the centre of the body and then out to extremity and external injuries. Please enter each injury on a separate line. • After typing in all injuries you can click the "Replace with what we select see note in comments" button (then hit OK) and the details for all injuries should appear in the table below (if the correct narrative has been entered). Clicking "" will erase all other changes and additions you've made in the table below. • This is a shortcut to diagnosis data entry but you should still check each line in the 2nd table to make sure everything was entered correctly by the computer. In some cases, the computer may not be able to give you the correct ICD10 code or AIS predot code and you will have to reword or highlight that line and click "edit". You can also delete lines in the table or add a new diagnosis if you don't know the narrative to enter. • If you don't know the narrative you can click the "ADD" button and enter the AIS predot code from your AIS 2005 manual. Once you add this predot code everything else will fill in automatically (10, severity and ISS body region). These are the two ways you should be entering anatomical diagnoses – please do not add 10 codes first. Please continuously check your AIS binder manual to look for the correct AIS codes and narrative wording to use.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Autopsy/Medical Examiner Report 2. Operative Reports 3. Radiology Reports 4. Physician's Notes 5. Trauma Flow Sheet 6. History & Physical 7. Nursing Notes/Flow Sheet 8. Progress Notes 9. Discharge Summary
Data History	NA
Data Attributes	Field Name: INJ_TXT Field Type: String Field Length: 4000

[Injury Coding] ICD–10 Code	
Description	Diagnoses Codes related to all identified injuries.
Element Values	International Statistical Classification of Diseases and Related Health Problems Tenth Revision, Canada (ICD–10–CA)
Additional Information	- Select the anatomical diagnosis from the Injury, Poisoning and Other Consequences of External Causes menu that corresponds to the ICD–10–CA Injury Codes. ICD–10–CA diagnoses codes from S00 to T98 can be entered: please exclude categories T36–T65 (poisonings and toxic effects) and T80–T88 (complications of surgery). - Diagnosis codes not properly mapped to the ICD–10–CA: - AIS liver and spleen contusions are mapped to ICD–10 CA as lacerations. - AIS Grade 2 liver and spleen lacerations are mapped to Grade 1 ICD–10 CA (AIS/ICD–10–CA does not differentiate between grade 1 and 2 but ICD–10 CA does). - Brain stem compression/uncal herniation (AIS predot 140202) codes to an ICD–10–CA injury diagnosis of S06.1 which is an undifferentiated ICD–10–CA injury diagnoses (no description provided) and has to be manually changed to one of the codes (S06.2, S06.25, S06.26). - NTDB only accepts diagnoses corresponding to S00–S99, T07, T14, T20–28 and T30–32; however, please enter all diagnosis codes as described above and check the NTDB box as "N" if the only injuries they have fall outside the NTDB range. You will get a Level 1 error during TQIP validation if you have included a patient that is not in their diagnosis inclusion criteria. - Max # that can be submitted to NTDB is 50.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Autopsy/Medical Examiner Report 2. Operative Reports 3. Radiology Reports 4. Physician's Notes 5. Trauma Flow Sheet 6. History & Physical 7. Nursing Notes/Flow Sheet 8. Progress Notes 9. Discharge Summary
Data History	NA
Data Attributes	Field Name: ICD10_01 – 50 Field Type: String Field Length: 9

[Injury Coding] ICD–10 Description	
Description	Diagnoses Code Descriptions related to all identified injury codes used.
Element Values	Free text field
Additional Information	• Auto–populates via Tri–code • Use standardized language for data analysis purposes.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Autopsy/Medical Examiner Report 2. Operative Reports 3. Radiology Reports 4. Physician's Notes 5. Trauma Flow Sheet 6. History & Physical 7. Nursing Notes/Flow Sheet 8. Progress Notes 9. Discharge Summary
Data History	NA
Data Attributes	Field Name: ICD10_01_As_Text Field Type: String Field Length: 4000

[Injury Coding] Pre–Dot Code	
Description	The Abbreviated Injury Scale (AIS) pre–dot codes that reflect the patient's injuries.
Element Values	Relevant value for data element
Additional Information	• The pre–dot code is composed of body region, type of anatomic structure, specific anatomic structure and level. • Direct data entry or software–generated coding from injury text or ICD codes. • Refer to AIS dictionary for the detailed descriptions of the AIS predot codes.
OTR Required	Yes
NTDB Required	Yes. Please see the definition in the current NTDB data dictionary.
Data Source Hierarchy	Injuries as described in the medical record and supporting documentation: 1. Trauma physician notes 2. Operative notes 3. Radiology reports 4. Autopsy reports 5. Medical progress notes
Data History	NA
Data Attributes	Field Name: PREDOT_01 – 50 Field Type: Integer Field Length: 6

Further Clarification

As summarized in the diagram below, the first digit identifies the body region; the second digit identifies the type of anatomic structure; the third and fourth digits identify the specific anatomic structure or, in the case of injuries to the external region, the specific nature of the injury; the fifth and sixth digits identify the level of injury within a specific body region and anatomic structure. The digit to the right of the decimal point is the AIS sverity code.

Body region (1)		Type of anatomic structure (2)		Specific anatomic structure (3/4)		
Code	Region	Code	Region	Type	Code	Region
1	Head	1	Whole Area	Whole area	02	Skin Abrasion
2	Face	2	Vessels		04	Contusion
3	Neck	3	Nerves		06	Laceration
4	Thorax	4	Organs (inc. muscles/ligaments)		08	Avulsion
5	Abdomen	5	Skeletal (inc. joints)		10	Amputation
6	Spine	6	Loss of Consciousness (head only)		20	Burn
7	Upper Extremity				30	Crush
8	Lower Extremity				40	Degloving
9	Unspecified				50	Injury – NFS
					60	Penetrating
					90	Trauma, other than mechanical
				Head – Loss of Consciousness	02	Length of loss of consciousness
					04–08	Level of consciousness
					10	Concussion
				Spine	02	Cervical
					04	Thoracic
					06	Lumbar
				Vessels, Nerves, Organs, Bones, Joints	02	Vessels
					04	Nerves
					06	Organs
					08	Bones
					10	Joints

[Injury Coding] Severity – AIS Severity	
Description	The Abbreviated Injury Scale (AIS) post–dot severity codes that reflect the patient's injuries.
Element Values	1 Minor 2 Moderate 3 Serious 4 Severe 5 Critical 6 Maximum 0 Combined with Other Injury 9 Unassigned / Not Applicable ? Unknown
Additional Information	• Auto–populated via Tri–code. • The digit after the dot of the AIS code represents severity ranging from 1 (minor) to 6 (maximum) with 9 representing unassigned severity. • Field cannot be blank. • Higher scores indicate an increase in severity (usually resulting in longer hospital stay, more medical interventions, and more rehabilitation needed) as well as an increased risk for death.
OTR Required	Yes
NTDB Required	Yes. Please see the definition in the current NTDB data dictionary.
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: AIS_SEV01 – 50 Field Type: Integer Field Length: 1

[Injury Coding] ISS Body Region	
Description	The Injury Severity Score (ISS) body region codes that reflect the patient's injuries.
Element Values	1 Head or Neck (includes brain, skull, C–spine) (Assign Asphyxia/Suffocation to Head body region for calculating ISS 2 Face (mouth, ears, nose and facial bones) 3 Chest (includes internal organs in the chest area, diaphragm, ribs and T–spine) (Assign Drowning to this body region) 4 Abdominal or Pelvic Contents (includes internal organs in the abdomen and L–spine) 5 Extremities or Pelvic Girdle (include sprains fractures, dislocations and amputations) 6 External (includes lacerations, contusions, abrasions and burns independent of their locations on the body surface. Penetrating injuries under Whole Area are also assigned to the External body as are hypothermia, frostbite and electrical injuries.) 9 Not Determined / Not Applicable ? Unknown
Additional Information	ISS Body Region is populated when you enter text in the Narrative that corresponds to a body region, or when you enter an AIS PreDot code.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ISS_BR01 – 50 Field Type: Integer Field Length: 1

[Comorbidities] Pre–Arrival Cardiac Arrest	
Description	Indication of whether patient experienced cardiac arrest prior to the ED/Hospital arrival.
Element Values	Y/N
Additional Information	• A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation. • The event must have occurred outside of the index hospital. • Pre–hospital cardiac arrest could occur at a transferring institution. • Any component of basic and/or advanced cardiac life support must have been initiated. • Field cannot be blank or Not Applicable.
OTR Required	Yes
NTDB Required	Yes. Please see the definition in the current NTDB data dictionary.
Data Source Hierarchy	1. EMS Run Report 2. Nursing Notes/Flow Sheet 3. History and Physical 4. Transfer Notes
Data History	NA
Data Attributes	Field Name: PRE_A_CRDC_ARR_YN Field Type: Character (Y/N) Field Length: 1

[Comorbidities] Comorbidity	
Description	Pre–existing co–morbid factors.
Element Values	Refer to Appendix H.
Additional Information	• Enter pre–existing factors present before patient arrival at the ED/hospital. There is now a speed form for the pre–existing conditions to be entered on. • Enter additional information in the 'Note`. • If a Pre–existing condition does not exist, no further data entry is required. For ACS reporting purposes, a response of No will be assumed and reported. • For any co–morbid condition to be valid for NTDB submission, there must be a diagnosis noted in the patient medical record that meets the definition notes below (or in Appendix 3: Glossary of Terms NTDS data dictionary). • Refer to *Pre–existing conditions* in the NTDB.
OTR Required	Yes
NTDB Required	Yes. Please see the definition in the current NTDB data dictionary.
Data Source Hierarchy	1. History & Physical 2. Physician's Notes 3. Progress Notes 4. Case Management/Social Services 5. Nursing Notes/Flow Sheet 6. Triage/Trauma Flow Sheet 7. Discharge Summary
Data History	NA
Data Attributes	Field Name: PECS / PECS_L_AS_TEXT Field Type: Integer / String Field Length: 2 / 4000

Outcome

[Initial Discharge] Discharge Status	
Description	Discharge Status is whether the patient left your hospital alive or dead.
Element Values	1 Alive 2 Dead
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record 2. Nursing Notes 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_STATUS Field Type: Integer Field Length: 2

[Initial Discharge] Discharge/Death Date	
Description	The date the patient was physically discharged from the hospital.
Element Values	MM DD YYYY
Additional Information	• Enter the patient's date of discharge (when they physically left the hospital or death for all patients including those who died in ED). • Clarification for patients declared NDD. Date/time that brain death was determined is death date/time.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_DATE Field Type: Date Field Length: 2, 2, 4

[Initial Discharge] Discharge/Death Time	
Description	The time the patient was physically discharged from the hospital.
Element Values	HH MM in 24–hour clock
Additional Information	• Enter the patient's time of discharge (when they physically left the hospital) or death using the 24–hour clock. • Used to auto–generate calculated field hospital length of stay.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_TIME Field Type: Time Field Length: 2, 2

[Initial Discharge] Discharge Order Date	
Description	The date the order was written for the patient to be discharged from the hospital.
Element Values	MM DD YYYY
Additional Information	• Enter the date the last order was written for the patient to be discharged from the hospital. • If patient died after being admitted to hospital then please enter the date of death. If patient died in ED this field will become inactive and will be mapped to n/a for NTDB. • If patient was discharged AMA from ward please enter the date they signed the AMA form. If no AMA form signed enter "?". • Rehab patients? Enter the physical discharge date the patient was discharged / transferred to Rehab as per TQIP.
OTR Required	Yes
NTDB Required	Yes. Please see the definition in the current NTDB data dictionary still called hospital discharge date in NTDS – different from when patient actually left hospital.
Data Source Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_O_DATE Field Type: Date Field Length: 2, 2, 4

[Initial Discharge] Discharge Order Time	
Description	The time the order was written for the patient to be discharged from the hospital.
Element Values	HH MM in 24–hour clock
Additional Information	- Enter the time the last order was written for the patient to be discharged from the hospital in 24–hour time (HH:MM). If patient died after being admitted to hospital then please enter the time of death. If patient died in ED this field will become inactive and will be mapped to n/a for NTDB. - If patient was discharged AMA from ward please enter the time they signed the AMA form. If no AMA form signed enter "?". - Rehab patients? Enter the physical discharge time the patient was discharged / transferred to Rehab as per TQIP.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_O_TIME Field Type: Time Field Length: 2, 2

[Initial Discharge] Total ICU Length of Stay	
Description	The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.
Element Values	Relevant value for data element.
Additional Information	• Reported in full–day increments with any partial calendar day counted as a full calendar day. Day 1 is the day they arrived at the ICU. Include both arrival and discharged from ICU dates. Please refer to the NTDB Data Dictionary for the detailed descriptions. • The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart. • At no time should the ICU LOS exceed the hospital LOS. • The null value "Not Known/Not Recorded" is reported if any dates are missing. • If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day. • The null value "Not Applicable" is reported if the patient had no ICU days according to the above description.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. ICU Flow Sheet 2. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: ICU_DAYS Field Type: Integer Field Length: 3

[Initial Discharge] Total Ventilator Days	
Description	The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day. Day 1 is the day Ventilation began.
Element Values	Relevant value for data element.
Additional Information	• Excludes mechanical ventilation time associated with OR procedures. • Non–invasive means of ventilatory support (CPAP or BiPAP) should not be considered in the calculation of ventilator days. • Reported in full–day increments with any partial calendar day counted as a full calendar day. Please refer to the NTDB Data Dictionary for the detailed descriptions. • The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient's chart. • At no time should the Total Ventilator Days exceed the hospital LOS. • The null value "Not Known/Not Recorded" is reported if any dates are missing. • The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above description.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Respiratory Therapy Notes/Flow Sheet 2. ICU Flow Sheet 3. Progress Notes
Data History	NA
Data Attributes	Field Name: VENT_DAYS Field Type: Integer Field Length: 3

[Initial Discharge] Hospital Total Days	
Description	The total cumulative number of days the patient spent in your facility.
Element Values	Relevant value for data element.
Additional Information	• Length of stay at the trauma centre is an auto–calculated element which will be displayed on the screen and is based on admission and discharge/death dates at the trauma centre. • Reported in full–day increments with any partial calendar day counted as a full calendar day. Please refer to the NTDB Data Dictionary for the detailed descriptions (i.e. Total Ventilator Days, Total ICU Length of Stay).
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: HOSP_DAYS Field Type: Integer Field Length: 3

[Initial Discharge] Discharged To	
Description	The disposition of the patient when discharged from the hospital.
Element Values	The table below lists patient's disposition.
Additional Information	• A patient's discharge to location is the place to which the patient is discharged or the services arranged for the patient immediately upon discharge from the trauma centre. • If they died please enter #44 (Morgue) even if they didn't go there (for NTDB submission). • Option #40 (Home) refers to the patient's current place of residence (i.e. hotel, prison, Child Protection Services if they were there before). • Discharge to any other non–medical facility not listed below should be coded as routine discharge (for example, to a homeless shelter). • The menu does not match the NTDB list but will be mapped accordingly. If a patient dies in ED this will be mapped to n/a but please fill out morgue for OTR reporting purposes.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Physician Order 2. Discharge Instructions 3. Nursing Notes/Flow Sheet 4. Case Management/Social Services Notes 5. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_DEST Field Type: Integer Field Length: 2

Code	Description
40	Home or Self Care (Routine Discharge)
41	Home with Services
42	Left AMA
43	Correctional Facility/Court/Law Enforcement
44	Morgue
45	Child Protective Agency
70	Acute Care Facility
71	Intermediate Care Facility
72	Skilled Nursing Facility
73	Rehab (Inpatient)
74	Long–Term Care
75	Hospice
76	Mental Health/Psychiatric Hospital (Inpatient)
77	Nursing Home
79	Another Type of Inpatient Facility Not Defined Elsewhere
80	Burn Center
/	Not Applicable
?	Unknown

[Initial Discharge] Discharge to Alternate Caregiver	
Description	The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.
Element Values	Y/N
Additional Information	This applies only to patients <18 years of age who were sent home (alive) with someone besides their legal guardian due to suspected physical abuse.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ED Record 2. Nursing Notes 3. Discharge Summary
Data History	NA
Data Attributes	Field Name: DIS_TO_ALT_CGVR_YN Field Type: Character (Y/N) Field Length: 1

[Initial Discharge] If Transferred, Facility	
Description	The code and description of the facility receiving the patient from your facility
Element Values	Please refer to the table for *[Initial Discharge] Discharged To*
Additional Information	• If option #70, Acute Care Facility, was chosen for the "Discharged To" data element please select from the list which facility they were transferred to. This is the same list as referring facility. • Another acute care facility: patient is transferred to an acute care inpatient institution (includes other acute, subacute, acute psychiatric, acute rehabilitation, acute cancer, acute paediatric, etc.).
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Discharge Summary 2. Nurses' Notes
Data History	NA
Data Attributes	Field Name: DIS_FACLNK Field Type: Integer Field Length: 4

[Initial Discharge] Ready for ALC	
Description	The date the patient was ready for an Alternate Level of Care.
Element Values	MM DD YYYY
Additional Information	• If the patient was ready for discharge on two different dates, enter the latest one (i.e. the one which gives the greatest number of ALC days). • Enter "NA" if an ALC form was not completed. Hospitals may wish to default this field to NA.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ALC Form 2. Nurses' Notes
Data History	NA
Data Attributes	Field Name: DIS_READY_DATE Field Type: Date Field Length: 2, 2, 4

[Initial Discharge] Reasons for Alternate Level of Care	
Description	The reason for Alternate Level of Care (ALC) days.
Element Values	1. Lack of available beds 2. Lack of available services (i.e. lack of home care, equipment etc.) 3. Other 4. Not Applicable
Additional Information	Enter "NA" if ALC was not ordered. Hospitals may wish to default this field to NA.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. ALC Form 2. Nurses' Notes
Data History	NA
Data Attributes	Field Name: IMP_DIS01–04 Field Type: Integer Field Length: 1

[Initial Discharge] Primary Payor	
Description	Primary source of payment for hospital care.
Element Values	1 Self Pay 2 HMO 3 PPO 5 Blue Cross Blue Shield 6 Automobile 7 Workers' Compensation 8 Medicare 9 Medicaid 10 Military (Tricare) 11 Other Commercial 12 Other Government 13 Not Billed for Any Reason 14 Charity 15 Other / Not Applicable ? Unknown
Additional Information	• Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments. • "Other Government" for OHIP; "Workers' Compensation" for WSIB.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Billing Sheet 2. Admission Form 3. Face Sheet
Data History	NA
Data Attributes	Field Name: PAYOR01 Field Type: Integer Field Length: 2

[If Death] Location	
Description	Place or site in which the patient's vital functions ceased permanently.
Element Values	1 Resuscitation Room 2 Emergency Department 3 Operating Room 4 Intensive Care Unit 5 Step–Down Unit 6 Floor 7 Telemetry Unit 8 Observation Unit 9 Burn Unit 10 Radiology 11 Post–Anesthesia Care Unit 12 Special Procedure Unit 16 Interventional Radiology 19 Neonatal Care Unit 20 Paediatric Care Unit 22 Hybrid OR ? Unknown
Additional Information	• Enter the location of the patient when he/she died. • Paediatric/neonatal ICUs and SDUs should be entered as 4. Intensive Care Unit and 5. Step–Down Unit, respectively.
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	1. Death Summary 2. Nursing notes
Data History	NA
Data Attributes	Field Name: DTH_LOC Field Type: Integer Field Length: 2

[If Death] Was organ donation requested?	
Description	Indicates if organ donation was requested?
Element Values	Y/N
Additional Information	
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ORG_STAT_YN Field Type: Character (Y/N) Field Length: 1

[If Death] Was request granted?	
Description	Indicates if organ donation was granted?
Element Values	Y/N
Additional Information	This field will be skipped unless 'Y' was entered in the previous field *Was organ donation requested?*
OTR Required	Yes
NTDB Required	No
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: ORG_GR_YN Field Type: Character (Y/N) Field Length: 1

QA Tracking

NTDB Complications	
Description	Any TQIP defined hospital event (complication) that occurred during the patient's stay at your hospital.
Element Values	The table below lists NTDB complications. Please refer to Appendix I for further details.
Additional Information	• The patient must experience the onset of signs and symptoms of a complication after arrival to your hospital. • Only report the first occurrence of all Hospital Events defined in the NTDS Data Dictionary • For trauma inpatients who sustain additional trauma injuries, the additional injuries can be documented as complications. The injuries should not be considered in the calculation of ISS at initial presentation. • Exception: Patients receiving CPR on arrival are excluded, unless another episode of cardiac arrest with CPR occurs at any time during the patient's stay, then the second episode is reported. • Besides ICD–10 and AIS injury, post–discharge information is not defined nor collected under the NTDS; anything that occurred after the patient was ordered to be discharged from the hospital after their initial encounter is considered post–discharge data. Therefore, if a patient is readmitted for a complication such as an SSI, that complication, as well as any additional data from the readmission, must not be reported to TQIP.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. History and Physical 2. Physician Notes/Flow Sheet 3. Progress Notes 4. Case Management/Social Services Notes 5. Nursing Notes/Flow Sheet 6. Triage/Trauma Flow Sheet 7. Discharge Summary
Data History	NA
Data Attributes	Field Name: FLT_TYPES Field Type: String Field Length: 50–100

Description
Acute Kidney Injury (AKI)
Acute Respiratory Distress Syndrome (ARDS)
Cardiac Arrest with CPR
Deep Surgical Site Infection
Deep Vein Thrombosis
Myocardial Infarction (MI)
Organ/Space Surgical Site Infection
Pulmonary Embolism
Stroke/CVA
Unplanned Intubation
Osteomyelitis
Unplanned Admission to the ICU
Severe Sepsis
Catheter–Associated Blood Stream Infection (CAUTI)
Central Line–Associated Blood Stream Infection (CLABSI)
Ventilator–Associated Pneumonia (VAP)
Alcohol Withdrawal Syndrome
Pressure Ulcer
Superficial incisional Surgical Site Infection
Delirium
Unplanned Visit to the Operating Room
Not Applicable
Unknown

Trauma Data Program (TDP)/Process Measure 1

Withdrawal of Life–Supporting Treatment (Y,N,U)	
Description	Treatment was withdrawn based on a decision to either remove or withhold further life–supporting intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.
Element Values	Y/N/U
Additional Information	• Reporting criterion: All Patients. • Do–not–resuscitate (DNR) order not a requirement. • A note to limit escalation of treatment qualifies as a withdrawal of life-supporting treatment. • These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life–supporting intervention (e.g. intubation). • Excludes the discontinuation of CPR and typically involves prior planning. • DNR order is not the same as withdrawal of life supporting treatment. • Element Value "2. No" must be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Physician Order 2. Progress Order 3. Case Management/Social Services Notes 4. Nursing Notes/Flow Sheet 5. Discharge Summary
Data History	NA
Data Attributes	Field Name: TQIP_WDCARE_YN Field Type: Character (Y/N/U) Field Length: 1

Withdrawal of Life–Supporting Treatment Date	
Description	Withdrawal of Life–Supporting Treatment Date
Element Values	MM DD YYYY
Additional Information	- Reporting criterion: All Patients. - Report the date the first of any 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 a life– supporting intervention(s) occurs (e.g. intubation). - The null value "Not Applicable" is reported for patients when *Withdrawal of Life-Supporting Treatment* is Element Value "2. No." - This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Physician Order 2. Progress Order 3. Respiratory Therapy Notes/Flow Sheet 4. Case Management/Social Services Notes 5. Nursing Notes/Flow Sheet 6. Discharge Summary
Data History	NA
Data Attributes	Field Name: TQIP_WDCARE_DATE Field Type: Date Field Length: 2, 2, 4

Withdrawal of Life–Supporting Treatment Time	
Description	Withdrawal of Life–Supporting Treatment Time
Element Values	HH MM in 24–hour clock
Additional Information	• Reporting criterion: All Patients. • Report the time the first of any 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 a life–supporting intervention(s) occurs (e.g. intubation). • The null value "Not Applicable" is reported for patients when *Withdrawal of Life-Supporting Treatment* is Element Value "2. No." • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Physician Order 2. Progress Order 3. Respiratory Therapy Notes/Flow Sheet 4. Case Management/Social Services Notes 5. Nursing Notes/Flow Sheet 6. Discharge Summary
Data History	NA
Data Attributes	Field Name: TQIP_WDCARE_TIME Field Type: Time Field Length: 2, 2

Venous Thromboembolism Prophylaxis	
Description	Venous Thromboembolism Prophylaxis
Element Values	1 Heparin 5 None 6 LMWH (Dalteparin, Enoxaparin, etc.) 7 Direct Thrombin Inhibitor 8 Xa Inhibitor (Rivaroxaban, etc.) 9 Coumadin (Retired 2019) 10 Other 11 Unfractionated Heparin ? ?
Additional Information	• Reporting criterion: All Patients. • Element Value "5. None" is reported if the first dose of venous thromboembolism prophylaxis is administered post–discharge order date/time. • Element Value "5. None" is reported if the patient refuses venous thromboembolism prophylaxis. • Element Value "10. Other" is reported if "Coumadin" and/or "aspirin" are given as venous thromboembolism prophylaxis. • Venous Thromboembolism Prophylaxis Types which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Venous Thromboembolism Prophylaxis Types. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Medication Summary 2. Nursing Notes/Flow Sheet 3. Pharmacy Record
Data History	NA
Data Attributes	Field Name: TQIP_VTEP_TYPE Field Type: Integer Field Length: 1

Venous Thromboembolism Prophylaxis Date	
Description	Venous Thromboembolism Prophylaxis Date
Element Values	MM DD YYYY
Additional Information	- Reporting criterion: All Patients. - Refers to date upon which patient first received the prophylactic agent indicated in Venous Thromboembolism Prophylaxis Type. - The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is Element Value "5. None." - This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Medication Summary 2. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: TQIP_VTEP_DATE Field Type: Date Field Length: 2, 2, 4

Venous Thromboembolism Prophylaxis Time	
Description	Venous Thromboembolism Prophylaxis Time
Element Values	HH MM in 24–hour clock
Additional Information	- Reporting criterion: All Patients. - Refers to time at which patient first received the prophylactic agent indicated in Venous Thromboembolism Prophylaxis Type. - The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is Element Value "5. None." - This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Medication Summary 2. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: TQIP_VTEP_TIME Field Type: Time Field Length: 2, 2

Highest Total GCS	
Description	Highest Total GCS
Element Values	Relevant value for data element
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • Refers to highest total GCS score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data. • Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival. • If patient is intubated then the GCS Verbal is equal to 1. • Best obtained when sedatives or paralytics are withheld as part of sedation holiday. • If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," report this as GCS of 15 IF there is no other contradicting documentation. • This particular data element is only required for patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. For the rest the null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Known/Not Recorded" is reported if reporting Highest GCS–40 Motor. • If reporting Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Neurology Assessment Flow Sheet 2. Triage/Trauma /ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_HIGH_GCS Field Type: Integer Field Length: 1

Highest GCS Motor	
Description	Highest GCS Motor
Element Values	Relevant value for data element
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • Refers to highest GCS motor on calendar day after ED/Hospital arrival (trauma centre arrival not referring facility). • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • Requires review of all data sources to obtain the highest GCS motor on calendar day after ED/hospital arrival. • Best obtained when sedatives or paralytics are withheld as part of sedation holiday. • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation. • The null value "Not Known/Not Recorded" is reported if reporting Highest GCS–40 Motor. • If reporting Highest GCS Motor, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Neuro Assessment Flow Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_HIGH_GCS_MR Field Type: Integer Field Length: 1

Associated GCS Qualifiers (up to 3) of Highest GCS Total	
Description	• Reporting Criterion – Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and/or scalp avulsion(s). • Documentation of factors potentially affecting the highest GCS on calendar day after ED/hospital arrival.
Element Values	1. Patient chemically sedated or paralyzed 2. Obstruction to the patient's eye 3. Patient intubated 4. Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes. Refer to NTDB data dictionary TQIP measures for processes of care for additional information
Data Source Hierarchy	1. Neurology Assessment Flow Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes 5. Medication Summary
Data History	NA
Data Attributes	Field Name: TQIP_HIGH_GCSQ01–03 Field Type: Integer Field Length: 1

Highest GCS 40 Motor	
Description	Highest GCS 40 Motor
Element Values	Relevant value for data element.
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • Refers to highest GCS–40 motor on calendar day after ED/Hospital arrival (not referring facility). • Requires review of all data sources to obtain the Highest GCS–40 Motor score on the calendar day after ED/Hospital arrival. • If a patient does not have a numeric GCS–40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. (E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patients, a Motor GCS–40 of 6 may be reported, IF there is no other contradicting documentation). • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Known/Not Recorded" is reported if Highest GCS – Motor is reported. • If reporting Highest GCS–40 Motor, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Neurology Assessment Flow Sheet 2. Triage/Trauma /ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_HIGH_GCS40_MR Field Type: Integer Field Length: 1

Initial ED/Hospital Pupillary Response

Description	Initial ED/Hospital Pupillary Response
Element Values	1 Both Reactive 2 One Reactive 3 Neither Reactive / Not Applicable ? Unknown
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • Please note that first recorded hospital vitals do not need to be from the same assessment. • If a patient does not have a listed element value recorded, but there is documentation related to their pupillary response such as Pupils Equal Round Reactive to Light (PERRL) report Element Value "1. Both reactive" IF there is no other contradicting documentation. • Element Value "2. One reactive" must be reported for patients who have a prosthetic eye. • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Known/Not Recorded" must be reported 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. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage/Trauma Flow Sheet 2. Nursing Notes/Flow Sheet 3. Progress Notes 4. History and Physical
Data History	NA
Data Attributes	Field Name: TQIP_TBI_PUPIL_RSP Field Type: integer Field Length: 1

Midline Shift	
Description	Midline Shift >5mm shift of the brain past its centerline within 24–hours after time of injury
Element Values	1 Yes 2 Not Applicable 3 Not Imaged (e.g. CT Scan, MRI) 4 Unknown / Not Applicable ? Unknown
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, report Element Value "1. Yes." • Radiological and surgical documentation from transferring facilities should be considered for this data element. • If the injury time is unknown, but there is supporting documentation that the injury occurred within 24–hours of any CT measuring a >5mm shift, report the Element Value "1. Yes" if there is no other contradicting documentation. • If the patient was not imaged within 24 hours from the time of injury, report the Element Value "3. Not Imaged (e.g. CT Scan, MRI)." • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Radiology Reports 2. Operative Reports 3. Physician Notes/Flow Sheet 4. Nursing Notes/Flow Sheet 5. Hospital Discharge Summary
Data History	NA
Data Attributes	Field Name: TQIP_TBI_ML_SHIFT Field Type: Integer Field Length: 1

Cerebral Monitors (up to 4)	
Description	Indicate all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), licox monitor, jugular venous bulb.
Element Values	1 Intraventricular Drain/ Catheter 2 Intraparenchymal Pressure Monitor 3 Intraparenchymal Oxygen Monitor 4 Jugular Venous Bulb 5 None / Not Applicable ? Unknown
Additional Information	Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. Report all that apply (up to 4). • Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI. • Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient. • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Triage/Trauma/ICU Flow Sheet 4. Nursing Notes/Flow Sheet 5. Progress Notes 6. Anesthesia Record
Data History	NA
Data Attributes	Field Name: TQIP_CMON01–04 Field Type: Integer Field Length: 1

Cerebral Monitor Date	
Description	Date of first cerebral monitor placement
Element Values	MM DD YYYY
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • If the cerebral monitor was placed at the referring facility, *Cerebral Monitor Date* must be the date of insertion at the referring facility. • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Applicable" is reported if Cerebral Monitor is Element Value "5. None." • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Triage/Trauma/ICU Flow Sheet 4. Nursing Notes/Flow Sheet 5. Progress Notes 6. Anesthesia Record
Data History	NA
Data Attributes	Field Name: TQIP_CMON_DATE Field Type: Date Field Length: 2, 2, 4

Cerebral Monitor Time	
Description	Time of first cerebral monitor placement
Element Values	HH MM in 24–hour clock
Additional Information	• Reporting criterion: Patients with at least one injury in AIS head regions, excluding patients with isolated scalp abrasions, scalp contusion, scalp lacerations, and/or scalp avulsions. • The null value "Not Applicable" is reported if Cerebral Monitor is Element Value "5. None." • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • If the cerebral monitor was placed at the referring facility, *Cerebral Monitor Time* must be the time of insertion at the referring facility. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Triage/Trauma/ICU Flow Sheet 4. Nursing Notes/Flow Sheet 5. Progress Notes 6. Anesthesia Record
Data History	NA
Data Attributes	Field Name: TQIP_CMON_TIME Field Type: Time Field Length: 2, 2

Trauma Data Program (TDP)/Process Measure 2

Transfusion Blood	
Description	Transfusion blood within 4 hours of ED/Hospital arrival
Element Values	Relevant value for data element.
Additional Information	• Reporting criterion: All patients. • Record the volume of packed red blood cells transfused (units or CCs) within the first 4 hours after trauma centre ED/Hospital arrival. If no blood transfused, please enter 0. If meets blood tracking criteria is "No" then '0' will automatically be filled out for this data field (and all subsequent data fields will be '/'). • If packed red blood cells are transfusing upon patient arrival, count as 1–unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site). • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes – Required for Adult Level 1 and 2 sites. Please see the definition in the current NTDB data dictionary
Data Source Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow Sheet 5. Blood Bank
Data History	NA
Data Attributes	Field Name: TQIP_BLOOD_4H Field Type: Integer Field Length: 5

Whole Blood	
Description	Volume of whole blood transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival. EXCLUDE: • Packed red blood cells transfusing upon patient arrival. • Cell saver blood.
Element Values	Relevant value for data element.
Additional Information	• Reporting criterion: All patients. • Refers to amount of transfused whole blood (CCs [mLs]) within first 4 hours after arrival to your hospital. • If no whole blood was given, then volume reported must be 0 (zero). • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	NA
Data History	NA
Data Attributes	Field Name: TQIP_BLOOD_24H Field Type: Integer Field Length:5

Transfusion Plasma	
Description	Volume of plasma (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival
Element Values	Relevant value for data element.
Additional Information	• Reporting criterion: All patients. • Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs[mLs]) within first 4 hours after arrival to your hospital. • If no plasma was given, then volume reported must be 0 (zero). • If plasma is transfusing upon patient's arrival, count as 1 unit or if reporting CC's, report the amount of CC's transfused upon arrival at your site. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Record 3. Operative Reports 4. Nursing Notes/Flow Sheet 5. Blood Bank
Data History	NA
Data Attributes	Field Name: TQIP_PLASMA_4H Field Type: Integer Field Length: 4

Transfusion Platelets	
Description	Volume of platelets (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival.
Element Values	Relevant value for data element.
Additional Information	• Reporting criterion: All patients. • Refers to amount of transfused platelets (CCs [mLs]) within first 4 hours after arrival to your hospital. • If no platelets were given, then volume reported must be 0 (zero). • If platelets are transfusing upon patient's arrival, count as 1 –unit (or if reporting CC's, report the amount of CC's transfused upon arrival at your site). • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Record 3. Operative Reports 4. Nursing Notes/Flow Sheet 5. Blood Bank
Data History	NA
Data Attributes	Field Name: TQIP_PLATE_4H Field Type: Integer Field Length: 4

Cryoprecipitate	
Description	Volume of solution enriched with clotting factors transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival. EXCLUDE: • Packed red blood cells transfusing upon patient arrival. • Cell saver blood.
Element Values	Relevant value for data element
Additional Information	• Reporting criterion: All patients. • Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first 4 hours after arrival to your hospital. • If no cryoprecipitate was given, then volume reported must be 0 (zero). • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Record 3. Operative Reports 4. Nursing Notes/Flow Sheet 5. Blood Bank
Data History	NA
Data Attributes	Field Name: TQIP_CRYO_4H Field Type: Integer Field Length: 4

Lowest ED/Hospital SBP	
Description	Lowest sustained (>5 min) systolic blood pressure measured within the first hour of ED/hospital arrival.
Element Values	Relevant value for data element
Additional Information	• Reporting criterion: All patients. • '/' is used for patients who do not meet the blood tracking criteria.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Triage/Trauma/ICU Flow Sheet 2. Operative Reports 3. Nursing Notes/Flow Sheet
Data History	NA
Data Attributes	Field Name: TQIP_LOW_SBP Field Type: Integer Field Length: 2

Angiography	
Description	First interventional angiogram for hemorrhage control within first 24 hours of ED/hospital arrival. EXCLUDE: • Computerized Tomographic Angiography (CTA).
Element Values	1 None 2 Angiogram Only 3 Angiogram with Embolization / Not Applicable ? Unknown
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. • Limit reporting angiography data to the first 24 hours following ED/hospital arrival. • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_ANGIO_TYPE Field Type: Integer Field Length: 1

Angiography Date	
Description	Date the first angiogram with or without embolization was performed at the trauma centre within first 4 hours after ED/Hospital Arrival.
Element Values	MM DD YYYY
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. • '/' is used if the data field Angiography is "None" or if patients do not meet the collection criteria. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_ANGIO_DATE Field Type: Date Field Length: 2, 2, 4

Angiography Time	
Description	Time the first angiogram with or without embolization was performed at the trauma centre
Element Values	HH MM in 24–hour clock
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. • '/' is used if the data field Angiography is "None" or if patients do not meet the collection criteria. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_ANGIO_TIME Field Type: Time Field Length: 2, 2

Embolization Sites (up to 8)	
Description	Organ/site of embolization for hemorrhage control
Element Values	1 Liver 2 Spleen 3 Kidneys 4 Pelvic (Iliac, Gluteal, Obturator) 5 Retroperitoneum (lumbar, sacral) 6 Peripheral Vascular (neck, extremities) 7 Aorta (Thoracic or Abdominal) (Retired 2020) 8 Other / Not Applicable ? Unknown
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. Report all that apply. • Embolization Sites which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. • Refer to the NTDS Change Log for a full list of retired Embolization Sites. • The null value "Not Applicable" is reported if Angiography is Element Value "1. None," "2. Angiogram only," or "4. Angiogram with stenting.". • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes. Refer to NTDB data dictionary TQIP measures for processes of care for additional information.
Data Source Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_ANGIO_ES01–08 Field Type: Integer Field Length: 1

Surgery for Hemorrhage Control Types	
Description	First type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival.
Element Values	1 None 2 Laparotomy 3 Thoracotomy 4 Sternotomy 5 Extremity 6 Neck 7 Mangled Extremity/ Traumatic Amputation 8 Other Skin, Soft Tissue (e.g. scalp laceration) 9 Extraperitoneal Pelvic Packing / Not Applicable ? Unknown
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. • If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon. • Element Value "1. None" is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option. • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes. Refer to NTDB data dictionary TQIP measures for processes of care for additional information.
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_HCS_TYPE Field Type: Integer Field Length: 1

Surgery for Hemorrhage Control Types Date	
Description	Date of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.
Element Values	MM DD YYYY
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. • Procedure start date is defined as the date the incision was made (or the procedure started). • If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon. • The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is Element Value "1. None." • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes. Refer to NTDB data dictionary TQIP measures for processes of care for additional information.
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_HCS_DATE Field Type: Date Field Length: 2, 2, 4

Surgery for Hemorrhage Control Types Time	
Description	Time of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.
Element Values	HH MM in 24–hour clock
Additional Information	• Reporting criterion: All patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival. • Procedure start time is defined as the time the incision was made (or the procedure started). • If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon. • The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is Element Value "1. None." • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes. Refer to NTDB data dictionary TQIP measures for processes of care for additional information
Data Source Hierarchy	1. Operative Reports 2. Procedure Notes 3. Progress Notes
Data History	NA
Data Attributes	Field Name: TQIP_HCS_TIME Field Type: Time Field Length: 2, 2

Antibiotic Therapy	
Description	Intravenous antibiotic therapy was administered to the patient within 24 hours after injury.
Element Values	Y/N
Additional Information	- Reporting criterion: All patients with any open fracture(s) - Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb codes descriptors that contain "amputation." - The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. - This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Medication Summary 4. Anesthesia Record 5. Nursing Notes/Flow Sheet 6. Pharmacy Record
Data History	NA
Data Attributes	Field Name: TQIP_ANTIBIOT_YN Field Type: Character (Y/N) Field Length: 1

Antibiotic Date	
Description	The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.
Element Values	MM DD YYYY
Additional Information	• Reporting criterion: All patients with any open fracture(s) • Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb codes descriptors that contain "amputation." • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Applicable" is reported if Antibiotic Therapy is Element Value "2. No." • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Medication Summary 4. Anesthesia Record 5. Nursing Notes/Flow Sheet 6. Pharmacy Record
Data History	NA
Data Attributes	Field Name: TQIP_ANTIBIOT_DATE Field Type: Date Field Length: 2, 2, 4

Antibiotic Time	
Description	The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.
Element Values	HH MM in 24–hour clock
Additional Information	• Reporting criterion: All patients with any open fracture(s) • Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb codes descriptors that contain "amputation." • The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. • The null value "Not Applicable" is reported if Antibiotic Therapy is Element Value "2. No." • This is a TQIP measure for the process of care, and non–TQIP sites can set to the default of 'Not Applicable' if information is not available.
OTR Required	Yes
NTDB Required	Yes
Data Source Hierarchy	1. EMS Run Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Medication Summary 4. Anesthesia Record 5. Nursing Notes/Flow Sheet 6. Pharmacy Record
Data History	NA
Data Attributes	Field Name: TQIP_ANTIBIOT_TIME Field Type: Time Field Length: 2, 2

Appendix A: Abbreviations

Abbreviation	Full name
AIS	Abbreviated Injury Scale
ALC	Alternative Level of Care
BAC	Blood Alcohol Concentration
CAS	Children's Aid Society
CDS	Comprehensive Data Set
CIHI	Canadian Institute for Health Information
CPAP	Continuous Positive Airway Pressure
CPR	Cardio–Pulmonary Resuscitation
CSF	Cerebrospinal Fluid
CT	Computerized Tomography
DAD	Discharge Abstract Database
DIE	Died in Emergency Department
DOA	Dead on Arrival at Hospital
ED	Emergency Department
EMS	Emergency Medical Service
FIM®®	Functional Independence Measure
GCS	Glasgow Coma Scale
GOS	Glasgow Outcome Scale
ICD	International Classification of Diseases
ICP	Intracranial Pressure
ICU	Intensive Care Unit
ISS	Injury Severity Score
LOS	Length of Stay
MAIS	Maximum Abbreviated Injury Scale
MVAR	Motor Vehicle Accident Report
NTDB	National Trauma Data Bank
NTDS	National Trauma Data Standard
OR	Operating Room
OTR	Ontario Trauma Registry
PTS	Paediatric Trauma Score
RANCHOS	Rancho Los Amigos Scale
RTS	Revised Trauma Score
SCU	Special Care Unit
TDP	Trauma Data Program
TRISS	Trauma Injury Severity Score
TTA	Trauma Team Activation
TTL	Trauma Team Leader
UTM	Universal Transverse Mercator
VSA	Vital Signs Absent

Appendix B: Address – Country

Patient/Injury Address – Country			
Acronym	**Country**	**Acronym**	**Country**
AF	Afghanistan	CM	Cameroon
AX	Akrotiri Sovereign Base Area	CA	Canada
AL	Albania	CV	Cape Verde
AG	Algeria	CJ	Cayman Islands
AQ	American Samoa	CT	Central African Republic
AN	Andorra	CD	Chad
AO	Angola	CI	Chile
AV	Anguilla	KT	Christmas Island
AY	Antarctica	IP	Clipperton Island
AC	Antigua and Barbuda	CK	Cocos (Keeling) Islands
AR	Argentina	CO	Colombia
AM	Armenia	CN	Comoros
AA	Aruba	CW	Cook Islands
AT	Ashmore and Cartier Islands	CR	Coral Sea Islands
AS	Australia	CS	Costa Rica
AU	Austria	IV	Cote d'Ivoire
AJ	Azerbaijan	HR	Croatia
BF	Bahamas	CU	Cuba
BA	Bahrain	CY	Cyprus
FQ	Baker Island	EZ	Czech Republic
BG	Bangladesh	CG	Democratic Republic of the Congo
BB	Barbados	DA	Denmark
BS	Bassas da India	DX	Dhekelia Sovereign Base Area
BO	Belarus	DJ	Djibouti
BE	Belgium	DO	Dominica
BH	Belize	DR	Dominican Republic
BN	Benin	EC	Ecuador
BD	Bermuda	EG	Egypt
BT	Bhutan	ES	El Salvador
BL	Bolivia	EK	Equatorial Guinea
BK	Bosnia and Herzegovina	ER	Eritrea
BC	Botswana	EN	Estonia
BV	Bouvet Island	ET	Ethiopia
BR	Brazil	EU	Europa Island
IO	British Indian Ocean Territory	FK	Falkland Islands (Malvinas)
VI	British Virgin Islands	FO	Faroe Islands
BX	Brunei	FM	Federated States of Micronesia
BU	Bulgaria	FJ	Fiji
UV	Burkina Faso	FI	Finland
BY	Burundi	FR	France
CB	Cambodia	FG	French Guiana
FP	French Polynesia	KZ	Kazakhstan
FS	French Southern Territories	KE	Kenya
GB	Gabon	KQ	Kingman Reef
GZ	Gaza Strip	KR	Kiribati
GG	Georgia	KU	Kuwait
GM	Germany	KG	Kyrgyzstan
GH	Ghana	LA	Laos
GI	Gibraltar	LG	Latvia
GO	Glorioso Islands	LE	Lebanon
GR	Greece	LT	Lesotho

GL	Greenland	LI	Liberia
GJ	Grenada	LY	Libya
GP	Guadeloupe	LS	Liechtenstein
GQ	Guam	LH	Lithuania
GT	Guatemala	LU	Luxembourg
GK	Guernsey	MC	Macau
GV	Guinea	MA	Madagascar
PU	Guinea–Bissau	MI	Malawi
GY	Guyana	MY	Malaysia
HA	Haiti	MV	Maldives
HM	Heard Island and McDonald Islands	ML	Mali
HO	Honduras	MT	Malta
HK	Hong Kong	RM	Marshall Islands
HQ	Howland Island	MB	Martinique
HU	Hungary	MR	Mauritania
IC	Iceland	MP	Mauritius
IN	India	MF	Mayotte
ID	Indonesia	MX	Mexico
IR	Iran	MQ	Midway Islands
IZ	Iraq	MD	Moldova
IM	Isle of Man	MN	Monaco
IS	Israel	MG	Mongolia
IT	Italy	MJ	Montenegro
JM	Jamaica	MH	Montserrat
JN	Jan Mayen	MO	Morocco
JA	Japan	MZ	Mozambique
DQ	Jarvis Island	BM	Myanmar
JE	Jersey	WA	Namibia
JQ	Johnston Atoll	NR	Nauru
JO	Jordan	BQ	Navassa Island
JU	Juan de Nova Island	NP	Nepal
NL	Netherlands	VC	Saint Vincent and the Grenadines
NT	Netherlands Antilles	WS	Samoa
NC	New Caledonia	SM	San Marino
NZ	New Zealand	TP	Sao Tome and Principe
NU	Nicaragua	SA	Saudi Arabia
NG	Niger	SG	Senegal
NI	Nigeria	RB	Serbia
NE	Niue	SE	Seychelles
NF	Norfolk Island	SL	Sierra Leone
KN	North Korea	SN	Singapore
CQ	Northern Mariana Islands	LO	Slovakia
NO	Norway	SI	Slovenia
MU	Oman	BP	Solomon Islands
PK	Pakistan	SO	Somalia
PS	Palau	SF	South Africa
PM	Panama	SX	South Georgia and the South Sandwich Islands
PP	Papua New Guinea	KS	South Korea
PF	Paracel Islands	SP	Spain
PA	Paraguay	PG	Spratly Islands
CH	People's Republic of China	CE	Sri Lanka
PE	Peru	SU	Sudan
RP	Philippines	NS	Suriname
PC	Pitcairn Islands	SV	Svalbard
PL	Poland	WZ	Swaziland
PO	Portugal	SW	Sweden
RQ	Puerto Rico	SZ	Switzerland

QA	Qatar	SY	Syria
TW	Republic of China (Taiwan)	TI	Tajikistan
EI	Republic of Ireland	TZ	Tanzania
MK	Republic of Macedonia	TH	Thailand
CF	Republic of the Congo	GA	The Gambia
UG	Republic of Uganda	TT	Timor–Leste/East Timor
RE	Reunion	TO	Togo
RO	Romania	TL	Tokelau
RS	Russia	TN	Tonga
RW	Rwanda	TD	Trinidad and Tobago
SH	Saint Helena	TE	Tromelin Island
SC	Saint Kitts and Nevis	TS	Tunisia
ST	Saint Lucia	TU	Turkey
SB	Saint Pierre and Miquelon	TX	Turkmenistan
TK	Turks and Caicos Islands		
TV	Tuvalu		

Appendix C: Definition of Trauma

External Cause of Injury Codes—Inclusions	
ICD–10–CA Code	**Definition**
V01–V99	Transport incidents
V01–V06, V09–V90	Land transport incidents
V91–V94	Water transport incidents
V95–V97	Air and space transport incidents
V98, V99	Other and unspecified transport incidents
W00–W19	Unintentional falls
W20–W44, W45.09, W46, W49	Exposure to inanimate mechanical forces
W50–W60, W64	Exposure to animate mechanical forces
W65–W70, W73, W74	Unintentional drowning and submersion
W75–W77, W81, W83, W84	Other unintentional threats to breathing except due to inhalation of gastric contents, food or other objects
W85–W94, W99	Exposure to electric current, radiation and extreme ambient air temperature and pressure
X00–X06, X08, X09	Exposure to smoke, fire and flames
X10–X19	Contact with heat and hot substances
X30–X39	Exposure to forces of nature
X50	Overexertion and strenuous or repetitive movements
X52	Prolonged stay in weightless environment
X58, X59	Unintentional exposure to other and unspecified factors
X70–X84	Intentional self–harm, excluding poisoning
X86, X91–X99, Y00–Y05, Y07–Y09	Assault, excluding poisoning
Y20–Y34	Event of undetermined intent, excluding poisoning
Y35, Y36	Legal intervention and operations of war

Historical changes due to updates to ICD–10–CA:

- Addition of W46: Contact with hypodermic needle (this was added in the 2009 version of ICD–10–CA)

- W45.00 (previous definition was Foreign body or object entering through skin. This was split into 2 codes in the 2012 version:

  o W45.00 Voluntary body piercing: **Excluded** from trauma definition

  o W45.09 Foreign body or object entering through skin: **Included** in trauma definition

External Cause of Injury Codes—Exclusions	
ICD–10–CA Code	**Definition**
W45.00	Voluntary body piercing
W78–W80	W78 Inhalation of gastric contents; W79 Inhalation and ingestion of food causing obstruction of respiratory tract; W80 Inhalation and ingestion of other objects causing obstruction of respiratory tract
X20–X29	Contact with venomous animals and plants
X40–X49	Unintentional poisoning and exposure to noxious substances
X51	Travel and motion
X53, X54, X57, Y06	X53 Lack of food; X54 Lack of water; X57 Unspecified privation; Y06 Neglect and abandonment
X60–X69	Intentional self–harm by poisoning
X85, X87–X90	Assault by poisoning
Y10–Y19	Poisoning of undetermined intent
Y40–Y59	Drugs, medicaments and biological substances causing adverse effects in therapeutic use
Y60–Y69	Misadventures to patients during surgical and medical care
Y70–Y82	Medical devices associated with adverse incidents in diagnostic and therapeutic use
Y83, Y84	Surgical and other medical procedures as the cause of abnormal reaction of the patient; or of later complication, without mention of misadventure at the time of the procedures
Y85–Y89	Sequelae of external causes of morbidity and mortality
Y90–Y98	Supplementary factors related to causes of morbidity and mortality classified elsewhere

Appendix D: Motor Vehicle Accident Report Information

Motor Vehicle Collision Report Information

Note: Definitions are taken from the Ministry of Transportation Motor Vehicle Collision Report manual (March 1989). The word 'accident' used in definitions has been replaced with "collision."

Ministry of Transportation Definitions for Impact Type (Box 45 on MVAR)

- **Approaching**

Initial direction of travel of each vehicle is opposite to the other and at least one vehicle was impacted on the front. One vehicle may be stopped but not disabled or parked.

- **Angle**

Included are collisions which occur at intersections and/or private drives, where the initial directions of travel are approximately 90 degrees to one another and neither vehicle is in the act of turning. Normally a vehicle entering a roadway from a private drive is in the act of turning and this is not considered an angle impact.

- **Rear End**

Vehicles are travelling in the same direction and the lead vehicle is struck in the rear.

- **Sideswipe**

Collisions involving side impacts where vehicles are travelling in the same or opposite direction.
Vehicles which sideswipe while approaching, i.e. no frontal impacts are coded as sideswipes.

- **Turning Movement**

Collisions in which vehicles are turning and impact location on one of the vehicles is on the side (lane changes are excluded on some roadways).

- **SMV Unattended Vehicle**

Single motor vehicle (SMV) collisions occur when a vehicle strikes a vehicle unattended by its driver. Included parked, stopped, disabled, abandoned and runaway vehicles, provided it was not under the care and control of a driver. Does not include vehicles stopped for traffic or standing while loading or unloading passengers or cargo.

- **SMV Other**

SMV initially collides with a fixed object, pedestrian, pedal cyclist or animal. Includes occurrences of Other Events provided in the Sequence of Events section.

Ministry of Transportation Definitions for Safety Equipment Used (protective devices) (Box 77 on MVAR)

- **Use Unknown**

Where the driver or passenger has left the scene of the collision and usage has not been determined.

- **Lap and Shoulder Belt**

Both lap and shoulder belt were worn. In most vehicles the unit is one assembly, however older models may have separate assemblies. Includes child in approved booster seat.

- **Lap Belt Only**

Only a lap belt exists and was worn. Older vehicles or trucks may be fitted with this equipment only. In newer vehicles rear seat or centre seat positions frequently have lap belts only. This includes child in approved booster seat.

- **Lap Belt Only of Combined Assembly**

Passenger altered the position of the shoulder harness so that only the lap portion was used or lap belt only was used in older vehicle with separate assemblies.

- **Child Safety Seat Used Incorrectly**

Child safety seat did not conform to one or more of the following:

  o Properly anchored
  o Approved equipment
  o Facing proper direction
  o Using restraint straps.
  o

Note: Approved equipment safety standards label on the rear of the seat, written as CMVSS213. Car beds are not approved safety equipment. Approved booster seats are coded under the type of restraint in use, if any. Infants should face backwards.

- **Child Safety Seat Used Correctly**

Child safety seat was all of the following:

  o Anchored properly
  o Approved equipment
  o Facing proper direction
  o Using restraint straps

Note: See notes for Child Safety Used Incorrectly.

- **Air Bags Deployed**

The vehicles were equipped with air bags, which were deployed on impact. Air bags are a passive restraint device.

- **Other Passive Restraint Device**

The vehicle was equipped with a passive restraint device other than an air bag.

- **Helmet**

For use when helmet was worn. In Ontario, C.S.A. approved helmets are required by operators and passengers of motorcycles, snowmobiles and off–road vehicles.

- **Equipment Not Used but Available**

Seating position was fitted with safety equipment in good repair but equipment was not used. Include equipment, which has been intentionally disabled.

- **No Equipment Available**

Seat position was not fitted with safety equipment, i.e. belts, helmets or approved child seats. Includes equipment, which has been inadvertently damaged and is not functional.

- **Other Safety Equipment Used**

Approved safety equipment in use is not detailed above. Detailed information is entered in the Description of Code(s) 97, 98, 99 field (found at bottom of Investigating Officer's Description of Collision and Diagram section of MVAR).

Guidelines for Entering MVAR Information for Injured Cyclists and Pedestrians

The following guidelines are provided for documenting motor vehicle collision data elements for cyclists and pedestrians.

Data Element	Cyclist	Pedestrian
Vehicle type Describes the type of vehicle (including pedestrian) that the patient was in, on or fell from. Vehicle type should never be documented as inappropriate for transport incidents (i.e. V01–V99) and should reflect the vehicle the patient was in, on or fell from. (Working Group 03/97)	Menu item 10 (bicycle)	• Menu item 16 (pedestrian) • Vehicle type should be documented as pedestrian for patients struck by a train whether the patient was walking or laying on the train tracks. Working Group 03/97)
Protective devices	• If wearing a helmet, menu item 8 (helmet) or 17 (helmet flew off) • If not wearing a helmet, menu item 9 (equipment available but not used) The Working Group agreed that helmets are theoretically available to all cyclists and therefore menu item 10 (no equipment available) should not be documented for cyclists. (03/97)	• If wearing specifically designed clothing for visibility, menu item 12 (other safety equipment used) • If documentation does not indicate that the patient was wearing any fluorescent clothing or any other type of safety device designed for increased visibility, inappropriate should be documented
Ejected Distance Ejected	Because some police forces document the distance ejected for cyclists and pedestrians and because some hospitals use this information for research purposes, these fields may be used as appropriate at your institution.	
Primary vehicle impact Describes the location of the initial impact on the vehicle the patient was travelling in or on.	Inappropriate (Working Group 03/97)	Inappropriate
Secondary vehicle impact Describes the location of the initial impact for a second vehicle involved the collision in which the patient not travelling in or on.	May be menu items 1–19 depending on area of damage to vehicle striking cyclist	May be menu items 1–19 depending on area of damage to vehicle striking pedestrian
Impact type Ministry of Transportation description for the vehicle the patient was travelling in or on.	Menu item 07 (single motor vehicle other)	Menu item 07 (single motor vehicle other)
Collision detail— primary impact Ministry of Transportation description of the collision in which the patient was injured.	Menu item 01 (impact with moving object) if cyclist struck by moving vehicle May also be other menu items depending on the circumstances of the collision	• Menu item 01 (impact with moving object) if pedestrian struck by moving vehicle • May also be other menu items depending on the circumstances of the collision
Collision detail— secondary impact The secondary impact collision detail describes the impact that relates to the	Should be documented as inappropriate unless a secondary External Cause Code is documented	Should be documented as inappropriate unless a secondary External Cause Code is documented

secondary External Cause Code when applicable.		
Position in vehicle	Cyclists (and motorcycle) drivers, should be coded as drivers (menu item #01) Cyclist (and motorcycle) passengers should be coded as left–rear if the passenger was sitting behind the driver (menu item #04) or hanger–on (menu item #08) for a position other than behind the driver	• Menu item 09

Appendix E: Prehospital – Procedure

Procedure	Procedure
None	Intravenous Fluids
Airway – Nasal	Laryngeal Mask Airway
Airway Opened or Cleared	LT Blind Insertion Airway Device
Airway – Oral	MAST
Arterial Line Maintenance	Nasogastric Tube
Assisted Ventilation	Pericardiocentesis
Bag Valve Mask	Pharmacological Restraints
Blood Draw	Physical Restraints
Blood Glucose Analysis	Rapid Sequence Intubation
Cardiac Monitor	Rescue
Chest Tube	Spinal Immobilization
Childbirth	Splinting
CNS Catheter	Thoracostomy – Needle
Combitube	Tracheostomy
CPR	Traction
Cricothyrotomy	Urinary Catheterization
Cricothyrotomy – Needle	Venous Access
Decontamination	Ventilator
Defibrillation – Automated	Wound Care
Defibrillation – Manual	Other
Defibrillation – NFS	Tourniquet
Endotracheal Tube – Nasal	KED
Endotracheal Tube – Oral	CPR Machine
Endotracheal Tube Route Not Recorded	C–Spine Immobilization
Esophageal Obturator Airway	Blood Product Administered
Extrication	Pelvic Immobilization
Intra–Aortic Balloon Pump	Not Applicable
Intraosseous Access or Infusion	Unknown

Appendix F: Admitting Service/Service Code

Gen6 Code	Description	Gen6 Code	Description
1	Trauma	65	Neurocritical Care
2	Neurosurgery	66	Paediatric Critical Care
3	Orthopedics	67	Paediatric Orthopedics
4	General Surgery	68	Intensivist
5	Paediatric Surgery	71	General Medicine
6	Cardiothoracic Surgery	72	Allergy
7	Burn Services	73	Dermatology
8	Emergency Medicine	74	Respirology
9	Paediatrics	75	Rheumatology
10	Anesthesiology	76	Paediatric Allergy
11	Cardiology	77	Paediatric Cardiology
14	Critical Care	78	Paediatric Dermatology
16	Documentation Recorder	79	Paediatric Endocrinology
19	ENT	80	Paediatric Gastroenterology
20	Family Medicine	81	Paediatric Nephrology
21	GI	82	Paediatric Neurology
23	Hospitalist	83	Paediatric Respirology
24	Infectious Disease	84	Paediatric Rheumatology
25	Internal Medicine	85	Cardiovascular Surgery
27	Nephrology	86	Transplant Surgery
28	Neurology	87	Paediatric Cardiovascular Surgery
29	Nurse Practitioner	88	Paediatric Neurosurgery
30	Nursing	89	Paediatric Oral Surgery
32	Ob–Gyn	90	Paediatric Plastic Surgery
34	Oncology	91	Paediatric Thoracic Surgery
35	Ophthalmology	92	Paediatric Transplant Surgery
36	Oral Surgery	93	Paediatric Traumatology
37	Oromaxillo Facial Service	94	Paediatric Urology
38	Ortho–Spine	95	Obstetrics Delivered
39	Palliative Care	96	Obstetrics Antepartum
43	Plastic Surgery	97	Obstetrics Aborted
45	Pulmonary	98	Newborn
46	Radiology	99	Paediatric Gynecology
47	Rehabilitation	100	Obstetric Postpartum
48	Respiratory Therapist	101	Otolaryngology And Otorhinolaryngology
52	Thoracic Surgery	102	Paediatric Otolaryngology
53	Trauma Resuscitation Nurse	103	Paediatric Ophthalmology
54	Triage Nurse	104	Psychiatry
55	Urology	105	Paediatric Psychiatry
56	Vascular Surgery	106	Paediatric Hematology
57	Psychology	107	Immunology
58	Chief Resident	108	Paediatric Immunology
59	Dental	109	Physical Medicine And Rehab (Physiatry)
60	Geriatrics	110	Paediatric Physical Medicine And Rehab (Physiatry)
61	Hematology	111	Radiotherapy
62	Neuropsychology	112	Genetics
63	Physician Assistant	113	Paediatric Dentistry
64	Surgical Resident	114	Stillborn

115	Cadaveric Donor		
116	Podiatry		
117	Neonatology		
118	Alternate Level Of Care (ALC)		
119	Blood Bank		
198	Other Surgical		
199	Other Non–Surgical		
/	Not Applicable		
?	Unknown		

Appendix G: Resuscitation Team Trauma Provider

Code	Description	Code	Description
1	Trauma	63	Physician Assistant
2	Neurosurgery	64	Surgical Resident
3	Orthopedics	65	Neurocritical Care
4	General Surgery	66	Paediatric Critical Care
5	Paediatric Surgery	67	Paediatric Orthopedics
6	Cardiothoracic Surgery	68	Intensivist
7	Burn Services	70	TTL
8	Emergency Medicine	71	General Medicine
9	Paediatrics	72	Allergy
10	Anesthesiology	73	Dermatology
11	Cardiology	74	Respirology
14	Critical Care	75	Rheumatology
16	Documentation Recorder	76	Paediatric Allergy
19	ENT	77	Paediatric Cardiology
20	Family Medicine	78	Paediatric Dermatology
21	GI	79	Paediatric Endocrinology
23	Hospitalist	80	Paediatric Gastroenterology
24	Infectious Disease	81	Paediatric Nephrology
25	Internal Medicine	82	Paediatric Neurology
27	Nephrology	83	Paediatric Respirology
28	Neurology	84	Paediatric Rheumatology
29	Nurse Practitioner	85	Cardiovascular Surgery
30	Nursing	86	Transplant Surgery
32	Ob–Gyn	87	Paediatric Cardiovascular Surgery
34	Oncology	88	Paediatric Neurosurgery
35	Ophthalmology	89	Paediatric Oral Surgery
36	Oral Surgery	90	Paediatric Plastic Surgery
37	Oromaxillo Facial Service	91	Paediatric Thoracic Surgery
38	Ortho–Spine	92	Paediatric Transplant Surgery
43	Plastic Surgery	93	Paediatric Traumatology
45	Pulmonary	94	Paediatric Urology
46	Radiology	95	Obstetrics Delivered
48	Respiratory Therapist	96	Obstetrics Antepartum
52	Thoracic Surgery	97	Obstetrics Aborted
53	Trauma Resuscitation Nurse	98	Newborn
54	Triage Nurse	99	Paediatric Gynecology
55	Urology	100	Obstetric Postpartum
56	Vascular Surgery	101	Otolaryngology And Otorhinolaryngology
57	Psychology	102	Paediatric Otolaryngology
58	Chief Resident	103	Paediatric Ophthalmology
59	Dental	104	Psychiatry
60	Geriatrics	105	Paediatric Psychiatry
61	Hematology	106	Paediatric Hematology
62	Neuropsychology	107	Immunology

108	Paediatric Immunology	**117**	Neonatology
109	Physical Medicine And Rehab (Physiatry)	**118**	Alternate Level Of Care
110	Paediatric Physical Medicine And Rehab (Physiatry)	**119**	Blood Bank
111	Radiotherapy	**198**	Other Surgical
112	Genetics	**199**	Other Non–Surgical
113	Paediatric Dentistry	**?**	Unknown
114	Stillborn		
115	Cadaveric Donor		
116	Podiatry		

Appendix H: Comorbidity

Code	Description
2	Alcohol Use Disorder
4	Bleeding Disorder
5	Currently Receiving Chemotherapy for Cancer
6	Congenital Anomalies **maps to N/A in ITDX when Age > 18
7	Congestive Heart Failure
8	Current Smoker
9	Chronic Renal Failure
10	Cerebral Vascular Accident (CVA)
11	Diabetes Mellitus
12	Disseminated Cancer
13	Advanced Directive Limiting Care
15	Functionally Dependent Health Status
19	Hypertension
21	Prematurity (Retired 2020)
23	Chronic Obstructive Pulmonary Disease (COPD)
24	Steroid Use
25	Cirrhosis
26	Dementia
30	Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder
31	Anticoagulant Therapy
32	Angina Pectoris
33	Mental/ Personality Disorder
34	Myocardial Infarction (MI)
35	Peripheral Arterial Disease (PAD)
36	Substance Use Disorder
37	Prematurity **maps to N/A in ITDX, when Age > 18
38	Pregnancy
39	Bipolar I/II Disorder
40	Major Depressive Disorder
41	Other Mental/Personality Disorders
42	Post–Traumatic Stress Disorders
43	Schizoaffective Disorder
44	Schizophrenia
45	Autism Spectrum Disorder (ASD)
46	Bronchopulmonary Dysplasia/Chronic Lung Disease
47	Ventilator Dependence
/	Not Applicable
?	Unknown

Further Clarification:

Diagnosis of "Alcohol Use Disorder" must be documented in the patient's medical record. You can collect "Alcohol Abuse in your registry but cannot report it to NTDB. The "Alcohol Use Disorder" definitions are consistent with the DSM 5, 2013 definition. Exclude "Tobacco Use Disorder and Alcohol Use Disorder" as per 2019 NTDB not to use with Substance Abuse disorder. If a patient reported that they smoked cigarettes within the 12 months prior to their injury, then you should report "Current Smoker" to the NTDB. A patient who is a current smoker does not need "Substance Abuse Disorder" to be reported to NTDB. "Current

Smoker" doesn't necessarily have a "Substance Abuse Disorder." Tobacco Use disorder and Alcohol Use disorder stated in the chart must be reported to NTDB. As per NTDB 2019 do not report both. Substance Abuse disorder includes: Caffeine, Cannabis, hallucinogens, inhalants, Opioids, sedatives, hypnotics and stimulants. As per TQIP webinar (April 2018). Major Psychiatric illness: It is now "Mental Personality Disorder" in NTDB. This must be consistent with the definition from the American Psychiatric Association DSM5. Documentation disorder must be in the medical record. Example "depressive disorder", "bipolar disorder".

Clarification Pre–existing Conditions:

Advanced directive limiting care: The patient had a written request limiting life sustaining therapy, or similar advanced directive. 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**:
  2016 definition: Consistent with APA DSM 5 – diagnosis of alcohol use disorder documented in the patient medical record.
  2015 definition: Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in absence of history of abuse.

- **Angina Pectoris**: Always use the most recent definition provided by the AHA. Consistent with the American Heart Association (AHA), May 2015, chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the centre 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 or Chest Pain 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. Excludes patients who are on chronic Aspirin therapy. Some examples are:

ANTICOAGULANTS	ANTIPLATELET	THROMBIN	THROMBOLYTIC
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/Attention deficit hyperactivity disorder (ADD/ADHD)**: History of a disorder involving inattention, hyperactivity or impulsivity requiring medication for treatment.

- **Bleeding disorder**: Always use the most recent definition provided by the American Society of Hematology. Consistent with the American Society of Hematology, 2015, 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) (2015/2016 definition): Any condition that places the patient at risk for bleeding in which there is a problem with the body's blood clotting process (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar medications). Do not include patients on chronic aspirin therapy.

- **Cerebrovascular 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).

- **Chronic Obstructive Pulmonary Disease (COPD)**: Always use the most recent definition provided by the WHO. 2017 update: Consistent with the World Health Organization (WHO) 2015, . lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis. Terms can be used for 2015 and 2016 patient charts and result in any one or more of the following:

  o Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs].)
  o Hospitalization in the past for treatment of COPD.
  o Requires chronic bronchodilator therapy with oral or inhaled agents.

- A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing.
- A diagnosis of COPD must be documented in the chart (2017). Do not include patients whose only pulmonary disease is acute asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.

- **Chronic renal failure**: Acute or chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

- **Cirrhosis**: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

- **Congenital Anomalies**: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic congenital anomaly.

- **Congestive Heart Failure**: The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury. Common manifestations are:

  - 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

- **Currently receiving chemotherapy 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.

- **Current Smoker**: A patient who reports smoking cigarettes every day or some days. Excludes patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff.)

- **Dementia**: (2015 definition) with particular attention to senile or vascular dementia (e.g., Alzheimer's.) 2016 update: documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's).

- **Diabetes mellitus**: Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent.

- **Disseminated cancer**: Patients who have cancer that has spread to one or more sites in addition to the primary site. AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include: "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, and bone.)

- **Functionally Dependent health status**: Pre–injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, and as a result of cognitive or physical limitations relating to a pre–existing medical condition, was 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 medical therapy, present prior to injury. A diagnosis of Hypertension must be documented in the patient's medical record. (2015/2016 definition): History of a persistent elevation of systolic blood pressure >140mm Hg and a diastolic blood pressure >90mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, angiotensin–converting enzyme (ACE) inhibitors, calcium channel blockers.)

- **Mental/Personality Disorder**: Always use them most recent definition provided by the APA. Consistent with American Psychiatric Association (APA) DSM 5, 2013, documentation of the presence of preinjury

depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post–traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

- **Myocardial Infarction**: History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

- **Steroid Use**: Regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

- **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.

- **Prematurity**: Babies born before 37 weeks of pregnancy are completed.

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

Appendix I: NTDB Complications

This section is extracted from the 'National Trauma Data Standard Data Dictionary 2023 Admissions by the American College of Surgeons, released in July 2022.

Acute Kidney Injury (AKI)

DESCRIPTION

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

EXCLUDE:

- Patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

KDIGO Staging of AKI Table:

Stage	Serum Creatinine	Urine Output
3	3.0 times baseline OR	< 0.3 ml/kg/h for ≥ 24 hours OR
	Increase in serum creatinine to ≥ 4.0mg/dl (≥353.6μmol/l) OR	Anuria for ≥ 12 hours
	Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to < 35ml/min per 1.73 m2	

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of acute kidney injury (AKI) must be documented in the patient's medical record.
- If the patient or family refuses treatment (e.g., dialysis) the condition is still considered to be present if a combination of oliguria and creatinine are present.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

DATA SOURCE HIERARCHY

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

Acute Respiratory Distress Syndrome (ARDS)

DESCRIPTION

Timing	Within 1 week of known clinical insult or new or worsening respiratory symptoms
Chest imaging	Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules
Origin of edema	Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present

Oxygenation

Mild	200 mm Hg < PaO2/FIO2 < 300 mm Hg with PEEP or CPAP ≥ = 5 cm H2Oc
Moderate	100 mm Hg < PaO2/FIO2 < 200 mm Hg with PEEP >5 cm H2O
Severe	PaO2/FIO2 < 100 mm Hg with PEEP or CPAP ≥ 5 cm H2O

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.

DATA SOURCE HIERARCHY

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

Cardiac Arrest with CPR

DESCRIPTION

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

INCLUDE:

- Patients who, after arrival at your 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 on arrival to your hospital.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- Cardiac arrest must be documented in the patient's medical record.

DATA SOURCE HIERARCHY

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

Deep Surgical Site Infection

DESCRIPTION

Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2.

AND

Involves deep soft tissues of the incision (e.g., fascial and muscle layers).

AND

Patient has at least one of the following:
    a. Purulent drainage from the deep incision.
    b. A deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non–culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing [ASC/AST]) or culture or non–culture based microbiologic testing method is not performed.

AND

Organism(s) identified from the deep soft tissues of the incision by culture or non–culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST]) or culture or non–culture based microbiologic testing method is not performed. A culture or non–culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.

AND

Patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non–culture based test that has a negative finding does not meet this criterion.

c. An abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

* The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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	Caesarean 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

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.

- A diagnosis of SSI must be documented in the patient's medical record.

- Consistent with the CDC January 2019 defined SSI.

DATA SOURCE HIERARCHY

1. History and Physical

2. Physician Notes/Flow Sheet

3. Progress Notes

4. Case Management/Social Services Notes

5. Nursing Notes/Flow Sheet

6. Triage/Trauma Flow Sheet

7. Discharge Summary

Deep Vein Thrombosis

DESCRIPTION

The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of deep vein thrombosis (DVT) must be documented in the patient's medical record, which may be confirmed by 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.

DATA SOURCE HIERARCHY

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

Myocardial Infarction (MI)

DESCRIPTION

An acute myocardial infarction (MI) must be noted with documentation of ECG changes indicative of an acute MI.

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 an acute myocardial infarction that occurred subsequent to arrival at your Centre.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.

DATA SOURCE HIERARCHY

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

Organ/Space Surgical Site Infection

Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

Infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

Patient has at least one of the following:

a. Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T–tube drain, CT guided drainage).

b. Organisms are identified from fluid or tissue in the organ/space by a culture or non–culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).

c. An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection.

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

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	Caesarean 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

Table 3. Specific Sites of an Organ/Space SSI

Code	Site	Code	Site
BONE	Osteomyelitis	MED	Mediastinitis
BRST	Breast abscess or mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity infection (mouth, tongue, or gums)
DISC	Disc space infection	OREP	Deep pelvic tissue infection or other infection of the male or female reproductive tract
EAR	Ear, mastoid infection	PJI	Periprosthetic Joint Infection
EMET	Endometritis	SA	Spinal abscess/infection
ENDO	Endocarditis	SINU	Sinusitis
GIT	Gastrointestinal (GI) tract infection	UR	Upper respiratory tract, pharyngitis, laryngitis, epiglottitis
LAB	Intraabdominal infection, not specified elsewhere	USI	Urinary System Infection
IC	Intracranial infection	VASC	Arterial or venous infection
JNT	Joint or bursa infection	VCUF	Vaginal cuff infection
LUNG	Other infection of the lower respiratory tract		

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the CDC January 2019 defined SSI.

DATA SOURCE HIERARCHY

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

Pulmonary Embolism

DESCRIPTION

A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system.

EXCLUDE:

• Subsegmental PEs.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- Consider the condition present if the patient has a VQ 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.

DATA SOURCE HIERARCHY

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

Stroke/CVA

DESCRIPTION

A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot
obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing
and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which
is temporary caused by a temporary clot. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

AND

- Duration of neurological deficit ≥24 h

OR

- Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents
- a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were
- performed for stroke, or the neurological deficit results in death.

AND

- No other readily identifiable non–stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, are identified.

AND

- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission).

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

DATA SOURCE HIERARCHY

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

Unplanned Intubation

DESCRIPTION

Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

ADDITIONAL INFORMATION

- Must have occurred during the patient's initial stay at your hospital.
- For patients who were intubated in the field or emergency department, or those intubated for surgery, an unplanned intubation occurs if they require reintubation >24 hours after they were extubated.

DATA SOURCE HIERARCHY

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

Osteomyelitis

DESCRIPTION

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organism(s) identified from bone by culture or non–culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.

3. Patient has at least two of the following localized signs or symptoms:

   - Fever (>38.0°C)
   - Swelling*
   - Pain or tenderness*
   - Heat*
   - Drainage*

AND at least one of the following:

a. Organisms identified from blood by culture or non–culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST) AND Imaging test evidence suggestive of infection (for example, x–ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

b. Imaging test evidence suggestive of infection (for example, x–ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.], which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis).

*With no other recognized cause

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint Infection.

DATA SOURCE HIERARCHY

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

Unplanned Admission to the ICU

DESCRIPTION

Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned
return to the ICU after initial ICU discharge.

INCLUDE:

- Patients who required ICU care due to an event that occurred during surgery or in the PACU.

EXCLUDE:

- Patients with a planned post–operative ICU stay.

ADDITIONAL INFORMATION

- Must have occurred during the patient's initial stay at your hospital.

DATA SOURCE HIERARCHY

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

Severe Sepsis

DESCRIPTION

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.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

DATA SOURCE HIERARCHY

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

Catheter–Associated Blood Stream Infection (CAUTI)

DESCRIPTION

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.

January 2019 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, and 3 below:

1. Patient had 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 on the date of event,

   OR
   - Removed the day before the date of event

2. Patient has at least one of the following signs or symptoms:
   - Fever (>38ºC): 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 >10⁵ CFU/ml.

January 2019 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2 and 3 below:

1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   - fever (>38.0ºC)
   - hypothermia (<36.0ºC)
   - apnea
   - 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 a bacterium of ≥10⁵ CFU/ml.

ADDITIONAL INFORMATION
- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined CAUTI.

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

Central Line–Associated Blood Stream Infection (CLABSI)

DESCRIPTION

A laboratory–confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1.

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de–access" of a port does not result in the patient's removal from CLABSI surveillance.

January 2016 CDC Criterion LCBI 1:

> Patient has a recognized pathogen identified from one or more blood specimens by a culture or non–culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing [ASC/AST]).

> **AND**

> Organism(s) identified in blood is not related to an infection at another site.

> **OR**

January 2016 CDC Criterion LCBI 2:

> Patient has at least one of the following signs or symptoms: fever (>38ºC), chills, or hypotension.

> **AND**

Organism(s) identified from blood is not related to an infection at another site.

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase–negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or 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]). Criterion elements must occur within the Infection Window Period, the 7–day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38º C), hypothermia (<36ºC), apnea, or bradycardia

AND

Organism(s) identified from blood is not related to an infection at another site

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase–negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non–culture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing [ASC/AST]). Criterion elements must occur within the Infection Window Period, the 7–day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3

calendar days after.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of CLABSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.

DATA SOURCE HIERARCHY

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

Ventilator–Associated Pneumonia (VAP)

DESCRIPTION

A pneumonia where the patient is on mechanical ventilation for >2 calendar days on the date of event, with day of ventilator placement being Day 1.

AND

The ventilator was in place on the date of event or the day before.

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**Laboratory**
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:

• New and persistent **or** progressive and persistent
 	
• Infiltrate
 	
• Consolidation
 	
• Cavitation
 	
• Pneumatoceles, in infants ≤1–year–old
 	
NOTE: In patients **without** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.
	• Fever (>38ºC or >100.4ºF)
	
	• Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)
	
	• For adults ≥70 years old, altered mental status with no other recognized cause.
	
	AND at least one of the following:
	
	• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements.
	
	• New onset or worsening cough, or dyspnea, or tachypnea
	
	• Rales or bronchial breath sounds
	
	• Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)
		• Organism identified from blood
		
		• Organism identified from pleural fluid
		
		• Positive quantitative culture or corresponding semi–quantitative culture result from minimally–contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate)
		
		• ≥5% BAL–obtained cells contain intracellular bacteria on direct microscopic exam (for example, Gram's stain)
		
		• Positive quantitative culture or corresponding semi–quantitative culture result 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, Legionella, and other Bacterial Pneumonias):		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**Laboratory**
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation Pneumatoceles, in infants ≤1–year–old NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	• Fever (>38ºC or >100.4ºF) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least one of the following: • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• Virus, Bordetella, Legionella, Chlamydia or Mycoplasma identified from respiratory secretions or tissue by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example: not Active Surveillance Culture/ Testing (ASC/AST). • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia) • Fourfold rise in Legionella pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. • Detection of L.pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm (PNU3 Immunocompromised Patients):		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**Laboratory**
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:

• New and persistent **or** progressive and persistent
 	
• Infiltrate
 	
• Consolidation
 	
• Cavitation
 	
• Pneumatoceles, in infants ≤1–year–old
 	
NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.
	• Fever (>38ºC or >100.4ºF)
	
	• 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 (for example: O2 desaturations [for example: PaO2/FiO2<240], increased oxygen requirements, or increased ventilator demand)
	
	• Hemoptysis
	
	• Pleuritic chest pain
		• Identification of matching Candida spp. from blood and one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing.
		
		• 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
		OR
		
		Any of the following from:
		LABORATORY CRITERIA DEFINED UNDER PNU2

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infants ≤1 year old	
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS/LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following: • New and persistent or progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1–year–old NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	Worsening gas exchange (for example:2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) And at least **three** of the following: • Temperature instability • Leukopenia (≤4000 WBC/mm3) or leukocytosis (>15,000 WBC/mm3) and left shift (>10% band forms) • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP Algorithm ALTERNATE CRITERIA (PNU1), for children > 1 year old or ≤ 12 years old:	
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS/LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following: • New and persistent or progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1–year–old NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	ALTERNATE CRITERIA, for child >1 year old or ≤12 years old, at least **three** of the following: • Fever (>38. 0°C or >100. 4°F) or hypothermia (<36. 0°C or <96. 8°F) • Leukopenia (≤4000 WBC/mm3) or leukocytosis (≥15,000 WBC/mm3) • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined VAP.

DATA SOURCE HIERARCHY

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

Alcohol Withdrawal Syndrome

DESCRIPTION

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).

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

DATA SOURCE HIERARCHY

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

Pressure Ulcer

DESCRIPTION

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.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- Pressure ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

DATA SOURCE HIERARCHY

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

Superficial incisional Surgical Site Infection

Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date).

AND

Involves only skin and subcutaneous tissue of the incision

AND

Patient has at least one of the following:

    a. Purulent drainage from the superficial incision.

    b. Organisms identified from an aseptically–obtained specimen from the superficial incision or sub cutaneous tissue by a culture or non–culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing [ASC/AST]).

    c. Superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non–culture based testing is not performed.

        AND

        Patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non–culture based test that has a negative finding does not meet this criterion.

    d. Diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

*The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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).

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

DATA SOURCE HIERARCHY

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

Delirium

DESCRIPTION

Acute onset of behaviors 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.

ADDITIONAL INFORMATION

- Onset of symptoms began after arrival to your ED/hospital.

DATA SOURCE HIERARCHY

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

Unplanned Visit to the Operating Room

DESCRIPTION

Patients with an unplanned operative procedure OR patients returned to the operating room after initial operative management of a related previous procedure.

EXCLUDE:

- Non–urgent tracheostomy and percutaneous endoscopic gastrostomy.
- Pre–planned, staged and/or procedures for incidental findings.
- Operative management related to a procedure that was initially performed prior to arrival at your centre.

ADDITIONAL INFORMATION

- Must have occurred during the patient's initial stay at your hospital.

DATA SOURCE HIERARCHY

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

Appendix J: Non–Operative Procedures

These procedures and definitions are from 2014 OTR Data Dictionary (Appendix F).

Procedure	Definition
Oral Intubation	The insertion of an oral endotracheal tube
Nasal Intubation	The insertion of a nasal endotracheal tube
Tracheotomy	The creation of a surgical opening through the trachea with insertion of a tracheostomy tube
Cricothyrotomy	The creation of a surgical opening through the cricothyroid membrane with insertion of a tracheostomy tube
Ventilation	Ventilation is assisted by an external medical device
Chest tubes	Tubes inserted into the chest cavity between the ribs to allow the drainage of fluids or trapped air
IV therapy	The insertion of a peripheral IV catheter into a vein
Central line	The percutaneous insertion of an IV needle or catheter into the internal jugular or subclavian vein for the purposes of monitoring venous pressure, delivering large amounts of fluids or delivering TPN (Total Parenteral Nutrition) solutions
Arterial line	The percutaneous insertion of an IV needle or catheter into an artery for the purposes of monitoring arterial pressure and for arterial blood sampling when this is done frequently
Cutdown	The insertion of an intravenous catheter through a surgical incision into a peripheral vein
ED thoracotomy	An incision of the chest wall done in the emergency department
CPR	Cardio–pulmonary resuscitation is a combination of chest compressions and ventilation
ICP Catheter/Bolt Insertion	The insertion of a catheter or bolt through the skull to monitor intracranial pressure
Burr holes	Openings created in the skull in order to relieve pressure. They are usually done as an emergent procedure in the OR, but can also be done in the ER/Trauma room
Halo traction or tongs	Applications of devices to the skull to apply C–spine traction and stabilization
Traction/pins	Pins are surgically inserted to facilitate applying traction directly to the bone
PEG tubes	A Percutaneous Endoscopic Gastrostomy Tube is a flexible Silastic tube placed into the stomach/duodenum through a puncture wound in the abdominal wall, with the assistance of an endoscope to visualize the puncture site and to help anchor the tube in the stomach
Foley	A type of flexible catheter inserted into the urinary bladder via the urethra
Gastric tube	A soft flexible tube that is inserted through a nostril or the mouth into the stomach
Angiography	An X–ray examination of the vessels of the body following injection of a contrast medium
Diagnostic Peritoneal Lavage (DPL)	Insertion of a small diameter flexible Silastic tube through the abdominal wall and infusion of lavage fluid into the peritoneal space
CT scan	A computerized (x–ray) tomography examination
Other	
MRI	(Magnetic Resonance Imaging) A special imaging technique used to image internal structures of the body, particularly the soft tissues
FAST	(Focused Assessment with Sonography for Trauma) A rapid, bedside, ultrasound examination performed to identify intra–peritoneal hemorrhage or pericardial tamponade
Reduction	The correction of a fracture, dislocation or hernia
Ultrasound	A type of imaging technique, which uses high–frequency sound waves
Sutures	Materials used in closing a surgical or traumatic wound
Transfusion	The introduction of whole blood or blood component directly into the blood stream
Intraosseous lines	The insertion of a needle into the bone marrow, used when IV access is not feasible or successful

Appendix K: Historical Information

Below are data elements which may be present in 2014 OTR Comprehensive Data Set (CDS), which are excluded from the Gen 6 OTR data set. Several modifications have been applied to enhance the accuracy and relevance of the information, aligning with the latest standards and requirements. Data elements may be present in the system but retired; 'Not Applicable' can be reported for these. The elements will be removed following the next software enhancement.

Section	Data Label
Demographic – Record Info	Campus Number
Demographic – Record Info	Readmission
Demographic – Record Info	Province
Demographic – Record Info	Province Health # Version
Demographic – Patient	Weight
Demographic – Patient	LHIN
Demographic – Patient	Email
Demographic – Patient	Approximation of Injury
Injury – Injury Information	Place of Injury/E84.9*
Injury – Injury Information	Protective Devices– Other
Injury – Mechanism of Injury	Intentional Injury
Injury – Mechanism of Injury	Primary E–Code*
Injury – Mechanism of Injury	Secondary E–Code*
Injury – Mechanism of Injury	Tertiary E–Code*
Injury – Mechanism of Injury	Activity E–Code
Injury – Mechanism of Injury	Specify Activity Code
Injury – Mechanism of Injury	Position in Vehicle–LAP
Injury – Mechanism of Injury	Location of Secondary Vehicle Impact
Injury – Mechanism of Injury	Impact Type
Injury – Mechanism of Injury	Collision Detail 1
Injury – Mechanism of Injury	Collision Detail 2
Prehospital – Scene/Transport	Incident Outside Ontario
Prehospital – Scene/Transport	Incident Outside Ontario–Other
Prehospital – Scene/Transport	Accident Number
Prehospital – Scene/Transport	Police Force
Prehospital – Scene/Transport	Police Force Division
Prehospital – Scene/Transport	Vehicle Type
Prehospital – Scene/Transport	Vehicle Type– Other
Prehospital – Scene/Transport	Ejected from vehicle
Prehospital – Scene/Transport	Ejected from Vehicle–Distance Ejected (in Metres)
Prehospital – Scene/Transport	Total Prehospital time calculation
Referring Facility –Vitals/Medication	Non–Operative Procedure Picklist
Referring Facility –Vitals/Medication	Non–Operative Procedure Picklist–Other
Referring Facility –Vitals/Medication	IV Sites
Referring Facility –Vitals/Medication	Vent/ or CPAP days at Primary hospital
Referring Facility –Vitals/Medication	Number of OR visits @ Primary Hospital
Referring Facility –Vitals/Medication	Date of first OR @ Primary Hospital
Referring Facility –Vitals/Medication	Start time of first OR @ Primary Hospital
Referring Facility –Vitals/Medication	Finish time of first OR @ Primary Hospital
Referring Facility –Vitals/Medication	Total time of OR @ Primary Hospital
Referring Facility – Procedures/ICD11	CCI Attribute (Mode)
Referring Facility – Notes	Facility Level
Referring Facility – Notes	Facility ID
Patient Tracking	Arrival/Admission

Patient Tracking	Arrival/Admission
ED/Resus – Arrival/Admission	Non–Operative Procedure Picklist
ED/Resus – Arrival/Admission	Non–Operative Procedure Picklist– Other
ED/Resus – Arrival/Admission	CT Scan Locations
ED/Resus – Arrival/Admission	Total IV Sites
ED/Resus – Arrival/Admission	Number of ICP Days
ED/Resus – Arrival/Admission	Post OR Disposition– if Other
Procedures – Procedures	CCI Attributes– Mode
Procedures – Procedures	Total Number of OR visits
Procedures – Procedures	Total Elapsed Procedure time
Diagnoses – Injury Coding	Maximum AIS
Diagnoses – Comorbidities	Comorbidity ICD10
Outcome – Initial Discharge	Did the patient receive home care?
Outcome – Initial Discharge	Did the patient receive home care?– if other
Outcome – Initial Discharge	If Transferred, Facility Other
Outcome – Initial Discharge	If Transferred, Facility Other
Outcome – Initial Discharge	RANCHOS Score
Outcome – Initial Discharge	ALC Form
Outcome – Initial Discharge	Reason for ALC Days– if Other
Outcome – If Death	Location– Other
Outcome – If Death	Location– Special Care Unit
Outcome – If Death	Other free text
Outcome – Related Admissions	Total Readmissions
QA Tracking – QA Items	Readmission Complications

Appendix L: Optional Data Elements

Below is a list of optional data elements in the OTR Gen6 software. OTR contains additional data elements beyond those required for the OTR. Completion of these data elements is left to the discretion of the individual hospital. In the case of non–mandatory data elements, edit checks will be allowed for null values.

Section	Data Label
Demographic – Record Info	Section Complete
Demographic – Record Info	Record Created Date/Time
Demographic – Record Info	Record Created By
Demographic – Record Info	Record Complete
Demographic – Record Info	Record Completed By ('Abstractor' in Gen6)
Demographic – Record Info	Record Completed Date
Demographic – Record Info	Was IRR done? (Y,N)
Demographic – Record Info	Initial Location
Demographic – Record Info	Medical Record #
Demographic – Record Info	Account #
Demographic – Record Info	Patient Name – Last
Demographic – Record Info	Patient Name – First
Demographic – Record Info	Patient Name – MI
Demographic – Record Info	Patient Origin
Demographic – Record Info	Inclusion Source
Demographic – Record Info	Inclusion Information – NTDB
Demographic – Record Info	Inclusion Information– Province
Demographic – Patient	Name – Last
Demographic – Patient	Name – First
Demographic – Patient	Name – MI
Demographic – Patient	Alias – Last
Demographic – Patient	Alias – First
Demographic – Patient	Alias – MI
Demographic – Patient	Gender Identity
Demographic – Patient	Race (allows up to 6)
Demographic – Patient	Ethnicity
Demographic – Patient	Racial Identity
Demographic – Patient	Primary Language Spoken
Demographic – Patient	Patient Address – Street 1
Demographic – Patient	Patient Address – Street 2
Demographic – Patient	Telephone
Demographic – Relative/Guardian	Relationship to Patient
Demographic – Relative/Guardian	Guardian
Demographic – Relative/Guardian	Name – Last
Demographic – Relative/Guardian	Name – First
Demographic – Relative/Guardian	Name – MI
Demographic – Relative/Guardian	Address – Same as Patient
Demographic – Relative/Guardian	Address – ZIP Code
Demographic – Relative/Guardian	Address – Postal Code
Demographic – Relative/Guardian	Address – Street 1
Demographic – Relative/Guardian	Address – Street 2
Demographic – Relative/Guardian	Address – City
Demographic – Relative/Guardian	Address – State
Demographic – Relative/Guardian	Address – County (Change to Province/ Territory)
Demographic – Relative/Guardian	Address – Country
Demographic – Relative/Guardian	Telephone
Demographic – Notes	Notes

Injury – Injury Information	Section Complete
Injury – Injury Information	Specify
Injury – Injury Information	Injury Address – ZIP Code
Injury – Injury Information	Injury Address – Postal Code
Injury – Injury Information	Injury Address – Street 1
Injury – Injury Information	Injury Address – Street 2
Injury – Injury Information	Domestic Violence
Injury – Mechanism of Injury	Activity Code – ICD 10
Injury – Mechanism of Injury	Alcohol Involvement–ICD10
Injury – Mechanism of Injury	Injury Mechanism 1
Injury – Mechanism of Injury	Injury Mechanism 2
Injury – Mechanism of Injury	Police Report Number
Injury – Mechanism of Injury	Disaster Casualty
Injury – Mechanism of Injury	Casualty Event
Injury – Notes	Notes
Prehospital – Scene/Transport	Section Complete
Prehospital – Scene/Transport	Fluid Amount
Prehospital – Scene/Transport	Inclusion Source
Prehospital – Scene/Transport	Trauma Alert Called in by EMS Date
Prehospital – Scene/Transport	Trauma Alert Called in by EMS Time
Prehospital – Scene/Transport	Prehospital Provider – Mode if Other
Prehospital – Scene/Transport	Prehospital Provider – Transport Role
Prehospital – Scene/Transport	Prehospital Provider – Scene EMS Report
Prehospital – Scene/Transport	Prehospital Provider – PCR #
Prehospital – Scene/Transport	Prehospital Provider – Dispatch #
Prehospital – Scene/Transport	Prehospital Provider – Call En Route Date
Prehospital – Scene/Transport	Prehospital Provider – Call En Route Time
Prehospital – Scene/Transport	Prehospital Provider – Rendezvous Pickup Location
Prehospital – Scene/Transport	Prehospital Provider – Arrived at Destination Date
Prehospital – Scene/Transport	Prehospital Provider – Arrived at Destination Time
Prehospital – Scene/Transport	Prehospital Provider – Transport Time Elapsed
Prehospital – Scene/Transport	Prehospital Provider – Notes
Prehospital – Treatment	Prehospital Vitals – Recorded Date
Prehospital – Treatment	Prehospital Vitals – Recorded Time
Prehospital – Treatment	Prehospital Vitals – Agency
Prehospital – Treatment	Prehospital Vitals – Unit
Prehospital – Treatment	Prehospital Vitals – Sedated?
Prehospital – Treatment	Prehospital Vitals – Eye Obstruction?
Prehospital – Treatment	Prehospital Vitals – Intubation Method (If Yes, Method)
Prehospital – Treatment	Prehospital Vitals – Respiration Assisted?
Prehospital – Treatment	Prehospital Vitals – Respiration Type (If Yes, Type)
Prehospital – Treatment	Prehospital Vitals – Assisted Resp Rate
Prehospital – Treatment	Prehospital Vitals – Supplemental O2
Prehospital – Treatment	Prehospital Vitals – Triage RTS
Prehospital – Treatment	Prehospital Vitals – PTS – Weight
Prehospital – Treatment	Prehospital Vitals – PTS – Airway
Prehospital – Treatment	Prehospital Vitals – PTS – Skeletal
Prehospital – Treatment	Prehospital Vitals – PTS – Cutaneous
Prehospital – Treatment	Prehospital Vitals – PTS – CNS
Prehospital – Treatment	Prehospital Vitals – PTS – Pulse Palp
Prehospital – Treatment	Prehospital Procedures – Agency
Prehospital – Treatment	Prehospital Procedures – Unit
Prehospital – Treatment	Prehospital Medications – Agency
Prehospital – Treatment	Prehospital Medications – Unit
Prehospital – Treatment	Prehospital Medications – Medication
Prehospital – Treatment	Prehospital Medications – Date
Prehospital – Treatment	Prehospital Medications – Time
Prehospital – Notes	Notes

Referring Facility – Referral History – Immediate Referring Facility	Section Complete
Referring Facility – Referral History – Immediate Referring Facility	If Other
Referring Facility – Referral History – Immediate Referring Facility	Length of Stay
Referring Facility – Referral History – Immediate Referring Facility	Referring Physician
Referring Facility – Referral History – Immediate Referring Facility	Late Referral
Referring Facility – Referral History – Immediate Referring Facility	Facility Level
Referring Facility – Referral History – Immediate Referring Facility	Transfer Rationale
Referring Facility – Referral History – Immediate Referring Facility	Transfer Rationale By
Referring Facility – Referral History – Additional Referring Facilities	If Other
Referring Facility – Referral History – Additional Referring Facilities	Arrival Date
Referring Facility – Referral History – Additional Referring Facilities	Arrival Time
Referring Facility – Referral History – Additional Referring Facilities	Departure Date
Referring Facility – Referral History – Additional Referring Facilities	Departure Time
Referring Facility – Referral History – Additional Referring Facilities	Length of Stay
Referring Facility – Referral History – Additional Referring Facilities	Referring Physician
Referring Facility – Referral History – Additional Referring Facilities	Late Referral
Referring Facility – Referral History – Additional Referring Facilities	Facility Level
Referring Facility – Referral History – Additional Referring Facilities	Transfer Rationale
Referring Facility – Referral History – Additional Referring Facilities	Transfer Rationale By
Referring Facility – Assessments	Immediate Referring Facility – Recorded Date
Referring Facility – Assessments	Immediate Referring Facility – Recorded Time
Referring Facility – Assessments	Immediate Referring Facility– Temperature Unit
Referring Facility – Assessments	Immediate Referring Facility – Temperature Route
Referring Facility – Assessments	Immediate Referring Facility – Converted Temperature Value
Referring Facility – Assessments	Immediate Referring Facility– Converted Temperature Unit
Referring Facility – Assessments	Immediate Referring Facility – Sedated?
Referring Facility – Assessments	Immediate Referring Facility – Eye Obstruction?
Referring Facility – Assessments	Immediate Referring Facility – Intubation Method (If Yes, Method)
Referring Facility – Assessments	Immediate Referring Facility – Respiration Assisted?
Referring Facility – Assessments	Immediate Referring Facility – Respiration Type (If Yes, Type)
Referring Facility – Assessments	Immediate Referring Facility – DBP
Referring Facility – Assessments	Immediate Referring Facility – Assisted Resp Rate
Referring Facility – Assessments	Immediate Referring Facility – O2 Saturation
Referring Facility – Assessments	Immediate Referring Facility – Supplemental O2
Referring Facility – Assessments	Immediate Referring Facility – Triage RTS
Referring Facility – Assessments	Immediate Referring Facility – GCS 40: Eye
Referring Facility – Assessments	Immediate Referring Facility – GCS 40: Verbal

Referring Facility – Assessments	Immediate Referring Facility – GCS 40: Motor
Referring Facility – Assessments	Immediate Referring Facility – Paediatric Trauma Score – Weight
Referring Facility – Assessments	Immediate Referring Facility – Paediatric Trauma Score – Airway
Referring Facility – Assessments	Immediate Referring Facility – Paediatric Trauma Score – Skeletal
Referring Facility – Assessments	Immediate Referring Facility – Paediatric Trauma Score – Cutaneous
Referring Facility – Assessments	Immediate Referring Facility – Paediatric Trauma Score – CNS
Referring Facility – Assessments	Immediate Referring Facility– Paediatric Trauma Score – Pulse Palp
Referring Facility – Assessments	Immediate Referring Facility – Alcohol Use Indicator
Referring Facility – Assessments	Immediate Referring Facility – Drug Use Indicator
Referring Facility – Assessments	Immediate Referring Facility – Drug Screen
Referring Facility – Assessments	Clinician Administered
Referring Facility – Assessments	If Other
Referring Facility –Vitals/Medication	Additional Vitals – Referring Facility
Referring Facility –Vitals/Medication	Additional Vitals – Assessment Type
Referring Facility –Vitals/Medication	Additional Vitals – Recorded Date
Referring Facility –Vitals/Medication	Additional Vitals – Recorded Time
Referring Facility –Vitals/Medication	Additional Vitals – Temperature Value
Referring Facility –Vitals/Medication	Additional Vitals – Temperature Unit
Referring Facility –Vitals/Medication	Additional Vitals – Temperature Route
Referring Facility –Vitals/Medication	Additional Vitals – Converted Temperature Value
Referring Facility –Vitals/Medication	Additional Vitals – Converted Temperature Unit
Referring Facility –Vitals/Medication	Additional Vitals – Paralytic Agents?
Referring Facility –Vitals/Medication	Additional Vitals – Sedated?
Referring Facility –Vitals/Medication	Additional Vitals – Eye Obstruction?
Referring Facility –Vitals/Medication	Additional Vitals – Intubated?
Referring Facility –Vitals/Medication	Additional Vitals – Intubation Method (If Yes, Method)
Referring Facility –Vitals/Medication	Additional Vitals – Respiration Assisted?
Referring Facility –Vitals/Medication	Additional Vitals – Respiration Type (If Yes, Type)
Referring Facility –Vitals/Medication	Additional Vitals – SBP
Referring Facility –Vitals/Medication	Additional Vitals – DBP
Referring Facility –Vitals/Medication	Additional Vitals – Pulse Rate
Referring Facility –Vitals/Medication	Additional Vitals – Unassisted Resp Rate
Referring Facility –Vitals/Medication	Additional Vitals – Assisted Resp Rate
Referring Facility –Vitals/Medication	Additional Vitals – O2 Saturation
Referring Facility –Vitals/Medication	Additional Vitals – Supplemental O2
Referring Facility –Vitals/Medication	Additional Vitals – GCS: Eye
Referring Facility –Vitals/Medication	Additional Vitals – GCS: Verbal
Referring Facility –Vitals/Medication	Additional Vitals – GCS: Motor
Referring Facility –Vitals/Medication	Additional Vitals – GCS: Total
Referring Facility –Vitals/Medication	Additional Vitals – RTS
Referring Facility –Vitals/Medication	Additional Vitals – Triage RTS
Referring Facility –Vitals/Medication	Additional Vitals – GCS 40: Eye
Referring Facility –Vitals/Medication	Additional Vitals – GCS 40: Verbal
Referring Facility –Vitals/Medication	Additional Vitals – GCS 40: Motor
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – Weight
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – Airway
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – Skeletal
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – Cutaneous
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – CNS
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – Pulse Palp
Referring Facility –Vitals/Medication	Additional Vitals – Paediatric Trauma Score – Total
Referring Facility –Vitals/Medication	Referring Facility Medications – Referring Facility

Referring Facility –Vitals/Medication	Referring Facility Medications – Medication
Referring Facility –Vitals/Medication	Referring Facility Medications – Date
Referring Facility –Vitals/Medication	Referring Facility Medications – Time
Referring Facility – Procedures/ICD10	Procedures – Referring Facility
Referring Facility – Procedures/ICD10	CCI Attributes – Status
Referring Facility – Procedures/ICD10	CCI Attributes – Location
Referring Facility – Procedures/ICD10	CCI Attributes – Extent
Referring Facility – Procedures/ICD10	Procedures – Start Date
Referring Facility – Procedures/ICD10	Procedures – Start Time
Referring Facility – Procedures/ICD10	Procedures – Diagnostic Result
Referring Facility – Inter–Facility Transport – Providers/Vitals	Referring Facility
Referring Facility – Inter–Facility Transport – Providers/Vitals	Mode if Other
Referring Facility – Inter–Facility Transport – Providers/Vitals	Transport Role
Referring Facility – Inter–Facility Transport – Providers/Vitals	Care Level
Referring Facility – Inter–Facility Transport – Providers/Vitals	PCR #
Referring Facility – Inter–Facility Transport – Providers/Vitals	UUID
Referring Facility – Inter–Facility Transport – Providers/Vitals	Dispatch #
Referring Facility – Inter–Facility Transport – Providers/Vitals	Call Received Date
Referring Facility – Inter–Facility Transport – Providers/Vitals	Call Received Time
Referring Facility – Inter–Facility Transport – Providers/Vitals	Call En Route Date
Referring Facility – Inter–Facility Transport – Providers/Vitals	Call En Route Time
Referring Facility – Inter–Facility Transport – Providers/Vitals	Meeting Location
Referring Facility – Inter–Facility Transport – Providers/Vitals	Arrived at Patient Date
Referring Facility – Inter–Facility Transport – Providers/Vitals	Arrived at Patient Time
Referring Facility – Inter–Facility Transport – Providers/Vitals	Arrived at Destination Date
Referring Facility – Inter–Facility Transport – Providers/Vitals	Arrived at Destination Time
Referring Facility – Inter–Facility Transport – Providers/Vitals	Transport Time Elapsed
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Referring Facility
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Agency
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Unit
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Recorded Date
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Recorded Time
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paralytic Agents?
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Sedated?

Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Eye Obstruction?
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Intubated?
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Intubation Method (If Yes, Method)
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Respiration Assisted?
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Respiration Type (If Yes, Type)
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – SBP
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – DBP
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Pulse Rate
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Unassisted Resp Rate
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Assisted Resp Rate
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – O2 Saturation
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Supplemental O2
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – GCS: Eye
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – GCS: Verbal
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – GCS: Motor
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – GCS: Total
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – RTS
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Triage RTS
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – Weight
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – Airway
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – Skeletal
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – Cutaneous
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – CNS
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – Pulse Palp
Referring Facility – Inter–Facility Transport – Providers/Vitals	Inter–Facility Vitals – Paediatric Trauma Score – Total
Referring Facility – Inter–Facility Transport – Procedures/Medications	Procedures – Referring Facility
Referring Facility – Inter–Facility Transport – Procedures/Medications	Procedures – Agency
Referring Facility – Inter–Facility Transport – Procedures/Medications	Procedures – Unit
Referring Facility – Inter–Facility Transport – Procedures/Medications	Procedures – Procedure

Referring Facility – Inter–Facility Transport – Procedures/Medications	Medications – Referring Facility
Referring Facility – Inter–Facility Transport – Procedures/Medications	Medications – Agency
Referring Facility – Inter–Facility Transport – Procedures/Medications	Medications – Unit
Referring Facility – Inter–Facility Transport – Procedures/Medications	Medications – Medication
Referring Facility – Notes	Notes
ED/Resus – Arrival/Admission	Section Complete
ED/Resus – Arrival/Admission	Time in ED
ED/Resus – Arrival/Admission	Mode of Arrival
ED/Resus – Arrival/Admission	Revised Response Level
ED/Resus – Arrival/Admission	Post Trauma Bay Disposition
ED/Resus – Arrival/Admission	Admitting Physician
ED/Resus – Arrival/Admission	Surgeon
ED/Resus – Arrival/Admission	Attending Physician
ED/Resus – Arrival/Admission	Trauma Alert Called in by EMS Date
ED/Resus – Arrival/Admission	Trauma Alert Called in by EMS Time
ED/Resus – Arrival/Admission	Response Activation Date
ED/Resus – Arrival/Admission	Response Activation Time
ED/Resus – Arrival/Admission	Response Activation Time Elapsed
ED/Resus – Arrival/Admission	TTL arrival
ED/Resus – Arrival/Admission	Revised Response Activation Time Elapsed
ED/Resus – Arrival/Admission	Has patient met Trauma Activation Criteria? (Y,N)
ED/Resus – Initial Assessment	Recorded Date
ED/Resus – Initial Assessment	Recorded Time
ED/Resus – Initial Assessment	Initial Vitals – Temperature Unit
ED/Resus – Initial Assessment	Initial Vitals – Temperature Route
ED/Resus – Initial Assessment	Initial Vitals – Converted Temperature Value
ED/Resus – Initial Assessment	Initial Vitals – Converted Temperature Unit
ED/Resus – Initial Assessment	Initial Vitals – Converted Weight
ED/Resus – Initial Assessment	Initial Vitals – Weight Converted Unit
ED/Resus – Initial Assessment	Initial Vitals – Weight – Timely
ED/Resus – Initial Assessment	Initial Vitals – Converted Height
ED/Resus – Initial Assessment	Initial Vitals – Converted Height Unit
ED/Resus – Initial Assessment	Initial Vitals – Height – Timely
ED/Resus – Initial Assessment	Initial Vitals – BMI
ED/Resus – Initial Assessment	Initial Vitals – Intubation Method (If Yes, Method)
ED/Resus – Initial Assessment	Initial Vitals – Respiration Type (If Yes, Type)
ED/Resus – Initial Assessment	Initial Vitals – DBP
ED/Resus – Initial Assessment	Initial Vitals – Triage RTS
ED/Resus – Initial Assessment	Initial Vitals – Paediatric Trauma Score – Weight
ED/Resus – Initial Assessment	Initial Vitals – Paediatric Trauma Score – Airway
ED/Resus – Initial Assessment	Initial Vitals – Paediatric Trauma Score – Skeletal
ED/Resus – Initial Assessment	Initial Vitals – Paediatric Trauma Score – Cutaneous
ED/Resus – Initial Assessment	Initial Vitals – Paediatric Trauma Score – CNS
ED/Resus – Initial Assessment	Initial Vitals – Paediatric Trauma Score – Pulse Palp
ED/Resus – Vitals	Recorded Date
ED/Resus – Vitals	Recorded Time
ED/Resus – Vitals	Assessment Type
ED/Resus – Vitals	Massive Hemorrhage Protocol
ED/Resus – Vitals	Massive Hemorrhage Protocol Date/ time
ED/Resus – Vitals	Frailty Score
ED/Resus – Vitals	Additional Vitals – Temperature Value
ED/Resus – Vitals	Additional Vitals – Temperature Unit
ED/Resus – Vitals	Additional Vitals – Temperature Route
ED/Resus – Vitals	Additional Vitals – Converted Temperature Value

ED/Resus – Vitals	Additional Vitals – Converted Temperature Unit
ED/Resus – Vitals	Additional Vitals – Paralytic Agents?
ED/Resus – Vitals	Additional Vitals – Sedated?
ED/Resus – Vitals	Additional Vitals – Eye Obstruction?
ED/Resus – Vitals	Additional Vitals – Intubated?
ED/Resus – Vitals	Additional Vitals – Intubation Method (If Yes, Method)
ED/Resus – Vitals	Additional Vitals – Respiration Assisted?
ED/Resus – Vitals	Additional Vitals – Respiration Type (If Yes, Type)
ED/Resus – Vitals	Additional Vitals – SBP
ED/Resus – Vitals	Additional Vitals – DBP
ED/Resus – Vitals	Additional Vitals – Pulse Rate
ED/Resus – Vitals	Additional Vitals – Unassisted Resp Rate
ED/Resus – Vitals	Additional Vitals – Assisted Resp Rate
ED/Resus – Vitals	Additional Vitals – O2 Saturation
ED/Resus – Vitals	Additional Vitals – Supplemental O2
ED/Resus – Vitals	Additional Vitals – GCS: Eye
ED/Resus – Vitals	Additional Vitals – GCS: Verbal
ED/Resus – Vitals	Additional Vitals – GCS: Motor
ED/Resus – Vitals	Additional Vitals – GCS: Total
ED/Resus – Vitals	Additional Vitals – RTS
ED/Resus – Vitals	Additional Vitals – Triage RTS
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – Weight
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – Airway
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – Skeletal
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – Cutaneous
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – CNS
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – Pulse Palp
ED/Resus – Vitals	Additional Vitals – Paediatric Trauma Score – Total
ED/Resus – Vitals	Medications
ED/Resus – Vitals	Medication Date
ED/Resus – Vitals	Medication Time
ED/Resus – Vitals	Warming Measures
ED/Resus – Labs/Toxicology	ABGs Drawn
ED/Resus – Labs/Toxicology	pH
ED/Resus – Labs/Toxicology	PaO2
ED/Resus – Labs/Toxicology	PaCO2
ED/Resus – Labs/Toxicology	Hematocrit
ED/Resus – Labs/Toxicology	INR
ED/Resus – Labs/Toxicology	Base Deficit/Excess
ED/Resus – Labs/Toxicology	Hemoglobin
ED/Resus – Labs/Toxicology	Platelets
ED/Resus – Labs/Toxicology	Lactate
ED/Resus – Labs/Toxicology	ROTEM EXTEM A10
ED/Resus – Labs/Toxicology	ROTEM EXTEM MCF
ED/Resus – Labs/Toxicology	ROTEM EXTEM ML
ED/Resus – Labs/Toxicology	ROTEM FIBTEM A10
ED/Resus – Labs/Toxicology	ROTEM FIBTEM MCF
ED/Resus – Labs/Toxicology	Drug Use Indicators
ED/Resus – Labs/Toxicology	Clinician Administered
ED/Resus – Labs/Toxicology	If Other
ED/Resus – Notes	Notes
Patient Tracking – Location/Service	Section Complete
Patient Tracking – Location/Service	Arrival Time
Patient Tracking – Location/Service	Departure Time
Patient Tracking – Location/Service	Elapsed Time
Patient Tracking – Location/Service	Detail
Patient Tracking – Location/Service	Stepdown/IMC Days
Patient Tracking – Location/Service	Start Time

Patient Tracking – Location/Service	Stop Time
Patient Tracking – Location/Service	Detail
Patient Tracking – Ventilator/Blood	Section Complete
Patient Tracking – Ventilator/Blood	Ventilator Tracking – Start Date
Patient Tracking – Ventilator/Blood	Ventilator Tracking – Start Time
Patient Tracking – Ventilator/Blood	Ventilator Tracking – Stop Date
Patient Tracking – Ventilator/Blood	Ventilator Tracking – Stop Time
Patient Tracking – Ventilator/Blood	Ventilator Tracking – Elapsed Time
Patient Tracking – Ventilator/Blood	Blood Product
Patient Tracking – Ventilator/Blood	Volume
Patient Tracking – Ventilator/Blood	Units
Patient Tracking – Ventilator/Blood	Location
Patient Tracking – Ventilator/Blood	Time Period
Patient Tracking – Notes	Notes
Providers – Resus Team	Section Complete
Providers – Resus Team	Called Date
Providers – Resus Team	Called Time
Providers – Resus Team	Responded Date
Providers – Resus Team	Responded Time
Providers – Resus Team	Timeliness
Providers – Resus Team	Elapsed Time
Providers – Resus Team	Notes
Providers – Resus Team	Emergency Medicine Provider
Providers – Resus Team	Called Date
Providers – Resus Team	Called Time
Providers – Resus Team	Responded Date
Providers – Resus Team	Responded Time
Providers – Resus Team	Arrived Date
Providers – Resus Team	Arrived Time
Providers – Resus Team	Timeliness
Providers – Resus Team	Elapsed Time
Providers – Resus Team	Notes
Providers – Resus Team	Anesthesiology Provider
Providers – Resus Team	Called Date
Providers – Resus Team	Called Time
Providers – Resus Team	Responded Date
Providers – Resus Team	Responded Time
Providers – Resus Team	Arrived Date
Providers – Resus Team	Arrived Time
Providers – Resus Team	Timeliness
Providers – Resus Team	Elapsed Time
Providers – Resus Team	Notes
Providers – Resus Team	Neurosurgery Provider
Providers – Resus Team	Called Date
Providers – Resus Team	Called Time
Providers – Resus Team	Responded Date
Providers – Resus Team	Responded Time
Providers – Resus Team	Arrived Date
Providers – Resus Team	Arrived Time
Providers – Resus Team	Timeliness
Providers – Resus Team	Elapsed Time
Providers – Resus Team	Notes
Providers – Resus Team	Orthopedics Provider
Providers – Resus Team	Called Date
Providers – Resus Team	Called Time
Providers – Resus Team	Responded Date
Providers – Resus Team	Responded Time
Providers – Resus Team	Arrived Date

Providers – Resus Team	Arrived Time
Providers – Resus Team	Timeliness
Providers – Resus Team	Elapsed Time
Providers – Resus Team	Notes
Providers – Resus Team	Provider Type
Providers – Resus Team	Provider
Providers – Resus Team	Called Date
Providers – Resus Team	Called Time
Providers – Resus Team	Responded Date
Providers – Resus Team	Responded Time
Providers – Resus Team	Arrived Date
Providers – Resus Team	Arrived Time
Providers – Resus Team	Timeliness
Providers – Resus Team	Elapsed Time
Providers – Resus Team	Notes
Providers – In–house Consults	Provider Type
Providers – In–house Consults	Provider
Providers – In–house Consults	Called Date
Providers – In–house Consults	Arrived Date
Providers – In–house Consults	Timeliness
Providers – In–house Consults	Notes
Providers – Notes	Notes
Procedures – Procedures	Section Complete
Procedures – Procedures	Reason for embolization
Procedures – Procedures	Operation #
Procedures – Procedures	Stop Date
Procedures – Procedures	Diagnostic Result
Procedures – Procedures	Service
Procedures – Procedures	Physician
Procedures – Procedures	Narrative
Procedures – Notes	Notes
Diagnoses – Injury Coding	Section Complete
Diagnoses – Injury Coding	NISS
Diagnoses – Injury Coding	Preliminary ISS
Diagnoses – Injury Coding	Tri–Code ICD 10
Diagnoses – Injury Coding	ICD9 Code
Diagnoses – Non Trauma Diagnosis/ICD10	ICD10 Code
Diagnoses – Comorbidities	Comorbidity – Note
Diagnoses – Notes	Notes
Outcome – Initial Discharge	Section Complete
Outcome – Initial Discharge	Discharge Condition
Outcome – Initial Discharge	Patient Directive Applied
Outcome – Initial Discharge	Discharging Physician
Outcome – Initial Discharge	Specify
Outcome – Initial Discharge	If Other
Outcome – Initial Discharge	Transfer Rationale
Outcome – Initial Discharge	Transfer Rationale By
Outcome – Initial Discharge	Impediments to Discharge 1
Outcome – Initial Discharge	Impediments to Discharge 2
Outcome – Initial Discharge	Impediments to Discharge 3
Outcome – Initial Discharge	Impediments to Discharge 4
Outcome – Initial Discharge	Ready for ALC
Outcome – Initial Discharge	ALC Days
Outcome – Initial Discharge	CritiCall Called
Outcome – Initial Discharge	CritiCall ID Referral #
Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Feeding Score
Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Feeding Status
Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Locomotion Score

Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Locomotion Status
Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Expression Score
Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Expression Status
Outcome – Initial Discharge – Disabilities	Disabilities – Pre–Existing – Total Score
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Feeding Score
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Feeding Status
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Locomotion Score
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Locomotion Status
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Expression Score
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Expression Status
Outcome – Initial Discharge – Disabilities	Disabilities – Discharge – Total Score
Outcome – Initial Discharge	Rehabilitation Potential
Outcome – If Death	Section Complete
Outcome – If Death	Manner (Suspected)
Outcome – If Death	Cause
Outcome – If Death	Withdrawal of Care
Outcome – If Death	Was autopsy performed?
Outcome – If Death	Medical Examiner #
Outcome – If Death	Autopsy #
Outcome – If Death	Autopsy Memo
Outcome – If Death	Organs Procured
Outcome – If Death	If Other, Specify
Outcome – If Death	If None, Reason
Outcome – If Death	Donor Status
Outcome – If Death	Date Organs Procured
Outcome – If Death	Time Organs Procured
Outcome – Billing	Section Complete
Outcome – Related Admissions – Related Admissions Info	Section Complete
Outcome – Related Admissions – Related Admissions Info	Admission Date
Outcome – Related Admissions – Related Admissions Info	Admitting Service
Outcome – Related Admissions – Related Admissions Info	Type of Admission
Outcome – Related Admissions – Related Admissions Info	If Unplanned, Reason
Outcome – Related Admissions – Related Admissions Info	Account #
Outcome – Related Admissions – Related Admissions Info	Total Charges
Outcome – Related Admissions – Related Admissions Info	Discharge Date
Outcome – Related Admissions – Related Admissions Info	Discharged To
Outcome – Related Admissions – Related Admissions Info	Memo
Outcome – Related Admissions – Related Admissions Info	Final Discharge Status
Outcome – Related Admissions – Related Admissions Info	Total Readmission Days
Outcome – Related Admissions – Related Admissions Info	Final Discharge Date
Outcome – Notes	Notes
QA Tracking – QA Items	Section Complete
QA Tracking – QA Items	ACS Questions
QA Tracking – QA Items	Filters
QA Tracking – QA Items	Category

QA Tracking – QA Items	QA Item
QA Tracking – QA Items	Response
QA Tracking – QA Items	Occurrence Date
QA Tracking – QA Items	QA Tracking
QA Tracking – QA Tracking	Section Complete
QA Tracking – QA Tracking	QA Item
QA Tracking – QA Tracking	Location
QA Tracking – QA Tracking	Service
QA Tracking – QA Tracking	Date Opened
QA Tracking – QA Tracking	Loop Closed
QA Tracking – QA Tracking	Notes
QA Tracking – QA Tracking	Provider
QA Tracking – QA Tracking	Reviewed By
QA Tracking – QA Tracking	Date
QA Tracking – QA Tracking	Comment
QA Tracking – QA Tracking	Contributing Factors
QA Tracking – QA Tracking	Determination – System Related
QA Tracking – QA Tracking	Determination – Disease Related
QA Tracking – QA Tracking	Determination – Provider Related
QA Tracking – QA Tracking	OFI Status
QA Tracking – QA Tracking	Grade
QA Tracking – QA Tracking	Care Given Status
QA Tracking – QA Tracking	Corrective Action 1
QA Tracking – QA Tracking	Status 1
QA Tracking – QA Tracking	Corrective Action 2
QA Tracking – QA Tracking	Status 2
QA Tracking – QA Tracking	Corrective Action 3
QA Tracking – QA Tracking	Status 3
QA Tracking – QA Tracking	Corrective Action 4
QA Tracking – QA Tracking	Status 4
QA Tracking – QA Tracking	Corrective Action 5 (Up to 10)
QA Tracking – QA Tracking	Status 5
QA Tracking – Notes	Section Complete
QA Tracking – Notes	Notes
Memo – Note 1	Note 1
Memo – Note 2	Note 2
Memo – Note 3	Note 3
TDP/Process Measure 1	Exclude from TQIP Submission
TDP/Process Measure 1	Meets Head Injury Tracking Criteria (Yes, No, Unknown)
TDP/Process Measure 2	Meets Blood Product Collection Criteria
TDP/Process Measure 2	Meets Open Fracture Collection Criteria (Yes, No, Not Known)

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