PATIENT TRACKING

LOCATION/SERVICE

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICU Days	**NTDB Element Number** N/A
Local V5 Field Name ICU Days	**NTDB Data Dictionary Page Number** 134-135

Element Value

- Minimum constraint: 1; Maximum constraint: 999
- Relevant value for data element
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

References

- For examples, see page 134 of the NTDB 2023 Data Dictionary.

VENTILATOR/BLOOD

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Total Ventilator Days	**NTDB Element Number** N/A
Local V5 Field Name Total Ventilator Days	**NTDB Data Dictionary Page Number** 136-137

Element Value

- Minimum constraint: 1; Maximum constraint: 999
- Relevant value for data element
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

References

- For examples, see page 136 of the NTDB 2023 Data Dictionary

PROVIDERS

RESUSCITATION TEAM

SURGEON CALLED DATE

Description

The date that the surgeon was called.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Called (Date)	**NTDB Element Number** N/A
Local V5 Field Name Called (Date)	**NTDB Data Dictionary Page Number** N/A

Element Value

- Minimum: 1990; Maximum: 2099
- Relevant value for data element.
- Common null values

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

SURGEON CALLED TIME

Description

The date that the surgeon was called.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Called (Time)	**NTDB Element Number** N/A
Local V5 Field Name Called (Time)	**NTDB Data Dictionary Page Number** N/A

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time.
- Common null values

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. ED Records

SURGEON ARRIVED DATE

Description

The date the first trauma surgeon arrived at the patient's bedside.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Arrived (Date)	**NTDB Element Number** N/A
Local V5 Field Name Arrived (Date)	**NTDB Data Dictionary Page Number** 35

Element Value

- Minimum: 1990; Maximum: 2099
- Relevant value for data element.
- Common null values

Additional Information

- Collected as MM-DD-YYYY.
- Limit reporting to the 24 hours after ED/hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of 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 within 24 hours of ED/hospital arrival.
- The null value "Not Applicable" is reported if *Element Value* "2. No" is reported for Highest Activation.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. History and Physical
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet

SURGEON ARRIVED TIME

Description

The time the first trauma surgeon arrived at the patient's bedside.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Arrived (Time)	**NTDB Element Number** N/A
Local V5 Field Name Arrived (Time)	**NTDB Data Dictionary Page Number** 36

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HHMM military time.
- Limit reporting to the 24 hours after ED/hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of 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 within 24 hours of ED/hospital arrival.
- The null value "Not Applicable" is reported if *Element Value* "2. No" is reported for Highest Activation.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. History and Physical
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet

IN-HOUSE CONSULTS

CONSULTS

Description

Record of other specialties consulted during the emergency room visit.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Type	**NTDB Element Number** N/A
Local V5 Field Name Type	**NTDB Data Dictionary Page Number** N/A

Element Value

- 1 - Trauma
- 2 - Neurosurgery
- 3 - Orthopedics
- 4 - General Surgery
- 5 - Pediatric Surgery
- 6 - Cardiothoracic Surgery
- 7 - Burn Services
- 8 - Emergency Medicine
- 9 - Pediatrics
- 10 - Anesthesiology
- 11 - Cardiology
- 12 - Chaplain
- 13 - Child Protective Team
- 14 - Critical Care
- 15 - Discharge Planner
- 16 - Documentation Recorder
- 17 - Drug/Alcohol Counselor
- 19 - ENT
- 20 - Family Medicine
- 21 - GI
- 22 - Home Health
- 23 - Hospitalist
- 24 - Infectious Disease
- 25 - Internal Medicine
- 26 - Laboratory
- 27 - Nephrology
- 28 - Neurology
- 29 - Nurse Practitioner
- 30 - Nursing
- 31 - Nutrition
- 32 - OB-GYN
- 33 - Occupational Therapy
- 34 - Oncology
- 35 - Ophthalmology
- 36 - Oral Surgery
- 37 - Orthomaxillo Facial Service
- 38 - Ortho-Spine
- 39 - Palliative Care
- 40 - Pharmacy
- 41 - Physiatry
- 42 - Physical Therapy
- 43 - Plastic Surgery
- 44 - Psychiatry
- 45 - Pulmonary
- 46 - Radiology
- 47 - Rehab
- 48 - Respiratory Therapist
- 49 - Social Services
- 50 - Social Worker
- 51 - Speech Therapy
- 52 - Thoracic Surgery
- 53 - Trauma Resuscitation Nurse
- 54 - Triage Nurse
- 55 - Urology
- 56 - Vascular Surgery
- 58 - Intensivist
- 98 - Other Surgical
- 99 - Other Non-Surgical
- Common null values

Additional Information

- Consults during an inpatient stay are not required.
- Multiple entries are allowed.

Data Source Hierarchy Guide

1. Nurses' Notes
2. Social Services Notes

PROCEDURES

ICD-10 HOSPITAL PROCEDURES

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. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICD-10 Procedure Code	**NTDB Element Number** N/A
Local V5 Field Name ICD-10 Procedure Code	**NTDB Data Dictionary Page Number** 63-64

Element Value

- Major and minor procedure ICD 10-PCS or ICD-10 CA procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.
- Common null values

Additional Information

- Report only procedures performed at your institution.
- Report all procedures performed in the operating room.
- Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Note that the hospital may report additional procedures.
- The null value "Not Applicable" is reported if the patient did not have procedures.

Diagnostic and Therapeutic Imaging:
Computerized tomographic Head*
Computerized tomographic Chest*
Computerized tomographic Abdomen*
Computerized tomographic Pelvis*
Computerized tomographic C-Spine*
Computerized tomographic T-Spine*
Computerized tomographic L-Spine*
Doppler ultrasound of extremities*
Diagnostic ultrasound (includes FAST) *
Angioembolization
Angiography
IVC Filter
REBOA
Diagnostic imaging interventions on the total body
Plain radiography of whole body
Plain radiography of whole skeleton
Plain radiography of infant whole body

Genitourinary:
Ureteric catheterization (i.e., Ureteric stent)
Suprapubic cystostomy

Transfusion:
The following blood products should be captured over first 24 hours after hospital arrival:

- Transfusion of red cells *
- Transfusion of platelets *
- Transfusion of plasma *

In addition to coding the individual blood products listed above assign the appropriate procedure code on patients that receive > 10 units of blood products over first 24 hours following hospital arrival
For pediatric patients (age 14 and under), assign the appropriate procedure code on patients that receive 40cc/kg of blood products over first 24 hours following hospital arrival

Cardiovascular:
Open cardiac massage
CPR

Respiratory:
Insertion of endotracheal tube* (exclude intubations performed in the OR)
Continuous mechanical ventilation*
Chest tube*
Bronchoscopy*
Tracheostomy

CNS
Insertion of ICP monitor*
Ventriculostomy*
Cerebral oxygen monitoring*

Gastrointestinal
Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Gastrostomy/Jejunostomy (percutaneous or endoscopic)
Percutaneous (endoscopic) gastrojejunoscopy

Musculoskeletal:
Soft tissue/bony debridements*
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

HOSPITAL PROCEDURE START DATE

Description

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Start (Date)	**NTDB Element Number** N/A
Local V5 Field Name Start (Date)	**NTDB Data Dictionary Page Number** 65

Element Value

- Minimum: 1990; Maximum: 2099
- Relevant value for data element.
- Common null values

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

HOSPITAL PROCEDURE START TIME

Description

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Start (Time)	**NTDB Element Number** N/A
Local V5 Field Name Start (Time)	**NTDB Data Dictionary Page Number** 66

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HHMM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Data Source Hierarchy Guide

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. Discharge Summary

DIAGNOSIS

INJURY CODING

AIS VERSION

Description

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name AIS Version	**NTDB Element Number** N/A
Local V5 Field Name AIS Version	**NTDB Data Dictionary Page Number** 99

Element Value

- AIS 2015

Additional Information

Data Source Hierarchy Guide

1. AIS Coding Manual

ISS

Description

The Injury Severity Score (ISS) that reflects the patient's injuries.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ISS	**NTDB Element Number** N/A
Local V5 Field Name ISS	**NTDB Data Dictionary Page Number** N/A

Element Value

- Minimum constraint: 1; Maximum constraint: 75
- Relevant ISS value for the constellation of injuries
- Common null values

Additional Information

- Field is auto calculated based on AIS Severity and ISS Body Region.

Data Source Hierarchy Guide

ICD-10 INJURY DIAGNOSES

Description

Diagnoses related to all identified injuries.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name ICD-10 Code	**NTDB Element Number** N/A
Local V5 Field Name ICD-10	**NTDB Data Dictionary Page Number** 97

Element Value

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 OR compatible ICD-10-CA code range.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in the element.

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician's Notes/Flow Sheet
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

AIS CODE

Description

The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name AIS Code	**NTDB Element Number** N/A
Local V5 Field Name AIS Code	**NTDB Data Dictionary Page Number** 98

Element Value

- The code is the 8-digit AIS code.

Additional Information

Data Source Hierarchy Guide

1. AIS Coding Manual

AIS SEVERITY

Description

The Abbreviated Injury Scale (AIS) severity codes that reflect that patient's injuries.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Severity	**NTDB Element Number** N/A
Local V5 Field Name Severity	**NTDB Data Dictionary Page Number** N/A

Element Value

- 1 – Minor Injury
- 2 – Moderate Injury
- 3 – Serious Injury
- 4 – Severe Injury
- 5 - Critical Injury
- 6 – Maximum Injury, Virtually Un-survivable
- 9 – Not Possible to Assign
- 0 – Combined with Other Injury

Additional Information

- The Element Value "9. Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury.

Data Source Hierarchy Guide

1. AIS Coding Manual

ISS BODY REGION

Description

The Injury Severity Score (ISS) body region codes that reflect the patient's injuries.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name ISS Body Region	**NTDB Element Number** N/A
Local V5 Field Name ISS Body Region	**NTDB Data Dictionary Page Number** N/A

Element Value

- 1 - Head or neck
- 2 - Face
- 3 - Chest
- 4 - Abdominal or pelvic contents
- 5 - Extremities or pelvic girdle
- 6 - External
- 9 - Not determined
- Common null values

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.
- Head or neck injuries include injury to the brain or cervical spine, skull, or cervical spine fractures.
- Facial injuries include those involving mouth, ears, nose, and facial bones.
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine.
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region.
- Injuries to the extremities or to the pelvic or shoulder girdle include sprains, fractures, dislocations, and amputations, except for the spinal column, skull, and rib cage.
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface.

Data Source Hierarchy Guide

1. AIS Coding Manual

COMORBIDITIES

This information was formerly categorized as “Comorbid Conditions”. The new name for this category is “Pre-Existing Conditions” in the current NTDS Data Dictionary.

PRE-HOSPITAL CARDIAC ARREST

Description

Indication of whether the patient experienced cardia arrest prior to ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Pre-Hospital Cardiac Arrest	**NTDB Element Number** N/A
Local V5 Field Name Pre-Hospital Cardiac Arrest	**NTDB Data Dictionary Page Number** 33

Element Value

- Yes
- No
- Common null values

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 advance cardiac life support must have been initiated.

Data Source Hierarchy Guide

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

ADVANCE DIRECTIVE LIMITING CARE

Description

The patient had a written request to limit life-sustaining treatment that restricted the scope of care for the patient during this patient care event.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 67

Element Value

- Yes
- No

Additional Information

- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center.
- Report Element Value “2. No” for patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.
- 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). 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).
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

ALCOHOL USE DISORDER

Description

Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient's medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 68

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.

Data Source Hierarchy Guide

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

ANTICOAGULANT THERAPY

Description

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting. EXCLUDE patients whose only anticoagulant therapy is chronic aspirin.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 69

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Reteplase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenacteplase
Lovenox	Eptifibatide	Drotrecogin alpha	kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Anticoagulant must be part of the patient's active medication.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History and 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

ATTENTION DEFICITY DISORDER/ATTENTION DEFICITY HYPERACTIVITY DISORDER

Description

A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 70

Element Value

- Yes
- No

Additional Information

- Present prior to injury
- A diagnosis of ADD/ADHD must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

BIPOLAR I/II DISORDER

Description

A bipolar I/II disorder diagnosis documented in the medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 71

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

BLEEDING DISORDER

Description

A group of conditions that result when the blood cannot clot properly.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 72

Element Value

- Yes
- No

Additional Information

- 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).
- Consistent with American Society of Hematology, 2015.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CEREBRAL VASCULAR ACCIDENT (CVA)

Description

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).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 73

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of CVA must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Description

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used but are now included within the COPD diagnosis.

EXCLUDE:

- Patients whose only pulmonary disease is asthma.
- Patients with diffuse interstitial fibrosis or sarcoidosis.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 74

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- Only report on patients ≥15-years-of-age.
- Consistent with World Health Organization (WHO), 2019.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15-years-of-age.

Data Source Hierarchy Guide

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

CHRONIC RENAL FAILURE

Description

Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 75

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of Chronic Renal Failure must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CIRRHOSIS

Description

Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.

EXCLUDE:

• Patients who no longer have cirrhosis due to a successful liver transplant.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 76

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CONGENITAL ANOMALIES

Description

Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 77

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of a congenital anomaly must be documented in the patient's medical record.
- Only report on patients <15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥15-years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no medical history is available for patients <15 years-of-age.

Data Source Hierarchy Guide

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

CONGESTIVE HEART FAILURE (CHF)

Description

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 78

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of CHF must be documented in the patient's medical record.
- 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:
  o Abnormal limitation in exercise tolerance due to dyspnea or fatigue
  o Orthopnea (dyspnea or lying supine)
  o Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
  o Increased jugular venous pressure
  o Pulmonary rales on physical examination
  o Cardiomegaly
  o Pulmonary vascular engorgement
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CURRENT SMOKER

Description

A patient who reports smoking cigarettes every day or some days within the last 12 months.

EXCLUDE:

- Patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 78

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Description

A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 80

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- 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.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

DEMENTIA

Description

Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 81

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease), or vascular dementia must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Consistent with the National Institute on Aging December 2017.

Data Source Hierarchy Guide

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

DIABETES MELLITUS

Description

Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 82

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of a diabetes mellitus must be documented in the patient's medical record.
- Report Element Value "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

DISSEMINATED CANCER

Description

Cancer that has spread to one or more sites in addition to the primary site AND in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 82

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Another term describing disseminated cancer is “metastatic cancer.”
- A diagnosis of cancer that has spread to one or more sites must be documented in the patient’s medical record.
- The null values “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

FUNCTIONALLY DEPENDENT HEALTH STATUS

Description

Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living (ADL).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 84

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Included patients who prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, were partially dependent or completely depending upon equipment, devices or another person to complete some or all activities of daily living.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

HYPERTENSION

Description

History of persistent elevated blood pressure requiring antihypertensive medication.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 85

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of a Hypertension must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Report Element Value "1. Yes" for patients who were non-compliant with their prescribed antihypertensive medication.

Data Source Hierarchy Guide

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

MAJOR DEPRESSIVE DISORDER

Description

A major depressive disorder diagnosis documented in the medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 86

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

History of a MI in the six months prior to injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 87

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- A diagnosis of MI must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

OTHER/MENTAL/PERSONALITY DISORDERS

Description

A diagnosis of any of the following documented in the medical record:

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 88

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

PERIPHERAL ARTERIAL DISEASE (PAD)

Description

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. Peripheral Arterial Disease (PAD) can occur in any blood vessel, but it is more common in the legs than the arms.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 89

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.
- A diagnosis of PAD must be documented in the patient's medical record.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15-years-of-age.

Data Source Hierarchy Guide

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

POST-TRAUMATIC STRESS DISORDER

Description

A post-traumatic stress disorder diagnosis documented in the medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 90

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

PREGNANCY

Description

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 91

Element Value

- Yes
- No

Additional Information

- Present prior to arrival at your center.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

PREMATURITY

Description

Babies born before 37 weeks of pregnancy are completed.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 92

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients <15 years-of-age.
- A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients <15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

SCHIZOAFFECTIVE DISORDER

Description

A schizoaffective disorder diagnosis documented in the medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 93

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

SCHIZOPHRENIA

Description

A schizophrenia diagnosis documented in the medical record.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 94

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

STEROID USE

Description

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

EXCLUDE:

- Topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 95

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone.
- Examples of chronic medical conditions are Chronic Obstructive Pulmonary Disease (COPD), asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

SUBSTANCE USE DISORDER

Description

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Comorbidity	**NTDB Element Number** N/A
Local V5 Field Name Comorbidity	**NTDB Data Dictionary Page Number** 96

Element Value

- Yes
- No

Additional Information

- Present prior to injury.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients >15 years-of-age.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.

Data Source Hierarchy Guide

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

OUTCOME

INITIAL DISCHARGE

HOSPITAL DISCHARGE STATUS

Description

The status of the patient upon discharge.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge Status	**NTDB Element Number** N/A
Local V5 Field Name Discharge Status	**NTDB Data Dictionary Page Number** N/A

Element Value

- 1 - Alive
- 2 - Dead

Additional Information

Data Source Hierarchy Guide

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

DISCHARGE/DEATH DATE

Description

The date the patient was discharged from the hospital, or the date of death as indicated on the patient's death certificate.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge/Death (Date)	**NTDB Element Number** NA
Local V5 Field Name Discharge/Death (Date)	**NTDB Data Dictionary Page Number** NA

Element Value

- Minimum constraint: 1990; Maximum constraint: 2099
- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY.
- This field reflects when the patient physically left the facility.
- The null value "Not Applicable" is reported if ED Discharge Disposition is "Morgue."
- The null value "Not Applicable" is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home, or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is "44, Morgue," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

DISCHARGE/DEATH TIME

Description

The time the patient was discharged from the hospital, or the time of death as indicated on the patient's death certificate.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge/Death (Time)	**NTDB Element Number** NA
Local V5 Field Name Discharge/Death (Time)	**NTDB Data Dictionary Page Number** NA

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Relevant value for data element
- Common null values

Additional Information

- Collected as HH:MM, military time.
- This field reflects when the patient physically left the facility.
- The null value "Not Applicable" is reported if ED Discharge Disposition is "Morgue."
- The null value "Not Applicable" is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home, or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is "44, Morgue," then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

HOSPITAL DISCHARGE DATE

Description

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharge Order (Date)	**NTDB Element Number** N/A
Local V5 Field Name Discharge Order (Date)	**NTDB Data Dictionary Page Number** 139

Element Value

- Minimum constraint: 1990; Maximum constraint: 2099
- Relevant value for data element
- Common null values

Additional Information

- Collected as MM-DD-YYYY.
- If multiple orders were written, report the final disposition order date.
- The null value “Not Applicable” is reported if ED Discharge Disposition is “Morgue.”
- The null value “Not Applicable” is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home, or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is “44, Morgue,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

HOSPITAL DISCHARGE TIME

Description

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharge Order (Time)	**NTDB Element Number** N/A
Local V5 Field Name Discharge Order (Time)	**NTDB Data Dictionary Page Number** 140

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Relevant value for data element
- Common null values

Additional Information

- Collected as HHMM, military time.
- If multiple orders were written, report the final disposition order date.
- The null value “Not Applicable” is reported if ED Discharge Disposition is “Morgue.”
- The null value “Not Applicable” is reported if ED Discharge Disposition is Home with Services, Correctional Facility/Court/Law Enforcement, Home, or Self Care (Routine Discharge), Left AMA, or Acute Care Facility.
- If Hospital Discharge Disposition is “44, Morgue,” then Hospital Discharge Time is the time of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Total Days: ICU	**NTDB Element Number** N/A
Local V5 Field Name Total Days: ICU	**NTDB Data Dictionary Page Number** 134-135

Element Value

- Minimum constraint: 1; Maximum constraint: 999
- Relevant value for data element
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

References

- For examples, see page 134 of the NTDB 2024 Data Dictionary.

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Ventilator	**NTDB Element Number** N/A
Local V5 Field Name Ventilator	**NTDB Data Dictionary Page Number** 136-137

Element Value

- Minimum constraint: 1; Maximum constraint: 999
- Relevant value for data element
- Common null values

Additional Information

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

Data Source Hierarchy Guide

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

References

- For examples, see page 132 of the NTDB 2024 Data Dictionary

TOTAL HOSPITAL DAYS

Description

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

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Hospital	**NTDB Element Number** N/A
Local V5 Field Name Hospital	**NTDB Data Dictionary Page Number** N/A

Element Value

- Minimum constraint: 1; Maximum constraint: 99999
- Relevant value for data element
- Common null values

Additional Information

- Recorded in full day increments, with any partial calendar day counted as a full calendar day
- If any dates are missing, then a LOS cannot be calculated.

Data Source Hierarchy Guide

1. ICU Nursing Flow Sheet
2. Calculate Based on Admission Form and Discharge Sheet
3. Nurses Progress Notes

HOSPITAL DISCHARGE DISPOSITION

Description

The disposition of the patient when discharged from the hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Discharged To	**NTDB Element Number** N/A
Local V5 Field Name Discharged To	**NTDB Data Dictionary Page Number** 138

Element Value

- 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
- Common null values

Additional Information

- Element Value = “40. Home” refers to the patient’s current place of residence (e.g., Prison, Child Protective Services, etc.).
- Element Value based upon UB-04 disposition coding.
  - **Note: For the convenience of ATR Users, the numbering of Element Values reported by NTDS has been updated to match what is in our registry. The registry vendor, Digital Innovations, Inc., ensures all Element Values are mapped properly when submitting to the National Trauma Data Bank (NTDB) and the Trauma Quality Improvement Program (TQIP).**
- Disposition to any other non-medical facility should be coded as 40.
- Disposition to any other medical facility should be coded as 79.
- The null value “Not Applicable” is reported if ED Discharge Disposition = 40, 41, 42, 43, 44, or 70.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Value above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

CAREGIVER AT DISCHARGE

Description

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge to Alternate Caregiver	**NTDB Element Number** NA
Local V5 Field Name Discharge to Alternate Caregiver	**NTDB Data Dictionary Page Number** NA

Element Value

- Yes
- No
- Common null values

Additional Information

- Only complete when Report of Physical abuse is Yes.
- Only complete for minors as determined by state/local Description, excluding emancipated minors.
- The null value “Not Applicable” should be reported for patients where Report of Physical abuse is No or where older than the state/local age Description of a minor.
- The null value “Not Applicable” should be reported if the patient expires prior to discharge.

Data Source Hierarchy Guide

1. Case Manager / Social Services’ Notes
2. Physician Discharge Summary
3. Nursing Notes
4. Progress Notes

DISCHARGE DESTINATION HOSPITAL

Description

The name of the receiving hospital of the patient transferred from the ED to another acute care hospital.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name If Transferred, Facility	**NTDB Element Number** N/A
Local V5 Field Name If Transferred, Facility	**NTDB Data Dictionary Page Number** N/A

Element Value

- Relevant value for data element
- Common null values

Additional Information

- If the patient was discharged to an inpatient rehabilitation facility, enter 999 and select the facility name from the Receiving Rehab Facility data field.

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. Trauma Flow Sheet
3. ED Records
4. Billing Sheet/Medical Records Coding Summary Sheet
5. Nursing Notes
6. Social Worker/Case Manager Notes

PATIENT TRANSFER MODE (SENDING FACILITY ONLY)

Description

Indicator of the mode of transport to the ED

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Discharge Transport Mode	**NTDB Element Number** N/A
Local V5 Field Name Discharge Transport Mode	**NTDB Data Dictionary Page Number** N/A

Element Value

- 1 - Ground Ambulance
- 2 - Helicopter Ambulance
- 3 - Fixed-Wing Ambulance
- 4 - Private/Public Vehicle
- 5 - Police
- 6 - Other
- Common null values

Additional Information

- This field is required by the sending facility only.
- Must enter a valid transfer facility value in the Discharged To field to make this field available.

Data Source Hierarchy Guide

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summar

TRANSFER RATIONALE

Description

The rationale for transferring the patient to another facility.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Transfer Rationale	**NTDB Element Number** N/A
Local V5 Field Name Transfer Rationale	**NTDB Data Dictionary Page Number** N/A

Element Value

- 1 - Economic
- 2 - Level of Care
- 3 - Personal
- 4 - System Protocol
- 5 - Other
- 6 - Managed Care Patient
- 7 – Organ Evaluation/Procurement
- Common Null Values

Additional Information

- This field is required by the sending facility only.

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. Physician Notes/Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Nursing Notes/Flow Sheet
5. Social Worker/Case Manager Notes

IF DEATH

LIFE SUPPORT WITHDRAWN

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.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Life Support Withdrawn	**NTDB Element Number** N/A
Local V5 Field Name Life Support Withdrawn	**NTDB Data Dictionary Page Number** N/A

Element Value

- Yes, life support was withdrawn.
- No, life support was NOT withdrawn.
- Common null values

Additional Information

- DNR 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 Description 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.
- The Element Value 'No' should be reported for patients whose time of death, according to your Hospital's Description, was prior to the removal of any interventions or escalation of care.
- Must enter ‘2 – Dead’ in the Discharge Status field to make the If Death tab available.

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Case Manager/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

AUTOPSY DONE

Description

Indicator that an autopsy was performed.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was autopsy performed?	**NTDB Element Number** N/A
Local V5 Field Name Was autopsy performed?	**NTDB Data Dictionary Page Number** N/A

Element Value

- Yes, autopsy done.
- No, autopsy not done.
- Common null values

Additional Information

- Entry is required when disposition is Death, DOA, or Died.
- Must enter '2 – Dead' in the Discharge Status field to make the If Death tab available.

Data Source Hierarchy Guide

AUTOPSY NUMBER

Description

Autopsy number.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Autopsy #	**NTDB Element Number** N/A
Local V5 Field Name Autopsy #	**NTDB Data Dictionary Page Number** N/A

Element Value

- Relevant value for data element.

Additional Information

- The Element Value accepts alpha and numeric characters. Spaces and dashes (-) are not accepted.
- Must enter '2 – Dead' in the Discharge Status field to make the If Death tab available.
- Must enter 'Y' in the Was Autopsy Performed? field to make this field available.

Data Source Hierarchy Guide

1. Autopsy Report

AUTOPSY RESULTS REQUESTED

Description

Indicator that a report of autopsy results was requested.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Autopsy Results Requested	**NTDB Element Number** N/A
Local V5 Field Name Autopsy Results Requested	**NTDB Data Dictionary Page Number** N/A

Element Value

- Yes, autopsy results requested.
- No, autopsy results not requested.
- Common null values

Additional Information

- The autopsy request form can be found on the ADH website (healtharkansas.gov) on the Trauma Section page.
- The form must be submitted to the Section Chief of the Trauma Section, Diannia Hall-Clutts.
- Must enter '2 – Dead' in the Discharge Status field to make the If Death tab available.
- Must enter 'Y' in the Was Autopsy Performed? field to make this field available.

Data Source Hierarchy Guide

AUTOPSY RESULTS RECEIVED

Description

Indicator that a report of the autopsy was received if an autopsy was requested.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Autopsy Results Received	**NTDB Element Number** N/A
Local V5 Field Name Autopsy Results Received	**NTDB Data Dictionary Page Number** N/A

Element Value

- Yes, autopsy results received.
- No, autopsy results not received.
- Common null values

Additional Information

- Must enter '2 – Dead' in the Discharge Status field to make the If Death tab available.
- Must enter 'Y' in the Was Autopsy Performed? field to make this field available.

Data Source Hierarchy Guide

ORGAN DONATION

Description

Indicator that a gift was made, of a differentiated structure (as a heart or kidney) consisting of cells and tissues and performing some specific function in an organism.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was organ donation requested?	**NTDB Element Number** N/A
Local V5 Field Name Was organ donation requested?	**NTDB Data Dictionary Page Number** N/A

Element Value

- Yes
- No
- Common null values

Additional Information

- Must enter '2 – Dead' in the Discharge Status field to make the If Death tab available.

Data Source Hierarchy Guide

1. Nurses Notes
2. Physician's Progress Notes
3. Representative for your facility's partnering organ procurement organization.

ORGAN DONATION REQUEST GRANTED

Description

Indicator that the donation of organs request was granted or denied.

Required in ATR Yes	**Required in NTDB** No
Web V5 Field Name Was request granted?	**NTDB Element Number** N/A
Local V5 Field Name Was request granted?	**NTDB Data Dictionary Page Number** N/A

Element Value

- Yes
- No
- Common Null Values

Additional Information

- Must enter '2 – Dead' in the Discharge Status field to make the If Death tab available.

Data Source Hierarchy Guide

1. Nurses Notes
2. Physician's Progress Notes
3. Representative for your facility's partnering organ procurement organization.

BILLING

PRIMARY METHOD OF PAYMENT

Description

The primary source of payment for hospital care.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Primary Payer	**NTDB Element Number** N/A
Local V5 Field Name Primary Payer	**NTDB Data Dictionary Page Number** 141

Element Value

- 1 - Medicaid
- 2 - Not billed (for any reason)
- 3 - Self-Pay
- 4 - Private/Commercial Insurance
- 5 - No Fault Automobile
- 6 - Medicare
- 7 - Other government
- 8 - Workers Compensation
- 9 - Blue Cross/Blue Shield
- 10 - Other
- Common null values

Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "4. Private/Commercial Insurance". *Please note for the purposes of answering the PRQ Payer Mix question*.
- Primary methods of payment which were retired greater than 2 years before the current NTDS version are no longer listed under Element Value. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments.

Data Source Hierarchy Guide

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

QA TRACKING

QA ITEMS

These data points can be found on the QA Tracking tab as a menu within the NTDB Complications button. This information is listed as “Hospital Event” in the current NTDS Data Dictionary.

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 (Stage 3) Table:

(SCr) 3 times baseline

OR
Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

OR
Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m²

OR
Urine output <0.3 ml/kg/h for > 24 hours

OR
Anuria for > 12 hours

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 100

Element Value
- Yes
- No

Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

Source Hierarchy

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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 collage, 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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 101

Element Value

- Yes
- No

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 Description.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 102

Element Value

- Yes
- No

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) Description of Alcohol Withdrawal Syndrome.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 103

Element Value

- Yes
- No

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 Guide

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

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Description

A 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 in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) 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 (>38^{0}C): Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place **OR** was removed the day before the DOI
   - Suprapubic tenderness with no other recognized cause
   - Costovertebral angle pain or tenderness with no other recognized cause
   - Urinary Urgency with no other recognized cause
   - Urinary frequency with no other recognized cause
   - Dysuria
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria >10^5 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 with no other recognized cause
   - bradycardia with no other recognized cause
   - lethargy with no other recognized cause
   - vomiting with no other recognized cause
   - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 104-105

Element Value

- Yes
- No

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 Guide

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

CENTRAL LINE-ASSOCIATED BLOODSTREAM 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 nonculture 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 nonculture 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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 106-107

Element Value

- Yes
- No

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 Guide

1. History and Physical
2. Physician's Notes/Flow Sheets
3. Progress Notes
4. Case Management/Social Services
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	Cesarean section	SPLE	Spleen surgery

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

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 108-110

Element Value

- Yes
- No

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 Guide

1. History and 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

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 111

Element Value

- Yes
- No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 112

Element Value
- Yes
- No

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

Data Source Hierarchy Guide

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

MYOCARDIAL INFARCTION (MI)

Description
An acute myocardial infarction must be noted with documentation of ECG changes indicative of 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 center.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 113

Element Value

- Yes
- No

Additional Information

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

Data Source Hierarchy Guide

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

ORGAN/SPACE 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 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

AND

Meets at least one criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Descriptions for Specific Types of Infections chapter.

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN

Operative Procedure Categories. Day 1 = the date of the procedure.

30 – day Surveillance			
Code	**Operative Procedure**	**Code**	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric Surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

90 – day Surveillance	
Code	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions

CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Table 3. Specific Sites of an Organ/Space SSI.

Code	Site	Code	Site
BONE	Osteomyelitis	LUNG	Other infections of the respiratory tract
BRST	Breast abscess mastitis	MED	Mediastinitis
CARD	Myocarditis or pericarditis	MEN	Meningitis or ventriculitis
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or gums)
EAR	Ear, mastoid	OREP	Other infections of the male or female reproductive tract
EMET	Endometritis	PJI	Periprosthetic Joint Infection
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than conjunctivitis	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 114-116

Element Value

- Yes
- No

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 Guide

1. History and 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

OSTEOMYELITIS

Description

Osteomyelitis must meet at least one of the following criteria:

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

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*, or 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 (e.g., not Active Surveillance Culture/Testing (ASC/AST)) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

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

* With no other recognized cause

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 117-118

Element Value

- Yes
- No

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 Description of Bone and Joint infection.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet

6. Triage/Trauma Flow Sheet
7. Discharge Summary

PULMONARY EMBOLISM (PE)

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 120

Element Value

- Yes
- No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheets
3. Progress Notes
4. Case Management/Social Services
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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 119

Element Value

- Yes
- No

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 Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 121

Element Value

- Yes
- No

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 Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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 blood flow to the brain (ischemic stroke). Or by 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, is 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).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 122-123

Element Value

- Yes
- No

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 Guide

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

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Description
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 subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
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).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 124-125

Element Value

- Yes

- No

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 Guide

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 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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 126

Element Value

- Yes
- No

Additional Information

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

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 127

Element Value

- Yes
- No

Additional Information

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

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services
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 operation 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 center.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 128

Element Value

- Yes
- No

Additional Information

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

Data Source Hierarchy Guide

1. History and 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

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: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	At least **one** of the following: • Fever (>38°C or >100.4°F) • 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 (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP Algorithm (PNU2 Viral, Legionnella, and other Bacterial Pneumonias):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	At least **one** of the following: • Fever (>38°C or >100.4°F) • 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 (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Virus, *Bordetella*, *Legionella*, *Chlamydia or Mycoplasma* identified from respiratory secretions or 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). • 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: • New or progressive **and** persistent infiltrate	Patient who is immunocompromised has at least ***one*** of the following: • Fever (>38°C or >100.4°F)	At least **one** of the following: • Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13 • Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: – Direct microscopic exam – Positive culture of fungi – Non-culture diagnostic laboratory test
• Consolidation	• For adults ≥70 years old, altered mental status with no other recognized cause • New onset of purulent sputum3, or change in character ofsputum4, or increased respiratory secretions, or increased suctioning requirements	Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**
• Cavitation • Pneumatoceles, in infants ≤1 year old	• New onset or worsening cough, or dyspnea, or tachypnea5 • Rales6 or bronchial breath sounds	
NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	• Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240]7, increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤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 or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable.	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (≤4000 WBC/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 or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable.	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 (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name NTDB Complications	**NTDB Element Number** N/A
Local V5 Field Name NTDB Complications	**NTDB Data Dictionary Page Number** 129-133

Element Value

- Yes
- No

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 Guide

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

MEASURES FOR PROCESSES OF CARE INFORMATION

The fields in this section should be collected and transmitted by Level 1 and Level 2 TQIP participating centers only. Please contact tqip@facs.org for information about joining TQIP.

HIGHEST GCS TOTAL

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).

Description

Highest total GCS on calendar day after ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Highest GCS Total	**NTDB Element Number** N/A
Local V5 Field Name Highest GCS Total	**NTDB Data Dictionary Page Number** 142

Element Value

- Relevant value for data element
- Minimum constraint: 3; Maximum constraint: 15
- Common null values

Additional Information

- Refers to highest total GCS within 24 hours 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 score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness, such as “AAOx3,” “awake alert and oriented,” or “patient with normal mental status,” interpret this as GCS of 15 IF there is no other contradicting documentation.
- The null value “Not Applicable” is reported for patients that do not meet collection criteria.
- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- 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.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

HIGHEST GCS MOTOR

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).

Description

Highest GCS motor on calendar day after ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS Motor	**NTDB Element Number** N/A
Local V5 Field Name GCS Motor	**NTDB Data Dictionary Page Number** 143-144

Element Value

- Pediatric (< 2 years)
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Appropriate response to stimulation
- Adult
  - 1 - No motor response
  - 2 - Extension to pain
  - 3 - Flexion to pain
  - 4 - Withdrawal from pain
  - 5 - Localizing pain
  - 6 - Obeys commands
  - Common null values

Additional Information

- Refers to highest GCS motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- 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.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

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).

Description

Documentation of factors potentially affecting the highest GCS on calendar after ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS Qualifier	**NTDB Element Number** N/A
Local V5 Field Name GCS Qualifier	**NTDB Data Dictionary Page Number** 145-146

Element Value

- Patient chemically sedated or paralyzed
- Obstruction to the patient's eyes
- Patient intubated
- Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye.
- Common null values

Additional Information

- Report all that apply.
- Refers to highest GCS assessment qualifier score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- 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 score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element does not apply to self-medication the patient may have administered (i.e., ETOH, prescriptions, etc.).
- Must be the assessment qualifier for the Highest GCS Total on calendar day after ED/hospital arrival.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier must be reported.
- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium.
- While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS-40 Motor.
- If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes
5. Medication Summary

HIGHEST GCS 40 - MOTOR

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).

Description

Highest GCS 40 motor on calendar day after ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name GCS 40: Motor	**NTDB Element Number** N/A
Local V5 Field Name GCS 40: Motor	**NTDB Data Dictionary Page Number** 147-148

Element Value

- Pediatric (<5 years)
  - 1 - None
  - 2 - Extension to Pain
  - 3 - Flexion to Pain
  - 4 - Localizes Pain
  - 5 - Obeys Commands
  - 7 - Not Testable
- Adult
  - 1 - None
  - 2 - Extension
  - 3 - Abnormal Flexion
  - 4 - Normal Flexion
  - 5 - Localizing
  - 6 - Obeys Commands
  - 7 - Not Testable

Additional Information

- Refers to highest GCS-40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- 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 patient's, 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.
- Report Element Value "0. Not Testable" if unable to assess (e.g., neuromuscular blockade).
- 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.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

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).

Description

Physiological response of the pupil size within 30 minutes or less of ED/Hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Pupillary response	**NTDB Element Number** N/A
Local V5 Field Name Pupillary response	**NTDB Data Dictionary Page Number** 149

Element Value

- 1 – Both reactive
- 2 – One reactive
- 3 – Neither reactive

Additional Information

- Please note that first recorded hospital vitals do no 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 PERRL "Pupils Equal Round Reactive to Light" submit Element Value 1. Both reactive IF there is no other contradicting documentation.
- The null value “Not Known/Not Recorded” should be submitted 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.
- Element Value “2 - One reactive” should 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.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. Nursing Notes/Flow Sheet
3. Progress Notes
4. History and Physical

MIDLINE SHIFT

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).

Description

>5mm shift of the brain past its center line within 24 hours after time of injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Midline shift	**NTDB Element Number** N/A
Local V5 Field Name Midline shift	**NTDB Data Dictionary Page Number** 150

Element Value

- Yes
- No
- Not Imaged (e.g. CT Scan, MRI)

Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, submit Element Value 1. Yes.
- Radiological and surgical documentation from transferring facilities should be considered for this data field.
- 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.
- 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)."

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Physician Notes/Flow Sheet
4. Nurse's Notes/Flow Sheet
5. Hospital Discharge Summary

CEREBRAL MONITOR

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).

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Cerebral Monitor	**NTDB Element Number** N/A
Local V5 Field Name Cerebral Monitor	**NTDB Data Dictionary Page Number** 151

Element Value

- Intraventricular drain/catheter (e.g., ventriculostomy, external ventricular drain)
- Intraparenchymal pressure monitor (e.g., Camion bolt, subarachnoid bolt, intraparenchymal catheter)
- Intraparenchymal oxygen monitor (e.g., Licox)
- Jugular venous bulb
- Common null values

Additional Information

- Report all that apply.
- 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.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

CEREBRAL MONITOR DATE

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).

Description

Date of first cerebral monitor placement.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Date	**NTDB Element Number** N/A
Local V5 Field Name Date	**NTDB Data Dictionary Page Number** 152

Element Value

- Relevant value for data element
- Minimum constraint: 2010; Maximum constraint: 2099
- Common null values

Additional Information

- Reported as MM-DD-YYYY.
- The null value “Not Applicable” is reported if the date field Cerebral Monitor is “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.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

CEREBRAL MONITOR TIME

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).

Description

Time of first cerebral monitor placement.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Time	**NTDB Element Number** N/A
Local V5 Field Name Time	**NTDB Data Dictionary Page Number** 153

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Reported as HHMM, military time.
- The null value “Not Applicable” is reported if the data field Cerebral Monitor is “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.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Reporting Criterion: Report on all patients.

Description

Type of first dose of venous thromboembolism prophylaxis administered to patient at your hospital.

EXCLUDE:

- Sequential compression devices.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name VTE Type	**NTDB Element Number** N/A
Local V5 Field Name VTE Type	**NTDB Data Dictionary Page Number** 154

Element Value

- None
- LMWH (Dalteparin, Enoxaparin, etc.)
- Direct Thrombin Inhibitor (Dabigatran, etc.)
- Xa Inhibitor (Rivaroxaban, etc.)
- Other
- Unfractionated Heparin (UH)
- Common null values

Additional Information

- 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 VenousThromboembolism Prophylaxis Types.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet
3. Pharmacy Record

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

Reporting Criterion: Report on all patients.

Description

Date of administration of first dose of VTE prophylaxis administered to patient at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name VTE Date	**NTDB Element Number** N/A
Local V5 Field Name VTE Date	**NTDB Data Dictionary Page Number** 155

Element Value

- Minimum constraint: 2010: Maximum constraint: 2099
- Common null values

Additional Information

- Reported as MM-DD-YYYY.
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type field.
- The null value “Not Applicable” is reported if Venous Thromboembolism Prophylaxis Type = “None”.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Reporting Criterion: Report on all patients.

Description

Time of administration of first dose of VTE prophylaxis administered to patient at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name VTE Time	**NTDB Element Number** N/A
Local V5 Field Name VTE Time	**NTDB Data Dictionary Page Number** 156

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Reported as HHMM, military time.
- Refers to time at which patient first received the prophylactic agent indicated in VTE Prophylaxis Type field
- The null value “Not Applicable” is reported if Venous Thromboembolism Prophylaxis Type is “None”.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet

PACKED RED BLOOD CELLS

Reporting Criterion: Report on all patients.

Description

Volume of packed red blood cells transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival.

EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell Saver blood.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Packed Red Blood Cells	**NTDB Element Number** NA
Local V5 Field Name Packed Red Blood Cells	**NTDB Data Dictionary Page Number** 157

Element Value

- Relevant value for data element

Additional Information

- Refers to amount of transfused packed red blood cells (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no packed red blood cells were given, then volume reported should be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

WHOLE BLOOD

Reporting Criterion: Report on all patients.

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Whole Blood	**NTDB Element Number** NA
Local V5 Field Name Whole Blood	**NTDB Data Dictionary Page Number** 158

Element Value

- Relevant value for data element

Additional Information

- 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).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

PLASMA

Reporting Criterion: Report on all patients.

Description

Volume of plasma (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival.

EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell Saver blood.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Plasma	**NTDB Element Number** NA
Local V5 Field Name Plasma	**NTDB Data Dictionary Page Number** 159

Element Value

- Relevant value for data element

Additional Information

- 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 should be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

PLATELETS

Reporting Criterion: Report on all patients.

Description

Volume of platelets (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival.

EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell Saver blood.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Platelets	**NTDB Element Number** NA
Local V5 Field Name Platelets	**NTDB Data Dictionary Page Number** 160

Element Value

- Relevant value for data element

Additional Information

- 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 should be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

CRYOPRECIPITATE

Reporting Criterion: Report on all patients.

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Cryoprecipitate	**NTDB Element Number** NA
Local V5 Field Name Cryoprecipitate	**NTDB Data Dictionary Page Number** 161

Element Value

- Relevant value for data element

Additional Information

- 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 should be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

ANGIOGRAPHY

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

First interventional angiogram for hemorrhage control within first 24 hours of ED/Hospital arrival.

EXCLUDE:

- Computerized tomographic angiography (CTA).

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Angiography	**NTDB Element Number** N/A
Local V5 Field Name Angiography	**NTDB Data Dictionary Page Number** 162

Element Value

- None
- Angiogram only
- Angiogram with embolization
- Angiogram with stenting
- Common null values

Additional Information

- Limit collection of angiography data to first 48 hours following ED/hospital arrival.
- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion
- Only report Element Value “Angiogram with stenting” if stenting was performed specifically for hemorrhage control.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

EMBOLIZATION SITE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

Organ / site of embolization for hemorrhage control.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Embolization Site	**NTDB Element Number** N/A
Local V5 Field Name Embolization Site	**NTDB Data Dictionary Page Number** 163

Element Value

- Liver
- Spleen
- Kidneys
- Pelvic (iliac, gluteal, obturator)
- Retroperitoneum (lumbar, sacral)
- Peripheral vascular (neck, extremities)
- ~~RETIRED 2020: Aorta (thoracic or abdominal)~~
- Other
- Common null values

Additional Information

- Report all that apply.
- 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.
- 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.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

ANGIOGRAPHY DATE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

Date the first angiogram with or without embolization was performed.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Angiography Date	**NTDB Element Number** N/A
Local V5 Field Name Angiography Date	**NTDB Data Dictionary Page Number** 164

Element Value

- Minimum constraint: 2013; Maximum constraint: 2099
- Common null values

Additional Information

- Reported as MM-DD-YYYY.
- Procedure start date is the date of needle insertion in the groin.
- The null value "Not Applicable" is reported if the data element Angiography is *Element Value* "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

ANGIOGRAPHY TIME

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

Time the first angiogram with or without embolization was performed.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Angiography Time	**NTDB Element Number** N/A
Local V5 Field Name Angiography Time	**NTDB Data Dictionary Page Number** 165

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Reported as HHMM military time.
- Procedure start date is the date of needle insertion in the groin.
- The null value "Not Applicable" is reported if the data element ***Angiography*** is *Element Value* "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TYPE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

First type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Surgery Hemorrhage Control Type	**NTDB Element Number** N/A
Local V5 Field Name Surgery Hemorrhage Control Type	**NTDB Data Dictionary Page Number** 166

Element Value

1. None
2. Laparotomy
3. Thoracotomy
4. Sternotomy
5. Extremity
6. Neck
7. Mangled extremity/traumatic amputation
8. Other skin/soft tissue
9. Extraperitoneal Pelvic Packing

Additional Information

- If unclear if surgery was for hemorrhage control, then consult TMD or operating/ consulting/relevant surgeon.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Element Value “None” is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL DATE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

Date of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Surgery Hemorrhage Control Date	**NTDB Element Number** N/A
Local V5 Field Name Surgery Hemorrhage Control Date	**NTDB Data Dictionary Page Number** 167

Element Value

- Minimum constraint: 2010; Maximum constraint: 2099
- Common null values
- Select Not Applicable if no surgery for hemorrhage control

Additional Information

- Reported as MM-DD-YYYY.
- 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.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TIME

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Description

Time of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Surgery Hemorrhage Control Time	**NTDB Element Number** N/A
Local V5 Field Name Surgery Hemorrhage Control Time	**NTDB Data Dictionary Page Number** 168

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Reported as HHMM military time.
- 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.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Reporting Criterion: Report on all patients.

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.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Withdrawal of Care	**NTDB Element Number** N/A
Local V5 Field Name Withdrawal of Care	**NTDB Data Dictionary Page Number** 169

Element Value

- Yes
- No
- Common null values

Additional Information

- Do-not-resuscitate (DNR) order not a requirement.
- A note to limit escalation of care 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-saving 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.
- The Element Value “No” should be reported for patients whose time of death, according to your Hospital’s Description, was prior to the removal of any interventions or escalation of care.

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Case Manager/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Reporting Criterion: Report on all patients.

Description

The date treatment was withdrawn.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Withdrawal of Care Date	**NTDB Element Number** N/A
Local V5 Field Name Withdrawal of Care Date	**NTDB Data Dictionary Page Number** 170

Element Value

- Minimum constraint: 1990; Maximum constraint: 2099
- Common null values

Additional Information

- Reported as MM/DD/YYYY.
- 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."

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Reporting Criterion: Report on all patients.

Description

The time treatment was withdrawn.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Withdrawal of Care Time	**NTDB Element Number** N/A
Local V5 Field Name Withdrawal of Care Time	**NTDB Data Dictionary Page Number** 171

Element Value

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HHMM, military time.
- Record the time the first of any existing life-sustaining 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-saving 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."

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

ANTIBIOTIC THERAPY

Reporting Criterion: Report on all patients with any open fracture(s).

Description

Intravenous antibiotic therapy was administered to the patient within 24 hours after injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Antibiotic Therapy	**NTDB Element Number** N/A
Local V5 Field Name Antibiotic Therapy	**NTDB Data Dictionary Page Number** 172

Element Value

- Yes
- No
- Common null values

Additional Information

- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes AIS code descriptors that contain “open” and all AIS extremity/limb codes descriptors that contains “amputation”.

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

ANTIBIOTIC THERAPY DATE

Reporting Criterion: Report on all patients with any open fracture(s).

Description

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Antibiotic Therapy: Date	**NTDB Element Number** N/A
Local V5 Field Name Antibiotic Therapy	**NTDB Data Dictionary Page Number** 173

Element Value

- Relevant value for data element
- Common null values

Additional Information

- Reported as MM-DD-YYYY.
- 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.”
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes AIS code descriptors that contain “open” and all AIS extremity/limb codes descriptors that contains “amputation”.

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
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5. Nursing Notes/Flow Sheet
6. Pharmacy Record

ANTIBIOTIC THERAPY TIME

Reporting Criterion: Report on all patients with any open fracture(s).

Description

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

Required in ATR Yes	**Required in NTDB** Yes
Web V5 Field Name Antibiotic Therapy: Time	**NTDB Element Number** N/A
Local V5 Field Name Antibiotic Therapy	**NTDB Data Dictionary Page Number** 174

Element Value

- Relevant value for data element
- Common null values

Additional Information

- Reported as HHMM military time.
- 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.”
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes AIS code descriptors that contain “open” and all AIS extremity/limb codes descriptors that contains “amputation”.

Data Source Hierarchy Guide

1. EMS Run Sheet
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APPENDICES

Appendix 1: ATR Change Log

The following changes have been made to the below data elements:

RETIRED DATA ELEMENTS	
TRANSFERRED FOR ORGAN PROCUREMENT (OUTCOME/INITIAL DISCHARGE)	NATIONAL PROVIDER IDENTIFIER (NPI) (ED/RESUS/ARRIVAL/ADMISSION)

NEW DATA ELEMENTS	
INITIAL FIELD DIASTOLIC BLOOD PRESSURE (PREHOSPITAL/TREATMENT)	INITIAL ED/HOSPITAL DIASTOLIC BLOOD PRESSURE (ED/RESUS/ INITIAL ASSESSMENT)
TRANSFER RATIONALE (OUTCOME/ INITIAL DISCHARGE)	

The following updates have been made to the data element locations:

UPDATED DATA ELEMENT LOCATIONS	
TRAUMA TRIAGE CRITERIA (STEPS 1 & 2) & (STEPS 3 & 4)	CHANGED: Moved to new PREHOSPITAL/TRIAGE sub-tab from PREHOSPITAL/SCENE/TRANSPORT sub-tab.

The following updates have been made to the data elements values:

UPDATED DATA VALUES	
AIS VERSION (DIAGNOSIS/INJURY CODING)	REMOVED: AIS 05, Update 08
AIS VERSION (DIAGNOSIS/INJURY CODING)	ADDED: AIS 2015

The following updates have been made to the data elements descriptions:

UPDATED DESCRIPTIONS	
DISCHARGE/DEATH DATE (OUTCOME/INITIAL DISCHARGE)	CHANGED: wording was changed from ‘time’ to ‘date’ within the description
ORGANS DONATED (OUTCOME: IF DEATH)	CHANGED: The title was changed to ORGAN DONATION REQUEST GRANTED and the description and values were updated correspondingly.

The following updates have been made to the sub-tab:

NEW SUB-TAB	
TRIAGE (PREHOSPITAL)	

UPDATED SUBTAB TITLES	
LABS/TOXICOLOGY (ED/RESUS)	CHANGED: Subtab was renamed as LABS/SCREENINGS/TOXICOLOGY

Appendix 2: NTDS Change Log

The following changes have been made to the NTDS Data Dictionary.

- See the National Trauma Data Standard Data Dictionary 2024 Admissions for more information about updates and changes: NTDS Data Dictionary | ACS (facs.org)

The following updates have been made to the NTDS required data elements descriptions:

UPDATED DESCRIPTIONS	
INTER-FACILITY TRANSFER	ADDED: INCLUDE: Patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center.
CIRRHOSIS (Pre-Existing Condition)	ADDED: EXCLUDE patients who no longer have cirrhosis due to a successful liver transplant.

The following changes have been made to the NTDS required data elements additional information:

ADDED/CHANGED ADDITIONAL INFORMATION	
INTER-FACILITY TRANSFER	ADDED: Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-andsystems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed January 15, 2019).
DEMENTIA (Pre-Existing Condition)	REMOVED: A diagnosis of dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record.
DEMENTIA (Pre-Existing Condition)	ADDED: A diagnosis of dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease), or vascular dementia must be documented in the patient's medical record.
ACUTE KIDNEY INJURY (Hospital Event)	REMOVED: 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.

HOSPITAL DISCHARGE DATE	ADDED: If multiple orders were written, report the final disposition order date.
HOSPITAL DISCHARGE TIME	ADDED: If multiple orders were written, report the final disposition order time.
ED DISCHARGE TIME	ADDED: If multiple orders were written, report the final disposition order time.
ED DISCHARGE DATE	ADDED: If multiple orders were written, report the final disposition order date.

Appendix 3: Logic Sequences Cheat Sheet

Patient's Homeless Status	Must enter n/a in the ZIP field to make this field available
Alternate Home Residence	Must enter n/a in the ZIP field to make this field available
Occupation	Must enter 'Y' in the Work Related field to make this field available
Occupational Industry	Must enter 'Y' in the Work Related field to make this field available
Investigation of Physical Abuse	Must enter 'Y' in the Report of Physical Abuse field to make this field available
Transport Role	Must enter '6 – Other', '/ - Not Applicable', or '? – Unknown' in the Mode field to make this field available
Post OR Disposition	Must enter "3 – Operating Room" in the Discharged To field to make this field available
ATCC Contacted Date and Time	Must enter "Y" in the Was ATCC utilized for patient transfer? field to make this field available
Administered Date and Time	Must enter "Y" in the IV antibiotics administered for any open fractures W/I 24 hours? Field to make this field available
If Yes, Specify	Must enter "Y" in the Did patient home medications list include anticoagulants? field to make this field available
Discharge Transport Mode	Must enter a valid transfer facility value in the Discharged To field to make this field available
If Death tab	Must enter "2 – Dead" in the Discharge Status field to make this tab available
Autopsy #	Must enter 'Y' in the Was Autopsy Performed? field to make this field available
Autopsy Results Requested	Must enter 'Y' in the Was Autopsy Performed? field to make this field available
Autopsy Results Received	Must enter 'Y' in the Was Autopsy Performed? field to make this field available

Acknowledgements

ACS Committee on Trauma

All participating board members

NTDS Work Group

All participating members listed in the 2024 NTDS Data Dictionary

Arkansas Trauma Registry Staff

Wei Wang, Kevin Barker

Arkansas Trauma Registry Users Group

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TAC Data Committee

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