

DEPARTMENT OF HEALTH
Division of Emergency Medical Operations
Office of Trauma



Florida Trauma Registry Manual

February 2008

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Florida Trauma Registry Data Dictionary and Submission Guidelines

Introduction

The Florida Trauma Registry Manual details the requirements for data collection and submission that are mandatory for Florida trauma centers.

This manual provides a description of each data point included in the state trauma registry. Other data may be collected in each local trauma registry to support that trauma center's needs. Additional information may be accessed through our website at: <http://www.doh.state.fl.us/demo/trauma/index.html>.

For further information, please contact:

Florida Department of Health
Division of Emergency Medical Operations
Office of Trauma
4052 Bald Cypress Way, Bin C-18
Tallahassee, Florida 32399-1738
Phone: (850) 245-4444
Fax: (850) 488-2512
E-mail: demo_tnc@doh.state.fl.us

Florida Data Dictionary Patient Definition

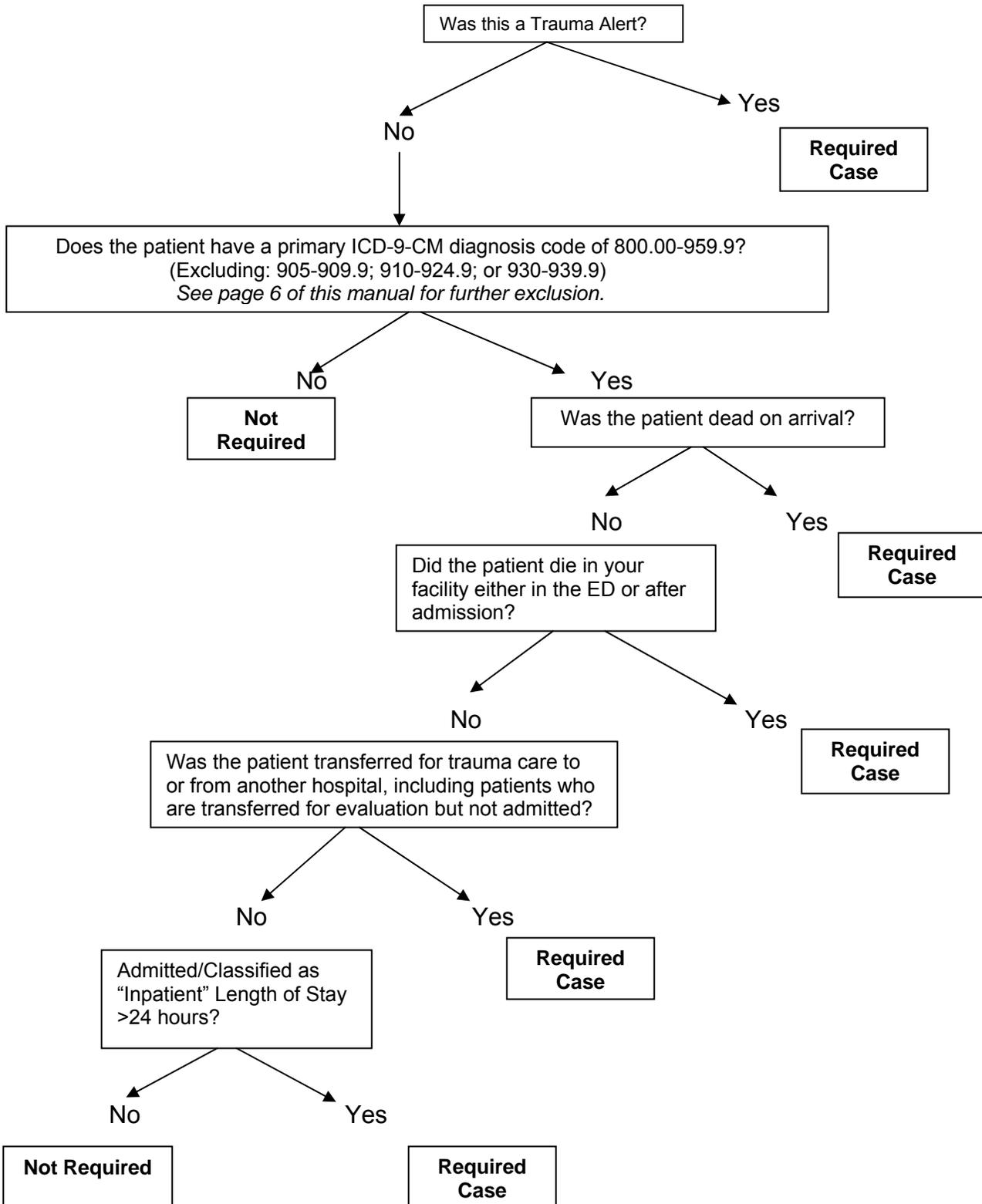
All patients presented to the hospital that meet any of the following criteria should be entered into the trauma center's registry and reported to the Florida Trauma Registry:

- A. All trauma alert patients presented to the hospital regardless of disposition (patients identified by the state trauma scorecard criteria in Rules 64J-2.004 and 64J-2.005, Florida Administrative Code).
- B. All deaths from injury, including patients who are dead on arrival, those who died in the emergency department or trauma resuscitation, or in the hospital.
- C. Any patient admitted to the hospital for 24 hours or more, transferred to the hospital, or transferred from the hospital due to an ICD-9-CM injury diagnosis of 800-959.9 (excluding: 905-909.9; 910-924.9; and 930-939.9).

See Trauma Registry Inclusion Criteria diagram on next page.

Trauma Registry Inclusion Criteria

(Follow downward until a **“Required Case”** is achieved)



Submission Schedule and Reporting Requirements

- A. Data verification: Data reported to the Florida Trauma Registry must be verified by the reporting hospital before submission to the Department.
- B. Records of patients with a death or discharge from the hospital/trauma center must be entered into the registry within 90 days of the close of quarter and submitted to the Department by the following due dates:

Quarter	Reporting Dates	Due date
Quarter One	January 1-March 31	Submit by July 1
Quarter Two	April 1-June 30	Submit by October 1
Quarter Three	July 1-September 30	Submit by January 1
Quarter Four	October 1-December 31	Submit by April 1

Data may be submitted using CD-ROM or diskette labeled with the hospital name and reporting period or by encrypted electronic format. Mail CD-ROM or diskette to:

Florida Department of Health
Office of Trauma
4052 Bald Cypress Way, Bin C-18
Tallahassee, Florida 32399-1738

For electronic submission call (850) 245-4444 ext. 2731

- C. Data submitted to the state must have all data points completed that are required in the minimum data set for inclusion in the determination of a hospital's trauma caseload volume. The data dictionary section of this manual details the required field values and whether or not each field is mandatory for the minimum data set requirements.

The trauma caseload volume is defined as a subset of patient records submitted to the trauma registry which excludes the following isolated injury diagnoses where the patient was not a trauma alert patient or did not die from injury:

- Isolated injury of 820-821.9 and age >64 years
- Isolated injury of 840-848.9

Records not completed for the minimum data set will not be included in the trauma center's trauma caseload volume.

- D. The Department reserves the right under section 395.404, Florida Statutes, to collect data from acute care hospitals, but acute care hospitals will not be required to submit quarterly data at this time.
- E. The Department will accept hospital data directly from NTRACS software download files. Those hospitals not using NTRACS must comply with the data requirements set forth in this manual and may provide either a single, flat ASCII text file, or a multiple file format that addresses each component of the data (demographics, prehospital, diagnoses, etc...). This file format must be submitted to and approved by the Department prior to the submission due date, and all data points must be coded to the Florida Trauma Registry requirements prior to receipt of the data.
- F. The Department will return an initial data completion and quality report to the reporting trauma center within 10 business days past the initial due date of the quarter, or the date of submission, whichever date is later.
- G. The reporting trauma center shall correct any reporting errors and resubmit the data within 20 business days of receipt of a data completion and quality report.
- H. Upon acceptance of complete and correct data, the Department will return a final summary report to the reporting trauma center.
- I. Data to be used for calculation of trauma caseload volume reported by the Florida Trauma Registry must be final as of 90 days past the initial due date of the quarterly reported data.
- J. The Department will publish the quarterly trauma caseload volume by 115 days past the initial due date of the quarterly data submission.
- K. The Department will publish the final calculation of the trauma centers' previous calendar year caseload volume by August 31st of the following year and submit a finalized annual report for signature by the trauma program manager in order to certify the accuracy of the data received.
- L. The Department may by site visit, desk audit or through an agent, audit a trauma center's medical records for the purpose of validating reported trauma registry data at any time.

DATA DICTIONARY

This section contains a description of each data point to be reported to the Florida Trauma Registry organized by section of the data (demographics, diagnoses, etc.)

DEMOGRAPHICS

PATIENT IDENTIFIER

OPTIONS: Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Patient Identifier/Medical Record Number - Medical record number or other patient identifier on the transcript of the medical information about a patient.

DATA ENTRY MODE: Direct Entry.

NOTE: This field may contain any alphanumeric data that will help identify the patient. If this number is unknown, a temporary number can be assigned. This temporary number can include letters or other characters.

SOCIAL SECURITY NUMBER

OPTIONS: 000-00-0000 = Infants
777-77-7777 = Unknown/Not Available
555-55-5555 = Illegal Immigrant

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Social Security Number - A 9-digit federal code registered to American citizens.

DATA ENTRY MODE: Direct Entry.

NOTE: This field cannot be partially filled.

FIRST NAME

OPTIONS: Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Patient's First Name - Given name as stated on birth certificate or change-of-name affidavit.

DATA ENTRY MODE: Direct Entry.

MIDDLE INITIAL

OPTIONS: Not Recorded
Not Available.

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Patient's Middle Initial - The first letter of the patient's given second name.

DATA ENTRY MODE: Direct Entry.

LAST NAME

OPTIONS: Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Patient's Last Name - Given name as stated on birth certificate or change-of-name affidavit.

DATA ENTRY MODE: Direct Entry.

GENDER

OPTIONS: F = Female
M = Male
X = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITION: Gender - Patient's gender.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

RACE

OPTIONS: A = Asian
B = Black/African-American
H = Hispanic
I = American Indian
O = Other
W = White
X = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Race - A family, tribe, people, or nation belonging to the same stock.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

BIRTH DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Date of Birth - The month, day, and year (mm/dd/yyyy) of the patient's birth.

DATA ENTRY MODE: Direct Entry

AGE

OPTIONS: -5 = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Age - The date of birth to the date that the patient presented to the hospital expressed in years.

DATA ENTRY MODE: Auto-generated or Direct Entry.

UNITS OF AGE

- OPTIONS:** H = Hours
D = Days
M = Months
Y = Years
-5 = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Units of Age - The unit in which the age is calculated from the date of birth to the date that the patient presented to the hospital. Preferably expressed in **years**.

DATA ENTRY MODE: Manual entry

CITY

OPTIONS: Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Patient's City of Residence - The name of the city in which the patient most often resides.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry

NOTE: If the patient is homeless or a transient, in the street address field insert "homeless" or "transient," then fill in your hospital's city and state. The zip code should then be "00000."

OCCUPATION

- OPTIONS:** Agriculture, Forestry, Fishing and Hunting
111 Crop Production
112 Animal Production
113 Forestry and Logging
114 Fishing, Hunting and Trapping
115 Support Activities for Agriculture and Forestry
- Mining, Quarrying, and Oil and Gas Extraction
211 Oil and Gas Extraction
212 Mining (except Oil and Gas)
213 Support Activities for Mining
- Utilities
221 Utilities
- Construction
236 Construction of Buildings
237 Heavy and Civil Engineering Construction
238 Specialty Trade Contractors
- Manufacturing
311 Food Manufacturing
312 Beverage and Tobacco Product Manufacturing
313 Textile Mills
314 Textile Product Mills
315 Apparel Manufacturing
316 Leather and Allied Product Manufacturing
321 Wood Product Manufacturing
322 Paper Manufacturing
323 Printing and Related Support Activities
324 Petroleum and Coal Products Manufacturing

325	Chemical Manufacturing
326	Plastics and Rubber Products Manufacturing
327	Nonmetallic Mineral Product Manufacturing
331	Primary Metal Manufacturing
332	Fabricated Metal Product Manufacturing
333	Machinery Manufacturing
334	Computer and Electronic Product Manufacturing
335	Electrical Equipment, Appliance, and Component Manufacturing
336	Transportation Equipment Manufacturing
337	Furniture and Related Product Manufacturing
339	Miscellaneous Manufacturing
Wholesale Trade	
423	Merchant Wholesalers, Durable Goods
424	Merchant Wholesalers, Nondurable Goods
425	Wholesale Electronic Markets and Agents and Brokers
Retail Trade	
441	Motor Vehicle and Parts Dealers
442	Furniture and Home Furnishings Stores
443	Electronics and Appliance Stores
444	Building Material and Garden Equipment and Supplies Dealers
445	Food and Beverage Stores
446	Health and Personal Care Stores
447	Gasoline Stations
448	Clothing and Clothing Accessories Stores
451	Sporting Goods, Hobby, Book, and Music Stores
452	General Merchandise Stores
453	Miscellaneous Store Retailers
454	Nonstore Retailers
Transportation and Warehousing	
481	Air Transportation
482	Rail Transportation
483	Water Transportation
484	Truck Transportation
485	Transit and Ground Passenger Transportation
486	Pipeline Transportation
487	Scenic and Sightseeing Transportation
488	Support Activities for Transportation
491	Postal Service
492	Couriers and Messengers
493	Warehousing and Storage
Information	
511	Publishing Industries (except Internet)
512	Motion Picture and Sound Recording Industries
515	Broadcasting (except Internet)
517	Telecommunications
518	Data Processing, Hosting and Related Services
519	Other Information Services
Finance and Insurance	
521	Monetary Authorities-Central Bank
522	Credit Intermediation and Related Activities
523	Securities, Commodity Contracts, and Other Financial Investments and
524	Insurance Carriers and Related Activities
525	Funds, Trusts, and Other Financial Vehicles

Real Estate and Rental and Leasing	
531	Real Estate
532	Rental and Leasing Services
533	Lessors of Nonfinancial Intangible Assets (except Copyrighted Works)
Professional, Scientific, and Technical Services	
541	Professional, Scientific, and Technical Services
Management of Companies and Enterprises	
551	Management of Companies and Enterprises
Administrative and Support and Waste Management and Remediation Services	
561	Administrative and Support Services
562	Waste Management and Remediation Services
Educational Services	
611	Educational Services
Health Care and Social Assistance	
621	Ambulatory Health Care Services
622	Hospitals
623	Nursing and Residential Care Facilities
624	Social Assistance
Arts, Entertainment, and Recreation	
711	Performing Arts, Spectator Sports, and Related Industries
712	Museums, Historical Sites, and Similar Institutions
713	Amusement, Gambling, and Recreation Industries
Accommodation and Food Services	
721	Accommodation
722	Food Services and Drinking Places
Other Services (except Public Administration)	
811	Repair and Maintenance
812	Personal and Laundry Services
813	Religious, Grantmaking, Civic, Professional, and Similar Organizations
814	Private Households
Public Administration	
921	Executive, Legislative, and Other General Government Support
922	Justice, Public Order, and Safety Activities
923	Administration of Human Resource Programs
924	Administration of Environmental Quality Programs
925	Administration of Housing Programs, Urban Planning, and Community
926	Administration of Economic Programs
927	Space Research and Technology
928	National Security and International Affairs

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITION: Occupation - The type of work or trade that the patient engages in that provides income. Use the appropriate 3-digit North American Industry Classification System (NAICS) code to indicate the patient's occupation.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

COUNTY OF RESIDENCE

OPTIONS: Not Available
Out of Country

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Patient's County of Residence - The county in which the patient most often resides.
NOTE: If the patient resides in a foreign country outside the United States, use "Out of Country."

DATA ENTRY MODE: Auto-generated or Direct Entry.

STATE OF RESIDENCE

OPTIONS: UK = Unknown

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Patient's State of Residence - The state in which the patient most often resides.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: If the patient is homeless or a transient, in the street address field insert "homeless" or "transient," then fill in your hospital's city and state. The zip code should then be "00000."

ZIP CODE

OPTIONS: "00000" = Homeless/Transient
"99999" = Not Known/Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Patient Zip Code - Numeric postal code for the locale in which the patient resides.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: If the patient is homeless or a transient, in the street address field insert "homeless" or "transient," then fill in your hospital's city and state. The zip code should then be "00000."

TRAUMA REGISTRY NUMBER

OPTIONS: None - Auto-generated

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Registry Number - The number assigned by the program that identifies the patient record. This number cannot be changed.

DATA ENTRY MODE: Auto-generated.

INJURY

INJURY DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **Injury Date** - Day, month, and year (mm/dd/yyyy) on which the injury occurred.

DATA ENTRY MODE: Direct Entry.

INJURY TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-5 = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **Injury Time** - Time that the injury occurred, expressed in military format.

DATA ENTRY MODE: Direct Entry.

INJURY LOCATION (CITY)

OPTIONS: Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: **Injury City** - The city in which the injury occurred.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

NOTE: If the patient is homeless or a transient, in the street address field insert "homeless" or "transient," then fill in your hospital's city and state. The zip code should then be "00000."

BLUNT/PENETRATING

OPTIONS: Blunt = Blunt type of injury
Burn = Burn injury
Penetrating = Penetrating type of injury
Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **Blunt** - Non-penetrating injury, from an external force causing injury. **Burn** - Tissue injury from excessive exposure to chemical, thermal, electrical, or radioactive agents. **Penetrating** - Injury resulting from a projectile force, piercing instrument, entering deeply and causing tissue and/or organ injury.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

SITE/PLACE OF OCCURRENCE (Location E-Code)

OPTIONS: (Coded according to ICD-9-CM coding requirements)

- E849.0** = Home
- E849.1** = Farm
- E849.2** = Quarry and Mine
- E849.3** = Industrial Places and Premises
- E849.4** = Place for Recreation and Sport
- E849.5** = Street and Highway
- E849.6** = Public Building
- E849.7** = Residential Institution
- E849.8** = Other or Specified Places
- E849.9** = Unspecified Place

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Injury Site/Place of Occurrence - The description of the location at which the patient was injured. Relevant ICD-9-CM code value for injury event.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ICD-9 E-CODE

OPTIONS: 928.9 Unspecified Accident

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: E-code - An index to external causes of injury and poisoning organized by the main terms that describe the accident, circumstance, event, or specific agent that caused the injury or other adverse effect.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INJURY LOCATION COUNTY

OPTIONS: Not Available
Out of Country

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Injury County - The county in which the injury occurred.

NOTE: If the injury occurred in a foreign country outside the United States, use "Out of Country."

DATA ENTRY MODE: Auto-generated or Direct Entry.

POSITION

OPTIONS: Driver = Driver of motor vehicle other than motorcycle
Passenger = Passenger in motor vehicle other than motorcycle
Motorcycle Driver = Motorcyclist
Motorcycle Passenger = Motorcycle passenger
Other Specified = Other specified person
Pedal Cyclist = Bicyclist
Pedestrian
Ride Animal = Riding an animal or occupant of animal-drawn vehicle
Streetcar Occ = Occupant of a streetcar
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Position - Information related to the position of the patient within, on, or outside the vehicle

at the time of the injury.

DATA ENTRY MODE: Auto-generated or Direct Entry.

SAFETY EQUIPMENT

OPTIONS: 2 Point Belt = 2 Point Restraint Only
3 Point Belt = 3 Point Restraint Only
Airbag = Airbag Only
Airbag & Belt = Airbag and Seatbelt
Airbag Deployed
Car Seat = Infant/Child Car Seat
Eye Protection
Hard Hat
Helmet
None
Padding
Protective Clothing
Seatbelt = Seatbelt Only
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Safety Equipment - The safety device in use or worn by the patient at the time of injury.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INJURY LOCATION STATE

OPTIONS: UK = Unknown

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Injury State - The state in which the injury occurred.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: If the patient is homeless or a transient, in the street address field insert "homeless" or "transient," then fill in your hospital's city and state. The zip code should then be "00000."

INJURY ZIP CODE

OPTIONS: "00000" = Homeless/Transient
"99999" = Not Known/Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Injury Zip Code - Numeric postal code of the locale in which the injury occurred.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: If the patient is homeless or a transient, in the street address field insert "homeless" or "transient," then fill in your hospital's city and state. The zip code should then be "00000."

PREHOSPITAL

EMS PROVIDER ID

OPTIONS: Not Recorded
Non-EMS
Not Available
Not Able to Get EMS Report

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: EMS (Emergency Medical Services) ID - The EMS provider's unique ID number issued by the state licensing authority.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

RUN NUMBER

OPTIONS: Not Recorded
Non-EMS
Not Available
Not Able to Get EMS Report

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Ambulance Run Number - The preprinted ambulance run number on the trip sheet.

DATA ENTRY MODE: Auto-generated or Direct Entry.

SCENE EMS REPORT

OPTIONS: C = Complete
I = Incomplete
M = Missing
X = Not Available
U = Not Able to Get EMS Report

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: EMS Report - The completeness of the written EMS responder's report according to requirements detailed in Rule 64J-2.002(5), Florida Administrative Code. The EMS responder transports patient from the scene to the initial hospital.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

CONDITION AT SCENE

OPTIONS: Alert = Alert
Resp. to Pain = Responds to Painful Stimuli
Unresponsive = Unresponsive
Verbal Stimuli = Responds to Verbal Stimuli
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: AVPU - Neurologic evaluation from ATLS to establish the patient's level of consciousness (ATLS Course Manual).

A = Alert
V = Responds to Verbal Stimuli

P = Responds to Painful Stimuli
U = Unresponsive

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

DISPATCH DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Dispatch Date - The date of dispatch of EMS to treat/transport the patient to the initial hospital.

EMS (Emergency Medical Services) - The arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of emergency medical services required to prevent and manage incidents that occur because of a medical emergency or accident, natural disaster, or similar situation.

DATA ENTRY MODE: Auto-generated or Direct Entry.

DISPATCH TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Dispatch Time - The time the first responder was dispatched to the scene of the injury.

EMS (Emergency Medical Services) - The arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of emergency medical services required to prevent and manage incidents that occur because of a medical emergency or accident, natural disaster, or similar situation.

DATA ENTRY MODE: Auto-generated or Direct Entry.

SCENE ARRIVAL TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Scene Arrival Time - The time the first EMS responder arrived at the scene.

DATA ENTRY MODE: Auto-generated or Direct Entry.

PATIENT CONTACT TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Patient Contact Time - The time the first EMS responder was able to physically contact the patient to begin prehospital treatment.

DATA ENTRY MODE: Auto-generated or Direct Entry.

DEPART SCENE TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Depart Scene Time - The time the EMS left the scene with the patient.

EMS (Emergency Medical Services) - The arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of emergency medical services required to prevent and manage incidents that occur because of a medical emergency or accident, natural disaster, or similar situation.

DATA ENTRY MODE: Auto-generated or Direct Entry.

ARRIVAL TIME (AT INITIAL HOSPITAL)

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Arrival Time - The time the patient arrived at the first hospital. **Initial Hospital** - The hospital where the patient was initially given care or evaluated. This may be at your institution or at a referring hospital. The patient does not have to be admitted to the referring hospital.

DATA ENTRY MODE: Auto-generated or Direct Entry.

PULSE (RATE AT SCENE)

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6= Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Scene Pulse Rate - Rate of the heartbeat, measured in beats per minute. The patient's initial radial or apical pulse taken at the scene (field value range 0-300).

DATA ENTRY MODE: Auto-generated or Direct Entry.

PREHOSPITAL: RESPIRATORY RATE AT SCENE

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6= Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Respiratory Rate - The act of breathing, measured in spontaneous unassisted breaths per minute without the use of mechanical devices (field value range is 0-99).

DATA ENTRY MODE: Auto-generated or Direct Entry.

PREHOSPITAL: SYSTOLIC BLOOD PRESSURE AT SCENE

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6= Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Scene Systolic Blood Pressure - Maximum blood pressure occurring during contraction of ventricles. The first systolic blood pressure taken at the scene (field value range is 0-300).

DATA ENTRY MODE: Auto-generated or Direct Entry.

PREHOSPITAL: EYE RESPONSE AT SCENE

OPTIONS: 1 = Does Not Open Eyes
2 = Opens Eyes to Pain
3 = Opens Eyes to Commands
4 = Spontaneous Eye Opening
-4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Eye Response - Initial Glasgow Coma Scale for Eye Opening

4 = Spontaneous
3 = To voice
2 = To pain
1 = No response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Pediatric Glasgow Coma Scale for Infants and Children:

Child/Infant Eye Opening

4 = Spontaneous
3 = Verbal stimuli
2 = Pain
1 = No response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

VERBAL RESPONSE AT SCENE

OPTIONS: 5 = Oriented and converses
4 = Disoriented and converses
3 = Inappropriate words
2 = Incomprehensible sounds
1 = No Response
-4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Verbal Response at Scene - Scene Glasgow Coma Scale for Best Verbal Response.

Adult Response

5 = Oriented
4 = Confused
3 = Inappropriate words
2 = Incomprehensible words
1 = No response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Glasgow Coma Scale for Infants and Children:

Child Verbal Response

- 5 = Oriented, appropriate
- 4 = Confused
- 3 = Inappropriate cries
- 2 = Incomprehensible words
- 1 = No response

Infant Verbal Response

- 5 = Coos, babbles
- 4 = Irritable cries
- 3 = Cries to pain
- 2 = Moans to pain
- 1 = No response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

MOTOR RESPONSE AT SCENE

- OPTIONS:**
- 6 = Obeys Commands
 - 5 = Localizes Pain
 - 4 = Withdraws from Pain
 - 3 = Flexes to Pain
 - 2 = Extends to Pain
 - 1 = No Response
 - 4 = Not Recorded
 - 5 = Not Available
 - 6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Glasgow Coma Scale for Best Motor Response

- 6 = Obeys commands
- 5 = Localizes pain
- 4 = Withdraw (pain)
- 3 = Flexion (pain)
- 2 = Extension (pain)
- 1 = No response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Pediatric Glasgow Coma Scale for Infants and Children:**Child Motor Response**

- 6 = Obeys commands
- 5 = Localizes painful stimulus
- 4 = Withdraws in response to pain
- 3 = Flexion in response to pain
- 2 = Extension in response to pain
- 1 = No response

Infant Motor Response

- 6 = Moves spontaneously
- 5 = Withdraws to touch
- 4 = Withdraws in response to pain
- 3 = Decorticate posturing in response to pain
- 2 = Decerebrate posturing in response to pain
- 1 = No response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ASSESSMENT QUALIFIER FOR GCS AT THE SCENE

OPTIONS: T = Intubated
TP = Intubated and chemically paralyzed
S = Chemically sedated
L = Legitimate values, without interventions
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Scene GCS Assessment Qualifier - A qualifier that describes the interventions already performed at the time the calculated GCS components were assessed.

T = Patient intubated when GCS components assessed at scene.

TP = Patient intubated and chemically paralyzed when GCS components assessed at scene.

S = Patient chemically sedated when initial GCS components assessed at scene.

L = Initial GCS components at scene are legitimate values, without interventions such as intubation and sedation.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

SCENE CPR

OPTIONS: Scene & Route CPR = Both scene and en route CPR
En route CPR = CPR done en route
Scene CPR = CPR done at the scene
Not Performed
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: CPR (Cardiopulmonary Resuscitation) - Procedure for revival after cessation of cardiac or pulmonary activity.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

AIRWAY AT THE SCENE

OPTIONS: Bag & Mask = Assisted by Bag/Mask
Cricothyrotomy = Cricothyrotomy
EOA = Esophageal Obturator Airway
Nasal ETT = Nasal Endotracheal Tube
Oral = Oral Airway
Oral ETT = Oral Endotracheal Tube
Trach = Tracheostomy
Not Performed
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Airway Management - A device or procedure used to prevent or correct obstructed respiratory passage.

DATA MODE ENTRY: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Enter the most invasive airway adjunct used either at the scene or during transport to your ED.

FLUID MANAGEMENT AT SCENE

OPTIONS: < 500 ml = Less than 500 ml administered
500-2000 = 500 to 2000 ml administered
>2000 ml = Greater than 2000 ml administered
IVF Unk Amount = IV Fluids, Unknown Amount
Not Recorded
Not Performed
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Fluid Management - IV crystalloid only, not to include blood or blood products, administered at the scene of the injury and en route to the first hospital to which the patient was transported.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

NEEDLE THORACOSTOMY

OPTIONS: Performed
Not Performed
Not Available
Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Needle Thoracostomy - A procedure that uses a slender hollow instrument to create a surgical opening in the chest wall (as for drainage).

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

THORACENTESIS/TUBE THORACOSTOMY

OPTIONS: Performed
Not Performed
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Thoracentesis/Tube Thoracostomy - The surgical puncture of the chest wall into the parietal cavity for the aspiration of fluid, or the surgical opening of the chest into the parietal cavity for the placement of a drainage tube (i.e., chest tube).

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

PREHOSPITAL: GCS

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Glasgow Coma Scale (GCS) - A scale used to determine a score based on the total of three readings on the patient.

Eye

4 = Spontaneous
3 = To voice
2 = To pain

1 = No response

Verbal

5 = Oriented

4 = Confused

3 = Inappropriate words

2 = Incomprehensible sounds

1 = No response

Motor

6 = Obeys command

5 = Localizes pain

4 = Withdraws (pain)

3 = Flexion (pain)

2 = Extension (pain)

1 = No response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Pediatric Glasgow Coma Scale for Infants and Children:

Child Eye Opening

4 = Spontaneous

3 = Verbal stimuli

2 = Pain

1 = No response

Child Verbal Response

5 = Oriented, appropriate

4 = Confused

3 = Inappropriate cries

2 = Incomprehensible words

1 = No response

Child Motor Response

6 = Obeys commands

5 = Localizes painful stimulus

4 = Withdraws in response to pain

3 = Flexion in response to pain

2 = Extension in response to pain

1 = No response

Infant Eye Response

4 = Spontaneous

3 = Verbal stimuli

2 = Pain

1 = No response

Infant Verbal Response

5 = Coos, babbles

4 = Irritable cries

3 = Cries to pain

2 = Moans to pain

1 = No response

Infant Motor Response

6 = Moves spontaneously

5 = Withdraws to touch

4 = Withdraws in response to pain

3 = Decorticate posturing in response to pain

2 = Decerebrate posturing in response to pain

1 = No response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Pick-List.

REVISED TRAUMA SCORE (RTS) AT SCENE

OPTIONS: Valid Value, 0 to 12
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: The Revised Trauma Score - "is based on the values of the Glasgow Coma Scale (GCS), systolic blood pressure, and respiratory rate. Raw values are used for triage; coded values are weighted and summed for outcome evaluation (RTS)". Champion et al. *J Trauma*. 1989 May;31(5):624-629.

Raw values (displayed):

Glasgow Coma Scale total points

4 = 13-15

3 = 9-12

2 = 6-8

1 = 4-5

0 = 3

Respiratory Rate - Number of respirations in one minute

4 = 10-29

3 = >29

2 = 6-9

1 = 1-5

0 = 0

Systolic Blood Pressure

4 = >89

3 = 76-89

2 = 50-75

1 = 1-49

0 = 0

DATA ENTRY MODE: Auto-generated or Direct Entry.

PREHOSPITAL: EMS SCENE TIME

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Scene Time of EMS - The total number of minutes spent at the scene by the EMS.

DATA ENTRY MODE: Auto-generated or Direct Entry.

TRANSPORT TIME

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Transport Time of EMS - The total number of minutes it took the EMS to get from the scene of the incident to the first hospital.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: Transport time is displayed in total minutes.

REFERRING HOSPITAL

HOSPITAL TRANSFER

OPTIONS: N = No
Y = Yes
V = Not Recorded
X = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Referring Hospital - The hospital where the patient was given care before reaching your hospital. Admission to the referring hospital is not necessary.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ARRIVAL DATE AT REFERRING HOSPITAL

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Referring Hospital Arrival Date - The date of the patient's arrival at the referring hospital shown by mm/dd/yyyy. **Referring Hospital** - The hospital where the patient was given care before reaching your hospital. Admission to the referring hospital is not necessary.

DATA ENTRY MODE: Direct Entry.

ARRIVAL TIME AT REFERRING HOSPITAL

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Referring Hospital Arrival Time - The time the patient arrived at the referring hospital. **Referring Hospital** - The hospital where the patient was given care before reaching your hospital. Admission to the referring hospital is not necessary.

DATA ENTRY MODE: Direct Entry.

REFERRING HOSPITAL: TRANSFER TIME

OPTIONS: Auto-generated or Direct Entry.

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Transfer Time - The time it took to transfer from the referring hospital to the ED.

DATA ENTRY MODE: None. Only used as a data item in custom reports.

DISCHARGE DATE AT REFERRING HOSPITAL

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Referring Hospital - The hospital where the patient was given care before reaching your hospital. Admission to the referring hospital is not necessary. **Referring Hospital Discharge Date** - The date of the patient's discharge from the referring hospital shown by mm/dd/yyyy.

DATA ENTRY MODE: Direct Entry.

DISCHARGE TIME AT REFERRING HOSPITAL

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Referring Hospital Discharge Time - The time the patient was discharged from the referring hospital. **Referring Hospital** - The hospital where the patient was given care before reaching your hospital. Admission to the referring hospital is not necessary.

DATA ENTRY MODE: Direct Entry.

REFERRING HOSPITAL NAME

OPTIONS: Not Recorded
Not Available
Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Referring Hospital - The name of the referring hospital.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ED ADMISSION

DIRECT ADMISSION

OPTIONS: N = No
Y = Yes
V = Not Recorded
X = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Direct Admission - Admission to your hospital without being evaluated (other than vital signs) in the ED prior to going to the floor/ICU.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ARRIVAL/ADMIT DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Arrival/Admit Date - If the patient was not a direct admit, this is the date of the patient's arrival to your ED shown by mm/dd/yyyy. This information should be taken from your ER log system or ER documentation. If the patient was a direct admit (i.e., Direct Admit = "Y"), use this field to enter the date the patient was admitted to your institution.

DATA ENTRY MODE: Direct Entry.

ED ADMISSION: ARRIVAL/ADMIT TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Arrival/Admit Time - If the patient was not a direct admit, this is the time of the patient's arrival to your ED shown by using a military time format.

DATA ENTRY MODE: Direct Entry.

NOTE: If the patient was a direct admit (i.e., Direct Admit = "Y"), use this field to enter the time the patient was admitted to your institution.

ARRIVED FROM

OPTIONS: Clinic/MD Office
Home
Jail = Jail/Prison
Nursing Home
Refer Hospital
Scene = Scene of Injury
Supervised Living
Urgent Care
Not Available
Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Arrived From - The location where the patient was prior to arriving.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

NOTE: If the patient went home from the place of injury before arrival at your hospital, select "Home." If the injury occurred at home, select "Scene."

TRANSPORT

OPTIONS: ALS = Advance Life Support Ambulance
ALS/Helicopter = Advance Life Support Helicopter Ambulance
BLS = Basic Life Support Ambulance
BLS/Helicopter = Basic Life Support Helicopter
AIR Transport = Non-medical Helicopter/Other Air Transport
Law = Police
PV= Private Vehicle
Walk = Walk In
Other
NR = Not Recorded
NA = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Transport - The mode of transport by which the patient arrived in your ED.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

TRAUMA ALERT TYPE

OPTIONS: RED (single criterion)
BLUE (two criteria)
GCS ≤ 12
JUDGE (paramedic/EMT judgment)
HOSP (called in hospital after patient arrival and not by EMS)
LOCAL (local criteria)
NA (not an alert)
NR (Not Reported)

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITION: The type of trauma alert called in accordance with the state trauma scorecard criteria in Rules 64J-2.004 and 64J-2.005, Florida Administrative Code.

RED TRAUMA ALERT CRITERIA

OPTIONS: AIRWAY = Active airway assist beyond oxygen (pediatric includes manual adjuncts)
BP = Systolic BP < 90 (pediatric BP ≤ 50)
HR ≥ 120 = HR ≥ 120 without radial pulses
MR ≤ 4 = Motor Response ≤ 4 or total GCS ≤ 12
GCS ≤ 12 = Patient's Glasgow Coma Scale is equal to or less than 12
PENET = Penetrating injury to head, neck, or torso
PARALYSIS = Paralysis, suspicion of SCI, or loss of sensation
FX = 2 or more long bone fractures (pediatric = open fx or multi fx/dislocation)
AMP = Amputation to wrist or ankle
BURN = 2nd or 3rd degree burns ≥ 15% body (pediatric ≥ 10%)
JUDGE = EMS/ED provider judgment in absence of other criteria
ALTSTAT = Altered mental status (pediatric)
NOPULSE = Faint or non-palpable radial/femoral pulse
DEGLOVE = Major degloving or flap avulsion (pediatric only)
LOCAL (local criteria)
NA = Not Available
NR = Not Reported

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITION: The single criterion used to call a trauma alert as defined by the state trauma scorecard criteria in Rules 64J-2.004(2) and 64J-2.005(2), Florida Administrative Code.

BLUE 1 TRAUMA ALERT CRITERIA

OPTIONS: AGE = Age \geq 55

DEGLOVE = Major degloving injury or flap avulsion $>$ 5" in adult

MOI = Ejected from MV or impacted steering wheel

BMR = Best Motor Response = 5

GSW = Gunshot wound to extremity

HR = Sustained HR \geq 120 beats/min

FX = Long bone fx from MVA or fall (single closed long bone fx for pediatric)

RR = Respiratory rate \geq 30 in adult

PULSE = Carotid/femoral pulse but radial/pedal pulse not palpable in pediatric

HGT/WEIGHT = Pediatric patient weight of \leq 11 kg or length \leq 33"

BP $<$ 90 = Pediatric systolic BP $<$ 90

CONSCIOUSNESS = Suspected amnesia or loss of consciousness in pediatric

NA = Not Available

NR = Not Reported

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITION: The first criteria of two or more used to call a trauma alert as defined by the state trauma scorecard criteria in Rules 64J-2.004(3) and 64J-2.005(3), Florida Administrative Code.

BLUE 2 TRAUMA ALERT CRITERIA

OPTIONS: AGE = Age \geq 55

DEGLOVE = Major degloving injury or flap avulsion $>$ 5" in adult

MOI = Ejected from MV or impacted steering wheel

BMR = Best Motor Response = 5

GSW = Gunshot wound to extremity

HR = Sustained HR \geq 120 beats/min

FX = Long bone fx from MVA or fall (single closed long bone fx for pediatric)

RR = Respiratory rate \geq 30 in adult

PULSE = Carotid/femoral pulse but radial/pedal pulse not palpable in pediatric

HGT/WEIGHT = Pediatric patient weight of \leq 11 kg or length \leq 33"

BP $<$ 90 = Pediatric systolic BP $<$ 90

CONSCIOUSNESS = Suspected amnesia or loss of consciousness in pediatric

NA = Not Available

NR = Not Reported

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITION: The second criteria of two or more used to call a trauma alert (can not be the same as Blue1) as defined by the state trauma scorecard criteria in Rules 64J-2.004(3) and 64J-2.005(3), Florida Administrative Code.

COMPLAINT

OPTIONS: Accident = Other Mechanism
Aircraft
Animal = Injured By Animal
Assault = Assault/Abuse
ATV = Off Road Vehicle
Bicycle = Bicycle Crash
Burn
Crush = Crushing Injury
Electrical = Electrical Injury
Fall

GSW = Gunshot Wound
Hang = Hanging
Inhale = Exposure/Inhalation
Machine = Farm/Heavy Equipment Incident
Marine = Boating/Water Accident
Pedestrian = Motor Pedestrian Crash
Motorcycle Crash = Motorcycle Crash
MVC = Motor Vehicle Crash
Oth = Not listed
Rape
Scoot = Non ATV
Sports = Occurred while engaged in a sporting activity
Stab Wound
Struck = Struck by an object, non-motor vehicle related
Suicide
Weath = Weather related
NR = Not Recorded
NA = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Chief Complaint - The complaint of an external cause that resulted in pain or injury that caused the patient to come to the hospital.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry

CONDITION

OPTIONS: Alert
Verbal Stimuli = Responds to Verbal Stimuli
Resp. to Pain = Responds to Painful Stimuli
Unresponsive
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Arrival Condition - Neurologic evaluation from ATLS to establish the patient's level of consciousness (ATLS Course Manual).

A = Alert
V = Responds to Vocal Stimuli
P = Responds to Painful Stimuli
U = Unresponsive
ATLS = Advanced Training Life Support

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ED DISCHARGE DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: ED Discharge Date - The date of the patient's discharge from or death in your emergency department at your hospital shown by mm/dd/yyyy.

DATA ENTRY MODE: Direct Entry.

ED DISCHARGE TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time

-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: ED Discharge Time - The time the patient was discharged from your ED or the time of death.

DATA ENTRY MODE: Direct Entry.

LENGTH OF STAY

OPTIONS: Not Available/Not Recorded = -0.1 Hours

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Hours and Minutes in ED - Calculated according to HCIA conventions. Arrival/Admit Date is counted as day 1. Date of hospital discharge is not used.

DATA ENTRY MODE: Pick-List.

INSTRUCTIONS: The length of stay in hospital is calculated from the Arrival/Admit Date and the Hospital (or ED) Discharge Date.

TRAUMA TEAM (LEVEL 1, 2, OR 3) ACTIVATION

OPTIONS: N = Trauma Team was Not Activated
1 = Level 1
2 = Level 2
3 = Level 3
V = Not Recorded
X = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Trauma Team - "A group of health care professionals organized to provide care to the trauma patient in a coordinated and timely fashion." The leader of the team must be a "qualified surgeon," with specific composition of the team based on your institutional requirements (*Resources for Optimal Care of the Injured Patient 2006*).

Trauma Team Activation - Announcement of incoming trauma patient via pager system to assemble all members of the trauma team in the ED resuscitation area.

Level 1 - Highest level of team activation at your institution using defined trauma triage guidelines.

Level 2 - Secondary level of team activation, if applicable, at your institution, using defined trauma triage guidelines.

Level 3 - The last type of notification/communication to the Trauma Team as defined in the user's Tertiary Activation system plan.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

NOTE: If the registry software has the Level 1, 2, or 3 separated, you will need to submit all trauma team activation related fields.

TRAUMA TEAM (LEVEL 1, 2, OR 3) ACTIVATION TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Activation Time - The time that the trauma team was called (activated).

DATA ENTRY MODE: Direct Entry.

NOTE: If the registry software has the Level 1, 2, or 3 separated, you will need to submit all trauma team

activation related fields.

NEUROSURGEON ARRIVED

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Neurosurgeon - Attending neurosurgeon or “surgeon” who has special competence as judged by the Chief of Neurosurgery.

Neurosurgeon Arrived - The earliest time of the neurosurgeon's arrival at the patient's bedside, whether in the ED, OR, or ICU.

DATA ENTRY MODE: Direct Entry.

NEUROSURGEON CALLED

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Neurosurgeon - Attending neurosurgeon or “surgeon” who has special competence as judged by the Chief of Neurosurgery.

Time Neurosurgeon Called - The time at which the neurosurgeon's assistance was requested.

DATA ENTRY MODE: Direct Entry.

NEUROSURGEON RESPONSE TIME

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Neurosurgeon Response Time - How long did it take for the neurosurgeon to arrive?

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Calculates the time the patient had to wait for the neurosurgeon.

NEUROSURGICAL TRAUMA PHYSICIAN TIMELY

OPTIONS: Y = Yes
N = No
V = Not Recorded
X = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Neurosurgical Trauma Physician Timely - Indicates whether the neurosurgical trauma physician responded within an acceptable amount of time.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: This field can also be changed by Direct Entry.

ORTHOPEDIC SURGEON PRESENT

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Orthopedic Surgeon Present - The earliest time of the orthopedic surgeon's arrival at the patient's bedside, whether in the ED, OR, or ICU.

DATA ENTRY MODE: Direct Entry.

ORTHOPEDIC SURGEON CALLED

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Orthopedic Surgeon Called - The time at which the orthopedic surgeon's assistance was requested.

DATA ENTRY MODE: Direct Entry.

ORTHOPEDIC SURGEON RESPONSE TIME

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Orthopedic Surgeon Response Time - How long did it take for the orthopedic surgeon to arrive?

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Calculates the time the patient had to wait for the orthopedic surgeon.

ORTHOPEDIC SURGEON PHYSICIAN TIMELY

OPTIONS: Y = Yes
N = No
V = Not Recorded
X = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Orthopedic Trauma Physician Timely - Indicates whether the orthopedic trauma physician responded within an acceptable amount of time.

DATA ENTRY MODE: Auto-generated or Direct Entry.

TRAUMA SURGEON ARRIVED

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Trauma Surgeon - Trauma surgeon or fourth-year surgical resident.

Trauma Surgeon Present - The earliest time of the trauma surgeon's arrival at the patient's bedside, whether in the ED, OR, or ICU.

DATA ENTRY MODE: Direct Entry.

TRAUMA SURGEON CALLED

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.) valid military time

-4 = Not Recorded

-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Trauma Surgeon - Fourth-year surgical resident, or attending trauma surgeon.

Trauma Surgeon Called - The time at which the trauma surgeon was called.

DATA ENTRY MODE: Direct Entry.

NOTE: Surgeon times and trauma team activation data should be recorded when known and applicable to the patient. It is recognized that the trauma surgeon participates in trauma team activation. In those cases, trauma team activation and surgeon time called will be identical. Surgeon response, however, is independent of patient arrival and will differ from time elapsed.

TRAUMA SURGEON RESPONSE TIME

OPTIONS: -4 = Not Recorded

-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Trauma Surgeon Response Time - The number of minutes it took for the trauma surgeon to arrive in the ED after patient arrived or surgeon was notified about the trauma patient, whichever time was later.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: Response time is calculated by using the Trauma Surgeon Called time minus the Trauma Surgeon Response Time, with consideration of the Patient Arrival Time.

ED ASSESSMENT I

TEMPERATURE IN ED

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Temperature - The first reading of the patient's temperature in the ED. The acceptable range is 0-110 degrees Fahrenheit or 0-41 degrees Celsius.

DATA ENTRY MODE: Direct Entry.

SYSTOLIC BLOOD PRESSURE IN ED

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Systolic - First reading of maximum blood pressure occurring during contraction of ventricles. Valid range is 0-300.

DATA ENTRY MODE: Direct Entry.

PULSE RATE IN ED

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Pulse Rate - The first reading of the rate of the heartbeat, measured in beats per minute.

DATA ENTRY MODE: Direct Entry.

RESPIRATORY RATE IN ED

OPTIONS: -4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Respiration Rate - The first reading of the act of breathing, measured in spontaneous, unassisted breaths per minute without the use of a mechanical device. The valid range for this field is 0-99 breaths per minute.

DATA ENTRY MODE: Direct Entry.

RESPIRATORY RATE QUALIFIER

- OPTIONS:** T = Patient intubated
TP = Patient intubated and paralytics
S = Patient chemically sedated
L = Legitimate values
V = Not Recorded
X = Not Available
Z = Not performed

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: GCS Assessment Qualifier - A qualifier that describes the interventions performed at the time the manual GCS was assessed.

T = Patient intubated when GCS assessed at referring hospital.

TP = Patient intubated and chemically paralyzed when GCS assessed at referring hospital.

S = Patient chemically sedated when initial GCS assessed at referring hospital.

L = Initial GCS at referring hospital are legitimate values, without interventions such as intubation and sedation.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

EYE SCORE ON GCS IN ED

- OPTIONS:** 1 = Does Not Open Eyes
2 = Opens Eyes to Pain
3 = Opens Eyes to Commands
4 = Spontaneous Eye Opening
-4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: GCS - Glasgow Coma Scale for Eye Opening

4 = Spontaneous eye opening

3 = Opens eyes to voice

2 = Opens eyes to pain

1 = No Response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

**Modified Pediatric Glasgow Coma Scale for Infants and Children
Infant and Child Eye Opening**

4 = Spontaneous

3 = Verbal stimuli

2 = Pain

1 = No Response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

VERBAL SCORE ON GCS IN ED

- OPTIONS:** 1 = No Response
2 = Incomprehensible Sounds
3 = Inappropriate Words
4 = Disoriented and Converses
5 = Oriented and Converses
-4 = Not Recorded

- 5 = Not Available
- 6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: GCS - Glasgow Coma Scale for Best Verbal Response

- 5 = Oriented
- 4 = Confused
- 3 = Inappropriate words
- 2 = Incomprehensible words
- 1 = No Response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Pediatric Glasgow Coma Scale for Infants and Children

Child Verbal Response

- 5 = Oriented, appropriate
- 4 = Confused
- 3 = Inappropriate cries
- 2 = Incomprehensible words
- 1 = No Response

Infant Verbal Response

- 5 = Coos, babbles
- 4 = Irritable cries
- 3 = Cries to pain
- 2 = Moans to pain
- 1 = No Response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

MOTOR RESPONSE ON GCS IN ED

- OPTIONS:**
- 1 = No Response
 - 2 = Extends to Pain
 - 3 = Flexes to Pain
 - 4 = Moves to Pain
 - 5 = Localizes Pain
 - 6 = Follows Commands
 - 4 = Not Recorded
 - 5 = Not Available
 - 6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: GCS - Glasgow Coma Scale for Best Motor Response

- 6 = Obeys commands
- 5 = Localizes pain
- 4 = Withdraws (pain)
- 3 = Flexion (pain)
- 2 = Extension (pain)
- 1 = No Response

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Pediatric Glasgow Coma Scale for Infants and Children

Child Motor Response

- 6 = Obeys commands

- 5 = Localizes painful stimulus
- 4 = Withdraws in response to pain
- 3 = Flexion in response to pain
- 2 = Extension in response to pain
- 1 = No Response

Infant Motor Response

- 6 = Moves spontaneously
- 5 = Withdraws to touch
- 4 = Withdraws in response to pain
- 3 = Decorticate posturing in response to pain
- 2 = Decerebrate posturing in response to pain
- 1 = No Response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Enter the patient's radial or apical pulse on arrival in your ED. Do not use the cardiac monitor rate. The range for this field is 0-300.

ASSESSMENT QUALIFIER FOR GCS ON ED ARRIVAL

- OPTIONS:**
- T = Intubated
 - TP = Intubated and chemically paralyzed
 - S = Chemically sedated
 - L = Legitimate values, without interventions
 - V = Not Recorded
 - X = Not Available
 - Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: T = Patient intubated when GCS components assessed upon ED arrival.
 TP = Patient intubated and chemically paralyzed when GCS components assessed upon ED arrival.
 S = Patient chemically sedated when initial GCS components assessed upon ED arrival.
 L = Initial GCS components upon ED arrival are legitimate values, without interventions such as intubation and sedation.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

REVISED TRAUMA SCORE IN ED

- OPTIONS:**
- 4 = Not Recorded
 - 5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: The Revised Trauma Score - "is based on the values of the Glasgow Coma Scale, systolic blood pressure and respiratory rate. Raw values are used for triage: coded values are weighted and summed for outcome evaluation (RTS)." Unweighted RTS range is from 0 to 12. Weighted RTS values range from 0 to 7.8408. Champion et al. *J Trauma*. 1989 May;31(5):624-629.

Raw values (displayed):

Glasgow Coma Scale total points:

- 4 = 13-15
- 3 = 9-12
- 2 = 6-8
- 1 = 4-5
- 0 = 3

Respiratory Rate - Number of respirations in one minute

4 = 10-29

3 = >29

2 = 6-9

1 = 1-5

0 = 0

Systolic Blood Pressure

4 = >89

3 = 76-89

2 = 50-75

1 = 1-49

0 = 0

Calculated values for use in Ps equation:

$RTS = 0.9368 \text{ GCSc} + 0.7326 \text{ SBPc} + 0.2908 \text{ RRc}$.

DATA ENTRY MODE: Auto-generated or Direct Entry.

WEIGHTED REVISED TRAUMA SCORE

OPTIONS: -4 = Not Recorded

-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Calculated Weighted Revised Trauma Score (RTS) - The Weighted Revised Trauma Score is a weighted sum of the coded variable values of the Glasgow Coma Scale, respiratory rate, and systolic blood pressure. The Weighted RTS is used in the equation to calculate the Probability of Survival. The current weights for the value for GCS, respiratory rate, and systolic blood pressure are 0.9368, 0.2908, and 0.7326, respectively. These weights are multiplied by the actual value for the three variables to obtain components of the Weighted Revised Trauma Score. Champion et al., *J Trauma*. 1989 May;29(5):623-9.

DATA ENTRY MODE: Auto-generated or Direct Entry.

CPR MANAGEMENT IN ED

OPTIONS: ED CPR = CPR Performed in ED

Not Recorded

Not Available

Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: CPR (Cardiopulmonary Resuscitation) - Procedure for revival after cessation of cardiac or pulmonary activity.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

AIRWAY IN ED

OPTIONS: Bag & Mask = Assisted by Bag/Mask

Cricothyrotomy = Cricothyrotomy

EOA = Esophageal Obturator Airway

Nasal ETT = Nasal Endotracheal Tube

Oral = Oral Airway

Oral ETT = Oral Endotracheal Tube

Trach = Tracheostomy

None

Not Recorded

Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Airway Management - A device or procedure used to prevent or correct obstructed respiratory passage.

DATA MODE ENTRY: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Enter the level of airway assistance used in your ED.

UNITS OF BLOOD GIVEN IN ED

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Refers to the number of units of blood given to the patient in the first 24 hours after injury, including blood given at the referring hospital or in transport from the scene.

Units of Blood - Whole blood, packed red blood cells, auto-transfused or cell saver blood that does not include platelets, fresh frozen plasma, or cryoprecipitate.

DATA ENTRY MODE: Direct Entry.

ETOH

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Blood Alcohol Level - A measurement of ethyl alcohol in the bloodstream from a sample of serum obtained for laboratory examination. Two units of measurement are used, as follows:

- mg/dl with a range of 0-700.00

- mg/l with a range of 0-7000.00

DATA ENTRY MODE: Direct Entry.

BASE DEFICIT

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Base Deficit - Arterial blood gas component showing the degree of acid/base imbalance with a normal range being +/- 2 mEq/L. A valid base deficit value range is +/- 80.

DATA ENTRY MODE: Direct Entry.

BASE DEFICIT TIME DRAWN

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Base Deficit - Arterial blood gas component showing the degree of acid/base imbalance with a normal range being +/- 2 mEq/L. A valid base deficit value range is +/- 84.

Base Deficit Time Drawn: Time (military time) blood was drawn for determining the base deficit.

TOXICOLOGY/DRUG SCREEN

OPTIONS: Sedatives - Hypnotics:
Barbiturates:
Diazepam (Valium)
Meprobamate (Equanil, Miltown)
Opiates:
Codeine
Heroin
Methadone
Morphine
Stimulants - Amphetamines:
Cocaine
PCP
Tricyclic Antidepressants:
Amitriptyline (Elavil)
Imipramine (Tofanil)
Dexepin (Sinequan, Adapin)
Cannabis:
Marijuana
Hashish
Not Recorded
Not Available
Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Toxicology/Drug Screen - Laboratory test used to detect the presence of drugs in the patient's blood or urine.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Enter the drugs present when drug screening was performed in the ED. You may enter more than one drug. Do not include drugs given to the patient during any phase of resuscitation.

TOTAL GLASGOW COMA SCORE IN ED

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Glasgow Coma Scale - A scale used to determine a score based on the initial best sum of three components: eye opening, verbal response, and motor response. The Glasgow Coma Scale's components are listed below.

Eye

4 = Spontaneous
3 = To voice
2 = To pain
1 = No Response

Verbal

5 = Oriented
4 = Confused
3 = Inappropriate words
2 = Incomprehensible sounds
1 = No Response

Motor

6 = Obeys command
5 = Localizes pain
4 = Withdraws (pain)
3 = Flexion (pain)

2 = Extension (pain)

1 = No Response

Valid range for GCS = 3-15

Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, "Trauma Scoring", *Trauma*, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996.

Modified Pediatric Glasgow Coma Scale for Infants and Children

Child Eye Opening

4 = Spontaneous

3 = Verbal stimuli

2 = Pain

1 = No Response

Child Verbal Response

5 = Oriented, appropriate

4 = Confused

3 = Inappropriate cries

2 = Incomprehensible words

1 = No Response

Child Motor Response

6 = Obeys commands

5 = Localizes painful stimulus

4 = Withdraws in response to pain

3 = Flexion in response to pain

2 = Extension in response to pain

1 = No Response

Infant Eye Response

4 = Spontaneous

3 = Verbal stimuli

2 = Pain

1 = No Response

Infant Verbal Response

5 = Coos, babbles

4 = Irritable cries

3 = Cries to pain

2 = Moans to pain

1 = No Response

Infant Motor Response

6 = Moves spontaneously

5 = Withdraws to touch

4 = Withdraws in response to pain

3 = Decorticate posturing in response to pain

2 = Decerebrate posturing in response to pain

1 = No Response

Modified from Davis RJ et al: Head and spinal cord injury. In: Rogers MC, *Textbook of Pediatric Intensive Care*, Baltimore, MD, Williams and Wilkins, 1987.

DATA ENTRY MODE: Auto-generated or Direct Entry.

ED ASSESSMENT II

HEAD CT SCAN RESULTS

OPTIONS: Negative = No Significant Finding

Positive = Significant Positive Finding, showing actual injury to brain only, not to include the bony structures or face.

Not Applicable

Not Performed

Not Available

Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Head - Portion of the body that contains the brain and organs of sight, smell, hearing, and taste.

CT Scan (Computerized Axial Tomography) - A diagnostic procedure that utilizes a computer to analyze X-ray data.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

HEAD CT DATE

OPTIONS: MM/DD/YYYY

“Blank” = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Head CT Date - The date that the first head CT scan was completed.

DATA ENTRY MODE: Direct Entry.

HEAD CT TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time

-4 = Not Recorded

-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Head CT Time - The time that the first head CT was documented.

DATA ENTRY MODE: Direct Entry.

ABDOMINAL CT SCAN RESULTS

OPTIONS: Negative = Negative

Positive = Positive, showing injury to abdominal organ. Injury to bony structures irrelevant.

Not Performed

Not Available

Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abdomen - Portion of the body that lies between the chest and the pelvis.

CT Scan (Computerized Axial Tomography) - A diagnostic procedure that utilizes a computer to analyze X-ray data.

DATA ENTRY MODE: Direct Entry.

ABDOMINAL CT DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abdominal CT Date - The date that the first abdominal CT was performed.

DATA ENTRY MODE: Direct Entry.

ABDOMINAL CT TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abdominal CT Time - The time that the abdominal CT scan was documented.

DATA ENTRY MODE: Direct Entry.

ABDOMINAL ULTRASOUND RESULTS

OPTIONS: Negative = No Significant Finding
Positive = Significant Positive Finding, showing actual injury to abdominal organ(s) only, not to include the bony structures.
Not Performed
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abdominal Ultrasound - The diagnostic use of ultrasonic waves directed to the abdomen for imaging of internal body structures and the detection of bodily abnormalities.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ABDOMINAL ULTRASOUND DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abdominal Ultrasound Date - The date that the first abdominal ultrasound was performed.

DATA ENTRY MODE: Direct Entry.

ABDOMINAL ULTRASOUND TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abdominal Ultrasound Time - The time that the first abdominal ultrasound was documented.

DATA ENTRY MODE: Direct Entry.

CHEST CT RESULTS

OPTIONS: Negative = No Significant Finding
Positive = Significant Positive Finding, showing actual injury to chest organ(s) or structure(s),
not to include the bony structures.
Not Performed
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Chest Computerized Tomography (CT) - A diagnostic procedure that utilizes a computer to analyze X-ray data of the patient's chest.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

CHEST CT DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Chest CT Date - The date that the first chest CT was performed.

DATA ENTRY MODE: Direct Entry.

CHEST CT TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Chest CT Time - The time that the first chest CT was documented.

DATA ENTRY MODE: Direct Entry.

DIAGNOSTIC PERITONEAL LAVAGE RESULTS

OPTIONS: Negative
Positive
Not Performed
Not Available
Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Peritoneal Lavage - Washing out of the peritoneal cavity with a fluid. **Peritoneal Cavity** - Region bordered by parietal layer of the peritoneum containing all the abdominal organs exclusive of the kidneys.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

PERITONEAL LAVAGE DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Peritoneal Lavage Date - The date that the first peritoneal lavage was performed.

DATA ENTRY MODE: Direct Entry.

PERITONEAL LAVAGE TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Peritoneal Lavage Time - The time that the first peritoneal lavage was documented.

DATA ENTRY MODE: Direct Entry.

AORTOGRAM RESULTS

OPTIONS: Negative = The aorta is free from injuries resulting from traumatic event.
Positive = The aorta has identifiable injuries as a result of the traumatic event.
Not Performed
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Aortogram - The roentgenographic visualization of the aorta after injection of a radiopaque substance.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

AORTOGRAM DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Aortogram Date - The date of the first aortogram performed.

DATA ENTRY MODE: Direct Entry.

AORTOGRAM TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Aortogram Time - The time that the first aortogram was documented.

DATA ENTRY MODE: Direct Entry.

ARTERIOGRAM/ANGIOGRAM RESULTS

OPTIONS: Negative
Positive
Not Recorded
Not Performed
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Arterio/Angiogram - X-ray film of all blood vessels (angiogram) and arteries (arteriogram) after the injection of a dye.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ARTERIOGRAM/ANGIOGRAM DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Arteriogram/Angiogram Date - The date of the first arteriogram/angiogram.

DATA ENTRY MODE: Direct Entry.

ARTERIOGRAM/ANGIOGRAM TIME

OPTIONS: 00:00 (midnight) through 23:59 (11:59 p.m.), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Arteriogram/Angiogram Time - The time that the first arteriogram/angiogram was documented.

DATA ENTRY MODE: Direct Entry.

ADMITTING SERVICE

OPTIONS: Burn = Burn Care Specialist
Cardiology = Cardiology
ENT = Ear, Nose, & Throat Specialist
Gen Surgery = General Surgery
Hand = Hand-Ortho Surgery
Neuro = Neurosurgery
Ophtha = Ophthalmology
Ortho = Orthopedics
Peds = General Pediatrics
Plastics = Plastic Surgery
Trauma = Trauma Surgery
Urology = Urology
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Admitting Service - The service to which the patient is designated upon admission to your hospital or, in the case of death in the ED, the service that gave the patient primary care in the ED.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ED DISPOSITION OF THE PATIENT

OPTIONS: DOA (Death) = Dead on Arrival
Death = Death in ED
Floor = Admitted to Floor Bed
Home = Discharged Home
ICU = Admitted to ICU
OR
Radiology
Telemetry = Monitored Telemetry Bed
Transfer = Transferred to Other Hospital
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: ED Disposition - The location of the patient following treatment in the ED.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

OR DISPOSITION

OPTIONS: DOA (Death)
Floor
ICU
Not Available
Not Done/Documented
Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: OR Disposition - The disposition of the patient from the operating room, if the patient went directly to the OR from the ER.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

HOSPITAL DIAGNOSES

AIS CODE

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: AIS Code - The following is excerpted from *The Abbreviated Injury Scale*, 1990 Revision, with the permission of the Association for the Advancement of Automotive Medicine:

The appropriate classification of injuries by type and severity is fundamental to the study of injury etiology. Scales for categorizing injuries are grouped into two types: scales which assess the patient's physiological status, which may change over the duration of the injury's treatment period, and those which describe the injury in terms of its anatomical location, specific lesion and relative severity.

USING THE DICTIONARY

FORMAT

The AIS dictionary is divided, for convenience, into nine sections in the following order: Head (Cranium and Brain), Face, Neck, Thorax, Abdomen and Pelvic Contents, Spine, Upper Extremity, Lower Extremity, External and Other. These sections are different from the six body regions used to calculate the ISS described below. These differences should be carefully noted to avoid errors in assigning injuries to the appropriate body region for calculating the ISS. Within each section, except the Spine and External, Burns, Other Trauma, injury descriptions are alphabetized by specific anatomical part and categorized in the following order: Whole Area, Vessels, Nerves, Internal Organs, Skeletal. In addition, Upper and Lower Extremities have a section on Muscles, Tendons, Ligaments. In most cases, the severity level in each anatomical category goes from least severe to most severe. Each injury description has been assigned a unique 7-digit numerical code. The single digit to the right of the decimal point is the AIS number, according to the following severity code: AIS Code 1 - Minor, AIS Code 2 - Moderate, AIS Code 3 - Serious, AIS Code 4 - Severe, AIS Code 5 - Critical, AIS Code 6 - Maximum, AIS Code 9 - Unknown.

GENERAL CODING RULES

A number of coding principles, however, applies across body regions. The rules that follow should be learned and applied.

1. Injuries described as "probable," "possible," "impression of," or "rule out" should not be coded unless they are substantiated in the medical record.
2. Foreign bodies are not injuries and therefore are not coded.
3. The AIS does not assign codes to consequences of injury (e.g., blindness) but rather to injury per se (e.g. optic nerve avulsion).
4. Surgical procedures and other treatment interventions should not be used to determine the severity of an injury.
5. AIS 6 is used only for injuries specifically assigned severity level 6 in the AIS. The use of AIS 6 is not an arbitrary choice simply because the patient died.
6. The "crush" injury description is used only when the injury meets the criteria in the dictionary.
7. Bilateral injuries are coded separately for organs such as the kidneys, eyes, ears, and extremities unless the dictionary specifically allows for coding as a single injury (e.g., lung injuries). Maxillae, mandibles, the pelvis and ribcage are coded as single structures.
8. An open fracture, by definition, means that the skin overlaying the fracture is lacerated. The external laceration is implicit in the code for open fracture and is not coded separately.
9. AIS 90 uses "not further specified" (NFS) to allow for coding injuries when detailed information is lacking. Injury unspecified means that an injury has occurred to a specific organ or body part, but the precise injury type is not known. For example, a kidney injury could be a contusion or a laceration, but this information may not be available. In this example, the kidney injury is coded as NFS. 99 is assigned to an injury NFS as to lesion or severity. Severity unspecified means that a specific injury (e.g. laceration) has occurred, but the level of severity is not specifically given or is unclear. In this example, the injury should be coded as laceration NFS. To the extent possible with the organizational framework of the AIS, 00 is assigned to an injury NFS as to severity. Use of NFS should not be confused with code 9, which is assigned in those

cases where trauma has occurred but no information is available regarding specific organ or region. For example, “blunt abdominal trauma” is assigned a Code 9.

10. If there is any question about the severity of an injury based upon all available documented information, code conservatively (i.e. the lowest AIS code in that injury's category).

11. Estimating Blood Loss -- A number of injuries to the skin, vessel lacerations, brain lesions, and internal organs are described in terms of blood loss by volume. The following table should help in assessing blood loss when information in the hospital chart is not specific, and in coding these injuries in children.

Weight 20% Blood loss Pounds KG CC 220 100 1500 165 75 1125 110 50 750 55 25 375 22 10 150 11 5 75 [All of the above is excerpted from *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL, pp.9 -13.]

For assistance with AIS coding questions: Association for the Advancement of Automotive Medicine, 2340 Des Plaines River Road, Suite 106, Des Plaines, IL 60018.

DATA ENTRY MODE: Direct Entry or Multiple Item Pick-List.

AIS ABDOMEN

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abbreviated Injury Scale (AIS) - “A consensus-derived, anatomically-based system that classifies individual injuries by body region on a 6-point ordinal severity scale ranging from AIS 1 (minor) to AIS 6 (currently untreatable).” *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL.

DATA ENTRY MODE: Auto-generated or Direct Entry.

NOTE: The AIS score is automatically entered into the appropriate body region as the diagnoses are selected from the AIS90 codes.

AIS CHEST

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abbreviated Injury Scale (AIS) - “A consensus-derived, anatomically-based system that classifies individual injuries by body region on a 6-point ordinal severity scale ranging from AIS 1 (minor) to AIS 6 (currently untreatable).”

Injury Severity Score (ISS) - “The ISS is a sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. The six body regions of injury used in the ISS are: those for Head, Face, Chest, Abdominal or Pelvic contents, Extremities or Pelvic girdle and External.” *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL.

DATA ENTRY MODE: Auto-generated or Direct Entry.

INSTRUCTIONS: The score is taken directly from AIS90.

AIS EXTREMITIES

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abbreviated Injury Scale (AIS) - “A consensus-derived, anatomically-based system that classifies individual injuries by body region on a 6-point ordinal severity scale ranging from AIS 1 (minor) to AIS 6 (currently untreatable).” *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL.

DATA ENTRY MODE: Auto-generated or Direct Entry.

INSTRUCTIONS: The score is taken directly from AIS90.

AIS FACE

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abbreviated Injury Scale (AIS) - "A consensus-derived, anatomically-based system that classifies individual injuries by body region on a 6-point ordinal severity scale ranging from AIS 1 (minor) to AIS 6 (currently untreatable)." *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL.

DATA ENTRY MODE: Auto-generated or Direct Entry.

INSTRUCTIONS: The score is taken directly from AIS90.

AIS HEAD/NECK

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abbreviated Injury Scale (AIS) - "A consensus-derived, anatomically-based system that classifies individual injuries by body region on a 6-point ordinal severity scale ranging from AIS 1 (minor) to AIS 6 (currently untreatable)." *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL.

DATA ENTRY MODE: Auto-generated or Direct Entry.

INSTRUCTIONS: The score is taken directly from AIS90.

AIS90 AIS

OPTIONS: 0-9

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Last digit of AIS90 code.

DATA ENTRY MODE: Auto-generated or Direct Entry.

CALCULATED AIS SKIN/SOFT TISSUE (EXTERNAL)

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Abbreviated Injury Scale (AIS) - "A consensus-derived, anatomically-based system that classifies individual injuries by body region on a 6-point ordinal severity scale ranging from AIS 1 (minor) to AIS 6 (currently untreatable)." *The Abbreviated Injury Scale*, 1990 Revision, Association for the Advancement of Automotive Medicine, Des Plaines, IL.

DATA ENTRY MODE: Direct Entry.

INSTRUCTIONS: The score is taken directly from AIS90.

AIS BODY

OPTIONS: 0000-9999

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: First four digits of AIS code.

DATA ENTRY MODE: Auto-generated or Direct Entry.

DX NUMBER

OPTIONS: 1-99

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Diagnosis Number - Position number that corresponds to the relative ICD-9 diagnosis code. Position #1 must correspond with the primary diagnosis. Diagnoses may be moved around, changing their number and relative importance.

DATA ENTRY MODE: Auto-generated or Direct Entry.

ICD-9 CODE

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: International Classification of Diseases (ICD-9) - Index to diseases and injuries. Diagnosis codes, or D codes, contain "terms referring to diseases (categories 001-799), injuries (categories 800-899, excluding poisonings by drugs and chemicals [categories 960-989]), the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (categories V01-V82), and morphology of neoplasms (M codes)." Source: *ICD-9-CM, The International Classification of Diseases, 9th Revision, Clinical Modification, Fifth Edition*, Context Software Systems, Inc., New York, McGraw-Hill, Inc., 1996, p. xviii. For assistance with coding questions: American Hospital Association, Clearinghouse for ICD-9-CM, 1 N. Franklin St., Chicago, IL 60606.

DATA ENTRY MODE: Direct Entry or Multiple Item Pick-List.

INSTRUCTIONS: All ICD-9 diagnosis codes must be coded for the patient with the primary diagnosis in the first position.

INJURY SEVERITY SCORE (ISS)

OPTIONS: 1-75
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Injury Severity Score (ISS) - "The ISS is a sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. The six body regions of injury used in the ISS are: those for Head, Face, Chest, Abdominal or Pelvic contents, Extremities or Pelvic girdle and External." Baker SP, O'Neill B, Haddon W, Long WB, *The Injury Severity Score: A method for describing patients with multiple injuries and evaluating emergency care. J Trauma.* 1974;14:187-196.

DATA ENTRY MODE: Auto-generated or Direct Entry.

PRE-EXISTING COMORBIDITY

COMORBIDITY CODE

OPTIONS: A.01 = History of Cardiac Surgery
A.02 = Coronary Artery Disease
A.03 = Congestive Heart Failure
A.04 = Cor Pulmonale
A.05 = Myocardial Infarction
A.06 = Hypertension
B.01 = Insulin Dependent
B.02 = Insulin Non-dependent
C.01 = Peptic Ulcer Disease
C.02 = Gastric or Esophageal Varices
C.03 = Pancreatitis
C.04 = Inflammatory Bowel Disease
D.01 = Acquired Coagulopathy
D.02 = Coumadin Therapy
D.03 = Hemophilia
D.04 = Pre-existing Anemia
E.00 = History of Psychiatric Disorders
F.01 = HIV/AIDS
F.02 = Routine Steroid Use
F.03 = Transplants
F.04 = Active Chemotherapy
G.01 = Bilirubin > 2mg % (on admission)
G.02 = Documented History of Cirrhosis
G.03 = Transplants
G.04 = Active Chemotherapy
H.01 = Undergoing Current Therapy
H.02 = Concurrent or Existence of Metastasis
I.01 = Rheumatoid Arthritis
I.02 = Systemic Lupus Erythematosus
J.01 = Spinal Cord Injury
J.02 = Multiple Sclerosis
J.03 = Alzheimer's Disease
J.04 = Seizures
J.05 = Chronic Demyelinating Disease
J.06 = Chronic Dementia
J.07 = Organic Brain Syndrome
J.08 = Parkinson's Disease
J.09 = CVA/Hemiparesis (Stroke with residual)
K.00 = Obesity
L.01 = Documented prior history of pulmonary disease with ongoing active treatment
L.02 = Asthma
L.03 = Chronic Obstructive Pulmonary Disease
L.04 = Chronic Pulmonary Condition
M.01 = Serum Creatinine > 2mg % (on admission)
M.02 = Dialysis (excludes transplant patients)
N.01 = Chronic Drug Abuse
N.02 = Chronic Alcohol Abuse
None = Not Available
P.00 = Pregnancy

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITION: Comorbidity Code - The code number assigned by the ACS Committee on Trauma to a comorbidity factor.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

PROCEDURES

DATE OF PROCEDURE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Date of Procedure - The date the patient underwent an operation/procedure shown by mm/dd/yyyy.

DATA ENTRY MODE: Direct Entry.

ICD-9 PROCEDURE CODE

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: P Codes or Procedure Codes - Provide a "...classification of a different mode of therapy, e.g., surgery, radiology, and laboratory procedures." Source: *ICD-9-CM, The International Classification of Diseases, 9th Revision, Clinical Modification*, Context Software Systems, Inc., New York, McGraw-Hill, Inc., 1996, p. vi.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

OPERATIVE LOCATION

OPTIONS: ED
Floor
ICU
OR
Radiology
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Operative Location - The place in which the procedure was performed, such as the operating room, radiology, endoscopy, ICU bedside, or the emergency room.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

TIME OF PROCEDURE

OPTIONS: 00:00 (midnight) through 23:59 (11:59), valid military time
-4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Time of Procedure - Time at which the patient underwent a procedure, expressed in military format.

DATA ENTRY MODE: Direct Entry.

COMPLICATIONS

PEER REVIEW JUDGMENT OF A COMPLICATION

OPTIONS: A = Acceptable
F = Defer Peer Review
U = Unacceptable
R = Acceptable with Reservations
W = Record will never go to Peer Review
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Judgment - Outcome of peer review of a complication.

Acceptable - Acceptable complication given the patient's course of disease, determined by peer review.

Unacceptable - Complication determined unacceptable by peer review, further follow-up needed.

Acceptable with Reservations - Acceptable complication with noted exceptions as determined by peer review process. Further explanation field should document the issue(s) discussed during the peer review process.

Peer Review - In-depth review of patient record by physician or nurse not directly involved in the patient's care.

Defer Peer Review - The patient record will not be brought forth for peer review.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

COMPLICATION CODE

OPTIONS: -4= Not Recorded
-5= Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Registry Software Code - Individual numeric code assigned to each complication listed in *Resources for the Optimal Care of the Injured Patient 1993*.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

PERFORMANCE IMPROVEMENT

PEER REVIEW JUDGMENT OF A PERFORMANCE IMPROVEMENT

OPTIONS: A = Acceptable
D = Not Done/Not Documented (Record will not undergo peer review)
P = Pending (Record has yet to complete peer review)
R = Acceptable with reservations
U = Unacceptable
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

Options for Trauma Death Performance Improvement Indicator:

PR = Preventable
PP = Potentially Preventable
NP = Non-preventable
V = Not Recorded
X = Not Available

DEFINITIONS: Judgment - Outcome of peer review of a performance improvement indicator.

Acceptable - Acceptable performance improvement indicator as determined by peer review.

Unacceptable - Performance improvement indicator determined unacceptable by peer review, further follow-up needed.

Acceptable with Reservations - Performance improvement indicator is acceptable with noted exceptions as determined by peer review process. Further explanation field should document the issue(s) discussed during the peer review process.

Peer Review - In-depth review of patient record by physician or nurse not directly involved in the patient's care.

Preventable - The trauma death is found to be preventable as determined by peer review. Further explanation should document the issue(s) discussed during the peer review process.

Potentially Preventable - The trauma death is found to be potentially preventable as determined by peer review. Further explanation field should document the issue(s) discussed during the peer review process.

Non-preventable - The trauma death is found to be non-preventable as determined by peer review.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

HOSPITAL OUTCOME

CIRCUMSTANCES OF DEATH

OPTIONS: Treatment Withheld
Burn Shock
Pulmonary Failure
Cardiovascular Failure
Multiple Organ Failure/Meta. = Multiple Organ Failure/Metabolic
Pre-existing Illness
Pending
Sepsis
Sepsis, Burn Wound
Sepsis, Trauma Wound
Trauma Shock
Trauma Wound
Other
Not Available
Not Performed
Not Recorded (Default)

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Circumstances of Death - This field is only applicable if you have indicated that the patient died. It is then used to indicate the cause of death. It is appreciated that in many instances this will require the user's judgment, as the exact cause of death may be unknown. If the cause is thought to be something that is not listed here, enter OTHER.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

INSTRUCTIONS: Enter the Patient's cause of death or "Other" if not listed.

DAYS IN HOSPITAL

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Days in Hospital is calculated according to HCIA conventions. Arrival/Admit Date is counted as day 1.

DATA ENTRY MODE: Auto-generated or Direct Entry.
NOTE: Hospital days are expressed in numerical terms.

TOTAL DAYS IN THE ICU

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: ICU - Any unit with a nurse-to-patient ratio of 1:1 or 1:2.

DATA ENTRY MODE: Direct Entry.

DEATH LOCATION

OPTIONS: ED = Emergency Department
Floor = General Nursing Unit
ICU = Intensive Care Unit
PICU = Pediatric Intensive Care Unit
PTA = Prior to Arrival
OR = Operating Room
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Death Location - The place or site in which the patient's vital functions ceased permanently.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

DISCHARGE DATE

OPTIONS: MM/DD/YYYY
"Blank" = Not Available/Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Discharge Date - The date of discharge from your hospital.

DATA ENTRY MODE: Direct Entry.

FIM EXPRESSION SCORE

OPTIONS: 4 = Independent
3 = Independent with Device
2 = Dependent - Partial Help Required
1 = Dependent - Total Help Required
8 = Not Applicable
9 = Unknown
-4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: FIM (Functional Independence Measure) - A score calculated to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression).

Motor (Expression) - Includes clear expression of verbal or nonverbal language. This means expressing linguistic information verbally or graphically with appropriate and accurate meaning and grammar.

4 = Independent: Expresses complex or abstract ideas intelligibly and fluently, verbally or non-verbally, including signing or writing.

3 = Independent with Device: Expresses complex or abstract ideas with mild difficulty. May require an augmentative communication device or system.

2 = Dependent - Partial Help Required: Expresses basic needs and ideas about everyday situations half (50%) or more than half of the time. Requires some prompting, but requires that prompting less than half (50%) of the time.

1 = Dependent - Total Help Required: Expresses basic needs and ideas less than half of the time. Needs prompting more than half the time or does not express basic needs appropriately or consistently despite prompting.

8 = Not Applicable: e.g., patient less than 7 years old, patient died.

9 = Unknown

Source: *Centers for Disease Control Trauma Registry Coding Guide*, June 1989.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

STATUS OF FIM EXPRESSION SCORE

OPTIONS: T = Temporary
P = Permanent
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **FIM** only applies to those patients greater than 7 years of age. "D" should be used for those patients 7 years of age and under or those patients who died. These assumptions will be updated as additional clarifications are obtained from the CDC.

Status of FIM Expression score - Indication whether the Expression of FIM score is temporary or permanent.

Temporary will be defined as likely to improve.

Permanent will be defined as unlikely to improve.

Source: *Centers for Disease Control Trauma Registry Coding Guide*, June 1989.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

FIM LOCOMOTION SCORE

OPTIONS: 4 = Independent
3 = Independent with Device
2 = Dependent - Partial Help Required
1 = Dependent - Total Help Required
8 = Not Applicable
9 = Unknown
-4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **FIM (Functional Independence Measure)** - A score calculated to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression).

Locomotion (Independence) - Includes walking once in a standing position, or using a wheelchair, once in a seated position, indoors.

4 = Independent: Walks a minimum of 150 feet without assisting devices. Does not use a wheelchair. Performs safely.

3 = Independent with Device: Walks a minimum of 150 feet but uses a brace (orthosis) or prosthesis on leg, special adaptive shoes, cane, crutches, or walkerette; takes more than a reasonable time; or there are safety considerations. If not walking, operates manual or electric wheelchair independently for a minimum of 150 feet; turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; maneuvers on rugs and over door sills.

2 = Dependent - Partial Help Required: If walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet, or walks independently only short distances (a minimum of 150 feet). If not walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet in wheelchair, or operates manual or electric wheelchair independently only short distances (a minimum of 50 feet).

1 = Dependent - Total Help Required: Expresses basic needs and ideas less than half of the time. Needs prompting more than half the time or does not express basic needs appropriately or consistently despite prompting.

8 = Not Applicable: e.g., patient less than 7 years old, patient died.

9 = Unknown

Source: *Centers for Disease Control Trauma Registry Coding Guide*, June 1989.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

STATUS OF FIM LOCOMOTION SCORE

OPTIONS: T = Temporary
P = Permanent
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **FIM** only applies to those patients greater than 7 years of age. "D" should be used for those patients 7 years of age and under or those patients who died. These assumptions will be updated as additional clarifications are obtained from the CDC.

Status of FIM Locomotion Score - Indication whether the Locomotion of FIM score is temporary, permanent, not recorded, not available, or not performed.

Temporary will be defined as likely to improve.

Permanent will be defined as unlikely to improve.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

FIM SELF-FEEDING SCORE

OPTIONS: 4 = Independent
3 = Independent with Device
2 = Dependent - Partial Help Required
1 = Dependent - Total Help Required
8 = Not Applicable
9 = Unknown
-4 = Not Recorded
-5 = Not Available
-6 = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: **FIM (Functional Independence Measure)** - A score calculated to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression).

Feeding - Assess as close to discharge as possible. Includes using suitable utensils to bring food to mouth, chewing, and swallowing (once meal is appropriately prepared). Opening containers, cutting meat, buttering bread and pouring liquids are not included as they are often part of meal preparation.

4 = Independent: Eats from a dish and drinks from a cup or glass presented in the customary manner on table or tray. Uses ordinary knife, fork, and spoon.

3 = Independent with Device: Uses an adaptive or assisting device such as a straw, spork, or rocking knife or requires more than a reasonable time to eat.

2 = Dependent - Partial Help Required: Performs half or more of feeding tasks but requires supervision (e.g., standby, cueing, or coaxing), setup (application of orthotics), or other help.

1 = Dependent - Total Help Required: Either performs less than half of feeding tasks, or does not eat or drink full meals by mouth and relies at least in part on other means of alimentation, such as parenteral or gastrostomy feedings.

8 = Not Applicable: e.g., patient less than 7 years old, patient died.

9 = Unknown

Source: *Centers for Disease Control Trauma Registry Coding Guide*, June 1989.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

STATUS OF FIM SELF-FEEDING SCORE

OPTIONS: T = Temporary
P = Permanent
V = Not Recorded
X = Not Available
Z = Not Performed

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: FIM (Functional Independence Measure) only applies to those patients greater than 7 years of age. "D" should be used for those patients 7 years of age and under or those patients who died. These assumptions will be updated as additional clarifications are obtained from the CDC.

Status of FIM Self-Feeding Score - Indication whether the Self-feeding of FIM score is temporary, permanent, not recorded, or not available.

Temporary will be defined as likely to improve.

Permanent will be defined as unlikely to improve.

Source: *Centers for Disease Control Trauma Registry Coding Guide*, June 1989.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

CALCULATED FIM SCORE

OPTIONS: -5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: FIM (Functional Independence Measure) - A score calculated to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression).

DATA ENTRY MODE: Auto-generated or Direct Entry.

HOSPITAL DISPOSITION

OPTIONS: Death = Death in Hospital
DOA (Death) = Dead on Arrival in ED
Died During Tre = Died During Treatment
Home = Discharged Home
Discharged, SNF = Discharged Extended Care Facility
Home Health = Home Health
Jail = Jail or Prison
Nursing Home = Nursing Home
Rehab = Rehabilitation Center
Transfer = Transferred to Another Hospital
Transfer, Acute Burn = Transferred to an Acute Burn Facility
Unable to Comp = Unable to Complete Treatment
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Hospital Disposition - The place to which the patient was released when discharged from your hospital.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

ORGAN DONATION

OPTIONS: Y = Yes, organs were donated
N = No, organs were not donated

V = Not Recorded
X = Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Organ Donation - To make a gift of a differentiated structure (as a heart, kidney, leaf, or stem) consisting of cells and tissues and performing some specific function in an organism.

DATA ENTRY MODE: Direct Entry.

VENTILATOR SUPPORT DAYS

OPTIONS: 0 to 999 = Days of Ventilator Support
-1 = Not Done/Not Documented
-3 = Pending
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Ventilator Support Days - This field is used to indicate the number of days that the patient required ventilator support. This number is used as a rough approximation of the number of days of critical care.

Ventilator Support - Ventilator assistance that involves maintenance of an airway with active mechanical ventilation. This would include all intubated patients on ventilators, or patients with tracheostomies while on mechanical ventilation (trached patients breathing on flow-bys would not count). Patients breathing mask oxygen also would not count here. Patients intubated for only part of a day for a surgical procedure do not count. These distinctions are arbitrary, but if used consistently, should provide some indication of acuity for each patient.

DATA ENTRY MODE: Direct Entry.

INSTRUCTIONS: Enter the number of days during this admission that the patient required ventilator support.

RESOURCE UTILIZATION

OPTIONS: Arterial Line
Central Venous
Endotracheal Intubation
Enteral Feeding
Packed Red Blood Cells
Specialized Bed
Swan-Ganz Catheter
Total Parenteral Nutrition
Tracheostomy
Transfusion of Blood
Transfusion of Fresh Frozen Plasma
Transfusion of Platelets
Tube Thoracostomy
Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: Resource Utilization - A list of resources used during the treatment and care of a trauma patient. Many require the patient to be in a highly skilled level of care unit such as an ICU.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

DRG CODE

OPTIONS: -5= Not Available

REQUIRED FOR MINIMUM DATA SET: NO

DEFINITIONS: DRG Code - This field is used to indicate the HCFA DRG for this patient's admission. The HCFA DRGs are updated annually and are based on the DRG assignment at the time of the patient's discharge from the hospital.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

BSCIP REFERRAL

OPTIONS: Y = Yes

N = No

N/A = Not Applicable

DEFINITIONS: BSCIP- Brian & Spinal Cord Injury Program (BSCIP);

BSCIP Referral- Timely referral made to the Brain & Spinal Cord Injury Program in accordance with section **381.74** Florida Statute.

DATA ENTRY MODE: Direct Entry

FINANCIAL

HOSPITAL CHARGES

OPTIONS: -4 = Not Recorded
-5 = Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Hospital Charges - The total amount charged for this admission at the acute care facility, expressed in a dollar figure.

DATA ENTRY MODE: Direct Entry.

PRIMARY PAYOR SOURCE

OPTIONS: Auto = Automobile Insurance
Commercial = Commercial Insurance
HMO = Health Maintenance Organization
Managed Care = Managed Care
Medicare = Medicare
Medicaid = Medicaid
Military/Champu = Military/Champus
Private Charity = Private Charity
Self Pay = Self Pay
Shriners = Shriners
Workers Comp = Workers Compensation
Other
None
Not Available
Not Recorded

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Primary Payor Source - The primary health and medical policy carried to assist in payment of medical bills.

DATA ENTRY MODE: Multiple Item Pick-List or Direct Entry.

WORK-RELATED INJURY

OPTIONS: Yes
No
Not Recorded
Not Available

REQUIRED FOR MINIMUM DATA SET: YES

DEFINITIONS: Work-Related Injury - Injury incurred having to do with employment (paid or unpaid).

DATA ENTRY MODE: Direct Entry.