Version April 01 2019

Alberta Trauma Web Registry: Data DICTIONARY

ALBERTATRAUMA SERVICES

Contents

Introduction

Alberta has a population of approximately 4.1 million people, with the majority of the population residing in several large urban centers. The balance of the population is scattered throughout the province over a large land mass characterized by mountainous and forested terrain. Many communities are small and often separated by long distances. In many areas surface transport of patients is extremely difficult or nonexistent. In the winter months, transportation between communities can be especially hazardous, time-consuming and detrimental to an injured person.

Tertiary trauma services are confined to the large urban areas. Secondary services are available but vary greatly in the type of services provided in the medium and smaller sized communities in the province. Primary health care services are generally available throughout the province, but in rural and remote communities the communities are too small to support a general practitioner. As well, there are a number of nursing stations scattered throughout the province that provide basic and ongoing health care in remote areas.

The establishment of an all-inclusive integrated Provincial Trauma System in 2008 in Alberta was an opportunity to maximize resources and reduce morbidity and mortality among the trauma injured population. Achievement of optimal patient outcomes for the injured patient was the overall goal of implementing the all-inclusive trauma system. This implementation established 5 district trauma centers (Level III trauma centers) in Fort McMurray, Grande Prairie, Red Deer, Lethbridge and Medicine Hat in addition to already established Level I and II adult and pediatric trauma centers in Edmonton and Calgary. In 2008/2009 all five district trauma centers began submitting a provincially standardized data set to the ATR, adding to the existing data in the ATR that had been collected since 1995 in Edmonton and Calgary.

The coordination of system wide data collection and analysis through the use of a trauma registry enables improvement, maintenance and on-going monitoring of quality trauma care, supports epidemiological research on injuries and trauma care outcomes, and enhances prevention strategies. The purpose of Alberta Trauma Web Registry data dictionary is to:

- To create and maintain a system of injury surveillance that provides an overall picture of the incidence of major trauma at the regional level and throughout the province.
- Provide standard definitions for data entry, and accuracy in data collection methodologies and consistent reporting. This streamlines and accentuates data collection within the province.

Patient Inclusion Criteria

Definition:

A trauma case is included in the ATR if it:

- Has an ICD external cause of injury code that meets the definition of Trauma (see table ICD-10-CA table below) but excludes
    - Poisoning: accidental, intentional or undermined (unless poisonous substance is corrosive or caustic).
    - Surgical misadventure
    - Choking related injury
- Has an ISS **greater than or equal to (≥)** 12, calculated using the Abbreviated Injury Scale (as of 2015: AIS 2005 Version, 2008 update; prior to 2015 AIS 1990, 1998 update) **OR** meets minor penetrating trauma definition (below).
- Meets one of the following criteria
    - Admitted to a trauma hospital; or
    - Died in the emergency department of a participating hospital after treatment was initiated (not admitted). Patients without an ISS score will be included in the TQIP submission.

Transfers (for Jan 1 2019)

As of January 1, 2019 all transfers will be entered into the trauma registry as follows:

Level 3 Trauma Centers transferring out to a higher level of care. (To a Level 1 or 2 trauma center):

The receiving facility that continues consultation, diagnosis and definitive treatment of the trauma patient will add the patient to the **Central Site Registry (ATR)** if they meet the inclusion criteria as above.

Level 3 Trauma Centers:

When sending a trauma patient to a higher level of care for consultation, diagnosis and/or definitive treatment; that trauma patient is entered into the site registry regardless of the Injury Severity Score.

Ensure all available data on that trauma patient is abstracted.

If that patient is returned to the sending trauma center for admission and has an Injury Severity Score of ≥12, that patient is entered into **Central Site (ATR)**

Please note: To ensure that patient records are not duplicated in the ATR Central Site , &/or that Level III's have not missed a patient in their site registries, lists of transfers from the Level III site to the Level I/II will be shared quarterly. (Level III data analysts to initiate request).

ICD-10-CA NTR INCLUSION CRITERIA

EXTERNAL CAUSE CODE CATEGORY	DEFINITION
V01-V99	Transport Incidents
W00-W19	Unintentional Falls
W20-W49	Exposure to Inanimate Mechanical Forces
W50-W64	Exposure to Animate Mechanical Forces
W65-W74	Unintentional Drowning and Submersion
W75-W77, W81, W83, W84	Other Unintentional Threats to Breathing, Except Due to Inhalation of Gastric Contents, Food or Other Objects
W85-W99	Exposure to Electric Current, Radiation and Extreme Ambient Air Temperature and Pressure
X00-X09	Exposure to Smoke, Fire and Flames
X10-X19	Contact with Heat and Hot Substances
X30-X39	Exposure to Forces of Nature
X50	Overexertion and Strenuous or Repetitive Movements
X52	Prolonged Stay in Weightless Environment
X58-X59	Unintentional Exposure to Other and Unspecified Factors
X70-X84	Intentional Self-Harm, Excluding Poisoning
X86, X91-X99, Y00-Y05, Y07-Y09	Assault, Excluding Poisoning and Neglect
Y20-Y34	Event of Undetermined Intent, Excluding Poisonings
Y35-Y36	Legal Intervention and Operations of War

*"Incident" and "unintentional" have been substituted for the terms "accident" and "accidental" used in the ICD 10 CA definitions.**ICD-10-**

ICD-10-CA NTR EXCLUSION CRITERIA

EXTERNAL CAUSE CODE	DEFINITION
W78-W80	Inhalation of gastric contents; inhalation and ingestion of food or other objects causing obstruction of respiratory tract
X20-X29	Contact with venomous animals and plants
X40-X49	Unintentional poisoning and exposure to noxious substances
X51	Travel and motion
X53, X54, X57, Y06	Lack of food or water, unspecified privation, neglect and abandonment
X60-X69	Intentional self-harm by poisoning
X85, X87-X90	Assault by Poisoning
Y06	Neglect and abandonment
Y10-Y19	Poisoning of undetermined intent
Y40-Y59	Drugs, Medicaments and biological substances causing adverse effects in therapeutic use
Y60-Y69	Misadventures to patients during surgical and medical care
Y70-Y82	Medical devices associated with adverse incidents in diagnostic and therapeutic use
Y83-Y84	Surgical and other medical procedures as the cause of abnormal reaction of the patient or later complication
Y85-Y89	Sequelae of external causes of morbidity or mortality
Y90-Y98	Supplementary factors related to morbidity or mortality classified elsewhere

*"Incident" and "unintentional" have been substituted for the terms "accident" and "accidental" used in the ICD 10 CA definitions.

Penetrating Trauma Patient Inclusion Criteria

- As of January, 1 2015 all penetrating injury, regardless of ISS should be captured according to the following definition. For further clarification see Appendix A.
    - The penetrating injury was the primary mechanism of injury

    a. ICD10 external cause of injury codes: W25, W260-9, W27, W28, W29, W30, W31, W32, W33, W3400-9, W44, W4500-9, W46, W53, *W54-59 (only biting not striking against or other contact)*, X72-X7409, X78, X93-X9509, X99, Y22-Y2409, Y28, Y350, Y354, Y364.
    - ICD10 external cause of injury codes typically classified as blunt, but where the most serious injury is obviously penetrating **AND** They met any of the following criteria:

        - The patient died in ED, **OR**
        - The patient was admitted to hospital for > 24 hours (i.e. discharge time - admitting time at trauma center was >24 hours), **OR**
        - The patient went to the main hospital OR for any surgery (not day/outpatient surgery)
        - Please see clarifications (Appendix A) for minor penetrating eye injuries and Psych patients.

Submitting Sites

City	Facility Name	Facility Number	Facility Trauma Level	Date Data Submission Began
Fort McMurray	Northern Lights Medical Centre	0117	Level III	2008, 2011*
Grande Prairie	Queen Elizabeth II Hospital	0056	Level III	2009
Edmonton	University of Alberta Hospital	0044	Level I	1995
Edmonton	Stollery Children's Hospital	0044	Level I	1995
Edmonton	Royal Alexandra Hospital	0043	Level II	1995
Red Deer	Red Deer Regional Hospital	0092	Level III	2008
Calgary	Foothills Medical Centre	0016	Level I	1995
Calgary	Rockyview General Hospital	0020/0147	Level IV	2008**
Calgary	Peter Lougheed Hospital	0148	Level IV	2007**
Calgary	South Health Campus	0576	Level IV	2014**
Calgary	Alberta Children's Hospital	0015	Level I	1995
Lethbridge	Chinook Regional Hospital	0071	Level III	2008
Medicine Hat	Medicine Hat Regional Hospital	0079	Level III	2009

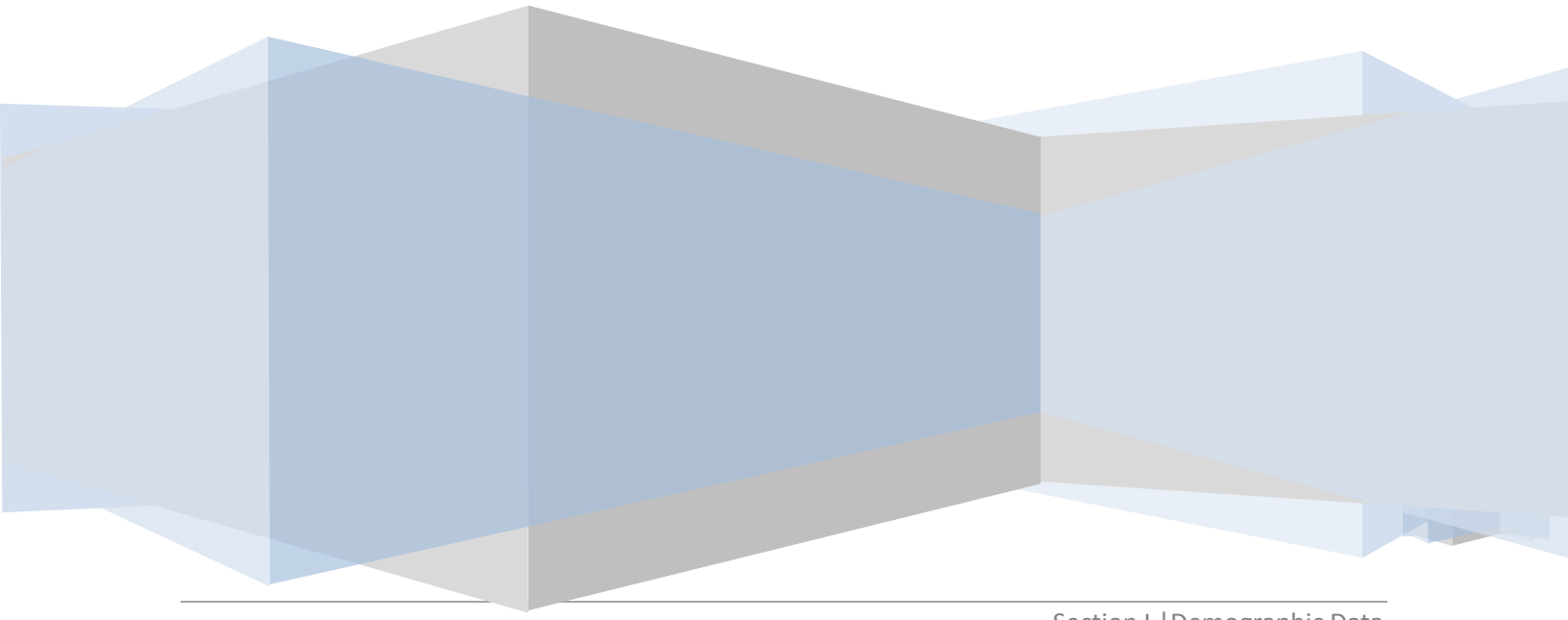
*Hospitals that have a year data submission began marked as YYYY, YYYY means that the submission was inconsistent - that there was a submission made in a previous year prior to the submissions becoming consistent.

**These hospitals are not in the central site ATR (Calgary site data only)

Acknowledgements

- Provincial Trauma Epidemiologist
- Alberta Level I, II, III Trauma Centre data analysts
- Alberta Level I, II, III Trauma Centre trauma coordinators
- Alberta Provincial Trauma Data Advisory Subcommittee
- Alberta Trauma Services Core Leadership Team

Section I Demographic Data



Demographics: Record Info

Record Created

Data Element	Record Created
Field Name	TRK_CREATED_WHEN; TRK_CREATED_WHEN_DATE; TRK_CREATED_WHEN_TIME
Field Type	Character
Field Length	16
Note	Automatically populated when user logs into ATR
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Record Created By

Data Element	Record Created By
Field Name	TRK_CREATED_USRLNK
Field Type	Character
Field Length	40
Note	Automatically populated when user logs into ATR; will fill in user log in name.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Facility (Formerly INST_NUM)

Data Element	Facility
Field Name	TRK_CREATED_FACLNK; FACILITY_LNK
Field Type	Character
Field Length	40
Note	Automatically populated with assigned facility number and name of facility for user who is logged in. ***This should be the facility number of the patient record that you are entering. If you enter for more than one hospital please make sure you log in using the correct facility number (e.g. Foothills vs. Rockyview). IT IS VERY IMPORTANT IF YOU ARE ENTERING LEVEL 4 OR OTHER NON-DESIGNATED SITES THAT YOU LOG IN UNDER THE APPROPRIATE FACILITY FOR REPORTING PURPOSES!!!***
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Trauma

Data Element	Trauma #
Field Name	TRAUMA_NUM
Field Type	Numeric
Field Length	9
Note	The trauma # is a 9 digit unique identifier assigned and populated by the ATR.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Patient Arrival Date

Data Element	ED or Hospital Arrival Date (for direct admission)
Field Name	PAT_A_DATE(_M;_D;_Y;_M_AS_TEXT;_DOW;_DOW_AS_TEXT; _Q;_Q_AS_TEXT) PAT_A_EVENT (patient arrival date/time)
Field Type	Date
Field Length	2,2,4
Note	Click the patient's arrival date at your trauma center from the calendar icon to the right of the text box or type it in manually. If any part of the date is unknown the whole date will be entered as "?". Arrival is defined as the date the patient was first triaged/registered at the trauma centre or date they were directly admitted. Please use the earliest date/time recorded on the patient's chart. Format MM/DD/YYYY Field cannot be n/a. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

Patient Arrival Time

Data Element	ED or Hospital Arrival Time (for direct admission)
Field Name	PAT_A_TIME(_H;_M) PAT_A_EVENT (patient arrival date/time)
Field Type	Time
Field Length	2,2
Note	Enter arrival time in ED (or hospital admission time for direct admits) using 24 hour clock. Arrival time is the earliest triage/registration time recorded in the patient chart or electronic record. If any part of the time is unknown the whole time will be entered as "?". Arrival is defined as the date the patient was first triaged/registered at the trauma centre or time directly admitted. Please use the earliest date/time recorded on the patient's chart. Format HH:MM in 24 hour clock. Field cannot be n/a. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

Medical Record

Data Element	Medical Record # (formerly Hospital #)
Field Name	PAT_REC_NUM
Field Type	Numeric
Field Length	13
Note	This is the same as the hospital ID number from old version of Collector.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Personal Health

Data Element	ULI
Field Name	PAT_NHI_NUM
Field Type	Numeric
Field Length	9
Note	Enter the patient's 9 digit **ULI** number; this is no longer entered in 2 fields and you do not enter the dash. Every effort should be made to obtain the patient's ULI. If ULI is unknown please enter '?' for unknown. Enter ULI for all patients (including non-AB residents). If patient is a non-AB resident please complete the "Other health care #" section if another health # is provided. **Do not use '/'.**If the patient previously lived/resided in a different Province or country and now resides in AB then enter: 1. ULI# 2. Old PHN# in "other" 3. Residence "/" as the patient now resides in AB
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Personal Health # Further Clarification:

Date field is now labeled ULI (from personal health number).

If you are unsure of the difference between ULI and PHN (or are unsure where to find these numbers in the chart) please ask other analysts/epidemiologist for clarification. Please ensure you understand the difference between ULI and PHN and what you are entering in the registry.

Not applicable answers are no longer necessary with ULI.

Other Health

Data Element	Other Health #
Field Name	PAT_PID_NUM
Field Type	Numeric
Field Length	12
Note	Enter the patient's non–Alberta Health Number or other identifying number as required by your institution if the patient is an out of province resident. This field will not be skipped if unknown or inappropriate is entered in the ULI field. If a non-Alberta Health Number is not available enter unknown '?'. Please do not enter anything in this section besides Other Health # (do not put in province they live in or any other information; please use the appropriate data fields or the notes section for that information).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Hospital Visit

Data Element	Hospital Visit #
Field Name	VISIT_NUM
Field Type	Numeric
Field Length	3
Note	Allows you to input sequential admissions for each patient. University of Alberta uses: Hospital Case number Royal Alexandra uses: Hospital Case Number Foothills uses: Admitted visit (up to analyst to assign #) Alberta Children's uses: Registry admission Fort McMurray uses: Registry admission Grande Prairie uses: Registry admission Red Deer uses: Registry Admission Medicine Hat uses: Registry Admission Lethbridge uses: Registry admission
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Name: Last

Data Element	Patient Name: Last
Field Name	PAT_NAM_L
Field Type	Character
Field Length	50
Note	Enter the patient's last name. If Unknown enter '?' Please enter a last name for all patients "/" should not be used. Field should not be blank
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Name: First

Data Element	Patient Name: First
Field Name	PAT_NAM_F
Field Type	Character
Field Length	50
Note	Enter the patient's first name. If Unknown enter '?' Please enter a first name for all patients "/" should not be used. Field should not be blank
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Name: Middle

Data Element	Patient Name: Middle
Field Name	PAT_NAM_M
Field Type	Character
Field Length	50
Note	Enter the patient's middle name or initial. A period should not be entered after the patient's initial. If unknown enter "?". If patient does not have a middle name enter '/' not applicable.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Origin

Data Element	Patient Origin
Field Name	PAT_ORIGIN
Field Type	Numeric
Field Length	1
Note	From the drop down list select where the patient came from. 1= Scene *(the location the patient was injured; if injured at home put scene,* if taken to Urgent care center enter scene 2= Referring Hospital 3= Other *(e.g. jail)*(patient came via private vehicle from another hospital) 4= Home *(also includes: residential living, assisted living, nursing home)* If patient injured at scene then went home enter home ?= Unknown Field should not be "n/a"
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Origin Further Clarification:

The definition of scene is where the patient was injured. If the patient came to trauma center directly from place of injury enter scene (1). If the arrival of the patient was not direct from place of injury then consider options 2-4.

Residence (if not Alberta)

Data Element	Residence (if not Alberta)
Field Name	PAT_HOME_TYPE
Field Type	Numeric
Field Length	2
Note	Select the patient's province of residence from the drop down menu if residence is outside Alberta. The default will be set to '/' for AB residents. 1= Ontario 2= Manitoba 3= Saskatchewan 4= British Columbia 6= Quebec 7= New Brunswick 8= Newfoundland 9= Prince Edward Island 10= Nova Scotia 11= Northwest Territories 12= Yukon Territory 13= United States 14= Other 15= Nunavut / = Not Applicable ? = Unknown Prior to 2017 residents of Nunavut were entered as #14 "Other".
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

NTDB Case

Data Element	NTDB Case?
Field Name	REG_INC_YN01
Field Type	Numeric
Field Length	1
Note	This question is defaulted to **Yes**. Level 1 and 2 adult should answer Yes to this question for ALMOST all patients (since almost all of their cases are central site cases and we are all submitting to NTDB). Level 3 and 4 trauma and pediatric trauma centers should enter this as no since they are not yet submitting to NTDB/TQIP (but will be in the future). Level 3 and 4 sites should still be filling out all subsequent NTDB data elements in the patient record as these are still required fields for ATR. **Note: when Level 3 sites do start submitting this will only be checked "Y" for central site cases (non-central site cases are already submitted by Level 1/2 sites).** 1. Yes 2. No /, Not applicable ?, Unknown Some patients who meet AB inclusion criteria do not meet NTDB criteria and should have this box checked No (we still enter these patients we just don't send them to NTDB). These patients include asphyxiation with no other injuries (e.g. hangings with no neck fracture, drownings) and hypothermia.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Is This a Central Site Case?

Data Element	Is this a central site case?
Field Name	REG_INC_YN02
Field Type	Numeric
Field Length	1
Note	A patient is a central site case if they have an ISS $\geq$ 12 ***or*** die in ED ***or*** meet the minor penetrating definition ***AND*** if they are a definitive site case Please consult between the Level 3 and Level 1/2 transferring sites to see who should have the central site case if patient was admitted to both sites. The record with the most details (ORs, ICU stays, hospital days) should be central site case **as agreed upon by both site Data Analysts.** The purpose of this question is so we only have 1 record for each patient encounter being pulling into our provincial stats so patients with the same injury are not being included in our stats more than one time for the same injury. 1. Yes 2. No ***The options of inappropriate and unknown are options in the ATR but should not be selected for this data element. All cases should be answered as Yes or No.**
ATR Required	Yes
NTDB Required	Yes
Hierarchy	N/A
History	N/A

As of January 1, 2019 all transfers will be entered into the trauma registry as follows:

Level 3 Trauma Centers transferring out to a higher level of care. (To a Level 1 or 2 trauma center):

The receiving facility that continues consultation, diagnosis and definitive treatment of the trauma patient will add the patient to the **Central Site Registry (ATR)** if they meet the inclusion criteria as above.

Level 3 Trauma Centers:

When sending a trauma patient to a higher level of care for consultation, diagnosis and/or definitive treatment; that trauma patient is entered into the site registry regardless of the Injury Severity Score.

Ensure all available data on that trauma patient is abstracted.

If that patient is returned to the sending trauma center for admission and has an Injury Severity Score of ≥12, that patient is entered into **Central Site (ATR)**

Please note: To ensure that patient records are not duplicated in the ATR Central Site , &/or that Level III's have not missed a patient in their site registries, lists of transfers from the Level III site to the Level I/II will be shared quarterly. (Level III data analysts to initiate request).

Demographic: Patient

Patient Name: Last

Data Element	Patient Name: Last
Field Name	PAT_NAM_L
Field Type	Character
Field Length	50
Note	Will be populated from first screen.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Name: First

Data Element	Patient Name: First
Field Name	PAT_NAM_F
Field Type	Character
Field Length	50
Note	Will be populated from first screen.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Patient Name: Middle

Data Element	Patient Name: Middle
Field Name	PAT_NAM_M
Field Type	Character
Field Length	50
Note	Will be populated from first screen.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Date of Birth

Data Element	Date of Birth
Field Name	DOB_DATE (_M;_D;_Y)
Field Type	Date
Field Length	2,2,4
Note	Enter the patient's date of birth (MM/DD/YYYY) or use the calendar icon on the right to select the correct DOB. Unknown '?' may be entered if any of the data components if the information is not available. Date of birth should be available through health records for most patients. • If Date of Birth is "?", complete variables: Age and Age Units. • If Date of Birth equals ED/Hospital Arrival Date (2017 update if DOB equals Injury date hasn't been updated in ATR and is under discussion), then the Age and Age Units variables must be completed. • Used to calculate patient age in years, months, days, hours or minutes. • Field cannot be '/' not applicable or blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Admission Form 2. Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes 6. Other electronic health records
History	N/A

Age

Data Element	Age
Field Name	AGE_VALUE
Field Type	Numeric
Field Length	3
Note	This is the patient's age at the time of injury in the units defined by Age Type (Years, Months, Days, Hours, Minutes) This field populates automatically and is calculated using: 1. Date of Birth AND 2. Date of Hospital Arrival (2017 update: calculated using Injury date has not been updated in ATR and because of high # of unknown responses is still under discussion). If Date of Birth is 'unk' but age is known it can be entered in manually. If Date of Birth is 'unk' and age is also unknown please manually enter '?' Must also complete Age Units if DOB is 'unk'.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Admission Form 2. Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes 6. Other electronic health records
History	N/A

Age in (Units)

Data Element	Age Units
Field Name	AGE_UNIT
Field Type	Numeric
Field Length	1
Note	Is populated automatically if date of birth is entered. If date of birth "Unk" enter the units of the patient's age if known. If patient age is 'Unk' leave blank (delete what is populated by default will be mapped to?). Numbered order of units is different from what is in NTDS data dictionary – will be mapped to correct values when data is sent. 1. Years 2. Months 3. Days 5. Hours 6. Minutes (new 2016) 7. Weeks
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Admission Form 2. Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes 6. Other electronic health records
History	N/A

Gender

Data Element	Gender
Field Name	PAT_GENDER
Field Type	Numeric
Field Length	1
Note	Please choose from drop down menu: 1. Male 2. Female Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment (should be coded as the gender that the patient identifies as according to NTDB).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Race

Data Element	Race
Field Name	PAT_RACE01, PAT_RACE02
Field Type	Numeric
Field Length	1
Note	This field will default to '/' not applicable. There is a drop down menu that can be manually changed, but **please do not change this field** as it will be submitted to NTDB but is not required by ATR.
ATR Required	**No**
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Ethnicity

Data Element	Ethnicity
Field Name	PAT_ETHNIC
Field Type	Numeric
Field Length	1
Note	This field will default to '/' not applicable. There is a drop down menu that can be manually changed, but **please do not change this field** as it will be submitted to NTDB but is not required by ATR.
ATR Required	**No**
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Postal Code

Data Element	Postal Code
Field Name	PAT_ADR_POST
Field Type	Character
Field Length	6
Note	Enter the patient's primary residential postal code (in A#A#A# format) with no space. Postal Code letters must be entered in upper case. If Alberta primary residence postal code is unknown, enter '?'. A primary residential address is not a PO Box but the physical location of their home. If patient does not have a primary residence enter '/ Please try to enter the actual physical address information if available (i.e. the postal code for a rural residence as opposed to a PO Box in town). Residential information is required for the ATR but will not be submitted to NTDB as per AB privacy regulations. This section will be mapped to n/a for NTDB. Alternate residence data element is removed as per the Data subcommittee on April 05 2018. Please enter "/" as Admitting is not accepting T1T1T1 across the province of Alberta and they are also entering "/"
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Billing Sheet / Medical Records Coding Summary Sheet 2. ED Admission Form 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

EXPLANATION: Postal Code for Homeless

- Admitting/Registration will no longer be using T1T 1T1 for homeless patients for their address. Going forward, for homeless patients, 'postal code' will be the postal code the hospital patient is admitted at; 'other postal code' will be defaulted to N/A and 'alternate residence' should be selected as homeless.

- We need to be consistent with admitting/registration.

- In the registry, under demographic, patient, patient address information: 'other postal code' has been defaulted to n/a for all the registries

City

Data Element	City
Field Name	PAT_ADR_CI
Field Type	Character
Field Length	50
Note	Enter the patient's city (or town/village/hamlet) of residence. Enter the patient's city of injury if the patient is homeless. If the patient spends the majority of time in one city, enter that city. Enter '?' if undetermined or unknown. Residential information is required for the ATR but will not be submitted to NTDB as per AB privacy regulations. This section will be mapped to n/a for NTDB.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Province

Data Element	Province
Field Name	PAT_ADR_REG
Field Type	Numeric
Field Length	2
Note	Select the patient's province of residence from the drop down list. Enter the patient's province of injury if the patient is homeless. If the patient spends the majority of time in one city, enter the corresponding province. Drop down list includes, in this order: Ontario Manitoba Saskatchewan British Columbia Alberta Quebec New Brunswick Newfoundland Prince Edward Island Nova Scotia Northwest Territories Yukon Territory Nunavut United States Other Not applicable Unknown Prior to 2017 admissions patients with residence in Nunavut were entered as 'Other'. Residential information is required for the ATR but will not be submitted to NTDB as per AB privacy regulations. This section will be mapped to n/a for NTDB.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

If Other (Province)

Data Element	If Other
Field Name	PAT_ADR_REG_S
Field Type	Character
Field Length	50
Note	Specify the patient's province/state or country of residence if 'other' was entered in the previous field. This field will be skipped if 'other' was not selected in the previous field.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Country

Data Element	Country
Field Name	PAT_ADR_CY
Field Type	Numeric
Field Length	3
Note	Enter the patient's country of residence from the drop down menu. Canada is at the top of the list. If the patient spends the majority of time in one country, enter that country as country of residence. The full country menu drop down list is in alphabetical order and can be viewed in the ATR. Unknown is at the bottom of the list. Field cannot be '/'. Field cannot be blank This data will be sent to NTDB as the only patient residential information we send.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary Disregard *"only completed when ZIP is not known/recorded"* – ATR requires this field to be completed and this will be sent to NTDB.
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Alternate Residence

Data Element	Alternate Residence
Field Name	PAT_ADR_ALT
Field Type	Numeric
Field Length	1
Note	Enter the patient's alternate residence from the drop down menu. This will be enabled if postal code is n/a. 1. Homeless 2. Undocumented-citizen 3. Migrant worker *(e.g. temporary foreign worker with no fixed residential address).* 4. Foreign Visitor* see note
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Admission Form 2. Billing Sheet / Medical Records Coding Summary Sheet 3. EMS Run Sheet 4. Triage Form / Trauma Flow Sheet 5. ED Nurses' Notes
History	N/A

Clarifications:

Homelessness is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.

Undocumented citizen is defined as a national of another country who has entered or stayed in another country without permission.

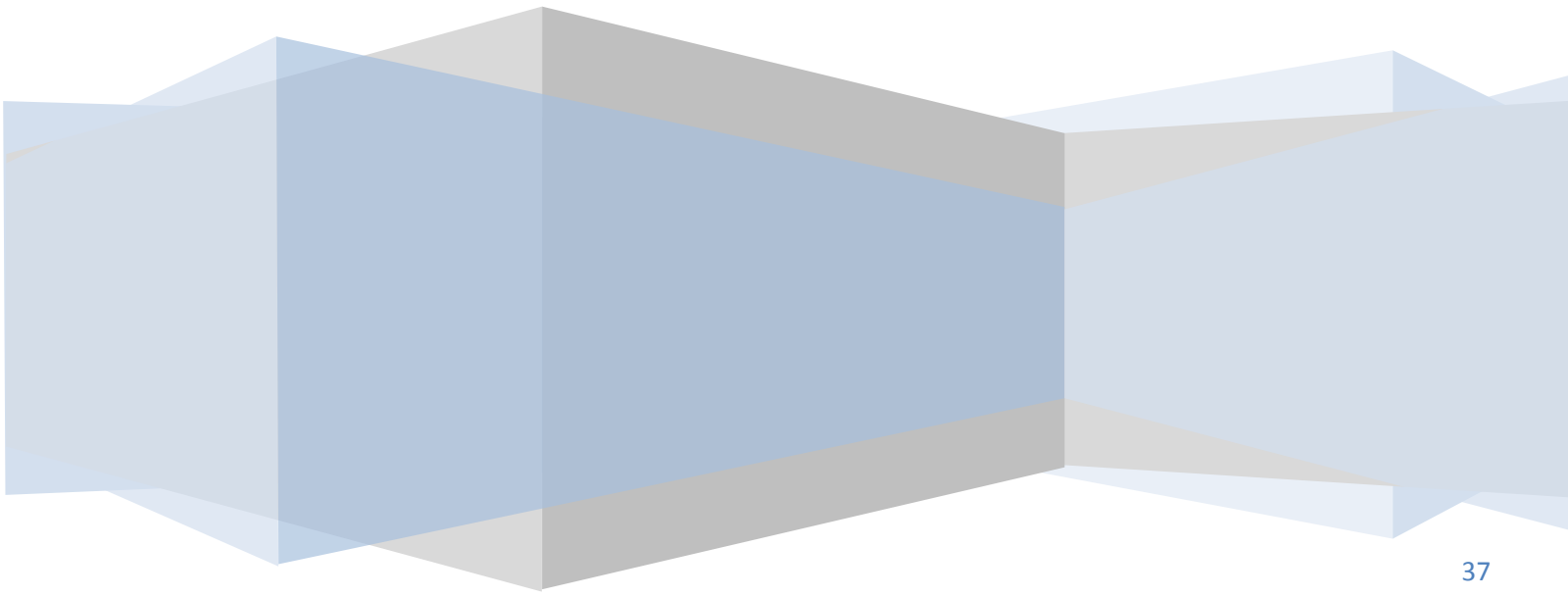
Migrant worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or a different country.

Foreign visitor is defined as any person legally visiting another country other than his/her usual place of residence for any reason. 2016 NTDS categorizes this as retired but please still fill out for ATR information (will not be sent to NTDB).

Notes

Data Element	Demographic Notes
Field Name	PAT_MEMO
Field Type	Text
Field Length	500
Note	Enter information in this area if you need to make a note about the demographic data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section II Injury Data



Injury: Injury Information

Work Related

Data Element	Work Related
Field Name	INJ_WORK_YN
Field Type	Numeric
Field Length	1
Note	Did injury occur at work? Work is defined according to NTDB as "paid employment". Self-employed work such as farming or ranching are considered work related injuries. 1. Yes 2. No Unknown Field cannot be "n/a" Field cannot be blank (Note that occupation and occupational industry should be documented if the injury is work related).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Clarification:

Please do not check "Yes" for students (as described in the old Collector system data dictionary). Work is defined by the NTDB as paid employment. This means we will not be able to track students injured at school in the occupation section as this section only becomes active if work-related is checked as "Yes".

Volunteers injured at a workplace are not generally considered work related injuries; however since many people completing internships and fellowships are receiving some sort of compensation (even if it is minimal) they would be checked "Yes" for work related if injured while at work. If the person is being compensated in any way for their work (i.e. meal stipend, other gifts) please check 'Yes' for work related (as per communication with NTDB Feb 26, 2016).

Occupation

Data Element	Occupation
Field Name	PAT_JOB
Field Type	Numeric
Field Length	2
Note	Only complete if work related is "Yes". If work related is "No" this field will be disabled Select the type of occupation that the patient was working in at the time of injury (no separate category for self-employed patients). Occupation **must** be documented for work related injury. Enter '?' if unknown. Ranchers and farmers who are injured on the farm during farming activities are considered work related.
ATR Required	Yes
NTDB Required	Yes-please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. EMS Run Sheet 3. ED Nurses' Notes
History	N/A

Further Clarification:

Example 1: Labourers may fall into a number of categories depending on the type of industry they are employed in. A labourer working on road construction would be documented as menu item 21 (construction and extraction occupations) while a laborer working in a warehouse as a shipper and receiver in a manufacturing industry would be documented as menu item 11 (Transportation and Material Moving Occupations).

Example 2: A rig worker in the oil and gas section had its own category as an occupation in the last version of Collector. In the 2015 ATR this occupation would be classified under construction and extraction.

A full listing of occupations and their definitions can be found on the following pages.

Menu for occupation:

1	Business and Financial Operations Occupations
2	Architecture and Engineering Occupations
3	Community and Social Services Occupations
4	Education, Training, and Library Occupations
5	Healthcare Practitioners and Technical Occupations
6	Protective Service Occupations
7	Building and Grounds Cleaning and Maintenance
8	Sales and Related Occupations
9	Farming, Fishing, and Forestry Occupations
10	Installation, Maintenance, and Repair Occupations
11	Transportation and Material Moving Occupations
12	Management Occupations
13	Computer and Mathematical Occupations
14	Life, Physical, and Social Science Occupations
15	Legal Occupations
16	Arts, Design, Entertainment, Sports, and Media
17	Healthcare Support Occupations
18	Food Preparation and Serving Related
19	Personal Care and Service Occupations
20	Office and Administrative Support Occupations
21	Construction and Extraction Occupations
22	Production Occupations
23	Military Specific Occupations
24	~~Student~~ *(don't use, students are not considered work related)*
25	Retired
26	Unemployed
27	Other *(e.g. private household services including childcare)*
/	Not Applicable *(if work related is 'No' this field will be disabled*
?	Unknown

NTDB Dictionary Definitions:

PATIENT'S OCCUPATION: The occupation of the patient.

Field Value Definitions:

- **Business and Financial Operations Occupations:**
  - Buyers and Purchasing Agents
  - Accountants and Auditors
  - Claims Adjusters, Appraisers, Examiners, and Investigators
  - Human Resources Workers
  - Market Research Analysts and Marketing Specialists
  - Business Operations Specialists, All Other
- **Architecture and Engineering Occupations:**
  - Landscape Architects
  - Surveyors, Cartographers, and Photogrammetrists
  - Agricultural Engineers
  - Chemical Engineers
  - Civil Engineers
  - Electrical Engineers
- **Community and Social Services Occupations:**
  - Marriage and Family Therapists
  - Substance Abuse and Behavioral Disorder Counselors
  - Healthcare Social Workers
  - Probation Officers and Correctional Treatment Specialists
  - Clergy
- **Education, Training, and Library Occupations:**
  - Engineering and Architecture Teachers
  - Postsecondary Math and Computer Teachers
  - Postsecondary Nursing Instructors and Teachers
  - Postsecondary Law, Criminal Justice, and Social Work Teachers
  - Postsecondary Preschool and Kindergarten Teachers
  - Librarians
- **Healthcare Practitioners and Technical Occupations:**
  - Dentists
  - All Other Specialists Dietitians and Nutritionists
  - Physicians and Surgeons
  - Nurse Practitioners
  - Cardiovascular Technologists and Technicians
  - Emergency Medical Technicians
  - Paramedics
- **Protective Service Occupations:**
  - Firefighters
  - Police Officers
  - Animal Control Workers
  - Security Guards
  - Lifeguards, Ski Patrol, and Other Recreational Protective Service

- **Building and Grounds Cleaning and Maintenance:**
  - Building Cleaning Workers
  - Landscaping and Grounds keeping Workers
  - Pest Control Workers
  - Pesticide Handlers, Sprayers, and Applicators
  - Vegetation/Tree Trimmers and Pruners
- **Sales and Related Occupations:**
  - Advertising Sales Agents
  - Retail Salespersons
  - Counter and Rental Clerks
  - Door-to-Door Sales Workers, News and Street Vendors, and Related Workers
  - Real Estate Brokers
- **Farming, Fishing, and Forestry Occupations:**
  - Animal Breeders
  - Fishers and Related Fishing Workers
  - Agricultural Equipment Operators
  - Hunters and Trappers
  - Forest and Conservation Workers
  - Logging Workers
- **Installation, Maintenance, and Repair Occupations:**
  - Electric Motor, Power Tool, and Related Repairers
  - Aircraft Mechanics and Service Technicians
  - Automotive Glass Installers and Repairers
  - Heating, Air Conditioning, and Refrigeration Mechanics, Installers, and Maintenance Workers
  - Machinery Industrial Machinery Installation, Repair, and Maintenance Workers
- **Transportation and Material Moving Occupations:**
  - Rail Transportation Workers
  - All Other Subway and Streetcar Operators
  - Packers and Packagers
  - Hand Refuse and Recyclable Material Collectors
  - Material Moving Workers
  - All Other Driver/Sales Workers
- **Management Occupations:**
  - Public Relations and Fundraising Managers
  - Marketing and Sales Managers
  - Administrative Services Managers
  - Transportation, Storage, and Distribution Managers
  - Food Service Managers
- **Computer and Mathematical Occupations:**
  - Web Developers
  - Software Developers and Programmers
  - Database Administrators
  - Statisticians
  - Computer Occupations

- All Other

- **Life, Physical, and Social Science Occupations:**
  - Psychologists
  - Economists
  - Foresters
  - Zoologists and Wildlife Biologists
  - Political Scientists
  - Agricultural and Food Science
  - Technicians
- **Legal Occupations:**
  - Lawyers and Judicial Law Clerks
  - Paralegals and Legal Assistants
  - Court Reporters
  - Administrative Law Judges, Adjudicators, and Hearing Officers
  - Arbitrators, Mediators, and Conciliators
  - Title Examiners, Abstractors, and Searchers
- **Arts, Design, Entertainment, Sports, and Media Occupations:**
  - Artists and Related Workers
  - All Other Athletes, Coaches, Umpires, and Related Workers
  - Dancers and Choreographers
  - Reporters and Correspondents
  - Interpreters and Translators
  - Photographers
- **Healthcare Support Occupations:**
  - Nursing, Psychiatric, and Home Health Aides
  - Physical Therapist Assistants and Aides
  - Veterinary Assistants and Laboratory Animal Caretakers
  - Healthcare Support Workers, All Other Medical Assistants
- **Food Preparation and Serving Related Occupations:**
  - Bartenders, Cooks, Institution and Cafeteria Cooks
  - Fast Food
  - Counter Attendants Cafeteria, Food Concession, and Coffee Shop
  - Waiters and Waitresses
  - Dishwashers
- **Personal Care and Service Occupations:**
  - Animal Trainers
  - Amusement and Recreation Attendants
  - Barbers, Hairdressers, Hairstylists and Cosmetologists
  - Baggage Porters, Bellhops, and Concierges
  - Tour Guides and Escorts
  - Recreation and Fitness Workers
- **Office and Administrative Support Occupations**:
  - Bill and Account Collectors
  - Gaming Cage Workers
  - Payroll and Timekeeping Clerks, Tellers

  - Court, Municipal, and License Clerks
  - Hotel, Motel, and Resort Desk Clerks

- **Construction and Extraction Occupations:**
  - Brick masons, Block masons, and Stonemasons
  - Carpet, Floor, and Tile Installers and Finishers
  - Construction Laborers, Electricians
  - Pipe layers, Plumbers, Pipefitters, Steamfitters and Roofers
  - Oil rig workers
- **Production Occupations:**
  - Electrical, Electronics, and Electromechanical Assemblers
  - Engine and Other Machine Assemblers
  - Structural Metal Fabricators and Fitters
  - Butchers and Meat Cutters
  - Machine Tool Cutting Setters, Operators, and Tenders
  - Metal and Plastic Welding, Soldering, and Brazing Workers
- **Military Specific Occupations:**
  - Air Crew Officers
  - Armored Assault Vehicle Officers
  - Artillery and Missile Officers
  - Infantry Officers
  - Military Officer Special and Tactical Operations Leaders, All Other

Occupation Industry

Data Element	Occupation Industry
Field Name	PAT_JOB_TYPE
Field Type	Numeric
Field Length	2
Note	Only complete if work related. Select the type of occupation industry that the patient was working in at the time of injury (no separate category for self-employed patients). Occupation industry **must** be documented for work related injury. Enter '?' if unknown.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. EMS Run Sheet 3. ED Nurses' Notes
History	N/A

Further Clarification:

Example 1: Labourers may fall into a number of categories depending on the type of industry they are employed in. A labourer working on road construction would be documented as menu item 8 (construction) while a labourer working in a warehouse as a shipper and receiver in a manufacturing industry would be documented as menu item 4 (Transportation and Public Utilities).

Example 2: A rig worker in the oil and gas section had its own category as an occupation in the last version of Collector. In the 2015 ATR this occupation industry would be classified under menu item 10 (natural resources and mining).

A full listing of occupations and *their* definitions can be found on the following pages.

Menu for occupation industry:

1	Finance, Insurance, and Real Estate
2	Manufacturing
3	Retail Trade
4	Transportation and Public Utilities
5	Agriculture, Forestry, Fishing
6	Professional and Business Services
7	Education and Health Services
8	Construction
9	Government
10	Natural Resources and Mining
11	Information Services
12	Wholesale Trade
13	Leisure and Hospitality
14	Other Services *(e.g. private household services including childcare)*
/	Not Applicable *(if work related is 'No')*
?	Unknown

NTDB Dictionary Definitions:

PATIENT'S OCCUPATIONAL INDUSTRY: The occupational history associated with the patient's work environment.

Field Value Definitions:

- **Finance and Insurance** - The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:
    - Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
    - Pooling of risk by underwriting insurance and annuities.
    - Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.
- **Real Estate** - Industries in the Real Estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.
- **Manufacturing** - The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling

equipment. However, establishments which make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

- **Retail Trade** - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:
    - Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
    - Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.
- **Transportation and Public Utilities** - The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.
- **Agriculture, Forestry, Fishing** - The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. The establishments in this sector are often described as farms, ranches, dairies, greenhouses, nurseries, orchards, or hatcheries.
- **Professional and Business Services** - The Professional, Scientific, and Technical Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. These activities require a high degree of expertise and training. The establishments in this sector specialize according to expertise and provide these services to clients in a variety of industries and, in some cases, to households. Activities performed include: legal advice and representation; accounting, bookkeeping, and payroll services; architectural, engineering, and specialized design services; computer services; consulting services; research services; advertising services; photographic services; translation and interpretation services; veterinary services; and other professional, scientific, and technical services.
- **Education and Health Services** - The Educational Services sector comprises establishments that provide instruction and training in a wide variety of subjects. This instruction and training is provided by specialized establishments, such as schools, colleges, universities, and training A3.11 centers. These establishments may be privately owned and operated for profit or not for profit, or they may be publicly owned and operated. They may also offer food and/or accommodation services to their students. The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities.
- **Construction** - The construction sector comprises establishments primarily engaged in the construction of buildings or engineering projects (e.g., highways and utility systems). Establishments primarily engaged in the preparation of sites for new construction and establishments primarily engaged in subdividing land for sale as building sites also are included in this sector. Construction work done may include new work, additions, alterations, or maintenance and repairs.

- **Government** – Civil service employees, often called civil servants or public employees, work in a variety of fields such as teaching, sanitation, health care, management, and administration for the federal, state, or local government. Legislatures establish basic prerequisites for employment such as compliance with minimal age and educational requirements and residency laws.
- **Natural Resources and Mining** - The Mining sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations, beneficiating (e.g., crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity.
- **Information Services** - The Information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, and (c) processing data.
- **Wholesale Trade** - The Wholesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The merchandise described in this sector includes the outputs of agriculture, mining, manufacturing, and certain information industries, such as publishing.
- **Leisure and Hospitality** - The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. This sector comprises (1) establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; (2) establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and (3) establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. The Accommodation and Food Services sector comprises establishments providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment.
- **Other Services** - The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grant-making, advocacy, and providing dry-cleaning and laundry services, personal care services, death care services, pet care services, photofinishing services, temporary parking services, dating services and private household services such as cooks, maids, butlers, childcare, gardeners, caretakers, etc.

Report of Physical Abuse

Data Element	Report of Physical Abuse
Field Name	INJ_ABUSE_RP_YN
Field Type	Numeric
Field Length	1
Note	A report of suspected **physical** abuse was made to law enforcement and/or protective services. 1. Yes *(reported the abuse to some type of authority: police, social services, child protective services)* 2. No *(no report was made to any authority even if abuse was suspected)* Unknown *(suspected abuse but unknown if actual referral or contact with another authority)* *n/a-(do not use)* This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Clarification:

This is only for report of physical abuse not neglect (i.e. CPS called for child who was in a car accident with a caregiver who was under the influence of alcohol = would be checked “No”). If abuse was suspected but the chart notes that no report was made check ‘No’.

Investigation of Physical Abuse

Data Element	Investigation of Physical Abuse
Field Name	INJ_ABUSE_INVST_YN
Field Type	Numeric
Field Length	1
Note	Required by NTDB. An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse. Only becomes active if previous question is answered "yes". 1. Yes 2. No *(report made but no investigation initiated)* Unknown N/A ~~*(do not use – will be inactive if previous question is No)*~~
ATR Required	No
NTDB Required	Yes -please see the definition in the current NTDB data dictionary
Hierarchy	1. Nursing/Physician Notes 2. Social work notes
History	N/A

Fatality at Scene

Data Element	Fatality at Scene
Field Name	ED_DOA_YN
Field Type	Numeric
Field Length	1
Note	Should be collected for **all mechanisms of injury** not just transportation related. 1. Yes 2. No ? Unknown Field should not be "N/A"
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Protective Devices

Data Element	Protective Devices
Field Name	INJ_RESTR, AIRBAG01, AIRBAG02, AIRBAG03, AIRBAG04, INJ_PDEV01, INJ_PDEV02, INJ_PDEV03, INJ_PDEV04, INJ_PDEV_S
Field Type	Numeric/Character
Field Length	1, 1, 1, 1, 1, 1, 1, 1, 1; Text (Other)
Note	Protective devices in use or worn (or not used/worn) by the patient at the time of the injury. Collect for all mechanisms of injury. Enter '/' for Car/Pedestrian incident where the pedestrian was injured. Choose from the 3 categories (restraint, airbag, and equipment) as applicable. Can enter at once by using the protective devices button or by category one at a time from the appropriate drop down lists. List of all protective device choices can be found below. If safety equipment is available and there is no safety equipment worn then it should be marked as "none". If there is no safety equipment available (or not appropriate) and none is worn then it should be marked as For example if a child is hurt riding an ATV and the child is not wearing a helmet this should be marked as "none", **not** "n/a". Enter None for where Ped vs Car where the Ped was injured This is not how the NTDB data dictionary says to enter these protective devices fields (NTDS data dictionary prefers entering 'None' as opposed to "n/a" however our mapping is coded to map "/" to "none" therefore please answer this question as it has been answered in the past to maintain data continuity) . Answering data element questions should be maintained consistently on a provincial basis and not on a site by site basis.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. History and Physical
History	N/A

Menu for protective devices:

Restraint (choose 1)	Airbag (choose up to 4)	Equipment (choose up to 4)
1. None	1. No airbags	1. None
2. Seatbelt – lap and shoulder *("3-point restraint")*	2. Airbags (did not deploy)	2. Helmet
3. Seatbelt – lap only	3. Front (deployed)	3. Eye Protection
4. Seatbelt – shoulder only	4. Side (deployed)	4. Protective clothing
5. Seatbelt - NFS	5. Airbag deployed other (knee, air belt, curtain, etc.)	5. Protective non-clothing gear (e.g. shin guard, padding)
6. Child booster seat	6. Airbag type unknown (deployed)	6. Hard hat
7. Child car seat	/ Not applicable *(not in a vehicle)*	7. PFD
8. Infant car seat	? Unknown	8. Other
9. Truck bed restraint		/ Not applicable
/ Not applicable *(not in a vehicle where restraints are the norm)*		? Unknown
? Unknown		

Clarification: "If documented that a "child restraint" was used or worn, but NOT properly fastened, either on the child or in the car, report Field Value "1.None"

Protective Devices-Air bag-Bus please enter "n/a"

Protective devices: you may select up to 2 restraints from the menu as per NTDB 2019.

Injury Address

Data Element	Injury Address
Field Name	INJ_ADR_POST; INJ_ADR_S01; INJ_ADR_CI; INJ_ADR_REG; INJ_ADR_CY
Field Type	Character/Integer
Field Length	Varies
Note	If patient was injured at home you can use the 'copy patient address' button to automatically fill in the information. Otherwise please fill in: **Postal Code** – Use capitals, no space if known (enter '?' if unknown) If there is a location of injury where you can look up the address (i.e. store location) please google the postal code. Field cannot be '/'. Will be sent to NTDB. Street – fill in street address of injury if information is available from ambulance report. Required for ATR, (for NTDB will be mapped to n/a). Since the decision was made by the Data subcommittee on APRIL 05 2018 to remove the data field "street address". Injury address is required due to postal code "unk" City – fill in city closest to where injury occurred; enter '/' if not applicable or '?' if unknown. Required for ATR, (for NTDB will be mapped to n/a). Province – Choose province of injury from drop down list (if not in Canada type '/', if unknown '?'). Required for ATR, (for NTDB will be mapped to n/a). Now included Nunavut! **Country** – Choose country of injury from drop down list (if unknown type '?'). Field cannot be '/' will be sent to NTDB. General descriptions of place of injury (school, business names, etc.) are to be entered in the "*specify*" text box.
ATR Required	Yes (all if information is available)
NTDB Required	Yes (shown in **red**: postal code, country) please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet
History	N/A

Injury Date

Data Element	Injury Date
Field Name	INJ_DATE
Field Type	Date
Field Length	2,2,4
Note	The date the injury occurred. Click the injury date from the calendar icon to the right of the text box or type it in manually. An approximation should be used if the actual date is not recorded, wherever possible (see note below re: estimates). For instance, if in the chart it is documented that the incident occurred 3 weeks ago, go back 3 weeks in the calendar, from the admission date and record that date as the incident date. ***You can no longer enter UU (or?) for only part of the date (DD or MM).*** Format MM/DD/YYYY Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Proxy measures (i.e. 911 calls) should not be used). '/' cannot be used. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Injury Time

Data Element	Injury Time
Field Name	INJ_TIME
Field Type	Time
Field Length	2,2
Note	The time the injury occurred. Enter injury time using 24 hour clock (HH:MM) Estimates of time of injury should be based on report by patient, witness, family or health care provider. Other proxy measures (e.g., 911 call time) **should not** be used. If there is no time approximation "?" may be entered (no partial unknowns accepted – for example if only the minutes are unknown). It is important to document an incident time when possible because calculations for elapsed times are based on this data element. '/' cannot be used. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

ICD10 Location Code

Data Element	ICD10 Location Code (formerly Primary Place of Injury/ ICD 10-CA)
Field Name	INJ_PLC_ICD1001
Field Type	Numeric
Field Length	1
Note	Select the place of injury that corresponds to the primary ICD 10 Mechanism (V01-Y98) to denote the place where the injury occurred. If the patient is injured while in hospital, select menu item #1 (residential institution) and enter the name of the hospital in the specify place of injury data element. If patient is living in hotel/motel, code as Home. If vacationing in hotel/motel, code as Public Building. For injuries occurring on the construction site of a home being built but not yet occupied use #6 (Industry). Only one ICD10 location can be documented for each of the primary, secondary and tertiary V Codes. **Therefore, if you only have 1 ICD10 MOI you should only have 1 ICD10 location code; if you have 2 ICD10 MOIs you must have 2 ICD10 location codes, etc.** 1. Field cannot be n/a 2. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Clarification

Please review CIHI ICD-10-CA manual (tenth revision, volume 1) page 1018 for further details.

https://www.cihi.ca/en/icd_volume_one_2012_en.pdf

Please see next page for definitions

Menu for ICD-10 place of injury:

0	**Home**	Includes any place of private residence that is non-institutional as well as their driveways, garages, gardens and yards; does not include private residences under construction
1	Residential Institution	Includes hospital, nursing home, assisted living, jail, orphanage, barracks, dormitory, homeless shelter if temporary housing, etc.
2	School/Other Institution/Public Area	Any building used by general public or a particular group of the public including adjacent grounds, driveways and parking lots. Examples: assembly hall, campus, church, cinema, clubhouse, college, court-house, dancehall, day nursery, gallery, hospital, institute for higher education, school (public or private), library, movie-house, museum, music-hall, opera, post office, public hall, theatre, youth centre, homeless shelter for anything other than temporary housing.
3	Sports/ Athletics Area	Place of recreation or sport, including: school playground, gym, athletic fields/courts/rinks, golf course, public park, holiday camp, resorts, race course, rifle range, stadium, public swimming pools, or organized ski area. DOES NOT include recreation/sport occurring at private home or yard. DOES NOT include back country activities (ATV, ski).
4	Street/ Highway	Includes highways and all other public roadways. Includes sidewalks but please identify sidewalk in the "*specify*" text box area. Excludes private driveways, parking lots, ramps, or roads in airfields, farms, industrial premises, mines, private grounds or quarries.
5	Trade/ Services Area	Includes airport, bank, café, casino, garage (commercial), gas station, grocery store, hotel, market, office building, petrol station, radio or TV station, restaurant, service station, shop (commercial), shopping mall, station (bus/rail/subway), store, supermarket, warehouse.
6	Industrial/ Construction Area	Includes construction site, buildings under construction, factory (building and premises), industrial plant and yard, warehouse, laboratory/science lab, commercial garage, loading platform in a store, dockyard, gasworks, oil rig and other offshore installations, pit, power-station, shipyard, tunnel under construction and **mines**.
7	Farm	Includes farm buildings (not home), land under cultivation, and private roads on farm/ranch

8	Other Specified Place of Occurrence	Use if none of the other options fit. May include back country activities, forest, lake, river, beach, desert, mountain, abandoned building, reservoir, public place NOS, zoo, military training ground, parking-lot and parking spaces, railway line, etc.
9	Unspecified Place of Occurrence	Use when there is no information about place of injury (unknown/not identified)
/	Not Applicable	Do not use for primary location code; may be used for 2nd or 3rd location codes.
~~**U?**~~	~~Unknown~~	Please do not use this: use #9 unspecified

Secondary ICD10 Location Code

Data Element	Secondary ICD10 Location Code (formerly Secondary Place of Injury/ICD 10-CA)
Field Name	INJ_PLC_ICD1002
Field Type	Numeric
Field Length	1
Note	Select the place of injury that corresponds to the Secondary ICD 10 Mechanism (V01-Y98) to denote the place where the injury occurred. See ICD10 location code for menu for place of injury This field should be skipped if a Secondary ICD 10 Mechanism was not entered (please enter '/').
ATR Required	Yes
NTDB Required	Yes -please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Tertiary ICD10 Location Code

Data Element	Tertiary ICD10 Location Code (formerly Tertiary Place of Injury/ICD 10-CA)
Field Name	INJ_PLC_ICD1003
Field Type	Numeric
Field Length	1
Note	Select the place of injury that corresponds to the Tertiary ICD 10 Mechanism (V01-Y98) to denote the place where the injury occurred. See ICD10 location code for menu for place of injury This field should be skipped if a Tertiary ICD 10 Mechanism was not entered.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Specify (Place of Injury)

Data Element	Specify Place of Injury
Field Name	INJ_PLC_MEMO
Field Type	Character
Field Length	215
Note	Describe the place of injury in detail (e.g. the name of the building/place).
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Intentional Injury

Data Element	Intentional Injury
Field Name	INJ_INTENT
Field Type	Integer
Field Length	1
Note	Was the injury intentional? Use "?" if the hospital chart questions whether the injury was intentional or does not specify intentional injury. Do not use homicide or child abuse as it is a legal determination / outcome. Use assault. This drop down list will be revised by DI. For now please do not use options 3, 4 or /. If using assault, record in the notes tab that the incident was intentional. If an individual is shot by a cop or injured in operations of war use #5 (Assault) An individual injured by a bouncer is #5 (Assault) 1. No 2. Suicide/Self Harm 3. Homicide 4. Child Abuse 5. Assault Agreed by Data subcommittee on April 05 2018 to change wording Suicide to Self-inflicted. Remove Homicide. Awaiting DI to do an update
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Primary ICD10 Mechanism

Data Element	Primary E-Code/ICD 10 (External Cause of Injury Code)
Field Name	INJ_ECODE_ICD10_01
Field Type	Character
Field Length	5
Note	
ATR Required	(V01-Y98) are a classification within the International Classification of Diseases (ICD-10-CA) that describes the nature of injury. ***This field cannot be blank/not applicable.*** Three ICD10 MOI codes can be documented in the ATR (primary, secondary, tertiary). The primary external cause code should describe the main reason a patient is admitted to the hospital according to CIHI coding standards. Record the event which came first (sequential events). Example 1: If a patient is involved in a motor vehicle collision and the car explodes resulting in burns to 30% of the body plus multiple system injuries (the most severe injury) the motor vehicle collision would be the primary Code and the explosion would be the secondary Code. Example 2: If a motorcyclist is rear-ended and is ejected from motorcycle and is subsequently run over code the rear-end collision as primary MOI and the patient getting run over as the secondary MOI. Example 3: A patient drives off the road and into water and drowns. Code the traffic loss of control non-collision first (driver would be V480) and then the drowning (W74 NOS drowning & submersion). Example 4: If a patient is assaulted (punched in face) and then falls and hits head code the assault as the primary MOI and the fall as a secondary MOI. Although if his fall is directly related to the assault (is punched and immediately goes down) you probably only want to code the assault. If he is assaulted and dazed and wanders around for a few minutes and then falls because his is woozy from being assaulted then code 2 MOIs. Choose a four digit ICD-10-CA External Cause of Injury code (V Code) for the etiology. Codes may be selected from a menu system as follows. The first menu presented lists 35 broad categories of injury corresponding to sections in the ICD manual. This menu is listed below. Categories W78-80, X20-29, X40-49, X51, X53-54, X57, X60-69, X85, X87-90, Y06, Y10-19, & Y40-Y98 should not be coded in the ATR as we do not collect these injuries. We don't include patients where they were admitted to treat the venom as opposed to the bite. This is still a poisoning even if they were bitten. See penetrating injury memo.

	After selecting a category from this first menu a second menu listing specific external cause codes will be displayed. After selecting a specific code from the second menu, a third menu listing appropriate fourth digits will be displayed. More details about ICD-10-CA codes can be found from https://www.cihi.ca/en/icd_volume_one_2012_en.pdf Intentional hit and run MVC collisions should be coded with an intentional V Code regardless of whether the driver is charged for the incident. Ignore this – this is absolute wrong. Would be coded as assault with vehicle Y02 **NOT** V00-V99 **If the final diagnosis is recorded as undetermined intentionally (i.e., Suspected Shaken Baby Syndrome, the code must reflect this.)** **Refer to NTDB data dictionary for Multiple Cause Coding Hierarchy**
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. History and Physical 5. Progress Notes
History	N/A

Clarification:

In the NTDS data dictionary on pages 20-21 it describes a multiple cause coding hierarchy. This is for the US ICD-CM coding. We are required to follow CIHI ICD10-CA coding rules (therefore the answers that we are given on the CIHI eQuery tool are the correct ones). CIHI multiple cause coding hierarchy codes by order of how the event occurred (as shown in multiple examples above and on our SharePoint site). Using CIHI Canadian coding system rules has been reaffirmed by NTDB email reply Feb 26, 2016. If you have questions about multiple external cause coding please rely on the discussions we have in the data analyst L&L, the previous examples shared and not on the NTDS NTDB data dictionary rules (which are for the US). The data in the ATR is required to be entered using Canadian ICD10-CA coding standards.

First Menu for V Code Selection:

V01 – V09	**Pedestrian injured in transport accident**
V10 – V19	Pedal cyclist injured in transport accident
V20 – V29	Motorcycle rider injured in transport accident
V30 – V39	Occupant of three - wheeled motor vehicle injured in transport accident
V40 – V49	Car occupant injured in transport accident
V50 – V59	Occupant of pick-up truck or van injured in transport accident
V60 – V69	Occupant of heavy transport vehicle injured in transport accident
V70 – V79	Bus occupant injured in transport accident
V80 – V89	Other land transport accidents
V90 – V94	Water transport accidents
V95 – V97	Air and space transport accidents
V98 – V99	Other and unspecified transport accidents
W00 – W19	Falls
W20 – W49	Exposure to inanimate mechanical forces
W50 – W64	Exposure to animate mechanical forces
W65 – W74	Accidental drowning and submersion
W75 – W84	Other accidental threats to breathing ***(exclusions: W78, W79 and W80)***
W85 – W99	Exposure to electricity/radiation/extreme temp/pressure
X00 – X09	Exposure to smoke, fire and flames
X10 – X19	Contact with heat and hot substances
~~**X20 – X29**~~	~~Contact with venomous animals and plants~~
X30 – X39	Exposure to forces of nature
~~**X40 – X49**~~	~~Accidental poisoning by and exposure to noxious substances~~
X50 – X57	Overexertion, travel and privation ***(exclusions: X51, X53, X54, X57)***
X58 – X59	Accidental exposure to other and unspecified factors
~~**X60-X69**~~	~~Intentional self-harm by poisoning~~
X70 – X84	Intentional self-harm
X85 – Y09	Assault ***(exclusions: X85, X87, X88, X89, X90, Y06.0-Y06.9)***
~~**Y10 – Y19**~~	~~Event of undetermined intent (Poisonings)~~
Y20 – Y34	Event of undetermined intent
Y35 – Y36	Legal intervention and operations of war
~~**Y40 – Y59**~~	~~Drugs, medicaments and biological substances causing adverse effects in therapy~~
~~**Y60 – Y69**~~	~~Misadventures to patients during surgical and medical care~~
~~**Y70 – Y82**~~	~~Medical devices w/ adverse incidents in diagnostic and therapy~~
~~**Y83 – Y84**~~	~~Px causing abnormal reaction/complication not during px~~
~~**Y85 – Y89**~~	~~Sequelae of external causes of morbidity and mortality~~
~~**Y90 – Y98**~~	~~Other factors related to morbidity/mortality~~
varies	Retired Mechanism Codes
/	Not applicable
?	Unknown

Secondary ICD10 Mechanism

Data Element	Secondary E-Code/ICD 10 (External Cause of Injury Code)
Field Name	INJ_ECODE_ICD10_02
Field Type	Character
Field Length	5
Note	Select a four–digit ICD 10 CA External Cause of Injury code for the etiology that is more closely related to the circumstances causing the injury. The secondary event code is used when you have two distinct events; this is a rare occurrence. Please enter '/' if there is no secondary MOI. Menu selection is the same as for Primary ICD10 mechanism. **Refer to NTDB data dictionary for Multiple Cause Coding Hierarchy**
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. History and Physical 5. Progress Notes
History	N/A

Clarification:

In the NTDS data dictionary on pages 20-21 it describes a multiple cause coding hierarchy. This is for the US ICD-CM coding. We are required to follow CIHI ICD10-CA coding rules (therefore the answers that we are given on the CIHI eQuery tool are the correct ones). CIHI multiple cause coding hierarchy codes by order of how the event occurred (as shown in multiple examples above and on our SharePoint site). Using CIHI Canadian coding system rules has been reaffirmed by NTDB email reply Feb 26, 2016. If you have questions about multiple external cause coding please rely on the discussions we have in the data analyst L&L, the previous examples shared and not on the NTDS NTDB data dictionary rules (which are for the US). The data in the ATR is required to be entered using Canadian ICD10-CA coding standards.

Tertiary ICD10 Mechanism

Data Element	Tertiary E-Code /ICD 10 (External Cause of Injury Code)
Field Name	INJ_ECODE_ICD10_03
Field Type	Character
Field Length	5
Note	Select a four–digit ICD 10 CA External Cause of Injury code (V Code) for the etiology that is more closely related to the circumstances causing the injury. The tertiary event code is used when you have three distinct events; this is a very rare occurrence. Menu selection is the same as for Primary ICD10 mechanism. **Refer to NTDB data dictionary for Multiple Cause Coding Hierarchy**
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. History and Physical 5. Progress Notes
History	N/A

Clarification:

In the NTDS data dictionary on pages 20-21 it describes a multiple cause coding hierarchy. This is for the US ICD-CM coding. We are required to follow CIHI ICD10-CA coding rules (therefore the answers that we are given on the CIHI eQuery tool are the correct ones). CIHI multiple cause coding hierarchy codes by order of how the event occurred (as shown in multiple examples above and on our SharePoint site). Using CIHI Canadian coding system rules has been reaffirmed by NTDB email reply Feb 26, 2016. If you have questions about multiple external cause coding please rely on the discussions we have in the data analyst L&L, the previous examples shared and not on the NTDS NTDB data dictionary rules (which are for the US). The data in the ATR is required to be entered using Canadian ICD10-CA coding standards.

Cause of Injury

Data Element	Specify Cause of Injury
Field Name	INJ_CAU_MEMO
Field Type	Character
Field Length	215
Note	Describe in more detail the cause of the injury. Enter broad categories preceding description. For example, MVC, Fall, Assault. Notes on cause of injury text: • If patient was injured in an MVC put type of vehicle they were travelling in first and where they were sitting then what they hit. • If there were 2 mechanisms of injury put them in sequential order • If weapons were used add them to the description • This section is used to put as many details as possible so in the future data users do not have to go back and get the chart when questions arise. • If your data elements are contradictory (e.g. vehicle type is minivan but ICD10 code is truck/cargo van) this description helps clarify. • Additionally if the description is too vague there may be questions if more than 1 code could possible cover the described situation so more details are always preferable to less.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. History and Physical 5. Progress Notes
History	N/A

Injury Type

Data Element	Injury Type
Field Name	INJ_TYPE01
Field Type	Numeric
Field Length	1
Note	Indicate whether the most serious injury is: 1. Blunt 2. Penetrating 3. Burns / Not applicable (should not be used) ? Unknown To document injury type, consider the cause of injury. For example, a patient struck by a motor vehicle is documented as a blunt injury even if his injuries include deep lacerations. For patients with more than one type of injury (i.e., blunt and penetrating) consider the most severe injury to determine the injury type. If there are concerns, consult your medical director or the physician responsible for the patient's care. For example, in an assault where injuries are the result of both stabbing and beating: • if the injuries include a head injury and a stab to the arm, the injury type would be documented as blunt because of the more severe head injury. • if the injuries include a laceration to any organ as a result of the stabbing and minimal injury from the beating, the injury type would be penetrating. • Please review the minor penetrating memo definition (dated Sep 15, 2015) bullet point #1 for penetrating injury definition. **Please code strangulation, hanging and/or drowning as "Blunt" type injury. Blast injuries** should be coded as blunt.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet 2. ED physician record 3. ED nursing record 4. Trauma nurse flow sheet 5. Trauma Physician
History	New minor penetrating trauma inclusion Sep 15, 2015 (should be used for all patients entered in new ATR from Jan 1, 2015).

Sports Code

Data Element	Sports Code
Field Name	INJ_ACT
Field Type	Numeric
Field Length	3
Note	If the patient is injured in any sports or recreational activity, select the activity of the patient from the following menu. Hospitals may wish to default this field to inappropriate which should be documented for all patients who are not injured in a sports or recreational activity.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet 2. ED physician record 3. ED nursing record 4. Trauma nurse flow sheet 5. Trauma Physician
History	N/A

Menu for Sports Code Selection:

1	Aerobics
2	Aircraft - Recreational motorized (e.g. fixed wing)
3	Aircraft - Recreational non-motorized (e.g. Glider)
4	ATV
5	Amusement Rides
6	Auto Racing
7	Badminton
8	Baseball (Hard Ball, Soft Ball, T–Ball, Slo–Pitch)
9	Basketball
10	Billiards/Pool/Shuffleboard
11	Boating – Motorized
12	Boating – Canoe
13	Boating – Kayak
14	Boating – Rowboat
15	Boating – Sailing
16	Boating - Windsurf/Sail Board
17	Boating - Pedal Boat
18	Boating - Wave runner, Sea Doo, etc.
19	Boating – Other, unspecified
20	Boxing (organized, would not include children at play)
21	Bowling (5 or 10 Pin)
22	Cricket
23	Croquet/Lawn Bowling
24	Curling
25	Cycling – Driver (if unspecified, assume driver)
26	Cycling – Passenger
27	Cycling – Unicycle
28	Dancing
29	Darts
30	Dirt Biking/Mini Bikes/Motocross
31	Diving
32	Fencing
33	Fire (Open Flames Outdoors – Charcoal and Gas Barbeques, Camp Fire)
34	Fireworks – User
35	Fireworks – Observer
36	Fishing
37	Football
38	Go Carting
39	Golf
40	Gymnastics (organized, would not include children at play)
41	Handball
42	Hang Gliding/Para Sailing
43	Hiking
44	Horse Back Riding
45	Hockey – Ice
46	Hockey - Street/Ball
47	Hockey - Field/Floor
48	Hockey – Inline
49	Horseshoes
50	Hunting - Bow & Arrow
51	Hunting – Gun
52	Hunting – Knives (main activity is hunting, injury caused by knife)

53	Jogging/Running
54	Lacrosse
55	Lawn Darts
56	Luge/Bobsled
57	Martial Arts (Judo, Kendo, Karate, Tae Kwon–Do, Jiu–Jitsu, etc.)
58	Mountaineering/Rock Climbing
59	Playground equipment (swings, slides, monkey bars, teeter totter in any location)
60	Play not further specified (i.e., running, jumping, skipping, general play activities)
61	Racquetball
62	Ringette
63	Rugby
64	Scuba Diving
65	Shooting - Bow & Arrow (i.e. targets)
66	Shooting - Gun (i.e. non-hunting use of firearm, targets, rifle range, skeet)
67	Skate Boarding
68	Skating – Ice (used in winter seasons if type of skating is not specified)
69	Skating – Inline
70	Skating – Roller
71	Skiing – Downhill - Recreational (use if type of skiing is not specified)
72	Skiing – Downhill – Racing
73	Skiing – Cross Country
74	Ski jumping (includes moguls and aerials stunts)
75	Sky Diving/Parachuting
76	Snowboarding
77	Snowmobiling – Driver (assume driver if not specified)
78	Snowmobiling – Passenger
79	Snowmobiling - Towed behind on toboggan, tube or sleigh
80	Soccer
81	Squash
82	Swimming – Pool
83	Swimming – Open Water
84	Swimming – Wading pool, location unspecified
85	Tennis
86	Tobogganing/Sledding/Snow Tubing (Not Towed)
87	Track & Field (organized)
88	Trampoline
89	Volleyball
90	Walking (For Exercise)
91	Water polo
92	Water–skiing/tubing
93	Weightlifting (recreational or organized, includes exercise equipment)
94	Wrestling (organized, does not include children at play)
95	Observer of Sporting Event
96	Other
97	Scooter - non–motorized
98	Rodeo sports
99	Scooter – motorized
/	Not applicable (default)
?	Unknown

Injury Mechanism

Data Element	Injury Mechanism
Field Name	INJ_MECH01, INJ_MECH02
Field Type	Numeric
Field Length	2
Note	Quick tab button for general categories of injury mechanism (for ATR and provincial reporting purposes). These are not the same as the ICD9/10 mechanism of injury categories. Choose up to two. Please click in order of primary and secondary mechanisms (whichever you click first will appear first). You can also choose from the drop down menu in the box. 1. MVC 2. Fall under 1m (3.3 ft.) 3. Fall 1-6 m (3.3 – 19.7 ft.) 4. Fall over 6m (>19.7 ft) 5. Fall – NFS 6. Assault 7. Motorcycle 8. Pedestrian 9. Bicycle 10. Other blunt mechanism 11. Knife 12. Handgun 13. Shotgun 14. Other gun 15. Glass 16. Biting 17. Other penetrating mechanism 18. Chemical burn 19. Inhalation burn 20. Thermal burn 21. Electrical burn 22. Other burn mechanism / Not applicable ? Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes 4. History and Physical 5. Progress Notes
History	N/A

Clarification

Motor vehicle crash details will only become inactive if #1, 7 or 9 is chosen. If a person riding a horse gets hit by a car enter #10 first then #1 so you can fill out the collision details. If a person is a pedestrian struck by a car enter #8 first then #1. This includes any motor vehicle (including off-road vehicles like forklifts, etc.).

Fall NFS should only be used if coding W19, otherwise you should have enough information to choose between Fall under 1m, fall 1-6 m or fall over 6m.

Motor Vehicle Crash Details:

All data elements in this section will be skipped unless options #1 (MVC) #7 (motorcycle) or #9 (bicycle) is/are chosen in the previous injury mechanism question (in either the first or second box).

Position in Vehicle

Data Element	Position in Vehicle
Field Name	INJ_VEH_POS
Field Type	Numeric
Field Length	2
Note	Enter the appropriate code for the patient's position in the vehicle from the drop down list. This data element should be used to indicate the position of the patient when injured in, on, or by a vehicle. Position in vehicle is a numbering system designed by the Alberta Dept. of Transportation to designate where the injured person was seated in a vehicle. This information can be found on the **ACRF**. All occupants of the third bench in a minivan or SUV should be coded as menu item #7, #8, or #9 (third row). Riders in a box of a pickup truck should be coded as menu item #12 (truck bed). Riders in the rear of an enclosed truck or van (e.g. cargo van with no seats in back) should be coded as menu item #11. Motorcycle and bicycle drivers **and** passengers should be coded as menu item #15 or #16 (motorcyclist or cyclist). Dirt bike should be coded as a motorcycle. If a patient is boarding and alighting or jumping from a vehicle then this field should be coded as "/" for not applicable. #5 should be used if unknown location in the backseat.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	Sitting on a person's lap is no longer an option to code.

Menu Selection for Position in Vehicle Detail:

1	**Driver (not motorcyclist or bicyclist)**
2	Front seat middle
3	Front seat passenger (includes ATV passenger side by side)
4	Second row left
5	Second row middle (includes ATV passenger or snowmobile passenger behind driver)
6	Second row right
7	Third row left
8	Third row middle
9	Third row right
10	Station wagon rear
11	Truck/van rear
12	Truck bed
13	Bus passenger
14	Passenger NFS
15	Motorcyclist (driver or passenger)
16	Bicyclist (driver or passenger)
17	Pedestrian
18	Hanging on or riding on Vehicle
19	Riding an animal
20	Other
/	Not applicable
?	Unknown

Impact Type

Data Element	Impact Type
Field Name	INJ_IMP_TYPE
Field Type	Numeric
Field Length	2
Note	Select the type of impact. Impact type is a description as defined by the Alberta Collision Report Form for the vehicle in which the patient was travelling in or on. Enter "/" for car/pedestrian as this is not applicable for Pedestrians. Animal riders select 13. "Other" See below for full selection menu.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. Billing Sheet / Medical Records Coding Summary Sheet 4. ED Nurses' Notes
History	N/A

Menu Selection for Impact Type:

1	**Struck Object**
2	Off Road Left
3	Right Angle (T–Boned)
4	Passing – left turn
5	Left Turn – across path
6	Sideswipe – opposite direction
7	Rear–end
8	Off Road Right
9	Head–On
10	Passing – Right Turn
11	Sideswipe – same direction
12	Backing
13	Other
/	Not applicable
?	Unknown

Impact Location Primary

Data Element	Location of Primary Vehicle Impact
Field Name	INJ_IMP_LOC
Field Type	Numeric
Field Length	2
Note	Enter the type of impact for the primary vehicle. **The primary vehicle for the purposes of the ATR is the one that the patient is travelling in or on.** Primary vehicle impact describes the location of the initial impact on a vehicle for those patients injured in motor vehicle or other transport collisions. Impact may be with another vehicle or a fixed object. The primary vehicle impact describes the location of first impact for the vehicle the patient was travelling in or on. Enter "I" for car/pedestrian. A diagram of the vehicle damage or area of impact is found on the **Alberta Collision Report Form** (Initial Point of Impact). If only "driver's side" is specified in the chart, record "left centre" (06). If "head on" is specified in the chart, record "front centre" (08). Record from the point of view as if you were sitting in the car in the driver's seat on the left side of the car (North American driver's location). Animal Rider "n/a" Menu options: 01. Right Front 02. Right Centre 03. Right Rear 04. Back Centre 05. Left Rear 06. Left Centre 07. Left Front 08. Front Centre 09. Top 10. Undercarriage 11. Rollover 12. Attachment from Rear ~~13. Information Missing~~ *(same as unknown therefore don't use)* 14. Other / Not Applicable ? Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run sheet
History	N/A

Collision Detail

Data Element	Collision Detail (primary and secondary details)
Field Name	INJ_VEH_INC_DET01, INJ_VEH_INC_DET02
Field Type	Numeric
Field Length	1
Note	Enter the appropriate code for collision detail from the drop down menu. The primary detail is the impact that results in the patient's most serious injuries, not necessarily the first injury recorded. Up to two collision details can be recorded. If pedestrians, bicyclists or horse riders are hit by a vehicle enter #1 (impact with moving object). If they hit a non-moving vehicle enter #2 (impact with a fixed object).Enter "/" for Boarding and alighting Enter "/" for Jumping from a vehicle Animal Riders "/" As per data subcommittee June 14 2018
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. Billing Sheet / Medical Records Coding Summary Sheet 4. ED Nurses' Notes
History	N/A

Menu Selection for Collision Detail:

1	**Impact with moving object**
2	Impact with fixed object
3	Submersion
4	Vehicle fire
5	Vehicle roll over
/	Not applicable
?	Unknown

Vehicle Type

Data Element	Vehicle Type
Field Name	VEH_TYPE
Field Type	Numeric
Field Length	2
Note	Select the type of vehicle that the patient was in or on. Use pedestrian (menu item #16) if the injured person is a pedestrian struck by a vehicle including a bicycle. Use #10 for injured bicyclists. SUVs and mini-vans should be coded as (#02) passenger vehicles Complete menu and further clarification can be found below.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. Billing Sheet / Medical Records Coding Summary Sheet 4. ED Nurses' Notes
History	N/A

Menu Selection for Vehicle Type:

1	**Bus**
2	Passenger Vehicle (includes mini–van, SUV ≤ 8 ppl)
3	Light Truck (vans > 9 people, pick-up trucks)
4	Heavy Truck (> half ton)
5	Recreation Vehicle (motorhome, etc.)
6	Motorcycle
7	Snowmobile
8	ATV
9	Boat
10	Bicycle
11	Transport Truck (semi-truck, etc.)
12	Logging Truck
13	Plane
14	Train
15	Farm Equipment
16	Pedestrian
17	Other (golf cart, animal if used for transport)
/	Not applicable
?	Unknown

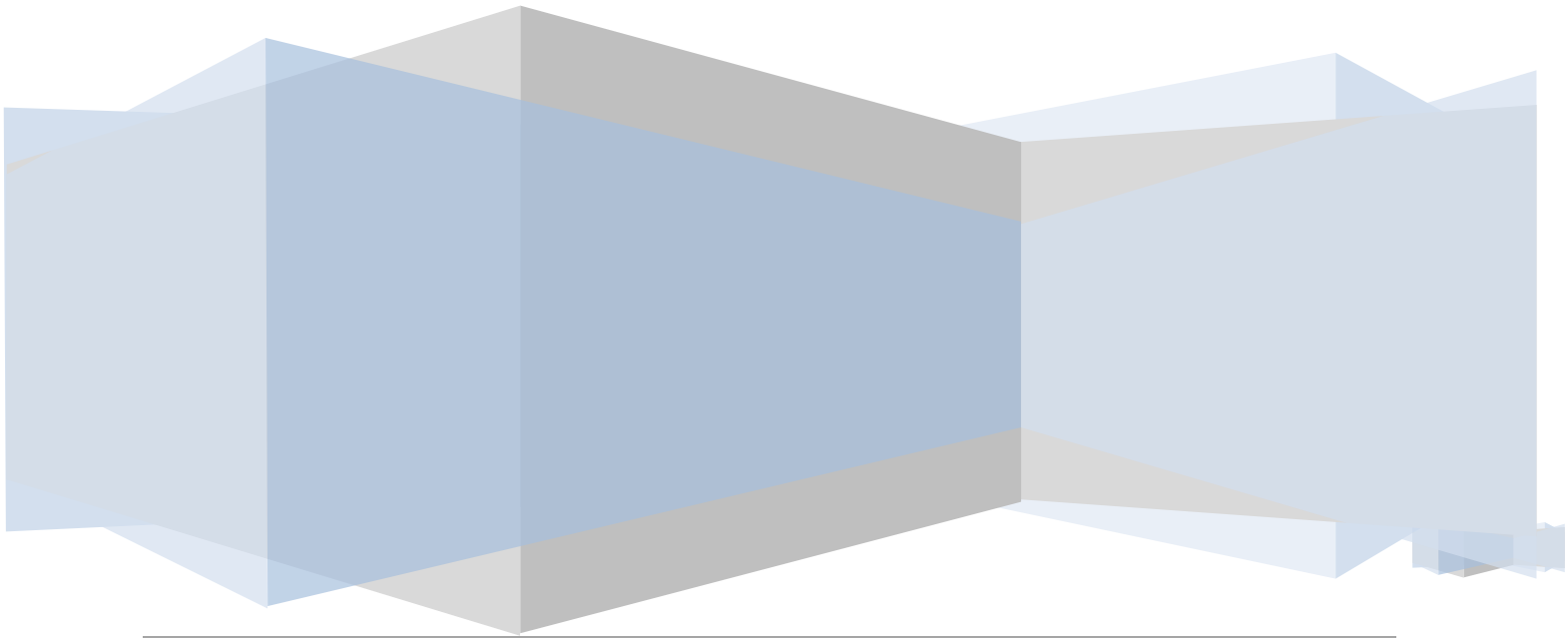
If Other Vehicle Type

Data Element	If Other Vehicle Type
Field Name	VEH_TYPE_S
Field Type	Character
Field Length	50
Note	Specify if 'other' entered in the previous field. This field will be skipped if 'other' was not selected in the previous field. If the person is on an animal can this be placed under “other”. Horse would be included under “other” but only if it falls under the E code (E800-848) or V codes (V01 – 99) i.e. used as transport. Dune buggies and motorized scooters/wheelchairs are also included in this category.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Notes

Data Element	Injury Notes
Field Name	INJ_MEMO
Field Type	Character
Field Length	500
Note	Enter information in this area if you need to make a note about the injury data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section III Prehospital (Scene) Data



Scene/Transport

Health Region

Data Element	Health Region – HEALTH REGION OF PLACE OF INJURY
Field Name	INJ_REGION
Field Type	Numeric
Field Length	2
Note	Please enter the health region of place of injury. Only options 1-5 are current – **do not use the old regions (#6-21)**. 1. South zone 2. Calgary zone 3. Central zone 4. Edmonton zone 5. North zone / Not Applicable (injured outside AB; will be captured in injury section previous) ? Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Was patient Extricated?

Data Element	Extrication Required
Field Name	PH_EXT_YN
Field Type	Numeric
Field Length	1
Note	Was extrication required at the scene? Extrication is documented if the patient was trapped and required release from the scene of the incident. Extrication includes extrication by medical personnel only (Police, Fire, EMS, and RCMP). Pedestrian caught under a vehicle/pinned by vehicle is extrication. A person buried under dirt (cave-in) is an extraction. Patient taken out on a spine board is not considered extrication. Bicyclists and Animal Riders select "n/a' 1. Yes 2. No / Not Applicable *(injuries <u>other than</u> MVCs or situations where patient might become trapped)* ? Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Extrication Time Required (in Minutes)

Data Element	Extrication Time Required (in Minutes)
Field Name	PH_EXT_MINS
Field Type	Numeric
Field Length	3
Note	Enter the time of extrication in minutes. Enter exact minutes if known. Do not use estimates. Enter '?' if unknown.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. Billing Sheet / Medical Records Coding Summary Sheet 4. ED Nurses' Notes
History	N/A

Scene/transport providers

Must click on the add button to add transport details. There should be a minimum of 1 line added for each patient entered (even if private transport). Non-applicable fields will deactivate if non-ambulance method of transport used. Please enter all modes of transport in the chronological order (time they arrived at patient). The last row item will be sent to NTDB if applicable as this should be the transport that takes the patient to hospital.

Provider Details

Mode of Transport

Data Element	Mode of Transport (Transport at Scene)
Field Name	PHP_MODES (list), PHP_MODE_SS (if other)
Field Type	Numeric
Field Length	1
Note	Enter the mode of transport from the scene of the incident. Enter the transport modes in chronological order. Enter the mode of transport that brought the patient to the facility first as per NTDB requirement Mode of transport refers to the vehicle/provider used during patient transport from the scene to hospital and between hospitals. Military helicopter ambulances should be coded as helicopter ambulances. Infinite modes of transport (land or air vehicles) can be documented for each run. A run is a prehospital transfer, which may be from the scene to a hospital or between transport vehicles. In the prehospital treatment tab (subsequent tab to fill out) please make sure all prehospital details are entered are in the same order as entered in the scene/transport providers tab (in same order of ambulance service #). You switch the order of providers (by ambulance #) provider vitals, and provider interventions using the green arrow ↑ and ↓ buttons. If the patient went directly to a district/tertiary trauma hospital, the first mode of transport from the scene will pertain to the run from the scene to the district/tertiary trauma hospital. Patients that are injured in your hospital are a walk-in.

	If mode is other please enter mode of transport in text box provided.
ATR Required	Yes
NTDB Required	Yes– all other modes of transport during patient care. please see the definition in the current NTDB data dictionary Field cannot be blank
Hierarchy	1. EMS run sheet
History	**Clarification:** Enter multiple transports (i.e. transport encounters with their own PCR form) in chronological order.

Menu Selection for Mode of Transport:

1	**Ground ambulance**
2	Helicopter ambulance (e.g. STARS, military)
3	Fixed–wing ambulance
4	Private vehicle or walk–in
5	Police
6	Public Safety
7	Water ambulance
8	Other (please enter mode if other in text box below)
/	~~Not applicable~~ (should not be used)
?	Unknown

Clarification: Scenario

Patient had an incident in Vancouver BC. Patient was seen at a hospital in Vancouver and then discharged home. 2 days later he was admitted to our Trauma Centre in Calgary as his injuries had exacerbated.

Based on this scenario for Scene data he was not brought to the hospital from the "scene "therefore, enter "not known/not recorded"

Transport Role

Data Element	New 2017: Transport Role
Field Name	
Field Type	Numeric
Field Length	1
Note	Used to help determine the logic for data being sent to NTDB (check to see if row data for unit transporting to your hospital is actually being sent or something else). Please choose from the drop down list below. Transport from scene to facility is direct transfer to any hospital. 1. Transport from Scene to Facility 2. Transport from Scene to Rendezvous 3. Transport from Rendezvous to Facility 4. Transport to Other 5. Non-transport (not transporting patient but treating patient) 6. Transport from Non-Scene Location / Not applicable ? Unknown If transport mode is EMS transport role will be required to be filled out (check added). If options 2 or 3 are check you will be required to fill out rendezvous pickup location.
ATR Required	Yes
NTDB Required	Yes – may not be directly sent (no data element in NTDS data dictionary) but to assist with logic in data being sent.
Hierarchy	1. EMS run sheet
History	New 2017

Transport from Rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital as per Data Subcommittee April 05 2018.

Ground to airport, airport to airport and ground to facility needs to be coded as 4-transport to other.

Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital.

Ambulance Service

Data Element	Ambulance Service # (Transport at scene)
Field Name	PHP_AGNC_SS
Field Type	Character
Field Length	50
Note	Type in Ambulance Service Name using to the station ID on the EMS Provincial Service Delivery Profile – stations document. Please use these common station IDs so it is consistently entered throughout the province and will also assist in data pulling from RW and data matching with EMS data. Will not be active to enter if ambulance mode of transport was not chosen for provider. Use Unit ID it reads Numeric Alpha Numeric As per conversation with Greg Vogelaar March 8 2018 use Unit ID. Should be numeric Alpha Numeric
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	Do not use PCR# or Event #.

Scene EMS Report

Data Element	Scene EMS Report (PCR Available, Transport at scene)
Field Name	PHP_RP_DETAILS
Field Type	Numeric
Field Length	1
Note	Please choose from the drop down list if the scene EMS report is present in the paper chart or on Siren please choose complete or incomplete. If the report is missing information and it becomes available after requesting from the appropriate EMS provider please choose complete. If the report is originally missing but you receive it by fax please choose complete (or incomplete as appropriate). Only choose missing if it is not available in the chart. Also if report is originally missing but you receive the report at a later date you will need to go back in to enter the transport and treatment fields previously marked as '?'. 1. Complete 2. Incomplete 3. Missing 4. Unreadable / Not applicable ? Unknown Will not be active to enter if ambulance mode of transport was not chosen for provider.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	N/A

PCR#

Data Element	PCR# (Transport at scene)
Field Name	PHP_PCR_NUMS
Field Type	Character
Field Length	39
Note	Enter the PCR number for each transport line entered (land or air vehicle). This includes flight number for air ambulance or fixed wing transport. If you cannot find the PCR# please call the appropriate EMS to see if they can give you the information. If PCR # is missing and can't be found enter "?". Will not be active to enter if ambulance mode of transport was not chosen for provider. Event number should be Alpha Numeric As per conversation with Greg Vogelaar from EMS on April 05 2018 the Event number is the one to be used for PCR number.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	N/A

Qualified Personnel

Data Element	# of Qualified Personnel (Transport at Scene)
Field Name	PHP_ACRS01S, PHP_ACRS02S, PHP_ACRS03S, PHP_ACRS04S, PHP_ACRS05S
Field Type	Numeric
Field Length	2,2,2,2,2
Note	Enter the number of personnel from each category accompanying the patient during the transport for the first transport (land or air vehicle) at the scene. For categories that are not applicable enter 0. If a PICU Transport Team is used, indicate number of people on team. Qualified personnel include: EMT – starts with 40 EMT–P – starts with 50 RT RN – starts with 65 MD PICU STARS usually have on board 1 nurse, 1 paramedic and sometimes 1 physician. If you do not know how many people of a certain category you can enter '?' for unknown – but you should make every effort to find out how many EMS personnel were on scene for transport. '/' not applicable **should not be used.**
ATR Required	Yes
NTR Required	No
Hierarchy	1. EMS run sheet
History	2015: removal of EMR and students - don't need to count (PICU removed and not added back in until 2017.

Call Details

Date Call Dispatched/Received

Data Element	Date Call Dispatched/Received
Field Name	PHP_D_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance call was received (MM DD YYYY). You can also choose the date from the calendar icon on the right. There is no default date (i.e. date of injury). It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene enter in chronological order with the transport taking patient to hospital last. This last row (transport unit transferring patient to your hospital) will be sent to NTDB. If date is unknown, '?' should be documented in the date and time data elements. If patients are not transported by EMS this field will become inactive and the null value 'n/a' will be sent to NTDB.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Time Call Dispatched/Received

Data Element	Time Call Dispatched/Received
Field Name	PHP_D_TIMES {list}
Field Type	Time
Field Length	2, 2
Note	Enter the time the ambulance call was received, by ambulance service, using the 24 hour clock (HH:MM) For EMS this is noted as time unit notified and for STARS it is called dispatch time. If time is unknown, '?' should be documented in the date and time data elements. If patients are not transported by EMS this field will become inactive and the null value 'n/a' will be sent to NTDB. Calgary sites arrival from Urgent Care Centres enter unk?
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Date En Route

Data Element	Date En Route
Field Name	PHP_E_DATES {list}
Field Type	Date
Field Length	2,2,4
Note	Enter the date the ambulance responded if different from the date call dispatched/received (MM DD YYYY). You can also choose the date from the calendar icon on the right. There is no default date (i.e. date of injury). It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene enter in chronological order with the transport taking patient to hospital last. If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Time En Route

Data Element	Time En Route
Field Name	PHP_E_TIMES {list}
Field Type	Time
Field Length	2,2
Note	Enter the time the ambulance unit was en route using the 24–hour clock (HH:MM). For STARS it is the time the helicopter lifts off. If time is unknown, '?' should be documented in the date and time data elements. Calgary sites if patient arriving from Urgent care centre enter unk?
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Rendezvous pickup location

Data Element	Rendezvous pickup location
Field Name	PHP_MLOCS
Field Type	Character
Field Length	90
Note	To be filled out at discretion of site. If ambulance cannot land/travel to patient scene location enter the rendezvous point (city, town, closest location) where they will meet someone who can bring them to patient. Please enter '/' if not applicable, do not leave blank. As per Data Subcommittee on Dec 12 2017 must collect this data element Provincially Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than hospital or airport as per Data subcommittee April 05 2018
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Date Arrive at Location

Data Element	Date Arrived at Scene Location (or rendezvous point)
Field Name	PHP_A_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance arrived at the scene/rendezvous point if different from the date of dispatch/call received or en route date (MM DD YYYY). You can also choose the date from the calendar icon on the right. Arrival is defined at date/time when the vehicle stopped moving. It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene enter in chronological order with the transport taking patient to hospital last. If date is unknown, '?' should be documented in the date and time data elements. If patients are not transported by EMS this field will become inactive and the null value 'n/a' will be sent to NTDB. Calgary sites patient arrival date from Urgent care centre please enter date patient arrived from Urgent care centre.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Time Arrived at Location

Data Element	Time Arrived at Scene Location (or rendezvous point)
Field Name	PHP_A_TIMES {list}
Field Type	Time
Field Length	2,2
Note	Enter the time the ambulance arrived on scene/rendezvous point using the 24–hour clock (HH:MM). This is recorded as the time EMS arrives on scene **NOT** the time EMS arrives at the patient's side. If time is unknown, '?' should be documented in the date and time data elements. If patients are not transported by EMS this field will become inactive and the null value 'n/a' will be sent to NTDB. Calgary sites patient arrival time from Urgent care centre please enter the time Triaged to Urgent care centre
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Date Arrive at Patient

Data Element	Date Arrived at Patient (Scene)
Field Name	PHP_P_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date EMS arrives at the patient's side (if different from the date of arrival at location) (MM DD YYYY). You can also choose the date from the calendar icon on the right. It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene enter in chronological order with the transport taking patient to hospital last. If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Time Arrived at Patient

Data Element	Time Arrived at Patient (Scene)
Field Name	PHP_P_TIMES {list}
Field Type	Time
Field Length	2,2
Note	Enter the time the ambulance personnel arrived at patient's side using the 24–hour clock (HH:MM). If time is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Date Departed Location

Data Element	Date Departed Location
Field Name	PHP_L_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance departed from the scene if different from the date of the incident (MM DD YYYY). For patients transported from the scene of injury, this is the date on which the unit transporting the patient from the scene departed from the scene (departure is defined at date/time when the vehicle started moving). It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene enter in chronological order with the transport taking patient to hospital last. If date is unknown, '?' should be documented in the date and time data elements. If patients are not transported by EMS this field will become inactive and the null value 'n/a' will be sent to NTDB. Calgary sites for patients departing Urgent care centre please enter the discharge date or departed from scene date from the PCR
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Time Departed Location

Data Element	Time Departed Location
Field Name	PHP_L_TIMES {list}
Field Type	Time
Field Length	2, 2
Note	Enter the time the ambulance departed from the scene using the 24–hour clock (HH:MM). For patients transported from the scene of injury, this is the time at which the unit transporting the patient from the scene departed from the scene (departure is defined at date/time when the vehicle started moving). If time is unknown, '?' should be documented in the date and time data elements. If patients are not transported by EMS this field will become inactive and the null value 'n/a' will be sent to NTDB. Calgary sites for patients departing Urgent care centres please enter the discharge time or departed from scene time from the PCR
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Scene Time Elapsed

Data Element	Scene Time Elapsed
Field Name	PHP_ELAPSEDSC
Field Type	Time
Field Length	2, 2
Note	Total scene time is a calculated field based on the time ambulance arrived at the scene location/rendezvous point to the time the ambulance departed the scene. Scene time will be displayed on the screen in hours and minutes when all times on this screen have been entered. **Arrival and departure dates should be documented from a patient care perspective. The arrival time of the first care transport should be documented even if the majority of care is given by another transport. The departure time of the transport responsible for the transport of the patient should be documented.** It is important to capture the date and time of on scene transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene, it may be necessary to combine the dates, times and the on scene procedures from both call reports. If dates or times are unknown, '?' should be documented in the date and time data elements. Scene arrival time minus ambulance departed scene time
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Date Arrived at Destination

Data Element	Date Arrived at Destination (from scene)
Field Name	PHP_AD_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance arrived at first hospital/trauma centre if different from the date departure from location (MM DD YYYY). If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Time Arrived at Destination

Data Element	Time Arrived at Destination (from scene)
Field Name	PHP_AD_TIMES {list}
Field Type	Time
Field Length	2, 2
Note	Enter the time the ambulance arrived with patient at first hospital/trauma centre from the scene using the 24–hour clock (HH:MM). Arrival is defined at date/time when the vehicle stopped moving (arrived at hospital) **NOT** TRIAGE TIME. If time is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Transport Time Elapsed

Data Element	Transport Time Elapsed
Field Name	PHP_ELAPSED2SC {list}
Field Type	Time
Field Length	2,2
Note	Transport time is a calculated field based on the time departed location (scene) to time of arrival in first hospital/trauma centre(time the patient physically arrives at hospital not the time they are triaged). This will be displayed in hours and minutes (HH:MM) when the time of arrival at destination has been entered. This only tracks patient time to arrival at hospital **NOT** time to triage. Time Scene departed minus time arrived at hospital
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Prehospital Triage Rationale

This section is required only for EMS programs that are also submitting to NIPSIS EMS quality program. NTDB would like us to submit "?" for all our patients. Please enter "?" for all patients and this will be the defaulted entry in a future ATR update.

Corresponds to Page 55 & 56 of NTDS data dictionary 2016 (trauma centre criteria and vehicular, pedestrian, and other risk injury).

PREHOSPITAL TRIAGE RATIONAL WILL BE DEFAULTED TO '?' AS PER NTDB RECOMMENDATIONS.

This section is only used for EMS programs that are also submitting to NIPSIS EMS quality program. Data fields for this section can be found on pages 52-53 of the 2017 NTDS data dictionary.

Prehospital Vitals

Provider: Ambulance Service

Data Element	Ambulance Service # (Transport from scene)
Field Name	PHAS_AGNCLNKS {list}
Field Type	Character
Field Length	40
Note	Type in Ambulance Service Name using to the station ID on the EMS Provincial Service Delivery Profile – stations document. Please use these common station IDs so it is consistently entered throughout the province and will also assist in data pulling from RW and data matching with EMS data. Please enter unit ID# s/b Alpha Numeric Alpha Will not be active to enter if ambulance mode of transport was not chosen for provider. Please enter unit ID# S/B Alpha Numeric Alpha as per conversation with Greg Vogelaar March 08 2018.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	Do not use PCR# or Event #.

At time GCS was calculated: Paralytic Agents?

Data Element	Paralytic Agents in Effect (Scene)
Field Name	PHAS_PAR_YNS {list}
Field Type	Numeric
Field Length	1
Note	Were paralytic agents in effect when the GCS at the scene was calculated? [For example, Rocuronium (Zemuron) or succinylcholine (Aventine).] 1. Yes 2. No ? Unknown / Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Clarification:

Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, and restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytics are often used with intubation BUT NOT ALWAYS. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range.

Typical paralytic agents are Rocuronium (Zemuron) and succinylcholine (Anectine). Others that are not in use in Alberta but which may be used elsewhere include: Vecuronium (Norcuron), Cisatracurium (Nimbex), Pancuronium (Pavulon), and Tubocurarine (Tubarine).

Pain killing drugs (analgesics) and/or sedating drugs may be used in combination with a paralysing agent. These agents alone **ARE NOT** paralytic agents and paralytic agents should be coded as “no” if these are the only medications administered. Examples of sedatives/analgesics include: Morphine, Demerol, Ativan/Lorazepam, Thiopental/Pentothal, Fentanyl, Ketamine, and Propofol.

If a patient was given paralytic agents prior to the trauma centre this should be answered ‘Yes’ or ‘Unknown’. Ask a trauma coordinator or medical director about the half time of the drug.

At time GCS was calculated: Intubated?

Data Element	Was patient intubated? (Scene)
Field Name	PHAS_INTUB_YNS {list}
Field Type	Numeric
Field Length	1
Note	Was the patient intubated at the time the GCS at the scene was calculated? Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy. ~~LMA, King, Combitubes are airway adjuncts not intubation.~~ LMA, King, Combitubes are airway adjuncts and included ad intubation as per requirement of NTDB and data subcommittee Jan 10 2019. 1. Yes 2. No ? Unknown / Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

At time GCS was calculated: Eye Obstruction?

Data Element	Was there an eye obstruction? (Scene)
Field Name	PHAS_E_OB_YNS {list}
Field Type	Numeric
Field Length	1
Note	Did the patient have an eye obstruction at the time the GCS at the scene was calculated? 1. Yes 2. No ? Unknown / Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Systolic Blood Pressure, SBP (Scene)

Data Element	SBP (Prehospital/Scene)
Field Name	PHAS_SBPS {list}
Field Type	Number
Field Length	3
Note	Defined as the patient's first recorded SBP upon arrival of EMS personnel at the scene. If the SBP is not taken or not documented (or EMS PCR is not available) document as '?' unknown. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Explanation:

- You should only report the first recorded vital signs measured at the **scene of injury**. Their complete definitions are found in the current NTDB data dictionary.
- If a patient is stabbed on the street and walks for help to a nearby house/business that location is **NOT** considered scene of injury because it is the second location.
- If a patient is taken by 1st EMS to a non-trauma hospital then discharged home (not transferred) and returns to a trauma center by 2nd EMS the next day or a few days after, the scene vitals are now not known/recorded by the 2nd EMS unless you are able to obtain the 1st EMS report with the vital signs at **scene of injury** taken/documented.
- If previous scene EMS report is available use scene vitals from that report but not EMS times. Use Ems times from the current PCR as that is the EMS which transported the patient to the trauma hospital.

Pulse Rate (Scene)

Data Element	Pulse Rate (Prehospital/Scene)
Field Name	PHAS_PULSES {list}
Field Type	Number
Field Length	3
Note	Defined as the patients first recorded pulse rate (#/min) (palpated or auscultated) upon arrival of EMS personnel at the scene. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the PR is not documented (or EMS PCR is not available) document as '?' unknown. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Explanation:

- You should only report the first recorded vital signs measured at the **scene of injury**. Their complete definitions are found in the current NTDB data dictionary.
- If a patient is stabbed on the street and walks for help to a nearby house/business that location is **NOT** considered scene of injury because it is the second location.
- If a patient is taken by 1st EMS to a non-trauma hospital then discharged home (not transferred) and returns to a trauma center by 2nd EMS the next day or a few days after, the scene vitals are now not known/recorded by the 2nd EMS unless you are able to obtain the 1st EMS report with the vital signs at **scene of injury** taken/documented.
  If previous scene EMS report is available use scene vitals from that report but not EMS times. Use Ems times from the current PCR as that is the EMS which transported the patient to the trauma hospital.

Unassisted Respiratory Rate (Scene)

Data Element	Unassisted Respiration Rate (Prehospital/Scene)
Field Name	PHAS_URRS {list}
Field Type	Number
Field Length	2
Note	Defined as the patient's first recorded unassisted RR upon arrival of EMS personnel at the scene (# per min). Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the RR is not documented (or EMS PCR is not available) document as '?' unknown. Enter '/' (not applicable) if patient respirations are assisted. Assisted Ventilation is defined as: • If there is something placed in the patient's airway to assist them in breathing such as ETT, King or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King or LMA the patient still had assisted ventilation. • If the patient is being bagged (bag-valve-mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated. • OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but ***by themselves are not assisted ventilation***. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation. • If a patients chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Explanation: same as previous page

O2 Saturation (Scene)

Data Element	Oxygen Saturation (Prehospital/Scene)
Field Name	PHAS_SAO2S {list}
Field Type	Number
Field Length	2
Note	Defined as the patient's first recorded O2 saturation taken upon arrival of EMS personnel at the scene (as a %). Values recorded can be between 0-100. ***This value should be based upon assessment before administration of supplemental oxygen if O2 saturation of patient was assessed before O2 was given.*** This may be documented as R/A (room air) breathing without O2 given. If the O2 saturation is not documented or was not taken before supplemental O2 was given, or EMS PCR is not available document as '?' unknown. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Explanation:

- You should only report the first recorded vital signs measured at the **scene of injury**. Their complete definitions are found in the current NTDB data dictionary.
- If a patient is stabbed on the street and walks for help to a nearby house/business that location is **NOT** considered scene of injury because it is the second location.
- If a patient is taken by 1st EMS to a non-trauma hospital then discharged home (not transferred) and returns to a trauma center by 2nd EMS the next day or a few days after, the scene vitals are now not known/recorded by the 2nd EMS unless you are able to obtain the 1st EMS report with the vital signs at **scene of injury** taken/documented.
- If previous scene EMS report is available use scene vitals from that report but not EMS times. Use Ems times from the current PCR as that is the EMS which transported the patient to the trauma hospital.

GCS: Eye (Scene)

Data Element	Eye (Scene)
Field Name	PHAS_GCS_EOS {list}
Field Type	Numeric
Field Length	1
Note	Defined as the patient's first eye-opening response for the GCS documented upon arrival of EMS personnel. If the eye-opening response is not documented or if the patient's eyes are swollen shut, or if the PCR is not available, enter '?' If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "Patient's pupils are PERRL," an Eye GCS of 4 may be recorded, **IF** there is no other contradicting documentation. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Menu Selection for GCS Eye Scale:

1	**No eye movement when assessed**
2	Opens eyes in response to painful stimulation
3	Opens eyes in response to verbal stimulation
4	Opens eyes spontaneously
/	Not applicable
?	Unknown

Explanation: Please see on the previous page

GCS: Verbal (Scene)

Data Element	Verbal (Prehospital/Scene)
Field Name	PHAS_GCS_VRS {list}
Field Type	Numeric
Field Length	1
Note	Defined as the patient's first verbal response for the GCS documented upon arrival of EMS personnel at the scene. Please use appropriate Adult or Pediatric scale. If the verbal response is not documented or if the PCR is not available, enter '?' unknown. **If the patient is intubated then the GCS Verbal score is '1'**. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient is oriented to person, place and time" a Verbal GCS of 5 may be recorded, **IF** there is no other contradicting documentation. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	**March 2005 Clarification**: Please report the first score

Menu Selection for GCS Verbal Scale:

1	No verbal response (peds: No vocal response)
2	Incomprehensible Sounds (peds: inconsolable, agitated)
3	Inappropriate Words (peds: inconsistently consolable, moaning)
4	Confused (peds: cries but is consolable, inappropriate interactions)
5	Oriented (peds: smiles, oriented to sounds, follows objects, interacts)
/	Not applicable
?	Unknown

Explanation: Please see on page

GCS: Motor (Scene)

Data Element	Motor (Prehospital/Scene)
Field Name	PHAS_GCS_MRS {list}
Field Type	Numeric
Field Length	1
Note	Defined as the patient's first motor response for the GCS documented upon arrival of EMS personnel at the scene. Please use appropriate Adult or Pediatric scale. If the motor response is not documented or if the PCR is not available, enter '?' unknown. **If the patient is under paralytics then the GCS motor score will be '1'.** Intubation alone does not indicate a GCS motor score of 1 since motor response can still be assessed. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, **IF** there is no other contradicting documentation. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Menu Selection for GCS Motor Scale:

Adult patient's motor response:	
1	None
2	Extension to pain
3	Flexion to pain
4	Withdraws from pain
5	Localizing pain
6	Obeys commands (adults) or Appropriate response to stimulation (peds ≤ 2 years)
/	Not applicable
?	Unknown

Explanation: Please see on page

Total GCS (Scene)

Data Element	Total GCS (Scene)
Field Name	PHAS_GCSSC {list}
Field Type	Numeric
Field Length	2
Note	Defined as the total GCS first documented upon arrival of EMS personnel at the scene. If the GCS is not documented or there is no EMS PCR available, enter '?'. Total GCS is calculated automatically if all 3 GCS components are entered. Total GCS values must be between 3-15, please do not enter n/a. If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented (AAOx3), the total GCS may be assumed to be 15, **IF** there is no other contradicting documentation. Component definitions and menu selections for GCS can be found on the 3 previous pages. If patients arrive by private vehicle/walk in the treatment section will become inactive and this data field will map to 'n/a' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Explanation: Please see on page

Initial Field GCS 40- Eye (Scene)

Data Element	Initial field GCS 40-Eye
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Eye) measured at the scene of injury. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Initial Field GCS 40- Verbal (Scene)

Data Element	Initial field GCS 40-Verbal
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Verbal) measured at the scene of injury. Please enter "unk"= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Initial Field GCS 40- Motor (Scene)

Data Element	Initial field GCS 40-Motor
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Motor) measured at the scene of injury. Please enter "unk"= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

RTS (Scene)

Data Element	RTS (Prehospital/Scene) Revised Trauma Score
Field Name	PHAS_RTS_WSC {list}
Field Type	Numeric
Field Length	5 (to 3 decimal places)
Note	Revised Trauma Score (RTS) at the scene is a calculated field based on Glasgow Coma Scale, systolic blood pressure, and unassisted respiratory rate. RTS is scored from the first set of data obtained from the patient. It is a physiological scoring system, with high inter-rater reliability and demonstrated accuracy in predicted death. RTS ranges from 0 to 7.84 where 0 predicts high probability of death and 7.84predicts high probability of survival. www.trauma.org The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will remain blank. RTS will be blank if unassisted respiration, SBP, or any component of GCS is not applicable.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

The calculation of the RTS is outlined below:

Coded Value x Weight = Score

Respiratory Rate (breaths/min)

>29	4	
10-29	3	
6-9	2	X0.2908=_____
1-5	1	
0	0	

Use 0 if patient arrived intubated

Systolic Blood Pressure (mm Hg)

>89	4	
76-89	3	
50-75	2	X0.7326=_____
1-49	1	
0	0	

Glasgow Coma Scale

13-15	4	
9-12	3	
6-8	2	X0.9368=_____
4-5	1	
< 5	0	

Total RTS (3 scores totalled) =_____

Triage RTS (Scene)

Data Element	Triage RTS (Prehospital/Scene) RTS Revised Trauma Score
Field Name	PHAS_RTS_USC {list}
Field Type	Numeric
Field Length	2
Note	The triage RTS at the scene is a calculated field based on Glasgow Coma Scale, systolic blood pressure, and unassisted respiratory rate used to calculate final scene RTS. The total triage RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will remain blank. RTS will be blank if unassisted respiration, SBP, or total GCS is not applicable. This is a score used for field triage for rapid identification of severely injured patients. Scores range from 0-12 and a triage-RTS < 11 indicates a need for transport to a designated trauma center (information from http://lifeinthefastlane.com/ccc/trauma-scoring-systems/). This is not necessarily how AB uses this score for triage at the scene or in hospital.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Clarification:Based on 3 physiological parameters:

GCS	TRIAGE RTS SCORE (ADD 3 COMPONENTS)
13-15	4
9-12	3
6-8	2
4-5	1
3	0
SBP	
>89	4
76-89	3
50-75	2
1-49	1
0	0
UNASSISTED RR	
10-29	4
>29	3
6-9	2
1-5	1
0	0

Prehospital Index (PHI)

Data Element	Prehospital Index
Field Name	PHAS_PHI_TOTALS {list}
Field Type	Numeric
Field Length	2
Note	The first PHI Trauma Score recorded on PCR or STARS report should be recorded. Use '?' if unknown (not recorded or EMS report not available). Unlike GCS, PHI can never be inferred from notes in the chart. If it is not explicitly stated enter '?'. PHI is a score between 0-23. PHI is a measure of how sick the patient is overall (GCS just gives a neurological assessment).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Prehospital Scene Interventions (all providers)

Provider: Ambulance Service

Data Element	Ambulance Service # (Transport from scene)
Field Name	PI_INT_AGNCLNKS {list}
Field Type	Character
Field Length	40
Note	Type in Ambulance Service Name using to the station ID on the EMS Provincial Service Delivery Profile – stations document. Please use these common station IDs so it is consistently entered throughout the province and will also assist in data pulling from RW and data matching with EMS data. Please enter unit ID# s/b Alpha Numeric Alpha Please enter unit ID# S/B Alpha Numeric Alpha as per conversation with Greg Vogelaar March 08 2018. Will not be active to enter if ambulance mode of transport was not chosen for provider.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	Do not use PCR# or Event #.

Prehospital Scene Interventions

Data Element	Prehospital Scene Interventions (formerly non-operative procedures)
Field Name	PH_INTS {list}
Field Type	Numeric
Field Length	2,2,2,2,2,2,2,2,2,2,2,2,2,2,2,2,2,2,2
Note	Select up to 19 non–operative procedures performed at the scene or en route to the first hospital. Please enter all interventions in order (#1-19) if possible. You no longer have an option to specify what 'other' intervention is (no blank text box). The analyst may enter this information in the prehospital notes section if they feel it is important. If no prehospital non-operative procedures were done (or the patient arrived by private vehicle) please enter '/'. If the information is missing from the chart and cannot be requested from EMS please enter '?'. Please see menu of prehospital scene interventions below.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

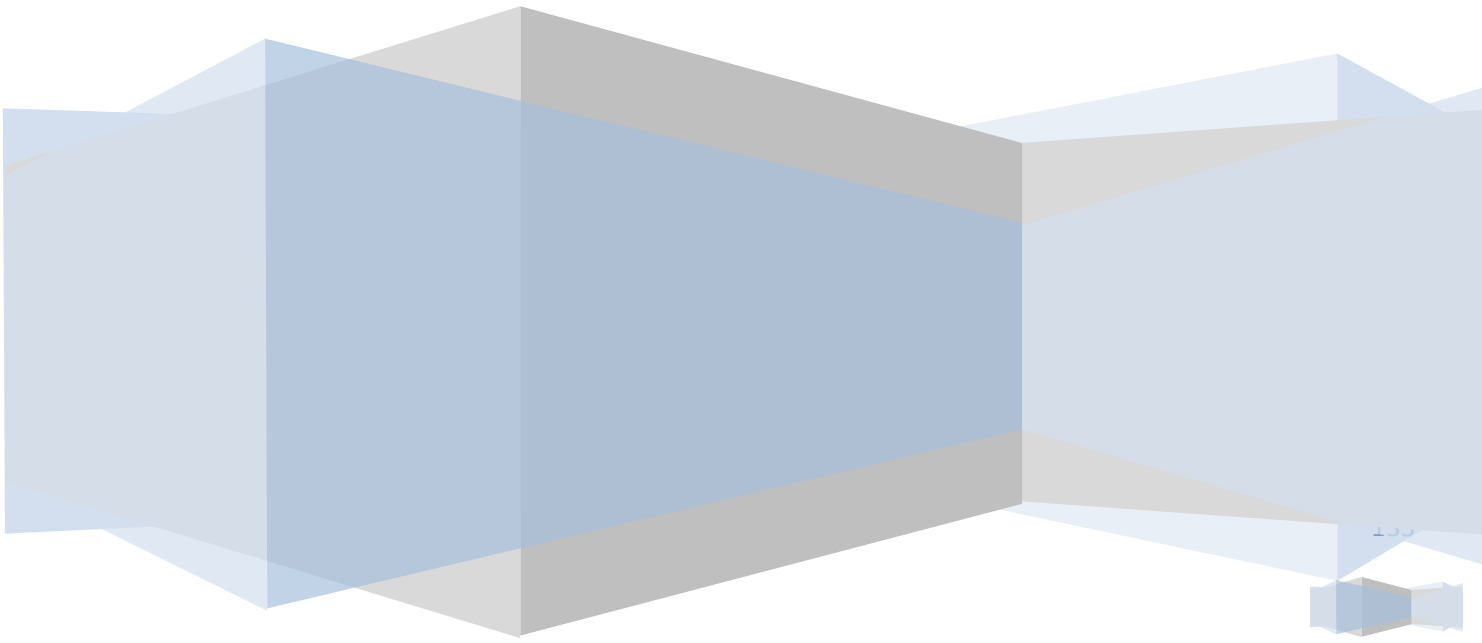
Menu for prehospital scene interventions:

1	Oxygen Administration
2	Oral Intubation
3	Tracheostomy
4	Cricothyroidotomy
5	Assisted Ventilation (manually bagged or by machine) BVM
6	Peripheral IV
7	Intraosseous infusion
8	Central line insertion
9	CPR
10	C–spine immobilization
11	Backboard
12	Chest tube insertion
13	Splinting
14	Oral/nasopharyngeal airway/OPA
15	Needle thoracentesis – decompression
16	Rapid sequence intubation
17	Pelvic binding
18	King LT, LMA, Combitubes
19	Other
/	Inappropriate
?	Unknown

Notes

Data Element	Prehospital Notes
Field Name	PH_NOTES
Field Type	Character
Field Length	500
Note	Enter information in this area if you need to make a note about the prehospital data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section IV Referring Facility Data



Referral History: Immediate Referring Facility (i.e. facility transferring to final trauma centre location)

Transfer In (Immediate Referring Facility)

Data Element	Transfer In
Field Name	IT_XFR_YN
Field Type	Numeric
Field Length	1
Note	Was the patient transferred to your trauma centre from another acute care or ambulatory facility? (Rural hospital, other trauma centre, reserve/northern nursing station, military base, anywhere with ambulatory (ED) care facilities). Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities. Primary physician offices (family docs) stand-alone ambulatory surgery centres (day surgeries) are not considered inter-facility transfers. If a patient goes from the scene to family doctor and then is transported to your hospital the patient is considered as coming from 'other' site with appropriate transport entered (EMS or private vehicle in the pre-hospital section as applicable). If a patient visits another hospital and is referred to your trauma centre but is transported by private vehicle to your centre please check "No "for referring facility. As per Data Subcommittee June 14 2018. All private vehicle patients are not considered as transfers as it is not part of the continuum of care. 1. Yes 2. No ? Unknown ***'/' can be chosen as an option but should not be checked for this variable use 'No' instead. If anything but 'Yes' is selected the entire referring facility sub-tab areas will become inactive.***
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Referring Facility (Immediate Referring Facility)

Data Element	Referring Facility
Field Name	RFS_FACLNK; RFS_FAC_S {if other}
Field Type	Numeric; Text
Field Length	4
Note	If you know the number of the facility transferring the patient to your trauma center please type in the box provided. Alternately click on the magnifying glass icon to the right for a list of facilities. You can scroll through the options or type in ID # or Name to search. Highlight and press select or double click on your choice. You can also click on the titles of "ID" or "Name" to have the list be sorted by intuition ID # or alphabetically by name of facility. You cannot search by province for out of AB facilities but by name of institution. *Note: Facility ID #'s do not have extra 0s at the beginning so the facility #'s won't necessarily be in order from 0-9999 but from the first digit (1, 100, 1000, 2, etc.)* If the institution is not in the drop down list choose "other" and type in the institution name in the box below. Please look carefully at the facility list in this data dictionary before choosing "other" as the name of the facility may be slightly different then what is written in the patient file. Referring institutions must be acute care facilities and should not include rehabilitation facilities or nursing homes. If an injury occurs in a non–acute care facility (i.e., nursing home), consider that facility to be the scene of the incident. In cases where patients are injured in an acute care facility and then transferred to a district/tertiary trauma hospital, consider the transferring facility to be both the scene and a referring facility. The same information should be entered in both scene and referring facility sections because the type of care rendered includes both the scene and a referring facility. A referring hospital is defined as the hospital that transfers the patient directly to the district/tertiary trauma hospital. Hospitals in which the patient is seen and released home with or without treatment before the patient is seen at a district/tertiary trauma hospital are not considered to be referring institutions. See below for a complete list of AB institutions. As per data subcommittee meeting Oct 04 2018 we are now to start collecting Urgent care centers as a referring facility
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A

Menu for referring facility (alphabetical order):

Institution #	Institution Name
0922	Airdrie Regional Health Centre
5555	Alberta Central Site
0001	Athabasca Healthcare Centre
0002	Banff - Mineral Springs Hospital
0003	Barrhead Healthcare Centre
0005	Bassano Health Centre
9708	BC - 100 Mile House General Hospital
9603	BC - Abbotsford General Hospital
9408	BC - Ashcroft District Hospital
9804	BC - Castlegar & District Hospital
9716	BC - Chetwynd Hospital
9419	BC - Clearwater Dr Helmcken Hospital
9502	BC - Comox St. John's Hospital
9756	BC - Cranbrook Regional Hospital
9654	BC - Creston Valley Hospital
9704	BC - Dawson Creek & District Hospital
9753	BC - Fernie District Hospital
9714	BC - Fort Nelson General Hospital
9701	BC - Fort St. John General Hospital
9409	BC - Golden & District General Hospital
9759	BC - Hudson's Hope Health Centre
9755	BC - Invermere District Hospital
9401	BC - Kamloops, Royal Inland Hospital
9302	BC - Kelowna General Hospital
9752	BC - Kimberly & District Hospital
9115	BC - Langley Hospital
9715	BC - MacKenzie District Hospital
9713	BC - McBride Hospital
9655	BC - Nakusp, Arrow Lakes Hospital
9652	BC - Nakusp, Slocan & Community HC
9501	BC - Nanaimo Regional General Hospital
9651	BC - Nelson, Kootenay Lake District Hospital
9653	BC - Nelson, Victorian Hospital
9109	BC - New Westminster, Royal Columbian
9303	BC - Penticton Regional Hospital
9111	BC - Powell River Hospital, Powell River
9703	BC - Prince George Hospital
9902	BC - Prince Rupert Hospital
9705	BC - Quesnel, GR Baker Hospital
9402	BC - Revelstoke, Queen Victoria Hospital
9404	BC - Salmon Arm, Shuswap Lake Hospital

9903	BC - Smithers, Bulkly Valley Hospital
9754	BC - Sparwood General Hospital
9910	BC - Stewart Health Centre
9717	BC - Stuart Lake Hospital, Fort St James
9116	BC - Surrey Memorial Hospital
9801	BC - Trail Regional Hospital
9720	BC - Tumbler Ridge Health Centre
9718	BC - Valemount Health Centre
9101	BC - Vancouver General
9119	BC - Vancouver, GF Strong Rehab
9102	BC - Vancouver, St. Paul's Hospital
9702	BC - Vanderhoof, St. John Hospital
9301	BC - Vernon Jubilee Hospital
9202	BC - Victoria, GVHS
0006	Beaverlodge Municipal Hospital
0139	Black Diamond - Oilfields General Hospital
0009	Blairmore - Crowsnest Pass Health Centre
0141	Bonnyville Healthcare Centre
0011	Bow Island Health Centre
0012	Boyle Healthcare Centre
0014	Brooks Health Centre
0015	Calgary - Alberta Children's Hospital
0016	Calgary - Foothills Medical Centre
0148	Calgary - Peter Lougheed Centre
0008	Calgary - Richmond Road Diagnostic & Treatment
0020	Calgary - Rockyview General Hospital
0155	Calgary - South Calgary Health Centre
0576	Calgary - South Health Campus
0572	Calgary - Southern Alberta Forensic Psychiatric Centre
0601	Calgary - Tom Baker Cancer Centre
0021	Camrose - St. Mary's Hospital
0022	Canmore General Hospital
0023	Cardston Health Centre
0025	Castor - Our Lady of the Rosary Hospital
0027	Claresholm General Hospital
0028	Coaldale Health Centre
0349	Cochrane Community Health Centre
0029	Cold Lake Healthcare Centre
0302	Cold Lake/Medley - CFB Hospital
0030	Consort Hospital and Care Centre
0031	Coronation Hospital and Care Centre
0032	Daysland Health Centre
0033	Devon General Hospital
0034	Didsbury District Health Services

0035	Drayton Valley Hospital and Care Centre
0036	Drumheller Health Centre
0350	East Edmonton Health Centre
0137	Edmonton - Alberta Hospital
0038	Edmonton - Cross Cancer Institute
0040	Edmonton - Glenrose Rehabilitation Hospital
0042	Edmonton - Grey Nuns Community Hospital
0041	Edmonton - Misericordia Community Hospital
0149	Edmonton - Northeast Community Health Centre
0043	Edmonton - Royal Alexandra Hospital
0578	Edmonton - Strathcona Community Hospital
0044	Edmonton - University of Alberta Hospital/Stollery
0045	Edson Healthcare Centre
0046	Elk Point Healthcare Centre
0049	Fairview Health Complex
0050	Fort MacLeod Health Centre
0052	Fort Saskatchewan Community Hospital
0133	Fox Creek Healthcare Centre
0117	Ft. Mac - Northern Lights Regional Health Centre
0053	Ft. Vermilion - St. Theresa General Hospital
0121	Grande Cache Community Health Complex
0056	Grande Prairie - Queen Elizabeth II Hospital
0605	Grande Prairie Cancer Centre
0132	Grimshaw/Berwyn and District Community Health Centre
0057	Hanna Health Centre
0058	Hardisty Health Centre
0123	High Level - Northwest Health Centre
0059	High Prairie Health Complex
0060	High River General Hospital
0061	Hinton Healthcare Centre
0063	Innisfail Health Centre
0065	Jasper (Seton) Healthcare Centre
0066	Killam Health Care Centre
0142	La Crete Health Centre
0067	Lac La Biche - William J.Cadzow Healthcare Centre
0068	Lacombe Hospital and Care Centre
0069	Lamont Health Care Centre
0070	Leduc Community Hospital
0071	Lethbridge - Chinook Regional Hospital
0603	Lethbridge - Jack Ady Cancer Centre
0770	Magrath Health Centre
0076	Manning Community Health Centre
0078	Mayerthorpe Healthcare Centre
6016	MB - Winnipeg Health Sciences Centre

0074	McLennan - Sacred Heart Community Health Centre
0604	Medicine Hat - Margery E. Yuill Cancer Centre
0079	Medicine Hat Regional Hospital
0080	Milk River Health Centre
1001	NU - Iqaluit, Baffin Regional Hospital
1004	NWT - Fort Smith Health Centre
1003	NWT - Hay River, H.H. Williams Hospital
1005	NWT - Inuvik Regional Hospital
1002	NWT - Stanton Yellowknife Hospital
0083	Olds Hospital and Care Centre
8888	Other Hospital/Ambulatory Care
9999	OUT OF COUNTRY
0084	Oyen - Big Country Hospital
0085	Peace River Community Health Centre
0768	Picture Butte - Piyami Community Health Centre
0087	Pincher Creek Health Centre
0088	Ponoka Hospital and Care Centre
0089	Provost Health Centre
0145	Rainbow Lake Health Centre
0091	Raymond Health Centre
0602	Red Deer - Central Alberta Cancer Centre
0092	Red Deer Regional Hospital Centre
0122	Redwater Health Centre
0093	Rimbey Hospital and Care Centre
0094	Rocky Mountain House Health Centre
7009	SK - Biggar Union Hospital
7045	SK - Goodsoil L Gervais Health Centre
7051	SK - Herbert Morse Hospital
7056	SK - Ile a la Crosse - St Joseph's Hospital
7064	SK - Kerrobert Integrated Health Facility
7301	SK - La Loche Health Centre (St Martin's)
7083	SK - La Ronge Health Centre
7076	SK - Leader Hospital
7080	SK - LLoydminster Hospital
7081	SK - Loon Lake Union Hospital
7085	SK - Macklin - St Joseph's Health Centre
7086	SK - Maidstone Union Hospital
7088	SK - Maple Creek Hospital
7090	SK - Meadowlake Hospital
7096	SK - Moose Jaw Union Hospital
7104	SK - Nipawin Hospital
7107	SK - North Battleford Hospital
7110	SK - Outlook Union Hospital
7959	SK - Prince Alberta Health Region (Hospital)

7129	SK - Regina General Hospital
7130	SK - Regina Pasqua Hospital
7133	SK - Rosetown & District Health Centre
7135	SK - Rosthern Hospital
7142	SK - Saskatoon - Royal University Hospital
7141	SK - Saskatoon - St Paul's Hospital
7140	SK - Saskatoon City Hospital
7144	SK - Shaunavon Hospital & Care Centre
7138	SK - St Walburg Health Complex
7149	SK - Swift Current Hospital
7154	SK - Turtleford Hospital
7156	SK - Unity ~~Hospital~~ & District Health Centre
7174	SK - Wynyard Integrated Facility
7176	SK - Yorkton Regional Health Centre
0925	Slave Lake Family Care Clinic
0118	Slave Lake Healthcare Centre
0095	Smoky Lake (George McDougall) Healthcare Centre
0096	Spirit River - Central Peace Health Complex
0120	St. Albert - Sturgeon Community Hospital
0099	St. Paul - St. Therese Healthcare Centre
0301	Standoff - Kai Nai Continuing Care Centre (Blood Indian Hospital)
0097	Stettler Hospital and Care Centre
0150	Stony Plain - WestView Health Centre
0134	Strathmore District Health Services
0119	Sundre Hospital and Care Centre
0136	Swan Hills Healthcare Centre
0385	Sylvan Lake Community Health Centre
0100	Taber Health Centre
0138	The Centennial Centre for Mental Health and Brain Injury
0101	Three Hills Health Centre
0102	Tofield Health Centre
0105	Two Hills Health Centre
0106	Valleyview Health Centre
0107	Vegreville - St. Joseph's General Hospital
0108	Vermilion Health Centre
0109	Viking Health Centre
0111	Vulcan Community Health Centre
0144	Wabasca/Desmarais Healthcare Centre
0112	Wainwright Health Centre
0113	Westlock Healthcare Centre
0114	Wetaskiwin Hospital and Care Centre
0116	Whitecourt Healthcare Centre
2001	YT - Whitehorse General Hospital

Menu for referring facility (numerical order):

Institution #	Institution Name
0001	Athabasca Healthcare Centre
0002	Banff - Mineral Springs Hospital
0003	Barrhead Healthcare Centre
0005	Bassano Health Centre
0006	Beaverlodge Municipal Hospital
0008	Calgary - Richmond Road Diagnostic & Treatment
0009	Blairmore - Crowsnest Pass Health Centre
0011	Bow Island Health Centre
0012	Boyle Healthcare Centre
0014	Brooks Health Centre
0015	Calgary - Alberta Children's Hospital
0016	Calgary - Foothills Medical Centre
0020	Calgary - Rockyview General Hospital
0021	Camrose - St. Mary's Hospital
0022	Canmore General Hospital
0023	Cardston Health Centre
0025	Castor - Our Lady of the Rosary Hospital
0027	Claresholm General Hospital
0028	Coaldale Health Centre
0029	Cold Lake Healthcare Centre
0030	Consort Hospital and Care Centre
0031	Coronation Hospital and Care Centre
0032	Daysland Health Centre
0033	Devon General Hospital
0034	Didsbury District Health Services
0035	Drayton Valley Hospital and Care Centre
0036	Drumheller Health Centre
0038	Edmonton - Cross Cancer Institute
0040	Edmonton - Glenrose Rehabilitation Hospital
0041	Edmonton - Misericordia Community Hospital
0042	Edmonton - Grey Nuns Community Hospital
0043	Edmonton - Royal Alexandra Hospital
0044	Edmonton - University of Alberta Hospital/Stollery
0045	Edson Healthcare Centre
0046	Elk Point Healthcare Centre
0049	Fairview Health Complex
0050	Fort MacLeod Health Centre
0052	Fort Saskatchewan Community Hospital
0053	Ft. Vermilion - St. Theresa General Hospital
0056	Grande Prairie - Queen Elizabeth II Hospital
0057	Hanna Health Centre

0058	Hardisty Health Centre
0059	High Prairie Health Complex
0060	High River General Hospital
0061	Hinton Healthcare Centre
0063	Innisfail Health Centre
0065	Jasper (Seton) Healthcare Centre
0066	Killam Health Care Centre
0067	Lac La Biche - William J.Cadzow Healthcare Centre
0068	Lacombe Hospital and Care Centre
0069	Lamont Health Care Centre
0070	Leduc Community Hospital
0071	Lethbridge - Chinook Regional Hospital
0074	McLennan - Sacred Heart Community Health Centre
0076	Manning Community Health Centre
0078	Mayerthorpe Healthcare Centre
0079	Medicine Hat Regional Hospital
0080	Milk River Health Centre
0083	Olds Hospital and Care Centre
0084	Oyen - Big Country Hospital
0085	Peace River Community Health Centre
0087	Pincher Creek Health Centre
0088	Ponoka Hospital and Care Centre
0089	Provost Health Centre
0091	Raymond Health Centre
0092	Red Deer Regional Hospital Centre
0093	Rimbey Hospital and Care Centre
0094	Rocky Mountain House Health Centre
0095	Smoky Lake (George McDougall) Healthcare Centre
0096	Spirit River - Central Peace Health Complex
0097	Stettler Hospital and Care Centre
0099	St. Paul - St. Therese-Healthcare Centre
0100	Taber Health Centre
0101	Three Hills Health Centre
0102	Tofield Health Centre
0105	Two Hills Health Centre
0106	Valleyview Health Centre
0107	Vegreville - St. Joseph's General Hospital
0108	Vermilion Health Centre
0109	Viking Health Centre
0111	Vulcan Community Health Centre
0112	Wainwright Health Centre
0113	Westlock Healthcare Centre
0114	Wetaskiwin Hospital and Care Centre
0116	Whitecourt Healthcare Centre

0117	Ft. Mac - Northern Lights Regional Health Centre
0118	Slave Lake Healthcare Centre
0119	Sundre Hospital and Care Centre
0120	St. Albert - Sturgeon Community Hospital
0121	Grande Cache Community Health Complex
0122	Redwater Health Centre
0123	High Level - Northwest Health Centre
0132	Grimshaw/Berwyn and District Community Health Centre
0133	Fox Creek Healthcare Centre
0134	Strathmore District Health Services
0136	Swan Hills Healthcare Centre
0137	Edmonton - Alberta Hospital
0138	The Centennial Centre for Mental Health and Brain Injury
0139	Black Diamond - Oilfields General Hospital
0141	Bonnyville Healthcare Centre
0142	La Crete Health Centre
0144	Wabasca/Desmarais Healthcare Centre
0145	Rainbow Lake Health Centre
0148	Calgary - Peter Lougheed Centre
0149	Edmonton - Northeast Community Health Centre
0150	Stony Plain - WestView Health Centre
0155	Calgary - South Calgary Health Centre
0301	Standoff - Kai Nai Continuing Care Centre (Blood Indian Hospital)
0302	Cold Lake/Medley - CFB Hospital
0349	Cochrane Community Health Centre
0350	East Edmonton Health Centre
0385	Sylvan Lake Community Health Centre
0391	Okotoks Health and Wellness Centre (urgent care)
0572	Calgary - Southern Alberta Forensic Psychiatric Centre
0576	Calgary - South Health Campus
0578	Edmonton - Strathcona Community Hospital
0601	Calgary - Tom Baker Cancer Centre
0602	Red Deer - Central Alberta Cancer Centre
0603	Lethbridge - Jack Ady Cancer Centre
0604	Medicine Hat - Margery E. Yuill Cancer Centre
0605	Grande Prairie Cancer Centre
0768	Picture Butte - Piyami Community Health Centre
0770	Magrath Health Centre
0922	Airdrie Regional Health Centre
0925	Slave Lake Family Care Clinic
1001	NU - Iqaluit, Baffin Regional Hospital
1002	NWT - Stanton Yellowknife Hospital
1003	NWT - Hay River, H.H. Williams Hospital
1004	NWT - Fort Smith Health Centre

1005	NWT - Inuvik Regional Hospital
2001	YT - Whitehorse General Hospital
5555	Alberta Central Site
6016	MB - Winnipeg Health Sciences Centre
7009	SK - Biggar Union Hospital
7045	SK - Goodsoil L Gervais Health Centre
7051	SK - Herbert Morse Hospital
7056	SK - Ile a la Crosse - St Joseph's Hospital
7064	SK - Kerrobert Integrated Health Facility
7076	SK - Leader Hospital
7080	SK - LLoydminster Hospital
7081	SK - Loon Lake Union Hospital
7083	SK - La Ronge Health Centre
7085	SK - Macklin - St Joseph's Health Centre
7086	SK - Maidstone Union Hospital
7088	SK - Maple Creek Hospital
7090	SK - Meadowlake Hospital
7096	SK - Moose Jaw Union Hospital
7104	SK - Nipawin Hospital
7107	SK - North Battleford Hospital
7110	SK - Outlook Union Hospital
7129	SK - Regina General Hospital
7130	SK - Regina Pasqua Hospital
7133	SK - Rosetown & District Health Centre
7135	SK - Rosthern Hospital
7138	SK - St Walburg Health Complex
7140	SK - Saskatoon City Hospital
7141	SK - Saskatoon - St Paul's Hospital
7142	SK - Saskatoon - Royal University Hospital
7144	SK - Shaunavon Hospital & Care Centre
7149	SK - Swift Current Hospital
7154	SK - Turtleford Hospital
7156	SK - Unity ~~Hospital~~ & District Health Centre
7174	SK - Wynyard Integrated Facility
7176	SK - Yorkton Regional Health Centre
7301	SK - La Loche Health Centre (St Martin's)
7959	SK - Prince Alberta Health Region (Hospital)
8888	Other Hospital/Ambulatory Care
9101	BC - Vancouver General
9102	BC - Vancouver, St. Paul's Hospital
9109	BC - New Westminster, Royal Columbian
9111	BC - Powell River Hospital, Powell River
9115	BC - Langley Hospital
9116	BC - Surrey Memorial Hospital

9119	BC - Vancouver, GF Strong Rehab
9202	BC - Victoria, GVHS
9301	BC - Vernon Jubilee Hospital
9302	BC - Kelowna General Hospital
9303	BC - Penticton Regional Hospital
9401	BC - Kamloops, Royal Inland Hospital
9402	BC - Revelstoke, Queen Victoria Hospital
9404	BC - Salmon Arm, Shuswap Lake Hospital
9408	BC - Ashcroft District Hospital
9409	BC - Golden & District General Hospital
9419	BC - Clearwater Dr Helmcken Hospital
9501	BC - Nanaimo Regional General Hospital
9502	BC - Comox St. John's Hospital
9603	BC - Abbotsford General Hospital
9651	BC - Nelson, Kootenay Lake District Hospital
9652	BC - Nakusp, Slocan & Community HC
9653	BC - Nelson, Victorian Hospital
9654	BC - Creston Valley Hospital
9655	BC - Nakusp, Arrow Lakes Hospital
9701	BC - Fort St. John General Hospital
9702	BC - Vanderhoof, St. John Hospital
9703	BC - Prince George Hospital
9704	BC - Dawson Creek & District Hospital
9705	BC - Quesnel, GR Baker Hospital
9708	BC - 100 Mile House General Hospital
9713	BC - McBride Hospital
9714	BC - Fort Nelson General Hospital
9715	BC - MacKenzie District Hospital
9716	BC - Chetwynd Hospital
9717	BC - Stuart Lake Hospital, Fort St James
9718	BC - Valemount Health Centre
9720	BC - Tumbler Ridge Health Centre
9752	BC - Kimberly & District Hospital
9753	BC - Fernie District Hospital
9754	BC - Sparwood General Hospital
9755	BC - Invermere District Hospital
9756	BC - Cranbrook Regional Hospital
9759	BC - Hudson's Hope Health Centre
9801	BC - Trail Regional Hospital
9804	BC - Castlegar & District Hospital
9902	BC - Prince Rupert Hospital
9903	BC - Smithers, Bulkly Valley Hospital
9910	BC - Stewart Health Centre
9999	OUT OF COUNTRY

Date of Arrival (Immediate Referring Facility)

Data Element	Date of Arrival at Immediate Referring Facility
Field Name	RFS_A_DATE
Field Type	Date
Field Length	2, 2, 4
Note	Enter the patient's date of arrival at the immediate referring facility (MM DD YYYY). For inter-facility transfer patients, this is the date on which the patient was first triaged/registered at the immediate referring facility after arriving from the scene. Please use the earliest date/time recorded from the patient's chart.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form / Trauma Flow Sheet 3. Nursing Notes 4. Netcare/ EDIS/ other in-hospital patient database
History	N/A

Time of Arrival (Immediate Referring Facility)

Data Element	Time of Arrival at Immediate Referring Facility
Field Name	RFS_A_TIME
Field Type	Time
Field Length	2, 2
Note	Enter the patient's time of arrival at the primary hospital using the 24–hour clock (HH:MM) For inter facility transfer patients, this is the date on which the patient was first triaged/registered at the immediate referring facility after arriving from the scene. Please use the earliest date/time recorded from the patient's chart.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form / Trauma Flow Sheet 3. Nursing Notes 4. Netcare/ EDIS/ other in-hospital patient database
History	N/A

Date of Departure (Immediate Referring Facility)

Data Element	Date of Departure from Immediate Referring Facility
Field Name	RFS_DIS_DATE
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date of departure from the immediate referring hospital for all patients (including admitted patients) (MM DD YYYY). For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. ED record 3. Nursing notes
History	N/A

Time of Departure (Immediate Referring Facility)

Data Element	Time of Departure from Immediate Referring Facility
Field Name	RFS_DIS_TIME
Field Type	Time
Field Length	2, 2
Note	Enter the time of departure from the immediate referring facility for all patients (including admitted patients) using the 24–hour clock (HH:MM). For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet 2. ED record 3. Nursing notes
History	N/A

Length of Stay (Immediate Referring Facility)

Data Element	Time of Departure from Immediate Referring Facility
Field Name	RFS_LOS; RFS_LOS_MINS
Field Type	Time
Field Length	2,2
Note	Length of stay is a calculated field based on the date and time of arrival of patient at immediate referral facility (triage) subtracted from the date and time of departure from immediate referral facility. This will be displayed in hours and minutes (HH:MM).
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Referring Physician (Immediate Referring Facility)

Data Element	Referring Physician
Field Name	RFS_MD_S
Field Type	Character
Field Length	50
Note	Type the name of the referring physician at the primary hospital. Format should be Surname, First (name or initial). If your site only records Surname this is ok; larger sites might want to record first name/initial if there are physicians with the same last name.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Admission Form 2. Triage Form / Trauma Flow Sheet 3. ED Nurses' Notes
History	N/A

Clarification:

Intracranial pressure is volume measurement of blood, brain tissue and cerebrospinal fluid within the skull. Each of the components has a relatively constant volume and each volume contributes to the overall ICP. ICP will increase whenever one or more of the contributing volume pressures increase. The normal range is 0 – 15 mm Hg (millimetres of Mercury).

ICP monitoring is used to evaluate a head injury patient's response to therapy and may also be used as a treatment modality to vent CSF. ICP is measured by one of two major types of devices:

1) Subarachnoid bolt or screw (many names for these please check with your coordinators), which is placed through the skull onto the surface of the brain,

2) Intraventricular or Codman catheter, which may have a fibre optic sensor in the catheter tip that is placed into the lateral ventricle of the brain on the patient's non-dominant side. Both types of measuring devices are connected to transducers and recorders which will display both numerical values of ICP and corresponding waveforms.

Referral History: Additional Referring Facility

Please add all other referring facilities that the patient was seen at. The Immediate referral facility will be listed at the top of the list.

Please enter all other additional referring facilities in backwards order (immediate referral facility → first facility seen at).

The fields that you enter will be exactly the same as for immediate referring facility. Please look at the above sections (Referring Facility # (if other), Arrival Date/Time, Departure Date/Time, Length of Stay, Referring Physician, Facility Level, Total Ventilator Days, Total OR Visits, ICP Days, and # of IV Lines) for descriptions of these variables and clarifications on how to complete these sections.

You can use the ↑ and ↓ keys to move the facility order around. You can also go in to each referral facility entry to EDIT or DELETE that entry.

Referring Facility: Assessments (Immediate Referring Facility)

Paralytic Agents? (Immediate Referring Facility)

Data Element	Paralytic Agents? (Immediate Referring Facility)
Field Name	RFAS_PAR_YN
Field Type	Numeric
Field Length	1
Note	Were paralytic agents in effect when the GCS at the immediate referring facility was calculated? [For example, Rocuronium (Zemuron) or succinylcholine (Anectine).] 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, and restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytics are often used with intubation BUT NOT ALWAYS. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range.

Typical paralytic agents are Rocuronium (Zemuron) and succinylcholine (Anectine). Others that are not in use in Alberta but which may be used elsewhere include: Vecuronium (Norcuron), Cisatracurium (Nimbex), Pancuronium (Pavulon), and Tubocurarine (Tubarine).

Pain killing drugs (analgesics) and/or sedating drugs may be used in combination with a paralysing agent. These agents alone **ARE NOT** paralytic agents and paralytic agents should be coded as "no" if these are the only medications administered. Examples of sedatives/analgesics include: Morphine, Demerol, Ativan/Lorazepam, Thiopental/Pentothal, Fentanyl, Ketamine, and Propofol.

If a patient was given paralytic agents prior to the trauma centre this should be answered 'Yes' or 'Unknown'. Ask a trauma coordinator or medical director about the half time of the drug.

Intubated? (Immediate Referring Facility)

Data Element	Was the patient intubated? (Immediate Referring Facility)
Field Name	RFAS_INTUB_YN
Field Type	Numeric
Field Length	1
Note	Was the patient intubated at the time the GCS at the immediate referring facility was calculated? Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitubes and LMA LMA, King, Combitubes are airway adjuncts and included as intubation as per requirement of NTDB and data subcommittee Jan 10 2019. 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Eye Obstruction? (Immediate Referring Facility)

Data Element	Eye Obstruction? (Immediate Referring Facility)
Field Name	RFAS_E_OB_YN
Field Type	Numeric
Field Length	1
Note	Did the patient have an eye obstruction at the time the GCS at the immediate referring facility was calculated? 1. Yes 2. No ? Unknown / Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Temperature (Immediate Referring Facility)

Data Element	Temperature (Immediate Referring Facility)
Field Name	RFAS_TEMP; RFAS_TEMP_U
Field Type	Numeric; Integer (units)
Field Length	5 (to one decimal place); 1
Note	Defined as the patients first recorded temperature upon arrival at the immediate referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in the first 30 minutes, document as '?'. You will need to choose if you are entering temperature in Celsius (C) or Fahrenheit (F) from the units drop down list. The other measure will be converted automatically.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Systolic Blood Pressure (Immediate Referring Facility)

Data Element	Systolic Blood Pressure (Immediate Referring Facility)
Field Name	RFAS_SBP
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded SBP upon arrival at the immediate referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If vitals are not taken in first 30 minutes, or if SBP was not taken or is undocumented, enter SBP as '?'.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Pulse Rate (Immediate Referring Facility)

Data Element	Pulse Rate (Immediate Referring Facility)
Field Name	RFAS_PULSE
Field Type	Numeric
Field Length	3
Note	Defined as the patients first recorded pulse rate (or heart rate in #/min) upon arrival at the immediate referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document '?'. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the PR is not documented, enter '?'.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Unassisted Respiration Rate (Immediate Referring Facility)

Data Element	Unassisted Respiration Rate (Immediate Referring Facility)
Field Name	RFAS_URR
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded unassisted RR upon arrival at the immediate referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document as '?'. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the URR is not documented, enter '?'. Enter '/' if patient respirations are assisted, that is, patient is intubated or being bagged. Assisted Ventilation is defined as: • If there is something placed in the patient's airway to assist them in breathing such as ETT, King or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King or LMA the patient still had assisted ventilation. • If the patient is being bagged (bag-valve-mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated. • OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but ***by themselves are not assisted ventilation***. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation. • If a patients chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

O2 Saturation (Immediate Referring Facility)

Data Element	Oxygen Saturation (Immediate Referring Facility)
Field Name	RFAS_SA02
Field Type	Numeric
Field Length	2
Note	Defined as the patient's first recorded O2 saturation taken upon arrival of at the immediate referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document as '?'. ***This value should be based upon assessment before administration of supplemental oxygen if O2 saturation of patient was assessed before O2 was given.*** This may be documented as R/A (or room air) breathing without O2 given. *If not, please enter the first O2 saturation recorded*. If the O2 saturation is not documented (or EMS PCR is not available) document as '?' unknown.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Eye (Immediate Referring Facility)

Data Element	Eye (Immediate Referring Facility)
Field Name	RFAS_GCS_EO
Field Type	Numeric
Field Length	1
Note	Defined as the patients first eye-opening response for the GCS documented upon arrival at the immediate referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If eye response is not taken in first 30 minutes, or if the eye-opening response is not documented enter '?'. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "Patient opens their eyes to voice command," an Eye GCS of 3 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Menu Selection for GCS Eye Scale:

1	**No eye movement when assessed**
2	Opens eyes in response to painful stimulation
3	Opens eyes in response to verbal stimulation
4	Opens eyes spontaneously
/	Not applicable
?	Unknown

Verbal (Immediate Referring Facility)

Data Element	Verbal (Immediate Referring Facility)
Field Name	RFAS_GCS_VR
Field Type	Numeric
Field Length	1
Note	Defined as the patients first verbal response for the GCS documented upon arrival at the immediate referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If verbal response is not taken in first 30 minutes or verbal response is not documented enter '?'. If the patient is intubated within the first 30 minutes before GCS is assessed document as '1'. Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitubes and LMA LMA, King, Combitubes are airway adjuncts and included as intubation as per requirement of NTDB and data subcommittee Jan 10 2019. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "when the patient speaks they are confused," a Verbal GCS of 4 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

Menu Selection for GCS Verbal Scale:

1	No verbal response (ped: No vocal response)
2	Incomprehensible Sounds (ped: inconsolable, agitated)
3	Inappropriate Words (ped: inconsistently consolable, moaning)
4	Confused (ped: cries but is consolable, inappropriate interactions)
5	Oriented (ped: smiles, oriented to sounds, follows objects, interacts)
/	Not applicable
?	Unknown

Motor (Immediate Referring Facility)

Data Element	Motor (Immediate Referring Facility)
Field Name	RFAS_GCS_MR
Field Type	Numeric
Field Length	1
Note	Defined as the patients first motor response for the GCS documented upon arrival at the immediate referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If motor response is not taken in first 30 minutes, or motor response is not documented, enter '?'. If the patient is under paralytics then the GCS motor score will be '1'. Intubation alone does not indicate a GCS motor score of '1' since motor response can still be assessed. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

Menu Selection for GCS Motor Scale:

1	No motor response
2	Extension to pain
3	Flexion to pain
4	Withdrawal from pain
5	Localizing pain
6	Obeys commands (Ped: appropriate response to stimulation)
/	Not applicable
?	Unknown

Total GCS (Immediate Referring Facility)

Data Element	Total GCS (Immediate Referring Facility)
Field Name	RFAS_GCS
Field Type	Numeric
Field Length	2
Note	Defined as the total GCS documented upon arrival at the immediate referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If the GCS or any component of the GCS is not documented enter '?'. If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented (A+Ox4) the total GCS may be assumed to be 15 **IF** there is no other contradicting documentation. Total GCS value must be between 3 and 15.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

Immediate Referring Facility GCS 40- Eye

Data Element	Immediate Referring Facility GCS 40-Eye
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Eye) measured at the Referring facility. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Immediate Referring Facility GCS 40- Verbal

Data Element	Immediate Referring Facility GCS 40-Verbal
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Verbal) measured at the Referring facility. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Immediate Referring facility GCS 40- Motor

Data Element	Immediate Referring Facility GCS 40-Motor
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Motor) measured at the Referring facility. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

RTS (Immediate Referring Facility)

Data Element	Total RTS (Immediate Referring Facility) Revised Trauma Score
Field Name	RFAS_RTS_W
Field Type	Numeric
Field Length	4
Note	Revised Trauma Score at the primary hospital is a calculated field based on Glasgow Coma Scale (all components), systolic blood pressure and unassisted respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will be displayed as '/' on the screen.
ATR Required	Yes
NTR Required	No
NTDB Required	No
Hierarchy	
History	

The calculation of the RTS is outlined below:

Coded Value x Weight = Score

Respiratory Rate (breaths/min)

>29	4	
10-29	3	
6-9	2	X0.2908=_____
1-5	1	
0	0	

Use 0 if patient arrived intubated

Systolic Blood Pressure (mm Hg)

>89	4	
76-89	3	
50-75	2	X0.7326=_____
1-49	1	
0	0	

Glasgow Coma Scale

13-15	4	
9-12	3	
6-8	2	X0.9368=_____
4-5	1	
< 5	0	

Total RTS (3 scores totalled)=_____

Triage RTS (Immediate Referring Facility)

Data Element	Triage RTS (Immediate Referring Facility) Revised Trauma Score
Field Name	RFAS_RTS_U
Field Type	Numeric
Field Length	2
Note	The triage RTS at the scene is a calculated field based on Glasgow Coma Scale (total score), systolic blood pressure, and unassisted respiratory rate used to calculate final scene RTS. The triage RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, triage RTS will remain blank. Triage RTS will be blank if unassisted respiration, SBP, or total GCS is not applicable. This is a score used for field triage for rapid identification of severely injured patients. Scores range from 0-12 and a triage-RTS < 11 indicates a need for transport to a designated trauma center (information from http://lifeinthefastlane.com/ccc/trauma-scoring-systems/). This is not necessarily how AB uses this score for triage at the scene or in hospital.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Clarification:

Based on 3 physiological parameters:

GCS	TRIAGE RTS SCORE (ADD 3 COMPONENTS)
13-15	4
9-12	3
6-8	2
4-5	1
3	0
SBP	
>89	4
76-89	3
50-75	2
1-49	1
0	0
UNASSISTED RR	
10-29	4
>29	3
6-9	2
1-5	1
0	0

Alcohol Use Indicator

Data Element	Alcohol Use Indicator (Immediate Referring Facility)
Field Name	RFS_IND_ALC
Field Type	Numeric
Field Length	1
Note	Choose from the drop down menu if patient was tested for/ had alcohol in blood at immediate referring facility. 1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [trace levels] <11 mmol/L) 4. Yes (confirmed by test [beyond legal limit] ≥ 11 mmol/L) Unknown *(if alcohol use is suspected but not confirmed by test)* The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyser test) while 17 mmol/L is equivalent to the 0.08 limit. Choice 1 will be mapped to 'No' for NTDB submission, while choices 2-4 will be mapped to 'Yes'. Submission will look at both referring and definitive centers answers for BAC tested so please answer for all sites where BAC may have been taken. Field cannot be blank Field cannot be Not Applicable
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

BAC (mmol/L) (Immediate Referring Facility)

Data Element	BAC (mmol/L) (Immediate Referring Facility)
Field Name	RFS_ETOH_BAC_LVL
Field Type	Numeric
Field Length	5
Note	Enter the patient's blood alcohol concentration in SI units (mmol/L) at the trauma center within 24 hours after first hospital arrival. Enter '?' if the results are not available. If previous field was '/' (for patients ≤ 9 years of age) or checked 'No' this section will be inactive and will be mapped to 0 for NTDB submission. If the lab results state < 2 or trace document as '0'. The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyzer test) while 17 mmol/L is equivalent to the criminal 0.08 limit. Cannot be 'n/a' if previous question was 'Yes'.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

Clarifications:

For the time being for this indicator as we may not be able to determine for most cases if drugs were illegal or prescription (i.e. marijuana, etc.). According to the NTDB we should be entering "?" if this is the case. We will be activating the next section (toxicology screen results) when "?" is entered in a future ATR update.

Please report all drugs that are tested for (either in serum or urine testing). The Core Leadership team for Alberta Trauma Services will be developing standard protocols for drug screening similar to alcohol testing guidelines. Until then please just report whatever information you find in the chart regarding drug use.

Analysts should be able to have access to medical reconciliation records (provincial, should be in inpatient section at front of chart) to see a current list of prescribed medications. This may help determine if they are prescription or illegal (though it may not tell you if patient was taking these meds according to the prescription directions).

We will also need to get a list from the lab of common drug names vs their chemical names that may be on the lab reports.

Drug Screen Results

Data Element	Drug Screen Results (ED/Resus: Labs/Toxicology)
Field Name	????
Field Type	Integer
Field Length	1
Note	Choose from the pop up menu (or from the drop down list on a line-by-line basis) which drugs were identified in patient's lab results. Check up to 13. Please enter drug name if option 13, 'Other' is chosen. This new data element must be filled out for everyone. If options 1-13 are checked please also fill out the clinician administered check box (yes, no or '?' do not use n/a). Clinician administered drugs will not be sent to NTDB. 1. AMP (Amphetamine) 2. BAR (Barbiturate) 3. BZO (Benzodiazepine) 4. COC (Cocaine) 5. mAMP (Methamphetamine) 6. MDMA (Ecstasy) 7. MTD (Methadone) 8. OPI (Opioid) 9. OXY (Oxycodone) 10. PCP(Phencyclidine) 11. TCA (Tricyclic Antidepressant) 12. THC (Cannabinoid) 13. Other 14. None (is reported for patient's whose only positive results are due to drugs administered at any facility/setting treating this patient event or for patients who were tested and had no positive results). 15. Not tested Unknown Lab results use chemical names for common drugs; please find a list of chemical names and the matching common names below. (Not yet available).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

Clinician Administered

Data Element	Clinician Administered (Immediate referring Facility: Labs/Toxicology)
Field Name	????
Field Type	Integer
Field Length	1
Note	Field values 1.Yes (Does not get sent to NTDB no need to answer) 2. No (tested positive for drugs that were **not** administered at any facility or setting treating this patient event).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

Referring Facility: Additional Vitals If additional vitals were taking at any referring facility (subsequent vitals taken at immediate referring facility, or vitals taken at a hospital before the immediate referring facility) please enter them here in the order they were taken. Please add all vitals that were taken.

Additional Referring Facility Number/Name

Data Element	Referring Facility (Additional Vitals)		
Field Name	RFAS_FACLNKS		
Field Type	Numeric		
Field Length	4		
Note	If you know the number of the referring facility that recorded additional vitals to be entered please type in the box provided. Alternately click on the magnifying glass icon to the right for a list of facilities. You can scroll through the options or type in ID # or Name to search. Highlight and press select or double click on your choice. You can also click on the titles of "ID" or "Name" to have the list be sorted by intuition ID # or alphabetically by name of facility. You cannot search by province for out of AB facilities but by name of institution. *Note: Facility ID #'s do not have extra 0s at the beginning so the facility #'s won't necessarily be in order from 0-9999 but from the first digit (1, 100, 1000, 2, etc.)* Facility #s will **not transfer** over from the referral history section so you will have to enter the facility # for all facilities including the immediate referring facility (which gets transferred over from the assessments page as the first line). If the institution is not in the drop down list choose "other" there is no text box to enter name of additional other referring facility in this section. Please look carefully at the facility list in this data dictionary before choosing "other" as the name of the facility may be slightly different then what is written in the patient file. Referring institutions must be acute care facilities and should not include rehabilitation facilities or nursing homes. If an injury occurs in a non–acute care facility (i.e., nursing home), consider that facility to be the scene of the incident. In cases where patients are injured in an acute care facility and then transferred to a district/tertiary trauma hospital, consider the transferring facility to be both the scene and the referring facility. The same information should be entered in both scene and primary hospital sections because the type of care rendered includes both the scene and referring facility. A referring hospital is defined as the hospital that transfers the patient directly to the district/tertiary trauma hospital. Hospitals in which the patient is seen and released home with or without treatment before the patient is seen at a district/tertiary trauma hospital are not considered to be referring institutions. See page **146-155** for a complete list of AB institutions.		
ATR Required	Yes	NTDB Required	No

Assessment Type

Data Element	Assessment Type (Additional Vitals)
Field Name	RFAS_ATYPES
Field Type	Numeric
Field Length	1
Note	Choose from the drop down menu if the vitals for the referring facility you are entering is: 1. Initial vitals taken (will most often only enter this) 2. Subsequent vitals 3. Final vitals taken Unknown Vitals already recorded (in previous section) for immediate referring facility should be the initial vitals taken at that facility.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Analysts can add multiple vitals taken at any/all referring facilities, but must enter the initial vitals for each referring facility (one set for each facility must be entered).

Paralytic Agents? (Additional Vitals)

Data Element	Paralytic Agents? (Additional Vitals)
Field Name	RFAS_PAR_YNS {list}
Field Type	Numeric
Field Length	1
Note	Were paralytic agents in effect when the GCS at the referring facility was calculated? [Most commonly used paralytic agents in AB are: Rocuronium (Zemuron) and Succinylcholine (Anectine)]. 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, and restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytics are often used with intubation BUT NOT ALWAYS. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range.

Typical paralytic agents are Rocuronium (Zemuron) and succinylcholine (Anectine). Others that are not in use in Alberta but which may be used elsewhere include: Vecuronium (Norcuron), Cisatracurium (Nimbex), Pancuronium (Pavulon), and Tubocurarine (Tubarine).

Pain killing drugs (analgesics) and/or sedating drugs may be used in combination with a paralysing agent. These agents alone **ARE NOT** paralytic agents and paralytic agents should be coded as "no" if these are the only medications administered. Examples of sedatives/analgesics include: Morphine, Demerol, Ativan/Lorazepam, Thiopental/Pentothal, Fentanyl, Ketamine, and Propofol.

If a patient was given paralytic agents prior to the trauma centre this should be answered 'Yes' or 'Unknown'. Ask a trauma coordinator or medical director about the half time of the drug.

Intubated? (Additional Vitals)

Data Element	Was the patient intubated? (Additional Vitals)
Field Name	RFAS_INTUB_YNS {list}
Field Type	Numeric
Field Length	1
Note	Was the patient intubated at the time the GCS at the referring facility was calculated? Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitubes and LMA LMA, King, Combitubes are airway adjuncts are included as intubation as per requirement of NTDB and data subcommittee Jan 11 2019. 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Eye Obstruction? (Additional Vitals)

Data Element	Eye Obstruction? (Additional Vitals)
Field Name	RFAS_E_OB_YNS {list}
Field Type	Numeric
Field Length	1
Note	Did the patient have an eye obstruction at the time the GCS at the referring facility was calculated? 1. Yes 2. No ? Unknown / Not applicable *(use for patients who arrive by private vehicle/non-ambulance)*
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Temperature/Unit (Additional Vitals)

Data Element	Temperature and Unit (Additional Vitals)
Field Name	RFAS_TEMPS {list}
Field Type	Numeric
Field Length	4 (to one decimal place)
Note	Defined as the patients first recorded temperature upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in the first 30 minutes, document as '?'. You will need to choose if you are entering temperature in Celsius (C) or Fahrenheit (F). The other measure will be converted automatically.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Systolic Blood Pressure (Additional Vitals)

Data Element	Systolic Blood Pressure (Additional Vitals)
Field Name	RFAS_SBPS {list}
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded SBP upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If vitals are not taken in first 30 minutes, or if SBP was not taken or is undocumented, enter SBP as '?'.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Pulse Rate (Additional Vitals)

Data Element	Pulse Rate (Additional Vitals)
Field Name	RFAS_PULSES {list}
Field Type	Numeric
Field Length	3
Note	Defined as the patients first recorded pulse rate (or heart rate) upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document '?'. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the PR is not documented, enter '?'.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Unassisted Respiration Rate (Additional Vitals)

Data Element	Unassisted Respiration Rate (Additional Vitals)
Field Name	RFAS_URRS {list}
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded unassisted RR upon arrival at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document as '?'. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the URR is not documented, enter '?'. Enter '/' if patient respirations are assisted, that is, patient is intubated, Combitubes or being bagged. Assisted Ventilation is defined as: • If there is something placed in the patient's airway to assist them in breathing such as ETT, King or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King or LMA the patient still had assisted ventilation. • If the patient is being bagged (bag-valve-mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated. • OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but ***by themselves are not assisted ventilation***. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation. • If a patients chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

O2 Saturation (Additional Vitals)

Data Element	Oxygen Saturation (Additional Vitals)
Field Name	RFAS_SAO2S {list}
Field Type	Numeric
Field Length	2
Note	Defined as the patient's first recorded O2 saturation taken upon arrival of at the referring facility (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document as '?'. ***This value should be based upon assessment before administration of supplemental oxygen if O2 saturation of patient was assessed before O2 was given.*** This may be documented as R/A (room air) breathing without O2 given. *If not, please enter the first O2 saturation recorded*. If the O2 saturation is not documented (or EMS PCR is not available) document as '?' unknown.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Eye (Additional Vitals)

Data Element	GCS Eye (Additional Vitals)
Field Name	RFAS_GCS_EOS {list}
Field Type	Numeric
Field Length	1
Note	Defined as the patients first eye-opening response for the GCS documented upon arrival at the referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If eye response is not taken in first 30 minutes, or if the eye-opening response is not documented document '?'. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "Patient opens their eyes to voice command," an Eye GCS of 3 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

Menu Selection for GCS Eye Scale:

1	**No eye movement when assessed**
2	Opens eyes in response to painful stimulation
3	Opens eyes in response to verbal stimulation
4	Opens eyes spontaneously
/	Not applicable
?	Unknown

Verbal (Additional Vitals)

Data Element	GCS Verbal (Additional Vitals)
Field Name	RFAS_GCS_VRS {list}
Field Type	Numeric
Field Length	1
Note	Defined as the patients first verbal response for the GCS documented upon arrival at the referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If verbal response is not taken in first 30 minutes or verbal response is not documented enter as '?'. If the patient is intubated within the first 30 minutes before GCS is assessed document as '1'. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "when the patient speaks they are confused," a Verbal GCS of 4 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

Menu Selection for GCS Verbal Scale:

1	No verbal response (ped: No vocal response)
2	Incomprehensible Sounds (ped: inconsolable, agitated)
3	Inappropriate Words (ped: inconsistently consolable, moaning)
4	Confused (ped: cries but is consolable, inappropriate interactions)
5	Oriented (ped: smiles, oriented to sounds, follows objects, interacts)
/	Not applicable
?	Unknown

Motor (Additional Vitals)

Data Element	GCS Motor (Additional Vitals)
Field Name	RFAS_GCS_MRS {list}
Field Type	Numeric
Field Length	1
Note	Defined as the patients first motor response for the GCS documented upon arrival at the referring facility (ED or inpatient unit if direct admission), within 30 minutes of arrival. If motor response is not taken in first 30 minutes or motor response is not documented enter as '?'. If the patient is under paralytics then the GCS motor score will be '1'. Intubation alone does not indicate a GCS motor score of not applicable since motor response can still be assessed. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

Menu Selection for GCS Motor Scale:

1	No motor response
2	Extension to pain
3	Flexion to pain
4	Withdrawal from pain
5	Localizing pain
6	Obeys commands (Ped: appropriate response to stimulation)
/	Not applicable
?	Unknown

Total GCS (Additional Vitals)

Data Element	Total GCS (Additional Vitals)
Field Name	RFAS_GCSSC {list}
Field Type	Numeric
Field Length	2
Note	Defined as the first total GCS documented within the first 30 minutes of arrival at the referring facility. If the GCS or any component of the GCS is not documented enter as '?'. If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented (A+Ox4) the total GCS may be assumed to be 15 **IF** there is no other contradicting documentation. Total GCS value must be between 3 and 15.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	

GCS 40- Eye (Additional Vitals)

Data Element	GCS 40-Eye (Additional Vitals)
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Eye) measured at the additional referring facility. Please enter “unk”= Not known/Not recorded as per2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

GCS 40- Verbal (Additional Vitals)

Data Element	GCS 40-Verbal (Additional Vitals)
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Eye) measured at the additional referring facility. Please enter "unk"= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

GCS 40- Motor (Additional Vitals)

Data Element	GCS 40-Motor (Additional Vitals)
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale (Eye) measured at the additional referring facility. Please enter “unk”= Not known/Not recorded as per2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

RTS (Additional Vitals)

Data Element	Total RTS (Additional Vitals) Revised Trauma Score
Field Name	RFAS_RTS_WSC {list}
Field Type	Numeric
Field Length	4
Note	Revised Trauma Score at the primary hospital is a calculated field based on Glasgow Coma Scale (all components), systolic blood pressure and unassisted respiratory rate. The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will be displayed as '/' on the screen.
ATR Required	Yes
NTR Required	No
NTDB Required	No
Hierarchy	
History	N/A

The calculation of the RTS is outlined below:

Coded Value x Weight = Score

Respiratory Rate (breaths/min)

>29	4	
10-29	3	
6-9	2	X0.2908=_____
1-5	1	
0	0	

Use 0 if patient arrived intubated

Systolic Blood Pressure (mm Hg)

>89	4	
76-89	3	
50-75	2	X0.7326=_____
1-49	1	
0	0	

Glasgow Coma Scale

13-15	4	
9-12	3	
6-8	2	X0.9368=_____
4-5	1	
< 5	0	

Total RTS (3 scores totalled)=_____

Triage RTS (Additional Vitals)

Data Element	Triage RTS (Additional Vitals) Revised Trauma Score
Field Name	RFAS_RTS_USC {list}
Field Type	Numeric
Field Length	2
Note	The triage RTS at the scene is a calculated field based on Glasgow Coma Scale (total score), systolic blood pressure, and unassisted respiratory rate used to calculate final scene RTS. The triage RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, triage RTS will remain blank. Triage RTS will be blank if unassisted respiration, SBP, or total GCS is not applicable. This is a score used for field triage for rapid identification of severely injured patients. Scores range from 0-12 and a triage-RTS < 11 indicates a need for transport to a designated trauma center (information from http://lifeinthefastlane.com/ccc/trauma-scoring-systems/). This is not necessarily how AB uses this score for triage at the scene or in hospital.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Clarification:

Based on 3 physiological parameters:

GCS	TRIAGE RTS SCORE (ADD 3 COMPONENTS)
13-15	4
9-12	3
6-8	2
4-5	1
3	0
SBP	
>89	4
76-89	3
50-75	2
1-49	1
0	0
UNASSISTED RR	
10-29	4
>29	3
6-9	2
1-5	1
0	0

Referring Facility: Procedures

Enter all procedures (non-operative and operative) done at all referring facilities before patient was transferred to definitive trauma centre. Please enter them in reverse order from immediate referring facility back to first referring facility.

Non-Operative Procedure

Data Element	Non–operative Procedure (All referring hospitals)
Field Name	RF_INTS {list}
Field Type	Numeric
Field Length	2
Note	Click the Non-operative button at the top left of the screen to enter up to 10 non–operative procedures at one time initiated any of the referral hospitals' emergency department only. Please enter them in reverse order from immediate referring facility back to first referring facility. ***Procedures already established which are being maintained should not be entered.*** If there were no non-operative procedures done in the ED please choose '/' from the drop down list so we know this section wasn't accidentally skipped. You can now enter Referring Facility # so we can track different non-op procedures being done at different facilities. Start date should be entered in the space provided, time may be entered as '/' unless a specific site wants to try and capture this information. Because dates and/or times will not be the same for all procedures (and the dates may also be different if occurring at different facilities) you will have to edit each non-operative procedure to enter the correct time. If complete or partial date or time is not documented enter '?'. You can enter more than 10 non-op procedures in total, but can only add 10 at one time. Please see below for complete list of procedures and further clarification.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ER Nursing Notes 2. Trauma Flow Sheet 3. Hospital Discharge Summary
History	N/A

Further Clarification:

Select non–operative procedures performed at all referring facilities. Procedures can be entered more than once (i.e. if procedure was done at more than one hospital, do not enter a procedure twice if it has been established at one hospital and is being maintained at the next hospital).

Assisted Ventilation is defined as:

- If there is something placed in the patient's airway to assist them in breathing such as ETT, King, Combitubes or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King, Combitubes or LMA the patient still had assisted ventilation.
- If the patient is being bagged (bag-valve-mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated.
- Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitubes and LMA
- LMA, King, Combitubes are airway adjuncts and included as intubation as per requirement of NTDB and data subcommittee Jan 10 2019.
- OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but ***by themselves are not assisted ventilation***. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation.
- If a patients chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.
- So if the analyst has selected "#1, Oral intubation" or "#2, King LT, LMA, Combitubes" they should also select "Assisted Ventilation". LMA, King and Combitubes are not intubation.

Backboard is no longer an option.

When coding for the trauma center, procedures already established which are being maintained should not be selected.

Extubation should not be included as a non-operative procedure.

CT Angio should be coded as Angiography (#20)

CT Angio should be coded as Angiography/CTA #20

Added CTA as per Data subcommittee April 05 2018

If patient went to CT scanner for Angio then should be recorded as #20. If patient went to Angio suite for Embolization etc., then enter #20 and #48.

Please carefully review all new options in the drop down list (i.e. CT scan locations).

Explanation:

If patient went to CT scanner for Angio then should be recorded as #20. If patient went to Angio suite for Embolization etc., then enter #20 and #48

Menu Selection for Non-operative Procedures:

1	Oral intubation with BVM ventilation (bagged) 1GZ31CAEP
2	King LT, LMA, Combitubes
3	Tracheostomy
4	Cricothyroidotomy
5	Ventilator/ Intubated with ventilator (make sure this is an "ND" code) 1GZ31CAND
6	Chest Tube insertion
7	Peripheral IV insertion
8	Central Line
9	Arterial Line
10	Cut down
11	ED Thoracotomy
12	CPR
13	ICP monitoring
14	Burr Holes
15	Halo Traction or Tongs
16	Traction/Pins
17	Peg Tubes
18	Foley Catheter Insertion
19	Gastric Tube Insertion
20	Angiography/CTA
21	DPL
22	CT Head Scan
23	Percardiocentesis
24	Intrasosseous Access
25	C–Spine precautions
26	Blood Product Administration
27	Major suturing
28	Other
29	Needle Thoracentesis
30	Splinting
31	Ultrasound
40	Closed Reduction
41	MRI
42	CT Scan Spine
43	CT Scan Face
44	CT Scan Chest
45	CT Scan Abdomen
46	CT Scan Pelvis
47	CT Scan Other
48	Angioembolization
49	CT Total Body (includes CT Chest, Abdomen, Pelvis)
/	Not applicable
?	Unknown

ICD9 & ICD10 Procedures (Referring Facility)

Please enter all OR procedures in this field. All burr hole procedures done in the OR are to be coded as "craniotomy" as per ATCLS decision. See Appendix A.

If patient arrived from a hospital outside of Alberta or out of Canada please enter "unk" for dates and times if information is unavailable. As per Data Subcommittee June 14 2018.

As per Data Subcommittee April 05 2018 please enter all OR procedures done at the Referring facilities here. We are no longer collecting #ORs. Therefore, we need to capture the types of procedures done here in this section.

Referring Facility: Inter-Facility Transport: Providers/Vitals

Must click on the add button to add inter-facility transport details. There should be a minimum of 1 line added for each patient entered (even if private transport) in the providers section if patient has a referring facility. Non-applicable fields will deactivate if non-ambulance method of transport used. Please enter inter-facility transport in reverse order (immediate referring facility to definitive trauma centre transport first, etc.). Inter-Facility Vitals does not need to be completed and the check for this section has been removed.

Referring Facility Number/Name

Data Element	Referring Facility
Field Name	ITP_FACLNKS {list}
Field Type	Numeric
Field Length	4
Note	If you know the number of the referring facility from where the transport originated enter it in the box provided. Alternately click on the magnifying glass icon to the right for a list of facilities. You can scroll through the options or type in ID # or Name to search. Highlight and press select or double click on your choice. You can also click on the titles of "ID" or "Name" to have the list be sorted by intuition ID # or alphabetically by name of facility. You cannot search by province for out of AB facilities but by name of institution. *Note: Facility ID #'s do not have extra 0s at the beginning so the facility #'s won't necessarily be in order from 0-9999 but from the first digit (1, 100, 1000, 2, etc.)* If the institution is not in the drop down list choose "other"; there is no text box to enter name of additional other referring facility in this section. Please look carefully at the facility list in this data dictionary before choosing "other" as the name of the facility may be slightly different then what is written in the patient file. Referring institutions must be acute care facilities/ambulatory care centres and should not include rehabilitation facilities or nursing homes. If an injury occurs in a non–acute care facility (i.e., nursing home), consider that facility to be the scene of the incident. In cases where patients are injured in an acute care facility and then transferred to a district/tertiary trauma hospital, consider the transferring facility to be both the scene and a referring facility. The same information should be entered in both scene and referring facility sections because the type of care rendered includes both the scene and referring facility. A referring hospital is defined as the hospital that transfers the patient directly to the district/tertiary trauma hospital. Hospitals in which the patient is seen and released home with or without treatment before the patient is seen at a district/tertiary trauma hospital are not considered to be referring institutions. See page **136-145** for a complete list of AB institutions.
ATR Required	Yes
NTDB Required	No

Mode of Transport (Referring Facility)

Data Element	Mode of Transport (Referring Facility)
Field Name	ITP_MODES {list}; ITP_MODE_SS {list} (mode if other)
Field Type	Numeric
Field Length	1
Note	Enter the mode of transport from the referring facility. Enter the transport mode by main mode of transport first, other methods in sequential order after that starting with the immediate referring facility and then in reverse order of referring facility transferred from. **Clarification:** Enter the main mode of transport that was used to deliver the patient to the facility. (e.g. STARS first, ground ambulance second). Mode of transport refers to the vehicle/provider used during patient transport from the scene to hospital and between hospitals. Military helicopter ambulances should be coded as helicopter ambulances. Infinite modes of transport (land or air vehicles) can be documented for each run. A run is a prehospital transfer, which may be from the scene to a hospital or between hospitals. If mode is other please enter mode of transport in text box provided.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS run sheet
History	**Clarification:** Enter the main mode of transport that was used to deliver the patient to the facility. (e.g. STARS first, ambulance second).

Explanation: e.g. patient coming from Chinook Regional Hospital (LRH) to FMC enter data as follows: 1. Ground to FMC; 2. Fixed wing to YYC airport; 3. Ground to Lethbridge airport.

For those submitting to TQIP: If a patient was transported from the scene of the injury by a fixed wing airplane to an airport, then transported from the airport by ground transportation to your hospital, you should report *Field Value* "1. Ground Ambulance" for **Transport Mode** to the NTDB. The reason being that the ground ambulance is the mode of transport that delivered the patient to your hospital, as indicated in the definition. You should report *Field value* "3. Fixed wing Ambulance" for **Other Transport Mode** to the NTDB. The reason is that the patient was transported by fixed wing from the scene to the airport, but not to your hospital, as indicated in the definition (this explanation came from TQIP)

Menu Selection for Mode of Transport:

1	**Ground ambulance**
2	Helicopter ambulance (e.g. STARS, military)
3	Fixed–wing ambulance
4	Private vehicle or walk–in
5	Police
6	Public Safety
7	Water ambulance
8	Other (please enter mode if other in text box below)
/	Not applicable (should not be used)
?	Unknown

Transport Role (Inter-Facility)

Data Element	New 2017: Transport Role (Inter-facility)
Field Name	
Field Type	Numeric
Field Length	1
Note	Used to help determine the logic for data being sent to NTDB (check to see if row data for unit transporting to your hospital is actually being sent or something else). Please choose from the drop down list below. Transport from scene to facility is direct transfer to any hospital. 1. Transport from Facility to your Facility 2. Transport from Facility to Rendezvous 3. Transport from Rendezvous to Facility 4. Transport to Other *(to be used to or from airports)* 5. Non-transport (not transporting patient but treating patient) / Not applicable ? Unknown If transport mode is EMS transport role will be required to be filled out (check added). If options 2 or 3 are check you will be required to fill out rendezvous pickup location.
ATR Required	Yes
NTDB Required	Yes – may not be directly sent (no data element in NTDS data dictionary) but to assist with logic in data being sent.
Hierarchy	1. EMS run sheet
History	New 2017

Explanation: ground to airport, airport to airport, ground to facility needs to be entered as **4- Transport to Other**

Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital.

Ambulance Service #

Data Element	Ambulance Service # (Transport at scene)
Field Name	ITP_AGNC_SS {list};
Field Type	Character
Field Length	50
Note	Type in Ambulance Service Number or Name (i.e. Edmonton AHS) with city before AHS (if applicable). If non-AHS service type in proper name of service. Will not be active to enter if ambulance mode of transport was not chosen for provider. Note: please continue to enter this data element as your site dictates until we decide if a more consistent provincial approach is needed. Use Unit ID it reads Numeric Alpha Numeric As per conversation with Greg Vogelaar March 08 2018,
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	**Clarification:** Do not use PCR# or Event #.

Inter-facility EMS Report

Data Element	Inter-facility EMS Report (PCR Available, Transport from Referring Facility)
Field Name	ITP_RP_DETAILS {list};
Field Type	Numeric
Field Length	1
Note	Please choose from the drop down list if the scene EMS report is available. 1. Complete 2. Incomplete 3. Missing 4. Unreadable / Not applicable-(don't use) ? Unknown Will not be active to enter if ambulance mode of transport was not chosen for provider.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	N/A

PCR#

Data Element	PCR# (Transport from Referring Facility)
Field Name	ITP_PCR_NUMS {list}
Field Type	Character
Field Length	40
Note	Enter the PCR number for the transport (land or air vehicle) that delivered the patient from the referring facilities. This includes flight number for air ambulance or fixed wing transport. If you can't find PCR# on report enter '?'. Will not be active to enter if ambulance mode of transport was not chosen for provider.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS run sheet
History	N/A

of Qualified Personnel

Data Element	# of Qualified Personnel (Transport from Referring Facility)
Field Name	ITP_ACRS01S {EMT, list}; ITP_ACRS02S {EMT-P, list}; ITP_ACRS03S {RT, list}; ITP_ACRS04S {RN, list}; ITP_ACRS05S {MD, list};
Field Type	Numeric
Field Length	2,2,2,2,2
Note	Enter the number of personnel from each category accompanying the patient during the transport for the first transport (land or air vehicle) at the scene. For categories that are not applicable enter 0. If a PICU Transport Team is used, indicate number of people on team. Qualified personnel include: EMT – starts with 40 EMT–P – starts with 50 RT RN – starts with 65 MD PICU STARS usually have on board 1 nurse, 1 paramedic and sometimes 1 physician. If you do not know how many people of a certain category you can enter '?' for unknown – but you should make every effort to find out how many EMS personnel were on scene for transport. '/' not applicable **should not be used.**
ATR Required	Yes
NTR Required	No
Hierarchy	1. EMS run sheet
History	2015: removal of EMR and students - don't need to count (PICU removed and not added back in until 2017.

Call Details

Date Call Dispatched/Received

Data Element	Date Call Dispatched/Received from referring facility
Field Name	ITP_D_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance call was received (MM DD YYYY). You can also choose the date from the calendar icon on the right. There is no default date (i.e. date of injury). **Arrival and departure dates should be documented from a patient care perspective. The arrival time of the first care transport should be documented even if the majority of care is given by another transport. The departure time of the transport responsible for the transport of the patient should be documented.** It is important to capture the date and time of inter-facility transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene, it may be necessary to combine the dates, times and the on scene procedures from both call reports. If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Time Call Dispatched/Received

Data Element	Time Call Dispatched/Received from referring facility
Field Name	ITP_D_TIMES {list}
Field Type	Numeric
Field Length	2, 2
Note	Enter the time the ambulance call was received, by ambulance service, using the 24 hour clock (HH:MM) For EMS this is noted as time unit notified and for STARS it is called dispatch time. If time is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Date En Route

Data Element	Date En Route to referring facility
Field Name	ITP_E_DATES {list}
Field Type	Date
Field Length	2,2,4
Note	Enter the date the ambulance responded if different from the date call dispatched/received (MM DD YYYY). You can also choose the date from the calendar icon on the right. There is no default date (i.e. date of injury). If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Time En Route

Data Element	Time En Route to referring facility
Field Name	ITP_E_TIMES {list}
Field Type	Numeric
Field Length	2,2
Note	Enter the time the ambulance unit was en route using the 24–hour clock (HH:MM). For STARS it is the time the helicopter lifts off. If time is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Meeting location

Data Element	Meeting location
Field Name	ITP_MLOCS {list}
Field Type	Character
Field Length	90
Note	Most of the time this should be entered as '/' not applicable since this is an inter-facility transport. Exceptions: sometimes STARS will meet a ground ambulance at a hospital landing pad or at some other location; 2 ground ambulances (e.g. 1 coming from out of province) may meet and transfer patient en route. If this is the case just enter as much detail about the meeting location as is in the chart.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS Run Sheet
History	N/A

Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital.

As per Data Subcommittee Dec 12 2017 must collect provincially

Date Arrive at Location

Data Element	Date Arrived at Referring Facility
Field Name	ITP_A_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance arrived at the transfer facility if different from the date of dispatch/call received or en route date (MM DD YYYY). You can also choose the date from the calendar icon on the right. Arrival is defined at date/time when the vehicle stopped moving. If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Time Arrived at Location

Data Element	Time Arrived Referring Facility
Field Name	ITP_A_TIMES {list}
Field Type	Numeric
Field Length	2,2
Note	Enter the time the ambulance arrived at transfer facility using the 24–hour clock (HH:MM). This is recorded as the time EMS arrives at transfer facility **NOT** the time EMS arrives at the patient's side. If time is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Date Departed Location

Data Element	Date Departed Location (Referring Facility)
Field Name	ITP_L_DATES {list}
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the ambulance departed from the transfer facility if different from the date of the incident (MM DD YYYY). For patients transported from a referral facility, this is the date on which the unit transporting the patient from the facility departed from that referring facility (departure is defined at date/time when the vehicle started moving). **Arrival and departure dates should be documented from a patient care perspective. The arrival time of the first care transport should be documented even if the majority of care is given by another transport. The departure time of the transport responsible for the transport of the patient should be documented.** It is important to capture the date and time of inter-facility transport regardless of whether they are air or land ambulance, therefore, initial and final dates and times of patient transfers should be included. If more than one ambulance service (either land or a combination of land and air services) is at the scene, it may be necessary to combine the dates, times and the on scene procedures from both call reports. If date is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Time Departed Location

Data Element	Time Departed Location (Referring Facility)
Field Name	ITP_L_TIMES {list}
Field Type	Numeric
Field Length	2, 2
Note	Enter the time the ambulance departed from the transferring facility using the 24–hour clock (HH:MM). For patients transported from a referring facility, this is the time at which the unit transporting the patient from the facility departed from that referring facility (departure is defined at date/time when the vehicle started moving). If time is unknown, '?' should be documented in the date and time data elements.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

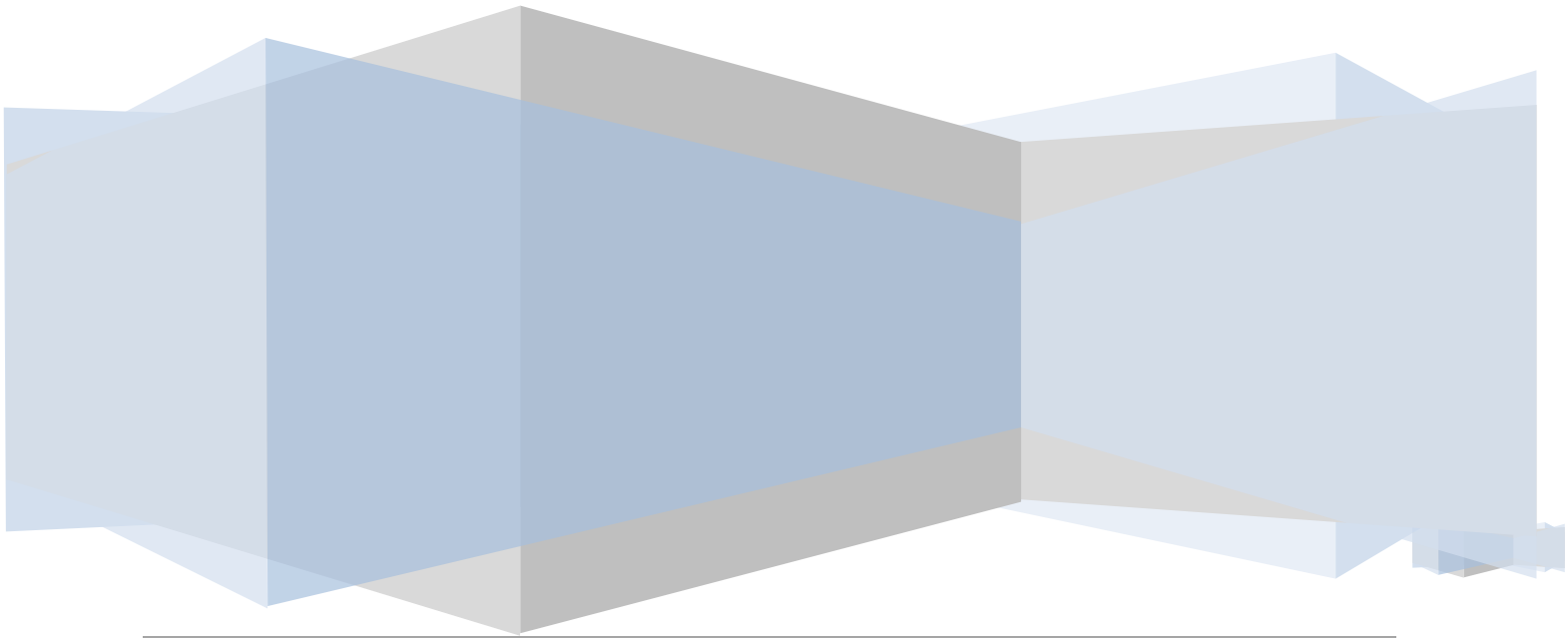
Transport Time Elapsed

Data Element	Transport Time Elapsed
Field Name	ITP_ELAPSEDSC {list}
Field Type	Numeric
Field Length	2,2
Note	Transport time is a calculated field based on the time departed location (referring facility) to time of arrival at trauma centre (or second referring facility). This will be displayed in hours and minutes (HH:MM) when the time of arrival at destination has been entered. This only tracks patient time to arrival at hospital **NOT** time to triage.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Referring Facility Notes

Data Element	Referring Facility Notes
Field Name	RF_MEMO
Field Type	Memo
Field Length	500
Note	This field is to be used for referring facility notes.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Section V ED/Resus Data



ED/Resus: Arrival/Admission

Direct Admit (Bypass ED)

Data Element	Direct Admit (Bypass ED)
Field Name	ED_BYPASS_YN
Field Type	Integer
Field Length	1
Note	Was the patient admitted directly to a service (an ICU, OR, ward bed, etc.) bypassing the emergency department? 1. Yes 2. No Unknown ~~Not applicable~~ *(do not use)* If checked No, ED arrival date and time will automatically fill in with the arrival date and time on the demographics page and ED discharge order and departure time will be inactivated as well as response level and TTA data elements. Injured at your hospital please enter as Direct Admit=yes Example: if patient fell at your hospital while as an inpatient
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

ED Arrival Date

Data Element	ED Arrival Date (trauma centre)
Field Name	EDA_DATE
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date of arrival at the trauma hospital emergency department (MM DD YYYY). This date must be entered for all cases including ED deaths and transfers, to ensure accurate reporting. Arrival is defined as the date the patient was first triaged/registered at the trauma centre. Please use the earliest date/time recorded on the patient's chart. If patient is admitted to ED (i.e. Direct Admit is checked "no") this section will automatically fill out from the demographics arrival date/time data elements. If Direct Admit is checked as "yes" this data field will be inactive. Field cannot be blank Field cannot be n/a
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

ED Arrival Time

Data Element	ED Arrival Time (Trauma Centre)
Field Name	EDA_TIME
Field Type	Numeric
Field Length	2, 2
Note	Enter the time of arrival at the trauma centre using the 24–hour clock (HH:MM). Arrival time is defined as the time the patient was first triaged/registered at the trauma centre. Please use the earliest date/time recorded on the patient's chart. If patient is admitted to ED (i.e. Direct Admit is checked "no") this section will automatically fill out from the demographics arrival date/time data elements. If Direct Admit is checked as "yes" this data field will be inactive. Field cannot be blank Field cannot be n/a
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

Signs of Life

Data Element	Signs of Life
Field Name	LIFE_SIGNS
Field Type	Numeric
Field Length	1
Note	A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress. This is a new data element which is submitted to the NTDB. Choose from the drop down menu. 1. Arrived with **no** signs of life 2. Arrived with signs of life ~~/ Not applicable~~ ~~? Unknown~~ According to NTDB submission rules "/" and "?" should not be chosen and this field cannot be left blank.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage/Trauma/Hospital Flow Sheet 2. Progress Notes 3. Nursing Notes 4. EMS Report 5. History & Physical
History	N/A

Mode of Arrival

Data Element	Mode of Arrival (at trauma centre)
Field Name	PAT_A_MODE
Field Type	Numeric
Field Length	1
Note	Enter the mode of transport for how the patient arrived at the trauma centre. **Clarification:** Enter the main mode of transport that was used to deliver the patient to the hospital (e.g. STARS or air ambulance). Mode of transport refers to the vehicle/provider used during patient transport from the scene to hospital or between hospitals. Military helicopter ambulances should be coded as helicopter ambulances. Patients that are injured in your hospital are a walk-in. Items 6-8 from the drop down list will be mapped to 'other' for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS run sheet
History	**Clarification:** Enter the main mode of transport that was used to deliver the patient to the facility. (e.g. STARS or fixed wing first).

Menu Selection for Mode of Transport:

1	**Ground ambulance**
2	Helicopter ambulance (e.g. STARS, military)
3	Fixed–wing ambulance
4	Private vehicle or walk–in
5	Police
6	Public Safety
7	Water ambulance
8	Other (please enter mode if other in text box below)
/	~~Not applicable~~ (should not be used)

?	Unknown

Response Level

Data Element	Response Level
Field Name	ED_TTA_TYPE01
Field Type	Numeric
Field Length	1
Note	What was the trauma team activation response level? 1. Full 2. Partial 3. Consult *(no activation but trauma consulted – for example RAAPID may consult TTA on phone but not needed in ED so TTA not called)* 4. No trauma activation Not applicable *(should not be used-use for non-level 1-3 trauma centres only)* Unknown Each hospital may use its own unique definition of the trauma team activation level (i.e. some facilities may not have partial activation). "/" should not be used, please use 4 (no trauma activation) instead. Unknown should be used if you cannot find the information but please check with your trauma coordinators first to see if they can find the information in their own records. If you check "?" you will not be able to fill out the activation date and time.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. TTA form 2. Trauma Coordinator records 3. ED Record 4. Triage Form/Trauma Flow Sheet 5. Nursing Notes
History	N/A

Response Activation Date

Data Element	Response Activation Date
Field Name	ED_TTA_DATE01
Field Type	Date
Field Length	2,2,4
Note	What was the date the trauma team activation was called? Enter in (MM DD YYYY) or click on the calendar icon on the right and click the correct date.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. TTA form 2. Trauma Coordinator records 3. ED Record 4. Triage Form/Trauma Flow Sheet 5. Nursing Notes
History	N/A

Response Activation Time

Data Element	Response Activation Time
Field Name	ED_TTA_TIME01
Field Type	Numeric
Field Length	2,2
Note	What was the time the trauma team activation was called? Enter in (HH:MM).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. TTA form 2. Trauma Coordinator records 3. ED Record 4. Triage Form/Trauma Flow Sheet 5. Nursing Notes
History	N/A

Response Time Elapsed

Data Element	Response Time Elapsed (time to call TTA)
Field Name	ED_TTA_ELAPSED01
Field Type	Numeric
Field Length	2,2
Note	This is a calculated field based on (Date/Time of Activation) – (Date/Time of ED arrival). Time is shown in (HH:MM). If TTA was activated before patient arrival in ED it will show Time < 0.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Trauma Criteria Met?

Data Element	Trauma Criteria Met?
Field Name	EDQ_RES01
Field Type	Numeric
Field Length	1
Note	Was the TTA criteria met for your facility? 1. Yes 2. No Unknown Not applicable *(use for non-level 1-3 trauma centres only)* Each hospital will use its own unique criteria for TTA. If you have questions about whether a patient met your hospital's TTA criteria please contact your trauma coordinators.
ATR Required	No
NTR Required	No
Hierarchy	1. TTA criteria documentation 2. TTA forms 3. Trauma Coordinator records 4. ED Record 5. Triage Form/Trauma Flow Sheet 6. Nursing Notes
History	N/A

Trauma Team Activated?

Data Element	Trauma Team Activated?
Field Name	EDA_TTA_YN
Field Type	Integer
Field Length	1
Note	Was the trauma team activated? Any type of activation as defined by your facility (full, partial, specific TTA member consults, etc.) 1. Yes *(please answer even if patient did not meet criteria so we can track over/under-calls)* 2. No *(please answer even if patient did not meet criteria so we can track over/under-calls)* Unknown Not applicable *(to be used only if your site does not have TTA criteria/procedures)* Each hospital may use its own unique definition of the trauma team. If you have questions about whether TTA was called please contact your trauma coordinators.
ATR Required	No
NTR Required	No
Hierarchy	1. TTA criteria documentation 2. TTA forms 3. Trauma Coordinator records 4. ED Record 5. Triage Form/Trauma Flow Sheet 6. Nursing Notes
History	N/A

Trauma Team Leader

Data Element	Trauma Team Leader
Field Name	EDP_MS_S
Field Type	Text
Field Length	50
Note	Enter the name of the Trauma Team Leader at the trauma centre. Please enter in the format Last name, First name/initial. If your site only records Surname this is ok; larger sites might want to record first name/initial if there are physicians with the same last name.
ATR Required	Yes
NTR Required	No
Hierarchy	N/A
History	N/A

Clarification:

You may want to enter CO in this area if your facility does not have a scheduled TTL (and enter the name of the ED physician in the appropriate space so we will have the CO's name and the information that this person was not scheduled.)

TTL Arrival Date

Data Element	TTL Arrival Date
Field Name	EDP_A_DATE
Field Type	Date
Field Length	2,2,4
Note	What was the date the TTL arrived? Enter in (MM DD YYYY) or click on the calendar icon on the right and click the correct date. This area will be inactive unless a TTL name entered (or CO).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. TTA form 2. Trauma Coordinator records 3. ED Record 4. Triage Form/Trauma Flow Sheet 5. Nursing Notes
History	N/A

TTL Arrival Time

Data Element	TTL Arrival Time
Field Name	EDP_A_TIME
Field Type	Numeric
Field Length	2,2
Note	What was the time the TTL arrived in the ED at the patient (or to wait for patient)? Enter in (HH:MM). This area will be inactive unless a TTL name entered (or CO).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. TTA form 2. Trauma Coordinator records 3. ED Record 4. Triage Form/Trauma Flow Sheet 5. Nursing Notes
History	N/A

TTL wait time elapsed

Data Element	TTL wait time Elapsed
Field Name	EDP_ELAPSED01
Field Type	Numeric
Field Length	2,2
Note	This is a calculated field based on (Date/Time of TTL arrival) – (Date/Time of Activation). Time is shown in (HH:MM). Time should not be < 0.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Post ED Disposition

Data Element	Post ED Disposition
Field Name	ED_DSP
Field Type	Integer
Field Length	2
Note	Enter the post ED destination of the patient. For Direct Admit use "n/a" See below for a full menu listing. The items in the drop down menu that are crossed off should not be used – we do not enter these patients into our registry (only admitted patients). NTDB criteria for this data field has a different list (different order) and will be mapped accordingly by DI software.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. History & Physical
History	N/A

Menu Options for post-ED disposition:

3	Operating Room
4	ICU
5	Step-down unit
6	Floor
8	Observation unit
9	Burn unit
14	Neonatal/Pediatric Care Unit
15	Other (EIP)
18	DOA
40	Home or Self-Care (Routine Discharge)
41	Home with Services
42	Left AMA
43	Correctional Facility/Court/Law Enforcement
44	Deceased or Expired (DIE)
45	~~Child Protective Agency~~
70	Acute Care Facility
71	~~Intermediate Care Facility~~
72	~~Skilled Nursing Facility~~
73	Rehab (inpatient)
74	~~Long-Term Care~~
75	Hospice
76	~~Mental Health/Psychiatric Hospital (inpatient)~~
77	Nursing Home
/	Not applicable NO!! Fill out location of admission please!
?	Unknown

If Other (Post ED Disposition)

Data Element	If Other (Post ED Disposition)
Field Name	ED_DSP_S
Field Type	Character
Field Length	50
Note	Specify a post ED destination for the patient if 'other' was selected from the previous menu.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

ED Physician

Data Element	ED Physician
Field Name	ATTP_MD_S
Field Type	Character
Field Length	50
Note	Enter the name of the emergency physician or attending physician as appropriate at your hospital. Please enter in the format Last name, First name/initial. Enter inappropriate ("/") for direct admits. If your site only records Surname this is ok; larger sites might want to record first name/initial if there are physicians with the same last name.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. History & Physical
History	N/A

Admitting Service

Data Element	Admitting Service (Trauma Centre)
Field Name	ADM_SVC
Field Type	Numeric
Field Length	2
Note	Select the **physician service** to which the patient was admitted. This should be the admitting service of the physician who admitted the patient. If a patient was transferred or died please enter '/'. See next page for a complete list of admitting services. The list has changed quite a bit so make sure you scroll all the way through too see if your option is there. ICU should not be checked (this is not a physician service it is a location). Most facilities have critical care specialists (Level 1 and 2) or internal medicine (Level 3) who admit these patients.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet
History	N/A

List of Menu Options for Admitting Service:

1	Trauma
2	Neurosurgery
3	Orthopedics
4	General surgery
5	Pediatric surgery
6	Cardiothoracic surgery
7	Burn services
8	Emergency Medicine
9	Pediatrics
11	Cardiology
14	Critical Care
19	ENT
20	Family Medicine
21	GI
23	Hospitalist
24	Infectious Disease
25	Internal Medicine
27	Nephrology
28	Neurology
32	Ob-Gyn
34	Oncology
35	Ophthalmology
36	Oral surgery
37	Oromaxillo Facial Service
38	Ortho-spine
43	Plastic surgery
45	Pulmonary
52	Thoracic surgery
55	Urology
56	Vascular surgery
~~**57**~~	~~ICU~~ *(don't use)*
98	Other surgical
99	Other non-surgical
/	Not applicable
?	Unknown

Admitting Physician

Data Element	Admitting Physician
Field Name	ADMP_MD_S
Field Type	Character
Field Length	50
Note	Enter the name of the admitting physician. Please enter in the format Last name, First name/initial. Enter "?" if unknown. If patient is transferred or died (no admission) enter '/'. If your site only records Surname this is ok; larger sites might want to record first name/initial if there are physicians with the same last name.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes
History	N/A

Post OR Disposition

Data Element	Post OR Disposition
Field Name	OR_DISP
Field Type	Numeric
Field Length	2
Note	Enter a post OR destination if the patient was transferred directly to the OR from the ED. This field will be skipped unless OR (menu item #3) was selected from the Post ED Destination menu. Post OR destination is the destination of the patient after leaving the operating room following discharge from the emergency department. If a patient is returned to the ED it should be coded as other. See below for a full menu listing of post-OR destinations.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. OR record 2. Nursing Notes
History	N/A

Menu Options for post-OR disposition:

4	ICU
5	Step-down unit
6	Floor
8	Observation unit added
9	Burn unit
14	Neonatal/Pediatric Care Unit
15	Other
42	Left AMA
44	Deceased or Expired (DIE)
/	Not applicable
?	Unknown

If Other (Post OR Disposition)

Data Element	If Other (Post OR Disposition)
Field Name	OR_DISP_S
Field Type	Character
Field Length	50
Note	Specify a post OR destination for the patient if 'other' was selected in the previous field. Will be inactive if ‘other’ was not chosen in previous field.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. OR record 2. Nursing Notes
History	N/A

ED Discharge Order Date

Data Element	ED Discharge Order Date (new 2016 admissions)
Field Name	
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the order was written for the patient to be discharged from the trauma centre emergency department (MM DD YYYY). Will be inactive if the patient is directly admitted to hospital (will be mapped to n/a for NTDB submission). If patient dies in ED (or is DOA) this will be the same date as ED Departure Date and Death date. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

ED Discharge Order Time

Data Element	ED Discharge Order Time (new 2016 admissions)
Field Name	
Field Type	Numeric
Field Length	2, 2
Note	Enter the time in 24 hour clock the order was written for the patient to be discharged from the trauma centre emergency department (HH:MM). Will be inactive if the patient is directly admitted to hospital (will be mapped to n/a for NTDB submission). If patient dies in ED (or is DOA) this will be the same time as ED Departure Date and Death time. If time is unknown (not recorded) please enter "?". Field cannot be blank
ATR Required	Yes
NTDB Required	Yes (NTDB NTDS Data Dictionary 2017 – Page 78)
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

ED Departure/Admitted Date

Data Element	ED Departure/Admitted Date
Field Name	EDD_DATE
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the patient was discharged from the trauma centre emergency department (MM DD YYYY). This is the date the patient physically left the ED. If patient dies in ED, please enter the date of death in this section. Will be inactive if the patient is directly admitted to hospital.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

ED Departure/Admitted Time

Data Element	ED Departure Time
Field Name	EDD_TIME
Field Type	Numeric
Field Length	2, 2
Note	Enter the time the patient was discharged from the trauma centre emergency department (HH:MM). This is the time the patient physically left the ED. Will be inactive if the patient is directly admitted to hospital. If patient dies in ED, please enter the time of death in this section. If time is unknown (not recorded) please enter "?".
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet 3. Nursing Notes 4. Netcare/EDIS/other in-hospital patient database
History	N/A

Time in ED

Data Element	Time in ED
Field Name	ED_LOS; ED_LOS_MINS; ED_LOS_HRS;
Field Type	Character
Field Length	11
Note	This is a calculated variable based on ED arrival date/time and ED Departure/Admitted date/time at trauma centre. It is reported in days, hours and minutes (# days, HH:MM).
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

ED/Resus: Initial Assessment

Weight/Units

Data Element	Weight/Units
Field Name	EDAS_WGT; EDAS_WGT_U
Field Type	Numeric
Field Length	6
Note	Enter the patient's first recorded weight in kilograms or pounds within **24 hours of arrival** at the hospital. Only 3 digits can be entered before the decimal place and 2 digits after. You do not have to enter the digits after the decimal place (the calculation will still work). Please choose whether you are entering in lbs. or kgs from the drop down list to the right. The registry will automatically calculate the weight in the other unit. Weight in km gets submitted to NTDB. Weight may be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. Field cannot be n/a. Field cannot be blank.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses notes 5. Self-report 6. Family report
History	N/A

ED/Resus: Initial Assessment

Weight/Units

Data Element	Timely
Field Name	EDAS_WGT; EDAS_WGT_U
Field Type	Numeric
Field Length	6
Note	The Timely field was added to allow to specify if the weight entered is within 24 hours or less of ED/hospital arrival. Valid entries in the field are 1. Yes 2. No. 3. Unk 4. Not applicable The Timely field will be enabled when Weight is valued. Note that the field is optional. If Timely is not completed, it is assumed that the Weight Value entered is timely (within 24 hours or less of ED/ hospital arrival.
ATR Required	No (optional)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses notes 5. Self-report 6. Family report
History	N/A

Height/Units

Data Element	Height/Units
Field Name	EDAS_HGT: EDAS_HGT_U
Field Type	Numeric
Field Length	6
Note	Enter the patient's first recorded height in centimeters or inches **within 24 hours of arrival** to the hospital. Only 3 digits can be entered before the decimal place and 2 digits after. You do not have to enter the digits after the decimal place (the calculation will still work). Please choose whether you are entering in cm or inches from the drop down list to the right. The registry will automatically calculate the weight in the other unit. Height in cm gets submitted to NTDB. If you enter a value that does not make sense (for example you meant to enter 400 cm but put inches, the second calculation will outline in red to indicate that the value is outside the normal range). Height may be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. Field cannot be n/a. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses notes 5. Self-report 6. Family report
History	N/A

ED/Resus: Initial Assessment

Height/Units

Data Element	Timely
Field Name	EDAS_HGT; EDAS_HGT_U
Field Type	Numeric
Field Length	6
Note	The Timely field was added to allow to specify if the height entered is within 24 hours or less of ED/hospital arrival. Valid entries in the field are 1. Yes 2. No. 3. Unk 4. Not applicable The Timely field will be enabled when Height is valued. Note that the field is optional. If Timely is not completed, it is assumed that the Height Value entered is timely (within 24 hours or less of ED/ hospital arrival.
ATR Required	No (optional)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. EMS Run Sheet 4. Nurses notes 5. Self-report 6. Family report
History	N/A

Paralytic Agents (in Effect)?

Data Element	Paralytic Agents in Effect? Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP. 1. Patient Chemically Sedated or Paralyzed
Field Name	EDAS_PAR_YN
Field Type	Integer
Field Length	1
Note	Were paralytic agents in effect when the first assessment of the GCS at the trauma centre was calculated? [Most commonly used paralytic agents in AB are: Rocuronium (Zemuron) and Succinylcholine (Anectine)]. 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance) – will be mapped to correct NTDB choice*
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Paralytic agents stop muscular activity e.g. posturing, tremors, rigidity, and restlessness. For patients who are intubated and mechanically ventilated, these agents reduce the patient's tendency to fight the ventilator. Paralytics are often used with intubation BUT NOT ALWAYS. Paralytic agents also help preserve or increase the cerebral venous draining in severe head injury patients helping to reduce or keep intracranial pressure to normal range.

Typical paralytic agents are Rocuronium (Zemuron) and succinylcholine (Anectine). Others that are not in use in Alberta but which may be used elsewhere include: Vecuronium (Norcuron), Cisatracurium (Nimbex), Pancuronium (Pavulon), and Tubocurarine (Tubarine).

Pain killing drugs (analgesics) and/or sedating drugs may be used in combination with a paralyzing agent. These agents alone **ARE NOT** paralytic agents and paralytic agents should be coded as "no" if these are the only medications administered. Examples of sedatives/analgesics include: Morphine, Demerol, Ativan/Lorazepam, Thiopental/Pentothal, Fentanyl, Ketamine, and Propofol.

If a patient was given paralytic agents prior to the trauma center this should be answered 'Yes' or 'Unknown'. Ask a trauma coordinator or medical director about the half time of the drug.

Was the Patient Intubated?

Data Element	Was the patient intubated? Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP 3. Patient Intubated
Field Name	EDAS_INTUB_YN
Field Type	Integer
Field Length	1
Note	Was the patient intubated at the time the first assessment of the GCS at the trauma centre was calculated? Intubation refers to oral/nasal intubation, Tracheostomy, or Cricothyroidotomy, King LT, Combitubes and LMA. If patient arrived with assisted ventilation then enter "unk" in the "assisted ventilation" data field because "n/a" gives an error. Upon arrival to Trauma center within 30 minutes they were ventilated it would also give an error. <u>LMA, King, Combitubes are airway adjuncts not intubation.</u> Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitubes and LMA <u>LMA, King, Combitubes are airway adjuncts and included as intubation as per requirement of NTDB and data subcommittee Jan 10 2019.</u> 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance) – will be mapped to correct NTDB choice for GCS assessment qualifiers*
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Sedated?

Data Element	Was the patient sedated? Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP 1. Patient Chemically Sedated or Paralyzed.
Field Name	EDAS_SED_YN
Field Type	Integer
Field Length	1
Note	Was the patient chemically sedated or paralyzed when the first assessment of the GCS at the primary hospital was calculated? 1. Yes 2. No Unknown Not applicable *(use for patients who arrive by private vehicle/non-ambulance) – will be mapped to correct NTDB choice for GCS assessment qualifiers* This does not apply to medications/drugs the patient self-administers (ETOH, prescriptions, etc.).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Examples of sedatives/analgesics include: Morphine, Demerol, Ativan/Lorazepam, Thiopental/Pentothal, Fentanyl, Ketamine, and Propofol, Etomidate, Haldol, Hydromorphone, Valium/Diazepam, versed/Midazolam

If a patient was sedated prior to the trauma center this should be answered 'Yes' or 'Unknown'. Ask a trauma coordinator or medical director about the half time of the drug.

Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.

If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.

Eye Obstruction?

Data Element	Eye Obstruction? Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP 2. Obstruction to the patient's eye
Field Name	EDAS_E_OB_YN
Field Type	Integer
Field Length	1
Note	Did the patient have an eye obstruction at the time the first assessment of the GCS at the trauma centre was calculated? 1. Yes 2. No Unknown ~~Not applicable~~ *(do not use)* Field cannot be blank Field cannot be n/a
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Temperature/Unit

Data Element	Temperature/Unit
Field Name	EDAS_TEMP; EDAS_TEMP_U
Field Type	Numeric; Integer (unit)
Field Length	4(to one decimal place);1
Note	Defined as the patients first recorded temperature upon arrival at the trauma center (ED or inpatient unit if ED bypass), 30 minutes or less of ED /hospital arrival. If vitals are not taken within 30 minutes, document as '?'. You will need to choose if you are entering the temp in Celsius (C) or Fahrenheit (F) from the units drop down list. The other measure will be converted automatically. (Please note that the first recorded/hospital vitals do not need to be from the same assessment.) Field cannot be n/a. Field cannot be blank.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. PCR/Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

Systolic Blood Pressure, SBP

Data Element	SBP
Field Name	EDAS_SBP
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded SBP upon arrival at the Trauma Centre (ED or inpatient unit if ED bypass), within 30 minutes of arrival. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated If vitals are not taken in first 30 minutes, or if SBP was not taken or not documented, enter as '?'. (Please note that the first recorded/hospital vitals do not need to be from the same assessment.) New 2016 NTDS: measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. Field cannot be n/a.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1.PCR/Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

Pulse Rate

Data Element	Pulse Rate
Field Name	EDAS_PULSE
Field Type	Integer
Field Length	3
Note	Defined as the patients first recorded pulse rate/heart rate upon arrival at the trauma center (ED or inpatient unit if ED bypass), within 30 minutes of arrival (expressed as a number per minute). Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated If vitals are not taken in first 30 minutes, or if PR was not taken or not documented, enter as '?'. (Please note that the first recorded/hospital vitals do not need to be from the same assessment.) New 2016 NTDS: measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. Field cannot be n/a.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

Unassisted Respiration Rate

Data Element	Unassisted Respiration Rate
Field Name	EDAS_URR
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded unassisted RR upon arrival at the trauma center (ED or inpatient unit if ED bypass), within 30 minutes of arrival (# per min). If vitals are not taken in first 30 minutes, or if URR was not taken or not documented, enter as '?'. Enter '/' if patient respirations are assisted, that is, patient is intubated, King LT, Combitube or being bagged. NTDB data dictionary says RR cannot be n/a however if this field is n/a the assisted respiration rate information will be sent instead (and will be mapped to 2. Assisted Respiratory Rate pg. 62) Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. Assisted Ventilation is defined as: • If there is something placed in the patient's airway to assist them in breathing such as ETT, King, Combitube or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King, Combitube or LMA the patient still had assisted ventilation. • If the patient is being bagged (bag-valve-mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated. • OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but ***by themselves are not assisted ventilation***. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation. • If a patients chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

O2 Saturation

Data Element	Oxygen Saturation
Field Name	EDAS_SAO2
Field Type	Numeric
Field Length	3
Note	Defined as the patient's first recorded O2 saturation taken upon arrival at the trauma center (ED or inpatient unit if ED bypass), within 30 minutes of arrival (expressed as a %). If vitals are not taken in first 30 minutes, or O2 saturation is not documented, enter as '?' unknown. Field cannot be n/a. Field cannot be blank
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

Supplemental O2

Data Element	Supplemental O2
Field Name	EDAS_SO2_YN
Field Type	Integer
Field Length	1
Note	Was the patient being given supplemental oxygen at the time the assessment of initial trauma centre O2 saturation level was being measured (within first 30 minutes of ED arrival or ED hospital bypass admission)? Refers to recorded O2 saturation data field above. 1. Yes 2. No Unknown Not applicable *(only use is initial ED/Hospital O2 saturation is recorded as '?')*
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	N/A

Clarification:

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

GCS: Eye

Data Element	GCS: Eye
Field Name	EDAS_GCS_EO
Field Type	Integer
Field Length	1
Note	Defined as the patients first eye-opening response for the GCS documented upon arrival at the trauma center (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If eye response is not taken in first 30 minutes, or if the eye-opening response is not documented enter '?' unknown. Field cannot be n/a. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	**Update Feb 2017**: field must be a minimum of 1 and max of 4, can no longer use n/a.

Menu Selection for GCS Eye Scale:

1	**No eye movement when assessed**
2	Opens eyes in response to painful stimulation
3	Opens eyes in response to verbal stimulation
4	Opens eyes spontaneously
/	Not applicable *(do not use)*
?	Unknown

Clarification:

Please see clarification

GCS: Verbal

Data Element	GCS: Verbal
Field Name	EDAS_GCS_VR
Field Type	Integer
Field Length	1
Note	Defined as the patient's first verbal response for the GCS documented upon arrival at the trauma center (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If verbal response is not taken in first 30 minutes, or verbal response is not documented, enter '?'. If the patient is intubated within the first 30 minutes before GCS is assessed document as "1". Field cannot be n/a. Please use the appropriate Adult or Pediatric GCS scale as applicable. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	**Update Feb 2017**: field must be a minimum of 1 and max of 5, can no longer use n/a.

Menu Selection for GCS Verbal Scale:

1	No verbal response (ped: No vocal response)
2	Incomprehensible Sounds (ped: inconsolable, agitated)
3	Inappropriate Words (ped: inconsistently consolable, moaning)
4	Confused (ped: cries but is consolable, inappropriate interactions)
5	Oriented (ped: smiles, oriented to sounds, follows objects, interacts)
/	Not applicable
?	Unknown

Clarification: Please see clarification from page 283

GCS: Motor

Data Element	GCS: Motor
Field Name	EDAS_GCS_MR
Field Type	Integer
Field Length	1
Note	Defined as the patient's first motor response for the GCS documented upon arrival at the trauma center (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If motor response is not taken in first 30 minutes, or motor response is not documented, enter '?'. If the patient is under paralytics then the GCS motor score will be '1'. Intubation alone does not indicate a GCS motor score of not applicable since motor response can still be assessed. Field cannot be n/a. Please use the appropriate Adult or Pediatric GCS scale as applicable. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, **IF** there is no other contradicting documentation.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	**Update Feb 2017**: field must be a minimum of 1 and max of 6, can no longer use n/a.

Menu Selection for GCS Motor Scale:

1	No motor response
2	Extension to pain
3	Flexion to pain
4	Withdrawal from pain
5	Localizing pain
6	Obeys commands (Ped: appropriate response to stimulation)
/	Not applicable
?	Unknown

Clarification: Please see clarification

Total GCS

Data Element	Total GCS (Trauma Centre)
Field Name	EDAS_GCS
Field Type	Numeric
Field Length	2
Note	Defined as the total GCS documented upon arrival at the trauma center (ED or inpatient unit if direct admission) within 30 minutes of arrival. If the total GCS (or any component of the GCS) is not documented enter '?'. If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented (AAOx3) the total GCS may be assumed to be 15 **IF** there is no other contradicting documentation. Total GCS value must be 3 – 15 Field cannot be n/a.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage Form / Trauma Flow Sheet 2. ED Record 3. Nurses notes
History	**Update Feb 2017**: field must be a minimum of 3 and max of 15, can no longer use n/a.

Clarification:

Please see clarification

Initial ED/hospital GCS 40-Eye

Data Element	GCS 40-Eye (Trauma Centre)
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale 40 (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival. Please enter “unk”= Not known/Not recorded as per2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Initial ED/hospital GCS 40-Verbal

a Element	GCS 40-Verbal (Trauma Centre)
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale 40 (Verbal) in the ED/hospital within 30 minutes or less of ED/hospital arrival. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

Initial ED/hospital GCS 40-Motor

Data Element	GCS 40-Motor (Trauma Centre)
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as first recorded Glasgow Coma Scale 40 (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Run Sheet
History	N/A

RTS

Data Element	RTS (Trauma Centre) **Revised Trauma Score**
Field Name	EDAS_RTS_W
Field Type	Numeric (Calculated to 3 decimal places)
Field Length	5
Note	Revised Trauma Score at the trauma centre is a calculated field based on Glasgow Coma Scale (all components), systolic blood pressure and unassisted respiration rate. . RTS is scored from the first set of data obtained from the patient. It is a physiological scoring system, with high inter-rater reliability and demonstrated accuracy in predicted death. RTS ranges from 0 to 7.84 where 0 predicts high probability of death and 7.84predicts high probability of survival. www.trauma.org The total RTS will be displayed on the screen. If any of the fields needed for the calculation of RTS are not valued, total RTS will be displayed as '/' on the screen.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

The calculation of the RTS is outlined below:

Coded Value x Weight = Score

Respiratory Rate (breaths/min)

>29	4	
10-29	3	
6-9	2	X0.2908=_____
1-5	1	
0	0	

Use 0 if patient arrived intubated

Systolic Blood Pressure (mm Hg)

>89	4	
76-89	3	
50-75	2	X0.7326=_____
1-49	1	
0	0	

Glasgow Coma Scale

13-15	4	
9-12	3	
6-8	2	X0.9368=_____
4-5	1	
< 5	0	

Total RTS (3 scores totalled)=_____

Triage RTS

Data Element	Triage RTS **Revised Trauma Score**
Field Name	EDAS_RTS_U
Field Type	Numeric
Field Length	2
Note	The triage RTS at the scene is a calculated field based on Glasgow Coma Scale (total score), systolic blood pressure, and unassisted respiratory rate used to calculate final scene RTS. The total triage RTS will be displayed on the screen. If any of the fields needed for the calculation of triage RTS are not valued, total RTS will remain blank. Triage RTS will be blank if unassisted respiration, SBP, or total GCS is not applicable. This is a score used for field triage for rapid identification of severely injured patients. Scores range from 0-12 and a triage-RTS < 11 indicates a need for transport to a designated trauma center (information from http://lifeinthefastlane.com/ccc/trauma-scoring-systems/). This is not necessarily how AB uses this score for triage at the scene or in hospital.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Clarification:

Based on 3 physiological parameters:

GCS	TRIAGE RTS SCORE (ADD 3 COMPONENTS)
13-15	4
9-12	3
6-8	2
4-5	1
3	0
SBP	
>89	4
76-89	3
50-75	2
1-49	1
0	0
UNASSITED RR	
10-29	4
>29	3
6-9	2
1-5	1
0	0

ED/Resus: Labs/Toxicology

Alcohol Use Indicator

Data Element	Alcohol Use Indicator (Trauma Centre)
Field Name	ED_IND_ALC
Field Type	Integer
Field Length	1
Note	A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter at either at your facility or the transferring facility. Choose from the drop down menu if patient was tested for/ had alcohol in blood at trauma center. 1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [trace levels] <11 mmol/L) 4. Yes (confirmed by test [beyond legal limit] ≥ 11 mmol/L) ~~Not applicable (≤ 9 years)~~ Unknown *(if alcohol use is suspected but not confirmed by test)* The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyzer test) while 17 mmol/L is equivalent to the 0.08 limit. Choice 1 will be mapped to 'No' for NTDB submission, while choices 2-4 will be mapped to 'Yes'. Submission will look at both referring and definitive centers answers for BAC tested so please answer for all sites where BAC may have been taken. Field cannot be blank Field cannot be n/a
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. 3. Nurses notes
History	N/A

ETOH/BAC Level (mmol/L)

Data Element	ETOH/BAC level (mmol/L) (Trauma Centre)
Field Name	ETOH_BAC_LVL
Field Type	Numeric
Field Length	6 (to 2 decimal places)
Note	Enter the patient's blood alcohol concentration in SI units (mmol/L) at the trauma center within 24 hours after first hospital arrival. Enter '?' if the results are not available. If previous field was '/' (for patients ≤ 9 years of age) or checked 'No' this section will be inactive and will be mapped to 0 for NTDB submission. If the lab results state < 2 or trace document as '0'. The legal alcohol limit is 11 mmol/L (equivalent to 0.05 on a breathalyzer test) while 17 mmol/L is equivalent to the criminal 0.08 limit. Cannot be 'n/a' if previous question was 'Yes'.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

Clarifications:

For the time being for this indicator as we may not be able to determine for most cases if drugs were illegal or prescription (i.e. marijuana, etc.). According to the NTDB we should be entering "?" if this is the case. We will be activating the next section (tox screen results) when "?" is entered in a future ATR update.

Please report all drugs that are tested for (either in serum or urine testing). The Core Leadership team for Alberta Trauma Services will be developing standard protocols for drug screening similar to alcohol testing guidelines. Until then please just report whatever information you find in the chart regarding drug use.

Analysts should be able to have access to medical reconciliation records (provincial, should be in inpatient section at front of chart) to see a current list of prescribed medications. This may help determine if they are prescription or illegal (though it may not tell you if patient was taking these meds according to the prescription directions).

We will also need to get a list from the lab of common drug names vs their chemical names that may be on the lab reports

Drug Screen Results

Data Element	Drug Screen Results (ED/Resus: Labs/Toxicology)
Field Name	????
Field Type	Integer
Field Length	1
Note	First recorded positive drug screen results within 24 hours after first hospital encounter either at your facility or the transferring facility as per NTDB. Choose from the pop up menu (or from the drop down list on a line-by-line basis) which drugs were identified in patient's lab results. Check up to 13. Please enter drug name if option 13, 'Other' is chosen. This new data element must be filled out for everyone. If options 1-13 are checked please also fill out the clinician administered check box (yes, no or? do not use n/a). Clinician administered drugs will not be sent to NTDB. 1. AMP (Amphetamine) 2. BAR (Barbiturate) 3. BZO (Benzodiazepine) 4. COC (Cocaine) 5. mAMP (Methamphetamine) 6. MDMA (Ecstasy) 7. MTD (Methadone) 8. OPI (Opioid) 9. OXY (Oxycodone) 10. PCP(Phencyclidine) 11. TCA (Tricyclic Antidepressant) 12. THC (Cannabinoid) 13. Other 14. None 15. Not tested Unknown Lab results use chemical names for common drugs; please find a list of chemical names and the matching common names below. (not yet available). Field cannot be blank Field cannot be n/a
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

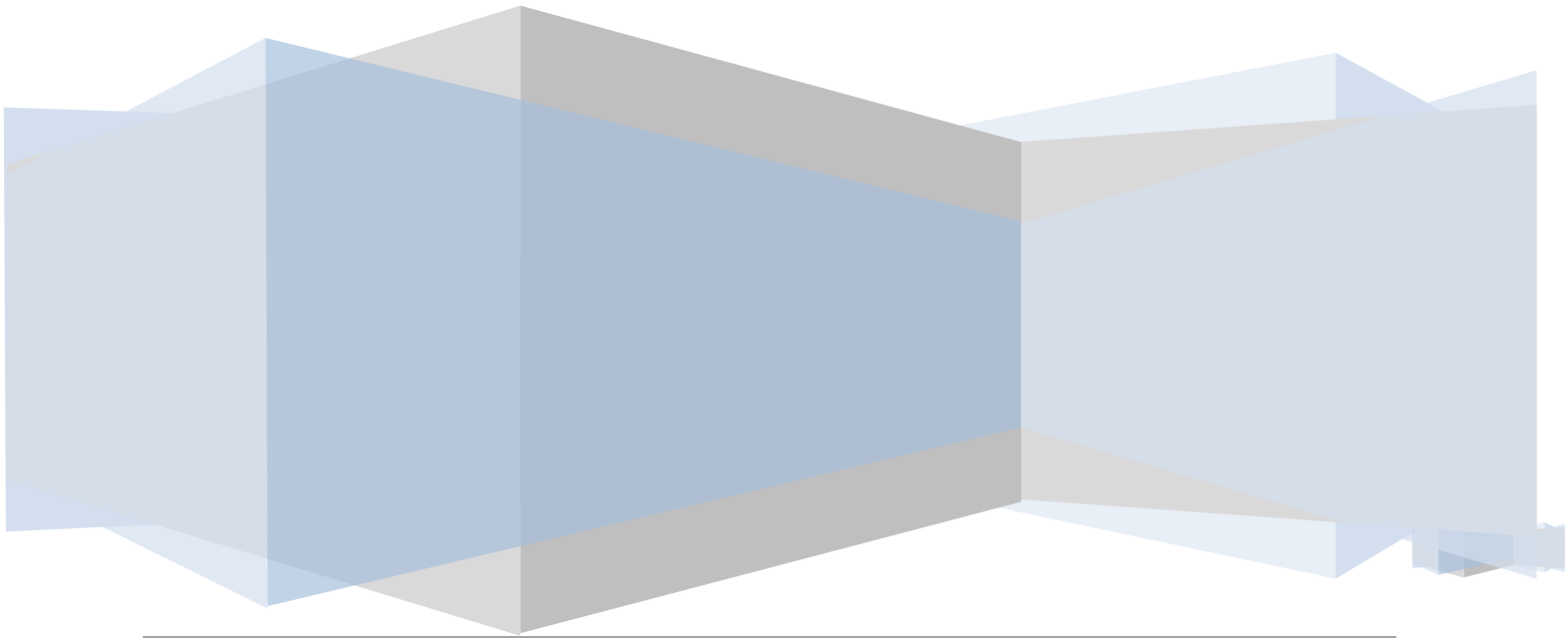
Clinician Administered

Data Element	Clinician Administered (ED/Resus: Labs/Toxicology)
Field Type	Integer
Field Length	1
Note	Field values 1.Yes (Does not get sent to NTDB no need to answer) 2. No (tested positive for drugs that were **not** administered at any facility or setting treating this patient event).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Lab Results 2. Triage Form / Trauma Flow Sheet 3. ED Record 4. Nurses notes
History	N/A

ED/Resus Notes

Data Element	Notes (Trauma Centre)
Field Name	ED_MEMO
Field Type	Memo
Field Length	500
Note	Enter information in this area if you need to make a note about the ED/Resus data entry that you, or another analyst, may need to refer back to at a later date. This is a good spot to include any details about drug use since that section is not yet consistently entered.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Section VI Patient Tracking



Patient Tracking: Location

Click the ADD button on the right side of the screen to enter all locations the patient is admitted to during their stay in the hospital. You do not have to enter initial ED visit information as this is collected in the ED/Resus section. If they are sent back to ED for any reason please enter that info. Please enter units in order of patient stay (1st ICU, 1st WARD, 2nd ICU, 2nd WARD, 3rd WARD. etc.). Not collecting OR data in this section at this time.

Location Code

Data Element	Location Code
Field Name	LT_CODES {list}
Field Type	Integer
Field Length	2
Note	Enter a location/unit that the patient was admitted to. See below for a full menu listing of hospital location codes. ICU is a unit with the ability to ventilate patients. Calgary (FMC) does not code its Burn Unit here. The Calgary burn unit does not accept ventilated patients and as such it is not considered an ICU.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	New

Menu Options for location code

2	Emergency Department
3	Operating Room *(don't use; not entering each OR visit in this section at this time)*
4	ICU
5	Step-down unit
6	Floor
8	Observation unit added
9	Burn unit
14	Neonatal/Pediatric Care Unit
16	Bed Requested
17	Bed Arrival
19	PICU
/	Not applicable
?	Unknown

Service

Data Element	Admitting Service (Trauma Centre – Patient Tracking)
Field Name	LT_SVCS
Field Type	Integer
Field Length	2
Note	Select the **physician service** to which the patient was transfer to at each location in the hospital. See next page for a complete list of admitting services. The list has changed quite a bit so make sure you scroll all the way through too see if your option is there. ICU should not be checked (this is not a physician service it is a location). Most facilities have critical care specialists (Level 1 and 2) or internal medicine (Level 3) who admit these patients.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Triage Form/Trauma Flow Sheet
History	New

List of Menu Options for Admitting Service:

1	Trauma
2	Neurosurgery
3	Orthopedics
4	General surgery
5	Pediatric surgery
6	Cardiothoracic surgery
7	Burn services
8	Emergency Medicine
9	Pediatrics
11	Cardiology
14	Critical Care
19	ENT
20	Family Medicine
21	GI
23	Hospitalist
24	Infectious Disease
25	Internal Medicine
27	Nephrology
28	Neurology
32	Ob-Gyn
34	Oncology
35	Ophthalmology
36	Oral surgery
37	Oromaxillo Facial Service
38	Ortho-spine
43	Plastic surgery
45	Pulmonary
52	Thoracic surgery
55	Urology
56	Vascular surgery
~~**57**~~	~~ICU~~ *(don't use)*
98	Other surgical
99	Other non-surgical
/	Not applicable
?	Unknown

Arrival Date/Time

Data Element	Arrival Date (Patient Tracking)
Field Name	LT_A_DATES {list}; LT_A_TIMES {list}
Field Type	Date/Numeric
Field Length	2,2,4; 2,2
Note	This is the arrival date and time of patient to a specific location in the trauma centre in (MM DD YYYY) and (HH:MM). If your site is not collecting the time for patient tracking stats please enter '/'. Time was originally put in so time of bed request (in the location code menu) could be entered. Traditionally only arrival and departure dates have been entered for patient tracking.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	New

Departure Date/Time

Data Element	Departure Date (Patient Tracking)
Field Name	LT_DIS_DATES {list}; LT_DIS_TIMES {list}
Field Type	Date/Numeric
Field Length	2,2,4; 2,2
Note	This is the discharge/departure date and time of patient from a specific location in the trauma centre in (MM DD YYYY) and (HH:MM). If your site is not collecting the time for patient tracking stats please enter '/'. Time was originally put in so time of bed request (in the location code menu) could be entered. Traditionally only arrival and departure dates have been entered for patient tracking.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	New

Elapsed Time

Data Element	Elapsed Time (Patient Locations)
Field Name	LT_ELAPSEDSC {list}
Field Type	Numeric (days, hours, minutes)
Field Length	2,2,2
Note	This is a calculated variable based on patient location arrival date/time and patient location departure date/time at trauma centre. It is reported in days, hours and minutes (__days, HH:MM). If time of arrival and departure is not being entered this data element cannot be calculated.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	New

Unit

Data Element	Unit (Patient Locations)
Field Name	LT_DETAILS {list}
Field Type	Character
Field Length	50
Note	Please type in the unit # or description in this text box.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	New

ICU and Stepdown/IMC Days

Data Element	ICU Days (LOS) and Stepdown or Intermediate Care Days (IMC) LOS
Field Name	ICU_DAYS; STEP_DAYS
Field Type	Numeric
Field Length	3
Note	This is the cumulative total length of ICU stay in days (across all ICU admissions). Admissions need not be continuous. If patients at UAH are being sent to the burn unit for ICU overflow please enter this as location code #4 ICU otherwise these days will not be counted. If there are no ICU stays you will have to enter the null value "0" yourself in the appropriate box. (This will be mapped to the null value '/' when submitting to NTDB). Each partial calendar day should be counted as a full (1) day. The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart. If any dates are missing then ICU LOS cannot be calculated (and should be entered as "?"). If the patient has multiple ICU episodes on the same calendar day count that as 1 day. ICU LOS should not exceed hospital LOS. Stepdown/IMC days will also be calculated from the patient location tracking entries. If there are no Stepdown/IMC stays you will have to enter the null value "0" yourself in the appropriate box. Observation unit days will be calculated here.
ATR Required	Yes
NTDB Required	Yes **ICU Days ONLY** please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU flow sheet 2. Nursing notes/flow sheet
History	N/A

Patient Tracking: Ventilator/Blood

Click the ADD button on the right side of the screen to enter all time periods the patient was on a ventilator or given blood products in the first 24 hours at the trauma center. Please enter all ventilator dates/blood products given in sequential order. You can switch the order of tracking entries by using the green arrow (↑ and ↓) buttons.

Start Date/Time

Data Element	Ventilator Start Date/Time (Patient Tracking)
Field Name	VD_STR_DATES {list}; VD_STR_TIMES {list}
Field Type	Date/Numeric
Field Length	2,2,4; 2,2
Note	This is the start date and time the patient was put on a ventilator (MM DD YYYY) and (HH:MM). • Excludes mechanical ventilation time associated with OR procedures (routine intubation for OR is not included). • Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator days. • Recorded in full day increments with any partial calendar day counted as a full calendar day. • The calculation assumes that the date of starting and stopping ventilator episode are recorded in the patient's chart. • If any dates are missing then a Total Vent Days cannot be calculated. • At no time should the Total Vent Days exceed the Hospital LOS. • The null value "/" is used if the patient was not on the ventilator according to the above definition.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU Respiratory Therapy Flowsheet 2. ICU Nursing Flow Sheet 3. Physician's Daily Progress Notes 4. Calculate Based on Admission Form and Discharge Sheet
History	New

Stop Date/Time

Data Element	Ventilator Stop Date/Time (Patient Tracking)
Field Name	VD_STP_DATES {list}; VD_STP_TIMES {list}
Field Type	Date/Numeric
Field Length	2,2,4; 2,2
Note	This is the stop date and time the patient was taken off a ventilator (MM DD YYYY) and (HH:MM). • Excludes mechanical ventilation time associated with OR procedures (routine intubation for OR is not included). • Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator days. • Recorded in full day increments with any partial calendar day counted as a full calendar day. • The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient's chart. • If any dates are missing then a Total Vent Days cannot be calculated. • At no time should the Total Vent Days exceed the Hospital LOS. • The null value "/" is used if the patient was not on the ventilator according to the above definition.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU Respiratory Therapy Flowsheet 2. ICU Nursing Flow Sheet 3. Physician's Daily Progress Notes 4. Calculate Based on Admission Form and Discharge Sheet
History	New

Elapsed Time

Data Element	Elapsed Time (Patient Locations)
Field Name	VD_ELAPSEDSC {list}
Field Type	Numeric (days)
Field Length	3
Note	This is a calculated variable based on patient ventilator start and stop dates/times at trauma centre. It is reported in days, HH:MM.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ICU Respiratory Therapy Flowsheet 2. ICU Nursing Flow Sheet 3. Physician's Daily Progress Notes 4. Calculate Based on Admission Form and Discharge Sheet
History	N/A

Total Ventilator Days

Data Element	Total Ventilator Days (Trauma Centre)
Field Name	VENT_DAYS
Field Type	Numeric
Field Length	3
Note	This is the cumulative total ventilator days during the patient's hospital stay - days need not be continuous. It will automatically calculate the days based on the entries in the ventilator tracking table. Any partial day counts as 1 day. The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart. If any dates are missing then ICU LOS cannot be calculated (and should be entered as "?"). This excludes mechanical ventilation time associated with OR procedures. Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator days. Total Vent days should not be greater that hospital LOS. '0' can be entered manually in this box if the patient was not on a ventilator during their stay at trauma centre. (This will be mapped to the null value '/' when submitting to NTDB).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU Respiratory Therapy Flowsheet 2. ICU Nursing Flow Sheet 3. Physician's Daily Progress Notes 4. Calculate Based on Admission Form and Discharge Sheet
History	N/A

Blood Product

Data Element	Blood Product
Field Name	BLOOD_TYPES {list}
Field Type	Integer
Field Length	1
Note	Select from the drop down menu what type of blood product the patient was given. Enter all each blood category in each time period on a different line of the table. Starting in 2017 you should be collecting blood product given for at least the first 24 hours (to match sites collecting for TQIP). You can also collect for all blood products given. 1. Packed Red Blood Cells 2. Plasma 3. Platelets 4. Other Blood Substitute Not applicable Unknown As per data subcommittee on April 05 2018 please collect "cumulative" #6 blood products in this section only. As first 4 hours and 24 hours are being collected in the TQIP section already. Level III sites collecting cumulative first 24 hours and then cumulative total admission.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow sheet 5. Blood Bank
History	New

CLARIFICATION:

Volume

Data Element	Volume (Blood Tracking)
Field Name	BLOOD_UNITS {list}
Field Type	Numeric
Field Length	4
Note	Enter the volume of blood product given (# of units). As per data subcommittee on April 05 2018 please collect "cumulative" #6 blood products in this section only. As first 4 hours and 24 hours are being collected in the TQIP section already. Level III sites collecting cumulative first 24 hours and then cumulative total admission.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow sheet 5. Blood Bank
History	New

Units

Data Element	Units (Blood Tracking)
Field Name	BLOOD_UNIT_MEASS {list}
Field Type	Integer
Field Length	1
Note	Please select from the drop down list item #1 (units). Do not choose '/' or '?'. As per data subcommittee on April 05 2018 please collect "cumulative" #6 blood products in this section only. As first 4 hours and 24 hours are being collected in the TQIP section already. Level III sites collecting cumulative first 24 hours and then cumulative total admission.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow sheet 5. Blood Bank
History	New

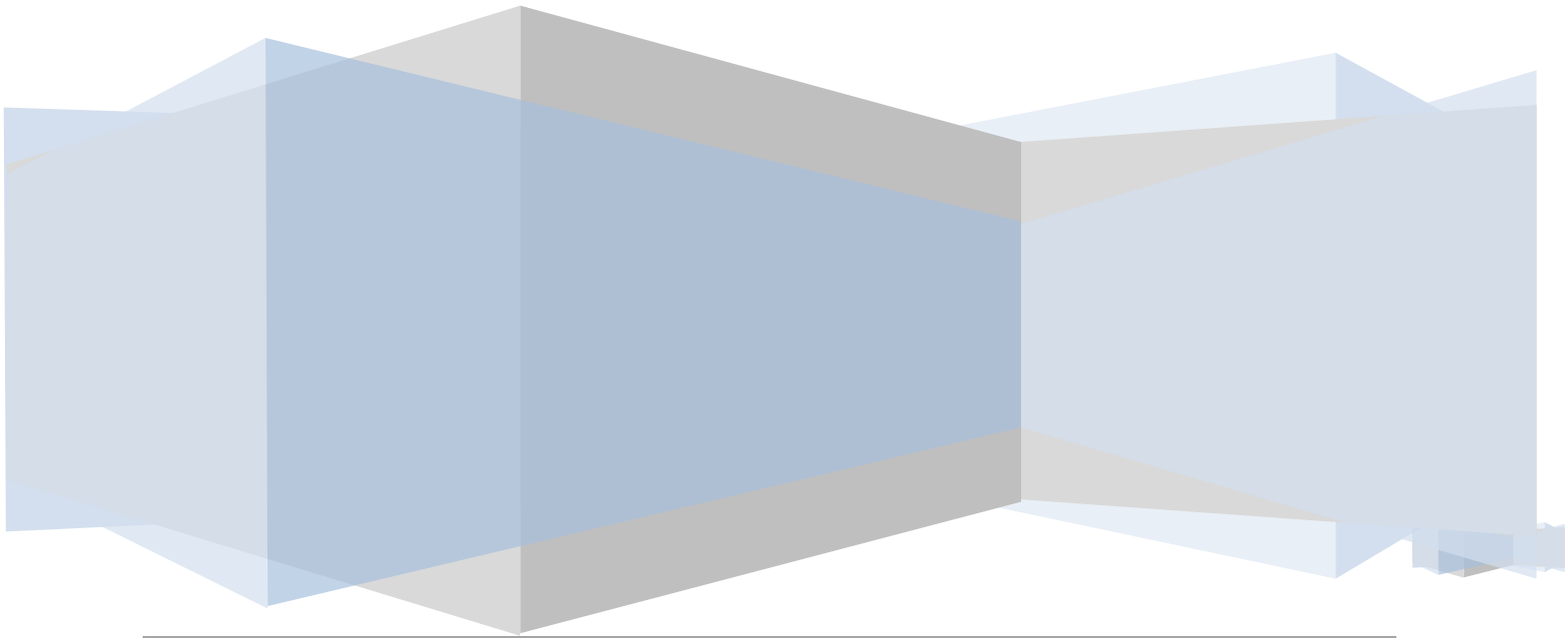
Time Period

Data Element	Time Period
Field Name	BLOOD_TIME_PDS {list}
Field Type	Integer
Field Length	1
Note	Select from the drop down menu the time period that the blood product was given to the patient. Enter all separate times/types of blood given. 1. Pre-hospital *(STARS)* 2. Transfer Hospital (any) 3. First 4 hours after ED arrival 4. First 24 hours after ED arrival (cumulative with first 4 hours) 5. First 48 hours after ED arrival (cumulative) 6. Total blood given (full hospital LOS, cumulative) during TC admission Not applicable *(use if no blood given)* Unknown As per data subcommittee on April 05 2018 please collect "cumulative" #6 blood products in this section only. As first 4 hours and 24 hours are being collected in the TQIP section already. Level III sites collecting cumulative first 24 hours and then cumulative total admission.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow sheet 5. Blood Bank
History	New

Patient Tracking Notes

Data Element	Notes (Patient Tracking)
Field Name	MEM05
Field Type	Memo
Field Length	500
Note	Enter information in this area if you need to make a note about the Patient Tracking (location, ventilator, blood) data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section VII Providers



ED Consults

Please enter all ED physician consult types who assisted with patient care in the ED. Enter each type only once. No need to enter Emergency Medicine or triage nurse (treat everyone).

Type

Data Element	ED Consult Type
Field Name	CS_TYPE01 (to 20); CS_TYPES {list}
Field Type	Integer
Field Length	2
Note	Record consults that are done in the ED only (by phone or in person). See below for a full list of menu options. If there were no consults outside of ED physicians/nurses please enter '/'.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Records 2. Trauma Flow Sheet 3. Nurses Notes
History	N/A

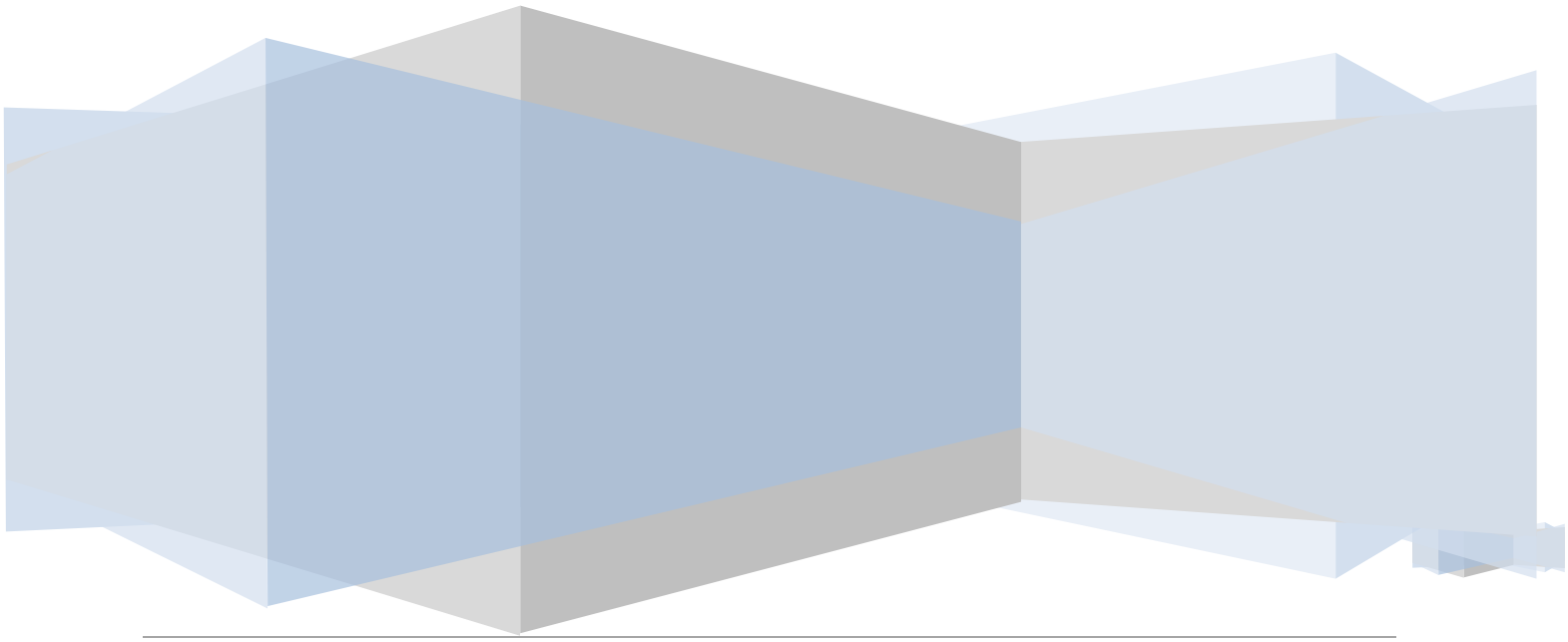
List of Menu Options ED Consult Type:

1	Trauma
2	Neurosurgery
3	Orthopedics
4	General surgery
5	Pediatric surgery
6	Cardiothoracic surgery
7	Burn services
8	~~Emergency Medicine~~ *(don't use)*
9	Pediatrics
10	Anesthesiology
11	Cardiology
14	Critical Care
19	ENT
20	Family Medicine
21	GI
23	Hospitalist
24	Infectious Disease
25	Internal Medicine
27	Nephrology
28	Neurology
29	Nurse Practitioner
30	Nursing
32	Ob-Gyn
34	Oncology
35	Ophthalmology
36	Oral surgery
37	Oromaxillo Facial Service
38	Ortho-spine
43	Plastic surgery
45	Pulmonary
46	Radiology *(interventional radiology (not general radiology) may consult – there should be a separate consult form for this)*
48	Respiratory Therapist
52	Thoracic surgery
53	~~Trauma Resuscitation Nurse~~ *(don't use)*
54	~~Triage Nurse~~ *(don't use)*
55	Urology
56	Vascular surgery
~~57~~	~~ICU~~ *(don't use)*
58	Physician Assistant
98	Other surgical
99	Other non-surgical
/	Not applicable *(if no one outside ED physicians consulted on patient)*
?	Unknown *(can be used if you see someone's name but aren't sure where they are from)*

Providers Notes

Data Element	Notes (Providers)
Field Name	MEM04
Field Type	Memo
Field Length	500
Note	Enter information in this area if you need to make a note about the ED Consult types/Providers data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section VIII Procedures



Procedures (Trauma Centre)

Enter all selected non-op (from the non-op procedures list) and ALL operative procedures done at the trauma center. Please try to enter them in the order they were done. You can switch the order of procedures by using the green arrow (↑ and ↓) buttons.

Non-Operative Procedures

Data Element	Non–Operative Procedures (Trauma Centre)
Field Name	ED_INTS {list}; ED_INT_DATES {list}; ED_INT_TIMES {list}
Field Type	Integer
Field Length	2
Note	Click the Non-operative button at the top left of the screen to enter up to 10 non–operative procedures at one time initiated in the trauma centre emergency department. Please enter them in order the procedure was done. ***Procedures already established which are being maintained should not be entered.*** If there were no non-operative procedures done in the ED please choose '/' from the drop down list so we know this section wasn't accidentally skipped. Start date and time **MUST** be entered in the space provided. Because dates and/or times will not be the same for all procedures you will have to edit each non-operative procedure to enter the correct time (and possibly some of the dates). Corrections for dates and times made in the non-ops table will not carry down into the ICD10 procedure below so you may want to enter them one at a time if the dates and times are all different. If date or time is not documented, or only partially documented, enter '?'. You can enter more than 10 non-op procedures in total, but can only add 10 at one time. Please see below for complete list of procedures and further clarification.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Trauma Flow Sheet 2. ED Record 3. Nursing Notes/Flow Sheet 4. Radiology Reports
History	N/A

Further Clarification:

Select non–operative procedures performed at the trauma centre from the drop down list. Enter the non-op procedure once – the one that was done first (start date and time). Do not enter a procedure twice or if it has been established at one hospital (or with a pre-hospital provider) and is being maintained at the trauma centre.

The non-op procedures from our drop down list are the ones that need to drop down into the ICD9& ICD10 section as they will be submitted to NTDB. This list of non-op procedures in the NTDB manual is a ***suggested*** list only. ICD9 codes have been removed from the registry as of June 15, 2016; however, due to the complexity and specificity of some of the non-op ICD10 codes ICD9 codes will still drop down for non-op procedures. They will not be sent to NTDB they are dropping down to ensure the analysts will not have to double enter the non-op procedures in both tables. There are 8 ICD10 codes for non-op procedures that must be individually entered by analysts (Angio embolization, angiography, closed reduction, CT other, major suturing, MRI, splinting, traction/pins). This is because the ICD10 code is specific to the location of the body (ICD9 codes are much more general). These ICD10 codes will have to be edited in the ICD9&10 procedures table after dropping down. In addition, please make sure you are double checking that the CT ICD10 codes that drop down are correct based on enhancement or none, analysts may have to change the last 2 letters of the code to make it correct.

You will have to enter start time for non-op procedures since this data is being sent to the NTDB.

Enter only the first CT done per body area (no need to enter multiple CT scans per body area).

Assisted Ventilation is defined as:

- If there is something placed in the patient's airway to assist them in breathing such as ETT, King or LMA then the patient has assisted ventilation. Even if the chart does not specifically say that they were bagged with an ETT, King or LMA the patient still had assisted ventilation.
- If the patient is being bagged (bag-valve-mask) then they have assisted ventilation. It does not matter if the patient is being bagged manually or if it is a machine that is doing the ventilation these patients have assisted ventilation. It is possible to have assisted ventilation without being intubated.
- Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitubes and LMA

- LMA, King, Combitubes are airway adjuncts and included as intubation as per requirement of NTDB and data subcommittee Jan 10 2019.

- OPA and NPA are adjuncts in the oropharynx that assist in keeping airway open but ***by themselves are not assisted ventilation***. Please ask your coordinator if these terms are present but no other terms in the chart specify assisted ventilation.
- If a patients chart specifically documents "no assistance" the analyst should clarify with their medical director or coordinator if this patient had assisted ventilation or not.
- So if the analyst has selected "#1, Oral intubation" or "#2, King LT, LMA, Combitubes" they should also select "Assisted Ventilation". LMA, King and Combitubes are intubation.

Backboard is no longer an option.

Extubation should not be included as a non-operative procedure.

CT Angio should be coded as Angiography/CTA #20

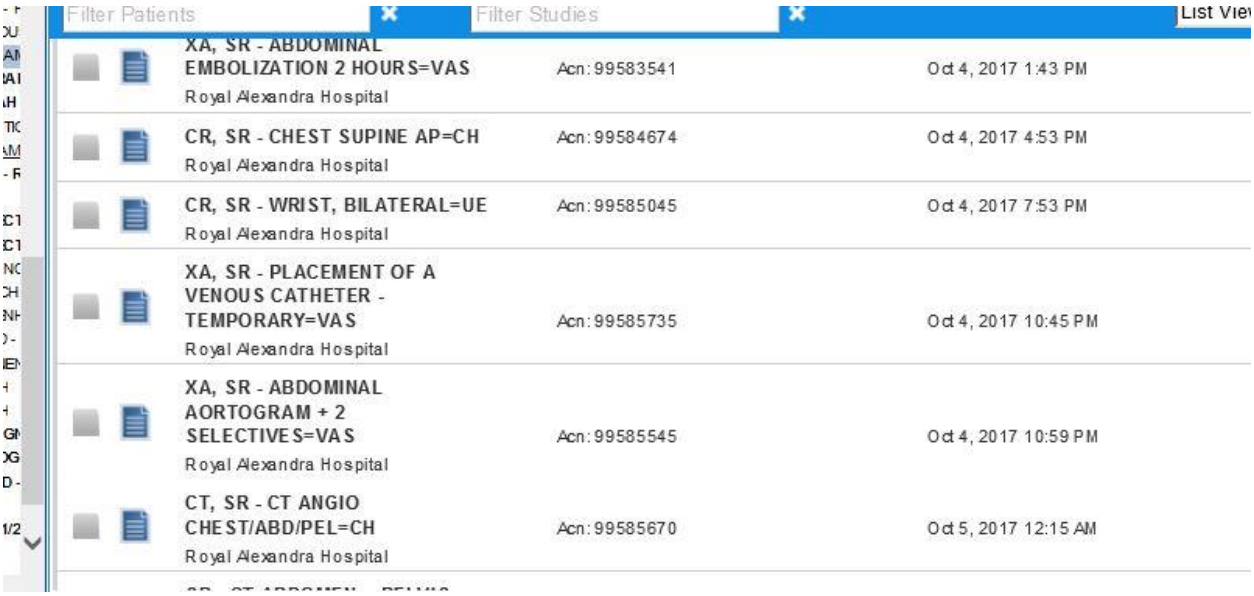
If patient went to CT scanner for Angio then should be recorded as #20. If patient went to Angio suite for Embolization etc., then enter #20 and #48.

Please carefully review all new options in the drop down list (i.e. CT scan locations).

The non-operative procedure information you enter will be transferred down to the procedures ICD9 & 10 table below. When submitting to NTDB these non-operative procedures need to have 10 codes attached. Non-operative procedures essential to the diagnosis, stabilization or treatment of a patient's injuries or complications done in the ED, ICU, ward or radiology should be captured (as per NTDB data dictionary 2016). You can include more procedures than what is in the ATR drop down list if you think it is necessary.

In the procedures ICD9 & 10 table you will also have to update the location of non-operative procedure (usually #2, ED) and service (usually #8 emergency medicine, or #46 radiology). <u>You do not need to enter stop date and time for any non-operative procedures, please enter '/'</u>.

Example of Ct Angiogram, CT embolization and CT Aortogram in Netcare



Menu Selection for Non-operative Procedures:

1	Oral intubation with BVM ventilation (bagged) 1GZ31CAEP
2	King LT, LMA, Combitubes
3	Tracheostomy
4	Cricothyroidotomy
5	Ventilator/ Intubated with ventilator (make sure this is an "ND" code) 1GZ31CAND
6	Chest Tube insertion
7	Peripheral IV insertion
8	Central Line
9	Arterial Line
10	~~Cutdown~~ (retired July 2016)
11	ED Thoracotomy
12	CPR
13	ICP monitoring
14	Burr Holes
15	Halo Traction or Tongs
16	Traction/Pins
17	~~Peg Tubes~~ (retired July 2016)
18	Foley Catheter Insertion (also condom catheter)
19	Gastric Tube Insertion
20	Angiography/CTA
21	~~DPL~~ (retired July 2016)
22	CT Head Scan
23	Percardiocentesis
24	Intraosseous Access
25	C–Spine precautions
26	Blood Product Administration-PRBC(retired July 2016) (added again as of April 05 2018)
27	Major suturing
28	~~Other~~
29	Needle Thoracentesis
30	Splinting
31	Ultrasound
40	Closed Reduction
41	MRI
42	CT Scan Spine
43	CT Scan Face
44	CT Scan Chest
45	CT Scan Abdomen
46	CT Scan Pelvis
47	CT Scan Other
48	Angioembolization
49	CT Total Body (new June 2016) (CT Chest, Abdomen and Pelvis)
/	Not-applicable *(use if no non-op procedures were done)*
?	Unknown

Trauma Centre Procedures & ICD10 CA/CCI only

Data Element	Trauma Centre Procedures As of July 15 2016 we are no longer entering ICD9 codes.
Field Name	~~PR_ICD9_S {list}~~; PR_ICD10_S {list}; PR_LOCS {list}; PR_OP_NUMS {list}; PR_STR_DATES {list}; PR_STR_TIMES {list}; PR_ELAPSEDSC {list}; PR_STP_DATES {list}; PR_STP_TIMES {list}; PR_SVCS {list}
Field Type	Varies
Field Length	Varies
Note	Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. Click on the Add button to the right of the procedures ICD9 & 10 section and a smaller screen will pop up. All operative procedures done at the trauma centre must be entered here. ***Some of the ICD10 codes for the non-operative procedures may need to be updated/ corrected in this section. All non-operative procedures should now drop down.*** If you know the ICD10 code for the procedure you are entering type the code in the appropriate box. Once you type in the code the procedure will pop up in the box to the right so you can check that you have entered the correct procedure. Alternatively, click the magnifying glass and choose from the ICD10 drop down lists for the procedure you are looking for. The first menus (large category procedure groups) for ICD10 are attached below. Enter the location code that the procedure was done at - menu for drop down list is given below. If this was an operative procedure enter the operation # for the patient that this procedure was done at. Enter the start date (MM/DD/YYYY) and start time (HH:MM in military time) of the procedure as marked on the patient chart. If start date or time is not documented enter '?'. If distinct procedures with the same procedure code are performed, their start times must be different. Enter the stop date (MM/DD/YYYY) and stop time of the procedure if it was done in the operating room. All procedures done outside an OR do not have stop date/time therefore enter '/'. If the procedure was done in the OR and stop date/time was not documented enter '?'. Enter the service of the physician/staff member that did the procedure from the drop down list. Drop down list is shown on page below. For non-op procedures where person who performed procedure may not be documented enter "?". You can use the + tab at the bottom of this screen to add another procedure without closing out of the screen. When you are done click ok and the

	procedures will be shown in list form. If you need to add another procedure later you can use the ↑ and ↓ buttons to move the procedure up or down to be grouped in order the procedures were done sequentially (date/time). If you need to add multiple procedures that occurred at one time or in one location you can click the "add multiple procedures" button in the top right of this section. Here you can add up to 10 procedures that were done at the same location, have the same start and stop date and time and were done by the same service. If you need to go in to edit times (since not all procedures usually end at the same time) you can edit each line individually after entering. • The Null value "Not Applicable" is used if the patient did not have procedures • Include only procedures performed at your institution. • Capture all procedures performed in the operating room. • Capture all procedures in the ED, ICU, ward or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications. • Procedures with an asterisk need to be only captured once as they have the potential to be performed multiple times. If there is no asterisk, capture each event even if there is more than one. • Note that the hospital may capture additional procedures. • Do not include Intubations performed in the OR. • Make sure to code any debridement "1VX59LAGX" for leg and "1TX59LAGX" for arm separately with the Open fractures ORIF. Field cannot be blank Field should not be Not Applicable unless patient had no procedures performed. **Please enter burr holes done in OR as "craniotomy" as per memo ATCLS. See Appendix A for memo** **Enter "Incision start time" and "Incision end time" for all operative procedures. Do not collect "Patient In Theatre" and "Patient Out of Theatre" as per TQIP data dictionary**
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Anesthesia Reports 3. Procedure Notes 4. Trauma Flow Sheet 5. ED Record 6. Nursing Notes/Flow Sheet 7. Radiology Reports 8. Hospital Discharge Summary

Menu Selection Location:

2	Emergency Department
3	Operating Room
4	Intensive Care Unit (ICU)
5	Step-down Unit
6	Floor
9	Burn Unit
14	Neonatal/Pediatric Care Unit
20	Diagnostic Imaging

Menu Selection Service:

1	Trauma
2	Neurosurgery
3	Orthopedics
4	General Surgery
5	Pediatric Surgery
6	Cardiothoracic Surgery
7	Burn Services
8	Emergency Medicine
9	Pediatrics
10	Anesthesiology
11	Cardiology
14	Critical Care
19	ENT
20	Family Medicine
21	GI
23	Hospitalist
24	Infectious Disease
25	Internal Medicine
27	Nephrology
28	Neurology
29	Nurse Practitioner
30	Nursing
32	Ob-Gyn
34	Oncology
35	Ophthalmology
36	Oral Surgery
37	Oromaxillo Facial Service
38	Ortho-Spine
43	Plastic Surgery
45	Pulmonary
46	Radiology
48	Respiratory Therapist
52	Thoracic Surgery
53	Trauma Resuscitation Nurse
54	Triage Nurse
55	Urology
56	Vascular Surgery
58	Physician Assistant
98	Other Surgical
99	Other Non-Surgical
/	Not Applicable
?	Unknown *(should be used for non-op procedures where documentation is not available for who did the procedure).*

Menu Selection ICD10 Procedure Codes:

Treatment Interventions
Tx Interventions Brain and Spinal Cord (1AA-1AZ)
Tx Interventions Nerves (1BA-1BZ)
Tx Interventions Eye and Ocular Adnexa (1CC-1CZ)
Tx Interventions External Ear NEC (1DA-1DE)
Tx Interventions Middle Ear [Tympanic Cavity] (1DF-1DL)
Tx Interventions Inner Ear (1DM-1DZ)
Tx Interventions Musculoskeletal Tissue Head, Nasal Cavity & Sinuses (1EA-1EY)
Tx Interventions Oral Cavity and Pharynx (1FA-1FX)
Tx Interventions Respiratory System (1GA-1GZ)
Tx Interventions Heart (and related structures) (1HA-1HZ)
Tx Interventions Great Vessels (1IA-1IS)
Tx Interventions Upper Body Vessels (1JD-1JY)
Tx Interventions Lower Body Vessels (1KA-1KT)
Tx Interventions Blood Vessels NEC (1KV-1KZ)
Tx Interventions Combined Sites for Congenital Heart Anomalies (1LA-1LD)
Tx Interventions Lymphatic System (1MA-1MZ)
Tx Interventions Digestive Tract (1NA-1NZ)
Tx Interventions Hepatobiliary Tract/Other Sites Abdominal Cavity NEC (1OA-1OZ)
Tx Interventions Urinary System (1PB-1PZ)
Tx Interventions Male Genital Organs (1QD-1QZ)
Tx Interventions Female Genital Organs (1RB-1RZ)
Tx Interventions Spine, Trunk and Pelvis (1SA-1SZ)
Tx Interventions Shoulder & Arm (excluding hand & wrist) (1TA-1TZ)
Tx Interventions Hand and Wrist (1UB-1UZ)
Tx Interventions Hip and Leg (1VA-1VZ)
Tx Interventions Ankle and Foot (1WA-1WV)
Tx Interventions Musculoskeletal System NEC (1WX-1WZ)
Tx Interventions Skin, Subcutaneous Tissue and Breast (1YA-1YZ)
Tx Interventions Body NEC (1ZX-1ZZ)

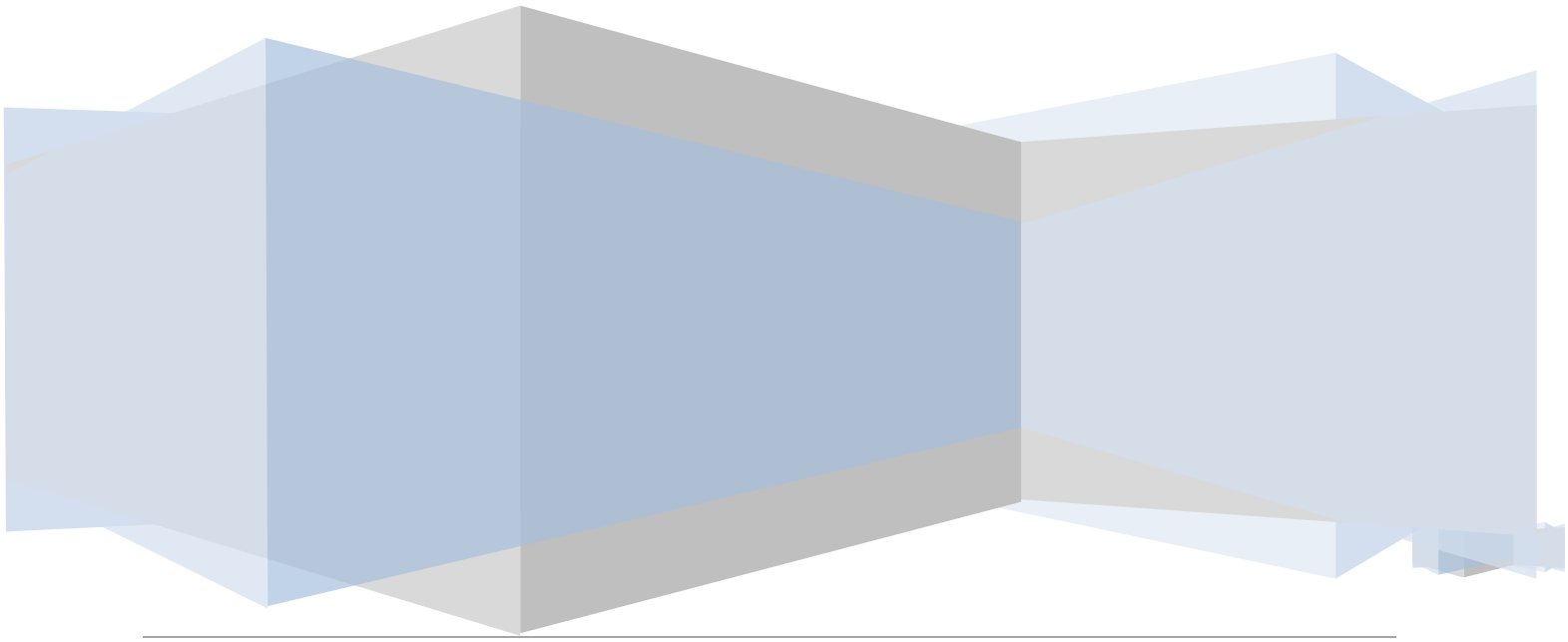
Diagnostic Interventions
Dx Interventions Brain and Spinal Cord (2AA-2AZ)
Dx Interventions Nerves (2BA-2BX)
Dx Interventions Eye and Ocular Adnexa (2CC-2CZ)
Dx Interventions External Ear NEC (2DA-2DE)
Dx Interventions Middle Ear [Tympanic Cavity] (2DF-2DL)
Dx Interventions Inner Ear (2DM-2DZ)
Dx Interventions Musculoskeletal Tissue Head, Nasal Cavity *[& Sinuses (2EA-2EY)]*
Dx Interventions Oral Cavity and Pharynx (2FA-2FX)
Dx Interventions Respiratory System (2GE-2GZ)
Dx Interventions Heart (and related structures) (2HD-2HZ)
Dx Interventions Great Vessels (2ID-2IM)
Dx Interventions Upper Body Vessels (2JE-2JZ)
Dx Interventions Lower Body Vessels (2KE-2KT)
Dx Interventions Circulatory System (2LZ)
Dx Interventions Lymphatic System (2MA-2MZ)
Dx Interventions Digestive Tract (2NA-2NT)
Dx Interventions Hepatobiliary Tract/Other Sites Abdominal Cavity NEC (2OA-2OZ)
Dx Interventions Urinary System (2PB-2PV)
Dx Interventions Male Genital Organs (2QE-2QZ)
Dx Interventions Female Genital Organs (2RB-2RZ)
Dx Interventions Spine, Trunk and Pelvis (2SA-2SZ)
Dx Interventions Shoulder and Arm (2TA-2TZ)
Dx Interventions Hand and Wrist (2UB-2UY)
Dx Interventions Hip and Leg (2VA-2VZ)
Dx Interventions Ankle and Foot (2WA-2WV)
Dx Interventions Musculoskeletal System NEC (2WY-2WZ)
Dx Interventions Skin, Subcutaneous Tissue and Breast (2YA-2YZ)
Dx Interventions Body NEC (2ZZ)

Diagnostic Imaging Interventions
Dx Imaging Interventions Nervous System (3AF-3AW)
Dx Imaging Interventions Eye and Ocular Adnexa (3CA-3CZ)
Dx Imaging Interventions Middle Ear [Tympanic Cavity] (3DL)
Dx Imaging Interventions Inner Ear (3DR-3DZ)
Dx Imaging Interventions Musculoskeletal Tissue Head, Nasal Cavity *[& Sinuses]* (3EA-3EY)
Dx Imaging Interventions Oral Cavity and Pharynx (3FE-3FY)
Dx Imaging Interventions Respiratory System (3GE-3GY)
Dx Imaging Interventions Heart (and related structures) (3HZ)
Dx Imaging Interventions Great Vessels (3ID-3IS)
Dx Imaging Interventions Upper Body Vessels (3JE-3JY)
Dx Imaging Interventions Lower Body Vessels (3KC-3KU)
Dx Imaging Interventions Blood Vessels NEC (3KV-3KZ)
Dx Imaging Interventions Circulatory System NEC (3LZ)
Dx Imaging Interventions Lymphatic System (3ML-3MZ)
Dx Imaging Interventions Digestive System (3NA-3NZ)
Dx Imaging Interventions Hepatobiliary Tract/Other Sites Abdominal Cavity NEC
Dx Imaging Interventions Urinary System (3PB-3PZ)
Dx Imaging Interventions Male Genital Organs (3QE-3QZ)
Dx Imaging Interventions Female Genital Organs (3RF-3RZ)
Dx Imaging Interventions Spine, Trunk and Pelvis (3SC-3SQ)
Dx Imaging Interventions Shoulder and Arm (3TA-3TZ)
Dx Imaging Interventions Hand and Wrist (3UB-3UZ)
Dx Imaging Interventions Hip and Leg (3VA-3VZ)
Dx Imaging Interventions Ankle and Foot (3WA-3WG)
Dx Imaging Interventions Musculoskeletal System NEC (3WY-3WZ)
Dx Imaging Interventions Skin, Subcutaneous Tissue and Breast (3YL-3YZ)
Dx Imaging Interventions Body NEC (3ZA-3ZZ)
Other
Clinical Laboratory Interventions (4AC-4TZ)
Antepartum Interventions (5AB-5CA)
Interventions Fetus (5FD-5FT)
Interventions During Labor and Delivery (5LB-5MD)
Postpartum Interventions (5PB-PD)
Cognitive, Psychosocial and Sensory Therapeutic Interventions (6AA-6VA)
Other Healthcare Interventions (7SC-7SP)
Immune/Genetic Interventions (8AA-8ZZ)
/, Not applicable
?, Unknown

Procedures Notes

Data Element	Notes (Procedures)
Field Name	PR_MEMO
Field Type	Memo
Field Length	500
Note	Enter information in this area if you need to make a note about the Procedures data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section IX Diagnosis



Diagnosis: Injury Coding

AIS Version

Data Element	AIS Version
Field Name	AIS_VER
Field Type	Numeric
Field Length	1
Note	Automatically enters AIS version 5 (or 2005) Update 08. In AIS 5, each injury description is assigned a unique 6 digit numerical code in addition to the AIS severity score. AIS Abbreviated Injury Scale is an anatomically based consensus driven, global severity scoring system that classifies each injury by body region according to its relative importance on a 6point ordinal scale. AIS of 1 is considered minor while an AIS of 6 is the maximum and is currently considered untreatable. Source: Association for the Advancement of Automotive Medicine, AIS 2005 Field cannot be blank Field cannot be Not Applicable.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	Previous AIS Version 90 (1998 update) used from 1995 to 2014.

ISS

Data Element	ISS Injury Severity Score
Field Name	ISS
Field Type	Integer
Field Length	2
Note	ISS is an anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an AIS score, allocated to one of six body regions: 1. Head/ neck (including c-spine) 2. Face 3. Chest (including T-spine) 4. Abdomen (including L-spine) 5. Extremities (including pelvis) 6. External The ISS is a calculated field based on the injury descriptions entered ~~below~~ in the "Narrative (Injury Text). The ISS is the sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. ISS ranges from 1 to 75 with 1 being minor and 75 being incompatible with life.
ATR Required	Yes
NTDB Required	No
Hierarchy	Calculated by program
History	Previous AIS Version 90 used from 1995 to 2014.

NISS

Data Element	NISS New Injury Severity Score
Field Name	NISS
Field Type	Integer
Field Length	2
Note	The NISS is a calculated field based on the injury descriptions entered below. The NISS is the sum of the squares of the 3 highest AIS codes regardless of body region. NISS ranges from 1 to 75. NISS outperforms the traditional ISS
ATR Required	Yes
NTDB Required	No
Hierarchy	Calculated by program
History	NEW

TRISS

Data Element	TRISS Trauma Injury Severity Score
Field Name	TRISS
Field Type	Numeric
Field Length	5
Note	The TRISS model is derived from Major Trauma Outcome Study (MTOS) data done in 1986. It uses logistical regression to predict patient survival probability. It is calculated for blunt and penetrating trauma only (not for burns). www.trauma.org TRISS is a calculated field based on the first recorded set of vital signs at the trauma centre. Because of the nature of this calculation in ATR, if TRISS cannot be calculated due to missing data the data element will appear blank on the screen. TRISS combines both physiologic and anatomic indices to characterize severity of injury and estimate patient survival probability (Ps). The physiologic index is the RTS as assessed at emergency department admission. The RTS is a weighted sum of coded values (0–4) of the Glasgow Coma Scale (GCS), systolic blood pressure (SBP) and respiratory rate (RR). Because TRISS requires the RTS, it does not calculate probability of survival for patients who are intubated at the time ED department GCS is calculated. www.trauma.org TRISS combines these physiologic and anatomic measures to estimate survival probability as follows: PS=1/(1+e to the minus b) where b=b0 + b1(RTS) + b2(ISS) + b3(age) Age=0 for age <55 years and age=1 for age >=55 years. The "b" are regression weights that differ for blunt and penetrating injury.
ATR Required	Yes
NTR Required	No
Hierarchy	Calculated by program
History	Previous AIS Version 90 used from 1995 to 2014.

Narrative

Data Element	Narrative (Injury text)
Field Name	INJ_TEXT
Field Type	Character
Field Length	500
Note	This is the "easiest" way to enter your injury coding; by typing in specific detail all injuries the patient received. Please type in order from head first, down the center of the body and then out to extremity and external injuries. Please enter each injury on a separate line. You can click the … button to expand this screen if you have many injuries to enter. You can add 27 diagnoses to the table. After typing in all injuries you can click the "Coding ICD10" button (then hit OK) and the details for all injuries should appear in the table below (if the correct narrative has been entered). **Clicking "Coding ICD9 & 10" will erase all other changes and additions you've made in the table below.** This is a shortcut to diagnosis data entry but you should still check each line in the 2nd table to make sure everything was entered correctly by the computer. In some cases the computer may not be able to give you the correct ICD10 code or AIS predot code and you will have to highlight that line and click "edit". You can also delete lines in the table or add a new diagnosis if you don't know the narrative to enter. If you don't know the narrative you can click the "ADD" button and enter the AIS predot code from your AIS 2005 manual. Once you add this predot code everything else will fill in automatically (ICD9&10, severity and ISS body region). **This are the two ways you should be entering anatomical diagnoses – please do not add ICD9 & 10 codes first. Please continuously check your AIS binder manual to look for the correct AIS codes and narrative wording to use.**
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Autopsy/Medical Examiner Report 2. Operative Reports 3. Radiology Reports 4. Physician's Notes 5. Trauma Flow Sheet 6. History & Physical 7. Nursing Notes/Flow Sheet 8. Progress Notes 9. Discharge Summary
History	N/A

ICD-10-CA Code

Data Element	ICD–10–CA Code
Field Name	ICD9_01 (to _27); ICD9_S {list}
Field Type	Character
Field Length	6
Note	Select the anatomical diagnosis from the Injury, Poisoning and Other Consequences of External Causes menu that corresponds to the ICD 10 CA Injury Codes. ICD–10 CA diagnoses codes from S00 to T98 can be entered: please exclude categories T36-T65 (poisonings and toxic effects) and T80-T88 (complications of surgery). NTDB only accepts diagnoses corresponding to S00-S99, T07, T14, T20-28 and T30-32; however, please enter all diagnosis codes as described above and check the NTDB box as "N" for any diagnosis codes that fall outside the NTDB range. You will get a Level 1 error during TQIP validation if you have included a patient that is not in their diagnosis inclusion criteria. Max # that can be submitted to NTDB is 50; however, only 27 diagnoses can be added to the ATR table. The AIS predot code will also be submitted in the section (with our dual AIS/ ICD10 coding system). For patients without final diagnoses (i.e. patients who die in ED….) Enter the generic AIS code "without confirmation of autopsy" if it is an ED death?
ATR Required	Yes
NTR Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Autopsy/Medical Examiner Report 2. Operative Reports 3. Radiology Reports 4. Physician's Notes 5. Trauma Flow Sheet 6. History & Physical 7. Nursing Notes/Flow Sheet 8. Progress Notes 9. Discharge Summary
History	N/A

Predot Code

Data Element	Predot Code
Field Name	PREDOT_01 (etc.); PREDOT_S {list}
Field Type	Numeric
Field Length	6
Note	The predot code is composed of body region, type of anatomic structure, specific anatomic structure and level. See below for further clarification. A complete description of body regions can be found in the AIS Dictionary. The AIS was originally developed to be used by crash investigators to standardize data on the frequency and severity of motor vehicle related injuries.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

Further Clarification:

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

The following conventions are used to assign the numeric to specific injury description:

1. **Region**
    1. Head
    2. Face
    3. Neck
    4. Thorax
    5. Abdomen
    6. Spine
    7. Upper Extremity
    8. Lower Extremity

9. Unspecified

2. **Type of Anatomic Structure**
   1. Whole Area
   2. Vessels
   3. Nerves
   4. Organs (incl. muscles/ligaments)
   5. Skeletal (incl. joints)
   6. Head – LOC

3. Specific Anatomic Structure or Nature

Whole Area

Skin
- 02 - Abrasion
- 04 - Contusion
- 06 - Laceration
- 08 - Avulsion
- 10 - Amputation
- 20 - Burn
- 30 - Crush
- 40 - Degloving
- 50 - Injury – NFS
- 60 - Penetrating
- 90 - Trauma, other than mechanical

Head – LOC

02	Length of Consciousness
04, 06, 08	Level of Consciousness
10	Concussion

Spine
- 02 - Cervical
- 04 - Thoracic
- 06 - Lumbar

Vessels, Nerves, Organs, Bones, and Joints are assigned consecutive two–digit numbers beginning with 02.

4. Level

Specific injuries are assigned consecutive two–digit numbers beginning with 02.

To the extent possible, 00 is assigned to an injury NFS as to severity or where only one injury is given in the dictionary for that anatomic structure .99 is assigned to an injury NFS as to lesion or severity.

AIS Severity

Data Element	AIS Severity Code (formerly MAIS)
Field Name	AIS_01 (etc.); AIS_S {list}
Field Type	Numeric
Field Length	1
Note	AIS severity is calculated for each injury description. The digit after the dot of the AIS code represents severity ranging from 1 (minor) to 6 (maximum) with 9 representing unassigned severity. Field cannot be n/a. Field cannot be blank.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	N/A
History	N/A

SEVERITY*	DESCRIPTION
1	MINOR INJURIES
2	MODERATE INJURIES
3	SERIOUS INJURIES
4	SEVERE INJURIES
5	CRITICAL INJURY
6	MAXIMUM INJURY, VIRTUALLY UNSURVIVABLE
9	NOT POSSIBLE TO ASSIGN

*Higher scores indicate an increase in severity (usually resulting in longer hospital stay, more medical interventions, and more rehabilitation needed) as well as an increased risk for death.

ISS Body Region

Data Element	ISS Body Region
Field Name	ISS_BR01 (to BR27); ISS_BRS {list}
Field Type	Numeric
Field Length	1
Note	ISS body region is populated when you enter text in the narrative that corresponds to a body region, or when you enter an AIS predot code. If you must choose body region yourself when entering a diagnosis the options are: 1. Head or Neck(includes brain, skull, c-spine) 2. Face (mouth, ears, nose and facial bones) 3. Chest (includes internal organs in chest area, diaphragm, ribs, t-spine) 4. Abdomen (includes internal organs in abd., l-spine) 5. Extremities (arms, legs, and pelvis) 6. External (lacerations, contusions, abrasions, and burns all outer body surfaces) Not applicable
ATR Required	Yes
NTDB Required	No (retired from collection 2016; still collected for ATR)
Hierarchy	N/A
History	N/A

Diagnosis: Comorbidities

Prehospital Cardiac Arrest?

Data Element	Prehospital Cardiac Arrest?
Field Name	PRE_A_CRDC_ARR_YN
Field Type	Integer
Field Length	1
Note	Did patient have a prehospital cardiac arrest? • These are patients who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation. • The event must have occurred outside of the reporting hospital, prior to admission at the centre in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring institution. • Any component of basic and /or advanced cardiac life support must have been initiated by a health care provider. 1. Yes 2. No Unknown ~~Not applicable~~ *(do not use)* Field cannot be blank Field cannot be Not Applicable
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. EMS Report 2. Triage/Trauma Flow Sheet 3. Nursing Notes
History	N/A

Pre-Existing Conditions

Data Element	Pre-existing Conditions (previously known as “co-morbidities”)
Field Name	PECS {list}; PEC_MEMOS {list}
Field Type	Integer
Field Length	2
Note	Enter pre-existing factors present before patient arrival at the ED/hospital. There is now a speed form for the pre-existing conditions to be entered on. If a Pre-existing condition does not exist, no further data entry is required. For ACS reporting purposes, a response of No will be assumed and reported. For any co-morbid condition to be valid for NTDB submission, there must be a diagnosis noted in the patient medical record that meets the definition notes below (or in Appendix 3: Glossary of Terms NTDS data dictionary)
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. History & Physical 2. Physician’s Notes 3. Progress Notes 4. Case Management/Social Services 5. Nursing Notes/Flow Sheet 6. Triage/Trauma Flow Sheet 7. Discharge Summary
History	N/A

Please see changes to the co-morbidities in the change log of the current NTDB data dictionary.

Pre-existing conditions:

0	No Known Co-morbid conditions (will be mapped to n/a for NTDB)
1	Other **Retired as per Jan 1 2019 admissions**
2	Alcohol use disorder
3	Anticoagulant Therapy
4	Bleeding disorder
5	Currently receiving chemotherapy for cancer
6	Congenital anomalies
7	Congestive Heart Failure (CHF)
8	Current smoker
9	Chronic renal failure
10	Cerebrovascular Accident (CVA)
11	Diabetes mellitus
12	Disseminated cancer
13	Advanced directive limiting care
15	Functionally dependent health status
16	Angina pectoris
17	Myocardial infarction
18	Peripheral Arterial Disease(PAD)
19	Hypertension **includes diet modification and exercise as per 2019 NTDB**
21	Prematurity
23	Chronic Obstructive Pulmonary Disease (COPD)
24	Steroid use
25	Cirrhosis
26	Dementia
27	Mental Personality Disorders
28	Substance Abuse Disorder
30	ADD/ADHD
/	~~Not applicable~~ *(please enter '0' no known co-morbid conditions as it is easier to pull this out in RW)*
?	Unknown

Clarification:

Diagnosis of "Alcohol Use Disorder" must be documented in the patient's medical record. You can collect "Alcohol Abuse in your registry but cannot report it to NTDB. The "Alcohol Use Disorder definitions are consistent with the DSM 5, 2013 definition. Exclude "Tobacco Use Disorder and Alcohol Use Disorder" as per 2019 NTDB not to use with Substance Abuse disorder.

If a patient reported that they smoked cigarettes within the 12 months prior to their injury, then you should report "Current Smoker" to the NTDB. A patient who is a current smoker does not need "Substance Abuse Disorder" to be reported to NTDB. "Current Smoker" doesn't necessarily have a "Substance Abuse Disorder."

Tobacco Use disorder and Alcohol Use disorder stated in the chart must be reported to NTDB. As per NTDB 2019 do not report both.

Substance Abuse disorder includes:

Caffeine, Cannabis, hallucinogens, inhalants, Opioids, sedatives, hypnotics and stimulants. As per TQIP webinar (April 2018).

Major Psychiatric illness: It is now “Mental Personality Disorder” in NTDB. This must be consistent with definition American Psychiatric Association DSM5. Documentation disorder must be in the medical record. Example “depressive disorder”, “bipolar disorder”.

Clarification Pre-existing Conditions:

Advanced directive limiting care: The patient had a written request limiting life sustaining therapy, or similar advanced directive.

Alcohol use disorder: (2015 definition) evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in absence of history of abuse. (2016 definition) Consistent with APA DSM 5 – diagnosis of alcohol use disorder documented in the patient medical record.

Angina Pectoris: Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA. Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of Angina or Chest Pain must be documented in the patient's medical record.

Anticoagulant Therapy: Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Excludes patients who are on chronic Aspirin therapy. Some examples are:

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

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

Bleeding disorder: Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology. A group of conditions that result when the blood cannot clot properly, present prior to injury. A bleeding disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand disease, Factor V Leiden). (2015/2016 definition): Any condition that places the patient at risk for bleeding in which there is a problem with the body's blood clotting process (e.g., vitamin K deficiency, hemophilia,

thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar medications.) Do not include patients on chronic aspirin therapy.

Cerebrovascular accident (CVA): A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory.)

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

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs].)
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing.
- A diagnosis of COPD must be documented in the chart (2017). Do not include patients whose only pulmonary disease is acute asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.

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

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

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

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

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea on lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure

- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

Currently receiving chemotherapy for cancer: A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

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

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

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

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

Functionally Dependent health status: Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

Hypertension: history of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of Hypertension must be documented in the patient's medical record. (2015/2016 definition): History of a persistent elevation of systolic blood pressure >140mm Hg and a diastolic blood pressure >90mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, angiotensin-converting enzyme (ACE) inhibitors, calcium channel blockers.)

Mental/Personality Disorder: Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use them most recent definition provided by the APA. Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

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

Peripheral Arterial Disease (PAD): Consistent with the Centers for Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC. The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in nay blood vessel, but it is more common in the legs than in the arms. A diagnosis of PAD must be documented in the patient's medical record.

Prematurity: Documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.

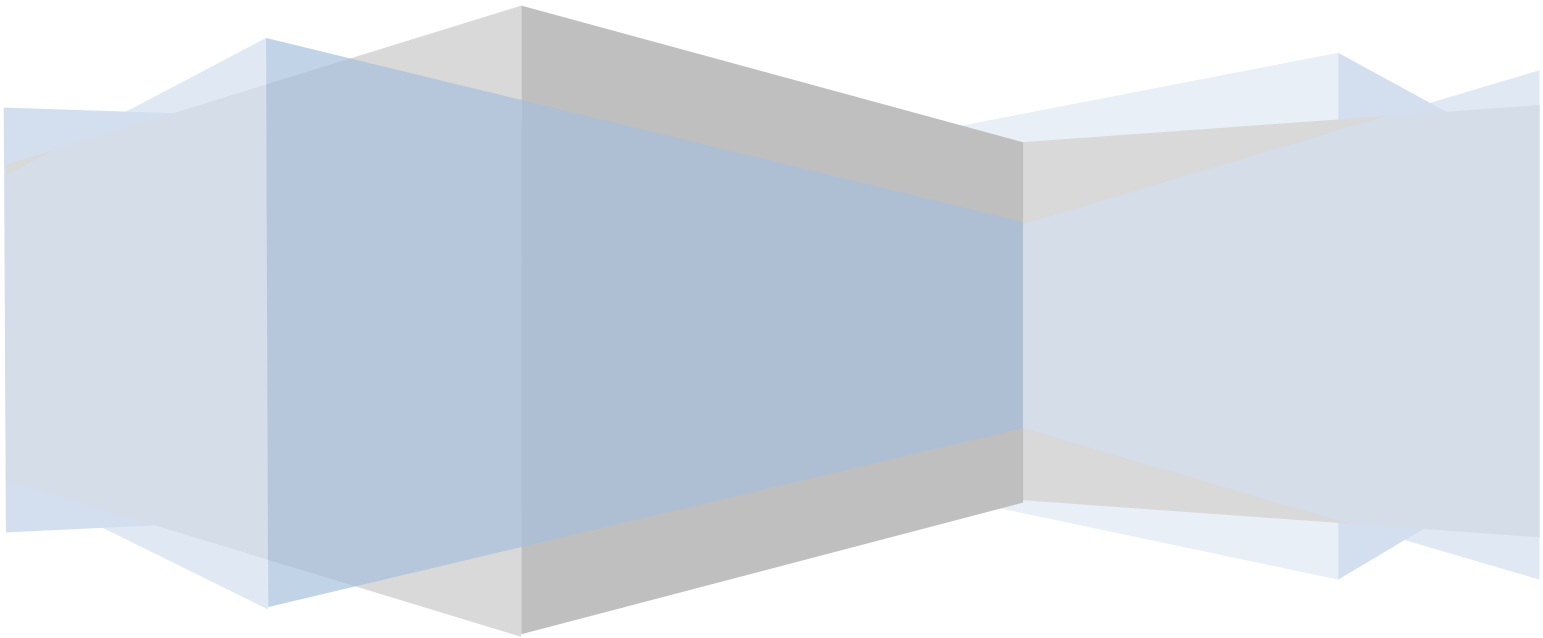
Steroid use: Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., prednisone, dexamethasone in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease.) Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

Substance Abuse Disorder: Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA. Documentation of Substance Abuse Disorder documented in the patient medical record, prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record. Exclude: Tobacco Use Disorder and Alcohol Use Disorder.

Diagnosis Notes

Data Element	Notes (Diagnosis)
Field Name	DX_MEMO
Field Type	Memo
Field Length	500
Note	Enter information in this area if you need to make a note about the Diagnosis data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section X: Outcome Data



Outcome: Initial Discharge

Discharge Status

Data Element	Separation Status
Field Name	DIS_STATUS
Field Type	Numeric
Field Length	1
Note	Enter the discharge status for all patients. 1. Alive 2. Dead
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Nursing Notes 3. Discharge Summary
History	N/A

Hospital Discharge Order Date

Data Element	Hospital Discharge Order Date (new NTDB data element as of 2016)
Field Name	DIS_O_DATE; DIS_O_EVENT
Field Type	Date
Field Length	2, 2, 4
Note	Enter the date the order was written for the patient to be discharged from the hospital (MM DD YYYY). If patient died after being admitted to hospital then please enter the date of death. If patient died in ED this field will become inactive and will be mapped to n/a for NTDB. If patient was discharged AMA from ward please enter the date they signed the AMA form. If no AMA form signed enter "?". Rehab patients? Enter the physical discharge date the patient was discharged / transferred to Rehab as per TQIP.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary still called hospital discharge date in NTDS – different from when patient actually left hospital.
Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
History	N/A

Hospital Discharge Order Time

Data Element	Hospital Discharge Order Time (new NTDB data element as of 2016)
Field Name	DIS_O_TIME; DIS_O_EVENT
Field Type	Numeric
Field Length	2, 2
Note	Enter the time the order was written for the patient to be discharged from the hospital in 24 hour time (HH:MM). If patient died after being admitted to hospital then please enter the time of death. If patient died in ED this field will become inactive and will be mapped to n/a for NTDB. If patient was discharged AMA from ward please enter the time they signed the AMA form. If no AMA form signed enter "?". Rehab patients? Enter the physical discharge time the patient was discharged / transferred to Rehab as per TQIP
ATR Required	Yes
NTDB Required	Yes – please see the definition in the current NTDB data dictionary still called hospital discharge date in NTDS – different from when patient actually left hospital
Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
History	N/A

Discharge/Death Date

Data Element	Discharge/Death Date
Field Name	DIS_DATE
Field Type	Date
Field Length	2, 2, 4
Note	Enter the patient's date of discharge (when they physically left the hospital) or death for all patients including those who died in ED (MM DD YYYY).
ATR Required	Yes
NTDB Required	No
Hierarchy	4. ED Record/Trauma Sheet 5. Nursing Notes/Flow Sheet 6. Discharge Summary
History	N/A

Discharge/Death Time

Data Element	Discharge/Death Time
Field Name	DIS_TIME
Field Type	Numeric
Field Length	2, 2
Note	Enter the patient's time of discharge (when they physically left the hospital) or death using the 24 - hour clock (HH:MM). Used to auto-generate calculated field hospital length of stay.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record/Trauma Sheet 2. Nursing Notes/Flow Sheet 3. Discharge Summary
History	N/A

ICU Days

Data Element	ICU Days (LOS)
Field Name	ICU_DAYS
Field Type	Numeric
Field Length	3
Note	This number will be carried over from the Patient Tracking: Location page. The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day. If any dates are missing then a LOS cannot be calculated. If a patient has multiple ICU visits in one day, this is counted as one calendar day ICU LOS should not exceed hospital LOS. "0" is used if patient had no ICU visits (mapped to "/" for NTDB submission).
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU flow sheet 2. Nursing notes/flow sheet
History	N/A

Total Ventilator Days

Data Element	Total Ventilator Days
Field Name	VENT_DAYS
Field Type	Numeric
Field Length	3
Note	This number will be carried over from the Patient Tracking: Ventilator page. The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day (this excludes mechanical ventilation time associated with OR procedures). Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator days. If any dates are missing then a LOS cannot be calculated. If a patient has multiple ICU visits in one day, this is counted as one calendar day. Total Vent days should not be greater that hospital LOS. "0" is used if patient was not on the ventilator during their hospital stay, this will be mapped to n/a for NTDB submission.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU Respiratory Therapy Flowsheet 2. ICU Nursing Flow Sheet 3. Physician's Daily Progress Notes 4. Calculate Based on Admission Form and Discharge Sheet
History	N/A

Total ICP Days

Data Element	Total ICP Days
Field Name	ICP_DAYS
Field Type	Numeric
Field Length	3
Note	Enter the number of ICP days at the trauma center. The cumulative amount of time ICP was monitored. Each partial or full day should be measured as one calendar day. Enter zero "0" if ICP monitoring is not used at the trauma center. • The calculation assumes that the date and time of starting and stopping an ICP monitoring episode are recorded in the patient's chart. • If any dates are missing then a Total ICP Days cannot be calculated. • At no time should the Total ICP Days exceed the Hospital LOS.
ATR Required	Yes
NTDB Required	No (only in TQIP section for Level 1 &2 adult centers) please see the definition in the current NTDB data dictionary
Hierarchy	1. ICU Nursing Flow Sheet 2. Nursing Notes 3. Physician's Progress Notes 4. Discharge Summary
History	N/A

Further Clarification:

Intracranial pressure is volume measurement of blood, brain tissue and cerebrospinal fluid within the skull. Each of the components has a relatively constant volume and each volume contributes to the overall ICP. ICP will increase whenever one or more of the contributing volume pressures increase. The normal range is 0 – 15 mm Hg (millimetres of Mercury).ICP monitoring is used to evaluate a head injury patient's response to therapy and may also be used as a treatment modality to vent CSF. ICP is measured by one of two major types of devices:

1) Subarachnoid bolt or screw, referred to as a Richmond bolt or screw, which is placed through the skull onto the surface of the brain,

2) Intraventricular or Camino catheter, which may have a fibre optic sensor in the catheter tip that is placed into the lateral ventricle of the brain on the patient's non dominant side. Both types of measuring devices are connected to transducers and recorders which will display both numerical values of ICP and corresponding waveforms.

Hospital Total Days

Data Element	Hospital Total Days
Field Name	HOSP_DAYS; HOSP_LOS; HOSP_LOS_MINS; HOSP_LOS_HRS
Field Type	Numeric
Field Length	3
Note	Length of stay at the trauma centre is a calculated field which will be displayed on the screen and is based on admission and discharge/death dates at the trauma centre. The day of admission is not counted in the calculation. The discharge date should be from your trauma centre only. A patient who is admitted and discharged on the same day will have a LOS of 1 day. A patient who is admitted on one day and discharged the next day will have a LOS of 1 day also.
ATR Required	Yes
NTDB Required	No
Hierarchy	N/A
History	N/A

Total # OR Visits

Data Element	Total # OR Visits
Field Name	OR_VISIT_CNT
Field Type	Numeric
Field Length	2
Note	Enter the number of OR visits (not procedures) at the trauma center. Only OR visits related to the injury or complications arising from the injury should be documented. Enter zero “0” if there were no OR visits.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED reports 2. OR reports 3. Nursing notes
History	N/A

Discharged To

Data Element	Discharged To
Field Name	DIS_DEST
Field Type	Integer
Field Length	2
Note	A patient's discharge to location is the place to which the patient is discharged or the services arranged for the patient immediately upon discharge from the trauma centre. If they died please enter #44, morgue even if they didn't go there (for NTDB submission). Option #40 (home) refers to the patient's current place of residence (i.e. hotel, prison, Child Protection Services if they were there before). Discharge to any other non-medical facility not listed below should be coded as routine discharge (for example, to a homeless shelter). For the full menu of discharge to locations please see below. The menu does not match the NTDB list but will be mapped accordingly. If a patient dies in ED this will be mapped to n/a but please fill out morgue for ATR reporting purposes.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Discharge Summary 2. Nursing Notes 3. Social Services Notes
History	N/A

Discharged To Menu Selection:

40	Home or Self-Care (routine discharge)
41	Home with Services
42	Left AMA
43	Correctional Facility/Court/Law Enforcement
44	Morgue
45	Child Protective Agency
70	Acute Care Facility
71	Intermediate Care Facility
72	Skilled Nursing Facility *(don't use, US designation only)*
73	Rehab (inpatient)
74	Long-term Care
75	Hospice
76	Mental Health/Psychiatric Hospital (inpatient)
77	Nursing Home
79	Another Type of Inpatient Facility Not Defined Elsewhere
?	Unknown

Clarifications:

Intermediate Care Facility (ICF): US designation for facilities for individuals with intellectual disabilities that provide comprehensive and individualized health care and rehabilitation services to promote their functional status and independence. For more information see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/institutional-care/intermediate-care-facilities-for-individuals-with-intellectual-disabilities-icfid.html

Skilled Nursing Facility: US determination, similar to inpatient rehab but with slightly less care by doctors, nurses, and rehab specialties. Please do not use this for our registry – use inpatient rehab.

Long-term care: In Alberta this would refer to supportive living facilities that combine accommodation services with other supports and care (such as meals, housekeeping, and social activities). They may also receive professional and personal support services through home care. These would be people who need assistance so they can't return home but not people with highly complex or serious health concerns. In Alberta, nursing homes would also be referred to as long term care but you should use option #77 if patients are discharged to a nursing home. Because this list comes from the US our terms do not match exactly. For more details see: http://www.health.alberta.ca/services/continuing-care-system.html

Hospice: also known as Palliative care, these facilities provide support and care to terminally ill patients and their families. For more information please see: http://www.thecareguide.com/index.php?/providerLists/setProvinceList/AB/HPC

Nursing Home (also auxiliary care): long-term care that provide accommodation, meals and housekeeping services as well health services for people with complex health needs who are unable to remain at home or in a supportive living facility. For more details see: http://www.health.alberta.ca/services/continuing-care-system.html or for a list of AB facilities check http://www.health.alberta.ca/documents/Nursing-Homes-Alberta-2015-04.pdf

Specify (Discharge To)

Data Element	Specify (Discharge To)
Field Name	DIS_DEST_S
Field Type	Character
Field Length	50
Note	If patient is being discharged to a specific institution or for specific services please enter the name of that facility as well as its general location/description here. You only need to enter this field if patient is being discharged to a medical facility or other institution. If patient is discharged home leave blank.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Discharge Summary 2. Nursing Notes 3. Social Services Notes
History	N/A

Wait time To Rehab

Data Element	Rehab Wait list Date Future data element
Field Name	
Field Type	Integer
Field Length	1
Note	This applies only to patients who are awaiting Rehab placement and wait listed. To clarity to the definition by Accreditation Canada, the ATS CLT determined that "ready for inpatient rehab" is determined by the following: 1. **For Level 3 Trauma Centers:** A notation/comment in the patient health record by the most responsible physician, in consultation with Allied Health and/or Transition Services, that the patient is waitlisted for inpatient rehab. 2. **For Level 1 and 2 (Adult and Pediatric):** A notation/comment in the patient health record by Physiatrist or Transition Services that the patient is waitlisted for inpatient rehab. Enter the date as MM DD YYYY 1. Yes 2. No Unknown Not applicable Peds – enter either "n/a" or auto populate in registry
ATR Required	Yes this data element is a Core Indicator for Accreditation
NTDB Required	No
Hierarchy	1. SCM 2. Progress Notes
History	N/A

Discharge to Alternate Caregiver

Data Element	Discharge To Alternate Caregiver
Field Name	DIS_TO_ALT_CGVR_YN
Field Type	Integer
Field Length	1
Note	This applies only to patients < 18 years of age who were sent home (alive) with someone besides their legal guardian due to suspected physical abuse (report of physical abuse checked 'Yes'). 3. Yes 4. No Unknown Not applicable-*(do not use, will be inactive if 3 conditions are not met and will be mapped to n/a for NTDB). Exception – can check n/a if rare case of emancipated minor.*
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	3. ED Record 4. Nursing Notes 5. Discharge Summary
History	N/A

Clarifications:

Only complete when Report of Physical Abuse is "Yes".

Only complete for minors as determined by local authority's definition (excluding emancipated minors).

Data element will be inactive if No Report of Physical Abuse (or if unknown), if person is older than the definition of minor, or if patient dies prior to discharge.

If Transferred, Facility

Data Element	If Transferred, Facility
Field Name	DIS_FACLNK; DIS_FACLNK_S
Field Type	Integer
Field Length	4
Note	If option #70, Acute Care Facility, was chosen for the "Discharged To" data element please select from the list which facility they were transferred to. This is the same list as referring facility. If you choose 'Other' from this menu please enter the acute care facility name in the 'If Other' text box.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Discharge Summary 2. Nurses' Notes
History	N/A

Primary Payor

Data Element	Primary Payor
Field Name	PAYOR01
Field Type	Integer
Field Length	2
Note	We do not enter this information in Canada. Defaulted to"?"
ATR Required	No
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Billing Sheet 2. Admission Form 3. Face Sheet
History	N/A

TQIP Section now called TDS

There is a separate tab called TDS with TQIP questions. This section will only be available for adult Level 1 and 2 sites, and this section must be filled out for all patients as of January 1, 2016. Click Ok at the bottom to save or Cancel if you want to start over.

TQIP: Core Questions

Exclude from TQIP Submission

Data Element	Exclude from TQIP Submission
Field Name	TQIP_WF_EXC_SUB_YN
Field Type	Integer
Field Length	1
Note	Please check **Yes** for all adult Level 1 and 2 **central site registry patients** (for both major and minor inclusion criteria). TQIP requires all sites to submit all patients that meet our registry inclusion criteria and TQIP will subset those patients as needed to fit analyses (these subsets will isolate more severely injured patients so the final subset may only include 30-50% of your submitted patients). Exclude patients with isolated Hangings, drownings and Hypothermia.
ATR Required	Yes
NTDB Required	Yes Required for TQIP submitting sites only starting with Jan 1, 2016 admissions; complete for all registry patients.
Hierarchy	N/A
History	N/A

Meets Head Injury Tracking Criteria

Data Element	Meets Head Injury Tracking Criteria
Field Name	TQIP_WF_MEETS_TBI
Field Type	Integer
Field Length	1
Note	Did the patient have at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and/or scalp avulsion(s)? 1. Yes 2. No ? Unknown If "No" is chosen then the ATR will fill out "/" automatically in the TBI screen. If you accidentally choose "No" then change it to Yes you will have to delete all the "/" answers and re-enter the appropriate answers.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes (TQIP required for adult Level 1 and 2 sites) please see the definition in the current NTDB data dictionary
Hierarchy	1. Autopsy/Medical Examiner Report 2. Operative Reports 3. Radiology Reports 4. Physician's Notes 5. Trauma Flow Sheet 6. History & Physical 7. Nursing Notes/Flow Sheet 8. Progress Notes 9. Discharge Summary
History	N/A

Meets Blood Products Collection Criteria

Data Element	Meets Blood Products Collection Criteria
Field Name	TQIP_WF_MEETS_BLOOD
Field Type	Integer
Field Length	1
Note	Did patient have any transfusion of packed red blood cells within the first 4 hours at the trauma center? 1. Yes 2. No ? Unknown If “No” is chosen then the ATR will fill out “/” automatically in the Blood Product screen. If you accidentally choose “No” then change it to Yes you will have to delete all the “/” answers and re-enter the appropriate answers.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes (TQIP required for adult Level 1 and 2 sites) please see the definition in the current NTDB data dictionary
Hierarchy	1. Trauma ED Sheet 2. Operative Reports 3. History & Physical 4. Nursing Notes/Flow Sheet 5. Progress Notes
History	N/A

Withdrawal of Life Supporting Treatment

Data Element	Withdrawal of Life Supporting Treatment
Field Name	TQIP_WDCARE_YN
Field Type	Integer
Field Length	1
Note	Treatment was withdrawn based on a medical decision to either remove or withhold further life sustaining intervention. This decision must be documented in the medical record and is often, but not always, associated with a discussion with the legal next of kin. A DNR is not a requirement.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Physician's Notes 2. Progress Notes 3. Case manager/Social Services Notes 4. Nursing Notes/Flow Sheet 5. Discharge Summary
History	N/A

Clarifications

A note to limit escalation of care qualifies as withdrawal of care. These interventions are limited to: ventilator support (with or without Extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-saving intervention (e.g. intubation).

Excludes: the discontinuation of CPR (typically involves prior planning)

DNR order is not the same as withdrawal of care.

Choose "No" for any patient whose time of death was prior to the removal of any interventions or escalation of care.

Withdrawal of Life Supporting Treatment Date

Data Element	Withdrawal of Life Supporting Treatment Date
Field Name	TQIP_WDCARE_DATE
Field Type	Date
Field Length	10
Note	If previous question is “Yes” please enter date from patient’s chart that withdrawal of care occurred on (MM/DD/YYYY). If the date is not in the chart enter “?”. If previous question is “No” or “?”, n/a will automatically be filled in by the program. Record the date the first of any existing life-sustaining intervention(s) is withdrawn (e.g. Extubation). If no interventions are in place, record the date the decision not to proceed with a life-saving intervention(s) occurs (e.g. intubation).
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Physician’s Notes 2. Progress Notes 3. Case manager/Social Services Notes 4. Nursing Notes/Flow Sheet 5. Discharge Summary
History	N/A

Withdrawal of Life Supporting Treatment Time

Data Element	Withdrawal of Life Supporting Treatment Time
Field Name	TQIP_WDCARE_TIME
Field Type	Time
Field Length	1
Note	If previous question is “Yes” please enter time from patient’s chart that withdrawal of care occurred on. If the time is not in the chart enter “?”. If the question Withdrawal of Care was answered as “No” or “?”, n/a will automatically be filled in by the program for time of withdrawal. Record the time (HH:MM) the first of any existing life-sustaining intervention(s) is withdrawn (e.g. extubation). If no interventions are in place, record the time the decision not to proceed with a life-saving intervention(s) occurs (e.g. intubation).
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Physician’s Notes 2. Progress Notes 3. Case manager/Social Services Notes 4. Nursing Notes/Flow Sheet 5. Discharge Summary
History	N/A

Meets Open Fracture Collection Criterion

Data Element	Meets open fracture collection criterion
Field Name	
Field Type	Collect on all patients with any open fracture(s) and or amputations.
Field Length	
Note	Intravenous antibiotic therapy was administered to the patient within 24 hours after first hospital encounter. 1. Yes 2. No 3. Not known
ATR Required	Not yet
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. ED notes 2. Medication Summary 3. Anesthesia Record 4. Nursing Notes 5. Pharmacy Record
History	N/A

Antibiotic Therapy

Data Element	Antibiotic Therapy
Field Name	
Field Type	Collect on all patients with any open fracture(s) and or amputations.
Field Length	
Note	1. Yes 2. No 3. Not applicable 4. Not known
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. ED notes 2. Medication Summary 3. Anesthesia Record 4. Nursing Notes 5. Pharmacy Record
History	N/A

Antibiotic Therapy

Data Element	Antibiotic Therapy Date
Field Name	
Field Type	Collect on all patients with any open fracture(s) and or amputations.
Field Length	
Note	The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	6. ED notes 7. Medication Summary 8. Anesthesia Record 9. Nursing Notes 10. Pharmacy Record
History	N/A

Antibiotic Therapy

Data Element	Antibiotic Therapy time
Field Name	
Field Type	Collect on all patients with any open fracture(s).
Field Length	
Note	The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.
ATR Required	Not yet
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. ED notes 2. Medication Summary 3. Anesthesia Record 4. Nursing Notes 5. Pharmacy Record
History	N/A

Venous Thromboembolism Prophylaxis Type

Data Element	Venous Thromboembolism Prophylaxis Type
Field Name	TQIP_VTEP_TYPE
Field Type	Integer
Field Length	Numeric
Note	If patient received VTE prophylaxis, what was the type of medication given for the 1st dose? Collect on all patients. 1. ~~Heparin~~ (unfractionated Heparin as per 2019 NTDB 5. None 6. LMWH (Dalteparin, Enoxaparin, etc.) 7. Direct Thrombin Inhibitor (Dabigatran, etc.) 8. Xa Inhibitor (Rivaroxaban, etc.) ~~9. Coumadin~~ (retired as per 2019 NTDB) 10. Other (Includes, Coumadin and Aspirin if they are reported as VTE) ? Unknown
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Medication Summary 2. Nursing Notes/Flow Sheet 3. Progress Notes 4. Pharmacy Record
History	N/A

Venous Thromboembolism Prophylaxis Date

Data Element	Venous Thromboembolism Prophylaxis Date
Field Name	TQIP_VTEP_DATE
Field Type	Date
Field Length	10
Note	Date (MM/DD/YYYY) of administration to patient of first prophylactic dose of heparin or other anticoagulant at your trauma center. If data element VTE Prophylaxis Type is “none” then date automatically becomes “n/a”.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Medication Summary 2. Nursing Notes/Flow Sheet 3. Progress Notes 4. Pharmacy Record
History	N/A

Venous Thromboembolism Prophylaxis Time

Data Element	Venous Thromboembolism Prophylaxis Time
Field Name	TQIP_VTEP_TIME
Field Type	Time
Field Length	5
Note	Time (HH:MM) of administration to patient of first prophylactic dose of heparin or other anticoagulant at your trauma center. If data element VTE Prophylaxis Type is “none” then time automatically becomes “n/a”.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Medication Summary 2. Nursing Notes/Flow Sheet 3. Progress Notes 4. Pharmacy Record
History	N/A

TQIP: TBI

Highest GCS Total

Data Element	Highest GCS Total **(no data element)**
Field Name	TQIP_HIGH_GCS
Field Type	Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).
Field Length	
Note	Highest recorded total GCS score calendar day after ED/Hospital arrival (trauma center arrival **not** referring facility). Highest Total GCS may be recorded after ED discharge (hospital admission) therefore careful review of all documentation is required. Range of values 3-15. If patient is intubated (paralytic drugs) verbal (motor) GCS will be 1. Score is best obtained when sedatives or paralytics are withheld as part of a sedation holiday. If patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as AAOx3 “awake, alert and oriented” or “patient with normal mental status” you may record a GCS of 15 IF there is no other contradicting documentation. “n/a” is used for patients who do not have a head injury and do not meet head injury tracking criteria.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Neuro Assessment Flow Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes
History	N/A

TQIP: TBI

Highest GCS Total within 24 Hours of Arrival

Data Element	Highest Total GCS Within 24 Hours of Arrival
Field Name	TQIP_HIGH_GCS
Field Type	Numeric
Field Length	2
Note	Highest recorded total GCS score calendar day of ED/Hospital arrival (trauma center arrival **not** referring facility). Highest Total GCS may be recorded after ED discharge (hospital admission) therefore careful review of all documentation is required. Range of values 3-15. If patient is intubated (paralytic drugs) verbal (motor) GCS will be 1. Score is best obtained when sedatives or paralytics are withheld as part of a sedation holiday. If patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as AAOx3 “awake, alert and oriented” or “patient with normal mental status” you may record a GCS of 15 IF there is no other contradicting documentation. “n/a” is used for patients who do not have a head injury and do not meet head injury tracking criteria.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	5. Neuro Assessment Flow Sheet 6. Triage/Trauma/ICU Flow Sheet 7. Nursing Notes/Flow Sheet 8. Progress Notes
History	N/A

Clarification: Example: Patient arrived on Jan 1st at 11:30pm total GCS=3 then on Jan 2nd at 01:00 am with GCS=6. Report GCS = 6 to TQIP

Highest GCS Motor

Data Element	Highest GCS Motor
Field Name	TQIP_HIGH_GCS_MR
Field Type	Numeric
Field Length	1
Note	Highest recorded GCS motor score on calendar day after ED/Hospital arrival (trauma center arrival **not** referring facility). Highest GCS motor may be recorded after ED discharge (hospital admission) therefore careful review of all documentation is required. "n/a" is used for patients who do not have a head injury and do not meet head injury tracking criteria. Choose the most appropriate response from the drop-down list (below). If patient is on paralytic drugs motor GCS will be 1. However, since this is the highest motor score within 24 hours, this score is best obtained when sedatives and/or paralytics are withheld as part of sedation holiday. If patient does not have a numeric GCS motor score recorded, but there is documentation relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus" a motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Neuro Assessment Flow Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes
History	N/A

Menu Selection for GCS Motor Scale:

1	No motor response
2	Extension to pain
3	Flexion to pain
4	Withdrawal from pain
5	Localizing pain
6	Obeys commands (Ped: appropriate response to stimulation)
?	Unknown

Associated GCS Qualifiers

Data Element	TQIP_HIGH_GCSQ01
Field Name	TQIP_HIGH_GCSQ01; TQIP_HIGH_GCSQ02; TQIP_HIGH_GCSQ03; TQIP_HIGH_GCSQS {list}
Field Type	Checkbox, integer list
Field Length	?
Note	Documentation of factors potentially affecting the highest GCS within 24 hours of ED/Hospital arrival. Highest Total GCS may be recorded after ED discharge (hospital admission) therefore careful review of all documentation is required. 1. Patient chemically sedated or paralyzed 2. Obstruction to the patient's eye 3. Patient intubated 4. Valid GCS (no sedatives, paralytics, intubation, or eye obstruction) Unknown Check all that apply. This refers to the highest GCS assessment qualifier score. "n/a" is used for patients who do not have a head injury and do not meet head injury tracking criteria. For more clarification regarding GCS qualifiers please see Section V (ED/Resus) pages.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. Neuro Assessment Flow Sheet 2. Triage/Trauma/ICU Flow Sheet 3. Nursing Notes/Flow Sheet 4. Progress Notes 5. Medication Summary
History	N/A

Clarifications:

This indicator does not apply to self-medication the patient may have administered (i.e. ETOH, prescriptions, etc.)

If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be checked.

Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, Rocuronium, (cis) atracurium, Vecuronium, or Pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record. Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given.

Highest GCS 40-Motor

Data Element	Highest GCS 40-Motor
Field Name	
Field Type	Numeric
Field Length	2
Note	Defined as the Highest GCS 40 motor on calendar day after ED/Hospital arrival. Please enter “unk”= Not known/Not recorded as per 2019 NTDB guidelines. We are currently not collecting this data field in Alberta.
ATR Required	Yes
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	
History	N/A

Initial ED/Hospital Pupillary Response

Data Element	Initial ED/Hospital Pupillary Response
Field Name	?
Field Type	Integer
Field Length	1
Note	First recorded physiological response of the pupil size **within 30 minutes or less** of ED/hospital arrival. Only collected for patients who meet head injury tracking criteria. 1. Both reactive 2. One reactive 3. Neither reactive / Not applicable (doesn't meet head tracking criteria) ? Unknown (info not documented, assessment unable to be completed due to facial trauma/foreign object in eye) First recorded vitals do not need to be from the same assessment. If a patient does not have a listed field value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" submit field value 1. If a patient has a prosthetic eye, field value 2 should be reported (unless it is not reactive then choose option 3).
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes please see the definition in the current NTDB data dictionary
Hierarchy	1. ED Nurses' Notes/Trauma Flow Sheet 2. Physician's Progress Notes 3. History & Physical
History	N/A

Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."

Cerebral Monitor Type

Data Element	Cerebral Monitor
Field Name	TQIP_CMON01; TQIP_CMON02; TQIP_CMON03; TQIP_CMON04; TQIP_CMONs {LIST}
Field Type	Checkbox, integer list
Field Length	?
Note	Indicate all cerebral monitors that were placed (check all that apply) from the following list: 1. Intraventricular drain/catheter (e.g. ventriculostomy, external ventricular drain (EVD)) 2. Intraparenchymal pressure monitor (e.g. Camino bolt, subarachnoid bolt, Intraparenchymal catheter) 3. Intraparenchymal oxygen monitor (e.g. licox monitor) 4. Jugular venous bulb' 5. None / Not applicable (doesn't meet head tracking criteria) ? Unknown (info not documented) Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI. A cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by the receiving trauma center to monitor this patient.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Procedure Notes 3. Triage/Trauma/ICU Flow Sheet 4. Nursing Notes/Flow Sheet 5. Progress Notes 6. Anesthesia Record
History	N/A

Cerebral Monitor Date

Data Element	Cerebral Monitor Date
Field Name	TQIP_CMON_DATE
Field Type	Date
Field Length	10
Note	Date of first cerebral monitor placement (MM/DD/YYYY). If the cerebral monitor was placed at a referring facility please record the date of insertion at the referring facility. n/a" is used for patients who do not meet head tracking (TBI) criteria or who did not have a cerebral monitor.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Procedure Notes 3. Triage/Trauma/ICU Flow Sheet 4. Nursing Notes/Flow Sheet 5. Progress Notes 6. Anesthesia Record
History	N/A

Cerebral Monitor Time

Data Element	Cerebral Monitor Time
Field Name	TQIP_CMON_TIME
Field Type	Time
Field Length	5
Note	Time of first cerebral monitor placement (HH:MM). If the cerebral monitor was placed at a referring facility please record the time of insertion at the referring facility. n/a" is used for patients who do not meet head tracking (TBI) criteria or who did not have a cerebral monitor.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Procedure Notes 3. Triage/Trauma/ICU Flow Sheet 4. Nursing Notes/Flow Sheet 5. Progress Notes 6. Anesthesia Record
History	N/A

Midline Shift

Data Element	Midline Shift
Field Name	?
Field Type	Integer
Field Length	1
Note	Occurs when there is a >5mm shift of the brain past its centre line within 24 hours after time of injury. Only collected for patients who meet head injury tracking criteria. Choose from the following options: 1. Yes 2. No 3. Not Imaged (e.g. CT scan, MRI not done within 24 hours from **time of injury**) / Not applicable (doesn't meet head tracking criteria) ? Unknown (info not documented, **OR** injury date/time unknown) If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, choose option 1 "Yes". Radiological and surgical documentation from transferring facilities should be considered for this data field. If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the field value "1. Yes" IF there is no other contradicting documentation.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Radiology Reports 2. OP Report 3. Physician's Progress Notes 4. Nursing Notes 5. Discharge Summary
History	N/A

TQIP: Blood Products

Transfusion Blood (4 Hours)

Data Element	Transfusion Blood (4 Hours)
Field Name	TQIP_BLOOD_4H
Field Type	Numeric
Field Length	5
Note	Collect on all patients. Record the volume of packed red blood cells transfused (units or CCs) within the first 4 hours after trauma centre ED/Hospital arrival. If no blood transfused please enter 0. If meets blood tracking criteria is "No" then '0' will automatically be filled out for this data field (and all subsequent data fields will be '/'). If packed red blood cells are transfusing upon patient arrival, count as 1-unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site). Must also complete the next 2 fields if not 0 (Transfusion Blood Measurement and Transfusion Blood Conversion).
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow Sheet 5. Blood Bank
History	N/A

~~Transfusion Blood (24 Hours)~~

~~Data Element~~	~~Transfusion Blood (24 Hours)~~ **Stop collecting as of Jan 01 2019 admissions**
~~Field Name~~	~~TQIP_BLOOD_24H~~
~~Field Type~~	~~Numeric~~
~~Field Length~~	~~5~~
~~Note~~	~~Record the cumulative volume of packed red blood cells transfused (units or CCs) within the first 24 hours after trauma centre ED/Hospital arrival. If blood was only transfused in first 4 hours then the amount is the same for 24 hours. If patients do not meet blood tracking criteria) "/' will automatically be filled out for all fields.~~ ~~If packed red blood cells are transfusing upon patient arrival, count as 1-unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site).~~ ~~Must also complete the next 2 fields if not '/' (Transfusion Blood Measurement and Transfusion Blood Conversion).~~
~~ATR Required~~	~~Yes~~
~~NTDB Required~~	~~Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary~~
~~Hierarchy~~	~~1. Trauma Flow Sheet~~ ~~2. Anesthesia Report~~ ~~3. Operative Report~~ ~~4. Nursing Notes/Flow Sheet~~ ~~5. Blood Bank~~
~~History~~	~~N/A~~

Transfusion Blood Measurement

Data Element	Transfusion Blood Measurement
Field Name	TQIP_BLOOD_MEAS
Field Type	Integer
Field Length	1
Note	The measurement used to document the patient's blood transfusion (Units, CCs, [MLs]). 1. Units 2. CCs (MLs) Must complete if fields Transfusion Blood (4 and 24 hours) are valued. Must also complete the next field (Transfusion Blood Conversion). "/" is used if patients do not meet blood tracking criteria or if no packed red blood cells were transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Transfusion Blood Conversion

Data Element	Transfusion Blood Conversion
Field Name	TQIP_BLOOD_CONV
Field Type	Numeric
Field Length	3
Note	The quantity of CCs [MLs] constituting a 'unit' for blood transfusions at your hospital. Must complete if fields Transfusion Blood (4 and 24 hours) and Transfusion Blood Measurement are valued. "/" is used if patients do not meet blood tracking criteria, if you are reporting transfusion blood measurement in CCs, or if no packed red blood cells were transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Transfusion Plasma (4 Hours)

Data Element	Transfusion Plasma (4 Hours)
Field Name	TQIP_PLASMA_4H
Field Type	Numeric
Field Length	5
Note	Record the volume of fresh frozen or thawed plasma transfused (units or CCs) within the first 4 hours after trauma centre ED/Hospital arrival. If no plasma is transfused please enter '/'. Value will automatically be '/' if no packed red blood cells transfused. If plasma is transfusing upon patient arrival, count as 1-unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site). Must also complete the next 2 fields if not '/' (Transfusion Plasma Measurement and Transfusion Plasma Conversion).
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow Sheet 5. Blood Bank
History	N/A

~~Transfusion Plasma (24 Hours)~~

~~Data Element~~	~~Transfusion Plasma (24 Hours)~~ **Stop collecting as of Jan 01 2019**
~~Field Name~~	~~TQIP_PLASMA_24H~~
~~Field Type~~	~~Numeric~~
~~Field Length~~	~~5~~
~~Note~~	~~Record the cumulative volume of fresh frozen or thawed plasma transfused (units or CCs) within the first 24 hours after trauma centre ED/Hospital arrival. If plasma was only transfused in first 4 hours then the amount is the same for 24 hours. If no plasma is transfused please enter '/'.~~ ~~If plasma is transfusing upon patient arrival, count as 1 unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site).~~ ~~Must also complete the next 2 fields if not '/' (Transfusion Plasma Measurement and Transfusion Plasma Conversion).~~
~~ATR Required~~	~~Yes~~
~~NTDB Required~~	~~Yes required for adult Level 1 and 2 sites- please see the definition in the current NTDB data dictionary~~
~~Hierarchy~~	~~1. Trauma Flow Sheet~~ ~~2. Anesthesia Report~~ ~~3. Operative Report~~ ~~4. Nursing Notes/Flow Sheet~~ ~~5. Blood Bank~~
~~History~~	~~N/A~~

Clarification: This field will be disabled in the ATR.

Transfusion Plasma Measurement

Data Element	Transfusion Plasma Measurement
Field Name	TQIP_PLASMA_MEAS
Field Type	Integer
Field Length	1
Note	The measurement used to document the patient's plasma transfusion (Units, CCs, [MLs]). 1. Units 2. CCs (MLs) Must complete if fields Transfusion Plasma (4 and 24 hours) are valued. Must also complete the next field (Transfusion Plasma Conversion). "/" is used if patients do not meet blood tracking criteria or if no plasma was transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Transfusion Plasma Conversion

Data Element	Transfusion Plasma Conversion
Field Name	TQIP_PLASMA_CONV
Field Type	Numeric
Field Length	3
Note	The quantity of CCs [MLs] constituting a 'unit' for plasma transfusions at your hospital. Must complete if fields Transfusion Plasma (4 and 24 hours) and Transfusion Plasma Measurement are valued. "/" is used if patients do not meet blood tracking criteria, if you are reporting transfusion plasma measurement in CCs, or if no plasma was transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Transfusion Platelets (4 Hours)

Data Element	Transfusion Platelets (4 Hours)
Field Name	TQIP_PLATE_4H
Field Type	Numeric
Field Length	5
Note	Record the volume of platelets transfused (units or CCs) within the first 4 hours after trauma centre ED/Hospital arrival. If no platelets are transfused please enter '/'. Value will automatically be '/' if no packed red blood cells transfused. If platelets are transfusing upon patient arrival, count as 1-unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site). Must also complete the fields if not 0 (Transfusion Platelets Measurement and Transfusion Platelets Conversion).
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow Sheet 5. Blood Bank
History	N/A

~~Transfusion Platelets (24 Hours)~~

~~Data Element~~	~~Transfusion Platelets (24 Hours)~~ **Stop collecting as of Jan 01 2019**
~~Field Name~~	~~TQIP_PLATE_24H~~
~~Field Type~~	~~Numeric~~
~~Field Length~~	~~5~~
~~Note~~	~~Record the volume of platelets transfused (units or CCs) within the first 24 hours after trauma centre ED/Hospital arrival. If platelets were only transfused in first 4 hours then the amount is the same for 24 hours. If no platelets are transfused please enter '/'.~~ ~~If platelets are transfusing upon patient arrival, count as 1 unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site).~~ ~~Must also complete the next 2 fields if not '/' (Transfusion Platelets Measurement and Transfusion Platelets Conversion).~~
~~ATR Required~~	~~Yes~~
~~NTDB Required~~	~~Yes required for adult Level 1 and 2 sites- please see the definition in the current NTDB data dictionary~~
~~Hierarchy~~	~~1. Trauma Flow Sheet~~ ~~2. Anesthesia Report~~ ~~3. Operative Report~~ ~~4. Nursing Notes/Flow Sheet~~ ~~5. Blood Bank~~
~~History~~	~~N/A~~

Clarification: This field will be disabled in the ATR.

Transfusion Platelets Measurement

Data Element	Transfusion Platelets Measurement
Field Name	TQIP_PLATE_MEAS
Field Type	Integer
Field Length	1
Note	The measurement used to document the patient's platelets transfusion (Units, CCs, [MLs]). 1. Units 2. CCs (MLs) Must complete if fields Transfusion Platelets (4 and 24 hours) are valued. Must also complete the next field (Transfusion Platelets Conversion). "/" is used if patients do not meet blood tracking criteria or if no platelets were transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Transfusion Platelets Conversion

Data Element	Transfusion Platelets Conversion
Field Name	TQIP_PLATE_CONV
Field Type	Numeric
Field Length	3
Note	The quantity of CCs [MLs] constituting a 'unit' for platelets transfusions at your hospital. Must complete if fields Transfusion Platelets (4 and 24 hours) and Transfusion Platelets Measurement are valued. "/" is used if patients do not meet blood tracking criteria, if you are reporting transfusion platelets measurement in CCs, or if no platelets were transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Cryoprecipitate (4 Hours)

Data Element	Cryoprecipitate (4 Hours)
Field Name	TQIP_CRYO_4H
Field Type	Numeric
Field Length	5
Note	Record the volume of solution enriched with clotting factors transfused (units or CCs) within the first 4 hours after trauma centre ED/Hospital arrival. If no cryoprecipitate is transfused please enter '/'. Value will automatically be '/' if no packed red blood cells transfused. If cryoprecipitate is transfusing upon patient arrival, count as 1-unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site). Must also complete the next 2 fields if not 0 (Transfusion Cryoprecipitate Measurement and Transfusion Cryoprecipitate Conversion).
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Trauma Flow Sheet 2. Anesthesia Report 3. Operative Report 4. Nursing Notes/Flow Sheet 5. Blood Bank
History	N/A

~~Cryoprecipitate (24 Hours)~~

~~Data Element~~	~~Cryoprecipitate (24 Hours)~~**Stop collecting as of Jan 01 2019**
~~Field Name~~	~~TQIP_CRYO_24H~~
~~Field Type~~	~~Numeric~~
~~Field Length~~	~~5~~
~~Note~~	~~Record the cumulative volume of solution enriched with clotting factors transfused (units or CCs) within the first 24 hours after trauma centre ED/Hospital arrival. If cryoprecipitate was only transfused in first 4 hours then the amount is the same for 24 hours. If no cryoprecipitate was transfused please enter '/'.~~ ~~If cryoprecipitate are transfusing upon patient arrival, count as 1-unit (or if reporting CCs, report the amount of CCs transfused upon arrival at your site).~~ ~~Must also complete the next 2 fields if not '/' (Transfusion Cryoprecipitate Measurement and Transfusion Cryoprecipitate Conversion).~~
~~ATR Required~~	~~Yes~~
~~NTDB Required~~	~~Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary~~
~~Hierarchy~~	~~1. Trauma Flow Sheet~~ ~~2. Anesthesia Report~~ ~~3. Operative Report~~ ~~4. Nursing Notes/Flow Sheet~~ ~~5. Blood Bank~~
~~History~~	~~N/A~~

Clarification: This field will be disabled in the ATR.

Cryoprecipitate Measurement

Data Element	Cryoprecipitate Measurement
Field Name	TQIP_CRYO_MEAS
Field Type	Integer
Field Length	1
Note	The measurement used to document the patient's cryoprecipitate transfusion (Units, CCs, [MLs]). 1. Units 2. CCs (MLs) Must complete if fields Cryoprecipitate (4 and 24 hours) are valued. Must also complete the next field (Transfusion Cryoprecipitate Conversion). "/" is used if patients do not meet collection criteria or if no cryoprecipitate was transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

Cryoprecipitate Conversion

Data Element	Cryoprecipitate Conversion
Field Name	TQIP_CRYO_CONV
Field Type	Numeric
Field Length	3
Note	The quantity of CCs [MLs] constituting a 'unit' for cryoprecipitate transfusions at your hospital. Must complete if fields Cryoprecipitate (4 and 24 hours) and Cryoprecipitate Measurement are valued. "/" is used if patients do not meet collection criteria, if you are reporting cryoprecipitate measurement in CCs, or if no cryoprecipitate was transfused.
ATR Required	Yes
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Blood Bank
History	N/A

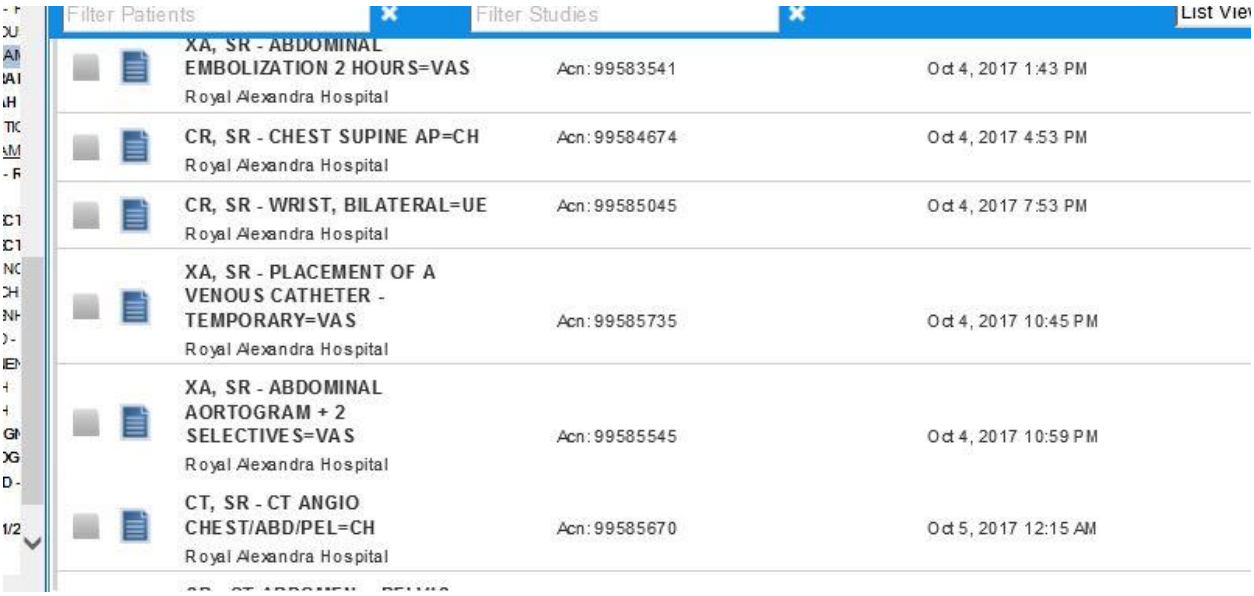
Lowest ED SBP

Data Element	Lowest ED SBP
Field Name	TQIP_LOW_SBP
Field Type	Numeric
Field Length	3
Note	Lowest sustained (>5 min) systolic blood pressure measured **within the first hour** of ED/hospital arrival. '/' is used for patients who do not meet the blood tracking criteria.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Triage/Trauma/ICU Flow Sheet 2. Operative Reports 3. Nursing Notes/Flow Sheet
History	N/A

Angiography

Data Element	Angiography
Field Name	TQIP_ANGIO_TYPE
Field Type	Integer
Field Length	1
Note	Collect only for all patients with transfused packed red blood cells within the first 4 hours after ED/hospital arrival. First interventional angiogram with or without embolization within first 24 hours of ED/Hospital arrival (don't collect data on angiograms > 24 hours after trauma center arrival). 1. None 2. Angiogram only 3. Angiogram with embolization 4. Angiogram with stenting (as per NTDB 2019)- only report if angiogram stenting was done for hemorrhage control. / Not applicable (patient doesn't meet blood tracking criteria) ? Unknown (info not documented) Excludes CTA.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
History	N/A

Example of Ct Angiogram, CT embolization and CT Aortogram in Netcare


Filter Patients
Filter Studies
XA, SR - ABDOMINAL EMBOLIZATION 2 HOURS=VAS
Acn: 99583541
Oct 4, 2017 1:43 PM
Royal Alexandra Hospital
CR, SR - CHEST SUPINE AP=CH
Acn: 99584674
Oct 4, 2017 4:53 PM
Royal Alexandra Hospital
CR, SR - WRIST, BILATERAL=UE
Acn: 99585045
Oct 4, 2017 7:53 PM
Royal Alexandra Hospital
XA, SR - PLACEMENT OF A VENOUS CATHETER - TEMPORARY=VAS
Acn: 99585735
Oct 4, 2017 10:45 PM
Royal Alexandra Hospital
XA, SR - ABDOMINAL AORTOGRAM + 2 SELECTIVES=VAS
Acn: 99585545
Oct 4, 2017 10:59 PM
Royal Alexandra Hospital
CT, SR - CT ANGIO CHEST/ABD/PEL=CH
Acn: 99585670
Oct 5, 2017 12:15 AM
Royal Alexandra Hospital

Angiography Date

Data Element	Angiography Date
Field Name	TQIP_ANGIO_DATE
Field Type	Date
Field Length	10
Note	Date the first angiogram with or without embolization was performed at the trauma centre (MM/DD/YYYY). '/' is used if the data field Angiography is "None" or if patients do not meet the collection criteria.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
History	N/A

Angiography Time

Data Element	Angiography Time
Field Name	TQIP_ANGIO_TIME
Field Type	Time
Field Length	5
Note	Time the first angiogram with or without embolization was performed at the trauma centre (HH:MM). '/' is used if the data field Angiography is "None" or if patients do not meet the collection criteria.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
History	N/A

Embolization Site

Data Element	Embolization Site
Field Name	TQIP_ANGIO_ES01; TQIP_ANGIO_ES02; TQIP_ANGIO_ES03; TQIP_ANGIO_ES04; TQIP_ANGIO_ES05; TQIP_ANGIO_ES06; TQIP_ANGIO_ES07; TQIP_ANGIO_ES08; TQIP_ANGIO_ES0s {LIST}
Field Type	Checkbox, integer list
Field Length	?
Note	Collect on all patients with transfused packed red blood cells within the first 4 hours after ED/hospital arrival. Check all that apply; organ/site of embolization for hemorrhage control. 1. Liver 2. Spleen 3. Kidneys 4. Pelvic (iliac, gluteal, obturator) 5. Retroperitoneum (lumbar, sacral) 6. Peripheral vascular (neck, extremities) 7. Aorta (thoracic or abdominal) 8. Other / Not applicable (angiography is 1. None or 2. Angiogram Only OR if patient doesn't meet blood tracking criteria) ? Unknown (info not documented)
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Radiology Reports 2. Operative Reports 3. Progress Notes
History	N/A

Surgery for Hemorrhage Control Type

Data Element	Surgery for Hemorrhage Control Type
Field Name	TQIP_HCS_TYPE
Field Type	Integer
Field Length	1
Note	First type of surgery for hemorrhage control within the first 24 hours of ED/Hospital arrival. Will be '/' if patient did not receive packed red blood cells in the first 4 hours after ED arrival. 1. None 2. Laparotomy 3. Thoracotomy 4. Sternotomy 5. Extremity 6. Neck 7. Mangled extremity/traumatic amputation 8. Other skin/soft tissue 9. Extraperitoneal Pelvic Packing / Not applicable (patient doesn't meet collection criteria) ? Unknown (missing documentation) If unclear if surgery was for hemorrhage control, then consult your site coordinator or operating/consulting/relevant surgeon.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Procedure Notes 3. Progress Notes
History	N/A

Surgery for Hemorrhage Control Date

Data Element	Surgery for Hemorrhage Control Date
Field Name	TQIP_HCS_DATE
Field Type	Date
Field Length	10
Note	Date of first surgery for hemorrhage control within 24 hours of ED/Hospital arrival performed at the trauma centre (MM/DD/YYYY). '/' is used if the data field Surgery for Hemorrhage Control is "None" or if patients do not meet the collection criteria. If unclear if surgery was for hemorrhage control, then consult you site coordinator or operating/consulting/relevant surgeon.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Procedure Notes 3. Progress Notes
History	N/A

Surgery for Hemorrhage Control Time

Data Element	Surgery for Hemorrhage Control Time
Field Name	TQIP_HCS_TIME
Field Type	Time
Field Length	5
Note	Time of first surgery for hemorrhage control within 24 hours of ED/Hospital arrival performed at the trauma centre (HH:MM). '/' is used if the data field Surgery for Hemorrhage Control is "None" or if patients do not meet the collection criteria. If unclear if surgery was for hemorrhage control, then consult you site coordinator or operating/consulting/relevant surgeon.
ATR Required	Yes (for adult Level 1 and 2 sites)
NTDB Required	Yes required for adult Level 1 and 2 sites please see the definition in the current NTDB data dictionary
Hierarchy	1. Operative Reports 2. Procedure Notes 3. Progress Notes
History	N/A

Outcome: If Death

Location (of Death)

Data Element	Location (of Death)
Field Name	DTH_LOC
Field Type	Integer
Field Length	2
Note	Choose from the drop down list the location of the patient's death at the trauma centre. 1. Resuscitation Room 2. Emergency Department 3. OR (Recovery Room) 4. ICU 5. Step-Down Unit 6. Floor 7. Telemetry Unit 8. Observation Unit 9. Burn Unit 10. Radiology 11. Post-Anaesthesia Care Unit 12. Special Procedure Unit 13. Labour and Delivery 14. Neonatal/Paediatric Care Unit 15. Other Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Nursing Notes 3. Discharge Summary
History	N/A

If Other Location (of Death)

Data Element	If Other (Location of Death)
Field Name	DTH_LOC_S
Field Type	Character
Field Length	50
Note	Specify if 'other' entered in the previous field. This field will be skipped unless 'other' was entered in the previous field.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. ED Record 2. Nursing Notes 3. Discharge Summary
History	N/A

Was the Medical Examiner Notified?

Data Element	Was medical examiner notified?
Field Name	DIS_ME_YN
Field Type	Integer
Field Length	1
Note	Was the Medical Examiner notified of the patient's death? 1. Yes (should be checked most of the time “acceded”) 2. No (older people sometimes go directly to funeral home) Unknown ~~Not applicable~~
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Autopsy Report 2. ED Record 3. Nursing Notes 4. Discharge Summary
History	N/A

Was Post Mortem Done?

Data Element	Was post mortem done?
Field Name	AUT_YN
Field Type	Integer
Field Length	1
Note	Was a Post Mortem examination done? This refers to a full autopsy not just an external autopsy. 1. Yes 2. No Unknown Not applicable
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Autopsy Report 2. ED Record 3. Nursing Notes 4. Discharge Summary
History	N/A

Was Post Mortem Report Received?

Data Element	Was post mortem report received?
Field Name	AUT_RESRC_YN
Field Type	Integer
Field Length	1
Note	Was a Post Mortem report received (if post mortem done)? 1. Yes 2. No Unknown Not applicable (if previous question is 2. No)
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Autopsy Report 2. ED Record 3. Nursing Notes 4. Discharge Summary
History	N/A

Was Organ Donation Requested?

Data Element	Was organ donation requested?
Field Name	ORG_STAT_YN
Field Type	Integer
Field Length	1
Note	Was the patient or patient's family asked about organ or tissue donation? 1. Yes 2. No Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Organ donation form 2. Nurses' notes
History	N/A

Was Request Granted?

Data Element	Was request granted? (Were organs donated?)
Field Name	ORG_GR_YN
Field Type	Integer
Field Length	1
Note	Was the patient an organ or tissue donor? This field will be skipped unless 'yes' was entered in the previous field. 1. Yes 2. No Unknown
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Organ donation form 2. Nurses' notes
History	N/A

Organs Procured (Donated)

Data Element	Organs Procured (Donated)
Field Name	ORG_DNR01 (up to 20); ORG_DNRS_L {list}
Field Type	Integer
Field Length	2
Note	Specify up to 20 organs or tissues procured from the patient. 0. None (used if organ donation permission was granted but no organs procured for some other reason). 1. Adrenal Glands 2. Bone 3. Bone Marrow 4. Cartilage 5. Cornea / Eye Tissues 6. Dura Mater 7. Fascialata 8. Heart 9. Heart & Valves 10. Intestine 11. Kidney 12. Liver 13. Lungs 14. Nerves 15. Pancreas 16. Skin 17. Stomach 18. Tendons 19. Whole eyes 20. Other Unknown If Other, please specify what was donated in the text area provided. Separate by, if more than one 'other'.
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Organ donation form 2. Nurses' notes
History	N/A

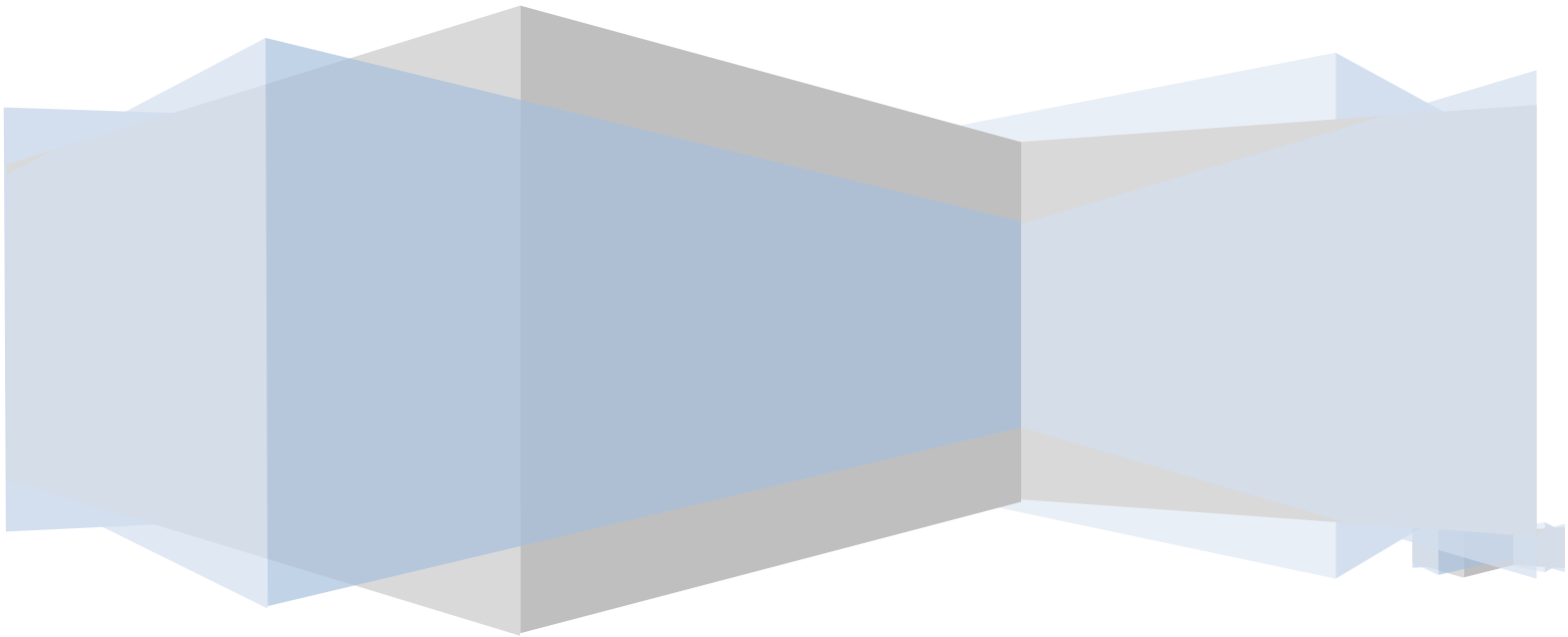
HOPE Involvement?

Data Element	HOPE Involvement
Field Name	OUTQ_TYPE01
Field Type	Integer
Field Length	1
Note	Was HOPE involved? This field will be skipped unless 'yes' was entered in the previous field (request granted). 1. Yes 2. No Unknown ~~Not applicable~~
ATR Required	Yes
NTDB Required	No
Hierarchy	1. Organ donation form 2. Nurses' notes
History	N/A

Outcome Notes

Data Element	Outcome Notes
Field Name	DIS_MEMO
Field Type	Character
Field Length	500
Note	Enter information in this area if you need to make a note about the Diagnosis data entry that you, or another analyst, may need to refer back to at a later date.
ATR Required	No
NTDB Required	No
Hierarchy	N/A
History	N/A

Section XI: QA Tracking



QA Tracking: QA Items

This sub-tab consists of the audit filters, site specific indicator questions, and NTDB complication list to be filled out. Please fill them all out in the order that they appear!

Audit Filter Questions

Data Element	Audit Filter Questions
Field Name	?
Field Type	Integer
Field Length	1
Note	When you click the "Audit Filter" button a list of 2 questions pops up. Options to answer each audit filter question are: 1. Yes 2. No Unknown Not applicable Standardized methods for answering each question can be found below. You can edit each line with an occurrence date (if applicable, for example, if you answered 'Yes' the patient had an unplanned return to the OR you can enter the OR date). You can also edit each audit filter line if there is QA tracking being done (Trauma Coordinators) and notes about that specific audit filter (why it is being tracked, if it was resolved, etc.) All audit filter questions must be answered for each patient (the first 2 lines in the table should be your audit filter questions).
ATR Required	Yes
NTDB Required	No
Hierarchy	1. EMS records 2. ED records 3. Trauma Sheet 4. Nursing Notes 5. Physician Progress Notes 6. ICU Forms 7. OR reports 8. Discharge Summary
History	ATR 2015: Revised pop up menu

Further Clarification: Audit Filters

Question 1: For all patients with prehospital care provider(s), are all prehospital ambulance reports from all phases of patient transport on the medical record (paper copy in chart? For out of province reports we are not expected to have/track down these prehospital records.

Yes	No	Unknown**	Not applicable
All ambulance reports are with the patient chart.	The ambulance reports are missing (stay missing or have to be tracked down).	You don't have all the information on prehospital ambulance care therefore you don't know if anything is missing. Unknown mode of transport.	This patient did not arrive by ambulance or was injured as an inpatient.

Question 2: For all patients with an acute epidural or subdural hematoma, was a craniotomy or burr procedure completed in the operating room more than 4 hrs after arrival in the **ED?**

Yes	No	Unknown**	Not applicable
Patient with an acute epidural or subdural hematoma had a craniotomy or burr hole that was performed in the OR **> 4 hrs after arrival in the ED.**	Patient with an acute epidural or subdural hematoma had a craniotomy or burr hole that was performed in the OR **≤ 4 hrs after arrival in the ED**.	There is no operating information in the chart (missing information).	This patient did not have an **acute** epidural or subdural hematoma (epidural chronic or sub-acute). OR neurosurgery has indicated that no operative intervention is needed or delay of > 4 hrs is appropriate.

Questions 3-16 are no longer collected as per decision of data subcommittee.

****With any of the unknowns due to missing information if that information later becomes available (is found, returned, etc.) these questions will need to be updated for that patient.**

Hospital Events (now in QA tracking)

Data Element	Hospital Events (Complications)
Field Name	FLT_TYPES=4, FLT_CODES
Field Type	Integer
Field Length	2
Note	From the NTDB button a pop-up menu will appear; check all complications that apply. Enter hospital on the speed form. If a hospital event does not exist, no further data entry is required. For ACS reporting purposes, a response of No will be assumed and reported If you are uncertain about a definition of a complication please refer to Appendix 3 in the NTDB data dictionary (page A3.4) (descriptions are too lengthy to include) or the NTDB complications presentations on the SharePoint site. For all hospital complications that follow the CDC definition [e.g., VAP, CAUTI, CLABSI, Osteomyelitis] always use the most recent definition provided by the CDC. The date box at the bottom is the date of QA tracking (trauma coordinators) and is not for the data analysts to enter. Please leave it blank.
ATR Required	Yes
NTDB Required	Yes (NTDB NTDS Data Dictionary 2017 – Page 105 and A3.4)
Hierarchy	1. Physician notes 2. Operative reports 3. Progress notes 4. Radiology reports 5. Respiratory Notes 6. Lab Reports 7. Nursing Notes 8. Discharge Summary
History	ATR 2017: Revised pop up menu

Please see changes to complications in the change log of the current NTDB data dictionary.

NTDB Complications List Selection:

4	Acute Kidney Injury
5	Acute Respiratory Distress Syndrome (ARDS)
36	Alcohol Withdrawal Syndrome (NEW 2017)
8	Cardiac Arrest with CPR
33	Catheter Associated Urinary Tract Infection (CAUTI)
34	Central Line Associated Bloodstream Infection (CLABSI)
11	~~Decubitus Ulcer~~ (Retired 2017)
12	Deep Surgical Site Infection
13	~~Drug or Alcohol Withdrawal Syndrome~~ (Retired 2017)
14	Deep Vein Thrombosis (DVT)/thrombophlebitis
15	Extremity Compartment Syndrome
18	Myocardial Infarction
19	Organ/Space Surgical Site Infection
29	Osteomyelitis
37	Pressure Ulcer (NEW 2017)
21	Pulmonary Embolism
32	Severe Sepsis
22	Stroke/CVA
38	Superficial Incisional Surgical Site Infection (NEW 2017)
23	~~Superficial Surgical Site Infection~~ (Retired 2017)
25	Unplanned Intubation
31	Unplanned Admission to the ICU
30	Unplanned Return to the OR
35	Ventilator Associated Pneumonia
1	Other **Retired as of Jan 01 2019 admissions**
2	Abdominal Compartment Syndrome (retired 2011)**
3	Abdominal fascia left open (retired 2011)
6	Base Deficit (retired 2011)
7	Bleeding (retired 2011)
9	Coagulopathy (retired 2011)**
10	Coma (retired 2011)
17	Intracranial pressure (retired 2011)
24	Systemic Sepsis (retired 2011)**
26	Wound Disruption (retired 2011)
28	Catheter-Related Blood Stream Infection (retired 2016)
16	Graft/Prosthesis/Flap Failure (retired 2016)**
20	Pneumonia (retired 2016)**
27	Urinary Tract Infection (retired 2016)**

Site Indicators

Updated for 2017: each site will now have their own section of indicator questions (button) which they can press to answer their site specific indicators. A pop up screen will appear and you will have to hit the 'Trigger' button which will load you questions. You will be able to answer these questions the same way as the Audit Filter questions (a check box beside each question with "yes, no, / or?" Please do not click the old "Filters" button as this is the old system that we do not use.

In addition, we have limited rows in the table for audit filters, NTDB complications and indicator questions – we are limited for now to 50 rows. If you have over 30 indicator questions please consider removing some. Also any indicator question that can be pulled directly from the ATR should be removed as it is just extra data being entered that we do not need.

ACH Site Indicator Questions: Last revised April, 2015

1. Utilization of ACH Transport team for transfer?

Yes	No	Unknown**	Not applicable

2. Hypothermic in the ED (< 35.0 C)?

Yes	No	Unknown**	Not applicable

3. Femur fracture to the OR within 24 hours from TCA?

Yes	No	Unknown**	Not applicable

4. Open long bone fracture to the OR within 6-12 hours from TCA (depending on the severity of the #?)

Yes	No	Unknown**	Not applicable

5. Definitive treatment of displaced acetabular fracture > 7 days from TCA?

Yes	No	Unknown**	Not applicable

6. If the patient had a GCS < 13 (measured at the trauma center), was the CT head performed within 4 hours of arrival to trauma center?

Yes	No	Unknown**	Not applicable

7. If the patient had a joint dislocation or fracture dislocation (hip, shoulder, knee, elbow), was it reduced within one hour of arrival to trauma center?

Yes	No	Unknown**	Not applicable

8. If the patient had an ischemic limb, was it re-vascularized within 6 hours from time of injury?

Yes	No	Unknown**	Not applicable

9. The patient had an ORIF of facial fractures (major fractures of mandible, maxilla or orbital fractures), was it completed </= 7 days after injury?

Yes	No	Unknown**	Not applicable

10. If the patient had operative repair of spinal fractures, was it completed </= 7 days after injury?

Yes	No	Unknown**	Not applicable

11. Did the patient with a first recorded scene GCS </= 8 receive a mechanical airway as an intervention at the scene?

Yes	No	Unknown**	Not applicable

12. Did the patient with a first recorded trauma centre GCS <=8 receive a mechanical airway as an intervention at the trauma centre?

Yes	No	Unknown**	Not applicable

13. Was there an unplanned ICU admission at the trauma centre?

Yes	No	Unknown**	Not applicable

14. Was there an unplanned ICU readmission at the trauma centre?

Yes	No	Unknown**	Not applicable

15. If Code 77 was not called, was it appropriately not called?

Yes	No	Unknown**	Not applicable

16. If the distance was < 200 kms, was total transport time from scene/sending hospital to the trauma centre > 2.5 hours? (should only be scene)

Yes	No	Unknown**	Not applicable

17. If the distance was 200-400 kms, was total transport time from scene/sending hospital to the trauma centre > 4 hours?

Yes	No	Unknown**	Not applicable

18. If the distance was > 400 kms, was total transport time from scene/sending hospital to the trauma center > 6 hours?

Yes	No	Unknown**	Not applicable

Foothills Medical Centre – Indicators are under review until further notice.

University of Alberta - Indicators are under review until further notice.

Chinook (Lethbridge) Site Indicators

1. If the distance was < 200 kms, was total transport time from scene~~/sending hospital~~ to the trauma centre > 2.5 hours? (should only be scene)

Yes	No	Unknown**	Not applicable
Yes the distance was <200 kms and the total transport time to trauma centre was >2.5 hours	No the distance was <200 kms and the transport time to trauma centre was not >2.5 hours	Unknown location of scene	Scene to the trauma centre is > than 200 km away from the trauma centre or pt is walk-in/private vehicle

2. If the distance was 200-400 kms, was total transport time from scene~~/sending hospital~~ to the trauma centre > 4 hours? (should only be scene)

Yes	No	Unknown**	Not applicable
Yes the distance was 200-400 kms and the total transport time to trauma centre was >4 hours	No the distance was 200-400kms but the total transport time was not > 4 hours	Unknown location of scene	Scene to trauma centre is <200 or >400 km away from the Trauma Centre or pt is a walk-in/private vehicle

3. If the distance was > 400 kms, was total transport time from scene~~/sending hospital~~ to the trauma centre > 6 hours? (should only be scene)

Yes	No	Unknown**	Not applicable
Yes the distance was >400 kms and the total transport time to the trauma centre was >6 hours	No the distance was >400 kms but the transport time was not >6 hours	Unknown location of scene	Scene to Trauma Centre is <400 km away from the Trauma Centre or pt is a walk-in/private vehicle

4. Did the patient with a first recorded scene GCS <= 8 receive a mechanical airway as an intervention at the scene?

Yes	No	Unknown**	Not applicable
Yes pt. with a first recorded GCS level <=8 did receive a mechanical airway at the scene	No pt. with a GCS<=8 did not receive a mechanical airway at the scene	Unable to determine if mechanical airway is given	GCS >8

5. Did the patient with a first recorded trauma centre GCS <=8 receive a mechanical airway as an intervention at the trauma centre?

Yes	No	Unknown**	Not applicable
Yes pt. with a first recorded GCS of <=8 received a mechanical airway at the trauma center	No pt with a GCS <=8 did not receive a mechanical airway at the trauma centre	Unable to determine if mechanical airway is given	GCS >8

6. Was the patient assigned a triage code of 4 or 5?

Yes	No	Unknown**
Yes pt was assigned a triage code of 4 or 5	No pt was not assigned a triage code of 4 or 5	Unable to determine triage code

7. Was the massive transfusion protocol initiated on this pt.?

Yes	No	Not applicable
Yes MTP was initiated	MTP was not initiated	Patient not seen at CRH

8. For patients with ischemic (i.e. pulseless) limb(s) secondary to severe fractures or penetrating arterial trauma, was the limb(s) re-vascularized (via fracture reduction, or an OR visit for repair, shunt or graft) within 6 hours of injury or transferred to a higher level of care within 2 hours?

Yes	No	Unknown**	Not applicable
Yes pt with ischemic limb(s) secondary to severe fractures or penetrating arterial trauma and was re-vascularized within 6 hours of injury or transferred to a higher level of care	No pt with ischemic limbs secondary to severe fractures or penetrating trauma was not re-vascularized within 6 hours of injury and or transferred to a higher level of care	Unable to determine time of injury/ unable to determine time of revascularization	No limb Ischemia Limb was amputated Died within 6 hours of injury

9. Did the patient receive operative management of major facial fracture(s) (mandible, maxilla or orbit) at the trauma centre, within 7 days of the injury?

Yes	No	Unknown**	Not applicable
Yes pt received operative management of major facial fractures within 7 days of injury at the trauma centre	No pt had major facial fractures but operative management was not done within the 7 days of injury at the trauma centre	Unknown time of operative management not documented	No major facial fracture(s) Major facial fracture(s) but documented that operative management was not required

			Major facial fracture(s) but documented planned delay in operative management Died within 7 days of injury or transferred within 7 days of injury

10. If the patient had a dislocated hip, shoulder, knee and/or elbow, was there an attempt to reduce it (them) within one hour of arrival at the trauma centre?

Yes	No	Unknown**	Not applicable
Yes pt had a dislocated hip, shoulder, knee and or elbow and reduction was attempted within one hour	No pt had a dislocated hip, should, knee and or elbow and reduction was not attempted within the hour	Unknown time of attempted reduction(s) not documented	No dislocation of hip, shoulder, knee, or elbow Died within 1 hr of arrival

11. Was a pelvic binder applied in ED?

Yes	No	Unknown**
Yes a pelvic binder was applied in ED	No a pelvic binder was not applied in ED	Unable to determine if a pelvic binder was applied

12. If the patient sustained a pelvic ring fracture and was hemodynamically unstable in the ED was pelvic splinting done?

Yes	No	Unknown**	Not applicable
Yes pt was hemodynamically unstable, had a pelvic fracture and pelvic splinting was done	Pt had a pelvic ring fracture, was hemodynamically unstable and no splinting was done	Unable to determine if pelvic splinting was done	No pelvic ring fracture Patient was hemodynamically stable Not transferred to a higher level of care

13. If the patient sustained a pelvic ring fracture and was hemodynamically unstable was an external fixator applied prior to; transport to higher level of care?

Yes	No	Unknown**	Not applicable
Yes pt. had a pelvic ring fracture, was hemodynamically unstable, and an external fixator was applied	No pt had a pelvic ring fracture, was hemodynamically unstable and an external fixator was not applied	Unable to determine if external fixator was applied	No pelvic ring fracture Pt was hemodynamically stable Not transferred to a higher level of care

14. If TT not activated was GS consulted at any time during the patient's stay at the trauma centre?

Yes	No	Unknown**	Not applicable
No TTA and GS was consulted	No GS was not consulted at anytime	Unable to determine	TT Activated Pt admitted under GS

15. Was GS arrival to the ED > 20 minutes when the TTA?

Yes	No	Unknown**	Not applicable
TTA and GS was >20 minutes	GS arrival was not >20 minutes when TTA	Unable to determine	TT not activated

16. Did this pt bypass a rural facility and come direct to the Trauma Centre?

Yes	No	Not applicable
Yes pt bypassed a rural facility and came direct to Trauma Centre	No pt did not bypass a rural facility and come direct to the Trauma Centre	Pt was a walk-in/private vehicle

17. Did the trauma patient have a laparotomy?

Yes	No
Yes pt had a lap	No pt did not have a lap

18. If a laparotomy was done, was it performed > 2 hours of arrival to the trauma centre?

Yes	No	Unknown**	Not applicable
		Unable to determine time to Lap	Laparotomy was not done

19. Did the pt receive TXA (tranexamic acid) by EMS or in ED?

Yes	No	Unknown**
Yes pt received TXA	No pt did not receive TXA	Unable to determine not documented

20. If the patient sustained a pelvic ring fracture and was hemodynamically unstable was pelvic artery embolization done prior to; transport to higher level of care?

Yes	No	Unknown**	Not applicable
Yes pt had a pelvic ring fracture, was hemodynamically unstable and pelvic embolization was done prior to transfer to a higher level of care	Pt had a pelvic ring fracture was hemodynamically unstable but did not have pelvic artery embolization	Unable to determine if pt received artery embolization	Pt has no pelvic fracture Pt was hemodynamically stable

21. If the patient sustained a traumatic splenic injury, was splenic artery embolization done?

Yes	No	Unknown**	Not applicable

22. Did the patient have a limb tourniquet applied by EMS prior to arrival to the ED?

Yes	No	Unknown**	Not applicable

23. Did the patient have a limb tourniquet applied in the ED?

Yes	No	Unknown**	Not applicable

Fort McMurray (northern lights) hospital

1. If < 200 kms from trauma centre, did patient arrive at trauma centre within 2.5 hours of initial EMS contact?

Yes	No	Unknown**	Not applicable

2. If 200-400 kms from trauma centre, did patient arrive at trauma centre within 2.5 hours of initial EMS contact?

Yes	No	Unknown**	Not applicable

3. If > 400 kms from trauma centre, did patient arrive at trauma centre within 2.5 hours of initial EMS contact?

Yes	No	Unknown**	Not applicable

4. Did patient receive TXA by EMS?

Yes	No	Unknown**	Not applicable

5. Did patient receive TXA in ED?

Yes	No	Unknown**	Not applicable

6. Was the massive transfusion protocol ordered?

Yes	No	Unknown**	Not applicable

7. Did general surgery arrive within 20 minutes of call or patient arrival?

Yes	No	Unknown**	Not applicable

8. Did Ortho arrive within 30 minutes of call or patient arrival?

Yes	No	Unknown**	Not applicable

9. Did Gyne arrive within 30 minutes of call or patient arrival?

10. Did Peds arrive within 30 minutes of call or patient arrival?

Yes	No	Unknown**	Not applicable

11. Was trauma record form used?

Yes	No	Unknown**	Not applicable

12. Was EMS patch form completed?

Yes	No	Unknown**	Not applicable

13. Was Trauma Coordinator consult form received from ED?

Yes	No	Unknown**	Not applicable

14. Was the trauma order set form completed?

Yes	No	Unknown**	Not applicable

15. Was time of contact with RAAPID within 2 hours of patient arrival?

Yes	No	Unknown**	Not applicable

16. Was time of arrival of transport team within 2 hours of contact with RAAPID?

Yes	No	Unknown**	Not applicable

Grande Prairie (QEII) Hospital

1. RAAPID utilized?

Yes	No	Unknown**	Not applicable

2. Surgical slate E1?

Yes	No	Unknown**	Not applicable

3. Surgical slate E2?

Yes	No	Unknown**	Not applicable

4. Surgical slate E3?

Yes	No	Unknown**	Not applicable

5.

Yes	No	Unknown**	Not applicable

6.

Yes	No	Unknown**	Not applicable

7.

Yes	No	Unknown**	Not applicable

8.

Yes	No	Unknown**	Not applicable

9.

Yes	No	Unknown**	Not applicable

10.

Yes	No	Unknown**	Not applicable

11.

Yes	No	Unknown**	Not applicable

Medicine Hat Hospital

1. Was the patient triaged a 4 or a 5?

Yes	No	Unknown**	Not applicable

2. Was the patient logrolled within 30 mins of arrival to the ED?

Yes	No	Unknown**	Not applicable

3. If the patient was < 200 km, was total transport time from scene/sending hospital to the trauma centre > 2.5 hrs.?

Yes	No	Unknown**	Not applicable

4. If the distance was 200-400 kms, was total transport time from scene/sending hospital to the trauma centre > 4 hrs.

Yes	No	Unknown**	Not applicable

5. Was a Trauma Nursing Record used?

Yes	No	Unknown**	Not applicable

6. Was RAAPID consulted from a referring facility?

Yes	No	Unknown**	Not applicable

7. Was a Trauma Lab /Diagnosis Panel ordered?

Yes	No	Unknown**	Not applicable

8. If the patient required spinal motion restriction, was this initiated by EMS?

Yes	No	Unknown**	Not applicable

9. Were spinal precautions documented as maintained or initiated in the ED?

Yes	No	Unknown**	Not applicable

10. If spines were cleared by a physician was this documented?

Yes	No	Unknown**	Not applicable

11. Was the Massive Transfusion Protocol ordered?

Yes	No	Unknown**	Not applicable

12. If the patient was hypothermic (temp < 35 degrees Celsius), were any rewarming adjunct use documented while in the ED?

Yes	No	Unknown**	Not applicable

13. Was the Trauma Team Activation Criteria form completed by ED staff?

Yes	No	Unknown**	Not applicable

14. Was TXA given within 3 hours of injury to poly trauma patients with significant hemorrhage/shock or risk for significant hemorrhage?

Yes	No	Unknown**	Not applicable

15. Did the Trauma Team Leader document on a Physician Trauma Record?

Yes	No	Unknown**	Not applicable

16. Did the physician dictate a consult in place of the physician trauma record?

Yes	No	Unknown**	Not applicable

17. If the patient had a dislocated hip, shoulder, knee or elbow was there an attempt to reduce it within one hour of arrival at the trauma centre?

Yes	No	Unknown**	Not applicable

18. Was the pelvic binder applied?

Yes	No	Unknown**	Not applicable

19. Did the patient bypass a rural facility and come direct to the trauma centre?

Yes	No	Unknown**	Not applicable

20. If the patient required a category one laparotomy, was it performed more than one hour after arrival in ED?

Yes	No	Unknown**	Not applicable

21. If patient had a femur fracture and was stable, was operative repair of the fracture done more than 24 hours after arrival in ED?

Yes	No	Unknown**	Not applicable

22. At any point during the patient's stay, did the patient have any unplanned return to the OR for the same single body system procedure?

Yes	No	Unknown**	Not applicable

23. Did the patient spend more than 2 hours at any hospital outside of Trauma centre?

Yes	No	Unknown**	Not applicable

24. For all patients assessed/treated in the ED, is minimum q 1 h documentation present in the medical record, from arrival in the ED, until admission (to the OR, ICU or other unit), death, or transfer to another hospital? This includes time spent in diagnostic imaging?

Yes	No	Unknown**	Not applicable

25. For all patients assessed/treated in the ED, with a diagnosis of skull fracture, intracranial injury or spinal cord injury, is sequential neurological documentation present in the ED record?

Yes	No	Unknown**	Not applicable

26. Did patient die during transport?

Yes	No	Unknown**	Not applicable

27. If the patient died, did he /she die within first 24 hours of arrival in the ED?

Yes	No	Unknown**	Not applicable

Red Deer Hospital Provincial Indicators

1. **Field Triage**: The number of all patients within the regional trauma system diagnoses with major anatomic injuries and those admitted to a Level 1 or 2 trauma centre

Yes	No	Unknown**	Not applicable

2. **Wait time for Rehab:** The time from the day the trauma patient is considered ready for inpatient rehabilitation as indicated in the medical record to the day when the patient is transferred to a rehabilitation program.

Yes	No	Unknown**	Not applicable

3. **TTA:** All trauma patients with a primary injury diagnosis admitted to the ED who satisfy local TTA protocols and for whom there is a TTA

Yes	No	Unknown**	Not applicable

4. **ED LOS:** Total number of trauma patients with a primary diagnosis of an injury with an ISS>12 discharged from ED within 4 hours.

Yes	No	Unknown**	Not applicable

5. **LOS in Acute Care:** Total number of acute care hospital days for all trauma patients with a primary diagnosis of an injury with an ISS> 12 admitted to an acute care setting and discharged alive.

Yes	No	Unknown**	Not applicable

6. **Complications during Hospital Stay:** All trauma patients admitted to the hospital with a primary diagnosis of a major anatomic injury and at least one secondary diagnosis included in the complication list

Yes	No	Unknown**	Not applicable

7. **Trauma Mortality:** The proportion of trauma patients admitted to hospital with a primary diagnosis of an injury with an ISS > 12 who die within 30 days

Yes	No	Unknown**	Not applicable

8. **Time to Definitive Trauma Centre:** Average and median time between the EMS's arrival at the injury scene and their arrival at a definitive trauma centre

Yes	No	Unknown**	Not applicable

9. Trauma patients with life threatening cerebral hematomas not receiving immediate surgery.

Yes	No	Unknown**	Not applicable

10. **Presence of Ambulance Report**: All trauma patients transported from the injury scene by EMS to the ED with a primary diagnosis of an injury with an ISS> 12 who have an accompanying PCR on the medical record.

Yes	No	Unknown**	Not applicable

Red Deer Central Zone Indicators

1. Did the patient spend more than 2 hours at any hospital outside of the trauma centre?

Yes	No	Unknown**	Not applicable

2. **Unplanned hospital readmission within 30 days of hospital discharge**: The proportion of patients with a primary diagnosis of an injury with an unplanned readmission to an acute care hospital within 30 days of hospital discharge.

Yes	No	Unknown**	Not applicable

3. **VTE Prophylaxis within 24 hours of admission**: The proportion of selected high-risk patients age 18 years and older who have VTE prophylaxis (pharmacological or mechanical) administered within 24 hours of their hospital admission

Yes	No	Unknown**	Not applicable

4. Was the **SMR (Spinal Motion Restriction) form** completed for all patients in spinal precautions

Yes	No	Unknown**	Not applicable

Red Deer Hospital site specific Indicators

1. If the patient is in SMR (Spinal Motion Restriction) was the spinal clearance form used?

Yes	No	Unknown**	Not applicable

2. For TTA was the nursing trauma record used?

Yes	No	Unknown**	Not applicable

3. Did the patient leave the sending hospital with an unstable airway? (GCS <8, facial trauma, copious secretions).

Yes	No	Unknown**	Not applicable

Royal Alexandra Hospital

1. Vascular procedure to Grey Nuns

Yes	No	Unknown**	Not applicable

2. TTL on calendar

Yes	No	Unknown**	Not applicable

3. TTA: Scheduled TTL arrived

Yes	No	Unknown**	Not applicable

4. CC form complete

Yes	No	Unknown**	Not applicable

5. ED documentation hourly 1 Vitals & GCS

Yes	No	Unknown**	Not applicable

6. TTL arrival within 20 mins of patient arrival

Yes	No	Unknown**	Not applicable

QA Tracking: QA Tracking

This section is meant for trauma coordinators. When we are ready to start using the site (and I have some guidelines on how coordinators do their data entry/patient follow up) this section of the data dictionary will be developed.

Appendix A: Memos

Date: Jan 10, 2017
To: ATR Data Analysts, Trauma Coordinators, Trauma Managers and Medical Directors
From: ATS CLT Trauma Data Subcommittee
RE: Penetrating Trauma Capture and Definition Clarification Update

It is the intent of the Alberta Trauma Registry (as per directive from Provincial Trauma Committee) to capture all penetrating trauma in registry which require the use of surgical/OR resources by admitted patients. Such data capture should commence for all sites Jan 1, 2015. This data will be included in the ATR as a central site case.

The definition of penetrating trauma is as follows:

Penetrating Trauma:

The primary mechanism of injury is penetrating. Primary mechanism of injury is defined as the type of mechanism leading to the patient's most serious injury, defined by AIS severity. Penetrating is defined as an injury that occurs when an object pierces the skin and/or enters the body, creating an open wound (as per NTDB trauma type E-code criteria document http://www.in.gov/isdh/files/APPENDIXVIIIBAssigningTraumaType_NTDS.pdf). All penetrating trauma (irrespective of ISS) is to be captured. This includes any patient where:

2. The penetrating injury was the primary mechanism of injury
    a. ICD10 external cause of injury codes: W25, W260-9, W27, W28, W29, W30, W31, W32, W33, W3400-9, W44, W4500-9, W46, W53, *W54-59 (only biting not striking against or other contact)*, X72-X7409, X78, X93-X9509, X99, Y22-Y2409, Y28, Y350, Y354, Y364.
    b. ICD10 external cause of injury codes typically classified as blunt, but where the most serious injury is obviously penetrating (***please sees examples 1-5 below***).

3. They met any of the following criteria:
    a. The patient died in ED, **OR**
    b. The patient was admitted to hospital for > 24 hours (i.e. discharge time - admitting time at trauma centre was >24 hours), **OR**
    c. The patient went to the main hospital OR for any surgery (not day/outpatient surgery)
    d. Please see clarifications below for minor penetrating eye injuries and Psych patients.

Examples:

1. A patient with an ISS=9 who is admitted to hospital following a fall onto a fence where he was impaled in the abdomen by a fence post with no other more serious injuries. This **would** be captured in the registry as the primary mechanism of injury (impalement) is penetrating.

2. A patient is in a car accident and is impaled by flying debris such as a piece of metal (and this impalement is the most serious injury). This **would** be captured in the registry as the primary mechanism of injury (impalement) is penetrating.

3. A patient is riding an ATV and gets impaled by a tree branch and has no other injuries (no rollover, crash, etc). This **would** be captured in the registry as the primary mechanism of injury (impalement) is penetrating.

4. A patient involved in a MVC who has an amputation with an ISS < 12 (partial lower arm, hand, or finger) **would not** be included as the amputation was not caused by a cutting instrument (ex. machete, lawn mower blade, etc.) This injury would be considered blunt.

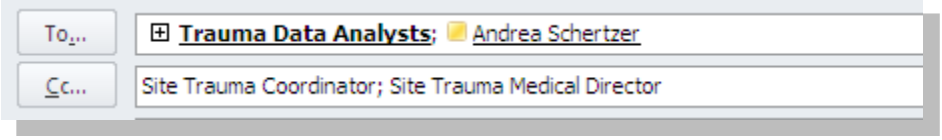
5. A patient is in a car accident and flying glass has caused lacerations. This **might be** captured in the registry. If this was the patient's primary injury, they met all criteria above they would be entered in the registry. ***Most patients will have other more serious blunt injuries from a car accident or will not be admitted if the only injuries are lacerations due to glass.***

Clarifications

- Penetrating injuries for inclusion can occur anywhere on the body (including extremities).
- This definition **does** include animal bites and foreign bodies (which NTDB document attached includes as "other" injury type) if they correspond to all criteria in 1 & 2 above. Patient who are bitten by venomous animals are not included as the primary mechanism of injury is poison (ICD10 exclusion criteria).
- Penetrating eye injuries will be included **only if there is a globe rupture.**
- Blunt injuries causing de-gloving **are not** penetrating.
- Psych patients admitted for psychological observation following penetrating injury (lacerations or punctures) will only be included if they meet **criteria 1 and 2a or b** (above) **AND had a surgical consult**. They will **not** be included if they were admitted to hospital >24 hours but had no surgical consult.

For situations where it is **unclear** as to whether or not a patient should be included in the registry the following procedure should be followed:

1. Email **all** of the following people to see if a group solution can be found:



2. If a consensus cannot be reached through the above means, the Provincial Epidemiologist will bring the issue to the data sub-committee for review.

Alberta Health Services

Memorandum

Date: April 9, 2018

To: Trauma Data Analysts, Trauma Coordinators and Managers, Trauma Medical Directors
All Level 1, Level 1 Pediatrics, Level 2 and 3 Trauma Centers, Alberta Health Services

From: Dr. Rohan Lall, Dr. Sandy Widder, Christine Vis
Alberta Trauma Services Core Leadership Team Co-Chairs

RE: Trauma Accreditation Distinction- Wait Time For Rehabilitation Core Indicator Definition

The 'Wait Time to Rehabilitation' core indicator was recently reviewed by the Alberta Trauma Services Core Leadership (ATS CLT) meeting on March 6, 2018.

As discussed, this core indicator is an important measure of institutional efficiency and system responsiveness. Early access to inpatient rehabilitation improves patient outcomes. The Accreditation Canada Core Indicator document does not exclude any level of Trauma Center that this indicator pertains to. It was also determined that not all Level 1-3 adult and pediatric trauma centers are currently collecting this indicator data.

As of April 1, 2018, the ATS CLT has agreed that all levels of trauma centers in Alberta Health Services (including pediatric centers) must collect data on this indicator for reporting to Accreditation Canada. At present, there is no element in the Alberta Trauma Registry for this indicator; therefore each trauma center must determine a manual abstraction/review process for data collection.

To add further clarity to the definition by Accreditation Canada, the ATS CLT determined that "ready for inpatient rehab" is determined by the following:

1. **For Level 3 Trauma Centers:** A notation/comment in the patient health record by the most responsible physician, in consultation with Allied Health and/or Transition Services, that the patient is waitlisted for inpatient rehab.

2. **For Level 1 and 2 (Adult and Pediatric):** A notation/comment in the patient health record by Physiatrist or Transition Services that the patient is waitlisted for inpatient rehab.

If there are any additional questions or clarification required, please contact the ATS Provincial Trauma Epidemiologist.

Alberta Health Services

Memorandum

Date: April 9, 2018

To: Trauma Data Analysts, Trauma Coordinators and Managers, Trauma Medical Directors
All Level 1, Level 1 Paediatics, Level 2 Trauma Centers, Alberta Health Services

From: Dr. Rohan Lall, Dr. Sandy Widder, Christine Vis
Alberta Trauma Services Core Leadership Team Co-Chairs

RE: Trauma Accreditation Distinction- Trauma Patient with Life Threatening Cerebral Hematomas Not Receiving Immediate Surgery Optional Indicator Definition

The 'Trauma Patient with Life Threatening Cerebral Hematomas Not Receiving Immediate Surgery' core indicator was recently reviewed by the Alberta Trauma Services Core Leadership (ATS CLT) meeting on March 6, 2018.

As discussed, this core indicator is an important measure of institutional efficiency and system responsiveness. The ATS CLT has determined this is an optional indicator that will be reported to Accreditation Canada.

As of April 1, 2018, the ATS CLT has agreed that Level 1 and 2 (Adult and Pediatric) Trauma Centers in Alberta Health Services must collect data on this indicator in the Alberta Trauma Registry and for reporting to Accreditation Canada.

After review of the varying definitions of craniotomy by other jurisdictions and based on consensus, cerebral hematomas will be defined as either a craniotomy OR burr hole procedure completed in an operating room only. It will NOT include bed side burr hole procedures completed in the Emergency Department, Intensive Care Unit or any other inpatient area. Patients with a life threatening cerebral hematoma will be defined as those requiring an operating room.

If there are any additional questions or clarification required, please contact the ATS Provincial Trauma Epidemiologist.

Appendix B: Fields Disabled

	Data no longer collected in the Province of Alberta as of April 25 2018 (decision made by Data Subcommittee	
	All fields should be disabled	
Tab Name	**Sub Tab Name**	**Field Name**
Demographic	Patient	Street Name
Demographic	Patient	Other Postal Code
Demographic	Record Info	Residence (If not Alberta) s/b "/" if Residence is AB
Injury	Injury Information	Abuse suspected by hospital staff
Injury	Injury Information	Street Address
Injury	Mechanism of Injury, Motor Vehicle Crash	Ejected from vehicle
Injury	Mechanism of Injury, Motor Vehicle Crash	Distance ejected
Prehospital	Prehospital information, Scene/Transport	NTS Grid
Referring Facility	Immediate Referring Facility	Facility Level
Referring Facility	Immediate Referring Facility	Total Vent Days
Referring Facility	Immediate Referring Facility	OR
Referring Facility	Immediate Referring Facility	IV
Referring Facility	Immediate Referring Facility	ICP
Referring Facility	Immediate Referring Facility	Vent
Referring Facility	additional referring facility	OR
Referring Facility	additional referring facility	IV
Referring Facility	additional referring facility	ICP
Referring Facility	additional referring facility	Vent
Referring Facility	Immediate Referring Facility	Facility Level
Referring Facility	additional referring facility	Facility Level
Referring Facility	Assessment	Drug Use Indicator
Referring Facility	additional vitals	PTS
Referring Facility	Inter-facility-transport	Arrive at patient
Referring Facility	Inter-facility-transport	Arrive at Destination
Referring Facility	Inter-facility-transport	Inter-facility vitals
Referring Facility	Inter-facility-transport	Inter-facility procedures
Referring Facility	Inter-facility-transport	Procedures/Medications
ED/Resus	Arrival/Admission	Admitting Surgeon NPI
ED/Resus	Initial Assessment	Assisted Resp
ED/Resus	Initial Assessment	PTS
ED/Resus	Labs/Toxicology	Drug Use Indicator
Procedures	Procedures	Other
Outcome	Initial Discharge	# IV lines
Outcome	Initial Discharge	Primary Payor

Appendix C: Change Log

2019		
	Patient Inclusion Criteria	Added definition for Transfers- Level 3 Transfers
	Central Site Transfer	Added definition for Transfers- Level 3 Transfers
	Protective Devices	Airbag present for Bus enter "n/a" as per email from TQIP Dec 18 2018.
	Height	Deleted " 30 minutes" added "within 24 hours as per 2019 NTDB Data dictionary
	Weight	Deleted "30 minutes" added within 24 hours as per 2019 NTDB Data dictionary
	Initial ED/Hospital GCS Assessment Qualifiers	Added but it is not a current data element as per 2019 NTDB Data dictionary
	Protective Devices	Added "If documented that a "child restraint" was used or worn, but NOT properly fastened, either on the child or in the car, report Field Value "1.None" as per 2019 NTDB Data dictionary
	Substance Abuse Disorder	Deleted "Alcohol Use Disorder" along with "Substance Abuse Disorder" must be reported to NTDB. Exclude "Tobacco Use Disorder and Alcohol Use Disorder" as per 2019 NTDB
	Highest Total GCS Within 24 Hours of Arrival	Deleted "within 24 hours of arrival" and changed to "calendar day" as per 2019 NTDB
	Highest GCS Motor	Deleted "within 24 hours of arrival" and changed to "calendar day" as per 2019 NTDB
	Transfusion PRBC, Plasma, Platelets, Cryoprecipitate (24 hours)	Retired all data elements of transfusion of 24 hours as per 2019 NTDB data dictionary
	Antibiotic Therapy	Added but it is not a current data element as per 2019 NTDB Data dictionary
	Antibiotic Therapy date and time	Added but it is not a current data element as per 2019 NTDB Data dictionary
	Intubation	"Intubation" now includes King LT, Combitubes and LMA as per decision made by data subcommittee on Jan 11 2019.
	Site Indicators	All site indicators have been updated
	Trauma Centre Procedures	Enter "Incision start time" and "Incision end time" for all operative procedures. Do not collect "Patient In Theatre" and "Patient Out of Theatre" as per TQIP data dictionary

2018		
	All Fields	NTR Requirement and corresponding NTR data dictionary page number were deleted as the NTDB data dictionary changes every year.
	All Fields	Spelling mistakes were corrected
	All Fields	Wherever there is “ICD coding” “ICD-10 CA/CCI” was added
	Patient Inclusion Criteria	“participating” was deleted and “trauma” was added
	Penetrating Trauma Patient Inclusion Criteria	All E codes were deleted as no longer collecting. Added W30 and W31 ICD-10 CA/CCI codes. Added “(not day/outpatient surgery)” in the criteria section
	All Fields	Added “Field cannot be blank”
	Personal Health # (ULI)	Added “ If the patient previously lived or resided in a different Province or country and now resides in AB then enter 1. ULI#2. Old PHN# in other. 3. Residence “/” as the patient now resides in AB”
	Patient Origin	Added “if patient taken to Urgent Care Centre enter scene” Added “ if patient injured at scene then went home enter home”
	Is this a central site case?	Deleted “ Please use new spreadsheets in Provincial directory data analysts folder to follow up with all transfer cases and determine who is a central site case (and track missed patients at your site”
	Postal Code	Added “Alternate residence data element is removed as per the Data subcommittee on April 05 2018. Please enter “/” as Admitting is not accepting T1T1T1 across the province of Alberta and they are also entering “/” “. Email was inserted by Provincial Epidemiologist
	Other Postal Code	Data Element removed stop collecting April 26 2018
	Street	Data Element removed stop collecting April 26 2018
	If Other	Deleted as already added in the drop down list in the ATR

2018

	Occupation	Inserted “If work related is “No” this field will be disabled”
	Protective Devices	Delete “n/a” should be “None” Added “ Enter “None” for where Ped vs Car where the Ped was injured” Agreed by all analysts to enter “None”, “N/A” and “None” if patient was not injured during an MVC. Agree with NTDB.
	Injury address	Street address not required by NTDB. Therefore not required to enter
	Primary Place of Injury/ ICD 9-CM	No Longer collecting as of July 15 2016
	Secondary Place of Injury/ ICD 9-CM	No Longer collecting as of July 15 2016
	Tertiary Place of Injury/ ICD 9-CM	No Longer collecting as of July 15 2016
	Intentional Injury	Agreed by Data subcommittee on April 05 2018 to change wording Suicide to Self-inflicted. Remove Homicide
	Primary E code/ICD9 (External Cause of Injury)	Data Element removed no longer collecting from July 15 2016
	Secondary E code/ICD9 (External Cause of Injury)	Data Element removed no longer collecting from July 15 2016
	Tertiary E code/ICD9 (External Cause of Injury)	Data Element removed no longer collecting from July 15 2016
	Primary E-Code/ICD 10 (External Cause of Injury Code)	Remove “V Codes” and add “External cause codes” Added “Refer to NTDB data dictionary for Multiple Cause Coding Hierarchy’
	Secondary E-Code/ICD 10 (External Cause of Injury Code)	Remove “V Codes” and add “External cause codes” “Refer to NTDB data dictionary for Multiple Cause Coding Hierarchy”
	Tertiary E-Code/ICD 10 (External Cause of Injury Code)	Remove “V Codes” and add “External cause codes” “Refer to NTDB data dictionary for Multiple Cause Coding Hierarchy”
	Ejected from Vehicle	Data element removed as per Data Subcommittee April 05 2018

2018		
	Distance Ejected	Data element removed as per Data Subcommittee April 05 2018
	NTS Grid Reference	Data element removed as per Data Subcommittee April 05 2018
	Transport Role	Transport from Rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital as per Data Subcommittee April 05 2018.
	Ambulance Service # (Transport at scene)	As per conversation with Greg Vogelaar March 8 2018 use Unit ID. Should be numeric Alpha Numeric
	PCR# (Transport at scene)	As per conversation with Greg Vogelaar from Ems on April 05 2018 the Event number is the one to be used for PCR number.
	Rendezvous pickup location	As per Data Subcommittee on Dec 12 2017 must collect this data element Provincially Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than hospital or airport as per Data subcommittee April 05 2018
	Date Arrived at Scene Location (or rendezvous point)	Calgary sites patient arrival date from Urgent Care Centre please enter date patient arrived from Urgent Care Centre
	Time Arrived at Scene Location (or rendezvous point)	Calgary sites patient arrival time from Urgent Care Centre please enter time patient arrived from Urgent Care Centre
	Date Departed Location	Calgary sites for patients departing Urgent care centre please enter the discharge date or departed from scene date from the PCR
	Time Departed Location	Calgary sites for patients departing Urgent care centre please enter the discharge time or departed from scene time from the PCR
	Scene Time Elapsed	Scene arrival time minus ambulance departed scene time
	Transport Time Elapsed	Time scene departed minus

2018		

	Prehospital vitals (SBP, Pulse Rate, UARR, O2, GCS (E,V,M))	• You should only report the first recorded vital signs measured at the **scene of injury**. Their complete definitions are found in the current NTDB data dictionary. • If a patient is stabbed on the street and walks for help to a nearby house/business that location is **NOT** considered scene of injury because it is the second location. • If a patient is taken by 1st EMS to a non-trauma hospital then discharged home (not transferred) and returns to a trauma center by 2nd EMS the next day or a few days after, the scene vitals are now not known/recorded by the 2nd EMS unless you are able to obtain the 1st EMS report with the vital signs at **scene of injury** taken/documented. • If previous scene EMS report is available use scene vitals from that report but not EMS times. Use Ems times from the current PCR as that is the EMS which transported the patient to the trauma hospital. As per email from NTDB.
	RTS (Prehospital/Scene)	Expanded abbreviation (RTS is scored from the first set of data obtained from the patient. It is a physiological scoring system, with high inter-rater reliability and demonstrated accuracy in predicted death. RTS ranges from 0 to 7.84 where 0 predicts high probability of death and 7.84predicts high probability of survival.) Source www.trauma.org
	Pediatric Trauma Score (PTS)	Data element removed
	Ambulance Service # (Transport from scene)	Please enter unit ID# S/B Alpha Numeric Alpha as per conversation with Greg Voglaar March 08 2018
	Facility Level (Immediate Referring/Additional Facility)	Data Element removed
2018		
	Ventilator Days (Immediate/Additional Referring Facility	Data Element removed

	Total Or Visits (Immediate Referring Facility)	Data Element removed. As per Data Subcommittee April 05 2018 please enter all OR procedures done at the Referring facilities in the Referring Facility Procedures section under the Non-operative data field. We are no longer collecting #ORs. Therefore we need to capture the types of procedures done in the Referring Facilities Procedures section.
	ICP Days (Immediate/Additional Referring Facility)	Data Element Removed
	Number of IV lines (Immediate/Additional Referring Facility)	Data Element Removed
	Drug Use Indicator	Data Element Removed
	Mode of Transport (Referring Facility)	For example a patient coming from Chinook Regional Hospital (LRH) to FMC enter data as follows: 1. Ground to FMC; 2. Fixed wing to YYC airport; 3. Ground to Lethbridge airport. For those submitting to TQIP: If a patient was transported from the scene of the injury by a fixed wing airplane to an airport, then transported from the airport by ground transportation to your hospital, you should report *Field Value* "1. Ground Ambulance" for **Transport Mode** to the NTDB. The reason being that the ground ambulance is the mode of transport that delivered the patient to your hospital, as indicated in the definition. You should report *Field value* "3. Fixed wing Ambulance" for **Other Transport Mode** to the NTDB. The reason is that the patient was transported by fixed wing from the scene to the airport, but not to your hospital, as indicated in the definition (this explanation came from TQIP)

	Transport Role (Inter-facility)	Explanation: ground to airport, airport to airport, ground to facility needs to be entered as **4- Transport to Other** Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital.
	PCR#	As per conversation with Greg Vogelaar on March 08 2018, the PCR number is the same as Event number and it is on SIREN as well.
	Meeting Location	Transport from rendezvous to facility should ONLY be used when EMS is meeting at other place other than airport or hospital. As per Data Subcommittee Dec 12 2017 must collect provincially
	Date Arrived at Patient(Referring Facility)	Data Element Removed
	Time Arrived at Patient(Referring Facility)	Data Element Removed
	Date Arrived at Destination (from Referring Facility)	Data Element Removed
	Time Arrived at Patient(Referring Facility)	Data Element Removed
	Admitting Surgeon NPI	Data Element Removed
	Paralytic Agents in Effect?	Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP. 1. Patient Chemically Sedated or Paralyzed
	Was the patient intubated?	Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP 3. Patient Intubated

2018		
	Was the patient sedated?	Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP 1. Patient Chemically Sedated or Paralyzed. See list of sedatives added
	Eye Obstruction?	Qualifier of the data element "Initial ED/ Hospital GCS Assessment Qualifiers in TQIP 2. Obstruction to the patient's eye
	Respiration Assisted?	NTDB dictionary 2018 "Initial ED/ Hospital Respiratory Assistance "
	ED Vital Signs (Temp, SBP, Pulse Rate, UARR, O2, GCS(E,V,M)	Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."
	Assisted Respiratory Rate	Data Element Removed
	RTS (Trauma Centre)	Expanded abbreviation. RTS is scored from the first set of data obtained from the patient. It is a physiological scoring system, with high inter-rater reliability and demonstrated accuracy in predicted death. RTS ranges from 0 to 7.84 where 0 predicts high probability of death and 7.84predicts high probability of survival Source www.trauma.org
	Alcohol Use Indicator (Trauma Centre)	As per NTDB "A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter at either at your facility or the transferring facility"
	Drug Use Indicator (Trauma Centre)	Data Element Removed

2018		
	Drug Screen Results	As Per NTDB "First recorded positive drug screen results within 24 hours after first hospital encounter either at your facility or the transferring facility."
	Blood Product	As per data subcommittee on April 05 2018 please collect "cumulative" #6 blood products in this section only. As first 4 hours and 24 hours are being collected in the TQIP section already.
	Non-Operative Procedures	Added CTA as per Data subcommittee April 05 2018 If patient went to CT scanner for Angio then should be recorded as #20. If patient went to Angio suite for Embolization etc., then enter #20 and #48. Blood Product Administration will be unretired.
	Other Non-Operative Procedures	Data element removed.

2018	
Trauma Centre Procedures	As of July 15 2016 we are no longer entering ICD9 Codes. As per NTDB "Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications." The Null value "Not Applicable" is used if the patient did not have procedures Include only procedures performed at your institution. Capture all procedures performed in the operating room. Capture all procedures in the ED, ICU, ward or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications. Procedures with an asterisk need to be only captured once as they have the potential to be performed multiple times. If there is no asterisk, capture each event even if there is more than one. Note that the hospital may capture additional procedures. Do not include Intubations performed in the OR. Make sure to code any debridement ("1VX59LAGX" for leg and "1TX59LAGX" for arm separately with the Open fractures ORIF.

2018

	AIS Version	AIS Abbreviated Injury Scale is an anatomically based consensus driven, global severity scoring system that classifies each injury by body region according to its relative importance on a 6point ordinal scale. AIS of 1 is considered minor while an AIS of 6 is the maximum and is currently considered untreatable.
	ISS Injury Severity Score	ISS is an anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an AIS score, allocated to one of six body regions: 7. Head/ neck (including c-spine) 8. Face 9. Chest (including T-spine) 10. Abdomen (including L-spine) 11. Extremities (including pelvis) 12. External With 1 being minor and 75 being incompatible with life
	NISS (New Injury Severity Score)	NISS outperforms the traditional ISS
	TRISS (Trauma Injury Severity Score)	The TRISS model is derived from Major Trauma Outcome Study (MTOS) data done in 1986. It uses logistical regression to predict patient survival probability. It is calculated for blunt and penetrating trauma only (not for burns). www.trauma.org TRISS requires the RTS, it does not calculate probability of survival for patients who are intubated at the time ED department GCS is calculated.
	ICD 9 CM Code	As of July15 2016 this data field is no longer automatically populating ICD-9-CM codes it is now ICD10CA only.
	ICD–10–CA Code	Enter the generic AIS code “without confirmation of autopsy” if it is an ED death?
	Co–morbid Factor	The null value “Not Applicable” is used for patients with no known co-morbid conditions.
2018		
	Co-morbid Factor	Change in NTDB 2018

		History of angina within 30 days = Angina Pectoris History of Myocardial Infarction = Myocardial Infarction Hypertension requiring Medication = Hypertension History of PVD = Peripheral Arterial Disease (PAD) Major Psychiatric Illness= Mental Personality Disorder Drug Use Disorder = Substance Abuse Disorder Diagnosis of "Alcohol Use Disorder" must be documented in the patient's medical record. You can collect "Alcohol Abuse in your registry but cannot report it to NTDB. The "Alcohol Use Disorder definitions are consistent with the DSM 5, 2013 definition. "Alcohol Use Disorder" along with "Substance Abuse Disorder" must be reported to NTDB. If a patient reported that they smoked cigarettes within the 12 months prior to their injury, then you should report "Current Smoker" to the NTDB. A patient who is a current smoker does not need "Substance Abuse Disorder" to be reported to NTDB. "Current Smoker" doesn't necessarily have a "Substance Abuse Disorder." Tobacco Use disorder as stated in the chart must be reported to NTDB along with "Substance Abuse Disorder." Must report both.
	Hospital Discharge Order Date	Patients who are discharged to Inpatient Rehab and placed on a waiting list prior to discharge as per NTDB/TQIP April 23 2018 Enter the physical discharge date the patient was discharged / transferred to Rehab
	Hospital Discharge Order Time	Patients who are discharged to Inpatient Rehab and placed on a waiting list prior to discharge as per NTDB/TQIP April 23 2018 Enter the physical discharge time the patient was discharged / transferred to Rehab

2018		
	Total IV Lines	Data Element Removed

	Primary Payor	Defaulted to "?"
	Record Complete	Data Element Removed
	TQIP Section	Now called TDS. There used to be a TQIP button at the bottom of the screen but now there is a separate tab at the top called TDS. Exclude patients with isolated Hangings, Drownings and Hypothermia.
	Initial ED/Hospital Pupillary Response	Vital signs must be within 30 minutes of arrival to the hospital, whether they are recorded by EMS or hospital staff. Please record the first recorded after the patient arrived in the ED or hospital. As per NTDB/TQIP "the definition does not specify that a specific service or hospital staff must have recorded the initial ED/hospital vital sign, just to report the patient's first recorded vital sign in the ED/hospital within 30 minutes or less of ED/hospital arrival."
	Intubation	Wherever "intubation" is in data dictionary a new definition was added. Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy, King LT, Combitube and LMA LMA, King, Combitubes are airway adjuncts and included ad intubation as per requirement of NTDB and data subcommittee Jan 10 2019.

2013			
	V1.0	All Fields	NTR Requirement and corresponding NTR data dictionary page number were added
		All Fields	NTDB Requirement and corresponding NTDB data dictionary page number were added
		All Fields	If they require a hierarchy it was added. Where applicable an NTR or NTDB Hierarchy was used.
		Visit # VISIT_NUM	Some sites use the case number. Some sites use registry number. What each site uses was added to the notes section
		Central Site Case CENT_CASE	Clarification: The sentence "In order to figure out if a patient has an ISS high enough to be sent to central site the diagnosis screen can be filled out first and then the central site case can be filled out" was added to the notes section
		Institution Number INST_NUM	A full list of institution numbers was added to the appendix. Clarification: If site 0177 is found that is a miscode for Fort McMurray. If something is coded under the General in Calgary that is actually the Rockyview hospital. As Calgary has never coded for the General and in Collector it says that the General has been blown up.
		Personal Health # PAT_ACT1; PAT_ACT2	NTDB Hierarchy added. Clarification: If patient is from out–of–province, leave this field blank. Unless the patient has a generated Alberta Health number. If the patient has a generated Alberta health number enter it here and fill in the "Other Health Number" with their non-Alberta Health number. If they do not have a non-Alberta health number put the province (if Canadian) or country that they live in.
		Other Health Number PAT_ACT_O	Clarification: If a non-Alberta Health Number is not available put the Province (if Canadian) or country of residence. NTDB Hierarchy added
		Date of Birth DOB_D; DOB_M; DOB_Y	NTDB Hierarchy added.

		Clarification: If Date of Birth is "Not Known/Not Recorded", complete variables: Age and Age Units. If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed. Used to calculate patient age in days, months, or years.
	Age RAW_AGE	Clarification: This is the patient's age at the time of admission in the units defined by Age Type (Years, Months or Days) This field populates automatically and is calculated using: Date of Birth AND Date of Admission. NTDB Hierarchy added.
	Height HEIGHT	Clarification: May be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. FMC did not use to collect this data field. As of
	Weight WEIGHT	Clarification: May be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. FMC did not use to collect this data field. As of Removed the statement: As of April 1st, 1995 hospitals will be required to collect weight for pediatric patients (i.e., < 16 years of age). Weight is a component of the Pediatric Trauma Score. Hospitals may document weight for adult patients as appropriate for their specific institution. Hospitals may wish to default this data element to inappropriate. All sites must collect this information now.
	Province PAT_ADR_ST	Correction: Homeless use to be entered "I". It said: Enter 'I' if the patient is homeless and does not spend the majority of time in one province. If the homeless patient spends the majority of time in one province, enter that province. Now this field matches City and Country and says: Enter the patient's province of injury if the patient is homeless. If the patient spends the majority of time in one city, enter the corresponding

		province. Enter 'U' if undetermined or unknown
	Occupation OCCUP	Clarification: Should be entered whenever possible for all injuries. Even if they are not work related.
	Incident Date INJ_DATE_D; INJ_DATE_M; INJ_DATE_Y	Clarification: An approximation should be used if the actual date is not recorded, wherever possible. For instance, if in the chart it is documented that the incident occurred 3 weeks ago, go back 3 weeks in the calendar, from the admission date and record that date as the incident date.
	Incident Time INJ_TIME_H INJ_TIME_M	Clarification: Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) can be used. If appropriate use 5 minutes before the EMS call. Time slots added.
	Fatality at Scene DEATH_S	Clarification: Should be collected for all mechanisms of injury NOT just transportation related
	Primary E-Code E_CODE	Data element name change: Primary E-Code/ ICD9 (External Cause of Injury)
	Secondary E-Code E_CODE_2	Data element name change: Secondary E-Code/ ICD9 (External Cause of Injury Code)
	Tertiary E-Code E_CODE_3	Data element name change: Tertiary E-Code/ ICD9 (External Cause of Injury Code)
	ICD 10 ICD10EXT_1	Data element name change: Primary E-Code/ICD 10 (External Cause of Injury Code)
	ICD 10 ICD10EXT_2	Data element name change: Secondary E-Code/ICD 10 (External Cause of Injury Code)
	ICD 10 ICDEXT_3	Data element name change: Tertiary E-Code/ICD 10 (External Cause of Injury Code)
	Specify CAUSE_INJ	Data Element name change: Specify Cause of Injury
	Sports/Recreational Code SPORT_CODE	Correction: removed the line Excludes ATV or Snowmobile used as a mode of Transportation. The analysts can't tell when an ATV or snowmobile is being used as transportation.

	Primary Place of Injury E849_X	Data element name change: Primary Place of Injury/ ICD9- CM
	Secondary Place of Injury E849_X_2	Data Element name change: Secondary Place of Injury/ ICD9-CM
	Tertiary Place of Injury E849_x_3	Data Element name change: Tertiary Place of Injury/ ICD 9-CM
	Primary Place of Injury U98_X	Data element name change: Primary Place of Injury/ICD10-CA
	Secondary Place of Injury U98_x_2	Data element name change: Secondary Place of Injury/ICD10-CA
	Tertiary Place of Injury U98_X_3	Data element name change: Tertiary Place of Injury/ ICD10-CA
	Specify PLACE_INJ	Data element name change: Specify Place of Injury
	Primary Injury Type INJ_TYPE	Clarification: An injury is defined as penetrating only if the patient is impaled by an object or if a missile enters or strikes the body. Missiles include bullets and pieces of glass or metal. Impaling objects may include, but are not limited to, knives, mails and fence posts. For patients with more than one injury type (for example blunt and penetrating), consider the most serious injury to determine injury type. Blast injuries should be coded as blunt.
	Intentional Injury INTENT_INJ	Clarification: Do not use homicide or child abuse. Use assault. If using assault, record in the text that the incident was intentional. If an individual is shot by a cop or injured in operations of war use #5 (Assault). An individual injured by a bouncer is #5 (Assault).
	Protective Devices PROT_DEV_1 to 4	Clarification: Collect for all mechanisms. If safety equipment is available and there is no safety equipment worn then it should be marked as “none”. If there is no safety equipment available and none is worn then it should be marked as “Inappropriate.” This should not be confused however with the likelihood of a sector of the population using safety equipment. For example if a Farmer is hurt riding a horse and he is not wearing a helmet this should be marked as none not inappropriate. However, if someone

		falls off a ladder this should be marked as inappropriate. Situations where it is unclear should be discussed with the ATR manager so that a list can be compiled of odd situations and how to code them.
	If Other PROT_DEV_O	Data element name change: If Other Protective Devices.
	Vehicle Type VEH_TYPE	Clarification: If the mechanism of injury falls under the E code (E800-848) or V codes (V01 – 99), and the person is riding an animal. Code vehicle type as other.
	If Other VEH_TYPE_O	Data Element Name Change: If Other Vehicle Type
	Extrication Required EXTRICATE	Clarification: Extrication includes extrication by medical personnel only (Police, Fire, EMS, RCMP).
	Position in Vehicle LAP, POS_IN_VEH	Clarification: If riding an animal code as other. If the position in the vehicle is unknown or is a passenger standing on a bus code as #5 Middle-2nd row- sleeper semi
	Location of Incident LOC_PLACE	Data Element Name Change: Location of Incident (City)
	If Other LOC_ST_O	Data Element Name Change: If Other Incident Location (If out of province) (City)
	Mode of Transport MODE_1_S(P)(L) MODE_2_S(P)(L) MODE_3_S(P)(L)	Clarification: Enter mode of transport sequentially.
	PCR# PHTN_1_S(P)(L) PHTN_2_S(P)(L) PHTN_3_S(P)(L)	Data Element Name change: PCR# OR EVENT #
	Time Call Received PRETIME_CH PRETIME_CM	Clarification: Enter the time the ambulance call was received, by ambulance service, using the 24 hour clock
	Time Unit Responded PRETIME_DH PRETIME_DM	Clarification: . EMS time unit responded should be recorded as the time they are en route. For STARS it is the time the helicopter lifts off.
	Date Arrived at Scene PREDATE_AD	Clarification: This is the date on which the unit transporting the patient from the scene arrived at the scene (arrival is

	PREDATE_AM PREDATE_AY	defined at date/time when the vehicle stopped moving).
	Time Arrived at Scene PREDATE_AH PREDATE_AM	Clarification: This is recorded as the time EMS arrives on scene not the time EMS arrives at the patient's side. (arrival is defined at date/time when the vehicle stopped moving)
	Date Left Scene PREDATE_LD PREDATE_LM PREDATE_LY	Clarification: Enter the date the ambulance departed from the scene if different from the date of the incident (departure is defined at date/time when the vehicle started moving)
	Time Left Scene PRETIME_LH PRETIME_LM	Clarification: (departure is defined at date/time when the vehicle started moving).
	Heart Rate (Scene) PULSE_S	Clarification: Defined as the patients first recorded HR upon arrival of EMS personnel at the scene. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the HR is not documented, enter not known
	Unassisted Respiration Rate (Scene) RESP_RAT_S	Clarification: Defined as the patient's first recorded unassisted RR upon arrival of EMS personnel at the scene. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the RR is not documented, enter not known. Enter not applicable if patient respirations are assisted, that is, patient is intubated or being bagged.
	Systolic Blood Pressure (Scene) SBP_S	Clarification: Defined as the patient's first recorded SBP upon arrival of EMS personnel at the scene. If the SBP is not taken or not documented, document as not known
	Was Patient Intubated? INTUBATE_S(P)(L)(A)	Clarification: Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy. LMA, King, Combitubes are airway adjuncts not intubation.
	Paralytic Agents in Effect PAR_AGNT_S(P)(L)(A)	Clarification: Fentanyl and Versed were removed from the list of paralytic agents. They are not paralytic agents.
	Eye (Scene) EYE_OPNG_S	Clarification: Defined as the patient's first eye-opening response for the GCS documented upon arrival of EMS

		personnel. If the eye-opening response is not documented or it the patients eyes are swollen shut, enter not known. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
	Verbal (Scene) VER_RESP_S	Clarification: Defined as the patient's first verbal response for the GCS documented upon arrival of EMS personnel at the scene. If the verbal response is not documented or if the patient is Intubated, enter not known. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
	Motor (Scene) MOT_RESP_S	Clarification: Defined as the patient's first motor response for the GCS documented upon arrival of EMS personnel at the scene. If the motor response is not documented or if the patient is Intubated, enter not known. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may

		be recorded, IF there is no other contradicting documentation.
	Total GCS (Scene) DISP_GCS_S	Clarification: Defined as the total GCS documented upon arrival of EMS personnel at the scene. If the GCS or any component of the GCS is not documented or if the patient was Intubated at the time GCS was calculated, enter not known. If the individual components are not documented but the total GCS is documented, this value may be used. If the documentation reflects the patient is awake, alert and oriented, the total GCS may be assumed to be 15.
	Non-Operative Procedures (Scene) NONOP_S_01	Clarification: If oral intubation is selected then assisted ventilation should also be selected. If c-spine immobilization is selected then backboard should also be selected. LMA, King and combitubes are not intubation.
	Date of Arrival at Primary Hospital REF_AR_D_D REF_AR_D_M REF_AR_D_Y	Clarification: For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
	Time of Arrival at the Primary Hospital REF_AR_T_H REF_AR_T_M	Clarification: For inter facility transfer patients, the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
	Date of Departure from Primary Hospital REF_DP_D_D REF_DP_D_M REF_DP_D_Y	Clarification: For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
	Time of Departure from Primary Hospital	Clarification: For inter facility transfer patients, this is the time at which the unit

	REF_DP_T_H REG_DP_T_M	transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
	Temperature TEMP_P(L)(A)	Clarification: Defined as the patients first recorded temperature upon arrival at the primary hospital (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in the first 30 minutes, document as not known. Change: Must be taken within 30 mins of arrival or coded unknown.
	Heart Rate PULSE_P(L)(A)	Clarification: Defined as the patients first recorded HR upon arrival at the primary hospital (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document not known. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the HR is not documented, enter not known. Change: Must be taken within 30 mins of arrival or coded unknown.
	Unassisted Respiration Rate RESP_RAT _P(L)(A)	Clarification: Defined as the patient's first recorded unassisted RR upon arrival at the primary hospital (ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document not known. Enter 0 if patient is documented as vital signs absent (VSA) before assistance is initiated. If the RR is not documented, enter not known. Enter not applicable if patient respirations are assisted, that is, patient is intubated or being bagged. Change: Must be taken within 30 mins of arrival or coded unknown.
	Systolic Blood Pressure SBP _P(L)(A)	Clarification: Defined as the patient's first recorded SBP upon arrival at the primary hospital(ED or inpatient unit if ED bypass), within 30 minutes of arrival. If vitals are not taken in first 30 minutes, document not known. If the SBP is not taken or not documented, document as not known

		Change: Must be taken within 30 mins of arrival or coded unknown.
	Eye EYE_OPNG_P(L)(A)	Clarification: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "Patient opens their eyes to voice command," an Eye GCS of 3 may be recorded, IF there is no other contradicting documentation. Change: Must be taken within 30 mins of arrival or coded unknown.
	Verbal VER_RESP _P(L)(A)	Clarification: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "when the patient speaks they are confused," a Verbal GCS of 4 may be recorded, IF there is no other contradicting documentation Change: Must be taken within 30 mins of arrival or coded unknown.
	Motor MOT_RESP _P(L)(A)	Clarification: If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. Change: Must be taken within 30 mins of arrival or coded unknown.
	BAC (mmol/L) ETOH_BAC _P(L)(A)	Change: recorded for age ≥ 9 years. Lab results <2 or trace code as 0.
	Non-Operative Procedure NONOP _P(L)(A)_01 to 20	Clarification: If the analyst has selected "Oral intubation" they should also select "Assisted Ventilation". If the analyst has selected c-spine immobilization they

		should also select backboard as these are rarely done one without the other. LMA, King and combitubes are not intubation. When coding for the trauma centre, procedures already established which are being maintained should not be selected. Extubation should not be included as a non-operative procedure. CT Angio should be coded as Angiography The type of CT such as Embolization/ coiling/ balloon Coiling does not need to be recorded.
	I.V. Sites IV_LINE _P(L)(A)	Clarification: I.O. is an I.V. Art line/ Central line is not an I.V.
	Ventilator Day VENT_DAY_P(L)(A)	Change: The cumulative amount of time spent on a ventilator (how to count it) has changed. Now every partial or full day should be measured as one calendar day. The old definition did not count the day that ventilation began. Now we do count that as 1 day.
	ICP Days ICP_DAY_P(L)(A)	Change: The cumulative amount of time spent on an ICP monitor (how to count it) has changed. Now every partial or full day should be measured as one calendar day. The old definition did not count the day that ICP began. Now we do count that as 1 day.
	All Secondary Hospital Fields	These were not corrected in this version of the data dictionary. Use the Primary Hospital field definitions.
	Direct Admission to Service (Bypass ED) DIRECT_ADM	Clarification: Direct to the Operating Room is a Direct Admission. Even if the Emergency Department is involved.
	Time of Arrival at Lead/ Trauma Hospital AMB_AR_T_H AMB_AR_T_M	Clarification: Use the time of triage unless there is an earlier time in the nurses notes.
	ED Departure Time EDD_TIME_H EDD_TIME_M	Clarification: If there is no departure time recorded use arrival at the unit minus 5 minutes.
	Admission Date ADM_DATE_D	Clarification: Defined as the date that the patient is registered as an inpatient. If

	ADM_DATE_M ADM_DATE_Y	the patient died in the emergency department or was discharged home from the emergency department, enter not applicable. Can be different from date of arrival or date registered in the ED.
	Admitting Service (Trauma Centre) ADMIT_SRV	Clarification: This should be the service that the physician is on that day. Unless it is a family doctor admitting to the ICU. Then this should be coded as ICU.
	Intensive Care Unit Visit ICU_1 to ICU_5	Clarification: Calgary (FMC) does not code its Burn Unit here. The Calgary burn unit does not accept ventilated patients and as such it is not considered an ICU.
	Total ICU LOS ICU_TTL	Clarification: This will include a burn unit stay at the UAH but not the FMC.
	Post ED Destination POST_ED	Clarification: Emergency in patients should be coded under other.
	Post OR Destination POST_OR	Clarification: Emergency in patients should be coded under other.
	Date of OR Visit (Trauma Centre) OP_01 TO 10_D OP_01 TO 10_M OP_01 TO 10_Y	Clarification: Only Operations related to the patient's most recent admission are included. Procedures done in the ED are not included. Procedures done in the ICU or recovery room are included.
	Operation CCI Procedures (Trauma Centre) OP_01 TO 10_T1 TO T8	Clarification: Only Operations related to the patient's most recent admission are included. Procedures done in the ED are not included. Procedures done in the ICU or recovery room are included.
	Co-Morbid Factors CO_MORB_01 TO 10	Clarification: Incidental findings should be included.
	Disposition DSCHG_TO	Clarification: If patient is homeless code under other and then in the "If Other (discharge disposition) field put homeless
2008		
N/a	Incident Time INJ_TIME_H INJ_TIME_M	Clarification. Injury time estimated (5 or 15) minutes prior to EMS arrival.
	IV Sites (Primary Hospital) IV_LINE_P	Institutional Option
	Operation #? Procedures (ICD 9 Procedure codes) OP_#_P(S)(A)_T1-8	NOT COLLECTED / CCI codes only as of April 01/08
	PTS (Trauma Centre) PTS_A	Decision: An unreliable score

		Operation #? CCI Procedures OP_#_P(L)(A)_T1-T8	Include procedures not done in the operating room
		Complications COMPLIC_#	Pop up menu revised
Appendix C		Provincial Report Definitions	
April 2007			
	N/a	Prehospital Index PHI	PHI becomes Trauma Score
Mar 2007			
	n/a	Residence (If not Alberta) RESID	Use “other” field for Nunavut until DI adds Nunavut as a selection.
		In AGE_TYPE	Clarification: Due to a problem in collector a patients age can only be entered in months if the patient is <12 months old.
		Province PAT_ADR_ST	Use “other” field for Nunavut until DI adds Nunavut as a selection.
		Primary Place of Injury U98_X	Change: For injuries occurring on the construction site of a home being built please use ICD 10 U98.6 (home under construction, not yet occupied)
		Secondary Place of Injury U98_X_2	Change: For injuries occurring on the construction site of a home being built please use ICD 10 U98.6 (home under construction, not yet occupied)
		Tertiary Place of Injury U98_X_3	Change: For injuries occurring on the construction site of a home being built please use ICD 10 U98.6 (home under construction, not yet occupied)
		Incident Location LOC_STATE	Use “other” field for Nunavut until DI adds Nunavut as a selection.
May 2005			
	n/a	Secondary E Code E_CODE_2	Clarification: The secondary event code is used when you have two distinct events. This is a rare occurrence
		ICD 10 ICE_10EXT	Clarification: Record the event that caused the most significant injuries
		Police Service POL_SERV	Decision: This is an institutional option
Mar 2005			
	N/a	Language Spoken PAT_LANG	Decision: This is an institution option; you may enter it if known.
		Memo Fields	Decision: Send all memo fields to the ATR

	Mode of Transport MODE_#_S(P)(L)	Clarification: Enter the mode of transport that delivered the patient to the facility. (e.g. STARS first, ambulance second). Military helicopter ambulances should be coded as helicopter ambulances.
	Ambulance Service (2nd or 3rd Transport at Scene) SV_NUM_2(3)_S	Clarification: NTR does not require information on second/third ambulance, but please include this for the ATR.
	Heart Rate PULSE_S(P)(L)(A)	Clarification: Please report the first recorded score.
	Unassisted Respiration Rate RESP_RAT_ S(P)(L)(A)	Clarification: Please report the first recorded score.
	Systolic Blood Pressure (SBP) SBP_ S(P)(L)(A)	Clarification: Please report the first recorded score.
	Was patient intubated? INTUBAT_S(P)(L)(A)	Clarification: Intubation refers to oral/nasal intubation; Tracheostomy; Cricothyroidotomy. (No combitubes or LMA).
	Eye EYE_OPNG_S(P)(L)(A)	Clarification: Please report the first score
	Verbal VER_RESP_ S(P)(L)(A)	Clarification: Please report the first score
	Motor MOT_RESP_ S(P)(L)(A)	Clarification: Please report the first score
	Total GCS DISP_GCS_ S(P)(L)(A)	Clarification: Please report the first score
	Total RTS DISP_RTS_S(P)(L)(A)	Clarification: Calculations should be based on the first recorded scores
	Temperature TEMP_P(L)(A)	Addition: Added this to note "Enter the patient's first recorded temperature in Celsius degrees at the primary hospital. Because a decimal point is allowed, 3 digits must be entered (includes the digit after the decimal point)."
May 2004		
N/a	Street PAT_ADR_S	Clarification: decided that homeless should be entered at "I"
	Postal Code PAT_ADR_PC	Clarification: Using T1T 1T1 is appropriate
	Primary E-Code E_CODE	Clarification: Record the event that caused the most significant injuries.
	Primary Place of Injury E849_X	Change: For injuries occurring on the construction site of a home being built please use ICD 9 E849.3 (home under construction)

		Secondary Place of Injury E849_X_2	Change: For injuries occurring on the construction site of a home being built please use ICD 9 E849.3 (home under construction)
		Tertiary Place of Injury E849_X_3	Change: For injuries occurring on the construction site of a home being built please use ICD 9 E849.3 (home under construction)
		Primary Injury Type INJ_TYPE	Clarification: any strangulation, hanging and/or drowning should be coded as "Blunt" type injury, this is to ensure consistency with NTR
		Vehicle Type VEH_TYPE	Clarification: SUV's and MPV's should be coded as passenger vehicles
		Extrication Required EXTRICATE	Clarification: A pedestrian caught under a vehicle is considered extrication. Use of a spine board only is NOT extrication
		Extrication Time Required EXTRIC_TIM	Clarification: Enter exact minutes if known. Do not use estimates. Enter 'U' if unknown.
		Ambulance Service SV_NUM_#_S(P)(L)	Clarification: This is an institutional option, can use PCR # or Event#
		Number of Qualified Personnel EMR_#_S(P)(L)	Clarification: EMR= someone trained in first aid and CPR
		Paralytic Agents In Effect PAR_AGNT_ S(P)(L)(A)	Clarification: Definition Added
		Non-operative Procedures (Scene) NONOP_S_#	Clarification: If procedure is not listed, use "other" and specify procedure in "if other".
		Other non-operative Procedure(s) (Scene) NONOP_S_O	Addition: Laryngeal mask and combitubes are not classified as intubation.
		Visit # VISIT_NUM	Clarification: Institution option use visit # or hospital case #
Mar 2004			
	N/a	AIS code AIS_#	Liver Laceration- have to enter min not Grade II – DI needs to upgrade
April 2003			
	N/a	Health Region LOC_REGION	Health regions were re-defined; new numbers were assigned. Do not use 01-17

Provincial Report Definitions

Appendix D

Provincial Trauma Report:

ISS ≥ Trauma N:

- All traumas with ISS ≥ 12 that are admitted, transferred, or die.
- Each site counts all their ISS ≥ 12; for provincial numbers, one cannot add all trauma numbers, we will account for 'double counting in transfers to higher center.

All trauma N:

- This will be a health record report that would include all trauma patients that are admitted, transferred, or die. Does not include the injury patients that are discharged from ER. All ISS scores.

Patients arriving direct (N):

- Patients that are received directly from point of injury (scene) to the ED (not a transfer from another site). Trauma patients ISS ≥ 12.

Patients transferred to higher level trauma center (N):

- Patients sent to higher level of care e.g. patients sent from Red to FMC, U of A etc. and not transferred back to rural site.

Age (mean):

- Mean age of the registry patients ISS ≥ 12 (that are admitted, transferred, or die)

Mortality (N):

- Number of registry patients ISS ≥ 12 that have died.

Provincial QI Filters Report:

Total N trauma ISS ≥ 12:

- All trauma with ISS ≥ 12 that are admitted, transferred, or die.
- Each site counts all their ISS ≥ 12; for provincial numbers, one cannot add all trauma numbers, we will account for 'double counting in transfers to higher center.

All trauma deaths in 24 hrs at your institution:

- All trauma deaths in the first 24 hrs at your site (in all likelihood these patients will have an ISS ≥ 12).

Total laparotomies/3month interval:

- Number of laparotomies per 3 month interval (quarter): note if one patient had 2 laparotomies, should only be counted as one.

Urgent laparotomies not done within 2 hours:

- Number of laparotomies that should have been done on an unstable patient (BP<90 systolic or receiving blood > 4 units in the first hour due to hemorrhagic shock) in the first 2 hours of arrival to trauma center.

TTL (ER physician/surgeon) not present within 20-30 minutes:

- All patients with TTA and a known TTL response and the time was greater than 20-30 minutes. (TTL/ER physician is expected to respond within 20 minutes upon TTA)

Triage guidelines violated:

- Pre-hospital guidelines to be formalized

Arrival times outside proposal guidelines for your patients to your institution from scene or other hospital

- ≤ 200 km arrive within 2.5 hrs
  The number of instances when the transfer time from another site or scene to your trauma center has a delay in transfer time > 2.5 hours

- 200-400 km arrive within 4 hours
  The number of instances when the transfer time from another site or scene to your trauma center has a delay in transfer time > 4 hours.

- >400 km arrive within 6 hours
  The number of instances when the transfer time from another site or scene to you trauma center has a delay in transfer time > 6 hours

- > 2 hours in hospital transferring to you
  If another site is transferring a patient to your trauma center, provide the number of instances when the time at another site is greater than 2 hours (not including the transfer time). Essentially the time from arrival to their site to the time left their site.