Trauma Data Dictionary Data Elements Index

PATIENT DEMOGRAPHICS

Admission Status…D_01
The admission status of the patient to your hospital.

Medical Record Number…D_02
The unique number assigned by the hospital to the patient in order to track the patient's medical record.

Trauma band Number…D_03
The unique number assigned to each patient at the time they are entered into the trauma system.

Patient's Last Name…D_04
The patient's legal last name.

Patient's First Name…D_05
The patient's legal first name.

Patient's Middle Initial…D-06
The patient's legal middle initial.

Patient's Alias Last Name…D_07
An alias last name given to the patient for confidentiality reasons. (Not required).

Patient's Alias First Name…D_08
An alias first name given to the patient for confidentiality reasons. (Not required).

Arrival Date…D_09
The date the patient arrived at your hospital.

Arrival Time…D_10
The time the patient arrived at your hospital.

Date of Birth…D_11
The patient's legal date of birth.

Age…D_12
The patient's age.

Age Units…D_13
The patient's age units i.e., Months, Days, Weeks, Years.

Sex…D_14
The patient's sex.

Race…D-15
The patient's race.

Ethnicity…D_16
The patient's ethnicity.

Social Security Number…D_17
The patient's social security number.

Patient's Home Address…D_18
Patient's address of residence.

Patient's Home Zip Code…D_19
Patient's home Zip code of primary residence.

Patient's Home City…D_20
The patient's city of residence.

Patient's Home State…D_21
Patient's state of residence.

Patient's Home County…D_22
The patient's county of residence.

Patient's Home Country…D23
Patient's country of residence.

Alternate Residence…D_24
Documentation of the type of a patient without a Zip/Postal code.

INCIDENT

Injury Incident Date…I_01
The date the injury occurred.

Injury Incident Time…I_02
The time the injury occurred.

ICD-10-CM Place of Occurrence External Cause Code…I_03
Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x).

Incident Location Zip Code…I_04
The ZIP code of the Incident location.

Incident Location City…I_05
The city or township where the patient was found or to which the unit responded.

Incident Location County…I_06
The county or parish where the patient was found or to which the unit responded (or best approximation).

Incident Location State…I_07
The state, territory, or province where the patient was found or to which the unit responded (or best approximation).

Incident Location Country…I_08
The country where the incident occurred.

Incident Address…I_09
The address where the incident occurred.

Incident Scene Latitude…I_10
The exact Latitude of the injury scene. (Prefer up to 6 decimal points, such as 45.528382).

Incident Scene Longitude…I_11
The exact Longitude of the incident scene. (Prefer up to 6 decimal points, such as -122.657473).

Mechanism of Injury…I_12
The mechanism of the event which caused the injury.

Fall Height in Feet…I_13
The distance in feet the patient fell, measured from the lowest point of the patient to the ground.

ICD-10-CM Primary External cause Code…I_14
External cause code used to describe the mechanism (or external factor) that caused the injury event.

ICD-10 Additional External Cause Code…I_15
Additional External Cause Code used in conjunction with the Primary External cause Code if multiple external cause codes are required to describe the injury event.

Protective Devices Used…I_16
Protective devices (safety equipment) in use or worn by the patient at the time of injury.

Child Specific Restraint…I_17
Restraint devices in use specific to children used by the patient at the time of injury.

Airbag Deployment…I_18
Indication of airbag deployment during a motor vehicle crash.

OSHA Personal Protection…I_19
Personal protective devices used by the patient (used for on job injury only).

Work Related…I_20
Was the cause of patient's injury related to work environment?

Patient's Occupation…I_21
The patient's work industry. (Used if injury is work related).

Patient's Occupational Industry…I_22
The patient's occupational industry associated with the patient's work environment. (Used if injury is work related).

PRE-HOSPITAL

Transport Mode…PH_01
The mode of transport delivering the patient to the hospital.

PCR/ePCR #...PH_02
The PCR/ePCR number unique to each patient care report from EMS. (If electronic ePCR, record the last six characters of the ePCR number).

Agency…_PH_03
The Oregon EMS agency license code used for the EMS agency that transported the patient to the hospital. (If non EMS transported patient mark N/A).

EMS Dispatch Date…PH_04
The date the EMS agency was dispatched to the incident scene.

EMS Dispatch Time…PH_05
The time the EMS agency was dispatched to the incident scene.

Date EMS at Patient…PH_06
The date that the first EMS personnel was at the patient's side. (If no EMS mark as N/A).

Time EMS at Patient…PH_07
The time the first EMS personnel was at the patient's side. (If no EMS mark as N/A).

EMS Unit Departure Date from Scene or Transferring Facility…PH__08
The date the EMS agency departed from the scene. (If no EMS mark N/A).

EMS Unit Departure Time from Scene or Transferring Facility…PH_09
The time the EMS agency departed from the scene. (If no EMS mark N/A).

EMS Unit Arrival Date at Hospital…PH_10
The date the patient arrived at hospital.

EMS Unit Arrival Time at Hospital…PH_11
The time the patient arrived at the hospital.

Mass Casualty Incident (MCI)…PH_12
Was this a Mass Casualty Incident, as indicated by EMS agency?

Response Time…PH_13
The calculated time from EMS Unit Dispatch to EMS Unit Arrival on scene of injury.

Scene Time…PH_14
The calculated time from EMS Unit Arrival on Scene to EMS Unit Departure Time from scene of injury.

Transport Time…PH_15
The calculated time from EMS Unit Departure from scene to EMS Unit Arrival Time at Hospital.

Pre-Hospital Procedures…PH_16
The pre-hospital procedures performed on the patient.

Date Pre-Hospital Vitals Taken…PH_17
The date the initial pre-hospital vitals were taken at the scene of injury.

Time Pre-Hospital Vitals Were Taken…PH_18
The time the initial pre-hospital vitals were taken at the scene of injury.

Initial Field Pulse Rate…PH_19
The initial field pulse rate recorded at the scene of injury. Recorded as beats per minute.

Initial Field Respiratory Rate…PH_20
The initial filed respiratory rate recorded at the scene of injury. Recorded as breaths per minute.

Initial Field Systolic Blood Pressure…PH_21
The initial field Systolic Blood Pressure recorded at the scene of injury.

Initial Field Oxygen Saturation (O2)…PH_22
The initial field oxygen saturation level recorded at the scene of injury.

Initial Field GCS – Eye…PH_23
The initial Glasgow Coma Score for eye response recorded at the scene of injury.

Initial Field GCS – Verbal…PH_24
The initial Glasgow Coma Score for verbal response recorded at the scene of injury.

Initial GCS – Motor…PH_25
The initial Glasgow Coma Score for motor response recorded at the scene of injury.

Initial Field GCS Total…PH_26
The total field Glasgow Coma Score recorded at the scene of injury.

Initial GCS Qualifier…PH_27
First recorded documentation of factors which make the GCS score more meaningful.

Initial End Tidal Carbon Dioxide (ETCO2)…PH_ 28
The numeric value of the patient's exhaled end tidal carbon dioxide (ETCO2) level measured as a unit of pressure in millimeters of mercury (mmHg).

Vehicle Pedestrian Other Injury Risk Factors…PH_29
EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of the injury EMS Run Report.

Trauma Center Criteria…PH_30
Physiological and anatomic EMS trauma criteria for transport to a triage center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the EMS Run Report.

Pre-Hospital Cardiac Arrest…PH_31
Did the patient suffer from a cardiac arrest event while in the pre-hospital setting, or at the scene of injury?

REFER-IN

Transfer In…REF_01
Was the patient a transfer into your hospital from another acute care hospital?

Referring Hospital…REF_02
The name of the referring hospital.

Referring Hospital Arrival Date…REF_03
The date the patient arrived at the referring hospital.

Referring Hospital Arrival Time…REF_04
The time the patient arrived at the referring hospital.

Referring Hospital Discharge Date…REF_05
The date the patient was discharged from the referring hospital.

Referring Hospital Discharge Time…REF_06
The time the patient was discharged from the referring hospital.

Length of Stay…REF_07
Calculated length of stay at referring hospital.

Date of Referring Hospital Vitals…REF_08
The date the referring hospital took the last set of vitals.

Time of Referring Hospital Vitals…REF_09
The time the referring hospital took the last set of vitals.

Referring Hospital Pulse…REF_10
The last recorded pulse from the referring hospital.

Referring Hospital Respiratory Rate…REF_11
The last recorded respiratory rate from the referring hospital.

Referring Hospital Systolic Blood Pressure… REF_12
The last recorded systolic blood pressure from referring hospital

Referring Hospital GCS – Eye…REF_13
The last recorded Glasgow Coma Score for Eye from referring hospital.

Referring Hospital GCS – Verbal…REF_14
The last recorded Glasgow Coma Score for Verbal from referring hospital.

Referring Hospital GCS – Motor…REF_15
The last recorded Glasgow Coma Score for Motor from referring hospital.

Calculated GCS Total (Adult and Pediatric) from Referring Hospital…REF_16
The total of the adult and pediatric Glasgow Coma Score from the referring hospital.

Referring Hospital GCS Qualifier…REF_17
Recorded documentation of factors which make the Glasgow Coma Score more meaningful.

Calculated Revised Trauma Score…REF_18
The calculated revised trauma score from the referring hospital.

EMERGENCY DEPARTMENT (ED)

Arrival Signs of Life…ED_01
Indication of whether patient arrived at ED/Hospital with signs of life.

Arrival Time…ED_02
The time the patient arrived in the ED/Hospital.

Arrival Date…ED_03
The date the patient arrived in the ED/Hospital.

Discharge Time…ED_04
The time the patient was discharged from the ED.

Discharge Date…ED_05
The date the patient was discharged from the ED.

Calculated Length of Stay in ED…ED_06
The length of stay the patient was in the ED.

Discharge Order Date…ED_07
The date the discharge order was written for the patient to leave the ED.

Discharge Order Time…ED_08
The time the discharge order was written for the patient to leave the ED.

Calculated Discharge Length of Stay…ED_09
The calculated time difference between when the order for discharge from ED was written and the patient physically left the ED.

ED Discharge Disposition…ED_10
The disposition of the patient at the time of discharge from the ED.

POLST…ED_11
Documentation of the patients having a POLST form.

Date of ED/Hospital Vitals…ED_12
The date of the first recorded vitals (within 30 minutes of admission) to the ED/Hospital.

Time of ED/Hospital Vitals…ED_13
The time of the first recorded vitals (within 30 minutes of admission) to the ED/Hospital.

ED/Hospital Temperature…ED_14
The first recorded temperature (recorded in Degrees Celsius) taken within 30 minutes of admission to the ED/Hospital.

ED/Hospital Pulse…ED_15
The first recorded pulse (within 30 minutes of admission to ED/Hospital).

ED/Hospital Respiratory Rate…ED_16
The first recorded respiratory rate (within 30 minutes of admission to ED/Hospital).

ED/Hospital Systolic Blood Pressure…ED_17
The first recorded systolic blood pressure (within 30 minutes of admission to ED/Hospital).

ED/Hospital Diastolic Blood Pressure…ED_18
The first recorded diastolic blood pressure (within 30 minutes of admission to ED/Hospital).

ED/Hospital O2 Saturation Level…ED_19
The first recorded O2 saturation level (within 30 minutes of admission to ED/Hospital.

ED/Hospital Respiratory Assistance…ED_20
Documentation which explains if the patient is receiving respiratory assistance in the ED/Hospital.

ED/Hospital Supplemental Oxygen (O2)…ED_21
Documentation which explains if the patient is receiving supplemental Oxygen (O2).

ED/Hospital Initial GCS – Eye…ED_22
The first recorded Glasgow Coma Score for Eye. (Within 30 minutes of admission to ED/Hospital.

ED/Hospital Initial GCS – Verbal…ED_23
The first recorded Glasgow Coma Score for Verbal. (Within 30 minutes of admission to ED/Hospital.

ED/Hospital Initial GCS – Motor…ED_24
The first recorded Glasgow Coma Score for Motor. (Within 30 minutes of admission to ED/Hospital.

ED/Hospital Initial Calculated GCS Total (adult and pediatric)…ED_25
The first calculated Glasgow Coma Score (adult and pediatric). (Within 30 minutes of admission to ED/Hospital.

ED/Hospital Initial GCS Qualifier…ED_26
The first recorded Glasgow Coma Score Qualifier that potentially effect the first assessment of GCS. (Within 30 minutes of admission to ED/Hospital).

ED/Hospital Initial Weight…ED_27
The first recorded weight in Kilograms. (Within 30 minutes of admission to ED/Hospital).

ED/Hospital Height…ED_28
The first recorded height in feet and inches at time of admission to the ED/Hospital.

ED Diagnosis…ED_29
The practitioner's description of the condition or problem for which the Emergency Department services were provided up to 50 codes.

LAB

Alcohol Screen…LAB_01
Used to document whether or not the patient was tested for alcohol use.

Alcohol Screen Results…LAB_02
Used to record the amount of alcohol shown in the alcohol test results. (Recorded as a decimal).

Drug Use Indicator…LAB_03
Used to document whether or not the patient was tested for use of illegal or prescription drugs.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)…LAB_04
Was SBIRT screening done with the patient?

Screening, Brief Intervention, and Referral to Treatment Result…LAB_05
Documentation as to whether or not the SBIRT screening was positive or negative.

Screening, Brief Intervention, and Referral to Treatment (SBIRT Brief Intervention)…LAB_06
Documentation showing that an SBIRT Intervention was completed with the patient.

Screening, Brief Intervention, and Referral to Treatment (SBIRT Referral to Treatment)…LAB_07
Documentation showing that a referral to treatment was made for the patient.

Lab Panel or Screening Used…LAB_08
Description of the drug screen used.

Drugs Found…LAB_09
Documentation of results from drug screening panel.

TRAUMA TEAM/PROVIDER

Activation Level…TTP_01
Documentation of the hospitals response to the activation of the trauma team, or documentation that there was no trauma team activated.

Activation Date…TTP_02
Documentation of the date the trauma team was activated.

Activation Time…TTP_03
Documentation of the time the trauma team was activated.

Providers…TTP_04
Documentation of the provider that responded to the trauma team activation.

Provider Specialty…TTP_05
The specialty of the provider responding to the trauma team activation.

Provider Notify Date…TTP_06
The date that the provider was notified of trauma team activation.

Provider Notify Time…TTP_07
The time that the provider was notified of trauma team activation.

Provider Arrival Date…TTP_08
The date that the notified provider arrived at the patient bedside.

Provider Arrival Time…TTP_09
The time that the notified provider arrived at the patient bedside.

Provider Phone Consultation…TTP_10
Documentation that the provider was contacted by telephone. (Phone consultations do not require an arrival date or time to be documented).

Calculated Provider Response Time…TTP_11
The calculated provider response time.

Provider Consultation Date…TTP_12
The date that a consultation occurred with a provider.

Provider Consultation Time…TTP_13
The time that a consultation occurred with a provider.

Provider Consultation Service or Specialty…TTP_14
The service of specialty of the provider giving the consult.

Consulting Physician…TTP_15
The name of the physician being consulted.

EMERGENCY DEPARTMENT/HOSPITAL PROCEDURES

ICD-10 Procedure…PR_01
The procedure performed on the patient in the ED/Hospital.

ICD-10 Procedure Long Text…PR_02
The description of the ICD-10 code selected for PR_01.

Procedure Location…PR_03
The location that the procedure was performed. (I.e. OR, ICU, etc.).

Procedure Date…PR_04
The date that the procedure was performed.

Procedure Start Time…PR_05
The time that the procedure was started. (For imaging the time that the radiation first hit the patient's body).

Procedure Stop Date…PR_06
The date that the procedure was stopped.

Procedure Stop Time…PR_07
The time that the procedure was stopped.

Procedure Physician…PR_08
The physician that performed, or interpreted the results from a procedure performed on the patient.

Procedure Results…PR_09
The results of the procedure performed on the patient.

Calculated Time to Procedure…PR_10
The calculated time to procedure. (Calculated time from procedure start to procedure stop).

Calculated Time to First OR Visit…PR_11
The calculated time to the patient's first OR visit.

INJURIES

AIS Six Digit Injury Identifier(s)…I_01
Six digit identifier from the Association for the Advancement of Automotive Medicine's (AAAM) Abbreviated injury Scale (AIS) 2005. Select all that apply.

AIS Code Long Text…I_02
The definition of the code selected in I_01.

AIS Body Part Injured…I_03
Corresponding body region for the AIS 2005 predot code entered.

AIS Calculated Injury Severity Score...I_04
Injury Severity Score calculated based on the hand coded (not including ICD-10-CM diagnosis codes). AIS scores entered. Overall scoring system for patients with multiple injuries. Value range = 1 to 75.

Severity Value (for ICD-10-CM diagnosis codes only)…I_05
Corresponding AIS severity code that reflects the severity of the ICD-10-CM injury diagnosis entered.

Body Part Injured (for ICD-10-CM diagnosis codes only…I_06
Corresponding body region for the ICD-10-CM injury diagnosis entered.

Estimated Injury Score (Calculated based on ICD-10-CM Injury Diagnosis Only)…I_07
Injury Severity Score calculated based on the ICD-10-CM injury diagnosis entered mapped to corresponding ICD-9-CM injury diagnosis entered. Overall scoring system for patients with multiple injuries.

TMPM AIS (using only AIS 2005 coded information)…I_08
Trauma Mortality Predictive Measure generated from patient's five worst injuries using AIS based scoring.

TMPM ICD-10-CM (ICD-10-CM using only ICD-10-CM information)… I_09
Trauma Mortality Predictive Measure generated from patient's five worst injuries using ICD-10-CM mapped to ICD-9-CM based scoring.

Comorbidities…I_10
Comorbid conditions documented in the patient's medical history either from the hospital or EMS. These are conditions that the patient had BEFORE the traumatic injury.

DISCHARGE

Date of Hospital Exit…DC_01
The date the patient exited the hospital.

Time of Hospital Exit…DC_02
The time that the patient exited the hospital.

Total Calculated Length of Stay…DC_03
The calculated total length of time the patient was in the hospital.

Hospital Discharge Order Date…DC_04
The date the discharge order was written for the patient.

Hospital Discharge Order Time…DC_05
The time the discharge order was written for the patient.

Hospital Calculated Discharge Length of Stay…DC_06
The length of time from when the patient discharge order was written to when they actually exited the hospital.

Hospital Discharge Disposition…DC_07
The patients discharge disposition after leaving the hospital.

Outcome at Hospital Discharge…DC_08
The patient's level of handicap at time of discharge from hospital.

Live/Die…DC_09
Documentation of whether the patient lived or died before discharge from the hospital.

Total Ventilator Support Days…DC_10
The total number of days the patient was on ventilatory support (see full data dictionary for calculation instructions).

ICU Length of Stay…DC_11
Total days that patient was admitted to the Intensive Care Unit (ICU). (See full data dictionary for calculation instructions).

Primary Payor…DC_12
The party responsible as primary payor for paying for charges the patient accrued while admitted to the ED/Hospital.

Total Hospital Charges…DC_13
The total cost in dollars for the care provided to the patient while admitted to the ED/Hospital.

Report of Physical Abuse…DC_14
Was a report of physical abuse made by the patient or patient's family, friends, caregiver, or anyone to a mandated reporter while patient was admitted the ED/Hospital?

Investigation of Physical Abuse…DC_15
Was an investigation into a claim of physical abuse started, or finished while the patient was admitted to the ED/Hospital?

Different Caregiver at Discharge…DC_16
Was the patient discharged to another caregiver (adult or pediatric patient) other than the caregiver they accused of physical abuse?

COMPLICATIONS

Issues/Problems…CO_01
A list of complications that the patient suffered while admitted to the ED/Hospital.

PI REVIEW

PI Indicators…PI_01
List of PI indicators that are pre-selected by the State of Oregon, or an individual hospital. (See full data dictionary for more information regarding PI Indicators).

Open / Closed Status…PI_02
The status of the PI Issue as selected in PI_01.

Closed Date…PI_03
The date the PI Issue has been reviewed and the issue has been closed.

Level of Review…PI_04
The highest level of review that the PI Issue was reviewed by.

Peer Review Committee Date…PI_05
The date the PI Issue went before the Peer Review Committee.

Date Identified…PI_06
The date the PI Issue was identified.

Death Review…PI_07
The date that the death of a patient was reviewed.

Source…PI_08
The source that the PI Issue was generated from. I.e. nursing, physician, ICU, etc.

Judgement of Errors…PI_09
The decision regarding the PI Issue. I.e. preventable error, unpreventable error, etc.

Judgement of Impact…PI_10
The decision regarding the impact of the PI Issue on the patient. I.e. No impact, major impact, etc.

Disease Related…PI_11
Was the PI Issue caused by the process of a disease? Such as a co-morbidity the patient was diagnosed with before the traumatic injury.

Provider Related…PI_12
Was the PI Issue caused by the judgement of a provider that cared for the patient while they were admitted to the ED/Hospital?

System Related…PI_13
Was the PI Issue caused by a system wide issue or standard of care?

READMISSION

Readmission Arrival Date…RE_01
The date of the patient's unplanned readmission to the ED/hospital.

Readmission Arrival Time…RE_02
The time of the patient's unplanned readmission to the ED/hospital.

Readmission Discharge Date…RE_03
The date of the patient's discharge from an unplanned readmission.

Readmission Discharge Time…RE_04
The time of the patient's discharge from an unplanned readmission.

Readmission Length of Stay…RE_05
The patient's length of stay in the ED/hospital for unplanned readmission.

Readmission Outcome…RE_06
The patient's Live/Die outcome from the unplanned readmission.

Readmission Procedure Date…RE_07
The date a procedure was performed on a patient who has an unplanned readmission.

Readmission Procedure Performed ICD-10-CM Code(s)…RE_08
The ICD-10-CM codes for procedures performed on the patient during an unplanned readmission.

Physician Performing Procedure…RE_09
The physician who performed the procedures on the readmitted patient.

Readmission Diagnosis…RE_10
The ICD-10 diagnosis codes for a patient with an unplanned readmission.

OUTCOME

Rehab Admission Date…O_01
The date the patient was admitted to a rehabilitation facility.

Rehab Discharge Date…O_02
The date the patient was discharged from the rehabilitation facility.

Rehab Discharge To…O_03
Where the patient went when discharged from the rehabilitation facility.

Self Care…O_04
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

Sphincter Control…O_05
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

Locomotion…O_06
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

Mobility & Transfer…O_07
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

Locomotion…O_08
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

Communication…O_09
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

Social Cognition…O_10
The top line is for the patients abilities BEFORE the traumatic incident and admission to rehabilitation facility. The bottom line is for the patient's abilities AFTER the traumatic incident an release from the rehab center.

PI ISSUES

PI Issues…PI_01
A list of state required PI Issues. This is a picklist.

Comments…PI_02
The comments and review notes for the PI Review Committee. Including the Trauma Registrar, Trauma Coordinator/Manager, and Trauma medical Director.

Print…PI_03
The ability to print the list of PI Issues along with comments by the PI Review Committee.

Open Close Date…PI_04
The status of the PI issue opened, pending, or closed.

Closed Date…PI_05
The date the PI Issue was closed.

Level of Review…PI_06
The level at which the PI Issue was reviewed.

PR Date…PI_07
The date the PI Issue went before peer review.

Death Review…PI_08
The determination of whether or not a trauma patient's death was preventable.

Date ID'd…PI_09
The date that the PI Issue was identified.

Source…PI_10
The source of the PI Issue. For example. Nursing, Rounds, Social Worker, etc.

Judgement of Errors…PI_11
The judgement of whether or not the cause of the PI Issue was justified, preventable, etc.

Judgement of Impact…PI_12
The level of impact that the PI Issue had on the patient's care and/or outcome.

Disease Related…PI_13
Whether or not the PI Issue was a result of the patient's disease process.

Provider Related…PI_14
Whether or not the PI Issue was a result of the provider's actions or judgement.

System Related…PI_15
Whether or not the PI Issue was a result of the trauma care system.

Further Explanation or Comments…PI_16
A free text field that can be used to enter further explanatory information regarding the PI Issues(s).

TQIP PAGE ONE

TBI Inclusion…TQ_01
Did the patient sustain injuries that would include patient as having a Traumatic Brain Injury?

Highest GCS Total...TQ_02
The highest GCS with 24 hours of ED/Hospital arrival.

Pupillary Response…TQ_03
Collect on patient's with at least one injury in AIS head region. Physiological response of the pupil size within 30 minutes or less of ED/Hospital arrival.

Midline Shift…TQ_04
Collect on patient's with at least one injury in AIS head region. >5mm shift of the brain past its center line within 24 hours after time of injury.

All Cerebral Monitors Placed…TQ_05
Collect on patient's with at least one injury in AIS head region. Indicate all cerebral monitors placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), licox monitor, jugular venous bulb.

Date of First Cerebral Monitor Placed…TQ_06
The date the first cerebral monitor was placed on the patient.

Time of First Cerebral Monitor Placed…TQ_07
The time the first cerebral monitor was placed on the patient.

VTE Inclusion…TQ_08
Were the patients injuries included in VTE.

VTE Type…TQ_09
Collect on all patients. Type of first dose of VTE prophylaxis administered to patient at your hospital.

VTE Date…TQ_10
The date of administration to patient of first prophylactic dose of heparin or other anticoagulants at your hospital.

VTE Time…TQ_11
The time of administration to patient of first prophylactic dose of heparin or other anticoagulants at your hospital.

TQIP PAGE TWO

Blood Inclusion…TQ_12
Was the patient included in the blood transfusion protocol?

Lowest ED/Hospital SBP…TQ_13
The lowest recorded Systolic Blood Pressure recorded in the ED/Hospital.

Transfusion Blood (4 hours)…TQ_14
Volume of packed red blood cells transfused (units or CC's) within first 4 hours after ED/Hospital arrival.

Transfusion Blood (24 Hours)…TQ_15
Volume of packed red blood cells transfused (units or CC's) within first 24 hours after ED/Hospital arrival.

Transfusion Blood Measurement…TQ_16
The measurement used to document the patient's blood transfusion (units, CC's [MLs].

Transfusion Blood Conversion…TQ_17
The quantity of CC's [MLs] constituting a "unit" for blood transfusions at your hospital.

Withdrawal of Care Inclusion…TQ_18
Was care withdrawn from patient due to severity of injuries and/or patient outcome predictions?

Withdrawal of Care…TQ_19
Was care withdrawn from the patient?

Withdrawal of Care Date…TQ_20
The date that care was withdrawn from the patient.

Withdrawal of Care Time…TQ_21
The time that care was withdrawn from the patient.

Trauma Data Dictionary

Appendix A

FACILITY DATA SET

Facility Name…FDS_01
The legal name of the trauma center entering data into the Oregon Trauma Registry.

Department Name…FDS_02
The name of the department entering data into the Oregon Trauma Registry.

Facility Address…FDS_03
The physical address of the trauma center.

Country Specification…FDS_04
The country that the trauma center is located in.

Facility Phone Number…FDS_05
The main phone number of the trauma center.

Telephone Extension…FDS_06
The telephone extension for the person or department responsible for entering data into the Oregon Trauma Registry.

TQIP/NSP…FDS_07
Does your trauma center participate in TQIP/NSP?

Registry Type…FDS_08
Do you use a trauma registry vendor other than TraumaOne?

TQIP Report ID…FDS_09
Your TQIP report ID.

Pediatric TQIP Report ID…FDS_10
Your facility TQIP report ID.

Other Registries Submitted…FDS_11
Does your trauma center send data to any other registries?

Primary Contact Name…FDS_12
The primary contact for your facilities program.

Primary Contact Title…FDS_13
The primary contacts Title.

Primary Contacts Email Address…FDS_14
The primary contacts email address.

Primary Contact Phone…FDS_15
The primary contacts phone number.

Primary Contact Fax…FDS_16
The primary contacts fax number.

Trauma Program Coordinator/Manager Contact…FDS_17
The name of your trauma centers Trauma Coordinator/Manager.

TPM/Coordinator Contact Title…FDS_18
The trauma centers Trauma Program Coordinators/Managers title.

TPM/Coordinator Contact Email Address…FDS_19
The trauma centers Trauma Program Coordinator/Managers email address.

TPM/Coordinators Contact Phone…FDS_20
The Trauma Program Coordinator/Managers telephone number.

TPM/Coordinators Contact Fax…FDS_21
The Trauma Program Coordinators/Managers fax number.

Trauma Medical Directors Contact Name…FDS_22
The name of the Trauma Program Medical Director.

Trauma Medical Directors Contact Title…FDS_23
The title of the Trauma Medical Director.

Trauma Medical Directors Email Address…FDS_24
The Trauma Medical Directors email address.

Trauma Medical Directors Contact Address…FDS_25
The Trauma Medical Directors physical address.

Trauma Medical Directors Phone…FDS_26
The Trauma Medical Directors telephone number.

Trauma Medical Directors Fax…FDS_27
The Trauma Medical Directors fax number.

Primary Trauma Registrar Contact Name…FDS_28
The name of the primary Trauma Registrar entering data into the Oregon Trauma Registry.

Primary Trauma Registrars Contact Title…FDS_29
The title of the primary Trauma Registrar.

Primary Trauma Registrars Contact Email Address…FDS_30
The primary Trauma Registrars email address.

Primary Trauma Registrars Contact Address…FDS_31
The physical address of the primary Trauma Registrar.

Primary Trauma Registrars Contact Phone…FDS_32
The primary Trauma Registrars telephone number.

Primary Trauma Registrars Contact Fax…FDS_33
The primary Trauma Registrars fax number.

ACS Verification Level…FDS_34
The trauma centers ACS verification level.

ACS Pediatric Verification Level…FDS_35
The trauma centers ACS pediatric verification level.

State Designation/Accreditation…FDS_36
The trauma centers State of Oregon designation/accreditation level.

Number of Beds…FDS_37
The number of beds your trauma center has (facility wide).

Number of Staff for Oregon Trauma Registry…FDS_38
The number of FTE employees your trauma center has dedicated to the Oregon Trauma Registry.

Other Registry Software…FDS_39
Does your trauma center use a third party trauma registry? If YES, What vendor/product and version of product?

Does Your Trauma Center Have a Pediatric Ward…FDS_40
Does your trauma center have a designated pediatric ward?

Does Your Trauma Center Have a Pediatric ICU…FDS_41
Does your trauma center have a designated pediatric intensive care unit?

Does Your Trauma Center Have a Separate Pediatric ED Staffed by Pediatric Trained Physicians…FDS_42
Does your trauma center have a separate and designated ED for pediatric care with pediatric trained physicians?

Date of Facility Demographics Submitted…FDS_43
The date that your trauma center submitted it's facility demographics.