New Zealand Major Trauma Minimum Dataset

Major Trauma National Clinical Network, Chair: Ian Civil

Core Items

Version 1.3

July 2015
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Background

In June 2012 the Ministry of Health and the Accident Compensation Corporation established and jointly funded the Major Trauma National Clinical Network (MTNCN). The role of the MTNCN is to provide clinical leadership and oversight to ensure there is a planned and consistent approach to the provision of major trauma services across New Zealand. The Network is led by Ian Civil and has membership from nominated sector representatives across a range of clinical disciplines and relevant organisations. A key objective of the Network is to lead the development and implementation of a national major trauma database, the New Zealand Major Trauma Registry (NZMTR).

A data subcommittee was convened to assist in the specifications and data components of NZTR. Following from the meetings of this subcommittee, this document reports the fields to be included in a New Zealand Major Trauma Minimum Dataset (NZMDS) for data collection and submission to a NZTR. It should be noted this dictionary will remain a “live” document during initial implementation, allowing changes and improvements to be made as the need for them arises.

This updated version of the Major Trauma Minimum Dataset is based on the original Version 1.2 drafted in November 2013 and reflects:

- Decision by the Major Trauma National Clinical Network to:
  - Change the ISS score to >12 to reflect the impact of the AIS 2005 coding and enable better alignment with the Australian trauma data, and
  - Include the National Health Index
- Changes to minor elements in the dataset to align with the Midland Regional Trauma Registry, in line with DHBs decision to use this Registry as the host for their trauma data

This dataset was determined with due consideration of the Midland Regional Trauma Registry and the Bi-National Trauma Minimum Dataset (BNTMDS) for Australia and New Zealand, used for the Australian Trauma Registry. The BNTMDS has been endorsed by the Australians following a decade’s worth of consultation with trauma stakeholders in Australia and New Zealand. To ensure alignment and potential for future comparison and collaboration, the NZMDS is identical or similar to the BNTMDS wherever possible.

The data dictionary describes the fields to be collected from all hospitals across New Zealand that currently care for major trauma patients. The data set for each patient will be submitted by the final treating hospital, the definitive care hospital, to the NZMTR at a national level. New Zealand hospitals are free to collect additional trauma data elements for hospital, DHB or regional purposes, and are not restrained to the New Zealand minimum data set described here.

A national dataset on all major trauma patients in New Zealand will provide, for the first time, a comprehensive description of severely injured patients in New Zealand, allowing for the monitoring of trends and patterns of injury. This dataset will form an invaluable resource for trauma research and provide data and information to inform guidelines and policy.

This updated version of the National Trauma Minimum Dataset has been endorsed by the Major Trauma National Clinical Network Operational Group, comprising:

National: Ian Civil, Siobhan Isles
Pre-hospital services: Tony Smith
South Island Region: Mike Hunter, Alan Lloyd
Central Region: Chris Lowry, Peter Hicks, Renate Donovan
Midland Region: Grant Christey, Alaina Campbell
Northern Region: Mike Roberts
Sponsors: Annette Pack, Gill Hall, Leila Dunphy

Guide for Use
This data dictionary has been designed to follow the patient journey, from the scene of injury to the referring hospital (where applicable) and finally to the definitive care hospital. In some instances the scene and referring hospital fields may not be applicable; however fields applying to the definitive care hospital should always be answerable.

This dictionary is designed to be completed by the final definitive care hospital. This is to ensure that the entire patient journey is captured by the NZMTR. Thus, any relevant data recorded at the scene and referring hospitals (where applicable) will need to be sent, either transferred with the patient or in a secure and timely manner following transfer, to the definitive care hospital.

Data to be transferred from the pre-hospital service and referring hospitals will include both scene-specific and referring hospital-specific fields, i.e. fields 4.01-4.09 and 5.01-5.11 respectively. Additionally, data from the referring hospitals is required for the fields which refer to either “first” hospital or for fields which may span across referring and definitive hospitals. For example 7.08 Total Length of Stay, refers to the sum of length of hospital stay in all referring and definitive care hospitals (where applicable).

All fields are mandatory, none more important than others. Where the value for the field is not known and has not been recorded, an option for “unknown” is provided. Further, when the field option does not apply, for example 4.02 Scene Pulse, when a patient’s first presentation is to the hospital emergency department, a non-applicable option is provided. Thus no field should be left blank.

Glossary of terms
Definitive Care Hospital
In general, the definitive hospital is the largest hospital the patient has been managed in. This is usually a tertiary hospital that is able to provide leadership and total care for all aspects of the injury.

However, if a patient has been transferred from one tertiary hospital to another, then the last tertiary hospital is the definitive care hospital. This is expected to be an exception.

Referring Hospitals
The acute care hospital from which the patient has been transferred from (to the definitive care hospital), usually in an effort to move the injured patient to a higher level of care where necessary resources optimise recovery.
**Pre-hospital**

Refers to any event that occurred prior to a patient arriving at the first presenting hospital. This includes scene and transfer, but does not include referring hospital care.

**Infant**

Refers to a child aged 0 – 12 months of age

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**Guide to meaning of categories and headings**

**DATA ELEMENT NAME**

**Identifying and definitional attributes**

**Definition**
A concise statement that expresses the essential nature of a data item and its differentiation from all other data items.

**Justification**
The reason for collecting this data item.

**Representational attributes**

**Guide for use**
These are comments designed to assist in further defining aspects of the data domain.

**Validation rules**
These are included to assist in reducing input error. Where validation rules are known to exist, they have been included.

**Data type**
The type of symbol or character, or other designation used to represent the data element, for example, String, Number, Date/Time.

**Maximum field size**
The maximum number of characters allowable to represent the data item values. Where multiple field options are allowed, this will be represented as the total field size, followed by depiction of this as an addition of two fields. For example, in 2.04 Ethnicity, where each field option is two characters, a maximum of two ethnicities may be selected allowing for a field size of 4 (2+2).

**Data domain**
The set of possible values for the data item. This may take the form of a code set, or a description of the possible values. Domain values are only specified where size of the code set is small enough to be reasonably reproduced in the document. In other instances the domain may be indicated by reference to a source document.
**Inclusion-exclusion criteria**

While registries from a sole hospital or regional registries benefit from broad patient capture, at a national or international level only patients with injuries which are deemed significant (by some definition) should be included. The comparatively small proportion of patients which will meet assigned inclusion criteria should fit within the funding and time constraints which are imposed, particularly on smaller hospitals or regions without local data collection previously in place. It is therefore reasonable to limit inclusion in to patients meeting specified criteria for major trauma.

Major trauma (and the inclusion criterion for the NZTR) is currently best defined at a national level as:

**INCLUSIONS**

All patients of any age admitted to hospital with either:

- Injury Severity Score (ISS) >12 (based on AIS 2005 Update 2008)
  - or
- Death following injury (including deaths in ED)

Even where patients meet all the inclusion criteria, the following patients will be excluded:

**EXCLUSIONS**

- Patients with delayed admissions more than 7 days after injury
- Poisoning or drug ingestion that do not cause injury
- Foreign bodies that do not cause injury
- Injuries secondary to medical procedures
- Isolated neck of femur fracture
- Pathology directly resulting in isolated injury
- Elderly (≥65 years of age) patients who die with superficial injury only (contusions, abrasions, or lacerations) and/or have co-existing disease that precipitates injury or is precipitant to death (e.g. Stroke, Renal Failure, Heart Failure, Malignancy).
- Hangings
- Drownings
Data Definitions
1.01  Definitive Care Hospital Code

**Identifying and definitional attributes**

**Definition**
The identifier for the establishment in which the episode of definitive (final) care occurred. Each hospital code will align to the Ministry of Health Hospital Code.

**Justification**
Collected for administrative purposes; to assist in service provider identification; to allow tracking of the patient journey; to allow for determination of hospital patient volumes and injury demographic comparisons across different hospitals.

**Representational attributes**

**Guide for use**
Use the code assigned to the facility.

**Validation rules**
Code must not be the same as 5.02 Referring Hospital

**Data type**
String

**Field size maximum**

**Data domain**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3260</td>
<td>Auckland City Hospital</td>
</tr>
<tr>
<td>3111</td>
<td>Ashburton Hospital</td>
</tr>
<tr>
<td>4611</td>
<td>Balclutha Hospital</td>
</tr>
<tr>
<td>4114</td>
<td>Bay of Islands Hospital</td>
</tr>
<tr>
<td>4013</td>
<td>Burwood Hospital</td>
</tr>
<tr>
<td>4011</td>
<td>Christchurch Hospital</td>
</tr>
<tr>
<td>4113</td>
<td>Dargaville Hospital</td>
</tr>
<tr>
<td>4211</td>
<td>Dunedin Hospital</td>
</tr>
<tr>
<td>5111</td>
<td>Dunstan Hospital</td>
</tr>
<tr>
<td>3411</td>
<td>Gisborne Hospital</td>
</tr>
<tr>
<td>8597</td>
<td>Gore Hospital</td>
</tr>
<tr>
<td>5911</td>
<td>Greymouth Base Hospital</td>
</tr>
<tr>
<td>4712</td>
<td>Hawera Hospital</td>
</tr>
<tr>
<td>3612</td>
<td>Hawkes Bay Hospital</td>
</tr>
<tr>
<td>4115</td>
<td>Hokianga Hospital</td>
</tr>
<tr>
<td>5812</td>
<td>Hutt Hospital</td>
</tr>
<tr>
<td>4021</td>
<td>Kaikoura Hospital</td>
</tr>
<tr>
<td>4112</td>
<td>Kaitaia Hospital</td>
</tr>
</tbody>
</table>
4513 Lakes District Hospital (Queenstown)
3214 Middlemore Hospital
3911 Nelson hospital
3215 North Shore Hospital
5611 Oamaru Hospital
4311 Palmerston North Hospital
4718 Patea Hospital
5312 Rotorua Hospital
8482 Royal New Zealand Naval Hospital
4511 Southland Hospital
4711 Taranaki Base Hospital
5329 Taupo Hospital
4811 Taumarunui Community Hospital
4911 Tauranga Hospital
8703 Te Aroha & District Community Hospital
5313 Te Kuiti Community Hospital
5211 Te Puia
5011 Thames Hospital
4411 Timaru Hospital
4415 Twizel Hospital
5311 Waikato Hospital
5511 Wairarapa Hospital
3811 Wairau Hospital
3216 Waitakere Hospital
5811 Wellington Hospital
3311 Whakatane Hospital
5711 Whanganui Hospital
4111 Whangarei Hospital

1.02 Incident number

Identifying and definitional attributes

Definition
An identifier which is unique to a specific trauma event for a specific person (an incident-specific not person-specific number).

Justification
Collected for administrative purposes, to assist in the identification of the same episode of care for a trauma incident;

Representational attributes

Guide for use
The code will be automatically generated by the Registry. Each incident number must be unique and not re-used over time within the establishment.

This field cannot be an identifying number, such as the NHI number.

Validation rules
Must not be identical to any other incident number

Data type
String

Field size maximum
10

Data domain
1.03 National Health Index

Identifying and definitional attributes

**Definition**
A unique combination of letters and numbers that is assigned by the Ministry of Health to each person using health and disability support services.

**Justification**
Collected for administrative purposes, to assist in the identification of the same patient who potentially could cross between administrative boundaries, and to enable analysis across services.

Representational attributes

**Guide for use**
The code is available on the patient notes. Sometimes a temporary NHI may be assigned to a patient particularly when they NHI cannot be found. If a temporary NHI is assigned, it will need to be merged with the original once known. The original NHI must be used in the registry.

**Validation rules**
3 Alpha 4 Numeric. Must adhere to NHI coding protocol

**Data type**
String

**Field size maximum**
10

**Data domain**

Refer to the following link for further information

2.01 Date of birth

Identifying and definitional attributes
Definition
The date of birth of the patient.

Justification
Collected for administrative purposes, to assist in individual identification and for derivation of age in demographic analyses.

Representational attributes
Guide for use
If date of birth is not known or cannot be obtained, Unknown should be recorded and provision should be made to collect or estimate 2.02 Age.

If year of birth is known (but date of birth is not) use the date, 0101YYYY of the birth year to estimate age (where YYYY is the year of birth).

Validation rules
Less than all other dates

Data type
Date/Time

Field size maximum
8

Data domain
<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>dd/mm/yyyy</td>
<td>Valid Date</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
2.02 Age

Identifying and definitional attributes

Definition
The age of the patient on the date of the injury event

Justification
Age is a core data element as a predictive measure of trauma treatment and outcomes; for demographic analyses.

Representational attributes

Guide for use
Age is automatically calculated in the registry based on the date of birth and date and time of injury.

Validation rules

<table>
<thead>
<tr>
<th>Data type</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Field size maximum</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Data domain</td>
<td>Value</td>
<td>Description</td>
</tr>
<tr>
<td></td>
<td>0-130</td>
<td>Automatically calculated once date of injury has been entered</td>
</tr>
</tbody>
</table>
### 2.03 Sex

#### Identifying and definitional attributes

**Definition**  
The biological distinction between male and female.

**Justification**  
Collected to determine sex specific treatment. It is also a core element in a wide range of social, labour and demographic statistics.

#### Representational attributes

**Guide for use**  
Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.

**Validation rules**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>1</td>
</tr>
</tbody>
</table>

**Data domain**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>?</td>
<td>Not known</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
2.04 Ethnicity

Identifying and definitional attributes

Definition
As defined by the Ministry of Health, an ethnic group is a social group whose members have one or more of the following four characteristics:
- they share a sense of common origins
- they claim a common and distinctive history and destiny
- they possess one or more dimensions of collective cultural individuality
- they feel a sense of unique collective solidarity.

Justification
Information on ethnicity is collected for monitoring injury patterns across different ethnic groups; ethnic group codes are key variables for determining the characteristics of the population who suffer from major trauma in New Zealand.

Representational attributes

Guide for use
Ethnicity is a self-identified characteristic in New Zealand. Ethnicity to be recorded as per Ethnicity Data Protocols for the Health and Disability Sector (1). This protocol allows for multiple levels of recording (1-4 with level 4 being the most specific). The NZTR requires coding at level 2 as a minimum, as per the protocol requirements. The data domain provided is for level 2 coding. A maximum of two ethnicities may be recorded.

Validation rules

Data type
String

Field size maximum
4 (2+2)

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>European not further defined</td>
</tr>
<tr>
<td>2.</td>
<td>NZ European / Pakeha</td>
</tr>
<tr>
<td>3.</td>
<td>Other European</td>
</tr>
<tr>
<td>4.</td>
<td>Maori</td>
</tr>
<tr>
<td>5.</td>
<td>Pacific Island not defined</td>
</tr>
<tr>
<td>6.</td>
<td>Samoan</td>
</tr>
<tr>
<td>7.</td>
<td>Cook Island Maori</td>
</tr>
<tr>
<td>8.</td>
<td>Tongan</td>
</tr>
<tr>
<td>9.</td>
<td>Niuean</td>
</tr>
</tbody>
</table>
10. Tokelauan  
11. Fijian  
12. Pacific Indian  
13. Pacific Islander  
14. Other Pacific  
15. Asian not further defined  
16. South East Asian  
17. Chinese  
18. Indian  
19. Other Asian  
20. Middle Eastern  
21. Latin American/Hispanic  
22. African  
23. Other  
24. Sri Lankan  
?  Unknown  
/.  Not stated

2.05 Weight

Identifying and definitional attributes

Definition
The weight of the person if ≤ 15 years of age on admission to the definitive care hospital, measured in kilograms.

Justification

Representational attributes

Guide for use
If not recorded to be estimated by a treating clinician

Validation rules

Data type
Number

Field size maximum
3

Data domain
Value | Description
---|---
1-999 + decimal | Weight (kilograms) to one decimal place
? | Unknown
/ | Not applicable
3.01 Date & Time of Injury

Identifying and definitional attributes

Definition
The date and time the person received the injuries requiring hospitalisation.

Justification
To identify the episode of injury by the date and time; date is used to calculate the age at date of injury; time is used to calculate the time to treatment and also report on the most common time of injury.

Representational attributes

Guide for use
If time is not accurately known, the best estimate should be used.
Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/11 00:01.

Validation rules
Must be less than or equal to:
- 4.01 Date & Time of Observations at Scene
- 5.03 Date & Time of Observations at Referring Hospital;
- 5.12 Date & Time of Departure from Referring Hospital; and
- 6.01 Date & Time of Observations at Definitive Care Hospital

Date must be greater than or equal to:
- 2.01 Date of Birth

Data type
Date and Time

Field size maximum

Data domain
<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>dd/mm/yyyy</td>
<td>Valid Date</td>
</tr>
<tr>
<td>00:00</td>
<td>Valid Time</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
3.02 Injury Cause

Identifying and definitional attributes

Definition
The ICD10 code which best describes the single environmental event, circumstance or condition (external factor) which was the primary circumstance or cause of the trauma event.

Justification
Enables categorisation of injury cause and identify trends in defining and monitoring cause of injuries.

Representational attributes

Guide for use
This code must be used in conjunction with an injury code and can be used with other disease codes. The external cause should be coded to the complete ICD-10-AM classification.

If two or more cause categories are judged to be equally important, select the one that comes first in the code list.

Validation rules

Data type
String

Field size maximum
6

Data domain
3.03  Dominant Injury Type

Identifying and definitional attributes

**Definition**
The dominant type of injury produced by the trauma event.

**Justification**
Collected to determine trends and calculation of TRISS (blunt and penetrating only).

Representational attributes

**Guide for use**
In most instances, determination of the dominant injury type will be based on the mechanism of injury, and relate directly to:

*Blunt* injuries generally occur from mechanisms such as motor vehicle collisions, pedestrian impacts, falls and sports injuries.

*Penetrating* injuries require skin penetration by an external force as the principal component of injury. Examples include stab and gunshot wounds, bomb fragments, lacerations from a single sharp instrument, glass-related injuries and impalements. This excludes closed contusions, compound fractures where the bone breaks the skin, but includes compound fractures where an external object travels through the skin and into the bone.

*Burn* injuries are caused by exposure to electrical, thermal or corrosive agents such as flames, hot substances, chemicals or radiation. Examples include situations where electricity has primarily damaged soft tissues (electrical burns).

*Unknown* - type of injury cannot be determined.

In some cases, the dominant injury type will not be readily apparent. For example, a patient injured in a severe motor vehicle collision (which generally results in blunt injuries) may have additional penetrating injuries. When compared with blunt injuries sustained in such an injury event, such penetrating injuries may be minor (as in superficially embedded glass from a broken window) or major (as in impalement on an object within the vehicle). In such cases, the dominant injury type may be established by additional review of:

- 3.08 Injury event description; and
- 7.05 AIS Injury Codes

Where an injury event results in both blunt and non-blunt trauma of equal AIS severity, the non-blunt injury type should be used.

**Validation rules**

**Data type**  String

**Field size maximum**  1
<table>
<thead>
<tr>
<th>Data domain</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blunt</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Penetrating</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Burns</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>
3.04  Place of Injury (Domicile) Code

Identifying and definitional attributes

Definition  The official New Zealand domicile code where the trauma event occurred.

Justification  Used in the analysis of injury incident on a geographical level.

Representational attributes

Guide for use  The domicile code should be derived from the address of injury where possible.

Where the domicile code is not derivable from the description of the location of injury, it should be approximated as best as possible.

Where no information is given other than the town or city where the injury event occurred, *Unknown* should be used. For example if the injury occurred somewhere in Auckland but the domicile code cannot be approximated, *Unknown* should be used and not a generic city code.

If the injury occurs in a location in which a New Zealand domicile code is not applicable, such as on a boat, plane or at an overseas location, code *Not Applicable* should be used.

Validation rule

Data type  Number

Field size maximum  4

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid domicile code</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>/.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

The MoH provides software to DHBs to access domicile codes. Refer to the following link for further information

3.05 Injury Intent

Identifying and definitional attributes

**Definition**
The most likely role of human intent in the occurrence of the trauma event as determined by a clinician’s assessment.

**Justification**
Used for injury surveillance.

Representational attributes

**Guide for use**
Select the code which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. Intent refers to the **intention to cause injury**, rather than the intention to perform an action which may or may not directly result in injury. For example, punching a hard surface in anger may result in injury but this was not the direct intention of the action, which was to express anger.

If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Validation rules

<table>
<thead>
<tr>
<th>Data type</th>
<th>String</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
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</tr>
</tbody>
</table>

**Data domain**

<table>
<thead>
<tr>
<th>Value</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional (injury)</td>
</tr>
<tr>
<td>2</td>
<td>Self-inflicted</td>
</tr>
<tr>
<td>3</td>
<td>By other</td>
</tr>
<tr>
<td>?</td>
<td>Not known</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
3.06 Place of Injury Occurrence

Identifying and definitional attributes

Definition
The type of location where the trauma event occurred.

Justification
To identify trends of injury and for injury prevention and control.

Representational attributes

Guide for use
ICD-10-AM code to be used. Note that this code has multiple levels depending on the amount of information supplied. For example, if the patient was injured on a basketball court code Y92.3 may be used; however if it was also known the patient was injured playing indoor basketball, then code Y92.31 should be used. Only the top coding level is provided below. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

If specific information is not available use the default fields below.

Data domain described as per ICD-10-AM International Statistical Classification of Diseases and Related data element Health Problems, Australian Modification

Validation rules

Data type
String

Field size maximum
1

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y92.09</td>
<td>Home</td>
</tr>
<tr>
<td>Y92.19</td>
<td>Residential institution</td>
</tr>
<tr>
<td>Y92.29</td>
<td>School, other institution and public administrative area</td>
</tr>
<tr>
<td>Y92.39</td>
<td>Sports and athletics area</td>
</tr>
<tr>
<td>Y92.49</td>
<td>Street and highway</td>
</tr>
<tr>
<td>Y92.59</td>
<td>Trade and service area</td>
</tr>
<tr>
<td>Y92.69</td>
<td>Industrial and construction area</td>
</tr>
<tr>
<td>Y92.7</td>
<td>Farm</td>
</tr>
<tr>
<td>Y92.88</td>
<td>Other specified place of occurrence</td>
</tr>
<tr>
<td>Y92.99</td>
<td>Unspecified place</td>
</tr>
</tbody>
</table>
3.07 Activity Engaged in when Injured

Identifying and definitional attributes

Definition
The type of activity the person was engaged in at the time of the trauma event.

Justification
To identify trends of injury and for injury prevention and control. The basis for identifying work-related and sport-related injuries.

Representational attributes

Guide for use
ICD-10-AM code to be used. Note that this code has multiple levels depending on the amount of information supplied.

If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

There are a number of subtleties in this coding system. Firstly there is no option for “travel”, so if a person is injured in a road traffic accident the reason for their travel should be documented; were they travelling to/for work (code as while working for income), or on holiday (code as engaged in sports or leisure). Further, if a professional rugby player is injured while playing rugby (and working for an income), the first in the code list should be chosen.

Validation rules

Data type
String

Field size maximum
1

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>U70.8</td>
<td>While engaged in sports or leisure</td>
</tr>
<tr>
<td>U73.09</td>
<td>While working for income</td>
</tr>
<tr>
<td>U73.1</td>
<td>While engaged in other types of work</td>
</tr>
<tr>
<td>U73.2</td>
<td>While resting, sleeping, eating or engaging in other vital activities</td>
</tr>
<tr>
<td>U73.8</td>
<td>While engaged in other specified activities</td>
</tr>
<tr>
<td>U73.9</td>
<td>During unspecified activity</td>
</tr>
</tbody>
</table>

Data domain described as per ICD-10-AM International Statistical Classification of Diseases and Related data element Health Problems, Australian Modification
3.08 Injury Event Description

Identifying and definitional attributes

**Definition**  
A textual description of the environmental event, circumstance or condition as the cause of injury.

**Justification**  
The narrative of the injury event is important as it identifies features of the event not necessarily revealed by coded data.

Representational attributes

**Guide for use**  
Text description should include information relating to the circumstances prior to and surrounding the trauma event (including place of injury and activity), and what 'went wrong' to cause the trauma event, and any environmental factors.

Validation rules

**Data type**  
Text

**Field size maximum**  
1000

**Data domain**
3.09 Safety Devices Used

Identifying and definitional attributes

Definition

The use (or lack of use) of safety equipment relevant to the injury cause.

Justification

Representational attributes

Guide for use

Seatbelt refers to the conventional car restraints used for adults; lap belts go over the waist and attach at two points, whereas sash-lap belts attach at 3 points, with one strap sitting diagonally from one shoulder to the opposite hip, and additionally across the waist.

Child car restraint applies to structures used specifically for small children; a child seat is for infants and smaller children and has an inbuilt harness system while a booster seat is for larger children to help ensure the conventional adult seatbelt sits properly across their bodies.

Helmet examples include bicycle, skiing, motorcycle, rock climbing.

Airbag deployed refers to the deployment of an airbag which directly protects, or attempts to protect, the person from injury. An airbag that deploys in the driver’s seat which does not serve to protect the injured person who is travelling in the back seat should not be recorded as airbag deployed.

Other Personal Protection Equipment refers to any other safety equipment which was in use at the time of injury, such as harnesses, protective clothing etc.

Up to two categories may be selected, for example airbag deployed and seatbelt: sash-lap may both apply.

Validation rules

Data type Number

Field size maximum 2 (1+1)

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No safety device</td>
</tr>
<tr>
<td>2</td>
<td>Seatbelt: sash-lap</td>
</tr>
<tr>
<td>3</td>
<td>Seatbelt: lap only</td>
</tr>
<tr>
<td>4</td>
<td>Child car restraint: child seat</td>
</tr>
<tr>
<td>5</td>
<td>Child car restraint: booster</td>
</tr>
<tr>
<td>6</td>
<td>Airbag deployed</td>
</tr>
<tr>
<td></td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Helmet</td>
</tr>
<tr>
<td>8</td>
<td>Other Personal Protection Equipment</td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Not stated/inadequately described</td>
</tr>
</tbody>
</table>
4.01 Date & Time of Observations at Scene

Identifying and definitional attributes

Definition
The date and time the Scene Observations (4.02 – 4.08) were recorded at the scene of injury.

Justification
Date and time of observations used as a proxy for time of arrival of ambulance at scene and thus enables calculation of transfer time from scene to first hospital; provides a time-stamp for observations which is important in time sensitive conditions such as major trauma.

Representational attributes

Guide for use
Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/2011 00:01

If 4.09 Mode of Transport from Scene is completed as either: 1 Road Ambulance, 2 Helicopter Ambulance, then should be completed even in the absence of any recorded Scene observations (4.02-4.08) to allow use as proxy for time of arrival at Scene.

Where the person’s first presentation is at either referring or definitive care hospital, code as Not Applicable. It is likely that if any of the scene fields (4.01-4.08) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any scene field is recorded as anything other than Not Applicable, it is likely that none of the scene fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as Not Applicable, yet all other scene fields are applicable).

Validation rules
Must not be completed as Not Applicable if any Scene Observations (4.02-4.08) completed.

Must not be completed as Not Applicable if 4.09 Mode of Transport from Scene is completed as either: 1 Road Ambulance, 2 Helicopter Ambulance,

Must be greater than or equal to:

- 3.01 Date & Time of Injury

Must be less than or equal to:

- 5.03 Date & Time of Observations at Referring Hospital (if applicable)
- 5.12 Date & Time of Departure from Referring Hospital (if applicable)
- 6.01 Date & Time of Observations at Definitive Care Hospital
- 6.13 Date & Time Index CT performed (if applicable)
- 6.14 ED Discharge Date & Time (if applicable)
- **7.14 Date & Time of Discharge from Definitive Care**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>dd/mm/yyyy</td>
<td>Valid Date</td>
</tr>
<tr>
<td></td>
<td>00:00</td>
<td>Valid Time</td>
</tr>
<tr>
<td></td>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td>./</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
4.02 Scene Pulse

Identifying and definitional attributes

**Definition**
The first recorded heart rate measured at the scene of trauma event, measured in beats per minute.

**Justification**
Used as a proxy to assess injury severity.

Representational attributes

**Guide for use**
First measurement taken by any ambulance or retrieval team at the scene of the injury.

Where the person’s first presentation is at either referring or definitive care hospital, code *Not Applicable*. If 4.01 Date & Time of Observations at Scene recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the scene fields (4.01-4.08) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any scene field is recorded as anything other than *Not Applicable*, it is likely that none of the scene fields should be recorded as *Not Applicable* (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as not applicable, yet all other scene fields are applicable).

If the person is in cardiac arrest at the time of first measurement, code 997 – Cardiac arrest

If the person's heart rate cannot be measured, code Unknown

Validation rules

**Data type**
Number

**Field size maximum**
3

**Data domain**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-300</td>
<td>Heart beats per minute</td>
</tr>
<tr>
<td>997</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
4.03 Scene Systolic BP

Identifying and definitional attributes

Definition The first recorded systolic blood pressure measured at the scene of trauma, measured in mmHg

Justification Used in several scoring and is one assessment of patient acuity.

Representational attributes

Guide for use First measurement taken by any ambulance or retrieval team at the scene of injury. Where the person’s first presentation is at referring or definitive care hospital, code Not Applicable. If 4.01 Date & Time of Observations at Scene recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the scene fields (4.01-4.08) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any scene field is recorded as anything other than Not Applicable, it is likely that none of the scene fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as not applicable, yet all other scene fields are applicable).

If the systolic blood pressure is not or cannot be measured, Unknown should be used.

Measurement protocol for resting blood pressure: The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed.

Validation rules

Data type Number

Field size maximum 3

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-300</td>
<td>Millimetre of mercury (mmHg)</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Identifying and definitional attributes

**Definition**
The first recorded unassisted rate of respiration measured at the scene of trauma, measured in number per minute.

**Justification**
Used in several scoring systems and is one assessment of patient acuity.

Representational attributes

**Guide for use**
First measurement taken by any ambulance or retrieval team prior to hospital. Where the person’s first presentation is at a referring or definitive care hospital, code *Not Applicable*. If 4.01 Date & Time of Observations at Scene recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the scene fields (4.01-4.08) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any scene field is recorded as anything other than *Not Applicable*, it is likely that none of the scene fields should be recorded as *Not Applicable*, (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as *Not Applicable*, yet all other scene fields are applicable).

If the person is in respiratory arrest at the time of first measurement, value 997 should be used.

If the respiratory rate is not or cannot be measured, *Unknown* should be used.

**Validation rules**

- **Data type**: Number
- **Field size maximum**: 3
- **Data domain**:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100</td>
<td>Number per minute</td>
</tr>
<tr>
<td>997</td>
<td>Respiratory arrest</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
4.05  Scene GCS Eye

Identifying and definitional attributes

**Definition**  The first recorded indication of the responsiveness to stimuli by eye opening at the scene of trauma.

**Justification**  GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at hospital.

Representational attributes

**Guide for use**  First measurement taken by any ambulance or retrieval team prior hospital. Where the person’s first presentation is at a referring or definitive care hospital, code *Not Applicable*. If 4.01 Date & Time of Observations at Scene recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the scene fields (4.01-4.08) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any scene field is recorded as anything other than *Not Applicable*, it is likely that none of the scene fields should be recorded as *Not Applicable* (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as *Not Applicable*, yet all other scene fields are applicable).

If eye response cannot be reliably assessed, record as ‘Unknown’.

**Validation rules**

**Data type**  Number

**Field size maximum**  1

**Data domain**  

<table>
<thead>
<tr>
<th>Code</th>
<th>Description (Adult-Child-Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None-No Response-No Response</td>
</tr>
<tr>
<td>2</td>
<td>Pain-Pain-Pain</td>
</tr>
<tr>
<td>3</td>
<td>Voice-Verbal Stimuli-Verbal Stimuli</td>
</tr>
<tr>
<td>4</td>
<td>Spontaneous-Spontaneous-Spontaneous</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
4.06 Scene GCS Voice

Identifying and definitional attributes

**Definition**
The first recorded indication of the level of verbal response at the scene of trauma.

**Justification**
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at definitive care.

Representational attributes

**Guide for use**
First measurement taken by any ambulance or retrieval team prior to hospital. Where the person’s first presentation is at a referring or definitive care hospital, code Not Applicable. If 4.01 Date & Time of Observations at Scene recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the scene fields (4.01-4.08) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any scene field is recorded as anything other than Not Applicable, it is likely that none of the scene fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as Not Applicable, yet all other scene fields are applicable).

Validation rules

**Data type**
Number

**Field size maximum**
1

**Data domain**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description (Adult-Child-Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None-No Response-No Response</td>
</tr>
<tr>
<td>2</td>
<td>Incomprehensible words-Incomprehensible words, cries-Moans to pain</td>
</tr>
<tr>
<td>3</td>
<td>Inappropriate words-Inappropriate words-Cries to pain</td>
</tr>
<tr>
<td>4</td>
<td>Confused-Confused-Irritable, cries</td>
</tr>
<tr>
<td>5</td>
<td>Oriented-Oriented-Coos, babbles</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
### 4.07 Scene GCS Motor

**Identifying and definitional attributes**

**Definition**
The first recorded indication of the level of motor response at the scene of trauma.

**Justification**
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at referring or definitive care. The GCS motor component alone may be useful as an independent predictor of outcome.

**Representational attributes**

**Guide for use**
First measurement taken by any ambulance or retrieval team prior hospital.

Where the person’s first presentation is at a referring or definitive care hospital, code *Not Applicable*. If 4.01 Date & Time of Observations at Scene recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the scene fields (4.01-4.08) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any scene field is recorded as anything other than *Not Applicable*, it is likely that none of the scene fields should be recorded as *Not Applicable* (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as *Not Applicable*, yet all other scene fields are applicable).

**Validation rules**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>Code</th>
<th>Description (Adult-Child-Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>1</td>
<td>None-No Response-No Response</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Extension to pain- Extension to pain- decerebrate posturing to pain</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Flexion to pain- Flexion to pain- Decorticate posturing to pain</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Withdraws to pain- Withdraws to pain- Withdraws to pain</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Localises pain- Localises painful stimulus–Withdraws to touch</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Obeyes commands- Obeyes commands– Moves spontaneously</td>
</tr>
<tr>
<td></td>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
4.08 Scene Total GCS

Identifying and definitional attributes

Definition
The first recorded total Glasgow Coma Scale score at the scene of trauma.

Justification
Used in several scoring systems and required for the assessment of coma and impaired consciousness.

Representational attributes

Guide for use
First measurement taken by any ambulance or retrieval team prior to hospital.
Where the person’s first presentation is at a referring or definitive care hospital, code Not Applicable. If 4.01 Date & Time of Observations at Scene recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the scene fields (4.01-4.08) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any scene field is recorded as anything other than Not Applicable, it is likely that none of the scene fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 4.05 Scene GCS Eye may be recorded as Not Applicable, yet all other scene fields are applicable).

If the total GCS is not or cannot be measured, Unknown should be used.

Validation rules

Data type
Number

Field size maximum
2

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-15</td>
<td>Total GCS</td>
</tr>
<tr>
<td>/ .</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
4.09  Mode of Transport from Scene

Identifying and definitional attributes

Definition  The type of transport by which the person left the scene of the trauma event.
Justification  To monitor patterns of transfer and mode of transportation used.

Representational attributes

Guide for use  If two modes of transport are used in the transfer of a patient from scene to the first hospital, the mode that received the patient from the scene of injury is to be recorded.

Validation rules

<table>
<thead>
<tr>
<th>Data type</th>
<th>String</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>Road Ambulance</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Helicopter Ambulance</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Private/Public Vehicle/Taxi/Walk-in</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Police/Prison/Fire Vehicle</td>
</tr>
<tr>
<td></td>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.01 Referring Hospitals

Identifying and definitional attributes

Definition
The identifier for the establishment or establishments from which the person was transferred from. Each hospital code will align to the Ministry of Health Hospital Code.

Justification
To identify the referring health service providers for patient tracking.

Representational attributes

Guide for use
As described in Guide for Use, this data dictionary is designed to be completed by the definitive hospital, allowing capture of all treatment and patient care along the patient journey. It is the responsibility of the definitive care hospital to capture the identity and relevant information recorded at a referring hospital for submission to the national registry, including the fields related to “first hospitals” 6.10-6.13.

There may be more than one Referring Hospital. The data from each referring hospital must be entered into the registry as a new facility tab.

Validation rules
If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, must be recorded as Not Applicable.

Data type
String

Field size maximum

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.</td>
<td>Not applicable (no referring hospital exists; patient’s first hospital presentation is at definitive care hospital)</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Refer to 1.01 for hospital codes
5.02 Date & Time of Observations at Referring Hospital

Identifying and definitional attributes

Definition
The date and time the first patient observations (5.03-5.11) were recorded upon arrival at the referring hospital.

Justification
Date and time of observations used as a proxy for time of arrival at referring hospital and thus enables calculation of transfer time from referring hospital to definitive care hospital; provides a time-stamp for observations which is important in time sensitive conditions such as major trauma.

Representational attributes

Guide for use
Where the person’s first presentation is at a definitive care hospital, code Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

If a Referring Hospital exists, should be completed even in the absence of any recorded Referring Hospital observations (5.0-5.11) to allow use as proxy for time of arrival at Referring Hospital.

Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/2011 00:01.

Validation rules
If 5.02 Referring Hospital recorded as Not Applicable, must be recorded as Not Applicable.

Must be greater than or equal to:
- 3.01 Date & Time of Injury
- 4.01 Date & Time of Observations at scene (if applicable)

Must be less than or equal to:
- 5.12 Date & Time of Departure from Referring Hospital
- 6.01 Date & Time of Observations at Definitive Care Hospital
- 6.14 ED Discharge Date & Time (if applicable)
- 7.14 Date & Time of Discharge from Definitive Care

Data type
Date/Time
<table>
<thead>
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<th>Field size maximum</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>Description</td>
</tr>
<tr>
<td>dd/mm/yyyy</td>
<td>Valid Date</td>
</tr>
<tr>
<td>00:00</td>
<td>Valid Time</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>/.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
5.03  Referring Hospital Pulse

Identifying and definitional attributes

**Definition**
The first recorded heart rate measured following arrival at the referring hospital, measured in beats per minute.

**Justification**
Used as a proxy to assess injury severity.

Representational attributes

**Guide for use**
Where the person’s first hospital presentation is at the definitive care hospital, code *Not Applicable*. If 5.02 Date & Time of Observations at Referring Hospital recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any Referring Hospital field is recorded as anything other than *Not Applicable*, it is likely that none of the Referring Hospital fields should be recorded as *Not Applicable* (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as *Not Applicable*, yet all other Referring Hospital fields are applicable).

If the person is in cardiac arrest at the time of first measurement, value 997 should be used.

Record the pulse as it is regardless of any interventions (such as drugs) which could potentially impact the pulse rate.

If the person’s heart rate cannot be measured, code *Unknown*.

Validation rules

**Data type**
Number

**Field size maximum**
3

**Data domain**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-300</td>
<td>Heart beats per minute</td>
</tr>
<tr>
<td>997</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.04 Referring Hospital Systolic BP

Identifying and definitional attributes

Definition
The first recorded systolic blood pressure measured following arrival at the referring hospital, measured in mmHg.

Justification
Used in several scoring systems including TRISS and is one assessment of patient acuity.

Representational attributes

Guide for use
Where the person’s first hospital presentation is at the definitive care hospital, code Not Applicable. If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

Record the systolic blood pressure as it is, regardless of any interventions (such as drugs), which could potentially impact the systolic blood pressure.

If the systolic blood pressure is not or cannot be measured, Unknown should be used.

Measurement protocol for resting blood pressure: The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed.

Validation rules

Data type
Number

Field size maximum
3

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-300</td>
<td>Millimetre of mercury (mmHg)</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.05  Referring Hospital Respiratory Rate

Identifying and definitional attributes

**Definition**
The first recorded rate of respiration measured following arrival at the referring hospital, measured in number per minute.

**Justification**
Used in several scoring systems including TRISS and is one assessment of patient acuity.

Representational attributes

**Guide for use**
Where the person’s first hospital presentation is at the definitive care hospital, code *Not Applicable*. If 5.02 Date & Time of Observations at Referring Hospital recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any Referring Hospital field is recorded as anything other than *Not Applicable*, it is likely that none of the Referring Hospital fields should be recorded as *Not Applicable* (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as *Not Applicable*, yet all other Referring Hospital fields are applicable).

If the person is in respiratory arrest at the time of first measurement, value 997 should be used.

If the person has been intubated at the time of first measurement, record the ventilator respiratory rate and complete 5.11 and 7.01.

If the respiratory rate is not or cannot be measured, *Unknown* should be used.

**Validation rules**

**Data type**: Number

**Field size maximum**: 3

**Data domain**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100</td>
<td>Number per minute</td>
</tr>
<tr>
<td>997</td>
<td>Respiratory arrest</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.06 Referring Hospital Temperature

Identifying and definitional attributes

Definition
The first recorded body temperature measured following arrival at the referring hospital, measured in degrees Celsius.

Justification
Useful in the measurement of a patient vital status. Very high and low temperatures can be an indication of organ decomposition for an injured patient. Hypothermia can present a significant management problem.

Representational attributes

Guide for use
Where the person’s first hospital presentation is at the definitive care hospital, code Not Applicable. If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

If the temperature is not or cannot be measured, Unknown should be used.

Validation rules

Data type
Number

Field size maximum
4

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.0 – 50.0</td>
<td>Temperature in Celsius</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.07 Referring Hospital GCS Eye

Identifying and definitional attributes

Definition
The first recorded indication of the responsiveness to stimuli by eye opening at the referring hospital.

Justification
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at hospital. Required for RTS and TRISS.

Representational attributes

Guide for use
Where the person’s first hospital presentation is at the definitive care hospital, code Not Applicable. If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

If eye response cannot be reliably assessed record as Unknown.

Validation rules

Data type
Number

Field size maximum
1

Data domain
Code Description (Adult-Child-Infant)
1 None-No Response-No Response
2 Pain-Pain-Pain
3 Voice-Verbal Stimuli-Verbal Stimuli
4 Spontaneous-Spontaneous-Spontaneous
/ Not applicable
? Unknown
5.08 Referring Hospital GCS Voice

Identifying and definitional attributes

Definition
The first recorded indication of the level of verbal response at the referring hospital.

Justification
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at definitive care. Required for RTS and TRISS.

Representational attributes

Guide for use
Where the person’s first hospital presentation is at the definitive care hospital, code Not Applicable. If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

If patient is intubated or is otherwise unable to respond by voice, record as '1' (no response), and complete 5.11 and 7.01.

Validation rules

Data type
Number

Field size maximum
1

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description (Adult-Child-Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None-No Response-No Response</td>
</tr>
<tr>
<td>2</td>
<td>Incomprehensible words- Incomprehensible words, cries- Moans to pain</td>
</tr>
<tr>
<td>3</td>
<td>Inappropriate words- Inappropriate words- Cries to pain</td>
</tr>
<tr>
<td>4</td>
<td>Confused- Confused –Irritable, cries</td>
</tr>
<tr>
<td>5</td>
<td>Oriented- Oriented –Coos, babbles</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.09 Referring Hospital GCS Motor

Identifying and definitional attributes

Definition
The first recorded indication of the level of motor response at the referring hospital.

Justification
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at referring or definitive care. The GCS motor component alone may be useful as an independent predictor of outcome. Required for RTS/TRISS.

Representational attributes

Guide for use
Where the person's first hospital presentation is at the definitive care hospital, code Not Applicable. If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

If patient is paralysed and/or sedated, record as 1 - No response, and complete 5.11.

Validation rules

Data type
Number

Field size maximum
1

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description (Adult-Child-Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None-No Response- No Response</td>
</tr>
<tr>
<td>2</td>
<td>Extension to pain- Extension to pain- Decerebrate posturing to pain</td>
</tr>
<tr>
<td>3</td>
<td>Flexion to pain- Flexion to pain- Decorticate posturing to pain</td>
</tr>
<tr>
<td>4</td>
<td>Withdraws to pain- Withdraws to pain– Withdraws to pain</td>
</tr>
<tr>
<td>5</td>
<td>Localises pain- Localises painful stimulus- Withdraws to touch</td>
</tr>
<tr>
<td>6</td>
<td>Obeys commands- Obeys commands– Moves spontaneously</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
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</table>
5.10 Referring Hospital Total GCS

Identifying and definitional attributes

Definition The first recorded total Glasgow Coma Scale score at the referring hospital.

Justification Used in several scoring systems including TRISS and required for the assessment of coma and impaired consciousness.

Representational attributes

Guide for use Where the person’s first hospital presentation is at the definitive care hospital, code Not Applicable. If 5.02 Date & Time of Observations at Referring Hospital recorded as Not Applicable, then should be recorded as Not Applicable. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as Not Applicable, that this field should also be recorded as Not Applicable. Further, if any Referring Hospital field is recorded as anything other than Not Applicable, it is likely that none of the Referring Hospital fields should be recorded as Not Applicable (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as Not Applicable, yet all other Referring Hospital fields are applicable).

If the total GCS is not or cannot be measured, Unknown should be used.

Validation rules

Data type Number

Field size maximum 2

Data domain

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<th>Code</th>
<th>Description</th>
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</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.11 Referring Hospital Vital Sign Qualifiers

Identifying and definitional attributes

Definition
Factors which may impact on vital signs and Glasgow Coma Scale score are recorded.

Justification
To enable consistent analysis of vital sign measurements.

Representational attributes

Guide for use
Of the following factors, record as many as are applicable at the time of measurement.

- Intubation (refer also to 7.01)
- Sedation
- Paralytic agents
- Respiration assisted

Validation rules

Data type
Text

Field size maximum
3

Data domain
<table>
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<tr>
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<th>Description</th>
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<tr>
<td>Yes</td>
<td>Factor is present</td>
</tr>
<tr>
<td>No</td>
<td>Factor is not present</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
5.12 Date & Time of Departure from Referring Hospital

Identifying and definitional attributes

**Definition**
The date and time patient departed from the referring hospital for transfer to the definitive care hospital.

**Justification**
Enables length of stay at referring hospital to be calculated.

Representational attributes

**Guide for use**
Where the person’s first hospital presentation is at the definitive care hospital, code *Not Applicable*. If 5.02 Date & Time of Observations at Referring Hospital recorded as *Not Applicable*, then should be recorded as *Not Applicable*. It is likely that if any of the Referring Hospital fields (5.03-5.11) are recorded as *Not Applicable*, that this field should also be recorded as *Not Applicable*. Further, if any Referring Hospital field is recorded as anything other than *Not Applicable*, it is likely that none of the Referring Hospital fields should be recorded as *Not Applicable* (exceptions exist, for example if a blind person is the patient 5.07 Referring Hospital GCS Eye may be recorded as *Not Applicable*, yet all other Referring Hospital fields are applicable).

Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/2011 00:01

**Validation rules**
Has to be completed if the following collected:

- 5.02 Referring Hospital (unless *Not Applicable*)

Must be greater than or equal to:

- 3.01 Date & Time of Injury
- 4.01 Date & Time of Observations at scene (if used)
- 5.03 Date & Time of Observations at Referring Hospital

Must be less than or equal to:

- 6.01 Date & Time of Observations at Definitive Care Hospital

**Data type**
Date/Time

**Field size maximum**
13

**Data domain**

<table>
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<th>Value</th>
<th>Description</th>
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</thead>
<tbody>
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<td>Valid Date</td>
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<td>Valid Time</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
5.13  Mode of Transport to Definitive Care Hospital

Identifying and definitional attributes

**Definition**
The type of transport by which the patient was transferred from either the referring hospital (if applicable) or from the scene, to the definitive care hospital.

**Justification**
To monitor patterns of transfer and mode of transportation used.

Representational attributes

**Guide for use**
If a patient is transferred from the scene to the referring hospital in a road ambulance but the mode of transport from the referring hospital to the definitive care centre is not recorded, this should be coded as unknown.

**Validation rules**

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<tr>
<th>Data type</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
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</tbody>
</table>

**Data domain**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fixed-wing Air Ambulance</td>
</tr>
<tr>
<td>2</td>
<td>Helicopter Ambulance</td>
</tr>
<tr>
<td>3</td>
<td>Private/Public Vehicle/Taxi/Walk-in</td>
</tr>
<tr>
<td>4</td>
<td>Road Ambulance</td>
</tr>
<tr>
<td>5</td>
<td>Police/Prison vehicle/fire</td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
6.01 Date & Time of Observations at Definitive Care Hospital

Identifying and definitional attributes

Definition
The date and time the first patient observations (6.02-6.09) were recorded upon arrival at the definitive care hospital.

Justification
Date and time of observations used as a proxy for time of arrival at definitive care hospital and thus enables calculation of transfer time from referring hospital to definitive care hospital; provides a time-stamp for observations which is important in time sensitive conditions such as major trauma.

Representational attributes

Guide for use
Should be completed even in the absence of any recorded Definitive Care Hospital observations (6.02-6.09) to allow use as proxy for time of arrival at definitive care hospital.

Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/2011 00:01

Validation rules
Must be greater than or equal to:
- 3.01 Date & Time of Injury
- 4.01 Date & Time of Observations at scene (if used)
- 5.03 Date & Time of Observations at Referring Hospital (if used)
- 5.12 Date & Time of Departure from Referring Hospital (if used)

Must be less than or equal to
- 7.12 Date & Time of Discharge from Definitive Care

Data type
Date/Time

Field size maximum
13

Data domain
Valid Date and Time

- dd/mm/yyyy: Valid Date
- 00:00: Valid Time
- ?: Unknown
- ./: Not applicable
6.02  Definitive Care Hospital Pulse

Identifying and definitional attributes

Definition
The first recorded heart rate measured following arrival at the definitive care hospital, measured as beats per minute.

Justification
Used as a proxy to assess injury severity.

Representational attributes

Guide for use
If the person is in cardiac arrest at the time of first measurement, value 997 should be used.

Record the pulse as it is regardless of any interventions (such as drugs) which could potentially impact the pulse rate.

If the person’s heart rate cannot be measured, code Unknown.

Validation rules

Data type
Number

Field size maximum
3

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-300</td>
<td>Heart beats per minute</td>
</tr>
<tr>
<td>997</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
6.03 Definitive Care Hospital Systolic BP

Identifying and definitional attributes

Definition
The first recorded systolic blood pressure measured following arrival at the definitive care hospital, measured in mmHg.

Justification
Used in several scoring systems including TRISS and is one assessment of patient acuity.

Representational attributes

Guide for use
If the systolic blood pressure is not or cannot be measured, Unknown should be used.

Measurement protocol for resting blood pressure: The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed.

Record the systolic blood pressure as it is, regardless of any interventions (such as drugs) which could potentially impact the systolic blood pressure.

Validation rules

Data type
Number

Field size maximum
3

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-300</td>
<td>Millimetres of mercury (mmHg)</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
6.04  Definitive Care Hospital Respiratory Rate

Identifying and definitional attributes

Definition
The first recorded rate of respiration measured following arrival at the definitive care hospital, measured in number per minute.

Justification
Used in several scoring systems including TRISS and is one assessment of patient acuity.

Representational attributes

Guide for use
If the person is in respiratory arrest at the time of first measurement, value 997 should be used.

If the person has been intubated at the time of first measurement, use the ventilator respiratory rate and complete 6.10 and 7.01.

If the respiratory rate is not or cannot be measured, Unknown should be used.

Validation rules

Data type
Number

Field size maximum
3

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100</td>
<td>Number per minute</td>
</tr>
<tr>
<td>997</td>
<td>Respiratory arrest</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>./</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
6.05  Definitive Care Hospital Temperature

Identifying and definitional attributes

Definition  The first recorded body temperature measured following arrival at definitive care hospital, measured in degrees Celsius.

Justification  Useful in the measurement of a patient vital status. Very high and low temperatures can be an indication of major physiologic compromise in an injured patient. Hypothermia can present a significant management problem.

Representational attributes

Guide for use  If the temperature is not or cannot be measured, unknown should be used.

Validation rules

Data type  Number

Field size maximum  4

Data domain  

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.0 – 50.0</td>
<td>Temperature in Degrees Celsius</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
6.06 Definitive Care Hospital GCS Eye

Identifying and definitional attributes

**Definition**
The first recorded indication of the responsiveness to stimuli by eye opening at the definitive care hospital.

**Justification**
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at hospital. Required for RTS and TRISS.

Representational attributes

**Guide for use**
If eye response cannot be reliably assessed, record as ‘Unknown’

*Not Applicable* option only to be used in instances where the field is truly not applicable, such as for blind patients.

**Validation rules**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Field size maximum</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Data domain</strong></td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>1</td>
<td>None-No Response-No Response</td>
</tr>
<tr>
<td>2</td>
<td>Pain-Pain-Pain</td>
</tr>
<tr>
<td>3</td>
<td>Voice-Verbal Stimuli-Verbal Stimuli</td>
</tr>
<tr>
<td>4</td>
<td>Spontaneous-Spontaneous-Spontaneous</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
6.07 Definitive Care Hospital GCS Voice

Identifying and definitional attributes

Definition The first recorded indication of the level of verbal response at the definitive care hospital.

Justification GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient's initial neurological status prior to arrival at definitive care. Required for RTS and TRISS.

Representational attributes

Guide for use Not Applicable option only to be used in instances where the field is truly not applicable, such as for mute patients.

If patient is intubated or is otherwise unable to respond by voice, record as ‘1’ (no response), and complete 6.10 and 7.01.

Data type Number

Field size maximum 1

Data domain Code Description (Adult-Child-Infant)
1 None-No Response-No Response
2 Incomprehensible words- Incomprehensible words, cries- Moans to pain
3 Inappropriate words- Inappropriate words- Cries to pain
4 Confused- Confused –Irritable, cries
5 Oriented- Oriented –Coos, babbles
/ Not applicable
? Unknown
6.08 Definitive Care Hospital GCS Motor

Identifying and definitional attributes

Definition
The first recorded indication of the level of motor response at the definitive care hospital.

Justification
GCS components are combined and used as an important component in a number of outcome prediction models, and provide an indication of the patient’s initial neurological status prior to arrival at referring or definitive care. The GCS motor component alone may be useful as an independent predictor of outcome. Required for RTS/TRISS.

Representational attributes

Guide for use
If patient is paralysed and/or sedated, record as 1-No response, and complete 6.10.
Not Applicable option only to be used in instances where the field is truly not applicable.

Validation rules

Data type
Number

Field size maximum
1

Data domain
<table>
<thead>
<tr>
<th>Code</th>
<th>Description (Adult-Child-Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None-No Response-No Response</td>
</tr>
<tr>
<td>2</td>
<td>Extension to pain- Extension to pain- Decerebrate posturing to pain</td>
</tr>
<tr>
<td>3</td>
<td>Flexion to pain- Flexion to pain- Decorticate posturing to pain</td>
</tr>
<tr>
<td>4</td>
<td>Withdraws to pain- Withdraws to pain– Withdraws to pain</td>
</tr>
<tr>
<td>5</td>
<td>Localises pain- Localises painful stimulus–Withdraws to touch</td>
</tr>
<tr>
<td>6</td>
<td>Obeys commands- Obeys commands– Moves spontaneously</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
6.09  Definitive Care Hospital Total GCS

Identifying and definitional attributes

**Definition**  The first recorded total Glasgow Coma Scale score at definitive care hospital

**Justification**  Used in several scoring systems including TRISS and required for the assessment of coma and impaired consciousness.

Representational attributes

**Guide for use**  If the total GCS is not or cannot be measured, *Unknown* should be used.

**Validation rules**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>2</td>
</tr>
</tbody>
</table>

**Data domain**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-15</td>
<td>Total GCS</td>
</tr>
<tr>
<td>/.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
### 6.10 Definitive Hospital Vital Sign Qualifiers

#### Identifying and definitional attributes

**Definition**
Factors which may impact on vital signs and Glasgow Coma Scale score.

**Justification**
To enable consistent analysis of vital sign measurement.

#### Representational attributes

**Guide for use**
Of the following factors, record as many as are applicable at the time of measurement.

- Intubation
- Sedation
- Paralytic agents
- Respiration assisted

**Validation rules**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Factor is applicable</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Factor is not present</td>
<td></td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>
6.11 Blood Alcohol Concentration on Arrival

Identifying and definitional attributes

Definition
The first blood alcohol concentration result recorded at the first presenting hospital (whether referring or definitive care hospital), measured in mmolL\(^{-1}\).

Justification
Alcohol affects the Glasgow Coma Scale.

Representational attributes

Guide for use
Must be taken within 6 hours of arrival at the first hospital. If outside of this time, record as unknown.

If the blood alcohol concentration is not or cannot be measured, *Unknown* should be used.

Validation rules

<table>
<thead>
<tr>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-120</td>
<td>Blood alcohol concentration (mmolL(^{-1}))</td>
</tr>
<tr>
<td></td>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
6.12 First Measured Venous Base Excess

Identifying and definitional attributes

Definition  The first recorded venous base excess recorded at the first presenting hospital (whether referring or definitive care hospital), measured in mmolL\(^{-1}\).

Justification  Clinical assessment of patient’s condition on arrival at definitive care hospital which may indicate the need for additional treatment. Identify complication of trauma.

Representational attributes

Guide for use  Must be taken within 6 hours of arrival at the first hospital. If outside of this time, record as Unknown.

If the venous base excess is not or cannot be measured, Unknown should be used.

Use venous result only. If arterial base excess is known, but not venous, value Unknown should be used.

Validation rules

Data type  Number

Field size maximum  3

Data domain  | Value | Description |
-------------|--------|-------------|
              -30 to 30 | Venous base excess value (mmolL\(^{-1}\)) |
            ? | Unknown |


6.13 First Measured INR

Identifying and definitional attributes

**Definition**
The first recorded prothrombin time INR recorded at the first presenting hospital (whether referring or definitive care hospital).

**Justification**
Clinical assessment of patient’s condition on arrival at definitive care hospital which may indicate the need for additional treatment. Identify complication or comorbidity.

Representational attributes

**Guide for use**
Must be taken within 6 hours of arrival at the first hospital. If outside of this time, record as *Unknown*

If the INR is not or cannot be measured, value *Unknown* should be used.

**Validation rules**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field size maximum</td>
<td>3</td>
</tr>
</tbody>
</table>

**Data domain**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0 – 3.0</td>
<td>INR value</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
6.14 Date & Time Index CT Performed

Identifying and definitional attributes

Definition The date and time the person received the first CT scan, if within 24 hours of injury,

Justification Represents the time required to initiate key diagnostic tests, and may be seen as a measure of the efficiency of the trauma system.

Representational attributes

Guide for use Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/2011 00:01

Validation rules Must be greater than or equal to:

- 3.01 Date & Time of Injury
- 4.01 Date & Time of Observations at scene (if used)

Must be less than or equal to:

- 24 hours exceeding 3.01 Date & Time of Injury
- 7.12 Date & Time of Discharge from Definitive Care

Data type Date/Time

Field size maximum 13

Data domain Valid Date and Time

dd/mm/yyyy Valid Date
00:00 Valid Time
? Unknown
/ Not applicable
6.15 ED Discharge Date & Time

**Identifying and definitional attributes**

**Definition**

The date and time patient left the emergency department at the definitive care hospital, or (if dying in the emergency department) the time of death.

**Justification**

Calculation of total length of ED stay at the definitive care hospital.

**Representational attributes**

**Guide for use**

Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25\textsuperscript{th} November 2011 should be reported as 25/11/2011 00:01

If a patient is a direct admission and goes directly to another area in the hospital on hospital arrival (such as ICU or OR), this should be the same as:

- 6.01 Date & Time of Observations at Definitive Care Hospital

**Validation rules**

Unless patient died in ED, must be greater than or equal to:

- 6.01 Date & Time of Observations at Definitive Care Hospital

Unless patient died in ED, must be less than or equal to:

- 7.12 Date & Time of Discharge from Definitive Care

**Data type**

Date/Time

**Field size maximum**

10 + 5

**Data domain**

Valid Date and Time

- dd/mm/yyyy Valid Date
- 00:00 Valid Time
- ? Unknown
- / Not applicable
6.16 Disposition After ED

Identifying and definitional attributes

Definition
The first location for which the patient departed on leaving the emergency department at the definitive care hospital.

Justification
To monitor the status and location of patients on departure from the ED.

Representational attributes

Guide for use
If a patient is a direct admission and goes directly to another area in the hospital on hospital arrival (such as ICU or OR), code the unit or department where the patient was admitted to.

If the patient goes home after ED they do not meet the inclusion criteria, and should not be submitted to the NZTR.

If a patient goes for an X-ray from ED this does not count as a discharge from ED and the location they are disposed to following the X-ray should be recorded.

Validation rules

Data type
Number

Field size maximum
1

Data domain
Code | Description
--- | ---
1 | Ward
2 | Intensive Care Unit (ICU)
3 | High Dependency Unit (HDU)
4 | Operating Room (OR)
5 | Death in ED
? | Unknown
7.01  Patient Intubated?

**Identifying and definitional attributes**

**Definition**  
Whether the person was intubated before or within 6 hours of arrival at the first hospital, (whether this is the referring or definitive care hospital).

**Justification**  
Identifies patients requiring definitive airway management and may be used in the evaluation of quality of care.

**Representational attributes**

**Guide for use**  
This field is designed to capture patients who require intubation for airway management, rather than those requiring intubation for the administration of anaesthesia prior to surgery; thus only those intubated before or within 6 hours of arrival at the first hospital are recorded and the location of this intubation is also recorded to provide context for the purpose of intubation.

Patients who have been intubated and extubated for the sole purpose of anaesthesia for an operative procedure are recorded as 1-No.

**Validation rules**  
If this field is completed Yes, 7.02 Date & Time Patient Intubated should not be completed as Not Applicable.

**Data type**  
String

**Field size maximum**  
1

**Data domain**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Yes: Pre-hospital</td>
</tr>
<tr>
<td>3</td>
<td>Yes: Emergency Department (at either referring or definitive care hospital)</td>
</tr>
<tr>
<td>4</td>
<td>Yes: ICU (at either referring or definitive care hospital)</td>
</tr>
<tr>
<td>5</td>
<td>Yes: Other</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
7.02  Date & Time Patient Intubated

Identifying and definitional attributes

Definition  The date and time patient was first intubated if intubated before or within 6 hours of arrival at the first treating hospital.

Justification  To calculate time to intubation; to establish whether the patient was intubated at the time of scene, referring hospital or definitive care hospital observations.

Representational attributes

Guide for use  If the patient has not been intubated, code as Not Applicable.

Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25\textsuperscript{th} November 2011 should be reported as 25/11/2011 00:01

Validation rules  Must not be completed as Not Applicable if 7.01 Patient Intubated is completed as Yes

Must be not applicable if data code 2 in 7.01 = Yes

Must be greater than or equal to:

- 3.01 Date & Time of Injury

Must be less than or equal to:

- 7.12 Date & Time of Discharge from Definitive Care

Data type  Date/Time

Field size maximum  13

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>dd/mm/yyyy</td>
<td>Valid Date</td>
</tr>
<tr>
<td>00:00</td>
<td>Valid Time</td>
</tr>
<tr>
<td>.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
7.03 Emergency Operative Procedures

Identifying and definitional attributes

**Definition**
Emergency operative intervention for life threatening or potentially life threatening conditions undertaken within 24 hours of arrival at hospital, whether that is a referring hospital or definitive care hospital.

**Justification**
Used to characterise procedures used to treat specific injury types to enable analysis of triage and treatment.

Representational attributes

**Guide for use**
Limited to immediate interventions for severe or potentially severe injuries only, including: thoracotomy, craniotomy, laparotomy or interventional radiology procedures to stop bleeding.

**Validation rules**
Must be completed 2,3,4 if 7.04 Operation Date & Time completed

**Data type**
String

**Field size maximum**
3

**Data domain**

<table>
<thead>
<tr>
<th>Data domain</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>3841800</td>
<td>No operation or none of the following procedures performed</td>
</tr>
<tr>
<td></td>
<td>3960000</td>
<td>Thoracotomy</td>
</tr>
<tr>
<td></td>
<td>3037300</td>
<td>Craniotomy</td>
</tr>
<tr>
<td></td>
<td>35321-10</td>
<td>Laparotomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interventional radiology</td>
</tr>
</tbody>
</table>
7.04 Date & Time for Each Emergency Procedure

Identifying and definitional attributes

Definition
The date and time emergency procedures are undertaken.

Justification
Allows time to each emergency procedure to be calculated.

Representational attributes

Guide for use
Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25th November 2011 should be reported as 25/11/2011 00:01

Start time is the time anaesthesia is administered.

Validation rules
Must be greater than or equal to:
  - 3.01 Date & Time of Injury

Must be less than or equal to:
  - 7.12 Date & Time of Discharge from Definitive Care

Must be less than or equal to 24 hours after:
  - Date and Time of 5.02 Referring Hospital Observations if applicable, if no Referring Hospital exists then 6.01 Date and Time of Definitive Care Hospital Observations

Data type
Date/Time

Field size maximum
20+

Data domain

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>dd/mm/yyyy</td>
<td>Valid Date</td>
</tr>
<tr>
<td>00:00</td>
<td>Valid Time</td>
</tr>
<tr>
<td>/</td>
<td>Not applicable</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Identifying and definitional attributes

**Definition**
The assigned Abbreviated Injury Scale anatomical scoring codes for each injury sustained by the patient.

**Justification**
The main purpose is to calculate the overall injury severity of the patient which can be used for TRISS and outcome analysis.

Representational attributes

**Guide for use**

If earlier AIS versions are used, these codes will need to be mapped to the comparable 2008 AIS estimates.

AIS codes can be entered by numerical values if available or by detailed description search. Codes can also be auto-populated by using the Tri-Code Injury section.

Tri-code and coding section can be used together, but once coding section utilised you cannot further enter through Tri-code without losing coding section information.

If the Tri-code section is not used manual entry of AIS codes can occur here.

**Validation rules**

**Data type**
String

**Field size maximum**
8

**Data domain**
AIS 2005 Update 2008 codes
7.06 Injury Severity Score

Identifying and definitional attributes

**Definition**  
The calculated Injury Severity Score based on the entered Abbreviated Injury Scale codes at discharge. ISS is an anatomical scoring system that provides an overall score for patients with multiple injuries.

**Justification**  
To determine severity of injury for trauma patients. Used to characterise patients and hospital outcomes based upon the presence, severity and type of injury.

Representational attributes

**Guide for use**  
This is automatically calculated on the Registry.

A non-zero integer number calculated based on AIS codes. If AIS codes are available, this will be derived as a calculated field. If an injury is assigned an AIS severity of 6 (unsurvivable injury), the ISS score is automatically assigned 75.

**Validation rules**

**Data type**  
Number

**Field size maximum**  
2

**Data domain**  

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 75</td>
<td>ISS codes</td>
</tr>
</tbody>
</table>
7.07  Number of Hours on Ventilator

Identifying and definitional attributes
Definition  The total number of hours on which mechanical ventilation was used
Justification  Ventilation increases risk of complications, such as Ventilator-Associated Pneumonia, and may lead to potentially poorer outcomes.

Representational attributes
Guide for use  Include use of mobile ventilators during transport.
Field allows for multiple “start” and “stop” episodes and calculates total hours spent on a mechanical ventilator.
Exception is when the only mechanical ventilation used occurs during an Operating Room procedure. When a patient is on a ventilator and remains so during an operation, this time will be included.

Validation rules
Data type  Number
Field size maximum  3
Data domain  Value  Description
  dd/mm/yyyy  Valid  Start Date
  00:00  Valid  Start Time
  dd/mm/yyyy  Valid  Stop Date
  00:00  Valid  Stop Time

Once the modification to the Registry is done this will change to a single field for hours.
7.08  Total Length of Stay

Identifying and definitional attributes

Definition
The total number of hospital days spent in both the referring and definitive care hospitals from date of first admission to date of discharge or death, measured in days.

Justification
Length of stay can be associated with increased risk of complications and poorer outcomes. Length of stay also reflects the use of hospital resources.

Representational attributes

Guide for use
This is automatically calculated on the registry.

Validation rules

Data type  Number
Field size maximum  5

Data domain  Value  Description
1-400.00  Valid days – this is automatically calculated on the Registry
/.  Not applicable
?  Unknown
7.09  Length of ICU Stay

Identifying and definitional attributes

Definition  The total number of hospital hours spent in the Intensive Care Unit (ICU) across both the referring and definitive care hospitals.

Justification  An important measure of the patient care process.

Representational attributes

Guide for use  Calculated length of hours stay in the intensive care unit at the referring and definitive care hospital.

Length of ICU stay ends on discharge from ICU.

Length of stay includes first admission and any readmissions.

Validation rules

Data type  Number

Field size maximum  6

Data domain  Value  Description
  dd/mm/yyyy  Valid Start Date
  00:00  Valid Start Time
  dd/mm/yyyy  Valid Stop Date
  00:00  Valid Stop Time

Once the modification to the Registry is done this will change to a single field for hours.
7.10 Diagnosis Made >48 hours After Arrival?

Identifying and definitional attributes

Definition
Whether a specified injury with an AIS ≥ 2 was diagnosed more than 48 hours after arrival at the first hospital and after tertiary survey and radiology reports reviewed.

Justification
Represents a quality measure to identify injuries which should have been identified but were not.

Representational attributes

Guide for use

Validation rules

Data type Number
Field size maximum 1

Data domain

Code Description
1 Yes
2 No
? Unknown
7.11 Discharge Destination from Acute Care

Identifying and definitional attributes

Definition
The location to which the patient was discharged from acute care in the definitive care hospital.

Justification
To determine the outcome status of patients.

Representational attributes

Guide for use
If the patient is discharged back to the usual or original place of residence such as a nursing home, aged care facility or special accommodation, code 1 – Home

Validation rules

Data type
Number

Field size maximum
2

Data domain

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Home</td>
</tr>
<tr>
<td>2</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>3</td>
<td>Residential aged care service or nursing home - not the usual place of residence</td>
</tr>
<tr>
<td>4</td>
<td>Special accommodation (includes prisons, hostels and group homes providing primarily welfare services) that is not the usual place of residence</td>
</tr>
<tr>
<td>5</td>
<td>Hospital for convalescence</td>
</tr>
<tr>
<td>6</td>
<td>Left against medical advice/discharge at own risk</td>
</tr>
<tr>
<td>7</td>
<td>Death</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>?</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
7.12 Date & Time of Discharge from Definitive Care

Identifying and definitional attributes

Definition
The date and time patient was discharged from the definitive care hospital, or (if died in hospital) the time of death.

Justification
To calculate length of stay at the definitive care hospital.

Representational attributes

Guide for use
Midnight should be entered as 00:01 of the following date (00:00 and 24:00 are not accepted). Example, midnight 25\textsuperscript{th} November 2011 should be reported as 25/11/2011 00:01

It is the date of separation from the definitive care hospital.

If not collected, can be concatenated if the following data is collected at the definitive care hospital:

- Episode of admitted patient care - separation date (METeOR ID: 270025)
- Episode of admitted patient care - separation time (METeOR ID: 270026)

Validation rules
Must be greater than or equal to:

- Date & Time of Arrival at Definitive Care Hospital
- ED Discharge Date & Time

Data type
Date/Time

Field size maximum
13

Data domain
Valid Date and Time
7.13 Type of Death

Identifying and definitional attributes

Definition The clinical cause of death

Justification

Representational attributes

Guide for use If a patient dies following admission to either the referring or definitive care hospital prior to hospital discharge the type of death should be recorded.

Validation rules

Data type Number

Field size maximum 2

Data domain Code Description

1 Central Nervous System (CNS)
2 Multiply Organ Failure (MOF)
3 Medical
4 Haemorrhage: Chest
5 Haemorrhage: Abdomen
6 Haemorrhage: Pelvis
7 Haemorrhage: Unspecified
? Unknown