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TRAUMA DATA COLLECTION AND MANAGEMENT

I. AUTHORITY: Division 2.5, California Health and Safety Code, Sections 1798.162, 1798.163, California Code of Regulations Sections 100255, 100257.

II. PURPOSE: To establish requirements for data collection and management by trauma system participants.

III DEFINITIONS:

A. "Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations.

IV. POLICY

A. Prehospital records:

In addition to normal patient information, prehospital providers shall, for all patients who meet the trauma triage criteria (Policy 553.25), record the following data on the patient care record: Anatomic, physiologic and/or etiologic triage criteria (if appropriate).

B. Level II trauma centers:

1. Level II trauma centers shall complete a trauma registry form for all patients who meet the following trauma registry inclusion criteria:

   a. ICD-9 800-959.9, AND

   b. Physically evaluated by trauma or burn surgeon in the ED or resuscitation area OR

   c. Death in Emergency Department OR

   d. Transfer for trauma services (note: may include inter-facility and intra-facility).

   Exclusion: Isolated burn without penetrating or blunt mechanism of injury

2. The registry shall include, but not be limited, to the data elements shown in Appendix 1.

3. In the event that a patient is first transported to a non-trauma center or a Level III or Level IV trauma center, and subsequently transferred to a Level II trauma center, the following information should be readily available from patient care and related records:
   a. Time patient arrived
   b. Mode of arrival
   c. Patient's vital signs, including:
      (1) blood pressure
      (2) pulse
      (3) respiratory rate
      (4) Glasgow Coma Score components
   d. Other clinical signs, as appropriate to determine the triage criteria (e.g., location of penetrating trauma)
   e. Emergency medical treatment rendered

f. Patient's response to treatment
g. Reason for transferring patient to the out-of-county trauma center
h. Time out-of-county trauma center was notified
i. Time patient left the transferring hospital for the receiving hospital
j. Transferring physician identifier
k. Receiving physician identifier

C. Level III and IV trauma centers and non-designated receiving facilities

1. Level III and IV trauma centers and non-designated receiving facilities shall complete a trauma registry form for all patients who meet the following trauma registry inclusion criteria:

   a. ICD-9 800-959.9, AND

   b. Physically evaluated by trauma or burn surgeon in the ED or resuscitation area OR

   c. Death in Emergency Department OR

   d. Transfer for trauma services (note: may include inter-facility and intra-facility)

   Exclusion: Isolated burn without penetrating or blunt mechanism of injury

2. The registry shall include, but not be limited, to:
   1. A unique case number/document location number
   2. Time patient arrived in:
      a. emergency department or trauma receiving area
      b. surgical suite
   3. Mode of arrival
   4. Emergency physician identifier
   5. Time surgeon and trauma team was requested
   6. Time surgeon and trauma team arrived at the requested location
   7. Surgeon identifier
   8. Anesthesiologist identifier
   9. Patient's vital signs, including:
      a. blood pressure
      b. pulse
      c. respiratory rate
      d. Glasgow Coma Score Motor component
   10. other clinical signs, as appropriate to determine the triage score (e.g., location of penetrating trauma)
   11. Mechanism of Injury (E-codes)
   12. Emergency department treatment
   13. Time initial surgery commenced
   14. Days in ICU
   15. Days in hospital
   16. Complications
   17. Discharge data, including:
      a. diagnosis
      b. operative procedures
      c. injury severity score
      d. patient condition
      e. disposition
      f. total hospital charges (aggregate dollars only)

D. Cooperation with other counties

1. Where patients from the Stanislaus County EMS system are transported to a trauma center or facility in another EMS system, Stanislaus County EMS will seek patient information that is equivalent to that provided by Stanislaus County EMS trauma centers.

2. Where patients from another EMS system are transported to a Stanislaus County EMS trauma center, Stanislaus County EMS will attempt to provide patient information which is equivalent to that provided by that system's designated trauma centers.

3. Hospitals and ambulance providers within the Stanislaus County EMS system are encouraged to cooperate with other EMS agencies in data collection and evaluation efforts.

Appendix Follows

Appendix 1: Data Elements for Level II Trauma Centers

Trauma Base Data Elements

1. Patient identification data

2. Demographic data
   a. Age and age unit
   b. Gender
   c. Ethnicity

3. Event data
   a. Cause
   b. Trauma type
   c. Category
   d. E-code
   e. Triage data
   f. Risk factors (co-morbid)
   g. Protective equipment usage

4. Event location

5. Referring hospital data
   a. Referring hospital admit vitals
   b. Referring hospital discharge vitals
   c. Referring hospital procedures

6. Prehospital data
   a. Transportation mode
   b. Transport agency
   c. Transport destination
   d. Scene procedures
   e. Vital signs on scene
   f. Scene Time

7. Hospital data
   a. Admitting service
   b. Time of trauma team notification
   c. Admission status
   d. Activation
   e. ED procedures
   f. Time/date of arrival
   g. First ED vitals
   h. 1 hour or discharge vitals
   i. Providers involved in care
   j. Full vital table
   k. ED disposition
   l. Time in ED
   m. Trauma Surgeon arrival time
   n. Physician identifier codes

8. Diagnosis data
   a. ICD-9
   b. AIS
   c. Severity
   d. AIS-98

9. Clinical data
   a. Blood type
   b. ETOH
   c. ETOH evident
   d. Toxicology
   e. Labs
   f. Fluid administration
   g. Blood volume given

10. Procedure data
   a. Procedures performed
   b. Location
   c. Provider
   d. OR cut time

11. Discharge data
   a. Time and date
   b. Disposition
   c. Discharge outcome

12. QI data
   a. Complications (see data dictionary for definitions)

13. Charges data
   a. Payments
   b. Charges
   c. Payor source

14. Death data