

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

TRAUMA PROGRAM

2005

ANNUAL REPORT

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Trauma Medical Director, Interim

The University of Mississippi Medical Center is a participant in the Central Mississippi Trauma Region and is a fully designated Level 1 Trauma Center by the Mississippi State Department of Health.

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2005-2006**

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Social Work

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Respiratory Therapy

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American Medical Response

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Emergency Medical Technology

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TRAUMA PROGRAM OVERVIEW

The Trauma Program at the University of Mississippi Medical Center (UMMC) operates under the guidance of the Trauma Medical Director and Hospital Administration. Two trauma program managers and three trauma registrars (one additional position to be filled) staff the trauma program office. The Trauma Service includes full-time faculty who manage and supervise resuscitation and surgical interventions in all cases. Twenty-four hour support of the departments of surgery, emergency medicine, pediatrics, orthopedics, neurosurgery, radiology, pathology, other surgical subspecialties, blood bank, nursing and allied health personnel are available immediately for the care of severely injured trauma patients.

In December 2003, the Mississippi State Department of Health fully designated the UMMC as a Level 1 trauma center for the state of Mississippi. This was achieved through a dedicated commitment by administration and medical staff to not only provide optimal patient care, but also foster leadership of team members, education, outreach, research, and concurrent performance improvement, which guides and directs the vision of the trauma program.

The Trauma Program personnel have consistently filled a leadership role in the development and implementation of optimal trauma care for the State of Mississippi. Responsibilities are held within the following committees and organizations:

- American College of Surgeons
- American College of Emergency Physicians

- Eastern Association for the Surgery of Trauma
- Society of Trauma Nursing
- Emergency Nurses Association
- American Trauma Society
- American Trauma Society MS Chapter
- American Society for Parental and Enteral Nutrition
- Shock Society
- American Burn Association
- National and International Surgical, Orthopedic, and Neurosurgical Associations
- Mississippi Trauma Advisory Council
- Numerous regional committee chair positions

The Trauma Team consists of personnel from the Department of Surgery, Section of Trauma/Critical Care and Division of Pediatric Surgery, Department of Pediatric, Division of Pediatric Emergency Medicine, nursing staff, and ancillary staff. Specifically the team consists of attending and residents, nursing staff, and support staff. The surgical faculty are trauma-committed surgeons with special interests and expertise in trauma care for the adult and pediatric populations. The Trauma Team evaluates, resuscitates, and definitely treats all major trauma patients.

As a Level 1 Trauma Center, the UMMC has the highest level of response for the major trauma patient. The Trauma Team requires the cohesive medical approach of physicians, nurses, and ancillary staff to assure that the trauma patient is evaluated, resuscitated, and treated expeditiously and appropriately. In addition, the program

continues to be active in allied initiatives from prevention to rehabilitation with the overall objectives to continually reduce death and disabilities from trauma.

While the main goal of the Trauma Program is optimal patient care, the program also provides leadership in education. There are on-going educational programs for physicians, nurses, and students in the form of trauma rounds and operative supervision as well as didactic discussions and conferences. Monthly orientation of new hospital personnel to their responsibilities within the Trauma Center, critical care courses designed to educate newly hired critical care nurses, trauma conference, continuing education, stall in-services, workshops, and updates on the optimal care of the trauma patient to pre-hospital providers, physicians, and nurses.

The Trauma Program has become a well-recognized educational resource. Outreach and educational efforts occur simultaneously. Outreach educational opportunities include but are not limited to Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), Trauma Nurse Core Curriculum (TNCC), and Advanced Trauma Life Support for Nurses

(ATCN). UMC has been a lead sponsor of the MS Trauma Symposium through the coordinated efforts with the American Trauma Society, MS Chapter.

Members of the Trauma Team are committed to trauma related research. Trauma surgical faculty are nationally and internationally recognized for their expertise in research. Work done at the UMMC has been presented many times at the national and international levels.

In addition to the medical/nursing staff, trauma program managers (TPM) are fundamental to the UMMC's trauma program progress, execution, and evaluation. Working in conjunction with the Trauma Medical Director, Hospital Administration, and various departments, the TPMs are responsible for the organization of services necessary for an interdisciplinary approach in delivery of optimal care to the trauma patient. Performance improvement initiatives direct the specifics to optimize the care provided to patients at the trauma center, trauma region, and statewide levels.

EMERGENCY DEPARTMENTS

The Adult and Pediatric Emergency Departments at the UMMC cared for 92,562 patients in the calendar year 2004. Of these, approximately 15,736 (17%) were treated for injuries. In the Adult Emergency Department (AED), there are 3 trauma rooms available for the assessment, stabilization, and treatment of trauma

patients. The Pediatric Emergency Department (PED) has 2 rooms available for the same purpose.

Emergency Medicine faculty provide 24 hour a day direct care of all patients in the emergency departments. They supervise emergency medicine and pediatric residents and interns from all services in the care of trauma and other ED illness/diseases. Emergency

Medicine physicians at UMMC provide on-line medical control via radio and telephone for ambulance personnel who are rendering care to victims of trauma in the field.

In response to a lack of emergency care and physicians in many rural areas of Mississippi, the University of Mississippi Medical Center has developed and will direct the operation of a rural health telemedicine initiative called TelEmergency.

Providing qualified emergency care in rural hospitals with low patient volumes can be cost prohibitive. Additionally, it is difficult to recruit and retain physicians to these areas. Utilizing a nurse practitioner as the healthcare provider, the Emergency Department of the University of Mississippi Medical Center will effectively provide emergency coverage in these participating hospitals through the TelEmergency system.

The nurse practitioner will function under the protocol of the University Emergency Department, as approved by the Board of Nursing. UMC educates and facilitates the placement of these specially trained nurse practitioners in rural emergency departments.

Rural hospitals have contracted with the University of Mississippi Medical Center to provide the faculty backup for the nurse practitioners who completed the program and were hired by the local facility. When these nurse practitioners staff the rural ED, they communicate with Emergency Medicine physicians at UMC via T-1 lines and a sophisticated telemedicine setup.

Generous funding has been provided by The Bower Foundation, who supported this training and state-of-the-art technology. The program is also linked to the Department of Health who has funded access to electronic medical records generated by the nurse practitioners. This allows them to surveil the state's rural

areas and Jackson for potential trends in public health or bioterror.

The program began operation on October 1, 2003, as a pilot project approved by the Boards of Medicine and Nursing, and has since seen an average of approximately 1,000 patients per month who would otherwise not have access to this high level of emergency care.

Upon arrival to the appropriate emergency department, the severely injured patient is evaluated immediately by the trauma team, headed by the trauma surgeon and emergency medicine attending physicians. The team also includes emergency medicine residents, surgery residents, rotating interns, nursing staff, and support staff. The inclusion of rotating interns on the team provides a valuable educational insight into the organization and operation of a trauma center for all physicians, regardless of intended specialty choice. The trauma team provides primary and secondary assessment of the injured patient to identify life-threatening injuries and administer immediate interventions.

The emergency medicine attending physician also coordinates a three-tiered trauma response. This system is designated to provide the appropriate level of trauma response for every patient and makes the best use of the trauma center resources. The emergency medicine attending uses anatomic, physiologic, mechanism of injury, and age criteria to determine the level of trauma team response required. These criteria are applied to patients arriving from the field as well as to those arriving by private vehicle or transferred from other hospitals.

AIRCARE

The AirCare program was established for the purpose of making the resources of the UMMC more readily available to patients and physicians throughout the state of Mississippi. The current aircraft is a Bell 230, twin turbine engine helicopter capable of transporting one or two patients and a medical crew of two or three. The aircraft is configured with all necessary emergency and critical care equipment, including a ventilator, 12 lead cardiac monitor, pulse oximeter, external pacer, multichannel IV pump, Propaq® invasive/noninvasive monitor and a full complement of medications.

The aircraft is staffed by flight nurses and flight paramedics selected from a large pool of qualified applicants. After being hired each employee is required to complete an extensive orientation/preceptorship program. This orientation includes rotations through the surgical suite, and intensive care units (medical,

neurosurgical, surgical, pediatric, and cardiac). It also includes cadaver laboratory rotations. This is orientation track requires 60-90 days to complete. Flight personnel are trained to provide advanced patient assessment, administration of medications and blood products, electrical therapy such as pacing, cardioversion, and defibrillation, rapid sequence intubation for airway control, and escharotomy for relief of circulatory restriction in patients with circumferential burns.

Family members are given an update on patient condition and an opportunity to visit briefly with the patient prior to each flight.

During the calendar year 2004, the AirCare team transported a total of 894 patients. Of that number, 353 transports (39%) were trauma related.

SURGICAL INTENSIVE CARE UNIT POST ANESTHESIA CARE UNIT

The Surgical Care Unit (SICU) and the Post Anesthesia Care Unit (PACU) are settings in which the critically ill trauma patient receives efficient, innovative, state-of-the-art health care. The primary focus is on resuscitation and stabilization of patient's pulmonary and hemodynamic parameters and the return of optimal functioning. Since most trauma patients require prolonged care after transfer from the SICU, one of the expectations is to teach the family members the signs

and symptoms to look for and how to care for the patient in areas such as skin care, suctioning, nutrition and range of motion.

In order to standardize care of the trauma patient, SICU and PACU nurses are cross-trained to both areas. All nurses are trained and evaluated annually on their ability to care for patients with invasive monitoring devices (i.e. Swan Ganz catheters, arterial lines, ICP

monitoring). The SICU also performs several types of dialysis (hemo, CAPD, CAVHD, CVVHD).

The SICU has a resident physician in the unit 24-hours a day. The resident is drawn from various surgical services, anesthesia, and emergency medicine. The full-time SICU medical director or designee makes rounds twice a day on all the patients and make plans for multidisciplinary care utilizing nursing, respiratory

therapy, pharmacist, physical/occupational therapists, social work, and pastoral services.

The SICU and PACU are committed to providing quality patient care, to continuous improvement through assessment, planning, implementation, and evaluation, to ongoing education, research endeavors while showing compassion, dignity, and respect for each individual.

NEUROSURGICAL TRAUMA SERVICE

The UMMC Department of Neurosurgery Trauma Service provides a well established management system for neurologically injured patients. The department has nationally and internationally renowned authorities in all aspects of neurological trauma. The Neurosurgery Trauma Service is well recognized and respected for its ability to manage traumatic brain injuries, traumatic spinal cord injuries, and peripheral nerve trauma. Input is solicited from each discipline during a weekly meeting held to discuss patient care needs. Each patient's needs are presented and problem solving utilized to ensure the very best of care during hospitalization and after discharge from the hospital.

The Neurosurgical Intensive Care Unit is fortunate to have full time neurointensivist physicians on duty, who work collaboratively with the neurosurgeons to provide the maximum level of comprehensive patient care at all times. Evidence based traumatic brain injury and spinal cord injury guidelines have been developed, implemented and are diligently followed within the trauma center.

In the Department of Neurosurgery, ongoing research is dedicated to understanding the pathophysiology of head trauma and testing novel treatments for secondary brain injury occurring in severe traumatic brain injured patients. Recently, the UMMC Neurosurgery Department was awarded a National Institute of Health sponsored research project to study hypothermia in severe brain injured patients. This is a multi-center study to be conducted over a 42-month period. Two of the studies worthy of mention are a study involving Xigris and another which will evaluate certain brain chemical biomarkers of brain trauma patients and any relevance to the diagnosis, treatment and prognosis of traumatic brain injury patients.

In recent years, a Traumatic Brain Injury Registry has been established. This type of registry documents the mechanisms of traumatic brain injury, as well as contributing factors, which will facilitate better understanding of the types of injuries within our communities. This data can then be analyzed to determine in which direction to focus research efforts.

ORTHOPEDIC TRAUMA SERVICE

The Orthopedic Trauma Service is capable of caring for a variety of orthopedic injuries. These services include traumatic and reconstructive spinal surgery, fractures, joint replacement, hand surgery, upper extremity reconstruction, arthroscopic surgery, shoulder and elbow surgery, sports medicine, pediatric orthopedics, microsurgery, pelvic/acetabular surgery, surgery of malunions and nonunions, and foot/ankle surgery.

The Department of Orthopedic Surgery and Rehabilitation maintains a three-fold purpose: 1) provide excellent patient care; 2) teach graduate and postgraduate students; and 3) conduct clinical and laboratory research.

The goal of the patient care program is to provide the highest quality patient care that is concerned with the patient's well being and not limited to just the specific disease condition or symptoms that are manifest. This includes a high level of technical competence and skills, a concern for the whole person's physical and mental well being and an integration of these two aspects so that the patient can return to full function.

While maintaining high quality care, the department continues to pursue excellence in the treatment of the whole patient through the example of compassionate care.

The objective of the teaching program is to conduct an outstanding program that produces medical students who have the cognitive knowledge, practical skills, and attitudes that are appropriate for their level of education.

The goal of the residency program is to develop the physician's skill in the diagnosis of all musculoskeletal injuries, diseases, and afflictions while learning and performing the appropriate surgical and nonsurgical interventions, follow-up care and rehabilitation with supervised training. The adequacy and appropriateness of this goal continue to be measured by the passing Board scores that are earned.

The goal of the research program is to conduct clinical and laboratory research that supports the patient care and teaching programs in advancing knowledge of the discipline. The potential for a solid research base is present.

TRAUMA REGISTRY

A core component of the Trauma Program is the Trauma Registry. The purpose of the registry is to identify and collect concurrent data on every trauma patient from pre-hospital through discharge. The data is used to track patient referral patterns, to identify performance improvement issues, and to assist in administrative planning, and research.

Abstraction involves identification of trauma patients as well as collection of data such as mechanism of injury, transport modality, safety equipment, blood transfusions, ICU days, complications, and discharge recommendations. Review of admission logs, trauma activation records, consultation records, transfer reports, and the daily admission census are done to facilitate

identification of the trauma patient. Accuracy of data is dependent on thorough documentation and availability of complete medical records, as well as dependence on the integrity of the registry software utilized. A Trauma Registry Handbook has been developed to facilitate the collection of accurate information for all registry data fields.

Eligibility requirements for inclusion into the Trauma Registry are as follows:

- Primary diagnosis 800-959.9 (ICD-9-CM)
- Plus any one of the following:
 - Transferred between acute care facilities to a higher level of care
 - Admitted to ICU
 - Hospitalization for 3 or more calendar days (excluding hip fractures from same height falls)
 - Expired during hospitalization
 - Admitted from ED to OR for major procedure (excluding plastic or single system orthopedic)

- Triaged to a trauma hospital by pre-hospital care regardless of severity
- Treated in the ED by the trauma team regardless of severity
- Survival probability $\leq 90\%$
- Sustained an injury with AIS ≥ 3

Part of the data collection process includes using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for abstracting and coding of the patient's injury, diagnosis, and procedures. This information is provided to the trauma surgeons and trauma program managers for research, outreach, prevention programs, and analysis/identification of performance improvement initiatives/issues. To date, the current trauma registry has collected data on 23,700 patients. The total number of patient for calendar year 2004 was 3060.

TRAUMA ACTIVATION CRITERIA – ADULT (2005)*

*This criteria was revised to a 2-tier system prior to the end of 2005.

Level 1 Activation

- Confirmed SBP < 90 mmHG at any time
- Respiratory compromise/obstruction
- GCS ≤ 8 with mechanism attributed to trauma
- Evidence of spinal cord injury
- Gunshot wound to the abdomen, neck, or chest
- Thermal injury to total body surface ≥ 30% or evidence of inhalation injury
- Transfer patient with unstable vital signs at the time of transfer or enroute including those requiring fluid and blood infusion

Level 2 Activation

- Vital signs stable and normal with history of hypotension
- Intubation in field or transferring facility
- GCS or 9-14
- 2 or more obvious or reported by transferring facility long bone fractures
- Pelvic fractures with hemodynamic stability
- Neurovascular compromise of limb
- Penetrating wound to torso or proximal extremity with hemodynamic stability
- Proximal traumatic amputation
- Crush injury to torso with hemodynamic stability
- Thermal injury to total body surface area 10-30% without evidence of inhalation injury

Level 3 Activation

- Patient to be admitted to another service (whether transfers or direct from scene) for injuries resulting from high energy impact, not to include falls from same height, stepping off curb, etc.

Patients who do not meet criteria but require evaluation for possible admission will be seen by the trauma service at the discretion of the Emergency Department attending. Examples would include:

- Ejection
- Fall > 15 feet
- Death of another occupant of same vehicle
- Major vehicle damage
- Pedestrian/cyclist thrown or run-over
- Rollover

TRAUMA ACTIVATION CRITERIA – PEDIATRIC (2005)

Level 1 Activation

- Hypotension according to age appropriate norms or clinical evidence of shock
- Respiratory compromise/obstruction
- GSC ≤ 8 with mechanism attributed to trauma
- Gunshot wound to abdomen, neck, or chest
- Transfer patient from outside hospital receiving blood to maintain vital signs
- Evidence of spinal cord injury
- Thermal injury to total body surface area $\geq 30\%$ or evidence of inhalation injury

Level 2 Activation

- Vital signs stable and normal with history of hypotension
- Intubation in field or transferring facility
- GCS 9-14
- 2 or more obvious or reported by transferred facility long bone fractures
- Pelvic fracture with hemodynamic stability
- Neurovascular compromise of limb
- Penetrating wound to torso or proximal extremity with hemodynamic stability
- Proximal traumatic amputation
- Crush injury to torso with hemodynamic stability
- Thermal injury to total body surface area 10-30% 2nd or 3rd degree within our evidence of inhalation injury

Level 3 Activation

- Patients who do not meet criteria but require evaluation for possible admission will be seen by the trauma service at the discretion of the Emergency Department attending. Examples would include:
- Ejection
 - Fall >15 feet
 - Death of another occupant of same vehicle
 - Major vehicle damage
 - Pedestrian/cyclist thrown or run-over
 - Rollover
 - All interfacility transfers requiring admission for injury

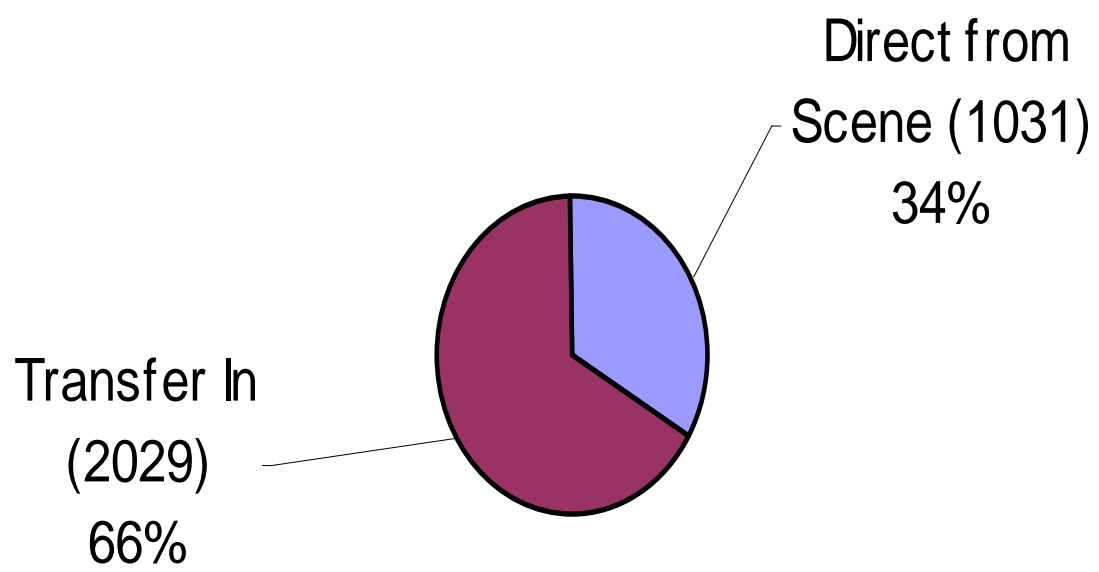
OVERALL SUMMARY

Transfer In vs Scene

Overall Summary

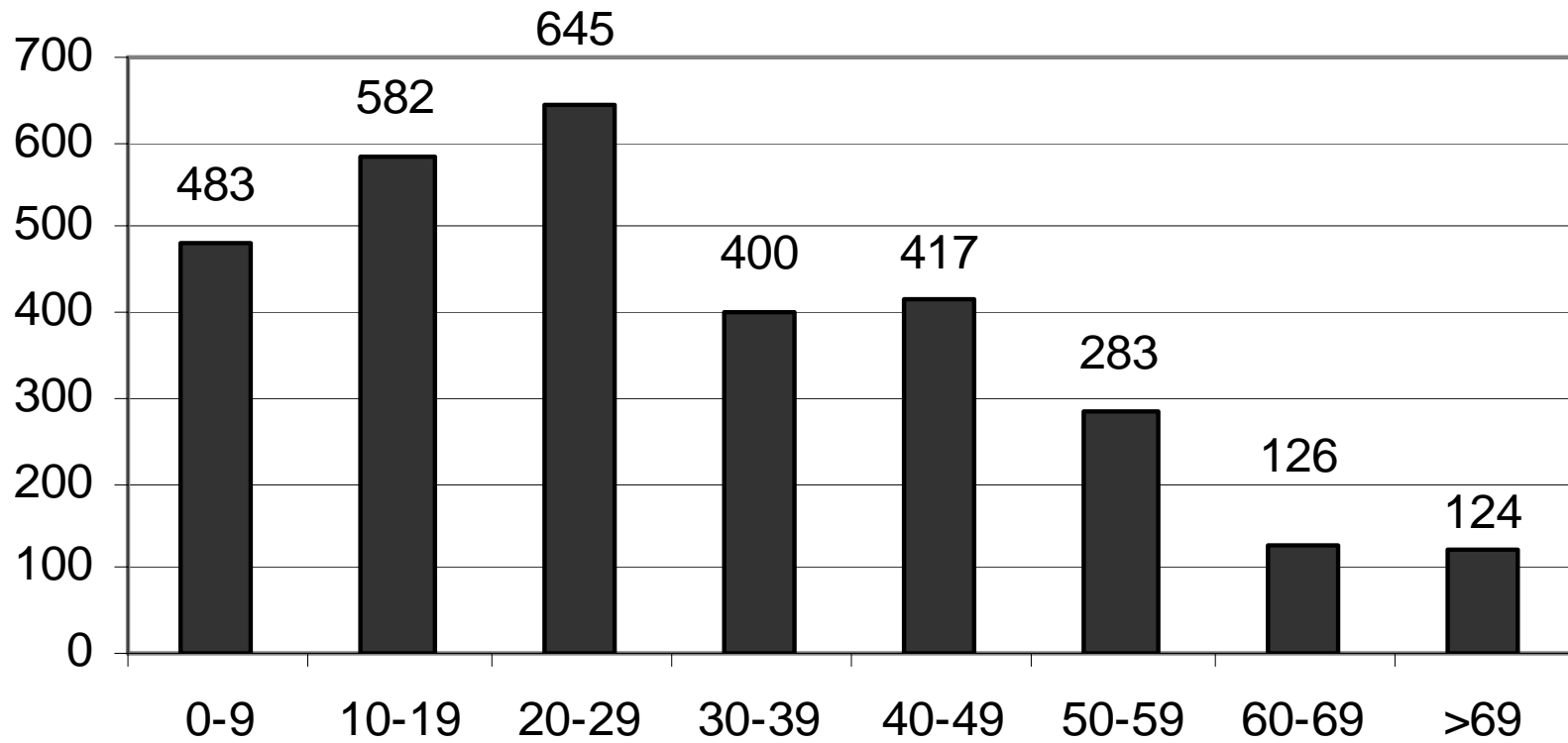
UMC Trauma Registry 2005

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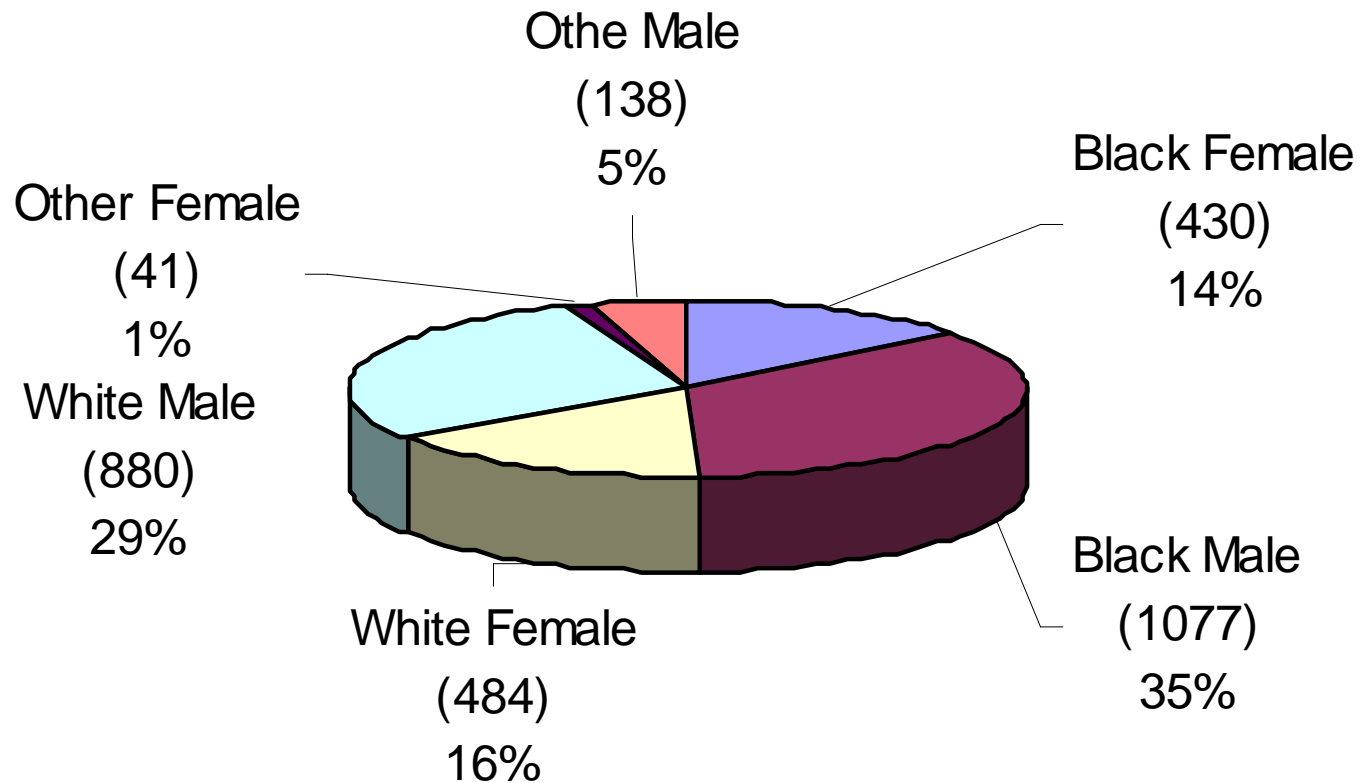
Age Distribution Overall Summary

UMC Trauma Registry 2005
n=3060



Gender and Race Overall Summary

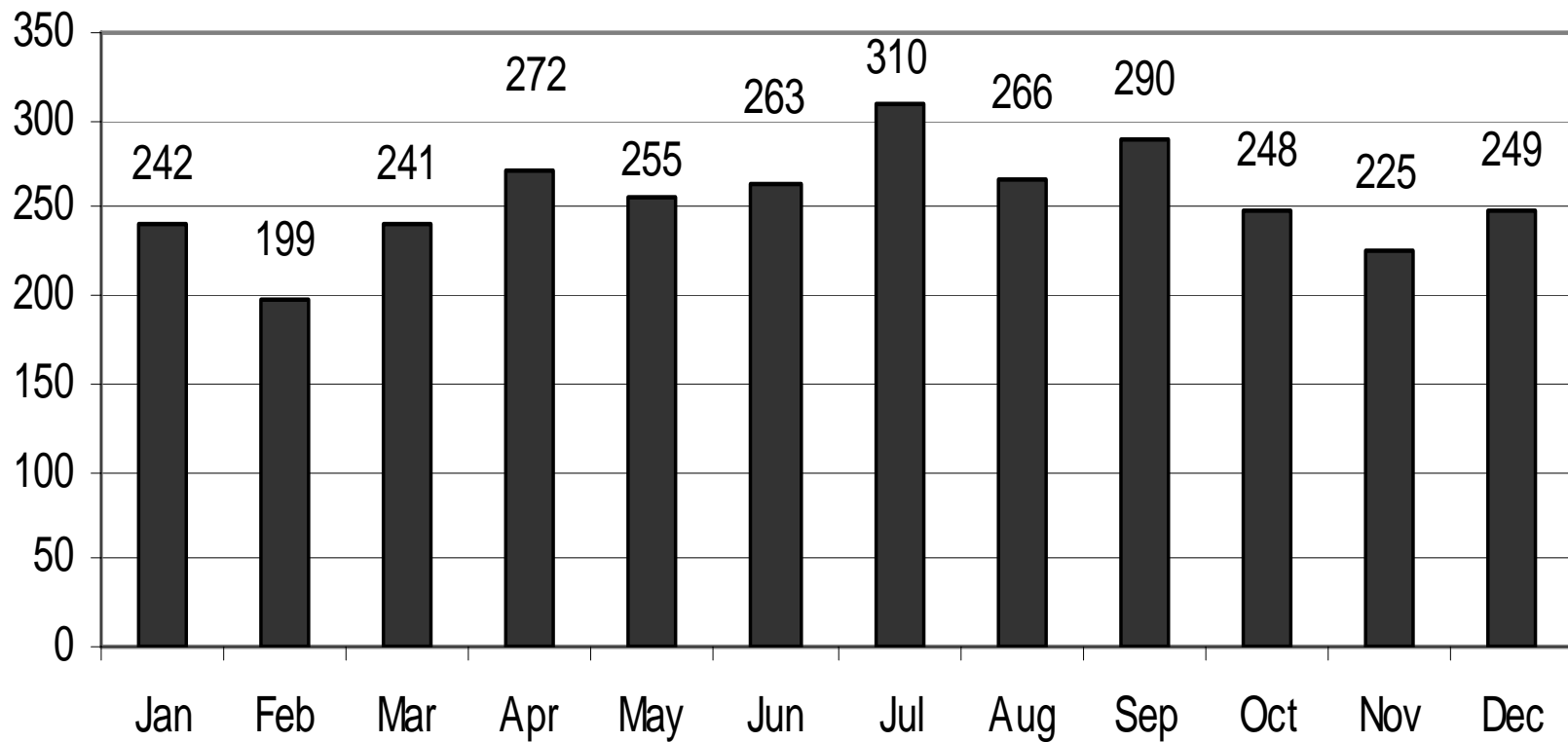
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Month Summary

Overall Summary

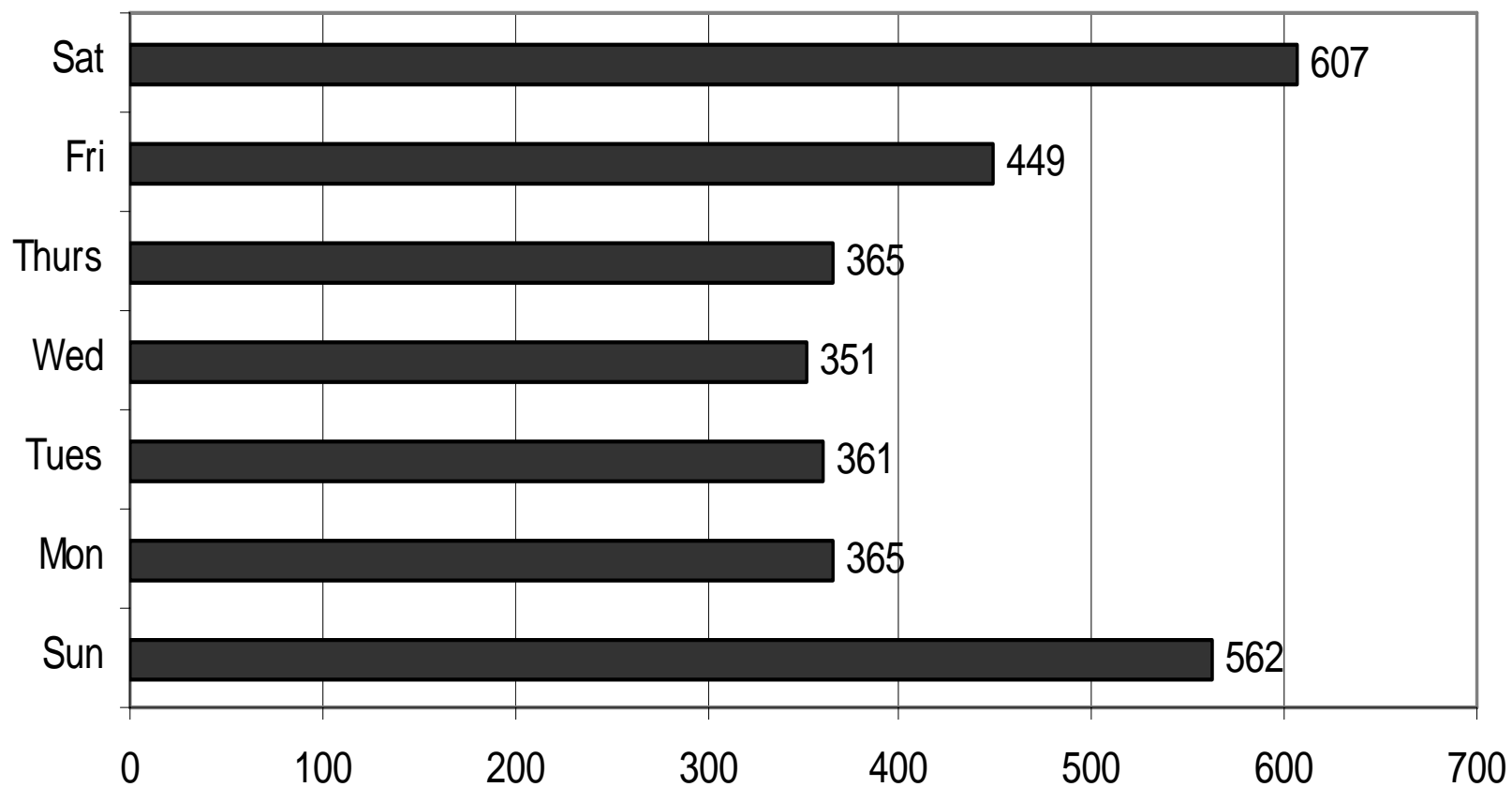
UMC Trauma Registry 2005
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Day of Admission Overall Summary

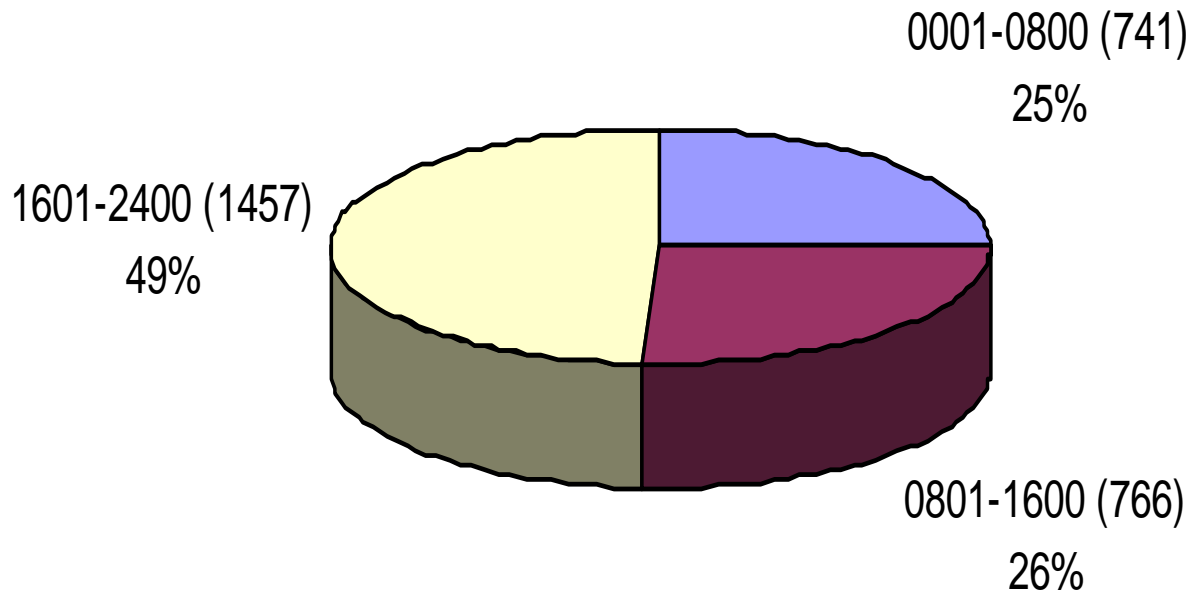
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n=3060



Time of Arrival Overall Summary

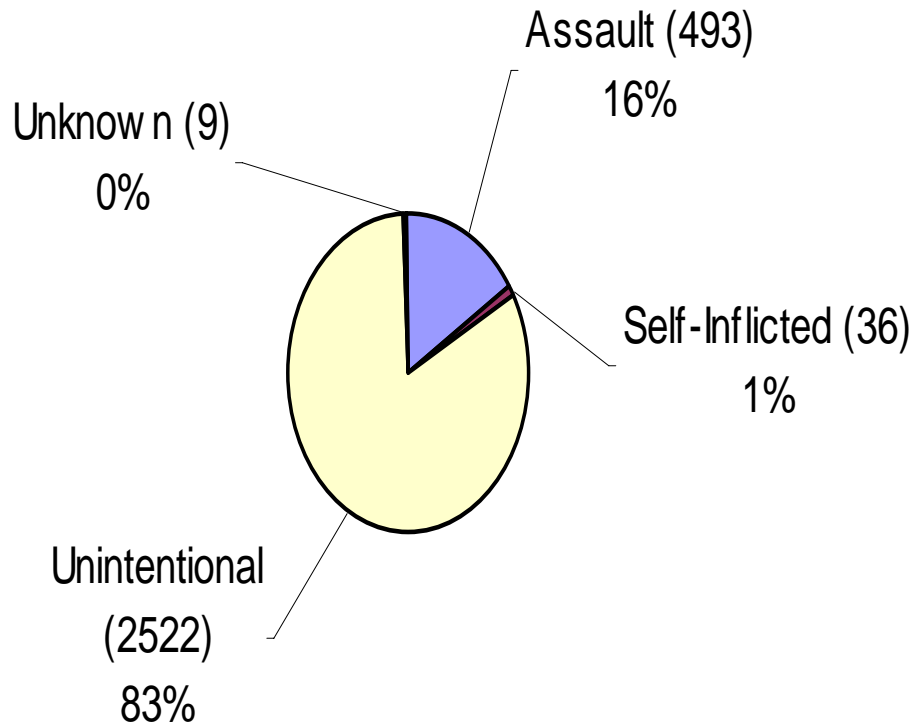
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Intent of Injury

Overall Summary

UMC Trauma Registry 2005
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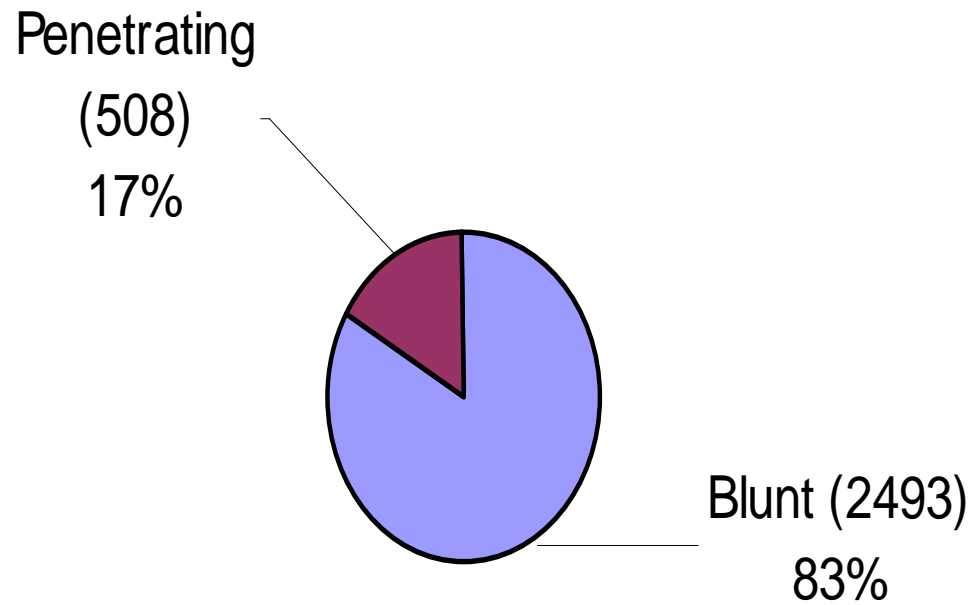


Blunt vs Penetrating

Overall Summary

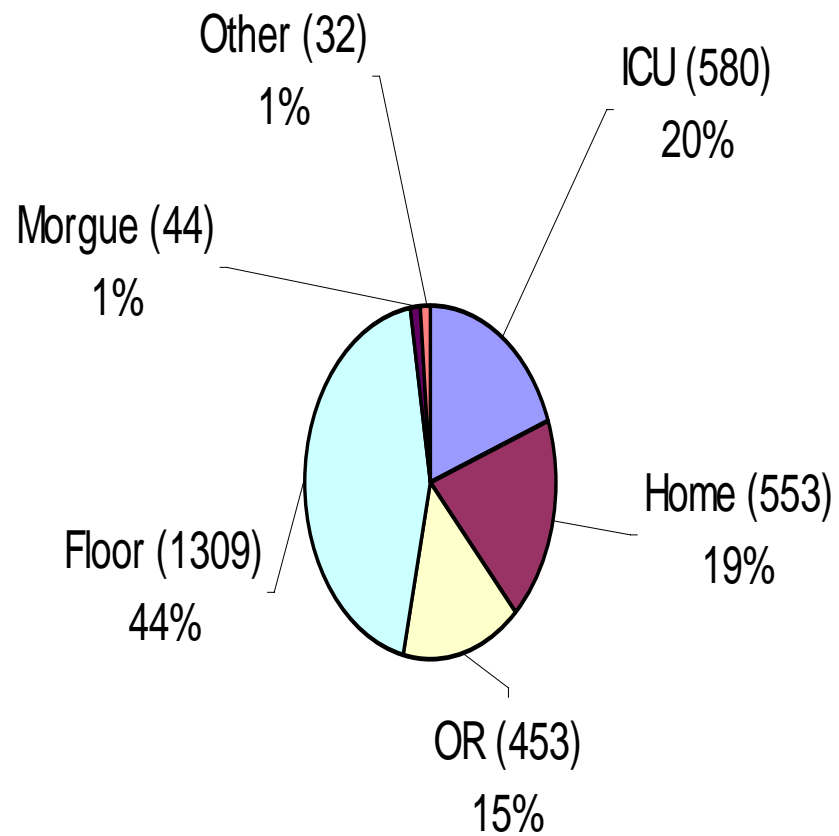
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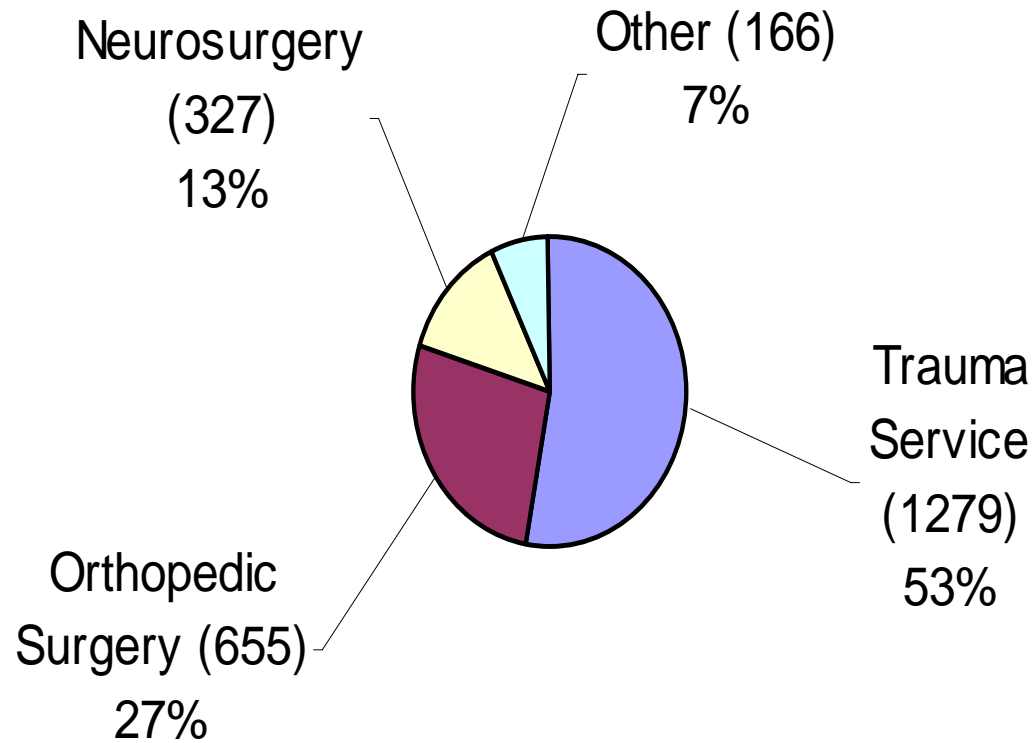
ED Disposition Overall Summary

UMC Trauma Registry 2005
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Admitting Service Overall Summary

UMC Trauma Registry 2005
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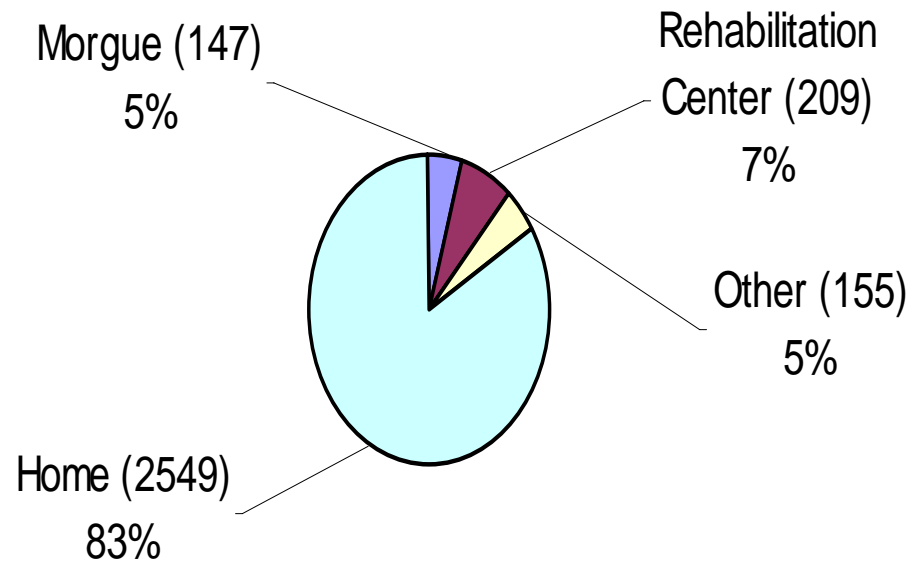


Hospital Disposition

Overall Summary

UMC Trauma Registry 2005

n=3060

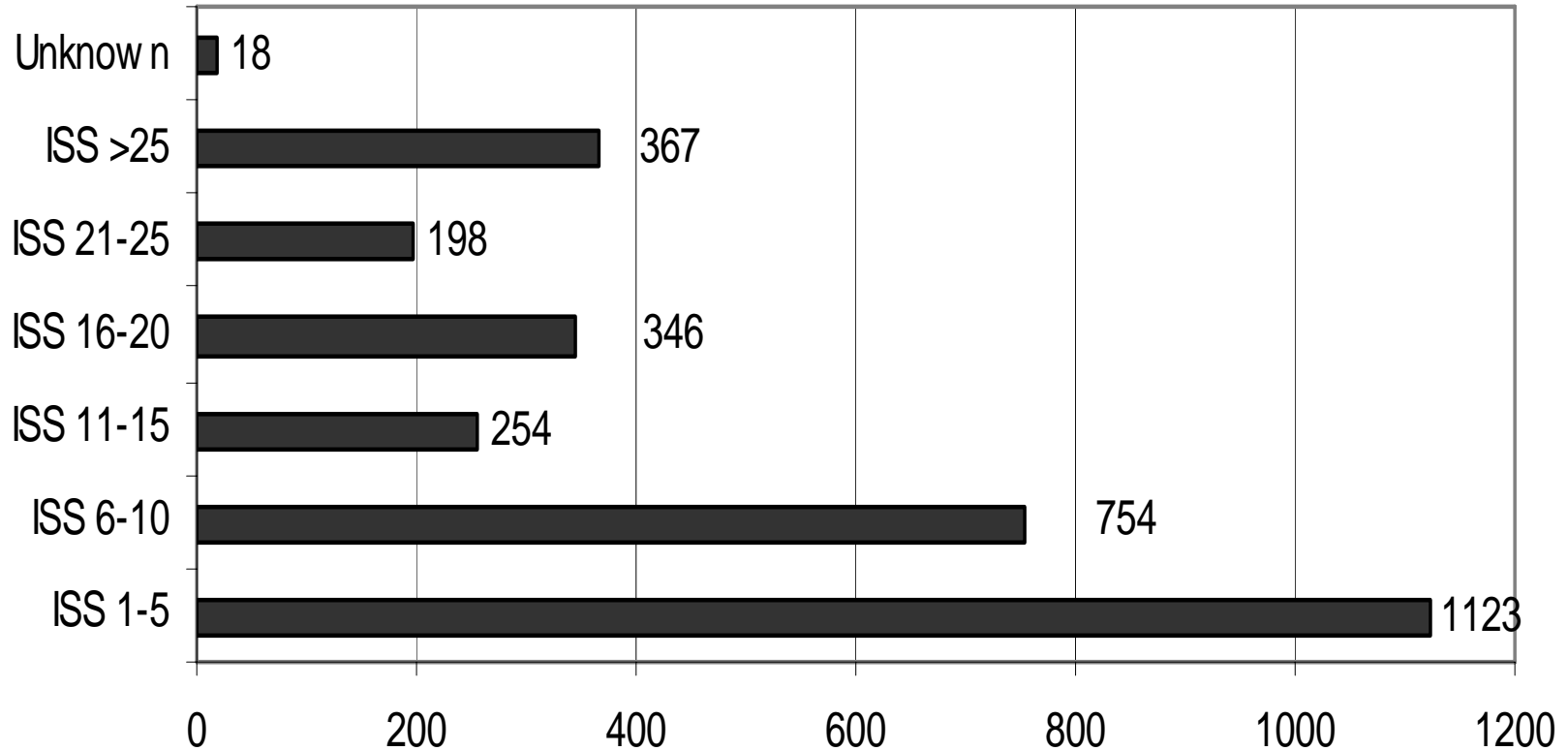


Injury Severity Score (ISS)

Overall Summary

UMC Trauma Registry 2005

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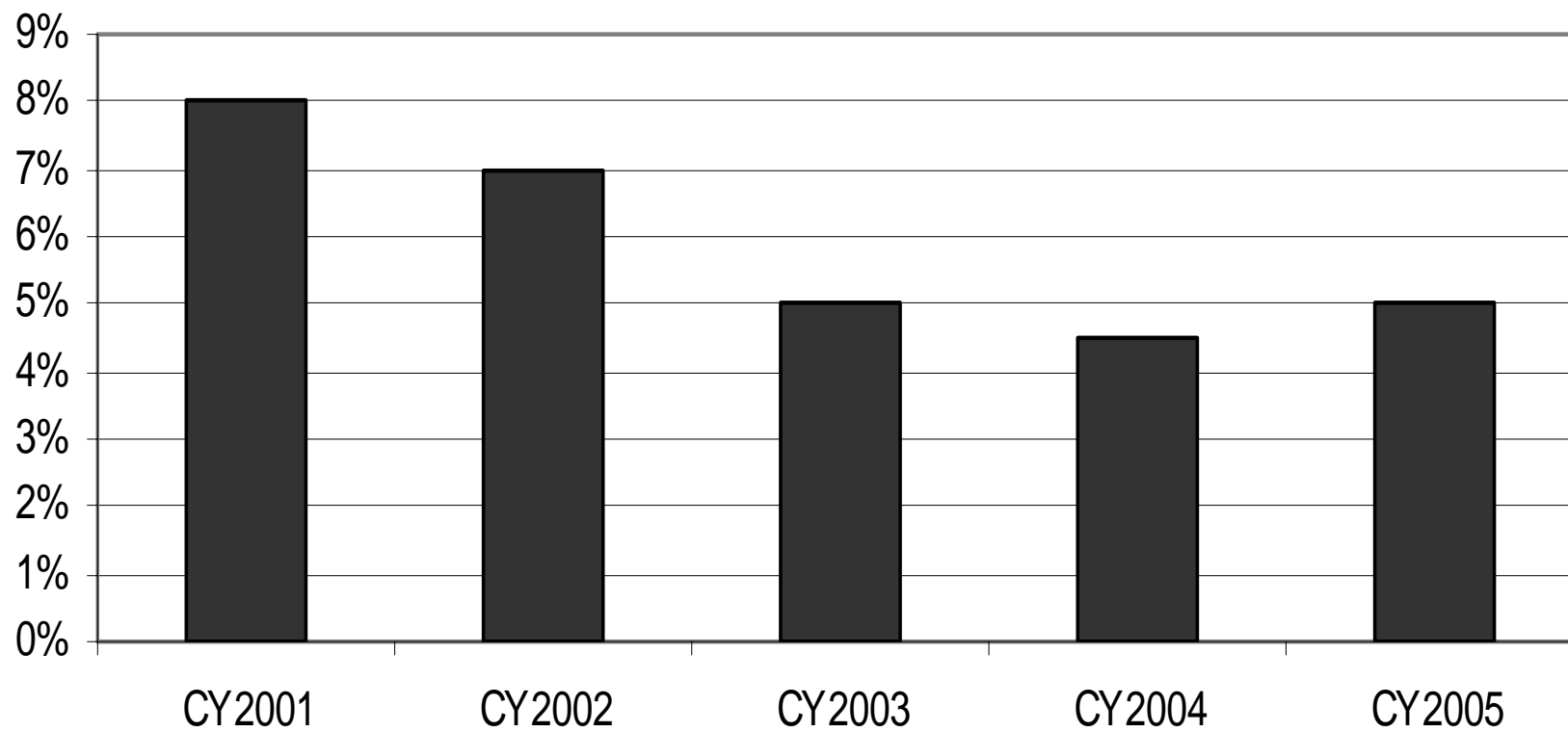


Mortality Percentage

2001-2005

UMC Trauma Registry 2005

n=3060

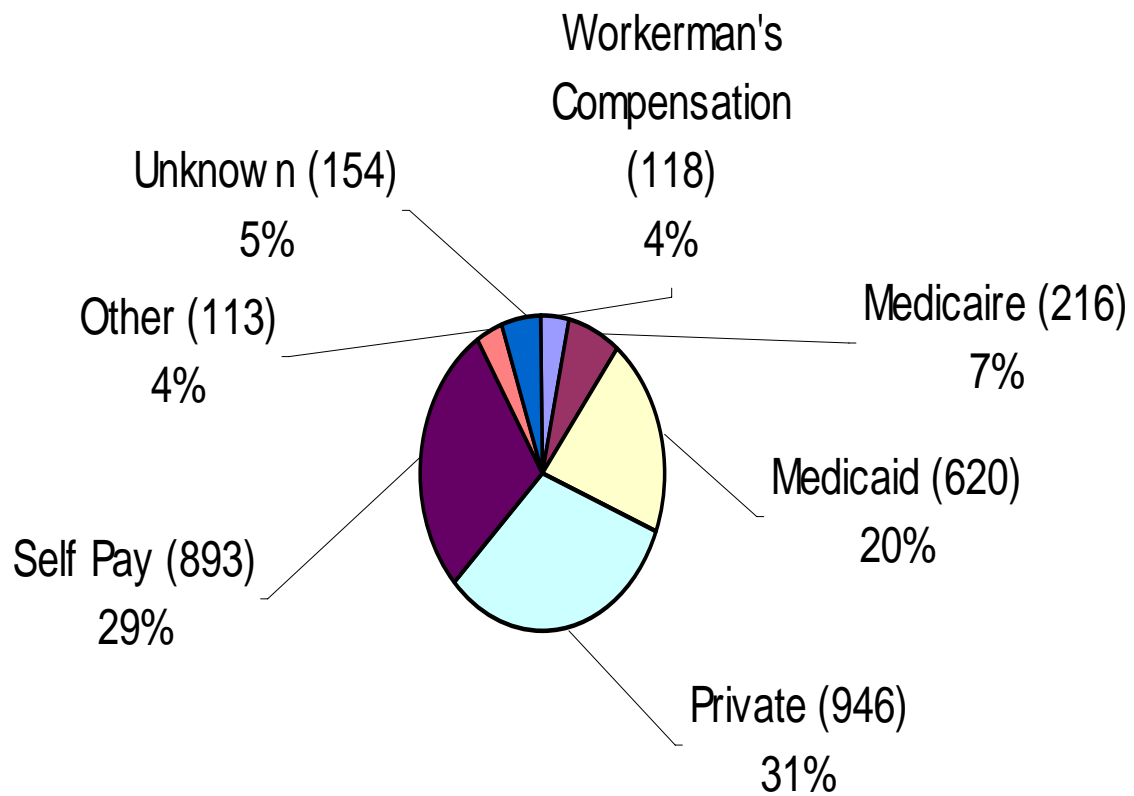


Payor Source

Overall Summary

UMC Trauma Registry 2005

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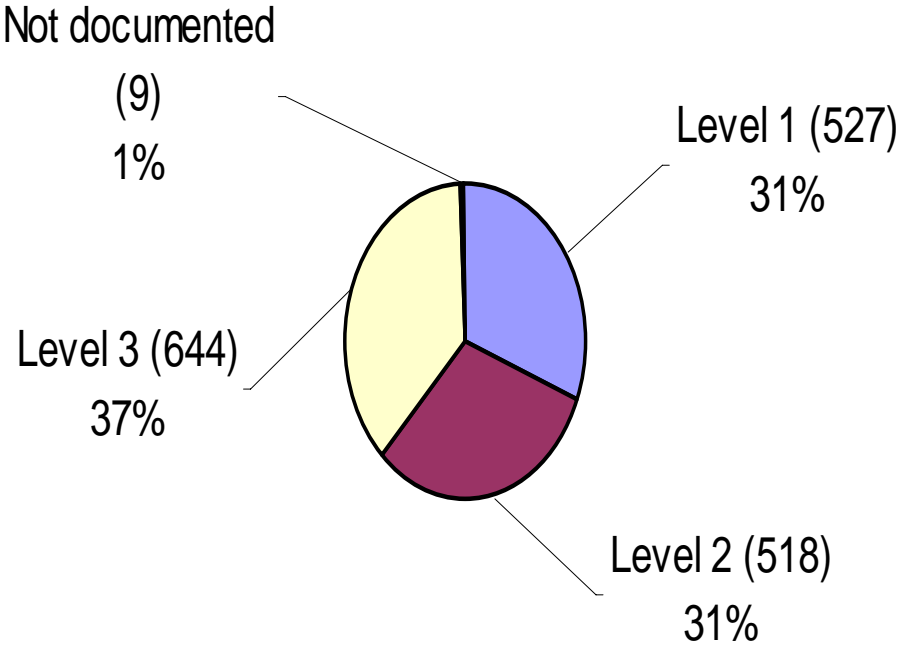


Level of Activation

Overall Summary

UMC Trauma Registry 2005

n=1827

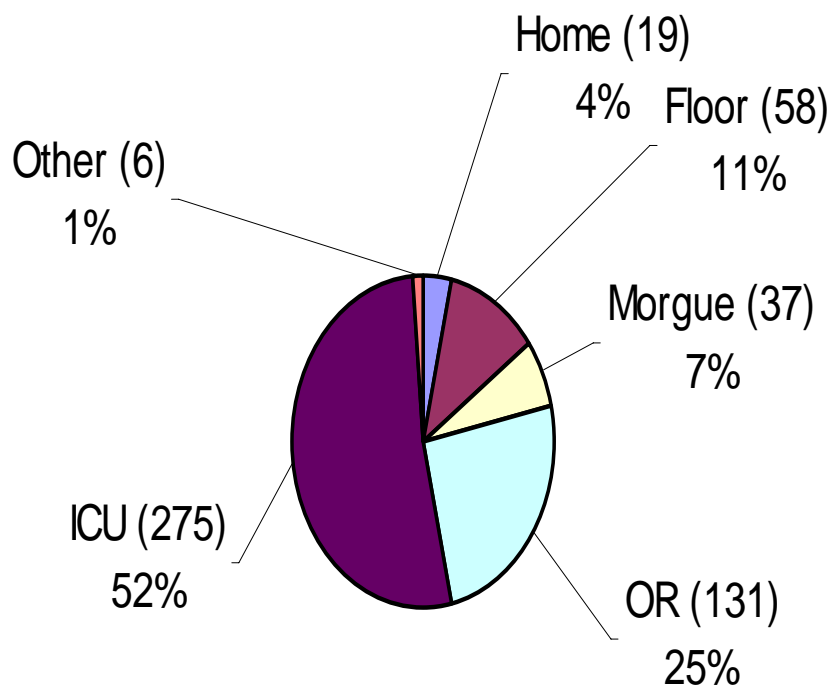


ED Disposition - Level 1 Activations

Overall Summary

UMC Trauma Registry 2005

n=526

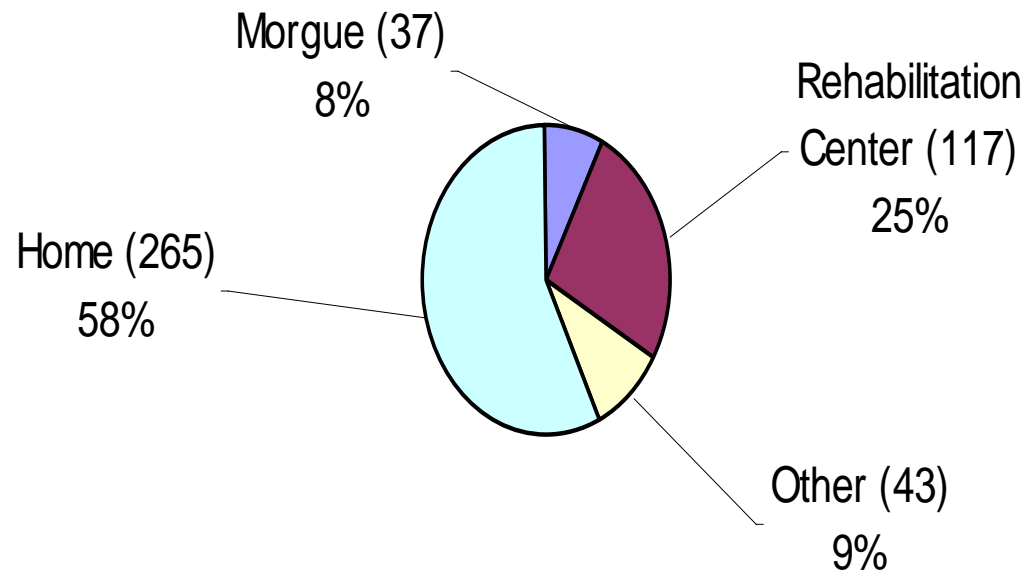


Hospital Disposition - Level 1 Activations

Overall Summary

UMC Trauma Registry 2005

n=527

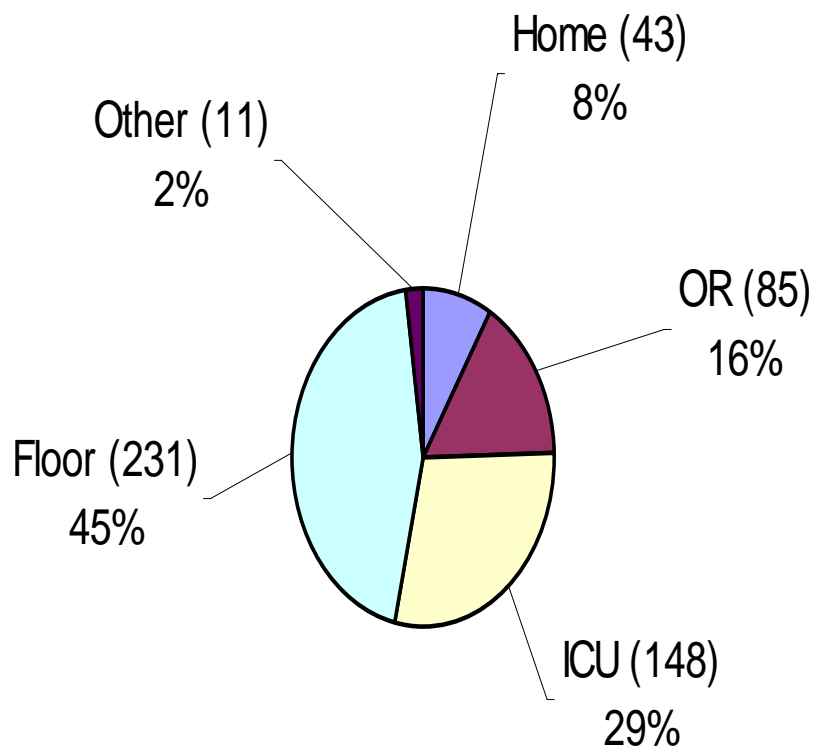


ED Disposition - Level 2 Activations

Overall Summary

UMC Trauma Registry 2005

n=518

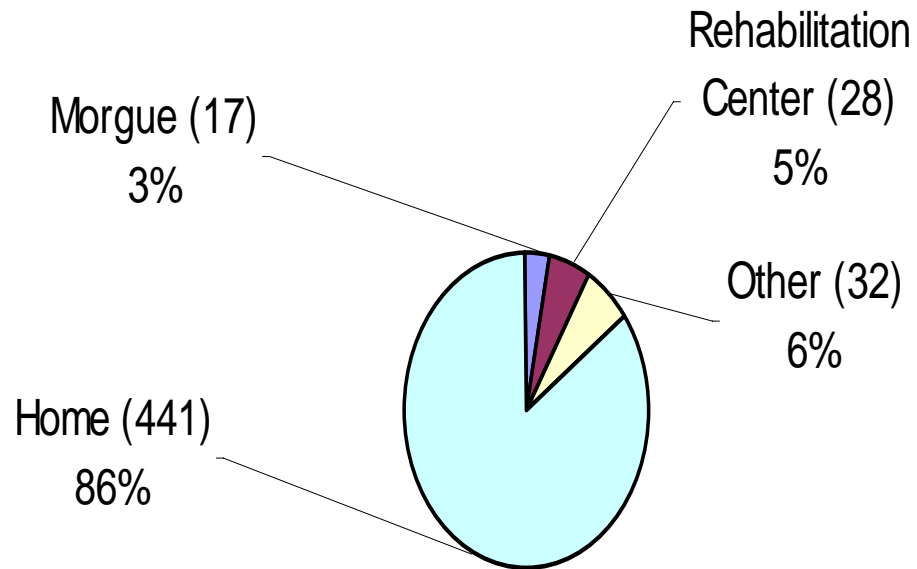


Hospital Disposition - Level 2 Activations

Overall Summary

UMC Trauma Registry 2005

n=518

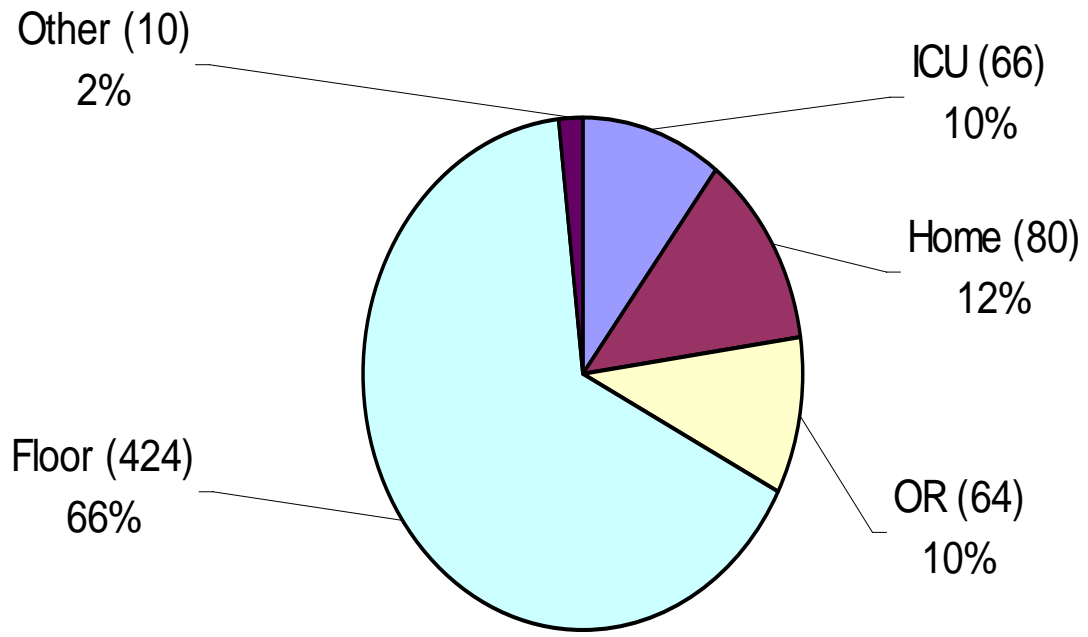


ED Disposition - Level 3 Activations

Overall Summary

UMC Trauma Registry 2005

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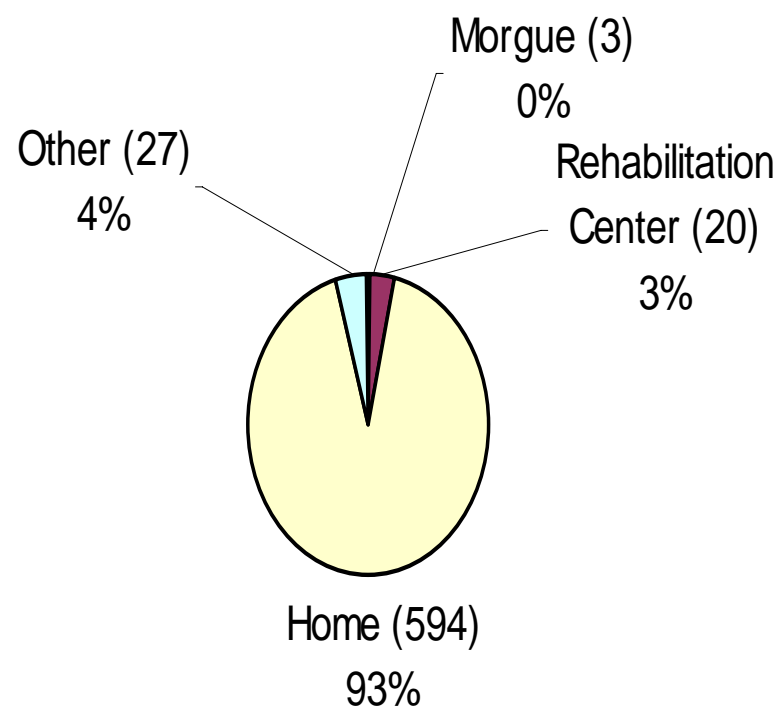


Hospital Disposition - Level 3 Activations

Overall Summary

UMC Trauma Registry 2005

n=644



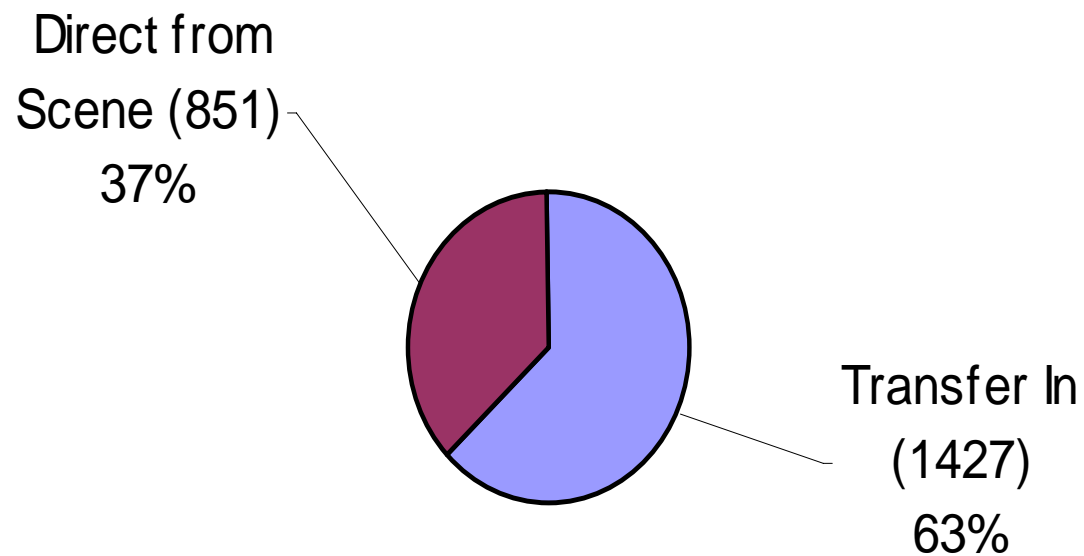
ADULT POPULATION

Transfer In vs Scene

Adult Population

UMC Trauma Registry 2005

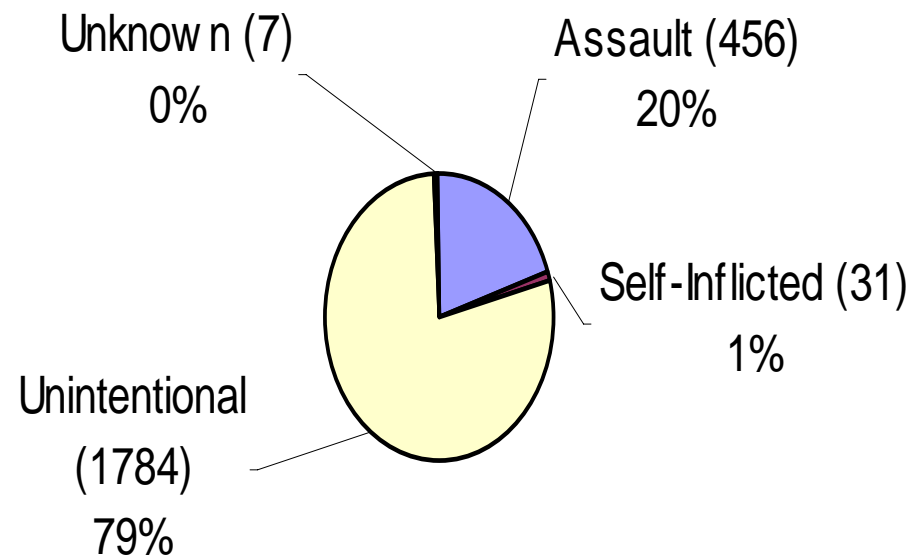
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Intent of Injury

Adult Population

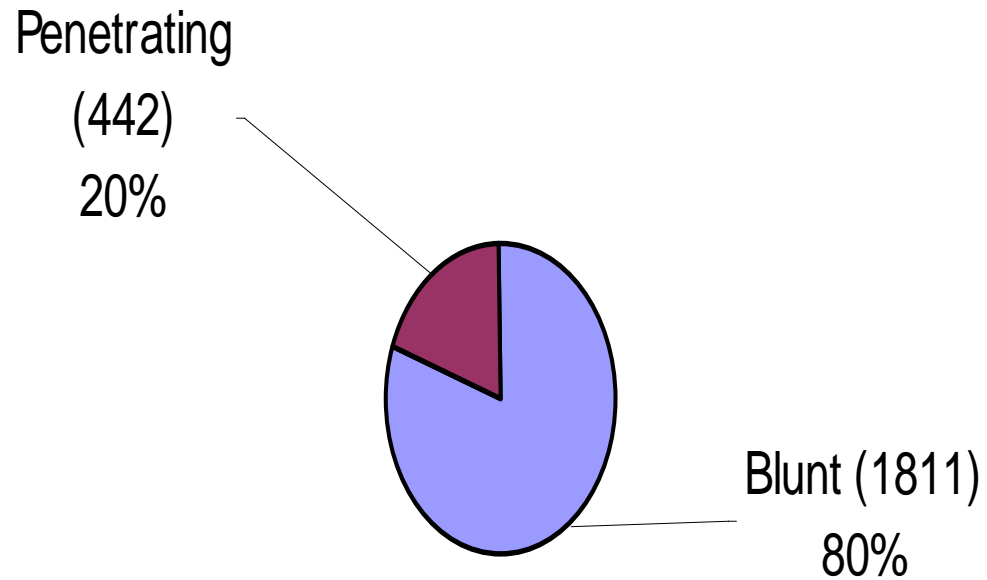
UMC Trauma Registry 2005
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Blunt vs Penetrating Adult Population

UMC Trauma Registry 2005

n=2278

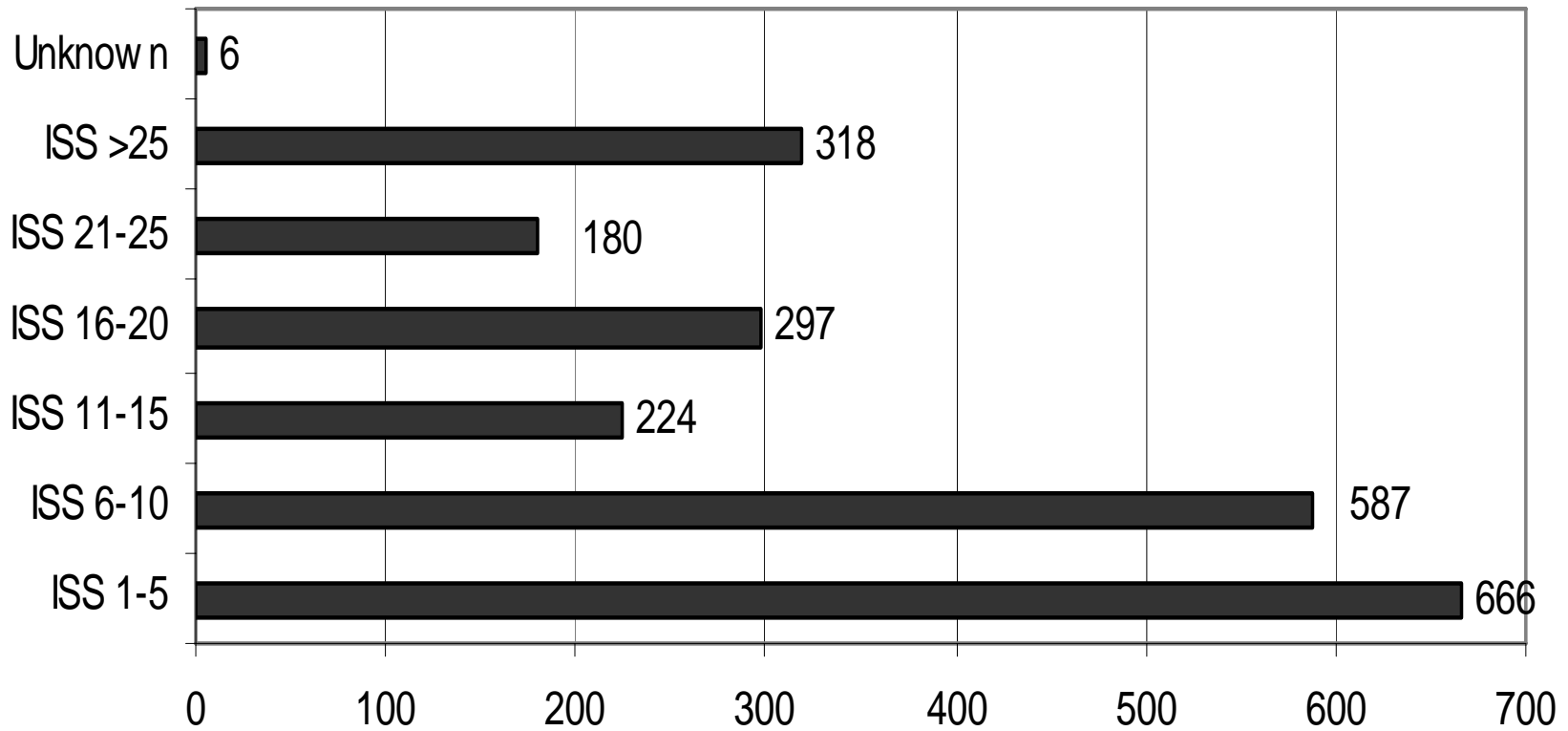


Injury Severity Score (ISS)

Adult Population

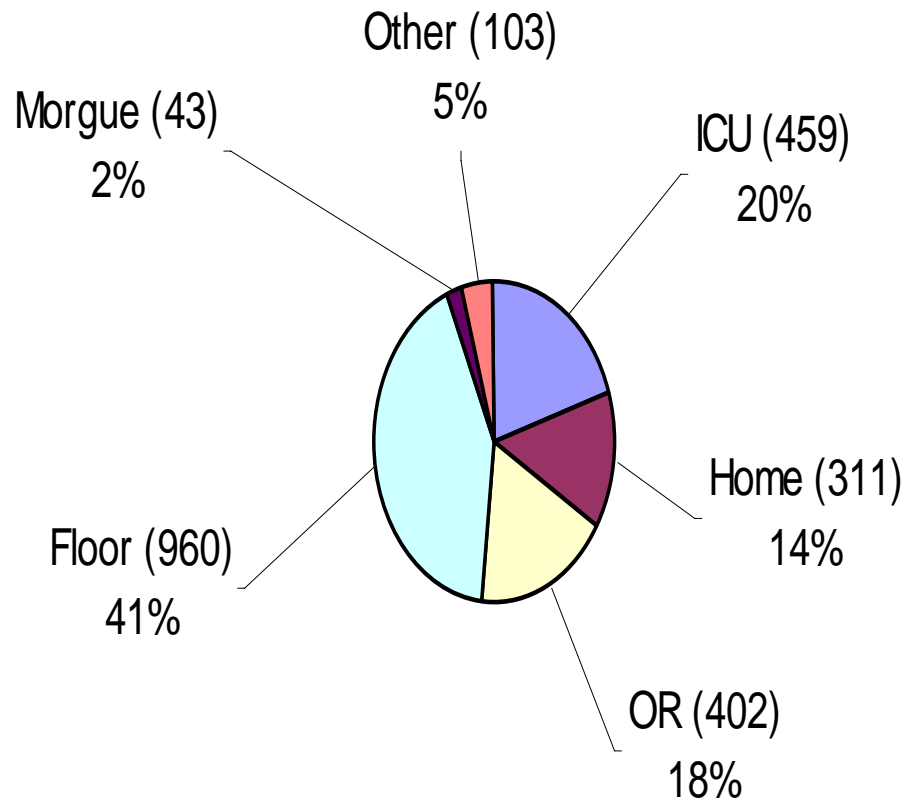
UMC Trauma Registry 2005

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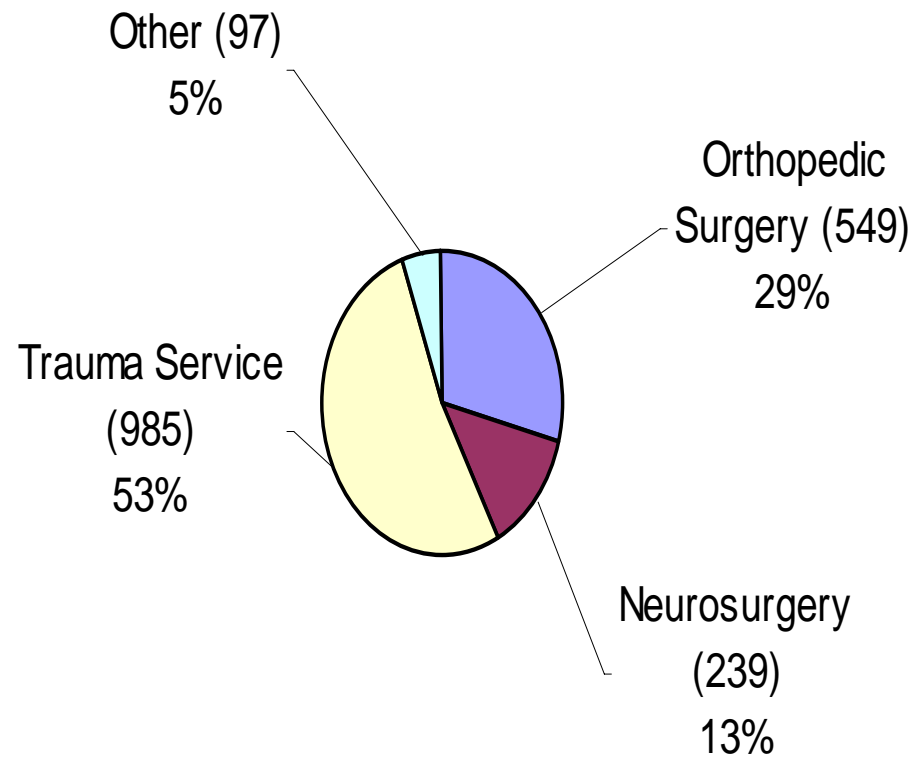
ED Disposition Adult Population

UMC Trauma Registry 2005
n=2278



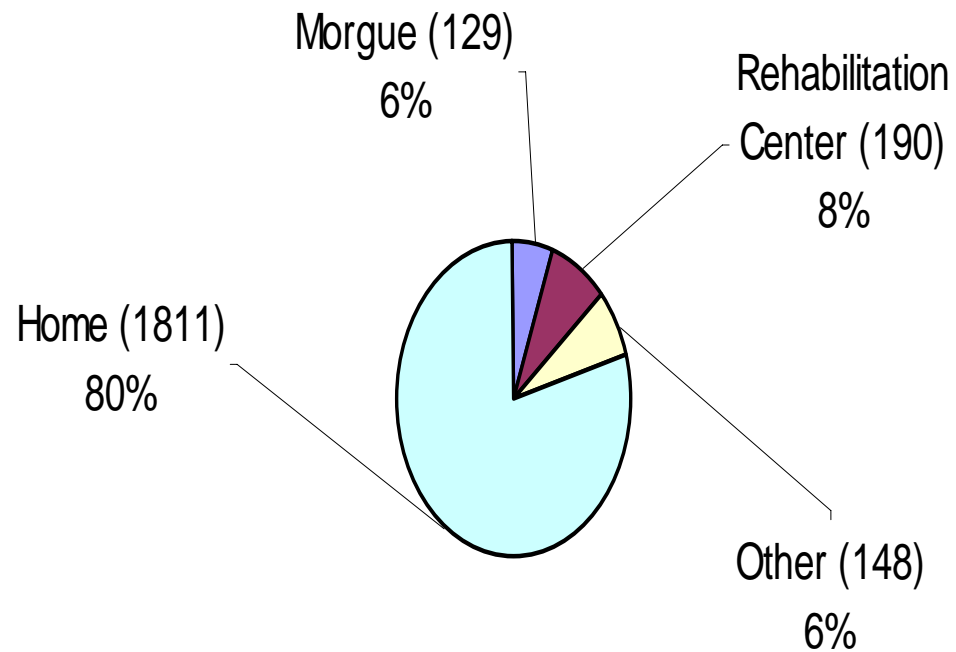
Admitting Service Adult Population

UMC Trauma Registry 2005
n=1870



Hospital Disposition Adult Population UMC Trauma Registry 2005

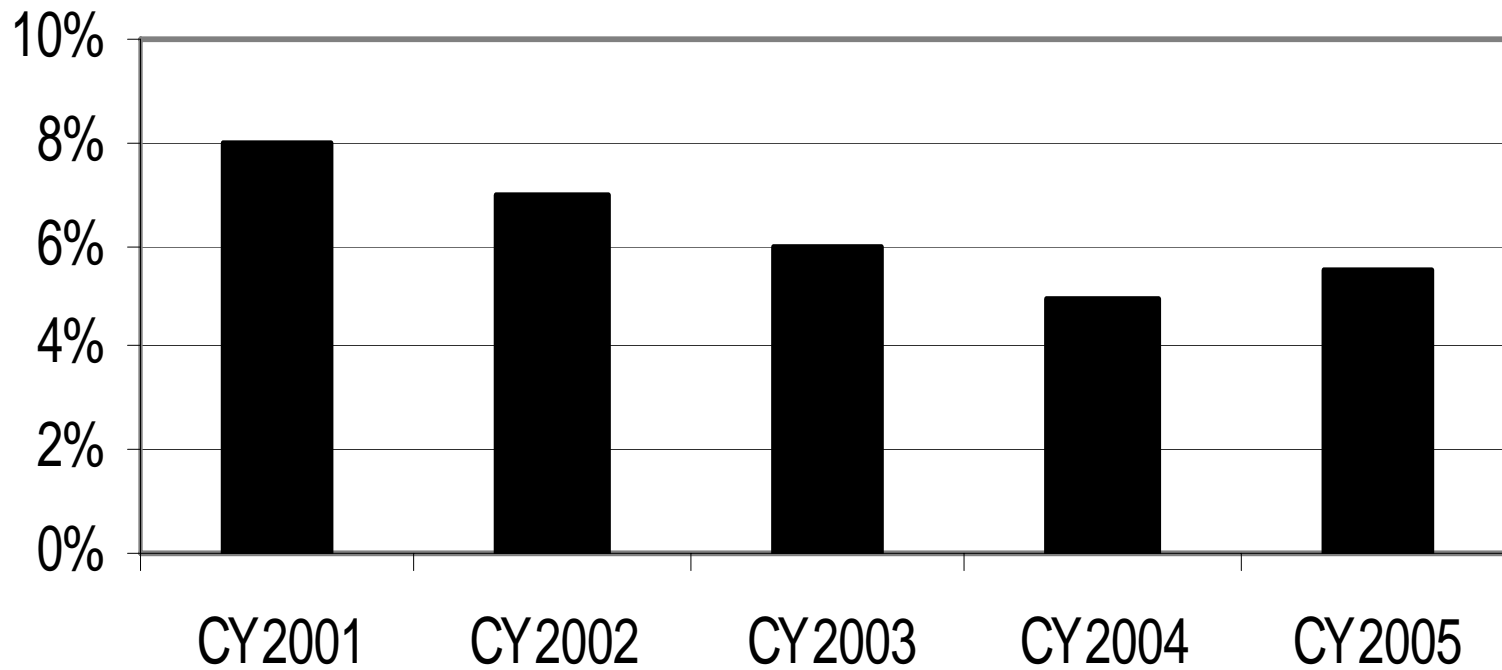
n=2278



Mortality Percentage - Adult

2001-2005

UMC Trauma Registry 2005

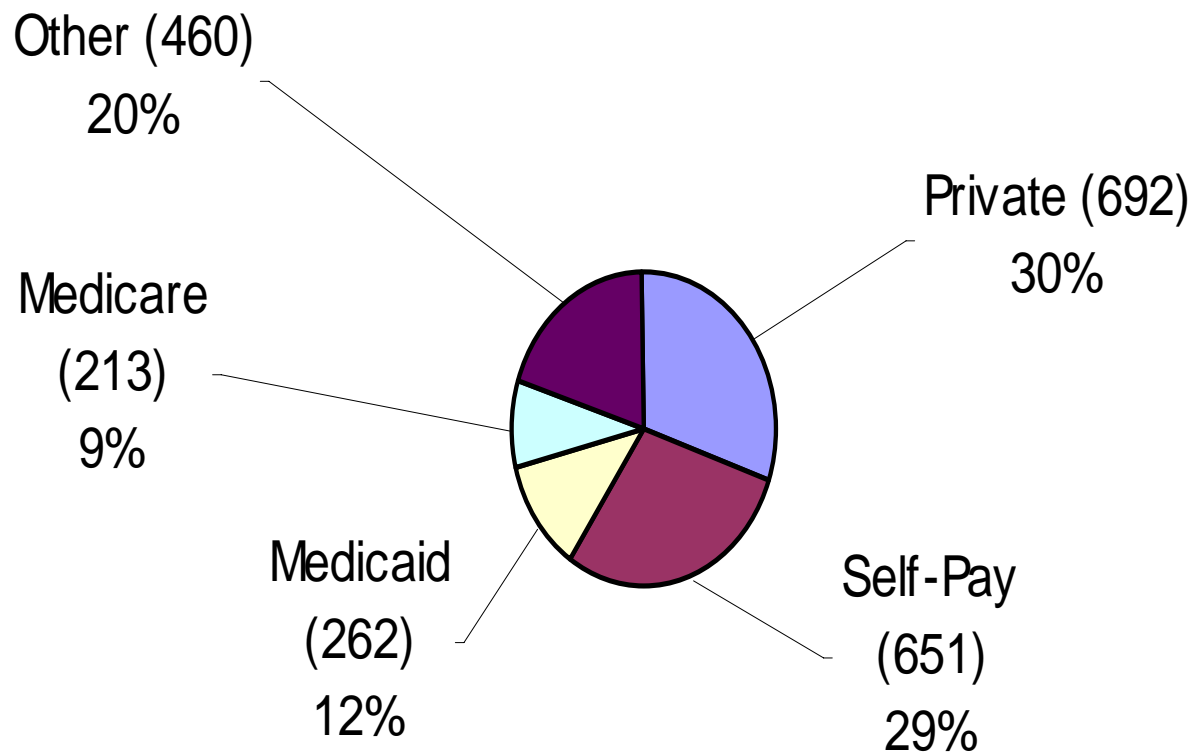


Payor Source

Adult Population

UMC Trauma Registry 2005

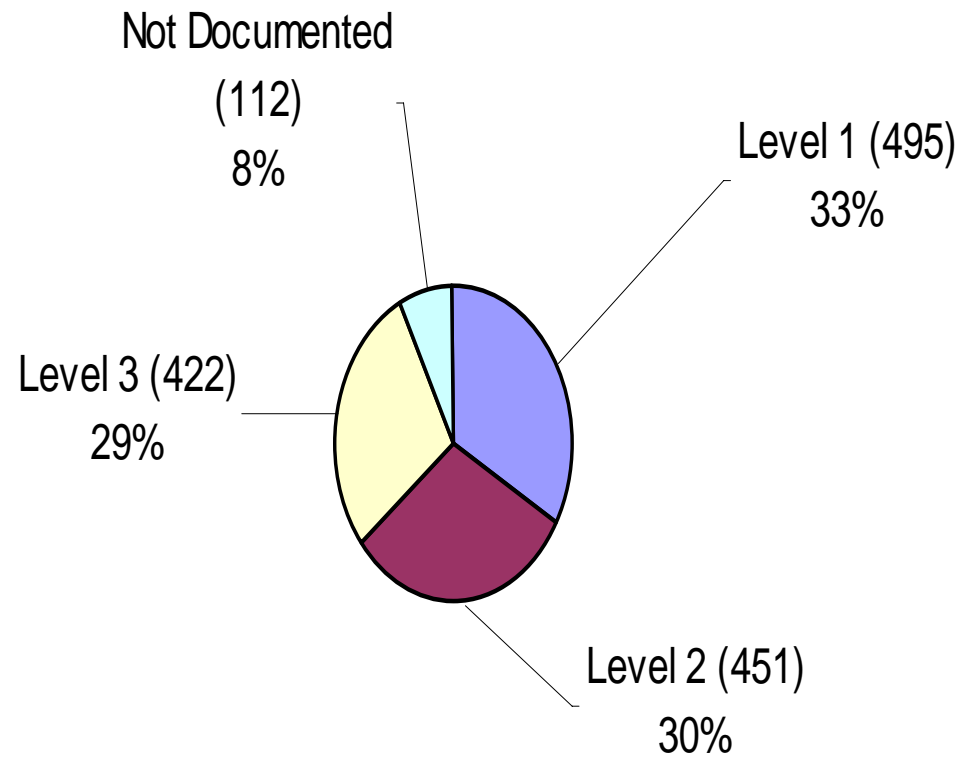
n=2278



Level of Activation Adult Population

UMC Trauma Registry 2005

n=1480

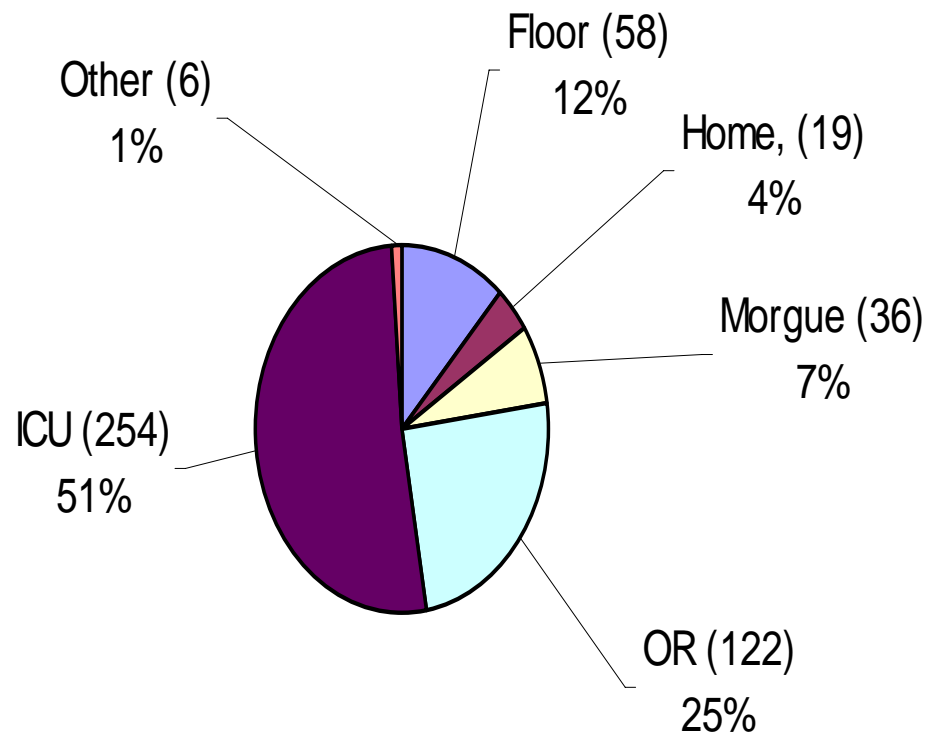


ED Disposition - Level 1 Activation

Adult Population

UMC Trauma Registry 2005

n=495

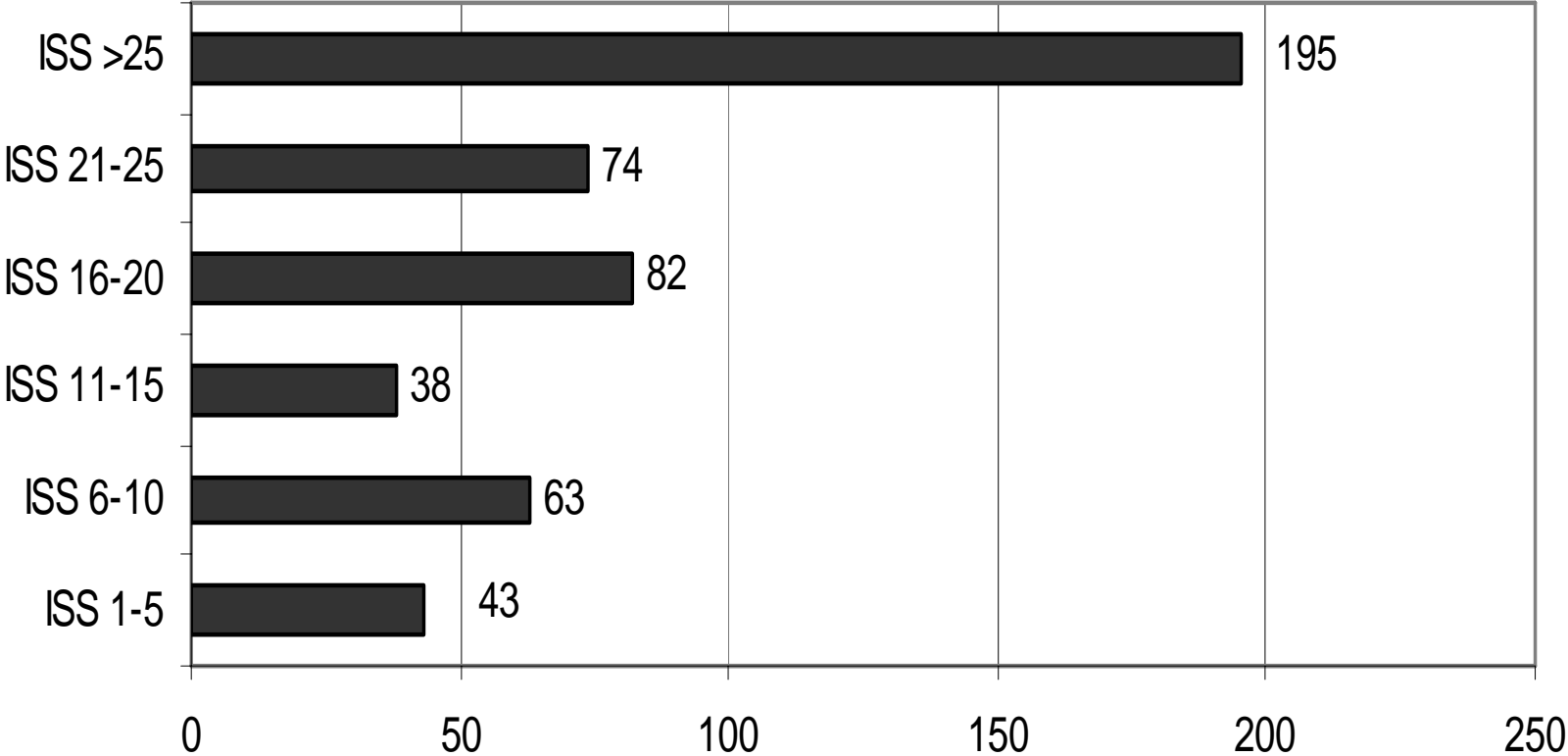


ISS - Level 1 Activations

Adult Population

UMC Trauma Registry 2005

n=495

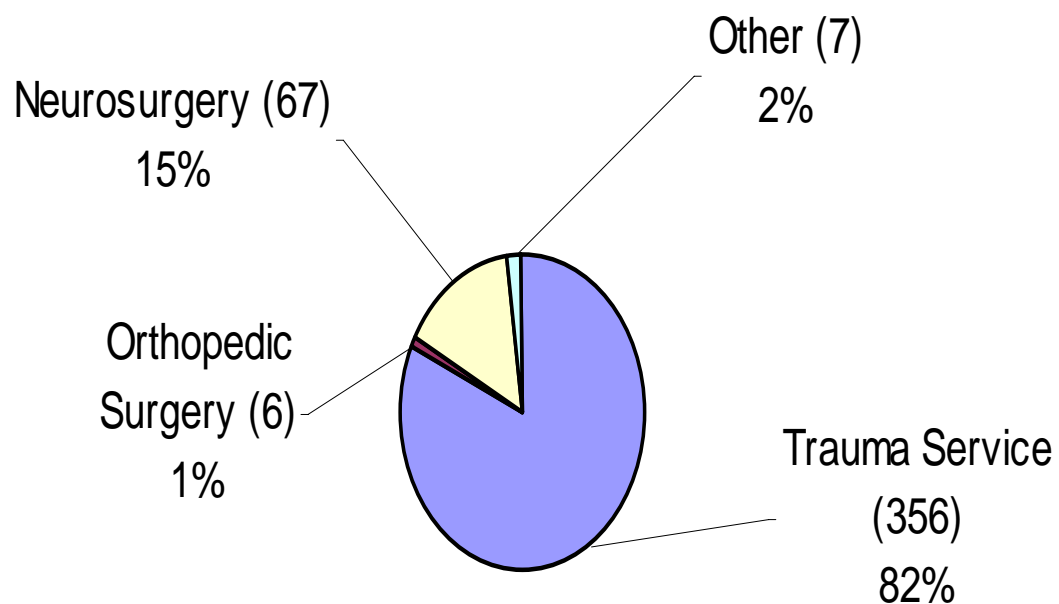


Admitting Services - Level 1 Activation

Adult Population

UMC Trauma Registry 2005

n=436

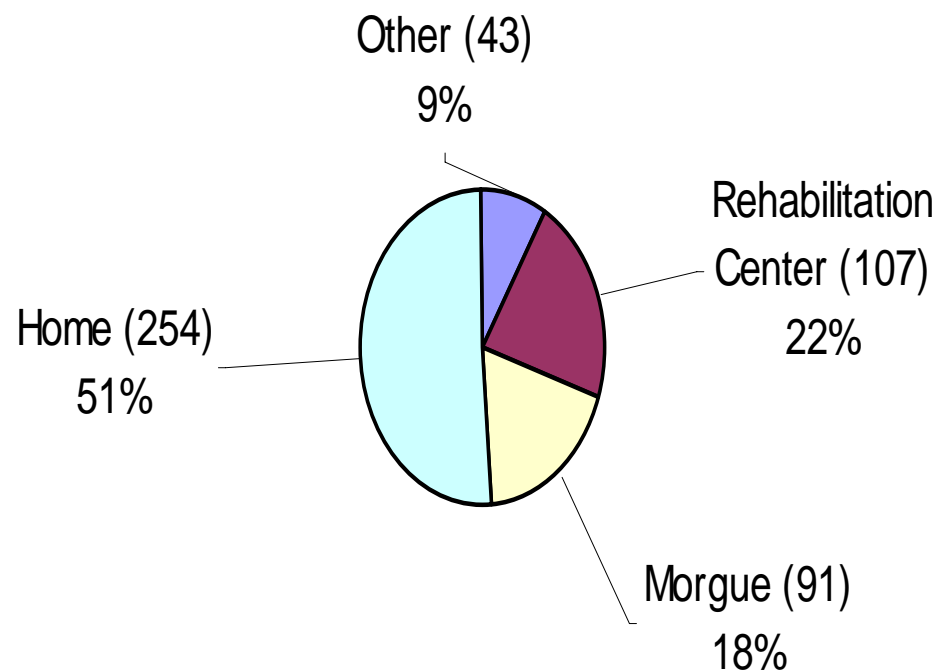


Hospital Disposition - Level 1 Activation

Adult Population

UMC Trauma Registry 2005

n=495

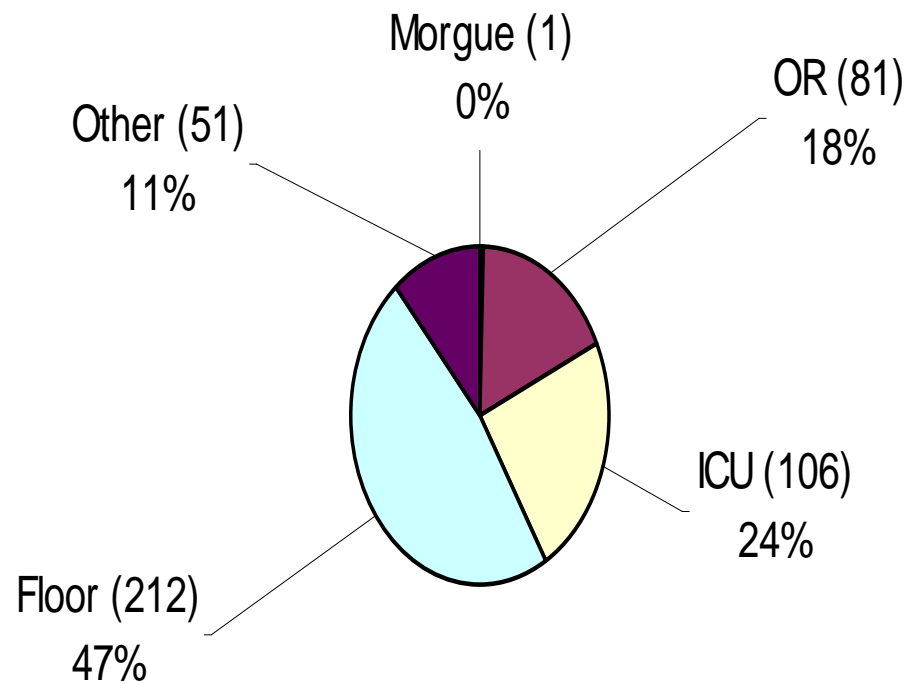


ED Disposition - Level 2 Activation

Adult Population

UMC Trauma Registry 2005

n=451

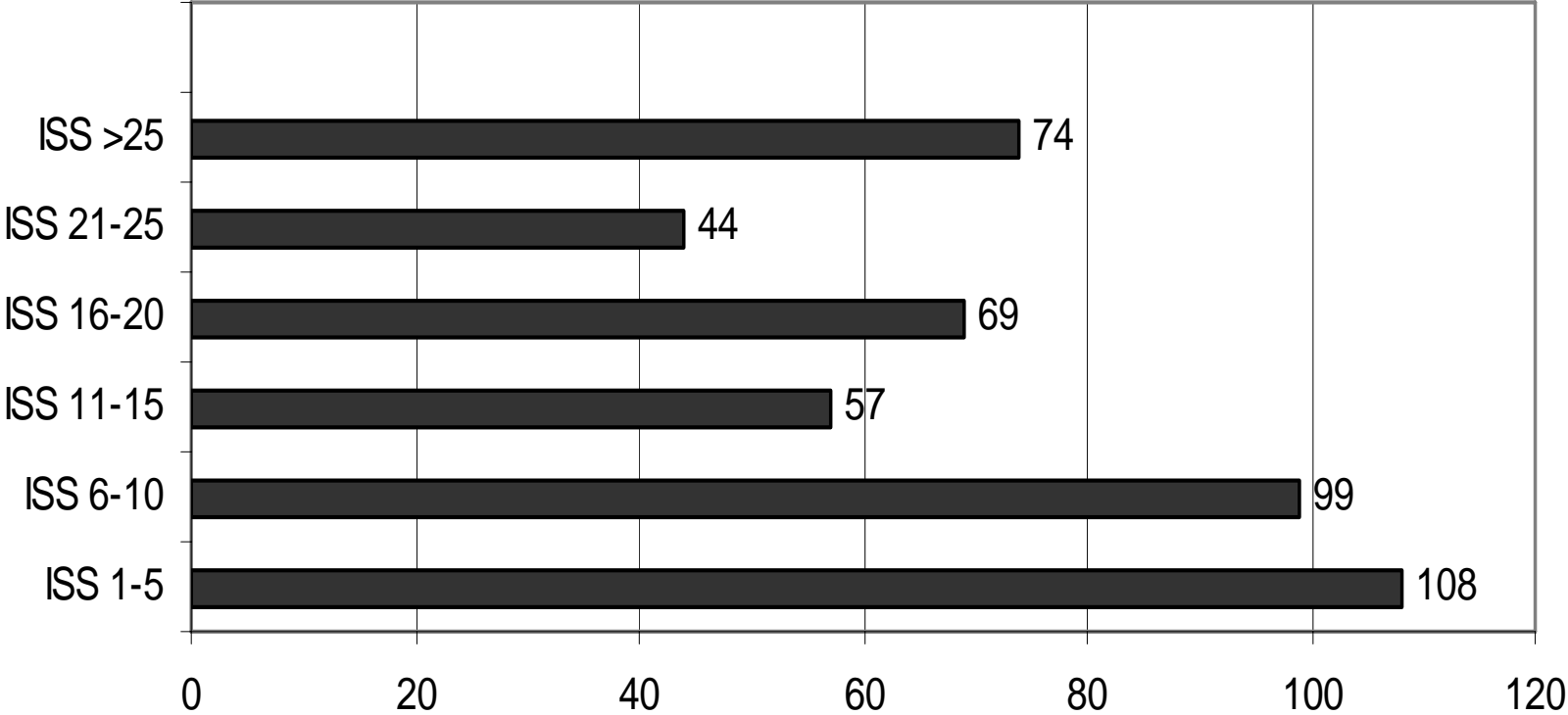


ISS - Level 2 Activations

Adult Population

UMC Trauma Registry 2005

n=451

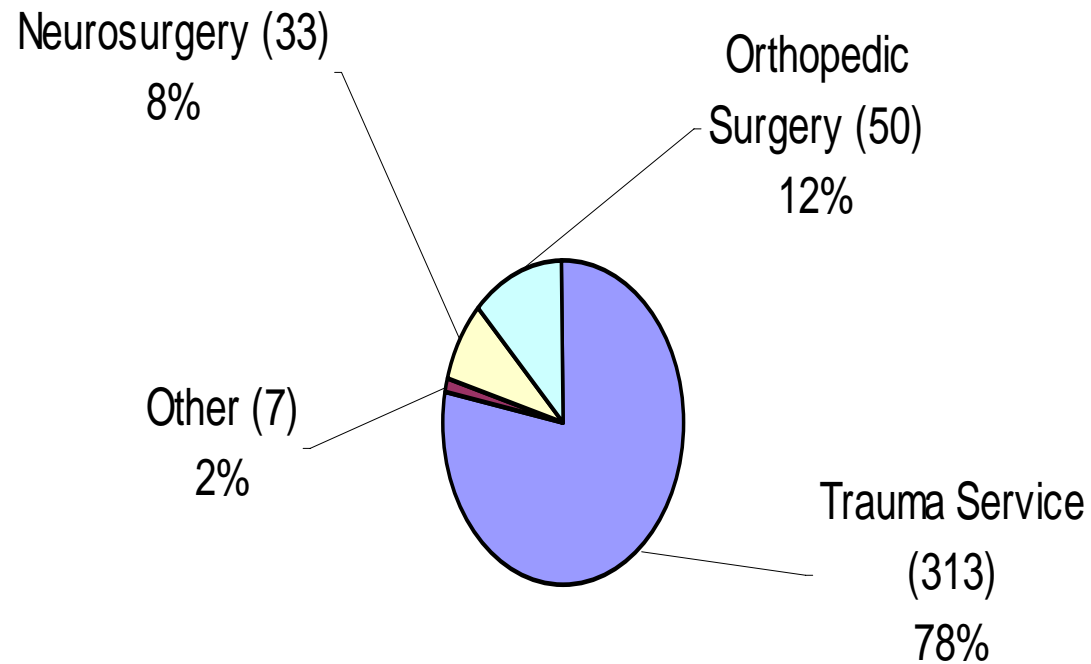


Admitting Services - Level 2 Activation

Adult Population

UMC Trauma Registry 2005

n=403

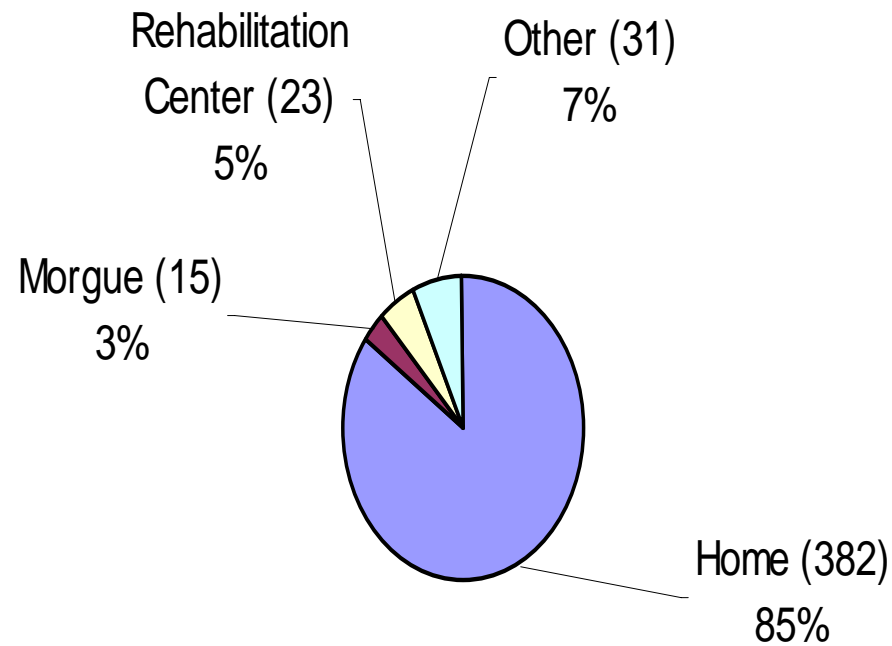


Hospital Disposition - Level 2 Activation

Adult Population

UMC Trauma Registry 2005

n=451

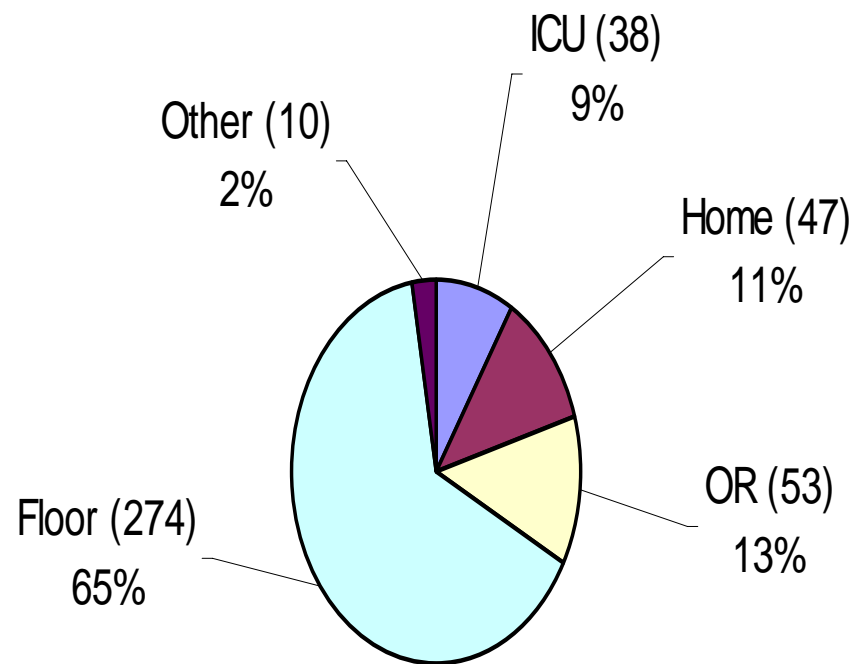


ED Disposition - Level 3 Activation

Adult Population

UMC Trauma Registry 2005

n=422

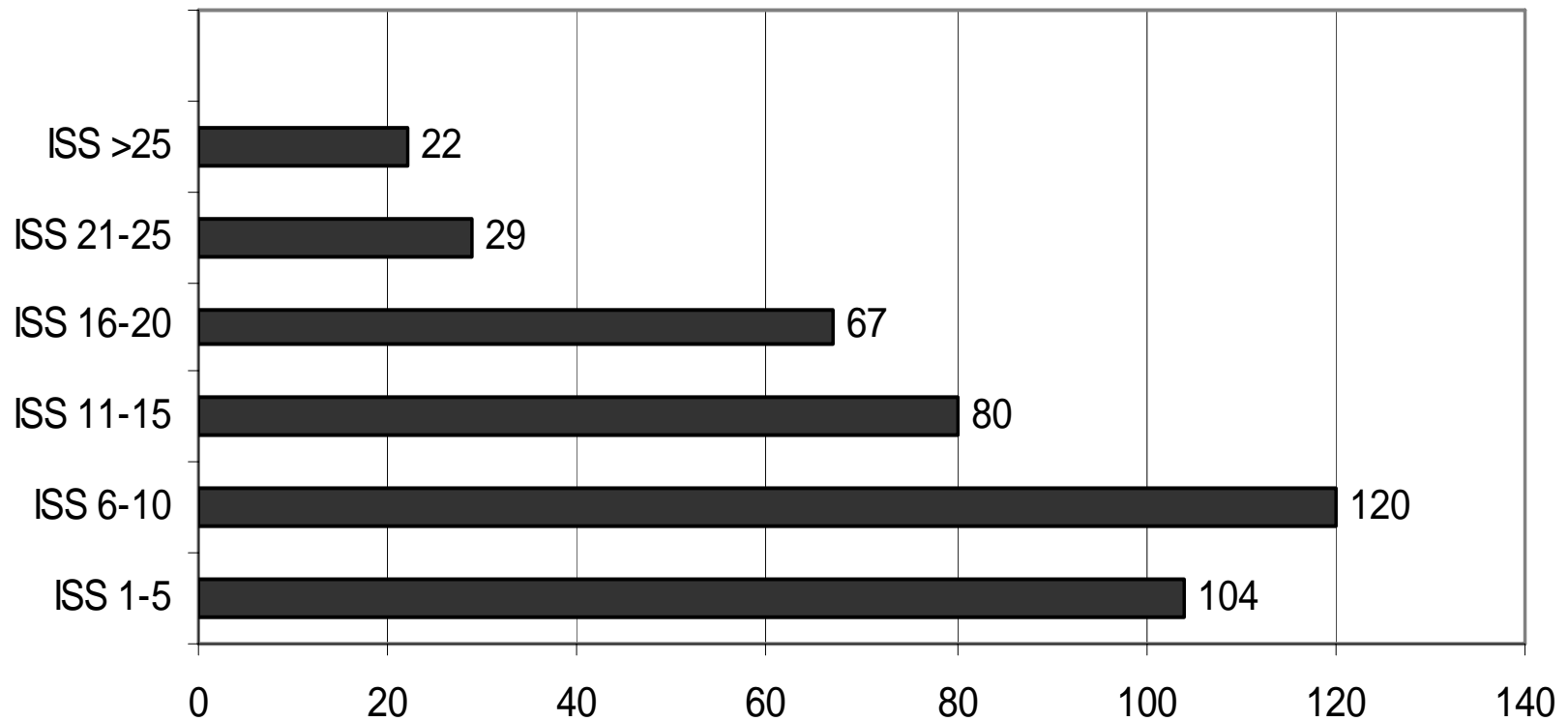


ISS - Level 3 Activations

Adult Population

UMC Trauma Registry 2005

n=422

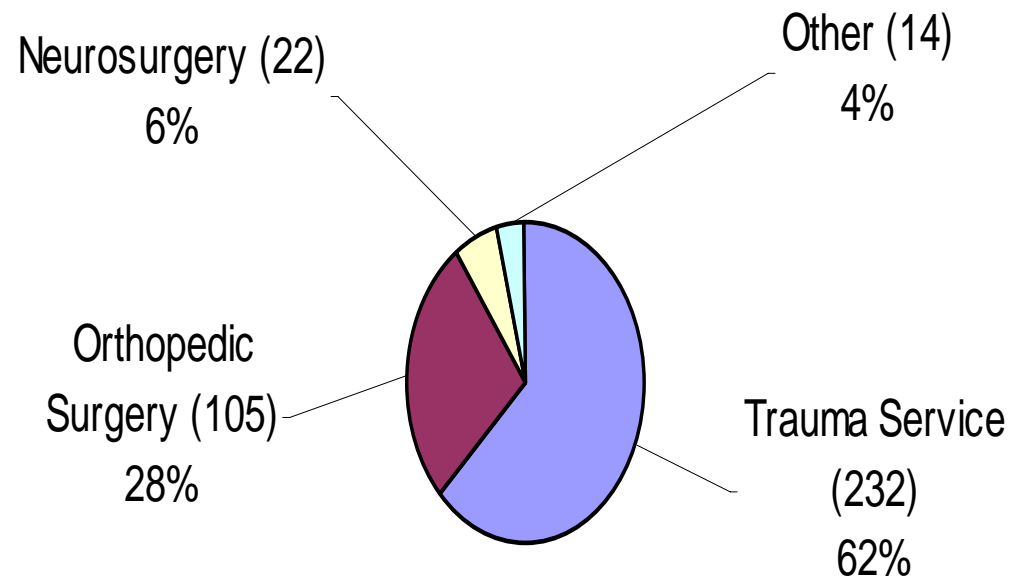


Admitting Service - Level 3 Activation

Adult Population

UMC Trauma Registry 2005

n=373

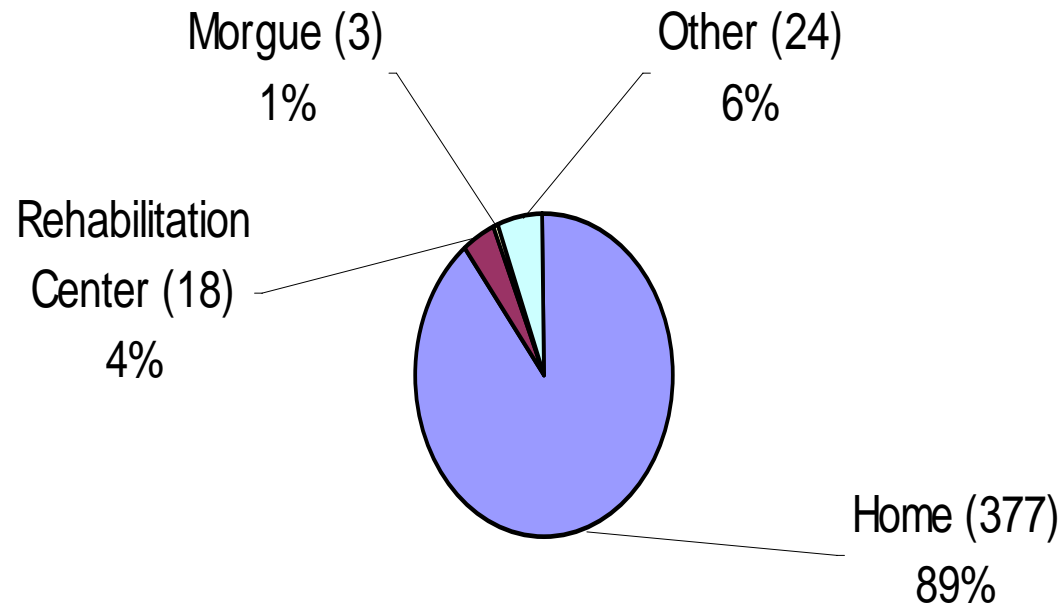


Hospital Disposition - Level 3 Activation

Adult Population

UMC Trauma Registry 2005

n=422

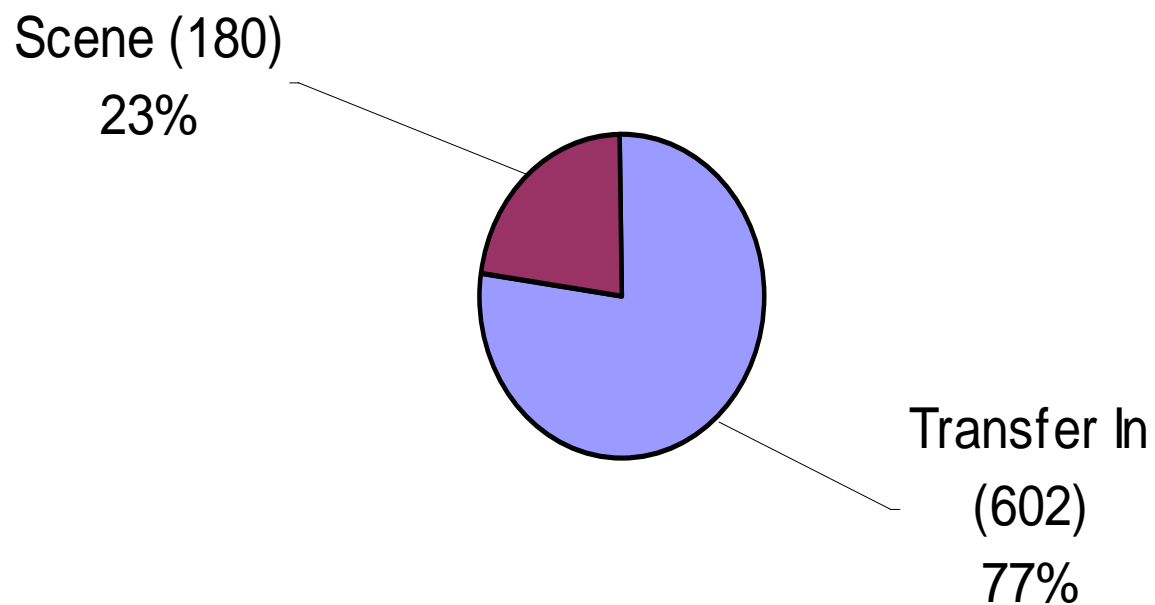


PEDIATRIC POPULATION

Transfer In vs Scene Pediatric Population

UMC Trauma Registry 2005

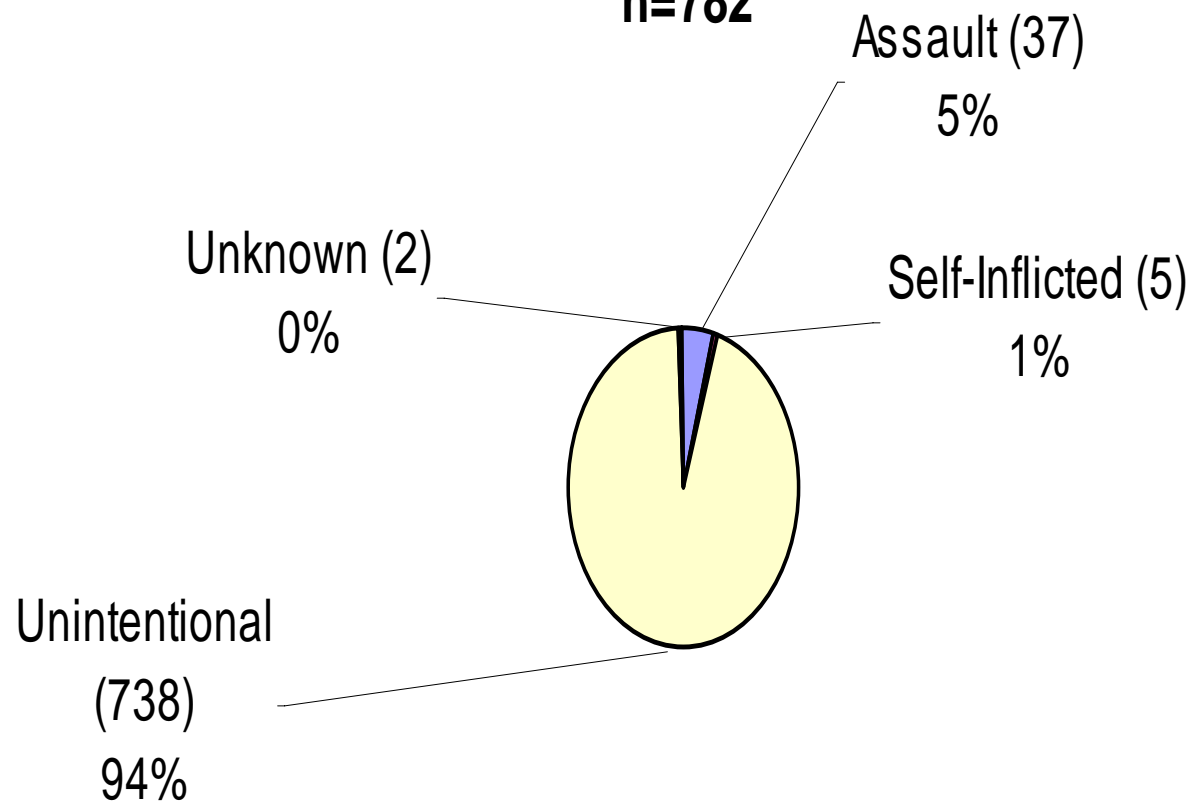
n=782



Intent of Injury Pediatric Population

UMC Trauma Registry 2005

n=782



Blunt vs Penetrating Pediatric Population

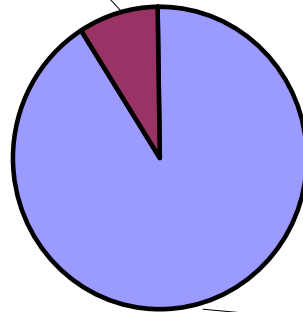
UMC Trauma Registry 2005

n=782

Penetrating

(66)

9%



Blunt (682)

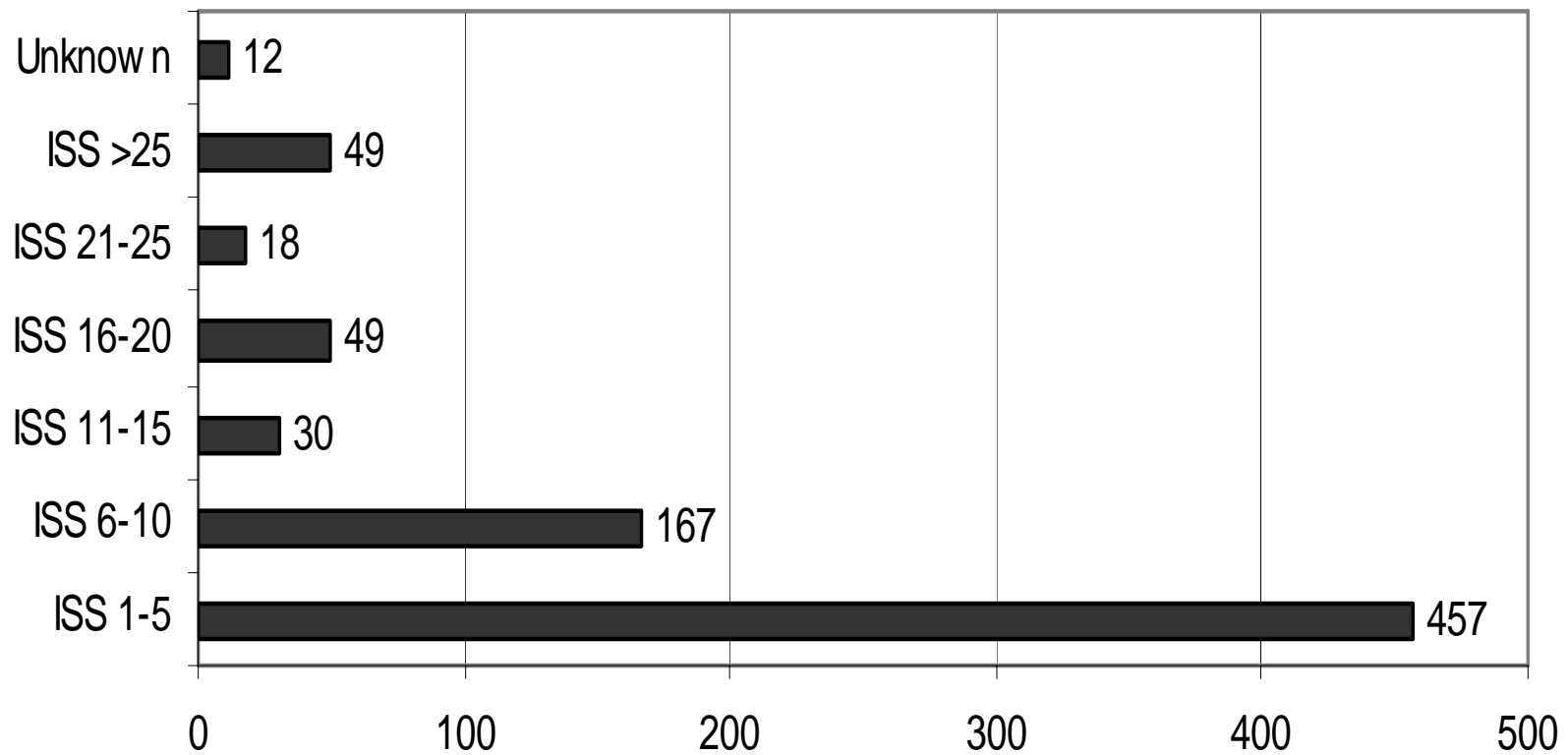
91%

Injury Severity Score (ISS)

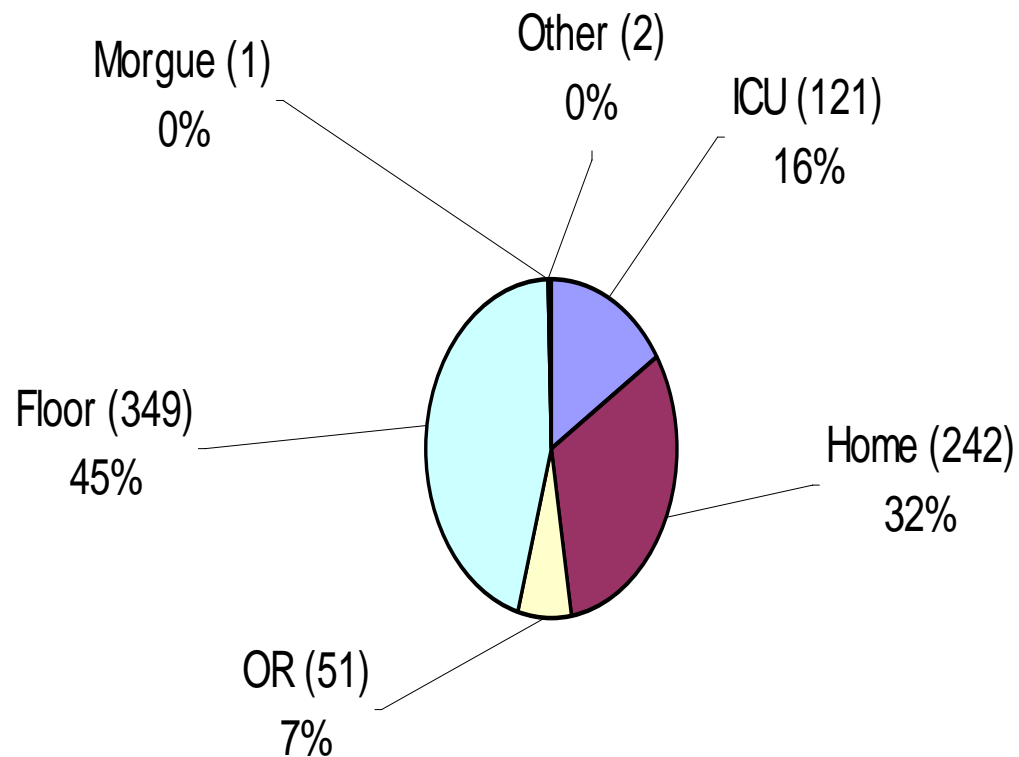
Pediatric Population

UMC Trauma Registry 2005

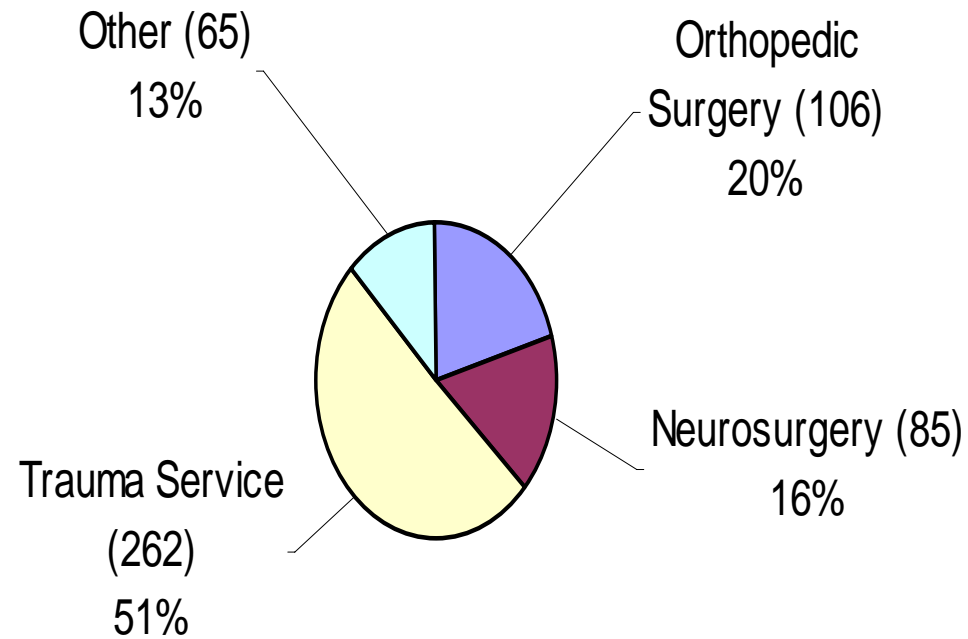
n=782



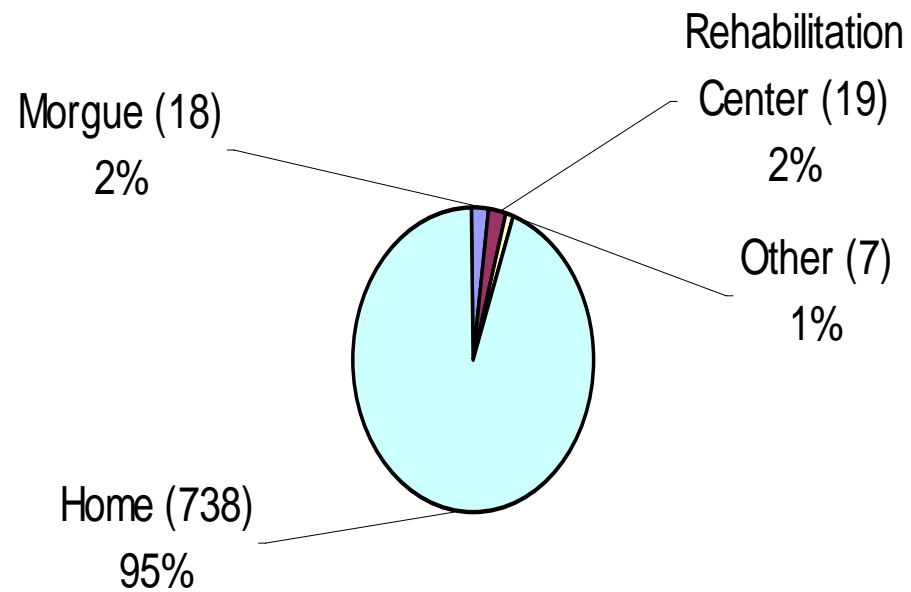
ED Disposition Pediatric Population UMC Trauma Registry 2005 n=766



**Admitting Service
Pediatric Population
UMC Trauma Registry 2005
n=518**

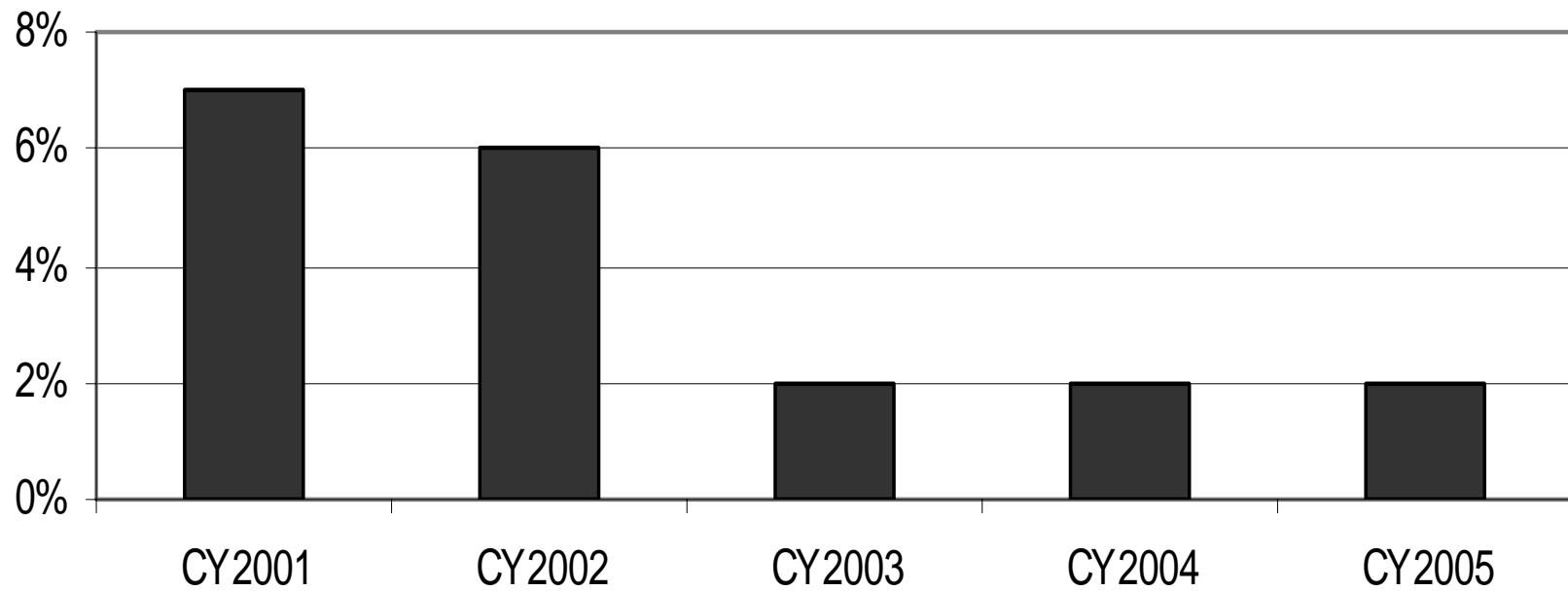


Hospital Disposition Pediatric Population UMC Trauma Registry 2005 n=782

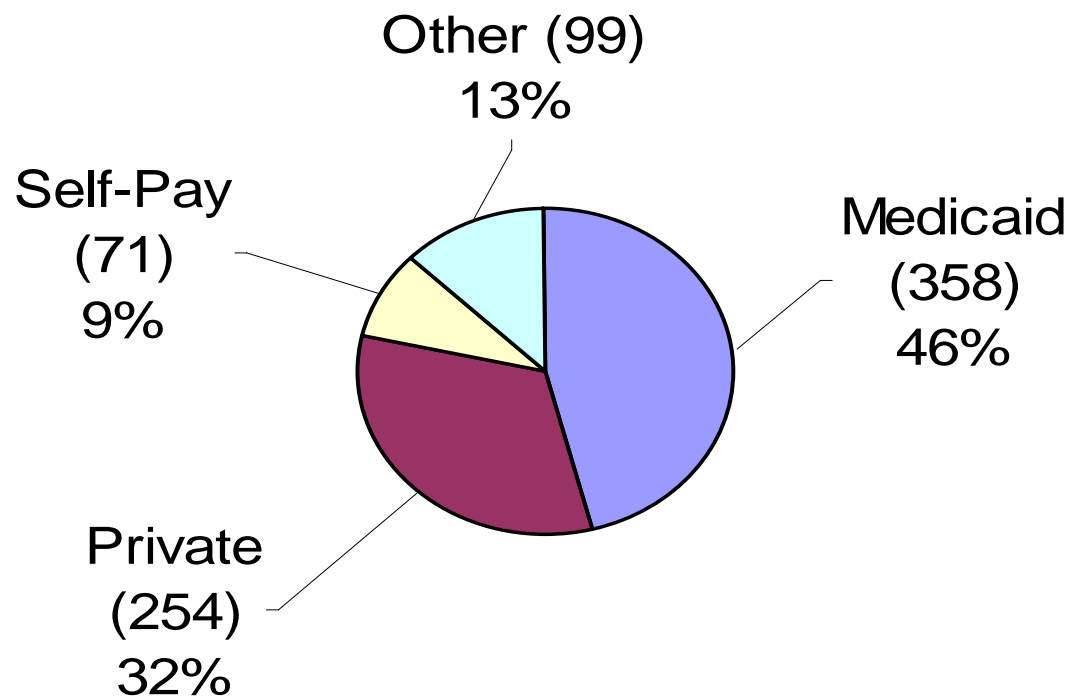


Mortality Percentage Pediatric Population 2001-2005

UMC Trauma Registry 2005



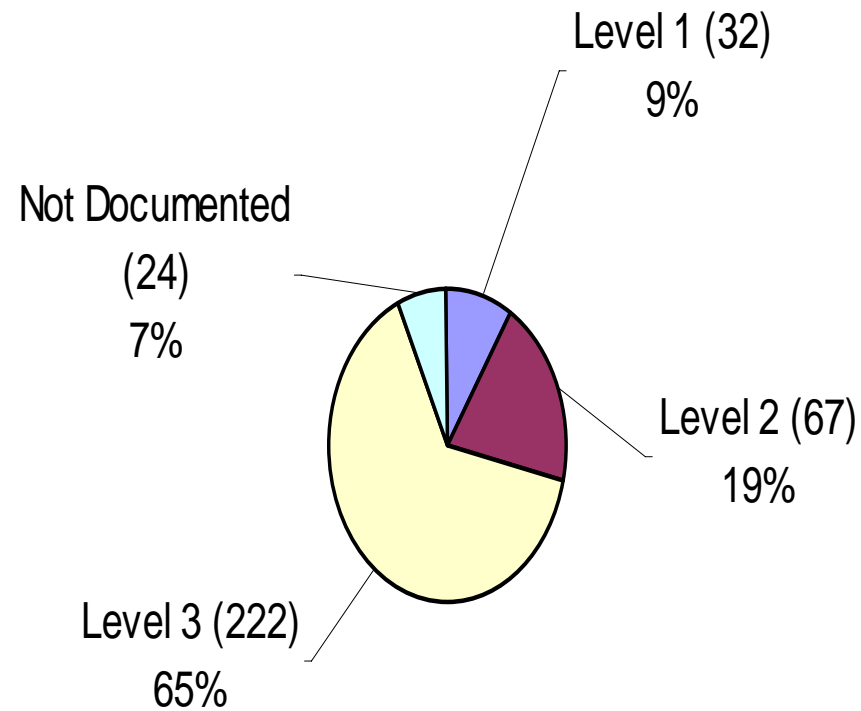
**Payor Source
Pediatric Population
UMC Trauma Registry 2005
n=782**



Level of Activation Pediatric Population

UMC Trauma Registry 2005

n=345

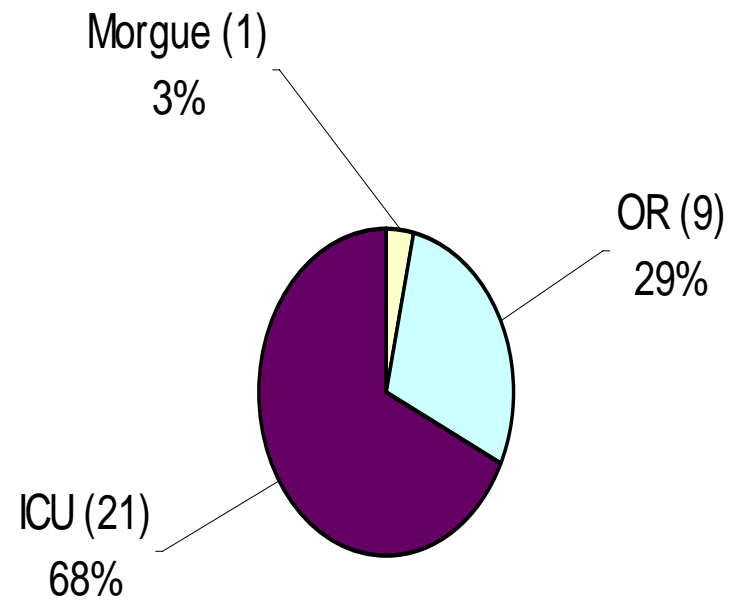


ED Disposition - Level 1 Activations

Pediatric Population

UMC Trauma Registry 2005

n=31

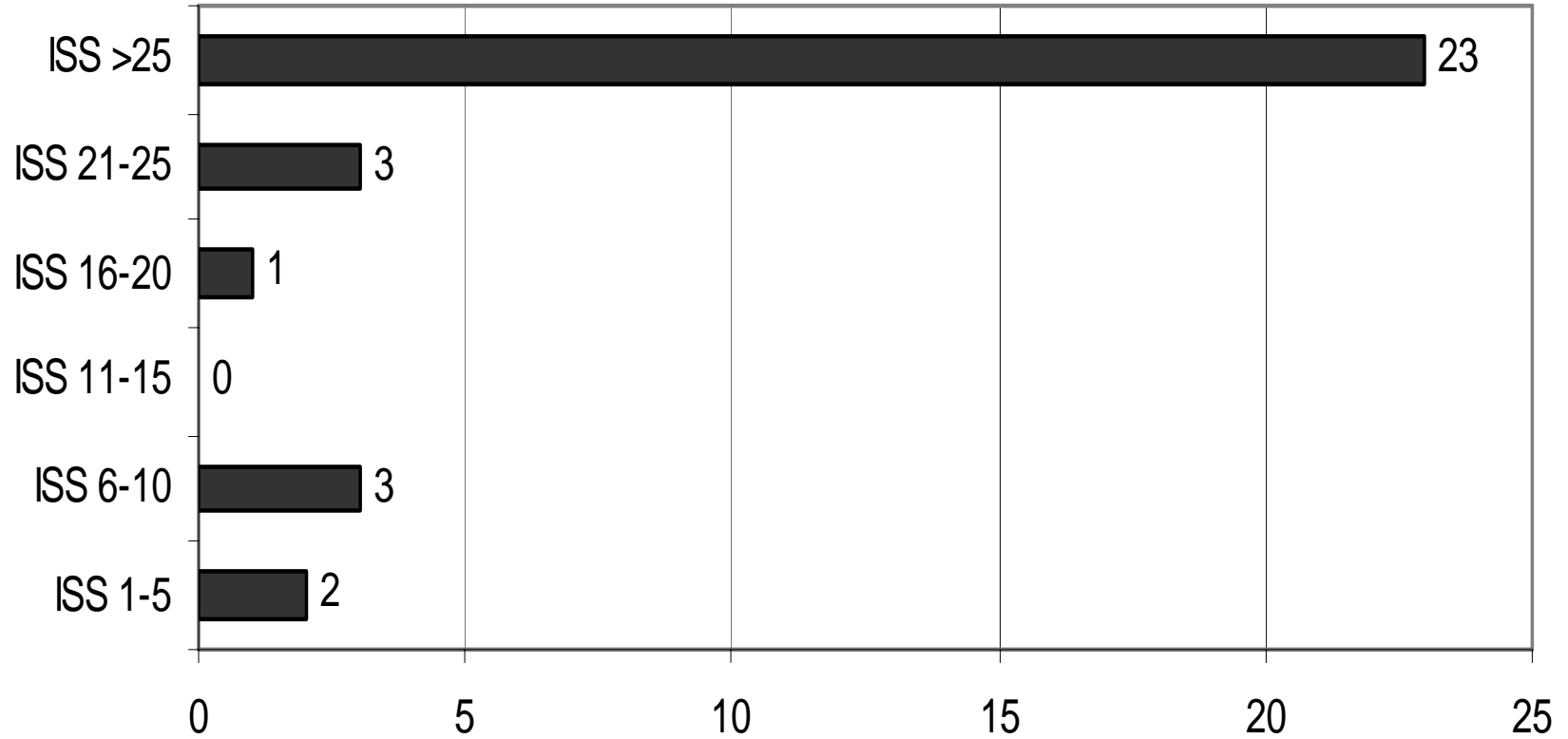


ISS - Level 1 Activations

Pediatric Population

UMC Trauma Registry 2005

n=32

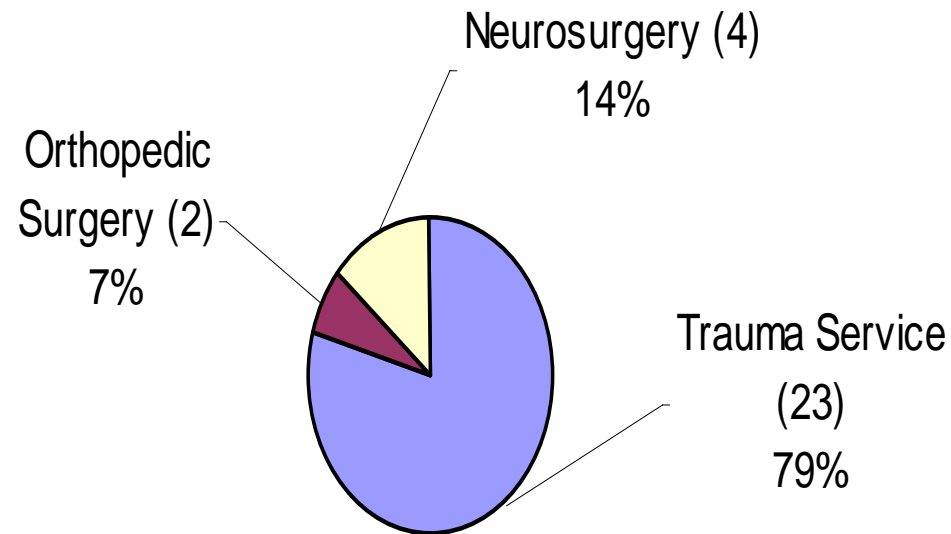


Admitting Service - Level 1 Activation

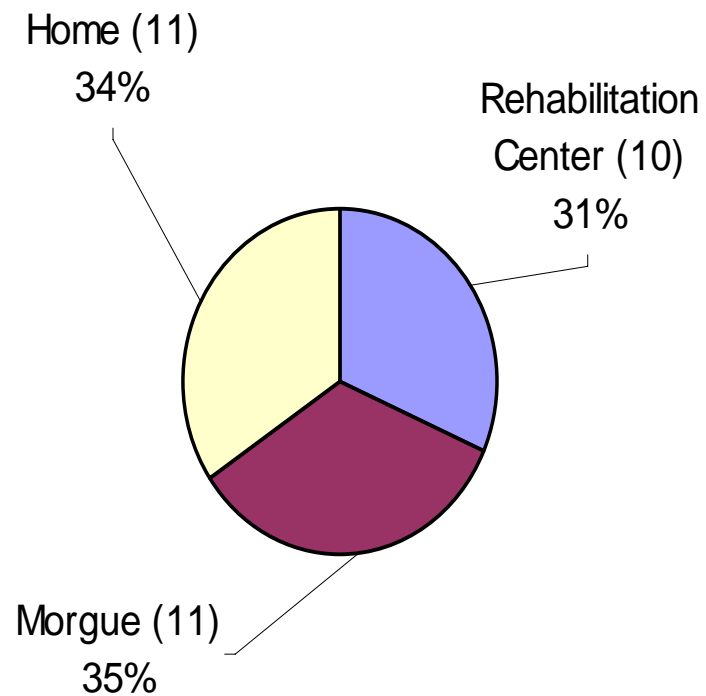
Pediatric Population

UMC Trauma Registry 2005

n=29



Hospital Disposition - Level 1 Activation Pediatric Population UMC Trauma Registry 2005 n=32

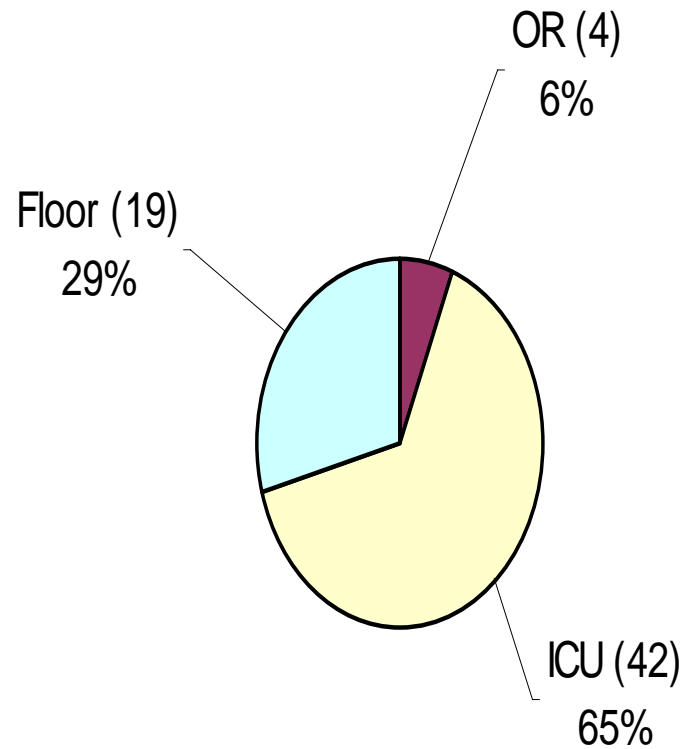


ED Disposition - Level 2 Activations

Pediatric Population

UMC Trauma Registry 2005

n=65

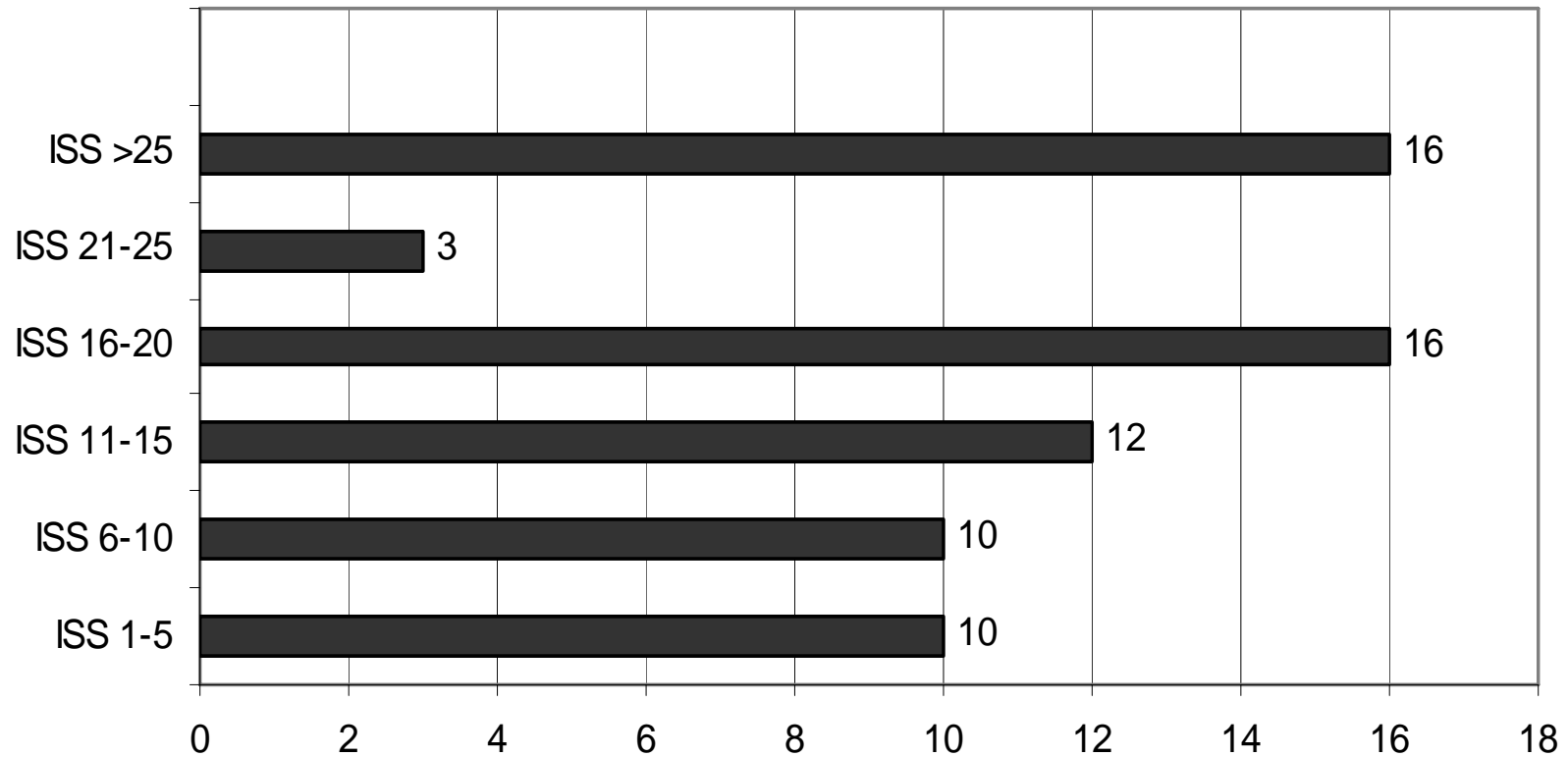


ISS - Level 2 Activations

Pediatric Population

UMC Trauma Registry 2005

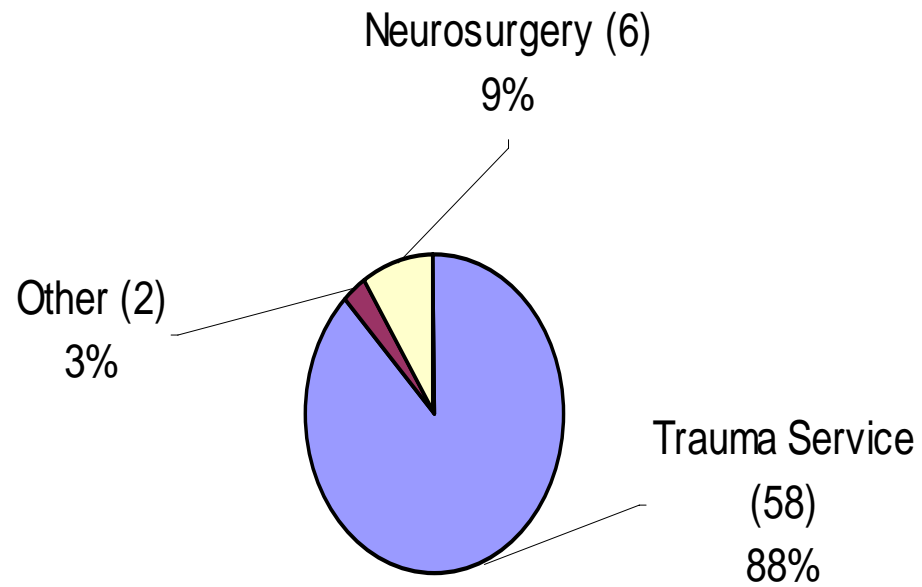
n=67



Admitting Service - Level 2 Activation Pediatric Population

UMC Trauma Registry 2005

n=66

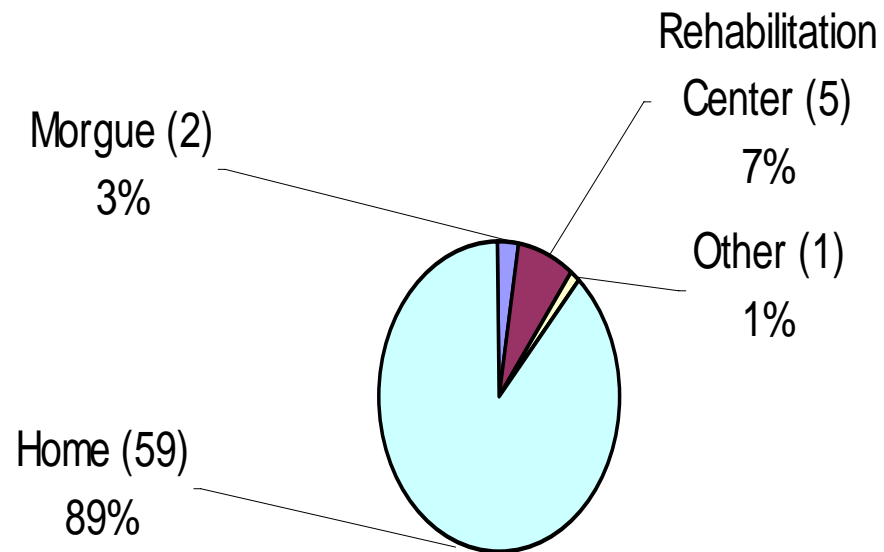


Hospital Disposition - Level 2 Activations

Pediatric Population

UMC Trauma Registry 2005

n=67

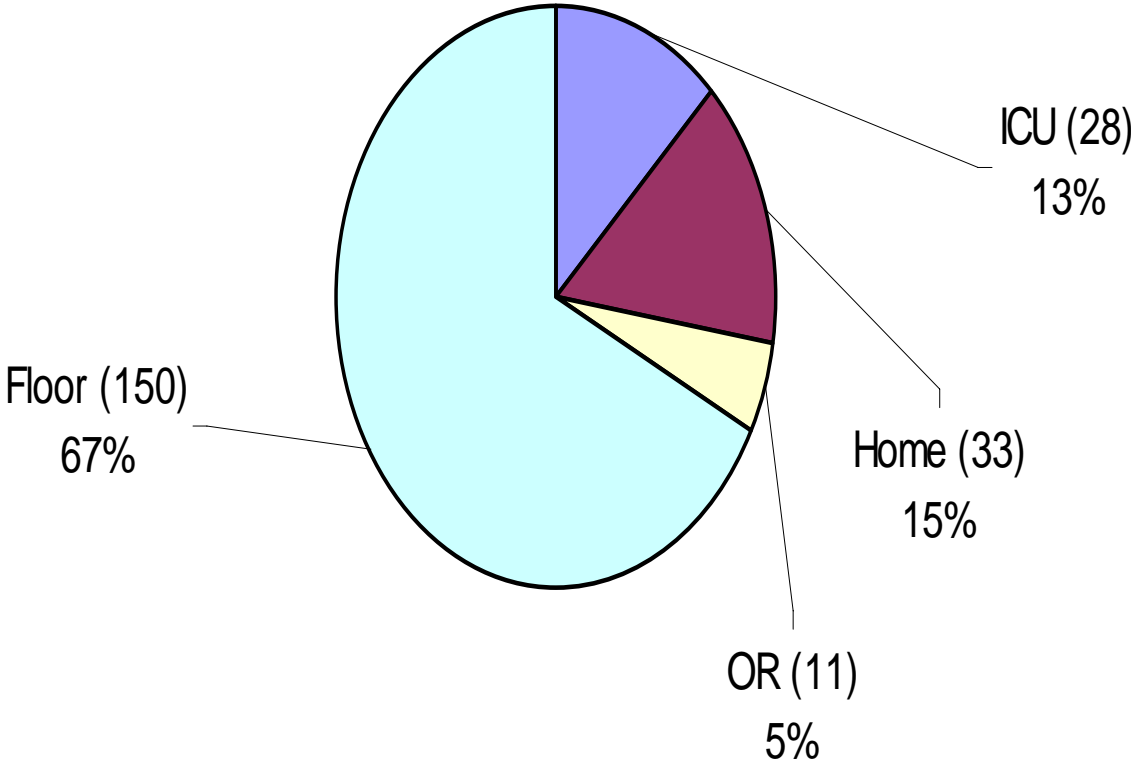


ED Disposition - Level 3 Activations

Pediatric Population

UMC Trauma Registry 2005

n=222

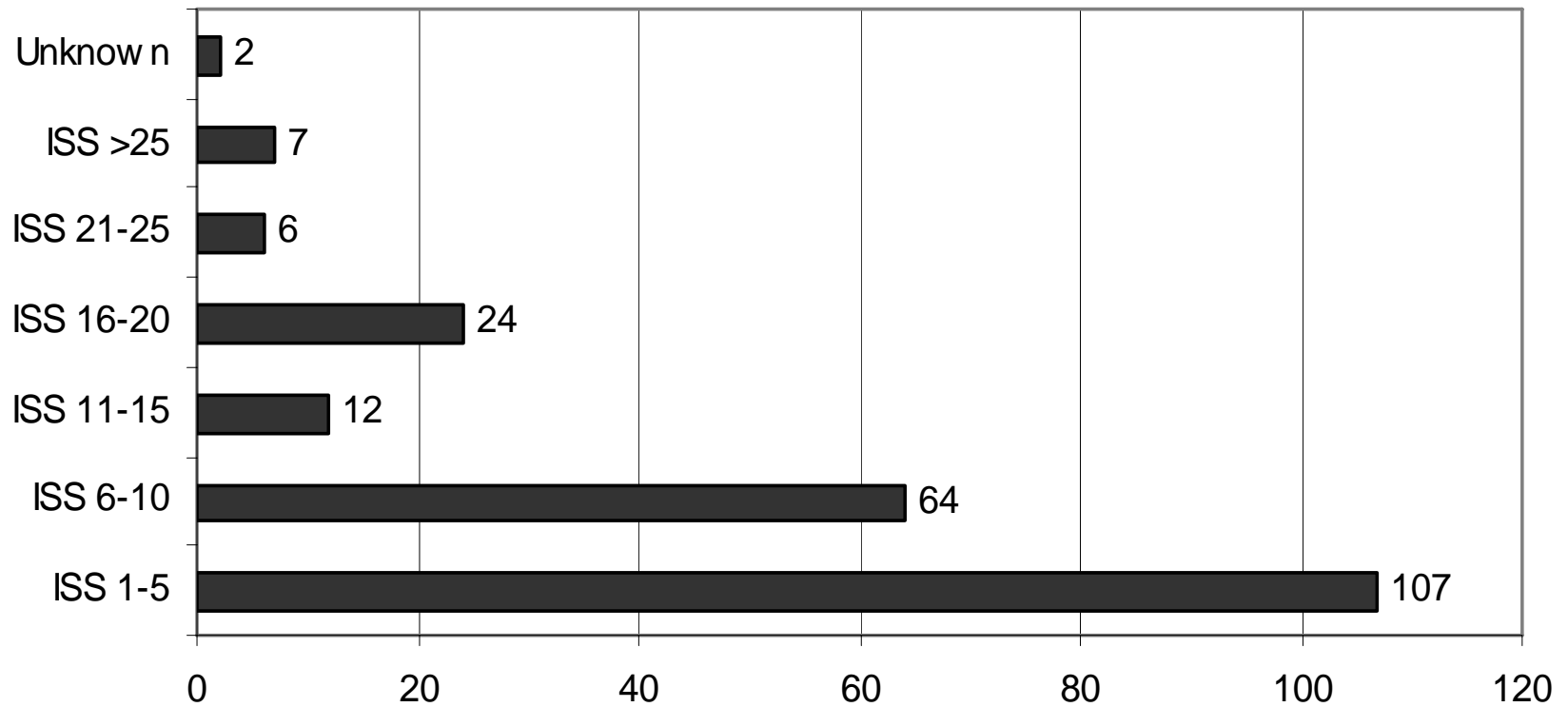


ISS - Level 3 Activations

Pediatric Population

UMC Trauma Registry 2005

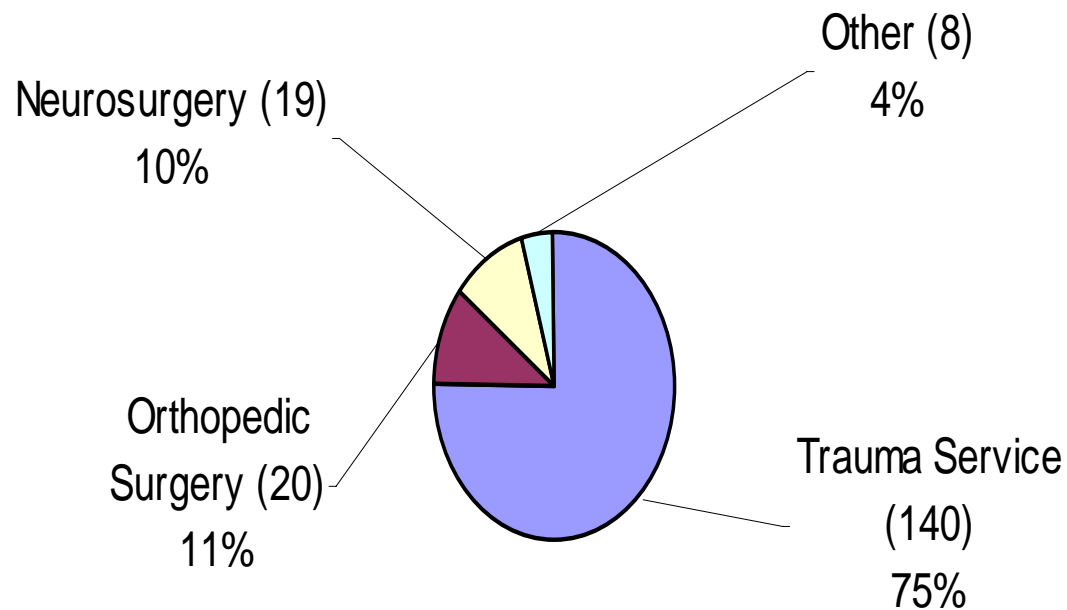
n=222



Admitting Service - Level 3 Activation Pediatric Population

UMC Trauma Registry 2005

n=187



Hospital Disposition - Level 3 Activation

Pediatric Population

UMC Trauma Registry 2005

n=222

