A Guide for Family and Friends of Trauma Patients

The University of Arizona Medical Center – University Campus
Southern Arizona’s Only Level I Trauma Center
A Letter to Families

Trauma affects everyone, not just the person injured but the entire network of friends and family. The trauma team at The University of Arizona Medical Center knows what a difficult time it can be for all involved when someone is seriously injured. Treating the injured is sometimes the easy part. The hard part is getting the person back to the status they were in before they were traumatized. Keeping the patient, family, and friends informed is vital to the healing process and the more you know, the easier the process will be. Trauma care can feel overwhelming as the treatment process is complex and involves many people.

This question-and-answer guide tells you what to expect at various stages of care, from admission to the trauma center to follow-up care after discharge. It should help explain the roles of the many specialists caring for your loved one. And, most importantly, it explains the crucial role that you play during the recovery process, from sharing vital medical information to providing home care and helping with rehabilitation.

As you support your family member or friend along the path of trauma treatment and recovery, we encourage you to ask questions. If you don’t understand a procedure or a technical term, don’t hesitate to ask for clarification. There is a glossary of medical terms in the back of this brochure for your convenience.

As a regional Level I trauma center, The University of Arizona Medical Center – University Campus has the highest level of trained health care personnel, resources, services, and equipment necessary for the best care of the critically injured patient. Please know that your loved one is being cared for by our region’s most advanced trauma team. We are dedicated to helping you. We work for you.

Peter Rhee, MD, MPH
Medical Director of Trauma Program
The University of Arizona Medical Center – University Campus
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Having a loved one in the hospital for a critical injury or illness can be an emotionally overwhelming experience for everyone involved. You, your family and your friends may have many questions. That is why it is essential to choose a spokesperson. This will help establish good communication with the health care providers who are caring for your family member or friend.

The patient’s spokesperson plays an important role in that patient’s care. Because critical care patients often cannot speak for themselves, the spokesperson keeps the lines of communication open between the health care providers and your family and friends.

When communicating with health care providers, we encourage the patient’s spokesperson to:

- Provide as much information about the patient, especially if he or she cannot communicate.
- Be sure to share the patient’s wishes regarding surgery, life-support equipment and other difficult decisions with the doctor.
- Make a list of the patient’s questions and concerns, as well as those of family and friends.

We welcome questions about the equipment, treatments and overall care of the family member or friend. Your loved one may be attached to several tubes and machines. Each one has a specific function, so we urge you to ask why they are being used.

To prevent infection, it is important to wash your hands before and after each visit. Please keep visits short, as your loved one needs rest. The nurse can provide you with visiting hour information.

Finally, we encourage you to take care of yourself. Your family member or friend will need your support when his or her condition improves.
How do trauma patients get from the site of the injury to the trauma center and what kind of treatment do they receive before arriving?

Trauma patients usually are brought to The University of Arizona Medical Center via helicopter or ambulance by emergency medical services (EMS) personnel. EMS providers are part of a statewide network of emergency care professionals whose job is to assess and transport injured patients to the trauma center using methods that assure every patient receives the highest degree of safety and emergency care.

From the incident site or en route to the trauma center, the EMS team alerts our trauma team of an incoming trauma patient. Once the trauma team receives the alert, the team assembles in the trauma resuscitation bay of the Emergency Department to prepare for arrival.

Where does the patient go after arriving at the trauma center?

After the trauma team assesses the severity of injuries in the Emergency Department, a level of care is determined which may include ordering specialized diagnostic tests. Based on the evaluation, the patient will go from the Emergency Department to one of the following:

- The operating room for emergency surgery.
- The trauma intensive care unit (ICU). Specially trained ICU nurses care for the patients around the clock and use advanced monitoring systems to track their condition.
- The “step down” unit or trauma surgical nursing unit. At this stage, less monitoring is recommended because the patient’s condition is considered stable. This level of care is considered a “step down” from the ICU.
When can we see our loved one?

Our most urgent priority when trauma patients arrive at the trauma center is to stabilize their condition. That may take several hours, during which time the trauma team may run clinical tests or perform surgery and other life-saving procedures.

Knowing how painful and frightening this period of waiting can be for families, we make every effort to let you see your loved one as soon as possible and learn the status of his or her condition.

When the members of the trauma team decide the patient is out of immediate danger, you may be able to visit for a longer period of time. We are dedicated to providing family-centered care. And we will work with you to ensure that your concerns are addressed.

Who gives information to the family about the patient’s status?

Our goal is to keep families informed at all times. When you arrive in the Emergency Department, you meet an Emergency Department nurse, social worker, or chaplain who serves as your contact with the trauma team and updates you on status.

If surgery is required, the social worker or chaplain will escort you to the surgical waiting room. Because this waiting period can be a difficult time, staff will update you at regular intervals until the surgery is over and the patient goes to the recovery area or an intensive care unit.

Our chaplains remain on call to families 24 hours a day as spiritual and informational resources for the duration of your loved one’s hospitalization. In addition, our social workers are also readily available to assist you. If you’d like to speak with the chaplain or social worker, please inform the patient’s nurse. The nurse will be able to contact them for you.

The trauma team “rounds” daily in the hospital. During these rounds, the team discusses injuries, the condition and plan of care including discharge planning for your loved one. You can expect to talk to the team during the late morning when the attending physician rounds. If you cannot meet with the team at that time, please share your concerns with the nurse and they can help to contact the team for you.

Who is responsible for a patient’s treatment during the hospital stay?

Many different medical and allied health professionals are involved in treating trauma patients at various stages of hospitalization, and it might appear to families that the team is constantly changing.

In fact, the team is led by an attending trauma surgeon who continually consults with other trauma surgeons and medical specialists to decide the best course of treatment. Depending on the nature of the patient’s injuries, other specialists may be called to assist in treatment. These specialists are also available around the clock through all stages of treatment.

What is the difference between an attending, a fellow, resident, and intern?

**Attending surgeon:** A surgeon who specializes in trauma care, directs the trauma team and consults with other surgeons and specialists as needed. A trauma surgeon is on call for immediate response at all times.

**Fellow:** A surgeon who has entered into specialized training for Trauma and Critical Care services.

**Resident:** A doctor who has completed medical school and is furthering his or her training in a specialty. Always works under the supervision of the attending physician.

**Intern:** A medical school graduate preparing to be licensed to practice in medicine.
The University of Arizona Medical Center – University Campus has been designated by the State of Arizona and verified by the American College of Surgeons as a Level I Trauma Center. Our trauma surgeons are immediately available 24 hours a day, 7 days a week, to care for seriously injured patients. Experts in their field, our trauma surgeons have the training and experience to handle all emergencies; their knowledge and responsiveness are continually enhanced by their active involvement in research and education as faculty members of The University of Arizona. All surgeons are specially trained and board certified in critical care medicine. This is the only surgical group in the region with such specialty training in both trauma and critical care.

The trauma surgeons

Peter M. Rhee, MD, MPH
Chief, Division of Trauma, Critical Care & Emergency Surgery
Medical Director, UAMC Trauma Center

Randall S. Friese, MD
Associate Professor of Surgery
Associate Medical Director, UAMC Trauma Center
Director, Acute Care Surgery Research

Donald Green, MD
Lynn Gries, MD
Bellal Joseph, MD
Gary Vereraysse, MD
Narong Kulvatunyou, MD
Terence O’Keeffe, MD
Andrew L. Tang, MD
Julie L. Wynne, MD
Another important team member is the trauma nurse practitioner (NP) or physician assistant (PA). A nurse practitioner (NP) is a registered nurse (RN) who has completed advanced education (a minimum of a master’s degree) and training in the diagnosis and management of common medical conditions and chronic illnesses. A Physician Assistant (PA) is a health professional who practices medicine under the supervision of a licensed physician. Trauma nurse practitioners and physician assistants are licensed by the state of Arizona. They attend daily trauma rounds, initiate, evaluate, and update patient care plans. Trauma nurse practitioners and physician assistants perform minor procedures, write prescriptions and coordinate follow-up care. They collaborate with the entire trauma team and assist in communication with consultants, patients and families. They assist with coordination of discharge planning and will provide you with patient/family education throughout the hospitalization phase. Please ask your nurse practitioner or physician assistant to clarify any questions you may have about physician instructions, follow-up or home care.

The trauma mid-level providers

Rhetta Yuill, PA-C  
Trauma Physician Assistant

Ana Davis, ACNP-BC  
Trauma Nurse Practitioner

Lisa Erickson, ACNP-BC  
Trauma Nurse Practitioner

Helene Henager, ANP-BC  
Trauma Nurse Practitioner

Rubria Marines-Price, ACNP-BC  
Trauma Nurse Practitioner

Christopher McLarty, MS, ACNP-BC  
Trauma Nurse Practitioner
In addition to trauma surgeons, our trauma center team includes other specialized surgeons, emergency medicine physicians, trauma nurses, and therapists.

Who are these specialists?

**Cardiologist:** Physicians who specialize in the study of the heart.

**Cardiovascular/thoracic surgeon:** Surgeons who specialize in heart, chest and blood vessels.

**Case manager:** A professional who seeks out and coordinates resources for the trauma patient being discharged.

**Emergency medicine physician:** A physician who specializes in emergency care and works with the trauma team in the emergency department.

**Gastroenterologist:** Physicians that study disorders of the stomach and intestines.

**Infectious diseases:** Physicians specializing in transmissible or communicable diseases.

**Internal medicine:** Physicians that study severe/chronic illnesses.

**Nephrologist:** Physicians specializing in the study of kidneys.

**Neurologist:** Physicians that study the nerves.

**Neurosurgeon:** Surgeon who specializes in brain, nerves and spinal cord.

**Occupational therapist (OT):** A therapist who helps patients gain independence in daily living skills, simple functional tasks such as moving in bed, going to school and job-related tasks.

**Ophthalmologist:** Physicians practicing in the study of eyes.

**Oral/facial:** Surgeons that specialize in mouth, teeth and face disorders.

**Orthopedics:** Surgeons specialized in bone and muscle disorders/injuries.

**Otolaryngologist:** Physicians that study the ear, nose and throat.

**Pastoral services:** Services offered for emotional and spiritual comfort to patients and families throughout hospitalization.

**Physiatrist (PMR):** A doctor specializing in physical medicine and rehabilitation who treats patients with disabling conditions that impair their daily functions. Physiatrists direct the rehabilitation plan for patients by prescribing and supervising physical, occupational and speech therapies.

**Physical therapist (PT):** A therapist who assists with rehabilitation aimed at the restoration of function and the prevention of disability following disease, injury or loss of a limb.

**Plastic:** Surgeons specializing in reconstructive surgery.

**Psychiatrist:** A doctor who evaluates and assists in the treatment of depression, agitation and other behavioral disorders that can affect the trauma patient.

**Pulmonologist:** Physicians studying disorders of the lungs.

**Respiratory therapist:** A health care professional who provides breathing support and respiratory treatments, including checking ventilators, suctioning breathing tubes and teaching breathing exercises to the patient.

**Social worker:** A professional trained to work in a trauma center who is experienced with coordinating social services needed by trauma patients and their families.

**Trauma nurse:** A registered nurse who has advanced training in the care of trauma patients.

**Urologist:** Physicians studying disorders of the urinary tract.
The pathway to recovery

Trauma patients are taken from the scene of the incident to the trauma center, where a trauma team stabilizes the patient and decides the best treatment. Some trauma patients are transferred to the trauma center for specialized trauma care after receiving their initial care at another hospital. Patients with less severe injuries may be placed in a “Step Down” unit while severely injured patient may need surgery and be placed in the intensive care unit (ICU).

The overall goal is to stabilize the patient’s condition. As the patient’s condition improves, the trauma team’s emphasis shifts toward physical and cognitive rehabilitation.

Before a patient leaves the hospital, he or she is typically transferred to the “Step Down” unit to work toward recovery. Even after the patient leaves the hospital, the trauma team continues to play a role in the recovery process through continual examinations, evaluations and referrals.

1. From the injury site, the emergency medical services team alerts trauma team of incoming patient. Some patients are evaluated at another hospital first then transferred here.

2. Transported to The University of Arizona Medical Center – University Campus by ambulance or helicopter. Evaluated and stabilized in the Emergency Department.

3. Depending on the patient’s condition, they will go to one of the following after the Emergency Department; OR, ICU, or “Step Down”.

4. Physical, occupational and cognitive rehabilitation or long-term nursing care. Discharged from hospital, sent home or cared for by family or home-health aide.

5. Outpatient services, such as family physicians, the trauma clinic or home care.
How can I help during trauma treatment and recovery?

The impact of traumatic injury on the patient’s family is profound. With no warning, you are thrown into a crisis and must make informed decisions.

It is common for families to feel overwhelmed, frightened, shocked and angry. We would like to offer a few suggestions to help you get through this very stressful time.

● Remember that the trauma team is your best ally during this crisis and will be with you every step of the way.

● Select one person to speak for your family and share information with the medical staff.

● Provide as much information about the patient’s medical history as possible.

● Ask questions and write down the answers. The more you know, the better you are able to cope.

● Visit the patient regularly and let him or her know you are there, even if he or she is not completely responsive. Talk to and touch your loved one — such reassurances can be very helpful to a patient.

What happens after the patient’s condition improves and he or she leaves the intensive care unit?

Patients move to the “Step Down” unit only when the members of their trauma team are sure their condition has improved to the point where they do not need intense, around-the-clock monitoring.

The focus of care for patients in the “Step Down” unit is to prepare them for home. Patients in a surgical nursing unit are considered well enough that their trauma team expects them to participate in their own care by eating, moving around and doing other activities to regain their mobility. Family members can be a great source of support at this time, encouraging the patient to take the first steps toward rehabilitation and recovery.

The trauma team remains actively involved in treatment and evaluates daily the patient’s plan of care. Members of the trauma team are always available to discuss the patient’s condition, as are the primary nurse and other staff involved in treatment.

Why am I asked to leave the room?

The welfare of our patients is our top priority. You may be asked to leave the room for small periods of time to ensure adequate rest and treatment. Staff may also ask you briefly to step out of the room so they may listen, concentrate, and assure accuracy of their assessment reporting. This ensures safe care to your family member. Please take these breaks to take care of yourself. Extreme stress can deplete your energy and affect your health. Use the resources available to you to get through this period. Remember to call on family, friends, clergy, and the trauma team to help support you.

When can I expect to see the trauma surgeon?

We believe it is important that you are present when the trauma surgeons round. This allows you time to ask questions and better prepare for your loved one’s recovery. Write questions down as you think of them and then ask when the team rounds. If you are unable to be present during rounds, please leave your questions with the nurse. Our Trauma surgeons strive to see all patients by noon; however, the trauma surgeons may be delayed on some days because of unforeseen circumstances. During these instances, your nurse, nurse practitioner or physician assistant will be able to provide you with updates.

Ask questions and write down answers.
How long are trauma patients hospitalized and when can they go home?

The recovery period is different for every patient, depending upon the nature of the injuries, the health and age of the patient and other factors. Likewise, discharge plans vary due to the injuries suffered and the support systems available to patients and their families. A case manager, social worker and the trauma team will develop a plan that considers everyone’s needs.

Our primary goal in the recovery of trauma patients is to help them regain independence. Many trauma patients recover from their injuries and are able to go directly home. Others may require long-term care for more serious injuries, such as a head injury. Options may include a rehabilitation center or skilled nursing facility.

After discharge, some trauma patients may follow up in the multi-specialty clinic located on the 5th floor of the main hospital. Follow up for specialty physicians may also be included on your discharge plans.

It is important for families and patients to remember that there is no set formula for recovery from traumatic injuries. Some patients have setbacks along the way, while others recover and are back to normal sooner than expected.

What is the procedure for discharging my loved one?

The hospital staff begins planning for discharge on the day of admission, ensuring a safe and timely discharge home or to a rehabilitation facility. Several staff work together to make sure the patient has what is needed after discharge from the hospital. Patients and their loved ones are part of the discharge team alongside their physicians and nurses.

Additional staff may also take part in discharge planning depending on the patient’s injuries and needs.

Additional staff may include:

- A social worker, to coordinate social services needed by trauma patients and their families.
- A nurse case manager, to arrange for home care needs like medications, beds and assistive devices, to assist with health insurance issues and arrange for transfer to the appropriate facility.
- A physical therapist, to teach injury specific exercises and use of assistive devices.
- An occupational therapist, to reteach daily living skills like bathing, eating, moving in bed, going to school or work and use of assistive devices.
- A speech therapist, to evaluate and treat talking, thinking and swallowing problems.

 Patients will receive care instructions throughout their stay. Trauma discharge instructions and any needed educational materials about their injuries, medications or treatments will be provided on day of discharge. Our nurses are dedicated to ensuring successful recovery at home. Please allow them time to prepare home care instructions after the surgeons’ discharge approval. Prescriptions can be obtained at a local retail pharmacy or the pharmacy located on the second floor lobby of the main hospital. It is ideal to obtain these while discharge paperwork is being completed.

Once cleared for discharge, trauma patients will need someone to provide them with comfortable clothing and transportation to their home.

Our nurses are dedicated to ensuring successful recovery at home.
Families experience many stressors when a loved one is hospitalized due to injury, and trauma situations may become even more stressful when the news media are involved. Because traumatic injuries may become newsworthy events, the media can become focused on hospitalized patients. This document is intended to help you and your family during this type of situation. It outlines what should be expected and offers guidelines and tips to help you communicate with the media.

**What can the media report?**
The media have the right to gather and report information regarding a patient’s injury and condition. Some information is public and some information is private.

**Public Information**
Any situation involving law enforcement, such as crimes, fires and motor-vehicle crashes, is public record. Reports are available through the Tucson Police Department or Pima County Sheriff’s Department and include information such as name, age, sex and other details about the persons involved. Officials may share this information with the media soon after an incident occurs.

Reporters may go to other sources for information, such as family members, friends, neighbors, teachers, co-workers, etc. Photographs are often taken from Facebook or school yearbooks.

Please note that the media commonly track social media sites for information about patients. Patients and their families should use caution about what medical information they share on Facebook or other social media sites.

**Private Information**
The federal Health Insurance Portability and Accountability Act, often referred to as the HIPAA Privacy Rule, governs how hospitals release medical information about patients to the media.

Under HIPAA, the hospital may release a one-word condition report to media on any patient listed in the hospital’s patient census directory. One word conditions include: good, fair, serious and critical. We will NEVER discuss any aspects of a patient’s care, other than the one-word condition, unless approval from the patient or family is given to do so.

Patients may choose to opt out of the hospital patient census directory or be placed under an alias to avoid information being released to the media regarding their hospitalization. To do so, patients should notify the floor nurse about their request and he/she will help determine which case is best for the patients.

The hospital may also report if a patient has been discharged. If a patient dies, UAMC will attempt to allow family members to notify relatives and friends before this information is disclosed. Under law, death is a reportable condition.

**Personal Privacy**
Most reporters work through the hospital’s Office of Public Affairs to receive information on trauma patients and their conditions. Occasionally someone unfamiliar with this process may try to contact you directly.

If patients are contacted directly, please call Office of Public Affairs at (520) 626-7301. Media relations personnel will take interview requests and ask patients ONCE if they would like to be interviewed. The media is not allowed on hospital property without being accompanied by Public Affairs personnel.

If patients would like to meet with reporters, Public Affairs will arrange the interview. If patients wish to delay an interview until a later date, Public Affairs will facilitate the interview when patients are ready.

Remember, the media may ask other sources for information, so patients should express their privacy preferences to those people the media could potentially question. It may be helpful to have a family spokesperson. If patients feel their privacy is being threatened, they should tell a nurse or contact hospital security.

**Away from the hospital**
Sometimes reporters will go to the home of a patient or family. Reporters and photographers have a right to seek an interview, and patients have the right to agree or refuse. The media are allowed to remain nearby as long as they remain off private property. Often the media will want to speak with a family member or friend going to and from the house. In this type of situation it would be helpful to have a trusted spokesperson for the patient’s family.
**Glossary of terms**

**Acute Respiratory Distress Syndrome (ARDS)** – Breathing difficulty from a condition that causes the lungs to stiffen.

**Advanced directives** – Preplanned directions to a family and the medical team about life-support wishes such as the use of artificial supportive measures at the end of life (similar to a Living Will).

**Allow Natural Death (AND, No Code)** – Instructions given to the staff that they are not to perform CPR (cardiopulmonary resuscitation) should a patient’s breathing or heart stop.

**Anoxia** – Lack of oxygen.

**Arrhythmia/Dysrhythmia** – Abnormal heart beat or rhythm.

**Arterial Blood Gas (ABG, Blood Gas)** – A blood test that determines the amount of oxygen in the blood and the amount of oxygen therapy required.

**Arterial Line (A-Line)** – A flexible plastic tube that is placed into a patient’s artery and is connected to a cardiac monitor to measure blood pressure; it also allows blood samples to be taken easily.

**Brain death** – The point at which all functions of the brain stop working and will never work again.

**Cardiac monitor** – An electronic device that is used by the staff to watch the electrical activity of the heart as well as blood pressures.

**Cardiopulmonary Resuscitation (CPR)** – Emergency treatments to restore breathing and/or heartbeat, which may include artificial resuscitation and pressure to the chest, and/or the use of electrical shock, intravenous medications and a ventilator.

**Central line (CVP, Triple Lumen Catheter, Cordis)** – A flexible plastic tube that is inserted into the neck, shoulder or groin, which allows a route for blood, fluids and medications to be given. It also measures pressures of the heart and allows blood samples to be taken easily.

**Cervical Collar (C-Collar)** – A brace placed around the patient’s neck to prevent movement.

**Chest tube** – A tube inserted into the chest, between the ribs, to drain air and/or fluid from around the lungs.

**Closed head injury** – A condition caused by a blow to the head, sudden movement or lack of oxygen to the brain.

**Collapsed lung** – A condition caused by fluid, blood or air collecting around the lung or from the lung not being filled with air.

**Coma** – A condition of deep unconsciousness.

**Computerized Axial Tomography (CT Scan, CAT Scan)** – A two-dimensional X-ray test used to diagnose many conditions, and which can be used to examine almost any part of the body.

**Concussion** – A temporary loss of consciousness due to an injury to the head.

**Contusion** – A bruise.

**Dialysis (CVVHD, CRRT)** – A mechanical method of removing fluid and chemicals from the blood of patients whose kidneys are not functioning properly.

**Echocardiogram (ECHO)** – An ultrasound test which provides a moving picture of the heart to assess how well it is functioning.

**Electrocardiogram (EKG)** – A machine that traces electrical activity of the heart and is used to check if it has been damaged.

**Electroencephalogram (EEG)** – A machine that traces the electrical activity of the brain, and which is used to check whether or not the brain is functioning normally.

**Endotracheal Tube (ET Tube)** – A plastic tube inserted through the mouth or nose into the windpipe to help with breathing by delivering oxygen or by helping to remove secretions from the lungs.

**Epidural/Spinal catheter** – A catheter that is inserted into the epidural/spinal space in the back for the injection/infusion of pain medications.
Glossary of terms

**Exploratory Laparotomy (EX-Lap)** – A surgical operation used to identify and repair internal injuries to organs such as the kidneys, liver, spleen, stomach or intestines. A diagnostic laparoscopy may be done to rule out injuries to organs.

**Extubate** – To remove a breathing tube.

**Feeding Tube** – A soft plastic tube placed in the nose or mouth that supplies liquid nourishment directly to a patient’s stomach.

**Foley / Urinary Catheter** – A soft plastic tube inserted into the bladder to drain urine.

**Fracture** – A broken bone.

**Gastrostomy Tube (PEG)** – A soft plastic tube inserted into the stomach to deliver liquid nourishment.

**Glasgow Coma Scale (GCS)** – A scoring system that describes the level of consciousness of a patient.

**Halo** – A metal ring used to prevent head movement in patients with neck injuries.

**Hematoma** – A collection of blood resulting from broken blood vessels. May consist of many sizes.

**Intracranial Pressure (ICP)** – Pressure in the head.

**Intracranial Pressure Monitor (Bolt, ICP monitor, Ventric, Ventriculostomy)** – A device inserted through the skull to monitor the pressure in the brain or to drain extra fluid/blood.

**Intubate** – To insert a tube that can be used to assist the patient with his or her breathing.

**Liver** – A body organ, located on the right side of the body under the rib cage. Its main functions relate to metabolism, the immune system and blood clotting.

**Living Will** – A legal document listing a patient’s wishes to receive or refuse medical treatments (similar to Advanced Directives).

**Myocardial Infarction (MI)** – Heart attack.

**Magnetic Resonance Imaging (MRI)** – A test that can provide images of a bone or a body area, by using magnets rather than X-rays or radioactive materials.

**Nasogastric/Orogastric Tube (NG, OG)** – Small plastic tubing inserted through the nose or mouth to deliver nourishment to or remove fluid or air from the stomach.

**Neurologic** – Anything having to do with the brain, spinal cord or nerves.

**Oximeter (Pulse-OX)** – A device that measures blood oxygen levels through the skin.

**Oxygen (O2)** – A molecule necessary for breathing and healing. The amount may need to be increased for patients with specific injuries.

**Paralysis** – A patient’s inability to move voluntarily, either completely or partially; can be temporary or permanent.

**Parenteral Nutrition (TPN)** – An intravenous solution of calories, protein, vitamins and minerals, given when the intestinal tract cannot be used for nourishment.

**Patient Controlled Analgesia (PCA)** – A device allowing patients to administer the amount of pain medication they want to receive.

**Pneumonia** – An infection of the lungs, usually resulting from bacteria that causes fluid to collect.

**Pneumothorax (pneumo)** – A collection of air in the space surrounding the lungs.

**Quadriplegia / Tetraplegia (Quad)** – Paralysis of the entire body, caused by injury to the spinal cord.

**Rehabilitation** – A course of treatment that is aimed at helping patients reach their highest possible level of functioning.

**Renal failure/Kidney failure** – The inability of the kidneys to perform their essential function, which is to cleanse the blood of chemicals or fluids.

**Rounds** – Scheduled visits by the trauma team to discuss the condition and plans for an individual patient.
Glossary of terms

**Sepsis** – Severe infection by bacteria or other organisms present in the blood or body tissues.

**Sequential Compression Device (SCDs)** – Stocking-like leg covers that inflate and deflate, which are used to improve circulation and prevent blood clots.

**Spleen** – An organ located under the rib cage on the left side of the body. Its main function relates to the immune system.

**Splint** – A rigid device used to prevent movement in an injured area; usually used for fractures.

**Spinal cord injury** – An injury to the spine that may cause paralysis; because it interferes with messages between the brain and the body.

**Suction** – The removal of air/fluid.

**Swan Ganz Catheter (PA Line, Swan)** – A flexible plastic tube inserted through a large vein in the neck, shoulder or arm, to reach the heart so that the cardiac monitor can display functions and pressures of the heart.

**Tracheostomy (Trach)** – An operative procedure that places a tube in a patient’s windpipe through a hole in the neck, so an endotracheal tube in the mouth can be removed.

**Traction** – Weights and pressure used to hold fractured bones in the proper position for healing.

**Traumatic Brain Injury (TBI)** – Damage to the brain from an injury.

**Ventilator (Vent, Respirator)** – A machine that is attached to an endotracheal tube or tracheostomy tube that delivers oxygen to a patient’s lungs in order to help with breathing.

**Vital Signs** – A patient’s temperature, rate of breathing, heart rate and blood pressure.

**Weaning** – The gradual removal of treatment and/or medication as a patient’s condition improves.

**X-ray** – A test producing a one-dimensional picture of the body, used to diagnose structural injury.
How you can get involved

**Injury Prevention**

Our trauma team treats more than 5,000 patients each year at our Level I trauma center. We’re committed to preventing traumatic injuries. Team members participate in several trauma prevention efforts throughout the community. Injury prevention presentations are customized for schools, health fairs, businesses, and community groups. Trauma team members also collaborate with EMS providers to educate and improve our trauma system to ensure optimal care of trauma patients in our region.

The trauma program welcomes participation from former patients who are willing to share their experience. If you are interested in finding out more about our injury prevention program or opportunities for community education and awareness, please contact us at: (520) 694-4806 or via email at trauma@uahealth.com

**Opportunities to Support the Trauma Center**

The UAMC Trauma Center is Southern Arizona’s only LEVEL I Trauma Center because it is the only one able to provide a broad array of highly-specialized medical services all day, every day, all year. To anyone in the region who suffers a significant traumatic injury, the presence of the UAMC Trauma Center can mean the difference between life and death. That vitally-important community benefit is a costly one, in part because technology is incessantly changing, facilities require periodic upgrading, and continual research in surgical and post-operative techniques is imperative. Therefore, **PRIVATE PHILANTHROPIC SUPPORT** of the UAMC Trauma Center is essential. If you, your family, or someone you know would like to:

1. Help the UAMC Trauma Center meet its ongoing need to acquire leading-edge, new technology, improve and expand its facilities, provide vital assistance to its nurses and support team, and continue its community outreach and injury-prevention programs, please contact:
   
   THOMAS SANDERS  
   Senior Development Officer  
   The UMC Foundation  
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2. Assist the University of Arizona Division of Trauma, Critical Care and Emergency Surgery with its ongoing research projects, UA Department of Surgery endowments, and training of the next generation of trauma surgeons, please contact:
   
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