

# Appendix IV: Database Description

The database collected for the project contains a multitude of information:

1. Videotapes. The videotapes were recorded on a VHS tape, stamped with two types of timecode: VITC and LTC. Video images were overlaid with the patient's vital signs data. The videotapes of a small number of the cases were also overlaid with transcriptions of verbal communications and major events.
2. Audio review tapes. These audiotapes were made while the subject matter experts reviewed videotapes and/or were interviewed.
3. Stress ratings. These ratings were given at one-minute intervals by one or more subject matter experts.
4. Admitting chart. The chart used by the Shock Trauma Center to register the patient's basic demographic information (with patient's identification removed) and the results of initial consultation.
5. Anesthesia chart. The chart used by the attending anesthesiologists during anesthetics. It contained the drugs used, timing of events, and logs of the patient's vital signs.
6. Physiological data. These data were captured during care by directly interfacing with patient physiological monitors.
7. Discharge summary. The summary was written at the end of the care, either after the patient was stable enough to leave the shock trauma center, or the patient expired.
8. Intubation analysis. The Intubation Analysis Questionnaire is a form to collect critical information about the events and performance during intubation.
9. Transcription of video tapes. To facilitate analysis of verbal communications, a number of selected cases were transcribed.
10. Post Trauma Questionnaire. It was a questionnaire to be completed at the end of videotaping.

The table included here describes the types of data available for each of the cases videotaped.