

**UCSF DEPARTMENT OF SURGERY  
QUALITY IMPROVEMENT CASE REVIEW REPORT**

Service Pediatric Surgery

To be completed by  
housestaff/attending

Part I

<b>Patient Name</b>		<b>MR#</b>	<b>DOB</b>
<b>Operation(s) Performed</b>		<b>Preoperative Diagnosis</b>	
<b>Date(s) of Operation(s)</b>		<b>Attending Surgeons(s)</b>	<b>MD#(s)</b>
<b>Date(s) of Occurrence(s)</b>		<b>Housestaff Surgeon(s)</b>	<b>MD#(s)</b>
<b>Occurrence(s): select all that apply</b>		<b>Service specific occurrence(s): select all that apply</b>	
<input type="checkbox"/> Death <input type="checkbox"/> Lasting organ failure <input type="checkbox"/> Unplanned return to OR <input type="checkbox"/> Unplanned readmission <input type="checkbox"/> Unplanned ICU care <input type="checkbox"/> Surgical site infection <input type="checkbox"/> Deep infection <input type="checkbox"/> Sepsis/ septic shock <input type="checkbox"/> Urinary tract infection		<input type="checkbox"/> Wound disruption <input type="checkbox"/> Bleeding/ transfusion <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Pneumonia <input type="checkbox"/> Respiratory failure/ intubation <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Cardiac arrest/ CPR <input type="checkbox"/> Myocardial infarction	
		<input type="checkbox"/> Error in drug dosage <input type="checkbox"/> Perioperative hypothermia <input type="checkbox"/> Pneumothorax/ hemothorax <input type="checkbox"/> Preterm labor <input type="checkbox"/> Other:	
<b>Narrative of Case:</b>			
_____			
_____			
_____			
_____			
<b>Occurrence related to: select all that apply</b>			
<input type="checkbox"/> Diagnosis <input type="checkbox"/> Surgical technique <input type="checkbox"/> Other:		<input type="checkbox"/> Underlying disease <input type="checkbox"/> Abnormal anatomy <input type="checkbox"/> Equipment malfunction	
		<input type="checkbox"/> Systems problem <input type="checkbox"/> Management	
Form completed by:		date	
Signature of attending		date	

To be completed by  
Section QI Chief

Part II

<b>Service Action Plan:</b> <input type="checkbox"/> No further action <input type="checkbox"/> Systems review <input type="checkbox"/> Root cause analysis <input type="checkbox"/> Other:	
<b>Narrative of Plan:</b>	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
Date of review by Service QI Committee	_____
Signature of Service QI Chief	_____ date

To be completed  
by Dept QI

Part III

<b>QI COMMITTEE REVIEW</b>	Date of review
<b>Discussion:</b> Physician issue(s) <input type="checkbox"/> yes <input type="checkbox"/> no      Systems failure <input type="checkbox"/> yes <input type="checkbox"/> no Complication management appropriate <input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Narrative of Plan:</b>	
_____	
_____	
_____	
_____	
<b>Action:</b> <input type="checkbox"/> No Action <input type="checkbox"/> Peer review <input type="checkbox"/> Refer to other service <input type="checkbox"/> RCA <input type="checkbox"/> Systems review <input type="checkbox"/> Other:	
Signature of QI Chair/date	_____