

UCSF DEPARTMENT OF SURGERY QUALITY IMPROVEMENT CASE REVIEW REPORT

Service Trauma

To be completed by
housestaff/attending

Part I

Patient Name		MR#	DOB
Operation(s) Performed		Preoperative Diagnosis	
Date(s) of Operation(s)		Attending Surgeons(s)	MD#(s)
Date(s) of Occurrence(s)		Housestaff Surgeon(s)	MD#(s)
Occurrence(s): select all that apply		Service specific occurrence(s): select all that apply	
<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"/> Failure to secure or protect airway <input type="checkbox"/> Missed injury <input type="checkbox"/> Delayed control of hemorrhage <input type="checkbox"/> Complication of tube or line placement <input type="checkbox"/> Omission of prophylactic interventions <input type="checkbox"/> Other:	
Narrative of Case:			

Occurrence related to: select all that apply			
<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	
<i>Form completed by:</i>		<i>date</i>	
<i>Signature of attending</i>		<i>date</i>	

To be completed by
Section QI Chief

Part II

Service Action Plan: <input type="checkbox"/> No further action <input type="checkbox"/> Systems review <input type="checkbox"/> Root cause analysis <input type="checkbox"/> Other:	
Narrative of Plan:	

<i>Date of review by Service QI Committee</i>	
<i>Signature of Service QI Chief</i>	
<i>date</i>	

To be completed
by Dept QI

Part III

QI COMMITTEE REVIEW		<i>Date of review</i>
Discussion: 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
Narrative of Plan:		

Action: <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:		
<i>Signature of QI Chair/date</i>		