

**UCSF - East Bay 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 Surgeon(s)	
Date(s) of Occurrence(s)		Housestaff Surgeon(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	
Form completed by:		date	
Signature of attending		date	

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:	

Date of review in M&M	
Signature of East Bay QI rep	date

To be completed
by Dept QI

Part III

QI COMMITTEE REVIEW	Date of review
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:	
Signature of QI Chair/date	