**TRAUMA PI ADJUDICATION FORM**

***Confidential:*** For Internal Use Only

**Patient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reviewer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical record #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Admit date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discharge date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attending trauma surgeon:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chart category**:

 Death  ISS > 25 w/survival  Epidural/subdural  Transfer

 Chest  Liver/spleen  Pelvis/femur  Non-surgical  Peds

**Trauma activation**:

 Category 1  Category 2  Consult  Trauma not involved

**Mechanism of injury**:

 MVC  MCC  Fall  GSW  Stab  Assault  Pedestrian  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographics**:

**Identified Injuries:**

**Major Procedures:**

**Outcome**:

 Alive  Deceased Total LOS: \_\_\_\_ days

**PI ISSUES/AUDIT FILTERS** [Note: Customize list to your center’s current PI filters]

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Y** | **Indicator** | **Action-oriented loop closure** |
|  |  | Pediatric (< 16 years old) |  |
|  |  | Unplanned return to OR |  |
|  |  | Return for like or similar issues |  |
|  |  | Cribari *over* triage/Cribari *under* triage |  |
|  |  | Transfer out |  |
|  |  | Death |  |
|  |  | Delay in diagnosis or missed injury on tertiary survey or clinic |  |
|  |  | Critical documentation deficiency/legibility issue  |  |
|  |  | Failure of MTP guidelines or activation |  |
|  |  | Long bone fracture fixation > 24 hours after patient arrival |  |
|  |  | ***Overutilization of CT*** |  |
|  |  | Penetrating chest trauma |  |
|  |  | SPB < 90 any time prior to CT |  |
|  |  | GSW chest or abdomen |  |

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**Discharge date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attending trauma surgeon:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PI referral source:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Autopsy available at time of summary:**

 Yes  No  N/A

**Summary:**

Arrival time:

Trauma surgeon arrival time:

**Timeline:**

|  |  |
| --- | --- |
| ED arrival to attending trauma surgeon evaluation |  |
| ED arrival to CT scan |  |
| ED arrival to surgery |  |
| ED arrival to ED discharge |  |
| ***Consults*** |  |
|  |  |
|  |  |
|  |  |

**TPM comments:**

 Case closed

 Sent for TMD review

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Trauma Program Manager

**TRAUMA MEDICAL DIRECTOR REVIEW**

**TMD comments:**

**DEATH:**

 Unanticipated mortality with OFI

 Anticipated mortality with OFI

 Mortality without OFI

**CASE CLOSED**

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Trauma Medical Director

**FINDINGS OF THE PEER REVIEW COMMITTEE**

A.) \_\_\_\_\_ The committee determined that there was an opportunity for improvement as it pertained to the decisions and actions of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

It was felt that SOME physicians in this doctor’s peer group would have done this differently.

B.) \_\_\_\_\_\_ The committee determined that there was an opportunity for improvement as it pertained to the decisions and actions of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

It was felt that MANY physicians in this doctor’s peer group would have done this differently.

C.) \_\_\_\_\_\_ The committee determined that there was an opportunity for improvement as it pertained to the decisions and actions of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

It was felt that MOST physicians in this doctor’s peer group would have done this differently.

D.) \_\_\_\_\_\_ The committee determined that there was an opportunity for improvement as it pertained to the decisions and actions of Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

It was felt that NEARLY ALL physicians in this doctor’s peer group would have done this differently.

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Trauma Medical Director

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