**Trauma Peer Review / Just Culture Pre-Review**

**Confidential**

Patient name:

Physician involved:

Medical record number:

Date of incident:

Admission diagnosis:

Reason for review:

Referred by:

**CASE SUMMARY**

**1. What happened?**

**2. What normally happens?**

**3. What does the procedure require (if applicable)?**

**REVIEWER SUMMARY**

**4. Why did it happen? (individual choices that may have contributed)**

**5. How was the organization managing the risk? (system issues that may have contributed)**

**6. Recommend case brought to Trauma Peer Review? (If yes, reason why)**

Trauma Peer Review Liaison (signature) Date

Department assigned:

Medical record number:

Practitioner under review:

Date of occurrence:

Assigned reviewer:

**PROFESSIONAL PRACTICE EVALUATION**

Guided by Just Culture AlgorithmTM v3.2

**Case description:**

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| **Designation and recommended action:**  **No practitioner issues identified**   * No further action * Informational letter (i.e., medical staff rules and regulations/policies/protocols) * Educational letter (i.e., opportunities for improvement in care)   **Human error** (inadvertently doing other than what was intended: a slip, lapse, or mistake)   * No further action — trend * Informational letter (i.e., medical staff rules and regulations/policies/protocols) * Educational letter (i.e., opportunities for improvement in care) * Collegial intervention: Department Chair/Vice Chair/Designee discussion with Practitioner * Repetitive: Department Chair/Vice Chair/VPMA to determine action (see Repetitive section below)   **At-risk behavior** (behavioral choice that increases risk where risk not recognized, or is mistakenly believed to be justified) **referred to PRC** (Professional Review Committee)   * Educational letter (i.e., opportunities for improvement in care) * Collegial intervention: Department Chair/Vice Chair/Designee/VPMA discussion with Practitioner * Repetitive: Department Chair/Vice Chair/VPMA to determine action (see Repetitive section below)   **Reckless behavior** (behavioral choice to consciously disregard a substantial and unjustifiable risk) **referred to PRC**   * Collegial intervention: Department Chair/Vice Chair/Designee/VPMA discussion with Practitioner * Monitor performance: FPPE for Professionalism (Cause) * Performance Improvement Plan (PIP): Department Chair/VPMA to define specifics   **Repetitive behavior** (repetitive errors or adverse event rate deemed unacceptable) **referred to PRC**   * Collegial intervention: Department Chair/Vice Chair/Designee/VPMA discussion with Practitioner * Monitor performance: FPPE for Professionalism (Cause) * Performance Improvement Plan (PIP): Department Chair/VPMA to define specifics   **System** (Applicable to all categories above)   * PSOC referral * Lean Strategies, Clinical Excellence or Team X |

**Comments:**

Signature Date