Trauma Peer Review / Just Culture Pre-Review

Confidential

Patient name: _____ Medical record number: _____

Physician involved: _____ 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: _____ Practitioner under review: _____

Medical record number: _____ Date of occurrence: _____

Assigned reviewer: _____

PROFESSIONAL PRACTICE EVALUATION

Guided by Just Culture Algorithm™ v3.2

Case description:

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 _____