PERFORMANCE IMPROVEMENT PATIENT SAFETY PLAN REVIEW PROCESS

EVENT REVIEW

PRIMARY LEVEL OF REVIEW

IDENTIFIED EVENT:

Date Event(s) Identified or Referred:

Timeline Documentation/Validation:

LEVEL OF HARM: ☐ None ☐ None Detected ☐ Minimal ☐ Moderate ☐ Severe ☐ Death

Primary Level of Review Completed By: Date of Review:

PLAN: Managed by Trauma Program Manager: Date:

SECONDARY LEVEL OF REVIEW

EVENT IDENTIFIED:

LEVEL OF HARM CONFIRMED: ☐ None ☐ None Detected ☐ Minimal ☐ Moderate ☐ Severe ☐ Death

System-Related Event	Provider-Related Event
Patient-Related Event	Staff-Related Event

SECONDARY LEVEL OF REVIEW: IDENTIFIED OPPORTUNITIES FOR IMPROVEMENT

SECONDARY LEVEL OF REVIEW: DEFINED CORRECTIVE ACTION PLAN(S):

System-Related Event	Provider-Related Event
Patient-Related Event	Staff-Related Event

Additional Discussion:

Reviewed by Trauma Medical Director: Date:

Closed by Medical Director: ☐ YES ☐ NO

REFERRED FOR TERTIARY/THIRD LEVEL OF REVIEW

Regional Advisory Council Performance Improvement Committee Date:_____

EMS Performance Improvement Committee: Date: _____

Trauma Peer Committee Review: Date: _____

Reason for Referral to Peer Review:

Subspecialties Involved:

DISCUSSION:

OPPORTUNITIES FOR IMPROVEMENT:

Trauma Multidisciplinary System Committee Review: Date:

Reason for Referral to Multidisciplinary System Committee:

Departments Involved:

Subspecialty Service Involved:

Opportunity for Improvement Identified: __Yes __No

See Multidisciplinary System Committee Agenda and Minutes for Meeting (Date):

QUATERNARY/FOURTH LEVEL OF REVIEW

Referred to: Date:

Reason for Referral:

OPPRTUNITIES FOR IMPROVEMENT:

CLASSIFICATIONS

Determination: ☐ Morbidity/Mortality without Opportunity for Improvement
☐ Morbidity/Mortality with Opportunity for Improvement
☐ Morbidity/Mortality with Regional Opportunity for Improvement
☐ Unable to Determine

SELECTED ACTION PLAN (SMART GOAL FORMAT:

Established workgroup: Date:

Goal:

Develop / Revise Management Guideline: Date:

Goal:

Other: Date:

Goal

DEFINE DATA MONITORED TO TRACK CORRECTIVE ACTION PLAN's PROGRESS AND NEEDED CHANGE:

Frequency of Reporting to Trauma Systems Committee: ☐ Monthly ☐ Quarterly ☐ Other

If "Other," please define:

Updates:

EVENT RESOLUTION ACHIEVED: ☐ YES ☐ NO **DATE ACHIEVED:**

RESOLUTION DEFINED BY:

Comments:

Additional Actions Defined: