TRAUMA SURGEON

EMS Run Sheet

Trauma Flow Sheet (either electronic or scanned)

Trauma H&P

Evidence of time all consultants were notified and when they responded. Also – if there is separate documentation that a consultant participated in the decision-making, viewed images, etc. (especially for second-tier activations), this virtual participation time is very helpful (to the surveyors and to the hospital)

All consultation reports (within the first 12 hours)

All operative or procedure notes

Anesthesia records including PACU

Critical care progress notes

Transfusion records (products, times)

Committee meeting minutes

Need to see how issues were identified (random anecdotal report, audit filter violation, concurrent review during rounding, random medical record review, or in association with death review.

Communication from TMD to provider (asking questions) and their response. Then committee discussion.

We need to see what was DONE (not planned) to protect future similar patients from whatever adversity was being discussed.

If a death, was it anticipated or unanticipated? And was there or was there not an OFI identified by the PI process?

Discharge Summary

**QI reviews of cases that involved concerns with ED care and outcomes/loop closure

NEUROSURGEON

Trauma H&P

Neurosurgery consult notes (within the first 12 hours)

ED trauma flow sheet or its digital equivalent documenting serial neuro exams in the ED

Time neurosurgery was called and responded if applicable

Total ED time and a summary of ED course of care

Any neurosurgical OP notes

Initial anesthesia evaluation and their surgical flow sheet

ICU intensivist and neurosurgery ICU notes (we will not review all, just a sample)

Initial PT/OT/SLP plan of care

Initial social services and or pastoral care notes

Quality process notes

Who reviewed (TPM, TMD, TQM, committee)

Their findings

Recommendations

Actions

Loop closure

Outcome

Access to relevant images (within the first 12 hours)
(Works best if directed by someone familiar with using the PACS system and at least be familiar with looking at CT/MRI of head and spine).

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EMERGENCY PHYSICIAN

EMS Run Sheet, Emergency Department H&P

ED Trauma Flow sheet with times of call and arrival of consultants

Time of ultrasound exam and when spinal precautions were removed

Length of stay for admitted trauma patients and for those discharged from the ED

Timing and type of blood products administered in the ED

Discharge summary

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TRAUMA NURSE

ED nursing focus:

1. Discharge Summary to review the flow of care and if any sentinel events are apparent
2. Trauma Flow:
    a. If Trauma alert called
    b. Team arrival times
    c. Arrival time and discharge time of patient
    d. Vital signs - frequency and completeness
    e. Neuro documentation if head/spine injury - frequency and completeness
        i. Nursing documentation-indicates flow of care/changes
        ii. Examples of how/if the nurse responded to a change in patient status
        iii. Summary of nursing documentation of patient condition on arrival and discharge

ICU nursing focus:

Goal: evidence of continuity of good nursing care, documentation of patient assessments per the center's ICU standards, timely documentation of communication to the appropriate physician of any significant clinical change and handoff shift to shift.

1. Trauma surgeon's or intensivist's Discharge summary to get overview of the patient's clinical course.
2. Summary graphics of vital signs, ICP, and neuro assessments. Circulation checks if extremity injury, vent settings and fluids and meds.
3. Nursing narrative strings looking for evidence of timely communication with MDs and critical thinking and appropriate actions.
4. Evidence of ongoing nursing assessments and necessary interventions during procedures i.e., CT scan.

OR review:

1. Timeliness to OR
2. Look for nursing documentation of patient condition
3. If case involves patients with decompensation or death in OR ask about the center's process, documentation, and PI.

PACU review:

1. Nursing admission assessment.
2. Validate the center's requirement for frequency of vital signs
3. Serial assessments, do these meet the patient's condition?
4. Confirm with navigator if there were any issues/complications in the PACU. If so, review PI that was performed on it

Acute Rehabilitation:

1. Were rehab resources ordered? If they were, timeliness of patient intake/assessment
2. Check if standard note or process.
3. Review rehab resources process:
    a. Do rehab team members attend multidisciplinary rounds – which team members attend?
4. SBIRT- who performs the screening? What tool is used (CAGE, AUDIT-C)? How is a consult for brief intervention obtained and documented?
5. Pastoral care, patient advocates, psychologists, other MSW consults-look at intake notes, look deeper depending on intake notes.
6. Review notes for family updates and involvement in GOC.
7. Where does Hospice, Palliative Care, and geriatric services fit in.? Review services and complicated placements

PI on all cases reviewed will be read. Any PI documentation on the patient including adverse events or care that triggers audit filter.

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