

TRAUMA PIPS AUDIT FILTER REPORT

TRAUMA PROGRAM – Performance Improvement & Patient Safety (PIPS)

1. Description:

Pt Name: _____ Gender: Male Female

Acct #: _____ Age: _____ Initial GCS in ED: _____

ED Arrival Date: _____ ED Disposition: ICU PCU Floor OR
 Morgue Transfer Home/ Jail

Hosp Discharge Date: _____ ISS: _____ NISS: _____

Trauma Activation Level: Alpha Bravo Trauma Consult None

Mechanism of injury: MVC MCC MPC ORV Pedal-cyclist Machine
 Fall High Fall (>6 ft) GSW Stabbing Other Assault Sports
 Other: _____

Diagnoses:

| | |
|-----|-----|
| 1.) | 2.) |
| 3.) | 4.) |
| 5.) | 6.) |

Operations:

| | |
|-----|-----|
| 1.) | 2.) |
| 3.) | 4.) |

Audit Filter(s) under review:

| | |
|-----|-----|
| 1.) | 2.) |
| 3.) | 4.) |

2. Disposition on Trauma AUDIT FILTER(s) or COMPLICATION(s):

| | |
|--------------------------|------------------------------|
| <input type="checkbox"/> | Acceptable |
| <input type="checkbox"/> | Acceptable with Reservations |
| <input type="checkbox"/> | Unacceptable |

| 3. CONTRIBUTING FACTORS | | Comments |
|--------------------------|--------------------------------------|----------|
| <input type="checkbox"/> | Delay in Diagnosis | |
| <input type="checkbox"/> | Error in Diagnosis | |
| <input type="checkbox"/> | Error in Judgment or Interpretation | |
| <input type="checkbox"/> | Error in Technique | |
| <input type="checkbox"/> | Deviation from Protocol or Guideline | |
| <input type="checkbox"/> | Inadequate Protocol | |
| <input type="checkbox"/> | System Factor | |
| <input type="checkbox"/> | Other Factor | |
| <input type="checkbox"/> | Patient Disease | |
| <input type="checkbox"/> | Care Appropriate | |
| <input type="checkbox"/> | Care Not Appropriate | |

| 4. ACTION/ FOLLOW-UP/ LOOP CLOSURE | |
|--|-------------------------|
| Action Recommended: | Loop Closure Completed: |
| <input type="checkbox"/> None required | |
| <input type="checkbox"/> Individual counseling | |
| <input type="checkbox"/> Education/ Training | |
| <input type="checkbox"/> Case Presentation | |
| <input type="checkbox"/> Guideline/Protocol development | |
| <input type="checkbox"/> Update/Change/ Acquire new equipment | |
| <input type="checkbox"/> Evaluate staffing/FTE's | |
| <input type="checkbox"/> Forward to Quality Management Committee (QMC) | |
| <input type="checkbox"/> Forward to Other Dept./Individual for review | |
| <input type="checkbox"/> Track/Trend | |
| <input type="checkbox"/> Other (Specify): | |

Reviewer's initials _____ Date: _____

Reviewer's Name (PRINT): _____

Thank you for taking the time to review this case and for assisting the Trauma Program with Trauma Performance Improvement efforts.