MINNESOTA
STATEWIDE TRAUMA SYSTEM

Trauma Performance Improvement

CASE REVIEW GUIDE

The questions in this guide are intended to advise the trauma program manager/coordinator in the review of a trauma case by suggesting the types of inquiries to make. It is not meant to be used as a checklist, but rather a guide.

Primary Review

- What went well?
- What didn't go well?
- Did any filters fall out/were metrics missed?
- Were there delays…
  - Activating the trauma team?
  - In the sequence of care and decision making?
  - Obtaining imaging or other diagnostic test or reports?
  - Making the decision to transfer?
  - Transferring the patient?
    - Finding a transferring ambulance service?
    - Obtaining prompt acceptance from a receiving facility?
    - Due to patient/family decision making?
- Did the patient meet TTA criteria? If so, was the team activated?
- Did the nursing care conform to industry and acceptable practice standards?
- Did the physician/provider care conform to industry and acceptable practice standards? What do you want the TMD to evaluate or address in addition to their review?
- What follow-up or investigation did you undertake? What did you learn?
- Were there opportunities to have done things differently? If the same patient came back tomorrow, would you want things to go differently? If so, what?
- Does something need to change or improve? If so, what actions should be taken?
- What action do you recommend for this case?
  - Further investigation
  - Close—no action needed
  - Refer to TMD
  - Create action plan(s) for identified issues(s) that should be improved
    - What must change to facilitate the needed improvement?
    - What activities should be undertaken to facilitate that change?

Medical Director Review

- What went well?
- What didn't go well?
- Did any filters fall out/were metrics missed?
- Were there delays
  - Activating the trauma team?
  - In the sequence of care and decision making?
  - Obtaining imaging or other diagnostic test or reports?
  - Making the decision to transfer?
  - Transferring the patient?
    - Obtaining prompt acceptance from a receiving facility?
    - Due to patient/family decision making?
- Did the patient meet TTA criteria? If so, was the team activated?
- Did the physician/provider care conform to industry and acceptable practice standards?
- What follow-up or investigation did you undertake? What did you learn?
- What do you think about the TPMs findings? Are the findings valid? Do you agree with their conclusions?
- Were there opportunities to have done things differently? If the same patient came back tomorrow, would you want things to go differently? If so, what?
- Does something need to change or improve? If so, what actions should be taken?
- What action do you recommend for this case?
  - Further investigation
  - Close—no action needed
  - Create action plan(s) for identified issues(s) that should be improved
    - What must change to facilitate the needed improvement?
    - What activities should be undertaken to facilitate that change?
  - Refer to tertiary case review committee
  - Refer to other hospital committee (e.g., Quality, Med. Staff, Executive)

Tertiary Case Review

- Why is the case being referred to the tertiary case review committee?
  - Interesting case?
  - Possible clinical care or process issue identified?
  - Complaint?
- What does the committee think about the care?
- What went well?
- What didn't go well?
- Did any filters fall out/were metrics missed?
- Were there delays
  - Activating the trauma team?
  - In the sequence of care and decision making?
  - Obtaining imaging or other diagnostic test or reports?
  - Making the decision to transfer?
  - Transferring the patient?
    - Finding a transferring ambulance service?
    - Obtaining prompt acceptance from a receiving facility?
    - Due to patient/family decision making?
- Did the nursing care conform to industry and acceptable practice standards?
- Did the physician/provider care conform to industry and acceptable practice standards?
- What did the committee think about the review of this case performed by those before them? Are their findings valid? Does the committee agree with their conclusions?
- Are there opportunities to have done things differently? If the same patient came back tomorrow, would the committee want things to go differently? If so, what?
- What action does the committee recommend for this case?
  - Close—no action needed
  - Create action plan(s) for identified issues(s) that should be improved
    - What must change to facilitate the needed improvement?
    - What activities should be undertaken to facilitate that change?
  - Refer to other hospital committee (e.g., quality, med. staff, executive)

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