Level 3 Inpatient Trauma PI Review Form

Demographics	Source of Information	Location
Last Name: Medical record #: Date of report	☐ Floor RN ☐ Inpatient RN Supervisor ☐ Other _____	☐ MS ☐ ICU ☐ Other _____

Admission Date: _____ **Discharge Date:** _____

Admission diagnoses/injuries: _____

_____

Patient Co-Morbidities: _____

_____

Disposition:
- ☐ Discharge to home
- ☐ Discharge to SNF
- ☐ Discharge to rehab
- ☐ Transfer (Reason:_____)
- ☐ Died

Admission Details:

☐ Admitted with a *Table 3* Condition:
- ☐ Hemothorax or Pneumothorax requiring a thoracostomy
- ☐ Sternum or scapula fracture
- ☐ Pelvic fracture (not isolated rami fractures)
- ☐ Three or more rib fractures
- ☐ Pulmonary Contusion
- ☐ Significant Fall:
  - ☐ >15 feet
  - ☐ >65 years old and fall from elevation or downstairs
  - ☐ Pediatric (<10 years old): >2 x patient's height

Admission with/for:

☐ Non-*Table 3* injury: _____

☐ Pain control only ☐ PT/OT ☐ Placement ☐ Palliative Care

☐ Care for Medical Condition: _____

☐ Other:_____

Admitting Provider: _____**Admitting Service:** _____

Surgery Consult: ☐ Yes ☐ No **Consulting Provider:** _____**Time of consult:** _____

Consult within 18-hours ☐ Yes ☐ No—If no, why? _____

Did the patient meet transfer criteria and be admitted locally? ☐ Yes ☐ No

If yes, why?_____

Was the patient admission appropriate in accordance with our admission policy? ☐ Yes ☐ No

If no, Identify conflict: _____

Admission orders used/appropriate? _____

_____

_____

_____

Did the patient decompensate during their stay? ☐ Yes ☐ No Time of Decompensation: _____
Which decompensation indicator was identified?

☐ Hypotension or decreasing blood pressure ☐ Fluctuating or increasing heart rate ☐ Diaphoresis or pallor
☐ Increasing agitation or anxiety ☐ fluctuating or worsening level of consciousness or mental status
☐ Increased work of breathing, shortness of breath or tachypnea, respiratory compromise/Intubation
☐ Compartment syndrome ☐ Neurologic decline ☐ Other: _____

Transfer:

Was the patient transferred? ☐ Yes/ ☐ No; If yes, Time EMS called: _____ time transfer occurred: _____

Name of transfer facility: _____

Did patient arrive at definitive care within 120 minutes of decompensation, if transferred: ☐ Yes/ ☐ No/ ☐ Unknown

Performance Improvement Findings and Actions:

Were there any complications during the admission? ☐ Yes/ ☐ No

If yes: _____

_____

Primary Review		**Secondary Review**	
Are there any patient care opportunities regarding the inpatient care?		Are there any patient care opportunities regarding the inpatient care?	
What follow up is needed or was completed? (Include dates and details)		What follow up is needed or was completed? (Include dates and details)	
Signature:	Date:	Signature:	Date: