Run trauma records using ICD 10 codes: **S00-T79.9**

4-6 weeks prior to your review, you need to provide the required Excel spreadsheet of list of trauma patients for the review year to the Trauma System Manager.

Flag the following:

- All Deaths
- All Transfers Out
- All admitted patients
- Pediatric patients < 15 years of age
- No Trauma Team Activations

Ten charts/cases will be chosen and those will be the charts you need to prepare for the onsite review team.

Please have paper copies of the following for each chart, if applicable:

- EMS trip sheet (if applicable)
- Trauma flow sheet, if used
- All ED documentation
- Provider's dictation
- History & Physical
- Discharge summary/transfer
- Follow-up from receiving facilities
    - Performance improvement associated with each case
    - Peer review, if applicable, with each case

Once the medical record is read, the reviewer would like to see the corresponding completed performance improvement documentation for that specific patient which may include meeting minutes where the case was reviewed. Any outcomes from performance improvement such as education provided or guideline development should be included. Optimally, the performance improvement documentation accompanies each separate trauma medical record.

- ☐ The electronic medical record (if applicable) is available to look up anything additional (lab results, radiology results, surgery/OR and ICU documentation etc…)
    - If electronic chart, please have one computer and one staff member available to help navigate the electronic chart for each reviewer.