

Big Country Regional Advisory Council TSA-D
Performance Improvement Form
~ EMS Provider ~

Date: _____

Name of Entity: _____

Person
 Completing Report: _____

<u>Reporting Period</u>	<u>Due Date</u>
___ (Jan → Mar)	April 30
___ (Apr → Jun)	July 31
___ (Jul → Sep)	Oct 31
___ (Oct → Dec)	Jan 31

Performance Improvement Criteria / Indicators		
1	Number of times scene time > 20 minutes for an injury-related call this quarter.	
2	Number of trauma related pediatric resuscitations.	
3	Number of patients that met the RAC-D definition of "Major Trauma" that were transported to hospitals outside of RAC-D this quarter.	
4a	Number of trauma-related patients pronounced dead on scene this quarter.	
4b	Number of non-preventable trauma deaths this quarter.	
4c	Number of potentially preventable trauma deaths this quarter.	
4d	Number of preventable trauma deaths this quarter.	
8a	Number of times Air Medical Services requested but unable to respond this quarter.	

Specific Occurrence Report		
Age: _____	Gender: _____	Chart Identification #: _____
Mechanism of Injury:		
Identified injuries and pertinent information:		
Patient Outcome:		
Provider Discussion:		
Contributing Factors: <input type="checkbox"/> Inadequate system guidelines/ protocols <input type="checkbox"/> Multiple patients <input type="checkbox"/> Extrication <input type="checkbox"/> Hospital diversion <input type="checkbox"/> Other:		

Please do not fill in this section – For RAC-D PI Committee Review	
___ No negative outcome ___ Minor negative outcome ___ Significant system performance error ___ Major deviation from desired system performance ___ Unable to determine	Standard of Care Met? Yes / No ___ RAC-D guidelines followed ___ Minor deviation from RAC-D guidelines ___ Significant deviation from RAC-D guidelines ___ Major deviation from RAC-D guidelines ___ Unable to determine
Action Plan ___ No action needed ___ Review with hospital or EMS provider ___ Track and Trend ___ Education ___ RAC-D guideline review	___ Hospital / EMS action plan requested ___ Refer to Texas DSHS ___ Assign to workgroup ___ Request closed Executive Committee review ___ Other: _____

Please complete and return to:

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