

**UCSF DEPARTMENT OF SURGERY
QUALITY IMPROVEMENT CASE REVIEW REPORT**

Service GS: Oncology

To be completed by
housestaff/attending

Part I

Patient Name		MR#	DOB
Operation(s) Performed		Preoperative Diagnosis	
Date(s) of Operation(s)		Attending Surgeons(s)	MD#(s)
Date(s) of Occurrence(s)		Housestaff Surgeon(s)	MD#(s)
Occurrence(s): select all that apply		Service specific occurrence(s): select all that apply	
<input type="checkbox"/> Death	<input type="checkbox"/> Wound disruption	<input type="checkbox"/> Persistent hyperparathyroidism	<input type="checkbox"/> Hepatic insufficiency
<input type="checkbox"/> Lasting organ failure	<input type="checkbox"/> Bleeding/ transfusion	<input type="checkbox"/> Hypocalcemia	<input type="checkbox"/> Pancreatic fistula
<input type="checkbox"/> Unplanned return to OR	<input type="checkbox"/> Deep vein thrombosis	<input type="checkbox"/> Airway obstruction	<input type="checkbox"/> Trocar site injury
<input type="checkbox"/> Unplanned readmission	<input type="checkbox"/> Pulmonary embolism	<input type="checkbox"/> Anastomotic leak/ stricture	<input type="checkbox"/> Band malposition/ malfunction
<input type="checkbox"/> Unplanned ICU care	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Negative/ nontherapeutic laparotomy	<input type="checkbox"/> Seroma/hematoma
<input type="checkbox"/> Surgical site infection	<input type="checkbox"/> Respiratory failure/ intubation	<input type="checkbox"/> Bowel obstruction	<input type="checkbox"/> Other:
<input type="checkbox"/> Deep infection	<input type="checkbox"/> Acute renal failure	<input type="checkbox"/> Biliary leakage/ stricture	
<input type="checkbox"/> Sepsis/ septic shock	<input type="checkbox"/> Cardiac arrest/ CPR		
<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Myocardial infarction		
Narrative of Case: _____ _____ _____ _____			
Occurrence related to: select all that apply			
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Underlying disease	<input type="checkbox"/> Systems problem	
<input type="checkbox"/> Surgical technique	<input type="checkbox"/> Abnormal anatomy	<input type="checkbox"/> Management	
<input type="checkbox"/> Other:	<input type="checkbox"/> Equipment malfunction		
Form completed by:		date	
Signature of attending		date	

To be completed by
Section QI Chief

Part II

Service Action Plan: <input type="checkbox"/> No further action <input type="checkbox"/> Systems review <input type="checkbox"/> Root cause analysis <input type="checkbox"/> Other:
Narrative of Plan: _____ _____ _____ _____
Date of review by Service QI Committee
Signature of Service QI Chief
date

To be completed
by Dept QI

Part III

QI COMMITTEE REVIEW	Date of review
Discussion: Physician issue(s) <input type="checkbox"/> yes <input type="checkbox"/> no Systems failure <input type="checkbox"/> yes <input type="checkbox"/> no Complication management appropriate <input type="checkbox"/> yes <input type="checkbox"/> no	
Narrative of Plan: _____ _____ _____ _____	
Action: <input type="checkbox"/> No Action <input type="checkbox"/> Peer review <input type="checkbox"/> Refer to other service <input type="checkbox"/> RCA <input type="checkbox"/> Systems review <input type="checkbox"/> Other:	
Signature of QI Chair/date	