Confidential For Peer Review Purposes Only

HOTRAC Regional Maternal Performance Improvement Indicators

Review all expectant mothers w/traumatic labor, transferred, hemorrhage, deaths.

Facility Name: _____ **Name of person completing form:** _____

MR #/Chart #: _____ **Admit date:** _____ **Discharge date:** _____

Race/Ethnicity: □ **Caucasian (non-Hispanic)** □ **Hispanic** □ **African American** □ **American Indian** □ **Asian** □ **Native Pacific Islander**

Patient Age: _____ **Date of Birth:** _____ □ **Inpatient** □ **Emergency Department**

Chief Complaint/MOI/
Patient Diagnosis/ Injuries: _____

Mode of Arrival (If ED visit): □ POV □ Ground _____ □ Air _____

**ALL "YES" RESULTS ARE INDICATORS AND REQUIRE REVIEW

Performance Improvement FILTER	YES	NO	COMMENTS
1. Was patient transferred to a facility outside of TSA-M?			If so, Why? _____ Where? _____
2. Was transfer of patient delayed by transportation issues?			If so, how?
3. Was patient transferred into the facility?			If so, why? _____
4. Was patient diverted by or difficulty transferring to a higher level of care?			If so, Why? _____ Where? _____
5. Was birth outside of the facility setting?			☐ Home ☐ EMS Unit ☐ Other: _____
6. Was the patient's labor/birth induced by a traumatic event?			
7. Did the mother test positive for drugs at delivery?			If so, was CPS contacted? ☐ Yes ☐ No If so, did baby test positive? ☐ Yes ☐ No
8. Did patient have a hemorrhage?			
9. Did patient die?			
10. Other issues or concerns.			

Mode of Departure: □ POV □ Ground _____ □ Air _____

Clinical Reviewer signature: _____