Trauma Program Performance Improvement & Patient Safety (PIPS)

LOOP CLOSURE DOCUMENTATION FORM

Is this a Provider Issue or a System Issue? _____

Issue(s):
Recommendation(s)/ Action Plan: (What changes do you recommend/ expect and how should this be accomplished?)
Names of Individuals with whom this was discussed, including dates/times:
Comments: Please comment on any relevant information not included in the above.

Signatures *and Acknowledgement*

_____ Date & Time _____
Provider/ Practitioner/ Staff Member (If appropriate)

_____ Date & Time _____
Provider/ Practitioner/ Staff Member (If appropriate)

_____ Date & Time _____
Person completing Loop Closure Documentation

For administrative use/ Loop Closure follow up and re-evaluation			
Metric to evaluate:			
Recommended follow-up frequency or date:			
Findings:			
Disposition: ☐ open ☐ closed	*Print Name:*	*Signature:*	*Date:*