COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: PROFESSIONAL STAFF PEER REVIEW DOCUMENTATION **POLICY NO. 616B**

PURPOSE:
To standardize the format for documentation of medical staff peer review for individual cases.

POLICY:
Harbor-UCLA Medical Center ensures that proper documentation of clinical case discussion related to writing medical staff peer review committee minutes is essential. This policy describes the appropriate format. Confidentiality of peer review related documents is as described in Policy #616C "Professional Staff Association Credentials, Files and Related Information".

PROCEDURE:

A. New cases reviewed by medical staff peer review committees must be documented including the following information:
   1. Patient's medical record number.
   2. Date of admission and discharge or death for inpatients; relevant dates of service for outpatients.
   3. Attending physician(s) associated with the care (employee or contractor numbers only).
   4. Resident(s) associated with the care (employee or contractor numbers only).
   5. Date of complication, when applicable.
   6. Additional information for case discussion:
      a. Reason for discussion; e.g., complication, death, etc.
      b. Brief case presentation and discussion.
      c. Conclusion(s) reached following discussion; e.g., opportunities identified to improve care; whether the event was preventable. Include factors that may have contributed to the complication or death, such as problems related to systems, equipment, policies or personnel/ staff. See (**ATTACHMENT A**) on page 3 for sample documentation.

B. In order for a peer review committee to close an individual case, one of the following provider categories must be used to summarize the conclusion of provider management:

Category 0	Clinical practice/treatment by the providers within this department was appropriate.

EFFECTIVE DATE: 10/28/91 **SUPERSEDES: 07/15**
REVISED: 9/96, 5/04, 12/06, 10/11, 1/12, 7/15, 11/15, 3/19
REVIEWED: 10/92, 2/96, 9/96, 12/98, 2/02, 5/04, 10/06, 1/09, 1/12, 6/15, 1/19, 3/19
REVIEWED COMMITTEE: Peer Review Oversight Committee (PROC)

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Nancy Blake, PhD, RN, NEA-BC, FAAN
Chief Nursing Officer

Category 1	Questionable clinical practice/treatment which was not clearly inappropriate.
Category 2	Clinical practice/treatment was inappropriate and had low probability of causing patient harm.
Category 3	Clinical practice/treatment was inappropriate and had high probability of causing patient harm.
Category N/A	There was no question of the clinical care by providers within this department. This case may have been reviewed because of a discrete question to be answered or for data monitoring purposes. **Note:** If the care provided by providers in this department was appropriate, Category 0 should be assigned, not N/A).

In addition, there should be a determination of the associated attending physicians' involvement and supervision in the care; i.e., direct involvement, supervisory, or unknown as documented in the medical record.

Department of Radiology: The Department of Radiology uses a different 3-tiered peer-review scale as recommended by the American College of Radiology called RADPEER (described below) but converts its scores to correspond with the provider categories described above as follows:

RADPEER Score	Provider Category
1	0
2	1
3a	2
3b	3
N/A	N/A

RADPEER Scoring System

Score 1 - Reviewer concurs with interpretation/patient care

Score 2 - Reviewer identifies a discrepancy in interpretation/patient care which would not ordinarily be expected to be made (i.e., an understandable misread)

Score 3a - Reviewer identifies a discrepancy in interpretation/patient care which should not be made most of the time, but is unlikely to be clinically significant

Score 3b - Reviewer identifies a discrepancy in interpretation/patient care which should not be made most of the time, and is likely to be clinically significant

Note: The term "patient care" includes procedural complications and the timeliness of communication of test results to appropriate clinical staff.

C. One of the following systems codes must be assigned by the peer review committee (or designee) in order to close each case.

Category A No systems contribution to any defects in care provided.

Category B There was a minor systems contribution to defects in care.

Category C There was a major systems contribution to defects in care.

D. Recommendations/Actions to further evaluate or correct identified problem:

- None - Care appropriate
- Follow-up to be presented at a future meeting (e.g., additional information, input from other staff members, autopsy findings, etc.),
- Coaching of involved physician or other staff person to address human error or at risk behavior, or disciplinary action for behavior that was deemed reckless in accordance with the LA County DHS Just Culture policy #311.4
- Educational conference to be convened
- Referral to another committee or department
- Referral to Chairperson, Medical Director or Division Chief
- Development of new or revised policy
- Referral to the Peer Review Oversight Committee (PROC)
- Other

Revised and Approved by:
Medical Executive Committee - 3/19

Janine R. E. Vintch, M.D.
President, Professional Staff Association

ATTACHMENT A

TOPIC	DISCUSSION	FOLLOW-UP ACTION
Case #9999999 **Resident M.D. e123456** **Attending M.D. c987654321**	Case was discussed due to intraoperative death of a 7-year-old female with hypoplastic left heart syndrome. The patient underwent a Norwood Procedure to improve her systemic flow. It is a combined outflow procedure from the left to the right ventricle. Eight to ten hours postoperatively the patient arrested. She was resuscitated but died one day later. Documentation revealed attending physician actively involved in the case. Conclusion following case discussion was that the cause of death may have been secondary to iatrogenic fluid overload and hypercalcemia. Post mortem is still pending. (Category 3) Recommendation: Chief Resident will report post mortem findings 10/25. An in-depth review of the I and O of this patient will be performed if fluid overload is identified. Also, suggestions on ways of preventing this complication will be presented to this committee by Chief Resident on 11/2. Systems of care were evaluated and it was determined that the lack of a device with capability to monitor CVP in the PACU may have contributed to this case. (Category B)	Chief Resident to report post-mortem findings 10/25. Chief Resident to report back 11/2.
Case #8888888 **Resident M.D. c0000001** **Attending M.D. e11111111**	Case was discussed due to finding of normal appendix at exploration in a 7 year old male with a diagnosis of appendicitis. The child was symptomatic pre-operatively with fever 102, WBC 23,000 and RLQ tenderness. Attending physician had supervisory involvement. Conclusion: Care was found to be appropriate considering the child's clinical presentation pre-operatively. (Category 0). No systems problems were identified, (Category A)	None necessary.