I. PURPOSE

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care. This policy covers all medical staff members as identified in the Medical Staff Bylaws. The term "physician" will be used in this document to represent all Medical Staff Members. Efforts are made to both evaluate individual physician performance as well as to improve the system of care.

Throughout this Policy, the phrase "Professional Practice Evaluation" replaces the traditional phrase "Peer Review." This policy refers to the records and proceedings of the Medical Staff, which has the responsibility of evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings of the Medical Staff that relate to this Policy in any way are protected from discovery pursuant to California Evidence Code, Section 1157.

Goals:

A. Identify opportunities for practice and performance improvement of individual physicians who have privileges in the Hospital.
B. Monitor clinical performance of Medical Staff physicians.
C. Monitor for significant trends in performance by analyzing aggregate data and case findings.
D. Assure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful.
E. Improve the quality of care provided by individual physicians.
F. Identify and help execute system-wide improvement, addressable by focused project teams and enterprise-wide performance improvement efforts.

II. POLICY STATEMENT

It is the policy of Lucile Packard Children's Hospital Stanford (LPCHS) to comply with statutory and regulatory requirements regarding ongoing professional practice evaluation and focused professional practice evaluation. Ongoing data review and findings of physician practice and performance are evaluated by professional practice evaluation committees with a focus on improvement. The findings of those committees are used to assess the quality of care of individual physicians.

III. DEFINITIONS

A. Professional Practice Evaluation
   1. Ongoing Professional Practice Evaluation (OPPE) is a program that allows the medical staff to identify professional practice trends that have an impact on quality of care and patient safety on an ongoing basis.

The program includes:

a. Evaluation of an individual physician's professional performance and includes opportunities to improve care based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual physician's performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system.

b. Multiple sources of information including, but not limited to, the review of individual cases, the review of aggregate data, compliance with hospital policies, the Rules and Regulations of the Bylaws of the Medical Staff, clinical standards, and the use of rates compared against established benchmarks or norms.

c. Individual evaluation is based on generally recognized clinically appropriate care. This process provides physicians with feedback for personal improvement and/or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

2. Focused Professional Practice Evaluation (FPPE) is a process whereby the Medical Staff evaluates to a greater extent the competency and professional performance of a specific physician. FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to regulations afforded in the investigation process. If a FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.

   a. The proctoring program is a component of FPPE (see Proctoring policy). Proctoring for newly appointed medical staff members is managed by the Medical Staff Services Department.

   b. Focused review is a second component of FPPE. Focused review is used when questions arise regarding a currently privileged physician's ability to provide safe, high-quality patient care based on a pattern of reviews of individual cases, a pattern of not meeting targets on OPPE indicators, or in unusual situations, one case of significant clinical concern, as determined by the Care Improvement Committee, the Vice President of Medical Affairs (VPMA), the Associate Vice President of Medical Affairs (AVPMA), President of the Medical Staff, and/or Department Chair. (See sections V.C. Thresholds for focused review and V.B.1 for Performance Review Committee).

B. Peer

1. A "peer" is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.
2. The level of subject matter expertise required to provide meaningful evaluation of a physician's performance will determine what "practicing in the same profession" means on a case-by-case basis.

C. Professional Practice Evaluation Committees (PPEC)

1. The "Professional Practice Evaluation Committee(s)" are designated by the Medical Executive Committee or its designee to perform professional practice evaluation on an ongoing basis. The Service Chief, or his/her designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all professional practice evaluations performed by or on behalf of the hospital. See Appendix A for procedure.
2. See Appendix B for list of professional practice evaluation committees.

D. Conflict of Interest

1. A member of the Medical Staff asked to perform professional practice evaluation may have a conflict of interest if he or she is not able to render an unbiased opinion due to some substantive and quantifiable reason such as involvement in the patient's care or direct competition with the physician under review.
2. It is the individual reviewer's obligation to disclose the potential conflict to the professional practice evaluation committee.
3. The professional practice evaluation committee's responsibility is to determine whether the conflict would prevent the individual from participating and the extent of that participation if allowed.
4. Individuals determined to have a conflict may be present during the group discussion and professional practice evaluation. They will, however, be required to recuse themselves from voting on the rating of the case.

IV. PRINCIPLES

A. The PPE Process should be viewed as an engine for learning and systems improvement rather than judgment or punishment. Individual attribution of suboptimal care will be performed only when system errors are excluded, educational opportunities have been fully exploited, or trend of concerning issues is noted.

1. Member driven, with a significant increase in self-reporting
2. Transparent
3. Constructive
4. Dynamic
5. Focused on both team function, individual and team accountability
6. Intimately linked with Quality Improvement

B. Human Factors

1. To err is human. Therefore, humans delivering health care will occasionally make errors, and simple human error does not necessarily indicate substandard care or a substandard caregiver. However, we are all responsible to continually identify and implement means of minimizing the effects of human fallibility on the care of patients.
2. Except in rare cases of clearly unacceptable care, the medical staff organization's primary goal is to support fellow medical staff members in their ongoing efforts to improve their own quality of care; equally importantly we aim to assist in identifying and encouraging systematic improvements in our care processes, always with the goal of improving the overall quality of care at LPCHS.

C. Confidentiality

1. Professional Practice Evaluation information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws (including California Evidence Code Section 1157), and regulations pertaining to confidentiality and non-discoverability.
   a. Committee members will sign a statement of confidentiality at initial participation and annually thereafter.
   b. Attendance will be kept for each professional practice evaluation meeting and committee members unable to maintain at least 50% attendance over a year may be replaced.
   c. The hospital will keep provider-specific professional practice evaluation and other quality information concerning a physician in a secure location. Provider specific professional practice evaluation information includes information related to:
      (1) Performance data for all dimensions of performance measured for that individual physician.
      (2) The individual physician's role in sentinel events, significant incidents, or near misses.
      (3) Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.
   d. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a medical staff leader or hospital employee. They shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall

have access to provider-specific professional practice evaluation information, and only for purposes of quality improvement and as part of their official duties. The components of the quality file which are available are limited to the Performance Report (unless otherwise stated).

(1) VPMA, Associate VPMA, President and Vice President of the Medical Staff (complete file is available)
(2) Medical staff service chiefs for members of their division only (complete file is available)
(3) Care Improvement Committee
(4) The involved physician (as provided in the Medical Staff Bylaws)
(5) Hospital Risk Management
(6) Hospital quality staff who support PPECs
(7) Medical staff services professionals to the extent that access to this information is necessary for the reappointment or re-credentialing process or formal corrective action
(8) Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)
(9) Credentials Committee at the time of re-appointment or upon request of the Chair.
(10) Department Chair.
(11) Chief Quality Officer
(12) Chief Medical Office

e. No copies of professional practice evaluation documents will be created and distributed unless authorized by VPMA, Associate VPMA, or President of the Medical Staff or policy.

D. Reliability of Review Process

1. Professional practice evaluation is conducted in a manner that is objective, equitable, timely and consistent.
   a. Case selection is done by use of pre-determined indicators and referrals. See Appendix A, B1and B2.
   b. Objective screening per pre-determined criteria is part of the screening process for case identification.
   c. Review of cases is performed by the PPECs or CIC members in accordance with procedures listed in Appendix D, E
   d. Follow-up is conducted as identified in Appendix A. and will be reported to the Medical Executive Committee as needed.
2. The Care Improvement Committee (CIC) will evaluate reliability of Professional Practice Evaluation committees based on reports submitted to CIC.

V. OVERSIGHT AND REPORTING

A. Direct oversight of the professional practice evaluation process is delegated by the Medical Executive Committee to the Care Improvement Committee.

1. The Care Improvement Committee will meet at least quarterly Additional meetings will be held if warranted. The CIC will follow the process outlined in Appendix A of this document except that the attending physician is not required to attend the meeting unless he/she requests to participate or unless requested by the PPEC chair.
2. The Care Improvement Committee will review cases that were identified at the Service PPEC level as significant system/process and team function issues and also upon recommendation of the PPE Leadership Council which are rated by the service PPECs in any of the following ways:

   Old Causal Analysis
   a. Delay/Error in diagnosis
   b. System or process issue
   c. Complex cases (i.e. reviewed by several services, involvement across specialties, complex improvements identified, etc.)
   d. Discretion of PPE Program Manager

   New Causal Analysis
   a. 2 or more services involved or reviewed
   b. 7 or more checkboxes marked
   c. P3 (care coordination) and/or P4 (interface/handoff) marked
   d. CN1 (assumption) and/or CN2 (Interpretation) marked
   e. C4 (high reliability environment) and D1 (standards, policies, processes) marked
   f. Discretion of PPE Program Manager

   Case ratings
   a. Each case reviewed at the PPEC will be rated with causal analysis. Care at LPCHS Stanford is provided by interprofessional teams, and one individual is seldom responsible for outcomes independent of others. As such, the PPE process identifies whether the rating should be attributed to "teams" or to individual physicians.
   b. If individual physician performance concerns are raised, the PPEC co-chairs will refer the case to the Performance Review Committee (V. B)
3. The PPE Leadership Council is an adjunct to the CIC and consists of the VPMA, AVPMA and the PPE Program Managers. The Council meets at least quarterly. The PPE Leadership Council functions as an advisory council to the CIC on professional practice evaluation issues including, but not limited to:

a. PPEC case reviews to determine appropriate action plan, including referral to CIC, Service Chiefs, Administrative Committees, or Medical Executive Committee
b. Professional Practice Evaluation Policy review
c. Recommendation of OPPE or case review indicators
d. Educational needs of the Medical Staff identified through professional practice evaluation, i.e. informed consent

4. The CIC may affirm or change the causal analysis rating of the service PPEC or it may change the rating. The CIC rating is final.
5. The CIC reviews the actions taken by the service PPEC to identify whether further action is required. If further action is required, the CIC will identify the appropriate committee, service, hospital administrator or physician leadership for required follow-up.
6. The Care Improvement Committee will report to the Medical Executive Committee at least once each year.

B Performance Review Committee

1. This is an ad hoc committee formed when there is a case in which concerns are raised regarding significant physician performance issues. The committee will be composed medical staff leadership including VPMA, AVPMA, CMO, President of the Medical Staff, CQO, Service Chief of the involved physician(s), and may include other subject matter experts. The PRC will determine if any of the following actions are needed: 1) no action, 2) track and trend case rating by physician, 3) form an ad hoc PRC to review performance, 4) develop a Performance Improvement Plan and/or request an FPPE. All data will be maintained in a confidential database that will be available for continuous reporting and trending of physicians

C. Reporting of OPPE Data

1. Lucile Packard Children's Hospital Stanford developed a strategic plan to revise the institution's OPPE reporting system to be more aligned with national best practices and The Joint Commission requirements. The new OPPE reporting builds on the existing measurement framework, which is based on the ACGME core competencies: patient care, medical knowledge, professionalism, interpersonal and communication skills, and systems-based practice. This structure aims to provide a holistic evaluation of a physician's professional practice. The Care Improvement Committee (CIC) has responsibility for approval of generic metrics and targets.

   The OPPE report includes a combination of generic metrics that apply to all specialties as well as 2-4 specialty-specific metrics. The following are the generic metrics:

i. Timely Completion of H&P Note
ii. Timely Completion of Operative Report
iii. HIMS Suspensions
iv. Behavioral Events
v. Grievances
vi. Compliments
vii. Annual Education: Attestation

The OPPE reporting includes 2-4 specialty-specific metrics for each specialty to better represent the specialized care that each specialty provides. Specialty-specific metrics are being developed with the Service Chief and PPEC Co-Chairs for each specialty.

2. OPPE profiles will be distributed to the Service Chiefs and the individual physicians twice a year. Individual Physician Profiles will be in each physician's credentialing file to be used as an assessment of quality of care upon reappointment.

3. Requests for physician performance data, see "Confidentiality of Medical Staff/Advance Practice Professional Staff Records".
   a. Requests for physician performance data will be made by the individual physician in writing.
   b. The most recent Physician Performance Report in total will be shared as designated in the request. No partial reports will be provided

D. Targets for focused review:
1. The following are examples when a focused review as part of the FPPE process may be requested by the PPEC Co-Chair, Service Chief, VPMA, AVPMA, CMO, or CQO.
   a. Any single egregious case or sentinel event as judged by the VPMA, AVPMA, the CIC, or President of the Medical Staff or designee may result in a focused review.
   b. If a physician's individual performance exceeds the predetermined target for generic and/or specialty OPPE metrics indicator (see Appendix C).

2. Upon completion of the FPPE, the results will be shared with the physician under review, who will have the opportunity to submit a response, on such terms as the PRC Ad-Hoc committee shall establish. This will occur prior to the report to the Medical Executive Committee.
3. The results of this review will be presented to the Medical Executive Committee, and in summary to the Board of Directors.

E. Circumstances which may require external professional practice evaluation:

1. External professional practice evaluation will take place under the following circumstances if deemed appropriate by the Care Improvement Committee, VPMA, AVPMA, President of the Medical Staff, and/or designee.
   a. Cases involving litigation, or the potential for a lawsuit as determined by Risk Management.
   b. Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or PPEC and conclusions from this review will directly affect a physician's membership or privileges.
   c. Lack of internal expertise or conflict of interest – when no one on the medical staff has adequate expertise in the specialty under review or when the only physicians on the Medical Staff with that expertise are determined to have a conflict of interest regarding the physician under review as described above.
   d. New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
   e. Miscellaneous issues –the Medical Executive Committee or governing board may require external professional practice evaluation in any circumstances deemed appropriate by either of these bodies.
2. The Care Improvement Committee will inform the Medical Executive Committee when there is a request for external professional practice evaluation

VI. RELATED DOCUMENTS

A. Medical Staff Bylaws and Rules and Regulations of the Medical Staff
B. Joint Commission Hospital Accreditation Standards: Medical Staff
C. Confidentiality of Medical Staff/Advance Practice Professional Staff Records

VII. APPENDICES

A. Professional Practice Evaluation Process/Procedure
B. Diagram for Medical Staff Quality LPCHS
C. Indicator List by Division/Department
D. Professional Practice Evaluation Worksheet
E. New Causal Analysis Taxonomy Tool

VIII. DOCUMENT INFORMATION

A. Legal Authority/References
   1. Medical Staff Standards located in the Joint Commission Hospital Accreditation Standards
   2. California Evidence Code 1157

B. Author/Original Date
   December 11, 2006

C. Distribution and Training Requirements
   1. This policy resides in the Medical Staff Office Policy Manual for LPCHS.
   2. New documents or any revised documents will be distributed to physicians through the Medical Staff Office.

D. Review and Renewal Requirements
   This policy will be reviewed and/or revised every three years or as required by change of law or practice.

E. Review and Revision History
   1. Medical Staff Quality Assurance and Improvement Activities October 2002
   2. Medical Staff Professional Practice Evaluation Policy December 2006; September 2009; October 2012; October 2016

F. Approvals
   1. Medical Executive Committee LPCHS: April 12, 2007, September 19, 2009; November 8, 2012; October 14, 2016
   2. LPCHS Hospital Board: April 20, 2007, October 16, 2009, November 16, 2012; October 18, 2016, April 20, 2018

This document is intended for use by staff of Lucile Packard Children's Hospital Stanford.
No representations or warranties are made for outside use.
Not for outside reproduction or publication without permission.

Appendix A

Professional Practice Evaluation Process/Procedure

A. Professional practice evaluation committees
   1. A quorum is required for all committee actions, including case analysis, closure of summary cases, and performance improvement activities.
   2. A quorum is defined as a minimum of three members, excluding any members who have cases under review.
   3. PPECs (see Appendix B) that meet on a regular basis to review (at least 4 times per year).
   3. In addition to cases identified by case review indicators, cases may be reviewed based on specific referral criteria (see B2).
   4. Individual PPECs identify follow-up actions needed based on individual case review and/or identified trends.
   5. Follow-up actions identified by the PPECs are assigned to the appropriate committee, service, and hospital administrator or physician leadership. Communication of action plan taken is reported back to that PPEC.

B. Indicators for review (see Appendix B for listing by committee)
   1. Rule and rate based indicators identify individual instances of non-compliance with administrative or clinical processes.
      a. The Care Improvement Committee approves generic OPPE indicators for the medical staff. Service specific metrics for Practice Based Indicators are selected by individual divisions/departments in collaboration with the analytics department.
      b. Predetermined targets for each indicator are identified (see Appendix C).
      c. When a target is exceeded, the Service Chief determines if a focused review is indicated.
      d. Rule and rate based indicators are evaluated periodically to determine if the indicator(s) and target(s) should be modified.
   2. Individual case review
      a. Cases for individual case review will be based on "significant clinical events" identified by:
         (1) Pre-determined review indicators including, but not limited to, return to ICU within 24 hours, unexpected expiration, unplanned return to surgery, and complications of a procedure.
         (2) Incident reports
         (3) Patient/family grievances
         (4) Sentinel events and events required by regulatory agencies to be reported

(5) Referral from physicians or other clinicians
(6) Referral from Mortality and Morbidity Committee
(7) Referral from Risk Management
(8) Referrals from Patient Safety/iCare

b. Patterns/trends for a rule or rate based indicator exceeding a target may result in individual case review.

c. Once a case is identified for review, a determination is made on whether a full review or a summary review is needed. This decision is made with input from the committee chairpersons.
(1) All cases which are identified to be summary cases are summarized by the Professional Practice Evaluation Program Manager (PPEPM) from review of the medical record. When summary cases are presented to the committee, any committee member may request a full review, which will be conducted at the next PPEC meeting
(2) As with all cases, a quorum is needed to determine that no full review is needed. A quorum is at least 3 committee members.
(3) A case summary is written by the PPEPM for all cases which are identified for full review. These cases are then assigned to a physician reviewer as described below.

d. The physician involved in the care of the patient will be invited to attend the PPEC meeting and/or provide a written input for all cases identified for full review.

e. Each case for full review will be assigned to a PPEC member and/or content expert for presentation to the committee.
(1) The primary focus for the physician reviewer is on whether there were improvement and learning opportunities related to medical decision-making and systems independent of the outcome of care.
(2) The case analysis may be deferred if it is determined that more information is required.

f. Committee members perform an analysis of each case (See Appendix D and Appendix E). A consensus must be reached for case analysis.

g. The physician is informed in writing of the case analysis findings, improvement opportunities and follow-up actions.

h. If the physician does not agree with the committee causal analysis, he/she may submit his/her written objection to the PPE Leadership Council.

(1) The objection to the causal analysis is reviewed by the VPMA/ Associate VPMA. The VPMA/ AVPMA determines whether the case would benefit from an external review (see Section V.D.) or review by the CIC.

(2) If the case does not meet criteria for external review, the written objection to the causal analysis is included with the PPEC case analysis

C. Participants in the review process:

1. The Service Chief will select participants for individual PPECs. Each PPEC will have a defined membership, and will not be composed of the whole division/service. The membership will be subject to approval of the VPMA or AVPMA.
2. Divisions which have a substantial population of patients who have community attending physicians should have a community attending physician(s) identified as a committee member in addition to faculty physicians.
3. The Service Chief(s) will consider rotation of members at least once every three years.
4. The Service Chief shall appoint two Co-chairpersons for each PPEC with the approval of Care Improvement Committee. An evaluation of the term of appointment should occur every three to six years. A chair may be reappointed by the service chief for additional terms.
5. The work of all physicians granted privileges will be reviewed through the professional practice evaluation process.
6. Fellow and resident physicians may participate on the professional practice evaluation committees as part of their medical education, but they will be non-voting members. RNs and APPs may be invited to any PPEC to participate in team reviews as non-voting members (Old Causal Analysis). In the process of the New Causal Analysis, all members are voting members.
7. Care provided by fellow and resident physicians will be attributed to the attending/supervising physician during the evaluation and causal analysis.
8. In the event of a conflict of interest or circumstances that would suggest a biased review, the Professional Practice Evaluation Committee (PPEC) or the CIC will replace, appoint, or determine who will participate in the process, so that bias does not interfere in the decision-making process.
9. Allied health professionals may participate in the review process if deemed appropriate based on their job responsibilities.
10. Center for Pediatric and Maternal Value will provide the following support to the committee:
    a. Provide PPEC with data for defined indicators.
    b. Provide PPEC with cases for review.
    c. Provide staffing and/or consultation for each PPEC.

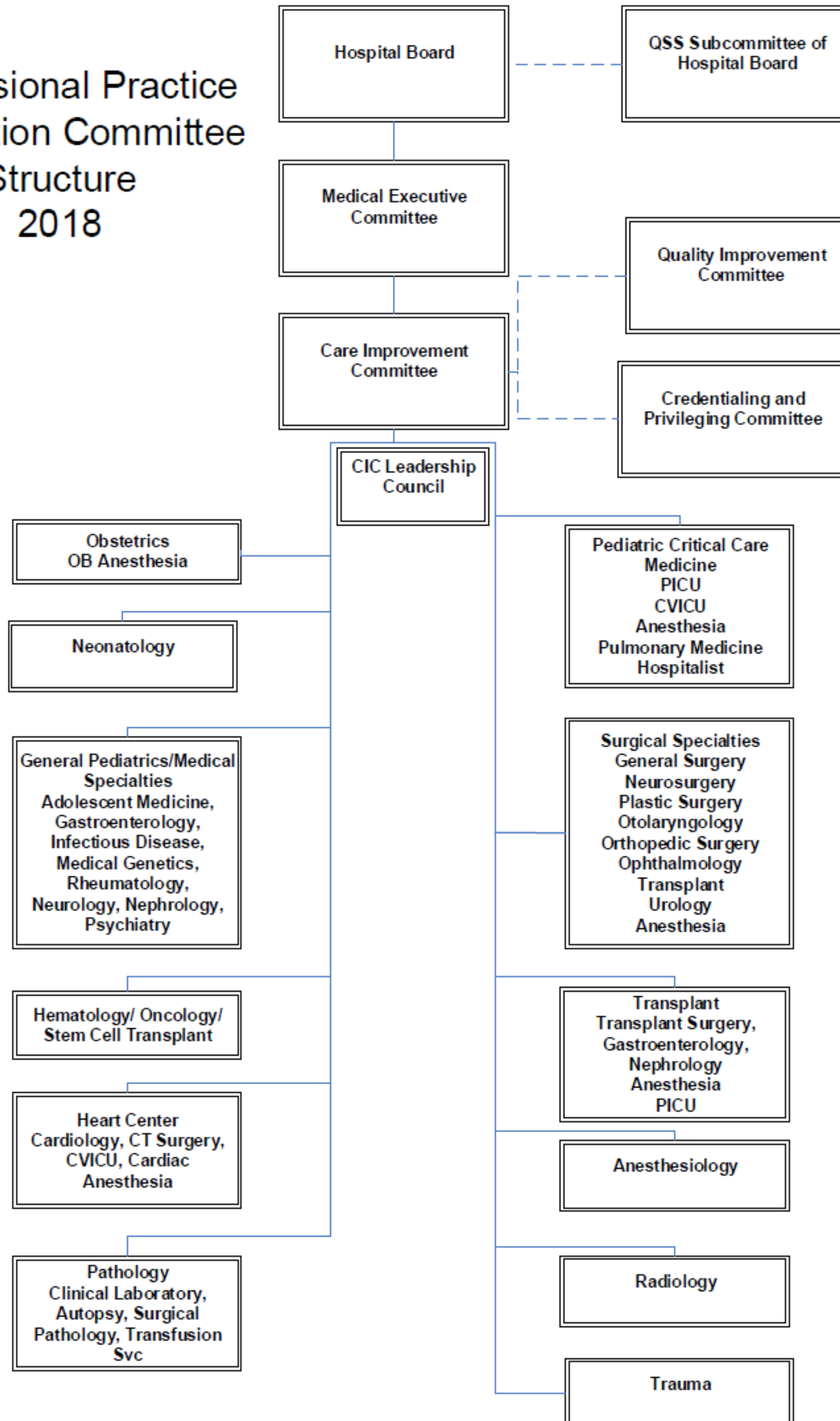
d. Advise Medical Staff as to what data is available.

e. Provide Medical Staff Office with OPPE data for physician performance reports and Physician Performance Improvement Plans and progress updates as appropriate

D. Professional practice evaluation time frames:

1. Professional practice evaluation will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the case is identified for review.
   a. Once a case is identified for review, it will be prioritized for review at the PPEC meeting.
   b. If the physician invited to the PPEC meeting has a conflict with the timing of the PPEC meeting, the physician may submit written input of his/her care provided in the case, or may request a postponement of the review for one month. After a one month postponement, the case will be reviewed with or without the presence of the physician(s) involved at the next meeting.
   c. For cases involving physicians on sabbatical, or for urgent cases which cannot be postponed, the timing of the review will be at the discretion of the Service Chief, or VPMA.
2. Complex cases may require additional review time beyond 90 days. The complex cases are monitored by the Center for Quality and Clinical Effectiveness. A complex case may be one where multiple services are involved, or one which requires external review for reasons identified in section V.D.

Appendix B



Appendix C

Indicator List by Division/Department

The Medical Staff at Lucile Packard Children's Hospital Stanford have selected the General Competencies and Expectations from the Accreditation Council for Graduate Medical Education (ACGME) as a framework for assessing the competency of each member of the medical staff. These competencies are also used for Board Certification. The following indicators have been selected for each competency, and will be used for all physicians. Each service may select additional indicators when appropriate.

Patient Care

Definition – Physicians are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.	**Target**
Indicator –Service specific metrics are selected by individual divisions/ departments.	**Per service specifications**

Medical Knowledge

Definition – Physicians are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences and the application of their knowledge to patient care and the education of others.	**Target**
Indicator – Most recent completion date of the annual education attestation. "Not available" indicates there is no completion date on file.	**N/A**

Practice Based Learning

Definition – Physicians are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve care.	**Target**
Indicator –Service specific metrics are selected by individual divisions/ departments	**Per service specifications**

Interpersonal Communication

Definition – Physicians are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the healthcare team.	**Target**
Indicator –Percentage of H&P notes in EPIC dictated ≤ 24 hours of admission	**≥ 90%**
Indicator – Total number of HIMS suspensions due to medical record incompletion	**≤ 3**

Professionalism

Definition – Physicians are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.	**Target**
Indicator – Patient Family Compliments in progress	**TBD**
Indicator – Patient Family Grievances	**≤ 1**
Indicator – Behavioral Events	**≤ 1**

System-based Learning

Definition – Physicians are expected to demonstrate an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize healthcare.	**Target**
Indicator –Service specific metrics are selected by individual divisions/ departments.	**Per service specifications**

Appendix D

CONFIDENTIAL QUALITY DOCUMENT
LUCILE PACKARD CHILDREN HOSPITAL
QUALITY REVIEW WORKSHEET

Service:	Source:	
MRN#:	☐ Clinical indicator	☐ Clinician reported
Patient Initials:	☐ Incident report	☐ Pathology
Incident Date:	☐ Patient complaint	☐ PCQCE referral
MD#:	☐ Referral from other service	☐ Risk Management referral
Indicator Codes:	☐ Other	

For every bold entry circled, briefly describe on back of form.
Every bold entry circled will be referred to the Care Improvement

Causal Analysis (Circle all that apply)

1. ***Delay in diagnosis/Error in diagnosis***
2. Error in technique
3. ***System or process issue (complete systems issues grid)***
4. Error in judgment
5. Patient non-compliance
6. Natural history of patient's disease
7. Policy compliance problem
8. Recognized complication of surgery, interventional procedure or treatment
9. Supervision/Delegation issue
10. Communication problem
    a. Hand-off communication between attending physicians
    b. Hand-off communication between attending physician and medical trainee
    c. Hand-off communication between attending physician and other healthcare team members
    d. Communication of critical/significant findings
    e. Communication with Patient/Family

Documentation (Circle all that apply)

1. No documentation issues
2. Incomplete or Inadequate (whether handwritten or printed)

Disposition/corrective action (Check appropriate box)

□ **No action required**
□ **Counseling**
Date provided;------------
□ **Education**
Date completed:------------
□ **Referral to Service Chief for MD Performance Improvement Plan (PIP)**
Date complete:______________
□ **Referral to Service Chief for Service Performance Improvement Plan (PIP)**
Date complete:______________

Section to be filled out after CIC review:
□ **Performance Improvement Plan** identified by CIC

Is this case a potential risk management issue/liability? □ Yes □ No

Systems Issues Grid	
Coordination of Care ☐ Lack of coordination between teams ☐ Goals of care not addressed ☐ Other	Human Factors ☐ Failure to recognize critical/significant changes in patient status ☐ Inadequate education/training/orientation ☐ Time pressure/fatigue ☐ Staffing/scheduling ☐ Other
Information Systems ☐ LINKS education or training ☐ LINKS interface ☐ PACS ☐ Pager/Cell phone ☐ Other	Processes: ☐ After hours/weekend ☐ Environment ☐ Equipment ☐ Medication administration and orders ☐ Policy Inadequate ☐ Lack of resources to adhere to policy

Brief description w/f/u action/referral/report back mechanism

MRN:__________________________________

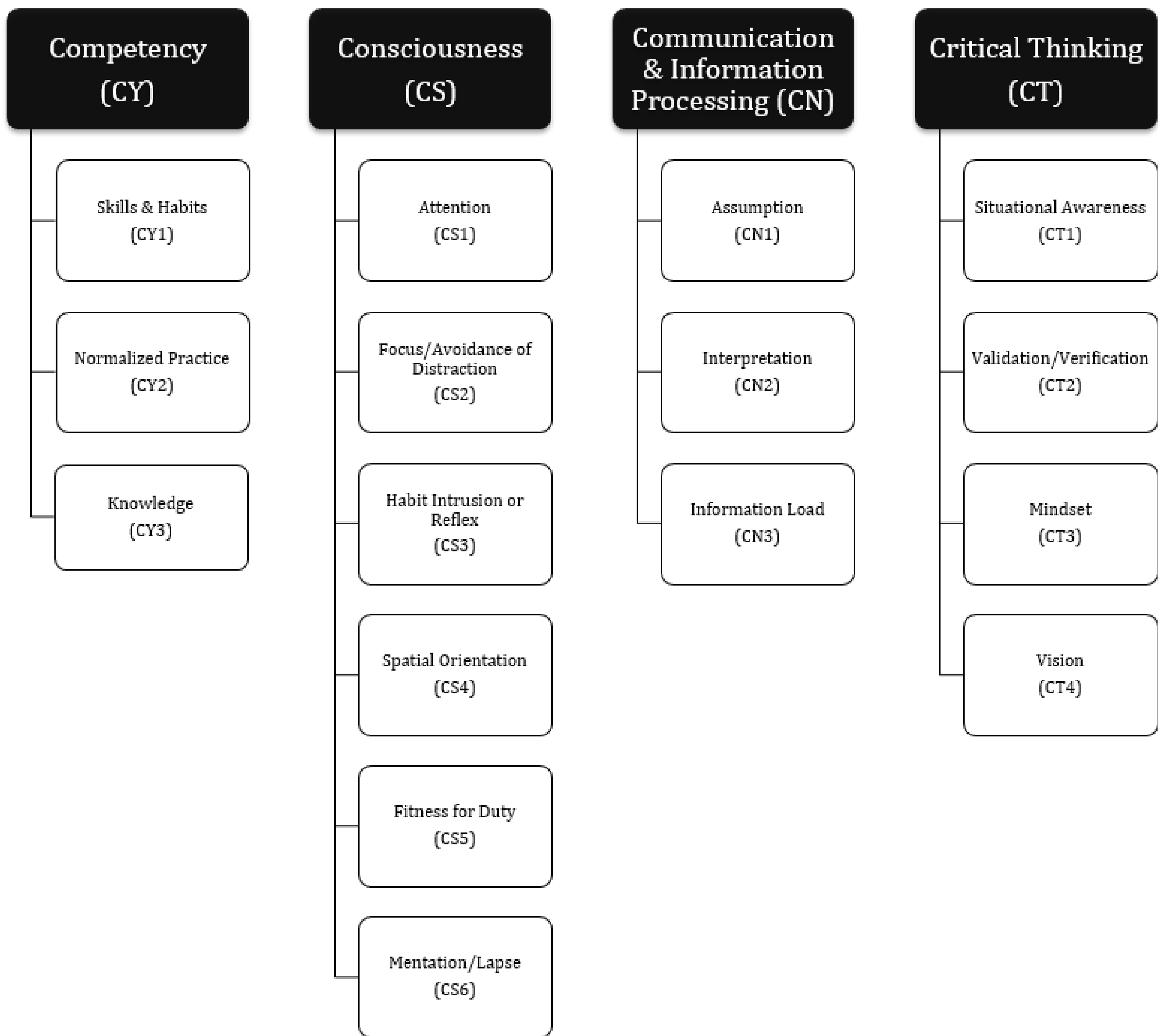
Causal Analysis (Briefly describe if the answer is in bold print)

Management (Briefly describe if management controversial or inappropriate)

Definitions of Ratings:

Causal Analysis		**Documentation**	
Delay or error in diagnosis	There is a delay in making a diagnosis or a misdiagnosis or a missed diagnosis. Example: ectopic pregnancy diagnosed when intrauterine pregnancy exists	No documentation issues	Documentation is accurate, complete, timely, and legible. Documentation meets all requirements by policy.
Error in technique	Failure to follow proper technique due to lack of compliance with policy, as in failure to maintain sterile field. -OR- Technique is not carried out as typical, as in clamp time exceeding limits which results in thrombus formation.	Incomplete or inaccurate documentation	Documentation is incomplete, incorrect, and does not reflect condition of patient, decision making of care options, or review of risk, benefits, alternatives.
System or process issue	A flaw in a hospital system which contributes or could contribute to a bad outcome, or creates significant difficulty for clinicians.		
Error in judgment	Choice of care delivered is different than what most physicians would choose. Example: Taking patient to surgery without conducting appropriate pre-op diagnostic tests.		
Patient non-compliance	Patient has not followed medical advice. This should not include patients who do not follow medical advice because of a lack of understanding.		
Natural history of patient's disease	Outcome is an expected result of the patient's medical condition. Example: Patient with multiple cardiac congenital anomalies has a cardiac arrest, despite receiving maximal care.		
Policy compliance problem	Failure to comply with hospital, state, or federal regulations. Example: Failure to review risks, benefits & alternatives for non-emergent use of blood products (Gann Act)		
Recognized complication of surgery or interventional procedure or treatment	Correct techniques and procedures are performed, however complication occurs which has been published as a known risk of the procedure. Or correct medication is ordered, however patient has a reaction which is a known risk of the medication. Example: Rejection to transplant even though care was managed appropriately.		
Supervision/delegation issues	Attending MD has not appropriately supervised and/or delegated an aspect of care to the trainee. –OR- Trainee acts independently without supervision of the attending MD.		

Appendix E: New Causal Analysis Taxonomy

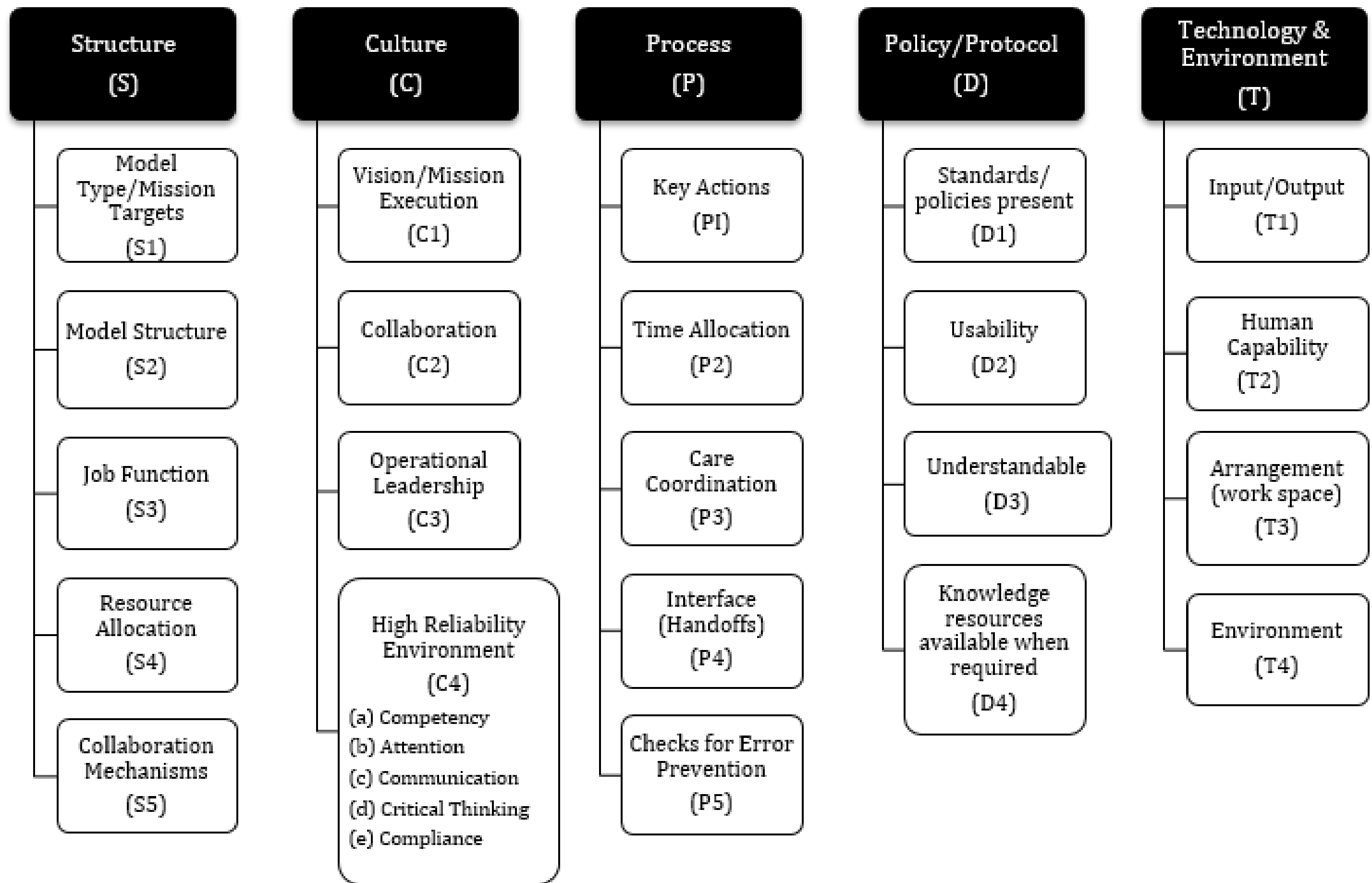


Descriptions for HPI Taxonomy

Taxonomy of *Teams and Human Factors*

Competency (knowledge & skills) (CY)	Consciousness (attention) (CS)	Communication & information processing (CN)	Critical Thinking (cognition) (CT)
(CY1) **Skills & Habits** Using the art & science of medicine to do something well. Ability to learn from experience and incorporate into practice.	**(CS1)** **Attention** Thoughtfulness about conduct of task. Fully aware of the relevant issues and performing to one's best ability.	**(CN1)** **Assumption** Assumptions can be problematic if the assumption is incorrect. Unverified assumptions should be minimized.	**(CT1)** **Situational Awareness** Aware & comprehending what is going on; recognizing when an act or condition deviates from desired path.
(CY2) **Normalized Practice** Practice that is, for an individual or team, the usual standard, custom or habit. Usually normalized practice lies within generally accepted standards of practice. If the usual practice of an individual or team lies outside generally accepted standards, it is termed "Normalized Deviance". Thoughtful examination of the justification for "Normalized Deviance" in practice is warranted.	**(CS2)** **Focus / Avoidance of Distraction** Keeping attention centered on task at hand.	**(CN2)** **Interpretation** Misinterpretation is forming an understanding that is not correct from something that is said or done. Interpretation errors are problematic and can be minimized by seeking validation.	**(CT2)** **Validation / Verification** Finding or testing the truth of something; examining information to determine whether the conclusions are indeed valid
(CY3) **Knowledge** Comprehension of fundamental principles & standard procedures. Knowledge of available resources.	**(CS3)** **Habit Intrusion or Reflex** Regular tendencies or practices can become almost reflex acts. The inclination to perform them without due consideration should be avoided. Regular practices should be modified as necessary to suit the situation.	**(CN3)** **Information Load** Prioritizing input is useful. Excessive sensory or cognitive input (overload) can be overwhelming & may impair performance.	**(CT3)** **Mindset** Maintaining an open mind, free of bias or preconceived notions. Avoidance of a fixed mental attitude or disposition that may predetermine the response to interpretations or situations.
	(CS4) **Spatial Orientation** Orientation to task, aware of position and direction (e.g.: surgical site check).		**(CT4)** **Vision** Optimal management of a situation by paying attention to the overall state of affairs ("big picture") as well as the finer details. Both are important. Tunnel vision is being overly focused on details of the task.
	(CS5) **Fitness for Duty** Adequate sleep & energy, fully engaged in task at hand. Performance not compromised by mental, physical or external factors.		
	(CS6) **Mentation / Lapse** Staying "in the moment". All humans are prone to have a lapse, to forget something, make a simple mistake.		

Taxonomy of Systems and Processes



Descriptions for HPI Taxonomy

Taxonomy of *Systems and Processes*

Structure (S)	Culture (C)	Process (P)	Policy / Protocol (D)	Technology & Environment (T)
(S1) **Model Type/Mission Targets** Model used or mission undertaken are appropriate for the stated goals.	(C1) **Vision/Mission execution** The vision is understood & the mission is executed satisfactorily and as planned.	(P1) **Key Actions** Necessary actions are identified and completed.	(D1) **Standards/Policies Present** Formally established.	(T1) **Input / Output** Displays, alarms, configurations appropriate for intended use.
(S2) **Model Structure** Model structure spans the full entirety of the project, has adequate levels of leadership, leveraging positions and experience.	(C2) **Collaboration** High morale & high-functioning teamwork (mutual trust, backup behavior, shared mental models, team oriented).	(P2) **Time Allocation** High yield activities are appropriately prioritized.	(D2) **Usability** Information correct, current, adequate, easy to access and well presented.	(T2) **Human Capability** Symbols, codes, controls, physical work.
(S3) **Job Function** Roles, responsibilities and expectations of job are well delineated so that the work undertaken is comprehensively addressed without unnecessary repetition of effort.	(C3) **Operational Leadership** Strong, committed leadership, unambiguous priorities, clear assignment of roles & responsibilities, appropriate responses to emerging issues.	(P3) **Care Coordination** Workflow is efficient, safe and timely. Progress of various processes is well coordinated.	(D3) **Understandable** Easy to comprehend because guidance detail is appropriate for the knowledge and skill-level of the user.	(T3) **Arrangement (work space)** Physical arrangement of work space is optimized to enhance rather than hinder workflow.
(S4) **Resource Allocation** Resources such as infrastructure, people, budget, equipment & other necessary items are sufficient. (S5) **Collaboration Mechanisms** Satisfactory collaboration is enabled by model design & function	(C4) **High Reliability Environment** Utilize error prevention strategies. **(C4a) Competency** Knowledge, skills, practice habits **(C4b) Attentive** Attentive, "in the moment". **(C4c) Communication** Neutral tone, concise, precise timely, standardized format. **(C4d) Critical Thinking** Good situational awareness, judgment, decisions. **(C4e) Compliance** Adhere to existing standards.	(P4) **Interface (Handoffs)** Satisfactory and timely transfer of information & responsibilities between individuals or teams. (P5) **Checks for Error Prevention** Checks, inspections, reviews are reliable and timely.	(D4) **Knowledge resources available where required** Job aids / Forcing functions available and utilized.	(T4) **Environment** Optimization of lighting, noise, climate and other relevant factors to enhance rather than hinder workflow.