Subject: Peer Review Activity

Policy: Review of circumstances as outlined in this policy will be conducted by a peer physician(s) acting as agent(s) of the Hendricks Regional Health Board of Trustees and Medical Staff for purposes of fact finding and forwarded to the appropriate medical staff committee for further review and/or action when necessary.

Purpose: To assist the medical staff in the development of strategies to continually enhance the quality of patient care at Hendricks Regional Health.

I. CIRCUMSTANCES FOR PHYSICIAN PEER REVIEW

A. Any aggregate or individual information derived from generic screens, medical staff monitors, adverse or serious adverse events, event notification (formerly) incident reports, complaints from patients, third party agencies or other sources of information within the hospital system that suggest possible deviation(s) from accepted standards of patient care, regulatory requirements or other policies that have been approved by the medical staff.

B. Performance of clinical procedures that fall outside the boundaries of documented competencies.

C. Potential clinical quality issue raised by another medical staff member.

D. Failure of the Medical Staff member to adhere to the Medical Staff Professional Conduct Statement and Citizenship Pledge

E. Breach in Duty as outlined in the Physician Just Culture Algorithm:
   1. Insufficient prevention, diagnosis, or treatment of patient diseases or conditions.
   2. Iatrogenic harm, i.e. harm caused by the physician incidental to the practice of medicine
   3. Inappropriate conduct not directly related to the practice of medicine

F. Disruptive/inappropriate conduct displayed by a physician. Examples of such conduct would include, but is not limited to, verbal or physical assaults of staff, patients, visitors, or other medical staff members, impertinent or inappropriate comments written in patient medical records or hospital records, or refusal to accept appropriate medical staff or committee assignments.

G. In the best interest of patient care and/or the orderly functioning of the hospital, whenever action must be taken immediately to suspend summarily all or any portion of the clinical privileges of a practitioner, such action shall be in accordance with Section II of the Corrective Action /Fair Hearing Plan.

H. This Policy shall not be interpreted to replace or supersede any provisions of the Medical Staff Bylaws and the documents associated therewith (e.g., Credentialing Manual, Corrective Action/Fair Hearing Plan). To the extent that there is any conflict between this Policy and the Bylaws, the Bylaws shall control.
II. PROCEDURES FOR PHYSICIAN CASE REVIEW

A. Quality Resource Management (QRM) or the Vice President of Medical Affairs (VPMA) will note circumstances requiring review based upon standards developed by the QRM personnel in conjunction with applicable medical staff committees.

B. QRM or VPMA will contact the chief of service or chairperson of the appropriate medical staff committee to inform him/her of the need for initial physician analysis, when the circumstances of the case appear to be physician-related. The service chief (chairperson) will be notified of non-sentinel events and requested to review the circumstances of the case. Initial review will be completed in a timeframe that adequately assesses the issues and permits sufficient time to prepare a fair and complete evaluation of the case to the Committee. In general, required review of non-sentinel events will be initiated within 4 weeks of notification of the service chair. This timeframe is waived when the circumstances requiring review represent a series of incidents that only become significant in aggregate over an extended period of time.

If the review involves a serious adverse event the initial review will be initiated within five (5) days of recognition of the event.

C. The chief of service or committee chairperson may opt to conduct the review or delegate it to another physician member of the committee within the same specialty as the physician being reviewed. In the event that equity of physician specialty cannot be accomplished with the existing physician members of the committee, the chair may utilize another member of the medical staff, or obtain appropriate review from an external peer review physician.

D. A standardized review worksheet sheet [See Appendix A and/or Appendix B - Just Culture Algorithm] will be utilized by the physician reviewer to aid consistency in the review process.

E. If the findings from the initial review are to be presented for peer review discussion at committee, then the individual practitioner will be informed of the general question being investigated at least 48 hours in advance of the scheduled review. The physician may provide input to the committee via the service chief, but will not be present during this initial discussion in order to facilitate an open dialogue.

NOTE: If the review involves a serious adverse event, results of the review (including the root cause analysis) must be presented to the Board of Trustees for resolution within sixty (60) days of event. This timeline may necessitate a called committee meeting to review the event and make recommendations.

F. Based on circumstances identified in the initial case review and with agreement of the committee chairperson and the initial physician reviewer, representatives of other health care disciplines, such as nursing, pharmacy, therapies, may be invited to participate in peer review discussions. Should information be insufficient for the Committee to make a decision, the committee chair or designee shall gather additional facts surrounding the case from the physician being reviewed or other appropriate personnel. This may include a request for the physician to appear before the committee.

G. Once the findings of the review are discussed to the satisfaction of the full committee, the committee is to determine preliminarily what, if any, corrective action is recommended for the physician, based on the facts presented.
H. The Chair/designee of the Committee will relay the findings of the Committee review to the affected practitioner who will have the opportunity to request an outside review of the case. An appropriate reviewer will be sought as soon as arrangements can be made and the results of the independent reviewer will be forwarded to the Committee for further consideration.

I. Based on findings, the Committee will determine if any additional information is required prior to making a final determination. The following action may be taken:

1. No additional investigation or fact finding activity necessary – forward recommendations to the Medical Executive Committee.
2. Additional investigation or fact gathering is necessary and an interdisciplinary group will complete investigation and present findings to the Committee. The Committee as a whole will then render recommendations for actions to be taken and forward them to the Medical Executive Committee.

IV. RECOMMENDATIONS/ACTIONS OF PEER REVIEW

Recommendations for disciplinary action(s) for a physician, based on peer review case findings, must be forwarded to the Medical Executive Committee (MEC) for review and approval, based on the Corrective Action/Fair Hearing Plan for Hendricks Regional Health.

Examples of actions that could be recommended include but are not limited to:

- Collegial discussion with physician involved
- Educational letter to physician involved with no response required
- Educational letter to physician involved with written response required
- Focused education on clinical procedure(s) through seminar and/or peer mentor arrangement
- Temporary limitation/restriction of clinical privileges
- Permanent limitation/restriction of clinical privileges
- Temporary suspension of all clinical privileges
- Permanent loss of all clinical privileges
- Loss of medical staff membership

Documentation stemming from peer review recommendations as described above will be placed in committee peer review minutes and, with full knowledge of the involved physician, physician-specific recommendations will be placed in the peer review file of the physician undergoing review. All such recommendations are subject to the provisions of the Medical Staff Bylaws and the procedures set forth therein regarding hearing and appeal rights of an adversely affected physician. If documentation is included in the individual’s file, the individual will have an opportunity to review it and respond in writing.

V. NON-PHYSICIAN PEER REVIEW

A. If a patient event is determined to be unrelated to physician intervention(s), QRM will assume responsibilities to initiate investigational processes with the appropriate clinical disciplines involved.

B. Nursing Services will discuss peer review investigations as a part of the Nursing Management meeting.
C. Findings and recommendation/actions of such non-physician peer review activity will be presented to the appropriate medical staff committee for review and acknowledgement.

VI. CONFLICTS OF INTEREST

Every attempt will be made to ensure that fair, equitable and non-biased procedures are utilized in all peer review proceedings. Conflicts stemming from social, political or business affiliations will be avoided when possible. Individuals involved in Peer Review activities shall be impartial peers and shall not have a conflict of interest with the subject of the Peer Review activity. A peer would also exclude individuals with blood relationships, spousal relationships, employer/employee relationships, or other potential conflicts that might prevent the individuals from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of Peer Review.

On occasion, peer review activity may be discussed directly at MEC, to avoid potential conflict(s) of interest at the service committee level. Likewise, when peer review discussion occurs at MEC, physician leaders with potential conflict(s) of interest are to be excused from the decision-making processes. In the event that there is question whether a non-biased review can be accomplished within the confines of the medical staff at Hendricks Regional Health, an outside physician reviewer may be sought.

VII. CONFIDENTIALITY

Peer review is held within the confines of the medical staff/quality committee structures of Hendricks Regional Health and therefore protected by IC 34-30-15 et seq. Informal conversations of peer review activities outside of the peer review committee structure are strictly prohibited.

Approved 1/2013
Hendricks Regional Health Medical Staff Peer Review Process - Not serious adverse events

VPMA Receives information from various venues

Nuisance complaint? Yes

No action necessary

No

Substantiated Event of serious nature?

QRM Contacts Chairman who reviews or delegates review

Yes

VPMA may collegially discuss with the practitioner. If this is a recurrent problem or may refer to the service chief for follow-up or may choose no action if the report is a singular occurrence

Standard of care breached or quality of care question?

Worksheet completed and filed with Committee - QA Information

Yes

Committee chair or designee solicits input from practitioner

Case discussed at Committee Level

Additional Investigation?

No

Committee decision recommendations

Yes

Interdisciplinary group completes investigation

Medical Executive Committee reviews findings and considers recommendations

Practitioner requests independent review?

Independent review completed

Yes

Practitioner

Report to the Board of Trustees

No

Actions taken

Additional information gathered and forwarded to MEC

More information required?

Revised 2006
Hendricks Regional Health Peer Review Worksheet

Medical Record # _______________  Event date: _______________

Attending MD: __________

__________________________________________________________________________________________

QRM Review:

___________________________________________________________________________________________

Physician Review

___________________________________________________________________________________________

Conclusion

Action

Unpredictable event

None required

Predictable event

Trend only

- Preventative measures taken to manage event occurrence

Education letter

- Minimal deviation from standard of care

MD

- Significant deviation from standard of care

Nursing

Event practitioner related

Other

(Specify)

Event not practitioner related

Committee review

Systems Issue Contributing To This Event

Hospital service not available

Physician Reviewer

Pertinent information not available

__________________________________________________________________________________________

Appendix A

Inadequate documentation

Other

Equipment not available

Specify)
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Appendix B
### Patient Centered Goal
Successful Prevention, Diagnosis, and Treatment of patient Diseases or Conditions.

### Categories of Breach
A. Insufficient prevention, diagnosis, or treatment of patient diseases or condition.  
B. Iatrogenic harm, i.e. harm caused by the physician incidental to the practice of medicine.  
C. Inappropriate conduct not directly related to the practice of medicine.  

Suspected Breach in the **Duty to Avoid Causing Unjustifiable Risk or Harm**
This path applies to a physician in any situation that actually or potentially leads to harm of persons or property. Examples from each category of possible physician breach include:

- A). Not ordering an indicated diagnostic test
- B). Writing a contraindicated prescription
- C). Disruptive operating room behavior

*This path can be applied in conjunction with suspected breaches in either the **Duty to Follow a Procedural Rule** or the **Duty to Produce an Outcome**.

Suspected Breach in the **Duty to Follow a Procedural Rule**
This path applies when a physician works within a system and is responsible for following a procedural (i.e., “how to”) rule created by the system. Examples from each category of possible physician breach include:

- A). Failure to use medical staff approved order sets for community-acquired pneumonia
- B). Not participating in a required pre-procedural time-out
- C). Not completing documentation according to a procedure.

Suspected Breach in the **Duty to Produce an Outcome**

- A). High patient return rate to the emergency department
- B). High prescription error rate
- C). Violations in time and attendance rules

**This path can be applied when the failure rate is assessed based on statistically valid, risk adjusted data and the adverse event rate is deemed unacceptable.**
Duty to Avoid Causing Unjustifiable Risk or Harm

- **Was the physician’s purpose to cause harm?**
  - **YES**: Consider punitive action
  - **NO**: Did the physician knowingly cause harm?
    - **YES**: Was the harm justified as the lesser of two evils?
      - **YES**: Support the physician in decision
      - **NO**: Consider punitive action
    - **NO**: Did the behavior represent a substantial and unjustifiable risk?
      - **YES**: Should the physician have known they were taking a substantial and unjustifiable risk?
        - **YES**: Console physician and conduct human error investigation
        - **NO**: Consider punitive action
      - **NO**: Did the physician consciously disregard the substantial and unjustifiable risk?
        - **YES**: Coach physician and conduct at-risk behavior investigation
        - **NO**: Do not consider physician action
  - **NO**: Do not consider physician action
Repetitive Human Errors

- Are there behavioral choices that are causing the repetitive errors?
  - NO
  - Are there system performance shaping factors?
    - YES: Consider system redesign
    - NO: Will physician make better choices?
      - NO: Consider punitive action
      - YES: Consider system redesign
    - YES: Will physician address personal performance shaping factors?
      - NO: Consider reassignment or termination
      - YES: Physician to remedy personal performance shaping factors
- YES: Will physician make different choices?
Duty to Follow a Procedural Rule

(System largely controlled by the physician)

Note: This test applies when the physician works within a system and is responsible for being a reliable component within that system.
Repetitive At-Risk Behaviors

- Are there system performance shaping factors that are causing the repetitive at-risk behavior?
  - NO: Consider punitive action
  - YES: Consider system redesign

- Are there personal performance shaping factors causing the repetitive at-risk behavior?
  - NO: Consider punitive action
  - YES: Will physician address personal performance shaping factors?
    - NO: Consider punitive action
    - YES: Physician to remedy personal performance shaping factors
**Duty to Produce an Outcome**

(System largely controlled by the physician)

Note: This test applies when the physician is aware that they control the system and is responsible for the output of the system.

- **Was the duty to produce an outcome known by the physician?**
  - YES: **Was it possible to produce the outcome?**
    - YES: **Did the social benefit exceed the risk?**
      - NO: Is the rate of failure to produce the outcome within the expectations of those to whom the duty is owned?
        - NO: **Investigate circumstances leading to failure to know of duty**
        - YES: **Support physician in decision**
          - YES: Accept rate of outcome
          - NO: **Investigate circumstances leading to impossibility**
    - NO: **Investigate circumstances leading to failure**
  - NO: **Assist physician in producing better outcomes, or consider punitive action**
### Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>At-Risk Behavior</td>
<td>Behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.</td>
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<td>Coaching</td>
<td>Supportive discussion with the physician on the need to engage in safe behavioral choices.</td>
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<td>Counseling</td>
<td>A first step disciplinary action; putting the physician on notice that performance is unacceptable.</td>
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<td>Disciplinary Action</td>
<td>Actions beyond remedial, up to and including punitive action or termination</td>
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<td>Human Error</td>
<td>Inadvertently doing other than what should have been done: a slip, lapse, mistake</td>
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<td>Impossibility</td>
<td>Condition outside of physician’s control that prevents duty from being fulfilled.</td>
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<td>Iatrogenic Harm</td>
<td>Harm caused by the physician incidental to the practice of medicine.</td>
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<td>Knowingly</td>
<td>Having knowledge that harm is practically certain to occur.</td>
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<td>Performance Shaping Factors</td>
<td>Attributes that impact the likelihood of human errors or behavioral drift.</td>
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<td>Punitive Action</td>
<td>Punitive deterrent to cause an individual or group to refrain from undesired behavioral choices</td>
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<td>Purpose</td>
<td>Conscious objective to cause harm.</td>
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<td>Reckless Behavior</td>
<td>Behavioral choice to consciously disregard a substantial and unjustifiable risk</td>
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<td>Remedial Action</td>
<td>Actions taken to aid physician including education, training, assignment to task appropriate knowledge and skill.</td>
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<td>Substantial and Unjustifiable Risk</td>
<td>A behavior where the risk of harm outweighs the social benefit attached to the behavior</td>
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