Examining the Peer Review Process: Reviewing and Monitoring Your Hospital’s Stroke Care

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Peer Review Objective

Discuss important components of an organized, comprehensive approach to peer review and interdisciplinary team involvement at the program level

Healthcare institutions should organize a multidisciplinary quality improvement committee to review and monitor stroke care quality benchmarks, indicators, evidence-based practices, and outcomes (Class I, Level of Evidence B).

The formation of a clinical process improvement team and the establishment of a stroke care data bank are helpful for such quality care assurances.

Identification of gaps or disparities in quality stroke care so specific interventions can be initiated to address these gaps or disparities. (New recommendation in 2013)

Stroke Case Scenario 1

Example of a patient event/concern sent and marked urgent to the Stroke Program Coordinator:

Person Referring: ED Medical Director
Reason for referral: Delay in TPA administration (administered 1 h 22 min after arrival)

As the Stroke Program Coordinator:
• What do you do with this information?
• How do you review the many facets of this case?
• Where and when do you begin?
• Who can you call for help?
• How do you develop, implement and assess an action plan?
• How do you communicate loop closure?
• Was the patient harmed?
Peer Review Process Outline

Referrals from ED staff or from staff from other departments:

• The Team Leader will determine if the case belongs to any of the ED workgroups.

• If the case fits into an existing ED working group, the EDPIP Team Leader will refer the case to the appropriate Working Group Leader who will assign the case for review to a member of the working group

• The working group will review the case and summarize their findings using the EDPIP Template (see draft – appendix 1 below) and submit the review back to the EDPIP Team Leader within 2 – 4 weeks

• Working groups will present their quality metrics, review relevant cases, and proposed action plans to the ED PI team when they are scheduled to report on a quarterly basis.

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Patient Name/MRN
Reason for referral:
Case Synopsis:

Issues identified:

Diagnostic Issue
Inadequate work-up
Misjudgment
Delay in consultation

Treatment Issue
Failure to treat
Delay in treatment
Wrong treatment
Technical error: e.g. line problem

Documentation
Inadequate/poor

Staffing issues
Staff experience
Staffing levels/workload
Supervision

Communication
Resident - attending
Attending - attending
Resident - resident
Physician – nurse
With consulting service
With PC/P specialist

Teamwork
Lack of clear responsibility
Other (specify)

Support services
Labs
Radiology
Blood bank
Other

Human Factors
Failure of memory/vigilance
Stress/Fatigue

Environmental Factors
Distraction/interruptions
Ergonomics (lighting, space, noise)
ED Overcrowding / hallway patients

Patient Factors
Behavioral issues
Language issues
Disease acuity/complexity

Equipment/technology
Availability (or lack of)
Quality (defective)
Failure to use appropriately
New/unfamiliar to operator

Proposed Plan of Action:
☐ No action needed  ☐ Monitor for recurrent  ☐ Continued problem requires PI Plan
☐ Individual cognitive error - requires Peer Review  ☐ Requires root cause analysis

CONFIDENTIAL, For Peer Review ONLY
Prioritization Score Matrix

<table>
<thead>
<tr>
<th>Probability of Recurrence</th>
<th>Catastrophic</th>
<th>Major</th>
<th>Moderate</th>
<th>Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Occasional</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Uncommon</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Remote</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

* Prioritization score of 2 or greater will require detailed case review and or root-cause analysis

Issues Identified:

<table>
<thead>
<tr>
<th>Diagnostic Issue</th>
<th>Communication</th>
<th>Human Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate work-up</td>
<td>NP/Resident - attending</td>
<td>Failure of memory/vigilance</td>
</tr>
<tr>
<td>Misjudgment</td>
<td>Attending - attending</td>
<td>Stress/Fatigue</td>
</tr>
<tr>
<td>Delay in consultation</td>
<td>NP/Resident – NP/Resident</td>
<td>Environmental Factors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Issue</th>
<th>Physician – nurse</th>
<th>Transitions in Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to treat</td>
<td>With consulting service</td>
<td>ED to ED (shift change)</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>With PCP/specialist</td>
<td>ED to Observation</td>
</tr>
<tr>
<td>Wrong treatment</td>
<td>Physician – NP/Resident</td>
<td>ED to Inpatient</td>
</tr>
<tr>
<td>Technical error: e.g. line problem</td>
<td>Transitions in Care</td>
<td>ED to Outpatient (home, SNIF)</td>
</tr>
</tbody>
</table>

| Documentation | ED to Observation | CTA/CTP did confirm occlusion in L ICA |

<table>
<thead>
<tr>
<th>Inadequate/poor</th>
<th>ED to Observation</th>
<th>CTA/CTP did confirm occlusion in L ICA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Staffing issues</th>
<th>Support services</th>
<th>Equipment/technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff experience</td>
<td>Labs/Blood bank</td>
<td>Availability (or lack of)</td>
</tr>
<tr>
<td>Staffing levels/workload</td>
<td>Radiology</td>
<td>Quality (defective)</td>
</tr>
<tr>
<td>Supervision</td>
<td>Pharmacy</td>
<td>Failure to use appropriately</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Plan of Action:</th>
<th>Initial Case Reviewed by: xxx</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No action needed</td>
<td>Date Presented at EDPI: _________________</td>
</tr>
<tr>
<td>☐ Monitor for recurrent</td>
<td>Prioritization Score : 1</td>
</tr>
<tr>
<td>☐ Continued problem requires PI Plan</td>
<td>Date Closed: ____________________</td>
</tr>
<tr>
<td>☐ Individual cognitive error - requires Peer Review</td>
<td>Requires root cause analysis</td>
</tr>
</tbody>
</table>
Case Summary

• The issue was related to inadequate documentation. tPA was delayed due to the need to perform CTA/CTP. No indication or reason was indicated in the chart.
• Inferences can be made based on CT reports that due to hyperdense sign a CTA/CTP was ordered, but there was no documentation in the record for the reason.
• IV tPA is the standard of care and should be administered as quickly as possible unless there is a clear documentation of clinical decision making.

Peer Review Definition

• Medical peer review is the process by which a professional review body considers whether a practitioner’s clinical privileges or membership in a professional society will be adversely affected by a physician’s competence or professional conduct. (AMA)

• The primary purpose of peer review is to help ensure the quality of nursing care through safe deliverance of standards of care and newly discovered evidence-based practices. (ANA, 1988)
Why is Peer Review Important?

• Improving the quality of care to patients is the main concern of clinicians everywhere

• Peer review is one of the most important methods

• Clinicians have the privilege of participating in and shaping the future of health care and have an obligation to undertake peer review for the collective good

• Promotes transparency and a culture of safety

Peer Review Purpose

• The primary purpose of peer review is to help ensure the quality of care through safe deliverance of standards of care and evidence based practices.

• Peer review is focused on the patient and on the results of care given by a group of professionals rather than on individual professional practitioners

• Review by peer groups is promoted by professional organizations as a means of maintaining standards of care.
Peer Review Like Business Process

- Consistency
- Balance
- Useful Actions
- Timeliness

Principles of Effective Peer Review

- Confidentiality
- Impartial review
- Protection of peer reviewers

- Findings and recommendations are supported
- Evidenced based research
- Protocol
- Statements
- Guidelines

- System and Process Issues
- Tracking of Peer review Cases
- Non-punitive
- Education

http://www.psqh.com/janfeb07/peer.html
Peer Review Committee

“peers are individuals who share the same profession, have similar training, work in similar environments and have similar proficiency in a clinical practice area or specialty”

Characteristics of Peers
- Specialty
- Domains of professional and individual practice requirements
- Types of patients and conditions, experience
- Peer review training/skills

Engagement
- Quality and Safety Information collection
- Data Analysis and Interpretation of results
- Recommendations

Peer Objectivity
- Use of resources
- Disclosure of any bias or conflict
- Decline review
- Attend Peer Review training

Technical and clinical skills
- Behavior performance
- Personal interactions

Behavior
- Attend Peer Review training

Train and support reviewers and participants
Policy & Rules

Please refer to your handout for a sample Peer Review Policy

• Rules & Policy related to case reviews and peer review must be established to ensure an non-punitive environment and foster a culture of continuous learning and patient safety.

• All case reviews should begin with statement of “ground rules”

Example of Ground Rules

• Cases are being reviewed for quality improvement purposes only and are for the duration and space of this meeting non-discoverable.

• Information disclosed at this meeting is not to be discussed outside of this room.

• Goals of this review is to discuss medical errors in an environment that facilitates learning, fosters medical maturity, promote academic development and leadership and create a forum for interdisciplinary growth.
Peer Review Policy

Defines collaboration and agreement of the characteristics of peer review

Purpose

• Peer Review Process
• Avoidance of conflict of interest and bias
• Define how outcomes will be documented and reported as well as feedback loop
• Scope of peer review

Peer Review Policy

• Sources of information utilized and access
• Storage of peer review documents
• Utilization of peer review outcome
• Requirements of participation
• Compliance for engagement of committee members
• Techniques applied to peer review
• Responsibilities and accountabilities for peer review leadership
• Criteria against which the performance will be reviewed
Validity and Reliability of Peer Review

• Evidence-based indicators directly link performance with safe, high quality patient care
• Changing health care arena
• Peer review “validity” and “reliability” remain critical

Validity and Reliability of Peer Review

• **Validity** of a peer review process is determined by the degree to which it assesses what it is intended to assess

• **Reliability** of peer review process is the degree to which one can depend on the accuracy of the method’s results. Reproducibility of the results is one gauge of reliability.
Peer Review Process

Identification of Cases

- Review
- Referrals
- Complications
- Pre-identified Populations
- Near Misses
- Concerns
- Monitoring PI Indicators
- Complaints

Patient Safety

Case Presentation

The Reviewer’s Resources

- Timely data
- Administrative data sets
- Disease or procedure specific data registries
- Clinical records
- Observation of clinical practice
- Clinical Practice Guidelines and Statements

- Policies & Procedures
- Research
- Structured stakeholder interviews
- Well structured stakeholder interviews
- Complaints
- Compliments and well structured patient experience surveys

(Australian Commission on Safety and Quality in Health Care 2010)
Case review: Delay in stroke diagnosis and potential candidate for urgent stroke treatment

- 70 yo Male
- Admitted with normal pressure hydrocephalus neurologically intact
- Hospital day # 2: Rapid response team (RRT) initiated for “change in mental status”. RRT nurse found pt awake, headache, vomiting, O X 1 (actually unidentified expressive aphasia), new blurred vision, unequal pupils, new onset AFIB.
- RRT resident called Neurosurgery physician assistant who ordered stat CT scan which was “(-)"
- RRT resident documented “CT (-), consider stroke” yet stroke alert never activated,
- MRI ordered next day
- MRI Positive for Left PCA acute infarct, consult to Neurocritical Care.

- Referred to Peer review team by neuro critical care MD for missed stroke diagnosis

Case Summary

- Case preparation by Performance Improvement Coordinator & Stroke Program Director
- Case presentation to peer review committee by Stroke Program Director
- Report of findings:
  - Staff did not recognize Posterior stroke circulation S & S
  - Staff did not follow stroke alert and stroke code hospital policy
  - Missed opportunity for urgent stroke treatment IV tPA and/or Neurointervention
  - Preventable & major opportunity
- Actions:
  - Case referred to RRT & Physician peer review committees
  - Education to providers of stroke alert process and policy
  - Discussion between stroke program director and Neurosurgery attending
  - Disclosure to family
  - Grand Rounds and other educational opportunities on posterior stroke circulation stroke and stroke alert process
FINAL REVIEW

- Meets Accepted Standard of Care
- Opportunity for Improvement – In Communication
- Upon further review, no quality of care issues identified
- Opportunity for Improvement – In Documentation
- Quality of Care Issue – In management of the Case
- Opportunity for Improvement – System Inadequacy – not a provider issue
- Quality of Care Issue – In Documentation
- Opportunity for Improvement – In management of the Case
- Opportunity for Improvement – In management and Documentation of the Case
- Care different than what reviewer might have done, but is within the accepted standards

REPORTING FINDINGS

- Non Preventable
- Potentially Preventable
- Preventable
- Appropriate Care
- Opportunity Major/Minor
Final Report of Stroke Scenario Review

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Reporting Findings

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- Potentially Preventable
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ACTIONS

Provide Feedback
Identify Barriers
Develop Action Plans

System Change
Recommendation

Categorizing root causes:
error, delay,
communication, policy
deviation

Documentation

Individual Performance
and Accountability
Sanctions and penalties
where non-compliance
impacts patient safety

System Inadequacy
Implement system
change into the
feedback loop

Monitor effectiveness of
changes
Intensive Interventions
Education

Case Closure

Referrals to other system
wide or departmental
peer review committees

Addressing Performance Concerns or Uncertainties

Serious Uncertainties

- Protect the safety of patients and the community
- Provide support to the Healthcare Professionals (HCP) to improve their performance
- Identify changes that need to be made to the HCP scope of practice or condition of practice
- Notify relevant regulatory authority

(Australian Commission on Safety and Quality in Health Care 2010)
Comprehensive Stroke Performance Improvement and Peer Review

Cases referred are reviewed by the appropriate peer review and Performance Improvement committee.

Examples of cases referred:
- Performance: VS; neuro Assessment; Dysphagia Screen; Communication
- Stroke Core Measures
- Complications: hemorrhage, Delay in stroke alert processes, therapies and treatment
- Medication error (rt-PA, anticoagulants)
- Intra-interdepartmental referral/protocol deviations
- Readmission
- Extension/Recurrent stroke
- Post procedure complications
- Infection
- Customer service failure identified
- Death

PIPR Committees
- Administrative Stroke Committee
- Stroke Focus Group
- Neurovascular/Neurovascular Grand Rounds
- Neurology/neurology Grand Rounds
- Neurosurgery/Neurosurgery Grand Rounds
- Carotid Oversight Committee

Review of action plans monthly until resolution achieved

System issue identified from the review action plan created to improve process or system

Opportunity for improvement identified, if provider issue identified referred to Dept Chair for action plan

If a potential opportunity for improvement is identified from another service, the case is referred to their PIPR committee (ETC, surgery, medicine, nursing, quality) for the review and feedback to the referring committee. Action plans that result from this peer review are communicated back to the core stroke team.

Peer Review Structure
References


Thank you!

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