Criteria for Peer Review

Example

1. ORYN Data (Core Measures)
2. QIO Reports
3. Data Advantage Reports
4. Surgery Review Indicators:
   - Morbidity/Mortality
   - Code Blue Review
   - Autopsy Criteria Met
     - If YES – chart contains documentation of discussion with family requesting autopsy
   - Surgical Consent not obtained as per policy
   - H&P not on chart prior to procedure
   - Normal tissue
   - Cases with no surgical specimen (specimen expected)
   - Discrepancy pre-op and post-op
   - Frozen / permanent section discrepancy
   - Post-op infection
   - Post-op complications related to surgery
     - Excessive bleeding (> 400 cc blood loss)
   - Intra-operative variances related to surgery:
     - Injury to another organ during surgery
     - Excessive bleeding (> 400 cc blood loss)
     - Foreign body retained
     - Intra-operative CPR / mortality
   - Immediate Post-operative note not written
   - Unplanned out-patient admission due to complication of surgery
   - Unplanned return to OR
   - Unplanned admission to ICU post-operatively related to surgery
   - Unplanned transfer to a higher acuity level of care / facility post-operatively related to surgery
   - Readmission < 30 days for surgical related problem
   - Operative mortality related to surgery
     - < 48 hours post-operatively
     - Within 30 days post-operatively
     - Patient Compliant
Criteria for Peer Review

Example

5. **Anesthesia Indicators:**
   - No anesthesia consent
   - Immediate pre-induction assessment not documented
   - Reintubation / laryngospasm (Rx)
   - Difficult airway / intubation
   - Tooth damage
   - Eye injury
   - Hyperthermia > 101 degrees
   - Hypothermia < 94 degrees
   - Surgery cancelled after induction
   - Pulmonary edema (Intra / post op)
   - Prolonged hypoxia (SaO2 > 10% of baseline)
   - Codes in OR / PACU
   - MI peri-op / post-op (within 24 hours)
   - OB epidural problems / complications
   - Post dura puncture (H/A requiring Rx)
   - Unplanned ICU admission
   - Unplanned outpatient admission
   - Unplanned readmission due to complication of anesthesia
   - CVA within 24 hours related to anesthesia
   - Neurological complications within 24 hours related to anesthesia
   - Mortality within 24 hours related to anesthesia
   - Unexplained change in patient condition in PACA
     - Prolonged nausea / vomiting
     - Prolonged PACU (> 2 hours)
     - Aspiration
     - Post operative infection related to anesthesia
     - Pneumonia
     - Patient Compliant

6. **Department of Medicine:**
   - Morbidity / Mortality
   - Code Blue Review
   - Autopsy Criteria Met
     - If YES – chart contains documentation of discussion
   - AMI after non-cardiac admission
   - Neurological deficit after non-neurologic admission
Criteria for Peer Review

Example

- Nosocomial pneumonia / septicemia
- Non-surgical Invasive Procedure Complication (central line, Swan Ganz, cut-down, chest tube, etc.)
- Unplanned transfer to ICU
- Readmission within 7 days of hospital discharge related to previous admission
- Readmission within 30 days of hospital discharge related to previous admission
- Patient Compliant

7. Radiology:
   - Procedure Correlation (High Volume, High Risk, Problem Prone)
     - Gall Bladder
     - MRI
     - CAT Scan (etc.)
   - Unplanned admission following outpatient procedure
   - Patient injury during procedure
     - Neurological deficit due to procedure
     - Seizure or convulsion
     - Severe headache requiring Rx
     - Pneumothorax secondary to lung biopsy
     - Arachnoiditis after myelogram
     - Extra Arachnoid Tap necessary after myelogram
   - Aspiration during procedure
   - Allergic reaction to contrast dye
   - Viscus Perforation
   - Unplanned return to radiology for additional films

8. Obstetrics:
   - C-Section Rate (Total # of C-sections / # or total deliveries)
   - VBAC Rate (# of successful deliveries / # attempted)
   - Post partum blood loss:
     - Hemoglobin <7
     - Drop of 3 or more grams
     - Blood loss > 500cc vaginal
     - Blood loss > 1000cc C-section
   - Hospital stay for C-sections > 3 days
   - C-section indications not met / documented
   - Delivery of infant greater than 20 weeks weighing <2500 grams
Criteria for Peer Review

Example

- Death of fetus weighing more than 500 grams
- Transfer of an infant to a higher level of care
- Apgar score of 5 or less at 5 minutes
- Infant birth trauma or seizures
- Unplanned post-partum return to delivery room or operating room
- Injury or trauma to mother including 4th degree tear
- Maternal mortality
- Unplanned readmission within 14 days
- Delivery without physician present

9. Pharmacy and Therapeutics:
   - Medication errors with ‘serious’ score per medication variances report
   - Patient received any of the drugs listed:
     - Phenytoin / Digoxin / Theophylline / etc.
       - If YES, then serum level measured
   - Drug exceeds specified limit
   - DUE results
   - ADRs
   - Drug ordered and not in formulary
   - Over 3 antibiotics administered concurrently or over 5 antibiotics administered in same hospital stay
   - 3rd generation antibiotic administered

10. Blood Utilization:
    - Transfusion criteria not met (RPBC, FFP, platelets)
    - Patient with suspected / confirmed reactions
    - C/T ratio – trend over time
    - Single unit transfused

11. Pathology:
    - Frozen Section / Histology Correlation (# of frozen / FNA’s with significant discrepancy with final diagnosis. Goal < 5%)
    - Number of frozen / FNAs deferred (Goal < 5%)
    - Number of amended diagnoses (Goal < 1%)
    - Cytology / Histology correlation
    - Peer Congruence:
      - External consultations
      - Internal / Blind Review
Criteria for Peer Review

Example

12. Emergency Medicine:
   - Transfers to acute care facilities
   - Unplanned return < 72 hours
   - Arrests / deaths in ER
   - LOS in ER > 3 hours
   - X-Ray over-read discrepancy
   - EKG over-read discrepancy
   - No documentation of call back for positive culture

13. Infection Control:
   - Nosocomial infections
   - Wound infections post op
   - Infections following insertions of a central line
   - Pneumonia following surgical episode
   - Death where nosocomial infections may have contributed

14. Utilization Review:
   - Failure to meet admission criteria
   - Re-admissions within 30 days
   - Inappropriate transfers
   - QIO Denial
   - LOS > established norm for diagnosis

15. Medical Records:
   - Clinical pertinence
   - Legibility studies
   - Delinquency in completions of medical records (H&P, immediate post-op note, verbal orders, etc).

This sample quality program tool is intended to be reviewed and revised by a hospital to meet that hospital’s unique circumstances. Neither this nor any quality program tool should be used until it has been adopted by a hospital’s medical staff and governing board. Nothing herein is a substitute for the independent medical or clinical decision-making of any person.