UCLA Resnick Neuropsychiatric Hospital

PEER REVIEW PS 010

Manual	Professional Staff	***Effective Date***	06/30/2006
Policy #	PS 010	***Date Revised***	06/30/2009
Responsible Person	Director, Professional Staff Services	***Next Scheduled Review***	05/31/2021

PURPOSE

The Peer Review Process is designed to measure, assess and improve performance on an organization wide basis by measuring and evaluating the quality of services provided to patients and the clinical performance of each Professional Staff member. Conclusions from the Peer Review process are used in the ongoing evaluation of clinical competence as well as at the time of reappointment of staff members, renewal and addition of privileges. In addition, other opportunities for improvement in either outcomes or processes that are noted in the Peer Review process are forwarded to appropriate hospital committees for review and action.

OBJECTIVES

The Professional Staff of the Resnick Neuropsychiatric Hospital at UCLA maintains an efficient and effective Peer Review process by ensuring that the following characteristics are met. The process is:

- Consistent
  All cases meeting defined criteria are reviewed according to defined procedures

- Timely
  Cases meeting defined criteria and requiring review are evaluated within reasonable time frames and according to R-NPH Peer Review protocols.

- Defensible
  Conclusions reached are supported by a rationale that addresses the issues for which the peer review was conducted, including reference to hospital policy and relevant literature and practice guidelines, as appropriate.

- Balanced
  Minority opinions and views of the reviewee are considered and noted.

- Useful
  The results are considered in clinician credentialing and privileging, and referred for action through the R-NPH performance improvement process when appropriate.

- Ongoing
  Peer Review conclusions are tracked over time and the effectiveness of actions taken are evaluated.

STRUCTURE

- Committees

  The *Peer Review Committee*, as defined in the R-NPH Professional Staff By-Laws, is a multidisciplinary committee made up of at least three members of the Professional Staff who are appointed by the Chief of Staff and represent Adult, Geriatric and Child Psychiatry Divisions, as well as a representative from Nursing, Social Work, Allied Health Professionals, Medical Records and Quality Management. The Committee is chaired by a member of the R-NPH Professional Staff. The Committee meets at least quarterly, and its proceedings recorded. Minutes of the Committee are forwarded to the Professional Staff Executive Committee. In addition, clinician specific information is stored in an electronic database that is queried by the Division Chiefs for ongoing evaluation of their members, as well as at the time of reappointment, for conducting focused/ongoing professional practice evaluations (FPPE/OPPE) as well as for for evidence of competence and quality of care.

The *Psychology Peer Review Subcommittee*, as defined by the R-NPH Professional Staff By-Laws and the UCLA Medical Center (MC) Medical Staff By-Laws, is a joint committee of the UCLA R-NPH and UCLA MC, and a subcommittee of the R-NPH Peer Review Committee. It is comprised of at least three psychologists privileged as allied health professionals at the UCLA MC, at least one of whom is also a member of the R-NPH Professional Staff. The Committee meets at least quarterly, and reviews the practice of psychologists and other Allied Health Professionals. Its proceedings are recorded, and minutes of the Committee are forwarded to the R-NPH Peer Review Committee and the UCLA MC Credentials Committee. In addition, clinician specific information is stored in an electronic database that is queried by the Division Chiefs for ongoing evaluation of their members, as well as at the time of reappointment, for conducting focused/ongoing professional pracdtice evaluations (FPPE/OPPE) as well as forfor evidence of competence and quality of care.

- Definitions and Time Frames

A "*peer*" is defined as a clinician from the same discipline as the reviewee, with current privileges to practice within the Division and essentially equal qualifications, i.e., documented skill and knowledge to provide the services being reviewed. When cases are reviewed by the committee for clinician-specific evaluation, they are referred to a Peer Review Committee member from the same discipline and with essentially equal qualifications. Because patient care at the R-NPH is rendered by a multidisciplinary team, the Peer Review Committee includes multidisciplinary staff. This ensures that the care provided by the team is reviewed and that multidisciplinary collaboration has been appropriate and delivered in a fashion that meets hospital standards.

Minutes of each Peer Review Committee contain a summary of the discussion, conclusions and any action taken by the Committee. Open items are tracked until closure by the Committee. Signed minutes are forwarded to the appropriate oversight Committee scheduled for the month following the approval of the minutes.

Clinician-specific information is available to the Division Chiefs for ongoing evaluation of their members immediately, and can be reported in aggregate format for specified time frames. At least a minimum of three cases are reviewed for each Professional Staff member prior to reappointment to ensure a review of quality of care for the reappointment process, while an ongoing review is maintained using division-specific criteria and indicators.

Case review is assigned to the next regularly scheduled Committee as soon as possible after an incident meeting criteria for review occurs or is reported. Once assigned, the report of committee discussion should be in the minutes as soon as possible, but not to exceed 3 months of assignment. Results of the case review are immediately forwarded to the appropriate Division Chief for review as part of the member's ongoing performance evaluation.

- Circumstances Requiring Outside Review

In circumstances in which no current Committee member has the qualifications or expertise to evaluate the care provided by a clinician, the Committee Chair is responsible to ensure that an appropriate review is performed. He or she, upon discussion with the Committee, may:

1. appoint one or more clinicians to participate on the committee on an ad hoc basis in order to conduct a thorough review of the case; or

2. the case may be referred to another clinician who is identified to have expertise in the issue, procedure, or practice being reviewed, and who reviews the case and prepares a verbal or written summary of conclusions; or

3. submit the case for review by the UCLA Medical Center (MC) Quality Management Service and assignment to the appropriate MC specialty Peer Review Committee.

- Participation By The Clinician Being Reviewed

  In instances in which questions arise as to the rationale for a clinician's decision or lack of information related to the case, the clinician is notified and a written response requested. If he or she wishes, the reviewee may also request to attend the committee meeting and present his or her rationale directly to the Committee. If no response is received from the clinician within 45 days of the Committee's initial request, a subsequent written request is made. The clinician's response is considered by the Committee and documented in the minutes.

  In all instances in which any recommendation is made or action taken by the Committee, notification of this recommendation or action is made in writing to the clinician involved. Any response to this notification will be addressed at the next meeting following receipt of the response.

- Staffing

  The Medical and Professional Staff Services Department of UCLA provides administrative support to the R-NPH Peer Review Committee and the Psychology Peer Review Subcommittee.

  The R-NPH Quality Management Department assists in assuring that cases meeting criteria for Peer Review are triggered for review ASAP after report of the incident. The Department also maintains current review sheets and materials to assure that reviews are consistent and according to guidelines agreed on by the Committees.

  A database of case reviews, discussions, conclusions and actions by individual clinician is maintained by the Medical and Professional Staff Services Department. This database provides information to the Division Chiefs for ongoing evaluation of their members, for the member profile reviewed at the time of reappointment, and can also be queried for data related to quality of care for the Credentials Committee or Professional Staff Executive Committee.

CRITERIA/INDICATORS

1. Death
2. Suicide
3. Suicide attempts
4. Discharge from unauthorized absence
5. Code Blue
6. Blood Transfusion
7. Seclusion and Restraint in which:
   -Adult > 90 minutes continuous seclusion and/or 8 hours restraints
   -Child (0–9 yo) > 1-hour restraint or seclusion
   -Child/Adolescent (9-17 yo) > 4 hours restraint or seclusion
   -Child/Adolescent > 7 days restraint or seclusion
   -Child/Adolescent > 12 events restraint or seclusion
   -Treating MD does not meet assessment timeframes
   -Restraint or seclusion assessed to be inappropriate given circumstances
8. Patient released from 72 hour hold in EMC
9. Cases in which a Patient Satisfaction Survey or patient complaint raises an issue or concern related to the quality of care delivered. The need for review is determined by the QM Director, R-NPH Patient Relations Specialist, Unit Director, Medical Director, Utilization Management Coordinator or Division Director.
10. Any reported incident ("unusual occurrence") or case in which the quality of care is questioned or hospital standards of care do not appear to be met, as determined by the QM Director, R-NPH Patient Relations Specialist, Unit Director, Medical Director, Utilization Management Coordinator or Division Director.
11. A sample of cases for a Professional Staff member within a 2-year period for an assessment of general competence and quality of service provided.

12. A sample of cases in which the rate of occurrence of any of the following:
    -Length of stay exceeding identified parameters
    -AMA discharge
    -Readmission within 30 days, and/or
    -Discharge to acute care exceeds a unit's average rate plus 2 standard deviations as calculated on a control chart calculated monthly

APPROVED:

Professional Staff Executive Committee	June 15, 2009/reviewed w/no revisions 5/22/2018
Governing Body	June 30, 2009/approved w/no revisions 5/31/2018