SUBJECT: Nursing Quality and Peer Review Council (NQPR)

PURPOSE: To review and monitor nursing practice and its impact on patient outcomes. Evaluation of the results of peer review and evaluation of data from the Patient Safety Council (PSC), verbal report, quality and Risk Management are the primary mechanisms of quality review. The review will evaluate information compared to Nursing Standards of Care and nursing evidenced based practice. The NQPR Council will provide assistance, support, and advice for the practice of nursing at VWCH.

Nursing Quality & Practice Peer Review Council Makeup
Chair: A member of Nursing Leadership who holds a management position.
Members: At least one member from each nursing area.

Scope of Council

1. The council by majority vote will render a decision whether an incident/occurrence represents deviation from standard of practice. The decision will be based on peer case review of documentation in the patient medical record.
2. Staff or employee behavioral issues/complaints will not be reviewed through this process but will be referred to the appropriate unit director.

Decision Making

1. Only patient care issues related to nursing practice will be peer reviewed.
   a. If case referred is not related to nursing practice it will be returned to the originator.
   b. If the case is referred for peer review, Unit Director will notify the employee.
   c. Employee may request to review medical record under the supervision of the Unit Director.
   d. Employee will be given the opportunity to submit clarifying information.
2. When reviewed, some cases may be found to be multidisciplinary in nature. If that is the case, information will be forwarded to the director of the appropriate area.
3. The review will include chart review performed by two or three anonymous peer consultants, assigned by the chair of the Nursing Peer Review Council. At least one reviewer will be from the unit where the occurrence happened and one will be from a like unit.

4. The reviewers will maintain strict confidentiality as per hospital policy.

Note: Reviewers are anonymous to the nurse whose care is being reviewed to promote non-biased review.

References
- ANA Code for Nurses, 1996
- ANA Scope & Standard of Practice 2004
- Health Sciences Center, University of New Mexico: Nursing Quality and Peer Review Council

Documentation of Peer Review Process
1. Meeting minutes and documentation of peer review will be confidential and protected information of the organization.
2. All documentation generated as part of the peer review process will be marked “confidential”.
3. If there is any question related to nursing practice, written clarification may be requested by the Chair of the Council. The employee will have 72 hours to respond to this request.
4. Any recommendations for nursing practice changes will be made as appropriate and will be presented to Nursing Administration.

Guideline Procedures
1. Mechanism for triggering Peer Review:
   a. Identify patient care occurrences including non-medication and medication related practice issues.
   b. Cases may be referred by:
      i. Any unit director, or at the request of any RN, through the appropriate unit director. Cases may also be referred by:
         1. Risk Management
         2. Nursing Staff
         3. Unit Director
         4. VP of Nursing
         5. Physicians
   c. Complete Abstract of Occurrence form
2. Medication incidents are sorted into 4 categories based on harm score.
   a. Category A, B, C, and D errors will be reviewed only if a pattern of errors for an individual staff member has been identified by Risk Management of the Unit Director.

3. Assignment of Peer Review Consultants for review.
   a. Once an incident has been identified for nursing peer review, the chair of the Nursing Quality & Practice Peer Review will request one RN from the unit involved and one RN from a like unit to independently review the chart prior to the review. The chair will meet with the Unit Director and the two RNs selected to peer review the case and the Unit Director the review is being conducted for to discuss process, sign statements, answer questions and complete the Nursing Peer Review Case Evaluation Form.
      i. Peer Review Consultants will be registered nurses with expertise/knowledge in the nursing specialty area to be reviewed.
      ii. Peer Review Consultants will not have been directly involved in the incident under review.
      iii. The chair will utilize council membership expertise to determine the best accepted consultant “mix” for the review.
      iv. Peer Review Consultants are encouraged to research nursing best practice literature to gain consensus when needed.
   b. The Case Review Evaluation and Summary Form will be completed and both the Evaluation and the Summary Forms will be returned to the council chair within 30 days from the date that the incident or occurrence was accepted for peer review.
   c. A copy of the preliminary findings will be forwarded to the Unit Director and presented to the employee.
   d. The employee will have an opportunity to respond to the preliminary findings. The time frame which has been chosen is 72 hours, extension through request.
   e. Special meetings of the council will be called in order to meet deadlines.

4. Resolution.
   a. The council will render a decision whether an incident/occurrence represents deviation from standard of nursing practice, based on documentation in the patient medical record as evaluated and reported by the Peer Consultants.
   b. If the unit director of an individual whose care has been peer reviewed is considering disciplinary action, existing Human Resources policies on discipline will be followed by the unit director.
   c. Broad peer review case summaries will be included in the quarterly report of the Professional Practice Steering Team.
i. Such summaries will not reveal the identity of the reviewed employees, however, will focus on the issues and contributing factors identified.

d. Recommendations from the Council for addressing contributing factors such as process deficiencies, will be reported to the Professional Practices Steering Committee for assigning improvement action and follow-through.

i. If changes in policy & procedure are recommended as a follow-up, these changes will be forwarded to the team for action and follow-through.

ii. If educational issues are identified, they will be forwarded to the Education Coordinator for action and follow-through.

iii. If physician issues are identified, they will be forwarded to Medical Executive Committee.

iv. The Hospital Risk Manager will coordinate the Root Cause Analysis process and track implementation of corrective actions in response to specific issues identified through peer review.