SECTION 4 – QUALITY ASSURANCE

Desert Cardiovascular Consultants, Las Vegas, NV

Quality Assurance Code 4.1

Policy:

In-office procedures have become increasingly popular. In-office procedure rooms provides an alternative to freestanding ambulatory surgery centers and hospital based outpatient surgery. In order to provide quality care for patients, DESERT CARDIOVASCULAR CONSULTANTS has an ongoing quality assurance program. This program objectively and systematically monitors and evaluates quality and appropriateness of patient care, and pursues opportunities to improve patient care and resolve problems.

Objectives:

1. Develop standards of practice related to the delivery of patient care.
2. Identify pertinent issues and/or problems.
3. Collect and analyze data related to a problem or issue.
4. Communicate results of QA activities to DESERT CARDIOVASCULAR CONSULTANTS staff.
5. Take corrective action and evaluate response.
6. Submit a quarterly report that reflects QA activities/findings.

Organization:

Responsibility for monitoring the Quality Assurance program is vested in the Governing Board. Committee membership shall include but not be limited to:

1. Medical Director
2. Administrative Representative (RN Supervisor)
3. Patient Care Representative (who may be the RN Supervisor)
4. Physician Representative (who may be the Medical Director)
5. Medical Office Representative

Committee members manage the programs of Risk Management, Infection Control, and Medical Records. Their duties shall include collecting, reviewing, and evaluation of appropriate data. The chairperson, usually the RN Supervisor, is responsible for identifying problems, implementing corrective actions, and evaluating the response.

Committee Duties:

1. Evaluate data submitted as part of the Quality Assurance program.
2. Review infection control program and appoint an employee who shall be responsible for monitoring the program.
3. Review standards of practice at DESERT CARDIOVASCULAR CONSULTANTS.
4. Recommend corrective action based on reports.

5. Review accidents, injuries, and safety hazards.
6. Review incident reports and appoint an employee who shall be responsible for monitoring the program. (Risk Management)
7. Review Patient Satisfaction Surveys.
8. Appoint a physician who is responsible to inspect medical records to ensure required documentation and patient data.
9. Review cases and perform quarterly chart reviews.
10. Review physician credentials and perform peer review of clinical performance.
11. Meet at least once every quarter, if necessary. Meetings may be more often if dictated by QA data.
12 Minutes of committee meetings will include date, time, persons attending, description and results of cases reviewed, recommendations, incident reports (Risk Management), Infection Control, complications, follow-up care referrals, transfers, death, patient satisfaction surveys, and patient complaints.
13. Communicate all QA activities to the Governing Board who will review and make appropriate recommendations, if necessary.
14. Ensure the Medial Director and procedure staff will schedule adequate time to conduct and support procedure suite surveys (regulatory, AAAASF, etc.), and all other QA related meetings.

Program:

Quality Assurance is a continuous process that ensures optimal patient care and clinical performance. This will be accomplished through monitoring and evaluation of data collected through chart review, patient complaints/comments, incident reports, peer review, and quarterly checks i.e., medication, environmental, and safety.

Data will be collected by retrospective chart review or direct observation. Data collected will be analyzed. When deficits are identified, causes should be determined, if possible, to arrive at problem resolution. A summary of deficits and alternate solutions will be written and presented to the QA Committee by the designated QA committee member.

All peer reviews will be submitted to the QA Committee and reviewed. If a problem is identified, corrective action will be taken and repeat evaluation performed. All departments will collect data and be responsible to report to the QA Committee.

The RN Supervisor will serve as the QA Coordinator.

Indicators for Evaluation:

A. Volume - log review
    1. Total number of procedures performed at DESERT CARDIOVASCULAR CONSULTANTS for that quarter
    2. Total number of procedures by type
    3. Total number of scheduled, added and canceled procedures

B. Incident Reports - log review (Risk Management)

1. Investigation of patient/employee incident reports
2. Total number of incident reports per quarter
3. Investigate reason/cause of incident reports

C. Environmental and Safety - direct observation
1. Stretchers in low position when patient unattended
2. Side rails up for all sedated patients
3. Emergency equipment available and functional
4. Drugs discarded after expiration date and replaced
5. Walkways free from clutter

D. Infection Control - direct observation
1. Proper use of gloves for all procedures
2. Proper disposal of contaminated needles/sharps
3. Proper handling of specimens
4. Proper disposal of infectious waste
5. Proper cleaning, disinfecting, sterilizing of equipment
6. Proper use of personal protective equipment
7. Proper disposal of linen
8. Log each incident and nature of observed infections

D. Infection Control - log review
1. Investigation of patient infections post discharge
2. Total number of post-discharge infections at DESERT CARDIOVASCULAR CONSULTANTS per quarter
3. Investigate and trace the source of logged infections

E. Complications, Referrals, Transfers - log review
1. Total number of procedural complications with description
2. Total number of follow-up care referrals with description
3. Total number of transfers to hospital with description
4. Total number of patient deaths with description

F. Patient Satisfaction - log review
1. Investigation of patient satisfaction surveys
2. Total number of patient complaints per quarter
3. Investigate cause of patient complaints in a timely manner
   - Was the patient's complaint addressed within one week per policy?
4. Documentation of Patient Complaint Evaluation for each patient complaint received via the Patient Satisfaction Survey

G. Documentation - chart review
1. The staff will review at least 1 chart per month per physician.
2. Any charts with known patient problems and/or complications will be reviewed. All other charts will be randomly selected but must include the first case carried out by each physician each month.

3. All charts will be reviewed to assure the required papers are present and signed appropriately (i.e.) consent, H&P, operative dictation, etc.
4. All charts will be reviewed to assure correct documentation is present (i.e.) allergies.
5. All charts will be reviewed to address any patient pre-op, intra-op, or postop problems or complications.
6. All charts will be reviewed for presence of tissue reports, verbal orders signed within 24 hours, patients response to treatment documented, discharge order signed by M.D. and documentation of a telephone call to the patient the day after surgery.
7. All charts reviewed will be discussed at the quarterly QA meeting, and discrepancies will be addressed.

Committee Structure

Quality Assurance Members (required):

Medical Director
RN Supervisor

Quality Assurance Coordinator – RN Supervisor

Committee Chairpersons:

Risk Management – RN Supervisor
Infection Control – RN Supervisor

Physician Peer Review Code 4.2

Policy:
An active, integrated and organized process of physician peer review will be maintained as part of a peer-based quality management and improvement program.

Principles:

1. The peer review program is the responsibility of the Medical Director. The actual mechanism of peer review is delegated to the physician members of the Quality Assurance Committee and reported to the Medical Director and is consistent with policies of AAAASF. The AAAASF Random Case Review, Unanticipated Sequelae Form, and Unanticipated Sequelae Addendum forms will be completed and reported on line at the AAAASF website, www.aaaasf.org. Results of peer review can be forwarded to AAAASF by email or surface mail for AAAASF administration to input reports for a nominal fee per physician. (Contact the AAAASF office for current reporting fees.)

2. Data will be collected and evaluated on a quarterly basis.

3. Data consists of, but is not limited to, the following:
    a. History and physical are adequate based on the chief complaint.
    b. Diagnoses are appropriate for the findings in the history and physical.
    c. Procedures are appropriate based on the diagnosis.
    d. Procedure is completed without physician-related complications.
    e. Complications are identified, documented, and managed appropriately.
    f. Procedure is one that is included in the physician's scope of practice as identified by his or her privileges.
    g. Required signatures of physician are present and dated.
    h. Adequacy of procedure consent form.
    i. Presence of a dictated or written operative report or its equivalent.
    j. Anesthesia record.

4. Data collection will be by chart review and conducted by the physician members of the Quality Assurance Committee.

5. Results of peer review will be maintained in the minutes of the Quality Assurance Committee, and discussed at the quarterly meeting.

6. Results of peer review activity will be used in the process of granting continuation of privileges.

7. A business agreement will be executed with each reviewing person to maintain compliance with HIPAA, if using outside reviewers.

Anesthesia Peer Review Code 4.3

Policy:
The facility uses RNs competent in the administration of conscious sedation to administer anesthesia under the direction of the physician. The anesthesia record will be reviewed during chart review.

Random Case Review Code 4.4

Purpose: To identify a means of monitoring and evaluating appropriate chart documentation in order to provide quality patient care.

Procedure:
1. Chart reviews will be performed by staff at least every quarter.
2. All charts with known patient problems and/or complications will be reviewed; all other charts will be randomly selected. This must include the first case by each physician each month during the reporting period for a total of three cases per physician per quarter. All charts will be reviewed to assure the required documents are present and signed appropriately (i.e.)consents, H&P, operative dictation, etc.
3. All charts will be reviewed to assure correct documentation is present (i.e.) allergies.
4. All charts will be reviewed to assure that all labs that were ordered preoperatively are present. All abnormal labs, pathology reports and medical clearance reports are initialed by the physician.
5. All charts will be reviewed to address any patient pre-op, intra-op or post-op problems or complications.
6. All charts will be reviewed for presence of tissue reports, verbal orders signed with 24 hours, patient's response to treatment documented, discharge order signed by M.D., and post-op call documentation.
7. All charts reviewed will be discussed at the quarterly QA meeting and discrepancies will be addressed.

Patient Satisfaction Surveys Code 4.5

Purpose: To establish a means of monitoring patient satisfaction to the delivery of patient care.

Procedure:
1. Patient satisfaction questionnaires will be handed out to patients.
2. Patient's written name on the survey is optional.
3. All questionnaires will be reviewed.
4. Any problems and/or complaints will be addressed accordingly by their nature.
5. A patient may be contacted by phone by the RN Supervisor if:
   a. The patient signs his/her name to the complaint.
   b. The patient complaint requires attention.

6. All questionnaires will be reviewed at the quarterly Quality Assurance Committee meeting.
7. All questionnaires will be kept on file at the facility for up to one year.

Risk Management Code 4.6

An active risk management program is essential as a part of any quality assurance program. The Medical Director is responsible for the risk management program under the direction of the Governing Board. Risk management and quality improvement depend on prompt and complete reporting of all events and hazards.

Introduction:
Effective event reporting is necessary in developing integrated risk management and quality improvement programs. In addition, analysis and evaluation of data will eventually reduce risk exposure.

Essentially, event reporting provides a mechanism to allow early intervention to ensure patient safety. Incident reports serve to document accurate records of untoward happenings or unanticipated occurrences so there can be a prompt assessment of risk exposure.

It is important that those involved in complying with event reporting procedures realize that detection and correction of unsafe practices or procedures is essential to provide a safe environment for patient care.

It is equally important to remember:
1. Incident reports should not be used as a basis for disciplinary purposes;
2. All corrective and preventive measures should be concerned primarily with the problem or event being reported and not the particular person involved.

Policy:
The employee who discovers, witnesses, or becomes aware of circumstances indicative of an unsatisfactory event will complete an incident report.

Definition:
An event is any happening that is not consistent with the routine operation of the facility or routine care of a particular patient. It may be an accident or a situation that may result in an accident. This might involve a patient, visitor, or employee.

Purpose:
1. To improve the management of patient care and treatment by assuring that appropriate and immediate intervention occurs for the patient's safety and to assure the prevention of recurrences.
2. To provide a database so that the care given can be analyzed.
3. To provide a record of the event.

Method of Reporting:

1. The event is to be documented on an incident report form, which will be completed within 24 hours of the occurrence by the employee who discovers, witnesses, or to whom the event is reported. **This report is not to be placed on the patient's chart.**

2. The following details are important and should be included in the report:
    a. What happened and what effect it had on the individual involved.
    b. Medically relevant facts as well as environmental details, if relevant to the event.
    c. Statements of patient or witnesses regarding degree of injury and what occurred.
    d. Injuries as observed by the physician or nursing personnel.
    e. Information which indicates final outcome.

3. The fact that an incident report has been filed should NOT be documented in the patient's medical record. All medically relevant events shall be recorded in the patient's medical record. The event must be described, the time of occurrence recorded, all actions taken and results of interventions. Subsequent monitoring of the patient's condition shall also be recorded.

4. Employees shall make no statements to patients, visitors, or any other persons not employed by the facility about the outcome or disposition of an event except at the specific direction of Administration. All incident reports shall be treated as confidential information.

Report Review:
1. Initial investigation of each situation will be conducted by the RN Supervisor and reported to the Medical Director.
2. The RN Supervisor and the Quality Assurance Committee will review all incident reports.
3. The Quality Assurance Committee will recommend corrective measures.

Physician Reporting:
1. Physicians have a responsibility to report events of which they are aware.
2. The physician may report the event by means of an incident report, or verbally to the RN Supervisor. The RN Supervisor will be responsible for reporting the event to the Medical Director and Quality Assurance Committee.
3. The physician will be responsible for reporting the event to his or her own insurance carrier.

Guidelines for Handling Potentially Serious Events:
1. Potentially serious events should be reported immediately to the facility's liability insurance carrier and/or the insurance carrier of the physician.

Guidelines for Reporting Hazards:
1. A hazard is a situation or condition that could produce an event if it is allowed to continue without correction. It need not be restricted to the physical condition of buildings or equipment. Hazards can include the methods and procedures by which tasks and activities are performed.
2. The correction of hazards is a first line defense in attaining the objective of a safe environment for patient care.
3. The person observing a hazard should report the hazard and should take immediate steps to protect other persons from the hazard.
4. Hazards are to be reported verbally or in writing to the RN Supervisor or Medical Director.

5. The individual sighting the hazard (e.g., water on the floor) may be able to correct it, in which case, no further action is needed. If equipment is defective or inoperable, it should be identified in writing with serial number, model number, lot number and name of manufacturer's and location.
   a. Broken or defective equipment involved in a patient event should be identified in the same manner on the incident report.
   b. Defective equipment should be immediately removed from service and sent for repair or evaluation.

Guidelines for reporting to the Department of Health:

1. If facility becomes aware of information that shows that the facility is not in compliance with any of the Department's regulations that are applicable and that non-compliance seriously compromises quality assurance or patient safety, the facility shall immediately notify the Department in writing of the noncompliance.

Unanticipated Operative Sequelae Code 4.7

Purpose: To identify and review all unanticipated operative sequelae that occurs within 30 days of procedure.

Procedures:

1. On or about 30 days after the procedure, a procedure staff member will follow up on each patient to determine if any unanticipated events have occurred.

2. The patient review will include, but is not limited to, the following: Unplanned hospital admissions, unscheduled return to the operating room for complications, infection, bleeding, other related injuries, cardiac problems, respiratory problems, allergic reactions, patient complaint, records from procedure relating to safety checklist (item counts, equipment operation, etc.), death.

3. If an unanticipated operative sequelae exists, a chart review must be completed. The review must include procedure performed, identification of the problem, all follow up treatments, outcome, reason for problem, assessment of efficacy and final disposition.