PATIENT SAFETY, CLINICAL PRACTICE AND QUALITY COMMITTEE (P_SQ_S)

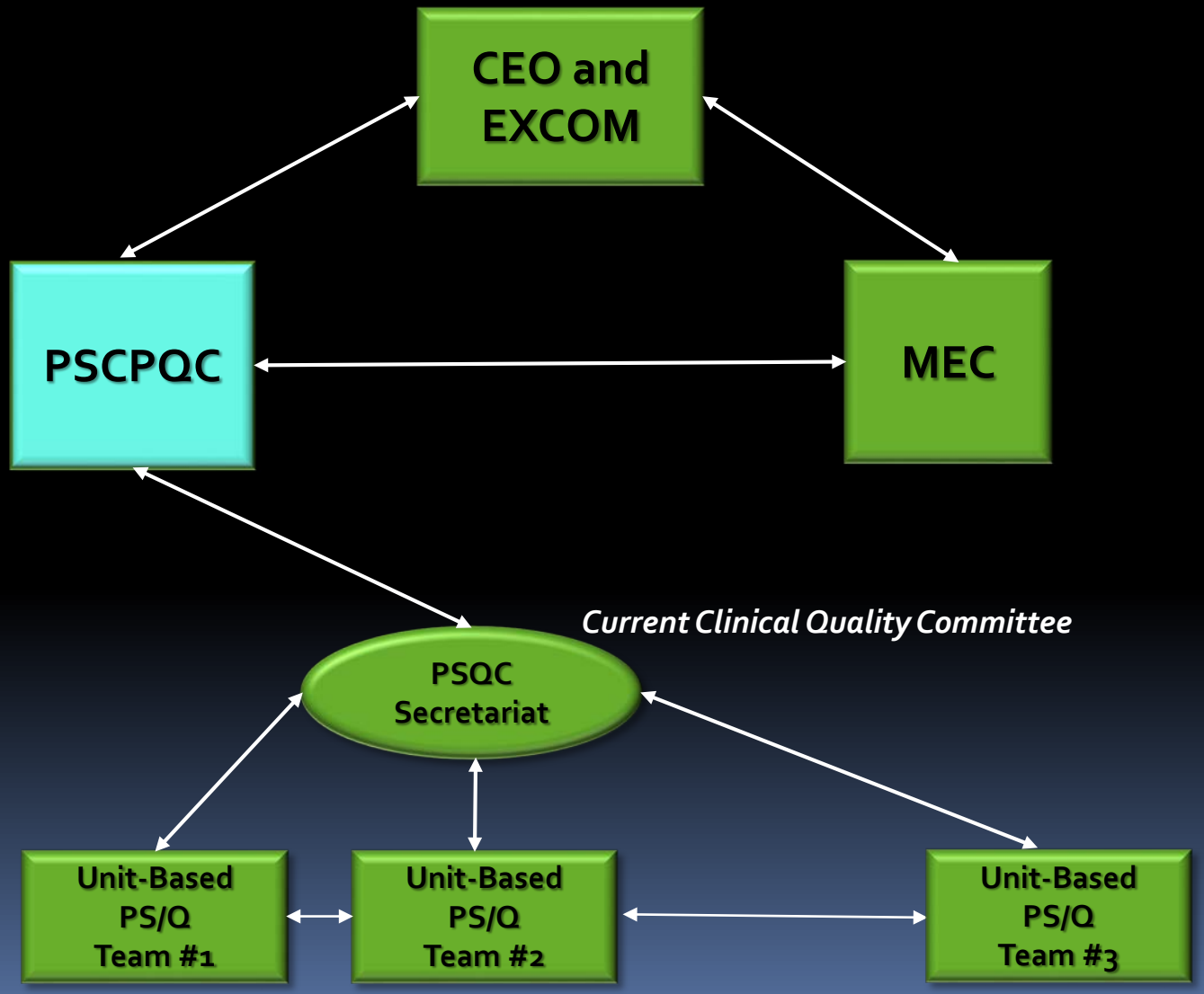
UPDATE

Clinical Center Research Hospital Board
July 20, 2018

PsQs

NAME	IC	SPECIALTY
Janice Lee, DDS, MD **Chair**	NIDCR	Oral and Maxillofacial Surgery and Craniofacial Anomalies
Chris Koh, MD, MHSc	NIDDK	Internal Medicine, Gastroenterology, Hepatology, Program Director, Hepatology (non-ACGME)
David Lang, MD	CC	Pediatrics Chair, HHS Medical Claims
Nitin Seam, MD	CC	Critical Care, Pulmonary Med, Internal Med, Sleep Med Interest in Medical education
Jeremy Davis, MD	NCI	Surgical Oncology Program Director, Oncology Fellowship (non-ACGME)
Tara Palmore, MD	CC	ID, Hospital Epidemiology
Lisa Horowitz, PhD, MPH	NIMH	Pediatric Psychologist Boston Children's Safety Program
Lauren Bowen, MD	NINDS	Clinical Fellow, Neurology, Internal Medicine
Deldelker James, RN	CC	Nursing Oncology and BMT Certified
Dachelle Johnson, PharmD	CC	Pharmacy Experience mainly Critical Care
CAPT Toni Jones, RN	CC	Patient Representative Oncology Nursing
Janet Valdez, PA	NHLBI	Mid-level provider at large, Transplant, Hematology
Colleen Hadigan, MD, MPH	NIAID	Staff Clinician at large, Pediatrics, Gastroenterology and Nutrition
Jen Kanakry, MD	NCI	Staff Clinician at large, Transplant
Laura Lee, MSN, RN	CC	Director, Office of patient Safety and Clinical Quality
Carrie Kennedy, JD, RN	OGC	OGC Representative, ex officio Registered Nurse
Gina Ford, RN	CC	PSCPQC Admin Associate

Managing Patient Safety and Quality



PsQs

- First meeting: April 24, 2017
- Monthly meetings
- Reviewed charge with Dr. Gilman
- Compiled priority list of areas that need attention and may need to be addressed by PSCPQC, N=29 items
  - Red Team reports
  - ORS/STARS
  - Areas identified by committee members
- Presented to the MEC and Annual Meeting of the NIH Clinical Staff

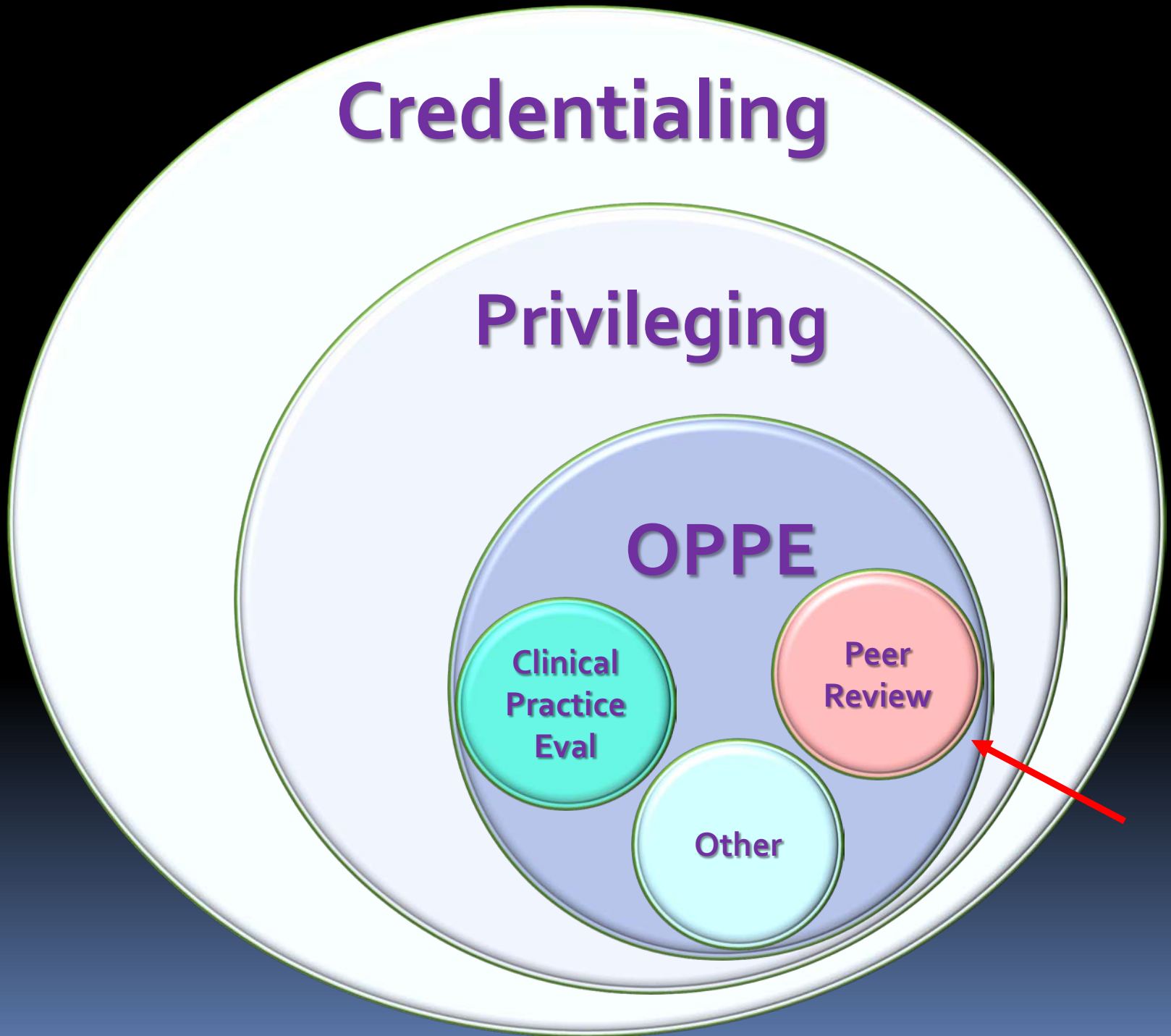
PsQs Priority – subcommittee reviews

1. Peer review – re-credentialing
   - Janice Lee, Colleen Hadigan, Jeremy Davis, Janet Valdez
2. Quality of consult service
   - David Lang, Jen Kanakry, Chris Koh, Janet Valdez, Schuyler Deming, Lisa Horowitz
3. High risk/low volume procedures
   - Toni Jones, Deldecker James, Jeremy Davis, Nitin Seam

Quality of clinical care
Culture of safety

Peer Review - Problem identification

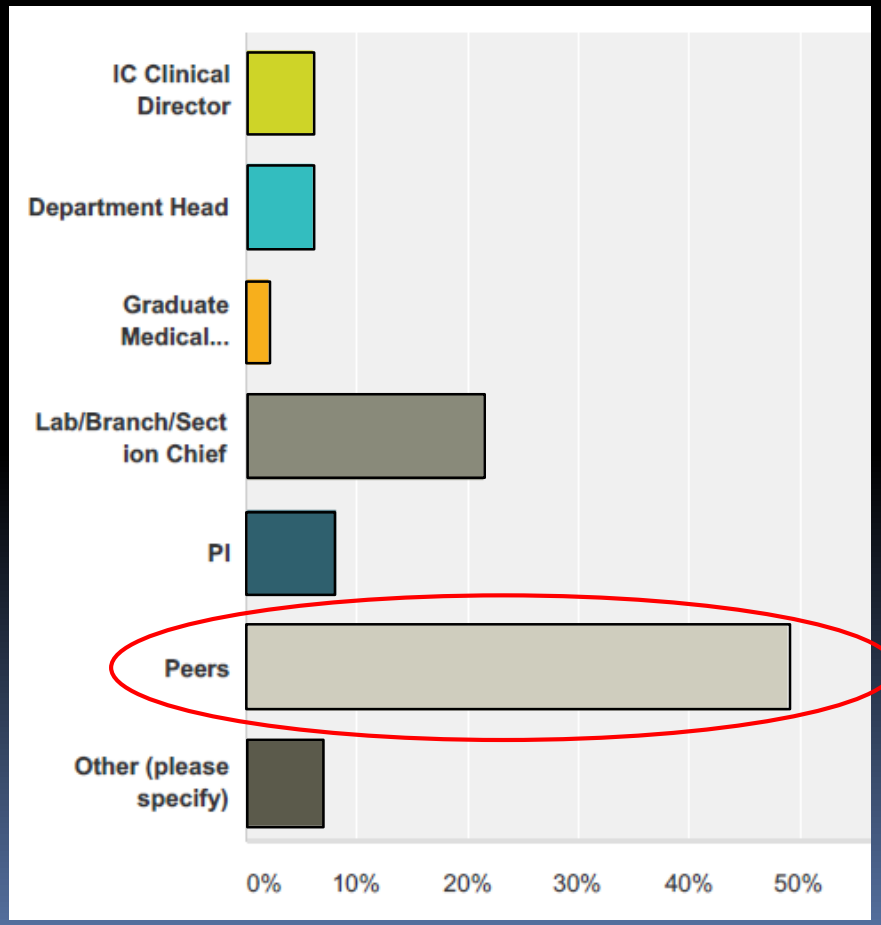
- How do we assess clinical care quality?
- No standardized process for peer review within or across Institutes at the NIH.
- Almost all ICs include some form of peer review:
  - two indicated a standard practice of sharing the results of the performance review with the clinician
  - one indicated sharing results only when corrective action was needed
  - many of the members of the PSCPQC were unaware of the OPPE, the frequency with which it is to be completed or who in their organization completes them


Credentialing
Privileging
OPPE
Clinical Practice Eval
Peer Review
Other

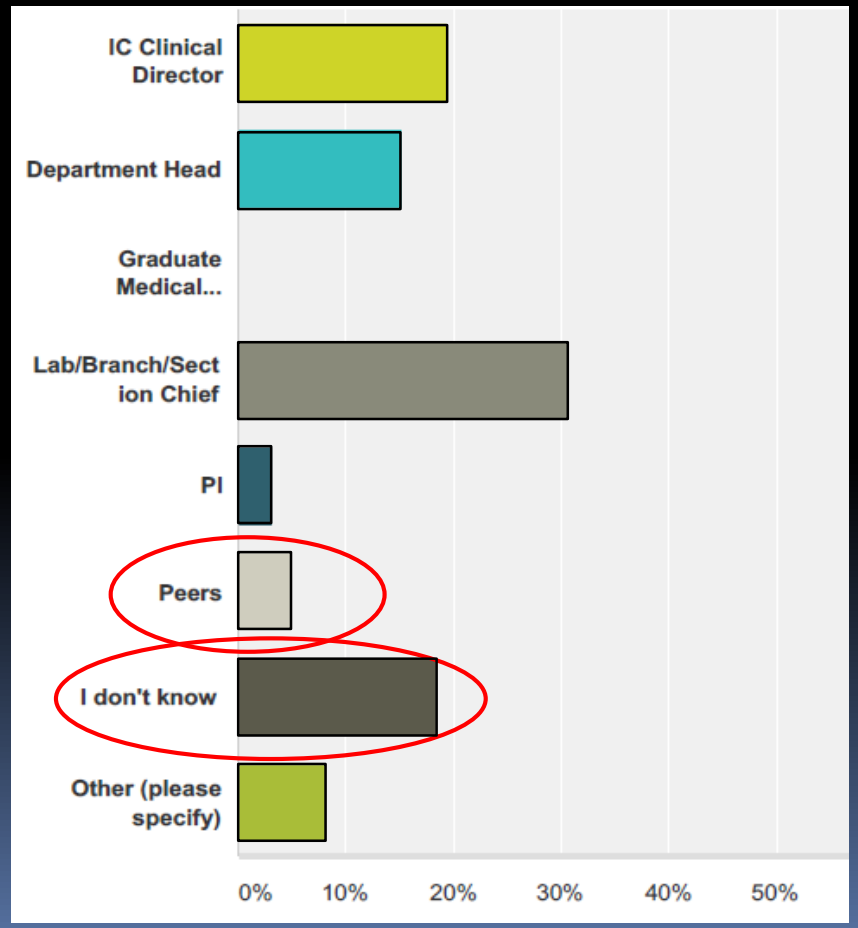
2016 Staff Clinician Survey: maintenance of certification, CME, performance evaluations

N = 104 (40%)

Who Can Best Assess your Clinical Skills?



Who Does?



Ongoing Professional Practice Evaluations

Designed to assess practitioner competence in the following six areas:

- Patient Care
- Medical/Clinical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems–Based Practice

From: J Hendery, Med Staff Cred/Privileging MEC presentation, 9/19/17

OPPE Form

Methods/Sources of Information Used in the Evaluation:

- Clinical performance data (57%)
- Discussion with others involved in provision of care (80%)
- Direct Observation (73%)
- Simulation (1%)
- External peer review (9%)
- Other (13%)

Keys Issues

- Missed opportunities for incorporating valuable peer review and quality feedback as part of performance evaluations
- General lack of awareness of current practices for performance evaluation
- Opportunity to enhance trans-NIH uniformity, compliance, and transparency with OPPE
- Opportunity to enhance communities of practice at the CC
- Inclusion of peer review may be important for assessment of high risk/low volume procedures (in setting of research hospital and rare diseases)

1. Sneddon A, MacVicar R. Annual trainer peer-review: impact on educational practice and sense of community. *Educ Prim Care*. 2016;27(2):114-120.
2. Nurudeen SM, Kwakye G, Berry WR, et al. Can 360-Degree Reviews Help Surgeons? Evaluation of Multisource Feedback for Surgeons in a Multi-Institutional Quality Improvement Project. *J Am Coll Surg*. 2015;221(4):837-844.
3. Bergum SK, Canaan T, Delemos C, et al. Implementation and evaluation of a peer review process for advanced practice nurses in a university hospital setting. *J Am Assoc Nurse Pract*. 2017;29(7):369-374.
4. Moriarity AK, Hawkins CM, Geis JR, et al. Meaningful Peer Review in Radiology: A Review of Current Practices and Potential Future Directions. *J Am Coll Radiol*. 2016;13(12 Pt A):1519-1524.

Recommendations

- Require employee co-signature at completion of all OPPE forms

- Partner the OPPE with PMAP:
  - Enhance compliance with Joint Commission standards (more than once a year)
  - Provide guaranteed direct feedback to employee about the content of the OPPE

Recommendations

- **Create a standardized peer-review process to coincide with the OPPE at the time of re-credentialing (every 2 years)**
  - **Clinicians – identify 3 peers/colleagues to evaluate performance and competence**
  - **Supervisor solicits an assessment using standardized form:**
    - **Quality of care**
    - **Timeliness – response and documentation**
    - **Professionalism**
    - **Interactions with trainees or subordinates**
- **Allows for performance evaluation that can account for the unique nature of clinical skills and practice in the NIH CC where standard performance metrics may be less applicable.**

Quality of consult service

- Problem identification
  - Availability
  - Communication
  - Consistency - timeliness, documentation policies

Summary of Pilot Data – S. Deming

- Over 80% of the time a consult question was identifiable to the reviewer, a consult note was completed, recommendations were performed by the primary team, and follow up was evident.
- Clinical supervision of trainees was documented less than 80% of the time
- Direct communication by consult service to primary team was documented in less than 35%
- CRIS orders were in finalized status less than 50% of the time.

Quality of consult service

- Actions
  - Availability – update roster of consult services and meet consult service chiefs, survey consult service chiefs (REDCap EDC)
  - Communication – CRIS consult service templates (linked to consult orders)
  - Consistency – update and revise the Medical Administrative Series (M76-5)
- Future Action
  - Assessment of consult quality

High risk/low volume procedures

- Problem identification - survey to clinicians and supervisors to gather information to define HRLV (REDCap EDC)
- Prioritize areas of risk
- Design methods to address risk for HRLV procedures