QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - SURGICAL CARE REVIEW (INCLUDING TISSUE REVIEW)

INDICATOR(S):

1. Unexpected return to surgery.

2. Unplanned removal of or damage to an organ or body part.

3. Unplanned transfer to ICU/CCU, or unplanned inpatient admission for outpatient surgical.

4. Nosocomial infection.

5. Pathology findings differ significantly from surgery findings, or pre- or post-op diagnosis.

6. Cardiac or respiratory arrest or CVA during or within 48 hours of surgery.

7. Incident resulting in or with the potential for adverse patient outcome.

8. Transfer to another ACF.

9. Surgery cancelled or delayed due to improper patient preparation, equipment failure, or scheduling/staffing problem.

10. Postoperative complications or adverse outcome.

11. Readmission to hospital within 31 days of surgical procedure for related reason.

12. Case does not meet procedure specific SIM criteria.

13. Missing sponge, needle, or instrument, or foreign body left in operative site, or break in sterile technique.

14. Wrong patient operated on or wrong procedure performed.

15. Physician requests review of case.

16. AMA.

SAMPLE: A representative sample of inpatient and outpatient surgical cases.
METHODOLOGY: Retrospective record screening by non-physician personnel for above indicators. Records identified through the screening process will be referred for physician peer review.
DATA SOURCE: Medical records, surgery log books, patient registers.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - MEDICAL RECORD REVIEW
(Medical, ICU/CCU, Skilled)

INDICATOR(S):

1. Admission order includes provisional diagnosis

2. H&P includes:
   a. Chief Complaint
   b. HPI
   c. Past History
   d. Family History
   e. Social History
   f. Review of Systems
   g. Physical Examination
   h. Diagnosis or Impression
   i. Plan

3. Progress notes:
   a. Appropriate frequency (every 48 hrs for acute medical, weekly for skilled, daily for critical care or cases which are difficult to diagnose or manage)
   b. Clinical problems clearly identified and correlated with specific orders as well as results of tests and treatments.

4. Discharge Summary:
   a. Gives reason for admission
   b. Describes physical condition on admission
   c. Gives course of treatment
   d. Gives physical examination and condition at discharge
   e. Gives discharge instructions/follow up plan

SAMPLE: A representative sample of inpatient medical, ICU/CCU, and skilled care cases.
METHODOLOGY: Retrospective record screening by non-physician personnel for above indicators. Results will be reported to Medical Staff Executive Committee for evaluation and appropriate action.
DATA SOURCE: Medical records, patient registers.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - MEDICAL RECORD REVIEW (Surgical)

INDICATOR(S):

1. Admission order includes provisional diagnosis

2. H&P dictated prior to surgery includes:
   a. Chief Complaint
   b. HPI
   c. Past History
   d. Family History
   e. Social History
   f. Review of Systems
   g. Physical Examination
   h. Diagnosis or Impression
   i. Plan

3. Informed Consent to procedure complete and accurate

4. Risks and Alternatives documented

5. Consultation (exceptions: emergency cases, minor cases, T&A's, repeat C-sections, and D&C's)

6. Operative Report:
   a. Dictated within 24 hours of procedure
   b. Includes preoperative and postoperative diagnosis
   c. Includes description of procedure

7. Progress notes:
   a. Appropriate frequency (at least every 48 hours, daily if critical or difficult to manage)
   b. Clinical problems clearly identified and correlated with specific orders as well as results of tests and treatments.

8. Discharge Summary:
   a. Gives reason for admission
   b. Describes physical condition on admission
   c. Gives course of treatment
   d. Gives physical examination and condition at discharge
   e. Gives discharge instructions/follow up plan

SAMPLE: A representative sample of inpatient medical, ICU/CCU, and skilled care cases.
METHODOLOGY: Retrospective record screening by non-physician personnel for above indicators. Results will be reported to Medical Staff Executive Committee for evaluation and appropriate action.
DATA SOURCE: Medical records, patient registers.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - MEDICAL RECORD REVIEW (Obstetrics)

INDICATOR(S):

1. Prenatal record from clinic present on record.

2. H&P includes:
   a. Chief Complaint
   b. HPI
   c. Past History
   d. Family History
   e. Social History
   f. Review of Systems
   g. Physical Examination
   h. Diagnosis or Impression
   i. Plan

3. Informed Consent to procedure if C-Section

4. Risks and alternatives if C-Section

5. Consultation if primary C-Section

6. Delivery Note or Operative Report:
   a. Dictated within 24 hours of procedure
   b. Includes description of procedure

7. Progress notes:
   a. Appropriate frequency (at least every 48 hours, daily if critical or difficult to manage)
   b. Clinical problems clearly identified and correlated with specific orders as well as results of tests and treatments.

8. Discharge Summary:
   a. Gives reason for admission
   b. Describes physical condition on admission
   c. Gives course of treatment
   d. Gives physical examination and condition at discharge
   e. Gives discharge instructions/follow up plan

SAMPLE: A representative sample of inpatient medical, ICU/CCU, and skilled care cases.
METHODOLOGY: Retrospective record screening by non-physician personnel for above indicators. Results will be reported to Medical Staff Executive Committee for evaluation and appropriate action.
DATA SOURCE: Medical records, patient registers.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - ER/OPD REVIEW

INDICATOR(S):

1. Unscheduled return to ER/OPD within 48 hours for related condition or admission to hospital within 1 month of evaluation and discharge from ED for related condition.

2. AMA or refuses treatment.

3. Transfer to another acute facility (exception - documented compliance with EMTALA).

4. Incidents, events, or patterns of care resulting in or with potential for adverse patient outcome (including adverse drug reactions).

5. Inappropriate setting to meet patient needs.

6. No documented followup instructions or followup plan for care.

7. Indication of infection, laceration, tear, or puncture following invasive procedure.

8. Abnormal results of diagnostic studies not resolved or addressed, or record does not explain why not resolved.

9. Physician requests review of case.

10. Cardiac or respiratory arrest.

11. Patient seen for a complication resulting from treatment or procedure on a previous visit/admission.

12. Discrepancy between initial and final x-ray, lab or EKG reading requiring an adjustment of patient management.

13. Missed diagnosis.

14. Emergency Room patient not seen by a physician or PA.

15. Narcotic dispensation without physician evaluation at time of presentation to the ER/OPD.

SAMPLE: A representative sample of outpatient/ER cases for all physicians.
METHODOLOGY: Retrospective and/or concurrent screening by non-physician personnel for above information. Cases identified through the screening process will be referred to physician review.
DATA SOURCE: Outpatient/ER records, Patient information systems.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - ICU/CCU REVIEW

INDICATOR(S):

1. "No Code" patient in ICU/CCU.
2. Transfer to another ACF.
3. Codes.
4. Deaths.
5. Incidents resulting in or with potential for adverse patient outcome.
6. Critical care equipment failure resulting in adverse outcome.
7. AMA.
8. Adverse effects or adverse patient outcomes, or care with potential for adverse outcome, including, but not limited to: development of GI bleed, renal insufficiency, CHF, pulmonary edema, pneumonia, abnormal ABG's, abnormal kidney function, decubitus, etc., not appropriately monitored or treated in a timely manner.
9. Physician requests review of case.

SAMPLE: A representative sample of all patients admitted to ICU/CCU.
METHODOLOGY: Retrospective and/or concurrent screening by non-physician personnel for above information. Cases identified through the screening process will be referred to physician review.
DATA SOURCE: Medical Record, Patient Information System.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - MEDICAL CARE REVIEW

INDICATOR(S):

1. Transfer to another acute care facility (unexpected).

2. Transfer from general unit to ICU/CCU, isolation, or emergency surgery.

3. Unexpected cardiac or respiratory arrest in already hospitalized patient.

4. Readmission within 31 days for related reason.

5. Nosocomial infection.

6. AMA.

7. Incidents resulting in patient injury or potential for injury or that alter patient therapy or LOS.

8. Physician requests review of case.

9. Medical care with potential for or resulting in adverse effects or adverse outcome for patient, including, but not limited to:

   A. Development or worsening of decubitus ulcers.
   B. Electrolyte abnormalities not monitored or treated in a timely manner.
   C. Medication choices not substantiated by appropriate diagnostic studies.
   D. Significantly abnormal diagnostic studies without documented awareness, treatment, or plan for followup.

SAMPLE: A representative sample of all medical admissions.
METHODOLOGY: Concurrent and/or retrospective record screening for above information by non-physician personnel. Cases identified during the screening process will be referred to physician review.
DATA SOURCE: Medical Record, Patient Information Systems.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - NEONATAL CARE REVIEW

INDICATOR(S):

1. Less than 34 or greater than 42 weeks EGA.

2. Apgar <4 at 1 minute or <6 at 5 minutes.

3. Resuscitation at birth.

4. Birth trauma (laceration, fracture, dislocation, palsies, severe molding, cephalhematoma, intracranial hemorrhage, forceps injury, etc.) (Code 767)

5. Meconium aspiration or significantly stained amniotic fluid or diagnosis of massive aspiration syndrome. (Code 770.1)

6. Transfer to NICU/another ACF.

7. Congenital anomaly.

8. Seizure.

9. RH isoimmunization/ABO incompatability.

10. Respiratory distress (grunting, retractions, cyanosis, resp rate over 70 for more than 4 hours).

11. Infection (Elevated temp over 101 for more than 4 hours, antibiotic use).

12. Hyperbilirubinemia: full term: >12 @ 24 hrs, >15 @ 48 hrs, > 20 anytime,
preterm: > 7 @ 24 hrs, >12 @ 48 hrs, >15 anytime.

13. Low pH.

14. Incidents with potential for, or resulting in, adverse outcome.

15. Delivery of an infant weighing < 1800 gm (4 lb).

16. Physician requests review of record.

SAMPLE: A representative sample of all newborns delivered.
METHODOLOGY: Concurrent and/or retrospective review for the above indicators by non-physician personnel. Cases identified through the screening process will be referred to physician review.
DATA SOURCE: Medical records, Delivery Room register, Patient Information System.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - OBSTETRICAL CARE REVIEW

INDICATOR(S):

1. Unexpected return to delivery or sugery, same stay.

2. Delivery unattended by physician.

3. Blood loss excessive, except with abruptio placenta or placenta previa, as evidenced by either a red cell transfusion, a hct < 22, a hgb < 7, or a decrease in hct of more than 11, or of hgb more than 3.5.

4. Fourth degree laceration or extension.

5. Mid/high forceps delivery or forceps injury to mother.

6. Eclampsia/toxemia. (Bp > 160/110).

7. Birth injuries (fx coccyx, dislocated hip, etc.).

8. Breech vaginal delivery.

9. Unexplained fever during labor/delivery or postpartum infection.

10. Any unusual conditions of placenta or cord. (abruptio, infarction, rupture, vasa previa, knotted cord, abnormal appearing cord, giant chorangioma, prolapse).

11. Ruptured membranes greater than 24 hours.

12. Transfer to another acute care facility (in active labor).

13. Gestation <35 or > 42 weeks.

14. Active labor more than 20 hours.

15. Second stage more than 2.5 hours.

16. Retained placenta > 30 minutes.

17. Total labor time < 3 hours.

18. Induction for indications other than diabetes, premature rupture of membranes, pregnancy induced hypertension, post-term gestation, intrauterine growth retardation, cardiac disease, isoimmunization, fetal demise, chorioamnionitis, or with over 4 hour labor (multip) or 6 hours labor (primip).

19. Primary C-section for failure to progress.

20. Delivery of an infant, by planned repeat C-Section or by induction, weighing <2500 grams (5.5 lb) or with hyaline membrane disease.

21. Maternal readmission within 14 days of delivery.

22. AMA.

23. Incidents with potential for or resulting in adverse patient outcome.

24. Physician requests review of case.

SAMPLE: All obstetric cases for all providers.
METHODOLOGY: Concurrent and/or retrospective screening by non-physician personnel for the above indicators. Cases identified through the screening process will be referred to physician review.

DATA SOURCE: Medical records, Delivery Room Register, Infection control reports, Patient information system.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - SKILLED/LONG TERM CARE REVIEW

INDICATOR(S):

1. Readmit to ACF.

2. Unexpected cardiac or respiratory arrest.

3. Nosocomial infection.

4. Incidents with potential for or resulting in adverse patient outcome.

5. Polypharmacy (more than 7 routine drugs). (Exception: documented drug regime review by physician or pharmacist with no changes indicated.)

6. Unexpected death. (No documentation of terminal condition).

7. AMA.

8. Patient or family complaints.

9. Patterns of care with potential for or resulting in adverse patient outcome, including, but not limited to:

   A. Abnormal vital signs without documentation of physician notification, awareness, and evaluation within 24 hours.
   B. Hydration or nutritional problems with no plan of care.
   C. Sudden onset of confusion or change in mental status.
   D. Mobility problems such as decrease in ADL, new contractures, ability to transfer.
   E. Pressure sores, development or worsening.
   F. Inappropriate use of restraints.
   G. Elimination problems, change in continence, urinary output, diarrhea or constipation.

10. Physician requests review of case.

SAMPLE: A representative sample of SNC/LTC patients.
METHODOLOGY: Concurrent and/or retrospective screening by non-physician personnel for the above indicators. Cases identified through the screening process will be referred to physician review.
DATA SOURCE: Medical records, infection control reports, Patient information system.

QUALITY INDICATORS

INDICATORS FOR: ACUTE CARE_____ SKILLED CARE_____ YEAR_____

ASPECT OF CARE/FUNCTION: MEDICAL STAFF - MORTALITY REVIEW

INDICATOR(S):

1. Death within 48 hours of admission (exception: documentation of known terminal disease).

2. Death in ER/OPD, including observation outpatient.

3. Death during or following surgery (within 30 days of surgical procedure).

4. Maternal death (within 42 days of delivery).

5. Perinatal death, including stillborn.

6. Unexpected death as inpatient - no documentation of critical or terminal condition.

7. Death in ICU/CCU.

8. Pediatric death.

9. Patient not resuscitated after cardiac arrest and no "Do Not Resuscitate" order documented on record.

10. DOA (and has been discharged from hospital or ER/OPD within past 7 days).

11. Death among patients treated in the hospital for injuries sustained immediately prior to treatment when death occurs within 30 days of injury or during hospitalization.

SAMPLE: All deaths.
METHODOLOGY: Retrospective and/or concurrent screening of records by non-physician personnel for the above indicators. Records identified through the screening process will be referred to physician review.
DATA SOURCE: Medical records, death register, patient information system.