HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER MATERNITY AND CHILDREN HOSPITAL

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|---|---|---|---|
| **Department:** | Medical Services | | |
| **Document:** | Multidisciplinary Policy and Procedure | | |
| **Title:** | Physicians On – going Professional Practice Evaluation, Peer Review and Unplanned Evaluation | | |
| **Applies To:** | All Medical Staff | | |
| **Preparation Date:** | January 05, 2025 | **Index No:** | MS-MPP-002 |
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## 1. PURPOSE:

1.1 Establish a standardized process and set guidelines for on-going professional practice evaluation, peer review, unplanned and focused professional practice evaluation of Maternity and Children Hospital Hafar Al Batin medical staff.

1.2 Define the type of data (indicators/criteria) to be collected for the on-going professional practice evaluation.

1.3 Use the information resulting from the evaluation to improve the quality and safety of patient care provided by the medical staff.

## 2. DEFINITIONS:

2.1 **On-going Professional Practice Evaluation 'OPPE":**

2.1.1 Is an on-going process to gather and review data/information on a regular basis on the physician's medical competencies and professional behaviours with the purpose of improving the quality and safety of the patient care provided by each medical staff member.

2.1.2 Though this process, practitioners receive feedback for potential personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice.

2.2 Focused Professional Practice Evaluation "FPPE," (focused review):
A time limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for:

2.2.1 All newly requested privileges.

2.2.2 Whenever a question arises regarding a practitioner's ability to provide safe high quality specific privilege patient care.

2.3 **Peer Review** – Medical peer review is the process by which a committee of physicians examines the work of a peer and determines whether the physician under review has met accepted standards of care in rendering medical services. Results of Peer Review are utilized as a pan of the on-going medical Staff evaluation and to improve the physicians and hospital performance as a whole.

2.4 **Peer** – is defined as a licensed independent practitioner with clinical privileges in the same specialty and with essentially equal qualifications as the evaluated medical staff member.

2.5 **Peer reviewer:**

2.5.1 Is a member of medical staff, in good standing, licensed and privileged in the same medical specialty as individual whose case is under review.

2.5.2 He/she will not have performed any medical management on the patient whose case is under review.

2.6 **External peer**– is a qualified practitioner peer with similar training and experience who can render an unbiased opinion on the quality or conduct of care for the case. He/she can be a member in good standing, not licensed in same specialty as the individual whose case is under review, requested to review regarding specific issues related to the management of the case under review.

## 3. POLICY:

3.1 All physicians at MCH will be subjected to annual on-going professional practice evaluation that includes:

- 3.1.1 Competency based, on-going monitoring and evaluation:
  - 3.1.1.1 Performed annually and when indicated by the findings of performance improvement plans.
  - 3.1.1.2 Encompasses behaviour, communication, ethics, discipline, professional growth and clinical results.
- 3.1.2 Peer Review Evaluation: Based on clinical criteria.

3.2 Unplanned evaluation for physicians will be initiated, if required, based on certain clinical or administrative criteria:( Will share in the total score of the physician annual evaluation by 20%.)

- 3.2.1 Unplanned Peer Review evaluation (Clinical)
- 3.2.2 Unplanned Disciplinary evaluation (Administrative)
- 3.2.3 Situations for Unplanned Peer Review may include, but is not limited to:
  - 3.2.3.1 **General Indicators:**
    - 3.2.3.1.1 Readmission within 30 days for related condition.
    - 3.2.3.1.2 Unscheduled return to Emergency Department (ED) within 48 hours.
    - 3.2.3.1.3 Quality of discharge summary.
    - 3.2.3.1.4 Unexpected transfer or return to ICU.
    - 3.2.3.1.5 Pharmacy e.g. duplicative therapy, incomplete or unclear orders, dosing errors, ordering medications to which the patient has a known allergy.
    - 3.2.3.1.6 Resource utilization.
    - 3.2.3.1.7 Antibiotic usage.
    - 3.2.3.1.8 Blood usage, according to guidelines, proper identification prior to use and handling transfusion reactions.
    - 3.2.3.1.9 Noncompliance with hospital policies and guidelines.
    - 3.2.3.1.10 Patient complaints.
    - 3.2.3.1.11 Sentinel events.
    - 3.2.3.1.12 Disruptive behaviour.
    - 3.2.3.1.13 Responsiveness to ED calls.
    - 3.2.3.1.14 Delays in responding to calls from nurses regarding critical values and or change in patient condition.
    - 3.2.3.1.15 Mortality and morbidity rates.
    - 3.2.3.1.16 Meetings attendance.
    - 3.2.3.1.17 Complete required continuous medical education courses as required e.g. NRP, PALS, ALSO....
    - 3.2.3.1.18 Complete patient's initial assessment in 24 hours and update it as required.
    - 3.2.3.1.19 Medical records as: updated, complete, legible, organized, dated timed and authenticated.
    - 3.2.3.1.20 Compliance with hand hygiene and other infection control precautions.
    - 3.2.3.1.21 Appropriateness of admission from ED and outpatient.
  - 3.2.3.2 **Surgical:**
    - 3.2.3.2.1 Volume and type of procedures
    - 3.2.3.2.2 Post-operative mortality/morbidity
    - 3.2.3.2.3 Organ injury
    - 3.2.3.2.4 Excessive bleeding/haemorrhage
    - 3.2.3.2.5 Retained foreign body
    - 3.2.3.2.6 General infection, and Surgical Site Infection
    - 3.2.3.2.7 Normal tissue or organ removed
    - 3.2.3.2.8 Proper, complete and timed post-operative notes.
    - 3.2.3.2.9 Delay on operating room start time due to physician being late.

3.2.3.3 **Anaesthesia:**

- 3.2.3.3.1 Mortality related
- 3.2.3.3.2 Respiratory arrests
- 3.2.3.3.3 Cardiovascular accidents within 24 hours
- 3.2.3.3.4 Anaesthesia related injuries e.g. secondary to intubation, broken teeth....
- 3.2.3.3.5 Use or reversal agents
- 3.2.3.3.6 Documentation of pre and post anaesthesia notes
- 3.2.3.3.7 Medication safety breaches
- 3.2.3.3.8 Participation during time out

3.2.3.4 **Obstetrics:**

- 3.2.3.4.1 Caesarean section rates (primary, repeat, total)
- 3.2.3.4.2 Induction rates
- 3.2.3.4.3 Percent of induction meeting criteria
- 3.2.3.4.4 Rates of operative vaginal deliveries
- 3.2.3.4.5 Shoulder dystocia rates and outcomes
- 3.2.3.4.6 Neonatal birth injuries
- 3.2.3.4.7 Rates of 3rd and 4th degree lacerations
- 3.2.3.4.8 Several neonates depression APGAR less than 3 at 5 minutes or ongoing resuscitation at 10 minutes.
- 3.2.3.4.9 Rates of preterm birth
- 3.2.3.4.10 Readmission related to obstetric complications
- 3.2.3.4.11 Postpartum complications
- 3.2.3.4.12 Maternal haemorrhage

3.2.3.5 **Emergency Room:**

- 3.2.3.5.1 Waiting time to see physician
- 3.2.3.5.2 Complaints
- 3.2.3.5.3 Return within 72 hours
- 3.2.3.5.4 Medical record completion
- 3.2.3.5.5 Complications
- 3.2.3.5.6 Misinterpretation of diagnostic tests e.g. imaging, EKG....

3.2.3.6 **Paediatrics:**

- 3.2.3.6.1 Complications from invasive procedures (umbilical arterial or venous catheter, lumbar punctures....)
- 3.2.3.6.2 Medication safety issues
- 3.2.3.6.3 Outcomes for certain diagnosis e.g. asthma, pneumonia....

3.3 Evaluators will use the two-way evaluation methodology/ giving sufficient space for feedback and discussion by the evaluated staff.

3.4 Physician annual evaluation will be utilized to set action plans for improvement of physician's performance, practice and patient care.

3.5 The medical director should approve the evaluation and the improvement action plan and make comments as required.

3.6 Heads of departments will report results of evaluations and reviews to the medical director and it will be discussed in the medical committee meetings.

## 4. PROCEDURE:

4.1 On-going Monitoring and evaluation of Physicians:

4.1.1 Every medical staff in MCH should have complete on-going annual evaluation before renewal of his/her contract.

4.1.2 The head of department (HOD) sets the priorities (SMART Goals) for measurement of certain data in the department for purposes of monitoring as well as improvement. It will be set on the first quarter of the year to assure the compliance of all physician.

4.1.3 Collected information includes, but is not limited to behaviour, professional growth as reflected on patient care, medical clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and clinical results of the department's medical staff member.

4.1.4 HOD reviews the on-going evaluation with the concerned physician.

4.2 Peer Review As part of Physician evaluation:

4.2.1 Peer Review is an on-going process to evaluate clinical practice of physicians.

4.2.2 Each physician who has the privilege to admit patients under his name will be subjected to peer review at least once per year.

4.2.3 Head of Department will:

4.2.3.1 Randomly selects at least one patient medical record from the patients seen by the physician under annual evaluation, during the evaluated year,

4.2.3.2 Distribute the case to peers from same specialty to be evaluated.

4.2.4 Document on the "Medical Staff Peer Review form;

4.2.5 The reviewers will submit the reports to the head of department within two weeks of referral.

4.3 Unplanned / Focused Evaluation for Medical Staff:

When the detailed practice of a specific physician is reviewed, this is considered Focused Professional Evaluation.

4.3.1 Administrative Corrective Actions for behavioural, ethical or professional misconducts, In case there is any violation related to behaviour, communication or ethical and professional conduct, a corrective action will be initiated by the head of department and medical director according to MCH.

4.3.2 Unplanned Peer Review

Criteria for initiating unplanned peer review evaluation may include but not limited to:

4.3.2.1 Unexpected complications in patient condition including those that result in major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

4.3.2.2 Anticipated complications defined through the specific medical department process and approved for review; e.g. 48 hours re-admissions, repeated inappropriate admissions from the emergency room and outpatient department .

4.3.2.3 Post-operative complications as defined by surgical departments.

4.3.2.4 Moderate to severe adverse drug reactions.

4.3.2.5 Patient complaints and/or grievances regarding a medical staff member or members and those patient complaints or grievances related to medical staff management or care rendered.

4.3.2.6 Staff complaints, grievances or concerns regarding a medical staff member related to the management of patient care.

4.3.2.7 Utilization issues: over and underutilization in care of patients.

4.3.2.8 Recommendations by root cause analysis e.g. sentinel or near miss events.

4.3.2.9 Inappropriate use of blood and blood components.

4.3.2.10 Inappropriate use of medications, repeated errors,

4.3.2.11 Appropriateness, timeliness, completion and legibility of medical records content.

4.3.2.12 Service specific defined performance indicators, as established and approved by the specific medical department.

Example: If an elevated surgical site infection rate is associated with a particular type of surgery, cases done by all relevant surgeons may be reviewed. If a particular surgeon has an unexpected level of this or other procedural complications, cases done by that particular surgeons may be reviewed.

4.3.3 Who can participates in the review:

4.3.3.1 Assignment:

4.3.3.1.1 HOD will assign peer reviewers.

4.3.3.1.2 If HOD is the individual being reviewed, the medical director will determine the peer review panel.

4.3.3.2 Conflict of interest:

4.3.3.2.1 A conflict of interest will preclude an individual from making a performance review in the evaluation of the performance of another practitioner.

4.3.3.2.2 A conflict of interest may exist if the reviewer has significant direct professional or personal involvement in the case under review. HOD will assign an alternative peer.

4.3.3.3 Special peer review panels:

4.3.3.3.1 If requested by HOD, medical director or credentialing and privileging committee, a special panel of peers may be assigned from External Reviewers e.g.:

4.3.3.3.1.1 Lack of internal expertise: There is no peer on staff with similar or like privileges in the speciality under review.

4.3.3.3.1.2 Ambiguity: there is confusion when internal reviewers reach conflicting or vague conclusions.

4.3.3.3.1.3 Litigation: When the hospital faces a potential medical malpractice suit, corporate legal counsel or risk management may recommend external review.

4.3.3.3.1.4 New technology / technique: There is a new technology/technique involved that the hospital does not have the expertise to assess whether the practitioner possesses the required skills associated with the new technology/technique.

4.3.3.3.2 The individual whose case is under review has the right to be present and presents his/her information regarding care management to the committee performing peer review.

4.3.3.4 Effectiveness of review process:

4.3.3.4.1 Consistency: The peer review process is consistent for all cases referred for peer review and will be conducted according to this defined process.

4.3.3.4.2 Routine Performance review: Time review initiated to time case closed should be two weeks, not to exceed 4weeks.

4.3.3.5 Fast track review:

4.3.3.5.1 Includes sentinel events cases, or as determined by HOD or medical director. Should be closed within 2 weeks.

4.3.3.5.2 Time frames is adhered to in a reasonable fashion.

4.3.3.5.3 In those instances, where peer review falls out of the required time frames (medical record incomplete, practitioner under review is unavailable, reviewing committee rescheduling etc.) the reasons for delay will be sent to the HOD. All efforts will be made to complete the peer review process as soon as practicable within the confines of the delay.

4.3.3.6 Defensible: The conclusions reached during the review are to be supported by rational that specifically address the issues for which the review was conducted, including as appropriate, reference to the literature and relevant clinical practice guidelines.

4.3.3.7 Balanced: Minority opinions and views of the individual under review are to be considered and recorded.

4.3.3.8 Useful: The results of review activities are to become part of the practitioner's quality profile and to be used for credentialing and privileging decisions, and as appropriate in performance improvement activities.

4.3.3.9 On-going: The review conclusions are tracked over time, and actions based on review conclusions are monitored for effectiveness by the HOD and credentialing and privileging committee.

4.3.4 How is the unplanned review done:

4.3.4.1 The head of the department (HOD) will:

4.3.4.1.1 Assign the case to the panel.

4.3.4.1.2 Inform the physician whose case is referred for peer review with the medical record number, date of admission of the case to be reviewed, the reason for review and the scheduled peer review meeting date.

4.3.4.2 The reviewers will document their opinion on the Medical Staff Peer and their minutes will reflect findings conclusions, recommendations and actions taken.

4.3.4.3 HOD reviews the results with the reviewers and they can decide:

4.3.4.3.1 No action to be taken

4.3.4.3.2 Discuss the case with the concerned physician and decide that self-acknowledged action plan is sufficient.

4.3.4.3.3 HOD sends an educational letter or develops improvement plan with the concerned physician.

4.3.4.3.4 Refer to Credential Committee.

4.3.4.3.5 Other recommendations for improvement regarding identified problems in system, concern about nursing etc.

4.4 The head of Department will:

4.4.1 Attach the on-going evaluation and peer review results (the on-going peer review accounts for 20% of the consultant's total evaluation score).

4.4.2 Discuss the results of the evaluation with the evaluated physician, giving sufficient space for feedback and counselling regarding his/her performance.

4.4.3 Uses the collected data to take actions that includes, but are not limited to:

4.4.3.1 Recommend action plans for improvement for physicians, with measurable objectives related to their areas of suboptimal performance in order to meet expectations.

4.4.3.2 Set target date, after which the physician is re-evaluated to decide if planned objectives have been met.

4.4.3.3 Amend clinical privileges as necessary/, by expansion or limitation, a period of counselling and oversight, or other appropriate action.

4.4.3.4 Make informed decisions regarding reappointment.

4.4.3.5 Recommend training and continuous education as needed.

4.4.4 Sends results of the evaluation to the medical director who should approve the evaluation and the improvement action plan and make any required comments.

4.4.5 If on re-evaluation after the period planned for improvement, the evaluator selects unsatisfactory status for the action plan progress it will be forwarded to the medical director to act and write his comment.

4.4.6 Submit the annual evaluation to the human resources department.

4.4.7 When the findings of the evaluation affect the appointment or privileges of the physician, the head of the department sends the results of the evaluation to the hospital medical director and the hospital credentialing committee with attached letter.

4.5 Human resources department will keep all information in the medical staff member's credential file, including the results of reviews, actions taken, and the impact of those actions on privileges (if any).

4.6 All evaluation items will be kept confidential.

## 5. MATERIALS AND EQUIPMENT:

5.1 Examples of Medical Staff Evaluation Indicators

## 6. RESPONSIBILITIES:

6.1 Physician
6.2 Medical Director
6.3 HR Director
6.4 QM&PS Director

## 7. APPENDICES:

7.1 Physician On-going Evaluation Form
7.2 Medical Staff Peer Review Form

## 8. REFERENCES:


8.1 Directorate of Health Affairs Holy Capital Maternity and Children Hospital , Kingdom of Saudi Arabia
8.2 Mosby, Ann Marriner Tomey (7th Edition), 2004 Guide to Nursing Management & Leadership.


## 9. APPROVALS:

| | Name | Title | Signature | Date |
|---|---|---|---|---|
| **Prepared by:** | Dr. Shaimaa Bayoumi Emara | Asst. Medical Director for Medical Quality | | January 05, 2025 |
| **Reviewed by:** | Dr.Tamer Mohamed Naguib | Medical Director | | January 06, 2025 |
| **Reviewed by:** | Mr. Fahid Mishnaf AlDhafiri | HR Director | | January 07, 2025 |
| **Reviewed by:** | Mr. Abdulelah Ayed Al Mutairi | QM&PS Director | | January 15, 2025 |
| **Approved by:** | Mr. Fahad Hezam Alshammari | Hospital Director | | January 19, 2025 |

## APPENDIX 7.1 Physician On-going Evaluation Form

Kingdom of Saudi Arabia
Hafar Al Batin Health Cluster
Maternity and Children Hospital

المملكة العربية السعودية
التجمع الصحي بحفر الباطن
مستشفى الولادة والأطفال

**ANNUAL PHYSICIAN COMPTENCY**

**Physician name:** .....**Rank:**.....
**Specialty:** ..... **Job Number:** .....

| | The Grading Scale to be used 1 (lowest) to 5 (highest) | |
|---|---|---|
| **Exceptional** | Work performance consistently exceeds standards | 5 |
| **Above Expectations** | Work is fully satisfactory and often exceeds performance standards | 4 |
| **Meet Expectations** | Work is fully satisfactory; employee consistently meets and occasionally may exceed performance standards. This represents the expected level of performance as established by the supervisor. | 3 |
| **Below Expectations** | Performance standard are not fully achieved; employee needs to improve performance during the next appraisal period (e.g. 12 months) | 2 |
| **Unsatisfactory** | • Employee has majority of performance standards below expectations.<br>• Employee must demonstrate improve work performance within immediate period of time (e.g. 3 months) | 1 |
| **Not Applicable** | Not applicable for the specialty or rank | - |

| | | | NA | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|---|---|
| 1 | **Patient Care, Medical Knowledge & Practice** | Patient Assessment | | | | | | |
| 2 | | Unexpected complications, adverse events | | | | | | |
| 3 | | Proper use of sedation (moderate and deep sedation), monitoring of patient during proper pre and post assessment. | | | | | | |
| 4 | | Medication errors | | | | | | |
| 5 | | Sentinel events | | | | | | |
| 6 | | Outcome of high risk procedures | | | | | | |
| 7 | | Outcome of surgery | | | | | | |
| 8 | | Unexpected mortality | | | | | | |
| 9 | | Percent of morbidity | | | | | | |
| 10 | | Uses blood and blood products according to guidelines, proper identification prior to use and proper handling of transfusion reactions | | | | | | |
| 11 | | Discrepancies between pre and post – operative pathological diagnoses. | | | | | | |
| 12 | | Appropriateness of admissions from the emergency room and outpatient department | | | | | | |
| 13 | **Quality of Medical Records** | Comprehensive, legibly, updated and completed on time, signed and authenticated | | | | | | |
| 14 | | Free of unapproved abbreviations | | | | | | |
| 15 | **Interpersonal & Communication Skills** | Patients and Families and creates a professional relationship with patients & obtain informed consent. | | | | | | |
| 16 | | Physicians and other healthcare professionals | | | | | | |
| 17 | | Works effectively as a member or leader of the healthcare team | | | | | | |
| 18 | **Practice - Based Learning & Improvement** | Updated BLS & Advanced Life Support Certification | | | | | | |
| 19 | | Actively participates in the departmental educational activities. | | | | | | |
| 20 | | Participates in quality improvement activities | | | | | | |
| 21 | **Professionalism** | Respects the patient's rights, privacy and autonomy ( Reported from Patients' Rights & Patients' Relations ) | | | | | | |
| 22 | | Accepts responsibility for patient care, including continuity. | | | | | | |
| 23 | | Attendance /Punctuality | | | | | | |
| 24 | | Dress Code (adhere according to hospital policy) | | | | | | |
| | **Total Scoring = Numerator / Denominator %** | | | | | | | |

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**ANNUAL PHYSICIAN COMPTENCY**

**Physician name:** .....**Rank:**.....
**Specialty:** ..... **Job Number:** .....

| OVERALL EVALUATION | Below Expectation ≤ 85 % | Meet Expectation > 85 - 92 % | Above Expectation > 92 - 95 % | Exceptional > 95 % |
|---|---|---|---|---|
| Just Tick One | | | | |

**Appropriated Action Needed :( By Head of the Department) :**

- ☐ Council the staff member.
- ☐ Place the staff member under supervision.
- ☐ Limit Privilege of Staff Member.
- ☐ Recommended for Re-privileging
- ☐ Recommended for continued medical staff membership (Re-appointment).
- ☐ Not recommended for continued medical staff membership.

**Recommendations:**

**Opportunities for Improvement:**

**Goals to achieve for the next year:**

**Department / Service Leader's / Supervisor's Comment:**

**Department/ Service Leader / Supervisor Signatory:**

**Name:** ..... **Signature**.....
**Hospital ID:** ..... **Date:** ..... **Time:** .....

**Staff Acknowledgment & Comment:**

(Please feel free to add any comment you have concerning your performance, your development, or your review. If you wish, you may give these comments directly to your supervisor in writing within the next five (5) working days. Add extra sheets as necessary).

**Staff Signatory:**

**Name:** ..... **Signature**.....
**Hospital ID:** ..... **Date:** ..... **Time:** .....

Note: Once completed and signed, provide a copy to the employee, retain a copy for department file, and send original to Medical Services.

**APPENDIX 7.2** Medical Staff Peer Review Form

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## MEDICAL STAFF UNPLANNED PEER REVIEW EVALUATION FORM

**Physician Name:** _____ **Computer No:** _____

**Specialty & Rank:** _____ **Patient MRN:** _____

**Source of Referral:**

- □ Quality Indicator (Describe)_____
- □ **Administration Concern:** □ Hospital Director □ Medical Director
- □ Patient/Family Complaint
- □ **Hospital Committees;** □Infection Control Committee □ Blood Utilization Review Committee, □ P&T Committee □ Mortality Morbidity Committee □ **OTHERS**:_____
- □ Case Possible Litigation
- □ **EVENTS:** □ Sentinel Events □ Adverse Events □ Reportable Events
- □ Others: _____

**Evaluation Case:** □ Clinical □ Non-clinical

| | YES | NO | NA |
|---|---|---|---|
| Appropriateness of Admission | ☐ | ☐ | ☐ |
| Appropriateness of Assessment | ☐ | ☐ | ☐ |
| Diagnosis and Plan of Care | ☐ | ☐ | ☐ |
| Proper Utilization of Investigations and Radiology | ☐ | ☐ | ☐ |
| Time Frame to Receive Treatment | ☐ | ☐ | ☐ |
| Acceptable Outcome of Care | ☐ | ☐ | ☐ |
| Quality of Medical Records Documentation (H&P, Care Plan, Progress and Operative Notes) | ☐ | ☐ | ☐ |
| Does the case represent a deviation from the standard of care for this patient population? | ☐ | ☐ | ☐ |
| Patient and Family Education adequate and timely | ☐ | ☐ | ☐ |
| Were there any identifiable breakdown in communication? | ☐ | ☐ | ☐ |
| Was judgment/decision making sound in this case? | ☐ | ☐ | ☐ |
| Were there any clinical process problems that contributed to the patient outcome? | ☐ | ☐ | ☐ |
| Could this incident have been readily prevented? | ☐ | ☐ | ☐ |
| Is there an educational opportunity? | ☐ | ☐ | ☐ |
| Is there a strong probability that this case will lead to litigation? | ☐ | ☐ | ☐ |

**Explanation of any above-noted deviations:**

_____

_____

_____

_____

_____

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التجمع الصحي بحفر الباطن
مستشفى الولادة والأطفال

## MEDICAL STAFF UNPLANNED PEER REVIEW EVALUATION FORM

**Physician Name:** _____ **Computer No:** _____

**Specialty & Rank:** _____ **Patient MRN:** _____

| Scoring: | | |
|---|---|---|
| | **SCORE** | **DEFINITION** |
| | 1 | Predictable event/case managed within standard of care. |
| | 2 | Unpredictable event/case management within standard of care or unintentional deviation from guidelines of clinical performance while intending to be compliant. |
| | 3 | Marginal deviation from standard of care/care outside contemporary standards of the medical staff department or departure from guidelines of clinical performance as a result of failure to recognize deviation or mistakenly believe deviation to be clinically justified. |
| | 4 | Significant deviation from standard of care, reckless behavior or persistent at risk behavior with noncompliance, repetitive human errors or intentional deviation from guidelines of clinical performance. |

**Reviewing Physician:**

**Physician Name:** _____ **Signature:** _____ **Date:** _____

**Physician Name:** _____ **Signature:** _____ **Date:** _____

**Head of Department Review:**

□ No action warranted

□ Educational letter to provide sufficient

□ Provided self – acknowledged action plan sufficient

**Head of the Department** _____ **Signature:** _____ **Date:** _____

**Meeting Review:** **Review Date:** _____

| Peer Review Action: (Check One) | Date |
|---|---|
| □ No action warranted | |
| □ Provider Self – acknowledge action plan sufficient | |
| □ Educational letter to the provider is sufficient | |
| □ Committee chairperson develops formal improvement plan with monitoring | |
| □ Refer to credential Committee | |
| □ System Problem Identified – Refer to:<br>Describe system issue: _____ | |
| □ Referral to Nursing Review – Describe Nursing concern | |
| □ Others | |

**Committee Chairperson:** _____ **Signature:** _____ **Date:** _____