UNIVERSITY of VIRGINIA HEALTH SYSTEM

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0132

A. SUBJECT: The Quality Reporting Process

B. EFFECTIVE DATE: January 1, 2014 (R)

C. POLICY:

A major goal of the Medical Center is to promote quality healthcare through a systematic program of performance improvement and patient safety enhancements. As the governing body for the institution, the Medical Center Operating Board (MCOB) is responsible for the review and oversight of these activities. Quality information flows to the MCOB *via* its Quality Subcommittee as well as through direct reports from senior management and from summaries of activities reported to it through the normal committee structures of the Medical Center and its Clinical Staff. One mechanism whereby information regarding the adequacy and quality of the services provided is collected, and through which improvements in quality and enhancements of patient safety are made, is known as the quality reporting process. All persons providing patient care or other services within or for the benefit of the Medical Center, regardless of employer ("individual reporters") are expected to participate in the reporting process as described below. The Medical Center's Patient Safety Committee (PSC) monitors the quality reporting process for the purposes of reviewing, evaluating and making recommendations on significant adverse or sentinel events and/or adverse trends.

D. PROCEDURE:

1. Any individual reporter may report a variance in the provision of quality care or a safety event, which is any event or circumstance that caused or has the potential to cause a medical error or injury. Events are reported through a Quality Report, utilizing the automated quality reporting system, "QR Track." Submitting a Quality Report does not replace required documentation of clinical facts in the patient medical record. If an event results in a significant adverse outcome for a patient, the manager and the medical director of the area shall be immediately notified (or administrator on-call after regular work hours) by the staff in the area.

   If the reported event has resulted in an unanticipated clinical outcome or change in a patient's condition, the responsible attending physician shall be notified. The responsible attending physician shall ensure that the patient, or when appropriate, his/her representative[1], is informed of this outcome and/or change in condition. (See Medical Center Policy No. 0293 "Disclosure of Outcomes")

[1] "Representative" has the same meaning as such terms as "legal representative", "surrogate decision maker", "healthcare agent" and "legally authorized representative." appearing in other Medical Center policies.

2. The manager (or designee) of the area where the event occurred shall analyze each Quality Report and take appropriate action based on that analysis to ensure patient safety. The analysis and description of the action(s) taken shall be documented in QR Track within five (5) business days of submission of the initial report.

3. The medical director of the area where the event occurred, in collaboration with the manager, shall analyze each Quality Report with a harm score of G, H or I or any other event involving physician practice. An analysis and description of the action(s) taken shall be documented in QR Track within 5 business days of submission of the initial report, unless a more immediate response is requested.

4. Patient Safety Officers (PSO) shall review each Quality Report on behalf of the Patient Safety Committee, assign a harm score (see Attachment 1) and investigate patient safety and quality matters to assess recommendations for change, in consultation with the area manager and medical director.

   When this review determines that the event may be a Sentinel Event[2] or meets other standards for review, the Patient Safety Officers, on behalf of the Patient Safety Committee, shall initiate and coordinate the analysis of that event. At the direction of the Patient Safety Committee, a root cause analysis (RCA) or a Quality Focused Review (FR) shall be conducted as described in the Quality Improvement and Patient Safety Plan. Participants shall include the healthcare professionals/staff directly related to the event being reviewed. In order to assure success of these reviews all healthcare providers shall participate in these reviews if requested by the chair of the session. Participants shall have an opportunity to review the report before it is finalized. The Patient Safety Committee will confirm if an event meets the definition of a Sentinel Event. The Medical Center Operating Board Quality Subcommittee will advise on the need to externally report.

5. In general, all quality reporting data including RCA/FR documents are maintained as internal documents held solely for quality improvement activities. In the extraordinary circumstance when external disclosure of an RCA may be necessary, the release of documents must be approved by the Medical Center Operating Board Quality Subcommittee.

6. Patient Safety staff shall report to the Patient Safety Committee information derived from the Quality Reports including (a) identified organizational problems that require ongoing monitoring and coordinated corrective actions; (b) information entered into a central data base and trended by various methods for evaluation of variances; (c) progress reports on monitoring of corrective action plans from institutional Root Cause Analysis/Focused Review.

7. The Patient Safety Committee shall make recommendations concerning patient safety or the adequacy and quality of services to the Clinical Staff Executive Committee and the Medical Center Operating Board Quality Subcommittee.

[2] Sentinel event: An unexpected or unexplained occurrence or process variance resulting in death or permanent loss of limb/function, or risk thereof.

(SUBJECT: The Quality Reporting Process)

SIGNATURE:

Robert S. Gibson, M.D., President, Clinical Staff

R. Edward Howell, CEO, UVA Medical Center

DATE: 12/18/13

Medical Center Policy No. 0132 (R)
Approved November 1991
Revised April 1995, April 1998, March 1999, October 2002, October 2005, June 2006, March 2009, December 2010, December 2013
Approved by Quality Committee
Approved by Clinical Staff Executive Committee

Attachment 1

QR Harm Score Categories

Category A: Unsafe Condition. (Non Event).

Category B1. Near miss. No harm; didn't reach patient; caught by chance.

Category B2. Near miss. No harm; didn't reach patient because of active recovery by care giver.

Category C: No Harm. Reached patient; no monitoring required.

Category D: No Harm. Reached patient; monitoring required.

Category E: Harm; temporary, intervention needed.

Category F: Harm; temporary, hospitalization needed.

Category G: Harm; permanent.

Category H: Harm; permanent; intervention required to sustain life.

Category I: Death.

Unknown

Other