

Confidential Peer Review Document

Peer Review Tool to Assist With Case Review

Med Rec#/pt initials	Involved MDs	MD Reviewer initials	Dept of Case reviewed	Event or Admit Date	Date of Review

Case Summary

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Review Findings	YES	NO	N/A	Comment
1. Was History & Physical appropriate and complete?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Was abnormal labwork addressed in the documentation and treatment plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Were abnormal diagnostic tests (x-rays, CT scans etc) and incidental findings addressed in the documentation and F/U?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Were the appropriate labs and radiologic tests ordered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Were the appropriate consults ordered and done timely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Were there any policy/procedure issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Did you identify any communication issues (e.g. handoff, clear responsibility for who was coordinating care etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Review Findings	YES	NO	N/A	Comment
8. Did you identify any process issues or opportunity for Dept improvement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Did you identify any opportunities for system /organizational improvement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Did you identify any medication history, medication reconciliation or medication administration issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. In your opinion, was this occurrence preventable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. In your opinion, was the standard of care met?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. In your opinion, if death or major impairment of bodily function occurred, was it expected as a result of the patient's condition <u>on presentation to the hospital?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Was there a concern about pt and/or pt/family shared decision making?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. In your opinion, does this case need to be referred for review by another Dept?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conclusions: Lessons Learned, Action Steps, System Concerns, Department Improvements				