Three Important Hospital Actions Concerning Incident Report Discovery

In one of the few cases to discuss hospital incident report privilege protections in medical malpractice actions, the administrator of a deceased patient's estate brought this action against a hospital for the failure to adequately monitor and treat the blood glucose levels of the patient. During the litigation, the administrator filed a motion seeking production of reports prepared in connection with the incident alleged to have contributed to the patient's death. The hospital opposed the motion claiming the reports were privileged patient work product under the Patient Safety and Quality Improvement Act.

In one of the plaintiff's written interrogatories, the plaintiff asked the hospital to state whether the incident identified in the complaint was reported to, or investigated by, any hospital or governmental committee, agency, or body. The hospital objected on the basis that the interrogatory sought privileged information, and directed the plaintiff to an attached privilege log, in which it claimed privilege on six documents including incident reports.

The trial court ordered the hospital to produce three documents it had collected within its patient safety evaluation system (PSES), and reported to Clarity PSO, a federally certified patient safety organization.

The Appellate Court of Illinois noted that a party may meet its burden of proving the applicability of a privilege by submitting the allegedly privileged materials for an in camera review or by submitting affidavits setting forth facts sufficient to establish the applicability of the privilege to the particular documents being withheld.

The court determined the reports prepared by the hospital in connection with the incident that allegedly contributed to the patient's death satisfied the requirements for privileged patient work product under the Patient Safety and Quality Improvement Act (Act). The court determined the hospital had demonstrated through its policies, documents, and unrebutted affidavits that the reports qualified as privileged patient safety work product (PSWP) under the Patient Safety and Quality Improvement Act of 2005 (PSQIA) and, therefore, were not discoverable. The court found the reports contained data, discussions, and reflections, which was the sort of information the Act protected, they were prepared by the hospital solely for submission to a federally certified patient safety organization, and the information they contained had the ability to improve patient safety and the quality of health care.

Also, the reports did not lose their status as privileged patient work product under the Act based on the Act's medical records exception merely because the information required to be in the patient's medical record was also contained in the reports and did not mean that the reports were no longer patient work product, and nothing in the record demonstrated that the reports contained information that should have been, but was not, included in patient's original medical records. The reports did not lose their status as privileged patient work product under Act based on the Act's exception for information collected and prepared for purposes other than reporting to a patient safety evaluation system, where an affidavit of the hospital's associate general counsel averred that the reports were assembled solely for submission to a federally certified patient safety organization, and nothing in the record demonstrated otherwise. The reports did not lose their status as privileged patient work product under the Act based on the reporting requirements of the Illinois Adverse Events Law, where, as of the date of the medical malpractice action, the Illinois Department of Public Health had not yet established an adverse health events reporting system, so that the hospital had no reporting obligation.

How To Report A Hospital

Zhe Xu

How To Report A Hospital:

System for Hospital Uniform Reporting (SHUR) United States. Congress. Senate. Committee on Finance. Subcommittee on Health, 1979 Report of the Pennsylvania Hospital for the Insane Pennsylvania Hospital for the Insane.1878 How to Report Statistics in Medicine Thomas Allen Lang, Michelle Secic, 2006 This volume presents a comprehensive and comprehensible set of guidelines for reporting the statistical analyses and research designs and activities commonly used in biomedical research **Code of Federal Regulations**, 2015 Special edition of the Federal Register containing a codification of documents of general applicability and future effect with ancillaries **Public Health Reports** Federal Register ,2013-04 Code of Federal Regulations United States. Internal Revenue Service, 2015 Special ,1967 edition of the Federal register containing a codification of documents of general applicability and future effect as of April 1 Veterans' Administration Response to the National Academy of Sciences' Report Entitled with ancillaries "Health Care for American Veterans" United States. Congress. House. Committee on Veterans' Affairs. Subcommittee on Medical Facilities and Benefits.1978 **Medicaid** Katherine M. Iritani,2010-10 In addition to standard Medicaid payments hospitals receive supplemental payments for uncompensated costs of care provided to uninsured and Medicaid patients These supplemental payments are referred to as disproportionate share hospital DSH payments In FY 2006 DSH payments totaled about 17 billion and non DSH supplemental payments exceeded 6 billion Hospitals DSH payments are limited to their uncompensated care costs that is their costs for covered care less Medicaid and other payments This report examined 1 how state DSH payments in 2006 compared to DSH payment limits and 2 certain aspects of states calculations of 2006 DSH payment limits Charts and tables Annual Report and Proceedings of The...annual Convention National League for Nursing, National League of Nursing Education (U.S.), 1917 Reports from the Commissioners Great Britain. Parliament. House of Commons, 1813 Hospitals: a County and Metropolitan Area Data Book, 1972 Genevieve W. Strahan, 1975

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