SENATE BILL REPORT
SB 5018

As of January 30, 2001

Title: An act relating to the imposition of civil penalties by the department of health against a licensed hospital that fails to report a required event.

Brief Description: Authorizing the department of health to impose civil penalties.

Sponsors: Senators Costa and Thibaudeau.

Brief History:
Committee Activity: Health & Long-Term Care: 2/1/01.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Joan K. Mell (786-7447)

Background: In December of 1999 the Institute of Medicine issued a report To Err is Human: Building a Safer Health System.– This report sparked a nationwide debate over hospital errors, which result in significant harm to individuals. The statistics on medical errors were reported to exceed or equal the incidence numbers for auto accident fatalities and other significant disease fatalities.

The Department of Health has been an active participant in the medical error debate, which included a focus on prescription errors. As a starting point, the department held statewide discussions on the issue and ultimately released a report in December of 2000, entitled Medication Errors Report and Recommendations.– While the report focuses on medication errors, it suggests an intent to undertake the broader issue of medical errors generally. The department intends to encourage dialog regarding medical errors, and foster an environment that treats errors as systemic problems,– not issues of personal responsibility.–

In this state by rule, hospitals must report adverse events, which include circumstances of unexpected death, permanent loss of function, patient suicide, infant abduction, sexual assault or rape, hemolytic transfusion reaction, surgery on the wrong patient or body part, system malfunction, or fire. There are 94 hospitals regulated in this state. Since 1999, 96 of these adverse events have been self reported by a hospital to the Department of Health. The reporting system is voluntary in that the department is not authorized to fine a hospital for failing to self report. The department could, however, recognize the failure to report as part of its inspection process. Currently, the department evaluates a hospital's reporting system in its licensing survey. To date, the department has not found a hospital failing to comply with the reporting requirement.

Whether a purely voluntary reporting system is the appropriate means to achieve an accurate measure of the error rate is currently debated. Some data suggest a purely voluntary reporting system does not encourage reporting. In New York, the state reporting system that requires reporting and imposes a penalty, records 38 incidents of surgery on the wrong side

in 1999. In the federal voluntary reporting system, only 10 incidents of surgery on the wrong side were reported over a five-year period. On the opposite side of the debate, proponents of a voluntary system argue imposition of a penalty discourages honest and frank discussion.

Summary of Bill: The Department of Health is authorized to impose a penalty of $1,000 per incident for failure to report a required event. The department can authorize spending the fine on improvements in the hospital that would reduce the error rate or reporting compliance.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: Ninety days after adjournment of session in which bill is passed.