Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care Committee

HB 1243

Brief Description: Increasing patient safety through disclosure and analysis of adverse events.

Sponsors: Representatives Green, Cody, Morrell, Appleton, Moeller, Darneille, Lovick, Kessler, Dickerson, Campbell, Linville, Chase, Ormsby, Haigh and Santos.

Brief Summary of Bill

- Requires that medical facilities submit reports to the Department of Health when a serious event or incident occurs.
- Provides that evidence of statements of apology or remedial acts by a health care provider is inadmissible in an action for professional negligence.

Hearing Date: 2/4/05

Staff: Chris Blake (786-7392).

Background:

Reporting Adverse Events
Each hospital is required to inform the Department of Health when certain events occur in its facility. These events include unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. Hospitals must report this information within two business days of the hospital leaders learning of the event.

Offers of Settlement
Under both a statute and a court rule, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible in a civil action to prove liability for the injury. In addition, a court rule provides that evidence of offers of compromise are not admissible to prove liability for a claim. Evidence of conduct or statements made in compromise negotiations are likewise not admissible.

In 2002, the Legislature passed legislation that makes expressions of sympathy relating to the pain, suffering, or death of an injured person inadmissible in a civil trial. A statement of fault, however, is not made inadmissible under this provision.

Summary of Bill:

Reporting of Events and Incidents

Medical facilities, which include ambulatory surgical facilities, childbirth centers, hospitals, and psychiatric hospitals, must report the occurrence of a serious event to the Department of Health (Department) within seven days of discovering the event. Serious events are defined as: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment.

Health care workers may file anonymous reports of serious events with the Department. Upon receipt of such a report, the Department shall require that the medical facility conduct an investigation and report to the Department within thirty days.

Medical facilities or health care workers may report the occurrence of an incident to the Department. An incident is defined as an event involving clinical care that could have injured the patient, but did not cause any injury or require the provision of additional health care services.

Reports of both serious events and incidents shall identify the facility, but may not identify any health care professionals, employees, or patients involved in the event or incident. Medical facilities must provide written notification to patients that may have been affected by the serious event.

The Department is responsible for investigating reports of serious events and establishing a system for medical facilities and health care workers to report serious events and incidents. In addition, the Department or a contractor of the Department must: evaluate the data from the reports to identify patterns of serious events and incidents, recommend ways to reduce the number and severity of serious events and incidents, advise reporting medical facilities of changes that can be made to reduce serious events and incidents, and make statewide recommendations regarding developments in health care practices and procedures. Recommendations by the Department or its contractor may be considered for licensing purposes, but are not mandatory unless adopted in rule. As of January 1, 2007 the Department must begin reporting annually to the Legislature and the Governor regarding the number of serious events and incidents, information derived from the reports received, and recommendations for legal changes to improve patient safety.

Reports that are made pursuant to a coordinated quality improvement committee or peer review committee have the same protections from discovery or introduction into evidence in a civil proceeding as those committees have. Medical facilities that do not have a coordinated quality improvement committee are granted the same protections from discovery or introduction into evidence in a civil proceeding as those committees possess as pertains to their serious event or incident reporting activities.

Statements of Apology

Limitations on the admissibility of evidence in civil proceedings of offers to pay medical expenses in professional negligence cases are expanded to protect (1) statements or conduct expressing apology, fault, or sympathy, or (2) statements regarding remedial actions that may be taken to address the act.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains an emergency clause and takes effect immediately.