HB 1243-S - DIGEST

(DIGEST OF PROPOSED 1ST SUBSTITUTE)

Finds that our health care and medical liability systems are not structured to promote disclosure and analysis of medical errors, whether they result in patient harm or not. Each medical error provides an opportunity to learn how to avoid future errors.

Declares an intent to promote full disclosure of medical errors and adverse health events, and to use the experience and knowledge gained from analysis of those events to advance patient safety in a nonpunitive manner.

Declares a further intent to promote full disclosure of medical errors to patients by substantially reducing the risk of liability exposure associated with such disclosure.

Requires each medical facility to report to the department the occurrence of any adverse event. The report must be submitted to the department within forty-five days after occurrence of the event has been confirmed.

Provides that if, in the course of investigating a complaint received from an employee of a licensed medical facility, the department determines that the facility has not undertaken efforts to investigate the occurrence of an adverse event, the department shall direct the facility to undertake an investigation of the event. If a complaint related to a potential adverse event involves care provided in an ambulatory surgical facility, the department shall notify the facility and request that they undertake an investigation of the event. The protections of RCW 43.70.075 apply to complaints related to adverse events or incidents that are submitted in good faith by employees of medical facilities.

Provides that medical facilities licensed by the department shall have in place policies to assure that, when appropriate, information about unanticipated outcomes is provided to patients or their families or any surrogate decision makers identified pursuant to RCW 7.70.065. Notifications of unanticipated outcomes under this section do not constitute an acknowledgment or admission of liability, nor can the fact of notification or the content disclosed be introduced as evidence in a civil action.

Provides that, beginning January 1, 2006, the department shall, during the annual survey of a licensed medical facility, ensure that the policy required in subsection (1) of this section is in place.

Provides that, when a report of an adverse event or incident under this act is made by or through a coordinated quality improvement program under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee for the purpose of preparing a report of an adverse event or incident shall be subject to the confidentiality protections of those laws and RCW 42.17.310(1)(hh).