On the Line (June 2004)

Save to myBoK

by Jill Burrington-Brown, MS, RHIA

Q: Why shouldn't we document incidents or incident reports in the patient's health record? Isn't it a part of the documentation of the patient's care? Don't incident reports become evidence if there is legal action?

A: First, we should define "incident" and the purpose of an incident report. An incident is something that happens that is not consistent with the standard of care, not a natural consequence of the patient's disease, or an out-of-the-ordinary event. The purpose of the incident report is to identify potential problems or risks as well as actual problems that need intervention. A healthcare organization should use the incident reporting system in a quality management program to look for emerging trends and system inadequacies and to provide feedback and education.

A patient's health record should never document or mention an incident report. According to the AHIMA practice brief "Maintaining a Legally Sound Health Record,""When an incident occurs, document the facts of the occurrence in the progress notes. Do not chart that an incident report has been completed or refer to the report in charting."[1]

An incident report should not be a method of documenting the patient's care but of documenting the incident, its investigation, and follow-up. The patient's care must be documented completely in the medical record. In this manner, when an incident report is investigated by the appropriate quality review committee, it becomes a part of the peer review process. When the incident report is mentioned in the medical record, it then becomes part of the patient care documentation and may be discoverable in states where protection is in place to prevent discovery.

In many states, incident reports have historically been protected from discovery as part of this peer review process. However, in recent years the definition of peer review has narrowed.[2] The Pennsylvania courts found in *Pennsylvania Protection and Advocacy, Inc. versus Houstoun* (228 F.3d 423 [3rd Cir.2000]) that "the requested peer review documents were records" as defined by the Protection and Advocacy for Mentally Ill Individuals Act and were not protected.[3]

Additionally, in *AMISUB, Inc. versus Buckley* (618 N.W.2d 684 [Neb.2000]), an incident report created for quality assurance purposes was not reviewed by the hospital's quality committee and did have some patient assessment information that the medical record did not have. Thus, "The state Supreme Court declined to extend the peer review privileges to...the incident reports…." It noted that the documents were not prepared upon the request of a hospital-wide staff committee or utilization review committee. The court found the reports were "merely factual accounts or fact compilations relating to the care of a specific patient [and therefore] are not privileged."[4]

However, in California the courts found that incident reports labeled as confidential documents intended for potential litigation were protected as part of attorney-client privilege and were therefore protected.[5]

It appears that the best way to protect incident reports from discovery is to make sure your policies and procedures are clear about the purpose of the incident reporting process and subsequent quality management process and that the reports themselves are labeled with clear directions to the user.

Incident Report Checklist

- The policy should define the report's primary purpose as the improvement of quality, peer review, or as attorney-client work product.
- Incident reports should have clear directions: how to report incidents, what to say in the report about the incident, and how the incident will be followed.
- Patient care staff should be trained in the process of incident reporting and in how to document the care of the patient in the medical record.

- All incident reports must be reviewed with follow-up noted for quality review purposes.
- Incident reports should not be copied. There should only be the original copy, and it must be maintained in a confidential file.
- Incident reports should not be filed or mentioned in the patient's medical record.
- Incident reports should be labeled as one or some combination of the following:
  - Incident
  - Confidential
  - Attorney-client work product

In all circumstances, when an incident report is requested as evidence or as part of a compulsory process, a healthcare organization should notify the facility attorney for the correct response.

Notes

1. Dougherty, Michelle. "Maintaining a Legally Sound Health Record." *Journal of AHIMA* 73, no. 8 (2002): 64A–G.
2. McLean, M.D., and R. Thomas. "The Implications of Patient Safety Research and Risk Managed Care." *Southern Illinois University Law Journal* 26 (2002): 272.
3. Ibid.
4. Horowitz, Alan C. "Legal Briefs: Incident Reports, Peer Review and Discovery." *Advance for Health Information Professionals* (February 26, 2001). Available online at www.advanceforhim.com/common/editorial/editorial.aspx?CC=712.
5. Scripps Health v. Superior Court (03 C.D.O.S. 4809), "What's New?" Available online at www.fishkinlaw.com/whatsnew.extend.html.

Jill Burrington-Brown *(jill.burringtown-brown@ahima.org) is an HIM practice manager at AHIMA.*

Article citation:
Burrington-Brown, Jill. "On the Line." *Journal of AHIMA* 75, no.6 (June 2004): 49,51.