Incident Reports: Non-Medical Occurrences Are Covered By Quality Review Privilege.

The Court of Appeals of Texas ruled that a nurse's incident report of a visitor's slip and fall in the hospital was covered by the quality review privilege.

That meant the hospital did not have to turn the incident report over to the attorneys who were suing the hospital on the visitor's behalf for compensation for the slip-and-fall incident.

Quality Review Privilege

The hospital has a quality review committee which reports to the board of directors. The committee investigates accidents and exposures involving employees, patients and visitors and incidents and events involving the safety and security of persons and property and reports its finding and recommendations regarding quality of care and hospital services.

Incident reports are prepared under the authority of the quality review committee, are not prepared in the regular course of the hospital's business of treating patients and are kept only in the files of the quality review committee.

Patient medical records, on the other hand, are prepared in the regular course of the hospital's business and are shared among providers within the hospital and outside for treatment purposes, provided there is authorization from the patient.

Patients' medical records, with proper attention to authorization for their release, can be used in litigation against the hospital, either by the patient to prove the patient's case or by the hospital to defend.

Quality assurance incident reports, unlike patients' medical records, are protected by the quality assurance privilege.

The quality assurance privilege, assuming the court is persuaded the privilege applies, prevents even the patient or other person about whom the occurrence report was written to use the report itself or to gather pertinent information from the report for use in a lawsuit. **In re Dallas Methodist, 2013 WL 1932865 (Tex. App., May 9, 2013).**

Patient's Fall: Absence Of Care Plan Seen By Court As Evidence Of Nursing Negligence.

The patient was a high fall risk, having fallen at home before coming to the hospital.

With this patient it was especially important for the hospital nurses fully to assess his risk of falling, to formulate a care plan consistent with the assessment and to implement appropriate fall prevention strategies, including mentioning in all shift-end nursing reports that the patient was a high fall risk.

There was no documentation of a full fall-risk assessment, fall care plan or implementation of many of the hospital's standard nursing interventions for high-fall risk patients.

The hospital's standard fall prevention protocols called for the bedrails to be raised, the bed to be placed in the lowest position, a bedside commode to be located at the bedside and the call bell to be placed within reach.

There was no specific occurrence documented in the chart that was a departure from the standard of care. However, absence of necessary documentation is itself evidence of nursing negligence.

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The elderly patient was admitted to the hospital by his family doctor for coughing, congestion, fever and difficulty breathing. He was diagnosed with pneumonia and COPD.

His family reported that he had recently fallen at home. Although he was able to ambulate with assistance he was still deemed a high fall risk.

The patient was found on the floor between his bed and the commode with a non-displaced hip fracture. He was transferred to another facility for orthopedic surgery.

He died a year later from unrelated causes, before his case went to court.

The medical review panel required by Louisiana's medical malpractice law concluded that there was no documentation in the chart of any specific occurrence that amounted to a departure from the standard of care by the patient's nurses. The panel recommended dismissal.

The Court of Appeal of Louisiana overruled the panel. The lack of necessary nursing documentation in the chart was itself substandard care. The Court let the family's case proceed.

Nursing Expert Points To Lack of Nursing Documentation

The family's nursing expert, chief of nursing education at a large hospital in the same state, reviewed the patient's medical chart for the family's case.

The patient had fallen at home. However, there was no documentation of any fall prevention plan or documentation that many of the nursing interventions that should have been included in his fall care plan were implemented with the patient before he was found on the floor.

There was also nothing in the nursing progress notes that the patient had rung his call bell for assistance before he was found on the floor. However, the nursing documentation in general and the documentation of the fall itself was so sketchy that the Court could not place any relevance on the fact that the patient ringing for assistance was never mentioned in the chart. **Walters v. West Louisiana Health, __ So. 3d __, 2013 WL 1810579 (La. App., May 1, 2013).**