LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Medical Records: Nursing Home Quality Assurance Documents Ruled Exempt From Grand Jury Subpoenas In Medicaid Fraud Investigation.

State authorities in New York went before a county grand jury trying to obtain indictments for Medicaid fraud at three nursing homes.

The grand jury issued subpoenas for fifty-nine separate categories of documentation to aid state authorities in the investigation.

The nursing homes resisted, that is, they asked the court to quash the subpoenas for incident/accident reports, monthly skin condition and pressure sore reports, monthly weight reports, infection-control reports and lists of facility-acquired infections.

Quality Assurance Privilege Applied To Nursing Home Quality Assurance

The Court of Appeals of New York ruled the Federal– and state-law quality assurance privilege applies to quality assurance documents generated in nursing homes and they are not proper targets for grand jury subpoenas.

Federal and state laws are intended to improve the quality of care at Medicaid-supported nursing facilities. That goal requires protection of the process of thorough and candid internal review from the pressure of possible legal recriminations for what internal quality assurance officers document in their reports.

Incident Reports versus Clinical Records

The court drew the line between incident reports, which are not prepared by quality assurance officers, and clinical records, which have a clear relationship to improving the quality of care for residents.

The court ruled incident/accident reports must be turned over as there is no quality assurance privilege for them, while clinical records relating to skin condition, weights and infection control are privileged and are not subject to court subpoenas. **Subpoena Duces Tecum to Jane Doe, Esq., __ N.E. 2d __, 2003 N.Y. Slip. Op 11299, 2003 WL 441990 (N.Y. App., February 25, 2003).**

Lab Tests Not Printed, Not Placed In Chart: Court Sees Possible Basis For Malpractice Lawsuit.

The Supreme Court of Oklahoma did not rule definitively that the first hospital was to blame for the patient's death from a heart attack at the second hospital.

However, the court did overrule a lower court's decision to throw out the case without giving the patient's widow her day in court before a civil jury.

Test Results Available On Computer Not Printed, Not Placed In Chart

The patient came to the emergency room with chest pains. CPK and CPK-MB tests were promptly ordered, done and logged on the hospital's computer system for access by staff physicians.

However, no one printed out the test results and placed them in the chart. His physician did not see the tests results, indicative of a mild myocardial infarction, and released him.

The state administrative code requires hospitals to document orders, treatment, tests and services in the patient's chart.

Administrative rules and regulations are relevant to the standard of care.

The obvious purpose is to assist physicians in treating patients.

Physicians depend on the reliability and trustworthiness of the chart.

SUPREME COURT OF OKLAHOMA
February 18, 2003

He came back the next day and was released again for the same reason.

The Supreme Court of Oklahoma acknowledged the test results were available to any hospital staff who wanted to access them on the computer, but the court felt it was also necessary for someone to see that they were printed out and placed in the chart, primarily for the benefit of institutions where the patient would subsequently receive care.

He went to another hospital a week later. His chart from the first hospital did not contain the ominous cardiac lab results and a cardiologist was never consulted. He died two days later. **Johnson v. Hillcrest Health Center, Inc., 2003 OK 16, __ P. 3d __, 2003 WL 355286 (Okla., February 18, 2003).**