Long-Term Care Survey Alert

RISK MANAGEMENT: Don't Let Incident Report Practices Imperil Your Nursing Facility

These tips will keep you off a slippery liability slope.

When a resident has an accident or a caregiver makes a patient safety error, the worst mistake you can make is to complete an incident report speculating about the cause.

Indeed, incident reports can be fodder for civil lawsuits or immediate jeopardy citations unless you follow a few rules for completing and maintaining them.

Just the facts: The best approach is very simple, says attorney **Joseph Bianculli**: Document "who, what, when and where--but definitely not why, unless state law requires a specific format or content." Speculation is a problem because "first impressions often turn out to be incorrect or incomplete," says Bianculli, who is in private practice in Arlington, VA.

Cautionary example: Bianculli recalls a case where a nursing home staff member documented that a resident choked to death on a hard-boiled egg. Yet an autopsy revealed the resident actually died from a stroke that caused him to become confused and somehow swallow the egg whole.

A safer bet: Facilities can write incident reports to document the factual occurrence and then turn the report over to the QA committee to do the investigation and root-cause analysis, suggests **Paula Sanders, JD**, partner, **Post & Schell** in Harrisburg, PA.

You can "keep that investigation separate from the form reporting the underlying facts," such as "a resident was found on the floor by x person at 2 a.m.," says Sanders. "The QA committee may find that the person was trying to get to the toilet and discuss that issue and how to address it so the problem doesn't recur."

Compare What You're Doing to State Requirements

Attorney **Brian Purtell** notes that "too often, facilities develop or use forms, logs and documentation" that they mistakenly believe are required--or were once needed but are no longer useful or needed.

Did you know? There's no federal requirement that a facility maintain a book of incident reports, advises Purtell, director of legal services for the **Wisconsin Health Care Association** and a member of the Madison-based law firm of **DeWitt Ross & Stevens**.

So if the state doesn't require the facility to write and maintain incident reports, look at what you are doing in that regard, he suggests. And state requirements governing incident reports vary. Some states require incident reports for specific kinds of incidents, says Bianculli. Or they require specific forms of reporting or make facilities keep the reports on the premises.

In other states, a facility can destroy incident reports and never turn them over to anyone, at least after the QA committee has considered them, Bianculli notes.

Real-world practice: Complying with what's allowed in California, **TSW**-managed nursing facilities log all reportable incidents but not by resident name, reports **Kathy Hurst, JR, RN,** director of healthcare operations for TSW Management Group in Anaheim, CA.

"Instead, we use the medical record identification number." The facilities send incident reports to offsite counsel who maintains them, Hurst adds.

Don't Win the Battle and Lose the Survey

Having the QA committee investigate an incident may provide some protection against surveyors accessing the incidents and root-cause analysis, says Purtell.
To do that, the facility needs a formalized process where the QA committee designates a member or subcommittee to investigate incidents and provide a report to the QA committee for review and quality improvement efforts, adds Purtell.

But if surveyors demand to see incident reports, "it's not a good idea to resist too hard," says Bianculli, even though a facility "technically has an argument" for not forking them over "if they are prepared for and under the auspices of the QA committee."

Keep in mind: From a survey perspective, a facility is sometimes better off showing surveyors that it has done an investigation and made some changes to address an incident, Sanders points out.