# PUBLICATION

## Incident Reports: Protection or Production?

**June 1, 2008**

One of the stickiest issues in long term care litigation is production of incident reports. In virtually every case a plaintiff seeks discovery of facility incident reports, particularly regarding the resident at issue. These incident reports may be internal quality assurance documents that include statements submitted or authored by eye witnesses (e.g., CNAs who observed or addressed a fall), as well as trending analyses that may be conducted and documented by the facility quality assurance committee. Incident reports also include reports that are required by federal and/or state authorities to be submitted to the administrative or regulatory body of the State.

In order to participate in the Medicare reimbursement program, a long term care facility is required to have a quality assurance committee:

A skilled nursing facility must maintain a quality assessment and assurance committee consisting of the Director of Nursing Services, . . . which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. 42 U.S.C. § 1395i-3(b)(1)(B)

Under this same section of the Social Security Act, the records of such committee are subject to strict confidentiality requirements and are expressly excluded from discovery. Under the Act, a state "may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such Committee with the requirements of this subparagraph." *Id*. Most states have similar "peer review" protection laws that likewise protect the work and materials of such a committee. For example, the Tennessee Peer Review Law of 1967 states, "All information, interviews, incidents or other reports, statements, memoranda or other data furnished to any [peer review] committee . . . are declared to be privileged." Tenn. Code Ann. § 63-6-219(e). The Tennessee Supreme Court "has emphasized that the 'broad language of the [peer review law] encompasses any and all matters related to the peer review process.'" *Stratienko v. Chattanooga-Hamilton County Hosp. of Auth*., 226 S.W. 3d 280, 283 (Tenn. 2007) (quoting *Eyring v. Ft. Sanders Parkwest Med. Center, Inc*. 991 S.W. 2d 230, 239 (Tenn. 1999)). Stratienko narrows the protection somewhat to documents that are not available from some "alternative" source, e.g., chart materials maintained in the ordinary course of business. *Id*. at 285- 286. Accordingly, a peer review committee may review nurses' notes from a resident chart as part of the review process. However, simply reviewing materials from an "alternative" source (i.e., the resident chart) does not shield those documents with the cloak of confidentiality. On the other hand, incident report forms and statements gathered solely for presentation and consideration by the committee should be protected as they are not so available from an "alternative" source.

Likewise, long term care facilities are required to report certain "unusual events" to the State. Such reports may generate surveys but are required by most state laws. *See e.g*., The Tennessee Health Data Reporting Act of 2002, Tenn. Code Ann. § 68-11-211. Similar protection from discovery is afforded to these reports as well. "The event report and the corrective action report . . . shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding, . . ." Tenn. Code Ann. 68-11- 211(d)(1).

What must a facility do to assure compliance with these standards so as to protect these reports? In a recent case in the Eastern District of Tennessee, a defendant sought to protect 18 documents, 17 as peer review protected and the eighteenth as immune under the Health Data Reporting Act of 2002. In addition to filing a privileged log identifying the date and general nature of the event reported, the defendant also filed the Affidavit of a member of the peer review committee. Key elements of that Affidavit on which the Court relied in upholding the privilege were:

- The affiant was a member of the peer review committee and reviewed all 18 of the documents in connection with the quality assurance process.
- The documents withheld were not prepared in the ordinary course of business or otherwise available from some "alternative" source.
- The documents were not maintained or kept with the resident nursing chart but rather were kept in a secure and separate area in the nursing department office. They were not seen by anyone other than members of the quality assurance committee nor accessible to anyone other than the administrator, director of nursing and assistant director of nursing, all of whom were members of the quality assurance committee.
- The documents were all reviewed by the quality assurance committee for purpose of determining if some kind of procedure might be implemented that would improve the quality of care or otherwise prevent the documented incident/ accident from occurring or reducing the likelihood or frequency of such occurrence.

In addition to reviewing the defendant's privilege log, affidavit and substantial briefing, the Court also reviewed in camera the documents in question, from all of which the Court concluded that the documents were protected under the Tennessee Peer Review Law (as to the first 17) and likewise privileged under the Health Data Reporting Act (Item No. 18). The Magistrate Judge's Memorandum and Order can be reviewed at Brown v. Sun Healthcare Group, Inc. et al; E.D. Tenn., 3:06-cv- 240 (May 27, 2008).

The lesson therefore is that if these documents are reviewed and worked with by the quality assurance committee of a facility and they are separated and maintained as confidential documents, they should be protected from discovery under both federal and applicable state law protections.