MAINE STATE LEGISLATURE

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120th MAINE LEGISLATURE

FIRST REGULAR SESSION-2001

Legislative Document **No. 1363**

S.P. 419 In Senate, March 5, 2001

An Act to Reduce Medical Errors and Improve Patient Health.

Reference to the Committee on Health and Human Services suggested and ordered printed.

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator RAND of Cumberland.
Cosponsored by Representative KANE of Saco and
Senator TREAT of Kennebec, Representatives: DUDLEY of Portland, DUPLESSIE of Westbrook, FULLER of Manchester, MURPHY of Berwick, TRAHAN of Waldoboro.

Printed on recycled paper

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §106 is enacted to read:

CHAPTER 106

HEALTH CARE QUALITY IMPROVEMENT

§371. Maine Health Care Quality Improvement Center established

The Maine Health Care Quality Improvement Center, referred to in this chapter as the "center," is established for the primary purpose of improving health care quality, increasing patient safety and reducing medical errors. The center may be operated within the department or may be contracted out to a nonprofit entity.

§372. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Health care facility. "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including, but not limited to, a radiological facility licensed under chapter 160, a health care facility licensed under chapter 405 or 405-D, a federally qualified health center or rural health clinic certified by the Division of Licensing and Certification within the Department of Human Services, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1665, a hospice provider licensed under chapter 1681, a community rehabilitation program licensed under Title 26, chapter 19 subchapter II, a state institution as defined under Title 34-B, chapter 1, a mental health facility licensed under Title 34-B, chapter 1, a drug outlet licensed under Title 32, chapter 117 or other entity licensed to provide health care.

2. Health care practitioner. "Health care practitioner" means a physician or other person certified, registered or licensed in the healing arts, including, but not limited to, a nurse, podiatrist, optometrist, chiropractor, physical therapist, acupuncturist, naturopathic doctor, dentist, psychologist and physician's assistant.

3. Major permanent loss of function. "Major permanent loss of function" means sensory, motor, physiologic or intellectual impairment that requires continued treatment or imposes persistent major restrictions in activities of daily living and that was not present on admission of the patient to a health care

facility or, in the case of a patient who was not admitted, at
2 the initiation of the provision of items or services to the
patient.
4
4. Sentinel event. "Sentinel event" means:
6
A. A serious injury that is not related to the natural
8 course of the illness or underlying condition of a patient
and that results in death or major permanent loss of
10 function or requires that the patient undergo significant
additional diagnostic or treatment measures;
12
B. A serious incident that adversely affects the health of
14 a patient, such as surgery on the wrong patient or wrong
body part, a poisoning within the facility, equipment
16 malfunction or user error, medication error, hemolytic
transfusion reaction involving administration of blood or
18 blood products that have blood group incompatibilities or
other incident that results in serious injury not
20 anticipated in the normal course of events;

22 C. An incident in which the patient is harmed or the
patient's safety is placed in jeopardy by a serious criminal
24 act or an administrative error, such as the release of an
infant to the wrong family;
26
D. Abuse that results in serious physical or mental harm;
28
E. An accident such as a fall, burn, electrocution or other
30 similar event occurring within the facility that is not
related to patient treatment and that results in serious
32 head injury, coma or permanent injury or that requires
significant additional therapeutic intervention or
34 hospitalization; or

36 F. Suicide of a patient in a setting where the patient
receives in-patient care.
38
§373. Duties of center
40
Utilizing the sentinel event reports submitted through the
42 process described in section 374 and other available data, the
center shall:
44
1. Assist health care facilities and health care
46 **practitioners.** Provide direct assistance to health care
facilities and practitioners to improve the quality of care to
48 patients and implement the requirements of this chapter;

50 **2. Research.** Conduct research to:

2 A. Develop a more complete understanding of the types and causes of medical errors in a variety of settings, levels of
4 care and patient populations;

6 B. Clarify the impact of systems and professional and organizational cultures on reducing medical errors and
8 improving patient safety; and

10 C. Evaluate the efficacy of automated information and diagnostic systems in improving clinical decision making,
12 reducing errors and advancing patient safety;

14 **3. Education.** Create a clearinghouse for the most recent information and data relative to patient safety. The information
16 must be accessible to health care facilities and the public in summary form. The center also shall conduct forums and seminars
18 for the purpose of disseminating information pertaining to patient safety. The forums must be conducted jointly with health
20 care facilities; and

22 **4. Reports.** Develop an annual report to the Legislature, health care facilities and the public that includes summary data
24 of the number and type of sentinel events of the prior calendar year by type of health care facility, rates of change and other
26 analyses and an outline of areas to be addressed for the upcoming year.

28

§374. Mandatory reporting of sentinel events

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The department shall adopt rules pursuant to section 376
32 establishing a mandatory reporting system for sentinel events. The reporting system must be designed to collect information,
34 allow for data analysis and protect patient confidentiality.

36 **1. Reporting requirements.** A health care facility shall report a sentinel event that occurs to a patient while the
38 patient is in the care or custody of the health care facility to the facility's licensing authority or entity and as provided in
40 subsection 2.

42 **2. Reporting.** A health care facility shall file a written report under subsection 1 within one week of the occurrence of
44 the sentinel event. The written report must contain the following information:

46

A. The name of the facility, including the names and titles
48 of the person in charge of the facility at the time of the sentinel event and the health care practitioner or other
50 person who may have caused the sentinel event to occur;

2 B. The name, title and phone number of the reporting individual;
4
C. The date and time of the sentinel event;
6
D. Patient information, including name, age, sex, ambulatory status and, where applicable, activities of daily
8 living status and cognitive level;
10
E. The type of sentinel event and a brief description of
12 the sentinel event;

14 F. The nature of the harm to the patient;

16 G. The activity of the patient at the time of the incident and the location where the incident occurred;
18
H. Any safety precautions taken prior to the sentinel event
20 and any equipment or safety devices in use during or prior to the sentinel event;
22
I. A brief description of corrective action taken;
24
J. The name and title of any witness to the sentinel event;
26 and

28 K. The date and type of notification provided to the patient and the patient's family, legal guardian or next of
30 kin.

32 **§375. Investigation of sentinel events; quality improvement**

34 Upon receipt of a report of a sentinel event, the center may complete an investigation and undertake quality improvement
36 planning as provided in this section.

38 **1. Investigation.** The center shall investigate the sentinel event to determine the cause of the sentinel event.
40 When the investigation is complete, the center shall issue a sentinel event report for release to the health care facility and
42 the public. The report must protect patient confidentiality.

44 **2. Quality improvement.** The center shall work with the health care facility to ensure that the facility establishes and
46 implements a quality improvement plan to address the cause of the sentinel event when such a plan is appropriate. The plan must be
48 time-limited, must address the problem or problems that resulted in the sentinel event and must reduce the risk of a similar event
50 happening in the future.

2 **§376. Rulemaking**

4 The department, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Board of Licensure 6 in Medicine, the State Board of Nursing and the Maine Board of Pharmacy shall adopt rules to implement this chapter. Rules 8 adopted pursuant to this section must require the appropriate state agency or board to provide a copy of the appropriate state 10 agency or board's report on a sentinel event to the center. Rules adopted pursuant to this chapter are routine technical 12 rules as defined in Title 5, chapter 375, subchapter II-A.

14

SUMMARY

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This bill establishes the Maine Health Care Quality 18 Improvement Center to improve the quality of health care provided to patients, increase patient safety and reduce medical errors. 20 The bill creates a mandatory reporting system for medical errors and events and incidents injurious to patients that involve 22 health care facilities designating these events and incidents "sentinel events."