

ASSEMBLY, No. 3033

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED FEBRUARY 20, 2020

Sponsored by:

Assemblywoman PAMELA R. LAMPITT

District 6 (Burlington and Camden)

SYNOPSIS

Clarifies that apologies by health care facilities and professionals to patients or their representatives for adverse events disclosed under “Patient Safety Act” are excluded from discovery and inadmissible in legal actions involving facilities and professionals.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning acts of apology for certain adverse health care
2 events disclosed pursuant to the "Patient Safety Act," and
3 amending P.L.2004, c.9.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. Section 3 of P.L.2004, c.9 (C.26:2H-12.25) is amended to
9 read as follows:

10 3. a. As used in this act:

11 "Adverse event" means an event that is a negative consequence
12 of care that results in unintended injury or illness, which may or
13 may not have been preventable.

14 "Anonymous" means that information is presented in a form and
15 manner that prevents the identification of the person filing the
16 report.

17 "Commissioner" means the Commissioner of Health.

18 "Department" means the Department of Health.

19 "Event" means a discrete, auditable, and clearly defined
20 occurrence.

21 "Health care facility" or "facility" means a health care facility
22 licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a State
23 psychiatric hospital operated by the Department of Human Services
24 and listed in R.S.30:1-7.

25 "Health care professional" means an individual who, acting
26 within the scope of the individual's licensure or certification,
27 provides health care services, and includes, but is not limited to, a
28 physician, dentist, nurse, pharmacist, or other health care
29 professional whose professional practice is regulated pursuant to
30 Title 45 of the Revised Statutes.

31 "Near-miss" means an occurrence that could have resulted in an
32 **[averse]** adverse event but the adverse event was prevented.

33 "Preventable event" means an event that could have been
34 anticipated and prepared against, but occurs because of an error or
35 other system failure.

36 "Serious preventable adverse event" means an adverse event that
37 is a preventable event and results in death or loss of a body part, or
38 disability or loss of bodily function lasting more than seven days or
39 still present at the time of discharge from a health care facility.

40 b. In accordance with the requirements established by the
41 commissioner by regulation, pursuant to this act, a health care
42 facility shall develop and implement a patient safety plan for the
43 purpose of improving the health and safety of patients at the
44 facility.

45 The patient safety plan shall, at a minimum, include:

46 (1) a patient safety committee, as prescribed by regulation;

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 (2) a process for teams of facility staff, which teams
2 are comprised of personnel who are representative of the facility's
3 various disciplines and have appropriate competencies, to conduct
4 ongoing analysis and application of evidence-based patient safety
5 practices in order to reduce the probability of adverse events
6 resulting from exposure to the health care system across a range of
7 diseases and procedures;

8 (3) a process for teams of facility staff, which teams are
9 comprised of personnel who are representative of the facility's
10 various disciplines and have appropriate competencies, to conduct
11 analyses of near-misses, with particular attention to serious
12 preventable adverse events and adverse events; and

13 (4) a process for the provision of ongoing patient safety training
14 for facility personnel.

15 The provisions of this subsection shall not be construed to
16 eliminate or lessen a hospital's obligation under current law or
17 regulation to have a continuous quality improvement program.

18 c. A health care facility shall report to the department or, in the
19 case of a State psychiatric hospital, to the Department of Human
20 Services, in a form and manner established by the commissioner,
21 every serious preventable adverse event that occurs in that facility.

22 d. A health care facility shall assure that the patient affected by
23 a serious preventable adverse event or an adverse event specifically
24 related to an allergic reaction, or, in the case of a minor or a patient
25 who is incapacitated, the patient's parent or guardian or other family
26 member, as appropriate, is informed of the serious preventable
27 adverse event or adverse event specifically related to an allergic
28 reaction, no later than the end of the episode of care, or, if
29 discovery occurs after the end of the episode of care, in a timely
30 fashion as established by the commissioner by regulation. The time,
31 date, participants, and content of the notification shall be
32 documented in the patient's medical record in accordance with rules
33 and regulations adopted by the commissioner. The content of the
34 documentation shall be determined in accordance with the rules and
35 regulations of the commissioner. If the patient's physician
36 determines that the disclosure would seriously and adversely affect
37 the patient's health, then the facility shall assure that the family
38 member, if available, is notified in accordance with rules and
39 regulations adopted by the commissioner. In the event that an adult
40 patient is not informed of the serious preventable adverse event or
41 adverse event specifically related to an allergic reaction, the facility
42 shall assure that the physician includes a statement in the patient's
43 medical record that provides the reason for not informing the
44 patient pursuant to this section.

45 e. (1) A health care professional or other employee of a health
46 care facility is encouraged to make anonymous reports to the
47 department or, in the case of a State psychiatric hospital, to the
48 Department of Human Services, in a form and manner established
49 by the commissioner, regarding near-misses, preventable events,

1 and adverse events that are otherwise not subject to mandatory
2 reporting pursuant to subsection c. of this section.

3 (2) The commissioner shall establish procedures for and a
4 system to collect, store, and analyze information voluntarily
5 reported to the department pursuant to this subsection. The
6 repository shall function as a clearinghouse for trend analysis of the
7 information collected pursuant to this subsection.

8 f. Any documents, materials, or information received by the
9 department, or the Department of Human Services, as applicable,
10 pursuant to the provisions of subsections c. and e. of this section
11 concerning serious preventable adverse events, near-misses,
12 preventable events, and adverse events that are otherwise not
13 subject to mandatory reporting pursuant to subsection c. of this
14 section, shall not be:

15 (1) subject to discovery or admissible as evidence or otherwise
16 disclosed in any civil, criminal, or administrative action or
17 proceeding;

18 (2) considered a public record under P.L.1963, c.73 (C.47:1A-1
19 et seq.) or P.L.2001, c.404 (C.47:1A-5 et al.); or

20 (3) used in an adverse employment action or in the evaluation of
21 decisions made in relation to accreditation, certification,
22 credentialing, or licensing of an individual, which is based on the
23 individual's participation in the development, collection, reporting
24 or storage of information in accordance with this section. The
25 provisions of this paragraph shall not be construed to limit a health
26 care facility from taking disciplinary action against a health care
27 professional in a case in which the professional has displayed
28 recklessness, gross negligence, or willful misconduct, or in which
29 there is evidence, based on other similar cases known to the facility,
30 of a pattern of significant substandard performance that resulted in
31 serious preventable adverse events.

32 The information received by the department, or the Department
33 of Human Services, as applicable, shall be shared with the Attorney
34 General in accordance with rules and regulations adopted pursuant
35 to subsection j. of this section, and may be used by the department,
36 the Department of Human Services, and the Attorney General for
37 the purposes of this act and for oversight of facilities and health
38 care professionals; however, the departments and the Attorney
39 General shall not use the information for any other purpose.

40 In using the information to exercise oversight, the department,
41 Department of Human Services, and Attorney General, as
42 applicable, shall place primary emphasis on assuring effective
43 corrective action by the facility or health care professional,
44 reserving punitive enforcement or disciplinary action for those
45 cases in which the facility or the professional has displayed
46 recklessness, gross negligence, or willful misconduct, or in which
47 there is evidence, based on other similar cases known to the
48 department, Department of Human Services or the Attorney

1 General, of a pattern of significant substandard performance that
2 has the potential for or actually results in harm to patients.

3 g. (1) Any documents, materials, or information developed
4 by a health care facility as part of a process of self-critical analysis
5 conducted pursuant to subsection b. of this section concerning
6 preventable events, near-misses, and adverse events, including
7 serious preventable adverse events, [and any document or oral
8 statement that constitutes the disclosure provided to a patient or the
9 patient's family member or guardian pursuant to subsection d. of
10 this section,] shall not be:

11 [(1)] subject to discovery or admissible as evidence or
12 otherwise disclosed in any civil, criminal, or administrative action
13 or proceeding; or

14 [(2)] used in an adverse employment action or in the
15 evaluation of decisions made in relation to accreditation,
16 certification, credentialing, or licensing of an individual, which is
17 based on the individual's participation in the development,
18 collection, reporting, or storage of information in accordance with
19 subsection b. of this section. The provisions of this paragraph shall
20 not be construed to limit a health care facility from taking
21 disciplinary action against a health care professional in a case in
22 which the professional has displayed recklessness, gross negligence
23 or willful misconduct, or in which there is evidence, based on other
24 similar cases known to the facility, of a pattern of significant
25 substandard performance that resulted in serious preventable
26 adverse events.

27 (2) Any document or oral statement that constitutes the
28 mandatory disclosure of any adverse event to a patient or the
29 patient's family member or guardian pursuant to subsection d. of
30 this section, and any document, gesture, or oral statement to the
31 patient, family member, or guardian associated with that disclosure
32 expressing benevolence, regret, apology, sympathy, commiseration,
33 condolence, or compassion shall not be:

34 subject to discovery or admissible as evidence or otherwise
35 disclosed in any civil, criminal, or administrative action or
36 proceeding; or

37 used in an adverse employment action or in the evaluation of
38 decisions made in relation to accreditation, certification,
39 credentialing, or licensing of a health care professional, which is
40 based on the professional's participation in the development,
41 collection, reporting, or storage of information for self-critical
42 analyses conducted in accordance with subsection b. of this section.
43 However, the provisions of this paragraph shall not be construed to
44 limit a health care facility from taking disciplinary action against a
45 health care professional in a case in which the professional has
46 displayed recklessness, gross negligence or willful misconduct, or
47 in which there is evidence, based on other similar cases known to
48 the facility, of a pattern of significant substandard performance that
49 resulted in serious preventable adverse events, and shall not be

1 construed to limit the discovery, admissibility, or use of any
2 document, gesture, or oral statement, or part thereof, expressing
3 negligence or fault concerning the adverse event disclosed.

4 h. Notwithstanding the fact that documents, materials, or
5 information may have been considered in the process of self-critical
6 analysis conducted pursuant to subsection b. of this section, or
7 received by the department or the Department of Human Services
8 pursuant to the provisions of subsection c. or e. of this section, the
9 provisions of this act shall not be construed to increase or decrease,
10 in any way, the availability, discoverability, admissibility, or use of
11 any such documents, materials, or information if obtained from any
12 source or context other than those specified in this act.

13 i. The investigative and disciplinary powers conferred on the
14 boards and commissions established pursuant to Title 45 of the
15 Revised Statutes, the Director of the Division of Consumer Affairs
16 in the Department of Law and Public Safety and the Attorney
17 General under the provisions of P.L.1978, c.73 (C.45:1-14 et seq.)
18 or any other law, rule, or regulation, as well as the investigative and
19 enforcement powers conferred on the department and the
20 commissioner under the provisions of Title 26 of the Revised
21 Statutes or any other law, rule, or regulation, shall not be exercised
22 in such a manner so as to unduly interfere with a health care
23 facility's implementation of its patient safety plan established
24 pursuant to this section. However, this act shall not be construed to
25 otherwise affect, in any way, the exercise of such investigative,
26 disciplinary, and enforcement powers.

27 j. The commissioner shall, pursuant to the "Administrative
28 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such
29 rules and regulations necessary to carry out the provisions of this
30 act. The regulations shall establish: criteria for a health care
31 facility's patient safety plan and patient safety committee; the time
32 frame and format for mandatory reporting of serious preventable
33 adverse events at a health care facility; the types of events that
34 qualify as serious preventable adverse events and adverse events
35 specifically related to an allergic reaction; the circumstances under
36 which a health care facility is not required to inform a patient or the
37 patient's family about a serious preventable adverse event or
38 adverse event specifically related to an allergic reaction; and a
39 system for the sharing of information received by the department
40 and the Department of Human Services pursuant to subsections c.
41 and e. of this section with the Attorney General. In establishing the
42 criteria for reporting serious preventable adverse events, the
43 commissioner shall, to the extent feasible, use criteria for these
44 events that have been or are developed by organizations engaged in
45 the development of nationally recognized standards.

46 The commissioner shall consult with the Commissioner of
47 Human Services with respect to rules and regulations affecting the
48 State psychiatric hospitals and with the Attorney General with
49 respect to rules and regulations regarding the establishment of a

1 system for the sharing of information received by the department
2 and the Department of Human Services pursuant to subsections c.
3 and e. of this section with the Attorney General.

4 k. Nothing in this act shall be construed to increase or decrease
5 the discoverability, in accordance with **【Christy v. Salem, No. A-
6 6448-02T3 (Superior Court of New Jersey, Appellate Division,
7 February 17, 2004)(2004 WL291160)】** Christy v. Salem, 366 N.J.
8 Super. 535 (App. Div. 2004), of any documents, materials or
9 information if obtained from any source or context other than those
10 specified in this act.

11 (cf: P.L.2012, c.17, s.190)

12
13 2. This act shall take effect immediately, and apply to any
14 event that falls within the scope of the “Patient Safety Act,”
15 P.L.2004, c.9 (C.26:2H-12.23 et seq.), as defined therein, occurring
16 on or after the effective date.

17 18 19 STATEMENT

20
21 This bill would clarify that apologies by health care facility
22 representatives and health care professionals to patients or their
23 parents or guardians for adverse events subject to patient disclosure
24 under the “Patient Safety Act,” P.L.2004, c.9 (C.26:2H-12.23 et
25 seq.), are generally excluded from discovery and inadmissible in
26 legal actions or proceedings involving those facilities and
27 professionals.

28 In accordance with the bill’s provisions, any document, gesture,
29 or oral statement to a patient, family member, or guardian
30 associated with the adverse event disclosure expressing
31 benevolence, regret, apology, sympathy, commiseration,
32 condolence, or compassion would not be: subject to discovery or
33 admissible as evidence or otherwise disclosed in any civil, criminal,
34 or administrative action or proceeding; or used in an adverse
35 employment action or in the evaluation of decisions made in
36 relation to accreditation, certification, credentialing, or licensing of
37 the apologizing health care professional. However, any document,
38 gesture, or oral statement, or part thereof, expressing negligence or
39 fault concerning the adverse event disclosed would be subject to
40 discovery and admissible in any action or proceeding, and could be
41 used by a health care facility to take disciplinary action against a
42 health care professional in a case in which the professional had
43 displayed recklessness, gross negligence or willful misconduct, or
44 in which there was evidence, based on other similar cases known to
45 the facility, of a pattern of significant substandard performance that
46 resulted in serious preventable adverse events.