Delaware Developmental Disabilities Council

Margaret O'Neil Building, 2nd Floor
410 Federal Street - Suite 2 Dover, Delaware 19903
Phone: 302.739.3333 ♦ Fax: 302.739.2015 ♦ Delaware Help Line: (800) 464-HELP (4357)

November 21, 2011

Susan Del Pesco, Director
Department of Health & Social Services
Division of Long Term Care Residents Protection
3 Mill Rd., Suite 308
Wilmington, DE 19806

RE: DLTCRP Prop. Asst. Liv. Medication Error & Record Regulation [15 DE Reg. 594(11/1/11)]

Dear Ms. Del Pesco,

The Developmental Disabilities Council (DDC) understands that the Division of Long-term Care Residents Protection (DLTCRP) proposes to adopt two discrete amendments to its assisted living facility regulation. First, it adopts the following definition of "significant medical error": "one which causes the resident discomfort or jeopardizes his or her health or safety." At 597. Second, it shortens the duration of retention of clinical records for discharged patients from 5 years to 3 years. At §19.3.

First, we have no objection to the new definition of "significant medication error". However, the Division is eliminating an "omission in treatment" as a source of significant injury prompting a report to the State. See §19.7.7.5. Under the current standard, if a nurse failed to check the sugar level of an individual with diabetes, failed to clean a wound per physician's orders, or failed to turn a patient with decubitus ulcers, such conduct would qualify as an omission in treatment prompting a report. Parenthetically, the Division includes "errors or omissions in treatment" as a reportable incident in its new IBSER regulation issued this month, 15 DE Reg. 600, 618-619, §§23.3.3 and 23.411. The Division may wish to consider retaining a reference to "significant omission in treatment" or, by analogy to the IBSER regulation, include a reference to "significant error or omission in treatment".

Second, the reduction in records retention from 5 years to 3 years is objectionable. By analogy, nursing homes must retain records for 6 years after discharge. [16 DE Admin Code 3201, §9.3] Group homes for persons with mental illness must retain records for 7 years after discharge.

]16 DE Admin Code, §8.1] Consider the following:

A. Individuals in all of these facilities will often have cognitive limitations and diminished capacity to maintain their own records. Indeed, some assisted living facilities (e.g. Somerford) have dedicated Alzheimer's units consistent with 16 DE Admin Code 3225, §7.0. Destroying medical records after only 3 years will predictably result in loss of valuable information. For example, pneumonia vaccinations may be spaced several years apart under CDC standards.

B. If the State were suspicious of Medicaid fraud (e.g. billing for prescriptions not actually provided), there could be no viable investigation after 36 months since records would be destroyed.

C. The general 2 year statute of limitation for medical malpractice [Title 10 Del.C. §8128; Title 18 Del.C. §6856] may be temporarily tolled if negligence is not detected or not reasonably discoverable. However, if records are destroyed after 36 months, patients harmed by negligence not readily discoverable may be prejudiced by destruction of records. The statute of limitation for not readily discoverable injuries is 3 years subject to an additional 90-day extension if a Notice of Intent to Investigate is issued. See Title 18 Del.C. §6856(4).

For these reasons, the 5-year records retention standard should be retained.

The Developmental Disabilities Council thanks you in advance for your consideration of our remarks. Should you have any questions regarding these please contact our office at 739-3333.

Sincerely,

Harline D. Dennison

Harline Dennision
Chair

cc. Delaware State Bar Association
Delaware Trial Lawyers Association
State Council for Persons with Disabilities
Governor's Advisory Council for Exceptional Citizens