Health Services
LOS ANGELES COUNTY

POLICIES AND PROCEDURES

SUBJECT: INCIDENTS INVOLVING POTENTIAL CLAIMS AGAINST THE COUNTY

POLICY NO: 311

PURPOSE:

To establish uniform guidelines for prompt reporting of clinical and non-clinical events, patient safety concerns and near misses.

SCOPE:

This policy applies to all Los Angeles County Department of Health Services (DHS) facilities.

POLICY:

Employees who become aware of an event involving a patient or a visitor shall report it immediately to their supervisor and shall report electronically using the Patient Safety Net (PSN) as soon as possible after the event has been detected and before reporting off duty. Patient safety concerns and near misses should be reported via the PSN. PSN entries may be completed anonymously.

.Employees without access to the PSN, shall complete a written event notification report.

Refer to DHS Policy No. 311.202, Adverse Event and Reporting to the State Department of Public Health, for reporting potentially adverse **clinical events**.

Refer to DHS Policy No. 311.203, Reportable Non-Clinical Events, for reporting potentially adverse **non-clinical** events.

INVESTIGATION

Each facility must investigate the cause of the event, patient safety concern, or near miss, in accordance with the attached "Procedures for Compliance with Los Angeles County Ordinance 2.76.590 Risk Management Protocol. The investigation will be conducted for the purpose of evaluating and improving the quality of patient care.

APPROVED BY:
REVIEW DATES:

EFFECTIVE DATE: January 1, 2008
SUPERSEDES: September 15, 1992

REFERENCES:

California Health and Safety Code § 1279.1(b)
Los Angeles County Ordinance 2.76.590

DHS Policies

311.1	Medical Device Reporting Program
311.2	Critical Clinical Event (including Sentinel Event) Reporting and Follow-up
311.201	Communication of Unanticipated Outcomes
311.202	Adverse Event Reporting to the State Department of Public Health
311.203	Reportable Non-Clinical Events
920	Accident/Injury Reporting

Procedures for Compliance with Los Angeles County Ordinance 2.76.590-Risk Management Protocol

PROCEDURES FOR COMPLIANCE WITH LOS ANGELES COUNTY ORDINANCE 2.76.590 RISK MANAGEMENT PROTOCOL – QUALITY IMPROVEMENT PROGRAM AND BOARD OF SUPERVISORS' MOTION OF DECEMBER 10, 1996 FOR CORRECTIVE ACTION PLANS
EFFECTIVE APRIL 15, 2007

This document shall describe the procedures required to comply with the Los Angeles County Ordinance 2.76.590 Risk Management Protocol – Quality Improvement Program (Attachment A). This document shall also describe the Department of Health Services (DHS) procedures required to comply with the Board of Supervisor's motion of December 10, 1996 to ensure that complete and appropriate corrective action plans accompany recommendations for settlement to the Board of Supervisors.

The goal of this protocol is to improve the delivery of medical services and reduce risks of county liability by assuring the prompt reporting, complete investigation, and timely implementation of corrective action regarding events involving patient safety, quality of care, potential liability, claims, and lawsuits as they arise out of the provision of medical services.

These procedures, as described below, will supercede any existing practices related to completion of reviews related to incidents, claims or lawsuits, and are proposed to support the timely review, analysis and promulgation of corrective actions for events involving patient safety, quality of care, potential liability, claims and lawsuits as they may arise out of the provision of medical services.

PROCEDURES

Each facility maintains an online event reporting system, the Patient Safety Net (PSN) which accepts and stores events and near misses reported by facility staff. The Risk Manager, or designee, is responsible for reviewing and screening the events reported in the PSN to determine whether further investigation or follow up is required. In the event that the Risk Manager, or designee, determines that no follow up is required, the event is maintained in the PSN database for use in tracking and trending events and near misses.

In the event that the Risk Manager, or designee, determines that follow up is required, the Risk Manager shall set up a risk management file. The Risk Manager shall inform the Quality Improvement and Patient Safety Program (QIPS) that a risk management file has been set up. **This notification should be via e-mail to QIPS@dhs.lacounty.gov no later than 72 hours of the event and within 24 hours of a sentinel event to inform the director that PSN event (#0000) has been identified for further investigation.**

New Claim Files

Upon receipt of a notice of a new claim file, QIPS shall send the facility a form letter **(Attachment B**) requesting that the facility identify whether the claim meets the criteria for a sentinel event or non-sentinel event. QIPS will send this notice via e-mail requesting a response within 10 business days. If no response is received within 10 business days, and the facility has not requested and been granted an extension, then the Senior Medical Director, DHS shall notify the Facility Chief Medical Officer and Chief Executive Officer of the delinquency and request an appropriate response within 3 (three) business days.

Requests for extensions shall be forwarded to ~~HSA~~QIPS and will be granted only in extreme emergency situations.

Event Review

If the Risk Manager, or designee determines that the event meets the criteria for a sentinel event review (Joint Commission criteria or SB1301), **the Risk Manager or designee shall begin an immediate investigation.** Within 45 calendar days from the date of the event, the facility shall complete a root cause analysis and develop a corrective action plan. For non-sentinel events, facilities shall complete an initial investigation and complete a corrective action plan within 45 days of the event. The corrective action plan for either a sentinel event or a non-sentinel event shall be submitted to QIPS for review upon completion by facility. Facilities shall use **Attachment B**-template to report their planned and completed corrective actions.

Facilities shall ensure that appropriate peer review and/or personnel review, as applicable, is completed on all events, either sentinel or non-sentinel within 45 days of the event. This peer review and/or personnel review shall include a determination of the individual's performance as related to this event as well as implementation of any necessary corrective actions. This personnel review should be conducted outside of the performance of a root cause analysis (RCA) process.

Upon receipt of the initial corrective action plan, QIPS will review the facility's plan and submit the facility's plan at the next available Executive Peer Review Committee for review, The Executive Peer Review Committee shall determine whether all appropriate corrective actions have been identified, make recommendations for additional corrective actions, and make recommendations for DHS-wide corrective actions, as applicable.

If the corrective action plan is not received within 45 calendar days of the date of notification to QIPS and the facility has not requested and been granted an extension, then the Senior Medical Director, DHS will notify the Facility Chief Medical Officer and Chief Executive Officer of the delinquency and request an appropriate response within 3 (three) business days. Requests for extensions shall be forwarded to QIPS and will be granted only in extreme emergency situations.

Within **135** calendar days of the event, the facility shall submit notification of completion of the corrective actions identified on the initial corrective action plan using the **Attachment B** template. Facilities shall also ensure that the information related to the investigation and corrective actions are entered into the PSN system.

Lawsuits

If a lawsuit is filed, County Counsel chairs a roundtable meeting which is held within six (6) months of the lawsuit being filed. Prior to the roundtable meeting, QIPS staff, together with facility staff, shall review facility and DHS corrective actions taken to date. After the roundtable meeting, should the need for additional corrective actions be identified, either at the individual facility or for the DHS system, the facility and DHS shall have 45 calendar days to complete those actions.

If the corrective action plan is not received within the 45 calendar day time frame and no request for extension has been received and approved by QIPS, the Senior Medical Director, DHS shall notify both the Chief Medical Officer and the Chief Executive Officer of

the delinquency and request an appropriate response within 3 business days. Requests for extensions shall be forwarded to QIPS and will be granted only in extreme emergency situations.

Review of Procedures

The procedures defined in this protocol shall be reviewed by the Risk Management Committee annually and updated as necessary to ensure timely initiation of investigation and completion of corrective actions related to events, claims and lawsuits.

Compliance Monitoring

QIPS staff shall monitor compliance with this protocol and report on activities and compliance with this protocol to the Executive Peer Review Committee monthly.

Compliance monitoring shall include the following:

- Percent compliance with timely reviews to be calculated as follows:
    - # open case files with completed corrective action plans within 45 days / # of open case files in that quarter
    - # new claim files with completed corrective action plans within 45 days / # new claim files in that quarter
        - NOTE: Date for these metrics will be collected 45 days after the end of the quarter to ensure accurate reporting of completed corrective actions.
- A quarterly report of cases scheduled for Executive Peer Review
- A quarterly report of cases pending Executive Peer Review (until the backlog of cases are completed).

2.76.590 Risk management protocol--Quality improvement program.

A. Purpose. The purpose of the ordinance codified in this section is to improve the delivery of medical services and reduce risks of county liability by assuring the continued maintenance of appropriate risk management and quality assurance protocols established by the department of health services relating to incidents of potential liability, claims, and lawsuits arising out of the provision of medical services.

B. Quality Improvement Program. The department of health services shall continue to maintain a quality improvement program that includes reporting, investigating, and initiating corrective action related to incidents involving potential liability, claims, and lawsuits as they arise out of the provision of medical services. Under the quality improvement program, risk management personnel shall be responsible for taking the necessary actions to ensure prompt reporting, complete investigation, and timely implementation of corrective action regarding these events.

C. Policy. It shall be the policy of the county of Los Angeles for the department of health services to:

1. Maintain a quality improvement program that continues to include the prompt reporting and investigation of incidents of potential liability, claims, and lawsuits arising out of the provision of medical services, along with recommending and ensuring the timely implementation of corrective action;
2. Create and maintain a risk management reporting form and procedure for the reporting of events involving quality, risk, safety, or personnel issues;
3. Assign risk management personnel to receive and review risk management reporting forms, review claims or lawsuits, and perform and direct appropriate responses;
4. Review and analyze, with attention to quality, risk, safety, and personnel issues, all risk management investigations, applicable third party administrator's investigations, and database information for the purpose of recommending and ensuring timely implementation of corrective action to prevent the reoccurrence of the same or similar type of event involving risk of county liability;
5. Maintain an inspection and audit division that independently verifies the implementation of corrective action;
6. Prepare a corrective action report to accompany any recommended settlement of a claim or lawsuit presented to the board of supervisors for approval where the department participates in the settlement;
7. Include in any contract with a third party administrator regarding claim and litigation management services language requiring the performance of an early investigation and report of incidents, claims, or lawsuits, and the development and maintenance of a database for tracking all reported incidents, claims, and lawsuits.

D. Implementation and Administration. The director, with the consultation and advice of the chief administrative officer and county counsel, shall prepare and issue appropriate instructions, guidelines, forms, protocols, and other documents necessary to carry out the purposes and requirements of this section with regard to the quality improvement program, and shall administer and enforce such program. The director shall include appropriate provisions to maintain confidentiality and applicable privileges relating to any information or documents which may be permitted or required by law. Copies of such instructions, guidelines, forms, protocols, and other documents, and any amendments thereto, shall be provided to all staff involved in the delivery of medical services. (Ord. 99-0030 § 1, 1999.)

COUNTY OF LOS ANGELES – HEALTH SERVICES ADMINISTRATION
QUALITY IMPROVEMENT AND PATIENT SAFETY PROGRAM

CONFIDENTIAL: The information contained in this document is privileged and strictly confidential under state law, including Evidence Code Section 1157 relating to medical professional peer review documents and Government Code Section 6254 relating to personnel records

Facilities are to complete this form and attach via e-mail to QIPS@ dhs.lacounty.gov with a copy to the facility Medical Director. If the Medical Director does not concur, he/she shall respond within 10 days via e-mail to QIPS @dhs.lacounty.gov and the Risk Manager, or designee for appropriate actions

Date *****

TO: QIPS Director

FROM: ***** (risk manager)

CC: Facility Medical Director

SUBJECT: Response to Notice of New Claim File Set up
(case name, PFN, CMS #)

- ☐ This new claim was previously identified as a sentinel event and a corrective action plan has been completed and sent to QIPS@dhs.lacounty.gov on (date_____ and PSN # _____).

- ☐ This new claim was previously identified as a non-sentinel event and a corrective action plan has been completed and sent to QIPS@dhs.lacounty.gov on (date_____ and PSN # _____).

- ☐ This new claim has been identified as a sentinel event, investigation has begun and a corrective action plan will be completed and forwarded to QIPS@dhs.lacounty.gov, using the attached template B, within 45 days of the date of the event.

- ☐ This new claim has been identified as a non-sentinel event, investigation has begun and a corrective action plan will be completed and forwarded to QIPS@dhs.lacounty.gov, using the attached template B, with 45 days of the date of the event.

- ☐ This new claim has not been previously identified as either a sentinel or non-sentinel event. Upon receipt of this notice, investigation has begun and a corrective action plan will be completed and forwarded to QIPS@dhs.lacounty.gov, using the attached template B, within 45 days of the date of the event.

ATTACHMENT B – TEMPLATE

This form shall be completed and forwarded, via e-mail attachment, to HSAQIPS as the facility's corrective action plan

CONFIDENTIAL

This information contained in the attachments is privileged and strictly confidential under state law, including Evidence Code section 1157 relating to medical professional peer review documents and Government Code section 6254 [c] relating to personnel.

MEDICAL MALPRACTICE LITIGATION REPORT

CORRECTIVE ACTION SUMMARY

Facility:
Patient:
ORS #:
PSN#:

BRIEF NARRATIVE SUMMARY:

Was event disclosed to the patient? Yes No N/A

RISK MANAGEMENT ISSUES:

	ISSUES
[ ] Systems [ ] Personnel	
[ ] Systems [ ] Personnel	
[ ] Systems [ ] Personnel	

FACILITY INVESTIGATIVE SUMMARY:

Date	Investigation (including all committee reviews and conclusions for reviews)

FACILITY CORRECTIVE ACTIONS (SYSTEMS)

Issue #	Action
	Systems issue
	Systems issue

FACILITY CORRECTIVE ACTIONS (PERSONNEL)

Personnel involved in event	Status (time of event)	Current Status	Corrective Actions Taken	Date

CONCURRENCE:

[xx] Facility has reviewed risk management issues in this case and has taken all appropriate corrective actions required.

Completed by:_____ _____**Date:**_____

Reviewed by:_____ **Date:**_____

Medical Director

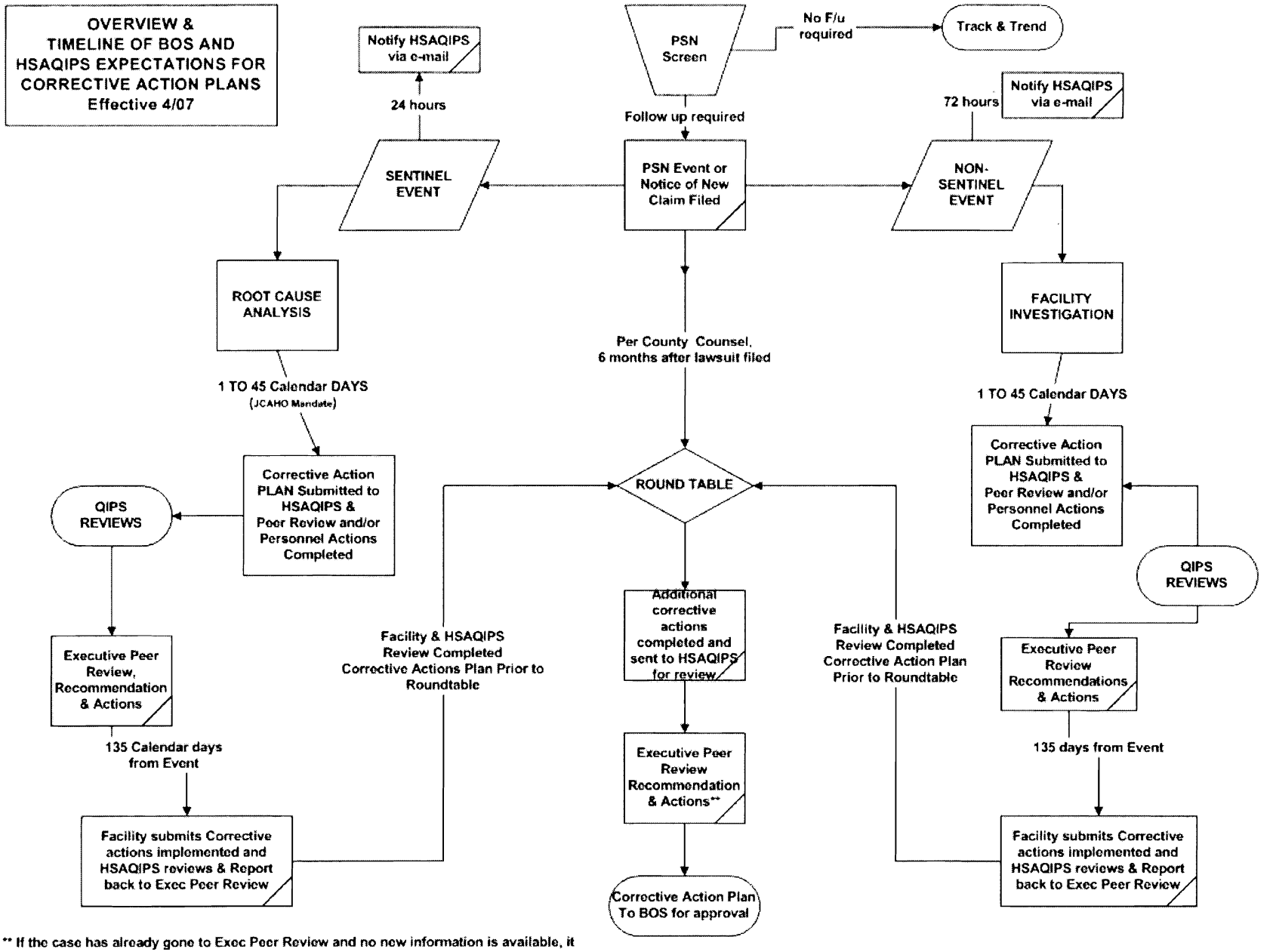
Reviewed by:_____ **Date:**_____

Hospital Administrator

Executive Peer Review

Additional Findings:

Additional Corrective Actions:



** If the case has already gone to Exec Peer Review and no new information is available, it will not have to go a second time at the time of settlement.