LAC+USC MEDICAL CENTER POLICY

Subject:	Original Issue Date:	Policy #
INVESTIGATION OF INCIDENTS INVOLVING POTENTIAL CLAIMS	11/12/13	**311**
	Supersedes: 11/12/13	Effective Date: 3/27/20

Departments Consulted:	Reviewed & Approved by:	Approved by:
Office of Risk Management Quality Improvement Medical Center Administration Medical Administration Nursing Services	Attending Staff Association Executive Committee Senior Executive Council	(Signature on File) Chief Medical Officer (Signature on File) Chief Executive Officer

PURPOSE

To establish uniform policy and procedures for prompt reporting and investigation of events or medical malpractice claims (claims) for the purpose of improving the quality of patient care and reducing the risks for county liability.

POLICY

Employees who become aware of an event involving a patient or visitor shall report it immediately to their supervisor and shall report electronically using the Safety Intelligence (SI) System. See Medical Center Policy 300 for event reporting guidelines.

Events potentially meeting criteria as a reportable adverse event (California Department of Public Health -CDPH) or sentinel events are immediately referred to the Chief Medical Officer for review.

Upon notification of a claim filed against LAC+USC, the Office of Risk Management will notify the Chief Medical Officer and establish a case file.

Adverse events, sentinel events and claims will be immediately investigated by the Office of Risk Management. Within 45 calendar days of the event or notification of new claim by the Department of Health Services (DHS), LAC+USC will complete an initial investigation and develop a corrective action plan. Initial investigations and development of corrective action plans for hospital acquired pressure ulcers will be completed within 60 calendar days.

PROCEDURE

1. Upon notification of an adverse event, sentinel event or claim, the Document Coordinator establishes an electronic case file stored in the Risk Management Shared Server.
2. The Document Coordinator enters the case on the “Case Review Timeline” for the purpose of tracking the progress of the corrective action plan.
3. A copy of the medical records is ordered from HIM and secured in the Office of Risk Management.
4. The case is assigned to an Associate Risk Manager (ARM) and the ARM initiates the investigation.
5. Investigation includes the following and is documented such as on the LAC+USC Office of Risk Management Review Activities Checklist (Attachment A):

a. Review of the relevant medical records, inclusive of the written chart and electronic systems containing documents, imaging, graphs or recordings
b. Identification of healthcare workers and witnesses involved in the care of the patient
c. Review of conclusions, findings and/or corrective actions taken as a result of quality improvement activities not related to personnel matters.
d. Interviews of pertinent staff and/or witnesses
e. Identification and review of contracts, if applicable to the care of the patient
f. Identification and review of relevant policies and procedures
g. Identification and sequestration of supplies and/or equipment relevant to the care of the patient
h. Determination as to whether or not the claim can be defended through review by subject matter experts, which may include, but are not limited to, medical faculty and nursing leadership
i. Referrals for review of current and past performance of individuals involved in the care of the patient through reviews of area personnel provided by accountable supervisors. Referral of medical staff identified as being involved in the care of the patient to the Attending Staff Office for review by the Attending Staff.
j. Any other specific reviews, such as Root Cause Analyses (RCA) of systems issues, as determined by the Director of Risk Management, Associate Medical Director, or Chief Medical Officer and Chief of Staff.

6. The ARM generates a corrective action plan (CAP) using the DHS Case Review Summary template (Attachment B) and will include the following:
    a. Brief narrative summary
    b. Facility investigation and findings
    c. Risk management issues
    d. Facility corrective actions (both system and individual)
7. The CAP is submitted to the Chief of Staff, Chief Medical Officer, Chief Nursing Officer and Chief Executive Officer for review and approval
8. The ARM sends the signed CAP to DHS Quality Improvement and Patient Safety by the designated due dates
9. The ARM secures and maintains all documents supporting the completed corrective actions in the electronic case file
10. In the event additional issues are identified during review of the CAP or the litigation process, the ARM will coordinate the development of corrective actions to address the identified issues

RESPONSIBILITY

Director of Risk Management
Associate Medical Director
Chief Medical Officer
Chief Nursing Officer
Chief Executive Officer
Attending Staff

PROCEDURE DOCUMENTATION

MC311A - LAC+USC Office of Risk Management Review Activities form (Attachment A)

REFERENCES

DHS Policy #311 – Incidents Involving Potential Claims Against the County
LAC+USC Medical Center Policy #300 - Event Notification Guidelines

ATTACHMENTS

Attachment A – LAC+USC Office of Risk Management Review Activities checklist

REVISION DATES

March 27, 2020